

YEAR THREE EVALUATION OF THE CANADIAN STRATEGY ON HIV/AIDS

Final Report



Canadian Strategy on HIV/AIDS

La Stratégie canadienne sur le VIH/sida

May 2002

Departmental Program Evaluation Division Applied Research and Analysis Directorate Information, Analysis and Connectivity Branch



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This report was originally prepared in English and translated into French. Although the quality of the translation of this document has been reviewed, because of the use of technical/methodological terminology, please note that in the event of any difference of interpretation in the two languages, the English language version should take precedence.

The Year Three Evaluation of the Canadian Strategy on HIV/AIDS is dedicated to the memory of JERZY JARMASZ, Ph.D, Senior Analyst, Departmental Program Evaluation Division

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Chronology

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Departmental Program Evaluation Division Comments on the Year Three Evaluation of the Canadian Strategy on HIV/AIDS

Issue

Year Three Evaluation of the Canadian Strategy on HIV/AIDS (CSHA).

Purpose

A Departmental Program Evaluation Division (DPED) objective is to improve the quality of evaluations and demonstrate with more rigour the linkages between program interventions and outcomes. As a result DPED has implemented an evaluation peer review process to assess the quality of draft evaluation reports. This is a summary of the qualifications on the conclusions and recommendations presented in the report that readers might wish to take into consideration regarding the validity of the conclusions and recommendations.

The Departmental Program Evaluation Division Comments on the Year Three Evaluation of the Canadian Strategy on HIV/AIDS will:

- present the concerns that have not been adequately addressed within the Year Three Evaluation Report of the CSHA; and
- identify the next steps for improving future CSHA evaluation activities.

Key Evaluation Issues

Health Canada and Correctional Service Canada committed to an independent evaluation of the CSHA which is to be submitted to the Treasury Board of Canada Secretariat. SPR Associates was contracted to conduct the Year Three Evaluation. The Year Three Evaluation was based on the evaluation framework developed in consultation with CSHA stakeholders. The evaluation questions are presented below¹.

1. To what extent has the Canadian Strategy on HIV/AIDS contributed to the achievement of the identified outcomes? This question is intended to identify the Strategy's contribution to the achievement of the outcomes, while documenting baselines for future assessments of Strategy achievements.

Health Canada. Evaluation Framework for the Canadian Strategy on HIV/AIDS. 2000.

- 2. What are the facilitators/barriers that enable/limit the achievement of the CSHA outcomes? The purpose of this question is to identify elements that facilitate the achievement of the CSHA outcomes and to identify elements that are barriers to the achievement of the CSHA outcomes. This question should help to identify areas that may require adjustments in policy and/or programming to ensure progress toward the achievement of the CSHA outcomes.
- **3. Is the CSHA investing in the appropriate areas to achieve the Strategy outcomes?** The purpose of this question is to determine whether the strategic approach/plan to address HIV/AIDS is reasonable. This question should also seek to establish whether the financial distributions within the CSHA are appropriately allocated to achieve the expected outcomes. For example, given the current state of the epidemic, the limited resources available and the role and mandate of the federal government to address HIV/AIDS, are allocations within the CSHA organized appropriately to maximize impact?
- 4. **Based on questions 1, 2 and 3, does the evaluation framework identify the information necessary to successfully complete the five-year evaluation?** The purpose of this question is to assess the evaluation framework to determine whether the proposed evaluation questions, performance indicators and the data collection and analysis strategy are appropriate to enable future assessments of Strategy achievements. This question should also identify gaps in the performance measurement tools, indicators and data to ensure that the five-year evaluation is more comprehensive.

Selected Evaluation Approach

The selected evaluation approach included a review of key CSHA documents; interviews with Strategy stakeholders, researchers and HIV/AIDS experts; surveys of approximately 150 recipients of CSHA funds; comparisons of international activities; and case studies of community based initiatives. Although the selected approach is considered appropriate for an examination of formative evaluation issues, this methodology has significant limitations when drawing conclusions of a summative nature (i.e., program effectiveness).

To increase the validity of evaluation conclusions, research designs that rely on surveys and consultations should be supplemented with designs that apply comparison groups and/or multiple measures over time. The Year Three Evaluation of the Canadian Strategy on HIV/AIDS did not utilize multiple comparison/control groups or multiple measures over time. Such an approach is necessary for developing valid conclusions on summative issues.

Key Concerns

This evaluation sought to examine formative (i.e., process) and summative (i.e., impact) issues, and as a result it cannot be considered a traditional formative evaluation. Since this evaluation was not a traditional formative evaluation, the selected evaluation approach had three important limitations.

These limitations relate to:

- Ability to develop valid cause and effect inferences;
- Data collection and analysis; and
- Utilization of program data.

These limitations are described in more detail below.

1. Ability to Develop Valid Cause and Effect Inferences

A research design is the strategy used to test the hypotheses or examine the research questions. It is important that the research design is valid and defensible.

As indicated above, this evaluation was not based on a quasi-experimental approach, but was based on a post-intervention, non-experimental design. That is, control groups and/or multiple measures in time were not utilized. This evaluation approach is considered the weakest approach for assessing cause and effect relationships.

This evaluation makes inferences regarding the impact (cause and effect relationship) of the CSHA. To draw conclusions of this nature, the internal validity of the evaluation design is critical. A post-intervention, non-experimental design cannot support the internal validity requirements necessary to make statements regarding program causes. A valid study should demonstrate that:

- CSHA activities happened *before* the observed outcomes/effects;
- CSHA activities and outcomes/effects are causally related; and
- some other variable or factor is not causing the observed outcome/effect.

The Year Three Evaluation of the CSHA was unable to meet these criteria because the methodology did not include a detailed examination of CSHA activities or outputs. Furthermore, the current efforts (governmental and non-governmental) to respond to HIV/AIDS in Canada have not been adequately described. For example, the provincial/territorial contributions to address HIV/AIDS issues in Canada were not sufficiently examined. Lacking this information, the evaluation cannot identify the federal contribution to the achievement of the observed outcomes.

Many of the conclusions identified in this evaluation are based on assumptions that cause and effect relationships exist. Given that this evaluation design cannot test cause and effect relationships, claims about program effectiveness are not reliable. Even though the evaluation provides insights that may be reflective of the success of the CSHA, the conclusions are presented in a manner that suggest the evaluation design could support an examination of cause and effect relationships. As a consequence, conclusions related to CSHA outcome achievement, CSHA efficiency and the recommendations are not supported by the evidence .

2. Data Collection and Analysis

Data collection methods are used to implement the research design. Data collection methods include qualitative and quantitative research techniques. Evaluation reports must provide sufficient information to judge the process used when designing and using the measuring instruments. For example, there must be an adequate description of how the samples for the qualitative and quantitative data collection methods were identified (i.e., criteria), selected (e.g., random or volunteer) and the sample sizes must be of sufficient size to draw valid conclusions.

The evaluation data consists largely of the subjective perspectives of invested stakeholders which is primarily anecdotal. The emphasis on utilizing anecdotal data limits the ability to develop reliable and generalizable conclusions. This is noted, for example, in the conclusions related to the research component of the CSHA. Furthermore, the discussion of the data collection methods are considered insufficient because the following elements are not clearly articulated in the Detailed Evaluation Working Paper:

- descriptions of the sampling universe, the sample size and the total response;
- descriptions of how the samples were selected;
- descriptions of how the research instruments and protocols were developed and implemented; and
- descriptions of the data collection and analytical plan.

Overall the analysis is considered weak. It is not clear how the analysis was conducted, how qualitative information was organized and how the various conclusions were derived. Moreover, the evaluation makes distinctions in the analysis based on what are identified as different levels of significance. Generally, statements regarding the significance of findings are not made unless appropriate statistical analyses are conducted. Finally, the weighting of different methods and evidence are not presented. While the focus of these limitations are directed to the Detailed Evaluation Working Paper they are significant and further emphasize the subjective nature of this evaluation report.

3. Utilization of Program Data

This evaluation insufficiently utilizes existing program activity and output information. Furthermore, there was also a lack of program outcome data available for the evaluation. Due to a lack of baseline information, this evaluation is unable to determine whether the observed impacts are a result of the CSHA.

To address this concern a significant investment was dedicated to the collection of new information. Despite this effort, there are gaps in its application to this project. This is evidenced by the incomplete discussions related to CSHA funded components/activities such as research, prisons and international action.

As suggested in the evaluation report, the findings presented are largely the perspectives of the individuals that participated in the consultation. These perspectives are extremely valuable and are consistent with the themes identified at the Gray Rocks Follow-up Meeting; however, do not constitute a complete or comprehensive evaluative analysis of the issues in question. The evaluation report reflects a wide-ranging community consultation and therefore provides valuable input to program managers.

Moving Forward and Next steps

These lessons learned will be helpful for improving future evaluation activities; for example, more effort must be devoted to program output and outcome tracking, changes must be made to the evaluation framework to more clearly express the logic of the program and a more rigorous evaluation methodology must be developed.

Activities currently being undertaken to improve future CSHA evaluation activities are presented in the *Canadian Strategy on HIV/AIDS Year Three Evaluation: Federal Government Partners Response and Action Plan.*

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Canadian Strategy on HIV/AIDS Year Three Evaluation: Federal-Government Partners Response and Action Plan

September 30, 2002

	Evaluation: Conclusions	Evaluation: Recommendations	Program Response: Current Status	Program Response: Action Required	Due Date for Completion	Contact
1	built on Federal efforts since 1990, creating a substantial and efficient response to HIV/AIDS which remains highly relevant to Canada's needs.	The Strategy should be continued with no major changes in direction, but elements should be expanded or modified, if resources are available, to build on the strengths of the existing Strategy, and to remedy its weaknesses.	CSHA stakeholders are developing a five- year strategic/operational plan to guide the work of the Strategy. A review of resource allocations under the CSHA, to ensure that funds are spent where they are most needed, is also underway.	Integrate the findings from resource allocation review into the strategic planning process. Identify funding priorities. (Also, please see recommendation #15).	Dec. 1, 2003	Manager, Public Accountability HIV/AIDS Division 946-3635
2	Outcomes: Incremental impacts of the Strategy have been modest but are still a significant accomplishment, given the available resources. Greatest impacts are noted in areas such as prevention, in the focus on those most at risk, and in promoting and supporting community capacity. Less satisfactory impacts have been noted regarding the quality of care, support and assistance, the promotion of broadly-based partnerships, and funding.	Areas identified as poorly impacted by the Strategy should be targeted for new efforts, with resources set aside for realistic undertaking of any new initiatives (e.g. targeting apparently weak areas such as quality of care, support and assistance, promotion of more broadly-based partnerships).	These findings confirm the outcome of the Gray Rocks stakeholder consultation (Oct. 2000), which identified ten broad strategic directions for the CSHA. The five-year strategic plan will identify funding priorities, and the resource allocation process will direct resources where they are most needed.	Complete the five-year strategic plan. Integrate the work on Directions 1 (Mobilize integrated action), 4 (Get public commitment, political leadership and funding), 5 (Build a strategic approach to prevention) and 6 (Build a strategic approach to care, treatment and support), and the findings from the International Affairs Directorate's evaluation report on its international collaboration activities.	Dec. 1, 2003	Manager, Public Accountability HIV/AIDS Division 946-3635

	Evaluation: Conclusions	Evaluation: Recommendations	Program Response: Current Status	Program Response: Action Required	Due Date for Completion	Contact
3.	Groups at Risk: A valuable feature of the Strategy has been its emphasis on marginalised groups. However, the vulnerable groups that have been identified by the Strategy (MSM, IDUs Aboriginal people, youth) are still in need of focussed attention.	The Strategy should continue with its efforts to place emphasis on these vulnerable groups.	One of the CSHA's three policy directions is increased focus on those at risk. Strategy stakeholders identified "engaging vulnerable Canadians" as one of ten strategic directions for the CSHA. Work has begun to design mechanisms to increase capacity for voice, increase access to services, and increase education and knowledge.	Complete the five-year strategic plan. Identify and direct funds to priority areas. Facilitate a working group which will develop options for engaging vulnerable Canadians in combatting the epidemic.	Dec. 1, 2003	Manager, Public Accountability HIV/AIDS Division 946-3635
4.	Partnerships: The reach of the Strategy in creating partnerships needs to be broadened to create more genuinely inclusive partnerships to fulfil the Strategy's "pan-Canadian" promise.	The "pan-Canadian" nature of the Strategy's decision-making should be strengthened overall, ideally through senior efforts by the federal government (Ministerial level or higher), to engage all levels of government, beginning with the provinces and territories. Other efforts could target departments and agencies as yet poorly involved in the Strategy (boards of education, public health bodies; other federal ministries and agencies etc.).	Participants in the Montreal stakeholder consultation (April 2002) identified engaging federal departments and agencies as one of the actions required to broaden the response to the epidemic. The CSHA supports various collaborative mechanisms, including four national bodies which provide advice at different levels to strengthen the Strategy's decision making. The Ministerial Council on HIV/AIDS, the F/P/T Advisory Committee on AIDS (FPT AIDS), the National Aboriginal Council on HIV/AIDS (NACHA) and the International HIV/AIDS Working Group continue to develop on-going cross-linkage opportunities	Identify opportunities for increasing federal departments and other Health Canada programs (e.g., Hepatitis C Prevention, Support and Research Program and Canada's Drug Strategy) involvement in the CSHA. Work with the four national bodies to ensure they continue to adapt to the changing context of the HIV/AIDS epidemic. Work with key players (including the regions) in the CSHA to define a framework for the optimal involvement and the roles and responsibilities of all players in the CSHA.	March 2003 On-going March 2004	Manager, Strategy Coordination and Partnerships HIV/AIDS Division 941-2673

	Evaluation: Conclusions	Evaluation: Recommendations	Program Response: Current Status	Program Response: Action Required	Due Date for Completion	Contact
5.	. Information: Many stakeholders indicated that they would like more information about the Strategy.	The Strategy should initiate a newsletter to carry information about its work to a wider audience of concerned partners and potential partners.	The HIV/AIDS NGOs publish newsletters and support websites. Strategy stakeholders have identified "building a broad information strategy" as one of the ten strategic directions for the CSHA. Elements of an information strategy already exist, such as CIHR's database of funded research projects, CAAN's Link-up, and the CATIE and Clearinghouse websites.	Develop a three-year communications and marketing plan for Health Canada and the CSHA. Develop a regular web-based HIV/AIDS bulletin focussing on the work of Health Canada. Establish a working group to develop a dynamic information process.	Sept. 2002 Aug. 2002 Apr. 2003	Manager, Public Accountability HIV/AIDS Division 946-3635
6.	Management of Costs for NGOs: Many NGOs indicated that the costs of applying for Strategy funding were very high relative to grants obtained.	The Strategy should consider ways to simplify its application and administrative procedures.	The HIV/AIDS G&C file and guideline review, done in response to the OAG report on Health Canada's G&C programs, has identified the need to standardize guidelines and develop minimum standards for project management for all HIV/AIDS funding programs.	The application and administrative procedures for NGO and community service organization funding will be reviewed as part of the implementation of the corrective action plan to ensure effective management of HIV/AIDS G&C funding programs.	March 2003	Manager Prevention, Care & Treatment Programs HIV/AIDS Division 957-1773

Evaluation: Conclusions	Evaluation: Recommendations	Program Response: Current Status	Program Response: Action Required	Due Date for Completion	Contact
7. An Open Process: The tendency of government to retreat to "behind closed doors" to make CSHA decisions is an issue of concern, particularly as it contradicts the premises of the Strategy regarding collaboration and partnerships. This practice and reflection of lack of inclusiveness and transparency was strongly indicated by the fact that minutes of the Federal/Provincial/Territorial committees were not for public use and could not be used for the evaluation report.	A mechanism to provide more open decision-making would be aided by ongoing information exchanges. For example, the Strategy could consider establishing a type of "monitoring committee" which would provide periodic information exchanges among all key partners, rather than just annual "input" such as at direction finding meetings.	The CSHA supports several opportunities for shared decision-making and partner information exchange. Part of the mandate of the Ministerial Council is to provide advice to the Minister on the flexibility and responsiveness of the CSHA. Other advisory bodies (F/P/T AIDS and NACHA) work with Health Canada to develop the CSHA's response to the epidemic. Key players of the CSHA are involved in the development of the World AIDS Day Report, periodic evaluations, and the review of resource allocations. The International HIV/AIDS Working Group, comprised of national and international NGO and other federal government departments, serves to facilitate information sharing and discussion on polices and programs related to the global HIV/AIDS epidemic.	Ensure that the development of the strategic plan for the CSHA engages and reflects the work of all stakeholders.	Dec. 1, 2003	Manager, Public Accountability HIV/AIDS Division 946-3635
Lack of inclusiveness was also suggested by the absence of the provinces-territories and NGOs from the planning and steering of the evaluation.	Additionally the Strategy could consider the creation of regional consultation fora which would meet periodically. Such venues could provide a more regular vehicle for bringing together a wide range of partners, and also a vehicle for considering regional issues.	The Health Canada Regional Offices set regional priorities for ACAP funding. All HIV/AIDS funding guidelines are under review. One outcome of this review will be a more consistent open and transparent approach to calls for funding proposals.	Explore a consistent approach to regional input through the implementation of the strategic plan, and the design of the CSHA Results-based Management and Accountability Framework (please see recommendation #15).	Dec. 1, 2003	Manager, Public Accountability HIV/AIDS Division 946-3635

	Evaluation: Conclusions	Evaluation: Recommendations	Program Response: Current Status	Program Response: Action Required	Due Date for Completion	Contact
		Federal/Provincial/Territorial discussions should also be made more transparent. A step in this direction would be to provide regular reports on the work of the Federal/Provincial/Territorial bodies to all partners and stakeholders.	F/P/T AIDS provides regular updates of its activities to the Ministerial Council on HIV/AIDS, the NACHA, and the F/P/T Heads of Corrections' Working Group on Infectious Disease. F/P/T AIDS also strives to include non-governmental representatives on the membership of its working groups.	Work with F/P/T AIDS to define options to strengthen linkages with the CSHA key players within its 2002-2003 strategic planning process.	March 2003	Manager, Strategy Coordination and Partnerships HIV/AIDS Division 941-2673
8	research Component: The research component of the Strategy may need to be reviewed as there were many areas of concern with this component. For example, in reports that some projects and researchers funded by the Strategy were not focussed on HIV/AIDS at all.	A specific review of the research component could be undertaken to address the program's focus on HIV/AIDS, its overall effectiveness, and the balance of community and other research. One method which should be considered for this review would include a peer review by international experts in the field of HIV/AIDS research. Otherwise, researchers emphasized the need for specialized evaluation work, tracking citation indexes, utilization by other researchers, etc.	The conclusions and recommendations are based on an apparently small amount of data. The CIHR manages \$10M of the \$13M CSHA dollars dedicated to research, but the surveys did not include any CIHR staff. Research projects funded by the CSHA through the CIHR are carefully checked for at least 50% HIV/AIDS content. Research projects funded through the Community-based research programs must address one or more goals of the CSHA.	A more in-depth focus on research activities will be incorporated in the CSHA Results-based Management and Accountability Framework (see recommendation #15).	March 2004	Departmental Program Evaluation Division 954-8914
9	are a major potential source for the future spread of the HIV/AIDS epidemic and the risks in correctional institutions are not being sufficiently addressed, as indicated by our case studies.	A review of the effectiveness of, and resources available for, CSC's current programming should be undertaken to ensure that programming levels are sufficient to control or reduce HIV/AIDS risks in prisons. This may be extremely important to the overall epidemic, since high levels of infection in prisons may ultimately impact on infections in the broader population	The CSHA's \$600K is only one portion of the resources CSC allocates to HIV/AIDS in prisons. The information about CSC was predominantly anecdotal, and cannot be generalized to all CSC institutions or to all inmates and staff.	A more in-depth focus on CSC's HIV/AIDS work will be incorporated into the CSHA Results-based Management and Accountability Framework (please see recommendation #15).	March 2004	Departmental Program Evaluation Division 954-8914

Evaluation:	Evaluation:	Program Response:	Program Response:	Due Date for	Contact
Conclusions	Recommendations	Current Status	Action Required	Completion	
10. Surveillance and Epidemiology: There is a need for better data on the progress of the HIV/AIDS epidemic.	A review of the surveillance function should be undertaken, including an examination of the actual surveillance work, and comparison to international models, to identify options for obtaining better data.	Health Canada's Centre for Infectious Disease Prevention and Control is internationally renowned for the quality of its HIV/AIDS epidemiology and surveillance work. At the request of national and international organizations the Division provides technical support to HIV/AIDS projects around the world. The analysis does not take account of the unique F/P/T relationship. It takes time and resources to build the F/P/T agreements that would lead to improved data collection across the country. The "broad information strategy", identified by Strategy stakeholders as one of the ten strategic directions for the CSHA, will incorporate better communication of existing surveillance information as well as other types of information.	To improve routine HIV/AIDS surveillance data, work is underway on a series of agreements with the provinces and territories to support the collection and transmission to Health Canada of more complete epidemiologic data on newly diagnosed cases of HIV and of AIDS. Modern HIV/AIDS surveillance (so called "second-generation" surveillance) includes the surveillance of HIV-associated risk behaviours. To address this in Canada, repeated cross-sectional surveys are being planned to obtain behavioural tend data from the two main HIV risk groups in the country-injecting drug users and men who have sex with men.	Dec. 1, 2003, for provincial/ territorial data agreements. March 31, 2003, for start of cross-sectional studies among IDU and Dec. 1, 2003, for start of studies among M.M.	Chief Division of HIV/AIDS Epidemiology and Surveillance 941-3155

Evaluation: Conclusions	Evaluation: Recommendations	Program Response: Current Status	Program Response: Action Required	Due Date for Completion	Contact
11. Setting Goals: More clearly defined and concrete goals are needed for the Strategy.	A systematic analysis of needs and gaps should be undertaken to identify activities that the Strategy could undertake, with a focus on the likely costs and benefits. This review should include an assessment of all current program elements, including verification of the extent to which all Strategy resources are fully dedicated to HIV/AIDS activities.	Agreed. CSHA stakeholders are developing a five-year strategic/operational plan to guide the work of the Strategy. The plan will include objectives for the 6 CSHA goals and success indicators, based on the S.M.A.R.T.E.R. approach. A review of resource allocations under the CSHA, to ensure that funds are spent where they are most needed, is also underway.	Complete the strategic/operational plan. Incorporate a cost/effectiveness analysis component into the CSHA Results-based Management and Accountability Framework (please see recommendation #15). Incorporate the assessment of the International Affairs Directorate's evaluation report on its HIV/AIDS international collaboration activities undertaken September 2002.	Dec. 1, 2003	Manager, Public Accountability HIV/AIDS Division 946-3635
12. Funding: The issue of funding levels needs to be addressed to either remedy the indicated problem of insufficient resources for the Strategy overall, or to put to rest discussion on this topic	Initially, a return to real (constant dollar) funding levels of 1993 might be undertaken by Health Canada, with any new funds allocated in a closely monitored as to cost-effectiveness. However, assessing actual needs should be a first step for a longer term solution.	The Ministerial Council's analysis of the adequacy of the federal investment in the CSHA concluded that a process for determining what might be an adequate budget is required.	A critical step is to identify realistic, measurable objectives and to determine the funding needed to reach each objective.	Dec. 1, 2003	Manager, Public Accountability HIV/AIDS Division 946-3635

Evaluation: Conclusions	Evaluation: Recommendations	Program Response: Current Status	Program Response: Action Required	Due Date for Completion	Contact
	Additionally, to aid current and ongoing assessment of the funding issue, a system for collecting data on the overall economics of the HIV/AIDS epidemic should be established.	Work to update the 1998 study of the economic burden of costs associated with care, treatment and support to persons living with HIV/AIDS is underway in the HIV/AIDS Division	Development of a methodology, including a clear approach, mechanisms and a critical path for an updated economic burden study.	March 2003	Manager, Policy Development and Analysis Unit HIV/AIDS Division 946-8110
	The Strategy should develop the business case for investments in HIV/AIDS based on estimates of the savings which could be expected from	Strategy stakeholders have identified public commitment, political leadership and additional funding as strategic issues for the CSHA.	Report assessing implications to economic burden.	March 2004	
	investments in HIV/AIDS prevention, etc.		Define opportunities for increasing CSHA funding. Work with key players in the CSHA to define a framework for the optimal involvement and the roles and responsibilities of all players in the CSHA (see rec.#4).	March 2004	Manager, Strategy Coordination and Partnerships HIV/AIDS Division 941-2673

Evaluation: Conclusions	Evaluation: Recommendations	Program Response: Current Status	Program Response: Action Required	Due Date for Completion	Contact
13. Leadership: The leadership of the Strategy (including stronger attention from senior officials) should be closely addressed. This could aid a higher level of co-participation by the provinces and territories and others. With stronger leadership, it is possible that the CSHA could better leverage funds from other federal departments or address other health related issues, such as drug abuse, or increasing general health care awareness among people with HIV/AIDS	Steps should be taken to raise discussions of Federal/Provincial/Territorial cooperation to the Ministerial level or higher.	The F/P/T Advisory Committee on AIDS, which provides policy advice to the Conference of Deputy Ministers of Health, has been successful in influencing crossjurisdictional policies in diverse areas. The F/P/T AIDS has undertaken a strategic planning process to develop a more strategic approach in accomplishing its work. Health Canada's International Affairs Directorate coordinates Canada's global leadership on HIV/AIDS issues.	Define opportunities for increasing the visibility of F/P/T AIDS' within its 2002-03 strategic planning process.	March 2003	Manager, Strategy Coordination and Partnerships HIV/AIDS Division 941-2673
		Strategy key players have identified the need to engage political leadership across governments and increase shared ownership for the CSHA among federal government departments as a focus for strategic action.	Identify opportunities for increasing federal departments involvement in and ownership in the CSHA.	March 2003	Manager, Strategy Coordination and Partnerships HIV/AIDS Division 941-2673
14. Changes now: Changes to the Strategy are indicated and desirable for Years Four and Five, particularly in the areas noted above, and should not necessarily wait for a year five evaluation	An action plan for Years Four and Five should be developed, building on issues and priorities noted in this evaluation.	CSHA stakeholders are developing a five- year strategic/operational plan to guide the work of the Strategy.	Complete the strategic/ operational plan, taking into account the issues and priorities noted in this evaluation.	Dec.1, 2003	Manager, Public Accountability HIV/AIDS Division 946-3635

Evaluation:	Evaluation:	Program Response:	Program Response:	Due Date for	Contact
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15. A Year Five Evaluation: A more specific evaluation methodology will be needed for the Year Five Evaluation, if the evaluation is to produce value-added information for the Strategy partners on the types of questions posed in the evaluation framework. Alternatively, it is possible that an evaluation per se is not the greatest need of the Strategy. Another evaluation, even with more rigorous methods is likely to show simply that the strategy is doing "good stuff" generally.	If an effective year five evaluation is to be developed, a detailed evaluation methodology should be developed as soon as possible. This could be done by putting the methodology itself out to tender far in advance of year 5. This should be a substantial effort, considering the complexity of the Strategy.\ A new evaluation framework would be prepared	Agreed. Simply repeating this evaluation exercise at another time, without investing in the development of a system to collect comprehensive program data and to further refine the evaluation strategy, will not produce a more rigorous or informative evaluation. The current evaluation framework must be revised to address the limitations identified in the Departmental Program Evaluation Division Comments on the Year Three Evaluation of the CSHA.	Based on the lessons learned from this evaluation and the evolution in the current approach to planning and conducting program evaluations, the CSHA will undertake the development and implementation of a Results-based Management and Accountability Framework (RMAF). The RMAF will include an improved evaluation strategy as well as standardized data collection tools and processes necessary for ongoing performance monitoring and for effective evaluation activities.	March 2004	Departmental Program Evaluation Division 954-8914

Evaluation: Conclusions	Evaluation: Recommendations	Program Response: Current Status	Program Response: Action Required	Due Date for Completion	Contact
Rather, it may be that the most important needs of the strategy are in the area of strategic and planning information, such as the "needs" study suggested by our discussions above.	New information to aid the year five and later evaluations should be developed through the sponsorship of more research on the Strategy itself, emulating research paper series such as those other programs have developed linking Departmental interests with interests of academic researchers (for example, those which HRDC Applied Research Branch has developed for its labour programs, or those which Health Canada's National Clearinghouse on Family Violence has developed for its information needs, or similar research programs seen at Statistics Canada.				
16. Partners in Evaluation: It is noted that this evaluation could have proceeded with greater effectiveness had a wider range of partners been involved in the refinement and steering of the evaluation.	A steering committee, with representation from all partners (provinces and territories as well as NGOs), and with representation from persons living with HIV/AIDS, should be established for the Year Five Evaluation and should start its work now to ensure that the evaluation meets the needs of all parties.	Agreed. A steering committee involving a wider range of key players can improve the effectiveness of future evaluation activities. It is extremely difficult (if not impossible) to meet the needs of all parties interested in evaluation studies. Future evaluation activities must incorporate the issues and perspectives that are necessary to achieve the objectives of an evaluation project.	Evaluation steering committees will be established to meet the expected results of future evaluation activities. Clear criteria for participation and the roles and responsibilities for evaluation steering committees will be developed in consultation with CSHA stakeholders.	Developed and implemented during planning phase of evaluation projects.	Departmental Program Evaluation Division 954-8914



The Year Three Evaluation of the Canadian Strategy on HIV/AIDS

A Report to Health Canada

January 2002

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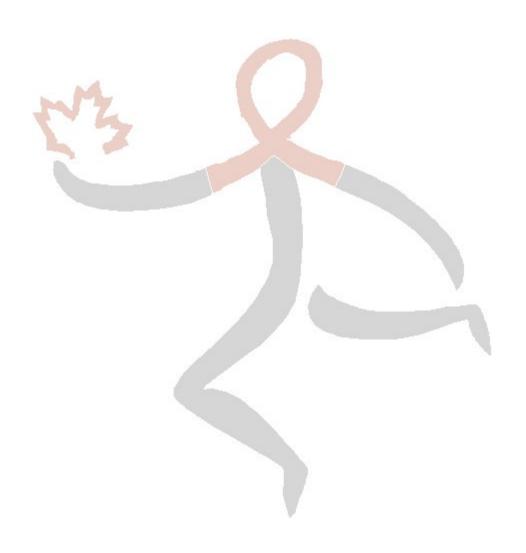


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List of Acronyms Used in the Report

ACAP AIDS Community Action Program

CAS Canadian AIDS Society

CATIE Canadian AIDS Treatment Information Exchange CIDA Canadian International Development Agency

CSC Correctional Service Canada
CSHA Canadian Strategy on HIV/AIDS
CTSP Care Treatment and Support Program

EMR Extramural Research
FNI First Nations and Inuit

HC Health Canada IA International Action

ICAD Interagency Coalition on AIDS and Development

IDU Injection Drug Users

LCDC Laboratory Centre for Disease Control

MSM Men who have sex with men

NAS-I National AIDS Strategy, Phase One NAS-II National AIDS Strategy, Phase Two

NGO Non-government organization

PCAP Prevention and Community Action Program

PICU HIV/AIDS Policy Integration and Coordination Unit

QOL Quality of Life

SLS Surveillance and Laboratory Science Program

SMCEM Strategic Management, Coordination, Evaluation and Monitoring

What Some CSHA Participants Said

"community organizations welcome a dedicated HIV/AIDS strategy along with the flexibility, accountability and clarity of the program". (a community organization)

"Health Canada's vision is now more 'businesslike', and less political; and community groups are more open and less distrustful". (a key stakeholder)

"the stability of CSHA funding has broken the boom and bust cycles characteristic of NAS I and NAS II which discouraged scientists from entering and remaining in the HIV field".

"there has been no increase in dollars for community work, but there has been a dramatic increase in expectations regarding reporting, data collection and evaluation". (a community organization)

"[there has been] a freeze on funding since NASII even though demands and service users have increased dramatically". (a national NGO)

"[CATIE and the AIDS Clearinghouse] helped to ensure correct information is distributed". (a community organization)

"information is not available for non-specialists, we need to reach health and social professionals and educate them on HIV/AIDS [so they can participate more effectively]". (a key stakeholder)

"lines of communications between Health Canada & community groups and Regional Offices & Headquarters needs to be improved, as well as more open/honest information and better collaboration between all partners, not just Health Canada". (a national NGO)

"I am very worried about renewal prospects for research grants in general. The renewal rate is too low and funding levels are about one-third of what they should". (a researcher)

"reviews took way too long, disbursements were months behind schedule, application forms were difficult to deal with – too many restrictions with training awards". (a researcher)

"the CSHA's influence is a strong focus on at-risk groups, resulting in more efficient use of resources". (a key stakeholder)

"ensure funds directed to Corrections Services Canada reach the level most needed – the inmate population". (a community organization)

"CSHA funding is allocated among too many micro-projects, rather than larger, more strategic and effective efforts". (a key stakeholder)

"collaboration to develop an Aboriginal Strategy for HIV/AIDS in prisons" [was a success]. (a key stakeholder)

"a greater involvement of regional coalitions [has aided community capacity]". (a key stakeholder)

"ACAP dollars support organizations that wouldn't exist without Federal funding. Needs studies, evaluations and community research, and planning is better now". (a key stakeholder)

"the work being done in prevention and educational programming should be increased with respect to sexual decision-making (youth, gay/bisexual youth, MSM) and the work [on] poverty, addictions, housing, and supportive employment should be emphasized". (a community organization)

"we need to strengthen Canada's international research efforts in clinical trials and drug resistance. These are of critical importance and other countries, e.g., USA, France, UK, Italy, the Netherlands, are major players. We are not on the map". (a researcher)

"our Province needs to get serious about addressing the issues instead of paying lip service as health is ultimately a provincial responsibility". (a community organization)

"it is surprising that as an active researcher in HIV/AIDS, I never hear anything about the Strategy. There should be a newsletter or some other active way of communicating" (a researcher).

"the evaluation process should have been iterative from the start and not 'end of phase' evaluation. Stakeholders should have been involved in the design and choice of indicators". (a researcher)

FINAL REPORT

1. Introduction

This Report and its Objectives: This is the final report for the Year Three Evaluation of the Canadian Strategy on HIV/AIDS (CSHA). This evaluation of the CSHA was undertaken in Summer 2000 to address four key evaluation questions: To what extent has the CSHA contributed to the achievement of its intended outcomes? What are the facilitators/barriers that enable/limit the achievement of the CSHA's intended outcomes? Is the CSHA investing in the appropriate areas to achieve its intended outcomes? Does the evaluation framework identify the information necessary to successfully complete the Year Five Evaluation? These issues were related to 22 more detailed research questions.

Additionally, the evaluators addressed some new questions which arose during the evaluation. Most importantly, as the evaluation developed it became clear very that the issue of <u>adequacy of resources</u> needed to be examined. This is because adequacy of resources, (both human resources and funding), was a concern of stakeholders throughout the evaluation. The issue of <u>needs</u> thus came to the fore in the evaluation team's analysis. As is noted below, a variety of methods were applied to address these questions and broader issues of rationale, effectiveness and future alternatives.

A Modest Evaluation: While the CSHA is an important and complex program related to a major health problem, it should be noted that this evaluation was an extremely modest undertaking -- an initial look at evaluating this important program¹. Another factor contributing to the modest nature of the research effort was that not all planned components were implemented, so that the evaluation plan was not completed. As a result, the evaluation's ability to answer some key questions in a definitive manner was highly restricted. Thus results presented here are mainly indicative (see Limitations of the Evaluation, next page).

2. Background on the HIV/AIDS Epidemic and the CSHA

The Epidemic and Federal Efforts Since 1990: The first case of AIDS identified in Canada was detected in 1982. Early HIV infections were primarily identified among gay men and people who had been infected through the national blood supply. Early in the epidemic, it was clear that AIDS was a disease with severe, usually fatal impacts on those infected, and one which threatened to spread rapidly if not contained by effective

The budget for this core evaluation was under \$90,000, a modest amount compared to many major federal evaluation studies, which apply budgets sometimes of many hundreds of thousands of dollars.

preventive efforts. From 1982 to December 31, 1999, a total of 45,534 positive HIV tests and 16,913 AIDS cases were reported to the Centre for Infectious Disease Prevention and Control (CIDPC) at Health Canada from all provinces and territories of Canada.² Recent estimates indicate that the prevalence of HIV infection in Canada at the end of 1999 was approximately 49,800 people, compared to 40,100 in 1996.³

This growth of the epidemic reflects the importance of this epidemic and its human costs. Although it is difficult to measure economic costs accurately, research by Albert et al. (1998) suggests that HIV/AIDS infection and the cost to fight the disease are extremely high. In their report, *The Economic Burden of HIV/AIDS in Canada*, Albert et al., estimated that the total cost of the HIV/AIDS epidemic from onset in the early 1980's up to 1997 was \$36 billion (or about \$1,200 per Canadian).

The Canadian Strategy on HIV/AIDS: In March 1998, the Federal government introduced a renewed approach to the HIV/AIDS epidemic in Canada. At that time, the Minister of Health announced the Canadian Strategy on HIV/AIDS (*CSHA*), which replaced the previous National AIDS Strategies (*NAS-I, 1990-1992, and NAS-II, 1993-1998*). The CSHA (sometimes referred to with as *the Strategy*) emphasized a *Pan-Canadian approach*, which was designed to be more than just a federal government initiative but rather to include all levels of government and all stakeholders in the effort against HIV/AIDS.

Annual funding for the CSHA was set at \$42.2 million -- shared between Health Canada (\$41.6 million) and Correctional Services Canada (\$0.6 million). As of 2001 these combined Federal initiatives represented an expenditure of nearly a half billion dollars (1990-2001) for the effort against HIV/AIDS. Combined with contributions by other governments, NGOs, volunteers and persons living with HIV/AIDS, these contributions have helped to develop and institutionalize a substantial response to the HIV/AIDS epidemic as of 2001. This response is reflected in the work of governments, NGOs and others, and the wide range of preventive and supportive services available in most Canadian communities today.

Limitations to the Evaluation: This Year Three Evaluation was a first step in the evaluation of the CSHA, to lay the groundwork for a year five evaluation planned for 2002-2003. Core components of the Year Three Evaluation were undertaken by SPR Associates (hereafter, the evaluators) and the results provided in this report. SPR's effort focused on stakeholder surveys (mainly obtaining informed assessments of the Strategy), a

² HIV/AIDS Epi Update, AIDS and HIV in Canada, April 2000.

Health Canada. "National HIV Prevalence and Incidence Estimates for 1999: No Evidence of a Decline in Overall Incidence" *HIV/AIDS Epi Update*, May 2001.

review of the literature and relevant documents and statistics⁴, and a small qualitative research component (four case studies). Another valuable component, an international comparison study (by Spigelman and Associates) provided important complementary information (see Methodology, below, and Section 3 and Annex 1 for details).

The limitations imposed by the modest scope of the above noted core components were exacerbated by the fact that other two key components of the evaluation were never implemented by Health Canada during the period of the evaluation. One was a cost-effectiveness analysis. This was never undertaken, although a financial analysis was completed. A second missing component was preparation of performance management reports on the Strategy -- reports intended to describe what activities were undertaken by the CSHA with what results. These reports, and CSHA annual reports for 1999-2000, and 2000-2001 were not available to the evaluators at the time of writing.

Thus, this report by the evaluators focuses to an extent on what was indicated by the surveys of stakeholders, with supplementary evidence drawn from the literature and document review (herein referred to as the Working Report), the case studies and the international comparison. Results are valuable as <u>indications</u> of the success of the strategy, but not definitive. Thus the <u>evaluators look to the Year Five Evaluation</u>, and ongoing efforts for more complete results which are needed to manage this important program in the future.

Other Considerations: It should be noted that the evaluation faced other obstacles of a substantial sort that would have thwarted even a major evaluation effort. For example, the evaluation examines only the <u>incremental</u> effects of the CSHA -- how well it has worked in strengthening the work of Health Canada and its partners in the fight against HIV/AIDS in 1998-2001. Therefore the evaluation does not directly assess the cumulative effects and value of all three phases of Federal work against HIV/AIDS since 1990 – although the evaluation suggests that this ten year effort has put a substantial structure of programs and organizations in place to deal with the HIV/AIDS epidemic. A future evaluation might give more attention to this broader long-term impact. Within we address this issue in relation to needs. A related consideration is that the Strategy is a tool for leveraging changes, most of which are generally beyond the direct control of Health Canada. This

Another limitation specific to this component was that little documentation and literature was actually found on the Strategy per se. Overall, documentation on the Strategy was thin, and a conclusion drawn by the evaluators was that perhaps insufficient groundwork was laid for the Year Three Evaluation of the CSHA, and that from an information point of view, the program was not ready for a comprehensive evaluation (based on the premise that a sound informational platform is needed for effective evaluation of a complex and important program such as the CSHA).

means that HIV/AIDS-related activities that are implemented by the provinces or territories, or NGOs or pharmaceutical companies or others can only be indirectly influenced by Health Canada and the CSHA. Thus for many issues, the causal link to the Strategy may be ambiguous.

3. Methodology of the Evaluation

Multiple Evaluation Components: While modest in overall scope, the evaluation had the advantage of different methodologies applied through several core components (see Section 3 in the main report, Annex 1, and technical reports for methodology details, including limitations noted regarding the lack of available literature and documentation).

One core component was a *Working Report* which presented a review of selected documents, statistics and literature. These documents were provided by Health Canada or identified through Internet and library database searches.

A second core component of the evaluation was a series of three national surveys of CSHA participants. The surveys were conducted in early 2001, of: key stakeholders (including government officials, strategy committee members, academics, etc. (48 were surveyed, for a response rate of 82%)), MGOs (national and local community organizations providing infrastructure for the effort against HIV/AIDS, or offering direct services to people living with HIV/AIDS (89 were surveyed, for a response rate of 67%)), and researchers in HIV/AIDS (30 were surveyed for a response rate of 45%). These surveys while indicative only, provided a "front-line" view of success and key issues from those most involved in and most experienced with HIV/AIDS.

A third core component provided more in-depth qualitative data. This component involved more in-depth <u>case studies</u> which were conducted with four organizations providing services to communities and/or persons living with HIV/AIDS. These case studies involved a national Aboriginal program serving First Nation communities across Canada, two community-based programs for at-risk groups, and programs in two federal correctional facilities.

Other components of the evaluation which are referred to within include two independent sub-studies: an <u>international comparison</u> of the CSHA to efforts against HIV/AIDS in five other countries (Spigelman, 2001), which was very useful; and a separate study of CSHA financial topics, but which was not used extensively.

Overall Timing: The evaluation began in August 2000, with data collection from November to May, 2001, and completion of a draft Final Report in late August, 2001, and a Final Report revised in November, 2001 to January 2002.

Results: A summary of indications of the evaluation follow, in Sections 4 to 9 below, with most findings referenced to the supporting data source. All data indicating percentages are drawn from the stakeholder and related surveys except where noted otherwise.

4. The CSHA's contribution to achievement of its Intended Outcomes

Overall Assessments: The evaluation results suggest that the Strategy has resulted in substantial achievements. This can be seen most clearly in the institutionalization of the response to the HIV/AIDS epidemic through the creation of a growing "pan-Canadian" alliance of governments and others in the effort against HIV/AIDS, and also in the growth of specific services and institutions. Such institutional responses are reflected in the important work of bodies such as the HIV/AIDS Clearinghouse, CATIE, the Canadian AIDS Society, and many other key national NGOs, and a widely developed structure of local community services. (Data from surveys and reviews of documentation) However, as is noted below, and within this report, there is still much more work to be done as the epidemic may have been "slowed", but not reversed.

Certain themes were also noted. For example, progress, while apparently incremental, was also seen to be modest. While a majority of all stakeholders surveyed (67%) rated the CSHA as "successful" in aiding Canada's response to HIV/AIDS, only 5% rated it as "very successful" suggesting that overall there has been modest progress. This theme of modest progress is evident in findings for a direct comparison of the CSHA to NAS-II. While 49% of stakeholders rated the CSHA as a small improvement, only 13% rated it as a great improvement over NAS-II.

Another thematic result is one of <u>different views</u> among stakeholder groups. The evaluation surveys indicated that key stakeholders who were closely involved in Strategy steering bodies, or who were prominent in the Strategy's work, such as Health Canada participants, rated the CSHA more positively than did representatives of national NGOs and local community agencies.

In its 2001 Annual Report, the Auditor General of Canada identified three specific CSHA projects as concerns: The Community AIDS Treatment Information Exchange; the Canadian HIV/AIDS Clearinghouse; and the Canadian AIDS Society. The evaluators would like to emphasize that the Auditor General's criticism was of Health Canada's management of the grant processes for these organizations, and not the projects or organizations themselves. The Auditor General conducted no evaluations of these three organizations, and the evaluators have seen no evidence to contradict the indications of this report that these three organizations are a useful and important part of the national effort against HIV/AIDS. A future study – even the Year Five Evaluation – might, however, examine the cost-effectiveness and detailed outcomes produced by such major projects.

Evaluating the Strategy generally, stakeholders indicated in surveys their assessment that the Strategy has had the strongest impacts in areas such as prevention, focussing on those most at risk, building community capacity, and improving information on HIV/AIDS. In contrast, stakeholders rated the Strategy weaker in areas such as the quality of care, treatment and support, assisting partnerships, and HIV/AIDS funding. Details of these impacts, and the related evidence from existing documents, surveys, case studies and other data sources are summarized below.

CSHA Impacts on HIV/AIDS Policy and Programming, Participation and Partnering: Stakeholders we surveyed generally rated the coordination and partnership initiatives of the CSHA positively but the impacts of these efforts were seen as highly variable. For example, the activities of policy coordination bodies were rated very positively, while impacts on partnerships were rated more variably.

As regards partnerships, CSHA impacts on NGOs working together and governments working with NGOs were rated very positively in stakeholder surveys. However, CSHA impacts on government-to-government collaboration was seen as weak and the Strategy was also deemed to be weak in "engaging all sectors -- health, schools, housing, etc." and "in engaging Provincial and other health bodies".

These findings from surveys were echoed in the case study results in which front line service providers indicated that there are barriers to effective partnership building. Some of these included their assessment that the Strategy creates more competition for limited funds. Other concerns emphasized the need for more coordination with other bodies such as welfare and public housing, and other health-related programs, such as drug addiction programs.

While partnership effects were positive generally, a number of NGO stakeholders emphasized that governmental "decision-making behind closed doors" was a factor which undermined the principles of partnership and pan-Canadian inclusiveness. This reality was evident to the evaluators in process features of the evaluation, such as the general exclusion of non-Health Canada partners from steering of the evaluation, and in the fact that it was not possible to cite information from minutes of the Strategy's Federal Provincial committees, as these meetings and their proceedings were deemed to be confidential.

CSHA Impacts on Community Capacity: Stakeholders indicated in surveys that the CSHA had helped organizations better address HIV/AIDS, improved community capacity for prevention, and strengthened the capacity of local communities generally. Strategy impacts on increasing the involvement of volunteers, involving broader communities, and improving of communities' ability to minimize risk factors were not rated as highly by stakeholders.

Generally, however, it was difficult to measure overall success of the CSHA in capacity building due to a lack of reliable databases and indicators. This lack of exact evidence points to a need for improved methods of measuring the change in community capacity, which should be a priority for monitoring and could be an issue for the Year Five Evaluation.

CSHA Impacts on HIV/AIDS Information and Use of Reliable Information in Decision-Making: The evaluation surveys indicated stakeholders saw the CSHA as having had a positive impact on providing more reliable information, and facilitating the sharing of information about HIV/AIDS. This was reflected in the evaluators own assessments of key information channels under the Strategy (Clearinghouse, CATI, etc.)

Yet, a continuing need for improved information was seen in the fact that just over 50% of stakeholders indicated that improvements were needed in information about the CSHA. A particular illustration from the case study findings is the need for more and better targeted information for prison inmates. Another is seen in stakeholders who reported never having seen any information about the CSHA.

Some community organizations also noted that information management was difficult due to limited resources and to the very extensive information available on HIV/AIDS generally. Also, evidence from the literature indicated a need for more reliable scientific information and epidemiological research.

CSHA Impacts on Research, Scientific Advancement and related Outcomes: The CSHA's impacts on research and research outcomes (therapies etc.), appeared to be varied, considering the evidence available to the evaluation. For example, current epidemiological statistics can be considered as part of this domain, and our analysis of existing statistics and epidemiology suggested significant needs to improve data and systems. (that current statistics simply do not allow us to measure the progress of the effort against the epidemic).

As to research in the formal (university or laboratory sense) the evaluation surveys suggest that some CSHA researchers have not been fully engaged by the CSHA, even when funded by the Strategy. For example, some researchers funded by CSHA reported that the work they were doing was not actually related to HIV/AIDS. Some researchers also pointed to a need to develop more of a "community" of HIV/AIDS researchers -- aiding collaboration, networking and information sharing. Also the surveys indicated a need for improvements in the dissemination of research findings and in the application of research to practical uses for communities. Of all the Strategy areas examined, research appeared -- as seen in stakeholder surveys -- to be the one area most in need of further review.

CSHA Impacts on Accountability (including evaluation): The evaluation surveys indicated that the CSHA has had positive impacts on certain developments in evaluation accountability, particularly in increasing available evaluation training resources.. However,

many NGOs reported that they had limited resources (human and financial) to complete new complex evaluation processes requested by the Department. A number of NGOs felt that the development of evaluation skills was beneficial, but others saw the costs of conducting evaluations as being high relative to the value of projects.

Examining the broader use of evaluation in the Strategy, some stakeholders had more strategic assessments. For example, a number of NGOs indicated that there was a need for more direct evaluation of governments' efforts rather than just the current focus of Health Canada on evaluating mainly the efforts of NGOs. They argued that equal scrutiny -- or significantly greater scrutiny than at present -- was needed for Health Canada's work.

Additionally, the evaluators had observations on the evaluation and accountability process. First, the complex structure of evaluations (regional, national, project evaluations) implemented under the Strategy did not appear to facilitate easy comparisons between regions or national roll-ups, and secondly, the absence of up-to-date performance monitoring reports suggested that CSHA resources for evaluation and monitoring were spread too thin.

CSHA Impacts on Provision and Access to Care, Treatment and Support: The evaluation survey results indicated that the CSHA's impact on certain aspects of care, treatment and support have been positive with higher ratings given for improving quality of life in legal, ethical, and human rights areas; and in improving the capacity of organizations to provide services. Modest impacts were indicated in improving the quality of life of persons living with HIV/AIDS (housing, employment, etc.); in improving the response of provincial/other health organizations; in improving training and human resources for staff; and in improving the quality of care generally.

The evaluation data also indicated that care, treatment and support are not uniform across regions. Data from the *Working Report* and surveys suggest that people living with HIV/AIDS are often forced to move or travel to large urban centres in order to obtain services, placing additional financial and psychological stress on these individuals. Additionally, information from case studies indicated that services are highly variable within regions, with different levels of service within different parts of major metropolitan areas.

The Aboriginal case study found that numerous gaps exist regards access to care, treatment, and support for Aboriginal people. As well, CSC case study findings suggested that inmates in correctional facilities have very significant unmet needs for effective prevention information, and do not receive a uniform level of care, treatment and support, as correctional institutions vary considerably in the programs and services that they offer.

CSHA Impacts on Prevention Initiatives/Preventing the Spread of HIV/AIDS: The document and statistical review underlined important prevention-related realities of the epidemic. These realities are that the epidemic continues at least at the same pace noted over the past several years, and that the total number of infected persons is rising, because those contracting the virus are living longer.

Nonetheless, the evaluation surveys suggested that the CSHA has had certain positive impacts in the area of prevention, with 57% of stakeholders indicating that the Strategy had helped to improve prevention capacity. Also on a positive note was that 90% of NGO/community agency representatives reported that they were active in information/education and prevention, and working with key populations at risk -- such as MSM, injection drug users, First Nations populations, youth, and prison inmates.

Information from case studies and key stakeholder interviews, however, pointed to the need for further improvements in the Strategy's prevention work, including the need for more prevention efforts generally, more extensive efforts in correctional facilities, more sustained community programming, better targeting of prevention information and better adaptation of prevention information to suit the varied needs of vulnerable populations. A number of stakeholders suggested that continued education of the general public was still needed, as a key part of prevention strategies.

CSHA Impacts on Social Factors and Outcomes: Minimizing Adverse Impacts on Individuals/Communities, Minimizing Social and Economic Risk Factors: The CSHA was seen by stakeholders to have had only very modest impacts in minimizing social risk factors, which appear to reflect the Strategy's relative ineffectiveness to date in extending partnerships to sectors such as health, schools and housing.

As these are areas of mainly Provincial responsibility, these modest impacts may also reflect the need of the Strategy to more fully engage the Provinces/Territories in the CSHA — to create a truly "pan-Canadian" Strategy.⁶

CSHA Impacts on Funding: While the creation of a permanent funding base for the Strategy was positively regarded by all stakeholders, the overall assessment of the Strategy's impact on funding was rated as being insufficient. For example, the Strategy was seen by key stakeholders and NGOs/community organizations to have had relatively poor impacts in leveraging new funding from the provinces or private sector sources, and had poor impacts on funding of local community services, joint programs, and allocations across HIV/AIDS program areas.

It is important to note that this view was not uniform in all provinces/territories. Participant assessments varied significantly across provinces. While engagement of the provinces was seen as a weak impact area for the Strategy generally, it is important to note that participants in some provinces gave the Strategy high marks for building partnerships with provincial governments.

Indeed, the level of funding for the CSHA was reported as a major concern by most stakeholders, who indicated a need for additional, and more predictable and sustained funding (see Highlights Section 8, below for further discussion).

In regards to the funding process, stakeholders noted both weaknesses and strengths. A weakness in the process is that many NGO and Community service stakeholders indicated that the Strategy funding process was too costly. Stakeholders suggested that very considerable resources were often expended in applications for Strategy funding, relative to the dollars obtained. A reported strength of the funding process is that stakeholders funded by the Strategy gave good marks to Health Canada in terms of the fairness in which the funds are allocated, and the information provided to organizations.

Indications of Outcomes Not Achieved: The Need to do More: The above results examining key Strategy outcome areas suggest that stakeholders see the Strategy as having produced many good results -- but not enough relative to the needs. These findings were reflected in stakeholder views that the CSHA and its partners should be doing more to help the effort against HIV/AIDS. This view -- that much more needs to be done -- was virtually unanimous among all stakeholders -- in government, NGOs and research.

5. What Facilitators/Barriers AFFECT Achievement of the CSHA's Intended Outcomes?

The Strategic Values of the CSHA: The Strategy appears to have been supported by the broad effort of governments and others to collaborate, reflecting some successes for the "Pan-Canadian" approach and related philosophical premises of the strategy. While a truly "Pan-Canadian" Strategy has still to be fully achieved, the fact that growing partnerships have been reported indicates that there has been improvement in this area, and this improvement has been identified as one of the most important facilitators of the work of the Strategy. However, while these effects of the CSHA were seen as positive, the incremental impacts tended to be assessed by Stakeholders as only moderate in most areas.

Complexity of the Epidemic as a Challenge: To some extent modest achievements can be explained simply because of the extraordinary complexity of the HIV/AIDS epidemic. Because the epidemic is interwoven with a wide range of social conditions, human behaviours and institutional constraints, designing initiatives to have any significant change or to have substantial impacts in the short-term is a daunting task. Also, additional complexities stem from the impact of changing social conditions and the wide range of players potentially able to impact on the HIV/AIDS epidemic.

The Main Barriers: Significant concrete barriers were revealed by the evaluation such as the <u>need for a stronger and broader partnering effort</u>, particularly with provinces/territories. Other findings suggested that there are substantial unmet needs for prevention, that there is insufficient reliable epidemiological data, and that there is a need

for standards to aid uniform care, treatment and support across regions. Finally, throughout all areas of the Strategy, the evaluation evidence suggested that the lack of financial and other resources is a key barrier to success (see Highlights Section 8 below, for further discussion).

6. Is the CSHA Investing in the Appropriate Areas to Achieve its Intended Outcomes?

Overall Effectiveness: Indications from stakeholders, documents and other evaluation data suggests that, overall, the Strategy investments has aided the continued development of a substantial and well-institutionalized effort to combat HIV/AIDS in Canada. The investment strategy appears to be effective, given the resources which are currently available, and the available evidence suggests that resources are being well-used. Lack of funds, however makes it difficult to assess questions as to the "best" or most efficient use of resources.

No "magic bullet" Solutions to Create Greater Efficiency: As well, the evaluators noted that the evidence suggests that substantial efficiency already appears to have been achieved with the Strategy dollars available. Thus it can be concluded that only modest gains in overall efficiency might be obtained from ongoing evaluations, performance reviews, etc., particularly for NGOs, which appear to have been assessed very intently. Simply put, marginal improvements in efficiency may be costly to obtain, and cannot compensate for the indicated broader shortfall in funding.

While the level of available funding was a prominent issue in the evaluation, no clear directions were suggested for ways in which the Strategy could achieve better results by improving the allocation of current funding across sub-programs. One reason for this is that there is at this time measure of success which allows comparing the value of one type of endeavour to another -- e.g., to compare the value of research to prevention. Therefore, while funding shortages are an issue for the CSHA, how to best allocate any additional resources is not obvious -- possibly pointing towards any adjustments being across the board. And only a few tactical suggestions can be offered, such as aiming more resources at the areas which are doing poorly, or aiming resources at broadly effective approaches which have been noted by stakeholders. This issue -- of understanding and ensuring cost-effectiveness -- points to a potentially valuable area for further research.

7. Is the Evaluation Framework Satisfactory for Year Five?

Incremental Changes in the Evaluation Approach: Issues of Needs and Benchmarking: Lessons from this evaluation suggest that there is a need to develop new definitions, tools and indicators to provide a more rigorous methodology to result in a useful Year Five Evaluation, with a focus on needs and benchmarking. A more rigorous methodology could be developed, for example, by: ensuring that the Year Five Evaluation

process includes or draws from a method to maintain and inventory HIV/AIDS resources in communities to identify gaps in services; directly evaluating Health Canada's components (most importantly the surveillance and epidemiological statistics; by evaluating the research program); developing rigorous methodologies to assess quality of care and satisfaction with services among persons living with HIV/AIDS; better assessing prevention efforts; applying a better method for measuring partnerships (some methods could be adapted from some regional evaluations now underway); harmonizing regional evaluations; and applying surveys to assess the impact of the CSHA on Canadian public behaviour.

A More Radical Approach: Change the Framework, Change the Approach: The data examined for this evaluation have pointed towards a number of important lessons about the CSHA and have identified a number of key areas needing refinement or development. Additionally, some clear indications are given regarding approaches to improving the Evaluation Framework (Health Canada, 2000) and therefore obtaining a better evaluation in Year Five. The experience of this very limited evaluation suggests that definitive answers to the evaluation questions previously posed may be too costly to obtain, or to obtain in the time frame available, given the lack of well-developed benchmark information. Standard research, using state of the art evaluation techniques and even a more substantial budget will likely not generate significantly more knowledge than this very exploratory evaluation.

Different Types of Questions: It is possible that the Year Five Evaluation should address some very different questions, for example: "what are the needs to fight the HIV/AIDS epidemic", and "what is the optimal level of investment for Canada in the effort against HIV/AIDS". Answers could aid the Department's decision-making and future plans, and may be more useful than a standard evaluation. These questions would focus effort on assessing needs and better benchmarking the Strategy effort, and would not focus on evaluating the current programs per se (with some exceptions, such as evaluating the research programs).

8. Adequacy of Funding of the CSHA and Related Issues.

Basic Funding Issues: In the original terms of reference for this evaluation, the question of funding was set out as a question of how to "invest appropriately" — how to allocate a fixed "pie" for HIV/AIDS, or how to improve efficiency of the effort. But throughout the evaluation CSHA participants in all sectors (government, NGOs, etc.) indicated that insufficient funding was the more critical issue for the effort against HIV/AIDS. Thus this issue is considered here to the extent that the evidence allows.

One illustration is the challenge of evaluating research, which tends usually to be a long term undertaking, often requiring the tracking of academic publications over time, longer-term assessments of citation indexes, etc.

In most of the key data sources examined, insufficient funding for the CSHA was indicated. (see *Working Report* and Spigelman). This was also evident in our own analysis of CSHA funding which showed a substantial decline in the real dollar value of the Strategy's funding since the budget for NAS-II was set in 1993. Indeed, the 2002 budget of \$42.2 million is equivalent to about \$30 million in 1993 constant dollars.

A significant financial shortfall was also suggested by the international comparison study (Spigelman, 2001), which indicated that Canada ranked last in investment per capita as compared to the U.S., U.K. and Australia. Spigelman's data suggested that as much as a four-fold increase would be needed to make Canada's efforts comparable to these peers. [Footnote: Based on comparisons of federal expenditures (Spigelman, 2002). "Sharing Experiences: Learning from 5 Countries' Experiences with the HIV/AIDS Epidemic".] These results strongly echoed views expressed at the Grey Rocks meetings in Fall 2000, that funding is a major issue for the Strategy.

Similarly, in the evaluation case studies, the evidence of insufficient resources was often reported, in community studies where valuable programs were cancelled, in the prisons where key needs for prevention efforts remained unmet, and so on. In many cases, program development and change appeared to be simply a matter of "robbing Peter to pay Paul", and running community NGOs through a maze of conditions and changes. This was seen most clearly in the case of one community program examined in our case studies component of the evaluation. This program which provided valuable preventive services to street youth and IDU, was cancelled by the Strategy, as insufficiently innovative, and then re-funded later as a project under another Health Canada program.⁸

The evaluation process itself also illustrated the degree to which the Strategy was spread thin, when important components on cost-effectiveness, and program monitoring could not be produced by the Department.

Overall, no data could be found to definitively validate the proposition put forward by stakeholders, that the strategy was underfunded, but all of the evidence found here pointed strongly in that direction, suggesting that some remedial action by Health Canada would be desirable (see Section 9, Conclusions and Future Directions).

Finding Directions: The above is not to say that the funding issue is simple. First, it is important to emphasize key contextual issues in funding. One such issue is that *although* stakeholders have indicated that the Strategy is significantly underfunded, their key meaning is that the effort against HIV/AIDS generally is underfunded. It does not follow that the entire gap in funding should be filled by Health Canada or the Strategy.

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This reflects another problem in some Strategy funding -- that pilot projects are funded with insufficient probability of follow-through by long term funders, who would almost always be Provincial-territorial agencies.

Indeed, institutional and constitutional factors make it important that other players, particularly the Provinces/Territories play a substantial role. Second, it is important to emphasize that because no numeric or concrete goals are set for the Strategy, it is difficult to estimate what the resources or level of effort should be for the CSHA. By defining such goals and identifying needs and gaps, funding needs of the Strategy would become more concrete.

There is also a need to ensure that any new funds which might be allocated will be used prudently as opposed to undertaking "crisis" style program expansions which often do not result in best use of funds.

Need for Data on Costs and Expenditures: More generally, the researchers observed that more data is needed on the total amount of money spent on HIV/AIDS in Canada as the CSHA is used as a tool to leverage funding from other sources, and a better understanding regarding the level to which this is being achieved is vital (See Working Report for details).

Additionally, it is significant that there is no assessment of the costs and benefits of investments in the effort against HIV/AIDS generally which would greatly aid the engagement of Canadians with the CSHA. Overall, studies of the economics of the epidemic suggest that increased investments in the effort against HIV/AIDS should result in very substantial societal cost savings. With the societal cost to treat each HIV/AIDS infected individual at \$153,000, it is clear that expanding the effort against HIV/AIDS, and reducing the growth of the epidemic could be of significant economic value to Canada.

A related consideration is that the cost-effectiveness for Canadian society of increasing investments in the effort against HIV/AIDS must be assessed against the returns from investment in other diseases (heart disease, breast cancer, etc.) or in health promotion generally.

These concerns notwithstanding, the evaluation indicates significant needs and numerous arguments for additional funding for the effort against HIV/AIDS and the Strategy if its goals are to be achieved. No current evidence exists to refute this hypothesis, and much evidence noted here, from surveys, documents (including the historic erosion of funds by inflation), and cases studies supports the hypothesis.

This suggests that the greatest need of the CSHA may not be another evaluation, but rather a firm goal refinement and needs assessment and determination effort, relative to clearly articulated goals, which would generate a realistic view of needs in this area, and the benefits to be derived from a more effective effort. Ideally, this would be a priority for all Strategy partners, and not a concern only for Health Canada, although Health Canada might introduce some partial remedies in the short term, as part of a process to strengthen the Strategy.

9. Conclusions and Future Directions

Conclusions: A number of key conclusions can be drawn regarding the Strategy's accomplishments, limitations and future directions. The Strategy appears to have had a positive impact on the effort against HIV/AIDS in the period 1998-2001, with advancements in promoting partnerships and in the continued growth of Canada's institutionalized response to HIV/AIDS. This institutionalization of the effort against HIV/AIDS is seen in the wide range of national and community programs established over the past decade which have continued to provide, and to expand on, services available to those living with HIV/AIDS. This accomplishment of incremental advances over the past three years in most areas is impressive, considering that financial resources for the program have remained unchanged prior to the new Strategy.

These accomplishments can be attributed to the CSHA's strategic positioning on key issues (emphasizing partnerships, those most at risk, and accountability), to the synergy created by the more inclusive "pan-Canadian" approach, and to the resulting partnerships and dialogue (e.g. the "Grey Rocks" conference). In emphasizing these directions, the Strategy would appear to represent good value for money. But while the CSHA has had some good impacts and has been effective in the period 1998-2001, its effects have been moderate at best, and the evaluation results indicate that it has not achieved "enough" relative to the strength of the epidemic and Canada's needs.

This need for more is seen in the overwhelming views of stakeholders that "more has to be done", a view shared by over 90% of stakeholders in government, in national NGOs, in community organizations, and in the research community. Significant unmet needs remain as seen in service gaps in communities; in weak preventive efforts in correctional institutions; in limited responses to the needs of Aboriginal people; in the high cost for communities accessing Strategy funding; in gaps in monitoring and review processes; in apparent weaknesses in the research programs; in the lack of reliable epidemiological and behavioural data; in the lack of measures of cost-effectiveness; and in the weak or limited reach of the Strategy to new partners.

Overall, the evaluation findings suggest the Strategy may have reached its limit in terms of its ability to leverage significant incremental advances in the effort against HIV/AIDS. While the Strategy may be "holding" the epidemic, to make significant advances in the future, a change is essential in either or both of financial and leadership resources devoted to the Strategy. The evaluation findings also suggest that "tinkering" with the program, such as reallocating resources, will probably result in only modest gains, or more likely a waste of effort, since the Strategy and its partners are already operating with a high level of effectiveness. Thus it is emphasized that greater gains may be made through partners better identifying goals, shortfalls and remedial strategies.

Some specific conclusions and recommendations/future directions are shown below.

Conclusions and Discussion	Recommendations/Future Directions	
General Assessment: The Strategy has built on Federal efforts since 1990, creating a substantial and efficient response to HIV/AIDS which remains highly relevant to Canada's needs.	The Strategy should be continued with no major changes in direction, but elements should be expand or modified, if resources care available, to build on the strengths of the existing Strategy, and to remedy its weaknesses.	
Outcomes: Incremental impacts of the Strategy have been modest but are still a significant accomplishment, given the available resources. Greatest impacts are noted in areas such as prevention, in the focus on those most at risk, and in promoting and supporting community capacity. Less satisfactory impacts have been noted regarding the quality of care, support and assistance, the promotion of broadly-based partnerships, and funding.	Areas identified as poorly impacted by the Strategy should be targeted for new efforts, with resources set aside for realistic undertaking of any new initiatives (e.g. targeting apparently weak areas such as quality of care, support and assistance, promotion of more broadly-based partnerships).	
Groups at Risk: A valuable feature of the Strategy has been its emphasis on marginalized groups. However, the vulnerable groups that have been identified by the Strategy (MSM, IDUs, Aboriginal people, youth) are still in need of focused attention.	The Strategy should continue with its efforts to place emphasis on these vulnerable groups.	
Partnerships: The reach of the Strategy in creating partnerships needs to be broadened to create more genuinely inclusive partnerships to fulfil the Strategy's "pan-Canadian" promise.	The "pan-Canadian" nature of the Strategy's decision-making should be strengthened overall, ideally through senior efforts by the federal government (Ministerial level or higher), to engage all levels of government, beginning with the provinces and territories. Other efforts could target departments and agencies as yet poorly involved in the Strategy (boards of education, public health bodies; other federal	
Information: Many stakeholders indicated that they would like more information about the Strategy.	ministries and agencies etc.). The Strategy should initiate a newsletter to carry information about its work to a wider audience of concerned partners and potential partners.	
Management of Costs for NGOs: Many NGOs indicated that the costs of applying for Strategy funding were very high relative to grants obtained.	The Strategy should consider ways to simplify its application and administrative procedures.	

Conclusions and Discussion	Recommendations/Future Directions		
An Open Process: The tendency of government to retreat to "behind closed doors" to make CSHA decisions is an issue of concern, particularly as it contradicts the premises of the Strategy regarding collaboration and partnerships. This practice and reflection of lack of inclusiveness and transparency was strongly indicated by the fact that minutes of the Federal/Provincial/Territorial committees were not for public use and could not be used for the evaluation report. Lack of inclusiveness was also suggested by the absence of the provinces-territories and NGOs from the planning and steering of the evaluation.	A mechanism to provide more open decision-making would be aided by ongoing information exchanges. For example, the Strategy could consider establishing a type of "monitoring committee" which would provide periodic information exchanges among all key partners, rather than just annual "input" such as at direction finding meetings. Additionally the Strategy could consider the creation of regional consultation fora which would meet periodically. Such venues could provide a more regular vehicle for bringing together a wide range of partners, and also a vehicle for considering regional issues. Federal/Provincial/Territorial discussions should also be made more transparent. A step in this direction would be to provide regular reports on the work of the Federal/Provincial/Territorial bodies to all partners and stakeholders.		
The Research Component: The research component of the Strategy may need to be reviewed as there were many areas of concern with this component. For example, in reports that some projects and researchers funded by the Strategy were not focused on HIV/AIDS at all.	A specific review of the research component could be undertaken to address the program's focus on HIV/AIDS, its overall effectiveness, and the balance of community and other research. One method which should be considered for this review would include a peer review by international experts in the field of HIV/AIDS research. Otherwise, researchers emphasized the need for specialized evaluation work, tracking citation indexes, utilization by other researchers, etc.		
Corrections Canada: Canada's prisons are a major potential source for the future spread of the HIV/AIDS epidemic and the risks in correctional institutions are not being sufficiently addressed, as indicated by our case studies.	ada: Canada's prisons are a A review of the effectiveness of, and resources available for, CSC's current programming should be undertaken to ensure that programming levels are sufficiently addressed,		
Surveillance and Epidemiology: There is a need for better data on the progress of the HIV/AIDS epidemic.	A review of the surveillance function should be undertaken, including an examination of the actual surveillance work, and comparison to international models, to identify options for obtaining better data.		

Conclusions and Discussion	Recommendations/Future Directions
Setting Goals: More clearly defined and concrete goals are needed for the Strategy.	A systematic analysis of needs and gaps should be undertaken to identify activities that the Strategy could undertake, with a focus on the likely costs and benefits. This review should include an assessment of all current program elements, including verification of the extent to which all Strategy resources are fully dedicated to HIV/AIDS activities.
Funding: The issue of funding levels needs to be addressed to either remedy the indicated problem of insufficient resources for the Strategy overall, or to put to rest discussion on this topic	Initially, a return to real (constant dollar) funding levels of 1993 might be undertaken by Health Canada, with any new funds allocated in a closely monitored as to cost-effectiveness. However, assessing actual needs should be a first step for a longer term solution Additionally, to aid current and ongoing assessment of the funding issue, a system for collecting data on the overall economics of the HIV/AIDS epidemic should be established. The Strategy should develop the business case for investments in HIV/AIDS based on estimates of the savings which could be expected from investments in HIV/AIDS prevention, etc.
Lea dership: The leadership of the Strategy (including stronger attention from senior officials) should be closely addressed. This could aid a higher level of co-participation by the provinces and territories and others. With stronger leadership, it is possible that the CSHA could better leverage funds from other federal departments or address other health related issues, such as drug abuse, or increasing general health care awareness among people with HIV/AIDS	Steps should be taken to raise discussions of Federal/Provincial/Territorial cooperation to the Ministerial level or higher.
Changes now: Changes to the Strategy are indicated and desirable for Years Four and Five, particularly in the areas noted above, and should not necessarily wait for a year five evaluation	An action plan for Years Four and Five should be developed, building on issues and priorities noted in this evaluation.

Conclusions and Discussion	Recommendations/Future Directions
A Year Five Evaluation: A more specific evaluation methodology will be needed for the Year Five Evaluation, if the evaluation is to produce value-added information for the Strategy partners on the types of questions posed in the evaluation framework. Alternatively, it is possible that an evaluation per se is not the greatest need of the Strategy. Another evaluation, even with more rigorous methods is likely to show simply that the strategy is doing "good stuff" generally. Rather, it may be that the most important needs of the strategy are in the area of strategic and planning information, such s the "needs" study suggested by our discussions above.	If an effective year rive evaluation is to be developed, a detailed evaluation methodology should be developed as soon as possible. This could be done by putting the methodology itself out to tender far in advance of year 5. This should be a substantial effort, considering the complexity of the Strategy. A new evaluation framework would be prepared New information to aid the year five and later evaluations should be developed through the sponsorship of more research on the Strategy itself, emulating research paper series such as those other programs have developed linking Departmental interests with interests of academic researchers (for example, those which HRDC Applied Research Branch has developed for its labour programs, or those which Health Canada's National Clearinghouse on Family Violence has developed for its information needs, or similar research programs seen at Statistics Canada.
Partners in Evaluation: It is noted that this evaluation could have proceeded with greater effectiveness had a wider range of partners been involved in the refinement and steering of the evaluation.	A steering committee, with representation from all partners (provinces and territories as well as NGOs, and with representation from persons living with HIV/AIDS, should be established for the Year Five Evaluation and should start its work now to ensure that the evaluation meets the needs of all parties.

Technical Note 1

Detailed Methodology Notes

Overview: Notes are provided below for each of the three key core components and methodologies applied to this report, the *Working Report* on literature, statistics and documents, The *Report on Surveys*, and the *Report on Case Studies*. The reader is directed to Spigelman (2001) for details on the international comparison study.

1.1. Methodology of the *Working Report* Component (Review of Documents, Statistical Data and Selected Literature)

Data Sources: The numerous documents examined for this report included those related to the CSHA activities (Evaluation Framework, Evaluation of NAS II, etc.), as well as other HIV/AIDS evaluation-related materials (HIV/AIDS Epi Updates, Evaluations of international activities, various web-sites, etc.). Some information is also drawn from other reports prepared for the evaluation, particularly *The International Study* (Spigelman, 2001).

Since the focus of this Review was on the CSHA, the documents reviewed were mostly Canadian materials relating to the CSHA, or the HIV/AIDS epidemic in Canada. However, a small number of international evaluations of HIV/AIDS strategies (Australia, Switzerland) are also examined for comparison purposes, although the reader is directed to the international comparison study (Spigelman, 2001) for a more complete international review.

The documents that were reviewed for this report were obtained from a variety of sources. Many were supplied to SPR by Health Canada (including reports on the Strategy, minutes from meetings, etc.); identified by consultants and stakeholders as particularly relevant to this evaluation; obtained through Internet searches throughout the duration of the evaluation (including information gathered from Health Canada's web site, statistical information and information about the CSHA, Correctional Service of Canada's web site, as well as international government web pages, web sites for non-governmental organizations, and other pertinent sites); and obtained through a library document search.⁹

Searches for literature and documents were done on the internet and library (using Medline, PubMed, EMBASE, CINAHL, MEDLINEplus, Social Sciences Abstracts, Social Work Abstracts, Canadian Periodical Index and other data bases), using search terms such as HIV/AIDS evaluation, HIV/AIDS program review, HIV/AIDS policy research, HIV/AIDS strategy, CSHA, NAS-II, HIV/AIDS surveillance, HIV/AIDS lessons learned, HIV/AIDS best practices, HIV/AIDS epidemiology, etc.

Volume of Literature: A challenge for the document and literature review was the overwhelming amount of literature published on HIV/AIDS more generally. Every year, thousands of HIV/AIDS evaluations, studies, reports and reviews are conducted around the world. To narrow the scope of the review, we focused on selected information that is relevant to Canada and the four main evaluation questions, examining the strengths and weaknesses of the Strategy based on available data, and reports on similar evaluations. As noted below, however, significant limitations in the literature were faced, particularly the dearth of research and writing on the Strategy per se.

Limitations: A key limitation for the literature and document review component was the lack of literature and research about the CSHA itself at the time the research was conducted. Much information was available about the HIV/AIDS epidemic generally, but with the Strategy only ending its third year, little had been written about the Strategy in journals, etc. Additionally, at the time of this research, there were no monitoring reports or annual reports of the CSHA, for 1999-2000 or 2000-2001.¹⁰ Thus, considerable information about the Strategy itself had to be drawn from a few key reports, such as: the Grev Rocks Report which summarized proceedings of a key conference of HIV/AIDS stakeholders in Fall, 2000; Aids in Canada 2000, a report from the national HIV/AIDS organizations; and reports and web-sites of specific organizations such as the Community AIDS Treatment Information Exchange (CATIE), Canadian HIV/AIDS Legal Network, Canadian HIV/AIDS Clearinghouse, Canadian Aboriginal AIDS Network, and the Canadian AIDS Society (CAS). It is emphasized that most of these documents were intended for other purposes (e.g. information for stakeholders or general purposes). Virtually no formal research was available on the Strategy itself, for example in systematic studies, or formal research published in refereed social science, public policy or health journals.

Another limitation was the variability and uncertain reliability of some of the available scientific data on the HIV/AIDS epidemic -- for example surveillance and epidemiological data prepared by Health Canada or others. This meant that some conclusions which the evaluators would have liked to draw, for example, about the actual course and growth of the epidemic -- in relation to the CSHA -- could not be tracked in any reasonably exact manner. A final limitation was that many documents of interest are not published or publicly available. An illustration was that some official documents could not be examined for the evaluation, such as minutes of the meetings of Federal-Provincial-Territorial HIV/AIDS committees because these documents were being kept confidential at the time of the research.

For example, departmental performance review reports on the CSHA, were not available at the time of writing, so that this key source of potential information was not available for this paper.

Conclusions Regarding This Component of the Methodology: The evaluators concluded that far too little foreground information for the Strategy was available for the evaluation, possibly raising the question as to whether the Strategy was actually "ready" to be evaluated.

1.2. Methodology of the Survey Component

The survey component summarizes findings from three national surveys which were conducted in early 2001 for the Year Three Evaluation of the CSHA. These were surveys of key stakeholders (including government officials, strategy committee members, academics etc.), NGOs (national and local organizations providing infrastructure for the effort against HIV/AIDS, or offering direct services to people living with HIV/AIDS), and researchers in HIV/AIDS who were funded by various Strategy research components. Throughout this report, these three groups are referred to collectively as *CSHA participants*.

A key element of the surveys was exploring the extent to which the participant groups in CSHA had similar views of the success of the Strategy. The surveys became a more important source of data for the evaluation in the absence of some other data inputs such as the cost-effectiveness analysis and CSHA performance reports.

The surveys examined general assessments of the CSHA; its current status and its incremental progress since 1998; assessments of specific components/activities in the CSHA and successes and obstacles; assessments of any negative impacts of the CSHA; and future directions, including identification of new activities which may be desirable for the CSHA and the broader effort against HIV/AIDS. Comparable questions were generally used in each survey to allow for assessments of the Strategy across the various participant groups surveyed.

Sampling and Response Rates: The three survey groups were sampled and surveyed in different ways. *Key Stakeholders* were identified by Health Canada, and interviews and surveys were attempted with a sample of 50 such persons including federal and provincial officials, representatives of major national NGOs, academics and others. Altogether 48 key stakeholders were surveyed, including 41 of the original sample of 50 (for a response rate of 82%), and an additional sample of 7 key stakeholders added to compensate for cases not surveyed from the initial group.

Participants in the key stakeholders survey were offered the opportunity to do an interview with the evaluators, or to complete a detailed questionnaire. Most participants self-completed the questionnaire, after which a brief follow-up interview was conducted by a member of the Evaluation team. Coverage was national in scope with the surveys implemented in both official languages. The surveys were completed between December 15, 2000 and March 15, 2001.

NGOs and community organizations were sampled from data bases provided by Health Canada. A sample of 132 NGOs and community organizations were surveyed from across Canada (starting with a data base of 169, from which duplicates and not-in operation cases were reviewed). The survey was conducted mainly by fax (with some supplementary surveys mailed, and a few completed by telephone interview. Initial FAX questionnaires were followed by Fax and telephone reminders. Altogether, 89 NGOs and community organizations completed the survey, for a response rate of 67%.

Researchers were identified by Health Canada, and an attempt was made to conduct a census survey of 72 researchers who could be identified in Health Canada data bases, and located (later, several cases were removed, where they indicated they were not actually active in HIV/AIDS research). They were also surveyed by FAX, with fax and telephone reminders to encourage responses. Responses were obtained from 30 of these persons, for a response rate of 45%.

The Questionnaires: The study questionnaires were designed to provide comparable data from all survey groups. Each part of the survey dealt with a different aspect of the Strategy (such as funding, capacity building, etc.) and each part had an initial question allowing the participant to indicate if they were informed about that particular aspect of the CSHA. If they indicated they were informed, they were asked to complete detailed questions indicating the extent to which the Strategy was deemed in various ways to have aided the effort against HIV/AIDS.

Thus the surveys provided assessments of the Strategy's strengths and weaknesses as seen by participants, across the full range of potential impacts areas (e.g. research, community capacity, evaluation etc.) and sub-areas within each area where the participant identified himself/herself as being informed on the topic. Statistical tables within indicate in each area and sub-area the percentage of each participant group indicating that the "CSHA helped" the effort against HIV/AIDS, providing a useful view of strengths and weaknesses of the Strategy. An overall response column is also included in most tables. Additionally, the surveys obtained qualitative data, for example participants' suggestions as to how the Strategy could be improved.

Limitations of the Surveys: A key imitation to be noted, is that the survey is only one data source, and mainly a source of informed opinion. It does not provide "hard data" on the impacts of the Strategy, but only assessments. Thus these data must be weighed against other evidence for a more complete view of how the CSHA has actually worked. However, these assessments are drawn from those most active in the work against HIV/AIDS, and thus uniquely important in their strategic potential, and "front-line" view of needs and issues.

Analysis and Presentation of Statistical Results: Statistical responses for the surveys are presented for a wide range of questions addressing the evaluation issues and detailed research questions. These results are usually in tables which show separate results for each of the three participant groups (key stakeholders, NGOs and community organizations, and researchers). A key indicator used throughout the report is the assessment of CSHA participants as to the extent to which the CSHA actually had *helped to improve the effort against HIV/AIDS*. The goal was to use this "lead indicator" to identify areas of strength and weakness in the CSHA, particularly identifying program areas where the Strategy seemed to "help".

Qualitative Data: Qualitative analysis involved compilation of quotes and comments, coding, and review by a team of three researchers to identify trends and typical assessments.

Indicators of Reliability, Survey Participants' Familiarity with the CSHA: An interesting indicator of reliability of the survey results is the level of familiarity most participants report regarding various aspects of the CSHA. *Most stakeholders reported that they were "somewhat to very familiar" with the effort against HIV/AIDS overall, and a substantial portion also indicated that they were able to make comparisons historically between the CSHA and NAS-II (See Display 3, page 10). This included 60% of key stakeholders, and 50% of NGO/community organization representatives -- a surprise, as study advisors thought that turnover and related factors would prevent most NGOs from assessing the historical picture.¹¹*

But stakeholders reported that they were "very familiar" in only a limited number of cases with the many various CSHA activities. For example, "very familiar" responses were obtained from only 39% of key stakeholders for community capacity; 32% for evaluation and accountability; 28% for research; and 27% for quality of support, treatment and care (see Display 2, below). Representatives of community organizations were most familiar with the way in which the Strategy has community capacity (however only 31% noted they were "very familiar"). Researchers were the least likely to note that they were very familiar with specific aspects of the strategy, with all categories scoring between 0-20% for "very familiar" responses. For this reason, it is necessary to use caution when examining certain results due to the fact that some survey participants are familiar mainly

Elsewhere, in detailed statistical reports separately submitted, these types of assessments were divided into two major categories to assess CSHA impacts: "helped" and "did not help," with the "neutral" percentage omitted. Percentages reported for "% indicating helped" are participants that replied "4" of "5" on the five-point scale. In some cases, percentages are reported here for "% indicating did not help" represent the number of participants that reported a rating of either "1" or "2" on the five-point (did not help-to-helpful") rating scale. All of the "3" responses or the mid-range responses were not counted. Also, the "don't know" responses were removed in calculating percentages helped and "did not help". Although mid-range indicators may provide interesting insight, these non-committal ratings have not been included in this report.

with certain areas in which they work the most. Since the CSHA covers such a vast array of topics regarding HIV/AIDS, and the scope of participants' work may be very specific, this should not be surprising.

1.3. Methodology of Case Study Component

Overview: The case study component was designed to provide the evaluators with information from the point of view of people living with HIV/AIDS and to provide indicative data for key evaluation questions.

Sampling: The case study organizations were chosen by Health Canada staff. The four organizations were chosen in order as serving a number of target populations and regions. Case studies were conducted (1) in two Correctional Services institutions in Ontario, (2) with a national not-for profit organization that serves Aboriginal populations across Canada, (3) with a community organization that serves street youth in Montreal (this organization had its main project funding cancelled during the case study), and (4) with a Vancouver community organization that provides a variety of services to people living with HIV/AIDS.

Limitations: The samples for both the organizations (four case studies involving three funded organizations and two prisons) and individuals who participated in the case study are extremely small, and thus, the opinions and experiences expressed in this report are not necessarily representative of the larger populations of organizations, programs and individuals. The intention of the case studies was to be illustrative of key topics and concerns, and thus to provide qualitative input to the larger CSHA Evaluation. Thus throughout the report, stakeholders perspectives are highlighted.

Initial contacts to begin the case studies: Individuals who were identified as contacts for the organizations by the Health Canada Project Team were contacted in order to inform them of the case study activities and inquiries were made as to whether or not the organization would participate. All of the organizations that were contacted agreed to participate. These organizations were then sent background materials, explaining the evaluation, the case study component, and the types of questions that would be used for the discussion groups or interviews with staff and clients. These key contacts identified potential participants, and assisted in organization of the discussion groups and interviews.

Documentary Evidence: As part of the case studies, relevant documents were also studied for each organization. These included numerous program brochures, web sites, annual reports on the organization, information that is made available to clients, etc.).

Interview guides were developed for both the interviews and discussion groups with staff, as well with the clients of the selected organizations. These guides were developed and distributed to SPR regional researchers who conducted the case studies. Researchers were instructed on the overall evaluation as well as the specifics of the case study goals and method. Individuals who participated in the interviews and discussion groups also received documents explaining the rationale, the general approach, methodology, process and sample questions. Considering that the case study organizations were unique, staff members were encouraged to be flexible when collecting data for the case studies.

Field Procedures and Results: Discussion groups and interviews were conducted with both staff and those that use the services of the organization. A wide range of staff participated in the case studies included the directors, administrators and operational staff members (i.e. executive directors, case workers, library staff, councilors, nurses, trainers, etc.). In Montreal, two interviews and one discussion group with staff members were conducted, along with two discussion groups with clients of the organization (eight individuals). In Vancouver, interviews and one discussion group with 6 staff members and a focus group with 6 clients were conducted. The Correctional Services case study included interviews and a discussion group with 5 staff members, a discussion group with two inmates and one-on-one interviews with four other inmates. The Aboriginal case study consisted of interviews with 2 staff members and 2 community health representatives who took part in the organization's "Train the Trainers" program. All groups and interviewees were highly cooperative and interested in the study goal, and making their views known on the CSHA (or CSHA-supported services, in the case of clients)

Limitations: The case studies were limited in several ways, most importantly in the extent of reach to persons living with HIV/AIDS. These limitations were set in part by the specific case studies which were chosen for the researchers. First, since the Aboriginal organization that was included in the case study was more involved with providing information and training to community health representatives, and not directly offering services for people with HIV/AIDS, no people living with HIV/AIDS were included in this case study.

Further, in each of the other case studies, an attempt was made to hold discussion groups with people living with HIV/AIDS, but this could not always be done. For example, in the Montreal case study, the members of the discussion group for clients were persons involved in a drug-use related HIV prevention program, but were not necessarily HIV/AIDS-infected persons.

Data Integration and Analysis: The information from the individual case studies was used to provide background information, a better understanding of the services provided, and indicators of findings related to specific issues. These working assessments were compiled and reviewed with the case study researchers by two members of SPR's evaluation team to arrive at a consensus view of key findings and conclusions.

Technical Note 2

1. Findings for Specific Stakeholder Groups: The surveys recorded some differences notably among the various stakeholder groups as noted below:

Findings Specific to the Key Stakeholder Survey: In general, key stakeholders were most positive about the effectiveness of the CSHA. In their view, the CSHA has been successful at creating new partnerships and increasing the number of volunteers, and they were generally positive about the impact of CSHA on evaluation and accountability. Key stakeholders were <u>less</u> positive about the impact of the CSHA regarding the quality of care, treatment and support and they noted that more funding is needed to improve the effectiveness of the fight against HIV/AIDS. Key stakeholders were almost unanimous that more could and needs to be done by the Federal government as well as by other partners.

Findings Specific to the Community Organization Survey: NGO/community agency representatives were much less likely than key stakeholders to rate various aspects of the CSHA favourably. However, NGO/community agency representatives did respond positively regarding the Strategy's impact on community capacity (including helping community organizations to increase capacity, and improving capacity for prevention). NGO/community agency representatives were also generally favourable about the CSHA's ability to assist with partnerships between NGOs, and between NGOs and government. However, they rated the CSHAs' ability to engage governments in working together and partnerships between all sectors (health, education, etc.), particularly with the provinces, more poorly. Ratings by NGO/community agency representatives of the CSHA's ability to improve the quality of care for persons living with HIV/AIDS was also generally poor, as were the ratings regarding the CSHA's impacts on funding, which was noted as a major problem area.

Findings Specific to the Survey of Researchers: The survey of researchers had the lowest response rate of all the surveys, and the findings raised many questions regarding the Strategy and its impact on research. The findings suggest that researchers, as a group, seem to be relatively uninformed in general about the Strategy, and about broader efforts against HIV/AIDS.

Where assessments were provided, researchers were less likely than stakeholders to rate some areas of the CSHA favourably. For example, researchers did not attribute much success to the CSHA in developing partnerships. They were generally more positive about research issues, impacts on community capacity, and quality of treatment and care.

Additionally, it was noted that Health Canada stakeholders were likely to be more positive about the Strategy that were NGO/community agency stakeholders.

2. Familiarity With CSHA Components and Activities: Stakeholder groups varied greatly in their familiarity with different component areas of the Strategy, as shown below. Researchers reported that they were "very familiar" in only a limited number of cases with the many various CSHA activities. For example, "very familiar" responses were obtained from only 39% of key stakeholders for community capacity; 32% for evaluation and accountability; 28% for research; and 27% for quality of support, treatment and care. Representatives of NGOs/community organizations were most familiar with the way in which the Strategy has community capacity (however only 31% noted they were "very familiar"). Researchers were the least likely to note they were very familiar with specific aspects of the strategy, scoring between 0-20% for "very familiar" responses.

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the think	Key Stakeholders	NGO/Community Organizations	Researchers
Canadian efforts against HIV/AIDS overall			
Very familiar	76%	28%	20%
Somewhat familiar	22	55	53
Not familiar at all	2	17	27
CSHA's impact on partnerships			
Very familiar	51	23	10
Somewhat familiar	36	58	43
Not familiar at all	13	19	47
CSHA's impact on community capacity			
Very familiar	39	31	4
Somewhat familiar	43	45	29
Not familiar at all	18	23	68
CSHA's impact on quality of support-treatme	ent-care		
Very familiar	27	18	3
Somewhat familiar	52	38	21
Not familiar at all	20	44	76
CSHA's impact on research on HIV/AIDS			
Very familiar	27	5	13
Somewhat familiar	48	33	63
Not familiar at all	23	62	23
CSHA's impacts on quality of information			
Very familiar	43	28	0
Somewhat familiar	41	52	40
Not familiar at all	15	20	60
How CSHA manages its funding			
Very familiar	56	29	3
Somewhat familiar	36	51	50
Not familiar at all	9	19	47
How CSHA impacts on evaluation			
Very familiar	32	21	0
Somewhat familiar	50	44	20
Not familiar at all	18	35	80

3. The Logic Model: Numerous models of the Strategy exist. For example, several models of inputs and outputs, program components and outputs can be found in the Evaluation Framework (Health Canada, 2000). One such model is the *Strategy Description*, which is provided in Figure 2.1 of the Framework. I illustrates the ways in which program components and activities are expected to impact on a wide range of areas of concern to the Strategy, including prevention, information, legal and human rights, access to care-treatment-and-services, and many other areas.

Another key model is the Logic Model, which describes key activities and intended impacts of the Strategy. This model could be improved in several areas, for example, in its original version it identifies certain impacts as being immediate and others as intermediate and others as long term, in ways that reflect an unproven causality or flow of impacts. For example, scientific advancements are identified as immediate outcomes, finding vaccines and therapies as intermediate, and finding a cure as long term. Yet the causal or temporal nature of these events cannot be known at this time. Similarly, provision of care treatment and support is identified as a long-term outcome when it is in fact an outcome that can occur at any stage of the Strategy. For the framework to be more useful in the year 5 evaluation, it should be revised and harmonized with other parts of the Framework, such as Figure 2.1, which provides a more comprehensive view of the Strategy.



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Recent Data Indicate HIV Infections Are Rising In Canada Among Men Who Have Sex With Men - *November 2000*;

AIDS and HIV in Canada - April 2000;

HIV Prevalence and Incidence in Canada: 40,100 Living with HIV Infection and 4,200 New Infections Per Year - *April 2000;*

HIV Testing Among Canadians: 15,000 Current HIV Infections May Not Be Diagnosed - *April 2000*:

HIV Infection Reporting in Canada - April 2000;

Positive HIV Test Reports in Canada - April 2000;

HIV and AIDS Among Youth in Canada - April 2000;

HIV and AIDS Among Women in Canada - April 2000;

Perinatal Transmission of HIV - April 2000;

HIV/AIDS and Ethnicity in Canada - April 2000;

HIV and AIDS Among Aboriginal People in Canada - April 2000;

HIV/AIDS Among Men Who Have Sex With Men - April 2000;

HIV/AIDS Among Injection Drug Users in Canada - April 2000;

Risk Behaviours Among Injection Drug Users in Canada - April 2000;

Oral Sex and the Risk of HIV Transmission - April 2000;

HIV Strain Surveillance in Canada - April 2000;

Primary HIV Anti-retroviral Drug Resistance in Canada - April 2000;

Anonymous HIV Testing in Canada - May 1999; and

Sexual Risk Behaviours of Canadians - May 1999

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The Research Questions

(numbered 1.0 to 4.02 from the Framework for an Evaluation of the CSHA, 2001)

Strategy Rationale

- 1.0 To what extent is the Strategy relevant to HIV/AIDS issues in Canada?
- 1.01 Is there a continuing need for Strategy initiatives?
- 1.02 To what extent does the Strategy focus on those most at risk?

Effectiveness of Overall Strategy Implementation and Management

- 2.0 To what extent is the implementation and management of the Strategy appropriate to enable achievements of the identified outcomes?
- 2.01 To what extent has the Strategy engaged key governmental and non-governmental stakeholders?
- 2.02 To what extent are resources leveraged from other sources?
- 2.03 To what extent are Strategy allocations appropriate?
- 2.04 Have the barriers to the successful implementation of the Strategy been addressed?

Strategy Results/Outcomes

- 3.0 To what extent has the Strategy contributed to achievement of its intended outcomes?
- 3.01 To what extent has the Strategy contributed to the development of scientific advancements?
- 3.02 To what extent has the Strategy increased the use of reliable information?
- 3.03 To what extent has the Strategy strengthened the coordination of HIV/AIDS policy/programming?
- 3.04 To what extent has the Strategy contributed to increased capacity to address HIV/AIDS issues?
- 3.05 To what extent has the Strategy contributed to increased involvement, participation and partnership?
- 3.06 To what extent has the Strategy contributed to finding vaccines and therapies?
- 3.07 To what extent has the Strategy improved the access to effective care, treatment and support?
- 3.08 To what extent has the CSHA contributed to minimizing adverse impacts on individuals/communities?
- 3.09 To what extent has the Strategy contributed improved access to effective prevention initiatives?
- 3.10 To what extent has the Strategy contributed to minimizing social and economic risk factors?
- 3.11 To what extent has the Strategy contributed to finding a cure?
- 3.12 To what extent has the Strategy contributed to preventing the spread of HIV?
- 3.13 To what extent has the Strategy contributed to the provision of care, treatment and support?

Cost-Effectiveness and Alternatives

- 4.0 To what extent has the Strategy adopted the most appropriate, efficient and cost-effective methods to achieve the intended outcomes of the CSHA?
- 4.01 To what extent is the Strategy cost-effective?
- 4.03 To what extent are the activities and outputs able to achieve the Strategy goals?
- 4.02 Are there alternative mechanisms to address Strategy goals?



Stakeholders and Organizations and Researchers Surveyed

Key Stakeholders Surveyed included:

- Dr. Paul Humphries, Ministries of Solicitor General and Correctional Services
- Mr. Mike Clark, Alberta Correctional Services
- Mr. Terry Youngman, Department of Justice
- Ms. Bonnie Lynch, Department of Justice
- Ms. Joyce Gosse, Her Majesty's Penitentiary
- Ms. Nancy Enns, Whitehorse Correctional Centre
- Ms. Patti Tait, Correctional Service Canada
- Mr. Paul Peterson, Manitoba Justice
- Ms. Elena Kanigan, Ministry of Health and Ministry Responsible for Seniors
- Dr. Eric Young, Saskatchewan Health
- Ms. Joanne Laskoski, Health Canada
- Ms. Esther Tharao, Ministerial Council on HIV/AIDS,
- Dr. Sholom Glouberman, Baycrest Centre
- Mr. Henry Koo, Health Canada
- Ms. Leslie Reid, Department of the Solicitor General
- Mr. Stephen James, Health Canada
- Dr. Lindy Samson, Children's Hospital of Eastern Ontario
- Mr. Neil Burke, Centre for Infectious Disease Prevention and Control
- Ms. Linda Jordan, Health Canada
- Ms. Tracey Donaldson, Health Canada
- Mr. Jeff R. Potts, Correctional Service of Canada
- Mr. Christopher Armstrong, Correctional Service Canada
- Ms. Nancy Sutton, Correctional Service Canada
- Mr. Morgan Pond, Department of Health & Community Services
- Ms. Brenda Cantin, Health Canada
- Mrs. Pat Mandl, Department of Health and Social Services
- Dr. Andree Corriveau, Department of Health and Social Services
- Dr. Ann Roberts, Nunavut Department of Health and Dept. of Social Services
- Ms. Jo-Ann MacDonald, Department of Health and Social Services
- Ms. Mahnaz Farhang Mehr, Department of Health
- Mr. Robert Throop, Champ Program
- Ms. Ann Swarbrick, Community AIDS Treatment, Information Exchange
- Mr. Art Zoccole, Canadian Aboriginal AIDS Network
- Ms. Debra Keays-White, Health Canada Brian Foster, Health Canada
- Mr. Cliff Gladue, Metis National Council
- Mr. Don Kilby, Ministerial Council on HIV/AIDS
- Dr. Bryce Larke, Government of Alberta
- Dr. Diane Rothon, BC Corrections
- Ms. Jane Oram, Health Canada
- Ms. Jennifer Hebert, Ministerial Council on HIV/AIDS
- Mr. John Stinson, Health Canada
- Ms. Josephine Muxlow, Correctional Services
- Mr. Ken Mews, Canadian Association for HIV Research

- Ms. Louise Binder, Canadian Treatment Advocates Council
- Mr. Michael O'Connor, Interagency Coalition on, AIDS and Development
- Mr. Albert McLeod, Manitoba Aboriginal AIDS Task Force
- Mr. Bob O'Neill, Canadian HIV Trials Network
- Mr. Earl Nowgesic, Assembly of First Nations
- Mr. Frank McGee, Ontario Ministry of Health
- Ms. Emmanuelle Morin, Saskatchewan AIDS Network
- Ms. Nina Arron, Health Canada Paul A. Sandstrom, Health Canada
- Mr. Phil Rauch, Alberta Community Council on HIV
- Mr. Phillip Haines, North Island AIDS Coalition Society
- Ms. Reeta Bhatia, Health Canada
- Mr. Robert Allan, AIDS Coalition of Nova Scotia
- Ms. Roda Grey, Inuit Tapirisat of Canada
- Ms. Sheila Genaille, Metis National Council of Women,
- Mr. Todd Armstrong, Pauktuutit Inuit Women's Assoc. The Canadian Inuit HIV/AIDS Network
- Mr. Steve Poulin, Health Canada

Community Organizations Surveyed:

Wabano Centre for Aboriginal Health Inc.

College of Family Physicians of Canada

Stepping Stone AIDS Committee of London

AIDS Yukon Alliance

Mainline Needle Exchange

Canadian Assoc. of Nurses in AIDS Care (CANAC)

Association of Canadian Medical Colleges (ACMC)

Memorial University of Newfoundland

Canadian Psychological Association

Council of Ministers of Education, Canada

Canadian Association for Community Care

United Caribbean AIDS Education Network

Centre local services communautaire

Prisoners with HIV/AIDS Supp. Action Network (PASAN)

The Teresa Group

Community Research Initiative of Toronto

AIDS Yellowknife

Centre medico-social communautaire

All Nations Hope AIDS Network

La Fondation du refuge pour, femmes chez Doris Inc.

Quesnel Tillicum Society

SIDA/AIDS Moncton Executive Director

AIDS Vancouver Island

Canadian Medical Association

Congress of Aboriginal Peoples

Interagency Coalition on AIDS and Development

AIDS Committee of Toronto (ACT)

A Loving Spoonful, Executive Director

Boys & Girls Club of Williams Lake & Dist.

AIDS Community Care Montreal,(ACCM)

Central Toronto Youth Services

AIDS Saint John

Metis National Council

Gay and Lesbian Health Serv. of Saskatoon Inc.

Canadian Public Health Association

AIDS Brandon Inc.

AIDS Calgary Awareness Association

Asian Community AIDS Services

Healing Our Spirit B.C. First Nations AIDS Society

AIDS Committee of Thunder Bay

AIDS Committee of Guelph and Wellington County

Planned Parenthood of Nova Scotia

National Association of Friendship Centres

ACCESS - The AIDS Committee Of Sudbury

AIDS Shelter Coalition of Manitoba Inc.

Kali-Shiva AIDS Services

Alberta Native Friendship Centre Association

Labrador Friendship Centre

Ontario AIDS Network

AIDS Niagara

Brandon Friendship Centre

Peel HIV/AIDS Network

Canadian Treatment Advocates Council

Kimamow Atoskanow Foundation

AIDS Comm. of Cambridge/Kitchener/Waterloo & Area (ACCKWA)

Community AIDS Treatment Information Exchange (CATIE)

Canadian Association of Social Workers (CASW)

First Nations of Quebec and Labrador -Health & Social Services Comm. REACH

Native Friendship Centre of Montreal Inc.

AIDS Committee Of Windsor

Planned Parenthood Pictou County

Metis Nation of Alberta Association (MNAA)

Women's Health Clinic

Deaf Outreach Project

Planned Parenthood Federation of Canada

AIDS Saskatoon

Metis Community Services

Northern AIDS Initiatives Inc.

AIDS Regina Inc.

The Family Healing Circle Lodge Inc.

Healthy Thompson Inc.

Winnipeg Gay/Lesbian Resource Centre

Good Shepherd Centres

Canadian Palliative Care Association

Art of Living Foundation

AIDS Committee of North Bay and Area

Peterborough AIDS Resource Network

HIV/AIDS Regional Services

Downtown Eastside Youth Activities Society

West Kootenay/Boundary AIDS Network Outreach/Support Society

YOUTHLINK - Inner City

AIDS Action Committee of Perth County

Sexual Health Services Coalition

Charlottetown Boys and Girls Club

Toronto People With AIDS Foundation

2-Spirited People of the First Nations

Ontario Aboriginal HIV/AIDS Strategy

School of Health & Human Performance

Mannawanis Native Friendship Centre Society

Voices of Positive Women

Village Clinic

Lower Mainland Purpose Soc. for Youth & Families

The Positive Women's Network

AIDS New Brunswick/SIDA Nouveau Brunswick

Native Women's Transition Centre Inc.

AIDS Prince George Society

Newfoundland/Labrador AIDS Commitee (NLAC)

Mainland South Teen Health Centre

Treatment Information Program

British Columbia Persons with AIDS Society

The Lesbian Gay Bi-Youth Line

Healing Our Nations

AIDS PEI

Native Women's Assoc. of the Northwest Territories

Asian Society for the Intervention of AIDS

Pauktuutit-Inuit Women's Association

Newfoundland and Labrador AIDS Committee

Fife House Foundation

Hamilton AIDS Network

Collegium for Work and Learning

Nechi Training

Research & Health Promotion Institute

AIDS Coalition of Nova Scotia

Youth Community Outreach AIDS Society

Man-to-Man & Women's Different Realities Project

Ontario Fed. of Indian Friendship Centres

Department of Public Health, City of Toronto

Community Based Research Centre Society

Alliance for South Asian AIDS Prev.

Planned Parenthood Alberta

Canadian Red Cross Society

Calgary Birth Control Association

Aboriginal Youth Self-Development Centre

The John Howard Society of Red Deer

Pride on Campus

Canadian Red Cross Society

Response & Education Society (CARES)

John Howard Society of Alberta

Planned Parenthood Edmonton

Elizabeth Fry Society of Edmonton

Bissell Centre, Gay & Lesbian Comm.

Centre of Edmonton

Jasper Children's Centre Society

AIDS Coalition of Cape Breton

Action Sero Zero

Actions Sida Cte-Nord

Bureau local d'intervention traitant du Sida (BLITS)

Bureau regional d'action Sida (BRAS)

CACTUS Montreal

Centre Option Prevention Toxicomanie-, Violence-Delinquance - Sida (TVDS)

Centre Sida amitie

Coalition Sida des Sourds du Quebec (CSSQ) Comite

d'aide et prevention au Sida Monteregie

Comite des personnes atteintes du VIH

First Nations of Quebec and Labrador Health and Social Services Comm.

Groupe d'action pour la prevention de la trans., du VIH et l'eradication du Sida

Groupe d'entraide a l'intention des personnes seropositives itinerantes et toxicomanes

Intervention Regionale et Information sur le Sida en Estrie (I.R.I.S.)

Maison Plein Coeur

Mouvement d'Aide et d'Information Sida (M.A.I.N.S. Bas-Saint-Laurent)

Mouvement d'information et d'entraide dans la lutte contre le sida

Mouvement d'information d'education et d'entraide

Point de Reperes

Regroupement des personnes atteintes du VIH-sida de Quebec

Sidaction (Trois-Rivieres) Inc.

Sida-Vie Laval

Spectre de rue 2

STELLA

Cumberland County Family Planning

Nova Scotia Advisory Comm. on AIDS

Planned Parenthood Bridgewater

Planned Parenthood Metro Clinic (N.S.)

PLWA Network of Saskatchewan

Regina Open Door Society

Safe Spaces Project

Sexuality Education Resource Centre

Sharp Advice

Street Outreach Collective

The Red Door

Researchers Surveyed included:

Treena Rae Orchard(Manitoba)

Thomas Kerr (B.C.)

Dr. M. John Gill(Alberta)

James Murray(Ontario)

Dr. Sue Ferrier (Ontario)

Susan Bridget Brogly (Quebec)

Ms. Amy Elizabeth Weber (Quebec)

Mr. William Fisher (Ontario)

Dr. Bill Coleman (B.C.)

Ms. Amanda Hoogbruin (B.C.)

Dr. Alex Chan (B.C.)

Evan Wood (B.C.)

Paula Karina Alice Braitstein (B.C.)

Dr. Robin Hanvelt (B.C.)

Dr. Martin Schechter (B.C.)

Samuel B. Sheps (B.C.)

Katharyn May (U.S.A.)

Lynne E. Leonard (Ontario)

Gail McDonald (Ontario)

Gina Maria Graziani-Bowering (Ontario)

Sharon Wabegijig (Ontario)

Dr. Samuel Ratnam (Maritimes)

Dr. Donovan Plumb (Maritimes)

Elise Roy, Instit. de recherche de l'Hopital general de Montréal

Gaston Godin, Université Laval

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Marie-Claude Boily, Centre hospitalier affilie universitaire de Québec

Michel Dorais, Université Laval

Michel Perreault, Université de Montréal

- Dr. Joe O'Neil, University of Manitoba
- Dr. Francis Plummer, University of Manitoba
- Dr. Grant McClarty, University of Manitoba
- Dr. Christopher Power, University of Calgary
- Dr. Kelly MacDonald, Mount Sinai Hospital
- Dr. Eric Cohen, Sunnybrook & Women's College Health Sciences Centre
- Dr. Brian Barber, University of Toronto
- Dr. Sadhna Joshi, University of Toronto
- Dr. Alan Cochrane, University of Toronto
- Dr. Chen Liang, Jewish General Hospital
- Dr. Emmanuel Faust, Sir Mortimer B. Davis-Jewish Gen. Hospital
- Dr. John Hiscott, Sir Mortimer B. Davis-Jewish General Hospital
- Dr. Lawrence Kleiman, Sir Mortimer B. Davis-Jewish Gen. Hospital
- Dr. Mark Wainberg, Jewish General Hospital-Lady Davis Inst.
- Dr. Michael Laughrea, Sir Mortimer B. Davis-Jewish Gen. Hospital
- Dr. Ralph Germinario, Sir Mortimer B. Davis Jewish Gen. Hospital
- Dr. Rongtuan Lin, Jewish General Hospital
- Dr. Luis Congote, Royal Victoria Hospital
- Dr. Marina B. Klein, Royal Victoria Hospital
- Dr. Gillian McCarthy, University of Western Ontario
- Dr. Jamie Scott, Simon Fraser University
- Dr. Anita Palepu, St. Paul's Hospital
- Dr. Martin T. Schechter, University of British Columbia
- Dr. Dixie Mager, B.C. Cancer Research Centre
- Dr. Lynne Elizabeth Leonard, University of Ottawa
- Dr. Robert Lafrenie, Northeastern Ontario Cancer Centre
- Dr. Peter Dickie, University of Alberta
- Dr. Kenneth Rosenthal, McMaster University
- Dr. Anita Rachus, Sunnybrook Health Sciences Centre
- Dr. Carol Roberts, Queen's University
- Dr. William Rowe, School of Social Work, McGill University
- Mr. Biull Ryan, McGill Centre for Applied Family Studies
- Mr. Stephen Hotz, Dept. of Epidemiology & Community Medicine, University of Ottawa
- Mr. Webster Schuyler, Laurentian University
- Ms. Barbara Cox, Memorial University of Newfoundland
- Ms. Lesley Barnes, Dalhousie University



Working Papers

The following Draft Working Reports informed the development of the Canadian Strategy on HIV/AIDS Year Three Evaluation Final Report.

- 1. Detailed Evaluation Working Paper for the Year Three Evaluation of the Canadian Strategy on HIV/AIDS.
- 2. Final Draft Working Paper on the Financial Analysis of the Canadian Strategy on HIV/AIDS
- 3. The Year Three Evaluation of the Canadian Strategy on HIV/AIDS: Working Paper on Case Studies
- 4. The Year Three Evaluation of the Canadian Strategy on HIV/AIDS: Working Paper of the Review of Documents, Data and Selected Literature
- 5. "Sharing Experiences" Learning from Five Countries' Experiences with the HIV/AIDS Epidemic: Working Paper
- 6. Working Paper on Surveys for The Year Three Evaluation of the Canadian Strategy on HIV/AIDS