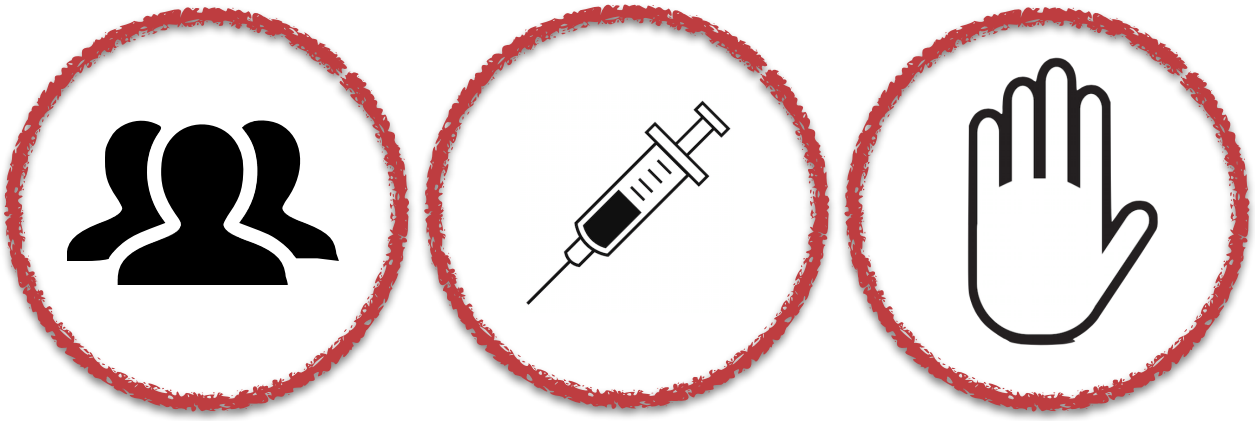
CHERT
Measuring the Impact of BC's HIV/HCV Community Organizations

Pacific AIDS Network

Key Themes from the Community HIV/HCV Evaluation & Reporting Tool (CHERT)

October 2014



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Acknowledgements

The Pacific AIDS Network (PAN) is indebted to the BC HIV/HCV Evaluation Advisory Group for their guidance and support in the development and implementation of the Community HIV/HCV Evaluation and Reporting Tool (CHERT). In the 2013 - 2014 fiscal year, members of the Advisory Group and other key community partners included:

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Sincere thanks are also extended to the Provincial Health Services Authority for funding this work.

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About This Report

Background

Welcome to the third 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 modelled 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 are the purposes of CHERT reporting?

- **Measuring Impact**

  Used over time, findings from the CHERT will measure the contribution community-based organizations (CBOs) are making to the success of the provincial strategy to address HIV and Hepatitis C in BC, as outlined in *From Hope to Health: Towards an AIDS Free Generation.*[1]

- **Program Planning & Improvement**

  The CHERT provides CBOs with the information they need to identify gaps and trends in service delivery that can be used to adjust services or develop new programs.

- **Standardization**

  By working with funders, the CHERT aims to streamline the data collected and reported from community-based HIV/HCV organizations in BC, with the hope of reducing the number of repetitive and time-consuming reporting requirements they must complete.

- **Accountability**

  The CHERT is a tool that organizations can use to compare the actual activity against what was planning for in initial proposals and logic models. Accountability is important for organizations' members, service recipients, partners and funders.

Design of the 2013 - 2014 CHERT

The 2013 - 2014 version of the CHERT included 97 questions, of which 4 were open-ended questions and 93 were closed-ended. The survey questions focused on programs and services

[1] BC Ministry of Health. (2012). From Hope to Health: Towards an AIDS-free Generation. Retrieved from: http://www.health.gov.bc.ca/library/publications/year/2012/from-hope-to-health-aids-free.pdf

that were delivered by the responding organizations during the 2012 - 2013 fiscal year. **CHERT questions were divided into the following 14 sections:**

1. Organization/Program Information
2. Program Delivery and Operation
3. Human Resources
4. Organizational/Program Funding
5. Partnerships
6. HIV/HCV Prevention
7. HIV/HCV Outreach
8. HIV/HCV Testing
9. HIV/HCV Treatment and Care
10. Social Support Services
11. Education and Training
12. Meaningful Client Engagement
13. Monitoring and Evaluation Work
14. Community Contribution to BC's Provincial HIV Strategy to Address HIV/AIDS

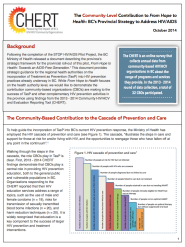
Data Limitations

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 advice from the BC HIV/HCV Evaluation Advisory Group and other community partners.

However, some data limitations continue to be present in the 2013 - 2014 findings. 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 third 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.

How this Report is Structured

In previous years the annual CHERT reports have described results from the majority of questions asked of respondents in the online survey. This year the report focuses on highlighting some key themes where the data showed interesting trends over time. Specifically, the key themes explored in this report include: human resources, harm reduction and stigma and discrimination. If you are interested in exploring all of detailed CHERT data that has been collected over the past three years, you can download the CHERT Supplemental Information Report here: http://pacificaidsnetwork.org/the-community-hivhcv-evaluation-and-reporting-tool-chert-2/.



Additionally, a separate report has been created that employs data from the 2013 - 2014 CHERT to assess the contribution CBOs are making to From Hope to Health: Towards and AIDS-free Generation (BC's provincial HIV strategy). This report is available for download from: http://pacificaidsnetwork.org/the-community-hivhcv-evaluation-and-reporting-tool-chert-2/

1.0 CHERT Respondents

A total of 32 executive directors or program managers of community-based HIV/HCV organizations in BC participated in the 2013 - 2014 round of CHERT data collection. The 2011 - 2012 and 2012 - 2013 rounds of data collection gathered responses from 30 organizations. Of the 44 community-based agencies that are member organizations of the Pacific AIDS Network, 73% (n = 32) completed the CHERT in the last year.

The 2013 - 2014 version of the CHERT included 97 questions, of which 4 were open-ended questions and 94 were closed-ended. The survey questions focused on programs and services that were delivered by the responding organizations during the 2013 - 2014 fiscal year. On average, respondents took 81 minutes to complete the survey.

As seen in Figure 1, the majority of 2013 - 2014 CHERT respondents primarily provide services in the Vancouver Coastal region (n = 11), followed by organizations contracted to provide services at the provincial level (n = 7) (see Figure 1). CHERT respondents were mainly community-based HIV/AIDS or AIDS service organizations (n = 19) or HIV/AIDS programs within non-AIDS service organizations (n = 5) (see Table 1). Furthermore, Table 2 demonstrates that CHERT respondents are providing services for a wide range of groups in the province, commonly including people living with HIV (n = 24, 75%), Aboriginal peoples (n = 27; 84%), people who use injection drugs (n = 22; 69%), and those co-infected with HIV and Hepatitis C (n = 20; 63%).

Figure 1. Number of CHERT respondents by BC region, 2013-2014 (n = 32)

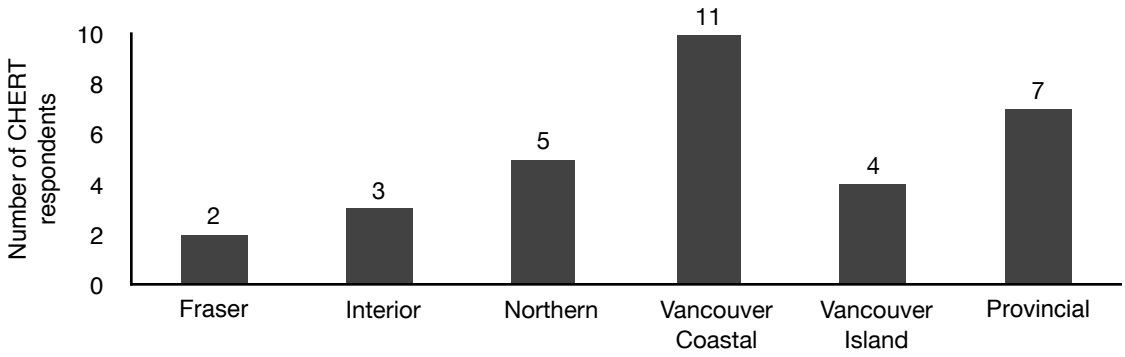


Table 1. CHERT respondents by type of organization (2013 - 2014) (n = 32)

Organization Types	Number of respondents
Community-Based HIV/AIDS or AIDS Service Organization	19
HIV/AIDS Project/Program within a Non-AIDS Service Organization	5
Community-Based Hepatitis C Organization or Hepatitis C Service Organization	1
Community Health Centre	1
Community-based HIV and Hepatitis C Organization	2
Other community-based organization (Supporting priority populations, e.g. harm reduction, integrated prevention work)	4

Table 2. Populations that represent a significant population of people served (>10%) by fiscal year

Population Groups	2012 - 2013 (n = 30)	2013 - 2014 (n = 32)
People living with HIV/AIDS	23 (77%)	24 (75%)
People who use injection drugs	23 (77%)	22 (69%)
Adults (ages 30 - 64)	22 (73%)	27 (84%)
People co-infected with HIV and HCV	21 (70%)	20 (63%)
Aboriginal people (First Nations, Inuit, Metis)	20 (67%)	24 (75%)
People who use non-injection drugs	18 (60%)	17 (53%)
People living with HCV	14 (47%)	18 (56%)
Men who have sex with men (MSM)	14 (47%)	16 (50%)
Gay, bisexual, transgendered, or two-spirited men	14 (47%)	15 (47%)
Youth (ages 15 - 29)	12 (40%)	12 (38%)
Social service and health providers	11 (37%)	10 (31%)
Families	9 (30%)	9 (28%)
Sex trade workers	9 (30%)	10 (31%)
Refugees/Immigrants	8 (27%)	7 (22%)
Elderly (ages 65+)	7 (23%)	10 (31%)
Incarcerated people	5 (17%)	7 (22%)
Lesbian, bi-sexual, transgendered, or two-spirited women	4 (13%)	7 (22%)
Children (ages 14 and under)	4 (13%)	3 (9%)
Other	1 (3%)	0

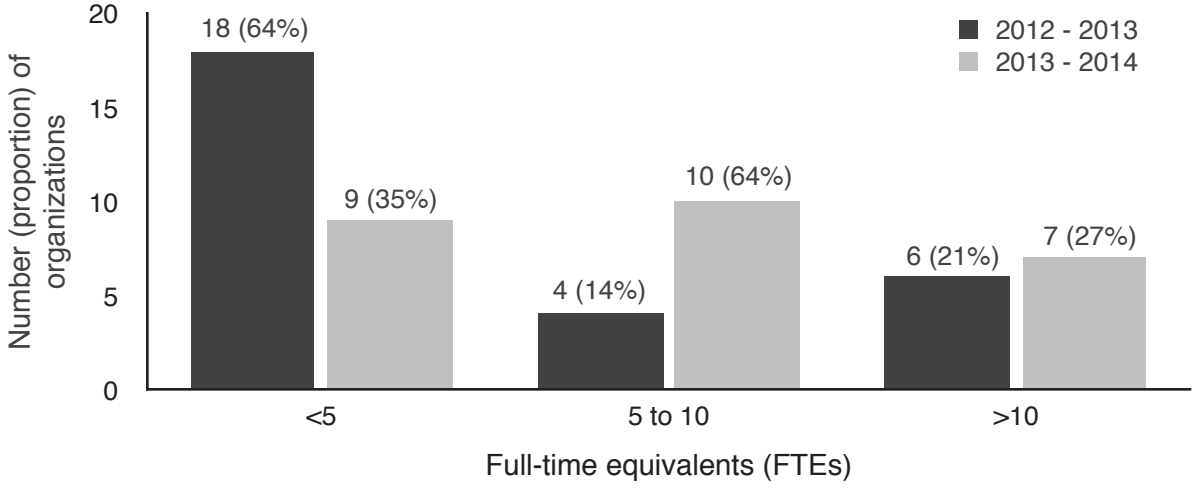
2.0 Key Theme: Human Resources

When examining the contribution community-based HIV/HCV organizations are making in BC, it is important to reflect on the human resources they have available to achieve their objectives and create change. This section of the report outlines some interesting trends related to CHERT respondents' paid and unpaid human resources over time.

Paid Staff for HIV/HCV Related Work

CHERT respondents whose mandate is to provide HIV and/or HCV focused services or programs are asked a series of questions related to their human resources. Comparing CHERT data from the 2012 - 2013 and 2013 - 2014 rounds of data collection, it appears that CBOs providing HIV/HCV services in BC are growing in size. As seen in Figure 2, organizations supported by 5 to 10 and 10 or more full-time equivalents (FTEs) increased in the last fiscal year. While a number of factors could have influenced this increase in support, one plausible explanation could be the influx of funding provided by the STOP HIV/AIDS Program. It is also possible that larger organizations completed the CHERT in the 2013 - 2014 fiscal year, when compared to 2012 - 2013.

Figure 2. Number (proportion) of CHERT respondents by full-time equivalents, 2012 - 2013 (n = 28) & 2013 - 2014 (n = 26)



Volunteers and Post-Secondary Students

Most non-profit organizations in Canada rely on volunteers to help them fulfill their missions. A recent study conducted by Statistics Canada shows that in 2010, roughly one-half of Canadians volunteered their time, energy and skills to groups and organizations, such as charities and non-

profits.[2] This support amounted to just under 2.1 billion volunteer hours, the equivalent of 1.1 million full-time jobs. Findings from CHERT show that community-based HIV/HCV organizations in BC also receive substantial support from volunteers.

As seen in Table 3, organizations responding to the CHERT have been heavily supported by volunteers over the past three years, on average. The data illustrated in Table 1 show a slight increase in the average number of volunteers supporting CHERT respondents in the last fiscal year. Similarly, the data in Table 4 demonstrate that the average number of volunteer hours supporting respondents per week over the last three years.

Table 3. Average numbers of volunteers (unpaid, peer & non-peer) that participated in HIV/HCV related work, by fiscal year

Type of volunteer work	2011 - 2012	2012 - 2013	2013 - 2014
HIV/AIDS related work	41 (n = 27)	40 (n = 27)	52 (n = 25)
HCV related work	15 (n = 26)	18 (n = 22)	22 (n = 24)

Table 4. Average volunteer hours/week supporting programs/organizations by fiscal year

	2011 - 2012	2012 - 2013	2013 - 2014
Estimated volunteer hours/week	81 hours/week	122 hours/week	132 hours/week

The volunteer support received by CHERT respondents is critical, as it provides CBOs with the human resources needed to extend their reach and improve their delivery of programs and services. Volunteerism is also important for individual volunteers, as it can provide an opportunity for people to use and practice their skills. Canadian society as a whole also benefits from volunteerism, as it strengthens trust, solidarity and reciprocity among citizens and creates opportunities for participation.[2]

In addition to volunteers, post-secondary students are a critical source of support for non-profit organizations. However, Table 5 illustrates that organizations responding to the CHERT utilized post-secondary student support less in the last fiscal year. This finding highlights the need to determine: (i) why CHERT respondents are not making use of this source of support; (ii) and how to better connect post-secondary students and CBOs with each other in the province.

Table 5. Total numbers of post-secondary students supporting organizations' HIV/AIDS and HCV related work, by fiscal year

Type of student support	2011 - 2012	2012 - 2013	2013 - 2014
HIV/AIDS related work	11	7	9
HCV related work	11	6	3

[2] Statistics Canada (2012). Canadian Social Trends: Volunteering in Canada. Retrieved from: http://www.statcan.gc.ca/pub/11-008-x/2012001/article/11638-eng.pdf

3.0 Key Theme: Harm Reduction

Risky practices that lead to the transmission of HIV and hepatitis C are a critical public health issue affecting communities across Canada.[3] The implementation of harm reduction programs have proven to reduce HIV and Hepatitis C incidence in a cost-effective manner.[4,5] This section of the report outlines interesting trends related to provision of harm reduction materials and services by CHERT respondents over the last three years.

Findings from the CHERT demonstrate that community-based HIV/HCV organizations in BC are increasingly adopting a focus on harm reduction approaches and services over time. As seen in Table 6, CHERT respondents are more commonly providing harm reduction services and education to their clients in the last fiscal year. Additionally, organizations are more commonly setting up or supporting satellite harm reduction distribution sites in the province. Similarly, findings from the CHERT show that the distribution of harm reduction supplies has become a more common component of organizations' mental health and/or substance use services in the last year (see Table 7).

Table 6. Types of primary HIV and/or HCV prevention services offered, by fiscal year

Type of primary prevention service offered	2011 - 2012 (n = 27)	2012 - 2013 (n = 25)	2013 - 2014 (n = 22)
Harm reduction services and education	8 (30%)	19 (76%)	20 (91%)
Setting up or supporting satellite harm reduction distribution sites	4 (15%)	6 (24%)	8 (36%)

Table 7. Components of CHERT respondents' mental health and/or substance use support services, by fiscal year

Components of mental health and substance use services	2012 - 2013 (n = 18)	2013 - 2014 (n = 19)
Counselling (one-on-one or group)	12 (67%)	12 (63%)

[3] Public Health Agency of Canada. (2006). I-Track: Enhanced Surveillance of Risk Behaviours among Injecting Drug Users in Canada. Retrieved from: http://www.phac-aspc. gc.ca/i-track/sr-re-1/pdf/itrack06_e.pdf

[4] Wodak, A., & Cooney, A. (2006). Do needle syringe programs reduce HIV infection among injecting drug users: A comprehensive review of the international evidence. *Substance Use and Misuse,* 41, 777-813.

[5] Berg, C.V.D., Smit, C., Brussel, G.V., Coutinho, R., & Prins, M. (2007). Full participation in harm reduction programmes is associated with decreased risk for human immunodeficiency virus and hepatitis C virus: Evidence from the Amsterdam Cohort Studies among drug users. *Addiction*, 102, 1454-1462.

Meetings (AA or NA)	5 (28%)	4 (21%)
Methadone maintenance	3 (17%)	1 (5%)
Peer support	10 (56%)	13 (68%)
Cognitive behavioural counselling	3 (17%)	4 (21%)
Clinical evaluation and prescription	-	1 (5%)
Community mental health groups (e.g. Schizophrenia Society, Head Injury Society)	2 (11%)	1 (5%)
Harm reduction supply distribution	6 (33%)	12 (63%)
Other	-	5 (26%)

Table 8 illustrates the total number of harm reduction materials distributed by CHERT respondents over the last three years. These numbers can be put into context by comparing them to the total numbers of harm reduction materials distributed across all harm reduction programs in BC in 2013. For instance, of the 4,076,780 condoms that were distributed BC-wide in 2013, data from the CHERT shows that respondents were responsible for distributing roughly 10% of them (423,390/4,076,780 x 100 = 10.4%)[6]. Similarly, it can be estimated that CHERT respondents were responsible for distributing roughly 12% of all needles in BC in 2013 (980,508/8,299,325 x 100 = 11.8%).

Table 8. Total number of harm reduction/prevention materials distributed, by fiscal year

Harm reduction/prevention material	2011 - 2012	2012 - 2013	2013 - 2014
Condoms	443,566	412,578	423,390
Lube	243,068	206,427	247,038
Needles	879,804	1,195,065	980,508
Needles returned	619,761	1,026,251	612,410
Pipes/glass tubes	10,966	31,224	34,353

It is important to highlight that while CBOs are playing a key role in the distribution of harm reduction materials, the total number of harm reduction materials distributed by CHERT respondents have not shifted substantially over the past three years (see Table 6).To improve the reach, quality and effectiveness of harm reduction programs in the future, community-based

[6] University of Victoria, Centre of Addictions Research of BC (2013). Harm reduction in British Columbia. Retrieved from: http://www.carbc.ca/Portals/0/propertyagent/558/files/427/harm%20reduction%20in%20bc%20infographic.pdf

HIV/HCV organizations and programs are encouraged to adopt the recently published best practice recommendations for Canadian harm reduction programs.[7] These best practice guidelines were developed by a Canada-wide team of researchers, service providers, policy makers and people with lived experience.

[7] Strike C, Hopkins S, Watson TM, Gohil H, Leece P, Young S, Buxton J, Challacombe L, Demel G, Heywood D, Lampkin H, Leonard L, Lebounga Vouma J, Lockie L, Millson P, Morissette C, Nielsen D, Petersen D, Tzemis D, Zurba N. Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and are at Risk for HIV, HCV, and Other Harms: Part 1. Toronto, ON: Working Group on Best Practice for Harm Reduction Programs in Canada. 2013.

4.0 Key Theme: Stigma & Discrimination

Despite the implementation of multi-sectoral programs and activities to address the stigma surrounding HIV and hepatitis C, it remains a substantial barrier to effectively addressing these public health issues. In *From Hope to Health,* the Ministry of Health defines fighting stigma and discrimination as a guiding principle of BC's provincial framework to address HIV, recognizing the role stigma and discrimination continue to play in preventing people from getting tested, and engaging and remaining on treatment.[1] Furthermore, the 2010 Provincial Health Officer's Annual Report argues that stigma and discrimination are key drivers of the HIV epidemic for gay and bisexual men in BC.[8] Reducing stigma and discrimination surrounding HIV/AIDS and hepatitis C is key to both stopping the spread of these epidemics and improving the quality of life for those affected in the province.[9]

Findings from the CHERT demonstrate that stigma and discrimination continue to act as a challenge at the community-level. Stigma and discrimination have been consistently reported as the second greatest operational challenge for CHERT respondents over the last three years (see Table 9).

Table 9. Operational challenges identified by respondents by fiscal year

Operational Challenge	2011 - 2012 (n = 30)	2012 - 2013 (n = 30)	2013 - 2014 (n = 32)
Limited funds/resources	23 (77%)	25 (83%)	24 (75%)
Stigma and discrimination	16 (53%)	15 (50%)	18 (56%)
Ongoing training for staff/ volunteers	14 (47%)	13 (43%)	12 (38%)
Inadequate staffing levels	14 (47%)	13 (43%)	14 (44%)
Transportation costs	12 (40%)	12 (40%)	10 (31%)
Cultural competency/ knowledge/skills	8 (27%)	5 (17%)	9 (28%)
Human resources recruitment and retention	10 (33%)	9 (30%)	9 (28%)

[8] British Columbia. Provincial Health Officer (2014). HIV, Stigma and Society: Tackling a complex epidemic and renewing HIV prevention for gay and bisexual men in British Columbia. Provincial Health Officer's 2010 Annual Report. Retrieved from: http://www.health.gov.bc.ca/pho/pdf/hiv-stigma-and-society.pdf

[9] Canadian HIV/AIDS Legal Network. (2014). Discrimination. Retrieved from: http://www.aidslaw.ca/EN/issues/discrimination.htm

Lack of inter-agency support and collaboration	9 (30%)	8 (27%)	9 (28%)
Rent increases	11 (37%)	4 (13%)	6 (19%)
Lack of receptiveness to human resource strategies	4 (13%)	2 (7%)	1 (3%)
Governance	4 (13%)	3 (10%)	4 (13%)
In-house conflict	4 (13%)	2 (7%)	4 (13%)
Staff capacity issues	9 (30%)	9 (30%)	6 (19%)
Other	2 (7%) Other: Growth capacity & Eviction issues	2 (7%) Other: Loss of funding & Program in a cross-disability organization	2 (6%) Other: Restructuring of programs & Relocation
None	1	1 (3%)	2 (6%)

Recognizing the importance of this issue, one of the most frequently addressed topics in respondents' HIV/HCV awareness raising workshops and trainings has been stigma and discrimination over the last three years (see Table 10). Similarly, stigma and discrimination have been a central focus of CHERT respondents' upstream prevention efforts over time (see Table 11).

Table 10. Topics addressed in HIV/HCV awareness raising workshops and/or training, by fiscal year

Topics addressed	2011 - 2012 (n = 21)	2012 - 2013 (n = 22)	2013 - 2014 (n = 21)
Harm reduction	21 (100%)	20 (91%)	20 (95%)
Stigma and discrimination	17 (81%)	21 (96%)	20 (95%)
HIV	18 (86%)	21 (96%)	20 (95%)
HCV	19 (91%)	21 (96%)	18 (86%)
STIs	14 (67%)	18 (82%)	18 (86%)
Testing	17 (81%)	19 (86%)	18 (86%)
Care, treatment and support	17 (81%)	16 (73%)	19 (91%)
Healthy sexuality	15 (71%)	16 (73%)	16 (76%)
Homophobia	8 (38%)	13 (59%)	13 (62%)
Community change	12 (57%)	10 (46%)	11 (52%)
Cultural safety	7 (33%)	11 (50%)	10 (48%)
Social determinants of health	15 (71%)	14 (64%)	14 (67%)

BC history of Aboriginal people	7 (33%)	6 (27%)	5 (24%)
Healthy self-esteem	11 (52%)	12 (55%)	13 (62%)
Talking to youth about sexuality	9 (43%)	11 (50%)	11 (52%)
Aboriginal issues and HIV	13 (62%)	12 (55%)	10 (48%)
Epidemiology	5 (24%)	10 (46%)	11 (52%)
Alternative therapy	6 (29%)	6 (27%)	8 (38%)
Co-infection	14 (67%)	13 (59%)	13 (62%)
Methadone matintenance	5 (24%)	6 (27%)	4 (19%)
Information for people newly diagnosed	10 (48%)	10 (46%)	11 (52%)
Other, please specify...	1 (5%)	4 (18%)	4 (19%)

Table 11. Types of upstream HIV and/or HCV prevention services offered, by fiscal year

Type of upstream prevention service offered	2011 - 2012 (n = 28)	2012 - 2013 (n = 26)	2013 - 2014 (n = 23)
Decreasing stigma and discrimination	20 (71%)	19 (73%)	21 (91%)
Education Support	21 (25%)	19 (73%)	18 (78%)
Nutrition/Food supplements	15 (54%)	17 (65%)	14 (61%)
Social justice	11 (39%)	8 (31%)	9 (39%)
Food security	9 (32%)	9 (35%)	10 (44%)
Equity	5 (18%)	4 (15%)	5 (22%)
Employment	4 (14%)	1 (4%)	2 (9%)
Shelter	6 (21%)	7 (27%)	6 (26%)
Sustainable resources	3 (11%)	2 (8%)	2 (9%)
Other	3 (11%)	4 (15%)	6 (26%)
None	1 (4%)	-	-

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.

5.0 Conclusions & Next Steps

The key themes highlighted in this report demonstrate how CHERT findings will become more useful as data is collected over time. Relevant stakeholders, such as CHERT respondents, PAN member organizations, the Ministry of Health, and health authorities are encouraged to reflect on the trends presented in this report and consider how they can be used to inform future directions of efforts to address the HIV and Hepatitis C epidemics in the province.

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 CHERT findings among stakeholders to improve their use.
    i. Engage stakeholders to contextualize findings presented in this report
    ii. Disseminate findings to relevant audiences, including CBOs, 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. Improve the use of CHERT findings among community-based HIV/HCV organizations in BC by packing the data in user-friendly and accessible ways.

4. Increase the CHERT's focus on measuring outcomes associated with the programs and services offered by CBOs in the province.

5. Aim to increase participation in annual CHERT data collection from community-based HIV/HCV organizations in BC.

Sincere thanks are extended to the Provincial Health Services Authority for funding this work.