The Community HIV/HCV Evaluation & Reporting Tool (CHERT)

Demonstrating the Work of Community-Based HIV/HCV Organizations in British Columbia

April 1, 2012 - March 31, 2013

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Pacific AIDS Network

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Acknowledgements

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About this Report

Welcome to the second annual Community HIV/HCV Evaluation and Reporting Tool (CHERT) report. The CHERT is an online survey that collects annual data from community-based HIV/HCV organizations in British Columbia (BC) about the range of programs and services they provide. Overall, the findings from this tool aim to demonstrate the value and impact of the work being done by community-based HIV/HCV organizations across the province. It is important to highlight that the design and concept of the CHERT has been heavily modeled from the successful work of the Ontario Community HIV and AIDS Reporting Tool (OCHART), in addition to the Program Evaluation Report Tool (PERT) of the AIDS Community Action Program, Public Health Agency of Canada (PHAC).

What is the purpose of CHERT reporting?

The data collected by the CHERT is of critical importance for the following reasons:

- **Standardization**

  The CHERT aims to streamline the data collected and reported by community-based HIV/HCV organizations across the province. Standardization in data collection will reduce the number of repetitive and time-consuming reporting requirements set out by individual funding agencies, allowing community-based groups to focus on achieving their visions and missions.

- **Program Planning and Improvement**

  Findings from the CHERT are intended to help community-based HIV/HCV organizations improve the design and delivery of their programs and services. For instance, the CHERT could help community-based organization to identify gaps and trends in service delivery that can be used to adjust services or develop new programs as necessary. Aggregate and agency-specific findings from the CHERT are available to all participating organizations on an annual basis.

- **Accountability to Funders**

  If desired by the respondents, CHERT findings can also be used to compare the actual activity of organizations to what was planned for in proposals and logic models.

- **To Demonstrate Success**

  The findings from this tool, used over time, will demonstrate the impact community-based HIV/HCV organizations are making across the province. Up until now, the HIV/AIDS and HCV sectors have not collected the qualitative and quantitative data that is needed to illustrate the value and impact of the work being done.

Design of the CHERT

The 2013 version of the CHERT included 87 questions, of which 3 were open-ended questions and 84 were closed-ended. The survey questions focused on programs and services that were delivered by the responding organizations during the 2012 - 2013 fiscal year. CHERT questions were divided into the following 12 sections:

1. Program Delivery and Operation
2. Human Resources
3. Partnerships and Collaborations
4. Funding
5. HIV/HCV Prevention
6. HIV/HCV Outreach
7. HIV/HCV Testing
8. HIV/HCV Treatment and Care
9. Social Support Services
10. Education and Training
11. Meaningful Client Engagement
12. Monitoring and Evaluation Work

Data Limitations

Since the first round of data collection with the CHERT in 2011 - 2012, many revisions have been made to the tool to improve the reliability and validity of the data. For instance, a number of definitions were added to the survey in order to increase the likelihood that all respondents would answer the questions in the same manner. Question wording and response options were also altered to improve the comprehensiveness and accuracy of the data requests. It is important to note that these revisions were largely guided by the wisdom of the BC HIV/HCV Evaluation Advisory Group and other community partners.

However, some data limitations noted in the 2011 - 2012 CHERT report continued to persist this year. First, CHERT respondents frequently provided estimates or approximate figures for data requests, as tracking systems for different indicators are not currently in place within all organizations. The use of aggregate data throughout the report is also a concern since results from larger organizations can often skew the results in one direction or the other. Given that this was only the second round of data collection with the CHERT, such challenges with a new survey tool can be expected and we aim to continue to improve upon them for next year.

Additional CHERT Reports

The following are additional CHERT reports that are available on the Pacific AIDS Network website:

- **The 2012 - 2013 CHERT Report Summary**
  - Available at: http://pacificaidsnetwork.org/programs-projects/evaluation/
- **The Community Contribution to BC's Provincial Strategy to Address HIV/AIDS**
  A report that employs data from the CHERT to demonstrate the key role community-based organizations are playing in the success of BC's provincial HIV strategy (also outlined in Section 7.0, p. 59-60)
  - Available at: http://pacificaidsnetwork.org/programs-projects/evaluation/

Key Findings

CHERT Respondents

A total of 30 community-based HIV/HCV organizations in BC completed the CHERT for the 2012 - 2013 year. Participation from organizations providing programs and services in each of the health authorities was fairly balanced, including high participation from provincial-level organizations.

People Served

Depending on the organizations' size and capacity, the number of unique clients served by each CHERT respondent in the last year varied considerably, from 78 to 15,684 individuals. People living with HIV/AIDS (77%; *n* = 23), those co-infected with HIV and HCV (70%; *n* = 21), and a range of high-risk populations comprised a significant proportion of the people served by most organizations.

How Community-Based Organizations Operate

Similar to results from 2011 - 2012, data from the CHERT demonstrates that community-based HIV/HCV organizations in BC are relatively small. The majority of organizations (*n* = 64%; 18) had less than 5 full-time equivalents (FTEs) available to support their work in the last year. Therefore, it is not surprising that respondents are dependent on volunteers and students to support their work.

The majority of organizations held some type of formal (83%; *n* = 25) and informal (87%; *n* = 26) partnerships in the last year. In discussing the benefits of forming such partnerships, respondents most commonly described the advantages of sharing resources, information and strategies with partner agencies (*n* = 11), such as sharing costs, the sharing of strategies to address challenges, and having access to expertise in a range of areas.

CHERT respondents were also asked to describe operational strengths and challenges facing their organizations in the last fiscal year. In terms of strengths, respondents most frequently discussed the value of engaging clients and other community members in the design, delivery and governance of their programs and services (*n* = 8). In terms of operational challenges, organizations most frequently mentioned having limited funds and resources to do their work (83%; *n* = 25), as well as stigma and discrimination (50%; *n* = 15).

Responding organizations relied heavily on provincial (63%) (e.g. BC health authorities, BC gaming) and federal government (17%) funding sources to conduct their work in the last year. These sources collectively accounted for 80% of funding received by responding organizations in the last fiscal year.

The Impact Community-Based Organizations are Making

Preventing the Spread of HIV and HCV

Results from the CHERT demonstrate that community-based organizations play a critical role in the prevention of HIV and HCV in BC. Similar to results from 2011 - 2012, the majority of organizations (87%; *n* = 26) reported that they provided some form of HIV and/or HCV prevention services in the last year. More specifically, the majority of respondents focused their efforts on the provision of *upstream* (86%; *n* = 26), *primary* (80%; *n* = 24) and *secondary* (77%; *n* = 23) prevention services, whereas *tertiary* prevention services (63%; *n* = 19) were less of a focus.

Outreach Efforts

In both the 2011 - 2012 and 2012 - 2013 rounds of data collection with the CHERT, 63% (*n* = 19) of responding organizations reported that they provided outreach services. Organizations providing outreach services in the last year collectively reached a total of 32,274 people and most commonly targeted people living with HIV/AIDS (79%; *n* = 15), in addition to a range of high-risk groups in their outreach services. In terms of outreach activities, CHERT respondents indicated that their organizations most commonly focused on providing information and education to the community (84%; *n* = 16), referral services (84%; *n* = 16), and home and hospital visits (68%; *n* = 13).

Testing for HIV and HCV

One third of respondents reported hosting or administering HIV or HCV testing in the last year (33%; *n* = 10). The majority of these organizations *hosted* testing services (*n* = 9) and collectively facilitated a total of 4,742 HIV tests and 1,100 HCV tests. The single organization that reported administering their own testing services tested a total of 150 and 100 people for HIV and HCV, respectively.

Treating HIV and HCV

The proportion of organizations providing HIV and/or HCV treatment services increased to 23% (*n* = 7) in the last year, from 10% (*n* = 3) in 2011 - 2012. This increase can be partially attributed to an improved definition of what HIV/HCV treatment services entail in the CHERT. Organizations providing treatment services reported that they treated a total of 635, 117 and 108 people for HIV, HCV and HIV/HCV co-infection, respectively. A small number of organizations reported the provision of adherence programs for HIV-treated people (17%; *n* = 5) and HCV-treated people (7%; *n* = 2).

Providing Social Support Services

Data from the CHERT demonstrate that community-based organizations are key players in the provision of social support services. The majority of organizations (>73%) provided referrals for food security and nutritional support, housing and mental health and substance use support services. However, a smaller proportion of organizations offered these support services in-house.

Education and Training Activities

The majority of respondents offered HIV/HCV education or training workshops in both the 2011 - 2012 (67%; *n* = 20) and 2012 - 2013 (73%; *n* = 23) years. In the last year, respondents provided an average of 82 education workshops and training sessions, reaching roughly 44,096 people.

Meaningful Client Engagement

CHERT data also shows that respondents are committed to community engagement. Organizations most frequently reported engaging clients in the management and delivery of their services (80%; *n* = 24), followed by engagement in evaluation (76%; *n* = 22) and research activities (53%; *n* = 16).

Monitoring and Evaluation Work

In comparison to 2011 - 2012 results, the proportion of organizations that conducted or commissioned any type of evaluation work increased from 62% (*n* = 18) to 80% (*n* = 24). When describing benefits of conducting evaluation work, most organizations (*n* = 20) discussed the value of having evidence to inform improvements in the design and delivery of their programs.

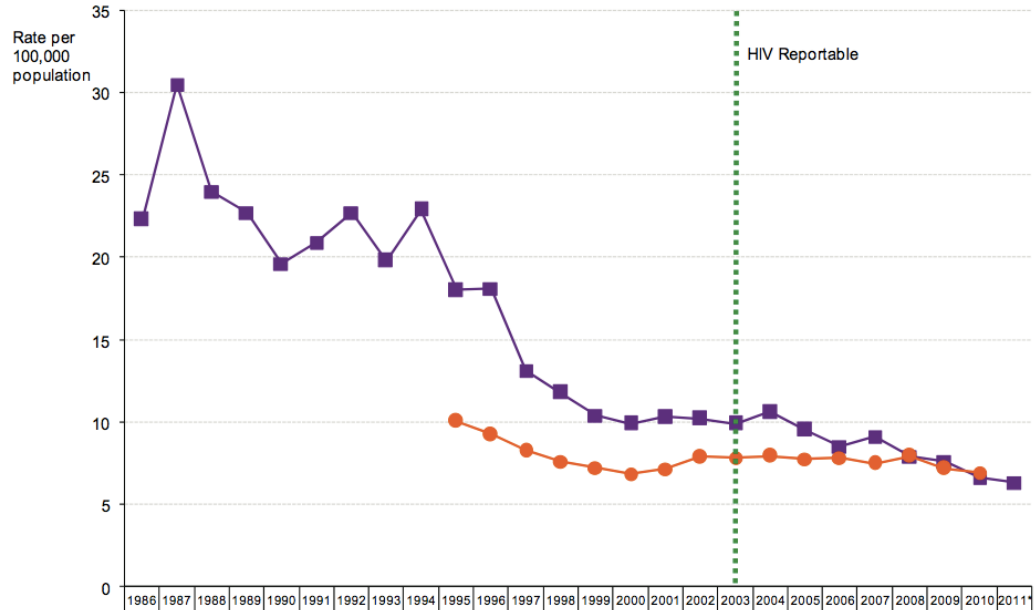
1.0 The Context of HIV/AIDS and Hepatitis C in BC

To provide some context for the results from the Community HIV/HCV Evaluation and Reporting Tool (CHERT), this report will begin with a summary of recent surveillance data on HIV/AIDS, Hepatitis C (HCV) and HIV/HCV co-infection in British Columbia (BC).

1.1 HIV/AIDS

HIV/AIDS continues to remain an issue of concern for BC. The estimated total number of people living with HIV in the province was 11,700 at the end of 2011, an increase from 11,040 at the end of 2008 (BC CDC, 2011a). In 2011, the rate of new HIV diagnoses decreased to the lowest point ever since the advent of the epidemic in BC to 6.3 per 100,000 population (298 cases) (BCCDC, 2011a) (see Figure 1). As illustrated in Figure 2, the highest rates of new HIV diagnoses were reported within the Vancouver Coastal and Northern health authorities, with a specific concentration of new diagnoses in the Vancouver, Northwest and Northern Interior Health Service Delivery Areas (BCCDC, 2011a). The BC Centre for Disease Control and Prevention (BC CDC, 2011a) notes that recent trends in these areas have been influenced by increased testing efforts associated with the provincial Seek and Treat for Optimal Prevention of HIV/AIDS (STOP HIV/AIDS) Pilot Project that commenced in 2010.

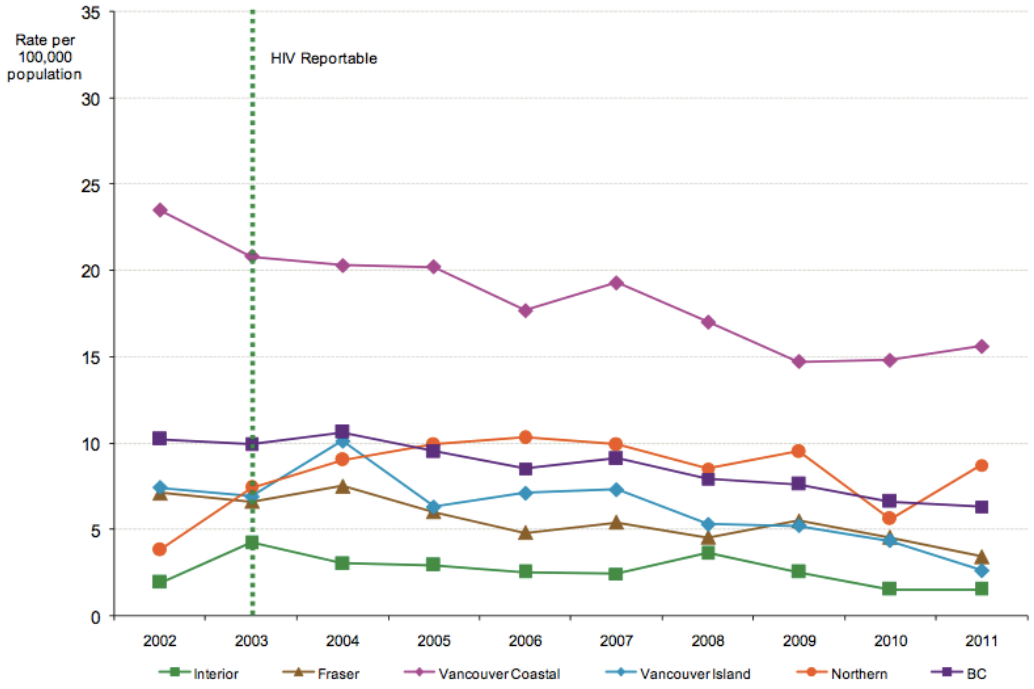
Figure 1. New HIV diagnoses in BC and Canada by historical trend, 1986 to 2011 (BCCDC, 2011a)



	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011*
BC Diagnoses	670	929	746	726	645	704	788	706	840	681	702	519	471	416	400	420	418	408	442	400	361	391	345	337	300	289
BC Rate	22.3	30.5	24.0	22.7	19.6	20.9	22.7	19.8	22.9	18.0	18.1	13.1	11.8	10.4	9.9	10.3	10.2	9.9	10.6	9.5	8.5	9.1	7.9	7.6	6.6	6.3
Canadian Rate										10.1	9.2	8.3	7.6	7.2	6.8	7.1	7.9	7.8	7.9	7.7	7.8	7.5	7.9	7.2	6.9	

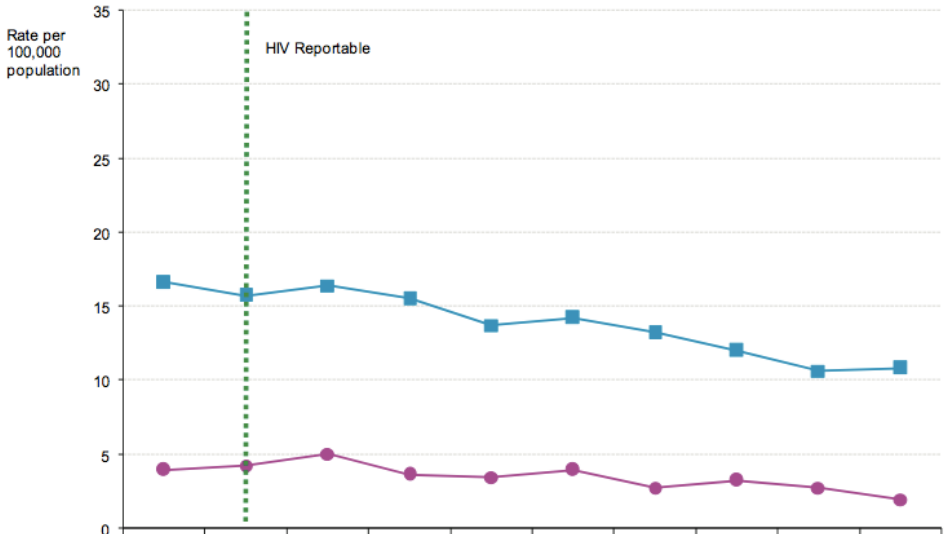
* 2011 Canadian rate is not available

Figure 2. New HIV diagnoses in BC by health authority, 2002 to 2011 (BCCDC, 2011a)



In terms of gender, rates of new HIV diagnoses have decreased for both males and females over the last decade in BC (BCCDC, 2011a). Rates of new diagnoses continue to be higher among males when compared to females in the province (see Figure 3). In 2011, the rate of new HIV diagnoses among males increased slightly to 10.8 per 100,00 population (245 cases) from a rate of 10.6 per 100,000 population (238 cases) in 2010 (BCCDC, 2011a). Among females in BC, the rate continued to decrease in 2011 to 1.9 per 100,000 population (43 cases) from a rate of 2.7 (62 cases) per 100,000 population in 2010. Rates were reported to be the highest among males aged 30-39 and among females aged 25-29 in 2011 (BCCDC, 2011a).

Figure 3. New HIV diagnoses in BC by gender, 2002 to 2011 (BCCDC, 2011a)

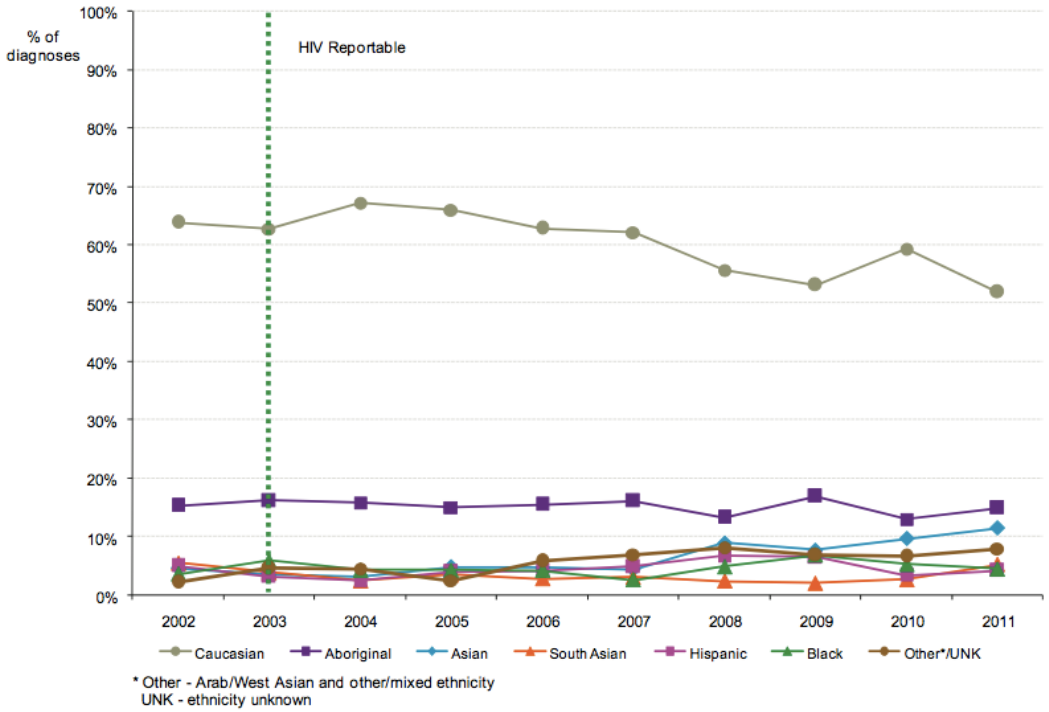


	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Diagnoses - Female	80	87	105	77	72	85	59	71	62	43
Diagnoses - Male	338	320	337	322	289	303	286	266	238	245
Diagnoses - Other *	0	1	0	1	0	3	0	0	0	1
Rate - Female	3.9	4.2	5.0	3.6	3.4	3.9	2.7	3.2	2.7	1.9
Rate - Male	16.6	15.7	16.4	15.5	13.7	14.2	13.2	12.0	10.6	10.8

* Other - transgender and gender unknown

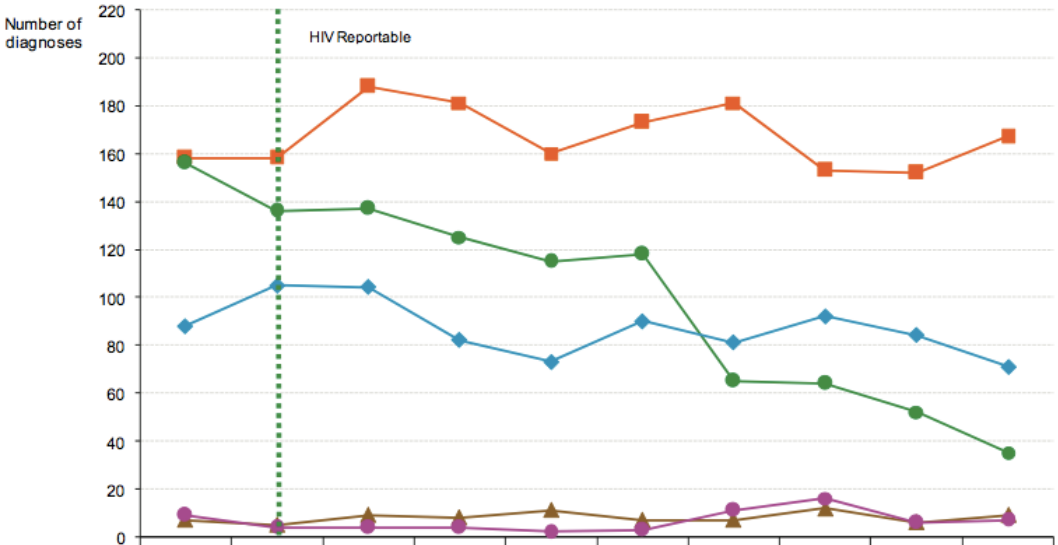
Following the historical trend in BC, Caucasian people continued to comprise the greatest proportion of people newly diagnosed with HIV in the province in 2011 (150 cases; 51.9%) (BCCDC, 2011a) (see Figure 4). Other highly affected groups include Aboriginal peoples (43 cases; 14.9%) and people of Asian ethnicities (33 cases; 11.4%) (BCCDC, 2011a). It is important to highlight that Aboriginal peoples continue to be disproportionately represented in BC's HIV epidemic. While Aboriginal peoples only comprise approximately 5% of the provincial population, roughly 15% of new HIV diagnoses occur within this group (BCCDC, 2011a). This burden of HIV infection is largely due to the history of colonization and discrimination experienced by Aboriginal peoples, which has contributed to inequities in the social determinants of health among this group today (BCCDC, 2011a).

Figure 4. New HIV diagnoses in BC by ethnicity, 2002 to 2011 (BCCDC, 2011a)



In terms of exposure categories, gay, bisexual and men who have sex with men (MSM) continued to represent the greatest number of new HIV diagnoses in BC in 2011 (167 cases; 57.8%) (see FIgure 5) (BCCDC, 2011a). As illustrated in Figure 5, the number of new HIV diagnoses among people who use injection drugs (IDU) in the province continued to decrease from 17.3% of all diagnoses (52 cases) in 2010 to 12.1% of all diagnoses (35 cases) in 2011. New HIV diagnoses due to heterosexual contact have remained relatively stable over the last few years, with a slight decrease from 84 cases (28.0%) in 2010 to 71 cases (24.6%) in 2011 (see Figure 5).

Figure 5. New HIV diagnoses in BC by exposure category - total, 2002 to 2011 (BCCDC, 2011a)



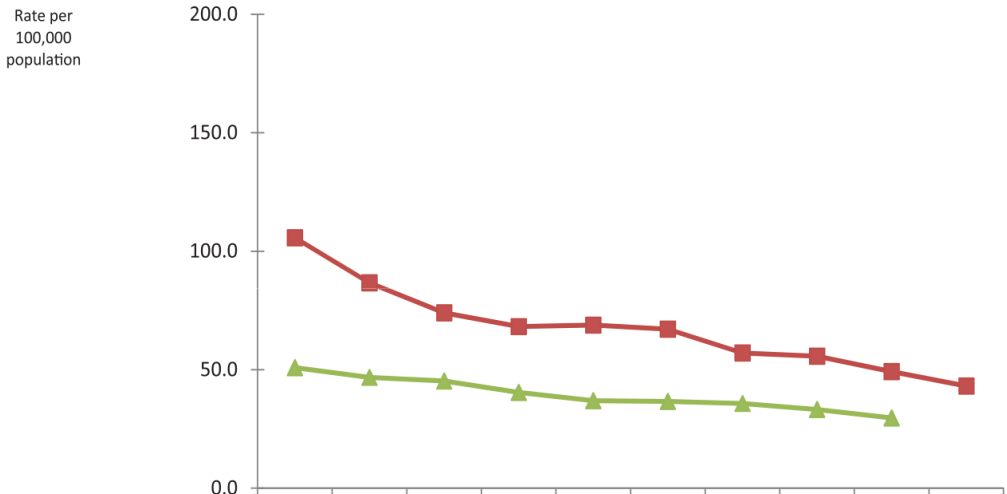
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
MSM	158	158	188	181	160	173	181	153	152	167
IDU	156	136	137	125	115	118	65	64	52	35
HET	88	105	104	82	73	90	81	92	84	71
Other	7	5	9	8	11	7	7	12	6	9
NIR/UNK	9	4	4	4	2	3	11	16	6	7

MSM - men who have sex with men
IDU - injection drug use
HET - heterosexual contact
NIR - no identified risk
UNK - exposure unknown
Other - blood/blood products, occupational, perinatal, and other exposures

1.2 Hepatitis C

While current BC specific estimates of Hepatitis C (HCV) prevalence are not available, it has been approximated that there may be 60,000 to 80,000 people infected with HCV in the province (Kuo, 2013). In terms of the virus's incidence, the BC CDC (2011b) reports that HCV rates continue to decline in BC (see Figure 6). In 2011, a total of 1970 HCV cases were identified in the province, with a rate of 43.1 per 100,000 (BCCDC, 2011b). This reduction is thought to be due to a decrease in illicit drug injection use and/or low numbers of susceptible persons in the key risk population, people who use injection drugs (Kuo). While the annual rates of HCV infection continue to decline in BC, they remain substantially higher than the national average (see Figure 6). Furthermore, the decreasing rates of HCV infection in the province should not mask the health care burden presented by existing cases that continue to progress to more serious sequelae (PHAC, 2011).

Figure 6. Hepatitis C rates by year, 2002 to 2011 (BCCDC, 2011b)



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
BC Hepatitis C Reports	4329	3573	3073	2864	2922	2892	2499	2484	2228	1970
BC Hepatitis C Rate	105.6	86.7	74.0	68.2	68.9	67.1	57.0	55.7	49.2	43.1
Canadian Hepatitis C Rate	50.9	46.8	45.2	40.4	36.9	36.6	35.8	33.2	29.6	

The highest rates of HCV infection in BC have also been identified among particular populations, including people who inject drugs, Aboriginal peoples and sex trade workers (Buxton & Krajden, 2007). Across all age groups in the province, males are more likely to be HCV positive, with a rate of 58.5 per 100,000 compared to that of 27.8 per 100,000 in females (BCCDC, 2011b). However, this gender gap is narrowing due to increasing infection rates among young females in the province (Buxton & Krajen, 2007; PHAC, 2011). For instance, a cross-sectional study of Aboriginal youth aged 18-30 in BC found that female participants had significantly higher rates of HCV than males (Cedar Project, et al., 2008).

In terms of geographical vulnerability, the highest HCV infection rates in BC were been identified in the Fraser East (62.1 per 100,00), Northern Interior (58.8 per 100,000) and Northeast (56.9 per 100,000) Health Service Delivery Areas (HSDAs) in 2011 (BCCDC, 2011b). On the other hand, the lowest rates of infection were found in the Richmond and North Shore/Coast Garibaldi HSDAs.

1.3 HIV/HCV co-infection

There is a current lack of surveillance data on HIV/HCV co-infection rates in BC at the population level. In effort to address this gap in information, Buxton and colleagues (2010) conducted a study that linked HIV-positive cases with both anti-HCV positive cases and anti-HCV negative testers in the BC surveillance and laboratory systems to determine the overall prevalence of HIV/HCV co-infection in the province. The authors found that 53% of study participants living with HIV were also infected with HCV. In terms of risk factors, it was found that HIV/HCV co-infection was more likely if participants reported to be people who use injection

drugs and/or of Aboriginal ethnicity (Buxton, et al., 2010). A recent systematic review also reported that HIV-positive men who have sex with men (MSM) are 4 times more likely to also acquire HCV, when compared with HIV-negative MSM (Yaphe, et al., 2012). The high estimated prevalence of co-infection in BC further supports the need for community-based programming to address these diseases along the continuum of prevention, diagnosis, treatment and care.

1.4 What does the surveillance data tell us?

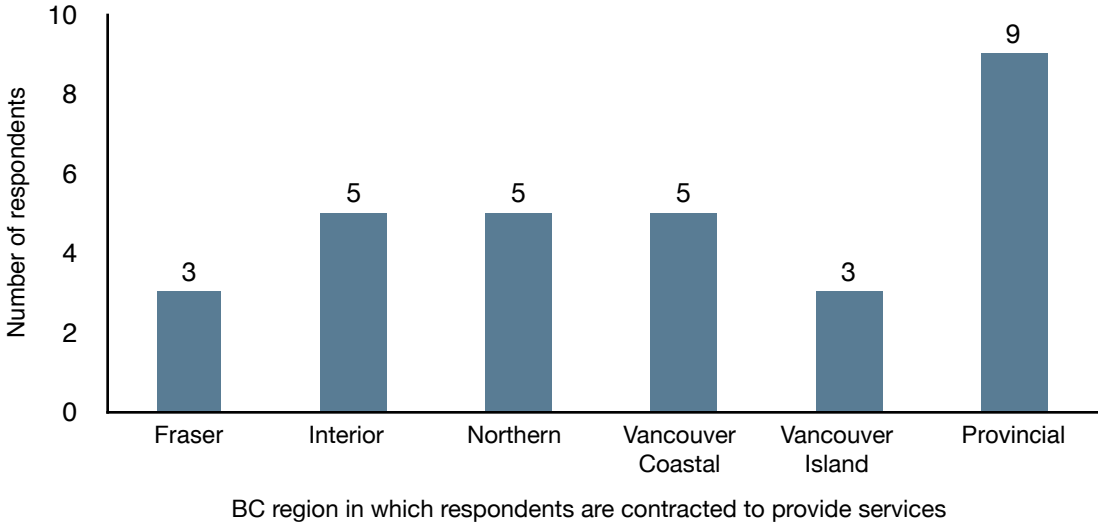
The data presented in this section demonstrate that HIV, HCV and HIV/HV co-infection continue to burden the BC health care system. Financially speaking, the social and economic costs associated with HIV/AIDS and HCV in the province are immense. For instance, it was estimated that all new HIV infections in 2007 represented $71.1 million in direct lifetime medical care and treatment costs, and an additional $395 million in indirect social costs (Pacific AIDS Network, 2009). These figures and data above justify the need for programing and services to effectively prevent the spread of HIV and HCV and to provide treatment and support for those living with these conditions.

2.0 CHERT Respondents

The CHERT was completed by a total of 30 executive directors or program managers of community-based HIV/HCV organizations in British Columbia (BC) for the 2012 - 2013 fiscal year. The 2011 - 2012 round of data collection was based on the same number of respondents (*n* = 30). Of the 43 community-based agencies that are member organizations of the Pacific AIDS Network, 70% (*n* = 30) completed the CHERT in the last year. As seen in Figure 7, participation from agencies providing services in each of the BC health authorities was fairly balanced. The majority of survey respondents indicated that they are contracted to provide services at the provincial level (*n* = 9) (see Figure 7).

The 2013 version of the CHERT included 87 questions, of which 3 were open-ended questions and 84 were closed-ended. The survey questions focused on programs and services that were delivered by the responding organizations during the 2012 - 2013 fiscal year. On average, respondents took 67 minutes to complete the survey.

Figure 7. Number of CHERT respondents by BC health authority (*n* = 30)



3.0 People Served

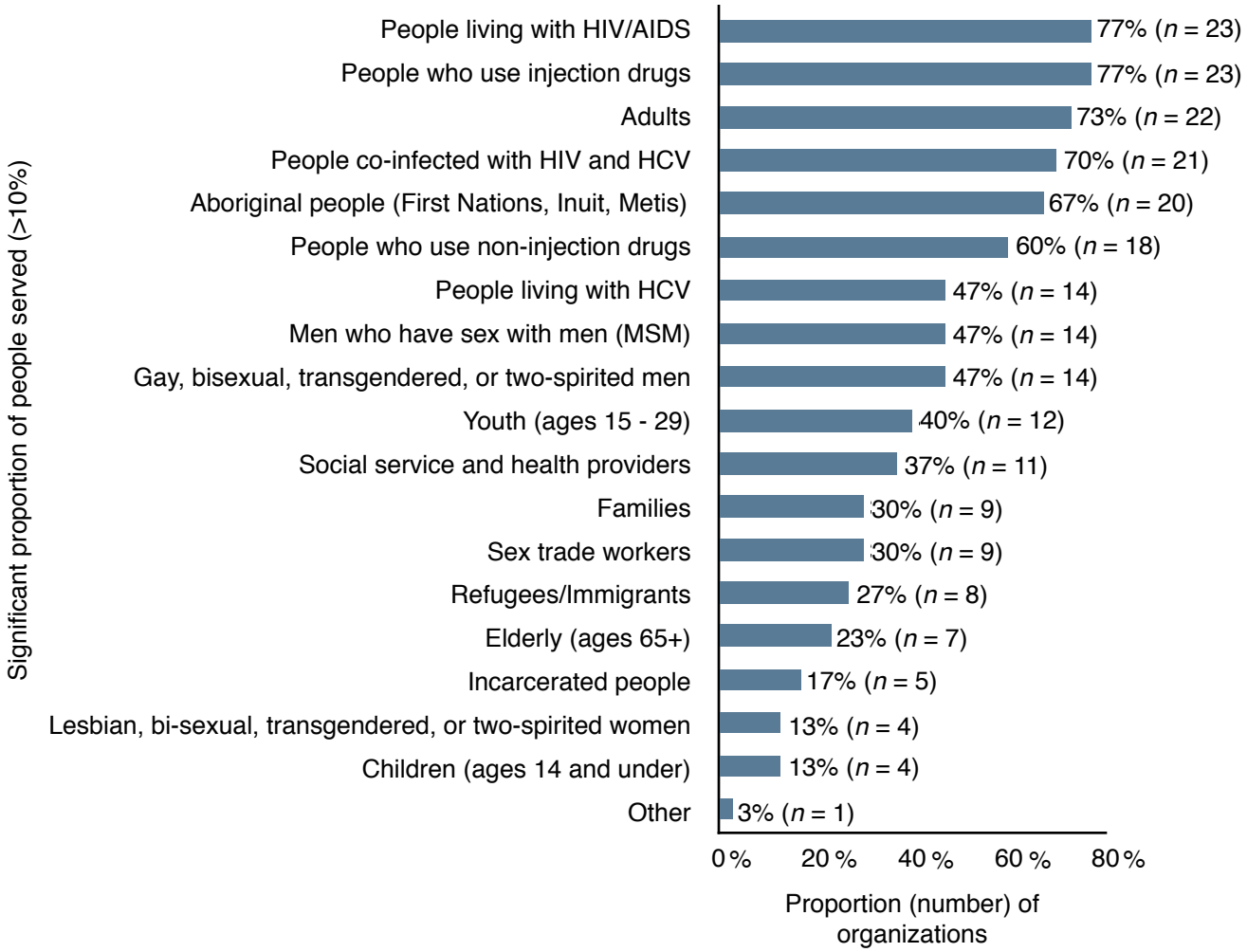
In the CHERT, respondents were asked to approximate the total number of times clients accessed services from their organizations in the last fiscal year. Across all responding organizations, it was reported that clients accessed their services a total of 303,499 times. With this data it can be estimated that on average, each individual client accessed programs or services from responding organizations roughly nine times in the last year. Depending on the organizations' size and capacity, the number of unique clients served by each CHERT respondent in the last year varied considerably, from 78 to 15,684 individuals.

Data from the CHERT also demonstrated that responding organizations served a substantial number of new, unique clients in the last fiscal year. Specifically, respondents indicated that a total of 3,724 new people were served by their organizations. Organizations also reported that a total of 267 clients were discharged from their services, for reasons such as relocation, no longer requiring services or client deaths.

The CHERT also asked respondents to specify the populations that made up a significant proportion (>10%) of the people they served in the last fiscal year. People living with HIV/AIDS (77%; $n = 23$) and those co-infected with HIV and HCV (70%; $n = 21$) comprised a significant proportion of the people served by the majority of respondents (see Figure 8). Consistent with results from 2012, high-risk populations also demonstrated to be a focus of many organizations' efforts, including people who inject drugs (77%; $n = 23$), Aboriginal peoples (67%; $n = 20$) and men who have sex with men (MSM) (47%; $n = 14$). Focusing on high-risk populations has been a widely adopted strategy since the advent of the epidemic, and continues to align with BC's provincial framework to address HIV/AIDS (BC Ministry of Health, 2012).

In terms of age, most respondents indicated that adults comprised a significant proportion of the people they served (77%; $n = 22$) in the last fiscal year, whereas fewer organizations focused on youth ($n = 40\%$; 12), the elderly (23%; $n = 7$) and children (13%; $n = 4$) (see Figure 8). Additionally, one respondent added that health sciences students also made up a significant proportion of the people they served in the 2012 - 2013 year.

Figure 8. Populations that represent a significant proportion of people served (>10%) (*n* = 30)



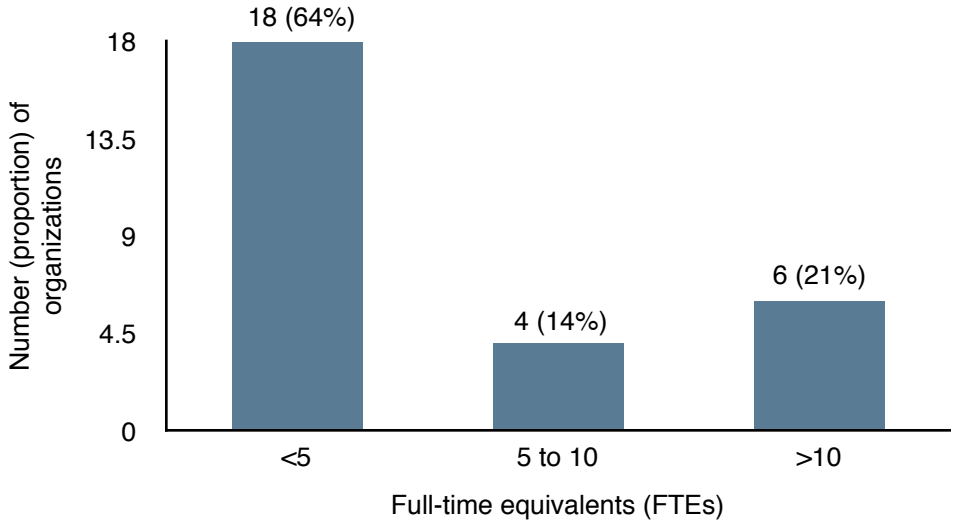
4.0 How Community-Based HIV/HCV Organizations Operate

4.1 Human Resources

4.1.1 Paid Staff for HIV/HCV Related Work

CHERT respondents who reported that their organizations' mandate is to provide HIV and/or HCV focused services or programs were asked a series of questions related to their human resources. Similar to results from 2011 - 2012, data from the survey demonstrates that community-based HIV/HCV organizations in BC are relatively small[1] (OCHART, 2007). As seen in Figure 9, the majority of organizations (*n* = 64%; 18) had less than 5 full-time equivalents (FTEs) available to support their work in the 2012 - 2013 year. Few organizations were staffed with higher levels of support, with only 4 (14%) organizations having 5 to 10 FTEs dedicated to their work and 6 (21%) organizations with more than 10 FTEs.

Figure 9. Number of community-based HIV/HCV organizations by full-time equivalents (*n* = 28)

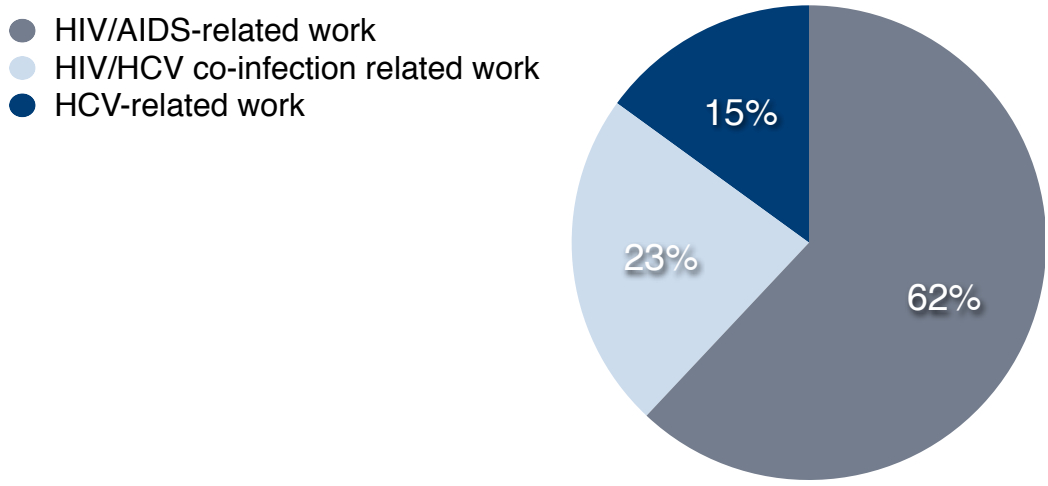


CHERT respondents were also asked to approximate what proportion of their organizations' FTEs were dedicated specifically to HIV, HCV, and HIV/HCV co-infection work. On average, organizations' dedicated the greatest proportion of their FTEs (62%) to HIV-related work, followed by HIV/HCV co-infection work (23%) and HCV-related work (15%).[2]

[1] OCHART (2007) defines small organizations as those that are supported by less than 5 FTEs to conduct their work.

[2] Note that this data is based on responses from a smaller number of CHERT respondents (*n* = 17), as many did not complete the data request.

Figure 10. Proportion of organizations' FTEs dedicated to HIV, HCV, or HIV/HCV co-infection work (*n* = 17)



4.1.2 Volunteers and Post-Secondary Students

Most non-profit organizations in Canada rely on volunteers to help them fulfill their missions. Given the relatively small size of organizations responding to the CHERT, it is not surprising that responding organizations are dependent on volunteers and students to support their work. In the last fiscal year, each organizations' HIV/AIDS related work was supported by an average of 40 volunteers, and HCV related work by an average of 18 volunteers. Further, CHERT respondents estimated that their organizations benefitted from an average of 122 hours per week, or roughly $39,719 worth of volunteer service per week.[3][4]

A handful of CHERT respondents (*n* = 3) reported that their organizations do not make use of volunteers as a source of support for their HIV/AIDS or HCV related work. While it is recognized that not every community-based organization has the need or capacity to successfully manage a team of volunteers, these CHERT respondents could consider the feasibility and usefulness of implementing a volunteer program.

In addition to volunteers, post-secondary students also played a significant role in supporting community-based HIV/HCV organizations in the last fiscal year. Data from the CHERT demonstrates that an average of 6 post-secondary students assisted each organization with their HIV/AIDS or HCV-related work.

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[3] This dollar amount was calculated by respondents and based on an assumed rate of $10/hour for unskilled volunteers, and $15/hour for skilled volunteers.

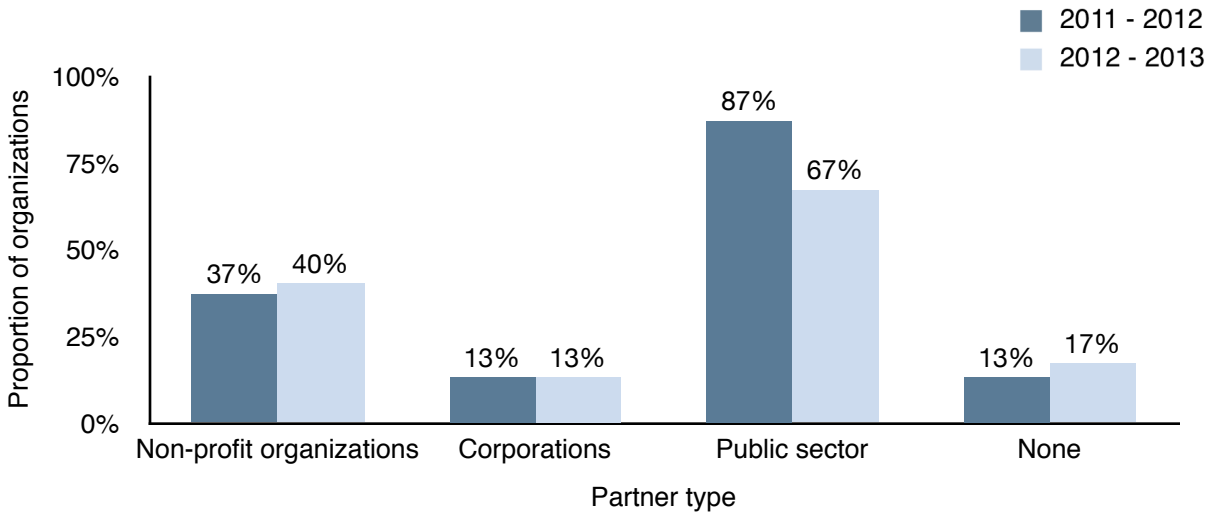
[4] Note that this data is based on responses from a smaller number of CHERT respondents (*n* = 15), of which most were larger organizations. Therefore, it is likely that this data is overestimated.

4.2 Partnerships and Collaboration

While non-profit agencies have traditionally operated independently, it is widely recognized that in order to effectively address the HIV and HCV epidemics in BC, a collaborative and unified response is required. The formation of collaborations and partnerships can help community-based HIV/HCV organizations to: (i) avoid service gaps and duplication; (ii) share lessons learned; (iii) provide more appropriate referrals for their clients; (iv) improve service delivery; and (v) strengthen the community-level response to HIV and HCV. In addition, the formation of partnerships may also be an effective way to respond to potential funding cuts for HIV or HCV related work.

The majority of CHERT respondents (83%; *n* = 25) reported that they held some type of *formal* partnership with other organizations or agencies in the last fiscal year (see Figure 11). Among those who held these partnerships, the majority collaborated with agencies or groups in the public sector, such as partnerships with the BC health authorities, government bodies, or universities (67%; *n* = 20). Partnerships with non-profit organizations were also held by a substantial number of CHERT respondents (40%; *n* = 12), whereas collaborations with corporations were less common (13%; *n* = 4). Some organizations reported that they did not hold any formal partnerships in the last fiscal year (17%; *n* = 5). As illustrated in Figure 11, the breakdown of formal partnerships held by community-based HIV/HCV organizations was quite consistent between the 2011 - 2012 and 2012 - 2013 CHERT reporting periods.

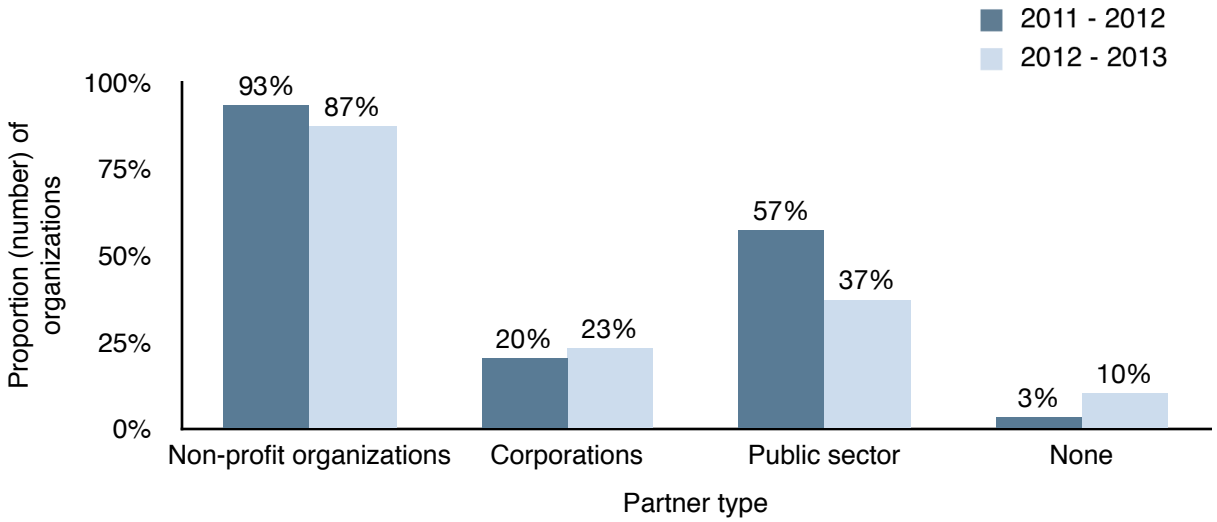
Figure 11. Proportion of formal organizational partnerships by partner type, 2011 - 2012 and 2012 - 2013 (*n* = 30)



CHERT respondents were also asked to describe the *informal* partnerships they held with other agencies or groups in the last fiscal year. As seen in Figure 12, most responding organizations (87%; *n* = 26) reported that they held partnerships with other non-profit organizations in the 2012 - 2013 year. This data demonstrates a commitment among CHERT respondents to work collaboratively with other non-profits to more effectively address HIV and HCV in BC. Informal

partnerships were also held with groups in the public sector (37%; *n* = 11), in addition to some corporations (23%; *n* = 7).

Figure 12. Proportion of informal organizational partnerships by partner type, 2011 - 2012 and 2012 - 2013 (*n* = 30)



To better understand the benefits of forming formal and informal partnerships for community-based HIV/HCV organizations, CHERT respondents were also asked to qualitatively describe the value these collaborations have had for their organizations. Respondents most commonly discussed the benefit of sharing resources, information and strategies with partner agencies (*n* = 11), such as sharing costs, the sharing of strategies to address challenges, and having access to expertise in a range of areas. Their comments included:

- *"We are able to share resources and experiences. For example, we are considering operating a mobile sexual health and harm reduction clinic and* [local university students] *overhauled and repaired the vehicle for free."*
- *"Sharing strategies for common challenges and sharing costs*."
- "*Draw from expertise of other partners and corporation*."

Other commonly reported benefits of establishing formal and/or informal partnerships were:

- enhanced program delivery (*n* = 6), including the ability to extend the reach of services and the provision of more focused and culturally responsive services
- strengthened networking (*n* = 4)
- enhanced capacity and support to achieve goals and create impact in addressing HIV and HCV (*n* = 3)
- enhanced communication across the sector (*n* = 3)
- opportunities for capacity building and skills development (*n* = 2)

Comments related to the above themes included:

- *"The backbone of much of our work is dependent on partnerships, both formal and informal. Partnerships or strategic alliances help us define and focus our programming..."*
- *"In-formal partnership agreements exist when we work together with partner organizations towards a shared outcome."*
- *"You help each other to achieve a common goal."*

Given that a handful of CHERT respondents reported that they did not hold any type of formal (17%; $n = 5$) and/or informal (10%; $n = 3$) partnerships in the last year, these agencies are urged to consider the above benefits of adopting a collective response in addressing HIV and HCV in the province.

4.3 Best Practices and Operational Challenges

In effort to explore best practices of delivering community-based HIV/HCV programs and services, CHERT respondents were asked to describe specific aspects of their organizations that worked particularly well in the last fiscal year. Respondents most frequently discussed the value of engaging clients and other community members in the design, delivery and governance of their programs and services (*n* = 8). Their comments included:

- *"The involvement of elders in activities is critical to success. And asking the community what activities they would like to be involved with at our organization."*
- *"What works best in our organization is the adoption of a peer-run model and the inclusion of people who use drugs in program development and service delivery."*

One respondent explained that the meaningful engagement of people living with HIV/AIDS allows their organization to provide a more responsive response to the HIV epidemic in BC:

- *"...the intimate, ongoing and decisive involvement of HIV-positive people enables* [our organization] *to assess quickly and routinely what's working and what needs changing in order to meet the ever evolving needs of the various populations affected by the epidemic."*

In reflecting on aspects of their organization that work particularly well, respondents also discussed the value of:

- partnerships and collaboration (*n* = 5)
- highly skilled, experienced and dedicated staff (*n* = 4)
- support from volunteers (*n* = 3)
- effective communication practices with members (*n* = 3)
- adopting harm reduction approaches (n = 3)
- adopting a holistic approaches (*n* = 2)
- using cultural practices (*n* = 2)
- focusing on community need (*n* = 2)
- implementing evidence-based strategies (*n* = 1)

Their comments describing the above themes included:

- *"We're proud of our partnerships with* [Aboriginal communities] *and the local friendship centre. It's working because of mutual respect and the willingness to work together to address HIV and HCV in Aboriginal Communities...our community partnerships were the result of a lot of thought and hard work and again the willingness to look at what the need of the community is not just the need of your own organization."*

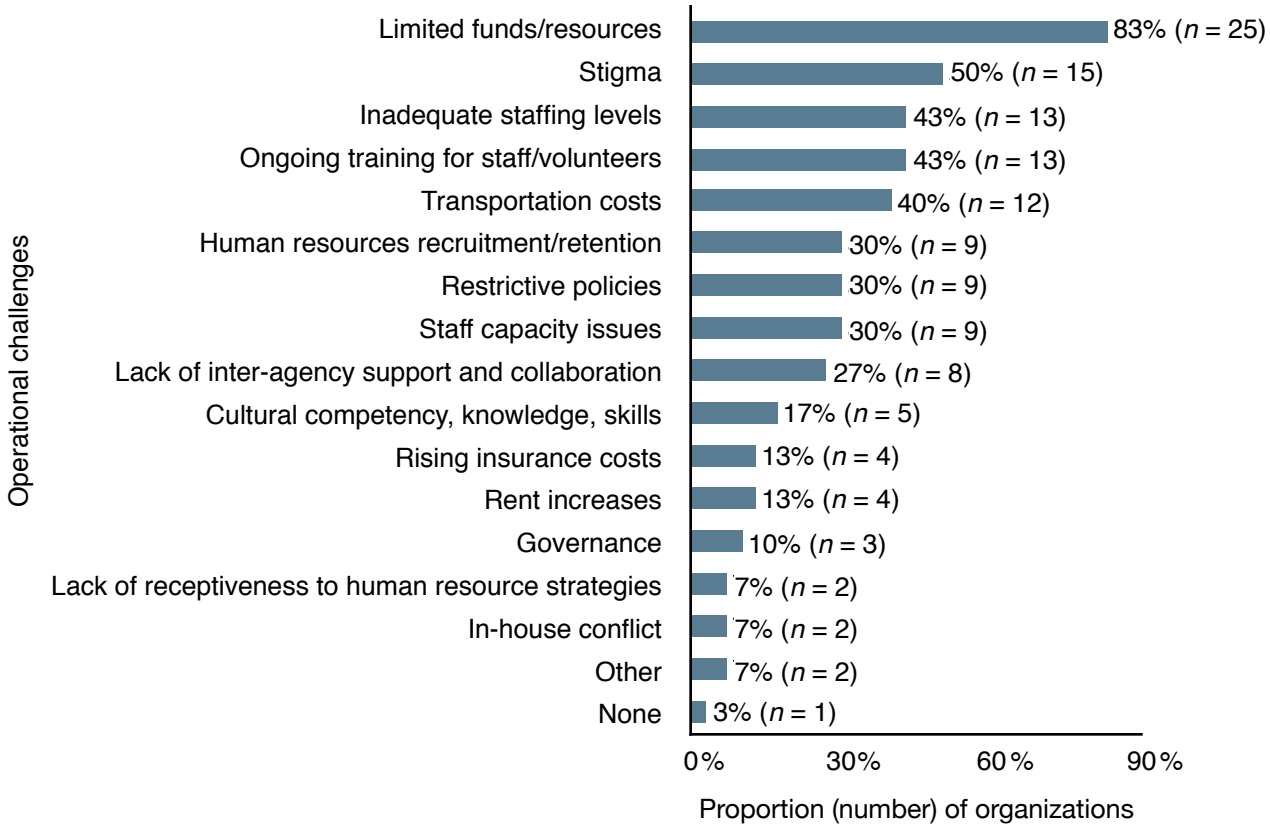
- *"Our partnership with* [a community group]*, has allowed for the development of a strong, community based response to stigma and lack of educational opportunities faced by people who use illicit drugs."*
- *"Our programming is working well...we have staff who are very passionate and dedicated to their jobs, who are frequently going above and beyond to serve the community."*
- *"Social media has been useful to keep membership informed on HIV/AIDS news, events and training."*
- *"...using well-researched strategies for program delivery and for governance and strategic planning. Commitment to partnering rather than competing."*

Another question in the CHERT asked respondents to identify operational challenges that their organizations faced during the last fiscal year (see Figure 13). In accordance with results from the 2011 - 2012 CHERT, the most frequently mentioned operational challenges were:

- limited funds/resources (83%; *n* = 25)
- stigma (50%; *n* = 15)
- inadequate staffing levels (43%; *n* = 13)
- ongoing training for staff/volunteers (43%; *n* = 13)
- transportation costs (40%; *n* = 12)

While limited funding and resources for community-based programs and services are well-known challenges facing such agencies, we must remember that stigma also continues to act as a significant barrier to prevention, testing, treatment and support efforts related to both HIV and HCV. This data should urge community-based HIV/HCV organizations to continue to focus on strategies to address stigma and discrimination, such as social media campaigns, educational campaigns for a wide variety of service providers and the general public, the promotion of laws and policies that ensure the full realization of all human rights, and the meaningful engagement of vulnerable groups in the provision of programs and services. Additionally, one respondent explained that their organization has also been challenged by past situations in which funding for programs or services has been lost.

Figure 13. Operational challenges faced by responding organizations (*n* = 30)



5.0 Funding for Community-Based HIV/HCV Organizations

CHERT respondents were also asked to describe the funding their organizations received in the 2012 - 2013 year.[5] As seen in Table 1, responding organizations rely heavily on provincial (63%) and federal government (17%) funding sources to conduct their work. These sources collectively accounted for 80% of funding received by responding organizations in the last fiscal year.

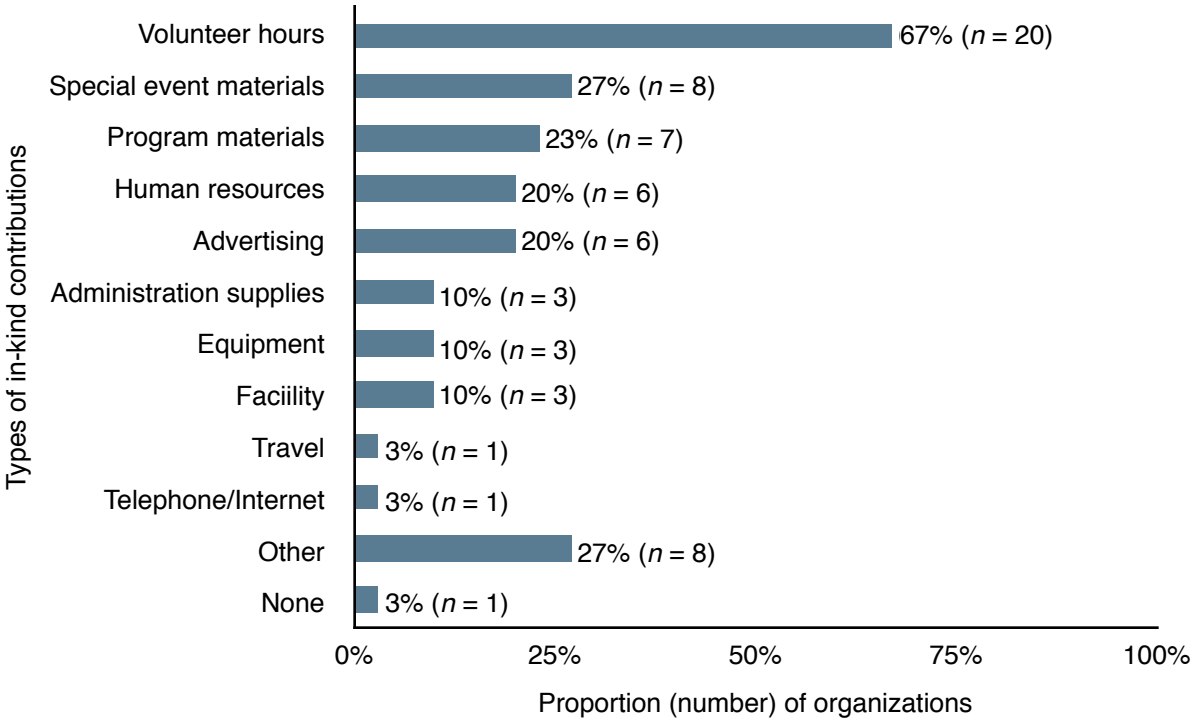
Table 1. Funding sources reported by CHERT respondents (*n* = 29)

Funding Source	%
Provincial government (e.g. BC health authorities, BC gaming, BC housing, etc.)	63
Federal government (e.g. AIDS Community Action Program, Hep C Program, etc.)	17
Foundation funding (e.g. MAC AIDS, Vancouver Foundation, etc.)	8
Internal fundraising (e.g. membership fees, other fundraising initiatives, etc.)	5
In-kind contributions	4
Private sector (e.g. corporate donations)	2
Social enterprise (i.e. businesses that help people/communities)	0.9
Research funding	0.1

The CHERT also took a closer look at the specific types of in-kind contributions community-based HIV/HCV organizations received in the last fiscal year. In accordance with results from the 2011 - 2012 CHERT report, the majority of respondents reported receiving in-kind contributions in the form of volunteer hours (67%; *n* = 20), special event materials (27%; *n* = 8), and program materials (23%; *n* = 7) (see Figure 14). Some respondents described that they also received in-kind contributions in the form of food (*n* = 3), harm reduction materials (*n* = 1), building materials (*n* = 1), legal services (*n* = 1), retail items for fundraising (*n* = 1) and service learning placements (*n* = 1).

[5] Note that the funding information provided in this section is based on data provided by CHERT respondents, not funding agencies themselves.

Figure 14. Types of in-kind contributions organizations received by CHERT respondents (*n* = 30)



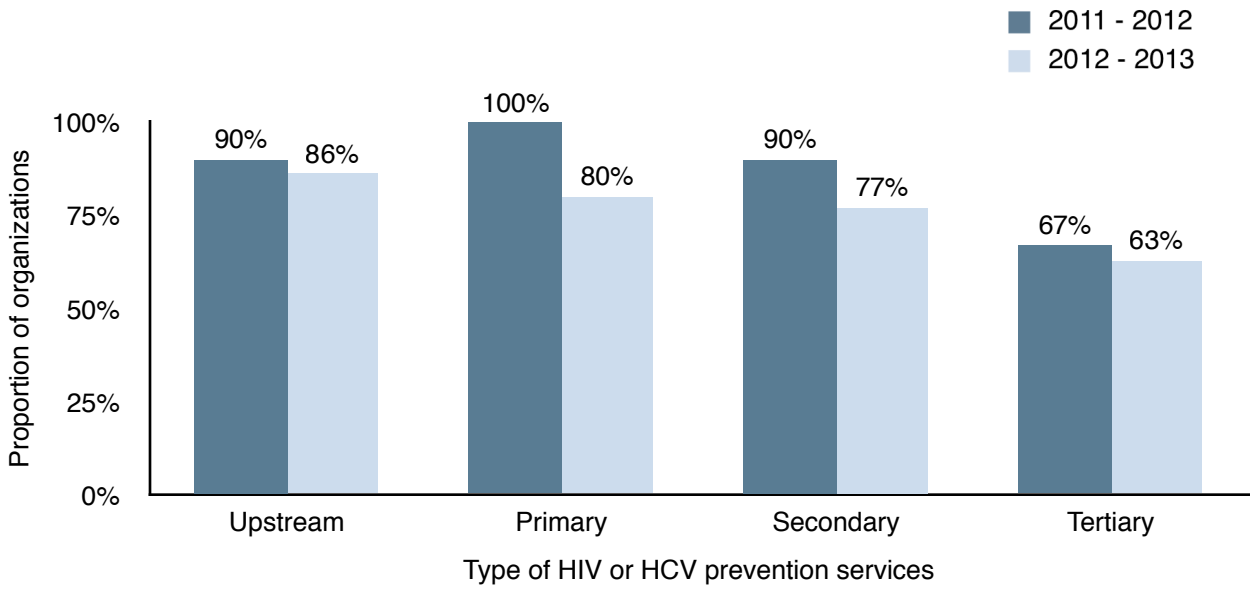
6.0 The Impact Community-Based Organizations are Making

6.1 Preventing the Spread of HIV and HCV

Data from the CHERT demonstrates that community-based HIV/HCV organizations play a critical role in the prevention of HIV and HCV in British Columbia. Similar to results from 2011 - 2012, the majority of responding organizations (87%; *n* = 26) reported that they provided some form of HIV and/or HCV prevention services in the last fiscal year. Organizations reporting that they did not provide prevention services (13%; *n* = 4) were most frequently provincial-level coalitions, networks or societies that tend to focus their efforts on supporting other organizations in their work.

As seen in Figure 15, the majority of CHERT respondents focused their efforts on the provision of *upstream* (86%; *n* = 26), *primary* (80%; *n* = 24) and *secondary* (77%; *n* = 23) prevention services in the last year. Comparatively, respondents reported a lesser focus on the provision of *tertiary* prevention services (63%; *n* = 19). In comparison to results from the 2011 - 2012 CHERT, it appears that fewer organizations provided each type of HIV or HCV prevention services in the 2012 - 2013 year (see Figure 15). This finding could reflect the shift to a greater number of provincial-level networks, societies and coalitions participating in the 2012 - 2013 round of data collection.

Figure 15. Proportion of organizations by type of HIV or HCV prevention service offered (*n* = 30)



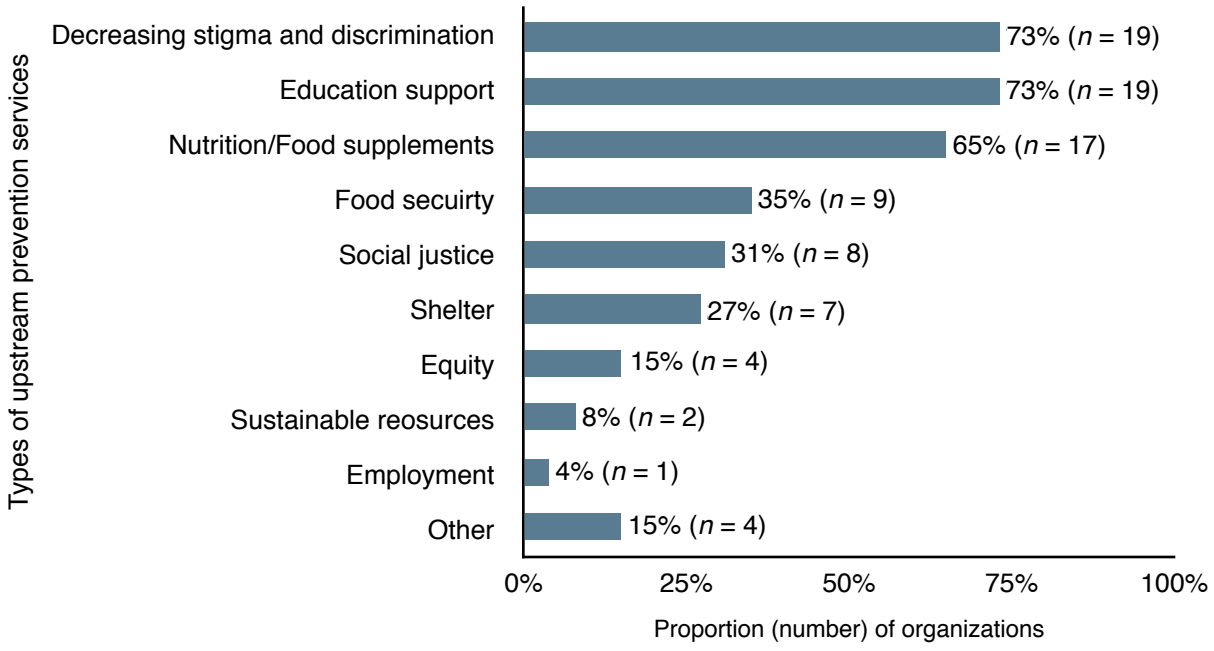
6.1.1 Upstream Prevention Services

As defined in the CHERT, upstream prevention involves:

> *"decreasing societal vulnerability to HIV/HCV infection, lowering individual risk through contextual interventions and preventing risk factors from arising (e.g. education, equity, employment, shelter, social justice, poverty reduction, decreasing stigma and discrimination)."*

While expanding access to biomedical prevention tools, such as STI treatment and treatment as prevention (TasP) are critical interventions for altering the course of the HIV and HCV epidemics, these strategies must be complemented by responses that address the structural drivers of HIV and HCV vulnerability. A range of upstream prevention services were provided by CHERT respondents in the last fiscal year to address such factors. Among the organizations offering upstream prevention services, efforts were most commonly focused on decreasing stigma and discrimination (73%; n = 19), education support (73%; *n* =19) and the provision of nutrition/food supplements (65%; *n* = 17) (see Figure 16). The focus of organizations' efforts on these specific upstream prevention services is consistent with 2011 - 2012 CHERT results. Other responses (15%; *n* = 4) spoke to the provision of integrated health promotion services and advocacy efforts.

Figure 16. Proportion of organizations by type of upstream prevention service offered (*n* = 24)



6.1.2 Primary Prevention Services

The CHERT defines primary prevention services as:

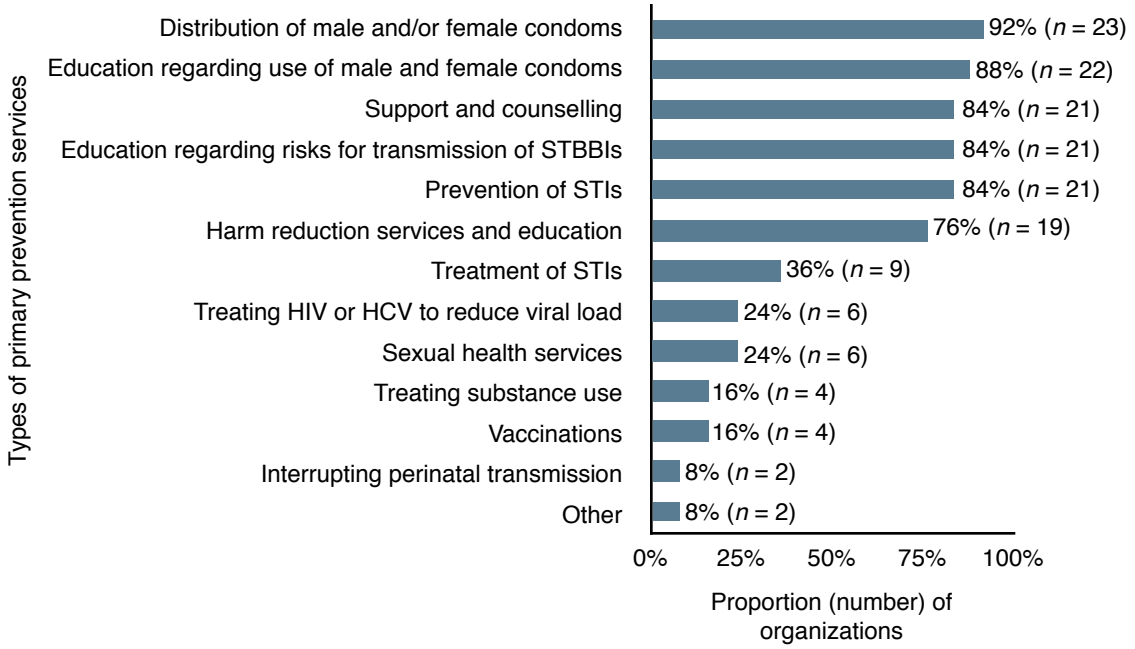
> *"the prevention of HIV/HCV acquisition and prevention of secondary transmission from HIV/HCV-infected individuals to others through the adoption and maintenance of HIV/HCV risk reduction behaviours (e.g. distribution of male and female condoms, condom negotiating skills, reduced number of partners/frequency of intercourse, etc.)."*

In accordance with results from the 2011 - 2012 CHERT, responding organizations' focused their primary prevention efforts on the distribution of harm reduction materials, prevention education, and support and counselling services in the last fiscal year (see Figure 17). Among respondents who offered primary prevention services, organizations most commonly provided:

- the distribution of male and/or female condoms (92%; *n* = 23)
- education regarding the use of male and female condoms (88%; *n* = 22)
- support and counselling (84%; n = 21)
- education regarding risks for the transmission of sexually transmitted blood borne infections (STBBIs) (84%; *n* = 21)
- prevention of STIs (84%; *n* = 21)
- harm reduction services and education (76%; *n* = 19)

Other responses (18%; *n* = 2) provided by CHERT respondents further specified the type of primary prevention services they offered, including the provision of a mobile health nurse and education presentations in high schools upon invitation.

Figure 17. Proportion of organizations by type of primary prevention service offered (*n* = 25)



The distribution of harm reduction materials is a critical element of HIV/HCV prevention, as this strategy has demonstrated to be effective in reducing the transmission of HIV and HCV (BCCDC, 2013; BC Ministry of Health, 2012). Data from the CHERT demonstrates that community-based HIV/HCV organizations play a vital role in the distribution of harm reduction and prevention materials in BC (see Table 2). For instance, CHERT respondents reported that they collectively distributed a total of 412,578 condoms and 206,427 sachets of lube in the last fiscal year (see Table 2).

Organizations also reported that they distributed a large amount of safer injection equipment, with the distribution of nearly 1.2 million needles in BC in the last fiscal year, which is a substantial increase from the amount distributed in 2011 - 2012 (see Table 2). Respondents estimated that roughly 86% (1,026,251) of these needles were returned to be safely disposed of. Among organizations that distributed needles, the number of needles distributed varied substantially, from a low of 150 to a high of 281,733. As noted in the 2011 - 2012 CHERT report, this variation could be a result of differences in organizational capacity, the concentration of injection drug use in particular communities, and/or the placement of needle exchange programs within some organizations and not others.

CHERT respondents also reported that they distributed a substantial amount of safer inhalation equipment in the last year, including the distribution of 31,224 pipes and glass tubes (see Table 2). Safer inhalation programs have demonstrated to be key in engaging people who use crack cocaine with harm reduction services. The distribution of safer inhalation equipment is particularly important given that many people who smoke drugs do not inject them, and therefore, without the distribution of safer smoking supplies these individuals may not have the opportunity to engage with harm reduction and other community services (Toward the Heart, 2013).

Table 2. Total number of harm reduction/prevention materials distributed, 2011 - 2012 and 2012 - 2013

Harm reduction/ Prevention material	Number Distributed in 2011 - 2012	Number Distributed in 2012 - 2013
Condoms	443,566	412,578
Lube	243,068	206,427
Needles	879,804	1,195,065
Needles returned	619,761	1,026,251
Pipes/glass tubes	10,966	31,224

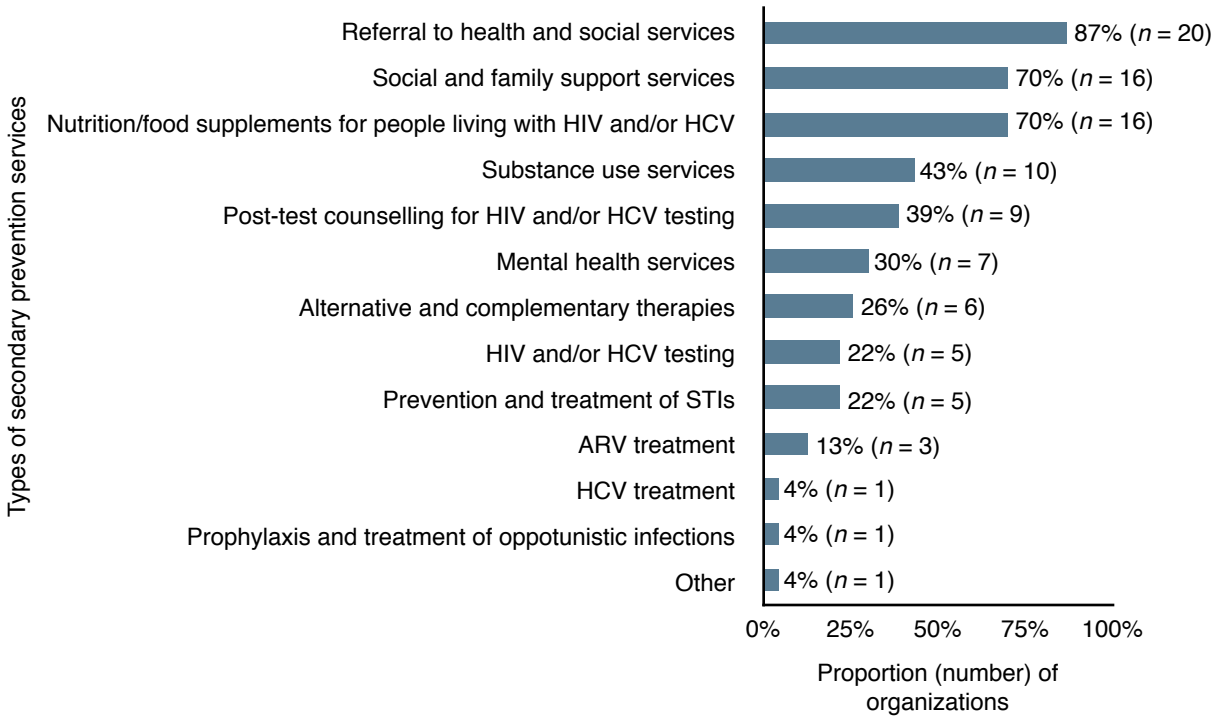
6.1.3 Secondary Prevention Services

The CHERT defines secondary prevention services as:

> *"preventing or delaying the progression of HIV/HCV infection to disease and disability including AIDS and opportunistic infections through prevention, prophylaxis, treatment and support services (e.g. HIV/HCV testing, antiretroviral (ARV) treatment, prophylaxis, and treatment of opportunistic infections, prevention and treatment of STIs)."*

Data from the CHERT show that community-based HIV/HCV organizations greatly contributed to the secondary prevention of both HIV and HCV in the last fiscal year. As seen in Figure 18, CHERT respondents focused their secondary prevention efforts on the provision of referrals to health and social services (87%; *n* = 20), social and family support services (70%; *n* = 16), and nutrition/food supplements for people living with HIV and/or HCV (70%; *n* = 16). The focus of respondents' secondary prevention services in these areas is consistent with results from the 2011 - 2012 round of data collection. One respondent specified that their organization offered counselling, strategic advisors and peer support as strategies of the secondary prevention of HIV and HCV.

Figure 18. Proportion of organizations by type of secondary prevention service offered (*n* = 23)



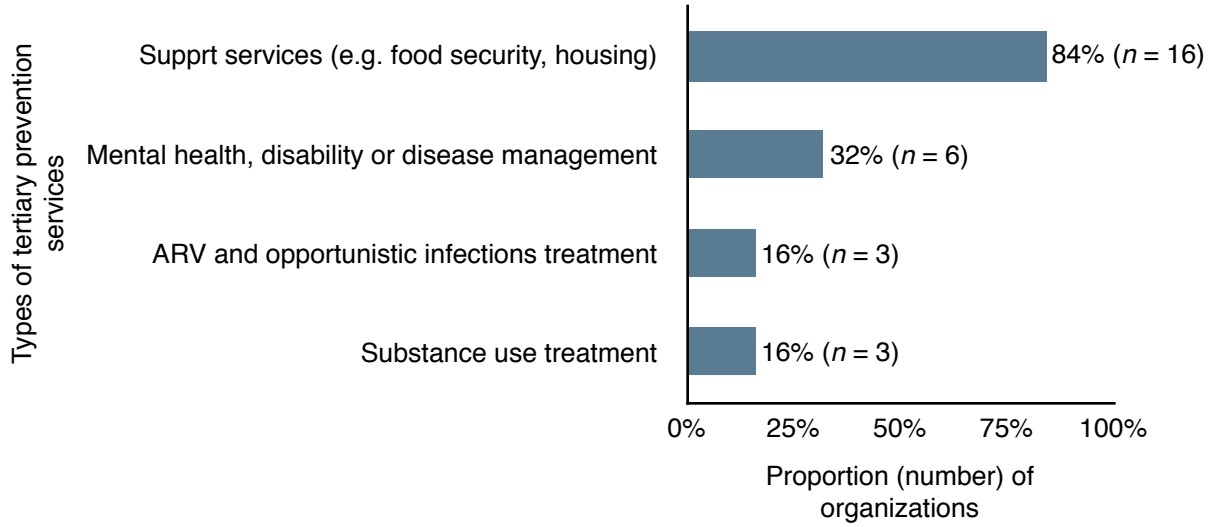
6.1.4 Tertiary Prevention Services

As defined in the CHERT, tertiary prevention services involve:

> *"ameliorating disease severity, preventing disability, enhancing quality of life and preventing mortality from HIV or AIDS (e.g. ARV and opportunistic infections treatment, harm reduction, drug and alcohol use treatment, mental health services, disability and disease management and support services)."*

In comparison to other prevention strategies, community-based organizations appear to play a less influential role in the tertiary prevention of HIV and HCV. Among organizations that did offer tertiary prevention services, the majority (84%; *n* = 16) focused their efforts on the provision of support services, such as food security and housing services. As illustrated in Figure 19, small numbers of CHERT respondents offered mental health, disability of disease management services (32%; *n* = 6), ARV and opportunistic infections treatment (16%; *n* = 3), and/or substance use treatment (16%; *n* = 3). These findings are consistent with results from the 2011 - 2012 CHERT.

Figure 19. Proportion of organizations by type of tertiary prevention service offered (*n* = 19)



6.2 Accessing Hard-to-Reach Populations: HIV/HCV Outreach Efforts

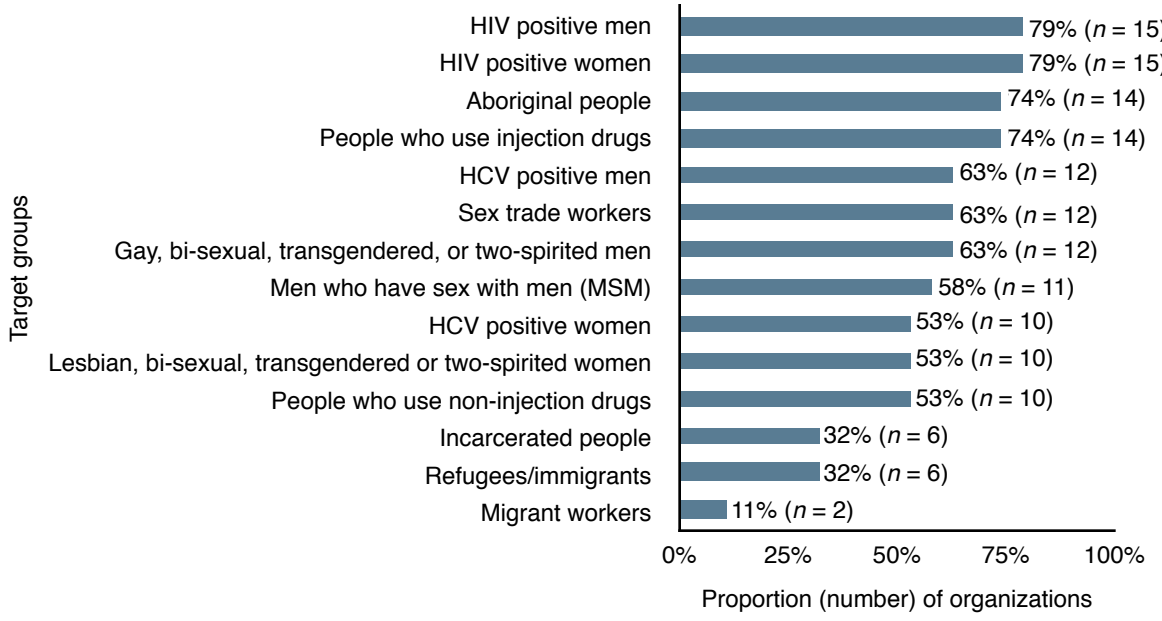
Outreach efforts for HIV and HCV provide access to hard-to-reach populations that are often in the greatest need for prevention, treatment and support services. Bringing information and services to the community level has demonstrated to be an effective strategy in overcoming access barriers commonly faced by highly affected populations. Given the trusting relationships community-based organizations often develop with marginalized populations, such agencies are critical players in the provision of outreach services.

In both the 2011 - 2012 and 2012 - 2013 rounds of data collection with the CHERT, 63% (*n* = 19) of responding organizations reported that they provided outreach services, whereas 37% (*n* = 11) did not. Among the organizations providing outreach services, it was reported that a total of 32,274 people were reached in the last fiscal year.

6.2.1 Who is being reached?

The survey also explored what types of people/community groups CHERT respondents served in their outreach efforts. As seen in Figure 20, organizations most commonly targeted men and women living with HIV/AIDS (79%; *n* = 15) in their outreach services. A range of high-risk groups were also reached, such as Aboriginal people (74%; *n* = 14), people who use injection drugs (74%; *n* = 14), sex trade workers (63%; *n* = 12) and gay, bi-sexual, transgendered, or two-spirited men (63%; *n* = 12). In terms of age, CHERT respondents most commonly provided outreach services to adults (89%; *n* = 17), followed by youth (68%; *n* = 13) and the elderly (58%; *n* = 11). When comparing 2011 - 2012 and 2012 - 2013 CHERT data, there does not appear to be any substantial differences in the types of people/community groups community-based organizations are reaching.

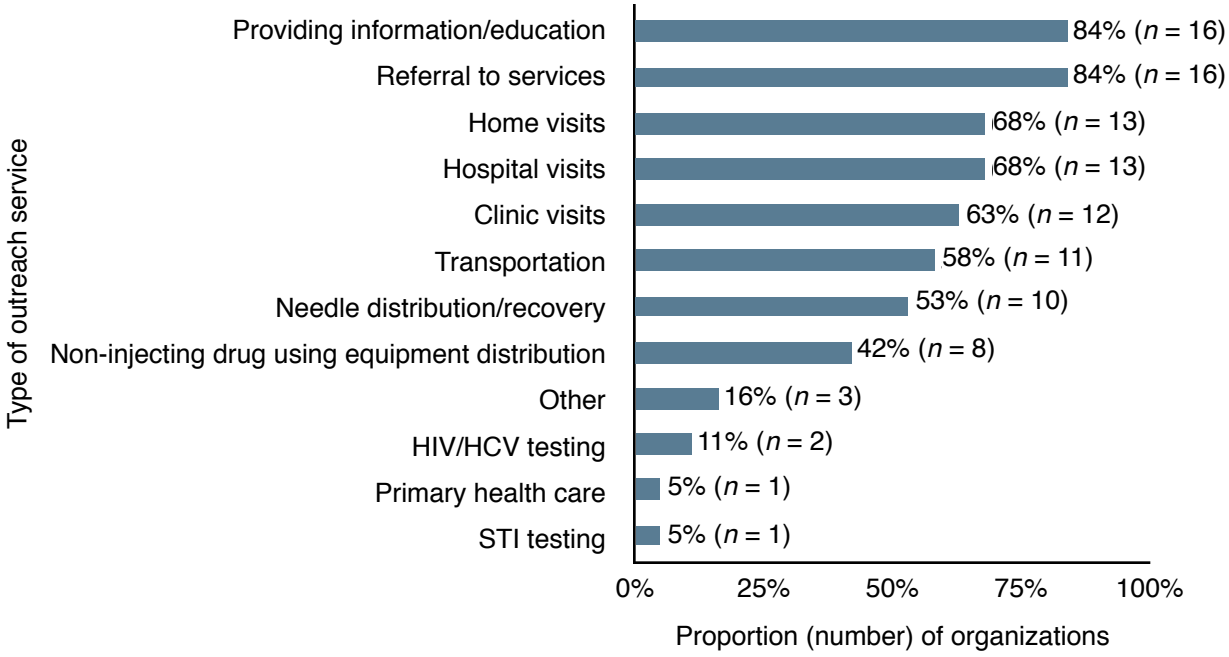
Figure 20. Proportion of organizations reaching target groups in outreach activities (*n* = 19)



6.2.2 Outreach activities

CHERT respondents were also asked to specify the types of outreach activities they offered in the last year. As seen in Figure 21, organizations most commonly focused on providing information and education to the community (84%; *n* = 16), referral services (84%; *n* = 16), and home and hospital visits (68%; *n* = 13).

Figure 21. Proportion of organizations by type of outreach activity delivered (*n* = 19)



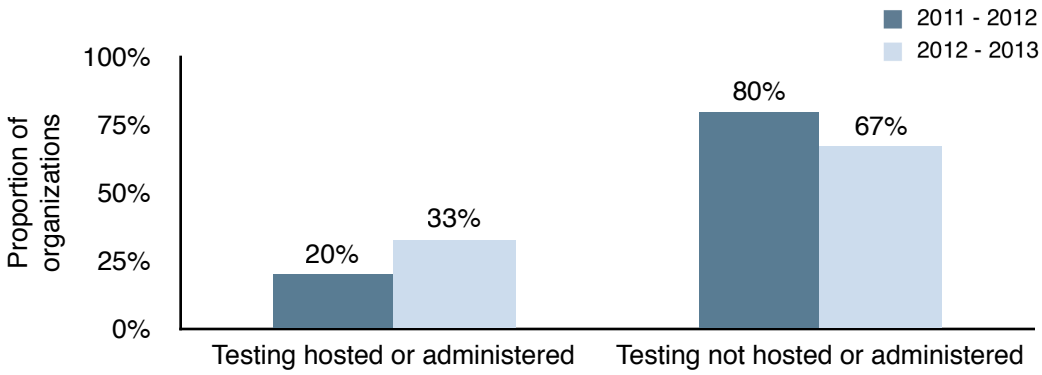
6.3 Testing for HIV and HCV

Detecting the presence of HIV and HCV within the community is key to reducing the spread of these viruses. The BC Ministry of Health (2012) has called for the increased reach of HIV testing across the province in order to diagnose people who are living with HIV, but are currently unaware of their status. The early detection of both HIV and HCV has demonstrated to improve the long-term survival of infected individuals, as early engagement with care can delay the speed at which their infections progress. Further, detecting HIV positive infections among those who were previously unaware of their status has demonstrated to reduce the prevalence of high-risk sexual behaviour among this group (Marks, Crepaz, Senterfitt & Janssen, 2005).

6.3.1 Identifying Positive Infections

CHERT respondents were asked to report whether their organizations hosted or administered HIV and/or HCV testing in the last fiscal year. While only one third of organizations reported hosting or administering HIV and/or HCV testing (33%; *n* = 10), the number of organizations providing these testing service increased from 2011 - 2012 (20%; *n* = 6) (see Figure 22). This increase could be due to: i) altered wording in the data request[6]; ii) the participation of different organizations in the 2012 - 2013 round of data collection; and iii) the increase of testing through the provincial STOP HIV/AIDS Pilot Project.

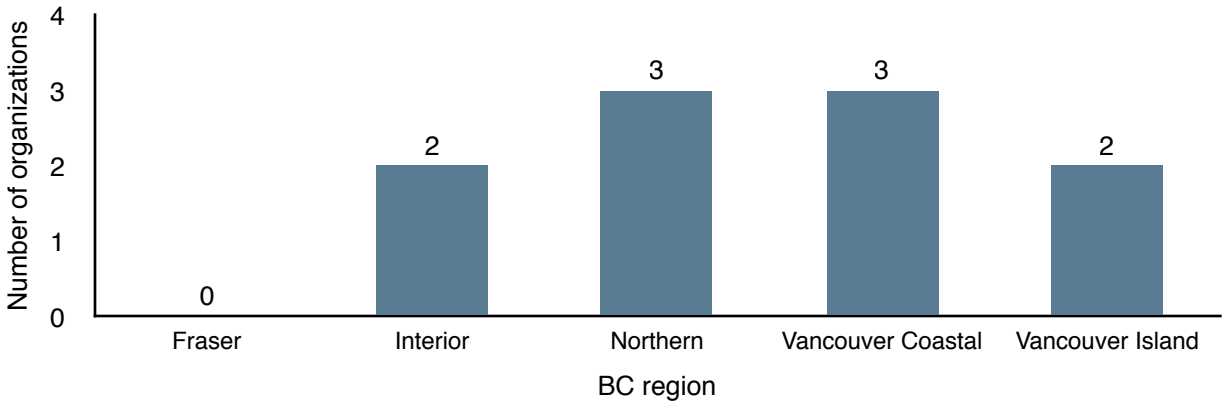
Figure 22. Proportion of organizations by administration or hosting of HIV or HCV testing (*n* = 30)



While it may have been expected that organizations hosting or administering testing would be concentrated in the Vancouver Coastal and Northern regions given the influence of the STOP HIV/AIDS Pilot, Figure 23 demonstrates that these organizations are dispersed throughout the province, with the exception of the Fraser region.

[6] In the 2011 - 2012 CHERT, respondents were asked whether their organizations, "*provided* HIV and/or HCV testing". In comparison, the 2012 - 2013 version of the survey asked respondents whether their organizations, "*hosted or administered* HIV and/or HCV testing".

Figure 23. Number of organizations hosting or administering HIV and/or HCV testing (*n* = 30)



6.3.2 Types of HIV/HCV Testing and Post-Positive Support

Among the ten organizations who reported hosting or administering HIV and/or HCV testing in the last year, nine of these organizations exclusively *hosted* HIV and/or HCV testing, whereas one organization reported *administering* the testing themselves[7].

Table 3 takes a closer look at the community-based organizations that reported *hosting* HIV and/or HCV testing (*n* = 9). While each of these organizations offered HIV testing (*n* = 9), only some of them also hosted HCV (*n* = 6) and HCV-PCR testing (*n* = 4). A total of 4,742 HIV tests and 1,100 HCV tests were hosted by these organizations in the last fiscal year (see Table 3).

Among those hosting testing, traditional blood draw was the most commonly reported testing technique, followed by point of care testing (56%; *n* = 5). One organization further specified that they use NAAT testing (Early HIV testing), which reduces the window period during which HIV infection cannot be detected.

Table 3. Number of organizations hosting HIV and/or HCV testing by type of test and number of people tested (*n* = 9)

	Number of organizations	Total number of people tested
Host HIV testing	9	4,742
Host HCV testing	6	1,100
Host HCV-PCR testing	4	-

[7] As defined in the CHERT, *hosting* testing referred to HIV/HCV testing that is offered by community-based organizations, but not administered by them. For instance, HIV/HCV testing in this case could be conducted by external groups such as the BCCDC. Conversely, administering HIV/HCV testing referred to testing that is actually administered by community-based organizations. In other words, external groups or agencies (e.g. BCCDC or health authorities) have not been involved in the direct provision of testing.

Only one CHERT respondent reported that their organization *administered* their own HIV and/or HCV testing in the last fiscal year. This organization conducted HIV, HCV and HCV-PCR testing using the traditional blood draw method to detect infections, and conducted a total of 150 HIV tests and 100 HCV tests (see Table 4).

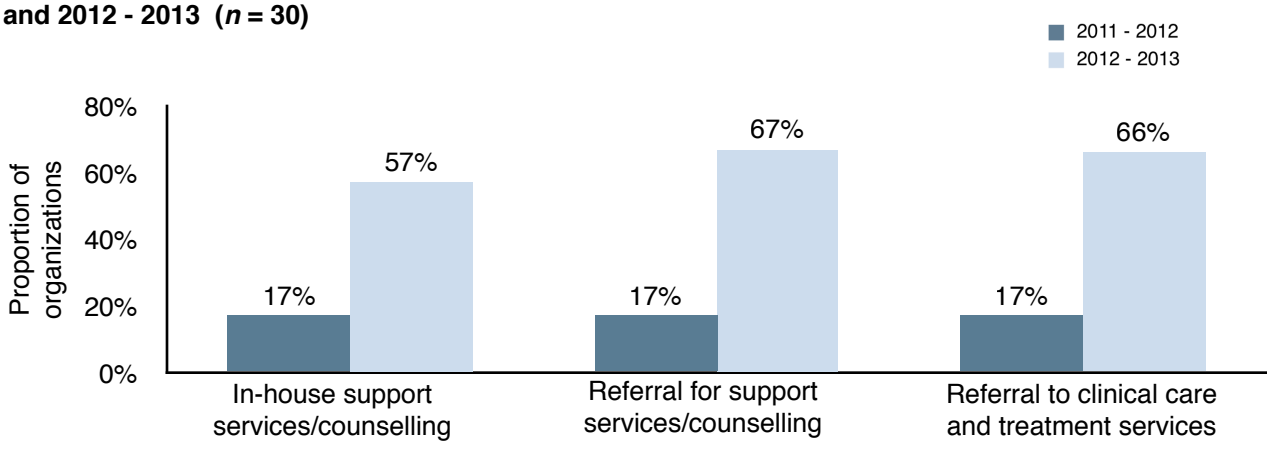
Table 4. Number of organizations administering HIV and/or HCV testing by type of test and number of people tested (*n* = 1)

	Number of organizations	Total number of people tested
Administer HIV testing	1	150
Administer HCV testing	1	100
Administer HCV-PCR testing	1	-

While post-test counselling is recommended for HIV and HCV tests regardless of whether the result in negative or positive, the CHERT specifically examined the provision of post-positive services among community-based organizations. Most CHERT respondents indicated that they provided post-positive referrals for support and counselling (67%; *n* = 20) and clinical care and treatment services (66%; *n* = 19) (see Figure 24). Over half of the CHERT respondents also reported that they provided in-house post-positive support services and counselling in the last year (57%; *n* = 17).

While it appears that the proportion of organizations offering post-positive services increased in the 2012 - 2013 year, it is unlikely that this data reflects a true increase in the provision of these services (see Figure 24). Rather, this increase reflects a change in how CHERT questions were asked in the 2011 - 2012 and 2012 - 2013 rounds of data collection.[8]

Figure 24. Proportion of organizations by different types of post-positive services, 2011 - 2012 and 2012 - 2013 (*n* = 30)



[8] In the 2011 - 2012 survey, only those organizations that reported offering HIV/HCV testing were asked about their post-positive testing services. Conversely, in the 2012 - 2013 round of data collection, all CHERT respondents were asked to provide data on their post-positive services.

6.4 Treating HIV and HCV

At the individual level, evidence has demonstrated that effective treatment for HIV and HCV can decrease the risk of disease-related morbidities, opportunistic infections, and mortality among infected people (Montaner, et al., 2010). As described by the Treatment as Prevention (TasP) concept developed by the BC Centre for Excellence in HIV/AIDS, adherence to HAART has also been shown to reduce the likelihood of HIV transmission at the community level (BC Ministry of Health, 2012).

6.4.1 HIV and HCV Treatment Services

The proportion of organizations providing HIV and/or HCV treatment services increased to 23% (*n* = 7) in the last year, from 10% (*n* = 3) in 2011 - 2012. This increase can be partially attributed to an improved definition of what HIV/HCV treatment services entail in the CHERT.[9]

Figure 25. Proportion of organizations providing HIV and/or HCV treatment services in 2011 - 2012 and 2012 - 2013 (*n* = 30)

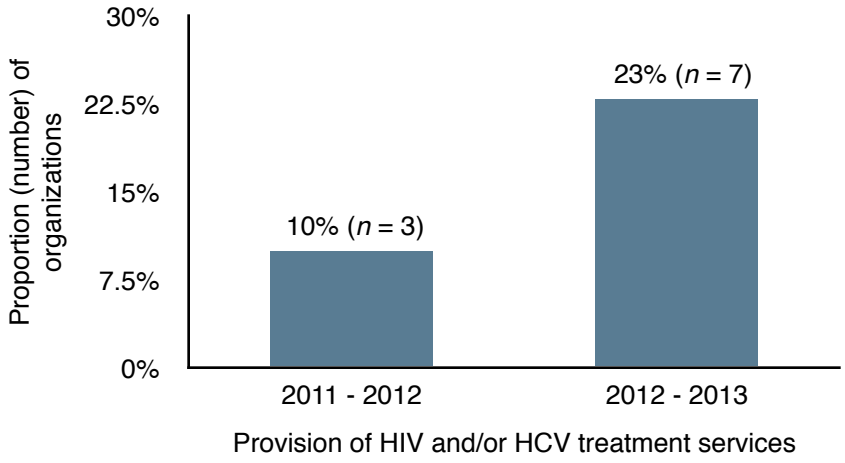


Table 5 illustrates the average and total numbers of people who received treatment for HIV, HCV, and HIV/HCV co-infection from CHERT respondents in both the 2011 - 2012 and 2012 - 2013 years. The average and total numbers of people receiving treatment for HIV and HIV/HCV co-infection appears to have increased in the last fiscal year, whereas the numbers of people receiving HCV treatment decreased slightly. Note that these trends should be interpreted with caution given that the 2011 - 2012 data was based on responses from a small number of organizations (*n* = 3) and a less comprehensive definition of what HIV and/or HCV treatment services entail.

[9] To better describe what "HIV and/or HCV treatment services" entail, the 2012 - 2013 version of the CHERT provided examples of what such treatment services could be, such as adherence programs, the provision of medical drugs for HIV/HCV, etc.

Table 5. Average and total numbers of people receiving treatment for HIV, HCV, and HIV/HCV co-infection from CHERT respondents, 2011 - 2012 and 2012 - 2013

	Average (total) number of people receiving treatment, 2011 - 2012 (*n* = 3)	Average (total) number of people receiving treatment, 2012 - 2013 (*n* = 7)
HIV	48 (96)	127 (635)
HCV	181 (181)	39 (117)
HIV/HCV co-infection	31 (62)	36 (108)

6.4.2 Adherence Programs

As described by the BC Ministry of Health (2012), "a cornerstone of the TasP approach is not only to treat medically eligible individuals with HAART, but also to implement comprehensive supports to retain them in care" (p. 10). Despite widespread knowledge that adherence to drug regimes to treat HIV and HCV is critical for treatment success, inadequate adherence remains a challenge in BC, particularly among vulnerable populations for a number of complex reasons (Kerr, et al., 2004; Wood, et al., 2003).

Data from the CHERT demonstrate that community-based HIV/HCV organizations play a small, but influential role in provision of adherence programs. Specifically, 5 (17%) organizations reported that they had an adherence programs in place for HIV-treated people, which included the following components:

- dedicated staff to support adherence (*n* = 4)
- individual counselling (*n* = 4)
- free meal programs (*n* = 3)
- accompaniment to doctor appointments (*n* = 3)
- outreach services (*n* = 3)
- peer support groups (*n* = 2)
- peer navigators (*n* = 2)
- directly observed therapy (*n* = 1)
- onsite medical storage (*n* = 1)
- maximally assisted therapy (*n* = 1)

A total of 2 (7%) CHERT respondents offered adherence programs for HCV-treated people in the last fiscal year, which included the following components:

- dedicated staff to support adherence (*n* = 2)
- peer support groups (*n* = 2)

- individual counselling (n = 1)
- outreach services (n = 1)
- accompaniment to doctor appointments (n = 1)
- free meal programs (n = 1)

It is important to note that while not every community-based organization has an official adherence program in place, the CHERT shows that many organizations provide support programs for people living with HIV and HCV that likely improve client engagement and retention in treatment (Anema, et al., 2009; Leaver, Bargh, Dunn & Hwang, 2007). In future rounds of data collection, the CHERT will explore how to better capture the community's contribution to engagement and retention in care.

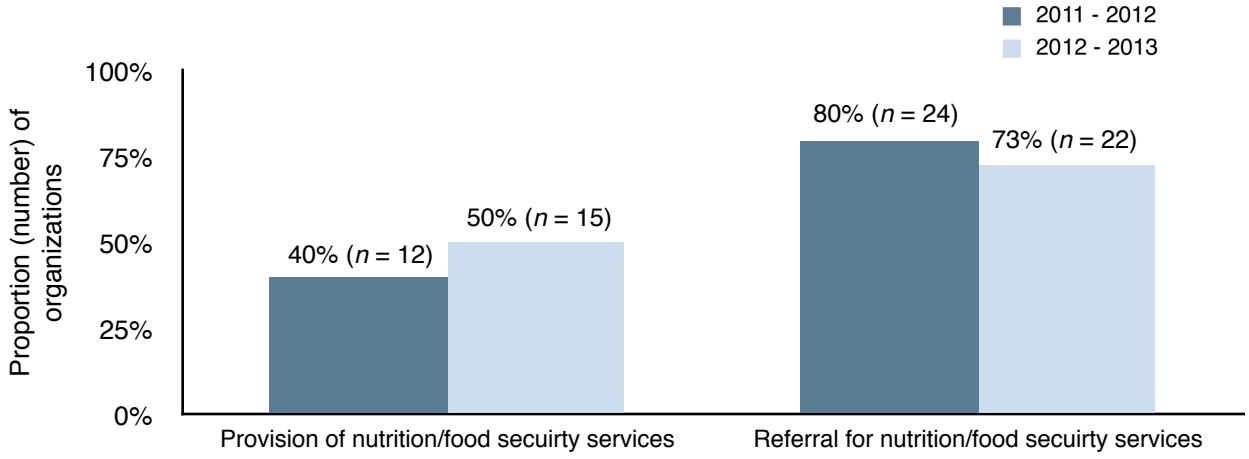
6.5 Providing Social Support Services

People at-risk or living with HIV/HCV in BC continue to face complex socioeconomic challenges, such as poverty, food insecurity and homelessness. Community-based HIV/HCV organizations are integral players in moving beyond the medical aspects of the HIV/HCV epidemics by focusing on addressing such structural issues. To exemplify the role community-based organizations play, CHERT respondents were asked a series of questions about the social support services they provided in the 2012 - 2013 year.

6.5.1 Nutrition and Food Security Support Services

In both the 2011 - 2012 and 2012 - 2013 rounds of data collection, the majority of CHERT respondents provided referrals for nutrition and/or food security services, rather than offering such services in-house (see Figure 26). In the last year, CHERT respondents referred a total of 4,136 clients to nutritional and/or food security services.

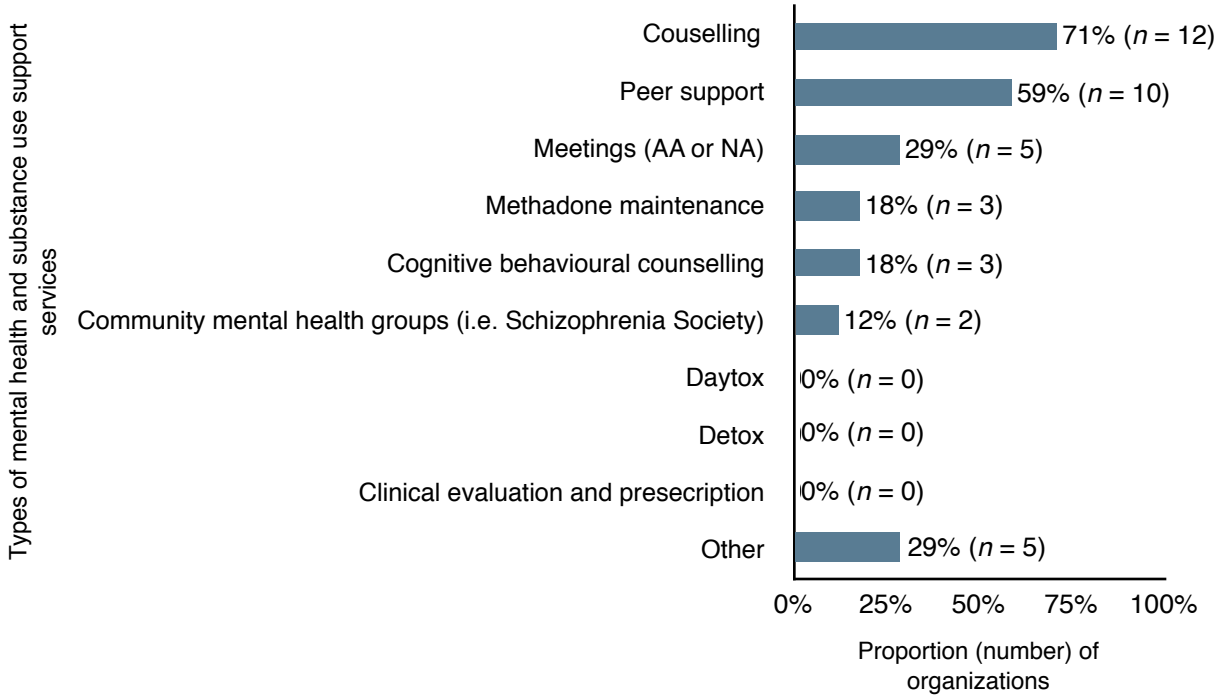
Figure 26. Proportion of organizations by provision or referral of nutrition and/or food security services, 2011 - 2012 and 2012 - 2013 (*n* = 30)



6.5.2 Mental Health and Substance Use Support Services

Over half of the CHERT respondents (59%; *n* = 17) reported that their organizations offered in-house mental health and/or substance use support services in the last year. As seen in Figure 27, these services most commonly included the provision of one-on-one or group counselling (71%; *n* = 12) and peer support (59%; *n* = 10) services. Respondents specified other (29%; *n* = 5) mental health and/or substance use services their organizations offered, such as workshops on needle protocols, harm reduction services and drug user support programs.

Figure 27. Proportion of organizations providing in-house mental health/substance use services by service type (*n* = 17)

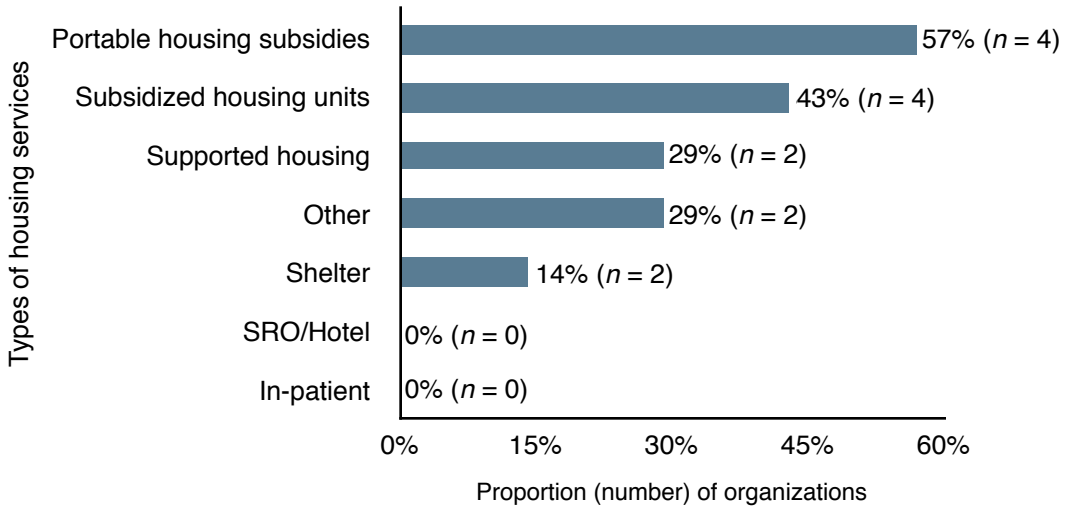


The majority of organizations (83%; *n* = 25) reported that they provided referrals for mental health and/or substance use services in the last year, collectively referring a total of 2,380 clients. Among these respondents, referrals were most commonly made to health authority mental health services (96%; *n* = 24) and mental health care providers (80%; *n* = 20). Other respondents specified that their organizations referred clients to detox and addictions treatment centres in the last year (12%; *n* = 3). Note that data on referrals made for mental health and/or substance use services were not collected in the 2011 - 2012 round of data collection.

6.5.3 Housing Services

A small number of CHERT respondents indicated that their organizations provided their own housing services in the last fiscal year (23%; *n* = 7). These organizations most frequently provided portable housing subsidies (57%; *n* = 4) and subsidized housing units (43%; *n* = 3) (see Figure 28). Other housing services provided by CHERT respondents included housing navigation services and enhanced supported housing (29%; *n* = 2).

Figure 28. Proportion of organizations providing housing services by type of service (*n* = 7)



Additionally, most organizations reported that they referred clients to housing services in the last fiscal year (80%; *n* = 24), collectively referring a total of 4,473 clients. Note that data on referrals made for housing services services were not collected in the 2011 - 2012 round of data collection.

6.5.4 Other Social Support Services

In addition to the provision of nutrition/food security, mental health and substance use and housing services described above, CHERT respondents were also asked to indicate whether they provided a range of other social support services in the last year. Respondents reported that their organizations most frequently provided:

- housing/tenancy assistance (32%; *n* = 13)
- transportation assistance (32%; *n* = 13)
- disability application assistance (32%; *n* = 13)

Additionally, respondents reported that their organizations most commonly *referred* clients to the following social support services:

- housing/tenancy assistance (70%; *n* = 21)
- access to medical/dental treatment (67%; *n* = 20)
- long-term disability assistance (67%; *n* = 20)
- welfare assistance (67%; *n* = 20)

6.6 Increasing Knowledge and Awareness: Education and Training Activities

Community-based organizations are a critical resource for HIV/AIDS and HCV education across BC. These organizations are making a substantial contribution in filling the current gaps in HIV/HCV education that exists within the education and health and social service sectors, and among people living with or at-risk for infection. Raising knowledge and awareness about HIV/AIDS and HCV is essential to providing a comprehensive prevention approach and helping to reduce stigma and discrimination associated with these diseases.

6.6.1 HIV/HCV Awareness Raising Workshops and Training Sessions

Data from the CHERT shows that community-based HIV/HCV organizations are key contributors in spreading education and awareness about HIV, HCV and HIV/HCV co-infection in the BC. This statement can be substantiated by the fact that the majority of CHERT respondents offered HIV/HCV awareness raising workshops and/or training in both the 2011 - 2012 (67%; *n* = 20) and 2012 - 2013 (73%; *n* = 23) years (see Figure 29). In the last year, CHERT respondents provided an average of 82 awareness workshops and/or training sessions, reaching roughly 44,096 people (see Table 6). While the 2012 - 2013 CHERT saw an increase in the average number of workshops delivered, a slight decrease was noted in the average and total numbers of people reached in comparison to the previous year.

Figure 29. Proportion of organizations by the provision of HIV or HCV awareness raising workshops and/or training, 2011 - 2012 and 2012 - 2013 (*n* = 30)

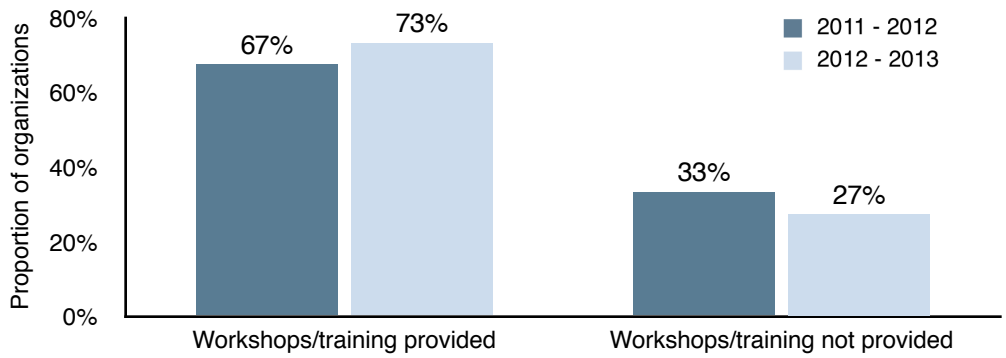


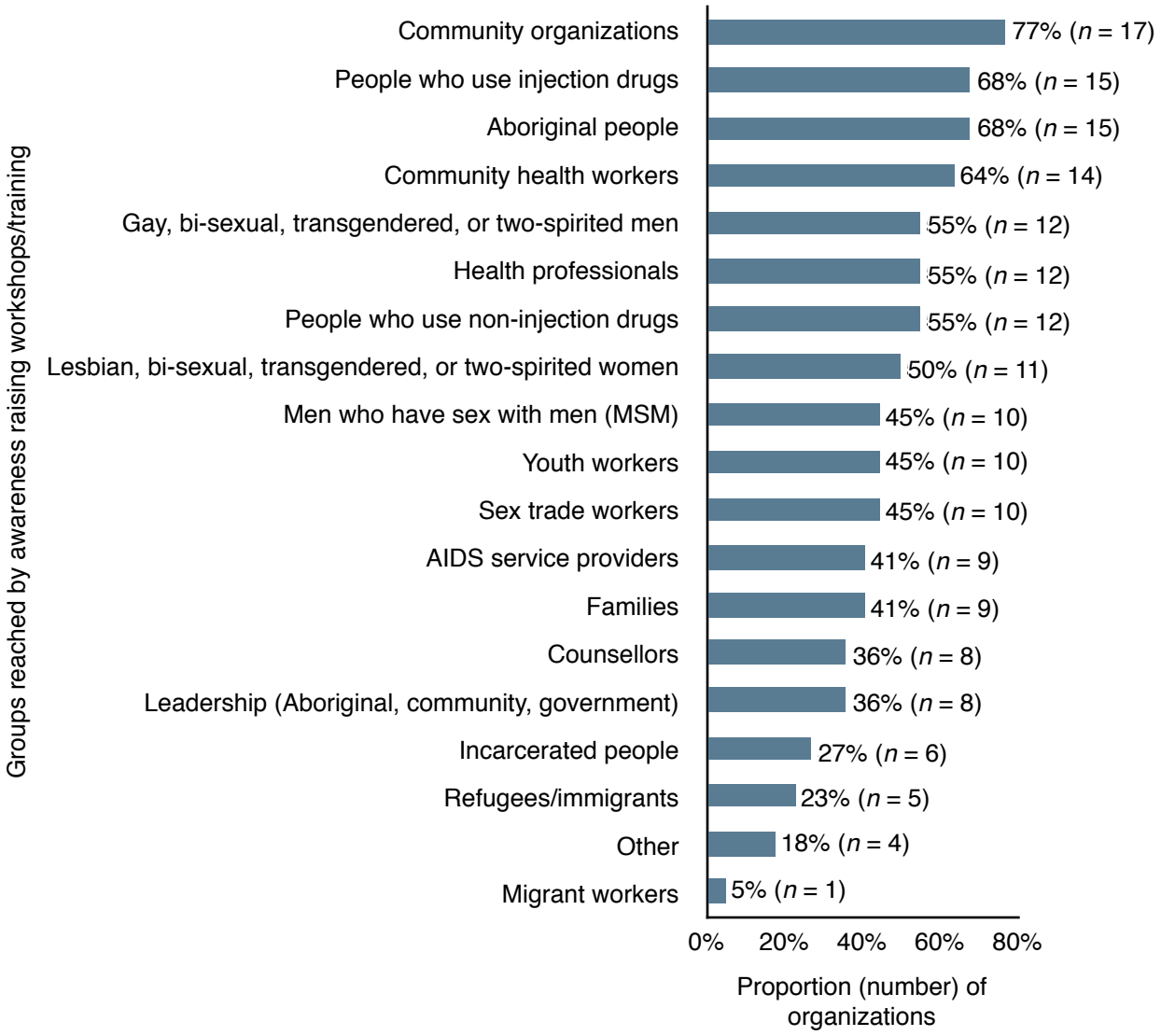
Table 6. Average and total numbers of HIV/HCV education workshops and/or training, 2011 - 2012 and 2012 - 2013

	2011 - 2012 (*n* = 20)	2012 - 2013 (*n* = 22)
Average number of workshops delivered	61	82
Average number of people reached	2,562	2,004
Total number of people reached	52,510	44,096

6.6.2 Groups Targeted by Awareness Raising Strategies

CHERT respondents targeted a wide range of groups in their awareness raising workshops and training sessions in the last year (see Figure 30). Similar to results from the 2011 - 2012 CHERT, community organizations (77%; *n* = 17), people who use injection drugs (68%; *n* = 15) and Aboriginal people (68%; *n* = 15) were most frequently targeted by organizations. Apart from the groups specified in Figure 30, organizations indicated (18%; *n* = 4) that they also targeted people living with HIV, high schools and detox/treatment facilities. In terms of age, adults (77%; *n* = 17) and youth (68%; *n* = 15) were most commonly targeted by these organizations, followed by the elderly (55%; *n* = 12) and children (18%; *n* = 4). The results illustrated in Figure 30 closely align with those found in the 2011 - 2012 CHERT.

Figure 30. Proportion of organizations by groups reached through HIV/HCV awareness raising workshops and/or training (*n* = 22)

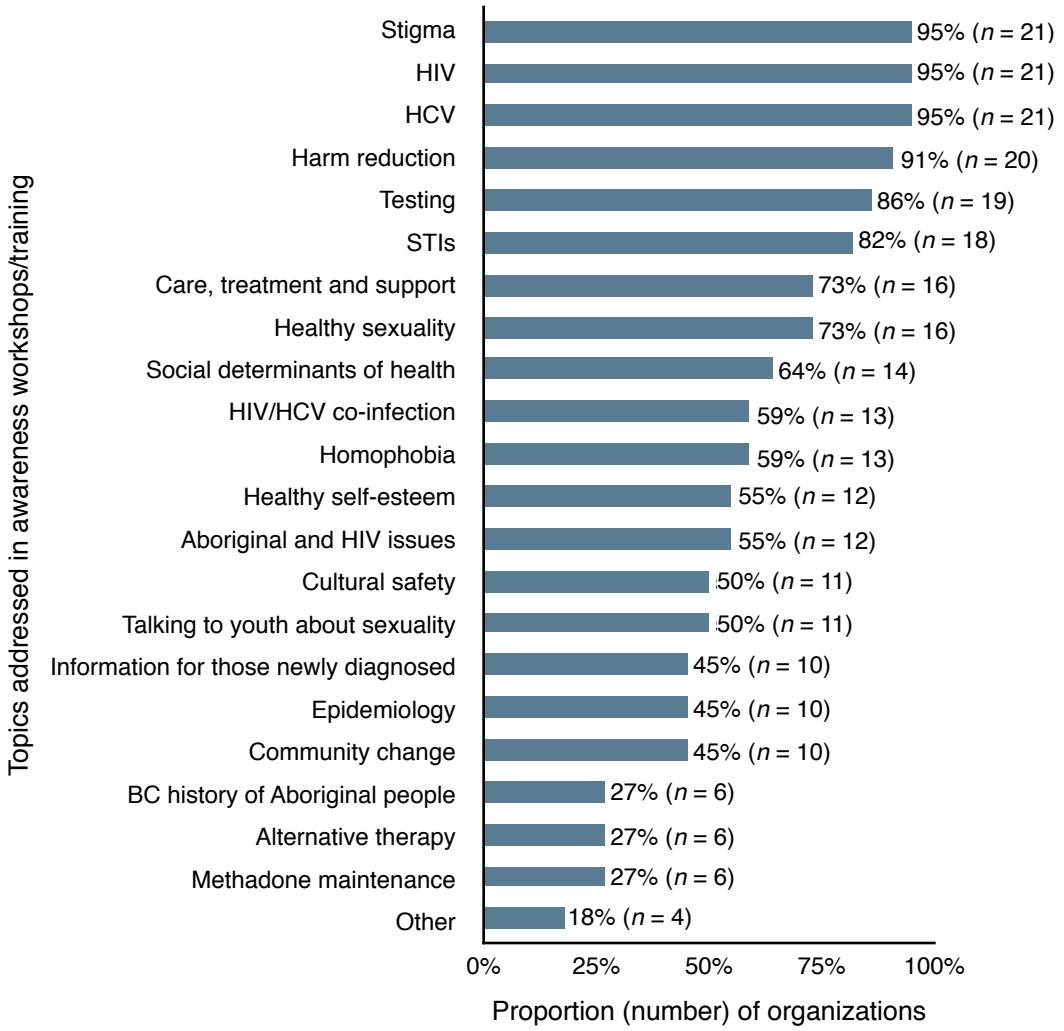


6.6.3 Topics Addressed Through Awareness Raising

CHERT respondents reported that they addressed a wide range of topics in their education and training workshops (see Figure 31). General education on HIV (95%; *n* = 21), HCV (95%; *n* = 21) and stigma (95%; *n* = 21) were the most frequently addressed topics. The concentration of educational workshops on HIV/HCV-related stigma and discrimination speaks to the community's commitment to addressing the pervasiveness of these issues in the province. Education on harm reduction (91%; *n* = 20), testing (85%; *n* = 19) and STIs (82%; *n* = 18) was also a strong focus of the workshops offered by respondents.

In addition to the topics listed in Figure 31, CHERT respondents reported that they also discussed: new treatments, the Take Home Naloxone Program, specific issues and needs for women living with HIV, healthy relationships, and condom negotiation strategies in their educational sessions (18%; *n* = 4).

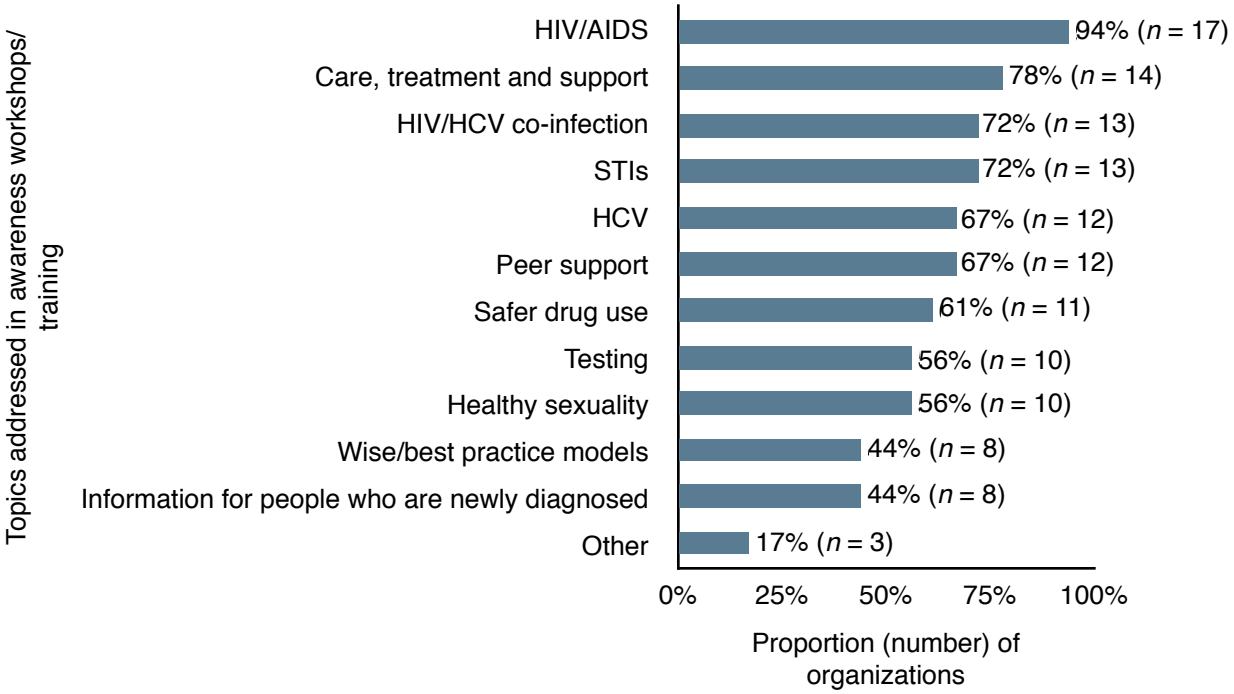
Figure 31. Proportion of organizations by topics addressed in HIV/HCV awareness raising workshops and/or training (*n* = 22)



6.6.4 Development of Educational Resources

To further explore the role community-based HIV/HCV organizations play in education and awareness raising, respondents were asked to indicate whether their organizations developed educational resources in the last fiscal year. Most CHERT respondents (60%; *n* = 18) reported that their organizations developed educational resources, which most commonly focused on general HIV/AIDS information, care, treatment and support, HIV/HCV co-infection and STIs (see Figure 32). These results are consistent with those found in the 2011 - 2012 CHERT report. Some respondents (17%; *n* = 3) described other topics that their educational resources address, including women specific topics, resilience/coping strategies, and access to community services.

Figure 32. Proportion of organizations by topics addressed in educational resources (*n* = 18)



6.7 Meaningful Client Engagement

The greater and more meaningful engagement of people living with HIV is a guiding principle of the community-based HIV/AIDS movement (International HIV/AIDS Alliance, 2010; UNAIDS, 2007). While there is not a formal policy guiding the greater and more meaningful engagement of people living with HCV, it is still considered to be a valuable way of working.

Engaging people living with, or at risk for, HIV/AIDS and HCV has been associated with a range of positive benefits. For instance, the meaningful engagement of clients has demonstrated to improve the relevance, acceptability and overall effectiveness of programs and services. Client engagement efforts have also demonstrated to improve decision-making processes, as the consideration of a diversity of perspectives can lead to more creative solutions and the development of sustainable decisions. Further, client engagement can enhance the capacity of people living with HIV/HCV to manage their conditions, and more effectively respond to the HIV and HCV epidemics.

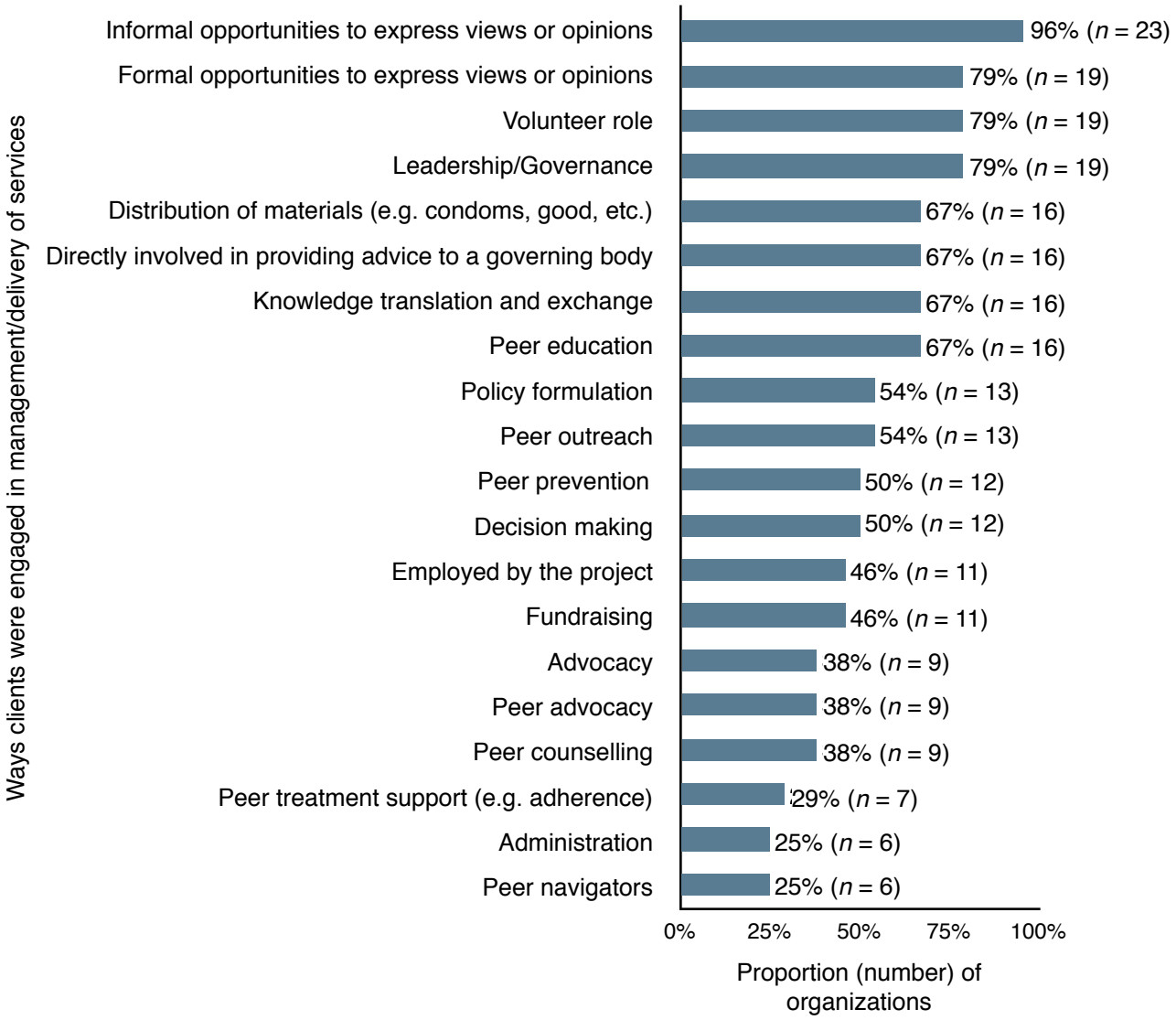
In the CHERT, respondents were asked to describe whether their clients were engaged in three main areas in the last fiscal year: *the management and delivery of programs and services*, *evaluation work*, and *research activities*.

6.7.1 Engaging Clients in the Management and Delivery of Programs and Services

Data from the CHERT show that community-based HIV/HCV organizations are committed to engaging the people they serve in the management and delivery of their programs and services, with over 80% (n = 24) of respondents reporting that they fostered this type of engagement in the last year. Figure 26 illustrates the specific ways in which respondents' clients have contributed to the management and/or delivery of services, most commonly including informal (96%; n = 23) and formal opportunities (79%; n = 19) for clients to express views or opinions and volunteer positions (79%; n = 19).

It appears that there has been an increase in the proportion of organizations that engaged their clients in leadership and governance roles in the last fiscal year (79%; n = 19), in comparison to data from 2011 - 2012 (61%; n = 14). Similarly, the 2012 - 2013 CHERT also shows increases in the proportion of organizations that engage their clients in the distribution of materials (i.e. condoms, safe injection equipment, food, etc.) (67%; n = 16) and providing advice to a governing body (67%; n = 16).

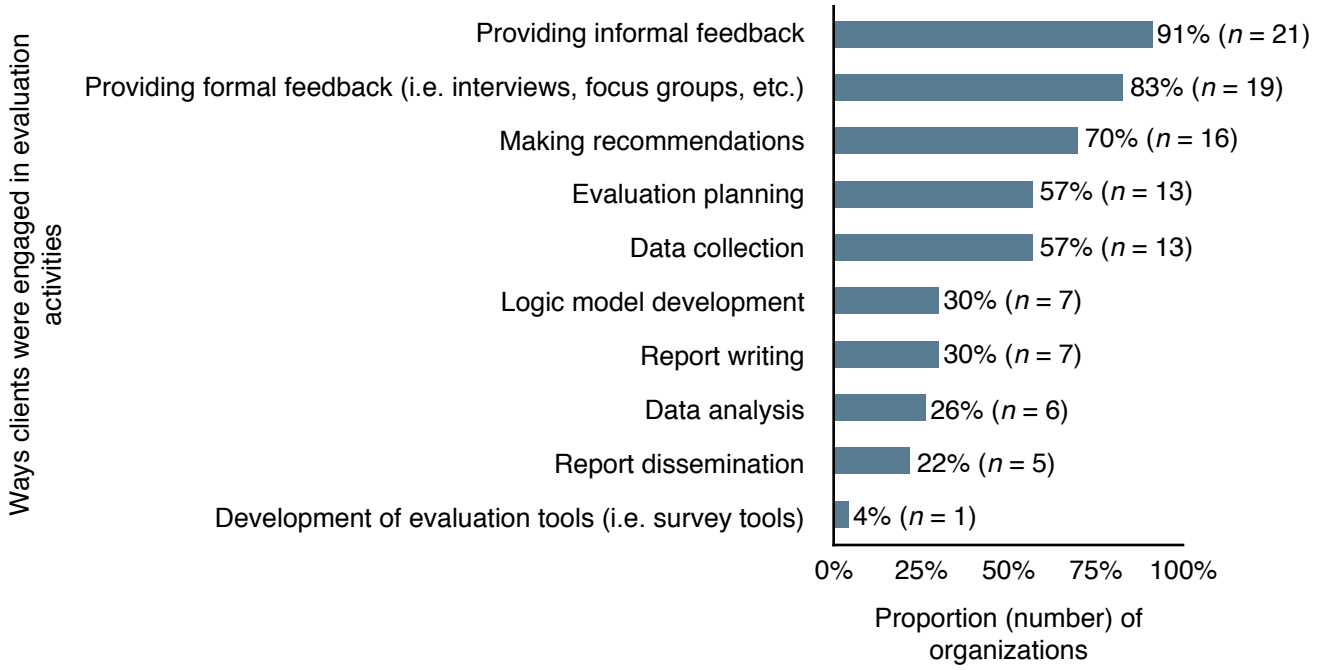
Figure 33. Frequency of ways in which clients were engaged in the management and/or delivery of services (*n* = 24)



6.7.2 Engaging Clients in Evaluation Activities

A strong commitment to client engagement can also be demonstrated by the substantial proportion of organizations that report engaging the people they serve in evaluation activities (76%; *n* = 22). As shown in Figure 34, clients were most commonly engaged in the provision of informal (91%; *n* = 21) and formal (i.e. interviews, focus groups, etc.) (83%; *n* = 19) feedback, in addition to making recommendations (70%; *n* = 16).

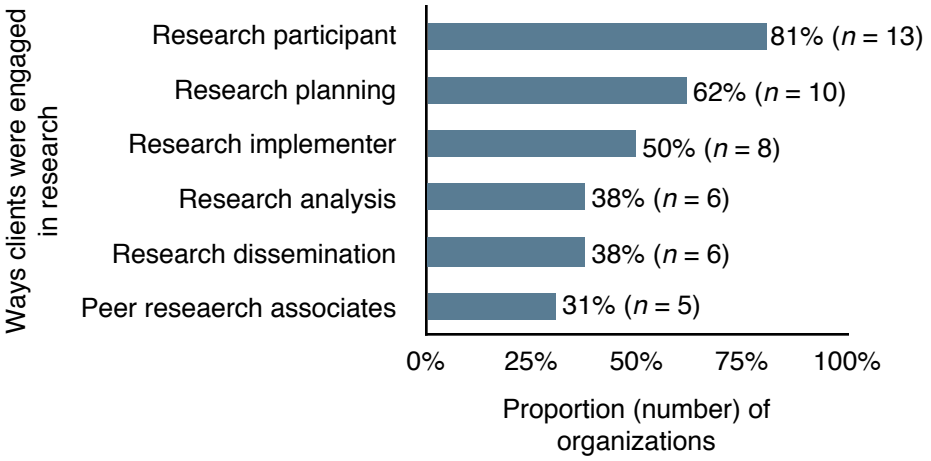
Figure 34. Frequency of ways in which clients were engaged in evaluation activities (*n* = 22)



6.7.3 Engaging Community in Research Activities

In contrast to the engagement of clients in the delivery of services and evaluation work, the engagement of people served in research activities was less frequently reported among CHERT respondents (53%; *n* = 16). This finding is consistent with results from 2011 - 2012. Among those who engaged clients in research activities, they were most frequently involved as research participants (e.g. interviewee) (81%; *n* = 13), and in the planning (62%; *n* = 10) and implementation of research activities (50%; *n* = 8) (see Figure 35).

Figure 35. Frequency of ways in which clients were engaged in research activities (*n* = 16)



While most respondents demonstrated a commitment to the greater and more meaningful involvement of their clients, evidence from both the 2011 - 2012 and 2012 - 2013 CHERT results demonstrates that this commitment could be strengthened in two main ways. First, community-based HIV/HCV organizations should aim to more *meaningfully* engage their clients in their work. Data from the CHERT demonstrate that clients were most commonly engaged in informal or passive ways - clients were frequently engaged as research participants or were provided with informal opportunities to provide feedback. While all levels of engagement have some value, meaningful engagement focuses on building the capacities of communities, which allows them to become empowered to participate in decision-making processes and to take their health in their own hands.

Second, community-based organizations should aim to strengthen the engagement of clients in their research activities given that involvement was limited in this area. This finding was confirmed in results from both the 2011 - 2012 and 2012 - 2013 rounds of data collection with the CHERT.

6.8 Monitoring and Evaluation Work

To effectively improve program delivery and demonstrate the value of work conducted by community-based HIV/HCV organizations in BC, the conduction of program evaluation work is essential.

6.8.1 Evaluation Work Being Conducted

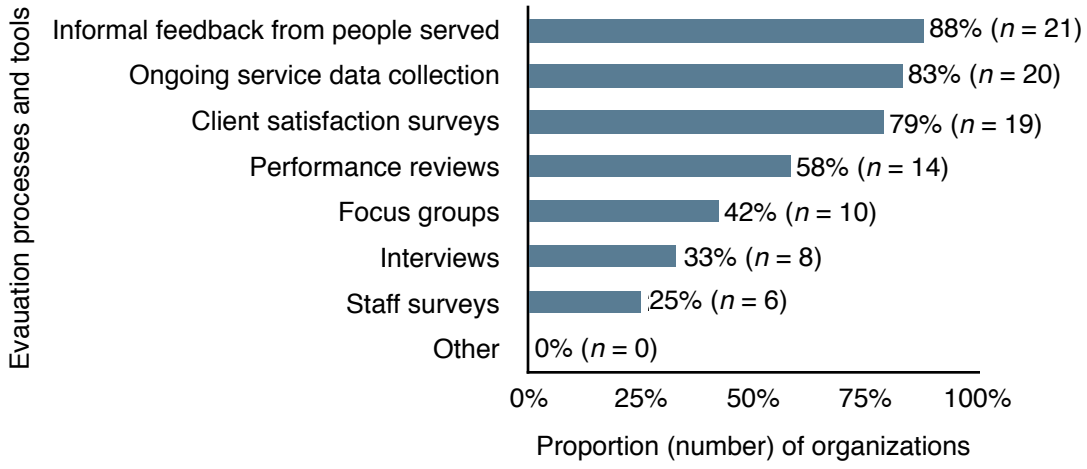
In comparison to results from the 2011 - 2012 CHERT data, the proportion of organizations that conducted or commissioned any type of evaluation work increased from 62% (*n* = 18) to 80% (*n* = 24) in the last year. This improvement could be partially due to the increasing development of a culture of evaluation among community-based HIV/HCV organizations in BC, which may have been facilitated by the work of the CHERT and the focus of the STOP HIV/AIDS Pilot Project on the evaluation and monitoring of programs.

Among the organizations who reported conducting evaluation work, the large majority of organizations reported conducting both process (91%; *n* = 20) and outcome (91%; *n* = 20) evaluations. However, some organizations reported that they only conducted or commissioned either process (9%; *n* = 2) or outcome (9%; *n* = 2) evaluation work.

6.8.2 Processes and Tools Used to Monitor and Evaluate Services

Figure 36 illustrates the types of processes and tools that organizations report using to monitor and evaluate their programs and services. Organizations most commonly reported collecting informal feedback from the people they served (88%; *n* = 21). While receiving informal feedback from clients is a valuable source of information, the use of more rigorous data collection methods, such as surveys or interviews, would allow for more reliable results. Other commonly reported processes and tools used for monitoring and evaluation work were conducting ongoing service data collection (83%; *n* = 20) and client satisfaction surveys (79%; *n* = 19). These results are consistent with the data reported by organizations in 2011 - 2012.

Figure 36. Processes and tools used by organizations to monitor and evaluate services (*n* = 24)



6.8.3 Evaluation Support

CHERT respondents were also asked if their organizations would find evaluation support to be valuable, such as an evaluator to assist them with planning or analysis or webinars on how to conduct evaluation work. The majority of respondents (83%; *n* = 24) reported that they would find this type of support valuable.

6.8.4 The Value of Conducting Evaluation Work

To explore the benefits of conducting evaluation work within community-based HIV/HCV organizations, CHERT respondents were asked to describe any changes they made to their program or services that were informed by evaluation in the last fiscal year. Among those who responded to this question (*n* = 20), the majority discussed improvements in the design and delivery of their programs and services (80%; *n* = 16), including:

- addressing service delivery gaps
- extending the range and reach of services to better meet client needs
- improved content and design of training workshops
- more tailored programming for at-risk groups, such as MSM and sex workers
- increased involvement of peers in educational programing
- implementation of quality improvement strategies
- shifting the hours in which services are available to better meet client needs
- altering the size and numbers of programs offered
- increasing the engagement of volunteers in all programing

Comments describing these improvements in program and service delivery included:

- *"We have increased the range of supplies in our harm reduction services to include water and nutritional support."*
- *"... we have a peer advisory committee that meets every 2 weeks to a month to provide ongoing process evaluation. Several changes to our educational program have been made as a result of this direction. For instance, we decided to hold peer-run street college curricula as opposed to having staff facilitate these outcomes."*
- *"We did some survey work to determine what is needed as far as training and support for our peers who do secondary needle exchange..."*
- *"We evaluate all of our trainings, in different ways, and these evaluations are used when developing future trainings, for fine tuning in some cases and for fairly radical program alteration at times as well."*

CHERT respondents also described other ways in which they used their monitoring and evaluation work, including:

- the implementation of improved measurement tools (i.e. more specific measures for adherence)
- to inform policy change
- to simplify reporting requirements
- to demonstrate the impact programs and services are making

7.0 The Community Contribution to BC's Provincial Strategy to Address HIV/AIDS

Following the completion of the STOP HIV/AIDS Pilot Project, the BC Ministry of Health released a document describing the province's strategic framework for the provincial roll-out of this pilot, *From Hope to Health: Towards an AIDS-Free Generation* (BC Ministry of Health, 2012). This document provides strategic guidance for the regional health authorities on the incorporation of Treatment as Prevention (TasP) into HIV prevention practices already underway in BC. While *From Hope to Health* focuses on the health authority level, we would like to demonstrate the contribution community-based organizations are making to the success of TasP and other complementary HIV prevention activities in the province using findings from the CHERT.

The Community-Level Contribution to TasP

To help guide the incorporation of TasP into the province's current HIV prevention response, the Ministry of Health has created the HIV cascade of prevention and care (see Figure 37). The cascade, "illustrates the steps in care and support for those at risk for and/or living with HIV, and the opportunities to reengage those who have fallen off at any point in the continuum" (BC Ministry of Health, 2012, p. 6).

Walking through the steps in the cascade, the role community-based organizations play in TasP is clear. First, data from the CHERT demonstrates that community-based organizations substantially contribute to HIV testing in the province, with 10 organizations reporting that they hosted or administered testing for roughly 4,892 people HIV in 2012 - 2013. Further, most CHERT respondents also provided post-positive services, including in-house support services and counselling (57%; $n = 17$), referrals for support and counselling (67%; $n = 20$) and referrals for clinical care and treatment services (66%; $n = 19$).

Moving along the cascade, we can also explore how community-based organizations have contributed to engaging and retaining people in care following positive diagnoses. A total of 7 organizations reported providing HIV treatment services in 2012 - 2013, treating roughly 635 people for HIV infection, and 108 for HIV/HCV co-infection. Recognizing the importance of retaining people on treatment, a small number of community-based organizations ($n = 5$) reported providing adherence programs in the last fiscal year, which included services ranging from individual counselling to free meal programs. Additionally, men and women living with HIV were reported as being the most commonly targeted group in CHERT respondents' outreach efforts. Such outreach efforts included services that would have enhanced engagement and retention in care, such as referral services, home, hospital and clinic visits and transportation.

Complementary HIV Prevention Activities

In the continuum of HIV prevention, testing, treatment and support, there are multiple instances in which people can become disengaged or "fall off" the cascade due to a range of barriers,

such as food insecurity, homelessness, mental health and addictions issues, and stigma and discrimination (Wilton & Broeckaert, 2013). Results from the CHERT have demonstrated that community-based organizations are key players in addressing these barriers. For instance, most organizations responding to the CHERT reported that they delivered in-house nutrition and food security services, or provided referrals for such services to a total of 4,136 clients in 2012 - 2013.

In effort to address homelessness in the province, some community-based organizations also provided housing services in the last year, such as portable housing subsidies and subsidized housing units (23%; *n* = 7). However, referring clients to such services was more common among community-based organizations, with a total of 4,473 referrals made in the last year.

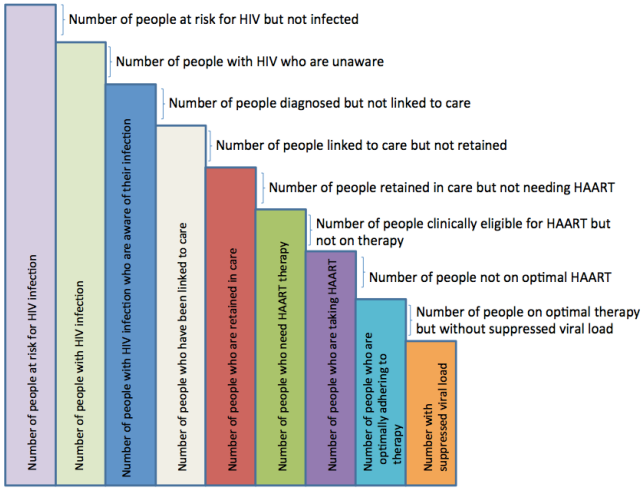
Similarly, over half of the CHERT respondents (59%; *n* = 17) offered in-house mental health and substance use support services to their clients in the last year, including services ranging from counselling to peer support. A substantial number of referrals for mental health and substance use services were also made by respondents, collectively referring a total of 2,380 clients to such services.

Recognizing the pervasiveness of HIV/AIDS related stigma in BC, CHERT respondents focused their prevention efforts on addressing this issue. Stigma and discrimination were the most frequently addressed topic in respondents' educational and training workshops, and also a focus of their upstream prevention services.

The Community Contribution

This brief analysis demonstrates the substantial contribution community-based organizations are making to the success of TasP, and the larger HIV prevention response in the province. In moving forward with the provincial strategy to address the HIV epidemic in BC, groups are urged to collaborate and engage with community organizations given their key role in this fight.

Figure 37. HIV cascade of prevention and care for BC (BC Ministry of Health, 2012, p. 6)



8.0 Conclusions and Next Steps

Findings from the CHERT continue to demonstrate that community-based organizations are critical players in addressing the HIV and HCV epidemics in BC. These organizations offer a wide range of programs and services in effort to effectively respond to the complexity of HIV and HCV today. In moving forward with the CHERT, the following next steps will guide our work:

1. Continue to improve the reliability and validity of questions asked in the CHERT by learning from data shortcomings and editing future versions of the survey

2. Disseminate findings among stakeholders
    i. Engage stakeholders to contextualize findings presented in this report
    ii. Disseminate findings to relevant audiences, including community-based organizations, the health authorities, the Ministry of Health, and federal partners. Also engage these groups in discussions about extending the reach and use of the CHERT in the province.

3. Facilitate the use of findings from the CHERT

4. Aim to increase participation rates from community-based HIV/HCV organizations in BC in the annual data collection with the CHERT

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