**Collective Impact Network Strategy Meeting Summary**

February 15th, 2017, BC Centre for Disease Control, 655 West 12th Avenue, Vancouver

**INTRODUCTION**

PAN is working in partnership with PHSA to develop a Collective Impact Network to improve HIV and HCV Prevention, Care and Treatment Services in BC. PHSA has contracted PAN to be the organization (“backbone”) supporting this collaborative work of organizations in BC. (More on collective impact below.)

The initial meeting to discuss a collective impact response to HIV and HCV in BC brought together PHSA funded groups on February 15, 2017. The day began with a welcome, territorial acknowledgement, and overview of the day from Drew Hart of the BC CDC. Icebreaker and introductions (Janice Duddy, PAN) led to an overview of the PHSA mandate and decision for collective impact from Drew.

PHSA Rationale for Collective Impact:

* Renewed BCCDC and BC Women’s HIV & HCV service delivery model was built on the principles of the collective impact model for social change.
* Creating a formal network for organizations to identify collaborative opportunities will have greater impact than working in isolation.
* Collective impact is a way to reach PHSA intended outcomes

PHSA long-term outcomes:

* Improve HIV and HCV prevention, diagnosis, linkage to care, and treatment outcomes
* Increase integration of HIV and HCV Services across the continuum of care
* Increase reach and coverage of HIV and HCV Services across the province
* Improve monitoring and evaluation of the impact of contracted agencies
* Reduced duplication and improved collaboration between service partners
* Respond to the shifting needs of the community and epidemic over time

**COLLECTIVE IMPACT PRINCIPLES IN THE CONTEXT OF HIV AND HCV IN BC**

Collective Impact is an approach to social change that uses the strengths of cross-sector and cross-community collaboration to work for change on a shared agenda. This model is structured in recognition that organizations cannot address the complexities of HIV and hepatitis C in isolation, and collaboration will have the most effect on long term social change. As the backbone organization, PAN provides facilitation and support to the network. This new network will complement and enhance the work PAN and PAN member organizations already accomplish, and help to build capacity in other organizations.

There are five foundation components to collective impact, and PAN has added a sixth for the HIV/HCV communities in BC.

**5+1 Components of a Collective Impact Network**

1. Collective Impact starts with a common agenda: what is the issue we need to address? Collective impact starts with identifying a problem and creating a shared vision to solve it
2. Collective Impact uses shared measurement. Shared measurement uses evaluation tools that track progress in the same way in each project towards the common goal. This allows for continuous improvement during the process and towards the end goal.
3. Collective Impact fosters mutually reinforcing activities, a coordination of collective efforts to maximize the end result. Different work projects may be ongoing, but they are all aiming for the same shared agenda.
4. Collective Impact encourages continuous communication, which builds a common language and frame of reference for participants, particularly important when working cross-sectorally. Continuous communication builds education about and trust in the collective impact process and between participants. Continuous communication energizes people in their work and creates connection to the larger effect of their work. Communication also builds capacity and knowledge.
5. Collective Impact has a strong backbone team dedicated to facilitate the work of the group’s shared agenda. The backbone team doesn’t drive the work, but it builds and enhances communications and work development in support of the common agenda.
6. PAN has added a 6th component to the framework: **inclusive decision-making**. Those who have the greatest stake in the agenda get to have a say about goal and how to reach it. Inclusive decision-making uses the principles of GIPA, MIPA and Nothing About Us, Without Us. Those affected have direct say in how they are affected by change.

**PARTICIPANTS AT THE TABLE**

This first meeting to build our work on collective impact was a group representing PHSA (BC Centre for Disease Control and BC Women’s Hospital and Health Centre) and PHSA funded organizations. This group included:

PHSA/ BC Centre for Disease Control: Annelies Becu, Drew Hart

PHSA/ BC Women’s Hospital and Health Centre: Jill Pascoe

PAN: Evin Jones, Stacy Leblanc, Janice Duddy, Mona Lee, Katrina Jensen, Janet Madsen

Community Based Research Centre for Gay Men’s Health: Jody Jollimore

Pacific Hepatitis C Network: Deb Schmitz

Pivot Legal Society: DJ Larkin

Positive Living BC: Ross Harvey, Adam Reibin, Glen Bradford, Elgin Lim

YouthCO: Sarah Chown, Dirceu Campos

Facilitator: Barbara McMillan

Regrets came from Donna Tennant of Positive Women’s Network

Groups introduced their organizations and mandates (see attached presentations for details). In brief:

**Pacific AIDS Network** (Evin)

PAN is a collaborative network of over 50 organizations in BC. PAN provides capacity-building skills development and leadership training for workplaces and people with lived experience of HIV and HCV to strengthen the response to HIV and HCV in BC. PAN also directs community based research and evaluation and serves as the collective voice of PAN members for advocacy issues. PAN already functions as a backbone organization in the province, providing aligned support, communications, skills building and leadership. PAN has the experience and fluidity to move this new approach to work forward.

**YouthCO** (Sarah)

YouthCO is a youth-led HIV and Hep C organization that seeks to reduce stigma related to HIV and Hep C in BC. PHSA deliverables include social and educational groups for youth (in partnership with Oak Tree Clinic); youth participation at Positive Living BC’s annual Positive Gathering; leadership opportunities within the organization; online information for youth with hepatitis C; Camp Moomba for youth infected and affected by HIV. Current challenges include building a peer base for hep C programming; youth indicate they most want in-person experiences, which is a challenge for provincial programming; youth with hep C have limited ace to treatment and care; ongoing stigma.

**Pacific Hepatitis C Network** (Deb)

Pacific Hepatitis C Network works to share information and work in partnerships that will strengthen the capacity of individuals and organizations in BC to prevent new HCV infections and to improve the health and treatment outcomes of people already living with HCV. In addition to ongoing work, Pacific Hep C is partnering with Help4Hep in the US to create Help4HepBC and Canada.

**Pivot Legal Society** (DJ)

Pivot Legal Society is a “strategic litigation organization.” Pivot does intentional work to make the maximum amount of change within its capacity. Currently Pivot is consulting different communities in Project Inclusion-“Stigma and exclusion are not inevitable”. DJ describes this as “ground up listening” to hear what the community has to say. Fundamental questions link to what services are desired and if the services were available, what stands in the way of accessing them?

**Community Based Research Centre for Gay Men’s Health** (Jody)

Community Based Research Centre for Gay Men’s Health (CBRC) focuses on facilitation, advocacy, capacity building and knowledge translation and exchange (KTE). Areas of focus include school based intervention, LGBTQ cultural competency, province-wide prevention, and scaling up services with the results of research findings from MPowerment Prince George, Totally Outright and GetCheckedOnline.

**Positive Living BC** (Elgin, Ross, Adam, Glen)

Positive Living BC is dedicated to empowering people living with HIV through mutual support and collective action. Services include HIV self-management and health promotion (including peer to peer networking and education); technical assistance for regionally-based HIV peer navigation programs (supporting local organizations in different regions of BC to develop peer navigator programs); communications and education with Pacific Hepatitis C Network.

**BACKGROUND: THE STATE OF HIV AND HCV IN BC**

Epidemiological Update, Jason Wong, BC CDC

Power point attached, but to note:

* HIV: 258 cases in 2016 (vs. 239 in 2015); 215 were in males and MSM remains the highest representation of risk. There was an increase in HIV in 20-39 year olds.
* It is predicted that HIV rates will decrease in MSM, heterosexual and people who use drugs risk groups in 2016.
* HCV: About 2300 cases were reported in 2016; a small number of these (101) was identified as an acute case.
* For those with who have been cured of HCV, opioid substitution therapy and ongoing mental health counselling have been shown to be protective against HIV infection and reinfection with hepatitis C.
* The least privileged materially and socially are the most likely to become infected with HCV.

The Community Response to HIV and HCV: Summary of Drug Policy Report, Evin Jones, PAN

Report attached, but to note:

PAN supports a network of over 50 organizations providing HIV and HCV services. In response to the increased demand on PAN’s member organizations meeting the needs of clients who use drugs, PAN’s October 2016 conference featured education on drug policy and the law, harm reduction programs and practices, and safe consumption sites. It also provided a place for open conversation about how the overdose (OD) crisis is impacting PAN members. Voices included people who use drugs, lawyers and advocates, frontline service workers, volunteers and leaders of community organizations. PAN members are dealing with drug related care and overdose care on a regular basis. Conference attendees expressed the need for capacity building in a few areas:

* overdose response training; consistent access to harm reduction supplies
* grief and loss support for frontline workers and peers
* ensure involvement of people with lived experience
* on a larger scale, advocacy for policy change

**DRAFT INTENDED IMPACT STATEMENT:**

**Improving the lives of people affected by HIV and hep C**

**IDENTIFYING ISSUES FOR COLLECTIVE ACTION**

Identifying a common agenda and a shared vision is the start of the collective impact process. What issues lend themselves to joint solutions through a collective impact approach - working together, aligning and coordinating efforts, measuring outcomes and impact? Facilitator Barbara McMillan noted that not all issues identified will lend themselves to joint solutions through a collective impact approach.

A number of overarching issues for action were identified by the group as a whole, and then smaller groups worked on more detailed approaches.

Overarching issues identified by large group:

Inequities

Programs and service in remote and rural areas

Differences in access to prevention, treatment and care in HIV vs HCV

Harm Reduction

Criminalization

Overdose crisis

Expanding harm reduction: supplies, services, treatment. PrEP, overdose response

Stigma

Aging epidemic

Mental Health

Meaningful Inclusion of Lived Experience

Building a common understanding of meaningful inclusion that reflects

Building capacity of those with lived experience, including people who use drugs, people of Indigenous heritage, people of colour, newcomers.

Cultural Competency: LGBTQ and Indigenous competency

Intersections that create risk: foster care, poverty, for example

Issues Identified by Small Groups

|  |  |
| --- | --- |
| **Issues** | **Potential Responses/ Activities** |
| **PEP, PrEP, Inequity to access**  Stigma  Cultural competency and respect  Financial resources  Voices of people with lived experience | Expanding access to PEP and PrEP |
| **Overdose Crisis**  Rural/ remote communities  Stigma  Cultural competency and respect  Financial resources  Voices of people with lived experience | * Expanded access to SCS, including work on legislative policy * Medicalization- prescribed opioid treatment, opioid replacement therapy, medical heroin, cocaine * Decriminalization * Provide support to frontline workers and peers * Universal access |
| **Criminalization of HIV Non-Disclosure** | * Public education and awareness including among the GBSM population (recognize that up to 80% of GBSM are “for” criminalization- SOURCE? Even higher among general population * Influence prosecutorial guidelines |
| **HIV and aging** | * Data gaps: Encourage data collection to continue; cohort studies take years to collect * Do population modelling- 5/10/15 years – and mapping out the anticipated service needs and plan accordingly * Coordinated provincial strategy – unique care needs, research, housing * Rural vs urban challenges |
| **Nothing About Us Without Us**  Including people with lived experience of HIV, HCV, people who use drugs, epi-identified at-risk populations, priority populations | * Working Groups to build accountability mechanism for the entire CI network * Transparent and comprehensive approach to policies and practices including conflicts of interest * Recommendations and governance * Mentorship, leadership, peer support * Remuneration for people * Leadership training * Outside the CI network, and with key partners/ stakeholders such as health authorities and funders, advocating for leadership and inclusion in decision making |
| **Services and Treatment for hep C** | * Advocating for national Pharmacare program * Engage/ educate primary care providers regarding treatment and testing guidelines * Increase the capacity of people with HCV in care * HIV and HCV crosses sectors, language of integration * Create a vibrant community response * Develop HCV billing codes to really track it * HCV training institute |
| **National Work to address** | * OD crisis (SIS, SCS) * Criminalization of HIV non-disclosure * Hep C treatment access |
| **Mental Health** | * Identify, promote and encourage successful mental health programs for people affected by HIV, HCV, people who use drugs, those who are aging. * Map gaps and look at an integrated approach |

**SHARED VISION/AGENDA DISCUSSION**

Based on conversations about the issues, the group felt several things were emerging that had potential for the common agenda

Primary

Collectively define and strengthen meaningful engagement of people with lived experience

Increase program equity and services for HIV and hep C throughout BC

OD crisis/ Harm reduction. There was discussion as to whether the OD crisis should be an issue in and of itself (“Contribute to reducing unnecessary harms and deaths from overdose crisis”) or placed under harm reduction as an overarching issue that would also include PrEP.

Secondary

Stigma reduction

**CONCERN WITH SHAPING PRIORITIES FOR A COLLECTIVE RESPONSE**

As facilitator Barbara noted, not all issues identified will lend themselves to joint solutions through a collective impact approach. Concerns were raised as the group began to explore the issues and the work that would be needed to address them. People felt:

* Organizational mandates aligned and misaligned with issues identified
* Collective impact work would lead to increased workloads
* People who should be decision makers at the table weren’t present

Jill (PHSA/BC Women’s Hospital and Health Centre) provided the PHSA rationale for using the collective impact model in context of these concerns:

* Collective impact will be used to identifying and aligning common goals of PHSA groups
* PHSA funded groups have shared commitment to PHSA long-term outcomes
* Collective impact can help identify potential partnerships among PHSA groups to reach goals; how can groups help each other with their work?
* Working in partnership and support will increase the overall impact of work
* PAN to bring PHSA groups together and add other voices at table as needed to achieve identified goals

**SHARED MEASUREMENT MODEL**

Shared measurement is a component of collective impact; it will also be a component of all of the PHSA funded groups. Janice Duddy (PAN) and Annelies Becu (PHSA/BCCDC) are working on frameworks that will have some shared measurement markers for individual programs as well as evaluation of the Collective Impact Network. This evaluation development work is in process, and will be piloted before it is implemented in full.

Power point attached.

**PERCEPTIONS OF THE DAY**

Participants reported they ended the day feeling “optimistic, appreciative, tired, apprehensive, and hopeful, all the while cognizant that “this is a complicated group and issues.” Other concluding thoughts and reported feelings about the day:

Curious (several said this)

[This is a] necessary conversation / happy for conversation

Lots to absorb; good stuff happened

Great potential/ excited

Big step/ big journey

Appreciative/ contemplative /

Productive

All the possibility

Anticipatory/ anxious/ overwhelmed/ apprehensive

**NEXT STEPS**

While the group didn’t achieve all that was set out to in the agenda, sufficient work was developed to identify some next steps:

* PAN and PHSA will debrief with facilitator, develop record of meeting and plan next steps
* Next meeting will be by the end of April
* A representative from PHAC will be invited to next meeting

**Attached presentations and reports:**

Epidemiology Update: HIV and HCV

Shared Evaluation