

SIGNIFICANT CHANGE STORY – BRITISH COLUMBIA

Building Evaluation Capacity, Improving Community-Based HIV and HCV Services

Importance of this Work: Two of the five primary objectives of REACH 2.0 were: (2) provide support and expertise for front-line organizations and services providers in participatory evaluation and (4) actively engage in rigorous Applied Program Science. Thanks to REACH resources and support in British Columbia (BC), the Pacific AIDS Network (PAN) was able to internally develop evaluation capacity, knowledge and skills. The creation of the necessary foundational structures and human resource expertise within PAN's CBR and Evaluation Department in turn, allowed us to support other organizations' evaluation needs. Extensive evaluation work has taken place with and on behalf of a number of BC health authorities; community-based organizations; and PHAC-funded community alliances and grant holders. PAN was also able to leverage REACH's infrastructure and to support several evaluation projects through fee-for-service contracts. This work, taken in combination, has created a stronger culture of evaluation in BC, created focus and enhanced collective capacity for evidence-informed program planning and implementation especially at the level of community-based services and programs.

Example – Health Authority Shared Measurement Framework Development:

To highlight this evaluation work in more depth, PAN has worked collaborative with three different BC health authorities to build *shared measurement* frameworks for their community-based, contracted HIV and HCV organizations. Shared measurement is an evaluation approach founded on coordination that moves beyond fragmented efforts to address complex social and health issues. For this work, shared measurement started with the health authority distributing funding for community-based HIV and HCV services with identified shared goals and outcomes. In order to measure the group's collective progress towards these outcomes, a set of common indicators or shared measurement framework was developed. This consistent collection of information (data) across all members of the group allowed each agency/organization to learn more about their own programming and the gains made collectively. It also allowed the group to identify gaps and opportunities for improvement at higher levels (e.g., sectoral or geographical levels) within each health authority region. This approach allowed for a stronger network to be built among partners, which has facilitated ongoing learning and quality improvement across sectors.

Implications for British Columbia and REACH: These health authority partners have seized an opportunity to use evaluation and shared measurement to more fully understand the impacts community-based organizations are having in addressing HIV and HCV in BC. Health authorities have been able to gather data about community-based approaches, which had not been collected previously, and allowed teams to compare relative effectiveness of different approaches to programs and services. Evaluation data have been used to inform decision-making, improve services, and build on successful practices. There have been challenges such as, learning about the importance of building trust between partners in a network and the difficulties of parsing out outcomes from programs with multiple funders. However, this process has been very beneficial for the health authorities involved and for PAN. Finally, while the BC team is learning from this work, we have been sharing findings and capacity-building tools with the national REACH network and increasing the reach of this evaluation capacity building work.

You can read more about our partnership with Northern Health here:

<https://pacificaidnetwork.org/pacific-aids-network/files/2018/07/2018-CAHR-NH-Shared-Measurement-Poster.pdf>

SIGNIFICANT CHANGE STORY – ALBERTA

Western Canadian HIV Supported Housing: Outcome Tools Development Project

Importance of the Project: The Outcome Tools Development Project grew out of a series of regional consultations and forums among HIV supported housing service providers. One of the first forums was held in June of 2009 in Edmonton, Alberta, where service providers from across the region gathered to discuss shared challenges. Service providers recounted how difficult it was to convince policy-makers that supported housing services played an important role in the lives of people living with HIV. Providers knew their programs were improving not just the physical health of people living with HIV, but also their quality of life. However, there was no quantitative data to demonstrate their impact on client outcomes.

The Multi-Province Team: Floyd Visser (The SHARP Foundation) and Dr. Cathy Worthington (University of Victoria) drafted the proposal for the Outcome Tools Development Project. This project brought together service providers from across Western Canada to design shared outcome measures and tools for HIV supported housing programs. Partners included The SHARP Foundation (Calgary, AB), Sanctum Housing (Saskatoon, SK), McLaren Housing Society (Vancouver, BC), and the Dr. Peter AIDS Foundation (Vancouver, BC), as well as researchers from Mount Royal University, the Southern Alberta HIV/AIDS Clinic, and an HIV positive peer. The project also involved representatives from the Calgary Homeless Foundation, Alberta Health Services, Alberta Health, and the Public Health Agency of Canada. The goal of creating these tools was to improve the ability of HIV housing service providers to demonstrate change in clients' lives, including quality of life and social determinants of health, and to create a tool that could be used across agencies for evaluation of services offered by Western Canadian HIV Supported Housing organizations.

Methods: The team utilized a participatory program evaluation approach, engaging service users and frontline service providers throughout the project. The team held a workshop to identify key client outcomes based on a range of HIV housing and more general housing tools, then interviewed residents and client family members to identify the outcomes that were important to them. A second meeting was held to develop the tools, resulting in both baseline-entry and follow-up tools primarily for use by case managers or other agency staff, and designed to assess client physical health, housing history, and quality of life. The team considered many factors during tool development based on client feedback, including potentially stigmatizing language, triggers, sensitivity around continued substance use, and reframing ideas of 'success'. This resulted in tools that were sensitive to complex client backgrounds and incorporated client perspectives about quality of life. The team pilot tested the tools and produced an administration guide, resulting in common tools that were easy to implement within programs.

Implications for REACH and HIV supported housing services: Prior to this project, HIV supported housing service providers lacked tools that could collect standardized data on client outcomes, making it difficult to demonstrate the importance of HIV supported housing services and to compare outcomes from various programs. The shared tools will contribute to informing supported housing services that improve not only physical health, but also quality of life for clients living with HIV. The tools provide a common method for measuring the successes of HIV supported housing services and create comparable data that can serve as evidence for the development of future programs. Additionally, the collaborative project established provider-provider relationships in Western Canada. This is an important outcome, as it allows service providers to learn from each other's experiences, and to work together to design more effective, and more appropriate supported housing programs for people living with HIV.

SIGNIFICANT CHANGE STORY – SASKATCHEWAN

TRC Call to Action #19:

We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities.

In late 2016, two representatives from Saskatchewan (Susanne Nicolay, then with Regina Public Health and now with Wellness Wheel, and Sugandhi del Canto from SHARE), joined REACH's STBBI POCT working group. This REACH working group was a community of practice comprised of researchers, community-based and frontline organizations, clinicians and policy makers. The group was chaired by Drs. Nitika Pant Pai (McGill University) and John Kim (National Laboratory on HIV/AIDS Surveillance) and coordinated by REACH staff.

Discussions between the National Laboratory and the Saskatchewan members of the working group led to an informal partnership focused on expanding HIV testing in the province. What started as casual conversations about the barriers and facilitators of testing in Saskatchewan became a pathway for dried blood spot (DBS) testing to take root across Saskatchewan.

Through a pilot project in Sioux Lookout, representatives from Regina Public Health and the Saskatoon Tribal Council (STC) were invited for DBS collection training in early 2017. A band council resolution was put forth and STC began offering DBS across their seven-member nations later that year. Follow-up testing was coordinated with SIDCN (the Saskatchewan Infectious Disease Care Network), an HIV and HCV clinic that is a member of Saskatchewan's REACH network. In the beginning, these on-reserve offers of DBS could be described as a clandestine operation, since the assay was not officially approved for use in Saskatchewan. However, STC and their REACH partners continued to offer DBS and share the successes and challenges of their initiative in presentations across the country. In the two years since the training in Sioux Lookout, DBS has been implemented in a number of other First Nation communities. These communities have described increased rates of testing and note that DBS testing seems to be far more acceptable to their client and patient populations than POCT or phlebotomy (the standard assays in the provincial guidelines).

In October of 2018, the largest ever DBS workshops were held in Saskatoon at the request of both FNIHB (First Nations and Inuit Health Branch) and the Saskatchewan Health Authority.

This represents a significant paradigm shift in the province's approach to HIV testing. Arguably, this sea change would have happened eventually but, without a doubt, the REACH-supported network that grew out of that STBBI working group was the catalyst of this change. DBS represents more than a testing technology – it is a REACH-driven mechanistic platform for effective inter- and intra-provincial collaboration aimed at policy improvements. In many ways, DBS represents HIV testing sovereignty for communities, returning control based on the will of the clients/patients and equipping Indigenous communities to offer resource-efficient testing.

Among the many ways in which this DBS journey has honoured OCAP, it particularly speaks to TRC Call to Action #19 – federal and provincial partners have worked alongside Indigenous leadership to implement community-driven testing technologies, supporting the cascade of care and improving health outcomes. This DBS journey is bringing Saskatchewan that much closer to reaching the undiagnosed, a journey in which REACH has played a vital part of that success.

SIGNIFICANT CHANGE STORY – QUEBEC

Mobilise!: Community mobilization to optimize access to combination HIV prevention for MSM in Montréal and Québec (2014-2018): Impact for people with lived experience and those at risk

Empowerment among MSM leaders and participants: As a community-based project, Mobilise! made it possible for over 31 MSM to participate in a tailored intervention that was based on the training they received as leaders and that built on their social networks, knowledge, and skills. Among leaders who mentioned their HIV status, 10/24 were living with HIV. There were between 3-13 people in each team. 17 team activities took place, for total of 79 participants. Team activities included participants from groups who are often excluded from mobilization and prevention initiatives aimed at MSM, including people living with HIV and people with diverse cultural/ethnic backgrounds. Four topics were covered during the 2-3 hr discussion: icebreaker questions on sex/prevention, HIV prevention strategies, access to health services, and participants' vision for the future in terms of HIV prevention in Montreal. **Impacts:** Created empowerment among leaders and participants, particularly in terms of participation and competency but also, to a lesser extent, in terms of benefits for self-esteem and critical consciousness. Leaders successfully generated creative/adapted spaces with a good balance of conviviality and inclusivity. The comments they provided at follow-up suggest need to create more opportunities for dialogue among MSM and create safe space to express needs in terms of access to prevention strategies and services.

Creation and dissemination of discussion kit and other awareness tools: New evidence-based awareness tools have been developed that will allow MSM in various communities to access up-to-date information on HIV prevention, sexual health, harm reduction strategies and access pathway toward services. Among these tools, a playful/informative discussion kit is available online (projetmobilise.org) for various stakeholders working in prevention and for anyone interested in health in their community.

General impact for people with lived experience and those at risk: MSM will ultimately benefit from this research project as it aims to increase knowledge and use of combination prevention strategies to reduce incidence of HIV in this population and to improve access to health services. Leaders have noted that they are more aware of the different realities of their community, and many have indicated they want to do more to help improve access to information/services. There are beneficial effects of having access to a safe space where sensitive issues can be addressed (sharing one's experience and hearing others).

Changes Mobilise! project brought about in programs, services or policies – (a) Partnerships and stronger inter-organizational linkages: Creation of an intersectoral coalition with actors involved in prevention of 43 members from 21 organizations (community organizations, clinics, public health authorities, etc.). The mandate of this coalition is to implement a community mobilization process. This intersectoral coalition of prevention actors has been taken over by the Direction régionale en santé publique. Improvements in partnerships and stronger inter-organizational linkages that make collaboration between organizations more efficient are anticipated as well. Other expected outcomes include improvements to the accessibility of services (increased visibility, greater acceptability) as well as the emergence of innovative, more effective system-wide strategies or prevention models; (b) **KTE to improve HIV prevention practices:** Development and transfer of knowledge that can enable practitioners to improve their practices in HIV prevention and sexual health promotion for MSM. There have been many KTE activities involving stakeholders, community members and actors and the scientific community; and (c) **Writing a regional consensus statement (in development):** The project enabled the development of an evidence-based consensus statement and contributed to the establishment of a strategic planning process to maximize access to combined prevention at the regional level.

Changes has Mobilise! project brought for community-based organization: The project has led to the development and transfer of knowledge that can help practitioners improve their HIV prevention and sexual health promotion practices for MSM (access to the kit online). The project has helped build organizational capacity and leadership in service integration and coordination.

SIGNIFICANT CHANGE STORY – THE ATLANTIC

Synergies for a Wider Range of Harm Reduction Services

Importance of the Project: The **Outcome Tools Development Project** grew out of a series of regional consultations reducing barriers to Atlantic Canada’s relatively conservative harm reduction landscape has long been top priority among the region’s researchers and community organizations. This story involves the four Atlantic provinces – New Brunswick (NB), Prince Edward Island (PEI), Nova Scotia (NS), and Newfoundland and Labrador (NL) – and takes place from 2014 to the present. It highlights the enhancement of harm reduction efforts which are related, albeit not exclusively, to the collaboration and synergies among key regional partners facilitated through AIRN/REACH 2.0.

While much work remains, significant changes in Atlantic Canada’s harm reduction landscape have occurred over the past five years. In 2014, access to community-based needle distribution and disposal (NDD) programs was severely limited across the region; free take home naloxone was non-existent; wait lists for opioid treatment and detox were commonly six months to a year; there were no formalized networks of people who use drugs; and PrEP was not yet approved for use anywhere in Canada.

Through tireless, multi-sectoral regional research, capacity building and KTE efforts, we have collectively contributed to key gains in all of these areas. For example, progress has been made in terms of (click links for more information): (1) Increased federal and provincial funding for harm reduction. In [Nova Scotia](#), NDD services across the three service providers on the mainland and in Cape Breton have been enhanced and stabilized, in accordance with some of the recommendations in a 2017 [AIRN report](#). The Safe Works Access Program in NL has expanded, as have the programs in NB; (2) EI is implementing Canada’s first [HCV elimination strategy](#), which includes treatment of people actively using drugs; (3) An [HCV elimination project](#) is also underway in NS to address the challenges associated with HCV screening, access, and linkage to care. The first phase of this research brings HCV POCT to harm reduction organizations; the second phase will involve testing a structured intervention designed to increase access and linkage to care and treatment; (4) [Naloxone](#) is available free of charge in the region, and widely accessible in NS, NB, and NL through pharmacies and community based organizations. PEI offers free naloxone through its needle exchange sites. NL was a forerunner for naloxone access in this region, and galvanised other provinces to take action; (5) Wait times for methadone and Suboxone treatment, as well as other opioid treatment services have decreased. [The Bailey Bus](#) – Canada’s only mobile methadone clinic established in 2012 to address the treatment wait list in Halifax – is no longer needed and was decommissioned this year. Direction 180, the Atlantic Region’s only low-threshold opioid replacement treatment program has recently moved in to a new, larger, and more effective [facility](#); (6) Involvement in the Quebec-Atlantic Node of [CRISM](#) (Canadian Research Institute on Substance Misuse) and the hosting of two symposia – [CRISM 2017](#) and [2018](#); (7) Increasing accessibility/decreasing barriers to PrEP. As of Dec 2018, all provinces except [PEI](#) include some coverage for PrEP, and stakeholders across region are advocating for greater accessibility (e.g. [Click here](#)); (8) Developing a formalized network of people who use drugs in Halifax (HANDUP) which provides advocacy, harm reduction, peer education and support services. The team produced a [video](#) in 2017 that has inspired many, with close to 25K views on Facebook alone. HANDUP members continue to be a critical voice for harm reduction efforts including [overdose prevention sites](#) and have recently been integrally involved in large-scale harm KTE efforts, including provincial and regional harm reduction symposia in [NS](#) and [NB](#); and (8) An expanded peer-based harm reduction outreach service through Mainline has been instrumental in empowering current and former drug users and service providers through its [Peer Navigator program](#). “After 26 years [in operation], we are finally being heard and know that people are finally listening to us,” says Mainline’s Director, Diane Bailey, who has been at the forefront of harm reduction services across the region. “AIRN’s [evaluation of Mainline](#) in 2016 made funders realize the effectiveness and impact of our work which has resulted in increased capacity and sustainability.”