

THE **COMMUNITY** HIV/HCV EVALUATION AND REPORTING TOOL



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

*A Collaborative Project of the
BC HIV/HCV Evaluation Advisory Group
and the Pacific AIDS Network*

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About this Report

Welcome to the first CHERT (Community HIV/HCV Evaluation and Reporting Tool) report. The CHERT is an online survey tool that aims to collect 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**
This tool aims to streamline and simplify the data collected by community-based HIV/HCV organizations. Standardization will reduce the number of repetitive and time-consuming reporting requirements set out by funding agencies, as the CHERT aims to centralize this reporting process. Another benefit of streamlining data collection will be the ability to compare programs offered across the province and between regions.
- **To Demonstrate Success**
The findings from this tool, used over time, will demonstrate the impact of community-based HIV/HCV organizations across the province. Up until now, this sector has not collected the qualitative and quantitative data that is needed to illustrate the value and impact of the work being done.
- **Program Planning**
The CHERT aims to help community-based HIV/HCV organizations to identify gaps and trends in service delivery that can be used to adjust services or develop new activities as necessary.
- **Program Improvement**
Data that is currently collected by funders is often unavailable to community-based organizations, limiting their ability to make evidence-based decisions on how to improve their programs and services. To address this issue, aggregate and agency-specific findings from the CHERT will be made available to all community-based organizations on an annual basis. This data will help community-based organizations to strengthen the delivery, and overall impact, of the work being done.

Design of the CHERT

The CHERT consists of 68 closed-ended questions that have been divided into the following 12 sections:

1. Program Delivery and Operation
2. Funding
3. Human Resources
4. Partnerships
5. HIV/HCV Prevention
6. HIV/HCV Outreach
7. HIV/HCV Testing
8. HIV/HCV Treatment & Care
9. Social Support Services
10. Education and Training
11. Greater and Meaningful Involvement of People Living with HIV and HCV
12. Evaluation

Data Limitations

Moving forward with the CHERT, we aim to learn from the shortcomings of the data collected in this first round to improve the reliability and validity of the findings in the future. The findings presented in this report should be interpreted with caution, as various limitations of the data collected have been identified. For instance, it is likely that respondents interpreted some of the survey questions in different ways, ultimately reducing the consistency of the data collected. Furthermore, 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, given that results from larger organizations can often skew the results in different directions. In effort to respond to this concern, ranges of responses provided by organizations have been included when necessary. As this was the first formal round of data collection with the CHERT, such challenges with a new survey tool can be expected and we aim to improve upon them for next year.

Key Findings

This report describes the findings from the first round of data collection with the Community HIV/HCV Evaluation and Reporting Tool (CHERT). The CHERT is an online survey that collects data from community-based HIV/HCV organizations in British Columbia (BC) about the range of programs and service they provide on an annual basis. Over time, the findings from this annual data collection tool aim to demonstrate the value and impact of the work being done by community-based organizations HIV/HCV organizations across the province. Other purposes of the CHERT are to standardize reporting processes for agencies and funders, in addition to program planning and improvement.

CHERT Respondents

A total of 30 executive directors or program managers of BC community-based HIV/HCV organizations completed the CHERT. Participation from organizations located in each of the five BC health regions was fairly balanced, with most respondents representing the Vancouver Coastal and Northern health regions. Data was also collected from organizations and networks that provide services at the provincial level. All of the data requests were based on programs and services delivered by organizations in the last fiscal year (April 1, 2011 – March 31, 2012).

People Receiving Services

Organizations responding to the CHERT indicated that they collectively provided services to an estimated 196,067 people in the last fiscal year. At this time, we are unable to confirm the accuracy of this estimate given that CHERT respondents could have interpreted this data request in different ways (ie. counting of clients accessing multiple services). A greater proportion of men (57%; $n = 111,919$) were served in comparison to women (39%; $n = 76,275$), while less than 1 percent of clients were transgendered women or men (0.08 and 0.02% respectively). In the previous fiscal year, a considerable number of new clients were served ($n = 77,684$). Further, CHERT respondents frequently reported that high-risk groups, people living with HIV/AIDS, and those co-infected with HIV and HCV comprise a significant proportion of people served by their organizations.

How Community-Based HIV/HCV Organizations Operate

Human Resources

Data collected from the CHERT demonstrates that community-based HIV/HCV organizations within BC are relatively small¹ (OCHART, 2007). Most respondents (63%; $n = 19$) report having less than 5 full-time equivalents (FTEs) to support their HIV/AIDS related work. Fewer paid staff were dedicated to HCV related work, with the large majority of organizations (93%) having less than 5 FTEs to support such efforts. However, community-based HIV/HCV organizations in BC are heavily supported by volunteers and students.

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

Partnerships and Collaboration

The majority of community-based HIV/HCV organizations reported that they have formal and informal partnerships with agencies across different sectors. Formal partnerships and collaborations were most commonly reported with agencies in the public sector (87%; $n = 26$), whereas informal partnerships reported were most commonly held with other non-profit agencies (93%; $n = 28$).

Operational Challenges

All respondents identified operational barriers that impact the effectiveness of their organization's service delivery. Commonly reported challenges were limited funds/resources ($n = 23$), stigma ($n = 16$), and inadequate staffing levels ($n = 14$). While limited resources are commonly identified as a challenge among community-based HIV/HCV organizations, the high proportion of organizations facing challenges surrounding stigma speaks to the importance of focusing on this issue as a sector.

Funding for Community-Based HIV/HCV

CHERT respondents received funding from a variety of sources in the previous fiscal year. Funding support from the BC Health Authorities was reported among the large majority of organizations (80%; $n = 24$)². Funding from the private sector, including foundations, (50%; $n = 15$) private donations (47%; $n = 14$), corporate donations (30%; $n = 9$) and sponsorships (23%; $n = 7$) was another substantial source of funding for CHERT respondents. The data demonstrates that fundraising initiatives supported the work of over half of the organizations (57%; $n = 17$). 43% ($n = 13$) of CHERT respondents indicated that they received in-kind donations in the last fiscal year. In comparison to other funding sources, fewer organizations reported that they received support from Federal Government initiatives, such as the AIDS Community Action Program (ACAP) (27%; $n = 8$) in the last year.

The Impact Community-Based HIV/HCV Organizations are Making

Preventing the Spread of HIV and HCV

CHERT respondents are dedicated to preventing the spread of HIV and HCV. Findings from the CHERT indicated that 93% ($n = 28$) of the responding organizations provided some form of HIV or HCV prevention services in the last year. While all 30 of the CHERT respondents reported that their organizations delivered primary prevention services, the large majority of organizations (90%; $n = 27$) indicated that they also provided upstream and secondary prevention services. In comparison to the strong focus on upstream, primary, and secondary prevention, respondents reported a weaker focus on tertiary prevention activities within their organizations (67%; $n = 20$).

² Note that while we can aggregate the proportion of organizations receiving funding from all BC Health Authorities, other funding sources cannot be aggregated in this way given how the data was collected.

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

CHERT respondents were asked a number of questions surrounding outreach programs and services. 63% of organizations ($n = 19$) indicated that their organizations delivered outreach programs in the last fiscal year, and successfully reached a range of high-risk groups. In terms of the types of outreach activities that were conducted, most organizations' resources focused on referral services (95%; $n = 18$), providing information and education to the community (89%; $n = 17$), and hospital visits (74%; $n = 14$).

Testing for HIV and HCV

Among community-based organizations that completed the CHERT, only 20% ($n = 6$) reported providing HIV and/or HCV testing in the last fiscal year, whereas the remaining 80% of organizations ($n = 24$) did not. This finding is not surprising given that testing for these viruses is typically conducted within clinics and hospitals in the province. Among the 6 organizations who did offer testing services in the last fiscal year, the majority were operating in the Vancouver Coastal ($n = 3$) and Northern ($n = 2$) Health Authority regions, whereas 1 organization was based in the Interior.

Treating HIV and HCV

As expected, the large majority of respondents (90%; $n = 27$) indicated that their organizations did not provide HIV and/or HCV treatment services in the last fiscal year. Those community-based organizations offering HIV and/or HCV treatment services (10%; $n = 3$) all have on-site clinics and were located in the Vancouver Coastal or Northern regions of the province.

Providing Social Support Services

In the CHERT, respondents were asked a series of questions surrounding types of social support services, including: nutrition and food security services, mental health and substance use support services, and housing services. The proportion of organizations offering different social support services was somewhat low (21 – 68%), demonstrating the importance of developing strong partnerships with relevant social service agencies to make effective and appropriate referrals for clients.

Increasing Knowledge and Awareness: Education and Training Activities

The majority of respondents (71%; $n = 20$) reported that their organizations offer HIV or HCV awareness raising workshops and/or training sessions. While an average of 61 workshops and/or training sessions were held by organizations in the last fiscal year, this number varied considerably (ranging from 0 workshops/year to 882 workshops/year). Main targets of these workshops and trainings included community organizations (86%; $n = 18$), health professionals (76%; $n = 16$), and Aboriginal peoples (81%; $n = 17$).

Greater and More Meaningful Involvement of People Living with HIV and/or HCV

The majority of respondents demonstrated that they are committed to the greater and more meaningful involvement of people living with HIV and HCV. Most respondents (57 – 79%)

indicated that they aim to involve members of their target populations in different aspects of their organizations' work. Community members were better engaged in organizational evaluation activities and the management and delivery of services when compared to community engagement in organizational research activities.

Monitoring and Evaluation Work Being Done

The majority of organizations report conducting or commissioning evaluation work within the last fiscal year. Among those who participated in evaluative activities, most conducted both process and outcome evaluations. While the majority of organizations are conducting some form of evaluation work on an annual basis, support in these endeavours is needed and would be valuable.

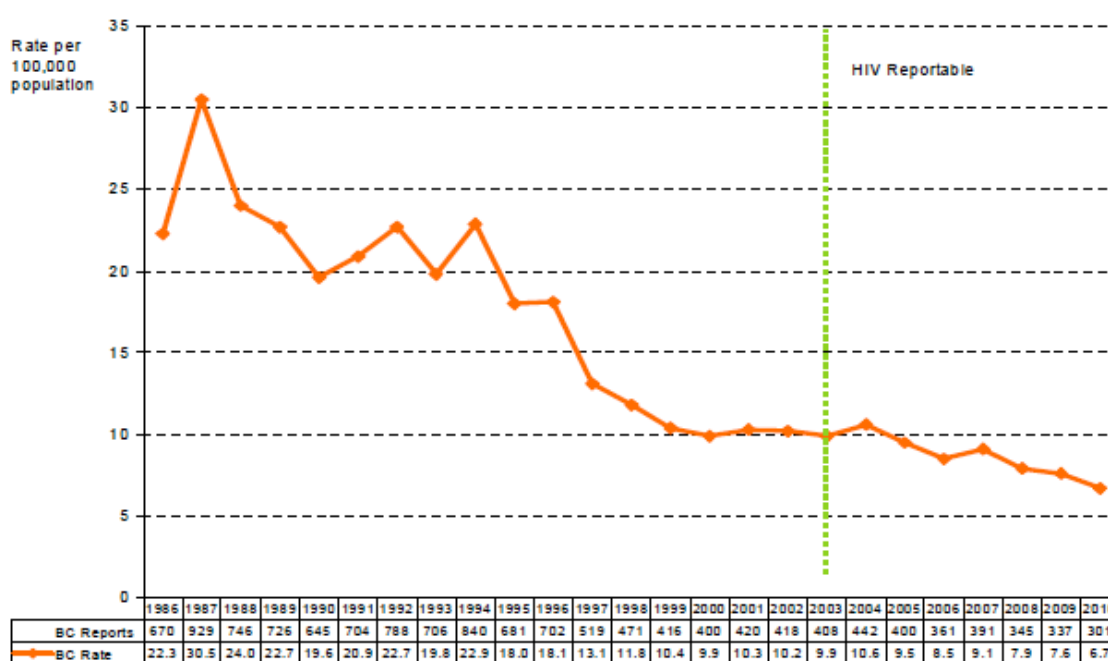
Conclusion

The findings presented in this report showcase the wide range of programs and services offered by community-based HIV/HCV organizations in the province. While areas for improvement have been identified, it is evident that community-based HIV/HCV organizations are positively contributing to the fight against HIV and HCV. To more conclusively comment on the extent of the impact community-based HIV/HCV organizations are making, data collected from future years of the CHERT is required.

1.0 Trends in HIV Infection In British Columbia

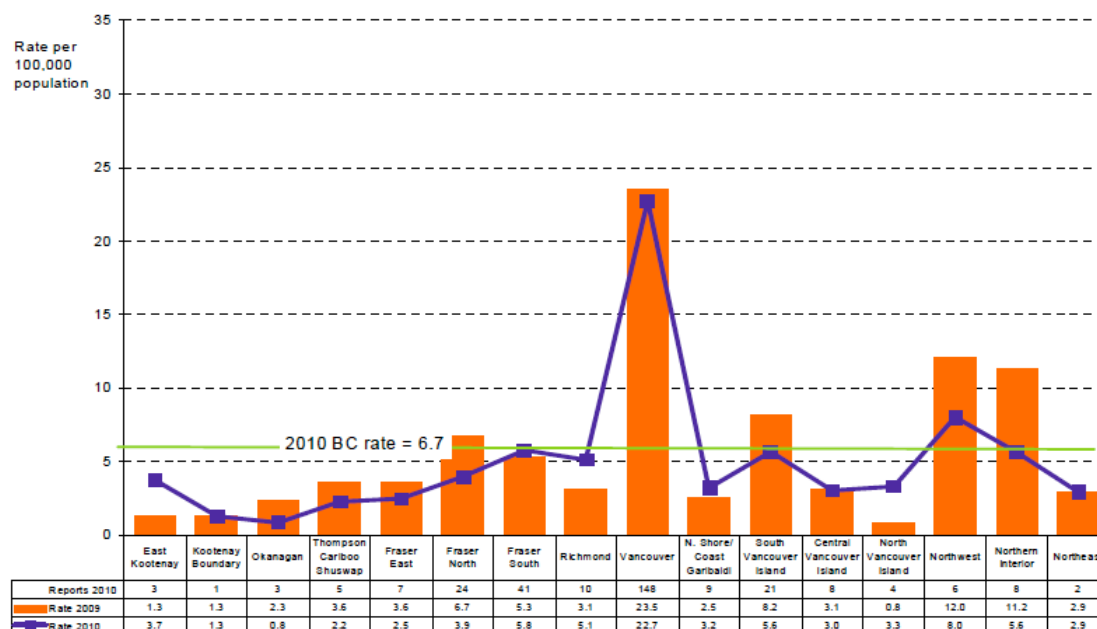
Since the advent of HIV/AIDS in British Columbia, the rate of new positive HIV tests in the province decreased to its lowest point ever in 2010 to 6.7 per 100,000 population (301 cases) (see Figure 1) (BC CDC, 2010). Despite this improvement, HIV/AIDS remains a significant problem for the province. Rates of new positive HIV tests continue to be higher among males when compared to females (BC CDC, 2010). In terms of age groups, the highest rates of new positive tests were found among females between 25-29 years of age, and among males 30-39 years of age in 2010 (BC CDC, 2010). While positive test rates continue to decrease over time, the substantial number of annually reported cases reinforces the importance of providing effective HIV prevention, treatment and care services.

Figure 1: Persons Testing Newly Positive for HIV in BC, 1986 to 2010 (BC CDC, 2010, p. 37)



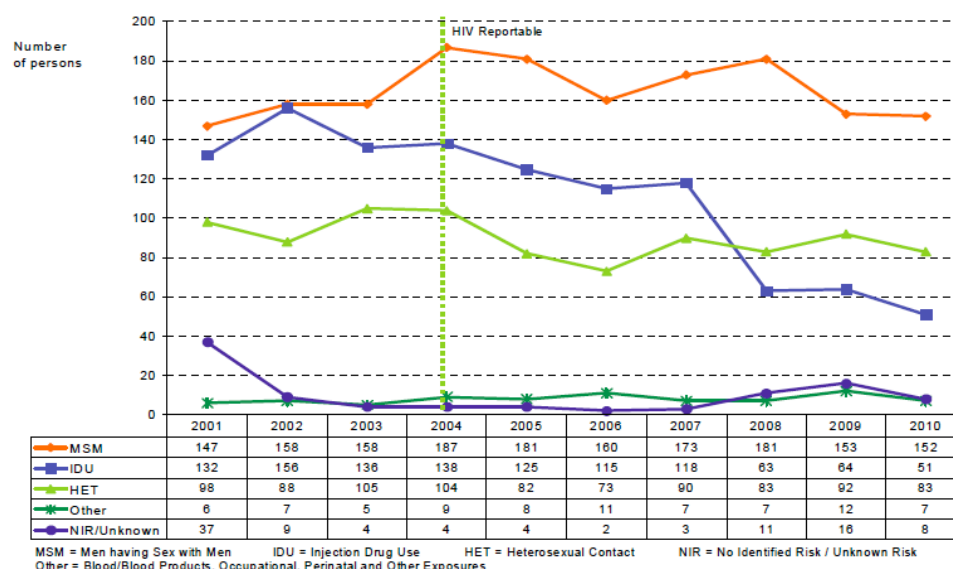
As illustrated in Figure 2, the highest rates of new positive HIV tests in 2010 were reported in the Vancouver (22.7 per 100,000 population) and Northwest (8.0 per 100,000 population) Health Service Delivery Areas (BC CDC, 2010).

Figure 2: Persons Testing Newly Positive for HIV by BC Health Authority, 2009 & 2010 (BC CDC, 2010, p. 38)



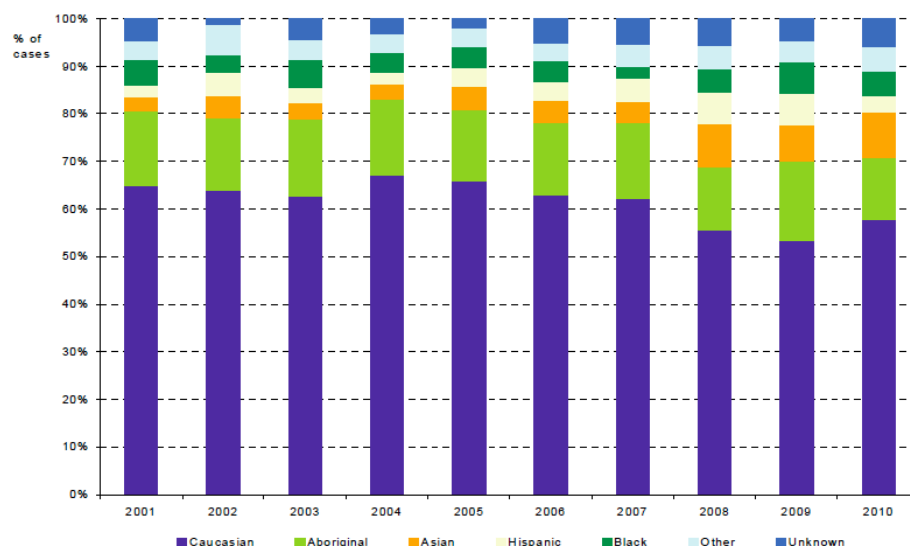
As shown in Figure 3, the greatest number of new positive HIV tests continued to be among men who have sex with men (MSM) in 2010, who accounted for approximately half (52%; $n = 152$ cases) of all positive cases. The number of people testing newly positive continued to decrease among injection drug users (IDUs) from 2009 to 2010 (from 64 to 51 cases respectively). The BC CDC speculates that this likely represents a true decrease in incidence given: (i) the increasing coverage of highly active antiretroviral therapy among IDUs, and (ii) the impact of HIV prevention programs targeted at this population (BC CDC, 2010). The number of new positive tests among heterosexual individuals has been relatively stable among both males and females in recent years (BC CDC, 2010).

Figure 3: Persons Testing Newly Positive for HIV in BC by Exposure Category, 2001 to 2010 (BC CDC, 2010, p. 44)



When examining the ethnicity of people testing newly positive for HIV, it is apparent that Caucasian people continue to be significantly impacted by the epidemic (see Figure 4). In 2010, 57.8% (174 cases) of all newly diagnosed cases were among Caucasian people (BC CDC, 2010). Aboriginal and Asian populations also continue to be disproportionately represented in the province's epidemic (BC CDC, 2010) (see Figure 4). In 2010, Aboriginal people represented 13% (39 cases) of all new infections, whereas those of Asian ethnicity made up 9.6% (29 cases). Aboriginal females continue to be particularly impacted by the epidemic, as they represented 33% (21 cases) of all new positive HIV cases in 2010, in comparison to 14.6% (39 cases) among Aboriginal males (BC CDC, 2010).

Figure 4: Persons Testing Newly Positive for HIV in BC by Ethnicity, 2001 to 2010 (BC CDC, 2010, p. 42)

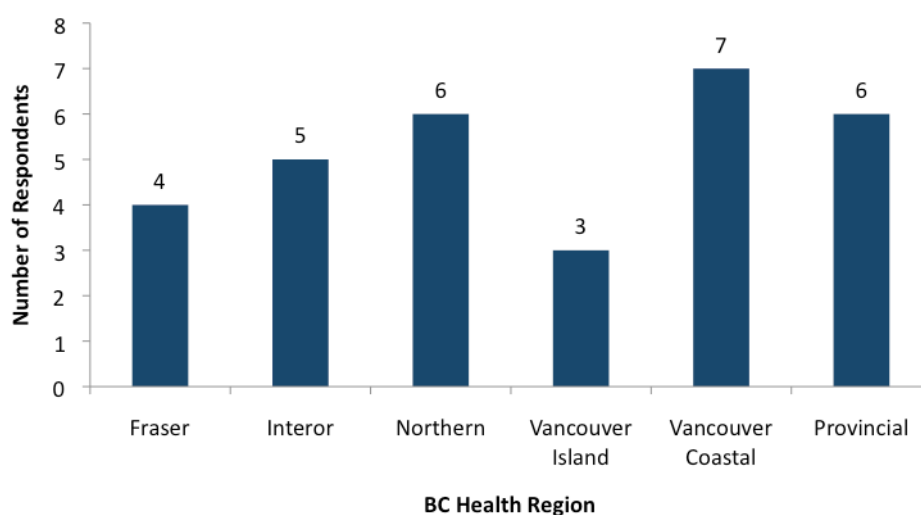


2.0 CHERT Respondents

The CHERT was completed by a total of 30 executive directors or program managers of community-based HIV/HCV organizations in BC. Of the 45 community-based HIV/HCV organizations that are current members of the Pacific AIDS Network, 67% ($n = 30$) of them participated in this round of data collection with the CHERT. As illustrated in Figure 5, participation from organizations providing services in each of the five BC health regions was fairly balanced. However, the majority of the CHERT respondents were from the Vancouver Coastal ($n = 7$) and Northern regions ($n = 6$). A considerable number of survey respondents ($n = 6$) were also representing provincial HIV/HCV networks and organizations.

The CHERT consists of 68 closed-ended questions, which were based on the programs and services delivered by organizations in the last fiscal year (April 1, 2011 – March 31, 2012). The average CHERT completion time was 72 minutes.

Figure 5: Number of CHERT Respondents by BC Health Region ($n = 30$)



3.0 People Receiving Services

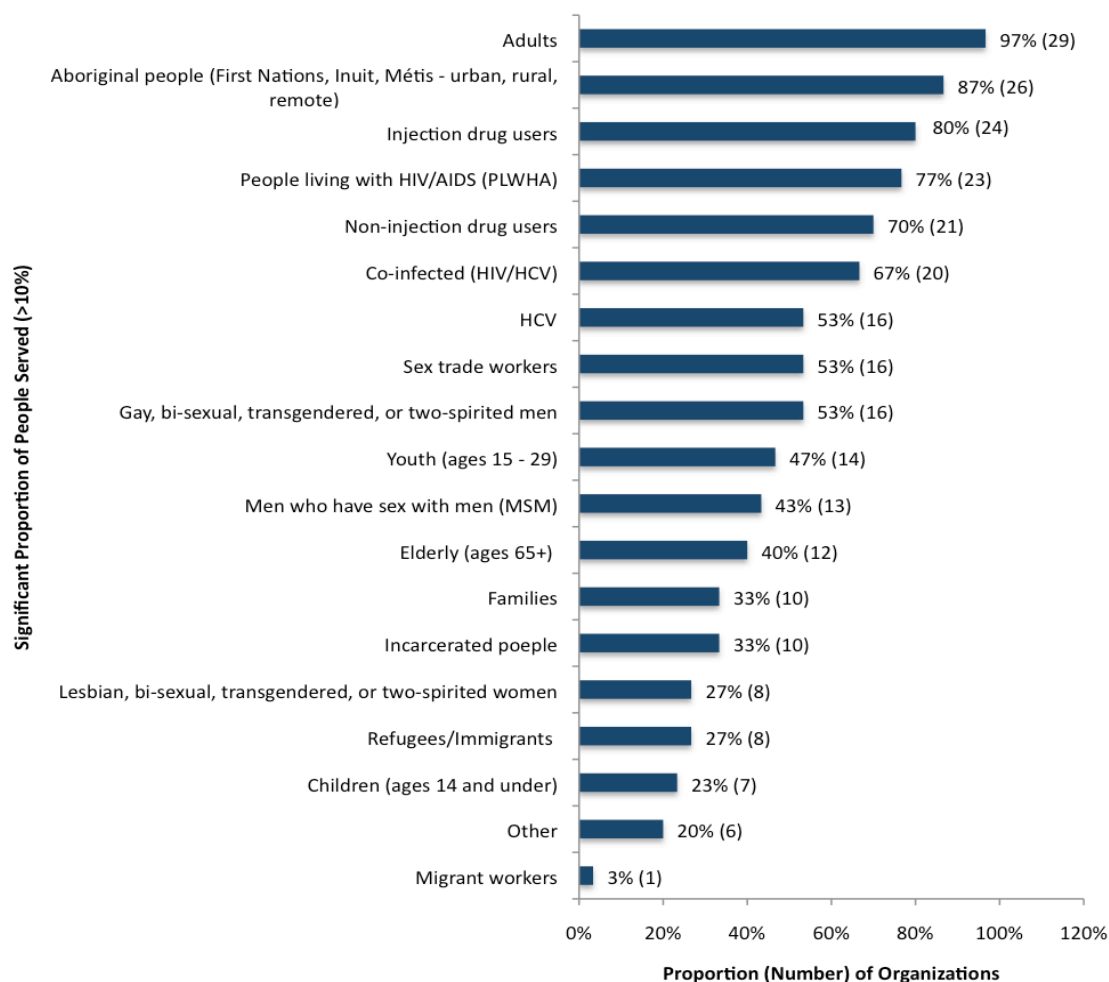
Organizations responding to the CHERT collectively provided services to an estimated 196,067 people in the last fiscal year. It is possible that this number is overestimated, as many respondents reported total number of visits per year, which is an estimate that would have duplicated the count of repeat clients. Among the total number of people served, approximately 57% ($n = 111,919$) were men and 39% ($n = 76,275$) were women. Transgendered women and men made up less than 1 percent (0.08% and 0.02% respectively) of all those served by CHERT respondents.³

³ Note that these proportions describing the gender breakdown of clients served does not add up to 100% since some CHERT respondents did not track gender-disaggregated information on the total number of people they serve.

Data from the CHERT revealed that responding organizations served a considerable number of new clients in the last fiscal year. Collectively, respondents estimated that they provided services for 77,684 new people from April 2011 to March 2012. Organizations also reported that they discharged approximately 21,592 people from their services in the last year. Reasons for discharge were variable, including: clients moving to different areas, clients no longer requiring services, and client deaths.

CHERT respondents were also asked to specify those populations that make up a significant proportion of the people they served (>10%). As illustrated in Figure 6, high-risk groups frequently made up a significant proportion of people served by organizations, including Aboriginal peoples (87%; $n = 26$), injection drug users (80%; $n = 24$), and sex trade workers (53%; $n = 16$). People living with HIV/AIDS (77%; $n = 23$) and those co-infected with HIV and HCV (67%; $n = 20$) also comprised a significant proportion of people served by the majority CHERT respondents. In terms of ages of people served by organizations, the majority of organizations reported that they served a significant proportion of adults (97%; $n = 29$), whereas youth (47%; $n = 14$), elderly (40%; $n = 12$) and children (23%; $n = 7$) were not a focus for the majority of respondents.

Figure 6: Populations That Represent a Significant Proportion of People Served (>10%) ($n = 30$)



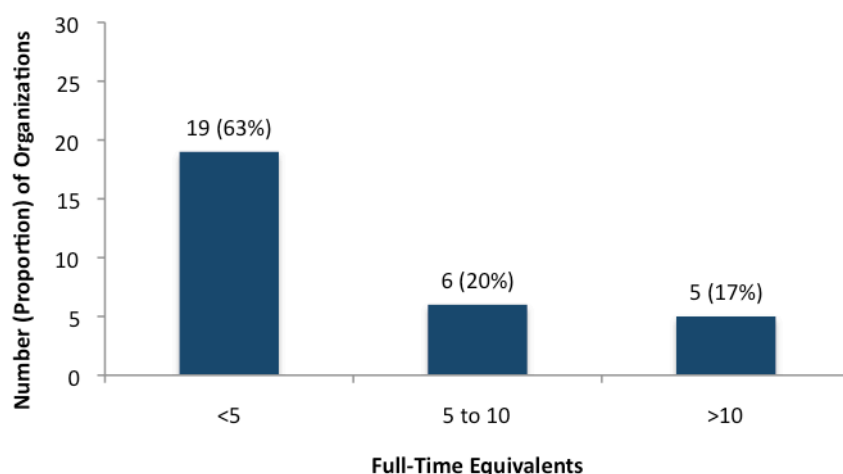
4.0 How Community-Based HIV/HCV Organizations Operate

4.1 Human Resources

4.1.1 Paid Staff for HIV/AIDS Related Work

CHERT respondents were asked a series of questions about their organizations' human resources within the last fiscal year. Data from the CHERT demonstrates that most community-based HIV/HCV organizations within the province are relatively small⁴ (OCHART, 2007). The majority of respondents (63%; $n = 19$) report having less than 5 full-time equivalents (FTEs) to support their HIV/AIDS related work (see Figure 7). Further, 6 community-based HIV/HCV organizations (20%) were staffed with 5 to 10 FTEs, whereas 5 organizations (17%) had more than 10 FTEs to conduct their HIV/AIDS related work.

Figure 7: Number of Community-Based HIV/HCV Organizations by Full-Time Equivalents for HIV/AIDS Related Work ($n = 30$)

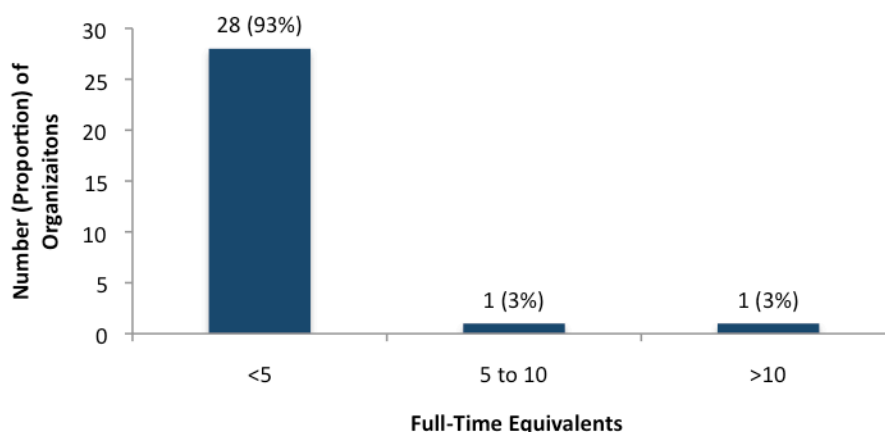


4.1.2 Paid Staff for HCV Related Work

In comparison to HIV/AIDS work, the CHERT revealed that there was significantly less paid staff dedicated to supporting HCV related work among community-based HIV/HCV organizations in 2011-2012. As depicted in Figure 8, 28 (93%) CHERT respondents had less than 5 FTEs dedicated to HCV programs and services. Only 2 CHERT respondents (7%) reported that their organizations had 5 or more FTEs to support their HCV work.

⁴ OCHART (2007) defines small organizations as those that are supported by less than 5 FTEs to conduct their work.

Figure 8: Number of Community-Based HIV/HCV Organizations by Full-Time Equivalents for HCV Related Work ($n = 30$)



4.1.3 Volunteers and Post-Secondary Students

Findings from the CHERT have shown that community-based HIV/HCV organizations in BC are dependent on volunteers and students to support their work. In the last fiscal year, each organization's HIV/AIDS related work was supported by an average of 41 volunteers. Whereas an average of 15 volunteers assisted organizations with their HCV related activities. In the 2011-2012 year, community-based HIV/HCV organizations benefited from an approximated average of 81 volunteer hours per week or roughly \$13,026 worth of service per week.⁵

In addition to volunteers, post-secondary students also provided significant support for organizations that responded to the CHERT. Within the last year, an average of 11 students assisted each organization with both their HIV/AIDS and HCV related work. Considering the critical role volunteers and students can play in strengthening organizational capacity, community-based HIV/HCV organizations should continue to attract and retain this assistance to effectively support their work moving forward.

4.2 Partnerships and Collaboration

The effectiveness of community-based HIV/HCV organizations is contingent on their ability to collaborate and partner with similar organizations to collectively enhance the delivery of services for people living with and at risk for HIV/HCV. The formation of collaborations and partnerships can help agencies 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. Additionally, the formation of partnerships may also be an effective way to respond to potential funding cuts for HIV or HCV related work.

⁵ This dollar amount was calculated based on an assumed rate of \$10/hour for unskilled volunteers, and \$15/hour for skilled volunteers.

The majority of organizations (87%; $n = 26$) reported that they have formed *formal* partnerships (such as agreements, contracts or memorandums of understanding) with a number of agencies in different sectors. Formal partnerships and collaborations were most commonly reported with: agencies in the public sector (87%; $n = 26$), other non-profit organizations (37%; $n = 11$), and corporations (13%; $n = 4$) (see Figure 9).

Similarly, 93% ($n = 29$) of respondents indicated that they have developed *informal* partnerships with other agencies and groups. The majority of informal partnerships reported were held with other non-profit agencies (93%; $n = 28$). Informal collaborations were also reported with agencies in the public sector (57%; $n = 17$) and corporations (20%; $n = 6$) (see Figure 10). A total of 4 (13%) organizations reported that they did not have any informal partnerships in the last fiscal year.

Figure 9: Proportion of *Formal* Organizational Partnerships by Partner Type ($n = 30$)

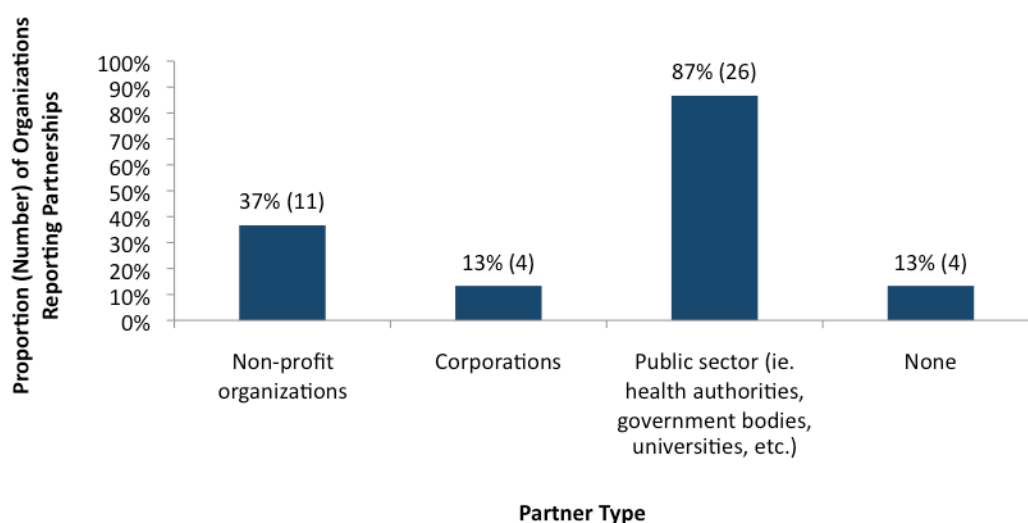
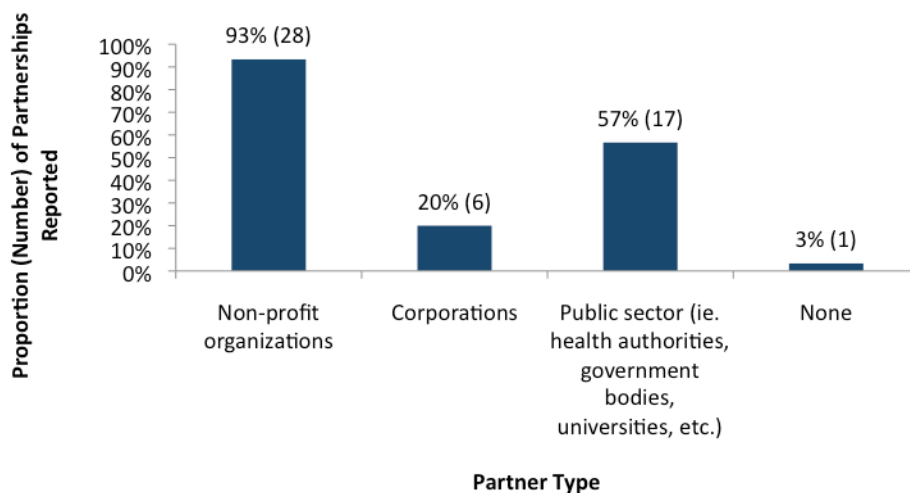


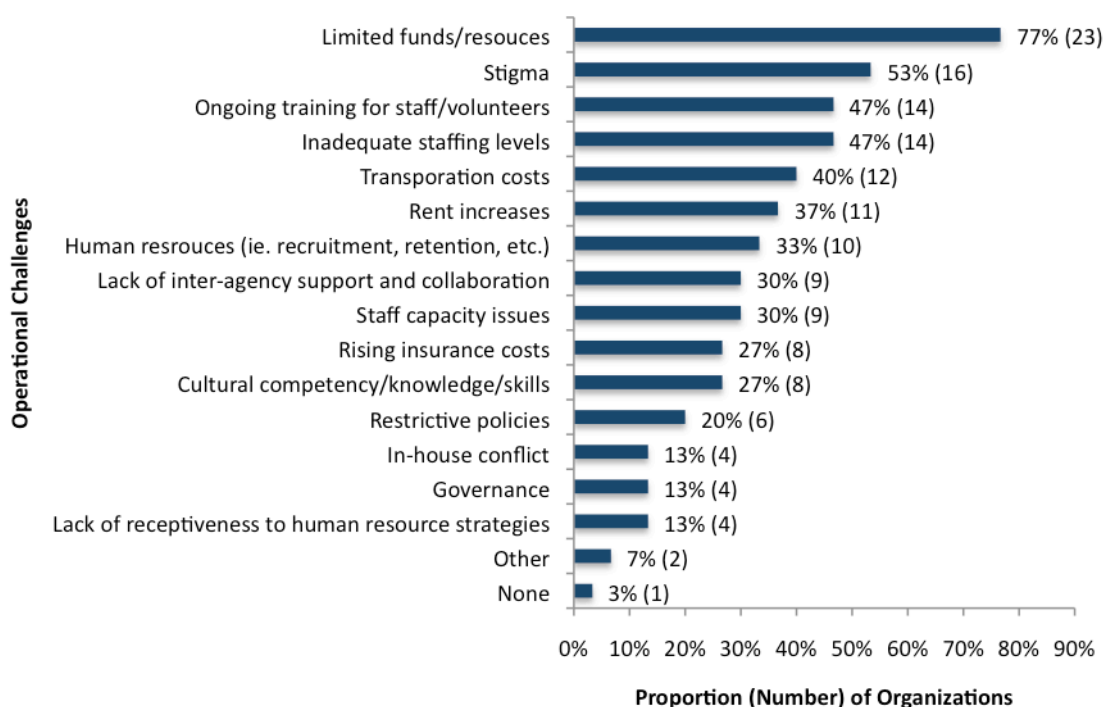
Figure 10: Proportion of *Informal* Organizational Partnerships by Partner Type ($n = 30$)



4.3 Operational Challenges

All respondents identified operational challenges that impact the effectiveness of their organizations' programs and services. As seen in Figure 11, the most commonly reported operational challenges were limited funds/resources (77%; $n = 23$), stigma (53%; $n = 16$), and inadequate staffing levels (47%; $n = 14$). While limited resources are commonly identified as a challenge among community-based HIV/HCV organizations, the high proportion of organizations facing challenges surrounding stigma speaks to the importance of focusing on this issue as a sector. Respondents also specified other operational challenges facing their organizations ($n = 2$), including growth capacity and eviction issues.

Figure 11: Operational Challenges Reported by Respondents ($n = 30$)

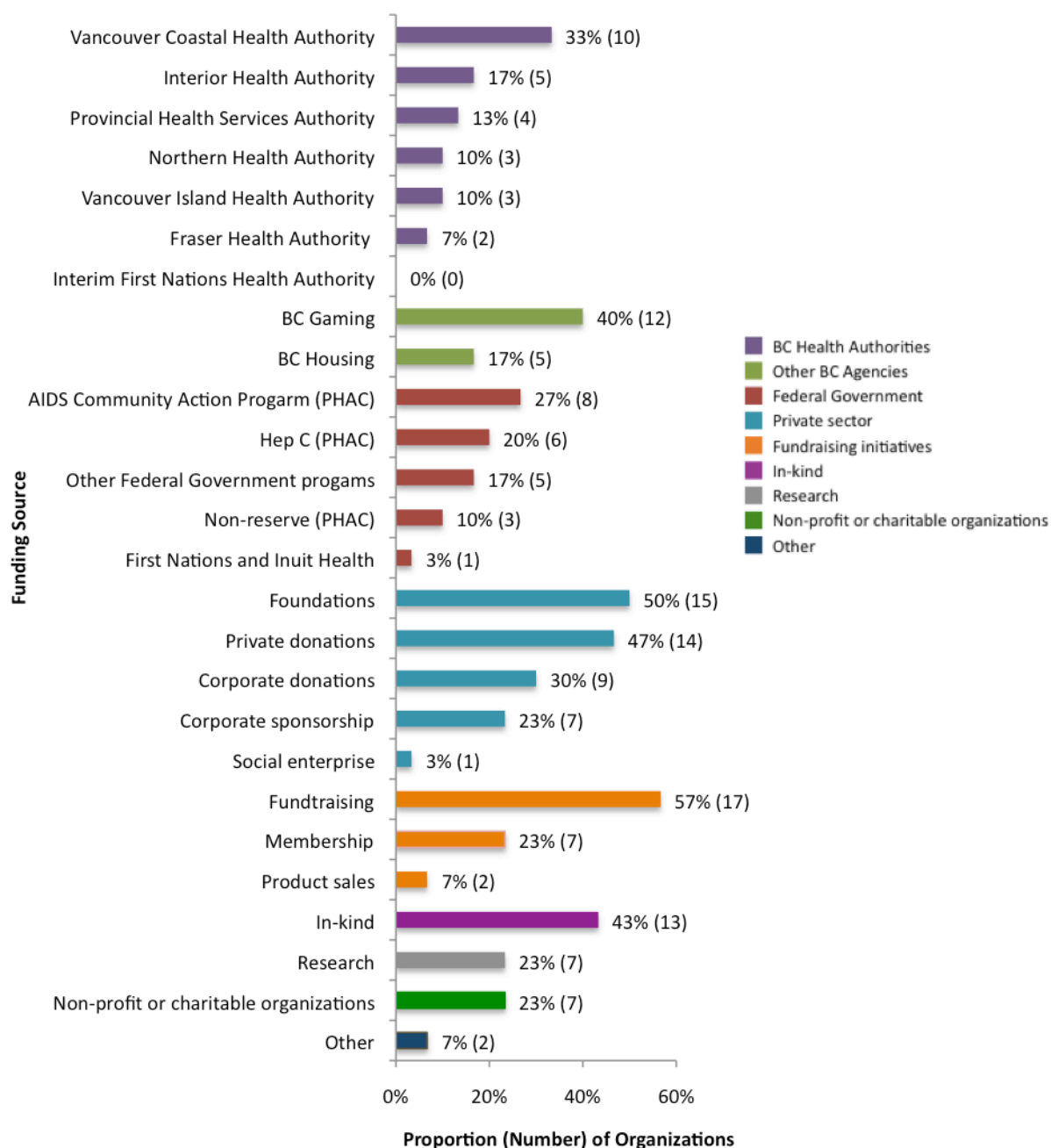


5.0 Funding for Community-Based HIV/HCV Organizations

THE CHERT also explored the different funding sources that community-based HIV/HCV organizations in BC are supported by. As Figure 8 shows, CHERT respondents received funding from a variety of sources in the previous fiscal year. Funding support from the BC Health Authorities was reported among the large majority of the organizations (80%; $n = 24$). Note that while we can aggregate the proportion of organizations receiving funding from all BC Health Authorities, other funding sources cannot be aggregated in this way given how the data was collected.

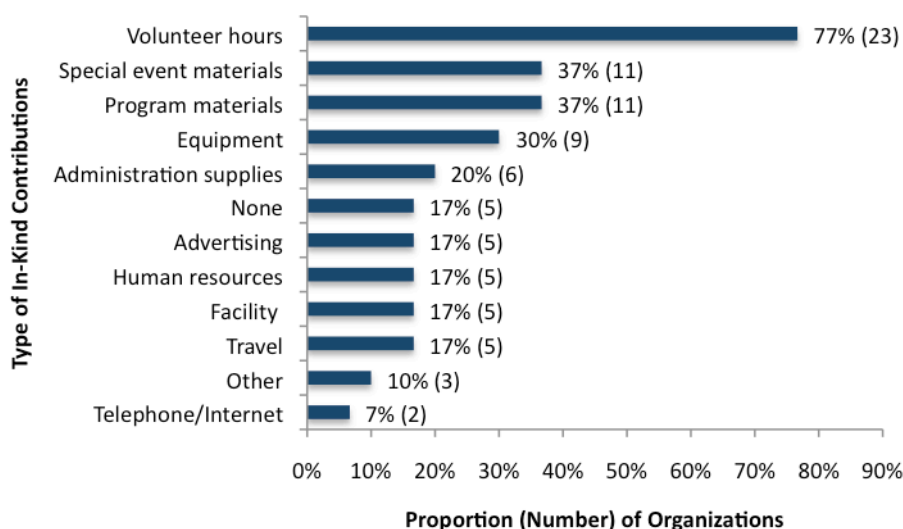
Funding from the private sector, including foundations, (50%; $n = 15$) private donations (47%; $n = 14$), corporate donations (30%; $n = 9$) and sponsorships (23%; $n = 7$) was another considerable source of support for CHERT respondents (see Figure 12). The data demonstrates that fundraising initiatives supported the work of over half of the organizations (57%; $n = 17$). 43% ($n = 13$) of CHERT respondents indicated that they received in-kind donations in the last fiscal year. In comparison to other funding sources, fewer organizations reported that they received support from Federal Government initiatives, such as the AIDS Community Action Program (ACAP) (27%; $n = 8$) in the last year. Other sources of funding are detailed below in Figure 8.

Figure 12: Sources of Funding for Community-Based HIV/HCV Organizations ($n = 30$)



CHERT respondents were also asked to specify what types of in-kind contributions their organizations received in the last fiscal year. As seen in Figure 13, a large proportion of organizations (77%; $n = 23$) reported receiving in-kind contributions in the form of volunteer hours. Other significant sources of in-kind contributions included: special event materials (37%; $n = 11$), program materials (37%; $n = 11$), and equipment (30%; $n = 9$) (see Figure 9). Given that a total of 5 organizations (17%) did not receive any in-kind contributions in the previous fiscal year, some community-based HIV/HCV organizations could consider the cost-saving benefits in-kind contributions can provide.

Figure 13: Types of In-Kind Contributions Organizations Received in the Last Fiscal Year ($n = 30$)

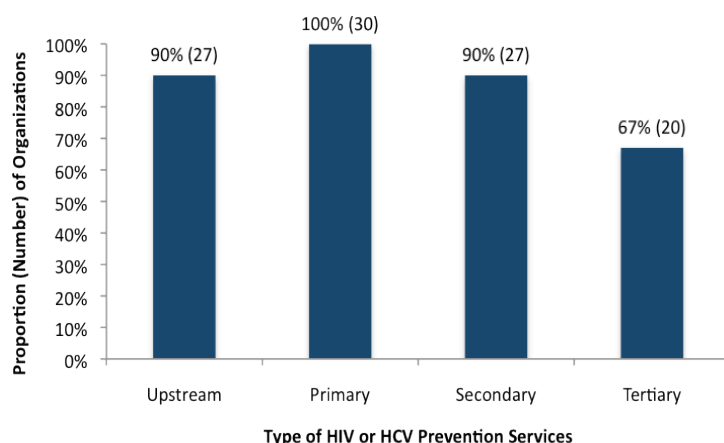


6.0 The Impact Community-Based HIV/HCV Organizations are Making

6.1 Preventing the Spread of HIV and HCV

CHERT respondents demonstrated that they are committed to preventing the spread of HIV and HCV within the community. Findings from the CHERT indicated that 93% ($n = 28$) of the responding organizations provide some form of HIV or HCV prevention services. While all 30 of the CHERT respondents reported that their organizations deliver primary prevention services, the large majority of organizations (90%; $n = 27$) indicated that they also provide upstream and secondary prevention services (see Figure 14). This data demonstrates that community-based HIV/HCV organizations are important players in the delivery of upstream, primary and secondary prevention programming in the province. In comparison, respondents reported a weaker focus on tertiary prevention activities within their organizations (67%; $n = 20$).

Figure 14: Proportion of Organizations by Type of HIV or HCV Prevention Service Offered ($n = 30$)



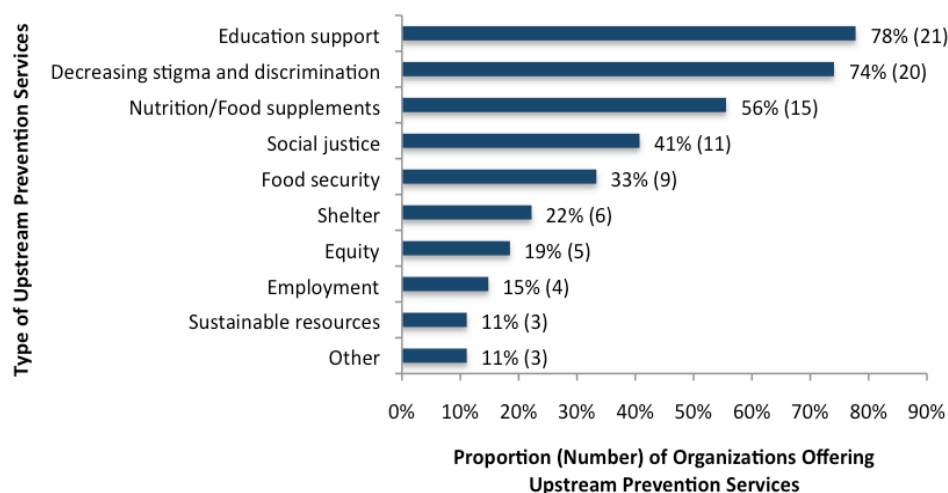
6.1.1 Upstream Prevention Services

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, and decreasing stigma and discrimination).

Among those organizations providing upstream prevention services, a variety of different types of services were offered in the last fiscal year. As illustrated in Figure 15, the most commonly provided upstream prevention services were educational support (78%; $n = 21$), activities aiming to decreasing stigma and discrimination (74%; $n = 20$), and nutrition/food supplementation (56%; $n = 15$).

Figure 15: Proportion of Organizations by Type of Upstream Prevention Service Offered ($n = 27$)



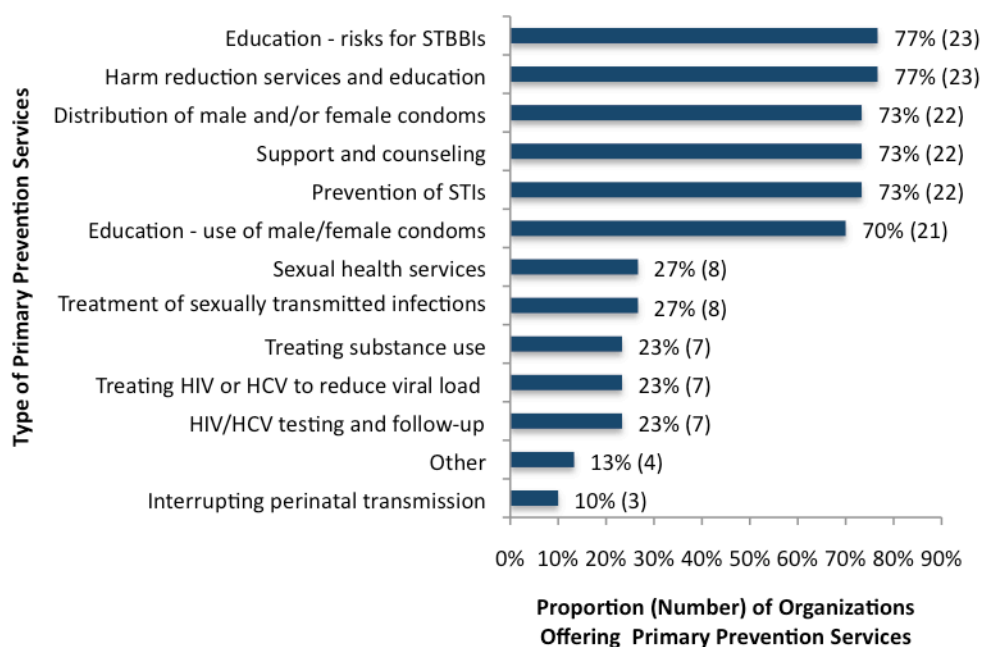
6.1.2 Primary Prevention Services

The CHERT defines primary prevention as:

the prevention 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. use of male and female condoms, condom negotiating skills, reduce number of partners/frequency of intercourse and abstinence).

As illustrated in Figure 16, organizations incorporated a wide range of primary prevention strategies in their approach to preventing the transmission of HIV in the previous fiscal year. Frequently delivered primary prevention services included: education regarding the risks for transmission of sexually transmitted blood borne infections (STBBIs) (77%; $n = 13$), harm reduction services and education (77%; $n = 23$), and the distribution of male and female condoms (73%; $n = 22$).

Figure 16: Proportion of Organizations by Type of Primary Prevention Service Offered ($n = 30$)



To effectively prevent the spread of the HIV, community members require access to condoms, clean injection and inhalation equipment, lubricant, and other harm reduction and prevention materials. Evidence from the CHERT has demonstrated that community-based organizations play a critical role in the distribution of harm reduction and prevention materials. Specifically, respondents reported that they collectively distributed an estimated 443,566 condoms in the last fiscal year (Table 1).

Organizations also indicated that they dispensed safer injection equipment, including the collective distribution of 879,804 needles in 2011-2012 (see Table 1). Of the total number of

needles that were distributed, approximately 70% of that amount (619,761) was returned to be safely disposed of. Among those organizations reporting the distribution of needles, the number of needles distributed varied significantly from a low of 60 to a high of 176,596. This variation is likely due to: differences in organizational capacity to distribute needles, the concentration of injection drug use in particular communities, and the placement of needle exchange programs within some community-based organizations and not others. Organizations responding to the CHERT also distributed safer inhalation equipment in the last year, including the distribution of 10,966 pipes and glass tubes.

Table 1: Total Number of Harm Reduction/Prevention Materials Distributed in 2011-2012 ($n = 26$)

Harm Reduction/ Prevention Material	Number Distributed in 2011- 2012
Condoms	443,566
Lube	243,068
Needles	879,804
Needles returned	619,761
Pipes/glass tubes	10,966

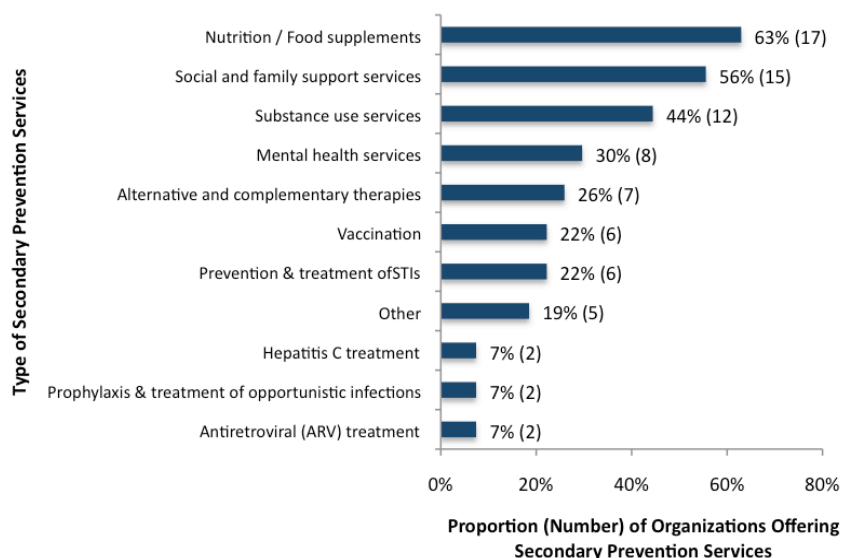
6.1.3 Secondary Prevention

The CHERT defines secondary prevention 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. antiretroviral treatment, prophylaxis, and treatment of opportunistic infections, and prevention and treatment of STIs).

Secondary prevention efforts are critical in preventing or delaying the progression of HIV or HCV infection to terminal diseases and disabilities, including AIDS and opportunistic infections. Within BC, community-based HIV/HCV organizations greatly contribute to the secondary prevention of both HIV and HCV by providing nutrition and food supplementation (63%; $n = 17$), social and family support (56%; $n = 15$), and substance use services (44%; $n = 12$) (see Figure 17). Other secondary prevention services offered by CHERT respondents are outlined in Figure 17.

Figure 17: Proportion of Organizations by Type of Secondary Prevention Service Offered ($n = 27$)



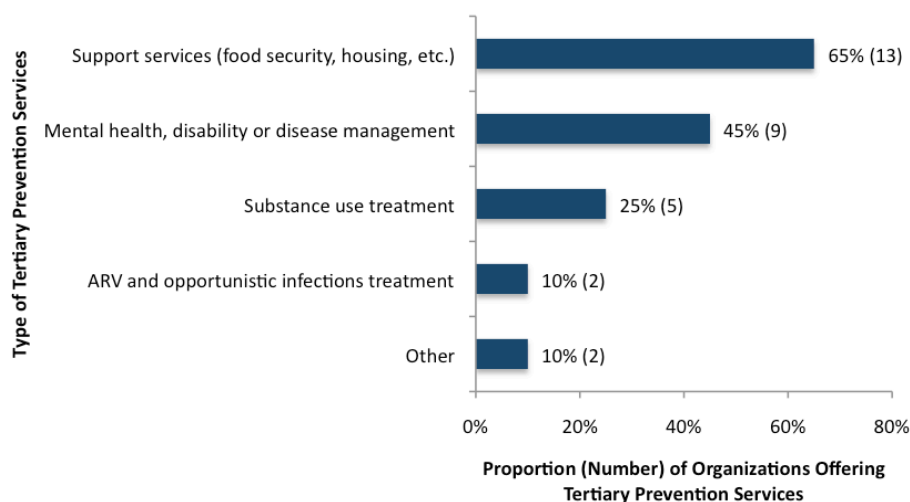
6.1.4 Tertiary Prevention of HIV

Tertiary prevention is defined in the CHERT as:

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

As expected, data from the CHERT indicated that community-based HIV/HCV organizations play a less influential role in the tertiary prevention of HIV and HCV. Among those organizations that did provide tertiary prevention services in the last fiscal year (67%; $n = 20$), there appeared to be a stronger focus on support services (65%; $n = 13$), such as food security and housing as opposed to treatment of substance use (25%; $n = 5$), HIV, and opportunistic infections (10%; $n = 2$) (see Figure 18).

Figure 18: Proportion of Organizations by Type of Tertiary Prevention Service Offered (n = 27)



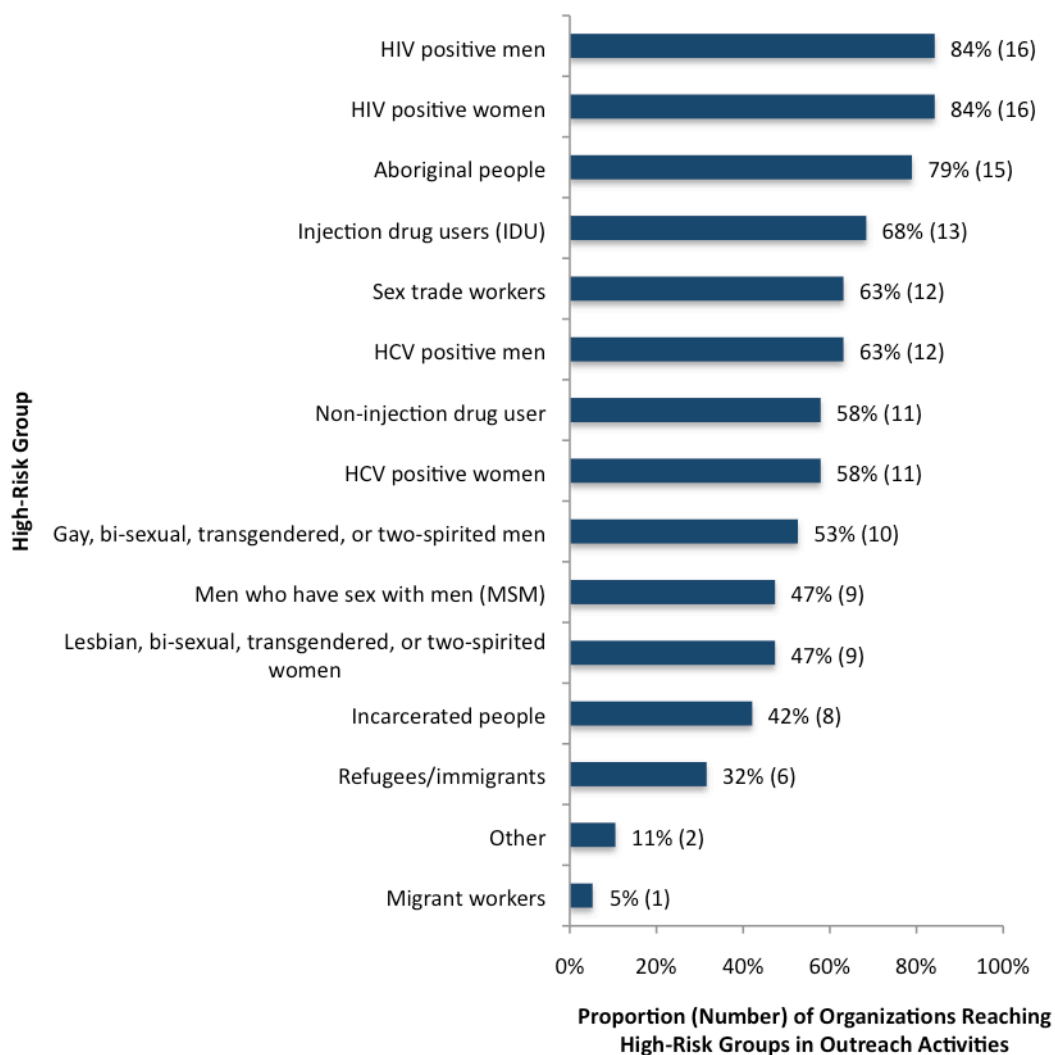
6.2 Accessing Hard-to-Reach Populations: HIV/HCV Outreach Efforts

Outreach efforts for HIV and HCV provide access to hard-to-reach populations whom often most require treatment, prevention, and support services. By bringing information and services to the community level, outreach services overcome access barriers commonly faced by highly affected populations.

6.2.1 Who is Being Reached?

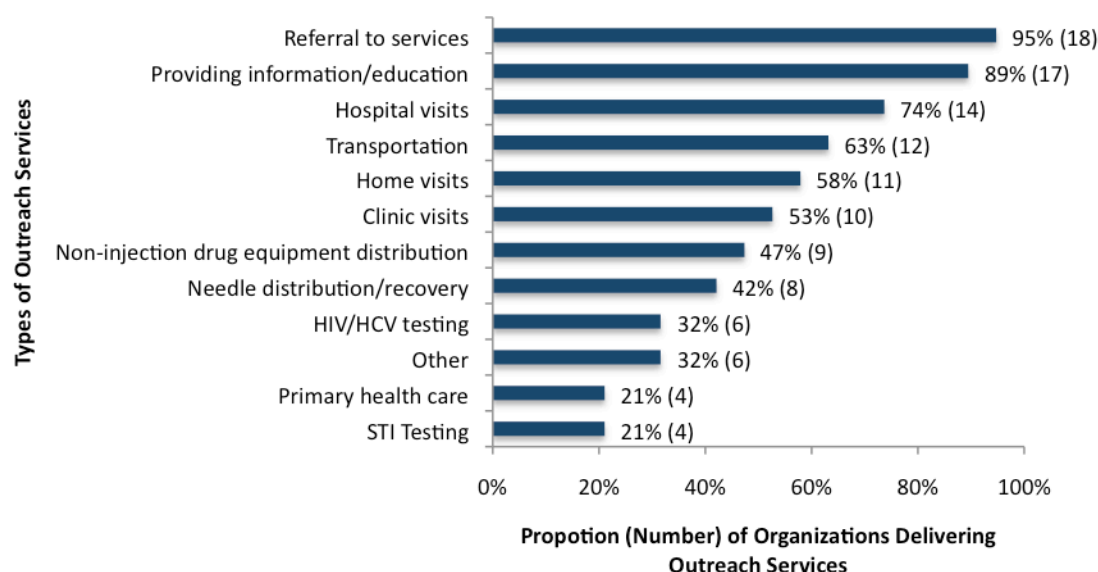
The CHERT asked respondents a number of questions surrounding outreach programs and services. While 63% of respondents ($n = 19$) indicated that their organizations delivered outreach programs in the last fiscal year, 37% of organizations ($n = 11$) did not offer such services. As seen in Figure 19, a range of high-risk groups were reached by those organizations conducting outreach activities. CHERT respondents focused their outreach activities on women and men living with HIV/AIDS (84%; $n = 16$), Aboriginal people (79%; $n = 15$), and injection drug users (68%; $n = 13$). While community members of various ages were targeted by organizations' outreach activities, adults (89%; $n = 17$) and youth (68%; $n = 13$) were particularly well reached.

Figure 19: Proportion of Organizations Reaching Different Groups in Outreach Activities ($n = 19$)



6.2.1 Outreach Activities

In terms of the types of outreach activities that were conducted in the last fiscal year, most organizations' resources focused on referral services (95%; $n = 18$), providing information and education to the community (89%; $n = 17$), and hospital visits (74%; $n = 14$) (see Figure 20).

Figure 20: 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 early detection of both HIV and HCV will also improve the long-term survival of infected individuals.

6.3.1 Identifying Positive Infections

Among community-based organizations that completed the CHERT, only 20% ($n = 6$) reported providing HIV and/or HCV testing in the last fiscal year, whereas the remaining 80% of organizations ($n = 24$) did not. This finding is not surprising given that the majority of community-based HIV/HCV organizations in BC do not have on-site clinics. Among the 6 organizations who did offer testing services in the last fiscal year, the majority were operating in the Vancouver Coastal ($n = 3$) and Northern ($n = 2$) Health Authority regions. The concentration of testing services within these regions could be due to a two factors. First, Vancouver's inner city and Prince George are home to the majority of BC's HIV cases and also display increasing rates of the virus (BC Centre for Excellence in HIV/AIDS, 2012). Second, both the Vancouver Coastal and Northern regions of BC are the pilot sites for the STOP HIV/AIDS Pilot Project, which aims to increase the expansion of HIV testing, treatment and support services to people living with, or at risk for, HIV infection (BC Centre for Excellence in HIV/AIDS, 2012).

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

Table 2 illustrates the different types of HIV/HCV testing and post-positive support offered by organizations in the last year. A total of 6 organizations offered HIV testing services and 5 provided HCV testing services. Although the majority of organizations ($n = 5$) offered or referred

clients to post-positive support, ideally all organizations testing for HIV and HCV would offer such post-testing support to improve the continuum of care for community members.

Table 2: Proportion of Community-Based Organizations Offering Different Types of HIV/HCV Testing and Post-Positive Support ($n = 7$)

HIV/HCV Testing Related Service	Number Organizations	
	Yes	No
HIV testing	6	1
HCV testing	5	2
HCV-PCR testing to confirm chronic hepatitis C infection	3	4
Post-positive referral for support and counseling services	5	2
Post-positive support services/counseling	5	2
Post-positive referral for clinical care and treatment services	5	2

Those CHERT respondents providing testing services were also asked about the specific testing method they employed in the last year. While 3 organizations provided *both* Point of care (rapid testing) and traditional blood draw testing services, 3 other organizations only offered the traditional blood draw method. While a total of 2,535 and 186 people were tested for HIV and HCV respectively, these numbers must be interpreted with caution, as only 3 respondents were able to provide data on the number of people tested in the last fiscal year.

6.4 Treating HIV and HCV

Effective treatment for HIV and HCV has demonstrated to decrease the risk of disease-related morbidities, opportunistic infections, and mortality among infected individuals (Montaner, et al., 2010). As argued by the “treatment as prevention” approach adopted by the STOP HIV/AIDS Pilot Program, expanding access to highly active antiretroviral therapy (HAART) for PLWHA will also play an important role in reducing the transmission of HIV at the community level (Montaner, et al., 2010).

6.4.1 HIV and HCV Treatment Services

As expected, the large majority of respondents (90%; $n = 27$) indicated that their organizations did not provide HIV and/or HCV treatment services in the last fiscal year. Those community-based organizations offering HIV and/or HCV treatment services (10%; $n = 3$) all have on-site clinics and were located in the Vancouver Coastal or Northern regions of BC. While the average numbers of people receiving treatment for HIV, HCV, and HIV/HCV co-infection were tracked in the CHERT (see Table 3), this data must be interpreted with caution, as only 3 respondents were able to provide this information.

Table 3: Average Number of People Receiving HIV/HCV Treatment From CHERT Respondents ($n = 3$)

HIV/HCV Treatment Type	Average Number of People Receiving Treatment ($n = 3$)
HIV	96
HCV	181
HIV-HCV co-infection	62

6.4.2 Adherence Programs

Although adherence to drug regimes designed to treat HIV/HCV is critical for treatment success, inadequate adherence remains a challenge within the province, particularly among vulnerable populations (Kerr, et al., 2004; Wood, et al., 2003). In effort to increase adherence to drug regimes for HIV and HCV positive people, a handful of organizations in the province offer treatment adherence programs. Specifically, 2 organizations provided an adherence program for PLWHA who are receiving treatment, and 1 organization reported the provision of an adherence program for HCV-treated people. It is important highlight that these numbers are likely underestimated, as only those offering HIV and/or HCV treatment services were able to respond to this question. The following components existed within the adherence programs offered by CHERT respondents in the last fiscal year:

- Individual counseling ($n = 2$)
- Onsite medical storage ($n = 2$)
- Staff dedicated to support adherence ($n = 2$)
- Maximally assisted therapy ($n = 2$)
- Free meal program ($n = 2$)
- Peer navigator ($n = 1$)
- Accompaniment to doctors appointments ($n = 1$)
- Outreach ($n = 1$)
- Directly observed therapy ($n = 1$)
- Peer support groups ($n = 1$)

6.5 Providing Social Support Services

People infected with HIV/HCV in BC continue to face complex socio-economic and health issues, such as poverty, food insecurity, homelessness, unemployment, and mental health challenges. To address this complexity, community-based HIV/HCV organizations operating within the province must offer responsive social support services or have systems in place to refer clients to more appropriate agencies. CHERT respondents were asked a series of questions surrounding social support services, including: nutrition and food security services, mental health and substance use support services, and housing services.

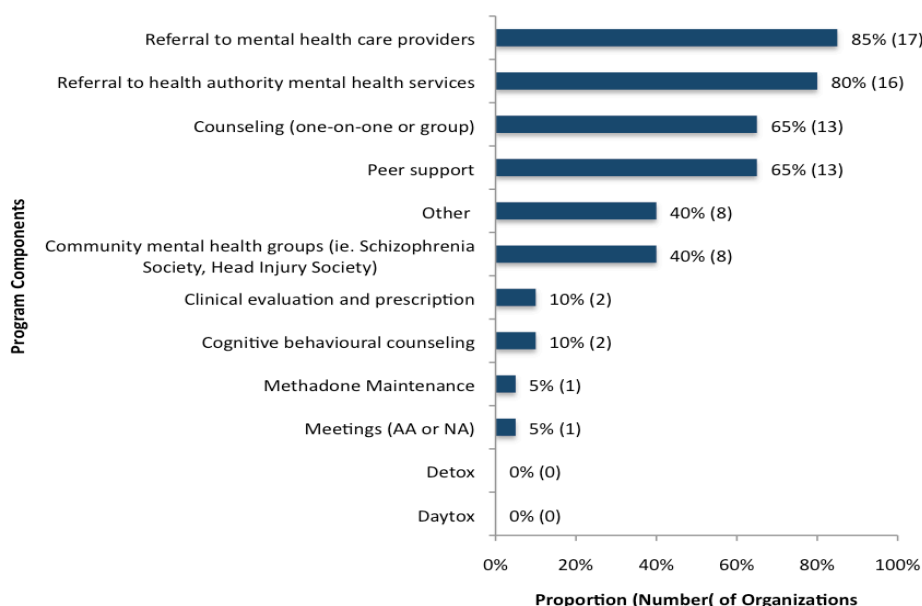
6.5.1 Nutrition and Food Security Support Services

The majority of respondents (56%, $n = 15$) indicated that their organizations do not offer nutrition and/or food security support services for their clients. Instead, most organizations (89%; $n = 24$) reported that they refer clients to other social service agencies that provide this kind of support.

6.5.2 Mental Health and Substance Use Support Services

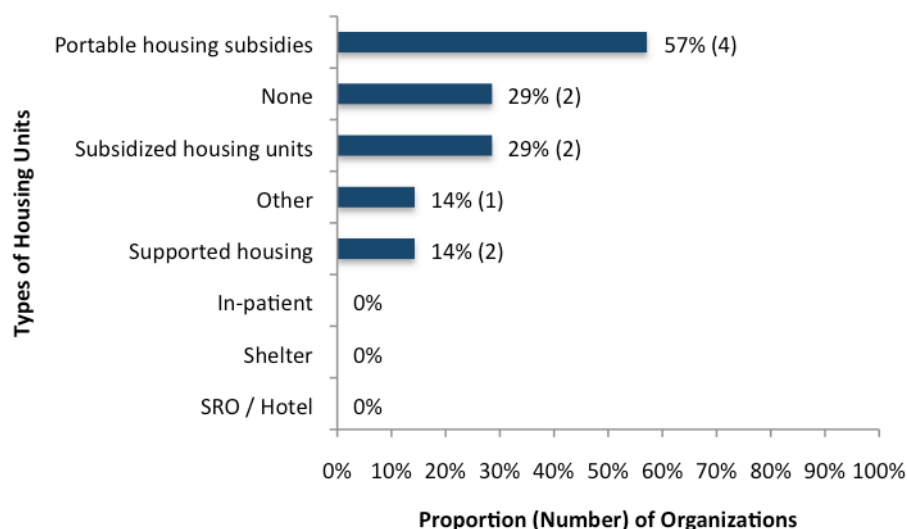
68% ($n = 19$) of CHERT respondents reported that their organizations offer mental health and/or substance use support services. The majority of these services focus on providing referrals to mental health care service providers (85%; $n = 17$) and to mental health services operated by the BC Health Authorities (80%; $n = 16$) (see Figure 21). Peer support (65%; $n = 13$) and counseling (65%; $n = 13$) also made up a significant focus of mental health and/or substance use support services offered by CHERT respondents. Figure 21 further illustrates the specific components of the mental health and substance use support services that were offered by responding organizations.

Figure 21: Components of Respondents' Mental Health/Substance Use Support Services and Programs ($n = 20$)



6.5.3 Housing Services

Findings from the CHERT also revealed that the majority of organizations (79%; $n = 22$) do not provide housing services. Among those offering housing services, portable housing subsidies (57%; $n = 4$) and subsidized housing units (29%; $n = 2$) were the most common types of housing units provided (see Figure 22).

Figure 22: Types of Housing Units Provided by Respondents that Offer Housing Services (*n* = 7)

This section has demonstrated the limited capacity of community-based HIV/HCV organizations to independently address the complexity of health and social issues that are often associated with HIV and HCV. This limited capacity should not be viewed as a negative finding given that the complexity of these diseases will require a collaborative and intersectoral response. However, these findings do illustrate the importance of developing strong partnerships with relevant social service agencies to make effective and appropriate referrals for clients with complex needs.

6.6 Increasing Knowledge and Awareness: Education and Training Activities

A key aim of community-based HIV/HCV organizations is to educate people at risk or living with HIV. Raising knowledge and awareness about HIV/AIDS, such as information on risk factors for HIV infection and disease progression, is essential to a comprehensive prevention approach.

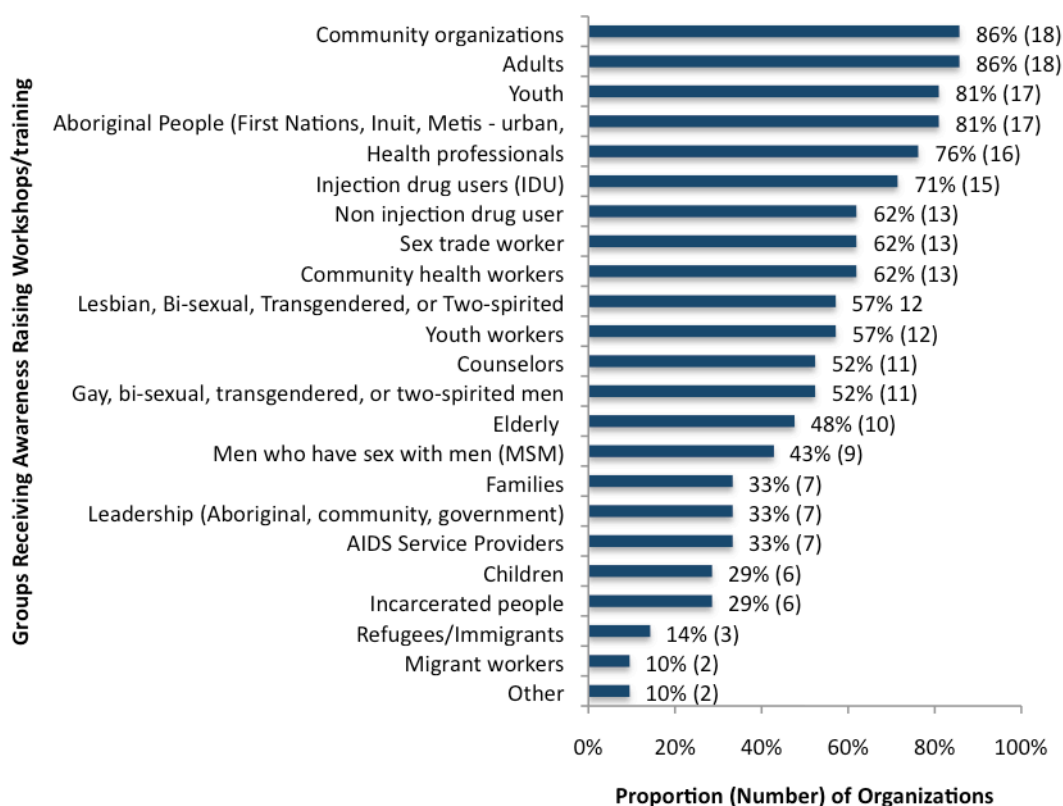
5.6.1 HIV/HCV Awareness Raising Workshops and Training Sessions

The majority of respondents (71%; *n* = 20) reported that their organizations offered HIV or HCV awareness raising workshops and/or training sessions in the last year. While an average of 61 workshops and/or training sessions were held by organizations, this number varied considerably (ranging from 0 workshops/year to 882 workshops/year). This wide range could be a result of some organizations having higher levels of staff and capacity, or some organizations may simply focus less on educational efforts and more on other activities. Of all those workshops and trainings that were delivered, a mean of 2,562 people and a total of 52,510 people were reached.

6.6.2 Groups Targeted by Awareness Raising Strategies

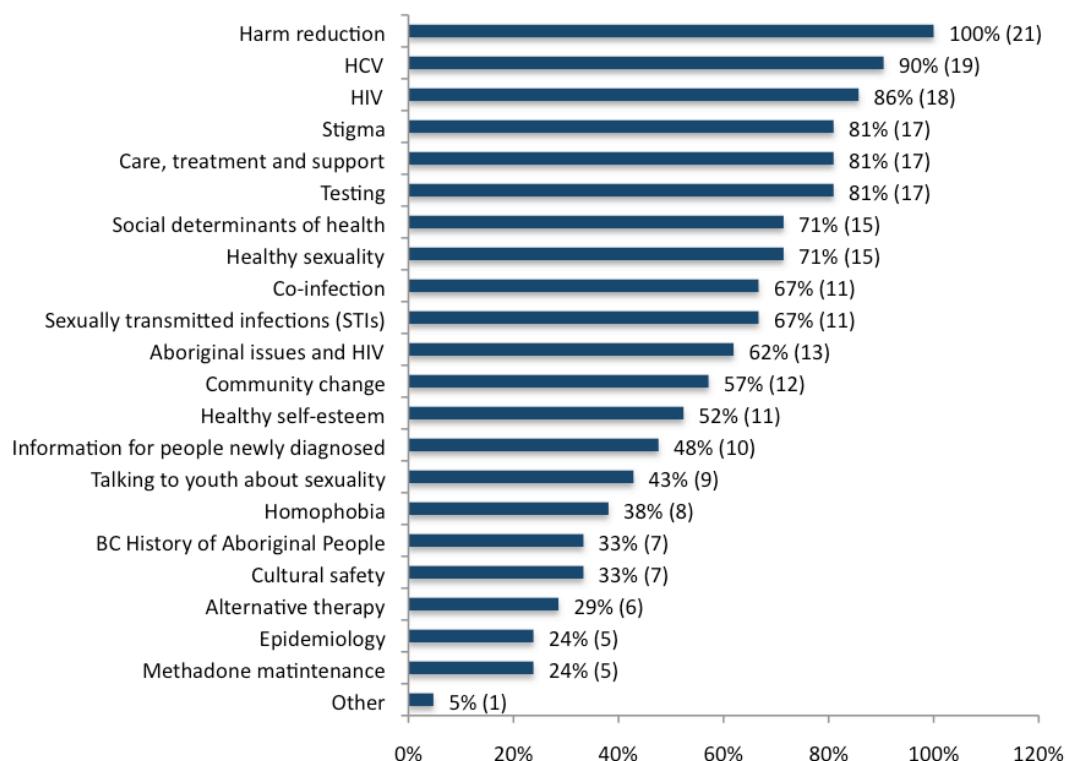
Main targets of awareness raising workshops and trainings included community organizations (86%; $n = 18$), health professionals (76%; $n = 16$), and Aboriginal peoples (81%; $n = 17$) (see Figure 23). In terms of the age of workshop participants, the majority were adults (86%; $n = 17$) and youth (81%; $n = 17$).

Figure 23: Groups Receiving Awareness Raising Workshops and/or Training from Organizations ($n = 21$)



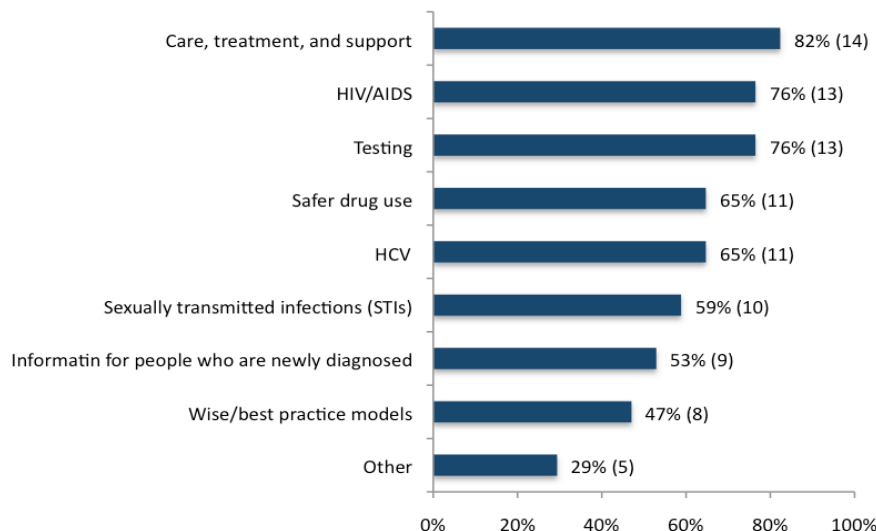
6.6.3 Topics Addressed Through Awareness Raising

A wide range of topics were addressed in the awareness raising workshops that were delivered (see Figure 24). The most frequently addressed topics were harm reduction (100%; $n = 21$), general information about HCV (90%; $n = 19$) and HIV (86%; $n = 18$), stigma (81%; $n = 17$), and care, treatment, and support for PLWHA (81%; $n = 17$).

Figure 24: Topics Addressed in Awareness Raising Workshops and/or Training (n = 21)

6.6.4. Development of Educational Resources

In effort to increase knowledge and awareness surrounding HIV/AIDS, many CHERT respondents report that their organizations develop educational resources, such as pamphlets or online information. While the content of such educational resources is variable between organizations, a focus on care, treatment and support for PLWHA (82%; $n = 14$) and general information on HIV/AIDS were commonly reported (76%; $n = 13$) (see Figure 25).

Figure 25: Topics Addressed in Educational Resources Developed by CHERT Respondents (n = 17)

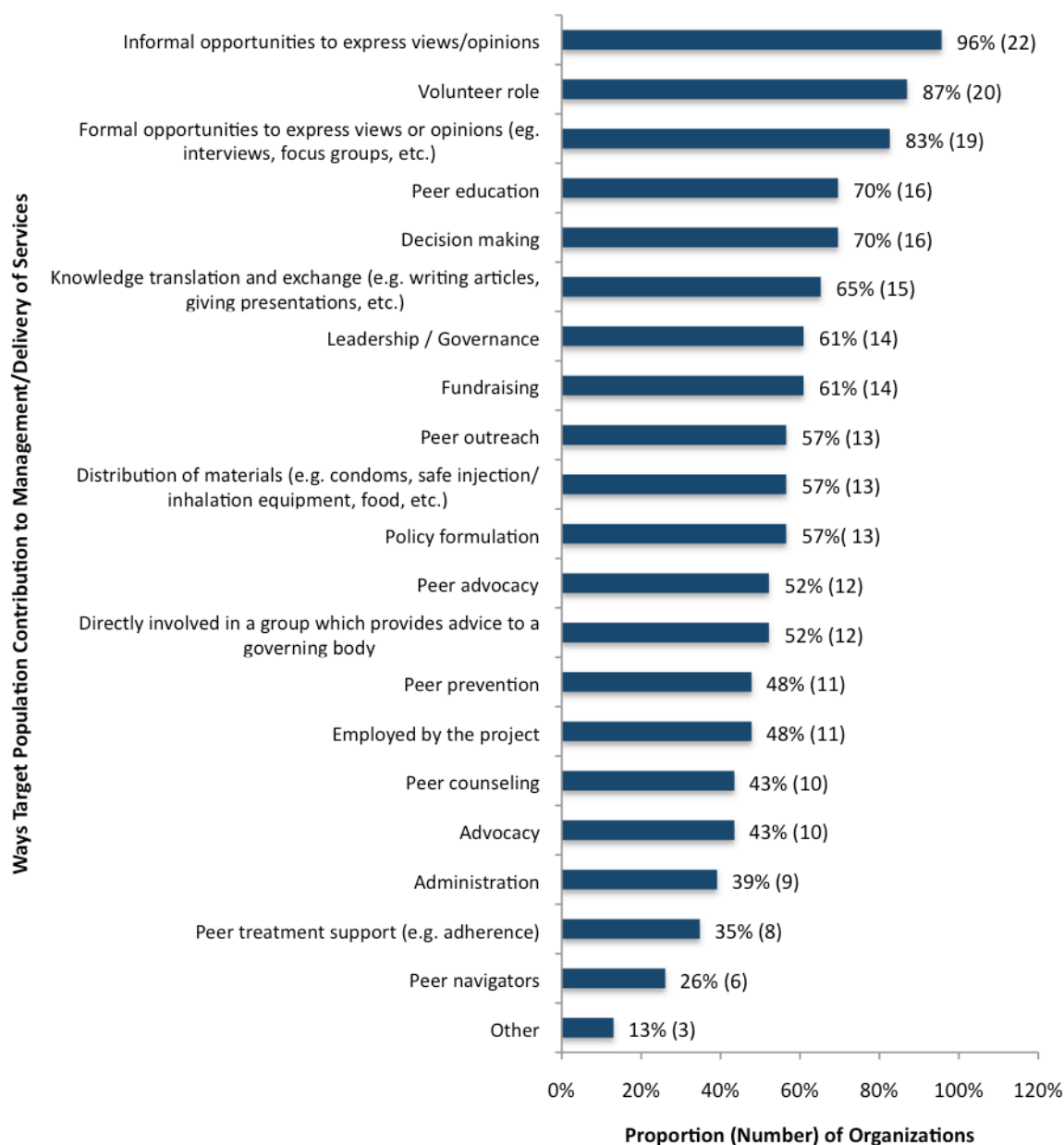
6.7 Greater and More Meaningful Involvement of People Infected with HIV and/or HCV

The greater and more meaningful involvement of people living with HIV and HCV are guiding principles of HIV/HCV movement. Engaging positive community members in organizational activities has been associated with a range of positive benefits. Given their lived experiences with HIV and HCV, involving positive individuals in program development and implementation will improve the relevance, acceptability, and overall effectiveness of programs (UNAIDS, 2007). Further, meaningfully engaging with community can enhance the capacity of positive individuals, organizations, and communities to respond to the HIV and HCV epidemics.

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

The majority of organizations that completed the CHERT have demonstrated that they are committed to the greater and more meaningful involvement of people living with HIV and HCV. Most respondents (57 – 79%) indicated that they aim to involve members of their target populations in different aspects of their organizations' work. Specifically, 77% (n = 23) of respondents reported that their target populations contribute to the management and/or delivery of their programs and services. Figure 26 illustrates the specific ways in which respondents' target populations have contributed to the management and/or delivery of services, including informal (96%; n = 22), and formal (83%; n = 19) opportunities for clients to express opinions and volunteer positions (87%; n = 20).

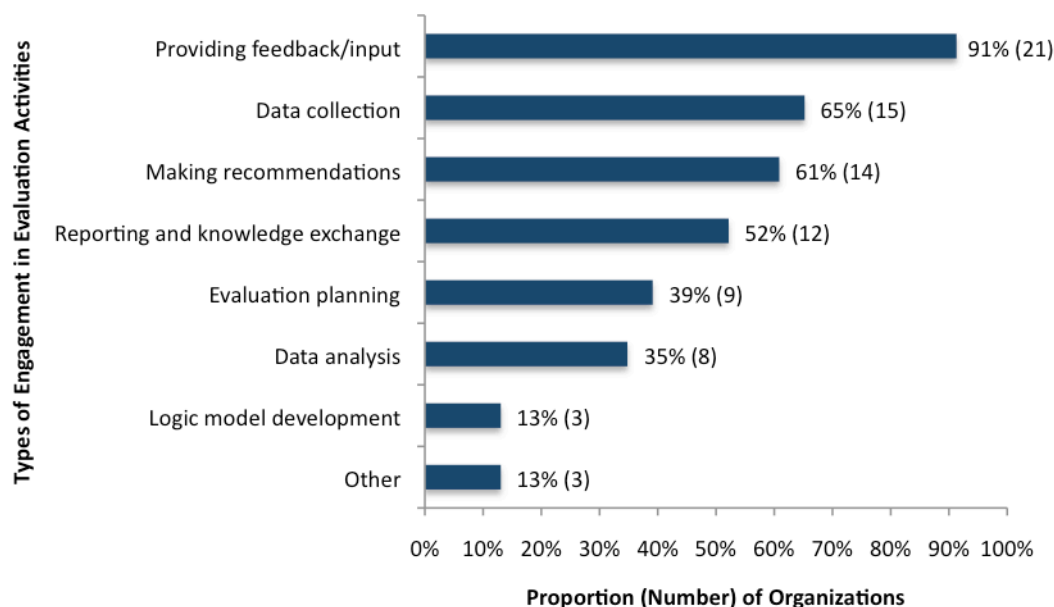
Figure 26: Ways Target Populations Contribute to the Management and/or Delivery of Services ($n = 23$)



6.7.2 Engaging Community in Evaluation Activities

A strong commitment to community engagement can also be demonstrated by the significant proportion of organizations that report engaging the people they serve in evaluation activities (79%; $n = 23$). As shown in Figure 27, organizations frequently report that their clients are involved in evaluation work by providing feedback or input (91%; $n = 21$). Approximately half of the respondents also indicated that their clients are involved in evaluation by assisting with data collection (65%; $n = 15$) and making recommendations (61%; $n = 14$).

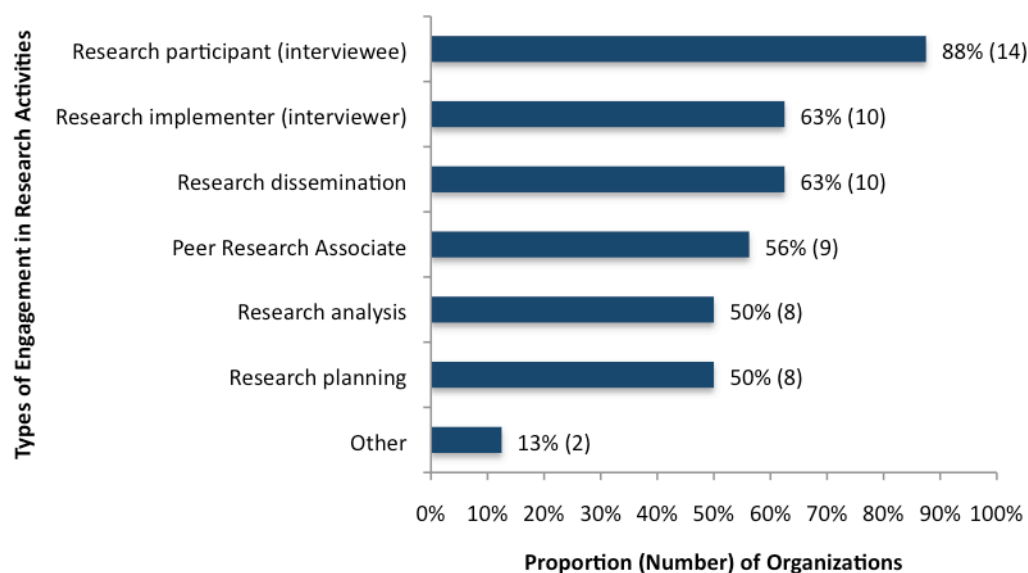
Figure 27: How People Served are Engaged in Organizational Evaluation Activities ($n = 23$)



6.7.2 Engaging Community in Research Activities

In comparison to the involvement of clients in program delivery and evaluation, the engagement of people served in research activities was less frequently reported (57%; $n = 17$) (see Figure 28). Among those organizations that do engage clients in research activities, community members are commonly involved as research participants (88%; $n = 14$), research implementers (63%; $n = 10$), and research disseminators (63%; $n = 10$).

Figure 28: How People Served are Engaged in Organizational Research Activities ($n = 16$)



While the majority of respondents demonstrated a commitment to the greater and more meaningful involvement of positive community members, this commitment could be strengthened within all aspects of work. In particular, people served should be better engaged within organizations' research activities since current levels of involvement were found to be low. Further, community members should be more *meaningfully* involved in the work of organizations by engaging them in roles that develop their leadership and capacity. Evidence from the CHERT indicates that when community members were engaged, they were most often involved in an *informal* and *passive* manner. For instance, community members were frequently engaged as research participants or were provided with informal opportunities to provide their feedback. Passively involving community members in HIV/AIDS work has often been found to be a tokenistic or insignificant exercise (Slevin, et al., 2008). When affected populations are more meaningfully engaged in HIV/HCV efforts, they are better able to contribute to the program at hand and community capacity will be enhanced.

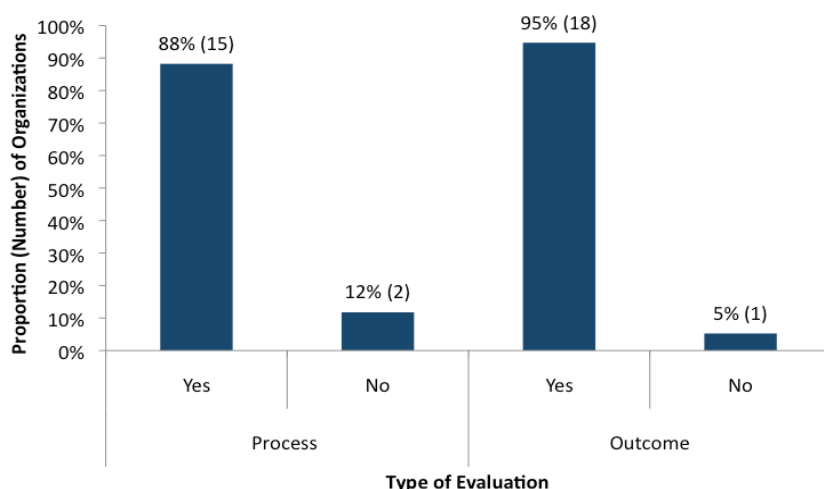
6.8 Monitoring and Evaluation Work Being Done

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 critical.

6.8.1 Types of Evaluation Being Done

Respondents were asked if their organizations have conducted or commissioned any process or outcome evaluations in the last fiscal year. While 62% ($n = 18$) of respondents indicated that their organization did conduct some evaluation work, 38% ($n = 11$) reported that they did not participate in any evaluative activities. Among those that conducted evaluations, the majority of organizations report conducting both process (88%; $n = 15$) and outcome (95%; $n = 18$) evaluation work (see Figure 29).

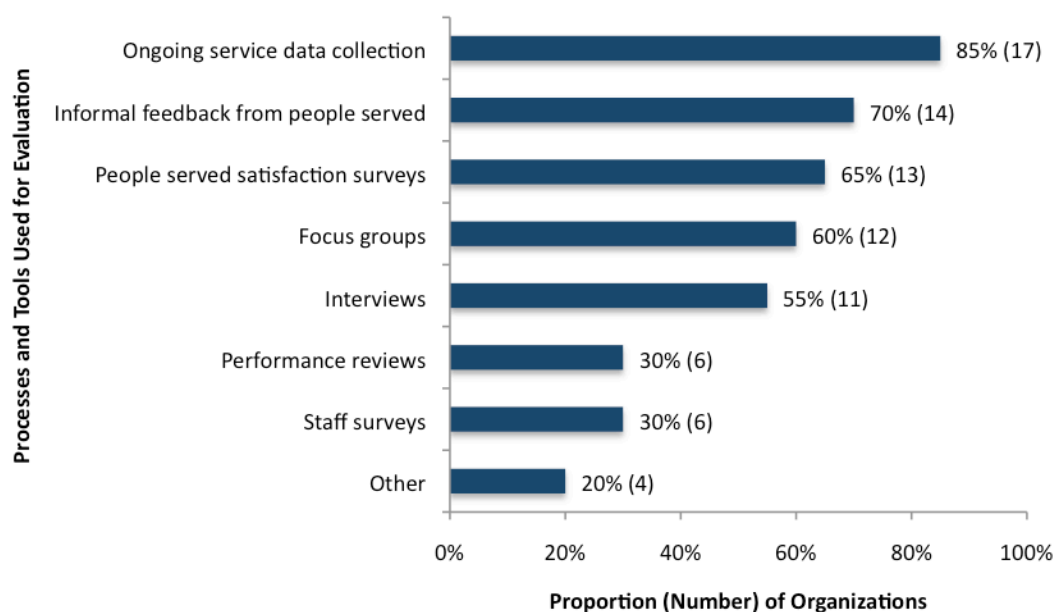
Figure 29: Proportion of Respondents Participating in Process and/or Outcome Evaluation ($n = 17; 19$)



6.8.2 Processes and Tools Used to Monitor and Evaluate Services

Figure 30 illustrates the types of processes and tools that organizations report using to monitor and evaluate their programs and services. Organizations commonly reported collecting ongoing feedback on the services they provide (85%; $n = 17$) through the conduction of client satisfaction surveys (65%; $n = 13$) and focus groups (60%; $n = 12$). Informal feedback from clients also served as a significant method by which organizations monitor their programs and services (70%; $n = 14$). While receiving informal feedback from clients is valuable, the use of more rigorous data collection methods for monitoring and evaluation, such as surveys or interviews, would strengthen the resulting evidence.

Figure 30: Processes and Tools Used by Organizations to Monitor and Evaluate Services ($n = 20$)



6.8.3 Evaluation Support is Required

Respondents were also asked if their organizations would find evaluation support valuable, such as an evaluator who would assist their organizations with evaluation planning and analysis. The majority of respondents (80%; $n = 16$) reported that their organizations would benefit from such assistance, demonstrating the need to support community-based HIV/HCV organizations with the conduction of evaluation work moving forward. Evaluation support for organizations could come in a variety of forms, ranging from evaluation capacity building efforts to assistance from an evaluator. It is important to note that the proportion of organizations reporting that they would find evaluation support valuable is likely underestimated, as only those who indicated that they are currently conducting evaluation work were asked this question.

7.0 Conclusion

The findings presented in this report showcase the wide range of programs and services offered by community-based HIV/HCV organizations in the province. While areas for improvement have been identified, it is evident that community-based HIV/HCV organizations are positively contributing to the fight against HIV and HCV. To more conclusively comment on the extent of the impact community-based HIV/HCV organizations are making, data collected from future years of the CHERT is required.

8.0 Next Steps for the CHERT

1. Learn from the shortcomings of this first round of data collection by modifying the CHERT
 - a. Work with the BC HIV/HCV Evaluation Advisory Group to: (i) evaluate this year's process of data collection and analysis and (ii) determine how the community can best use the CHERT.
2. Disseminate the findings among stakeholders
 - a. Engage executive directors and program managers who participated in the CHERT to contextualize the findings presented in this report.
 - b. Engage the larger HIV/HCV sector in BC to further contextualize the findings.
 - c. Disseminate findings to key BC Health Authority, Ministry, and Federal partners. Engage these groups in discussions about the potential future use of the CHERT.
3. Aim to engage all community-based HIV/HCV organizations operating in BC in the annual collection of data with the CHERT
4. Seek an improved online data gathering platform that will increase the ease of data collection and extend the utility of the tool for organizations (ie. allow organization's to access their own data over time).

9.0 References

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