# Compendium of Evaluation Tools to Measure Outcomes for Community Based Projects funded under the HIV & Hepatitis C Community Action Fund

**PUBLIC HEALTH AGENCY OF CANADA**
Centre for Communicable Diseases Infection and Control

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PROTECTING AND EMPOWERING CANADIANS TO IMPROVE THEIR HEALTH

Public Health Agency of Canada | Agence de la santé publique du Canada

Canada

**TO PROMOTE AND PROTECT THE HEALTH OF CANADIANS THROUGH LEADERSHIP, PARTNERSHIP, INNOVATION AND ACTION IN PUBLIC HEALTH.**

—Public Health Agency of Canada

Également disponible en français sous le titre :
Guide de rapport d'évaluation de projet - Fonds d'initiatives communautaires en matière de VIH et d'hépatitis C

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**Acronyms**

| | |
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| PHAC | Public Health Agency of Canada |
| AIDS | Acquired Immune Deficiency Syndrome |
| HCV | Hepatitis C Virus |
| Hep C | Hepatitis C |
| HPV | Human Papilloma Virus |
| HIV | Human Immunodeficiency Virus |
| KTE | Knowledge Transfer and Exchange |
| MSM | Men who have Sex with Men |
| PHA | People Living With HIV |
| REB | Research Ethics Board |
| STBBIs | Sexually Transmitted and Blood-borne Infections |
| STI | Sexually Transmitted Infections |

## Background

The aim of the Public Health Agency of Canada's (PHAC) *HIV and Hepatitis C Community Action Fund* (Community Action Fund) is to contribute to better health outcomes for Canadians by addressing HIV, hepatitis C and other sexually transmitted and blood-borne infections (STBBIs).

As a condition of funding under the Community Action Fund, all funded recipients will engage in the performance measurement and outcome assessment of interventions and activities. Funded interventions and activities will require a rigorous assessment of both *outputs* and *outcomes,* showing how they contribute to the funding program's first and second level expected outcomes**:**

- Increased knowledge of effective HIV, hepatitis C or related STBBI interventions and prevention evidence;
- Increased awareness and knowledge of risk factors and stigmatizing behaviors;
- Strengthened capacity (skills, competencies and abilities) of priority populations and audiences to prevent infection and improve health outcomes;
- Enhanced application of knowledge of community-based interventions;
- Improved access to health, social and support services; and
- Increased uptake of personal behaviors that prevent the transmission of HIV, hepatitis C or related STBBIs.

The Community Action Fund will have an enhanced focus on populations most at risk for and affected by HIV, hepatitis C and related STBBIs. The primary target audiences for funded activities are members of priority populations[1] and audiences such as front line workers and other public health professionals.

## Purpose

To support performance measurement and evaluation by funded recipients, the Centre for Communicable Diseases and Infection Control developed this compendium of validated evaluation tools. The purpose of the Compendium is to provide funded recipients with evaluation tools that will support them in their evaluation activities, and to respond to PHAC's requirement to measure the achievement of project outcomes. The Compendium should be considered as a resource. While the use of the tools included in the Compendium is strongly recommended when and where applicable, it is not mandatory. The fact sheets have been developed and written for an audience with some experience in evaluation, including data collection and analysis, so collaboration between the project team and the

[1] Priority populations of the Community Action Fund include: gay men and other men who have sex with men; people who use drugs; Indigenous people; ethno-cultural communities, particularly those representing countries with high HIV or hepatitis C prevalence, including immigrants, migrants and refugees; people engaged in the sale, trade or purchase of sex; people living in or recently released from correctional facilities; transgender people; people living with, or affected by, HIV and/or hepatitis C; and women and youth among these populations, as appropriate.

project evaluator is recommended in order to identify and adapt the most appropriate tools for each intervention and intended population.

In addition to the Compendium, other resources or tools are available to support project level outcome evaluations. Funded recipients under the Community Action Fund will be required to have an evaluation plan and will be able to dedicate up to 10% of their budget in the contribution agreement to assess their project's results. Recipients will be encouraged to refer to CCDIC's Project Evaluation Report Guide, provided to all funded recipients, to clarify evaluation expectations. They will also be encouraged to speak with their program consultant to discuss questions related to their evaluation.

The tools presented in the Compendium were identified through an extensive literature review and website search, followed by an assessment of the tools' quality and utility for the evaluation of outcomes of community-based programs in HIV, hepatitis C and related STBBI prevention. Some tools were adapted by an external contractor with research and evaluation expertise in order to address existing gaps in outcomes and priority populations. The fact sheets and tools were reviewed and validated by external evaluation experts, including those connected to community-based organizations. Revisions to the Compendium were made based on recommendations from reviewers.

The recommended tools are presented in seven sections:

1. Individuals' (priority population members') awareness and knowledge;
2. Individuals' skills, capacity, and competency;
3. Workers' and volunteers' capacity and competency;
4. Healthy behaviors of priority population members;
5. Capacity to access to care and support for people infected with HIV, hepatitis C and/or other STBBIs;
6. Collaboration, coordination, and networking; and
7. Use of evidence and effective interventions.

Each section includes a description and list of tools. Each tool in the Compendium has an attached fact sheet that outlines when it is best to use the tool, how to administer the tool, and considerations for analysis. Also included are considerations and resources for additional support in ethical conduct of evaluations, and more information on data collection methodologies used in these tools. Another way to navigate the Compendium is through the index in Appendix B of this document, which cross lists all tools according to outcomes, intervention type and population, and by types of infection.

**When to use tools**

Organizations and their evaluator should ensure that there is a good fit between the expected outcomes or results from the project activities or intervention and the outcomes that the tools measure. For example, if the project is designed to deliver an educational

activity that is a one-time presentation that covers only basic information about HIV, the evaluation tool should include only these types of questions. The project evaluation would not use a tool that examines confidence to make different choices and/or reduce risk behaviors. As well, some tools are intended to measure changes as a result of an educational or support series, so the measurements may not be appropriate for a one-time session or event. In general, it is important that the activities or intervention align well with the information provided in the fact sheet about each tool, as well as be a good fit with outcomes and participant populations. Project evaluators are encouraged to use multiple tools to measure the same outcome in order to create a stronger results story. Finally, tools should be used during all cycles of the project to document progress, not just at the end.

**Considerations for adapting tools**

Although the tools in the Compendium were selected partly because they have established validity; that is, they measure what they are intended to measure; it is not necessarily the case that they will be valid in all contexts. A tool is valid in the context in which it is assessed,[2] which means that users of these tools may need to adapt them to their own contexts. Adaptations are recommended whenever users feel that certain questions, response choices, or language used in tools may not work well with their participants. Tools can be adapted to respond to the follow issues:

1. **Suitability for community interventions** - There may be particular questions that are more suitable to certain community interventions and participant population(s). It is acceptable to use the most appropriate questions from a selection of tools intended to measure the same outcome with the knowledge that the adapted tool(s) may no longer be considered valid.

2. **Level of literacy of participants** - When working with populations with lower literacy and different levels of language proficiency; consider administering the tool(s) orally or using symbols and pictures to represent the language used.

3. **Appropriateness of language** - The language used in tool(s) may require adaptation so that it is aligned with the culture or context of participant population(s), including using more relevant or local language.

4. **Length of the tool** - Some of the tools are lengthy, so it is acceptable to use those questions that are appropriate for the intervention and participant population. Conversely, some of the tools are very short, so it is also acceptable to combine questions from more than one tool, as long as the tools are measuring the same

[2] Edwards, N., & Barker, P. M. (2014). The importance of context in implementation research. *Journal of Acquired Immune Deficiency Syndromes, 67*(2). Retrieved from http://journals.lww.com/jaids/Pages/toc.aspx?year=2014&issue=11011.

outcome. Make sure that there is little, if any, duplication when blending questions; otherwise the completion rate will be negatively impacted.

5. **Sensitivity of the topic** - For some interventions, it may not be appropriate to administer a questionnaire at the beginning of sessions due to sensitive issues and the need to establish trusting relationships with participants. Consider incorporating some group-building exercises or pre-interviews prior to launching the questionnaire.

While not considered an adaptation, format, font type/size and method of administration (written, oral etc.) may be changed, as needed.

While adapting tools in these ways above is encouraged, it is important to recognize that each of the tools included in the Compendium was developed through an intensive and knowledge-based process, incorporating a great deal of expertise and experience. That contribution should continue to be acknowledged. Even if the tool is adapted in a significant way, the original source and inspiration for the tool should be cited as identified under each tool, in any evaluation or annual report. However, it is not necessary to include the source in the actual survey or questionnaire that is administered to participants.

**Limitations**

The current tools included in the Compendium correspond to the program's expected outcomes and were cited in publications between the periods of 2009-2014; therefore, they should not be viewed as an exhaustive list of tools. The Public Health Agency of Canada will update the Compendium in the future to address gaps and to reflect current knowledge of HIV, hepatitis C and related STBBIs.

**Ethical Considerations and Resources**

As outlined in the Public Health Agency of Canada's *Policy for Research Involving Humans*, when a project funded through a grant or contribution agreement includes research involving humans, the research portion of the project must be reviewed by a Research Ethics Board (REB). Research involving humans is defined as an activity designed to test a hypothesis or answer a research question using a systematic collection of data including both qualitative and quantitative approaches. In some situations, program evaluations with vulnerable populations which collect sensitive data should have their evaluation protocol and data collection tools reviewed by a REB to ensure that the evaluation is designed and will be conducted in a manner that respects and protects the rights and welfare of participants. This can be done through local REBs housed in universities or other institutions, or through the Research Ethics Board at PHAC.

Regardless of whether or not an evaluation protocol is reviewed by an REB, it is important to adhere to ethical practices to protect participants' rights and privacy. Below are some principles and practices to keep in mind:

- ✓ Ensure that participants provide informed consent to participate and that the process respects their rights.
- ✓ Tell participants why you are using the questionnaire, checklist, interview etc., being clear that it is to evaluate the activity or project, to help make improvements. It is not intended to evaluate participants.
- ✓ If any personal identifying information is being collected, ensure that confidentiality is being maintained and that collected information is kept in a secure location where no one but the evaluator can access it. Tell participants how their information will be stored and for how long it will be retained before it will be destroyed. Ensure that the least amount of personal identifying information is being collected to complete the evaluation.
- ✓ To protect personal identifying information, consider implementing security measures for any electronic and/or hard copy record(s) (e.g., password protection and locked filing cabinet storage; data encryption tools to secure data on laptops or other personal computers)
- ✓ Participation should be voluntary, so tell participants that it is okay if they do not participate in the assessment. Give them a way to do something else at the same time that is similar to completing the survey, checklist or being interviewed, so that confidentiality of this decision is protected. Participants also have the right to withdraw at any time, without any negative consequences; and if they do, the information they provide up to that point must not be kept.
- ✓ If you are collecting information in a group setting, ensure that people feel safe and that the space is confidential. Ensure that no one can see their answers (can see their screen or papers) and put completed questionnaires into a sealed envelope.
- ✓ Ensure that there is support for participants in case any of the questions creates discomfort or acts as a trigger.
- ✓ Importantly, the evaluation should not be collecting individual identifying health information. If the project collects this type of information, ensure that you are meeting the applicable legal obligations in your jurisdiction.
- ✓ When analyzing and reporting on results, ensure that individuals will not be identifiable.
- ✓ Develop ways of sharing results with participants as well as getting input that meets their needs (e.g. using community venues; including meal or snacks).
- ✓ The evaluation is an opportunity to get participant input on improvements or changes.

Some useful resources on ethics of evaluation in community contexts are:

1. **A Project Ethics Community Consensus Initiative (ARECCI):**
   http://www.aihealthsolutions.ca/arecci/guidelines/

Guidelines for informed consent are found at:
http://www.aihealthsolutions.ca/arecci/guidelines/tool/informed_consent/

2. The **Learning Place for Community-Based Research in HIV/AIDS** has an on-line module on informed consent, as well as an ethics review for community researchers at:
http://www.cbrlearningplace.ca/

3. The **HIV/AIDS Research Ethics Board at the University of Toronto** has a 2 page guide on informed consent at:
http://www.research.utoronto.ca/wp-content/uploads/2012/10/GUIDE-FOR-INFORMED-CONSENT-HIV-REB.pdf

## SECTION 1: TOOLS TO MEASURE INDIVIDUALS' AWARENESS AND KNOWLEDGE

This section of the Compendium presents tools that can be used to measure the intended program outcome: increased individual awareness and knowledge, related to the funding program's expected outcomes: "Increased knowledge about effective STBBI interventions and prevention evidence" and "Increased knowledge and awareness about risk factors for STBBIs and stigmatising behaviors." Awareness and knowledge are important outcomes for this funding program because they orient priority population members' choices and behaviors.

The tools in this section measure how much individuals in the priority population know about HIV/AIDS, hepatitis C, and/or STBBI and their prevention and transmission. Some tools measure the extent to which people have beliefs about the diseases and their transmission that are inaccurate.

The tools included in this section can be used to measure the following aspects of awareness and knowledge:

- Knowledge about HIV and AIDS as a disease
- Knowledge about HIV- STI transmission routes and prevention
- Knowledge of medication to prevent HIV
- Misconceptions about HIV transmission
- Knowledge about testing and counseling services for HIV-AIDS
- Beliefs about level of HIV infectiousness
- Knowledge of HIV treatment for people living with HIV
- Stigmatizing attitudes towards people with HIV
- Self-stigmatizing attitudes of people living with HIV
- Knowledge of hepatitis C
- Knowledge of STIs

Note that, in many instances, the questions about HIV may also be used for hepatitis C.

**Knowledge and Awareness tools**

**AK1. HIV KNOWLEDGE QUESTIONNAIRE**

A newer version of the well-known 18-question Carey and Schroder HIV Knowledge Scale (2002), a questionnaire measuring knowledge of HIV transmission, was reduced to 10 questions and tested for appropriateness for different high-risk populations and subgroups.

**AK2. HIV KNOWLEDGE QUESTIONNAIRE – AFRICAN & CARIBBEAN CANADIAN PEER VOLUNTEERS**

A 22- question questionnaire measuring knowledge of HIV transmission; developed to assess the effectiveness of training of peer volunteers recruited from the African and Caribbean communities in Ottawa, specifically hairdressers and barbers.

**AK3. STI/HIV PREVENTION KNOWLEDGE – INDIGENOUS STAND EVALUATION QUESTIONNAIRE**

A section of a long questionnaire that covers a range of issues relevant to healthy decision-making that affects HIV risk. These 10 questions assess levels of STI/HIV prevention knowledge.

**AK4. HIV KNOWLEDGE SURVEY**

This 33-question measure has been used in a study of the effectiveness of a peer education program for high-school students. Although longer, the measure is more comprehensive than the others in the Compendium, as it includes knowledge about sexual and drug-related transmission, as well as risk-reduction strategies.

**AK5. HIV/AIDS TRANSMISSION MISCONCEPTIONS**

Two short questionnaires assessing the extent to which participants have common misconceptions about HIV transmission and infection.

**AK6. INFECTIOUSNESS BELIEFS SCALE**

A scale intended for people living with HIV, to assess their beliefs about their level of HIV infectiousness.

**AK7. HIV TESTING AND COUNSELLING BELIEFS SCALE**

A short questionnaire which assesses knowledge (beliefs) about HIV testing and counselling services.

**AK8. HIV TREATMENT KNOWLEDGE**

This scale is intended for people with HIV; it may be most useful for people who are newly diagnosed. An optional item can be used with pregnant women.

**AK9. HIV STIGMA SCALE**

A 19-question tool with three subscales, measuring: negative attitudes to people living with HIV (PHAs), perceived discrimination in the community, and support for equitable treatment of PHAs.

**AK10. STIGMATIZING ATTITUDES TOWARDS PEOPLE LIVING WITH HIV/AIDS**

This 27 item questionnaire developed and validated in Québec in both French and English, covers 7 dimensions of stigma: 1) concerns about occasional encounters; 2) avoidance of personal contact; 3) responsibility and blame; 4) liberalism; 5) non-

discrimination; 6) confidentiality of seropositive status; and 7) criminalization of HIV transmission.

**AK11. HIV SELF-STIGMA SCALE**

A 40-item measure used in many studies of self-stigma or negative attitudes toward self among people living with HIV. It can be divided into four shorter versions, each measuring a more specific aspect of self-stigma: personalized stigma subscale; disclosure subscale; negative self-image subscale; and public attitudes subscale.

**AK12. HCV KNOWLEDGE QUESTIONNAIRE # 1**

A 6-item measure used in a study of the effectiveness of a peer-education program for hepatitis C prevention, developed and delivered among men vulnerable to HCV infection.

**AK13. HCV KNOWLEDGE QUESTIONNAIRE # 2**

A 5-item measure used in an evaluation of HCV resources developed in Canada.

**AK14. STI KNOWLEDGE SCALE**

A 27-item measure of STI knowledge; covering HPV, hepatitis, gonorrhea, and chlamydia.

**AK15. ASIAN MEN WORKSHOP QUESTIONNAIRE**

A 6-part questionnaire that was developed and used in an evaluation of community-based intervention with Asian MSM in Toronto.

## SECTION 2: TOOLS TO MEASURE INDIVIDUALS' SKILLS, CAPACITY AND COMPETENCY

This section of the Compendium presents tools that can be used to measure the intended program outcome of improved skills, capacity and competency related to the overall funding program's expected outcome of "Strengthened capacity (skills, competencies and abilities) of priority populations and target audiences." This outcome includes skills, capacity and competency of individuals infected with, affected by, or vulnerable to HIV, hepatitis C and related STBBIs.

The tools included in this section can be used to measure the following aspects or dimensions of skills, competency and capacity:

- Skills, competency and capacity for individuals to engage in prevention behaviors, including measures of self-efficacy. Self-efficacy is the level of confidence people have that they can perform healthy behaviors or make healthy choices.
- Skills, competency and capacity of individuals infected with HIV, hepatitis C and related STBBIs to engage in behaviors that reduce the risk of transmission.

There are several measures of self-efficacy for various prevention behaviors, notably on condom use. You can pick and choose questions from among these measures that are most relevant to your intervention and priority population, recognizing that this may impact the validity of the tool.

The tools in this section are listed below:

**Skills, Competency and Capacity Tools**

**SCC1. CANADIAN SEXUAL HEALTH INDICATORS: SEXUAL BEHAVIOR CAPACITIES**

Section of a questionnaire developed for Canadian youth 16-24, assessing confidence in preventive sexual practices for HIV and STIs.

**SCC2. CONDOM USE SKILLS OBSERVATION**

Observation of people demonstrating their level of skill in using condoms on a model penis; for 11 behaviors that reduce risk of condom failure and three that assess proper condom disposal.

**SCC3. CONDOM USE SKILLS SELF EFFICACY**

A short questionnaire which assesses participants' level of confidence that they can use condoms correctly.

**SCC4. CONDOM SELF-EFFICACY FOR MSM**

A short questionnaire measure that forms part of the tools used in the overall *Theory of Planned Behavior*,[3] widely used to predict condom use and other outcomes in HIV.

**SCC5. CONDOM ERRORS AND PROBLEMS SCALE**

A 14-question questionnaire that assesses how often in the last six months people using condoms made errors in using them or had problems with them; included here is a measure of competency in this important behavior.

**SCC6. SELF-EFFICACY FOR CONDOM USE IN EMOTIONAL DISTRESS SCALE**

Short questionnaire that assesses confidence in the capacity to use condoms when feeling upset or down, developed for high-risk youth with mental health and/or emotional challenges.

**SCC7. SELF-EFFICACY FOR PREVENTION MEASURE**

A 10-question questionnaire that assesses an individual's confidence in the ability to engage in prevention through safer sex and talking with people. This scale is appropriate for use with any population engaged in prevention work.

**SCC8. SEXUAL HEALTH CAPACITY SCALE**

Short questionnaire which assesses knowledge and confidence in preventive sexual practices for HIV and STI among MSM.

**SCC9. ABILITY TO REFUSE RISKY SEXUAL SITUATIONS SCALE**

Short questionnaire that assesses participants' self-efficacy to refuse sex under pressure, without protection against HIV and STIs.

**SCC10. CAPACITY TO MANAGE SEX RISK SCALE**

Short (4 –item) tool that assesses vulnerable youths' (homeless and runaway youth, substance abusers, having dropped out of school, parenting youth) capacities to manage sex and sex-related risk.

**SCC11. HEALTHY SEXUALITY QUESTIONNAIRE – INDIGENOUS WOMEN**

Short questionnaire for women participating in workshops or activities focused on developing confidence and capacity to become empowered in their sexuality.

[3] Ajzen, I. (2000). *The theory of planned behavior: Habit, perceived control, and reasoned action*. Mannheim: Mannheimer Zentrum für Europäische Sozialforschung**.**

## SECTION 3: TOOLS TO MEASURE WORKERS' AND VOLUNTEERS' CAPACITY AND COMPETENCY

This section of the Compendium presents tools that can be used to measure the intended program outcome of improved skills, capacity and competency related to the overall funding program's expected outcome of "Strengthened capacity (skills, competencies and abilities) of priority populations and target audiences." This outcome includes skills, capacity and the competency of people working with individuals infected with, affected by, or vulnerable to HIV, hepatitis C and related STBBIs. They can be service providers, peer workers, or volunteers.

The tools included in this section can be used to measure the following aspects or dimensions of skills, competency and capacity:

- Skills, competency and capacity of community-based service providers, volunteers and peer leaders to carry out effective prevention.
- Skills, competency and capacity of community-based service providers, volunteers and peer leaders to provide adequate support to people living with HIV and related STBBIs and/or hepatitis C, as well as people at risk.

The tools in this section are listed below:

**Skills, Competency and Capacity of Workers and Volunteers Tools**

**SCCW1. OUTREACH WORKER EFFECTIVENESS FORM**

Ongoing recording form for peer outreach workers to record the effects of their interventions - can be adapted to any content and population.

**SCCW2. LOG SHEET FOR PEER VOLUNTEERS**

Ongoing recording form for peer volunteers to record the prevention messages they delivered.

**SCCW3. EDUCATOR CAPACITIES FOR SEXUALITY AND PREVENTION EDUCATION**

This relatively long questionnaire asks educators to assess their level of comfort in teaching about sexuality and HIV/AIDS; it could be used in peer educator contexts.

**SCCW4. TRAIN-THE-TRAINER TRAINING EFFECTIVENESS QUESTIONNAIRE**

Questionnaire designed to be used by peer-trained workers once they have had the opportunity to carry out some prevention, health promotion and support on their own.

**SCCW5. PEER EDUCATOR FOCUS GROUP GUIDE**

Qualitative focus group discussion guide for youth peer educators assessing their competency in peer intervention in HIV prevention education.

**SCCW6. PEER VOLUNTEER CAPACITY QUESTIONNAIRE**

Qualitative questionnaire for volunteer educators assessing the effectiveness of their intervention in HIV prevention education.

**SCCW7. COMMUNICATION SELF-EFFICACY FOR HIV AND STI PREVENTION**

Short questionnaire which assesses the confidence in capacity to talk with others about HIV, STIs and prevention. Self-efficacy is the level of confidence people have that they can perform healthy behaviors or make healthy choices.

**SCCW8. SUPPORT STAFF CAPACITIES INTERVIEW**

Qualitative interviews which assess support workers' (e.g. support group coordinator, outreach workers) capacities to address issues encountered by people living with HIV.

**SCCW9. VOLUNTEERS' RELATIONSHIP SKILLS SCALE**

Short interview that assesses services received from volunteers by people living with HIV or hepatitis C, in terms of relationship quality, trust and comfort level in discussing personal matters.

## SECTION 4: TOOLS TO MEASURE HEALTHY BEHAVIOR OUTCOMES

This section of the Compendium presents tools that can be used to measure the intended program outcome: "Increased uptake of personal behaviors that prevent the transmission of HIV, hepatitis C and related STBBIs."

The Tools included in this section can be used to measure the following aspects or dimensions of health behavior:

- Behavior to prevent contracting HIV, hepatitis C or related STBBIs, by non-infected people
- Behavior of people living with HIV, hepatitis C or related STBBIs to prevent transmission to others
- Behavior of people living with HIV, hepatitis C or related STBBIs to manage and improve their health and well-being

The tools in this section are listed below:

**Healthy Behavior Tools**

**B1. CONDOM USE/UNPROTECTED ANAL OR VAGINAL SEX**

Frequency of unprotected intercourse (as reported by participants) is a very widely used measure of transmission risk levels (in surveillance) and intervention outcomes. A distinction is usually made between behavior with casual and steady partners. Some studies assess the consistency of condom use as a more positively-focused alternative. Measurement and scoring instructions are provided for several different measures, and their relative advantages are explained:

- HIV Risk Score
- Unprotected anal insertive (UAI ) Index
- Sexual risk behavior scores: Condom use during unprotected insertive (UIAI) and receptive (URAI) anal intercourse
- UAVI (Unprotected Anal/Vaginal Intercourse)
- TRB (Transmission Risk Behavior) Indices, for PHAs

**B2. PROTECTIVE SEXUAL BEHAVIOR SCORE**

Measures of three practices that reflect participants' purposeful decision to reduce HIV transmission risks during anal intercourse with casual partners among MSM: serosorting, strategic positioning, and withdrawal before ejaculation.

**B3. HEALTHY SEXUAL BEHAVIOR QUESTIONNAIRE FOR MSM**

Questionnaire used before and after participation in a series of group workshops, measuring unprotected anal sex behavior of MSM with different types of partners/relationships.

**B4. PERSONAL SEXUAL BEHAVIORS - INDIGENOUS STAND EVALUATION QUESTIONNAIRE**

This is a section of a longer questionnaire developed for Indigenous youth that covers a range of issues relevant to healthy decision-making that affects HIV risk. This section uses 36 questions to assess personal sexual behavior, with sections for male, female and transgender.

**B5. REASONS FOR UNPROTECTED SEX MEASURE**

This short questionnaire assesses reasons for unprotected sex after an HIV diagnosis; it can be seen as the flip side of the protective behaviors in the tools listed above.

**B6. TESTING ATTITUDES, INTENTIONS AND BEHAVIOR**

A short interview or questionnaire that assesses attitudes toward HIV testing, intentions, and testing behavior.

**B7. TESTING HISTORY MEASURE – INDIGENOUS STAND EVALUATION**

This is a section of a longer questionnaire developed for Indigenous youth that covers a range of issues relevant to healthy decision-making that affects HIV risk. This short section asks about testing history for HIV and STIs.

**B8. DISCLOSURE PRACTICES SCORE**

Calculated risk assessment score of the propensity of PHA for HIV status disclosure to sexual partners, based on two questions.

**B9. INTERVIEW: TALKING TO OTHERS ABOUT HIV AND RISK – COMMUNICATION FREQUENCY AND RANGE**

This structured interview measures communication behavior about HIV and risk: what topics are discussed, and with whom.

**B10. RISK COMMUNICATION BEHAVIOR SCALE**

This short questionnaire asks about communications about risks in the participants' last sexual encounter. Although developed for MSM, it can be used by all priority populations.

**B11. SILENCING THE SELF/SELF-ADVOCACY SCALE**

This short (excerpted – the full scale is not published) questionnaire asks about the extent to which participants are able to self-advocate in their relationships. It has been used to assess the outcomes of interventions aiming to empower vulnerable women in their relationships and health care.

**B12. PSYCHOSOCIAL OUTCOMES CHECKLIST**

A checklist of possible psychosocial outcomes or changes for participants of supportive intervention.

**B13. INTERVIEW GUIDE**

A series of interview questions to assess whether outreach participants have incorporated risk reduction behaviors.

**B14. QUESTIONNAIRE TO ASSESS INJECTING RISK BEHAVIOR**

A short injecting risk questionnaire that measures the frequency in the sharing of equipment among people who inject drugs. It was designed in the UK to be administered by interview or self-administered questionnaire.

## SECTION 5: TOOLS TO MEASURE CAPACITY TO ACCESS SUPPORT AND CARE

This section of the Compendium presents tools that can be used to measure the intended program outcome: "Reduced barriers to access prevention, diagnosis, care, treatment and support."

The emphasis is on building capacity to access care and support, both for providers and those affected by HIV, hepatitis C and related STBBIs, as these are the dimensions of the outcome that are within the purview of community-based organizations. Capacity to access treatment is included in some of the tools that are assessing how support activities help people living with HIV or hepatitis C access or navigate treatment, i.e., as an element of support. The tools included in this section can be used to measure the following aspects or dimensions of capacity to access support and care:

- Capacity to access support services
- Quality of relationships with community-based program volunteers or paid staff
- Social and community support for living with a chronic condition

Note that capacity to access testing is covered in Section 4 on healthy behaviors. The tools in this section are listed below:

**Capacity to Access Care and Support tools**

**ACS1. ACCESS TO AND USE OF SUPPORTIVE AND ANCILLARY HEALTH SERVICES**

This is an interview checklist used by a service provider to assess a client's (a person living with HIV and/or hepatitis C) awareness of available services.

**ACS2. HEALTH ACCESS WHEN LIVING WITH HIV/ HEPATITIS C – QUALITATIVE INTERVIEW**

Short qualitative interview about the effects of living with HIV or hepatitis C on access to physical and mental health services, with a question about the effects of the intervention. It includes a question about links to ethnocultural communities or Indigenous culture.

**ACS3. INDIGENOUS OR ETHNOCULTURAL MSM EXPERIENCES IN ACCESSING SERVICES QUESTIONNAIRE**

Short questionnaire about the experiences of minority MSM in accessing mainstream services. The questionnaire could be used to assess staff and volunteers' level of understanding of the needs and experiences of MSM in minority cultural groups, and their capacity to address these needs. It could also be adapted for use with youth or women in minority cultural groups, as the focus is on intersecting vulnerabilities.

**ACS4. CHRONIC ILLNESS RESOURCES SURVEY**

Multiple-component questionnaire that assesses the level of support for people living with HIV or hepatitis C in six domains: personal; family and friends; neighborhood/community; organizations; worksites; and media and policy.

**ACS5. PHOTOVOICE FOR CULTURAL MINORITY PARTICIPANTS**

Photovoice is an action research technique that can be used in evaluation. It involves having participants take photographs or make videos that they feel represent their experiences, and then speak to those experiences in a group interview as they describe their productions. In HIV contexts, it has most often been used with people living with HIV who are minorities or marginalized, including people who speak limited English or French.

## SECTION 6: TOOLS TO MEASURE COLLABORATION, COORDINATION AND NETWORKING

This section of the Compendium presents tools that can be used to measure the extent to which community-based programs' collaboration, coordination and networking activities are effective. Collaboration, coordination and networking are expected to contribute to the program outcome: "Improved use of evidence, and effective interventions." The tools included in this section can be used to measure the following aspects or dimensions of collaboration, coordination and networking carried out by community-based organizations:

- Overall partnership effectiveness
- Effectiveness of linkages and coordination in the provision of support and services to people infected with, affected by, or vulnerable to HIV, hepatitis C and related STBBIs
- Benefits of participating in partnerships and collective work

These tools can be applied to all priority populations, target audiences and intervention types. Some can be used at the level of the entire organization, and some can also be applied to particular programs or intervention streams within organizations.

The tools in this section are listed below:

**Collaboration, coordination and networking tools**

**CCN1. COALITION BENEFITS CHECKLIST**

Short, on-line checklist of possible benefits to community members and/or organizational partners participating in a health empowerment coalition.

**CCN2. PARTNER INTERVIEW GUIDE**

Short interview about partnership quality and the collaboration with Indigenous people and other community-based organizations.

**CCN3. PARTNER SURVEY - HCV**

Questionnaire about the impact of partnerships on relationship quality and the ability to conduct effective intervention for HCV. The survey assesses benefits, drawbacks, satisfaction, reach, and value.

**CCN4. REFERRAL FOLLOW-UP CARDS**

Tracking system using client-carried cards and a follow-up check-in to assess the effectiveness of referrals between agencies and services. This system can also be used to measure capacity to access services.

**CCN5. NETWORK EFFECTIVENESS QUESTIONNAIRE**

Short questionnaire that assesses the effectiveness of inter-organizational networks in linking people living with HIV, other STIs or hepatitis C and other clients to other services.

**CCN6. COMMUNITY OWNERSHIP AND PREPAREDNESS INDEX**

This is an adaptation of an index developed to measure the strength of a marginalized community (female sex workers) to mobilize, self-organize and to assume their own sustainable 'community organizations' on six dimensions: leadership, governance, resource mobilization, community collective network, engagement with the state, and engagement with key influencers. It has been adapted here to the context of people living with HIV, hepatitis C and other STIs, but could also be adapted for use by other priority populations who are attempting to organize (e.g., youth, people who inject drugs, transgendered people, MSM from minority communities).

## SECTION 7: TOOLS TO ASSESS IMPROVED USE OF EVIDENCE AND OF EFFECTIVE INTERVENTIONS

This section of the Compendium presents tools that can be used to measure the extent to which community-based organizations are engaging in knowledge transfer and exchange (KTE) to use evidence-informed practices found elsewhere and to develop new knowledge to inform their practices and those of other organizations. KTE is expected to contribute to the program outcome: "Improved use of evidence, and effective interventions." The tools included in this section can be used to measure the following aspects or dimensions of collaboration, coordination and networking:

- Organizational capacity to engage in community-based research;
- Organizational capacity to engage with research;
- Organizational capacity to engage in evaluation.

These tools are generally not specific to priority populations or intervention types. They are to be applied to the entire organization.

The tools in this section are listed below:

**Tools for assessing engagement in KTE**

**KTE1. CAPACITY TO ENGAGE IN COMMUNITY-BASED RESEARCH MEASURE**

This tool was used to assess barriers and facilitators to engaging in community-based research, based on a survey of Canadian community-based organizations.

**KTE2. DO OUR DECISION-MAKING PROCESSES HAVE A PLACE FOR RESEARCH EVIDENCE?**

This tool was developed for health system organizations, but the section suggested here could be used by community-based organizations to assess their organization's attitudes toward and interest in using research evidence in decision-making about programs.

**KTE3. EVALUATION CAPACITY DIAGNOSTIC TOOL**

From the website: http://informingchange.com/cat-resources/evaluation-capacity-diagnostic-tool: "It captures information on organizational context and the evaluation experience of staff and can be used in various ways. For example, the tool can pinpoint particularly strong areas of capacity as well as areas for improvement, and can also calibrate changes over time in an organization's evaluation capacity. In addition, this diagnostic can encourage staff to brainstorm about how their organization can enhance evaluation capacity by building on

existing evaluation experience and skills. Finally, the tool can serve as a precursor to evaluation activities with an external evaluation consultant[4]."

## APPENDIX A: ADDITIONAL INFORMATION

### 1. Focus groups

Focus groups are semi-structured group interviews:

- Semi-structured because they follow a predefined interview guide, in which all the questions are asked in a fairly, but not completely, standardized way
- Unlike an individual interview, in which just one person at a time is interviewed in a private setting, a group of individuals is interviewed together
- The interviewer in a focus group is called the moderator: it is his or her task to ensure that the interview guide is completed during the focus group session
- The groups may last from one to two hours: 90 minutes is a good length
- Six to ten people is best: fewer than six and there is not enough group dynamic; more than ten and some people will contribute very little
- To capture everything that is said, it is preferable to record the session, but only if all participants give their agreement. Do not capture names on the recording.
- In evaluation practice, participants may know each other or work together, and the moderator must be able to decode and deal with existing dynamics

**Advantages and disadvantages of focus groups as an evaluation methodology**

Advantages of focus groups:

- Groups will generate more ideas than the same number of individuals alone
- They can provide intensive exploration of a wide range of issues
- They can provide rich dramatic feedback on issues: more compelling than questionnaire statistics
- They are relatively easy to organize and carry out

Disadvantages of focus groups:

- The group's responses will be different from each individual's responses
- Will tend to produce extreme or polarized opinions
- Influenced by group dynamics and strong personalities.

**These are useful resources on focus groups:**

- ✓ Ontario Women Health Network Guide to Focus groups : a detailed, step by step guide http://www.owhn.on.ca/toolkit/GuidetoFocusGroups.pdf

[4] Change, I. (n.d.). *Evaluation Capacity Diagnostic Tool.* Retrieved May 05, 2016, from http://informingchange.com/uploads/2015/01/Evaluation-Capacity-Diagnostic-Tool-10.16.pdf

- ✓ Evaluation Handbook a Guide for Aboriginal Organizations, Canadian Aboriginal AIDS Network, http://www.caan.ca/wp-content/uploads/2012/05/Evaluation-Handbook-English.pdf: Table 16, on page 16, has a useful summary tables comparing the strengths of focus groups, interviews and other methods
- ✓ USAID's brief overview Guide to focus groups: *http://pdf.usaid.gov/pdf_docs/pnadw110.pdf*
- ✓ The Paloma- Wellesley Guide to Participatory Program Evaluation, section starting on page 82 on Interviews and Focus Groups, contrasts these two methods of data collection. 2010: http://www.wellesleyinstitute.com/wp-content/uploads/2010/03/WorkingTogether1.pdf

**2. Calculating averages**

When a tool has more than one question, the questions can be put together to get an overall score. It is very common for questionnaire-type tools to have multiple questions: this is because each question is considered to have different weaknesses, and putting them together tends to have the weakness cancel each other out to make a better overall measure. We recommend that you always calculate the average rather than the total of the questions that are being put together, because sometimes participants don't answer all the questions, and the total would give a misleading result.

To calculate the average, add up the total number of all of the questions the person answered, and then divide that number by the total number of questions answered.

For example,

- ✓ If person A answered 10 out of 10 questions that used a five point scale and his total for those questions was 15 (out of a possible 50), his average score would be 15 divided by 50, or the equivalent of 3.0 out of 5.0.
- ✓ If person B only answered 8 of the 10 questions and his total score for those 8 questions was 15 (out of a possible 40), his average score would be 15 divided by 40, or the equivalent of 3.75 out of 5.0.

### 3. Tips for passwords

To be able to match before and after questionnaires completed by the same participant, without having their name on the questionnaires, you can use a code or password.

**Code**: this is a number / letter combination that you make up for each person, and put on their questionnaires (for example K4TZ7Y). Keep a list of each person's name and code in a secure location, such as a password-protected computer file. The disadvantage of this method is that the person's name has been recorded somewhere, even if it is secure.

**Password**: To avoid having to keep a list of names, have participants generate their own password or unique identifier. Although many people are familiar with PIN numbers and similar passwords, people in priority populations may not be, so it is important to explain why you are doing this. Keep the password as simple as possible, so that people will generate the exact same one each time they are asked.

Depending on the type of participants, you will want to avoid passwords that are based on address or telephone numbers.

For example:

- Ask people to write out their name in full on a slip of paper (that they keep to themselves and then later tear up)

- To write down (or enter, if on computer), proceed as follows :
  - the last letter of your last name: _____
  - the third letter of your first name: _____
  - the second letter of your last name: _____

Usually three letters are enough to generate unique codes for each person.

Each time you ask participants to complete a tool, have them go through the same process.

Before and After Versions: an example

In the example below, a questionnaire has been adapted to assess how much people think they increased their knowledge about HIV as a result of having participated in an educational workshop. You would do this when you can only measure change after the end of an intervention.

**HIV Knowledge Questionnaire: Before and After a Workshop**

| | | | | **Correct answer: Before** | **Correct answer: After** |
|---|---|---|---|---|---|
| 1a. Before this workshop, I thought that: pulling out the penis before a man climaxes/cums keeps a woman from getting HIV during sex | ☐ Yes | ☐ No | ☐ Don't know | 1 point for NO | 1 point for NO |
| 1b. Now I think that: pulling out the penis before a man climaxes/cums keeps a woman from getting HIV during sex | ☐ Yes | ☐ No | ☐ Don't know | 1 point for NO | 1 point for NO |
| 2a. Before this workshop, I thought that: a woman can get HIV if she has anal sex with a man | ☐ Yes | ☐ No | ☐ Don't know | 1 point for YES | 1 point for YES |
| 2b. Now I think that: a woman can get HIV if she has anal sex with a man | ☐ Yes | ☐ No | ☐ Don't know | 1 point for YES | 1 point for YES |
| 3. Before this workshop, I thought that: showering, or washing one's genitals/private parts after sex keeps a person from getting HIV | ☐ Yes | ☐ No | ☐ Don't know | 1 point for NO | 1 point for NO |
| 3b. Now I think that: showering or washing one's genitals/private parts after sex keeps a person from getting HIV | ☐ Yes | ☐ No | ☐ Don't know | 1 point for NO | 1 point for NO |
| 4a. Before this workshop, I thought that: there is a vaccine that can stop adults from getting HIV | ☐ Yes | ☐ No | ☐ Don't know | 1 point for NO | 1 point for NO |
| 4b. Now I think that: there is a vaccine that can stop adults from getting HIV | ☐ Yes | ☐ No | ☐ Don't know | 1 point for NO | 1 point for NO |
| 5a. Before this workshop, I thought that: people are likely to get HIV by deep kissing or putting their tongue in their partner's mouth, if their partner has HIV | ☐ Yes | ☐ No | ☐ Don't know | 1 point for NO | 1 point for NO |
| 5b. Now I think that: people are likely to get HIV by deep kissing or putting their tongue in their partner's mouth, if their partner has HIV | ☐ Yes | ☐ No | ☐ Don't know | 1 point for NO | 1 point for NO |
| 6a. Before this workshop, I thought that: a woman cannot get HIV if she has sex during her period | ☐ Yes | ☐ No | ☐ Don't know | 1 point for NO | 1 point for NO |
| 6b. Now I think that: a woman cannot get HIV if she has sex during her period | ☐ Yes | ☐ No | ☐ Don't know | 1 point for NO | 1 point for NO |
| 7a. Before this workshop, I thought that: a natural skin condom works better against HIV than latex condom does | ☐ Yes | ☐ No | ☐ Don't know | 1 point for NO | 1 point for NO |

| | | | | | |
|---|---|---|---|---|---|
| 7b. Now I think that: that: a natural skin condom works better against HIV than latex condom does | ☐ Yes | ☐ No | ☐ Don't know | 1 point for NO | 1 point for NO |
| 8a. Before this workshop, I thought that: having sex with more than one partner can increase a person's chance of being infected with HIV | ☐ Yes | ☐ No | ☐ Don't know | 1 point for YES | 1 point for YES |
| 8b. Now I think that: having sex with more than one partner can increase a person's chance of being infected with HIV | ☐ Yes | ☐ No | ☐ Don't know | 1 point for YES | 1 point for YES |
| 9a. Before this workshop, I thought that: a person can get HIV from oral sex | ☐ Yes | ☐ No | ☐ Don't know | 1 point for YES | 1 point for YES |
| 9b. Now I think that: a person can get HIV from oral sex | ☐ Yes | ☐ No | ☐ Don't know | 1 point for YES | 1 point for YES |
| 10a. Before this workshop, I thought that: using Vaseline or baby oil with condoms lowers the chance of getting HIV | ☐ Yes | ☐ No | ☐ Don't know | 1 point for NO | 1 point for NO |
| 10b. Now I think that: using Vaseline or baby oil with condoms lowers the chance of getting HIV | ☐ Yes | ☐ No | ☐ Don't know | 1 point for NO | 1 point for NO |
| | | | | TOTAL BEFORE points:____ | TOTAL AFTER points:____ |

Source: Oglesby, W. H., & Alemagno, S. A. (2013). Psychometric properties of an HIV knowledge scale administered with populations at high risk for HIV infection. Health Promotion Practice, 14(6), 859-867.

**SCORING:** Create each person's total before program and after program HIV Knowledge Score by calculating their total number of points for each. They get a point for each correct answer, and no points for the wrong answer or "don't know."

**ANALYSIS:** Compare the before and after scores for each person, noting how many people say they improve, how many stay the same, and how many get worse.

**APPENDIX B: INDEX OF TOOLS BY OUTCOME AND SECTION**

**SECTION 1: TOOLS TO MEASURE INDIVIDUALS' AWARENESS AND KNOWLEDGE**

AK1. HIV KNOWLEDGE QUESTIONNAIRE
AK2. HIV KNOWLEDGE QUESTIONNAIRE – AFRICAN & CARIBBEAN CANADIAN PEER VOLUNTEERS
AK3. STI/HIV PREVENTION KNOWLEDGE - INDIGENOUS STAND EVALUATION QUESTIONNAIRE
AK4. HIV KNOWLEDGE SURVEY
AK5. HIV/AIDS TRANSMISSION MISCONCEPTIONS
AK6. INFECTIOUSNESS BELIEFS SCALE
AK7. HIV TESTING AND COUNSELLING BELIEFS SCALE
AK8. HIV TREATMENT KNOWLEDGE
AK9. HIV STIGMA SCALE
AK10. STIGMATIZING ATTITUDES TOWARDS PEOPLE LIVINGWITH HIV/AIDS
AK11. HIV SELF-STIGMA SCALE
AK12. HCV KNOWLEDGE QUESTIONNAIRE # 1
AK13. HCV KNOWLEDGE QUESTIONNAIRE # 2
AK14. STI KNOWLEDGE SCALE
AK15. ASIAN MEN WORKSHOP QUESTIONNAIRE

**SECTION 2: TOOLS TO MEASURE INDIVIDUALS' SKILLS, CAPACITY AND COMPETENCY**

SCC1. CANADIAN SEXUAL HEALTH INDICATORS: SEXUAL BEHAVIOR CAPACITIES
SCC2. CONDOM USE SKILLS OBSERVATION
SCC3. CONDOM USE SKILLS SELF EFFICACY
SCC4. CONDOM SELF-EFFICACY FOR MSM
SCC5. CONDOM ERRORS AND PROBLEMS SCALE
SCC6. SELF-EFFICACY FOR CONDOM USE IN EMOTIONAL DISTRESS SCALE
SCC7. SELF-EFFICACY FOR PREVENTION MEASURE
SCC8. SEXUAL HEALTH CAPACITY SCALE
SCC9. ABILITY TO REFUSE RISKY SEXUAL SITUATIONS SCALE
SCC10. CAPACITY TO MANAGE SEX RISK SCALE
SCC11. HEALTHY SEXUALITY QUESTIONNAIRE – INDIGENOUS WOMEN

**SECTION 3: TOOLS TO MEASURE WORKERS' AND VOLUNTEERS' CAPACITY AND COMPETENCY**

SCCW1. OUTREACH WORKER EFFECTIVENESS FORM
SCCW2. LOG SHEET FOR PEER VOLUNTEERS
SCCW3. EDUCATOR CAPACITIES FOR SEXUALITY AND PREVENTION EDUCATION
SCCW4. TRAIN-THE-TRAINER TRAINING EFFECTIVENESS QUESTIONNAIRE
SCCW5. PEER EDUCATOR FOCUS GROUP GUIDE
SCCW6. PEER VOLUNTEER CAPACITY QUESTIONNAIRE
SCCW7. COMMUNICATION SELF-EFFICACY FOR HIV AND STI PREVENTION
SCCW8. SUPPORT STAFF CAPACITIES INTERVIEW
SCCW9. VOLUNTEERS' RELATIONSHIP SKILLS SCALE

**SECTION 4: TOOLS TO MEASURE HEALTHY BEHAVIOR OUTCOMES**

B1. MEASURES OF UNPROTECTED ANAL/VAGINAL INTERCOURSE
B2. PROTECTIVE SEXUAL BEHAVIORS SCORE
B3. HEALTHY SEXUAL BEHAVIOR QUESTIONNAIRE FOR MSM
B4. PERSONAL SEXUAL BEHAVIORS - INDIGENOUS STAND EVALUATION QUESTIONNAIRE
B5. REASONS FOR UNPROTECTED SEX MEASURE
B6. TESTING ATTITUDES, INTENTIONS AND BEHAVIOR
B7. TESTING HISTORY MEASURE – INDIGENOUS STAND EVALUATION

**INDEX OF TOOLS BY INTERVENTION TYPE**

**Tools for: Anti-stigma/discrimination campaign**


**Tools for: Social marketing campaign on HIV, hepatitis C or related communicable diseases**


**Tools for: Social media intervention on HIV, hepatitis C or related communicable diseases**


**Tools for: Targeted education activities for priority population**

AK6. INFECTIOUSNESS BELIEFS SCALE
AK7. HIV TESTING AND COUNSELLING BELIEFS SCALE
AK8. HIV TREATMENT KNOWLEDGE
AK9. HIV SELF-STIGMA SCALE
AK12. HCV KNOWLEDGE QUESTIONNAIRE # 1
AK13. HCV KNOWLEDGE AND CAPACITY QUESTIONNAIRE #2
AK14. STI KNOWLEDGE SCALE
SCC1. CANADIAN SEXUAL HEALTH INDICATORS: SEXUAL BEHAVIOR CAPACITIES
SCC2. CONDOM USE SKILLS OBSERVATION
SCC3. CONDOM USE SKILLS SELF-EFFICACY
SCC4. CONDOM SELF-EFFICACY – MSM
SCC5. CONDOM ERRORS AND PROBLEMS SCALE
SCC6. SELF-EFFICACY FOR CONDOM USE IN EMOTIONAL DISTRESS SCALE
SCC7. SELF-EFFICACY FOR PREVENTION MEASURE
SCC8. SEXUAL HEALTH CAPACITY SCALE
SCC9. ABILITY TO REFUSE RISKY SEXUAL SITUATIONS SCALE
SCC10. CAPACITY TO MANAGE SEX RISK SCALE
B3. HEALTHY SEXUAL BEHAVIOR QUESTIONNAIRE FOR MSM
B6. TESTING ATTITUDES, INTENTIONS AND BEHAVIOR MEASURE
B7. TESTING HISTORY - INDIGENOUS STAND EVALUATION QUESTIONNAIRE
B9. INTERVIEW: TALKING TO OTHERS ABOUT HIV AND RISK- COMMUNICATION FREQUENCY AND RANGE
B10. RISK COMMUNICATION BEHAVIOR SCALE
B11. SILENCING THE SELF/SELF-ADVOCACY SCALE

**Tools for: Targeted awareness activities for priority population**
AK1. HIV KNOWLEDGE QUESTIONNAIRE
AK2. PRE AND POST HIV/AIDS TRAINING QUIZ FOR AFRICAN & CARIBBEAN CANADIAN PEER VOLUNTEERS
AK3. STI/HIV PREVENTION KNOWLEDGE - INDIGENOUS STAND EVALUATION QUESTIONNAIRE
AK4. HIV KNOWLEDGE SURVEY
AK5. HIV/AIDS TRANSMISSION MISCONCEPTIONS
AK6. INFECTIOUSNESS BELIEFS SCALE
AK7. HIV TESTING AND COUNSELLING BELIEFS SCALE
AK8. HIV TREATMENT KNOWLEDGE
AK11. HIV SELF-STIGMA SCALE
AK12. HCV KNOWLEDGE QUESTIONNAIRE # 1
AK13. HCV KNOWLEDGE AND CAPACITY QUESTIONNAIRE #2
AK14. STI KNOWLEDGE SCALE
SCC1. CANADIAN SEXUAL HEALTH INDICATORS: SEXUAL BEHAVIOR CAPACITIES
SCC3. CONDOM USE SKILLS SELF-EFFICACY
SCC4. CONDOM SELF-EFFICACY – MSM
SCC5. CONDOM ERRORS AND PROBLEMS SCALE
SCC6. SELF-EFFICACY FOR CONDOM USE IN EMOTIONAL DISTRESS SCALE
SCC7. SELF-EFFICACY FOR PREVENTION MEASURE
SCC8. SEXUAL HEALTH CAPACITY SCALE
SCC9. ABILITY TO REFUSE RISKY SEXUAL SITUATIONS SCALE
SCC10. CAPACITY TO MANAGE SEX RISK SCALE
SCC11. HEALTHY SEXUALITY QUESTIONNAIRE – INDIGENOUS WOMEN
B6. TESTING ATTITUDES, INTENTIONS AND BEHAVIOR MEASURE

**Tools for: Skill building sessions to increase capacity to engage in risk reduction behaviors**
AK2. PRE AND POST HIV/AIDS TRAINING QUIZ FOR AFRICAN & CARIBBEAN CANADIAN PEER VOLUNTEERS
AK3. STI/HIV PREVENTION KNOWLEDGE - INDIGENOUS STAND EVALUATION QUESTIONNAIRE

AK4. HIV KNOWLEDGE SURVEY
AK5. HIV/AIDS TRANSMISSION MISCONCEPTIONS
AK6. INFECTIOUSNESS BELIEFS SCALE
AK7. HIV TESTING AND COUNSELLING BELIEFS SCALE
AK8. HIV TREATMENT KNOWLEDGE
AK11. HIV SELF-STIGMA SCALE
AK12. HCV KNOWLEDGE QUESTIONNAIRE # 1
AK13. HCV KNOWLEDGE AND CAPACITY QUESTIONNAIRE #2
AK14. STI KNOWLEDGE SCALE
SCC1. CANADIAN SEXUAL HEALTH INDICATORS: SEXUAL BEHAVIOR CAPACITIES
SCC2. CONDOM USE SKILLS OBSERVATION
SCC3. CONDOM USE SKILLS SELF-EFFICACY
SCC4. CONDOM SELF-EFFICACY – MSM
SCC5. CONDOM ERRORS AND PROBLEMS SCALE
SCC7. SELF-EFFICACY FOR PREVENTION MEASURE
SCC8. SEXUAL HEALTH CAPACITY SCALE
SCC9. ABILITY TO REFUSE RISKY SEXUAL SITUATIONS SCALE
SCC10. CAPACITY TO MANAGE SEX RISK SCALE
SCC11. HEALTHY SEXUALITY QUESTIONNAIRE – INDIGENOUS WOMEN
B1. MEASURES OF UNPROTECTED ANAL/VAGINAL INTERCOURSE
B2. PROTECTIVE SEXUAL BEHAVIORS SCORE
B3. HEALTHY SEXUAL BEHAVIOR QUESTIONNAIRE FOR MSM
B4. PERSONAL SEXUAL BEHAVIORS - INDIGENOUS STAND EVALUATION QUESTIONNAIRE
B5. REASONS FOR UNPROTECTED SEX
B6. TESTING ATTITUDES, INTENTIONS AND BEHAVIOR MEASURE
B7. TESTING HISTORY - INDIGENOUS STAND EVALUATION QUESTIONNAIRE
B8. DISCLOSURE PRACTICES SCORE
B9. INTERVIEW: TALKING TO OTHERS ABOUT HIV AND RISK- COMMUNICATION FREQUENCY AND RANGE
B10. RISK COMMUNICATION BEHAVIOR SCALE
B11. SILENCING THE SELF/SELF-ADVOCACY SCALE
B12. PSYCHOSOCIAL OUTCOMES CHECKLIST
B13. INTERVIEW GUIDE
B14. QUESTIONNAIRE TO ASSESS INJECTING RISK BEHAVIOR

**Tools for: Training and skill building sessions to build the capacity of service providers and volunteers**
SCCW1. OUTREACH WORKER EFFECTIVENESS FORM
SCCW2. LOG SHEET FOR PEER VOLUNTEERS
SCCW3. EDUCATOR CAPACITIES FOR SEXUALITY AND PREVENTION EDUCATION
SCCW4. TRAIN-THE-TRAINER TRAINING EFFECTIVENESS QUESTIONNAIRE
SCCW5. PEER EDUCATOR FOCUS GROUP GUIDE
SCCW6. PEER VOLUNTEER CAPACITIES QUESTIONNAIRE
SCCW7. COMMUNICATION SELF-EFFICACY FOR HIV AND STI PREVENTION
SCCW8. SUPPORT STAFF CAPACITIES INTERVIEW
SCCW9. VOLUNTEERS' RELATIONSHIP SKILLS SCALE

**Tools for: Outreach to priority populations to increase their capacity to engage in risk reduction behaviors**
SCC1. CANADIAN SEXUAL HEALTH INDICATORS: SEXUAL BEHAVIOR CAPACITIES
SCC6. SELF-EFFICACY FOR CONDOM USE IN EMOTIONAL DISTRESS SCALE
SCC7. SELF-EFFICACY FOR PREVENTION MEASURE
B1. MEASURES OF UNPROTECTED ANAL/VAGINAL INTERCOURSE
B2. PROTECTIVE SEXUAL BEHAVIORS SCORE
B3. HEALTHY SEXUAL BEHAVIOR QUESTIONNAIRE FOR MSM
B4. PERSONAL SEXUAL BEHAVIORS - INDIGENOUS STAND EVALUATION QUESTIONNAIRE

B5. REASONS FOR UNPROTECTED SEX
B6. TESTING ATTITUDES, INTENTIONS AND BEHAVIOR MEASURE
B7. TESTING HISTORY - INDIGENOUS STAND EVALUATION QUESTIONNAIRE
B8. DISCLOSURE PRACTICES SCORE
B9. INTERVIEW: TALKING TO OTHERS ABOUT HIV AND RISK- COMMUNICATION FREQUENCY AND RANGE
B10. RISK COMMUNICATION BEHAVIOR SCALE
B11. SILENCING THE SELF/SELF-ADVOCACY SCALE
B13. INTERVIEW GUIDE
B14. QUESTIONNAIRE TO ASSESS INJECTING RISK BEHAVIOR

**Tools for: Outreach to priority populations for awareness and education**
AK1. HIV KNOWLEDGE QUESTIONNAIRE
AK2. PRE AND POST HIV/AIDS TRAINING QUIZ FOR AFRICAN & CARIBBEAN CANADIAN PEER VOLUNTEERS
AK3. STI/HIV PREVENTION KNOWLEDGE - INDIGENOUS STAND EVALUATION QUESTIONNAIRE
AK4. HIV KNOWLEDGE SURVEY
AK5. HIV/AIDS TRANSMISSION MISCONCEPTIONS
AK6. INFECTIOUSNESS BELIEFS SCALE
AK7. HIV TESTING AND COUNSELLING BELIEFS SCALE
AK8. HIV TREATMENT KNOWLEDGE
AK11. HIV SELF-STIGMA SCALE
AK12. HCV KNOWLEDGE QUESTIONNAIRE # 1
AK13. HCV KNOWLEDGE AND CAPACITY QUESTIONNAIRE #2
AK14. STI KNOWLEDGE SCALE
SCC1. CANADIAN SEXUAL HEALTH INDICATORS: SEXUAL BEHAVIOR CAPACITIES
SCC7. SELF-EFFICACY FOR PREVENTION MEASURE
B5. REASONS FOR UNPROTECTED SEX
B6. TESTING ATTITUDES, INTENTIONS AND BEHAVIOR MEASURE
B12. PSYCHOSOCIAL OUTCOMES CHECKLIST
B13. INTERVIEW GUIDE

**Tools for: Interventions to promote retention and care in treatment**
AK8. HIV TREATMENT KNOWLEDGE
B12. PSYCHOSOCIAL OUTCOMES CHECKLIST
ACS1. ACCESS TO AND USE OF SUPPORTIVE AND ANCILLARY HEALTH SERVICES INTERVIEW CHECKLIST
ACS2. HEALTH ACCESS WHEN LIVING WITH HIV/ HEPATITIS C – QUALITATIVE INTERVIEW
ACS3. INDIGENOUS OR ETHNOCULTURAL MSM EXPERIENCES IN ACCESSING SERVICES QUESTIONNAIRE
SCCW9. VOLUNTEERS' RELATIONSHIP SKILLS SCALE

**Tools for: Activities to help people living with HIV/AIDS, hepatitis C or related communicable diseases access resources and services**
AK8. HIV TREATMENT KNOWLEDGE
SCCW8. SUPPORT STAFF CAPACITIES INTERVIEW
SCCW9. VOLUNTEERS' RELATIONSHIP SKILLS SCALE
B11. SILENCING THE SELF/SELF-ADVOCACY SCALE
B12. PSYCHOSOCIAL OUTCOMES CHECKLIST
ACS1. ACCESS TO AND USE OF SUPPORTIVE AND ANCILLARY HEALTH SERVICES INTERVIEW CHECKLIST
ACS2. HEALTH ACCESS WHEN LIVING WITH HIV/ HEPATITIS C – QUALITATIVE INTERVIEW
ACS3. INDIGENOUS OR ETHNOCULTURAL MSM EXPERIENCES IN ACCESSING SERVICES QUESTIONNAIRE

**Tools for: Activities to improve collaboration, coordination and networking**
SCCW1. OUTREACH WORKER EFFECTIVENESS FORM
SCCW2. LOG SHEET FOR PEER VOLUNTEERS
SCCW4. TRAIN-THE-TRAINER TRAINING EFFECTIVENESS QUESTIONNAIRE

SCCW5. PEER EDUCATOR FOCUS GROUP GUIDE
SCCW7. COMMUNICATION SELF-EFFICACY FOR HIV AND STI PREVENTION
SCCW8. SUPPORT STAFF CAPACITIES INTERVIEW
SCCW9. VOLUNTEERS' RELATIONSHIP SKILLS SCALE
ACS1. ACCESS TO AND USE OF SUPPORTIVE AND ANCILLARY HEALTH SERVICES INTERVIEW CHECKLIST
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**Tools for: Activities to increase capacity to use best and promising practices**
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KTE2. DO OUR DECISION-MAKING PROCESSES HAVE A PLACE FOR RESEARCH EVIDENCE?
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AK14. STI KNOWLEDGE SCALE
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B1. MEASURES OF UNPROTECTED ANAL/VAGINAL INTERCOURSE
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B5. REASONS FOR UNPROTECTED SEX MEASURE
B8. DISCLOSURE PRACTICES SCORE
B10. RISK COMMUNICATION BEHAVIOR SCALE
B12. SILENCING THE SELF/SELF-ADVOCACY SCALE
ACS3. INDIGENOUS OR ETHNOCULTURAL MSM EXPERIENCES IN ACCESSING SERVICES QUESTIONNAIRE

**Tools for: Indigenous people (First Nations, Inuit and Métis)**
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AK5. HIV/AIDS TRANSMISSION MISCONCEPTIONS
AK14. STI KNOWLEDGE SCALE
SCC1. CANADIAN SEXUAL HEALTH INDICATORS: SEXUAL BEHAVIOR CAPACITIES
SCC6. SELF-EFFICACY FOR CONDOM USE IN EMOTIONAL DISTRESS SCALE
SCC7. SELF-EFFICACY FOR PREVENTION MEASURE
SCC9. ABILITY TO REFUSE RISKY SEXUAL SITUATIONS SCALE
SCC10. CAPACITY TO MANAGE SEX RISK SCALE
SCC11. HEALTHY SEXUALITY QUESTIONNAIRE – INDIGENOUS WOMEN
SCCW7. COMMUNICATION SELF-EFFICACY FOR HIV AND STI PREVENTION
SCCW8. SUPPORT STAFF CAPACITIES INTERVIEW
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B4. PERSONAL SEXUAL BEHAVIORS - INDIGENOUS STAND EVALUATION QUESTIONNAIRE
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B7. TESTING HISTORY - INDIGENOUS STAND EVALUATION QUESTIONNAIRE

B8. DISCLOSURE PRACTICES SCORE
B9. INTERVIEW: TALKING TO OTHERS ABOUT HIV AND RISK- COMMUNICATION FREQUENCY AND RANGE
B11. SILENCING THE SELF/SELF-ADVOCACY SCALE
B12. PSYCHOSOCIAL OUTCOMES CHECKLIST
B13. INTERVIEW GUIDE

**Tools for: Ethnocultural communities**
AK1. HIV KNOWLEDGE QUESTIONNAIRE
AK2. PRE AND POST HIV/AIDS TRAINING QUIZ FOR AFRICAN & CARIBBEAN CANADIAN PEER VOLUNTEERS
AK5. HIV/AIDS TRANSMISSION MISCONCEPTIONS
AK7. HIV TESTING AND COUNSELLING BELIEFS SCALE
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B11. SILENCING THE SELF/SELF-ADVOCACY SCALE
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**Tools for: People living with HIV/AIDS, other STIs and/or hepatitis C**
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AK8. HIV TREATMENT KNOWLEDGE
AK11. HIV SELF-STIGMA SCALE
SCCW8. SUPPORT STAFF CAPACITIES INTERVIEW
SCCW9. VOLUNTEERS' RELATIONSHIP SKILLS SCALE
B5. REASONS FOR UNPROTECTED SEX
B8. DISCLOSURE PRACTICES SCORE
B10. RISK COMMUNICATION BEHAVIOR SCALE
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ACS2. HEALTH ACCESS WHEN LIVING WITH HIV/ HEPATITIS C – QUALITATIVE INTERVIEW
ACS3. INDIGENOUS OR ETHNOCULTURAL MSM EXPERIENCES IN ACCESSING SERVICES QUESTIONNAIRE
ACS4. CHRONIC ILLNESS RESOURCES SURVEY

**Tools for: Youth**
AK3. STI/HIV PREVENTION KNOWLEDGE – INDIGENOUS STAND EVALUATION QUESTIONNAIRE
AK4. HIV KNOWLEDGE SURVEY

AK7. HIV TESTING AND COUNSELLING BELIEFS SCALE
AK12. HCV KNOWLEDGE QUESTIONNAIRE #1
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SCC9. ABILITY TO REFUSE RISKY SEXUAL SITUATIONS SCALE
SCC10. CAPACITY TO MANAGE SEX RISK SCALE
B4. PERSONAL SEXUAL BEHAVIORS – INDIGENOUS STAND EVALUATION QUESTIONNAIRE
B7 TESTING HISTORY MEASURE – INDIGENOUS STAND EVALUATION QUESTIONNAIRE

**Tools for: Front-line service providers and community workers volunteers; and peers, including people living with or at risk of HIV/AIDS, other STIs and/or hepatitis C.**
AK6. HIV/AIDS TRANSMISSION MISCONCEPTIONS
SCCW1. OUTREACH WORKER EFFECTIVENESS FORM
SCCW2. LOG SHEET FOR PEER VOLUNTEERS
SCCW3. EDUCATOR CAPACITIES FOR SEXUALITY AND PREVENTION EDUCATION
SCCW4. TRAIN-THE-TRAINER TRAINING EFFECTIVENESS QUESTIONNAIRE
SCCW5. PEER EDUCATOR FOCUS GROUP GUIDE
SCCW6. PEER VOLUNTEER CAPACITIES QUESTIONNAIRE
SCCW7. COMMUNICATION SELF-EFFICACY FOR HIV AND STI PREVENTION
SCCW8. SUPPORT STAFF CAPACITIES INTERVIEW
SCCW9. VOLUNTEERS' RELATIONSHIP SKILLS SCALE

**Tools for: Community-based organizations addressing HIV/AIDS, other STIs and/or hepatitis C**
SCCW1. OUTREACH WORKER EFFECTIVENESS FORM
SCCW2. LOG SHEET FOR PEER VOLUNTEERS
SCCW4. TRAIN-THE-TRAINER TRAINING EFFECTIVENESS QUESTIONNAIRE
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**Tools for: General or targeted populations for social marketing or social media campaigns**
AK1. HIV KNOWLEDGE QUESTIONNAIRE
AK6. HIV/AIDS TRANSMISSION MISCONCEPTIONS
AK9. HIV STIGMA SCALE
AK10. STIGMATIZING ATTITUDES TOWARDS PEOPLE LIVINGWITH HIV/AIDS
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B6. TESTING ATTITUDES, INTENTIONS AND BEHAVIOR MEASURE

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AK12. HCV KNOWLEDGE QUESTIONNAIRE # 1
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SCCW8. SUPPORT STAFF CAPACITIES INTERVIEW
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**STI- specific or STI-relevant tools**

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