



Community Solutions
Planning & Evaluation

Facilitating Outcome Evaluation Among HIV/AIDS Service Providers in BC

Prepared for
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February 2008

Executive Summary

The PHSA HIV/AIDS Program has recently adopted a leadership role in developing tools and capacity to promote the use of evidence-based practice among HIV/AIDS service providers in BC. As part of this initiative they commissioned a needs assessment regarding outcome evaluation with the intent of eventually developing a provincial evaluation resource that will support all HIV/AIDS service providers in the province. The following report documents consultations with HIV/AIDS service providers regarding their need for support with outcome evaluation and highlights other evaluation resources provided across Canada.

A total of 66 stakeholders were consulted via 15 individual phone interviews and three facilitated consultation sessions. An additional 14 phone interviews were conducted with key informants regarding existing models of evaluation support across Canada.

Major findings demonstrate that outcome evaluation among HIV/AIDS service providers in BC, including regional health authorities, varies depending on an agency's capacity. Although HIV/AIDS service providers recognize the need for accountability and wish to know if they are making a difference, outcome evaluation is usually conducted on a minimal and ad-hoc basis due to various constraints. Most evaluation activity is process-oriented with a focus on collecting data regarding outputs (i.e. units of service), and there is little interpretation or use of this data. Very few service providers describe evaluation, both process and outcome, as playing a significant part in the program planning process. Further, ASOs and PHSA community contractors do not make a distinction between 'evaluation' and 'reporting to the funder'. Evaluation is largely perceived as a reporting exercise rather than an activity that benefits the organization.

HIV/AIDS service providers in BC face significant barriers in conducting outcome evaluation including a lack of time, staff, funding, knowledge and expertise, common outcome measures, and information technology. Other frustrations and disincentives include different reporting requirements among funders and not seeing their evaluation results used in meaningful ways. Additional evaluation challenges specific to the field of HIV/AIDS are associated with engaging and tracking clients, measuring the impact of prevention activities, the broad range of services provided, providing service in rural areas, and the high staff turnover in ASOs.

When outcome evaluation does occur, it is largely because there is funding and/or staff time available, it is made a requirement by the funder, and there is access to expertise and data collection tools. It is also facilitated by building evaluation into the front-end of program planning, having an organizational culture that values evaluation, and accreditation.

HIV/AIDS service providers in BC are pleased to see the PHSA take a leadership role in developing a provincial evaluation resource. Suggestions for increasing outcome evaluation include more financial resources, a provincial evaluation resource person(s), standardized data collection and reporting forms, outcome evaluation software, information technology upgrades, clear and realistic guidelines from funders, greater knowledge transfer exchange, and staff training. Service providers stress that a provincial evaluation resource should remain simple and not take resources away from actual service delivery. Aboriginal service providers also emphasize that it should respect OCAP principles of ownership, control, access and possession.

Five existing models of evaluation support from across Canada were investigated: a provincial resource person, online reporting tools, outcome evaluation software, an academic research partnership, and accreditation. The experience of other provinces emphasizes the importance of involving stakeholders fully in the development of any form of evaluation support.

In BC, possible options to facilitate greater outcome evaluation among HIV/AIDS service providers include a provincial evaluation resource person(s), standardized online data collection and reporting, and HIV/AIDS specific accreditation.

It is recommended that PHSA establish a Provincial Evaluation Working Group that can further discuss options for a provincial evaluation resource and begin to develop ownership of the process. Membership on this working group would include broad representation from ASOs, PHSA community contractors, regional health authorities, PHSA, Ministry of Health, PHAC, and other stakeholders. The activities of a Provincial Evaluation Working Group should ideally be supported by a part-time coordinator to ensure the process moves forward in a timely manner. It is also recommended that federal and provincial HIV/AIDS funders, through a separate sub-committee of a Provincial Evaluation Working Group, meet to formally discuss the feasibility of harmonizing and streamlining reporting tools.

A Provincial Evaluation Working Group is advised to involve stakeholders from the beginning, start small, build on existing data collection and reporting tools, and budget adequately for stakeholder consultation, training, promotion, and knowledge transfer exchange activities.

Acknowledgements

It has been a distinct pleasure for Community Solutions to conduct this needs assessment for the Provincial Health Services Authority of BC. The interviews and consultation sessions were extremely productive and I wish to thank all of the participants and key informants for their time and thoughtful answers to my questions.

I am most grateful to Kim Louie, Jill Doctoroff, William Booth, Amrit Rai, and Darren Cound for their support in arranging the consultation sessions. I would also like to thank Michelle de Cordova and John Dube for their additional assistance and insights.

Finally, I would like to thank Janice Duddy of the PHSA for the privilege of conducting this research and I look forward to discussing the results in order to chart the course ahead.

Respectfully,

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Contents

Introduction	9
Methodology.....	11
Benefits of Outcome Evaluation	13
Results.....	14
Outcome Evaluation Activity.....	14
ASOs and PHSA Community Contractors	14
Regional Health Authorities.....	15
Factors Facilitating Outcome Evaluation.....	16
Challenges with Outcome Evaluation.....	16
Suggestions to Increase Outcome Evaluation	18
Models of Evaluation Support.....	19
BC Community Based HIV/AIDS Research Capacity-Building Program.....	20
PERT.....	21
OCHART	22
CLEAR	24
Alberta Community Council on HIV	25
HOMES Evaluation Software	26
Accreditation/Lower Mainland Purpose Society	28
Conclusions	30
Recommendations.....	32
Glossary.....	33
Appendix A.....	35
List of Stakeholders Interviewed	35

Introduction

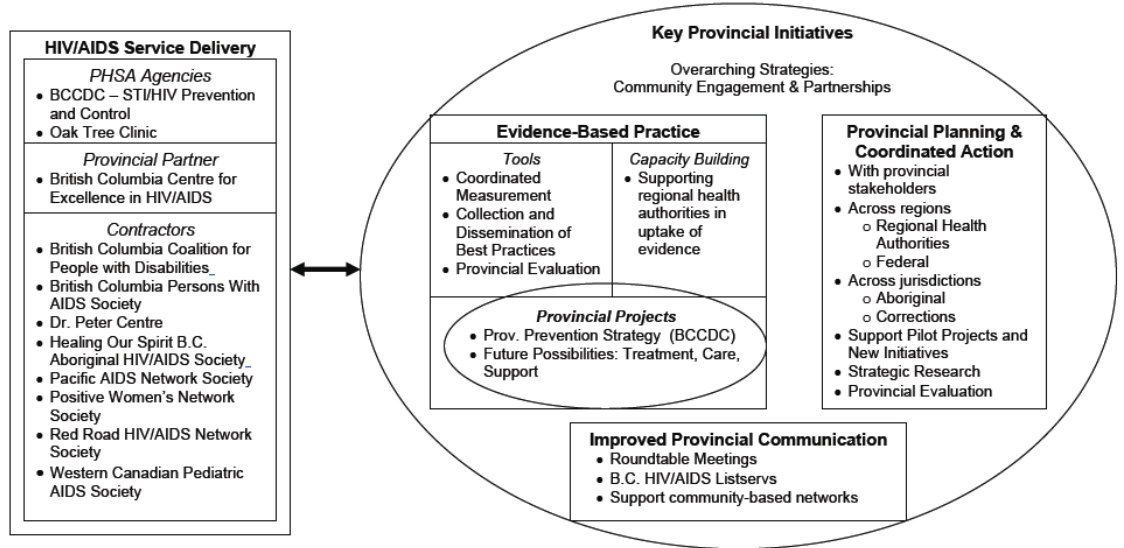
The Provincial Health Services Authority (PHSA) plays a leadership role in supporting the delivery of effective and high-quality province-wide health care programs and services, including those addressing HIV/AIDS. Traditionally, the PHSA's HIV/AIDS Program has functioned under two mandates: service delivery through contracted agencies and provincial partners, and supporting the work of the regional health authorities.

In October 2006 the PHSA HIV/AIDS Program released a new strategic framework entitled, *Collaborating for Action: Provincial Health Services Authority HIV/AIDS Strategic Framework*. This document outlines an expanded mandate for the HIV/AIDS Program with respect to a number of key provincial initiatives:

- **HIV/AIDS Service Delivery** – provided through PHSA agencies, provincial partnerships, and through contracted services.
- **Fostering Evidence-Based Practice** – provide the tools and capacity for the province to respond to the epidemic using evidence and best practices in order to ensure the most effective and efficient approach.
- **Provincial Planning and Coordinated Action** – with a focus on action, develop policy, address jurisdictional issues, and provide space for all those working on HIV/AIDS in the province to work together to plan as a unified team.
- **Improved Provincial Communication** – improve communication between all stakeholders working on HIV/AIDS in the province. This will support the work of the other roles of the HIV/AIDS Program.

To fulfill this second function of fostering evidence-based practice among HIV/AIDS service providers, the HIV/AIDS Program is taking a leadership role in working to develop tools and capacity (see Figure below). To this end, they have commissioned the following needs assessment regarding outcome evaluation with the intent of eventually developing a provincial evaluation resource that will support increased outcome evaluation among all HIV/AIDS service providers in the province.

Facilitating Outcome Evaluation Among BC HIV/AIDS Service Providers



The following report documents consultations with HIV/AIDS service providers in BC regarding their need for a provincial evaluation resource and presents other models of evaluation support provided across Canada.

Methodology

Needs Assessment

A total of 66 stakeholders were consulted via 15 individual phone interviews and three facilitated consultation sessions. Stakeholders included were:

- AIDS service organizations (ASOs) representing small and large, urban and rural, and aboriginal and non-aboriginal agencies (22)
- other PHSA community contractors (8)
- regional health authority HIV/AIDS contract managers (7)
- Ministry of Health managers (1)
- Public Health Agency of Canada (PHAC) evaluation consultants (1)
- evaluation consultants working with ASOs (1)

A complete listing of stakeholders is presented in Appendix A.

Fifty-one individuals attended three consultation sessions held between November 2007 and January 2008. The first session was one and a half-hours long and occurred during a Red Road HIV/AIDS Network Quarterly Skills Building Session in Parksville. The second consultation was two hours in length and occurred during a Fraser Valley Regional HIV/AIDS Committee meeting in Surrey. The last consultation was similarly two hours long and was convened with members of the Community HIV/AIDS Committee (C-HAC) in Vancouver.

During both the phone interviews and consultation sessions, stakeholders were asked to comment on:

- what types of evaluation activities they currently doing
- what types of challenges and barriers they experience with respect to outcome evaluation
- what types of evaluation resources would encourage them to do more outcome evaluation

Prior to conducting the interviews and consultation sessions participants were informed about confidentiality and how the results would be used.

Models of Evaluation Support

Another 14 phone interviews were conducted with existing models of evaluation support across Canada. Models were identified either through information referrals obtained during the stakeholder interviews or were provided directly by PHSA. The models were

examined in terms of their purpose, format, operational costs, time to implement, effectiveness, sustainability, accessibility, and appropriateness with respect to BC's own needs. Each model was then written up as an example case study highlighting some of the benefits and challenges experienced as well as recommendations for implementation.

Benefits of Outcome Evaluation

Conducting an assessment of the evaluation activities of HIV/AIDS service providers implicitly infers that program evaluation is both a necessary and beneficial practice, and indeed, the experience of many organizations has shown this to be true. Program evaluation is formally defined as:

... the systematic collection and analysis of information about program activities, characteristics, and outcomes to make judgments about the program, improve program effectiveness and/or inform decisions about future programming.¹

Practice over time has demonstrated that evaluation, both process and outcome-oriented², can be useful for:

- confirming attainment of goals and objectives
- assessing program impacts
- maintaining program quality
- improving service delivery
- identifying strengths and weaknesses
- highlighting areas for expansion of a successful program
- pinpointing problems of a struggling program
- keeping a program focused and on track
- promoting informed decision-making
- justifying budget allocations
- ensuring accountability to program stakeholders
- retaining or increasing funding
- assessing cost-effectiveness and efficiency
- clarifying mission, purpose and goals
- identifying staff and volunteer training needs
- increasing staff participation in the planning process
- enhancing positive publicity
- recruiting and retaining skilled staff

¹ Patton, M.Q. (1997). Utilization-focused Evaluation. Sage Publications.

² See Glossary on page 33 for definitions of common evaluation terms.

Results

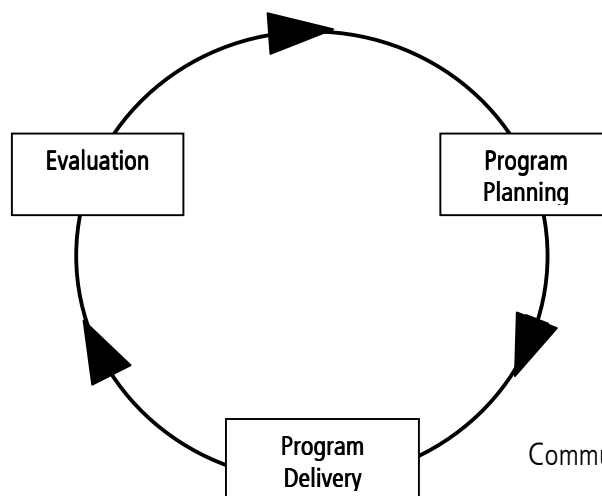
Outcome Evaluation Activity

a) ASOs and PHSA Community Contractors

Outcome evaluation among ASOs and other PHSA community contractors varies greatly depending on an agency's size and capacity. Overall, however, and with the exception of agencies that are accredited, it is usually conducted on a minimal and ad-hoc basis due to various challenges detailed below. Most evaluation activity is process-oriented with an emphasis on tracking output data, i.e. units of service. Outcome evaluation assessing the overall impact or changes as a result of a program is more likely to occur if a program is new, controversial, high priority, short-term, or at risk of funding cuts.

Data collection is predominantly quantitative versus qualitative largely because of the focus on outputs described above plus a lack of expertise in qualitative research. ASOs are conscientious data collectors, however, they acknowledge there is little subsequent interpretation or use of this data. As one stakeholder stated, *"Sometimes it seems like we're collecting data just for collection's sake."* Similarly, very few ASOs described evaluation, both process and outcome, as playing a significant part in the program planning process [see Figure below]. Rather than feeding evaluation results back into programming decisions (e.g. "Plan-Do-Study-Act"), it often seems to be a stand-alone activity that agencies scramble to complete under difficult circumstances. ASOs recognize the need to be accountable and clearly want to know if they are making a difference, but the focus of their energy appears to be on reporting outputs to the funder rather than monitoring outcomes for the benefit of the agency. It is interesting to note that rarely during these consultations did ASOs make a distinction between 'evaluation' and 'reporting'. In some cases, confusion was also observed around the use of basic evaluation terminology.

Figure: Simplified Program Planning Process



Only one of the thirty ASOs and PHSA community contractors consulted reported having an in-house evaluator. Some will contract an external evaluator when there are funds available or it is important to have an objective third party perspective.

b) Regional Health Authorities

There is similarly very little structured evaluation of HIV/AIDS services within the regional health authorities, both internally and externally with their community contractors. However, HIV/AIDS contract managers clearly recognize of the importance of addressing this issue. In 2002 the Ministry of Health transferred all contracts with community-based HIV/AIDS service providers to the newly created regional health authorities. The scope of this reorganization was such that many regional health authorities have not had the opportunity to renegotiate new contracts with their community contractors to date. Contract managers acknowledge that their evaluation expectations are not always clear and several have articulated a desire to develop a more structured evaluation process once these contracts are re-negotiated.

All contract managers receive some form of quarterly report from their community contractors, again with an emphasis on outputs, i.e. service delivery statistics. Vancouver Coastal Health, the Vancouver Island Health Authority, and Fraser Health each provide their community contractors with Microsoft Excel templates of varying length outlining established reporting criteria for tracking. In some cases, these templates ask for only a fraction of the total data that ASOs are known to collect. Contract managers are then required to summarize this basic output data along with their own internal programs and transfer it into a data collection workbook developed by the Ministry of Health. For some contract managers, this means collating data by hand which can be very time-consuming.

Although none of the regional health authorities have a dedicated position for evaluation (with the exception of Vancouver Coastal Health who has a performance management position that focuses on the reporting of outputs), all have access to surveillance and research staff who can partially assist with evaluation.

Factors Facilitating Outcome Evaluation

HIV/AIDS service providers were asked to comment on what factors facilitated outcome evaluation occurring in their agency. Their responses included:

- time
- funding
- when it is a requirement of funding
- resources and support from the funder (e.g. PHAC)³
- access to evaluation expertise (internal and/or external)
- leadership support
- contracting an evaluation consultant
- an organizational culture that values evaluation
- staff and stakeholder buy-in
- seeing their evaluation results used in a meaningful way
- building it into the front-end of program planning and budgeting
- access to data collection tools
- access to simple and accessible technology
- accreditation
- using a simple evaluation design

Challenges with Outcome Evaluation

Service providers were also asked to identify what challenges or barriers they have experienced with respect to outcome evaluation. The most common responses were:

- lack of time
- lack of staff
- lack of funding
- lack of knowledge and expertise
- lack of information technology to collect data
- different reporting requirements among funders
- unclear expectations from funders
- lack of common outcome measures
- not hearing back from funders, feels like a meaningless exercise

Additional responses included:

- staff resistance, benefits of evaluation not understood/appreciated
- confusion around basic evaluation terminology

³ Programs funded under the AIDS Community Action Program (ACAP) receive dedicated evaluation funds (approximately 10% of the total program budget) plus support from a PHAC Evaluation Consultant.

- lack of expertise in qualitative research
- difficult to measure impacts of prevention
- unrealistic expectations of what a program can achieve in the short-term
 - overemphasis on long-term outcomes
 - trying to demonstrate attribution versus contribution
- unrealistic expectations for evaluating small grants
- divergence between outputs and outcomes important to funders versus ones important to ASOs
- challenges with engaging and tracking clients:
 - marginalized
 - transient
 - ill state of health
 - low literacy
 - language and cultural barriers
 - over-researched
 - equate evaluation with surveillance of the individual
 - confidentiality issues
 - HIV interventions are often short, serve multiple purposes, and take place in difficult circumstances (e.g. the street)
- scope of HIV/AIDS services in BC is broad with respect to:
 - population served
 - services provided
 - geography
- external evaluation consultants
 - lack clients' trust
 - don't understand the program at the same level as staff
 - don't build internal capacity
- quarterly reporting is unmanageable
- lack of creativity allowed in reporting to funders
- high staff turnover in ASOs
- political versus evidenced-based decision-making causes staff to lose faith in the usefulness of evaluation
- truly rigorous outcome evaluation uses sophisticated, long-term, and expensive research designs
- lack of qualified consultants in rural areas
- HIV/AIDS services in rural areas are closely integrated with other services making them harder to evaluate

Suggestions to Increase Outcome Evaluation

Service providers were pleased to see PHSA take the lead on this issue and offered several suggestions of ways to increase the amount of outcome evaluation being conducted. They strongly emphasized that any type of evaluation support developed must be simple, practical, and not divert already scarce resources from service delivery. Aboriginal service providers also emphasize that it should respect OCAP principles of ownership, control, access and possession. These suggestions included:

- financial resources
 - ensure that evaluation is a standard budget line item
- human resources
 - internal and external
 - a provincial evaluation resource person
- harmonized and streamlined funder reporting forms
- clear, realistic guidelines and expectations from funders
- standardized, yet flexible, data collection tools
- information technology upgrades
- evaluation software, e.g. HOMES (see pg. 26)
- training
- greater knowledge transfer exchange from funders to increase appreciation and commitment to evaluation
- embedding evaluation practice into program planning and delivery
- evaluation champions who can build a culture of appreciation
- accreditation
- basing programs on evidence and best-practices established in the literature (in the absence of funds to conduct rigorous outcome evaluation)
- more emphasis on contribution versus attribution of effect on long-term outcomes
- list of evaluation consultants who work around the province, including rural regions
- opportunities to share best practices in evaluation

Models of Evaluation Support

The following case studies describe five existing models of evaluation support in Canada: a provincial resource person, online reporting tools, an academic research partnership, outcome evaluation software, and accreditation. The examples originate from British Columbia, Alberta, Ontario, and nationally. When choosing these case studies attention was paid to focusing on resources that go beyond the provision of a simple manual or training opportunity. Table 1 on page 29 presents a quick overview of each model in terms of its format, approximate cost, source of funding, time to implement, sustainability prospects, and accessibility.

Case Study #1 – Provincial Resource Person **BC Community Based HIV/AIDS Research Capacity-Building Program**

The Community-Based Research (CBR) Capacity-Building Program is a national program funded by the Canadian Institute for Health Research (CIHR) designed to improve the skills of ASOs in designing, implementing, and disseminating community-based research through the provision of a 'CBR Facilitator'. The role of a CBR Facilitator is to work collaboratively with ASOs to identify and coordinate a wide-range of initiatives that incorporate community-based research.

In BC, the CBR program is hosted by BCPWA. The present CBR Facilitator, Francisco Ibañez-Carrasco, works with approximately eight to ten ASOs at any one time on short-term projects of varying scope. While the CBR Facilitator does not conduct the actual research, assistance may be provided at all stages of a project including proposal development, brokering partnerships, development of tools, and knowledge transfer into policy. Projects are chosen on a first-come, first-served basis, with an emphasis on ASOs located outside of Metro Vancouver. The program began in 2003 with a grant of \$80,000 and is now on its third funding cycle

with CIHR. The present budget of \$85,000 does not include funds that ASOs must individually raise, with Ibañez-Carrasco's assistance, from other funding agencies to actually conduct the research.

Ibañez-Carrasco notes that his first year in the position was largely spent on marketing and promotion in order to raise the awareness and understanding of CBR among ASOs and develop trusting relationships. Today, demand for his services is high. To accommodate this demand, he has integrated a community service internship component into the program through his connections with the Health Research and Methods Training Facility (HeRMeT) at Simon Fraser University and the School of Social Work at the University of British Columbia. Both undergraduate and graduate students are matched with appropriate CBR research projects. The CBR program also relies on volunteers provided through BCPWA.

Benefits

An evaluation of the CBR program conducted in 2006 concluded that ASOs were satisfied with the program and felt that the CBR Facilitator was

a valuable resource. Further, ASOs believed they had acquired better research skills through the mentoring of the CBR Facilitator.

Challenges

One challenge Ibañez-Carrasco has experienced with the program is convincing ASOs of the value of CBR. He has also had to correct a misperception among some ASOs that the service was only available to BCPWA. Lastly, over time he has observed that some of the individual staff he has mentored to build capacity have moved on to use their new skills elsewhere.

Recommendations

Ibañez-Carrasco estimates that approximately 40% of all the research projects conducted through CBR to date could be classified as program evaluation. Asked if he thinks such a program model would work for building evaluation capacity, Ibañez-Carrasco responds positively. However, he cautions that adequate time be allocated in the beginning stages to develop relationships with ASOs and increase their understanding of the benefits of evaluation for themselves, their organization, and their clients.

Case Study #2 – Online Reporting Tools

PERT

PERT (Project Evaluation and Reporting Tool) is a reporting tool developed in 2006 by the Public Health Agency of Canada (PHAC) to help monitor and document the effectiveness of PHAC-funded community-based projects. When PHAC was formed in 2004, it became evident that standardized data collection was needed to help evaluate population health programs across the country. PERT was developed as a self-administered, common data collection tool with questions relevant to all community-based programs.

PERT was developed through an extensive two-year consultation and pilot testing process with both internal and external PHAC stakeholders. The tool covers eleven categories: Monitoring, Resources And Sustainability (Financial, Human, And Other), Partnerships, Target Population Involvement, Education/Awareness/Outreach Activities, Training For Paid Staff And Volunteers, Media Coverage, Action On Policy, Project Outcomes, Evaluation Reporting And Dissemination, and PHAC Project Support. In addition, individual program areas within PHAC such as the AIDS Community Action Program (ACAP) have developed tailored questions to assess their specific

outcomes. Once a funded-project has completed PERT, either on paper, electronically, or online, it goes to a PHAC Program Consultant who reviews it and forwards it on to a PHAC Evaluation Consultant. The Evaluation Consultant then collates and analyzes the data to produce a regional report, which is then shared back with funded projects and internal and external stakeholders.

Mustafa El-Kobtan, Evaluation Consultant with PHAC, notes that PERT is both a reporting tool to meet accountability requirements and also a data collection tool to help demonstrate the effectiveness of community initiatives. PERT draws directly on research from PHAC's *Effectiveness of Community Interventions Project* that investigated what common indicators are required to measure the effectiveness of community interventions. For example, outcomes for ACAP-funded programs focus on changes in knowledge, attitudes and behaviours specific to HIV and Hepatitis C. However, it is important to note that PERT does not actually assist with the measurement of these identified outcomes, it only asks for a report on which ones have been achieved. Therefore to help agencies further, PHAC has

recently conducted a literature review for each program area and developed a compilation of valid and reliable tools to measure the impact of common interventions. This listing will be posted on a website and made widely available to the community.

All ACAP funded-projects in BC have participated in the PERT pilot. PHAC is now in the second phase of the pilot, having finished confirming the validity of the measures and clarifying some of the definitions and questions. Once the second phase of the pilot is completed, PERT will become obligatory for all ACAP-funded projects. Although it was initially designed to be completed every quarter, there is some discussion that this may switch to semi-annually.

Benefits and Challenges

While El-Kobtan acknowledges that completing PERT can be a lengthy process, he reports that most of the funded projects involved in the pilot have said it gave them the opportunity to streamline their data collection processes and strengthen their evaluation capacity. These projects have also appreciated receiving the aggregated data back in a regional report format.

Case Study #3 – Online Reporting Tools

OCHART

In 2003, the AIDS Bureau of the Ontario Ministry of Health and Long Term Care and the Ontario Region of PHAC launched the *Ontario Community HIV/AIDS Reporting Tool (OCHART)* initiative (www.ochart.ca). One of the main drivers of OCHART was a realization that the province lacked the data needed to properly identify emerging trends in HIV/AIDS and plan responsive services. Secondly, reporting requirements for ASOs were onerous, with two levels of governments asking organizations to complete similar reports. Working collaboratively with ASOs, the AIDS Bureau and PHAC struck a provincial working group and contracted with the Ontario HIV Treatment Network (OHTN) to assist in the creation of a common reporting tool.

Development of OCHART was a three-year process, during which extensive consultation and training occurred with ASOs. In order to ensure that agencies had the technical capacity to use OCHART, a needs assessment was conducted and the AIDS Bureau provided significant technology upgrades for some ASOs. ASOs are now required to submit OCHART reports online twice a year, in April and October.

Alignment with PERT

Although OCHART and PERT serve similar purposes, OCHART was already in use for two years when PHAC introduced PERT as a pilot. Therefore, PHAC Ontario Region decided to continue using OCHART

instead of adopting PERT. However, they recently hired a consultant to compare the two forms who concluded that OCHART collects more extensive data than PERT but is less detailed with respect to outcome measurement. As a result they will be making some small revisions to OCHART to ensure it aligns as much as possible with PERT. In order for PHAC Ontario Region to report on PERT, the data from OCHART will be exported into the PERT database as a backend activity.

Knowledge Transfer Exchange

An important component of OCHART has been knowledge transfer exchange. For two years now, PHAC and the AIDS Bureau have held *Knowledge Transfer Exchange Days* where executive directors from 75 ASOs are invited to review and discuss a summary data report entitled *The View From the Frontlines*. This annual report presents aggregate OCHART data for the province and provides a picture of trends in HIV/AIDS service and outcomes. ASOs have reportedly been extremely pleased with this report and appear to appreciate the value of reporting even more as a result. They have since requested the ability to extract agency-specific data from OCHART, which is currently in development. It is hoped that once agencies are able to instantaneously extract their own data they will be even more committed to using OCHART.

Benefits

The annual operational cost of OCHART is approximately \$150,000 a year, which includes management of the database by OHTN plus the knowledge transfer conference and annual summary report. From the funders' perspective, OCHART has meant more timely and accurate data on the broader health and social needs of clients, the types of services being provided, regional differences in need, and emerging trends. Anita Fervaha, PHAC Program Consultant, notes that the reaction of ASOs to OCHART has been mostly positive and observes, "*The community had been asking us to move ahead in evaluation for many years, and now I feel we've finally caught up with that.*"

Lori Lucier, Executive Director of the AIDS Committee of Toronto (ACT), a large urban ASO, says that having a combined provincial and federal reporting form is "*great*". During the first year ACT had to change their database significantly in order to align it better with OCHART, which she says was a "*huge effort*". However, she notes that the ease of submitting their report has improved greatly the second time around. Now that they have done it twice she is looking forward to doing some internal benchmarking and comparisons within her own agency. John Maxwell, Director of Special Projects at ACT, also likes the fact that he can easily pull statistics from OCHART to assist with

program planning and revenue development.

Challenges

Challenges observed with OCHART have been mostly technical. There were some problems faced with the volume of submissions on the first official reporting deadline, which have since been resolved. Secondly, smaller ASOs tend not to be as advanced with information technology and have reported difficulties using it. Another challenge has been staff who are uncomfortable with the use of technology in general. As a result, a significant amount of time and resources have been directed towards training, including webcast trainings for staff in outlying regions. High staff turnover in ASOs also presents a problem with agencies having to constantly train new staff. In response, OHTN has developed an online training component that can be used at anytime.

Varying interpretations of OCHART questions and categories has also been an issue. For example, questions assessing the amount and type of financial assistance provided to clients may be interpreted in many ways by different ASOs. For this reason, Lucier of ACT admits to being somewhat skeptical of the data at times, knowing the difficulties they themselves went through trying to

adapt their own data to the OCHART form. Mark Fisher, Manager of Data Systems at OHTN, acknowledges that the data is only as good as what is entered and that OCHART needs to continue to develop more clarity and common definitions around certain questions. Lucier also notes that while most ASOs are comfortable seeing aggregate provincial data, some may be less comfortable with the prospect of seeing comparative data between regions or agencies.

Another challenge became evident after the first trial run in 2006. While the AIDS Bureau tends to fund organizations as a whole, PHAC only funds specific programs through ACAP. Since OCHART was designed for ASOs to enter data at an organizational level, PHAC was not able to extract data on individual programs, making it difficult to assess their particular impact. This issue was resolved by integrating the PHAC logic model into OCHART and asking ACAP-funded programs to complete their logic model online as part of the OCHART submission process. This information is then automatically rolled up into OCHART, thus allowing PHAC to extract specific ACAP data.

Recommendations

Fervaha advises those considering something similar to build on existing reporting tools that ASOs are already familiar with. For example, OCHART was largely based on a long-standing activity report that AIDS Bureau-funded programs were required to submit quarterly. She also strongly recommends involving ASOs from the outset and including a significant consultation, training, and knowledge transfer exchange component. Lucier warns others not to underestimate the fear that some ASOs will have around common data collection and information technology and stresses the importance of having a mutual basis of understanding of database categories and definitions. Fisher recommends that questions be developed fully before designing the database platform.

The AIDS Bureau and PHAC Ontario Region view OCHART as an evolving tool with feedback from ASOs continually being incorporated into upgraded versions. ASOs have since asked for a common client management database that can feed directly into OCHART and track clients from agency to agency. This database is currently in development at a cost of \$300,000 and will be piloted at 25 agencies this coming year.

Case Study #4 – Academic Research Partnership CLEAR

The Community-Linked Evaluation AIDS Resource (CLEAR) was formed in 1999. Funded by the Ontario AIDS Bureau and based at McMaster University, CLEAR was designed to be a multi-disciplinary research unit with a mandate to *“provide equitable access to evaluative services and expertise to increase the effectiveness, efficiency, and relevance of ASOs and HIV/AIDS programs ...and ...promote the use of research and evaluation.”*

CLEAR received \$1million in funding annually and consisted of one director/main investigator, ten part-time faculty, one part-time health economist, one part-time statistician, two research assistants, and two secretaries. Approximately 30% of its annual budget was directed towards ten faculty researchers and the remaining 70% towards administration, research assistants, and other infrastructure. Since CLEAR was physically located in McMaster’s Systems-Linked Research Unit, it was able to take advantage of certain operational economies of scale between the two departments. Participating ASOs also received grants of \$5,000 to \$10,000 to help offset the time staff spent on evaluation.

The activities of the CLEAR research team were overseen by a committee consisting of ASO representatives, the CLEAR

investigators, AIDS Bureau staff, and other stakeholders in HIV/AIDS research. Research areas included organizational capacity, information systems, recruitment and retention of volunteers, prevention, supportive care, and costing. Community input into these research priorities was provided through representation on the CLEAR Committee and through direct contact with participating ASOs.

Benefits

Over its lifetime, CLEAR worked on 176 collaborative research projects with 56 community-based ASOs. CLEAR research findings have been published and presented in peer-reviewed journals, research abstracts, conferences, and a working paper series. CLEAR investigators believe that the unit was successful in developing a greater research perspective among ASOs and greater use of evidence-based planning to improve service delivery. They also note the development of an ASO activity tracking mechanism as another achievement. A third-party evaluation conducted in 2002 following the first funding cycle also found that the unit was effective at increasing ASO’s understanding of research and evaluation and increasing overall evaluation activities within ASOs.

Challenges

Major challenges cited in operating CLEAR included bridging the distinct cultures of community and academia, developing trust with ASOs, and high staff turnover in ASOs. Another significant challenge was accommodating the research priorities of both the ASOs and the CLEAR investigators. Since much of what the ASOs wanted to know wasn’t directly publishable in academic journals, CLEAR investigators worked to broaden specific ASO research questions to a higher level in order to meet the needs of both.

In March 2007, after eight years and two funding cycles, the AIDS Bureau chose not to renew the CLEAR contract, citing a desire to see more evaluation occur at the individual program level versus the broader system level. The CLEAR Provincial Advisory Committee has evolved into an ASO Evaluation Working Group, which is now being consulted on provincial evaluation needs. To date, approximately 10% of the original CLEAR funding has been re-directed towards OCHART and approximately 30% towards the development of a common client-management database. The ASO Evaluation Working Group has also conducted a needs assessment and will be making recommendations regarding the remaining funding shortly.

Case Study #5 – Outcome Evaluation Software Alberta Community Council on HIV

The Alberta Community Council on HIV (ACCH) is an umbrella organization of thirteen ASOs that, similar to the Pacific AIDS Network in BC, presents a unified voice on provincial HIV issues in addition to working in the areas of training, community and organizational development, and community-based research. An additional responsibility of ACCH is stewardship of the Alberta Community HIV Fund (ACHF). This fund employs a joint fund disbursement model whereby funding from PHAC and Alberta Health and Wellness is pooled and administered in a single contract to ACHF. ACHF, in turn, is responsible for allocating these funds every three years. Under this arrangement, agencies report directly to ACHF, who then submits one single report to PHAC and the province. This unique funding arrangement was the impetus for the development of a common provincial HIV/AIDS evaluation framework for all thirteen ACCH partner agencies.

HOMES Project

In 2004 ACCH partner agencies requested standardized data collection and reporting to help with outcome measurement. ACCH formed an Evaluation Working Group which included representation from each service type and region in the province. Using the provincial evaluation framework already developed, the working group began to identify common outcome measures based on what each agency was already

collecting as well as the outcomes and indicators identified in the shared evaluation framework.

The next step was to select a database platform. The working group ultimately chose the HOMES software developed by the Canadian Outcomes Research Institute (CORI) in Calgary. HOMES is a management information system that assists agencies with data collection for outcome measurement and other types of evaluation (see “HOMES” below). The working group saw HOMES as having several advantages over other systems: it is widely-known and popular in Alberta, it was already being used by some of their partner agencies, it runs on Internet Explorer and didn’t require computer upgrades, and the support services from CORI were affordable. In addition, HOMES allowed each partner agency to develop custom data collection templates for their specific programs in addition to the common templates created by the working group.

ACCH partner agencies then proceeded to work with CORI staff to design standard survey templates on HOMES that linked directly with the outcome measures identified in their provincial evaluation framework. These survey templates have integrated some, but not all, elements of PERT. In the future, partner agencies will also be able to submit their narrative reports directly through HOMES so ACHF will be able to

easily combine them into one report to the funders. The next task of the working group will be to map out common output data for collection. It is important to note, however, that although ACHF-funded agencies will be required to use HOMES to submit a narrative report, they have not been forced to use HOMES to collect other data. While some are using HOMES extensively, others have chosen to complete the outcome surveys on paper.

Benefits

Ellie Colver, Program Director with ACCH, believes that the HOMES initiative has had several benefits for their partner agencies. It is now easier for ACCH to get a clearer picture of their provincial impact. She also observed how the process of standardization gave agencies an opportunity to critically reflect upon how much data they collect. Colver also likes the fact that the survey templates on HOMES are relatively easy to use and link directly to the outcomes identified in their provincial evaluation framework.

Challenges

It has been seven years since ACCH partner agencies began collaborating around evaluation and four years since they began standardizing their data. One participant involved since the beginning says that at times their progress has felt “glacial”, although they also acknowledge that Alberta is farther ahead than other provinces. Colver recalls that it was a lot of work to achieve

consensus on the standardized data, partially because of the diverse nature of services provided by each partner agency. One example she gives is the definition of youth: are they 18 to 29 years or 18 to 35 years? However, she believes the process was greatly facilitated by already having a shared provincial evaluation framework in place and by having all thirteen ASOs under one umbrella organization.

Colver also recalls that one of the biggest challenges was convincing

certain agencies to use HOMES, particularly those that already had their own database system. While some agencies immediately saw the benefits of the process, others were concerned about the prospect of additional reporting. Lisa Ireland, CORI Regional Manager for BC, notes that the process of identifying data for HOMES almost always reduces and streamlines the data collection process for agencies. Colver also admits that HOMES can be intimidating and cumbersome for some users. CORI is presently working on limiting the visibility of

interface options to only those used by an agency.

Recommendations

Colver offers several suggestions for other provinces moving in this direction: involve agencies in the process, build on data they are already collecting, and budget appropriately for ongoing support. ACCH has also offered to share their HOMES surveys with ASOs in BC.

HOMES Evaluation Software

The Hull Outcome Monitoring and Evaluation System (HOMES) is a management information system developed by the Canadian Outcomes Research Institute (CORI) with support from the Muttart Foundation in Edmonton. CORI is a non-profit charitable organization formed in 1997 with a mandate to provide education, research, training, and software in outcome measurement at the lowest possible cost to non-profit organizations. Their head office is located in Calgary with staff in Alberta, BC, and Ontario.

HOMES is an Internet-based database designed to facilitate outcome measurement. Although HOMES comes with many features, it is most commonly used for data collection, outcome measurement, and case management. It is a very flexible database that allows users to customize their own data collection templates for specific programs. One feature of HOMES is the ability to input a program

logic model and directly link it with outcome data collection. Outcome measures are designed in the form of surveys that collect pre- and post-intervention data that is aggregated to provide a picture of overall impacts. HOMES is particularly useful for creating common outcome and case management protocols across a variety of agencies. It also aligns with both COA and CARF accreditation structures. Although HOMES is a very powerful database, Lisa Ireland, CORI Regional Manager for BC, estimates that most agencies are only using 20% of its full capacity.

Use in Canada

The use of HOMES in Canada has been quietly growing over time, to a point where approximately 800 organizations in Canada and 100 in BC now use HOMES regularly. The large majority of these are human and social service agencies. Big Brother Big Sisters of Canada has used HOMES extensively for years

and is now expanding its use into their Australian offices. CORI is also partnering with the United Way of Canada in a five-city project to build internal evaluation capacity. Staff from CORI are working with United Way offices and their partner agencies to initially develop outcome measurement tools and improve data collection. Later on HOMES will be introduced as an option for partner agencies to facilitate their outcome measurement. Within BC's regional health authorities, HOMES is being used by the BC Women's Hospital and Health Centre's Fir Square Combined Care Unit program and at Fraser Health's Maxxine Wright Community Health Centre in Surrey. Seven women's shelters in BC have also recently piloted HOMES.

Implementation

When an organization expresses an interest in HOMES, they receive a visit from a CORI representative who provides an overview of CORI

services and a demonstration of the HOMES system. Then a user agreement is signed and CORI assists the agency to do an organizational assessment looking at their readiness, capacity, reporting requirements, and data needs. Ireland says that agencies usually require approximately \$6,000 to implement HOMES depending on the size of their agency. This estimate includes the organizational assessment, assistance with set-up, training for staff, and follow-up consultation. Agencies are charged an annual licensing fee of \$200, a one-time set-up fee of \$300, and a one-day mandatory staff training fee of \$800. CORI recommends that larger agencies appoint and train at least one in-house trainer to do the set-up. Otherwise, CORI staff are available for additional consultation in the areas of HOMES database training, logic model development, research design, measurement tool selection and design, data analyses, and outcome report writing at a rate of \$75 an hour. As of 2007 CORI is funded exclusively through these fee-for-service activities and does not require external funding.

Challenges

Challenges with HOMES tend to be related to the set-up time, staff turnover, and resistance to use.

Implementation can vary from three months to one year depending on the agency. Ireland estimates that set-up and customization take eighty percent of the time and only 20% is actually required for front line training and data entry. She describes the process as *“short-term pain for long-term gain”*. The most persistent problem with users is negotiating the two levels of security protocol necessary to log on to their accounts, an issue that disappears with training but is exacerbated in agencies with high staff turnover. Another challenge is the reluctance of staff who are uncomfortable using technology in general.

Ireland has also observed problems with agencies who get started on HOMES without a clear plan of what data they need to collect and why. She suggests that groups start with small, meaningful pieces of data collection first so they don't become overwhelmed by all the features of the system.

Security

The Alberta Association of Women's Shelters have used HOMES extensively for several years and have put it through a rigorous security check. BC regional health authorities who use it have also stringently assessed the security of

the database. The system uses encryption technology similar to that used in Internet banking and cannot be accessed through Internet search engines. Staff can only log on to their own agency's database and ten security levels are available. Further, staff can only view interface options available for their security level. The system is backed up daily and constantly monitored for unusual activity.

Ownership of Data

The HOMES database is stored on servers at CORI's head office in Calgary. Agencies have full ownership and access to their data and cannot see other agencies' data sets. It is important to note, however, that once a user-agreement is signed, CORI retains the right to use the HOMES data, on an aggregate basis only, for use in a nationwide research project investigating best practices in outcome measurement. That is, CORI can only do research on HOMES data if it accumulates enough data from across Canada so that each client, staff, program name, agency name, and other identifiable information is made anonymous. If an agency ceases to use HOMES, their data is downloaded to a Microsoft Excel or Access file which they are then given.

Case Study #6 – Accreditation **Accreditation/Lower Mainland Purpose Society**

Accreditation is a process whereby an agency or service provider is recognized by an external body as meeting certain predetermined standards. Being accredited assures an agency's stakeholders that its services are both accountable and of the highest quality. The most popular accrediting bodies in Canada are the Council on Accreditation (COA), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Canadian Accreditation Council of Human Services (CAC), and the Canadian Council on Health Services Accreditation (CCHSA). Although these organizations tend to assess the same areas, each follows a different process.

Steps in the Process

Steps in the accreditation process usually involve meeting with the accrediting body, conducting a self-evaluation, and having a two to three day site visit, after which the body renders an accreditation result. During the site visit a team of peer reviewers determines congruency between established standards and actual practice by interviewing stakeholders, reviewing documents, and observing services. Accreditation standards are widely recognised best practices originating from research in the areas of leadership and governance, financial management, performance and quality improvement, administration and management, information technology, health and safety, ethics and rights, and service delivery. Standards can be

both generic and tailored to a specific field of service.

Benefits and Challenges

The benefits of accreditation are numerous including:

- assurance to consumers that an organization meets internationally accepted standards
- a more integrated and individualized approach to services
- increased accountability to funders, referral agencies, and the community
- a continuous quality improvement process
- more efficient and cost-effective administration and management
- a marketing tool for promoting programs
- increased staff morale

However, accreditation can also be a significant burden for agencies with few resources.

Increased Outcome Evaluation

One by-product of accreditation is increased evaluation. John Dube, a COA peer reviewer, notes that outcome measurement is an integral part of the accreditation process. For example, COA has specific performance and quality improvement standards on *Support for Performance and Outcome measurement, Analysis and Reporting of Information, and Use and Communication of Quality Information to Make Improvements*. Agencies who are working towards accreditation must

collect sufficient and appropriate output and outcome data that will demonstrate effective program plans and service delivery.

Lynda Fletcher-Gordon is Executive Director of the Lower Mainland Purpose Society, a multi-service agency with an HIV/AIDS education and support program serving residents of the Fraser North Region. Fletcher-Gordon says that going through the accreditation process with COA was hugely beneficial. *"Initially we were worried and a bit overwhelmed, but once we embraced the exercise we could see the value."* Although they had been doing some evaluation prior to accreditation, the HIV/AIDS program had always struggled with defining and tracking outcomes within their highly marginalized client group. She recalls that the accreditation process forced them to develop realistic outcome measures that staff could assess on a regular basis. She also observed increased buy in from staff for evaluation when they become part of a Continuous Quality Improvement process.

Specific HIV/AIDS Standards

The Canadian Accreditation Council of Human Services is currently in the process of re-drafting their generic and program-specific standards and have expressed a willingness to work collaboratively with service providers in BC to customize standards for HIV/AIDS services.

Table: Brief Summary of Evaluation Support Models

	CBR Facilitator	PERT	OCHART	ACCH/HOMES	CLEAR	Accreditation
Location	BC	National	Ontario	Alberta	Ontario	National
Format	provincial resource person	online reporting tool	online reporting tool	outcome evaluation software	academic-ASO research partnership	agency accreditation
Approximate Cost	minimum \$85,000 annually	n/a	\$150,000 annually (not including initial development)	~\$6,000 per agency to set-up, plus \$200 annual licensing fee	\$1 million annually	based on size of agency, minimum \$10,000 every 1, 3 or 5 years
Source of Funding	Canadian Institute of Health Research	Federal Government	Federal & Provincial Government	Alberta Community HIV Fund plus Individual Agencies	Provincial Government	Agency
Time to Implement	~1 year	n/a	~3 years	~4 years	~1 year	~12 – 18 months
Sustainability Prospects	Medium (dependent on external funding)	High (obligatory, considerable investment of resources)	High (obligatory, considerable investment of resources)	Medium ⁴ (dependent on agencies' commitment to use)	Low (now folded)	High (losing accreditation not an option)
Accessibility	Dependent on demand	Obligatory	Obligatory	Affordable	Dependent on demand	Optional for agency

⁴ CORI/HOMES itself has very high sustainability because it is not dependent on external funding.

Conclusions

1. Outcome evaluation among HIV/AIDS service providers in BC, including regional health authorities, varies depending on an agency's capacity. Although service providers recognize the need to be accountable and clearly want to know if they are making a difference, outcome evaluation is usually conducted on an ad-hoc and minimal basis. Most evaluation activity is process-oriented with a focus on collecting data regarding outputs (i.e. units of service), and there is little interpretation or use of this data. Very few service providers describe evaluation, both process and outcome, as playing a significant part in the program planning process.
2. ASOs and PHSA community contractors do not make a distinction between 'evaluation' and 'reporting to the funder'. Evaluation is largely perceived as a reporting exercise rather than an activity that benefits the organization.
3. HIV/AIDS service providers in BC have identified significant barriers in conducting outcome evaluation including a lack of time, staff, funding, knowledge and expertise, common outcome measures, and information technology. Other frustrations and disincentives include different reporting requirements among funders and not seeing their evaluation results used in meaningful ways. Additional evaluation challenges specific to the field of HIV/AIDS are associated with engaging and tracking clients, measuring the impact of prevention activities, the broad range of services provided, providing service in rural areas, and high staff turnover in ASOs.
4. When outcome evaluation does occur, it is largely because there is funding and/or staff time available, it is made a requirement by the funder, and there is access to expertise and data collection tools. It is also facilitated by building evaluation into the front-end of program planning, having management or an organizational culture that values evaluation, and accreditation.
5. HIV/AIDS service providers in BC are pleased to see the PHSA take a leadership role in developing a provincial evaluation resource. Suggestions for increasing outcome evaluation include more financial resources, a provincial evaluation resource person, standardized data collection and reporting forms, outcome evaluation software, information technology upgrades, clear and realistic guidelines from funders, greater knowledge transfer exchange, and staff training. **Service providers stress that a provincial evaluation resource should remain simple and not take resources away from actual service delivery.** Aboriginal service providers also emphasize that it should respect OCAP principles of ownership, control, access and possession.

6. Possible options to facilitate greater outcome evaluation among HIV/AIDS service providers include a provincial evaluation resource person(s), standardized online data collection and reporting, and HIV/AIDS specific accreditation.

Recommendations

General

1. That PHSA establish a Provincial Evaluation Working Group that can further discuss options for a provincial evaluation resource and begin to develop ownership of the process.
2. That membership on a Provincial Evaluation Working Group include:
 - a) broad representation from ASOs
 - b) PHSA community contractors
 - c) regional health authorities
 - d) PHSA
 - e) Ministry of Health
 - f) PHAC
 - g) BC Provincial CBR Facilitator
 - h) BC Aboriginal Capacity and Research Development (ACADRE) or Network Environments for Aboriginal Research BC (NEAR-BC)
3. That PHSA strategically cultivate and recruit opinion leaders and evaluation champions for membership on a Provincial Evaluation Working Group.
4. That federal and provincial HIV/AIDS funders, through a separate sub-committee of a Provincial Evaluation Working Group, meet to formally discuss the feasibility of harmonizing and streamlining reporting tools.
5. That PHSA support the activities of a Provincial Evaluation Working Group with a part-time coordinator to ensure the process moves forward in a timely manner.
6. That this report be disseminated widely to BC HIV/AIDS service providers via a number of vehicles and formats in order to share the results with stakeholders, build support for a Provincial Evaluation Working Group, and recruit potential working group members.

Provincial Evaluation Working Group

7. That a Provincial Evaluation Working Group involve stakeholders from the beginning, start small, build on existing data collection and reporting tools, and budget adequately for stakeholder consultation, training, promotion, and knowledge transfer exchange activities.

Glossary

Evaluation Framework - A plan for evaluation that provides details on what a program is expected to achieve and how this will be assessed. Identifies data that needs to be collected in order to answer the evaluation questions.

Indicator – Specific data that tracks a program’s success on achieving outcomes. Observable, measurable characteristics or changes that represent achievement of an outcome.

Logic Model - A flow chart that illustrates how the activities of a program or initiative are expected to lead to the achievement of final outcomes.

Outcome – Benefits or changes as a result of a program or intervention. Outcomes answer the question, "What difference does the program make?" Outcomes may be anticipated or unanticipated, and fall along a continuum from short-term to intermediate and long-term.

Outputs – Direct products generated by a program such as activities, services, events, products, and participation.

Outcome Evaluation – A study conducted periodically or at the end of an intervention to determine the extent to which anticipated outcomes were achieved. Provides information about the impacts and effectiveness of a program.

Process Evaluation – A type of evaluation that focuses on how a program was implemented and operates. The primary purpose is to generate information for program improvement.

Appendix A

List of Stakeholders Interviewed

List of Stakeholders Interviewed

AIDS Vancouver Island	Katrina Jensen
ANKORS	Cheryl Dowden
Balfour Consulting Group	Kim Balfour
BCCDC	Mike Rekart
BC Community Based HIV/AIDS Research Capacity- Building Program	Francisco Ibañez-Carrasco
Fraser Health	Amrit Rai
Interior Health	Mary Bates
Living Positive Resource Centre	Daryle Roberts
Ministry of Health	Stephen Smith
Northern Health	Kathy Mac Donald
	Mary Margaret Proudfoot
Positive Living North	Catherine Baylis
Positive Living Northwest	Deb Schmitz
Public Health Agency of Canada	Mustapha El-Kobtan
Vancouver Coastal Health	Chris Buchner
Vancouver Island Health Authority	Audrey Shaw

List of Stakeholders Attending Consultations

AIDS Vancouver	William Booth
ASIA	Jill Doctoroff
BCCDC	Ciro Panessa
	Juanita Maginley
BCPWA	Ross Harvey
	Adrian de Vries
	Jackie Haywood
	Julia Smith
	Miriam Maxcy
	Paul Kerstan
	Richard Harrison
	Ruth Marzetti
	Suzan Krieger
	Terry Howard
	Zoran Stjepanovic
CATIE	Tricia Smith
Cowichan Tribes	Fairlea Mendoza
	Joe Wilson
	Margaret Bogley
CTAC/CATIE/BCPWA	Sandy Lambert
DIVERSEcity	Harpal Johl
Dr. Peter Centre	Maxine Davis

First Nations Chiefs' Health Committee Fraser Health	David Clellamin Amrit Rai David Portesi
Healing Our Spirit	Elizabeth Benson Gerald Harrold Karl Sunshine
Indian Residential School Survivors Society Kla How Eya Aboriginal Society Kwakiutl District Council Health Lower Mainland Purpose Society	Jen Smith Darron Cound Shelley Henderson Ashfaque Ahmed Roslyn Cassells
Mennonite Central Committee BC	Bridget Findlay John Jenkinson Susie Jenkinson
National Congress of Black Women Foundation Okanagan Metis and Children Family Services Pacific AIDS Network Pacific Community Resource Society	Nalda Callender Brian Mairs Miriam Martin Tom Hetherington Mark Smith
Pacific Connections Services Positive Women's Network	Sam Mohan Marcie Summers Bronwyn Barrett
Red Road HIV/AIDS Network	Claudette Cardinal Rodney Horne Geraldine Trimble
Tillicum Lelum Aboriginal Friendship Centre	Beth Luchies Dennis Ano
Vancouver Native Health Western Canadian Pediatric AIDS Society	Doreen Littlejohn Luke Balson

Additional Case Study Interviews

AIDS Bureau, Ontario Ministry of Health AIDS Committee of Toronto Alberta Community Council on HIV BC Community Based HIV/AIDS Research Capacity- Building Program	Joanne Lush Lori Lucier Ellie Colver Francisco Ibañez-Carrasco
Canadian Accreditation Council of Human Services Canadian Outcomes Research Institute	Sandra Maygard Lisa Ireland Angelica Miller
Council on Accreditation Peer Reviewer/Policy Development Consultant Lower Mainland Purpose Society McMaster University Ontario HIV Treatment Network	John Dube Lynda Fletcher-Gordon Gina Browne Mark Fischer

Facilitating Outcome Evaluation Among BC HIV/AIDS Service Providers

Public Health Agency of Canada

Mustapha El-Kobtan (Vancouver)
Sarah Barber (Edmonton)
Anita Fervaha (Toronto)