Second Annual Summary and Analysis of Data Provided by Community-based HIV/AIDS Services in Ontario

To the End of Fiscal Year 2006-07

A Collaborative Project of the
AIDS Bureau, Ministry of Health and Long-Term Care and the
Public Health Agency of Canada, Ontario Region
January 2008

Preface

The AIDS Bureau of the Ministry of Health and Long-Term Care and the Ontario Region of the Public Health Agency of Canada (PHAC) AIDS Community Action Program (ACAP) fund a variety of community-based organizations – including AIDS service organizations (ASOs), community health centres and other organizations – to provide HIV/AIDS prevention and support services.

The AIDS Bureau provides ongoing operational funding and one-time grants to ASOs, public health units, community health centres and other organizations. It also provides ongoing funding for IDU outreach services in a number of communities.

ACAP funded Operational Programs and Time-Limited Projects are required to complete logic models which represent a map of the work to be done within the year. These logic models have evolved into an on-line reporting tool which records the "planned" outputs/deliverables and the "actual" outputs/deliverables and links them directly to the on-line OCHART. October 2006 to March 2007 is the first reporting period for which ACAP Logic Model data has been recorded on-line and ACAP data can now be analyzed and presented back to stakeholders. Also, the ACAP Time-Limited Project cycle ended on March 31, 2007 and we are now able to share some information from their final reports. A full evaluation report of ACAP Time-Limited Projects will be available by April 2008.

The purposes of collecting and reporting data on community-based HIV/AIDS services are:

- **Accountability**: the reports allow the organizations, the AIDS Bureau and the Public Health Agency of Canada to check actual activity against program plans and logic models. They also provide information on how resources were used.
- **Planning**: the reports may identify trends that can be used to adjust services or to develop new services locally and provincially.
- **Quality Improvement/ Evaluation**: the reports may provide information that organizations can use to strengthen their services.

Data Limitations

The data in this report should be interpreted with caution. This is only the second year that agencies have fulfilled their reporting requirements using OCHART, and agencies may have interpreted OCHART questions in different ways or used different definitions. It is also the first year that agencies used the web-based OCHART tool, and the first year that ACAP agencies were required to complete logic models as well as OCHART. These changes may have resulted in some data inaccuracies.

Data quality and consistency are improving over time. OCHART includes more precise data definitions, and reports are being monitored to ensure greater consistency.

It is important to note that organizations provide program level – rather than client level – data. As a result, it is possible to identify the type and number of services provided, but not the exact number of people served or the mix of services that each person used.

How the Report is Organized

To help agencies understand the link between the information in this report and the data they provide through OCHART, the report is set out using the same sections as the OCHART form.

Acknowledgements

The AIDS Bureau and the Ontario Region of PHAC would like to thank the organizations that provided the data used in this report. It takes time to collect data and complete OCHART, and the funders appreciate the attention that agencies give to completing the forms.

The AIDS Bureau and PHAC would also like to thank the small advisory group who provided advice on effective ways to present the data:

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The AIDS Bureau and PHAC would like to thank the Ontario HIV Treatment Network (OHTN) for its support of OCHART, which includes developing the web-based OCHART forms, providing ongoing training and support to agencies on the use of OCHART, housing the data, and extracting the data and completing the analysis for this report.

For more information about completing OCHART forms or to request agency-specific data and reports, agencies should contact:

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Key Findings and Trends in 2006-07

More diagnoses in women and the African and Caribbean community. There was a slight increase in new HIV diagnoses – mainly due to more diagnoses in women, who accounted for 30% of newly diagnosed infections in 2006 (compared to 25% in 2005, and more diagnoses in people from the African and Caribbean communities who accounted for 25% of newly diagnosed infections in 2006 (compared to 20% in 2005). Most new diagnoses (48%) were in men who have sex with men.

Organizations are serving more diverse populations. Organizations report providing services in 39 different languages. Over the past two years, there has been an increase in the number of organizations serving all ethnic groups – and particularly in the proportion of organizations reporting serving clients from Middle Eastern/Arab (+17%), South Asian (+15%), and other Black (+13%) communities. To meet the needs of more diverse clients, agencies identified the need for more interpretation and translation services, more culturally appropriate resources, more information on immigration and settlement issues, and more cultural competency training for staff.

More women are using ASOs. The average number of women using community-based support services has increased by 73% since 2004-05. Over the same period, the number of men has increased by 54%. In 2006-07, about 25% of people using support services were new clients.

More clients are facing issues of domestic violence, sexual violence and abuse. More organizations reported serving clients dealing with issues of violence and abuse. This is likely related to the increase in the number of women seeking services. However, the most common health and social issues faced by clients continue to be unemployment, homelessness, mental health issues and food security.

Clients are more involved in services. More organizations reported involving clients in services. The most marked increases were in the number of organizations employing people with HIV/at risk, recruiting clients for paid jobs, and involving clients in data collection, research and evaluation. This type of client involvement is particularly important given the fact that unemployment was identified as the key issue facing most clients.

The International AIDS Conference (AIDS 2006) had a positive impact on activities. During 2006-07, organizations reported more education presentations, more community development meetings, more participants, more awareness activities, and more media contacts. These increases are likely due to AIDS 2006.

Organizations are using a mix of tools/approaches to deliver education messages. For example, organizations use the internet to provide information and education, but continue to rely on phone and in-person contact to provide test counselling and referral services.

More organizations are distributing prevention resources. There was an increase in the number of organizations distributing all types of prevention resources, and in the range of resources being distributed. This may be due to the Ontario Harm Reduction Distribution Program, introduced in 2006-07 and funded by the Hepatitis C Secretariat.

Organizations provided 40% more support services. Agencies reported more clients using more support services. The increase in the number and range of services used (+40%) was greater than the increase in the number of clients. This means that clients are using more services. This may be due to better reporting, clients' more complex needs, the increasing focus on case management for clients, or to agencies having greater capacity to provide services because of

recent funding increases. In 2006-07, more clients accessed case management, training/skills development, complementary therapies, buddy programs, referral services, and intake and assessment services.

More organizations are providing assistance with transportation. Transportation was identified as an unmet need in many community plans, more organizations reported providing financial assistance in the form of bus tickets, and more reported developing transportation services or recruiting more volunteers to provide transportation.

Volunteers who provide practical support give significantly more time than those involved in fundraising, education or other activities. The type of role that volunteers have appears to affect their level of involvement and the number of hours they donate.

More peers are involved in IDU outreach programs. Programs reported a 131% increase in active peers and a 258% increase in new peers in 2006-07. The increase may be due to a more concerted effort by programs to recruit and retain peers and/or better data collection.

Organizations are responding in creative ways to emerging trends. Organizations identified a number of emerging trends including more women, more newcomers, more injection drug users and more clients with complex needs seeking services. They are using a number of innovative strategies to respond, including recruiting staff and volunteers who have the skills to meet clients needs (e.g., peers, cultural competency), developing more partnerships with other organizations, providing more training for staff, and developing new programs and services.

Organizations are actively engaged in program planning and evaluation. There was an increase in the number of organizations that reported using all types of monitoring processes and tools – particularly client satisfaction surveys, focus groups, performance reviews, environmental scans and external evaluations. The field appears to be developing an evaluation and quality improvement culture.

Organizations are applying the lessons they learn to strengthen their programs. The lessons that organizations learn from their monitoring and evaluation are being used to guide strategic planning, to make their programs more effective, to develop new partnerships, to engage their communities, and to develop new/different ways to meet unmet needs.

The Context for Our Work: Trends in HIV Infection in Ontario

The main goals of the programs/organizations funded by the AIDS Bureau and ACAP are:

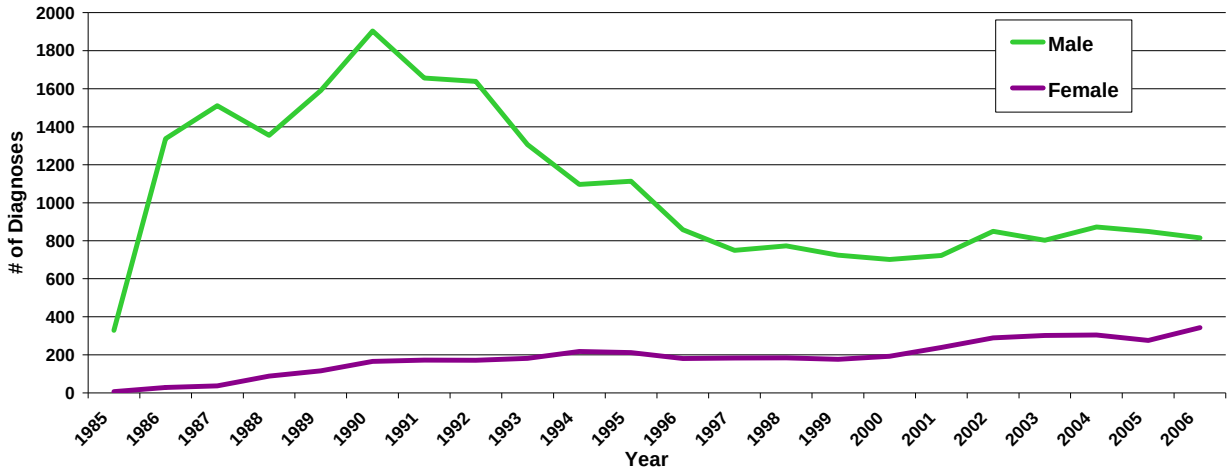
- to prevent the spread of HIV
- to improve the health and well-being of people living with HIV and their communities.

The programs and services organizations provide are developed in response to the needs of their communities, and are shaped by the nature of the epidemic in their regions.

Number of new HIV diagnoses increases – particularly in women and in the African and Caribbean communities

According to the Ontario Epidemiologic Monitoring Unit at the University of Toronto, which is responsible for HIV surveillance, there was a slight (3%) increase in new HIV diagnoses (i.e., first-time positive test results) in 2006 (1,158 new diagnoses) compared to 2005 (1,124) (Figure 1).

Figure 1: Number of HIV Diagnoses (adjusted[1]) Among Males and Females by Year of Diagnosis, Ontario, 1985 to 2006



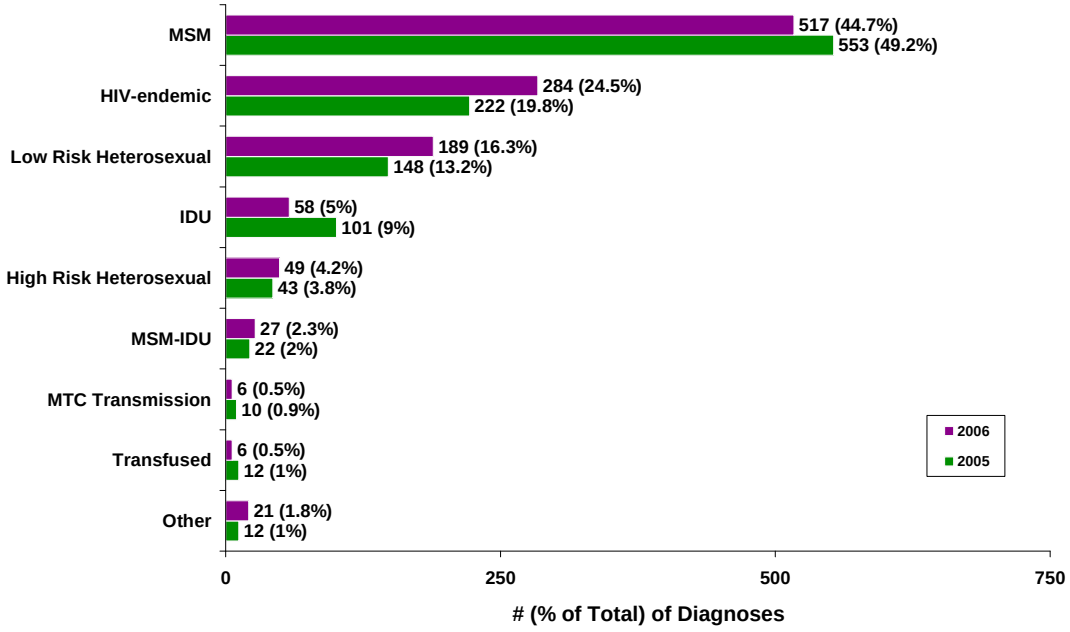
1 Unknown sex assigned according to the distribution of cases with known sex (see Technical Notes); thus, totals may differ due to rounding
Source of data: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care
From: http://www.phs.utoronto.ca/ohemu/doc/2007/Table1.pdf - accessed January 2, 2008

The increase was mainly due to more diagnoses in women who accounted for 30% of new diagnoses in 2006 compared to 25% in 2005.

In terms of risk factors (Figure 2), the greatest increase occurred in people from the African and Caribbean community who accounted for 25% of new diagnoses in 2006, compared to 20% in 2005; and in people who reported being low risk heterosexuals (16% of cases in 2006 compared to 13% in 2005).

In 2006, the number of men who have sex with men who tested positive dropped to 517 from 553; however, gay men still accounted for 48% of new infections. There was also a significant drop in the number of people with injection drug use as a risk factor: from 101 in 2005 to 58 in 2006. However, preliminary information on new diagnoses in 2007 indicates that the number has increased, and that the drop in injection drug use-related infections in 2006 was an anomaly rather than a trend.

Figure 2: Number (adjusted[1]) of HIV Diagnoses by Year of Test and Exposure Category - 2005 to 2006

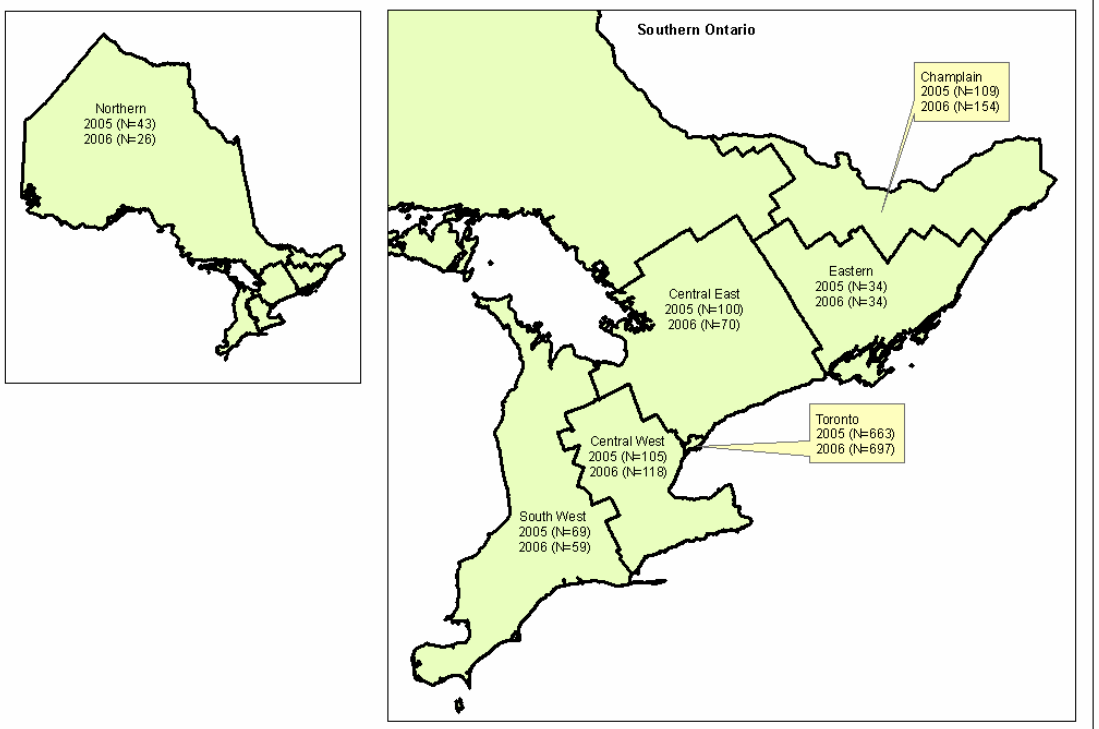


[1] Unknown exposure categories assigned according to the results of the Laboratory Enhancement Study (see Technical Notes); thus, totals may differ due to rounding
Source of data: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care
From: http://www.phs.utoronto.ca/ohemu/doc/2007/Table2.pdf - accessed January 2, 2008

Fewer diagnoses in Northern, Southwest and Central East Ontario, but more in Ottawa, Toronto and Central West

While the overall number of HIV diagnoses increased in 2006, the increase did not occur consistently in all regions of the province (Figure 3). Three regions experienced fairly significant drops in the number of new diagnoses: Northern (60%), Central East (30%) and Southwest (14%). Three saw an increase: Champlain (39%), Central West (12%) and Toronto (5%) One - the Eastern region -- had the same number of new diagnoses each year.

Figure 3. Number (adjusted) of HIV Diagnoses by Health Region, 2005 and 2006



The epidemiology of the epidemic continues to vary by region, with Ottawa and Thunder Bay having more injection drug use-related infections, and Toronto having more infections in gay men and people from the African and Caribbean communities.

In terms of testing, 413,079 HIV tests were done in 2006 – of which 28% were positive. The number of tests in 2006 was up 5% from 392,061 in 2005. The number of HIV tests increased in every region in 2006 except the Eastern region.

More Ontarians are living with HIV

Because of more effective treatments for HIV, the number of people living with HIV in Ontario continues to increase. According to statistical modeling done by the Ontario HIV Epidemiologic Monitoring Unit, by the end of 2005:

- 33,194 people in Ontario had been infected with HIV (not all of whom have been diagnosed)
- 8,799 had died
- 24,891 were living with HIV.

With more people living longer with HIV, funded organizations are likely providing services for more people over a longer period of time; however, because OCHART collects program rather than client-level data, it is not possible to determine exactly how many people are using community-based HIV prevention, care and support services or how long they receive services.

For more information on epidemiological data for Ontario, see (http://www.phs.utoronto.ca/ohemu/mandate.html).

1. Organization Information

At the end of 2006-07, 77 organizations were receiving funding from the AIDS Bureau and/or PHAC – up from 74 at the end of 2005-06. Although 77 organizations were funded in the last half of 2005-06, this report includes data from 76 agencies. For the list of funded organizations that provided information for this report, please see Appendix A.

Services are located across the province

As the following map illustrates, funded organizations are located across the province. Although most agencies are located in urban centres, many provide services for large geographic areas. In 2006-07, 77 organizations provided services from 87 different sites, enhancing their capacity to serve their communities. Figure 4 also indicates the number of staff funded by the AIDS Bureau and/or PHAC in each location.

Figure 4. Location of Organizations by Staff Size and by LHIN, Ontario, 2006 (First Half)

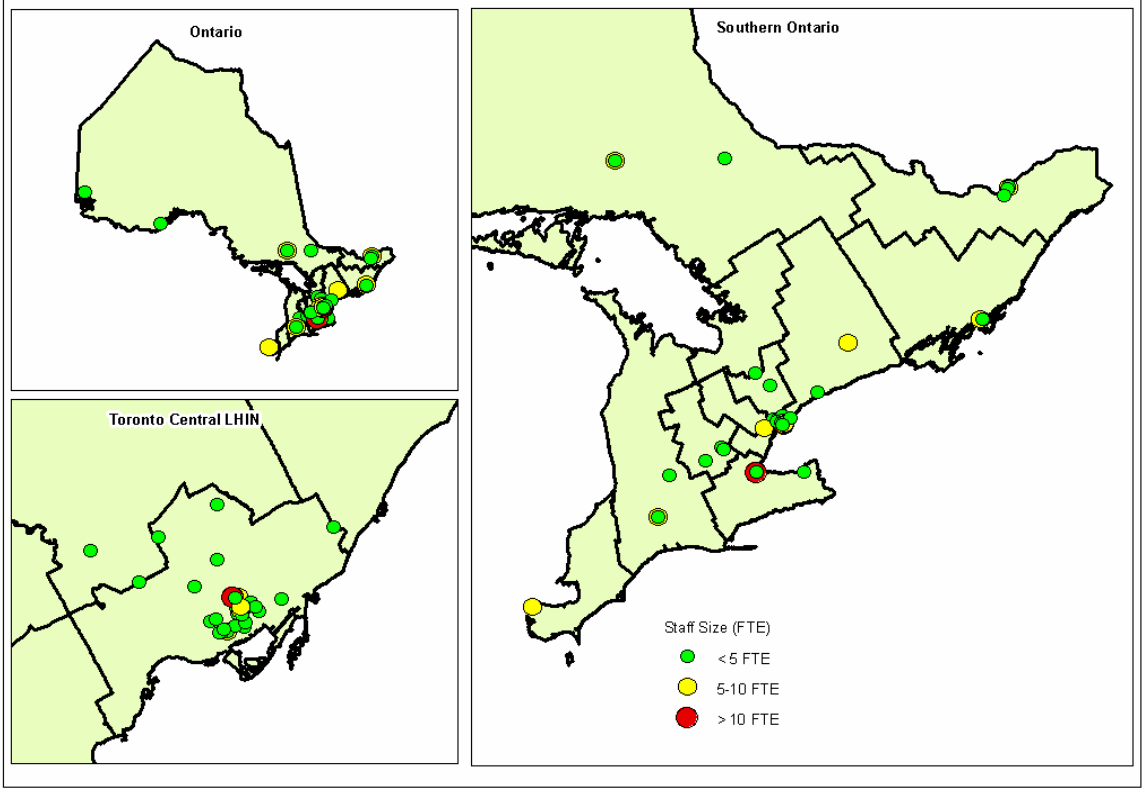
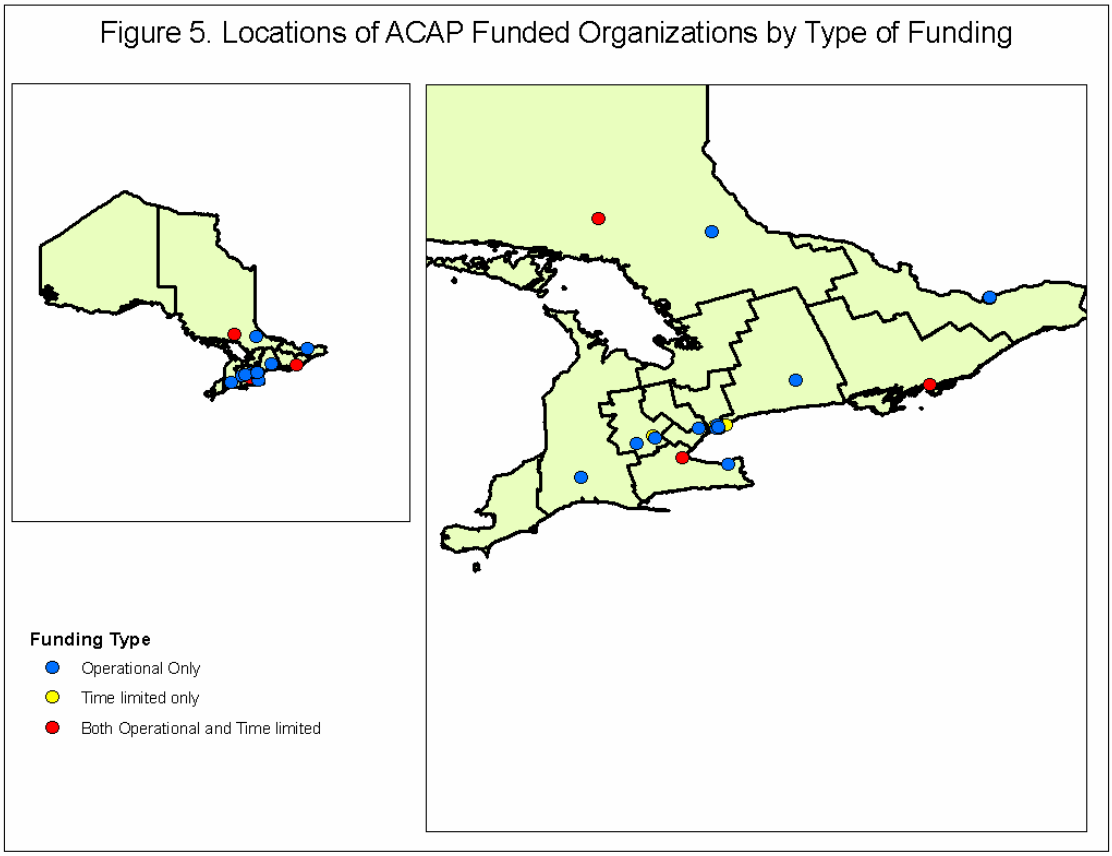


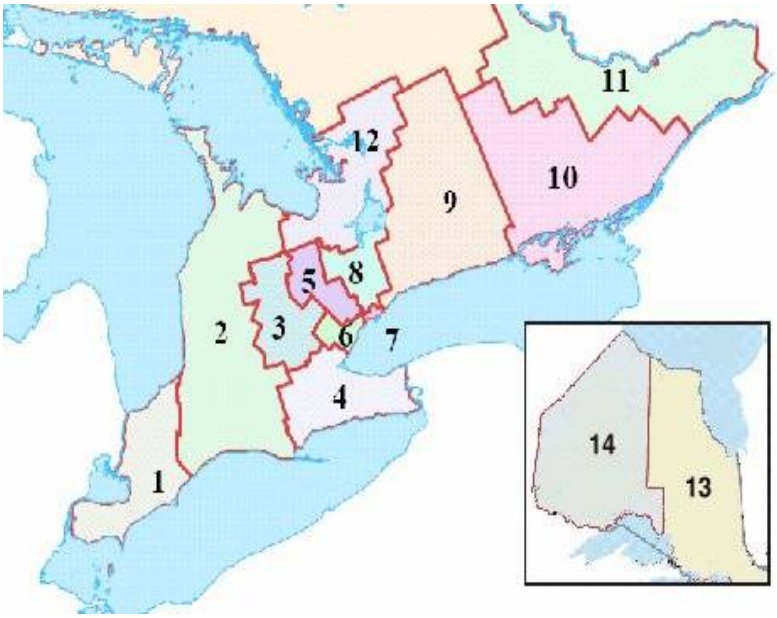
Figure 5 shows the location of ACAP-funded projects



The relationship between epidemiological regions and LHIN regions

Most health services in Ontario, including hospital services, home care, long-term care homes, community health centres, and mental health and addiction services, are now planned, coordinated and funded by 14 Local Health Integration Networks (LHINs).

Figure 6: Ontario's Local Health Integration Networks (LHINs)



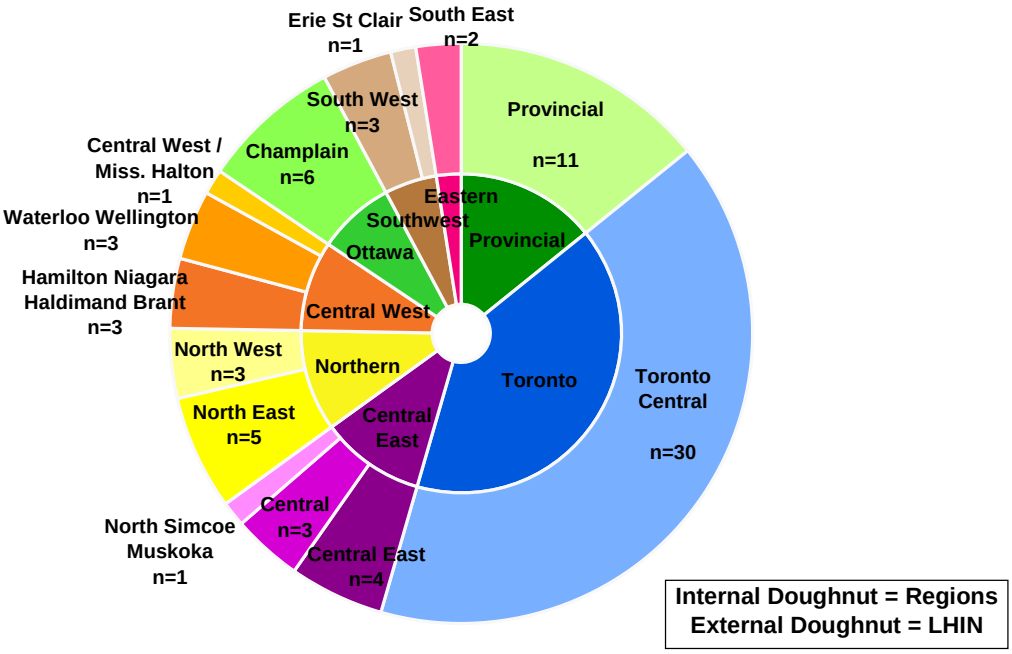
1. Erie St. Clair
2. South West
3. Waterloo, Wellington
4. Hamilton, Niagara, Haldimand, Brant
5. Central West
6. Mississauga, Halton
7. Toronto Central
8. Central
9. Central East
10. South East
11. Champlain
12. North Simcoe, Muskoka
13. North East
14. North West

Epidemiological information on HIV is provided by 7 regions. To ensure the anonymity of individual agency data, this report describes programs, services and activities for the province as a whole, by region or by LHIN.

Although ASOs are not funded through the LHINs – and some serve more than one LHIN region – ASOs should be aware of LHIN plans and priorities. It is also important for all funded organizations to understand the relationship between the regions used for epidemiological data and the LHIN regions.

Figure 7 illustrates the number of funded organizations within each LHIN region and how the LHIN regions relate to the regions used to report epidcmiological data. For example, in the Northern region, there are two LHIN regions – North West and North East – which have three and five funded organizations respectively. Although most provincial organizations (i.e., organizations funded to provide services across the province) are located in Toronto, they are treated as a separate group to avoid distorting the amount of service provided in Toronto.

Figure 7: LHIN Distribution Across Regions



Note: for purposes of this report and analysis, two LHIN regions – Central West and Mississauga Halton -- are combined.

Services are available in 39 languages

Funded organizations report that they commonly provide services in a total of 39 languages. In addition to the 15 languages listed in OCHART, 14 agencies reported providing services in more than 20 "other" languages. While we know the number of languages, we do not know the extent of services provided in each language (e.g., brochures or written materials, counselling). Table 1 lists the number of organizations that reported providing services in certain languages.

Table 1: Number of Organizations Providing Services in Selected Languages

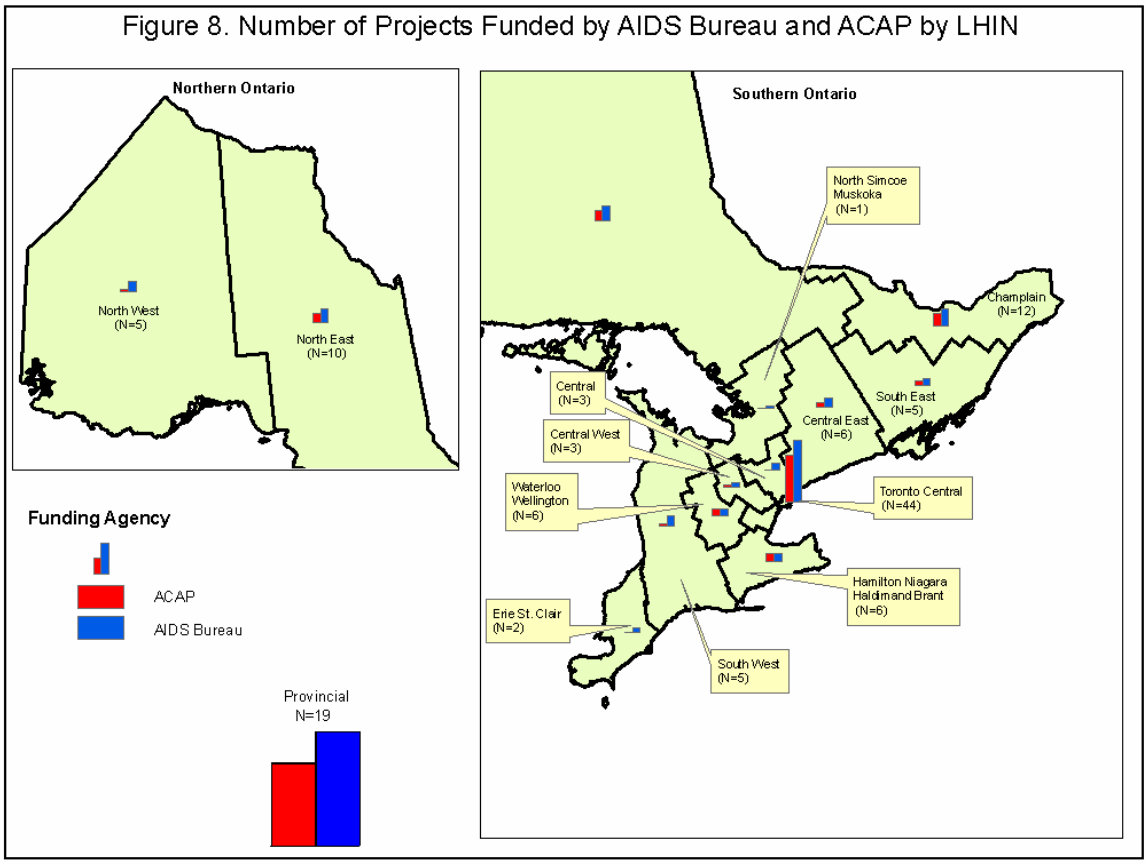
Language	# of Orgs
English	76
French	22
Other	14
Spanish	11
Tamil	7
Hindi	7
Mandarin	6
Punjabi	6
Portuguese	5
Cantonese	5
Cree	4
Ojibway	4
Somali	4
Vietnamese	4
Arabic	3
Sign	1

As would be expected, agencies providing services in three or more languages tend to be located in or around Toronto, Ottawa and other urban centres that have large immigrant populations or whose mandate is to serve particular ethnocultural communities.

2. Program/Project Information

The following map (Figure 8) indicates the number of AIDS Bureau and ACAP funded organizations/projects in each LHIN. Of the 45 projects and programs funded by ACAP in 2006-07, all projects were involved in Creating Supportive Environments, 20 in Prevention Initiatives, 15 in Health Promotion for PHAs, and 10 in Strengthening Community-Based Organizations.

Figure 8. Number of Projects Funded by AIDS Bureau and ACAP by LHIN



AIDS Bureau/ACAP funding supports 189.56 FTEs

In the first half of 2006-07, organizations used AIDS Bureau and PHAC funding to support the equivalent of 189.56 FTEs.

About ACAP-funded organizations

To meet the criteria for ACAP funding, the projects must support one or more of the four ACAP Funding Approaches: Prevention Initiatives, Health Promotion for People with HIV/AIDS, Strengthening Community-based Organizations, and Creating Supportive Environments.

From 2005-06 through 2006-07, all ACAP Operational and Time-Limited Projects were involved in Creating Supportive Environments, including development activities to strengthen their relationships with other sections (e.g., mental health, settlement/immigration, media and faith

communities), and the development of a media campaign to reduce homophobia and promote healthy sexuality.

Most ACAP-funded organizations reported being involved in Prevention Initiatives, such as working with at-risk populations, offering prevention workshops and providing peer outreach programs.

Under the funding approach Health Promotion for PHAs, ACAP-funded organizations worked to:

- improve environments and services for immigrant, refugee and minority populations (e.g., translating resources, develop peer education and outreach campaigns)
- conduct health promotion activities, such as health promotion and leadership development workshops for PHAs, educating and networking with health care providers about the issues and needs of PHAs, and developing policies related to HIV and immigration.

Those organizations funded under Strengthening Community-Based Organizations worked to develop and maintain their Volunteer Programs to enhance the capacity of organizations to provide outreach, educational and supportive services and activities.

3. Governance

Organizations are asked to provide information about how they organized and governed.

59% of funded organizations are AIDS Service Organizations

Of the 76 organizations whose data are included in this report, the majority (45 or 59%) are AIDS service organizations (ASOs) (Figure 9). The remainder are community health centres, hospitals or non-ASOs that offer some HIV/AIDS programming.

Figure 9: Number of Organizations by Type

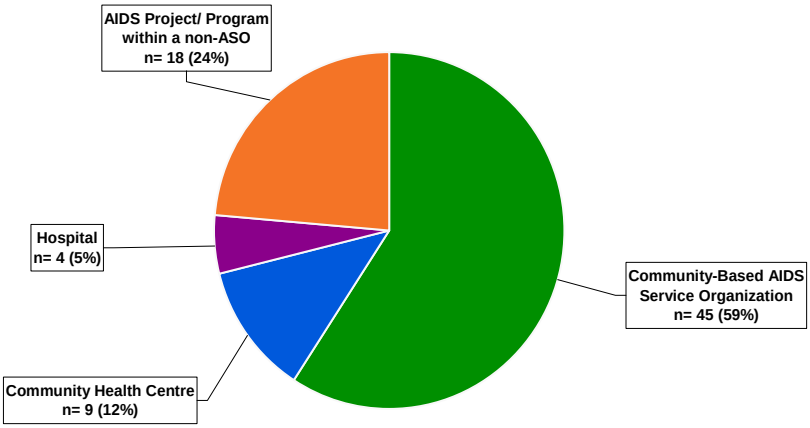
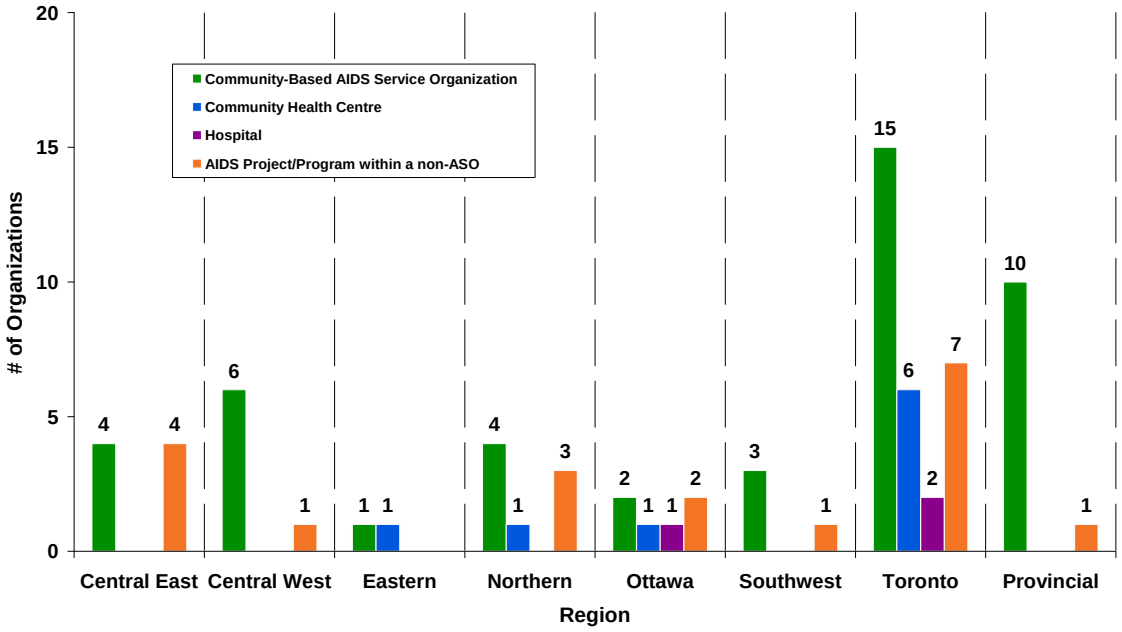


Figure 10 shows the mix of types of organizations funded in each region.

Figure 10: Number of Organizations by Type and Region



In terms of governance, over 90% have a Board of Directors, operating and human resource policies, a conflict of interest policy, and a policy on equity and discrimination, and 80% have a policy on involving people living with HIV/their target population in their programs and services (Table 2). About 28% of the funded organizations are unionized.

Table 2: Number and Proportion of Organizations with Policies in Place

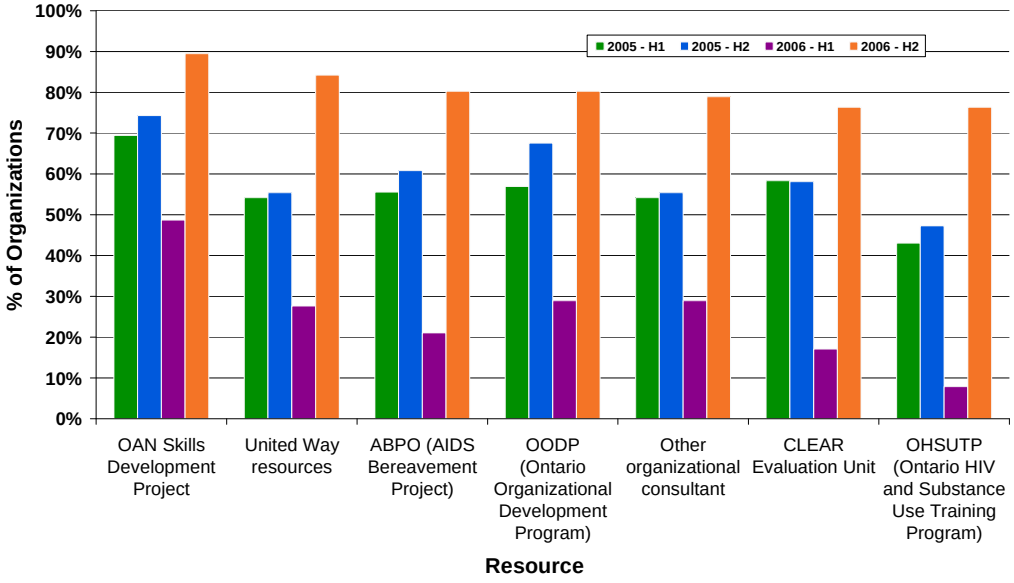
Policy	Number	%
Collective Agreement	21	27.6%
Conflict of Interest	72	94.7%
Equity /Discrimination	69	90.8%
Governance/Board of director roles and responsibilities	76	100.0%
HR/Operating Policies	75	98.7%
Target population/ PHA involvement	61	80.3%

A significant proportion of agencies are involved in activities designed to build their own organizational capacity

A number of programs and resources have been developed to support funded agencies and enhance their capacity to operate stable effective organizations, including skills building programs offered by the Ontario AIDS Network, and the services of organizational development consultants provided by the Ontario Organizational Development Program. In fact, the primary role of a number of provincial organizations is to enhance the capacity of local organizations. Funded agencies can also access expertise and resources through other non-HIV specific organizations, such as the United Way.

During 2006-07, 69 (93.2%) of agencies reported using the resources of at least one of the capacity building programs listed in OCHART (Figure 11).

Figure 11: Organizational Resources Used by Agencies - 2005 - 2007



The most frequently used capacity building resources in 2006 were OAN skills building and United Way programs – which were used by over 80% of organizations in the second half of the year. The low use of capacity building programs in the first half of 2006-07 was likely due to AIDS 2006: agencies may have been too busy with preparations for the conference to use or provide capacity building services. However, they compensated with higher than average use in the last half of the year. It's interesting to see the relatively high use of United Way services. This indicates that organizations are well connected within their communities, and that the United Way offers programs that they find valuable. It would be worthwhile to learn more about the type of services available from the United Way so that agencies can capitalize on these programs, and HIV-specific capacity building programs can ensure they do not duplicate services provided by the United Way.

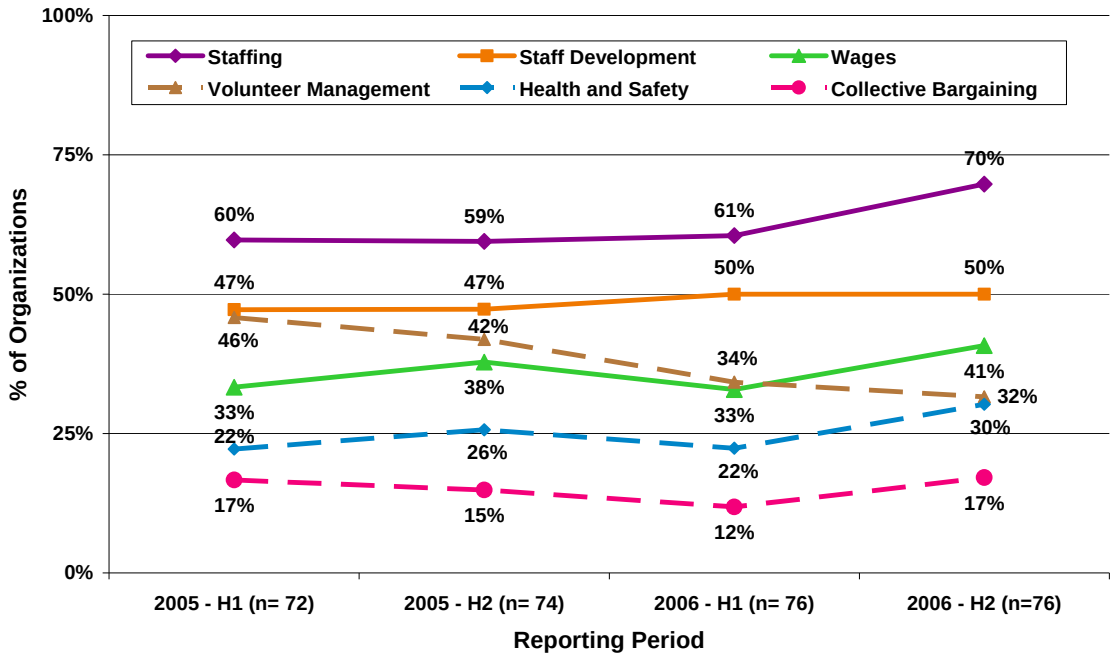
Overall, there was an increase (20%) in the use of capacity building services in 2006-07 compared to 2005-06. This may be a result of increased need on the part of organizations, increased opportunity (more capacity building services available) or better reporting.

4. Human Resource Issues

Most funded agencies are small, community-based organizations that have historically faced some challenges retaining and recruiting staff. Frequent staff turnovers have a negative impact on agencies' ability to deliver consistent, high quality programs, and they increase recruitment and training costs. Through OCHART, the AIDS Bureau and PHAC monitor human resource trends in order to understand the issues facing funded organizations. The information can also be used to help organizations develop effective recruitment and retention policies and strategies.

During 2006-07, a number of organizations reported HR issues (Figure 12). A larger proportion (10%) of organizations identified staffing as an issue in the last half of 2006-07 than in the previous three reporting periods. There was also an increase in the proportion of organizations reporting health and safety (8%) and wage issues (13%).

Figure 12: Organizational Human Resource Issues



In addition to the quantitative data on HR issues, organizations provide qualitative information. From their comments, it was clear that a number of agencies continue to struggle with staff turnover and recruitment issues, and some report long-term vacancies in key positions. Although some agencies noted that the increase in funding in 2006-07 allowed them to increase staffing levels, others reported that they do not have enough staff to meet the needs of their communities, particularly needs related to the increase in immigrant and refugee clients.

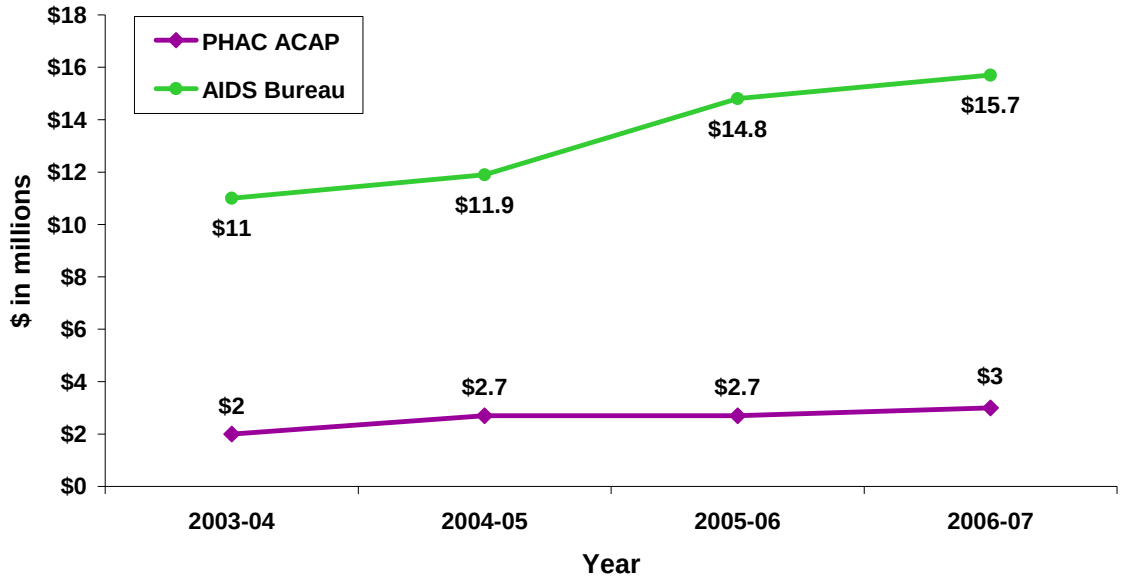
Several organizations identified cultural competency as a key skill for staff to develop, and some are actively providing training in this area. During 2006-07, some agencies reported that they are working to ensure they meet health and safety standards. A small number of agencies in Toronto are also working together to enhance their HR skills and tools, including developing a performance management system. One agency has joined a training cooperative in its community in order to give staff more options for personal and professional development.

5. Organizational Funding

AIDS Bureau and PHAC funding increased 13% in 2006-07

Figure 13 illustrates the total amount of funding provided by the AIDS Bureau and the Ontario Region of PHAC ACAP program each year from 2003-04 to 2006-07. During 2006-07, the amount of funding from PHAC increased by 11%, while the amount of funding from the AIDS Bureau increased about 6%. Since 2003-04, the amount of funding provided by the AIDS Bureau has increased by $4.7 million (43%) and the amount of funding provided by PHAC has increased by $1 million (50%).

Figure 13: Annual PHAC and AIDS Bureau Funding as Reported by Organizations



Agencies are funded in different ways to provide different services

At the end of 2006-07, 77 organizations were receiving funding from the AIDS Bureau and/or PHAC. Table 3 lists the number of organizations that received different types of funding in the last half of 2006-07 (i.e., ongoing Community-based AIDS Education and Support Program funding and/or IDU outreach funding from the AIDS Bureau, Operational and/or Time-Limited Project funding from ACAP).

Table 3: 2006 – H2 Organizations Reporting Different Funding Types

2006 – H2	Funding Source	Number
AIDS Bureau	Community-based AIDS Education and Support Program (CBAESP)	63
	HIV/IDU Program	15
ACAP	Operational	29
	Time-Limited	16

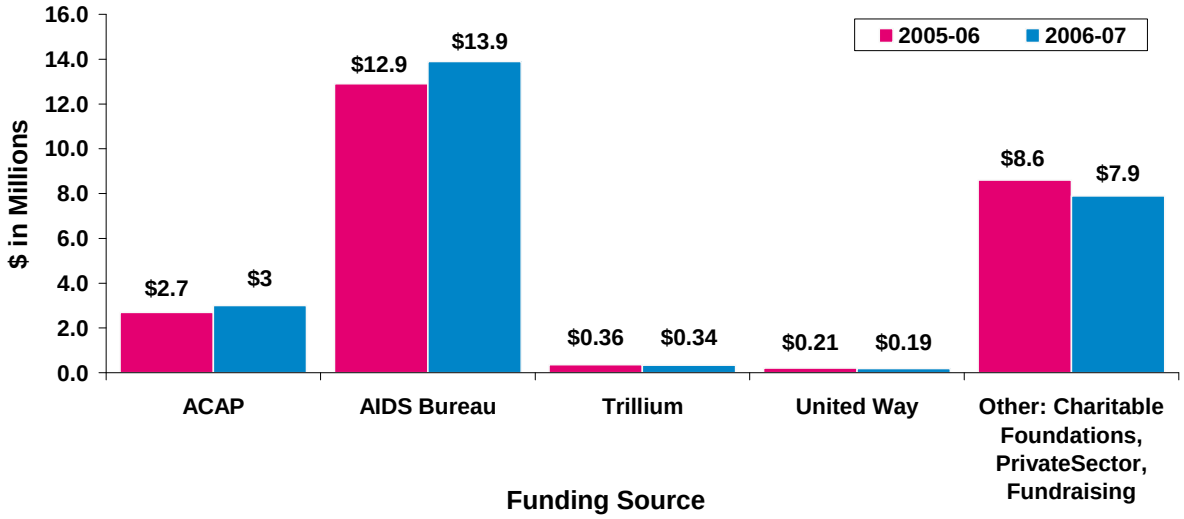
ASOs rely on fundraising for almost one-third of their budgets

Almost all organizations funded by the AIDS Bureau and/or PHAC receive funding from other sources (e.g., Trillium, United Way, fundraising). Some, such as CHCs, hospitals and Fife House receive the majority of their funding from other parts of the Ministry of Health and Long-Term Care or other provincial ministries (e.g., Municipal Affairs and Housing).

The capacity of agencies to attract funding from other sources is a strength – unless agencies are spending a disproportionate amount of time/resources on fundraising or are becoming increasingly dependent on unstable sources of funding (e.g., time-limited grants) to support core programs and services.

Through OCHART, the AIDS Bureau and PHAC monitor funding trends. Figure 14 looks at the sources of funding only for ASOs that consider the AIDS Bureau their main funder. It illustrates that, compared to previous years, these agencies are receiving both a smaller amount and a smaller proportion of their funding from fundraising. It is not clear whether this is because organizations were not able to fundraise as much in 2006-07, or whether – with the increase in both AIDS Bureau and ACAP funding – it was less necessary for them to fundraise.

Figure 14: AIDS Service Organizations: Selected Sources of Funding



Agencies received $708,062 in in-kind contributions

A different number of agencies reported receiving in-kind contributions in each OCHART reporting period:

- 35 (49%) in the first half of 2005-06
- 19 (26%) in the second half of 2005-06
- 17 (22%) in the first half of 2006-07
- 27 (36%) in the second half of 2006-07.

The reason for this variation is unknown.

Agencies that reported receiving in-kind contributions in 2006-07 estimated their value as approximately $708,000. The most common types of in-kind contributions were:

- rent/space
- staff support
- administrative support
- medical, food and personal care items, including clothing, make-up (4 agencies)
- technical support, including help with web sites (2 agencies)
- assistance developing materials, such as brochures or documentaries (1 agency)
- transportation services (1 agency)
- fund raising, including items donated for auction or resale.

ACAP supports organizational sponsorship of satellite sites, agencies, programs and coalitions. Sponsorship includes “in-kind” contributions.

Agencies received a wider range of in-kind harm reduction resources

Agencies have traditionally reported receiving harm reduction resources, such as condoms, needles and brochures that they can redistribute. In 2006-07, more agencies also reported receiving in-kind resources, such as safer crack kits, tourniquets, alcohol swabs, water, injection filters, cookers and spoons. A small number of agencies also received vitamin C. The increase in the type and number of in-kind harm reduction resources in 2006-07 is likely due to the implementation of the Ontario Harm Reduction Distribution Program by the Hepatitis C secretariat of the Ministry of Health and Long-Term Care.

6. Catchment Area Characteristics

The types of programs and services provided by each agency are shaped, in part, by the characteristics of their communities.

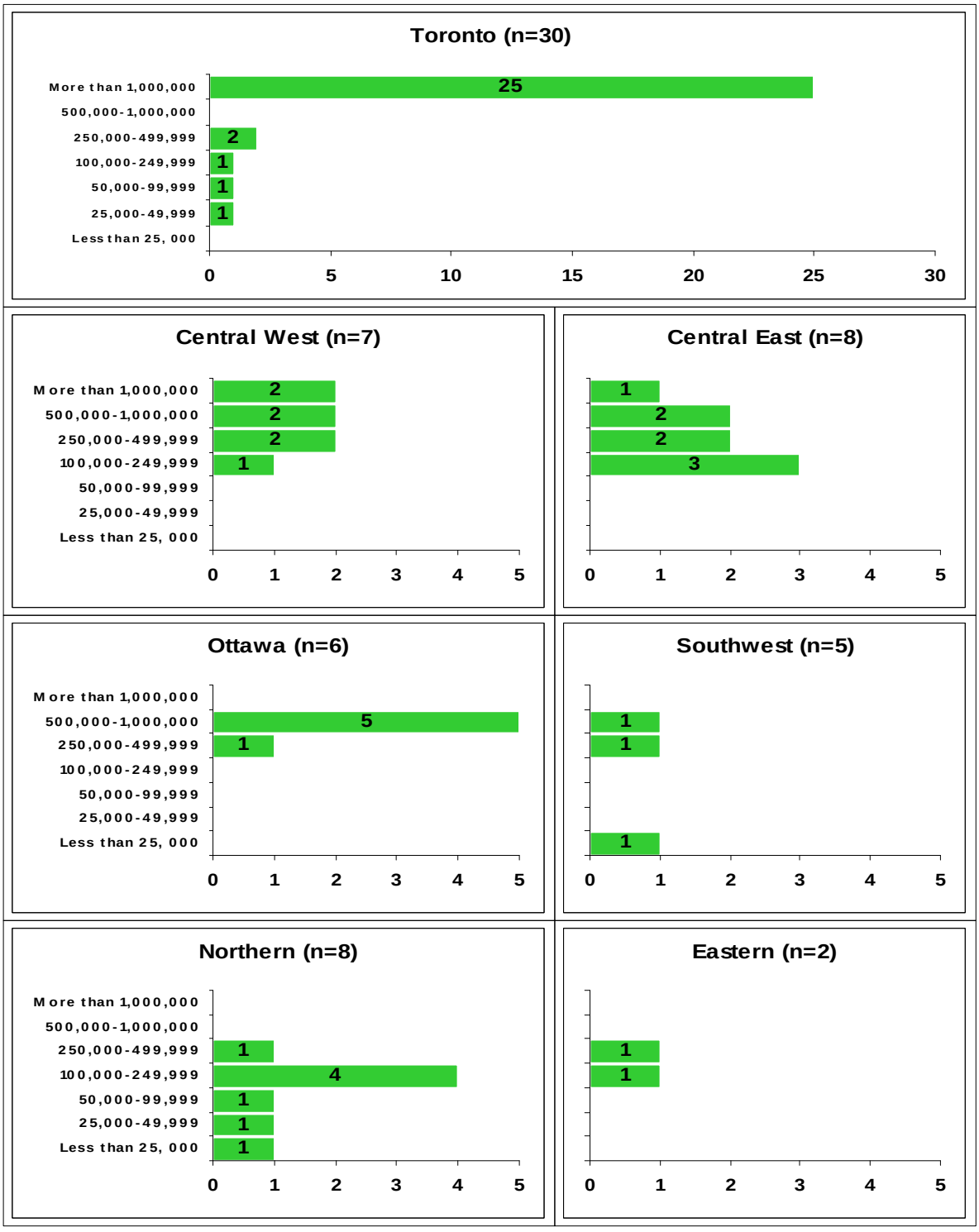
In the north and rural areas, agencies are serving relatively small populations spread across large geographic areas.

Figure 15 shows the number of organizations in each region that report serving populations of different sizes. Outside Toronto and the provincial organizations, all agencies are serving populations under 1 million and most are serving areas with populations of less than 500,000. However, even within Toronto and Ottawa, there are some agencies that focus on serving a small proportion of the population.

Central West, which is the fastest growing region in the province, appears to have fewer organizations relative to the size of its population than Toronto. However, it also has significantly fewer cases than Toronto.

In more rural and remote parts of the province, agencies are serving relatively small populations spread across large geographic areas. Geographic distribution of people and services has significant implications for program delivery.

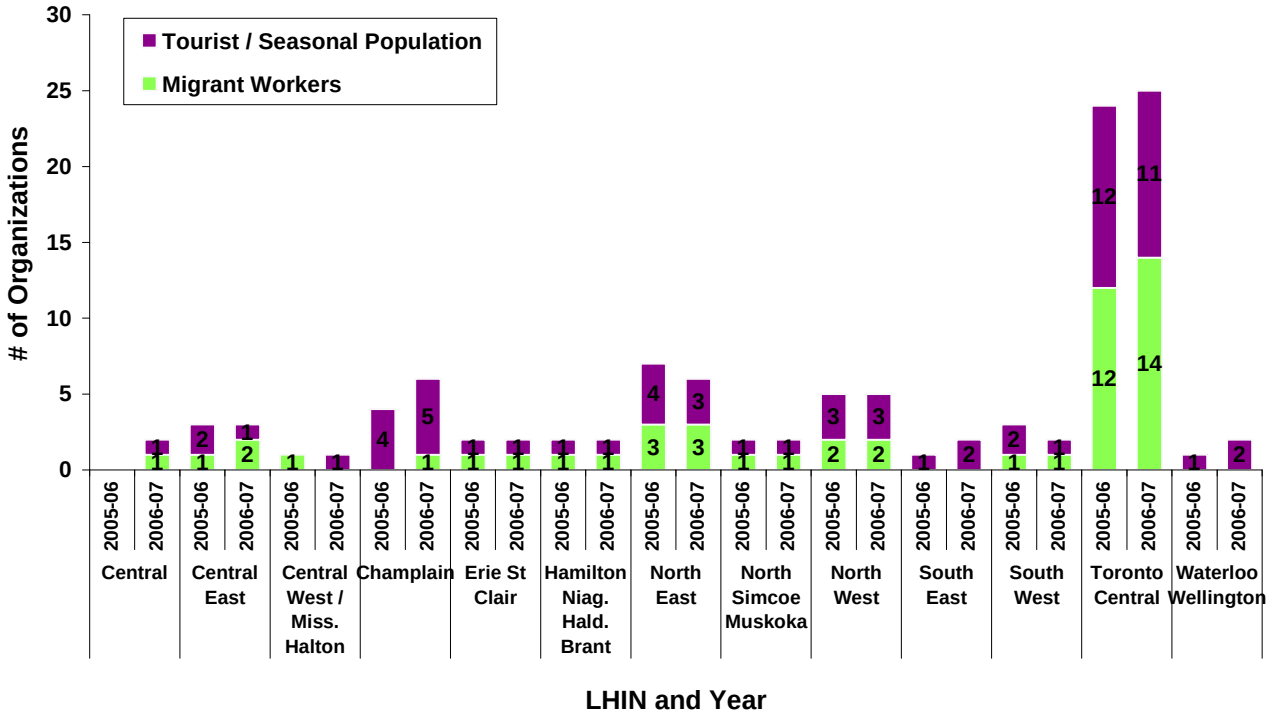
Figure 15: Number of Organizations per Population Size by Health Region



The number of organizations serving migratory and/or seasonal populations increased slightly in 2006-07

Because of where they are located in the province, some community-based organizations serve a population that will vary or shift over the year. In 2006-07, 27 agencies in 11 of the province's LHIN regions reported serving migrant populations (Figure 16) – up from 23 in 2005-06.

Figure 16: Organizations Serving Migrant or Tourist/Seasonal Populations by LHIN



Geographic areas with migrant populations face the challenge of continually reaching new people coming into the region with prevention information and support services. The only LHIN regions where agencies did not report serving migrant populations in 2006-07 were: Central West, South East and Waterloo Wellington.

Thirty-three agencies in 14 LHIN regions reported serving seasonal populations (Figure 16) – compared to 32 organizations in 13 LHIN regions in 2005-06. Organizations with seasonal populations will see surges in demand at certain times of the year, and may need different program and staffing strategies to meet client needs.

Social and economic characteristics of communities affect service needs

In addition to migrant and/or seasonal populations, agencies identified a number of other geographic/community factors that affect needs and services, including:

- large immigrant and highly diverse populations
- large refugee population
- economic issues, such as poverty, under-housing, unemployment and loss of population because of work and housing shortages
- proximity to a university or college
- proximity to correctional institutions
- the age and socioeconomic status of the population (e.g., young communities, baby-boomer communities, blue collar communities)
- rapid population growth.

7. Target Populations

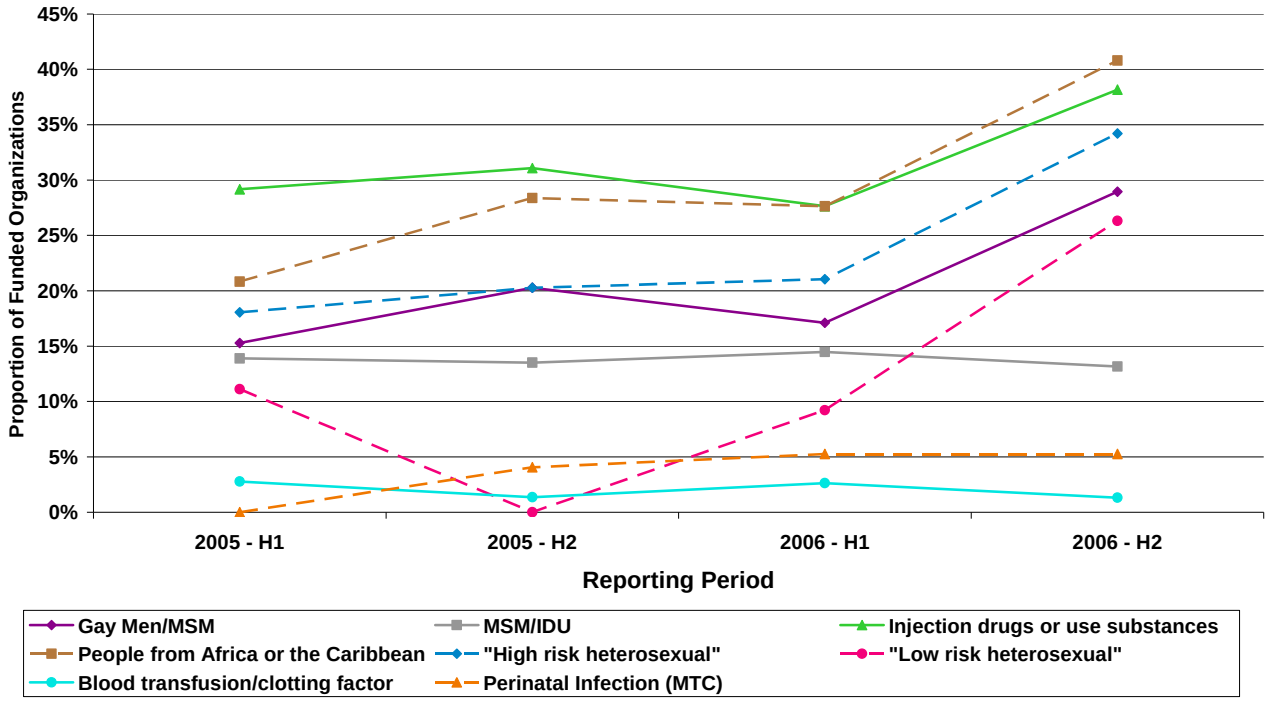
Over the past two reporting years, OCHART has asked funded organizations to identify the type of risks their target populations faced, based on the risk categories used in epidemiological data reports and on the HIV test requisition form.[1]

Organizations target primarily communities with the greatest risk

As Figure 17 illustrates, the largest number of agencies are targeting those communities with the greatest risk. In the second half of 2006-07, there was a marked increase in the proportion of organizations that reported targeting people from Africa and the Caribbean, people who use injection drugs, high risk heterosexuals, gay men and low risk heterosexuals. These trends are consistent with epidemiological data, which showed increased diagnoses in these populations in 2005-06.

A smaller number of organizations continue to report targeting people whose risk factor is blood transfusion or perinatal infection. These agencies include organizations, such as Hemophilia Ontario, whose role is to support people infected through the blood supply, as well as those with long-term clients who were infected through the blood supply. The approximately 20 agencies that report targeting perinatal infections includes the small number of agencies that serve families and children with HIV, as well as agencies working with women to avoid perinatal infections.

Figure 17: Organizations Self-Reporting an Increase in Risk Factors of Target Populations



[1] 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.

When asked about any changes in risk factors, agencies reported that they are seeing the following:

- drug users changing from injecting to smoking crack cocaine
- a marked increase in the use of crystal methamphetamine and crack cocaine
- a larger number of men who have sex with men who report high risk behaviours, such as unprotected anal sex.

In terms of the populations they are seeing, agencies reported:

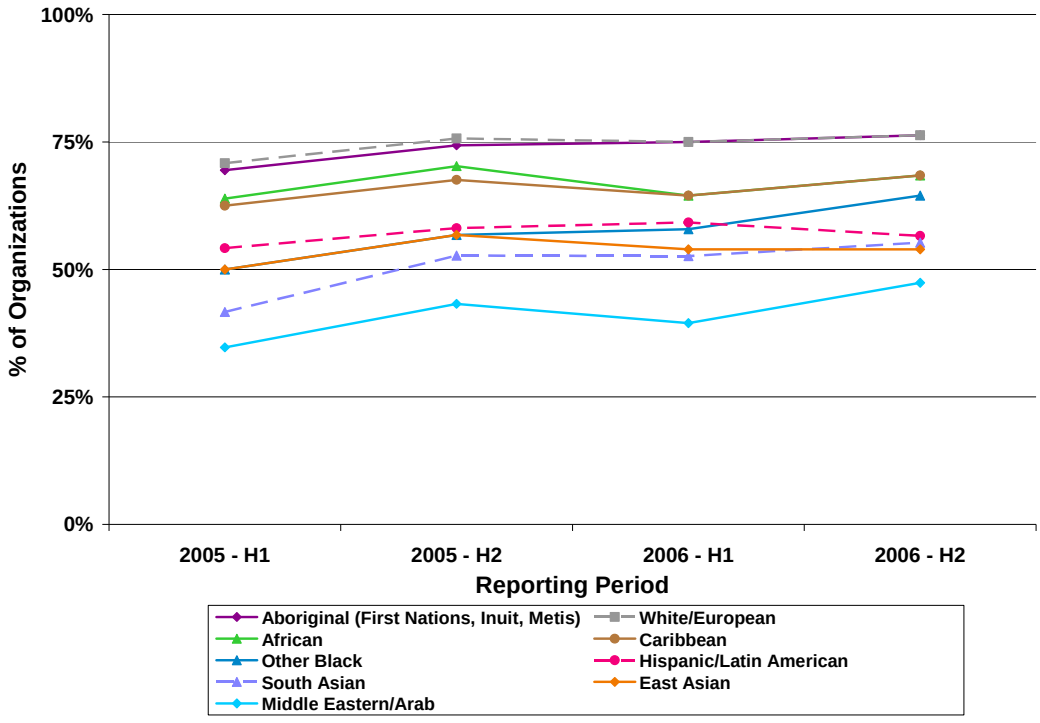
- more women, including young women
- more clients from African and Caribbean communities – due in part to people who attended the International AIDS Conference in 2006 and remained in Canada
- more requests for information about anonymous testing from the African and Caribbean communities
- more trans youth and other two spirit youth coming out in the Thunder Bay region
- more pregnant women who are substance users
- a substantial increase in Aboriginal women seeking services
- more gay service users.

More organizations are able to serve culturally diverse clients

OCHART asks organizations to indicate the race/ethnicity of the people they serve based on the ethnic categories established by Statistics Canada.

Community-based organizations are serving culturally diverse populations (see Figure 18). Over the past two years, there has been an increase in the number of organizations serving all ethnic groups.

Figure 18: Race/Ethnicity of Populations Served over Time

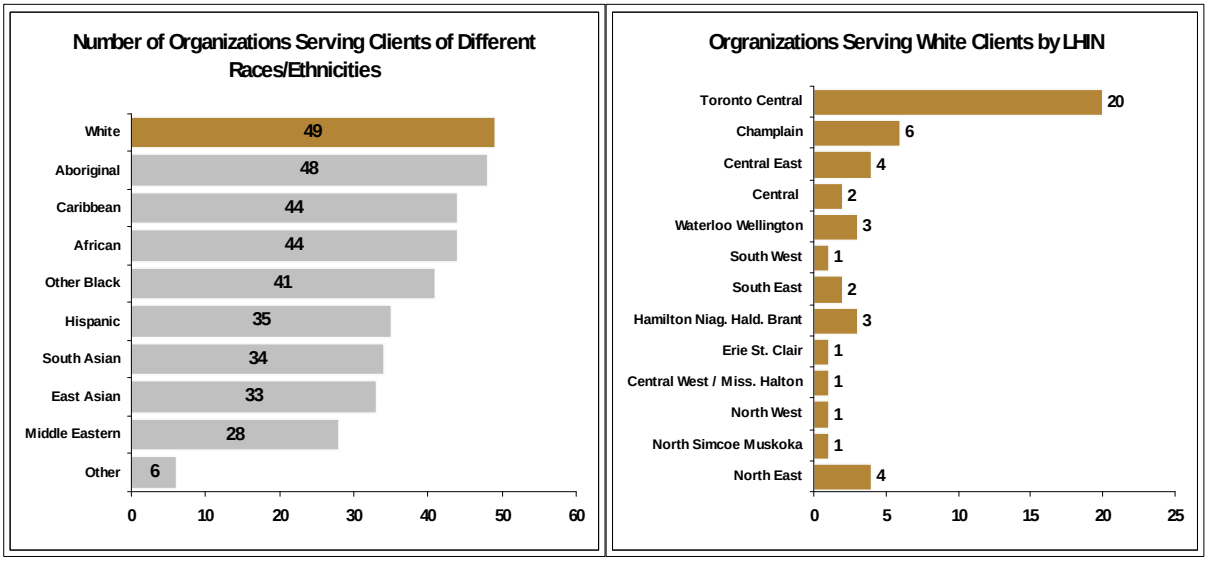


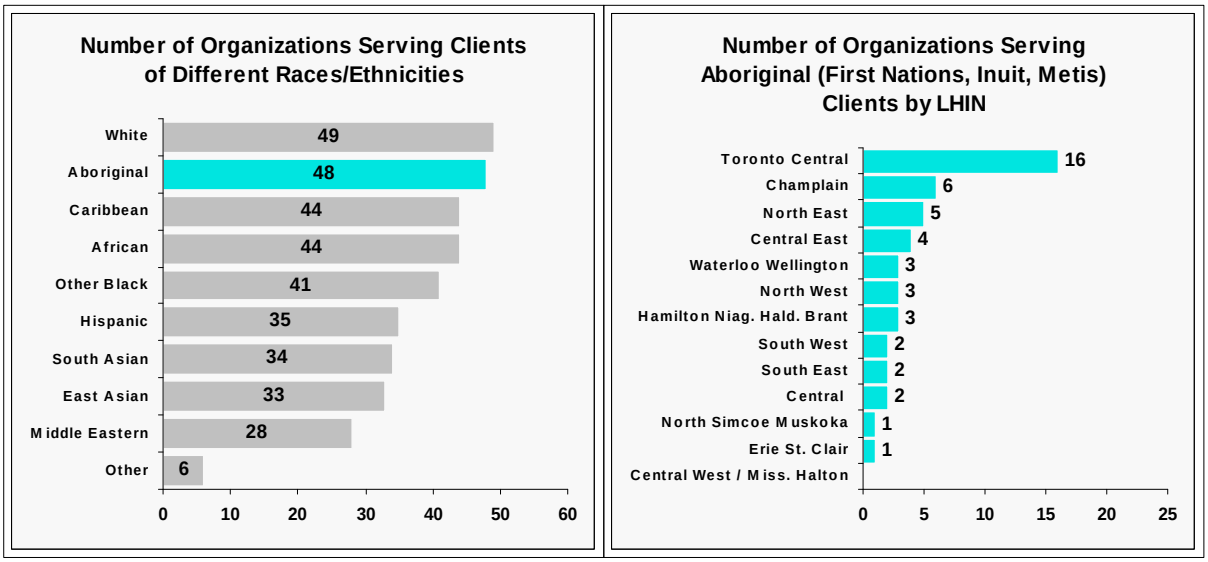
The most dramatic increase has been in the proportion of organizations reporting serving clients from Middle Eastern/Arab (+17%), South Asian (+15%), and other Black (+13%) communities. The largest proportion (75%) of organizations serve White/European and Aboriginal clients.

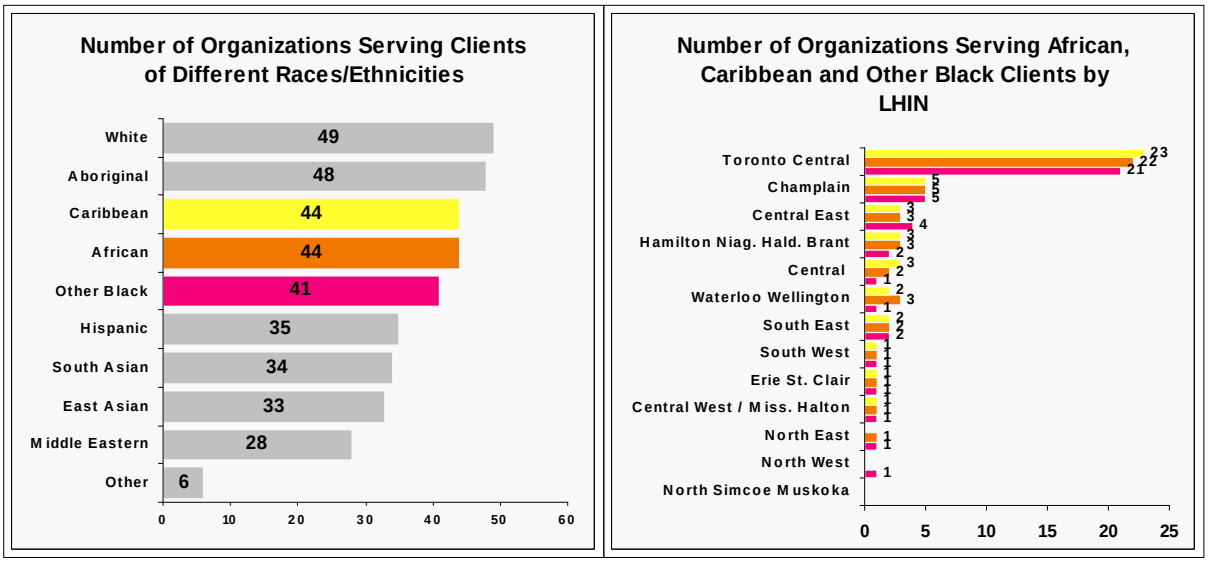
Culturally diverse clients can find services in almost all parts of the province

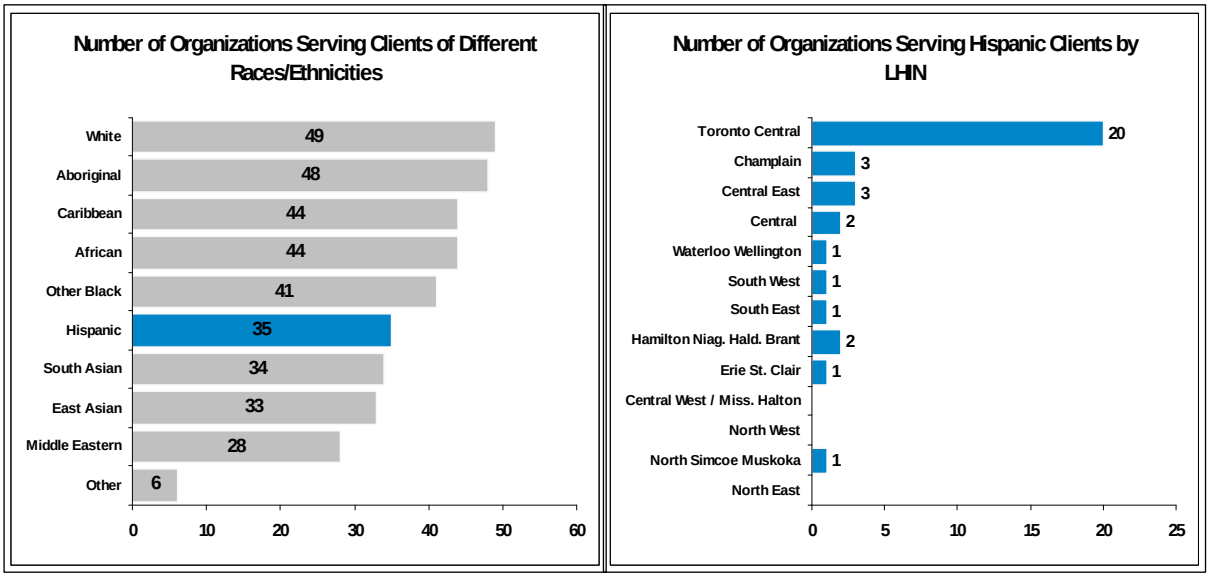
The following series of figures (Figure 19) show the number of organizations in each LHIN region that report serving clients from different ethnoracial communities. In each case, the chart on the left highlights particular ethnocultural cultural groups, and the chart on the right indicates how many organizations in each LHIN region report serving those cultural groups.

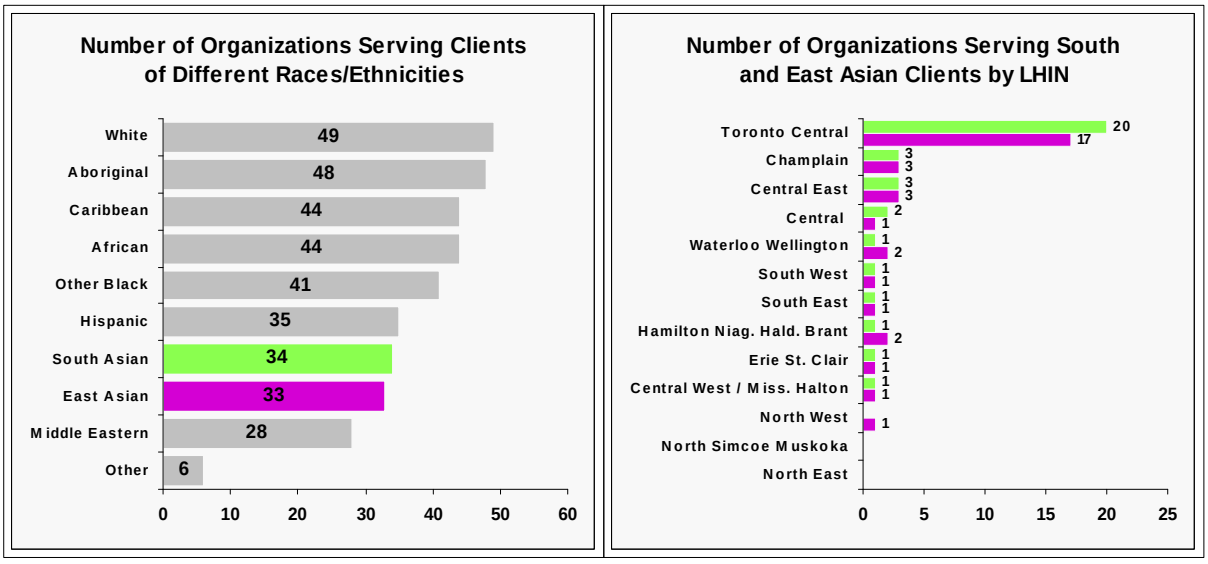
Figure 19: Organizations Serving Clients of Different Races/Ethnicities (n=65)

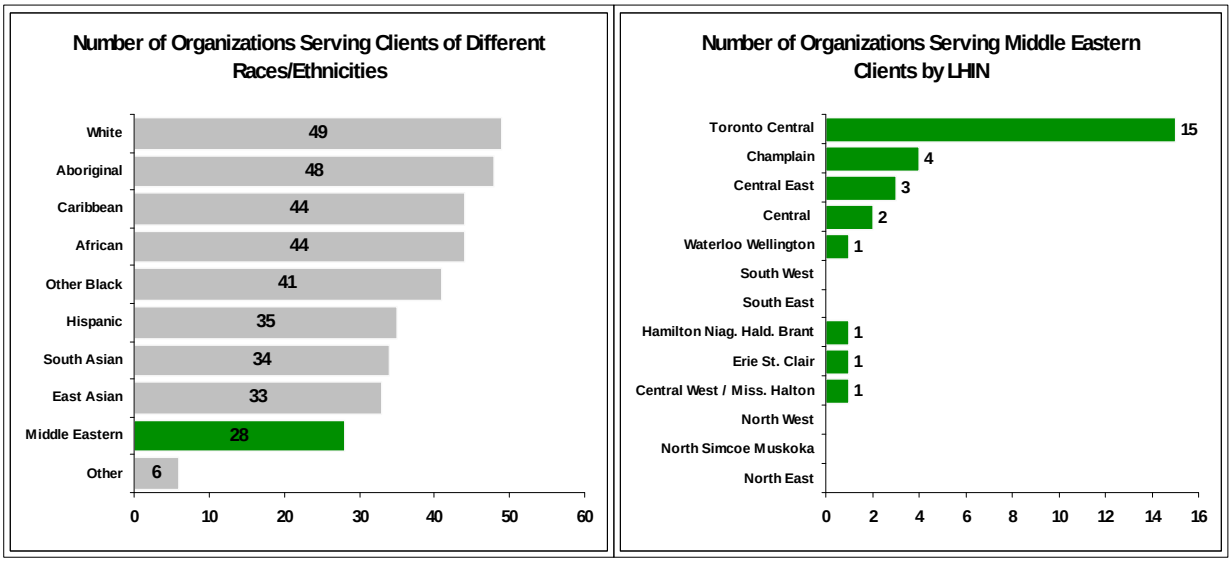





Number of Organizations Serving Clients of Different Races/Ethnicities
White 49
Aboriginal 48
Caribbean 44
African 44
Other Black 41
Hispanic 35
South Asian 34
East Asian 33
Middle Eastern 28
Other 6
0 10 20 30 40 50 60
Number of Organizations Serving African, Caribbean and Other Black Clients by LHIN
Toronto Central 23 22 21
Champlain 5 5 5
Central East 3 3 4
Hamilton Niag. Hald. Brant 3 2
Central 3 2 1
Waterloo Wellington 2 3 1
South East 2 2 2
South West 1 1 1
Erie St. Clair 1 1 1
Central West / Miss. Halton 1 1 1
North East 1 1
North West 1
North Simcoe Muskoka
0 5 10 15 20 25


Number of Organizations Serving Clients of Different Races/Ethnicities
White 49
Aboriginal 48
Caribbean 44
African 44
Other Black 41
Hispanic 35
South Asian 34
East Asian 33
Middle Eastern 28
Other 6
0 10 20 30 40 50 60
Number of Organizations Serving Hispanic Clients by LHIN
Toronto Central 20
Champlain 3
Central East 3
Central 2
Waterloo Wellington 1
South West 1
South East 1
Hamilton Niag. Hald. Brant 2
Erie St. Clair 1
Central West / Miss. Halton
North West
North Simcoe Muskoka 1
North East
0 5 10 15 20 25


Number of Organizations Serving Clients of Different Races/Ethnicities
White 49
Aboriginal 48
Caribbean 44
African 44
Other Black 41
Hispanic 35
South Asian 34
East Asian 33
Middle Eastern 28
Other 6
0 10 20 30 40 50 60
Number of Organizations Serving South and East Asian Clients by LHIN
Toronto Central 20 17
Champlain 3 3
Central East 3 3
Central 2 1
Waterloo Wellington 1 2
South West 1 1
South East 1 1
Hamilton Niag. Hald. Brant 1 2
Erie St. Clair 1 1
Central West / Miss. Halton 1 1
North West 1
North Simcoe Muskoka
North East
0 5 10 15 20 25



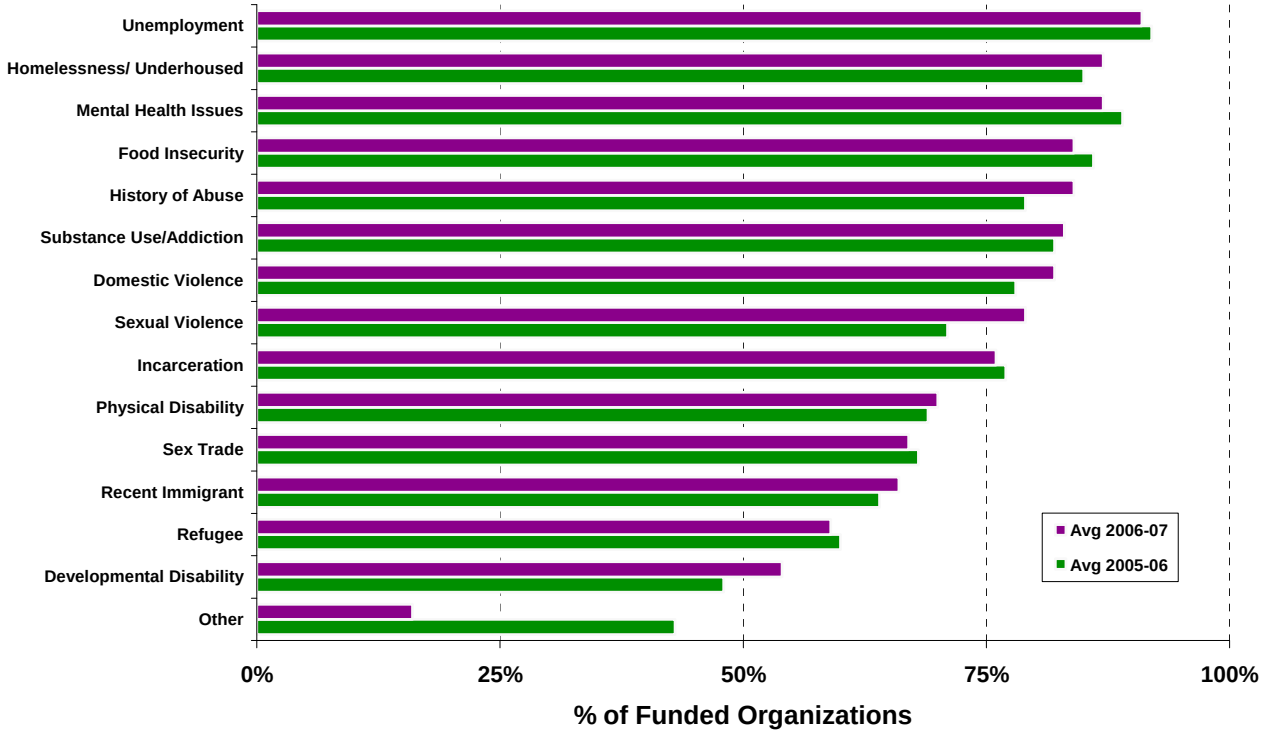
Central West/Mississauga Halton is the only LHIN region that did not report serving Aboriginal clients. Two LHIN regions – North East and North Simcoe, Muskoka – did not report serving Asian clients, and three LHIN regions – North East, North West and Simcoe Muskoka – did not report serving African, Caribbean and/or Black clients in 2006-07. Fewer LHIN regions report serving Hispanic or Middle Eastern clients.

More clients face issues of domestic violence, sexual violence, abuse and disability

OCHART also asks organizations to identify the health and social issues that their clients/target populations faced during the reporting period. The health and social factors mentioned by the greatest number of organizations in 2006-07 (see Figure 20) continued to be unemployment (95%), homelessness (90%) mental health issues (91%), food insecurity (88%), and incarceration (78%). In addition, a larger number of organizations reported clients dealing with issues of abuse (88%), domestic violence (85%) and sexual violence (83%). This increase is likely due to the larger number of women seeking HIV services.

More agencies (56%) report serving clients who have developmental disabilities, which may be related to changes in the social service system, including the closing of residential programs. A number of community plans talked about the challenges of serving this population and the need to develop different skills, supports and resources.

Figure 20: Organizations Self-Reporting Health and Social Factors of Clients



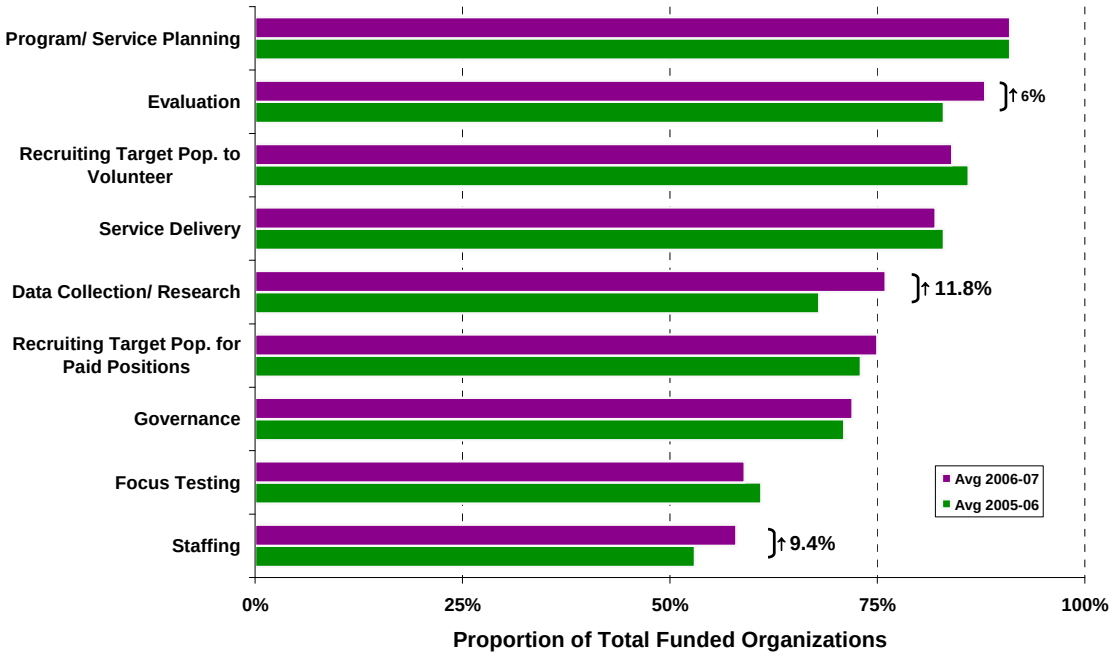
The complex issues that clients face reinforce the importance of comprehensive programs and services that meet people's health, psychosocial, social and economic needs, and the need to address the social determinants of health.

More organizations are employing clients and involving them in data collection and evaluation

One of the goals of the provincial, federal and the pan-Canadian strategies is greater involvement of people living with HIV/AIDS (GIPA) and populations at risk in their services. Figure 21 compares how organizations involved members of their target populations in 2005-06 and 2006-07. It is encouraging to see an increase in the number of organizations who are employing and recruiting people living with HIV/AIDS or people at risk, and who are involving them in meaningful activities such as data collection/research, evaluation and the governance of their organizations. These initiatives are particularly important given the earlier data, which indicated that unemployment is the most pervasive social problem facing clients.

Organizations also continue to involve members of their target populations as volunteers and in service delivery.

Figure 21: Organizations Reporting Involvement of Target Populations in Organizational Activities



In addition to the categories listed in Figure 21, organizations reported that members of their target populations were involved in:

- delivering outreach programs
- distributing education and harm reduction materials
- strategic planning
- participating in videos to share their life experiences
- participating in art projects.

8. Partnerships

Community-based HIV/AIDS organizations are expected to develop and maintain partnerships with other organizations in order to provide enhanced, coordinated services for people living with HIV and populations at risk.

Organizations are sharing resources to achieve common goals

Figure 22 is a comparison of the number and type of partnerships between and among HIV/AIDS organizations by region in 2005-06 and 2006-07. In all regions except Southwest, there was an increase in the number of partnerships with other HIV organizations or programs.

In most regions, there was also an increase in the number of collaborative partnerships, which indicates that organizations are finding more effective ways to work together.

OCHART defines three types of partnerships:

- Consultative – Organizations share information. Activities include providing information, resources, referrals or skills development.
- Operational – Organizations share work as well as financial and other support, and work together to achieve common goals and objectives. Activities include sharing meeting space, joint fundraising events, and joint management of support groups
- Collaborative – Organizations share decision making. Partners develop consensus and share responsibility for outcomes.

Figure 22: AIDS Service Organizations: Partnerships by Region

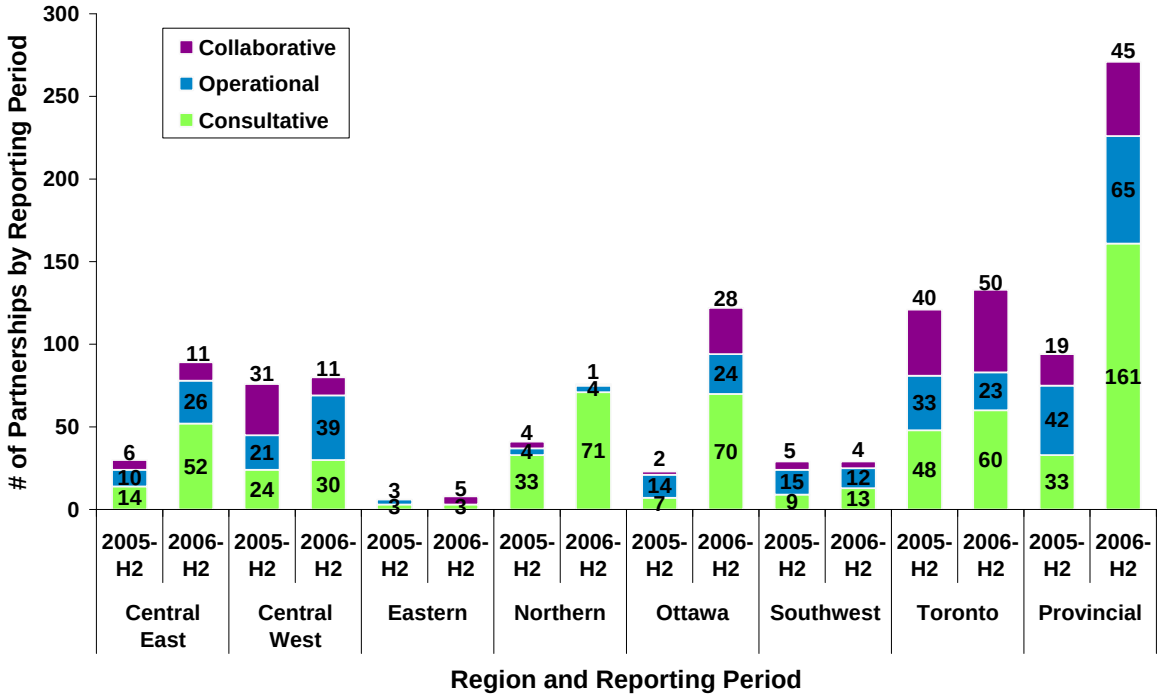
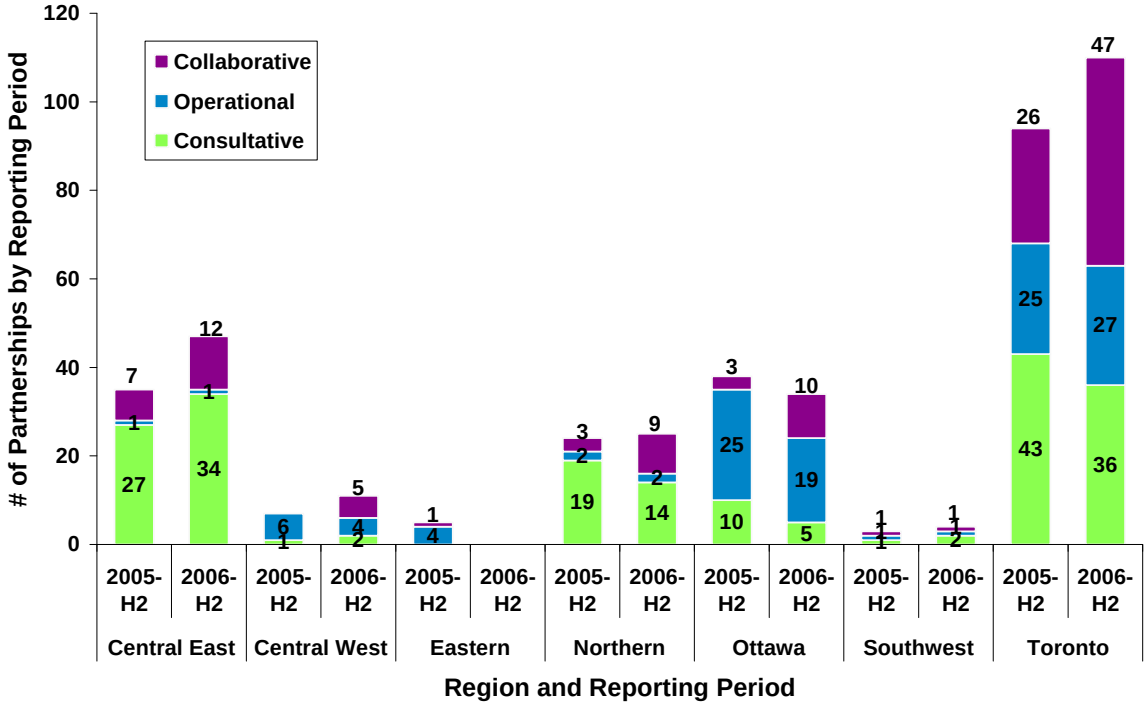


Figure 23 is a comparison of the number and type of partnerships between HIV/AIDS organizations/programs and non-HIV specific organizations (e.g., mental health providers, housing providers) by region in 2005-06 and 2006-07. Five of seven regions reported an increase in the number of partnerships and, in general, there has been an increase in collaborative partnerships with these other sectors.

Figure 23: Non-AIDS Service Organizations: Partnerships by Region



ACAP supports the establishment and maintenance of partnerships through all its funded projects and programs under the funding approach Creating Supportive Environments. It is a requirement of funding that organizations establish relevant and meaningful partnerships in order to share expertise, maximize resources, and ensure sustainability of the work. During 2006-07, ACAP projects and programs reported either new or stronger partnerships with other sectors including mental health, settlement/immigration, media, faith, and other health sector agencies, as well as with other ASOs.

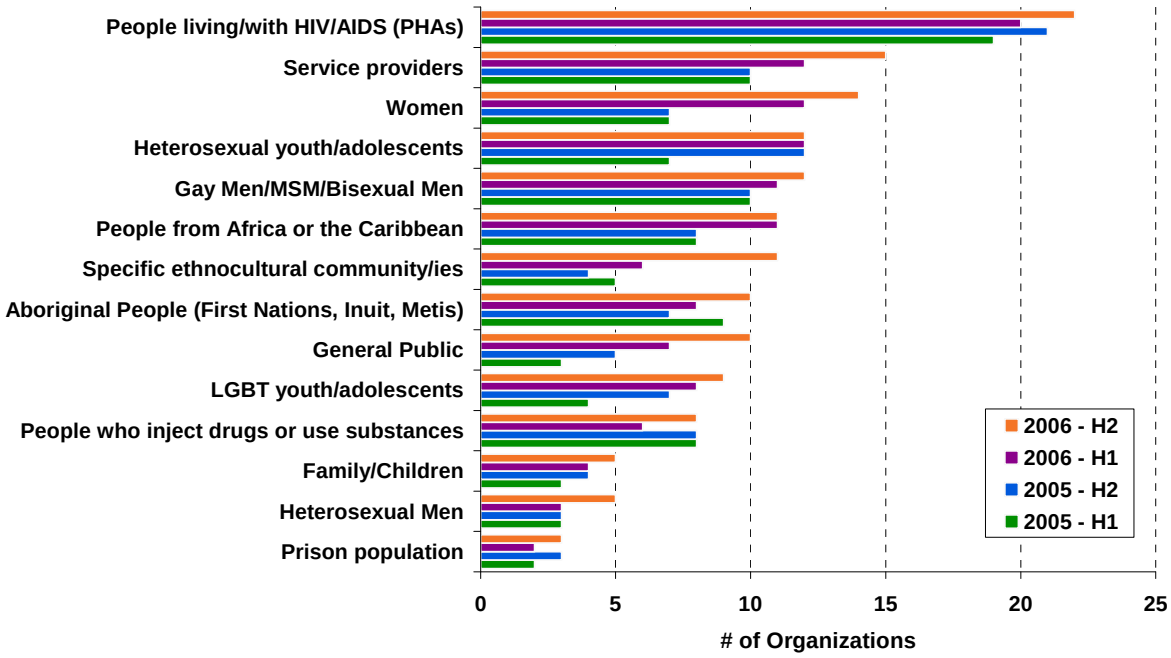
9. Education and Community Development

During the second half of 2006-07, 64 organizations were funded by the AIDS Bureau and/or PHAC to provide education and community development services – up from 60 in the first half of the year: 25 were funded by the AIDS Bureau only, 5 by PHAC only and 34 by both the AIDS Bureau and PHAC.

Education programs target a range of populations

OCHART asks organizations to rank the populations they target in order of priority (see Figure 24). The purpose of this question is to see whether all populations at risk within a given geographical area are being targeted by services. Every population is identified as a #1 priority for at least one organization.

Figure 24: Organizations Identifying Specific Populations as Priority #1 for Education and Community Development



Because there are no rules or restrictions on how organizations answer this question, some rank populations from 1 to 10; others identify a number of different populations as their number 1 priority. This makes it difficult to analyze or display the data. In general, more agencies reported a wider range of priority populations in 2006-07 than in the previous year. The target populations that agencies report tend to reflect the make up of the population in each region. For example, agencies in the north do not tend to target African and Caribbean or other specific ethnocultural communities because their population is less culturally diverse than centres in the south; however, they are more likely to target Aboriginal people.

More focus on women and youth

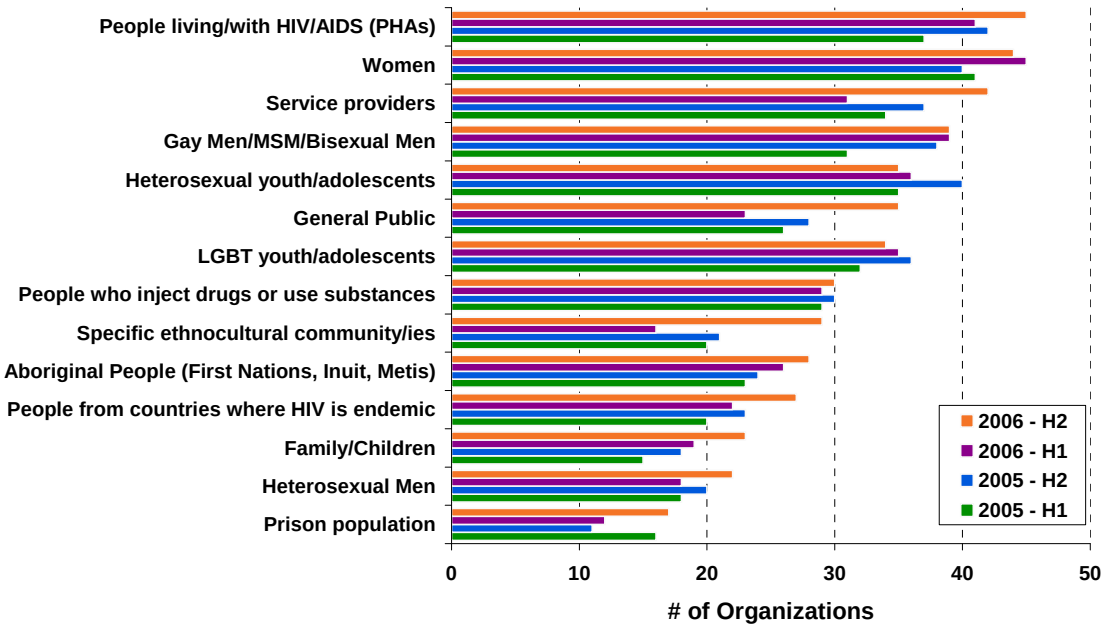
In terms of changes in target populations over time, in 2006-07 there was an increase in the number of organizations that identified women as their #1 priority for education (Figure 25). This is consistent with the increasing number of diagnoses in women.

There was also an increase in the number of organizations identifying LGBT youth as their #1 priority for education. This is consistent with concern that young gay men are at increasing risk, and with the goal of supporting and destigmatizing marginalized groups.

More organizations report targeting Aboriginal people and families for education

There was also an increase in the number of organizations reporting that Aboriginal people are now one of their top priorities – particularly in the Toronto, Northern, and Eastern regions. The number of Toronto organizations targeting Aboriginal people more than doubled in one year.

Figure 25: Organizations Selecting Specific Populations as Priority #1 to #6 for Education and Community Development

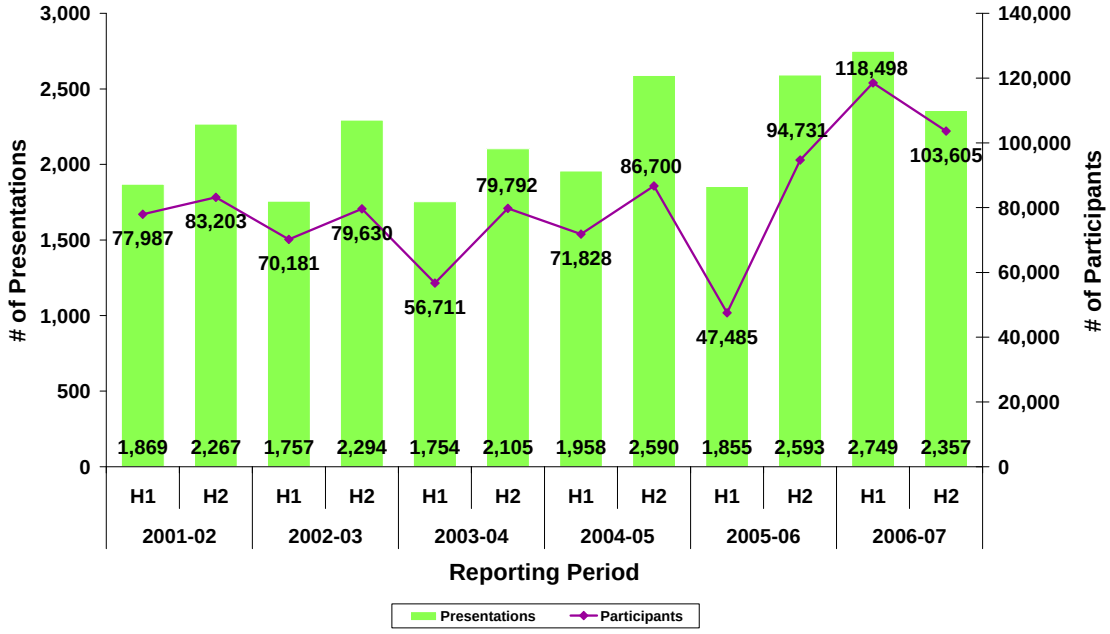


There was also an increase in the number of organizations targeting education programs to families and children – particularly in Toronto, Central West and provincially. This is likely related to the increase in diagnoses in women.

15% increase in education presentations in 2006-07

Organizations gave a total of 5,106 education presentations to 222,103 participants in 2006-07 (Figure 26): an increase of 15% in the number of presentations and 56% in the number of people reached compared to 2005-06. It is possible that some of this increase was due to the International AIDS Conference held in Toronto in 2006.

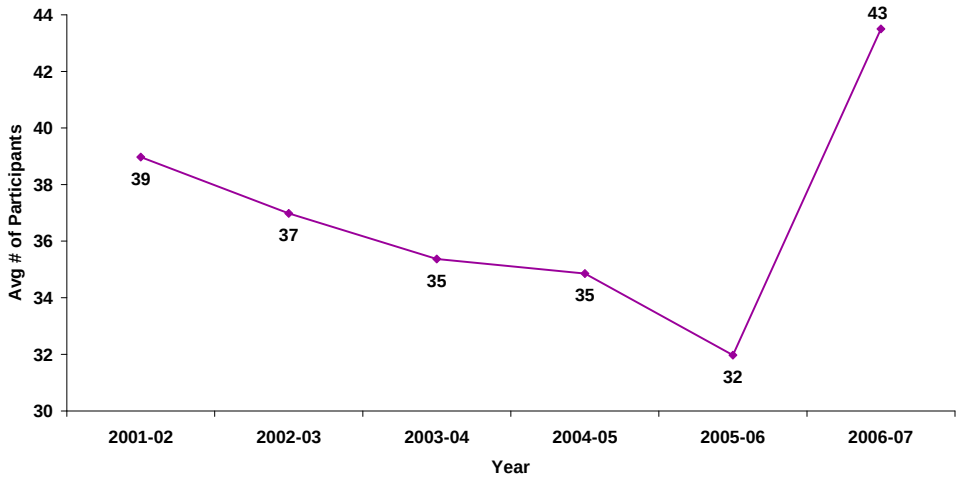
Figure 26: Number of Education Presentations and Participants by Reporting Period



As Figure 27 illustrates, the average number of participants per presentation increased significantly in 2006-07 – possibly due to the International AIDS Conference. This illustrates the impact that high profile events, like the conference, can have on public and media interest.

The steady decline in average number of participants per presentation between 2001-02 and 2005-06 may be a symptom of changing public attitudes towards AIDS (i.e., "AIDS is no longer a problem", "we already know about AIDS") or it may reflect Ontario's more targeted approach

Figure 27: Average[1] Number of Participants per Education Presentation 2001-2007



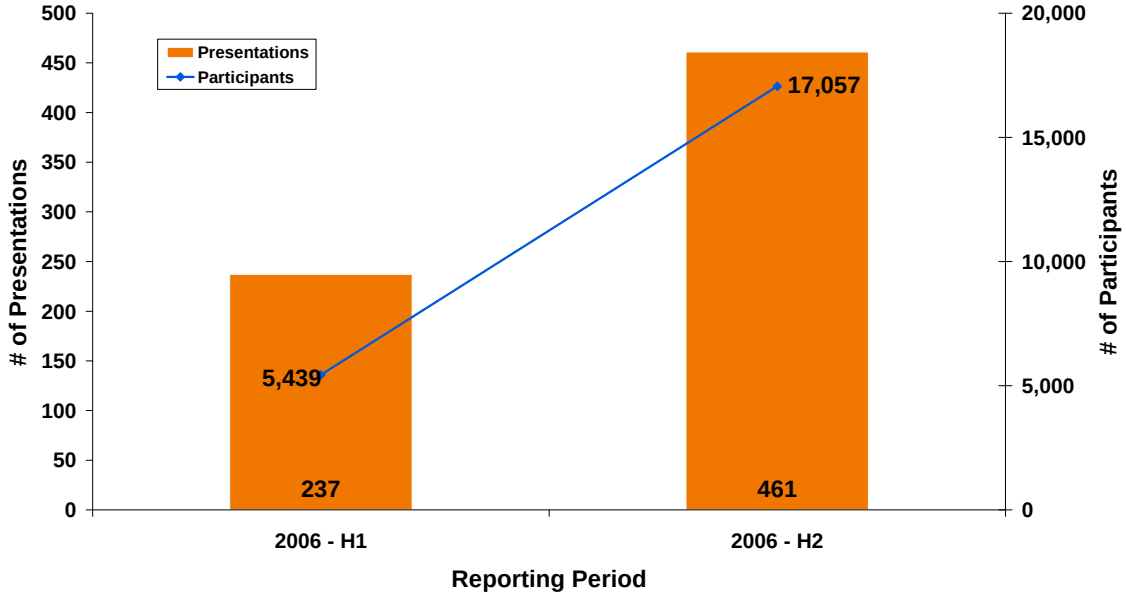
[1] Averages were calculted by dividng the total number of participants (H1+H2) by the number of presentations.

to HIV prevention and a focus on delivering messages to smaller groups.

ACAP-funded organizations responsible for 14% of presentations

The 39 agencies funded by ACAP to provide education and workshops gave a total of 698 presentations in 2006-07, which involved a total of 22,496 participants (see Figure 28). This represents about 14% of all presentations and 10% of participants in 2006-07. The average number of participants per ACAP-funded presentation was 32.

Figure 28: Total Number of ACAP Funded Education Presentations and Participants



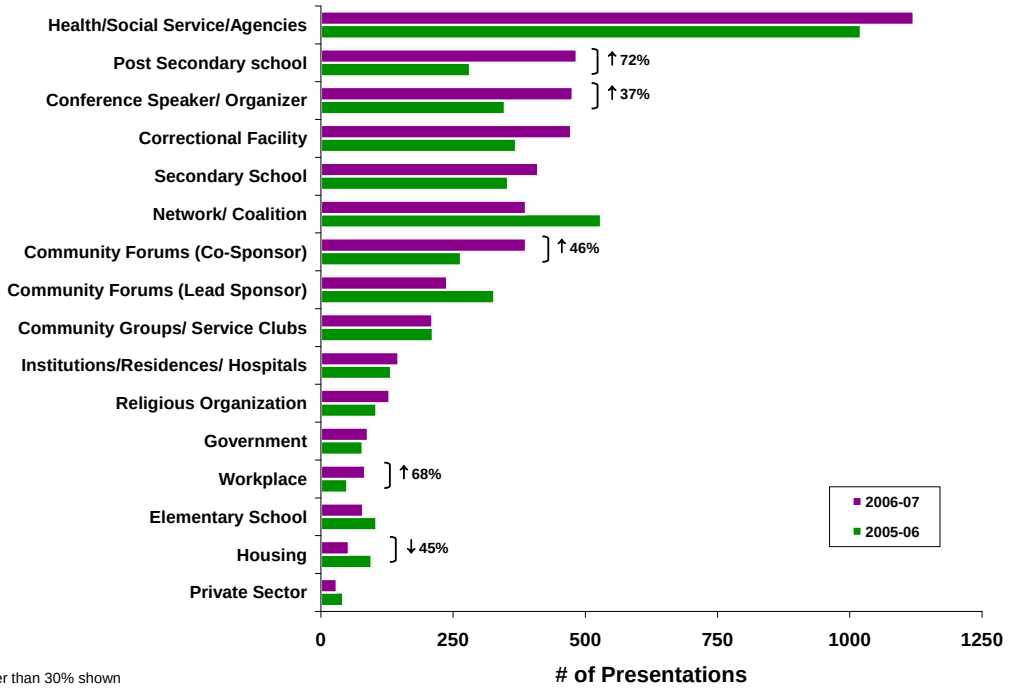
More presentations to health and social services agencies, secondary and postsecondary schools, conferences and correctional facilities

As Figure 29 shows, HIV/AIDS programs gave more presentations to health and social service agencies, correctional facilities, secondary and postsecondary schools, and conferences than in the previous year.

It is interesting to note the increase in the number of community forums where AIDS organizations were co-sponsors and the decrease in those where they were the lead sponsor. This may reflect a maturing of partnerships with other organizations in their communities and more focus on coordinating/integrating services.

The increase in presentations in correctional facilities and secondary and postsecondary schools indicates that organizations are making a concerted effort to reach populations at risk and youth.

Figure 29: Education Presentations by Location

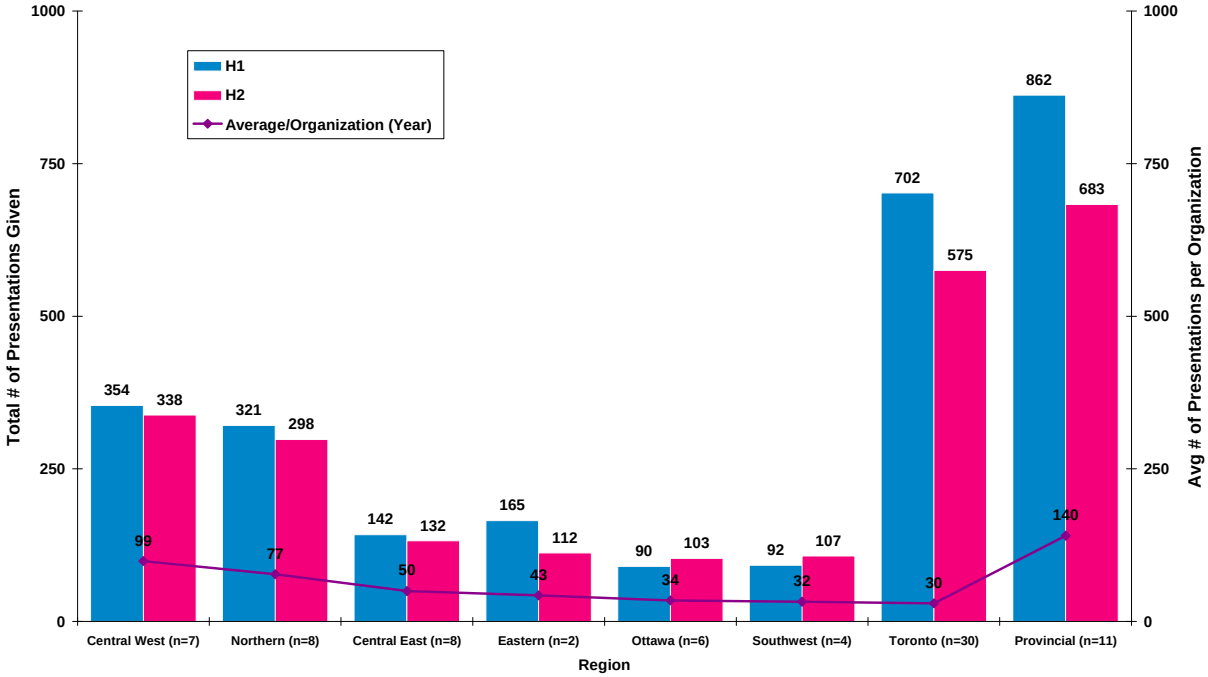


Note: Changes greater than 30% shown

Organizations in Central West and Northern regions give more presentations

Figure 30 shows the number of education presentations given by region in 2006-07 and the average number of presentations per organization in each region. Although organizations in

Figure 30: Total and Average[1] Number of Presentations by Region for 2006-07



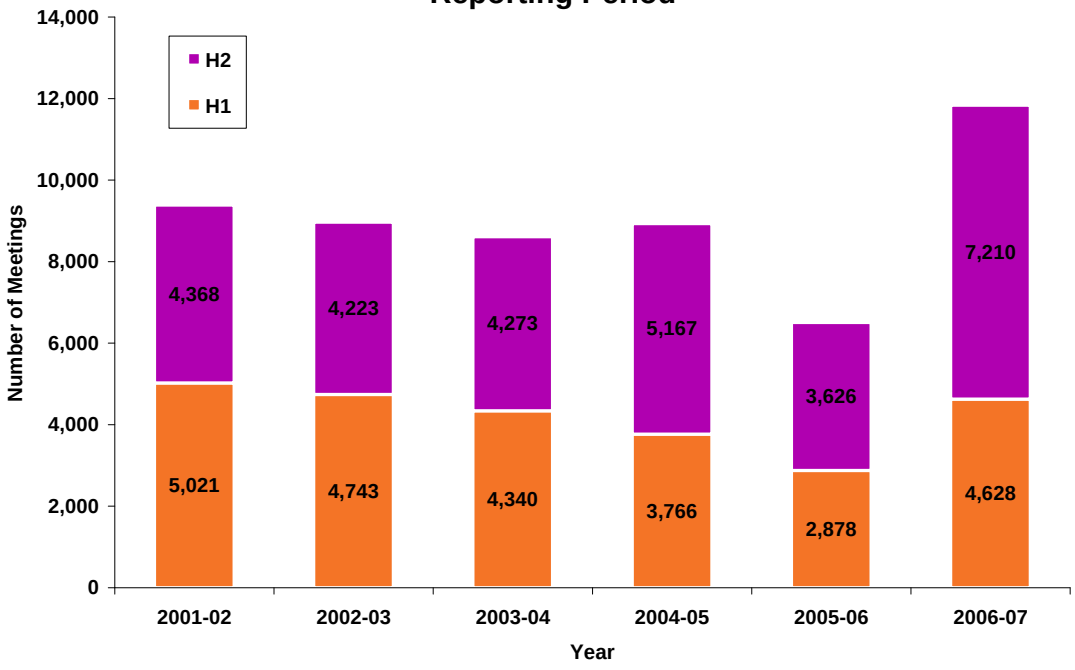
[1] The average number of presentations made was calculated by dividing the total number of presentations for the fiscal year by the number of organizations that reported making presentations.

Toronto give more presentations overall, organizations in all other regions give more presentations per organization. Organizations in Toronto give, on average, just under three presentations per month, while organizations in other regions give between three and eight per month. The highest rates of presentations per organization are in Central West and Northern regions.

More community development meetings

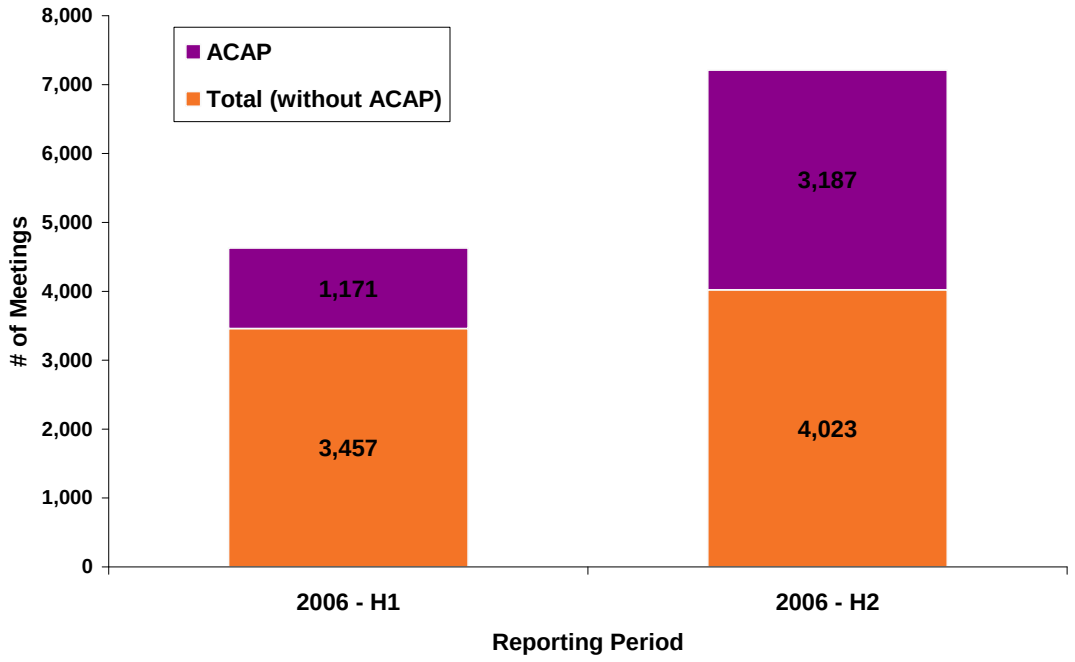
Organizations held or participated in 82% more community development meetings in 2006-07 than in the previous year (see Figure 31). Most meetings were held in the second half of the year so this trend cannot be attributed to the International AIDS Conference. However, some meetings that occurred in the fall (H2) may be the result of AIDS 2006, such as community development meetings to coordinate services for people with HIV who came to the conference and decided to stay in Canada and meetings held to disseminate information from the conference.

Figure 31: Community Development Meetings Held by Reporting Period



In 2006-07, organizations used ACAP funding to support a total of 4,358 – or 37% – of the community development meetings held during the year (Figure 32). This work aligns with the ACAP Funding Approach, Creating Supportive Environments.

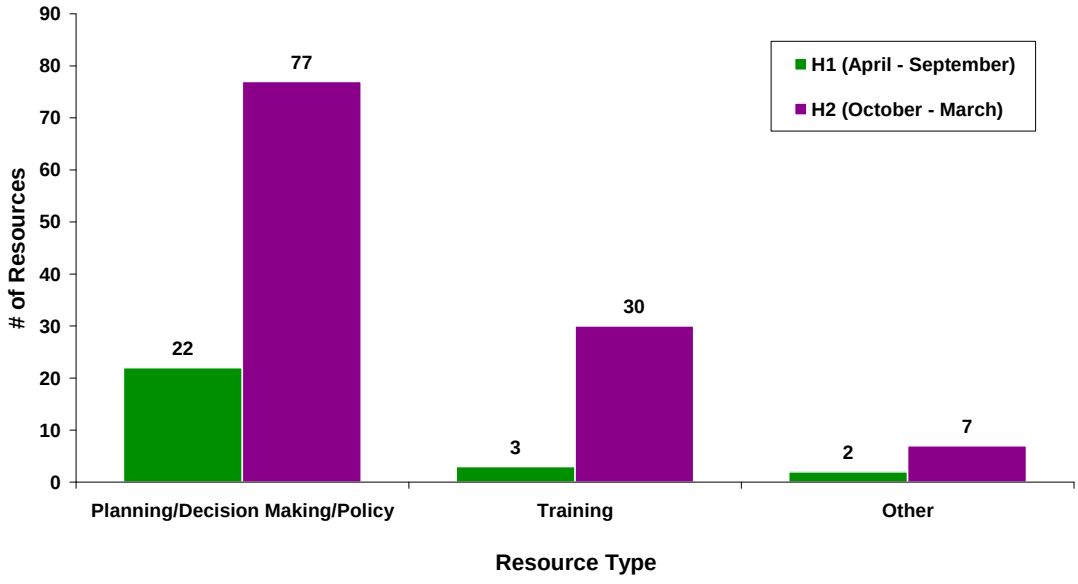
Figure 32: Community Development Meetings: Total showing ACAP Funded



ACAP-funded organizations develop planning and training resources

Organizations funded by ACAP are asked to report on the number of resources they develop to support community development activities (Figure 33). In 2006-07, the organizations developed 99 planning/decision making/policy resources and 33 training resources. A list of ACAP funded

Figure 33: Number of Resources Developed by Type of Resource and Reporting Period - 2006-07

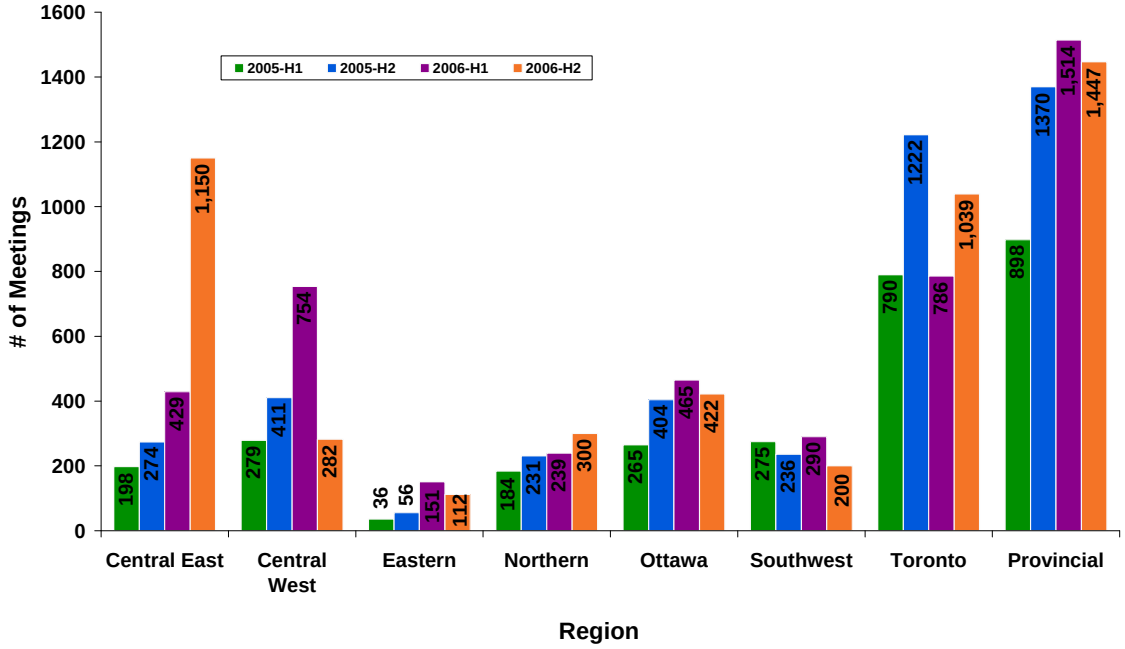


Operational Programs and Time-Limited Projects is provided at the end of this document. For detailed descriptions including resources produced, please go to:

http://www.phac-aspc.gc.ca/aids-sida/about/reg_ontario_e.html

The following figures provides a regional analysis of community development meetings, showing the number held in each region in each reporting period (Figure 34), and the average number of community development meetings per organization in each region (Figure 35).

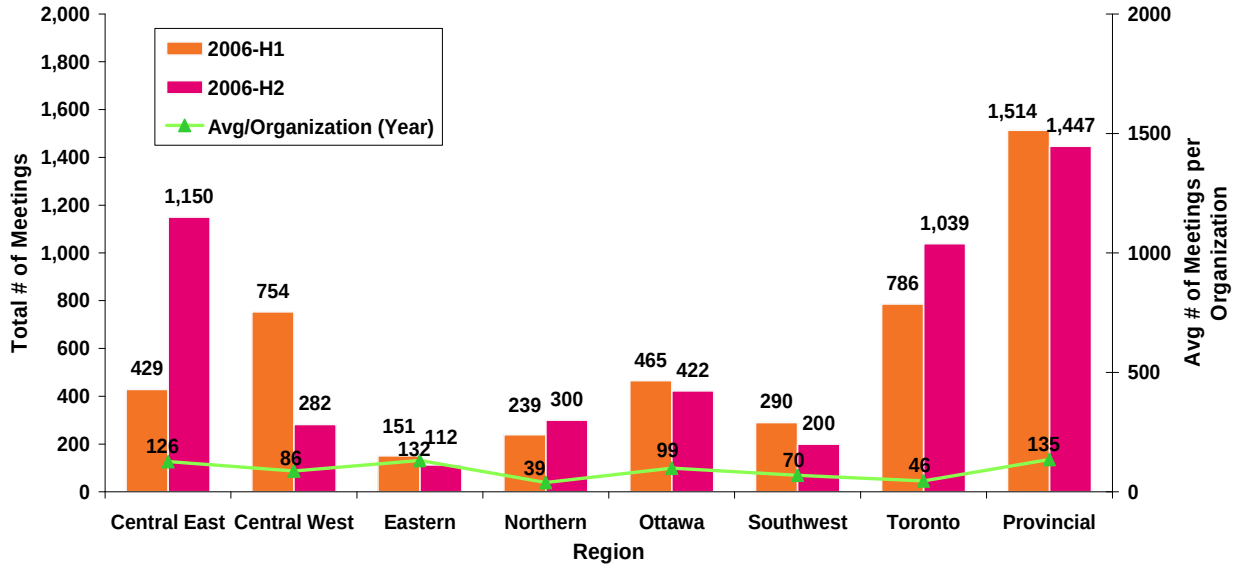
Figure 34: Community Development Meetings by Region



The most marked increases in the number of community development meetings in 2006-07 occurred in Central East, Central West, Northern and Ottawa regions.

In terms of number of community development meetings per organization, they range from 39 – or just over 3 per month – in Northern region to 132 per organization – or 11 per month – in Eastern region.

Figure 35: Total and Average[1] Number of Community Development Meetings by Region for 2006-07

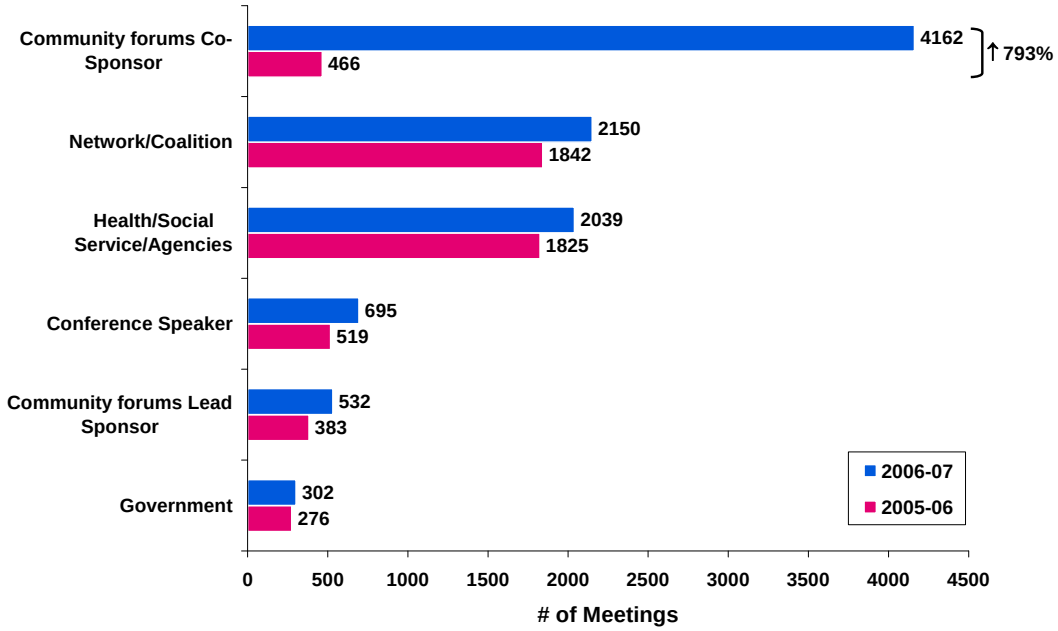


1 - Avg calculated by adding H1 and H2 for each Region and dividing by # of Organizations in that Region.

More meetings with workplaces, schools and religious organizations

During 2006-07, there was an increase in community development meetings in all locations, but the most significant increase (793%) was in the number of community forums co-sponsored by the funded organizations (Figure 36) – which was equal to about 55 meetings per funded

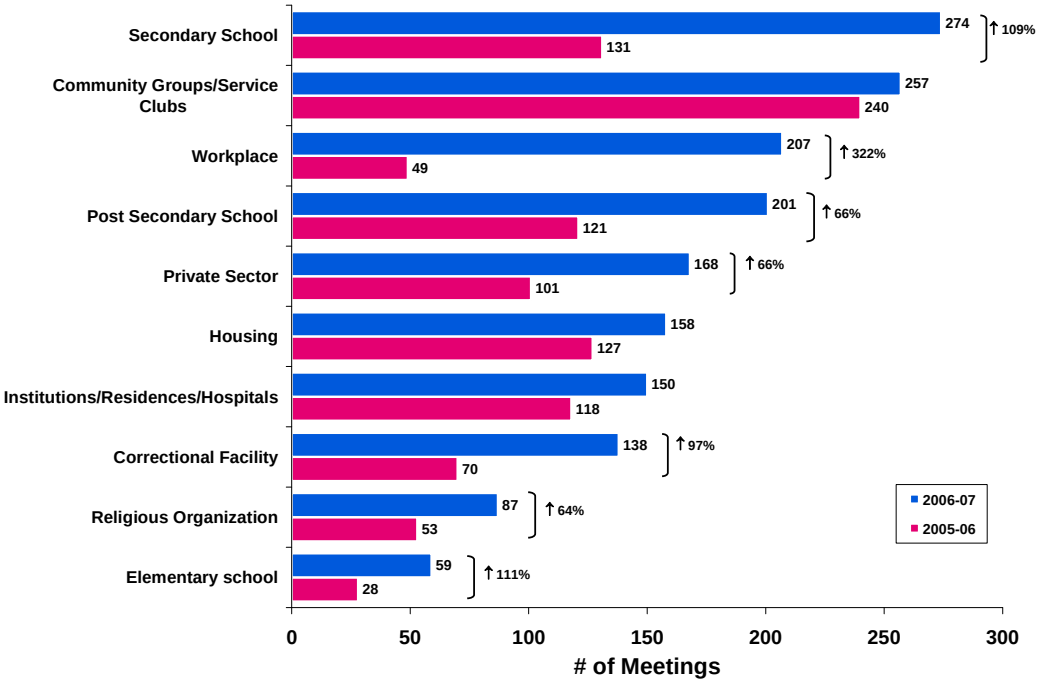
Figure 36: Community Development Meeting Locations (>300)



organization. This increase is probably related to AIDS 2006.

There was also an increase in meetings organized with workplaces, schools, and religious organizations (Figure 37). This trend is encouraging because there had been a drop in meetings with these groups in previous years. It also indicates that organizations are trying to address employment, stigma and social support issues, and are targeting youth.

Figure 37: Community Development Meeting Locations (<300)



Emerging Trends in Education and Community Development

Organizations reported shifts in the groups requesting education as well as in their education and community development needs.

Shifts in groups

During 2006-07, agencies reported receiving more requests for or interest in HIV education from:

- faith-based organizations
- schools – including student counsellors at universities and students working on assignments
- group homes and youth detention centres
- health care and other service providers, particularly those serving positive clients in the African and Caribbean communities, emergency services, and home care nurses and personal support workers
- younger adults and youth at risk
- teenagers who have lived with HIV since birth
- people in prison
- specific ethnocultural communities, including Aboriginal and Inuit communities and Korean students
- women in general, young women, and women from specific ethnocultural communities including South Asian, African Diaspora, and Muslim communities.

Shifts in education/community development needs

Organizations noted an increased interest in or demand for education about:

- immigration and settlement issues
- culturally competent services
- legal issues related to prostitution and safer sex work
- privacy and disclosure
- training and support on prison issues
- HIV and aging
- interpretation services to assist physicians specializing in HIV care.

They also reported requests for:

- advice for social service agencies and teachers on addressing and raising awareness of LGBTQ youth situations and issues
- e-learning and informal learning sessions
- information on specific programs and projects, such as body-mapping, the theory of AIDS-related multiple loss, developing safety plans when leaving a volatile relationship, the social service system, mental health issues, and rapid point-of-care HIV testing and HIV testing in general
- workshops/training on how to: manage the doctor-patient relationship, understand research, manage HIV, manage destructive coping mechanisms, change management and train-the-trainer programs
- education for parents about sexual health and sexual hygiene workshops for youth
- PHA speakers
- community-based research into gay men's prevention
- other social services, such as supportive housing for people with mental health issues, increased demand for supportive housing where the HIV positive individual is struggling with mental health issues.

Responding to Emerging Trends

To respond to emerging education and community development needs, organizations report that they are creating new partnerships or strengthening existing ones, referring clients to the most appropriate service to meet their needs.

A number of organizations are also hiring more staff to meet specific needs, training staff in other skills (e.g., cultural competency) and developing more capacity by using volunteers and students. Some have brought in speakers (volunteer and paid), developed workshops, increased the number of presentations, refocused existing services or workshops to target specific populations, increased their participation in working groups, extended their outreach to new locations, and created advisory committees for new initiatives.

Other strategies include:

- developing an LGBTQ youth group and LGBTQ resource library
- hosting a community forum to develop an action plan to address emerging needs
- advertising services through the media, community agencies, and communication with service providers
- creating information materials such as a documentary, web-based training modules, information displays, and brochures
- attending workshops in Aboriginal and Inuit communities in order to reach out to these communities and include them in their governance structure
- distributing safer crack use kits
- requesting additional funding.

10. Outreach Initiatives

(Note: this section does not include the outreach services provided by agencies that are specifically funded under the AIDS Bureau IDU Outreach initiative: their activities are reported separately in section 13 of this report. However, it does include outreach to injection drug users by agencies that are NOT funded under the IDU Outreach initiative.)

Organizations funded to provide HIV prevention and education often offer outreach services for populations at risk. This section of the report summarizes information provided to OCHART on their outreach activities.

Priority populations for outreach services vary geographically

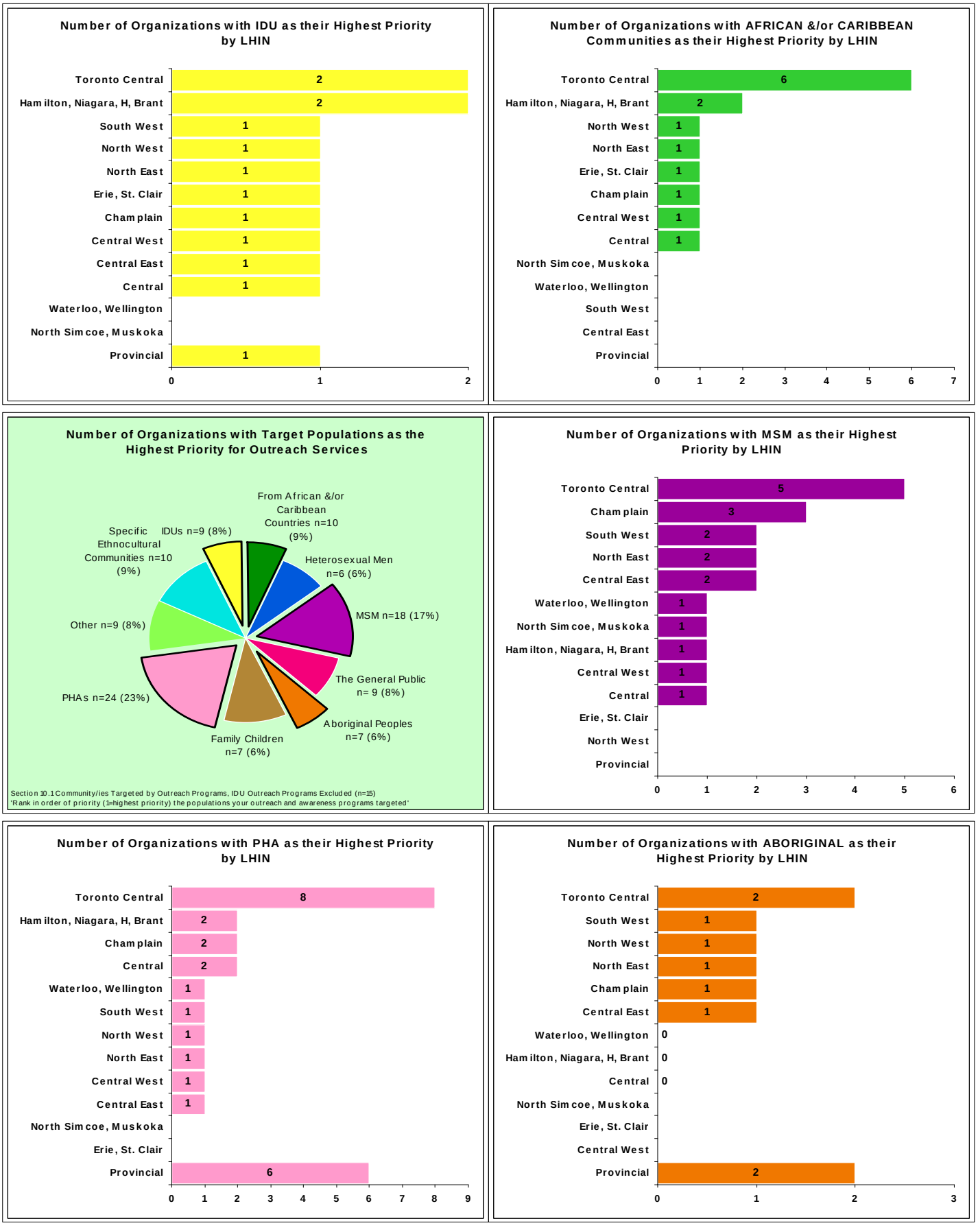
In Figure 38, the pie chart shows the number of organizations that identified each population as its highest priority for outreach services. One-quarter of organizations (23%) identified people living with HIV as their highest priority for outreach services, 17% identified men who have sex with men, 9% identified African and Caribbean communities, 9% identified specific ethnocultural communities, and 8% identified injection drug users (note: the number and proportion of agencies identifying injection drug users is low because this section does NOT include the IDU outreach programs).

The bar graphs in Figure 38 show how many organizations in each LHIN have identified each of five populations as their highest priority – (starting from the top left and moving clockwise around the page: Injection drug users, people from African and Caribbean communities, men who have sex with men, aboriginal communities, and people living with HIV). Although more organizations reported people living with HIV as a priority, many of those organizations are provincial. In terms of LHIN regions, more LHIN regions have organizations that report gay men as their highest priority for outreach. As one would expect, the LHIN regions targeting Aboriginal people for outreach services are mainly in the northern part of the province, while those targeting the African and Caribbean communities are in or around Toronto and Ottawa, and those whose highest priority is drug users are in regions of the province with high rates of HIV infection in that population.

Organizations also identified other priority populations for outreach services, including:

- youth
- single refugee women with dependent children
- newcomer women
- francophone gay, lesbian, bisexual and transsexual people.

Figure 38: Number of Organizations Prioritizing Different Target Populations



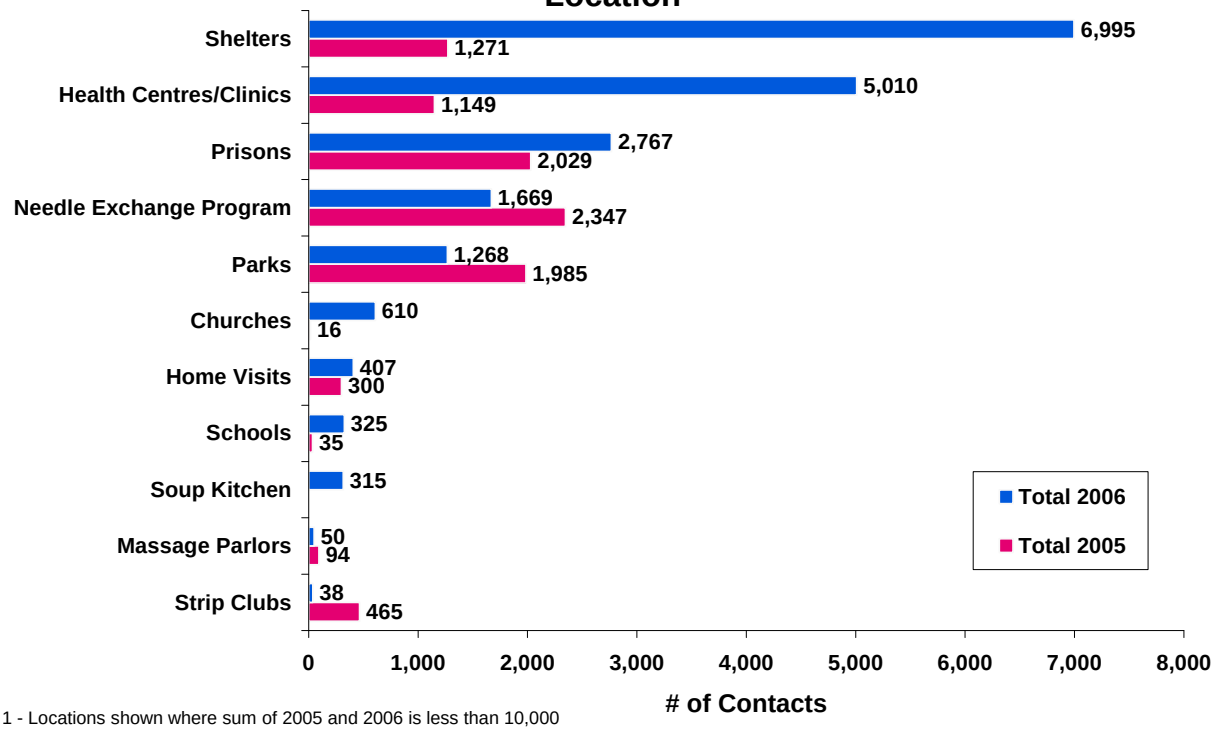
Outreach contacts down 19% in 2006-07

The total number of outreach contacts by funded organizations – in all locations – was down about 19% – from 418,991in 2005-06 to 339,379 in 2006-07. The change may be due to changes in data collection, or it may indicate that it is taking more time to make outreach contacts.

Outreach locations shifting

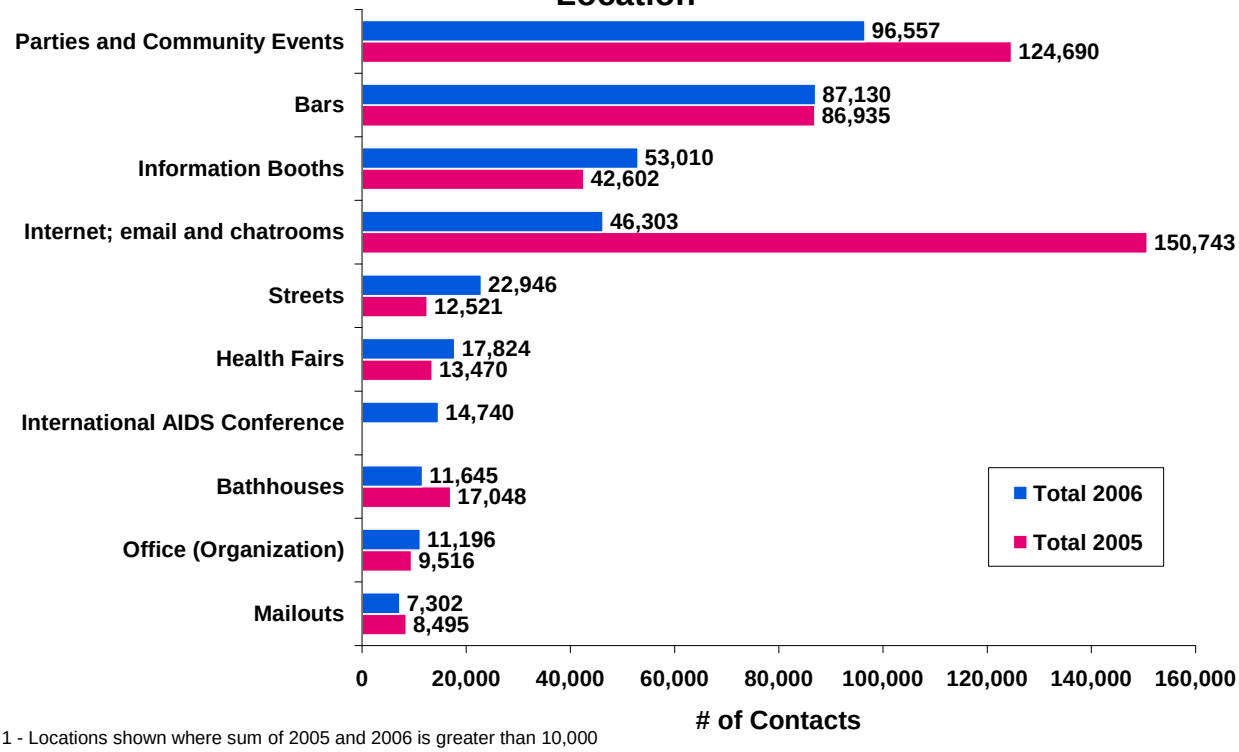
Figures 39 and 40 compare the location of outreach contacts in 2005-06 and 2006-07 where the total number of contacts in 2005 and 2006 were less than 10,000 and greater than 10,000 respectively. Organizations made significantly more contacts in shelters (+450%) and health centres (+336%) than in the past. This may indicate that organizations are developing closer partnerships with these other services/settings.

Figure 39: Number of Outreach Contacts[1] (< 10,000) by Location



1 - Locations shown where sum of 2005 and 2006 is less than 10,000

Figure 40: Number of Outreach Contacts[1] (> 10,000) by Location



1 - Locations shown where sum of 2005 and 2006 is greater than 10,000

There was also an increase in contacts in prisons (+36%), on the street (+83%) and through the International AIDS Conference, while the number made at parks (-36%), needle exchange programs (-29%) and parties (-23%) dropped. The decrease in the number of Internet and chatroom (-69%) contacts is probably due to more accurate counting.

Figure 41 shows the location of outreach activities funded by ACAP in 2005-06 and 2006-07 as well as the number of contacts in each location. In 2006-07, there was a significant increase in the number of contacts in shelters, bars and parties – in fact, ACAP-funded organizations accounted for 70% of all contact made in shelters. There was also a drop in contacts through information booths, health fairs, street outreach and the Internet. Once again, some of the differences in the number of Internet contacts may be due to more accurate ways of counting contacts in 2006-07 or to reporting errors in 2005-06.

Figure 41: ACAP Funded Organizations: Outreach Activity Contacts by Location

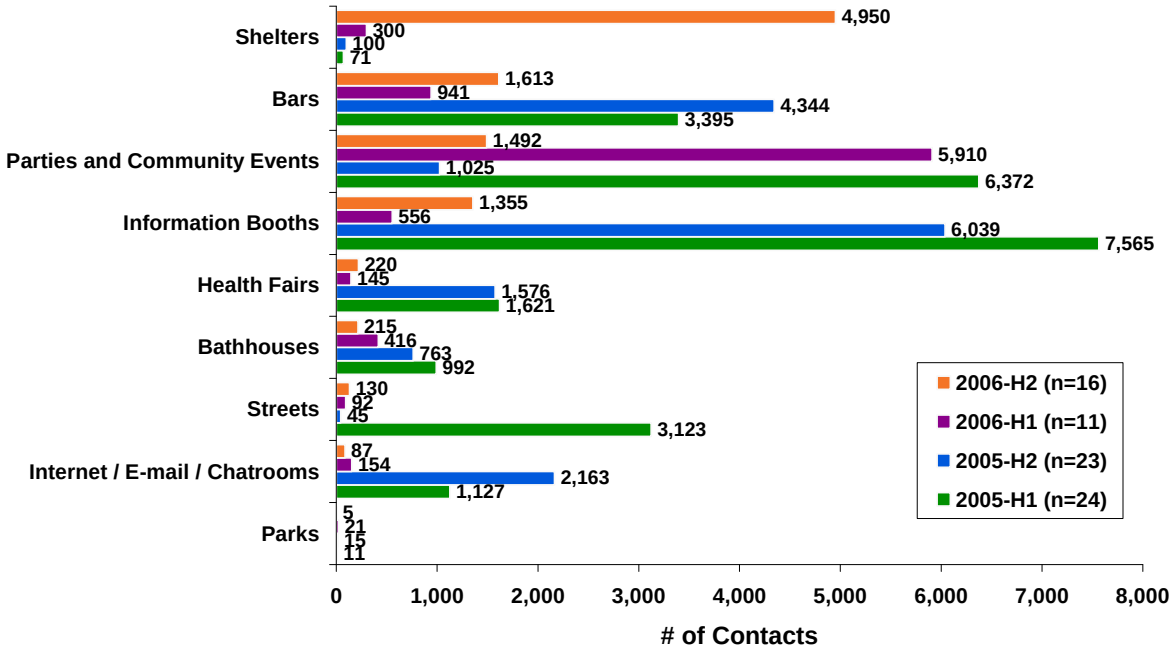
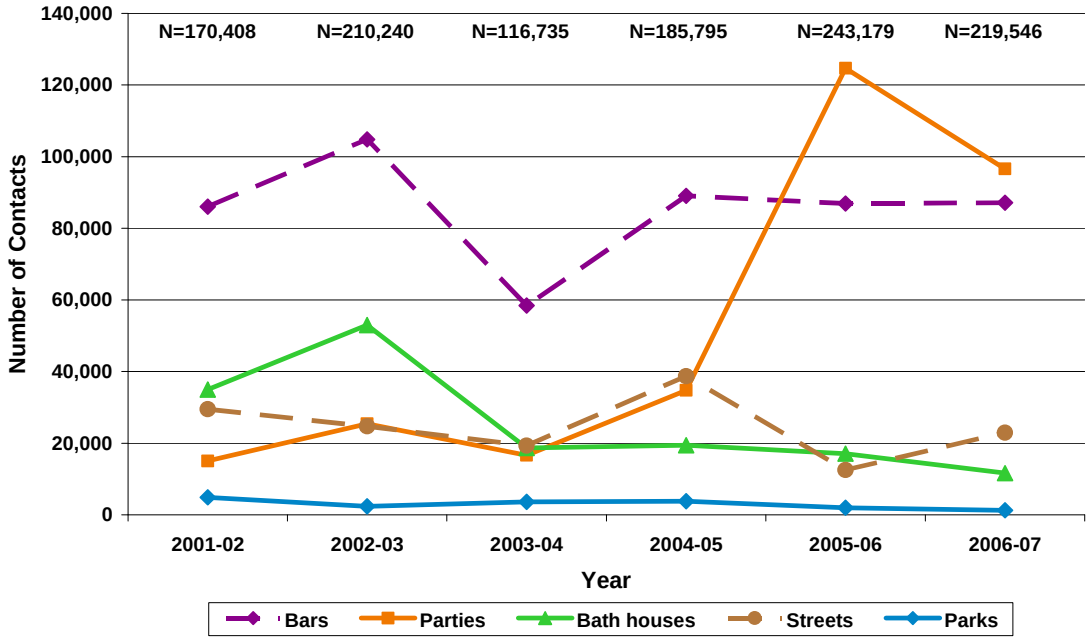


Figure 42 shows the shift in outreach locations over time. Although there were fewer outreach contacts through parties in 2006-07 than in 2005-06, it still accounts for the largest number of contacts – and a significant increase over contacts in this location in earlier years. This may be

Figure 42: Selected Outreach Activities Reported by Location Over Time

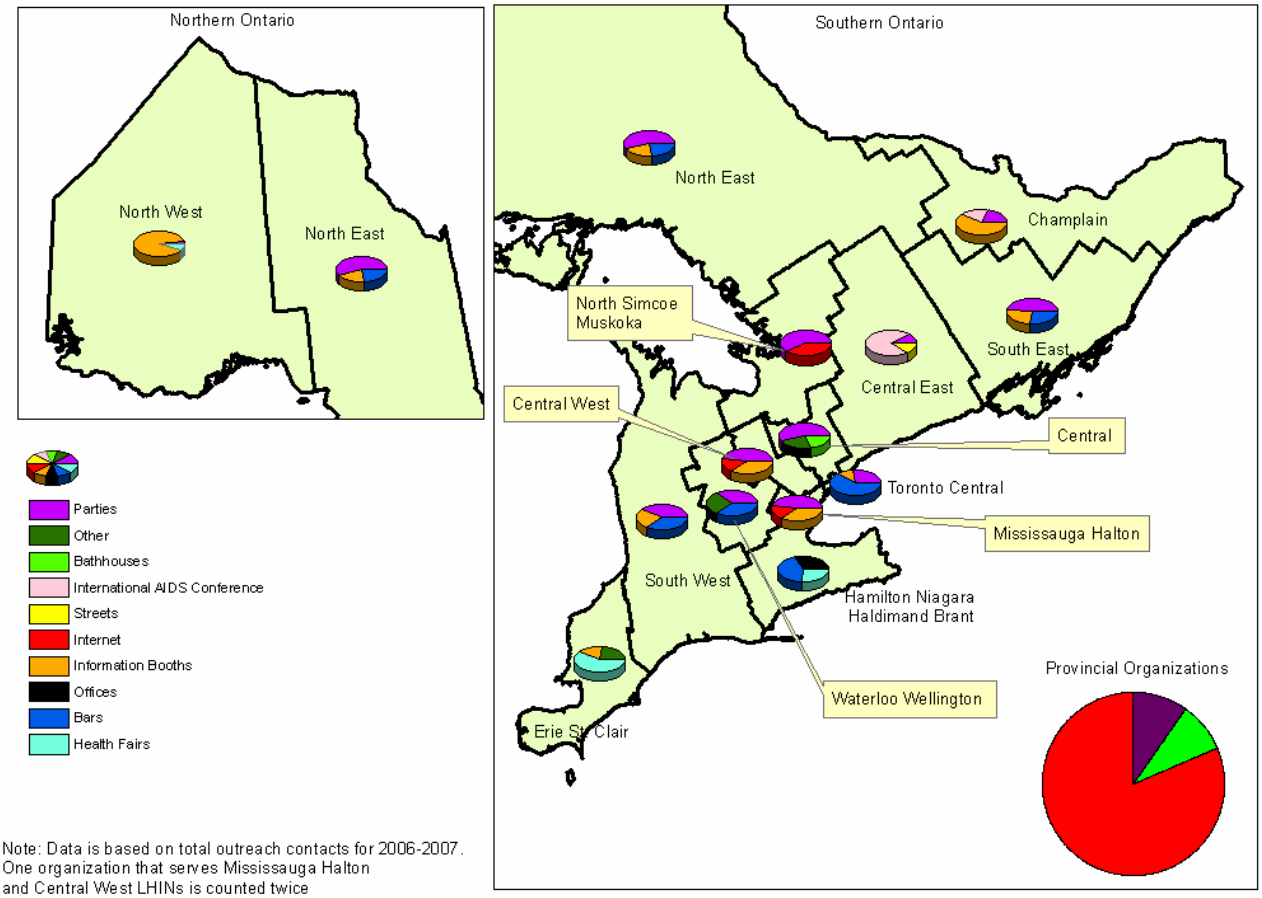


due to changes in police practices, which are moving people out of parks and off the streets into private homes. The number of contacts through bars has remained relatively steady except for a drop in one year. There has been a steady decline in outreach through bath houses.

Figure 43 illustrates the top three locations for delivering outreach services by LHIN. The differences across the province reflect local needs and target populations as well as organizational capacity and resources. For example, parties are the most common outreach location in the North East, North Simcoe Muskoka, the South East, and most areas around Toronto, but bars are the most common location in Toronto and Hamilton Niagara Haldimand Brant.

In communities with outreach services that target gay men, the most common locations for outreach will depend in part on whether the communities have openly gay populations. In large urban centres with openly gay populations, outreach is more likely to occur in bars, while in smaller communities, it is more likely to occur at parties.

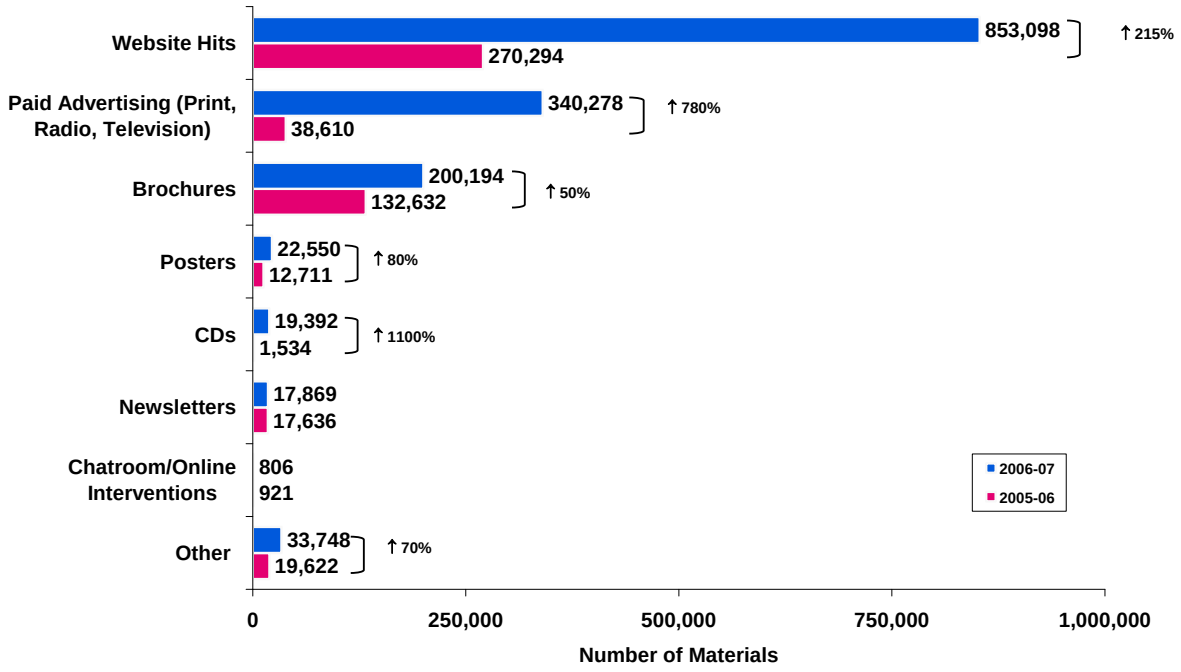
Figure 43. Top Three Outreach Activity Locations by LHIN



Websites and paid advertising used to raise awareness

In 2006-07, organizations made significantly more use of websites, paid advertising and CDs than in 2005-06 to raise awareness of HIV (Figure 44). They also made more use of traditional tools, such as brochures and posters. The large increase in awareness campaigns and activities is likely related to AIDS 2006.

Figure 44: Awareness Campaigns and Activities



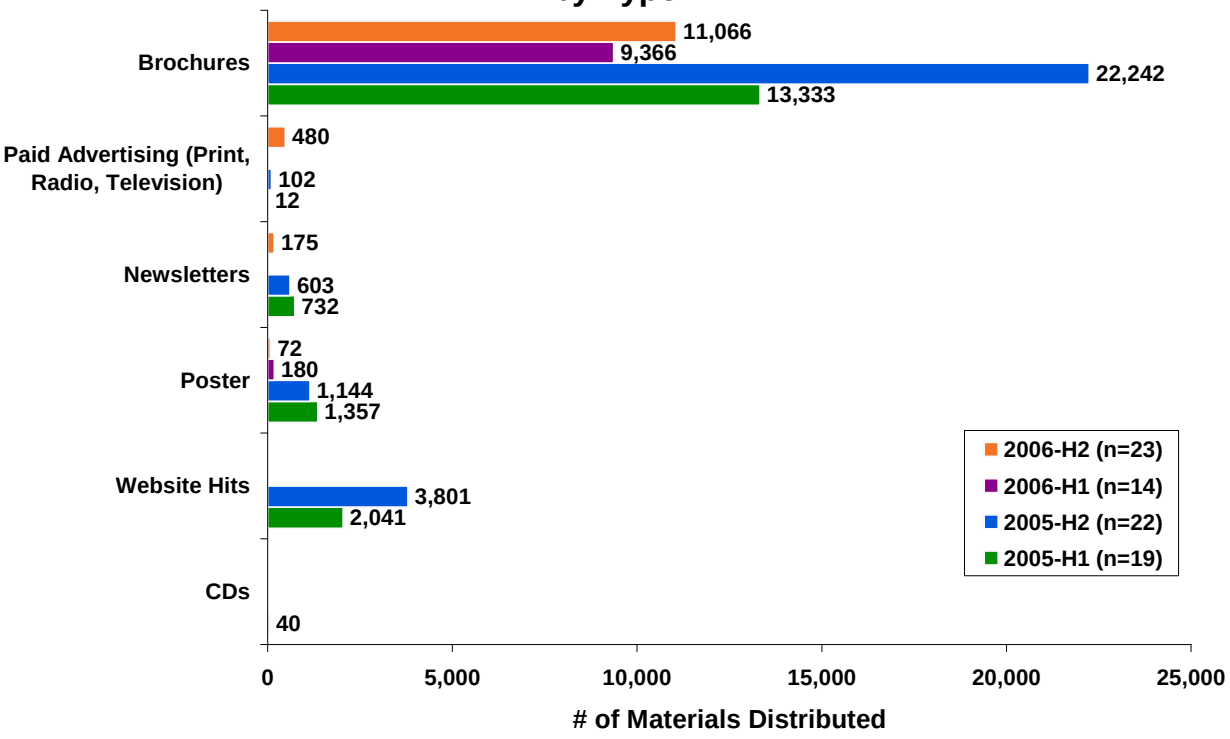
Other awareness activities included:

- mailouts of condoms/condom packages/brochures with inserted condoms/walk-ins for condoms
- postcards/cards
- tattoos
- t-shirts
- videos/DVDs/CD ROMs
- radio
- booklets/reports/manuals
- window displays
- transit shelters
- workshop/presentations
- press releases
- playing cards
- unpaid advertising—television, print
- paid advertising in business directory
- email campaign/outreach
- library/resource centre
- membership cards

ACAP funding used primarily to develop brochures

Organizations funded by ACAP in 2006-07 for awareness activities reported using that funding primarily to develop brochures and to support some paid advertising (Figure 45) – although the production and distribution of brochures was down significantly in the last half of 2006-07. The heavy reliance on brochures would be consistent with the number of ACAP-funded projects that reported using their funding to translate materials into other languages, thereby creating more supportive environments for immigrant, refugee and minority populations.

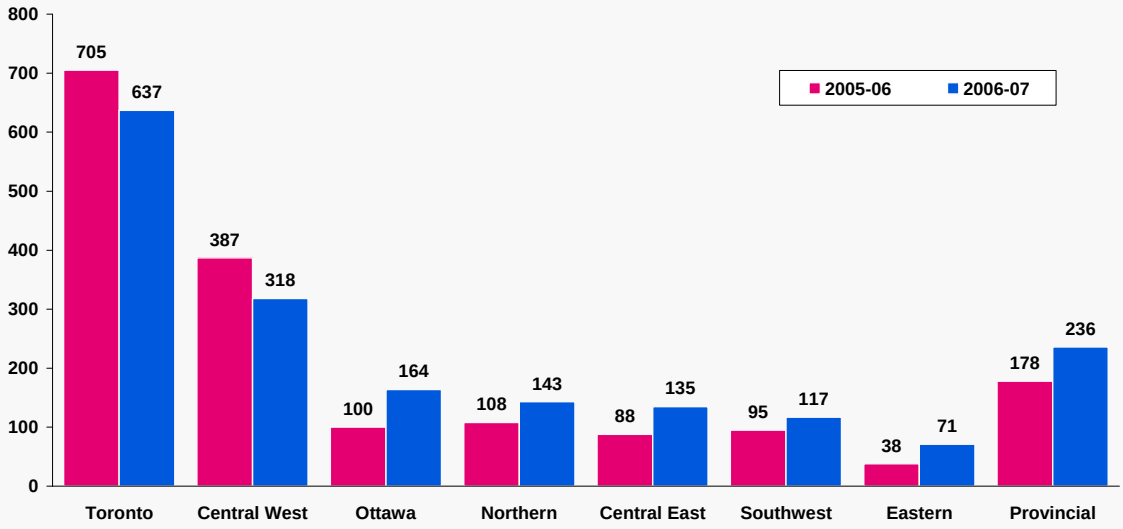
Figure 45: ACAP Funded Organizations: Awareness Activities by Type



More media contacts in most regions in 2006-07

Most regions saw an increase in media contacts in 2006-07, likely due to the interest created by the International AIDS Conference – although it was surprising that the number of media contacts was down in Toronto, where the conference was held (Figure 46).

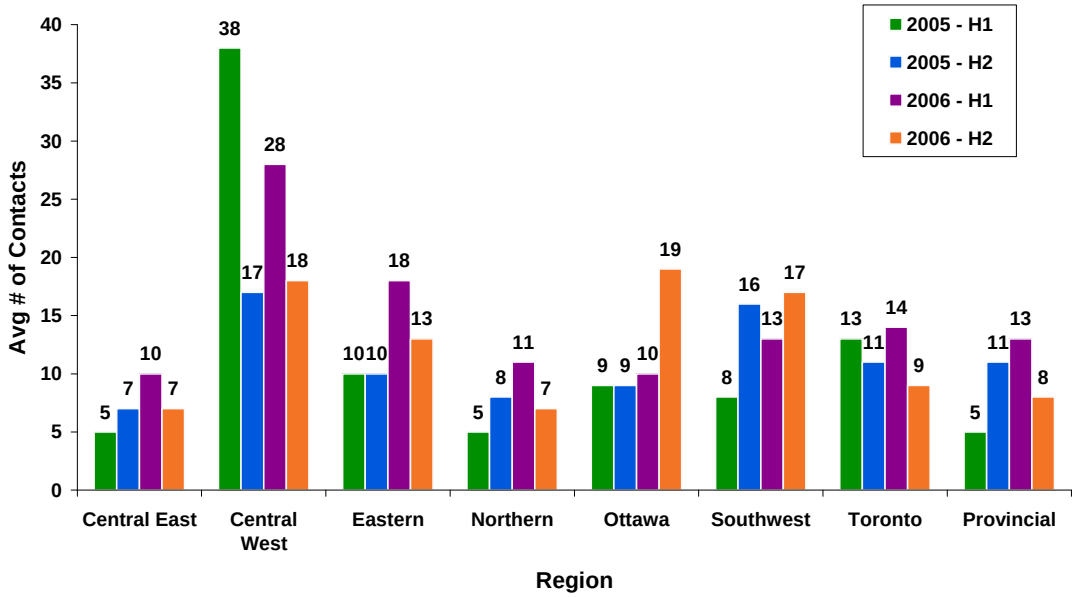
Figure 46: Total Number of Media Contacts by Health Region



When the information on media contacts is analyzed in terms of the number of organizations in each region, it appears that organizations in some regions, such as Central West, Eastern, Ottawa and Southwest, are making more use of media than those in other parts of the province – although media contacts have increased in most regions (Figure 47).

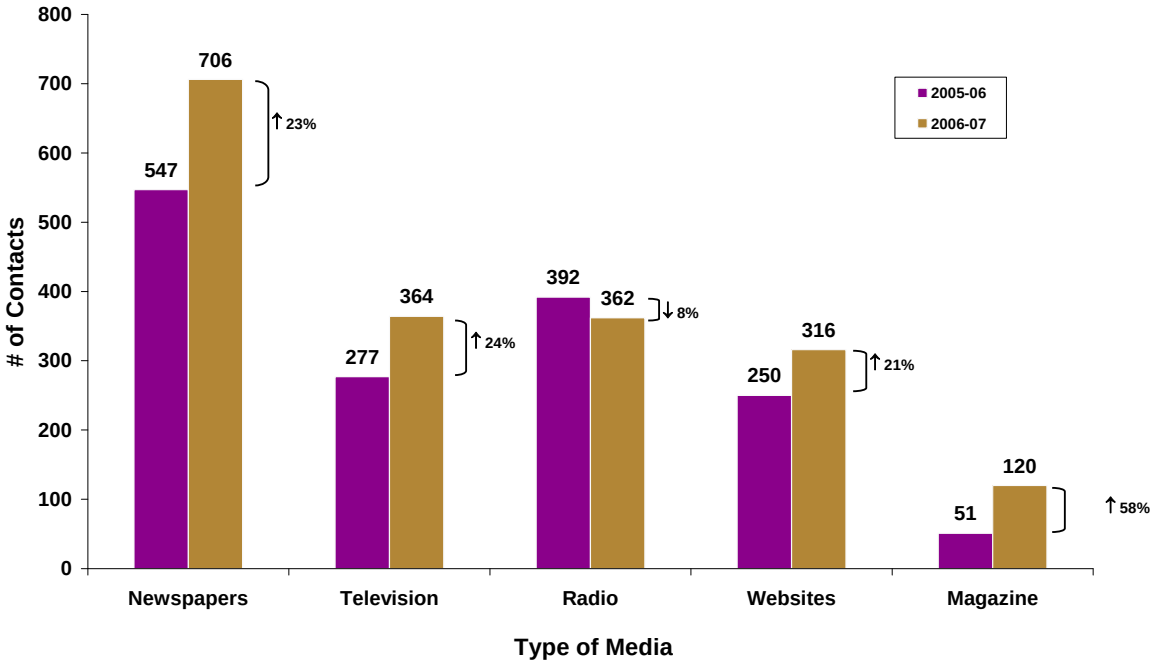
Six of the eight regions also reported more media activity during the first half of 2006-07, which coincided with the 2006 International AIDS Conference.

Figure 47: Average Number of Media Contacts by Region and Reporting Period



Organizations also reported significantly more contacts/media coverage through television, web-based media, newspapers and magazines than in the previous year (Figure 48). The only type of media used less in 2006-07 than in 2005-06 was radio. The overall increase in coverage in almost all types of media may be due to a concerted effort on the part of organizations to use the media and/or increased media interest in HIV-related stories because of the conference.

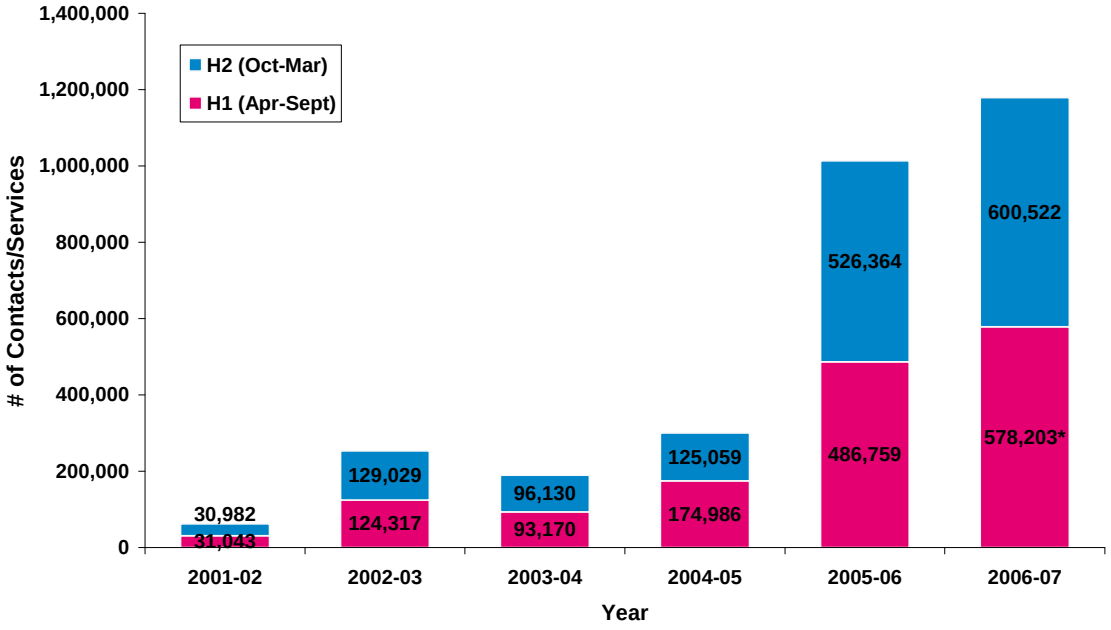
Figure 48: Organizational Reporting of Media Contacts



Phone and internet outreach services continue to grow

The number of services provided by telephone and Internet continued to increase in 2006-07 – although not as dramatically as in the previous years (Figure 49).

Figure 49: Telephone and Internet Contacts/Services

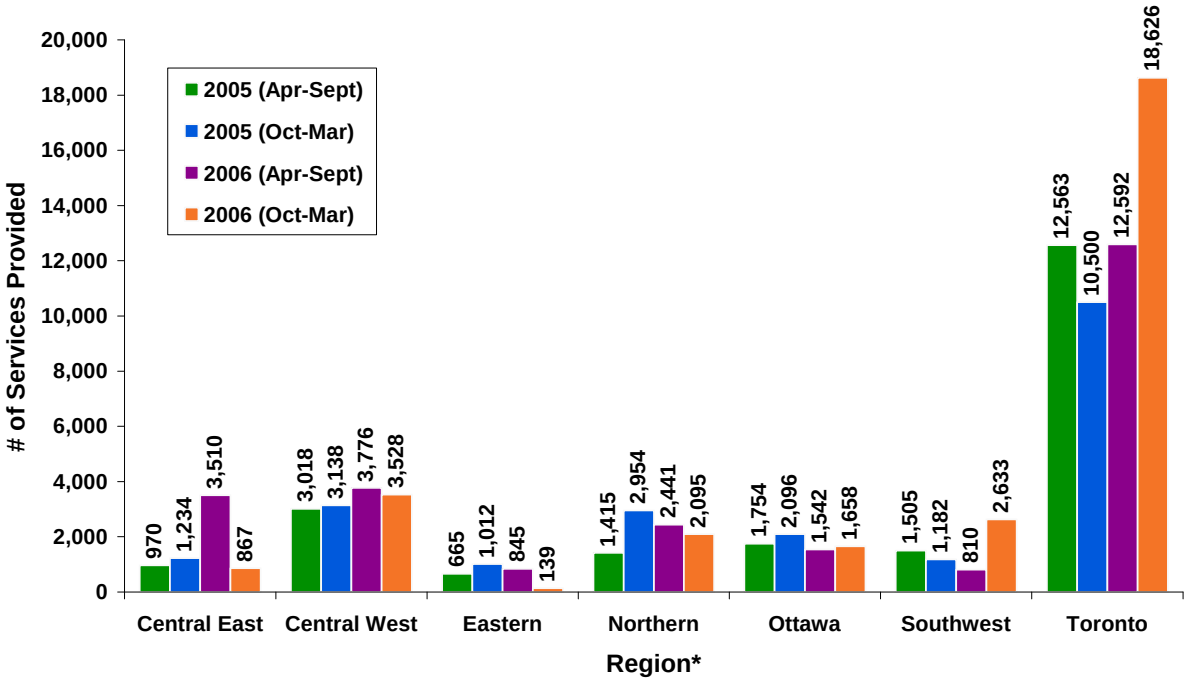


*Total in 2006-07 H1 estimated due to reporting error

The vast majority (91%) of phone and internet outreach services are reported by provincial organizations, such as CATIE, which provides treatment information services for the country. Provincial organizations accounted for over half a million Internet and phone contacts in 2006-07.

Figure 50 shows the distribution of the remaining Internet and phone contacts by region. Some regions, such as Central West and Toronto appear to be making more use of Internet outreach than others. The wide variation in average telephone/Internet use over time is likely due to organizations trying to find more effective ways to monitor and count these contacts (e.g., unique web site hits versus all hits) or errors in reporting. The most marked increases in use of the Internet and phone between 2005-06 and 2006-07 occurred in Southwest and Toronto regions.

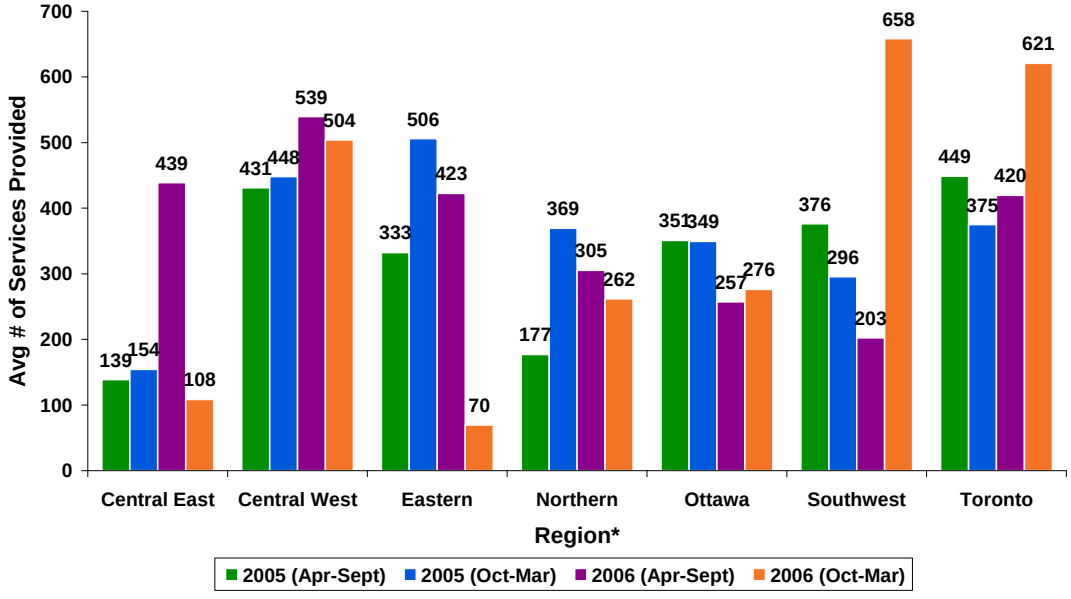
Figure 50: Telephone & Internet Activity by Region*



* Provincial data removed to show more data for other regions:
2005 - H1 = 465,260 2006 - H1 = 532,337 (estimate due to reporting error)
2005 – H2 = 496,149 2006 - H2 = 567,782

Figure 51 shows the average number of Internet and phone contacts per organization in each region. Although organizations in Toronto report a high number of total Internet contacts, their average number of contacts per organization is comparable to organizations in other regions.

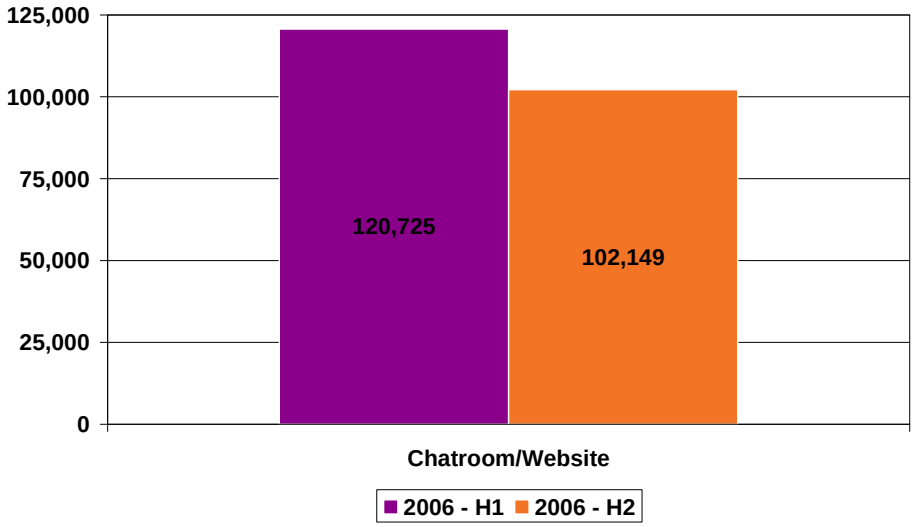
Figure 51: Average Telephone & Internet Activity per Organization by Region*



* Provincial data removed to show more data for other regions

Those organizations that received ACAP funding to support Internet outreach reported using the funding to support chatroom and website contacts (Figure 52).

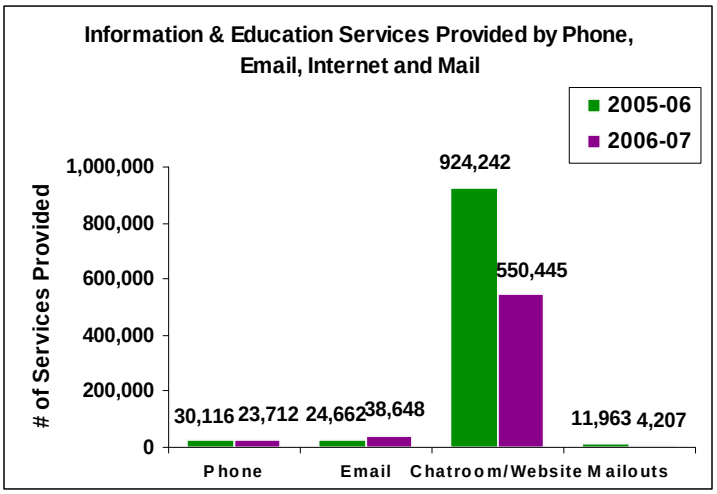
Figure 52: ACAP Funded Information and Education Services Provided by Internet Type

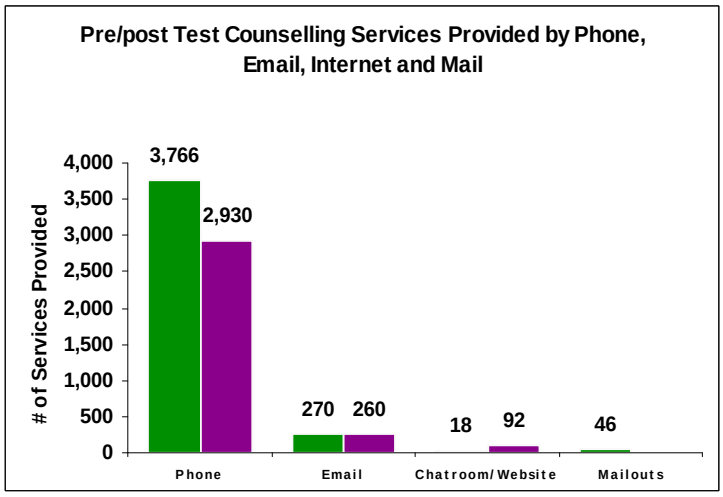


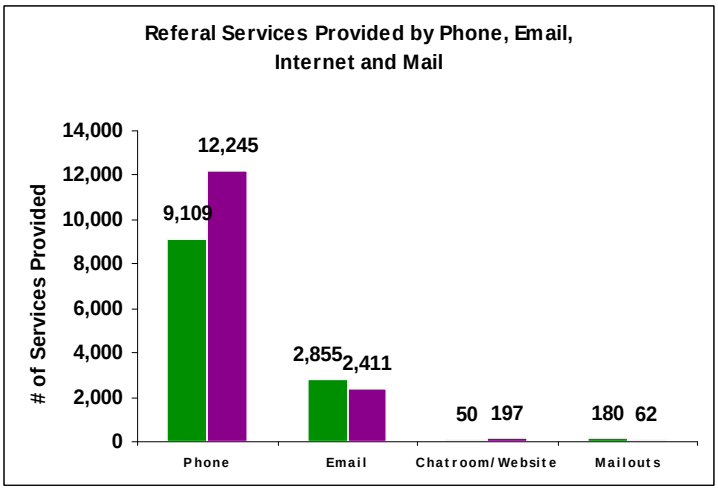
Organizations use different outreach approaches to deliver different types of services

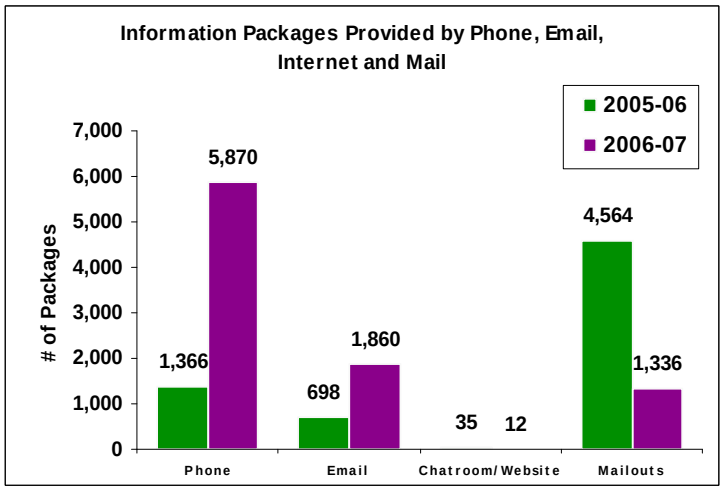
The following series of charts (Figure 53) shows the type of outreach approach or media used to deliver different types of services. Pre-test counselling and referrals are more frequently delivered by phone while more general information and education are often delivered using email and chatrooms. This information reinforces that the development of Internet services does not eliminate the need for more traditional approaches, such as mailouts.

Figure 53: Outreach Approaches to Deliver Different Types of Services





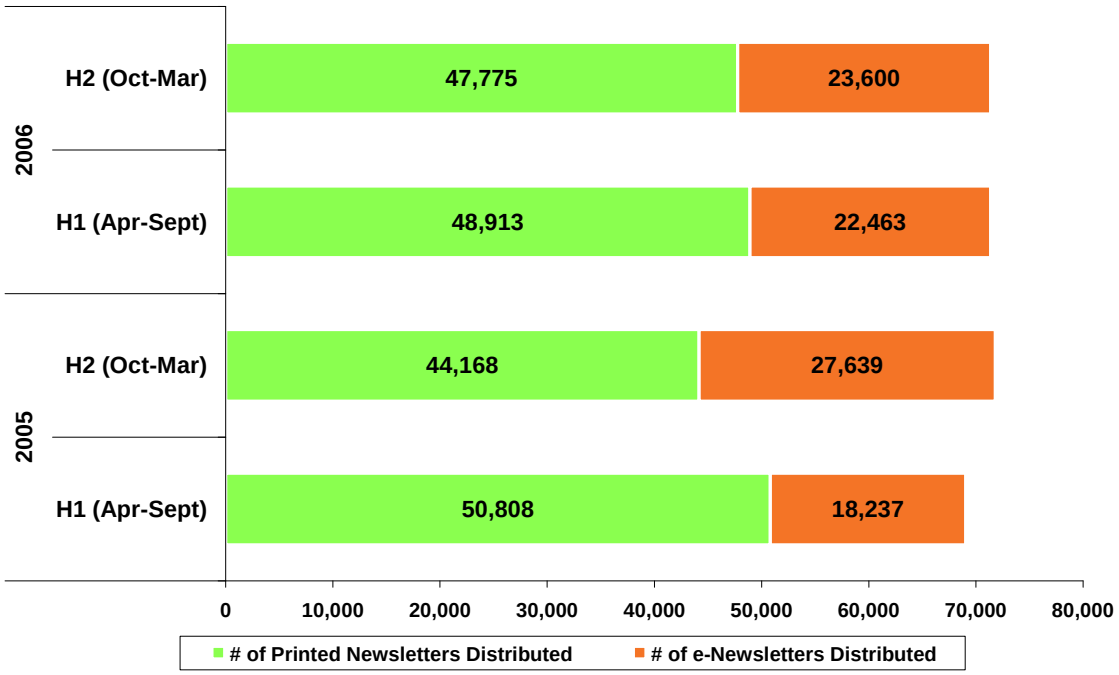




Organizations continue to rely on newsletters

Organizations distributed slightly more newsletters in 2006-07 than in 2005-06 (Figure 54). When the second half of 2006-07 is compared to the same time period in 2005-06, there was almost a 10% increase in the number of printed newsletter distributed and a 15% decrease in the number of e-newsletters. This change may be due to a decrease in the number of newsletters produced, changes in the way organizations count their newsletters or reporting errors. It appears that organizations are still working to determine the most effective ways to develop and distribute newsletters.

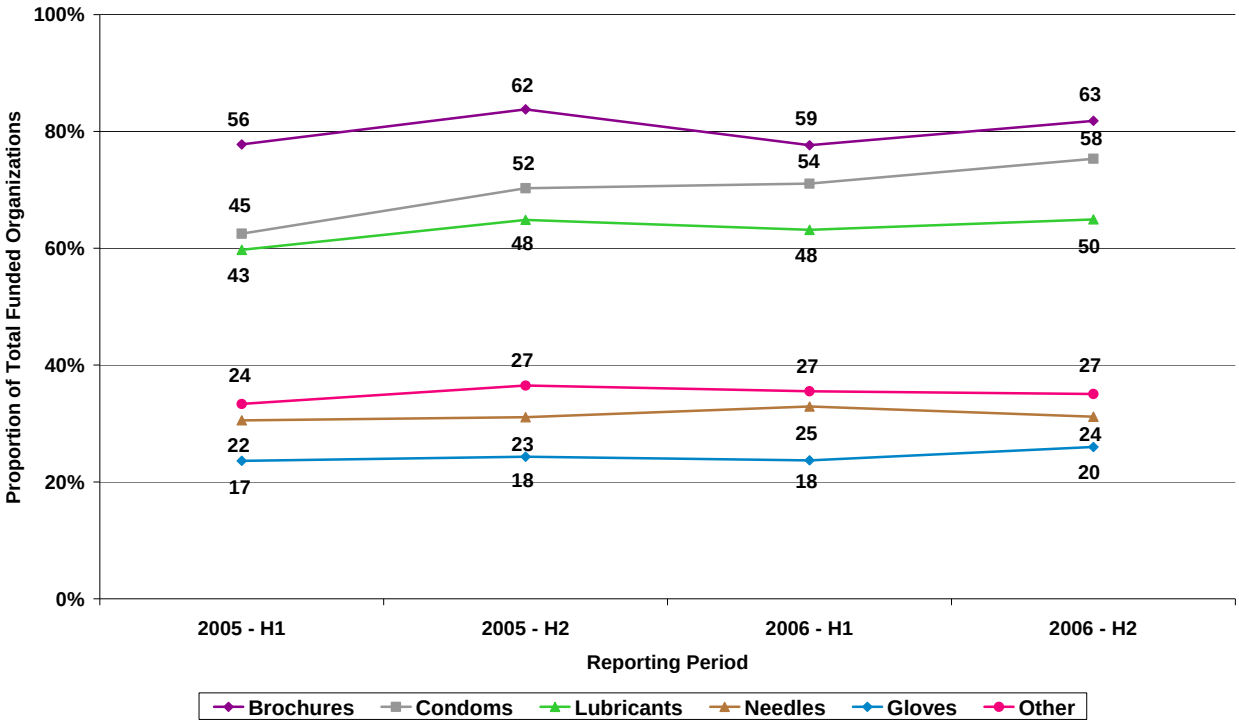
Figure 54: Newsletters Distributed by Reporting Period



75% of organizations distribute condoms, 31% distribute needles

Most organizations distribute some type of prevention resources. As Figure 55 shows, the most common is brochures followed by condoms, and lubricants. There has been a steady increase in the number of organizations distributing condoms and lubricants while the number distributing other types of resources has remained relatively constant.

Figure 55: Number of Organizations Distributing Prevention Resources



The "other" category included resources such as:

- other drug-related equipment, such as safe crack kits, sharps containers, filters, cookers and water
- dental dams and female condoms
- food hampers, clothing, toiletries and baby supplies
- vitamins
- transit tickets.

More demand for other drug equipment, less demand for needles

When asked about any changes in requests for prevention resources, organizations reported more clients asking for other drug-related equipment, such as crack pipes, cookers, tourniquets, vitamin C and E, antibiotic cream, safer crack kits, and sterile water – and a decrease in requests for sharps and injection supplies. This is consistent with organizations' reports that they are seeing an increase in the number of people smoking cocaine rather than injecting.

Organizations also reported an increase in requests for:

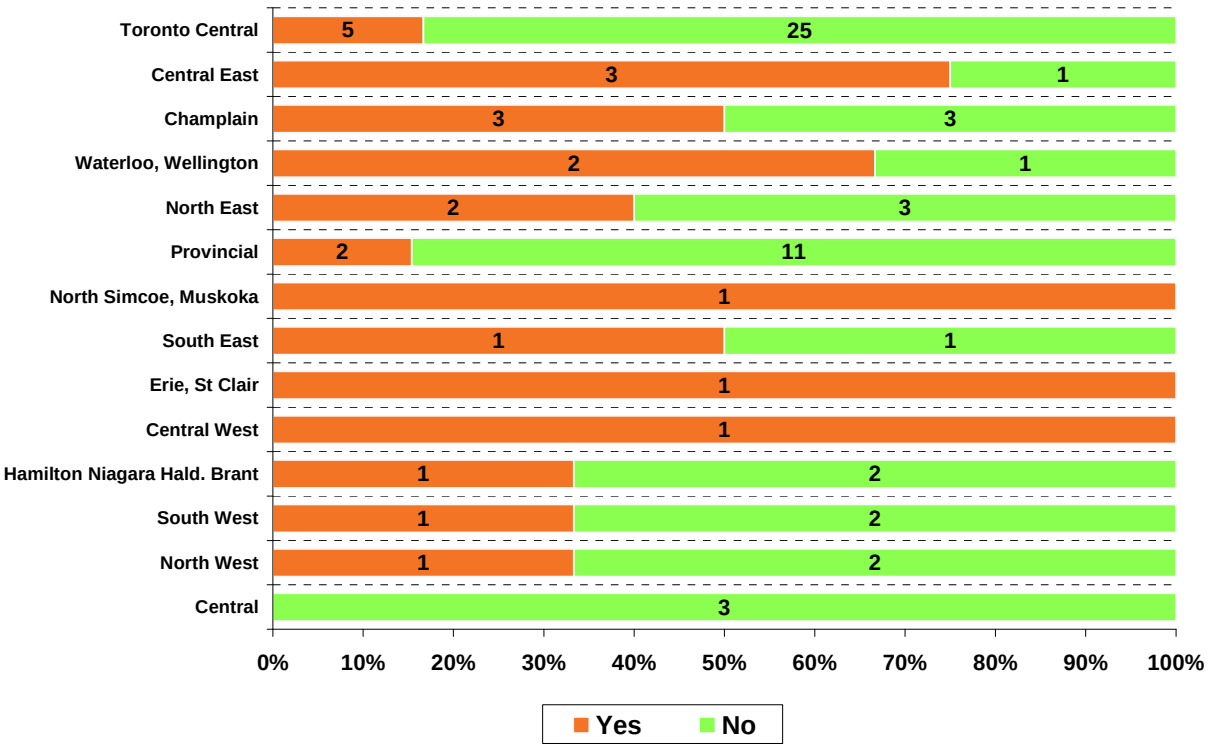
- basic necessities, such as food, warmer clothing, long-term subsidized housing, transit tickets, baby supplies, and financial assistance
- harm reduction resources, such as condoms, female condoms, lubricant, dental dams, and gloves – especially from post-secondary schools, youth institutions, and group homes, as well as from First Nations communities, gay community commercial venues (bars, baths), and from third parties such as clubs, party promoters, and student groups

- educational materials including brochures, information on condoms, information on specific ASOs, quick-read information sheets, smaller sized brochures on HIV/AIDS and other STIs, HIV Prevention Guidelines, manuals, postcards, and posters
- immigration information
- more ethno and gender-specific information and resources, including Asian language brochures and videos, Aboriginal materials, information on sexual health and safer sex for women, and materials for two spirit women and women who have sex with women.

Access to needles

Given the high risk of HIV infection from sharing needles, the AIDS Bureau is particularly interested in access to needles and other drug equipment. As of the end of 2006-07, there was at least one organization distributing needles in every LHIN region except Central (Figure 56). However, it's clear from this figure that other resources (besides needles) are more easily available from more sites. The large number of organizations distributing resources other than needles may be due to the implementation of the Ontario Harm Reduction Distribution Program funded by the Hepatitis C Secretariat of the Ministry of Heath and Long-Term Care, which makes a range of resources available to agencies at no cost.

Figure 56: Organizations Distributing Needles by LHIN



Emerging Trends in Outreach Services

Organizations reported increased or unmet demand for outreach services from the following groups:

- newcomers and refugees
- women in general, Vietnamese and Filipino women, women with young children, women in prison, young women
- Spanish-speaking people (including youth and women)
- youth including street youth, youth from ethno-specific communities, youth in correctional institutes, francophone young adults (immigrants) in high schools
- people in "outlying areas"
- senior's groups
- faith-based organizations
- families
- gay/bisexual/MSM
- sex trade workers
- the South Asian transgendered community and Asian sex workers
- ESL students
- francophone schools
- service providers, and staff at hospices and long-term care facilities.

In terms of the types of outreach services and materials, organizations reported an increase in requests for:

- information on safer sex and risk behaviours, the risks, realities and vulnerabilities of trans identified youth, condoms, non-biomedical information, reports from the 2006 International AIDS Conference, HIV Foundations (formerly HIV 101), HIV/HCV co-infection
- ethno and gender-specific materials
- web-based outreach services
- referrals to GPs
- hepatitis C related referrals and services
- troupe performances, requests for information about the Ontario HIV Substance Use Training Program (OHSUTP) services, up-to-date posters, speakers from the Speaker's Bureau
- safer crack use kits
- housing and other supports for women and children
- interpretation services.

One organization identified the increasing trend for gay men to "hook up" on the Internet, which will require new outreach approaches. Another reported a low turnout for its women's programming, which helped identify the need to evaluate the program.

Responding to Emerging Trends in Outreach

Organizations report using a number of strategies to respond to emerging trends in outreach services, including hiring staff and developing partnerships with other agencies to expand and strengthen services. Other strategies included:

Changes in staffing/staff development

- recruiting more volunteers
- developing training programs for volunteers, including online outreach training packages and modules so volunteers can provide more online/chatroom outreach

- recruiting peer ambassadors – including peer youth trainees
- meeting with program staff to ensure that they are not duplicating programming
- assigning a program coordinator to work exclusively on women's issues
- offering more sexual health training to outreach workers and youth counselors

Changes in programming

- creating an on-line presence on social networking sites, such as You Tube and Facebook
- developing a speakers bureau
- revamping existing service delivery to reflect changing demographics and needs
- branching out from Chinese-specific websites to others that attract a diverse ethno-racial group of men
- providing more outreach in outlying areas and planning to set up an office in the northern part of the organization's catchment area
- holding a Young Women's Think Tank to brainstorm potential new avenues for outreach to young HIV-positive women
- launching a message board for gay/MSM
- developing a wider range of presentations tailored to specific audiences
- distributing safer crack use kits
- developing new programming for housing
- introducing a clothing support program for women and children through a partnership with a retail outlet
- developing the Adopt-A-Family Program over the holidays to allow the young children to receive presents

Developing new partnerships or networks

- seeking out family physicians who are accepting new patients, and helping clients attend appointments
- making referrals to a hepatitis C program
- developing proposals for the trans community
- working in partnership with school administrators to reach visa students in private ESL schools; developing partnerships with sex workers and women's organizations

Developing or reallocating resources

- reallocating resources to meet the increased demand
- developing a more comprehensive brochure on condoms and advocating with public health for female condoms
- developing and distributing new resources and outreach materials such as flyers, pamphlets, post-cards, and website
- creating an easily accessible in-house sexual health resource centre for youth
- creating a culturally sensitive resource/information manual and baggies of condoms, lubricant and Traditional Native inserts designed by other street-involved youth
- asking pharmaceutical companies for samples and financial assistance for families/women with children
- obtaining a winter needs grant to support families over the winter months.

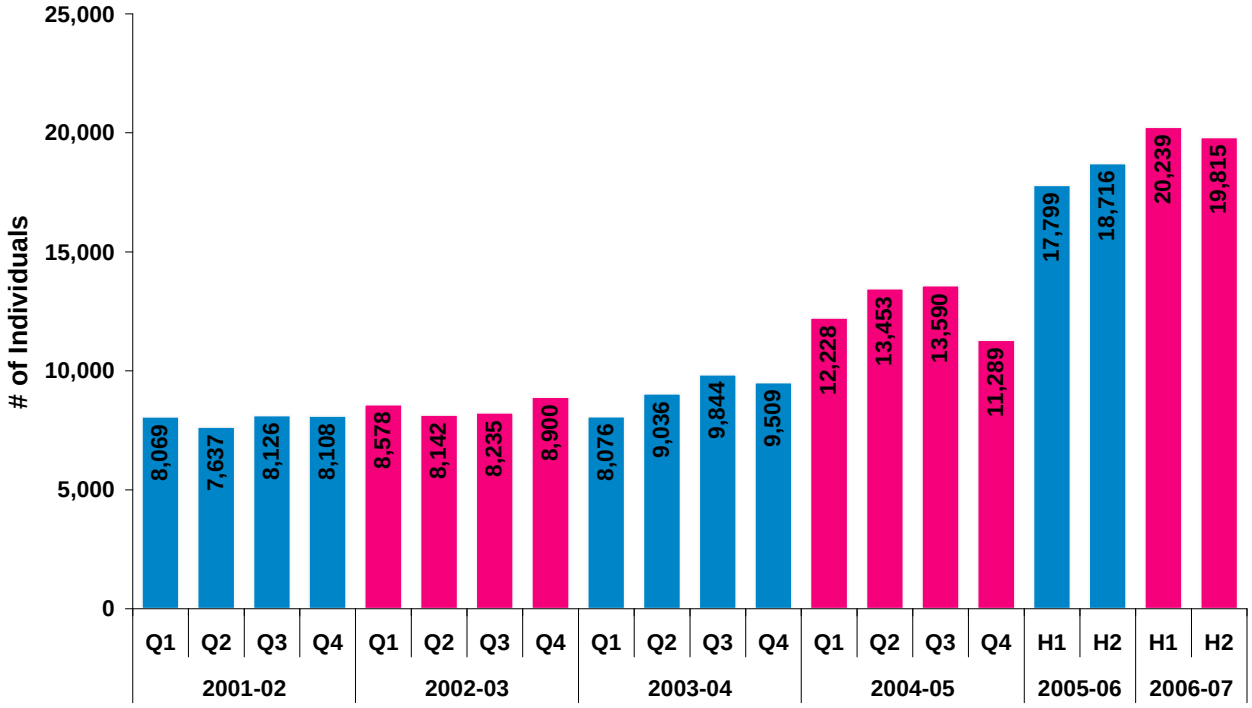
11. Support Services

Sixty-four organizations completed the OCHART section on support services in 2006-07 (e.g., counselling, practical support, referrals to other services) for people living with HIV, family/friends, people affected by HIV (i.e., populations at risk) and others – up from 60 in the first half of the year.

Number of people using support services continues to grow

As Figure 57 indicates, the number of clients using support services appears to increase with each reporting period beginning in 2004-05. Because the same client may receive services in more than one reporting period, it is not possible to determine the total number of clients served in a given year, or what proportion of clients are new, ongoing or returning each year.

Figure 57: Number of Clients who Used Support Services During Each Reporting Period



Support services used mainly by people living with HIV and people at risk

Figure 58 shows change in the type of clients receiving support services. People living with HIV still made up the largest proportion of people using support services in 2006-07; however, the number of clients who are affected increased by 34% compared to 2005-06, as agencies focus on reaching people/communities at risk. The number of clients in the "other" group has also increased – by 258% since 2005-06. Agencies report that some clients in the "other" category are

people with hepatitis C (but not infected with HIV) who are unable to access comprehensive support services from other sources.

Figure 58: Delivery of Support Services by Client Type

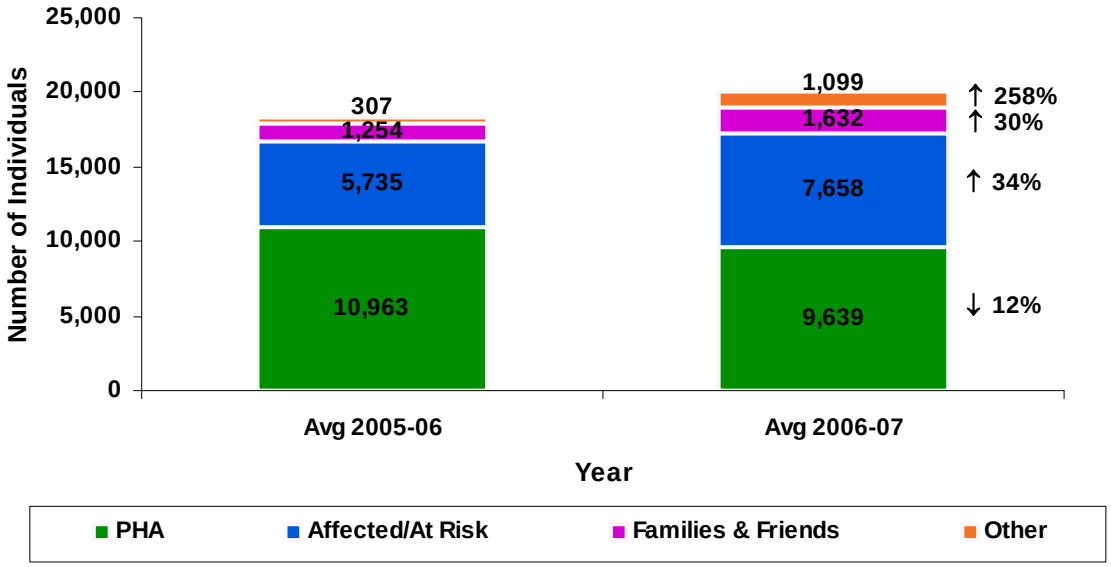
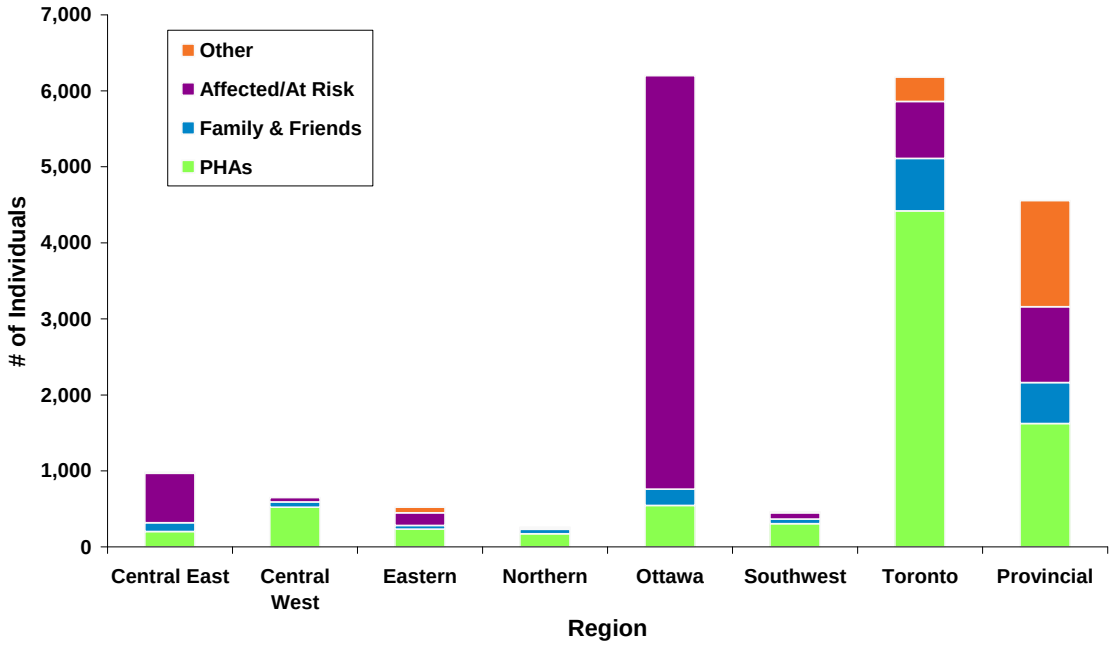


Figure 59 shows the breakdown of clients by region. Most regions report serving mainly people living with HIV, while some regions report serving mainly people at risk. The high proportion of at risk/affected clients in Ottawa is due to reporting from the public health unit. The large proportion of "other" clients reported by provincial organizations is mainly the agencies/service providers who are the main target of many provincial services.

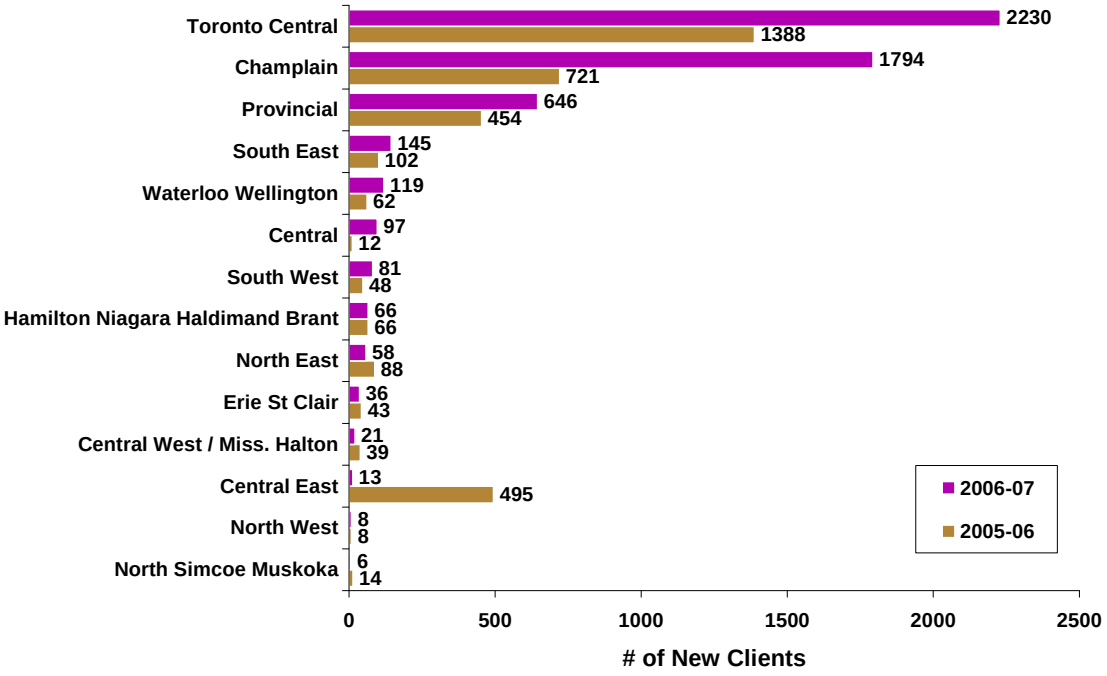
Figure 59: Distribution of Clients Using Support Services by Region (2006 - H2)



Over one-quarter of support clients were new in 2006-07

Of the 19,927[2] clients served by all organizations during 2006-07, 5,320 (27%) were new to the agencies. Figure 60 illustrates the number of new clients by LHIN region over the past two years. Not surprisingly, the LHIN regions that saw the largest number of new clients are those in large urban centres with high rates of HIV: Toronto Central and Champlain.

Figure 60: New Support Service Clients Reported by LHIN

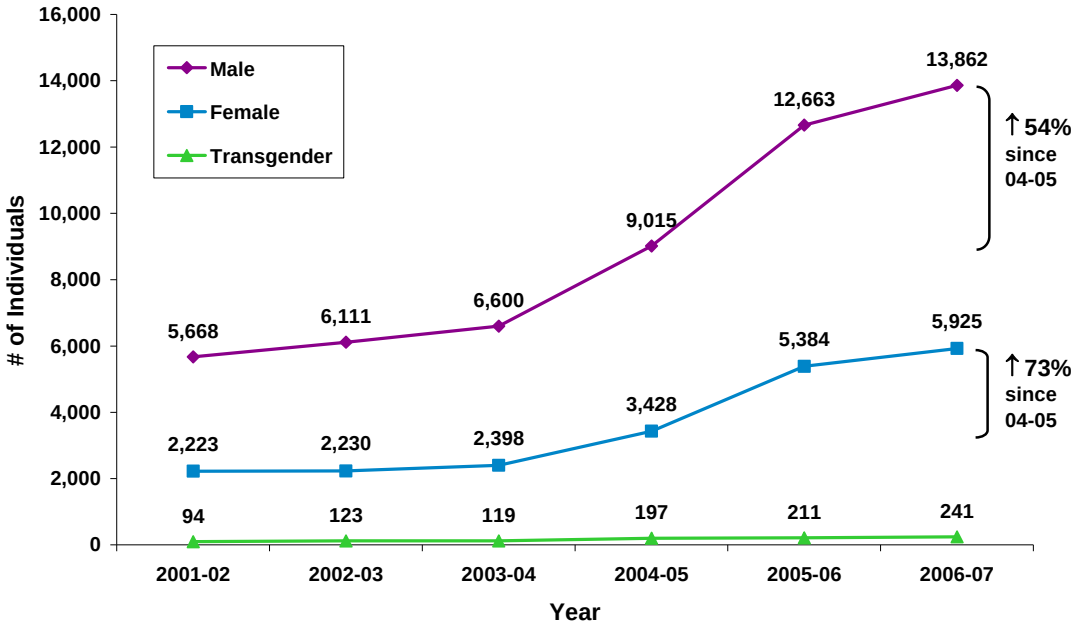


More women are using ASOs

Since 2004-05, the average number of women using community-based support services has increased by 73%, while the number of men has increased by 54% over the same period (Figure 61). There has also been an increase in the number of transgendered clients using support services.

[2] Number is the average of the total number of clients served in the first half of the year and the second half of the year.

Figure 61: Average Number of Support Service Users by Gender



Among the 5,925 women served in the last half of 2006-07:

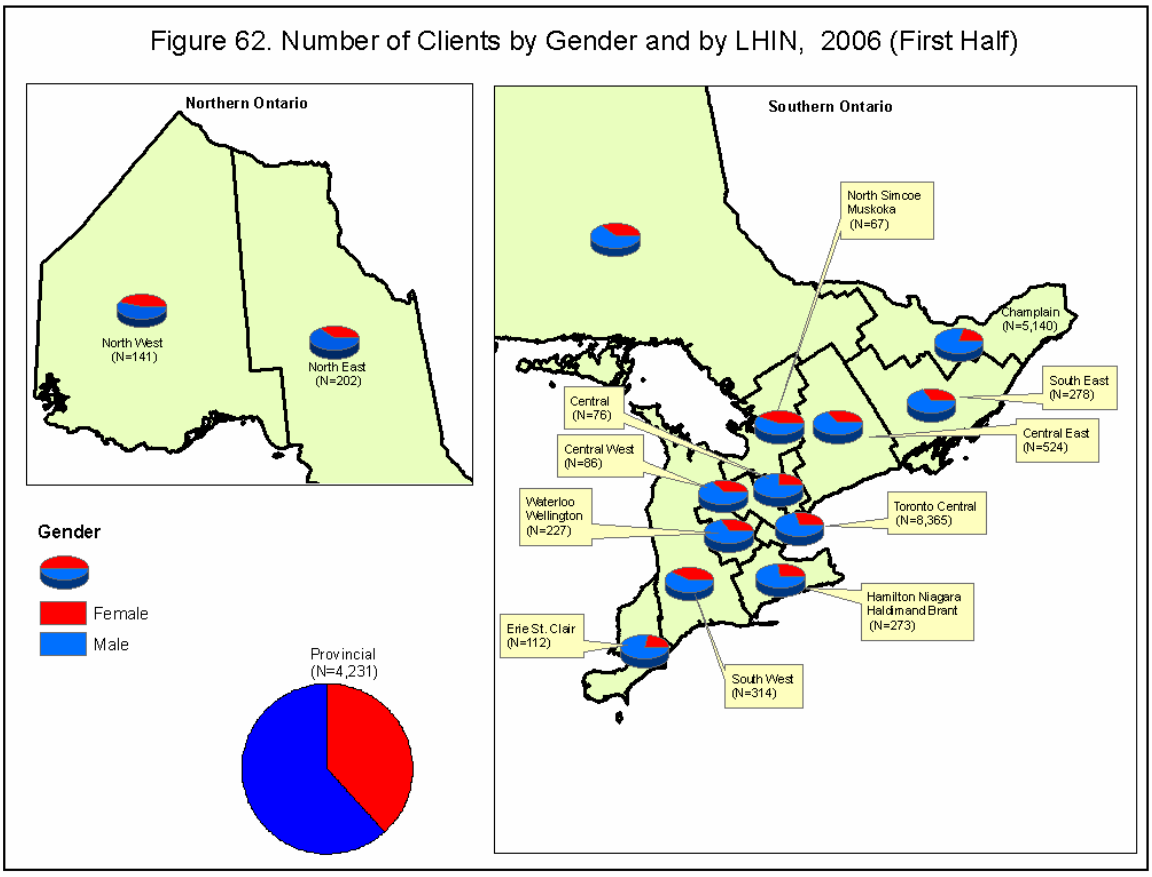
- 2,504 (42%) were PHAs
- 1,875 (32%) were affected
- 830 (14%) were family and friends
- 695 (12%) were other.

Women account for almost half of all family and friends served by ASOs.

Organizations in all parts of the province are serving women

Every LHIN region in Ontario has at least one organization that reports providing HIV support services for women in two of the four populations groups: PHAs and family or friends of someone who is infected. By the second half of 2006-07, all except one LHIN region also had organizations serving women in a third group: affected.

Figure 62 shows the proportion of support service clients in each LHIN region who are male and female (note: numbers of transgendered clients is too small to show on chart). The LHIN regions serving the largest number of women with HIV are: Toronto Central, Champlain Ottawa, South East, and Waterloo Wellington; however, LHIN regions serving the largest proportion of women clients are: North West, North Simcoe Muskoka, North East and South West.



The increase in the number of women being served in some LHIN regions (e.g., Waterloo Wellington, South East) may be due to an increase in the number of women with HIV in those regions, changes in agency data collection processes, or changes that have made services more accessible to women. For example, with the establishment of the Masai Clinic in Waterloo Wellington and the close links between the clinic and community-based AIDS organizations, women are likely now being seen in both places, and the same women may be being counted by both organizations. The Masai Clinic may also be attracting women from outside the region.

Agencies in two LHIN regions (Champlain, Central East) report serving significantly more affected women than women with HIV compared to other LHIN regions. This may reflect specific efforts to target women at risk.

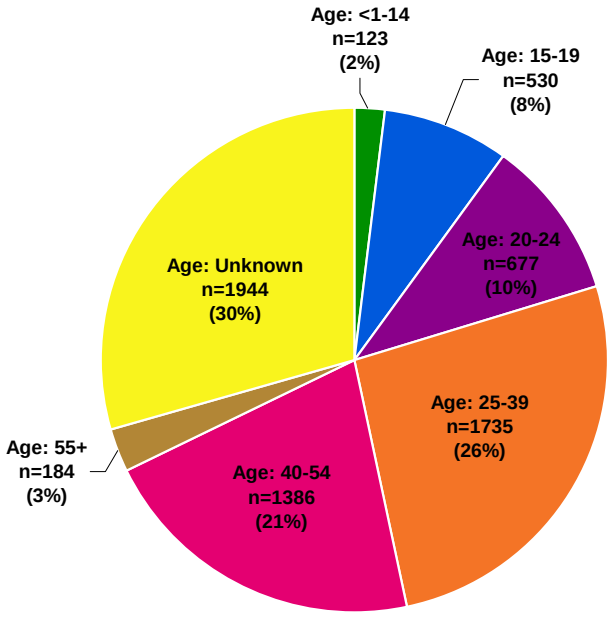
Organizations in 7 of 14 LHIN regions report serving transgendered clients

Half of the LHIN regions have organizations that reported serving transgendered clients in 2006-07: Central East, Central West, Champlain, Hamilton Niagara Haldimand Brant, South East, South West and Toronto. Organizations reported serving just over 100 transgendered clients in 2006-07 (not including those served by provincial organizations).

Most clients are between the ages of 25 and 54

The majority of people using support services (47%) continue to be between the ages of 25 and 54, while 10% are under age 20, 10% are between the ages of 20 and 24, and 3% are over age 55 (Figure 63). However, the age of a significant proportion of clients (30%) is unknown.

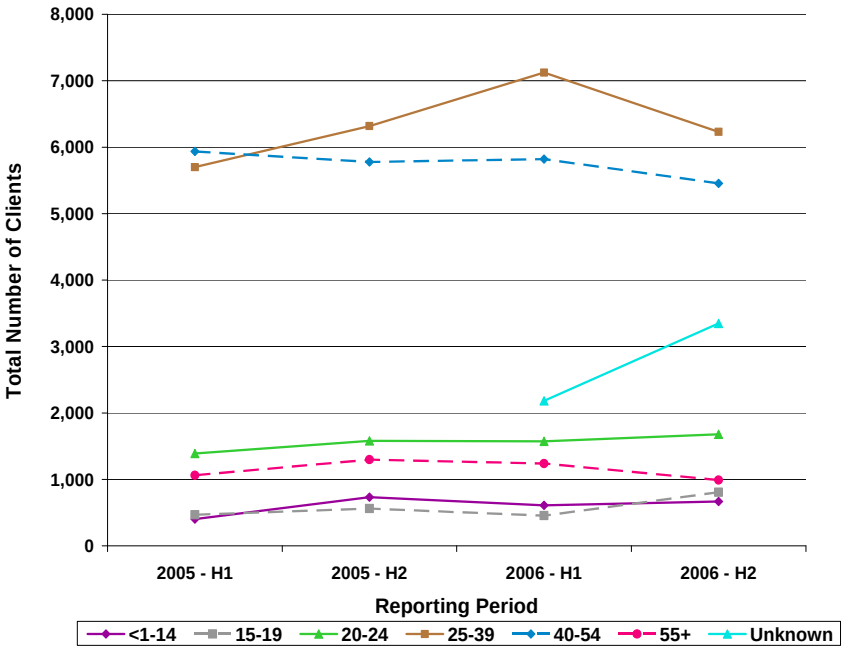
Figure 63: Support Services Provided by Age: 2006 - H2



During the first half of 2006-07, there was an increase in the number of clients between the ages of 25 and 39, but by the second half the number was comparable to the same period in 2005-06.

By tracking the age distribution of clients over time, it may be possible to assess the effectiveness of both prevention and treatment programs. Having an aging client base in support programs indicates that both treatment and prevention programs are working.

Figure 64: Number of Clients Using Support Services by Age



More clients from high risk populations

Organizations reported that, in 2006-07, they were seeing more:

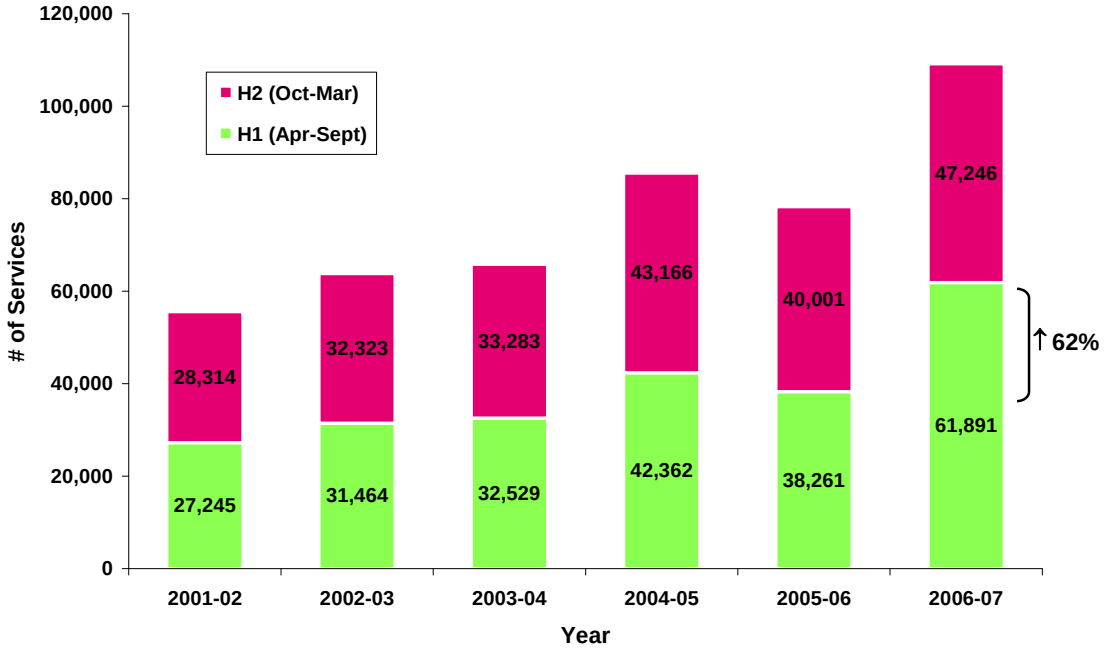
- women living with HIV
- people who use substances
- "street" populations
- gay men returning for support services
- immigrants and refugees
- people from the African and Caribbean communities – many of them young
- Aboriginal people – particularly women and youth, and two spirit and trans women
- people who are/were incarcerated
- nontraditional families
- clients in hospital
- long-term survivors.

A 40% increase in support services

Organizations are required to track the total number of clients who access each type of service during each reporting period. A client may use more than one type of service during a reporting period but would be counted only once for each service regardless of how often they use them. For example, a client may attend six counselling sessions but would be counted only once as having accessed counselling services.

Agencies reported more clients using more support services during 2006-07 (Figure 65). In fact, the increase in the number and range of services used (40%) was much greater than the increase in the number of clients (see Figure 57).

Figure 65: Number of Support Services Provided

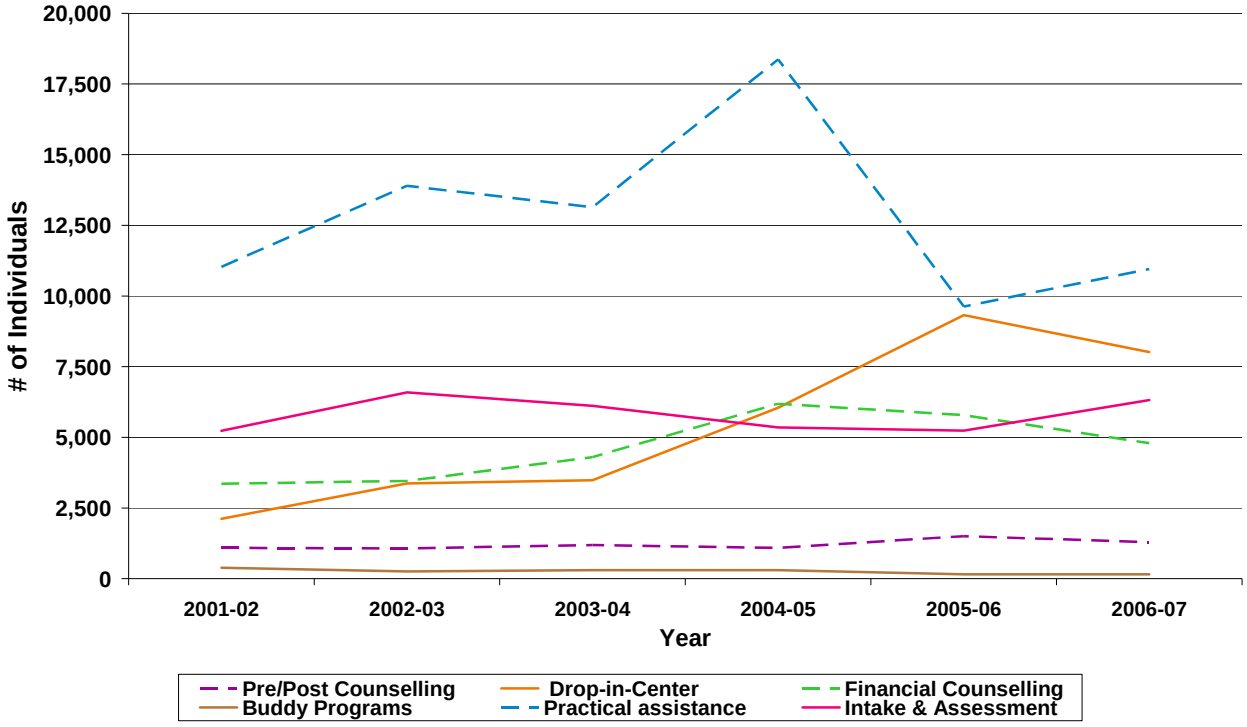


The increase in services used may be due to the increase in funding, which allowed organizations to hire more staff and provide more services and/or to increased demand from a larger number of clients, or it may be due to clients' increasingly complex needs. There is also anecdotal information that suggests some of the increase may be due to the AIDS 2006 delegates who remained in Canada and required services.

Because support services are not clearly defined (i.e., is a counselling session 15 minutes or 1 hour?) and organizations are counting only the number of people who used a given service and not how much or what mix of services they used, it is difficult to interpret these numbers or determine the level of service available in different parts of the province.

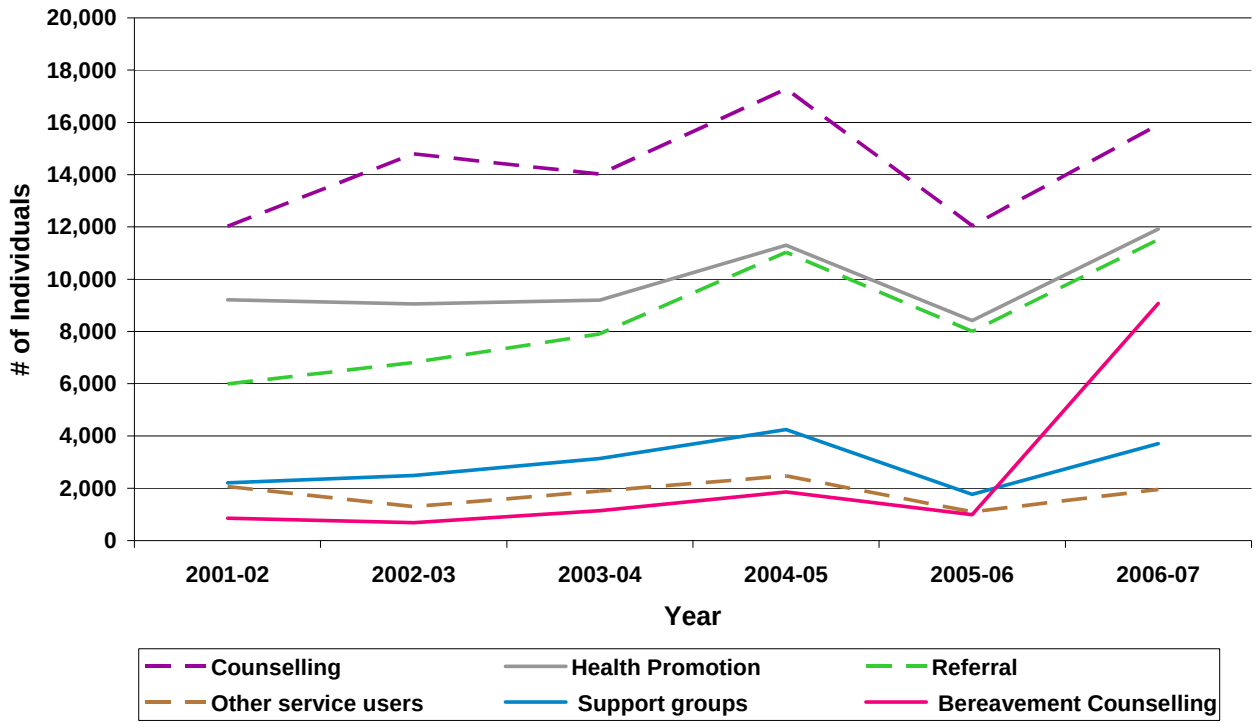
The following figures[3] show the trend in the number of clients using different support services. Figure 66 and Figure 67 list support services that have been part of reporting since 2001-02, while Figure 68 lists support services added when OCHART was introduced in 2005-06.

Figure 66: Support Services Provided (since 2001) where the Increase from 05-06 to 06-07 was <30%



[3] Note: the numbers for figures 66, 67 and 68 were calculated by adding together the number of services used in each reporting period of each year.)

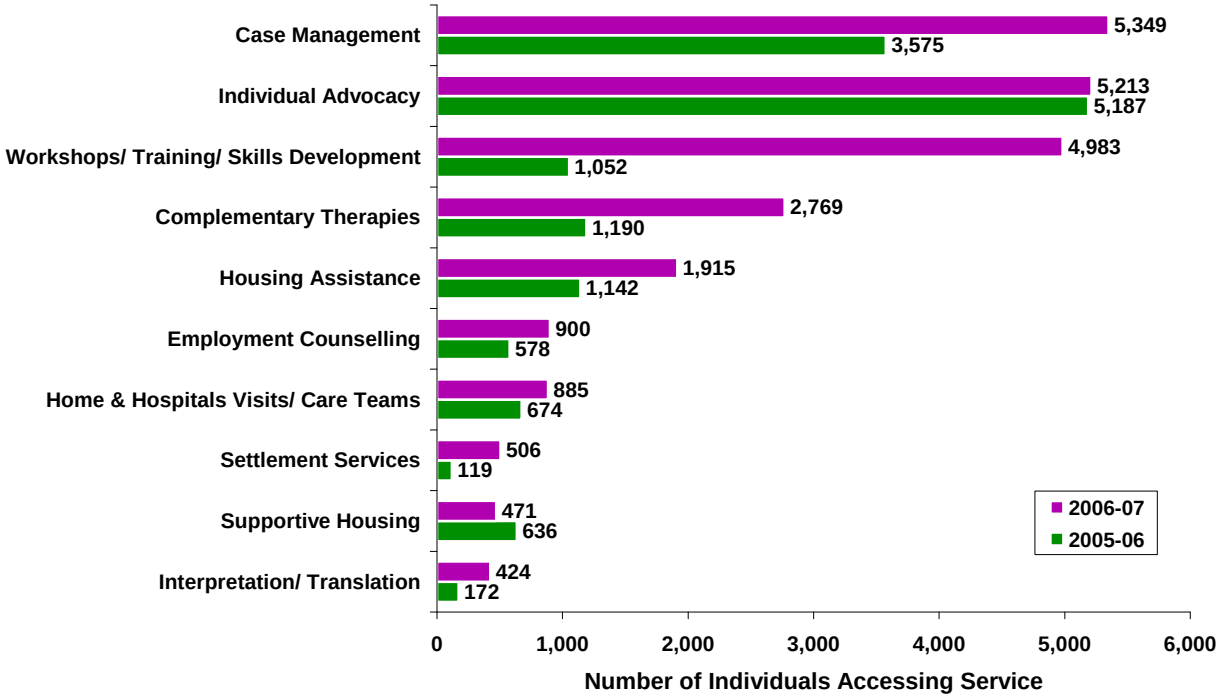
Figure 67: Support Services Provided (since 2001) where the Increase from 05-06 to 06-07 was >30%



In terms of the support services that have been tracked since 2001, a significant and growing number continue to make use of counselling and practical support services, and a growing number are accessing health promotion services, referral services, drop-in services and support groups. Note: the drop in the number of services used in 2005-06 was due to the switch to OCHART, which meant that service usage is reported only twice a year, instead of four times a year. The marked increase in bereavement services in 2006-07 was related to sessions held at AIDS 2006.

Among the services that have been tracked since the introduction of OCHART (Figure 68), more clients are accessing case management services (+50%), advocacy (+5%), skills development (+373%), and complementary therapies (+133%). There is also a growing demand for housing assistance (+68%) and employment counselling (+83%) – which reflects the complex social needs of people living with HIV and communities at risk. There has also been a significant increase in the number of clients using settlement services (+325%) and interpretation and translation services (+146%), which reflects the impact of HIV on newcomers, including refugees as well as the large number of people with HIV who remained in Canada after AIDS 2006. The increased use of employment counselling and training/skills development may be related to the larger proportion of people with HIV interested in continuing to work.

Figure 68: Support Services Provided (*New Services Added 2005)



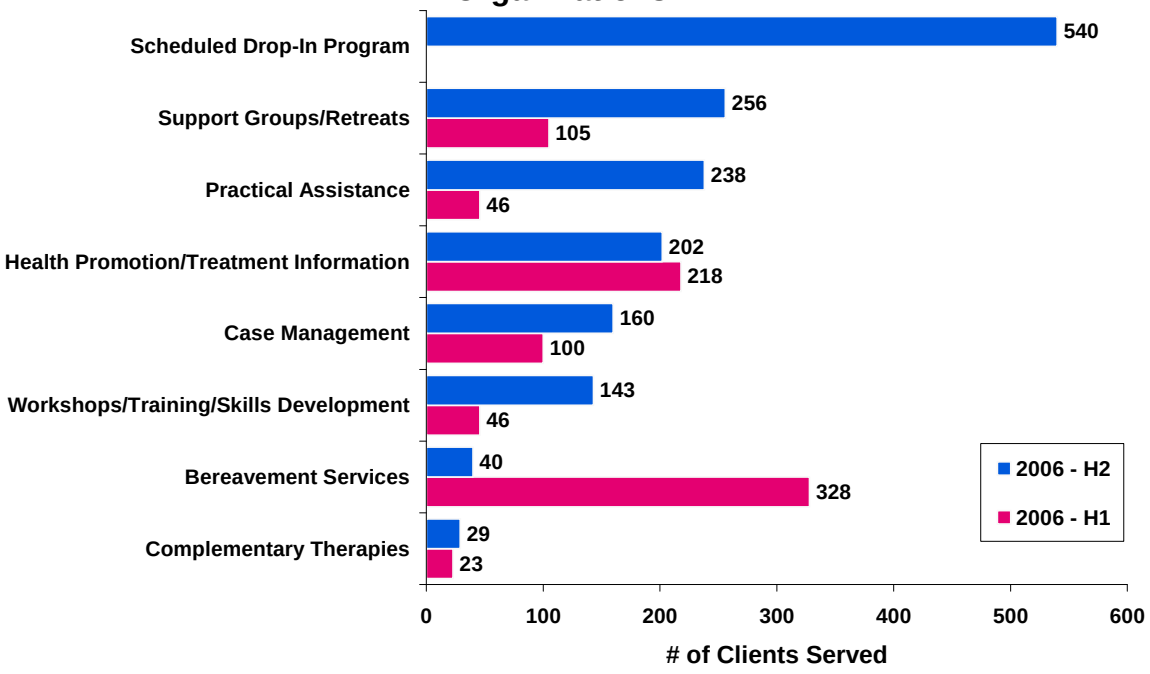
In terms of the "other" services that agencies reported providing, they included:

- a cab ride program
- information about HIV testing
- infant formula
- medical services (e.g., blood work, vaccinations, doctor services)
- a community kitchen
- holiday hamper programs
- tutoring services for children.

ACAP funding used to provide drop-in and other services

In 2006-07, organizations that received ACAP funding reported that they used the funding to provide a range of support services, focusing particularly on drop-in programs, bereavement services, support groups, practical assistance and health promotion and treatment information, and workshops (see Figure 69).

Figure 69: Number of Clients Served by Type of Support Service and by Reporting Period - ACAP Funded Organizations



People living with HIV most likely to use practical assistance

In terms of the types of services used most frequently by different types of clients, organizations reported that:

- people living with HIV in 2006-07 were more likely to use practical assistance and referrals
- people at risk were more likely to use counselling services
- family and friends were more likely to use practical assistance.

Slight differences between services used by women and men

When the services used are analyzed by gender, there are slight differences between the types of services used by women and those used by men.

The services used most often used by women were:

- counselling
- practical assistance
- health promotion and treatment information
- referrals
- case management

- intake and assessment services.

The services used most often by men were:

- counselling
- drop-in services
- practical assistance
- referrals
- health promotion and treatment information
- financial counselling
- individual advocacy
- intake and assessment services
- case management services
- support groups.

Regional variations in support services

It is possible to use OCHART data to examine and compare the mix of services provided in different parts of the province. For example, as the following charts from two LHIN regions (Toronto n = 31 organizations (Figure 70), and North East n = 5 organizations (Figure 71)) illustrate, both regions provide the full range of support services, but clients may access certain services at different times of year or there may be more demand for certain services based on local needs.

Figure 70: LHIN: Toronto Central - Support Services Provided in 2006-07

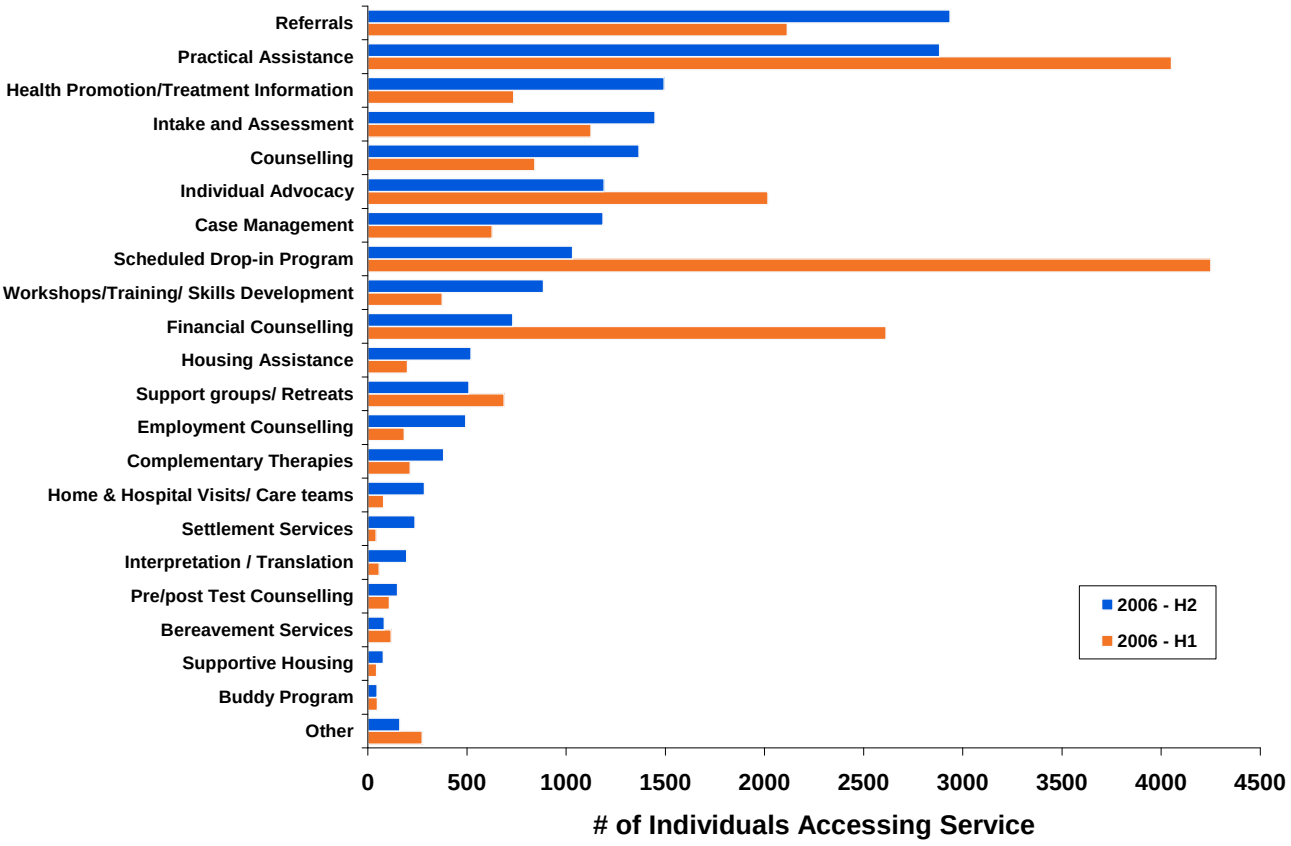
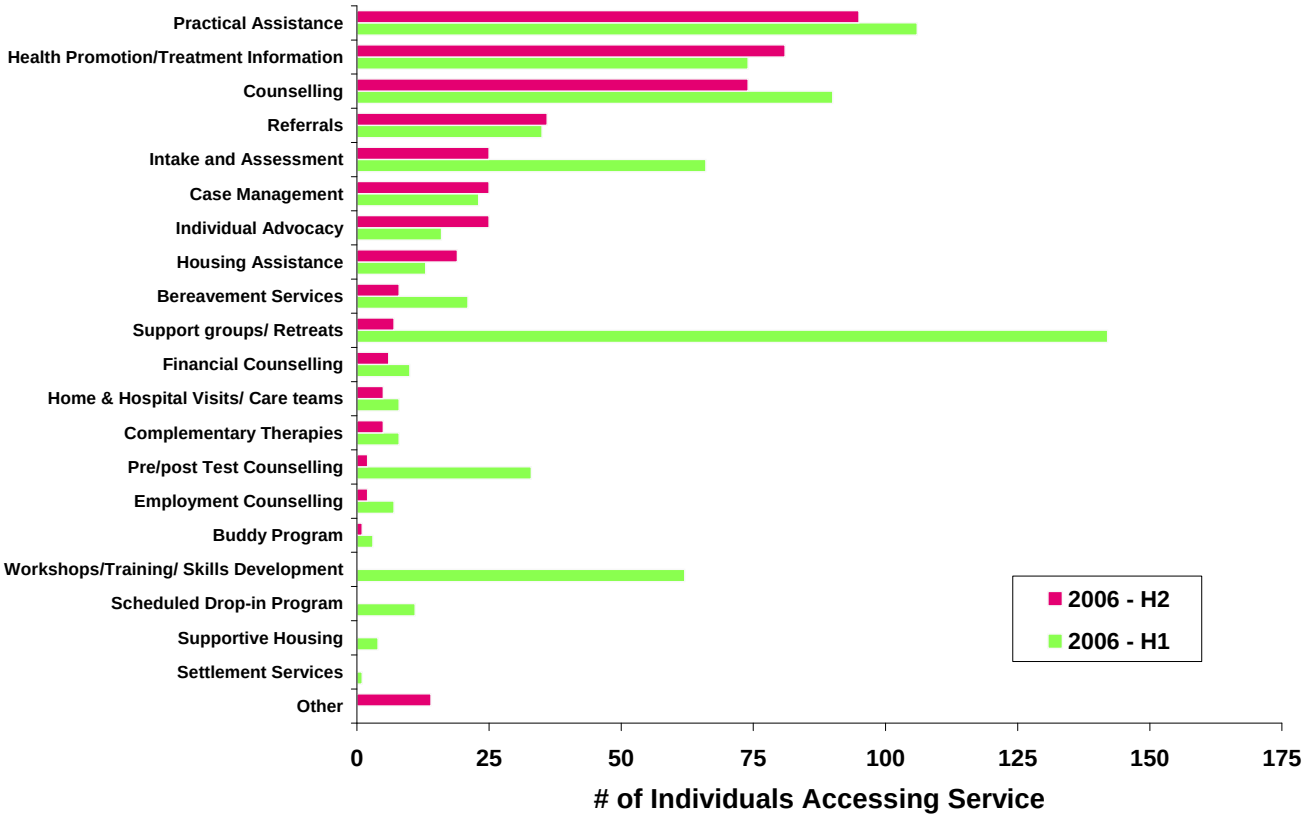


Figure 71: LHIN: North East - Support Services Provided in 2006-07



The increase in drop-in services and individual advocacy in Toronto in the first half of 2006-07 is likely related to AIDS 2006.

Regionally, we are seeing some significant changes in demand for services. For example, between the first and second halves of 2006-07, there was more than a 100% increase in the number of clients using:

- employment counselling
- buddy programs
- interpretation and translation services
- settlement services.

These service increases are consistent with trends reported by organizations including: more clients living longer and needing help with employment, more clients becoming ill and needing support, and more clients who are recent immigrants or refugees.

Trends in support groups

Over the past three years, there has been a steady increase in the number of support groups provided by community-based organizations (Figure 72).

Figure 73 illustrates the number of support groups held in each region by target group (i.e., people living with HIV, affected/at risk, family and friends, other).

In all regions except Northern, the majority of support groups are for people living with HIV.

Figure 72: Number of Support Groups for Service Users

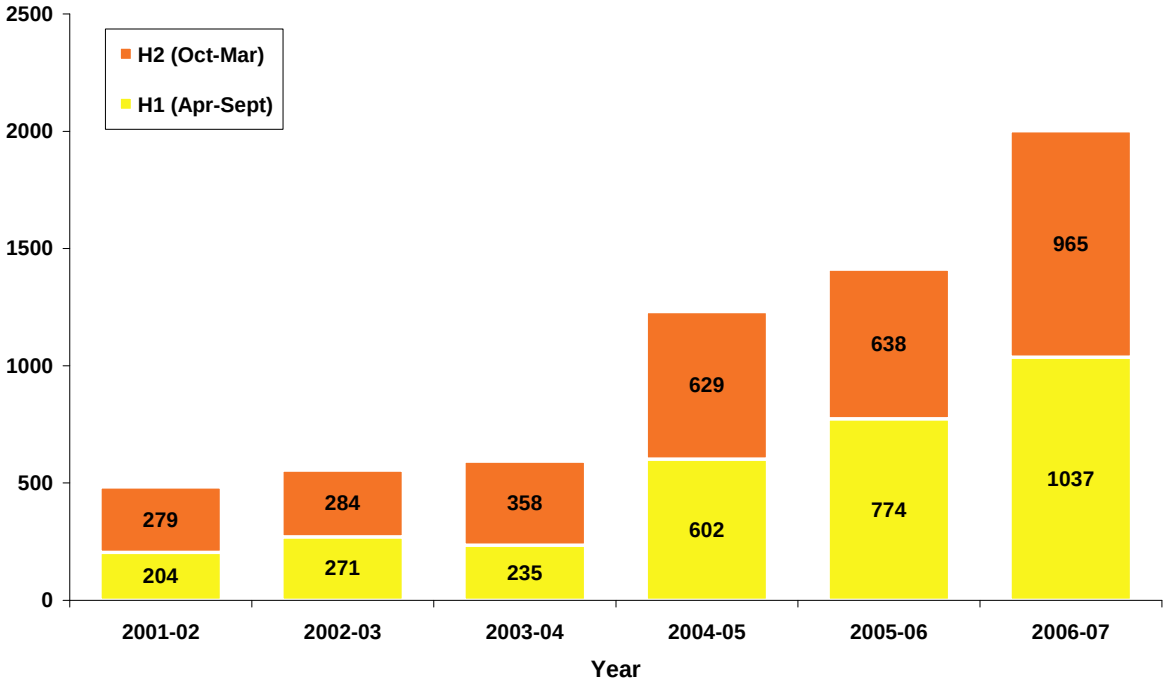
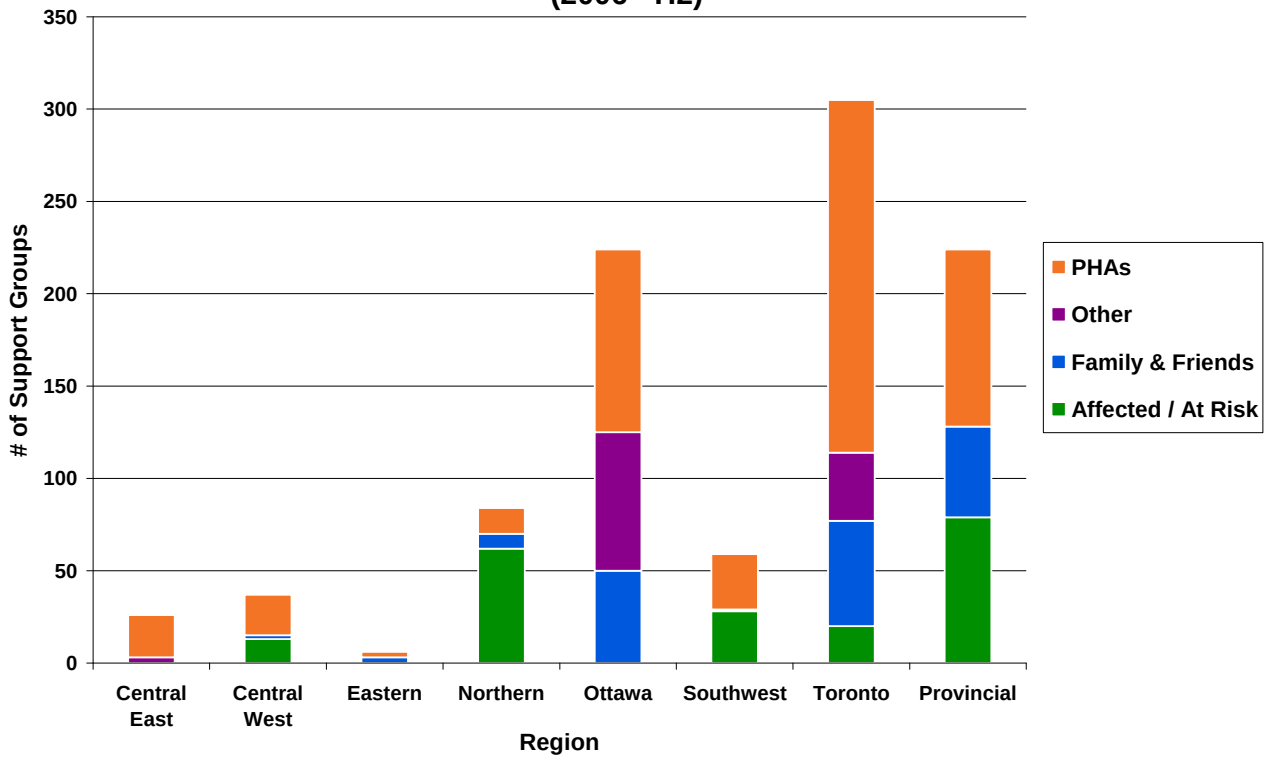


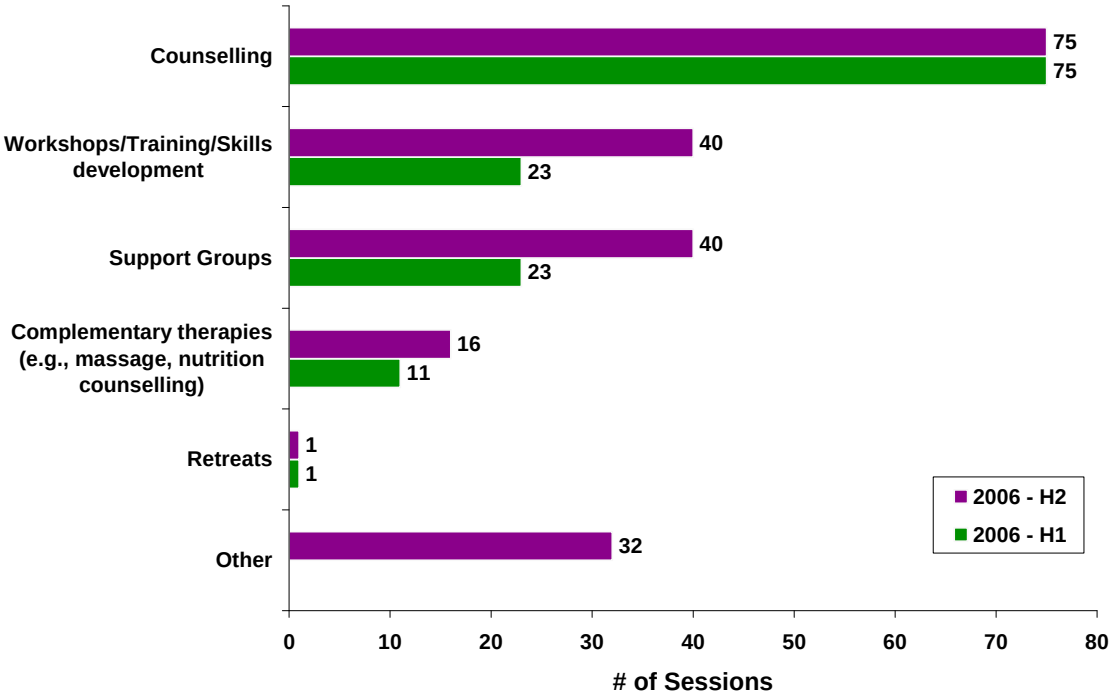
Figure 73: Support Groups Reported by Client Type and Region (2006 - H2)



ACAP Health Promotion for PHAs

ACAP funds a number of organizations to provide health promotion programs for people living with HIV. Figure 74 lists the type of services provided as part of this program, and shows that agencies were able to provide more sessions in the second half of the year. The additional sessions were used to provide more support groups, skills training, complementary therapies and "other" services, which included monthly scheduled drop-ins for young people living with HIV/AIDS and weekly scheduled drop-in sessions for all individuals living with HIV/AIDS.

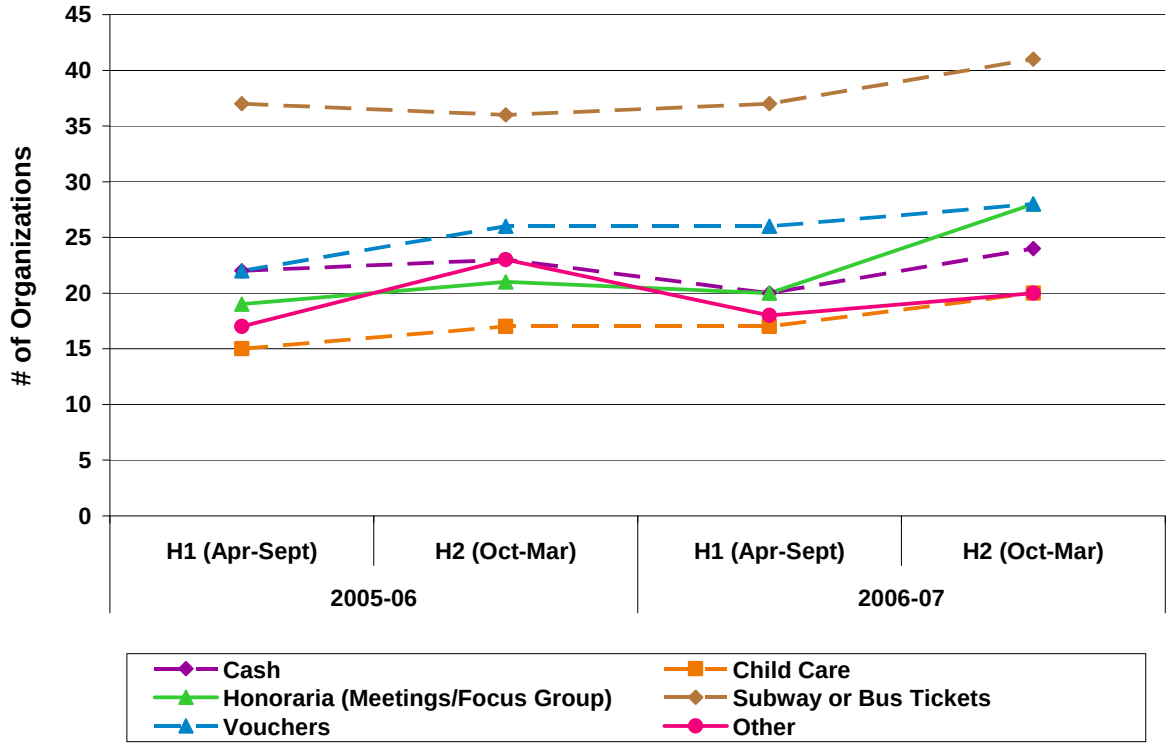
Figure 74: Sessions Provided by ACAP Funded Organizations



Increase in assistance with transportation

OCHART asks organizations whether they provide financial assistance to clients, and the type of financial assistance they provide. This information provides a way to assess clients' financial stability and identify gaps in other services, such as social assistance. About 70% of organizations indicated that they are providing financial assistance in the first half of 2006-07 and 78% in the second half up from 61% and 62% in each reporting period in 2005-06 (Figure 75). Financial assistance can be provided in different forms, such as cash, vouchers and bus tickets. In 2006-07, more organizations provided assistance with bus tickets than in the past. There was also an increase in honoraria for people participating in meetings and focus groups (reflecting the greater involvement of people living with HIV), child care (reflecting the increasing number of women accessing services) and vouchers.

Figure 75: Number of Organizations Providing Different Types of Financial Assistance



The high demand for assistance with bus tickets is consistent with the transportation issues identified in many community plans.

In addition to the items listed above, organizations reported providing financial assistance in the form of:

- basic necessities, such as food, nutritional supplies, baby supplies, clothing, child's car seats, winter clothes, socks, work clothes, hygiene products
- assistance with housing, rent, utilities, and moving costs
- assistance with health care costs, such as prescription co-pay amounts and Trillium deductibles, complementary and alternative therapies, dental costs and glasses
- equipment such as orthotics, helmets, knee pads, crutches, medical supplies, wheel chairs, medical alert bracelets and other assistive devices
- parking costs, telephone and television during hospital stays
- items that enhance quality of life, such as gift cards, phone cards, Christmas hampers and camp fees.

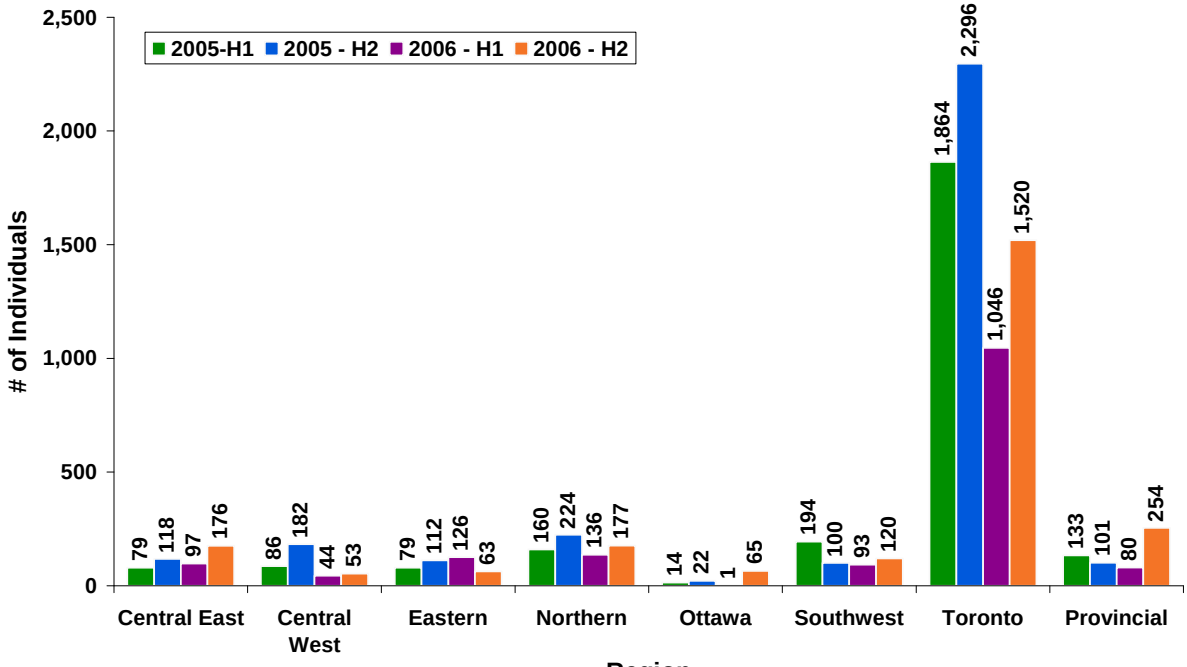
The growing need for financial assistance indicates that income stability is an issue for many clients, and that income programs like social assistance and ODSP are not providing enough income to allow people with HIV to manage their health (e.g., attend appointments, have adequate food).

Financial assistance increases by 28%

OCHART also asks organizations about the value of the financial assistance they provide and the number of clients who receive financial assistance. The questions are voluntary, so fewer organizations responded: 44 in 2005-06, 42 in the first half of 2006-07 (55%) and 50 in the second half (66%). Based on the information provided by organizations, it appears that the amount of financial assistance provided to clients in 2006-07 increased by 29% from 2005-06 to over $862,000. The increase may reflect the larger number of organizations providing this information rather than an actual increase in the amount of financial assistance available to people living with HIV.

As figure 76 illustrates 1,623 people received financial assistance in the first half of 2006-07 and 2,428 in the second half, a decrease from the previous year when 2,609 people received assistance in the first half and 3,155 in the second half.

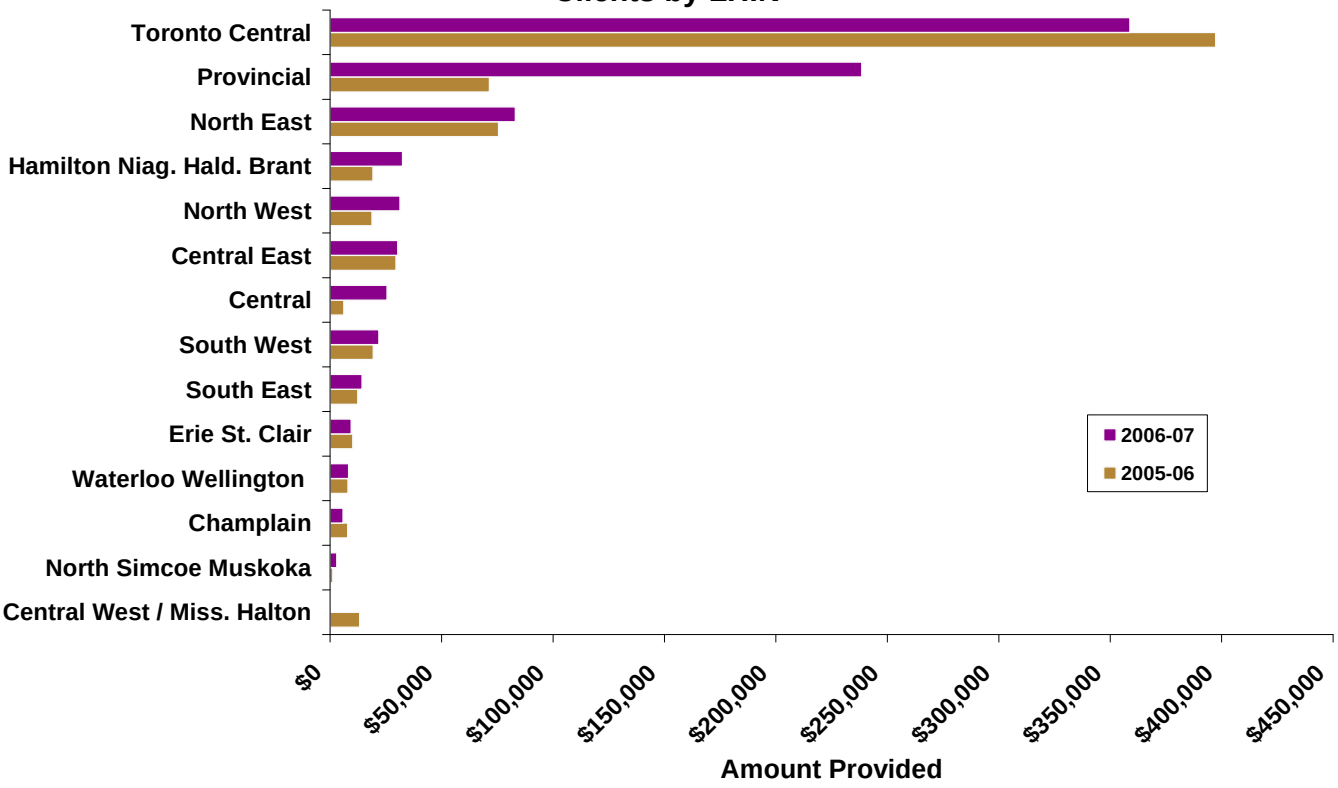
Figure 76: Number of Individuals Receiving Financial Assistance* by Region



*Note that this question is voluntary and thus may not reflect actual numbers

Although the overall amount of financial assistance increased in 2006-07 (Figure 77), the actual number of people receiving financial assistance dropped in a number of regions, including Toronto, Southwest, Central West, Eastern and Northern (Figure 76). In fact, the only regions providing financial assistance to more people in 2006-07 than in 2005-06 were Central East and Ottawa. This means that, in most regions, people who are receiving financial assistance are receiving more financial assistance than they did in the past. This may indicate that, for people living with HIV, the need for financial assistance increases over time. We cannot tell from the data whether there were fewer people requiring financial assistance during the reporting year or whether because individuals needed more support, agencies could only assist a smaller number of people. It may also be that there were errors in reporting or double counting of people in 2005-06, which were corrected in 2006-07.

Figure 77: Voluntary Reporting of Financial Assistance Provided to Clients by LHIN

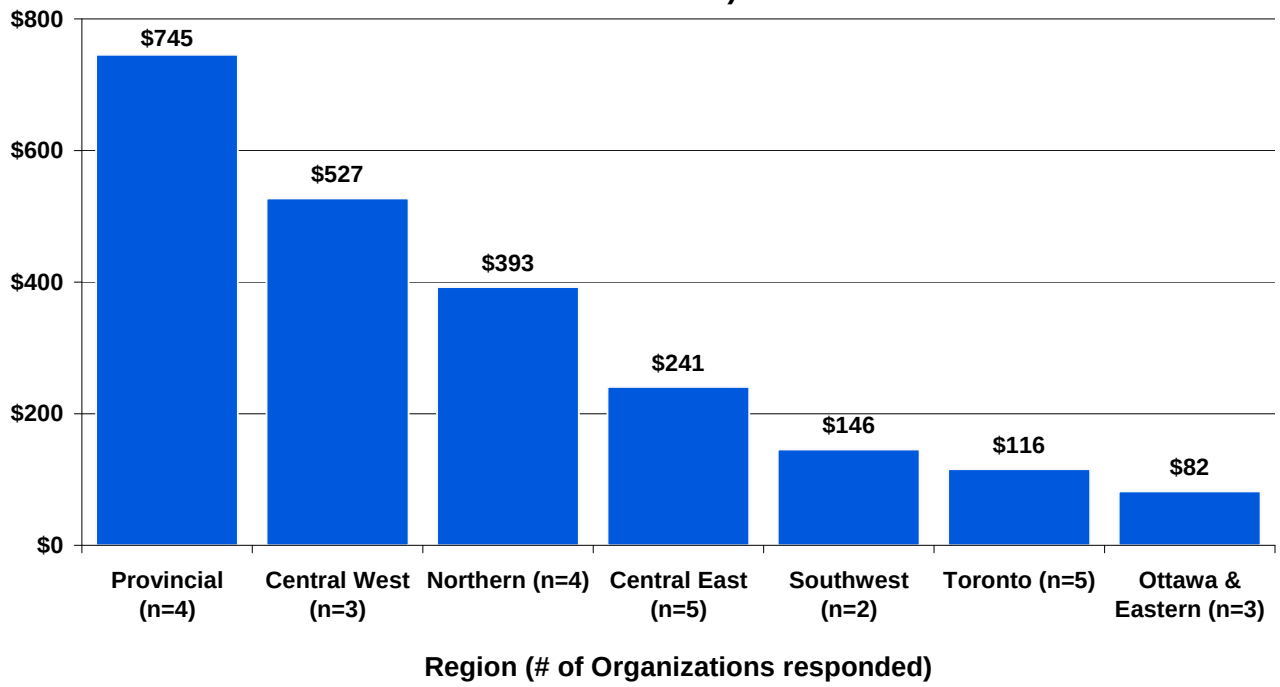


The relatively large amount of financial assistance provided by provincial organizations is due to the Positive Action Fund, which is fundraised and administered by the Ontario AIDS Network. The purpose of that fund is to provide financial assistance to people living with HIV across the province. The OAN distributes Positive Action Funds to ASOs who, in turn, distribute it to clients. This means there may be some double counting of that funding in these totals.

Higher rates of financial assistance in rural and remote areas

While organizations in Toronto Central distribute more money in financial assistance to more people than any other LHIN, they provided less financial assistance in 2006-07 than in 2005-06, and they give significantly less assistance per person than organizations in other LHIN regions (Figure 78). Toronto organizations provided an average of about $116 per person in 2006-07, which is less than the $393 per person distributed by organizations in the Northern region or the $527 per person distributed by organizations in Central West region. The higher amounts of financial assistance in more rural and remote areas may reflect higher costs in those areas for items such as travel and fresh food, as well as the lack of other social services that may be available in larger centres (e.g., food banks).

Figure 78: Average[1] Amount of Financial Assistance Provided per Individual by Health Region - 2006-07 (IDU Outreach Programs excluded)



1 Averages were calculated by dividing Amount of Financial Assistance Given Out by Number of Service Users (section 11.5). This information is not required by organizations and is only provided on a voluntary basis. Thus, the data only represents the organizations that provided information in this section (26 organizations).

Emerging Trends in Support Services

During 2006-07, organizations reported the following trends:

- increased demand for practical and social assistance including food security, basic necessities (e.g., clothing), housing and living expenses, transportation, disability benefits and assistance with medical expense and equipment – and more people using emergency food services
- more clients wanting assistance with employment, legal and immigration issues
- more people using the Harm Reduction/Needle Exchange Program
- clients needing more intense services (i.e., more service encounters, Buddy programs) and workers needing more education on complex health needs, such as interactions between medications required to treat tuberculosis and HIV
- more requests for access to complementary therapies such as massage, Reiki, naturopathy
- for women and children, more requests for fertility consultations, services for adolescents who have been living with HIV since birth, and the need for closer collaboration with the Children's Aid Society when parents are not able to care for their children because of illness
- more interest in bereavement services for family/friends.

In general, organizations report serving more clients who are living in poverty and more dealing with severe health issues including mental health concerns, and kidney and liver disease.

Responding to Emerging Trends

To respond to emerging trends in support services, organizations are using a number of strategies, including:

New partnerships

- developing more partnerships (e.g., with a clothing retailer)
- training staff in other organizations on HIV issues
- meeting with public health, community police and addiction services to discuss implementing the "Four Pillars" approach to drug use in the community.

New/extended programs

- establishing an interactive website that allows sex workers to contact the ASO when they need supplies
- initiating new programs and services, such as a Buddy program, a dental program, long-term survivors support group, a community kitchen, providing and promoting on-site testing
- extending hours into the evenings and weekends

Changes in staffing

- applying for more funding, fund raising and hiring new staff
- recruiting more peers – particularly youth

Fundraising

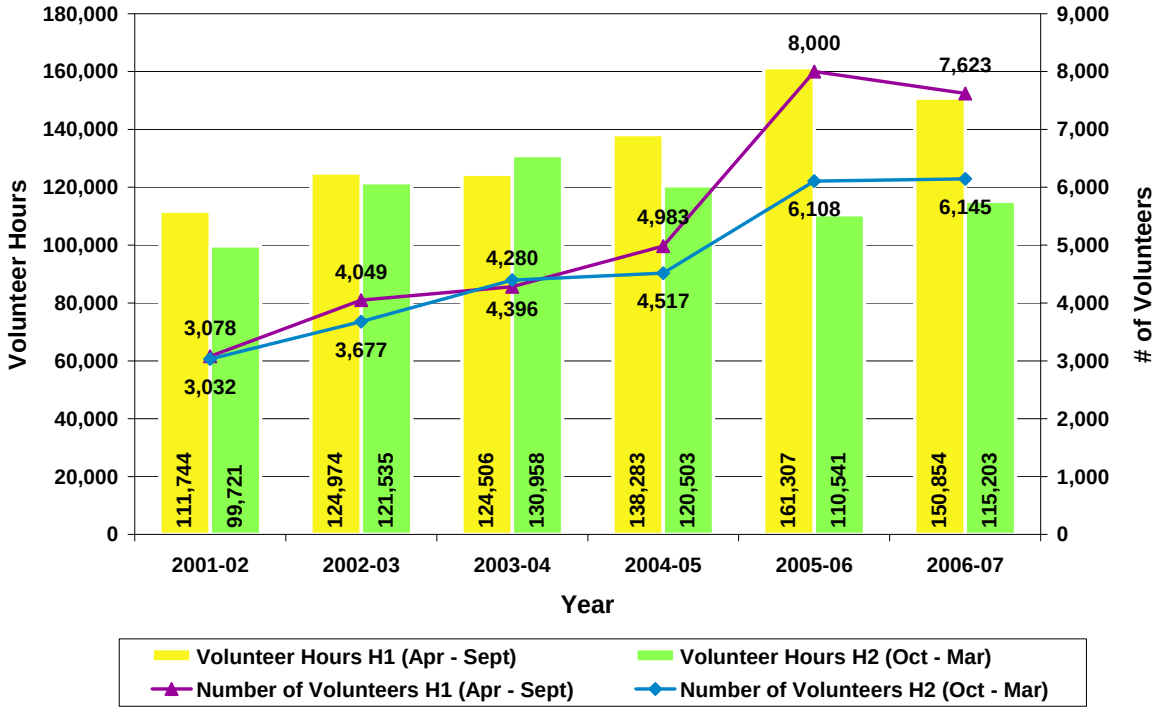
- obtaining funding to be able to provide gift cards, phone cards, nutritional supplements and bus tickets

12. Use of Volunteers and Students

Slight decrease in number of volunteers and volunteer hours

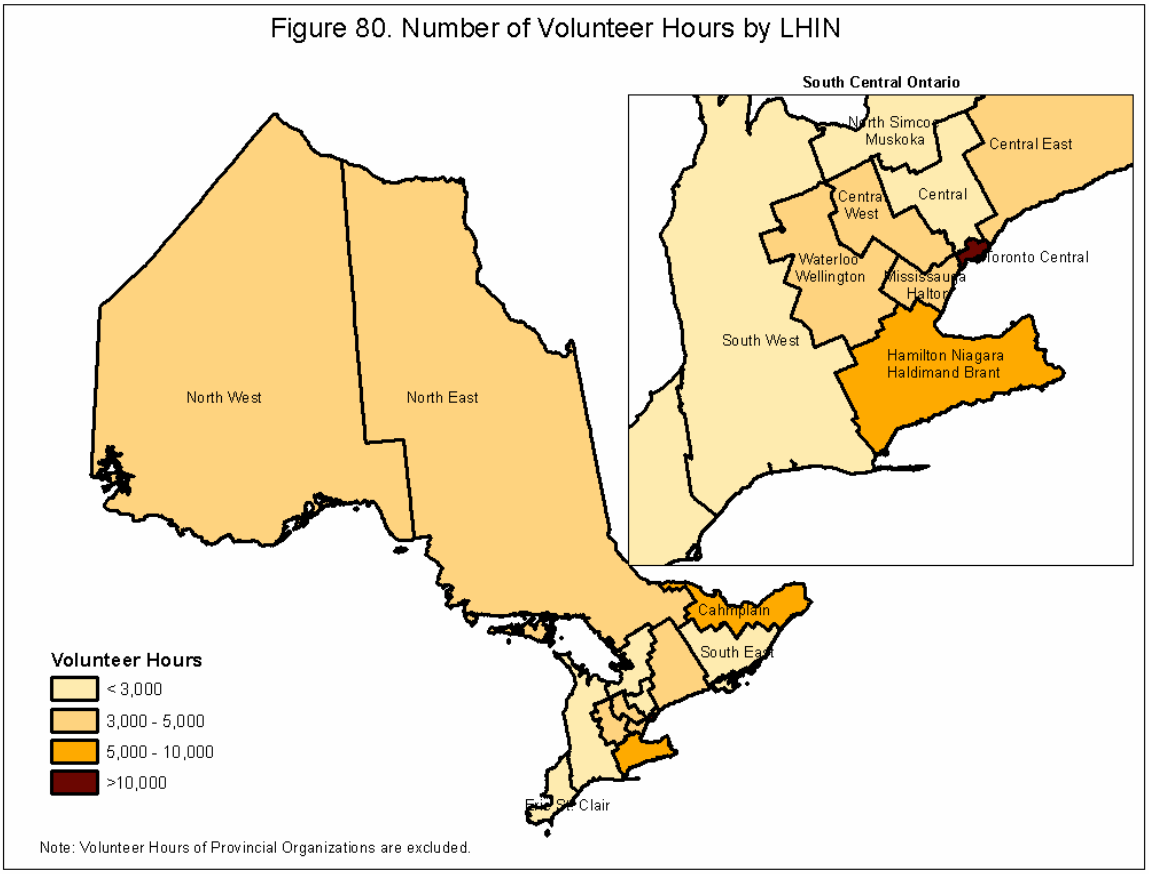
During the last half of 2006-07, organizations had about 5% fewer active volunteers than in 2005-06 (Figure 79). This is the first time since 2001-02 that there has not been an increase in active volunteers, and the decrease occurred despite the large number of volunteers recruited to assist with the international conference. The large number of active volunteers in the first half of the year is likely due to the conference.

Figure 79: Number of Volunteers and Hours Volunteered by Reporting Period



Despite this decrease, organizations continue to attract a significant number of volunteers to help deliver programs and services, and volunteers contributed over 266,000 hours of service during the year – or the equivalent of 146 full-time staff. The total number of volunteer hours of service was down slightly from the almost 272,000 in 2005-06.

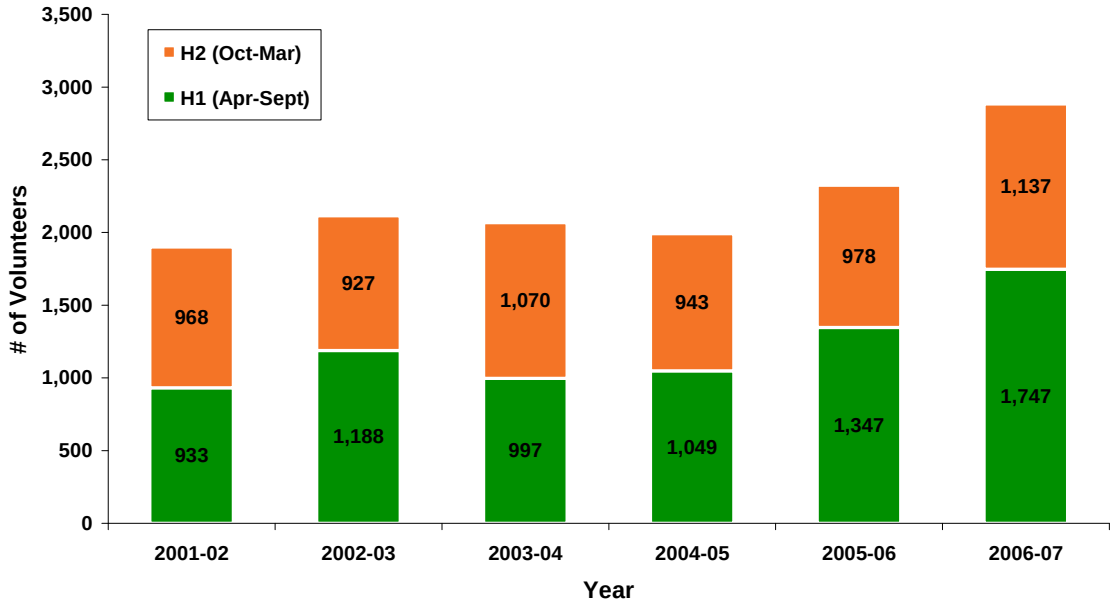
Figure 80 illustrates the number of volunteer hours of service by LHIN. As would be expected, the large urban centres, such as Toronto, Ottawa and Hamilton, reported the largest number of volunteer hours. Perhaps more surprising is the higher number of volunteer hours in more sparsely populated northern LHIN regions compared to LHIN regions in the south.



More new volunteers

As Figure 81 indicates, about 21% of volunteers in 2006-07 were new compared with 16% in 2005-06. It appears that a growing number of people are volunteering for a short length of time, which means that community-based organizations must continue to devote significant effort and resources to recruiting and training new volunteers.

Figure 81: Number of New Volunteers Each Year



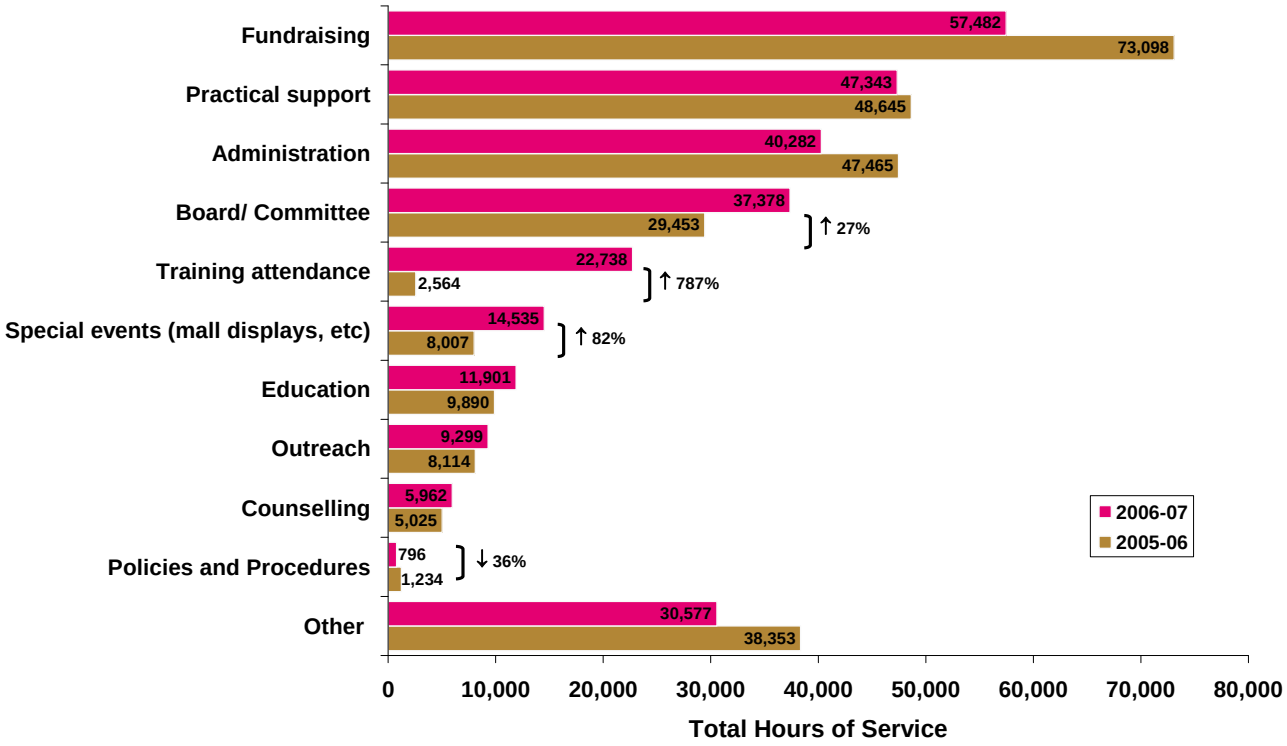
Volunteer roles shift

In 2005-06, about 27% of volunteer hours were devoted to fundraising. In 2006-07, only 21% of volunteer hours were used for fundraising, and there was a significant increase in the number of volunteer hours devoted to serving on boards and committees, attending training events and organizing special events (Figure 82).

Number of volunteer hours down slightly

Volunteers provided a total of 278,293 hours of service in 2006-07, down 2.4% from 2005-06. The drop in volunteer hours was somewhat surprising given the large number of volunteers required for AIDS 2006. During the year, volunteers continued to play a key role in fundraising, providing practical support for clients, providing administrative support for the organizations, and serving on boards and committees.

Figure 82: Hours of Service Provided by Volunteers for Different Organizational Activities



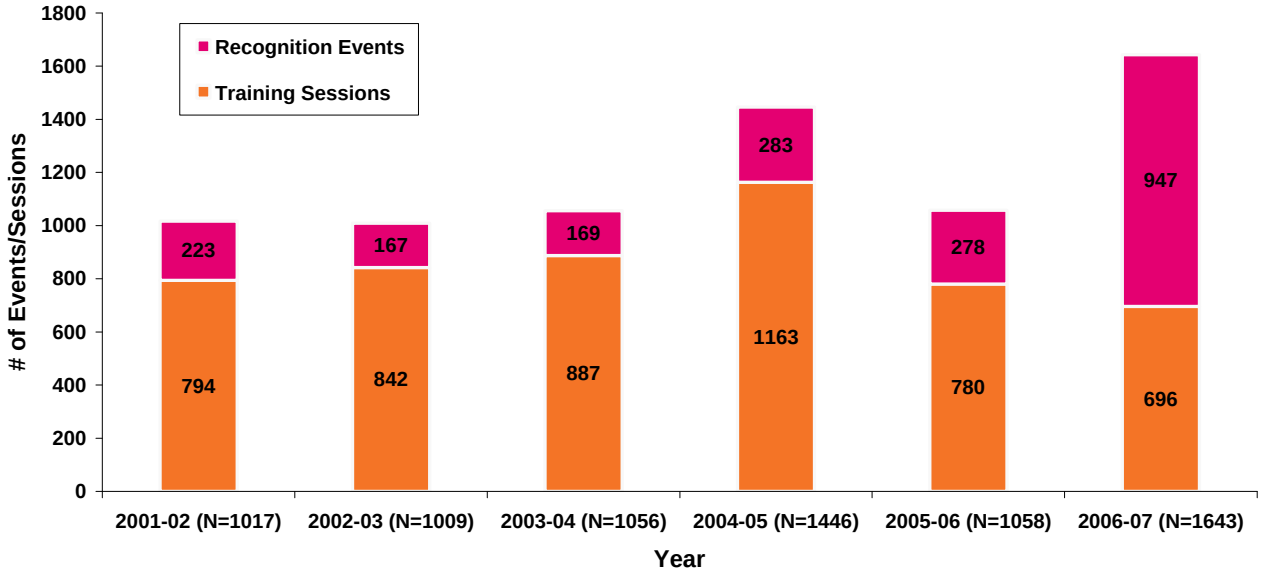
Other volunteer activities in 2006-07 included:

- assisting with the International AIDS Conference
- providing technical and computer skills and support
- developing materials, such as newsletters, graphic designs and red ribbons
- operating the food bank
- providing legal advice or other professional expertise
- helping with maintenance, renovations and gardening
- renovating offices
- training other volunteers.

More volunteer recognition events

Training and recognition programs are effective ways to recruit and retain volunteers, increase volunteer satisfaction, reduce recruitment costs and improve the quality of volunteer services. Although organizations had fewer volunteers in 2006-07 and held fewer training events, they reported holding over three times as many volunteer recognition events. More analysis is required to ensure that this reflects the actual number of events and is not a reporting error.

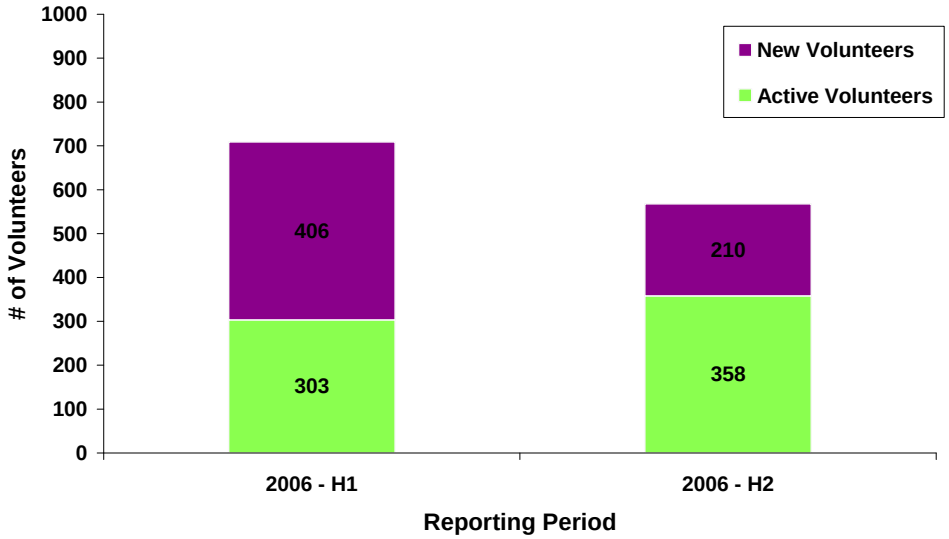
Figure 83: Volunteer Training Sessions and Recognition Events



Number of hours per volunteer depends on volunteer tasks

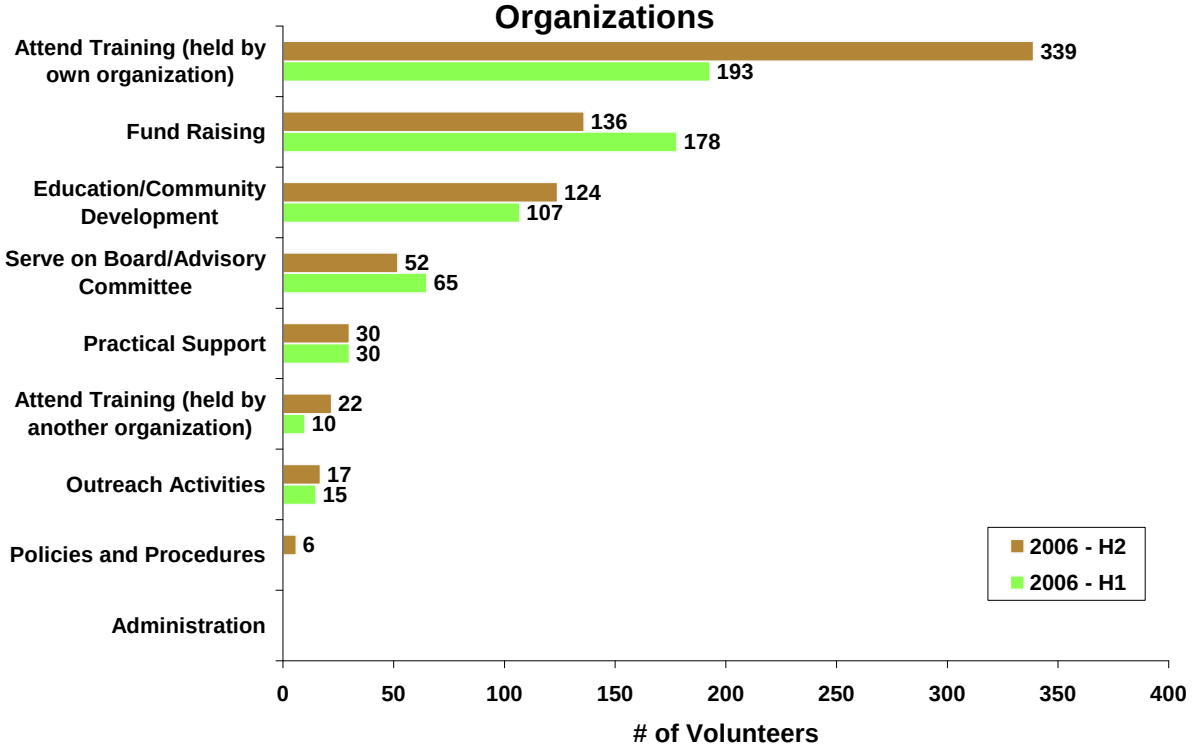
Under the ACAP funding approach Strengthening Community-based Agencies, PHAC funds volunteer coordinators and activities for five organizations. In 2006-07, ACAP-funding organizations reported having a total of 709 volunteers in the first half of 2006-07 and 568 in the second half of the year (Figure 84) who provided a total of 24,282 hours of service – or the equivalent of approximately 14 full-time staff. The higher number of volunteers in the first half of the year may be related to AIDS 2006.

Figure 84: Volunteers (New and Active) at ACAP Funded Organizations



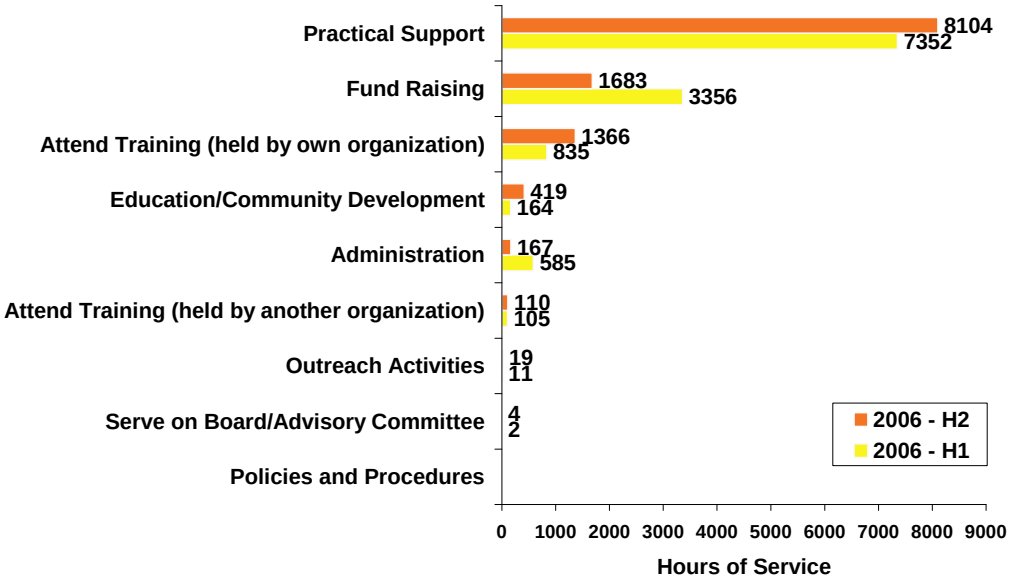
Organizations funded by ACAP reported using volunteers primarily to provide practical support (Figure 85).

Figure 85: Volunteers by Activity Type - ACAP Funded Organizations



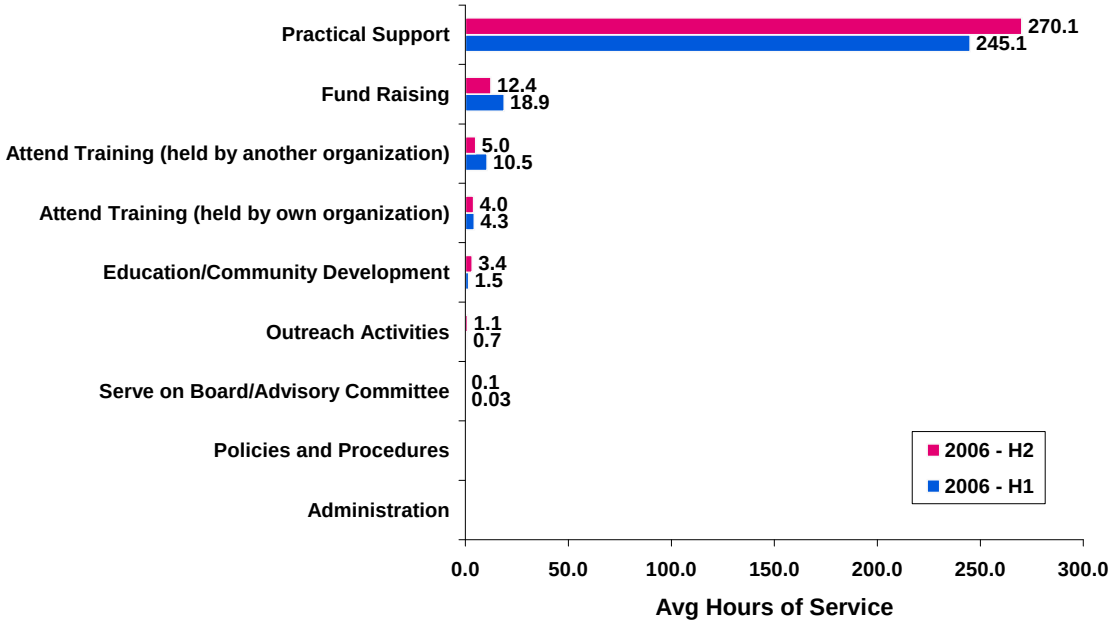
An analysis of the number/type of volunteers and the number of volunteer hours revealed that a relatively small number of people volunteer to assist with practical support compared to fundraising or education/community development; however, practical support volunteers provide on average about 250 hours each every six months, compared to about 15 hours provided by each fund raising volunteer, and 2.5 hours by each education and community development volunteer (Figure 86). Volunteers appear to become more intensely involved with the agencies when they are directly involved in "front line" work.

Figure 86: Hours of Volunteer Service by Activity Type - ACAP Funded Organizations



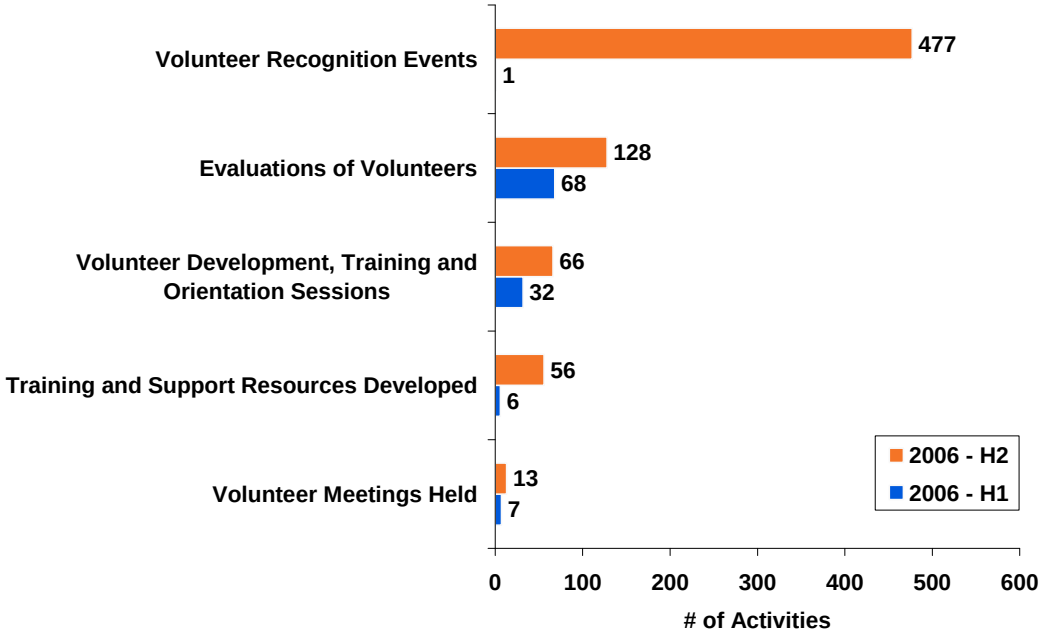
During 2006-07, volunteers at these agencies spent an average of 253 hours per volunteer providing practical support compared to between 12 and 19 hours per volunteer involved in fundraising, and between 1.5 and 3 hours per volunteer involved in community development (Figure 87).

Figure 87: Average Hours of Service per Volunteer by Activity · ACAP Funded Organizations



ACAP-funded organizations also held over half of all volunteer recognition events – almost all of which took place in the second half of 2006-07 (Figure 88). Both the timing and number of events may be related to AIDS 2006.

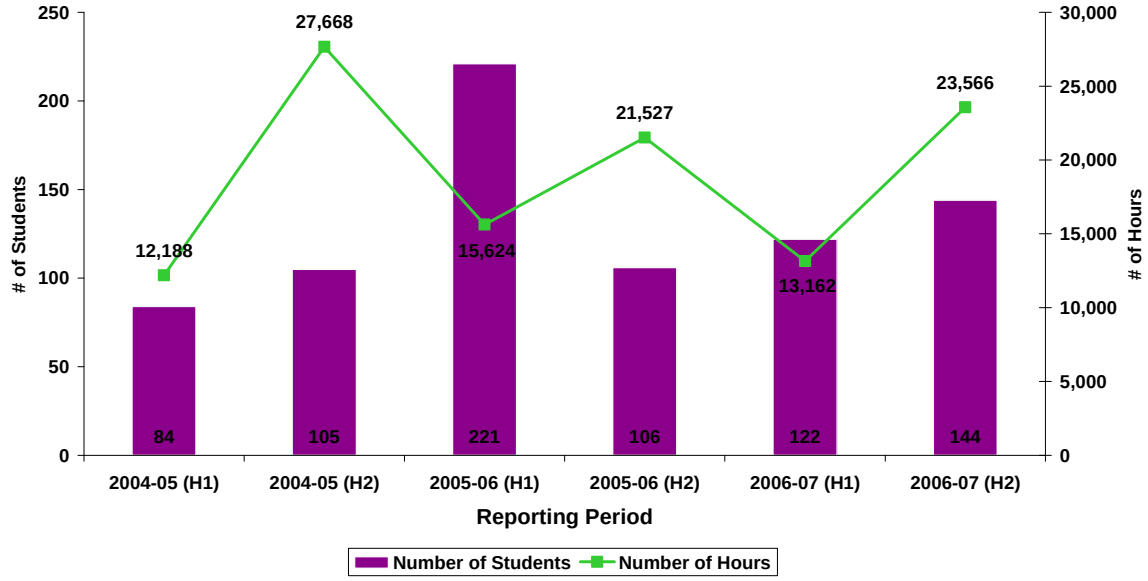
Figure 88: Volunteer Related Activities Reported by ACAP Funded Organizations



Wide variation in number of students and student hours

The number of students volunteering or doing placements at ASOs and the number of hours they contribute continues to change dramatically from one reporting period to the next. Organizations had significantly fewer students in the first half of 2006-07 compared to the first half of 2005-06 (Figure 89). In the second half of both years, organizations benefited from a relatively large number of hours given the number of student volunteers. Between the first and second half of 2006-07, there was a 79% increase in the number of service hours contributed by students despite only an 18% increase in the number of students. In fact, the hours of work provided by students in the last half of 2006-07 were the equivalent of about 13 full time staff.

Figure 89: Student Volunteers and Hours Contributed by Reporting Period

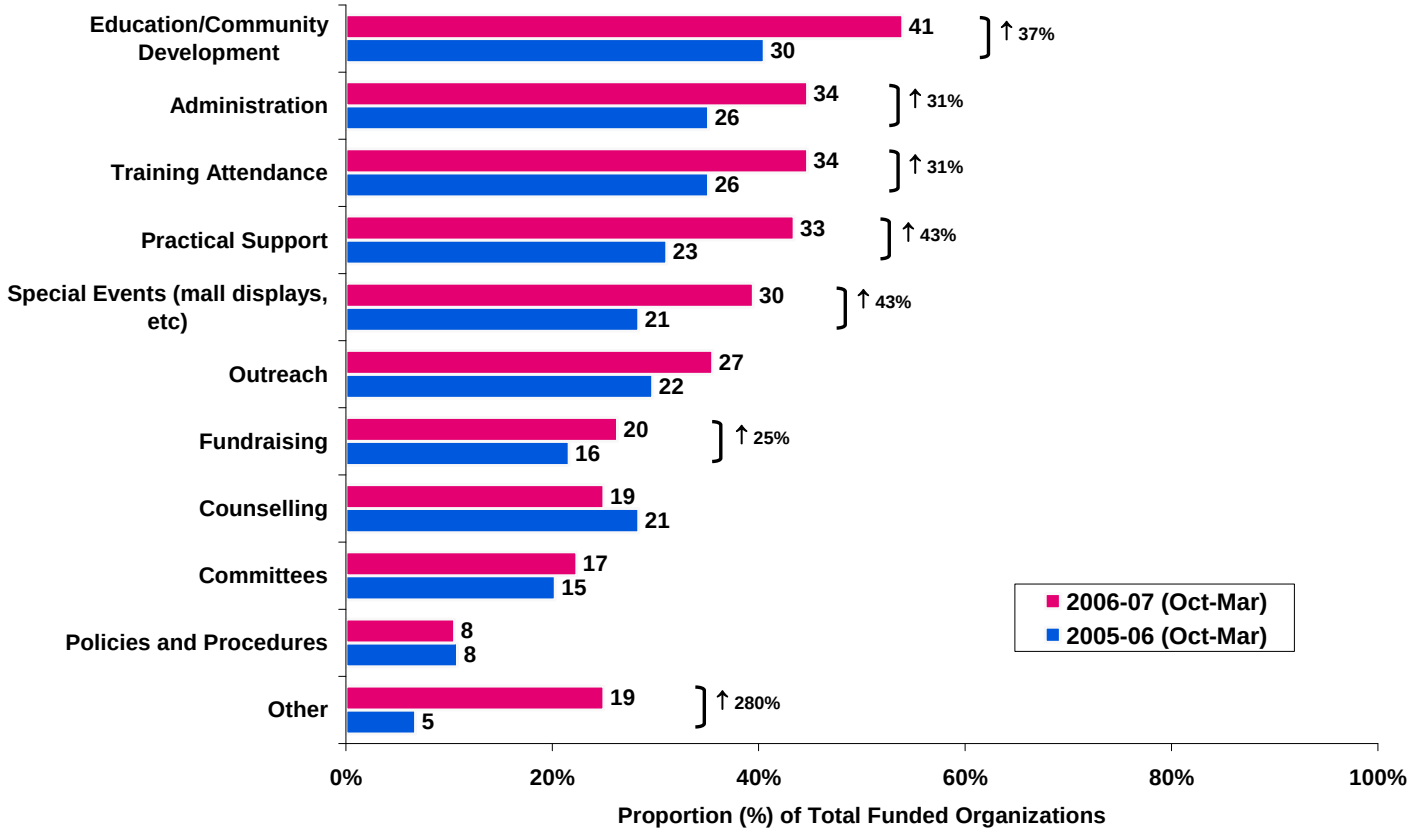


The number of students and hours likely varies based on whether the students are in high school and trying to meet requirements for community service or in post-secondary programs and completing placements.

More students involved in practical support, special events and education

Organizations involve students in a wide range of activities. In 2006-07, more organizations reported using students to provide practical support, plan special events, provide education and community development services (Figure 90). This may indicate that organizations are attracting more college and university students with skills in these areas, or that they have found effective ways to use high school students. It may also reflect a concerted effort to reach/work with youth (i.e., focus on peer education and outreach).

Figure 90: Student Volunteer Involvement in Organizational Activities



Organizations also reported that students were involved in other activities, such as:

- developing and/or evaluating programs
- conducting client intake interviews
- providing referrals
- researching information for clients
- running/facilitating drop-in programs
- providing services such as massage.

Emerging Trends in Volunteer Services

In terms of emerging trends in volunteer services, organizations identified increased use of volunteers to assist with:

- fundraising and in-kind donations coordination
- office support
- educational/training support
- prevention education programmes and presentations
- assembly of harm reduction supplies
- client home/personal support – including light chores, cooking, visiting, child care, relieving family members and driving
- spiritual counseling

- peer support groups
- supporting the Waiting Room Information Project (website involvement, maintaining and replenishing stock, ordering additional materials as required).

Organizations reported needing more volunteers with experience in fundraising, serving on boards and committees, training, facilitation and interpretation, and translation – including French translation. Only one organization reported a decrease in need for volunteers.

Some organizations reported that – particularly with the high school requirement for community service – they are seeing younger volunteers who need more support. Organizations are also seeing more volunteers who are women from ethnocultural communities, more who are newcomers, and more Spanish-speaking volunteers – many of whom see this as a way to integrate into the workforce. One organization reported more students volunteering because they are interested in being involved in research related to HIV.

Responding to Emerging Trends in Volunteer Services

Organizations are using the following strategies to respond to emerging volunteer trends:

- recruiting volunteers with specific skills, such as fundraising skills, ability to assist with child care and ability to provide translation services
- using community college students to provide office support
- partnering youth volunteers with senior volunteers
- developing tools for volunteers, such as scripts to help solicit in-kind donations
- developing programming and new partnerships to support volunteers as they integrate into the paid workforce
- developing training strategies, such as providing regular anti-racism and anti-oppression training for volunteers and using a partner agency's volunteers to train their volunteers.

As some organizations noted:

"We (more actively than before) recruit from among those whose professional lives extend into their choice of volunteer roles, such as finding nurses to help with smoking cessation support, health sciences students to research actual HIV/AIDS awareness in post-secondary environments and help develop more targeted awareness campaigns, professional clergy for spiritual counselling, RMTs for Complimentary Therapies, pre-med and medical students to collect client-friendly data for distribution, immigration workers for newer clients."

"[We] are sending many interested volunteers to Hospice Alliance so that they will be trained as care givers for those who are in the last stages of life. [We] are also sending our volunteers who have completed the Hospice Training to become trained as personal support workers."

"We submitted a joint proposal for a volunteer coordinator that would span 3 agencies."

13. IDU (Injection Drug Use) Outreach Programs

In 2006-07, the AIDS Bureau of the Ontario Ministry of Health and Long-Term Care funded 16 HIV and IDU (Injection Drug Use) Outreach Programs. The goal of these programs is to reach injection drug users and link them to prevention/harm reduction services, such as needle and syringe exchange programs, and/or to testing and treatment services.

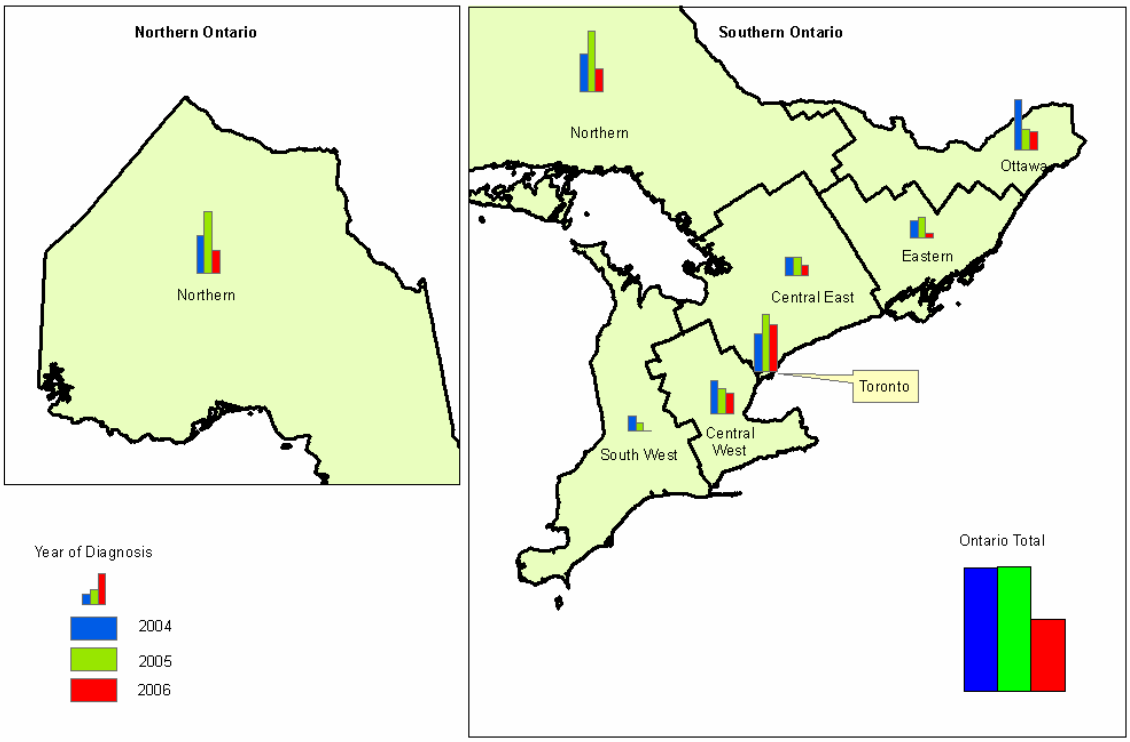
The following is a summary and analysis of their activities.

Trends in HIV Infection in Drug Users

The number of new HIV diagnoses among people who inject drugs increased in 2005 and decreased in 2006. However, based on a preliminary analysis of 2007 data, the drop in the number of cases in 2006 appears to be an anomaly rather than a trend.

Figure 91 illustrates the number and location of new diagnoses in each region from 2004 through 2006. Cases are concentrated in Toronto, Ottawa, Northern and Central West regions.

Figure 91. Number of New Drug- related HIV Diagnoses by Health Region and by Year, 2004-2006



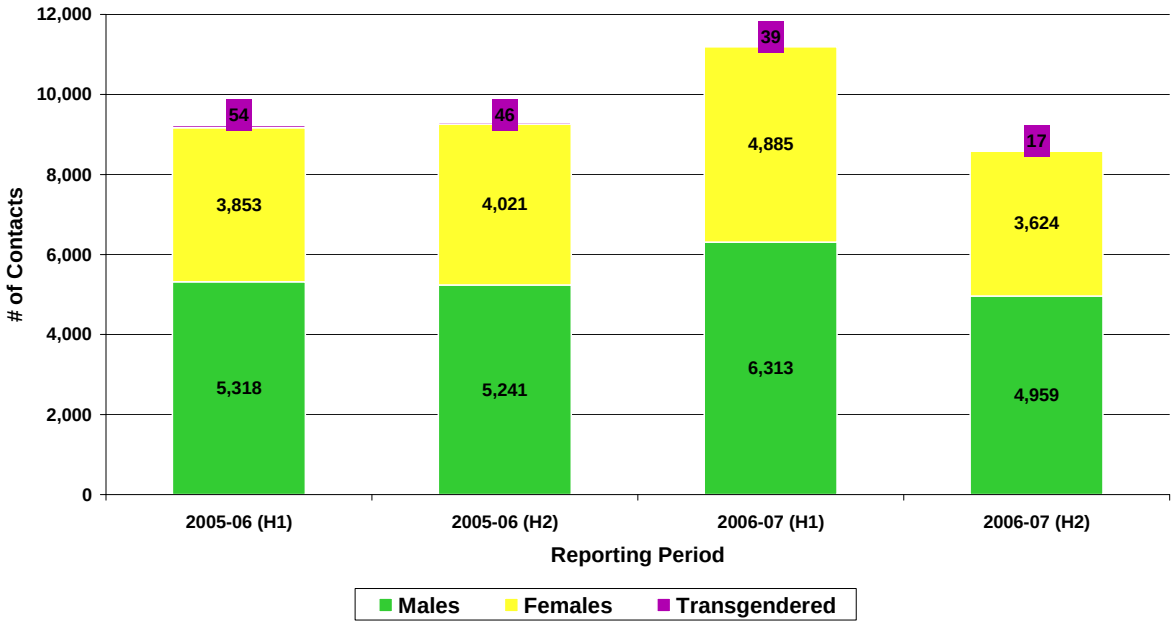
Source: HIV update, Ontario HIV Epidemiologic Monitoring Unit, University of Toronto.

Number of outreach and inservice contacts fluctuates

The IDU Outreach Programs do not collect client-specific data, so they cannot provide information on the actual number of people served, but the programs do track the number of outreach and in-service contacts during each reporting period.

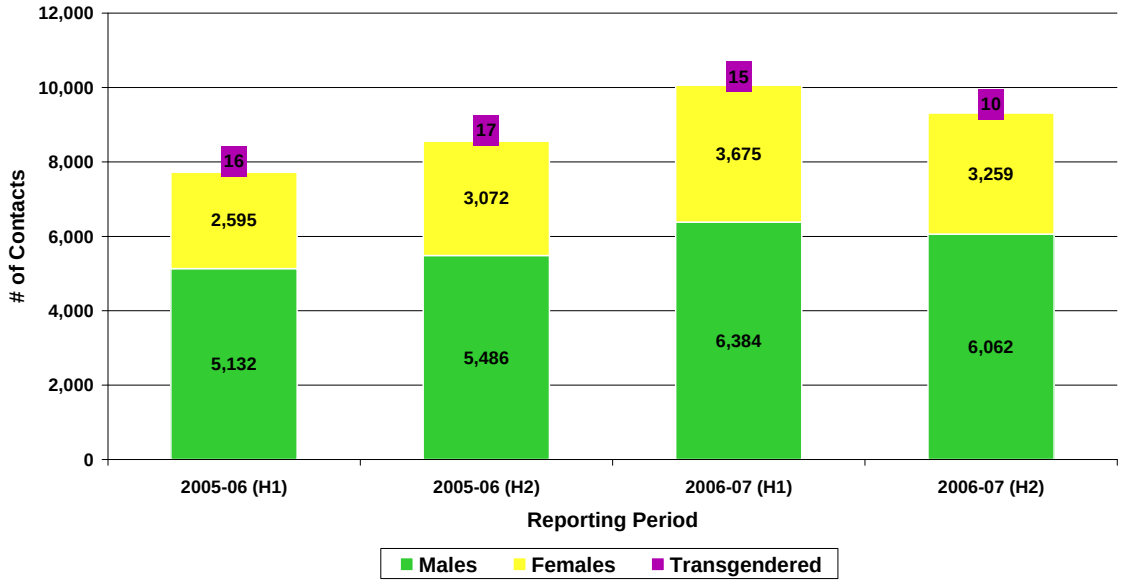
Figures 92 and 93 show the number of outreach and in-service contacts by gender over the past two years. In both cases, there was a significant increase in contacts with males and females in the first half of 2006-07 and then a drop in the second half (winter) of 2006-07. More analysis is required to understand the factors behind these changes.

Figure 92: Number of Outreach Contacts (New & Repeat) by Gender



Of the 8,600 total outreach contacts in the second half of 2006-07, 5,831 were contacts with repeat clients and 2,769 were contacts with new clients. Of the 9,321 inservice contacts in the last half of 2006-07, 7,861 were with repeat clients and 1,470 were with new clients. It appears that IDU outreach programs have formed trusting relationships with a large group of clients.

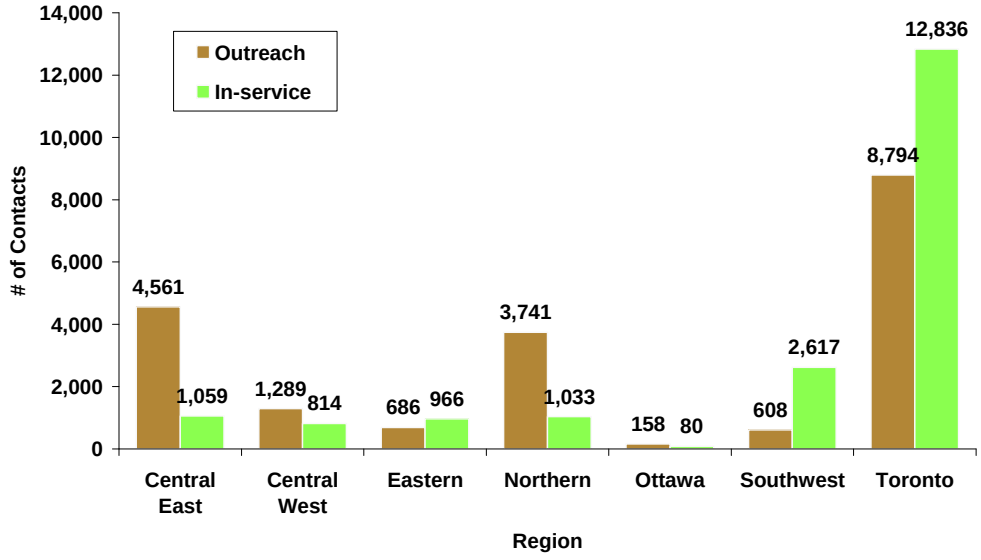
Figure 93: Number of In-Service Contacts (New & Repeat) by Gender



Strategies to reach clients vary by region

Figure 94 illustrates the number of outreach and in-service contacts by region. Regions such as Central East, Central West, and Northern rely on outreach programs to connect with clients while – in 2006-07, regions such as Toronto, Southwest and Eastern reached the majority of their clients though in-service contacts.

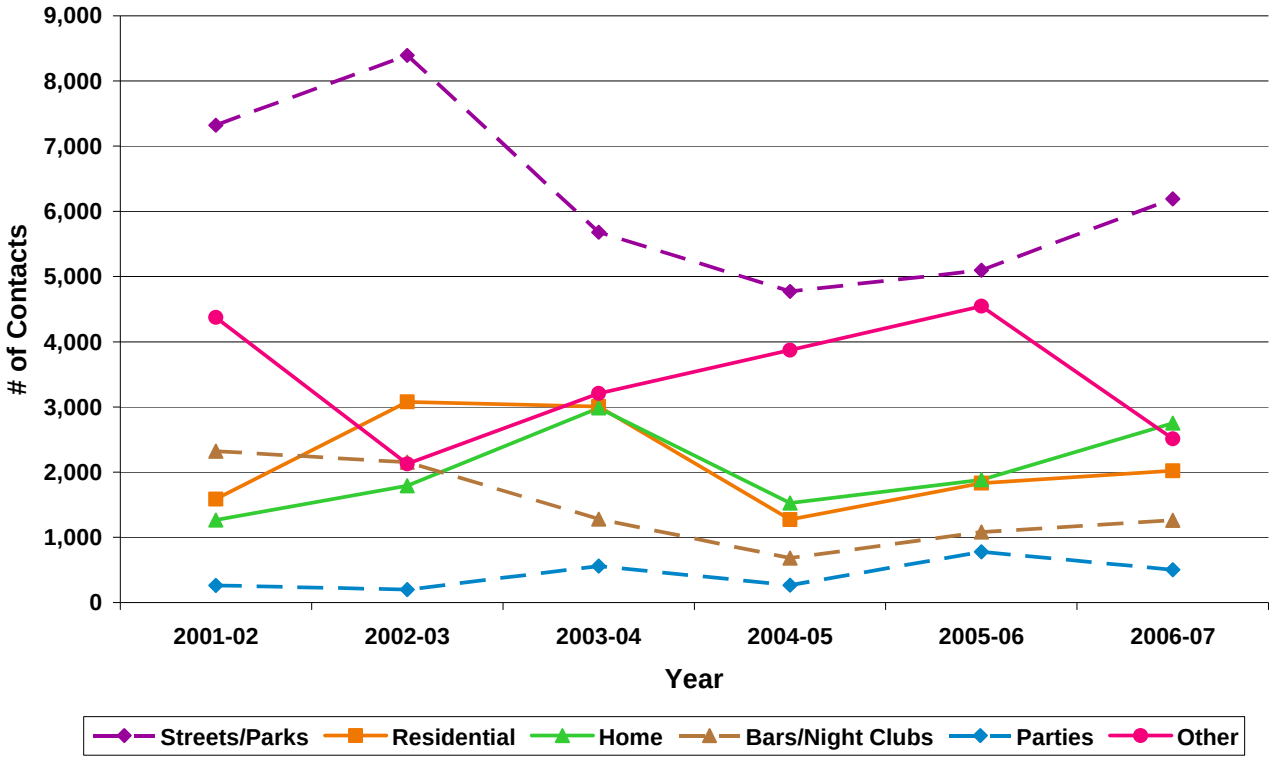
Figure 94: 2006-07: Outreach & In-service Contacts by Region



Streets and parks remain main location for outreach contacts

In 2006-07, there was an increase in street and park outreach. Over the past two years, there has also been an increase in the number of contacts made in other locations, such as homes, residential settings (i.e., shelters, addiction treatment programs), and bars and nightclubs (Figure 95).

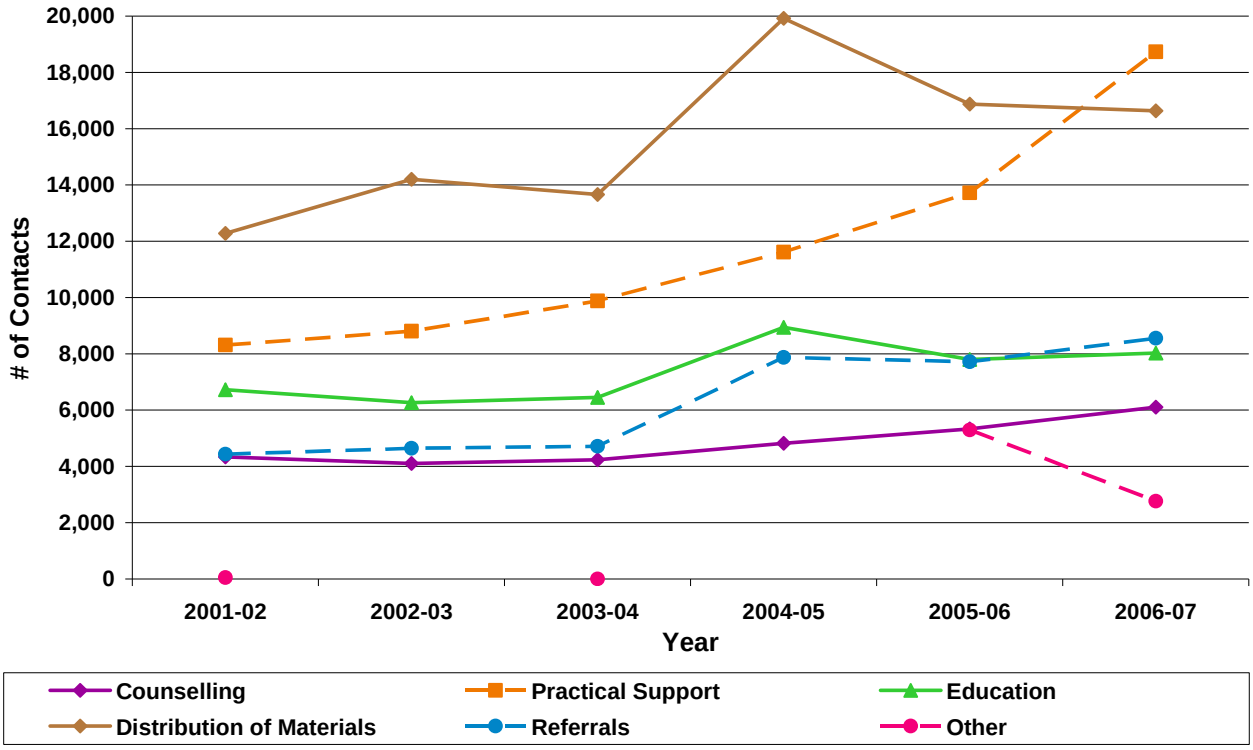
Figure 95: IDU: Outreach Contacts Made by Location



IDU outreach programs providing more practical support services

Over the past two years, there's been a marked increase in the amount of practical support provided by IDU outreach programs as well as a steady increase in the number of referrals and counselling services provided (Figure 96). It appears that the programs are shifting from providing general education and distributing materials to providing more client-specific services. This may reflect a more long-term relationship with some clients who have developed trust with the service providers and are using the outreach programs to connect with other services.

Figure 96: IDU: Number and Types of Services Provided



IDU Outreach Programs also reported providing other services in 2006-07, including hygiene kits, food, medical care, transportation and telephone services.

Peer Activities

All IDU Outreach Programs are required to have a strong peer component. They are expected to recruit peers to help reach other injection drug users, and to provide training and support. In 2006-07, programs reported a 131% increase in active peers and a 258% increase in new peers (Figures 97 and 98). Most of the increase occurred in the second half of the year.

Figure 97: Peer Involvement (New and Active) by Reporting Period

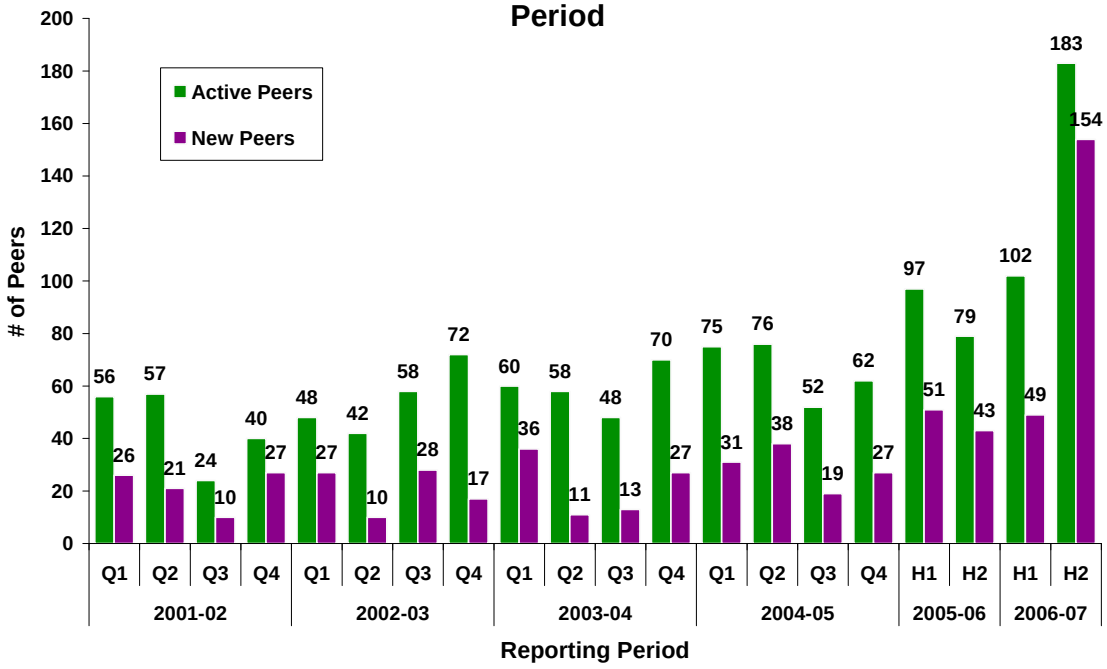
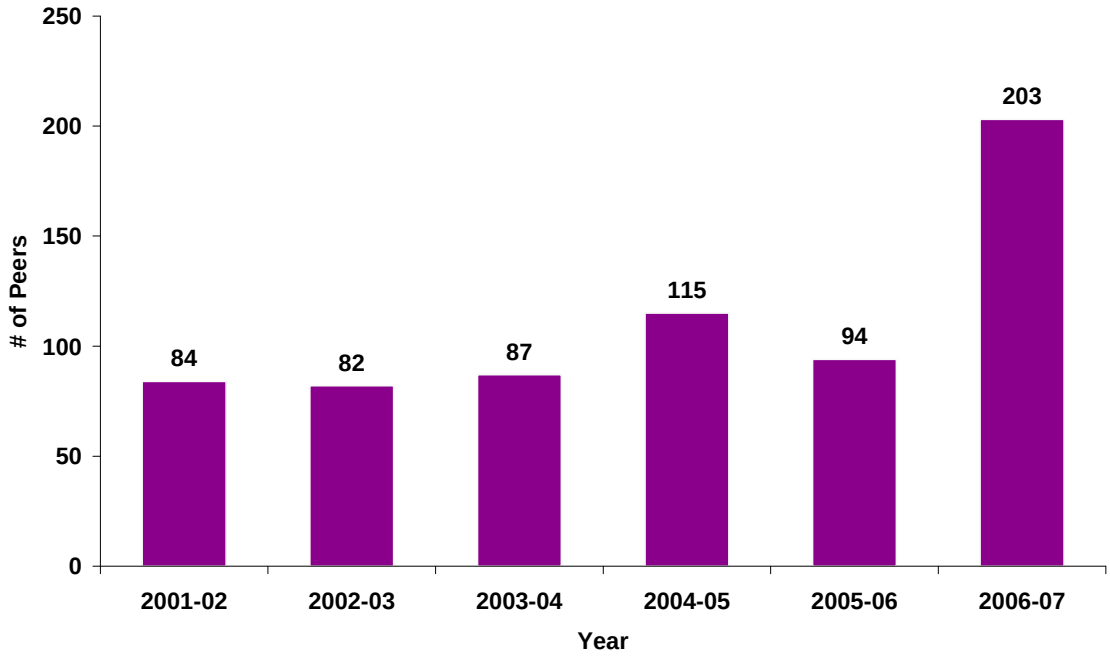


Figure 98: Total New Peers by Year

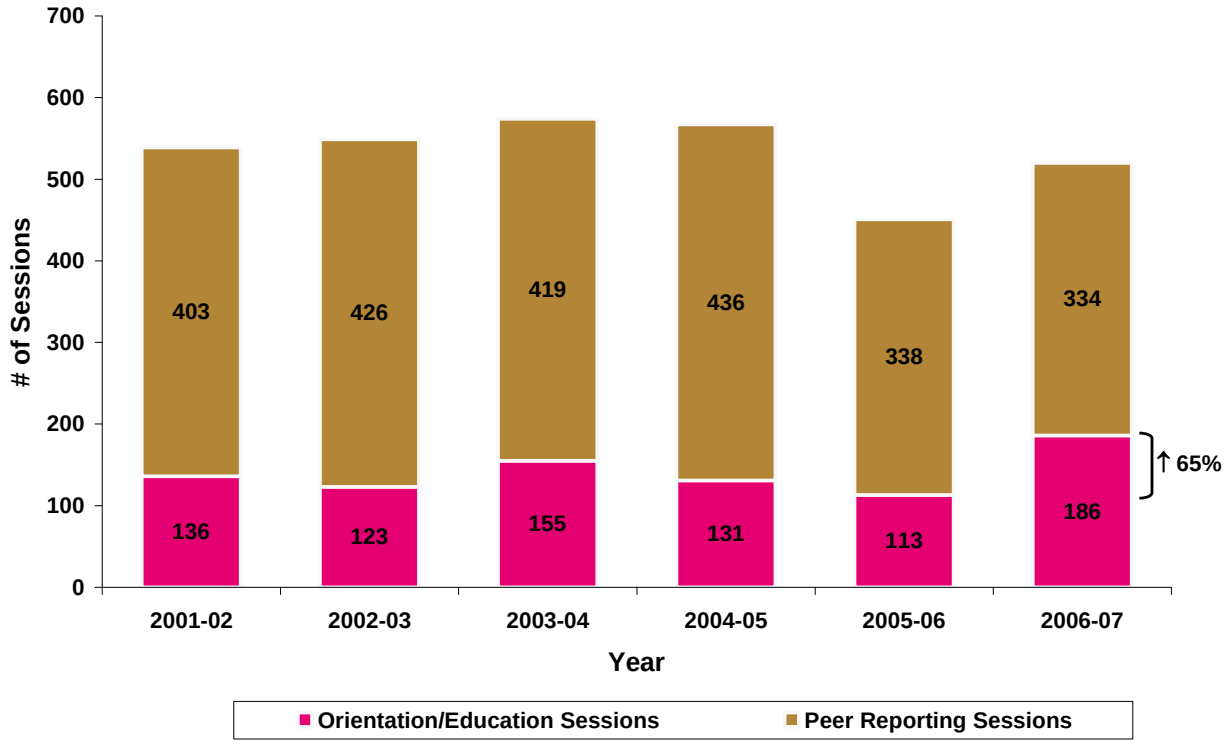


More orientation/education for peers

As part of their peer programs, IDU outreach programs provide orientation and education sessions. In 2006-07, IDU outreach programs reported a 65% increase in orientation and education sessions for peers compared to 2005-06. This may indicate a stronger focus on recruiting peers.

IDU Outreach Programs are expected to hold regular reporting/feedback sessions with peers in order to monitor their activities, provide support, and learn from their contacts with other injection drug users. The number of peer reporting sessions in 2006-07 was similar to 2005-06, which was down from previous years (Figure 99). The drop may be a function of the change to OCHART reporting.

Figure 99: IDU: Peer Involvement - Peer Sessions



Peers are more active in certain parts of the province

Peers are mainly involved in distributing information and materials, and in informal interactions with other drug users. Figure 100 illustrates the number of peer contacts by LHIN region by type of activity. In 2006-07, organizations in Toronto Erie St. Clair and Central East reported increased use of peers to distribute materials compared to the previous year; and organizations in Erie St. Clair, Champlain, Central West, North East, South East, Central East and Hamilton Niagara Haldimand and Brant reported greater use of peer in informal interactions with their peers.

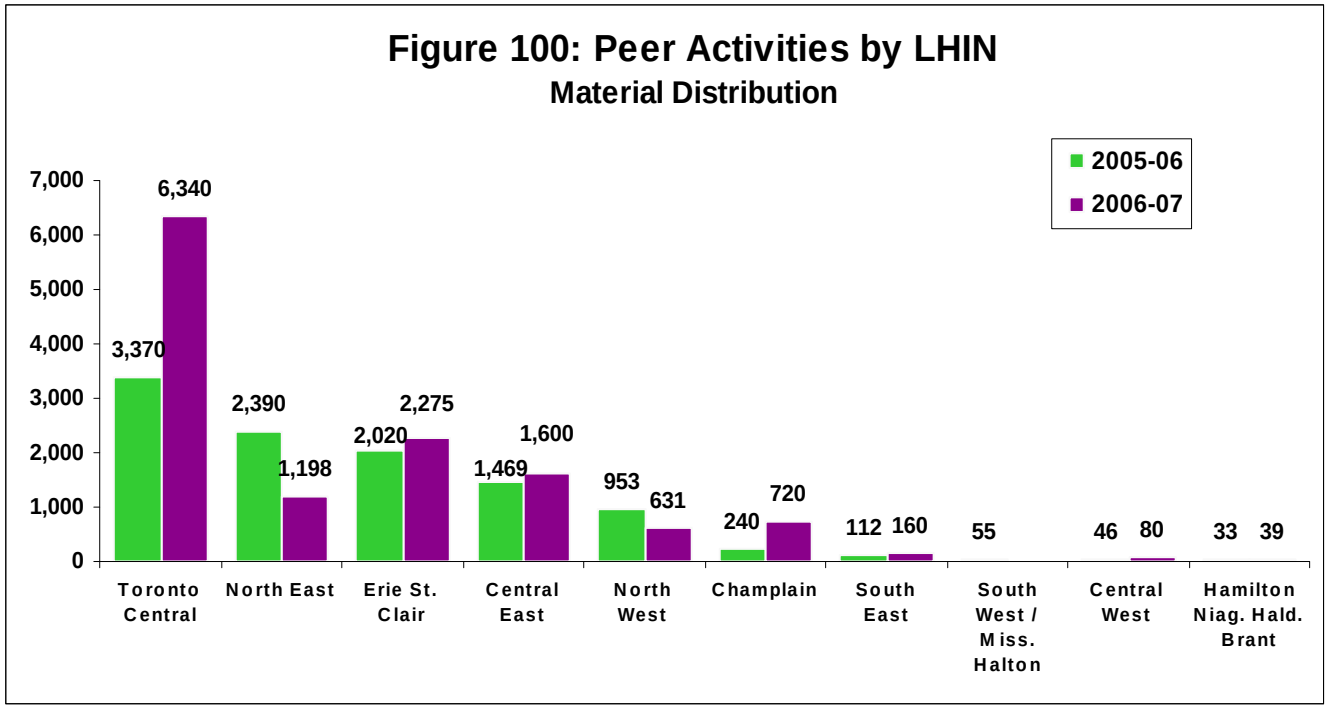
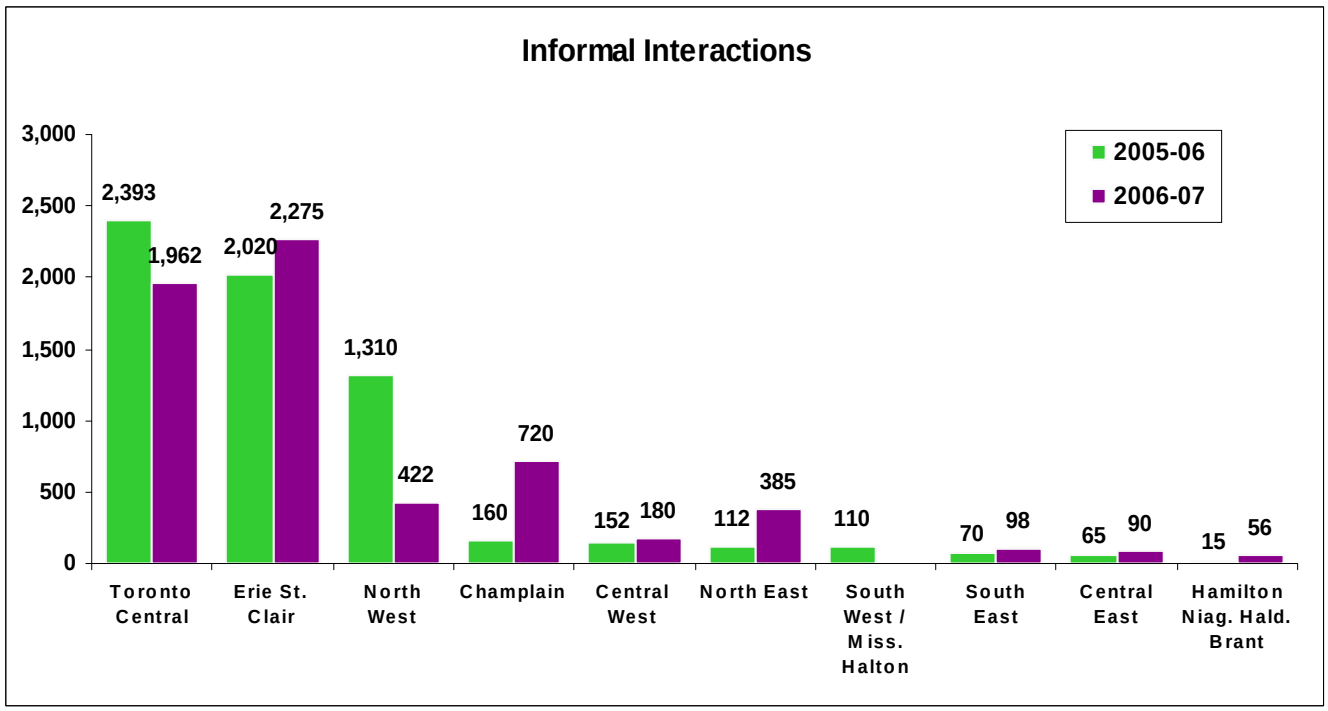


Figure 100: Peer Activities by LHIN
Material Distribution
2005-06
2006-07
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
3,370
6,340
2,390
1,198
2,020
2,275
1,469
1,600
953
631
240
720
112
160
55
46
80
33
39
Toronto Central
North East
Erie St. Clair
Central East
North West
Champlain
South East
South West / Miss. Halton
Central West
Hamilton Niag. Hald. Brant


Informal Interactions
2005-06
2006-07
3,000
2,500
2,000
1,500
1,000
500
0
2,393
1,962
2,020
2,275
1,310
422
160
720
152
180
112
385
110
70
98
65
90
15
56
Toronto Central
Erie St. Clair
North West
Champlain
Central West
North East
South West / Miss. Halton
South East
Central East
Hamilton Niag. Hald. Brant

More community development

For IDU outreach programs, community development includes activities designed to help the program become integrated with other services. They include making contacts with other agencies, making presentations about the program, and attending community meetings. These activities are intended to help create a supportive social environment for the program and its clients, and overcome any public concerns about services for people with addictions. Both staff and peers can be involved in community development, and the data includes the activities of both groups (Figure 101).

Figure 101: Total Number of Community Development Activities

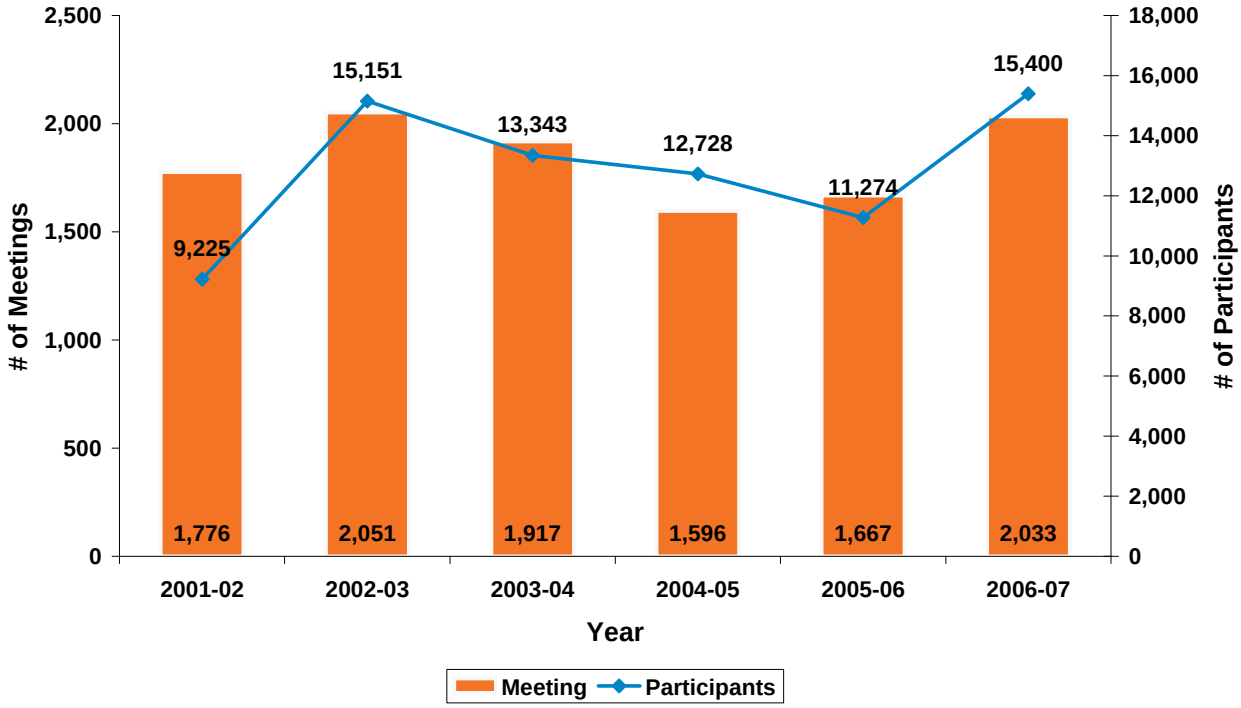


Figure 102 shows the number of different types of community development activities per reporting period. In the last half of 2006-07, organizations reported being involved in more agency contacts.

Figure 102: Number of Community Development Activities by Type

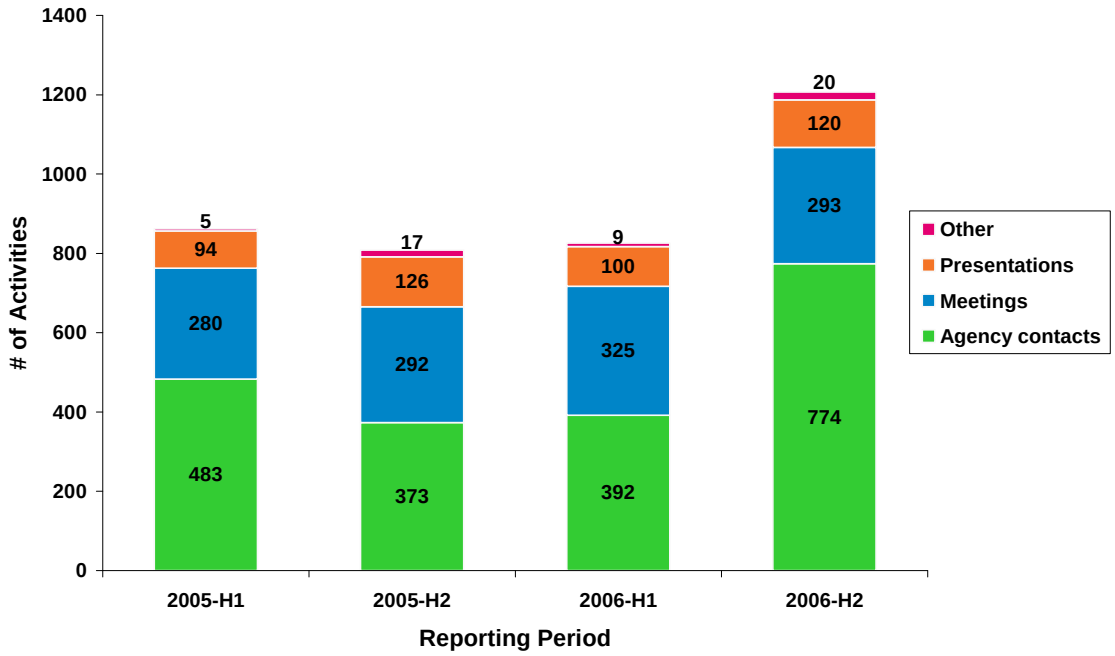
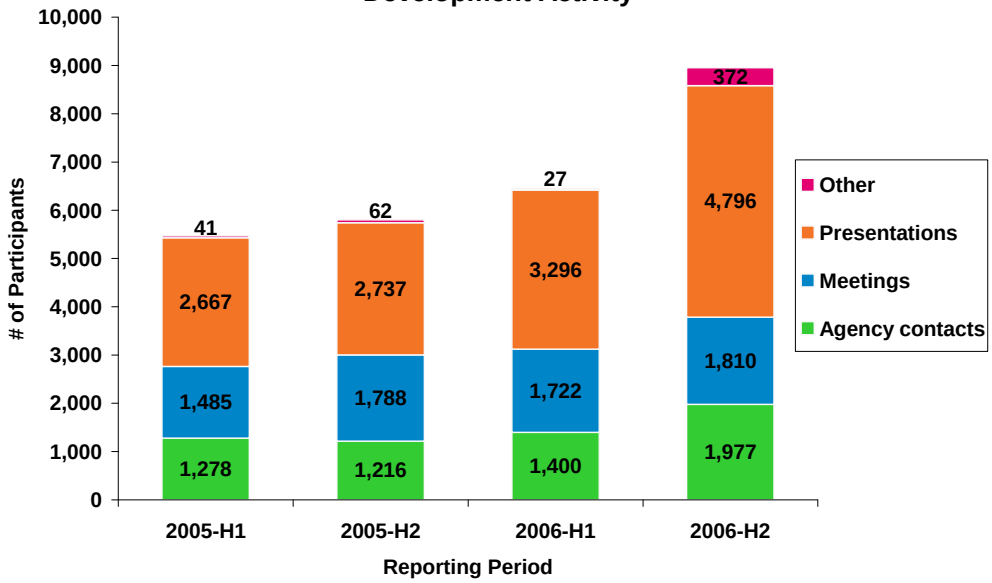


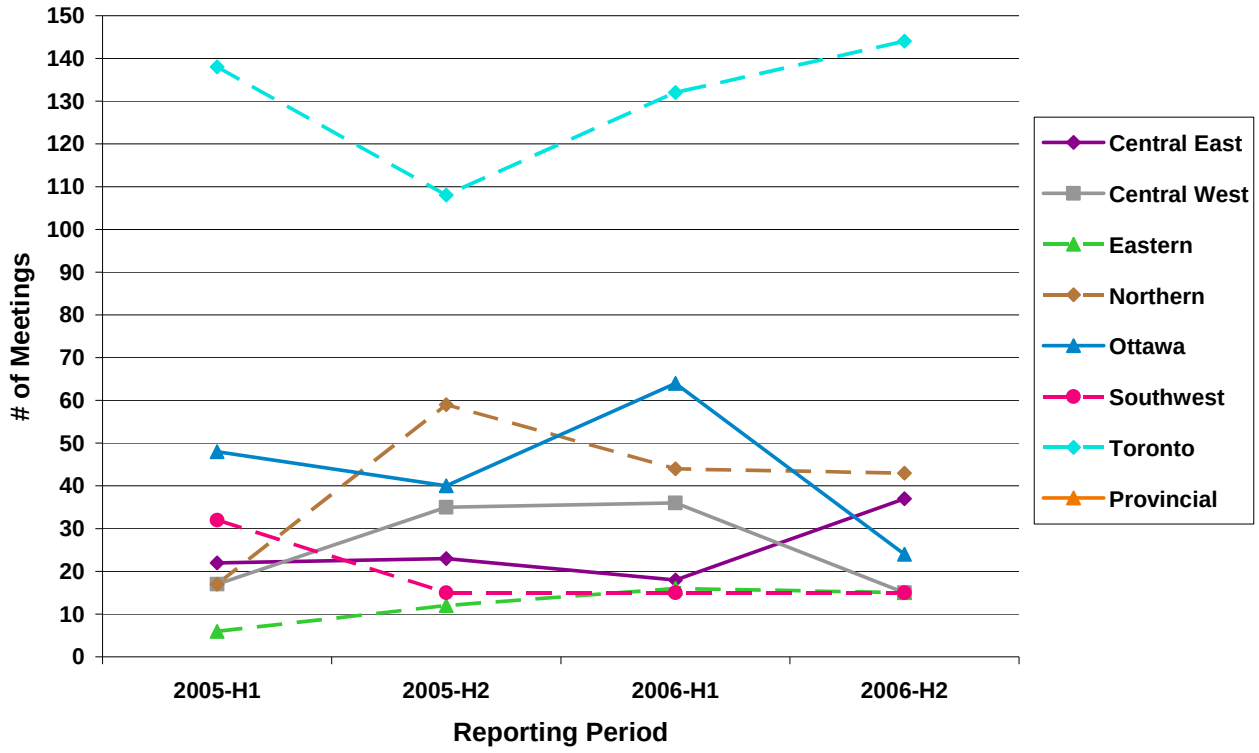
Figure 103 shows the number of participants involved in each type of activity. Through their community development activities in 2006-07, IDU Outreach Programs reached a total of 8,092 people – up ~50% from 5,404 in 2005-06. As would be expected, programs reach a larger number of people through presentations than agency contacts; however, in terms of impact on their clients, agency contacts may be more effective. The increase in agency contacts may indicate that outreach programs are becoming more effective in engaging other agencies in meeting client needs.

Figure 103: Number of Participants by Community Development Activity



When the number of community development meetings is analyzed by region (Figure 104), organizations in the Toronto Region reported holding significantly more meetings than any other region.

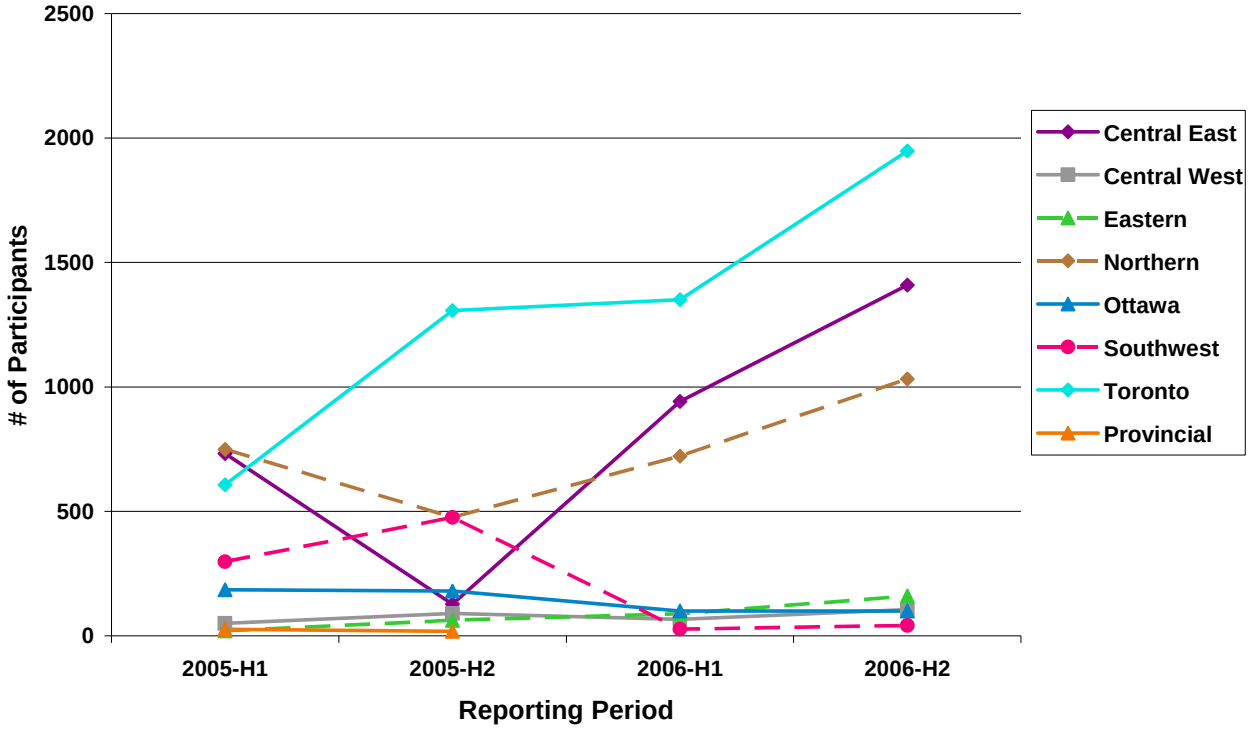
Figure 104: Community Development Meetings by Region



The high level of activity in this region is consistent with high rates of drug-related HIV infections and is likely due to a highly organized harm reduction group in that region. It is also consistent with community plans for the region. The peak in number of community development meetings in the Northern region coincided with community planning; however the number has stayed relatively high since that time.

In terms of a regional analysis of the impact of presentations, IDU programs in the Toronto, Central East and Northern regions reached significantly more people in 2006-07 than 2005-06 (Figure 105). They were also the regions with the greatest number of community development meetings.

Figure 105: Number of Participants at Presentations by Region



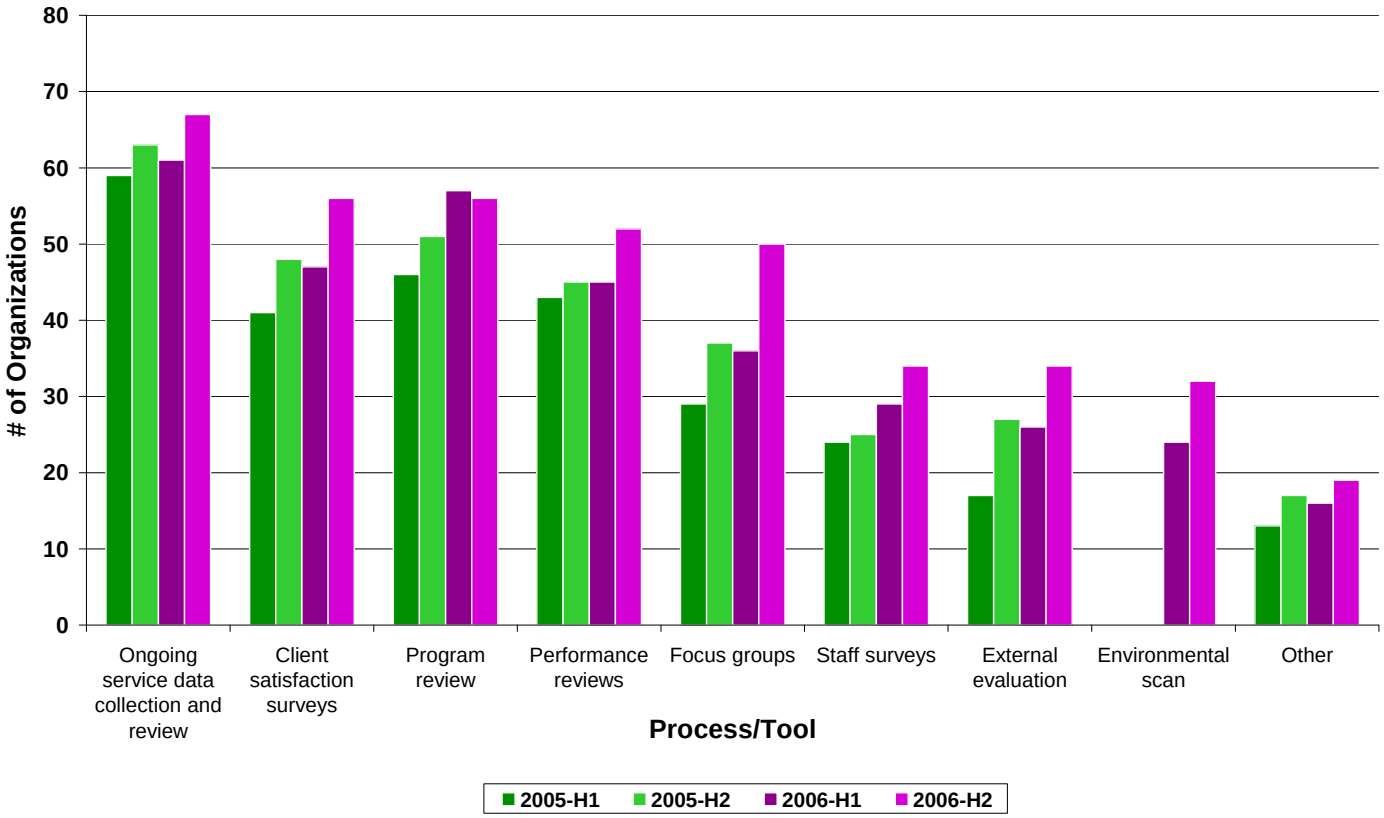
14. Program Planning and Evaluation

Organizations funded by the AIDS Bureau are required to submit program/service plans, and to monitor the effectiveness and impact of their services. Organizations funded by PHAC are required to complete program logic models, and monitor their ability to achieve outputs/deliverables and outcomes/impacts in their on-line logic models and evaluation plans. OCHART asked organizations to describe how they are monitoring services, the lessons they have learned, and how they are using that information to refine their programs.

ASOs are developing an evaluation/quality improvement culture

Figure 106 indicates the types of processes and tools that organizations are using to monitor their programs. In 2006-07, there was an increase in the number of organizations reporting using all types of processes and tools – particularly client satisfaction surveys, focus groups, performance reviews, environmental scans and external evaluations.

Figure 106: Monitoring Processes and Tools



In general, funders are seeing a strong commitment on the part of organizations to evaluate and improve their programs and services. Organizations want to know if what they are doing is working, and the field is developing an evaluation and quality improvement culture.

In addition to the categories in the OCHART form, organizations identified other processes and tools that they use to monitor their programs, including:

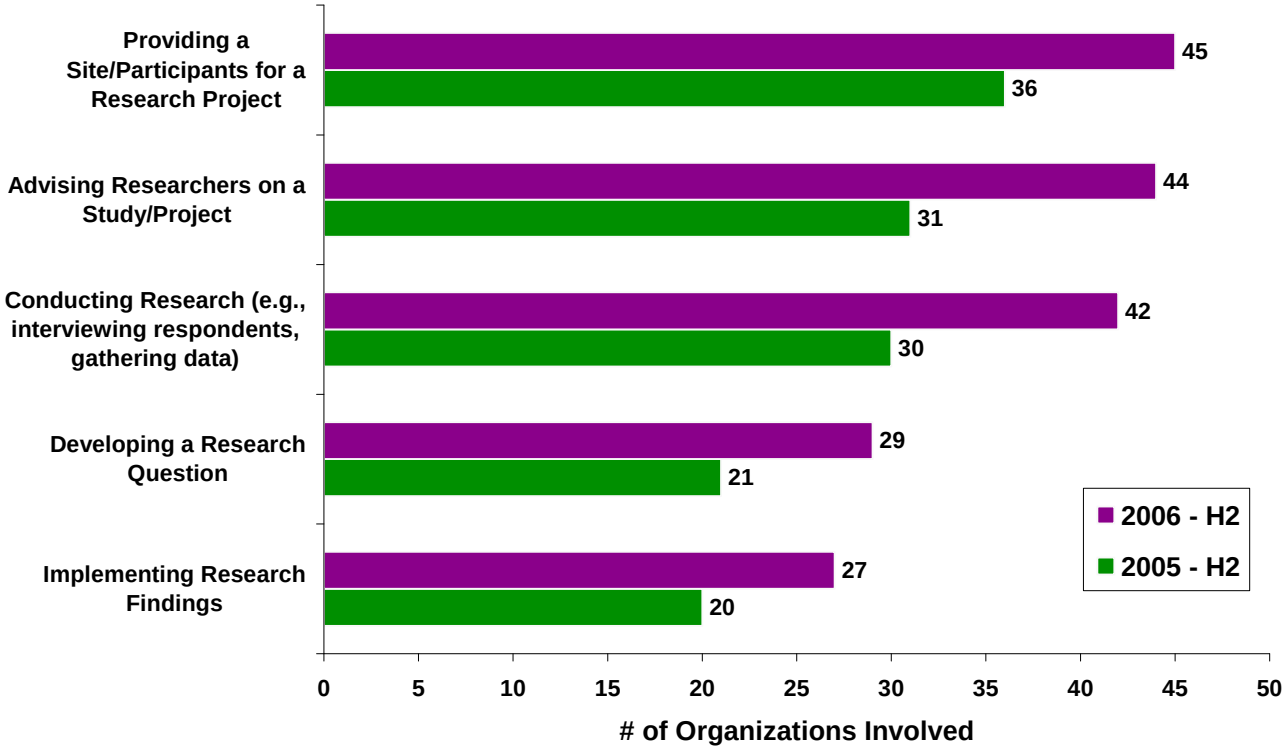
- regular staff meetings to discuss operational issues and how to improve services
- an advisory committee made up of PHAs
- research studies conducted by an external academic institute
- a strategic planning process that involved service users, volunteers, staff and the community
- a community-based needs assessment process to inform planning
- evaluation of every education session
- continuing to develop/implement local community plan, which provides information on service effectiveness
- tracking response times to requests for services received by telephone twice a year
- using a new data collection tool (Penelope Program) for case management and to monitor trends.

More organizations actively involved in research

In 2006-07, there was a marked increase in the number of organizations that reported being involved in community-based research (Figure 107). The most significant increases were in the number of organizations involved in conducting research (40%) and advising researchers on a project (42%). This indicates that more organizations are becoming active participants in research (beyond simply providing people to participate in surveys and studies), and is a very positive sign. The increase is likely due to major research projects, such as the housing and health study.

It is also encouraging to see a 35% increase in the number of organizations that are implementing research findings. This indicates a growing trend towards evidence-based practice.

Figure 107: Organizational Involvement in Community-Based Research



Lessons Learned from Monitoring and Evaluation

From their efforts to monitor their programs, organizations identified the following lessons learned:

Strategic Planning

- a better understanding of gaps in services, current trends, how to involve people in meaningful ways, what works and what doesn't for participants, how to be more innovative with resources, how to meet the various needs of different population groups who access our services; and who we need to develop partnerships with to ensure a continuum of care.
- the need for more strategies to enhance capacity and meet growing demand (e.g., more staff, more volunteers, more fundraising)
- the need for strategies to reduce discrimination against drug users within the health care system and to counter aggressive policing measures in bars and crack houses that may drive people underground and prevent them from receiving the information and harm reduction resources they need
- the need to explore alternate models of health care delivery for people who use drugs, such as Shelter Health Network where clients can access non-traditional service models instead of using the emergency department as a primary care clinic
- changes required to make a safety/harm reduction program more accessible to women, street-involved sex workers, the gay and lesbian community, as well as the transgendered community.

"Recording individual activities has become a priority in our organization and staff are actively participating in OCHART and other evaluation tools as a way to help the agency develop new funding proposals and identify emerging trends."

Organizational Management

- when shifting the focus of an organization, it's important to include agency volunteers, staff, and clients in decision processes and communicate changes to community partners and potential collaborators

Factors that Increase Program Effectiveness

- the benefits of a central location, which has led to more clients "dropping in" for services and has helped strengthen relationships and increase consultations with other organizations
- the effectiveness of the Safer Crack Use Initiative – user uptake was immediate, high and sustained; marginal decline in number of people reporting oral sores. Issues: many clients declined the mouthpiece because they preferred alternate materials; there has been a reduction in sharing behaviour but an increase in public drug use; safe, appropriate disposal of glass stems is an issue.
- the most effective way to reach young adults in the African and Caribbean communities is by building networking contacts and trusting relationships with community members and groups, before attempting prevention or education
- PHA speakers are very effective

ACAP funded projects and programs have reported the following outcomes:

- Prevention and education resources developed as part of Time-Limited Projects will continue to be used.
- As a result of efforts to create more supportive environments, organizations have developed more trusting relationships with their communities. As one service user said, "When I go there now, I feel like I am going to visit somebody in their house .. everybody is so kind and so friendly."
- Lessons learned from health promotion efforts are being integrated into ongoing knowledge transfer activities.
- Many of the partnerships developed as a result of ACAP funding have outlived the Time-Limited Projects.

- peer support is effective in meeting the needs of individuals who have suffered multiple losses but effective peer training must focus on basic skills of self-awareness, communication, reflection, emotional release, and consolidation of meaning from experiences
- environmental scan/focus groups led to new support groups
- the work that community organizations do to help people manage relationships with physicians is very helpful
- the PHA Leadership Development Program is reaching a larger and more diverse group of people, and there is a high degree of satisfaction with this new program
- skills programs are most successful when designed by experts in the topic area
- the important role that prenatal groups, new moms' support group and toddler groups play in helping women openly discuss their HIV status
- a more concrete system for tracking numbers of Needle Exchange clients revealed that many more individuals are using the service than previously thought.

Unmet Service Needs

The need for:

- services for the growing number of youth with concurrent disorders
- additional supports for aging or older PHAs, and more programming focusing on the needs of gay men and sero-discordant gay couples
- positive prevention programs that also address the health needs of PHAs and help them live full and productive lives
- more information on viral load and HIV transmissibility
- more drop-in programs – particularly for people who are homeless or coming out of jail
- support for parents in navigating the education system
- information for the public on female condoms.

Human Resources

- an aging volunteer workforce and the need to develop the capacity to engage younger volunteers.

Other Resources

- the need for more language- and culture-specific materials and resources, and more education for newcomers
- presentations and workshops require new technology (e.g., PowerPoint) so organizations must develop new skills and tools
- unique approaches may be required to reach bisexual men in the African and Caribbean communities.

ACAP Time-Limited Projects identified promising practices and lessons learned

Through the course of their work, ACAP Time-Limited Projects have learned valuable lessons about working with their target populations and managing organizational change, which they included in their final reports.

The projects identified a number of challenges that made their work more difficult over the past two years, including:

- the limited human, material and financial resources in many agencies and communities

- working with diverse gender, cultural and linguistic groups, especially in a context of limited resources
- the stigma and discrimination their target populations continue to face.

However, projects also described several promising or successful strategies for addressing these challenges.

Invest the time required to develop projects. Every Time-Limited Project reported that activities took more time to develop than they had anticipated – particularly to develop new or strengthen existing partnerships and to provide outreach to new populations. Because projects take time to develop, it's important for organizations to be realistic about the types of goals they can accomplish in a short period and about how much time to allocate for the ground work (e.g., building trust, creating service agreements) that must be done before they can implement outreach, prevention or service integration projects. As one agency observed, developing a trusting relationship between ASOs and communities "is a long and time consuming process, and an agency needs to be prepared to give the process the time necessary for success. This needs to be built into project timelines."

Develop strong partnerships. All the Time-Limited Projects described the importance of partnerships and inter-agency collaboration, ranging from informal cooperation to integrated service delivery, in achieving their goals. As agencies noted, when they work collaboratively with other service providers and with their target populations, "service users are empowered because they gain knowledge of additional services and are connected with more service providers." Resource-sharing also helped agencies maximize their resources, and share their expertise with others: "each partner in the project came into it with a different perspective and experience."

Establish structural supports. Structural supports, such as service agreements, decision-making processes, advisory and management committees, and other structures that support transparency and communication, are key to creating and maintaining organizational partnerships. Projects emphasized that structural supports should be established as early as possible. Many groups reported that, if they were to do their project over again, they would develop partnership agreements, planning processes and other structures earlier in their projects' life cycle.

Incorporate peer-led projects. The meaningful involvement of target populations at all levels and stages of planning is a key success factor. When educational materials are designed by and for members of their target populations, they use language, music, and images that resonate with the cultural group. Projects that used peer education reported that peers were able to have culturally informed discussions about: the advantages and disadvantages of holding workshops for mixed or homogenous gender and generational groups, strategies to combat homophobia and HIV-related stigma in their communities, and appropriate ways to approach faith leaders, elders and other community leaders. Two projects noted that GIPA principles helped insure the meaningful involvement of their target populations in project activities.

Set realistic goals. Since time-limited funding is, by its nature, short-lived, it's important to set clear, realistic goals that can be achieved within the project life cycle. Projects whose purpose was to produce a media campaign, educational materials, or other concrete deliverables were able to use the production and distribution of these materials to measure project success. Projects working on agency integration, peer education and outreach must also establish clearly defined milestones, even where the Time-Limited Project is part of a much larger, long-term effort. This helps projects to measure success, and gives staff a sense of accomplishment.

How Agencies Plan to Apply the Lessons Learned

Organizations plan to apply the lessons learned in a number of ways.

Maintain and expand partnerships. Organizations plan to maintain existing partnerships and explore new ones in order to deliver better programs and services to their clients. Examples of new/planned partnerships included: making connections with a food co-op; working with service providers and health care professionals to target specific populations, including women at risk and drug users; working with community partners to develop a proposal for an alternate model of care delivery, working with a housing group to create a housing guide for PHAs, partnering with larger ASOs to be able to benefit from their skills and resources, and providing training for partner agencies.

Develop services to meet specific needs. Organizations have already developed or plan to develop services targeting specific populations or unmet needs including: language-specific services, programs to address homelessness, programs for women, support for people co-infected with HIV and hepatitis C, and resources for Aboriginal women, youth, and transgendered clients. Some organizations plan to change the focus of support group programming to address unmet needs, implement a Programs Committee to guide new programs, make more extensive use of group therapy programs (based on positive evaluations), establish a regional support group (in partnership with other agencies) and develop a travel program.

Create new education and awareness tools. As part of their efforts to reach a wider audience, several organizations plan to modify existing presentations, develop new workshops, engage in more web-based outreach, create more public education workshops, create Power Point presentations, publish and disseminate new brochures, get involved in video production, and expand youth engagement initiatives. Several organizations are producing materials in different languages, including a Spanish Fotonovela that can be used in English as a Second Language classes. One organization plans to develop a pilot health education program for student placement. Another is convening an internal journal club whose members will examine research on education and awareness. A third plans to contact schools, businesses and services clubs. One organization plans to acquire a van to enhance its outreach services.

Engage the community. Organizations intended to engage the community through regular meetings, working groups, peer advisory panels, and other forums for client feedback and active involvement. Clients, the community and peers will be engaged in discussing the ethnocultural and other barriers that limit access to services, and in ongoing planning for services.

Build the paid and volunteer workforce. Several organizations plan to focus on staff, volunteer and board recruitment, training and ongoing development – including training in cultural competency. Some plan to provide more administrative staff and technical support for front line and clinical staff. Some plan to create new positions to meet changing needs, such as a new outreach worker, and a coordinator who speaks the language of the target group. Several organizations also plan to implement programs that will help them evaluate staff, volunteers and peers and assess their training needs. One organization plans to require staff members to attend at least three board meetings bi-annually as a way to improve communications between board and staff.

Conduct/participate in research. A smaller number of organizations indicated that they plan to be involved in research activities, including re-activating a research advisory committee, developing projects, submitting proposals to CIHR, and holding community forums to disseminate the results of research activities.

Enhance evaluation. Several organizations plan to use what they have learned to enhance their capacity to evaluate their programs and services. They plan to develop tools, such as a needs assessment survey. Some of the activities they plan to evaluate include ongoing campaigns, programs, and a library. Several organizations also reported that they are working with other organizations to develop a common assessment tool and database that will help them evaluate their programs and services.

Increase funding. Several organizations reported that they plan to increase funding for their programs using strategies such as fundraising, exploring other sources of funding, and fundraising initiatives, and diversifying and broadening their funding base.

Appendix A: Alphabetical List of Funded Organizations

Organization	LHIN	Region
2-Spirited People of the 1st Nations	Toronto Central (Provincial)	Provincial
Access AIDS Network - Sault Ste. Marie	North East	Northern
Access AIDS Network - Sudbury	North East	Northern
AIDS Committee of Cambridge, Kitchener, Waterloo and Area	Waterloo Wellington	Central West
African and Caribbean Council on HIV/AIDS in Ontario	Toronto Central	Toronto
African Community Health Services	Toronto Central	Toronto
Africans In Partnership Against AIDS	Toronto Central	Toronto
AIDS Action Committee of Perth County	South West	Southwest
AIDS Bereavement Project of Ontario-sponsored by Fife House Foundation, Inc	Toronto Central (Provincial)	Provincial
AIDS Committee of Guelph & Wellington County	Waterloo Wellington	Central West
AIDS Committee of Guelph and Wellington County - HIV Outpatient Clinic	Waterloo Wellington	Central West
AIDS Committee of London	South West	Southwest
AIDS Committee of North Bay and Area	North East	Northern
AIDS Committee of Ottawa	Champlain	Ottawa
AIDS Committee of Simcoe County	North Simcoe Muskoka	Central East
AIDS Committee of Toronto	Toronto Central	Toronto
AIDS Committee of Toronto – Positive Youth Outreach	Toronto Central	Toronto
AIDS Committee of Toronto - VIVER	Toronto Central	Toronto
AIDS Committee of Windsor	Erie St Clair	Southwest
AIDS Committee of York Region	Central	Central East
AIDS Niagara	Hamilton Niagara Haldimand Brant	Central West
AIDS Thunder Bay	North West	Northern
Alliance for South Asian AIDS Prevention	Toronto Central	Toronto
Asian Community AIDS Services	Toronto Central	Toronto
Association of Iroquois and Allied Indians	South West	Southwest
Barrett House - Good Shepherd Ministries	Toronto Central	Toronto
Black Coalition for AIDS Prevention	Toronto Central	Toronto
Bruce House	Champlain	Ottawa
Canadian AIDS Treatment Information Exchange	Toronto Central (Provincial)	Provincial
Casey House Hospice	Toronto Central	Toronto
Central Toronto Community Health Centres	Toronto Central	Toronto
Centre for Spanish-speaking Peoples	Central	Central East
Centre Francophone de Toronto	Toronto Central	Toronto
City of Ottawa Public Health	Champlain	Ottawa
Family Service Association of Toronto	Toronto Central	Toronto

Fife House	Toronto Central (Provincial)	Provincial
FIFE House - OHSUTP	Toronto Central	Toronto
Hamilton AIDS Network	Hamilton Niagara Haldimand Brant	Central West
Hassle Free Clinic	Toronto Central	Toronto
Hamilton Public Health & Community Services	Hamilton Niagara Haldimand Brant	Central West
Hemophilia Ontario	Toronto Central (Provincial)	Provincial
HIV & AIDS Legal Clinic (Ontario)	Toronto Central (Provincial)	Provincial
HIV/AIDS Regional Services	South East	Eastern
Hospice Toronto	Toronto Central	Toronto
Kingston Community Health Centres, Street Health Centre	South East	Eastern
Lawrence Heights Community Health Centre	Toronto Central	Toronto
LOFT Community Services	Toronto Central	Toronto
Maggie's: The Toronto Prostitutes' Community Service Project	Toronto Central	Toronto
Nishnawbe Aski Nation	North West	Northern
Ont. Assoc.of the Deaf, Deaf Outreach Program	Toronto Central (Provincial)	Provincial
Ontario Aboriginal HIV/AIDS Strategy	Toronto Central (Provincial)	Provincial
Ontario AIDS Network	Toronto Central (Provincial)	Provincial
Ontario Organizational Development Program	Toronto Central (Provincial)	Provincial
PASAN (Prisoners with HIV/AIDS Support Action Network)	Toronto Central (Provincial)	Provincial
Peel HIV/AIDS Network Inc	Central West / Mississauga Halton	Central West
Peterborough AIDS Resource Network	Central East	Central East
Pink Triangle Services	Champlain	Ottawa
Regent Park Community health Centre	Toronto Central	Toronto
Somerset West Community Health Centre	Champlain	Ottawa
South Riverdale Community Health Centre	Toronto Central	Toronto
St. Stephen's Community House	Toronto Central	Toronto
Sudbury Action Centre For Youth	North East	Northern
Syme-Woolner Neighbourhood and Family Centre	Central	Central
The AIDS Committee of Durham Region	Central East	Central East
The Teresa Group	Toronto Central	Toronto
The Works, City of Toronto Public Health	Toronto Central	Toronto
Toronto People With AIDS Foundation	Toronto Central	Toronto
Union of Ontario Indians	North East	Northern
Voices of Positive Women	Toronto Central (Provincial)	Provincial

Warden Woods Community Centre	Central East	Central East
Wassay Gezhig Na Nahn Dah We Igamig	North West	Northern
Women's Health in Women's Hands	Toronto Central	Toronto
Youth Services Bureau of Ottawa	Champlain	Ottawa
YOUTHLINK Inner City	Central East	Central East

* Note that for the purposes of this report, “Provincial” was added as both a LHIN and Region to distinguish data between organizations mandated to serve the entire Province (or Country in the case of CATIE) and those mandated to serve a specific area of Ontario.

Appendix B

The View from ACAP-funded Agencies

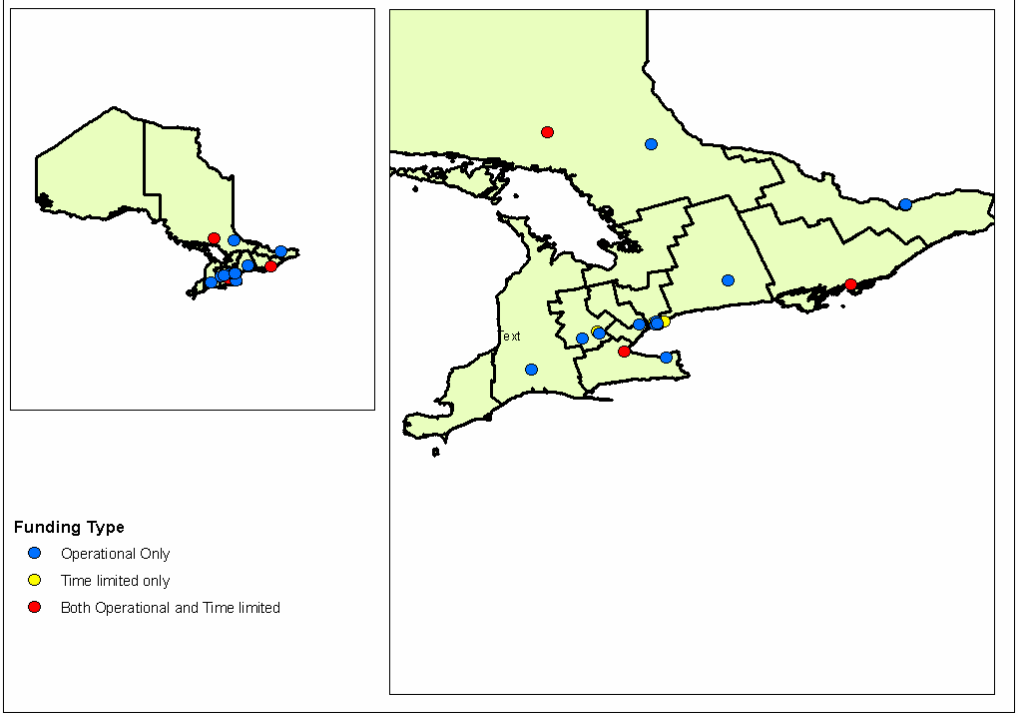
The Ontario Region of the Public Health Agency of Canada (PHAC) AIDS Community Action Program (ACAP) funds a variety of community-based organizations to provide HIV/AIDS prevention and support services. During 2006-07, ACAP provided approximately $3.017 million through two streams of funding:

- 3 to 4-year Operational Programs for 29 ASOs. The purpose of Operational funding is to fund programming, key positions within an organization, and overhead and administrative costs.
- 2-year funding for 16 Time-Limited Projects. The purpose of Time-Limited funding is to enhance the ability of community-based organizations working in HIV/AIDS to respond to emerging needs by providing dedicated funds for short-term, self-contained initiatives.

ACAP funded projects and programs are required to complete logic models which represent a map of the work to be done within the year. These logic models have evolved into an on-line reporting tool which records the "planned" outputs/deliverables and the "actual" outputs/deliverables and links them directly to the on-line OCHART. October 2006 to March 2007 is the first reporting period for which ACAP Logic Model data has been recorded on-line and ACAP data can now be analyzed and presented back to stakeholders. Also, the ACAP Time-Limited Project cycle ended on March 31, 2007 and we are now able to share some information from their final reports. A full evaluation report of ACAP Time-Limited Projects for 2005-06 to 2006-07 will be available by April 2008.

Figure 1 shows the location of ACAP-funded projects by type of funding

Figure 1. Locations of ACAP Funded Organizations by Type of Funding



To meet the criteria for ACAP funding, ACAP projects and programs must support one or more of the four Funding Approaches: Prevention Initiatives, Health Promotion for PHAs, Strengthening Community-Based Organizations, and Creating Supportive Environments.

From 2005-06 through 2006-07, all ACAP Operational Programs and Time-Limited Projects were involved in Creating Supportive Environments including community development activities to strengthen their relationships with other sectors (e.g., mental health, settlement/immigration, media, and faith communities) and the development of a media campaign to reduce homophobia and promote healthy sexuality.

Most ACAP-funded organizations reported being involved in Prevention Initiatives, such as working with at-risk populations, offering prevention workshops and providing peer outreach programs.

Under the funding approach Health Promotion for PHAs, ACAP-funded organizations worked to:

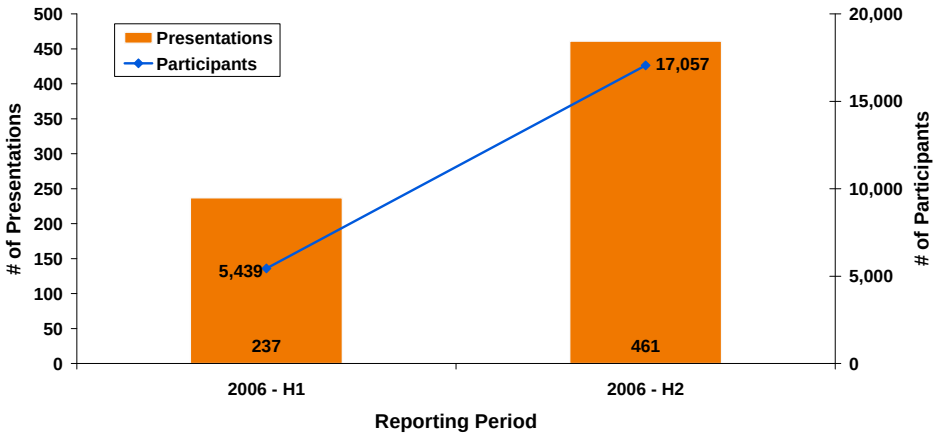
- improve environments and services for immigrant, refugee and minority populations (e.g., translating resources, developing peer education and outreach campaigns)
- conduct health promotion activities, such as health promotion and leadership development workshops for PHAs, educating and networking with health care providers about the issues and needs of PHAs, and developing policies related to HIV and immigration.

Those organizations funded under Strengthening Community-Based Organizations worked to develop and maintain their Volunteer Programs to enhance the capacity of organizations to provide outreach, educational and supportive services and activities.

Education and Community Development

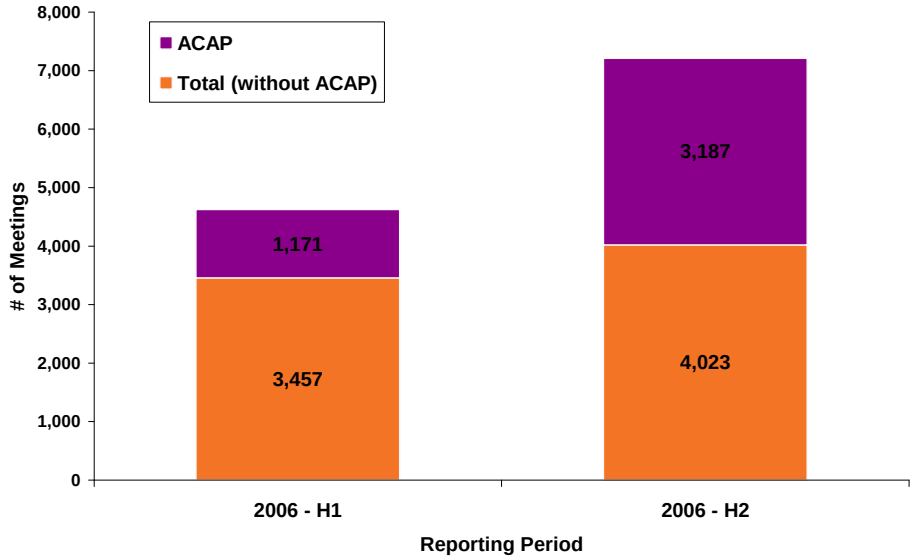
The 45 agencies funded by ACAP to provide education and community development services gave a total of 698 presentations in 2006-07, which reached a total of 22,496 participants (see Figure 2). This represents about 14% of all presentations given by community-based AIDS programs and 10% of participants reached in 2006-07. The average number of participants per ACAP-funded presentation was 32.

Figure 2: Total Number of ACAP Funded Education Presentations and Participants



In 2006-07, organizations used ACAP funding to support a total of 4,358 – or 37% – of the community development meetings held during the year (Figure 3). This work aligns with the ACAP Funding Approach, Creating Supportive Environments.

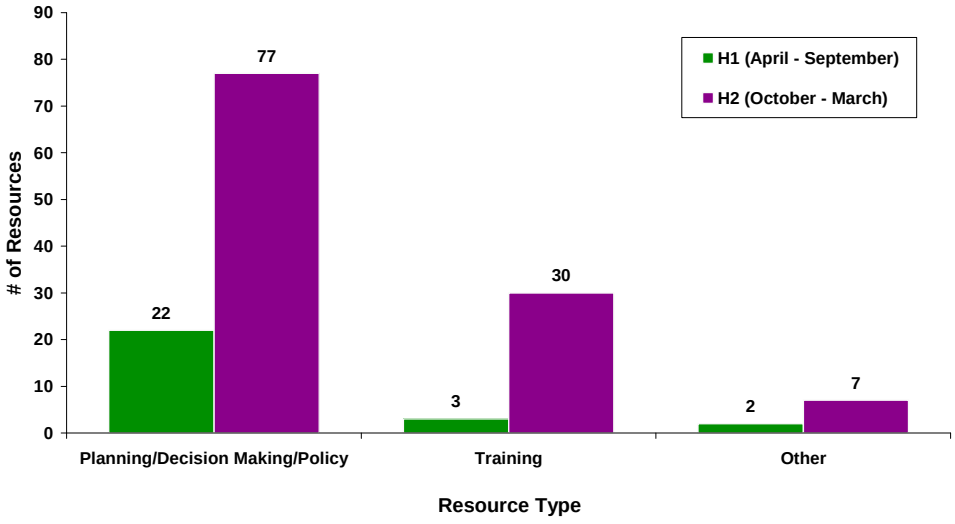
Figure 3: Community Development Meetings: Total showing ACAP Funded



Organizations funded by ACAP are asked to report on the number of resources they develop to support community development activities (Figure 4). In 2006-07, the organizations developed 99 planning/decision making/policy resources and 33 training resources. A list of ACAP funded Operational Programs and Time-Limited Projects is provided at the end of this section. For detailed descriptions including resources produced, please go to:

http://www.phac-aspc.gc.ca/aids-sida/about/reg_ontario_e.html

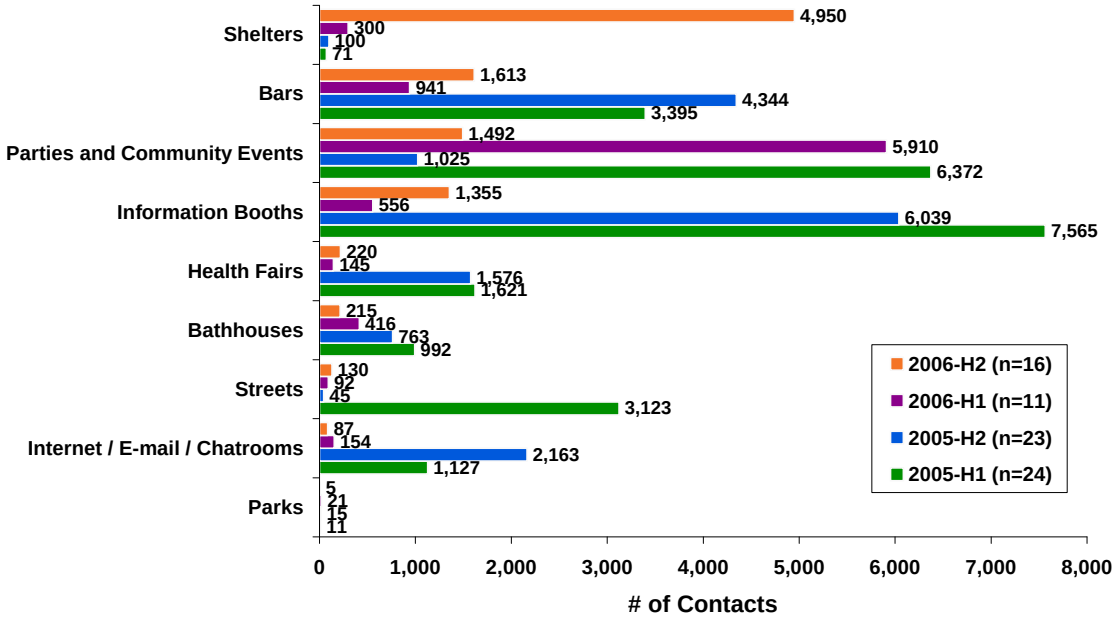
Figure 4: Number of Resources Developed by Type of Resource and Reporting Period - 2006-07



Prevention – Outreach Services

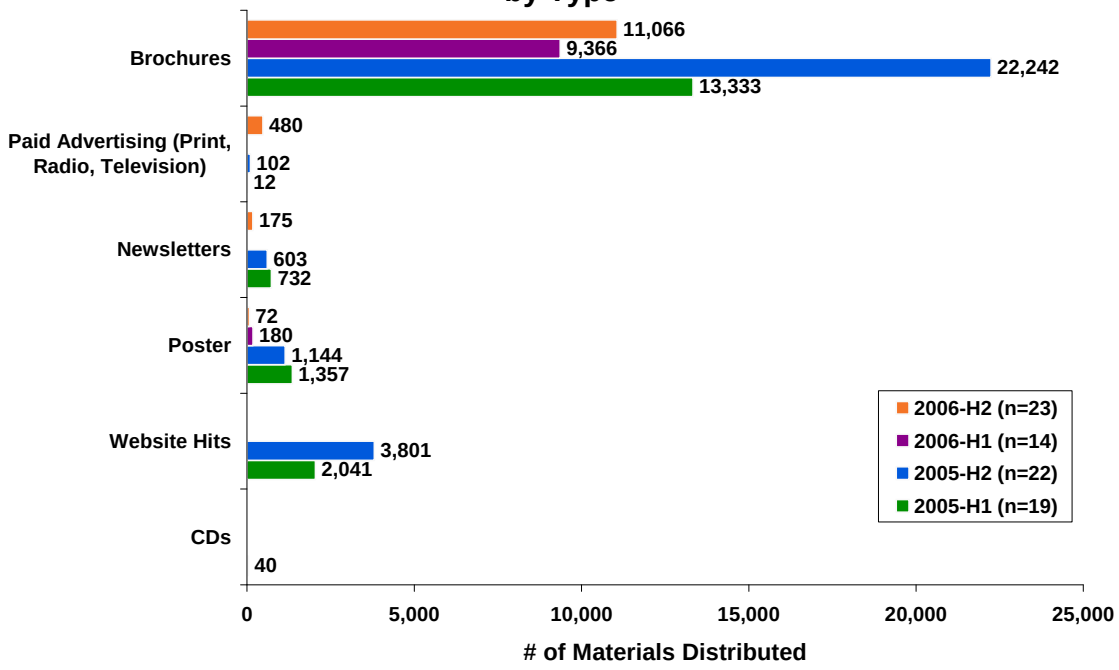
Figure 5 shows the location of outreach activities funded by ACAP in 2005-06 and 2006-07 as well as the number of contacts in each location. In 2006-07, there was a significant increase in the number of contacts in shelters, bars and parties and a drop in contacts through information booths, health fairs, street outreach and the Internet. Some of the differences may be due to more accurate ways of counting contacts in 2006-07 or to reporting errors in 2005-06.

Figure 5: ACAP Funded Organizations: Outreach Activity Contacts by Location



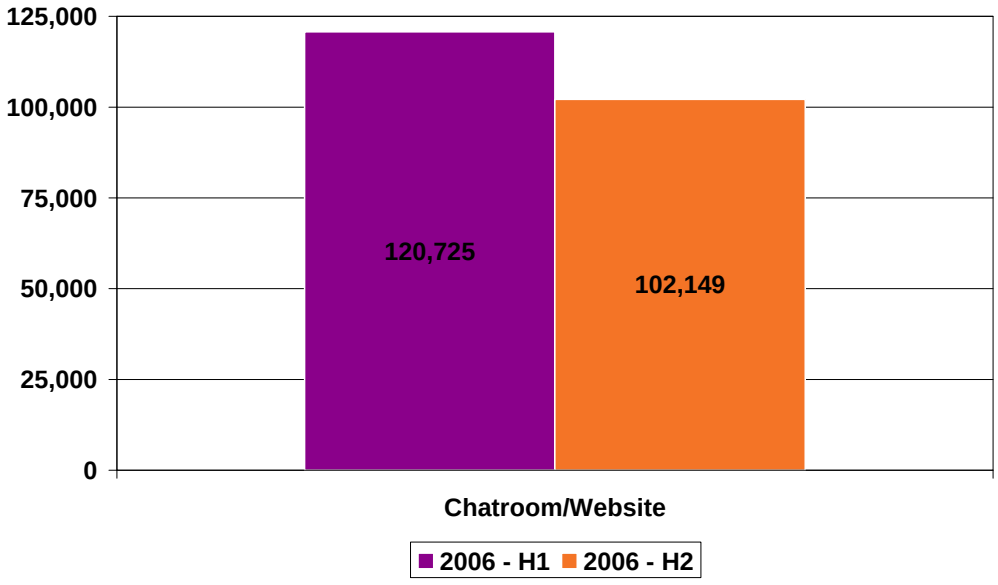
Organizations funded by ACAP in 2006-07 for awareness activities reported using that funding primarily to develop brochures and to support some paid advertising (Figure 6) – although the production and distribution of brochures was down significantly in the last half of 2006-07. The heavy reliance on brochures would be consistent with the number of ACAP-funded projects that reported using their funding to translate materials into other languages, thereby creating more supportive environments for immigrant, refugee and minority populations.

Figure 6: ACAP Funded Organizations: Awareness Activities by Type



Those organizations that received ACAP funding to support Internet outreach reported using the funding to support chatroom and website contacts (Figure 7).

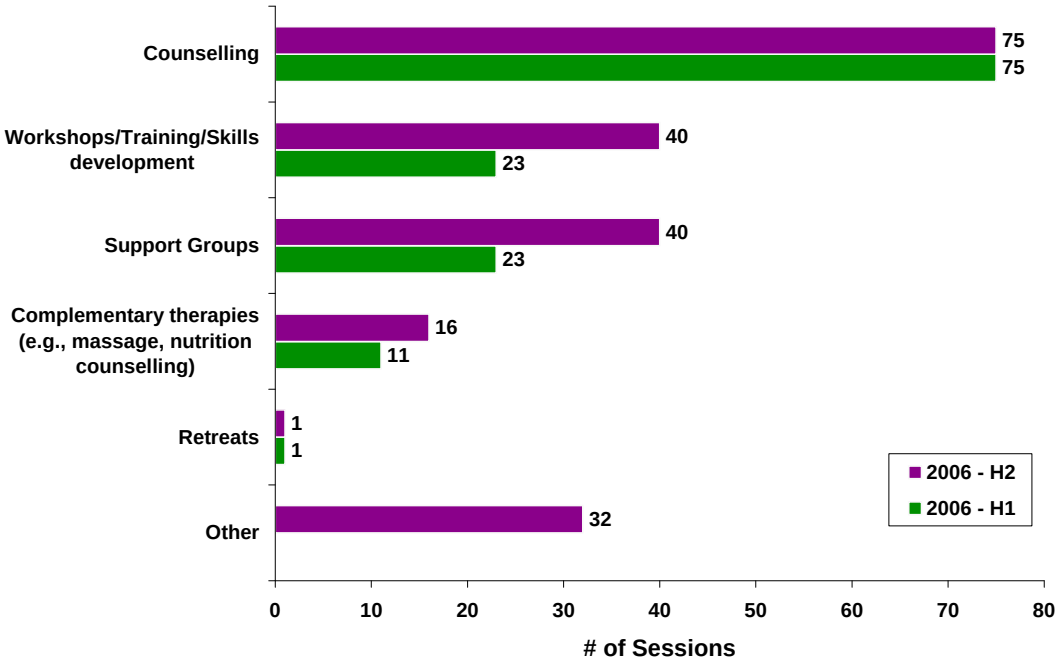
Figure 7: ACAP Funded Information and Education Services Provided by Internet Type



Health Promotion for People with HIV/AIDS

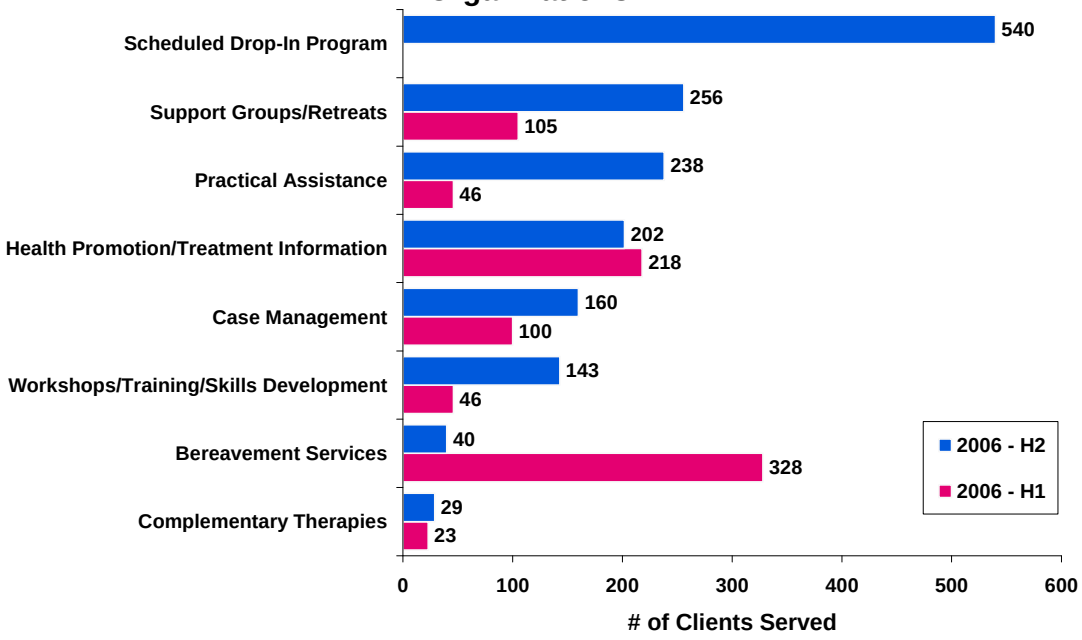
ACAP funds a number of organizations to provide health promotion programs for people living with HIV. Figure 8 lists the type of services provided as part of this program, and shows that agencies were able to provide more sessions in the second half of the year. The additional sessions were used to provide more support groups, skills training, complementary therapies and "other" services, which included monthly scheduled drop-ins for young people living with HIV/AIDS and weekly scheduled drop-in sessions for all individuals living with HIV/AIDS.

Figure 8: Sessions Provided by ACAP Funded Organizations



In 2006-07, organizations that received ACAP funding reported that they used the funding to provide a range of support services, focusing particularly on drop-in programs, bereavement services, support groups, practical assistance and health promotion and treatment information, and workshops (see Figure 9)

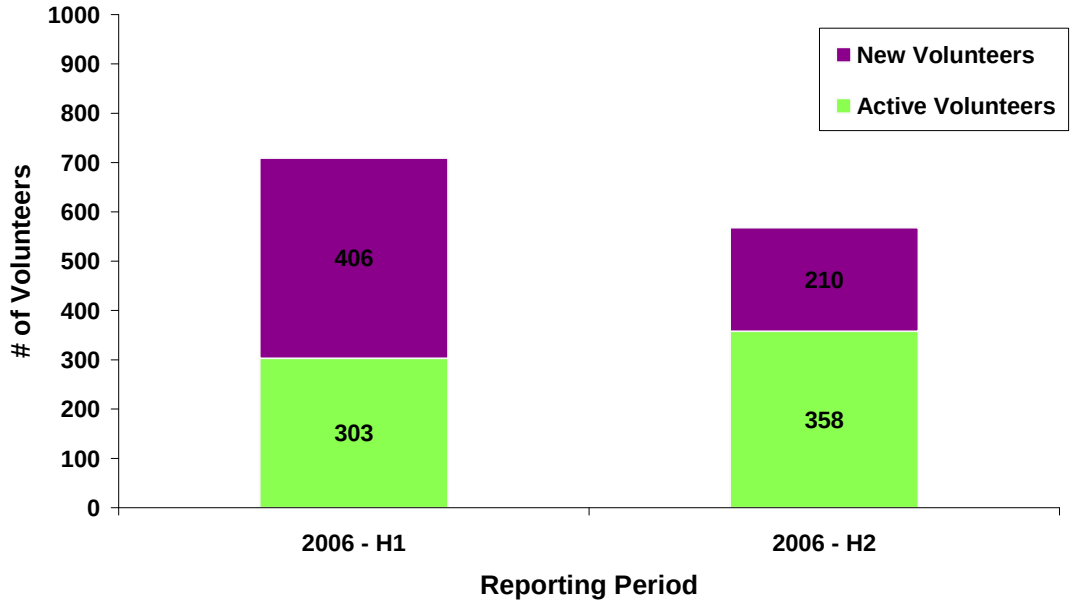
Figure 9: Number of Clients Served by Type of Support Service and by Reporting Period - ACAP Funded Organizations



Strengthening Community-based Organizations

Under the ACAP Funding Approach Strengthening Community-based Agencies, PHAC funds volunteer coordinators and activities for five organizations. In 2006-07, ACAP-funding organizations reported having a total of 709 volunteers in the first half of 2006-07 and 568 in the second half of the year (Figure 10) who provided a total of 24,282 hours of service – or the equivalent of approximately 14 full-time staff. The higher number of volunteers in the first half of the year may be related to AIDS 2006.

Figure 10: Volunteers (New and Active) at ACAP Funded Organizations



Organizations funded by ACAP reported using volunteers primarily to provide practical support (Figure 12). An analysis of the number/type of volunteers and the number of volunteer hours revealed that a relatively small number of people volunteer to assist with practical support compared to fundraising or education/community development (Figure 11); however, practical support volunteers provide on average about 250 hours each every six months, compared to about 15 hours provided by each fund raising volunteer, and 2.5 hours by each education and community development volunteer (Figure 12 and 13). Volunteers appear to become more intensely involved with the agencies when they are directly involved in “front line” work.

Figure 11: Volunteers by Activity Type - ACAP Funded Organizations

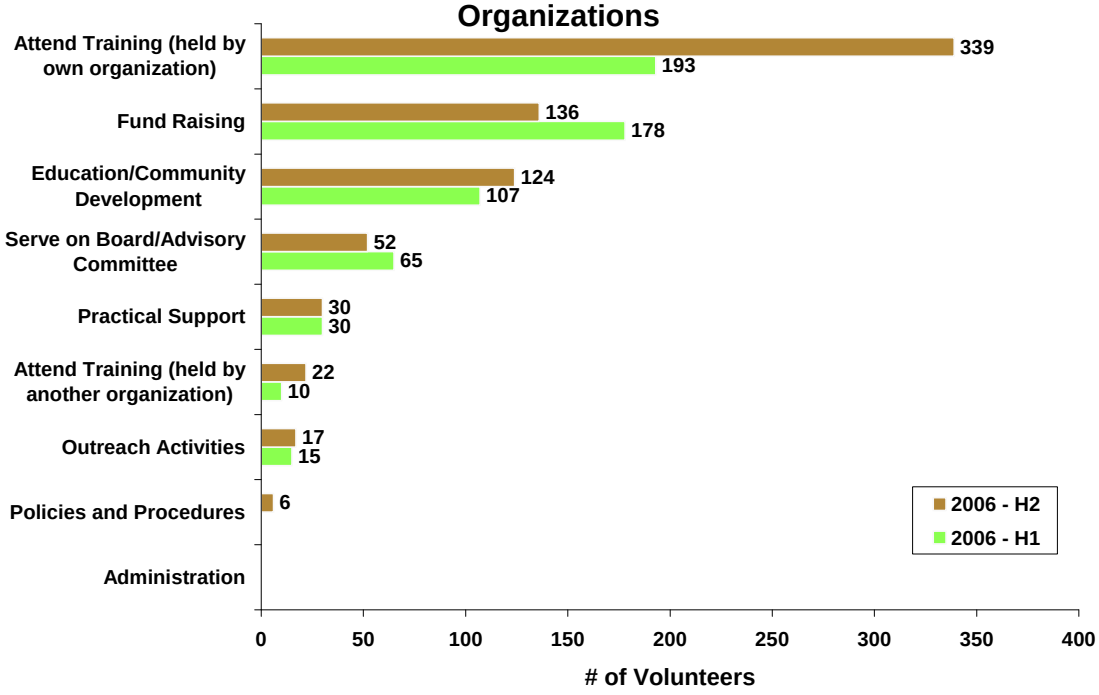


Figure 12: Hours of Volunteer Service by Activity Type - ACAP Funded Organizations

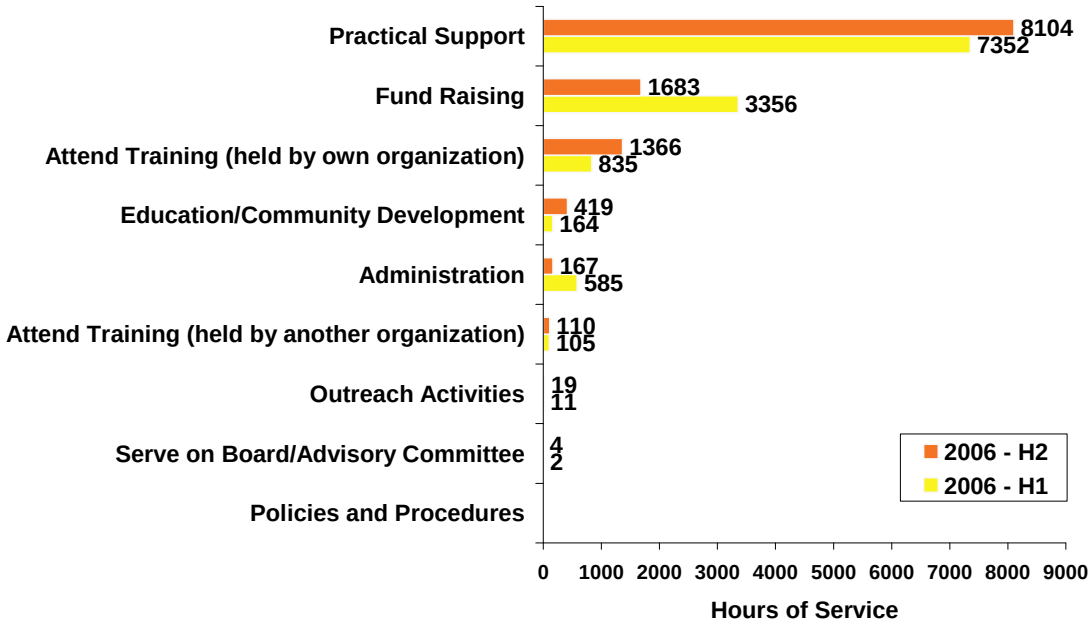
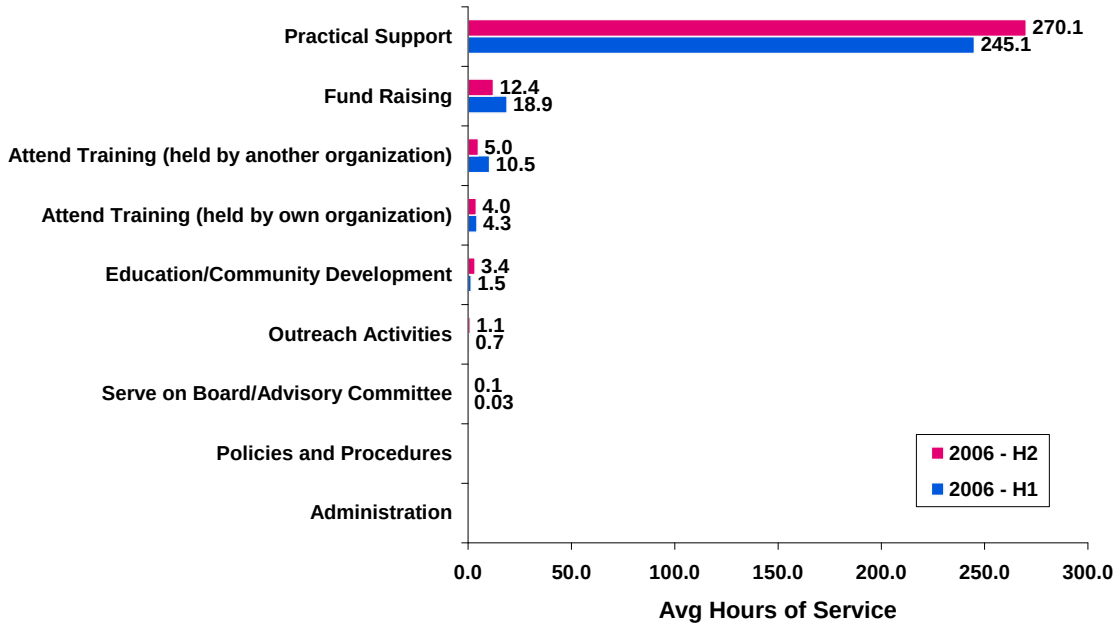


Figure 13: Average Hours of Service per Volunteer by Activity · ACAP Funded Organizations



ACAP-funded organizations also held over half of all volunteer recognition events – almost all of which took place in the second half of 2006-07. Both the timing and number of events may be related to AIDS 2006.

Impact of ACAP Time-Limited Project Funding

From April 2005 to March 2007, ACAP funded 16 two-year Time-Limited Projects. The purpose of Time-Limited funding is to enhance the ability of existing agencies to respond to emerging needs in their community or within their organizations, by providing dedicated funds for short-term, self-contained initiatives. Agencies that received Time-Limited funding undertook a range of activities including the development of new education and outreach campaigns and tools, the improvement of service delivery, the integration of programs, and the creation of new strategies to support people living with HIV.

An evaluation of these projects is currently underway, and will be available by April 2008. The following is a preliminary summary of the impact these projects had on their communities, staff, volunteers and target populations, and the ways in which they supported the 4 ACAP Funding Approaches.

- *Prevention Initiatives:* A majority of the projects reported work that included HIV prevention: both work with at-risk populations, and with other service agencies. Activities included harm reduction workshops, peer outreach, and web-based "HIV 101" learning modules. Projects reported that the prevention and education resources developed during the funding period will continue to be used.

- *Creating Supportive Environments:* All ACAP-funded agencies contributed to creating supportive environments. Some projects focused on working with immigrant, refugee and

racialized minority groups. ACAP funding supported the translation of resources into languages used by target populations, and the development of peer-driven education and outreach campaigns. Projects reported that as a result of their work, trusting relationships developed between service providers and community members. A service user says, "When I go there now I feel like I am going to visit somebody in their house…everybody is so kind and so friendly."

- *Health Promotion for PHAs:* Several projects engaged in health promotion work that included a media campaign to reduce homophobia and promote healthy sexuality; work to educate health service providers about risk reduction work with IVDUs; and work on policy relating to immigration and HIV. One group notes that as a result of this work, "we continue to integrate learnings from this project…into ongoing knowledge transfer activities."

- *Strengthening Community-Based Organizations:* All projects reported either new or strengthened partnerships across diverse sectors including mental health, settlement/immigration, media, faith, and other health sector agencies, as well as with other ASOs. Many noted that these partnerships have outlived the Time-Limited projects. As one agency observed, "While a project such as this one is Time-Limited, it is important to see the issues of integration and coordination as ongoing."

Lessons Learned

As the demographics and needs of those living with and affected by HIV change, community services have to evolve to meet changing needs. Through the course of their work, ACAP Time-Limited projects have learned valuable lessons about working with their target populations and managing organizational change. They have also identified factors that make their work more challenging, such as: the limited human, material and financial resources in many agencies and communities; the challenges of working with diverse gender, cultural and linguistic groups, especially in a context of limited resources; and the stigma and discrimination their target populations continue to face.

Despite these challenges, agencies were also able to identify promising or successful strategies.

A significant lesson learned – one that was mentioned by every Time-Limited project – was that project activities took time, and often much more time than anticipated. While in some cases this had to do with the scope and amount of work that was undertaken, time-related challenges were most frequently mentioned in the context of developing new partnerships or significantly strengthening existing ones, and conducting outreach to new populations. Particularly for Time-Limited projects, there is a need to be realistic not just about the types of goals that can be accomplished in a short period, but about how much time needs to be allocated for the ground work of trust-building, service agreement creation, and other activities that need to precede outreach, education, or service integration. Projects learned that significant time and resources need to be allocated to these 'pre-project' activities. As one agency observed, developing a trusting relationship between ASOs and communities "is a long and time consuming process, and an agency needs to be prepared to give the process the time necessary for success. This needs to be built into project timelines."

While time and resource limitations are an inherent challenge in Time-Limited projects, projects identified many successful strategies for overcoming or mitigating these challenges. These included:

- *Strong partnerships*: All of the Time-Limited projects described the importance of partnerships and inter-agency collaboration, ranging from informal cooperation to integrated service delivery, in helping them to achieve their goals. Agencies noted that when they work collaboratively with other service providers and with their target populations, "service users are empowered because they gain knowledge of additional services and are connected with more service providers." Resource-sharing also helped agencies to maximize their resources, and to share their expertise with others: "each partner in the project came into it with a different perspective and experience."
- *Structural supports*: To support the creation and maintenance of organizational partnerships, projects also noted the importance of service agreements, decision-making processes, advisory and management committees, and other structures that support transparency and communication. Projects emphasized that these need to be created as early as possible. Many groups reported that, if they were to do their project over again, they would develop partnership agreements, planning processes and other structures earlier in their projects' life cycle.
- *Peer-led projects*: The meaningful inclusion of target populations at all levels and stages of planning was noted as a key factor in successful project activities. Projects noted that when educational materials were designed by and for members of their target populations, the materials used language, music, and images with cultural resonance. Additionally, where peer education was used, peers were able to have culturally informed discussions about the advantages and disadvantages of holding workshops for mixed or homogenous gender and generational groups; about strategies to combat homophobia and HIV-related stigma in their communities; and about appropriate ways to approach faith leaders, elders and other community leaders. Two projects noted that GIPA principles helped to insure the meaningful involvement of their target populations in project activities.
- *Realistic goals*: Since Time-Limited funding is, by its nature, limited, projects emphasized the importance of establishing clear, realistic goals that can be achieved within the project life cycle. Projects whose purpose was to produce a media campaign, educational materials, or other concrete deliverables were able to identify and measure project success by the production and distribution of these materials. However, projects working on agency integration, peer education and outreach also noted the need for clearly defined milestones, even where the Time-Limited project is part of a much larger, longer-term effort. This helps projects to measure their success, and also gives staff a sense of accomplishment when working towards long-term goals.

ACAP Operational Programs
For detailed descriptions, please see:
http://www.phac-aspc.gc.ca/aids-sida/about/reg_ontario_e.html

2-Spirited People of the 1st Nations 202 - 593 Yonge Street, Toronto, ON M4Y 1Z4 Tel: (416) 944-9300/ Fax: (416) 944-8381 www.2spirits.com	Services and Projects Development Program 6963-06-2002/4480447
ACCESS AIDS Network 111 Elm St., Unit 203, Sudbury ON P3C 1T3 Tel: (705) 688-0500/ Fax: (705) 688-0423 www.accessaidsnetwork.com	Healthy Sexuality Program 6963-06-2002/2370438
ACCESS AIDS Network 111 Elm St., Unit 203, Sudbury ON P3C 1T3 Tel: (705) 688-0500/ Fax: (705) 688-0423 www.accessaidsnetwork.com	Community Education and Prevention Program 6963-06-2002/2370437
AIDS Committee of Cambridge Kitchener, Waterloo and Area (ACCKWA) 85 Frederick Street, Kitchener, ON N2H 2L5 Tel: (519) 570-3687/ Fax: (519) 570-4034 www.acckwa.com	Community Education Program 6963-06-2002/4480443
AIDS Committee of Guelph and Wellington County **Masai Centre for Local, Regional and Global Health** 409 Woolwich Street, 2nd Floor, Guelph, ON N1H 3X2 Tel: (519) 763-2255/ Fax: (519) 763-8125 www.aids.guelph.org	Wellington & Grey-Bruce Rural Prevention / Outreach Program 6963-06-2002/4480444
AIDS Committee of London 120 - 388 Dundas Street, London, ON N6B 1V7 Tel: (519) 434-1601/ Fax: (519) 434-1843 www.aidslondon.com	HIV Prevention Services for Gay, Bisexual and Men who have sex with Men 6963-06-2002/2370445
OODP Sponsored by AIDS Committee of London 120-388 Dundas Street, London, ON N6B 1V7 Tel: (519) 434-1601/ Fax: (519) 434-1843 www.oodp.ca	Ontario Organizational Development Program 6963-06-2002/2370444

AIDS Committee of North Bay & Area 269 Main Street West, #201, North Bay, ON P1B 2T8 Tel: (705) 497-3560/ Fax: (705) 497-7850 www.aidsnorthbay.com	HIV Education Services Program 6963-06-2002/4480438
AIDS Committee of Ottawa 251 Bank Street, Suite 700, Ottawa, ON K2P 1X3 Tel: (613) 238-5014/ Fax: (613) 238-3425 www.aco-cso.ca	The Gay Men's Health and Wellness Project 6963-06-2002/2370442
AIDS Committee of Toronto 399 Church St., 4th floor, Toronto, ON M5B 2J6 Tel: (416)340-2437/ Fax: (416) 340-8224 www.actoronto.org	Health Promotion for People Living With HIV/AIDS 6963-06-2002/2370446
VIVER: Sponsored by AIDS Committee of Toronto (ACT) 399 Church St., 4th floor, Toronto, ON M5B 2J6 Tel: (416)340-2437/ Fax: (416) 340-8224 www.actoronto.org	VIVER: Portuguese-Speaking Case Management 6963-06-2004/4480463
VIVER Sponsored by AIDS Committee of Toronto 399 Church St., 4th floor, Toronto, ON M5B 2J6 Tel: (416)340-2437/ Fax: (416) 340-8224 www.actoronto.org	VIVER: Portuguese-Speaking Community Development 6963-06-2002/2370441
PYO Sponsored by AIDS Committee of Toronto 399 Church St., 4th floor, Toronto, ON M5B 2J6 Tel: (416)340-2437/ Fax: (416) 340-8224 www.actoronto.org	Positive Youth Outreach - Health Promotion and Outreach to HIV Positive Youth 6963-06-2002/2370447
AIDS Niagara Normandy Resource Centre 111 Church Street, St. Catherines, ON L2R 3C9 Tel: (905) 984-8684/ Fax: (905) 988-1921 www.aidsniagara.com	Community HIV Prevention and Education Program 6963-06-2002/4480434
AIDS Thunder Bay 574 Memorial Avenue, Thunder Bay, ON P7B 3Z2	Enhancing Healthy Options Program (EHOP) 6963-06-2002/4480445

Tel: (807) 345-1516/ Fax: (807) 345-2505 www.aidsthunderbay.org	
Alliance for South Asian AIDS Prevention 126- 20 Carlton St., Toronto, ON M5B 2H5 Tel: (416) 599-2727/ Fax: (416) 599-6011 www.asaap.ca	South Asian PHA Program/Volunteer Program 6963-06-2002/4480433
Asian Community AIDS Services 107- 33 Isabella St., Toronto, On M4Y 2P7 Tel: (416) 963-4300/ Fax: (416) 963-4371 www.acas.org	Creating and Sustaining Healthy and Effective Communities / Volunteer Development Program 6963-06-2002/2370432
Bruce House 312 Parkdale Avenue, Ottawa, ON K1Y 4X5 Tel: 613-729-0911 x 24/ Fax: 613-729-0959 www.brucehouse.org	Volunteer Support Program 6963-06-2002/2370440
Fife House 571 Jarvis Street, 2nd Floor, Toronto, ON M4Y 2J1 Tel: 416-205-9888 x 33/ Fax: 416-205-9919 www.fifehouse.org	Fife House Volunteer Services Program 6963-06-2002/4480431
Hamilton AIDS Network 140 King Street East, #101, Lower Level, Hamilton, ON L8N 1B2 Tel: (905) 528-0854/ Fax: (905) 528-6311 www.aidsnetwork.ca	PHA Resource Program 6963-06-2002/2370435
HIV/AIDS Regional Services (HARS) 844A Princess St., Kingston, ON K7L 4G5 Tel: (613) 545-3698/ Fax: (613) 545-9809 www.hars.ca	Regional Prevention and Education Program 6963-06-2002/4480432
Ontario AIDS Network 468 Queen Street East, #105, Toronto, ON M5A 1T7 Tel: (416) 364-4555/ Fax: (416) 364-1250 www.ontarioaidsnetwork.on.ca	Ontario AIDS Network PHA Program 6963-06-2002/2370434
Peel HIV/AIDS Network 315 - 1515 Britannia Road East, Mississauga, ON L4W 4K1	Health Promotion for People Living With and Affected by HIV/AIDS 6963-06-2002/2370436

Tel: (905) 362-2025/ Fax: (905) 362-2030 www.phan.ca	
Peterborough AIDS Resource Network 159 King Street, Suite 302, Peterborough, ON K9J 2R8 Tel: (705) 749-9110/ Fax: (705) 749-6310 www.parn.ca	PARN HIV Education Program - Building Our Community Response 6963-06-2002/4480430
Prisoners With HIV/AIDS Support Action Network 314 Jarvis St., #100, Toronto, ON M6B 2C5 Tel: (416) 920-9567/ Fax: (416) 920-4314 www.pasan.org	Prison In-Reach Project 6963-06-2002/2370431
Teresa Group 124 Merton St., Suite 300, Toronto, ON M4S 2Z2 Tel: (416) 596-7703/ Fax: (416) 596-7910 www.teresagroup.ca	Volunteer Support Program 6963-06-2002/4480449
Toronto PWA Foundation 399 Church St., 2nd floor, Toronto, ON M5B 2J6 Tel: (416) 506-1403/ Fax: (416) 506-1404 www.pwatoronto.org	Volunteer Program 6963-06-2002/4480437
FFL Sponsored by Toronto PWA Foundation 399 Church St., 2nd floor, Toronto, ON M5B 2J6 Tel: (416) 506-1403/ Fax: (416) 506-1404 www.pwatoronto.org	Food For Life 6963-06-2002/4480435
Voices of Positive Women 66 Isabella St., Suite 105, Toronto, ON M4Y 1N3 Tel: (416) 324-8703/ Fax: (416) 324-9701 www.vopw.org	Peer Network Community Collaboration Program 6963-06-2002/2370428

ACAP Time-Limited Projects
2005-06 to 2006-07

For detailed descriptions, please see:
http://www.phac-aspc.gc.ca/aids-sida/about/reg_ontario_e.html

ACCESS AIDS Network (Sudbury Site) 111 Elm Street, Suite 203, Sudbury, ON P3C 1T3	Enhancing Supportive – IDU Services 6963-06-2004/6420449

Tel. 705-688-0500/ Fax.705-688-0423 www.accessaidsnetwork.com	
AIDS Committee of Guelph & Wellington County Masai Centre for Local, Regional & Global Health 409 Woolwich Street, 2nd Floor, Guelph, ON N1H 3X2 Tel. 519-763-2255/ Fax. 519-763-8125 www.aids.guelph.org	Masai Centre: A New Paradigm for Excellence in HIV/AIDS Care, Treatment, Support & Prevention 6963-06-2004/4480454
AIDS Committee of Toronto 399 Church Street, 4th floor, Toronto, ON M5B 2J6 Tel. 416 340 2437/ Fax. 416 340 8224 www.actoronto.org	Case Management for People Living with HIV/AIDS 6963-06-2004/4480457
Alliance for South Asian AIDS Prevention 20 Carlton Street, #126, Toronto, ON M5B 2H5 Tel: 416-599-2727/ Fax: 416-599-6011 www.asaap.ca	Cover the Right Things/ Discover with a Cover - Healthy Sexuality resources for South Asian Men who have Sex with Men 6963-06-2004/6420455
Asian Community AIDS Services 33 Isabella Street, Suite 107, Toronto, ON M4Y 2P7 Tel. (416) 963-4300 x 27/ Fax. (416) 963-4371 www.acas.org	Developing culturally competent and holistic treatment support & health promotion models for vulnerable ethnoracial people living with HIV/AIDS 6963-06-2004/6420458
Black Coalition for AIDS Prevention 110 Spadina Ave, Suite 207, Toronto, ON M4V 2K4 Tel. 416-977-9955/ Fax. 416-977-2325 www.black-cap.com	Muungano (Together): African and Caribbean ASOs working together to coordinate HIV/AIDS services for communities from Endemic regions in the GTA and surrounding areas 6963-06-2004/6420462
Centre Francophone de Toronto 22 College Street, Toronto, ON M5G 1K3 Tel. (416) 922-2672/ Fax. (416) 922-6624 www.centrefranco.org	VIH/SIDA : Lisalisani – Kombit – Entraide communautaire 6963-06-2004/1140426
Fife House 2nd floor – 571 Jarvis St., Toronto, ON M4Y 2J1 Tel. 416 205 9888/ Fax. 416 205 9919 www.fifehouse.org	Wellesley Supportive Housing Development Project 6963-06-2004/4480455
Hamilton AIDS Network	COPEC: Community Outreach People from

140 King Street East, #101, Lower Level, Hamilton, ON L8N 1B2 Tel. 905 528-0854/ Fax. 905 528-6311 www.aidsnetwork.ca	Endemic Countries 6963-06-2004/4480460
HIV/AIDS Regional Services 844A Princess St., Kingston, ON K7L 4G5 Tel. 613-545-3698/ Fax. 613-545-9809 www.hars.ca	Harm Reduction in LGL 6963-06-2004/6420450
Native Men's Residence 14 Vaughan Rd, Toronto, ON M6G 2N1 Tel : 416-652-0334/ Fax : 416-652-3138 www.nameres.org	Na-Me-Res/Tumivut Aboriginal Homeless Youth HIV/AIDS Prevention Initiative 6963-06-2004/6420456
Ontario AIDS Network 468 Queen Street East, #105, Toronto, ON M5A 1T7 Tel. 416-364-4555/ Fax.416-364-1250 www.ontarioaidsnetwork.on.ca	Making Connections 6963-06-2004/6420460
CAAT Sponsored by Regent Park Community Health Centre 465 Dundas Street East, Toronto, ON M5A 2B2 Tel. 416 364-2261/ Fax. 416 364-0822 www.regentparkchc.org	Committee for Accessible AIDS Treatment: Improving service for immigrant & refugee PHAs through improving relevant policies & programs 6963-06-2004/4480456
MCHC Sponsored by Somerset West Community Health Centre 55 Eccles Street, Ottawa, ON K1R 6S3 Tel. 613 238-821/0 Fax. 613 238-7595 www.swchc.on.ca	Multi-Cultural Health Coalition: Ethnocultural Peer Training for HIV/AIDS Prevention 6963-06-2004/4480459
Warden Woods Community Centre 74 Fir Valley Court, Scarborough, ON M1L 1N9 Tel. 416-694-1138/ Fax. 416-694-1161 www.wardenwoods.com	Scarborough HIV/AIDS Prevention Project (SCHAPP) Young People Rethinking Gender Roles 6963-06-2004/4480452
Women's Health in Women's Hands Community Health Centre 2 Carlton Street, Suite 500, Toronto, ON M5B 1J3 Tel. 416-593-7655/ Fax. 416-593-5867 www.whiwh.com	HIV Education and Prevention Project for African and Caribbean Women (HEP Project) 6963-06-2004/4480462