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

To the End of Fiscal Year 2008-09

A Collaborative Project of
the AIDS Bureau, Ontario Ministry of Health and Long-Term Care and
the Public Health Agency of Canada, Ontario and Nunavut Regional Office
March 2010

Table of Contents

Acknowledgements

The AIDS Bureau and the Public Health Agency of Canada (PHAC) Ontario and Nunavut Agency Regional Office (ARO) would like to thank the programs that provided the data used in this report. It takes time to collect data and complete the Ontario Community-based HIV and AIDS Reporting Tool (OCHART), and the funders appreciate the attention programs and staff give to completing the forms. The AIDS Bureau and PHAC's Ontario and Nunavut ARO would also like to thank all the individuals who worked with us to improve the OCHART questions and the accuracy of OCHART data.

In addition, the AIDS Bureau and PHAC's Ontario and Nunavut ARO 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 programs on the use of OCHART, housing the data, and extracting the data and completing the analyses for this report.

For more information about completing OCHART forms or to request program-specific data and reports, please contact: Greg Mitchell at 416-642-6486 ext 2303 or gmitchell@ohtn.on.ca

Contributors

Joanne Lush, Senior Program Consultant, AIDS Bureau, Ministry of Health and Long-Term Care

Len Lopez, Program Consultant, Public Health Agency of Canada, Ontario and Nunavut Agency Regional Office, AIDS Community Action Program

Nadia Ghani, Evaluation Consultant, Public Health Agency of Canada, Ontario and Nunavut Agency Regional Office, AIDS Community Action Program

Greg Mitchell, OCHART Coordinator, OHTN

Michelle Song, OCHART Database Specialist, OHTN

Jean Bacon, Director, Policy and KTE, OHTN

Charles Shamess, Director, Evidence-based Practice Unit, OHTN

Preface

Welcome to the 4th annual OCHART (Ontario Community-based HIV and AIDS Reporting Tool) report: ***The View from the Front Lines***.

Twice each year, the community-based HIV/AIDS programs funded by the Ontario Ministry of Health and Long-Term Care AIDS Bureau and the Public Health Agency of Canada (PHAC) Ontario and Nunavut ARO, AIDS Community Action Program (ACAP), are required to complete the web-based OCHART. Programs that receive ACAP funding are also required to complete a web-based logic model that is linked to OCHART.

The data and information provided through OCHART give funders the information they need to:

- review the range of services provided
- identify emerging issues and trends
- inform planning and
- account for use of public resources.

The purposes of OCHART reporting are:

- Accountability: the reports allow the programs, 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 programs can use to strengthen their services.

The data analysis and reports also give community-based programs information about services, trends and client needs that they can use to improve existing services and plan new ones.

What's Different About this Year's Report?

1. **It is more focused**. This report provides key findings and emerging trends from some questions in the 2008-09 OCHART reports. To see the summary of responses to *all* 2008-09 OCHART questions, go to https://www.ochart.ca/documents/OCHART_Supplementary_Tables_by_Region.pdf
2. **Some data from previous years have been revised.** We are continually working to make OCHART data as accurate as possible. To that end, we have corrected some data entry errors from previous years so the numbers in this report may differ from those in past reports.
3. **Some questions are new or slightly different.** We are still refining the OCHART questions to make sure we collect useful information. The questions used in 2008/09 may differ from the questions in 2009/10. To minimize confusion, all charts in this report and in the online summary of OCHART responses are numbered to match the relevant 2008-09 OCHART question, and the questions are included in each section.
4. **Data provided by provincial programs is reported differently**. Eleven programs that complete OCHART reports are considered "provincial" -- that is, their mandate is to provide services across the province.
    - Of those 11 programs, five provide services directly to clients (i.e., people living with HIV, people at risk, people affected). The 2008-09 OCHART report includes the data from these programs. Two of the five -- the Ontario Aboriginal HIV and AIDS Strategy (OAHAS) and the Hemophilia Ontario -- have regional staff/satellites so their data are included in the regions where the services are delivered. The data from the other three provincial programs that provide client services are captured in a separate category as provincial programs.

- Six are resource programs, such as the Ontario AIDS Network (OAN), that provide capacity building services for other community-based HIV/AIDS programs. All data from the provincial resource programs for sections 9 to 13 have been removed from the general analysis and are included in a separate section. This was done for two reasons: because the activities they provide (e.g., training, skills building, knowledge transfer and exchange) do not "fit" in the current OCHART questions (a new OCHART section is being developed to capture their activities), and because the large volume of some of their activities (e.g., Internet hits reported by CATIE) can distort overall results.

The following table lists the provincial programs that provide services to clients as well as those that are resource programs.

Provincial HIV/AIDS Programs

Provincial Programs that Provide Services Directly to Clients	Provincial Programs that are a Resource for Other HIV/AIDS Programs*
HIV & AIDS Legal Clinic (Ontario) (HALCO)	African and Caribbean Council on HIV/AIDS of Ontario (ACCHO)
Ontario Aboriginal HIV and AIDS Strategy (OAHAS)	AIDS Bereavement Project of Ontario (ABPO)
Hemophilia Ontario	Canadian AIDS Treatment Information Exchange (CATIE)
Prisoners' HIV/AIDS Support and Action Network (PASAN)	Ontario AIDS Network
Voices of Positive Women	Ontario Organizational Development Program (OODP)
	Ontario HIV and Substance Use Training Program

** Provincial resource programs provide training, information and other services to enhance the capacity of other community-based HIV programs.*

How the Report is Organized

This report follows the same order as the OCHART form:

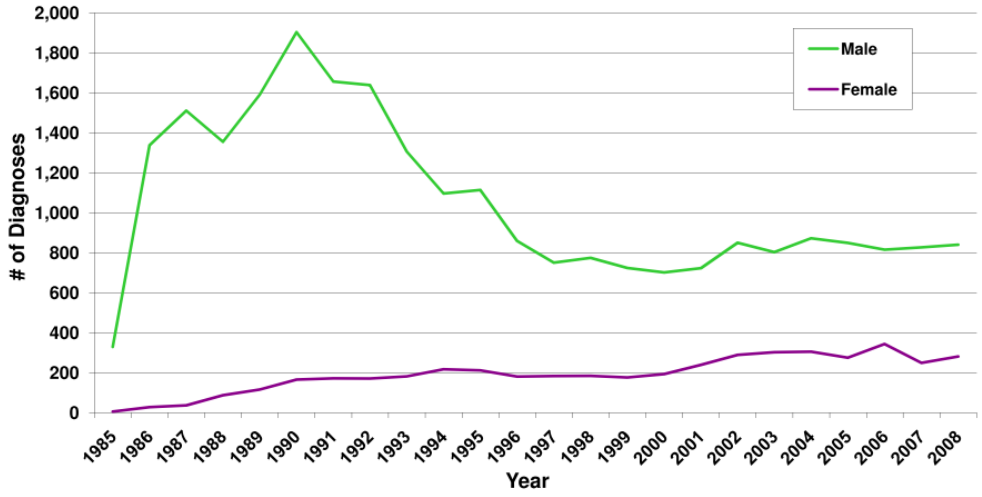
Section	Contents
Part I: Context – Trends in HIV Infection	Epidemiological data and information on how the data are aggregated and presented
Part II: How We Work	Information on the organization, governance, funding, staffing, planning, evaluation and partnerships of community-based organizations, taken from OCHART sections 1 through 5, 7 and 8
Part III: Who We Serve	Information on the catchment area and populations community-based organization service, taken from OCHART section 6
Part IV: What We Do	Information on the programs and services provided by funded organizations, taken from OCHART sections 9 through 13
Part V: ACAP Report	A separate summary of the programs funded by the Public Health Agency of Canada AIDS Community Action Program

Part I. Trends in HIV Infection in Ontario

New Diagnoses Up Slightly in 2008

The number of new HIV diagnoses in 2008 (1,120) was up 4.6% compared to 2007 (1,068) – but it was still down from the peak year during the past 10 years (i.e., 1,177 in 2004).

Figure 1: Number of HIV Diagnoses (adjusted[1]) Among Males and Females by Year of Diagnosis, Ontario, 1985 to 2008



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/Table1.pdf - accessed September 15,2009

In 2008, 75% of new diagnoses were in men and 25% in women, which is comparable to earlier years: 77% and 23% in 2007 and 70% and 30% in 2006 (the year with the highest number of new diagnoses in women to date). These gender trends continued in the first two quarters of 2009 (i.e., 76% of cases in men and 24% in women).

Year	# of Men Diagnosed	# of Women Diagnosed	Total
2006	809	338	1,147
2007	822	246	1,068
2008	840	280	1,120

Steady Increase in New Cases in MSM Over Past Three Years

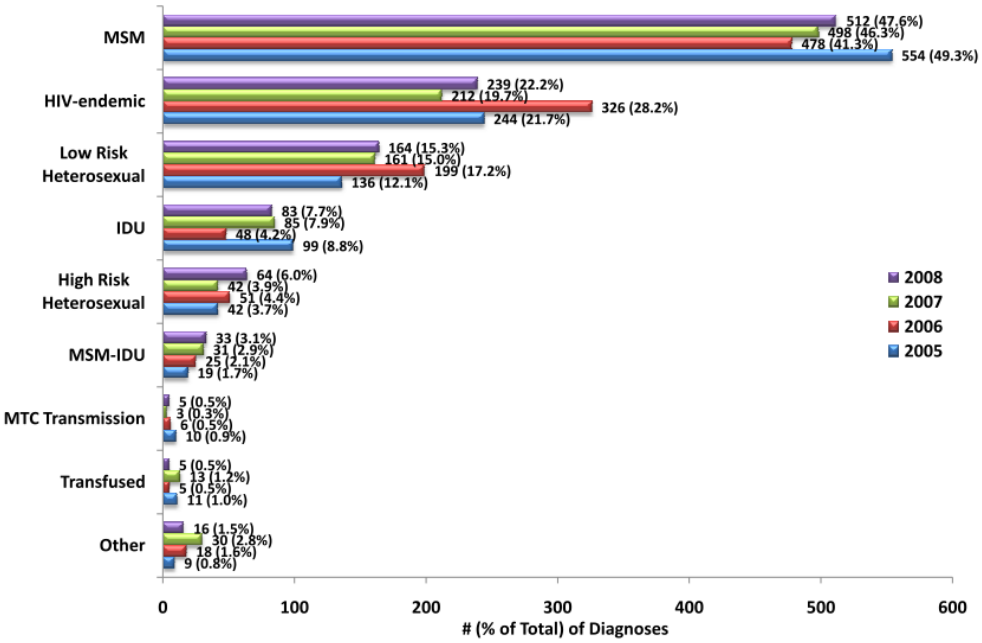
In terms of risk factors for HIV infection (Figure 2), the picture has been the same for at least the last four years:

- Men who have sex with men --including those who also use injection drugs -- still account for about 50% of new diagnoses.
- People from countries where HIV is endemic account for almost one quarter of new cases.
- People who report injecting drugs account for about 8% of new diagnoses.
- High risk heterosexuals (i.e., people whose sexual partners have a risk factor for HIV, such as having HIV, using injection drugs or being a man who has sex with men) accounted for 6% of new diagnoses in 2008 – up from 4% in 2007.

Note: Case finding with people whose risk factor was low risk heterosexual activity usually reveals they are high risk (i.e., they have a sexual partner who: is infected with HIV, injects drugs, or is a man who has sex with men).

Over the past three years, there's been a steady increase in new diagnoses among men who have sex with men.

Figure 2: Number (adjusted[1]) of HIV diagnoses by Year of Test and Exposure Category - 2005 to 2008



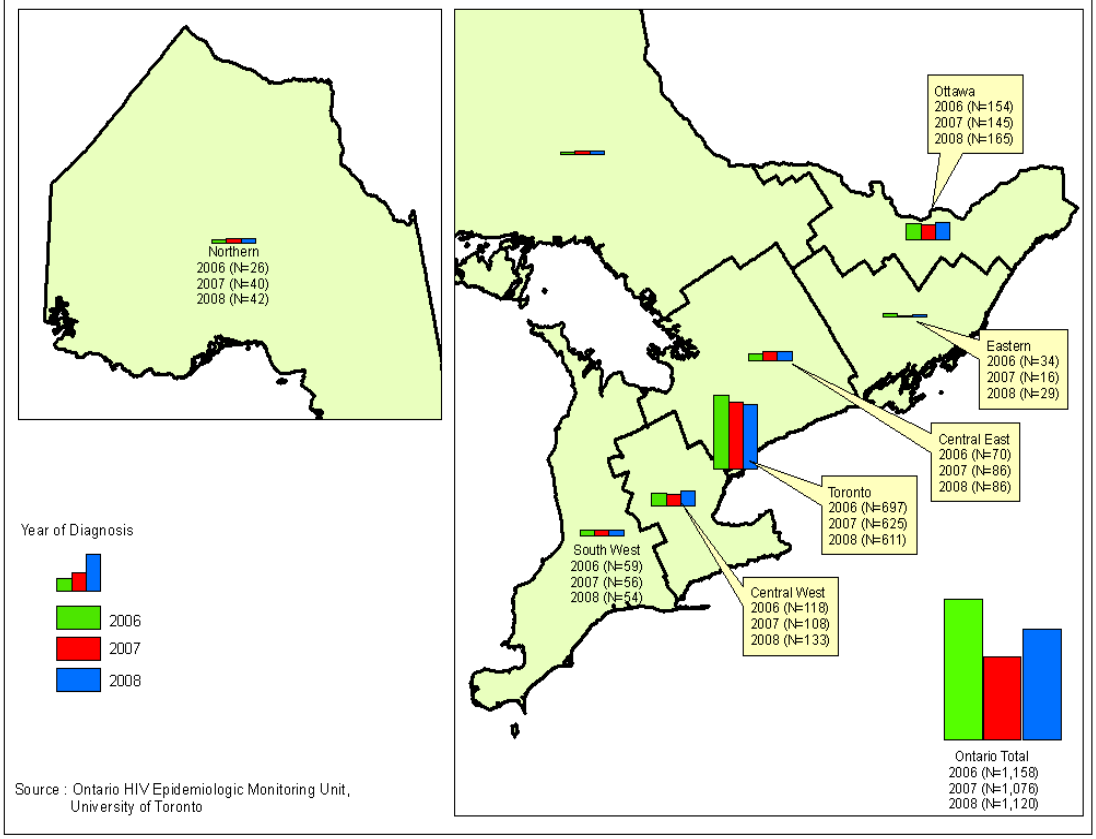
Source: HIV Laboratory, Laboratory Branch, Ontario Agency for Health Protection and Promotion. MSM = men who have sex with men; HIV-endemic = people from countries where HIV is endemic, such as Africa and the Caribbean; IDU = injection drug use; MTC = mother-to-child transmission.

Although slightly fewer people were tested in 2008 (402,110) than in each of the previous two years (410,252 in 2007 and 413,068 in 2006), the proportion that tested positive remained about the same (.28%) – which indicates that Ontario's HIV testing programs continue to reach people at risk.

Toronto and South West See Drop in New Cases

Toronto and the South West were the only regions where the number of new HIV diagnoses each year decreased between 2006-07 and 2008-09. All other regions saw a similar or a slightly higher number of new diagnoses each year. It is encouraging to see a steady decline in new cases in Toronto, where the prevalence of HIV is higher than in other parts of the province. However, that picture may be changing. In 2009, there was an increase in syphilis cases among gay men in Toronto, which is an indicator of unsafe sex and often a precursor to higher HIV rates. In the first half of 2009, there was an increase in HIV diagnoses in gay men.

Figure 3. Number of HIV Diagnoses by Health Region, 2006-2008



For more specific information on the epidemiology of HIV in Ontario, please go to the Ontario HIV Epidemiologic Monitoring Unit at http://www.phs.utoronto.ca/ohemu/mandate.html.

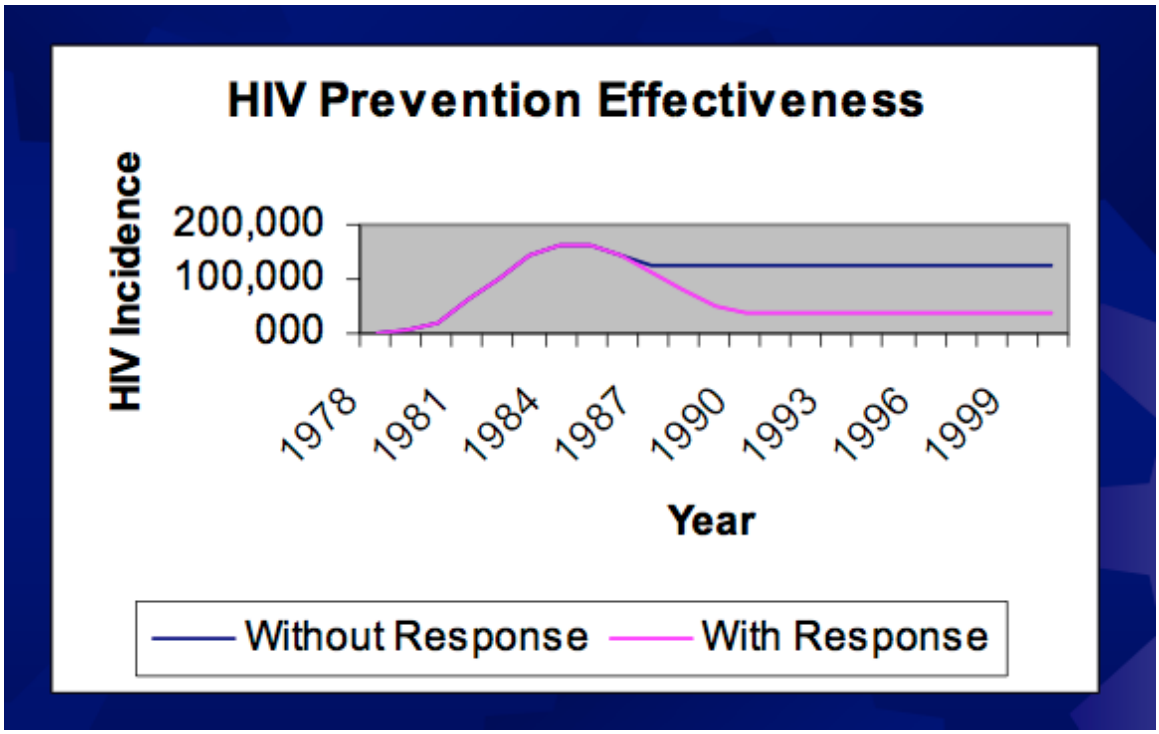
Prevention Programs are Limiting the Increase in New Infections

Ontario continues to have over 1,000 new HIV diagnoses each year, and funded programs sometimes question whether education, prevention and outreach programs are making a difference.

According to health economists in the US (Holtgrave, 2002), community-based HIV programs have reduced the severity of the epidemic in that country and are cost-effective. As the following figure illustrates, the US economists estimated conservatively (based on modeling of infectious diseases) that – *without* prevention programs – the number of new infections would have declined slightly to about 123,000 a year and remained relatively constant at the rate. However, because of prevention programs, the number of new infections has declined significantly and the US was

able to avoid over 1 million new infections between 1985 and 2000 at a relatively low cost (about $9,000 to avert an infection compared to >$200,000 to treat each infection).

Figure 4: Effectiveness of Prevention Programs in the US



Dr. Robert Remis of the Ontario HIV Epidemiological Monitoring Unit applied the same analysis to Ontario's projected (modeled) number of new infections. Based on his findings, between 1984 and 2007, Ontario has been able to avoid between 6,728 and 13,456 new infections – thanks in part to prevention interventions.

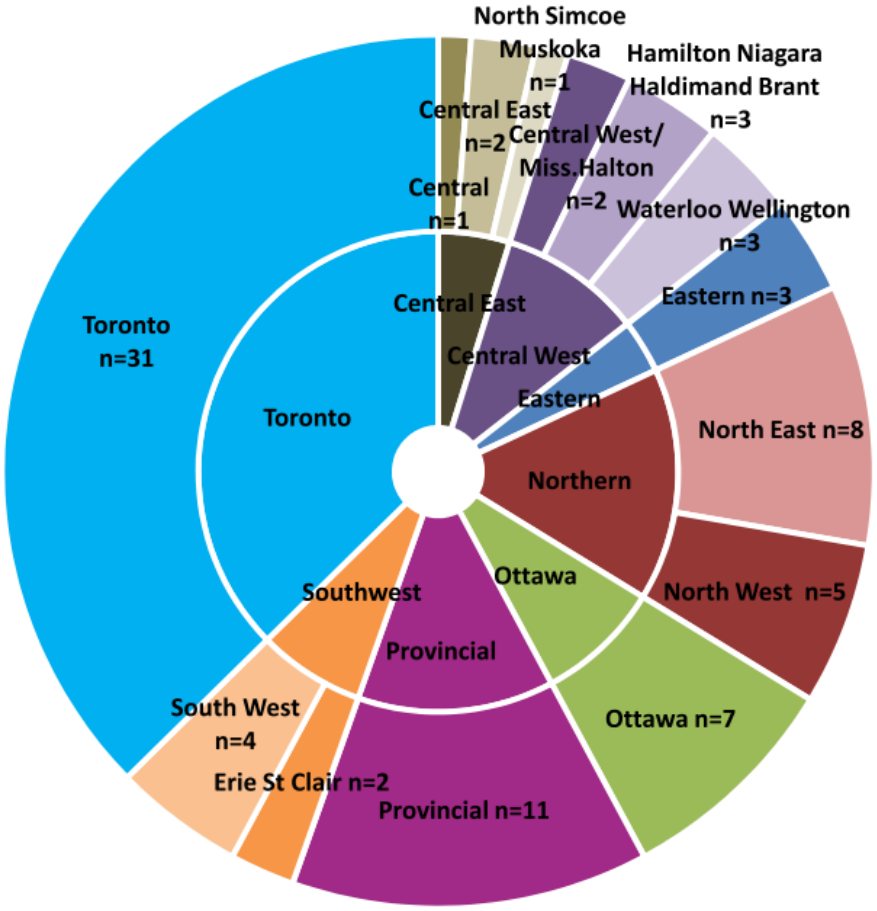
For more information on the epidemiology of HIV in Ontario, see the Ontario HIV Epidemiological Monitoring Unit web site http://www.phs.utoronto.ca/ohemu/mandate.html

Part II: How We Work

In 2008-09, a total of 83 programs (located in 67 agencies or organizations) completed OCHART compared to 77 in 2007-08; however the increase was mainly due to the regional satellites of Hemophilia Ontario reporting as separate programs within their regions instead of as a single provincial program. This change was made in order to understand the type/level of services provided in each region.

The chart below indicates how funded programs are distributed across the province: the inner circle represents the regions and the outer circle the Local Health Integration Network (LHIN).

Figure 5: Program Distribution Across Region and LHIN



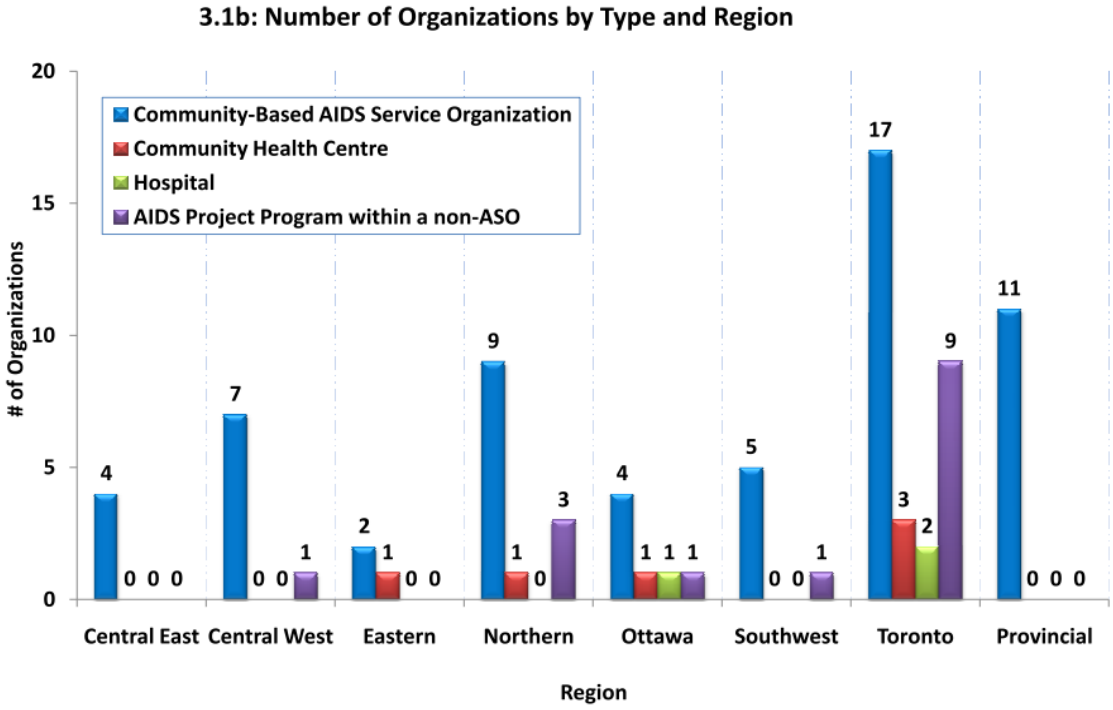
This report includes the breakdown of data by region in order to ensure that regional differences are not lost in provincial data. Information by LHIN is available on request.

Community-based HIV/AIDS Programs Provided by a Mix of Organizations

Of the 83 programs whose data are included in this report, the majority (58 programs or 70%) are AIDS service organizations (ASOs). The others are: community health centres, hospitals or non-ASOs that offer some HIV/AIDS programming.

Figure 3.1 shows the mix of types of programs funded in each region in 2008-09. There are community-based AIDS services organizations (ASOs) in all regions, and at least three funded HIV programs in each region. For a list of the programs that submitted OCHART reports in 2008-09 by region, see Appendix A.

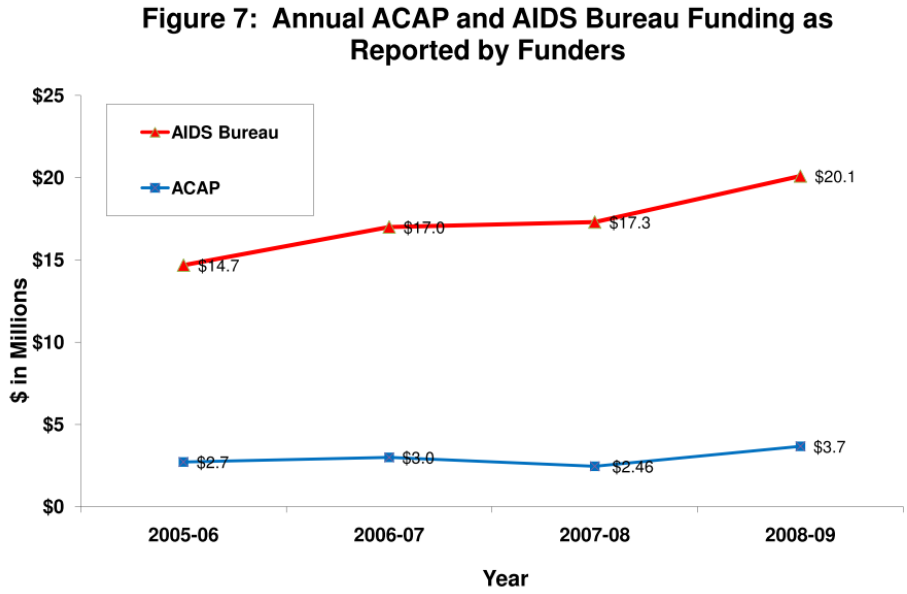
Government Funding Up 20% in 2008



Both AIDS Bureau and ACAP funding increased in 2008-09 by just over 20% overall:

- AIDS Bureau funding increased by 16%
- ACAP funding increased by 50.4%.

The following graph shows the actual amount of funding provided by the two funders each year.



The increase in PHAC's Ontario and Nunavut ARO funding between 2007-08 and 2008-09 was due to the ramping up of resources under the Federal Initiative to Address HIV/AIDS. (Note: 2008-09 is the final year of increases under the federal strategy).

The following graph is a breakdown of AIDS Bureau and ACAP funding by region. It illustrates that the Toronto region receives almost half of the funding from these two levels of government. The figure for Toronto region includes the provincial service programs (i.e., those that provide direct client services) but NOT the provincial resource programs (i.e., those that provide training, information and other services to enhance the capacity of other community-based HIV programs). The provincial service programs were included because a significant number of the clients they serve are in the Toronto region.

Figure 7a: AIDS Bureau and ACAP Funding by Region

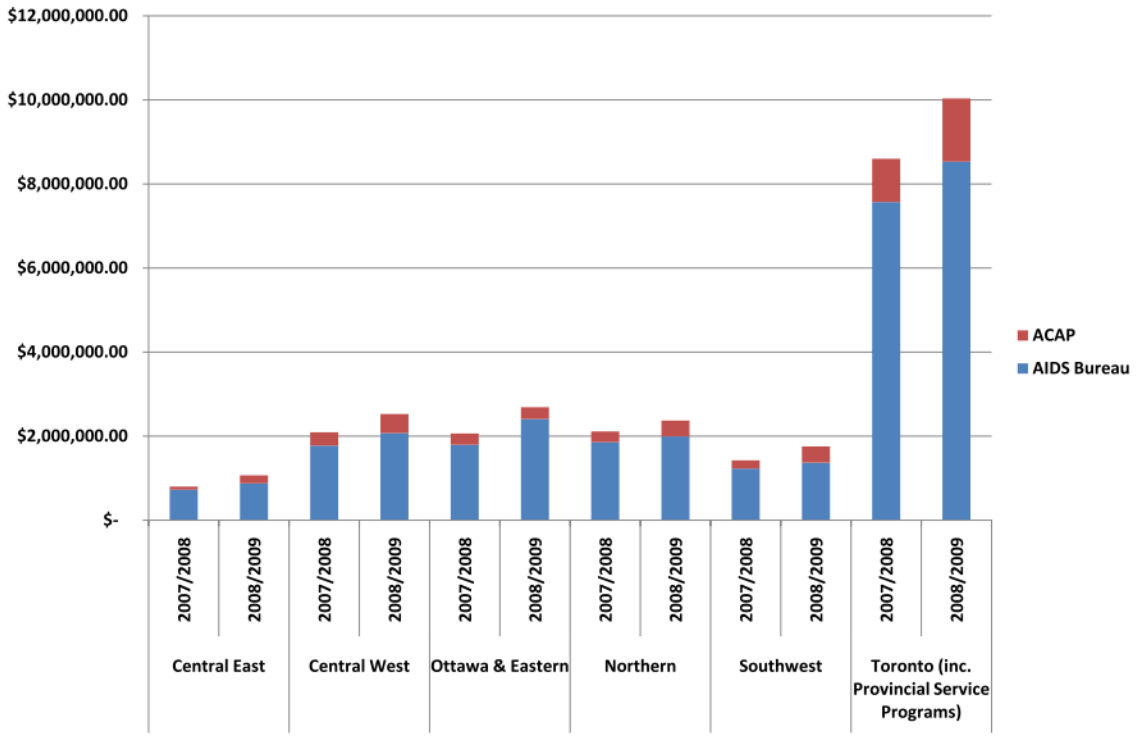


Figure 7b shows the total amount of funding to programs located in Toronto, including provincial resource programs.

Figure 7c looks at the relationship between funding levels and prevalence of HIV by region for the year 2007, which is the most recent year for which we have HIV prevalence data. It shows that, in four of the six regions, the level of funding is relatively consistent with HIV prevalence. In the other two – Northern and Central West – funding is higher than prevalence. Programs in the Northern Region face different costs related to providing services over a large rural geographic area, and programs in Central West are likely providing services for a significant number of people who are "counted" in Toronto but live outside the city. Prevalence rates used in this document are based on where people were tested as opposed to where they actually live.

Figure 7b: AIDS Bureau and ACAP Funding - Agencies Located in Toronto

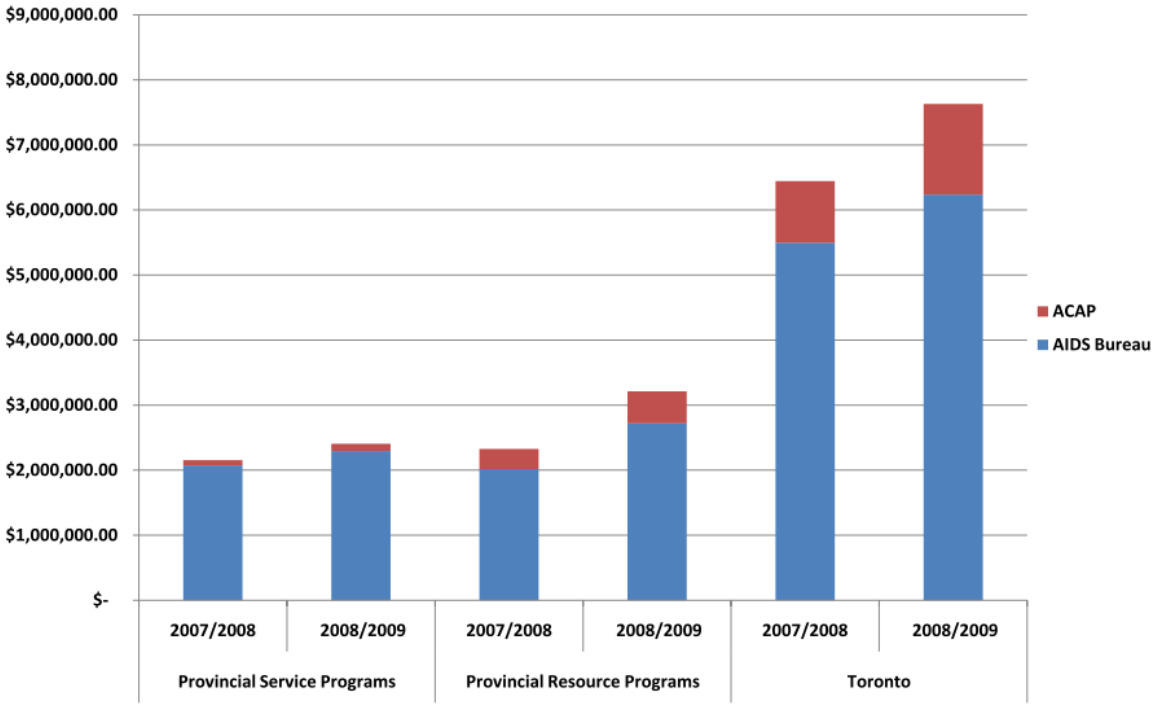
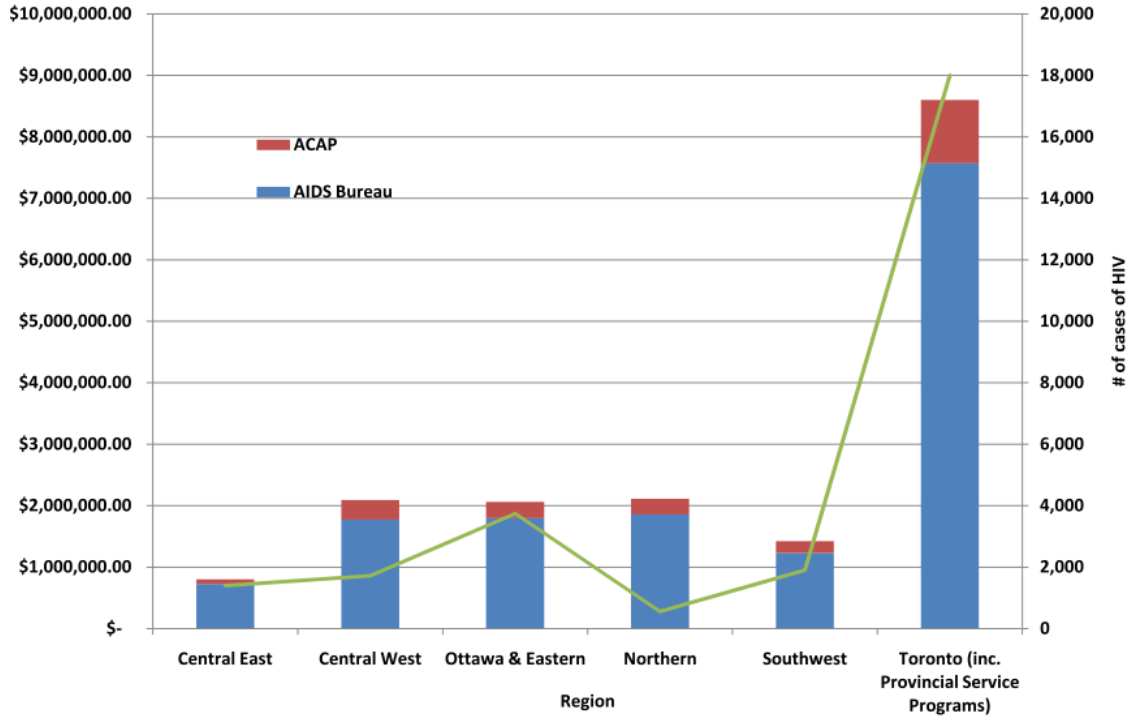


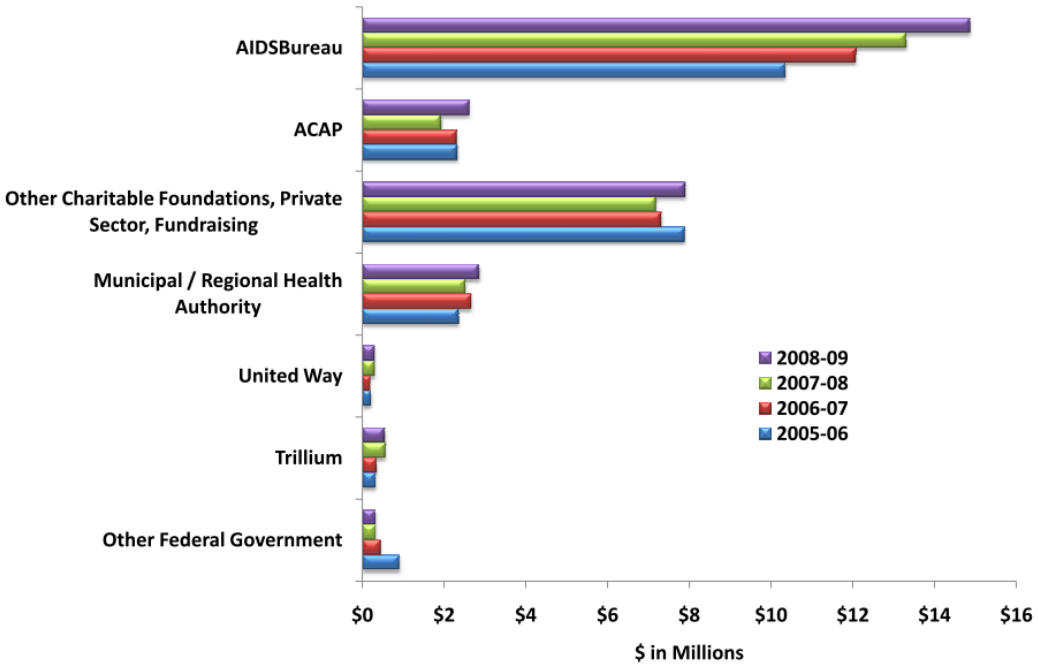
Figure 7c: AIDS Bureau and ACAP Funding vs HIV Prevalence by Region - 2007



Half the Programs Report Increase in Fundraising

Community-based AIDS service organizations (unlike community health centres and hospitals) depend on fundraising for part of their operating budgets each year. In 2008-09, these programs reported maintaining the level of funding from other sources, such as Trillium Grants and the United Way. They also reported an increase in other charitable organizations and fundraising – reversing a three-year downward trend (see Figure 5.4).

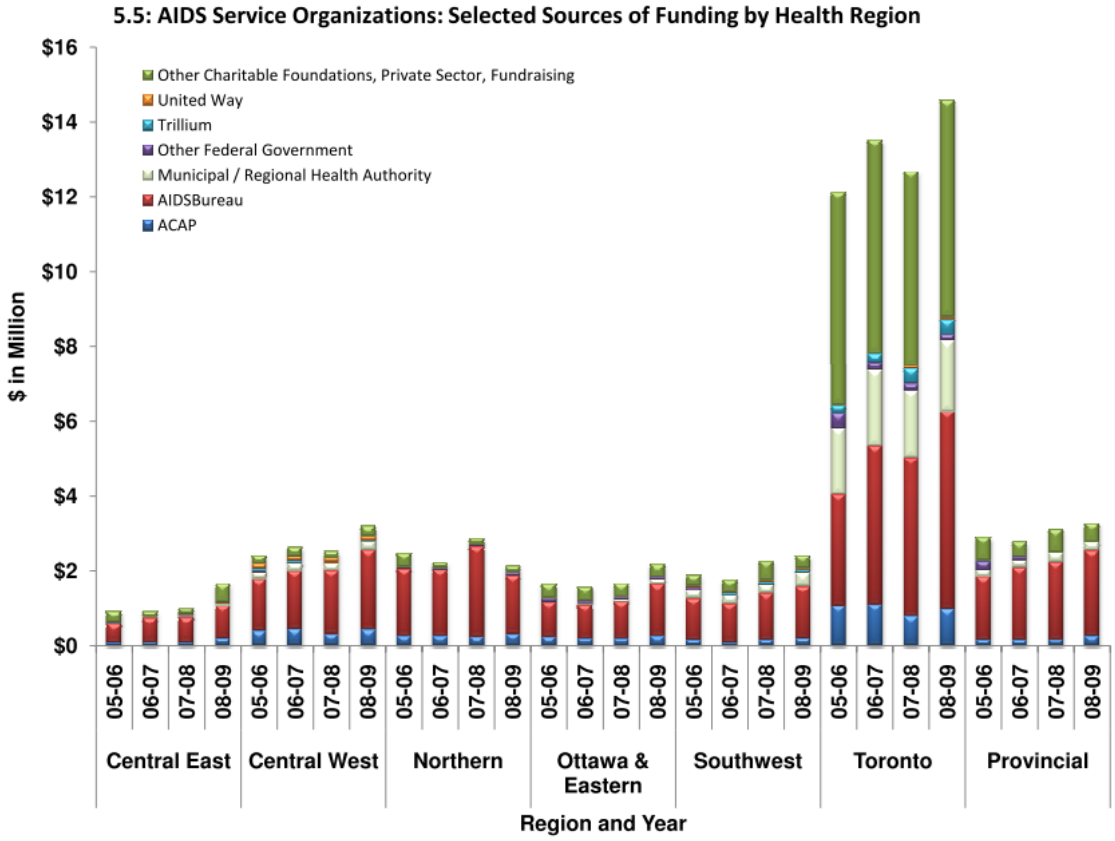
5.4: AIDS Service Organizations: Selected Sources of Funding



A closer look at the data revealed that about half the programs saw a marked increase in fundraising and donations while the other half saw a marked decrease. It would be interesting to learn more about the factors that make some programs so successful at fundraising (e.g., type of events, approaches to fund raising, size of community, board involvement, dedicated fundraising staff).

The extent to which programs depend on fundraised dollars varies significantly across the province. For example, of the 83 programs that submitted OCHART reports in 2008-09, fundraising accounts for only 1% of revenue for two while it accounts for at least 30% of revenue for seven. Three programs rely on fundraising for 48% or more of their budgets.

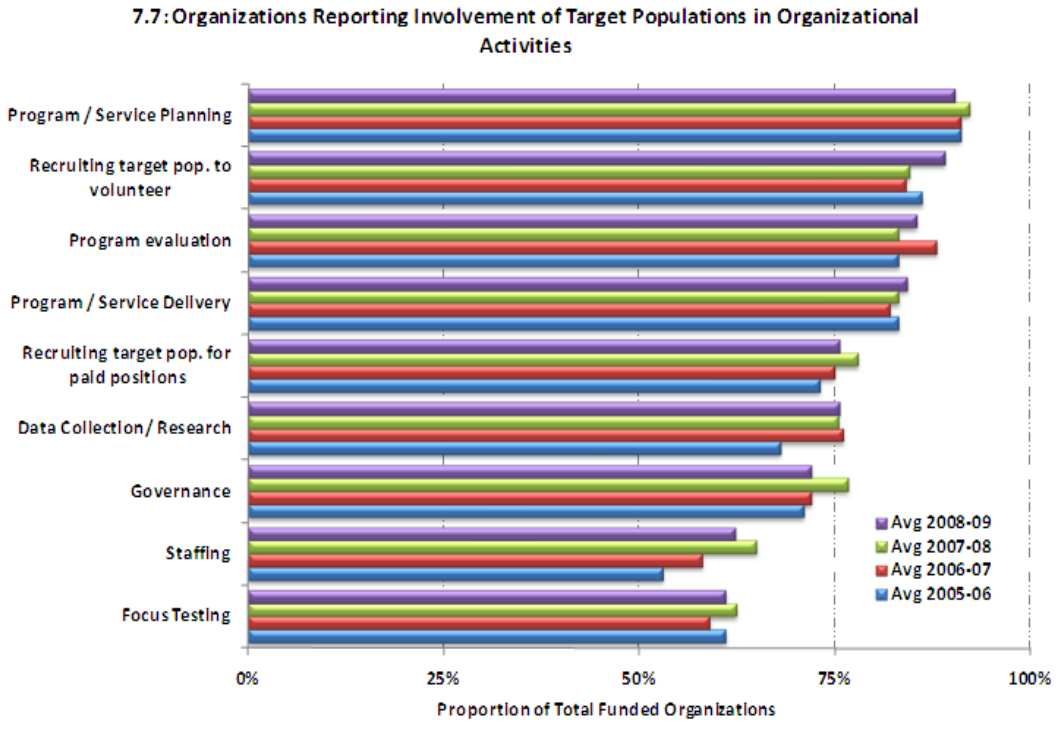
As the following regional funding breakdown illustrates, programs in certain regions – such as Toronto, Central West and South West – are more likely to receive some funding from their municipal government or regional health authority, while programs in the Northern and Eastern regions are mainly dependent on AIDS Bureau and ACAP funding.



Programs Continue to Involve People with HIV

Compared to 2006-07, a slightly smaller proportion of programs recruited or employed people with HIV into staff or governance positions in 2008-09; however, a larger proportion recruited people with HIV as volunteers and to assist with program evaluation and delivery.

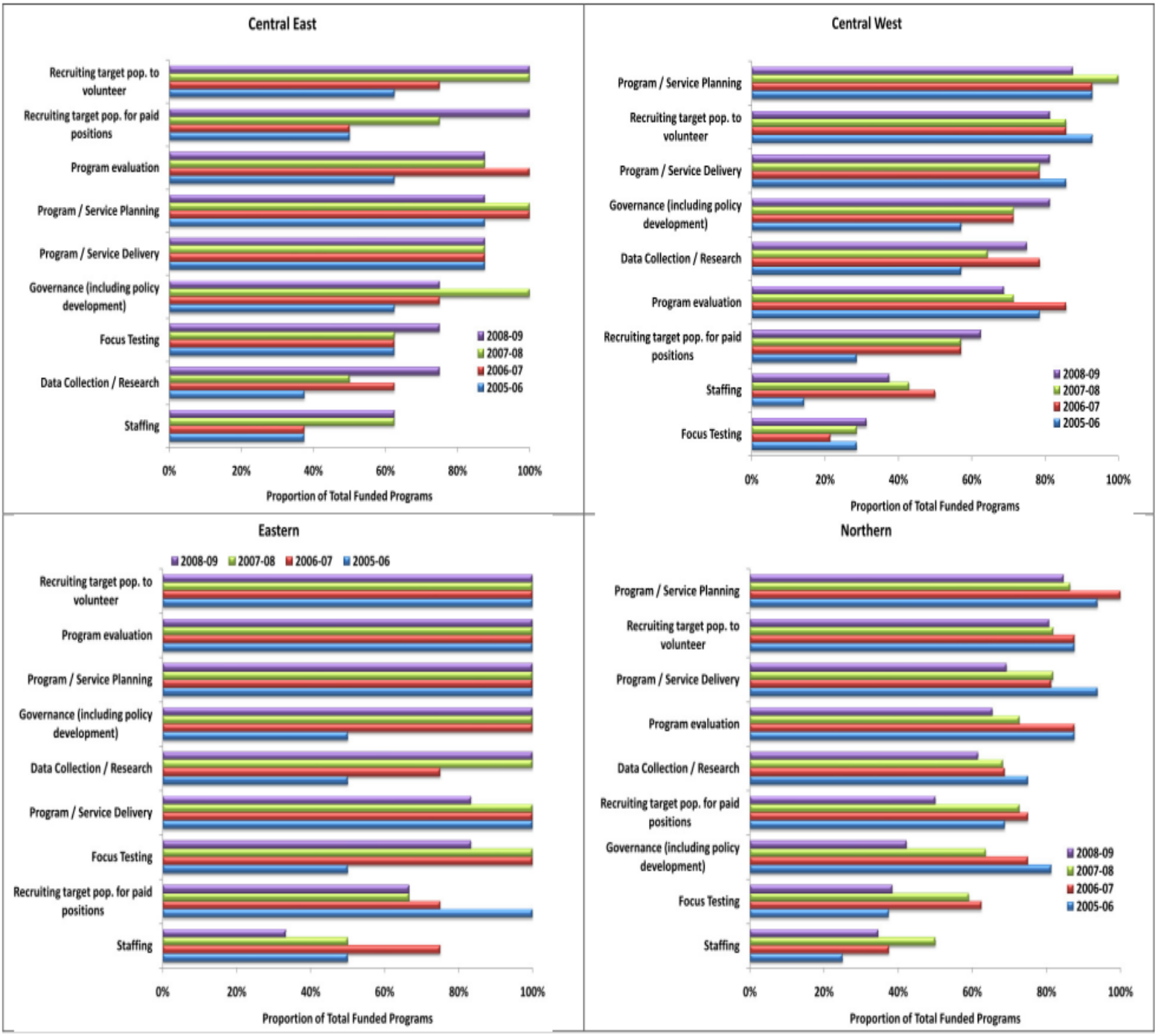
7.7 How does your organization involve target populations in its work?



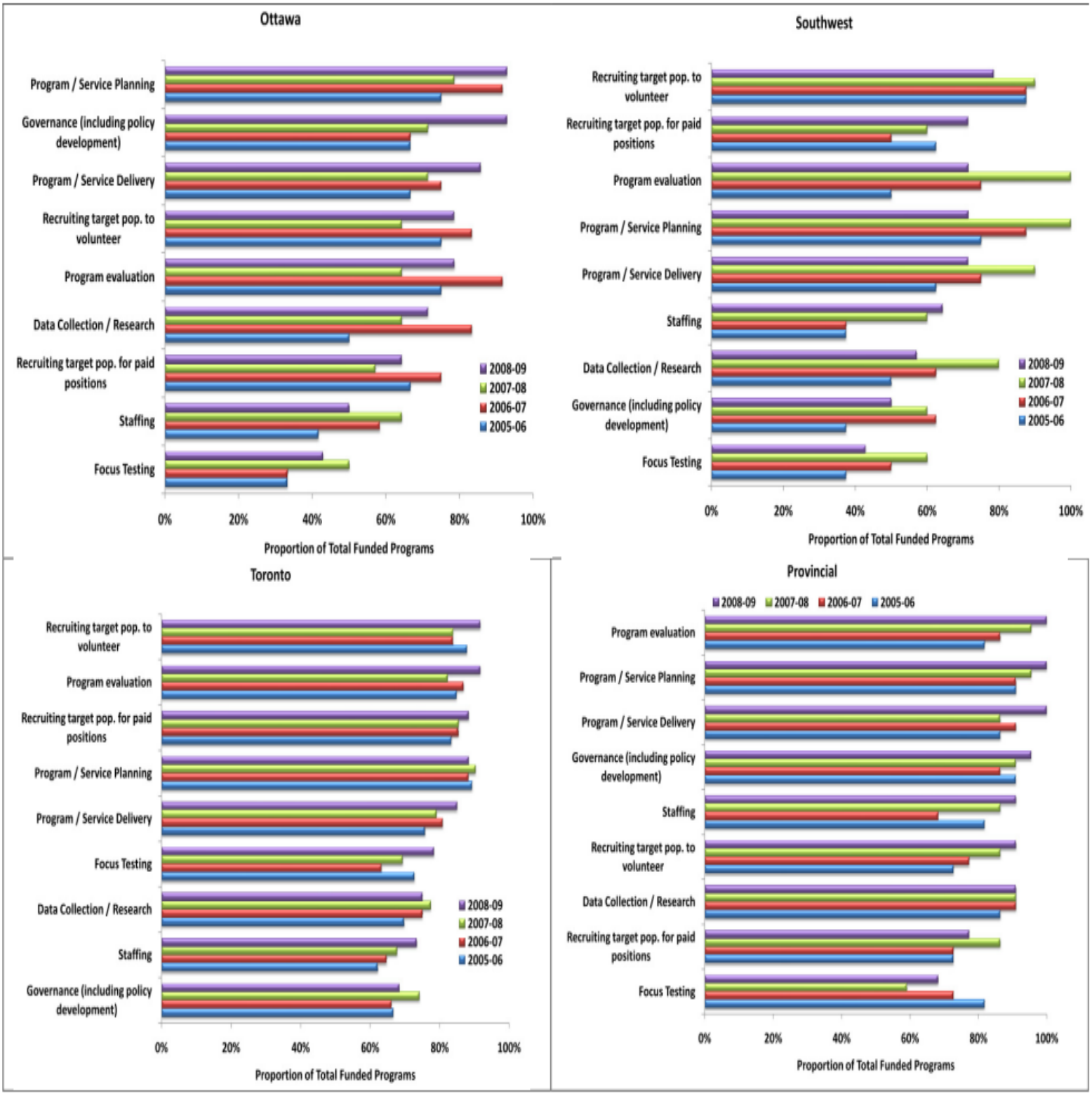
When we look at greater or more meaningful involvement of people with HIV by region, we see that – in most regions – the focus is still on recruiting people with HIV to volunteer or assist in program evaluations. While a larger proportion of programs are trying to recruit people with HIV to paid positions, a much smaller proportion are actually employing people with HIV (staffing) or involving them in governance. This gap may be due to the fact that there are a limited number of paid positions in community-based programs, and their availability depends on funding and staff turnover, so the proportion of organizations with people with HIV in governance and volunteer positions may be better indicators of the involvement of people with HIV than the proportion with people with HIV in paid positions. As the following regional breakdowns indicate, the proportion of programs with people with HIV involved in governance also varies across the province (i.e., higher in Ottawa and the Eastern Region than in other regions).

In terms of the more meaningful involvement of people with HIV, it would be helpful to have a larger discussion that would explore both the benefits and challenges of providing opportunities for people with HIV to volunteer and work within community-based programs. It would be interesting to learn more about the different strategies that programs are using to reach and recruit people with HIV and to create meaningful opportunities for them.

Regional Breakdown for Chart 7.7



Regional Breakdown for Chart 7.7



PHA Leadership and Training Programs Create Demand for More Meaningful Opportunities

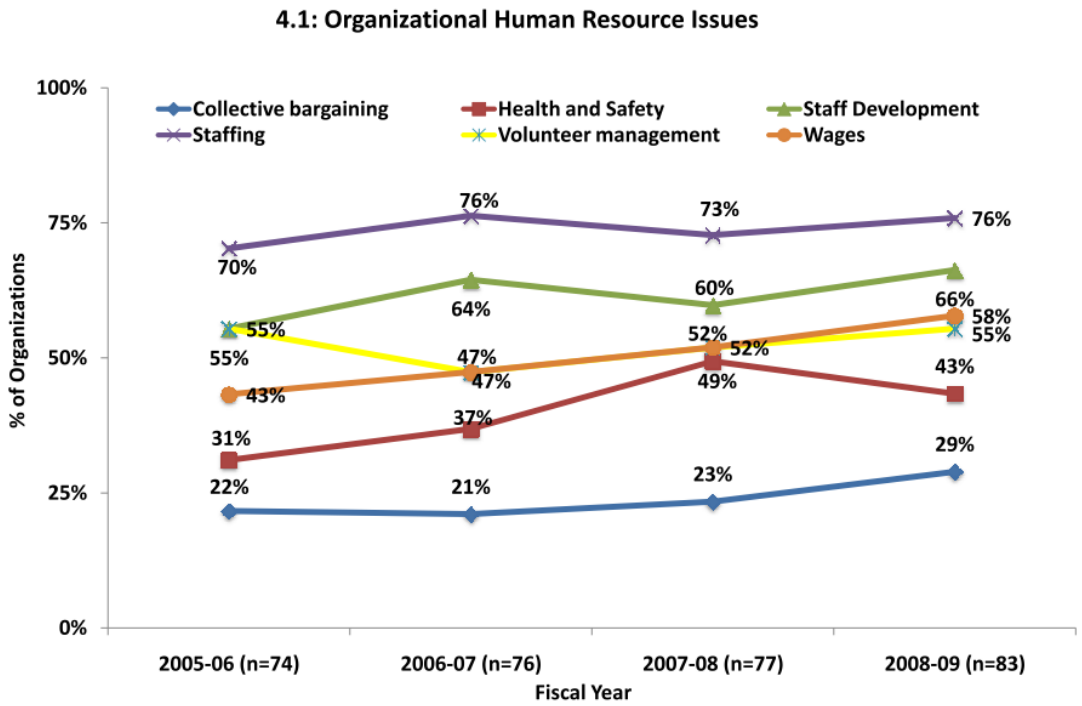
Over the past year, the OAN, CAAT and other organizations have offered leadership and skills development programs for people living with HIV. Graduates of these programs now expect and are looking for meaningful volunteer and employment opportunities that will allow them to use their new skills. However, the relatively low number of people with HIV in paid positions or on boards may indicate that there are barriers to people with HIV working in the field (e.g., lack of opportunities, the need for more skills, financial issues such as potential loss of disability benefits) as well as barriers for programs (e.g., being flexible enough to accommodate employees who may require periods of time off because of their health). There may be a need for capacity building within organizations, and other strategies to address issues related to the greater involvement of people with HIV/AIDS (GIPA) and the meaningful involvement of people with HIV/AIDS (MIPA).

Key HR Issues Continue to be Staff Turnover/Development, Wages and Volunteer Management

OCHART question 4.1: Human resource problems/issues actively being dealt with during this reporting period

A significant proportion of programs continue to struggle with:

- staff turnover, including ED turnover
- managing volunteers
- wage issues (e.g., problems retaining staff because wages are not competitive, funding for part-time or time-limited positions so people leave to take full-time jobs elsewhere).



Fifty-two per cent of the programs specifically reported issues with staff changes, including new hires, reworking of existing positions, people on extended medical leave, and loss or amalgamation of positions during the year (down from 70 in 2007-08 but still about half of all programs), and 57% are anticipating staff changes in the 2009-10 year. Several plan to hire hepatitis C workers.

One new staffing issue was identified: a program that is now operating longer hours to meet client needs is facing some staffing challenges trying to provide extended services. This raises the question of whether programs have the capacity to be flexible and adapt services to meet client needs, which is key to continuous quality improvement.

Although staff turnover is disruptive and recruitment can take time, programs do not seem to be having problems finding people to hire. However, retention continues to be a serious issue.

All but one program reported staff participating in a range of education and training opportunities during the year, including OAN skills building, resiliency training through the AIDS Bereavement Project of Ontario (ABPO), cultural competency training, crisis intervention training and hepatitis C training. Most arranged for staff to attend conferences. One program has developed a staff skills development program designed to retain staff; another identified the need for change management strategies to help staff cope with changes within the program.

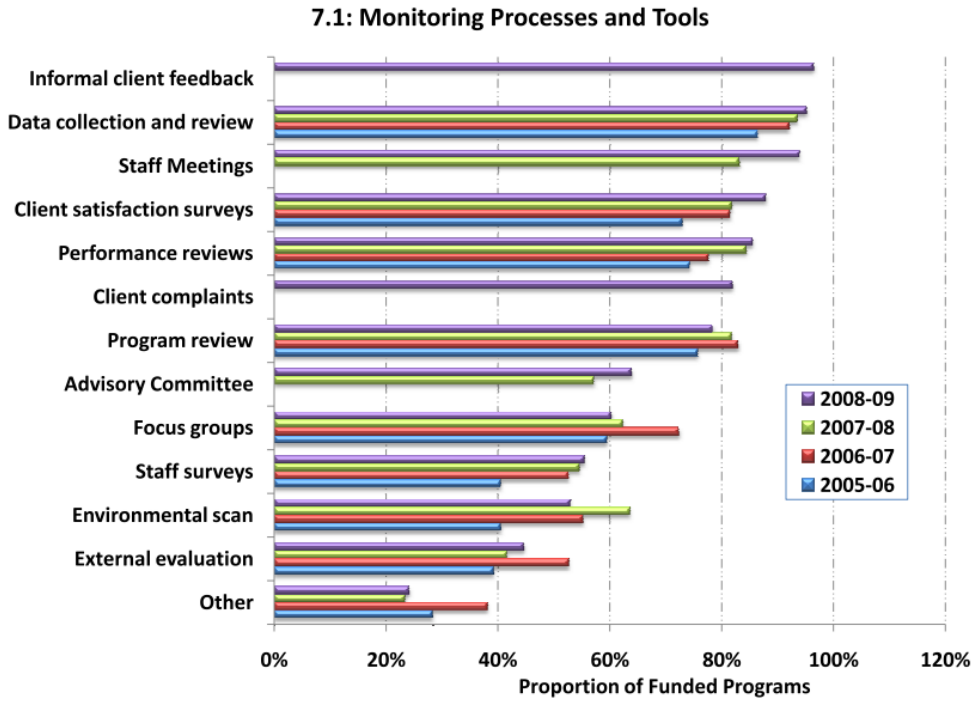
It would be helpful to know whether staffing issues/turnover rates in programs are similar to those in other comparable community-based agencies (e.g., community mental health and addiction services, shelters and other outreach programs) and part of the nature of community-based work. It would also be interesting for programs to identify the types of training, professional development and other supports that are effective in retaining staff.

Programs Use Evaluation to Identify Better Ways to Deliver Programs/Services

OCHART question 7.1: What processes/tools have you used in this reporting period to monitor/evaluate the effectiveness/impact of your services?

Programs are actively monitoring and evaluating their services. As Figure 7.1 illustrates, more are using staff meetings, client satisfaction surveys and performance reviews to assess and improve their services. Almost all use informal client feedback as well as client complaints to monitor and guide their services (reported in OCHART for the first time in 2008-09).

Almost all programs report that they are learning lessons from their evaluation (see list following Figure 7.1). It would be interesting to have more detail on how programs are using evaluation to improve their services, and to create opportunities for programs to share what they learning to strengthen the field.



The lessons learned from monitoring and evaluation range from the general (e.g., better understanding of client needs or program strengths and weaknesses, knowledge about what is working, less duplication of services) to the specific, including:

- effective service models for: IDU outreach workers to connect with people at risk (e.g., different locations, different strategies); programs to engage youth (using popular youth culture), young gay men (a drop-in with counselors available instead of a psycho-educational group) and East African women in prevention programming (integrating prevention and support with communal activities such as crafts or a community kitchen); and partnerships with other agencies
- the need for close links between IDU outreach workers and support service workers
- the need for better training for support group facilitators and peer workers
- food security is a growing issue for people with HIV
- changes in the items offered through the food bank program
- the lack of services for people with hepatitis C and the implications for HIV programs
- the need for data and statistics on certain populations (e.g., South Asian), and for more information on key issues such as disclosure, criminalization, and immigration issues
- the need for a coordinated approach to needle recovery
- the need for more interactive web services and web content
- an increase in aging clients who need wellness activities/support for long-term survivors
- the need for a region-wide volunteer recruitment plan.

Programs report using the lessons learned in a variety of ways, including:

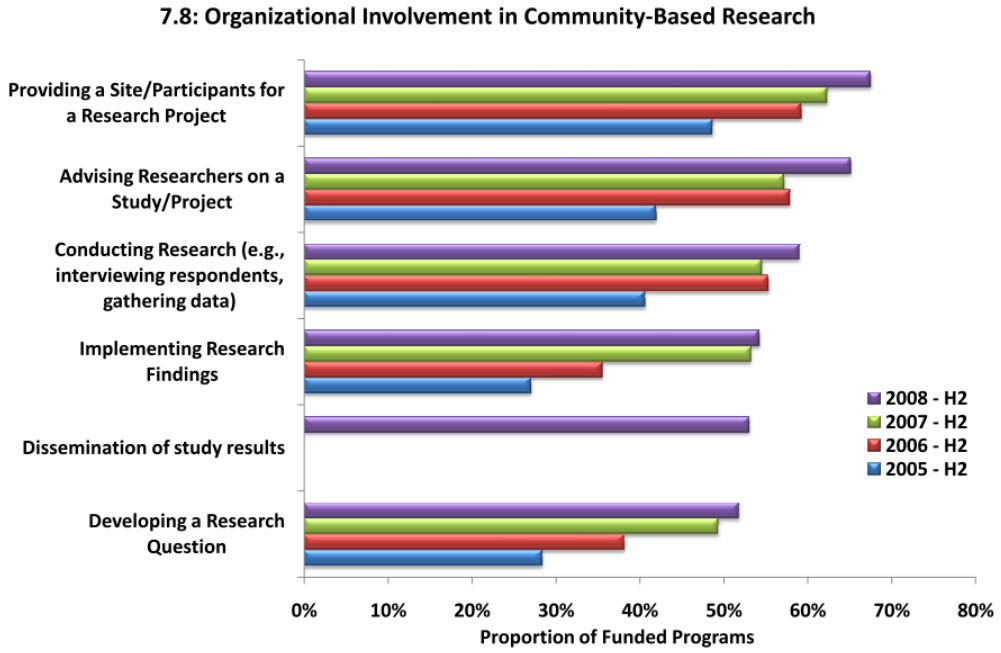
- creating new services, reconfiguring/adjusting/expanding existing ones and eliminating out-dated ones
- establishing new partnerships to address unmet needs (e.g., with housing organizations, police, food banks)

- reviewing and revising training programs or developing new ones
- recruiting staff with specific skills
- increasing satellite sites.

Increase in CBR and evidence-informed practice

OCHART question 7.8: If your organization is involved in community-based research, please describe how.

The proportion of programs involved in research continues to increase. About 70% are either working with a researcher on a study or project or providing a study site or participants. More are actively involved in conducting research, and in implementing and disseminating findings.



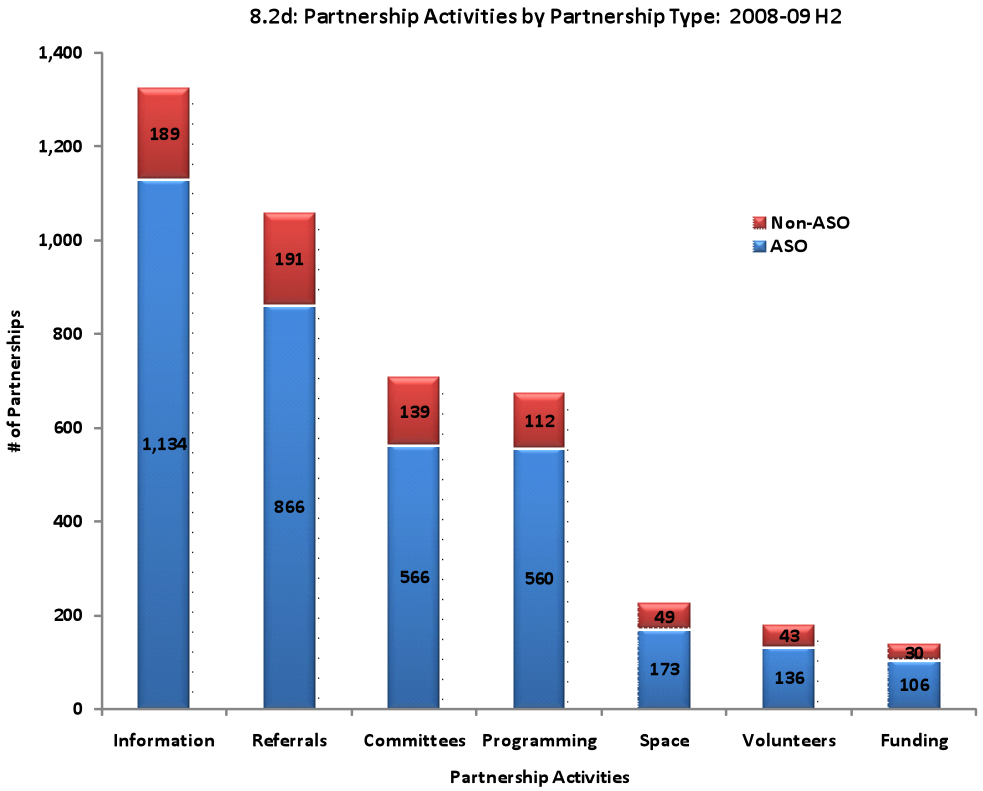
As chart 7.7 indicated, people with HIV are also more involved in research.

Partnerships are Mainly with Other HIV Programs and Focus on Information and Referrals

OCHART question 8.2: Identify your key partnerships and describe how they contribute to your program/services.

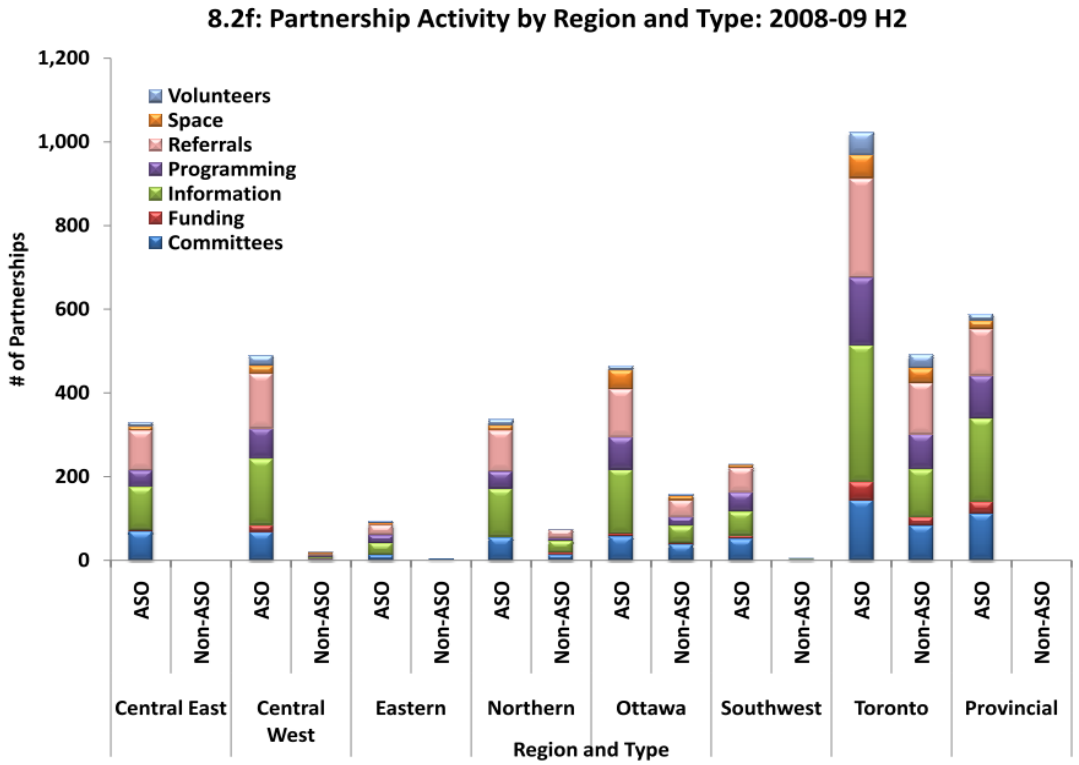
The 2008-09 OCHART asked more specific questions about partnerships, including what types of activities partners do together and the focus of each partner's programs and services.

As Figure 8.2d shows, most partnerships are with other HIV programs, and most involve exchanging information and referrals between agencies. However, a significant number involve joint programming and some include sharing space, volunteers or funding. (Note: a partnership between two HIV programs will likely be reported by both programs in OCHART, so there is likely some double counting of partnerships.)

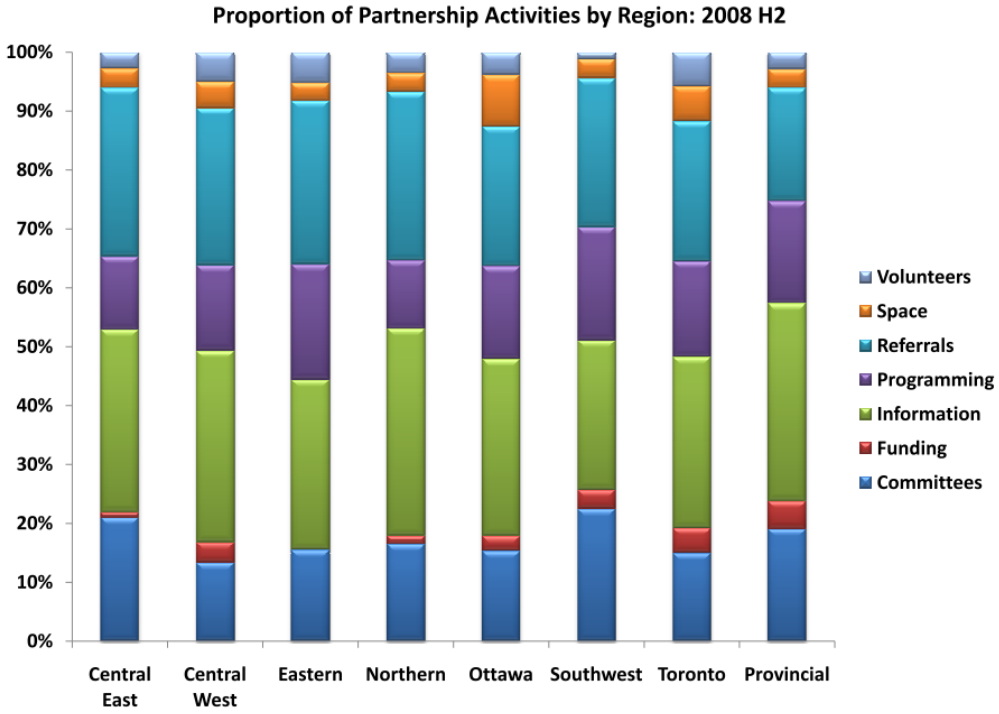


The benefits of partnerships among community-based HIV/AIDS organizations are fairly obvious: they provide mutual support, help meet client needs, help avoid duplication of services and create a community of practice, where those in the field can learn from one another. It would be interesting to learn more about the benefits of partnerships with non-ASOs and their impact on services. For example, do programs that have strong partnerships outside the HIV world benefit in tangible ways, such as better case management for clients through more timely referrals, help with programming, or access to space or other resources.

When partnership types are examined by region, almost all regions have some programs that are sharing space, volunteers or funding – so the nature of partnerships does not seem to be driven by size of community or number of programs within a region.



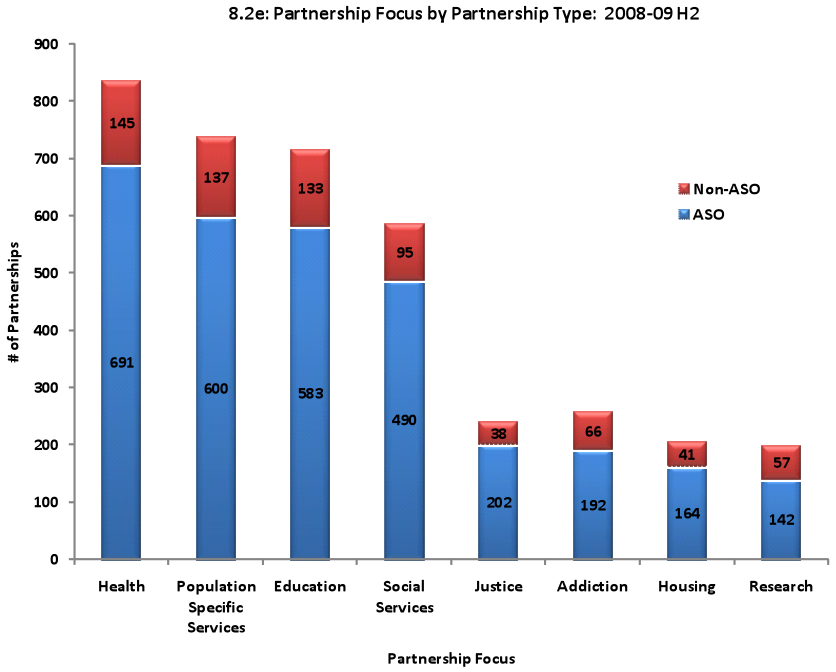
As the following figure shows more clearly (based on proportion of partnerships rather than actual numbers), programs in Ottawa are more likely to share space than those in other regions, which may be due to the fact that many of the programs funded in Ottawa are part of other organizations, such as community health centres and the public health unit. The South West and



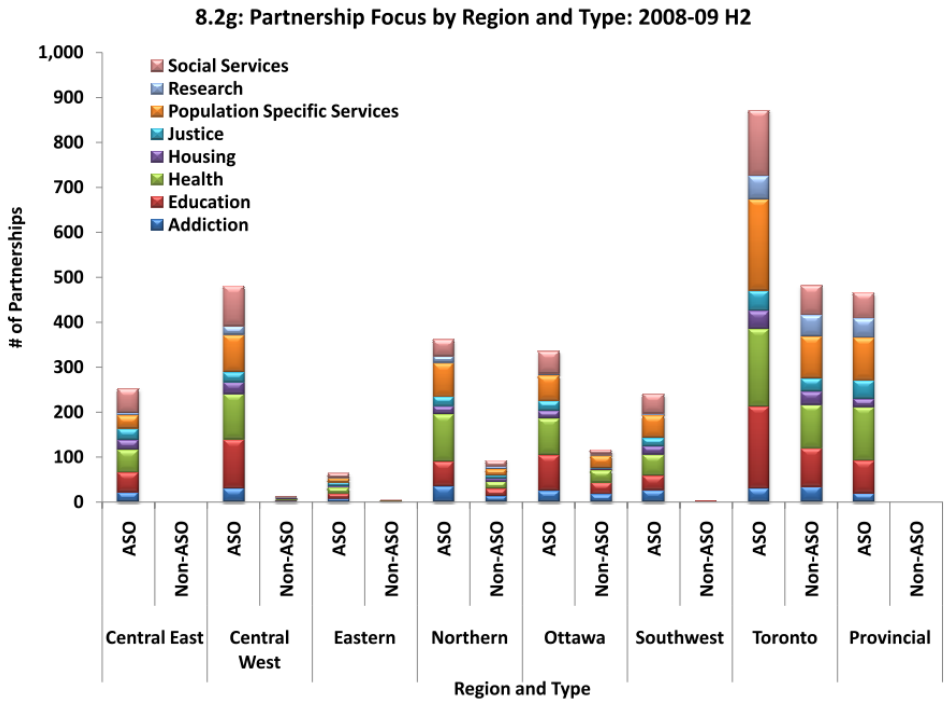
Eastern regions report higher rates of joint programming than other regions.

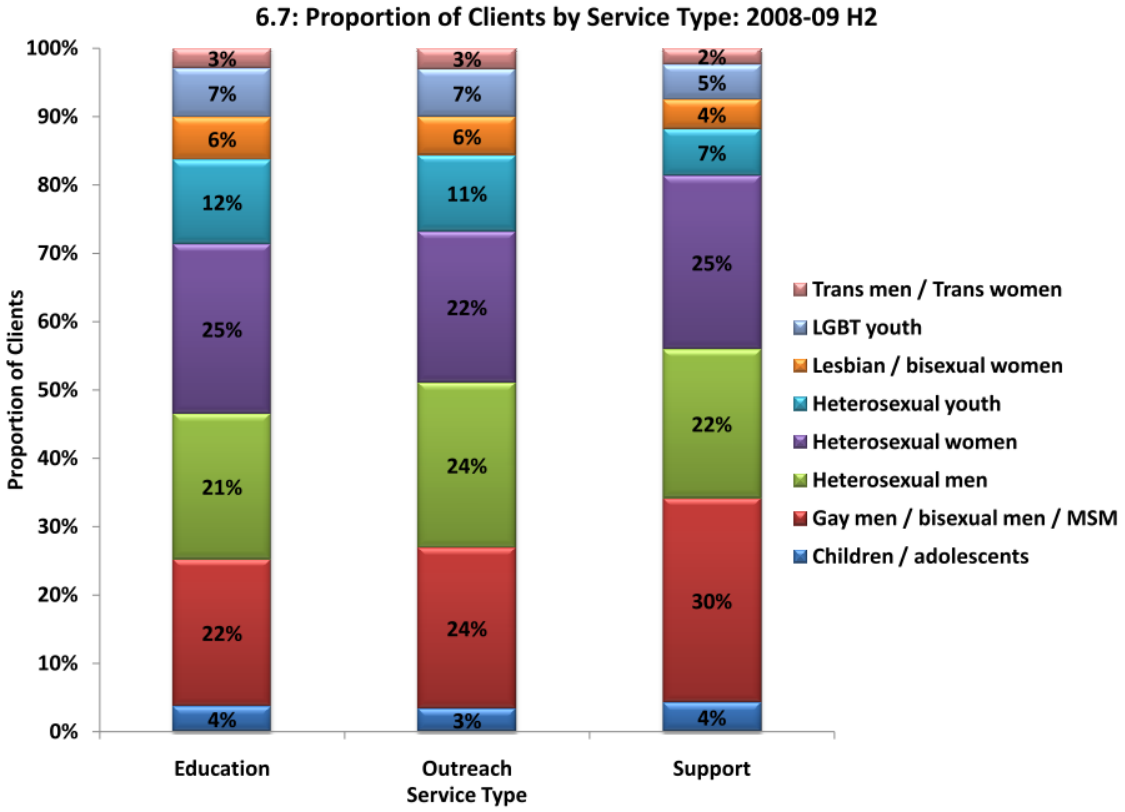
Partners Provide Health, Population-specific, Education and Social Services

Programs report that most of their partners provide health services, population specific services, education and social services. A smaller number provide justice-related services (e.g., legal services, correctional services, services for prisoners), addiction, housing and research services.



The following figure shows the number of partnerships by focus and by region.





In terms of the focus of their partnerships, regions with high rates of IDU-related infections (e.g., the Eastern, Northern, South West, Ottawa and Central East) report a larger proportion of partnerships with addiction services. Provincial programs and those in Toronto have stronger relationships with research organizations.

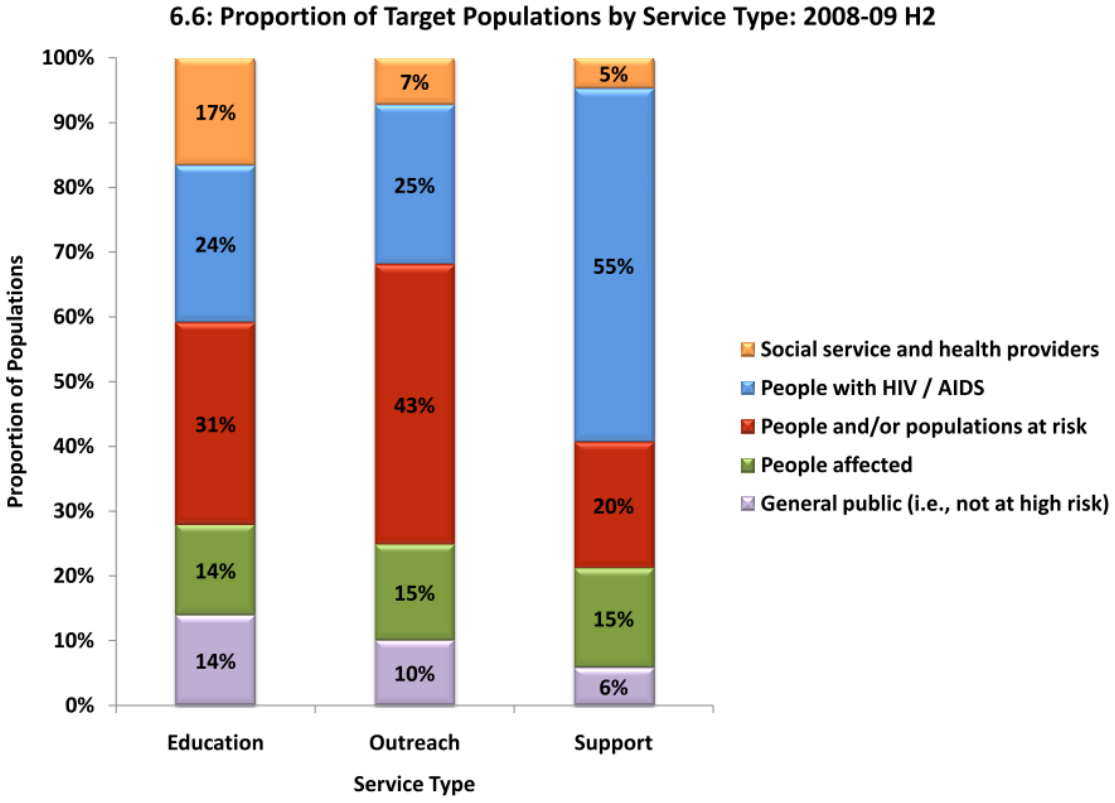
Part III: Who We Serve

Programs Designed to Serve People with HIV and Populations at Risk

OCHART question 6.6: Please indicate what proportion of your programs are designed to serve or target.

As would be expected, the education and outreach services offered by programs target primarily people or populations at risk and people with HIV, followed by people affected (i.e., family, friends), the general public and health and social service providers.

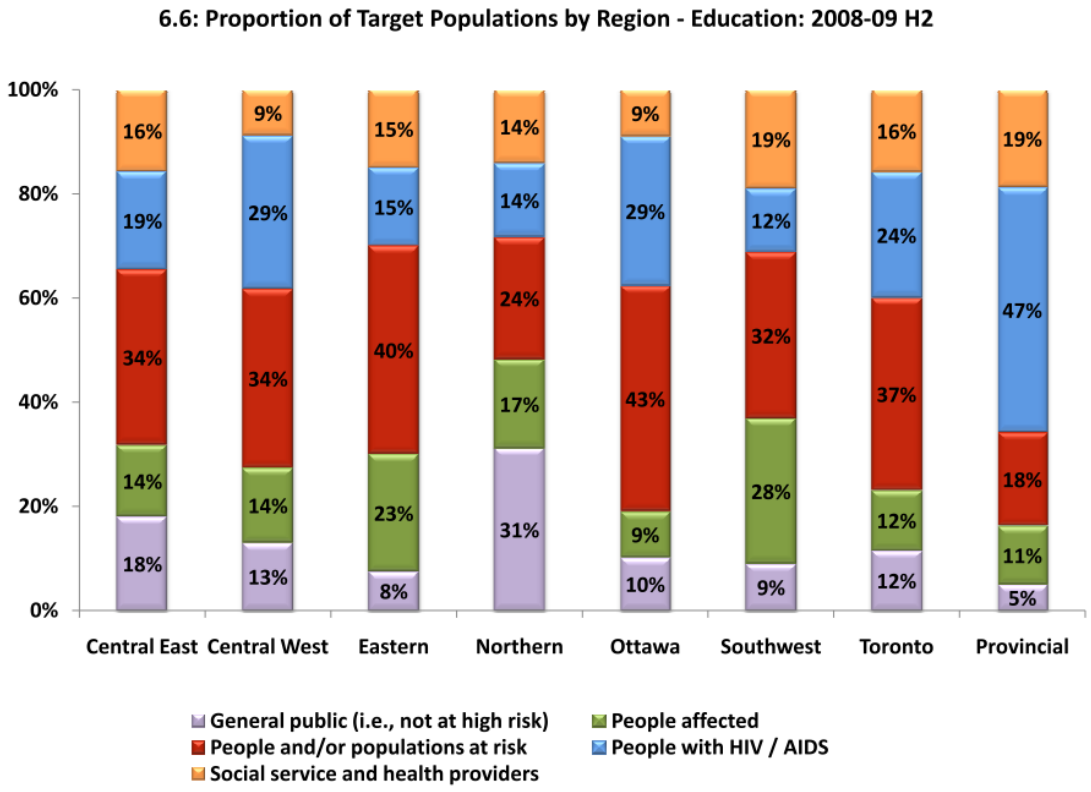
Support services target mainly people living with HIV/AIDS, populations at risk and people affected by HIV.

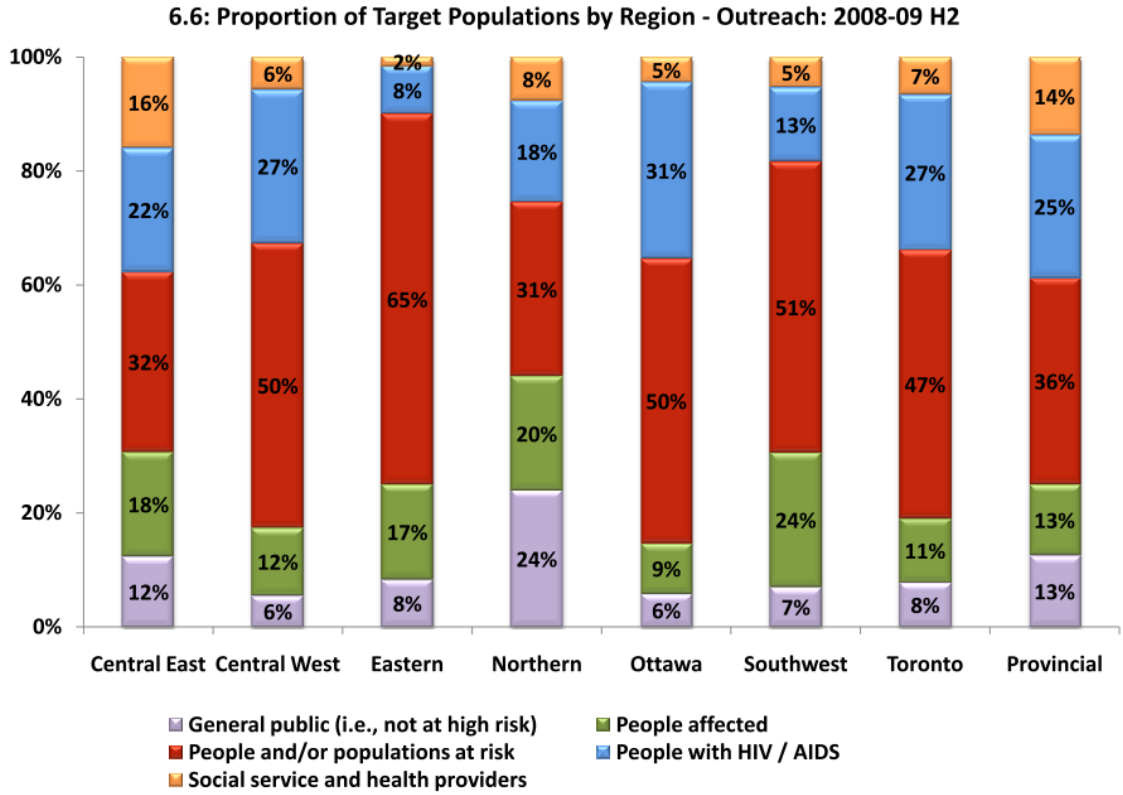


2008-09 was the first year that the question about target populations was asked in this way, so it is not possible to compare responses with previous results. However, it is interesting to note that about a quarter of education and outreach programs are targeted to people with HIV, which may indicate a stronger emphasis on POZ prevention or healthy living programs for people with HIV.

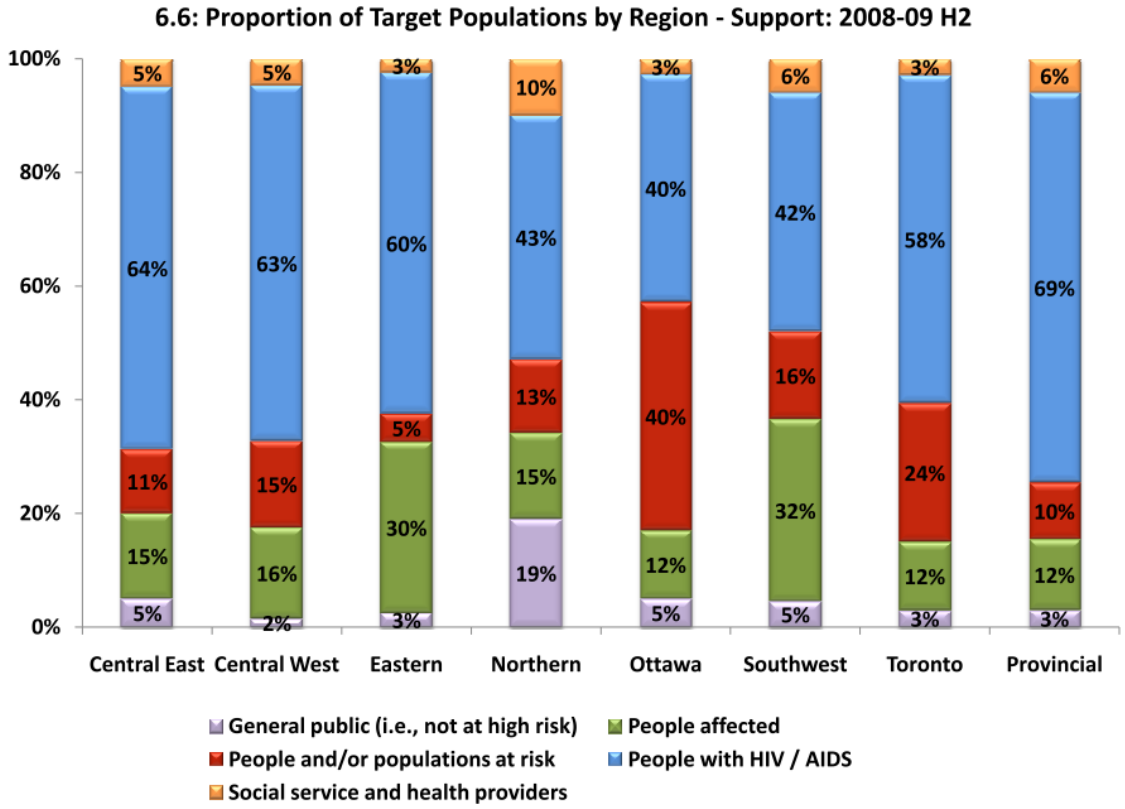
The following charts provide a breakdown of target populations by region for each type of services: education, outreach and support. Based on the proportion of education and outreach programs targeted to people with HIV, it appears that this group may be more of a focus for provincial organizations, and in Ottawa, Central West and Toronto than in other regions. This may be due to the larger number of people with HIV living in those parts of the province, and to new initiatives for people with HIV, such as healthy living programs and POZ prevention.

Compared to other regions, education programs in the Eastern South West and Central East and outreach services in the Eastern region target predominantly people at risk.





When it comes to support services, programs in Ottawa and Toronto regions are targeting a larger proportion of people at risk than other regions; while the Eastern and South West regions are targeting more people affected.



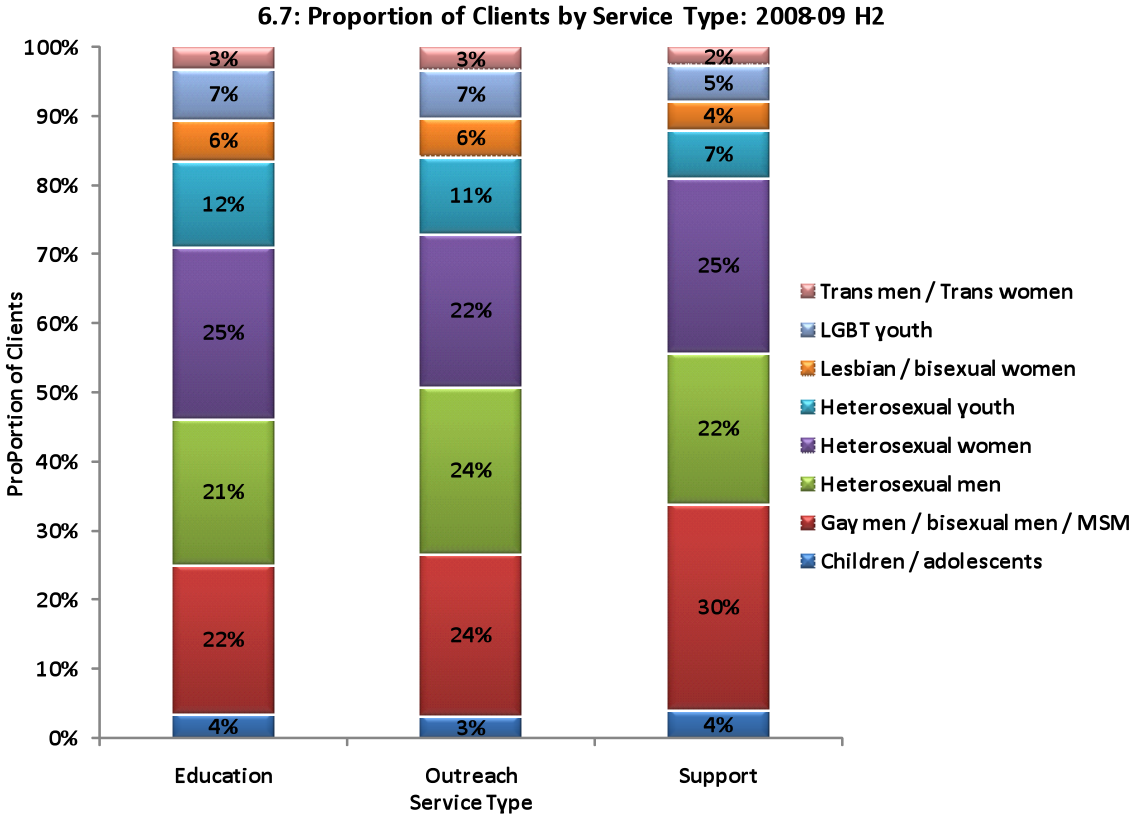
The high proportion of people at risk being targeted for support services may be due to the fact that programs that are NOT funded specifically for IDU outreach report their IDU services in the support section (section 11) rather than in the IDU outreach section (section 13). This situation will change in 2009-10, when all programs will report their harm reduction services for substance users in section 13.

Gay Men, Heterosexual Women and Heterosexual Men are the Main Users of Services

OCHART question 6.7: Please indicate what proportion of the people who use your education, outreach and support services are in each epidemiological risk groups.

In 2008-09, programs reported that most clients for all types of services – education, outreach and support services – were gay or bisexual men, heterosexual women and heterosexual men. A smaller proportion of clients are youth, lesbian or bisexual women or trans men/trans women.

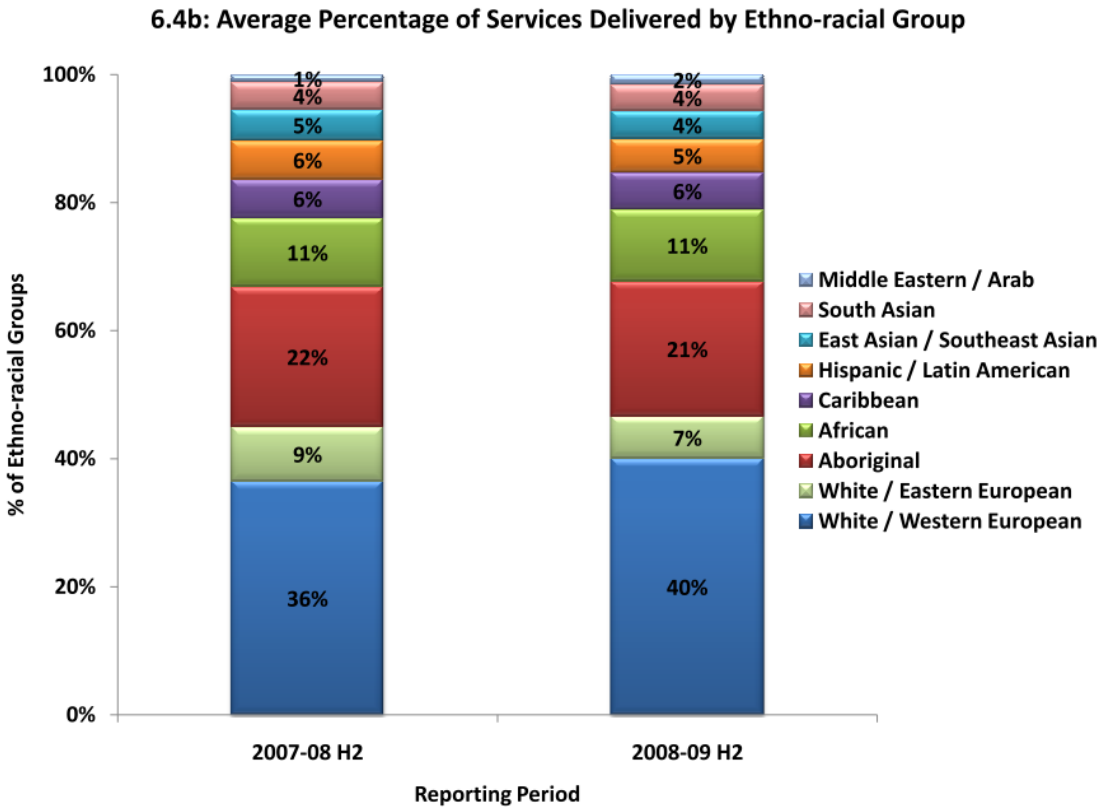
The high proportion of heterosexual women and men using services compared to gay men is somewhat surprising given that about 50% of new diagnoses and the majority of people living with HIV are gay men. Given that less than 15% of services are targeted to the general public (Figure 6.6), most of the heterosexual men and women being targeted must have some risk (e.g., injection drug use, involved in sex work, members of a high risk population).



Clients are Predominantly White, Aboriginal, African and Caribbean

OCHART question 6.4: Please indicate what percentage (approximately) of your services is delivered to each ethno-racial group.

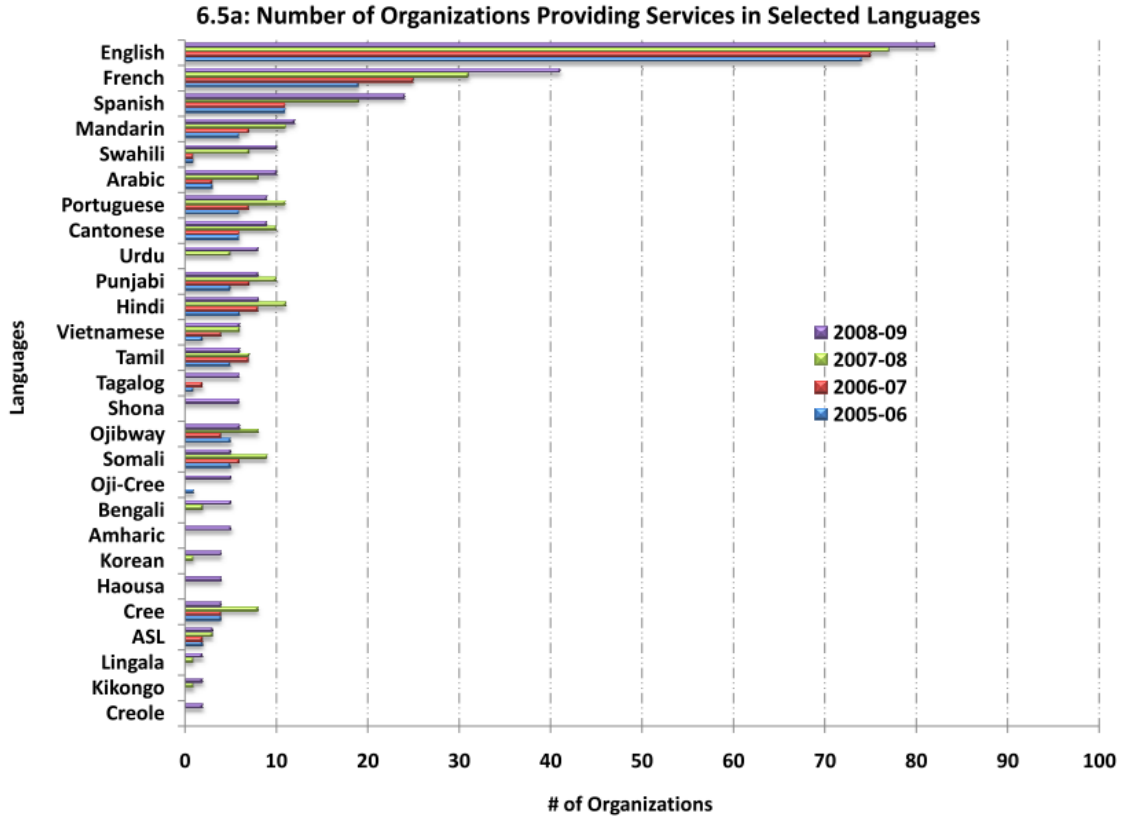
Between 2007-08 and 2008-09, there was remarkably little change in the ethnic mix of clients being served provincially. Most clients are White/Western European, Aboriginal and African – although programs are also serving clients who are Eastern European, Hispanic, East Asian and Southeast Asian and Middle Eastern or Arab.



More Services in Languages Other than English

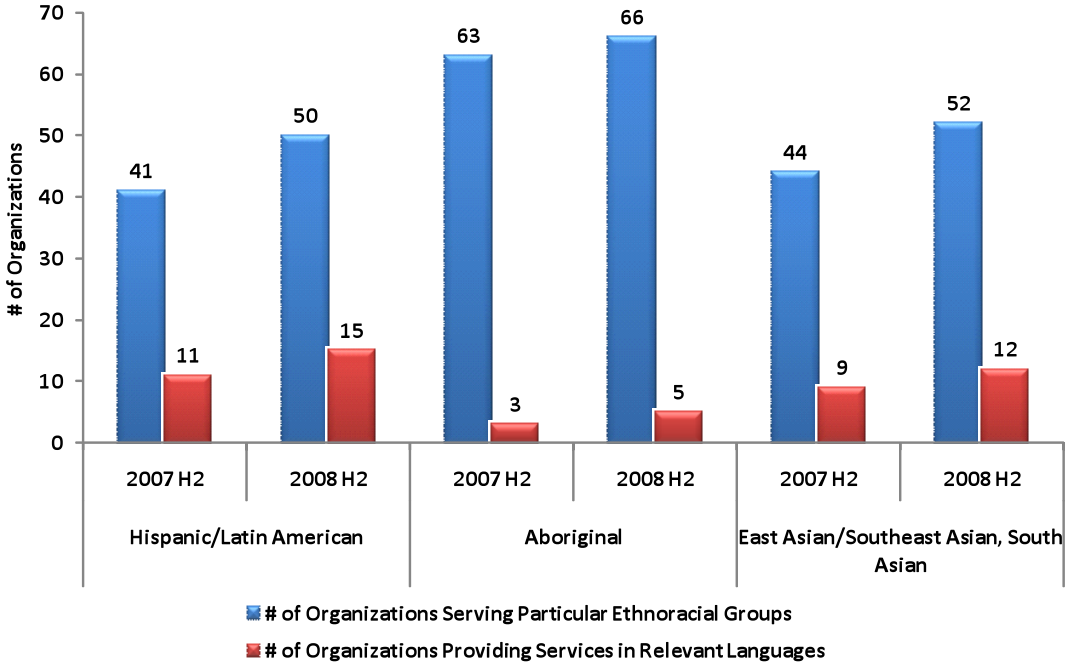
OCHART question 6.5: Please indicate the languages in which you provide services.

When asked about emerging trends, five regions (Central East, Central West, Ottawa, South West and Toronto) identified an increase in newcomers – particularly younger newcomers -- who need education and prevention information and services, as well as assistance with immigration issues. In recognition of the need for more culturally competent services, more programs are now able to provide services in languages other than English. However, it's clear from the variation from year to year that the language capacity within programs is often dependent on a single staff person who speaks a particular language or group of languages (e.g., Urdu, Punjabi, Hindi). If that person leaves, the capacity is lost.



Although the number of programs that report serving particular ethnoracial groups (i.e., Hispanic, Aboriginal, Asian) increased between the last half of 2007-08 (H2) and the last half of 2008-09, only a small proportion are able to provide a range of services in relevant languages. From the following graph, it appears that a number of programs have the capacity to provide information, brochures and support services in multiple languages, but are less able to provide outreach or education. One program reports using volunteers to translate a training manual into multiple languages. Looking at the data on volunteers (Section 4.4), it appears that other agencies are also using volunteers to enhance their language capacity.

6.5c: Number of Organizations that Report Serving Particular Ethnoracial Groups and Number that Provide Services in Relevant Languages: 2007-08 and 2008-09 H2

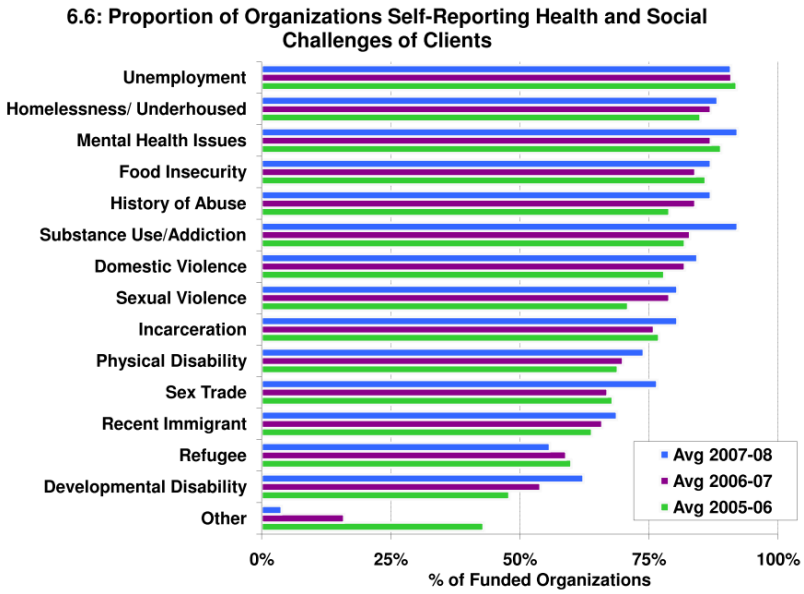


A Different Picture of Client Needs in 2008-09

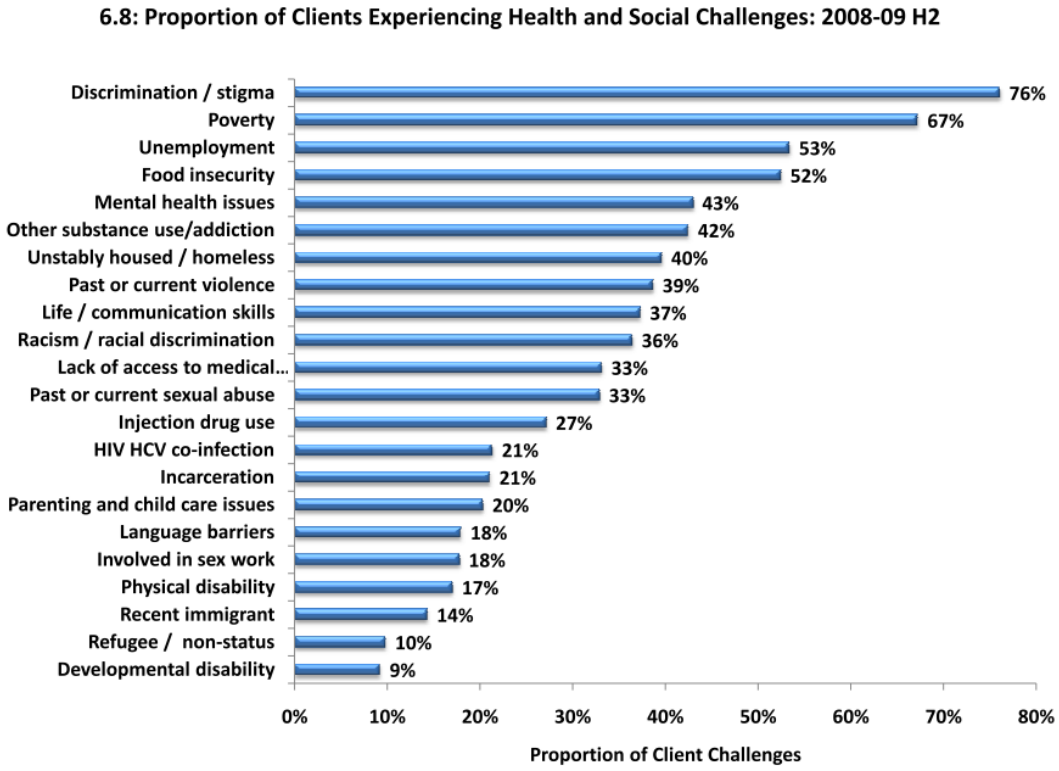
OCHART question 6.8: Please indicate approximately what proportion of the people who use your services face the following health and social challenges.

In the past, OCHART has asked programs to identify whether they had any clients facing a range of health and social challenges – so the data we received indicated what proportion of organizations had clients with, for example, mental health issues or addictions. In 2008-09, the question was changed to ask programs to estimate the proportion of their clients who had each of the health and social challenges. As the following two graphs illustrate (the first from last year's report), the new question provides a clearer picture of client needs.

In past years, almost all programs reported having clients dealing with issues such as mental health, substance use, unemployment and unstable housing, food insecurity and abuse.



In 2008-09, programs reported that stigma and poverty (challenges not included in previous OCHARTs) affect 76% and 67% of all clients. Issues that almost all programs reported dealing with in previous years, such as mental health issues, addictions and housing problems, actually affect a smaller – but still significant – proportion of clients (43%, 42% and 40% respectively). Violence is an issue for 4 out of every 10 clients, while more than 3 in 10 are coping with past or current sexual abuse. Almost 1 in 5 has been in prison or is involved in sex work, while 1 in 3 lacks access to medical services.



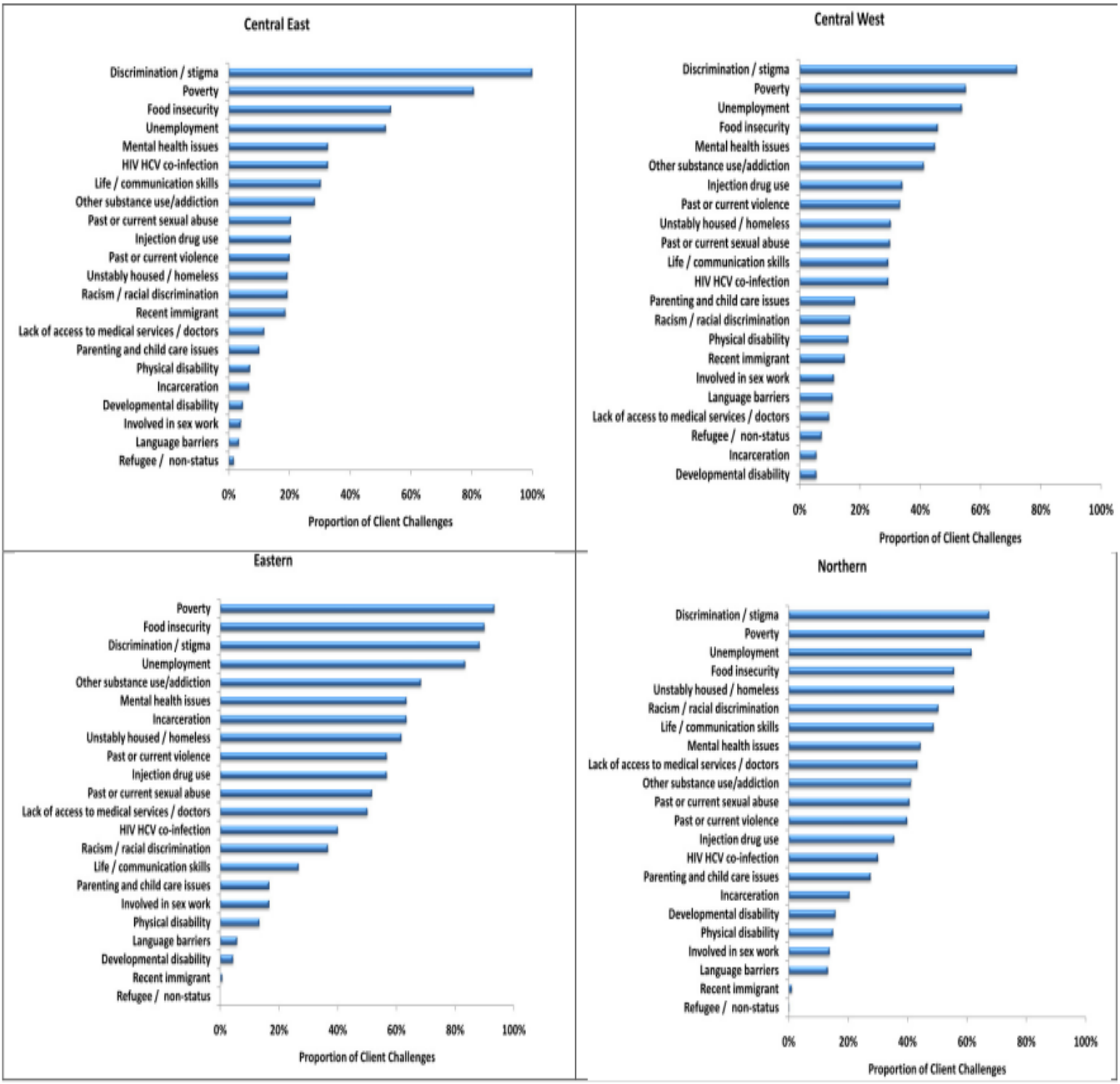
This figure reinforces the complex needs of people with or at risk of HIV – and the need for active efforts to fight both stigma and poverty, and to help people deal with unemployment, food security, mental health, addiction and housing issues. On the other hand, the figure also highlights the resilience of many people with HIV. For example, while unemployment is an issue for 53% of clients, it appears that a sizeable portion (47%) is not struggling with employment challenges. The same is true of mental health challenges, addiction and housing. Despite the fact they are facing a life-limiting, stigmatizing disease, many people with HIV appear to be coping. There may be opportunities to learn from those who are doing well to help those who are struggling.

In the category of discrimination and stigma, OCHART does not distinguish between HIV-related stigma and other forms of discrimination (e.g., homophobia, sexism, stigma related to mental health problems or substance abuse, or the impact of criminalization) – although there is a separate category for racism and racial discrimination. It is possible that the high proportion of clients dealing with discrimination and stigma may be related to the criminalization of non-disclosure or discrimination faced by recent immigrants – although programs reported that they are seeing a relatively small proportion of clients who are recent immigrants or have status issues.

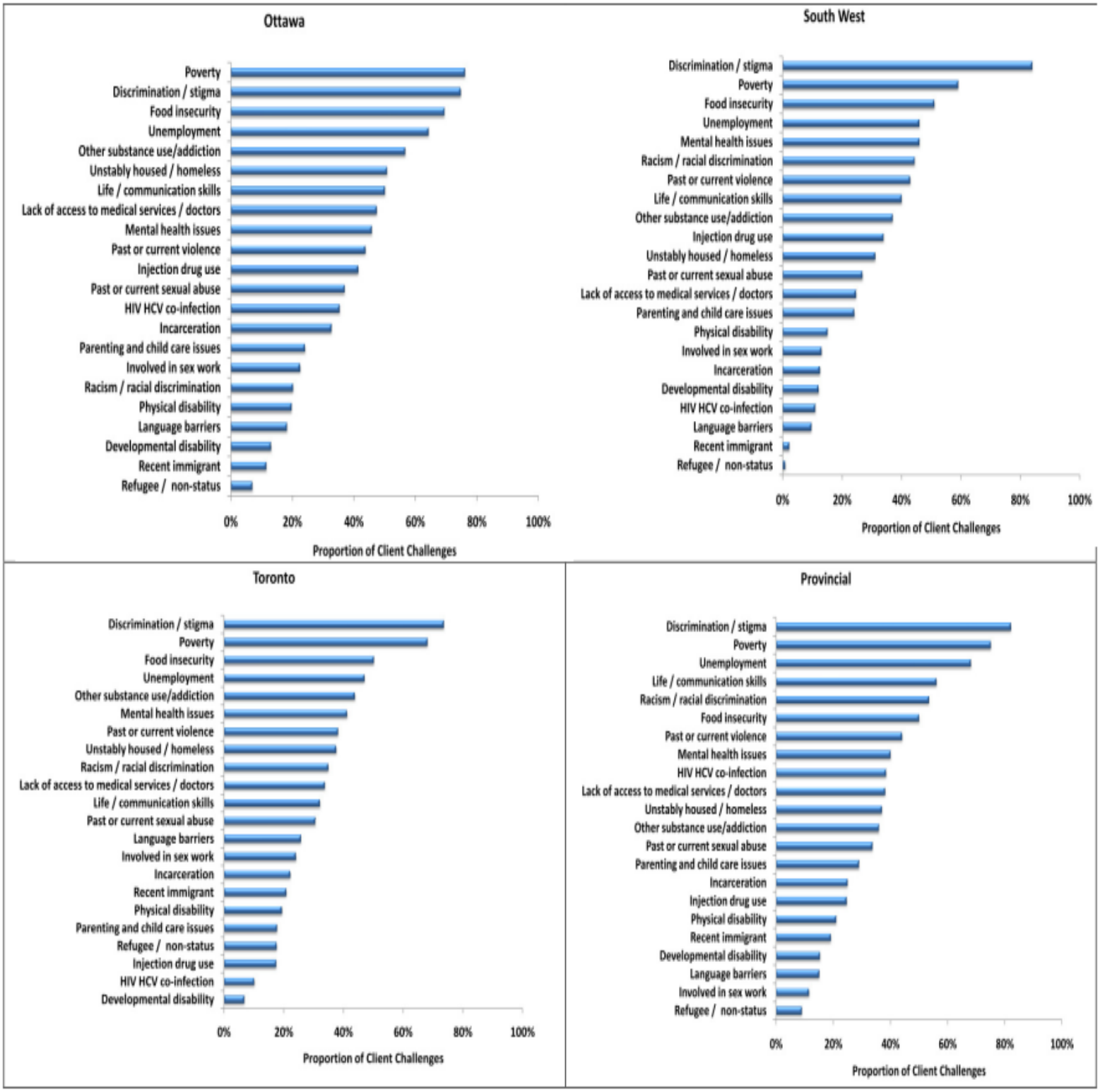
The regional breakdown of client challenges (on the next two pages) shows that discrimination/stigma, poverty, unemployment and food security are problems for clients in all parts of the province. Substance use is a greater issue for clients in Toronto and Ottawa than in other regions, while finding appropriate housing is a greater issue for clients in the Northern region than in other parts of the province. Language barriers affect a larger proportion of clients in Toronto, Ottawa, Northern and Central East regions.

It would be interesting to learn more about how programs are responding to clients' complex needs, and to what extent they are attempting to meet those needs on their own or in partnership with other health and social services. It would also be useful to know what programs are doing to address the stigma and discrimination that appears to be an issue for most clients, and the impact of any anti-stigma initiatives.

Regional Breakdown – Chart 6.8



Regional Breakdown – Chart 6.8



Overall, clients in the Eastern Region appear to have the greatest overall needs, while those in Toronto, Central West and South West appear to be faring better. As would be expected, a very small proportion of clients in the South West, Eastern and Northern regions are coping with issues related to immigration.

Part IV: Our Programs and Services

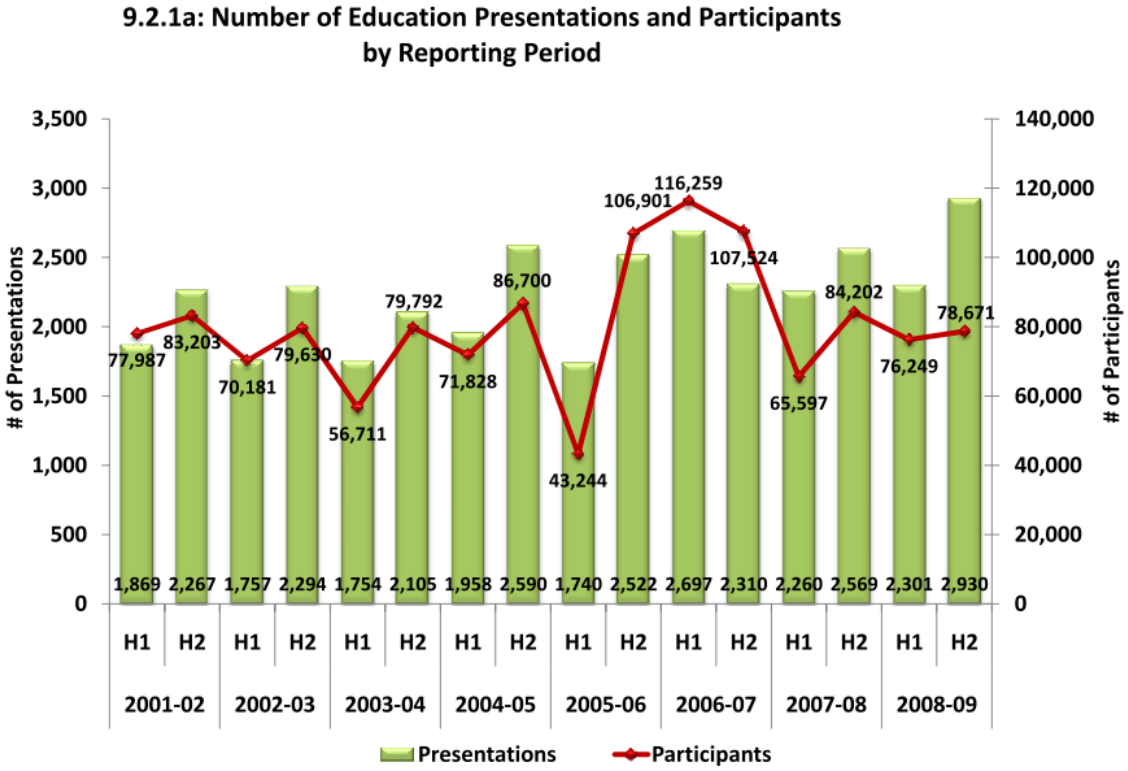
4.1 Education and Community Development

OCHART question 9.2.1: Indicate the number of education and community development activities undertaken during the reporting period.

Education Presentations Up

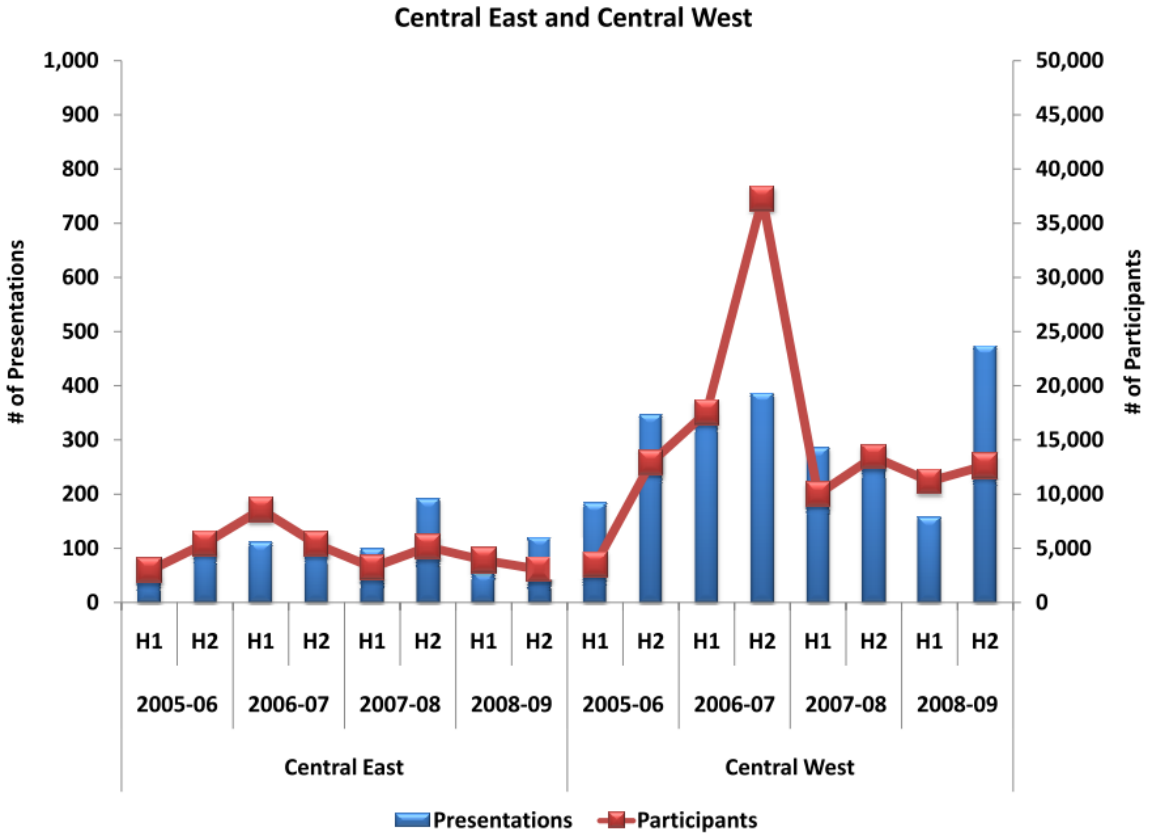
Although some programs reported a drop in the number of education presentations, the overall number of presentations increased in 2008-09. The number of presentations would have been higher but one community had to cope with an extended transit strike, which caused many events to be cancelled.

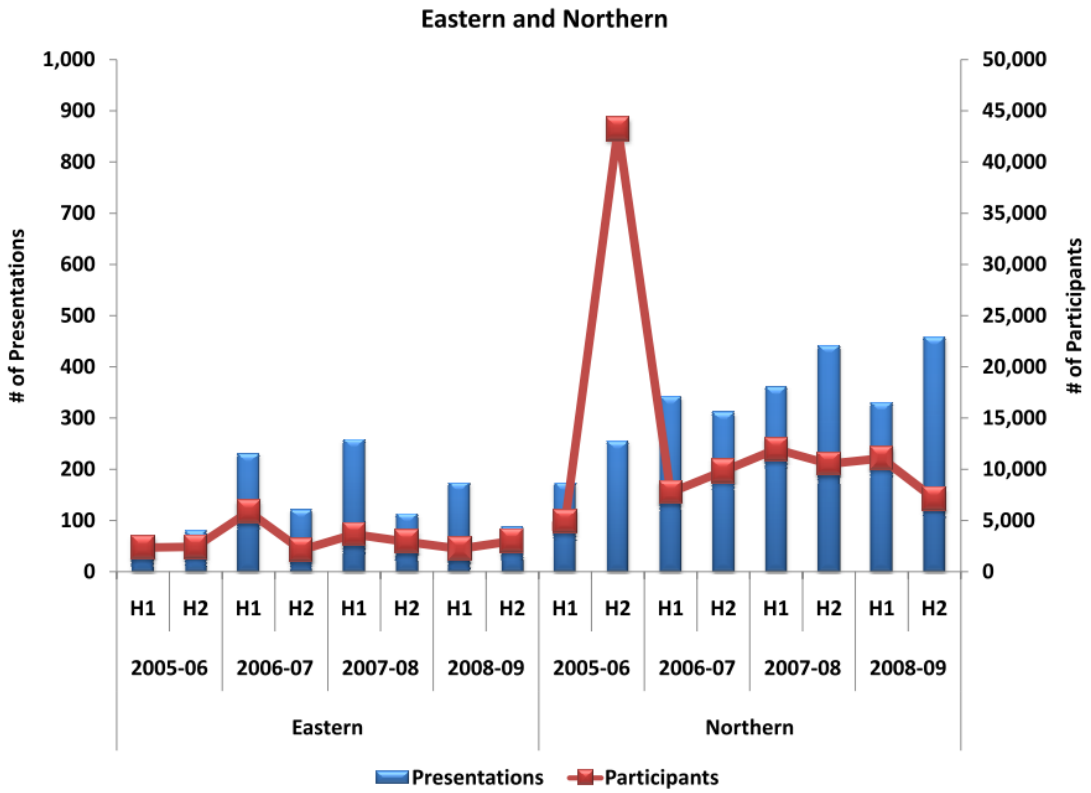
The average number of participants per presentation was lower than in the past, but the total number of participants was higher than in the previous year. The trend to make education presentations to smaller groups of people continues.



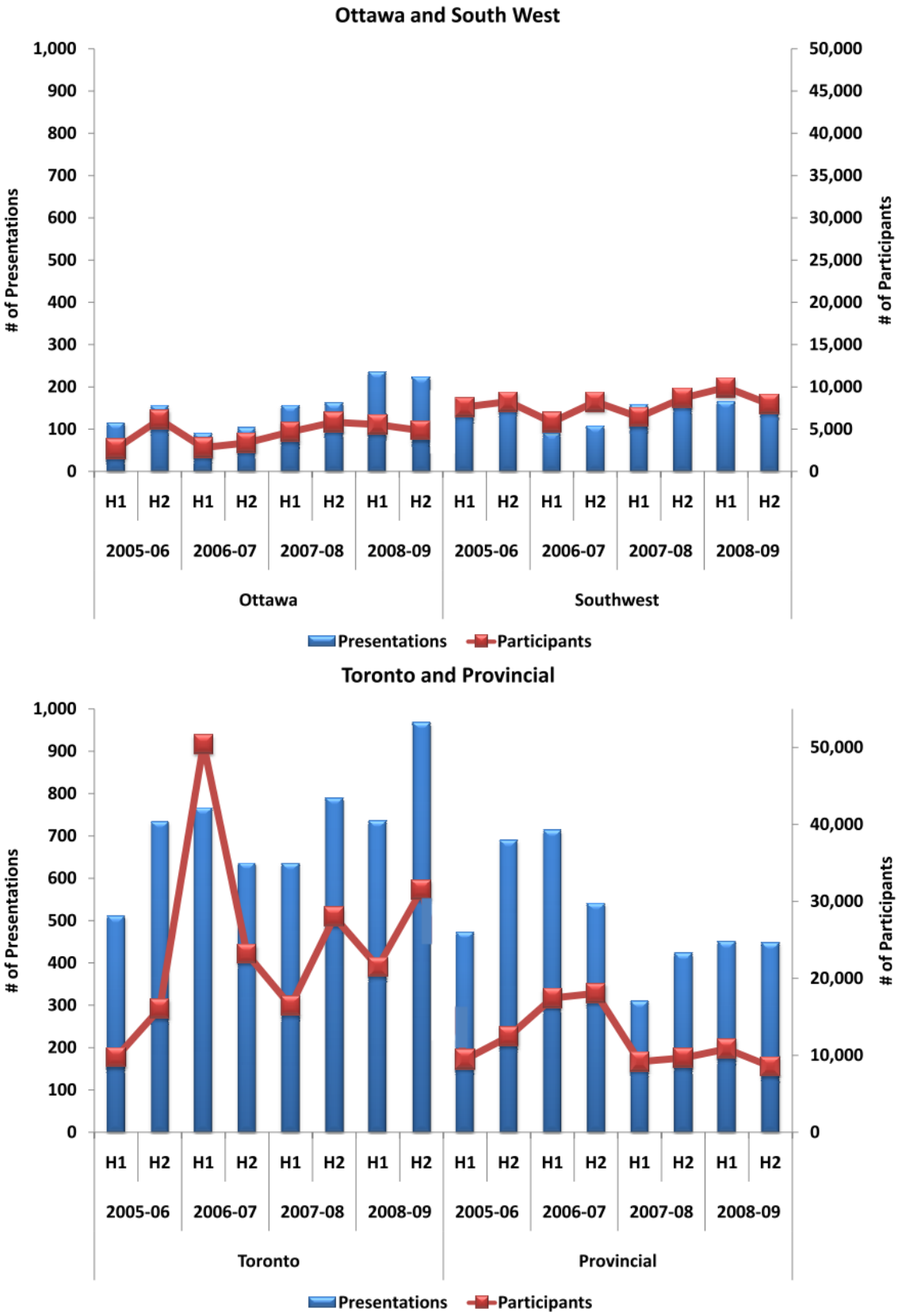
The following graphs show the number of presentations and participants by region. In general, there's been an increase in presentation in Central West, Northern and Toronto regions. The decrease in provincial presentations is due in part to the fact that presentations given by the regional satellites of provincial programs are now counted in the regions.

Regional Breakdown – Chart 9.2.1a





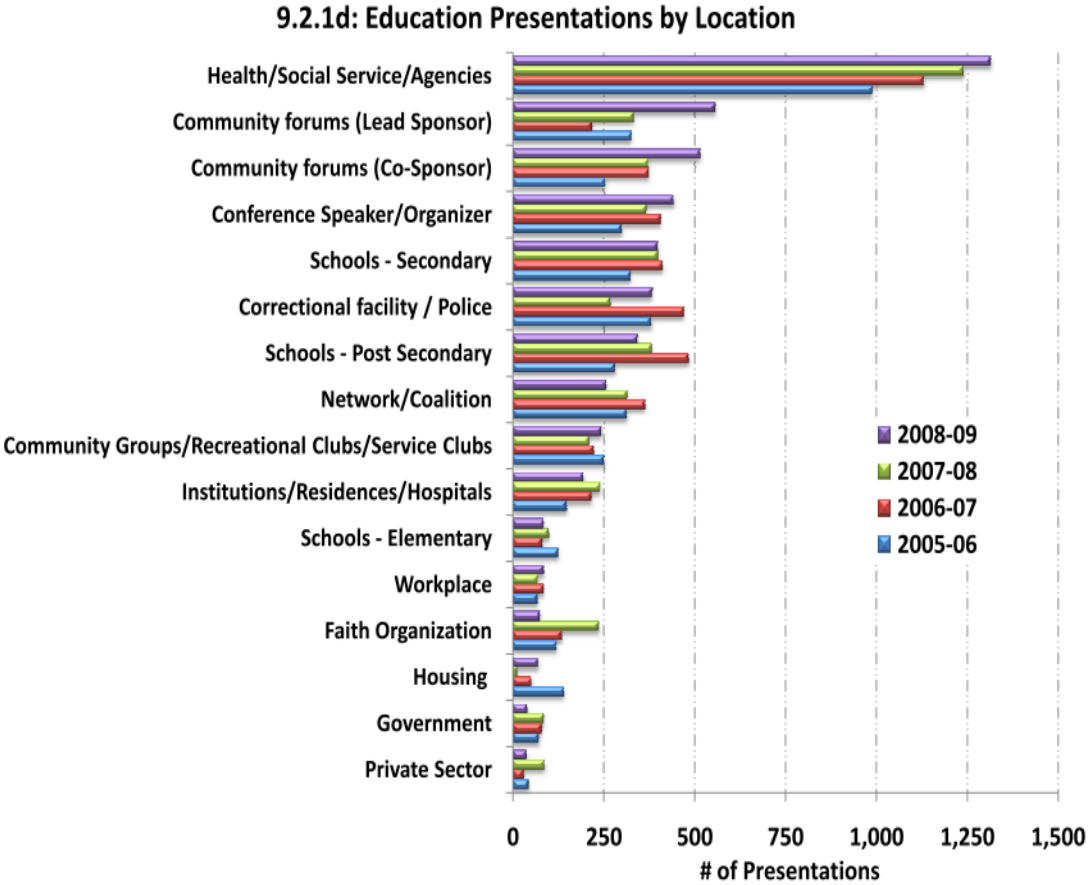
Regional Breakdown – Chart 9.2.1a



More Presentations to Health and Social Service Agencies

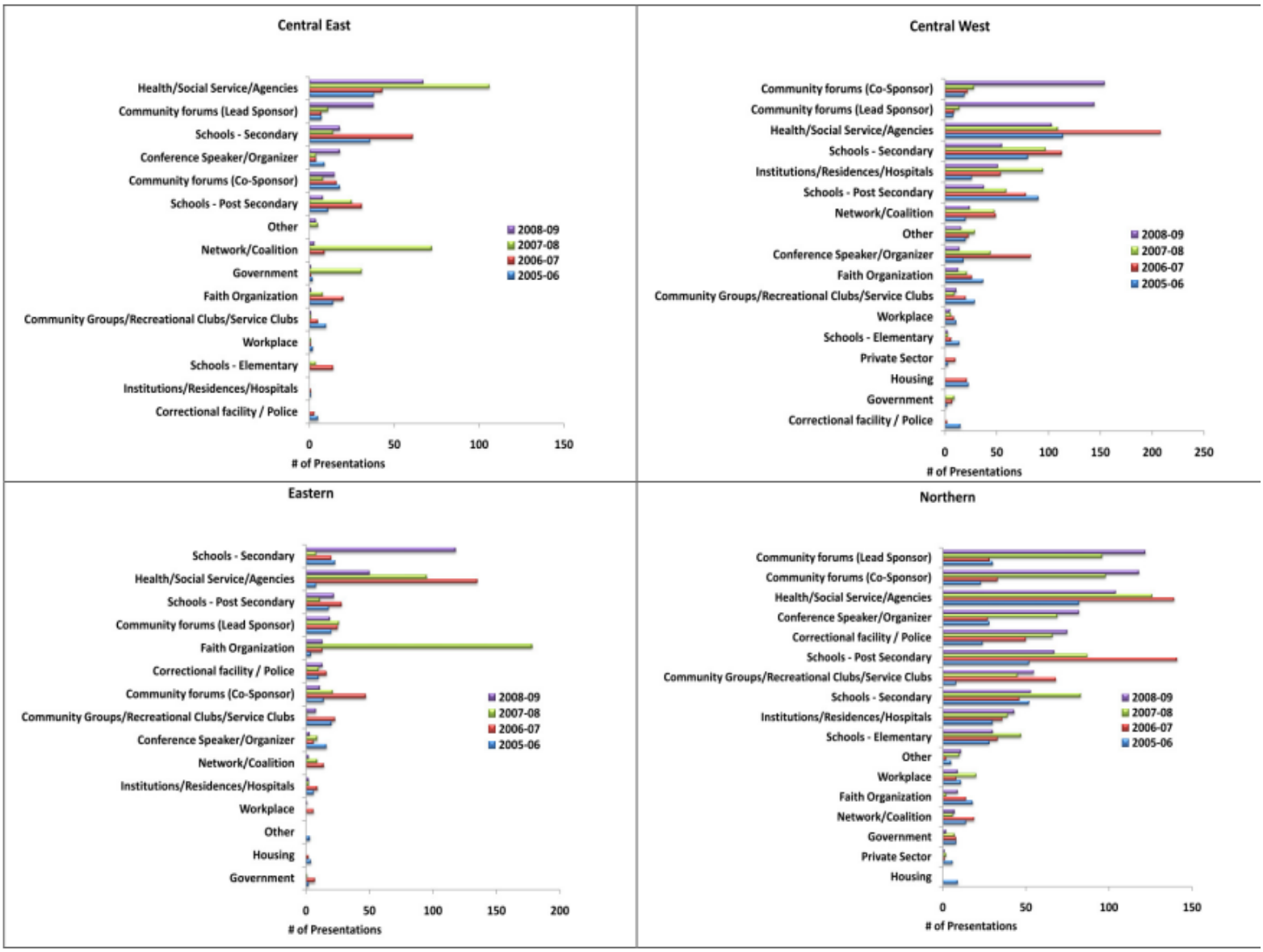
As the following graph illustrates, the number of presentations to other health and social service agencies – including police, long-term care homes, youth agencies and mental health and addiction agencies – continues to increase. The large proportion of presentations to health and social services agencies is surprising given that programs said the main targets of their education programs are people at risk and people with HIV (see Figure 6.6). It would be interesting to know whether programs feel that working through other health and social agencies is one of the best ways to reach their target populations – and whether these contacts lead to other benefits, such as better partnerships, more referrals and more services for clients.

It appears that programs are playing a larger role in educating other providers and professionals. Programs in all regions reported more requests for presentations from a range of agencies. Programs in two regions reported that other agencies were taking advantage of their knowledge and skills in reaching certain populations: in one case African and Caribbean and in the other Aboriginal. Some are working with other agencies and their municipal governments to plan substance use strategies. One program regularly receives requests to speak to students enrolled in vocational and professional programs, such as massage therapy, chiropractic, naturopathy, nursing and medicine. One program found that its requests for education were coming from the same agencies/communities and is currently reviewing its priorities to ensure programs meet community needs. One region expanded the invitee list for its Opening Doors conference, and is now using the larger list to offer education to more organizations.

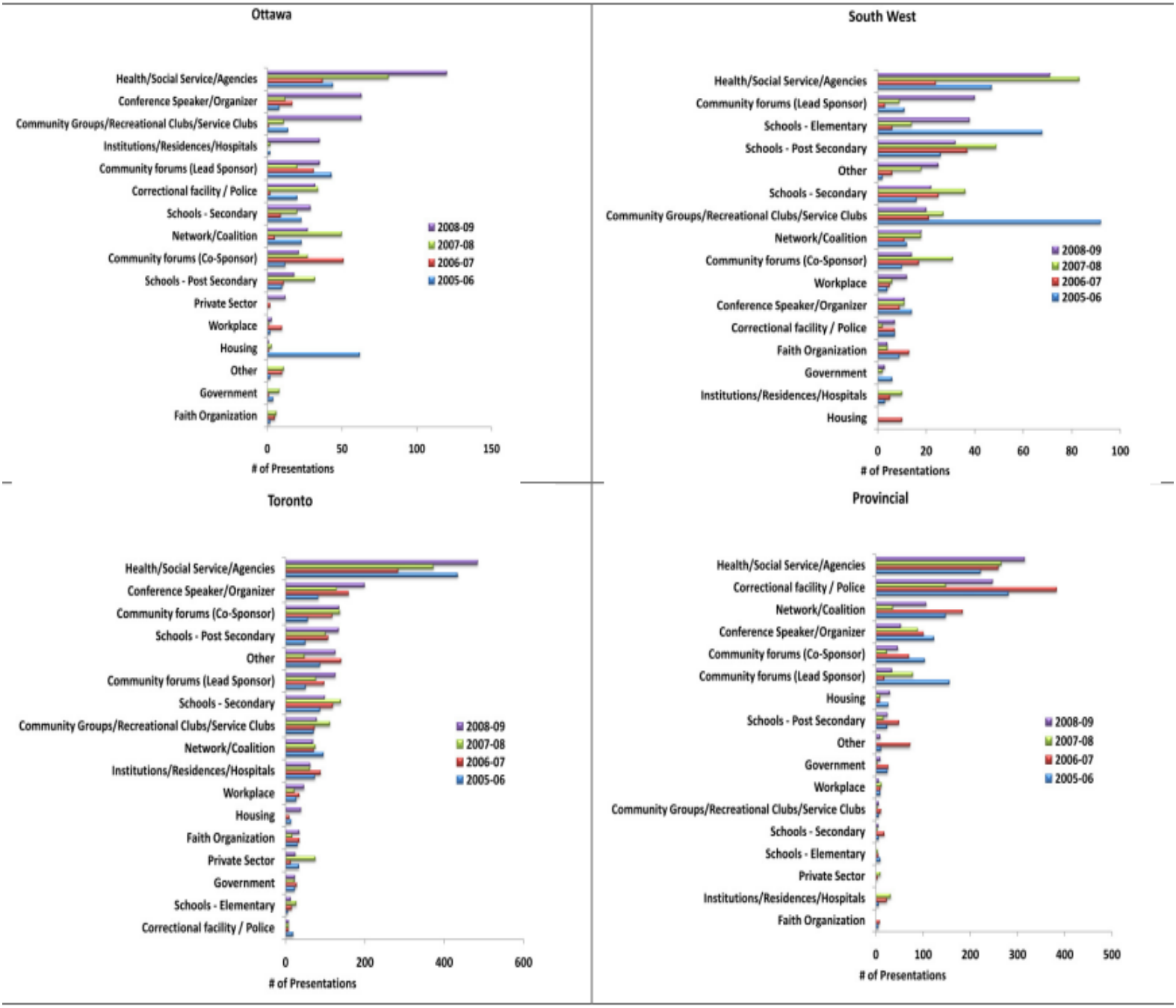


A regional analysis of the location of education presentations shows that the Eastern region has focused mainly on schools, while most others have made most of their presentations to health and social service agencies or in community forums. Two regions that both have high rates of infection in substance users – Northern and Ottawa – have targeted many of their presentations to police and correctional facilities.

Regional Breakdown – Chart 9.2.1 d



Regional Breakdown – Chart 9.2.1 d



Emerging Trends in HIV Education

More education for youth – including LGBTQ youth

Programs in all regions reported more demand for education for and about youth – particularly LGBTQ youth. In some communities, school boards are supportive of presentations that include LGBTQ issues; in others, programs are still looking for effective ways to reach LGBTQ youth, such as:

- creating LGBTQ-friendly areas in the community
- participating in projects with community arts and theatre programs
- involving LGBTQ youth in a more general activity for LGBT people (rather than continuing to hold a poorly attended group for LGBTQ youth).

Of these issues, both education for youth and women were also identified as emerging trends in 2007-08.

Some programs report strong working relationships with schools to deliver HIV education, while others have seen their relationship deteriorate. Strategies include establishing a volunteer youth speakers bureau, running a peer-based HIV Ambassador Program in the schools, using/providing computer technology to engage youth, and creating safe spaces for youth.

In terms of reaching youth, one program questioned whether there is enough programming for people between the ages of 19 and 27.

More demand for education for women

Programs in five regions reported increased demand for education for women, particularly young women, Aboriginal women and African and Caribbean women and marginalized women involved in sex work. Programs that target younger women focus on self-esteem and healthy sexuality and relationships, and the link between violence and the risk of sexually transmitted diseases.

New strategy for faith-based communities

A number of programs reported trying to work with faith-based communities, particularly to reach people at risk in the African and Caribbean community and other ethnoracial groups. One noted that an effective way to engage faith communities is to begin with related issues such as self-esteem, healthy relationships and preliminary sex education and then work up to HIV prevention.

Increase in homophobia and stigma

Although programs reported that over three-quarters of the people they serve have experienced stigma and discrimination (see Figure 6.8), only two specifically mentioned discrimination as an emerging trend. Those two reported more discrimination in the form of police presence in areas where drug using clients live and offer sex trade services and assaults on trans youth peer workers.

Hot topics for education in 2008-09

- Criminalization*
- Immigration issues
- Disclosure
- Women's issues, including pregnancy, reproductive health and domestic violence
- HIV/hepatitis C co-infection
- Trans issues
- Mental health issues
- Condoms (brands, how to negotiate condom use)
- Treatment literacy
- Aboriginal culture and teachings
- Substance use and needle disposal

* also a hot topic in 2007-08

The Needs of Older Gay Men

Although programs in all regions reported more demand for programs for youth, women and newcomers, only one program talked about the need for new education/prevention approaches for gay men age 40 and older, which is the highest risk age group for new HIV infections. Two regions identified the need for information on aging but only for people already infected as opposed to older people who may be at risk of becoming infected. Does this mean that programs already have effective education/prevention programs for older gay men or that this is a group that is not well represented in education programs? It may be useful to encourage more discussion about the factors that contribute to an increased risk with age in gay men (e.g., prevalence of HIV in that age cohort, frequency of exposure, social/cultural factors) and the strategies programs are using to reach older gay men.

Emerging trends in education services by region

In **Central East**, there were more requests for presentations by women and people who use substances, and more demand for outreach to the African and Caribbean community. There was ongoing demand from schools for education presentations, and more interest in harm reduction in the community due to an increase in crack use and hepatitis C in the region. Programs responded by:

- Recruiting women and people who use substances to the Speaker's Bureau
- Developing a peer-based school outreach program, called the HIV Ambassador Program
- Working with the new IDU outreach workers to raise awareness of issues in the community and offer workshops for service providers
- Planning to offer more comprehensive information on hepatitis C in the next fiscal

Central West reported greater need education for youth and for service providers, particularly those working with HIV-positive newcomers. Programs also received more requests for workshops about sexuality and disclosure, and information on criminalization, particularly from gay men with HIV. Programs responded by:

- Completing a series of trainings for youth volunteers to assist with community outreach
- Using communication technologies and networking to make it easier to engage youth
- Developing new curriculum for training for service providers and new partnerships in the community
- Investigating new ways to engage young men who have sex with men and distribute accurate HIV information
- Holding workshops on criminalization and disclosure.

The **Eastern** Region reported an increase in requests for presentations from faith organizations and more demand from rural youth. Programs responded by adapting to meet those needs.

Programs in the **Northern** region are seeing more requests to present to youth groups, police agencies (particularly about needle recovery and safety) and from agencies that service Aboriginal peoples. Programs responded by:

- Expanding youth partnerships with the focus on networking and cost-sharing
- Working collaboratively with local arts and theatre communities to reach out to LGBTQ youth.
- Renewing existing partnership with the two local Aboriginal HIV Education Groups
- Giving presentations on needle safety to the general public, and police agencies.

Ottawa is seeing increasing demand for culturally appropriate, population specific information (e.g., in different languages, targeted to black men who have sex with men), and more demand for information on treatments to help people age with HIV. Programs responded by:

- Developing partnerships with other agencies to develop materials

- Developing information on age-related conditions experienced by people with HIV.

The **South West** reports an increase in demand for HIV education in public schools. Programs responded by:
- Developing new partnerships with local agencies to develop education materials and training for LGBTQ youth
- Developing a youth speakers bureau.

Toronto ASOs are seeing more demand for education for youth, women and heterosexual men, and more interest in HIV and HCV co-infection, trans issues, and aging with HIV. They have also received more complaints from people with HIV who are having trouble accessing programs in non-ASO organizations. Programs responded by:
- Expanding youth programming and partnering with other organizations that serve youth
- Providing integrated training about HIV/STI and hepatitis C co-infection for staff, volunteers and community partners
- Inviting community partners to have develop relevant resources (in terms of language and content)
- Increasing advocacy and training to help people with HIV overcome barriers to accessing services.

The **provincial** programs that provide direct client services reported more demand for information about criminalization and disclosure, and harm reduction education for Aboriginal youth. More clients are also looking for information about healthy living, employment, medication and research. Programs responded by:
- Creating a legal guide about HIV disclosure for gay men in Ontario
- Developing partnerships with agencies that serve youth
- Developing stronger relationships with clinicians to help provide advice on aging with HIV.

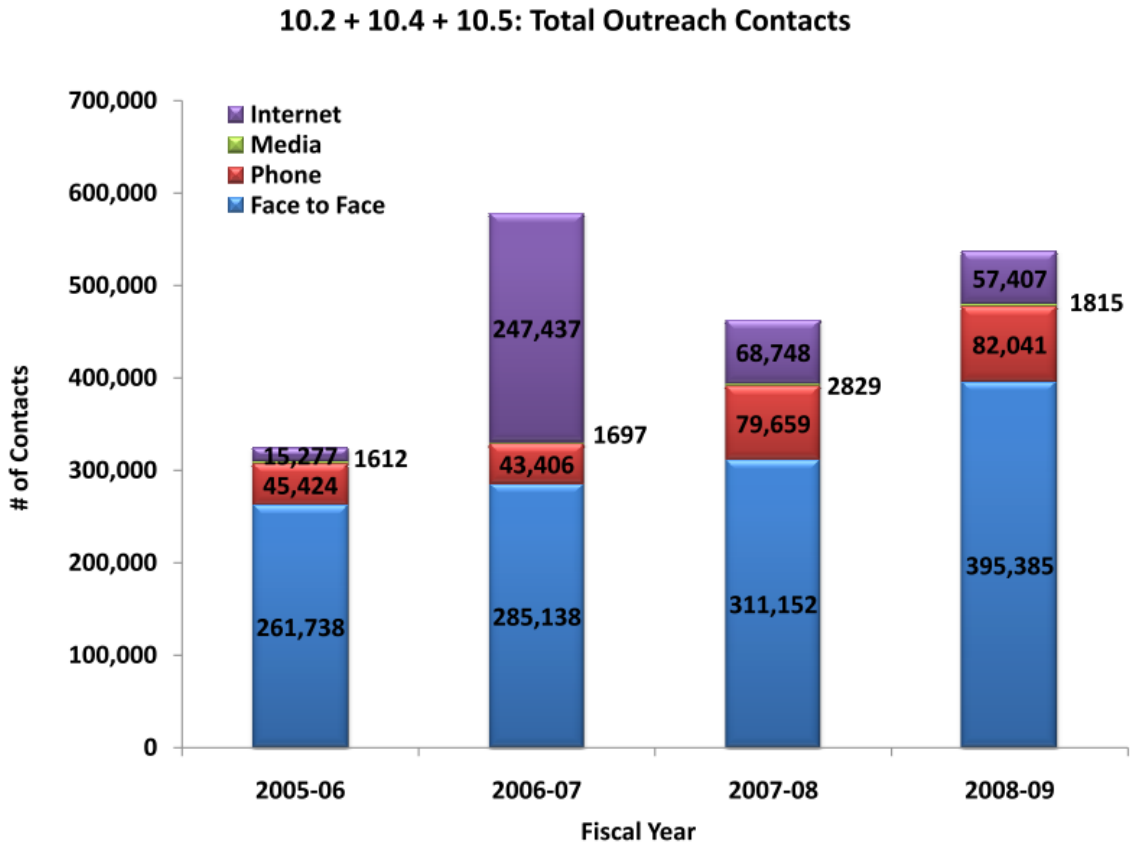
4.2 Outreach Initiatives

Programs funded to provide HIV prevention and education often offer outreach services for people with HIV and populations at risk.

OCHART questions 10.2Indicate the outreach activities undertaken during the reporting period; 10.4 Indicate the media contacts that occurred during the reporting period; and 10.5 Phoneline and Internet Activity

Face-to-face contacts up

In 2008-09, programs reported more outreach contacts than in the previous year, but fewer than in 2006-07. There was a marked increase (37%) in face-to-face contacts, which is probably the most effective way to deliver outreach programs, and a decrease in Internet contacts. There has also been a significant increase in phone contacts over the past two years.



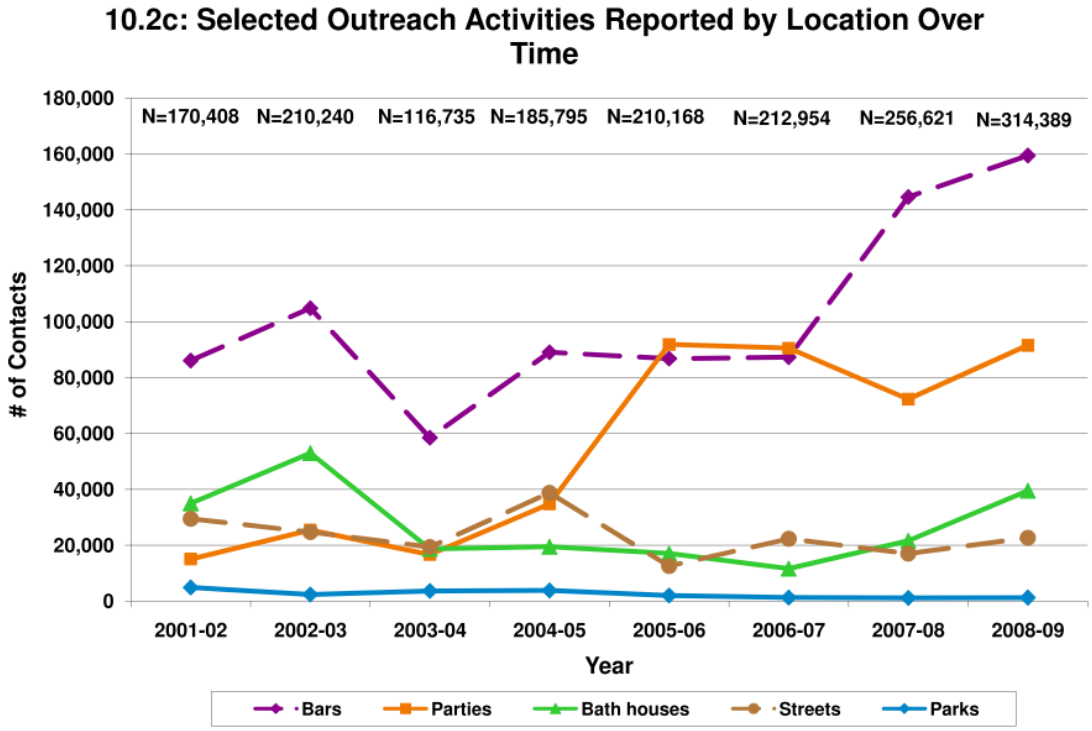
The Internet is an increasingly important source of information for many people. However, programs continue to struggle with the best way to "count" Internet outreach and to assess the impact of Internet information on knowledge and behaviour. The drop in Internet contacts is likely due to more accurate ways to count these contacts. Some are now counting web sessions as opposed to web hits as a way to discern those actually spending time on the site and using information or services. It would be useful to identify best practices in counting Internet outreach contacts and assessing their impact.

Some programs reported a drop in web site visits in 2008-09, while one reported a 29% increase in daily hits on its website.

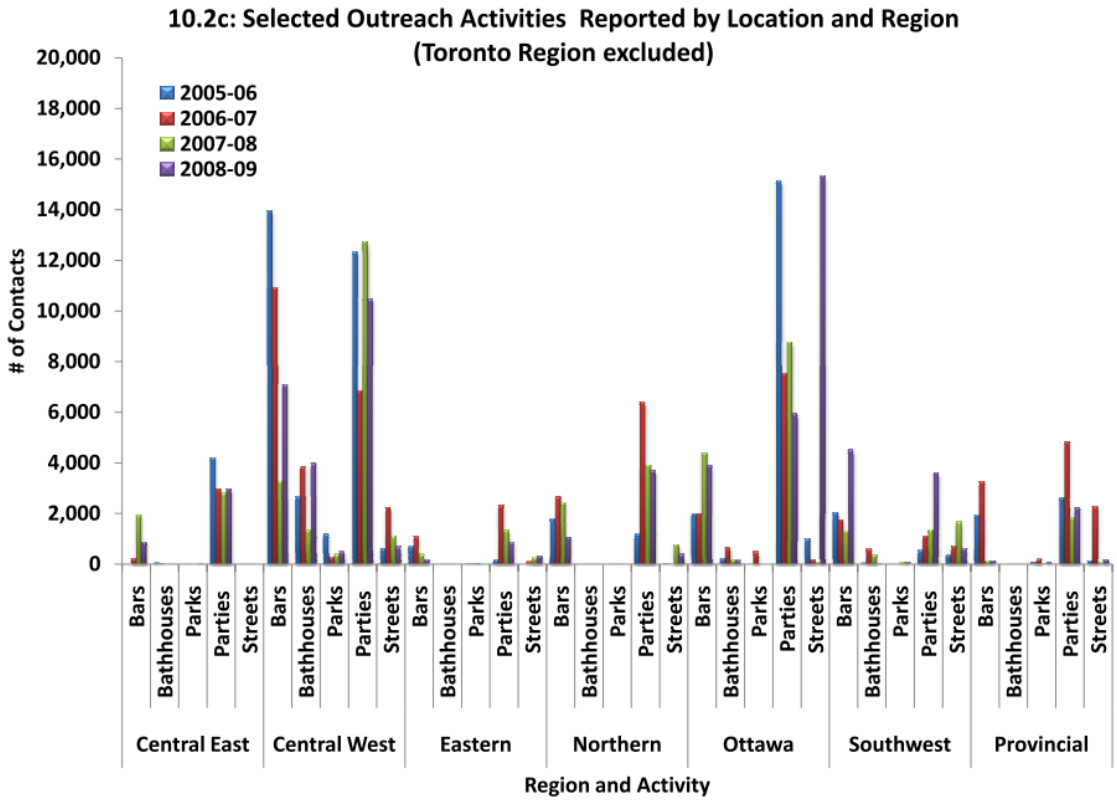
More outreach in bars and bathhouses

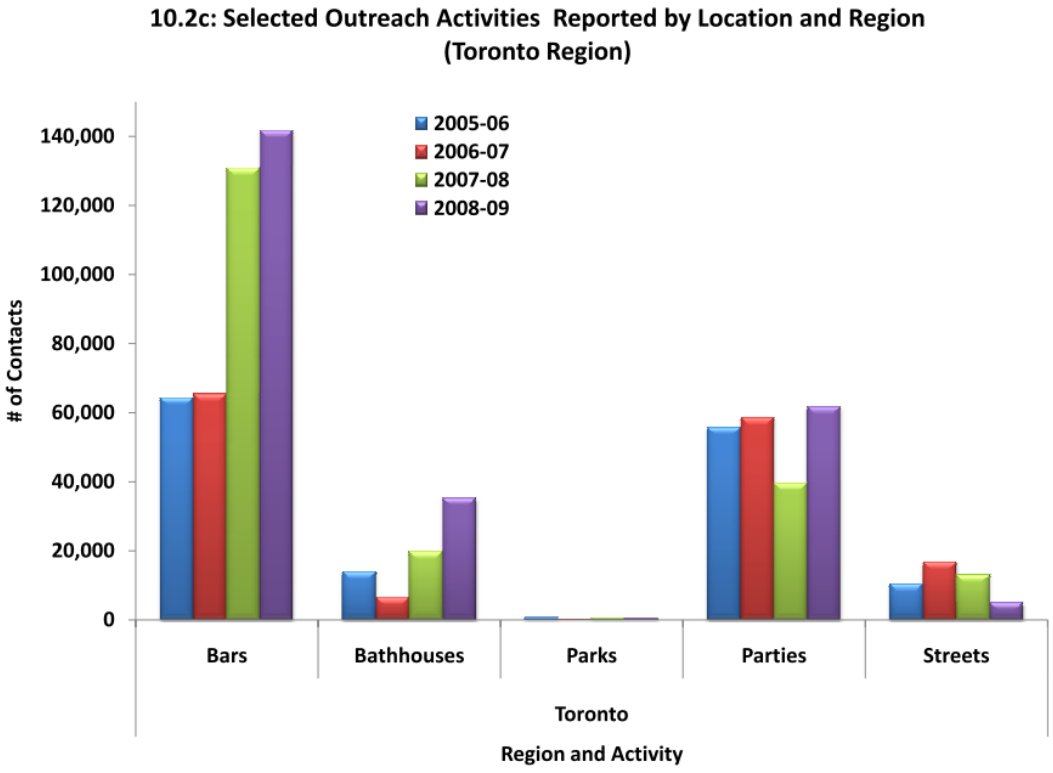
OCHART question 10.2: Record the number of contacts made in each location

Bar and bathhouse outreach continued to increase in 2008-09. The increase was likely due to the Gay Men's Sexual Health Alliance strategy being implemented province-wide.



As the following graphs illustrate, programs based in Toronto, where there is a more visible gay community and a relatively large number of gay bars, largely drove the change.

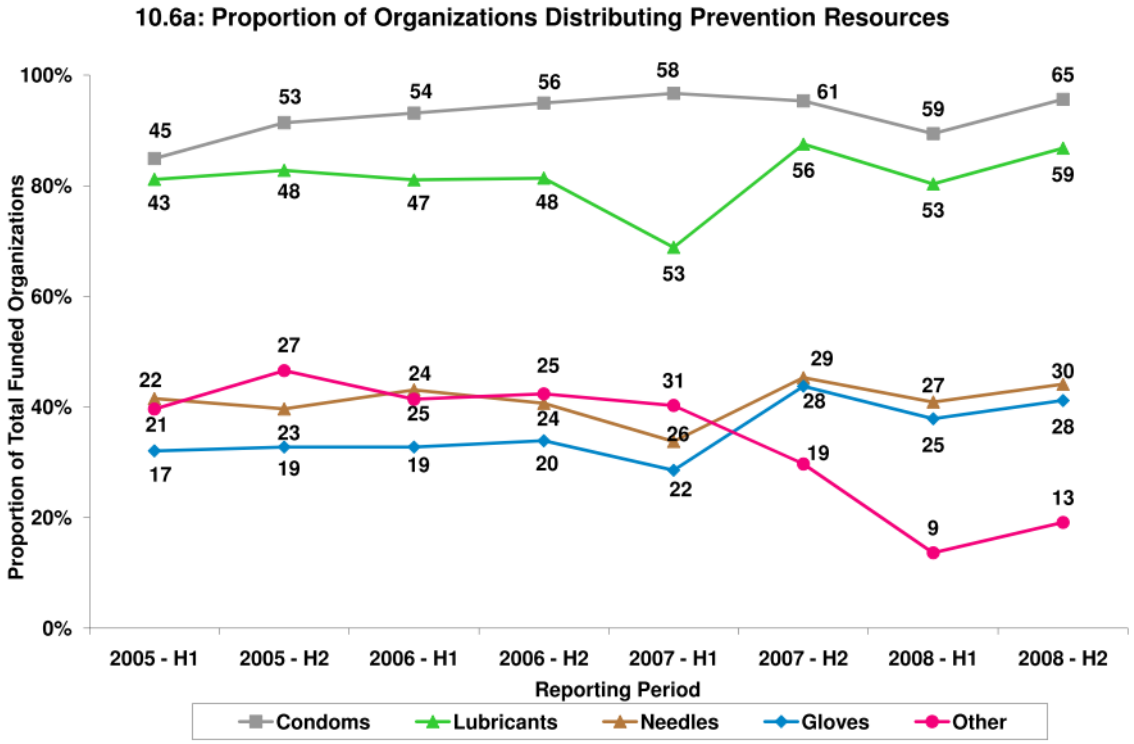

10.2c: Selected Outreach Activities Reported by Location and Region
(Toronto Region excluded)
2005-06
2006-07
2007-08
2008-09
# of Contacts
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
Bars
Bathhouses
Parks
Parties
Streets
Central East
Central West
Eastern
Northern
Ottawa
Southwest
Provincial
Region and Activity


10.2c: Selected Outreach Activities Reported by Location and Region
(Toronto Region)
2005-06
2006-07
2007-08
2008-09
# of Contacts
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
Bars
Bathhouses
Parks
Parties
Streets
Toronto
Region and Activity

Demand for Resources Varies by Region

OCHART question 10.6: Which of the following resources do you distribute on a regular basis?

By the end of 2008-09 (H2), more programs were distributing all "traditional" types of prevention resources.

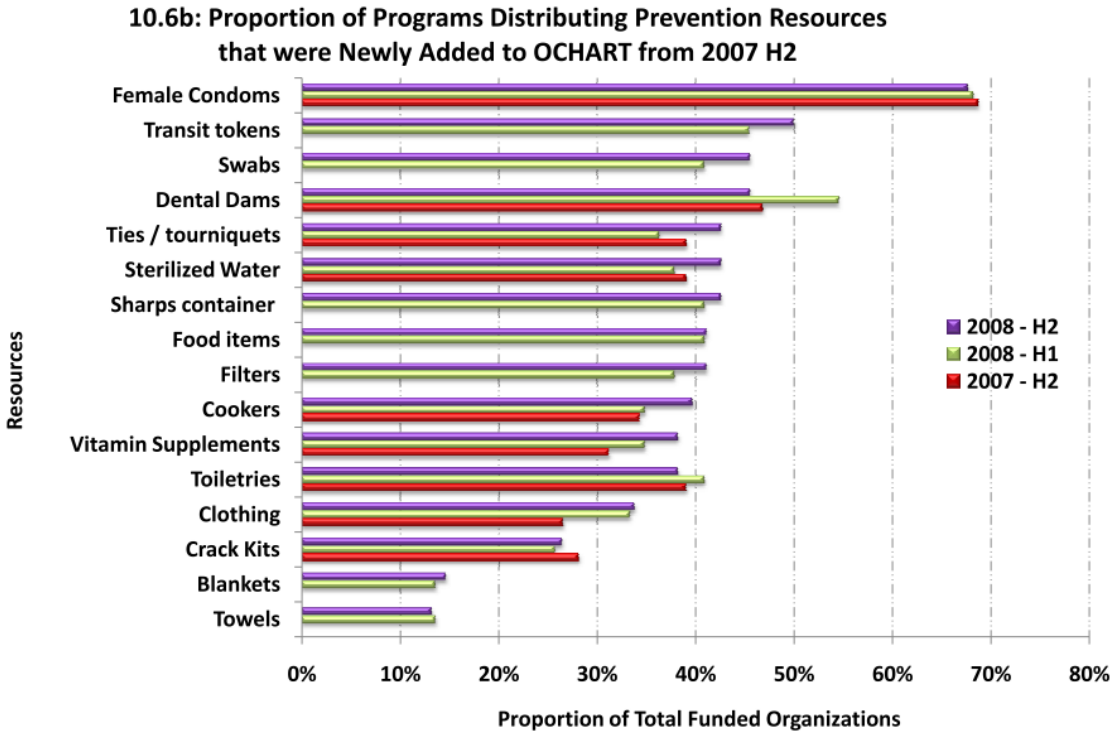


Programs noted that the Ontario Harm Reduction Distribution Program is helping them meet needs for prevention resources.

"Other" prevention resources included: traditional medicines (e.g., sweet grass, cedar), nutritional supplements, first aid supplies and orthotics.

In addition to these resources, there has been a steady increase in the proportion of programs distributing other types of products and supports (see Figure 10.6b). The number of programs now distributing tokens, food and clothing reinforces the transportation and poverty issues that many people with HIV and people at risk face.

(Note: Historically, programs that were not specifically funded to provide IDU outreach services have reported their substance-related resources in this section. Beginning in 2009-10, all organizations will report these resources in section 13, which should provide a clearer picture of harm reduction services for people who use substances.)



Shifts in demand for prevention resources vary regionally:

- Programs in the **Central East** have seen a marked increase in new clients using prevention resources -- particularly harm reduction services -- and more demand for food, assistance with transportation, phone cards, emergency funds for hydro, and male and female condoms. They report an increase in youth using injection drugs.
- **Central West** has also seen an increase in demand for crack kits, vitamins, male and female condoms (from heterosexual women, sex workers and men who have sex with men), bus tickets and withdrawal and treatment services.
- The **Eastern Region** reports a general increase in demand for all resources.
- The **Northern Region** reports more requests for male and female condoms -- including on-the-street requests and a growing population involved in the sex trade. There were more requests for toiletries, food, bus tickets and information on housing, shelters, food banks, and soup kitchens -- not necessarily related to injection drug use, which raises the possibility of a growing homeless population.
- **Ottawa** is seeing an increased demand for condoms and requests for particular brands of condoms, particularly from the African and Caribbean community.
- Programs in the **South West** report increased demand for safer drug use equipment (although they do not distribute safer crack kits) and for male and female condoms and lubricants, as well as more medical and social services.
- **Toronto** programs report increased demand for female condoms, male condoms, safer crack kits and food items -- particularly access to ethnocultural foods. More clients are using crystal meth and some programs have formed a crystal meth coalition to assess their needs and identify resources required to reduce their risk. Programs working with “non-integrated” communities, such as Muslim women’s groups, need “informal, out-of-the-system HIV/AIDS outreach and health promotion efforts” and outreach to the “gate-keepers, including parents, grandparents and faith leaders”.

More youth and women using outreach services

Programs in all seven regions reported more demand for youth outreach, including youth at risk, gay youth, youth working in the sex trade and faith-based youth. Two regions -- Central East and Central West -- reported more demand for harm reduction services. Three regions -- Northern, Ottawa and Toronto -- reported more outreach to women, including services for women leaving prison, services for Asian women, and outreach to migrant sex workers from China. The South West Region reported an increase in Aboriginal clients, particularly women, and provincial programs reported an increase in demand from women from diverse/endemic countries.

To respond to changing needs and demands, programs in all regions are working more closely with other agencies and providing information on other services in their communities. It would be interesting to know whether more collaboration with other agencies to meet outreach needs leading to stronger partnerships. Programs in a number of regions are also making more use of the Internet and other strategies to reach youth.

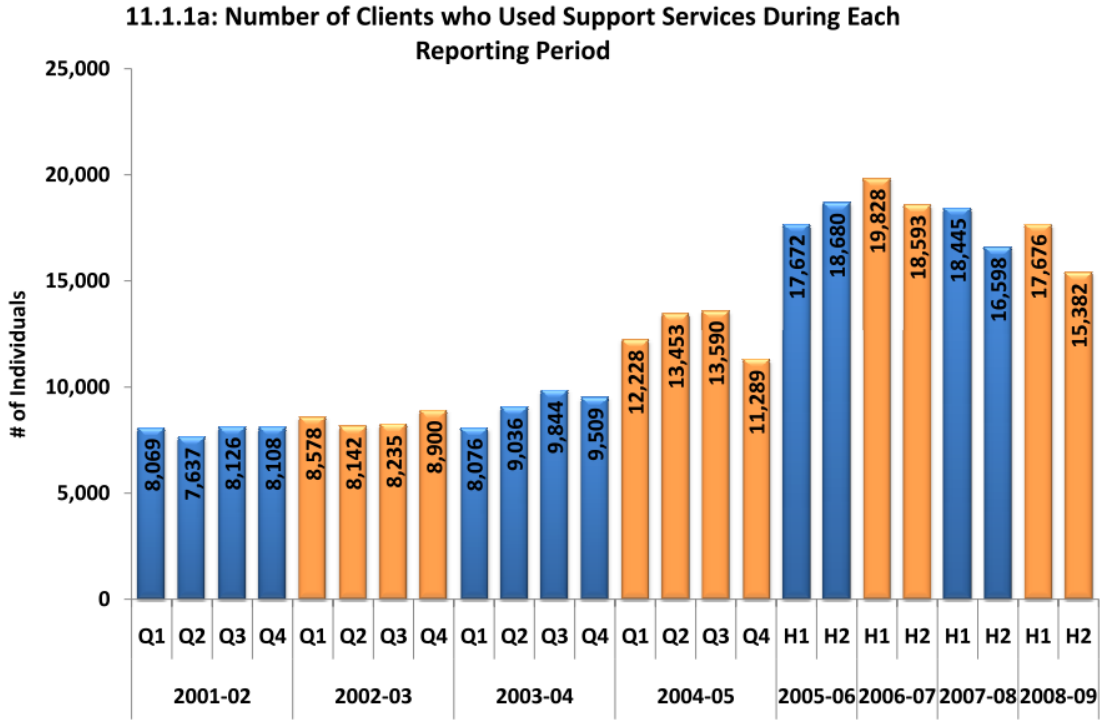
4.3 Support Services

In 2008-09, 69 programs completed the OCHART section on support services (compared to 64 in 2006-07 and 67 in 2007-08), which included counselling, practical support, referrals, training and skills development for people with HIV, their family and friends, people affected by HIV (i.e., populations at risk) and others – compared to 61 in the previous year.

Demand for support services remains strong

OCHART question 11.1: Please describe the people who received support services during the reporting period. Record the total number of people who accessed service, NOT the number of times service were accessed.

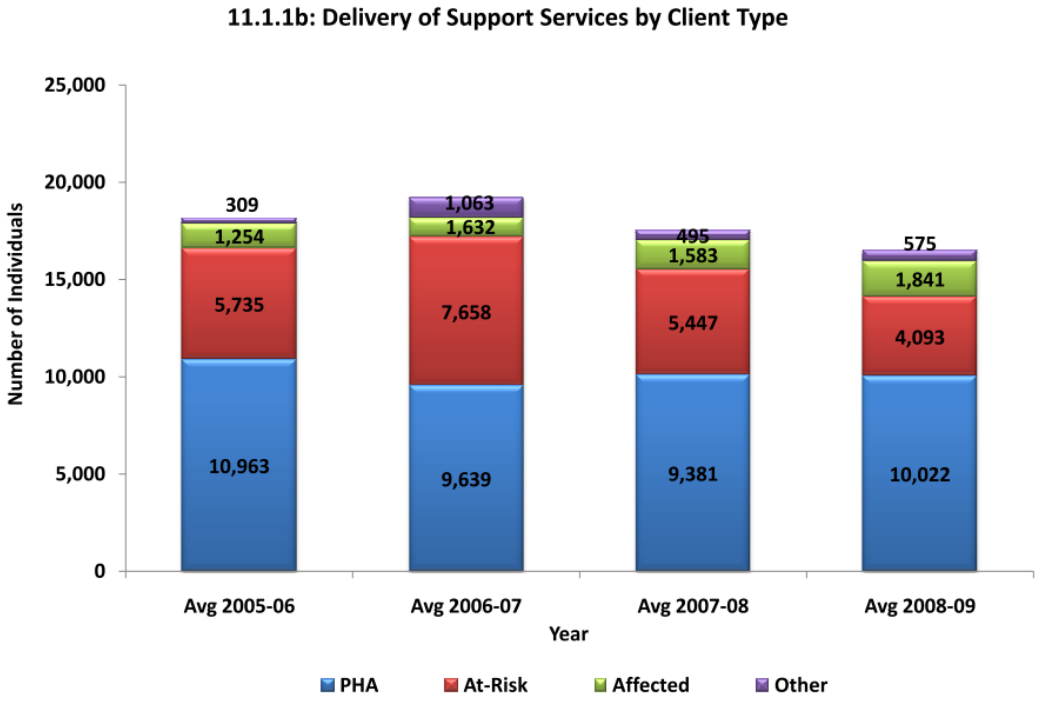
Programs continue to serve, on average, over 16,000 people per half year. The numbers have dropped slightly due to more accurate counting of clients among programs using the Ontario Community-based AIDS Services and Evaluation (OCASE) tool. As of March 2009, two of the largest programs in Ontario were using OCASE, which is a web-based case management program that helps programs monitor client needs and the services they receive.



OCASE, which is supported by the AIDS Bureau, involves an initial client intake and assessment, which will help reinforce a consistent approach to assessing client needs. OCASE is now being implemented in AIDS service organizations across the province. It will lead to more accurate counting of clients as well as more comprehensive information on the mix of services that clients use. It should contribute to higher standards of care and more/better referrals.

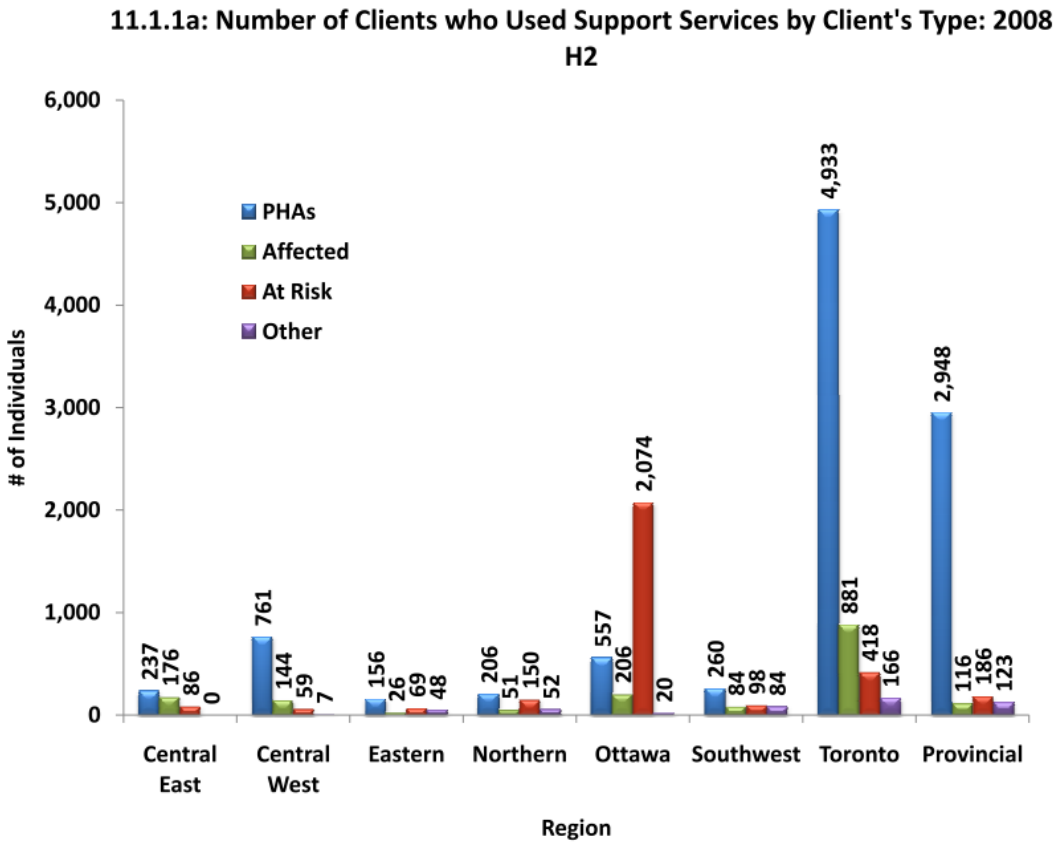
More clients with HIV

While the overall number of support service clients may be down slightly, programs are serving more people with HIV, and more people affected (i.e., partners, family members) than they did in 2007-08.



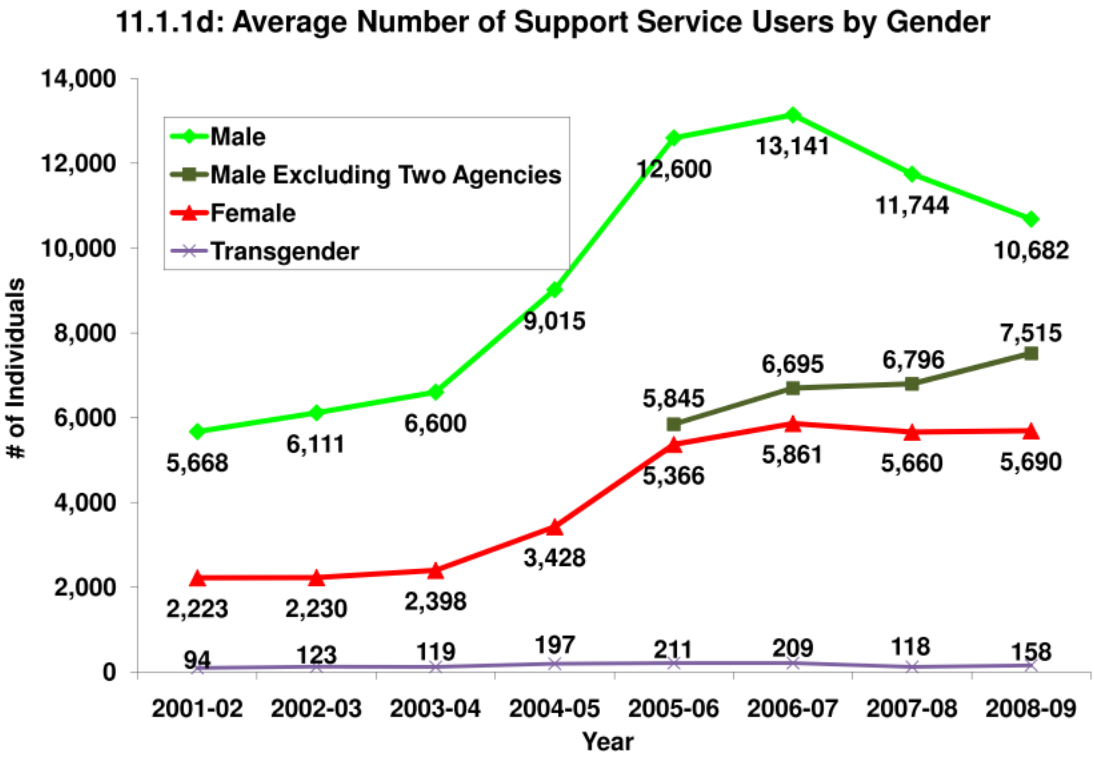
Compared to their target groups for support services (see Figure 6.6), programs reported serving a larger proportion of people with HIV (61% compared to 55%) in 2008-09 and a larger proportion of people at risk (24% compared to 20%).

The following chart (11.1.1a) lists support service clients by group by region. In most regions, the majority of clients who use support services are people living with HIV. The notable exception is Ottawa where the number of people at risk is about four times as high as the number of people with HIV. This is likely due to the public health/prevention services targeting injection drug users. It is also interesting to note that Toronto-based programs provide more support services to people affected than people at risk. This is likely due to the fact that many services for at-risk individuals are captured under outreach and IDU outreach.



Programs serve more men and more women

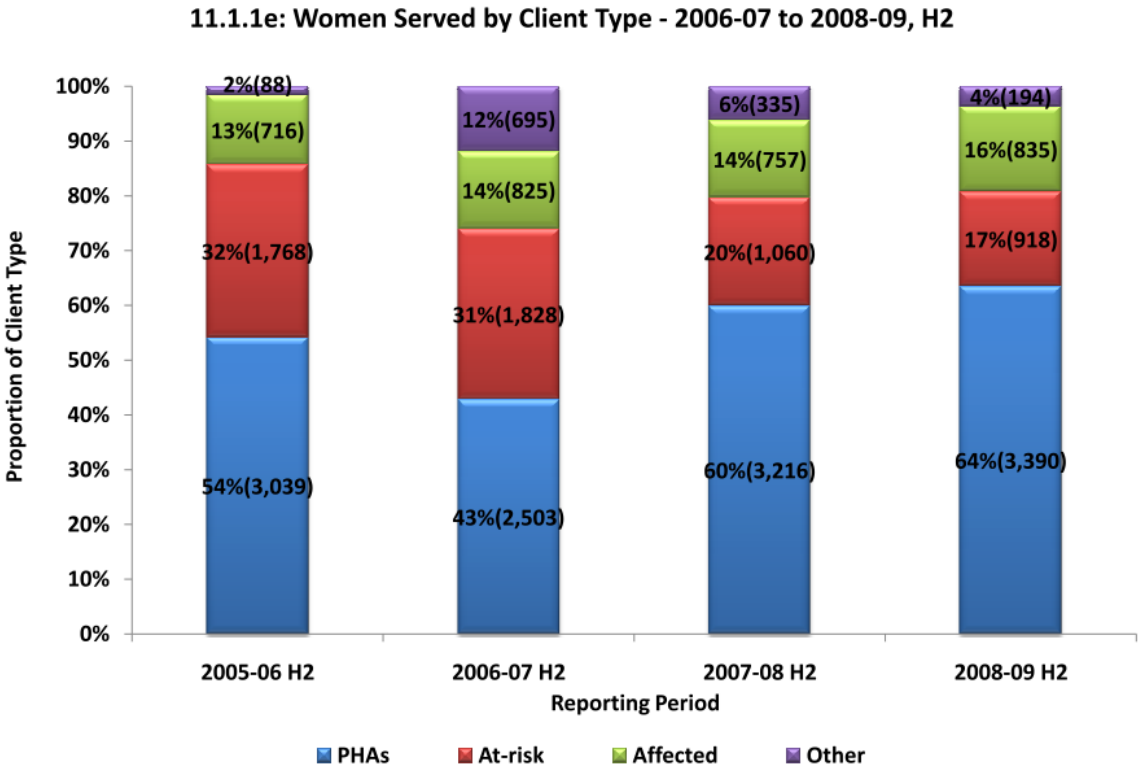
Figure 11.1.1d reinforces the importance of carefully analyzing aggregate data to ensure that it doesn't obscure real trends. For example, total OCHART data for the number of male clients (bright green line) appears to show a marked decline in the number of men using support services. However, a closer look at the data revealed that the downward trend was the result of reporting anomalies in two agencies: one with a large number of programs, which discovered it had been double counting some clients; and a second that reported a large number of clients in 2005-06 and 2006-07 but is no longer providing support services. When those two programs are removed from the analysis (dark green line), the picture is very different: there has been a steady increase in male clients across the other programs.

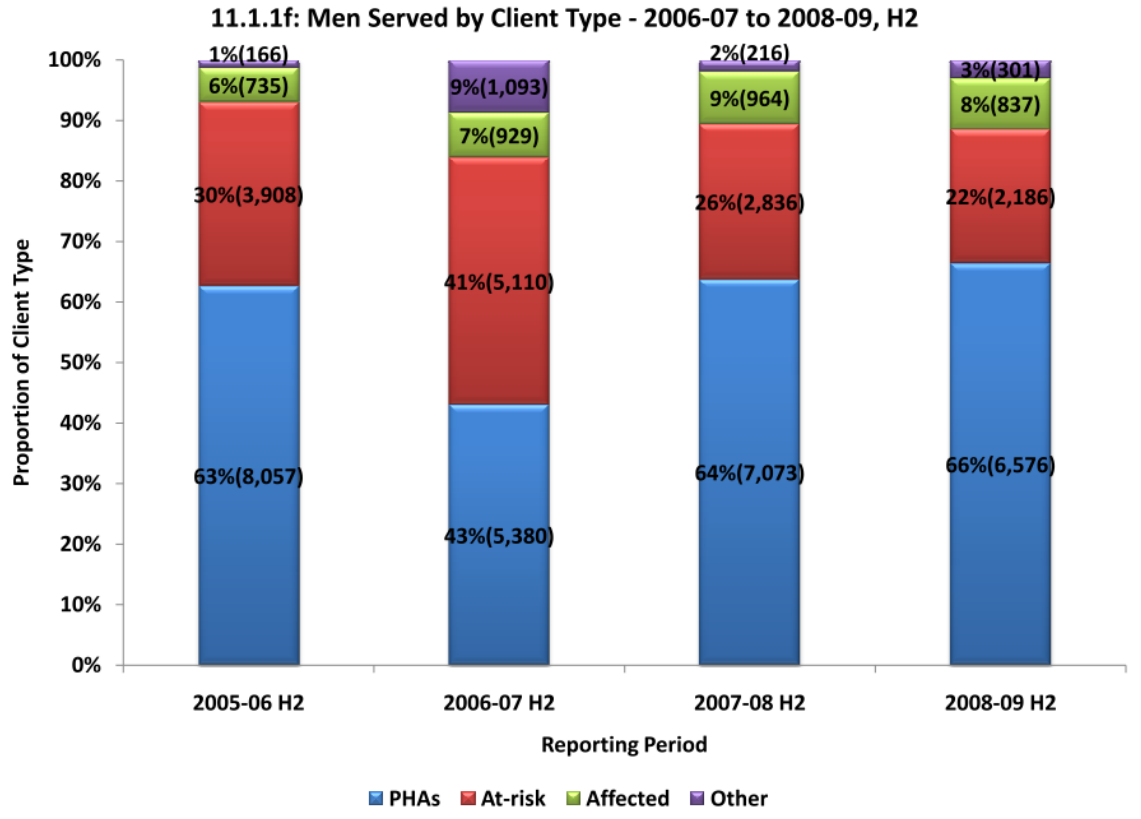


Although women account for one-quarter of new diagnoses (see Figure 11.1.1d), they appear to be more likely than men to use support services: they account for over one-third of service users. This trend may be due to many women's complex needs (e.g., financial dependence, domestic violence, more likely to be diagnosed later in the infection) – or it may reflect the fact that women, in general, are more likely to use health services than men.

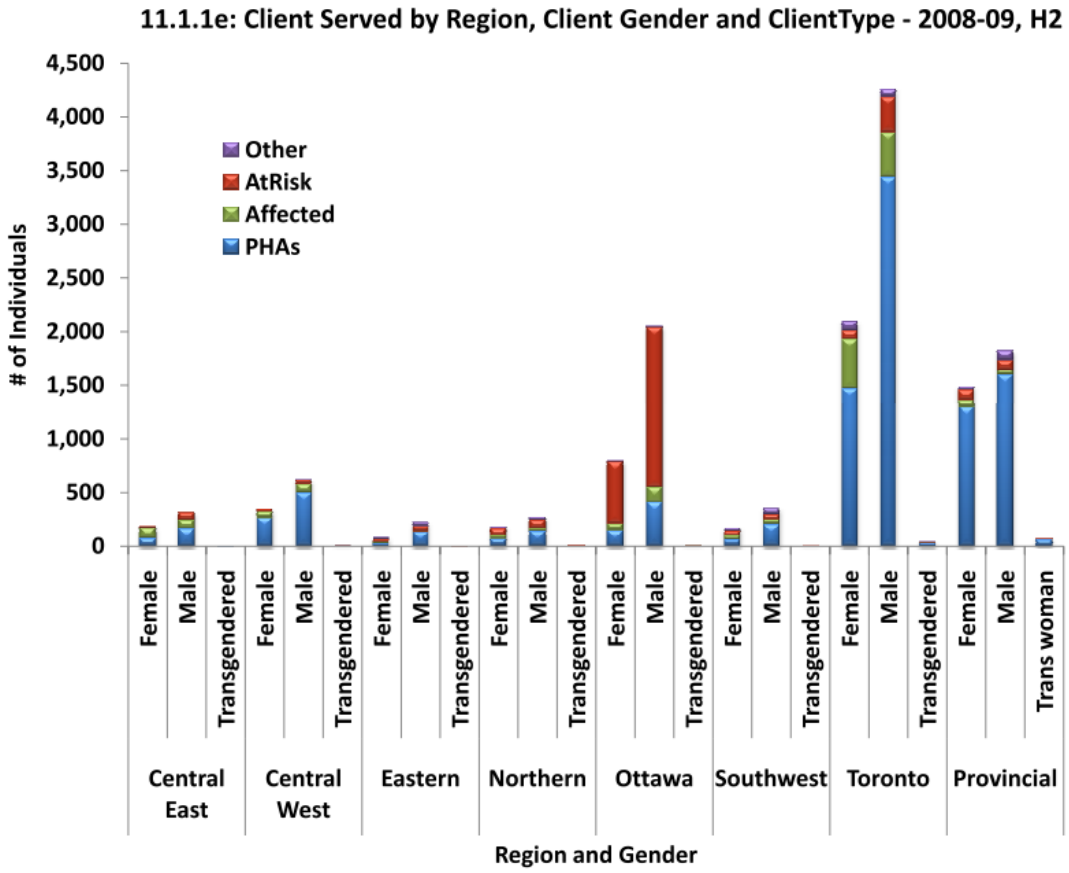
It would be interesting to know whether the increase in women clients is having an impact on the type and mix of services offered. Overall, there does not appear to be significant gender differences in the type of support services used – although service utilization may be driven by the services available and skills/capacity of the programs rather than by client need.

A growing proportion of the women and men who use support services are living with HIV, compared to 2006-07.



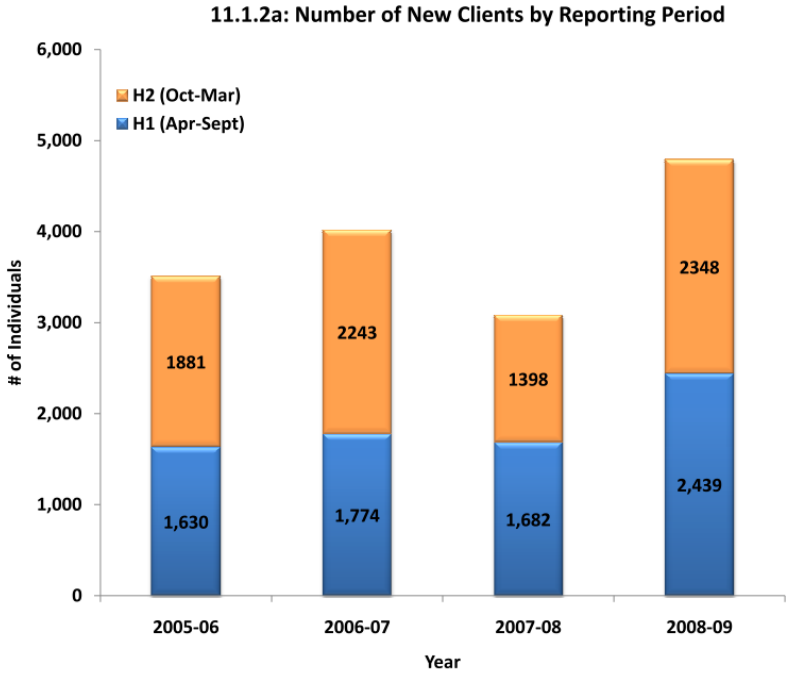


When OCHART data are analyzed by region, they show that certain regions – such as Toronto and Central West –serve large numbers of women with HIV, while Ottawa serves a large number of women at risk. In the Northern region, programs see almost as many female as male clients – which is markedly different from the pattern in the rest of the province (except for provincial programs).

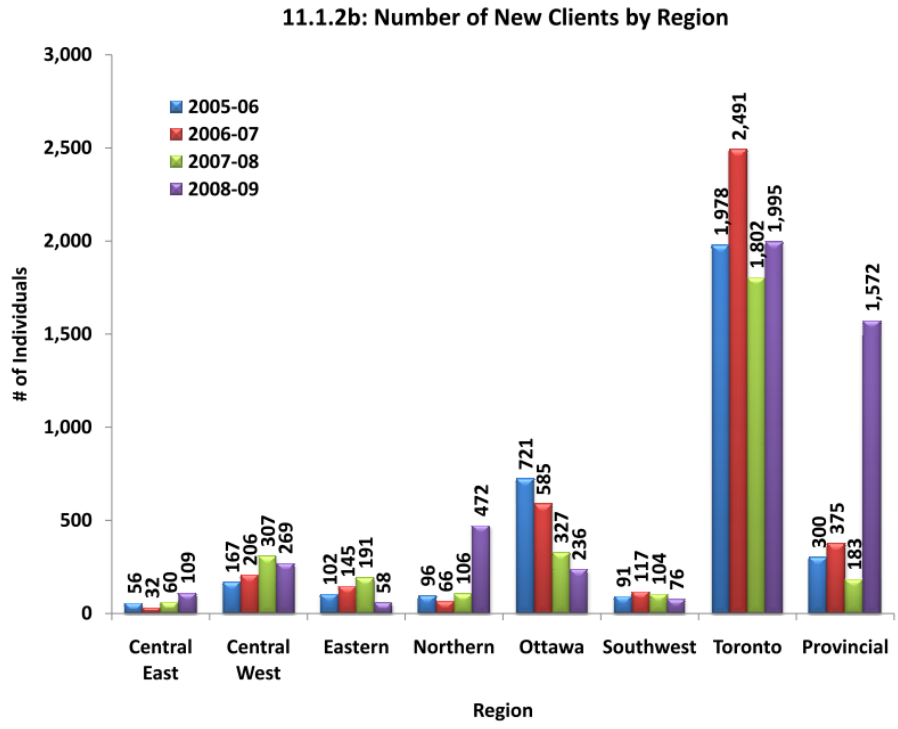


More New Clients

Programs continue to see a growing number of new clients: 14 to 15% of clients in 2008/09 were new clients. It would be interesting to know more about service usage patterns (e.g., how long people continue to use services, the mix of services they use).

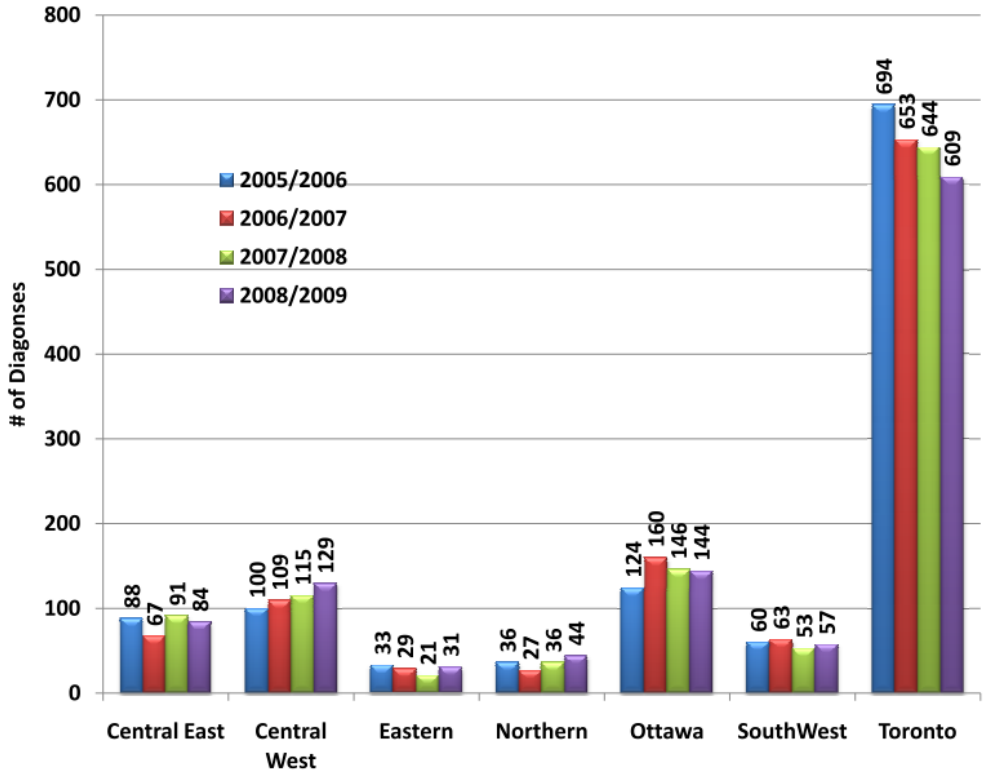


Regions reporting the largest increase in new clients are Northern and Central East. The increase in the Northern Region was due mainly to one organization.



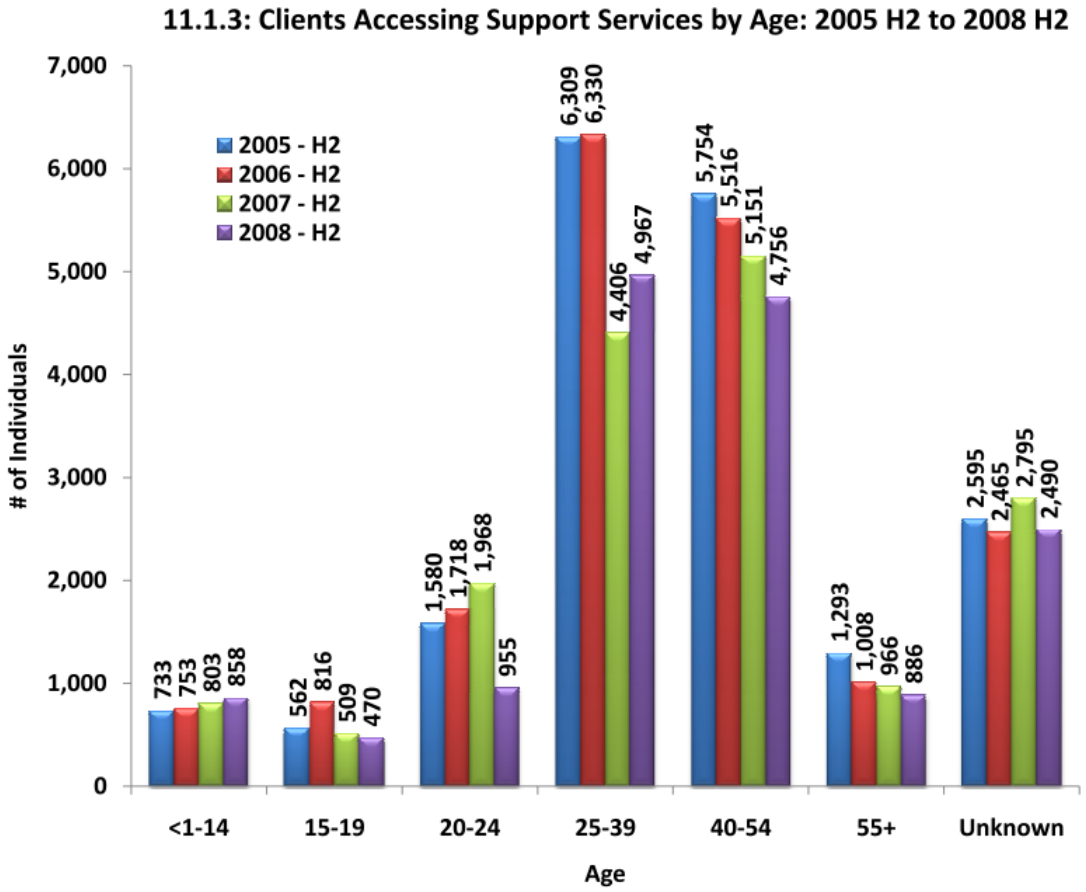
When we compare the location of new clients (Figure 11.1.2b) with the location of new diagnoses, there *does* appear to be a direct correlation between the number of new diagnoses and the number of new clients – however, we do not have enough information about when clients access services, how long they access services, or whether they move in and out of services over time (depending on their needs) to determine the proportion of new clients who are recently diagnosed.

Figure 8: New Diagnoses by Region



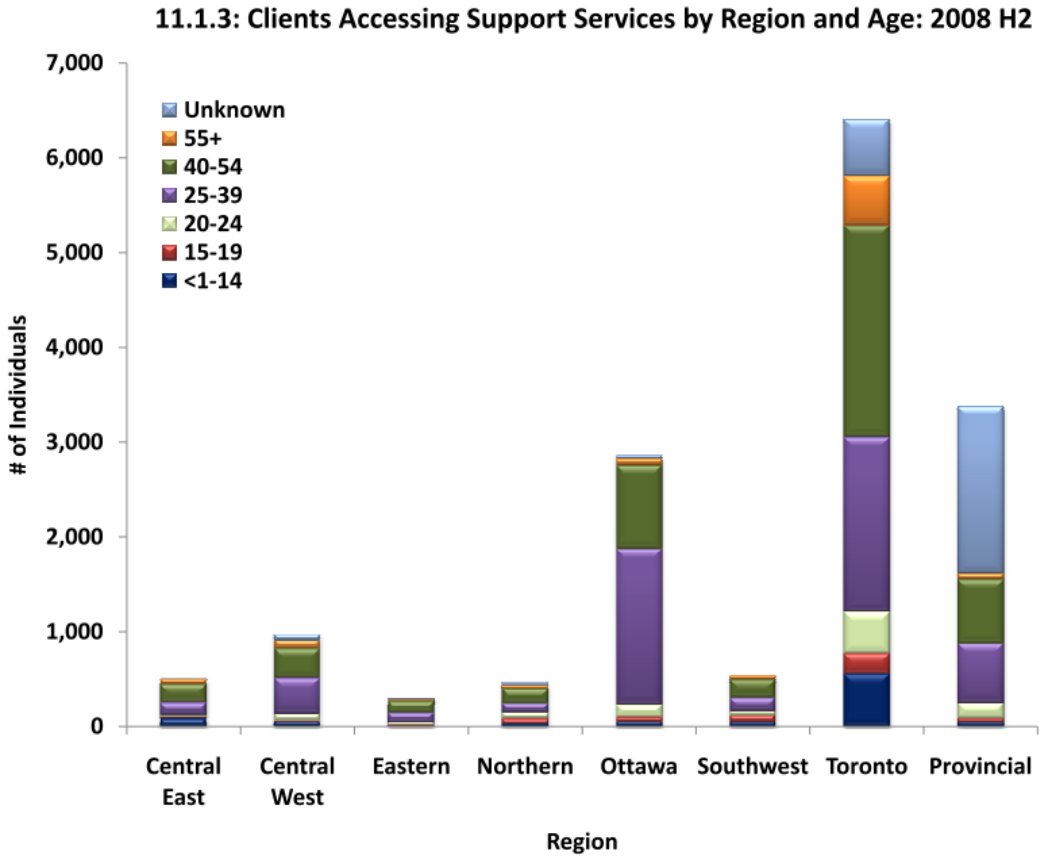
Clients are older

While prevention and outreach services appear to be focusing more on youth, most of the people using support services are between the ages of 25 and 54, and most are over age 35. It would be interesting to know whether older clients have different needs and are having an impact on the type and mix of services being used. It would also be useful to know to what extent our programs are accessible to and appropriate for aging clients.



Toronto is the only region that reports serving a significant number of children (<14), although children also make up a noticeable percentage of clients in Central East.

In most regions, the majority of support service clients are between the ages of 40 and 54.



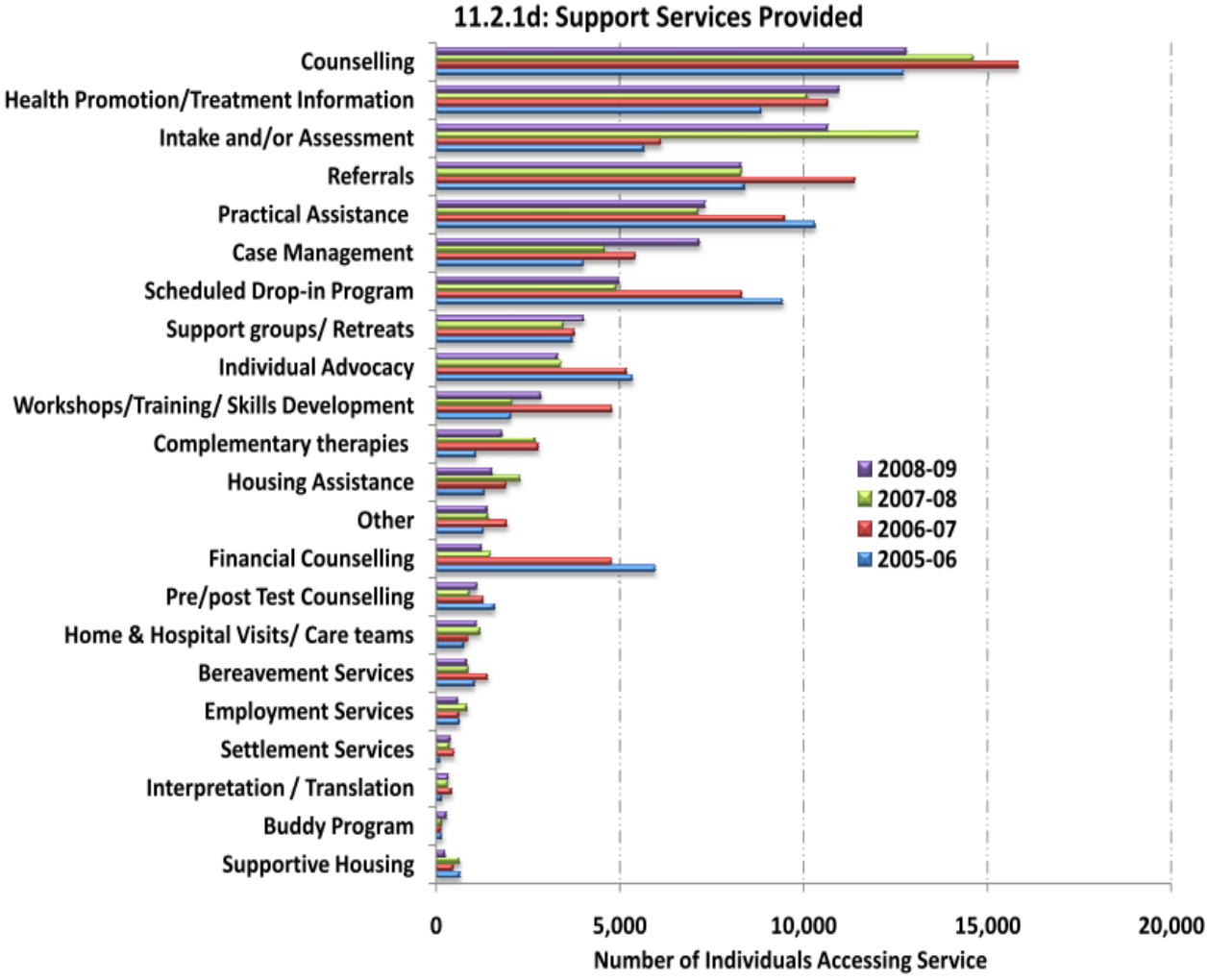
Age	Central East	Central West	Eastern	Northern	Ottawa	South West	Toronto	Provincial
Unknown	6	62	10	26	31	0	595	1760
55+	50	89	21	35	76	31	519	65
40-54	192	312	121	152	878	191	2237	673
25-39	128	374	104	101	1646	146	1839	629
20-24	21	69	35	61	132	40	436	161
15-19	16	14	8	59	40	71	222	40
<1-14	86	51	0	25	54	47	550	45

Programs offer more intake and assessment and case management services

OCHART question 11.2.1: Record all services provided this reporting period to male, female and transgender persons. Please note the following: record how many of the above Service Users accessed the service, NOT the number of times the service was accessed.

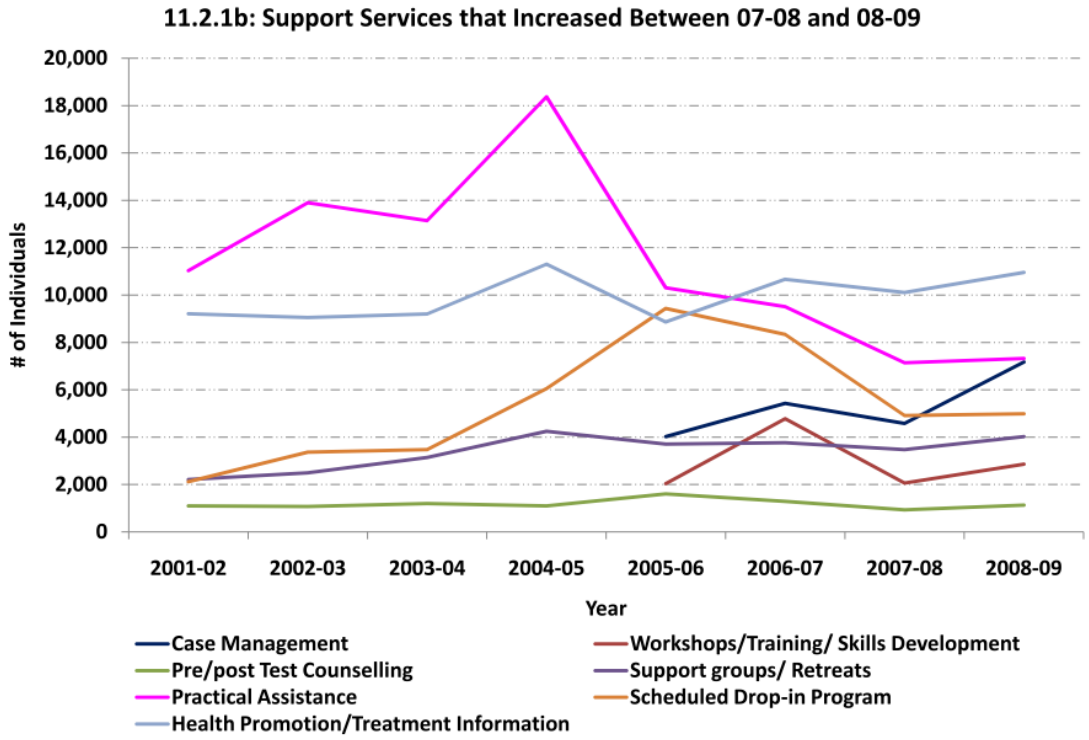
In 2008-09, more individuals accessed intake and assessment services, case management services and support groups than in previous years, and the demand for practical assistance and referrals remained high. It would be interesting to know whether the greater availability and use of intake, assessment and case management services are leading to more comprehensive, integrated services for clients.

There was a small but growing demand for settlement, interpretation, home and hospital visits, and buddy services, which reflects the needs of newcomers as well as the growing number of people aging with HIV whose needs may be increasing.

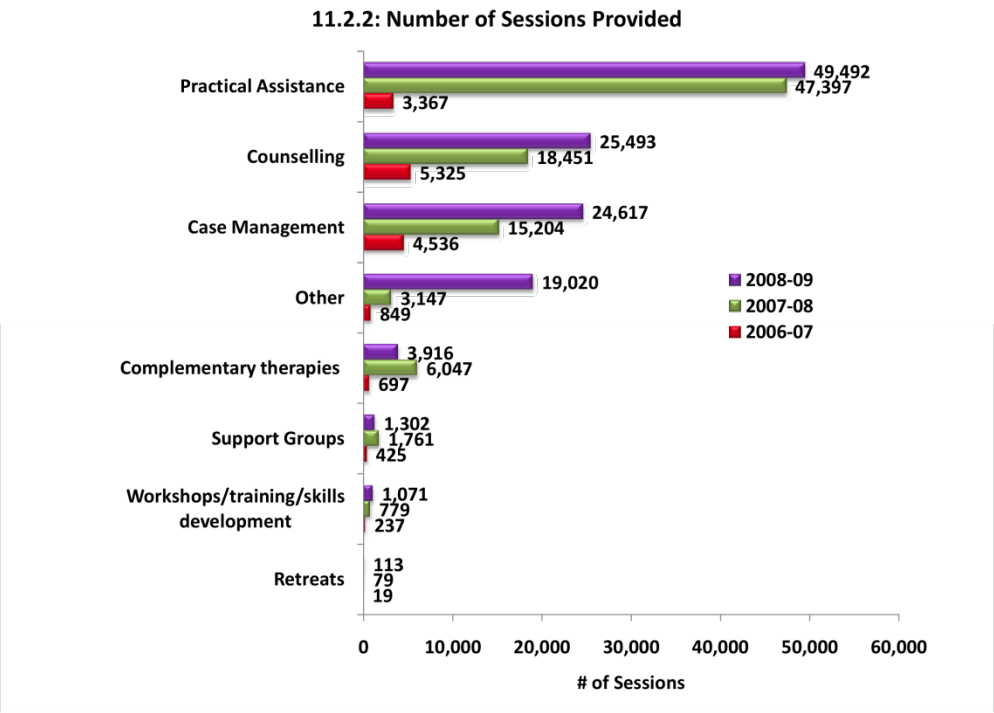


The following graph shows the support services that increased between 2007-08 and 2008-09: the most dramatic increase was in intake and assessment services followed by case management

services (the categories “case management” and “workshops, training, skills development” were added to OCHART in 2005-06). The drop in practical support services is likely due to more accurate counting rather than a real drop in services. In the past, clients using a number of practical assistance services might have been counted several times. As more programs begin to use OCASE, they are able to track the exact number of clients as well as the mix of services they use.



In an effort to measure intensity of service, programs were asked about the number of sessions provided to clients. As the following figure illustrates the capacity for programs to track the number of sessions is improving over time. Although programs appear to provide mainly practical assistance, there was a significant increase in 2009-09 in the number of counselling, case management and “other” sessions.

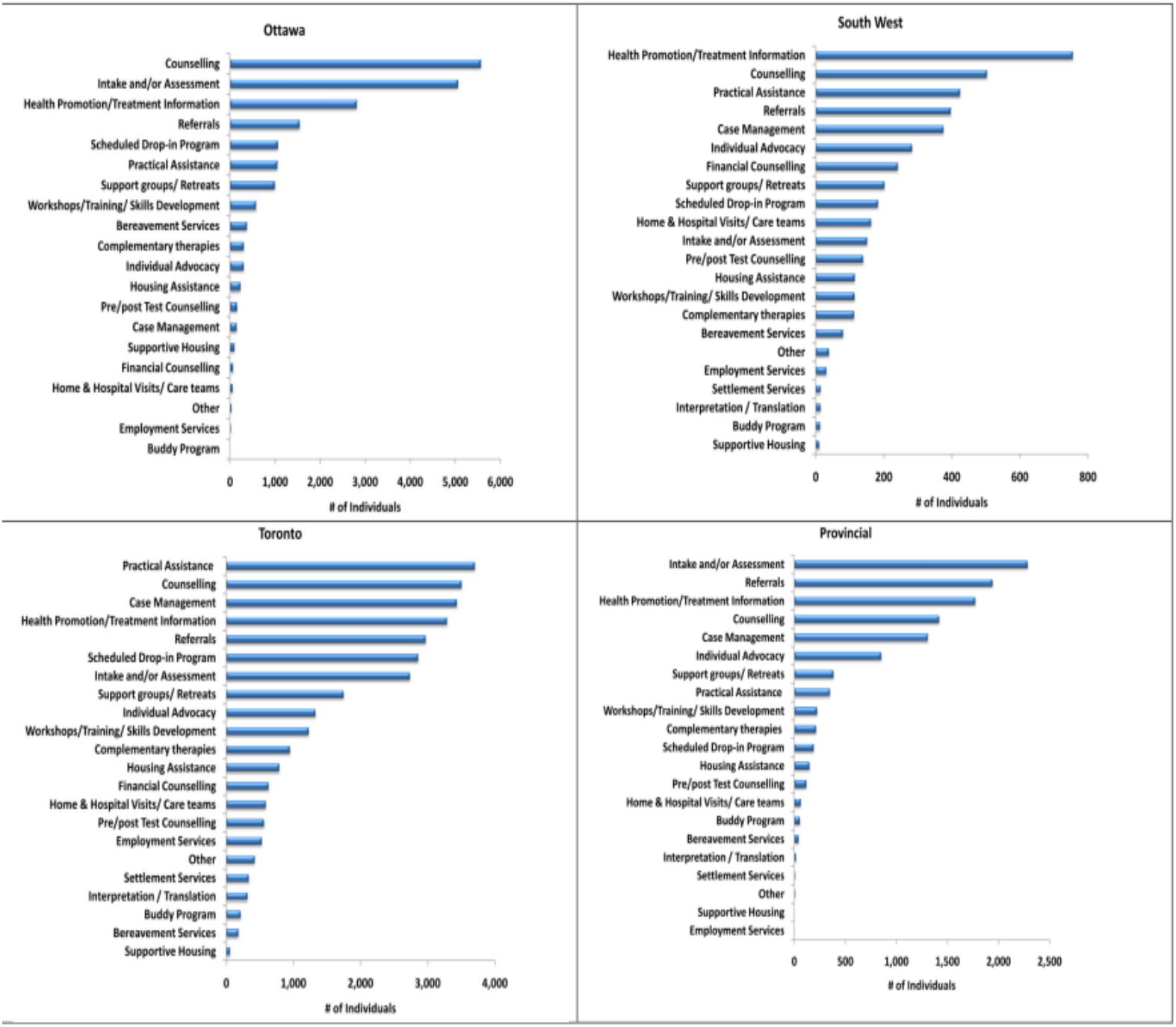


Availability of Services Varies by Region

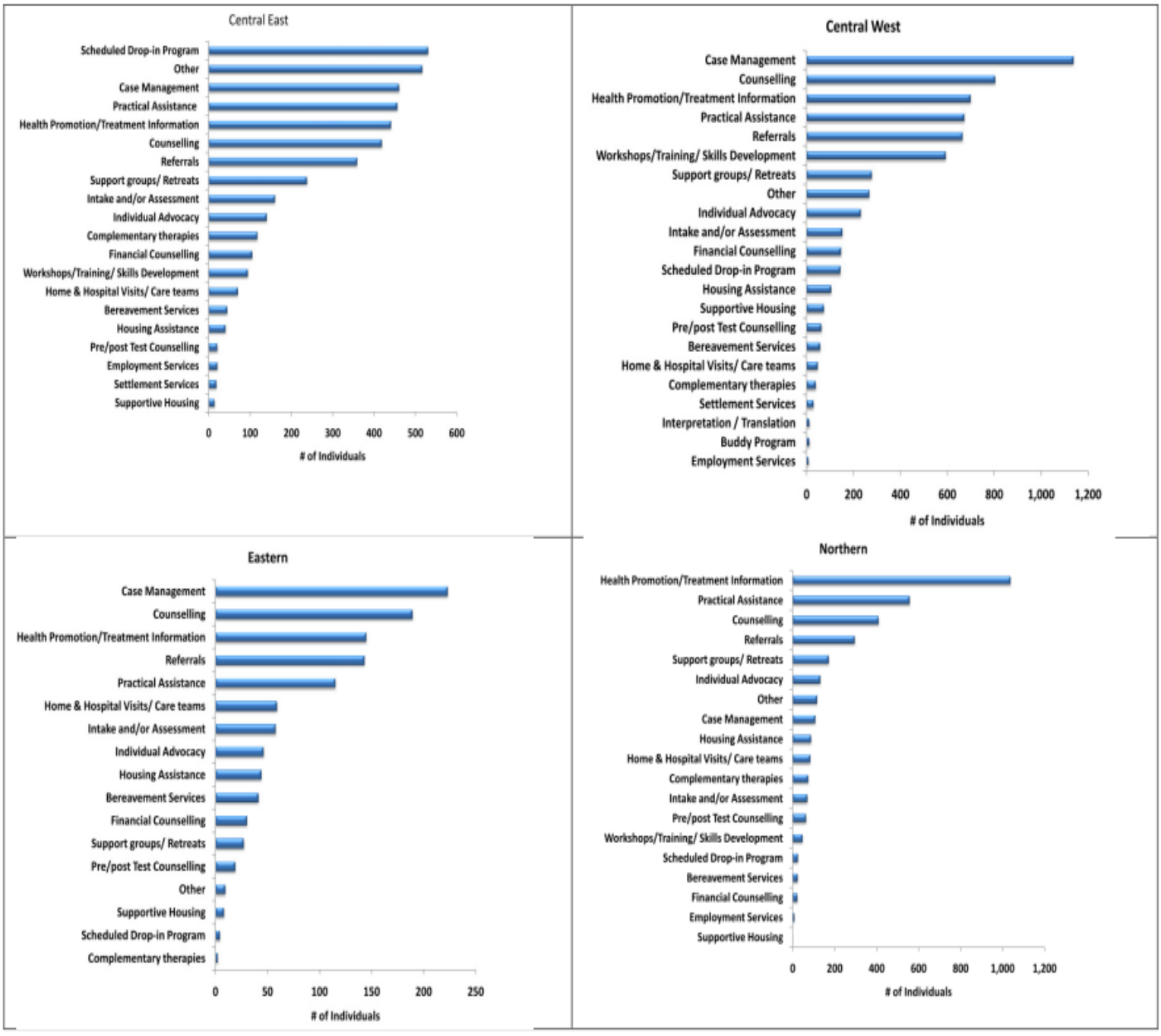
The types of support services provided and used vary across the province. Toronto-based programs provide significantly more practical assistance than programs in other regions, while programs in Central East focus more on referrals. In all regions, it appears that the "core" services are counselling, case management, intake and assessment, referrals and health promotion. The field might benefit from a discussion of the "core" services that should be provided by all programs and "other" services that could be provided by referral to other agencies.

Very few clients are accessing employment services, supportive housing or settlement services directly from HIV programs – and access to practical assistance appears to vary across the province.

Regional Breakdown – Chart 11.2.1D



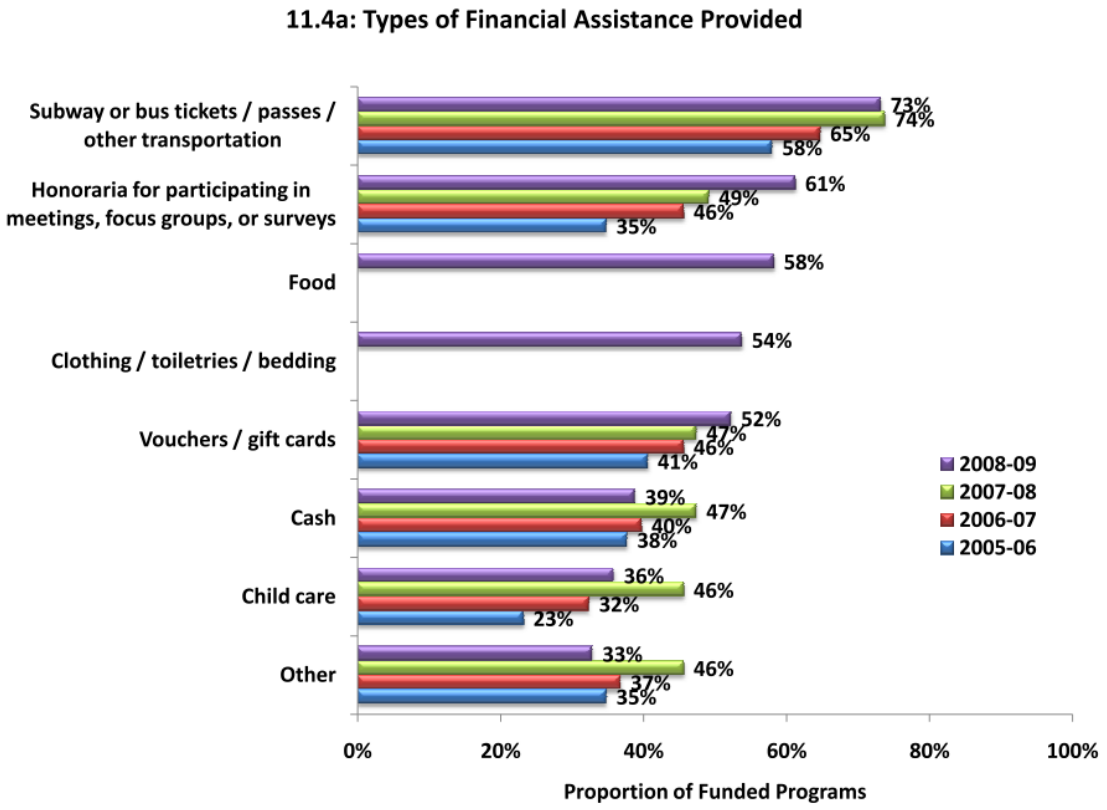
Regional Breakdown – Chart 11.2.1D



Growing demand for financial assistance

OCHART question 11.4: Financial Support - What other assistance do you provide?

More programs are providing financial assistance for clients, primarily in the form of bus tickets, food, clothing and vouchers.



Emerging trends in support services by region

The emerging trends identified by programs reinforce that poverty is a serious issue for people accessing their services.

In **Central East**, there was more demand for practical assistance, such as food banks, financial assistance, help accessing Ontario Works (OW) and Ontario Disability Support Program (ODSP), and more requests for support groups for women, youth and people affected by HIV. There was also increasing concern about the number of cases of people charged for not disclosing their HIV status. Programs responded by:

- Forging new partnerships with food provider networks to ensure the sustainability and effectiveness of food banks
- Exploring new funding sources and increasing fundraising efforts
- Focusing more on youth in prevention programs
- Establishing partnerships within the community to access health care and establish strong relationships with ODSP and OW workers
- Monitoring criminal charges related to nondisclosure, and updating clients as needed
- Training long term survivors in peer support for assisting an aging PHA population
- Developing programs using a holistic approach and utilizing the knowledge and experience of support and prevention staff as well as client expertise

- Creating and implementing tools for evaluating community experiences

Central West reported an increase in newcomers, women with HIV who are pregnant, and children with HIV. These changes meant more need for translation and immigration services, practical support and assistance adapting to a new culture and finding employment. Programs responded by:

- Obtaining funding for an ethno-racial focused worker and developing a curriculum to train interpreters around providing HIV/AIDS informed and sensitive interpretation.
- Growing and nurturing relationships with partner agencies (i.e., housing, food, OW and ODSP, health and hospitals) to enhance programs and services
- Enhancing peer related support skills

Access to affordable, safe housing continues to be an issue in the **Eastern** Region. Programs also report more clients with complex mental health issues, and a larger number of older clients in rural communities who are finding it increasingly difficult to manage their health. Programs responded by working with the housing registry and other stakeholders.

Programs in the **Northern** region are seeing more clients who are unable to find a family doctor, and more demand for support groups for HIV+ women and social groups for people with HIV. To help meet the practical needs of clients, a northern focused financial support program has been established. Programs responded by:

- Developing new partnerships and strengthening existing ones
- Developing outreach program to meet clients where they are
- Working with and supporting local food security partners
- Running focus groups to determine the need for an HIV+ women's support group
- Providing home visits to homebound and hard to reach clients.

Ottawa is seeing increasing demand from African and Caribbean women with HIV, clients who inject steroids and clients with age-related illnesses. Many clients are struggling to manage on a reduced standard of living, complicated by hospital and health care cutbacks. Programs responded by:

- Networking with other agencies to expand support
- Advocating on behalf of those who require assistance and services
- Seeking partnership with local food producers and agencies

The **South West** reports an increase in Aboriginal clients, and in demand for counselling, financial assistance, food assistance and food vouchers. Programs responded by:

- Developing new partnerships with employment services and stronger relationships with housing providers
- Establishing a new food bank with locally produced food
- Referring clients to larger more resourced agencies.

Toronto ASOs are seeing more and younger gay men who are positive and who also use crystal meth and are involved in the sex trade or cyber sex trade. They are also seeing more women with immigration and housing issues or underlying health issues (e.g., cancer), and more women are accessing food bank services. There has been an increase in demand for addiction treatment and withdrawal management services and for supportive housing. More older clients are presenting with non-HIV related issues. Programs responded by:

- Expanding youth programming including hiring of new peer support worker
- Developing new positive youth support group
- Developing partnership with mainstream housing service agencies
- Enhancing support group topics for long-term survivors
- Monitoring changes in increases in volume to ensure changes are not an anomaly and take appropriate action

- Developing an enhanced strategy in dealing with food insecurity
- Developing a stronger relationship with partner agencies to enhance programs and services
- Expanding and enhancing peer related support

Only a small number of **provincial** programs provide direct client services. Those that do report significantly more requests for legal immigration services, women's support groups, financial assistance, help finding employment and information on disclosure strategies. Programs responded by:

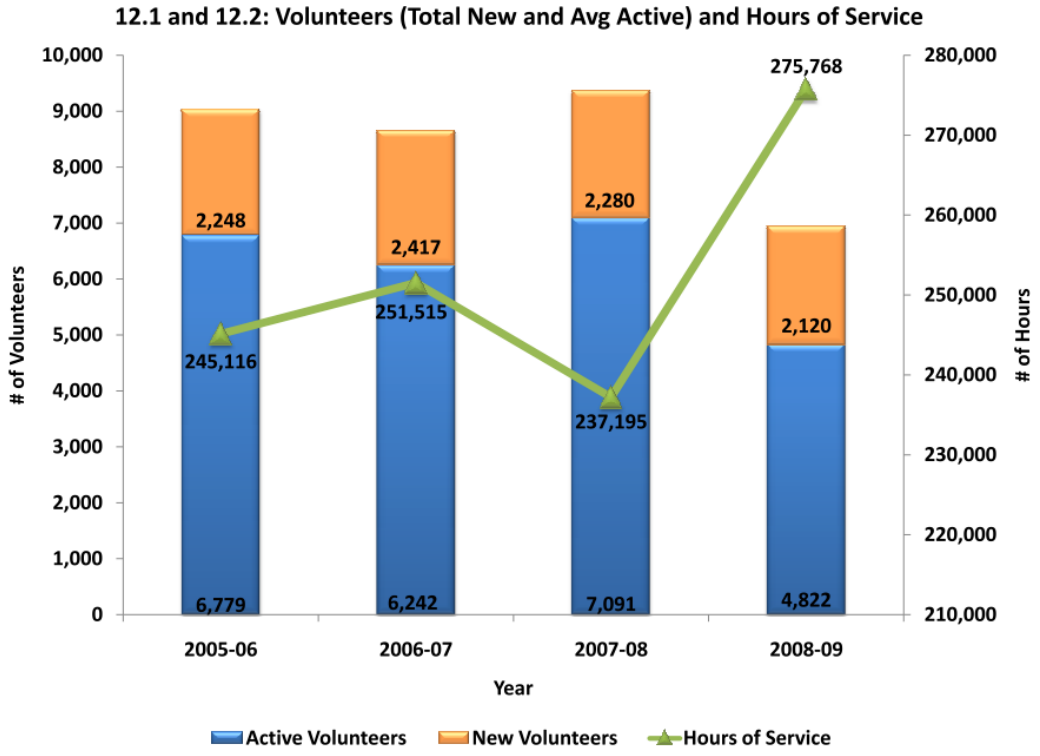
- Exploring partnerships with other organizations offering job placement assistance
- Hiring new staff with focus on immigration

4.4 Use of Volunteers

OCHART questions 12.1 Volunteers and Volunteer Management and 12.2 Volunteer Activities

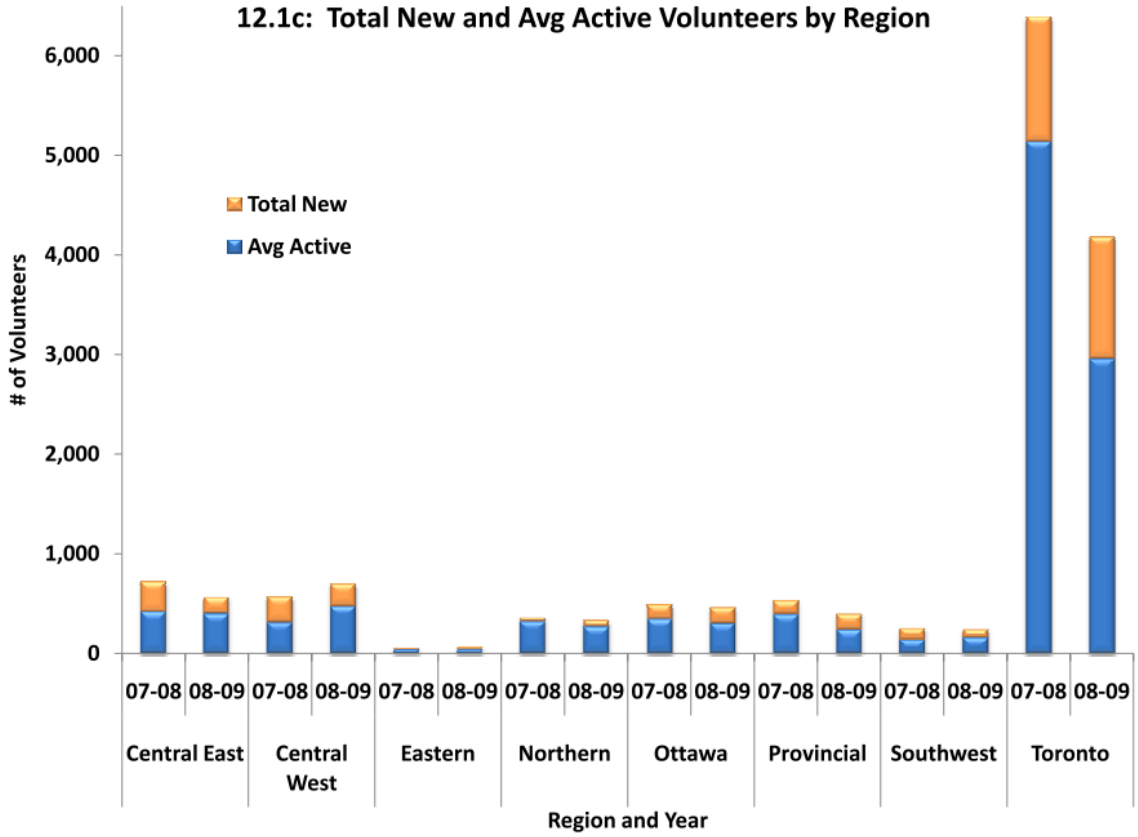
The total number of volunteers in community-based HIV services – both new and active – dropped in 2008-09 by 7% and 32% respectively. The decrease is likely due, in part, to more accurate data collection on volunteers.

While programs may have fewer volunteers, they report more volunteer hours, which appears to indicate that the people who volunteer are more involved with the programs.



The most significant drop in volunteer numbers occurred in Toronto (see Figure 12.1c), and was due to more accurate reporting.

Some programs are more effective than others at recruiting and retaining volunteers. It might be useful to identify best practices in recruiting and retaining volunteers, and to discuss more focused recruitment strategies, such as seeking out people with very specific skills, defining meaningful roles for volunteers and linking with private businesses with volunteer sponsorship programs (e.g. give employees time-off to volunteer).

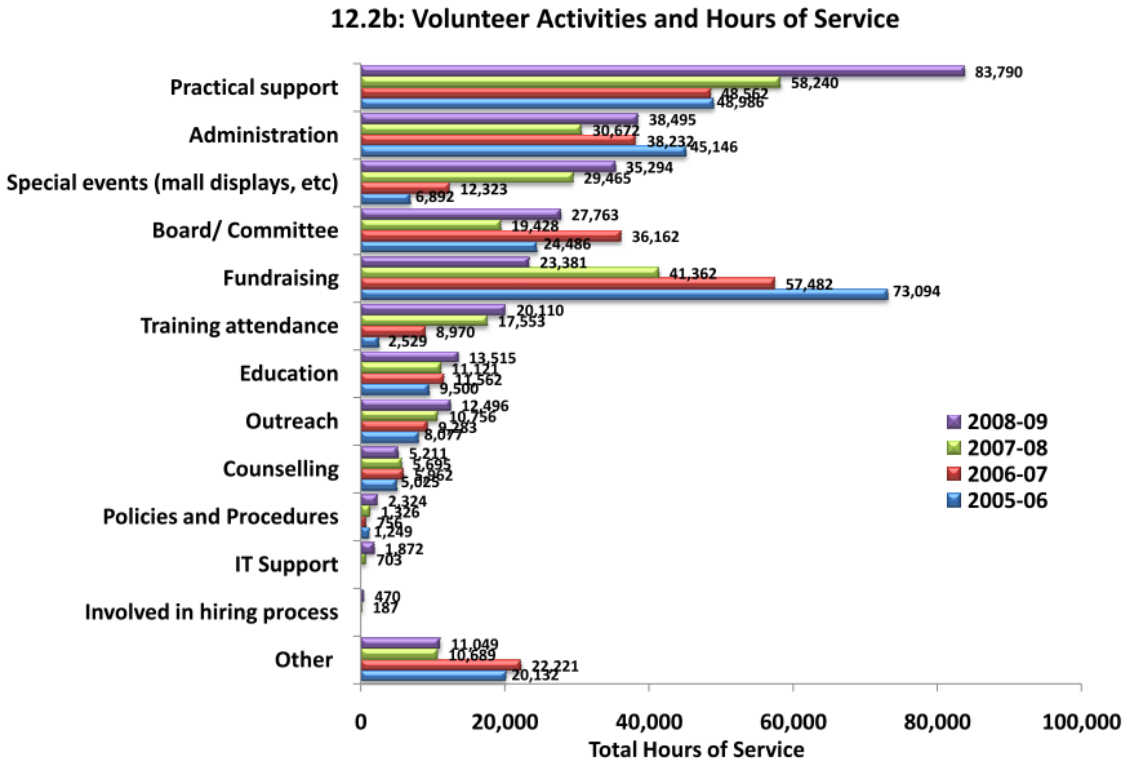


	Central East		Central West		Eastern		Northern		Ottawa		Provincial		South West		Toronto	
	07-08	08-09	07-08	08-09	07-08	08-09	07-08	08-09	07-08	08-09	07-08	08-09	07-08	08-09	07-08	08-09
Total New	301	165	258	227	19	31	38	69	151	162	142	157	113	82	1,258	1,227
Avg Active	418	397	310	472	36	36	321	265	345	301	389	237	138	158	5,135	2,958

Volunteers more involved in direct service delivery

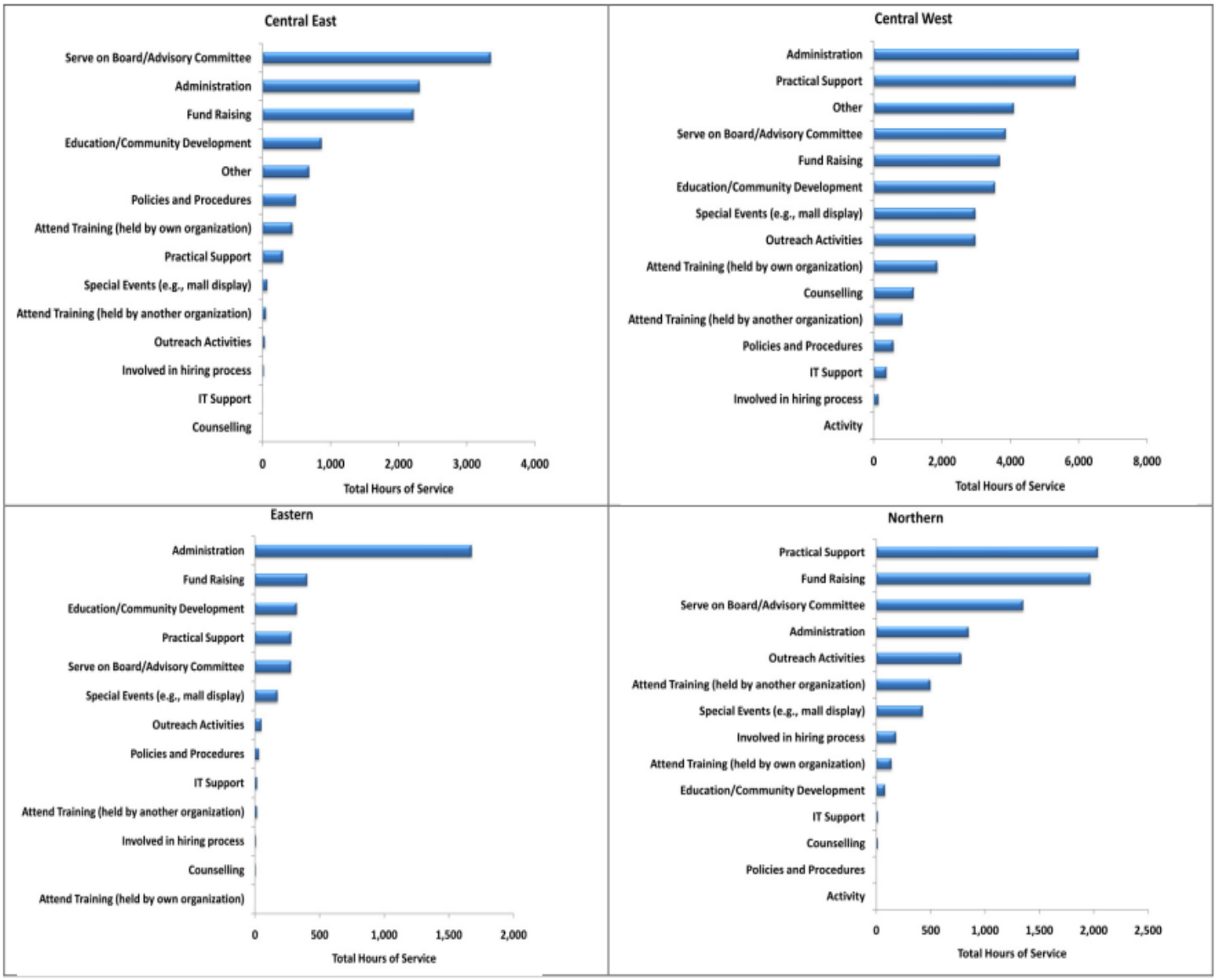
In 2008-09, programs reported more volunteer hours spent delivering programs such as practical support, education and outreach. It is difficult to know whether this increase was necessary to fill a gap in services within programs or whether programs are attracting volunteers with those types of skills. It may also be that programs are acting on knowledge that the more involved volunteers are in direct service delivery related activities, the easier it is to retain them.

Volunteers appear to be less involved in fundraising than in the past. "Other" activities include: interpretation and translation services, friendly visiting, the food bank program, and stuffing condom kits.

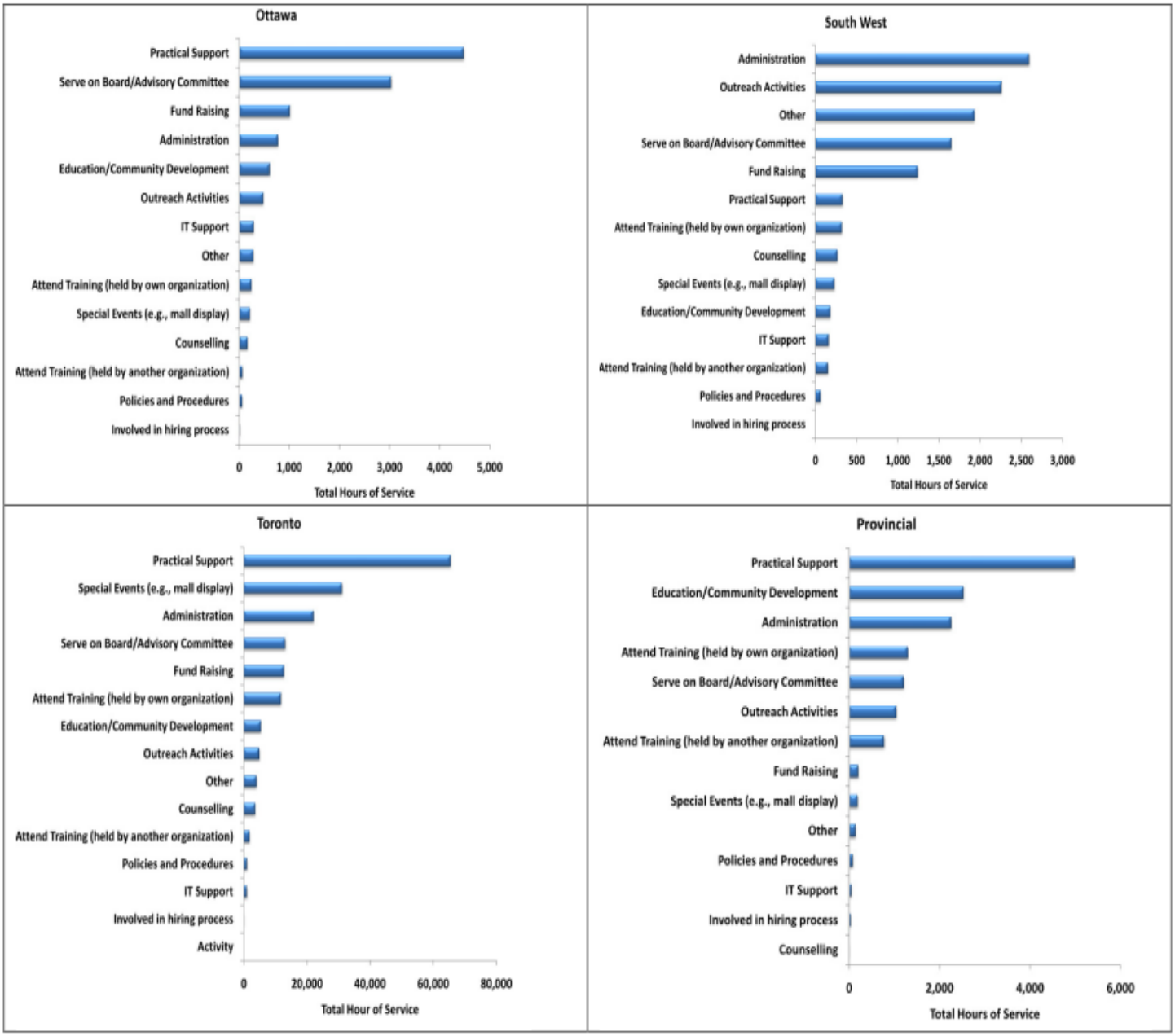


Volunteers in Ottawa, Toronto, the Northern Region and Central West are more likely to be involved in providing practical support, while those in Central East, Central West, Eastern and South West Regions are more likely to be involved in administration and/or serve on boards and committees.

Regional Breakdown – Chart 12.2b



Regional Breakdown – Chart 12.2b



New approaches to training and supporting volunteers

Across the province, programs are seeing changes in volunteers and adapting to support them and make use of their skills.

Central East reports more youth – particularly young women – volunteering. Volunteers are also actively used to provide English as a second language training for the LGBTQ community. In some cases, clients need more skills to be able to volunteer in program-related activities. To respond, programs have:

- Started a HIV Ambassador program to accommodate requests by schools and young people, and make volunteering more accessible
- Streamlined volunteer recruitment and training processes.
- Implemented a volunteer survey to determine volunteer training needs.
- Set up a neighbor office within a satellite space that is large enough to provide a safe space for ESL classes

Programs in **Central West** have seen a dramatic increase in demand for volunteer shifts from students as part of provincial rule of mandatory high school volunteer services as well as more families and church groups/faith communities volunteering (i.e., short term, event volunteering). Volunteers are asking for more training opportunities and would like initiatives be more client focused. Programs are also receiving more requests for women with HIV who can speak to groups. To respond, they have:

- Created more volunteer opportunities or expanded programs.
- Developed printed self-orientation materials to help short-term volunteers understand basic expectations
- Changed programming to accommodate and fast track volunteer orientations and trainings
- Provided opportunities for students to develop their talents, skills, and abilities.

The **Eastern** region did not report any particular shifts in its volunteer programs, but a volunteer coordinator was hired to promote the program.

In the **Northern** region, programs have experienced an increase in need for volunteers to: support fundraising and special events, safer sex programs, and outreach; accompany clients to appointments and other visits; and help people with HIV with domestic duties. While programs are finding it difficult to recruit volunteers for fundraising, they are seeing more youth who want to volunteer specifically with safer sex programs and outreach. To respond, programs have:

- Placed free advertisements to promote fund-raising volunteer opportunities
- Evaluated current volunteer programs and revised job descriptions and tasks to reflect current need for volunteers.

Ottawa reports that it's difficult to recruit volunteers because of the large number of organizations in the community that depend on volunteers. However, they are seeing more recent immigrants who want to volunteer as a way of acquiring skills and experience. The process that programs use to engage one-time, "event" volunteers is not suitable for volunteers being recruited for more long-term, program related activities. To respond, programs are:

- Forging new partnerships so volunteers can be shared among organizations
- Developing a different process to orient/train high school students who want to volunteer but are not interested becoming an ongoing volunteer.

In the **South West,** volunteers want to be more involved in activities that use their skills and experience. Youth want to be involved on committees to develop leadership skills, and people with HIV want more connection with volunteers who are living with HIV. The programs themselves have identified the need to recruit volunteers with more specific skills so they can be used to deliver programs. To respond to these shifts, programs are:

- Expanding the use of leadership volunteers and allowing volunteers to take lead roles in major and minor events
- Seeking funding for Volunteer Coordinator position to better manage wants and needs, also seeking to recruit more program volunteers
- Developing a speakers bureau training for youth to assist with community presentations.

Toronto programs are receiving more requests for volunteer opportunities from: high school and university students; newcomers trying to build Canadian experience; and corporations looking for ways for their staff to give back to the community. During the downturn, many volunteers are seeking opportunities to help expand their resumes and with the hope of having volunteer experience lead to employment. Volunteers themselves are asking for more training and capacity building on issues related to HIV and immigration, criminalization and impact on newcomers, service access barriers, life skill issues, mental health issues and treatment literacy issues. Some also need interpretation and translation services. To respond, programs are:

- Developing new partnerships with the institutions of learning for the purpose of student placements. A proposal was also submitted to Human Resources Development Canada for summer job funding to support student volunteers.
- Developing an Emergency Response Volunteer database to assist Support Services Unit
- Liaising with other service providers to translate documents and interpret their services to clients.
- Increasing volunteer recruitment and training
- Encouraging suitable volunteers to apply, and doing more hands-on training
- Partnering with local agencies that cater to newcomers to provide more training on HIV and immigration.

Provincial programs report an increase in the number of people with HIV involved in more responsible volunteer positions, which requires more staff time for supervision. They have also seen an increase in client requests for volunteers to visit them, accompany them to appointments and help with domestic duties. In general, they need volunteers with more specific skills to help with programming. Programs are also seeing an increase in youth volunteers and in clients making the transition to being volunteers. To respond, provincial programs:

- obtained additional funding and partnered with other agencies to support greater involvement of people with HIV
- encouraged peer mentors to offer practical support in areas where they feel comfortable
- developed new strategies for volunteer recruitment and build relationships with other service providers / agencies / professionals
- increased the number of volunteer clients at drop-ins and attempted to find funding for volunteer coordinator
- considered providing training/workshop sessions for youth to become peer educators.

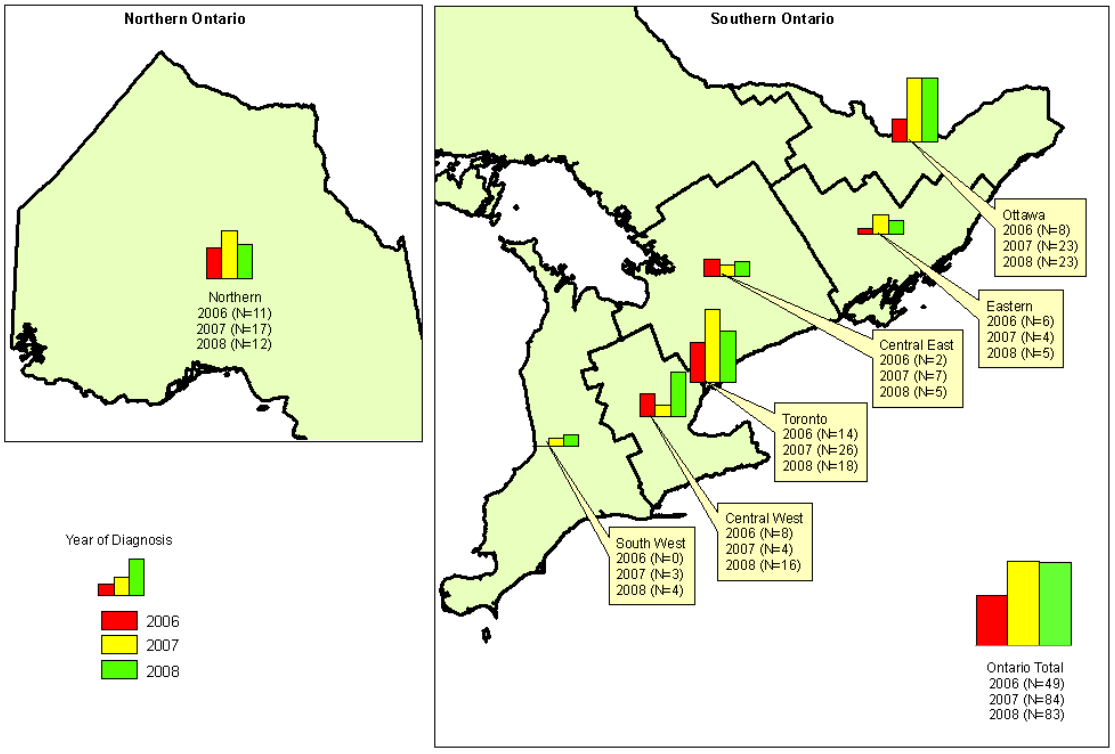
4.5 IDU Outreach Programs

In 2008-09, the AIDS Bureau funded 18 injection drug use (IDU) outreach programs to reach substance users and connect them with harm reduction services, including needle exchange programs, addiction treatment, HIV testing and other support services.

Trends in HIV Infection in Drug Users

The number of new HIV diagnoses in people who use drugs dropped or remained stable in most regions in 2008; however, there was a marked increase in IDU-related diagnoses in South West and Central West regions.

Figure 9. Number of New Drug-related HIV Diagnoses by Health Region and by Year, 2006-2008

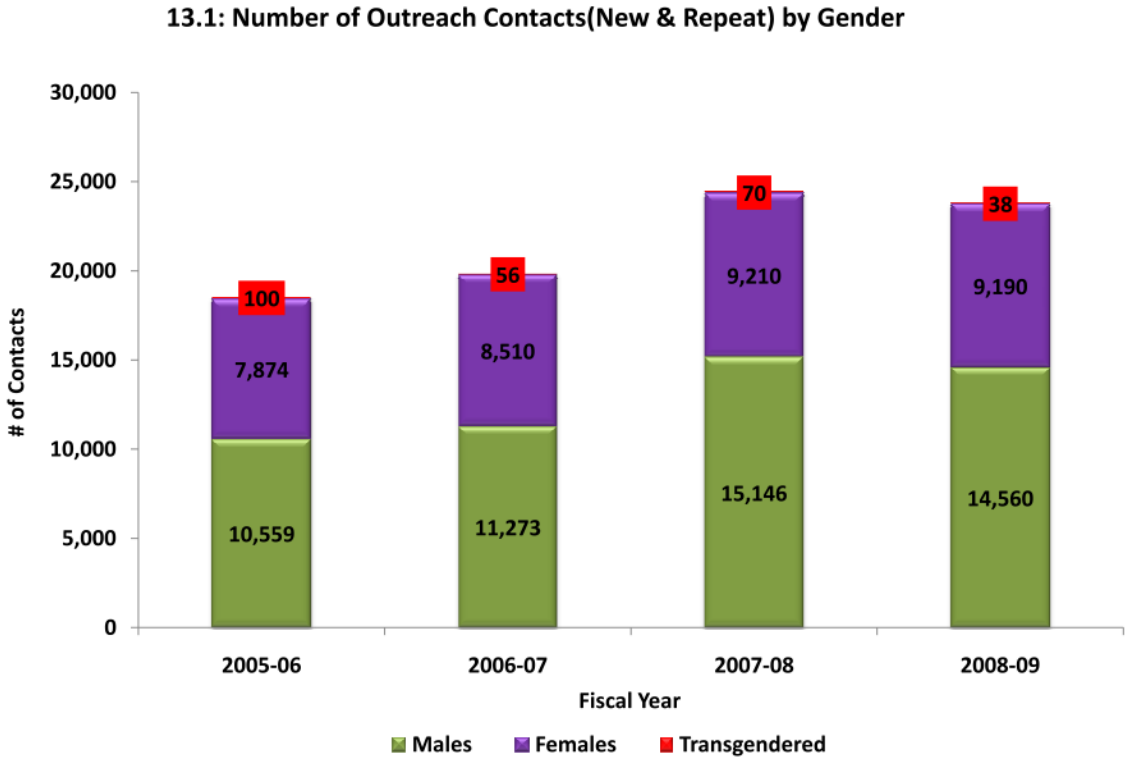


Source: HIV Update, Ontario HIV Epidemiologic Monitoring Unit, University of Toronto

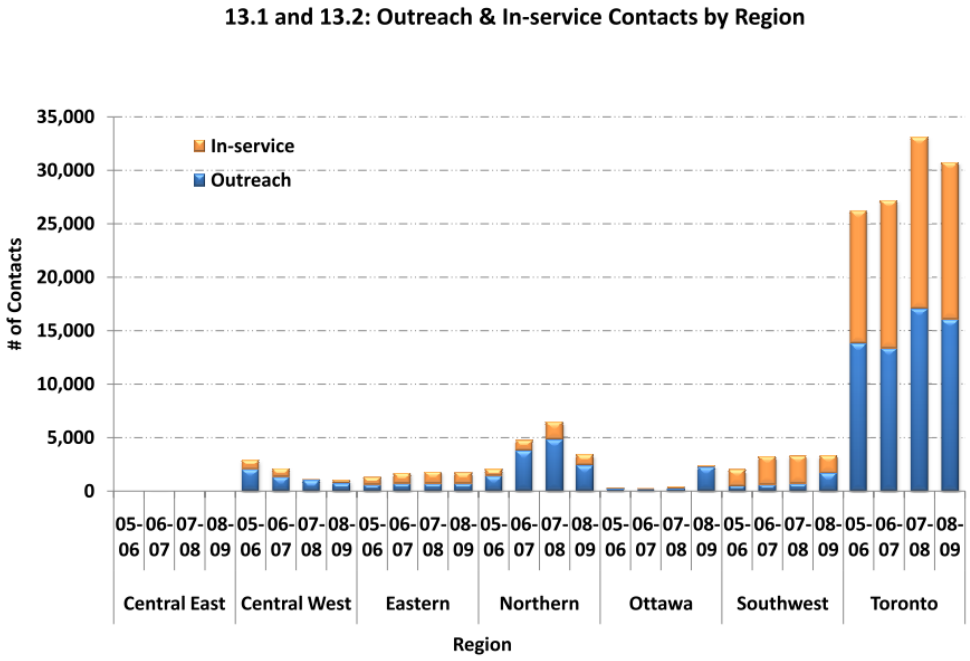
Contacts down slightly

OCHART question 13.1: Outreach Contacts - Record the number of outreach contacts made with clients (by gender) during this reporting period. Each client should be counted only once.

Both the number of outreach and in-service contacts were down slightly in 2008-09 compared to 2007-08. It is extremely difficult to "count" outreach contacts, and the drop may be due to more accurate counting rather than a change in activity.



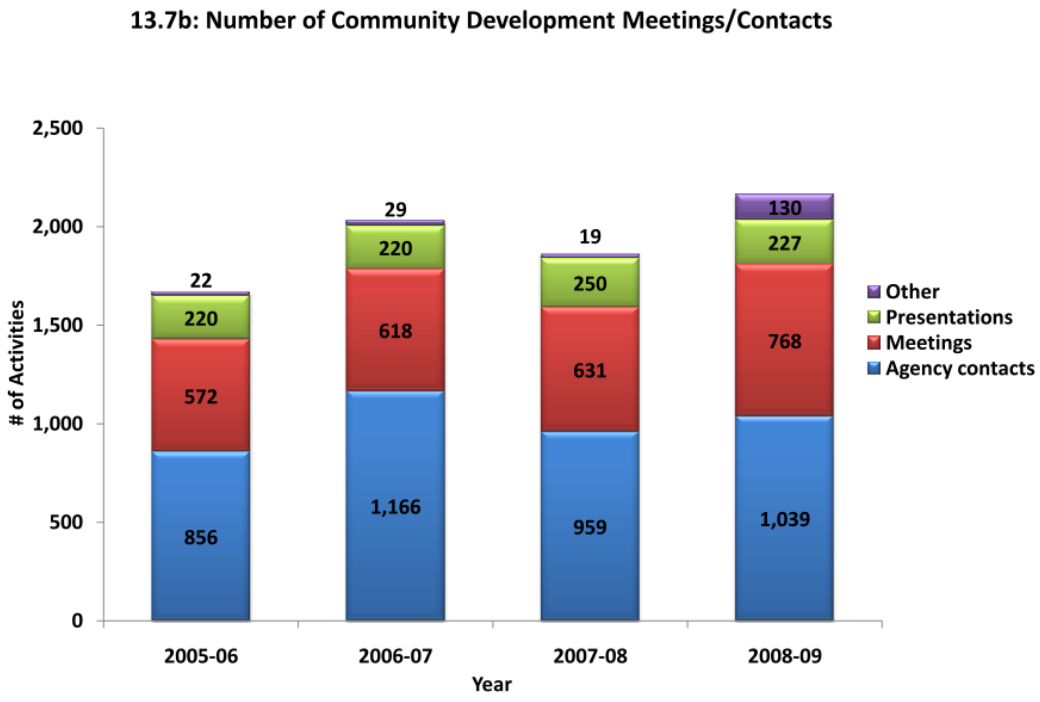
The South West region responded to its increase in IDU-related cases with a significant increase in outreach contacts while -- over the past two years -- both the number of in-service and outreach contacts in Central West have declined. Ottawa also appeared to have a significant increase in outreach services. This may be due to the fact that the safe inhalation materials -- which used to be provided by Ottawa Public Health and reported in section 11 as support services -- are now provided through the IDU outreach program and reported in this section of OCHART.



Increase in community development activities

OCHART question 13.7: Community Development - Record the number of meetings and consultations in which staff or peers participated during the reporting period.

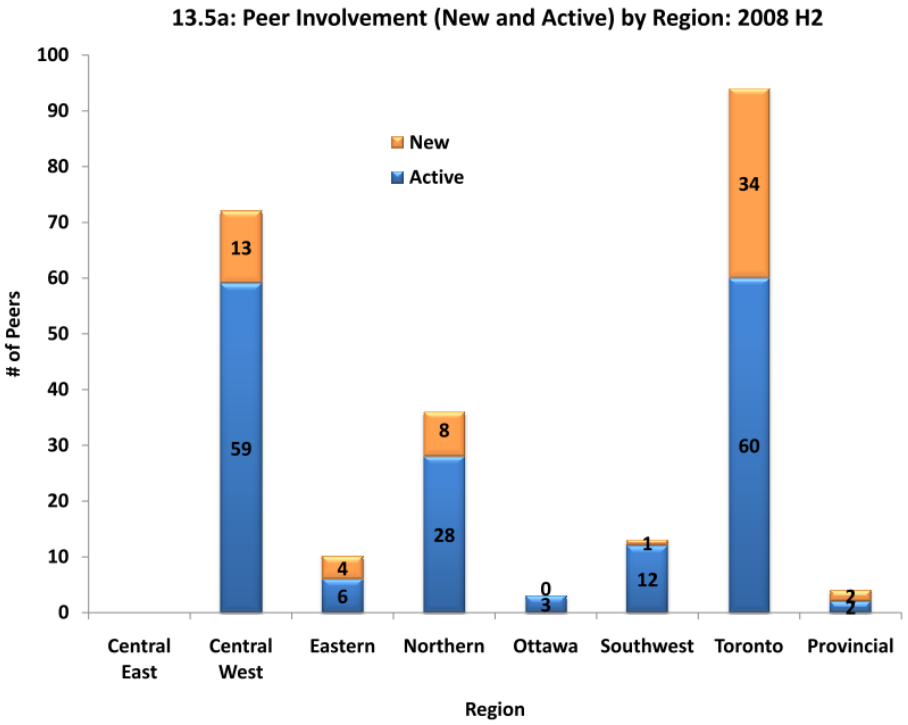
The number of community development meetings and agency contacts by IDU outreach programs increased between 2007-08 and 2008-09. "Other" activities include participating in conferences, health fairs and research activities.



Peers stay active in outreach programs

OCHART question 13.5: Peer Involvement - Record the number of peers active in the program during the reporting period.

IDU outreach programs appear to be effective in keeping peers involved over a long period of time. Most peers involved in the programs in all regions had been active in the previous year. At the same time, programs continue to attract new peers – particularly in Toronto, Central West, Central East and the Northern regions.



Emerging Trends in IDU Outreach

Central East reported that more sex trade workers, youth and women are accessing the IDU outreach program as more clients move from downtown Toronto to Scarborough because of the cost of housing. To respond, the program has:

- Partnered with Youthlink in the provision of services.
- Hired a youth peer to build trust with the youth community who are distrustful of service providers.
- Sought new funding sources to adapt outreach program to meet the needs of the new communities accessing services.

Central West has also seen an increased demand from young women as well as more clients injecting morphine and Oxycontin. Demand for prevention resources and education about HIV and hepatitis C co-infection has also increased. The program also reported that clients do not seem to be using cookers on a 1:1 ratio with supplied syringes: clients find single use cookers hard to use because of the short handle (i.e., difficult to hold). To respond, the program has:

- expanded outreach in more areas

- used peers to reach youth clients
- worked closely with other partner organizations
- Provided education and information session in different shelters, youth centres, schools, colleges and community organization.

In the **Northern** region, programs have seen increases in skin infections, harmful hygiene practices and a demand for safer inhalation materials (e.g. crack pipes). Clients are getting younger. Although demand is increasing, outreach workers find it difficult to reach the target population because of community resistance. To respond, programs have:

- added staff and obtained bikes to increase the program range
- distributed bottles of anti-bacterial hand sanitizer and information cards on safer hygiene practices
- developed a funding proposal to conduct a time-limited project on engaging at-risk populations to learn about their substances of choice and their learning styles
- worked with health department and local police to understand community and advocate for support and harm reduction.

In **Ottawa**, outreach workers reported an increase in the number of IV cocaine users transitioning to smoking crack cocaine. To respond, the program changed staffing patterns to allow the Inhalation Van to operate more nights and workers are collaborating more closely on client care and program planning.

The **South West** region has seen an increase in need for medical services as well as more public concern about discarded syringes. The region also reported more Fentanyl on the street and a number overdose deaths related to this drug in the last 6 months of the year. Because of long wait lists for methadone maintenance treatment (MMT), workers have been referring clients to other communities for treatment. “MMT options are seriously limited, clients are getting desperate and are unhappy that the local clinic is so backed up that they are unable to even add people to the waiting lists at this time.” To respond, the region has:

- launched a new initiative to develop a peer based community syringe recovery program
- improved communication with health units and local medical services, and investigated having a nurse practitioner accompany street outreach team and provide abscess care, prevention education and basic medical care products
- increased overdose prevention efforts, made bulletin boards specifically on Fentanyl and started a word-of-mouth information campaign about the risks of using this drug without high opioid tolerance
- worked with clients to access MMT, organizing OW transportation funding and/or helping them relocate out of the city.

Outreach workers in **Toronto** reported a sharp increase in the number of needles distributed as well as requests for information about hepatitis C. Service users with HIV are having trouble maintaining their HIV Primary Care Physicians because of their inability to make it to their appointments. To respond, the programs have:

- improved the responsiveness of satellite sites and, with funding from the City of Toronto, expanded mobile service to deliver services seven days a week.
- applied for Hepatitis C funding.

4.6 Provincial Resource Programs

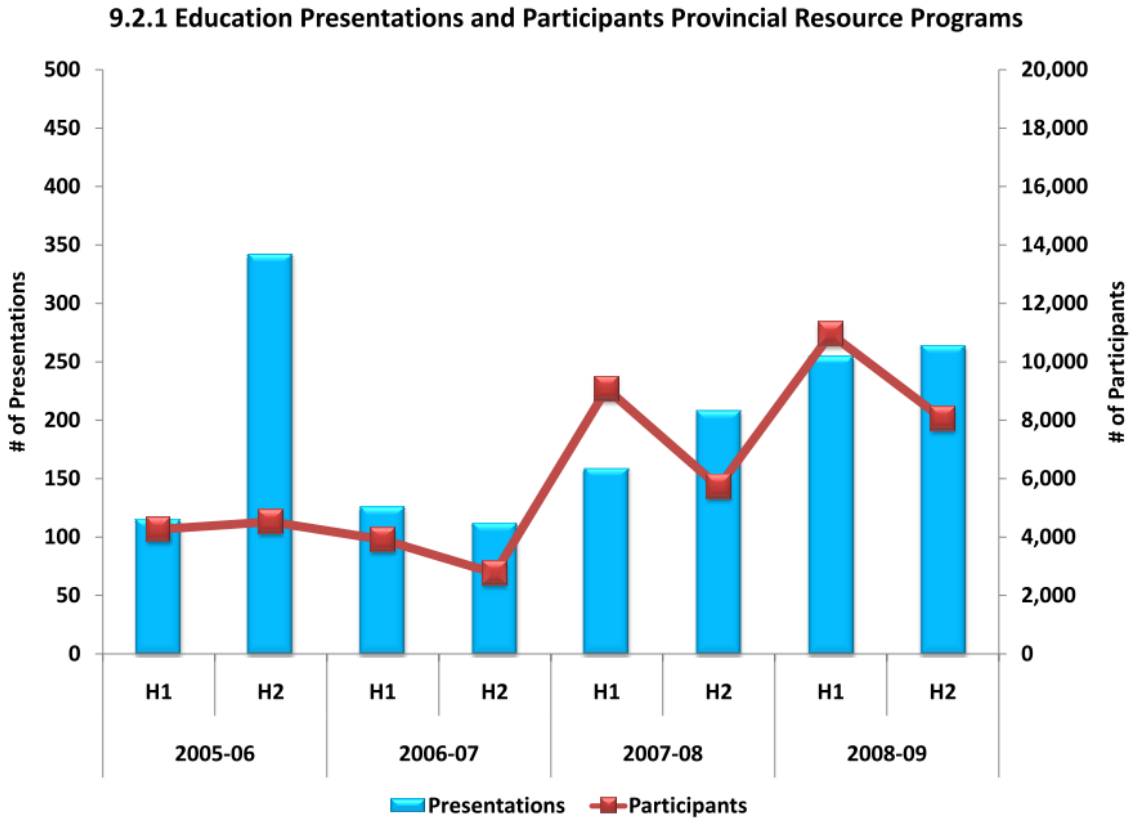
Six of the programs funded by the AIDS Bureau and PHAC's Ontario and Nunavut ARO are provincial programs that act as "resources" for other programs rather than providing outreach or support services directly to people with HIV or at risk.

Most provincial resource programs provide training and information. Because their services are different from those of other OCHART programs (and often from each other), it is difficult to analyze them. In 2010, OCHART will include a new section to capture more meaningful information on their activities.

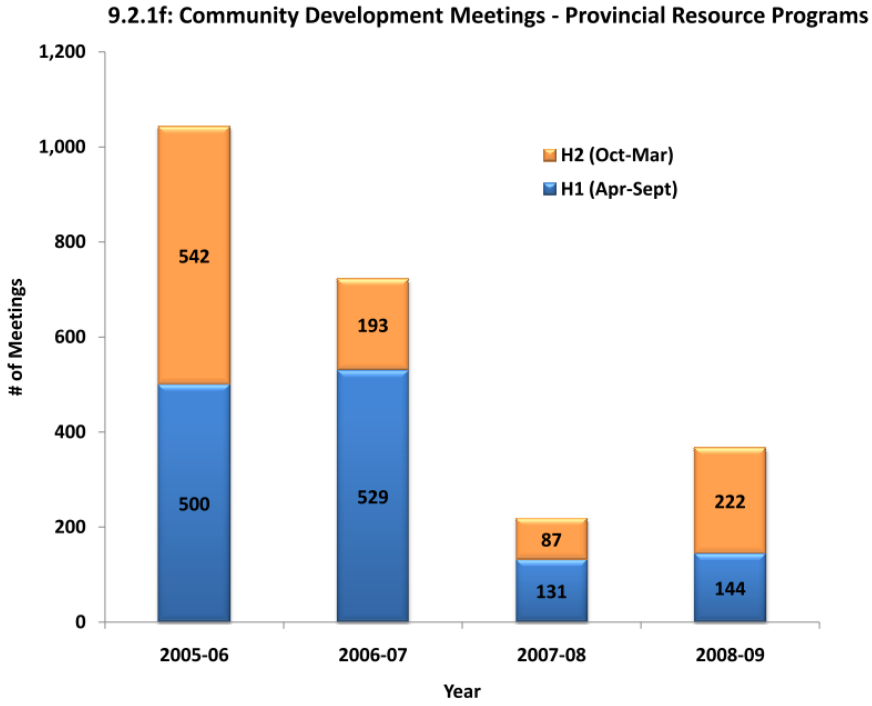
In the meantime, here is some data on these programs.

More presentations but fewer community development meetings

Provincial resource organizations report an increasing number of education presentations to more participants over the past two years.

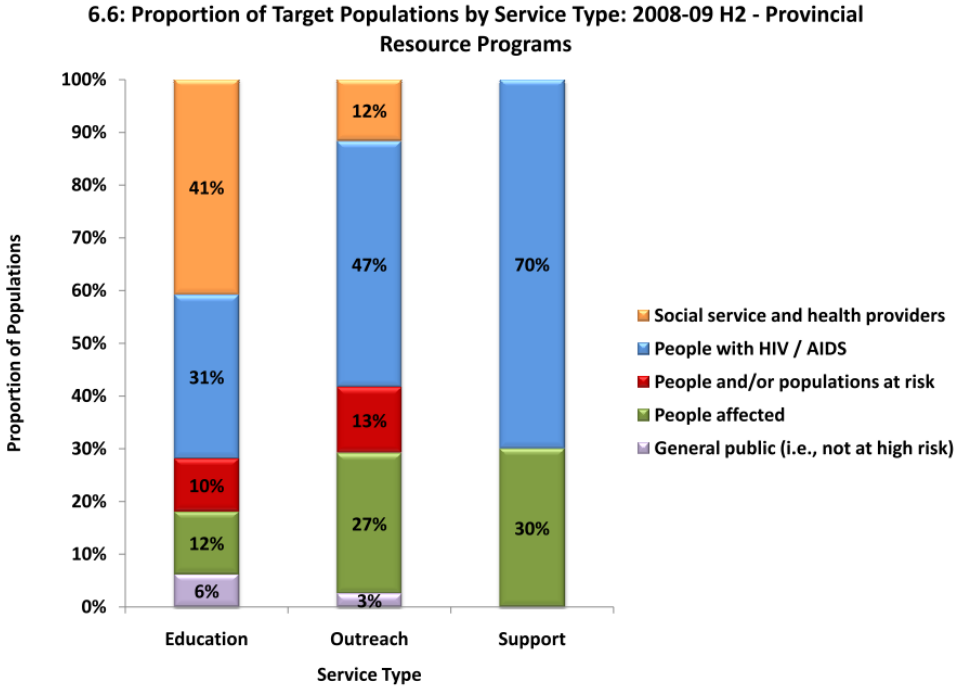


Over that same two-year period, the number of community development meetings has decreased.



Education services target other providers, outreach and support services target people with HIV

Provincial programs help other agencies provide more effective services. Although their programs do not deliver services directly to clients, their activities are designed primarily to enhance the quality of life of people living with HIV.



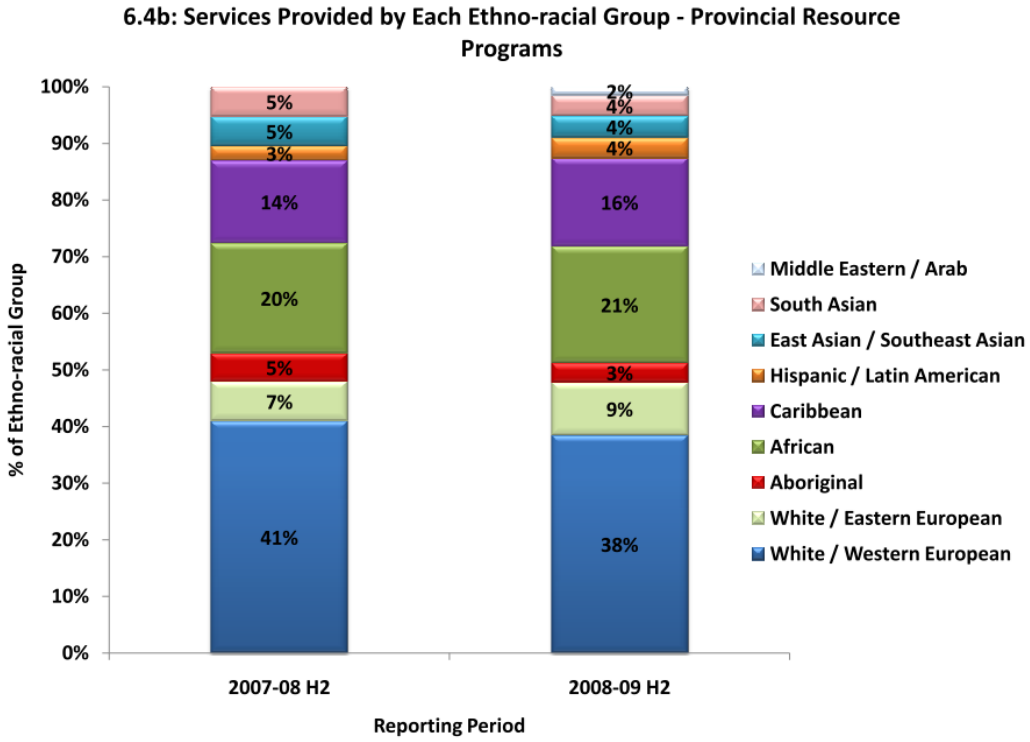
Most of their activities are currently captured under education and outreach services: only one organization reports providing support services.

In terms of emerging trends in education, provincial resource programs reported an increase in requests for materials, presentations and partnerships, and for services that can help individuals and organizations deal with loss. Programs responded by:

- Developing more resources, workshops, trainings and tools
- Developing new partnerships.

Provincial programs designed to meet culturally diverse needs

Although provincial resource programs do not provide direct client services, some are population-specific. Overall, provincial services appear to be addressing the needs of diverse cultural groups. The relatively low proportion serving Aboriginal people is due to the fact that the Ontario Aboriginal HIV/AIDS Strategy is counted as a provincial program that provides direct client services – although it also acts as a resource to other organizations in their efforts to serve Aboriginal clients.



Part V: ACAP Report

The AIDS Community Action Program (ACAP) of the Public Health Agency of Canada (PHAC) uses a community development/intervention model to reach individuals at risk of or living with HIV/AIDS. Its goals are to prevent the acquisition and transmission of new infections, slow the progression of the disease and improve the quality of life, and reduce the social and economic impact of HIV/AIDS. In 2008-09 ACAP provided $3.7 million in funding to support a variety of community-based HIV/AIDS programming. Recent research shows that investment in community-based interventions is effective in improving health protective behaviour and reducing the transmission of HIV in risk populations, especially when it involves outreach, peer education and financial support for community-based programs[1]. These findings validate ACAP as an on-going funding program.

Two streams of funding

ACAP consists of two funding streams -- operational and time-limited. The purpose of *operational funding* is to fund AIDS Service Organizations (ASOs) whose main mandate is specific to addressing HIV/AIDS in Ontario. This includes funding for key HIV/AIDS programming. *Time-limited* funding is available to voluntary, non-profit and non-governmental organizations actively dealing with HIV/AIDS issues. This funding is for specific, time-limited activities that address unmet HIV/AIDS needs and priorities – not for ongoing work. Examples of time-limited initiatives are: pilot projects, projects to develop best practice models and education and awareness campaigns.

Four funding approaches

To meet the criteria for ACAP funding, ACAP projects must support one or more of the four funding approaches:

1. Prevention initiatives, such as: working with at-risk populations, offering prevention workshops and providing peer outreach programs
2. Health promotion for PHAs such as: developing and conducting health promotion activities (specifically: leadership development workshops for PHAs, educating and networking with health care providers about needs of PHAs) and improving environments and services of immigrant, refugee and ethnoracial populations (specifically: translating resources, developing peer and education outreach campaigns).
3. Strengthening community based organizations, for example maintaining strong volunteer programs and strengthening the capacity of organizations.
4. Creating supportive environments: by contributing to one or more of the first three funding approaches, projects have activities that contribute to creating supportive environments. These include community strengthening their relationships with other sectors(e.g. settlement/immigration, mental health, media, and faith communities) and developing media campaigns to reduce homophobia and promote healthy sexuality.

1. Holtgrave, D. (2007). Resilient organizations, mobilized communities and evidence based HIV prevention programs: Examining the influence of national investment in HIV/AIDS capacity building. *Journal of Public Health Management and Practice,* 13 S1-S4.

ACAP Program Logic Model: Deliverables and Impacts

ACAP funded activities are expected to produce deliverables/outputs (e.g., presentations, plans, policies/guidelines, products, partnerships, approaches), which inform short-term, intermediate and long-term impacts/outcomes as illustrated in the ACAP Program Logic Model (see Appendix B). In general, ACAP funded initiatives result in deliverables/outputs and in some cases, short-term impacts/outcomes. Intermediate and long-term impacts/outcomes are more complex to measure as they depend on the work of other programs and sectors.

An analysis of the extent to which ACAP-funded projects are meeting the short, intermediate and long-term impacts/outcomes as outlined by the ACAP Program Logic Model, will be included in the ACAP National Report (to be released summer 2010).

2008-09 Funded Projects By Stream and Approach

In 2008-09, ACAP continued to fund the 29 operational projects from 2007-08. Eleven of these had a primary focus on prevention, 11 were focused on health promotion and seven were targeted towards strengthening community-based organizations. This report focuses on data provided by these projects during the continued phase of their activities. Due to a late start date, four time-limited projects began late in the final quarter of the 2007-08 fiscal year and did not have deliverables to report during that period. They submitted OCHART reports in 2008-09 and are included in this report (1 project did not complete the OCHART). A new cycle of operational and time-limited projects began in late March 2009 and their data will be captured in the 2009-10 OCHART Report (i.e. the year their activities occurred).

The following table lists the number of projects in each funding approach.

Type of project	Number of Projects in Funding Approach		
	Prevention	Health promotion for PHAs	Creating supportive environments
Operational	11	11	7
Time-limited	3	1	0
Total*	14	12	7

** Note these are the projects that had deliverables in 2008-09. The total number is greater than the number of funded projects because projects may be involved in more than one funding approach.*

A detailed list of projects by funding approach can be found in Appendix C.

Data submission process

All ACAP funded projects that completed activities in 2008-09 submitted annual project logic models that map their activities over the year. At the beginning of the fiscal year (April 1st), projects enter their "planned" activities, deliverables/outputs and impacts/outcomes into the project logic model.

On October 31st and April 30th organizations input their "actual" deliverables/outputs. The online logic model links their data directly to the online OCHART. If there are variances between planned and actual deliverables/outputs, organizations provide explanations and revise their activities as necessary.

There are significant advantages to programs, clients and government funders of having a common provincial-federal reporting tool compared to other PHAC region where ACAP projects that are also funded by the province or territory may be required to submit two reports. For programs, it helps streamline the reporting process and reduce the administrative burden on staff. For clients, it means more front-line staff time is now devoted to providing services. For the provincial and federal government, it supports more collaborative planning and more effective use of resources.

ACAP Results

To reflect the ACAP Program Logic Model, data in this section has been organized by the activities and deliverables/outputs associated with each funding approach, while taking into consideration that some activities and deliverables/outputs associated with different funding approaches may overlap.

The analysis includes comparisons between projects planned activities and actual deliverables, which reveal the extent to which projects are reaching their targets. In general, OCHART data shows that there was a decrease in ACAP activities and deliverables in 2008-09. This was due to a new funding cycle for time-limited projects where there were fewer projects funded.

1. Prevention Initiatives

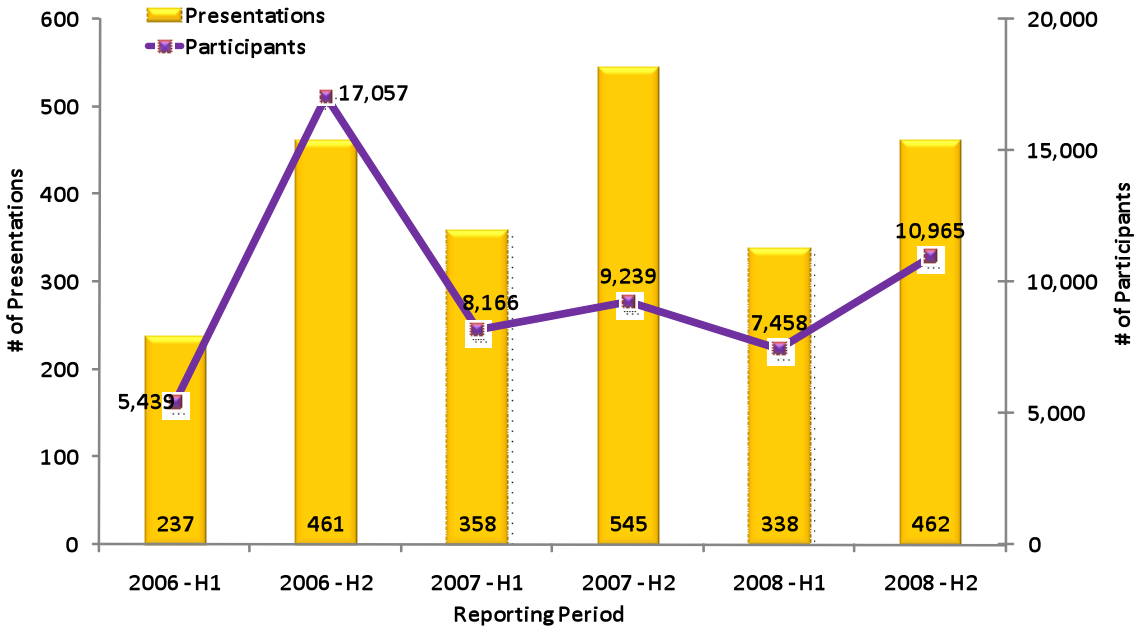
Prevention initiatives funded by ACAP include education presentations, the development of resources, outreach programs, awareness campaigns, Internet and media contacts, and policy development.

Fewer Education Presentations, More Community Development Meetings

OCHART question 9.2.1 Indicate the number of (education and community development) activities undertaken during the reporting period.

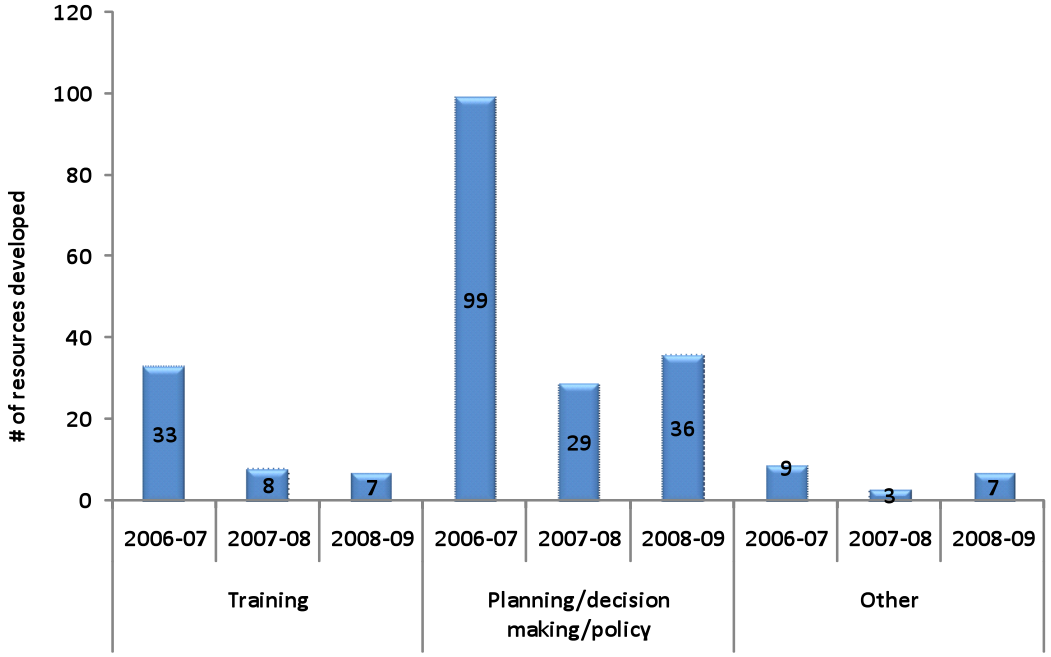
In 2008-09, 22 ACAP-funded projects reported providing education and community development services. They gave a total of 800 presentations (down from 903 in 2007-08), which reached a total of 18,423 participants (up from 17,407 in 2007-08) – or an average of 23 participants per presentation (see Figure 9.2.1a). Compared to 2007-08, this represents an 11.1% decrease in the number of presentations, but a 5.8% increase in the number of participants. In terms of targets, the funded programs exceeded their combined targets for presentations (691) and for participants (13,278) for the year.

9.2.1a: Education Presentations and Participants - ACAP Funded Projects



Twenty-six ACAP-funded projects were responsible for a total of 2,679 community development meetings in 2008-09, up slightly from the previous year (2,407). This number was slightly higher than their overall target of 2,671 community development meetings.

9.2.2b: Education Resources Developed- ACAP Funded Projects



Five projects did not meet their targets for number of presentations, while six did not reach their targets for number of participants and nine did not meet their targets for community development. The most common explanations were issues or structural problems in their communities (e.g., a transit strike, fewer municipal health fairs, lack of transportation or child care services for people to attend presentations, higher police presence in parts of the city, more stigmatization, poor response from schools and other venues, such as bars), changing clients needs or lack of demand for some programs, and program-related issues (e.g., changing priorities, staff turnover). In some cases, events were rescheduled to the next fiscal year.

Projects that exceeded targets identified several factors that contributed to their success, including new partnerships with universities and community agencies, new promotional materials, the anti-HIV stigma campaign and a high-profile community initiative to clean up used needles, which led to requests for more presentations.

Resources Developed

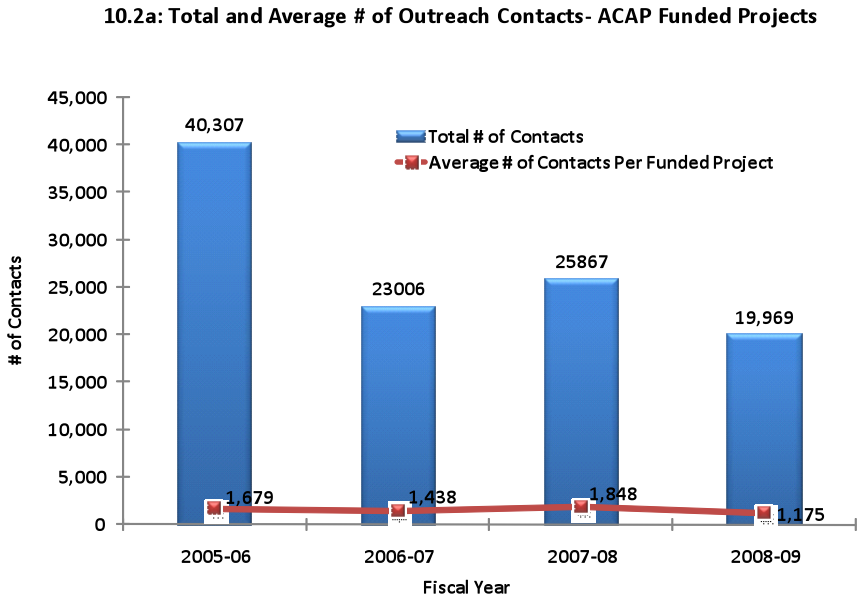
OCHART question 9.2.2: During this reporting period, please indicate the number of resources developed

ACAP-funded projects are asked to report on the number of resources they develop to support their community development activities (Figure 9.2.2a). In 2008-09, the organizations developed a total of 50 resources (up from 40 in the previous year but down from 141 in 2006-07. The fewer number of resources developed compared to 2006-07 was due to the fact that there were no time-limited project activities in 2007-08 and fewer time-limited projects and activities in 2008-09.

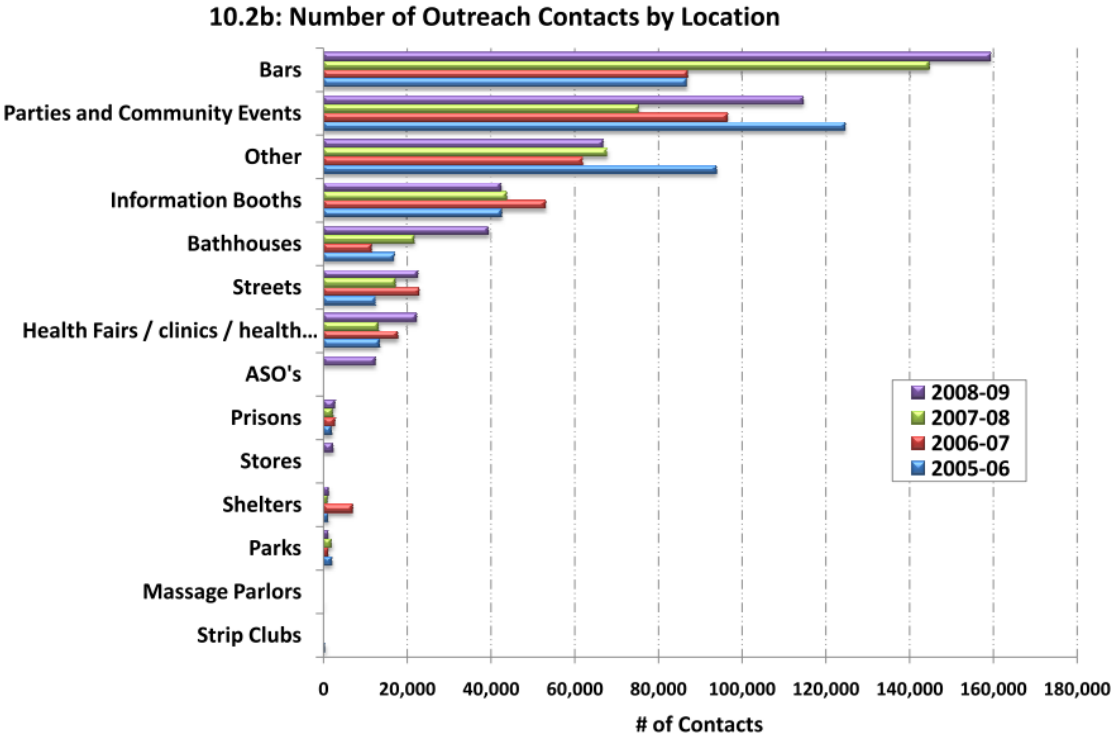
For detailed descriptions of funded projects and their resources, please go to http://www.phac-aspc.gc.ca/aids-sida/about/reg_ontario-eng.php#acap

ACAP-Funded Programs Maintain Party, Bar and Street Outreach

OCHART question 10.2: Indicate the outreach activities undertaken during the reporting period.



In 2008-09, ACAP funding supported a total of 17 projects to provide 19,969outreach contacts – an average of 1,175 contacts per project. The total number of outreach contacts exceeded the target of 11,934. Only three projects did not meet their targets, and the reasons included: staff shortages and changes in the way outreach services are being delivered.

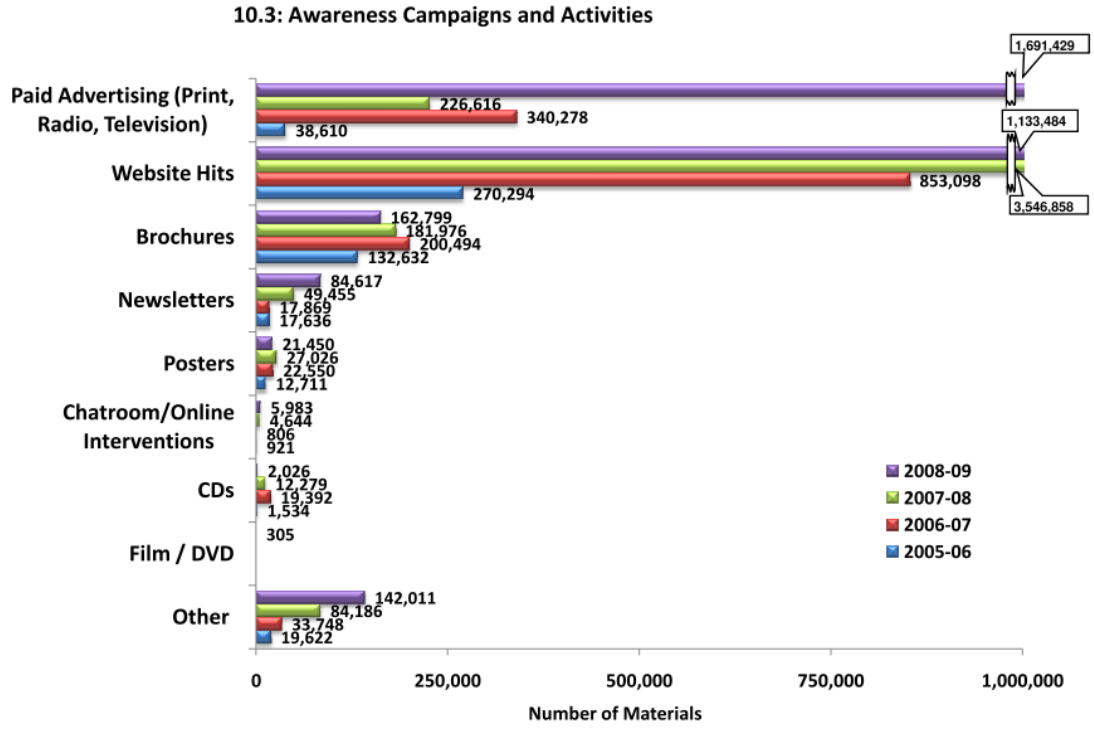


The majority of the outreach contacts occurred in bars, at information booths, at parties, and through the agencies themselves. “Other” locations for outreach included needle exchange programs, one-to-one counselling sessions, visits to barbershops, and outreach to newcomers.

Awareness Focuses on Condom Distribution, Brochures and Advertising

OCHART question 10.3: Indicate the awareness campaigns/activities undertaken during the reporting period.

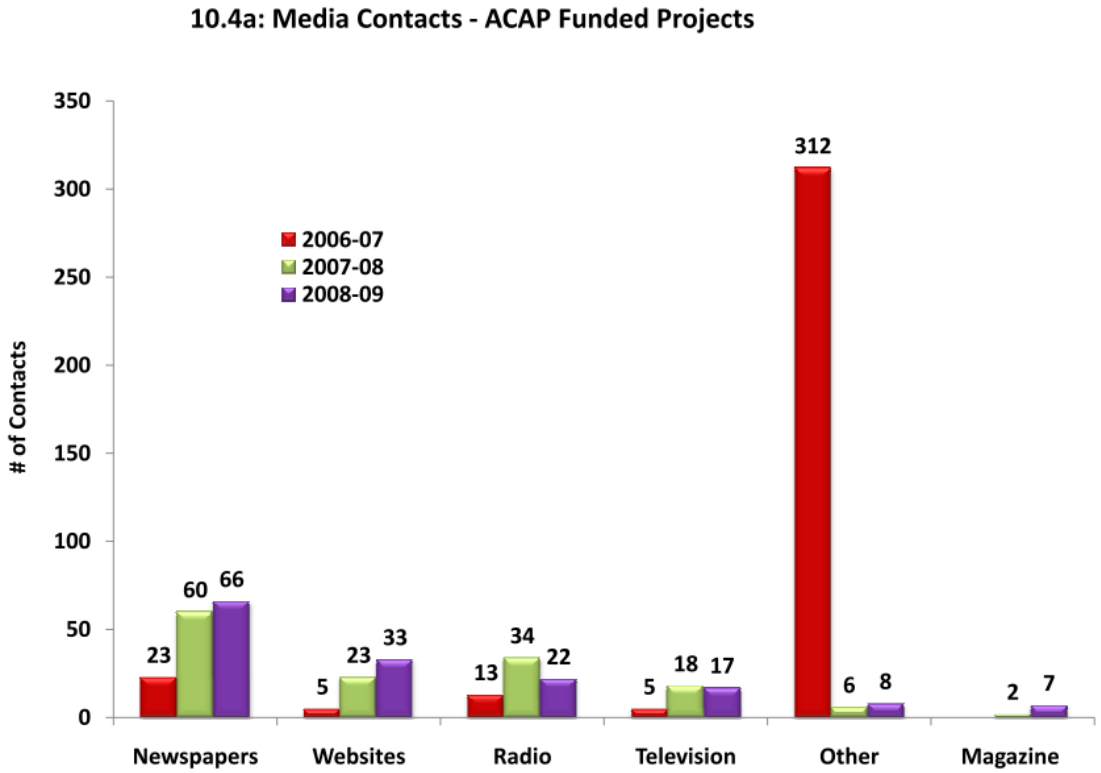
ACAP funded 13 projects for awareness activities in 2008-09, and the total number of awareness activities (97) was almost double the target (55). Only four projects fell short of their targets, largely due to awareness materials not being completed or distributed within the fiscal year. Projects reported using their ACAP funding primarily to support “other” awareness activities – which included providing condoms and lube, high school public awareness announcements, and training packages. The next most common awareness activities were brochures and paid advertising. During 2008-09, there was also a significant increase in chatroom and online interventions.



Media Contacts Up

OCHART question 10.4: Indicate the media contacts that occurred during the reporting period.

ACAP-funded projects reported a total of 153 media contacts in 2008-09 – up slightly from the previous year. Over the past three years, ACAP-funded project have reported steady increases in both traditional (newspaper) and new (website) media contacts. The higher number of "other" media contacts in 2006-07 may have been due to AIDS 2006 and/or reporting errors.

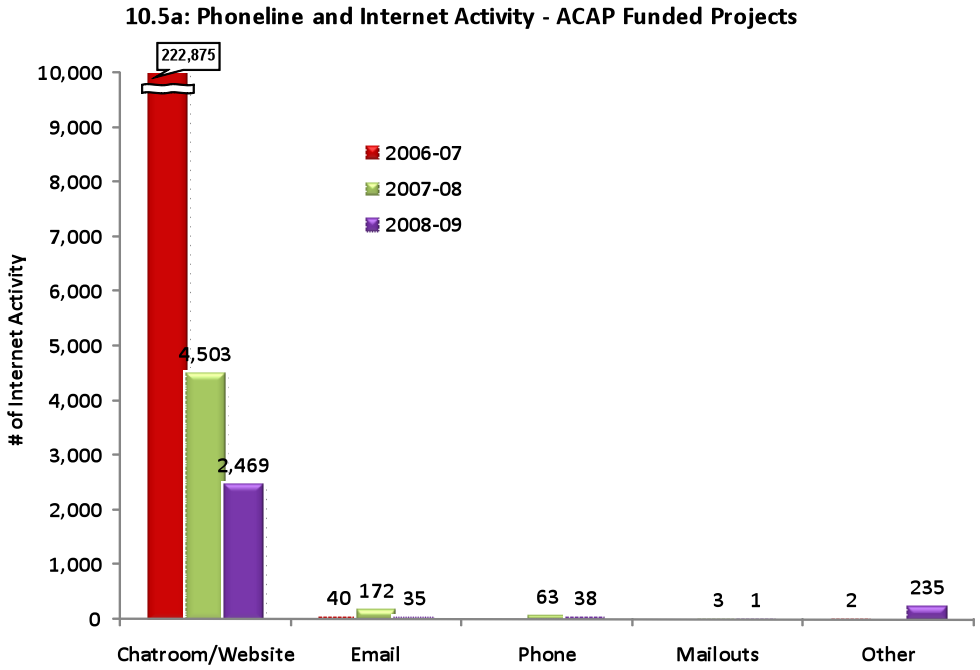


Website and Chatroom Activity Down, but Exceeds Targets

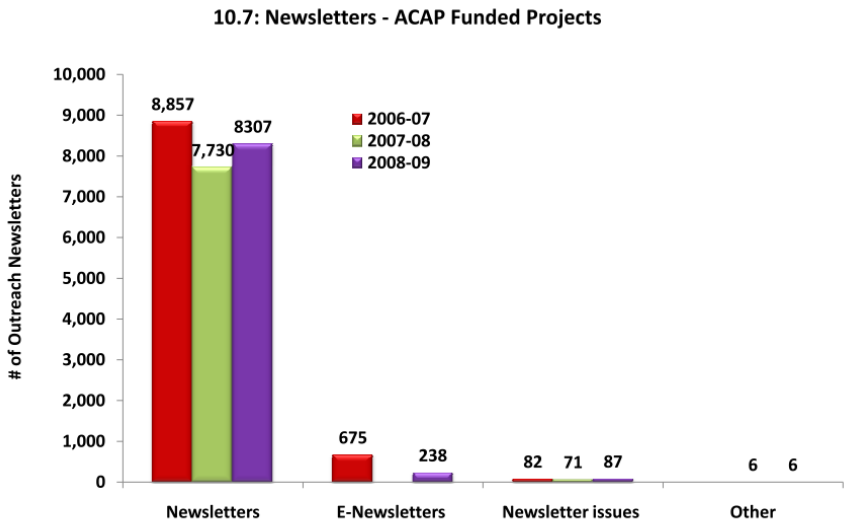
OCHART question 10.5: Record the number of services provided by phone or Internet.

In 2008-09, 10 projects reported being involved in 16 activities that involved phone or Internet outreach. Of those 16 activities, six did not meet their targets while at least three exceeded their targets by more than 500%. The main reason for not reaching the targets was lack of training in Internet outreach for outreach workers.

Overall, the total number of chatroom/website contacts (2,469) was down from the previous year (4,503) -- mainly due to the smaller number of projects with deliverables in 2008-09. However, the number of chatroom/website contacts exceeded targets for 2008-09 (873) by almost three times. In fact, the role of chatroom/website contacts is even greater than the figure indicates because the "other" category is dedicated hours to online outreach by one program, which also exceeded its planned target by more than 300%. (Note: the high number of chatroom/website contacts in 2006-07 was a reporting error.)



Seventeen programs were funded for newsletter-related activities. In 2008-09, they produced a total of 87 newsletter issues, and distributed 8,307 printed newsletters. Only four programs reported developing e-newsletters and their target was to develop/distribute 207 e-newsletters. They exceeded their distribution target by 31% (238). Looking at the data, it seems more work is required to ensure that projects have the capacity to monitor the number of e-newsletters downloaded from their web sites as well as those they "push out" to clients or volunteers and that they are counting issues in the same way. In terms of print newsletters, the overall target was to distribute 9,290 copies. Despite the fact that eight projects fell short of meeting their targets, the total number of newsletters distributed (8,307) was slightly higher than in the previous year. Projects that missed their targets did not provide a lot of detail, but one factor appeared to be not creating as many issues of a newsletter as originally intended, which also meant fewer copies produced and distributed.



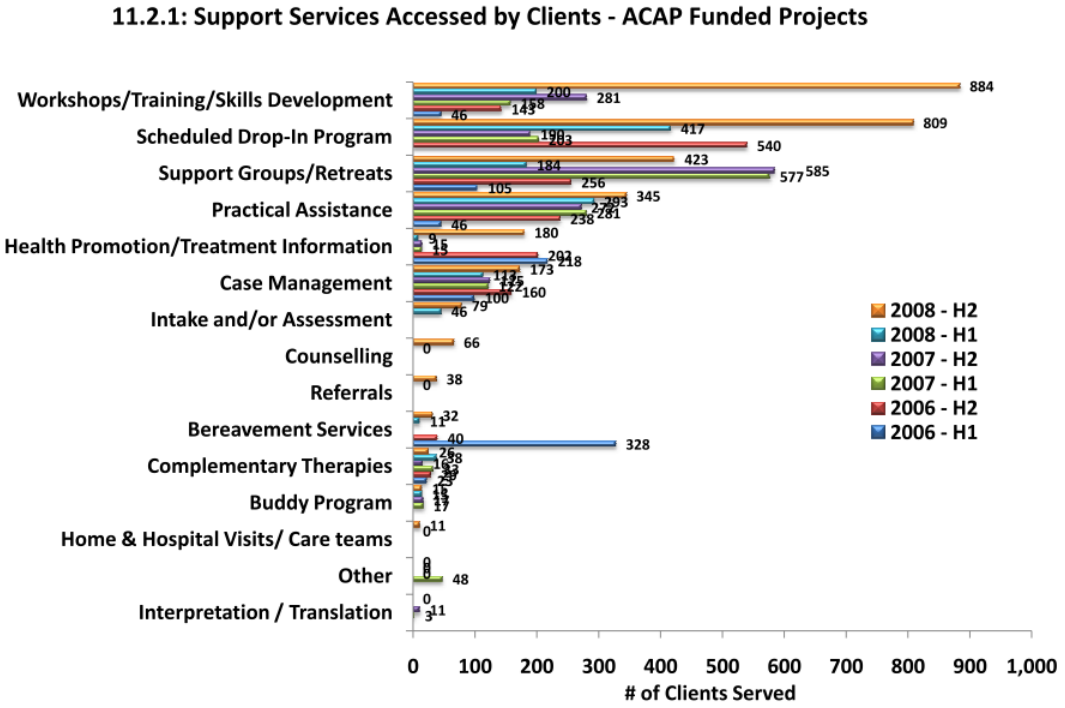
2. Health Promotion for People with HIV/AIDS

OCHART question 11.2.1: Services Provided - Record all services provided this reporting period to male, female and transgender persons. Record the total number of people who accessed service, NOT the number of times service were accessed.

In 2008-09, ACAP funded 11projects to provide health promotion projects for people with HIV (compared to 11 in 2006-07 and 16 in 2007-08); however, 13 ACAP-funded projects reported using ACAP funding to provide support services for clients (which is where health promotion activities for people with HIV are mainly captured). This is due to the fact that some projects funded by ACAP for other approaches, such as prevention initiatives, may have provided a support service such as counseling as part of that project (i.e., there is some overlap between approaches).

Increase in Workshops, Training and Drop-ins

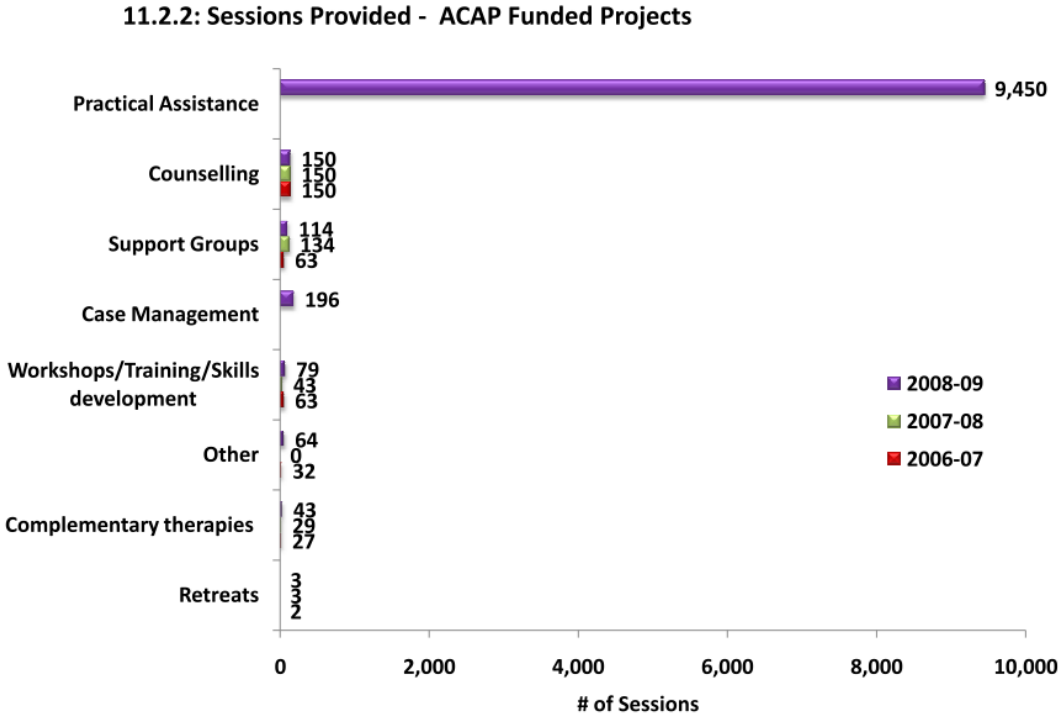
Health promotion activities included mainly offering workshops and trainings, and providing drop-in programs. Although projects provided fewer support groups than in previous years, they provided more practical assistance, health promotion, case management, counselling and referral services.



Although the total number of health promotion activities accessed by clients in 2008-09 (4,407) was about 48% higher than in 2007-08, projects did not meet their combined overall target for 2008-09(4,863). Six projects met or exceeded their targets, but seven fell short. Reasons included: lack of interest in the community (i.e., cancellations, no-shows); illness (of clients); natural attrition; scheduling conflicts; weather, and lack of transportation.

Efforts to Measure Intensity of Service

Figure 11.2.2 lists the number of sessions reported by ACAP-funded projects. It appears there is a problem with these data, as the number of sessions for items such as counselling and support groups is too low given the reported number of clients served. Projects may be counting individual clients rather than the total number of counselling and support group sessions. This issue will be addressed with the projects for the next reporting year. The high number of practical assistance sessions is due to one project, which is now using OCASE to track services so the number is likely accurate.



3. Strengthening Community-based Organizations

OCHART question 12.1: Volunteers and Volunteer Management & 12.2 Volunteer Activities

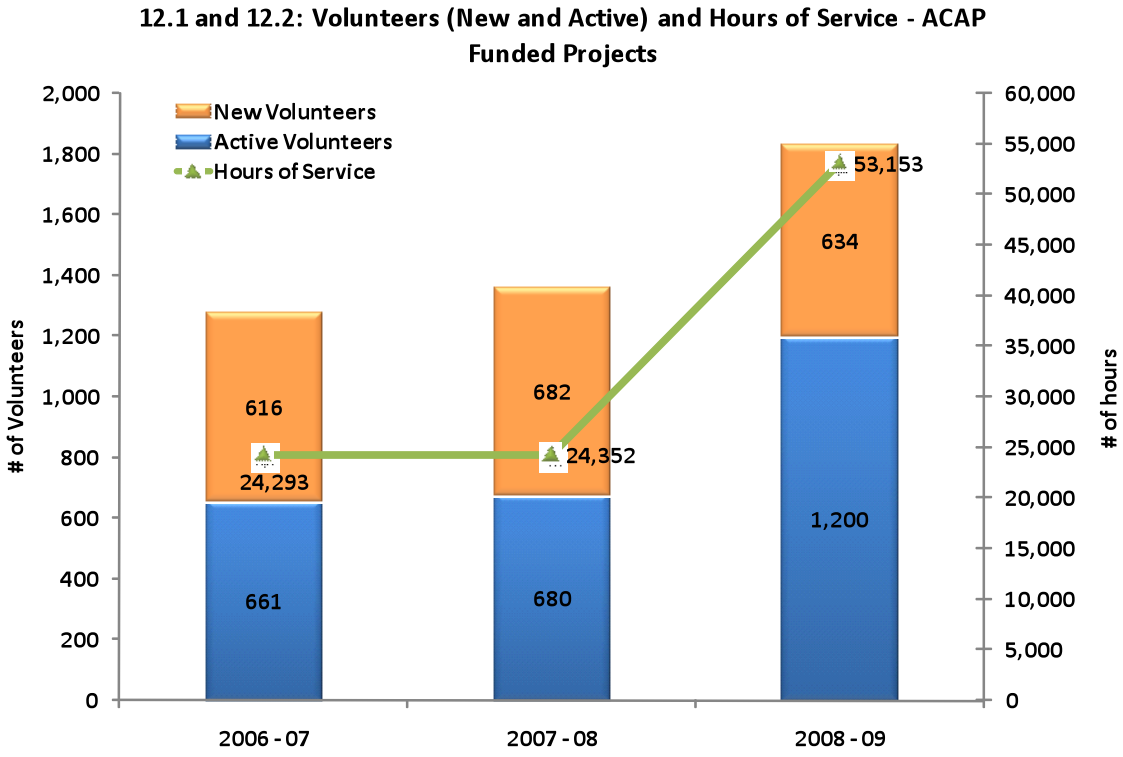
ACAP supports activities that increase the skills and abilities of the people who work at all levels of the community-based AIDS movement: board members, staff and volunteers. ACAP also supports initiatives that provide training for staff and volunteers in areas such as community development, fund raising, evaluation, and marketing of programs and services to an organization's intended audience.

Number of Volunteers and Volunteer Hours Increases

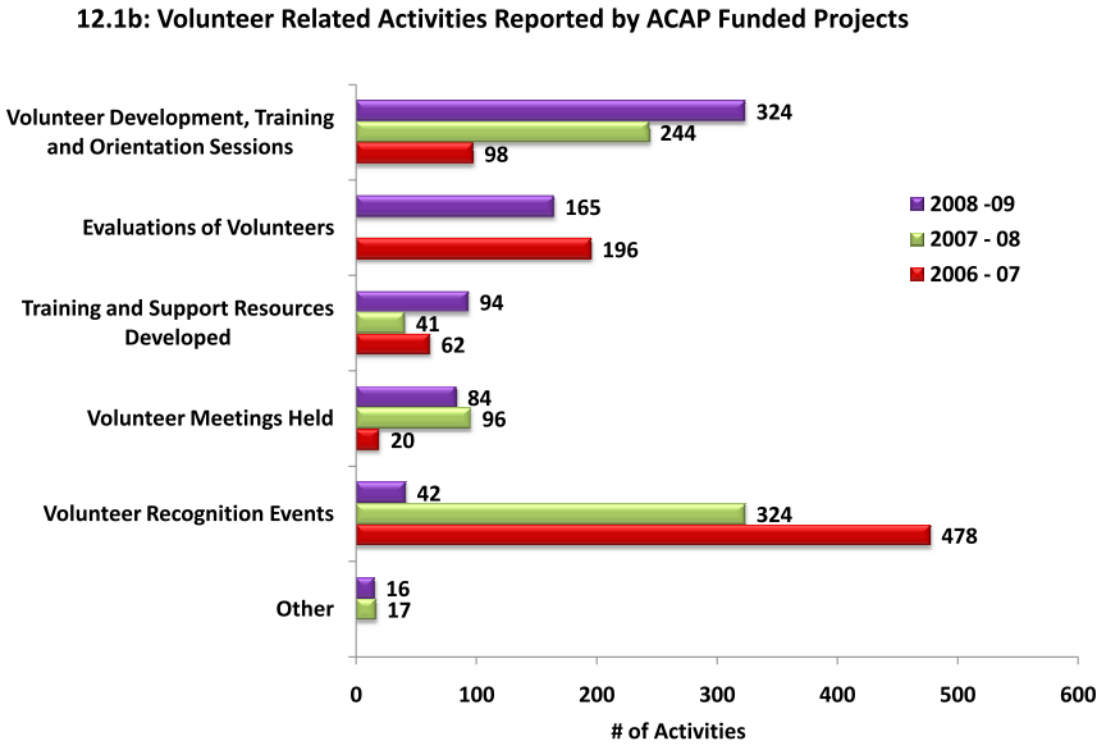
In 2008-09, 17 ACAP-funded projects reported having activities that involve volunteers. The number of active volunteers increased significantly over the past year. It appears that ACAP-funded projects were able to retain almost all their active and new volunteers from the previous year as well as attract new volunteers. This trend is in contrast with the OCHART data for all funded programs, which showed a decrease in the number of volunteers. These findings indicate that projects that have dedicated resources to support volunteers are better able to attract and retain volunteers.

During 2008-09, volunteers in ACAP-funded projects and projects provided a total of 53,153 hours of service – more than double the amount in each of the previous two years – and the equivalent of approximately 30 full-time staff.

These projects reported a total of 1,834 volunteers during the year, which slightly exceeded their overall target (1,806), but the actual number of hours of services was slightly lower than the target (54,841). Nine projects fell short of their target for number of volunteers, while 10 missed their targets for volunteer hours. The main reason projects gave was that the need for volunteers for certain activities changed over the course of the year.



Focus on Volunteer Training



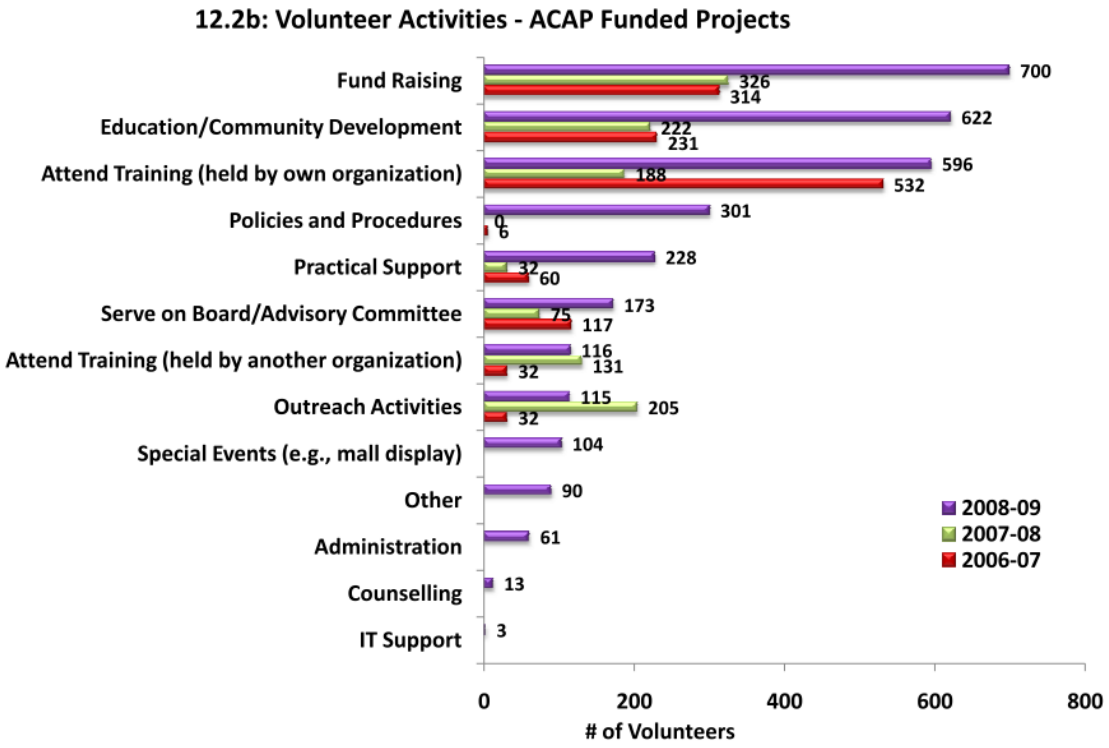
Over the past three years, ACAP-funded projects have invested less in volunteer recognition and more in volunteer training, development and orientation. This approach is consistent with feedback from volunteers who value training more than recognition.

The 4 projects that did not meet their targets for volunteer evaluation and recognition reported problems such as staff illness or holidays and scheduling changes. Some events were moved into the next fiscal year.

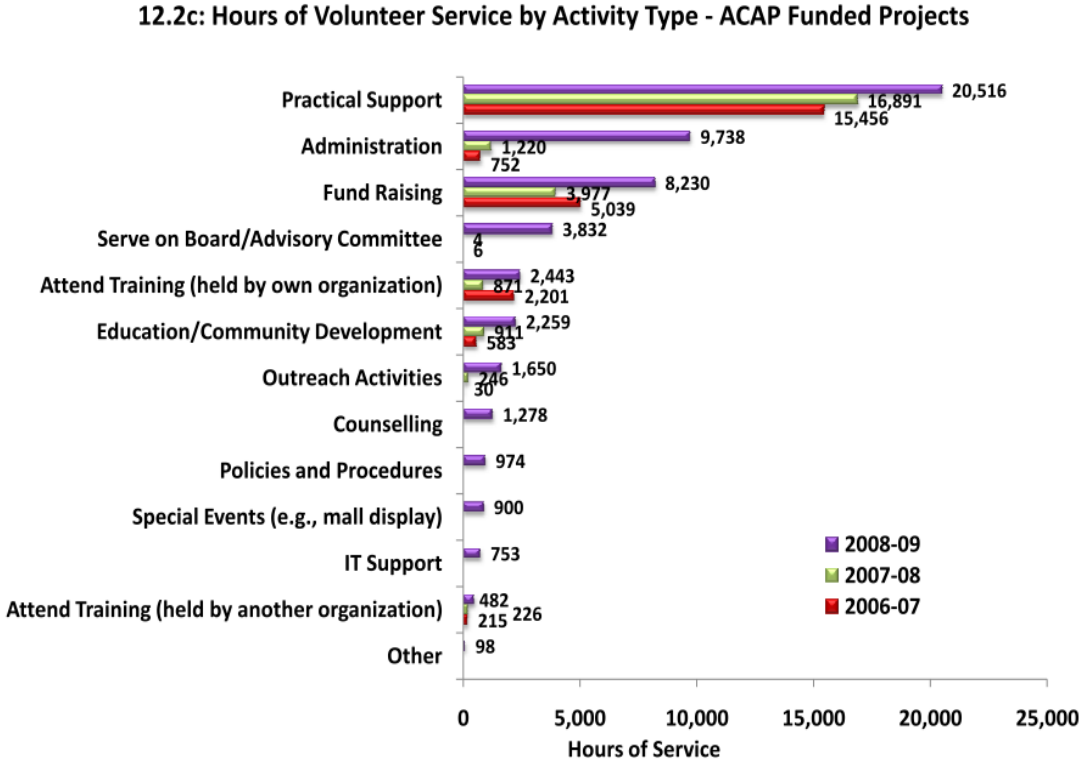
More Volunteers Involved in Fundraising and Education

Figure 12.2b lists the type of activities done by volunteers at ACAP-funded projects in 2008-09. Volunteers in these organizations were more active in fundraising (which was not true of volunteers overall – see Figure 12.2b, page 71). They were also more active in education and community development, policies and procedures and practical support, which is consistent with the experience in non-ACAP funded agencies. It would be interesting to know whether organizations are actively recruiting volunteers with these types of skills.

Of the 17 ACAP-funded projects that reported providing volunteer services, eight met or exceeded their targets for volunteer services. Those that did not reported limitations such as staffing shortages, events being scaled back and changes in programs that reduced the need for volunteers.

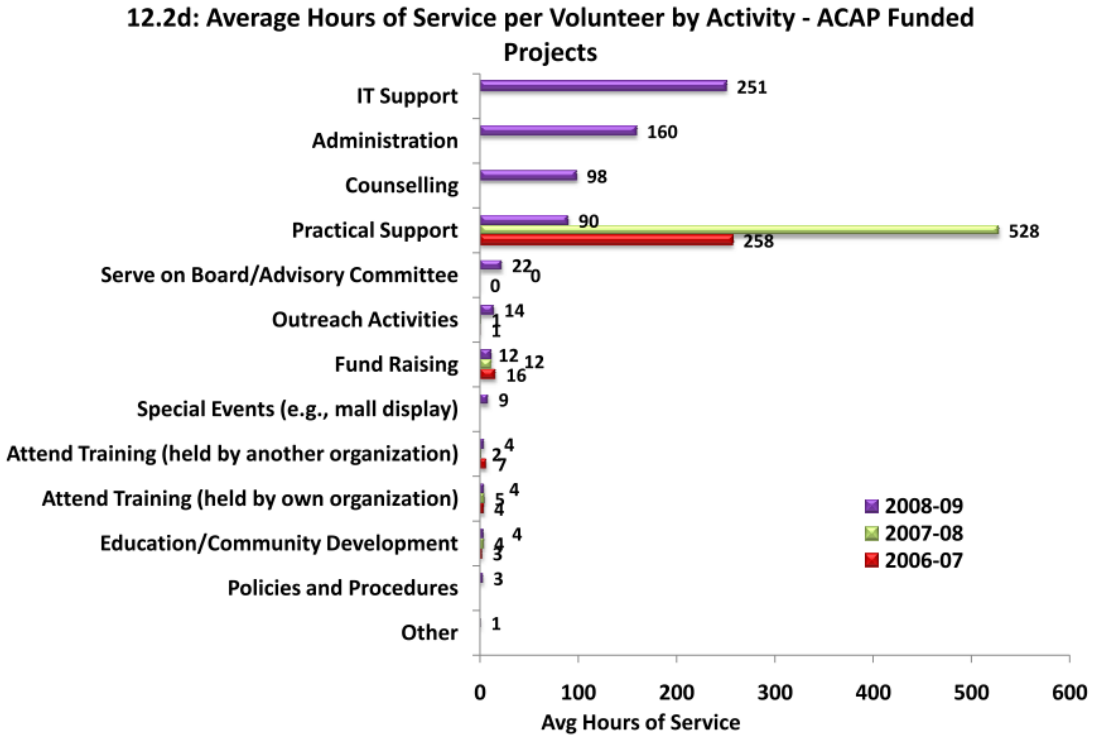


More Volunteer Hours for Practical Support, Administration and Fundraising



The data showed the same trend in terms of volunteer intensity as in previous years: volunteers provide significantly more hours of practical support than other services. However, in 2008-09, they provided more hours of administrative, fundraising, education, outreach and other services than in the past.

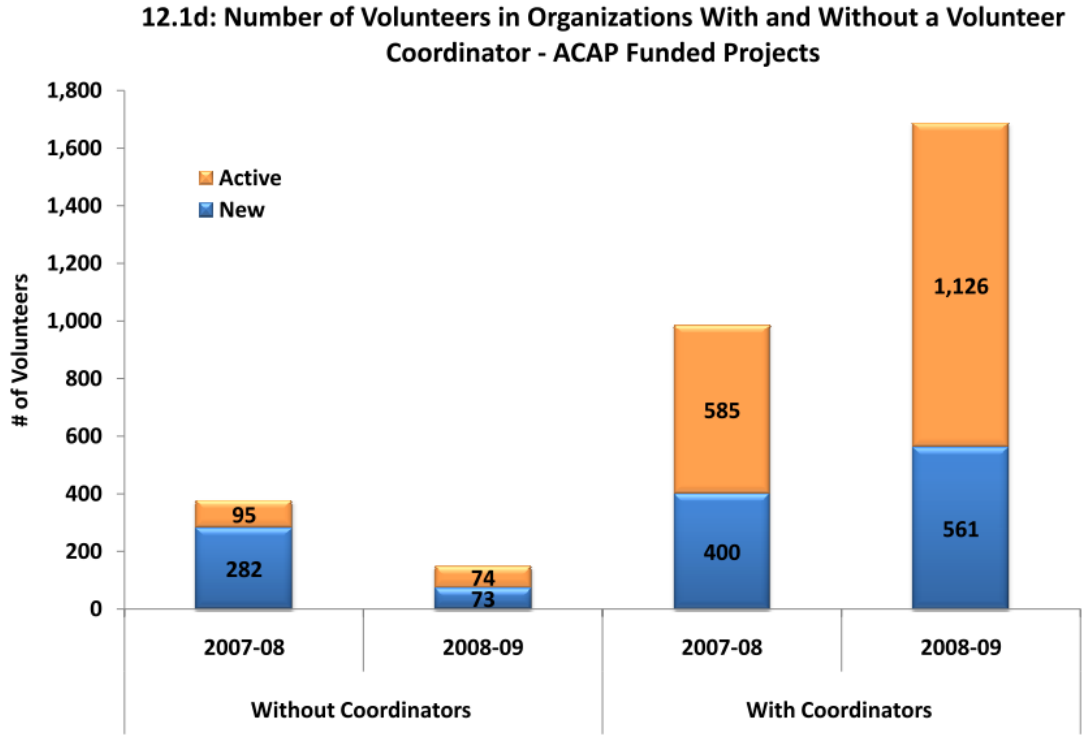
When the number of hours of service are divided by the number of volunteers involved in a particular activity, it appears that volunteers who provide IT support, administration, counselling and practical support give the most hours per person. This may be due to the fact that these activities are considered meaningful and make effective use of volunteer skills and talents.



Volunteer Coordinators Influence Volume of Volunteer Activities

During 2008-09, ACAP funded nine unique volunteer coordinators within organizations. Investment in volunteer coordinators appears to pay off in terms of volunteer activity. Over the past two years, the projects with funding for coordinator positions reported significantly more volunteers and volunteer activity than projects not funded for a coordinator (see Figure 12.1d).

However, not all of the difference can be attributed solely to having that role. Programs that have volunteer coordinators tend to be larger, have more clients and activities, and offer more scope for volunteers.



Conclusion

ACAP funded projects are making a significant contribution to ACAP's goals of HIV prevention, health promotion for PHAs, education and volunteer development in Ontario. In terms of key accomplishments:

- They exceeded targets for knowledge development and sharing, illustrated by the increase in community development meetings, outreach and media contacts.
- There was an overall increase in workshops, trainings and drop-ins.
- The increase in the number of volunteers and volunteer hours.
- Volunteers provide excellent return on investment in volunteer programs: in 2008-09 alone they provided services equivalent to 30 full time staff, and many are involved in either generating more money for the programs through fundraising or reducing their expenses by providing practical support and administration activities.

The additional funding provided by ACAP leverages a significant amount of activity, and is contributing to measurable impacts/outcomes in terms of increased awareness, knowledge and skills related to HIV prevention and increased access to risk reduction resources, services and social support for the populations targeted by funding projects. A detailed analysis of the deliverables/outputs and impacts/outcomes of ACAP projects in Ontario will be provided in the roll-up of ACAP results across the country (report to be released summer 2010).

Appendix A: Funded Programs by Health Region

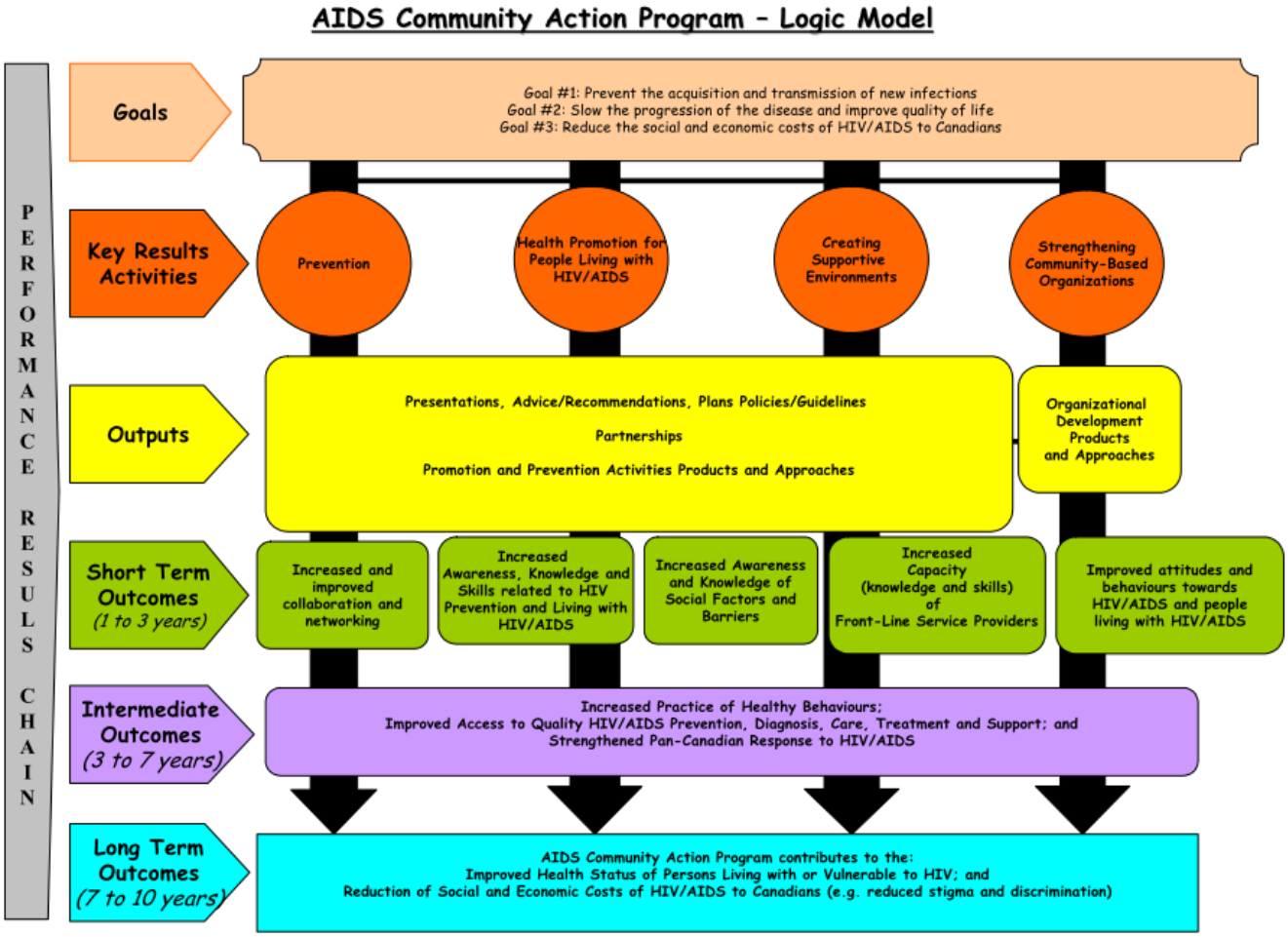
Organization Name	LHIN	Health Region
AIDS Committee of Durham Region	Central East	Central East
AIDS Committee of Simcoe County	North Simcoe Muskoka	Central East
AIDS Committee of York Region	Central	Central East
Peterborough AIDS Resource Network	Central East	Central East
AIDS Committee of Cambridge, Kitchener, Waterloo and Area	Waterloo Wellington	Central West
AIDS Committee of Guelph and Wellington County - Masai	Waterloo Wellington	Central West
AIDS Committee of Guelph and Wellington County	Waterloo Wellington	Central West
AIDS Niagara	Hamilton Niagara Haldimand Brant	Central West
Hamilton AIDS Network	Hamilton Niagara Haldimand Brant	Central West
Hamilton Public Health & Community Services	Hamilton Niagara Haldimand Brant	Central West
Hemophilia Ontario - CWOR	Central West	Central West
Peel HIV/AIDS Network	Central West	Central West
HIV/AIDS Regional Services	South East	Eastern
Ontario Aboriginal HIV/AIDS Strategy - KINGSTON	South East	Eastern
Street Health Centre, Kingston Community Health Centres	South East	Eastern
Access AIDS Network - Sudbury	North East	Northern
AIDS Committee of North Bay and Area	North East	Northern
AIDS Thunder Bay	North West	Northern
Algoma Group Health	North East	Northern
Hemophilia Ontario - NEOR	North East	Northern
Hemophilia Ontario - NWOR	North West	Northern
NishnawbeAski Nation	North West	Northern
Ontario Aboriginal HIV/AIDS Strategy - COCHRANE	North East	Northern
Ontario Aboriginal HIV/AIDS Strategy - SUDBURY	North East	Northern
Ontario Aboriginal HIV/AIDS Strategy - THUNDER BAY	North West	Northern
Sudbury Action Centre For Youth	North East	Northern
Union of Ontario Indians	North East	Northern
WassayGezhig Na NahnDah We Igamig	North West	Northern
AIDS Committee of Ottawa	Champlain	Ottawa
Bruce House	Champlain	Ottawa
City of Ottawa Public Health	Champlain	Ottawa
Hemophilia Ontario - OEOR	Champlain	Ottawa
Ontario Aboriginal HIV/AIDS Strategy - OTTAWA	Champlain	Ottawa
Somerset West Community Health Centre	Champlain	Ottawa
Youth Services Bureau of Ottawa	Champlain	Ottawa
AIDS Committee of London	South West	South West
AIDS Committee of Windsor	Erie St Clair	South West
Association of Iroquois and Allied Indians	South West	South West
Hemophilia Ontario - SWOR	South West	South West
Ontario Aboriginal HIV/AIDS Strategy - LONDON	South West	South West
Ontario Aboriginal HIV/AIDS Strategy - WALLACEBURG	Erie St Clair	South West
2-Spirited People of the First Nations	Toronto Central	Toronto
Africans In Partnership Against AIDS	Toronto Central	Toronto
AIDS Committee of Toronto - PYO	Toronto Central	Toronto
AIDS Committee of Toronto - VIVER	Toronto Central	Toronto
AIDS Committee of Toronto	Toronto Central	Toronto
Alliance for South Asian AIDS Prevention	Toronto Central	Toronto

Asian Community AIDS Services	Toronto Central	Toronto
Barrett House - Good Shepherd Ministries	Toronto Central	Toronto
Black Coalition for AIDS Prevention	Toronto Central	Toronto
Casey House Hospice	Toronto Central	Toronto
Central Toronto Community Health Centres	Toronto Central	Toronto
Centre for Spanish-speaking Peoples	Toronto Central	Toronto
CENTRE FRANCOPHONE DE TORONTO	Toronto Central	Toronto
Family Service Toronto	Toronto Central	Toronto
Fife House	Toronto Central	Toronto
Hassle Free Clinic-HIV/AIDS Counselling& Support Program/Women	Toronto Central	Toronto
Hospice Toronto	Toronto Central	Toronto
LOFT Community Services	Toronto Central	Toronto
Maggie's: The Toronto Prostitutes' Community Service Project	Toronto Central	Toronto
New Heights Community Health Centre	Toronto Central	Toronto
Ont. Assoc. of the Deaf, Deaf Outreach Program	Toronto Central	Toronto
South Riverdale Community Health Centre	Toronto Central	Toronto
St. Stephen's Community House	Toronto Central	Toronto
Syme-WoolnerNeighbourhood and Family Centre	Toronto Central	Toronto
The Teresa Group	Toronto Central	Toronto
The Works, City of Toronto Public Health	Toronto Central	Toronto
Toronto People With AIDS Foundation - CAAT	Toronto Central	Toronto
Toronto People With AIDS Foundation - FFL	Toronto Central	Toronto
Toronto People With AIDS Foundation	Toronto Central	Toronto
Warden Woods Community Centre	Toronto Central	Toronto
YOUTHLINK Inner City	Toronto Central	Toronto
African and Caribbean Council on HIV/AIDS in Ontario	Provincial	Provincial
AIDS Bereavement Project of Ontario-sponsored by Fife House Foundation, Inc	Provincial	Provincial
Canadian AIDS Treatment Information Exchange	Provincial	Provincial
FIFE House - OHSUTP	Provincial	Provincial
Hemophilia Ontario	Provincial	Provincial
HIV & AIDS Legal Clinic (Ontario)	Provincial	Provincial
Ontario Aboriginal HIV/AIDS Strategy	Provincial	Provincial
Ontario AIDS Network	Provincial	Provincial
Ontario Organizational Development Program	Provincial	Provincial
PASAN (Prisoners with HIV/AIDS Support Action Network)	Provincial	Provincial
Voices of Positive Women	Provincial	Provincial

* 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.

** Note that there were six organizations who reported during the period covered in the report (2005 to 2007-08) that either no longer exist or are no longer funded. Their historical data has been included/maintained in order to reflect actual activity.

Appendix B: ACAP Logic Model



Appendix C: ACAP-funded Projects by Type and Funding Approach

ACAP Operational Projects 2008-09

(Projects funded in 2008-09 – activities and deliverables are counted in 2008-09)

PREVENTION INITIATIVES

Project Number	Project Title	Agency Sponsor
6963-06-2002/2370431	Prison In-Reach Project	Prisoners With HIV/AIDS Support Action Network
6963-06-2002/2370438	Healthy Sexuality Program	ACCESS AIDS Network
6963-06-2002/2370445	HIV Prevention Services for Gay, Bisexual and MSM	AIDS Committee of London
6963-06-2002/4480430	PARN HIV Education Program - Building Our Community Response	Peterborough AIDS Resource Network
6963-06-2002/4480432	Prevention & Education Program	HIV/AIDS Regional Services
6963-06-2002/4480434	Community HIV Prevention and Education Program	AIDS Niagara
6963-06-2002/4480438	HIV Education Services Program	AIDS Committee of North Bay and Area
6963-06-2002/2370437	Community Education and Prevention Program	Access AIDS Network
6963-06-2002/2370442	Gay Men's Health and Wellness Project	AIDS Committee of Ottawa
6963-06-2002/4480433	Community Education Program	AIDS Committee of Cambridge, Kitchener, Waterloo and Area
6963-06-2002/4480444	Wellington & Grey-Bruce Rural Prevention/ Outreach Program	AIDS Committee of Guelph and Wellington County

HEALTH PROMOTION FOR PHAs

Project Number	Project Title	Agency Sponsor
6963-06-2002/2370428	Peer Network Community Collaboration Program	Voices of Positive Women
6963-06-2002/2370434	Ontario AIDS Network PHA Program	Ontario AIDS Network
6963-06-2002/2370441	VIVER: Portuguese-Speaking Community Development	Sponsored by AIDS Committee of Toronto
6963-06-2002/2370446	Health Promotion for PHAs	AIDS Committee of Toronto
6963-06-2002/2370447	Positive Youth Outreach: Health Promotion and Outreach to HIV-Positive Youth	Sponsored by AIDS Committee of Toronto
6963-06-2002/4480433	South Asian PHA Program/Volunteer Program	Alliance for South Asian AIDS Prevention
6963-06-2002/4480435	Food For Life	Sponsored by Toronto People with AIDS Foundation
6963-06-2002/4480445	Enhancing Healthy Options Program (EHOP)	AIDS Thunder Bay
6963-06-2002/2370435	PHA Resource Program	Hamilton AIDS Network
6963-06-2002/2370436	Health Promotion for People living with and Affected by HIV/AIDS	Peel HIV/AIDS Network
6963-06-2004/4480463	VIVER: Portuguese-Speaking Case Management	Sponsored by the AIDS Committee of Toronto

STRENGTHENING COMMUNITY-BASED AIDS ORGANIZATIONS

Project Number	Project Title	Agency Sponsor
6963-06-2002/2370432	Creating and Sustaining Healthy and Effective Communities / Volunteer Development Program	Asian Community AIDS Services
6963-06-2002/2370440	Volunteer Support Program	Bruce House
6963-06-2002/2370444	Ontario Organizational Development Program	Sponsored by AIDS Committee of London
6963-06-2002/4480431	Fife House Volunteer Services	Fife House
6963-06-2002/4480433	South Asian PHA Program/Volunteer Program	Alliance for South Asian AIDS Prevention
6963-06-2002/4480437	Volunteer Program	Toronto People with AIDS Foundation
6963-06-2002/4480449	Volunteer Support Program	The Teresa Group

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

ACAP Time-Limited Projects 2007-08

(Projects were funded at the end of the fiscal year in March 2008 – activities and deliverables are counted in 2008-09**)**

PREVENTION INITIATIVES

Project Number	Project Title	Project Sponsor
6963-06-2007/6420468	« SIDA : Ulbuntu / Komipesa / Angajmant Kominoté / Engagement communautaire »	Centre francophone de Toronto
6963-06-2007/6420470	Operation Hairspray Phase2 : HIV/AIDS Prevention in Ottawa's African and Caribbean Communities	Somerset West Community Health Centre
6963-06-2007/8890459	« Despierta Comunidad Latina » Raising Awareness among HIV+ and – Men (Gay, Bisexual and MSM)	Centre for Spanish Speaking Peoples

HEALTH PROMOTION FOR PHAs

Project Number	Project Title	Project Sponsor
6963-06-2007/6420466	Black PHA Prevention Project	Black Coalition for AIDS Prevention

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

ACAP Operational Projects 2008-09

(Projects were funded at the end of the fiscal year in March 2009 – activities and deliverables will be counted in 2009-10**)**

PREVENTION INITIATIVES

Project Number	Project Title	Agency Sponsor
6963-06-2008/4480498	Sexual Health Promotion for Gay Men and HIV - positive Gay men	AIDS Committee of Windsor
6963-06-2008/4480499	AIDS Support Chatham-Kent: Prevention Education and Outreach to Sex Workers and people using Injection Drugs	AIDS Support Chatham-Kent
6963-06-2008/4480500	Healthy Sexuality Outreach Program	AIDS Committee of Durham Region

HEALTH PROMOTION FOR PHAs

Project Number	Project Title	Project Sponsor
6963-06-2008/4480494	Words into Deeds: Engaging People living with HIV/AIDS in the response to HIV affecting African and Caribbean communities in Ontario	African and Caribbean Council on HIV/AIDS in Ontario c/o BlackCap

STRENGTHENING COMMUNITY-BASED AIDS ORGANIZATIONS

Project Number	Project Title	Agency Sponsor
6963-06-2008/4480493	Community Volunteer Program	AIDS Committee of York Region

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

ACAP Time-Limited Projects 2008-09

(Projects were funded at the end of the fiscal year in March 2009 – activities and deliverables will be counted in 2009-10**)**

PREVENTION INITIATIVES

Project Number	Project Title	Project Sponsor
6963-06-2008/4480472	Aboriginal Sex Worker Outreach and Education Project	MAGGIE'S The Toronto Prostitute Community Service Project
6963-06-2008/4480477	Mano en Mano Peer Educator HIV/AIDS Prevention Training Course	Centre for Spanish-Speaking Peoples
6963-06-2008/4480478	Ethiopian Association HIV/AIDS Prevention Project	Ethiopian Association of Ontario
6963-06-2008/4480479	HIV/STI/Hep C Prevention Model for Migrant Farm workers in Ontario	Asian Community AIDS Services
6963-06-2008/4480488	Lisanga/Eskwad/Integration et Appropriation Communautaire	Centre francophone de Toronto

HEALTH PROMOTION FOR PHAs

Project Number	Project Title	Project Sponsor
6963-06-2008/4480464	Positive Prevention - Train the Trainer	AIDS Committee of Guelph & Wellington County
6963-06-2008/4480469	PHA Engagement in POZ Prevention for Gay Men	Toronto People With AIDS Foundation
6963-06-2008/4480473	The Positive Prevention Project: Developing Youth-led Strategies Supporting a Common Approach to HIV, Hepatitis C and STI Prevention	Planned Parenthood Toronto
6963-06-2008/4480475	Negotiating Disclosure: An HIV Serostatus Disclosure Model for African and Caribbean Women	Women's Health in Women's Hands
6963-06-2008/4480476	Centralized Service Coordination Pilot Project for People Living with HIV/AIDS (PHAs) Who Face Health and Mental Health	LOFT Community Services

STRENGTHENING COMMUNITY-BASED ORGANIZATIONS

Project Number	Project Title	Project Sponsor
6963-06-2008/4480482	The "AhtFra" Project: Interpreter Services for People with HIV/AIDS	AIDS Committee of Cambridge Kitchener, Waterloo and Area (ACCKWA)
6963-06-2008/4480474	Integrating a Common Approach to HIV, Sexually Transmitted Infections, and Hepatitis C	AIDS Committee of Toronto
6963-06-2008/4480480	Engaging Populations at Risk	AIDS Thunder Bay
6963-06-2008/4480490	MSM Program Infrastructure Development Project	Hamilton AIDS Network

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