Health Canada Santé Canada

FORMATIVE EVALUATION OF THE FIRST NATIONS AND INUIT HEALTH BRANCH HIV/AIDS PROGRAM

FINAL REPORT

Presented to

Health Canada
Departmental Audit and Evaluation Committee

October 14, 2004

Canada

ACTION PLAN - [HIV/AIDS Program]
[Action Plan for 2004-05]
September 2004

1. Evaluation Conclusion:
The lack of corporate files at national office have contributed to the lack of continuity in program development and implementation. With respect to national projects, there are inadequate materials to indicate how decisions for funding or non-funding are made (eg. eligibility criteria and guidelines for funding).
Evaluation Recommendation:
Improve the overall program administration at the national level by ensuring that there are adequate corporate files maintained, project criteria developed, and guidelines for proposals and funding. This will require ensuring that the necessary human and financial resources are available at both the regional and national level to carry out these activities.
Program Response
Current Status
Insufficiently organized corporate files and historically high staff turnover, contributing to lack of consistency in program administration. No standard solicitation, review and approval processes are in place (ie. set funding guidelines and criteria) to guide proposal submissions and project funding approval. No national process and guidelines are available to guide proposal based project funding and accountability in the regions.

Action Required	Timeline	Lead
Create the corporate memory of the program through a stable process that captures information and supports decision-making.		Links: PPHB/ BPMD
• Existing electronic records of G & C and contracts established.	Sept. 2004	
• Reorganization and standardization of HQ central corporate files completed.		
Develop standard processes and time lines, guidelines, work plan, budget and reporting templates.	June 2004	HASWG National Program Coordinator (NPC)
Implement an HIV/AIDS sub-working group (HASWG) to guide national program delivery (i.e. priorities, planning, implementation and evaluation).	March 2004	
Consult with Aboriginal stakeholders, as appropriate, for feedback in relation to HIV/AIDS program initiatives and delivery.		HASWG
• Monthly meetings/teleconference/consultation with Aboriginal stakeholder	October 2004	NPC
• Planned meetings with CAAN, CIHAN, NACHA		

2. Evaluation Conclusion

Reported lack of communication between national and regional offices have made it difficult to implement a national strategy, as well as coordinate and manage the program consistently across all regions.

Evaluation Recommendation

Improve communication and clarify roles and responsibilities among national and regional offices.

Program Response

Current Status

National-Regional communications are currently done mainly via email and phone calls.
National office has initiated teleconference calls with the regions in the past year.

Action Required	Time line	Lead
The HASWG will provide a forum for regular exchange of information between National Office and all the Regions in addressing pertinent issues including, but not limited to, HIV/AIDS, evidence-based program planning, implementation and evaluation, surveillance and research, national coordination of the program, best practices, and accountability. • quarterly teleconference • face-to-face meeting annually	3-4 / yr teleconference next teleconference Sept. 2004	NPC HASWG
The HASWG will identify and document expectations and delineate roles and responsibilities of the National and Regional offices.	reinstated in 2003	

3. Evaluation Conclusion

As currently designed and delivered, the National program has 1 designated FTE for which salary resources are allocated from program funds. Given the size of the program, the multiple regional delivery mechanisms involved, number of key stakeholders, proportion of program funds as contribution agreements, and the anticipated results to be achieved by the program, this level of staffing is inadequate. Likely many of the challenges the program has experienced to date can be linked either directly or indirectly to this lack of resources for managing the program.

Evaluation Recommendation:

Provide program resources that will ensure adequate delivery and management of the program. Any changes to the program should include a re-analysis of actual required resources to manage a program with these characteristics and this size within a results-based management framework.

Program Response

Current Status

There has been no increase in funding to the HIV/AIDS Program since 1993 (2.5M/yr FNIHB core funding) and 1998 respectively (additional CSHA funding 1.1M/yr). Since then, the demands for accountability and performance measurement have increased significantly, as well as coordination of the program at the regional level due to increased stakeholder consultation and collaboration. Most of the funds (approx. 95%) have been committed to the communities through G&C funding. Most regions do not have a dedicated FTE to coordinate the program and manage the work.

Action Required	Time line	Lead
Continue the current work within the present funding constraints, while defining and moving toward more efficient processes. The HASWG will examine better ways to collaborate efforts and resources within HC, FNIHB, and other internal stakeholders.	On agenda Sept.4 (teleconference)	HASWG NPC/CDCD
Leverage opportunities to promote the HIV/AIDS program in concert with other diseases, best practices and other programs (e.g., Hep C, sexually transmitted infections, addictions and harm reduction, youth).	June 2004 (draft action plan)	HASWG
Consider the re-allocation of funds between or within regions, to at least temporarily support an FTE (or portion thereof) in each Region to manage/administer the HIV/AIDS program more effectively. \ • Included in CSHA TB Submission with PPHB for increase of FTEs in regions and NHQ • Anticipated additional funding	June 2004 October 2004	HASWG CDCD HASWG NPC

4. Evaluation Conclusion

With its current design, the program has the objective of increasing accessibility to care, treatment and support for people living with HIV/AIDS and their families in FN/I communities. Given the level of resources available and the capacity of the organizations and communities involved, respondents from the various stakeholder groups indicated that this program objective is extremely difficult to achieve for many regions and communities.

Evaluation Recommendation:

Revisit the design of the program to ensure that the program's activities and services are compatible with resources and capacity. Clarify what kind of activities and services could be successfully implemented under the Care, Treatment and Support component of the Program

Program Response

Current Status

Presently, the components of the HIV/AIDS Program include four areas: prevention; community development; coordination; and care, treatment, and support. As mentioned, funding for the program has not increased . The present level of funding is insufficient for regions to meet all the current elements of the HIV/AIDS Program. The majority of the 93% G&C funding was allocated towards AIDS management and support and community development.

Action Required	Time line	Lead
The HASWG will revisit and update the program's mandate, goal, objectives, and components to more realistically meet expectations within current funding constraints.	June 2004	HASWG
Revisit the scope of the components within the HIV/AIDS program, in particular care, treatment, support.	June 2004	HASWG
• Logic model developed to reflect requirements of TB Submission	August 2004	
Seek additional funds to meet the needs of this rising epidemic.	2005-06	HASWG
• TB Submission over a five year plan	fiscal year	NPC/CDCD

5. Evaluation Conclusion

Program currently provides one-year funding that often arrives in communities very late in the fiscal year. Consequently, there is a heavy focus on short-term activities, with less focus on longer-term strategic projects.

Evaluation Recommendation:

Consider arrangements, taking into account program authorities and TBS guidelines, that permit longer-term, strategic projects. Alternative funding arrangements, such as multi-year funding would allow the program to move from activity based events to the development of program components that support an overall integrated approach to promoting healthy lifestyles in FNI/I communities. This approach would be more likely to provide program activities that result in the identified intermediate and longer term outcomes that are identified in the program logic model for the program.

Program Response

Current Status

Program funding is currently allocated to the Regions on an annual basis; therefore, communities are subject to one year funding periods. Historically, regions have received their funding very late in the fiscal year, making it very difficult to plan ahead and manage their funding to communities effectively. The 3.6M is dedicated reserve funding towards the HIV/AIDS Program; therefore, guaranteed ongoing funding annually. According to the current Financial Terms of Authority, funding terms can go to a maximum of three years.

Action Required	Time line	Lead
Establish a process that respects critical planning and reporting dates and focuses on a single allocation of funds thereby enabling a longer-term program environment to be developed. • Regions have a multi-year plan (draft Funding Application Guidelines in process)	August 2004	HASWG NPC BPMD

6. Evaluation Conclusion:		
With a results-based management environment, it is essential that those responsible for delivering a program have a framework for measuring program performance. At present, it is impossible to determine accurately to what extent outcomes are being systematically achieved through the program.		
Evaluation Recommendation:		
Develop and implement a performance measurement framework and evaluation plan for the program.		
Program Response		
Current Status		
The program currently has no accountability framework (with a performance measurement strategy and evaluation plan) to guide program planning, implementation, reporting, and evaluation. The Communicable Disease Control Division is currently developing a division wide accountability framework to guide further development of the accountability structures needed for each individual program. Work is continuing with BPMD to develop a CDCD logic model that will guide the development of performance indicators for each program		
Action Required	**Time line**	**Lead**
Develop the necessary accountability framework, including a performance measurement strategy and evaluation plan, for the program. • Logic Model • RMAF • RBAF	 August 2004 March 2005 March 2005	NPC HASWG Links: BPMD,PPHB DPED

1. Acronyms included in this Action Plan refer to:

FN:	Assembly of First Nations
HASWG:	HIV/AIDS Sub-Working Group
CAN:	Canadian Aboriginal Aids Network
PPHB:	Population & Public Health Branch
NACHO:	National Aboriginal Council on HIV/AIDS
BPMD:	Business Planning and Management Directorate
CIHAN:	Canadian Inuit HIV/AIDS Network
NPC:	National Program Coordinator
FTE:	Full Time Equivalent
FNIHB:	First Nations and Inuit Health Branch
CDCD:	Communicable Diseases Control Division
DPED:	Departmental Program Evaluation Division
C.S.H.A:	Canadian Strategy on HIV/AIDS

Formative Evaluation of the First Nations and Inuit Health Branch HIV/AIDS Program

Final Report

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Executive Summary

Purpose of the Study

The purpose of the present report is to present the findings from a formative evaluation of Health Canada's First Nations and Inuit Health Branch (FNIHB) HIV/AIDS Program. This program is administered under the FNIHB Communicable Disease Control Division (CDCD). The management consulting firm of Goss Gilroy Inc. was hired by Health Canada to conduct the formative evaluation during the summer and fall of 2003. The intended audience of this report, are the communities served by the FNIHB HIV/AIDS Program, Health Canada and the Treasury Board Secretariat.

This 5 year Evaluation was conducted as part of the *Canadian Strategy on HIV/AIDS (CSHA)* evaluation as per Treasury Board Secretariat of Canada requirements. This evaluation focuses on the activities funded during the past five years (i.e., 1998/99-2002/03) under the FNIHB HIV/AIDS Program. The FNIHB had also committed to conducting an evaluation of the FNIHB HIV/AIDS Program in Health Canada's 2002/2003 Report on Plans and Priorities.

The evaluation was designed to provide information to address two key questions:

- ***Has the FNIHB HIV/AIDS Program been implemented and delivered as designed?***
- ***To what extent has the FNIHB HIV/AIDS Program contributed to the achievement of expected short-term outcomes?***

The expected short-term outcomes for the program, as outlined in the program logic model include:

- Increased community awareness;
- Improved utilization of health promotion resources;
- Increased accessibility of care, treatment and support for people living with HIV/AIDS and their families; and
- Improved linkages for HIV/AIDS programming.

The results of the evaluation will serve two major purposes. They are as follows:

1. to contribute to better decision making around how best to deliver the program and provide strategies for continuous improvement;

2. to provide objective information to assist with decisions on the program's future. This includes key strategic directions, scope and allocation of resources, program priorities and policy development.

Program Description

The FNIHB HIV/AIDS program has two main levels: national and regional. The national level assumes a coordinating role, and works with national Aboriginal organizations. The regional level ensures the delivery of the program at the community level through contribution agreements.

In 1998/99, total resources for the program were set at $3.6 million. Of this, $2.5 million is received from the Branch Research Allocation (BRAC), and $1.1 million from the Canadian Strategy on HIV/AIDS (CSHA), established in 1998. It should be noted that the funding amount has not changed since 1993, and 1998 respectively. Funding to the regions are distributed on a per capita basis and sent to the communities by the FNIHB Regional offices.

Funds allocated to management of the program are restricted to one full-time equivalent (FTE) program manager at the national office. There is no allocation of funds for program delivery and management at the regional level. Regional staff manage the program by including this program with management responsibilities for other programs.

Evaluation Approach and Methodology

In order to address issues related to program delivery and the progress towards achieving short-term outcomes, the following methods were used for the evaluation:

- *Literature and Document Review*: The information reviewed included available program information such as operational, financial, epidemiologic and surveillance data, progress reports, action plans, and strategies. The review was undertaken to identify relevant trends, issues, successes and challenges faced with respect to program delivery.

- *Key Informant Interviews*: The evaluation team conducted 33 interviews with a diverse group of respondents including national program representatives, regional program representatives, representatives from other related programs, national and regional Aboriginal organizations, and community representatives.

- *Case Studies*: Case studies were conducted with two regions (Saskatchewan and Pacific) and with one organization that received funding from the national component (Pauktuutit Inuit Women's Association). Methodology included document review, site visits with communities and organizations, interviews with community and organization representatives, and focus groups with individuals from the community.

Main Evaluation Findings

Program Focus Issues

Each region administers the program in a slightly different manner, taking into account the needs of the region, its environment and the established relationships with provincial and territorial governments, as well as regional Aboriginal AIDS organizations. This flexible approach is viewed as important by the stakeholders and allows them to adapt to specific needs.

In many instances, often due to funding constraints and regional or program-level requirements, there is a heavy focus on short activity-based projects rather than what could be viewed as strategic planning projects or longer-term projects. This focus on activity-based projects was considered detrimental by some stakeholders to the development of a longer-term plan of action to address HIV/AIDS issues, even at the community level.

Concerns were also raised by some stakeholders that often what was needed at the community level was an integrated approach to health care and a focus on healthy lifestyles, rather than separate emphasis on various diseases.

Program Funding Issues

Overall, respondents felt that funding levels were too low. Lack of funding was deemed to have an impact on the quality of the initiatives, the types of activities undertaken (e.g., primarily education and awareness activities), and the level of coverage in some regions.

Many of the community representatives were frustrated with the delays they perceived in obtaining annual funding. Delays in obtaining the funds and the requirements that these funds be spent within the fiscal year puts pressure on communities and organizations, and has an impact on the type and quality of activities that can be undertaken.

Through the document review and interviews with key informants, the evaluation team was made aware that there are limited funds available within the current program structure for actual delivery and management of the program.

Communication and Collaboration Issues

Most of the national and regional program representatives indicated the need for better communication overall with respect to the program. Their concerns included improved communication between national office and the regions, between the regions themselves, and between Health Canada and the First Nations and Inuit communities.

From interviews and case studies, it appears that many of the regions have built solid relationships with Aboriginal service organizations, with the provincial and territorial governments and with individual FN/I communities.

Interviews with regional program representatives indicated that their expectations the national office would play a coordinating role with respect to the program were left unmet. A number of examples were cited by regional staff of how it was difficult to get information or direction with

respect to the program such as program objectives and funding guidelines. Regional and national program representatives attributed this confusion and poor communication to heavy staff turnover at the national office, lack of management continuity at the national office, and the lack of clearly defined roles and responsibilities for the national and regional offices.

Overall Program Administration

A review of files and interviews with national and regional program representatives indicate deficiencies in program administration. At the national level, there were few corporate files available, and many of these were incomplete. At the national level, there are no formal criteria developed for the selection of projects, and no common guidelines or application forms to help organizations applying to the program.

Project Monitoring and Performance Information

Generally, at this stage in a program, it is reasonable to expect that a performance measurement framework would have been developed and implemented. While there was an initial logic model developed by Health Canada, a full performance measurement framework has not been developed. The lack of a clear performance framework in which to administer the program also impeded on the availability of performance information for the evaluation. At this point, the reporting tends to be activity-based at the community level with limited roll-up of information at the regional or national level. There is no common set of performance indicators.

Short-term Outcome: Increased community awareness

Overall, the key stakeholders interviewed reported that there is an increase in the level of awareness within Aboriginal communities about HIV/AIDS issues. Throughout the case studies and interviews, the evaluation team found examples where funding has led to the development of culturally sensitive materials and innovative ways of communicating about HIV/AIDS to communities' target audiences.

Although the intermediate and longer-term outcomes of these activities are not measurable at this stage, there is evidence that awareness about HIV/AIDS and methods to prevent the disease are reaching FN/I communities. It is expected that over the longer-term, these messages will be successful and help to reach the goal of reducing the incidence of HIV/AIDS among the FN/I communities.

Short-term Outcome: Improved utilization of health promotion resources

Community level activities are generally integrated within the health centres that work with the community, the community leaders, and the schools to promote healthy lifestyles and to address HIV/AIDS issues. The evaluation team also found some examples of Aboriginal organizations that were funded by the program to provide the link between scientific information, cultural experts and FN/I communities. This link resulted in the provision of scientifically accurate, and culturally appropriate education and promotion resources for individual FN/I communities.

Short-term Outcome: Increased accessibility to care, treatment & support

Respondents from all stakeholder groups interviewed indicated that the funds in the program are too limited to significantly address the issues of care, treatment and support for people living with HIV/AIDS and their families. Overall, the key stakeholders felt that there were definite gaps in the availability of services for First Nations and Inuit with respect to the care and treatment of Aboriginal people living with HIV/AIDS. Through the case studies, however, the evaluation team was provided with some excellent examples of unique approaches to providing services and support to individuals and their families affected by HIV/AIDS.

Short-term Outcome: Improved linkages for HIV/AIDS programming

Regional and national program representatives and Aboriginal service organization representatives reported that the program's funding has helped to support the development of Aboriginal service organizations at the national and regional levels. These organizations then provide support to individual Aboriginal communities.

One issue that was raised in key informant interviews and case studies was that there is often inadequate coordination among activities either within a province or territory or between provinces and territories to ensure that groups are not repeating the development of materials or approaches. Many pointed to the need for increased participation in networking and sharing activities such as conferences and meetings.

Recommendations

The evaluation team has developed the following main recommendations based on the findings.

Recommendation #1 - Improve the overall program administration at the national level by ensuring that there are adequate corporate files maintained, project criteria developed, and guidelines for proposals and funding.

Given the high level of turnover among program staff and lack of continuity among management at the national level, the national office does not have an adequate set of corporate files for this program. In addition, with respect to national projects, there are inadequate materials to indicate how decisions for funding or non-funding are made (e.g., eligibility criteria, guidelines). This will require ensuring that the necessary human and financial resources are available at both the regional and national level to carry out these activities.

Recommendation #2 - Improve communication and clarify roles and responsibilities among national and regional offices.

The program was implemented by the various regions without clear guidance or coordination from the national office. As a result, there is confusion and lack of clarity with respect to many aspects of the program. High turnover of staff at national office also placed considerable stress on the communications between national office and the regions. The need for clear program documentation and guidelines that respect the need for flexibility among the regions is required.

Recommendation #3 - Provide program resources that will ensure adequate delivery and management of the program.

As it is currently designed and delivered, the program has one FTE for which salary resources are allocated from program funds. Given the size of the program, the multiple regional delivery mechanisms involved, number of key stakeholders, proportion of program funds as contribution agreements, and the anticipated results to be achieved by the program, this level of staffing is inadequate. Likely many of the challenges the program has experienced to date can be linked either directly or indirectly to this lack of resources for managing the program. Any changes to the program should include a re-analysis of actual required resources to manage a program with these characteristics and this size within a results-based management environment.

Recommendation #4 - Revisit the design of the program to ensure that the program's activities and services are compatible with resources and capacity. Clarify what kind of activities and services could be successfully implemented under the Care, Treatment and Support component of the Program.

As currently designed, the program has the objective of increasing accessibility to care, treatment and support for people living with HIV/AIDS and their families in FN/I communities. Given the level of resources available and the capacity of the organizations and communities involved, respondents from the various stakeholder groups indicated that this program objective is extremely difficult to achieve for many regions and communities.

Recommendation #5 - Consider arrangements, taking into account program authorities and Treasury Board guidelines, that permit longer-term, strategic projects.

The program currently provides one-year funding that often arrives in communities very late in the fiscal year. As a result, there is a heavy focus on short-term activities, and less focus on longer-term strategic projects. As mentioned by numerous stakeholders, alternative funding arrangements, such as multi-year funding, would allow the program to move from activity-based events to the development of program components that support an overall integrated approach to promoting healthy lifestyles in FN/I communities. This approach would be more likely to provide program activities that result in the identified intermediate and longer-term outcomes that are identified in the program logic model for the program.

Recommendation #6 - Develop and implement a performance measurement framework and evaluation plan for the program.

In a results-based management environment, it is essential that those responsible for delivering a program have a framework for measuring program performance. Ideally, the framework should be developed in conjunction with representatives from the various stakeholder groups, in particular those who will be responsible for the ongoing performance data collection and monitoring. At present, it is impossible to determine accurately to what extent outcomes are being systematically achieved through the program. It will be very difficult to perform any type of summative evaluation work without an evaluation plan that is integrated with an implemented performance measurement framework for this program. Given that this is a component of the overall Canadian Strategy on HIV/AIDS (CSHA), it will be important that there is some compatibility with performance indicators and evaluation issues for the overall strategy. The initial step in developing the framework will be to ensure that the current logic model is accurate and validated by the various stakeholder groups. Once the activities, outputs and outcomes have been confirmed, indicators for outputs and outcomes should be developed. Key indicators for ongoing monitoring of program performance will need to be chosen and agreed upon by the various stakeholder groups. Given the diverse delivery mechanisms for the program, and the number of groups involved in developing program activities, it will be important that a concerted effort is made to engage various stakeholders in the multiple stages of the development of the framework. Once chosen, the indicators will need to be integrated into a performance measurement strategy that outlines who will be collecting the data, when the data will be collected and reported, and who has responsibility for compiling and reporting the program data at various levels (e.g, community, regional, national). Finally, an evaluation strategy or plan should be developed that is integrated with the ongoing performance measurement and reporting framework. This will ensure that program data required to address summative evaluation issues is systematically collected.

1.0 Introduction

The purpose of the present report is to present the findings from a formative evaluation of Health Canada's First Nations and Inuit Health Branch (FNIHB) HIV/AIDS Program. The management consulting firm of Goss Gilroy Inc. was hired by Health Canada to conduct the formative evaluation during the summer and fall of 2003. The evaluation focussed on the activities funded during the past five years (i.e., 1998/99-2002/03) under the FNIHB HIV/AIDS Program of the Canadian Strategy on HIV/AIDS.

The report is divided into the following sections:

Section 1 provides a brief overview of the program, including program reach, program resources, and expected short-term outcomes.

Section 2 presents some contextual issues with respect to the program, and HIV/AIDS among Aboriginal people in general.

Section 3 provides details on the evaluation context, the methodology and approaches used during the study, as well as some limitations and constraints for the evaluation process.

Sections 4 describes the evaluation findings with respect to the two main evaluation issues: program design and delivery, and achievement of short-term outcomes.

Section 5 presents the evaluation team's main recommendations for the program.

1.1 Program Description

The FNIHB's HIV/AIDS program is one component under the overall Canadian Strategy on HIV/AIDS (CSHA). In this section, we initially define HIV/AIDS, describe the overall development of the CSHA, then focus on describing the FNIHB program, including objectives, resources, and program components.

1.1.1 Background and Definition of HIV/AIDS

The Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS). HIV attacks the immune system, resulting in AIDS, a chronic, progressive illness that leaves infected people vulnerable to opportunistic infections and cancers. The median time from HIV infection to AIDS diagnosis now exceeds 10 years. No cure or vaccine exists, although antiviral treatments can delay the onset of AIDS and prolong life.

HIV is transmitted through bodily fluids including:

- unprotected sexual intercourse;
- needle-sharing;
- pregnancy, delivery and through breastfeeding (from an infected mother to her infant); and,
- occupational exposure to infected bodily fluids.

The first case of AIDS in Canada was reported in 1982. The HIV/AIDS epidemic is actually several epidemics, occurring in specific populations. The early epidemic primarily affected men who have sex with men (MSM) and those who received blood and blood products. The current epidemic, measured from 1997, primarily affects injection drug users (IDU), MSM's and, increasingly women. Since 1985, adult females have accounted for 15% of positive HIV test reports among adults. The proportion of females each year has increased from 12% between 1985 and 1997, to approximately 25% of the adult positive HIV test reports from 2001 to the first half of 2003.

Various social and economic behavioural factors (such as high rates of poverty, substance abuse, sexually transmitted diseases, limited access to or use of health care services) are risk factors for HIV infection. According to Health Canada data, the Aboriginal population is relatively over-represented in the ethnic breakdown of HIV cases[1] (see Table 3).

[1] Health Canada Website: www.hc-sc.gc.ca/english/diseases/aids.html (date: 12/1/2003)

1.1.2 Canadian Strategy for HIV/AIDS

Background to the Strategy

To address the HIV/AIDS crisis in Canada in the 1980's, Health Canada (HC) supported a variety of projects including ad hoc research, surveillance and the development of communities and service organizations involved in HIV/AIDS issues. In 1990, HC formalized a strategy and launched Phase 1 of the National AIDS Strategy (NAS I). NAS I established the framework for future partnerships with provincial and federal governments.

Phase 2 (NAS II) was introduced in 1993 with a budget of $211 million over five years. The goals of the strategy were:

1) to stop the transmission of the human immunodeficiency virus (HIV);
2) to search for effective vaccines, drugs and therapies; and,
3) to treat, care for and support people infected with HIV, their caregivers, families and friends.

The success of Phases 1 and 2 of the National Aids Strategy provided the momentum for Health Canada to seek sustained funding for a new Canadian strategy on HIV/AIDS. In 1998, the federal government announced sustained funding for the CSHA supporting a new approach to meet the challenges of the HIV/AIDS epidemic in Canada.

Canadian Strategy on HIV/AIDS

CSHA was developed through direct collaboration with a number of stakeholders. These stakeholders represented different levels of government (federal, provincial and territorial), the research community, community-based organizations, at-risk groups, Aboriginal communities, health care professionals, persons living with HIV/AIDS and the private sector. The federal government has committed to ongoing annual expenditures of $42.2 million to the Strategy[2].

The CSHA places emphasis on addressing the needs of groups that have traditionally been socially and economically marginalised, such as Aboriginal people, intravenous drug users, men who have sex with men (MSM), prison inmates and other groups.

[2] This funding is at approximately the same level that was allocated annually during NAS II, the previous Strategy announced in 1993.

The goals of the CSHA are to:

- prevent the spread of HIV infection in Canada;
- find a cure;
- develop and provide vaccines, drugs and therapies;
- ensure care, treatment and support for Canadians living with HIV/AIDS, their families, friends and caregivers;
- minimize the adverse impact of HIV/AIDS on individuals and communities; and
- minimize the impact of social and economic factors that increase individual and collective risk for HIV infection.

1.1.3 Background to FNIHB HIV/AIDS Program for First Nations and Inuit

In 1993, the Medical Services Branch (MSB) of Health Canada (now the First Nations and Inuit Health Branch) took measures to address the complex needs of First Nations people living on-reserve and Inuit communities with respect to HIV/AIDS issues. The Branch allocated $12 million over five years for First Nations on-reserve and Inuit communities HIV/AIDS programming during Phase 2 of the National Aids Strategy (NAS II).

In 1997, in order to plan the next phase of HIV/AIDS programming, the MSB initiated a strategic planning process. An HIV/AIDS Focus Group composed of representatives from the Health Canada regions, approximately fifteen Aboriginal organizations, and the Departmental Aboriginal AIDS Committee was established to help with this process. The HIV/AIDS Focus Group produced a report which identified and ranked, in order of importance, strategic issues relating to HIV/AIDS among First Nations on-reserve and Inuit communities; and developed options for the continuation of HIV/AIDS program and services after NAS II.[3]

The HIV/AIDS Focus Group supported the continuation of dedicated funding of $2.5 million per year for HIV/AIDS programming. As well, the Focus Group recommended the co-management of the HIV program with First Nations and Inuit organizations at the national and regional level.

[3] *Medical Services Branch Future Action: Decreasing the Incidence of HIV/AIDS,* Report of the Medical Services Branch HIV/AIDS Focus Group, March 1997

It was recommended that the Focus Group participate in the development of an operational plan for 1998/99 and beyond. A draft report *(Partnership Agenda)* was developed by the Focus Group which describes the major areas of First Nations and Inuit HIV/AIDS Program. The four main areas described in this document are:

Prevention: The objective of prevention is to further the progress made in increasing awareness of HIV/AIDS and develop effective prevention strategies by improving First Nations and Inuit HIV/AIDS communication mechanisms to facilitate the timely and comprehensive transfer of information and resources.

***Community Development*:** The objective of community development is to ensure that First Nations and Inuit community-based HIV/AIDS service organizations have the necessary capacity to develop education and prevention programs, to facilitate education and prevention services, and to provide prevention programs and care/treatment services.

Care, Treatment and Support: The objective of care, treatment and support is to identify options and mechanisms to provide access to on-reserve treatment, care and support programs that address the needs of First Nations and Inuit people with HIV/AIDS.

Program Coordination: The objective of program coordination is the development of a coordinated approach to HIV/AIDS programming in order to develop effective services.

1.1.4 Program Levels

The FNIHB HIV/AIDS program has two main levels: national and regional. The national level assumes a coordinating role, and works with national Aboriginal organizations. The regional level ensures the allocation and disbursement of funding to FN/I recipients for the delivery of the program at the community level.

It should be noted that there was no documentation available that clearly outlined the expected roles and responsibilities of the two levels, or how they were to interact. There was some discussion of roles and responsibilities in the *Partnership Agenda*[4], however, from interviews with stakeholders, the evaluation team determined that this document was never formally

[4] *Partnership Agenda*, First Nations and Inuit HIV/AIDS Program, Medical Services Branch, Draft Operational Plan, 1998/99 and Beyond

adopted by FNIHB. It should be noted that despite the lack of documentation, the evaluation team found through the interviews that various roles and responsibilities have evolved. These are described below.

National Activities

The overall objective of the FNIHB is to support the regions, other branches within Health Canada, and National Aboriginal organizations in the coordination of health programs to enable effective program development, delivery and evaluation. Under this general objective, the FNIHB HIV/AIDS program manager at the national office manages the budget and disbursement of funds to the regional offices and provides support as needed to the regions. The program manager also advances First Nations and Inuit issues at Federal/Provincial/Territorial (FPT) meetings as required, interacts with National Aboriginal HIV/AIDS service organizations, and funds, alone or in partnership with other Health Canada branches, a number of projects, including:

- the development of an Aboriginal Strategy on HIV/AIDS in Canada and various HIV/AIDS awareness activities undertaken by the Canadian Aboriginal AIDS Network;
- the development of education and prevention projects for Inuit communities provided by the Pauktuutit Inuit Women's Association;
- ongoing work with the Chiefs' Committee, the development of a First Nations Peer Youth Education Manual, and training sessions by the Assembly of First Nations;
- support to the National Aboriginal Council on HIV/AIDS (NACHA) – an advisory group made up of representatives from First Nations, Inuit, Métis, and the community that provides advice on issues related to current care, treatment, support and access to on-reserve populations and Inuit communities;
- the provision of scholarships for attendance to the Annual International Two Spirited Gathering that addresses transmission of HIV, issues of sensitivity, discrimination, and healthy sexuality among two-spirited (gay and lesbian) people; and,
- various other ad hoc activities carried out by national Aboriginal service organizations involved in HIV/AIDS issues.

Regional Activities

Each region administers the program in a slightly different manner, taking into account the needs of the communities, its environment and the established relationship with provincial and territorial governments, as well as Aboriginal AIDS service organizations. Distribution of the regional funds involves both proposal-based projects and formula-based distribution of funds to individual communities. The funding allocations and scope of the projects vary significantly ranging from a few hundred dollars to over $100K.

The evaluation team's review of annual work plans and information from interviews indicate that a wide variety of organizations and activities are funded. Some regions fund regional level Aboriginal AIDS organizations in conjunction with specific individual community-level projects. Other regions focus on funding individual communities. It appears that the majority of funding is allocated to activities within the realm of prevention and community development including awareness activities, education and development of materials. More detailed summaries of activities by region are provided in Appendix A.

1.1.5 FNIHB HIV/AIDS Program Resources

Resource Allocations

In 1998/99, total resources for the program were set at $3.6 million. Of this, $2.5 million is received from the Branch Research Allocation (BRAC), and $1.1 million from the Canadian Strategy on HIV/AIDS (CSHA), established in 1998. It should be noted that the funding amount has not changed since 1993, and 1998 respectively.

A regional allocation mechanism developed by the federal government through consultation with First Nations was used for distributing resources in an equitable and fair manner. The formula takes into account regional population sizes (using the total **Registered Indian** population from the Indian Register at INAC), and relative size and remoteness of communities[5].

[5] Assembly of First Nations approved Modified Berger formula or AFN-MBF

Resource allocation at the regional and national levels are provided in Table 1

Table 1

Annual Resources FNIHB HIV/AIDS Program

	BRAC	CSHA
Pacific Region	$441,023	$235,767
Yukon Region	$80,986	$24,244
Alberta Region	$260,054	$60,195
Saskatchewan Region	$309,866	$90,350
Manitoba Region	$305,228	$91,200
Ontario Region	$451,911	$167,223
Quebec Region*	$241,179	$83,283
Atlantic Region	$144,753	$47,729
National Component	$265,000	$300,000

* These amounts do not include funding for the Cree or Inuit in the Quebec Region
Source: National Office for Program

Program Staff

Funds allocated to the management of the program are restricted to one full-time program manager at the national office. There is no allocation of funds for program delivery and management at the regional level. Regional representatives reported through the interviews that, at the time of the evaluation, they were delivering and managing this program in addition to the multiple responsibilities they already had with other programs.

Expenditures by Sub-Activities

Table 2 contains the actual program expenditures by sub-activity for 2002-03 according to region and national office. Approximately one-half of expenditures (51%) was in the sub-activity area of Community Development. The other largest portion of expenditures (32%) was in the sub-activity area of AIDS management and support. Approximately 15% of expenditures was categorized under the sub-activity of AIDS prevention. Finally, a small proportion (2%) was expended in the area of AIDS Care, Treatment and Support. Approximately 93% of expenditures was in the form of contributions.

Table 2: Actual Expenditures by Sub-activities

2002/2003 ACTUAL EXPENDITURES BY SUB-ACTIVITIES
FY 02-03
HIV/AIDS

SUB-ACTIVITY	RESOURCE CATEGORIES	ATLANTIC	QUEBEC	ONTARIO	MANITOBA	SASK	ALBERTA	PACIFIC*	YUKON	HQ	TOTAL
REGIONAL ALLOCATIONS		19,482	28,462	69,913	35,458	40,026	30,206	66,791	16,251	95,000	381,591
520 AIDS Management and Support	Salaries				-31,092						-31,092
	Operations and Maintenance		137	525	1,446	17,947	3,857	70,953		4,510	101,375
	NHF										0
	Capital										0
	Contributions	48,124			35,936		10,477	48,361		124,583	267,481
	Sub-Total	48,124	137	525	36,550	17,947	14,334	119,314	0	129,093	367,024
521 AIDS Community Development	Salaries							64,427			64,427
	Operations and Maintenance							45,588		29,827	75,415
	NHF										0
	Capital										0
	Contributions	48,119	291,101	381,725		275,582	126,310	118,777	34,177	278,645	1,454,436
	Sub-Total	48,119	291,101	381,725	0	275,582	126,310	228,792	34,177	308,472	1,594,278
522 AIDS Prevention	Salaries										0
	Operations and Maintenance				117						117
	NHF										0
	Capital										0
	Contributions	48,118	5,000	220,539		114,885	24,000	18,000	63,054		493,596
	Sub-Total	48,118	5,000	220,539	117	114,885	24,000	18,000	63,054	0	493,713
523 AIDS Care, Treatment and Support	Salaries										0
	Operations and Maintenance			67	295		14,739				15,101
	NHF										0
	Capital										0
	Contributions	48,119		888							49,007
	Sub-Total	48,119	0	955	295	0	14,739	0	0	0	64,108
Sub-Total AIDS		192,481	296,239	603,917	36,962	408,198	179,383	366,105	97,231	437,565	2,618,081

* These figures were derived from the Pacific Region's year end fiscal report. Due to possible coding errors, they may not provide an accurate representation of how the funds were spent in each category.

2.0 Issues - HIV/AIDS in Aboriginal Communities

When evaluating FNIHB HIV/AIDS Program, it is important to understand the context and resulting issues that are facing First Nations on-reserve and Inuit communities. As well, it is important to take into account the new document by the Canadian Aboriginal AIDS Network, (CAAN), *Strengthening Ties - Strengthening Communities, An Aboriginal Strategy on HIV/AIDS in Canada* – (July 2003), which is the result of wide consultations with key stakeholders across Canada. To provide some context for the evaluation findings, these are briefly described below.

2.1 HIV Infection Rates & AIDS Cases

As mentioned previously, the Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS). As described below, statistics as reported by Health Canada show that HIV/AIDS among some Aboriginal groups remains a continuing concern.

Surveillance of HIV infection and AIDS Cases

Surveillance data are being enhanced by improved documentation of ethnicity in reported AIDS and HIV positive cases. This will provide improved HIV/AIDS surveillance data for Aboriginal people. The evaluation team was informed through the interviews that accurate surveillance is an ongoing challenge and is essential to understanding how HIV/AIDS impacts on various Aboriginal groups. There are several significant limitations to the accuracy of ethnicity data obtained from AIDS and HIV surveillance information. These include the following:

- potential mis-classifications of ethnic status;
- individuals who may not wish to state their ethnicity;
- variations in the completeness of ethnicity reporting between and within provinces;
- reporting delays.

It should also be noted that no data is currently available to differentiate First Nations on-reserve and off-reserve populations.

Better surveillance data, including ethnicity, gender, age group and exposure category, can be an important tool for directing programs, such as the FNIHB HIV/AIDS program, to where they will have the most impact. It should be noted that this type of data needs to be requested and collected under the guidance of legislation and guidelines that protect privacy and individual information.

Positive HIV Tests

Ethnicity reporting for positive HIV test reports is not as complete as that of reported AIDS cases due to inconsistent ethnicity reporting. Reporting of HIV is more recent than AIDS (available only since 1998), and there is still some concern regarding documentation of confidential information. Provinces and territories that report ethnic information include British Columbia, Yukon territory, Alberta, Saskatchewan, Manitoba, Prince Edward Island, and Newfoundland and Labrador. HIV ethnicity data are not available for the remaining provinces and territories.

In 1998, 19.2% of positive HIV tests with known ethnicity were among Aboriginal persons, compared to a high of 25.5% in 2001. The proportion of positive HIV test reports attributed to Aboriginal persons between January and June 30, 2002 is 26.5%. These proportions are higher than the proportions attributed to Aboriginal persons for reported AIDS cases. [6]

Although there are limitations to the data available on the rates of HIV/AIDS infection among Aboriginal communities, recent data from British Columbia, Alberta and Saskatchewan (1993-1997) show that Aboriginal people comprise 15%, 26% and 43% respectively of newly diagnosed HIV-positive cases in their respective provinces.[7]

The data also indicate the following:

- Aboriginal people are infected at a younger age than non-Aboriginal people;
- injection drug use is the most common method of transmission;
- Aboriginal people are disproportionately represented among high-risk groups such as inner city injection drug users and prison inmates; and

6 *HIV/AIDS Epi Update*, Centre for Infectious Disease Prevention and Control, Health Canada, April 2003

7 Ibid.

- the high degree of movement of Aboriginals between inner cities and rural areas/reserves may bring the disease to even the most remote community.

Box 1: HIV Figures

Of the estimated 2,740 Aboriginal people living with HIV infection at the end of 1999, their risk factors for HIV infection were:

- 54% through injection drug use
- 15% through heterosexual sex
- 23% through male to male sexual activity
- 6% through male to male sexual activity and injection drug use

Source: Centre for Infectious Disease Prevention and Control, Health Canada, *HIV and Aboriginal People in Canada: Report on the Estimated Number of HIV infections Among Aboriginal People in Canada.* Prepared by the Focus Group on Aboriginal HIV Estimates and Bureau of HIV/AIDS, STD and TB, April 2001

AIDS Cases

Typically if untreated, HIV will progress to AIDS within 10 years. As a result, patterns of AIDS cases may provide insights to the patterns of infections among populations in the previous decade. Another factor to take into account in examining patterns of AIDS cases is that the recent improvements in medications have decreased the number of AIDS cases.

Since 1982, when the first AIDS case was reported in Canada, a total of 85.7% (15,713/18,336) case reports have included ethnic information. The total number of reported AIDS cases has declined over the last 10 years from 1,723 cases in 1992 to 297 in 2001. From January to June 2002, 75 AIDS cases were reported. The number of cases in all ethnic groups, however, has not declined at the same rate. Caucasians have historically represented the largest proportion of reported AIDS cases, yet this proportion has declined over the years. With a decrease among Caucasians, there has been a corresponding increase in the proportion of reported AIDS cases among other ethnic groups. Since 1994, the increase in the proportion has been most notable among the Aboriginal and African-Canadian populations.

In 2001, Aboriginal persons comprised 3.3% of Canada's population. In the same year, they accounted for 5.5% of reported AIDS cases with known ethnicity. This proportion increased to 12.9% in 2002. As of June 30, 2003 this proportion increased to 20%. This indicates that Aboriginal persons are over-represented in reported AIDS cases.[8]

Table 3 provides a comparison of positive HIV test reports between the Caucasian and Aboriginal ethnic groups.

Table 3

Comparison of Positive HIV Test Reports Between Selected Ethnic Groups, 1998 - June 30, 2002

	Caucasian n=1823	Aboriginal n=688
Gender / Female	16.8%	45.3%
Age (Years)		
20-29	16.9%	27.9%
30-39	39.7%	39.5%
40-49	28.4%	22.3%
Exposure Category		
Male sex with Male (MSM)	38.8%	7.7%
Injection Drug Use (IDU)	34.7%	60.6%
Heterosexual Sex	21.6%	26.4%

Source: HIV/AIDS Epi Updates, Health Canada, April 2003

2.2 Funding Issues

In May 2002, Health Canada published the *Year Three Evaluation of the Canadian Strategy on HIV/AIDS*. This study included an "*Aboriginal case study which found that numerous gaps exist regarding access to care, treatment, and support for Aboriginal people."*[9]

8 HIV and AIDS in Canada, November 2003 - Surveillance report to June 30, 2003

9 Final Draft Report of the Year Three Evaluation of the Canadian Strategy on HIV/AIDS, SPR Associates Inc., January 2002, p. 14

In June 2003, the Standing Committee on Health of the House of Commons, presented its report: *Strengthening the Canadian Strategy on HIV/AIDS*. The report stated that: "The non-governmental organizations pointed to serious inadequacies in the level and nature of the response to populations under federal jurisdiction such as First Nations and Inuit people in the general population and inmates in federal correctional institutions. Over the last decade, while the rates of HIV/AIDS have increased sharply among certain subgroups of these specific populations, the level of funding has remained the same. The Health Committee wants to ensure adequate future support for federal government commitments to these populations falling directly under its responsibility."[10]

The Committee made a number of recommendations with respect to improving the situation for communities at risk including peoples living with HIV/AIDS, youth, Aboriginal or ethnic communities. It recommended that:

- The federal government increase the total funding for the renewed Canadian Strategy on HIV/AIDS to $100 million annually. This increased federal funding specifically designates $5 million annually to each of the two at-risk sub-populations (First Nations and Inuit as well as inmates) falling under federal jurisdiction.[11]

- Health Canada and other federal partners provide stable, long-term funding for regional Aboriginal AIDS service organizations to develop culturally appropriate practices to fight HIV in the community and to help implement specific programs to deal with the HIV/AIDS -related needs of the disproportionately large Aboriginal population in prisons.[12]

10 *Strengthening the Canadian Strategy on HIV/AIDS,* Report of the Standing Committee on Health, Bonnie Brown, M.P., Chair, House of Commons Canada, June 2003, p. 8

11 Ibidem, p. 9-10

12 Ibid., p. 14

2.3 Aboriginal Strategy on HIV/AIDS in Canada

Since its inception in 1998, the Canadian Strategy on HIV/AIDS (CSHA) has been building a pan-Canadian response to HIV/AIDS through numerous consultative mechanisms, including a collaborative planning and direction-setting process for the CSHA. At meetings in Grey Rocks in the Fall of 2000 and a follow-up meeting in Montreal in 2002, the need to develop unique approaches for Aboriginal peoples within the CSHA was identified as an important long-term goal. Guidelines for the development of the Aboriginal Strategy on HIV/AIDS in Canada were completed in August 2001.

The Aboriginal Strategy on HIV/AIDS in Canada (ASHAC) for First Nations, Inuit and Métis People – *Strengthening Ties - Strengthening Communities* – was finalized in 2003. It was co-funded by two branches of Health Canada (PPHB and FNIHB - specifically through the FNIHB HIV/AIDS program).

" The Canadian Strategy on HIV/AIDS has six goals that the ASHAC supports, yet some of these goals are beyond the direct scope of the Aboriginal community. For instance it is unlikely that Aboriginal HIV/AIDS dollars will be doing medical research to find a cure, yet ASHAC supports continued efforts to find a cure, so that ALL people living with HIV/AIDS can rid this disease from their bodies and lives. This can also include reducing the factors that place individuals at risk for HIV/AIDS."[13]

The First Nations and Inuit Health Branch's HIV/AIDS program supports four major areas of activity – prevention; community development; care, treatment and support; and program coordination. These address at least some of the strategic goals set by the ASHAC. Other programs within Health Canada and more particularly, the Canadian Strategy on HIV/AIDS, will address other areas of the Strategy.

13 *Strengthening Ties - Strengthening Communities*, An Aboriginal Strategy on HIV/AIDS in Canada for First Nations, Inuit and Métis People, May 2003, p. 3

Box 2 - Key Strategic Areas
Aboriginal Strategy on HIV/AIDS in Canada

1. Coordination and Technical Support
2. Community Development, Capacity Building and Training
3. Prevention and Education
4. Sustainability, Partnerships and Collaboration
5. Legal, Ethical and Human Rights Issues
6. Engaging Aboriginal Groups with Specific Needs
7. Supporting Broad Based Harm Reduction Approaches
8. Holistic Care, Treatment and Support
9. Research and Evaluation

Box 2 above outlines the nine strategic areas that ASHAC will support.

The rationale, objectives and expected outcomes were established for each of the key strategic areas of the Aboriginal Strategy on HIV/AIDS in Canada and will serve as a framework to review results and accomplishments.

3.0 Evaluation Context, Objectives and Methodology

This section outlines the context for the evaluation, the objectives, evaluation methodology, and limitations of the evaluation of FNIHB's HIV/AIDS Program.

3.1 Evaluation Context and Objective

The purpose of the present report is to present the findings from a formative evaluation of Health Canada's First Nations and Inuit Health Branch (FNIHB) HIV/AIDS Program. The management consulting firm of Goss Gilroy Inc. was hired by Health Canada to conduct the formative evaluation during the summer and fall of 2003. This evaluation focuses on the activities funded during the past five years (i.e., 1998/99-2002/03) under the FNIHB HIV/AIDS Program

This 5 year Evaluation was conducted as part of:

1) the*Canadian Strategy on HIV/AIDS* Evaluation as per Treasury Board Secretariat of Canada requirements;

2) the workplan as identified in the *Health Canada's 2002/2003 Report on Plans and Priorities;*

3) the federal governments' accountability to report on the progress and results of the program to Canadians.

The intended audience of this report, are the communities served by the FNIHB HIV/AIDS Program, Health Canada and the Treasury Board Secretariat.

The results of the evaluation will serve two major purposes. They are as follows:

1. to contribute to better decision making around how best to deliver the program and provide strategies for continuous improvement;

2. to provide objective information to assist with decisions on the program's future. This includes key strategic directions, scope and allocation of resources, program priorities and policy development.

The evaluation addressed two key questions:

- *Has the HIV/AIDS program been implemented and delivered as designed?*

- *To what extent has the HIV/AIDS program contributed to the achievement of expected short-term outcomes?*

The first issue relates to program implementation. The focus is on the delivery of the program to date, and whether it has been able to deliver planned activities consistently and effectively. The second area that was investigated was the extent to which the program has achieved expected short-term outcomes. The expected short-term outcomes, as outlined in the logic model developed by Health Canada staff[14] included in the terms of reference (see Appendix B), included:

- Increased community awareness;
- Improved utilization of health promotion resources;
- Increased accessibility of care, treatment and support for people living with HIV/AIDS and their families;
- Improved linkages for HIV/AIDS programming.

This was a **formative evaluation**, which typically occurs in the mid-cycle of a program. Formative evaluations typically focus on the following issues:

- examining management issues of how the policy, program or initiative is being implemented;
- whether risk is being managed;
- whether the performance measurement system is generating valid and reliable performance data;
- whether adjustments are necessary;
- whether progress toward the achievement of the outcomes is occurring.

Note: The logic model was not validated by the consultants or program management, since it was beyond the scope of this mandate. It will need to be reviewed and amended as a result of the evaluation.

Terms of reference were initially developed to guide the evaluation study. Once the evaluation team began to develop the methodology, it was discovered that the program did not have the data required to accurately report on outputs and outcomes for the program.

The original FNIHB HIV/AIDS Logic Model (See Appendix B) did not include performance indicators. There was no baseline data, hence outcomes were very vague and difficult to analyse. This original Logic Model had not been validated by the FNIHB Senior Management, and there was insufficient documentation to determine the extent to which this model was used in the FNIHB HIV/AIDS Program. For the purposes of this evaluation, the preliminary HIV/AIDS Logic Model was used as a guide until an updated version can be developed and validated.

The absence of a performance measurement framework resulted in no systematic collection of information according to common indicators, and no compilation or "roll-up" of program data. As a result, the evaluation team had to rely on solely qualitative approaches (e.g., key informant interviews, case studies) in the attempt to address the evaluation issues within the time frame and budget allocated for the evaluation. As well, during the initial meetings with the project authority for the evaluation study and through consultations with representatives from FNIHB, it was agreed that some methods outlined in the original terms of reference were not appropriate for the current evaluation (e.g., survey of community nurses).

3.2 Evaluation Methodology

The Methodology was agreed upon by members of the Health Canada HIV/AIDS Committee (See Appendix C). The Committee was composed of representatives from the following offices:

FNIHB HIV/AIDS Program Headquarters and regional offices;
Health Canada's CSHA Program;
FNIHB Business Planning and Reporting Division,
Health Canada's Departmental Program Evaluation Directorate; and
Goss Gilroy Inc. (The Contractor).

The FNIHB HIV/AIDS Program Officer provided Goss Gilroy Inc.with a list of contacts. The contacts included FNIHB regional officers responsible for the HIV/AIDS Program, previously funded recipients, past FNIHB HIV/AIDS Program Officers and members of the Health Canada National Aboriginal Council on HIV/AIDS.

The FNIHB National Office and regional offices have reviewed the evaluation to ensure its validity. The case studies were also reviewed by FNIHB staff in the regions in which the cases studies were conducted. In some instances, the project contacts for case studies were re-contacted by the evaluation team to clarify information as the information was compiled in the draft evaluation report. It should be noted that not all information derived from the case studies has been re-validated by the participating communities due to the timing of the evaluation (summer) and the changes in personnel at the community level. It was decided that an ethics review process was not required because this was a formative evaluation without any special needs governing human subjects or controversial issues.

In order to address issues related to program delivery and the progress towards achieving short-term outcomes, the following qualitative methods were used:

- ***Literature and Document Review***: A literature and document review was conducted by the evaluation team. The information reviewed included available program information such as operational, financial, epidemiologic and surveillance data, progress reports, action plans, and strategies. The review was undertaken to identify relevant trends, issues, successes and challenges faced with respect to program delivery. Documents were identified through interviews, HC staff, and via internet searches.

- ***Key Informant Interviews***: The evaluation team conducted interviews with a diverse group of respondents. All interviews followed a semi-structured interview guide (see Appendix C for interview guides). Interviews in the National Capital Region and during site visits were held in-person when appropriate. All other interviews were conducted by telephone. Participants in the key informant interviews were assured during the interview process that individual responses would not be linked back to identified individuals in the evaluation report. The following groups of respondents were interviewed:
    - National program representatives (n= 2)
    - Regional program representatives (n= 11)
    - HC representatives from other related programs (n = 7)

- National/Regional Aboriginal organizations (n=5)
- Community representatives (n =8)

- ***Case Studies***: Case studies were conducted with two regions (Saskatchewan and Pacific) and with one organization that received funding from the national component (Pauktuutit Inuit Women's Association). For the regional case studies, the methodology included document review, site visits with communities and organizations, interviews with community/organization representatives, and focus groups with individuals from the community. For the national case study, the methodology included document review and interviews both in-person and by phone. Participants in the case study were assured that, while the community and projects would be identified in the case study, responses would not be linked to individuals who participated in interviews and focus groups.

Analysis of Qualitative Information

Given the nature of the methods chosen for the evaluation, the information collected during the evaluation was qualitative. The evaluation team used a common grid analysis approach to draw out the major themes for each evaluation issue across methods and respondents. As illustrated in **Table 4**, a grid analysis of qualitative data permits an ongoing analysis of issues as the team collects information. Information from each respondent or document is matched with the corresponding evaluation issue. Major themes can then be identified from the data across various respondents.

Table 4

Sample Grid Analysis Structure

Information Source	Stakeholder Group	Issue: Implemented as designed	Issue: Short-term outcome community awareness	Etc.
Key informant #1				
Key informant #2				
Activity report #1				
Case study document #1				
Site visit interview #1				
Etc.				

3.3 Challenges in Conducting the Evaluation

The evaluation was formative in nature and focussed on two major issues: program design and delivery and short-term outcomes. The evaluation team encountered various challenges in conducting the evaluation. Some of these challenges had impact on the outcomes of the evaluation itself, related to the quality and quantity of information available for the evaluation.

- ***Lack of background information to inform the evaluation*** - Very little project information (either at the national or regional level) was available in corporate headquarter files. As well, the extensive staff turnover at national office during the past several years resulted in very little corporate memory on how the program evolved and the rationale for projects chosen and funded over the past several years. The team also had difficulties in securing interviews with senior managers who would have been aware of the evolution of the program.

- ***Availability of respondents -*** It should be noted that with the exception of the regional program representatives group, the evaluation team had considerable challenges in securing interviews with appropriate representatives in many of the other key informant groups. In particular, current and former senior managers at the national office were not available for interviews. As a result, with the exception of regional program representatives, there were a number of key respondents in each of the groups who were not available for interviews. One contextual issue that may have contributed to the unavailability of respondents within communities was that the time period for the evaluation included the late spring and summer months.

- ***Absence of an evaluation framework*** - An evaluation framework has not been developed for the program (e.g., there were no indicators, no method selection, approach). While a logic model has been developed, this does not appear to have been widely distributed among key stakeholders. As well, there is no evaluation plan or indicators for the program.

- ***Absence of performance measurement data*** - FNIHB had not developed a performance measurement framework for the program at the time of this evaluation. As a result, there was very little performance measurement data available for the evaluation.

4.0 Evaluation findings

This section outlines the main findings from the evaluation study. The evaluation findings are presented according to program design and delivery issues, followed by achievement of short-term outcomes, including examples of best practices.

4.1 Program Design and Delivery

Through interviews with key stakeholders, the study team examined a number of issues related to program design and delivery. The main areas covered were:

- program focus;
- program funding;
- communication and collaboration issues between stakeholders;
- overall program administration;
- performance monitoring;
- overall program strengths and challenges.

Program Focus Issues

As mentioned previously, each region administers the program in a slightly different manner, taking into account the needs of the region, its environment and the established relationships with provincial and territorial governments, as well as regional Aboriginal AIDS organizations. This flexible approach is viewed as important by the HC regional and community representatives and allows them to adapt to specific needs.

In many instances, often due to funding constraints and regional or program-level requirements, there is a heavy focus on short activity-based projects rather than what could be viewed as strategic planning projects or longer-term projects[15]. This focus on short-term activity-based projects was considered detrimental by some HC regional, community and Aboriginal organization representatives. They reported that the emphasis on short-term detracted from the development of longer-term strategies to address HIV/AIDS issues. Many respondents from the communities and Aboriginal organizations, particularly in the larger, more established

15 It should be noted that this is not the case in all regions. Some regions have chosen to support work on strategies initially, and have then moved into more project-based funding.

communities, pointed to the need to develop a longer-term action plan coupled with stable multi-year funding. This would allow sustained efforts in prevention, training and ensure better capacity building at the community level and in the Aboriginal service organizations involved in HIV/AIDS programming.

Concerns were raised by representatives from communities, organizations and HC regional representatives that often what was needed at the community level was an integrated approach to health care and a focus on healthy lifestyles. The concern was also raised that the FNIHB Communicable Disease Division programs be more integrated.

With respect to integrated approaches, some respondents indicated that health fairs which focus on a number of health related issues tend to attract more participants when compared with single issue events (e.g., HIV/AIDS event). Although better attendance results are achieved with integrated events, there are challenges in trying to adequately fund an integrated event when, in some regions, there are specific requirements that the funding be spent exclusively on HIV/AIDS activities or events. However, what should also be taken into account with respect to integrated events is the perspective provided by one interviewee that HIV/AIDS funding and events should remain separate, so there is continued attention paid specifically to HIV/AIDS issues in the Aboriginal context.

One other issue with respect to program focus is the concentration on prevention and community development with very little emphasis on care, treatment and support, or in coordination. Most key informants and representatives from case studies indicated that, for the most part, this restricted focus is due to the lack of funds available. Care, treatment and support and coordination components were deemed to be very costly and require considerably more capacity in many instances.

Program Funding Issues

Distribution of the funds often involves both proposal based projects, and the distribution of funds on a per capita basis to individual communities. The value and scope of the projects range from a few hundred dollars to over $100K. Although a population based approach to the distribution of funds appears fair in principle, there are also drawbacks to this approach. As was

noted by the HC regional and national representatives, this approach to distribution of funding means that very little money is available to certain communities to carry out HIV/AIDS related activities.

Overall, respondents felt that funding levels were too low. Lack of funding was deemed to have an impact on the quality of the initiatives, the types of activities undertaken (e.g., primarily education and awareness activities), and the level of program coverage within individual communities, and across communities within some regions.

Many of the community representatives were frustrated with the delays they perceived in obtaining annual funding. Delays in obtaining the funds and the requirements that these funds be spent within the fiscal year puts pressure on communities and organizations, and has an impact on the type and quality of activities that can be undertaken. The evaluation team was unable to determine the main reasons for delays in funding in previous years due to a lack of availability of previous program managers and HC senior officials to participate in interviews.

Interviews with representatives from HC regional and national offices, Aboriginal organizations, and communities indicated a strong concern with respect to yearly activity-based funding. Many indicated that they would prefer to develop 3-5 year action plans that could be funded on a multi-year basis. This would allow for better planning of activities over a period of time and would give them the ability to develop longer-term strategies. They also reported that there should be some flexibility in terms of the activities carried out, to allow them to take advantage of new opportunities or to extend on activities/projects that have been very successful. Reporting would still be done on a yearly basis, but performance trends could be established over time. A multi-year funding approach would also encourage the development of long-term plans at the community level, rather than focus on one-time activities.

Through the document review and interviews with key informants, the evaluation team was made aware that there are limited funds available within the current program structure for actual delivery and management of the program. As previously stated, at this point, there is officially one FTE associated with the entire management and delivery of the program. This FTE is located at national office. At the time of the evaluation, the regions were delivering and managing the program through staff already associated with other programs. There were no additional salary funds available for regional delivery.

Communication and Collaboration Issues

Most of the HC national and regional respondents indicated the need for better communication overall. Respondents felt that broad partnerships and collaborative efforts were critical to ensuring that comprehensive and relevant approaches to addressing HIV/AIDS work is undertaken. Their concerns included improved communication between national office and the regions, between the regional offices, and between Health Canada and the First Nations and Inuit communities. From the regional interviews and case studies, it appears that many of the regions have built solid relationships with Aboriginal service organizations, with the provincial and territorial governments, and with individual Aboriginal communities. An example of a region that has managed to have effective collaborations with a number of stakeholders is Québec (see **Box 3**).

Box 3 - Permanent Committee on HIV/AIDS

The resources provided by FNIHB have allowed the Quebec Regional Office to work closely with its major partners – the provincial government and the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC). Money was provided to hire a full-time HIV/AIDS coordinator. A Permanent HIV/AIDS Committee was set up to provide guidance to the coordinator. This committee is composed of 17 persons, including representatives from First Nations, health centres, Health Canada and Aboriginal persons with HIV/AIDS. This Committee has supported the creation of linkages between stakeholder groups. They were successful in supporting the development of a provincial Aboriginal HIV/AIDS strategy *Circle of Hope*; providing a coordinated approach to on and off reserve HIV/AIDS programming and in the development of appropriate communication tools which are widely distributed to both First Nations communities and organizations both on and off reserve as well as to other non-Aboriginal HIV/AIDS service groups.

Interviews with regional representatives indicated that there were unmet expectations that the national office would play a coordinating role with respect to the program. A number of examples were cited by regional staff of how it was difficult to get information or direction with respect to the program in areas such as clarification of program objectives, or program guidelines. Many attributed this confusion and poor communication to heavy staff turnover, lack of management continuity, and the lack of clearly defined roles and responsibilities. Nevertheless, it was noted in many interviews that communication has improved significantly in the past few months. This improvement was attributed to the recent structural and organizational changes at the national level with respect to the program.

Overall Program Administration

A review of files and interviews with HC national and regional representatives indicate some deficiencies in program administration. At the national level, there were few corporate files, and many of these were incomplete. Again, at the national level, there are no formal criteria developed for the selection of projects, and no common guidelines or application forms to help organizations applying to the program. There was no formal call for proposals to the national organizations and projects "trickle in" over the course of the year. This makes planning the budget and managing the financial resources difficult.

Project Monitoring and Performance Information

Generally, at this stage in a program, it is reasonable to expect that a performance measurement framework would have been developed and implemented. While there was an initial logic model developed by Health Canada, a full performance measurement framework has not been developed. The lack of a clear performance framework in which to administer the program also impeded on the availability of performance information for the evaluation. At this point, the reporting tends to be activity-based at the community level with limited roll-up of information at the regional or national level. There is no common set of performance indicators.

One concern that was raised by representatives from community and Aboriginal organizations with respect to monitoring performance was the need to account separately for on and off-reserve clients. This is not always possible, as there is considerable movement in the communities between those living on and off-reserves. However, interviews with representatives from the national office indicated that although activities must be focussed on-reserve, there is no need to distinguish between on and off-reserve at the client level.

Larger communities or regional Aboriginal AIDS organizations often receive funding from various other sources (including within Health Canada, provincial governments, regional health authorities). The lack of a coordinated approach to reporting on performance can place a burden on these non-governmental organizations, although all respondents interviewed recognized the need for accountability.

Overall Program Strengths and Challenges

Respondents were asked to identify what they felt were the strengths of the FNIHB program, as well as the challenges facing the program in the future.

Representatives from HC regional offices, communities, and Aboriginal organizations reported that the program had demonstrated success in the development of appropriate materials to support prevention activities at the community level. More accurate and appropriate tools have been made available as a result of the funding such as posters, videos, CDs, plays, and games. One important aspect with respect to the materials developed is that they are assessed by the groups as being culturally sensitive and appropriate for different communities.

Although many noted that there was still denial in certain communities, most respondents reported that there had been increases in the levels of awareness about HIV/AIDS issues within Aboriginal communities across Canada.

Many of those interviewed also presented examples of increased capacity in the communities. Some examples included increasingly stronger project proposals being prepared by communities, and the use of innovative and creative ways to reach various community members, in particular youth.

Most of the representatives interviewed reported that the program remains useful and is important to communities in which the need for the program remains ongoing. Most noted that impacts from the investment in health promotion activities usually can only be assessed in the longer-term.

Respondents also reported that there are various challenges facing the program. These covered a wide range of issues including:

- the need to better coordinate work completed on and off- reserve on HIV/AIDS with broad issues such as the need over the long-term to address some of the key determinants of health for Aboriginal people;
- the need for a more holistic and integrated approach to all blood-borne diseases (STDs, HIV/AIDS, Hepatitis C) which would enable them to make better use of limited resources – many already do this in their workshops and training sessions;

- the need to focus on encouraging healthy lifestyles;
- the need to support multiple harm reduction strategies, including needle exchange programs; and,
- the need to recognize the reality that in many cases people affected by HIV/AIDS must move off-reserve to access the necessary services, such as testing, treatment or care.

Funding was identified as a critical challenge, with very limited resources available to address all the issues. Funding focusses on prevention work and training/capacity development. The current budget was identified as insufficient to adequately address treatment and care issues.

4.2 Short-Term Outcomes

This section describes the findings with respect to the short-term outcomes that had been identified for the FNIHB HIV/AIDS Program in the logic model included in the Terms of Reference for the study (see Appendix B)[16]. These include:

- Increased community awareness;
- Improved utilization of health promotion resources;
- Increased accessibility of care, treatment and support for people living with HIV/AIDS and their families;
- Improved linkages for HIV/AIDS programming.

These conclusions are based on qualitative evidence gathered from interviews with key stakeholders, case studies and file reviews (when available). As previously noted, a performance measurement framework has not yet been developed for this program. As a result, the evaluation team did not have access to compiled measures of these outcomes over a period of time.

4.2.1 Increased Community Awareness

Overall, the key stakeholders interviewed reported that there is a general increase in the level of awareness within Aboriginal communities about HIV/AIDS issues.

16 Please note that this logic model was not validated by the consultants during the course of this study, as it was beyond its mandate to do so.

In some instances, the Community Leaders provide support to the community health workers who had moved towards integrating their efforts with other prevention strategies such as needle exchange programs, educational programs, or prenatal counselling. **Box 4** provides one such example - that of the Battleford's Tribal Council Community Based HIV/AIDS Program and the Battleford's Sexual Health Clinic.

Box 4 - Battleford's Tribal Council (BTC) HIV/AIDS Program and Sexual Health Clinic

Community Awareness /Utilization and Accessibility of Health Resources
The BTC receives funding to provide accessible, culturally appropriate preventive counselling, testing for HIV and supportive counselling for individuals and family members, and to raise awareness of causes and prevention of HIV/AIDS in communities among youth and young adults. It offers its services within the Battlefords Sexual Health Clinic as well as outreach programs in BTC communities through school presentations and individual counselling. Partnerships with Elders and community leaders encourage community participation. They have excellent local relationships with the Team Wellness Group, the Pre-natal Centre, Circle of Learning, Drugstore, and Young Parent's Programs.

Although there is no formal advertising, they have seen a general rise in referrals by doctors and in the number of clients consulting the clinic over the years. There is a growing need for additional educational activities with youth, which has been their major focus. However, they would like to broaden their work with the elders and adult population.

Limited resources means that they cannot respond to all requests for training or information sessions. They can, with the resources presently available, only offer the Sexual Health Clinic on a part-time basis (1.5 days a week) but would like to see a full-time clinic in the future to respond to demands.

Partnerships and Collaborations
Critical elements of their success include working closely with partners – Prince Albert STD Clinic, Prairie North Regional Health Authority, BTC community schools , and the BTC Indian Health Services Community Program – and being integrated with the Medical clinic. The drugstore which is located within the same building also provides a needle exchange program.

Performance Information
BTC staff have also developed a performance framework which highlights their goals, the major components of their program – prevention, community development, care, treatment and support and program coordination. The framework identifies their reach (major clients) and expected outcomes. They have also identified quantitative and qualitative indicators and they are starting to track this information. This will provide a baseline for future performance reporting.

Throughout the case studies and interviews, the evaluation team found examples where funding has led to the development of culturally sensitive materials and innovative ways of communicating about HIV/AIDS to communities' target audiences.

Examples include:

- community health fairs which promote healthy lifestyles and provide participants with information on a number of issues, including HIV/AIDS;
- theatrical plays developed and produced by students on HIV/AIDS related issues and presented to members of different communities;
- culturally sensitive posters allowing Aboriginal people to identify more closely with the issue;
- culturally sensitive CDs and radio announcements which are broadcasted on community radio stations at regular intervals;
- innovative condom covers;
- poster and t-shirt contests held for school-age children to sensitize them to the issue and that demonstrate that younger children have understood and are able to re-state key messages and concepts;
- age-appropriate school curricula focussing on key issues for different age groups;
- fashion shows and suppers that encourage community participation in the discussion of various health related issues in an interactive environment;
- the ability to bring resources to remote communities for training sessions such as medical personnel, people who are HIV+, or Aboriginal service organizations; and
- the integration of information sessions on HIV/AIDS and other health related issues such as STDs or Hep C with culturally and age-appropriate activities such as a recreational or day-camp program for children during the summer months.

At this stage, the outcomes of these activities are not measurable. However, there is anecdotal evidence that awareness about HIV/AIDS and methods to prevent the disease are reaching the FN/I communities and it can be expected that over the longer- term, these messages will result in outcomes that assist in reaching the goal of reducing the incidence of HIV/AIDS among FN/I communities. There also appears to be a somewhat better utilization of health resources among many of the communities.

Another good example of development of community awareness activities is the work undertaken by the Pauktuutit Inuit Women's Association as described in Box 5.

Box 5 - Pauktuutit Inuit Women's Association

The Pauktuutit Inuit Women's Association has received money from FNIHB to develop information materials, carry out workshops, develop AIDS FAIRS, educate youth in communities by involving them in the development of certain materials, and the Lifesavers Program, described below. These initiatives were undertaken under the direction of the Canadian Inuit HIV/AIDS Network (CIHAN). Two of these initiatives are the Arctic Youth Fairs and the Lifesavers Program.

Arctic Youth Fairs - The purpose of the Arctic Youth Fairs is to provide an opportunity to youth living in Arctic communities, particularly Inuit Youth, to participate in their own education around HIV/AIDS and Hep C and to provide them with an opportunity to share what they have learned with their contemporaries and community members. The projects and information created by the students are shared at a traditional Inuit feast or gathering. The participation of community elders and other leaders helps to de-stigmatize HIV/AIDS in participating communities across the North. Some of the materials created by the Youth have been included in national messaging for Inuit across Canada Many of the projects from both 2001 and 2002 have been shared with other indigenous populations in Panama, New Zealand and Dominica. Self-esteem and the recognition of self-worth, in relation to the issue of health promotion and personal health protection, have been identified as the biggest benefits of the Arctic Youth HIV/AIDS Fair component.

The Lifesavers Program - The primary purpose of this project was to take advantage of the largest gatherings of Inuit youth ever held in Nunavut (Arctic Winter Games 2002) as an opportunity to provide information and prevention materials to Inuit and other visiting youths in an environment of significant potential risk. The materials produced as part of the project included posters, HIV/AIDS Hep C Passports to Information, passport envelopes and inserts, traditionally flavoured condom covers for Inuit, t-shirts, CIHAN pins. All materials were produced without specific mention of the Arctic Winter Games to make them less time specific so they could be used at different future events, thus making the production of materials more cost-effective.

The Steering Committee members were actively involved in the above activities. This also served as a capacity-building activity. Respondents in the case study noted how these activities had helped their communities to develop more understanding and awareness of these health issues and to understand the nature of CIHAN activities overall. The kits/materials are now used as a basic tool for community-based activities throughout Inuit communities.

Although representatives from communities and Aboriginal organizations reported that progress has been made in reaching members of Aboriginal communities across Canada, they also indicated that there remains considerable denial about HIV/AIDS issues within segments of some communities. Community and Aboriginal organization representatives also indicated that there is a strong and recognized need to continue the educational and communication efforts that

were started in the past few years. Individuals engaging in high risk behaviours remain a critical issue both on and off-reserve. Increased movement between on and off-reserve communities increases the potential risk of disease transmission.

4.2.2 Improved Utilization of Health Promotion Resources

At the community level, activities are generally integrated within the health centres who work with the community, the community leaders, and the schools to promote healthy lifestyles and address HIV/AIDS issues. One example is the frequent availability of condoms in key areas (e.g., health centres, Council offices, recreational facilities). Some communities have also approved needle exchange programs as one harm reduction strategy. Three examples of this improved utilization of health promotion resources are briefly described below:

Ahtahkakoop First Nation:

The Ahtahkakoop Cree Nation Health Centre has put in place a number of program activities related to HIV/AIDS. Some of these have been funded through the FNIHB HIV/AIDS program. Activities include the collection, organizing and cataloguing of available resources on the subject of HIV/AIDS; the expansion of lesson plans for in-school education (from kindergarten to Grade 9); the development of interactive activities for a variety of ages; and the development of public education messages including bulletin boards, poster displays, newsletter articles and oral presentations to health staff and committee members. Opportunities are also provided for school groups to present to the community their interpretation and knowledge of HIV concepts. These sessions may involve guest speakers. In order to transmit the message, they have hired a group that performed an “afternoon for kids session” and a “dinner theatre” for adults. A nurse comes in twice a month to conduct testing for sexually transmitted diseases (STDs). They have also planned talent shows using health skits. The objective is to encourage healthy lifestyle choices, growth in self-esteem, and compassion and understanding of people living with HIV/AIDS.

With the nurse's help, the Health Centre will be starting a "needle exchange" program, particularly for self-identified Injection Drug Users (IDUs). This was developed using a team approach involving the Community Health Representative and the elders to develop a policy which was approved by the Chief and Council in June 2003.

The Health Centre representatives felt it was critical to continue working on prevention, with a focus on harm reduction strategies. They were particularly concerned with developing appropriate approaches to reach at risk young adults. These youths are hard to reach and do not come in for training sessions or workshops. Staff training on HIV/AIDS issues and the development of nursing guidelines are also important. However, it is also important to provide nurses with the communication skills needed to properly reach the community and schools.

Chee Mamuk:

Chee Mamuk, located in Vancouver, has a mandate to provide culturally appropriate on-site, community-based HIV/AIDS, Hepatitis and STD education and training to Aboriginal communities, organizations and professionals in BC. Their offices are located at the BC Centre for Disease Control, allowing for easy access to HIVexperts such as scientific peers and educators. Consulting with cultural peers and educators, the organization provides the link between scientific and cultural peers to produce accurate, relevant, and appropriate information for education, awareness and prevention activities. The FNIHB HIV/AIDS program contributes funds to assist Chee Mamuk in its work with on-reserve communities in BC.

Kwalin Dun First Nations:

The Kwalin Dun First Nations Health Centre carries out a number of activities in partnership with other stakeholders: RCMP, Yukon Family Services (Outreach Counsellors), Shookum Jim Friendship Centre, Indian and Northern Affairs, Blue Feather Youth Centre, Blood Tiers Four Directions Centre, Alcohol and Drug Services, Yukon College and other agencies. Some of these activities have been funded partially through the FNIHB HIV/AIDS program.

The "No Fixed Address Van" was a new addition to the HIV/AIDS Prevention Program. The Kwanlin Dun First Nation nurses provide services along with other agencies. Information about the prevention of HIV and other STDs is handed out targeting intravenous drug users. The van also acts as a needle exchange site. They also developed a "vein card" as a health prevention and promotion tool for teaching IDUs how to protect their veins, prevent HIV/AIDS and other STDs, and reduce harm. This approach is considered a success with trust continuing to evolve between the street involved community and the health centre staff.

4.2.3 Increased Accessibility of Care, Treatment & Support for People Living with HIV/AIDS and their Families

Most respondents indicated that the funds in the program are too limited to significantly address the issues of care, treatment and support for people living with HIV/AIDS and their families. Overall, the key stakeholders felt that there were definite gaps in the availability of services for First Nations and Inuit with respect to the care and treatment of Aboriginal people living with HIV/AIDS. They must often go off-reserve to obtain the necessary support, care and treatment. As well, many respondents provided examples of how there remains significant levels of stigmatism in many FN/I communities for people and their families living with or affected by HIV/AIDS.

Through the case studies, however, the evaluation team was provided with some excellent examples of unique approaches to providing services and support to individuals and their families which are affected by HIV/AIDS. Two examples of such services were examined in the case study in BC and are presented in **Boxes 6** and 7.

Box 6: Canim Lake Band, BC
TSQLEXS RE WUMEC (CIRCLE OF LIFE)

The Canim Lake Band is located in interior BC. The Band has formed a support group which they call the Circle of Life. The group members (approximately 20 band members and a retired community nurse) range from adolescents to elders. The group members have conducted a number of activities including:

- providing support to those individuals and their families affected by HIV/AIDS;
- developing a Community HIV/AIDS policy for the Band;
- organizing awareness activities such as an annual AIDS walk, logo and poster contests, a "Show your Support" quilt, displays at pow-wows; and
- participating in provincial conferences on HIV/AIDS and sharing their experiences as a group concerned with HIV/AIDS issues in a First Nations community.

In the past, some of the group's funding has been provided by the FNIHB's HIV/AIDS program.

Box 7: Healing Our Spirit, BC
COMMUNITY SUPPORT

Healing Our Spirit is a provincial Aboriginal organization based in Vancouver, BC. The organization was founded and incorporated in 1992, and has the mandate of preventing and reducing the spread of HIV and AIDS, and providing care and support services to Aboriginal peoples infected and affected by HIV/AIDS. One of their programs is the Aboriginal HIV/AIDS Community Education Programs that offers holistic and culturally appropriate HIV/AIDS prevention workshops to various groups both on and off-reserve. One particularly unique service is the education and support services that they provide for families and individuals affected by HIV/AIDS. These services are provided in the privacy of the family's home, and are offered to families who have a member that has been diagnosed with HIVor AIDS. As well, they provide basic in-home HIV/AIDS information sharing and private, one-to-one information sessions for newly-diagnosed individuals.

4.2.4 Improved Linkages for HIV/AIDS Programming

Some key informants reported that the program's funding has helped to support the development of Aboriginal service organizations at the national and regional levels. These organizations then provide support to individual Aboriginal communities. One issue that was raised in key informant interviews and case studies was that often there is insufficient coordination among activities either within a province or between communities in different

provinces and territories to ensure that groups are not repeating the development of materials or approaches. Many pointed to the need for increased participation in networking and sharing activities such as conferences and meetings.

Some examples of linkages having occurred as a result of funding from the program include:

- The BC region hosts an annual Aboriginal HIV/AIDS conference. The conference is attended by representatives from communities, Aboriginal HIV/AIDS organizations, government, and the medical community.
- CAAN's development of the Aboriginal Strategy on HIV/AIDS in Canada (ASHAC) for First Nations, Inuit and Métis People – *Strengthening Ties - Strengthening Communities* – that was finalized in 2003.
- The Manitoba HIV/AIDS Working Group (MFNAWG), which now includes a TB/HIV epidemiologist, receives some funding to ensure regional involvement of the major stakeholders and to play a coordinating role, linking representatives from the First Nations and Health Canada.
- In Atlantic Canada, *Healing our Nation* (formally the Atlantic First Nations Aids Task Force AFNATF) promotes cross-branch relationships and understanding of issues by First Nations Leadership/Tribal Councils in the Atlantic region. It also fosters the establishment of linkages to Friendship Centres, non-governmental organizations, and provincial organizations. It has worked with the medical community and health professionals to better understand how the virus is transmitted and how to promote both on and off-reserve strategies to prevent the spread of HIV/AIDS.

5.0 Recommendations

The evaluation team has developed the following main recommendations based on the findings described in Section 4.0.

Recommendation #1 - Improve the overall program administration at the national level by ensuring that there are adequate corporate files maintained, project criteria developed, and guidelines for proposals and funding.

Given the high level of turnover among program staff and lack of continuity among management at the national level, the national office does not have an adequate set of corporate files for this program. In addition, with respect to national projects, there are inadequate materials to indicate how decisions for funding or non-funding are made (e.g., eligibility criteria, guidelines). This will require ensuring that the necessary human and financial resources are available at both the regional and national level to carry out these activities.

Recommendation #2 - Improve communication and clarify roles and responsibilities among national and regional offices.

The program was implemented by the various regions without clear guidance or coordination from the national office. As a result, there is confusion and lack of clarity with respect to many aspects of the program. High turnover of staff at national office also placed considerable stress on the communications between national office and the regions. The need for clear program documentation and guidelines that respect the need for flexibility among the regions is required.

Recommendation #3 - Provide program resources that will ensure adequate delivery and management of the program.

As it is currently designed and delivered, the program has one FTE for which salary resources are allocated from program funds. Given the size of the program, the multiple regional delivery mechanisms involved, number of key stakeholders, proportion of program funds as contribution agreements, and the anticipated results to be achieved by the program, this level of staffing is inadequate. Likely many of the challenges the program has experienced to date can be linked either directly or indirectly to this lack of resources for managing the program. Any changes to the program should include a re-analysis of actual required resources to manage a program with these characteristics and this size within a results-based management environment.

NOTE: Current epidemiological data suggests that Aboriginal seroconversion rates are two to seven times that of the general population. The FNIHB CDCD has one national program manager. Hence, it is impossible for the FNIHB HIV/AIDS Program Manager to address all the workload responsibilities and collect data.

Recommendation #4 - Revisit the design of the program to ensure that the program's activities and services are compatible with resources and capacity. Clarify what kind of activities and services could be successfully implemented under the Care, Treatment and Support component of the Program.

As currently designed, the program has the objective of increasing accessibility to care, treatment and support for people living with HIV/AIDS and their families in FN/I communities. Given the level of resources available and the capacity of the organizations and communities involved, respondents from the various stakeholder groups indicated that this program objective is extremely difficult to achieve for many regions and communities.

Recommendation #5 - Consider arrangements, taking into account program authorities and Treasury Board guidelines, that permit longer-term, strategic projects.

The program currently provides one-year funding that often arrives in communities very late in the fiscal year. As a result, there is a heavy focus on short-term activities, and less focus on longer-term strategic projects. As mentioned by numerous stakeholders, alternative funding arrangements, such as multi-year funding, would allow the program to move from activity-based events to the development of program components that support an overall integrated approach to promoting healthy lifestyles in FN/I communities. This approach would be more likely to provide program activities that result in the identified intermediate and longer-term outcomes that are identified in the program logic model for the program.

Recommendation #6 - Develop and implement a performance measurement framework and evaluation plan for the program.

In a results-based management environment, it is essential that those responsible for delivering a program have a framework for measuring program performance. Ideally, the framework should be developed in conjunction with representatives from the various stakeholder groups, in particular those who will be responsible for the ongoing performance data collection and monitoring. At present, it is impossible to determine accurately to what extent outcomes are being systematically achieved through the program. It will be very difficult to perform any type of summative evaluation work without an evaluation plan that is integrated with an

implemented performance measurement framework for this program. Given that this is a component of the overall Canadian Strategy on HIV/AIDS (CSHA), it will be important that there is some compatibility with performance indicators and evaluation issues for the overall strategy. The initial step in developing the framework will be to ensure that the current logic model is accurate and validated by the various stakeholder groups. Once the activities, outputs and outcomes have been confirmed, indicators for outputs and outcomes should be developed. Key indicators for ongoing monitoring of program performance will need to be chosen and agreed upon by the various stakeholder groups. Given the diverse delivery mechanisms for the program, and the number of groups involved in developing program activities, it will be important that a concerted effort is made to engage various stakeholders in the multiple stages of the development of the framework. Once chosen, the indicators will need to be integrated into a performance measurement strategy that outlines who will be collecting the data, when the data will be collected and reported, and who has responsibility for compiling and reporting the program data at various levels (e.g, community, regional, national). Finally, an evaluation strategy or plan should be developed that is integrated with the ongoing performance measurement and reporting framewok. This will ensure that program data required to address summative evaluation issues is systematically collected. Although the FNIHB HIV/AIDS Program is not responsible for gathering surveillance and epidemiological data; the importance of this data to inform decision making is critical, and sufficient resources need to be devoted by Health Canada to support the process.

Appendix A: Regional Activities

A brief description of the kind of activities that are funded at the regional level is provided below. Each region administers the program in a slightly different manner taking into account the needs of the communities, its environment and the established relationship with provincial and territorial governments, as well as Aboriginal AIDS service organizations. Distribution of the funds involves both proposal based projects and the distribution of funds on a per capita basis to individual communities. The value and scope of the projects can vary significantly and range from a few hundred dollars to over $100K. This material is based on information contained in the annual work plans and reports submitted by the regions to national office. These provide a brief overview of the type of projects funded and the range in financial value.

Pacific Region

The Pacific Region provides support to various groups and organizations. Some of these include:

- The Red Roads Aboriginal HIV/AIDS Society represents on and off reserve HIV/AIDS organizations in BC and is a main source of consultative advice on Aboriginal HIV/AIDS issues (co-ordination and capacity building). This Society also plays a major role in implementing the BC Aboriginal HIV/AIDS Strategy (*The Red Road: Pathways to Wholeness - An Aboriginal Strategy for HIV/AIDS in BC*);
- Healing our Spirit Aboriginal HIV/AIDS Society provides direct services to on and off reserve Aboriginal people in BC (prevention and community development and care, treatment and support);
- First Nations Alcohol and Drug Treatment Centres HIV/AIDS Workshops and HIV Surveillance (8 centres - prevention and surveillance);
- First Nations Chiefs Health Committee HIV and HTLV Prenatal Surveillance project in collaboration with the Canadian Blood Services and funded mostly by the Health Canada Laboratory Centre for Disease Control, Division of HIV/AIDS (surveillance);
- Chee Mamuk provides on-site, community-based HIV/AIDS, Hepatitis and STD education and training to on-reserve communities;
- Vancouver Native Health Society Female Condom Project (prevention);

- pre and post-test community health nurses training (prevention);
- condom supply and distribution (prevention); and
- AIDS 101 Education Workshops on-Reserve (prevention - 198 First Nations Reserve in B.C.).

Projects range in value from $27,000 to close to $200,000 and focus on coordination, capacity building, prevention, community development, surveillance, and care, treatment and support.

Yukon Region

Most of the effort in the Yukon is on prevention of HIV/AIDS through education. The education awareness is targeted at various age groups in the communities with an emphasis towards community-based programs, ownership and development. There were also some care, support and treatment initiatives undertaken, including the provision of information on current and future caregivers of HIV positive community members. Resources for the projects ranged from $3,000 to over $20,000 and support was provided to eight First Nations communities.

As well, funds were provided in 2001/2002 and 2002/2003 to the Council of Yukon First Nations (CYFN) for the HIV/AIDS Awareness Research Project, which will provide the foundation for an HIV/AIDS strategic plan for the Yukon First Nations. It was initiated in response to a growing need for first hand information on HIV/AIDS and the Yukon First Nations.

Alberta Region

The regional office works closely with the provincial government. A Joint Review Committee examines and funds proposals submitted by First Nation communities. Seven goals are provided to the communities for project planning purposes. These are taken from the *Alberta Aboriginal HIV Strategy 2000-2003*[17] and are designed to assist groups to meet their HIV challenges, to address prevention and education needs as well as to accept and support their people living with the disease. The seven goals are to:

- build capabilities in Aboriginal communities;
- build strong partnerships;

[17] Alberta Region noted that this Strategy has not been reviewed and updated for 2004.

- enhance care and support services;
- use safer sex and harm-reduction practices;
- increase culturally appropriate resources;
- demonstrate effectiveness of HIV programs; and
- enhance HIV epidemiological data.

First Nations and/or Tribal Councils are funded on a proposal-based system. The value of the projects range from $3,000 to $15,000, and amounts are based on population. As well, two organizations which directly serve Alberta's reserves have received funding – Feather of Hope Aboriginal Prevention Society[18] and Nechi Training, Research & Health Promotions Institute. The value of their projects range from $25,000 to 50,000.

Saskatchewan Region

In Saskatchewan, the focus of the work of most communities is on increasing knowledge and awareness on HIV/AIDS issues both for the community at large and youth. Education of health care workers was also emphasized, and many communities also funded projects in community development as well as care treatment and support. Funding goes to support both on-going as well as specific activities carried out by First Nation communities, Tribal Councils and non-aligned Bands to address HIV/AIDS related issues. The value of the projects range from $2,000 to $50,000.

There are two different approaches for submitting proposals for base funds depending on the size of the allocation (less than $7,500 and more than $7,500). A call letter is sent out to First Nation communities, Tribal Councils, non-aligned Bands and Aboriginal AIDS Service Organizations in April. Staff in the service centres provide support to these groups (as requested) during the preparation of their proposals. Proposals are evaluated on the basis of merit.

18 The Alberta Region noted that at the time of this report (2004), this society was no longer in existence.

Manitoba Region

The Manitoba HIV/AIDS Working Group (MFNAWG), which now includes a TB/HIV epidemiologist, receives some funding to ensure regional involvement of the major stakeholders and to play a coordinating role, linking representatives from the First Nations and Health Canada.

Examples of program funding includes the following organizations and communities:

- ***Health Organization/Anishinaabe Mino-Ayaawin (AMA)***, in Winnipeg, receives funding for a HIV/AIDS Educator position which serves seven communities . The educator's focus includes care and support, local and regional networking, and building community-based capacity. Yearly funding is approximately $38,000.
- ***Tribal Councils***: funding is provided to partially or totally fund HIV/AIDS Health Educator positions for tribal councils supporting many communities. Activities include training sessions for health and social services staff and community leaders; community-based integrated health program planning, development and implementation; and, workshops and other activities to reach the community. Six Tribal Councils receive funding which range from $20,000 to $60,000 per year.
- ***Non-affiliated Bands***: Fourteen bands receive funding which range between $2,000 and $14,000 per year. The objective is to develop community-based activities and to strengthen ownership of HIV/AIDS issues by involving band staff and programs. The emphasis is placed on youth in developing cultural teaching tools, prevention and educational activities.

Ontario Region

Ontario Region First Nations receive their HIV/AIDS funding annually through a consolidated contribution agreement. The Chiefs of Ontario Policy and Planning Committee determined allocation by using a base funding formula, population and remoteness factors for each First Nation. The allocation varies from 3.5 to 13.2. The Political Territorial Organization (PTOs) manage funding on behalf of their member nations.

The four (4) Political Territorial Organizations are provided funding for the AIDS Educators by the Provincial government. These AIDS Educators form or makeup the Ontario First Nations HIV/AIDS Education Circle (OFNHAEC) and are funded and supported by Health Canada FNIHB annually. The Circle attempts to meet quarterly to engage in activities related to networking, support, collaboration, and advocate on behalf on the First Nations in Ontario. The Circle developed and completed a five-year workplan, which has been reviewed and ratified by the Chief's of Ontario Health Coordination Unit.

The AIDS Educators and the First Nation communities primarily focussed and utilized the HIV/AIDS funding for prevention, promotion of healthy lifestyle and positive sexual health, and education. These initiatives were accomplished through conducting workshops targeting youth and the general public as well as training for the community health workers.

Quebec Region

The FNIHB program has allowed the Quebec region to carry out a number of activities which include support to the Permanent Committee on HIV/AIDS at the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) as well as to First Nations communities.

- ***First Nations of Quebec and Labrador Health and Social Services Committee***: The resources provided by the FNIHB Program allowed them to establish the Standing Committee for the Québec First Nations and Inuit HIV/AIDS Strategy (The Circle of Hope), which involves numerous stakeholders including the provincial government, Health Canada, and representatives from First Nations and Inuit. The FNIHB program provides $150,000 per year to support this committee to develop, promote and deliver the work plan described in the Circle of Hope Strategy under the technical direction of the FNQLHSSC and the coordination of the FNIHB. This committee identifies themes and areas of priority and provides guidance to communities applying for funding. The region has also provided financial resources to support the development of education/information materials which are widely distributed across the province to both on and off-reserve stakeholders.

- ***First Nations Communities***: The Quebec regional program also provides funding for activities carried out within Aboriginal Communities in Quebec. These include workshops, education and information sharing among health workers (capacity building), youth education and public awareness activities and promotion of healthy lifestyles and responsible sexual behaviour. The value of these projects range between $5,000 and $10,000 .

Atlantic Canada

The Atlantic Region provides funding on an on-going basis for two major projects:

- ***Healing our Nation*** (formally the Atlantic First Nations Aids Task Force AFNATF) receives approximately $100,000 per year. This project promotes cross-branch relationships and understanding of issues by First Nations Leadership/Tribal Councils in the Atlantic region. It also fosters the establishment of linkages to Friendship Centres, non-governmental organizations, and provincial organizations. It has worked with the medical community and health professionals to better understand how the virus is transmitted and how to promote both on and off-reserve strategies to prevent the spread of HIV/AIDS. Cross-cultural training, referral services, and the development of appropriate educational material are other activities carried out by this organization.
- ***Labrador Inuit Health Commission*** receives approximately $42,000 per year. Its activities include the identification of effective prevention approaches and strategies to deal with HIV/AIDS programming in Labrador Inuit communities; the development and promotion of a video; training sessions for health workers and youth; and, the development of culturally appropriate protocols for counselling, care and support of individuals affected by HIV/AIDS.

Two other communities receive smaller amounts of funding to support the delivery of community-based training opportunities and to enhance the resources and programming material available.

Appendix B:

FNIHB HIV/AIDS Program Logic Model
Health Canada's HIV/AIDS Program Logic Model
Clients: First Nations on Reserve and Inuit People Living in Labrador and Quebec

Contribution Agreement Objectives	- Develop initiatives to control and prevent the spread of HIV infection in the on-reserve population - Reduce the health, social and economic impacts of HIV/AIDS for on-reserve populations - Encourage and support the active involvement of the on-reserve community in community-based HIV/AIDS program - Identify options/strategies for the provision of on-reserve treatment, care and support programs that will facilitate the people with HIV/AIDS remaining in or returning to their home community - Provide timely and comprehensive education and prevention programs - Increase the knowledge base of the epidemiology of the HIV/AIDS epidemic in FN/I communities - Ensure that appropriate skills exits at the community level to provide prevention programs and care/treatment services and that the capacity is developed within the community and organizations - Develop a coordinated approach associated with HIV/AIDS programming for the residents		
Components	Prevention	Community Development	Treatment and Support
Inputs	Physicians / Community Health Nurses (CHN) / Para-professionals / Support Staff and Volunteers		
Key Activities	Facilitate the development of primary prevention activities at the community or regional or national levels (as applicable) for the residents living with HIV/AIDS	Develop the capacity to address HIV/AIDS by providing HIV/AIDS awareness programs and relevant training opportunities	Provide appropriate care, treatment, and support for residents in the community living with HIV/AIDS

Outputs	Treatment / treatment options New cases identified to be HIV+ Support groups / counselling sessions Community partnerships established (F/T/P regional) Community initiatives - types - (i.e. awareness in-service and on-going educational services for staff)
Short-term Outcomes	Increased community awareness about HIV/AIDS Improved utilization of health promotion resources Increased accessibility of treatment for patients and families Improved linkages for HIV/AIDS programming
Long-term Outcomes	Reduced incidence of HIV/AIDS among First Nations and Inuit people

Source: Health Canada, RFP /Contract Reference #: HQ0300461 / Project Title: Evaluation of the HIV/AIDS Program for First Nations on Reserve and Inuit Living in Labrador and Québec, Issue Date: January 8, 2002, p. 3endix C: Interview Guides

Appendix C: Name of Committee Members

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A/Program Manager HIV/AIDS Program
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APPENDIX D: REFERENCES

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Appendix E: Interview Guides

Guide for Interviews with National Organizations

Health Canada is currently conducting an evaluation of the HIV/AIDS Program delivered by the First Nations and Inuit Health Branch. They have hired Goss Gilroy Inc. to conduct the evaluation which has a national scope and is focussing on program relevance, design and delivery issues, and program success.

The approach that is being used for the evaluation includes key informant interviews with regional offices responsible for delivering the program, staff at FNIHB national office, and national stakeholder organizations. In addition, the consultants will be conducting case studies of four successful projects resulting from the program, and interviews with individual representatives from some of the communities involved with the HIV/AIDS program.

Below we have listed a number of questions that the consultants would like to cover in an interview with you during an interview. It is anticipated the interview would take approximately 45 minutes to one-hour of your time. We have attempted to cover a lot of issues in our questions, and, as a result, all questions may not be applicable for you.

Background/Context

- Did you play any role in the design of the FNIHB HIV/AIDS program? If yes, please describe your involvement.

Program Design & Delivery

- Please describe briefly the projects your organization has carried out with resources available from the FNIHB/AIDS program?

- How would you describe your relationship with the national office with regard to this program? What aspects of this relationship work well? Which aspects are more challenging?

- What type of monitoring do you perform for projects funded under this program (e.g., financial, results, success) ? From your perspective is this amount and type of monitoring sufficient?

- What is the level of satisfaction among communities and organizations involved with the program with regard to:
    - program design and delivery
    - amount of funding
    - outcomes/success of their projects

Program Success

- Below we have listed a number of potential short-term outcomes that may have resulted from some of the projects and communities funded under the program. Please comment for each area: 1) to what extent the program has made progress in achieving specific outcomes to date; 2) what is the likelihood of achieving these specific outcomes in the near future (next 2 years); and 3) what aspects of the program assist or detract from achieving these outcomes.
    - increased capacity among First Nations and Inuit communities to address HIV/AIDS issues

  - increased participation and partnership among and within First Nations and Inuit communities in addressing HIV/AIDS issues
  - increased community awareness of HIV/AIDS issues
  - improved utilization of health promotion resources
  - increased accessibility to prevention, care and treatment supports for patients and families
  - increased linkages for HIV/AIDS policy coordination and programming

- What other short-term outcomes have you observed being achieved by the Program?

- From your perspective, how likely is it that the program will achieve some of the more longer-term outcomes?
  - reduced incidence of HIV/AIDS among First Nations and Inuit communities
  - enhanced treatment and care for those infected and affected by HIV/AIDS
  - enhanced quality of life for First Nations and Inuit people living with HIV/AIDS

- Which aspects of the Program would be more likely to assist in achieving these longer-term outcomes?

- Which aspects of the Program would be more likely to detract from achieving these longer-term outcomes?

Rationale and Alternatives

- From your perspective, is there a continued need for a FNIHB HIV/AIDS Program as it is currently designed and delivered? Why or why not?

- What would be some more appropriate alternatives to the current Program?

- What are the Program's most obvious strengths? Weaknesses or challenges?

Evaluation of the FNIHB HIV/AIDS Program

Guide for Interviews with Regional Contacts

Health Canada is currently conducting an evaluation of the HIV/AIDS Program delivered by the First Nations and Inuit Health Branch. They have hired Goss Gilroy Inc. to conduct the evaluation which has a national scope and is focussing on program relevance, design and delivery issues, and program success.

The approach that is being used for the evaluation includes key informant interviews with the FNIHB regional offices responsible for delivering the program, staff at FNIHB national office, and national stakeholder organizations. In addition, the consultants will be conducting case studies of four successful projects resulting from the program, and interviews with individual representatives from some of the communities involved with the HIV/AIDS program.

Below we have listed a number of questions that the consultants would like to cover in an interview with you during an interview. It is anticipated the interview would take approximately 45 minutes to one-hour of your time. We have attempted to cover a lot of issues in our questions, and, as a result, all questions may not be applicable for you and your region.

Background/Context

- Please describe briefly your role and your office's role with regard to FNIHB HIV/AIDS program?

- Did you play any role in the design of FNIHB HIV/AIDS program? If yes, please describe your involvement in the design.

- From your perspective, what do you see as the primary objective(s) of the FNIHB HIV/AIDS program?

Program Design & Delivery

- How is the FNIHB HIV/AIDS program delivered in your region?
  - What was the rationale for using this type of delivery?
  - What are the strengths of using this type of delivery?
  - What are some of the challenges?

- How are decisions made with regard to how to allocate funding? (e.g., proposal-based, population-based) If proposal based, how do you assign priorities?

- How would you describe your relationship with the national office with regard to this program? What aspects of this relationship work well? Which aspects are more challenging?

- How do you relate with other regional offices with regard to this program? Do you share best practices, success stories, etc.?

- What type of monitoring do you perform for projects funded under this program (e.g., financial, results, success) ? From your perspective is this amount and type of monitoring sufficient?

- What is the level of satisfaction among communities and organizations involved with the program with regard to:
    - program design and delivery
    - amount of funding
    - outcomes/success of their projects

Program Success

- Below we have listed a number of potential short-term outcomes that may have resulted from some of the projects and communities funded under the program. Please comment for each area: 1) to what extent the program has made progress in achieving specific outcomes to date; 2) what is the likelihood of achieving these specific outcomes in the near future (next 2 years); and 3) what aspects of the program assist or detract from achieving these outcomes.
    - increased capacity among First Nations and Inuit communities to address HIV/AIDS issues
    - increased participation and partnership among and within First Nations and Inuit communities in addressing HIV/AIDS issues
    - increased community awareness of HIV/AIDS issues
    - improved utilization of health promotion resources
    - increased accessibility to prevention, care and treatment supports for patients and families
    - increased linkages for HIV/AIDS policy coordination and programming

- What other short-term outcomes have you observed being achieved by the Program?

- From your perspective, how likely is it that the program will achieve some of the more longer-term outcomes?
    - educed incidence of HIV/AIDS among First Nations and Inuit communities
    - enhanced treatment and care for those infected and affected by HIV/AIDS
    - enhanced quality of life for First Nations and Inuit people living with HIV/AIDS

- Which aspects of the Program would be more likely to assist in achieving these longer-term outcomes?

- Which aspects of the Program would be more likely to detract from achieving these longer-term outcomes?

Rationale and Alternatives

- From your perspective, is there a continued need for a FNIHB HIV/AIDS Program as it is currently designed and delivered? Why or why not?

- What would be some more appropriate alternatives to the current Program?

- What are the Program's most obvious strengths? Weaknesses or challenges?

Questions for FNIHB HIV/AIDS Funding Strategy - Community Contacts

- What activities have been carried out with FNIHB funding (description)?
  - how successful were these projects in meeting the needs of the community?
  - Were they part of an overall strategy or plan of action?
  - Was any monitoring done to measure the results of these projects?

- What is your general understanding of the FNIHB HIV/AIDS program?
  - What do are its strengths?
  - What are some of the challenges?
  - How could the program be improved in the future?

- What issues is your community facing with respect to HIV/AIDS and the promotion of healthy lifestyles?

- What are your future needs with respect to the HIV/AIDS Program?