

The Alberta Community HIV Fund Community Planning Committees

A Needs Assessment

Prepared for
Alberta Community Council on HIV
by



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ACHF Community Planning Committees: A Needs Assessment

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ACHF Community Planning Committees: A Needs Assessment

Executive Summary

Background

The Alberta Community HIV Fund (ACHF) is a unique joint community/provincial/federal fund disbursement model developed through consultation with representatives from Alberta community-based HIV organizations, persons living with HIV/AIDS, the regional health authorities and provincial and federal health departments.¹ The unique fund, administered by the Alberta Community Council on HIV (ACCH), includes consultation with community planning committees (CPCs) in the various regions of the province during periodic calls for funding proposals.

A recent evaluation of the ACHF funding model included a call to critically examine the role of CPCs, among other recommendations. *Midbo Consulting* was contracted by ACCH to conduct a needs assessment focused on CPCs and their major roles. The assessment intends to: (1) identify current/future stakeholders in HIV programming, and (2) identify CPC support needs regarding strengthening their ability to fulfill key roles.

Methodology

The assessment used a qualitative approach, collecting information through telephone interviews from key stakeholders in the province's CPCs. Questions were asked concerning CPC roles and needed supports, structure, membership, and local challenges.

CPCs—at-a-Glance

CPCs have been aligned with Alberta's regional health authorities (RHAs). There are nine RHAs and ten related CPCs in the province. This report assembles regional environmental data along with information about each CPC's structure and membership with the exception of *Aspen Regional HIV Consortium*, as its representatives could not be reached during the course of the study.

¹ Alberta Community Council on HIV. (May, 2006). *Request for Proposals: Capacity Development Initiative with Alberta Community HIV Fund Community Planning Committees.*

Findings

Fifteen individuals from nine CPCs completed interviews. Responses to each question were grouped together into primary and/or secondary themes as appropriate. In brief, the needs assessment found that:

- Almost all CPCs meet predominantly to review (in past years) ACHF project and (currently) operational proposals.
- Most CPCs (or what appears to be the use of the “CPC” descriptor) trace their inception back as far as the introduction of ACHF and its associated funding-related activities.
- CPCs associated with larger consortia, and with longer histories, demonstrate a wider range of HIV/AIDS – related activities.
- Most CPCs report having lost track of, never having, or not using existing terms of reference. It appears that the majority of CPCs are essentially governed by what they are expected to do in relation to the review of ACHF-related proposals.
- All CPCs are HIV/AIDS-focused, and in most cases, further focused on the review of funding proposals. Respondents spoke about a wider range of current, potential, or desired initiatives – beyond the proposal.
- Representation by persons living with HIV in CPC membership, while valued, has been absent from many CPCs due to a lack of individuals or a lack of connection between the CPC and local communities.
- Many respondents referred to significant growth in their communities and regions, and touched on associated challenges and problems including increased demand for services, time constraints, and needs of workers.
- Several respondents commented about lack of energy and fatigue associated with the HIV/AIDS cause – around their CPC and/or consortia tables – and in communities at large, despite enduring stigma and general ignorance about the disease.
- A number of respondents spoke of the pressures associated with expecting their partnering agencies to shoulder the HIV/AIDS work associated with CPCs.
- Generally, respondents felt that their CPCs and/or associated coalitions were not as effective as they could be. There were also concerns about fluctuating

or collapsing involvement levels. Some respondents, however, were satisfied and pleased with their CPC's effectiveness and involvement levels.

- Concerning improving CPC size and/or effectiveness, the most-mentioned support is some type of funding to CPCs that will allow them to either cover participation costs or hire staff to assist in coordinating their activities. The second-most mentioned support includes skills building, training, and orientation activities related to CPC operation. Other supports mentioned include the ability to increase internal and external communications relative to CPC activity.
- The majority of respondents perceive their CPCs as performing well in collaboratively identifying needs and priorities related to HIV in their communities and regions. Respondents again stress the need for more effective communication – this time about the importance of CPCs as well as what they do. Respondents mention difficulties in examining rural and larger regional priorities, given the fact that many CPCs are dominated by urban-based organizations. Respondents also commented on CPC ability to determine priorities, but suggested that the means to respond is insufficient.
- Approximately half of respondents perceive their CPCs as performing well in using a community based intersectoral approach to HIV work. Several are very satisfied with CPC ability here. Respondents stress the need for partnering organizations to be encouraged and empowered to embrace a larger portion of the work involved in HIV/AIDS generally. Leadership is mentioned again, this time in the context of what stakeholders are able to directly contribute to the stakeholder group.
- Respondents are split over whether their CPC is experienced (and able) or inexperienced (and less able) in the review of funding proposals.
- Respondents are remarkably diverse in their responses as to how CPCs can increase community networking ability. The only agreement seems to be that CPCs could use some type of activity, improvement or clarification in this area.

Recommendations

Five specific recommendations to ACHF for action going forward emerged from the data collection and analysis associated with this needs assessment. The recommendations are presented in order of priority, beginning with the highest priority:

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- *Investigate impacts of the economic boom on HIV/AIDS in Alberta*
Goal: to strengthen and protect the HIV/AIDS infrastructure during times of rapid change, while addressing emerging HIV/AIDS priorities related to rapid economic growth.
- *Re-establish a shared understanding of the CPC's purpose*
Goal: to clarify the role(s) CPCs will play in the next few years.
- *Convene a community leadership forum*
Goal: to invigorate and establish ongoing leadership tradition and expectation with respect to HIV/AIDS in Alberta's communities and regions.
- *Provide funds for CPC use*
Goal: to maximize CPC input into operational reviews.
- *Provide structured ACHF operational review orientation*
Goal: to maximize CPC input into operational reviews.

Each of these recommendations, further elaborated in the report, is seen as needed and achievable – most importantly by the respondents who raised the related needs.

Background

Alberta Community HIV Fund²

The Alberta Community HIV Fund (ACHF) is a unique joint community/provincial/federal fund disbursement model developed through consultation with representatives from Alberta community-based HIV organizations, persons living with HIV/AIDS, the regional health authorities and provincial and federal health departments. ACHF provides funding to community organizations to support HIV prevention and care and support activities. ACHF is administered by the Alberta Community Council on HIV (ACCH), a partnership of fourteen non-profit, community-based HIV organizations who come together to present a unified provincial voice on common HIV issues, provide training opportunities, and participate in community and organizational development.

Evaluation of the ACHF

In 2005, a consultant completed an independent review and evaluation of the Alberta Community HIV Funding model. The report included a critical examination of the role of community planning committees (CPCs) and recommendations to strengthen this particular component of the funding model.³

The ten CPCs located throughout Alberta provide a coordinated and collaborative approach to the delivery of HIV programming and projects in rural and urban communities in Alberta. As part of the ACHF model, CPCs promote community engagement and encourage stakeholder involvement and partnerships related to HIV/AIDS. The ACHF draft terms of reference for CPCs suggest the following tasks or roles for CPCs⁴:

- use available data to collaboratively identify needs and priorities and use a community based intersectoral (multi-agency/multi-disciplinary) approach to HIV prevention, health promotion for people living with HIV, harm reduction and the management of related activities;
- oversee the review and response to community agency proposals submitted to the Alberta Community HIV Fund for HIV prevention, health promotion

² Alberta Community Council on HIV. (May, 2006). *Request for Proposals: Capacity Development Initiative with Alberta Community HIV Fund Community Planning Committees.*

³ Ibid.

⁴ Ibid.

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for people living with HIV, harm reduction and the management of related activities; and

- increase community networking among agencies, individuals, families and caregivers as it relates to HIV programming and project activities.

CPCs are diverse in terms of structure/organization, expertise/skill level and overall focus. Membership may be drawn from local AIDS service organizations (ASOs), community-based organizations (CBOs), representatives from the regional health authority (RHA) of the area served, and individuals who are representative of populations and sub-populations reflecting the local incidence of HIV or those at risk.⁵

Some CPCs are highly organized groups with a clear mandate of HIV; others function through or as part of pre-existing groups/coalitions dealing with a broad range of health/social issues. Some CPCs may limit their work to providing a local review of and feedback on community proposals prior to formal review by the ACHF Provincial Population Health Consortium. The details regarding the form and extent of a CPC's work vary by CPC, based on local context and community dynamics.⁶

Strengths of CPCs

ACHF has, over time, identified several CPC-related strengths. CPCs have acted as a source of information for community-based organizations regarding ACHF funding processes, and provided structured information when reviewing community proposals for the ACHF Provincial Population Health Consortium. They've also assisted in identifying community needs by facilitating community interaction between projects and local ASOs.⁷

Challenges Encountered by CPCs

ACHF has also, over time, identified several CPC-related challenges. CPCs have experienced numerous challenges including lack of local input on HIV needs, issues and priorities, and limited participation or input from population specific reviewers/specialists. In some situations, CPCs may have experienced a lack of local leadership if their work is not directly related to the mandate, priorities and interests of other community agencies. Some CPCs have noted a lack of time and

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

resources to define and strengthen their group, including issues related to recruiting, training and supporting members on an ongoing basis. ASOs and some CPCs have expressed concerns about the burden of expectations placed upon volunteers, such as the time required to review proposals.⁸

Some CPCs have existed in a context where political dynamics pose challenges in terms of their ability to maintain and/or develop ongoing relationships with partner organizations, such as ASOs and CBOs. Some CPC members have also noted challenges using surveillance data to guide their work, and a lack of familiarity with the work, issues and populations served in other parts of the province.⁹

Recommendations to Improve the CPC Role

The recent ACHF evaluation recommended¹⁰:

- clarifying the responsibility for ensuring that local CPCs are operating effectively
- establishing localized training to ensure that CPC members are familiar with their roles and responsibilities, and
- providing additional resources to recruit and retain members as necessary.

The recent evaluation final report includes the following detail¹¹:

Critically Examine the Role of CPCs

The importance of encouraging community stakeholder involvement, of hearing the “community voice” and building buy-in for local HIV/AIDS work was seen as potential contributions of CPCs. This aspect of the ACHF model has also promoted the development of community partnerships and capacity-building in other organizations to engage in HIV/AIDS-related work. When CPCs are working effectively they can help to identify community needs, they can provide information to help review proposals more thoroughly and screen proposals before submitting to the PC, they can act as a useful source of information for organizations on the projects and operational funding processes, and serve to facilitate community interaction between projects and the local ASO. In some communities, however, CPCs were generally assessed as falling short of their potential role; in these communities there is limited community involvement in

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Broadview Applied Research Group Inc. (October, 2005). *The Alberta Community HIV Fund: An Independent Review and Evaluation of the Funding Model (Final Report)*.

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CPCs, limited representation of community members and a lack of understanding of their roles and responsibilities. Further, ASO staff reported feeling responsible for recruiting and retaining CPC members, supporting the activities of the CPC and ensuring that it performs the functions expected of it in the funding model. Clarifying the responsibility for ensuring that local CPCs are operating effectively, establishing localized training to ensure that CPC members are familiar with their roles and responsibilities and providing additional resources to recruit and retain members appears necessary. Considering alternative structures to “hear the community voice” and build buy-in for local HIV/AIDS work should also be examined. This could include using a model similar to that of the PC could be used by having external “experts” review project proposals or shifting the CPC role from proposal review to more of a visioning and guiding role for HIV programs and services in their respective communities. (pp. viii-ix)

Needs Assessment Focus¹²

The needs assessment is intended to: (1) identify current/future stakeholders in HIV programming, and (2) identify CPC support needs regarding strengthening their ability to fulfill key roles.

In this context, key CPC roles are taken to be to:

- collaboratively identify HIV-related needs and priorities
- use a community-based intersectoral (multi-agency/multi-disciplinary) approach to HIV work
- oversee the review and response to community agency proposals (see note¹³)
- increase community networking related to HIV initiatives.

Interview questions are focused and framed by these concepts.

Methodology

This assessment was completed using a qualitative research approach. The type of sampling included aspects of *criterion*, *convenience*, and *opportunistic* methods. The intent was to collect data from two individuals in each of the ten CPCs. One of the individuals to be interviewed was a representative of an ACHF

¹² Alberta Community Council on HIV. (May, 2006). *Request for Proposals: Capacity Development Initiative with Alberta Community HIV Fund Community Planning Committees*.

¹³ This role has changed given the changes in project and operational funding streams, and will be acknowledged as having a different emphasis.

operationally funded organization in the area. The other was to be an individual with CPC experience from another organization. Most of the respondents, then, were known to the needs assessment working group, and were already listed as key contacts.

The consultant collected data through semi-structured telephone interviews that were simultaneously transcribed. Interview participants were given an opportunity to review and revise the resulting transcript if desired/required. Lists of current CPC stakeholders and potential CPC stakeholders were sent by email from one of the two respondents in the CPC region.

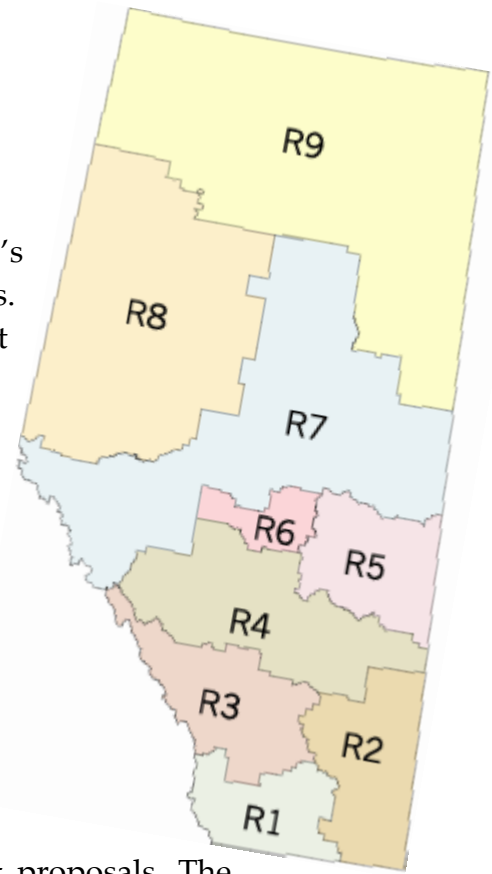
Interview Questions

- (1) *(a) Please identify your CPC's current stakeholders. (b) Please identify possible or likely future stakeholders for participation in your CPC. (c) Do you have terms of reference for your CPC? (d) How many times have you met in the past year or so? (e) Does your CPC have sub-committees? (f) What is the major focus for your CPC? (g) Is there HIV representation on your CPC?*
- (2) *Are there elements about your local context and community dynamics that specifically affect your CPC's ability to function?*
- (3) *Please comment on your stakeholder group's involvement and effectiveness.*
- (4) *What support, if any, is needed to improve your stakeholder group's size and/or effectiveness?*
- (5) *What support, if any, is needed to improve your CPC's ability to collaboratively identify local and regional HIV-related needs and priorities?*
- (6) *What support, if any, is needed to improve your CPC's ability to use a community based intersectoral (multi-agency/multi-disciplinary) approach to HIV work?*
- (7) *What support, if any, is needed to improve your CPC's ability to oversee the review and response to ASO operational proposals?*
- (8) *What support, if any, is needed to improve your CPC's ability to increase community networking related to HIV initiatives?*

CPCs—at—a—Glance

CPCs and Regional Health Authorities (RHAs)

CPCs have, over time, been aligned with Alberta's specific geographic regional health authorities. There are nine RHAs in the province (pictured at right¹⁴); there are ten ACHF-related CPCs in the province. The *Edmonton Regional HIV Consortium* is linked to two RHAs. Further, both *Aspen Regional HIV Consortium* and *Jasper Community Team* are linked to the same RHA, as are *Bow Valley HIV Advisory Team* and *Calgary Coalition on HIV and AIDS*.



CPCs have access to regional information from their stakeholders and others. Alberta's nine RHAs are able to provide demographic and other data of use to CPCs in planning, coordinating, and evaluating funding proposals. The Alberta Community HIV Fund partners provide quantitative regional environmental data from a number of sources in their funding criteria (included below).¹⁵

Information provided by respondents to the needs assessment (i.e. current and possible future stakeholders, brief CPC descriptions) is also included below, along with detailed RHA maps illustrating the geographic areas that individual CPCs find themselves linked with.

Provincial Organizations

There are two ACHF-funded organizations that are designated "provincial." Provincial organizations must meet certain criteria: (1) a province-wide membership; (2) a board of directors comprised of individuals from across the

¹⁴ Alberta Government. Available at http://www.health.gov.ab.ca/regions/RHA_map.html. Accessed September 5, 2006.

¹⁵ Alberta Community HIV Fund Provincial Consortium. *ACHF – Funding 2006 Criteria for Funding Operational Organizations*. Available at: http://www.acch.ca/pdf/2006_app_F.pdf. Accessed September 5, 2006.

province; and (3) provision of program activities in 70% or more of the province's health regions. CPCs across the province are expected to review operational funding proposals from these organizations, along with the applications from their own regional organizations.

Currently, two provincial organizations receive ACHF operational funding in Alberta. *Alberta Community Council on HIV (ACCH)* provides programming, supports, and leadership to its membership – comprised of ACHF operationally-funded regional organizations in Alberta. Of specific interest to this assessment is the organization's stewardship of the ACHF. *Kimamow Atoskanow Foundation*, located in Onoway Alberta, provides provincial programming to Aboriginal people in urban and non-urban areas. Consideration of individual CPC/health region descriptions below should occur with awareness of connections between each CPC and their regional organizations, as well as the provincial organizations mentioned.

Lethbridge HIV/HCV¹⁶ Community Consortium
Chinook Regional Health Authority (Region 1)



Alberta Government Picture¹⁷

(note: lack of image focus and clarity is present in the source original and not related to image use here)
Population: 153,732¹⁸

Operationally Funded AIDS Service Organization(s)

Lethbridge HIV Connection

Regional Environmental Data¹⁹

- 4.82% of Alberta's population
Alberta Health and Wellness Population Registry File (March 31, 2004)
- 3.93% of Alberta's land area
Alberta Health and Wellness (April 1, 2003)
- 2.02% of HIV diagnosis in Alberta

¹⁶ Hepatitis C Virus

¹⁷ Alberta Government. Available at http://www.health.gov.ab.ca/regions/map_01.gif. Accessed August 29, 2006.

¹⁸ Alberta Government. Population registry file (March 31, 2004). Available at http://www.health.gov.ab.ca/regions/RHA_comm1.html. Accessed August 29, 2006.

¹⁹ Alberta Community HIV Fund Provincial Consortium. *ACHF – Funding 2006 Criteria for Funding Operational Organizations*. Available at: http://www.acch.ca/pdf/2006_app_F.pdf. Accessed September 5, 2006.

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- As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 1.87% HIV prevalence
 - Based on number of persons in Alberta accessing Southern and Northern Alberta Clinics (2005)
- 8.81% of persons self identifying as Aboriginal
 - According to census data by region (2001)
- 3.88% of STI diagnosis in Alberta
 - As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 4.90% of incarcerated persons in Alberta
 - According to Alberta Justice (Provincial, Youth, Remand – average numbers at month end first half of 2005; CSC number of offenders 2002, 2003, 2004)
- 5.03% of Alberta's population under 30 years of age
 - According to Alberta Health and Wellness (mid-year by new region, May 14, 2003)
- 2.97% of Hepatitis C diagnosis in Alberta
 - As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 1.71% of newcomers to Canada in Alberta
- 4.72% of population in private households with low income in Alberta

Regional Community Planning Committee

The Lethbridge HIV/HCV Community Consortium is a sub-committee of a well-structured and focused Community Harm Reduction Network that aims to provide coordinated, collaborative population health approaches to the delivery of harm reduction services within the Chinook Health Region. Various sub-committees may be developed to respond to needs as identified by the Network.²⁰

A standing sub-committee is formed each year (The Lethbridge HIV/HCV Community Consortium – the specific ACHF-focused CPC) to review project proposals submitted for ACHF funding. This committee is a requirement of ACHF and is chaired by the Chinook Health Region, Sexual Health Manager and the Lethbridge HIV Connection Executive Director. The CPC does not include stakeholders from the Network who are seeking funding in the current period/year.

The Lethbridge HIV/HCV Community Consortium appears to share some similarities with The Jasper Community Team (one of the two CPCs in Aspen Regional Health Authority (region 7)). They, as with the Jasper team, are a larger and quite structured health-related consortium (though focused on HIV and HCV, and harm reduction generally) that can provide valuable input into HIV-related priority setting and planning activities. As with The Jasper Community Team, The Lethbridge Consortium handles ACHF proposal reviews through a sub-committee.

²⁰ Community "Harm Reduction" Network. *Terms of Reference*. Available from network members.

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Current CPC Stakeholders²¹

Alberta Alcohol and Drug Abuse Commission (AADAC) (Lethbridge)
Chinook Health Region
Community and Social Development Group, City of Lethbridge (about to join)
Lethbridge HIV Connection
Lethbridge Family Services
School of Health Sciences, University of Lethbridge

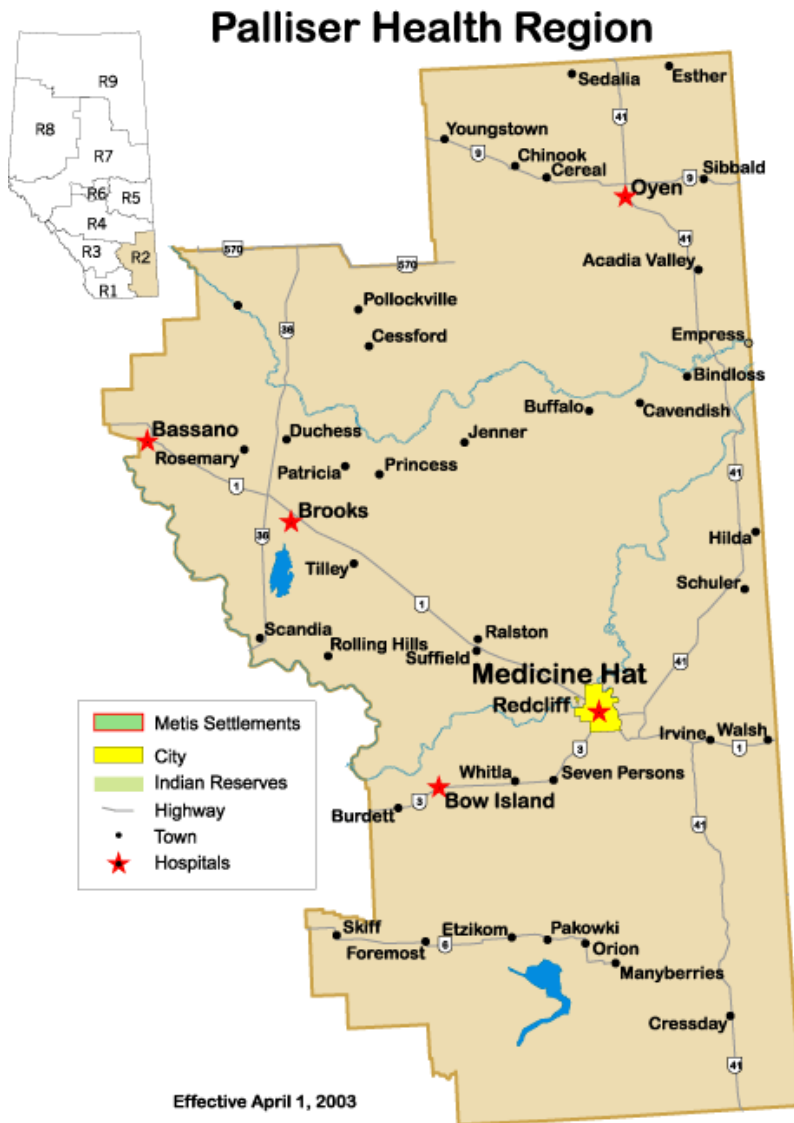
Desired Additional Stakeholders

A new Aboriginal organization
A youth outreach group

²¹ The term "stakeholder" and "member" are synonymous in this document when describing organizations and individuals comprising CPC membership.

H5 Virtual Advisory Committee

Palliser Health Region (Region 2)



Alberta Government Picture ²²
Population: 99,450²³

Operationally Funded AIDS Service Organization(s)

HIV/AIDS Network of South Eastern Alberta Association (HANSEAA)
(Medicine Hat)

²² Alberta Government. Available at http://www.health.gov.ab.ca/regions/map_02.gif. Accessed August 29, 2006.

²³ Alberta Government. Population registry file (March 31, 2004). Available at http://www.health.gov.ab.ca/regions/RHA_comm2.html. Accessed August 29, 2006.

Regional Environmental Data²⁴

- 3.14% of Alberta's population
Alberta Health and Wellness Population Registry File (March 31, 2004)
- 6.00% of Alberta's land area
Alberta Health and Wellness (April 1, 2003)
- 3.83% of HIV diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 2.57% HIV prevalence
Based on number of persons in Alberta accessing Southern and Northern Alberta Clinics (2005)
- 0.75% of persons self identifying as Aboriginal
According to census data by region (2001)
- 2.30% of STI diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 1.77% of incarcerated persons in Alberta
According to Alberta Justice (Provincial, Youth, Remand – average numbers at month end first half of 2005; CSC number of offenders 2002, 2003, 2004)
- 3.18% of Alberta's population under 30 years of age
According to Alberta Health and Wellness (mid-year by new region, May 14, 2003)
- 2.00% of Hepatitis C diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 0.90% of newcomers to Canada in Alberta
- 2.82% of population in private households with low income in Alberta

Regional Community Planning Committee

H5 Virtual Advisory Committee has been in existence between three and four years. It is HIV/AIDS focused, and includes sub-committee(s) (e.g. client support and harm reduction committee). As in some other communities, staff turnover, inadequate record keeping, and loss of organizational history has made it challenging for current staff to move forward with CPC initiatives – and understanding. However, the committee has a strong group of stakeholders, and others who are not employed by the ASO in positions of leadership.

Current CPC Stakeholders:

HIV/AIDS Network of South Eastern Alberta Association
Human Resources and Employment Canada
John Howard Society (Medicine Hat)
Mywasin Aboriginal Services
Sexual Health, Palliser Health Authority
Positive Culture Company²⁵

²⁴ Alberta Community HIV Fund Provincial Consortium. *ACHF – Funding 2006 Criteria for Funding Operational Organizations*. Available at: http://www.acch.ca/pdf/2006_app_F.pdf. Accessed September 5, 2006.

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Sexual Abuse Recovery Committee (Medicine Hat)

1 individual: retired sexual health nurse

Desired Additional Stakeholders:

A physician

People living with HIV and/or HCV

²⁵ A consultant involved in, among other things, initiatives related to HIV/AIDS.

Bow Valley HIV Advisory Team (HAT)

Calgary Health Region (Region 3)



Alberta Government Picture²⁶
Population: 1,143,194²⁷

Operationally Funded AIDS Service Organizations

Associated with the Bow Valley HIV Advisory Team

AIDS Bow Valley (Banff)

Regional Environmental Data²⁸

Environmental data describes region 3 in its entirety, though there are two CPCs in the region providing services in distinctly different circumstances.

²⁶ Alberta Government. Available at http://www.health.gov.ab.ca/regions/map_03.gif. Accessed August 29, 2006.

²⁷ Alberta Government. Population registry file (March 31, 2004). Available at http://www.health.gov.ab.ca/regions/RHA_comm3.html. Accessed August 29, 2006.

²⁸ Alberta Community HIV Fund Provincial Consortium. *ACHF – Funding 2006 Criteria for Funding Operational Organizations*. Available at: http://www.acch.ca/pdf/2006_app_F.pdf. Accessed September 5, 2006.

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- 36.29% of Alberta's population
Alberta Health and Wellness Population Registry File (March 31, 2004)
- 5.95% of Alberta's land area
Alberta Health and Wellness (April 1, 2003)
- 38.91% of HIV diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 41.41% HIV prevalence
Based on number of persons in Alberta accessing Southern and Northern Alberta Clinics (2005)
- 15.71% of persons self identifying as Aboriginal
According to census data by region (2001)
- 32.78% of STI diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 21.56% of incarcerated persons in Alberta
According to Alberta Justice (Provincial, Youth, Remand – average numbers at month end first half of 2005; CSC number of offenders 2002, 2003, 2004)
- 35.34% of Alberta's population under 30 years of age
According to Alberta Health and Wellness (mid-year by new region, May 14, 2003)
- 34.56% of Hepatitis C diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 51.01% of newcomers to Canada in Alberta
- 35.51% of population in private households with low income in Alberta

Regional Community Planning Committee

Bow Valley HIV Advisory Team, one of two CPCs in Region 3, has operated since 2000. The CPC focuses its work in the western part of the region. It is HIV-related and focused on proposal reviews. In fact, the CPC meets only to review funding proposals related to ACHF. The Bow Valley Team is unique in the sense that the individuals involved are all “very, very” used to doing committee work and working together due to the nature of the region. A regional expectation and style ensures that unless there is a really concrete purpose for meeting, a meeting won't be called.

Current CPC Stakeholders:

AADAC (Canmore)
AIDS Bow Valley (Banff)
Calgary Health Region (Canmore)
FCSS (Canmore)
Town of Banff Community Services

Desired Additional Stakeholders:

Human resource employee(s) from local employers, particularly hotels or related service industry businesses.

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A physician from Banff, Canmore, or Lake Louise.

Representation from Lake Louise, Kananaskis, or Morley.

Representation from ASO target populations.

Calgary Coalition on HIV and AIDS (CCHA)

Calgary Health Region (Region 3)



Alberta Government Picture²⁹
Population: 1,143,194³⁰

Operationally Funded AIDS Service Organization(s)

AIDS Calgary Awareness Association

The Society Housing AIDS/HIV Restricted Persons (SHARP) Foundation

Safeworks, Calgary Health Region

²⁹ Alberta Government. Available at http://www.health.gov.ab.ca/regions/map_03.gif. Accessed August 29, 2006.

³⁰ Alberta Government. Population registry file (March 31, 2004). Available at http://www.health.gov.ab.ca/regions/RHA_comm3.html. Accessed August 29, 2006.

Regional Environmental Data³¹

Environmental data describes region 3 in its entirety, though there are two CPCs in the region providing services in distinctly different circumstances.

36.29% of Alberta's population

Alberta Health and Wellness Population Registry File (March 31, 2004)

5.95% of Alberta's land area

Alberta Health and Wellness (April 1, 2003)

38.91% of HIV diagnosis in Alberta

As reported to Alberta Health and Wellness (2003, 2004, 2005)

41.41% HIV prevalence

Based on number of persons in Alberta accessing Southern and Northern Alberta Clinics (2005)

15.71% of persons self identifying as Aboriginal

According to census data by region (2001)

32.78% of STI diagnosis in Alberta

As reported to Alberta Health and Wellness (2003, 2004, 2005)

21.56% of incarcerated persons in Alberta

According to Alberta Justice (Provincial, Youth, Remand – average numbers at month end first half of 2005; CSC number of offenders 2002, 2003, 2004)

35.34% of Alberta's population under 30 years of age

According to Alberta Health and Wellness (mid-year by new region, May 14, 2003)

34.56% of Hepatitis C diagnosis in Alberta

As reported to Alberta Health and Wellness (2003, 2004, 2005)

51.01% of newcomers to Canada in Alberta

35.51% of population in private households with low income in Alberta

Regional Community Planning Committee

Calgary Coalition on HIV and AIDS has been working as a community-driven coalition since approximately 1986. CCHA consists of a steering committee (which acts as the ACHF-related CPC) and four (currently) working groups – youth; care, treatment and support; prevention; and Aboriginal (not currently active). CCHA's major focus is HIV/AIDS related.

Current CPC Stakeholders:

AIDS Calgary (3 people)

Calgary Birth Control Association (2 people)

Canadian Red Cross (representing the Aboriginal community)

Safeworks Calgary, Calgary Health Region

SHARP Foundation

Southern Alberta Clinic, Calgary Health Region

³¹ Alberta Community HIV Fund Provincial Consortium. *ACHF – Funding 2006 Criteria for Funding Operational Organizations*. Available at: http://www.acch.ca/pdf/2006_app_F.pdf. Accessed September 5, 2006.

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3 individuals: 2 persons living with HIV (MSM community); 1 person (youth community)

Desired Additional Stakeholders:

People living with HIV outside the MSM³² community

People involved with injecting drugs or sex work

Representation from countries where HIV is endemic (e.g. immigrant populations)

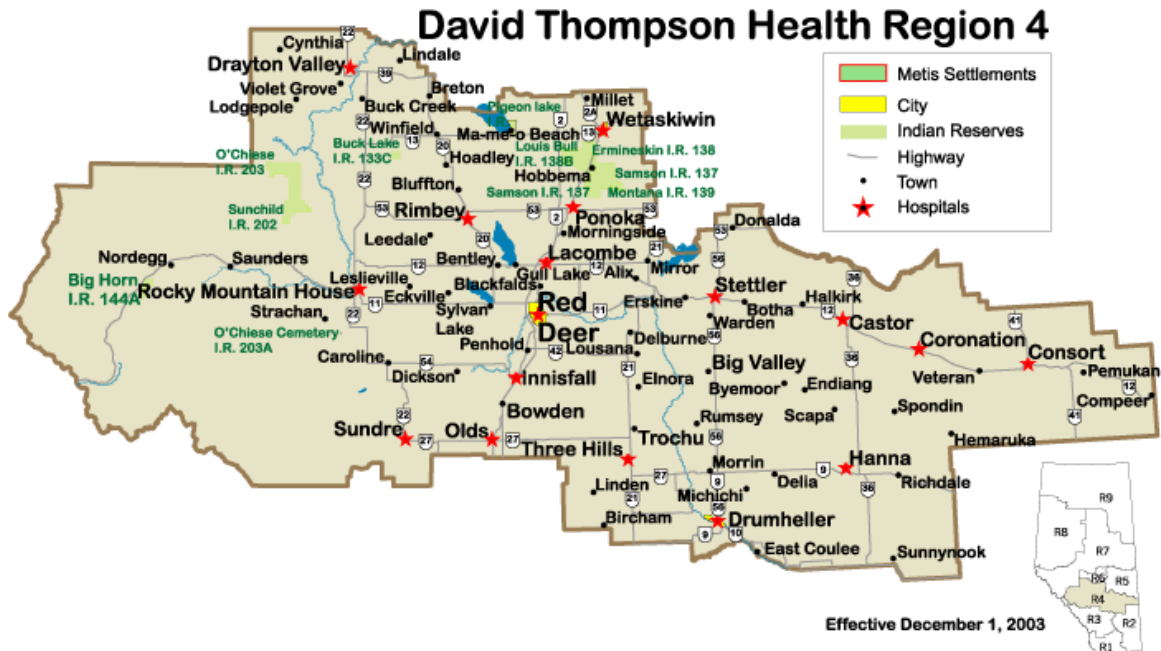
Regional mental health organization(s)

Representation from gay and/or lesbian support groups

³² Men having sex with men.

Central Alberta

David Thompson Regional Health Authority (Region 4)



Alberta Government Picture³³
Population: 290,176³⁴

Operationally Funded AIDS Service Organization(s)

Central Alberta AIDS Network Society (CAANS) (Red Deer)

Regional Environmental Data³⁵

- 9.13% of Alberta's population
Alberta Health and Wellness Population Registry File (March 31, 2004)
- 9.28% of Alberta's land area
Alberta Health and Wellness (April 1, 2003)
- 2.22% of HIV diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 3.75% HIV prevalence
Based on number of persons in Alberta accessing Southern and Northern Alberta Clinics (2005)
- 11.91% of persons self identifying as Aboriginal
According to census data by region (2001)

³³ Alberta Government. Available at http://www.health.gov.ab.ca/regions/map_04.gif. Accessed August 29, 2006.

³⁴ Alberta Government. Population registry file (March 31, 2004). Available at http://www.health.gov.ab.ca/regions/RHA_comm4.html. Accessed August 29, 2006.

³⁵ Alberta Community HIV Fund Provincial Consortium. *ACHF - Funding 2006 Criteria for Funding Operational Organizations*. Available at: http://www.acch.ca/pdf/2006_app_F.pdf. Accessed September 5, 2006.

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- 8.58% of STI diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 31.87% of incarcerated persons in Alberta
According to Alberta Justice (Provincial, Youth, Remand – average numbers at month end first half of 2005; CSC number of offenders 2002, 2003, 2004)
- 9.35% of Alberta's population under 30 years of age
According to Alberta Health and Wellness (mid-year by new region, May 14, 2003)
- 10.94% of Hepatitis C diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 2.07% of newcomers to Canada in Alberta
- 7.53% of population in private households with low income in Alberta

Regional Community Planning Committee

Central Alberta CPC does not meet in person – it is a virtual group. It is primarily HIV-focused. The CPC has been in existence for about eight years. The large list of stakeholders is linked to the virtual nature of the group, and the fact that people are brought into specific tasks as the need arises (and as their expertise is needed).

Current CPC Stakeholders:

For full CAANS operational and provincial operational:

Central Alberta AIDS Network Society
Social Planning, City of Red Deer
Medical Officer of Health, David Thompson Health Region
Social Work Faculty, Red Deer College

For health promotion fund approach:

Bowden Institution
Health Networks (Red Deer city-based; brings agencies together who work in health to share information.)
Residential Society of Red Deer

For harm reduction fund approach:

AADAC (Red Deer)
Public Health, David Thompson Health Region
Red Deer Family Services
An individual who is a drug user

For supporting community based organizations fund approach:

People's Place Shelter (Red Deer) (homeless shelter)
Volunteer Department, Red Deer Regional Hospital
An individual who is a CAANS Volunteer

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For creating supportive environments fund approach:

Red Deer and District Community Foundation

An individual who is a community member, a former CAANS staff (10+ years ago)

Other representation as needed:

Regional Mental Health, David Thompson Health Region

Public Health, David Thompson Health Region

Sexual Health, David Thompson Health Region

Red Deer Remand Centre

Safe Harbour (Red Deer detox/mat program)

Desired Additional Stakeholders:

Organization(s) working with the immigrant population

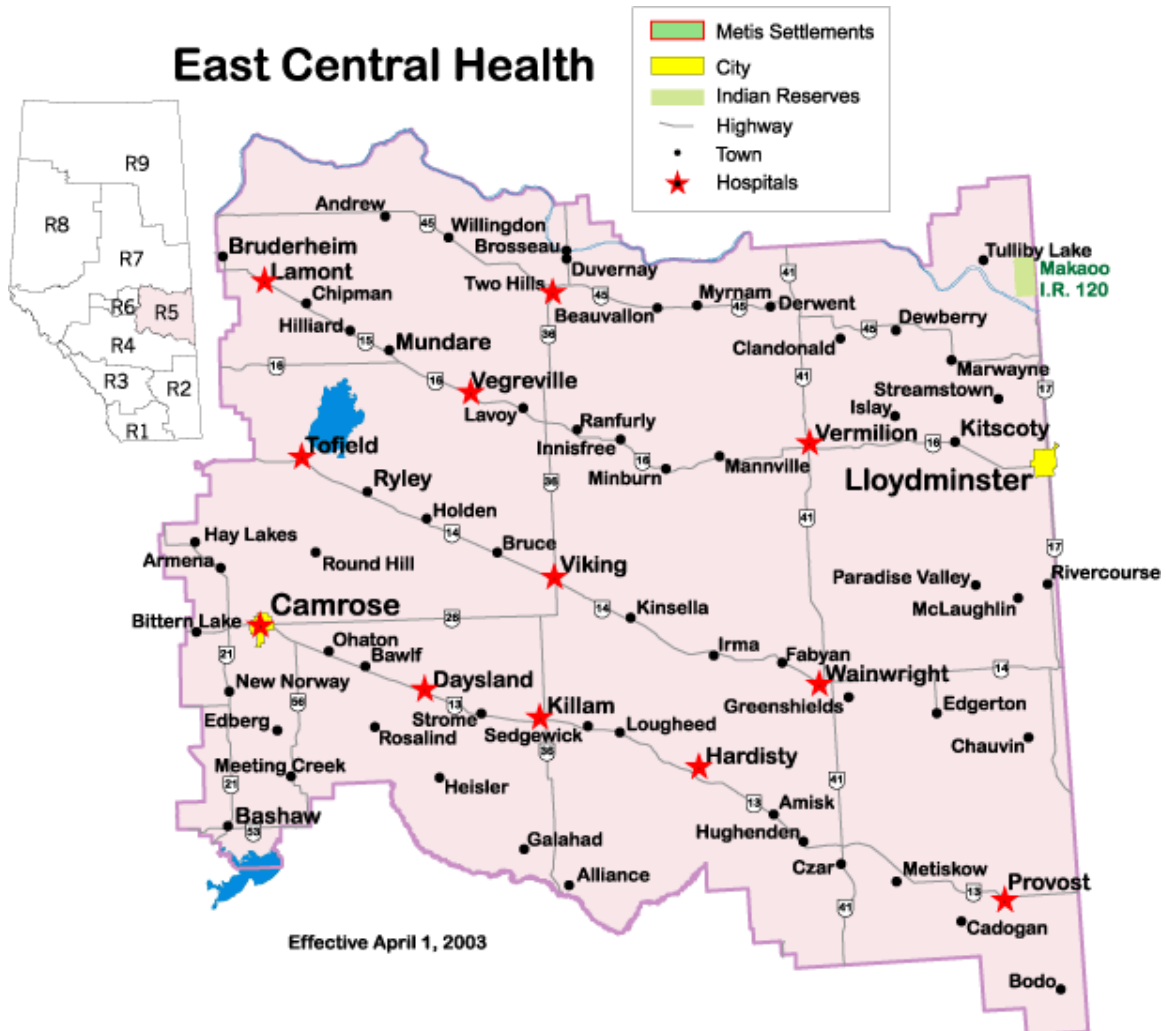
For profit businesses or nonprofits that represent business

Other regional mental health organization(s)

Edmonton Regional HIV Consortium

East Central Health (Region 5)

Capital Health (Region 6)



Alberta Government Picture ³⁶
Population: 108,659³⁷

Operationally Funded AIDS Service Organization(s)

There are no ACHF operationally funded AIDS Service Organizations located in region 5.

³⁶ Alberta Government. Available at http://www.health.gov.ab.ca/regions/map_05.gif. Accessed August 29, 2006.

³⁷ Alberta Government. Population registry file (March 31, 2004). Available at http://www.health.gov.ab.ca/regions/RHA_comm5.html. Accessed August 29, 2006.

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Regional Environmental Data³⁸

- 3.44% of Alberta's population
Alberta Health and Wellness Population Registry File (March 31, 2004)
- 5.10% of Alberta's land area
Alberta Health and Wellness (April 1, 2003)
- 0.60% of HIV diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 1.34% HIV prevalence
Based on number of persons in Alberta accessing Southern and Northern Alberta Clinics (2005)
- 1.07% of persons self identifying as Aboriginal
According to census data by region (2001)
- 1.97% of STI diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 0.00% of incarcerated persons in Alberta
According to Alberta Justice (Provincial, Youth, Remand – average numbers at month end first half of 2005; CSC number of offenders 2002, 2003, 2004)
- 3.25% of Alberta's population under 30 years of age
According to Alberta Health and Wellness (mid-year by new region, May 14, 2003)
- 1.69% of Hepatitis C diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 0.47% of newcomers to Canada in Alberta
- 2.72% of population in private households with low income in Alberta

Regional Community Planning Committee

The *Edmonton Regional HIV Consortium* is the CPC for regions 5 and 6. See below for a description.

³⁸ Alberta Community HIV Fund Provincial Consortium. *ACHF – Funding 2006 Criteria for Funding Operational Organizations*. Available at: http://www.acch.ca/pdf/2006_app_F.pdf. Accessed September 5, 2006.

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42.32% HIV prevalence

Based on number of persons in Alberta accessing Southern and Northern Alberta Clinics (2005)

17.77% of persons self identifying as Aboriginal

According to census data by region (2001)

35.35% of STI diagnosis in Alberta

As reported to Alberta Health and Wellness (2003, 2004, 2005)

28.83% of incarcerated persons in Alberta

According to Alberta Justice (Provincial, Youth, Remand – average numbers at month end first half of 2005; CSC number of offenders 2002, 2003, 2004)

30.53% of Alberta's population under 30 years of age

According to Alberta Health and Wellness (mid-year by new region, May 14, 2003)

36.21% of Hepatitis C diagnosis in Alberta

As reported to Alberta Health and Wellness (2003, 2004, 2005)

41.16% of newcomers to Canada in Alberta

37.67% of population in private households with low income in Alberta

Regional Community Planning Committee

Edmonton Regional HIV Consortium is focused on HIV/AIDS. It has a very large membership (31 at last count), however over time numbers of stakeholders attending meetings has decreased and stabilized at around 8-10. The large consortium is an umbrella coalition that includes sub-committee(s). The actual (if defined narrowly) CPC is a proposal review sub-committee composed of about four people from the larger consortium. If one wishes to broadly define CPC, then the entire consortium could be considered the CPC for these regions, including the sub-committee engaged in proposal review. It seems that individuals involved in the Edmonton consortium use CPC as a descriptor for both the larger umbrella group and the smaller proposal review sub-committee.

Current CPC Stakeholders:

AADAC (Edmonton)

African Canadian Society of Alberta

Alberta Family and Children's Services (ICYHP)

Madeleine Sanam Foundation (French speaking community, specifically from Africa with a focus on women.)

Kairos House, Catholic Social Services

Northern Alberta HIV Clinic, Capital Health

HIV Edmonton (2 persons)

Living Positive

Planned Parenthood Edmonton

Streetworks, Boyle Street Community Services

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Desired Additional Stakeholders:

Municipal, provincial and/or federal politician

Additional RHA representation

Aspen Regional HIV Consortium
Aspen Regional Health Authority (Region 7)



Alberta Government Picture⁴²
Population: 174,126⁴³

Operationally Funded AIDS Service Organization(s)

HIV West Yellowhead (Jasper; primary association with the Jasper Community Team, described next) is located in region 7.

⁴² Alberta Government. Available at http://www.health.gov.ab.ca/regions/map_07.gif. Accessed August 29, 2006.

⁴³ Alberta Government. Population registry file (March 31, 2004). Available at http://www.health.gov.ab.ca/regions/RHA_comm7.html. Accessed August 29, 2006.

Regional Environmental Data⁴⁴

- 5.50% of Alberta's population
Alberta Health and Wellness Population Registry File (March 31, 2004)
- 20.75% of Alberta's land area
Alberta Health and Wellness (April 1, 2003)
- 3.83% of HIV diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 4.39% HIV prevalence
Based on number of persons in Alberta accessing Southern and Northern Alberta Clinics (2005)
- 21.58% of persons self identifying as Aboriginal
According to census data by region (2001)
- 5.09% of STI diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 0.00% of incarcerated persons in Alberta
According to Alberta Justice (Provincial, Youth, Remand – average numbers at month end first half of 2005; CSC number of offenders 2002, 2003, 2004)
- 5.84% of Alberta's population under 30 years of age
According to Alberta Health and Wellness (mid-year by new region, May 14, 2003)
- 5.48% of Hepatitis C diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 0.98% of newcomers to Canada in Alberta
- 4.68% of population in private households with low income in Alberta

Regional Community Planning Committee

Attempts to interview a stakeholder from *Aspen Regional HIV Consortium* were unsuccessful, so further information is not presented. This CPC may also review the applications from ASOs in region 6 whose service may extend to region 7.

⁴⁴ Alberta Community HIV Fund Provincial Consortium. *ACHF – Funding 2006 Criteria for Funding Operational Organizations*. Available at: http://www.acch.ca/pdf/2006_app_F.pdf. Accessed September 5, 2006.

Jasper Community Team

Aspen Regional Health Authority (Region 7)



Alberta Government Picture⁴⁵
Population: 174,126⁴⁶

Operationally Funded AIDS Service Organization(s)

HIV West Yellowhead (Jasper; primary association with the Jasper Community Team, described below) is located in region 7.

⁴⁵ Alberta Government. Available at http://www.health.gov.ab.ca/regions/map_07.gif. Accessed August 29, 2006.

⁴⁶ Alberta Government. Population registry file (March 31, 2004). Available at http://www.health.gov.ab.ca/regions/RHA_comm7.html. Accessed August 29, 2006.

Regional Environmental Data⁴⁷

- 5.50% of Alberta's population
Alberta Health and Wellness Population Registry File (March 31, 2004)
- 20.75% of Alberta's land area
Alberta Health and Wellness (April 1, 2003)
- 3.83% of HIV diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 4.39% HIV prevalence
Based on number of persons in Alberta accessing Southern and Northern Alberta Clinics (2005)
- 21.58% of persons self identifying as Aboriginal
According to census data by region (2001)
- 5.09% of STI diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 0.00% of incarcerated persons in Alberta
According to Alberta Justice (Provincial, Youth, Remand – average numbers at month end first half of 2005; CSC number of offenders 2002, 2003, 2004)
- 5.84% of Alberta's population under 30 years of age
According to Alberta Health and Wellness (mid-year by new region, May 14, 2003)
- 5.48% of Hepatitis C diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 0.98% of newcomers to Canada in Alberta
- 4.68% of population in private households with low income in Alberta

Regional Community Planning Committee

The Jasper Community Team model, as described by the Alberta Government's Municipal Excellence Network⁴⁸, is an innovative, intersectoral service delivery system, particularly focused on linking hard-to-reach individuals with resources relevant to their health, social, educational and recreational needs. As related in Municipal Excellence Network communications, the team feels that this model, with local modifications, could be transferable to any rural community; they are developing a toolkit to help guide other communities. The team provides a community outreach services program.⁴⁹ Despite the many challenges the team has faced since the model's inception, collaboration has been identified as helping the community expand the level and continuity of service for clients

⁴⁷ Alberta Community HIV Fund Provincial Consortium. *ACHF – Funding 2006 Criteria for Funding Operational Organizations*. Available at: http://www.acch.ca/pdf/2006_app_F.pdf. Accessed September 5, 2006.

⁴⁸ Alberta Government. Available at http://www.menet.ab.ca/bins/view_practice.asp?pid=294. Accessed August 29, 2006.

⁴⁹ Ibid.

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beyond what any of the participating agencies had expected, increasing the community's capacity to respond to emerging and ongoing issues.⁵⁰

The Jasper Community Team addresses and plans around a wide range of community health-related needs, including HIV, functioning as an umbrella coalition that includes a sub-committee to deal with ACHF proposal reviews. This combination of CPC activity (as a limited part of an umbrella group linked with a particularly focused sub-committee) is seen elsewhere as well, however, the Jasper Community Team represents a type of CPC that is highly developed, secure in its collaboration, and currently offering joint programming. This community collaboration appears to have very strong partnerships offering equally strong support for its stakeholders.

Current CPC Stakeholders:

Under the lead of FCSS, the Jasper Community Team regularly meets to share information and plan programs together. The Team is currently comprised of 19 agency members and three community representatives.⁵¹

Those who have been identified as working directly with ACHF funding proposals (direct CPC-related ACHF activity) are an employee and a board member from HIV West Yellowhead.

Desired Additional Stakeholders:

AADAC (from Hinton, Edson, Whitecourt and/or Jasper)

Drug Action Coalitions (in Hinton and Edson)

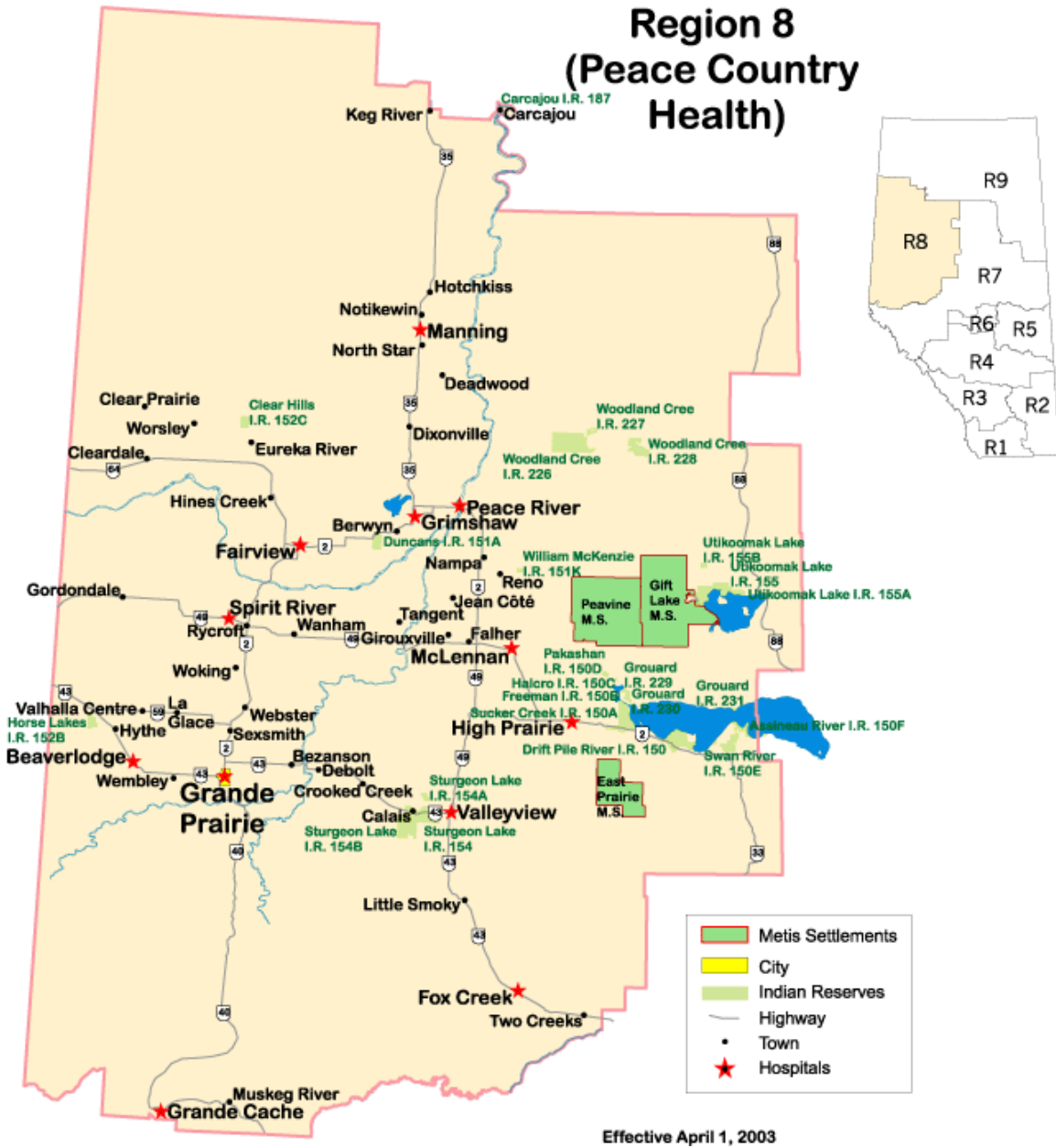
A person representing the municipal government level (representing at least one community)

Friendship Centres (there is no Friendship Centre in Jasper)

⁵⁰ Jasper Community Team. (n.d.). Community Outreach Services and the Jasper Community Team: A Brief History. Available at http://www.menet.ab.ca/menetatt/practice_294/Jasper%20-%20Attachemnt%20-%20Short%20Story%20Updated.doc. Accessed August 29, 2006.

⁵¹ Ibid.

Peace Country Community HIV Care Team
Peace Country Health (Region 8)



Alberta Government Picture ⁵²
Population: 132,845⁵³

⁵² Alberta Government. Available at http://www.health.gov.ab.ca/regions/map_08.gif. Accessed August 29, 2006.

⁵³ Alberta Government. Population registry file (March 31, 2004). Available at http://www.health.gov.ab.ca/regions/RHA_comm8.html. Accessed August 29, 2006.

Operationally Funded AIDS Service Organization(s)

HIV North Society (Grande Prairie)

Regional Environmental Data⁵⁴

- 4.20% of Alberta's population
Alberta Health and Wellness Population Registry File (March 31, 2004)
- 18.66% of Alberta's land area
Alberta Health and Wellness (April 1, 2003)
- 2.62% of HIV diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 1.82% HIV prevalence
Based on number of persons in Alberta accessing Southern and Northern Alberta Clinics (2005)
- 11.90% of persons self identifying as Aboriginal
According to census data by region (2001)
- 5.34% of STI diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 11.07% of incarcerated persons in Alberta
According to Alberta Justice (Provincial, Youth, Remand – average numbers at month end first half of 2005; CSC number of offenders 2002, 2003, 2004)
- 4.65% of Alberta's population under 30 years of age
According to Alberta Health and Wellness (mid-year by new region, May 14, 2003)
- 4.35% of Hepatitis C diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 0.85% of newcomers to Canada in Alberta
- 3.20% of population in private households with low income in Alberta

Regional Community Planning Committee

Peace Country Community HIV Care Team has evolved over its more than seven years of existence. The major focus has been around information sharing about HIV North Society, how to draw other organizations into its activities, and to look into what individual organizations are doing around HIV. This includes round table sharing, presentations from each group as it pertains to HIV—related work, topic areas from HIV North, and involvement in special projects with HIV North.

Current CPC Stakeholders:

AADAC (Grande Prairie)

⁵⁴ Alberta Community HIV Fund Provincial Consortium. *ACHF – Funding 2006 Criteria for Funding Operational Organizations*. Available at: http://www.acch.ca/pdf/2006_app_F.pdf. Accessed September 5, 2006.

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Cool Aid Society (A youth and teen drop-in program.)

FCSS (Grande Prairie)

Friendship Center (Grande Prairie)

Gay and Lesbian Association of the Peace (2 persons)

HIV North Society

Odyssey House (A women's shelter.)

Peace Country Health (The RHA)

RCMP (Grande Prairie)

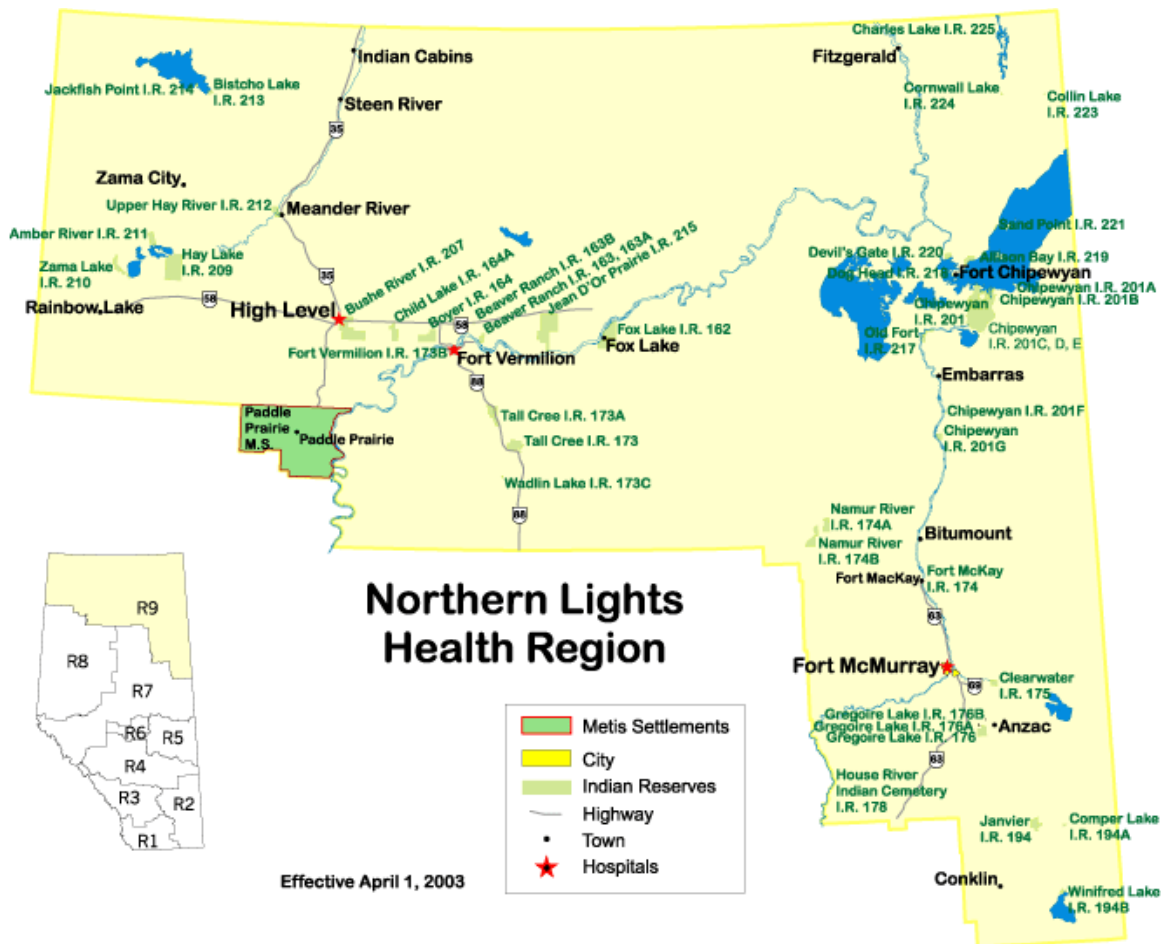
Desired Additional Stakeholders:

The Community Village agencies (This fall HIV North Society is moving into "the community village." Agency staff believe that every agency in that building needs to be a part of the community care team. This would bring four or five new stakeholders to the CPC.)

Mental health organizations

Fort McMurray Community Advisors Team (CAT)

Northern Lights Health Region (Region 9)



Alberta Government Picture⁵⁵
Population: 71,478⁵⁶

Operationally Funded AIDS Service Organization(s)

Wood Buffalo HIV & AIDS Society (Fort McMurray)

Regional Environmental Data⁵⁷

2.29% of Alberta's population

Alberta Health and Wellness Population Registry File (March 31, 2004)

⁵⁵ Alberta Government. Available at http://www.health.gov.ab.ca/regions/map_09.gif. Accessed August 29, 2006.

⁵⁶ Alberta Government. Population registry file (March 31, 2004). Available at http://www.health.gov.ab.ca/regions/RHA_comm9.html. Accessed August 29, 2006.

⁵⁷ Alberta Community HIV Fund Provincial Consortium. *ACHF - Funding 2006 Criteria for Funding Operational Organizations*. Available at: http://www.acch.ca/pdf/2006_app_F.pdf. Accessed September 5, 2006.

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- 28.54% of Alberta's land area
Alberta Health and Wellness (April 1, 2003)
- 0.40% of HIV diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 0.54% HIV prevalence
Based on number of persons in Alberta accessing Southern and Northern Alberta Clinics (2005)
- 10.51% of persons self identifying as Aboriginal
According to census data by region (2001)
- 4.71% of STI diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 0.00% of incarcerated persons in Alberta
According to Alberta Justice (Provincial, Youth, Remand – average numbers at month end first half of 2005; CSC number of offenders 2002, 2003, 2004)
- 2.83% of Alberta's population under 30 years of age
According to Alberta Health and Wellness (mid-year by new region, May 14, 2003)
- 1.81% of Hepatitis C diagnosis in Alberta
As reported to Alberta Health and Wellness (2003, 2004, 2005)
- 0.86% of newcomers to Canada in Alberta
- 1.14% of population in private households with low income in Alberta

Regional Community Planning Committee

Fort McMurray Community Advisors Team is currently at a formation stage. Staff turnover and loss of organizational history has made it difficult to “pick up” from whatever was left before. The newly established Advisors Team has a core group of key stakeholders in place, as noted below under “current CPC stakeholders.”

Current CPC Stakeholders:

FCSS, Regional Municipality of Wood Buffalo
Family and Community Services, Northern Lights Regional Health Centre
Mental Health Services, Northern Lights Regional Health Authority
Wood Buffalo HIV & AIDS Society

Desired Additional Stakeholders:

AADAC
A physician

Findings

The needs assessment working group originally arrived at an agreed-upon target of twenty interview respondents, two from each of ten CPCs in the province. By the end of the study, fifteen individuals from nine CPCs had completed interviews. One CPC representative, the only identified contact in that CPC, was unable to be reached after repeated attempts. Additionally, three CPCs were only able to provide one participant each.

Responses to each question were grouped together and primary and secondary themes were identified. Certain questions that were designed to collect specific information (e.g. lists of stakeholders) were not grouped for theme identification. Direct quotes from participants are used below, in most cases, to name primary and secondary themes.

How many times have you met as a CPC in the past year or so?

“The CPC tends to meet when funding cycle comes along.”

Almost all CPCs meet predominantly to review (in past years) ACHF project and (currently) operational proposals. Few CPCs meet according to a schedule that wanders too far from project and/or operational requirements. Those that do are engaged in work that goes beyond ACHF-prescribed application review elements (for example, the Calgary Coalition on HIV and AIDS has a steering committee – which functions as their CPC for ACHF purposes – as well as working groups, such as youth or prevention).

How long has your CPC been in existence?

“As long as there has been ACHF there has been a CPC in our community.”

Most CPCs (or what appears to be the use of the “CPC” descriptor) trace their inception back as far as the introduction of ACHF and its associated local funding-related activities. Some respondents were even unsure of this link, due to short times in their positions or the lack of official records. A small number of respondents reported being engaged in starting-up or reorganizing activities (not due to the creation of a new ASO, but rather related to organizational growth cycles), suggesting a very inconsistent or relatively non-existent CPC activity level in their region.

“Some really good history there...” – CPCs with longer histories.

CPCs associated with larger consortia, and with longer histories, demonstrate a wider range of HIV/AIDS – related activities. These consortia tend to convene the CPC as a sub-committee.

Do you have terms of reference for your CPC?

“We have the [ACHF] review tools which are used and referred to.”

Most CPCs report having lost track of, never having, or not using existing terms of reference. It appears that the majority of CPCs are essentially governed by what they are expected to do in relation to the review of ACHF-related proposals. It follows that activities falling outside that sphere are likely routinized by whatever leadership and/or core group is active in the CPC. There are, of course, exceptions – current terms of reference are in place for, and used by, the Lethbridge HIV/HCV Community Consortium that relate to its CPC activities.

What is the major focus for your CPC?

“Hoping that the focus will continue beyond the proposal.”

All CPCs are HIV/AIDS-focused, though their over-arching consortia (where they exist) may wander farther into a number of health-related areas (e.g. harm reduction generally). Additionally, most CPCs are further focused on the review of proposals. Respondents generally (throughout the interview) spoke about a wider range of current, potential, or desired initiatives in relation to their CPC and/or consortium. A large question sits in the midst of this assessment: what will CPCs that, until now, have focused only on (project and operational) proposal reviews, do after reviewing operational proposals this fall?

Is there HIV representation on your CPC (i.e. either someone living positive or someone designated as representing affected groups)?

“That representation has been transient at best.”

HIV representation, while valued, has been absent from many CPCs due to a lack of individuals or a lack of connection between the CPC and local communities. A few CPCs reported ongoing HIV representation (of various types) and active recruitment of specific populations. In essence, respondents indicated a clear willingness to improve this area when possible.

Are there elements about your local context and community dynamics that specifically affect your CPC's ability to function?

"My mantra these days is 'good times are not always good times.'"

Many respondents referred to significant growth in their communities and regions, and touched on associated challenges and problems. It appears that social services generally have been considerably strained, and there is a perception that resources are not keeping pace. Respondents went on to link the effects of this growth to a list of challenges.

"There is a greater demand in our city for everything."

Influx of workers, population growth generally, and housing shortages have – in some communities – created significant demand for all types of services. Some respondents indicated that not only they, but their colleagues in the community were highly affected by side effects to economic growth and prosperity.

"Everyone is so pushed for time."

Many respondents also commented on how little time is available to the representatives of community organizations already involved, or potentially involved, with their CPCs. Lack of time for meetings has, in some cases, created hierarchies for individuals as they must weigh the relative worth of one initiative, meeting, or committee over another.

"Now the workers are the people in need as much as they used to serve people in need."

There are concerns that, in some communities, AIDS organizations and nongovernmental organizations generally may experience increasing difficulty in attracting, training, and retaining skilled employees. Comparisons are made with private sector opportunities that offer significantly higher wages and benefits, even at entry levels. There are also concerns that front-line workers may soon be unable to afford living in their communities while working for lower-paying social service nonprofits.

"There seems to be some fatigue generally among agencies and organizations with the whole [area of] HIV/AIDS."

Several respondents commented about lack of energy and fatigue associated with the HIV/AIDS cause – around their CPC and/or consortia tables – and in communities at large. At the same time, some respondents indicated that stigma

and general ignorance in their communities remained significant, indicating much work to be done. It is not surprising that respondents also described encountering the enduring notion that HIV/AIDS is not a problem for the community they work in. This was disturbing for those respondents who have detected increased HIV infection risk in populations and/or social situations that coexist with rapid economic growth.

“It’s really hard for us to ask them to take on this work without paying them.”

A number of respondents spoke of the pressures associated with expecting their partnering agencies to shoulder the HIV/AIDS work associated with CPCs. In some cases, financial burden was linked to large geographic distances; in others, a link was made to the time commitment that is expected. Additionally, there were some concerns about the discontinuation of the project stream and potential for partners to fall away if they are unable to access funding for HIV-related work.

Please comment on your stakeholder group’s involvement and effectiveness.

“I don’t think it’s as effective as it needs to be.”

Generally, respondents felt that their CPCs and/or associated coalitions were not as effective as they could be. There were also concerns about fluctuating or collapsing involvement levels. Comments were also made concerning a perceived change in effectiveness and/or involvement over time...with the CPC currently perceived as less effective and/or experiencing less involvement. Those respondents reporting relatively effective CPCs with more stable involvement linked that state with the strength of core groups or networks that had existed without significant change over time.

“I have confidence in them.”

Despite concerns about effectiveness and involvement, a number of respondents were able to point to their CPC’s successes in managing and completing proposal reviews over time. Some respondents were – quite simply – satisfied and pleased with their CPC’s effectiveness and involvement levels.

What support, if any, is needed to improve your stakeholder group's size and/or effectiveness?

Some supports are needed to improve stakeholder group size and/or effectiveness.

Funding for CPCs

The most-mentioned support is some type of funding to CPCs that will allow them to either cover participation costs or hire staff to assist in coordinating their activities. It is sometimes unclear as to whether this is a reflection of decreasing individual organizational capacity for community work of this nature or difficulty in CPCs to cope with what is expected from them – or both.

Skills building and orientation

The second most-mentioned support includes skills building, training, and orientation activities related to CPC operation – from provincial HIV information to increasing clarity about the roles of CPCs and how-tos related to reviewing funding applications. There was also a concern about nurturing leadership in CPCs – including attracting people with greater decision-making power to the consortia.

Increased communications

Other supports mentioned include the ability to increase internal and external communications. Internal communications needs include creating consistent understanding, job descriptions, and terms of reference for CPCs province-wide. External communications needs include assisting CPCs in sharing what it is that they do, how others can participate, and the difference they are making. The primary target audience for this would be potential CPC stakeholders.

What support, if any, is needed to improve your CPC's ability to collaboratively identify local and regional HIV-related needs and priorities?

"I think we do really well there."

The majority of respondents perceive their CPCs as performing well in collaboratively identifying needs and priorities related to HIV in their communities and regions. Several are very satisfied with CPC ability here. Many respondents, however, including those expressing satisfaction in this area, had suggestions for supports that could further enhance CPC ability.

Effective communications and recruitment

Respondents again stress the need for more effective communication – this time about the importance of CPCs as well as what they do. Education and communication is seen as helpful to stakeholder recruitment. The involvement of people living positive is stressed.

Help in addressing rural and regional priorities

Respondents mention difficulties in examining rural and larger regional priorities, given the fact that many CPCs are dominated by urban-based organizations. CPCs need more rural-specific information and statistics.

The means to respond

Respondents also commented on CPC ability to determine priorities, but suggested that the means to respond is insufficient. Increased resources are requested.

What support, if any, is needed to improve your CPC's ability to use a community based intersectoral (multi-agency/multi-disciplinary) approach to HIV work?

"I think we actually do a fairly decent job with that...it's in our nature."

Approximately half of respondents perceive their CPCs as performing well in using a community based intersectoral approach to HIV work. Several are very satisfied with CPC ability here. As in the previous interview question, many respondents, including those expressing satisfaction in this area, had suggestions for supports that could further enhance CPC ability.

Encouraging deeper involvement

Respondents stress the need for partnering organizations to be encouraged and empowered to embrace a larger portion of the work involved in HIV/AIDS generally. Greater involvement is seen as being supported by increasing the meaningfulness and clarity associated with stakeholder participation, and is facilitated by more consistent approaches to planning and linking stakeholder capacities to HIV-related needs.

Address leadership

Leadership is mentioned again, this time in the context of what stakeholders are able to directly contribute to the stakeholder group. There is a perceived need for shared leadership and shared responsibility among all stakeholders – greater “ownership”, if you will, of the issue. Clear understanding of the common purpose of the stakeholder group is stressed.

What support, if any, is needed to improve your CPC’s ability to oversee the review and response to ASO operational proposals?

Experienced versus inexperienced

The one major theme that emerges from respondents in this area is a split between respondents who feel their CPCs (and they, themselves, at times) are experienced at this task, and those respondents who feel their CPCs (and they, themselves, at times) are inexperienced at this task. This should not be surprising, given the up-and-down nature of ASO staffing cycles and CPC stakeholder involvement that has been mentioned by respondents during the assessment.

Some clear suggestions for improving CPC ability to oversee operational proposal review are made:

- clarity around ACHF expectations (including CPC nuances and primary purposes in general)
- resources to assist CPCs in review (e.g. travel dollars, honoraria for HIV-positive reviewers and if possible other reviewers, etc.)
- additional information about provincial proposals
- support to operationally-funded agencies with staff leadership experiencing the process for the first time
- identification and communication of provincial priorities that could help guide decision-making at the local and regional levels
- access to prior application review work for orientation and skills building purposes
- an orientation to the process
- unbiased basic information about the operationally-funded organization
- ensuring that individuals from the operationally-funded organization are not part of the review process
- ensuring that a sufficiently representative and diverse group of stakeholders is involved

What support, if any, is needed to improve your CPC's ability to increase community networking related to HIV initiatives?

"To be honest, I can't imagine only reviewing proposals."

Respondents are remarkably diverse in their responses as to how CPCs can increase community networking ability. The only agreement seems to be that CPCs, despite their potential for streamlined adaptation to ACHF expectations, could use some type of activity, improvement or clarification in this area. Respondents provide a list of statements that often resonate with comments made elsewhere during the assessment. Several respondents agreed that they were unsure what support might be needed. Each of the other respondents has individually unique comments and suggestions:

- "The CPC doesn't do networking, the ASO does."
- "A combination of virtual and in-person situations."
- "My main concern would be the schools."
- "We do this all the time."
- "We need to be innovative and creative about how to do that...something that would have some meaning."
- "Let's minimize redundancies and increase our effectiveness in the use of our dollars and doing the work we're mandated to do...CPC gives us an opportunity to be focused."
- "We need more education going into private industry."
- "We need someone dedicated to that activity."
- "Right now, it would be improving abilities within our ASO."
- "We need to get better at shouting out what we're doing so that people will take a greater interest."
- "Our CPC does not community network. It *is* community."

It may be useful to further clarify the nature of community networking in the CPC environment.

Any other information that you would like to include, based upon our interview discussion.

"I think it's important to note that like the provincial consortium, the CPCs play just as valuable a role and each one of them is a piece of the same wheel."

"With the membership we have and the number of people coming, I don't know how reflective they can be in really understanding the needs of the community in

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depth. More than anything, it's an assessment of the organization and whether they can do it."

"I'm glad to see the project stream gone; in our area it was really more a grab for money (generally). Not as serious. Didn't really build capacity in the community."

"I'm really disappointed that the project funding was folded into the operational funding. From a community development perspective, I see that as a disaster. I think that it undermines the whole concept of community development."

"Over the years, there has been a provincial gathering of CPC reps; I think our [CPC co-chair] found that helpful."

"...the government needs to look more closely at the impacts that this growth is having on our society. By that I mean that it's not just a lack of skilled workers, but the other problems that come (e.g. increased drugs and alcohol, unstable family situations for children)."

"...what I'm saying about HIV is what I would say about any other social issue [in the city]. We're moving at such a rapid pace and the only thing the news or government seems to pick up are the private sector issues."

"People are changing all the time on the CPC."

"Our group is very, very good in regards to what we want to do and where we want to go. We're very compatible that way."

"I think it's pretty stark and pretty negative right now...we're not in very good shape for this CPC scenario."

"The expectations of the role of the CPC are quite large. It's a luxury...to have any extra time at all. It's a big undertaking and expectation from ACCH and the funders to expect this added responsibility on top of everything else."

"What about the future of the agency?"

Recommendations

Five specific recommendations to ACHF for action going forward emerged from the data collection and analysis associated with this needs assessment. The recommendations are presented in order of priority, beginning with the highest priority.

1. Investigate Impacts of the Economic Boom on HIV/AIDS

Respondents indicated significant impacts and challenges related to Alberta's rapid economic growth. This factor appears to be related to a wide array of actual and perceived CPC and ASO needs, and was linked with a strong sense of urgency.

Some form of research initiative should be initiated into the larger impacts of Alberta's boom economy on: (1) HIV and AIDS in the province; and (2) HIV/AIDS organizations and coalitions in the province. This may occur in tandem with any similar initiative that is underway or currently planned from a social service and/or health perspective. The HIV/AIDS service infrastructure needs to be examined in relation to the increasing demands being placed on it.

This is also an opportunity for ASOs/CPCs and/or ACCH to work with other organizations, in a leadership role, to advocate for government and/or private sector responses if required.

Goal: to strengthen and protect the HIV/AIDS infrastructure during times of rapid change, while addressing emerging HIV/AIDS priorities related to rapid economic growth.

2. Re-establish Understanding of the CPC's Purpose

Respondents indicated uncertainty about the purposes associated with CPCs, and additionally expressed a wide array of hopes and expectations for potential CPC activity.

The purpose(s) for CPCs must be discussed, rationalized, clarified, and clearly communicated during this time of transition (i.e. end of project stream). A continuum of potential CPC activity that recognizes the latent or active community action potential in community coalitions should be delineated,

discussed, and understood. Planning, activity, and advocacy roles should be evaluated and understood.

This provides an opportunity for CPCs to re-establish or re-invent themselves as desired with reference to meaningful purpose.

Goal: to clarify the role(s) CPCs will play in the next few years.

3. Convene a Community Leadership Forum

Respondents spoke often, and from multiple perspectives, of a perceived current lack of leadership – or apparent leadership challenges – in relation to their CPCs, and HIV/AIDS work generally in their communities and regions.

Opportunities should be provided for CPC and ASO representatives from across the province to attend a focused, skills-based, and meaningful HIV/AIDS-related leadership conference. Participants may use the opportunities presented to establish, extend, and develop leadership skills and abilities that are directly related to the leadership roles they are expected to maintain in their communities and regions. Present speakers who occupy provincial, national, and/or international HIV/AIDS-related leadership roles.

Additionally, an opportunity is provided for planning, networking, building alliances, and meeting with key ACCH and ACHF leaders.

Goal: to invigorate and establish ongoing leadership tradition and expectation with respect to HIV/AIDS in Alberta's communities and regions.

4. Provide Funds for CPC Use

There is substantial agreement among respondents that additional (i.e. "new") funds or resources must be made available for CPCs to support and/or compensate for specific participation expectations (e.g. proposal review). CPCs should be provided with reasonable resources with which to conduct proposal reviews.

Support can be offered to CPCs that wish to replace the discontinued project funding from ACHF with project funding from other potential sources (i.e. information sharing about possibilities and opportunities). While the number of dollars provided may not be high, the impact and goodwill generated at the community level may be substantial.

Goal: to maximize CPC input into operational reviews.

5. Provide Structured ACHF Operational Review Orientation

Respondents perceive a lack of ACHF orientation opportunities specifically related to the CPC role in reviewing funding proposals. This perception was often coupled with staff turnover, lack of sufficient records, and information management challenges at the local level.

Undoubtedly, some form of ACHF orientation has existed, if in various forms, over the years, and has been available to ASOs and CPCs. A structured, well-communicated, portable, and effective orientation should be developed for use with ASOs and CPCs this fall. The orientation must clarify boundaries, expectations, and gains associated with proposal review.

This also provides an opportunity for ACHF to re-engage with CPCs, establish province-wide standards where needed (e.g. terms of reference, role descriptions), and offers a communication and dialogue platform for ACHF partners.

Goal: to maximize CPC input into operational reviews.

Conclusion

The needs of individual CPCs or CPCs as a broad group are not unlike the needs facing any organization. Despite their variations and local adaptations, CPCs together face challenges and needs that are shared.

Significant changes in the external environments in which CPCs function are clearly evident. The impacts of rapid economic growth and the associated side effects are being broadly reported by respondents. This requires immediate study, analysis and response. Infrastructures need to be strengthened and preserved.

Questions and confusion about purpose in any group or organization should not be ignored. It is clear that respondents are calling for re-examination of the CPC's purpose, and a shared vision is required. This is particularly important as CPCs become responsible for proposal review every three years, rather than every year (with the end of project funding).

Leadership is an ongoing challenge and requires ongoing attention. Respondents have made it clear that they are concerned about leadership and how it can be cultivated and maintained. In order to develop a focus on leadership, it will be important to convene a discussion about leadership – and an understanding of what it means and how it should or could be exercised in this context.

Ongoing concerns about funding are commonplace among charities and nonprofit organizations. It is important, given respondents desire for funds to use in CPC activities, to recognize that priority setting steps may have to be taken. To what extent should CPCs receive funds to help them accomplish their goals? Where will these funds come from?

Training and orientation are always a need in organizations and CPCs are no different. There may be a perception that orientation opportunities are not available or that clear guidelines are unavailable. It is likely that orientation, guidelines, training, etc., are available – but underused or understated. Respondents want to know that orientation occurs, and that clear guidelines are always available. This will come with improvements in communication and a fuller understanding of the impacts of staff turnover in small organizations.

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The challenge, then, to the ACHF partners is to re-establish a shared understanding of what CPCs are meant to do, how they can best do it, and who can best lead it. Listening to the expressed needs of the regional CPCs is a good start. Engaging the CPCs in meaningful dialogue is the next step.

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