Evaluation Survey Report:

PHAC's HIV and Hepatitis C Community Action Fund (CAF) Processes and Impacts – reported by community-based organizations in BC

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1.0 Executive Summary

The Public Health Agency of Canada (PHAC) invests $26.4 million a year in community-based programs across Canada to address HIV, hepatitis C (HCV) and other sexually transmitted and blood borne infections (STBBIs). PHAC integrated its funding for community-based organizations into the HIV and Hepatitis C Community Action Fund (CAF) following a stakeholder consultation process in 2014. PHAC solicited Letters of Intent (LOIs) for the new CAF in February 2016. While the amount of investment remained unchanged from previous years, a marked shift was seen in priorities including a stronger focus on prevention, priority populations and eligible activities.

Through the CAF solicitation process, many organizations – here in BC and across Canada - that had been previously funded by PHAC were not funded. Many of these organizations had brought tremendous region- and community-specific expertise, capacity and infrastructure to the frontlines. The outcome of the CAF solicitation process led to concerns about the structural and HIV and HCV service gaps[1] - particularly for the Interior region (no organizations funded) and the Fraser region (highly under-resourced). As part of the advocacy efforts to address these concerns, the Pacific AIDS Network (PAN) launched a survey to better understand and evaluate the CAF – the Letters of Intent (LOI) process and the subsequent Transitional Funding process or full proposal application process, and their impact on PAN member and allied organizations and the communities they serve.

All PAN member organizations (whether or not they took part in CAF LOI solicitation process and whether or not they were successful with their application); and all non-member organizations who were successful in their CAF application in BC were asked to participate in an electronic or a paper-based survey. A total of 25 projects (i.e. respondents) from 23 community-based organizations completed this BC-focused CAF evaluation survey. The following evaluation report provides a summary of respondents' demographics; PHAC funding history (prior to the CAF) and previously funded projects; and participation in the LOI, full proposal, signing of contracts, and transitional funding processes. This report also highlights quantitative and qualitative data on CAF results and process, as well as previous and ongoing efforts in responding to the impacts of PHAC CAF results.

This evaluation survey clearly reiterates the concern for *undoing* some of the hard work previously accomplished by the HIV and HCV community-based sectors, and a loss of capacity – much of which that had been historically funded by PHAC. While the importance of prevention as the new CAF focus is acknowledged, the fear and risks of STBBI spikes as a result of diminished frontline support organizations who hold tremendous expertise in providing care to the most marginalized and stigmatized populations should not be underestimated.

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[1] For example, these concerns were extensively discussed by PAN members and leadership at PAN's annual provincial fall conference in October 2016 – a letter summarizing these concerns was subsequently sent to then federal Minister of Health Jane Philpott in November 2016. See: https://pacificaidsnetwork.org/2016/12/22/pan-correspondence-with-federal-minister-of-health-regarding-community-action-fund-concerns/

PAN encourages PHAC to consider the evaluation findings in this report and undertake its own evaluation to improve the process of implementing and evaluating the current CAF projects, and to improve and minimize negative unintended consequences of any future funding calls (the CAF and beyond).

Finally, one limitation to note regarding this survey: findings are limited to the data gathered from the specific questions asked of participants concerning the CAF funding application process and subsequent outcomes. These survey results do not reflect all aspects affecting organizations' engagement in the process or the ultimate funding decisions made by PHAC.

2.0 Background

2.1 Concerns of the Community-Based Organizations regarding PHAC's New HIV and Hepatitis C Community Action Fund

The Public Health Agency of Canada (PHAC) invests $26.4 million a year in community-based programs across Canada to address HIV, hepatitis C (HCV) and other sexually transmitted and blood borne infections (STBBIs) (PHAC, 2017). Following a stakeholder consultation process that begun in 2014, PHAC announced the merging of its funding for community-based organizations into the HIV and Hepatitis C Community Action Fund (CAF) (PHAC, 2016a). The amount of investment remained unchanged from previous years; however, a shift was seen in priorities including a stronger focus on prevention, priority populations and eligible activities (PHAC, 2017). The solicitation of Letters of Intent (LOIs) for this new integrated funding (i.e. the new CAF) was announced in February 2016, and successful applicants were invited to submit full proposals and were to receive the new funding starting April 1, 2017 (PHAC, 2016a).

While 124 organizations across Canada (16 British Columbia (BC) organizations supporting regional projects) were successful in the application process, including 41 new organizations (PHAC, 2016b), a significant number of organizations that have been previously funded by PHAC who have tremendous region- and community-specific expertise, capacity and infrastructure were not. As a result, BC's community-based HIV and HCV sectors became highly concerned for the structural and service gaps, particularly for the Interior region (no organizations funded) and the Fraser region (highly under-resourced). On November 2, 2016, the Pacific AIDS Network (PAN) voiced these concerns, as well as concerns related to the LOI process, on behalf of its members in a letter to the then federal Minister of Health, Dr. Jane Philpott. On November 9, PHAC released a statement, announcing a transitional funding to support those unsuccessful organizations with the impact of their loss of funding until March 31, 2018.

Following Dr. Philpott's response letter to PAN and with the release of the Transitional Funding, PAN continued its own advocacy and supported its members' advocacy to: better understand the concerns related to the CAF process and impacts; communicate these concerns to PHAC; and alleviate some of the negative impacts felt by the BC's HIV and HCV community as a result of the CAF outcomes.

2.2 Purpose and Objective of PAN's Evaluation of PHAC's CAF Process and Outcomes

The Pacific AIDS Network (PAN) is a proactive member-based coalition that provides a network to the abilities and efforts of almost 50 member organizations and people affected by HIV and HCV, and acts as a voice for the community-based response to the HIV, HCV and related issues in BC. PAN facilitates communication and the sharing of best practices, and provides opportunities for professional/workforce development and leadership training to our members and to people with lived experience. PAN also promotes community-based research and evaluation; and

undertakes collective action to influence public perceptions and policies affecting persons living with HIV and/or HCV and those most "at risk."

As part of its continued advocacy efforts, PAN launched a survey built of a survey that had been conducted by the Ontario AIDS Network (OAN) in April 2017. This survey aimed to better understand and evaluate the PHAC's Community Action Fund (CAF) – the Letters of Intent (LOI) process and the subsequent Transitional Funding process or full proposal application process, and their impact on community-based organizations, including PAN member organizations. PAN plans to use the findings of this evaluation survey to:

- Develop a comprehensive document that speaks to the various CAF processes (challenges and strengths) and loop that information back to PHAC so as to potentially help improve future PHAC funding calls;
- Help map out community-based service delivery in BC's HIV, hepatitis C and related conditions sector; and
- Help identify service gaps that will and have flowed from PHAC CAF funding decisions, in order to enable PAN and PAN members to better communicate those gaps to PHAC, the federal government, the province (Ministry of Health), the Health Authorities and other key stakeholders.

3.0 Methods

All PAN member organizations (whether or not they took part in CAF LOI solicitation process) and non-member organizations who were successful in their CAF application in BC were asked to participate in an electronic or a paper-based survey. PAN identified the non-member organizations through PHAC's list of all successful CAF recipients. An electronic survey link was distributed to 66 community-based organizations via email in July 2017.

The survey was not anonymous and potential survey participants were informed that the evaluation report will list all organizations or projects who completed the survey. However it was also made clear that no responses will be attributed to any individual organization or project. Due to a low response rate one month into the survey launch, PAN took a targeted approach during PAN's in-person annual fall conference in October 2017 and provided a paper-based survey to member organizations who have not completed the survey but have been impacted by the PHAC CAF process or outcomes. PAN closed the survey in December 2017.

The survey questions explored the organization's (or project's) demographics, previous PHAC funding prior to the CAF, LOI phase of the CAF, full proposal phase of the CAF, signing of contribution agreements or grant contracts, transitional or top-up funding, and CAF process and results. The survey included both closed- and open-ended questions.

4.0 Summary of Findings

4.1 Organization/Project Demographics

A total of 25 projects from 23 community-based organizations completed this BC-focused[2] CAF evaluation survey (two organizations completed 2 surveys each – one for each of their projects funded by the CAF), yielding a survey response rate of 35% (i.e. 23 organizations out of 66 responded). As there are 25 distinct entries, this report will refer to the 25 projects as the "respondents" hereon.

As Figure 1 illustrates, 96% (n=23) of the respondents reported that their organizations are PAN members and 4% (n=2) reported that they are not. The respondents' organizations serve various health regions and health service delivery areas (HSDAs) in BC, with Vancouver being the HSDA served by the highest number of respondents, followed by Fraser East and Fraser North (Figure 2). The organizations and projects who participated in this survey are (as written in their survey responses):

- Pacific AIDS Network (PAN): Canadian Positive Leadership Development Institute (PLDI)
- Pacific AIDS Network (PAN): Provincial Capacity Building and Skills Building Project
- Health Initiative for Men (HIM): a local [within BC] project
- Health Initiative for Men (HIM): a national project
- Positive Living Society of British Columbia
- Cammy LaFleur Street Outreach Team
- Positive Living Fraser Valley Society
- Prince George New Hope Society
- DTES HIV/IDU Consumers' Board
- Pacific Hepatitis C Network
- Positive Women's Network
- McLaren Housing Society
- Quesnel Tillicum Society
- AIDS Vancouver Island
- ASK Wellness Society
- Positive Living North
- Stride with Purpose
- Pivot Legal Society
- A Loving Spoonful
- AIDS Vancouver
- YouthCO
- ANKORS

[2] Two projects are part of National Alliance; however, they are tied to BC organizations

Figure 1. Are you a PAN member? (n=25)

Figure 2. BC health regions and HSDAs respondent organizations (n=25)

Region	Hsda	
Vancouver Coastal	Vancouver	15
	Richmond	12
	North Shore/Coast Garibaldi	9
Fraser	Fraser East	13
	Fraser North	13
	Fraser South	12
Northern	Northern Interior	11
	Northeast	7
	Northwest	7
Interior	Okanagan	10
	East Kootenay	8
	Kootenay Boundary	8
	Thompson Cariboo Shuswap	8
Island	Central Vancouver Island	9
	North Vancouver Island	9
	South Vancouver Island	9

4.2 Previous PHAC Funding (prior to the CAF)

About half of the respondents (52%; n=13) received PHAC funding in 2014-2017 (prior to the CAF), while 48% (n=12) did not (Figure 3). Of the 13 respondents who were previously funded by PHAC, one respondent did not answer the question about how long they received PHAC funding prior to the CAF. Of the 12 respondents who answered, the majority (n=8) has a long history of being funded by PHAC, reporting that they were funded for 16 years or more (5 said for 16-20 years; and 3 said for 20+ years) (Figure 4). The most common project types funded by PHAC in 2014-2017 amongst the respondents were prevention/education (n=12), followed by support (n=8). Other types of projects funded included community development (n=2), capacity building

(n=1) and volunteer (n=1) (Figure 5). The populations served by the most number of respondents are *gay, bisexual, two-spirited and other men who have sex with men* (n=11), *Indigenous peoples* (n=11), and *people living with HIV/AIDS* (n=11). The populations served by the least number of organizations are *people from countries where HIV is endemic* (n=3) and *community-based organizations (staff and volunteers) and policy makers* (n=1) (Figure 6). On average, 3 Full Time Equivalents (FTEs) were employed by the 13 previously PHAC-funded respondents in the 2014-2017 cycle.

Figure 3. Did your organization receive PHAC funding in 2014-2017 (prior to the CAF)? (n=25)

Figure 4. How many years has your organization received HIV/AIDS and/or HCV funding from PHAC? (n=12)

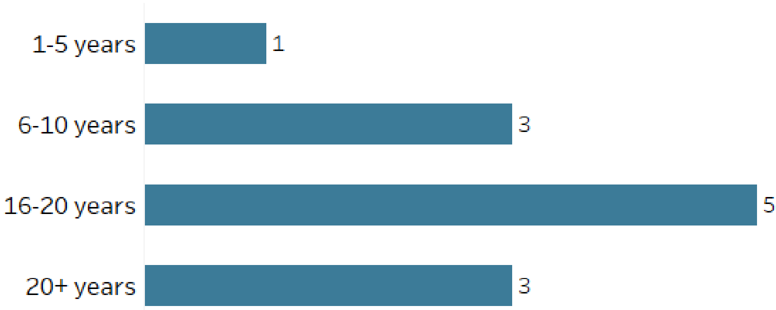


Figure 5. What type of projects did the PHAC funding support in your organization in the 2014-2017 cycle? (n=13)

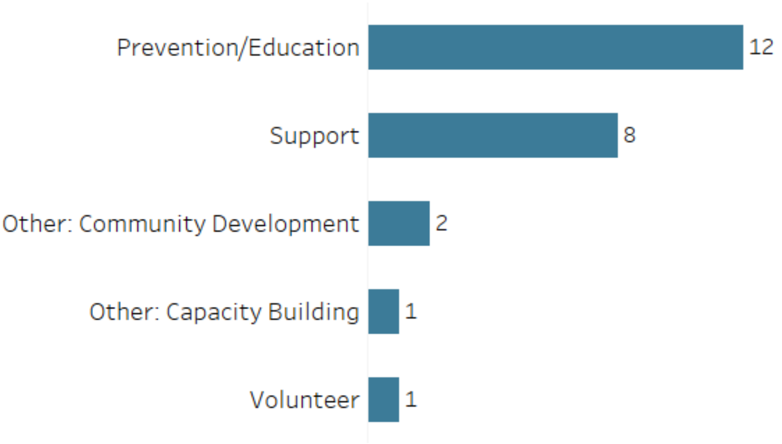
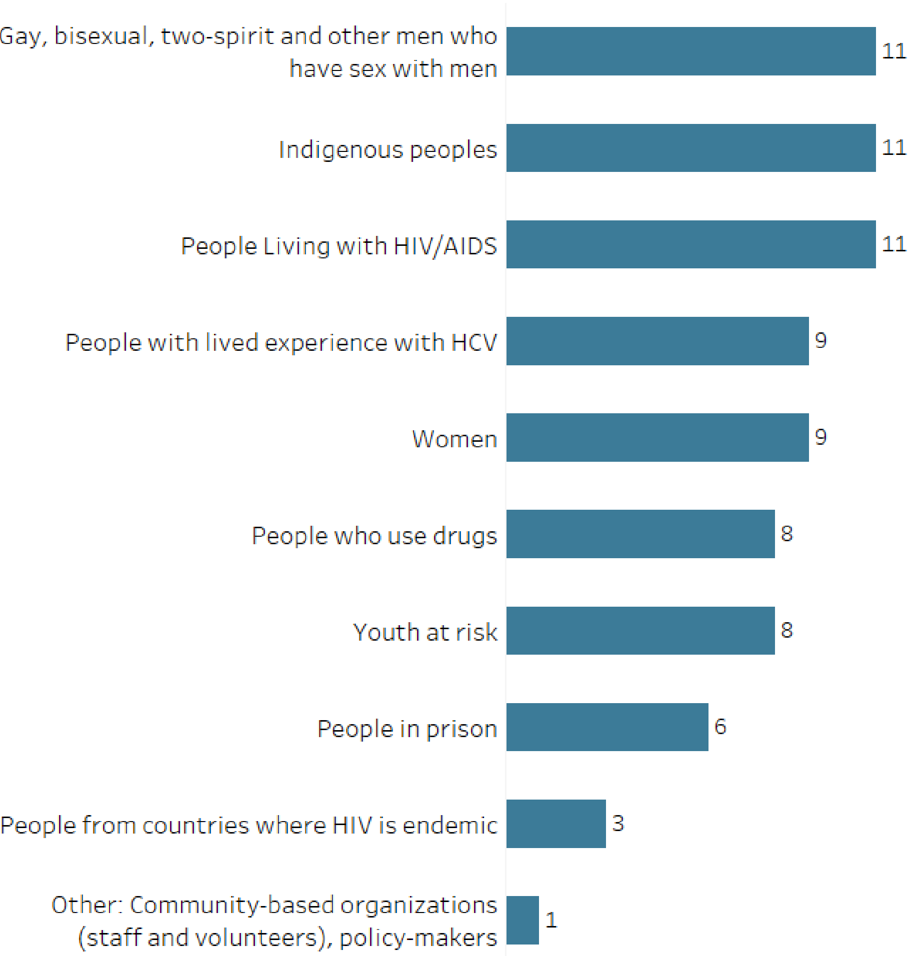


Figure 6. Which priority populations were served by your PHAC funded projects in 2014-2017? (n=13)



4.3 CAF – Letter(s) of Intent (LOI) Phase

The majority of respondents (75%; n=19) indicated that they participated in the Letter of Intent (LOI) phase (step 1) of PHAC's CAF (Figure 7). Of the 6 respondents who did *not* submit an LOI, 3 provided reasons on *why*, which included: not eligible (n=2); and was unaware of CAF call (n=1). The majority of LOIs respondents submitted or participated in were single organization contribution agreements (n=13), followed by community alliance contribution agreements (n=12). Some respondents submitted or participated up to two LOIs; however, no respondents submitted more than two LOIs. Only two Indigenous-led LOIs were submitted, both as single organization contribution agreements (Table 1).

Figure 7. Did your organization submit an LOI to PHAC as part of the new CAF (for new projects and projects starting on April 1, 2017)? (n=25)

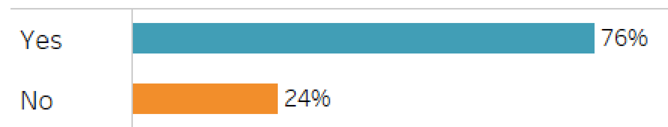


Table 1. How many LOIs did your organization submit or participate in? (n=19)

	1	2	2+	Total
Contribution Agreement (single organization)	11	2	0	13
Contribution Agreement (community alliance)	8	4	0	12
Grant	0	1	0	1
Indigenous-led: Contribution Agreement (single organization)	2	0	0	2
Indigenous-led: Contribution Agreement (community alliance)	0	0	0	0
Indigenous-led: Grant	0	0	0	0

4.4 CAF Full Proposal Application

Out of 19 respondents who submitted or participated in the LOI phase, less than half (42%; n=8) were invited to submit a full proposal (step 2) for the CAF (Figure 8). As multiple LOIs were submitted by a single organization in some cases, the total number of projects invited to submit a full proposal goes beyond eight. The community alliance contribution agreement is the most common type of project that has been invited to submit a full proposal (n=5), followed by the single organization contribution agreement (n=4) then Indigenous-led, single organization contribution agreement (n=1) (Figure 9). As expected, all respondents who were invited to submit a full proposal proceeded with submitting one (100%; n=8). All projects invited to submit a full proposal are 5-year projects and the most commonly focused-on priority populations amongst these projects are *people living with, or affected by, HIV and/or HCV* (n=6) and *gay men and other men who have sex with men* (n=6) (Figure 10).

All respondents invited to the full proposal process (100%; n=8) were asked to make revisions in their application by PHAC. The majority of respondents were asked to make "some changes" to their objectives (6 of 8 respondents); budget (5 of 8); activities (5 of 8); and outcomes (5 of 8) (Figure 11). Further, the majority of respondents were asked by PHAC to change the amount of funding requested to be *less* than what they originally requested in their LOI (62%; n=5), and a few respondents were *not* asked to make any changes to the funding amount (38%; n=3) (Figure 12).

Respondents were asked to describe their experience working with PHAC and negotiating through the full proposal process in an open-ended question. There were more negative experiences than positive with a high number of respondents feeling frustrated due to the timeliness challenges (n=5). Respondents noted significant delays in feedback by PHAC, as well as lack of reciprocation on respecting timelines including a long delay between a verbal approval and establishing/signing of actual agreements. A couple of respondents (n=2) also reported a lack of clarity as a major source of challenge working with PHAC. On the other hand, a few respondents (n=3) applauded the responsiveness and good communication of the PHAC regional office staff. Please refer to Table 2 for further details on qualitative responses to this question.

Figure 8. Was your organization invited to submit a full funding proposal for the CAF (for new projects and projects starting on April 1, 2017)? (n=19)

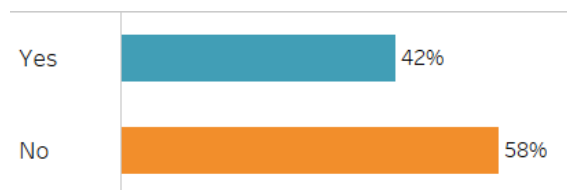


Figure 9. Which of the following was your organization invited to submit a full proposal for the CAF? (n=8)

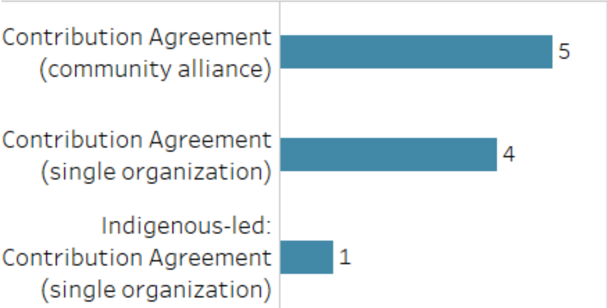


Figure 10. If your organization was successful in the LOI process and you were invited to submit a full proposal for the new CAF, which areas of focus or priority populations will be served and for how many years? (n=8)

Area of focus / priority population	3 Years	4 Years	5 Years
People living with, or affected by, HIV and/or hepatitis C	0	0	6
Gay men and other men who have sex with men	0	0	6
Indigenous people	0	0	5
People who use drugs	0	0	4
Transgender people	0	0	3
Women and youth among these populations, as appropriate	0	0	3
Capacity Building	0	0	2
People engaged in the sale, trade or purchase of sex	0	0	2
Ethno-cultural communities, particularly those representing countries with high HIV or hepatitis C prevalence, including immigrants, migrants, and refugees	0	0	0
People living in or recently released from correctional facilities	0	0	0
Social Marketing	0	0	0

Figure 11. Type of revisions requested by PHAC in full proposal application process (n=8)

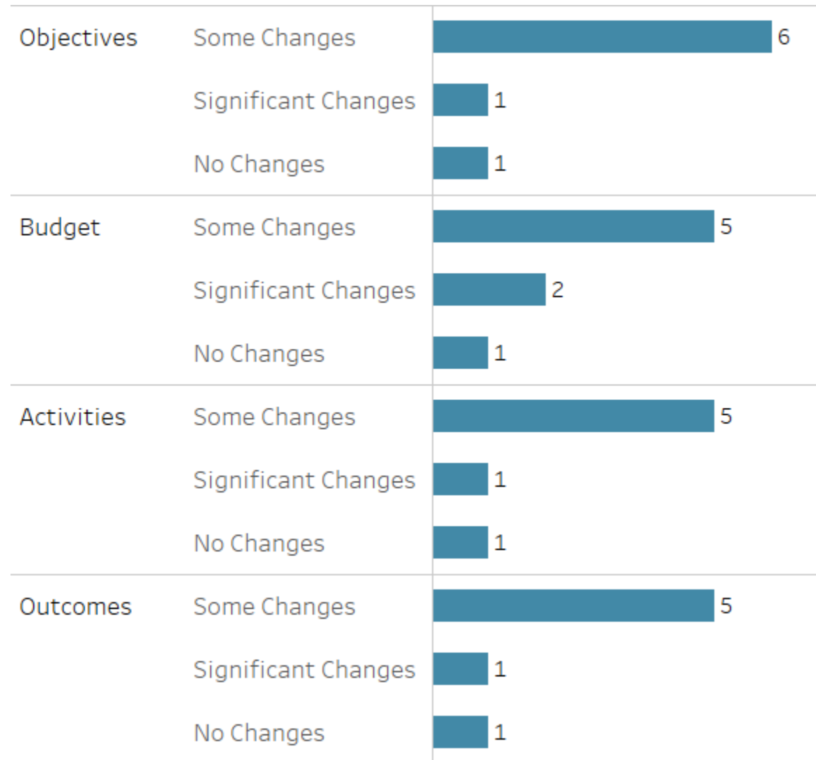


Figure 12. Were you asked by PHAC to change the amount of funding requested in the full proposal from what you had originally requested in your LOI (n=8)

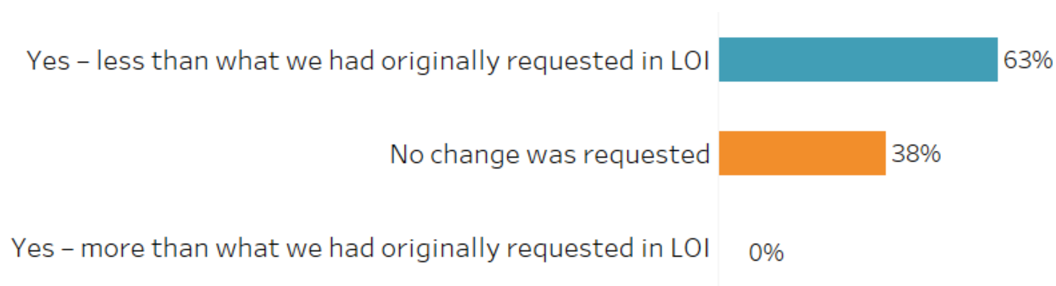


Table 2. Summary of the respondents' experiences working with PHAC and negotiating through the full proposal process (n=7)

Themes	Subthemes	Quotes
Positive	Regional office staff (n=3)	Communication with regional staff was sympathetic, understanding and responsive. This project was being managed regionally, which made a difference, as the person we worked with locally was quite responsive (both in terms of

		content and timing of the response) to our queries. The regional PHAC staff were also open to face-to-face meetings, which made the process a bit easier, and saved time related to back and forth.
	Others: • Accommodating process (n=1) • Reasonable application process (n=1) • Timely (n=1)	PHAC has been quite accommodating throughout this process… The application process itself was reasonable for the amount of money and length of proposed term for funding. We received timely answers to the few questions we had.
Negative	Timeliness-related challenges (n=5)	Lengthy delays in feedback. Timelines established by PHAC were not respected… [We were] given short, tight deadlines - which was not reciprocated [by PHAC]. … very disappointed in the amount of time between verbal approval and actual agreements and funding flow. Still waiting on evaluation info.
	Lack of clarity (n=2)	It was very difficult. The response from our LOI was confusing and not very clear.
	Others: • Application template (n=1) • Budgeting (n=1) • Disconnect between national and regional PHAC offices (n=1) • Disorganized (n=1)	… templates for the call were frustrating to use. Budgeting to the dollar/penny was difficult to do within the limitations we were given. Perceived sense of disconnect between regional and national offices. Negotiations were chaotic and frenetic

4.5 Signing of Contribution Agreements/Grant Contracts

Of the 8 respondents who were invited to submit and subsequently submitted a full proposal, 7 completed the questions in this section. Among the 5 CAF objectives, the ones most commonly addressed by the respondents' proposals are: increase knowledge of effective HIV, HCV and/or related STBBI interventions and prevention evidence (n=5); strengthen capacity of priority populations and target audiences to prevent infection and improve health outcomes (n=5); and increase uptake of personal behaviours that prevent infection and improve health outcomes (n=5) (Figure 13). Among the 7 CAF priorities, the ones most addressed by the respondents' proposals are: reduce new HIV or HCV infections through targeted combination prevention interventions (n=6); identify evidence-informed solutions to addressing barriers to prevention, diagnosis and treatment services, including legal and policy barriers that impact efforts to slow the spread of STBBI (n=5); and address stigma related to HIV or HCV or populations affected by these infections (n=5) (Figure 14). All respondents (100%; n=7) indicated that their activities

address one or more of the priorities populations. Other groups addressed by the respondents' activities include: public health and health care professionals (n=5); non-governmental organizations (n=4); policy and decision makers/leaders (n=5); educators (n=2); and researchers/academics/trainees (n=1) (Figure 15).

With regards to the amount of funding the respondents are receiving in their new signed contribution agreement/grant, 57% of the respondents (n=4) received the same amount as what they asked for in their full proposal. On the other hand, 29% of the respondents (n=2) received less than what they asked for in their full proposal and 14% (n=1) received more than what they asked for in their full proposal (Figure 16). Five respondents provided dates of their contract (whether it be the contribution agreement or grant) fully signed with PHAC – 1 respondent signed theirs in May; 3 signed theirs in June; and 1 signed theirs in July. Five out of six respondents who answered whether they started receiving payments from PHAC indicated that they are receiving payments at the time they answered the survey, whereas one indicated they were not.

Figure 13. Which of the CAF objectives did your proposal address? (n=7)

Objective	Count
Increase knowledge of effective HIV, hepatitis C and/or related STBBI interventions and prevention evidence	5
Strengthen capacity (skills, competencies and abilities) of priority populations and target audiences to prevent infection and improve health outcomes	5
Increase uptake of personal behaviours that prevent the transmission of HIV, hepatitis C and/or related STBBI	5
Increase access to health and social services for priority populations	4
Enhance application of knowledge in community-based interventions	3

Figure 14. Which of the CAF priorities did the activities in your proposal address? (n=7)

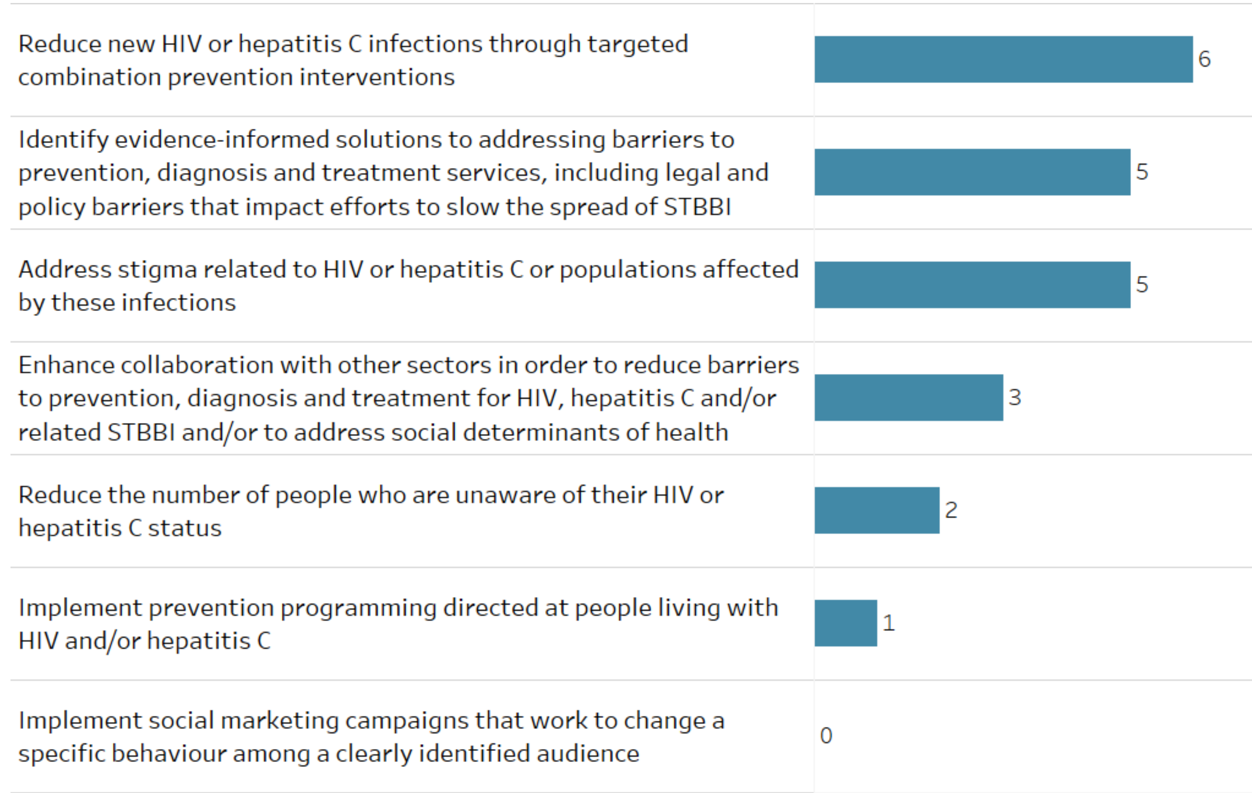


Figure 15. Which groups do your activities address? (n=7)

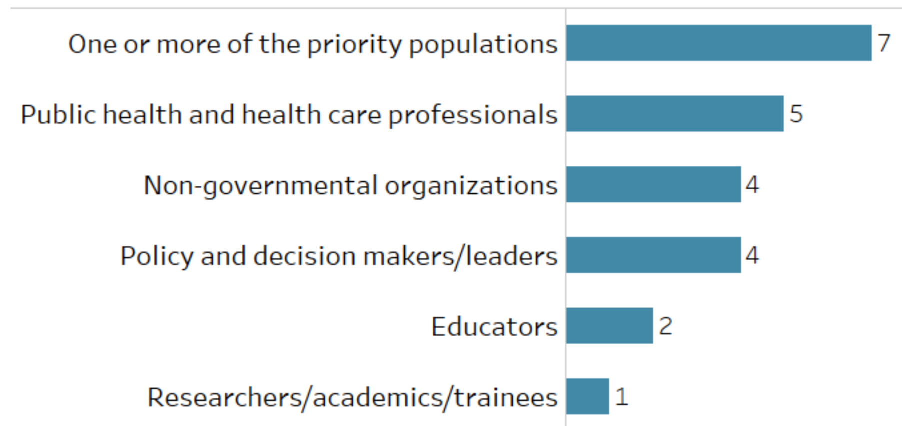
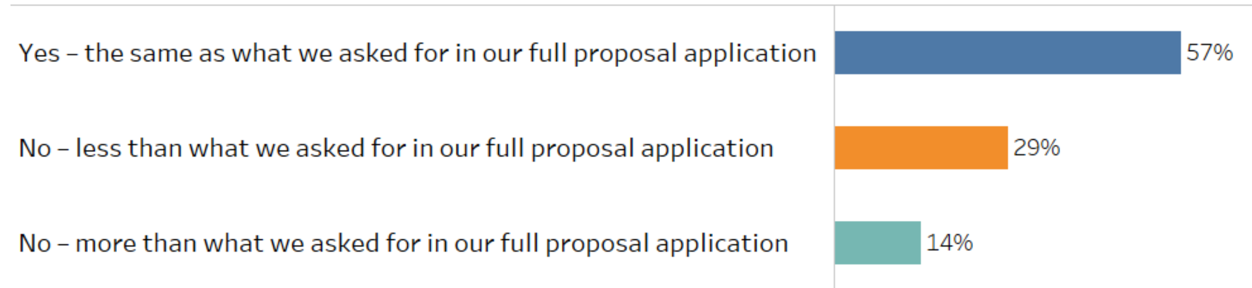


Figure 16. In your new signed contribution agreement/grant from PHAC, is the amount of funding you are receiving the same as the one you asked for in your full proposal? (n=7)



4.6 Transitional or Top-Up Funding

Eight respondents reported that they applied for transitional or top-up funding (18 respondents answered this question) (Figure 17). Please note that 11 of 19 respondents who participated in the LOI phase were not invited to submit a full proposal (refer to section 3.4 CAF Full Proposal Application). As a result of the transitional or top-up funding, a high majority of the respondents' organizations who applied to this funding (88% n=7) will receive funding to close projects funded by PHAC in 2014-2017 (prior to the CAF) and will receive the same amount of funding as the 2014-2017 annual funding. Additionally, 75% of the respondents (n=6) will receive funding for writing and submitting proposals to other funding sources and 63% (n=5) will receive funding to hire consultants to develop transition plans. Only 25% of the respondents (n=2) will receive funding to relocate staff or project activities to other organizations; and for intersectoral meetings or training opportunities to transfer project knowledge (Figure 18).

One respondent provided qualitative response on the limitations of activities eligible for the transitional fund and challenges faced in being reimbursed the negotiated amount from PHAC. Based on this respondent's comments, PHAC and its transitional funding did not support the closure activities in a way that best serves its members. There was a significant delay in receiving communications around eligibility of activities, and only one-third of the previous funding cycle amount was approved to cover the "eligible" activities in the end. However, the challenge continued with delayed payment from PHAC – at the time of completing this survey, the respondent indicated it had been two months since PHAC approved the amount yet they still had not received the payment.

Five of eight respondents (62%) were asked by PHAC to make revisions in their transitional or top-up funding applications. "Some changes" were asked to be made in activities (n=4), objectives (n=3), outcomes (n=3), and budget (n=2). Two respondents reported that they were asked to make "significant changes" to their budget (Figure 19). Please refer to Table 3 for the summary of qualitative responses on respondents' experiences working with PHAC and negotiating through the transitional or top-up funding process.

Figure 17. Did your organization apply for transitional or top-up funding? (n=18)

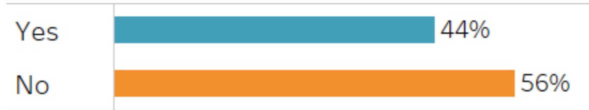


Figure 18. As a result of the transitional or top-up funding, will your organization… (n=8)

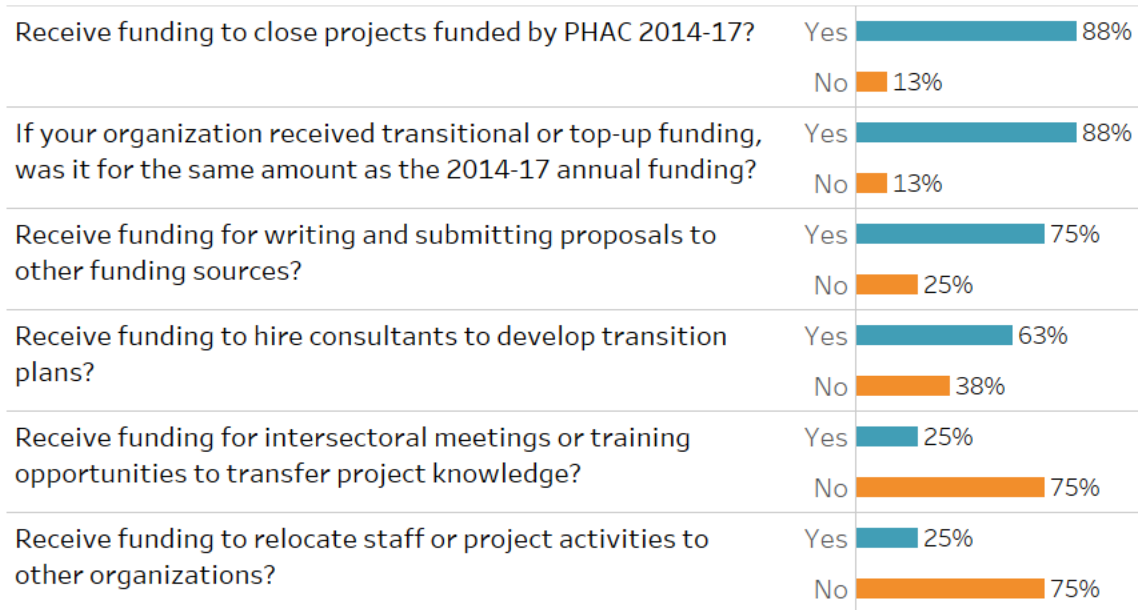


Figure 19. Transitional or top-up funding application revisions requested by PHAC (n=5)

Activities	Some Changes	4
	Significant Changes	1
	No Changes	0
Objectives	Some Changes	3
	Significant Changes	1
	No Changes	1
Outcomes	Some Changes	3
	Significant Changes	1
	No Changes	1
Budget	Some Changes	2
	Significant Changes	2
	No Changes	1

Table 3. Summary of the respondents' experiences working with PHAC and negotiating through the transitional or top-up funding process (n=8)

Themes	Subthemes	Quotes
Positive	Regional office staff (n=6)	The BC Region staff were very supportive and compassionate towards our funding loss. The Vancouver PHAC Office staff have been very helpful and cooperative and sympathetic.
Neutral	Neutral (n=2)	Neutral. It was all very business-like...
Negative	Communication (n=2)	Communications were infrequent and inadequate, sometimes to the point of being misleading and often feeling outright disingenuous. [We experienced] lack of clear communication... they have been less than supportive and unclear in communicating their decisions and expectations.
	National process (n=2)	The National PHAC process has been confusing since the LOI process began.
	Others: • Unsupported (n=1) • Time-consuming (n=1) • Lack of clarify (n=1)	It would have been much appreciated to have someone assigned to our file to learn from and support us in the closure process.

• Inconsistent feedback (n=1) • Poorly planned process overall (n=1) • Extremely stressful (n=1)	As a Board, it has been a frustrating and time-consuming experience. We spent days preparing reports and budgets (something none of us had ever previously done) and hours on phone calls that included a lot of reporting-specific jargon that we were unfamiliar with. There was no true negotiation. The decisions appeared to have been made prior to LOIs even being submitted. The transition funding seemed much more like backtracking in response to community outrage than a well thought out plan. From start to finish the process was a poorly-led disaster. The entire process was extremely stressful.

4.7 CAF Results

A small proportion of the respondents (17%; n=4) lost a previously funded project as of March 31, 2017 as a result of the new CAF (Figure 20). In 2017/18, 32% of the respondents (n=7) will receive the same amount of funding (whether it be through the CAF or transitional/top-up funding) as they did in 2016/17, where as 23% (n=5) will receive more and 9% (n=2) will receive less than they did in 2016/17. The rest of the respondents (36%; n=8) will not be receiving any funding in 2017/18. The number of respondents who will not be receiving any funding almost doubles in 2018/19 (64%; n=14), indicative of the termination of transitional or top-up funding. In 2018/19, 9% of the respondents (n=2) will be either receiving the same or less than what they received in 2016/17; whereas 18% (n=4) will be receiving more than what they received in 2016/17 (Figure 21). Nine respondents provided further details on the net financial difference. In total, there is a net loss of $1.38 million in 2017/18 or 2018/19 compared to 2016/17 among the respondents. One respondent said they gained $40,000 and another respondent reported their budget tripled.

As demonstrated in Figure 22, the impacts felt by the priority populations can be stipulated by the respondents' answers to how they envision the PHAC funding changes will affect the services for priority populations in their region or community. Based on this survey, the Indigenous peoples will suffer the most as 83% of the respondents (n=15) reported that the PHAC funding changes will lead to loss of services for the Indigenous people in their region/community (17% of respondents (n=3) reported that there will be no change of services for the Indigenous people in their region/community). Women and youth populations are also predicted to experience a loss of services (78% of respondents (n=14) projected loss while 22% (n=4) projected no changes in services). Similarly, 78% of respondents (n=14) said people who use drugs in their region/community will experience loss of services; 17% (n=3) said they will experience no change; and 6% (n=1) said they will experience gain of services.

Although the net loss is greater overall, some priority populations are expected to experience a relative gain in services compared to other populations. Almost a quarter of the respondents (24%; n=5) reported that gay men and other men who have sex with men in their regions/community will experience a gain in services, while 57% (n=12) reported this population will lose services and 19% (n=4) reported there will be no change in services. Similar trends are seen in people engaged in the sale, trade or purchase of sex population – 16% of the respondents (n=3) said this population in their region/community will experience gain in services, 63% (n=12) said they will lose services, and 21% (n=4) said they will not experience change in services (Figure 22).

Respondents were also asked about helpful resources that would have helped them through any of the PHAC CAF applications. Increased access to PHAC staff when preparing the application had the highest number of votes (n=13), followed by support from an outside evaluator when developing proposal (n=11). Increased collaboration between organizations rated highly (n=10), as did grant writer support (n=9) and peer review (n=9) (Figure 23).

Figure 20. As a result of the new CAF model, did your organization lose a previously funded project as of March 31, 2017? (n=23)

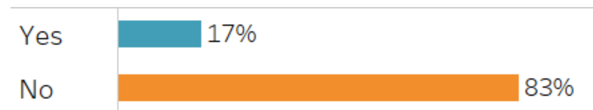


Figure 21. As a result of the new CAF model (including transitional or top-up funding), will your organization receive more or less PHAC funding in 2017/18 or 2018/19, compared to 2016/17? (n=22)

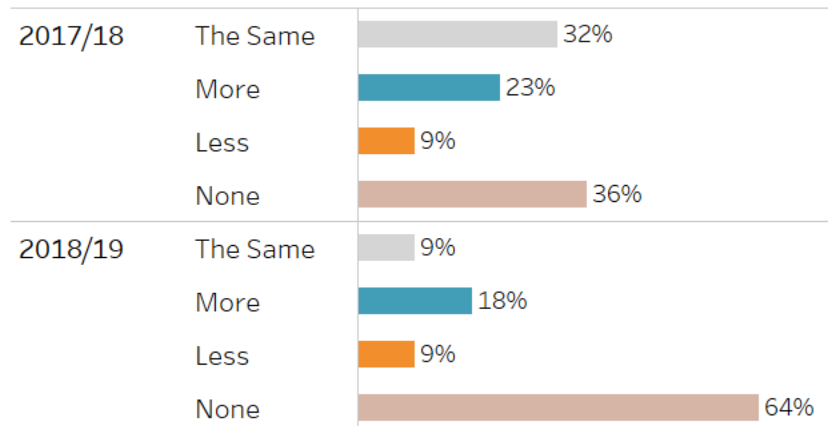


Figure 22. How will the changes in PHAC funding affect services for priority populations in your region/community? (see 'n' below for the number of respondents who answered to each of the priority populations)

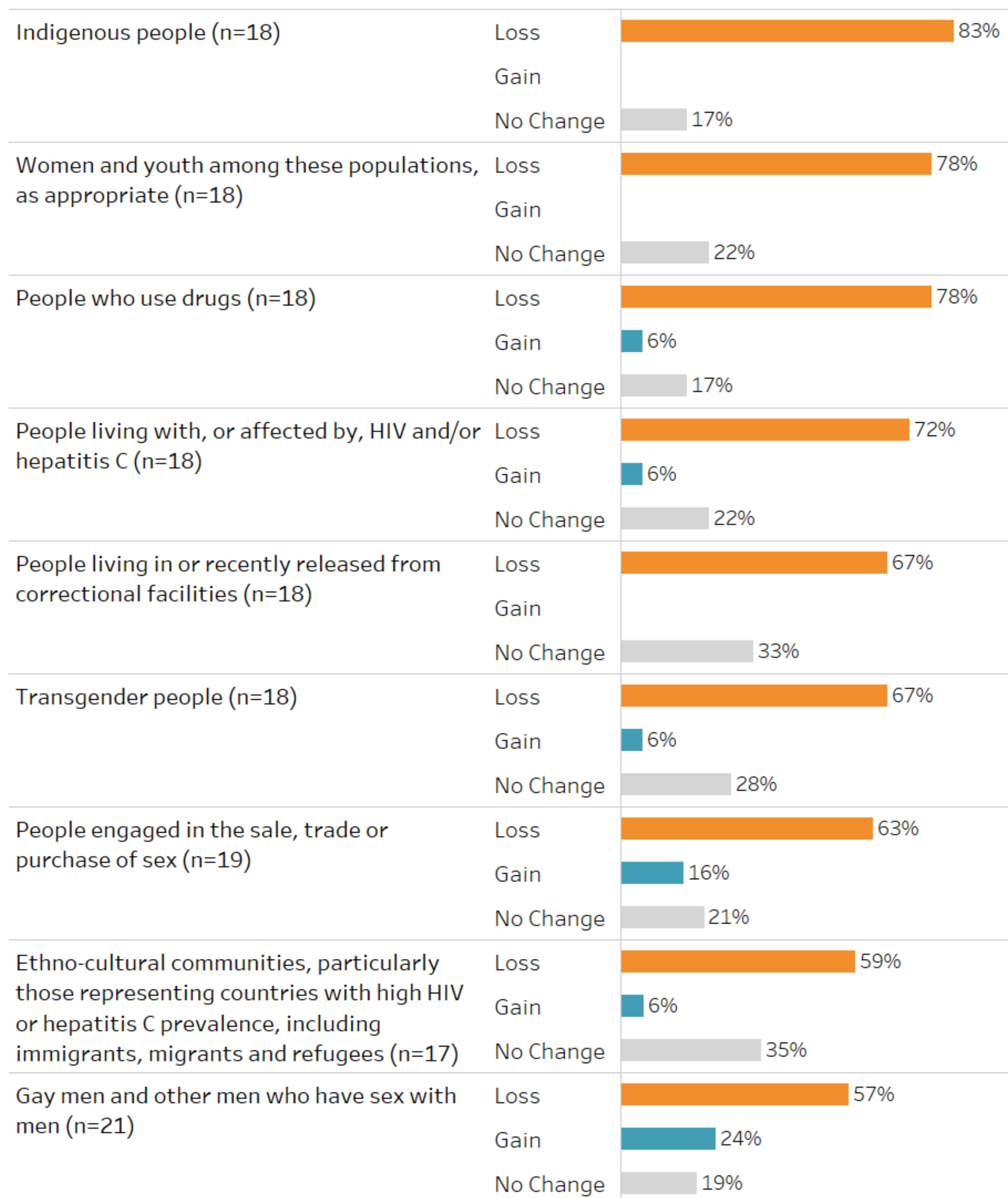
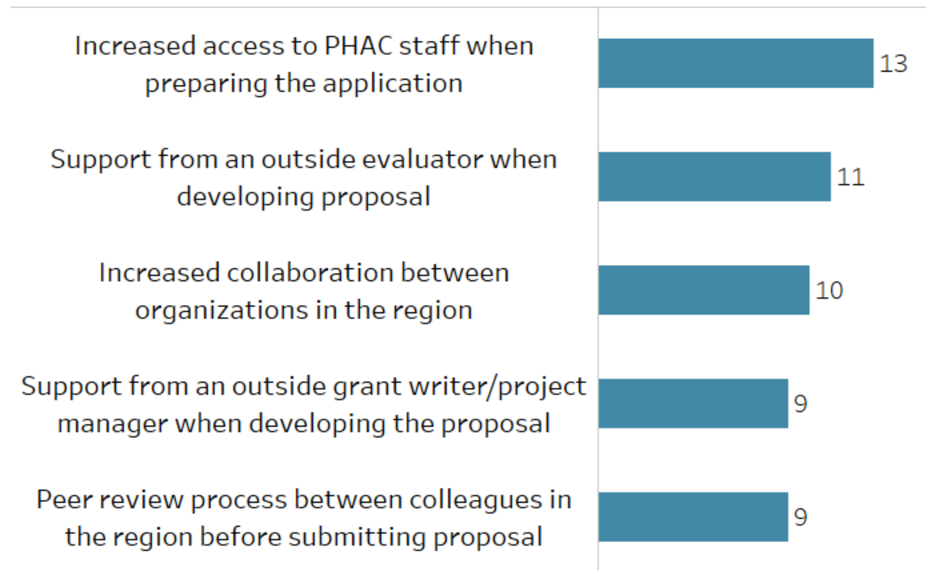


Figure 23. Which of these resources would have helped you with any of the phases or the PHAC CAF applications? (n=21)



4.8 CAF Process

The respondents were asked a series of open-ended questions related to the CAF process. In terms of what went well during the CAF process (Table 4), the respondents appreciated the access to and support from PHAC (n=4) as well as the regional office and its staff (n=4). One respondent was particularly grateful to the PHAC regional office staff and PAN for their advocacy efforts on the transitional funding. The respondents also acknowledged the collaborations between organizations (n=3) and welcomed the LOI submission process ahead of the full proposal (n=2). Some respondents reported that there was nothing that went well during the CAF process (n=2).

Concerning what was challenging throughout the CAF process (Table 5), the respondents most frequently identified communication as an area of issue (n=6). The lack of, unclear and delayed communication caused a degree of confusion and frustration amongst the respondents. Following communication, the respondents expressed dissatisfaction around poor planning and delayed process (n=5). The unexplained and unfair delays in some cases led to lost time to react and missed opportunities to apply for other funding. Inconsistency (n=4), access to PHAC staff (n=3), and lack of transparency (n=2) were also identified as challenges. Inconsistency in PHAC's messaging around directions, deadlines and expectations, as well as messaging between what's said and what's written created stress and frustration amongst respondents. Further, respondents commented on inconsistent messaging between various staff at PHAC. Lack of regular and timely access to PHAC staff and lack of clarity around how decisions were made also left respondents feeling unsupported and in the dark.

The respondents also described lessons they would carry forward for future funding calls (Table 6). Communication (n=7) was most frequently identified theme. Overall, respondents expressed that increased communication that is more transparent and consistent would be vital to making the process clearer, building the trust between PHAC and community-based sector, and addressing the needs of priority populations. Further, respondents described the need for PHAC to allow community-based organizations (CBOs) to communicate before any final decisions are made and also for PHAC to fully answer any questions CBOs may have. Respondents also called for greater partnerships/collaborations as well as community engagement (n=4). Increased partnerships between PHAC and local health authorities, and amongst PHAC, CBO operations and CBO governance body would benefit responding to challenges and changes. Furthermore, increased community engagement through provincial and national community-based networks was identified as an important strategy for PHAC to take on for its future funding processes.

Planning (n=3) was also identified as a key theme for lessons learned, where respondents urged PHAC to plan better and ahead of time, especially around the transition fund, evaluation and community alliance approach for improved implementation. More supports from PHAC throughout the process (n=2); consideration of local contexts and regions in PHAC's decision-making, especially during LOI phase (n=2); increased internal capacity at PHAC to undertake funding processes (n=2); and increased leadership at PHAC and CBOs were additionally identified as lessons learned. Lastly, two respondents expressed that they will not or will be hesitant to apply for PHAC funding in the future.

Table 4. Summary of the respondents' open-ended answers on what worked well during the CAF process from planning, application, decision-making, to signing of agreements (n=16)

Subthemes	Quotes
Access to and support from PHAC (n=4)	Access to PHAC staff when we had specific questions about both the process and content of our application. Great response when there were challenges in the technical side of the application process.
Regional office and its staff (n=4)	The regional office staff were responsive and tried to be transparent and communicative. I feel that PAN and the PHAC regional office were helpful in assisting us to advocate for transition funding and to respond to the decisions being made. They are the entities that understand the work we do the ground.
Collaborations between organizations (n=3)	The collaboration between organizations in the region. PHAC did not influence this in any way. The organizations worked well together despite a process that encouraged competitiveness and secrecy.
Online FluidSurveys Tool (n=2)	The online/fluidsurvey tool was easy to use.

LOI (n=2)	Process of LOI first before completing an entire application reduced work load.
Nothing went well (n=2)	Absolutely nothing worked well.
Others: • Webinars (n=1) • Flexibility (n=1) • PAN (n=1) • Shift in funding structure and priority (n=1)	The webinars by national PHAC staff were appreciated. PHAC flexibility. I feel that PAN and the PHAC regional office were helpful in assisting us to advocate for transition funding and to respond to the decisions being made. They are the entities that understand the work we do on the ground. We are glad they prioritized gay, bi and other men who have sex with men. This is clearly where the epidemiology says we should be focusing. We're grateful they are funding structural change, as opposed to front-line service delivery.

Table 5. Summary of the respondents' open-ended answers on what was challenging about the CAF process from planning, application, decision-making, to signing of agreements (n=16)

Subthemes	Quotes
Communication (n=6)	Communication - caused great confusion. Not a highly communicative process… Communication overall was challenging and not as transparent as it could have been. Duration of time it took to get a response back. No response for months and months following submission of the LOI. No one could tell me the status.
Poor planning and delayed process (n=5)	Flawed process from the beginning… given the amount of time available (started process in 2015 or earlier) and given the amount of resources dedicated to the entire CAF transition, we don't understand why there was such urgency at the end of the process. Why did community have to have such short deadlines given the amount of time taken by PHAC to plan and implement the process? Process delayed by months - by the time we found out we were unsuccessful the time to plan or react was greatly diminished.
Inconsistency (n=4)	The constant changing of deadlines and expectations was not only unfair but also exhausting and only added to stress and mistrust within the sector. Staff turnover at PHAC was challenging during negotiations, not have consistency between people we were speaking with at PHAC. Over the last 3 or 4 years, I feel that PHAC had changed direction so many times in terms of how funding would role out.

	With regard to the signing of the agreement and dispensing of funds, that process has been frustrating for [us] as there is a lack of clarity and incongruity between what is listed in the four-page booklet around eligible expenses for the PHAC transition funds and what the PHAC representatives deem to be actual eligible expenses.
Access to PHAC staff (n=3)	Lack of regular, timely access to PHAC staff. No opportunity to review with anyone prior to submission.
Lack of transparency (evidence undermined) (n=2)	The response to our LOI completely blind-sided us and made us feel that there was another agenda that was not reflective of the important work we do in our region, the leadership we have demonstrated with our programs and the successful outcomes of our projects. No real clarity (dollar amounts, alliances, too many things left to interpretation). No opportunity to review with anyone prior to submission. Webinars did not accurately reflect expectations. Zero transparency.
Others: • Complex application and lack of capacity (n=1) • Lack of community contribution (n=1) • National PHAC office (n=1)	Complex application. Lot of work for me as an unpaid peer to receive nothing. Community could have contributed much more and networks like PAN, COCQ-SIDA, OAN could have played a much different and contributing role if [asked]. Everything emanating from or having to do with Ottawa was opaque, wildly over-complicated and intensely frustrating.

Table 6. Summary of the respondents' open-ended answers on what lessons they bring forward for future PHAC funding calls (n=12)

Subthemes	Quotes
Communication (n=7)	If you are going to make a dramatic change then communication is vital and making sure that the communication was super clear was so important. With inconsistencies with communication eroded trust with the community-based sector. Opening greater lines of communication may help to address operational challenges, to help promote the change that's needed to meet the needs of priority populations. I also think that if there were questions that came up as a part of the LOI then there should have been some ability for organizations to respond before final decisions were made. To demand answers to questions about the application over and over if need be.

Partnerships/collaborations and community engagement (n=4)	PHAC and health authorities to work [together] through programming challenges and changes. Greater collaboration between the funder, the operational level and governance level of services. All three parties are needed in order to ensure that those who are most affected by STBBIs have access to the most cost-effective and comprehensive services possible. Leveraging relationships with provincial and national community-based networks and engaging them as important partners in the consultation and communication strategy.
Planning (n=3)	What the implications were was so important and perhaps developing a transition plan ahead of time. Evaluation plans should have prioritized and ready to start at the start of funding. [We] needed to know what the evaluation process was going to look like at the start of the contribution agreements in order to plan. Should have pilot the community alliance approach ahead of time to determine if it is viable and to improve implementation.
Support from PHAC (n=2)	More support for organizations facing closure. Organizations should have iterative support from all funders.
Consideration of local contexts and regions in decision-making (n=2)	Have regional representatives with a better sense of the local context and need evaluating LOIs. A sense of the context is critical to determining local need and organizational capacity. I feel that regions should have been [considered] in the LOI results. They know the organizations and projects in BC and how STBBI's impact the populations in our region and what programs have created excellent outcomes.
PHAC capacity (n=2)	PHAC needs to have sufficient internal capacity to do the work required to make the necessary funding decisions with respect to the proposals it received. More capacity at PHAC to undertake such a large process.
Will not or be hesitant to apply in the future (n=2)	For my own organization I would not bother applying again. The process is flawed and lacks accountability at all levels. If I worked for PHAC I would take a serious look at expectations of and support provided to funded organizations. The expectations are high while the support and openness is nearly non-existent.
Leadership at PHAC and CBOs (n=2)	It is really important to have leaders [at PHAC] who understand and are competent, genuine and ethical partners with community-based programs and organizations. In hindsight, we recognize that [our organizational] leadership had not been listening to both the Board of Directors' and PHAC's urgings to adopt an integrated service model. In this

	lack of communication and change, [the ones who lost the most are members] who never had any say in how the organization operated.
Others: • Transparency (n=1) • Bureaucracy (n=1) • Seek external help/support (n=1) • Careful reading of the guidelines (n=1)	The process needs to be clearer. [Reduce] Ottawa bureaucracy. To bring in outside help if necessary. READ READ READ the guidelines ... then read them some more.

4.9 Responding to the impacts of PHAC CAF results

The respondents were asked if they feel that there is a role for the BC health authorities; the Ministry of Health; and the community-based HIV and HCV sectors in BC to play in responding to the impacts of PHAC CAF results. All respondents answered *yes* to all three groups having a role (Figure 24). The biggest role the BC health authorities play is advocacy (n=7) (Table 7). The respondents felt the health authorities needed to make aware to themselves, to the public and to their provincial and federal minsters of health of the impacts of the CAF results, particularly the irreplaceable and irreversible service and regional gaps. The respondents also felt that it is the responsibility of the BC health authorities to fund lost services (n=4). Moreover, increased partnership with PHAC to better align their funding processes (e.g. streamlining federal funding into health authority funding; delineating who should fund what) was also highlighted as an important next step for BC health authorities (n=3).

The roles and responsibilities expected of the Ministry of Health in responding to the impacts of PHAC CAF results were very similar to those of the BC health authorities (Table 8). The respondents not only wanted the Ministry of Health to advocate the impacts of the service gaps and increased funding, they also wanted the Ministry to pressure PHAC and the federal government to evaluate the CAF process and to keep the same total dollar allocated for HIV and HCV services per province. There was a total of six respondents who saw *advocacy* as a role of the Ministry of Health. The respondents also wanted the Ministry of Health to look for ways to fund and support the lost services within BC, whether it be through allocating more funds to the BC health authorities or through seeking alternate sources of funding (n=5). One respondent advised that the Ministry of Health to partner with PHAC to delineate what programs/services should be funded provincially vs. by PHAC, and to direct BC health authorities to increase support of direct support programs.

Similarly, the respondents felt that the greatest role for the community-based HIV and HCV sectors in BC to play is advocacy (n=10) (Table 9). Advocating for agencies and services that lost funding and their negative impacts felt by the people living with HIV and HCV must be continued with PHAC, Ministry of Health, BC health authorities and beyond to gain financial support to minimize the gaps and to prevent spikes in STBBI infections from occurring. The next biggest role for the BC's HIV and HCV community-based sectors to play is to continue the unified and

coordinated approach to address the gaps in service provision (n=5). Other roles included acknowledging the change and strategizing a good process forward (n=1) and to adhere to the GIPA/MIPA and Nothing About US, Without Us Principles (i.e. informing the members/clients about the changes in the funding process so they are able to be involved) (n=1).

Additionally, respondents were asked what actions their organizations took to respond to the impacts of the PHAC CAF results relating to advocacy and/or programming (Table 10). Most commonly, the respondents organized or participated in political actions, including campaigns, rallies and making an impact statement (n=6); and contacted their local, provincial and federal political leaders such as Members of the Legislative Assembly (MLAs) and Members of Parliament (MPs) (n=6). The respondents also took their matters directly to PHAC by engaging with the PHAC regional office, and writing letters to and speaking with the president of the PHAC (Dr. Mithani) (n=5). Moreover, engaging and strategizing with other community-based organizations/partners (n=3); communicating and discussing with other stakeholders and networks (n=3); and exploring other funding (n=2) were identified as actions taken by respondents. PAN's role as a provincial network in coordinating a provincial response and also working with national partners was highlighted. Unfortunately, one organization regretfully informed us that they made the difficult decision to close their doors.

Figure 24. Do you feel that there is a role for the...

BC health authorities to play in responding to the impacts of the PHAC CAF results? (n=18)	Yes	100%
	No	
Community-based HIV and HCV sectors in BC to play in responding to the impacts of the PHAC CAF results? (n=18)	Yes	100%
	No	
Ministry of Health to play in responding to the impacts of the PHAC CAF results? (n=17)	Yes	100%
	No	

Table 7. Please describe the role the BC health authorities play in responding to the impacts of the PHAC CAF results (n=15)

Themes	Quotes
Advocacy (n=7)	It is essential that the BC Health authorities (1) make sure the provincial Health ministry (and Minister) understand the impact of the cuts in BC, and enlist the support of senior ministry people (including the Minister) in directly approaching the federal minister responsible and putting pressure on her to

	reverse the cuts, and (2) directly approach the federal minister responsible and put pressure on her to reverse the cuts. The loss of several key organizations will leave HUGE irreplaceable gaps especially in Fraser East and the Kootenay regions the Health Authorities should be extremely proactive in advocating for a full review and answers to what went wrong on such a large Canada wide scale. The impacts to the Health Authorities will be long term and to a large extent irreversible.
Fund lost services (i.e. direct frontline services) (n=4)	PHAC decided, through the introduction of the CAF, to move away from direct support of programs, which provided support to vulnerable populations. Instead, it chose to focus on prevention strategies, aimed at improving access to STBBI prevention interventions, and increasing the knowledge of priority populations around effective STBBI prevention strategies. BC health authorities now need to step in and support those programs, which provide direct support to affected populations, as this falls more within their mandates.
Partner and align with PHAC (n=3)	Working in partnership with PHAC and the province to delineate what programs and services should be funded by PHAC and what should be provincially funded. Health care funding is a provincial mandate, so in some ways there is a greater need for more provincial funding for services. A provincial funding model could also mean closer relationships and greater contextual understanding of the local situations for organizations and priority populations. That said, there is a recognition that health care costs are ballooning while federal transfer dollars are not. That is a disconnect in the funding envelope that needs to be remedied before services can be downloaded to the provinces in this way.
Others: • Make aware lack of capacity to fund lost services (n=1) • Strategize alternative funding (n=1)	Being clear that the HAs do not have the funding to replace services that have been lost. Looking at ways for alternate source funding

Table 8. Please describe the role the Ministry of Health play in responding to the impacts of the PHAC CAF results (n=14)

Themes	Quotes
Advocacy (n=6)	Additionally, the MoH should continue to pressure PHAC and the federal government to evaluate the process with honesty and integrity. Something that was lacking throughout the process. Advocacy - why are these cuts occurring, and is there a more supportive process that could take place to ensure that while

	the face of the services (i.e. the organizations delivering them and the way in which they are currently being delivered) may change, that the total dollar amount allocated for services, per province, does not change. While it is inarguable that there are operational inefficiencies or practices that need to change, the loss of funding has the greatest impacts on those who are already marginalized and vulnerable. The organization staff will be okay with severance packages and other forms of financial support but the organizations' members may not necessarily have alternative options for accessing services. They are ultimately the ones who suffer most in this situation and they need the most advocacy by the MoH to retain/regain the service dollars lost at a provincial level as a result of these changes.
Look for ways to fund and support lost services (n=5)	As the entity which governs and directs BC health authorities, decisions around increasing the support of direct service support programs needs to come from the Ministry of Health. The MoH must look seriously at the impacts and consider providing funding to health authorities to assist in replacing the most impactful programs.
Others: • Partner with PHAC (n=1) • Accountability (n=1) • Same role as health authorities (n=1)	Working in partnership with PHAC and the province to delineate what programs and services should be funded by PHAC and what should be provincially funded. As the entity which governs and directs BC health authorities, decisions around increasing the support of direct service support programs needs to come from the Ministry of Health. Awareness. No one is accountable. Same reasons as Health Authorities.

Table 9. Please describe the role the community-based HIV and HCV sectors in BC play in responding to the impacts of the PHAC CAF results (n=13)

Themes	Quotes
Advocacy (n=10)	Actively advocate for agencies who have lost funding. Exemplify that the loss of funding negatively affects people living with HIV/HCV, which can result in lack of resources and supports for individuals and could lead to a spike in infections as a result. Continued advocacy, with PHAC as well as the Ministry of Health and BC health authorities, to encourage continued financial support of those programs, which no longer meet the criteria for support under the CAF.
Unified and coordinated approach (n=5)	Trying to have a coordinated response to address gaps in service provision. Share impacts and statistics. Unified approach.

Others: • Acknowledge the change and strategize a good process forward (n=1) • GIPA/MIPA and Nothing About Us, Without Us principles (n=1)	Acknowledge that there is a need to change how services are being delivered. Commit to a process of making these changes in collaboration with core funders, so that both sides (funders and community-based HIV and HCV sectors) are prepared to work together and deliver the best possible services. Engage organization members in the process, informing them of how the frameworks upon which these federal and provincial funding calls are based have an impact which services are funded (or not), and work together to determine how to best meet local needs in the context of these federal frameworks. [Our] members expressed how sad and angry they felt at not being more involved in the process to change the organization in order to meet the requests of the funder to integrate and update services. They explained how having greater knowledge of that process would have changed their actions and how much they desired to be involved in that decision-making. In other words, adhere to GIPA/MIPA and NAUWU principles!

Table 10. Summary of actions taken by respondents' organizations relating to advocacy and/or programming in response to the impacts of the PHAC CAF results (n=15)

Themes	List of actions taken by respondents
Organizing or participating in political actions (including campaigns, impact statements, rallies, etc.) (n=6)	▷ Rallies ▷ World AIDS Day demonstration at regional PHAC offices ▷ Campaigns (regional and provincial) ▷ Community coalition (MPs attend) ▷ Impact statement submitted to Bloodlines magazine ▷ BC region calls and CAS calls
Contacting political leaders (n=6)	▷ Met with MPs (both own and opposition) (n=2) ▷ Worked with members on a coordinated response to the federal Minister of Health ▷ Letters to MLAs and MPs ▷ Letters to Minister of Health ▷ Contacted provincial and federal government representatives ▷ Met with BC Ministry of Health to discuss and identify geographic and population gaps
Communicating and meeting with PHAC (n=5)	▷ Advocated to PHAC on negative impact on the HIV programming and the community ▷ Engaged in discussions with PHAC regional ▷ Solicited letters from community partners that were went to Dr. Mithani (president of PHAC) ▷ Met with Dr. Mithani in January 2017 to articulate our concerns about the CAF process and outcomes ▷ Provided feedback directly to PHAC

Engaging and strategizing with other community-based organizations/partners (n=3)	▷ Collectively problem solved ▷ In conversations with another CBO to see how the program can collaborate at the provincial and national levels ▷ Engaged community partners
Communicating and discussing with other stakeholders and networks (n=3)	▷ Brought forward and is a standing item at the monthly STOP CIC meetings ▷ Shared information across PAN provincial network through various mediums like eNews and direct communications with EDs of PAN member organizations ▷ Supported dialogues around strategy to have funding restored
Exploring other funding (n=2)	▷ Continue to look for alternate funding opportunities (n=2) (e.g. through internal fundraising, events, health authorities and grant writing)
Others: • Organization closure (n=1) • Coordinating a response as a provincial network (n=1) • Coordinating a response with national partners (n=1) • Hiring consultants (n=1) • Submitting an application to other funding (n=1)	▷ Made the difficult and gut-wrenching decision to wind up the agency's services ▷ Brought the PHAC CAF results forward at PAN's two provincial fall meetings and related sustainability issues ▷ Liaised with sister networks (OAN and COCQ-SIDA) and national partners in trying to have a coordinated response ▷ Hired consultants for transition planning and transition funding activities ▷ Submitted an LOI to Health Canada

4.10 Final Respondent Comments

The respondents were given an opportunity to openly share any words or thoughts at the end of the survey. The devastating impacts felt by the community were echoed again in these answers. One respondent was particularly concerned about the loss of Bloodlines magazine as it provided an important connection for Indigenous people living with HIV to support services. Bloodlines magazine also provided "a platform to share [Indigenous people's] personal experiences in living with HIV." Another respondent described the reality of their members/clients. Despite the treatment advancements for HIV that now deem HIV as a chronic manageable disease, the PLHIV clients who face issues of poverty, addictions, homelessness, and/or mental complications have the HIV service organizations as their only resource where "they feel safe to reach out from very marginalized and isolated positions due to stigma and discrimination." With the lost services, the respondent worried that these clients will now "go forward alone and unsupported. This is truly where the loss of funding will be most felt."

One respondent urged PHAC to "take a real honest look at what went wrong and own it." There is a need for sincere and proactive actions to ensure that the "HIV/HCV safety net in Canada remains strong and the commitment to the 90-90-90 plan stays firmly at the forefront of funding

calls." Key steps to undo some of the damage and improve future funding calls include: transparency, proper reviews, ability to review prior to submission, and recognition of and support for decades of hard work by HIV/HCV service organizations. The concern for *undoing* all the hard work the community-based sector did and all the accomplishments the sector has achieved was reiterated; "new infections will likely get missed and will not be caught early due to no services in Fraser East – service provider and public education will also end in Fraser East."

Another respondent expressed regrets at losing highly skilled and experienced employees and peers and that the work in communities has also been responsible for addressing stigma on a systemic level. They believed that the PHAC CAF results have caused a huge damage to this sector and was concerned that the changes and new directions guided by the CAF were neither well-informed nor respectful to this sector.

One respondent thanked PAN for its great advocacy on securing transitional funding, and appreciated PAN's hard work and commitment to serving the sector especially during times of changes like this. Although the process had challenges the transitional funding was very helpful to this respondent. Another respondent remained hopeful about the coordinated approach the BC HIV and HCV community-based sectors are taking, by stating, "the people united will never be defeated."

5.0 Conclusion

This evaluation survey clearly reiterated the concerns of BC community-based organization respondents working in HIV and HCV sectors, regarding the new CAF decisions and related funding changes/loss, and the resulting service loss and devastating impacts. Geographically, the Interior and Fraser regions are going to face significant service gaps. Among priority populations the survey respondents work with, the negative impacts of service loss will be most felt by the Indigenous peoples, women, youth, and people who use drugs.

This survey also informed that the majority of the respondents' organizations who applied to the transitional funding will receive this funding to close projects funded by PHAC in 2014-2017, to write and submit proposals to other funding sources, and/or to hire consultants to develop transition plans. However, only two respondents will receive this funding to relocate staff or project activities to other organizations; and for intersectoral meetings or training opportunities to transfer project knowledge. This adds to the concerns of losing critical region- and community-specific expertise, capacity and infrastructure carried by those organizations and projects that have been previously funded by PHAC but are no longer funded by the new CAF.

With regards to working with PHAC and negotiating through the full proposal process and transitional funding process, as well as the overall CAF process from planning, application, decision-making, to signing of agreements – respondents reported on more negative experiences were reported than positive ones. Respondents expressed feeling frustrated due to timeliness

challenges including delays in feedback by PHAC, as well as lack of reciprocation by PHAC on respecting timelines. Other challenges included communication (e.g. unclear and delayed communication causing confusion), working with the PHAC national office, inconsistency (e.g. changing deadlines and expectations; incongruity between what is listed as eligible expenses for the Transitional Funding and what PHAC representatives deem to be actual eligible expenses), and poor planning and delayed process. On the other hand, respondents' positive experiences related to working with PHAC regional staff and collaborating amongst community-based organizations.

A number of lessons to carry forward in future calls were identified. Particularly, the need for improved communication and a transparent process that builds trust between PHAC and community-based sector was highlighted. Respondents also urged PHAC to improve its reviewing process (e.g. opportunity to review application with a PHAC staff prior to submission) and to be clear and consistent around their expectations to the contracted organizations and partners. Additionally, respondents identified a number of resources that would be helpful for the CAF application process. They include increased access to PHAC staff during application preparation; support from an outside evaluator when developing proposal; increased collaboration between organizations; grant writing support; and peer review.

The survey underscored the roles of the BC health authorities, the Ministry of Health, and the community-based HIV and HCV sectors in responding to the impacts of PHAC CAF results. Advocacy to make aware the irreplaceable and irreversible service and regional gaps resulting from the new CAF decisions was highlighted as the top role for all three parties. Other roles to fill these gaps included for BC health authorities to fund lost services; for the Ministry of Health to partner with PHAC to delineate what programs/services should be funded provincially vs. federally; and for the community-based HIV and HCV sectors to continue the unified and coordinated approach to address the gaps in service provision.

The concern for *undoing* all the hard work the community-based sector did and all the accomplishments the sector has achieved was reiterated in this survey. While the importance of prevention as the new CAF focus is acknowledged, the fear and risks of STBBI spikes as a result of diminished frontline support organizations who hold tremendous expertise in providing care to most marginalized and stigmatized populations should not be underestimated. PAN encourages PHAC to consider the evaluation findings in this report and conduct an evaluation of their own to improve the process of implementing and evaluating the CAF projects, and to improve and minimize any negative unintended consequences in future funding calls.

6.0 References

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