Frontline Measures: Evaluating HIV Prevention at AIDS Service Organizations

by

Nicole R Greenspan

A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Institute of Health Policy, Management and Evaluation
University of Toronto

© Copyright by Nicole R Greenspan 2015
Abstract

A key component in the response to HIV is the delivery of prevention programs by community-based organizations, especially those that reach communities most affected by the epidemic. The effectiveness of these programs remains hard to determine. In Ontario, there have been a number of efforts to support AIDS Service Organizations (ASOs) with research and evaluation. Yet issues regarding evaluation and decision-making continue to pervade HIV prevention work, and this remains an area that is not widely researched. In order to expand understanding of HIV prevention program evaluation, I carried out a qualitative case study of two ASOs in Ontario and their HIV prevention program monitoring and evaluating (M&E) practices. Employing a constructivist approach, I conducted in-depth interviews with 23 ASO managers, staff, volunteers, and government funders, and reviewed approximately 100 documents. A Community Reference Group which included policymakers and people living with HIV provided advice on key stages of the research process.

Despite differences in size of the organizations, there were common M&E practices: discrete one-time evaluations, routine monitoring, and tacit assessments. The ways in which these informed each other was complex. Tacit knowledge was drawn upon to make explicit information derived from M&E required by government funders meaningful. Overall, relationships were an important theme: relationships were an important indicator of programmatic success; and M&E practices were important in maintaining relationships between organizations and their funders. Accountability to government funders required M&E that was
different than what was needed to maintain relationships with the communities these organizations served.

A deeper understanding of M&E practices at ASOs can contribute to responses to the ‘evidence-based practice’ movement. This research describes community-based discernment strategies that shed light on the knowledge-building processes in communities, which is an important part of ‘practice-based’ and ‘community-defined’ evidence. The lessons learned in this research may be a resource for evaluators, policymakers, and other stakeholders in HIV prevention.
Acknowledgments

I would like to thank the case organizations and people that participated in this study. In addition, the members of the Community Reference Group provided invaluable input and guidance into this study.

This thesis is a culmination of a lot of work which I would not have been able to accomplish without the support of many colleagues, friends and family, for which I am grateful. It would have not been possible without the encouragement, direction and patience of my thesis committee. Thanks goes to Rhonda Cockerill, for being there through the many years of this project, and who helped me navigate all the steps, from coursework, proposal, thesis and defense. To Cathy Worthington, who provided great input and advice along the way. And Winston Husbands, from whom I have learnt so much through his mentorship, as well as his ability to persevere; I would not be where I am today without his encouragement to believe in my work and my potential.

I would also like to thank the thesis defense committee members: Jan Barnsley, David Brennan, and the external examiner Jacqueline Gahagan. Thanks also goes to the Ontario HIV Treatment Network (OHTN), the Canadian Institutes of Health Research Social Research Centre in HIV Prevention (SRC), and the Ontario Graduate Scholarship Program (OGS) which provided financial support through doctoral awards.

A special thanks goes to my friends and family that supported me throughout this process. To the smart ladies in my life that have provided huge amounts of emotional support - Pamela, Alicia, Anthea and Ana - I am grateful for your presence in my life, and what we've shared over these years. To my fellow PhDers - Doe, Alex and Suzanne (among others) - thank you for the good times, including the space to think out loud, and to commiserate. Thank you to Pots, who has taught me so much, and fed me such good food. I spent the last months working on this thesis while starting a postdoctoral fellowship at Memorial University of Newfoundland, and the support of colleagues and friends there has been invaluable, thank you.
# Table of Contents

Abstract ................................................................................................................................. ii  
Acknowledgments .................................................................................................................. iv  
Table of Contents ................................................................................................................. v  
List of Tables ........................................................................................................................ vii  
List of Figures ....................................................................................................................... viii  
List of Appendices ............................................................................................................... ix

Chapter 1  Introduction........................................................................................................... 1  
    1.1  Background .................................................................................................................. 3  
    1.2  Study .......................................................................................................................... 18

Chapter 2  Literature Review.............................................................................................. 22  
    2.1  Tacit and explicit knowledge ....................................................................................... 23  
    2.2  Evidence-based debates ............................................................................................... 25  
    2.3  Accountability ............................................................................................................. 32  
    2.4  Health promotion and community development models ......................................... 37  
    2.5  Communities of practice ........................................................................................... 39  
    2.6  Definitions and theories of monitoring and evaluation ............................................ 41  
    2.7  Summary .................................................................................................................... 60

Chapter 3  Methods............................................................................................................... 63  
    3.1  Qualitative research .................................................................................................... 63  
    3.2  Case studies ................................................................................................................ 66  
    3.3  Research orientation and process .............................................................................. 69  
    3.4  Setting ........................................................................................................................ 76  
    3.5  Data collection .......................................................................................................... 79  
    3.6  Analysis ....................................................................................................................... 84  
    3.7  Rigor ........................................................................................................................... 86  
    3.8  Ethical considerations ............................................................................................... 87

Chapter 4  Case Descriptions............................................................................................ 90  
    4.1  Case A ......................................................................................................................... 90  
    4.2  Case B ......................................................................................................................... 91  
    4.3  Cross-case similarities ............................................................................................... 93  
    4.4  Cross-case differences ............................................................................................ 94

Chapter 5  Results: Overview ............................................................................................ 97  
    5.1  How do ASOs evaluate their HIV prevention programs? ........................................... 97  
    5.2  What influences how ASOs evaluate their HIV prevention programs? ................. 102

Chapter 6  Results: Complexity ......................................................................................... 107  
    6.1  Complexity of HIV prevention practice ................................................................... 107  
    6.2  Complexity of evaluation practices ....................................................................... 111  
    6.3  Summary .................................................................................................................. 132
Chapter 7  Results: Plurality.................................................................................................................. 134
  7.1  Multiple evaluation measures ................................................................................................. 134
  7.2  Multiple stakeholders............................................................................................................... 144
  7.3  Tensions .................................................................................................................................. 146
  7.4  Summary ............................................................................................................................... 149

Chapter 8  Results: Relationships.................................................................................................. 150
  8.1  Relationships as an indicator of success ............................................................................... 151
  8.2  Relationships as a reason to evaluate .................................................................................... 157
  8.3  Relationship between tacit and explicit knowledge .............................................................. 168
  8.4  Summary ............................................................................................................................... 171

Chapter 9  Discussion and Conclusion ....................................................................................... 175
  9.1  Major findings ........................................................................................................................ 175
  9.2  Community-based discernment strategies .......................................................................... 182
  9.3  Limitations ............................................................................................................................. 187
  9.4  Implications ........................................................................................................................... 191
  9.5  Conclusion ............................................................................................................................. 196

References ........................................................................................................................................ 198
Appendices ........................................................................................................................................ 213
List of Tables

Table 1. Interview Participants from Case Organizations ............................................................... 81

Table 2. Interview Participants from Government Funding Organizations ..................................... 81

Table 3. Differences Between Case A and B .................................................................................. 96

Table 4. OCHART Sections ........................................................................................................ 119
List of Figures

Figure 1. PRS Tiers of Evidence (CDC, 2013) ................................................................. 11

Figure 2. M. Power’s (2000) General Quality Assurance Model .................................... 47

Figure 3. Cousins and Earl (1992) Dimensions of Collaborative Inquiry ..................... 57

Figure 4. Definition of Evaluation Used in Study ............................................................ 60

Figure 5. Case A Sources of Funding (2010-2012) .......................................................... 91

Figure 6. Case B Sources of Funding (2010-2012) .......................................................... 93
# List of Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A</td>
<td>CRG Terms of Reference</td>
<td>214</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Invitation Letter to Case Organizations</td>
<td>215</td>
</tr>
<tr>
<td>Appendix C</td>
<td>Interview Guide</td>
<td>218</td>
</tr>
<tr>
<td>Appendix D</td>
<td>Information Sheet</td>
<td>219</td>
</tr>
<tr>
<td>Appendix E</td>
<td>Informed Consent Form</td>
<td>220</td>
</tr>
<tr>
<td>Appendix F</td>
<td>Approval Letter from REB</td>
<td>224</td>
</tr>
<tr>
<td>Appendix G</td>
<td>OCHART Form – Sections 9-13</td>
<td>225</td>
</tr>
</tbody>
</table>
Chapter 1
Introduction

Although the past 30 years have included many successes in dealing with the HIV epidemic, it remains unstable among several communities in Ontario (Remis, Swantee, & Liu, 2012), and there is renewed urgency to determine ways in which HIV prevention might be made more effective (Adam, Husbands, Murray, & Maxwell, 2007). Policy makers, academics, and program deliverers have called for research to help develop and maintain effective HIV prevention programs (Coates, Richter, & Caceres, 2008; Remis, et al., 2012).

A key component of Ontario’s response to HIV is the delivery of prevention programs by diverse AIDS service organizations (ASOs) (Cain, 1993; Guenter et al., 2001). Research with ASO staff in Ontario conducted in 2001 found that many participants expressed frustration with not knowing whether their prevention work was successful or not; few participants felt confident that they knew whether or not their HIV prevention strategies were bringing about desired changes in behaviour or HIV infection rates (Guenter, et al., 2001). Issues and concerns regarding evaluation pervade HIV prevention work across jurisdictions (Rugg et al., 2000; Rugg, Carael, Ties Boerma, & Novak, 2004).

Research (primarily from the US) has emerged on assessing the effectiveness of HIV prevention programs using randomized control trials (RCTs) that measure behavioural outcomes related to HIV risk. Advice regarding the methodological quality of these studies has been published in order to produce ‘research-based’ evidence of program success (Flores & Crepaz, 2004). The Centers for Disease Control and Prevention (CDC) has taken a leadership role in the US and has: set standards for evidence-based best practice in HIV prevention interventions; collected interventions that were most successful based on a hierarchy of evidence; published a compendium of HIV prevention interventions showing evidence of effectiveness; and scaled up dissemination and implementation of interventions (Collins & Tomlinson, 2014; Fenton, Wolitski, Lyles, & Aral, 2009).

The challenges associated with the uptake of this research and related programs by ASOs have been explored by researchers, policy makers, and prevention practitioners (Dolcini et al., 2010; Dworkin, Pinto, Hunter, Rapkin, & Remien, 2008; Gandelman, DeSantis, & Rietmeijer, 2006;
Miller & Greene, 2005; Miller & Shinn, 2005; Owczarzak, 2012; Owczarzak & Dickson-Gomez, 2011a, 2011b; Veniegas, Kao, Rosales, & Arellanes, 2009). A body of work has emerged that critiques some of the underlying assumptions of the process of transferring knowledge to ASOs (Auerbach & Smith, 2008; Dworkin, et al., 2008; Miller, 2001; Miller & Shinn, 2005; Norton, Amico, Cornman, Fisher, & Fisher, 2009; SFAF, 2008; Trickett, 2011). The main critiques in this work have centered on how this process assumes that there is a lack of knowledge about effective HIV programming at ASOs, and that criteria of success based solely on behavioural outcomes of program participants do not meet the concerns or needs of HIV prevention program implementers. However, the criteria of success that are important to ASOs remains unclear.

How ASOs evaluate their own programs is already known, to some degree, by practitioners in the HIV system. However, a systematic understanding of current insights is lacking, as is a critical understanding of evaluation practices in community settings.

Community-based HIV prevention programming in Canada is influenced by the US and other international jurisdictions. It is also influenced by number of local factors, such as: Canada’s distinctive organization and delivery of health services that are funded by both federal and provincial levels of government and delivered provincially; and changes to Canada’s public health system. Specific Canadian institutions and actors have developed over time in order to respond to local issues and contexts related to HIV. There have been a number of federal initiatives to coordinate a nationwide approach to HIV/AIDS in Canada, beginning with the 1990 National AIDS Strategy, and continuing with the Federal Initiative to Address HIV/AIDS in Canada, which is a partnership of the Public Health Agency of Canada (PHAC), Health Canada, the Canadian Institutes of Health Research and Correctional Service Canada (Government of Canada, 2004). In addition, a blueprint for the collective, multi-sectoral and coordinated pan-Canadian response to HIV is the strategy described in Leading Together: Canada Takes Action on HIV/AIDS, which was originally planned to guide the response to HIV from 2005-2010 (Health Canada, 2005), and was renewed in 2013 (Leading Together Championing Committee, 2013).

While there are no national leadership or formal prescriptions for ‘research-based’ programming in the Canadian response to HIV, there are a number of institutional actors and other forces promoting the use and production of research in community-based HIV programming (Flicker et al., 2009). Concurrently, there is also more attention paid to evaluation issues related to
community-based programming, including a call for increasing evaluation capacity at community-based organizations (Natalie Kishchuk Research and Evaluation Inc., 2010), and emphasis on the importance of tracking and monitoring government-funded HIV programs (Evaluation Directorate, 2014).

The purpose of this case study is to expand the understanding of evaluation of HIV prevention programs at ASOs. It describes characteristics of two ASOs in an urban area in Ontario, Canada, including the evaluation practices they employ. It explores the factors that influence these evaluation practices, and the social and political context in which they operate. The impact of evaluation practices on the community of practice involved in HIV prevention programs at ASO is examined. In addition, the role that evaluation practices play in maintaining accountability is explored.

The remainder of this chapter covers two topics: background to the issue of evaluation at ASOs in Ontario, and a detailed description of the research study. The background to the issue of evaluation at ASOs in Ontario begins with a description of the role that ASOs have played in the response to HIV, and details about specific support for research and evaluation at ASOs in Ontario. Next, there is a description of how the CDC has approached the transfer of research on effectiveness of HIV prevention programs to practitioners, and the challenges and critiques of this approach. How this research study contributes to those critiques is described. The second half of this chapter describes the rationale, purpose, research questions and significance of this study in detail.

1.1 Background

1.1.1 ASOs as a response to the HIV epidemic

While ASOs have been part of the response since the beginning of the HIV epidemic, the response to HIV and AIDS has always involved tensions related to who are seen as ‘experts’ (Altman, 1994). Literature about the tensions and issues faced by ASOs internationally and over time has explored the role that these organizations fulfill in relation to the state, the communities they serve, and other community-based organizations (Altman, 1994). The history of ASOs as a community-based response to the early HIV epidemic in the US has been described in various literature by journalists (Shilts, 1988) and social scientists (Miller & Greene, 2005). The
tensions between biomedical scientists, government officials, and affected communities, especially in terms of who were seen as the ‘experts’ have been documented; these tensions have had significant impact on the responses to HIV (Altman, 1994; Miller & Greene, 2005). For example, affected individuals and communities organized, questioned, challenged and re-defined initial government responses to the epidemic (Altman, 1994).

In Canada, various national HIV policy documents articulate the important role community-based organizations play in the response to HIV (Government of Canada, 2004; Health Canada, 2005; PHAC, 2005), and research has explored the relationship between community-based ASOs, other social service institutions and the state (Cain, 1995, 1997). Echoing themes from Altman (1994), case studies of ASOs in Ontario by Cain (1993, 1995) showed that over time, ASOs in Ontario have become more formalized and bureaucratic, and the political nature of their work changed, along with the strategies they employ. Cain (1993, 1995) explored how receipt of government funding and an ongoing relationship with the state were linked to changes in ASOs’ orientation and work.

While ASOs are diverse, they share a history of emerging as a response to HIV with the intention of reflecting the concerns of communities affected by HIV (Altman, 1994). What is meant by ‘community’ can be contested and there is a wide range of social science literature that captures some of these debates (Duguid, 2005; MacQueen et al., 2001). In the response to HIV, the communities involved are often people from socially-marginalized groups that are perceived to have been neglected or served poorly by traditional health care and social service providers (Cain, 1993). Although the relationship between people from these communities and ASOs are complex, these organizations play a significant role in providing HIV prevention and support programs, delivering HIV specific strategies, and providing HIV-related education or leadership in relation to other sectors and agencies. HIV is central to ASOs’ organizational missions, and ASOs are intended to provide community-based responses to HIV, not only as a disease, but also its physical, emotional, social and political dimensions (Miller, 2001). This often necessitates a dual mandate of providing services as well as promoting social change (Cain, 1993; Miller, 2001). In addition, people who work for ASOs often represent a collective social identity (i.e., gay men, people who use drugs, etc.) or form one in response to being similarly affected by HIV (Altman, 1994). Many people who work and volunteer at ASOs are from the communities that are highly impacted by HIV to which these organizations seek to provide services and support.
It has been noted by several authors that ASOs and other community-based responses face a variety of pressures related to the scope their HIV work should entail (Cain, 1995; Miller & Greene, 2005). ASOs provide social support for people living with HIV (PHAs) and education and outreach for those who are not infected (Altman, 1994). Striking a balance between these has been cited as a tension faced by ASOs (Miller & Greene, 2005). The kinds of expertise that are required to carry out these functions may differ, and resources at ASOs are often limited. Regardless of these tensions, HIV prevention in and of itself is a complex undertaking (Auerbach, Parkhurst, & Cáceres, 2011; Piot, Bartos, Larson, Zewdie, & Mane, 2008; Wright, 2003). Early prevention efforts that involved providing basic information about HIV transmission, while important, have not been sufficient in bringing about consistent reductions in HIV transmission (Adam, et al., 2007; Piot, et al., 2008). Research points to a wide range of vulnerabilities and reasoning processes that influence HIV risk taking, and these lead to a need for multiple interventions aimed at a variety of audiences (Adam, et al., 2007; Merson, O'Malley, Serwadda, & Apisuk, 2008) and attention to social and structural drivers of the epidemic (Auerbach, et al., 2011). Non-biomedical socio-behavioural interventions are particularly important to the current HIV epidemic as transmission rates continue to be high and unstable among specific groups. Currently, there are only a few biomedical interventions that are effective in preventing HIV, and these are limited to very specific circumstances (i.e. anti-retroviral therapy to prevent the transmission of HIV from a mother to their child). The success of introducing new biomedical interventions that may emerge relies on complementary behavioural and education prevention services and campaigns (Coates, et al., 2008; Holtgrave & Curran, 2006). Common HIV prevention interventions carried out by ASOs include condom distribution, social marketing and other interventions aimed at reducing HIV risk behaviours. Some of these are community-level interventions aimed at people from communities at higher risk of HIV (i.e., social marketing media campaigns aimed at men who have sex with men). Other HIV prevention interventions are delivered at the group or individual level; these include programs that host activities such as workshops, group sessions, individual counseling and outreach. Currently, programs do not share consistent or common labels, definitions, standards, characteristics, categories, classifications, or codes (Akers & Hervey, 2003). This can cause issues for monitoring and evaluation. For example, programs are not consistent across governmental funders or ASOs in terms of duration (e.g., was it a 5-minute encounter, or a 1-hour session, etc.?); method of delivery (e.g., was it a one-on one or group session, or a
pamphlet?); venue or setting (e.g., was it carried out on the street, in a bar, or at the ASO?); provider/deliverer (e.g., was it a social worker, case manager, or volunteer?); target population (e.g., men who have sex with men, people who use drugs, or youth?), or cost (Akers & Hervey, 2003). While it is recommended to use a variety of different interventions of mixed durations, methods, venues, etc. in order to best reach target populations, the lack of consistent definitions or classifications can make it difficult to use standardized monitoring and evaluation techniques.

Qualitative research on HIV prevention work in ASOs in Ontario describes the challenging and complex nature of HIV prevention work, the commitment of the workers carrying it out, and the difficulties in determining effectiveness (Guenter, et al., 2001). Prevention work has been characterized as complex and multi-layered, and includes interventions at individual and societal levels (Guenter, et al., 2001). ASO prevention workers in Ontario come from diverse backgrounds and reported bringing “their skills, past experience, passions, politics, and perseverance to the work” (Guenter, et al., 2001, p. 45). In this research, while they perceived the work as contributing to social change, ASO workers questioned whether their programs had any effect on target groups and used a variety of means to gauge success (Guenter, et al., 2001). Tools cited by participants to measure their success were: program evaluation, focus groups and interviews, and client feedback (Guenter, et al., 2001). The list of indicators that participants provided included outcomes (i.e., decreasing infection rates); process measures (i.e., ability to engage participants, program accessibility, and meeting objectives); and responses from community and other agencies/institutions (i.e., people call, people are aware of program, other organizations seek input, requests to do presentations, calls from the ‘corporate world’) (Guenter, et al., 2001). Guenter et al.’s (2001) discussion highlighted that there are other available measures, such as measures about societal attitudes and stigma, that did not appear to be generally adopted by ASOs. The authors posed a number of discussion questions to be explored in order to enhance HIV prevention work. These included, “What measures of program effectiveness would be most useful to Ontario ASOs? How can currently existing measurement tools be acceptably adapted to suit Ontario’s prevention programs? What new measures of effectiveness could be developed to provide ASOs with the information they need to know whether their strategies are working?” (Guenter, et al., 2001, p. 45).
1.1.2 Support for research and evaluation at ASOs in Ontario

In Ontario, there have been a number of efforts designed to support community-based organizations with research and evaluation related to HIV programming. The largest funder in the province, the Ontario Ministry of Health and Long-Term Care’s AIDS Bureau (AIDS Bureau) funded the Community-Linked Evaluation AIDS Resource (CLEAR) Unit at McMaster University from 1999-2007 to carry out research and evaluation with community-based organizations receiving AIDS Bureau funding throughout the province, and to transfer capacity to conduct research to ASOs (see fhs.mcmaster.ca/slru/clear/home.htm). Since 2008, the Ontario HIV Treatment Network (OHTN) has offered a Rapid Response Service to community-based HIV organizations in Ontario, to increase their access to research evidence and support evidence-informed programs, service delivery and advocacy. This service offers brief syntheses of key findings in the literature about requested topics (see www.ohtn.on.ca/Pages/Knowledge-Exchange/Rapid-Responses/Rapid-Response-Service.aspx). In addition, the OHTN Evidence-Based Practice Unit (EBPU) provides advice and assistance with evaluation, develops guidelines for services at ASOs, and helps develop “a culture of accountability and continuous quality improvement” (OHTN, 2013, p. 2). The EBPU brings together two monitoring and evaluation initiatives funded by the AIDS Bureau: the Ontario Community-based Agency Services Evaluation (OCASE) and the Ontario Community-based HIV and AIDS Reporting Tool (OCHART). OCHART is a collaborative project of the Ontario Regional Office of PHAC and the AIDS Bureau; it is a system that these two funders use to monitor the work carried out at organizations they fund. It includes a website (www ochart.ca) where funded organizations complete and submit monitoring reports. The data that these organizations submit is analyzed and summarized in a yearly report called View from the Frontlines. In addition, an annual Knowledge Translation & Exchange (KTE) Day is hosted by these funders to review and discuss the report. These two funders maintain the OCHART system with support from the OHTN EBPU which develops the web-based OCHART tool, provides ongoing training and support, houses and extract the data, and completes analyses for the annual report.

This dense network of institutional actors influences HIV programming and evaluation practice at ASOs in Ontario. The promotion of programmatic decision-making based on research and monitoring and evaluation is influenced by a movement towards ‘evidence-based’ and/or ‘evidence-informed practice’ seen in health and social service fields (Armstrong, Waters,
Crockett, & Keleher, 2007; Brownson, Fielding, & Maylahn, 2009; Fink, 2013; Muir Gray, 1998; Nutley, Walter, & Davies, 2003; A. Roberts & Yeager, 2006; Steinberg & Luce, 2005) in the US and internationally, which has been particularly emphasized in aspects of the response to HIV in the US (Korda, 2013).

1.1.3 Effectiveness of HIV prevention and the technology transfer approach

While the response to HIV has involved locally-developed initiatives, there has also been a growing body of research regarding HIV prevention interventions worldwide (Merson, et al., 2008; Pequegnat & Stover, 2009). Research has emerged, primarily from the US, assessing the effectiveness of HIV prevention programs using behaviour change models measured by positivist social science methodologies. Meta-analysis of this research indicates that some HIV programs are able to decrease HIV risk behaviours for some populations (Lyles et al., 2007; Noar, 2008). In the most efficacious behavioral interventions, risk reductions in the order of 20%-30% are observed (Auerbach & Smith, 2008).

Pequegnat and Stover (2009) attempted to summarize the progress in HIV prevention research by focusing on the ‘payoffs’ of research about behaviour that have been funded by the US National Institute of Health (NIH). In their 2009 summary, they described five periods:

- Period I (1983-1985): Identification of risk factors - knowledge, attitudes and behaviours (KAB);
- Period II (1986-1991): Test of concept of HIV interventions;
- Period IV (1998-2004): Technology transfer and cost-effectiveness of programs; and

Pequegnat and Stover (2009) asserted that “while many AIDS researchers might disagree with the division of AIDS research into five periods, there would be agreement that there has been unprecedented progress in AIDS prevention research during these past 25 years” (p. 171). Since the focus of Pequegnat and Stover’s (2009) summary is NIH-funded projects, their summary may be best understood as a description of the trends in funding HIV prevention research by a major funder in the US up to 2009.
On the topic of ‘payoffs’ from technology transfer in Period IV, Pequegnat and Stover (2009) identified two: “investigators recognized that guidelines (toolkits) for technology transfer/information dissemination must be developed if NGOs can adapt them for local conditions”; and “investigators realized that the seeds of technology transfer must be built into the original design of the study” (Pequegnat & Stover, 2009, p. 192). How HIV prevention research has proceeded in light of these realizations is not addressed in their summary, but the theme of technology transfer in HIV prevention work continues to be found in the literature beyond Period IV (for examples of articles about technology transfer of HIV prevention programs published after 2004, see Collins et al., 2012; Collins, Johnson, & Lyles, 2007; Collins & Tomlinson, 2014; Dolcini, et al., 2010; Dworkin, et al., 2008; Fenton, et al., 2009; Glasgow, Eckstein, & Elzarrad, 2013; Kegeles et al., 2012; Miller & Greene, 2005; Norton, et al., 2009; Owczarzak, 2012; Owczarzak & Dickson-Gomez, 2011a, 2011b; Veniegas, et al., 2009).

In the US, the CDC has taken a leadership role in setting standards for evidence-based best practice in HIV prevention interventions and dissemination (Collins, et al., 2012; Collins, et al., 2007; Collins & Tomlinson, 2014; Fenton, et al., 2009; Lyles, Crepaz, Herbst, & Kay, 2006). Fenton (2009) provided a detailed description of this CDC approach to improving the effectiveness of HIV prevention programs, including the underpinning conceptual framework guiding this process. The CDC approach is supposed to address issues with the lack of uptake of evidence-based HIV prevention programs among program providers (Collins & Tomlinson, 2014; Fenton, et al., 2009). In the US, community planning groups (CPGs) make resource allocation decisions to address HIV in their regions (Fenton, et al., 2009). CPGs were responsive to the early HIV epidemic and relied on ‘home grown’ interventions that had not been evaluated but were based on theories of behaviour change, formative research findings, or the developer’s experience with the target population (Fenton, et al., 2009). While the number of evaluated interventions grew as the epidemic progressed, this did not seem to impact practice in the field (Fenton, et al., 2009). Research showed that the methods of dissemination used (such as reports at scientific presentations and articles in scholarly journals) were unlikely to reach CPGs and implementers of HIV prevention programs (i.e., ASOs) (Goldstein, Wrubel, Faigeles, & DeCarlo, 1998). The CDC took steps to address this problem, based on a framework that describes “movement of interventions from research to practice” (Fenton, et al., 2009, p. 597). This framework involves four processes:
1. Research steps, including intervention trial development to dissemination of results in the form of published reports

2. Research synthesis

3. Program practice steps that involve identifying and translating interventions, and supporting their implementation

4. Monitoring and evaluation

Step 1 was identified as “typically undertaken by university faculty in response to a need for the development of an intervention to meet unmet needs identified through formal or informal needs assessments” (Fenton, et al., 2009, p. 598). Step 2 required “critical examination of results in order to identify and characterize those interventions with the strongest evidence of efficacy” (Fenton, et al., 2009, p. 599). This was undertaken by the CDC’s Prevention Synthesis Research (PRS) Project, which used a hierarchy of evidence model to determine evidence of efficacy (CDC, 2013; Lyles, et al., 2006) (see Figure 1). Only RCTs, which showed statistically significant evidence of self-reported change on specified behavioural outcomes in the intervention group (and no negative outcomes) from evaluation studies that have at least two publications in peer-reviewed journals, were considered to have met the Tier I Best-Evidence criteria (CDC, 2013; Lyles, et al., 2006). Tier II Promising-Evidence programs had to meet the same criteria, but the sample size requirements, retention rates and follow-up period criteria are less strict than Tier I (CDC, 2013; Lyles, et al., 2006). Tiers III and IV included theory-based interventions – interventions which were based on behavioral science theories, but lacked the empirical evidence to satisfy CDC criteria for evidence-based interventions (CDC, 2013; Lyles, et al., 2006). Interventions in these categories may have had some data that described them and their impacts, such as process or outcome monitoring data, but these kinds of data do not satisfy the CDC’s criteria about adequate methods to measure effectiveness (CDC, 2013; Lyles, et al., 2006). ‘Unevaluated interventions’ comprised the lowest category in the Tiers of Evidence framework; this category included all other interventions that have not been evaluated using methods that the CDC recognizes (CDC, 2013; Lyles, et al., 2006).

Only programs from Tier I and II have been part of the CDC’s Replicating Effective Programs (REP) Project, where materials needed to support the implementation of these interventions by
program adopters are developed (Collins & Tomlinson, 2014; Fenton, et al., 2009). REP is part of Step 3 of the CDC’s approach; it involved CDC staff and the original researchers and associated groups working together to package interventions (Collins & Tomlinson, 2014; Fenton, et al., 2009). Step 3 is also carried out by the CDC’s Diffusion of Effective Behavioral Interventions (DEBI) Project (Collins & Tomlinson, 2014; Fenton, et al., 2009). The DEBI Project involves the marketing of interventions and provides technical assistance to adopters of interventions (Collins & Tomlinson, 2014; Fenton, et al., 2009; Kegeles, et al., 2012).

![Figure 1. PRS Tiers of Evidence (CDC, 2013)](image)

1.1.4 Challenges associated with technology transfer approach

A number of challenges were identified with the technology transfer approach adopted by the CDC. For example, during the REP project, technical and organizational issues (such as the mismatch between funder and agency cycles, and the loss of organizational memory from staff turnover) were identified as a challenge to the CDC approach (Neumann, Sogolow, & Holtgrave, 2000). Agency capacity to implement DEBIs emerged as a critical issue (Gandelman, et al., 2006). Training and providing other capacity-building supports were developed and incorporated into the CDC’s approach in order to address these issues (Collins & Tomlinson, 2014; Fenton, et al., 2009; Kegeles, et al., 2012).

Other concerns identified with the CDC approach have included the apparent lack of consideration of economic issues in determining evidence-based recommendations (Fenton, et
Holtgrave (2004) identified five barriers to adopting research-based HIV prevention interventions, including:

1. lack of financial, human, and temporal resources to deliver what tend to be relatively intensive HIV prevention interventions;
2. lack of resources to pay the enrolment incentives that characterize HIV prevention intervention trials;
3. high levels of staff turnover;
4. lack of sufficient training opportunities; and
5. lack of science-based interventions specifically focused on a particular community being served (thereby requiring adaptation of the intervention for the community at hand) (Holtgrave, 2004, p. 19).

While these challenges represent broad areas, Holtgrave’s (2004) solution was to propose a framework where quantitative policy analysis (i.e., different forms of economic evaluation research) would be used in addition to intervention effectiveness studies.

Another challenge that has emerged is related to the adaptation processes that community-based organizations have had to undertake when implementing a DEBI (McKleroy et al., 2006), and how fidelity to core elements of programs is maintained (or not) (Korda, 2013; Owczarzak & Dickson-Gomez, 2011a). These issues are of particular concern to the emerging field of implementation science; research has shown that level of implementation by service providers affects the outcomes obtained by health promotion and prevention interventions (Durlak & DuPre, 2008).

Dolcini et al. (2010) studied six organizations in California that were funded to carry out DEBIs and identified that there was considerable variation in the extent to which these organizations were able to carry these interventions out with ease. In addition, they noted a great deal of variation in the extent to which these organizations carried out assessment and preparations for the implementation of these interventions (Dolcini, et al., 2010). They suggested that funding and training for organizations that are considering undertaking a DEBI should be expanded to
include a two phase process (Dolcini, et al., 2010). The first phase would provide support for the organization to conduct a needs assessment and select a program that was appropriate for their target population, organizational capacity, etc., and the second phase would provide support for the organization to adapt and implement the program (Dolcini, et al., 2010). This solution draws on theories from the field of implementation science, which also includes developing measures of progress or implementation processes, and other continuous quality improvement activities (Glasgow, et al., 2013).

However, the identification of these issues and the solutions proposed do not challenge the underlying assumptions or framework upon which the CDC approach is based. Dolcini et al. (2010) cited Roger’s (2003) work on diffusions of innovations, in particular, how receptiveness to innovation in facilitated when programs originate within an organization, and when decisions regarding uptake are not mandated. However, as Dolcini et al. (2010) described,

The DEBI process by its very nature prohibits this [process of originating programs] from taking place… [and] the adoption of an intervention is frequently in response to a mandate, or what Rogers (2003) calls an authority innovative decision, that may be met with resistance by staff and management. (p. 1844)

Unfortunately, this does not address a major issue identified in research about the implementation of the DEBI system, where the “top down” approach is criticized by the service delivers who favor an exchange of knowledge (Auerbach & Smith, 2008; Kegeles, et al., 2012; Owczarzak, 2012; Owczarzak & Dickson-Gomez, 2011a, 2011b; SFAF, 2008).

### 1.1.5 Critiques of underlying assumptions of CDC approach and calls for research

A different approach to looking at the gap between science and practice in HIV prevention was initiated by Miller (2001) in a study that sought to understand the perceived need for and attitudes towards externally-developed HIV prevention programs by organizations that provide HIV services across Illinois. Miller (2001) positioned these organizations as a ‘natural audience’ for the dissemination of research-based HIV prevention programs as well as a unique resource from which prevention scientists could learn about the intricacies of implementing prevention interventions in communities. Miller (2001) viewed organizations as resources that possessed
knowledge and expertise about prevention, whereas the technology transfer approach does not. Miller (2001) found that organizations were more likely to adopt programs (or program components or ideas) developed by the CDC if they fit with existing organizational missions and resources, addressed local populations, and filled gaps in, rather than duplicated, existing services. Organizations paid attention to evidence, but process evidence about the acceptability of programs and their use by peer agencies was weighted more heavily than information about outcomes (Miller, 2001). This is important to note because the dominant CDC approach does not include any weighting of other measures outside of outcome measures when determining best evidence in HIV prevention practice.

Miller (2001) also investigated the relationship between adoption of externally-developed programs and organizational characteristics. Organizational characteristics such as the level of resources devoted to HIV prevention, centrality of HIV to the organizational mission, and organizational age and size distinguished whether an organization fit one of three identified profiles (Miller, 2001). These three distinct profiles included organizations that had adopted entire externally-developed programs, those that had adopted components of programs, and those with little experience adopting externally-developed programs (Miller, 2001). Overall, Miller’s (2001) study shows the adoption of externally-developed programs is not a straightforward phenomenon, and that a diverse array of organizational characteristics are important to consider when seeking a deeper understanding of implementation of research-based HIV prevention interventions.

The critique of dominant approaches to technology transfer and HIV prevention was further developed by Miller and Shinn (2005). Their critique highlighted the similarities between the DEBI system and the Institute of Medicine’s model for prevention science (Miller & Shinn, 2005). In this model, the fourth and fifth steps of the prevention-intervention research cycle involve large-scale trials of interventions that demonstrate their efficacy under controlled conditions and more widespread implementation in the community. Miller and Shinn (2005) identified four problems with this model:

First, the model fails to consider the capacity of organizations and communities to implement evidence-based prevention programs. Second, it ignores how the degree of congruence among community, organizational, and program values can facilitate or undermine program
success. Third, it displays a pro-innovation bias that ignores the value of indigenous practices. Finally, it assumes a simplistic model of how community organizations make decisions to adopt innovations. (p. 169)

Miller and Shinn (2005) suggested that the weakness in the approach taken by the CDC comes from the assumption that there is no knowledge within the communities or organizations that have been involved in HIV prevention practice. Two suggestions are provided: researchers should locate, study, and help disseminate successful indigenous programs that fit community capacity and values; and researchers should build on theoretical models of how locally developed programs work to make existing programs and policies more effective (Miller & Shinn, 2005). They suggested that the relevance of HIV prevention programming to real environments (as opposed to experimental settings) is a crucial element; thus it is not surprising that the process of establishing only the efficacy of prevention programs and then disseminating them to communities has had limited success. They urged that researchers give programs developed in communities equal footing and attention as those that are developed by researchers themselves (Miller & Shinn, 2005). As they stated, “In addition to the possibility that communities can learn from programs developed by researchers, we suggest that researchers may improve the quality of community life by learning from communities.” (Miller & Shinn, 2005, p. 181).

Dworkin et al. (2008) provided another critique of the process of rolling out DEBIs and identified the following issues: communities negatively perceived the top-down mode of dissemination of DEBIs; the extent to which local innovations are embraced, bolstered, or eliminated is not clear in the DEBI system; and that there are contextual and methodological considerations that shape community preparedness to adopt externally-developed programs. Dworkin et al. (2008) promoted the idea of community preparedness as important to technology transfer of HIV preventions. As Dworkin et al. (2008) stated,

There may be more than one kind of evidence that matters in the process of dissemination. Even if local agencies have not had the resources to conduct a massive, controlled intervention trial does not mean that they have not learned valid and accurate lessons about what works and what does not. Over-reliance on the RCT as the primary standard of evidence can disregard local lessons and represents a missed opportunity. At worst, there is
the potential to erode prevention that has worked in underserved settings but has not been well measured. (p. 54)

In order for dissemination processes to occur, Dworkin et al. (2008) highlighted the need for all stakeholders to understand and inform each other’s implicit theories, preferences and perspectives regarding intervention adaptation and implementation. Dworkin et al. (2008) asserted that the best chance to promote technology transfer will come from a ‘next generation’ of HIV interventions that incorporate new research paradigms with different criteria for evidence which are needed to adequately learn from the iterative processes between researchers and communities.

Many of these themes were echoed in a series of panel discussions convened by the San Francisco AIDS Foundation (SFAF) at various US and international HIV conferences about the nature of evidence in evidence-based HIV prevention in 2007 and 2008 (Auerbach & Smith, 2008; SFAF, 2008). The tensions between multiple “ways of knowing” that were salient to academics, service providers, and communities were evident in these discussions, and there was a strong critique of the dominance of RCTs in HIV prevention research and the CDC’s Tiers of Evidence (SFAF, 2008). There was a call for prevention research to address a greater degree of complexity, including moving beyond research-based evidence of the efficacy of individual interventions toward a range of good practices, applicable in diverse circumstances, that takes into consideration multiple ways of knowing (SFAF, 2008). Representatives from community-based organizations reported the tensions they faced in demands of program evaluation, while they continued to carry out their mandate to respond to the clients they serve, many of which need immediate services (SFAF, 2008). They also reported a sense of paternalism from academic and other government-affiliated researchers, and recognition of community knowledge and experience was a suggested paradigm shift (SFAF, 2008). These discussions highlighted the need for evidence derived by research to be translated into terms that are valid and credible with a number of audiences, including funders, politicians, as well as organization and individuals who will implement and use programs (SFAF, 2008).

Research by Owczarzak and Dickson-Gomez (2011b) and Owczarzak (2012) showed that the experience of service providers working at eight community organizations in Wisconsin echoed the concerns discussed by Miller (2001), Miller and Shinn (2005), Dworkin et al. (2008), and the
SFAF (2008). These service providers, who had received training in DEBIs, were critical of the top down approach of the DEBI system, and perceived that their experience or expertise, as well as the current programs carried out at their agencies, were devalued (Owczarzak, 2012; Owczarzak & Dickson-Gomez, 2011b). Owczarzak (2012) discussed how the capacity-building model used in the CDC’s approach operates as a ‘deficit model’ of service providers and community organizations, and how this marginalizes alternate explanations of why organizations may or may not adopt an intervention and implement it with fidelity. In this research, interview participants discussed the tensions between knowledge that was considered credible by the CDC’s standards, and their experiential knowledge, which they felt was not reflected in the DEBI program. Owczarzak (2012) described service providers’ interpretations of effectiveness, which were broader than the CDC’s criteria, and were related to the context in which these service providers operated. Owczarzak (2012) concluded that,

An expanded dissemination model would require both researchers and practitioners to acknowledge the limits of their particular approaches and recognize the strengths and benefits of the other contributors. Such an approach to intervention dissemination offers a way to acknowledge and incorporate what CBOs see as valuable evidence of effectiveness, such as participant satisfaction, community response, and individual level changes. It presents the opportunity to shift away from ‘deficit’ models of CBOs and other service providers, and draw on the strengths, knowledge base, and skills of these agencies. (p. 82)

Norton et al. (2009) set out a research agenda to clarify pressing needs for systematic inquiry to address challenges in implementing evidence-based HIV prevention in real-world settings. They called for research to better understand : (1) the organizational context in which interventions are implemented; (2) the intervention characteristics in facilitating or impeding the implementation process and; (3) theory-based multi-level implementation models (Norton, et al., 2009). Further echoing these themes, Trickett (2011) called for research into community culture, including the culture of community organizations in order to understand them better before mounting interventions.

1.1.6 Contribution of research

This research contributes to the critical analysis and literature by Miller (2001), Miller and Shinn (2005), Dworkin et al. (2008), SFAF (2008), Owczarzak (2012), Norton et al. (2009), and
Trickett (2011). Miller (2001) implied that evaluation measures that are salient to community-based organizations that carry out HIV prevention programs differ from the outcomes focus of the CDC approach. Miller and Shinn (2005) and SFAF (2008) have put out a call for research that gives equal footing to programs developed in communities. A deeper understanding of evaluation measures that are important to organizations that implement HIV prevention programs contributes to the goal of paying equal attention to the programs developed in communities as those that are research-based (Miller & Shinn, 2005). SFAF (2008) and Owczarzak (2012) recommended that in order to build validity and credibility with organizations carrying out programs, a better understanding of the terms that research evidence could be translated into is required. This research study helps clarify the criteria that are required in order to accomplish Dworkin et al.’s (2008) goal of improving technology transfer with a ‘next generation’ of HIV interventions based on new research paradigms and different criteria for evidence that adequately reflect the iterative processes between researchers and communities. SFAF (2008) recommended that research investigators possess sufficient ‘community literacy’ to be able to understand communities and maintain an ongoing dialogue, and this study contributes to that understanding. Norton et al.’s (2009) and Trickett (2011) called for research into the context in which programs are delivered and the characteristics of these programs. This research study directly addresses these issues.

1.2 Study

1.2.1 Rationale

While it is acknowledged that evaluation of HIV prevention program is an issue, evaluation criteria that ASOs value and employ has not been explored to a great extent. There is very little research about the social and political context in which ASOs operate and how this influences the delivery and evaluation of HIV prevention programs. Norton et al. (2009) argued that advancing evidence-based HIV prevention interventions requires research into the context in which programs are delivered. This case study helps fill the identified knowledge gap by identifying evaluation criteria and practices of two ASOs, and by exploring what influences these, taking the social and political context in which these organizations operate into account.

This study provides an in-depth look at fairly complex phenomena (evaluation of HIV prevention programs by ASOs) in which context plays an important role. Case studies are a
useful strategy for this type of research in that they concentrate on experiential knowledge of the cases selected (Stake, 2005) and they seek to explore complex phenomena in real-life contexts, especially when the boundaries between phenomenon and context are not clear (Stake, 1995; Yin, 2009). More details about the rationale of the methods employed in this study are included in Chapter 3.

1.2.2 Purpose

The purpose of this case study is to expand the understanding of HIV prevention program evaluation at ASOs. Specifically, this study aims to identify evaluation practices related to HIV prevention programs employed by ASOs, and explore what influences these practices. The aim is to contribute to a deeper understanding of evaluation at community-based organizations, which is an area that is not widely researched.

Evaluation can be defined in a number of different ways; while some definitions focus on the narrow purpose of assessing merit, worth, and/or value of programs, others are more expansive. Mark et al. (1999, 2000) described evaluation as ‘assisted sense-making’ and outlined four purposes of evaluation: to assess merit or worth; for oversight and compliance; for program improvement; and knowledge development. This case study employed an expansive definition, and included evaluation for all of these purposes and any others that emerged; participants defined what evaluation was and what purpose(s) evaluation served for them. For a detailed discussion of evaluation definitions and theories, see Chapter 2.

Monitoring is recognized as an important component of evaluation in this study. Monitoring is defined as “a continuous function that uses systematic collection of data on specified indicators, to provide management and the main stakeholders of an ongoing development intervention with indicators of the extent of progress and achievement of objectives and progress in the use of allocated funds” (Görgens-Albino & Kusek, 2009, p. 2). Posovac and Carey (2007) describe monitoring as a means to evaluation and Hatry, Wholey, and Newcomer (2004) argue that monitoring was an important subset of evaluation. There has been debate about the appropriate balance between monitoring and evaluation activities in international HIV work (Rugg, Peersman, & Carael, 2004). For a more detailed discussion about monitoring and evaluation, see Chapter 2.
1.2.3 Research questions

This study is organized around the following research questions:

- How do ASOs evaluate their HIV prevention programs? What evaluation practices are carried out? What qualities or attributes of HIV prevention programs are used to make judgments about these programs?
- What influences evaluation practice and the judgments of important characteristics and/or the value of HIV prevention programs by ASOs?

The process of developing these questions is detailed in Chapter 3.

1.2.4 Significance

A deeper understanding of evaluation measures that are important to ASOs addresses issues that have been identified in the literature. For example, it contributes to the goal of giving due consideration to the programs developed in communities, in addition to those that are research-based (Miller & Shinn, 2005). Miller and Shinn (2005) urged that community-based programs receive this equal footing and attention with the hope that researchers may improve the quality of community life by learning from communities. SFAF (2008) and Owczarzak (2012) recommended that in order to build validity and credibility with organizations carrying out programs, a better understanding what aspects of programs are valued by these organizations is required. Dworkin et al. (2008) envisioned that improving technology transfer would require a ‘next generation’ of HIV interventions based on new research paradigms and different criteria for evidence that adequately reflect the iterative processes between researchers and communities, and this research study helps clarify the criteria that are required in order for this to be accomplished. SFAF (2008) recommended that researchers possess sufficient ‘community literacy’ to be able to understand communities and maintain an ongoing dialogue, and this study contributes to that understanding. Norton et al.’s (2009) and Trickett (2011) called for research into the context in which programs are delivered and the characteristics of these programs; this research addressed these issues directly.

There are a number of other characteristics of this study that contribute to its significance. Rather than applying externally-derived criteria for success of HIV prevention programs, it identifies HIV prevention evaluation criteria and practices from the perspective of community-
based organizations that deliver these programs. This allows for many issues that have been minimized in much of the HIV prevention evaluation literature, such as the complexity of community-based work, and how the local, social and political context in which HIV prevention work is conducted influences evaluation practice come to light. It is a qualitative study, which has been lacking in the literature, and this allows for an exploration of diverse peoples’ understanding of the issues involved. It also allows for development of a critical understanding of evaluation practices in community settings, which might contribute to insight about the current state and consequences of evaluation practice in the public sector.
Chapter 2
Literature Review

The purpose of this study is to expand the understanding of HIV prevention program evaluations by identifying evaluation practices related to these programs and exploring what influences these practices. This chapter introduces the literature and theoretical frameworks outside of HIV that relate to this study. These complement the literature and frameworks about HIV introduced in the first chapter. The concepts introduced in this chapter frame the issues that come up in the delivery of HIV prevention program and their evaluation at community-based organizations. They help structure the results that emerged from this study, and are referred to in the discussion and conclusions of this study.

In this chapter, concepts from broad frameworks and debates in the literature that provide context for the issues introduced in the first chapter are presented first. These include concepts related to debates about forms of knowledge, specifically, tacit and explicit knowledge and debates about evidence-based practice. These debates are important to understand because they explain some of the arguments that underpin the CDC technology transfer approach and its critiques. By understanding these debates, the circumstances that HIV practitioners and evaluators currently face can be put in context of larger discourses. This allows for the evaluation practices described by the organizations in this study (the first research question) to be understood in light of these larger discourses. Evaluation practice can be understood as contributing to building knowledge, and linking current debates about knowledge allows for a deeper examination and understanding of evaluation practices observed in this study.

Following the debates about forms of knowledge, the role of accountability in evaluation practice is reviewed as this is a predominant motivator behind evaluation activities and therefore important to understand when exploring what influences evaluation practice (the second research question of this study). Health promotion and community development models are also reviewed because of the important role they play in underpinning HIV prevention work in community settings; these are also important to understand when exploring what influences evaluation practice. Following this, the concept of ‘communities of practice’ is reviewed as this is a framework that emerged as important in conceptualizing this study. Finally, specific definitions of evaluation terms used in this study are detailed.
2.1 Tacit and explicit knowledge

When looking at evaluation that occurs in practice, it is important to understand the kinds of knowledge that practitioners use and develop. One of the ways of doing this is through understanding tacit and explicit knowledge. Tacit and explicit knowledge remain a disputed area (Kothari et al., 2012). Duguid (2005) explained that different accounts of knowledge can be favored by different disciplines. The term ‘tacit knowledge’ was first described by Polanyi (1966), who stated, “we can know more than we can tell”. Polanyi’s work described tacit knowledge as difficult to communicate, acquired through practice and experience, and related to individual skills while embedded in context (Kothari, et al., 2012). In addition, Polanyi saw it as inseparable from explicit knowledge (Kothari, et al., 2012). Different disciplines have different conceptualizations of tacit knowledge, so different terms may be used to describe it, such as skill, intuition, unarticulated knowledge, and experiential knowledge (Kothari, et al., 2012).

Descriptions of tacit knowledge, or ‘know how’, are sometimes presented in contrast to explicit, codified knowledge, or ‘knowing that’ (Duguid, 2005; Kothari, et al., 2012). It is the relationship between these two concepts that is often disputed: Are they opposite and entirely different? Do they lie on a continuum (Duguid, 2005; Kothari, et al., 2012)? Duguid (2005) explored how economists favor a view of tacit knowledge that reduces it to information held by individuals that is merely uncodified. In this view, tacit knowledge might be thought of as ‘not-yet’ explicit knowledge. Duguid (2005) explained how community of practice theory would have a different view of tacit knowledge, including the proposition that knowledge (tacit and otherwise) could be something more than information held by an individual (e.g., it could be something a community holds) (see section 2.5 in this chapter for a more detailed account of community of practice theory). Duguid (2005) also discussed the relationship that Polanyi and another philosopher, Gilbert Ryle, described between tacit and explicit knowledge,

Ryle, like Polanyi, argues that the two aspects of knowing are complementary, knowing how helps to make knowing that actionable. They are not, however, substitutable: Accumulation of know that does not lead to knowing how. Know that, we acquire in the form of explicit, codified information. By contrast, “we learn how,” Ryle argued, “by practice” (1949, p. 41). The idea that knowing that does not produce knowing how is important. (p. 111)
Duguid (2005) argued that in Polanyi’s view, explicit knowledge isn’t a “self-sufficient base, but a dependent superstructure” (p. 111), something to which tacit knowledge contributes.

Wharf-Higgins et al. (2011) researched how evidence was defined and used in public health departments in British Columbia implementing the 2009 Healthy Living initiative. Through interviews with public health staff and decision-makers, they found that frontline practitioners were drawn to grassroots and local lived experience evidence, which the authors called tacit wisdom (Wharf-Higgins, et al., 2011). They noted that “evidence applied in practice reflects an amalgam of academic/clinical research, community needs/feedback, and practitioner experiences, and that this accumulated information is transitioned, rather than translated to the local public health context” (Wharf-Higgins, et al., 2011, p. 283). In addition, they noted that, their participants’ sources of information included non-experimental data, their tacit professional experiences and observations, community judgments, theory, and knowledge of the literature combined as a “cumulative wisdom derived from systematic analysis of these and an understanding of the situations and populations in which they would be applied” (Pronk & Goetzel, 2010, p. 127 cited in Wharf-Higgins et al., 2011) as a basis for their interpretation and adaptation. This experiential knowing is often termed ‘evidence-informed’, ‘evidence-influenced’, and ‘evidence-inspired’ (Nutley, et al., 2003; Nutley, Walter, & Davies, 2007) and reflects a way to make sense of data, stories, and statistics in order to adapt existing interventions or implement innovative but untested ones in a process of knowledge transition (Wharf-Higgins, et al., 2011). Wharf-Higgins et al. (2011) also noted instances where the use of research by practitioners was instrumental (where evidence directly influences policy and practice), and others where the use was conceptual (when research informs practitioner discussions, motivates new ideas, or improves understanding of issues in the field). Closely associated with conceptual use was the process use of research (where the experience of evaluating a project provides practitioners with new way of thinking and/or behaving that result from new learning); Wharf-Higgins et al. (2011) noted that conceptual and process uses were significant to the practitioners they studied.

Similarly, Kothari et. al’s (2012) research on the knowledge that public health workers drew on to carry out their work highlights some of these ideas. They demonstrated the dialectic nature of tacit and explicit knowledge by showing how the public health workers in the four public health
units in Ontario they studied used their tacit knowledge to evaluate explicit knowledge about public health issues published in research studies.

Understanding the debates about the complexity of and relationships between tacit and explicit knowledge helped frame this research study. For example, the CDC technology transfer approach values explicit knowledge about specific impacts of interventions, whereas the critiques of this approach imply that tacit knowledge has an important role to play, and that this is neglected in the CDC approach. In this study, ideas about tacit and explicit knowledge helped frame the results to the first research questions about how organizations evaluate their HIV prevention programs. For example evaluation practices described by study participants are presented as to whether they drew on (or built) explicit or tacit knowledge in the results section. The role that tacit knowledge played in understanding the explicit, standardized monitoring and evaluation described is explored in the results and discussion.

2.2 Evidence-based debates

Since the emergence of evidence-based medicine (EBM) in the 90s, there has been a proliferation of related movements in other disciplines, and a variety of responses in research and practice domains. This section outlines this emergence, and some of these responses. These debates about evidence-based practice are relevant to this study and important to explore because they offer an opportunity to conceptually frame some of the complex reactions that occur in the practice of community-based HIV prevention to hierarchies of evidence noted in Chapter 1 (see, for example, Owczarzak, 2012).

2.2.1 Evidence-based medicine

Pope (2003) described the emergence and development of EBM as a contemporary social movement that has had an impact on a variety of disciplines, whose evolution began in the 90s, when it “became the fashionable coinage to describe a process of self-consciously incorporating research evidence into medical practice” (p. 269). While the idea that scientific research should be an important part of medical knowledge was not new, this development involved the incorporation of the relatively newer (and previously less exalted) discipline of epidemiology into the practice of medicine (Pope, 2003). The incorporation of these research methods, which measure disease in populations and evaluate the impact of medical interventions on groups rather
than individuals, place great value on the RCT (i.e., consider it the ‘gold standard’) – which is a particular and explicit form of evidence – in medical research and practice (Pope, 2003). Work by the Evidence-Based Medicine Working Group (1992), Rosenberg and Donald (1995), and Sackett and Rosenberg (1995) has been cited as clearly articulating the goal, ideology and tactics of the EBM movement (Pope, 2003). Sackett and Rosenberg (1995) defined EBM as “the ability to track down, critically appraise (for its validity and usefulness), and incorporate [the] rapidly growing body of evidence into clinical practice” (p. 249, cited in Pope, 2003). Pope (2003) explored the issues behind some of the hostile responses from clinicians to EBM, and located these around EBM’s specification of evidence, epitomized by the RCT, as “rational/technical rather than contingent/experiential” (p. 269). Pope (2003) described,

The critics of EBM suggested that there were fundamental differences between the science encapsulated in EBM and the nature of everyday medical work. The central problem, according to these critics, lay with the nature of RCT evidence, essentially with the issue of internal versus external validity. Randomized trials provided an overview of the effect of an intervention on all the patients included in a trial. Making the shift between this type of evidence and medical practice was problematic. Trial evidence described the benefits from an intervention applied to a group of people, and had external validity, but the clinician had to decide whether these average benefits applied to an individual patient who consulted them. The opponents of EBM argued that the EBM approach ignored the complex variation and individuality inherent in medical work… These critics argued that, in order to make sense of the unique circumstances of the individual case, doctors used a form of practical knowledge or judgement quite different to the knowledge offered by EBM. The evidence base of EBM was technical: it was capable of formulation, and might be written in journals or specified as rules or guidelines. By contrast, the opponents of EBM claimed that medicine drew on a more nebulous type of knowledge variously referred to as the ‘other kind of medicine’ or the ‘grey zones’ of clinical practice… Many critics of EBM argued that this clinical judgement or ‘art’ was a feature of all medical work. (p. 273)

Pope (2003) described how the EBM movement threatened the experiential model of practice that some medical professionals valued, and was bound up in power relations within and among medical research and practitioners. Pope (2003) stated,
By privileging technical knowledge that can be formulated and specified, and which is allied so closely with science (albeit with a rather narrow experimental version of science) EBM thus presents a significant threat to clinical judgement and ultimately control over medical work… The EBM movement has constructed and defined the nature of medical work as technical and has emphasized the scientific aspect of the art/science dualisms [found in medical practice]… EBM has provided a formulated, explicitly rational frame that directly challenges the experiential model of practice offered in surgeons’ accounts [of practice]…

Not only can technical work practices be subjected to external control and surveillance, they can also be routinized. Routine work is susceptible to standardization and may be repetitive and boring. It also loses its prestige and mystery and, thus, power. (p. 278)

In response to some of the early critics (see Blaivas, 1995; Evans, 1995), Sackett and Rosenberg (1996) modified their definition of EBM to “the conscientious, explicit, and judicious use of current best evidence in making decision about the care of individual patients” (p. 71). They also attempted to articulate a role for practitioner expertise as the arbiter of explicit evidence by stating.

The practice of EBM means integrating individual clinical expertise with the best available external clinical evidence from systematic research..... External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision. (Sackett, et al., 1996, p. 71)

However, debates within medicine about the fate of individual clinical judgement in EBM still remain; and further critique of the concepts have been raised by medical practitioners, philosophers and social scientists alike (Knaapen, 2014; Mykhalovskiy & Weir, 2004).

Mykhalovskiy and Weir (2004) detailed how social science inquiries about EBM have addressed concerns beyond changes in clinical decision-making. They promoted understanding EBM as a social knowledge relation, where EBM is viewed as a practice of knowledge that involves various social actors, and encouraged further empirical investigation of EBM as a form of reasoning and suggested exploring its relationship to other ways of knowing (Mykhalovskiy & Weir, 2004). Knaapen’s (2014) work built on this and described how definitions of EBM fail “to reflect the transformations EBM has brought about in the way medicine is practiced and
conceptualized” (p. 823). Knaapen (2014) summarized the two new key principles that EBM has promoted: 1) a new epistemological basis and classification of knowledge for medicine, namely, a hierarchy of knowledge which ranks forms of knowledge and places RCTs at the top; and 2) the production, promotion and use of evidence-based tools (such as guidelines, syntheses and reviews of evidence, etc.) to bring evidence to practitioners – many of which are produced by experts in this new area. Both of these key principles have been widely criticized (Knaapen, 2014; Mykhalovskiy & Weir, 2004).

Knaapen (2014) discussed the politics of ranking knowledge and its exclusionary nature which hides the messiness of actual practice, and gives financial interests of specific actors invested in RCTs (such as the pharmaceutical industry) unprecedented power to shape medical practice. Differing critiques offer different responses on how to overcome the problems introducing by ranking knowledge (such as relying on individual doctors and patients, valorizing more diverse types of medical research, or redesigning RCTs to incorporate more of the diversity of clinical practices) (Knaapen, 2014).

Knaapen (2014) also discussed the findings of empirical evidence on the actual production of EBM guidelines in practice, which has shown that “diverse knowledge is relied upon to determine what counts as evidence [in EBM] in the first place” (p. 828). Studies have shown that a pragmatic diversity in biological, clinical, and even contingent kinds of knowledge and justification are relied on when designing clinical guidelines (Moreira, 2005), to apply RCT evidence to diverse subpopulations (Will, 2009) and to select what does and does not count as evidence in EBM in the first place (Knaapen, 2013). Knaapen (2014) contended that while this has shown that EBM has not created a positivist, objectivist practice of medicine (which assuages the fears expressed by critics, and threatens the supposed dream of proponents), it does show the rise of a new ‘regulatory objectivity’, which is invested in institutional procedures that establish a “deliberate and conscious formation of an internal consensus – often recognized to be pragmatic and situation-dependent – about how to proceed ‘objectively’” (Cambrosio, Keating, Schlich, & Weisz, 2009, p. 655 cited in Knaapen, 2014). This is contrasted to ‘disciplinary objectivity’, where the judgment of experts is trusted by virtue of their professional status as morally virtuous (Knaapen, 2014).
Knaapen (2014) explored the impacts of this ‘regulatory objectivity’ in medicine by the threats it makes to two hallmark characteristics of the medical profession: 1) the monopoly of medical professionals to perform their work, when guidelines are used to de-professionalize medical practice by transferring more routinized and protocolized work to others (such as nurses or patients themselves); and 2) medical professionals’ privileged authority to evaluate their own work, when guidelines are used as norms by third parties to evaluate professionals’ behavior.

Knaapen (2014) highlighted how these perspectives place EBM within M. Power’s (1997, 2000, 2005) ‘audit society’, which posited that broad social transformations have contributed to reduced trust in professionals, and given rise to a variety of quality assurance systems allowing managers to monitor and regulate professionals’ work. It has been proposed that professionals have resisted these new systems in an effort to preserve their professional autonomy, status, and skills. However Knaapen’s (2014) review showed that responses have been more varied, and that there is more complexity than the image presented by a polarized divide between EBM ‘proponents’ and ‘opponents’. First, Knaapen (2014) pointed to accounts of some professionals’ enthusiasm of EBM and its standards, and how EBM tools (e.g., guidelines, systematic reviews, etc.) are rarely produced or imposed by external parties – typically they are produced by (or in participation with) medical professionals and their organizations. This repositions EBM tools and their development by medical professionals as a “defensive strategy to avoid externally controlled regulation” (Knaapen, 2014, p. 803). It serves to maintain the collective autonomy of the medical profession (albeit, at the cost of the autonomy of individual physicians) and introduces a new kind of hierarchical intra-professional regulation, where instead of third parties, it is the ‘knowledge and administrative’ elite of the medical profession that employs standards to order, assess and direct the work of the rank and file doctors, and serves to ward-off external control. Second, Knaapen (2014) described how the use of standardized protocols derived by EBM does not replace the expertise of professionals, instead it requires this expertise and existing routines of local practice, and in some cases, leads to making professional work visible to outsiders in ways that enhance professionals’ status. In particular, standards “can be especially appealing for groups whose professional work is criticized or goes unrecognized”, especially when the “production of shared professional standards allows these groups to claim and defend their unique domain of expertise against other professional groups, thus enhancing
the scientific status and legitimacy of their professional work and jurisdiction” (Knaapen, 2014, p. 831). Knaapen (2014) stated,

If evaluative standards developed from within the professional group can enhance that groups’ professional status, this is because who develops the standards is in control of what is made measurable, comparable, and governable and what is left informal, flexible, ambiguous, and invisible. Standards that can function as professional resource rather than external restraint typically reflect and explicate existing work practices (rather than modify them) and build in enough flexibility and ambiguity so professional judgment and discretion remain required to understand and follow standards. (p. 831)

Understanding the history and complexity of reactions to evidence-based medicine also explains some of the rise of popularity in evidence-based practice in a number of fields, which is discussed in the next section.

2.2.2 Evidence-based “everything”

Many authors have noted how the term ‘evidence-based practice’ has become ubiquitous, with expansion of this movement across health care disciplines (Steinberg & Luce, 2005), and policy fields in a number of social service sectors (e.g., health care, education, social work, criminal justice system, etc.) (Nutley, et al., 2003). Much literature has focused on providing discipline-specific definitions, introductions to terminology, and examples of it in practice in health care settings; this literature tends to uncritically promote the evidence-based practice movement. Some theorizing and investigations also have focused on whether practitioners are actually using evidence in their practice, and barriers and/or facilitators to the uptake of research evidence in practice. These have produced a variety of suggestions on how to increase the uptake of research evidence in practice. One of these is promoting increasing partnerships between researchers and practitioners (Nutley, et al., 2003). Another is the suggestion to move from ‘research into practice’ models towards what Nutley et al. (2003) term ‘research in practice’ models, where there is a “shift in focus from researcher-as-disseminator to practitioner-as-learner, [which] encourages a multi-dimensional rather than unidimensional view of the process of research implementation” (p. 133). Nutley et al. (2003) stated,
This approach argues that no matter how discrete and pre-existent it appears, evidence is always inextricably intertwined with the actions, interactions and relationships of practice. In rejecting the neat separation of research and practice, this view also disputes the hierarchy inherent in this dualism, a hierarchy that privileges the objective ‘facts’ of research over the subjective ‘knowledge’ of practice. (p. 133)

Within public health and health promotion, there has been a proliferation of writing on evidence-based practice, what it is, and how to make it better (Armstrong, et al., 2007; Eriksson, 2000; Waters & Doyle, 2002). There is also an increasing number of textbooks in a variety of disciples that introduce learners to their professions through the lens of evidence-based practice; these include: medicine (Straus, Richardson, Glasziou, & Haynes, 2011); public health (Fink, 2013); healthcare policy (Muir Gray, 1998); and social work (A. Roberts & Yeager, 2006).

Within nursing, while there has been expansion of the evidence-based practice movement, there has also been some vocal critiques; these have been based on philosophical concerns, originated from humanistic perspectives that underpin some aspects of nursing practice, particularly nurse-patient relations (Mitchell, 2013). Within nursing, there has been a call for more radical re-conceptualizations of evidence-based practice, as well as broader knowledge construction practices in nursing (Mitchell, 2013; Welsh & Lyons, 2001). Welsh and Lyons (2001) called for a deeper understanding of the relationships between tacit and explicit knowledge in practice – which was explored in section 2.1.

2.2.3 Practice-based evidence to community-based evidence

As noted above, there have been a number of responses to the evidence-based practice movement across various disciplines (Knaapen, 2014; Mykhalovskiy & Weir, 2004; Pope, 2003). Nutley et al.’s (2003) ‘research in practice’ suggestions may be understood as a precursor to other models that have emerged. Martinez et al. (2010) discussed how the concept of ‘practice-based evidence’ has emerged over concerns about increasing pressure from funders and policy-makers for practitioners to carry out only evidence-based programs (either predominantly, or exclusively) as a condition of receipt of funding. The practice-based evidence movement seeks to recognize practices and programs that may lack empirical evidence based on RCTs and/or other quantitative research methods, but have been created or improved through the experience of organizations carrying them out, using methods such as observation and tacit
assessment, which may or may not be combined with other explicit research techniques (Isaacs, 2008, as cited in Martinez, et al., 2010). Martinez et al (2010) noted that ‘practice-based evidence’ is the ‘practice to science’ complement to the ‘science to practice’ paradigm.

As a further refinement of the concept, and to be more considerate of models that value the role of culture (especially as it relates to communities that are disenfranchised) in determining effectiveness, Martinez et al. (2010) advanced the idea of ‘community-defined evidence’, which is “a set of practices that communities have used and determined to yield positive results by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community” (Martinez, et al., 2010, p. 12). These authors state that this working definition purposely does not specify either the term ‘community’ or ‘community consensus’, as these vary across jurisdiction, including differing ways of measuring successes, based on particular priorities and parameters of what constitutes success (Martinez, et al., 2010).

Overall, the debates about evidence-based practice presented above help frame some of the issues inherent in the hierarchical knowledge schema that underlies the CDC approach to community-based HIV programming (Collins & Tomlinson, 2014; Fenton, et al., 2009). In addition, these debates also allow the critiques of this approach from Miller (2001), Miller and Shinn (2005), Dworkin et al. (2008) and SFAF (2008) to be expanded on, with a view towards the complexity of reactions that a number of disciplines are experiencing with regards to their responses to the expansion of evidence-based practice.

In particular, the concept of ‘community-defined evidence’ allowed for a deeper understanding of how ASOs determined success and the processes in which knowledge and practices reached levels of acceptance. These concepts helped frame this research study, and provided a conceptual frame from which to understand the evaluation of HIV prevention programs at ASOs.

2.3 Accountability

Accountability can be an important motivator of evaluation; it is important to understand the role that accountability plays in evaluation practice in order to explore what influences evaluation practice in specific settings. Accountability is one of the many purposes of evaluation, and many authors acknowledge the important role that it plays in evaluation (Alkin, 2013). Alkin and
Christie (2013) described one of the roots of evaluation as lying in accountability, and proposed that accountability “situates and legitimizes evaluation as a fundamental process for generating systematic information for decision-making” (p. 15). In its most generic sense, accountability is described as holding someone to account to someone else for something, that is, requiring a justification or explanation of what has been done, and ‘giving an account’ (i.e., being answerable or capable of being accounted for) (Alkin, 2013; Bemelmans-Videc, Lonsdale, & Perrin, 2007; P. J. Rogers, 2005). Aucoin and Jarvis (2005) described how within government, virtually everyone to whom an account is due is also accountable to someone else at the higher level, with the ultimate authority resting on the electorate. In the literature, this has been described as the problem of ‘many eyes’ in accountability, where there is a long list of potential stakeholders (who value a multitude of norms) that demand answers about programs (Bemelmans-Videc, 2007).

Rogers (2005) described the most common form of accountability in evaluation is a focus on simple justifications by requiring program managers to report back to funders on their performance compared to agreed plans and targets; which, in theory, sounds attractive, but in practice, diminishes the complexity of funder and program relations. It also does not address the effects (which can be intended or unintended) that monitoring and evaluation systems that are used for accountability may have on practice. Many authors have called for careful consideration of issues such as: who is being held accountable, to whom, for what, how, and with what consequences (Bemelmans-Videc, et al., 2007; P. J. Rogers, 2005). In addition, literature on accountability has linked practices such as evaluation and audit closely with “the exercise of power and the legitimacy of policies, and those pursuing them” (Bemelmans-Videc, et al., 2007, p. 3), therefore, discussions about evaluation and accountability need to be attuned to issues of power.

Mayne (2007) explored the changing characterizations of accountability in light of new approaches in the public sector, such as ‘new public management’, particularly the focus on results over process. Mayne (2007) described traditional notions of accountability being characterized as: “focusing on process, especially on the extent to which administrative rules and procedures have been followed; hierarchical, with a junior party being accountable to a senior party; and assigning blame when things go wrong” (p. 65). Mayne (2007) distinguished the features of modern public management that run counter to this version of accountability: a focus
on results (intended outcomes) compared to process (outputs); the extensive use of partnering, where relationships between government funders and service providers are considered less hierarchical and more collaborative; and a desire to provide service providers with more discretion and flexibility to encourage innovation and learning (which is not well supported by notions of accountability that focus mainly on following rules and procedures). How notions of accountability can be reconciled with these new approaches remains to be seen. However, some accountability institutions have proposed rearticulating accountability in ways that are more congruent with current approaches to public management, and include learning as an important component. The Auditor General of Canada (2002) has suggested that accountability be reconsidered as a “relationship based on obligations to demonstrate, review, and take responsibility for performance, both the results achieved in light of agreed expectations and the means used” (p. 5 cited in Mayne, 2007). In addition, the Auditor General of Canada (2002) argued that,

[Accountability] asks ministers and managers to demonstrate credibly that they are learning (from mistakes as well as successes), taking corrective action where appropriate, and following up on weaknesses, rather than focusing only on who is at fault when things go wrong. (p. 16 cited in Mayne, 2007)

There are a number of issues in the evaluation literature on accountability and learning that pertain to conflicts and complications with these two purposes for evaluation. These issues are especially germane to understanding what influences evaluation practice. Literature has described how evaluation for the purpose of accountability differs from evaluation for facilitating improvements (or generating knowledge) in terms of modes of inquiry, suggested methods, as well as audiences (Mark, et al., 2000; Patton, 2008). The problems that result from attempting to fulfill too many functions or serve too many audiences, such as fulfilling none of them particularly well, are recorded (Lehtonen, 2005; Mark, et al., 2000). In particular, critical literature about the ‘explosion’ of performance measurement in social programs highlighted the differences in indicators and practices that are intended to provide accountability (and confer legitimacy) compared to those that are intended for learning and improvement, and the value of the latter over the former is highly praised (Freeman, 2002; M. Power, 2000). The value of evaluation for learning or organizational improvement is so highly lauded that recent authors
have suggested that it be required as part of establishing accountability and legitimacy (Perrin, 2007).

There are some descriptions of evaluation that fulfill both accountability and learning functions. Lehtonen (2005) described the Organization for Economic Co-operation and Development’s (OECD) Environmental Performance Review (EPR) program, which involves carrying out systematic reviews of member countries’ environmental policies. The EPR program is a response to the growing emphasis on performance management and accountability in the OECD member countries; its primary goals include capacity building of individual governments to carry out their own national evaluations and make progress on environmental issues, and improve policy dialogue – these are learning functions (Lehtonen, 2005). Additionally, an EPR program goal is to stimulate greater accountability from governments towards public opinion; this goal is an accountability function, which is unofficially recognized as the main purpose of the EPR program (Lehtonen, 2005). Experiences in carrying out EPR reviews in a number of countries showed that there are “formidable difficulties involved in attempts to combine the partly contradictory functions of learning and accountability into a single evaluation framework” (Lehtonen, 2005, p. 183). The shortcomings of the EPR program have been attributed to their attempt to serve too many audiences and fulfill too many functions at the same time (Lehtonen, 2005). However, Lehtonen (2005) contended that it is still possible to promote learning and accountability at the same time, with due consideration and care to identify the primary functions and main clients for each evaluation exercise.

Owen (2007) articulated an approach to accountability that considers explicitly the payoffs of evaluation for both government funders, as well as service providers who receive government funding. In this work, Owen (2007) suggested that evaluation practice would be improved if it was based on the notion of mutual accountability, where evaluation efforts provide information that meets the needs of both of these stakeholders. Owen (2007) contended that traditional notions to accountability, called ‘accountability up’, involved government funders setting the evaluation agenda and the methodological approaches to be used. In this traditional schema, government funders were the primary audience for the evaluation findings. Service providers that received government funding were required to collect and assemble findings and report them to the funder (Owen, 2007). Owen’s (2007) alternative schema emphasized the need for the funders to be held ‘accountable down’ to providers in addition for the providers to be
accountable up. In this schema, in addition to reporting key measures that are of use to the funder for their accountability purposes, service providers show that they are using the findings from their own inquiries (in which they set the agenda and determine the approaches) for internal decision-making and program improvement (Owen, 2007). Essential to ‘accountability up and down’ is a “genuine commitment to evaluation findings being useful to individual providers”, who need to see that “investment in evaluation has a direct payoff for them and internal improvement focussed evaluation can deliver this payoff” (Owen, 2007, p. 191). In this regard, Owen (2007) quoted Rist (1995),

Demand for evaluation… may be motivated by a genuine desire to learn from experience, or merely to meet a bureaucratic requirement with no intention of using the gathered information. If the demand is genuine, evaluation information will potentially be used to help improve projects and programs… However, if information is merely being collected as a bureaucratic ritual, there is little reason to expect any quality in the data, any motivation on the part of those generating the data to ensure accuracy or any substantial trust in the enterprise. (p. 173)

However, these authors have not addressed the consequences of these issues on either programming or evaluation practice, including the increased burden to address accountability to multiple audiences, as well as demonstrate learning and program improvement resulting from evaluation. At a time when a number of authors call into question whether or not the ultimate goal of more traditional views of accountability (i.e., providing information about outcomes of government-funded work to external audiences to confer credibility and legitimacy on the work and the distribution of government funds to service providers who undertake this work) is actually being achieved (Bemelmans-Videc, et al., 2007; Feller, 2002; Freeman, 2002), it is important to understand the consequences of additional accountability demands for learning and/or program improvement. These are particularly germane when exploring what influences evaluation practice at ASOs and helped frame the understanding what influences evaluation practice in this research study.
2.4 Health promotion and community development models

Community-based HIV prevention draws on models from health promotion and community development practice. This section reviews some of these models, with particular attention to ones that emphasize relationships. These are important to understand because of their influence on HIV prevention and evaluation practice at ASOs.

Health promotion and community development highlight the powerful role that social relationships have on health and well-being; this has garnered a lot of interest among health promotion practitioners and researchers for a number of years (Heaney & Israel, 2008; Thoits, 2011). Currently, there is no one theory that adequately explicates the link between social relationships and health; various conceptual models and theories have guided research in this area (Heaney & Israel, 2008). These generally link social support and networks to increasing health promoting behaviours, and mitigating stressors through individual-, organizational- and community-level coping resources (Heaney & Israel, 2008). In reviewing the research on links between social relationships and health, Heaney and Israel (2008) cited the relevance of House’s (1987) writing from more than two decades ago:

> Although the results of individual studies are usually open to alternative interpretations, the patterns of results across the full range of studies strongly suggests that what are variously termed social relationships, social networks, and social support have important causal effects on health, exposure to stress, and the relationship between stress and health. (p. 136)

Heaney and Israel (2008) described several key terms that are used in studies of the health-enhancing components of social relationships, such as: social integration, which refers to the existence of social ties; social support, which is one of the important functions of social relationships (i.e., providing emotional, informational, and/or instrumental assistance); and social networks, which refers to the web of social relationships that surround individuals, and encompasses linkages between people that may or may not provide social support and that may serve functions other than providing support. Social capital has been used to describe certain resources and norms that arise from social networks (Ferlander, 2007; Heaney & Israel, 2008).
While social relationships can be sources of support, they can also be problematic. Thoits (2011) referred to the “dark sides” of relationships: they can be tense, conflicted, overly demanding, and become sources of stress rather than benefit, and these can cancel out the ameliorative effects on health of more positive social relationships. Among professionals or within a community of practice, relationships can be problematic: they can be asymmetrical (i.e., shaped by how power is distributed). Most health promotion and community development models are explicit that the term *social support* is positive (i.e., it connotes beneficent intentions or consequences related to social relationships), and distinguishing it from intentional negative interactions (e.g., social undermining behaviors such as angry criticism and hassling) (Heaney & Israel, 2008; Thoits, 2011). Overall, the concepts of social capital, social networks and social support emphasize the importance of relationships for positive health outcomes (Glanz, Rimer, & Viswanath, 2008)

Health promotion and community development models also emphasize collaborative relationships within communities of practice (Glanz, et al., 2008; Minkler, Wallerstein, & Wilson, 2008). In these models, collaboration is thought to lead to a more effective approach to complex health and social issues than can be achieved by one organization alone (Minkler, et al., 2008). Collaboration is also seen as key to community empowerment and other health promoting social practices (Minkler, et al., 2008).

It is interesting to note that there are tensions within types of health promotion and community development practice. Some aspects of social work have a strong emphasis on relationships that promote healing, where trust, respect, mutuality and interaction are emphasized as important to individuals as well as practitioners responding to individual and community needs (Goldstein, Miehls, & Ringel, 2009). However, other social work practices lack this emphasis, and rely more on cognitive/behavioural techniques and other evidence-based practice interventions (Goldstein, et al., 2009). Goldstein et al. (2009) characterized relationship-based social work as being informed by psychoanalytic theory, which is underpinned by philosophy and other disciplines that may not be derived from or emphasize the importance of empirical evidence building. Goldstein et al. (2009) contrasted this to cognitive/behavioural techniques and other evidence-based practice interventions which are informed by theories drawn from behavioural psychology, in ways that are more readily measurable, and emphasize the importance of empirical research-based evidence. Some parallels can be drawn to the tensions that Pope (2003) described in the EBM movement (which relies on technical knowledge that can be formulated
and specified), and those that countered that the practice medicine drew on more nebulous types of knowledge.

Overall the emphasis on relationships in health promotion models, particularly related to social support and networks (Heaney & Israel, 2008; Thoits, 2011), organizational collaboration (Minkler, et al., 2008), and relational aspects of health and well-being (Goldstein, et al., 2009) are important to keep in mind when looking at what influences evaluation practice because these are important concepts embedded in the worldviews that underpin HIV prevention programs at ASOs.

### 2.5 Communities of practice

A framework that is helpful to understand the context of HIV prevention work at ASOs frames the funders, ASO management and staff, and volunteers as members of a community of practice. Communities of practice, originally described by Lave and Wenger (1991) and further developed by Wenger (1999), are defined as groups of people who come together to carry out activities in everyday life or the workplace, and are distinct from formal structures or groups (Barton & Tusting, 2005, p. 111). In Lave and Wenger’s (1991) earliest writing, the concept of situated learning was coined to describe how most of the learning for practitioners occurs in social relationships rather than in classroom settings. Communities of practice were loosely defined as people from the same discipline improving their skills alongside experts and being involved in increasingly complicated tasks; in this writing, the interactions between novices and experts in a field, and the process by which newcomers developed a professional identity, were the central themes (Lave & Wenger, 1991). Brown and Duguid (1991) further developed the concept from its original emphasis on existing skills to include the creation of new knowledge to respond to work-related issues. These authors also highlighted the interaction of workers across different communities, a concept known as ‘community-of-communities’ (Brown & Duguid, 1991).

Wenger (1999) refined the concept of communities of practice by characterizing them as: undertaking a joint enterprise in that they have a common endeavour; being mutually engaged (they interact with each other in many ways); and developing a shared repertoire of common resources of language, styles and routines in which they express their identities as members of a group (Barton & Tusting, 2005).
Li et al. (2009) described the increasing attention to communities of practice in the health care sector. In their discussion of the concept, they characterized it as evolving, originally developed as a social learning theory which has increasingly been applied as a management tool (Li, et al., 2009). They highlighted the tension between satisfying individuals’ needs for personal growth and the organizational ‘bottom-line’ in workplace-based communities of practice (Li, et al., 2009). They highlighted the key characteristics of the concept of communities of practice as the support for formal and informal interaction among members, the emphasis on learning and sharing knowledge, and the importance of fostering a sense of belonging among members (Li, et al., 2009). Koliba and Gajda (2009) provided an extensive review of literature and use of the concept of communities of practice across social science and professional disciplines, including health care (Dewhurst & Navarro, 2004; Gabbay et al., 2003; Lathlean & Le May, cited in Koliba & Gajda, 2009), networks of non-governmental organizations (Rohde, 2004; White, 2004 cited in Koliba & Gajda, 2009), and evaluation (Fetterman, 2002 cited in Koliba & Gajda, 2009). Koliba and Gajda (2009) explored the ways in which communities of practice have come to be used descriptively, as an analytic framework. They also described how communities of practice can be understood as relational structures, through which knowledge is socially constructed, where the “shared tools and techniques of a community of practice are the medium through which meaning is negotiated and learning occurs” (Koliba & Gajda, 2009, p. 103).

Some theories have included only cursory attempts to deal with power issues that come up within communities practice. For example, while Lave and Wenger (1991) acknowledged the hierarchy of power that exists between experts and novices, they did not provide much insight into the potential for conflict among these groups. They also did explore the implications of the distribution of power when discussing their case studies of communities of practice (J. Roberts, 2006). Marshall and Rollinson (2004) suggested that accounts of building shared understandings within communities of practice could be “easily misconstrued as being excessively quiescent and consensual” (p. S74). While some empirical studies have sought to examine power relations in specific communities of practice (e.g., Contu & Willmott, 2003; Mørk, Hoholm, Ellingsen, Edwin, & Aanestad, 2010), the area remains undertheorized.

Even with this limitation, community of practice concepts are helpful to understand the context of HIV prevention work. In the case of this research, the concept of a community of practice is understood as an analytic framework through which the ASOs funders, management, staff and
volunteers that were interviewed are viewed as undertaking the joint enterprise of HIV prevention among communities at risk. They interacted with each other in person at ASOs, in meetings, at conferences, or other community-based events. Some interaction was also online via email exchanges, filling out online reporting systems, as well as other social media platforms that were part of HIV prevention work (websites, online campaigns, etc.). All of these interactions were part of their mutual engagement. The shared repertoires they co-create about HIV prevention shaped the work they undertook and changed over time.

Communities of practice theories about situated learning have highlighted the co-constructed nature of knowledge, meaning that learning among members of a community of practice is situated in a specific context and embedded within a particular social and physical environment (Lave & Wenger, 1991). Situated learning comes from engagement, and the fundamental process of learning comes about through participation in a community of practice (Barton & Tusting, 2005). By understanding these ASO funders, workers and volunteers who were interviewed as a community of practice and involved in situated learning, the plurality of ways in which knowledge is developed and shared in HIV prevention can be explored. This can lead to a deeper discussion about what constitutes ‘evidence’ in ‘evidence-based’ programming and how HIV prevention communities of practice respond to it. In addition, it allows for recognition of community knowledge and experience (Miller & Shinn, 2005; SFAF, 2008), and opens the discussion about what practices are involved in the creation and reification of this knowledge.

2.6 Definitions and theories of monitoring and evaluation

The field of evaluation employs a number of definitions of the term ‘evaluation’. While many of these emphasize the merit and/or worth of something (referred to as the evaluand), there are many more expansive definitions as well (Mark, Greene, & Shaw, 2006). Evaluation ‘definitions’ and ‘theories’ are terms that are often used interchangeably in the evaluation literature (Mark, et al., 2006). Different theories emphasize different aspects of the process and/or outcomes of evaluation. This section explores some of these and describes their relevance to this research study. The specific terms (and their definitions) that were utilized in this study are introduced in this section.
2.6.1 Definitions and theories of evaluation

Patton (2008) stated that “to evaluate something means systematically determining its merit, worth, value, quality, or significance” (p. 38). Mark et al. (2006) described how the root of the term ‘evaluate’ is ‘value’, which intrinsically involves determining the merit and/or worth of something. They described how various definitions of evaluation differ in terms of the components they include. A popular definition from Scriven (1991) focused on the general function evaluation serves:

Evaluation refers to the process of determining the merit, worth, or value of something, or the product of that process. … The evaluation process normally involves some identification of relevant standards of merit, worth, or value; some investigation of the performance of the evaluands on these standards; and some integration or synthesis of the results to achieve an overall evaluation or set of associated evaluations. (Scriven, 1991, p. 139 cited in Mark et al., 2006)

Other definitions have specified evaluation purposes:

Program evaluation is the systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future programming. (Patton, 1997, p. 23 cited in Mark et al., 2006)

Further, at least some historically important definitions have specified methods:

Evaluation research [considered the same as evaluation] is the systematic application of social research procedures in assessing the conceptualization and design, implementation, and utility of social intervention programs. In other words, evaluation research involves the use of social research methodologies to judge and to improve the planning, monitoring, effectiveness, and efficiency of health, education, welfare, and other human service programs. (Rossi, Freeman, & Lipsey, 1999 cited in Mark et al., 2006)

To Mark et al. (2006), evaluation has many faces, is dynamic in nature, and involves a number of approaches. Attempts have been made to describe what the field encompasses by designing ‘meta-models’ that aim to capture and summarize the plethora of evaluation approaches that
have been developed (Mark, et al., 2006). One of these ‘meta-models’ was devised by Shadish, Cook and Leviton (1991). They organized seven prominent (and primarily US) approaches into three stages, thereby classifying evaluation theorists as first-, second-, or third-stage theorist, in order to describe the development of major evaluation approaches up to 1991 (Shadish, et al., 1991). In this ‘meta-model’, Shadish, Cook and Leviton (1991) advanced that first-stage evaluation theorists emphasized “a search for truth about effective solutions to social problems” (p. 67). The work of evaluation theorists Michael Scriven and Donald Campbell, which emphasized the use of procedures to determine valid and unbiased information about the performance of social programs, were ascribed to this stage (Shadish, et al., 1991). In the second stage, other theorists attempted to go beyond previous work and “generated many alternatives predicated on detailed knowledge of how organizations in the public-sector operate, aimed at producing politically and socially useful results” (Shadish, et al., 1991, p. 67). These theorists – Carol Weiss, Joseph Wholey and Robert Stake – were attuned to details of organizational processes and decision-making, and attempted to shape evaluation into these organizational realities (Shadish, et al., 1991). The third and final stage – represented by Lee Cronbach and Peter Rossi – “then produced theories that tried to integrate the alternatives generated in the first two stages” (Shadish, et al., 1991, p. 67). While the limitations of this model have been noted (the over-individualization of complex evaluation theories, the under-emphasis of structural and societal factors, and the emphasis on male evaluation theorists), it is still valued as a method to understand the various emphases of different approaches to evaluation.

Continuing on this theme of understanding the various emphases of different approaches, another ‘meta-model’ was devised by Alkin (2004, 2013), which attempted to trace different theorists’ views and influences in an ‘evaluation theory tree’ – a graphical representation modeled after a tree with three branches. The foundational roots of this tree (social accountability, social inquiry, and epistemology) were depicted as a trunk, and evaluation theorists were mapped onto one of three branches (methods, valuing, and use) based on their relative degree of emphasis on: “(a) issues related to the methodology being used; (b) the manner in which data are to be judged or valued; and (c) the user focus of the evaluation effort” (Alkin, 2013, p. 7). Alkin (2013) acknowledged that that these three branches (also called streams) have intersected at times, and many theorists address all three issues to some extent.
Overall, narrower definitions and theories of evaluation tend to focus on the assessment of merit, worth, and/or value, using empirical social science methods, and are usually based on positivist or post-positivist worldviews that emphasize objectivity and causality. These definitions and theories draw most heavily on Stage 1 in Shadish, Cook and Leviton’s (1991) model. Donald Campbell’s work (see D. T. Campbell, Stanley, & Gage, 1963) formed a foundation for the methods component of these definitions. Michael Scriven’s contributions pushed evaluators to consider valuing as a central feature to evaluation (see Alkin, 2013; Shadish, et al., 1991), and broadened the field to consider other kinds of methods, which is why Alkin (2013) placed him on the valuing branch. However, more expansive definitions and theories do not solely focus on assessment of merit, worth, and/or value. Julnes and Mark (1998) and Mark, Henry and Julnes (1999, 2000) developed the idea of evaluation as ‘assisted sense-making’, and described multiple purposes of evaluation: to assess merit or worth; for oversight and compliance; for program improvement; and knowledge development. Although they do not emphasize it in their work, they acknowledged that other purposes may motivate evaluation activities (Mark, et al., 2000). The underlying worldview of Julnes and Mark’s (1998) and Mark, Henry and Julnes’ (1999, 2000) evaluation as ‘assisted sense-making’ idea is described as emergent realism – an alternative paradigm to positivism and constructivism that “is better able to support the knowledge construction activities of evaluators” (Julnes & Mark, 1998, p. 46). It is this expansive view of evaluation that was employed in this research study. Evaluation was understood as assisted sense-making, which aimed to capture, make sense of, and assess programs for multiple purposes (such as assessing merit or worth, for oversight and compliance, for program improvement, or knowledge development) as well as other purposes that emerged.

2.6.2 Definitions of monitoring

Monitoring and evaluation are often understood as distinct, yet complementary activities (Görgens-Albino & Kusek, 2009). Posovac and Carey (2007) described monitoring as a means to evaluation. Patton (2008) described a ‘marriage’ between monitoring and evaluation, where “findings from monitoring data can generate questions to be answered by evaluation through more in-depth inquiry, helping to focus and increase the utility of scarce evaluation resources” (p. 129). Shadish et al. (1991) described the work of Joseph Wholey as a significant contribution to evaluation theory about monitoring, with the specific focus of helping program management evaluate and improve government social programs. Patton (2008) described the expertise and
thoughtful deliberation of Hatry, Whooley, and Newcomer (2004), who believe that “monitoring and evaluation can and should be considered an important subset of program evaluation” (Hatry, et al., 2004, p. 676 cited in Patton, 2008).

Patton (2008) described how the term ‘monitoring and evaluation (M&E)’ is more commonly used in international evaluation circles. The Organization for Economic Cooperation and Development (OECD) defined monitoring as

A continuous function that uses systematic collection of data on specified indicators, to provide management and the main stakeholders of an ongoing development intervention with indicators of the extent of progress and achievement of objectives and progress in the use of allocated funds. (Görgens-Albino & Kusek, 2009, p. 2)

In contrast, evaluation was defined as:

The systematic and objective assessment of an ongoing or completed project, program, or policy, including its design, implementation, and results. The aim is to determine the relevance and fulfillment of objectives, development efficiency, effectiveness, impact, and sustainability. An evaluation should provide information that is credible and useful, enabling incorporation of lessons learned into the decision-making process of both recipients and donors. (Görgens-Albino & Kusek, 2009, p. 2)

In these definitions, monitoring is described as a ‘continuous function’, while evaluation may occur sporadically, prior to, during, or after a program has been implemented. The purpose of monitoring fits into the larger aims of evaluation. ‘Performance monitoring’, ‘performance measurement’, ‘performance indicators’ and ‘monitoring systems’ are terms that are often used interchangeably in the evaluation literature. In this thesis, the terms ‘monitoring’ and ‘performance measurement’ are used interchangeably.

In this research study, monitoring was considered an important subset of evaluation. Monitoring activities were understood as an important piece of a larger group of activities that make up evaluation practice. Monitoring practices and what influenced these were explored in this study.
2.6.3 Trends and issues in monitoring

The evaluation literature has been discussing the intensification of monitoring and evaluation in health, social services and the public sector for a number of years (Aubert & Bourdeau, 2012; Bowerman, Raby, & Humphrey, 2000; Chang, 2007; Feller, 2002; Freeman, 2002; Greene, 1999; Mark, et al., 1999; Patton, 1997, 2008; M. Power, 1994, 1997, 2000, 2003, 2005). In particular, there has been a move towards monitoring for outcomes; some go as far as suggesting that the current political environment is one of “outcomes mania” (Patton, 2008, p. 248).

Increasing demands for outcome monitoring and evaluation is described as one of the features of ‘new public management’ (M. Power, 2003, 2005). ‘Results-based management’ – where managerial decision-making is based on outcomes – is posited as intending to serve a number of functions, including increasing accountability, bettering managerial decision-making, and program improvement (Patton, 2008). However, the major goal of providing information about outcomes of government-funded work to external audiences is usually to confer credibility and legitimacy on the work and the distribution of government funds to service providers who undertake this work; this is valued over program learning or improvement functions (Freeman, 2002). In addition, there are a number of authors who call into question whether or not credibility and legitimacy are indeed granted through increasing monitoring and performance management (Bemelmans-Videc, et al., 2007; Feller, 2002; Freeman, 2002) and what this says about trust between people, governments, and organizations (M. Power, 1994, 1997, 2000, 2003, 2005).

There have been reports of the symbolic and ceremonial use of performance measurement systems, and the lack of impact they have on improving performance valued by managers across jurisdictions (Chang, 2007; Feller, 2002).

liberal preference for exercising economic control at a distance through the ‘managerialist’ instruments of accounting, budgetary control, auditing and quality assurance” (M. Power, 2003, p. 191). He contended that this increasing prominence of quality assurance ideas and practices built on older concerns with fraud, waste and abuse inside government, merging them with efforts to focus performance measurement and evaluation on outcomes rather than inputs and processes (M. Power, 2005). He described the general schema of these quality assurance ideas as a loop, where organizations establish objectives, design performance measures to reflect those objectives, monitor actual performance and then feed the results of this monitoring back to management for attention (M. Power, 2000) (see Figure 2).

Figure 2. M. Power’s (2000) General Quality Assurance Model

M. Power drew attention from specific monitoring and reporting parts of the system, towards the push to verify the structure as a whole, and posited that it is the integrity of the entire loop of self-observation and control that is a significant part of the ‘audit explosion’ (M. Power, 2000, 2005). In this way,

The ultimate significance of the audit explosion lies not so much with the rise of formal monitoring in wide and widening areas of social and economic life; it is more to do with the consequent elevation of auditing to an administrative and management style in its own right… [and monitoring and evaluation] as all-purpose solution[s]… for a wide variety of control and quality issues. On this view, the audit is not simply a practice but also a cultural value in which the auditee is the product of a profound transformation of the subject, the construction of an ‘auditable’ professional self. (M. Power, 2000, p. 191)
M. Power (2000, 2005) pointed out how the intensification of monitoring occurred without a critical understanding of these practices and their consequences, and suggested that this may be, fundamentally, an ideologically-driven system for disciplining and controlling professionals in the public sector that were once regarded as experts (such as doctors, teachers, etc.) and not an instrument of genuine accountability. To M. Power (2000), making organizations and the work they carry out ‘auditable’ has had “much to do with agendas for control of these organizations” (M. Power, 2000, p. 114). Performance measurement systems “create and support a window on organizational life, one which is often demanded by outside agencies, and which makes various kinds of internal and external intervention possible” (M. Power, 2000, p. 114). Quality assurance and other performance measurement models express aspirational dimensions of practice, that is, they have not always been closely linked to actual organizational practices, or operational capacity (M. Power, 2000) – in some cases, they may not have even been possible. For example, the prospect of a “light, self-directed audit process, which harnesses productive learning and self-help to regulatory compliance” (M. Power, 2000, p. 117) has been an attractive ideal, but may not be viable for a number of reasons. One of the consequences of these aspirational models has been that imposing standardized monitoring criteria may change or damage the ways in which practice was valued by the people who carry out the work, or those most impacted by it. M. Power (2005) described inconclusive (but increasing) evidence of profound transformations of professional subjects into ‘auditable’ selves no longer sure of their right and capacity to make judgements and whose civic motivation is ‘crowded out’ by excessive monitoring (Shore and Wright, 2000; Frey & Jegen, 2001 cited in M. Power, 2005). A lighter view of the negative consequences of the ‘audit explosion’ viewed it as an expensive, but harmless ritual, which was important to secure external legitimacy (M. Power, 2000). The focus of M. Power’s (2000, 2005) analyses has not been on proving that these negative consequences occur (or measuring their frequency or impacts), it has been to surface the issue of possible negative consequences of the intensification of monitoring and evaluation in the public sector, consequences which he contended have been rendered systematically invisible, denied, or made irrelevant. He has called for a greater understanding of the complex issues in trust between people, organizations, and governments, and for more research about individuals and organizations that have experienced the ‘audit explosion’ (M. Power, 2005).
Bowerman et al.’s (2000) response to M. Power (1994, 1997) provided evidence that there may be more of an ‘audit mess’ rather than a coherent ‘audit society’. Bowerman et al. (2000) drew on academic literature, official and unofficial reports and interviews with auditors, inspectors and auditees across three major public service organizations (health care, police, and schools) in the UK (Bowerman, et al., 2000). They questioned whether ‘audit’ was the most appropriate word to describe the nature of public sector monitoring activity, as it has traditionally been associated with ideas of external verification, independence and public accountability (Bowerman, et al., 2000). Their research showed that public sector organizations in the UK were subject to an intensification of monitoring, but the connections between these activities and external verification and public accountability were a struggle (Bowerman, et al., 2000). They argued that a ‘performance measurement society’ was a more appropriate label for the UK public sector (Bowerman, et al., 2000). The overriding message of their work was that auditing, inspection and performance monitoring were well entrenched, but appeared to be “muddled, uncoordinated and lacking clear purpose” (Bowerman, et al., 2000, p. 96). They asserted that the most fundamental task that remained was to know more about what was being achieved operationally within organizations by monitoring practices, and suggested detailed organizational-based case studies in order to address these questions (Bowerman, et al., 2000). While some case studies of the impact of performance monitoring systems have been completed (see Lehtonen, 2005; Weets, 2011), there remains a limited understanding of the impact of these systems on community-based services. This research study addressed that gap and provided a glimpse into some of the issues related to how monitoring and evaluation may be affecting providers of community-based HIV services at ASOs.

### 2.6.4 Definitions of specific evaluation terms

Throughout this thesis, a number of specific terms are used to describe the evaluation practices that ASOs employed to evaluate their HIV prevention programs, and what influenced these. The definitions of evaluation (which includes monitoring/performance measurement) used in this research study were described in Sections 2.6.1 and 2.6.2. Definitions of other evaluation terms are included below.

**Evaluation practice:** a practice or set of practices that involve developing an action-oriented understanding that assists in the practical reasoning and reflection about a program or activity.
Evaluation practices generate practical knowledge that results in being able to apply the lessons learned. These provide an opportunity to reflect and reason about a program or activity. This definition draws on literature that understands evaluation as ‘assisted sense-making’ (Julnes & Mark, 1998; Mark, et al., 1999, 2000). Evaluation practice aims to capture, make sense of, and assess programs for multiple purposes, such as assessing merit or worth, for oversight and compliance, for program improvement, or knowledge development (Mark, et al., 2000), as well as other purposes. This expansive definition includes monitoring, which is seen as an important subset of evaluation (Görgens-Albino & Kusek, 2009; Hatry, et al., 2004; Patton, 2008).

**Evaluation criteria**: the qualities or attributes of programs that are used to capture, make sense of, assess/make judgments about these programs. Closely related to evaluation criteria are **indicators**: important constructs that were defined and operationalized into evaluative criteria (e.g., indicators of program success) (M. F. Smith, 2005). Indicators can be distinguished as **process indicators** (which focused on the implementation of a program, or providing an understanding of contextual factors that might affect implementation) or **outcome indicators** (which focused on the desired effects or impact of a program on participants – for example, reductions in HIV risk behaviours, increases in HIV and health-related knowledge, etc.) (Donabedian, 2005).

**Formal evaluation**: monitoring and evaluation practices that draw on formal ways of knowing. These include explicit or codified practices that are transmittable in formal, systematic language – evaluative information that can be formulated in sentences, and/or can be captured in drawings or writing (Nonaka, 1994; Nonaka & von Krogh, 2009 citing Michael Polanyi).

**Informal/tacit assessment**: assessments that draw on or build tacit knowledge or experience, usually developed from lived experience. Tacit knowledge has personal quality, which makes it hard to formalize and communicate; it is deeply rooted in action, commitment, and involvement in a specific context (Kothari, et al., 2012, p. citing Michael Polanyi). For a detailed discussion of tacit knowledge, see section 2.1 in this chapter.

**Outputs**: tangible products that results from a program’s activities (e.g., number of workshops hosted, number of condoms distributed) (Mark, 2005). Output measurement can also involve assessing the number and type of people who participated in a program (Mark, 2005). In program logic models, outputs fall between activities and outcomes; outputs should lead to
desired outcomes (Mark, 2005). It has been noted that outputs are more specific than outcomes; measuring outputs is easier and cheaper than measuring outcomes (Mark, 2005).

**Outcomes**: enduring changes due to a program or its activities; they can include changes, results, and impacts that may be short or long term, proximal or distal, intended or unintended, and primary or secondary (Mathison, 2005). Outcomes can be measured at different levels (e.g., individual, organizational, community, policy, etc.) (Mathison, 2005).

**Formative evaluation**: evaluation conducted during the development or delivery of a program, with the intention of providing feedback to improve it; can also focus on program plans or designs (Mathison, 2005). Michael Scriven described this as reporting “to” the program (Mathison, 2005).

**Summative evaluation**: evaluation done at the end or upon completion of a program; typically for the purpose of decision-making (Mathison, 2005). Michael Scriven described this as reporting “on” the program (Mathison, 2005).

**Stakeholders**: people who have a stake or a vested interest in a program (Greene, 2005; Patton, 2008). Wholey, Hatry and Newcomer (2010) define stakeholders as, “individuals, groups, or organizations that can affect or are affected by an evaluation process or its findings” (p.31). Patton (2008) describes that the term has been borrowed from management consulting, and highlights how the process of clearly and explicitly identifying people who can benefit from an evaluation is so important that evaluators have adopted this ‘special’ term for potential evaluation users. General definition of the term are purposefully broad so that the full range of possible stakeholders can be considered; however, Greene (2005) distinguished four groups of people who have a stake in a program: a) people who have decision authority over the program, including other policy makers, funders, and advisory boards; b) people who have direct responsibility for the program, including program managers, and direct service staff; c) people who are the intended beneficiaries of the program, their families, and their communities; and d) people disadvantaged by the program, as in lost funding opportunities – this group could also be seen as including members of the general public, or taxpayers that support public programs (Patton, 2008).
Community advisory committees: comprised of knowledgeable, prominent and credible members in their field of expertise and/or with lived experience of the issues addressed in a program. They provide input and guidance concerning aspects related to the program; their composition is representative of the community participating in the program or implementing it.

Learning organizations: organizations that support learning that results in organizational capacity building (Gill, 2010). Organizational learning is understood as a continuous process of “forming and applying collective knowledge to problems and needs… that helps the organization continually improve, achieve goals, and attain new possibilities” (Gill, 2010, p. 6). Organizational learning supports the process that organizations undertake to understanding and making sense of their programs and their impacts, and to use this knowledge to make decisions about developing, maintaining, modifying or improving them.

2.6.5 Specific evaluation approaches

The field of evaluation includes a plethora of approaches that emphasize different aspects of the process and/or outcomes of evaluation. This section includes a brief review of some of these that are relevant to this research study.

Collaborative and participatory approaches to evaluation have been employed in the community-based HIV response for a number of years. Approaches that value community involvement are often recommended for evaluating community-based HIV programs because these programs are usually collaborative and influenced by social justice issues. Cousins, Whitmore, and Shulha (2012) described collaborative enquiry as an umbrella term for a class of evaluation approaches that involves multiple stakeholders (such as program staff, participants, policy-makers, etc.) in evaluation decision-making or other activities related to evaluation planning and implementation. These include participatory evaluation (motivated by either practical or transformative aims), fourth-generation evaluation and empowerment evaluation (Cousins, et al., 2012) – these are described in more detail below. King (2005) contended that there are multiple origins of these evaluation approaches, and their roots reflect disparate traditions and disciplines which all value the importance of participants interactively studying their own issues, solutions, and responses. King (2005) described four distinguishing features of collaborative and participatory approaches: 1) direct and active involvement of participants in evaluation planning and implementation; 2) a fostering of participant ownership during the evaluation process through a variety of interactive
activities; 3) the role of the professional evaluator as partner, facilitator, or coach; and 4) increasing the evaluation capacity of individuals or organizations through the purposeful use of the evaluation process. The nature of people’s involvement in collaborative and participatory evaluation can range on a continuum from shared responsibility for evaluation activities among evaluators and participants to participants’ complete control of the evaluation process (King, 2005). For evaluations that fall on side of the continuum of shared responsibility between evaluators and participants, it is the nature of the relationship between them that determines whether or not the evaluation is participatory – situations in which the evaluator retains complete control of evaluation decision-making are not participatory (King, 2005).

The actual use of findings derived from evaluations using a variety of approaches (including more traditional as well as collaborative and participatory approaches) has been a topic in the literature for a number of years. A number of authors have discussed the problem that there is an assumption of direct, instrumental use of evaluation finding, whereas this rarely occurs in actual practice (Lehtonen, 2005; Patton, 2008). One of the responses to this is to focus on process use, which considers the impact of evaluation as resulting from “engaging in evaluation thinking and engaging in evaluation processes (in contrast to impacts that come from using specific finding)” (Patton, 1997, p. 111). Patton (2008) described process use as “distinct from the use of the substantive findings in an evaluation report”, and “equivalent to the difference between learning how to learn versus learning substantive knowledge about something” (p. 153). Identified process uses include enhancing shared understandings, program and organizational development, and increasing engagement, self-determination and ownership – these have been particularly associated with collaborative and participatory evaluation approaches (Patton, 1997, 2008). Not all stakeholders may value the process uses of evaluations, but those that do are likely to find collaborative and participatory evaluation approaches attractive because they are embedded in these approaches. Preskill, Zuckerman, and Matthews (2003) contended that collaborative and participatory evaluation approaches:

(a) contribute to participants’ sense of ownership of, and commitment to the evaluation; (b) provide participants with opportunities for learning about effective evaluation practice; (c) results in more useful recommendations; and (d) enhance the use of evaluation findings. (p. 424)
Preskill et al. (2003) suggested that the extent to which stakeholders are involved in a particular evaluation can vary greatly depending on the disposition and capacities of the evaluator and the client, and the evaluation context. The underlying philosophies and histories of these approaches can be traced to the emergence of collaborative and participatory research paradigms that cross a variety of disciplines (Wallerstein & Duran, 2008). Some describe the history of participatory research generally as being based on two historical traditions that represent two distinct approaches: collaborative utilization-focused research with aspirations of efficiency (sometimes called the Northern Tradition) and participatory research for emancipation and social change (sometimes called the Southern tradition) (Wallerstein & Duran, 2008). The Northern tradition is often traced to the intellectual legacy of Kurt Lewin whose work in the 1940s challenged positivist notions of objectivity in research and advocated for practitioner involvement instrumentally to increase the relevance and efficiency of research. The Southern tradition, greatly influenced by the work of exiled Brazilian philosopher Paulo Freire, was proposed as a research method that responds and challenges what Martin-Baró (1994) called the ‘collective lie’ of prevailing ideological constructions of social problems, intended to awaken a sense of injustice that mobilizes everyday people for change (Torre, Fine, Stoudt, & Fox, 2012). Both of these traditions emphasize the active participation of a specified community in the research process with the aim of producing relevant knowledge to help the needs of that community. The community is conceptualized as a group of people who share characteristics or concerns; sometimes, it is understood as a field in which research is undertaken, where the specific needs, problems, and/or interventions within that specified community are the subject of research questions.

Within both the Northern and Southern traditions the level of community participation is often conceptualized as a continuum where different levels of participation are understood as different amounts of community control over the process and outcomes of research (Chung & Lounsbury, 2006). At one end of the continuum is a conventional academic research situation where community members are passive participants in research processes and have little influence over the research process or outcome; the other end of the continuum is conceptualized as an empowering situation where community members work as equal partners with researchers (or are researchers themselves) to define research questions and execute research projects, as well as to determine its applications (Chung & Lounsbury, 2006). On this continuum, sharing power...
(which is conceived of as being achieved through equal partnership between researchers and community members) is thought to a) lead to more accurate research results (Viswanathan et al., 2004); and b) a sense of empowerment among community members, and potential changes in existing power structures that shape health decisions and outcomes (L. Green et al., 1995). In some instances, these two outcomes of participatory research are conflated, with reports of instrumental participatory research (from the Northern tradition) resulting in emancipatory outcomes and social change. Whether or not the differences between instrumental/efficiency and emancipatory paradigms can be merged or reconciled remains a debate (Guta, Flicker, & Roche, 2013). This debate is part of a growing body of academic literature that addresses other related issues in participatory research paradigms, such as the complexities of collaboration (Trickett & Espino, 2004), participation (Cooke & Kothari, 2001), and the limitations related to participatory paradigms in HIV research specifically (Chung & Lounsbury, 2006).

Preskill et al. (2003) contended that many participatory and collaborative evaluations attempt to engage stakeholders in determining an evaluation’s purpose, key questions, and sometimes its design and implementation. Most collaborative and participatory evaluation approaches highlight the instrumental nature of stakeholder involvement, that is, they draw from the Northern tradition and stress the benefits of increasing the utilization of evaluation findings, and/or process use (such as enlightenment, or capacity building). The Southern tradition’s emphasis on ‘giving voice’ and empowering communities to reframe and address issues on their own terms is less emphasized, but elements are visible in some participatory approaches, specifically, in empowerment evaluation. Specific collaborative and approaches are described below.

2.6.5.1 Fourth-generation evaluation

Guba and Lincoln (1989) developed an approach called fourth-generation evaluation in response to what they believed to be inadequacies of previous evaluation methodologies. They posited that earlier generations of evaluation models (which they described as have three distinct generations focusing on objectives, then description, then judgement) lacked intensive stakeholder participation (Guba & Lincoln, 1989; Y.S. Lincoln, 2005). The underlying assumptions to fourth-generation evaluation (which involves intensive stakeholder participation) draws on constructivism, which posits that there is no single reality to which stakeholders respond (Guba
& Lincoln, 1989; Y.S. Lincoln, 2005). In this approach, the interaction between evaluators and stakeholders is considered an interactive epistemological exercise and an epistemological commitment is made to expand the range of audiences that have access to data, information, and interpretations (Guba & Lincoln, 1989; Lay & Papadopoulos, 2007; Y.S. Lincoln, 2005). In fourth-generation evaluation, values are assigned a central role in evaluation activities (Guba & Lincoln, 1989; Lay & Papadopoulos, 2007; Y.S. Lincoln, 2005).

2.6.5.2 Participatory evaluation

Cousins and Whitmore’s (1998) work described fundamental theoretical aspects of collaborative inquiry. King (2005) described how this work differentiated between: a) practical participatory evaluation (motivated by a practical desire to increase ownership of the evaluation process and use of results by involving stakeholders); b) transformation participatory evaluation (which explicitly targets oppressed and disenfranchised groups to become leaders of evaluation to support empowerment, social change and social justice, and c) participatory monitoring and evaluation (described as an ongoing, organic process that makes explicit both the routine oversight of programs as well as more formal studies). Cousins and Earl (1992) built a three dimensional tool for differentiating alternative collaborative approaches along three fundamental dimensions: 1) control of technical evaluation decisions (evaluator vs. stakeholder), 2) stakeholder selection for participation (diverse group vs. homogeneous primary user group), and 3) depth of participation by stakeholders (participation in selected aspects vs. comprehensive participation in technical evaluative processes) (see Figure 3). This tool was intended to help map any given collaborative inquiry project, at any given point in time, by locating its coordinates in three-dimensional space (Cousins & Earl, 1992).
Further developments and critiques of this tool have emerged, but overall, it has been understood as providing a useful approach to measuring participatory evaluation that allows for empirical application in research on collaborative inquiry (Cousins, et al., 2012).

2.6.5.3 Empowerment evaluation


The use of evaluation concepts, techniques and findings to foster self-improvement and self-determination… it is designed to help people help themselves using a form of self-evaluation and reflection. Program participants – including clients – conduct their own evaluations; an outside evaluator often serves as a coach or additional facilitator depending on internal program capabilities. The aim is to try and understand what’s going on in a situation from the participant’s own perspective as accurately and honestly as possible and then proceed to improve it with meaningful goals and strategies and credible documentation. (p. 90)
Fetterman (2002) described an important difference between traditional and empowerment evaluation in that in empowerment evaluation, stakeholders establish their own goals, processes, outcomes and impacts before proceeding to assessing themselves in terms of what they have established. Fetterman (2002, 2005) stressed the importance of communication among stakeholders, and dialogue among stakeholders is one of the most important parts of the empowerment evaluation process. In empowerment evaluation processes, stakeholders and evaluators are considered equals; there is an emphasis on valuing the expertise of program participants and putting them back in the “driver’s seat” (Fetterman, 2002, p. 99). Fetterman (2002, 2005) described three steps to empowerment evaluations: 1) establishing a mission, 2) taking stock, and 3) planning for the future. Fetterman (2002) contended that these steps build capacity in communities, and foster a sense of community among members of a community of practice – common understandings are built through dialogue. Fetterman (2002) described empowerment evaluation as creating a “folk culture of evaluation”, where “people internalize the logic and values of evaluation as they participate in the process of conducting their own evaluations… [this] is often referred to as process use” (Fetterman, 2002, p. 101).

2.6.6 Participatory monitoring and evaluation

Participatory monitoring and evaluation (PME) is an approach in which multiple stakeholders in an intervention (funders, service providers, etc.) work together to decide how to assess progress, conduct data collection and analysis, and take action on their findings (Jackson, 2005). In this approach mutual learning is encouraged. Various stakeholders jointly participate in producing knowledge, and in adjusting the design or operations of programs in light of lessons learned (Jackson, 2005). The participatory monitoring aspect of this approach is mainly concerned with short-term performance assessment of outputs and outcomes; the participatory evaluation aspect is primarily focused on longer term outcomes and impacts (Jackson, 2005).

Jackson (2005) contended that while the purpose of PME may be transformative (with respect to giving voice to marginalized groups), more often PME has been undertaken for more instrumental reasons (i.e., to improve sustainability or effectiveness). PME has been widely practiced at program, institutional, and policy levels in a number of global jurisdictions (Jackson, 2005).
The key 10 steps in PME include: 1) deciding who participates, 2) forming a multi-stakeholder committee or group to lead the process, 3) establishing goals for the PME exercise, 4) identifying key performance issues for assessment, 5) developing results indicators, 6) gathering relevant data, 7) analyzing the findings, 8) preparing the report, 9) sharing the findings, and 10) taking action on the findings (Jackson, 2005). As with other participatory approaches, stakeholder involvement in PME can range from low-level to high-level participation, which would include shared control over decisions and resources (Jackson, 2005). The time it takes to build authentic stakeholder relationships can contribute to the resource intensive (time consuming and expensive) nature of PME; however, proponents of this approach point to how experience has shown that the benefits of this approach significantly outweigh the costs (Jackson, 2005).

2.6.7 Summary of definition of evaluation

A number of definitions of evaluation terms, theories and approaches have been reviewed in this section. This study employed a definition of evaluation that synthesized a number of concepts found in the literature. Evaluation practice was defined as a set of practices that involve developing an action-oriented understanding that assists in the practical reasoning and reflection about a program or activity; this definition draws on literature that understands evaluation as ‘assisted sense-making’ (Julnes & Mark, 1998; Mark, et al., 1999, 2000). In this study, evaluation practice was understood as aiming to capture, make sense of, and assess programs for multiple purposes (such as assessing merit or worth, for oversight and compliance, for program improvement, or knowledge development) (Mark, et al., 2000), as well as other purposes that emerge in practice, for example, to increase critical reflection, or to ‘tell the story’ of a program. This expansive definition draws on literature that positions monitoring as an important subset of evaluation (Görgens-Albino & Kusek, 2009; Hatry, et al., 2004; Patton, 2008). These concepts are summarized in Figure 4.
2.7 Summary

This chapter introduced the literature and theoretical frameworks outside of HIV that relate to this study. First, concepts from broad frameworks and debates in the literature that were relevant to this study were reviewed. These included tacit and explicit knowledge and debates about evidence-based practice. These debates are important to understand because they explain some of the arguments that underpin the CDC technology transfer approach and its critiques.

In this chapter, concepts related to tacit and explicit knowledge were discussed; these terms were defined, and the literature on the contested nature of their relationship with one another was explored. Examples of research on the role of tacit and explicit knowledge in public health practice in Canada were provided. By understanding these debates, the circumstances that HIV practitioners and evaluators currently face can be put in context of larger discourses. For example, the CDC technology transfer approach values explicit knowledge about specific impacts of interventions, whereas the critiques of this approach imply that tacit knowledge has an important role to play, and that this is neglected in the CDC approach. In this study, ideas about tacit and explicit knowledge helped frame the results to the first research questions about how organizations evaluate their HIV prevention programs. For example evaluation practices described by study participants are presented as to whether they drew on (or built) explicit or tacit knowledge, and the ways in which tacit knowledge was used to understand explicit knowledge is described in the discussion section.
In this chapter, debates about evidence-based practice were explored by describing the history of the evidence-based medicine movement, how it developed in response to critiques, and the subsequent the proliferation of evidence-based practice movements in health and social work areas. A particular response to evidence-based practice – community-defined evidence – was introduced; this concept helped frame this research study and allowed for a deeper understanding of how ASOs determined success and the processes in which knowledge and practices reached levels of acceptance.

Following this, the important role that accountability plays in evaluation was described. Accountability is recognized as one of the roots of evaluation, and plays a significant role in motivating and justifying expanding monitoring and evaluation activities in ‘new public management’ trends in the public sector. Re-conceptualizations of accountability due to ‘new public management’ were described. Evaluation for accountability was contrasted to evaluation for learning, and how these may or may not be combined was detailed, as well as identifying a gap in knowledge about the consequences of evaluation for learning becoming part of being accountable in the public sector. These concepts about accountability were important in answering the second research questions about what influences evaluation practice, and they help frame the results and discussion sections.

Models from health promotion and community development practice were explored in section 2.4, particularly those that emphasized social support and networks (Heaney & Israel, 2008; Thoits, 2011), organizational collaboration (Minkler, et al., 2008), and relational aspects of health and well-being (Goldstein, et al., 2009). These are important to understand because of their influence on HIV prevention and evaluation practice at ASOs.

The concept of ‘communities of practice’ was reviewed. The plurality of ways in which knowledge is developed and shared in HIV prevention can be explored by understanding the ASO funders, workers and volunteers interviewed in this study as a community of practice undertaking a joint enterprise with regards to HIV prevention; who are mutually engaged (i.e., they interact with each other in many ways); who develop shared repertoires of common resources of language, styles and routines in which they express their identities as members of a group; and who are involved in situated learning (Barton & Tusting, 2005). This was an important framework used in this study.
Finally, evaluation definitions and theories were discussed. Narrower definitions of evaluation that focus on the assessment of merit, worth, and/or value were contrasted with more expansive definitions. The definition of evaluation employed in this study was described – this expansive view of evaluation frames evaluation as assisted sense-making, aimed at capturing, making sense of, and assessing programs for multiple purposes. The relationships between monitoring and evaluation present in the literature were discussed, and how this research study understood these relationships was described. In this research study, monitoring was considered an important subset of evaluation. Trends in monitoring were reviewed, and definitions of specific evaluation terms that were used in this study were described. Evaluation approaches pertinent to this study were described, focusing on collaborative and participatory approaches such as fourth-generation evaluation, participatory evaluation, empowerment evaluation, and participatory monitoring and evaluation. All of these approaches value process uses of evaluation, which is an important concept that helped frame the discussion and conclusions of this study. A graphical representation of the ways in which evaluation and monitoring were defined and related to each other in this research study was included in Figure 4.

Overall, these ideas, concepts, and frameworks helped frame this research study about evaluation of HIV prevention programs at ASOs.
Chapter 3
Methods

The purpose of this chapter is to outline the methodological approaches I employed in this study, to discuss the rationale for these approaches, and to describe how I implemented them. In this chapter, I provide a description of the underpinnings and principles of qualitative and case study research, including the rationale for a case study approach for this research. I then present the research orientation (constructivism), community-based approach, and methodological framework employed (interpretive description); and describe the research process and my roles as the researcher. I include a description of the setting, data collection and analysis. Finally, I highlight the study’s ethical considerations.

3.1 Qualitative research

Health sciences involve a number of dynamic and complex concerns, and research methods that reflect this complexity are important. One of the ways in which research about health has sought to deal with complexity is a move towards qualitative research approaches. This trend within health sciences has been growing in recent years (Appleton & King, 2002; Bourgeault, Dingwall, & De Vries, 2010; Creswell, 2008; Denzin & Lincoln, 2011; Eakin & Mykhalovskyi, 2005; Faltermayer, 1997; J. Green & Thorogood, 2013; Padgett, 2012; Pope & Mays, 1993, 2008, 2009). The nature and drivers of this growing interest have been the topic of much discussion (Eakin & Mykhalovskyi, 2005; Pope & Mays, 2009). One of the identified drivers is the increasing recognition of the limitations of conventional health research approaches, such as experimental designs and epidemiological surveys, for understanding the experiential, behavioral and social structural dimensions of health and health care (Eakin & Mykhalovskyi, 2005; Pope & Mays, 1993). A more instrumental view presents the contribution of qualitative research in ameliorating the use and uptake of more conventional health research approaches, such as RCTs. In a recent review, O’Cathain, Thomas, Drabble, Rudolph and Hewison (2013) described the potential value of qualitative research for RCTs, including: improving the implementation of intervention research studies, facilitating interpretation of the findings, helping trialists to be sensitive to the human beings involved in trials, and saving money by steering researchers towards interventions more likely to be effective in future trials. Qualitative approaches have been promoted as a complement to quantitative research in several practice areas, such as studies...
of health care quality (Pope, Van Royen, & Baker, 2002) and evaluation of complex interventions (M. Campbell et al., 2000). Qualitative approaches have been used in KTE research (Armstrong, et al., 2007). One sign of the growing significance of qualitative approaches in health research is the dedication of a special issue of the British Medical Journal to this topic in 2008 (see Kuper, Reeves, & Levinson, 2008).

The limitations of conventional quantitative research approaches have been highly evidenced in the field of HIV. The rich contextual data from qualitative research has been recognized as pivotal in understanding the complex social phenomena and socio-behavioural aspects of HIV, for example, the impact of structural issues in people’s everyday lives, and the importance of culture in determining crucial factors, such as risk and negotiation (R. Power, 1998). Insights into social phenomena have had important impacts on the response to HIV and other health care issues. For example, research highlighted the experience of HIV by those living with it, and this was contrasted to biomedical conceptions, which helped reform the ways in which patient populations were understood by researchers and cared for by health practitioners (Mykhalovskiy & Cain, 2008). Qualitative research has also proved valuable in formative research and development of programs, especially in developing a deeper understanding of communities at higher risk for HIV (R. Power, 1998).

The growth of interest in qualitative research has occurred concurrently with shifts in the philosophy of science away from positivism, objectivism, and quantification towards alternatives including post-modern, critical and constructivist viewpoints that value narrative inquiry and other approaches. Thus the epistemological and theoretical underpinnings of qualitative research can vary widely (Eakin & Mykhalovskiy, 2005; Guba & Lincoln, 2000). The adaptability of qualitative approaches is another reason why they can prove to be so useful to health scientists. Qualitative research takes place in natural settings, enabling researchers to “develop a level of detail about the individual or place and to be highly involved in actual experiences of the participants” (Creswell, 2003, p. 181). Qualitative research often uses multiple methods that are interactive and humanistic (Creswell, 2003). The relationship with research participants is emphasized, and sensitivity to the participants of the study and seeking to build rapport and credibility with the individuals in the study are important attributes (Creswell, 2003). Qualitative research is often interpretive, and allows the researcher to filter data through a personal lens that is situated in a specific sociopolitical and historical moment (Creswell, 2003).
The weaknesses and challenges associated with qualitative research have been noted by a number of authors (Creswell, 2003, 2014; Stake, 1995). Qualitative research is often portrayed as subjective, slow, time-consuming, costly, labor-intensive and can produce more questions rather than simply providing answers (Stake, 1995). Other critics note that the mass of data accumulated in case studies and other qualitative approaches is difficult to process, and produces narratives that can “over-persuade” (Simons, 2009). There is discussion in the literature about the generalizability of qualitative research findings (Padgett, 2012). Proponents of qualitative research often address this issue by providing more expansive definitions of generalizability than what is employed by quantitative researchers; qualitative researchers address these issues as transferability and ‘naturalistic generalizations’ (see Maxwell, 2002; Padgett, 2012; Stake, 1995). The extent that these are considered limitations to qualitative research and how to respond to them depends on how they are perceived and interpreted, to some degree, this involves the underlying research paradigm that is informing the critique. For example, the limitations that the subjective nature of this research poses would be different to positivists compared to other post-modern approaches (such as constructivist).

A proponent of qualitative approaches, Flyvbjerg (2006) described all research methods as involving some sort of bias and subjectivity (not just qualitative approaches). Flyvbjerg (2006) contrasted “general, context-independent knowledge or theory” or “neat scientific formulae, general propositions, and theories” that could be generally formalized (Flyvbjerg, 2006, p. 237) with “concrete, context-dependent knowledge” (Flyvbjerg, 2006, p. 224) that offers an in-depth exploration of a complex issue. Flyvbjerg (2006) asserted that from both understanding-oriented and action-oriented perspectives, “it is often more important to clarify the deeper causes behind a given problem and its consequences than to describe the symptoms of the problem and how frequently they occur” (Flyvbjerg, 2006, p. 229). Patton (2002) framed aspects of qualitative research as both a strength and a weakness, and stated,

The human element in qualitative research inquiry is both its strength and weakness – its strength in allowing human insight and experience to blossom into new understandings and ways of seeing the world, its potential weakness in being so heavily dependent on the inquirer's skills, training, intellect, disciple, and creativity. Because the researcher is the instrument of qualitative inquiry, the quality of the results depends heavily on the qualities of that human being. (p. 513)
Overall, qualitative research methods allowed for this research study to explore and generate a detailed understanding about complex phenomena that occur in a real-life setting. It also allowed for me, as the researcher, to draw on my training, skills and intellect to filter data through a personal lens that is situated in a specific sociopolitical and historical moment. It permitted me to be sensitive to the study participants’ lived experiences. Overall, the methods I employed were well suited to derive Flyvberg’s (2006) “concrete, context-dependent knowledge” and offered an in-depth exploration and deeper understanding of the complex issue of evaluation of HIV prevention at ASOs.

3.2 Case studies

Case studies are a practical strategy for research that seeks to understand complex social phenomenon in contemporary real-life contexts; and their usefulness has been recognized by many social science disciplines, including a rich history in public health concerns (Padgett, 2012; Stake, 1995; Yin, 2009). Case studies are an in-depth exploration of a system bounded by time and activity (Stake, 1995). A case is system which has boundaries and working parts (such as a person, organization, or series of related events), and not a generality (Stake, 1995). In a case study, a case is (or multiple cases are) examined over time through detailed, in-depth data collection involving multiple sources of information rich in context (Stake, 1995). Case studies are appropriate when researchers have no control over events and the boundaries between phenomena and context are not clear, which is what health science researchers often find when addressing pressing public health questions (Stake, 1995; Yin, 2009). This method allows for researchers to retain the holistic and meaningful characteristics of real-life events, such as small group behaviour, organizational processes and inter-organizational relations (Yin, 2009). Qualitative case studies concentrate on experiential knowledge of the case and pay close attention to the influence of its social, political and other contexts, which is particularly useful in public health issues (Stake, 2005).

Case study methods involve the collection of a full variety of evidence; this can include documents, interviews and observations (Yin, 2009). In case study research, credibility is established by triangulating the descriptions and interpretations (Stake, 2005). Merriam (1998) described case studies as particularistic, descriptive, or heuristic, where particularistic studies relate to the specific focus of the case, descriptive studies provide a complete and very literal
description of the cases, and heuristic case studies shed light on the examined phenomena, and explain the reasons for a problem, the background of the situation, what happened, and why. Stake (2005) distinguished between intrinsic and instrumental case studies, where intrinsic studies seek to develop a better understanding of a specific case, and instrumental studies examine cases mainly to provide insight or to advance the understanding of an issue. Instrumental case studies can be particularly powerful at unpacking important complex issues that relate to public health questions.

The approach of case studies can vary based on the epistemological underpinnings of a study. Yin’s (2009) approach to case studies relies on post-positivist philosophies and suggests a variety of strategies to deal with concerns of objectivity and researcher bias. In contrast, Stake’s (1995, 2005) approach is commensurate with constructivist philosophies, and strategies to reveal, unpack and manage multiple interpretations of reality are emphasized. The differences in these approaches to case study research are important to note, especially with regards to the role of theory, the role of the researcher, and the ultimate goal of the research.

Post-positivist approaches to case studies focus on explaining causal elements in relationships of interest and the role of theory is more predominant than in constructivist approaches (Yin, 2009). Post-positivist case studies either test or develop a theory using a deductive approach; a thorough review of the literature helps develop propositions which are then tested in the case study (Yin, 2009). The role of the researcher in a post-positivist case study is that of a distanced observer who attempts to remain objective, and steps to reduce researcher bias are recommended (Yin, 2009). The explanatory nature of case studies is emphasized in post-positivist approaches (Yin, 2009).

In constructivist approaches to case studies, the role of theory is not as predominant, and the preference is to describe the complexity of the cases studied, including an understanding of their context (Stake, 1995, 2005). Inductive inquiry strategies are usually employed in constructivist case studies; the more useful questions are constructed once into the research process which involves the researcher becoming immersed in data collection and analysis (Stake, 1995, 2005). The researcher’s role is that of a participant observer (not distanced observer) (Stake, 1995, 2005). The researcher attempts to use interpretive methods with reflexivity in order to carry out responsive data analysis, this includes a recognition of the multiple realities that may exist,
including the researchers’ perspectives (Stake, 1995, 2005). In constructivist case studies, the meanings generated, by the researcher or the reader of the case study reports, are valued (Stake, 1995, 2005). The goals of constructivist case studies differ from post-positivist ones; constructivist case studies are often exploratory or descriptive, and include an understanding of context (Stake, 1995, 2005). The intrinsic interest in the cases that are being studied drive the researcher in constructivist case studies (Stake, 1995, 2005).

I took a case study approach to this research as it is an appropriate method for investigating evaluation of HIV prevention at ASOs. Case studies are appropriate when researchers have no control over events and the boundaries between phenomena and context are not clear (Stake, 1995; Yin, 2009). This is an apt description of evaluation practice at ASOs; as a researcher, I had no control over evaluation practice or other events at the cases I studied. In addition, the complex social phenomena of evaluation practice at ASOs were a situation where the boundaries between the phenomena and its real-life context are not clear. Further rationale as to why I took a case study approach and what it meant for my research is included in section 3.2.2. Further explanation of the constructivist research orientation I took and its impact on the process of carrying out this study are included in section 3.3.1.

3.2.1 Purpose

The purpose of this case study is to expand the understanding of HIV prevention program evaluation at ASOs. Specifically, this study aims to identify evaluation practices related to HIV prevention programs employed by ASOs, and explore what influences these practices. The aim is to contribute to a deeper understanding of evaluation at community-based organizations, which is an area that is not widely researched.

3.2.2 Rationale for methods

In order to develop a deeper understanding of the complex phenomena of evaluation of HIV prevention programs at ASOs, I employed a qualitative constructivist case study method. In carrying out this study, I was informed by community-based research principles, and I used a methodological framework called interpretive description. Each of these elements is described and justified below.
Case studies are an appropriate method for investigating complex social phenomenon in contemporary real-life contexts, especially when the boundaries between phenomena and context are not clear (Stake, 1995); this is an apt description of evaluation of HIV prevention at ASOs. Evaluating HIV prevention at ASOs involves practices and processes that are influenced by important contextual conditions, such as the current state of the HIV epidemic and the political context in which it is occurring, the kinds of funders and program implementers, and other contemporary institutional practices. These important contextual conditions are highly pertinent to evaluation of HIV prevention programs.

As discussed in Chapter 1, evaluation at community-based agencies is a particular area of study that was not widely researched. This paucity of available research, combined with the diversity of stakeholders and types of HIV prevention programs suggested an approach that could accommodate diversity and complexity of multiple voices and contexts, and that was exploratory in nature. Some conventional health research approaches (i.e., experimental designs or epidemiological surveys) would have required me to create study protocols (i.e., interventions or survey instruments) that would have required an over-simplification of complex ideas. Thus, the research method I chose to undertake was as an exploratory qualitative study, taking into account a broad understanding of what constitutes evaluation, the complexity of HIV prevention programs at ASOs, as well as the context of the communities that these organizations serve.

I used an instrumental collective case study methodology to research the evaluation practices employed by two ASOs in Ontario, and to explore what influences these practices. This allowed for me to study the cases with enough depth to describe them in sufficient descriptive narrative so that readers could experience events, validate the conclusions drawn and enable naturalistic generalizations (Stake, 1995, 2005) about HIV program evaluation or evaluation of practice at community-based organizations more broadly.

### 3.3 Research orientation and process

The research orientation, process and role that I took in this study align with constructivism and community-based research. This section describes constructivism, interpretive description and community-based research. In keeping with these approaches, the research process and my roles as the researcher are described.
3.3.1 Constructivism

In this study, a constructivist orientation was employed; this epistemological stance is commensurate with Stake’s (1995, 2005) approach to case studies. The ontological beliefs underpinning constructivism are that reality is relative (i.e., there is no one, singular, absolute reality) and there are local and specific constructed realities (Appleton & King, 2002; Guba & Lincoln, 2000). Constructivism describes a situation in which individuals seek understanding of the world in which they live and work, and develop subjective meanings of their experiences, which are varied and multiple (Creswell, 2003). The aim of constructivist inquiry is deeper understanding where knowledge is seen as “individual reconstructions coalescing around consensus” (Guba & Lincoln, 2000, p. 166). Being informed by this orientation meant that my role as the researcher was to look for the complexity of views rather than narrowing meanings into a few ideas; the goal of the this study was to rely as much as possible on the participants’ views of the situation being studied (Creswell, 2003). In keeping with this orientation, the role of theory in this constructivist case studies was not predominant; I took a reflective stance, and was committed to deliberating on participants’ recollections and records, and not necessarily following the conceptualizations of theorists or audiences (Stake, 2005). As Stake described, “local meanings are important, foreshadowed meanings are important, and readers' consequential meanings are important” (Stake, 2005, p. 450).

As Cain (1993) asserted, “organizations are not monoliths; they are made up of people with different opinions, political orientations, and interpersonal styles” (p.673). Stake’s case study method (1995, 2005) allowed me to capture multiple realities and understandings of the evaluation criteria and practices (and what influences these) held by diverse stakeholders in a community of practice involved in HIV prevention at ASOs. This method also allowed for me to concentrate on the experiential knowledge of the two cases, paying close attention to the influence of the social, political and other contexts in which they are embedded. Further discussion about how constructivism shaped the case study method I employed (in comparison to other case study approaches that are possible) is included in section 3.2).

3.3.2 Interpretive description

The specific constructivist methodological framework I employed in this case study was interpretive description (ID). ID is a qualitative research methodology aligned with
constructivism and naturalistic lines of inquiry (Thorne, 2008). It is a relatively new qualitative methodology, first developed and presented in 1997 by nurse researchers Thorne, Reimer-Kirkham, and MacDonald-Emes (1997). ID aims to generate knowledge relevant for the clinical contexts of applied health disciplines; it proposes organizing qualitative research inquiries around a disciplinary orientation or conceptual frame, in order to address complex experiential questions that are relevant to applied health disciplines (Hunt, 2009; Thorne, 2008). In ID, qualitative design decisions are made in keeping with the nature of the discipline and its questions, and is helpful in meeting the need for new knowledge pertaining to the subjective, experiential, tacit, and patterned aspects of human health experience so that it can be of use in practice (Hunt, 2009; Thorne, 2008). The theoretical and practical knowledge the researcher brings to the project from their disciplinary experience is acknowledged in ID; this perspective extends qualitative description to the realm of interpretation and explanation (Hunt, 2009; Thorne, 2008). ID studies use multiple data sources and an inductive analytic approach; broader questions drive the analysis (instead of line-by-line coding) and constant comparative methods are emphasized (Hunt, 2009; Thorne, 2008). ID draws analytic inspirations from many inductive and interpretivist qualitative data techniques such as grounded theory and ethnographic methods (Thorne, 2008). The findings of ID inquiries are considered “tentative truth claims”; they are ordered to form a coherent professional narrative which experts in the area will acknowledge as persuasive (Hunt, 2009; Thorne, 2008).

There are a number of features of the ID approach that were particular useful for my study. Because ID aims to use a disciplinary orientation in order to address complex experiential questions that are relevant to applied health disciplines, I was able to focus on health policy concepts and frameworks to address the research questions about the complexity of evaluation at ASOs. The practice orientation of ID allowed me to recognize and draw on my professional experience as an evaluator, while still pursuing a rigorous approach to research design and analysis. For more description of the process that led to me using this approach, see section 3.3.4.

3.3.3 Community-based research

Over the past number of decades, participatory paradigms to health research have gained recognition and significance internationally, as well as across a number of disciplines
In particular, community-based research (CBR) has been taken up in various communities affected by HIV in Canada (Flicker, et al., 2009). Some of the principles of CBR underpinned this study, in particular, that working with community members renders research more accessible, accountable, and relevant to people’s lives and work (Israel, Schulz, Parker, & Becker, 1998). Some of the features of CBR are: enhancing the relevance and use of the research data by all partners involved; joining partners with diverse skills, knowledge and expertise in addressing complex problems; improving quality and validity of research by incorporating the local knowledge of the people involved; and having the potential to link across the cultural differences that may exist between partners involved (Israel, et al., 1998).

By taking a community-based research approach, I was able to improve the relevancy of this study. It allowed me to better access and understand a variety of practitioner and community perspectives about evaluation at ASOs. It also paved the way for the findings to be shared appropriately with stakeholders.

3.3.3.1 Community Reference Group

The CBR approach I took in this study emphasized conducting research in community settings (at the ASOs where HIV prevention is carried out), and involving community members in a Community Reference Group (CRG), which included organizational representatives, PHAs and people from communities highly impacted by HIV, and policy-makers. Input and advice from the CRG into key stages of the research process helped to ensure that the project produced results that were relevant to members of the community-based HIV sector. Individuals who were well-respected within the sector were approached to join this group. The CRG included five decision-makers, front-line staff, and other stakeholders (i.e., funders) from CBOs and ASOs in the local area.

The CRG provided invaluable advice and input into key stages of the research process over the course of 4 meetings held in 2011-2013 (see Appendix A for the CRG terms of reference). Individual members’ interests and availability were taken into account; discussions with CRG members occurred during CRG meetings, via email, and during one-to-one meetings that were scheduled when members were not available to attend the group meetings. In particular, the CRG was involved in case selection and guiding data collection (including access to cases, participants and documents and refining interview questions). Discussions I had with members of the CRG in
meetings, via email and in other venues were also invaluable in refining of emerging concepts, verification and validation of the study findings. Overall, input and advice from the CRG helped ensure that the study produced relevant results and paved the way for knowledge to be shared appropriately with stakeholders.

3.3.4 Research process

The research methods I employed in this study were not fixed at the beginning or unchangeable; throughout the process of carrying out this research study, I developed various aspects of the method (this is congruent with an inductive constructivist research orientation, and ID). The initial research questions I posed, as suggested by Stake (2005), provided the conceptual structure of the research, and involved issues that were complex and situated (Stake, 2005). They dealt with the topical concern of evaluating HIV prevention programs at ASOs. Using Stake's (2005) approach, I initially identified the ‘foreshadowed problem’ related to the topic: some literature emphasizes that effective HIV prevention programs change participants’ self-reported HIV risk behaviour; however, ASOs deliver HIV prevention programs within social and political contexts which exert pressure on their work and performance (Miller & Greene, 2005). These pressures could lead to ASOs to focus less on behaviour change, while emphasizing different aspects of what an effective HIV prevention program is or what it achieves.

As the study progressed, I followed Stake’s (2005) suggestion to take note of the issues under development: What kinds of evaluative criteria were valued about specific HIV prevention programs carried out by the community of practice involved in HIV prevention at ASOs? What kinds of evaluation practices were pursued, and what influenced which ones were pursued? This reflective thinking helped interpret patterns of data and reformed the issues as data collection and analysis occurred. It also helped refine the initial research questions I proposed. The initial questions were:

1) How do ASOs evaluate their HIV prevention programs? Specifically, what qualities or attributes of HIV prevention programs are used to make judgments about these programs? How are these attributes or qualities measured? Are these attributes recorded? Are they communicated with various ASO stakeholders? How are they communicated? Who designs and carries out evaluation activities? How often and what evaluation activities are carried out?

2) How do ecological pressures such as institutional controls, host community norms, peer relationships, professionalization and other forces influence evaluation practice and the
judgments of important characteristics and/or value of HIV prevention programs by ASOs?

Throughout the course of data collection, following Stake’s (2005) suggestions, and a process of reflection influenced by my courses and a deeper understanding of the constructivist approach, I realized that shifting the research questions was appropriate. I had originally been influenced by the concepts that Miller and Greene (2005) felt were important – ecological pressures (such as institutional controls, host community norms, and peer relationships) that influenced whether an ASO was likely to take up an externally-developed program, and I included these concepts in the second research question I proposed. However, constructivism allows for an inductive approach, and in carrying out the interviews and preliminary data analysis, these concepts did not strongly emerge, and they did not seem strongly linked to each other in any way. It seems appropriate to shift the research questions to allow for understandings that were emerging from process of carrying out the research. The final research questions were:

1) How do ASOs evaluate their HIV prevention programs? What evaluation practices are carried out? What qualities or attributes of HIV prevention programs are used to make judgments about these programs?
2) What influences evaluation practice and the judgments of important characteristics and/or value of HIV prevention programs by ASOs?

When I first began to develop this research, I did not anticipate using ID as a methodological framework. However, after assessing various qualitative research methodologies, I decided that this framework was a good fit for the questions and aims of this project. For example, ID is aligned with a constructivist orientation, which allows for multiple realities to be explored. ID was developed in order to address complex experiential questions that are relevant to applied health disciplines, and evaluation of HIV programs at ASOs had many complex experiential elements to them. It offered a rigorous approach to research design and analysis that allowed for an acknowledgement of my previous professional practice experience. ID was originally developed to address the needs of nurse researchers; it allows for recognition of influence of a practice orientation on research questions asked. This is one of the features of ID that make it relevant for applied health disciplines beyond nursing, like program evaluation. After reading some work by Hunt (2008, 2009) which successfully applied ID in a study of the experiences of doctors, nurses, and midwives in the particular clinical context of humanitarian work, I felt that this methodological framework could adequately address the interdisciplinary process of carrying out evaluation of HIV prevention activities in ASOs. My professional practice
experience in evaluation and its influence on the research questions pursued is consistent with the ID approach and the goals of this inquiry.

3.3.5 Researcher’s role

The interpretative nature of this research method required that I recognized my role as a research instrument, and explicitly acknowledge and draw from my disciplinary background in program evaluation and community-based research. While understanding that my theoretical and practical knowledge in the area of evaluating HIV prevention is part of the interpretive lens I brought to the project, I also remained attuned to my biases, values, and personal experiences with the research processes employed and issues at hand (Creswell, 2003).

My professional identity has encompassed roles within and supportive of ASOs – as a program evaluator, research consultant, staff member and board member. I have conducted evaluations for multiple HIV-related programs at a number of community-based agencies, and I was an Evaluation Consultant at a public health department on a team that administered the municipal AIDS grants program. My professional experiences involved becoming part of a network of individuals and agencies involved in the community-based response to HIV; some of these professional experiences prompted me to identify a research question that was relevant to both the professional community and the academic literature. My professional experiences facilitated access to organizations and individual research participants; I had pre-existing collegial relationships with some of the individuals I interviewed in this project. As a professional, I have grappled with issues in the current practice of evaluation of programs at ASOs, including developing capacity of frontline workers at ASOs in program planning tools like program logic models, incorporating planning and evaluation into the service delivery context of ASOs, and working with program implementers to develop feasible evaluations that are targeted for specific audiences (i.e., audiences that are internal to the organization vs. the scientific research community). Through these experiences I have come to understand the complex nature of human behaviour related to HIV, the interpersonal and structural conditions that individuals experience that have an impact on their health, how these can affect how service providers understand and carry out their work, and the challenges inherent in HIV prevention. I have been attuned to places where the models, theories and language that researchers and program evaluators use coincide (and disconnect) with those used by other stakeholders involved in
community-based HIV prevention work. As a graduate student, I have assimilated theoretical and empirical bodies of knowledge (described in the previous chapters), course materials, and current practice and issues in health services outcomes and evaluations. This collection of professional and educational experiences formed the interpretive lens that I brought to the entire process of conducting this research project.

Throughout the process of conducting this project, I was attuned to the process of seeking knowledge that was inductively generated from within the data, and developed within the context of that data (Thorne, 2008). Using a research journal, I carefully noted and regularly examined the frameworks and theories that I brought into the study to be aware of the ways in which they were influencing what I saw and heard. I aimed to retain an awareness of the ways in which my disciplinary knowledge shaped the research processes I employed throughout the project. In addition to this reflexive approach, I employed other methods to ensure quality and rigor, such as keeping in frequent contact with my academic committee, and being advised by my CRG.

3.4 Setting

HIV prevention work is carried out in a number of settings. While some HIV prevention programs involve bio-medical interventions, a more common focus is on providing psycho-social support, community engagement and community development programs or services to people at risk of acquiring or transmitting HIV. The scope of this kind of HIV prevention work in Canadian cities is difficult to estimate, given that a number of small community-based organizations (CBOs) deliver HIV-related programs in addition to several more established community health centres (CHCs) and HIV-dedicated ASOs.

The focus of this research was on HIV prevention programs that are based on principles of health promotion and community development delivered by ASOs. Though diverse, ASOs share a common history that they emerged as a community-based response to HIV and AIDS with the intention of addressing the needs of marginalized communities that were particularly affected by HIV (Altman, 1994; Cain, 1993). ASOs are often charged with the dual mandate of providing services as well as promoting social change (Cain, 1993; Miller, 2001), and people who work for ASOs often represent a collective social identity (i.e., gay men, people who use drugs, etc.) or form one in response to being similarly affected by HIV (Altman, 1994). These elements contribute to a unique role that ASOs play in the response to HIV; they are the contextual
conditions that are important to understand when looking at evaluation of HIV programming in depth. Miller and Greene (2005) identified some factors that exert pressure on ASOs’ decision-making: institutional controls, host community norms, peer relationships, and professionalization. Broadly speaking, many ASOs in Canadian cities offer support services for PHAs and prevention programming (which includes education and outreach) for those who are not infected (Cain et al., 2013). The focus of this research was only on their HIV prevention programs as these are complex undertakings in need of attention.

The Ontario AIDS Network’s (OAN) membership includes 44 organizations across Ontario providing community-based HIV prevention and support for PHAs (OAN, 2013). The organizations are geographically diverse, many are oriented towards specific population groups, the mix of HIV prevention and PHA support programs carried out by these organizations varies, and the size of these organizations ranges widely. Sources of funding for these organizations may come from municipal, provincial, and/or federal governmental funds; some organizations may also receive funds from foundations or private donations.

3.4.1 Case sampling strategy and selection

In order to expand the understanding of evaluation in HIV prevention work, this collective case study involved two distinct cases in an urban centre in Ontario: a larger ASO with relatively larger resources for HIV prevention programming and evaluation that serves multiple populations (Case A), and a smaller ASO with less resource endowments for HIV prevention programming and evaluation that targets a specific racialized population (Case B). These organizational characteristics (levels of resources devoted to HIV prevention, organization size and target population) have appeared in research about evaluation and implementation of ‘science-based’ HIV programs at ASOs (Miller, 2001). Focusing on prevention programs at two organizations allowed for the opportunity for intensive study which could capture an understanding of each of the cases’ complexities, which is a strategy advocated by Stake (2005). In addition, reporting on two cases allowed for sufficient descriptive narrative to be offered so that readers could experience the happenings of the case "vicariously and draw their own conclusions" (Stake, 2005, p. 450).

Suggestions on how to conduct case studies on multiple cases differ depending on whether they take a positivist or constructivist approach. Yin’s (2009) positivist approach to multiple or
collective case studies differs from Stake’s constructivist approach (2005). Yin (2009) suggests that multiple case studies rely on replication logic to support the validity of results; replication logic involves selecting multiple cases in order to predict similar results (Yin, 2009). Replication logic is similar to conducting multiple experiments; however, it differs from sampling logic commonly used in surveys or other studies where the prevalence or frequency of a particular phenomenon is determined (Yin, 2009). Sampling logic requires an operational enumeration of the entire universe of potential participants, and then a statistical procedure for selecting a subset of the participants to be studied (Yin, 2009). Inferential statistical procedures are used to establish results that can be assumed to represent the entire universe (Yin, 2009). Replication logic involves selecting multiple cases (where statistical sampling is not possible) in order to predict similar results (Yin, 2009). Stake’s (2005) advice is to choose cases because understanding them will lead to better understanding and perhaps better theorizing about a still larger collection of cases (Stake, 2005). However, cases should not be considered a representative sample. Purposive sampling, building in variety (but falling short of structured representation) guides instrumental case study selection, and selecting cases that offer the opportunity for intensive study and to learn about the phenomena of interest are recommended by Stake (2005).

Using Stake’s (1995, 2005) advice for case selection, the opportunity to learn from the case was of primary importance in identifying appropriate cases. The cases were identified as interesting due to the potential they provided to learn about the phenomenon under study. Case A was identified, approached and consented to participate in the spring of 2011. It was selected because it presented an opportunity to learn about HIV prevention program evaluation in-depth; it was a large organization with a good reputation as an established and credible organization that had a long history in the HIV response. The Executive Director (ED) of the organization was approached with a description of the purpose of the study, the data collection procedures involved, and the commitment required (see Appendix B). Consent was obtained in writing from the ED to involve the organization as a case prior to initiating data collection procedures (individual interviewees also provided informed consent). With the help of the CRG, Case B was then identified, approached, and a letter from the ED confirmed their consent to participate as a case prior to the initiation of data collection at the organization in winter 2011. Case B was selected because it differed in key characteristics of interest from Case A (size, specificity of
target population). For both cases, the purpose of the research was clarified and it was understood that the role of the project or the researcher would not include evaluating any HIV prevention programs at their organizations.

Stake (1995) suggests that by using this method, it is not expected that all potential cases will be represented, but that researchers can have confidence that they will find common problems related to the phenomenon under study and that deep learning about the issue can be achieved.

3.5 Data collection

Data were collected from multiple sources; this is recommended in constructivist case study (Stake, 1995) and ID approaches (Thorne, 2008). The primary method of data collection I employed was one-on-one in-depth interviews. I also reviewed documents that related to program planning and evaluation, and attended some meetings as a participant observer.

3.5.1 Interviews

I conducted interviews with a community of practice involved in HIV prevention at ASOs; this group included EDs, managers, staff and volunteers at ASOs. I also conducted interviews with funders, that is, people who administer government grants that fund community-based organizations to carry out HIV prevention. These funders have close ties to community-based organizations; many of them volunteered or worked in community-based HIV programs before they became government employees. They often share the same values, use the same language, and actively participate in the same discourses related to HIV prevention as people who work at ASOs. There are federal, provincial and municipal government sources that have specific funding streams for community-based HIV prevention. In order to attend to the diversity within this community practice, I used purposive sampling, with an eye towards maximum variation, to select interviewees to be approached. My aim was not to ensure the sample was ‘representative’, but rather to reflect certain kinds of perspectives built from a set of angles of vision whose nature and boundaries could be acknowledged and addressed (Thorne, 2008). The kinds of groupings that were included in the sample were: volunteers, staff and management at the case organizations; funders from municipal, provincial and federal governments. Interviewees’ gender and race/ethnicities’ reflected the populations that the organizations served; I was also attuned to interviewing people with a mix of years of experience at ASOs. Recommendations for whom to
approach for interviews were sought from the CRG, EDs, managers, and staff at the two cases. Some funders also made recommendations about other funders to approach.

In-depth qualitative interviews allowed for elicitation of respondents’ views, opinions, and their frameworks of meaning (Britten, 1995; Creswell, 2003). Interviews allowed for me to ‘control’ the line of questioning, and made it possible for participants to provide historical information (i.e., their experience with HIV prevention programs and evaluation over time) (Creswell, 2003). I used a general interview guide approach (Turner, 2010). In this approach, the interview guide lists issues that will be explored during the course of the interview, and it leaves the interviewer free to explore, probe and ask questions that will elucidate and illuminate particular subjects (Turner, 2010). The advantages of this approach are that it allows the interviewer to decide on how to best to use limited time, and it allows for a systematic and focused approach to the interview while still leaving space to explore topics as they emerge (Turner, 2010). In contrast to other interview methods, this approach can be framed as either too rigid or too flexible. Compared to the informal conversational interview, it is less flexible (Turner, 2010). Compared to the standardized open-ended interview, it can be more flexible, where a more personal approach to each interview is allowed, where asking or changing questions can be based on participants’ responses to previous questions (Turner, 2010). Given the exploratory nature and topic of this study, I felt the general interview guide was the appropriate choice for me to allow for co-construction of rich data with interviewees with multiple professional backgrounds about complex phenomena. The interview guide approach allowed for some structure within the interview around questions and probes about characteristics of HIV prevention programs, evaluation practices and the context or pressures within which these occurred. However, it also offered the flexibility for me to tailor the interview to the professional position the interviewee held (i.e., volunteer, staff, manager, or funder) and to develop rapport, and ask follow-up or probing questions based on participants’ responses to previous questions. This was key to generating and exploring rich descriptions of participants’ views, opinions, and their frameworks of meaning related to HIV prevention evaluation.

I compiled an initial interview guide, and this was reviewed by the CRG; reflection after the first interviews allowed for a refinement of the structure and questions (see Appendix C for the interview guide for ASO staff). All first interviews (N=23) followed this general structure. I conducted follow-up interviews (N=2) with a manager from each case organization who was
responsible for submitting reports to government funders in order to probe more deeply about specific programs and evaluation practices that arose; this allowed for some iteration between data collection and analysis.

I conducted the interviews between November 2011 and May 2013; each was held face-to-face at the interviewees’ office. I approached each interviewee individually and provided them with an information sheet about the study (see Appendix D). Prior to beginning the interview, I obtained informed consent from the interviewee (see Appendix E). Interviews lasted roughly 1 hour and were digitally recorded and transcribed.

The total number of interviewees was 23: 18 were volunteers, staff or management from the case organizations, and 5 were funders (see Table 1 and Table 2).

<table>
<thead>
<tr>
<th></th>
<th>Volunteers</th>
<th>Staff</th>
<th>Management</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case A</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Case B</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3</td>
<td>9</td>
<td>6</td>
<td>18</td>
</tr>
</tbody>
</table>

Table 1. Interview Participants from Case Organizations

<table>
<thead>
<tr>
<th>Funders</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Municipal</td>
<td>2</td>
</tr>
<tr>
<td>Provincial</td>
<td>1</td>
</tr>
<tr>
<td>Federal</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 2. Interview Participants from Government Funding Organizations

The 5 funders included 2 from municipal, 1 from provincial, and 2 from federal governments (all of these funders had funded both organizations) (see Table 2). Of the 23 interview respondents 15 (65%) were male and 8 (35%) were female; 14 (61%) were from racialized communities. The group of respondents was split in terms of experience volunteering and working in HIV: 12 (52%) had 2-8 years of experience and 11 (48%) had 10-31 years of experience.
3.5.2 Document review and participant observation

Reviewing documents and conducting participant observations are ethnographic methods of data collection that allow for insights to be generated from everyday activities; they may also uncover perception or routines of which the participants themselves may be unaware (Mays & Pope, 1995). The use of documents in health research is promoted as an opportunity to become exposed to subjective knowledge or discourses that might enlighten underlying beliefs, opinion, and attitudes about phenomena, and the advantage they offer is that they minimize the extent to which researchers have shaped their construction (Thorne, 2008). Prior (2008, 2010) advocates for a deeper understanding of documents in health research, moving from treating documents primarily as just sources of data or evidence, towards framing them as ‘active agents’ which influence social interaction and schemes of social organization. One of the limitations of using documents is that knowledge of what went into the making of a document is required in order to understand the use to which it ought to be put (Thorne, 2008). In light of this, a document review that focused on the content, production and function of documents related to HIV prevention programming and evaluation was adopted for this study.

I sought out documents that were used to help HIV prevention planning and evaluation at the case organizations and among the funders by asking interviewees for them and by attending meetings; some public documents were also retrieved online (i.e., newsletters). In particular, documents that included monitoring and evaluation information about HIV prevention programs that were discussed in the interviews were requested from all interviewees. The follow-up interviews with both managers at the case organizations involved reviewing some of these documents to get a deeper understanding of their content, production and function.

Documents were received in hard copy or via email and online, and I kept a catalogue of them. I paid particular attention to the documentation required by government funders from the case organizations. While there were some differences in their sources of funding, both cases received support from the same federal, provincial and municipal government HIV-specific grants. OCHART is a collaborative project of the Ontario Regional Office of PHAC and the AIDS Bureau. Programs receiving funding from these sources are required to submit reports using an online system (see www.ochart.ca) every 6 months. A yearly report called View from the Frontlines is produced, and an annual KTE Day is hosted by PHAC and the AIDS Bureau,
with support from the OHTN. Municipal sources require different reports every 6 months. I collected documents related to compiling the data and actual submissions to OCHART; I also collected submissions to municipal sources where relevant. In the interviews with funders, and the follow-up interviews with managers, we discussed OCHART, including the data that are submitted, the reports that are produced, and the role that these play in HIV prevention work. In addition, I attended an OCHART KTE Day meeting as a participant observer.

Other documents I reviewed included annual reports, strategic plans, some program proposals, evaluation reports, evaluation forms, blank client surveys, and forms used to capture outreach work.

In total, about 135 documents were collected, roughly 100 of these related to program planning, monitoring and evaluation. In analysis, documents were reviewed for their content, for example, how they described an HIV prevention program, and what evaluative criteria were included. Documents were also analyzed in how they were produced, and the role they played in the coordination of activities across individuals involved in carrying out HIV prevention, and within the community of practice across organizations. For example, the ways in which data about HIV prevention programs was collected by volunteers and staff and shared with managers responsible for submitting OCHARTs was explored. The role that View from the Frontlines and OCHART KTE Day played in this community of practice was investigated.

The documents provided a source of data that allowed me to supplement, compare, and contrast the data from interviews. Key documents were analyzed using the techniques described in detail in section 3.6. This included coding the documents, identifying themes and linkages using constant comparison methods, and extracting key quotes which are presented in the results chapters.

I attended 5 meetings - 2011 and 2012 Annual General Meetings (AGMs) at both case organizations, and one OCHART KTE day as a participant observer (Angrosino & Mays de Perez, 2000). My field notes included recording some of the events and my responses to the situations I witnessed (Mays & Pope, 1995). In addition, I kept a research journal throughout the duration of the study.
3.6 Analysis

I employed qualitative data analysis techniques that corresponded with constructivism and the ID approach to cases studies (Stake, 1995; Thorne, 2008). The ID approach recommends a concurrent and responsive relationship between data collection and analysis, an emphasis on constant comparison, and an inductive approach where the research strives to go beyond the initial concepts guiding the research during analysis (Thorne, 2008).

I transcribed the initial interviews shortly after they were conducted, and read them multiple times to clarify essential features; throughout this process I wrote reflexive memos about issues that arose (Sandelowski, 1995). As data collection ensued, I worked with 2 professional transcribers; I proofed each transcript that I received from them (Sandelowski, 1995). I used Atlas.ti (see www.atlasti.com), a qualitative analysis software program, to organize the interviews, coding, and reflexive memos. After each interview was proofed and uploaded into Atlas.ti, I read the transcript and wrote an interview synopsis. I returned to these synopses at various stages of the analysis to be mindful of the whole of each interview so as to not lose the coherence of each during the coding process.

Coding facilitated the process of identifying categories and linkages in the data, and exploring relationships and patterns between individuals, cases, incidents and data sources (Thorne, 2008). I began open coding the transcripts by compiling a program inventory for each case. I read all the transcripts, coded and made memos for each HIV prevention program that was discussed. I reviewed documents related to these programs and extracted substantive content for the program inventory memos. This was a form of incident-to-incident coding recommended by the grounded theory approach (Charmaz, 2006). ID promotes the use of analytic maneuvers that borrow from existing qualitative approaches, such as grounded theory and ethnography, in order to work with data so that patterns and relationships become observable (Thorne, 2008). The goal is to inductively build some sort of coherency using an iterative reasoning process that includes an acknowledgement of the implications of understanding pattern and relationships in various ways (Miles & Huberman, 1994 cited by Thorne, 2008). Thorne (2008) described the process as

Remain[ing] mindful… of the obligation to account for the relationship between the technique [used] and the underlying approach to what constitutes knowledge from which it has been extracted.. [which] ensures that attention to technique does not degrade the analytic
process into a collection of empty categories that will have limited usefulness to the generation of new knowledge. (p. 153)

As such, I followed an inductive approach that drew on the processes of grounded theory, specifically, constant comparison, which did not limit the generation of new knowledge.

The program inventory helped guide further data collection, specifically the follow-up interviews with managers and some requests for more documentation from interviewees. I contrasted and compared the programs in the inventories. Initially, the lists of programs in the inventories were named and grouped based on the name referred to them in interviews and documents, and/or the position(s) funded to carry them out. I transformed the list to organize the programs based on their method of delivery (i.e., counseling, workshops, outreach, etc.) and other approaches (i.e., use of volunteers); this helped me analyse which evaluative criteria related to HIV prevention programs were valued by this community of practice. This exercise helped me move beyond the initial concepts and recognize patterns within and across the case organizations. Maintaining the case as the unit of analysis (and not individual HIV prevention programs or methods) helped focus the analysis, and helped develop categories and linkages in the data. I used axial coding as it supported an increase in the level of conceptual abstraction in the analysis (Charmaz, 2006). Once I identified themes, I compiled all the data related to each of them from the interviews and the document review. I identified representative descriptive text in order to describe the extent, depth and nature of the themes (Creswell, 2003). Finally, I wrote individual case descriptions, and then compared and contrasted them. This cross-case comparison captured their similarities and differences. These processes enabled me to interpret the data, in light of the research questions, the extant literature, and other issues that emerged from the research process.

3.6.1 Verification

Preliminary findings were presented at a research conference in November 2012; members of the CRG and interview participants were in attendance and their responses were used to refine the analytic process and the final steps of data collection. Provisional findings were presented at a CRG meeting in May 2013, and individual meetings with CRG members unable to attend were conducted in June and November 2013, prior to the finalization of the analysis. The CRG members were invited to respond to the findings and discuss how consistent these were with their own experiences; the discussions provided insights that were incorporated into the iterative
data analysis process. The aim of this verification process was to increase the trustworthiness of the data analysis.

### 3.7 Rigor

I employed a number of strategies during the study to maintain its rigor; these were employed to increase the trustworthiness of the study (Padgett, 2012).

*Prolonged engagement* is recommended in order to help reactivity to a researcher’s presence, and to reduce withholding information or other respondent biases (Padgett, 2012). I had more than 22 months of varied encounters with participants in this study (including one-on-one interviews, and interacting with them while attending AGMs and other meetings). I employed *data triangulation* to increase the confidence that the findings of the study were trustworthy (Padgett, 2012). Data from interviews were corroborated with data from the document review. *Peer debriefing and support* is recommended to address researcher bias, in order to “keep the researcher honest” (Y. S. Lincoln & Guba, 1985 cited in Padgett, 2012, p. 211). I met with a fellow PhD candidate on a regular basis to discuss my process and progress, this helped me explore and be attuned to my personal biases. *Negative case analysis* is recommended during analysis to promote a critically self-reflexive stance, which enhances fairness and gives equal attention to differing viewpoints (Padgett, 2012). I actively searched for disconfirming evidence during analysis, and I consulted with my CRG on discrepant findings where they appeared. An *audit trail* is recommended in order to adopt a spirit of openness and documentation of the steps taken in data collection and analysis; this can be considered a meta-strategy for enhancing rigor because it documents the other strategies employed (Padgett, 2012). Throughout the duration of the study I kept a journal which detailed the analytic choices I made, and included self-reflexive memos, in addition to documenting my progress.

*Member checking* is recommended as a strategy to enhance rigor, although it raises a lot of questions, and is noted as “one of the more problematic rigor strategies in both theory and practice” (Padgett, 2012, p. 212). There has been some debate as to whether it is appropriate in all qualitative research studies (Bradshaw, 2001). However, current advice is that member checking strategies that enhance verification of findings are important (Morse, Barrett, Mayan, Olson, & Spiers, 2008), and that researchers should use be thoughtful about the member
checking strategies they employ, and that they tailor them to their study appropriately (Sandelowski, 2008). Sandelowski (2008) described member checking as

Research participants are asked to evaluate one or more of the following: whether (a) researchers accurately rendered their experiences that were the target of study, in the service of what Joseph Maxwell described as descriptive validity; (b) researchers fully captured the meaning those experiences had for them, in the service of what Maxwell called interpretive validity; or whether (c) researchers’ final interpretive (e.g., ethnographic, phenomenological) accounts of those experiences do justice to them, in the service of what Maxwell called theoretical validity. (p. 502)

In this study, I used a member checking approach that is consistent with CBR principles, and that was able verify my findings’ interpretive and theoretical validity. I met with the CRG, and invited them to respond to my findings and discuss how consistent these were with their own experiences. The insights these were incorporated into the iterative data analysis process I followed. In addition, discussions with the CRG helped validate my final interpretations.

3.8 Ethical considerations

The research process was conducted in accordance with University of Toronto ethical regulations. Approval was obtained from the HIV Research Ethics Board at the University of Toronto prior to data collection in June 2011, and maintained for the duration of the study (see Appendix F for the letter of approval). I strove to maintain respect for organizations and individuals participating in the study while making research public knowledge (Creswell, 2003).

3.8.1 Consent

There were no deceptive or coercive practices involved in this study. The purpose of this research was explained and was clear to all cases and participants throughout the research process (Creswell, 2003; Simons, 2009). At the outset and throughout the study, efforts were made to clarify that the study purpose was to explore ASOs evaluation practices, not to evaluate any specific programs. Further, it was important that participants understood that their evaluation practices were not being evaluated, judged, or held up to any standard. I recognized that the cases I studied have relationships with funders and other stakeholders that involve reporting
requirements; the data collection techniques I employed uncovered and explored these; and there was the potential that dissonance between what people believe, say, and practice could have been uncovered (Merriam, 1998). Thus, it was important that participants consent to participate, this consent was obtained at the outset, and their willingness to participate was maintained. Participants were informed that they were able to withdraw their participation at any time. A signed informed consent letter was obtained prior to interviews. Participants were provided a copy of their informed consent letter. No honoraria were offered for participating in the study. In addition, permission was sought for access to documents; these were not copied without explicit permission.

3.8.2 Confidentiality

I took steps to conceal the identity of the organizations and the individual participants. However, given the nature of this sector, complete anonymity (which would offer some protection from unwarranted or unfair judgement from unexpected quarters and even agreed audiences) could not be guaranteed (Simons, 2009). The identity of the cases and the senior management interviewed is likely to be deciphered by those familiar with ASOs in Ontario, even though I took steps such as referring to staff positions (and not names) in written reports (Simons, 2009). Given these limitations, I still strove to keep information confidential by maintaining it in a manner that protects the information from release to unauthorized individuals, in order to secure trust and promote the conditions necessary to gather honest and valid data (Simons, 2009).

Individual participant responses were kept confidential. A code was assigned to each participant, and I kept records of each participant’s name, position, their code, and their contact information in an encrypted file, separate from other data collected. I retained all consent forms, which identified participants, and securely stored all study data in a locked filing cabinet, and password protected files on my hard drive.

No data are reported that a participant asked to be kept in confidence. Participants are only referenced in ways that conceal their identity, for example using pseudonyms or other identifiers (i.e., their role). While this does not guarantee anonymity, it reduces the likelihood that individuals and institutions will be identifiable. EDs of the case organizations were provided an opportunity to see how their cases are reported in the dissertation and to respond, if necessary, with what they felt increased the accuracy, relevance and fairness of the information presented.
(Simons, 2009). They were asked to provide this as a written response that would be included in the dissertation, within a specific timeframe (Simons, 2009). This was an important aspect that was discussed with cases as their participation in the study was secured.
Chapter 4
Case Descriptions

This chapter describes the case organizations, and provides a cross-case comparison of similarities and differences between the cases.

4.1 Case A

Case A is a large, established ASO that provides HIV prevention and support services to a number of different populations that have been most affected by HIV. The organization was established in the early 1980s, and was one of the results of community responses and activism related to the local AIDS epidemic at that time. The organization has a history of volunteer involvement in carrying out its work. In addition, it has a history of developing and adopting a number of different kinds of programs and services for their clients (people with HIV and those at risk of acquiring it); the kinds of programs and services it has offered over time have changed with changes in the epidemic. For example, earlier in the epidemic, caregiver support and bereavement services were emphasized. After some time, other programming focusing on health promotion and outreach were developed in response to the changes in the epidemic.

Case A is structured similarly to other registered charitable not-for-profit organizations. It is governed by a membership and a volunteer Board of Directors; membership is not required in order to be a client of the organization (i.e., to receive services, or participate in programs). Operational decisions and management are carried out by the ED and several directors and managers.

The agency has a history of obtaining its funding for all its programs and services from multiple levels of government (both ongoing and time-limited grants) and through private donations solicited by fundraising efforts (see Figure 5). During the 2010/2011 and 2011/2012 fiscal years, a majority (over 65%) of the funding for the agency has come from government and other grants. Grants from the federal, provincial and municipal governments made up the majority of these grants (approx 80%). Of all the government grants received, the largest share was received from the province (approx 70%), followed by the municipality (approx 20%), and the federal government (approx 10%). There were a total of 8 difference sources of governmental grants (5...
from the municipality; 2 from the province; and 1 from federal sources). There were 10 sources of grants that were non-governmental.

**Figure 5. Case A Sources of Funding (2010-2012)**

The organization is similar to others in that its largest expense (approx 60%) is its human resources (salaries and benefits).

The organizational structure, services, and staff are similar to many other ASOs. Most of the staff at the agency carry out programs or services to either support PHAs or provide education, outreach, and community-development programs to communities at risk for HIV within the programs and service umbrella. HIV prevention activities are carried out by a number of different staff members who mainly report to the same manager, though some are spread out across the agency.

### 4.2 Case B

Case B is a smaller, established ASO that has been at the forefront of the struggle to address HIV and AIDS in a specific racialized community since the late 1980’s. Based on their budgets, Case B is approximately one-quarter the size of Case A (see section 4.4.1 below in this chapter for details on cross-case differences). The organization provides support for PHAs, prevention and outreach to various populations (i.e., youth, women, newcomers, etc.) within this racialized
community. While programs and services offered over the years have changed, the organization’s commitment to the health and well-being of their racialized community has been consistent. Their mission involves preventing HIV and improving the quality of life of PHAs from this racialized community.

The organization is governed by members and an elected Board of Directors made up of volunteers from the community. Members attend AGMs; membership is not required to receive services at the organization. Operational decisions and management are carried out by the organization’s ED. The organization’s management has also included a Director of Programs to whom staff report. Volunteer involvement is important in carrying out the work of the organization.

The organization is funded for all of its programs and services by a number of sources; almost all (99%) is obtained through governmental or other grants (only 1% is from private donations) (see Figure 6). During the 2010/2011 and 2011/2012 fiscal years, 75% of the total value of grants received were directly from federal, provincial and municipal government sources, and roughly 25% were from other foundations and grants. Of the government grants received, the largest portion (roughly 60%) was received from the provincial government, followed by 2 sources of federal government funding (25%), and municipal government funding (15%). In the past year, there were 4 sources of governmental funding: 2 sources of federal grants, and 1 source each from provincial and municipal governments. There were 4 sources of grants that were non-governmental. The largest expense of the organization is spent on human resources.
The structure of the organization is similar to Case A and other ASOs where most of the staff deliver support services, HIV prevention and outreach. A very small number of staff are involved in carrying out the organization’s administration; these staff report directly to the ED. HIV prevention and outreach programs are spread out across more than one department and staff in these positions may report to a Director of Programs or to the ED.

The organization’s most recent strategic plan contains four directions; none of these are specifically related to HIV prevention. Programming and services related to both prevention of HIV and support for PHAs are mentioned specifically in two of the directions. In the strategic plan, a list of programs and services is included to set the context for the agency’s directions. This list includes both PHA support and HIV prevention activities that have been carried out over the past five years.

### 4.3 Cross-case similarities

While these two organizations are distinct from each other in terms of size and their target population, they share some important characteristics.

Both organizations rely on multiple funding sources, including government grants, grants from foundations and other non-governmental sources, and donations from individuals. Government
funding comes from multiple government sources, including different levels of government (municipal, provincial, and federal), as well as multiple sources within a specific level of government (i.e., multiple funding streams from the municipal or federal governmental sources, some which are specific to HIV, and others which are not). This results in a number of requirements to be fulfilled by these agencies to respond to each funder’s needs as each granting agency has specific requirements with regards to program proposals, monitoring and evaluation. A number of performance monitoring activities, based on each governmental source’s requirements, is carried out. In addition, both organizations make efforts to present information about the work they carry out to their respective members and donors through annual reports and newsletters.

The work at both organizations is informed by principles of health promotion, which emphasize an understanding of HIV within a social determinants of health framework. HIV prevention work is important, but not an entirely distinct activity from other activities that the organization carries out such as support for PHAs, and other community development initiatives. For example, while both organizations have departments where HIV prevention workers are clustered, other parts of the organization also carry out HIV prevention programming. Therefore, everyone involved in HIV prevention may not report to the same manager, and all HIV prevention work is not captured in a distinct report. In addition, HIV prevention initiatives are not solely focused on preventing the acquisition of HIV by people who are currently uninfected; they are often designed to include PHAs.

### 4.4 Cross-case differences

A cross-case analysis of the data collected showed differences between these two cases. For a summary of these differences, see Table 3 below.

#### 4.4.1 Size

Case A is a larger organization than Case B. Case A’s revenues and expenses are approximately four times larger than Case B’s. There is double the number of staff and more management positions at Case A compared to B.
4.4.2 Target population

Case B’s focus is one specific racialized community, but within this community, there is a diversity of populations based on age, gender, sexual orientation, substance use, Canadian residency status, etc. Case B focuses its work on these populations within their racialized community. Case A does not serve a specific racialized community; programs and services are targeted to multiple populations based on characteristics such as age, gender, and language. In their most recent strategic plan, Case A specified some specific priority populations.

4.4.3 Approach

Both Case A and B used specific language to convey their mission and focus in their most recent strategic plans. Based on these terms and data from interviews and documents collected, specific themes that related to elements of health promotion and community development principles were noted. Currently, at Case A, an asset-based approach is presented as a belief and ideal in their work. In this approach, assets could be described as the collective resources which individuals and communities have at their disposal; these are understood to be protective against negative health outcomes and promote health status (Glasgow Centre for Population Health, 2011). An asset based approach makes visible and values the skills, knowledge, connections and potential in a community; it is a response to the shortcomings of taking a ‘deficits’ or ‘treatment’ approach to the delivery of public health and other social services (Glasgow Centre for Population Health, 2011). Interview participants had divergent views as to whether this approach was currently applied in practice; but the concept was frequently cited.

Comparatively, Case B emphasizes an approach that puts primary importance on the fact that the response to HIV in their racialized community is being addressed by members of that racialized community. This approach is one of the pillars in health promotion; community action is recognized as one of the foundations of health promotion in the Ottawa Charter for Health Promotion (WHO, 1986), a seminal document that describes the main concepts and principles of health. Care for individuals and groups from the community, provided by the organization’s management, staff and volunteers who are from the community, and a commitment to this ideal, is emphasized as one of the strengths of the organization in their work.
4.4.4 Monitoring and evaluation

At both organizations, the capacity of the specific individuals involved in carrying out an HIV prevention program (i.e., managers, staff, and volunteers) had an impact on program implementation, monitoring and evaluation activities. At Case A, the capacity of these individuals had a notable, but modest impact on the kinds of monitoring and evaluation activities carried out. At Case A, there were organizational supports, systems and structures in place so that the monitoring data required to run and report on many programs were already setup and in use. These would remain even if an individual left a position and a new person was hired. Therefore, new staff or volunteers could be trained on the existing monitoring and evaluation systems and structures, and their capacity (or lack of it) only had a modest impact on a program’s implementation, monitoring or evaluation.

In contrast, Case B was very dependent on the capacity of individuals who hold staff and management positions in their program implementation, monitoring and evaluation activities. Some of this is tied to Case B’s smaller size, which is related to less organizational systems and infrastructure. It may also relate to the age of the organization and/or the funders, and type of funding available, for example, funding which provided less support for monitoring and evaluation organizational development. At Case B, staff with strong evaluation or research interests began initiatives that greatly increased the monitoring and evaluation of specific programs. These initiatives were not sustained as individuals left positions at the organization; the capacity of the new staff hired had an impact on what program implementation, monitoring and evaluation activities were pursued.

<table>
<thead>
<tr>
<th></th>
<th>Case A</th>
<th>Case B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Size</strong></td>
<td>Larger</td>
<td>Smaller</td>
</tr>
<tr>
<td><strong>Target population</strong></td>
<td>Multiple populations</td>
<td>Specific racialized community</td>
</tr>
<tr>
<td><strong>Approach</strong></td>
<td>Asset-based approach</td>
<td>By the community, for the community</td>
</tr>
<tr>
<td><strong>M&amp;E</strong></td>
<td><em>Somewhat</em> dependent on individual staff capacity</td>
<td><em>Very</em> dependent on individual staff capacity</td>
</tr>
</tbody>
</table>

Table 3. Differences Between Case A and B
Chapter 5
Results: Overview

The purpose of this study was to expand the understanding of HIV prevention program evaluations conducted by ASOs. In order to contribute to a deeper understanding of evaluation at these organizations, this study aimed to identify evaluation practices related to HIV prevention programs employed by ASOs, and explore what influences these practices. Answers to questions about HIV prevention program evaluation practices and criteria, and what influences these at ASOs are not simple or clear-cut.

This chapter provides an overview of the results that are presented in more detail in Chapters 6, 7, and 8. Because it is an overview, participants’ quotes and excerpts from documents are not included in this chapter. Detailed explorations of the themes of complexity, plurality and relationships are included in Chapters 6, 7 and 8; these chapters include representative quotes from participants and excerpts from documents reviewed.

The first research questions for this study were: How do ASOs evaluate their HIV prevention programs? What evaluation practices are carried out? What qualities or attributes of HIV prevention programs are used to make judgments about these programs? Answers to these questions revealed that evaluation practices and judgements about programs were complex and plural. Chapter 6 and Chapter 7 explore the themes of complexity and plurality in detail; these themes are introduced below in section 5.1.

The second research question was: What influences evaluation practice and the judgments of important characteristics and/or value of HIV prevention programs by ASOs? Influencers are introduced below in section 5.2. Answers to the second research question revealed that relationships were an important theme in evaluation practice. Chapter 8 explores the theme of relationships in more detail.

5.1 How do ASOs evaluate their HIV prevention programs?

This study revealed a number of different answers to questions about HIV prevention programming and the evaluation practices related to them at ASOs. While there may have been
many ways of presenting this study’s data, the themes of complexity and plurality emerged during analysis. These themes addressed the first research questions about how ASOs evaluate their programs and the qualities of HIV prevention programs that are used to make judgements about them. These themes are introduced here and explored more fully in Chapters 6 and 7.

Broadly speaking, these two cases showed characteristics of learning organizations (Gill, 2010); they employed various kinds of evaluation practices to assist in the process of understanding and making sense of their programs, and used this knowledge to make decisions about developing, maintaining, modifying or improving them. Evaluation practices were used at different stages of organizational and program life cycles, where appropriate. For example, formative evaluation techniques such as needs assessments and/or consultation with key stakeholders were employed for program development, and process monitoring techniques such as tallying condoms distributed or reviewing post-workshop participant feedback forms were employed during program implementation. Formal summative evaluation techniques were generally not used to review programs.

5.1.1 Complexity

At the ASOs in this case study, the organization and delivery of HIV prevention work was not straightforward – prevention programs and activities were not discrete or distinct from other kinds of work these agencies carried out. These other kinds of work could include providing psychosocial support for individuals with HIV, capacity building for communities impacted by HIV, and/or research and knowledge development. In addition, the size and scope of programs were immensely varied at these ASOs, ranging from something as large as an initiative that involved workers from across multiple agencies, to something as small as a series of workshops that one worker carried out (for more details see Chapter 6, section 6.1.2). These characteristics are important to consider when understanding the complexity and plurality in evaluation practice. These ASOs evaluated their HIV prevention programs in a variety of ways, specifically: one-time discrete formal evaluations, routine monitoring, and tacit assessment (for more details see Chapter 6, section 6.2).

Large, more extensive and formal one-time evaluations sometimes occurred; this depended on funding and human resources. These usually employed formative evaluation techniques, when a new program was being designed, or a pilot program was being assessed. ASO program staff led
some of these evaluations; in these cases, convening and/or consulting with community advisory committees or other stakeholder groups was common. In some rare instances, programs were developed by ASO staff, managers or volunteers working with academic researchers and/or potential funders; it is only in these rare circumstances that quantitative outcome assessment was employed to determine aspects of a program’s impact (for more details see Chapter 6, section 6.2.1).

There was a difference in the number of formal evaluations compared to routine monitoring: one-time discrete formal evaluations occurred much less frequently than routine monitoring, which was a common practice (especially monitoring for government funders). Each grant received from government bodies or other sources had their own monitoring requirements that were fulfilled. The program activities that each of these grants supported were reported to funders on a six-month or yearly basis, and varied from brief to longer descriptive narrative reports, usually focusing on outputs and qualitative description of activities; each reporting tool had its own internal logic that captured details about programs as required by the specific funder.

In addition, all the agencies’ activities were captured in OCHART every six months. OCHART was an intricate and interconnected system which involved collecting a variety of agency data, submitting it using a complex online system, and reviewing and discussing the data with OCHART administrators (PHAC, the AIDS Bureau and the OHTN) and representatives from other ASOs. A number of interactions were involved within the agencies to collect data; the process of gathering data and inputting it into OCHART had some routinized, and some less standardized elements at both case organizations. In addition, a number of interactions were involved in making meaning of the data; data input into OCHART from each agency was amalgamated by OCHART administrators, presented in a yearly report called View from the Frontlines, and presented at an annual OCHART KTE annual meeting which managers from ASOs attended. These provided opportunities for this community of practice to develop shared meanings, engage in collective sense-making, and socially construct knowledge and evidence about community-based HIV work. Compared to other reporting systems, OCHART required more effort to learn and maintain; it also provided more information back to ASOs and opportunities for negotiation and relationship building within the community of practice and among others involved in organizing and delivering of HIV prevention services at community-based organizations. The OCHART system, in addition to other reporting requirements, and the
relationships between explicit evaluation practices and tacit assessments added to the complexity of monitoring and evaluation practices.

Evaluation practices were usually carried out informally, using tools or methods that were developed locally, and were highly dependent on the program staff’s evaluation skills. Some of the evaluation practices at these ASOs involved applying and building tacit knowledge, and were not recorded. The combination of tacit assessments, along with explicit monitoring and evaluation techniques made evaluation practices complex and plural (for more details, see Chapter 6, section 6.2.3).

5.1.2 Plurality

The participants in this study described a number of qualities or attributes of HIV prevention programs that were used to make judgments about these programs. As described earlier, HIV prevention work was difficult to classify, and the size and scope of programs varied a great deal; also, the specific HIV prevention activities or methods of delivery employed by programs differed substantially. Indicators of program success differed based on which specific activities or methods were employed. For example, indicators of program success for brief outreach encounters in a bar (for example, number of outreach contacts made and condoms distributed, and increases in awareness about safer sex issues) were different than indicators of success for a longer, more engaged, multi-day retreat with people from a group at high risk for HIV (for example, level of participant engagement, increases in rates of intention to practice safer sex, and participant reports of increases in self-esteem or personal change). However, substantial evaluation of specific HIV prevention activities or methods of delivery (i.e., just outreach or multi-day retreats) was not common at these ASOs. In OCHART, HIV prevention activities were not distinguished from other activities (such as support services for people living with HIV), and generally, outputs were emphasized in View from the Frontlines.

In addition, multiple indicators of success were valued by participants in this study, including indications that programs were delivered in ways that were congruent with underlying principles of health promotion and community development (process indicators) as well as indications that the programs had the desired impact on participants (outcome indicators). Overall, multiple evaluation criteria for HIV prevention programs at these organizations were valued, contributing
to the plurality of monitoring and evaluation practice (for more details see Chapter 7, section 7.1).

Across many different methods of program delivery, one of the process indicators that was repeatedly cited as important was popularity. Popularity had multiple components: the number of participants reached (especially among people from communities that are overrepresented in the HIV epidemic); the engagement of participants in program activities; and whether the program was recognized within an agency, or more generally across other organizations involved in delivering HIV prevention programs. These aspects of popularity were captured both quantitatively and qualitatively, with emphasis on qualitative and tacit assessments (for more details see Chapter 7, section 7.1.2).

In addition, outcome indicators were valued by this community of practice, even though they were difficult to quantitatively capture. Outcome indicators discussed by respondents included: reductions in HIV risk behaviours, increases in HIV and health-related knowledge, reductions in social isolation and HIV-related stigma, and increases in relationships, capacity and resiliency related to health and well-being. Some outcome indicators that were valued were hard to attribute solely to HIV prevention programs or ASOs work. Many of the assessments for these outcomes were carried out informally, and were based on tacit knowledge or experience. Some more formal monitoring and evaluation techniques to capture outcomes were occasionally employed. However, there were challenges with identifying and implementing appropriate techniques, and securing the required resources to measure outcomes. Formal outcome indicators of program impact were considered valuable, but systematically collecting these was deemed out of the range of possibility for most programs or agencies, in light of their program delivery mandates and other organizational responsibilities (for more details see Chapter 7, section 7.1.3).

There were a number of audiences for evaluation results; these added to the plurality of evaluation practices at these agencies (for more details see Chapter 7, section 7.2).

In summary, this study revealed a number of different answers to questions about evaluation practice and the qualities of HIV prevention programs that are used to make judgements about them at ASOs. The ASOs in this case study evaluated their HIV prevention programs in a variety of ways. Evaluation helped them make judgements about their programs, as well as assisted them
in making sense of their work, as organizations, and as a sector. While there was no clear pre-determined evaluation framework that was articulated by the organizations, generally speaking, judgments and sense-making were based on a number of assessments that were occurring concurrently, including: discrete one-time evaluations, routine monitoring, and tacit assessments. There was an emphasis on routine monitoring (specifically OCHART) and tacit assessment, which was implicit in most service delivery decisions, as well as being involved in making sense of information derived from other evaluation practices. A variety of evaluative criteria about HIV prevention was valued. Overall, the monitoring and evaluation practices at these organizations were marked by complexity and plurality. More detailed descriptions of these themes, including representative quotes from participants, are included in Chapters 6 and 7.

5.2 What influences how ASOs evaluate their HIV prevention programs?

This study revealed a number of different influencers of evaluation practices and criteria, but no clear model or framework within which they all fit. These included:

- the pressure for accountability to funders;
- the capacity to carry out formal evaluation coupled with the perspective that tacit knowledge may be sufficient;
- and aspects of the health promotion and community development models that underpin practice.

While there may have been many ways of presenting this study’s data, the theme of relationships emerged during analysis. This theme addressed the second research question about what influences how ASOs evaluate their programs. The identified influencers highlighted the important role that relationships between individuals and groups played within this community of practice. These influencers are introduced in this section, and discussed in more detail in Chapter 8.

The **pressure for organizations to be accountable to funders** was noticeable, and this influenced monitoring and evaluation practices and criteria at the cases studied. This influence was stronger on monitoring practices and criteria; even when some funders allowed for interaction and negotiation, funders had the final say in the design and content requested in the
routine monitoring reports they required. Accountability issues also influenced evaluation practices and criteria to a certain extent; however, evaluations were usually designed and undertaken in specific circumstances with a less routinized approach, tailored to those circumstances, and had a more developed focused on learning (and less emphasis on providing data for oversight or compliance to higher authorities). The importance of accountability was particularly highlighted when allocating and spending government funds (compared to funding received from foundations or through private donations). Members of this community of practice described that they felt that a higher degree of reporting was expected by the general public about how ASOs spent public dollars and the activities on which they spent those dollars, compared to the kinds of stakeholders involved in foundations or private donations. There was ongoing discussions and tensions about how much monitoring should be required by government funders, especially what was an ‘appropriate’ or ‘right’ amount. This highlighted the dynamic relationship between individuals that work at these agencies and the government departments that provide HIV-specific funding.

The interaction between monitoring and evaluation for accountability, and monitoring and evaluation for learning was not clear-cut. For example, although the primary purpose behind the OCHART system was accountability (for oversight and compliance), program improvement was stated as a secondary goal, and some aspects of the system were designed for that purpose (i.e., the facility to request special OCHART data tabulations, and much of the facilitated discussion at OCHART KTE days). In addition, government funders required some display of program change or improvement in their reports; federal, provincial and municipal funders required agencies to report about a number of details beyond quantitative outputs (i.e., program participant feedback, outcomes observed, trends, etc.) and any changes that would be pursued based on these. However, respondents at both of these agencies did not cite OCHART or other government funding reporting as practices that increased their learning in significant ways. For the most part, respondents reported that they were carrying out monitoring practices in order to be accountable and maintain good relations with their funders. When these agencies wanted to learn, other assessments were conducted for that purpose.

Accountability to stakeholders other than government funders, such as members of the agency, was less clearly defined. There were some differences in monitoring and evaluation criteria that were valued when reporting to members (in annual reports or at AGMs) compared to criteria
valued by funders. Annual reports contained some similar data about program activities and outputs that were contained in government reports (i.e., number of program participants, number of volunteer hours, etc.) and included details about audited financial statements that were similar to financial reports submitted to government funders. However, the emphasis on these data was minimal in annual reports, and information about mission, vision, and other agency planning was emphasized. At AGMs, more engaged discussions among members related to the make-up of the Board of Directors and current social issues (for example, at Case B, immigration policy and practice spurred an engaged discussion at an AGM). Monitoring and evaluation practices seemed to have a less important role to play in maintaining the relationships between these agencies and their members, when compared to managing their relationships with government funders.

Another influencer of evaluation practice and criteria was the capacity (including financial and human resources) to carry out formal evaluation and the perspective that tacit knowledge held by program implementers may be sufficient. Monitoring and evaluation required capacity and resources, such as: skills in data collection, analysis, reporting, planning and supervision; time; and financial support. Competition for these resources between supporting programming or supporting monitoring and evaluation efforts were noted. The capacity and resources available for monitoring and evaluation varied at different times within an agency, among individuals, and across agencies. For example Case A was larger and had better infrastructure to support monitoring and evaluation; whereas Case B’s evaluations were more dependent on individual staff’s capacity and interest in evaluation. However, both agencies were able to conduct more extensive evaluations of programs at critical moments when they had secured the time and financial resources to do so, in addition to carrying out their program delivery and monitoring responsibilities. However, insecurities about the kind, amount and quality of monitoring and evaluation practices were reported by respondents at both case organizations. The need for more evaluation, or improvements in the quality of evaluations was a contested issue among respondents. Some respondents identified the need for more supports for community-based organizations to carry out additional and higher quality evaluations.

In some instances, a program deliverer’s tacit knowledge or lived experience as a member of the group that their program was targeting (i.e., young gay men, women from a racialized community, etc.) was seen as adequate in order to judge the merit or worth of a program (including its activities, or its impact). In these cases, large amounts of more formal monitoring
or evaluation data were not considered a good use of limited resources, or not necessary. However, some respondents spoke of the disconnections between their identity or lived experiences and the groups their programs were targeting, how they employed further assessments with program participants or other stakeholders to judge how their programs were being received, and the limits of tacit assessments. For example, a young woman delivering a program to HIV-positive youth discussed how involving an HIV-positive peer facilitator would help her assess how the program was being received by participants. It is important to note that in these cases, more formal monitoring or evaluation practices were not entirely abandoned. However, their role was secondary, or supplemental to tacit assessment and knowledge building. This highlights important issues related to the relationship between tacit and explicit knowledge in this community of practice.

Finally, aspects of the health promotion and community development models that underpin HIV prevention practice at these agencies were also important influencers of evaluation practice and criteria at these ASOs. Health promotion and community development models emphasize the importance of relationships between individuals and groups that promote health and well-being (Heaney & Israel, 2008; Thoits, 2011). They also emphasize collaborative relationships within communities of practice (Glanz, et al., 2008; Minkler, et al., 2008).

Across diverse HIV prevention activities and programs carried out at the organizations in this case study, establishing, maintaining or strengthening relationships among individuals from communities at high risk for HIV that promote health and well-being was highly valued, and often cited as a key measure of success of a program (even when it was difficult to measure quantitatively). Building or strengthening relationships between individuals and organizations, such as ASOs or other social service programs or services (such as sexual health clinics, services for substance users, etc.) was also highly valued as a key indicator of success. In addition, building or maintaining collaborative relationships between individuals who worked at ASOs, or between ASOs and other organizations, was also another key indicator of success. All of these relate to the concepts of social capital, social networks and social support that are found in health promotion and community development models that seek to capture dimensions of programming that may ameliorate individual and community health, and led to a focus on these types of outcomes, either explicitly, or implicitly. This demonstrates that the relational aspects of health
promotion and community development models influence the indicators of success considered key by these agencies.

Another interesting facet about relationships within this community of practice and how they are associated with monitoring and evaluation is the role that monitoring and evaluation practices played in maintaining relationships between agencies and their funders. Some of the funders’ monitoring of programs occurred during the course of back and forth exchanges between program implementers and funders. The content of monitoring or evaluation reports was valued less than these exchanges. Monitoring happened through the relationship between people who worked for departments that provided government funding and program implementers at ASOs and through the process of back and forth discussion throughout the period of time that programs were funded, rather than the actual numbers that end up being reported in OCHART. However, the practice of submitting reports, and attending events (such as OCHART KTE day) were considered important in building and maintaining a positive relationship with funders, and a collective, socially constructed knowledge and evidence base among this community of practice. While the data presented in reports was of use for only a small and limited number of tasks, the relationship building and maintaining aspects between funders and agencies was noteworthy.

Overall, HIV prevention program evaluation practices and criteria at these organizations were greatly influenced by issues related to relationships between individuals and groups. More detailed descriptions of this theme, including representative quotes from participants, are included in Chapters 6, 7, and 8.
Chapter 6
Results: Complexity

The HIV prevention work and associated evaluation practices at the ASOs studied were complex. Some of the complexity of HIV prevention work and evaluation at these organizations might be similar to issues that other health promotion and community development initiatives tackle (Glanz, et al., 2008). In addition, literature on the complexity of HIV prevention work (Piot, et al., 2008; Wright, 2003) and issues in classifying HIV programs and activities (Akers & Hervey, 2003) allude to some of the specific issues that these case organizations contended with in carrying out and evaluating their HIV prevention work.

This chapter explores features of the complexity of HIV prevention work and evaluation practices at the two cases and provides examples from case documents and interviews. It begins with a description of two of the features that made HIV prevention practice complex: the lack of clear distinction between HIV prevention and other agency activities; and the difficulty in defining or classifying HIV prevention work. An overview of different evaluation activities which shows the complexities involved in evaluation practice follows. These evaluation activities included discrete one-time evaluations, formal routine monitoring and tacit assessment. How these evaluation practices were connected (or not) with each other is explored, as these have implications on the complexity of evaluation practice.

Evaluation at these organizations was complex in that the practices and evaluative criteria employed were intricate, with many connecting parts. There were also several evaluation systems that were intended to be connected to each other, but did not, in practice connect or inform each other well.

6.1 Complexity of HIV prevention practice

Respondents described their HIV prevention work as complex. As a manager stated,

Prevention is a complex issue. How people think about engaging in choices or making different choices, isn't just about having a condom available. It's, you know, 'How do I talk about my body? How do I talk about my history? My sexuality? My, my belief around sexuality?' You know, all that impacts prevention. (Manager, AM06).
Two features that made the HIV prevention practice complex were the lack of clear distinction between HIV prevention and other agency activities; and the difficulty in defining or classifying HIV prevention work. These are described in the next two sections.

6.1.1 Lack of distinction between prevention and other activities

The organization and delivery of HIV prevention work was not straightforward at these organizations. At both organizations, HIV prevention programs and activities were not discrete or distinct from other kinds of work the agency carried out, for example, providing psychosocial support for individuals with HIV, capacity building for communities impacted by HIV, or research and knowledge development. In agency documents, such as annual reports and strategic plans, HIV prevention programming was not captured separately from other agency activities.

This lack of distinction of HIV prevention work was also noted in the way staff were organized and managed; while both organizations had a department where most HIV prevention staff members were clustered, other parts of the organization also carried out HIV prevention programming or activities. Staff members who carried out prevention were in different departments and did not report to the same supervisor; in addition, their positions were funded by different funders.

HIV prevention work was carried out by a number of people at these agencies, including paid managers and staff, and unpaid volunteers. The HIV prevention program responsibilities carried out by managers included program design, supervision and reporting to funders. Staff were responsible for carrying out program activities, and were also involved in program design and reporting. Roles and responsibilities for volunteers varied widely. Several HIV prevention programs involved training and supervising a number of volunteers – some staff supervised one or two volunteers that occasionally helped them with their programs, others supervised 10-20 volunteers that were essential to carrying out the HIV prevention program as it had been designed. Volunteer training and management was a large element of these staff positions. The differences in how many volunteers, staff and managers were involved in carrying out an HIV prevention program, and what their respective roles and responsibilities were, added to the complexity of HIV prevention work at these agencies.
Another layer of complexity involved the kind of prevention pursued by a program. HIV prevention initiatives were not often distinctly focused on preventing the acquisition of HIV by people who are currently uninfected (sometimes referred to as primary prevention); many included PHAs in their HIV prevention programs (sometimes referred to as secondary prevention). This was seen as a strength of a program. As a staff member described,

We also included HIV positive young men [in our structured HIV prevention program]…

That was also helpful. (Staff, BW12)

Integrating primary and secondary prevention has interesting implications and added a level of complexity in evaluation. For example, a program that only engages in primary prevention with individuals from communities at high risk for HIV acquisition might be able to monitor whether program participants decreased their behaviours that put them at high risk for acquiring HIV, and/or whether they acquired HIV after participating in their program. A program that involves both HIV-negative and HIV-positive participants could not rely on HIV acquisition as an indicator of the program’s impacts on participants. For more details on the plurality of evaluative criteria employed by these agencies, see Chapter 7.

6.1.2 Definition and classification difficulties

Another aspect contributing to the complexity of HIV prevention programming at these organizations was that their programs and activities were difficult to define and classify. For funders, managers, staff and volunteers, what an HIV prevention ‘program’ was could mean multiple things. The agencies carried out multiple HIV prevention activities, and how they were organized, or conceptualized as fitting into coordinated systems or plans depended on the audience to which they were being communicated. For example, sometimes activities were grouped into ‘programs’ based on funding, who carried it out, the target population, or other features. Overall, respondents described programs that showed great diversity in size and scope.

For example, a funder described a large program that was spread out across the province, where 15 staff members at different agencies were carrying out prevention work with a specific target population. This ‘program’ was also referred to as a “strategy” (Funder, F05), and specific funding was provided for agencies to undertake their HIV prevention work with the specific target population that this program was trying to reach. The workers involved were employees of
separate agencies, but they were connected to this province-wide program. In terms of human resources, this was an example of the largest kind of program described by respondents. While some stakeholders might view a “strategy” as a series of linked programs, from the point of the view of the funder, it was conceived of as a single program.

In contrast, a mid-sized program described by multiple respondents involved a coordinated set of counseling activities targeting a group at high risk for HIV delivered in a community setting outside one of the case organizations. It was supervised by a manager and three staff carried it out, and an advisory committee guided the development and implementation of the program.

Distinctively small programs were also discussed by multiple respondents. Examples of these smaller programs including a series of educational workshops about topics related to sexual health and sexuality for specific groups (i.e., gay men or young heterosexual women), hosted at the case organization or other agencies. These workshop series were branded with a particular name that would appeal to the specific target groups. These workshops were only one part of the work carried out by the staff members, and only a small piece of what they were responsible for overall.

In sum, from interviews and organizational documents, it was apparent that the size and scope of HIV prevention programs were incredibly diverse. Given this diversity, challenges arose in the capacity to make generalizations, comparisons, and/or determinations of specific evaluation practices or criteria that were meaningful across programs. This added to the complexity of evaluation practices.

For example, in OCHART reports, some activities, such as the numbers of workshops delivered, were reported by categories based on the type of worker who delivered it, based on a funding stream. This method of capturing activities was meaningful to the funder. However, it was not necessarily meaningful to the case organizations. For example, at one organization, a particular funding stream provided only enough financial resources to support half of a staff position, and the other half of the financial resources for this position came from municipal funding. The manager responsible for submitting OCHART reports made decisions regarding the appropriate way to capture this worker’s activities in OCHART in order to report the most reliable data within the required categories. This process reduced the meaningfulness that the data had for the case organization.
In order to monitor their programs in ways that were meaningful to them as well as collect the information that OCHART required, respondents described multiple monitoring activities they carried out that were supplemental to OCHART. Coordinating all these activities that individuals carried out, and linking them (i.e. pulling data from a personal system so that it could be input into OCHART) was at times very complicated. For example, in the process of submitting an OCHART report, only some of the activities involved in carrying out a small branded educational workshop program were included, and these were amalgamated with other activities/programs by manager. Yet the level of detail that a staff member described he collected in an “evaluation diary” (Staff, AW01) for this program was very detailed,

I track to see who [are] regulars (participants who return) and who is not... I actually was beginning to think about tracking to see how much more [we] attract poz men as opposed to others because I thought that might be interesting to track... I track what topic has been identified [by participants for future workshops]... Because I keep attendance figures... I know what’s the more [popular topic].... But also, on [website used to promote workshops], it allows people to pre-book and tell me ahead of time [they] are interested in… coming to [and to track popularity]… [The funders] weren’t interested in [details about their relationship with a previous collaborating organization]… they just wanted to know how many sessions, how many participants. (Staff, AW01)

Other respondents described tacitly assessing workshop outcomes and relationships with participants and any collaborating organizations involved. This added to the complexity of evaluation practices.

6.2 Complexity of evaluation practices

The case organizations in this study evaluated their HIV prevention programs in a variety of ways. Some evaluation practices were very intricate and detailed, and included explicit forms and data collection systems; others involved non-recorded and tacit processes. The ways in which these evaluation practices were connected to each other (or not) were complex. In order to be carried out, evaluation required resources, and balancing resource requirements in order to maintain a mixture of evaluation practices, as well as service delivery, was complicated at these organizations.
While there was no clear pre-determined evaluation framework that was articulated by the organizations, generally speaking, judgments about HIV prevention programs were based on a number of assessments that were occurring concurrently, including: discrete one-time evaluations, formal routine monitoring, and tacit assessments. Some of these practices or the data they derived were connected to each other, for example, routine monitoring data might be included in a discrete one-time evaluation report, or a portion of tacit assessments might be included in the qualitative sections of routine monitoring reports to funders. However, most aspects of these practices were not connected, with each requiring its own resources. Case organizations exhibited strategies to attain balance between the need for all of these kinds of assessments, along with their service delivery requirements.

One manager explained that tacit knowledge and experience needed to be combined with some monitoring and other data; this was partly due to the resources limitations that organizations had to deal with. As another manager explained, there was limited funding to support formal evaluation,

there's a need to be able to demonstrate need and effectiveness…. The challenge remains for prevention, ‘How do we do that?’ you know, when you get a grant of thirty thousand dollars a year, which is supposed to be for your staff person, and program materials, you're supposed to run a program, and the maximum amount you can ask for evaluation is two percent of the budget, to a maximum of one thousand dollars. Well, what are you going to get with a thousand dollars worth of evaluation? Other than maybe some help in somebody helping you design a pre and post survey? (Manager, AM09)

The following sections examine each of these types of evaluation practices (discrete one-time evaluations, formal routine monitoring, and tacit assessment) in more detail and highlight the complexities of each practice. The ways in which these practices were connected to each other (or not) is also examined.

6.2.1 Discrete one-time evaluations

Discrete one-time program evaluations carried out by these organizations tended to be larger and intermittent; they fell outside the scope of normal program delivery and other routine monitoring practices. The occasions in which these intermittent evaluations were carried out depended on
availability of funding and human resources, and were often related to times in the life cycle of a program where the knowledge derived from these efforts would be useful to guide planned future efforts. Even the smaller case organization (which had less financial and human resources) carried out these resource-intensive ‘special’ evaluations when it fit into their program development or other plans. Routine monitoring occurred at both of the cases more frequently and required different (and less) resources; however, routine monitoring data rarely played a large role in one-time evaluations.

Examples of one-time evaluations included extensive needs assessments for particular racialized groups at one of the case organizations that set the stage for their ensuing HIV prevention programming. These needs assessments were carried out by agency staff; funding for their positions came from the AIDS Bureau during a time of development of several Ontario-wide strategies targeting groups at higher risk for HIV. This funding was new to the agency. The needs assessments were aligned with the Ontario-wide strategies; carrying them out involved convening community advisory committees that guided the process, verified the analysis and recommendations, and supported decision-making around the resulting new programming efforts undertaken by the agency staff. The methods used in these reports included conducting interviews with local stakeholders (such as program implementers, researchers, and funders with experience working with the target populations), scanning for relevant existing local programs, compiling available epidemiologic data, and reviewing best practices and other research literature. The time it took to conduct these evaluations was noted by respondents, as was the value in informing subsequent programming. As a manager described,

[The needs assessment was] part of [a staff member at the agency’s] job. It was kind of, you know, it was new money to the agency… And we spent, gosh, probably eighteen months getting that report done before we did anything in terms of interventions. [The staff person] then did the campaign, and then did the workshop series. (Manager, BM15)

These needs assessments did not include any routine monitoring data the agency had been collecting and reporting to funders. In contrast, a one-time evaluation was conducted by the other case organization to assess the first year of their pilot program which offered counseling to gay men in a community setting. The methods used included a survey of potential program participants, and follow-up interviews and focus groups with people involved in the program.
From reviewing organizational documents, it is apparent that routine data collected by the program such as completed feedback forms from program participants and other data collected in the course of running the program were used in the report.

The routine monitoring data included in this report were relevant to the purpose of this evaluation which provided answers to a number of different questions about the program in terms of feasibility, difference from other programs, and acceptability given that it was delivered in an unusual community setting. The report also described program challenges, suggestions for program improvement, and analysis on whether program objectives were being met. The inclusion of routine monitoring data into this one-time evaluation was one of a small number of examples of this practice; for the most past, routing monitoring data was collected for other purposes and not well connected to other evaluation practices.

6.2.2 Routine monitoring

In comparison to discrete one-time evaluations, monitoring of HIV prevention programs happened more frequently, was required to maintain relationships and fulfill obligations to funders, and monitoring reports submitted to funders were more structured. These features contributed to the emphasis on monitoring practices; monitoring for funders was identified as a key practice.

Routine monitoring specifically to fulfill funder requirements was a common practice at both cases. Each grant required its own reports; most grants required reports about financial details and the activities carried out that were specific to the funding opportunity (although OCHART was an exception to this, and required reporting on all activities carried out by the agency during the reporting period). Respondents noted an increase in the amount of reporting required for funders over time. Each grant’s reporting requirements were different. A manager described reporting to foundations and non-governmental funders as less onerous than government funders,

[Names several foundations], they're much less rigorous [demanding] … I don't know that they spend a lot of time [scrutinizing them]… But the source of money is different. It's not public dollars. They're not defending it against the kind of budgets where you're fighting for every penny these days, fighting against cuts. It's really different. (Manager, BM15)
In addition, each governmental source of funding had their own mandate, organization, and requirements, and these had impacts on what they required from funded agencies in terms of monitoring and reporting.

6.2.2.1 Routine monitoring for government funders

Government monitoring requirements were complicated and detailed. Most required semi-annual reports with details about specific program outputs that were relevant to the specific funding opportunity; these were tied to the larger objectives of each government grant. PHAC’s ACAP program and the AIDS Bureau were the only two funders that had harmonized their reporting requirements in OCHART. The lack of harmony between reports funders required was cited as a source of complexity. As one municipal funder described,

[It’s] complicated. All of the ASOs have to [submit] OCHARTs. So [agencies that receive municipal HIV-specific funding from us] have to do that too… But, we ask for some things that OCHART doesn’t, particularly these [indicators that City Council requires]. And we don’t just fund ASOs, we [also] fund organizations that do not have to give data to OCHART. It’s different [depending on the agency]. (Funder, F21)

This respondent highlighted the benefits of harmonizing monitoring requirements, but cited the resources required to do this as a barrier; they noted that, “[PHAC] had two full-time program evaluators designing their reporting tool [which is beyond our resources].” (Funder, F21).

One of the reasons that harmonizing monitoring tools represented a large feat was that each tool had its own format and internal logic that organized the data that agency staff were required to submit. For example, municipal HIV-specific monitoring reports required a separate report for each program that detailed the activities carried out that were specific to the funding opportunity, submitted to the funder by email; each report described activities at the program level. In contrast, provincial and federal HIV-specific monitoring reports were submitted using OCHART, an online system; and each OCHART submitted described activities across the entire organization, including organization-wide characteristics such as governance, partnerships, etc. in addition to amalgamated data about programmatic activities carried out during the reporting period. Another system called OCASE (Ontario Community-Based AIDS Services and Evaluation) was required by funders to monitor clients’ use of support services. The differences
in the unit of analysis (programs for municipal funding, the organization as a whole for OCHART, client-level data for OCASE), and the total number of different funders’ monitoring systems that an organization had to deal with added complexity to the process of collecting, organizing and submitting monitoring data to funders. As a manager at a case organization described,

we have OCHART; we [have] OCASE [Ontario Community-Based AIDS Services and Evaluation]. We have iCAMS [Immigration - Contribution Accountability Measurement System], through CIC [Citizenship and Immigration Canada]… It's kind OCHART for Citizenship and Immigration Canada. You know, we have logic models for PHAC. We have City reports. We have NSP [Newcomer Settlement Program] reports for Ontario, the list goes on and on and on. And they're all different frameworks with different expectations in terms of knowledge and data. (Manager, BM15)

While there was some overlap in terms of data required by some of these reporting systems, most of the requirements were significantly different. The complexity involved in the collection, reporting, and uses of monitoring data for two of these systems (municipal reports and OCHART) are provided in the sections below.

6.2.2.2 HIV-specific municipal reports

Reports for municipal HIV-specific funding were submitted semi-annually, and included information about staffing, financial statements, and project outputs. The reports required a level of detail from the agencies that received time-limited project funding which allowed the reader of the report to see progress on all of the activities that were included in project proposals, as well as specific information that linked to the funders’ broader objectives, such as civic engagement.

Examples of interim reports that captured all these details from one case organization were approximately eight to ten pages in length. Final reports required additional items (quantitative process indicators, outputs and a narrative statement about the project); an example of one final report from a case organization was approximately 26 pages in length. In 2012, both case organizations were required to submit reports about two municipally-funded time-limited
projects. Thus, the number of pages of reporting required was approximately 18 pages for interim reports and approximately 52 pages for final reports for these grants.

These funding reports were submitted by email; the lack of an online system that captured the data meant there were no internal data consistency checks during the submission process. This could have contributed to the kind and degree of funders’ scrutiny of the data. Some respondents noted increased scrutiny of data submitted to municipal funders, however, this was a contested issue. As a funder described,

There is a section in the application form that we ask for stuff [like a sentence or paragraph about how participants feel about the program]. But if they don’t fill it out or it’s sketchy, if they reported their [quantitative] data, it’s pretty hard for us to be so strict as to... really come down on them. (Funder, F21)

This lead to some skepticism about whether or how funders processed the huge amount of information they required, and how individuals at the funding organizations differed in how much data they needed to see. As a manager described,

I think, it depends who the worker is at the [funder]. Yeah, some scrutinize a lot, and they're wholly unreasonable... Others are like ‘Yeah, I get you and I'm going to trust you.’ (Manager, BM15)

The lack of online system for the submitted monitoring data limited what funders could do with the data they collected. As a funder described,

It’s only been recently that the Board of Health asked us to report on [data that was collected in reports from funded agencies]... That is a bit of a scramble for us... because... we had to hand-search all the applications... They’re hard copies with [each agency] putting in all their numbers... going through them and figuring out [which project reported on number of people testing]... and then we’ve got to add them all up and put them in the testing [data]... Of course if we had an online application where people could [enter their monitoring data]... the database would be built right into the fields… you could just extract the data. Then that would be very easy to report on. (Funder, F21)
The reports required for HIV-specific municipal funding can be contrasted to OCHART, an online system that included internal data consistency checks during the submission process. Reports required for HIV-specific municipal funding required less information about agency characteristics than OCHART (i.e., governance, other funding sources, etc.). Interim municipal reports were less lengthy than OCHART; however, final reports for two municipally-funded programs were similar in length to an OCHART submission. Quantitative data collected for municipal reports was included in OCHART submissions, however, this data had to be amalgamated with other data, and at times, re-categorized to make sense within the OCHART system. In addition, the amount of detail required by the two systems was different, which added to the complexity of collecting data and submitted these reports.

6.2.2.3 OCHART

The most developed and routinized monitoring system was OCHART; in some ways, it was the most predominant monitoring activity at both agencies, and the most developed system among funders. Reports on all of the agencies’ activities were submitted semi-annually using this complex online system, which consisted of multiple linked pages where quantitative and qualitative data were entered about a number of different agency characteristics and all programmatic activities carried out during a reporting period. At both case organizations, the process of gathering data to fill out OCHART was complicated and involved individuals across the organizations. Adding to its complexity, OCHART was developed over time, and while much of the data required was consistent (or similar), changes to the system occurred with some frequency. Changes to OCHART, even when considered minor by some respondents, were considered stressful or burdensome for other respondents. Overall, OCHART required more effort to learn and maintain compared to other funders’ reporting systems; it also provided more information back to ASOs.

Data input into OCHART from each agency was amalgamated by PHAC and the AIDS Bureau, with assistance from the OHTN, presented in a yearly report called View from the Frontlines, and presented at an OCHART KTE annual meeting in which managers from ASOs participated. In addition, the agencies could make requests for specific OCHART data reports. Negotiation between agencies and funders over OCHART were evident; OCHART played a role in building shared meanings and repertoires within this community of practice. Whether or not OCHART
was a good source of information for programmatic or agency decision-making was disputed; however, there was agreement on OCHART’s role in monitoring for accountability purposes. The OCHART system itself was complicated, and when added to other reporting requirements, added to the complexity of monitoring and evaluation practices at the case organizations. This section describes these features of OCHART in more detail.

6.2.2.3.1 OCHART’s online system

Every six months, a manager entered data and submitted it using the OCHART system, which involved logging into an online system, and entering a substantial amount of data into a number of linked screens. Each screen captured one section; there were a total of 12 sections. A blank.pdf version of an entire OCHART form which included all 12 sections was 42 pages in length (see Table 4).

<table>
<thead>
<tr>
<th>Agency Info</th>
<th>No. of pages</th>
<th>Section No.</th>
<th>Section Name</th>
<th>No. of pages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18</td>
<td>Section 1</td>
<td>Organization and Contact Information</td>
<td>2 ½</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Section 2</td>
<td>Program/project Information</td>
<td>1 ½</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Section 3</td>
<td>Governance</td>
<td>2 ½</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Section 4</td>
<td>Human Resource Issues</td>
<td>2 ½</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Section 5</td>
<td>Organizational Funding</td>
<td>1 ½</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Section 6</td>
<td>Catchment Area and Target Population</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Section 7</td>
<td>Program Planning and Evaluation</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Section 8</td>
<td>Partnerships</td>
<td>1 ½</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activities/Services Info</th>
<th>No. of pages</th>
<th>Section 9 &amp; 10</th>
<th>Education and Outreach</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24</td>
<td>Section 11</td>
<td>Support Services</td>
<td>4 ½</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Section 12</td>
<td>Volunteer and Related Activities</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Section 13</td>
<td>IDU/Substance Use</td>
<td>6 ½</td>
</tr>
</tbody>
</table>

Table 4. OCHART Sections

Sections varied in the number of questions they asked and their length (from 1.5 to 11 pages). The first sections required basic contact information about the organization, individuals at the organizations, and the projects funded by ACAP or the AIDS Bureau and asked a number of questions about the agency and the population it serves (i.e., governance, human resources, funding, catchment area, planning and evaluation and partnerships). These sections were a total of 18 pages of the blank form. The remaining sections captured details about the programmatic activities and services provided by the agency (i.e., education and outreach, support services,
volunteer activities, and services for substance users); these sections were the largest, a total of 24 blank pages of the form (see Appendix G for a copy of the OCHART form).

There was diversity in the format of questions: many checklist or lists with ‘yes/no’ options; many fields where quantitative data was required (i.e., number of staff, events, dollar amounts, or dates); and open-ended text boxes for descriptions of themes, trends, or other commentary. In all the sections on programs and services provided by the agency, there were extensive tables which were used to capture the number of service delivery activities completed and the number of participants. These sections seemed to emphasize the importance of the number of activities carried out and the number of participants or service users. Activities were required to be reported by categories such as type of worker who delivered them (Strategy Worker or other), the intended audience (selected from a drop-down list), and location (selected from a list of possible locations). In Section 11, details about the gender, age, and type of support services users (PHA, person affected by HIV such as family member or partner, or person at-risk, etc.) and the services they accessed were also required. A frequently used category across the entire form captured whether the work carried out was ‘ACAP funded’ or ‘All Other Funding’.

A complete OCHART form was very long and contained a lot of detailed information. A number of elements were designed to help maintain consistency in the data, including: training; embedded details in the online form (such as instructions, definitions, and examples); prompts in the system; training documents available on the website; and some review at OCHART KTE days. In addition, some sections were pre-populated with information the organization had submitted in the previous reporting period. If the person responsible for filling out OCHART was unsure or had a different interpretation about what a category or term meant, there were instructions on what the funders who received submitted OCHARTs had intended. However, the logic, sections, specific questions and/or categories included in OCHART were not necessarily intuitive or meaningful for the agency, nor were these based on the way the agency categorized, defined, or prioritized their programs. For example, as discussed above in section 6.2.1 about a definition and classification difficulties, workshops that an agency delivered were reported in OCHART based on the type of worker who delivered them), which was a method of capturing activities that were meaningful to the funder. However, this reduced the meaningfulness of the data at one of the case organizations. It required the manager to make pragmatic decisions that allowed them to provide the most reliable data within the required OCHART categories.
However, there were other ways in which the workshops delivered were important to the agency, for example, how many, in total were carried out by a particular staff person (as opposed to dividing it based on their funding stream), and/or how many were from a particular workshop series that had been branded by the agency. In this way, the ability for OCHART to allow agencies’ to monitor their own work in ways that were meaningful for them was limited, and agencies carried out routine monitoring for their own uses in other ways (see section 6.2.2.4 for more details about routine monitoring for internal uses).

6.2.2.3.2 Process of collecting and inputting data

Managers at the organizations were responsible for collecting agency data and submitting OCHARTs. This involved a semi-annual process that included: reminding staff that their program data was required, receiving data from staff and/or pulling it from internal databases, logging into the online OCHART system, amalgamating data received from staff/databases and making sense of it in terms of OCHART requirements, entering it into the fields in OCHART, responding to prompts about internal data consistency checks generated by OCHART, and submitting them when completed (which included online steps as well as submission of hardcopy attachments sent by email to funders). At both case organizations, the process of gathering data and inputting it into OCHART had some routinized steps, but at least some portion of the data was gathered less standardized or systematic ways. The most routinized process was at the larger agency, where several databases where multiple staff and volunteers input their program activities were developed and maintained; these were accessed by the manager to collect some of the data that was input into OCHART. This process was fairly routinized. However, the ways in which the manager collected qualitative data about programs, and how they recorded their choices when amalgamating data was not standardized. In addition, at the smaller agency, the ED responsible for submitting OCHARTs worked with a manager to collect and amalgamate some of the data that was input into OCHART in a non-standardized way. As this manager described,

Yeah. And I often, basically what happens, it’s not the best way... I get the data and I try to make it all make sense in a way that we want to present the information to OCHART. [We don’t have a systematic way of collecting data from each of the frontline workers]. We should.... sometimes [it is] like pulling teeth [to get the data]. But that’s a whole other story...
We're often in... crisis response mode.... I know it's normal [at other agencies]. (Manager, BM13)

The level of detail required to complete a whole OCHART submission required an intricate understanding of the logic of each of the sections – particularly section 9-13, which were the longest sections of the OCHART form. An intricate understanding was also required about what activities were carried out by the agency (with attention to details such as by whom, funded by what source, intended for which audience, etc.), and how to organize and present this information in a way which was consistent with the internal logic of each of the sections. In short, completing an OCHART submission required a noticeable amount of effort and time, regardless of whether the process of collecting data was somewhat routinized or not; it also required a certain kind of expertise - collecting and amalgamating agency data required making sense of information and presenting it in OCHART, based on the system’s internal logic(s).

Each section of OCHART followed its own internal logic, and some questions within a section were linked by this logic. Some of the logic in each section was intuitive, but some was harder to grasp. In addition, this logic was not necessarily shared between different sections. For example, the final subsection in Section 9 & 10 – Education and Outreach included three questions on peer involvement. How the ‘peers’ that were reported about in answers to these questions were similar or different to the ‘volunteers’ reported about in Section 12 – Volunteer and Related Activities was unclear. The logic of Section 12 – Volunteer and Related Activities was also slightly different than Section 9 & 10 – Education and Outreach. The number of volunteers and their hours of service were required to be reported by funding category: ‘ACAP’ or “All Other Funding’. This was a different kind of information and level of detail than what was required about peer involvement in Section 9 & 10. In addition, question 12.2 required that the number of volunteers and hours of service be reported by activity, but the list of activities provided was not the same as - nor was it related to - the list provided in question 13b in Section 9 & 10 (see Appendix G).

While the logic, sections, specific questions and/or categories included in OCHART were not necessarily meaningful for the case organizations, submitted OCHARTs made it possible for the AIDS Bureau and PHAC, with the assistance of the OHTN, to amalgamate data about their funded organizations’ activities, and report this information to a variety of stakeholders,
including the organizations themselves. A number of reporting mechanisms such as annual reports (View from the Frontlines and supplementary documents) and events (OCHART KTE day) were used to disseminate collected OCHART data and analysis; these provided the opportunity to negotiate meanings and develop shared repertoires among funders and ASOs. These are explored in the next section.

6.2.2.3.3 View from the Frontlines & OCHART KTE day

View from the Frontlines were lengthy reports (82 to 141 pages), published annually since 2007, which provided summaries and analysis of collected OCHART data, and linked these with other contextual information (such as epidemiological data, other studies, and/or overall trends in provincial health social services sectors). View from the Frontlines reports, and the associated OCHART KTE day discussions and evaluation reports allowed this community of practice to build shared meanings and repertoires; they allowed for negotiations between funders and ASOs and shared learning. Complexity was evident by the intricate and very detailed nature of View from the Frontlines reports. It was also evident in the process of building shared meanings; this required making links and interconnections between many different and sometimes confusing aspects OCHART data, other data (i.e. epidemiologic), and individuals’ experiences.

As with other aspects of the OCHART system, over time, View from the Frontlines reports maintained a similar structure, with some changes; these changes show the negotiated nature of the OCHART system between OCHART administrators (PHAC, AIDS Bureau and the OHTN) and ASOs. An example of this is the ways in which service users are reported. Over time, the categories used to describe an agency’s service users reflect a compromise between categories used in official HIV epidemiological reports and categories that were more meaningful to ASOs. The initial report, published in 2007, included several charts and accompanying narrative about trends with regards to clients served by ASOs grouped by categories that were used in official epidemiological reports about HIV in Ontario, such as: 'gay men/men who have sex with men (MSM)'; 'people from HIV-endemic countries'; 'low risk heterosexual'; 'perinatal infection', etc. This section was introduced with a comment about how these categories are not necessarily meaningful to ASOs, and provided a rationale for using these categories:

The AIDS Bureau and PHAC are aware that these categories are not widely used in the community; however, they are used here so OCHART reports can be compared with
epidemiological data to determine whether services are reaching people living with HIV and populations at risk. (View from the Frontlines 2001-6, p. 17)

The next annual report, published in January 2008, included a similar section. However, it was smaller (only one chart compared to three), and it included a footnote,

The AIDS Bureau and PHAC are aware that these categories are not widely used in the community, and this question will be changed in 2008/09. (View from the Frontlines 2007, p. 29)

The following annual report did not include any charts or trends about clients served grouped in these categories, however, the report published in 2010 included four charts and accompanying narrative about trends with regards to clients served by ASOs grouped into new categories, such as: 'people living with HIV/AIDS (PHA)', 'populations at risk', 'people affected by HIV (i.e., family, friends)', 'general public', and 'health and social service providers'. These four charts were all related to answers provided to OCHART question 6.6. An additional OCHART question 6.7 required information about clients based on types of services accessed by epidemiological risk group. However, these epidemiological risk group categories differed from previous years and differed from official HIV epidemiological reports. They were: 'gay men/bisexual men/MSM'; 'heterosexual women'; 'heterosexual men'; 'heterosexual youth'; 'LGBT youth'; 'lesbian/bisexual women'; and 'trans men/trans women'. Reporting using both of these categorizations of client types (PHA/General public/etc. and MSM/heterosexual women/etc.) was consistently used throughout the next three annual reports (2010, 2011, 2012).

While it was not explicit how these new categories emerged from discussion with ASOs or their representatives, there are several mechanisms in the OCHART system that allowed for negotiation among OCHART administrators and ASO representatives over the OCHART system. One of these was the involvement of some representatives from ASOs in a small advisory group that assisted in the development of OCHART. In the first three View from the Frontlines reports, lists of various ASO staff and managers from across the province that were part of this group were included. Another mechanism is during discussions at the annual KTE day.
OCHART KTE days were one-day events, held annually since 2007, where ASO representatives and funders were invited by OCHART administrators to review the View from the Frontlines report and discuss issues related to the report, OCHART and emerging trends in the sector. The agenda usually included: presentations by OCHART administrators with selected charts, information and analysis; breakout discussion groups about topics selected by administrators, with an emphasis on discussion about how OCHART data has been or could be used by ASOs; and special presentations on related projects. These events emphasized shared learning about: the current epidemiology of the epidemic; how activities carried out by funded organizations, as explained by OCHART data and interpretations, related to the current epidemic; and how OCHART data could be used for future decision-making at ASOs. These events allowed for opportunities to make meaning out of OCHART data, and for the negotiation and co-construction of shared repertoires.

Annually, OCHART KTE day attendees from 2010 onwards were sent follow-up evaluation surveys (approximately 70% of attendees responded to these evaluation surveys each year); evaluation reports from OCHART KTE 2010 onwards were compiled and made available on the ochart.ca website. These reports also highlighted the negotiations between OCHART administrators and ASOs about specific issues, such as changes to OCHART, the View from the Frontlines report, and OCHART KTE. For example, the conclusion section of the 2011 OCHART KTE day evaluation report listed 10 steps that OCHART administrators would undertake in the following year to respond to KTE day participants and evaluation survey respondents. The 2012 OCHART KTE evaluation report explained a number of modifications to the schedule of OCHART KTE day that were undertaken in order to respond to previous participants’ feedback, along with data that showed that these changes were well received by participants. In addition, evaluation reports contained a number of indicators to show participants’ reported learning and use of OCHART. The majority of data reported showed participants’ satisfaction and other positive comments about learning from View from the Frontlines reports, and OCHART KTE day activities and interactions; some reported data showed participants’ dissatisfaction or lack of learning from aspects of OCHART. Providing indicators that there may be disagreement reveals how important learning from OCHART is to OCHART administrators.
Elements of the OCHART system showed signs of negotiation and the co-construction of shared repertoires, and this highlighted some of the interdependencies between government funders and funded organizations. However, government funders held a different kind of power than funded organizations, and their need for a monitoring system to hold funded agencies accountable was the primary purpose of OCHART. As a funder explained,

The first and foremost role of OCHART is to provide accountability for the funding that [agencies] receive… that is its function. It has other by-products, but its function is to provide accountability for funding. (Funder, F05)

The case organization managers interviewed who were most experienced with OCHART agreed that OCHART fulfilled this purpose. However, funders and managers from the case organizations disagreed on the value of OCHART to address other purposes. Funders directly involved in OCHART framed the system as an ‘opportunity’ and were very interested in promoting the use of OCHART data for identifying trends, informing decision-making, and/or improving programs and services at ASOs. In contrast, managers at case organizations did not share the same perspectives. One manager noted that while some data once proved useful in some agency strategic planning, it hadn’t otherwise proved useful, and highlighted the main reason for completing OCHARTs was to fulfill obligations that come with the receipt of funding. Overall, there was agreement about OCHART’s role in fulfilling accountability requirements. This issue is explored in more detail in Chapter 8.

In summary, OCHART was the most developed and routinized monitoring system at these organizations. It was the most predominant monitoring activity at both agencies, and the most developed system among funders. OCHART required agencies to fill out a complex form online, and the process of gathering data to fill it out was complicated and involved individuals across the organizations. It required a certain kind of expertise - collecting and amalgamating agency data required making sense of information and presenting it based on internal logic of the OCHART form. Each section of the form followed its own internal logic, and some questions within a section were linked by this logic. While some of the logic was intuitive, some was harder to grasp. In addition, the logic of one section did not necessarily link to the logic of another section. While the logic, sections, specific questions and/or categories included in OCHART were not necessarily meaningful for the case organizations, submitted OCHARTs
made it possible for the funders to amalgamate data about their funded organizations’ activities, and report this information to a variety of stakeholders, including the organizations themselves. Overall, OCHART required more effort to learn and maintain compared to other monitoring and reporting systems; it also allowed the funders to provide more information back to ASOs.

OCHART, especially the View from the Frontlines reports and OCHART KTE days, played a role in building shared meanings and repertoires within this community of practice. Whether or not OCHART was a good source of information for programmatic or agency decision-making was disputed; however, there was agreement on OCHART’s role in monitoring for accountability purposes. The OCHART system itself was complicated, and when added to other reporting requirements, added to the complexity of monitoring and evaluation practices at the case organizations.

At the case organizations, OCHART was considered an insufficient source of information to make many programmatic decisions. One of the ways in which monitoring data collected for funders was supplemented was the collection of additional program data for staff or agency use.

6.2.2.4 Routine monitoring for internal use

While funder requirements were a key driver of much of the routine data collection at the case organizations, additional routine program data was collected by some program staff. These monitoring practices varied widely within each case organization. Many of the staff that collected this type of monitoring data explained its utility to their program’s development or implementation and some day-to-day decision making. However, data synthesis, analysis and summarizing practices were much less developed, and some respondents mentioned that data collected were not being utilized to its fullest capacity.

For example, a staff member discussed how forms used to collect data about outreach shifts allowed him to monitor distribution of condoms and other safer sex supplies, and understand details about significant conversations between his outreach volunteers and the people they had contact with. This allowed him to carry out specific responsibilities of his job: to manage the agency’s condom inventory and to manage his program volunteers. These forms also allowed for the collection of data that was necessary to fill out OCHARTs and other government reports; however, the information from the forms that was important to the staff member (i.e., types or
brands of condoms, volunteer questions or concerns) was much more detailed than what was included in OCHART submissions.

When the outreach forms come to me from bathhouse outreach, special events, community events etc., I read the forms to see what types of conversations they're having to see what type of questions were asked and how my volunteers are answering. So it's sort of an ongoing training piece that I have with my volunteers to ensure that if they have any question, I'm there to answer it. If they're answering any questions wrong, then I'm there to fix, correct it and let them know 'Okay, you answered this wrong. This is the right information.' So, I read all of it, so it's like I'm at the frontline, but I'm not there… And then, then I take all of that information, I put it into a folder, give to my volunteer who enters it into the system, and then enters it into Excel, and then I go through the Excel and make sure everything's entered properly, all the information I need for my report writing is there. And then, I also cross examine, to see 'Are we doing the same amount as last year? Are we dropping? If so, why are we dropping? If we increase, how, why did we increase the amount of distribution?' … I get a specific amount every year for condoms and lube. And I have to plan how many condoms; what type of condoms, what brand of condom; is it large, flavoured, etc.; how much lube to order; how much lube is the city going to donate to us. Like, so these are all different planning pieces that I have to do, every year when the city sends out the condom donation forms. (Staff, AW02)

Another staff member explained that the intake and exit interviews of participants of a multi-day retreat program generated a lot of data, and helped fulfill an overall purpose of monitoring and managing a program, and gathering participant feedback,

We just want to make sure that we capture certain things in the process, and make sure that we have a clear direction in terms of managing the project, and as well, hearing what they [participants] have to say. (Staff, BW14)

How routine data that was collected for internal purposes was analyzed, summarized and shared was the least developed area, and some respondents criticized the lack of these activities.

I know that a lot of other programs and departments are exploring ways of doing that [assessing participants’ satisfaction], utilizing survey tools, like SurveyMonkey or other
things like that, and getting a little more creative around the way information is captured beyond just, “Did you like it? Tell us on a scale of 1 to 5.” …But… that data needs to then go somewhere. There needs to be, like a movement... towards something. So, there’s a lot of agencies, [our agency] included, where we collect this information and it doesn’t actually do very much other than sit somewhere. You know, it’s great that ten people loved your workshop but how will that change, how will that improve… your program, your workshop? …I think the next step is to build the capacity of organizations like [ours] to …move that forward in some…sort of significant way. (Staff, BW12)

The information and learning gleaned from just collecting or only minimally reviewing data that was routinely collected, at times, contributed to the tacit assessments that occurred within this community of practice.

6.2.3 Tacit assessment

Tacit assessment of prevention programs was a preponderant evaluation practice within this community of practice. These tacit assessments involved informal (often non-recorded) appraisals of merit or other information, and were based on embodied, intuitive, or experiential knowledge. Professional and social interaction between program implementers and program participants, non-participants, other program implementers, funders, etc., were important in formulating tacit assessments. Tacit assessment was an evaluation practice used to judge both the process as well as the impacts of program activities, and could also be applied to other issues related to decision-making, such as developing greater understandings about clients’ needs, or assessing individual or organizational performance. The ways in which tacit assessment was used in combination with more formal evaluation methods was complex: while some elements of activities or programs were only assessed tacitly, often tacit assessments were combined with other evaluation processes when formally sharing information about a program. Tacit assessment was regarded as a meaningful and responsive form of evidence building among this community of practice, and contributed to the overall complexity of evaluation practice.

The ability to tacitly assess a program and make changes was linked to the idea of program implementers possessing embodied and intuitive knowledge as a result of being members of the community that the programs sought to reach. As a manager described,
Well, the concept of just 'the gut' I think is really important. And kind of that sense of automatic feedback… we recruit people based on that sense of knowing…. we recruited [name of staff] because she was a young woman who…[lived and] operated in some of those communities and came up through our programs… She knows what's best. You know, the [funder name] doesn't know what's best. I don't know what's best, in terms of those populations. She knows what's best. And … I think that's an important thing for all of us to remember, it really is… evaluation can take place in a number of ways, and sometimes, it's 'You know what? This workshop isn't going so well, and I'm going to turn it this way.' It's as simple as that. (Manager, BM15)

Interaction with program participants, other program implementers, or professionals from settings where program activities take place were important in formulating tacit assessments. In some cases, this was particularly important when more explicit or standardized evaluation practices were not suitable. For example, a staff member described the difficulties she encountered with using standard feedback forms when conducting workshops with youth; and the methods of her ‘informal’ evaluation practices that helped her determine how workshops were being received and what impacts they had.

The evaluations that we give out [to participants after delivering a workshop]... they don’t fill them out a lot... So, sometimes it’s good to just be really aware of the comments that are being made, take notes that - there’s always me and another facilitator - and maybe a volunteer as well. And we’re always looking out for different random comments that come up. And we sometimes have one on ones with youth. We usually stay for about half an hour after and have youth individually come up to us - and ask us very private questions. That kind of thing... Also, we’ve had teachers email us and tell us that, “We’ve had a lot less occurrences of people asking to be taken to the clinic ‘cause they know where to go. (Staff, BW17)

Tacit assessment was relied upon for issues beyond program evaluation: it was an important part of how case organizations understood and responded to communities’ needs, and it was included in how funders’ made some decisions. A manager described how he conceived of a new program based on his experiences hosting a forum at a community centre that resulted in a more
participatory discussion at a local bar following the event; his observations allowed for the development of a more responsive program.

At the end of [the forum] one of the panelist said quite casually, ‘I’m going to go off to the [name of nearby bar]... if anyone wants to continue the discussion, come on down with me’. And, a couple of the other panelist [agreed].. so, we all went off to the [bar]... And what happened was that small group of guys, who had said nothing in the forum [were really engaged in the conversation at the bar]. . . I observed that, I was very interested in that phenomenon, and they stayed for an hour and a half, maybe two hours... after they had already been sitting in a forum, on the same topic, for two hours already... the point was that they talked there, but they didn’t talk [at the forum]. So that led me to the thought that there is something much more comfortable for some people, that some people don’t feel comfortable to talk in a formal setting... so that’s the format that we shifted to... a more conducive environment... and a format was friendlier because they were in small groups, and it wasn’t about a panel of experts leading a discussion, they were having a discussion among themselves that we facilitated. (Staff, AM03)

Tacit assessment derived from interaction between funded organizations and funders over time was also part of how funders made decisions. As a funder described,

Often decisions get made about funding projects on the… basis of past relationships that program consultants have had with that project. Which in many ways [compared to formally submitted reports and evaluation], it's much more intuitive. It's based on a more holistic view and understanding of the organization than the evaluation data, because [of the personal contact and]… communication with the organization. (Funder, F18)

Tacit assessment and knowledge building contributed to the large amount of information that members of this community of practice held in their minds and memories about programs and their impacts. There was complexity to the ways in which tacit assessments combined with other evaluation practices. It was often the source that was drawn upon by staff or managers responsible for writing narrative reports to funders. Tacit knowledge was also used to evaluate or explain explicit information that was captured by other evaluation methods, which made the information more meaningful. For example, explaining trends in participant numbers or feedback. It was also relied upon to make sense of OCHART data; it informed the analysis of the
data presented in *View from the Frontlines*, and it was drawn upon during discussions at OCHART KTE day to interpret the meaning of data and derive plans for future action. In these ways, tacit knowledge provided an infrastructure through which new information was made sense of and turned into information that could inform future plans.

Sharing tacit knowledge through social and professional interactions among individuals, either informally, or in organized events such as OCHART KTE day, allowed for the process of collective sense-making within the community of practice, which was a complex process that involved making connections across information held by and the experiences of number of different members of this community of practice.

### 6.3 Summary

Overall, the HIV prevention programming and the evaluation practices employed by these case organizations were complex. The complexity of HIV prevention work described in literature (Piot, et al., 2008), and the difficulties in classifying HIV programs (Akers & Hervey, 2003) were noted at these organizations. This chapter described two features that made HIV prevention practice complex: the lack of clear distinction between HIV prevention and other agency activities; and the difficulty in defining or classifying HIV prevention work (the size and scope of what was considered a ‘program’ was diverse).

This chapter also described the multiple kinds of evaluation activities that occurred at these organizations concurrently, including discrete one-time evaluations, formal routine monitoring (for government funders and internal purposes) and tacit assessment. The ways in which evaluation systems, such as OCHART and other routine monitoring, that were intended to be connected to each other, but did not, in practice connect or inform each other well were explored. Evaluation practices such as one-time evaluations and routine monitoring were intricate and detailed, and produced explicit information. Individual and collective sense-making of this information relied on tacit assessments based on embodied and experiential knowledge that were shared in social and professional interactions. All of these practices were part of the social construction of knowledge that was used to make judgments about HIV prevention programs at ASOs.
In addition to being complex, evaluation practices at these organizations were plural. The following chapter explores plurality in more detail.
Chapter 7
Results: Plurality

Some people might assume that evaluating HIV prevention programs at ASOs would involve focusing on the number of HIV infections averted as a result of the programs they offer. However, a concentrated interest in averting new HIV infections was not predominant at the case organizations in this study. Estimating the number of infections averted may not be an appropriate task for individual ASOs, as most of their HIV prevention programs are not designed in a way that facilitates measuring the numbers of infections averted. There were many more indicators of success that were valued by this community of practice beyond averting new HIV infections. In fact, indicators of success and other aspects of evaluation practices at these organizations could be characterized as being plural – evaluation measures and practices were not singular, they contained several aspects or dimensions.

This chapter explores the plurality of HIV prevention work and evaluation practices at the two cases and provides examples from case documents and interviews. It begins with a description of how the variety of program delivery methods employed by these organizations required different evaluative criteria to appropriately capture, make sense of, and assess their programs. Then, the multiple dimensions of an important process indicator – popularity – are described. Following this, there is an overview of the multiple outcome indicators which shows the plurality of impacts that are valued by this community of practice. The multiple evaluation stakeholders are then described. How this results in tensions in evaluation practice is explored.

In this chapter, the term plurality is used to refer to aspects of evaluation that were not singular or unidimensional. At times, it also refers to multiple competing interests that stakeholders held.

7.1 Multiple evaluation measures

From interviews and the organizational documents reviewed, it was apparent that there was no one indicator that a program was working. As a result, this community of practice utilized a number of different evaluative criteria and practices to capture, make sense of, and assess their programs. Evaluative criteria depended on the intervention methods and perspectives employed; these are discussed in the next section. Process measures (such as popularity), and multiple outcomes measures were valued; these are discussed in the section that follows.
7.1.1 Variety of programs and appropriate evaluative criteria

As discussed in Chapter 6, the HIV prevention programs at these cases were complex. In addition, both organizations described delivering their HIV prevention programs using a plurality of very different intervention methods. These included: one-on-one counseling, brief outreach in community settings, support groups, workshops, social media campaigns etc. Some evaluative criteria were only appropriate for some of these methods of delivery, therefore no one indicator of success was deemed appropriate for all HIV prevention work. Meaningful evaluative criteria also depended on the perspective that the program was based on; however, this also introduced further complexity and plurality to evaluation. As a staff member stated,

If you're talking about doing things from a structural perspective, or a social determinants of health perspective… [things are] hard to measure…And if you're talking about structural things, you're not going to ask someone individually if their self esteem has changed as a result of your [brief outreach] conversation. Because you asking that is coming from a structural place, but asking it on an individual level is a little silly, unless you've had eight sessions with them, then maybe. But in one encounter, they'll be like 'Are you joking? Who do you think you are? No, you haven't helped my self-esteem, get over yourself.' … It's silly. It's strange to ask that. (Staff, AW11)

Perhaps as a result of the diversity of perspectives held, the most appropriate evaluative criteria for each type of method were hard to determine; no consensus among respondents was evident. For example, one staff member (AW01) described the numerous indicators of success they considered when evaluating workshops. These quantitative and qualitative indicators of success included:

- workshop design that was responsive to community members’ needs;
- workshop content that was evidence-informed;
- workshops that were carried out in partnership with other organizations;
- the workshop’s attendance and popularity;
- that workshop participants were engaged and participated throughout the duration of the workshop;
- that the workshop fulfilled its intended objectives;
that participants took the resources that were made available to them; and
that the workshop met the funders’ expectations.

From this list, it is evident that process indicators were highly valued by this staff member. In contrast, another staff member’s (BW17) assessment of their workshops included two outcome indicators (whether or not HIV stigma was reduced, and if participants’ patterns of testing for HIV were improved), and only one process measure (participant engagement).

This staff member worked with racialized youth in schools, and increasing HIV testing rates of this population may be a more pertinent issue than for others. Thus, the population served may also impact what evaluative criteria were considered meaningful.

However, across the plurality of different program types and populations served, one particular process measure was cited as important: popularity. This process measure had multiple dimensions; these will be explored in the next section.

7.1.2 Multiple dimensions of popularity

One of the most cited process measures that was important about HIV prevention programs was popularity. Respondents highlighted multiple dimensions of popularity that were important when assessing the success of a program: the program’s reach, participant engagement, and the acclaim for the program (especially from within the sector). Each of these dimensions will be explored in this section.

The first dimension of popularity was reach of a program – how many people participated, and to some extent, what the demand for the program was like. When asked how they assessed whether a program at their organization was running well, a manager replied,

Bums in seats… Are there bums in the seats?… Is there a sense that guys want to come? Is there more demand, than supply of spots? Popularity. (Manager, BM15)

A staff member described how the noticeable reduction in attendance at a workshop series compared to a previous series of workshops they had conducted was an important indicator of the lack of success of the current program they were carrying out.
When we were doing [name of previous project] we were doing it in conjunction with a community group. At times, we had to turn people away because the room was over capacity. The numbers I’m looking at [for the current program] are 9, 4, 9, 9, 8, and 6. (Staff, AW01)

This staff member emphasized how low these numbers were, and went on to describe their frustration and desire to make changes to the program.

The importance of participants reached was also noticeable in reports to government funders. In OCHART, almost every question about any activity carried out by the organization included a space where the number of participants was required. In municipal reports, after providing the number of activities carried out (i.e., workshops or outreach events), the total number of participants was required. Overall, the number of participants reached was an important dimension to measure the popularity and success of a program.

The second dimension of popularity was participant engagement. While a program’s reach was most often captured in quantitative measures, participant engagement had quantitative as well as qualitative components. Quantitatively, engagement could mean the number of people retained. As a staff member described,

[An] indicator is.. [are] you are reaching newer people…? Another indicator is that you have people also coming back. OK, so both things, I know they sound contradictory, but they are both important. (Staff, AW01)

Engagement could also mean the number of people who drop by an organization that eventually end up participating in a program’s activities. As a staff member stated,

The amount of community engagement that we're able to get, getting people coming through the door and participating in the activities that we provide here... [is] a very tangible way to measure the success of the program. (Staff, AW08)

Qualitatively, engagement was measured (often tacitly) by how much energy, enthusiasm, or interest program participants showed. A staff member described how they could tell when the workshops they delivered were going well,
I think when people are engaged and they’re asking questions. …When they’re sometimes a little uncomfortable…, you know, laughing a little, you can tell that… you’re getting to certain areas that they’re not… usually able to discuss. … [I can tell the workshop is going well] … when they’re engaged… and when there’s some sort of response. You know, not just sitting there with their earphones on. (Staff, BW17)

Another staff member described how tacit assessment of participant engagement could be validated by observing the kind of impact it had on the number of resources participants took with them:

A good program is interactive as well, …. people can actually talk about what they think, what is upsetting them... in ways that don’t have answers. There is no pat answer for this question, so let’s talk about it. So, ‘why didn’t the community come out to this workshop’? We talked about it.... And that actually led to people taking a few more extra pieces of literature. (Staff, AW01)

The third dimension of popularity was acclaim for the program. Public recognition, support or praise for a program was highly valued among this community of practice. Acclaim from other members within the sector was particularly highly valued. For example, a manager explained how the success of a new program was apparent because staff from other organizations were interested in it, and they had been invited to present at conferences about it. Another manager described the kind of attention a successful program had generated,

[The staff responsible for program coordination] did a presentation at a conference last year. And [there] was… this buzz. The funder joked about it the next day… he really talked up this program in different ways… [I think that some of this buzz is also part of what the funders are valuing about the program]... There was this excitement that started to trickle through… That was... a key indicator to me. (Manager, AM06)

The popularity of a program was not unidimensional; and it was an important process indicator. Outcome indicators were also valued; these are described in the next section.
7.1.3 Multiple outcome indicators

Multiple outcome indicators were reported as important by the case organizations. Most HIV prevention programs were not designed in a way that facilitated assessing the number of infections averted as a result of the program. Discussions about outcome indicators at these organizations studied revealed that, while averting new HIV infections was deemed important, there was ambivalence about outcomes of HIV prevention work. While many outcomes were valued, some of the most common indicators required in reports to government funders (i.e., behaviour change) were contested. These issues will be explored in this section.

Occasionally, the importance of averting HIV infections was clearly stated. For example, in a View from the Frontlines report, data from a special study about the estimated cases of HIV averted were presented,

The focus of education and outreach programs is to prevent new HIV infections. A recent analysis, conducted by the OHTN, revealed that the investments in prevention programs in Ontario contributed to 12,087 averted cases of HIV between 2001 and 2009. (View from the Frontlines 2012, p. 52)

However, even when the intention of reducing HIV infections was clearly stated, the ability to measure it in relation to HIV prevention programs at these organizations was challenging. As a manager stated,

I think it is important… when we’re talking about HIV prevention what we’re trying to do is reduce the risk of HIV transmissions. That’s what we’re trying to do. But we rarely, rarely, rarely have an opportunity to do the kind of evaluation that would give us the hard answers… or the fuller answers [to whether we were successful or not in achieving that]. I think these changes [to use more before and after measures of resiliency] in evaluation are going to give us the beginnings of some useful measures and what we want to do with that information is then be able to prioritize what we’re doing and focus more on the things that are more successful. (Manager, AM03)

There were multiple outcome measures that were considered useful or important to members of this community of practice. These included increasing resiliency, reducing isolation, and
changing knowledge and behaviour. The interest in these indicators revealed some of the underlying logic of the HIV prevention programs that these ASOs carried out. Each of these indicators will be discussed in turn.

Increased resiliency and capacity to respond to life challenges in ways that improved health and well-being were important, not just to prevent new HIV infections from occurring, but to support people living with HIV, as well as communities most affected by HIV. A staff member described how their perceptions of success of their program changed after discussions about the effect of the program with a participant who had seroconverted after attending the program. At first, this staff member had considered this participant’s seroconversion as an indicator of the failure of the program. However, after hearing the participant attribute their increased capacity to deal with their illness to the program, the staff member’s view of their program and its outcomes changed. They stated,

Our [program’s] focus was on building [participants’] emotional and social capacity to respond and apply. A lot of emphasis and focus on… inoculation of stress and anxiety and all these other sort of things. A lot of teaching them how to be self-reflexive and how to utilize different coping strategies, …how to begin to build their internal capacity to respond to multiple trauma experiences. And it was those things that he was able to draw on, and outline… as helping him having moved through this really difficult period in his life. It was then I was like, ‘Oh, the program does work.’ (Staff, BW12)

Reducing social isolation was also seen as a key outcome of HIV prevention work. A manager described,

Reducing isolation, helping young men deal with their trauma, getting them connected to other social services, helping them identify peers, as well [as behaviour change]. Peers in the community but also, ...who’s a mentor.... And that’s a really valuable thing that ASOs have maybe not traditionally been positioned to be expected to deliver. [This idea] that you could find your place. You could create a network. You can... find a group of people that are interested in your well-being, your welfare. In addition to an ASO. ... Because an ASO, you can’t call on at 4 o’clock on a Sunday morning when your boyfriend has beaten you up. But maybe the guy that you met at [a program], maybe you can call him. (Manager, BM15)
Reducing isolation was seen as a step in the underlying logic of how HIV transmission was prevented by the program. It was believed that if someone’s isolation was reduced, it would reduce the chance that they would engage in behaviours that could lead to HIV (e.g., unprotected sex). A staff member described,

[Loneliness is] a huge problem [among our target group]. …[How I conduct the workshops is all] about increasing social contacts because that makes people happy. When they are happier, they take condoms, they take brochures, when they socialize... they just do. I can see it... we have one [workshop] where it’s a clear cut lecture, ... They’re gone, that’s it. [When we have a workshop] where people are talking to each other, they get to know each other a little bit in the workshop, that sort of thing, ... there is a reason why they come and they have a reason to come again. And that’s primarily things like isolation and loneliness. And it helps break that. Well if you’re not feeling as lonely, because there is more relationships in their life, more meaningful relationships in their lives, then they are less likely… to take risks around HIV as well. They are less likely to engage in ... situations where they are doing it out of a sense of desperation or depression. (Staff, AW01)

Increasing capacity to respond to life challenges in ways that improved health and well-being and reducing social isolation were seen as appropriate outcomes to evaluate programs where there was some kind of sustained contact with participants, for example, in a multi-session program. These were not seen as appropriate for programs where there was only brief contact with participants, for example, in outreach, or as a result of social marketing campaigns. However, there were two outcome indicators that were cited as important across most programs: increasing knowledge and decreasing HIV risk behaviours. The interest in these outcomes by funders was apparent in routine monitoring – organizations were required to report the changes in knowledge and behaviour of program participants in OCHART. Some staff also valued changes in knowledge; as one staff member described,

The goal [of the workshops is]… to give them … the tools to realize what’s putting them at risk and what’s not and they can make their own decisions past that point. [To increase their] awareness and knowledge. (Staff, BW17)

This was based on an underlying logic that increasing someone’s knowledge would lead them to not engage in behaviours that could lead to HIV.
However, the importance of these outcomes was contested, especially with regard to behaviour change. The complexity of people’s lives was seen as greater than what quantitative measures of behaviour change could capture. As a volunteer stated,

Different outcomes [are important]... If you’re working with ethno-racialized communities… experiences of racism, experiences of internalized homophobia, and how they interact to put people at a variety of health disparities…. Just simple stuff like intimacy between people… or the experience of their body image… So why are we so focused on behavior change? Perhaps we should look at more complex interactions between things. (Volunteer, AV20)

In interviews, funders at federal, provincial, and municipal levels all expressed reservations about using behaviour change as an outcome indicator. Some of these reservations were related to the lack of complexity that quantitative measures of behaviour change were able to capture. As one funder stated,

I think… whenever you boil something complex like behaviour change down into a quantitative indicator, like ‘Are you using condoms? Are you using clean needles? Are you not sharing your needles?’ it's very difficult for people to answer that, in a yes/no manner, because often there are shades of grey. And usually the answer is ‘Sometimes’ or ‘Yes, but -’ or ‘Yes, except -’. So I think you really need that nuanced information about when and under what circumstances. And that's usually going to be unique to the individual answering that question. (Funder 18)

A major concern about this outcome, among funders and others, was the difficulty with attributing reported changes in behaviour to the work carried out by an agency. As this funder stated,

If you work with people and communities, as whole people in communities, and provide interventions that address the social determinants of health then eventually, you will see an improvement in health outcomes, but… it's very difficult to directly attribute any one thing that any one project does, to that ultimate outcome of reduction in HIV infections, or even a change in risk related behaviour, because that's really complex. The things that affect people’s choices in decision making are environmental. The best we could ever hope to do is… fund work that has some influence on that. But it's very difficult for us to attribute that
directly…. Part of what we should want to know when we're asking about things like behaviour change is: Why did this work? What was it that prompted this change? And it’s usually not going to be just the content of the particular workshop or… a particular project. There are probably going to be lots of other circumstances: a relationship with a particular person or a particular group of people in agencies; something more intangible like a sense of community; material support like helping people get off the street and into supportive housing. There's usually going to be a lot of different factors that have enabled that change to take place. (Funder, F18)

As a staff member described,

I think behaviour changes all the time, for many different reasons. And I think… it wouldn't be something ‘real’ to believe that someone would have changed their behaviour just because of the [HIV prevention] work we do. Because … you know, things happen in people's lives all the time…. If I feel vulnerable, if I feel lonely … that will change my behaviour as well, no matter how much I know about all those [HIV related] things…. That's why I think that change of behaviour is something that is very subjective… Okay, you can measure [it], but… you don't [have] behaviour change because of the amount of information or education that you get, but because of a bunch of other stuff that happens in life, basically. (Staff, AW08)

Among this community of practice, the difficulty in attributing behaviour change to HIV prevention programs was a prominent issue, especially when behavior change was measured quantitatively. As a result of these attribution issues, there was an ambivalence about outcome measures overall. As a funder stated,

[B]ehaviour change is] something, I'm going to just use the word struggle... I'm also a firm believer in process... Like there is... an impact on community as well... Maybe there was a different change that then got [the participants] ready for another level... So... maybe the change that you meted out was that people... became a little more trusting of the system and the structure so that the next time they went through a program, they might actually be closer to, willing to talk about... [for example] a different way of substance use... So I, I'm not as concrete and absolute, right? So [saying] this... is the only way it should be delivered because it... meets the outcomes... the desired impact, I'm not as... firmly committed to that. Although
of course, you want that impact to be met, right? But it doesn't mean the program is crap if it doesn't meet that complete goal. (Funder, F05)

Overall, outcome measures were seen as valuable, but there was a lot of contestation and some ambivalence about them. There was no one outcome measure that predominated evaluation practice. In addition, a program’s processes or outcomes were not the only things valued; successful programs had other qualities that were seen an important and hard to describe. For example, when talking about a program that was highly successful, a manager explained,

There’s no...‘yes, this is the [one] indication that the program is perfect and it works and it captures the kind of magic of the program’ (Manager, BM15)

In this case, the idea that program was ‘perfect’ referred to the process of carrying out it, and that it ‘works’ referred to its outcomes. The ‘kind of magic of the program’ transcends these categories, and alludes to something equivocal – and possibly mysterious – about the program. Given these ambiguities, the kind of evaluative criteria that was valued and employed was influenced by the diverse interests of evaluation stakeholders. This is explored in the next section.

7.2 Multiple stakeholders

These case organizations had a diverse variety of evaluation stakeholders, and this influenced evaluative criteria and practices. An example of this was described in Chapter 6, section 6.2.2, where the complexity of routine monitoring for government reporting was detailed and compared to routine monitoring for internal uses.

Another example of multiple stakeholders’ involvement in program planning, delivery, and evaluation was the practice of convening various ad hoc program advisory committees. These committees were common practice at both case organizations. They were designed to be specific to the needs of the program, the organization hosting the program, and the community that the program intended to serve. Members of the community that the program intended to serve and those with personal or professional experience with the community and/or their issues were convened to provide guidance on programmatic and evaluation decisions. Occasionally, government funders were included in these committees. Some committees were very involved in
guiding the design of evaluation activities, the competing interests of different committee members influenced evaluation criteria and practices. Overall, prioritizing the needs of some stakeholders over others affected the kind of evaluation criteria and practices undertaken at the case organizations.

Some respondents noted the importance of evaluation in that it allowed their organization “to tell the story of a program” (Manager, BM15) to specific stakeholders that made organizational decisions, such as an organization’s Board of Directors. As a manager described,

For me, we’re doing a presentation to the Board next week on the initial findings of the evaluation [of a specific program], the Board is really interested. (Manager, BM15)

Greene (2005) distinguished four evaluation stakeholder groups, the first one being people who have decision-making authority. This group includes an organization’s Board of Directors, and the kinds of evaluative information they require can be different than other stakeholders.

At these case organizations, routine monitoring and other evaluation practices allowed for coordination between the managers, staff members, and volunteers involved in carrying out a program. These practices focused primarily on capturing process indicators. For more details about the routine monitoring practices for internal use, see Chapter 6, section 6.2.2.4. In Greene’s (2005) framework, these stakeholders are part of the group of people that have direct responsibility for the program.

Evaluative information that addressed members’ concerns was different than other stakeholder groups. Both of the case organizations had members; people from communities served by the organization that paid a small annual fee to attend and vote at AGMs. At these meetings, and within the annual reports and newsletters distributed to members, these organizations used evaluation results to capture and describe their work (and its success) to members. At both case organizations, the number of clients/program participants, and the number of services/programs provided to clients were highlighted in annual reports, and part of EDs’ presentations to AGM attendees. The number of volunteer hours contributed over the past year was also an important indicator of success highlighted, as were qualitative indicators of impact of the agency’s work. At one AGM, an ED ended their presentation by recounting a story of a program participant who reported experiencing less isolation as a result of attending one of the organization’s programs.
The ED cited this story as how they knew that the organization was making a difference and having an impact. Members of an ASO are part of Greene’s (2005) third stakeholder group: people who are the intended beneficiaries of the program and their communities.

Respondents in this study identified that some kinds of evaluation were designed to address the concerns of people who were not part of this sector, or linked to community-based organizations. For example, a manager described their experience of reviewing a *View from the Frontlines* report, which contained an analysis that estimated the number of averted HIV infections and cost savings to Ontario’s health care system due to HIV prevention programs. This manager described how this information was not useful for them or their agency in making decisions about their programs or activities. However, this manager discussed that that stakeholders that weren’t part of the organization or sector might find this information about the value of HIV prevention work convincing. These stakeholders are part of Greene’s (2005) fourth stakeholder group: people who may be disadvantaged by the program (as in lost funding opportunities). Patton (2008) describes this group as including members of the general public, or taxpayers that support public programs.

Overall, each of these stakeholder groups had diverse interests, and there was a plurality of kinds of evaluative criteria related to HIV prevention programs that were valued. These case organizations had limited resources for evaluation, and managing the competing interests of diverse stakeholders produced tensions. These are explored in the next section.

### 7.3 Tensions

Are a result of the multiple evaluation measures and stakeholders, members of this community of practice expressed a number of tensions and uncertainties regarding evaluation practice. A desire to ‘do more’ or ‘do better’ evaluations was expressed by many participants, but there was a lack of clarity about what that would entail. In monitoring practices, there was a tension between capturing a number of very specific indicators and the burden that this created. There were also tensions in meeting the demands for evaluation that served multiple different stakeholders. These will be explored in this section.

An area of ongoing tension in evaluation practice was the amount of monitoring required for government funding, and whether or not this presented an undue burden. Members of this
community of practice noted how reporting in OCHARTs had grown over the years, and noted its increasing onerousness. Several different drivers behind the ongoing changes to OCHART were identified. One funder identified the demand for more specific monitoring indicators from senior management, even though this conflicted with other recommendations about evaluation practice. As she stated,

> There is this constant tension… between this incessant demand for very specific indicators and very specific evidence of particular types of change, and at the same time, there was a blue ribbon panel, probably close to seven years ago… that recommended that we should be reducing the reporting burden of our funded projects and that we should just be collecting a couple of really key indicators and not overburdening them with [these]… big twenty page reports. So, we keep hearing that, and that's direction that we also hear from senior management, but we also hear ‘But you need to collect all this really specific information’. (Funder, F18)

Another funder explained the pressure to keep some specific indicators in OCHART that came from the funded organizations themselves, in order for their work to be fully acknowledged. She described the process of involving representatives from community-based organizations in the process of developing OCHART as resulting in getting “a lot more information than you need,” and stated,

> [Organizations] want to tell you everything; they want to show you how busy they are; they want you to understand how, the scope and range of their services to the nth degree. And if you don't acknowledge some of those things, you're not acknowledging some of the work that some people do. And the reality is, I don't think our OCHART needs to be to the extent that it is, but to, every time now I've opened up the discussion, it's added things. (Funder, F05).

Another driver for increased monitoring for accountability was increased public scrutiny of government funding. A manager explained how this shift towards more accountability was currently focused on financial accountability for the process of carrying out programs. As they described,
I think there’s certainly a bit of a shift towards more accountability [for government funding]. But more than ever it is...very much around financial accountability. [In so far as]...can you connect the dollars to the program? So … how much did you spend on the workshop? How much on meals? How many people came to the workshop? And that’s…largely the extent of it. I don’t know if there’ll be more of a trend… of us measuring longer-term outcomes or mid-term outcomes. (Manager, BM15)

However, how much monitoring was enough (or too much) was an ongoing discussion within this community of practice. One manager described the ideal situation between a government funder and a funded organization as one where there is trust, belief in the expertise of the organization, and “just the right kind of accountability systems in place” (Manager, BM15). For a detailed discussion about accountability, see Chapter 8, section 8.2.

Another tension was about meeting the needs of multiple stakeholders. A manager described that they felt their evaluation practices weren’t “quite where I would like them to be” (Manager, BM15). They identified tensions in the kind of evaluation that was important for the community they served and other types of evaluation valued by other stakeholders. They also discussed the challenge in identifying evaluation practices that could both confirm the success of programming as well as identify where improvements could be made. As they stated,

We could be telling a much better story about the success. Because… we can see it every day: someone walks in, they don’t have a home, they don’t have a mattress, they don’t have clothes, they don’t have food, they don’t have income supports, …within a couple of weeks, they’re going to have those five things… And that’s a really important story to tell and what a good thing to do beyond telling it anecdotaly and telling it based on our observation. Not to say that observation isn’t an important evaluative tool… I think especially within our community it’s an important tool. But there are more ways that we could be telling our story - and more ways that we can really be confirming the success of our programming - but also identifying where improvements can be made. And that’s the challenge. (Manager, BM15)

Another manager at this organization said a lack of compelling evaluative data or reports was the reason that the agency had been unable to secure additional funding for a popular program after it had reached the end of the initial funding it had received. This highlighted the tensions in managing the demands for evaluation information that multiple kinds of stakeholders required.
7.4 Summary

Overall, evaluation at these organizations was plural in that the practices and evaluative criteria employed were not unidimensional, and they reflected the interplay between different stakeholder’s needs and interests, and the capacities and priorities of the case organizations. There was no one indicator of success for all HIV prevention work; this community of practice utilized a number of different evaluative criteria and practices to capture, make sense of, and assess their programs. Evaluative criteria depended on the intervention methods and perspectives employed in carrying out HIV prevention work. Individuals placed different amounts of emphasis on the importance of process vs. outcome indicators of programs. A common process measure was popularity; three dimensions of popularity were important: a program’s reach, participant engagement, and acclaim for the program.

There was ambivalence expressed about measuring the outcomes of HIV prevention work at these organizations. Averting new HIV infections was valued as one of many outcomes that were deemed important and difficulties in attributing local HIV prevention efforts on observed HIV rates were noted. Other outcomes were valued, such as increasing resiliency, reducing isolation, and changing knowledge and behaviour of program participants. Some of these indicators revealed the underlying logic behind a program, where the indicator was considered an intermediate step towards HIV prevention. However, there were difficulties in quantitatively assessing these indicators, and other attribution problems, such as attributing behaviour change to increasing knowledge or other programmatic activities. Overall, outcome measures were seen as valuable, but there was a lot of contestation and some ambivalence about them. There was no one outcome measure that predominated evaluation practice. In addition, a program’s processes or outcomes were not the only things valued; successful programs had other qualities that were seen an important and hard to describe, like the “magic of the program” (Manager, BM15).

These case organizations had a diverse variety of evaluation stakeholders; these included those with decision-making authority, those with direct responsibility for the program, intended beneficiaries, and the general public. This contributed to tensions and ongoing uncertainties about evaluation practice.

In addition to being complex and plural, evaluation practices at these organizations focused on relationships. The following chapter explores these relationships in more detail.
Chapter 8
Results: Relationships

The purpose of this study was to expand the understanding of HIV prevention program evaluations by identifying evaluation practices and exploring what influences these practices at ASOs. The previous two chapters described the complex and plural characteristics of evaluation practices. This chapter focuses on what influences these practices by exploring the theme of relationships.

The first research questions for this study were: How do ASOs evaluate their HIV prevention programs? What evaluation practices are carried out? What qualities or attributes of HIV prevention programs are used to make judgments about these programs? Answers to these questions revealed that evaluation practices (including those that captured, made sense of, and assessed programs) were complex and plural. Chapter 6 and Chapter 7 explored these themes. The second research question was: What influences evaluation practice and the judgments of important characteristics and/or value of HIV prevention programs by ASOs? Specific influencers were introduced in Chapter 5. These were:

- the pressure for accountability to funders;
- the capacity to carry out formal evaluation coupled with the perspective that tacit knowledge may be sufficient; and
- aspects of the health promotion and community development models that underpin practice.

These influencers revealed that evaluation played an important role in connecting people or ideas, meaning that relationships were an important theme in evaluation practice. For example, evaluation practices were an important piece of the relationship between case organizations and their government funders (and through them, a larger public). Another example is how the relationship between tacit and explicit knowledge was understood by members of this community of practice. This chapter explores the theme of relationships in detail, and provides further examples. It begins with a description of how relationships were an important indicator of success among this community of practice. Relationship building between program participants, between program participants and the organization, and among the organizations
that deliver programs were all important indicators of success. This shows how the relational aspects of health promotion and community development models influenced HIV programs and evaluation practice. Following this, an exploration of accountability to government funders is provided, with specific attention to how relationships were an important reason to carry out evaluations. The relationship between different evaluation practices is also explored.

8.1 Relationships as an indicator of success

Respondents identified a number of indicators of success of their HIV prevention programs, as explored in Chapters 6 and 7. In addition to the process indicator (popularity) and outcome indicators (increasing resiliency, reducing isolation, and changing knowledge and behaviour) explored in Chapters 7, the relational aspects of HIV prevention programming were highly valued by this community of practice, and were an important indicator of success.

A key measure of success across diverse HIV prevention programs was establishing, maintaining and strengthening relationships among individuals from communities at high risk for HIV that promote health and well-being. These interpersonal relationships were not often measured quantitatively, but were nonetheless important to tacit assessments. Relationships among program participants as an indicator of success are described below in section 8.1.1.

In addition, relationships between individuals and organizations such as ASOs or other social services were also highly valued as a key indicator of success. In particular, establishing and maintaining relationships with individuals from communities at high risk for HIV who were not connected to care was important. These are described below in section 8.1.2.

Finally, collaborative relationships among individuals who worked at ASOs, or among ASOs and other organizations, were also another key indicator of success. These are described in section 8.1.3.

This focus on relationships shows the influence of the health promotion and community development models that underpin HIV prevention programs among this community of practice. While some of this relationship building is considered an intermediate step along the way to prevention of new HIV infections, more generally, it is believed to result in overall better health and well-being outcomes. This is based on health promotion and community development
principles, such as the concepts of social capital, social networks and social support that stress the importance of relationships for health outcomes (Glanz, et al., 2008). Aspects of relationships that promote healing – trust, respect, mutuality and interaction – are emphasized in social work and community development literature (Goldstein, et al., 2009). Collaboration is seen as key to community empowerment and other health promoting social practices (Minkler, et al., 2008). Among this community of practice, these ideas led to a focus on relationships in evaluating programs, either explicitly or implicitly. This demonstrates the importance of relational aspects of health promotion and community development models in determining the indicators of success considered key by the case organizations.

8.1.1 Relationships among participants

Building relationships among program participants was often cited by members of this community of practice as an important indicator of success of their HIV prevention programs. As discussed in Chapter 7, reducing isolation was seen as key outcome of HIV prevention work. In some instances, developing relationships among program participants was seen as an end in itself. However, members of this community of practice also linked increasing the number of supportive relationships among program participants in a series of intermediate steps that could lead to reduced HIV transmission. They posited that with more meaningful relationships in their lives, program participants were less likely to engage in situations where they were putting themselves at risk for HIV motivated by a sense of hopelessness or despair.

The effect of social relationships on program participants’ lives was considered important and impactful, even when some of the downsides of social relationships were considered. As a manager described,

There are some negatives to the fact that we're building… social networks because sometimes the networks… aren't all that positive nor are they highly protective in some cases. But we're doing it because I do believe that they're more protective than not. And you’re going to have the drama; you’re going to have the gossip and the rumours, but chances are, you'll have found a couple of good friends… [A lot of things happen when people are brought together] and it would happen whether they were exposed to that community through [name of program] or not. And I believe that we're getting people exposed and integrated and connected to a community sooner than they would have
otherwise…. And that year, where you didn’t have any friends and maybe you were dating that guy that’s kind of shady, if you have friends within that year, no matter what the craziness that is happening, in terms of the gossip and the silliness, that’s still protective I think… [There is a] different level of problems… problems with your friends, versus problems with your housing or the fact that you're highly isolated. Because if you fight with friends, they're still your friends… there's still something there. …There is also a sense of belongingness I think, ‘I'm part of this circle, whether I’m being sometimes marginalized or not, I’m still within a circle at least’. Versus being completely outside of a circle… A lot of shady stuff does happen, no matter who you're friends with, by the way… And … this is a life problem, not an HIV risk or a population at risk issue…. this is a life problem. Good, have life problems, because everybody does (laugh). And good, focus on those, because we want to get rid of these other problems. (Manager, BM15)

While building relationships among participants was important in assessing an HIV program’s impacts, formal evaluation about these relationships were rare. In monitoring reports to government funders, there were no required questions about relationships among program participants. Relationships among participants were tacitly assessed by the people involved in program delivery. This reflected the implicitness of relationship building among participants as an objective of some programs – particularly ones where there was some kind of sustained contact with participants, for example, a multi-session program. Using relationships to gauge a program’s success was not seen as appropriate for programs where there was only brief contact with participants, for example, in outreach, or as a result of social marketing campaigns. In these cases, relationships between people from communities at high risk for HIV and social service organizations were valued, and these are described in the next section.

8.1.2 Relationships between participants and organizations

Building the relationship between program participants and organizations that deliver social services was often cited by respondents as an important indicator of success of their HIV prevention programs. These relationships could be with the ASO delivering the program, other ASOs, or other social service agencies. A manager described that they knew they had run a successful program when,
[Participants] created a positive association, an affinity with [our organization]. (Manager, AM03)

A staff member described how building relationships were more important than just changing HIV risk behaviours,

We're building a relationship; we're doing one piece of a very big puzzle. So if they continue to not use condoms, I don't think I've done my job badly... I also don't think that I haven't done an important piece of the larger puzzle. (Staff, AW11)

A funder described the importance of supporting organizations so that they could build relationships with program participants,

Helping groups build capacity to maintain relationships with their clients and communities – that’s part of what I’m going for. (Funder, F22)

A particularly important indicator of success was when program participants who had previously had little contact with ASOs wanted more programs, services or support from the organization.

One of the outcomes of [a successful program] is... participants have really said... ‘What's next?... We need more. We're ready for more.’ (Manager, BM15)

This strong indicator of success also included participants who were previously resistant to seeking out social services starting to ask their ASOs to provide them, or participants choosing to become more involved with the delivery of programs at the organization as a volunteer or peer worker. It also included participants who were previously reluctant to address issues like addictions (or other health and well-being issues that were beyond the scope of HIV prevention programs) being willing to access treatment at referral organizations.

An important aspect of this success indicator is how it values the relationship between people from communities at high risk for HIV and the social services sector. Using a relational approach, these relationships are considered beneficial to individuals and communities. In contrast to this, some cognitive/behavioural approaches are based on techniques that intend to address a particular issue and ‘fix’ or ‘solve’ it permanently, without the need for continued use of further support, programs, or other social services. While both of these approaches inform the
HIV prevention programs that are carried out, it is through an understanding of the indicators of success that are valued by this community of practice that the weight of relationship building, and therefore the importance of relational aspects of HIV prevention work at these organizations are revealed.

In contrast to evaluating relationship building among participants, there was more formal monitoring and evaluation of relationships between individuals from communities at high risk for HIV and organizations. Routine monitoring reports included reports on numbers of referrals made, number of peers and/or volunteers involved in carrying out programs, and other assessments of volunteer participation. Tacit assessments of program participants’ relationships with the ASO were ongoing. These evaluations practices were similar to those used to capture and assess the relationships among organizations that deliver HIV program; these relationships are explored in the next section.

8.1.3 Relationships among organizations

Building, maintaining, and strengthening collaborative relationships among individuals who worked at ASOs, or among ASOs and other organizations or businesses, was also another key indicator of success. As a manager described,

[A sign of success is that] this project has always had facilitators who’ve been interested and have come from elsewhere that aren’t [our organization's] staff. (Manager, AM03)

These relationships may be in order to facilitate the ability of the ASO to carry out their work in community settings where they would like to reach individuals from communities at high risk, such as bathhouses, bars or clubs. As a staff member described,

Having a good working relationship with the bath house managers is key for being able to be in there and do the outreach because if you don’t have that, then they don’t want you in there. [To] be accountable to them, so that if something does go wrong, they know who to get in contact with and find out what happened. And so… those pieces also play a role [in being able to deliver the program]. (Staff, AW02)

Mutuality and trust were important characteristics of these relationships. As a staff member described,
You need to foster relationships with management [of the businesses we work with]; that requires working with people who don't get harm reduction and making it palatable for them, and going with their feedback. So straws in some places, straws not in other places. Drug cards that talk about cocaine in some clubs, not in other clubs. So we sort of pick and choose. The more they trust us, the more stuff we get to bring in, because they see that we're not dealing [drugs]. They see that we're not drawing in police attention. When police do come in, they see that we have affable relationships, we're not getting busted for anything…. The caliber and quality of the relationship with our business partners, is another success measure. (Staff, AW04)

Relationships with other organizations were also seen as an additional level of impact a program could have (beyond impacts on participants). Educating other professionals about issues that could reduce stigma or discrimination faced by people from communities at high risk for HIV was seen as valuable. This staff member described that a successful workshop series could have impacts beyond just participants,

I think the multiplicity of relationships, volunteers, a community partners group, [beyond] the actual participants themselves [are important]. And… the providers, the people who are coming in as guest speakers [at workshops], I think to a certain degree they are also important as well, in terms of a relationship, because it brings them in contact with the community… I’ve had situations where I brought in… one guy who was an educator with the ambulance service, EMS, to talk to bathhouse workers. And that was to talk to bathhouse workers about what to do when there is an overdose and you’re calling EMS… And there, there was definitely… a real learning curve for him in dealing with gay culture, which he wanted, and the ambulance service identified as a population that they wanted to do more work with. So that’s… a very good program… that’s a really clear example of yet another relationship that very much helped that person by coming there. (Staff, AW01)

Similar to monitoring and evaluating relationships between program participants and organizations, relationships were a feature in monitoring reports to government funders, and other formal evaluation practices. OCHART reports included a separate section on partnerships which included identifying partners, describing how they contribute to programs, and the results
achieved from partnerships. Reports about partnerships to municipal funders were also qualitatively described. Relationships were also tacitly assessed.

This emphasis on relationships reflects the health promotion and community development models that underpin practice. In these models, collaboration is thought to lead to a more effective approach to complex health and social issues than can be achieved by one organization alone (Minkler, et al., 2008). Overall the emphasis on relationships shows the influence of health promotion and community development models that emphasize social support and networks (Heaney & Israel, 2008), relational aspects of health and well-being (Goldstein, et al., 2009), and organizational collaboration (Minkler, et al., 2008).

8.2 Relationships as a reason to evaluate

As described in Chapters 6 and 7, evaluation practice at these case organizations was complex and emphasized plurality. In addition to being influenced by health promotion and community development models that stress relationships among individuals and organizations, evaluation practice was also influenced by pressures for accountability, especially accountability to government funders. The amount of monitoring required by government funders was increasing, and the desire to maintain relationships with these funders (and others) motivated organizations to keep pace and continue to carry out these practices.

8.2.1 Increasing accountability for government funders

Accountability to a number of stakeholders was important to both case organizations; one organization explicitly included accountability to multiple stakeholders in their strategic plan. However, the increasing amount of data that government funders required was noted, and was contrasted to what other sources of funding, such as foundations, required. These increases were justified by a number of members of this community of practice as needing to meet increasing pressure for accountability for government funds, because they were distributing ‘public dollars’, and during a time when overall, governments were not well attuned to the issues and goals related to HIV work.
But the source of money is different [compared to foundations]… It's really different…. When it comes to public dollars, there's a general shift towards higher levels of accountability for everybody, including the [provincial and municipal government funders], because they operate within a larger entity, which is often not friendly towards some of their work and some of their goals… So, as we're fighting, I feel like they're fighting alongside us, to kind of keep our doors open and to keep the work moving forward. (Manager, BM15)

Evaluation practices were seen as supporting a ‘fight’ that both HIV-specific government funders and funded organizations were facing together. As a manager explained,

[OCHART’s been] useful for many levels…. it's actually been really helpful to help us maintain our funding in the province. And as we've gone to fight those higher-level advocacy fights at [the federal level] and elsewhere, we've got something to go on. (Manager, BM15)

Increasing amounts of public scrutiny were observed, as well as anticipation of more to come. As a funder noted,

[There is] a higher level of public scrutiny on the use of public dollars… and that is happening… I was going to say… community wide, but it's really [it’s] more than just Canada… Given the economic situation in the world, there's a lot more scrutiny on the use of public dollars. And certainly in Ontario and the US, we're seeing that, and the optics of how public dollars are spent has a difference lens to it now than it used to… It's made us… want to do more official evaluation and have it in place, because we know the questions will come. (Funder, F05).

Aucoin and Jarvis (2005) discuss how within government, virtually everyone to whom an account is due is also accountable to someone else at the higher level, with the ultimate authority resting on the electorate. In the HIV sector, participating in monitoring activities (and other formal evaluation practices) allowed specific HIV-related government funders to have more information about the work that was accomplished at the organizations to which they had provided funding. This was understood as helping these government departments continue to maintain the resources and support for HIV work in the government-funded health sector, in a climate where maintaining these was challenging. This highlights how certain evaluation practices – the explicit ones (discrete one-time evaluations and monitoring for government
funders) – were understood as contributing to an important relationship between funded organizations and governments funders, as allies, at a time when senior government officials (and the general public) are not highly aware of or responsive to current HIV issues.

Literature on accountability links practices such as evaluation and audit closely with “the exercise of power and the legitimacy of policies, and those pursuing them” (Bemelmans-Videc, et al., 2007, p. 3). Within this community of practice, monitoring and evaluation information provided “something to go on” (Manager, BM15) which contributed to the credibility and legitimacy of the activities funded by the government, and the organizations carrying them out. Pursuing this legitimacy could be conceived as part of maintaining a relationship and trust with the general public that HIV-related work funded by governments was appropriate, relevant and professionally carried out. In these ways, explicit evaluation practices were part of the ways in which organizations maintained their relationships with government funders, and through them, the general public.

8.2.2 Accountability and pressures for outcomes

This pursuit of legitimacy did not come without costs – the burden of what was required to accomplish this kind of accountability was an ongoing issue. There was an ongoing discussion about whether government funders’ monitoring and evaluation requirements were too onerous. The burden these requirements placed on organizations were understood as potentially detracting from either providing services, or other evaluation practices that could inform internal organizational or programmatic decision-making in more direct ways. This was in contrast to government funders’ requirements which were seen as addressing other stakeholders’ (i.e., the general public’s) concerns.

Some of the tensions in these discussions revolved around the kind of data required for accountability. A manager described how they judged the onerousness of monitoring for accountability requirements in light of the amount of funding received, and that there wasn’t pressure to report outcomes,

[OCHART] is feeling increasingly onerous. I think they've added more questions. It feels like it. But in relation to the amount of money that we get, it's not incredibly onerous. We're well
funded. It's not outcome based. You know, it's very much output based and observational versus, ‘These are your outcomes.’ (Manager, BM15)

However, the pressure for government bodies to collect and report on outcomes of their funded work was increasing. One funder identified the anticipated need for more data about impacts,

So when we're inside managing [the government funds we provide to organization]… we know it's just a matter of time before they start looking at us, and saying ‘How do you know what you fund is worth [or] has any impact?’ (Funder, F05).

Another funder noted the internal pressure of senior officials to move towards more intervention and outcome oriented monitoring data. For them, historically, funding programs were based on community development principles; based on assumptions that creating supportive environment and addressing social determinants of health would create improvements in health, even if these were very difficult to attribute to any one activity. They described the move towards narrower perspectives,

But from a more narrow public health perspective, so particularly for people who, increasingly [are in positions of authority in government public health agencies], and who come from a medical background, from their perspective, we should be funding, and we should be able to deliver and measure the effect of interventions, that are very targeted to, and calculated to very specifically change people's behaviours in specific measurable ways. So, a lot of growth has happened, not just in [name of HIV funding program] but in all of our funded programs within the last, I'd say at least the last five years, has been this effort to increasingly collect those sorts of [outcome] measurements at the level of funded projects. (Funder, F18)

The increasing interest in outcomes was also evident in the ways in which View from the Frontlines reports have changed over the years. Increasingly, data was presented in ways in which the work carried out by funded organization could be conceived as outcomes sought after by government funders. The 6th edition of View from the Frontlines (2011) was the first edition in which some of the data was presented in relation to outcomes. In the section ‘What’s Different About this Year’s Report’, it states,
In this year’s report, we have organized the data to reflect the activities that funded organizations undertake to achieve our common goals as illustrated in the following logic model, which is a synthesis of both the AIDS Bureau and ACAP funding program logic models. This new structure reinforces how different activities contribute to one or more goals. It also begins to shift us away from simply reporting on activities (outputs) to understanding and assessing their impact (outcomes). (*View from the Frontlines 2011*, p. iii)

By the 2013 edition of *View from the Frontlines*, the most substantive section of the report was structured around these outcomes derived from synthesizing these funders’ logic models – chapter titles were based on outcomes such as ‘Improving Knowledge and Awareness’ and ‘Improving Access to Services’. The authors of this report carefully crafted the primarily output-level data from funded organizations and other information in order to achieve this new structuring. This crafting took some effort, as OCHART was originally designed as a monitoring tool for outputs, as this funder describes,

We… use the [*View from the Frontlines*] report internally, when we have to do presentations to managers, explaining what it is that we fund, and just highlighting some of the accomplishments of the work. And that report in particular, we also use to highlight the partnerships [between provincial and federal government bodies] because it's a unique model. So it's used for those sorts of strategic reasons, but it's not, the content of that, in terms of evaluating our effectiveness as a funding program, or the effective of organizations in achieving particular outcomes is not, that's not typically what we'd use the *View from the Frontlines* report for... It was never designed, OCHART in particular, was never designed to be a tool that collects outcomes…. It was designed to meet very specific monitoring needs. So not even really evaluation needs, but the monitoring needs of program consultants, just to get a sense of what work the projects that they work with are doing in each reporting period.

(Funder, F18)

The amount of effort required to maintain this kind of reporting system, as well as craft it into something that speaks to outcomes was noted by this municipal funder, who regarded OCHART as an improvement on the current reporting employed municipally.

If we had an… online application [and monitoring system] where people could [input their program data]… the database would be built right into the fields. [Then] you could just
extract the data… that would be very easy to report on [to more senior government officials]. Right? It’d be still hard with the outcomes. [Because] really what we’re doing is we’re trying to follow a program logic model… that says, ‘Okay, this is what the literature says works, so if we do this, this and this, we get that outcome at the end.’… if somebody had the ability to spend time examining OCHART - and what we could say from OCHART [submitted by agencies to which we also provide funding]… or how [we] could design [our monitoring] … to be similar… that would be fantastic… if somebody could do that…. The thing is [that PHAC] had… two full-time program evaluators, I think, designing their reporting tool. [And the system] … requires maintenance ongoingly… [but] it would be a fantastic job… to get that sorted and straightened. And then at the end we could actually say, you know, ‘When we do all of these things, we get this’. (Funder, F21)

Evaluation literature has been discussing the move towards monitoring for outcomes for a number of years (Greene, 1999; Mark, et al., 1999; Patton, 2008); some go as far as suggesting that the political environment is one of “outcomes mania” (Patton, 2008, p. 248). While the ultimate goal of providing information about outcomes of government-funded work to external audiences is to confer credibility and legitimacy on the work and the distribution of government funds to service providers who undertake this work, there are a number of authors who call into question whether or not this does indeed happen (Bemelmans-Videc, et al., 2007; Feller, 2002; Freeman, 2002) and what this says about trust between people, governments, and organizations (M. Power, 1997, 2000). While assessing whether credibility and legitimacy of the government-supported community-based HIV sector was indeed maintained or increased by the outcomes monitoring and reporting carried out by this community of practice was beyond the scope of this research, it is important to note that ASOs had other means of developing credibility and legitimacy for their work, based on their relationships with members of their organizations, and other people from the communities they serve. The history of ASOs includes their emergence as a response to HIV based on the unmet needs of marginalized communities affected by HIV (Altman, 1994). These organizations were founded, organized, and run by staff and volunteers who were individuals from these communities, and this has remained the case. These organizations (and the people who work at them) developed complex relationships with the communities they intended to serve. These relationships were one way to inform, as well as gauge the relevance and impact of the work they carried out, and through this process, develop
and maintain their legitimacy and credibility in the eyes of a ‘public’. These relationship building practices were both formal (through community engagement practices like advisory boards and presenting annual reports at AGMs) and informal – unrecorded dialogue between individuals, friends and groups in homes, bars, community centres or organizations. They were iterative and dialogical, and non-linear. The kind of evaluative information that these organizations used to inform these practices and dialogues drew more upon tacit, embodied, experiential knowledge than it did on the more explicit knowledge that was involved in monitoring for government funders. However, the current growth in evaluation practice is more directly related to maintaining relationships with government funders, and through them, a ‘general public’. This ‘general public’ is conceived of as larger than the ‘public’ these organizations serve, who may neither be well attuned, nor very receptive to addressing the issues that people from communities affected by HIV face. This relates to the issue of ‘many eyes’ in accountability, where there is a long list of potential stakeholders that may require answers about programs or organizations (Bemelmans-Videc, 2007). These stakeholders can value a multitude of norms that may not always coincide (Bemelmans-Videc, 2007).

8.2.3 Accountability or learning (or learning for accountability)

This growth in explicit evaluation practice for government funders was purported to not only fulfill the purpose of accountability to audiences outside the HIV sector, but to also support planning and quality improvement (within the sector). Program proposals, routine monitoring and special evaluations for government funders required organizations to demonstrate that they were learning from carrying out their programs, monitoring and evaluating them, and making improvements to them in light of these lessons learnt, or planning new programs as a result. This tension between evaluation for accountability and learning for planning/program improvement was apparent in OCHART. As stated in OCHART forms and View from the Frontlines reports, the primary purpose of OCHART was for accountability. A funder described accountability as the “first and foremost role of OCHART” (Funder, F05). An additional or secondary purpose was to inform planning and program improvement. However, certain aspects of View from the Frontlines and the majority of OCHART KTE Day events were heavily focused on this purpose – particularly on the direct use of the data for planning and program improvement. A great deal of discussion at OCHART KTE days was devoted to topics selected by OCHART administrators, with an emphasis on how OCHART data had been or could be used by ASOs.
From reviewing documents, it was apparent that OCHART administrators placed a great deal of value on learning from OCHART. In particular, annual publications of evaluation reports about KTE days focused a great deal on describing quantitatively and qualitatively how KTE day participants reported learning from and using OCHART data to inform planning and improvements at their organizations. The majority of these descriptions were about participants’ satisfaction and other positive comments about learning from View from the Frontlines and OCHART KTE day activities and interactions. Most commonly, these evaluations identified a high percentage of participants who reported feeling satisfied or very satisfied with KTE day activities and discussions, and some specific comments from participants about learning new information at KTE days. However, these evaluation reports also included some accounts of participants’ dissatisfaction or lack of learning from aspects of OCHART. For example, the evaluation report about an annual KTE day stated that “overwhelmingly, almost all (≥ 90%) participants were “satisfied” or “very satisfied” with the morning breakout discussion” (KTE Day evaluation report 2013, p. 7). Further positive comments were included, such as “Participants enjoyed the opportunity to network with staff from agencies in their region with whom they didn’t usually have contact, share program activities, and to learn from one another’s experience [emphasis in original].” (KTE Day evaluation report 2013; p. 7)

However, some accounts of participants’ dissatisfaction or lack of learning were also included:

A quarter of the comments received indicated that some participants felt they did not learn any new information; there was repetition between how the data was used and could be used, and there was a need to change the focus of future discussions. (KTE Day evaluation report 2013, p. 7)

In addition, some direct quotes from participants’ post-event surveys were included that expressed this dissatisfaction, such as, “… I didn’t feel I gained anything from taking part in the discussions.” And “This discussion was not especially informative…” (KTE Day evaluation report 2013, p. 7)

By reporting on these elements so thoroughly, OCHART administrators showed that they place a great deal of value on learning from OCHART.
For some members of this community of practice, there was an idealized notion of OCHART in that it could fulfill both accountability and learning purposes (at least to some degree). As discussed in Chapter 6 in this study, there was agreement among individuals from case organizations as well as government funders that OCHART was fulfilling the purpose of accountability, but there was disagreement on the value of OCHART in addressing learning, or direct use of OCHART data for planning or program improvement. Funders directly involved in OCHART framed the system as an ‘opportunity’ and were very interested in promoting the use of OCHART data for identifying trends, informing decision-making, and/or improving programs and services at ASOs. A funder described that, while View from the Frontlines reports were only used by people in government for ‘strategic reasons’ (to explain the work accomplished to more senior government officials and to highlight unique inter-governmental partnerships), the main use of these reports was by funded organizations.

My sense though is for the most part, the View from the Frontlines report seems to be useful and used by the agencies that we fund. (Funder, F18)

In contrast, managers at case organizations felt that the system was important to meet government funders’ needs. As a manager stated,

In terms of [the] broader applicability [of information from OCHART], I think it's great for the funders. It's really great for them. But in terms of… are there lessons learned through OCHART? Yeah, sometimes, minor ones. But does it create a kind of a sea change in terms of program planning or evaluation or implementation? … View from the Frontlines doesn't [give a lot of information about our organization’s work that we want to know about]… However, the OHTN is always saying ‘If you need us to generate reports, if you need analysis of the reports, if you need to look at five years of data, we will do it for you.’ And that's great. (Manager, BM15)

This manager noted that while some OCHART data once proved useful in some agency strategic planning, it hadn’t otherwise proved useful, and highlighted the main reason for completing OCHARTs was to fulfill obligations that come with the receipt of funding. These two case organizations may have had a different relationship with their OCHART data than other organizations – at OCHART KTE days; other organizations provided examples of the ways in which they had used OCHART data to inform their decisions/programs, etc. However, overall, in
practice, OCHART was more consistently described as a successful tool for accountability than for learning.

There are a number of issues in the evaluation literature on accountability and learning that pertain to conflicts and complications with these two purposes for evaluation. Literature describes how evaluation for the purpose of accountability differs from evaluation for facilitating improvements (or generating knowledge) in terms of modes of inquiry, suggested methods, as well as audiences (Mark, et al., 2000; Patton, 2008). The problems that result from attempting to fulfill too many functions or serve too many audiences, such as fulfilling none of them particularly well, are recorded (Lehtonen, 2005; Mark, et al., 2000). In particular, critical literature about the ‘explosion’ of performance measurement in social programs highlight the differences in indicators and practices that are intended to provide accountability (and confer legitimacy) compared to those that are intended for learning and improvement, and the value of the latter over the former is highly praised (Freeman, 2002; M. Power, 2000). The value of evaluation for learning or organizational improvement is so highly lauded that recent authors have suggested that it be required as part of establishing accountability and legitimacy (Perrin, 2007). These tensions were evident in how this community of practice framed the value of OCHART. While it was designed as a system to monitor for accountability, the promotion of learning or program improvement was emphasized. Yet, the actual, direct impact OCHART had on programmatic change or improvement was not clearly evident at the case organizations studied. However, the importance that funders placed on program planning and improvement based on explicit knowledge derived from monitoring practices implied that in order to be accountable to them, a certain kind of demonstration of learning from explicit knowledge was required. This process was conceived of as linear, or, at best, iterative (with improvements to programs being continually reassessed, as in the quality improvement cycle). While some of these kinds of application of explicit knowledge were present within this community of practice, it did not reflect the more complex and plural evaluation practices and the diffuse application of the knowledge gained and the relationships built during the process of carrying out their programs and related evaluations. This could be because of the difficulty in summarizing all the kinds of information, knowledge and experiences that goes into decision-making about HIV prevention programs at ASOs, which is a complex process discussed further in Chapter 9. The implications of requiring a demonstration of a specific kind of learning in order to meet
government funders’ increasing amount of requirements for accountability is also discussed further in Chapter 9.

8.2.4 Process uses and relationships

The actual use of evaluation findings have been a topic in literature for a number of years, with a number of authors discussing the problematic assumptions of direct, instrumental use of evaluation findings in light of actual practice (Lehtonen, 2005; Patton, 1997). Process use considers the impact of evaluation as resulting from “engaging in evaluation thinking and engaging in evaluation processes (in contrast to impacts that come from using specific findings)” (Patton, 1997, p. 111). Identified process uses include enhancing shared understandings, program and organizational development, and increasing engagement, self-determination and ownership (particularly associated with participatory and empowerment evaluations) (Patton, 1997, 2008). In this sector, OCHART was particularly well designed and allowed for a number of process uses, especially enhancing shared understandings. Details on multiple components of OCHART (semi-annual online submissions, yearly reports, and annual KTE days) and how these facilitated negotiations and shared understandings among funded organizations and government funders were described in Chapter 6. Funders viewed participating in the OCHART process as an opportunity for engagement with funded organizations, and organizations viewed participating in OCHART as a way to maintain harmonious relationships with their government funders.

Building shared understandings through OCHART KTE day facilitated ongoing relationships within the sector across organizations, and between government funders and organizations. The value of relationship building came from the process itself, more than from the data. These relationships served to not only strengthen programmatic work, but also served as the means to evaluating it as well. As a funder stated,

[While OCHART...] is used as a monitoring tool… there's a challenge with time delays because in our region, we have not very many program consultants for the number of projects that we fund… The time that it takes them to review and approve and go back and forth with agencies, about their deliverables and what they're reporting in OCHART… It would be more accurate to say that the monitoring happens through that relationship and through that process of back and forth discussion, rather than the actual numbers that end up being reported in OCHART. (Funder, F18)
In this way, relationships are understood as not only an important outcome of, or a necessary component (through inter-organizational collaboration) to successful organizational work; they are also the means by which to evaluate the work carried out, and a reason for carrying out evaluation practices.

These relationships with funders were informed by evaluative information that relied on a particular kind of data – explicit and linear. However, the relationships with community members relied more heavily on a different kind of knowledge, one that was more tacit, embodied, and experiential. The relationship between these kinds of data and knowledge will be explored in the next section.

8.3 Relationship between tacit and explicit knowledge

As discussed in Chapter 6, tacit assessment was regarded as a meaningful and responsive form of evidence-building among this community of practice. The ability to tacitly assess programs and make changes was linked to the idea of program implementers possessing embodied and intuitive knowledge as a result of being members of the community that the programs sought to reach. Interaction between program providers and participants, other program implementers, or professionals from settings where program activities take place were important in formulating tacit assessments. Interaction between program staff/managers and funders were also important in making tacit assessments, and played a role in how funders made some decisions. Tacit assessment and knowledge building contributed to the large amount of information that members of this community of practice held in their minds and memories about programs and their impacts.

While there were several ways in which tacit and explicit knowledge related to each other, among this community of practice, tacit knowledge was predominantly an infrastructure or foundation that explicit knowledge was made sense of and turned into information that could inform future plans. This section explores this relationship.

Among this community of practice, the use of tacit knowledge to understand, interpret and make use of explicit knowledge was evident in the ways in which existing research evidence, and personal and professional experiences of community members were drawn upon in program development. The needs assessments conducted by one of the case organizations (described in
Chapter 6, section 6.2.1 Discrete one-time evaluations) involved convening community advisory committees that guided the process, verified the analysis and recommendations presented, and supported decision-making around the resulting new programming efforts undertaken by the agency staff. These community advisory committees were made up of people who were from the communities that the programs intended to serve; some had additional professional expertise in the community and/or the issues that their communities were facing. The staff member in charge of carrying out the needs assessment was also from the community that the program intended to serve. They carried out interviews with local stakeholders (such as program implementers, researchers, and funders with experience working with the target populations), scanned for relevant existing local programs, compiled available epidemiologic data, and reviewed best practices and other research literature. The collected data was interpreted by the staff members and advisory committees in light of their own experiences and embodied knowledge. This was particularly helpful where existing evidence was scant on issues relevant to the specific communities that the program was intended to serve, and allowed for generalizations that may be relevant to these communities to be drawn from existing evidence. This was one way of addressing an important gap in existing explicit knowledge.

Tacit knowledge is not only important in program development, but required to understand and interpret the explicit knowledge that was used in monitoring programs. For example, tacit knowledge was relied on to analyze OCHART data in order to produce the narrative interpretation that accompanied the tables and graphs in View from the Frontlines reports. In addition, the tacit knowledge of program providers and managers was required to inform discussions at OCHART KTE days about the meaning of OCHART data. It was particularly important for any discussion about what future improvements or other actions were warranted. Without the embodied, experiential knowledge that these individuals held about their communities and their work, the data in OCHART would hold little meaning. The data in OCHART provided only a partial picture of something complex and tacit knowledge was used to fill the gaps. Tacit knowledge allowed for broader contextual information to be considered, and provided information about the ‘why’ behind OCHART data, and what OCHART data might mean. In these ways, tacit knowledge was an infrastructure through which new information was made sense of and turned into information that could inform future actions.
Some of the limits of tacit knowledge were described by members of this community of practice. Some respondents spoke of the disconnections between their identity or lived experiences and the communities their programs were targeting. For example, an older staff member who was gay did not have the same lived experience as the young gay men in his program, nor did he have the same experience as gay program participants from different ethno-racialized communities than his own. A young woman delivering a program did not share the same religious affiliation as some of her female program participants; in addition, her HIV status was not the same as theirs. Both of these staff members discussed the strategies they employed in order to learn from the tacit assessment of program participants who were part of communities that they themselves were not part of. Explicit techniques were employed, like hosting focus groups of gay men from different racialized communities in order to develop culturally competent and relevant materials for a social media campaign. This is an example of a formative evaluation to help develop and plan a program’s implementation. A technique that was intended to tacitly assess the impact of a program involved recruiting an HIV-positive peer to co-facilitate (along with the HIV-negative staff member) a multi-session support and skill-building group for HIV-positive youth. By tapping into the tacit knowledge and lived experience of an individual from the community that the program attempting to serve, the staff member hoped to be better able to assess the impact the program was having on participants.

It is important to note that in these cases, more formal monitoring or evaluation practices were not entirely abandoned. However, their role was supplemental to tacit assessment and knowledge building; and tacit knowledge was required to make sense of more explicit knowledge.

While explicit knowledge was considered necessary in community-based HIV prevention work, there were specific ways in which it was useful. As a manager stated,

‘Is it an art or is it a science?’ And it's really, in so many ways, both. And it has to be, to be… truly responsive. And if [a program is] peer based and if it's led by community members and if … it's coming from a place of knowing the community that you're working with and not having to explain that to anybody. ...That part, that's part of the reason why [name of organization] exists... is there an evidence base to say that, you know, ethno-specific ASOs are any more effective than mainstream ASOs? And we don't know, but our gut tells us so. And based on what people walking through the door tell us, that's the case. And you know,
when we finish a workshop, we feel like a connection to the people that we're talking with
and vice versa. … And nor do we need to be collecting humongous amounts of data to tell us
that the programs are going well. You know? [We need to show] people are coming to the
program and they're engaged and they're staying and they're learning and, good. What else do
we need to know? … Are we epidemiologically [informed] and in terms of transmission,
that has to be accurate, absolutely. We need to have the science down. But when it comes to
kind of the human side of it, the art-based side of it, they [program staff and volunteers]
know what they know. (Manager, BM15)

Competition for limited human and financial resources between supporting programming,
monitoring and evaluation for accountability, and monitoring and evaluation for learning was
evident at the case organizations studied. The capacity (including expertise) to carry out formal
evaluations and the perspective that tacit knowledge held by program implementers was
sufficient to gauge the process and impact of program delivery influenced actual evaluation
practice at these organizations. Explicit forms of data, such as epidemiologic and program
monitoring data were required for accountability purposes. However, the responsive and relevant
aspects of HIV prevention work were more dependent on tacit assessments and knowledge
building that took into account the lived experiences of program participants and implementers
from communities most affected by HIV.

8.4 Summary

Overall, relationships were a large influencer of HIV prevention program evaluation practice
within this community of practice. Relationships were an important indicator of success among
this community of practice: relationship building between program participants, between
program participants and the organization, and among the organizations that deliver programs
were all important indicators of success. This highlights how the relational aspects of health
promotion and community development models influenced HIV programs and evaluation
practice. The pressure for accountability to funders, and the capacity to carry out formal
evaluation coupled with the perspective that tacit knowledge may be sufficient were also
important influencers of evaluation practice.

Relationships within the sector were an important reason to carry out evaluations – evaluation
practice was influenced by pressures for accountability, especially increasing accountability to
government funders, and through them, a ‘general public’. Explicit monitoring and evaluation practices (originally designed to monitor outputs, but increasingly required to be about outcomes) were seen as conferring credibility and legitimacy to HIV-related work funded by governments. Pursuing this legitimacy could be conceived as part of maintaining a relationship and trust with the ‘general public’, which was larger than the communities that these organizations served. It was noted that ASOs had other means of developing credibility and legitimacy for their work, based on their relationships with members of their organizations, and other people from the communities they serve. The kind of evaluative information that this community of practice used with the communities they served drew more upon tacit, embodied, experiential knowledge than it did on the more explicit knowledge that was involved in monitoring for government funders. However, growth in evaluation practice was more directly related to maintaining relationships with government funders, and through them, a ‘general public’ conceived of as larger than the ‘public’ these organizations serve. This ‘general public’ may neither be well attuned, nor very receptive to addressing the issues that people from communities affected by HIV face. This is contrasted with the communities that ASOs serve, which are made up of people more attuned to these issues.

Growth in explicit evaluation practice for government funders was purported to not only fulfill the purpose of accountability (to audiences outside the sector), but also to support planning and quality improvement (within the sector). The most well-developed monitoring system (OCHART) was originally designed to monitor for accountability, however, the promotion of learning/program improvement was emphasized. Yet, the actual, direct impact OCHART had on programmatic change or improvement was not clearly evident at the case organizations studied. However, this did not diminish the importance that funders placed on program planning and improvement based on explicit knowledge derived from monitoring practices, which implied that in order to be accountable to them, a certain kind of demonstration of learning from explicit knowledge was required. This process was conceived of as linear, (or, at best, iterative). While some of these kinds of application of explicit knowledge were present within this community of practice, it did not reflect the more complex and plural evaluation practices and the diffuse application of the knowledge gained (and the relationships built) during the process of carrying out programs and related evaluations.
In some ways, the monitoring and evaluation data was not as important as the relationships with funders (and others) that were maintained by these practices. Within this sector, OCHART was particularly well designed and allowed for a number of process uses, especially enhancing shared understandings. Building shared understandings through OCHART KTE day facilitated ongoing relationships within the sector across organizations, and between government funders and organizations. The value of relationship building came from the process itself, more than from the data. These relationships served to not only strengthen programmatic work, but also served as the means to evaluating it as well. Relationships within the sector were understood as not only an important outcome of, or a necessary component (through inter-organizational collaboration) to successful HIV work; they were also the means by which to evaluate the work carried out, and a reason for carrying out evaluation practices.

Relationships with funders were informed by evaluative information that relied on a particular kind of data – usually quantitative, based on monitoring reports, that was explicit and standardized across organizations. However, the relationships with community members relied more heavily on a different kind of knowledge, one that was more tacit, embodied, and experiential. Within this community of practice, there were several ways in which tacit and explicit knowledge related to each other. However, tacit knowledge was predominantly an infrastructure or foundation that was used to make sense of explicit knowledge in order to turn it into something meaningful, such as information that could inform future plans. Among this community of practice, the use of tacit knowledge to understand, interpret and make use of explicit knowledge was evident in the ways in which existing research evidence, and personal and professional experiences of community members were drawn upon in program development. Competition for limited human and financial resources between supporting programming, monitoring and evaluation for accountability, and monitoring and evaluation for learning was evident. The capacity (including expertise) to carry out formal evaluations and the perspective that tacit knowledge held by program implementers was sufficient to gauge the process and impact of program delivery influenced actual evaluation practice at these organizations. Explicit forms of data, such as epidemiologic and program monitoring data were required for accountability purposes. However, the responsive and relevant aspects of HIV prevention work were more dependent on tacit assessments and knowledge building that took into account the
lived experiences of program participants and implementers from communities most affected by HIV.
Chapter 9
Discussion and Conclusion

The purpose of this study was to expand the understanding of HIV prevention program evaluations by identifying evaluation practices related to these programs and exploring what influences these practices. The previous chapters explained the complex and plural characteristics of evaluation practices, and how relationships influenced these practices. This chapter discusses the results of this study in light of the existing literature.

First, I summarize the major findings that were described in Chapters 6, 7, and 8. Following that, I present the concept of community-based discernment strategies. Then, I describe the limitations of this research study, and explore implications for practice and theory. Finally, I present a brief conclusion.

9.1 Major findings

In this section I summarize the major findings from this research study, which were explored in detail in Chapters 6, 7, and 8. Overall, evaluation practices and judgements about programs at the case organizations were complex and plural. In addition, relationships were an important influencer of evaluation practice.

9.1.1 Complexity and plurality of evaluation practices

Overall, the HIV prevention programming and the evaluation practices employed by these case organizations were complex. Previous literature has examined the complexity of HIV prevention work (Piot, et al., 2008), and the difficulties in classifying HIV programs (Akers & Hervey, 2003). However, previous work has not considered how the complexity of HIV prevention work impacts evaluation. At the case organizations studied two features that made HIV prevention practice complex that had implications for evaluation were: the lack of clear distinction between HIV prevention and other agency activities; and the difficulty in defining or classifying HIV prevention work (the size and scope of what was considered a ‘program’ was diverse).

The evaluation work carried out by the case organizations was complex in that multiple kinds of evaluation activities occurred at these organizations concurrently, including discrete one-time evaluations, formal routine monitoring (for government funders and internal purposes) and tacit
assessment. Routine monitoring was a key aspect of evaluation practice. Each grant received from government funders had its own reporting requirements. While some harmonizing between the requirements for provincial and federal sources of HIV-specific funding has been made in OCHART, I observed that most other routine monitoring practices were not connected to each other, and they didn’t inform each other well. They were designed to meet the requirements of each individual funder well. Evaluation practices such as one-time evaluations and routine monitoring were intricate and detailed, and produced explicit information. Individual and collective sense-making of this information relied on tacit assessments based on embodied and experiential knowledge that was shared in social and professional interactions. All of these practices were part of the social construction of knowledge that was used to make judgments about HIV prevention programs at ASOs. This is similar to Duguid’s (2005) proposition that explicit knowledge isn’t a “self-sufficient base, but a dependent superstructure” (p. 111), something to which tacit knowledge contributes. Within the community of practice I studied, tacit knowledge may not be fully translatable into explicit knowledge, but made a valuable contribution to understanding or applying explicit knowledge – it acted as a filter, or infrastructure, which was applied to new explicit knowledge. More details about tacit knowledge are discussed in section 9.1.2.

In addition to being complex, evaluation at these case organizations was plural in that the practices and evaluative criteria employed were not unidimensional. There was no single indicator of success for all HIV prevention work; this community of practice utilized a number of different evaluative criteria and practices to capture, make sense of, and assess their programs. Evaluative criteria depended on the intervention methods and perspectives employed in carrying out HIV prevention work. Individuals placed different amounts of emphasis on the importance of process measures compared to outcome indicators of programs. A common process measure was popularity. Three dimensions of popularity were important: a program’s reach, participant engagement, and acclaim for the program. This has some similarities to previous work by Owczarzak (2012) which noted that community-based HIV service providers in Wisconsin who were trained to carry out DEBIs valued the satisfaction of their program participants and the community response to the program. Owczarzak (2012) noted that these criteria were not included in the DEBIs system’s definitions of effectiveness, and recommended the CDC approach be altered to incorporate them.
During this research, I noted that within the community of practice studied, there was ambivalence about outcomes of HIV prevention work. Averting new HIV infections was valued as one of many outcomes that were deemed important. One of the problems with relying on infections (or infections averted) as an indicator of success stemmed from the difficulty in attributing local HIV prevention efforts to observed HIV rates.

Within this community of practice, other outcomes were valued, such as increasing resiliency, reducing isolation, and changing knowledge and behaviour of program participants. However, there were difficulties in quantitatively assessing behaviour change, as well as attributing it to increasing knowledge or other programmatic activities. First, the complexity of people’s lives was seen as greater than what quantitative measures of behaviour change could capture. For example, there was difficulty in boiling down engagement in HIV risk behaviors into quantitative indicators. It was felt that questions about using condoms and clean needles could be very difficult to answer with clear cut yes/no answers, because there were often nuances and exceptions (answers like ‘sometimes’ or ‘yes, but -’ or ‘yes, except -’) that were individually unique. Second, even if some kinds of behavior changes were captured, it was difficult to attribute that change to something the program or organization had done. Funders and staff alike discussed how behavior changes could occur for many different reasons, or as a result of many things combined, such as changes in relationships, more intangible ideas (i.e., growth in a sense of community), or increasing material support (i.e., helping people get off the street and into supportive housing). These things and other changing circumstances in people’s lives that are not related to the programs were understood as contributing factors to behavior change, which made attributing it to HIV program activities difficult.

Overall, outcome measures were seen as valuable, but there was a lot of contestation and some ambivalence about them. No one outcome measure predominated evaluation practice. In addition, a program’s processes or outcomes were not the only things valued; successful programs had other qualities that were seen as important and hard to describe, like the “magic of the program” (Manager, BM15).

The case organizations I studied had a diverse variety of evaluation stakeholders; these included those with decision-making authority, those with direct responsibility for the program, intended individual beneficiaries and their communities, and the general public. The variety of evaluation
stakeholders and their differing needs in terms of evaluative information has been discussed in the evaluation literature (Greene, 2005; Patton, 2008). The evaluation stakeholders of the case organizations I studied valued different kinds of information, and this contributed to tensions and ongoing uncertainties about evaluation practice. For example, government funders required explicit information; however, relationships with community members relied more heavily on different kinds of knowledge that was more tacit, embodied, and experiential. This is discussed further in the next section.

9.1.2 The influence of relationships on evaluation

Overall, I noted that relationships were a large influencer of HIV prevention evaluation practice. Relationships were an important indicator of success, these included: relationships between program participants, relationships between program participants and the organization, and relationships among the organizations that deliver programs. This highlights how the relational aspects of health promotion and community development models (see Goldstein, et al., 2009; Heaney & Israel, 2008; Minkler, et al., 2008; Thoits, 2011) influenced HIV programs and evaluation practice.

The pressure for accountability to funders, and the capacity to carry out formal evaluation coupled with the perspective that tacit knowledge may be sufficient were also important influencers of evaluation practice. Relationships within the sector were an important reason to carry out evaluations – evaluation practice was influenced by pressures for accountability, especially increasing accountability to government funders, and through them, a ‘general public’. The case organizations I studied carried out explicit monitoring and evaluation practices (originally designed to monitor outputs, but increasingly required to be about outcomes) in the hopes of conferring credibility and legitimacy to HIV-related work funded by governments. Pursuing this legitimacy could be conceived as part of maintaining a relationship and trust with the ‘general public’, which was larger than the communities that these organizations served (Aucoin & Jarvis, 2005). However, I would contend, based on the findings of this study that these ASOs had other means of developing credibility and legitimacy for their work, based on their relationships with members of their organizations (and other people from the communities they serve). The kind of evaluative information that this community of practice used with the communities they served drew more upon tacit, embodied, experiential knowledge than it did on
the more explicit knowledge that was involved in monitoring for government funders. However, growth in evaluation practice seemed more directly related to maintaining relationships with government funders, and through them, a ‘general public’ conceived of as larger than the ‘public’ these organizations serve. However, it was noted by several interviewees in this study that in the present social and economic context, the ‘general public’ may not be very well attuned, nor very receptive to addressing some of the issues that people from local communities affected by HIV face. This presents challenges if too many resources are diverted towards evaluation for these audiences. There has been a call to increase community engagement in non-profit organizations, for example, Smith (2010) described how increasing and more intensive efforts to hold community-based non-profit organizations accountable for spending governmental funds has increased the focus on performance management for government programmatic priorities (including outcomes). Smith (2010) argued that this pushes these organizations away from attending to the concerns expressed by the communities they serve, and that citizen engagement in non-profit organizations should be fostered, not neglected. The case organizations I studied had a history (and a current practice) of engagement with the communities they served, however, the attention to and growth of these practices were not as explicit as growth in monitoring and evaluation for government funders.

I noted that growth in explicit evaluation practice for government funders was purported to not only fulfill the purpose of accountability (to audiences outside the sector), but to also to support planning and quality improvement (within the sector). OCHART, the most developed monitoring system, was originally designed to monitor for accountability, however, the promotion of learning/program improvement was emphasized. Yet, the actual, direct impact OCHART had on programmatic change or improvement at the case organizations I studied was not clearly evident. However, this did not diminish the importance that funders placed on program planning and improvement based on explicit knowledge derived from monitoring practices. This implied that in order to be accountable to these organizations, a certain kind of demonstration of learning from explicit knowledge was required. This process was conceived of as linear, sequential, or, at best, iterative.

I would argue that, while some of these kinds of linear applications of explicit knowledge did occur, this does not reflect the more complex and plural evaluation practices and the diffuse application of knowledge gained (and the relationships built) during the process of carrying out
programs and related evaluations at these case organizations. As demonstrated by this study, this sector draws on a number of complex and plural processes in order to keep their responses to HIV relevant to the communities they serve. Knowledge is gained through experience, and actions based on new knowledge may not follow a linear, sequential sequence. As pressure to use monitoring data to demonstrate a certain kind of learning increases, this sector will have to become more adept at articulating the experiential knowledge gained in delivering programs, and use these to justify their subsequent action, or be forced to make decisions based on limited and limiting information that standard monitoring practice amasses.

Patton (2004) discussed how monitoring and evaluating HIV programs suffer from the same issues that the field of evaluation struggles with. He described the “nearly universal phenomenon that the data most useful to local programs fail to provide what donors want” (Patton, 2004, p. 165), and how “accountability demands routinely trump hopes for and intentions of program improvement” (Patton, 2004, p. 166). Patton (2004) criticized how “deeply entrenched mechanistic linearity is in evaluation” (p.168), and how this is at odds with the complex practice of HIV work. Patton (2004) wrote,

The dominant concept of evaluation in [monitoring and evaluation of HIV programs] is a traditional inquiry into an autonomous intervention delivered in a linear-outcomes model to isolate and attribute its impacts, including conducting quasi-experimental designs. I am openly skeptical about the utility of such designs in these circumstances. Indeed, the controls needed to even attempt such designs risk having the evaluation design interfere with the effective creation and implementation of complex and dynamic systems interventions that are too messy and emergent to be appropriately evaluated by static designs and linear, mechanistic attribution models....In essence, I would argue that HIV/AIDS is best understood as a dynamic, complex systems phenomenon. To be useful and insightful, evaluation designs need to match the nature of the phenomenon. (p. 169)

While Patton was writing about HIV efforts and monitoring and evaluation in developing countries, the same could be applied to the situation in Ontario, as I observed at the case organizations in this study. Questioning whether ‘more is better’ in monitoring for oversight and compliance also fits into critical studies of accountability (Bemelmans-Videc, et al., 2007; Feller, 2002; Freeman, 2002; M. Power, 1994, 1997, 2000, 2003, 2005).
In this study, I observed that in some ways, the data involved in evaluation practices was not as important as the relationships with funders (and others) that were maintained by these practices. Within this sector, OCHART was particularly well designed and allowed for a number of process uses, especially enhancing shared understandings. Building shared understandings through OCHART KTE day facilitated ongoing relationships within the sector across organizations, and between government funders and organizations. The value of relationship building came from the process itself, more than from the data. These relationships served not only to strengthen programmatic work, but also as the means to evaluating it as well.

Relationships within this sector were understood as not only an important outcome of, or a necessary component (through inter-organizational collaboration) to successful HIV work; they were also the means by which to evaluate the work carried out, and a reason for carrying out evaluation practices.

Relationships with funders were informed by evaluative information that relied on a particular kind of data – explicit and linear. However, the relationships these organizations had with community members relied more heavily on a different kind of knowledge, one that was more tacit, embodied, and experiential. Within this community of practice, there were several ways in which tacit and explicit knowledge related to each other. However, tacit knowledge was predominantly an infrastructure or foundation that explicit knowledge was made sense of and turned into information that could inform future plans (see Duguid, 2005).

Among this community of practice, the use of tacit knowledge to understand, interpret and make use of explicit knowledge was evident to me in the ways in which existing research evidence, and personal and professional experiences of community members were drawn upon in program development. There was competition for limited human and financial resources between supporting programming, monitoring and evaluation for accountability, and monitoring and evaluation for learning. I observed that the capacity (including expertise) to carry out formal evaluations and the perspective that tacit knowledge held by members of the community of practice was deemed sufficient to gauge the process and impact of program delivery had an influence on the actual evaluation activities undertaken at these organizations. Explicit forms of data, such as epidemiologic and program monitoring data were required for accountability purposes. However, the responsive and relevant aspects of HIV prevention work were more dependent on tacit assessments and knowledge building that took into account the lived
experiences of program participants and implementers from communities most affected by HIV. This is similar to other research about other public health practitioners in Canada, where it has been shown that they draw on their own professional expertise, as well as knowledge held by the communities they partner with and whom they serve, in order to filter, make sense of, and apply knowledge from research evidence (Kothari, et al., 2012; Wharf-Higgins, et al., 2011).

9.2 Community-based discernment strategies

In this section, I introduce the concept of ‘community-based discernment strategies’. As introduced in Chapters 1 and 2, there have been several notable shifts in multiple health disciplines towards the promotion of an empirically-supported evidence base to inform practice (in medicine, social work, public health, etc.) (Steinberg & Luce, 2005). Beginning in the early 1990’s with the evidence-based medicine movement, this approach relies on quantitative measurements (especially RCTs) and manualization of approaches or treatments (usually referred to as interventions). Over time, there have been a number of responses to this movement across various disciplines (Knaapen, 2014; Martinez, et al., 2010; Mykhalovskiy & Weir, 2004; Pope, 2003). One of these responses is the emergence of ‘practice-based evidence’ movements, which Martinez et al. (2010) discussed as emerging over concerns about increasing pressure from funders and policy-makers for practitioners to carry out only evidence-based programs (either predominantly, or exclusively) as a condition of receipt of funding. Martinez et al (2010) noted that ‘practice-based evidence’ is the ‘practice to science’ complement to the ‘science to practice’ paradigm; this movement seeks to recognize practices and programs that may lack empirical evidence based on RCTs and/or other quantitative research methods, but have been created or improved through the experience of organizations carrying them out, using methods such as observation and tacit assessment, which may or may not be combined with other explicit research techniques (Isaacs, 2008, as cited in Martinez, et al., 2010). As a further refinement of the concept, Martinez et al. (2010) advanced the idea of ‘community-defined evidence’, which is “a set of practices that communities have used and determined to yield positive results by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community” (Martinez, et al., 2010, p. 12).

This research study sought to explore the HIV prevention evaluation practices of ASOs and what influenced these; in the process of answering these research questions, a clearer picture emerged
of the ways in which this success was determined and the processes in which knowledge and practices reached levels of acceptance. These community-based discernment strategies dealt with the complexities involved in HIV prevention work among communities at higher risk for HIV. They also emphasized plurality, and the fostering of relationships.

9.2.1 Complexity of community-based discernment strategies

Overall, the community-based discernment strategies employed by this community of practice were complex. They were highly responsive, and tailored to the specific needs of programs, the organizations hosting these programs, and the community that were intended to be served by them. Individual and collective tacit knowledge development was a feature of these community-based discernment strategies, many of which were largely undocumented.

This community of practice employed various ways of determining the success of their HIV prevention programs, and included processes in which knowledge and practices reached levels of community acceptance. These community-based discernment strategies made use of data derived from all of the evaluation practices described in Chapter 6 (i.e., discrete one-time evaluations, routine monitoring, and tacit assessment). They utilized tacit assessment, based on personal and professional experience, to assess more explicit knowledge. These community-based discernment strategies were complicated, and dealt with the complexity that was inherent in HIV prevention work by being responsive to the specific needs of the program and the community that the program intended to serve.

An example of this was the practice of convening various ad hoc program advisory committees in order to inform program planning, implementation, and evaluation, described in section 7.2. These committees were common practice for a variety of programs, and were designed to be highly responsive to the specific needs of the program, the organization hosting the program, and the community that the program intended to serve. Members of the community that the program intended to serve and those with personal or professional experience with the community and/or their issues were convened to provide guidance on programmatic and evaluation decisions. The number of committee members, length and frequency of meetings, and the kind of guidance and/or involvement in program implementation and evaluation carried out by different committees varied considerably. Some committees were convened over a number of years (with original members being replaced), while some others were relatively short-lived. The history of
committee membership, processes and decisions were complicated, and not usually recorded. In many cases, minutes of meetings were kept that detailed only the decisions made, with minimal details recorded of the discussions that had ensued. Many members of this community of practice could give rich narrative accounts of committee participation. Tacit individual and collective knowledge were built by being involved on a committee; this included knowledge about communities, and programming and evaluation to address HIV related issues. It also included experiential knowledge about how to deal with multiple sources of information, and built the relationships between people within this sector. While much of the experience of community advisory committees was undocumented, most members also accrued knowledge about the process of being on a community advisory committee, and the collective process of discernment that was ongoing in this sector.

9.2.2 Plurality of community-based discernment strategies

Overall, the community-based discernment strategies employed by this community of practice emphasized plurality. They were responsive to multiple stakeholders’ needs, and employed multiple methods to support the process of building knowledge and reaching acceptance. This community of practice valued multiple dimensions of the process and outcomes of their HIV prevention work. Multiple stakeholders’ needs contributed to the various ways of determining the success of their HIV prevention programs, and the processes in which knowledge and practices reached levels of community acceptance. These community-based discernment strategies were complex (see above); they also emphasized plurality.

An example of how community-based discernment strategies emphasized plurality was an HIV prevention program that secured additional research funding in order to assess the program’s implementation and outcomes. The program had been adapted from an existing US program designed for a community at high risk for HIV based on local knowledge and experience, including the personal and professional experiences of the staff member carrying out the program, with guidance from the organization’s management, and input from a community advisory committee. The research project that sought to capture and assess the modified program was advised by a committee made up of people with lived experience and academic expertise. The research project collected quantitative and qualitative data about the program and the participants’ experience. Traditional quantitative evaluation methods of analysis were not seen as
effective in capturing the outcomes of the project; one of the ways this was addressed involved working with an arts organization to write and produce a play, in which some of the program participants performed. Overall, this process involved a number of committees and individuals in a variety of roles, and drew on multiple sources of knowledge. Different stakeholders’ needs were met with a variety of methods of gathering and disseminating information.

In addition to being complex and emphasizing plurality, community-based discernment strategies also fostered relationships between people within this sector.

9.2.3 Relationships and community-based discernment strategies

The community-based discernment strategies employed by this community of practice fostered relationships, especially among individuals and organizations in the community-based HIV sector. This occurred through interaction, and building shared understandings. Various ways of determining success of HIV prevention programs were employed, and included processes in which knowledge and practices reached levels of acceptance.

An example of this are the ad hoc advisory committees discussed above in section 9.2.1. These committees involved a number of different kinds of stakeholders, including program implementers, funders, and people with lived experience of the issues facing the communities that programs intended to reach. These committees required individuals (who may have held very different opinions and experiences) to work together, assess a variety of information, and build shared understandings of complex issues facing vulnerable communities. It also involved decision-making about possible solutions, and building shared understandings about the consequences and effects of these decisions. These interactions occurred in meetings, and through communication via email. The relationships built among members of this sector also involved participating in various kinds of events and meetings beyond advisory committee meetings.

This shared meaning-making involved assessing explicit information, such as existing research, monitoring data, etc. using tacit experiential knowledge held by committee members. The collective meaning-making helped socially construct knowledge, allowing it to reach collective levels of acceptance and strengthened relationships across this community of practice.
Overall, through this research study I observed practices and processes that advance the understanding of the ways in which this community of practice determined success and the processes in which knowledge and practices reached levels of community acceptance. This contributes to the growing interest in ‘community-based evidence’ (Martinez, et al., 2010; Nebelkopf et al., 2011).

When you take into account the nuances of evaluation practices at ASOs, issues around how ‘evaluation’ is defined emerge. Narrower definitions of ‘evaluation’ focus on the assessment of merit, worth, and/or value, using empirical social science methods, and are usually based on positivist or post-positivist worldviews that emphasize objectivity and causality. More expansive definitions do not solely focus on assessment of merit, worth, and/or value, and draw from a variety of worldviews. However, even more expansive definitions tend to emphasize formal evaluation practices, that is, explicit or codified practices that are transmittable in formal, systematic language. However, when applying these definitions of evaluation to community-based work, a lot about community-based practices that generate and refine experiential knowledge is missed. The community-based discernment strategies employed at the organizations I studied were thoughtful and were frequently concerned with important issues that are hard to quantify. They valued the voices of multiple stakeholders, and were concerned about the impacts and utility of community-based work, with an emphasis on relationships within and across the sector and communities infected and affected by HIV.

In the DEBI system, unevaluated interventions reside at the bottom of the pyramid, in a devalued position (see Chapter 1). It has been noted that there are problems with the uptake of evidence-based interventions in the DEBI system from service providers (Dolcini, et al., 2010; Dworkin, et al., 2008; Gandelman, et al., 2006; Miller & Greene, 2005; Miller & Shinn, 2005; Owczarzak, 2012; Owczarzak & Dickson-Gomez, 2011a, 2011b; Veniegas, et al., 2009). There is some evidence that part of these problems is related to service providers’ criticisms that these programs do not reflect their own practice-based knowledge (Owczarzak, 2012) I would also contend that a greater appreciation of what ‘evaluation’ might mean to community-based organizations could address some of these issues, and the DEBI system as a whole. This fits in with work by Miller (2001), Miller and Shinn (2005), Dworkin et al. (2008), and the SFAF (2008) which called for a greater appreciation of the experiential knowledge that service providers bring to research-based evidence in the practice of community-based HIV work. A
greater appreciation of knowledge that service providers bring would also include an expansion of the idea of what constitutes success in HIV prevention programming in future research. In the DEBI system, the main criteria of success of an HIV program relies on decreases in reports of HIV risk behaviours from program participants. My research shows that service providers are interested in a variety of indicators of success that are much broader, such as process and outcome indicators that relate to social determinants of health and other health promotion models. Incorporating these details in future studies of HIV prevention programs may make them more likely to be taken up by community-based service providers.

**9.3 Limitations**

In this section, I describe the limitations of this study. The limitations associated with qualitative research have been cited by a number of authors (Creswell, 2003, 2014; Padgett, 2012; Patton, 2002; Pope & Mays, 2008; Stake, 1995). Qualitative research is sometimes perceived as subjective, and may produce more questions rather than simply providing answers (Stake, 1995). However, the extent that these and other issues are considered limitations depends on how they are perceived and interpreted; to some degree, this involves the underlying research paradigm that is informing the critic. For example, the limitations that the subjective nature of this research poses would be different to positivists compared to other post-modern approaches (such as interpretivist or constructivist). Flyvbjerg (2006) suggested that all research methods involve some sort of bias and subjectivity. In carrying out this research project, I followed recommendations provided to researchers carrying out qualitative case studies (Padgett, 2012; Patton, 2002; Simons, 2009; Stake, 1995, 2005; Thorne, 2008). I acknowledged that I was the main instrument in data collection, and that my values and judgements informed what I did during the research and how I understood and portrayed the cases and individuals that were part of this study. I employed a qualitative constructivist case study method, using an interpretive description methodological framework, and informed by community-based research principles, that explicitly allowed for sensitivity to my study participants’ lived experiences; and drew on my training, skills and intellect to filter data through a personal lens, that takes into consideration that I am situated in a specific sociopolitical and historical moment. I was reflexive during the process of this research, and used techniques to ensure the rigor of this qualitative study, included using a study journal throughout. Flyvbjerg (2006) describes that contrary to common belief, that falsification of the researchers’ preconceived notions is more common than
verification in case studies. By being reflexive in my approach to this study, I remained aware of my preconceived notions about the issues I studied, and was open to the falsification of them during the course of the research. Overall, the qualitative research methods employed allowed for this research study to explore and generate a detailed understanding about complex phenomena that occurred in a real-life setting. The methods employed were well suited to derive what Flyvbjerg (2006) called “concrete, context-dependent knowledge” (p. 224) and offered an in-depth exploration and deeper understanding of the complex issue of evaluation of HIV prevention at ASOs.

### 9.3.1 Generalizability

Discussion abounds about the kinds of generalizations that can be drawn from qualitative research (Creswell, 2003, 2014; Padgett, 2012; Patton, 2002; Pope & Mays, 2008; Stake, 1995). In addition, there is also discussion about the limitation of case studies, which tends to centre around what type of generalizations can be appropriately drawn from these types of studies due to the small number of cases usually employed (Stake, 2005; Yin, 2009). As described in the methods section, I did not randomly sample organizations or participants in this study, or use any other technique that would be adequate to make statistical generalizations to a wider population. To some critics, this introduces the limitations of lack of breadth, the inability to show how frequently the phenomena I discovered is occurring (in a population), or external validity where I could generalize the results to other cases.

Again, the extent to which this is a limitation and the appropriate response to it depends on the approach taken (Padgett, 2012). Padgett (2012) discussed how constructivists have questioned the relevance of generalizability, and have argued that an emphasis on generalizability strips away the context that confers credibility on a qualitative study. Instead of discussing generalizability of the sample, qualitative researchers are concerned more about the transferability of the study’s findings (Padgett, 2012). In this research, I studied the issue of evaluation of HIV prevention programs at ASOs, at two case organizations in-depth. By doing this, I was not aiming to produce what Flyvbjerg (2006) called “general, context-independent knowledge or theory” or “neat scientific formulae, general propositions, and theories” that could be generally formalized (Flyvbjerg, 2006, p. 237). The method I used was well-suited to produce “concrete, context-dependent knowledge” (Flyvbjerg, 2006, p. 224) that offers an in-
depth exploration of a complex issue. Flyvbjerg (2006) asserted that from both understanding-oriented and action-oriented perspectives, “it is often more important to clarify the deeper causes behind a given problem and its consequences than to describe the symptoms of the problem and how frequently they occur” (Flyvbjerg, 2006, p. 229). Following Stake’s (1995, 2005) advice, I focused on the intricacies of my two case organizations, their HIV prevention programs and their evaluation practices. I have aimed to describe these comprehensively to readers, in the hopes of providing readers with enough detail so they can experience the happenings of the case “vicariously and draw their own conclusions” (Stake, 2005, p. 450). This is a process that Stake (2005) referred to as “naturalistic generalization” which is posited against “explication (propositional) generalizations” (Stake, 1995, p. 85).

### 9.3.2 Limitations of using community of practice framework

Some limitations to this study were introduced by using a community of practice framework to understand the HIV prevention work and evaluation at ASOs. By framing the funders, ASO management and staff, and volunteers interviewed in this study as members of a community of practice, certain groups were missed. For example, by including only groups that are involved in carrying out (or funding) HIV prevention work, the perspectives and experiences of program participants were not captured. The importance of including program participants’ experiences is highlighted in evaluation literature, especially in fourth-generation evaluation and other collaborative approaches (Cousins, et al., 2012; Guba & Lincoln, 1989; King, 2005). There was also an additional group missing: people from the communities that these organizations intend to serve that are not affiliated with these kinds of organizations. The perspectives and experiences of both of these groups may have more fully rounded out the context of HIV prevention work that was studied. However, they fell outside the scope of what I could feasibly undertake in this research study. Future research to address the perspective and experiences of program participants with regards to HIV prevention programs and their evaluation should be considered. In addition, understanding the perspectives of community members that are not affiliated with community-based organizations could shed further light on these issues.

There are other limitations introduced specifically by including the funders within the community of practice I engaged in this study. There are differences between funders and people who manage, work, or volunteer at ASOs. There is some discussion about ASOs losing their
connection to the communities they serve while strengthening their ties to the state, and the problems that this introduces (Cain, 1993, 1995). In this study, I observed that accountability to funders, especially government funders, was well developed, but the ways in which ASOs were accountable to the communities they serve were less so. In addition, the kinds of conversations that happen among people who work or volunteer at an ASO are different than with funders. It is possible that the people who manage, work, or volunteer at ASOs could be thought of as one of the communities within the community of practice I engaged in this study. However, there were compelling reasons to include funders within the community of practice I engaged in this study. Their perspectives and experiences deepened the understanding of HIV prevention work and evaluation. In addition, almost all of the funders interviewed discussed with me their previous experiences as volunteers, staff or managers of community-based organizations. All the funders described a certain kind of responsibility for HIV prevention work. Even though they were not frontline service providers, and some of the settings were not possible for them to access (e.g., a female nurse couldn’t conduct outreach in a bathhouse), they felt responsible for programs that were relevant and useful for communities at high risk for HIV. Some of the staff and management at the ASOs also identified funders as their allies, partners, or brothers and sisters. It should also be noted that the government funders included in this study were government employees in departments that specifically provided funds to nonprofit organizations to carry out community-based HIV work. The perspectives and experiences of other government funders, responsible for different funding streams were not captured, and how these may differ is not known.

A further limitation, which has been noted in critiques of community of practice theory, is how this framework tends to conceptualize community in a way that implies consensus, and devalues or suppresses social difference (Contu & Willmott, 2003; Marshall & Rollinson, 2004; Mørk, et al., 2010). Fuller development of issues related to power and control, and how these shape social relations and use of evaluation in the community-based HIV sector might have been possible had an alternative framework been selected. In addition, the methods employed by this study did not allow for issues of power within relationships (e.g., asymmetries between funders and program implementers) to be fully unpacked, and for the impact of these on evaluation practice to be well understood. Issues about the unequal distribution of power within this community of practice might have also helped inform a more nuanced understanding of the impacts of performance
monitoring systems that are called for in work by M. Power (1994, 1997) and Bowerman et al. (2000) about ‘audit explosions’, ‘audit messes’, ‘performance monitoring societies’. For example, I am left with questions such as, “Are program implementers, given their need to maintain cordial relationships with their government funders, really in a position to surface the negative consequences of intensification of monitoring and evaluation? And, if they are not in a position to do this, can these issues really be discerned?” The frameworks and methods I employed introduced some limitations and perhaps restricted the amount of understanding about how increasing monitoring and evaluation demands impact the community-based HIV sector.

Despite these limitations, this study has some important insights to offer in the realm of evaluation at ASOs. Overall, employing a qualitative constructivist case study method, which used an interpretive description methodological framework, and was informed by community-based research principles, was an appropriate and useful choice for this study. Despite the shortcomings outlined above, some implications for practice and theory can be drawn. I explore these in the next section.

9.4 Implications

Despite the limitations I identified, some implications for practice and theory can be drawn from the findings of this study.

9.4.1 Implications for community-based practice

Overall, this community of practice uses a plurality of practices in order to evaluate its HIV prevention work. However, the pressure to monitor for accountability to government funders was a dominant factor in evaluation practice, and was growing. In particular, there was pressure to demonstrate program planning and improvement based on explicit knowledge derived from monitoring practices, a process which was conceived of as linear, sequential, or, at best, iterative. As discussed above, this community of practice draws on a number of complex and plural processes in order to keep their responses to HIV relevant to the communities they serve. If pressure for monitoring or demonstrating a certain kind of learning moves this sector away from the concerns of the communities they hope to serve and towards making decisions based on limited and limiting information that standard monitoring practice amasses, the response to HIV will not likely find relevant and timely ways to address the continuing epidemic among
communities that are most at risk for HIV. Another way to respond to this pressure may be to become more adept at articulating the experiential knowledge gained in delivering programs or accumulated in other ways through interacting with the communities they serve, and relying on this knowledge when asked to explain program planning and improvement. Nonaka and von Krogh (2009) suggest that a degree of tacit knowledge can be articulated. Patton (2004) suggested that to “be useful and insightful… evaluation… need[s] to match the nature of… HIV… which is best understood as a dynamic, complex systems phenomenon” (p. 169). This framing of the HIV epidemic could allow for more diverse kinds of knowledge to be valued in the response to HIV.

Managers and staff at ASOs who were involved in reporting to government funders were in agreement with funders that some level of monitoring for accountability was necessary. However, the amount of monitoring that was considered appropriate was an ongoing negotiation. These negotiations were based on the impacts that increasing monitoring requirements had on practice, especially in terms of burdening community-based agencies with further data collection and reporting. They were also based on ideas and rationalizations about how increasing amounts of monitoring requirements for accountability might provide benefits. Funders described that they either anticipated or had been given guidance from the people they reported to that more monitoring information was needed, even if the benefits of increased reporting were not explicit. Some respondents expressed the hope that increased monitoring of additional outputs would produce the kind of information that could ‘prove’ the important impact of community-based HIV prevention work to the general public, which may not be well attuned to the issues that communities at high risk for HIV face. However, converting reporting on outputs to information about outcomes is a difficult endeavour; and knowing more about different outputs do not necessarily result in knowing more about impacts. In addition, it is difficult to persuasively quantify impacts of community-based work, especially for stakeholders who may hold social or political views that are opposed to government-funded social health and welfare programs. Thus, this proposed benefit of more monitoring seems unlikely. Another proposed benefit – that organizational learning and program improvement would occur from more monitoring – also seems unlikely. As discussed above, it was not evident that program planning or improvement at the cases studied occurred as a result of the data from OCHART. Overall, the negotiations about what is an appropriate amount of monitoring for accountability would benefit from a closer
examination of the proposed benefits, in order to balance them thoughtfully against the additional burdens increasing monitoring creates.

The need for community-based organizations to monitor and evaluate their HIV prevention programs for a variety of reasons, including providing information to a variety of stakeholders is a fait accompli. However, how they are to fulfill this requirement is less clear. There is a need to support this sector’s capacity in formal monitoring and evaluation, as well as recognize the value of tacit knowledge. These cases were quite dependent on the skills and capacities of individuals, usually staff (and sometimes volunteers) to carry out monitoring and evaluation activities. Many of them have not had training. In addition, a funder also talked about their own lack of capacity to make recommendations on the evaluation plans of organizations who were applying for funding. Support for formal monitoring and evaluation capacity building among the entire sector seems warranted. This would likely be better if it fostered formal monitoring and evaluation capacity along with building community-based discernment strategies that recognize tacit knowledge.

Capacity building around how to identify, assess, adopt, or create tools and measures that are reasonable and appropriate for ASOs to use to better capture their work is recommended. For example, an area that could be developed further is better tools and measures to capture and understand the effect of programs in enhancing relationships that support health and well-being among communities at high risk for HIV. Other areas include: how monitoring and evaluation could be harnessed to foster community engagement, and/or mechanisms to further develop accountability to the communities that are served by these organizations.

An important implication for practice from this study is the acknowledgement that there is an inherent difficulty with providing support for monitoring and evaluation specifically for HIV prevention, since it is embedded within the context of ASO work that involves other activities and mandates (e.g., providing support to people living with HIV). With no obvious ‘HIV prevention department’ at an agency, there is no defined group of workers to target HIV prevention focused literature, program or evaluation support to. In addition, with no standard definition of what a program is, and a great deal of variation in size and scope, it is hard to standardize program evaluation approaches. Evaluation literature often tries to distinguish programs at different levels, and planning and evaluation advice is given that is appropriate to
these levels; for example, the Kellogg Foundation (1998) suggests project, cluster and program/policy-making levels. These levels are appropriate for an organization that provides funding to specific projects, which are sometimes clustered into groups that address issues of particular importance to the agency and is governed by policies that cut across programs and clusters. Based on this, these are inappropriate levels for the case organizations I studied, which are the recipients of numerous diverse funding sources (not the provider of project funding). Capacity building efforts need to recognize the diversity of programmatic activities carried out, and take into consideration their complexity, as well as the local organization of ASOs and the context in which they are embedded.

While ASOs have been part of the community-based response to HIV since the beginning of the epidemic, the response to HIV has always involved tensions between scientists, government officials, and affected communities as to who are seen as ‘experts’ (Altman, 1994; Miller & Greene, 2005). Given the need to understand multiple divergent perspectives, constructivist, collaborative and participatory approaches to evaluation make a particularly good fit. In this study, I noted that this community of practice tended towards using a participatory monitoring and evaluation approach, as described by Jackson (2005), for instrumental (rather than transformative) reasons. This seems like an appropriate response to the possible threat of more ‘top down’ approaches, as shown by the CDC’s approach to HIV prevention programs in the US. This echoes Knaapen’s (2014) description of how the medical profession has repositioned the tools related to evidence-based medicine as a “defensive strategy to avoid externally controlled regulation” (p. 803). This serves to maintain the collective autonomy of the profession (albeit, at the cost of the autonomy of individual practitioners) and introduces a new kind of hierarchical intra-professional regulation, where instead of third parties, it is the ‘knowledge and administrative’ elite of the profession that employs standards to order, assess and direct the work of the rank and file professions, and serves to ward-off external control. The hierarchies among the practitioners involved in the delivery of community-based HIV programs may be less visible and formalized. Participatory approaches to monitoring and evaluation that build capacity and give voice to more marginalized individuals and groups will likely be the most useful in furthering monitoring and evaluation practice in HIV prevention.

Attending to the diversity and complexity of programming, and capacity building in evaluation approaches that give voice to more marginalized groups are likely to be important to consider in
future evaluation policy and practice in this sector, given that there is a move towards the integration of services related to HIV, hepatitis C and other sexually transmitted and blood-borne infections (CATIE, 2015). While it is difficult to predict the kinds of effects that this move will have on individual ASOs, it could require significant changes to some organizations such as: the expansion of the kinds of services provided, the types of client they are targeting, and/or the communities that these organizations are intended to serve. For example, currently, an ASO could evaluate their level of community engagement using tools that have been developed to measure the ways in which people living with HIV are meaningfully involved in decision-making at their organization; this is referred to as the greater involvement and meaningful engagement of people living with HIV/AIDS (GIPA/MIPA) (OAN, 2011). However, an integrated approach may require an organization to consider the needs of people living with Hepatitis C, and how they can meaningfully engage people from this community in their organizational decision-making. There may be a need to adapt existing tools, and develop new ones in order to appropriately evaluate the complex aims and work carried out by these organizations.

9.4.2 Theoretical implications

There are a number of potential opportunities for theory development from this study; a few of these will be discussed in this section. This research study built upon several responses to the evidence-based practice movement, such as the practice-based evidence movement, and the concept of community-defined evidence (Martinez, et al., 2010). The community-based discernment strategies I observed being carried out among this community of practice explains the ways in which success among community-based providers of HIV prevention programs was determined, as well as the processes by which knowledge and practices reached levels of acceptance. These community-based discernment strategies dealt with the complexities involved in HIV prevention work among communities at higher risk for HIV. They also emphasized plurality, and the fostering of relationships. Concepts related to community-based discernment strategies could be developed further; the aim of this further development would be to recognize the discernment strategies that are already in practice and how these can be understood within the evidence-based practice movement. The hope is that fostering the integration of community-based discernment strategies with other more traditional evidence-based methods, we will be better equipped to deal with the ongoing challenges of making HIV prevention programming
most effective, useful, and relevant to communities and individuals at risk and most affected by HIV.

Another area for further theory development relates to how knowledge production can be more participatory and inclusive, and how monitoring and evaluation practices can contribute to this process. Collaborative and participatory approaches to evaluation, discussed in Chapter 2, address the importance and value of incorporating participants in evaluation. However, there could be further development of the ways in which these approaches could be harnessed to allow for more inclusive processes of knowledge production, particularly processes that embrace plurality and allow for integration for multiple ways of knowing. Beyond just ‘giving voice’, there lies the possibility of changing the ways knowledge is produced to be more inclusive of diverse communities.

Finally, the finding that this community of practice has an implicit, but sustained interest in developing relationships that enhance health and well-being among individuals and communities has implications for theory. In particular, there could be more development of theory about relationships among people at risk for HIV and HIV prevention programs. While there is a long history of research on social supports and health outcomes, there continues to be a lack of research on specific mechanisms through which social relationships and social support improve physical and psychological well-being (Thoits, 2011). In addition, social support and HIV research has tended to focus on people living with HIV; the role that social support plays in HIV prevention among people who are HIV-negative is less understood (Darbes, Chakravarty, Beougher, Neilands, & Hoff, 2012). It would be helpful to have a deeper understanding of specific dimensions of social supports, mechanisms through which HIV risk is mitigated in individuals and communities, and how prevention programs delivered to communities at higher risk of HIV might apply mitigation mechanisms.

9.5 Conclusion

Community-based HIV prevention programs are key in the response to HIV, yet their effectiveness can be hard to determine, and how this influences how program implementers and funders make decisions about their programs has been unclear. This research study sought to expand the understanding of HIV prevention program evaluations by identifying evaluation practices related to these programs and exploring what influences these practices at ASOs. By
doing, this, I had hoped to better understand the role that monitoring and evaluation played in capturing, making sense of, and assessing programs (including judging the merit or worth of HIV prevention programs) by implementers and funders of these programs.

This study was informed by community-based research principles, and I utilized a qualitative constructivist case study method, and an interpretive description methodological framework to study two community-based organizations in Ontario over a period of three years. Evaluation practices at these organizations were complex and plural, and emphasized relationships with program participants, and between service providers and governmental funders. Monitoring and evaluation practices – both formal and tacit – assisted in a collective “sense-making” of HIV prevention work with diverse communities. This study provided a rich picture of community-based discernment strategies currently employed at ASOs. This study provides a deeper understanding of evaluation and accountability, and how small organizations that serve diverse communities must balance their multiple accountabilities to funders and the communities they serve. It also reveals relationships between formal evaluation practices and tacit knowledge development within organizations that rely on embodied community knowledge to remain relevant, meaningful and effective.

This study generated information about attributes or qualities of HIV prevention programs that are important to program implementers and the state of current evaluation practices at two ASOs. It also generated information about the contextual factors and other influencers that are linked to evaluation practices. It described the situation faced by ASO HIV prevention program implementers in an urban area in Ontario, Canada. It may be used to provide other ASOs with information about HIV prevention evaluation criteria and practices; and could help to educate current and future program evaluators about the social and political considerations involved in measuring HIV prevention work. It also contributes to a critical understanding of evaluation practices in community settings, which leads to insight about the current state and consequences of evaluation practice in the public sector.
References


211


Appendices
Appendix A
CRG Terms of Reference

Membership
The membership shall include, but is not limited to:
- Representative from AIDS Service Organizations (ASOs)
- Policy-makers and/or funders
- Other stakeholders
The CRG will involve at least one person living with HIV (PHA).

Role and Purpose
The Community Reference Group will provide advice and feedback to the Principal Investigator (PI) on the following aspects of the research project:
- Case selection
- Interview guides
- Verification of findings
- Dissemination and knowledge transfer and exchange (KTE) strategies
- Promotion of the study

Input and advice from the CRG will help ensure: that the project produces relevant results and knowledge that will be shared appropriately with stakeholders; and that action plans associated with the research receive community input and are appropriate to stakeholders’ needs and concerns. No financial compensation for participating will be offered.

The research project is the doctoral thesis of the PI. The PI, under the supervision of her academic supervisor, has overall responsibility for the study. These responsibilities include:
- Budget and overall project management
- Data collection and analysis
- Ethical standards
- Reports to funder(s)
- Thesis defense and other University of Toronto requirements
- Final report(s) and other dissemination activities

The PI will administratively support the CRG, and keep members informed of the study progress. The PI will circulate agendas and prepare notes or minutes for CRG meetings.

Accountability
The members of the CRG are accountable to the stakeholders, organizations and individuals that they represent. The PI is accountable for directing the design and implementation of the project and the dissemination of the results, within the requirements of the Department of Health Policy, Management and Evaluation and the University of Toronto.

Schedule of CRG meetings
CRG meetings will include CRG members, the PI, and other members of the thesis committee who may want to attend. The CRG will meet 2-3 times/year over the duration of the project. Meetings will not exceed 3 hours. Where necessary, members may be able to attend by phone teleconference. The schedule of meetings is as follows:
July 2011 Introductions to CRG and study, case selection, interview guides, KTE planning
March 2012 Feedback on preliminary results from Case A; preparing for Case B data collection
October 2012 Feedback on results from preliminary analysis
May 2013 Feedback on analysis and conclusions, reviewing case descriptions, KTE
Appendix B
Invitation Letter to Case Organizations

September 14, 2011

Shannon Thomas Ryan
Executive Director
The Black Coalition for AIDS Prevention
20 Victoria St. 4th floor
Toronto, Ontario M5C 2N8
(416) 977-9955 ext. 227
s.ryan@black-cap.com

Re: Request to Participate in Case Study Research

Dear [Organization Name],

This letter is a request for your organization to participate in my case study research project as a case. It outlines what participating in this research project would require from your organization. I am conducting this project for my PhD thesis in the Department of Health Policy, Management and Evaluation (University of Toronto), under the academic supervision of Dr. Rhonda Cockerill (University of Toronto), and my thesis committee (Dr. Winston Husbands from ACT and Dr. Cathy Worthington from the University of Victoria).

By participating as a case, your organization may benefit by being exposed to new information about HIV prevention evaluation research and practices. Upon the conclusion of the research, I would be happy to make a presentation to your staff or management about my findings and to prepare a summary of the research for your organization.

What is the project about?

As you know, evaluation of HIV prevention programs at ASOs can be a complex undertaking. Research from the US has involved randomized trials to determine science-based effective behavioural interventions. However, from the frontlines of HIV prevention work at ASOs, it is hard to tell if the interventions that have been studied in trials are better than the programs that are already running at ASOs. Also, ASO work usually involves more than just the program participants’ reports of their HIV risk behaviour (which is the main criteria used for judging science-based interventions). In light of this, the purpose of this study is to expand the understanding of evaluation of HIV prevention programs at ASOs. Specifically, it aims to identify qualities or attributes of HIV prevention programs that are used to make judgments about HIV prevention programs at ASOs. It will also focus on the evaluation practices of ASOs while taking into consideration the social and political context of ASO work. This study is important because it will address gaps in the scientific literature and it will provide other ASOs with information about HIV prevention evaluation criteria and practices. It could help to educate program evaluators about considering the social and political context and other evaluation criteria to measure HIV prevention work.

A Community Reference Group (CRG) comprised of ASO representatives and other stakeholders is advising this project. Current members of the CRG include Jessica Cattaneo.
What would your organization’s participation as a case in this project entail?
The research project is a case study of two ASOs that conduct and evaluate their HIV prevention programs. [ACT] has agreed to be a case, and I am hoping that you would agree for your organization to be the second case. As a case, I would like to conduct interviews with various stakeholders at and related to your organization, review documents about HIV prevention program evaluation at your organization, and attend and observe meetings at your organization. I will spend six to eight months studying both cases; this means I would spend about three to four months studying your case. I will analyze the data from your case separately from the other case, as well as doing a cross-case analysis. My findings will be written up in a thesis dissertation. The study will take two years to complete. Here are some further details about some steps of the study. I would be happy to discuss any of these with you.

Interviews
The interviews I will carry out will be recorded one-on-one in-depth interviews about evaluation and HIV prevention programs with various stakeholders at and related to your organization. These include: staff members, volunteers, members of your management team, one of your funders, and an interview with you as the Executive Director. In total I hope to carry out at least five, but no more than 10 interviews for your case. Consent will be obtained from individuals prior to the interview. I will not be offering any honoraria to participants.

Document Review and Meetings
I would like to review documents that relate to HIV prevention program evaluation; these could include internal reports or communications, and reports to funders (i.e., OCHART forms, etc.). If there are any meetings where HIV prevention programs will be discussed, I would like to attend and take notes. Meeting attendees will be asked for their consent for me to attend, take notes and include my observations in my analysis.

Confidentiality
While I will take steps to conceal the identity of the cases and individuals interviewed (by assigning pseudonyms and securely storing the data collected) given the nature of this study, complete anonymity cannot be guaranteed. As the ED of the case, you will have an opportunity to see how the case is reported in the context of the dissertation and to respond, if necessary, with what you feel increases the accuracy, relevance and fairness of the information presented.

Why participate?
Your organization’s participation in this research would be greatly appreciated, and is pivotal to the success of this research project. Unfortunately, I’m not able to offer your organization an honorarium for participating. To be clear, I will not be evaluating any HIV prevention programs or evaluation practices at your organization, or making value judgments about your organization; my aim is to identify and assess the issues affecting how ASOs such as yours understand their HIV prevention programs. I believe that this will contribute to the state of scientific knowledge and could help improve evaluation and HIV prevention programming overall. By participating
as a case, your organization may benefit by being exposed to new information about HIV prevention evaluation research and practices. I would be happy to make a presentation to your staff or management about my findings and to prepare a summary of the research for your organization.

If you are willing to participate, I would need a letter of support from your organization, which I would submit to the University of Toronto HIV Research Ethics Review Board. Thank you for taking the time to consider participating.

Sincerely,

Nicole Greenspan
Nicole Greenspan, MHSc
PhD candidate, Health Services Research
nicole.greenspan@gmail.com

416-871-3026
Appendix C
Interview Guide

1. Intro
   • [I explain my background/the research project]
   • How long have you been involved in HIV work?
   • Please describe an HIV prevention program that you have been involved in.
     o [Probe about: target population, type of intervention, timeframe of the intervention, their role, decisions they made about the program, overall objective of the program]

2. Characteristics of HIV prevention programs
   • Please describe some characteristics/indicators of success of this program. When the program is going well, how can you tell? Or, if it is going badly?
     o [Probe about: what attributes are important to you about the program, what do you base decisions about the program on, what would you compare two programs on, do you record these anywhere]
   • In the US the DEBI’s measured the success of their programs by asking program participants to describe their HIV risk behaviors before entering the program, and again, at the end of the program to measure self-reported HIV risk behavior change and compared it to a control group. What do you think of this?
     o [Probe about: what do you think of behaviour change as an indicator of success in HIV prevention programs?]

3. Evaluation Practices
   • What kind of recording do you do for your program? Who funds your program and what kind of reporting do they require?
     o [Probes: What evaluation activities related to HIV prevention programs are carried out at your organization? How often are these carried out? Who is responsible for them? Do you use client feedback forms? How do you record the number of people who participated in your program? Where do you keep records like this? What evaluation activities are carried out on a regular basis for funders? What is the funding cycle of your program and the evaluations and reports required by your funder? What kind of information do your funders want in their reports? Do you collect more than this?]

4. Context/pressures
   • Do you think there are any other pressures on what makes an effective HIV prevention program?
     o [Probes: Do you think funders, community members, other ASO workers, agree with you about what is a successful HIV prevention program? Is your funder as interested in this characteristic as you are? Would community members think it’s important? Are there any other things influencing this?]
Appendix D
Information Sheet

What is the project about?
AIDS services organizations (ASOs) have been key deliverers of HIV prevention programs since the beginning of the response to HIV/AIDS. However, research has documented that workers at ASOs can often feel frustrated with knowing whether the work they are doing is having an impact on behaviour or infection rates. In the US, there has been research using randomized control trials to determine science-based effective HIV prevention programs. In these studies, HIV prevention program participants report the things they do that put them at risk for HIV before they enroll in the program, at the end of the program, and at some point after the program. Their responses are compared to people who weren’t in the program. It is hard to tell if the programs that have been studied this way are better than the programs that are already running at ASOs. It is also hard to tell how participants’ reports of their HIV risk behaviour fit in with other things about HIV prevention programs that people at ASOs find important about their programs. The purpose of this study is to expand our understanding of evaluation of HIV prevention programs at ASOs. It is a case study that will describe characteristics of two ASOs that conduct and evaluate their HIV prevention programs. Specifically, it aims to identify qualities or attributes of HIV prevention programs that are used to make judgments about these programs. It will also focus on the ways in which these organizations evaluate their programs while taking into consideration the social and political context of ASO work.

Individual interviews with people who run HIV prevention programs, managers and funders of ASOs, and other stakeholders such as ASO board members will be carried out. Documents and meetings about evaluation at ASOs will also be studied. Three to four months will be spent studying each case. The study will take two years to complete.

This study is important because it will address gaps in the scientific literature and it will provide other ASOs and elsewhere with information about HIV prevention evaluation criteria and practices. It could help to educate program evaluators about considering the social and political context and other evaluation criteria to measure HIV prevention work.

Who is involved in the project?
Nicole Greenspan is a PhD student at the University of Toronto, and she is carrying out this project for her thesis. She is working under the supervision of Dr. Rhonda Cockerill, and a thesis committee (Dr. Winston Husbands from the AIDS Committee of Toronto and Dr. Cathy Worthington from the University of Victoria). There is a Community Reference Group made up of ASO representatives and other stakeholders that are advising this project. This project has undergone review and been approved by the University of Toronto HIV Research Ethics Board. This study was supported by a Studentship Award from the Ontario HIV Treatment Network (OHTN).

If you would like further information about this study, contact
Nicole Greenspan
nicole.greenspan@gmail.com
416-871-3026
Appendix E
Informed Consent Form

You are being asked to participate in an interview or you are part of a meeting that is being observed as part of a study of evaluating HIV prevention at AIDS service organizations (ASOs). In order to know if you would like to participate in this interview or to consent to being observed, you should understand its risks and benefits to be able to make an informed decision. Make sure that all your questions have been answered before agreeing to participate.

What is the project about?

ASOs have been key deliverers of HIV prevention programs since the beginning of the response to HIV/AIDS. The purpose of this study is to expand our understanding of evaluation of HIV prevention programs at ASOs. It is a case study that will describe characteristics of two ASOs. Specifically, it aims to identify qualities or attributes of HIV prevention programs that are used to make judgments about these programs. Individual interviews with people who run HIV prevention programs, managers and funders of ASOs, and other stakeholders such as ASO board volunteers will be carried out. Documents and meetings about evaluation at ASOs will also be studied. The time period for the study will be approximately one year.

Who is involved in the project?

Nicole Greenspan is a PhD student at the University of Toronto, and she is carrying out this project for her thesis. She is working under the supervision of Dr. Rhonda Cockerill, and a thesis committee. There is a Community Reference Group made up of ASO representatives and other stakeholders that are advising this project. This project has undergone review and been approved by the University of Toronto HIV Research Ethics Board. This study was supported by a Studentship Award from the Ontario HIV Treatment Network (OHTN).

How will the interview work?

You are being asked to participate because of your involvement with HIV prevention programs at ASOs. If you agree to be in the study, you will be asked to complete an interview with the researcher (Nicole Greenspan). This will last approximately an hour. The time and location for
the interview will be arranged at your convenience. During the interview you will be required to verbally respond to a series of questions. With your consent, your answers will be recorded on paper and by audio recorder. You may refuse to answer any questions. Sometime after the interview, the researcher will be in touch and provide you with notes which summarize the interview. You will be asked if there is any misunderstanding or disagreement about the content of the interview and if there is any information you would like to be excluded from the study. You may also be asked to complete a follow up interview.

**How will being observed as a participant work?**

You are being asked for your consent because of your participation in a meeting at an ASO that is being observed for the purpose of this research study. The researcher will be taking notes about the meetings. With your consent, some of these meetings may be recorded. You should be aware that any of your interactions with the researcher may constitute some form of data gathering.

Please ask the researcher about anything that worries you, and tell the researcher if you change your mind about being in this study.

**What are the conditions for participating?**

**Participation in this study is voluntary.** You may decide not to be in this study, or to be in the study now and change your mind later. Please contact the researcher if you chose to withdraw. You may leave the study at any time without affecting your employment status. You may refuse to answer any question you do not want to answer, or not answer an interview question by saying “pass” if at any time if you do not feel comfortable.

**What risks and benefits are there?**

There may be some social risks involved in participating in this study. As a participant, there could be potential for you to recall controversial or sensitive issues related to evaluating HIV prevention programs. You have the right to not answer any questions during the interview that may put you at risk professionally. Your interview responses and any personal details collected will be kept confidential.
You may not receive any direct personal benefit from participating in this project, but the information you share will help expand our understanding of evaluating HIV prevention, with the hope of improving practices of policies about evaluating HIV prevention work.

You will not be financially compensated for participating in this research study.

**How will you make sure my information remains confidential?**

All information shared during the interview and observed in meetings will be kept confidential. No names will be included in any written notes, publications or presentations. All data will be kept securely (i.e., using password protection or kept in a locked place) by the researcher. Upon completion of this project, all data will be destroyed or stored in a secure location.

There may be some limitations to the degree of privacy and confidentiality that can be ensured because the interviews and observation will focus on your professional experience with an ASO and therefore there may be identifying information in the transcripts or notes. However, complete transcripts or field notes will only be reviewed by the researcher or her supervisor(s). Quotations from interview transcripts may be used to support ideas but no personal names will be used and quotes that would have potentially identifying information will not be used. While this does not guarantee anonymity, it reduces the likelihood that you would be identifiable.

**Where can I go for questions about my rights as a participant?**

If you have any questions about your rights as a research participant or have concerns about this study, the Office of Research Ethics can be contacted at 416-946-3273 or by e-mail at ethics.review@utoronto.ca. The Office of Research Ethics is a group of overseers who have approved the conduct of this research study. These people are not part of the study team. Everything that you discuss will be kept confidential.

Where can I go for more information about the results or any other information about this study?

The results of the research maybe published in reports and professional journals. You can request a copy of these by contacting the researcher, or if you have any other questions about the study: Nicole Greenspan at 416.871.3026 or nicole.greenspan@gmail.com
**Consent**

I understand the purpose of this project and I have had a chance to ask questions. I voluntarily consent to participate in this project with the understanding I can stop at any time with no penalty to me. I have received a copy of this consent form.

___________________________  __________________________  __________
Participant Name (please print)         Participant Signature       Date

My signature means that I have explained the study to the participant named above. I have answered all questions

___________________________  __________________________  __________
Name of Person Obtaining Consent         Signature          Date

If you would like further information about this study, contact
Nicole Greenspan
nicole.greenspan@gmail.com
416-871-3026
Appendix F
Approval Letter from REB

PROTOCOL REFERENCE # 26631

July 11, 2014

Dr. Rhonda W Cockerill
INST OF HEALTH POLICY, MANAGEMENT & EVALUATION
DALLA LANA SCHOOL OF PUBLIC HEALTH

Nicole Greenspan
INST OF HEALTH POLICY, MANAGEMENT & EVALUATION
DALLA LANA SCHOOL OF PUBLIC HEALTH

Dear Dr. Cockerill and Nicole Greenspan,

Re: Your research protocol entitled, "Frontline measures: Evaluating HIV preventon at AIDS Service Organizations"

ETHICS APPROVAL

Original Approval Date: July 12, 2011
Expiry Date: July 11, 2015
Continuing Review Level: 1
Renewal: Data Analysis Only

We are writing to advise you that you have been granted annual renewal of ethics approval to the above-referenced research protocol through the Research Ethics Board (REB) delegated process. Please note that all protocols involving ongoing data collection or interaction with human participants are subject to re-evaluation after 5 years. Ongoing research under this protocol must be renewed prior to the expiry date.

Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your protocol. Note that annual renewals for protocols cannot be accepted more than 30 days prior to the date of expiry as per our guidelines.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events should be reported to the Office of Research Ethics as soon as possible. If your research is funded by a third party, please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Yours sincerely,

Raj Maharaj
REB Co-Chair

Darrell Tan, M.D., Ph.D.
REB Co-Chair

Dario Kuzmanovic
REB Manager

OFFICE OF RESEARCH ETHICS
McMurrich Building, 12 Queen's Park Crescent West, 2nd Floor, Toronto, ON M5S 1S8 Canada
Tel: +1 416 946-3271 • Fax: +1 416 946-5763 • ethics.review@utoronto.ca • http://www.research.utoronto.ca/for-researchers-administration/ethics
Appendix G
OCHART Form – Sections 9-13
Partnership Activities
- Information
- Referrals
- Space
- Volunteers
- Funding
- Programming
- Committees
- Other (please specify):

Partner’s Area of Focus
- Addiction
- Health
- Education
- Social Services
- Population Specific Services
- Housing
- Justice
- Research
- Other (please specify):

Please describe the results achieved from the partnerships that have been mentioned above:

Please save the information

Top ↑

Section 9 & 10 - Education and Outreach

1. Education Prevention by age

In this question, we want to learn more about who you are specifically trying to reach with your education work.

When selecting your intended audience, please check off priority populations only if this is the audience that you specifically targeted and intended to reach, with information tailored specifically to that population. You should not ask your participants to self-identify, but neither should you check off priority populations only because you think a general public audience might happen to have members of priority populations in it.

For example: A workshop about aging with HIV that focuses on medication management, healthy eating, or retirement planning for PHAs advertised to PHA groups and held at a drop-in for PHAs is a workshop intended for PHAs. You would check off “People living with HIV” in this case. An HIV/AIDS NCT workshop with content not specific to PHAs, that has not been advertised specifically to PHAs, and held in a community centre, is not specifically targeted to PHAs. You should not check off “People living with HIV” in this case, even some of your audience members may be HIV+.

<table>
<thead>
<tr>
<th>Type of worker delivering presentation</th>
<th># of Presentations</th>
<th># of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select the type of worker who provided the presentation. Worker types refer to specific, AIDS Board-funded strategy positions for the African &amp; Caribbean Strategy, Gay Men’s Strategy, and the Wild strategy. For all other workers, select “Other prevention, education, support, outreach worker”.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| | | |
| | | |
| | | |
### Intended Audience (Select no more than four options)

- PP - People living with HIV
- PP - Gay Men/Men who have sex with Men (MSM)
- PP - People who use drugs
- PP - Aboriginal peoples
- PP - African, Caribbean or Black People
- PP - Women at risk
- Policy makers
- PP - Youth at risk
- PP - Incarcerated people
- Practitioners, professionals or service providers
- General public
- Students

For the each audience list past green bubbles beside each option with the following:
- PP - Youth at risk: includes Aboriginal youth
- PP - Women at risk: women who are represented in the priority population groups or engage in high-risk activities with them (e.g., sharing needles or other drug equipmen and/or engage in sexual activity)
- PP - Incarcerated People: includes individuals who are currently incarcerated, have a history of involvement with the criminal justice system and/or are accessing programs/services for ex-prisoners
- Practitioners, professionals or service providers: includes health care practitioners, social service providers, police, corrections staff, faith leaders, teachers, administrators, and staff of other workplaces/businesses
- Policy makers at all levels of government and their staff (municipal, provincial, federal)
- Students: includes all school ranges (elementary, secondary, high school, college, university)

### Presentation Forms (Select no more than two options)

- HIV/AIDS 101
- Gender Identity
- Anti-homophobia
- Diversity/Anti-oppression/Cultural Competence
- Living with HIV
- Grief and Loss
- HIV Decline

For the following options, have a green bubble with the following:
- Population specific issues: includes presentations that focus on a specific population and issues that are important for them (e.g., Aboriginal Peoples, Women, Africans, Caribbeans or Black communities, Gay/MSM/WOM, etc.)
- Living with HIV: includes speaker bureau presentations

### Intended Audience

<table>
<thead>
<tr>
<th>Extended Audience</th>
<th>Presentation Form</th>
<th># of presentations</th>
<th># of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>ACAP</td>
<td>All other funding</td>
</tr>
<tr>
<td>Practitioners, professionals or service providers</td>
<td>Anti-homophobia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gay Men’s Strategy Worker</td>
<td>HIV/AIDS 101</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women &amp; HIV/AIDS Initiative</td>
<td>Diversity/Anti-oppression/Cultural Competence, Addressing Violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Addressing Violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sent C 101</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other prevention, education, support, outreach worker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Aboriginal peoples</td>
<td>Anti-homophobia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy makers</td>
<td>Addressing Violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - African, Caribbean or Black People</td>
<td>Population Specific Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioners, professionals or service providers</td>
<td>Diversity/Anti-oppression/Cultural Competence</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1b. Presentation Type

Please enter the total number of presentations provided in the reporting period as reported in 1a) by type of presentation. The grand total of presentations by type should match the grand total of all presentations listed in 1a.

<table>
<thead>
<tr>
<th>Type</th>
<th>Total # of Presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACAP</td>
<td>All other Funding</td>
</tr>
</tbody>
</table>

**Type 1 - Short (under 3 hours) 1-day workshops in this reporting period**

**Type 2 - Longer workshops (half to full day; or workshop series) in this reporting period**

**Type 3 - Conference presentations in this reporting period.**

1c. Presentation Location

Of the presentations reported in question 1b, at which locations did they occur?

<table>
<thead>
<tr>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACAP</td>
</tr>
<tr>
<td>All other Funding</td>
</tr>
</tbody>
</table>

- ASOs (own ASO and other ASOs)
- Schools (elementary, secondary, college, university)
- Small local service agency (includes agencies that provide direct services to clients such as community health centres, mental health programs, addiction/treatment programs, settlement agencies, public health, social services, Ontario Works, agencies that help clients find housing, shelters, etc.)
- Correctional facility (includes prisons, halfway houses, detention centres, youth facilities, open custody, etc.)
- Police facility (includes police station, police academy, precinct, or other law enforcement administrative offices)
2. In-service Education Requests (pursuant to policy 15.5)

2a. In addition to formal, scheduled education sessions with groups, educators often respond to individual requests for information via phone, email, or drop-in to the agency.

For the reporting period, record the total number of requests by mode (walk-in, phone, email) and by audience (academic, community, etc.). Record the total number of requests by mode (walk-in, phone, email) and by topic of request (academic, community, etc.).

<table>
<thead>
<tr>
<th>Worker Type</th>
<th>Audience</th>
<th>Topic of Request</th>
<th>Total Numbers of Requests by Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Walk-in</td>
</tr>
<tr>
<td>Academic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Audience</th>
<th>Topic of Request</th>
<th>Total Numbers of Requests by Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Walk-in</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Academic: Community Strategy Walker

<table>
<thead>
<tr>
<th>Audience</th>
<th>Topic of Request</th>
<th>Total Numbers of Requests by Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Walk-in</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Community: HIV/AIDS Worker

<table>
<thead>
<tr>
<th>Audience</th>
<th>Topic of Request</th>
<th>Total Numbers of Requests by Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Walk-in</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Gay Men’s Strategy Walker
### Community Development

Please describe your community development meetings (e.g., active participation in networks, meetings with school boards, service providers, residents, etc.). Record active partnerships as a result of community development in OCM/ET Section 9 - Partnerships.

Insert a green bubble after the question title with the following: For this reporting period, “Community development” is a structured intervention that gives communities greater control over the conditions that affect their lives, is the process of building communities with a focus on environmental, social and/or economic aspects of community well-being. It works at the level of social groups/organizations (e.g., service providers) rather than with individuals or families (e.g., service users, clients, etc.).

<table>
<thead>
<tr>
<th>Worker Type</th>
<th>Purpose</th>
<th>Total # of</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Purpose Total # of Meetings

<table>
<thead>
<tr>
<th></th>
<th>AGAP</th>
<th>All Other Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy/Coalition/Strategic Issue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy/Board Meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AIDS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women &amp; HIV/AIDS Initiative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy Development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other prevention, education, support outreach worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Partnership/Relationship Building</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Director/Program Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy/Board Meeting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**AIDS**: When you think about your community development work in this reporting period, what are some successes you would like to highlight?

**B.** What barriers have you encountered in community development work, and how are you addressing them?

**C. RESOURCE DEVELOPMENT & DISTRIBUTION** (replacing 3.2.2, 3.2.3)

Please list all education resources included, developed internally and by external agencies distributed except those distributed as part of coordinated awareness or social marketing campaign. For resources associated with awareness campaigns, report in question 8. Report newsletter distribution here.

<table>
<thead>
<tr>
<th>Type of resource</th>
<th>Name of Resource</th>
<th>Total # distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health education materials for patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of resource</td>
<td>Primary intended audience for resource</td>
<td>Name of Resource</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>General public</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PP - African, Caribbean or Black People</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PP - Youth or Young Adults</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PP - People living with HIV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PP - People who use drugs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PP - Woman at risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PP - Alcoholics</td>
<td></td>
</tr>
</tbody>
</table>

8a. Please report any substances distributed through education, community development, and outreach activities here. Please report any substances distributed through awareness campaigns here.

<table>
<thead>
<tr>
<th>Safe sex materials</th>
<th>Distributed X</th>
<th># (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male condoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female condoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental dams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lubricants</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8b. Please describe any changes in demand for safe sex materials during your education, community development, and outreach activities this reporting period.

9. AWARENESS CAMPAIGNS (replacing 13.)

9a. If your agency participated in or organized an awareness or social marketing campaign during this reporting period, please describe it here.

<table>
<thead>
<tr>
<th>Name of campaign</th>
<th>Involved in planning</th>
<th># of Meetings</th>
</tr>
</thead>
</table>
9b. Awareness Campaign Materials Distributed

Record the number of contacts/resources distributed through the components of your organization's current HIV awareness campaign. If you did not develop the resource, leave this column blank and record only the number distributed.

Note: Record the grand total of materials developed and distributed across all awareness campaigns (e.g., add the materials from all awareness campaigns together), do not report separately for each awareness campaign.

<table>
<thead>
<tr>
<th>Campaign Component</th>
<th># Developed</th>
<th># Distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ACAP</td>
<td>All Other</td>
</tr>
<tr>
<td></td>
<td>Funding</td>
<td>ACAP</td>
</tr>
</tbody>
</table>

- Materials - agency promotional materials
- Materials - prevention education
- Campaign specific blog (Only report the number developed)
- Campaign specific Facebook page (Only report the number developed)
- Campaign specific Twitter feed (Only report the number developed)
- Film DVD
- Health information or support resources for P3As
- Manuals/training kits

- Newsletter or news article
- Other: This needs to be at the bottom of the list.
- Press releases P3As
- Prevention, safer sex or harm reduction materials
- Website or campaign specific webpage (Only report the number developed)
- Workshop presentation materials

10. OUTREACH ACTIVITIES

For this reporting form, outreach is defined as: Agency representatives going to where community members socialize or congregate.

Describe all significant face-to-face outreach events (this requires a 2-way, in-person interaction between agency staff/volunteers and a number of the target population). Report brief contacts (e.g., casual discussions when people pass by a boothqual) as 1 contact.) For faith-based and business partners record all contact here.

<table>
<thead>
<tr>
<th>Audience</th>
<th>Bar/nightclubs</th>
<th>Businesses</th>
<th>Clinic/health centers</th>
<th>Community public spaces</th>
<th>Correctional Facilities</th>
<th>Drop-in Centers</th>
<th>Faith Organizations</th>
<th>Management offices</th>
</tr>
</thead>
</table>


<table>
<thead>
<tr>
<th>Audience</th>
<th>Community centre</th>
<th>Barber/shop, restaurant, coffee shop, community kitchen, etc.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PP - People living with HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Gay/bisexual MSM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - People who use drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Aboriginal peoples</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - African, Caribbean or Black People</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Women at risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Youth at Risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Incarcerated people</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Public</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Repatriation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**All Other Funding Continued**

<table>
<thead>
<tr>
<th>Audience</th>
<th>Mobile host/club</th>
<th>Bathhouses</th>
<th>Businesses</th>
<th>Church/health centre</th>
<th>Community public spaces</th>
<th>Correctional Facilities</th>
<th>Drop-in Centre</th>
<th>Faith Organizations</th>
<th>Management protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td>PP - People living with HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Gay/bisexual MSM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - People who use drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Aboriginal peoples</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - African, Caribbean or Black People</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Women at risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Youth at Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Incarcerated people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Public</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ACAF**

<table>
<thead>
<tr>
<th>Audience</th>
<th>Bar/nightclubs</th>
<th>Bathhouses</th>
<th>Businesses</th>
<th>Church/health centre</th>
<th>Community public spaces</th>
<th>Correctional Facilities</th>
<th>Drop-in Centre</th>
<th>Faith Organizations</th>
<th>Management protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td>PP - People living with HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Gay/bisexual MSM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - People who use drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Aboriginal peoples</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - African, Caribbean or Black People</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Women at risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PP - Youth at Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Page 25 of 42
**ACAP Continued**

<table>
<thead>
<tr>
<th>Audience</th>
<th>Mobile</th>
<th>Other ASOs</th>
<th>Other community agencies</th>
<th>Shelters</th>
<th>Street (includes parks)</th>
<th>Strip clubs</th>
<th>Women’s centre</th>
<th>Other (specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gay/bisexual MSM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who use drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal peoples</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African, Caribbean or Black People</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women at risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth at Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incarcerated people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Public</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**10b. Please describe all beliefs outreach contexts here (this refers to contexts at large public events, such as PROE, where contexts tend to be limited to handing out pamphlets, condoms, etc.)**

<table>
<thead>
<tr>
<th>Special Event info/brief</th>
<th>Other</th>
<th>Please describe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ACAP</td>
<td>All Other Funding</td>
</tr>
<tr>
<td>People living with HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gay/bisexual MSM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who use drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal peoples</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African, Caribbean or Black People</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women at risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth at Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incarcerated people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Public</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**11. ONLINE/SOCIAL MEDIA OUTREACH**

**11a. Please report online and social media outreach here (report social media used as part of awareness campaigns in Question 9)**

<table>
<thead>
<tr>
<th>Media Type</th>
<th>Reach</th>
<th>Extent of Use</th>
</tr>
</thead>
</table>
### 11b. What is the approximate size of the audience you are reaching through Facebook (e.g. total number of friends or followers)?

**Number of Facebook followers:**

### 12a. What was your outreach activity in this reporting period, what are some successes you would like to highlight?

**Outreach activity:**

**Successes highlighted:**

### 12b. What barriers have you encountered in your outreach work, and how are you addressing them?

**Barriers encountered:**

**Strategies for addressing barriers:**

### 13. PEER INVOLVEMENT IN EDUCATION AND OUTREACH

#### 13a. Please describe how peers are involved in your education, outreach, and community development work.

** peers involved in education, outreach, and community development work:**

**Level of involvement:**

For each activity, enter the total number of unique peers involved and how often peers are involved in this activity. Peers can be counted more than once.

<table>
<thead>
<tr>
<th>Activity</th>
<th># of peers involved</th>
<th>Extent of peer involvement (how often are peers involved in this work?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-service education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness campaign</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness campaign joining</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11. Support Services

**Instructions**

☐ Our organization does not provide these services.

### 11.1 Service Users
Please describe the people who received support services during the reporting period. Record the total number of people who accessed service, **NOT** the number of times service were accessed.

#### 11.1.1 Number of Clients Served by Gender.
Record the number of people by gender in of the following groups who receive support services during the reporting period.

All new clients in the past 6 month reporting period should be recorded under the new column and not included in the Active column.
11.1.2 This question has been removed and questions 11.1.1 and 11.1.3 have been expanded to capture new clients.

11.1.3 Number of Clients Served by Age

The best practice would be to collect this information from your clients. This information affects the kinds of services people need. If you are unable to collect this information, you can provide an estimate.

All new clients in the past 6 month reporting period should be recorded under the new column and not included in the Active column.

<table>
<thead>
<tr>
<th>Age</th>
<th>PHAs New Active</th>
<th>Affected (family, friend, partner of PHA) New Active</th>
<th>At-risk (engages in unsafe sexual and/or drug use behaviours) New Active</th>
<th>Other (please specify) New Active</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1-14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-39</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-54</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
month reporting period.

11.2.1 Services Provided

Record all services provided this reporting period to male, female and transgender persons. Please note the following:

record how many of the above Service Users accessed the service, NOT the number of times the service was accessed.

a Service User may be counted in more than one category, but only once in each category.

the number of Service Users recorded for each service cannot exceed the total number of Service Users listed in 11.1.1.

To enter information use the "Add Service" component located on the Right hand side. Select the category of service and the population that you are working with and then enter the number of services users for each gender. Click Add Service and it will appear in the list to the left. The ACAP information is provided directly from your logic models. As you add information it will be summed to the total column. You can edit the total but this cannot be less than the logic model value.

<table>
<thead>
<tr>
<th>Service</th>
<th>People living with HIV/AIDS (PLUs)</th>
<th>Affected (family/friends/partner)</th>
<th>At-risk (engages in unsafe sexual and or drug use behaviours)</th>
<th>Other1 [state here]</th>
<th>Other2 [state here]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake &amp;/or Assessment</td>
<td>M F MTF FTM</td>
<td>M F MTF FTM</td>
<td>M F MTF FTM</td>
<td>M F MTF FTM</td>
<td>M F MTF FTM</td>
</tr>
<tr>
<td>Case management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health promotion/Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scheduled Drop-in Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practical Assistance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home &amp; Hospital visits/Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>teams</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support Groups/Retreats</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre/post Test Counselling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buddy Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Counselling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bereavement Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workshops/Training/ Skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing Assistance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Advocacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supportive Housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpretation / Translation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complementary therapies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e.g., massage, nutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>counselling)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify below)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11.2.2 Sessions Provided

<table>
<thead>
<tr>
<th>Service</th>
<th>ACAP</th>
<th>All Other Funding</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Lal
<table>
<thead>
<tr>
<th>Intake and/or Assessment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td></td>
</tr>
<tr>
<td>Counselling</td>
<td></td>
</tr>
<tr>
<td>Health Promotion/Treatment Information</td>
<td></td>
</tr>
<tr>
<td>Scheduled Drop-in Program</td>
<td></td>
</tr>
<tr>
<td>Practical Assistance</td>
<td></td>
</tr>
<tr>
<td>Food Programs</td>
<td></td>
</tr>
<tr>
<td>Retreats</td>
<td></td>
</tr>
<tr>
<td>Home &amp; Hospital Visits/ Care teams</td>
<td></td>
</tr>
<tr>
<td>Support Groups</td>
<td></td>
</tr>
<tr>
<td>Pre/post Test Counselling</td>
<td></td>
</tr>
<tr>
<td>Buddy Program</td>
<td></td>
</tr>
<tr>
<td>Financial Counselling</td>
<td></td>
</tr>
<tr>
<td>Bereavement Services</td>
<td></td>
</tr>
<tr>
<td>Referrals</td>
<td></td>
</tr>
<tr>
<td>Workshops/training/skills development</td>
<td></td>
</tr>
<tr>
<td>Employment Services</td>
<td></td>
</tr>
<tr>
<td>Housing Assistance</td>
<td></td>
</tr>
<tr>
<td>Individual Advocacy</td>
<td></td>
</tr>
<tr>
<td>Supportive Housing</td>
<td></td>
</tr>
<tr>
<td>Settlement Services</td>
<td></td>
</tr>
<tr>
<td>Interpretation / Translation</td>
<td></td>
</tr>
<tr>
<td>Complementary therapies (massage, nutrition counselling)</td>
<td></td>
</tr>
<tr>
<td>Other1</td>
<td></td>
</tr>
<tr>
<td>Other2</td>
<td></td>
</tr>
</tbody>
</table>

**11.3 Support Groups** Record the number of support groups for service users conducted during this period 🎉
<table>
<thead>
<tr>
<th>Service Users</th>
<th>ACAP</th>
<th>All Other Funding</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHAs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affected (family/friends/partner)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At-risk (engages in unsafe sexual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and/or drug use behaviours)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11.4 Financial Support Please indicate the amount of financial assistance given to service users during the reporting period and the number of service users who received financial assistance. Please indicate the form of financial assistance you provide:

Note: this information is now mandatory.

Amount of Financial Assistance Given Out

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

Number of Service Users

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>

What other assistance do you provide?

- Cash
- Child care
- Clothing / toiletries / bedding
- Food
- Honoraria for participating in meetings, focus groups, or surveys
- Subway or bus tickets / passes / other transportation
- Trillium or Health Services
- Deductibles
- Vouchers / gift cards
- Other

11.5 During this reporting period, have you identified any shifts or changes in demand for support services (e.g., client age or gender, type of service requested/provided)?

11.6 How are you responding to these emerging trends? (e.g., change in programming, new partnerships, requests for
12. Volunteer And Related Activities

Instructions

Our organization does not provide these services.

12.1 Volunteers and Volunteer Management

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number of Volunteers</th>
<th>All Other Funding</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteers active during this reporting period (NOT including new volunteers)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New volunteers since last reporting period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training and support resources developed during this reporting period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluations of volunteers during this reporting period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Events held to recognize volunteers during this reporting period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteer development, training and orientation sessions during the reporting period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular volunteer meetings held by your organization during this reporting period</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12.2 Volunteer Activities

Record the number of volunteers by type of volunteer work. Individuals may be counted in more than one category, but only once in each category. (Enter partial hours of service as a decimal.) Include training of your volunteers provided by other organizations in this section.

<table>
<thead>
<tr>
<th>Volunteer Activity</th>
<th>Number of Volunteers</th>
<th>All Other Funding</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attend Training (held by another organization)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attend Training (held by own organization)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education/Community Development</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
12.2b "Attend Training", please describe how you think volunteer training has contributed to the organization

- Increased organizational/network capacity
- Increased knowledge/skills
- Volunteers report increased self confidence
- Other

12.3 Student Placements
(*A reminder to record the number of student placements, not the number of volunteers who happen to be students.)

Record the number of students on field placements at your organization and their hours of service during the reporting period.

<table>
<thead>
<tr>
<th>Number of Students</th>
<th>Hours of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACAP</th>
<th>All Other Funding</th>
<th>Total</th>
<th>ACAP</th>
<th>All Other Funding</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12.4 Student Activities

Please check off the areas the students assisted in:

- Administration
- Committees
- Counseling
- Drug
- Education/Community Development
- Fundraising
- Outreach
- Policies and Procedures
- Practical Support
- Referrals
- Special Events (mall displays, etc)
- Training attendance
- Other
12.5 During this reporting period, have you identified any shifts or changes in demand for volunteer activities/services (e.g., client age or gender, type of service requested/provided)?

12.6 How are you responding to these emerging trends? (e.g., change in programming, new partnerships, requests for funding)

Please explicitly save the information

Save
Save and move to next section

Top ↑

13. IDU/Substance Use Services

Instructions

This section is to be completed by any organization or program that provides harm reduction services for clients who use substances.

My organization provides IDU/substance use service: ☐ Yes ☐ No

Do you receive ACAP funding for IDU/substance use services?: ☐ Yes ☐ No

13.1 Outreach Contacts

13.1.1 Record the total number of outreach CONTACTS during this reporting period: __________

13.1.2 Record the number of individual outreach clients (by gender) during this reporting period. Each client should be counted only once. Your ACAP activity is entered into your Logic Model

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Trans Woman</th>
<th>Trans Man</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACAP All Other Funding</td>
<td>ACAP All Other Funding</td>
<td>ACAP All Other Funding</td>
<td>ACAP All Other Funding</td>
</tr>
<tr>
<td>New</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 13.2 In-service Contacts

13.2.1 Record the total number of in-service CONTACTS during this reporting period:

### 13.2.2

Record the number of individual in-service clients (by gender) during the reporting period. Each client should be counted only once. Your ACAP activity is entered into your Logic Model.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Trans Woman</th>
<th>Trans Man</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACAP All other Funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeat clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total In-service Clients:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

### 13.3a Services Provided

Record the number of individual clients who received each service during the reporting period. A client may be counted in more than one service category but only once in each category. The number of clients who accessed each service should not exceed the total number of contacts listed in 13.1.2 and 13.2.2.

We understand that not all agencies are able to complete this question. If you are unable to, please tell us why:

- Our organization doesn’t provide any of these services to Substance Users.
- Our organization doesn’t have the tools to track these services.
- Other:

### 13.3b Services Provided

<table>
<thead>
<tr>
<th>Service</th>
<th>Male</th>
<th>Female</th>
<th>Trans Woman</th>
<th>Trans Man</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACAP All other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

*Note: The table is incomplete and contains placeholders.*
13.3b

Have you heard from your clients about long wait times for services? If possible, could you tell us what services pose the biggest challenges? (e.g., primary care/medical services; addiction treatment services; mental health services; housing services)

And were there referrals that you want to make but could not because the service was not available in your area? Please explain.

13.4 Location for Outreach Services

For the purposes of this report, outreach is defined as work provided in locations where community members congregate or socialize. Record the total number of individuals contacted in each location during the reporting period. A client may be counted in more than one location.
13.5a Peer Involvement

Record the number of peers (by gender) active in the program during the reporting period.

<table>
<thead>
<tr>
<th></th>
<th>Male ACAP</th>
<th>Female ACAP</th>
<th>Trans Woman ACAP</th>
<th>Trans Man ACAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of peers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of new peers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of meetings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of peer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13.6 Peer Activities

Record the number of client contacts made by peers by activity. Clients may be counted in more than one activity category, but only once in each category.
### 13.7 Community Development

Record the number and type of community development activities in which staff or peers participated during the reporting period.

<table>
<thead>
<tr>
<th>Community Development Activity</th>
<th>Number of Meetings/Contacts</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ACAP</td>
<td>All other Funding</td>
</tr>
<tr>
<td>Agency contacts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community clean-ups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meetings/committees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presentations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing training, orientation, field trips</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research (e.g., focus groups)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social events (e.g., BBQs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### 13.8 Please indicate whom you are making community development contacts with.

<table>
<thead>
<tr>
<th>Contacts</th>
<th>Yes / No</th>
<th>Number of Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction service providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s Aid Society</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
13.9 Drugs of Choice

Please indicate whether any of your clients use the following substances, and rank the 3 most commonly used substances by placing the number 1, 2 or 3 beside them in the “ranking” column.

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Yes / No</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphetamines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecstasy (and other Party Drugs such as K and GHB)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mushrooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methadone (non-prescribed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methamphetamine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine (non-prescribed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opiates such as Dilaudid/Oxycontin/Oxycodone/Percocet (non-prescribed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solvents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steroids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13.10a Harm Reduction Resources Distributed

(*Reminder: this is related to equipment you distribute specifically to clients who use substances.)

- Safer Injection Equipment
- Safer Inhalation Equipment
13.10b How do you dispose of the equipment that is returned to you? Have you experienced any challenges?

13.11
During this reporting period, have you identified any shifts or changes in demand for HIV/IDU/substance use services (e.g., client age, gender or ethnicity, drug of choice, type of service requested/provided, changes in social attitudes in the community/access to harm reduction programs, access to mental health and addiction services, changes in policing practices)?

13.12
How are you responding to these emerging trends? (e.g., change in programming, new partnerships, requests for funding)