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

To the End of Fiscal Year 2009-10

(April 1, 2009 to March 31, 2010)

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
January 2011

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Acknowledgements

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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. This includes developing the web-based OCHART tool, providing ongoing training and support to programs on the use of OCHART, housing the data, 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

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Preface

Welcome to the 5th annual OCHART (Ontario Community 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
account for use of public resources.

The data analyses 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.

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.

What's Different About this Year's Report?

1. **Consistency, Accuracy and Stability:** There are fewer changes in trends and data shifts. This is positive news in that it seems that programs are collecting and reporting data more accurately. It also points to more stable programs delivering services in a more consistent manner.
2. **Changing Policy Environment:** Some programs had significant challenges with delivery of services. For example, the increase in the number of people living with HIV being criminally charged with non-disclosure of HIV status has impacted many programs and resulted in a significant amount of education for both clients and other service providers.
3. **Some data from previous years has 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.
4. **Changes to IDU/Substance Use Services reporting:** In previous years, the IDU Outreach section of OCHART was restricted to agencies specifically funded by the AIDS Bureau to deliver IDU outreach programs. In 2009/10, this section of OCHART was revised and opened to all agencies that provide harm reduction services for clients who use substances. This change gives us a more robust and accurate picture of programming for people who use substances in Ontario. Because of these changes, data for some other sections of the report (e.g. outreach and support services) may seem different this year when compared to previous years. This is

because some data previously reported in other sections of OCHART are now being reported in the IDU/Substance Use Services section.

This report provides key findings and emerging trends from selected questions in the 2009-10 OCHART reports. To see the summary of responses to *all* 2009-10 OCHART questions, go to https://www.ochart.ca/documents/2011/OCHART_Supplementary_Tables_by_Region.pdf

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 serve, 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

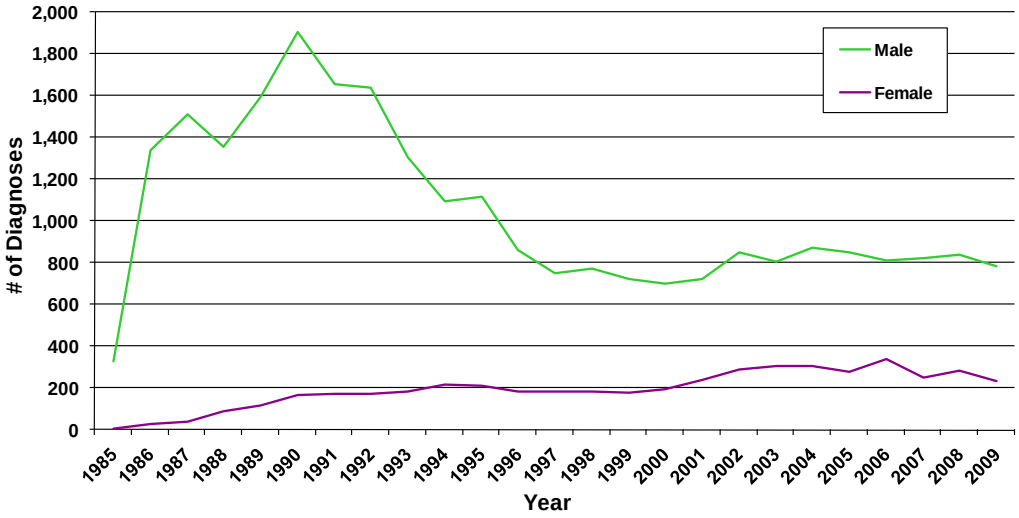
Figure titles are numbered according to the OCHART question and do not necessarily flow in sequential order in the report.

Part I: Trends in HIV Infection in Ontario

New Diagnoses Down Slightly in 2009

In 2009, 77% of new HIV diagnoses were in men and 23% in women, which is consistent with trends in recent years: 75% men and 25% women in 2008 and 77% and 23% in 2007. However, the actual number of new HIV diagnoses in 2009 (1,013) was down 10% compared to 2008 (1,121) – and is the lowest it has been since 2001 (961).

Figure 1: Number of HIV Diagnoses (adjusted[1]) Among Males and Females by Year of Diagnosis, Ontario, 1985 to 2009



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 13,2010

More people were tested in 2009 (425,366) than in 2008 (402,110) or in any year since HIV testing began. Given that the number of HIV tests in most risk categories remained stable or increased in 2009 (see Table 1), the lower number of new HIV diagnoses does not appear to be related to changes in testing patterns. The lower positivity rate in almost all risk categories may be due to the impact of prevention efforts. It will be interesting to see whether this slight drop in new diagnoses is sustained over time and to identify the contributing factors.

Table 1: Number (adjusted[1]) of HIV tests and positivity rate (%) by year-quarter of test and exposure category, Ontario, 1996 - 2009 Q4

	MSM		MSM-IDU		IDU		Transfused		HIV-endemic	
Year-	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
2007	22,298	2.14	1,524	2.12	18,787	0.44	5,294	0.18	12,696	1.84
2008	25,623	1.98	1,365	2.32	17,853	0.46	4,744	0.1	11,468	2.19
2009	27,433	1.8	1,281	2.11	17,498	0.43	4,407	0.14	12,545	1.42

Table continued from above	High risk hetero		Low risk hetero		Mother to child		Total	
Year-	#	Rate	#	Rate	#	Rate	#o	Rate
2007	14,909	0.28	302,247	0.05	2,440	0.08	410,656	0.26
2008	14,815	0.42	307,511	0.05	2,457	0.24	414,936	0.27
2009	14,561	0.28	315,710	0.05	2,360	0.42	425,366	0.24

The HIV Lab assigns cases to the exposure category most likely to represent the source of HIV infection, as follows: Men who have sex with men (MSM); MSM and injection drug use (IDU); IDU; Mother-to-child transmission (MTC); Blood product recipient prior to November 1985; Blood transfusion recipient prior to November 1985; Origin/residence in an HIV-endemic area; Heterosexual transmission (with sub-categories of High-risk heterosexual and Low-risk heterosexual); Unknown (not indicated, NIR)

Although fewer men were diagnosed with HIV in 2009-10 (781 compared to 841 in 2008 – a drop of 7% in one year), men still account for more than three of every four new diagnoses. The number of women diagnosed each year has also dropped by about 30% over the past four years: from 337 in 2006 to 232 in 2009.

Year	# of HIV Tests Male	# of Men Diagnosed	# of HIV Tests Female	# of Women Diagnosed	Total
2006	182,076	810	221,420	337	1,147
2007	184,617	822	217,018	246	1,068
2008	188,970	841	218,180	280	1,121
2009	Unknown	781	Unknown	232	1,013

*The number of tests by gender for 2009 is unknown at this time as the lab is still in the process of confirming this data.

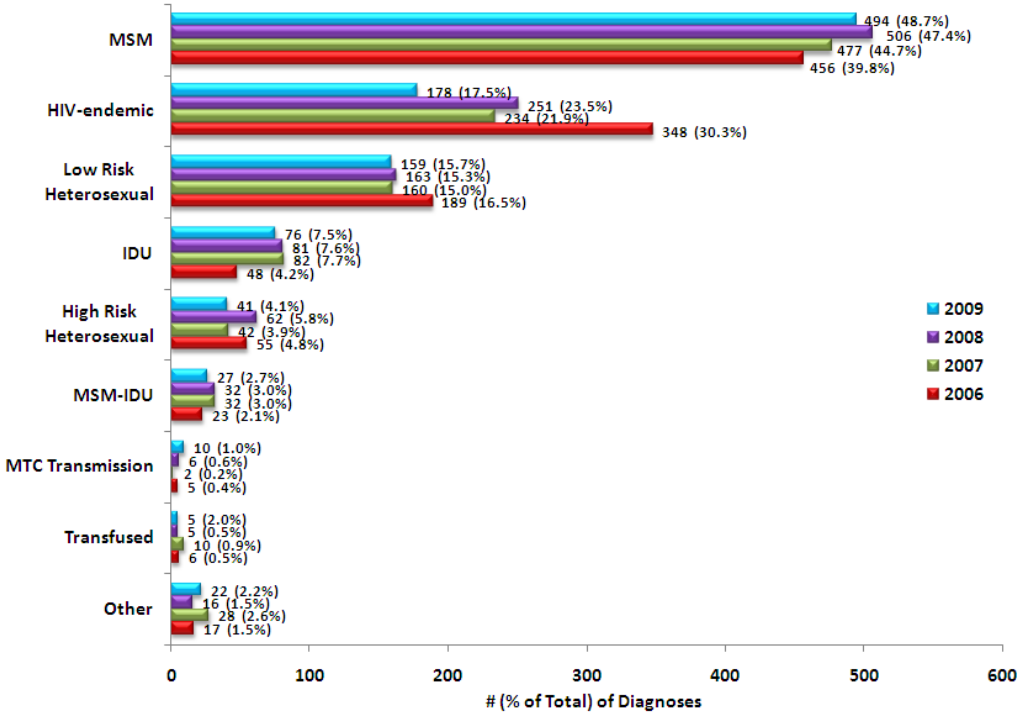
Slight Decrease in New Cases in Most Risk Categories

In terms of risk factors for HIV infection (Figure 2), the number of new cases was down in almost every category. Compared to 2008, HIV diagnoses in 2009 decreased in:
People from countries where HIV is endemic: Africa and the Caribbean (73 fewer cases, 29.2% decrease)
People who reported high risk heterosexual activity (21 fewer cases, 33% decrease)
People who reported low risk heterosexual activity* (4 fewer cases, 2.5% decrease)
Men who have sex with men (12 fewer cases, 2.5% decrease)
Men who have sex with men who also report injection drug use (5 fewer cases, 14.7% decrease)
People who report injection drug use (5 fewer cases, 6.7% decrease).

Note: Follow-up with people who report low risk heterosexual activity as their risk factor often reveals they have had a high risk exposure (i.e., they have a sexual partner who: is infected with HIV, injects drugs, or is a man who has sex with men).

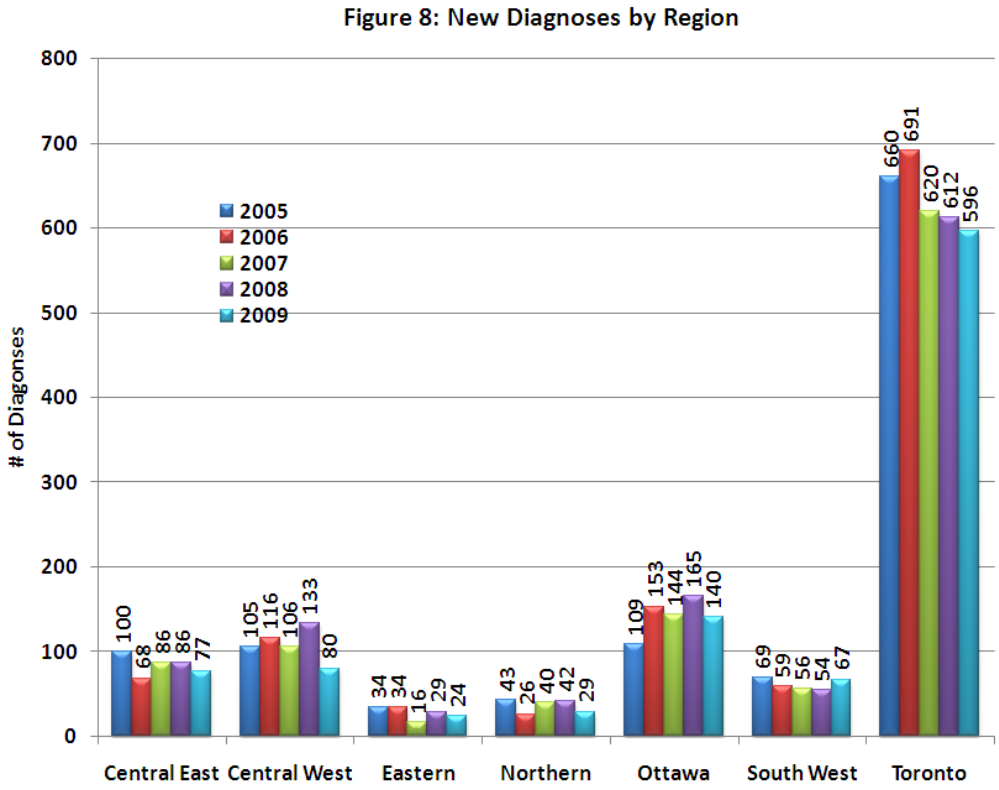
While the number of new cases has dropped in almost all risk categories, men who have sex with men still account for about half of all new HIV diagnoses. Figure 2 shows both the proportion of diagnosed by exposure category as well as the actual number of diagnoses by year.

Figure 2: Number (adjusted[1]) of HIV diagnoses by Year of Test and Exposure Category - 2005 to 2009



Source: HIV Laboratory, Public Health Laboratory Toronto, 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.

South West Sees Increase in New Cases



The South West Region was the only health region to see an increase in new HIV diagnoses in 2009-10 (67) compared to 2008-09 (54). Except for Central West, which had a dramatic 40% drop in new diagnoses (from 133 to 80); all other regions saw a more modest decline. 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.

For more information on the epidemiology of HIV in Ontario, see the Ontario HIV Epidemiological Monitoring Unit web site. The site also includes both Health Region and Public health Unit specific data.

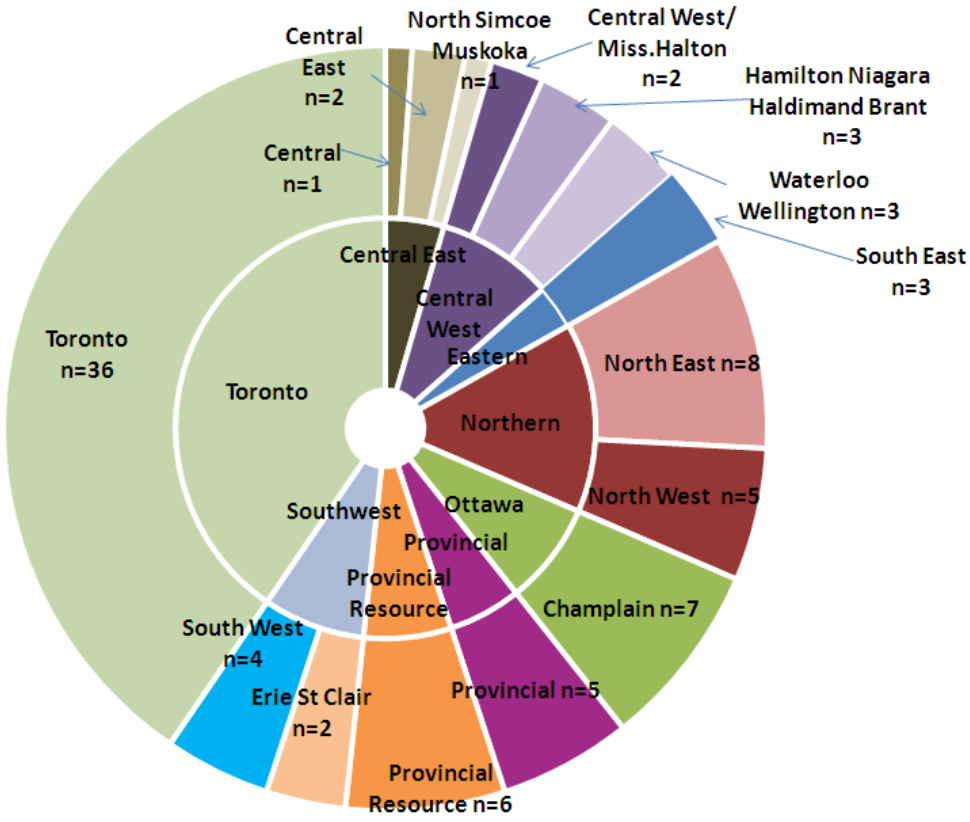
http://www.phs.utoronto.ca/ohemu/mandate.html

Part II: How We Work

In 2009-10, a total of 88 programs in 71 agencies submitted OCHART reports compared to 83 programs in 2008-09; the increase was due to a new ACAP funding cycle that saw 27 new projects funded. Five of these 27 new projects were in programs new to OCHART.

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). The five new programs were added in the South West and Toronto LHINs.

Figure 5: Program Distribution Across Region and LHIN



This report provides data for the province and by region. Information by LHIN is available on request through the OHTN OCHART staff contact in the acknowledgments.

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

Of the 88 programs whose data are included in this report, 49 (56%) are in AIDS Service Organizations (ASOs) and the other 39 (44%) are in HIV programs within community health centres, hospitals or other community-based organizations:
AIDS Service Organizations are stand-alone community-based service providers whose sole mandate is to provide prevention and support services to people living with and at-risk of HIV/AIDS.
Community Health Centres are non-profit, community-governed organizations that use interdisciplinary teams of health providers to deliver primary health care, health promotion and community development services. In this context, they are usually funded (by the AIDS

Bureau or ACAP) to provide either ethno-specific or IDU-related HIV support and prevention programs.
Hospital programs generally have staff funded who work in an HIV testing clinic or as support for PHAs.
Other community-based organizations are usually funded to provide population specific programs that focus mainly on HIV prevention and support services.

Table 2 shows the number of each type of organization funded as well as the types of services provided.

Figure 3.1b (below) shows the mix of types of programs funded in each region in 2009-10. There are AIDS service organizations in all regions, and at least three funded HIV programs in each region. For a list of the programs that submitted OCHART reports in 2009-10 by region, see Appendix A.

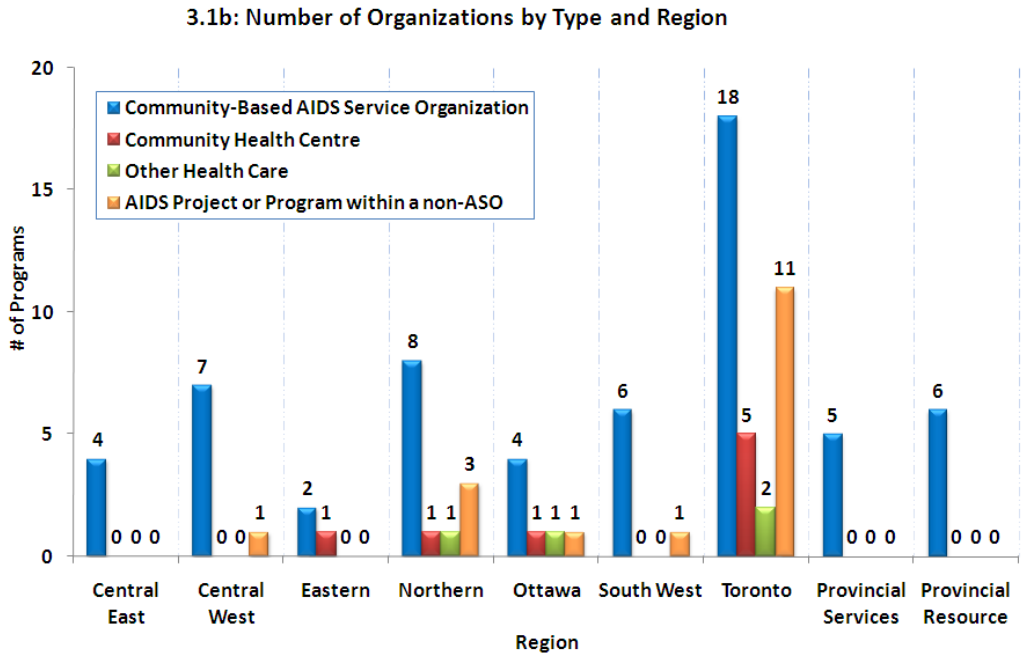


Table 2: Number of Programs by Type of Service Funded in 09/10

	Education	Outreach	Support	Volunteer	IDU
ASO	58	53	52	57	21
CHC	2	2	3	3	5
Non ASO	13	13	11	13	5
Other Healthcare Institutions	2	2	2	2	2
Total	**75**	**70**	**68**	**75**	**33**

The numbers above do not add up to the total of 88 who submitted OCHART reports as some programs enter data in more than one of the Types of Service categories.

Provincial Programs

Most of the programs that submit OCHART reports provide services within their local communities or geographic service areas; however, a small number are provincial programs that have a mandate to serve the entire province. The provincial programs fall into two categories: those that provide services directly to clients and those that are a resource for other HIV/AIDS programs (e.g. providing training, information, resources, expertise). The following table lists the provincial programs in each of those two categories.

Provincial HIV/AIDS Programs

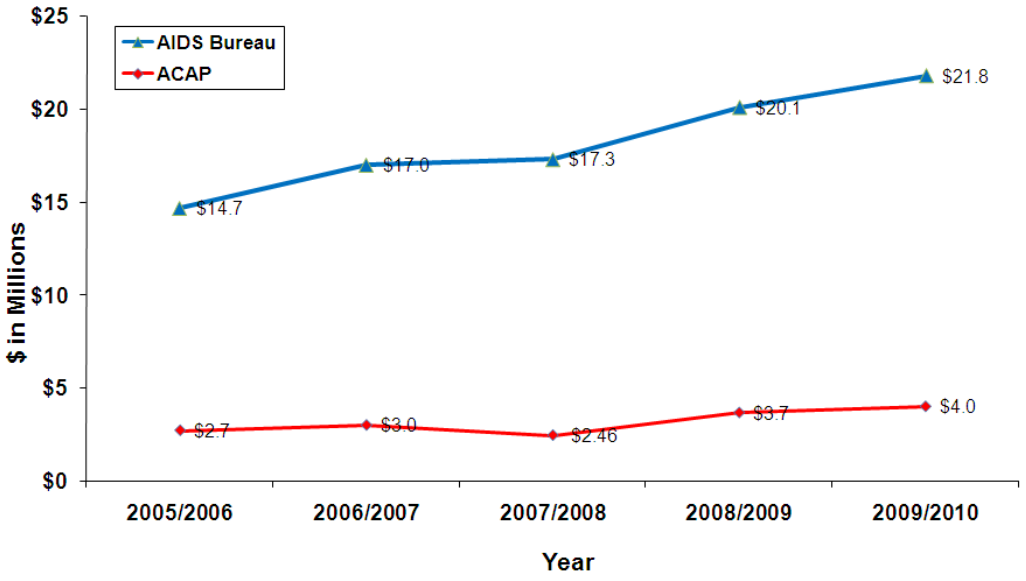
Provincial Programs that Provide Services Directly to Clients	Provincial Programs that are a Resource for Other HIV/AIDS Programs*
HIV & AIDS Legal Clinic (Ontario) (HALCO)	African and Caribbean Council on HIV/AIDS in Ontario (ACCHO)
Ontario Aboriginal HIV and AIDS Strategy (OAHAS)	AIDS Bereavement Project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

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

Government Funding

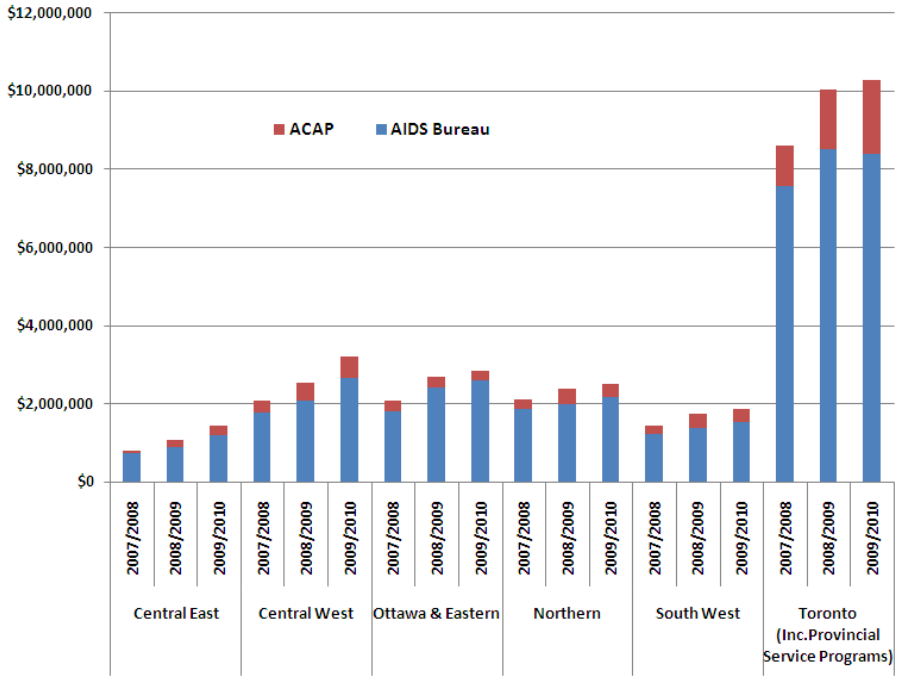
The following graph shows the actual amount of funding provided by the two government funders each year: the AIDS Bureau and ACAP.

Figure 7: Annual ACAP and AIDS Bureau Funding as Reported by Funders



The difference in ACAP funding between 2008-2009 and 2009-2010 reflects newly funded projects that ACAP originally anticipated beginning in 2008-2009 which were delayed until 2009-2010.

Figure 7a : AIDS Bureau and ACAP Funding by Region



Graph 7a illustrates AIDS Bureau and ACAP funding by region. It shows that the Toronto region receives almost half the funding from these two levels of government. The figure for Toronto region includes the funding for 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 in the Toronto Region because a significant number of the clients they serve are in that area.

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

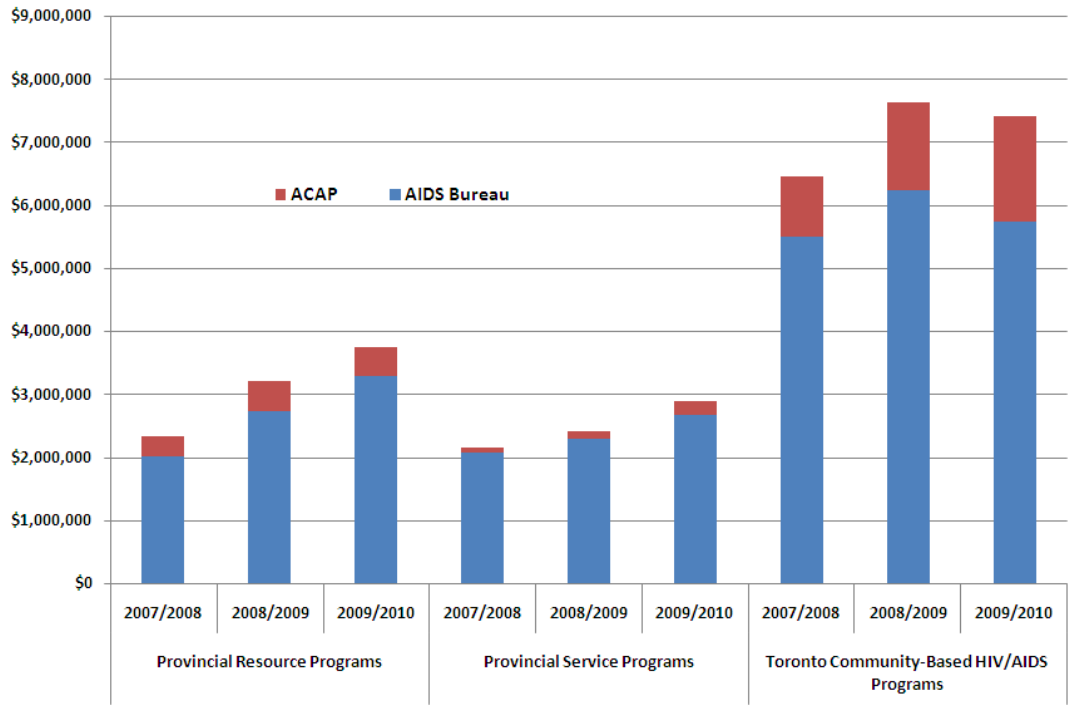


Figure 7b shows the total amount of funding to programs located in Toronto, including provincial resource programs. The drop in AIDS Bureau funding for community-based HIV/AIDS programs in Toronto in 2009-10 is due to a transfer of AIDS Bureau funds to support the work of the Gay Men's Sexual Health Alliance from the AIDS Committee of Toronto to the Ontario AIDS Network. This transfer did not result in any loss of services in Toronto.

Figure 7c : AIDS Bureau and ACAP Funding (2009/2010) vs HIV Cumulative Diagnoses (1985-2008) by Region

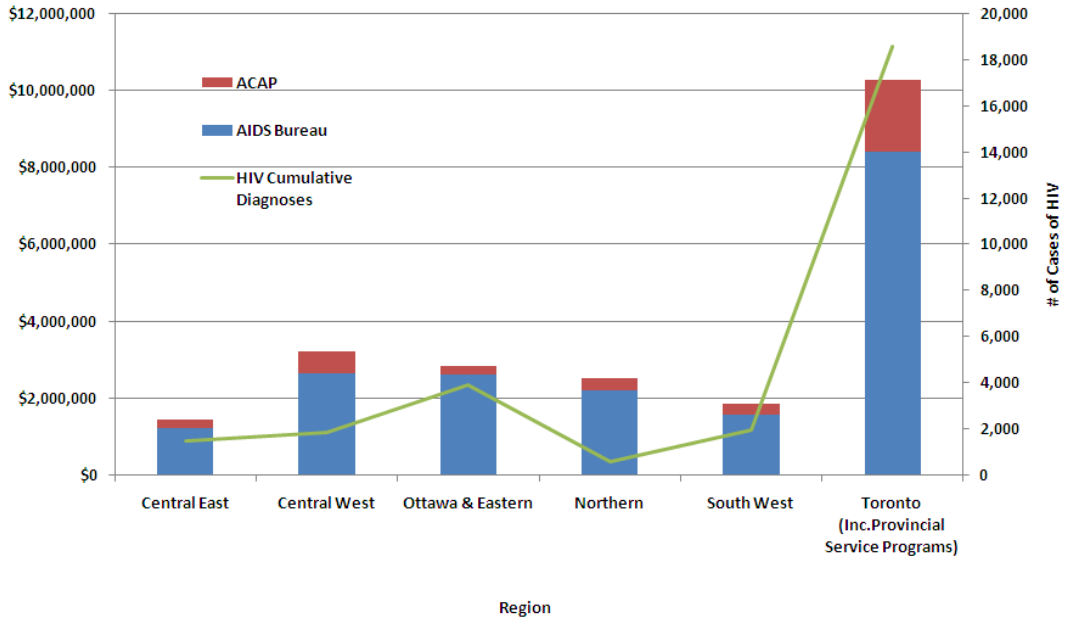
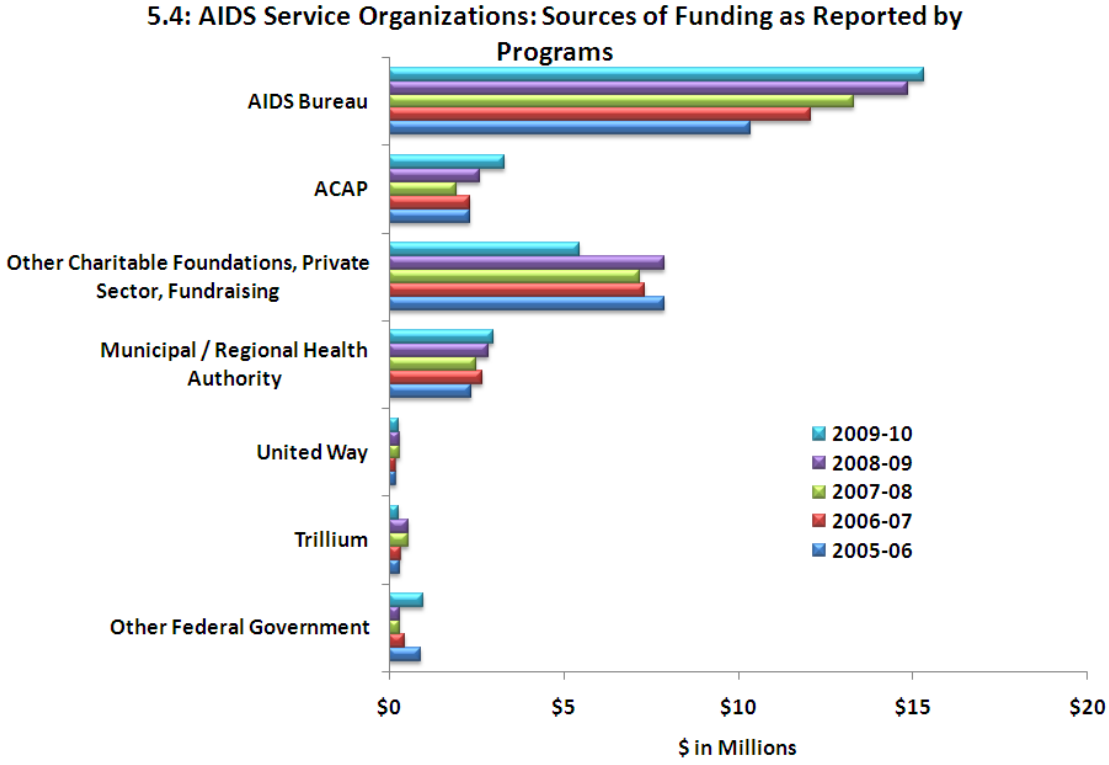


Figure 7c looks at the relationship between funding levels and prevalence of HIV by region for the year 2008, which is the most recent year for which we have HIV prevalence data. It shows that, in four of the six regions, the level of funding is relatively consistent with HIV prevalence. In the other two – Northern and Central West – funding is higher than prevalence. This is consistent with previous year's data.

Note: Prevalence rates used in this document are based on where people were tested as opposed to where they actually live.

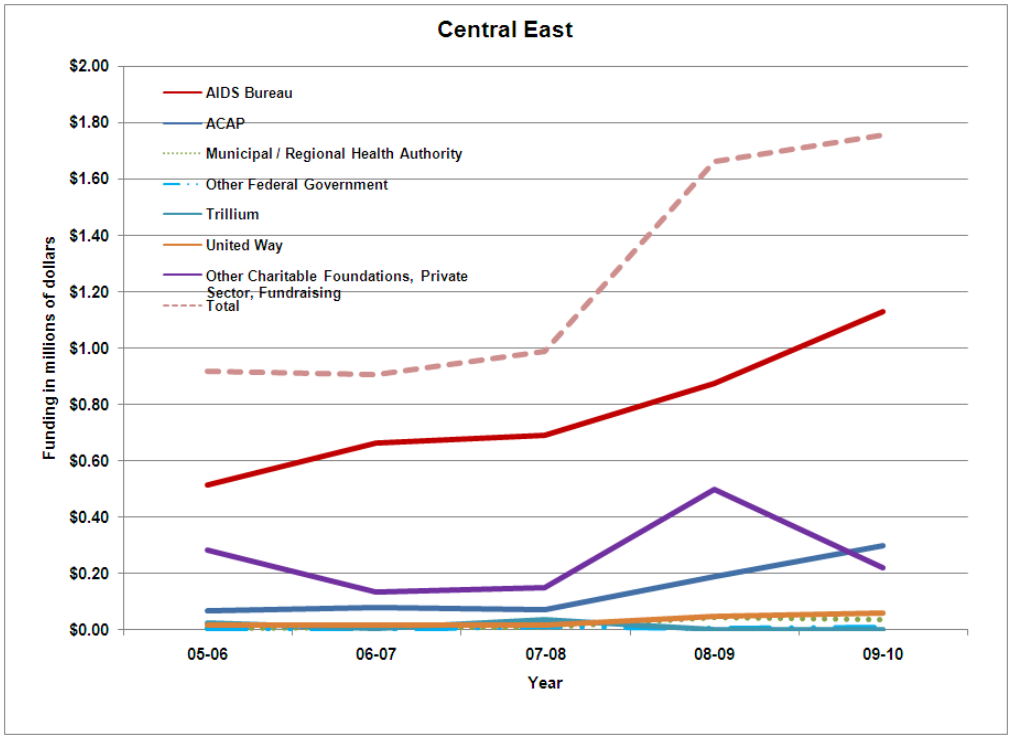
Sources of Funding Vary by Region

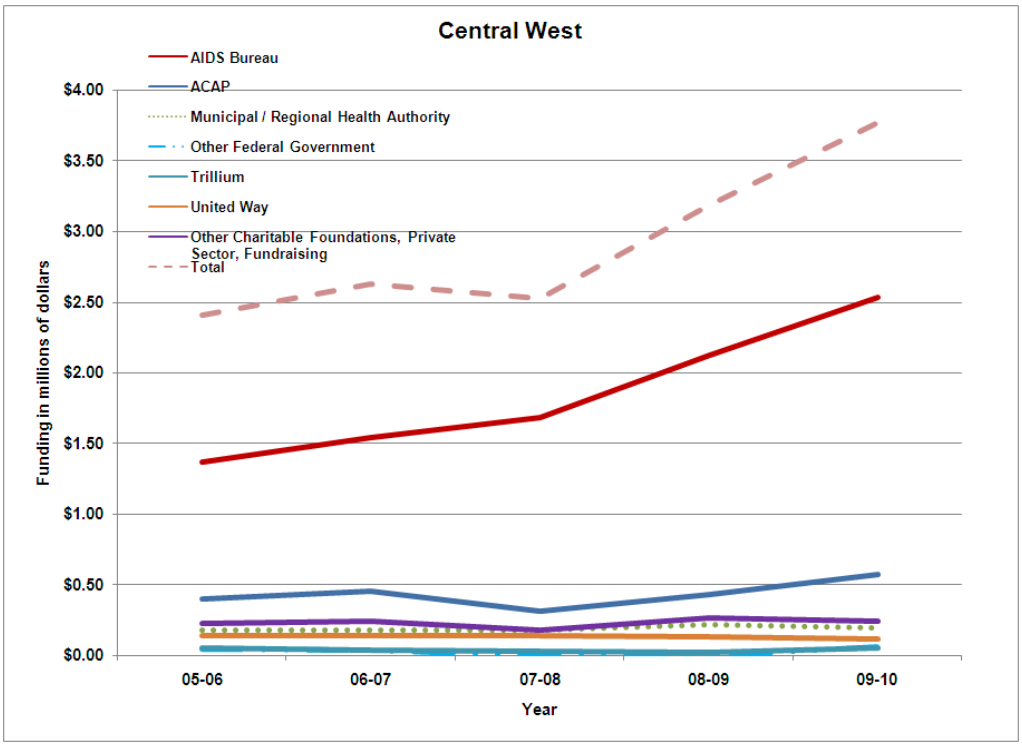
Community-based AIDS service organizations (unlike many of the other organizations that have HIV programs); seek funding to support their programs from a number of sources in addition to the AIDS Bureau and ACAP, such as municipal governments and/or regional health authorities, the United Way, and other government funding programs. Many programs also fundraise in their communities through special events such as AIDS Walk for Life and others.

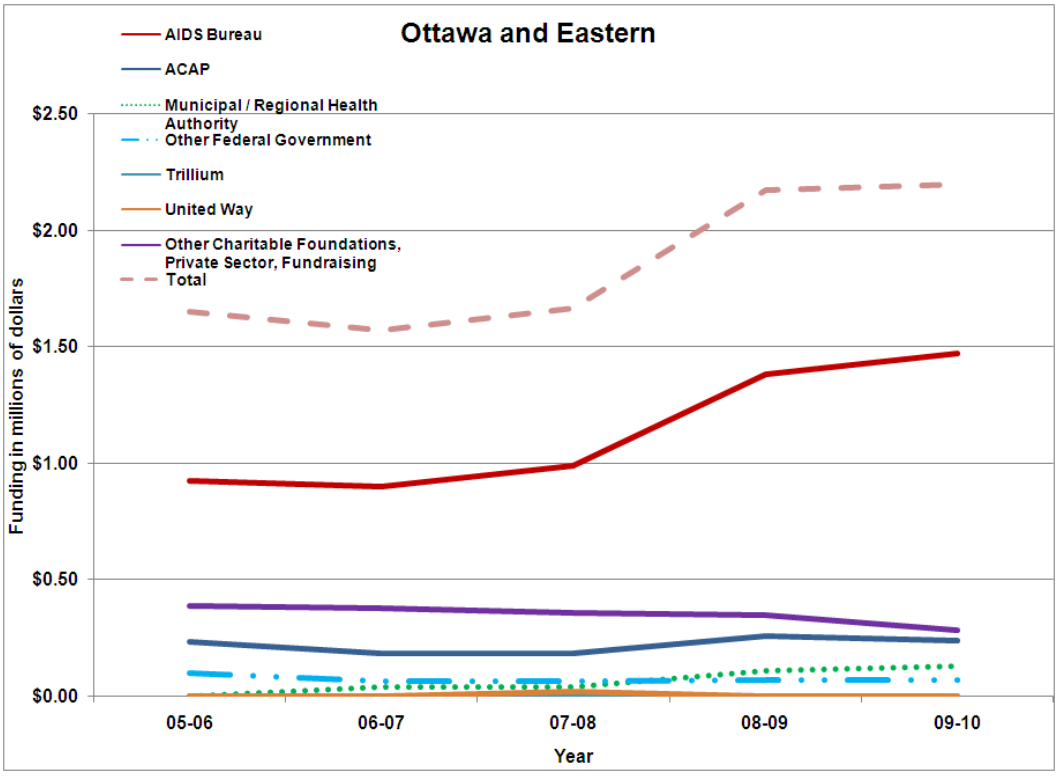


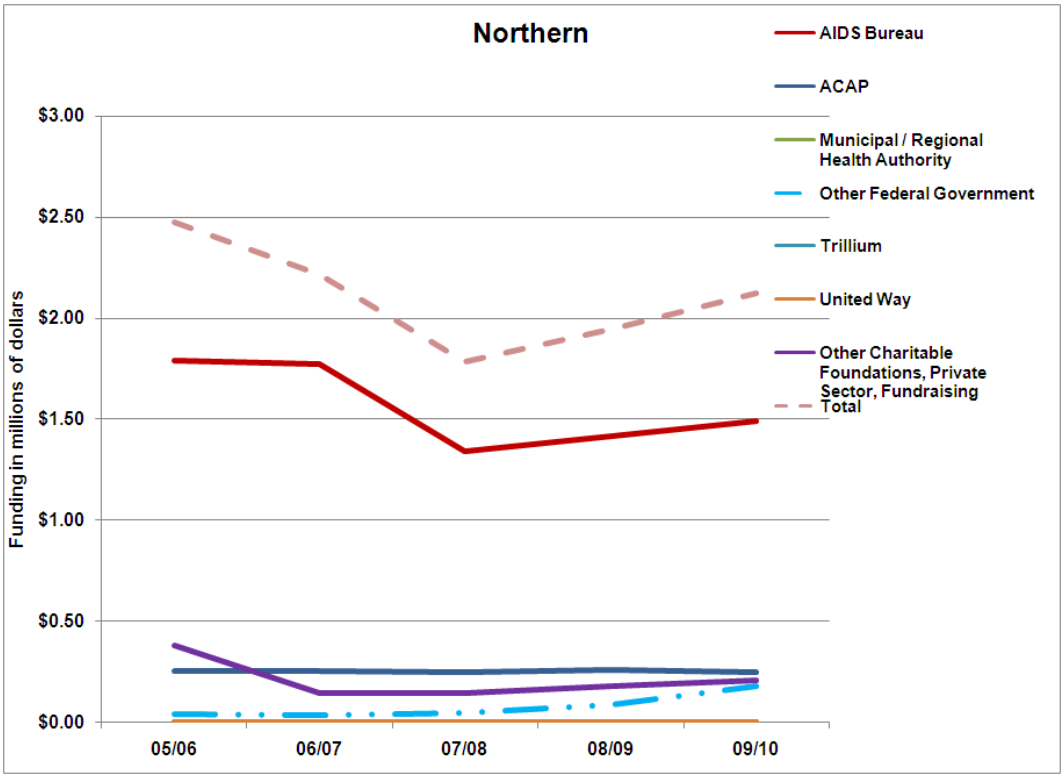
As the following regional funding breakdown illustrates (Figure 5.5) programs in certain regions – such as Toronto, Ottawa, Central West and South West – are more likely to receive some funding from their municipal government or regional health authority, while programs in the Northern and Central East regions are mainly dependent on AIDS Bureau and ACAP funding. It would be interesting to identify the strategies programs have used to engage/secure ongoing funding from their local government or LHIN to see whether they could be used effectively in other parts of the province. Programs in Toronto tend to fundraise a larger proportion of their budgets (although less in 2009-10 than in previous years).

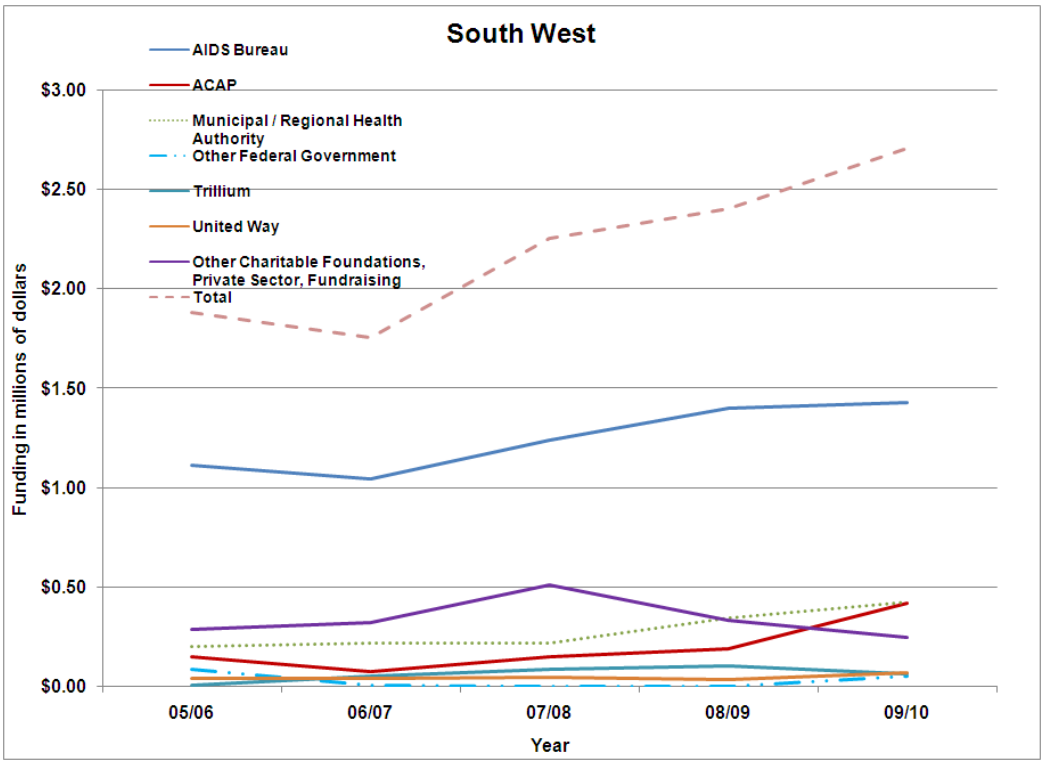
5.5b: AIDS Service Programs: Sources of Funding by Health Region

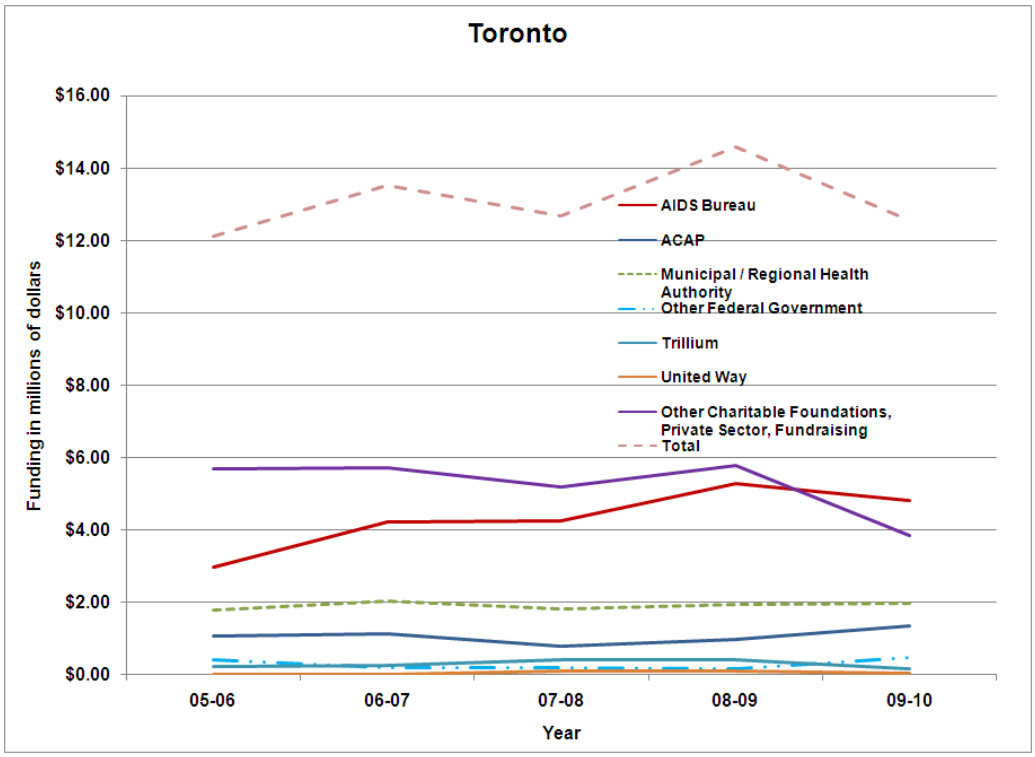




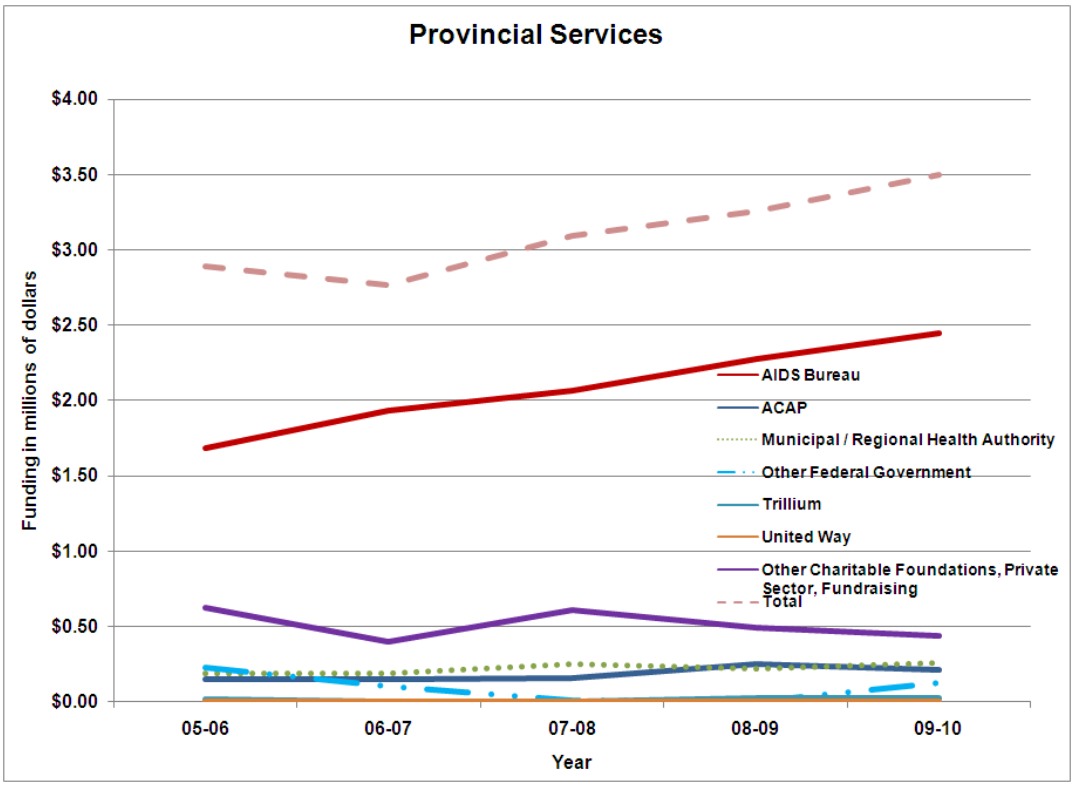

Ottawa and Eastern
AIDS Bureau
ACAP
Municipal / Regional Health Authority
Other Federal Government
Trillium
United Way
Other Charitable Foundations, Private Sector, Fundraising
Total
$2.50
$2.00
$1.50
$1.00
$0.50
$0.00
Funding in millions of dollars
05-06
06-07
07-08
08-09
09-10
Year


Northern
AIDS Bureau
ACAP
Municipal / Regional Health Authority
Other Federal Government
Trillium
United Way
Other Charitable Foundations, Private Sector, Fundraising
Total
$3.00
$2.50
$2.00
$1.50
$1.00
$0.50
$0.00
Funding in millions of dollars
05/06
06/07
07/08
08/09
09/10





Note: The drop in funding for community-based HIV/AIDS programs in Toronto in 2009-10 is due to a transfer of AIDS Bureau funds, to support the work of the Gay Men's Sexual Health Alliance, from the AIDS Committee of Toronto to the Ontario AIDS Network. This transfer did not result in any loss of services in Toronto.



Half the Programs Report Decrease in Fundraising

In 2009, the 30 programs that raise funds in their communities reported a decrease in income from fundraising to the lowest level in the past five years (see Figure 5.4). A closer look at the data revealed that about 12 of the organizations saw a slight increase in fundraising and donations while 18 saw a decrease of at least 20% and ten had a drop of more than 45%. A significant proportion of the decline in fundraised dollars was due to the fact that one Toronto-based program did not hold one of its premier fundraising events in 2009-10. Some of the decline is also due to the end of grants from charitable foundations, such as Trillium which gives time-limited grants, as well as a drop in philanthropic support from the private sector and people within their own communities due, perhaps, to the uncertain financial environment.

The extent to which programs depend on fundraised dollars varies significantly across the province. For example, in 2009-10, fundraising accounted for 27% of revenue for three programs, 35% for four programs and 50% or more for two programs.

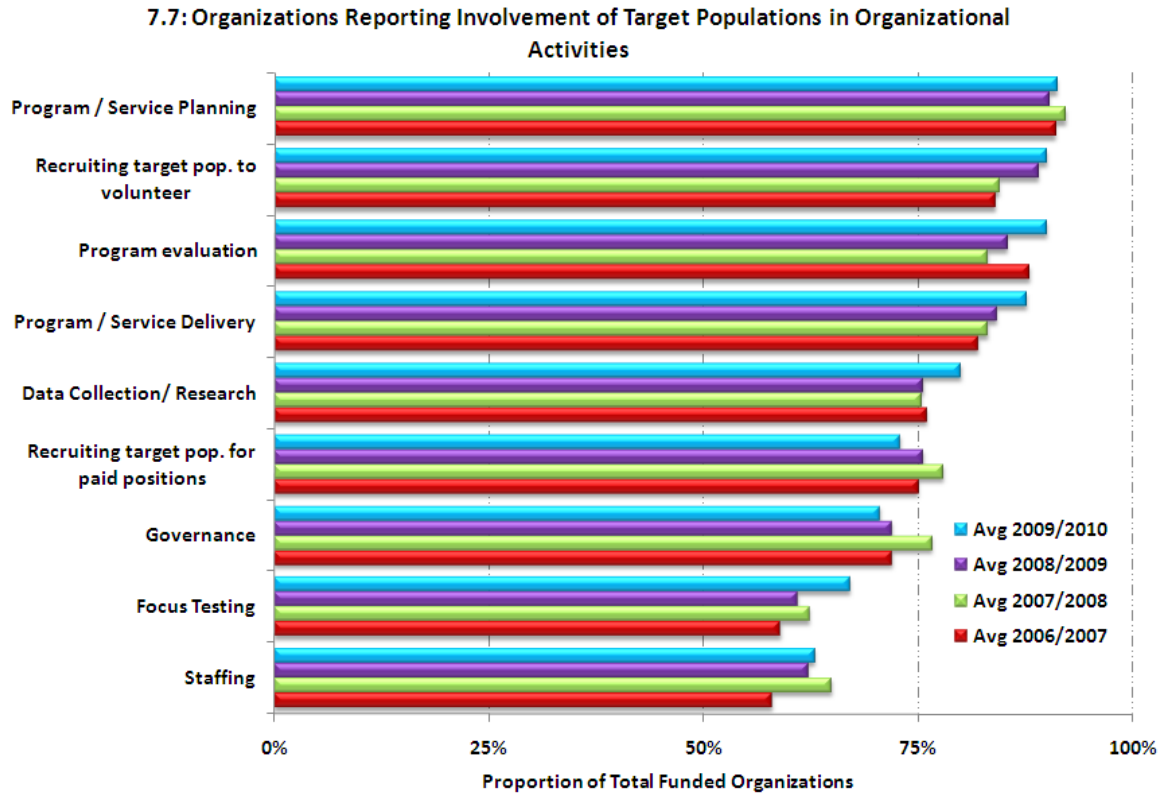
Greater and More Meaningful Involvement of People- With and At-Risk of HIV

As in past years, all programs made efforts to involve people with or at-risk of HIV in their organization. Overall, there has been more focus on the meaningful rather than just greater involvement of people with or at-risk of HIV.

In 2009-10, more organizations reported having people with or at-risk of HIV involved in program evaluation, service delivery, research/data collection and focus testing than in previous years; however, fewer reported having HIV-positive or at-risk people in governance roles or paid staff positions. Due to the ambiguity of the definitions of ‘Target Populations’

(i.e. are these PHAs, IDU peers, other peers, etc?) and their 'involvement' in this section, we will be refining these questions over the next year in order to have a more accurate picture of GIPA, MIPA and peer involvement in programs.

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

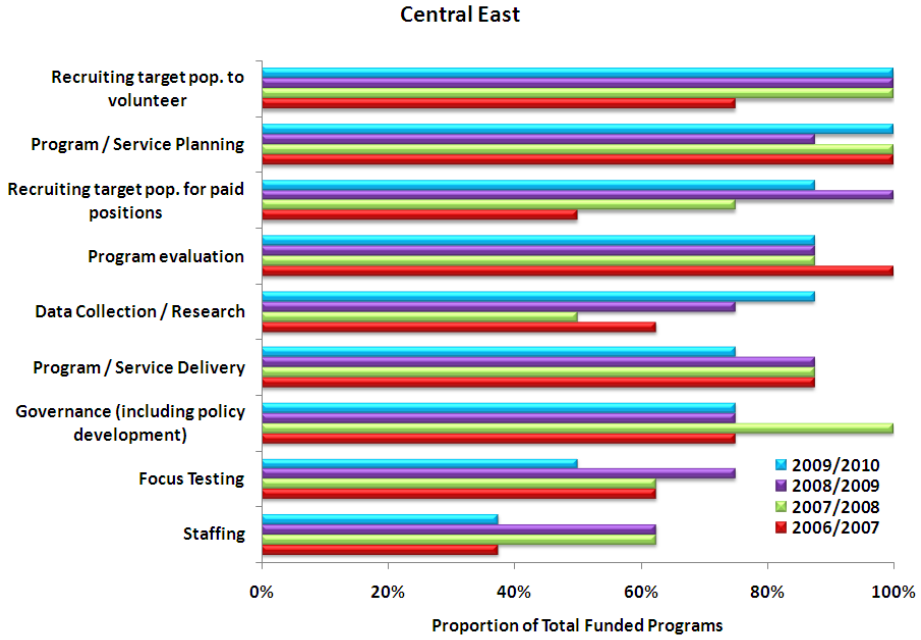


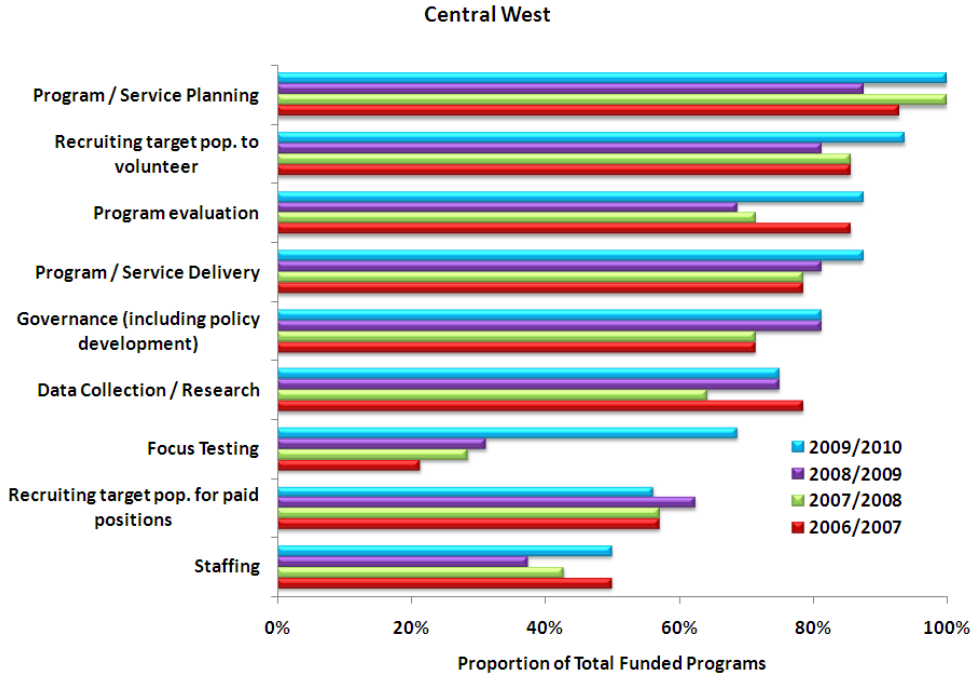
Many organizations continue to experience challenges recruiting people with or at-risk of HIV to their boards. Programs report that the barriers to meaningful involvement are similar to those that keep clients from accessing services, such as lack of adequate transportation and the fear of being identified as someone with HIV.

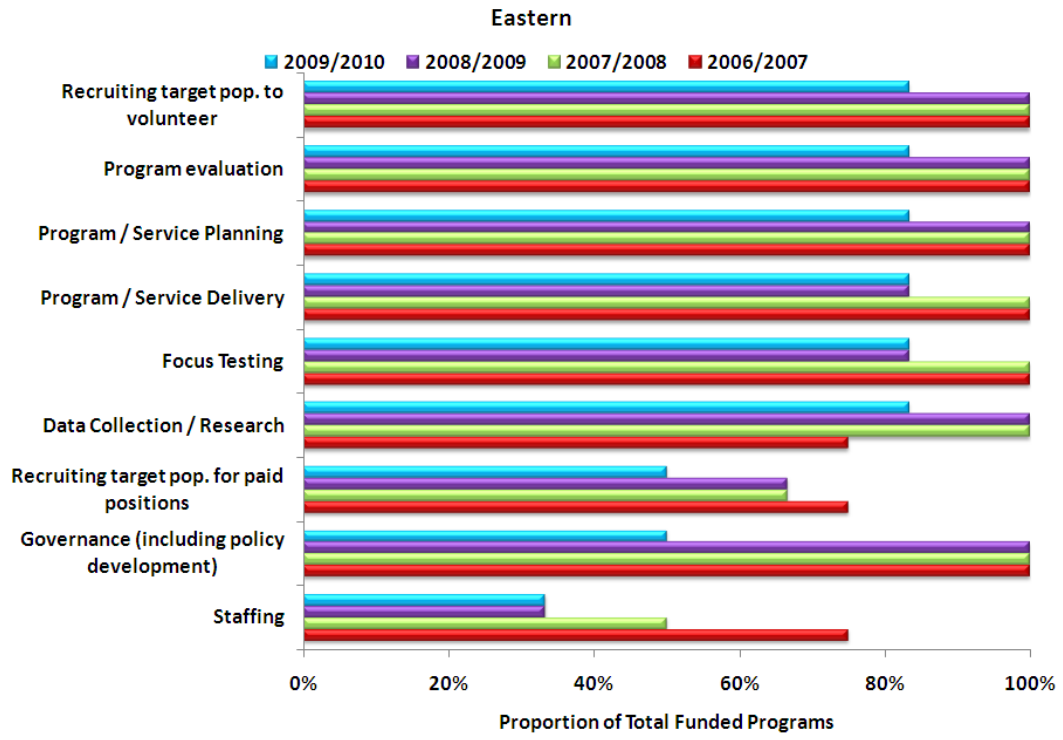
To overcome these challenges, some organizations are involving clients in innovative ways such as creating an advisory committee for their Support Services program. This appears to be less intimidating for clients than being a board member but still allows for meaningful input into program development and delivery. Others are using focus groups, surveys, needs assessments and other evaluation methods to promote greater involvement. As we track efforts to involve target populations in our work, the information may help identify the types of activities that lead to greater and more meaningful involvement.

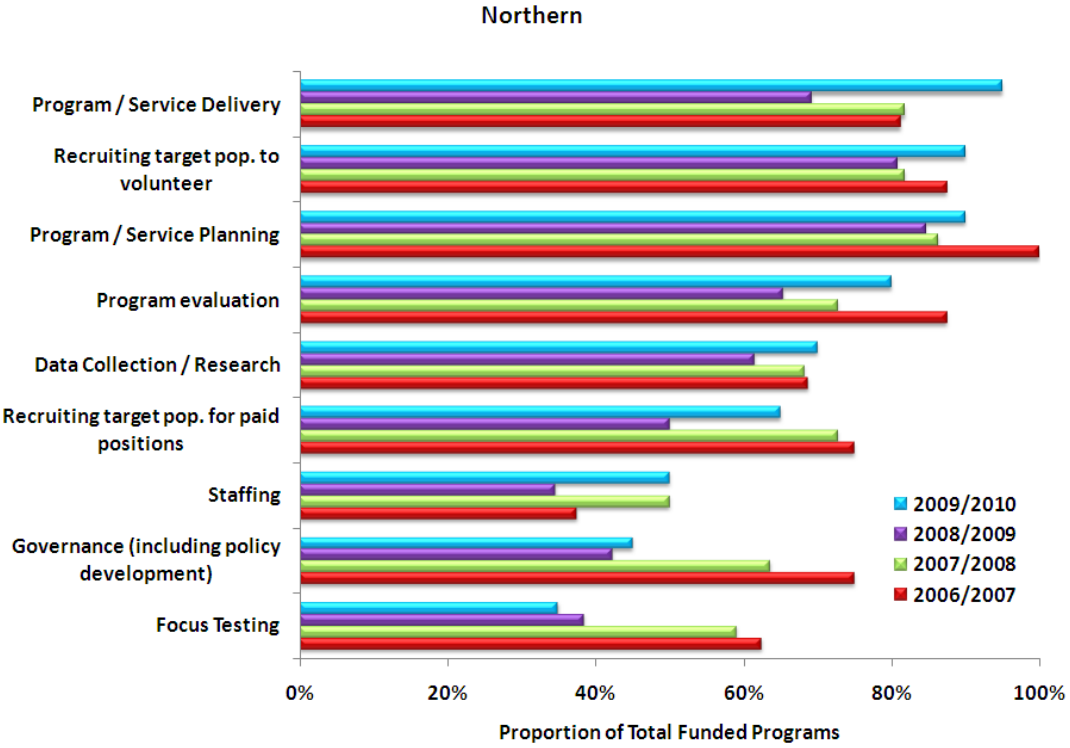
Regional Breakdown for Chart 7.7

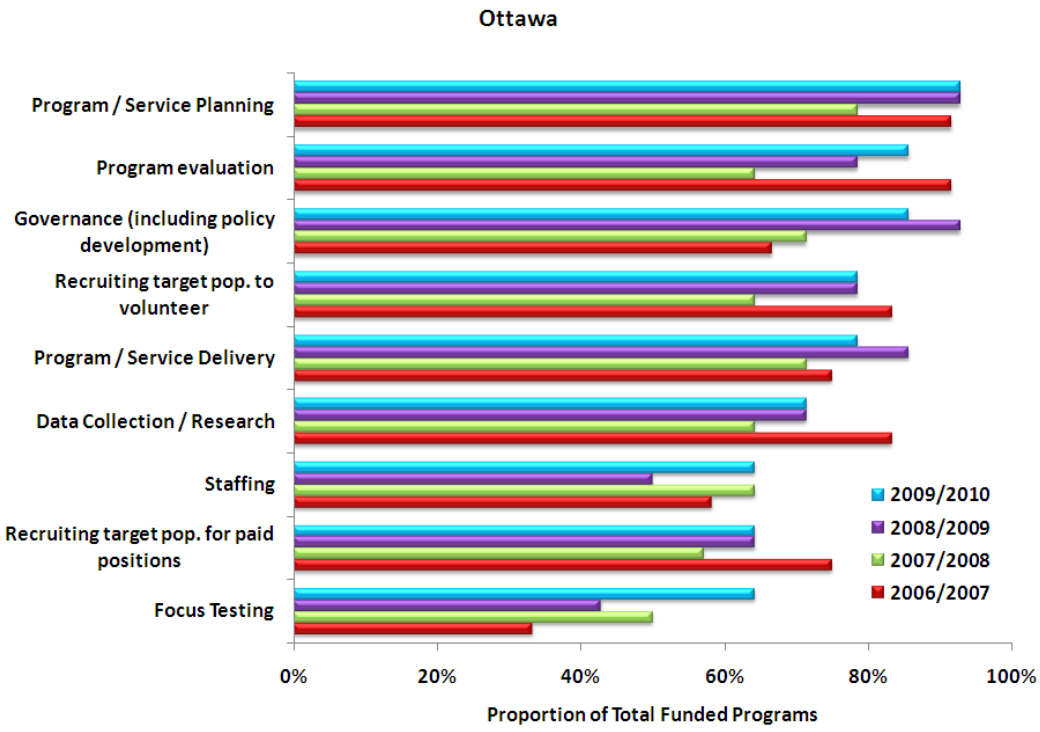
As the following regional breakdowns indicate, most regions primarily are involving their target populations through recruitment for paid or volunteer positions, and participation in program planning and evaluation and service delivery. Ottawa and Central West have a somewhat greater emphasis on recruiting for governance while Central East, Eastern and Northern involve their target populations through recruiting them to volunteer and in program planning.

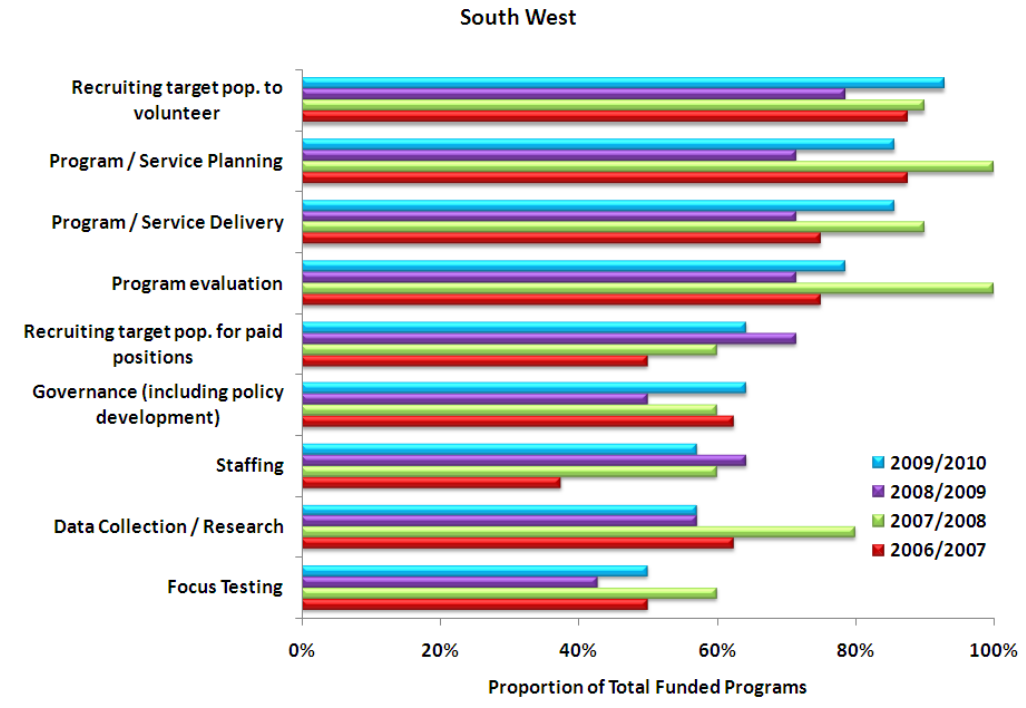




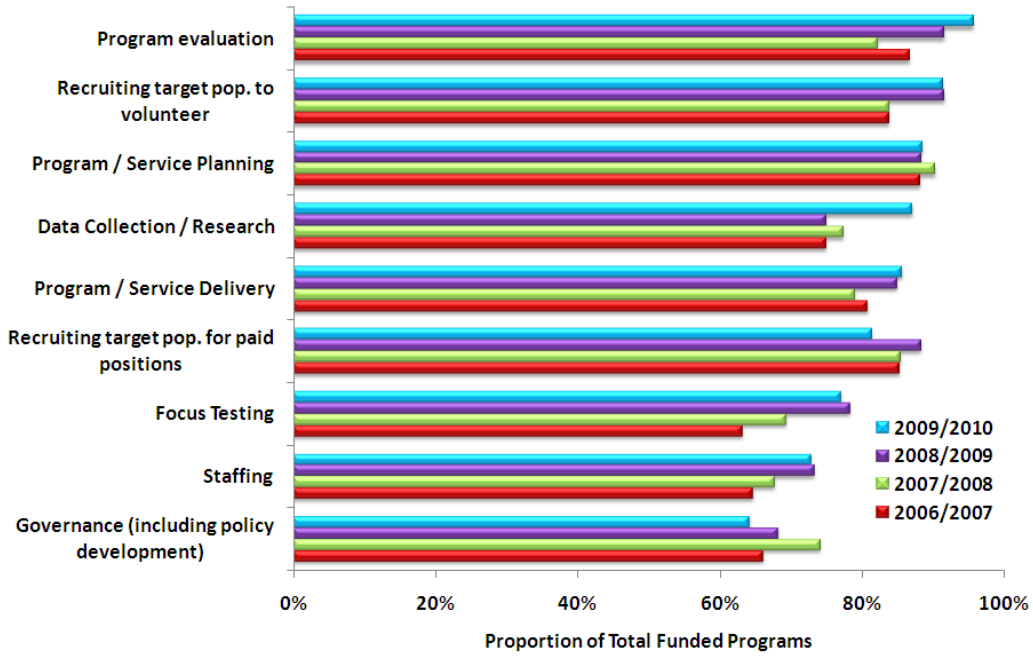

Eastern
2009/2010
2008/2009
2007/2008
2006/2007
Recruiting target pop. to volunteer
Program evaluation
Program / Service Planning
Program / Service Delivery
Focus Testing
Data Collection / Research
Recruiting target pop. for paid positions
Governance (including policy development)
Staffing
0%
20%
40%
60%
80%
100%
Proportion of Total Funded Programs


Northern
Program / Service Delivery
Recruiting target pop. to volunteer
Program / Service Planning
Program evaluation
Data Collection / Research
Recruiting target pop. for paid positions
Staffing
Governance (including policy development)
Focus Testing
2009/2010
2008/2009
2007/2008
2006/2007
0%
20%
40%
60%
80%
100%
Proportion of Total Funded Programs

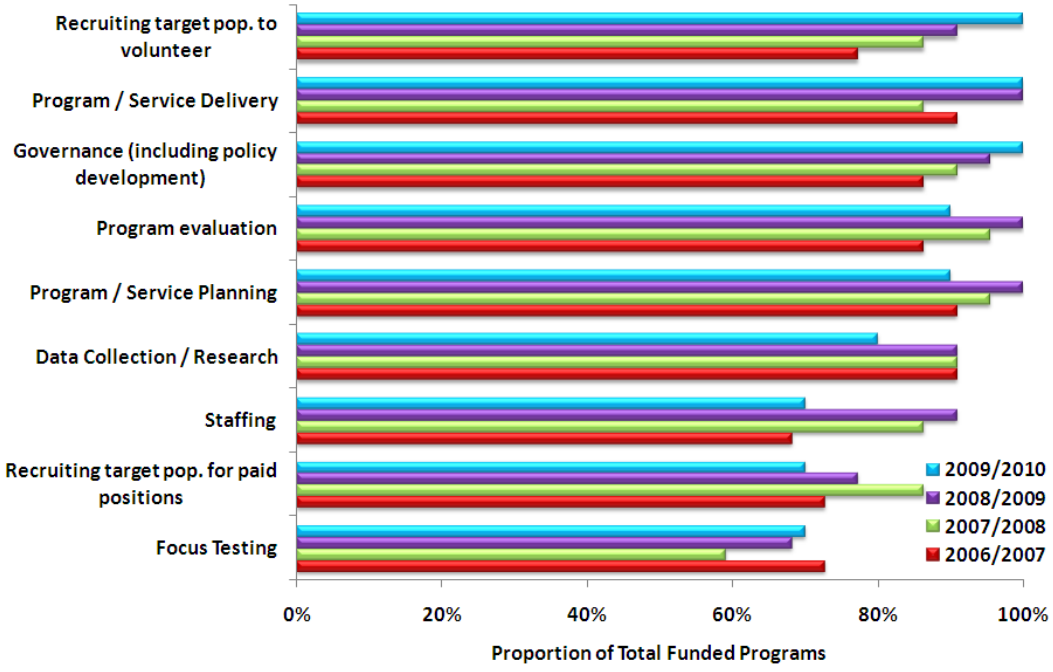

Ottawa
Program / Service Planning
Program evaluation
Governance (including policy development)
Recruiting target pop. to volunteer
Program / Service Delivery
Data Collection / Research
Staffing
Recruiting target pop. for paid positions
Focus Testing
2009/2010
2008/2009
2007/2008
2006/2007
0%
20%
40%
60%
80%
100%
Proportion of Total Funded Programs


South West
Recruiting target pop. to volunteer
Program / Service Planning
Program / Service Delivery
Program evaluation
Recruiting target pop. for paid positions
Governance (including policy development)
Staffing
Data Collection / Research
Focus Testing
2009/2010
2008/2009
2007/2008
2006/2007
0%
20%
40%
60%
80%
100%
Proportion of Total Funded Programs

Toronto



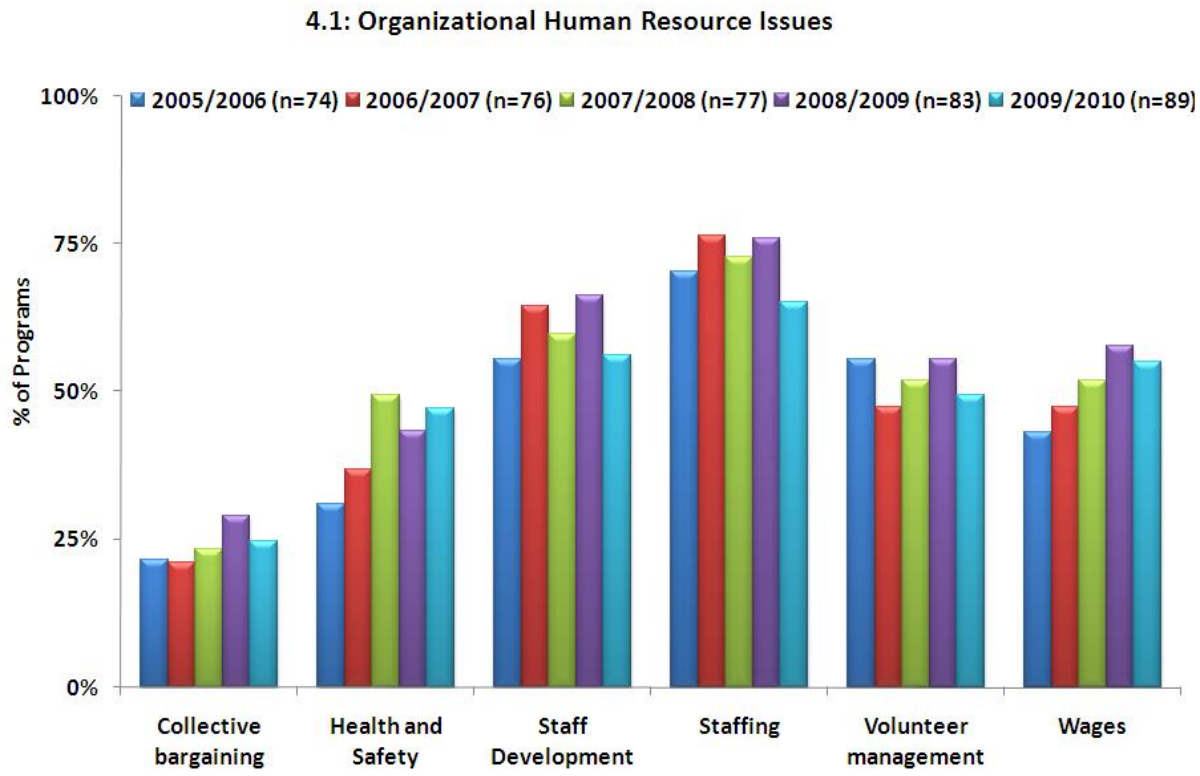
Provincial Services



Changes in Human Resource Management

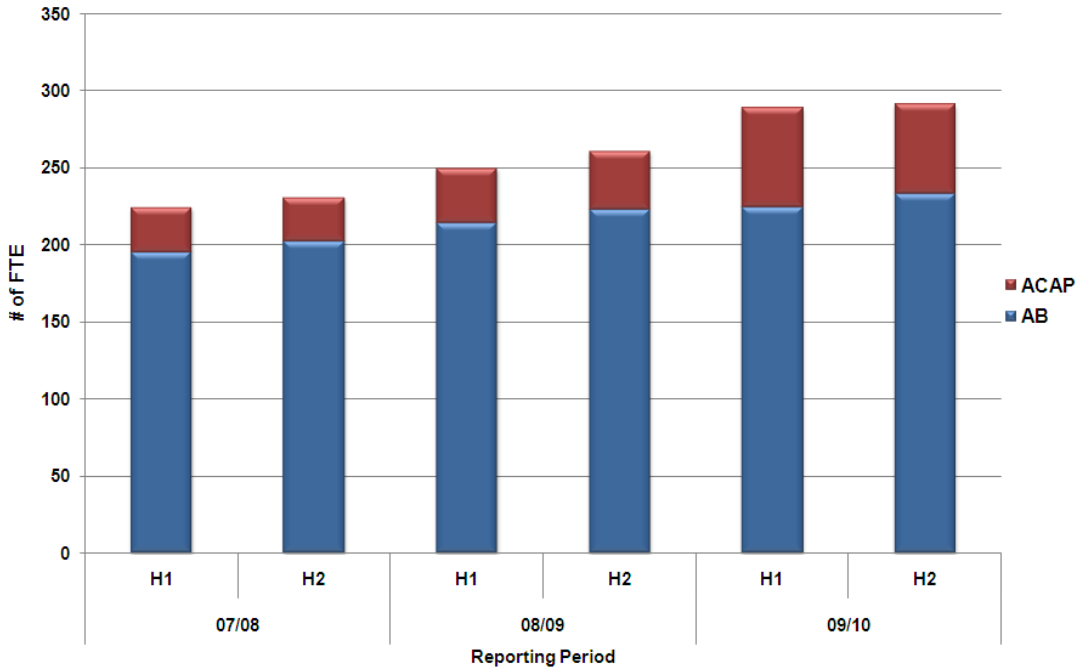
OCHART question 4.1: Human resource problems/issues actively being dealt with during this reporting period

Although organizations continue to report that they are dealing with a range of HR issues - including staff off due to illness or on short or long-term leave - there was a drop in the proportion of organizations reporting staffing and staff development issues. This may indicate that more programs are developing the capacity to manage HR issues.



It may also be due to the impact of having more positions. When we look at the number of full-time equivalent positions funded by the AIDS Bureau and ACAP over the past three years (Figure 2.2b), we see a steady increase from just over 200 in 2007-08 to almost 300 in 2009-10; or about 50%. Part of this increase is due to new ACAP projects but there has also been a steady increase in the number of ongoing full-time equivalent (FTE) positions funded by the AIDS Bureau. H1 and H2 refer to the first (April to September) and second (October to March) reporting periods for OCHART.

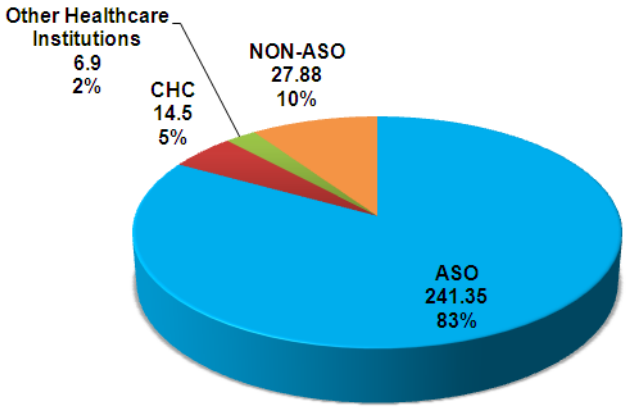
2.2b - Total AIDS Bureau and ACAP Funded FTE



Most of the full-time equivalent positions - 241 or 83% - are in AIDS service organizations, which tend to be smaller organizations with less administrative or HR infrastructure than a CHC or a hospital. The increase in new positions comes from funding provided by the AIDS Bureau and ACAP.

Figure 2.2a shows that the large majority (83%) of positions funded in Ontario are through the ASO sector. Although there has been some distribution of funding to other kinds of health and organizations, government funders continue to support the stabilization and growth of the ASO sector.

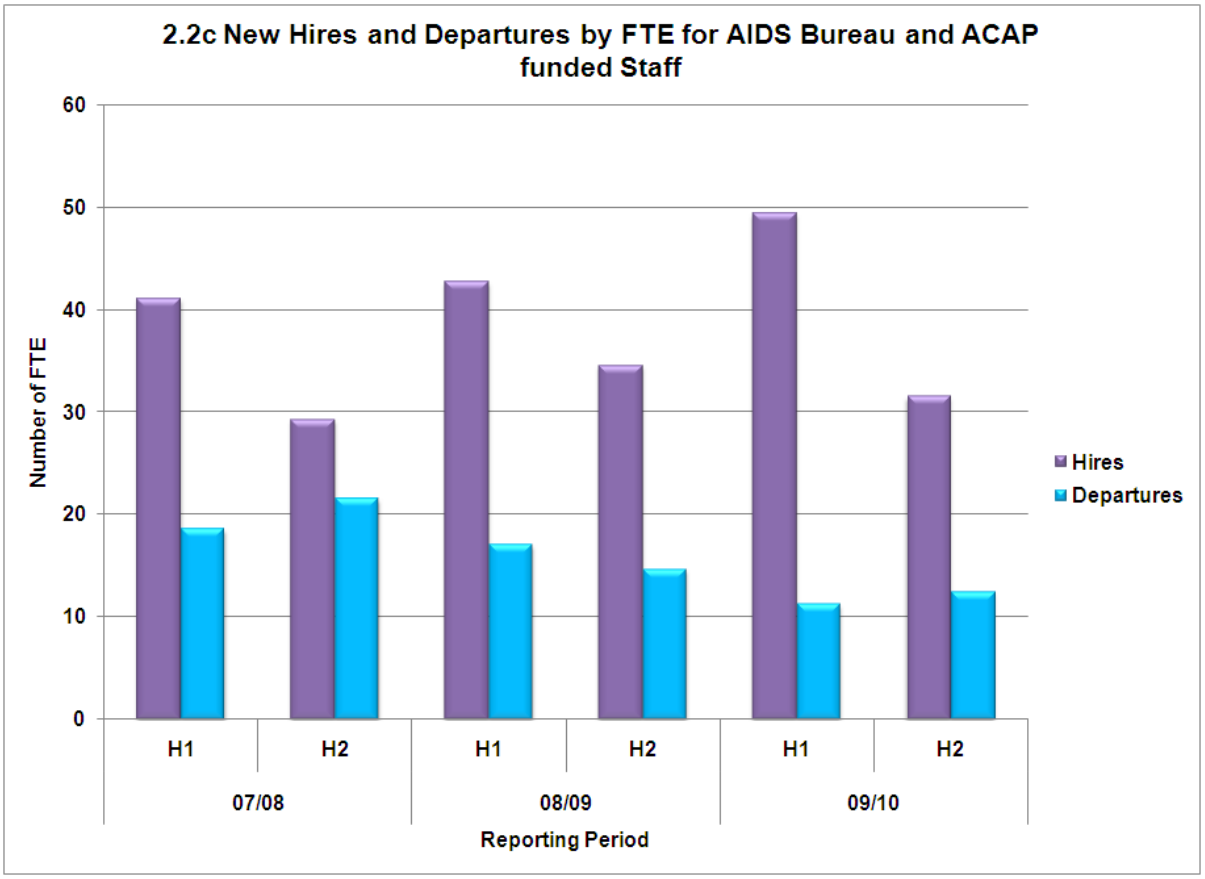
2.2a: Proportion of Total FTE by Agency Type 2009 H2



While the HR situation is improving and the turnover in positions seems to be lessening, staffing is still an issue. About 48% of the programs 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, and 58% are anticipating staff changes in the 2010-11 year.

Figure 2.2c below shows the number of new hires and departures of FTEs over the past three years. It does appear that the rate of turnover is declining which should lead to more stability and consistent service delivery for programs. What is not clear from this data is how long positions may be open and thus the length of time programs and services may be disrupted.

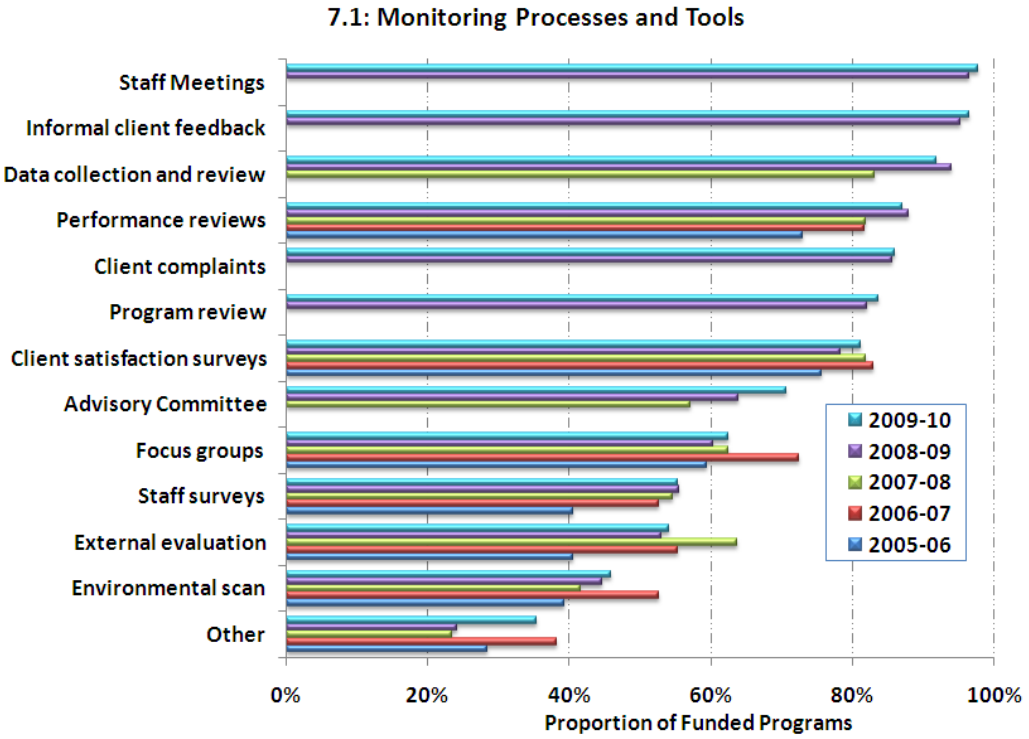
Despite these staffing issues, it appears that programs are able to sustain their activities as there was no significant decrease in the quantity of services delivered over the year.



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?

More than 90% of programs are actively monitoring and evaluating their services in some way. As Figure 7.1 illustrates, most are using staff meetings, informal and formal client feedback (i.e., surveys, complaints) and performance reviews to assess and improve their services. A much smaller proportion are surveying staff or using external evaluation. New categories such as staff meetings and client feedback were added in 08/09.



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:

Hiring a human resources specialist (funded through the Ministry of Training, Colleges and Universities) who helps address many HR priorities.

Conducting a confidential annual staff survey, which proved to be an excellent tool to assess how the organization is doing in terms of staff morale, job satisfaction, and burn-out. Staff also appreciated being asked for feedback and felt they are being valued and heard. The results were used to inform HR and professional development planning. The process created an atmosphere of openness because the information is shared at all levels.
Engaging various stakeholders, including community partners, community members, staff and volunteers, in helping to develop an agency evaluation framework and evaluate its

programs and services. This process helped enhance services, identify best practices, identify gaps in services, and develop appropriate responses to challenges and barriers. It also ensured the program remains client and community-centred and accountable to its stakeholders.

Having their IDU worker be a member of a Mental Health and Street Outreach Service, which helps provide clients with access to a multidisciplinary team that has skills in mental health, spiritual counselling, addiction assessment and counselling, social services and housing.

Creating a local HIV/AIDS network, which played a significant role in the willingness of HIV programs and other agencies in the region to work collaboratively.

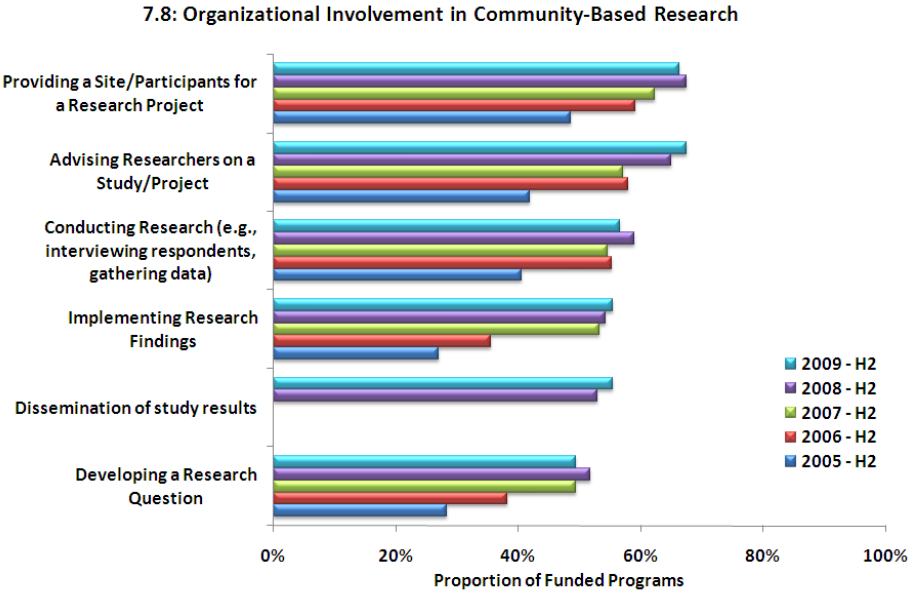
Continuing to build capacity in strengths-based approaches such as Appreciative Inquiry. This is a significant cultural shift from focusing on problem solving and addressing PHAs' deficiencies. As a result, clients, staff and volunteers are more engaged.

Better integration of HIV services with housing, primary care, addictions and mental health, which is helping the program meet clients' complex needs and takes the onus off clients to coordinate their own care.

Increase in Community-Based Research and Evidence-Informed Practice

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

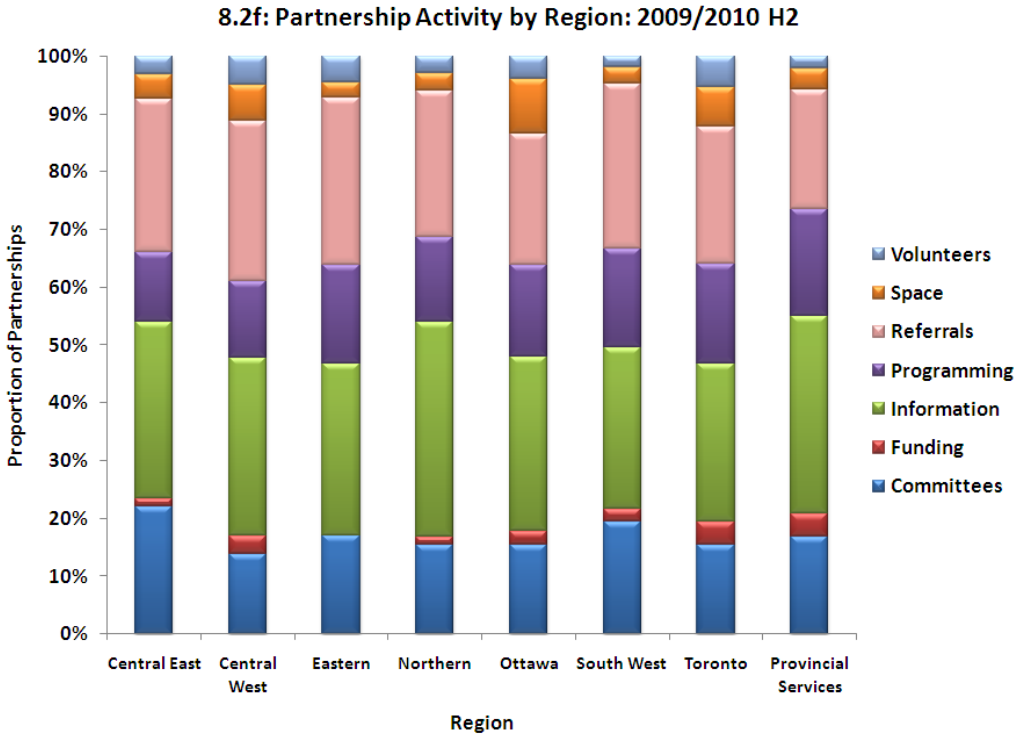
The proportion of programs involved in community-based research continues to increase. About 70% (Figure 7.8) are either working with a researcher on a study or project, or providing a study site or participants. More are actively involved in conducting research, and in implementing and disseminating findings.



Partnerships Focus on Sharing Information and Referrals

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

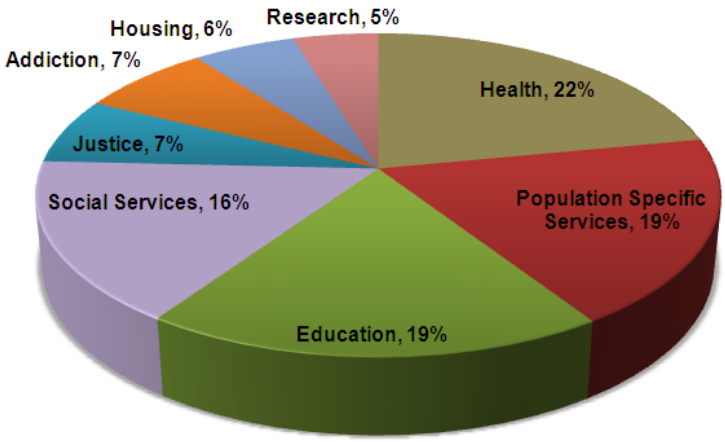
All HIV programs are expected to work in partnership with one another and with other agencies to deliver prevention and support services. Partnerships vary in intensity. Some involve simply the sharing of information while true working relationships often involve the actual sharing of resources, such as space, staff or budgets to achieve common goals. Figure 8.2f shows the proportion of different types of partnerships ASOs and other funded programs reported in the second half of 2009-10. Most partnerships are for the purposes of sharing information and referrals, about 30% involve joint programming and committee work and some are partnerships that involve sharing space, volunteers or funding.



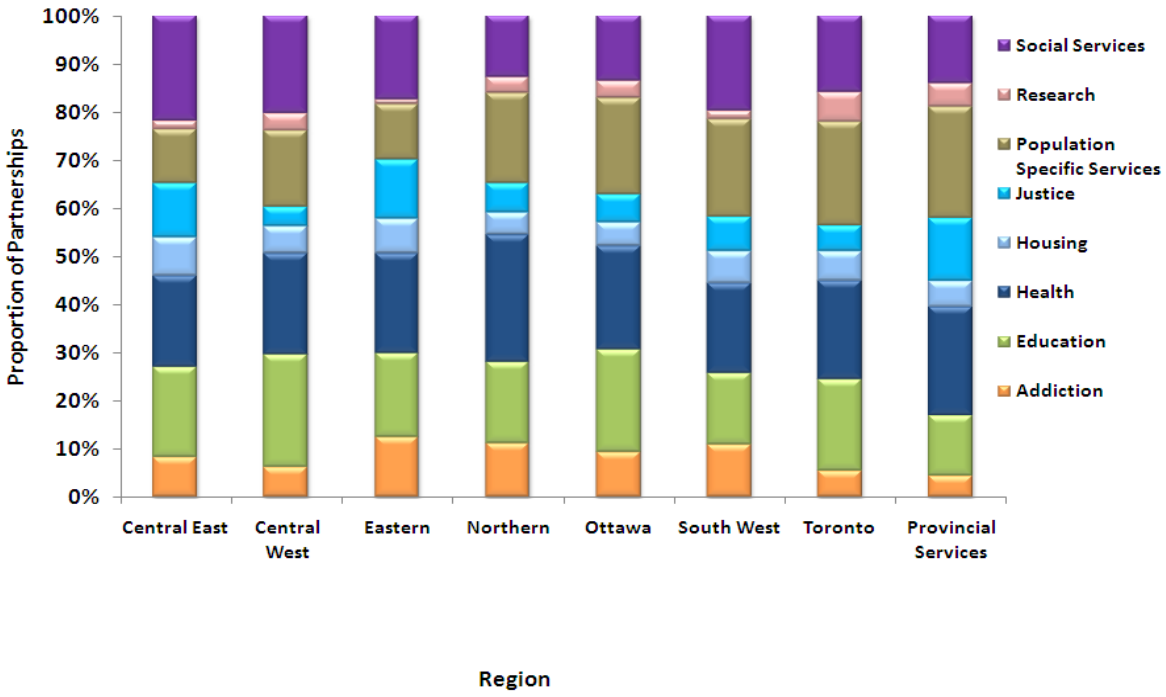
Partners Provide Health, Population-specific, Education and Social Services

As in past years, programs report that most of their partners provide health, education, population specific and social services. A smaller number provide services such as legal, correctional, services for prisoners, addiction, housing and research. (See Figures 8.2e and 8.2g below)

8.2e: Partnerships by Focus - 2009/2010 H2



8.2g: Partnership Focus by Region: 2009/2010 H2



Although programs are asked to update their partnership information for each OCHART reporting period, there has been little change in the data over the past few years. This may mean that OCHART is not an effective way to capture information on how partnerships evolve or their impact. Other methods, such as case studies, may be a more useful way to demonstrate the benefit of different types of partnerships.

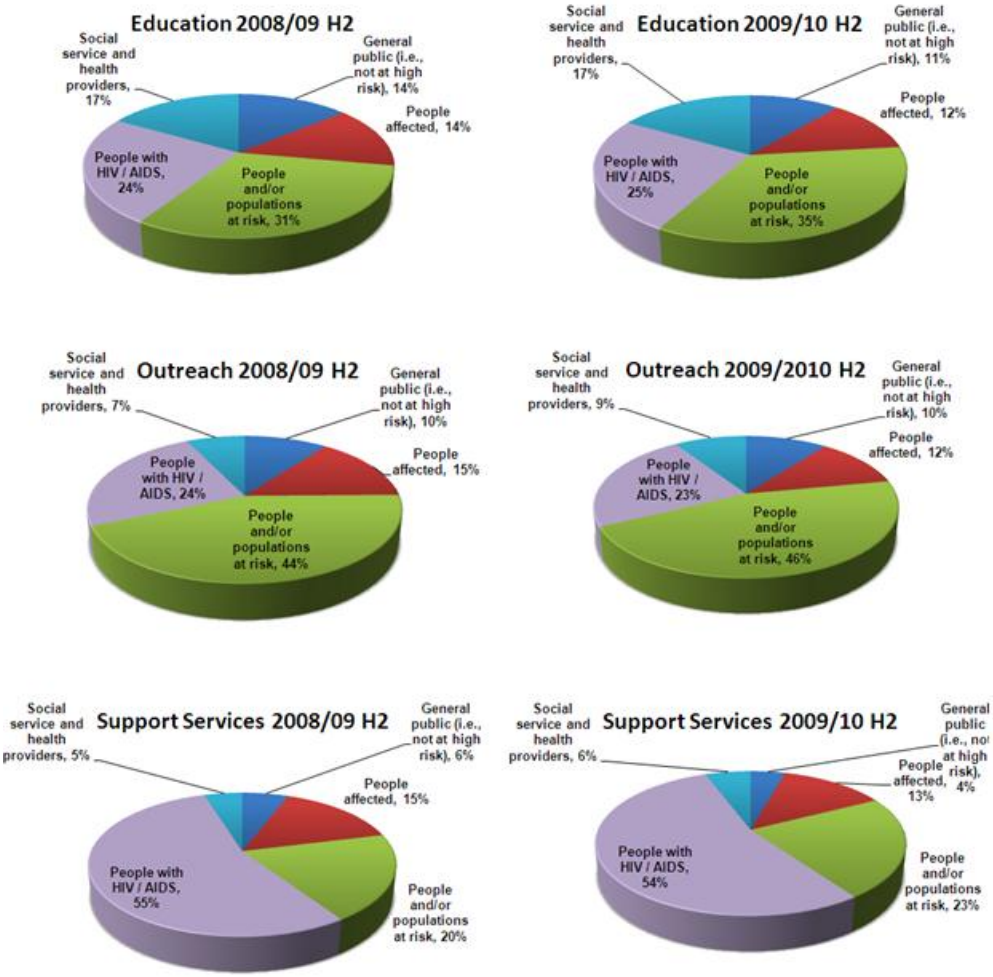
Part III: Who We Serve

Programs Designed to Serve People with HIV and Populations At-Risk

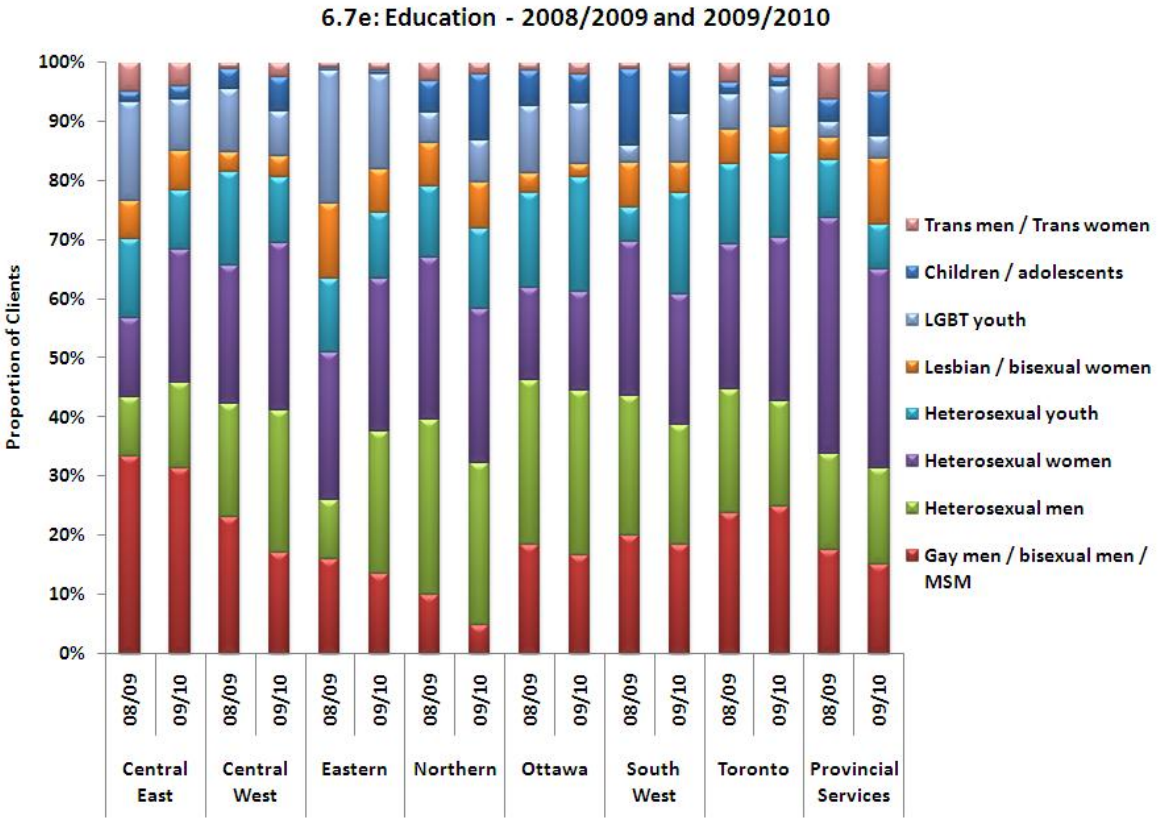
OCHART question 6.6: Please indicate what proportion of your programs are designed to serve or target the following populations

OCHART asks programs to estimate the proportion of target populations they serve. Over the past two years, the target populations for education services have stayed very consistent: people at-risk followed by people with HIV and social service and health providers. The target populations for outreach services have shifted slightly away from people with or at-risk of HIV to people affected and social service and health providers. This is likely due to the changing of the IDU Outreach section, where programs are now reporting this kind of outreach in a different section. The target populations for support services also shifted slightly, with more emphasis being placed on people affected and the general public than in the past. (See Figures 6.6a)

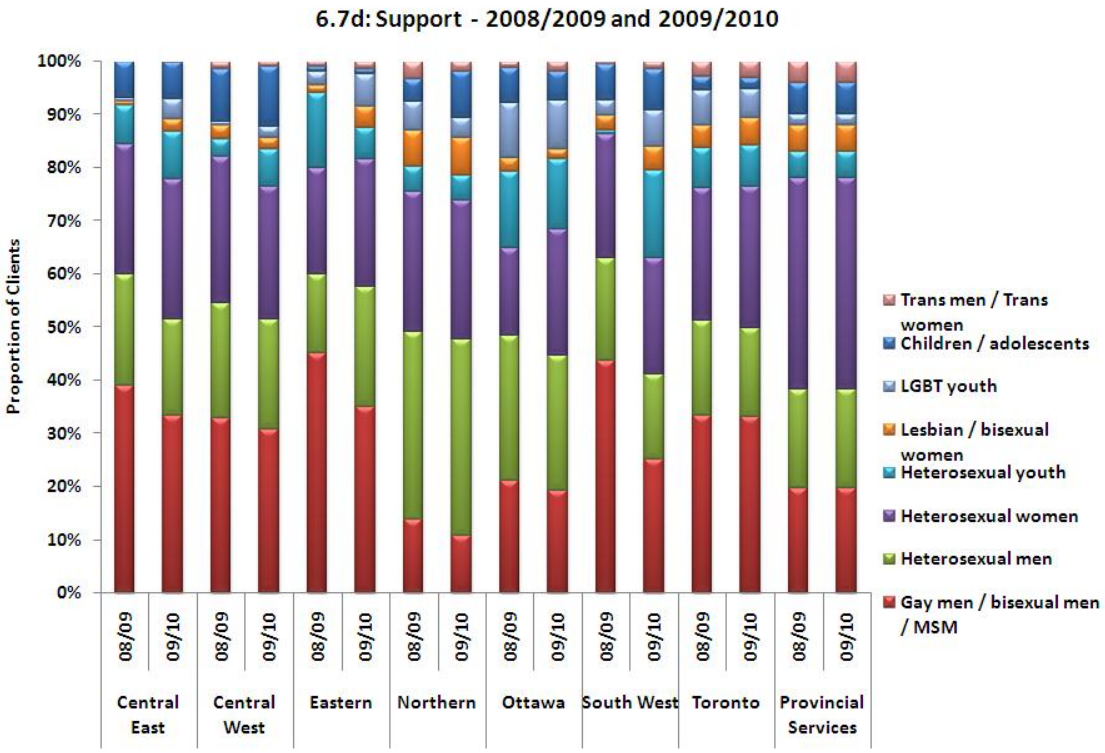
6.6a: Proportion of Target Populations by Service Type: 2008/09 and 2009/10 H2



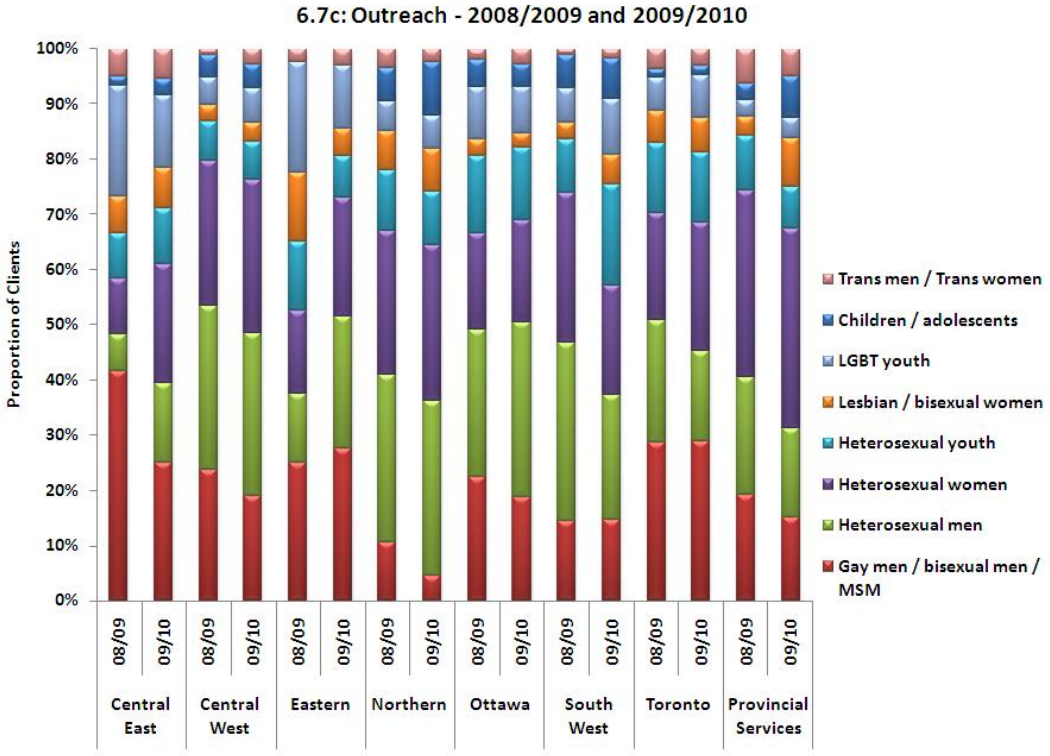
Education programs vary more widely in their target groups by region (Figure 6.7e). Central East and Eastern regions mostly focus on people at-risk and other service providers. Northern and Toronto have similar proportions of education to people at-risk, affected, living with HIV and service providers. The South West targets mainly the general population, which may be driven by their focus on combating stigma and discrimination. Central West focuses a significant amount of its education on people with HIV, which reflects its specific projects. Provincial programs have the stronger focus on people living with HIV, which is likely due to the OAN PHA Leadership program and the Strive to Thrive program of the AIDS Bereavement Project of Ontario.



When it comes to support services (Figure 6.7d), programs in the Eastern region target a larger proportion of people at-risk than other regions. Ottawa and South West focus both on people with HIV and those at-risk. All other regions report focusing more than 50% of their support programs on people with HIV.



In terms of Outreach, almost all regions focus mainly on populations at-risk followed by people living with HIV. Compared to other regions, South West and Eastern report putting more focus on outreach to the general public. This may reflect efforts to create supportive communities for people with HIV and populations at-risk.

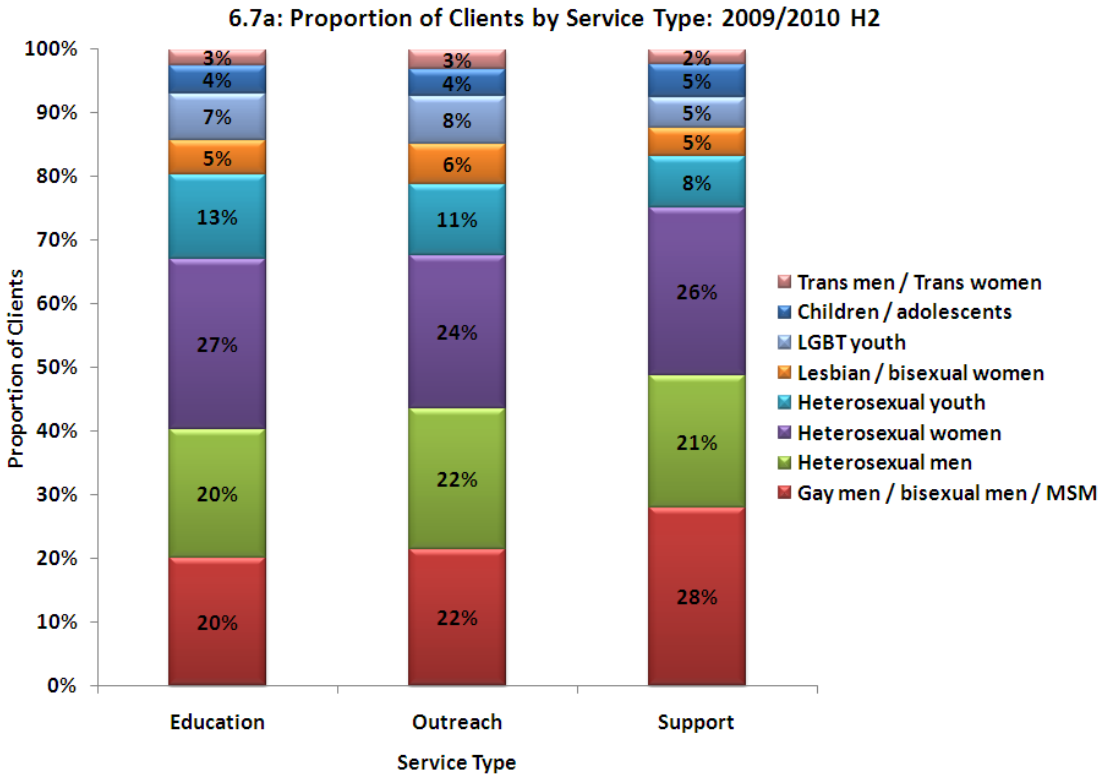


Service Use

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

Programs are also asked to *estimate* the proportion of people using their services who would fall in each of the risk categories used for HIV testing/epidemiology in Ontario. As in past years, 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. Programs report that a much smaller proportion of clients are children and adolescents, heterosexual youth, LGBT youth or trans men and trans women.

Given that almost 50% of new diagnoses are in men who have sex with men, there seems to be a disproportionate focus on heterosexual men and women in education and outreach services. Again though, this is an estimate of populations served and we may see more accurate counting as programs use case management and other systems to better capture their activity data and thus be able to more accurately show who they serve. It would also be interesting to dig deeper into who is accessing and receiving services, when they do and for what reasons.



In most regions outreach work focuses on gay men and heterosexual women and men. Northern region has a much lower proportion of outreach to gay men, which is consistent

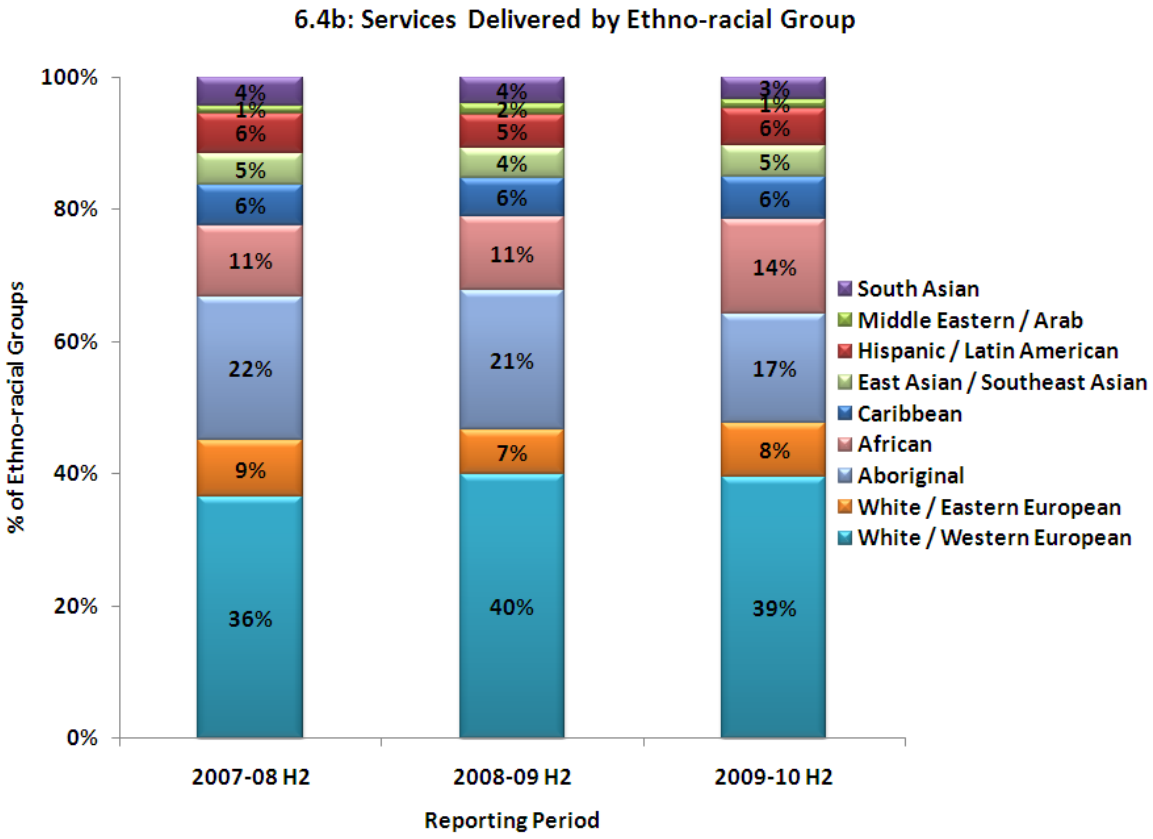
with the epidemiology of HIV in the north where most new diagnoses are in injection drug users – many of whom are women. Outreach to LGBT youth is relatively low in most areas except Central East, Eastern and South West. In OCHART Section 13, programs report their outreach to people who use substances though they are not asked to estimate who they are reaching. It is very challenging to be able to track this sort of demographic information while working in the street or social settings.

Except in the North, support services target gay men and heteosexual adults most often. The South West and Ottawa have relatively higher proportions of heterosexual youth in support programs.

Clients are Predominantly White, Aboriginal, African and Caribbean

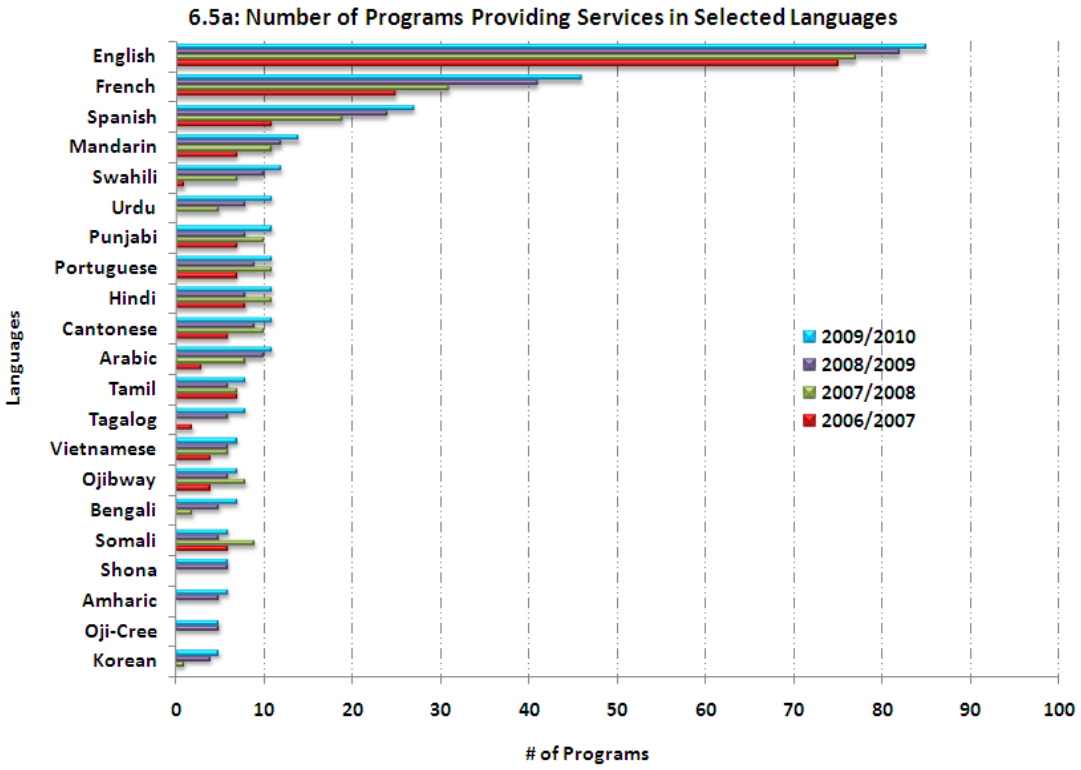
OCHART question 6.4: Please indicate what percentage (approximately) of your services is delivered to each ethno-racial group.

Over the past three years, there has been relatively little change in the ethnic mix of clients that programs report serving (see Figure 6.4b). It should be noted that these data are based on estimates rather than recorded information, and that estimating service users' ethnicity is challenging, particularly for education and outreach services. As programs develop case management systems, they will be able to provide a more accurate service user profile over time.



More Services Offered in Languages Other than English

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



About 50% of programs report that they offer some services or resources in French and more than 25% in Spanish. In 2009-10 (see Figure 6.5a), there were more programs providing services in all languages except Ojibway and Somali.

It is important to note that this does not reflect a program's ability to fully deliver services in these languages.

Often a program's ability to offer services in a language other than English depends on one staff person or a volunteer who speaks that language. This means it may be difficult for people to consistently access information and services in their language of choice.

A Similar Picture of Client Needs in 2009-10

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

Programs are asked to indicate what proportion of clients face various health and social issues. Between 2008-09 and 2009-10 (see Figure 6.8), the main issues remained the same: over 50% of clients struggle with stigma, poverty, unemployment and food insecurity while 30 to 40% are coping with mental health issues, housing instability, problems accessing care, addictions, violence and a lack of life skills.

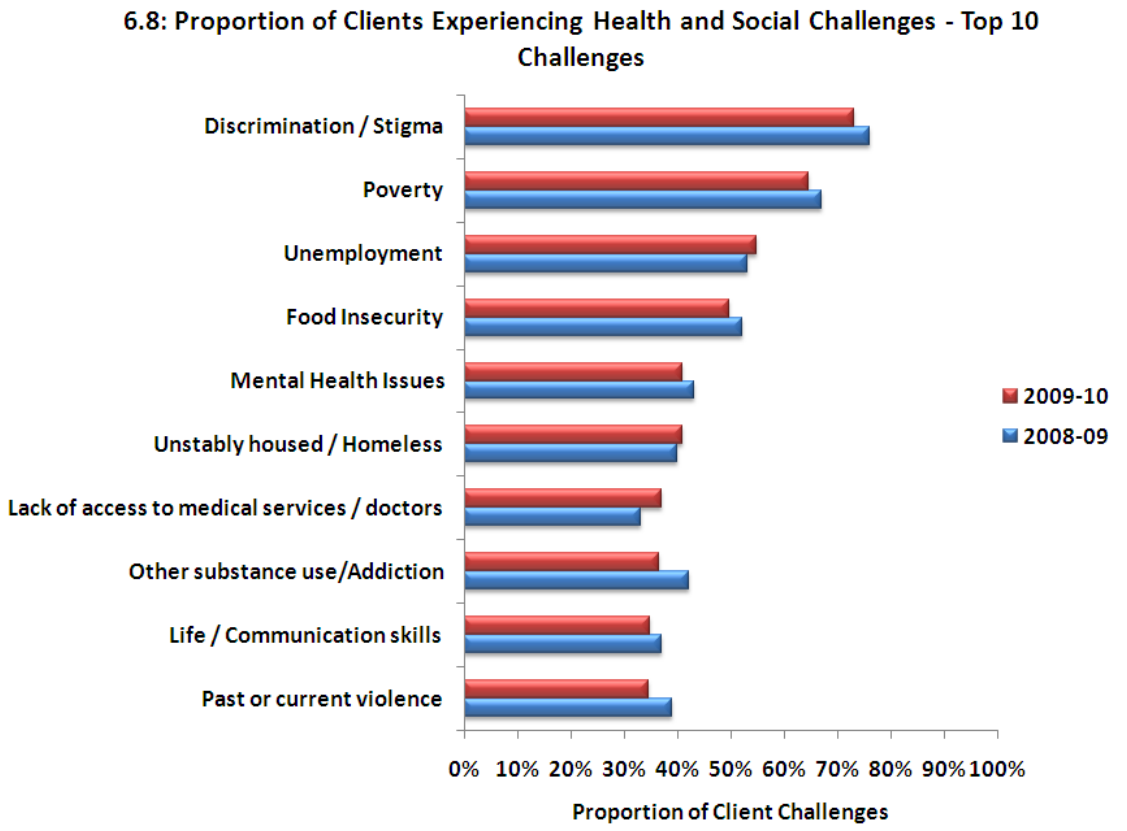


Figure 6.8 again reinforces the complex needs of people with or at-risk of HIV – and the need for partnerships with other service providers to address issues such as unemployment, food security, mental health, addiction and housing.

The regional breakdown of client challenges shows that discrimination/stigma, poverty, unemployment and food security are still the main concerns in all parts of the province. Incarceration is a bigger concern in Eastern, Northern and Ottawa than in other regions. Still troubling is lack of access to medical care noted in Central East, Ottawa and the Northern Regions.

Overall, clients in the Eastern and Northern Region appear to have the greatest overall needs, which may be a reflection of the challenges associated with accessing services in large rural and/or remote geographic areas.

Part IV: Our Programs and Services

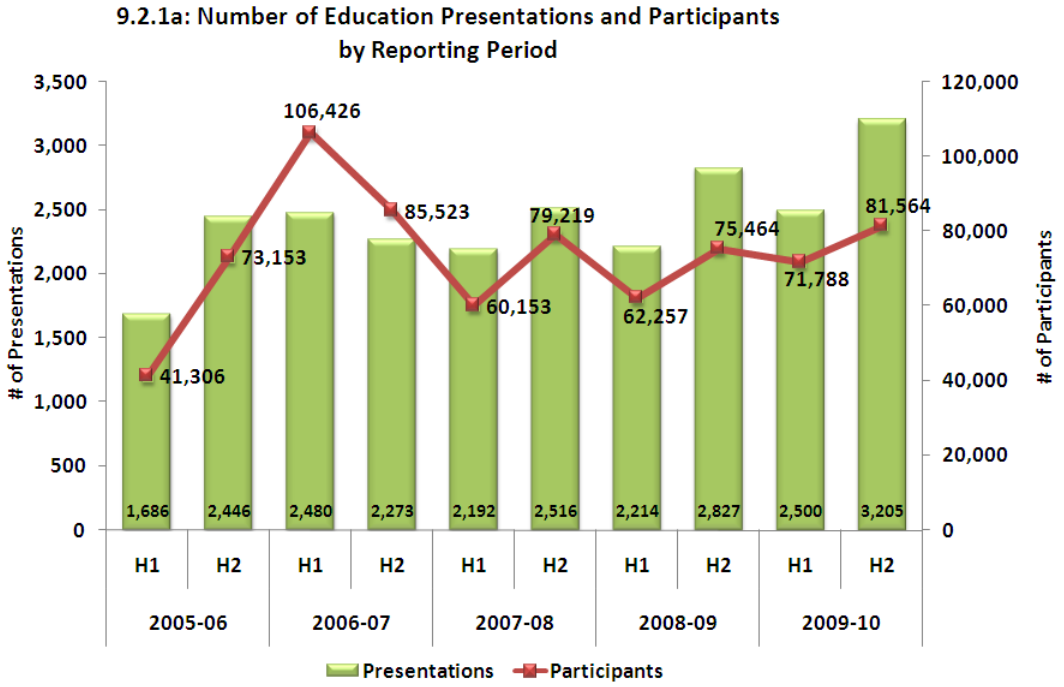
As noted earlier in this report, funded programs provide a mix of education, outreach, support, volunteer and IDU outreach services.

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 Participants and Presentations Up

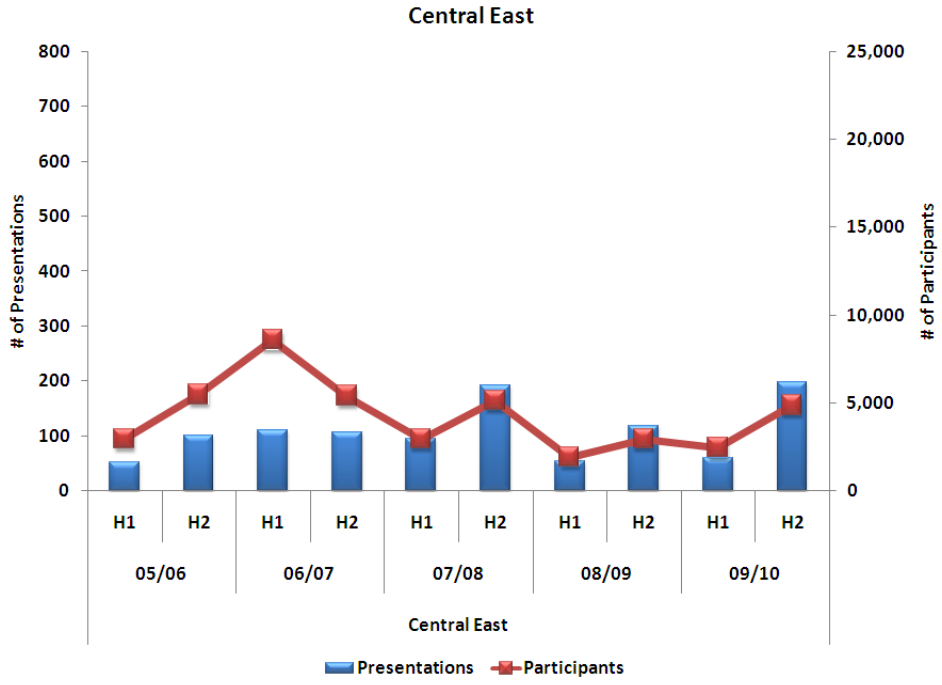
In 2009-10 (see Figure 9.2.1a), programs gave more presentations than in each of the past five years and reached more participants (153,342* over the year). Common subjects for education sessions over the past year were: harm reduction, at-risk youth, disclosure of HIV status and criminalization of transmission, settlement and immigration issues, and mental health. H1N1 influenza, while a significant public health event in 2009/10, appeared to have minimal impact on education activities. Three programs reported their presentations were delayed or they filled in for Public Health due to H1N1 and some projects reported having flu pandemic kits available or doing other pandemic preparedness planning. Overall, H1N1 appeared not to have significant impact on their work.

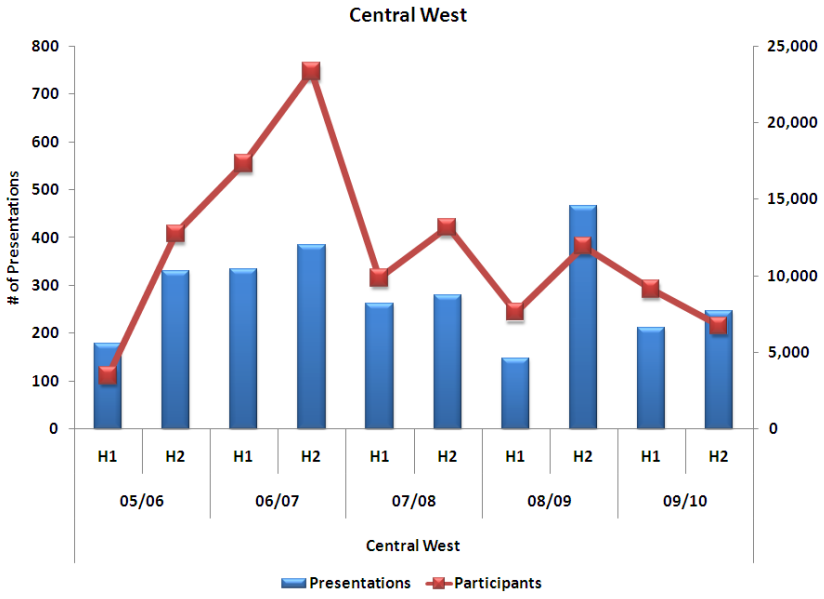


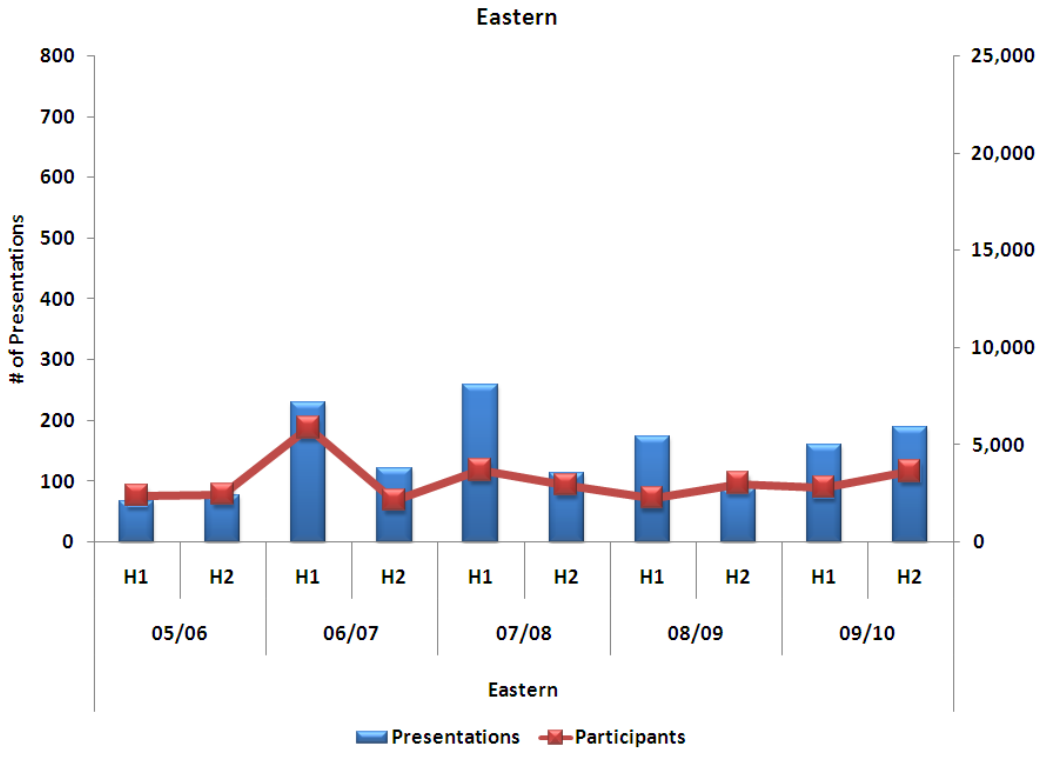
*Note: Figure 9.2.1a is different than presented in previous years. We have removed the 'Other' category data recorded in the Education section of OCHART. Some of this data is related to education activities while some is not. As such, we will be shifting this data to the appropriate sections over the coming year. Due to this removal, the text above the graph on the number of participants for 09/10 should state 153,342, not 158,060.

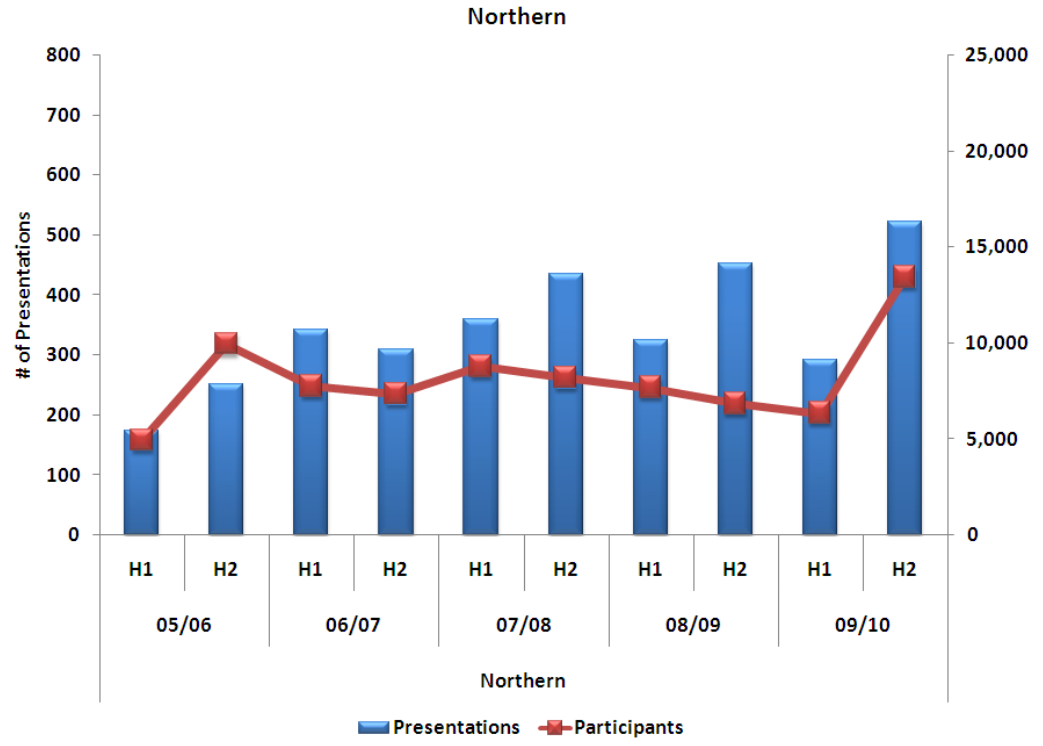
The following regional graphs (9.2.1a) show the number of presentations and participants by region. In general, most of the increase in presentations occurred in Central East, Ottawa and Toronto regions. Northern Region had a significant increase in secondary and post-secondary schools presentations/participants as a result of concerted efforts around anti-homphobia and anti-stigma education in three cities.

Regional Breakdown – Chart 9.2.1a






Eastern
800
700
600
500
400
300
200
100
0
# of Presentations
25,000
20,000
15,000
10,000
5,000
0
H1
H2
05/06
06/07
07/08
08/09
09/10
Eastern
Presentations
Participants


Northern
800
700
600
500
400
300
200
100
0
# of Presentations
25,000
20,000
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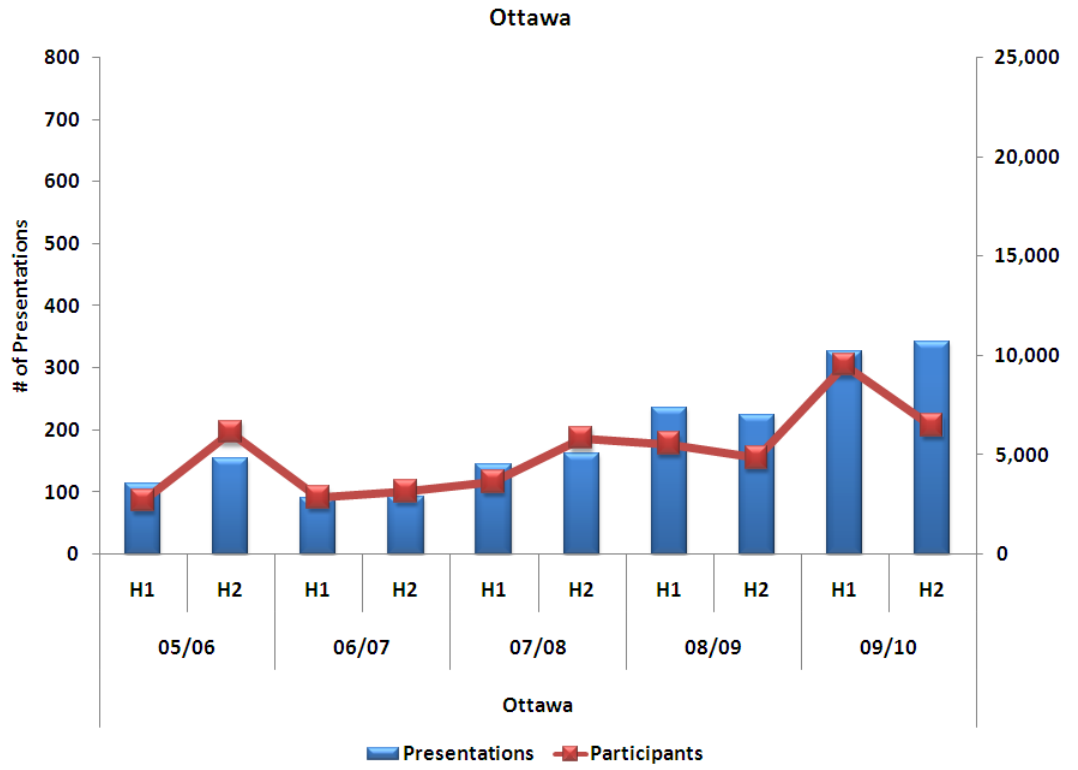
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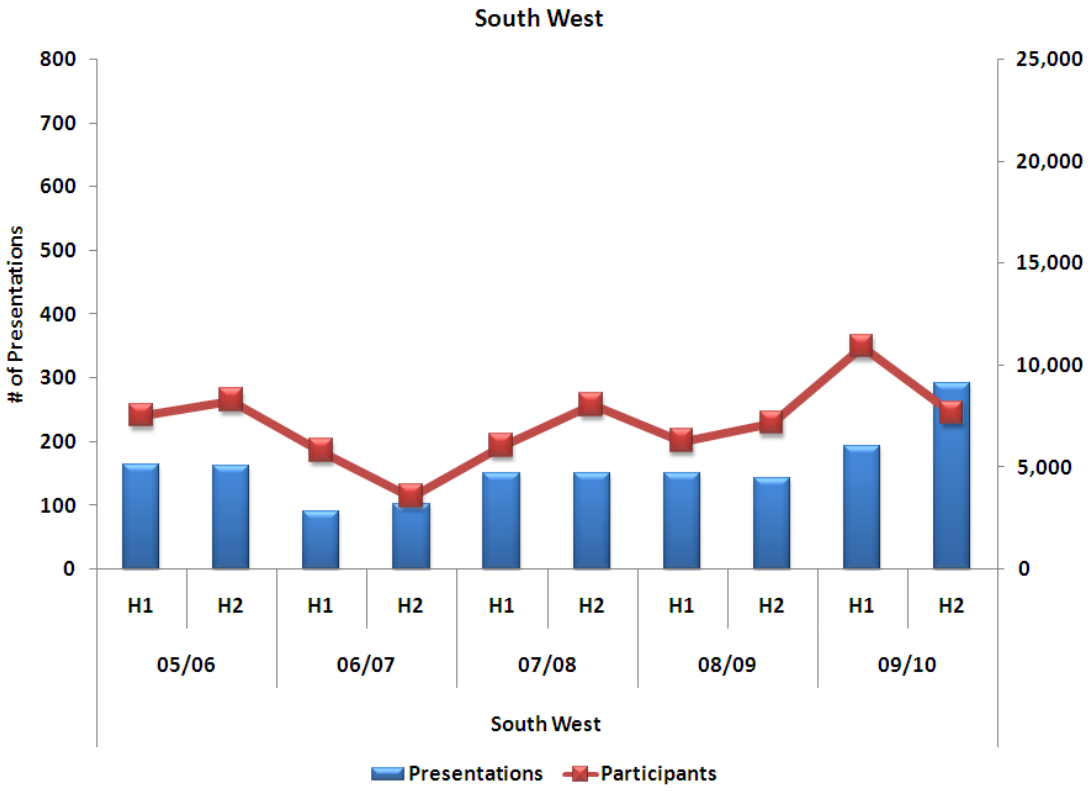
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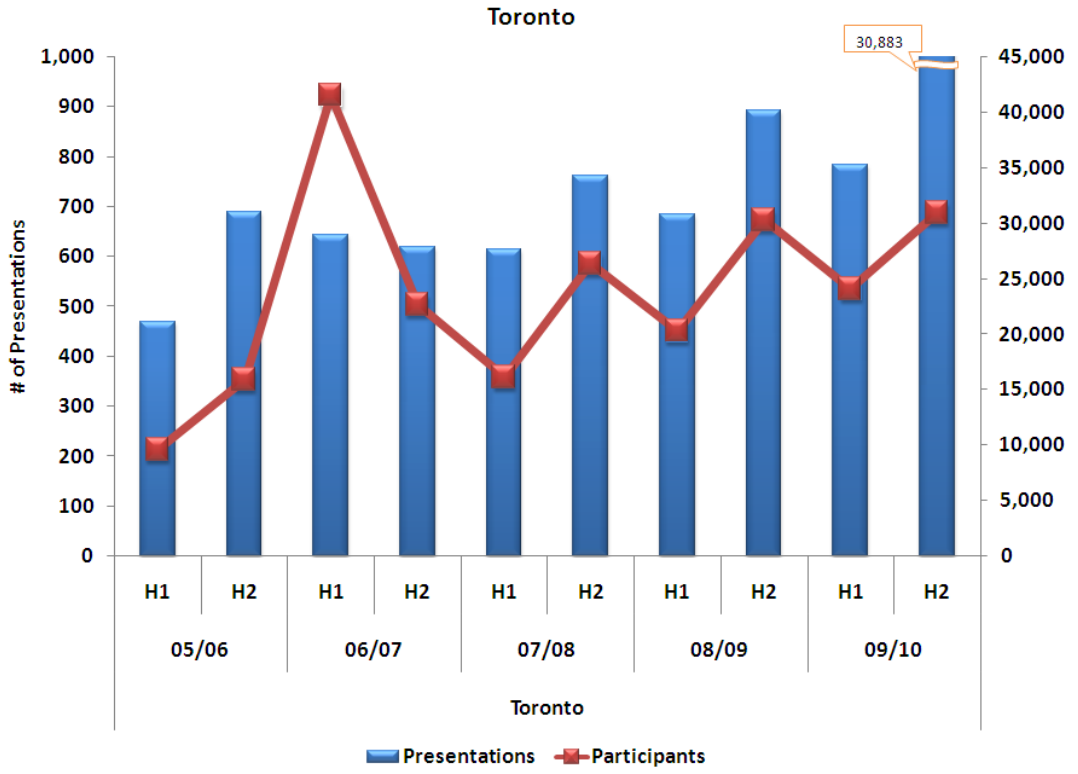
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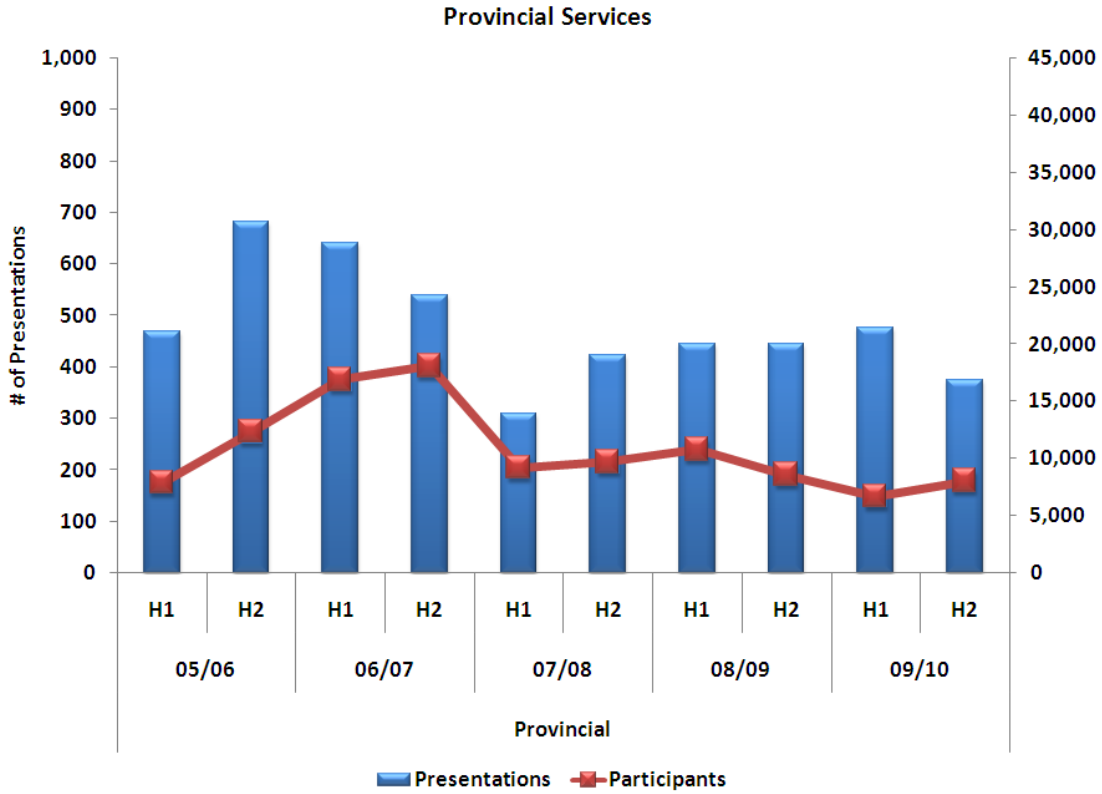
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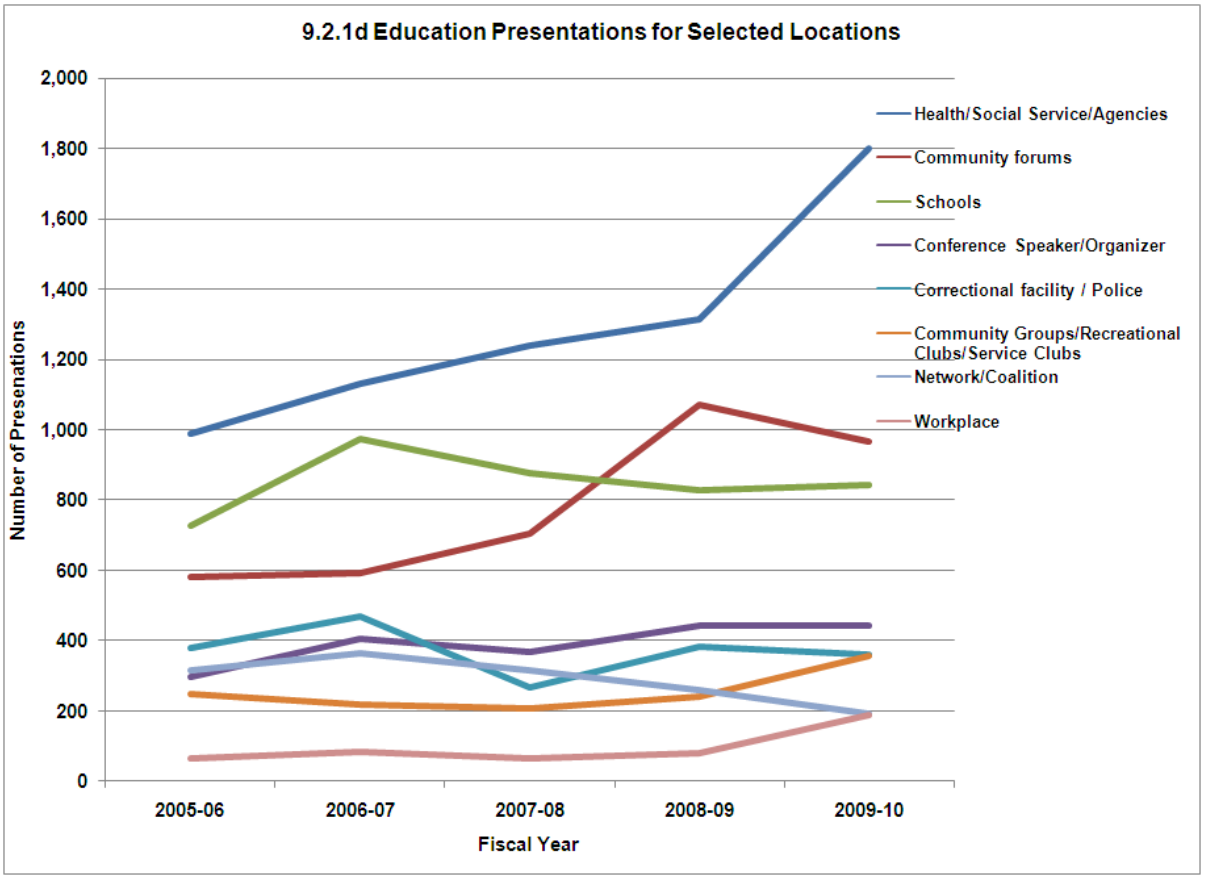
Provincial
Presentations
Participants

More Presentations to Community Groups and Health and Social Service Agencies

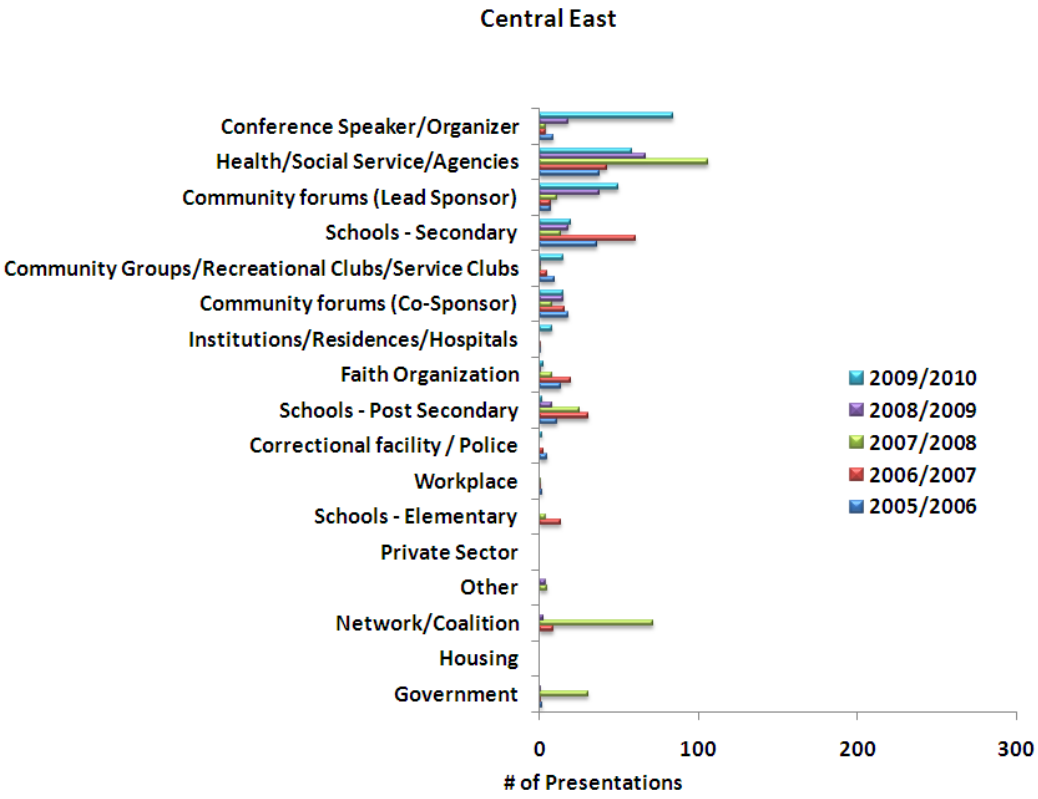
As the following graph illustrates (Figure 9.2.1d), programs made more presentations to community groups, health and social service agencies and workplaces than in the previous year. The goal of these types of presentations is to create more supportive communities for people with or at-risk of HIV -- although it is often difficult to determine their impact. It would be interesting to assess whether communities that have large numbers of presentations see an increase in access to other health and social services or other positive outcomes (e.g., more employment opportunities for people with HIV, more volunteers).

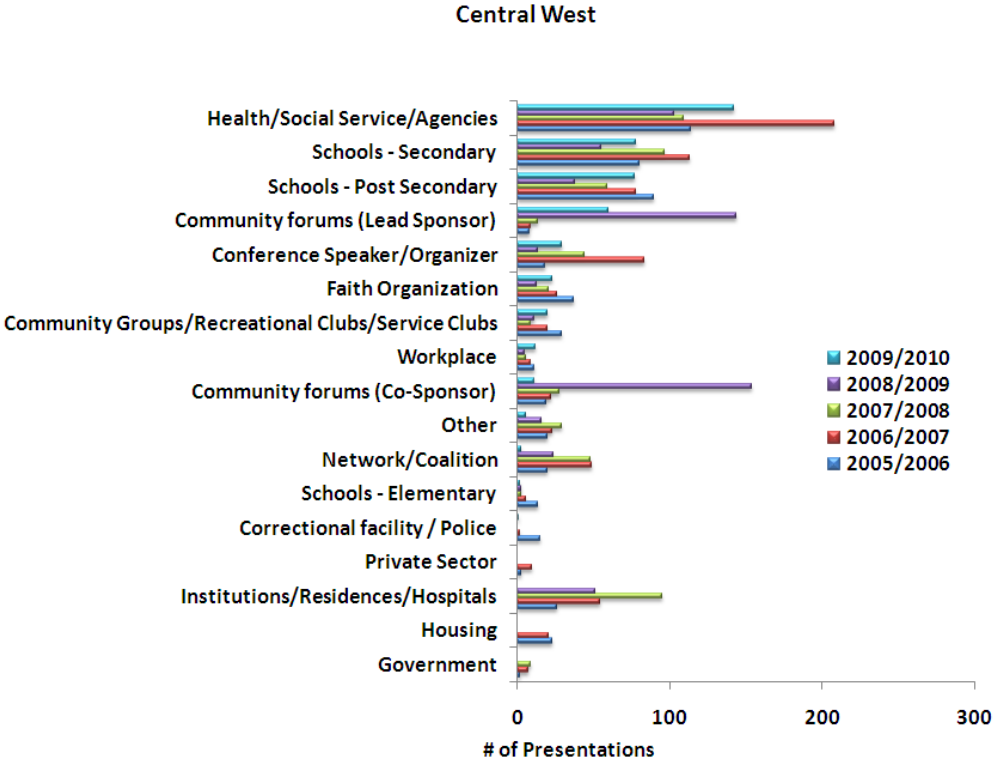


A regional analysis of education presentations (see Regional Breakdown 9.2.1d)shows that the majority of regions focus on health and social services while Central East focused on conferences and Ottawa on community forums.

Secondary and post secondary schools are among the top locations for education and the focus of school-based presentations is often on reducing stigma and homophobia. Some communities have seen an increase in gay/straight alliance clubs and it will be interesting to explore the impact this type of initiative is having on students and school systems.

Regional Breakdown 9.2.1d





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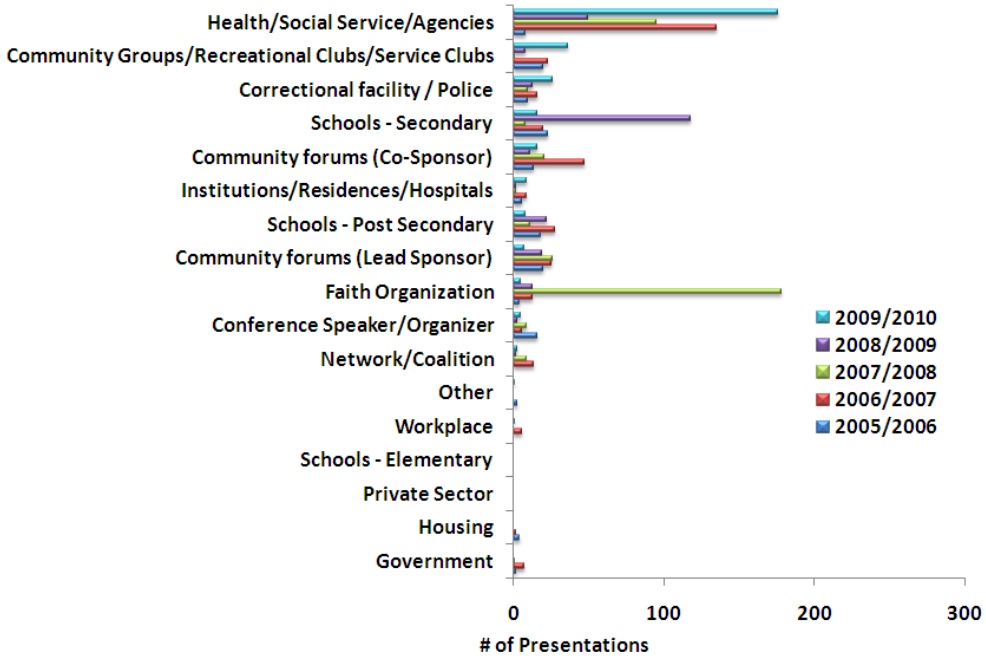

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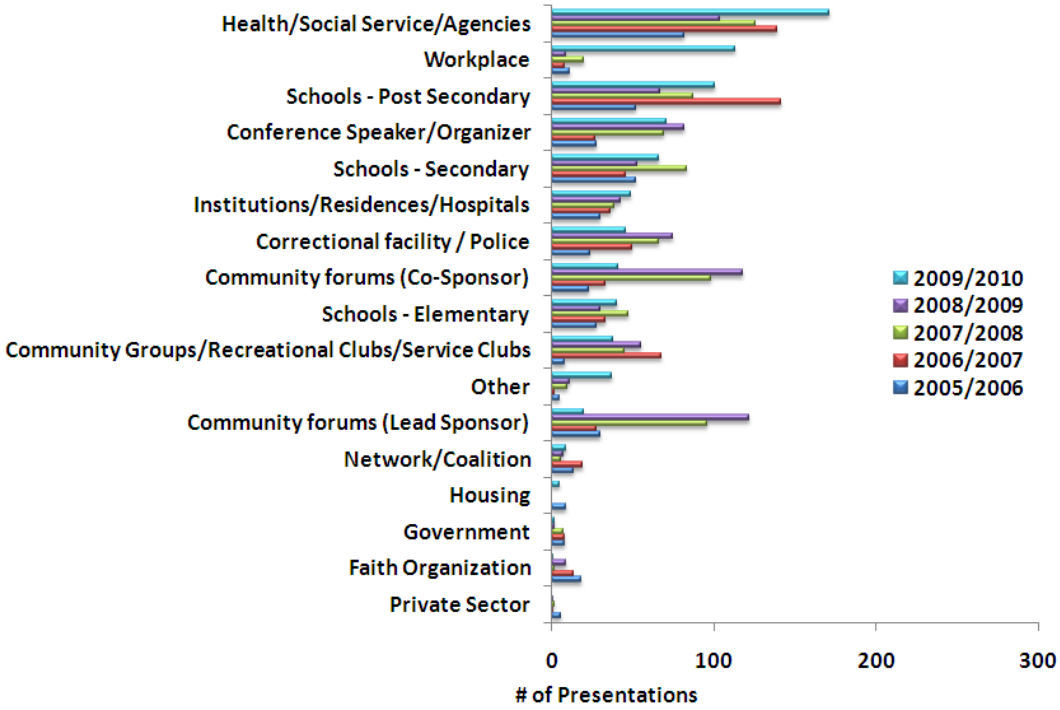

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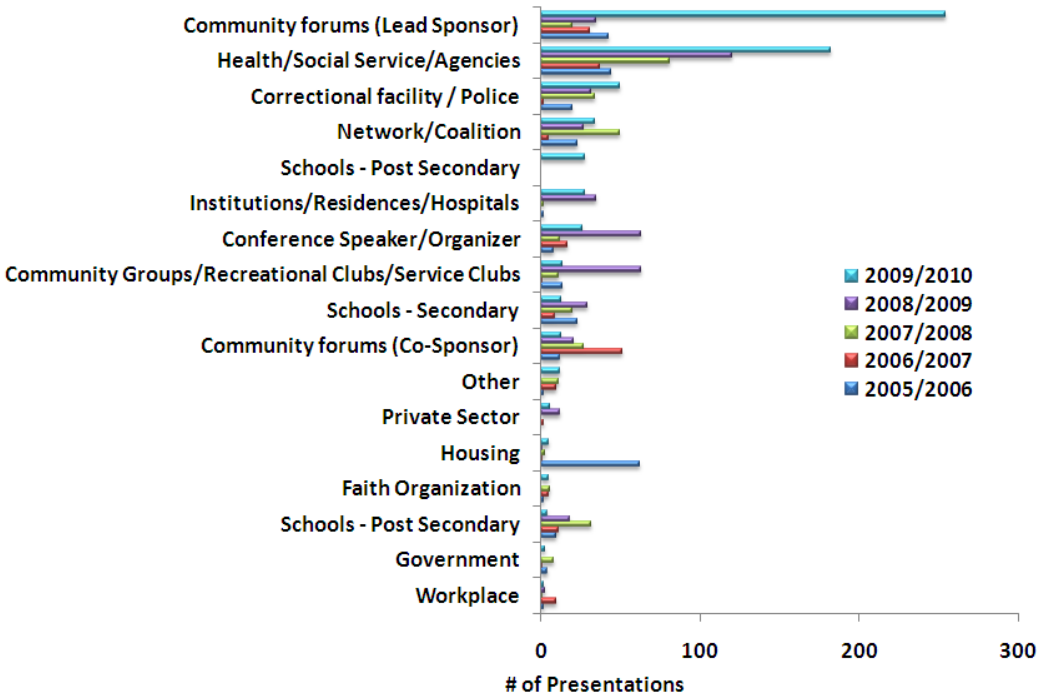

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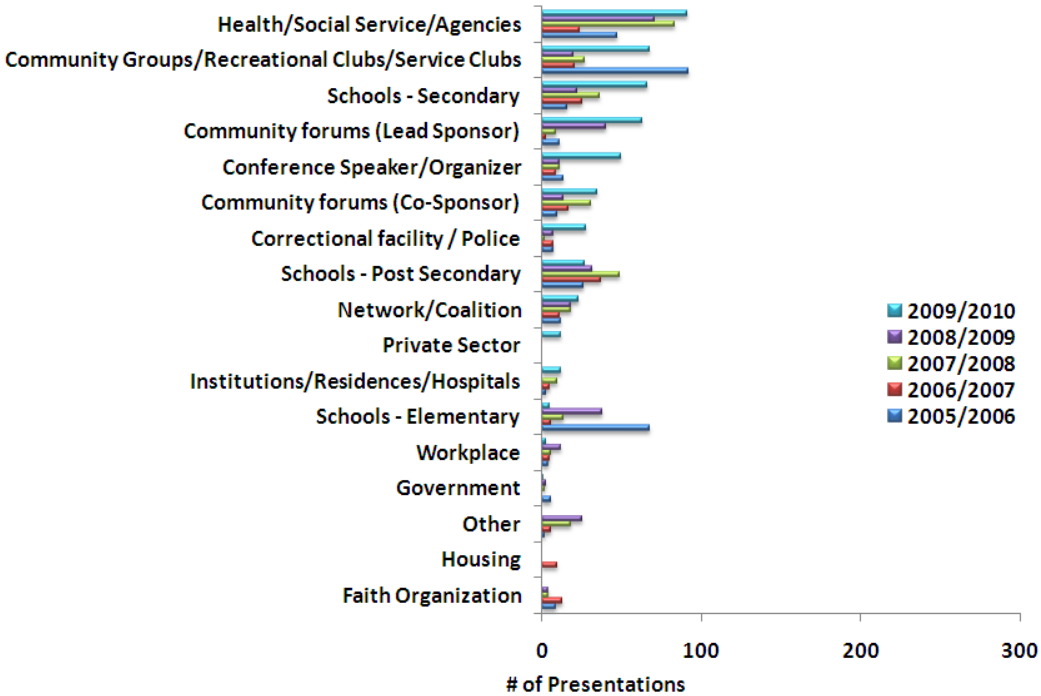

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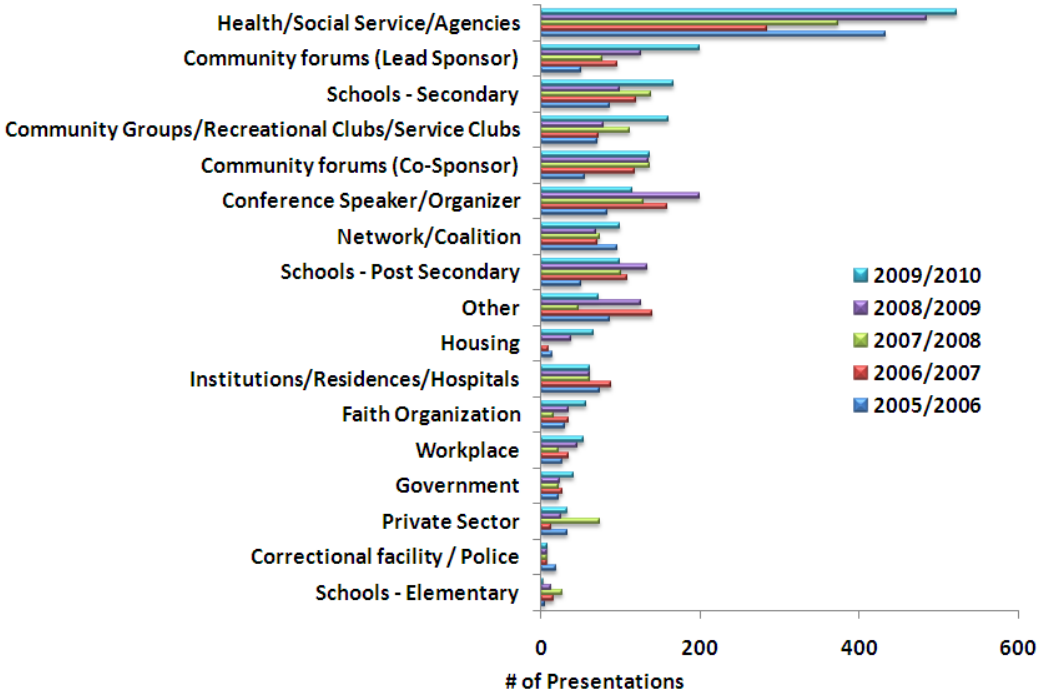
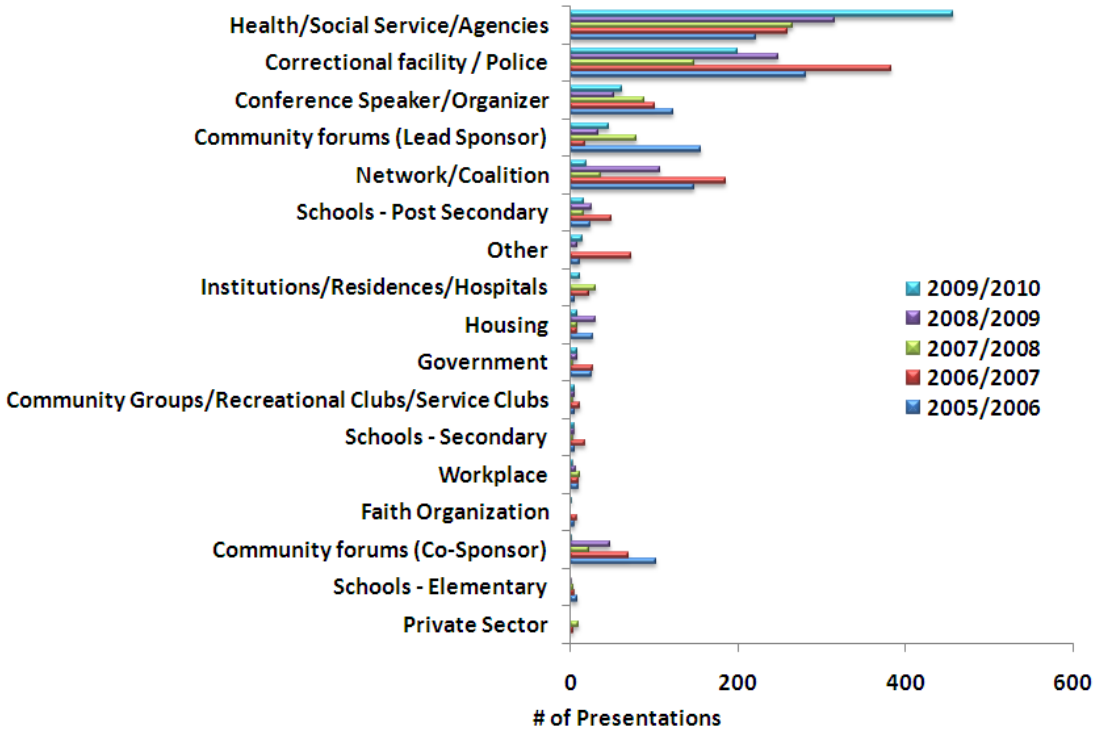


Provincial Services



Emerging Trends in HIV Education Across Ontario

Programs are asked to identify any emerging trends in HIV education. In 2009-10, they reported the following:

More demand for harm reduction education

A number of programs report an increase in requests from other service providers for education on harm reduction and implementing harm reduction principles. One has developed a workshop manual for training and to hand out to other service providers.

More education for youth at-risk

Seven regions received requests for education for high-risk youth. Requests came from group homes, other youth correction facilities, pride events, and schools. Topics included information for Aboriginal, Black, and immigrant youth, young women as well as LGBT and trans-youth. One program responded to this demand by developing a testing campaign by and for youth. Most programs developed tailored presentations for youth, such as "gossip and HIV/AIDS".

Other hot topics for education in 2009-10

Criminalization and Disclosure*
HIV/hepatitis C co-infection*
Trans issues*
Aboriginal culture and teachings*

* All of these were also hot topics in 2008-09

More demand for education for aging PHAs

Programs in four regions reported increased demand for education from long-term care facilities, addictions programs, seniors groups and people with HIV who are reaching retirement age. Programs are developing training resources and partnerships to meet the need for information on aging and HIV.

Increase in anti-homophobia and anti-stigma education

More programs are conducting school-based education to address homophobia and HIV-related stigma. Many programs are asked regularly by schools to give presentations on homophobia and stigma. In many communities they are the only organizations that can address these issues.

More newcomer/migrant, settlement and immigration requests

Nine programs in three regions received requests from other service providers and community groups for presentations on newcomer, migrant and other settlement and immigration issues. To meet the needs of newcomers, HIV programs are developing new partnerships with settlement agencies, faith groups, ethno-cultural media outlets, ethno-cultural professional associations, creating new resources, training staff and recruiting volunteers to provide translation services.

Regional Highlights

In addition to the overall trends described above, there were some interesting regional trends:

One program in the Northern Region received more requests for placement opportunities for students.

In Central West, one program received requests for skills-building opportunities to enhance employability. The program is looking for new partnerships and referrals to other agencies that can meet this education need.

Ottawa and Toronto Regions also identified the need for education to service providers around working with youth and adults in the sex trade, noting increased use of the internet in sex trade work.

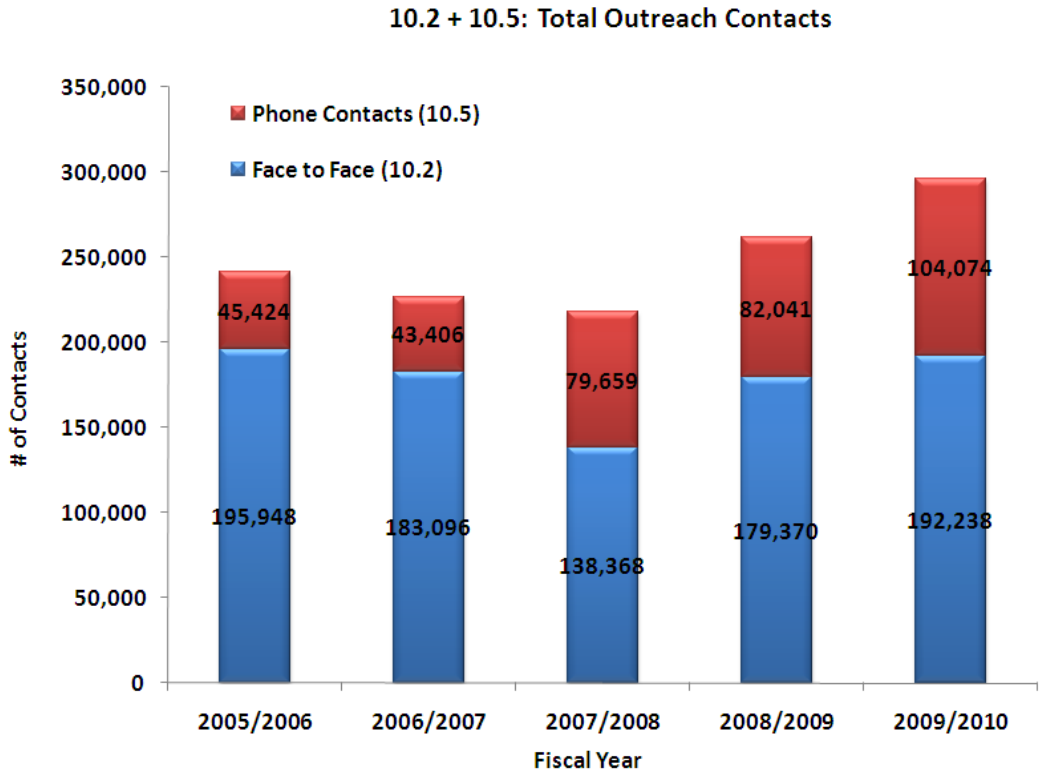
4.2 Outreach Initiatives

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

OCHART questions 10.2 Indicate 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

Phone Contacts Up

In 2009-10, programs reported more outreach contacts than in the previous year and there was a marked increase (26%) in phone contacts (see chart 10.2+10.5 below). Since 2005, there has been an increase of 63% in face-to-face outreach and 129% in phone contacts. This is in part due to better data collection and may also be the result of new outreach workers across the province funded by the AIDS Bureau and ACAP.



Please note, if comparing this graph to previous years, the numbers have been changed to correct an error by one program which had been including condom distribution in its face-to-face outreach contacts. When those activities were removed, there was a significant drop in those contacts – however, the trend to more face-to-face contacts over the past two years remains the same.

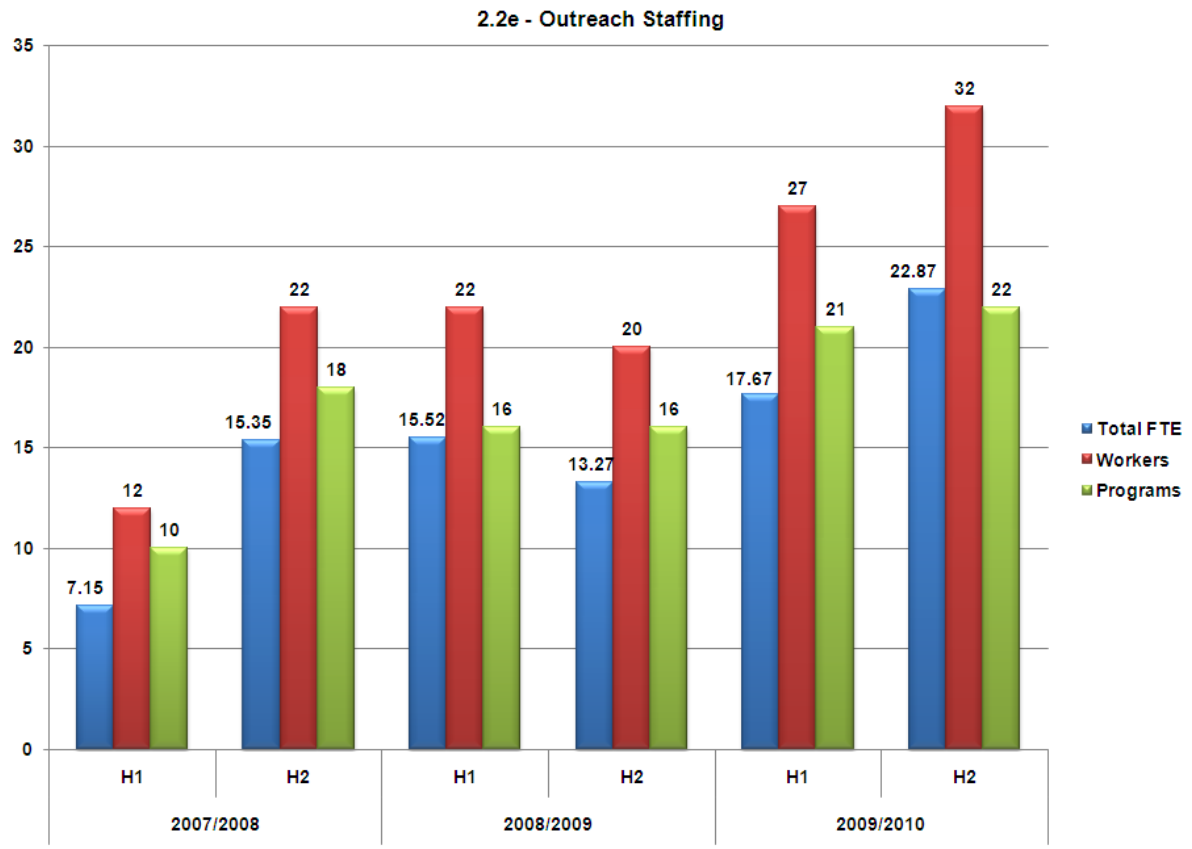
Counting Contacts Still a Challenge

Programs continue to struggle with the best way to "count" internet outreach contacts and to assess the impact of internet-based education on knowledge and behaviour. The dramatic increase in internet contacts in the past year is likely due to programs counting website hits or contacts made in chatrooms that are not necessarily direct interactions. This is similar to the challenge programs have counting outreach at health fairs or large events.

The increasing use of online outreach, particularly to reach gay men, likely allows for more one-to-one discussion than outreach in other settings such as bars, and may help explain both the increase in internet contacts and the decrease in bar outreach. A provincial resource guide was developed to help programs doing online outreach with gay men that may be assisting programs to do this work more effectively.

More Outreach Workers

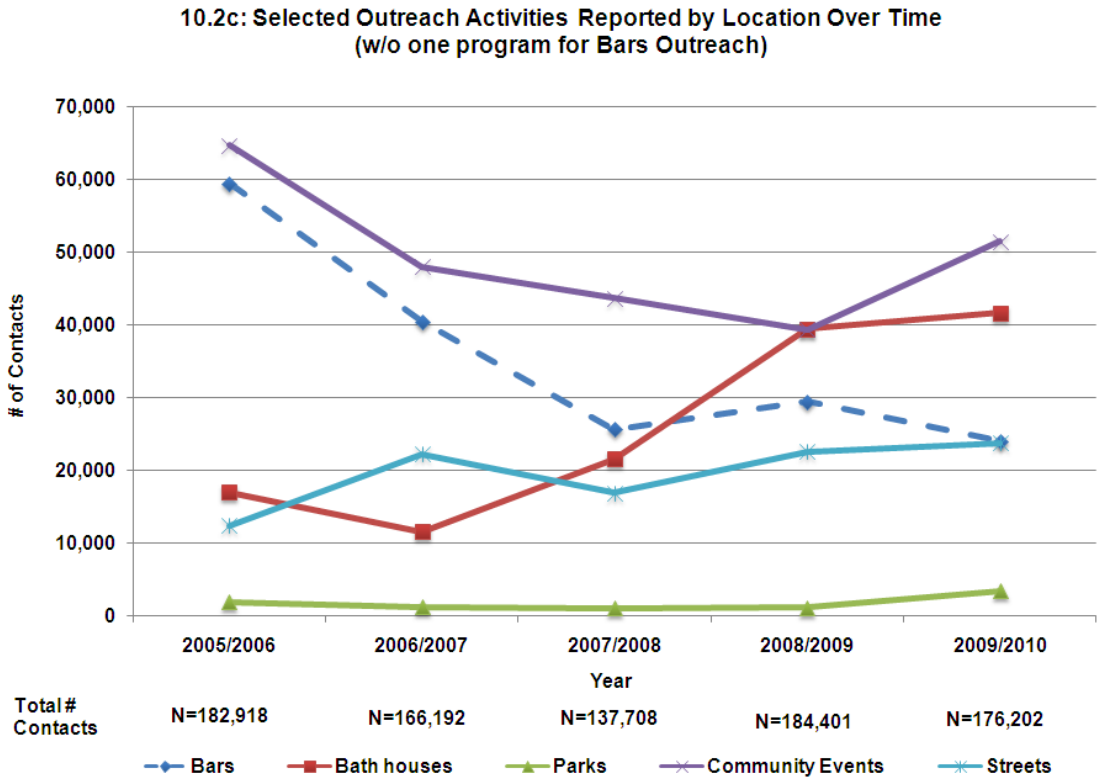
As Figure 2.2e illustrates, the number of outreach workers almost tripled between 2007 and 2009 (from 12 to 32) and the number of outreach programs more than doubled (10 to 20). This trend reflects the evidence that outreach is the most effective way to reach marginalized populations at-risk of HIV. It will be important to monitor the outcomes and impact of this investment in outreach over time. Given most of these workers are largely involved in prevention activities, OCHART will look at ways to better capture their work and its impact as well as the challenges of delivering outreach programs.



More Outreach on Streets, Parks and in Bathhouses

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

Due to a reporting error by one Toronto program in outreach contacts, we have revised data from previous years in graph 10.2c. It now shows a decrease in bar outreach over the past five years and an increase in street, park and bathhouse outreach. This shift has not decreased the overall number of outreach contacts, which have consistently gone up over the past three years, and underscores again the impact of additional outreach workers.



As would be expected, programs and regions report differences in their outreach activities, which reflects the local target populations, geography, the services programs offer, and other services provided in their regions.

Central East and Eastern regions do most of their outreach at community events and bars though both are increasing street outreach.

Central West has seen a decrease in bar and community events outreach and an increase in street outreach. Outreach activity in Northern region has remained relatively stable over the past three years.

The South West has seen a steady increase in park outreach. They have also seen an increase in outreach at community events as well as on the streets. Provincial programs have seen a decrease in outreach at community events but an increase on the streets.

Ottawa's outreach has declined over the past year except in bars. This trend is likely due to vacancies in positions and challenges with program delivery. Toronto has seen an increase in bathhouse outreach due to dedicated programming in those settings, as well as outreach at community events and on the streets.

Demand for Resources Varies by Region

Historically, programs that were not specifically funded to provide IDU outreach services have reported their distribution of substance-related resources in this section. Beginning in 2009-10, all programs reported these resources in section 13, except for ACAP funded outreach projects. This should provide a clearer picture of harm reduction services for people who use substances.

The outreach resources captured here focus on safer sex and include brochures, condoms and other safer sex items and materials.

In 2009-10, almost all regions (7 of 8) reported increased demand for female condoms. Given that these items have not been widely distributed in the past, it would be interesting to know the reasons for the increased demand. Most regions also reported increases in requests for harm reduction materials.

Of note is the number of programs reporting increased requests for resources and services from women in general and from women involved in the sex trade.

Shifts in demand for prevention resources vary regionally:
Programs in the Central East Region have seen an increase in the general demand for information and resources as a result of an increase in staff conducting outreach.
Central West Region has also seen an increase in requests for information and outreach, particularly from immigrant women and for female condoms.
The Eastern Region reported an increase in requests from women for information on hepatitis C.
The Northern Region reported increased demand for HIV and pregnancy testing as well as for free condoms for men and women.
Ottawa Region reported an increase in requests for safer sex kits by businesses such as barbershops through the outreach work of the African and Caribbean programs. Some have reported that they prefer not to have these pre-packaged in kits by the HIV programs. It may be a sign of the stigma associated with HIV that people are less likely to pick up free condoms packaged in ways that link them to AIDS.
Programs in the South West Region saw more demand for safer sex kits and for harm reduction materials by an Aboriginal group.
Toronto Region programs reported an increase in demand for financial assistance and for help with bedbug infestations.

Regional Shifts in Demand for Outreach Services and Responses to Emerging Issues

Programs in all regions are working with other agencies to maintain or develop new partnerships to reach their target populations. Many are trying new strategies to increase

outreach to seniors with HIV, women, newcomers and youth through better collaboration between support and prevention programs and new approaches to internet outreach. Regions also identified the following trends:

Central East Region

- More women accessing services (more of whom are engaging in survival sex/escort work) as well as the number of referrals for outreach services by community agencies.
- More focus by one program on youth and men who have sex with men using youth blogs and other online social media.

Central West Region

- More women accessing services (more of whom are engaging in sex work).
- More success by one program in youth outreach by offering safer piercing kits and using a strong peer-based approach with a tailored workshop for youth substance use and sex.
- More emphasis on the importance of online and face-to-face outreach.
- Lastly, one program is focusing on outreach to seniors and developing partnerships with agencies that support seniors.

Eastern Region

- Broadening outreach services in rural areas, and continuing to meet clients where they are located.
- More women accessing services.

Northern Region

- More requests for safer inhalation equipment.
- More women accessing/requesting services, particularly outreach to women involved in sex work.
- A new partnership by one program with a university hockey team to promote safer sex and increase outreach to students.
- More focus on outreach for youth with testing information now available online, tailored resources, and outreach to community gatherings for LGBT youth.
- More requests to two agencies for basic needs supplies (food and financial resources).

Ottawa Region

- More women and women involved in sex work accessing/requesting services.
- More requests to one program for information on transmission from HIV positive and HIV negative men.
- A new partnership between one program and a long-term care facility to facilitate outreach to an aging population.

- More requests for financial support from clients.

South West Region

- Greater need for outreach to Aboriginal Communities and youth (especially young gay males and other men who have sex with men).
- More emphasis on reaching out to youth through online chatlines, building partnerships with university LGBT groups, and having gay youth sit on the Gay Men's Sexual Health Alliance advisory committee.
- More partnerships with Aboriginal elders to reach Aboriginal Communities.

Toronto Region

- More online outreach, outreach to newcomers, settlement agencies, specific newcomer/immigrant communities and women, youth, men who have sex with men within those communities, and sex workers are identified as key outreach areas.
- More requests to one program for outreach and programming tailored to Muslim women that is supported by Muslim men and an overall outreach to those of the Muslim faith supported by religious leaders.
- Less access to community sites where at-risk adults can be found (shelters, half-way houses), but greater access to community sites where at-risk youth are likely to be.
- More success reaching youth through the Many Men, Many Voices Program (3MV) and Roots of Risk interventions.
- New partnerships with housing agencies, faith organizations, out-of-the-cold, child and family services, and ethno-culturally specific drop-in programs.

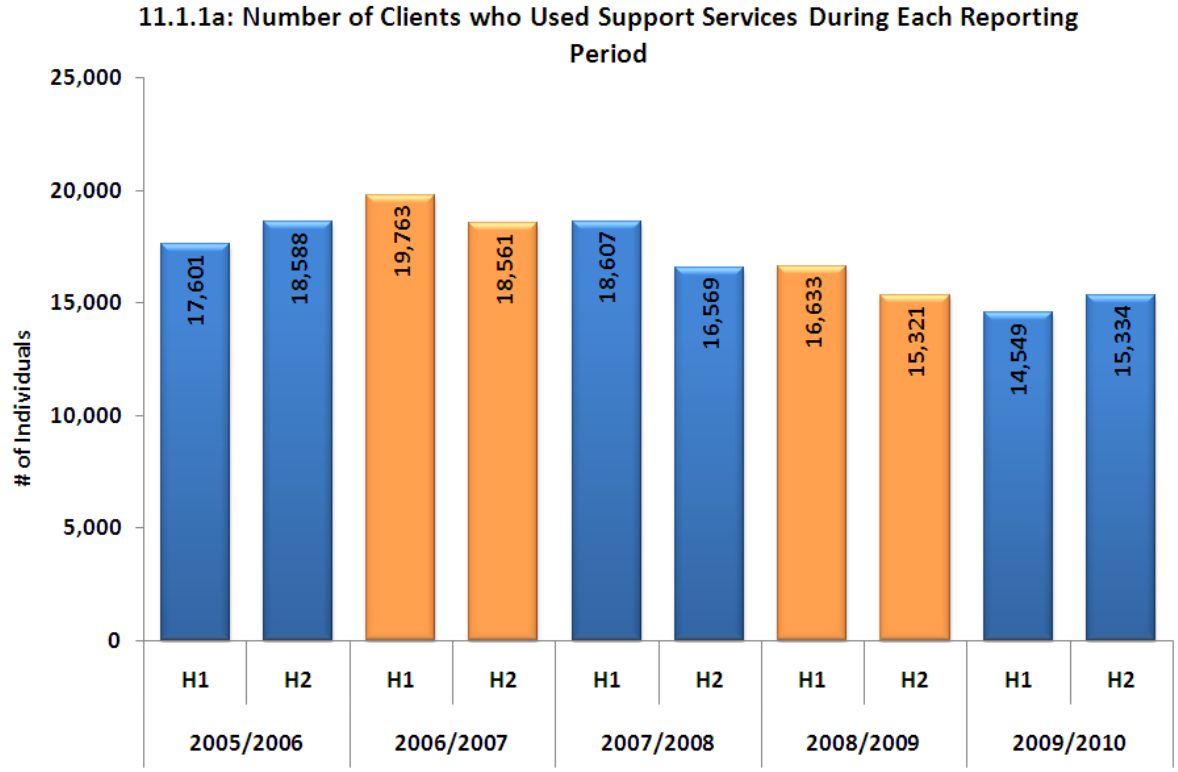
4.3 Support Services

Support Services

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 services were accessed.

In 2009-10, 68 programs reported providing support services (compared to 67 in 2007-08 and 69 in 2008-09). Support services include counselling, practical support, referrals, training and skills development for people with HIV, their family and people affected by HIV.

Programs continue to serve, on average, over 15,000 people during each OCHART reporting period (see Figure 11.1.1a). The total number of clients served continued to drop slightly in 2009-10 due to the fact that, with the Ontario Community-based AIDS Services and Evaluation (OCASE) tool, some programs are now able to count clients more accurately (i.e., less potential double counting of clients who use more than one support service within a program).

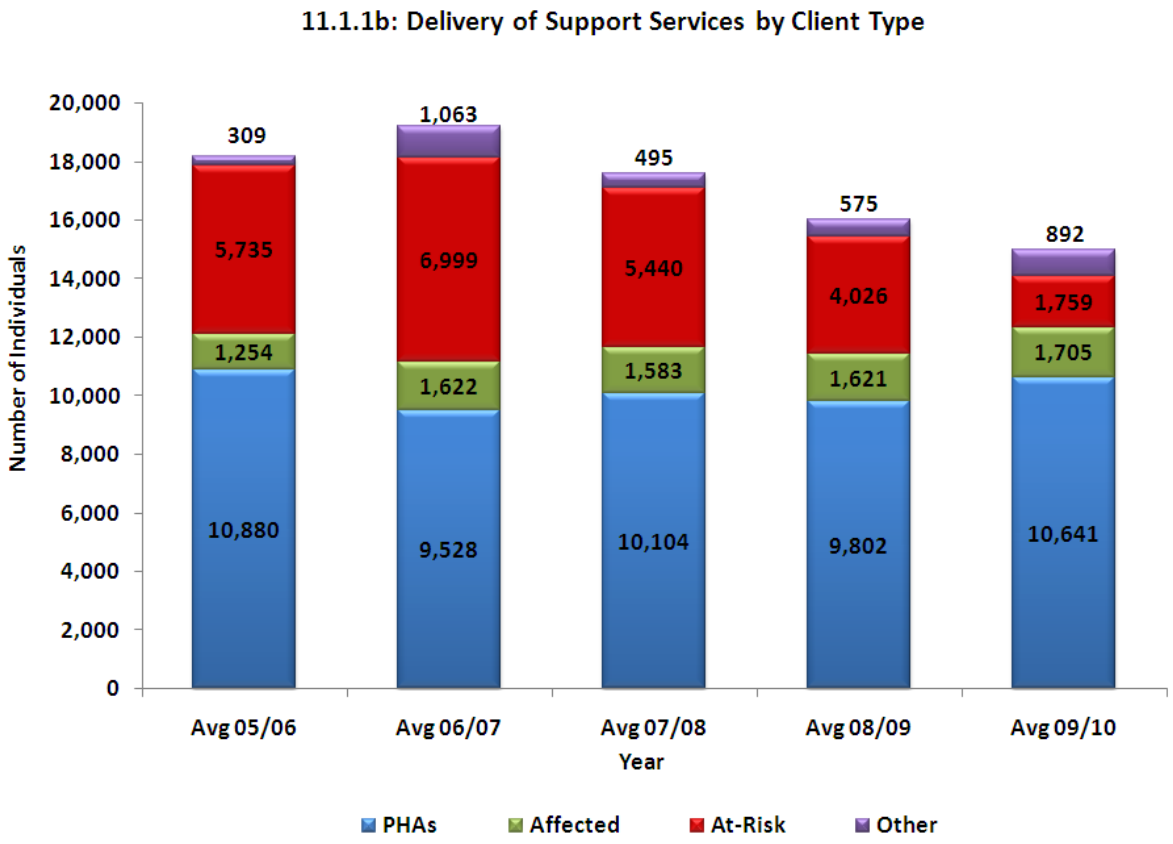


As of March 2010, 28 AIDS Service Organizations and HIV programs in Ontario were using OCASE, a web-based case management system that helps programs monitor client needs and the services they receive. OCASE, which is supported by the AIDS Bureau, involves an initial client intake and assessment, which helps programs take a more consistent approach to assessing client needs. In addition to more accurate client counting and assessment, OCASE will provide more comprehensive information on the mix of services that clients use.

More Clients with HIV

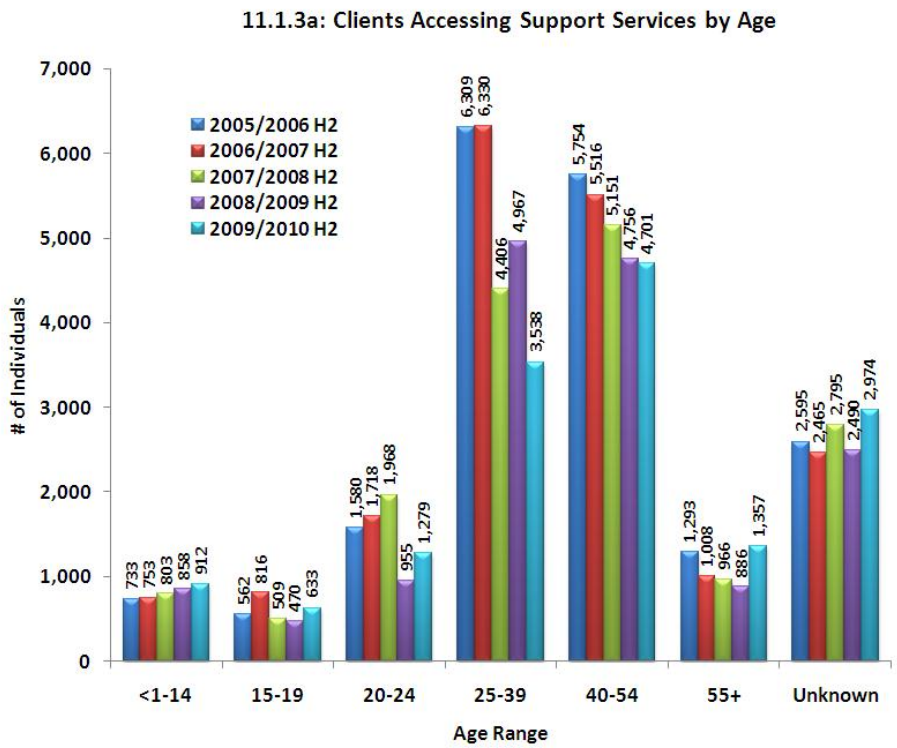
In 2009-10, programs served – on average – 1,000 more people with HIV than in 2008-09, but fewer people at-risk and people affected (i.e., partners, family members). (see Figure 11.1.1b)

Note: This is the first year when a number of programs (27) are now reporting their at-risk clients in IDU Outreach in Section 13 and so some of the at-risk numbers in this section may be affected by that change.

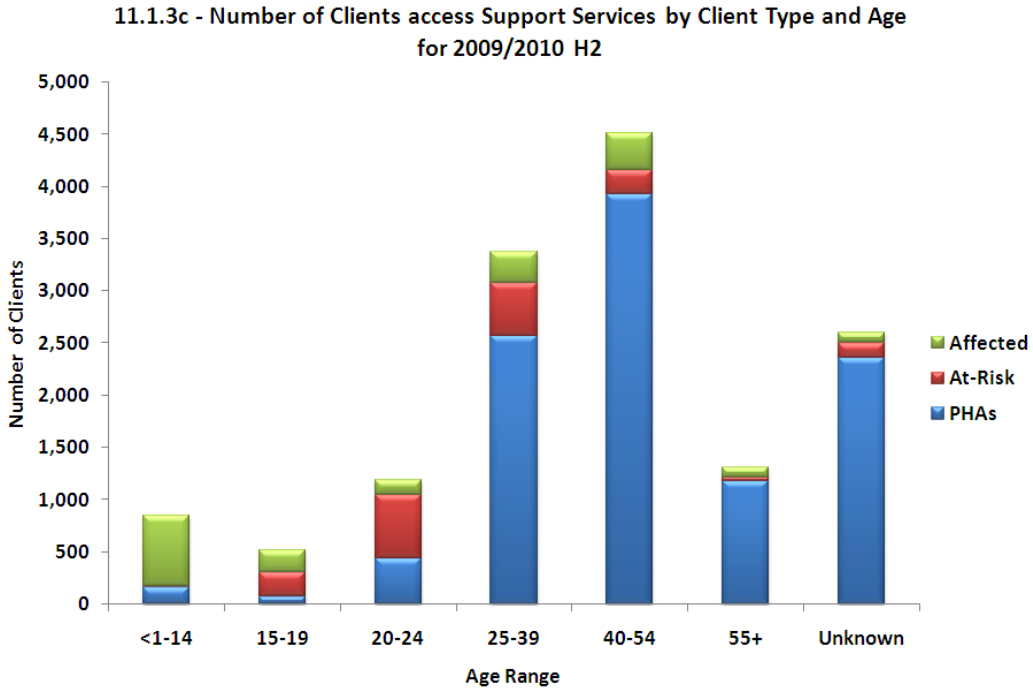


While most people using support services are between the ages of 25 and 54, significantly more clients between the ages of 20 and 24 and 55 and older used support services in 2009-10 (see Figure 11.1.3a below). Based on the age of people using support services, it appears that new clients include both people who are recently diagnosed and those who have been infected for some time who either need services again (i.e., returning clients) or for the first time.

Note: The large number of clients whose age is unknown can be attributed to one program that does not collect data on age.

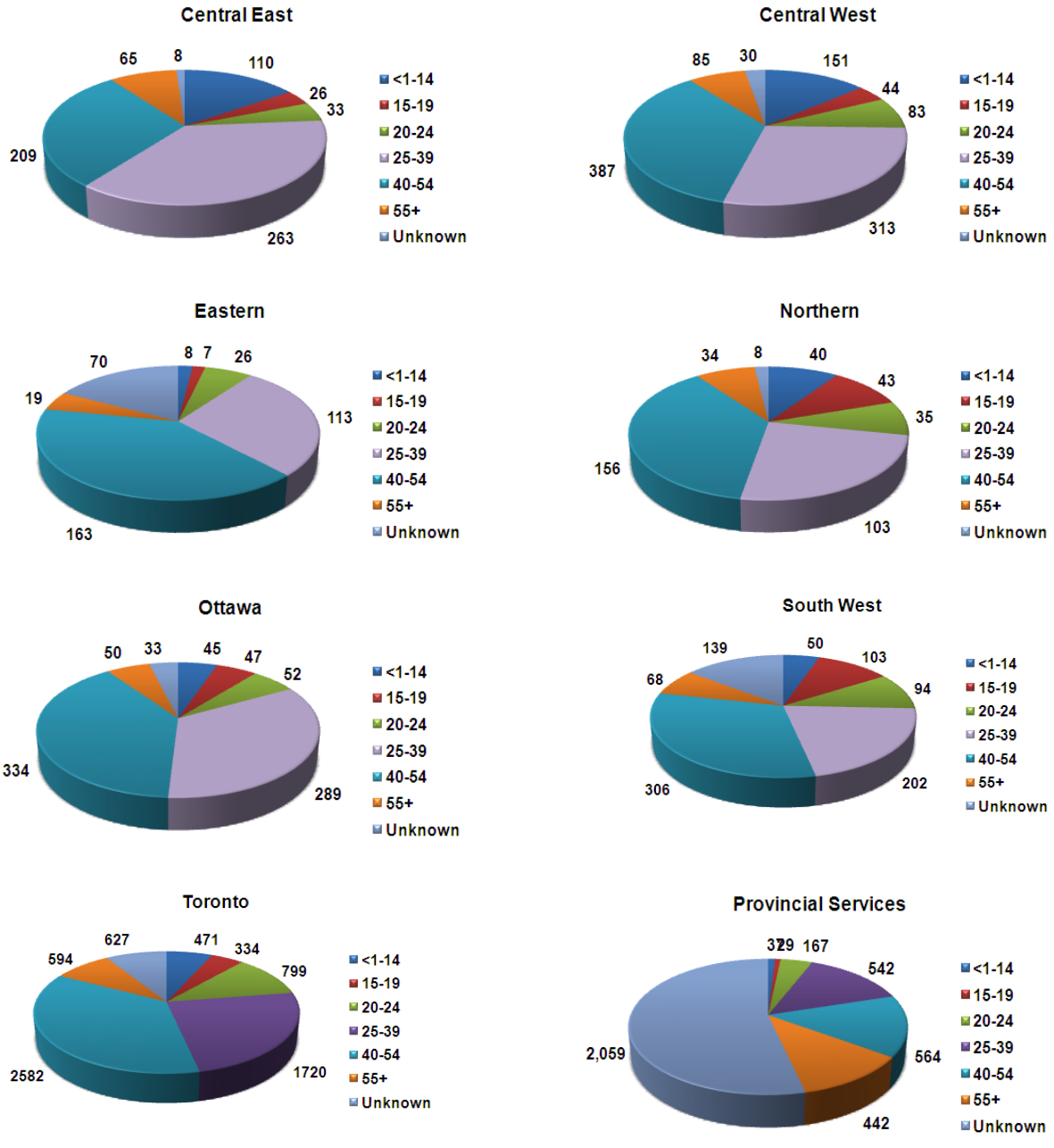


As Figure 11.1.3c shows, the largest group of people with HIV accessing services are 40 to 54 years old, while people at-risk are more likely to be younger (i.e., 20 to 39 years old) and a significant proportion of people affected are children under age 19. The aging of people with HIV underscores the need to develop appropriate services that meet the needs of older clients.



In most regions, most clients who use support services are between the ages of 40 and 54 except for Central East where most are between the ages of 25 and 39.

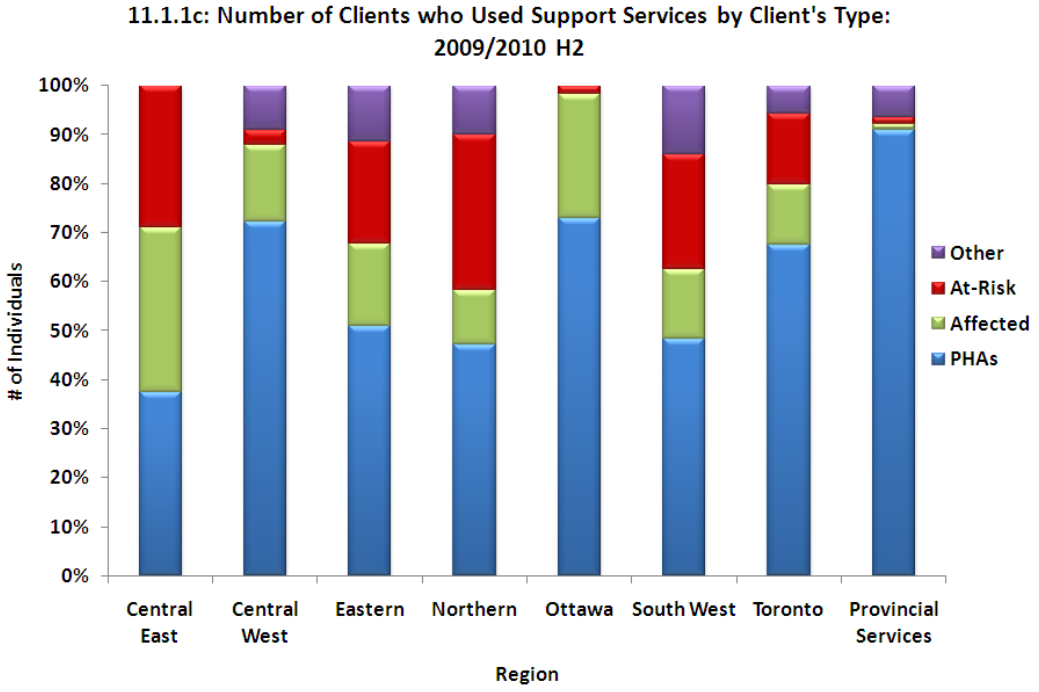
11.1.3d: Proportion of Clients Accessing Support Services by Region and Age: 2009/10 H2



People living with HIV continue to be the main users of support services. Of note, this is the first year when a number of programs (27) are now reporting their at-risk clients in IDU Outreach in Section 13.

There appears to have been a steady decline in the number of at-risk clients using support services across the province. It is not clear from the data whether this is because programs are working to capacity to meet the needs of people living with HIV or because fewer people at-risk are seeking support services from HIV-specific programs.

The following chart (11.1.1c) lists support service clients by group for each region. In all regions, the majority of clients who use support services are people living with HIV, although Central East is serving a significant number of clients affected and at-risk. The table underneath 11.1.1c shows the actual number of clients by health region.



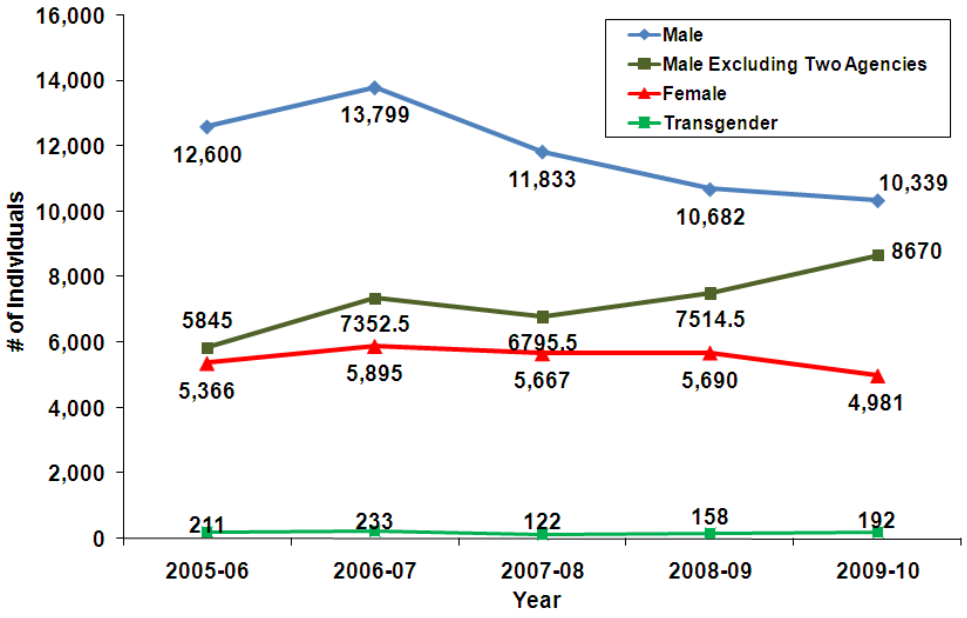
Health Region	PHAs	Affected	At-Risk	Other
Central East	267	240	207	0
Central West	777	169	32	98
Eastern	207	68	85	46
Northern	198	46	133	42
Ottawa	602	224	24	0
South West	465	137	224	136
Toronto	5,115	880	2,195	405
Provincial Services	3,488	48	55	249

Programs Serve More Men and Fewer Women

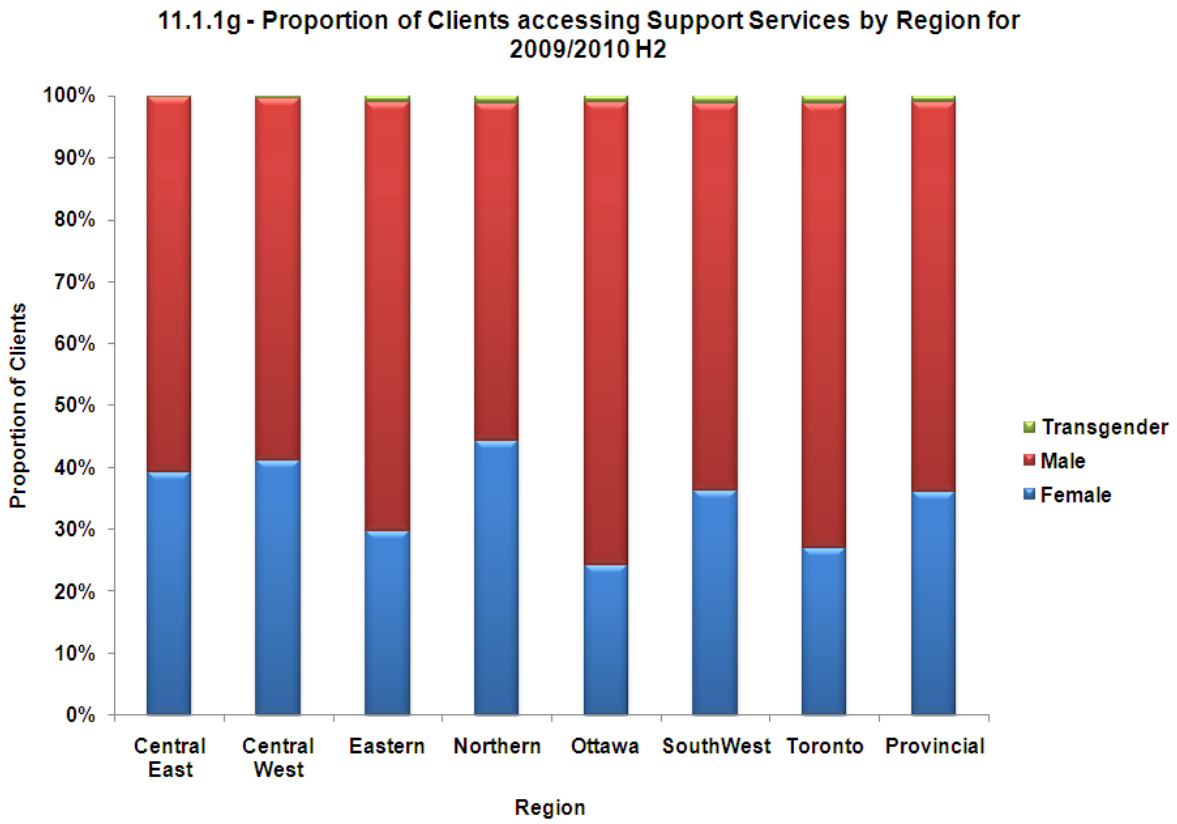
At first glance, the number of male clients served appears to have dropped, however, a closer look at the data revealed that the downward trend was the result of reporting anomalies in two agencies. Since moving to the OCASE system, one program with a large number of clients, discovered it had been double counting some of those clients; and a second 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 (see Figure 11.1.1d dark green line), the picture is very different: there has been a steady increase in male clients across the other programs.

In 2009-10 alone, there was a 15% increase in the number of men being served. There has been a decrease in the number of female clients.

11.1.1d: Average Number of Support Service Users by Gender



The percentage of support services users who are women varies by region from a low of 24% in the Ottawa region to a high of 44% in the Northern region. It would be interesting to know whether the changes in relative numbers of male and female clients served is having an impact on the type and mix of services that programs offer. 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.

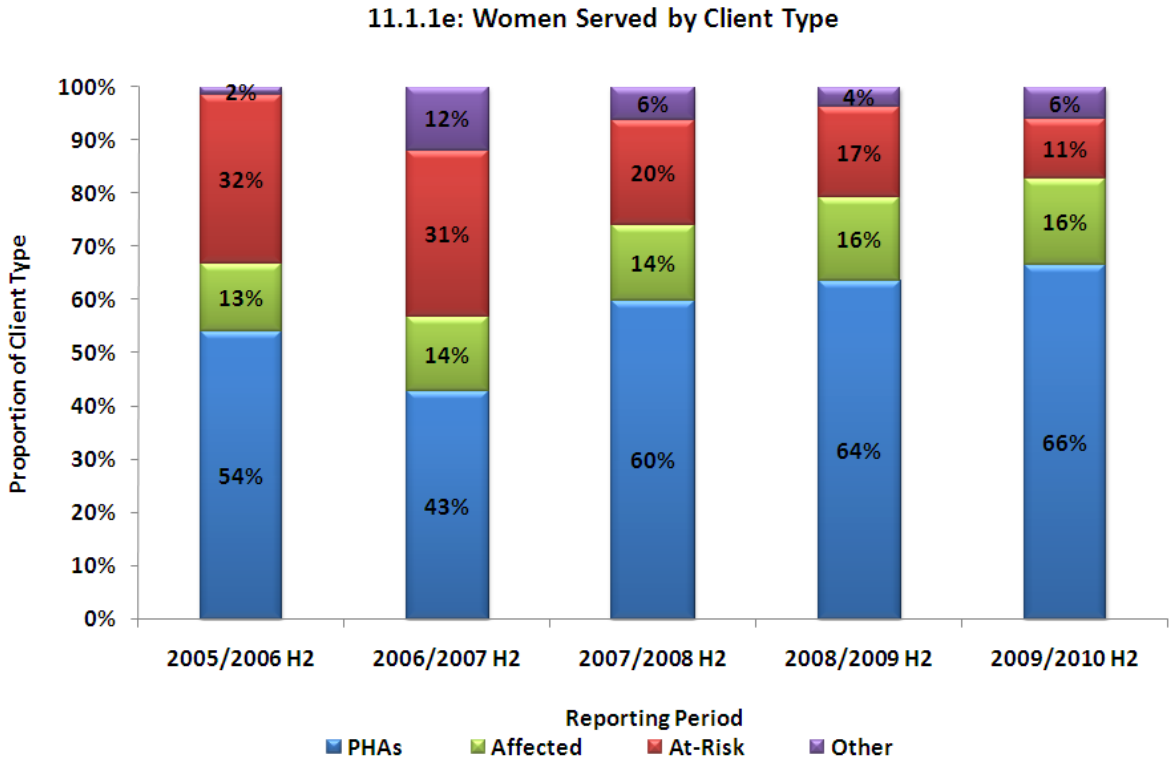


Number of Clients Accessing Support Services by Region

In all regions, programs are serving mainly clients with HIV -- although Central East and South West and Toronto have significant numbers of at-risk and affected clients. Provincial programs almost entirely serve people living with HIV. It appears that the Northern region has an active outreach program to the trans community and targeting people at-risk.

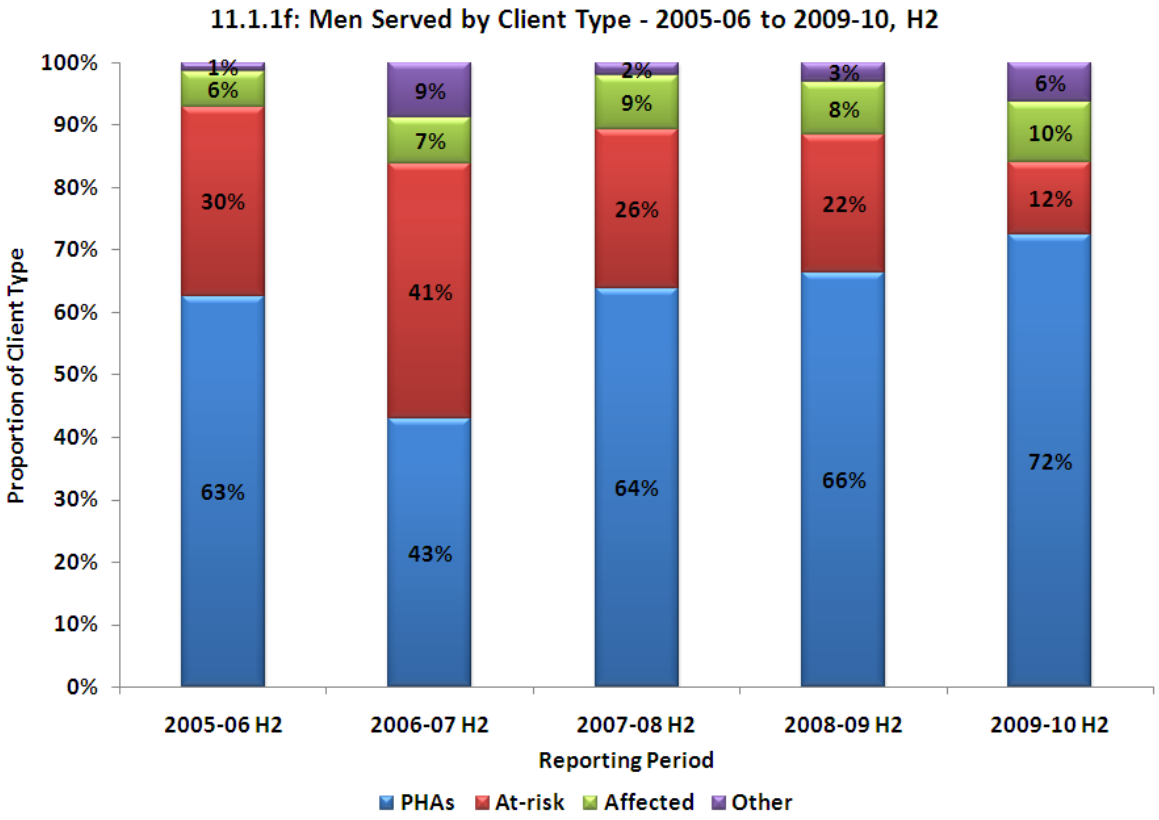
It is important to note that the changes in at-risk clients in this and future years may be due in part to some programs reporting that data in Section 13 for their IDU clients instead of this section.

The proportion of female clients by client type has been relatively stable as has the proportion of women living with HIV. The apparent drop in women at risk being served is likley due to programs shifting their reporting to the IDU Section.



Fiscal Year	PHAs	At-Risk	Affected	Other
2005-06 H2	3039	1768	716	88
2006-07 H2	2503	1828	825	695
2007-08 H2	3216	1060	757	335
2008-09 H2	3390	918	835	194
2009-10 H2	3276	546	807	299

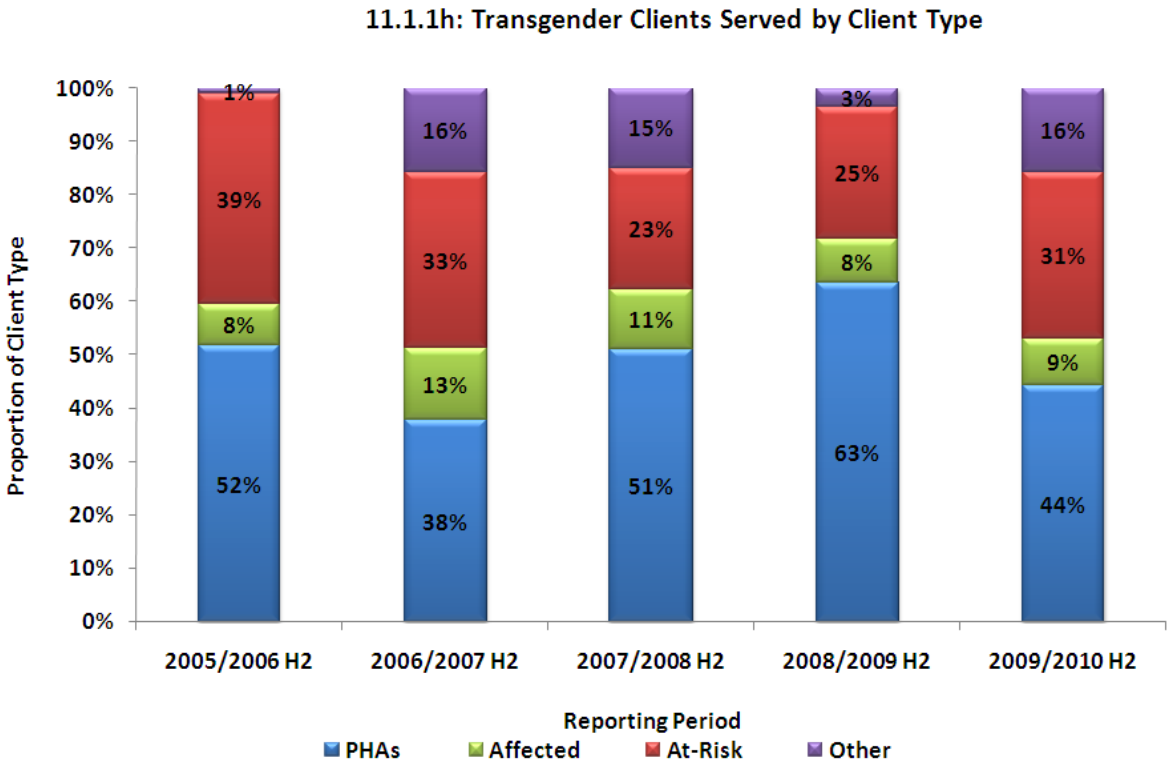
The opposite trend occurred with male clients (Figure 11.1.1f). The number of men with HIV using support services increased by almost 900 while the number of at-risk men served dropped by almost 1,000. Again, this may be due to programs reporting this in the IDU section of OCHART. As programs enhance their capacity to track clients over time, we should learn more about when and why people enter or leave services and provide more effective supports.



Fiscal Year	PHAs	At-Risk	Affected	Other	Total
2005-06 H2	8,057	3,908	735	166	12,866
2006-07 H2	5,380	5,110	929	1,093	12,512
2007-08 H2	7,073	2,836	964	216	11,089
2008-09 H2	6,576	2,186	837	301	9,900
2009-10 H2	7,468	1,198	991	652	10,309

Transgender Clients

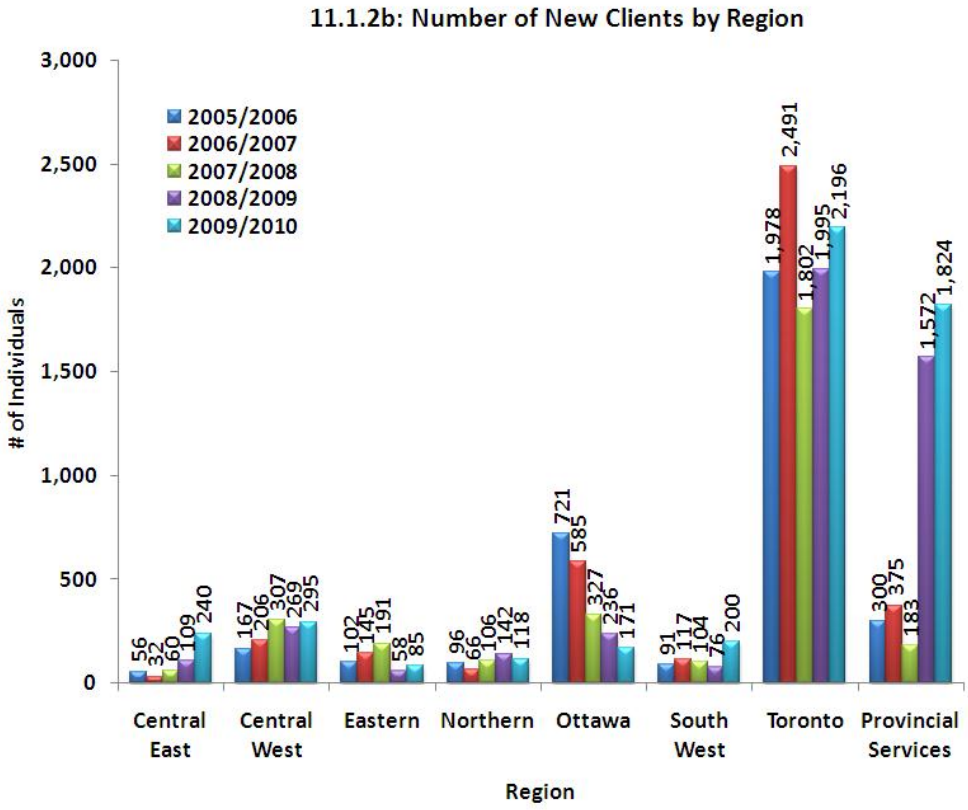
Programs report transgender clients in all regions though three do not have trans men as clients while all regions report trans women clients. It will be useful to understand more fully transgender clients use of services and how our sector can better serve their needs.



Fiscal Year	PHAs	Affected	At-Risk	Other
2005/2006 H2	105	16	80	2
2006/2007 H2	87	31	76	36
2007/2008 H2	72	16	32	21
2008/2009 H2	92	12	36	5
2009/2010 H2	70	14	49	25

More New Clients

In the second half of the reporting year (H2), the number of new clients increased by almost 500. Every region except Northern reported an increase. The large number of new clients in the Northern Region in 2008-09 was a reporting error.



The goal is to ensure that all people diagnosed with HIV have access to services. Ideally everyone who is diagnosed would be connected to community-based programs so they would be aware of the services available. However, many people do not necessarily need or seek out services when they are first diagnosed, and it is difficult to find links between the number of people newly diagnosed and the number of new users of support services. As we refine our data collection and case management systems, we may be able to determine what proportion of newly diagnosed people access and use community-based support services.

Programs Offer More Intake and Assessment and Case Management Services

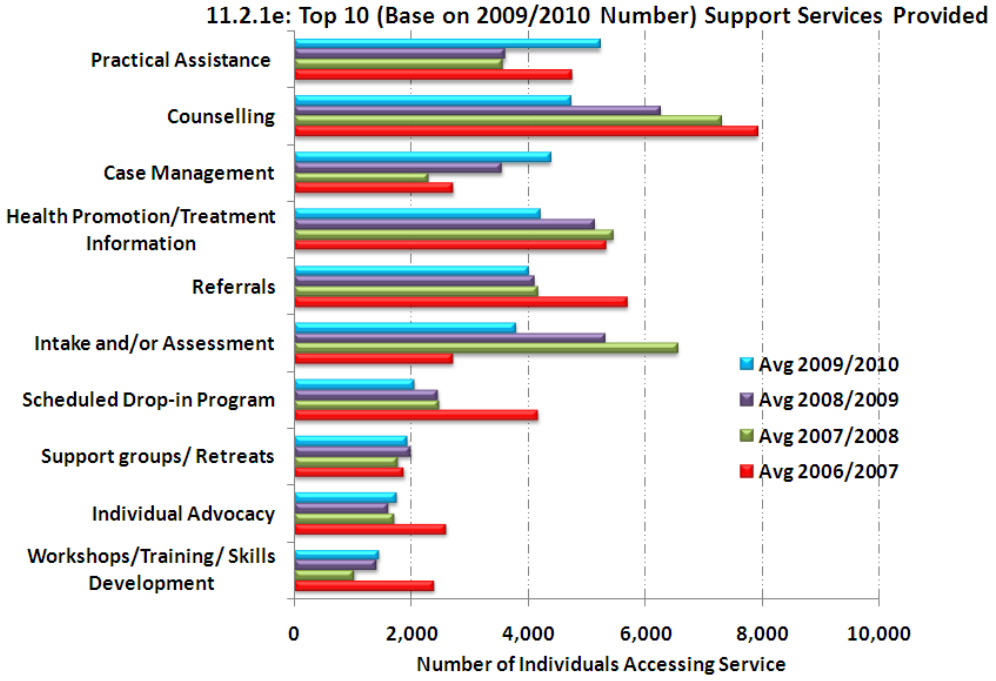
OCHART question 11.2.1: Record all services provided this reporting period to male, female and transgender persons. Please note the following: record how many of the above Service Users accessed the service, NOT the number of times the service was accessed.

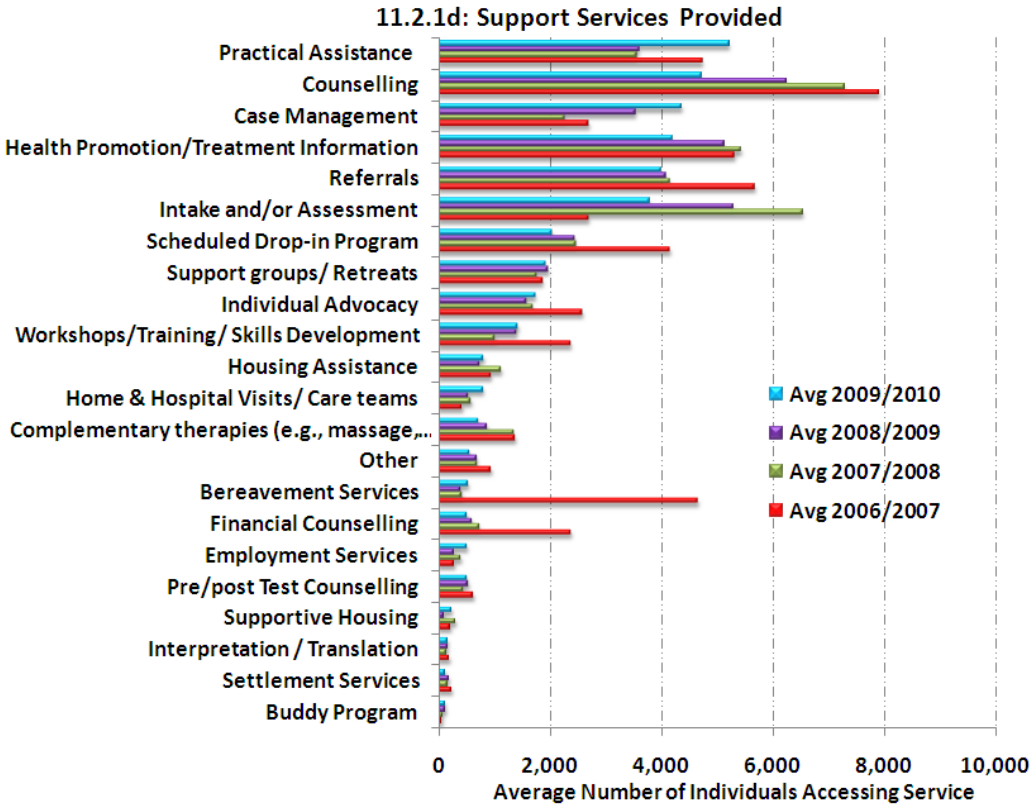
In 2009-10, more individuals accessed practical assistance and case management services than in previous years, and the demand for support groups, individual advocacy and referrals remained high (see Figures 11.2.1d and 11.2.1e). Of interest are several new ACAP funded projects focusing on case management that started in 09/10 that may lead to more comprehensive services being provided.

There was a small but growing demand for home and hospital visits during the year, and there is some anecdotal evidence that people who have been living with HIV for many years may need more complex care for their health issues (e.g., aging, co-morbidities). In 2009-10, more clients used workshops/skills development services, which may indicate an increased

interest in return to work for many people with HIV and/or reinforce the fact that employment is an issue for people with HIV.

The drop in the number of counselling services provided is likely not an actual drop but rather a shift to counting those sessions as case management, again perhaps a reflection of the use of case management systems.

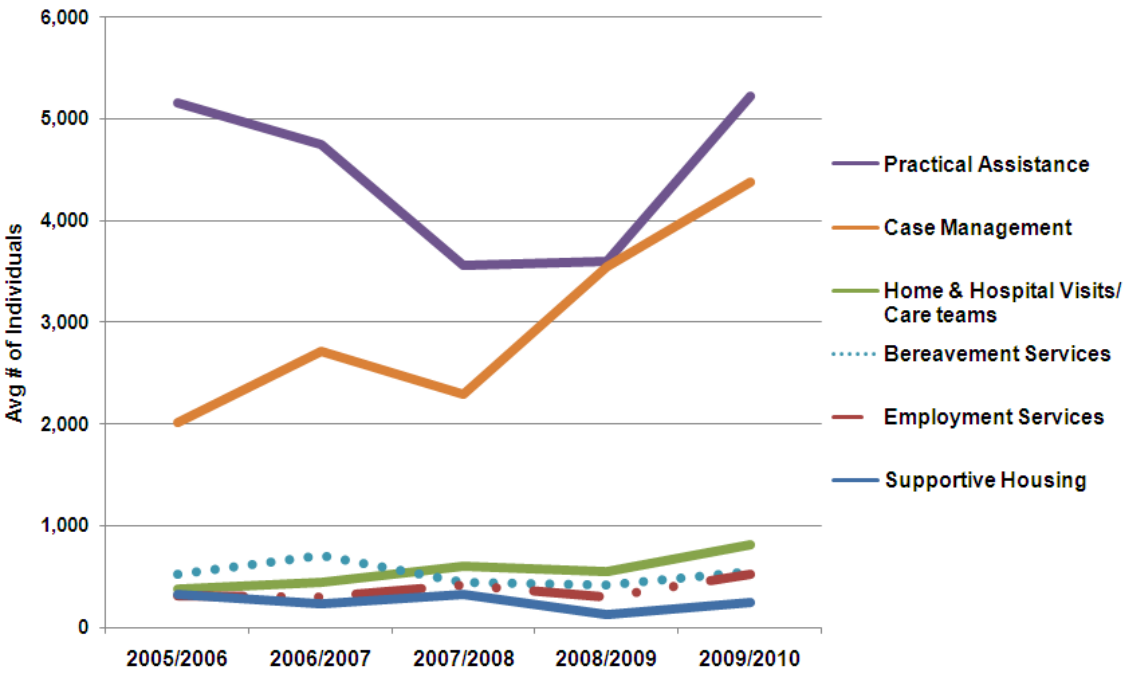




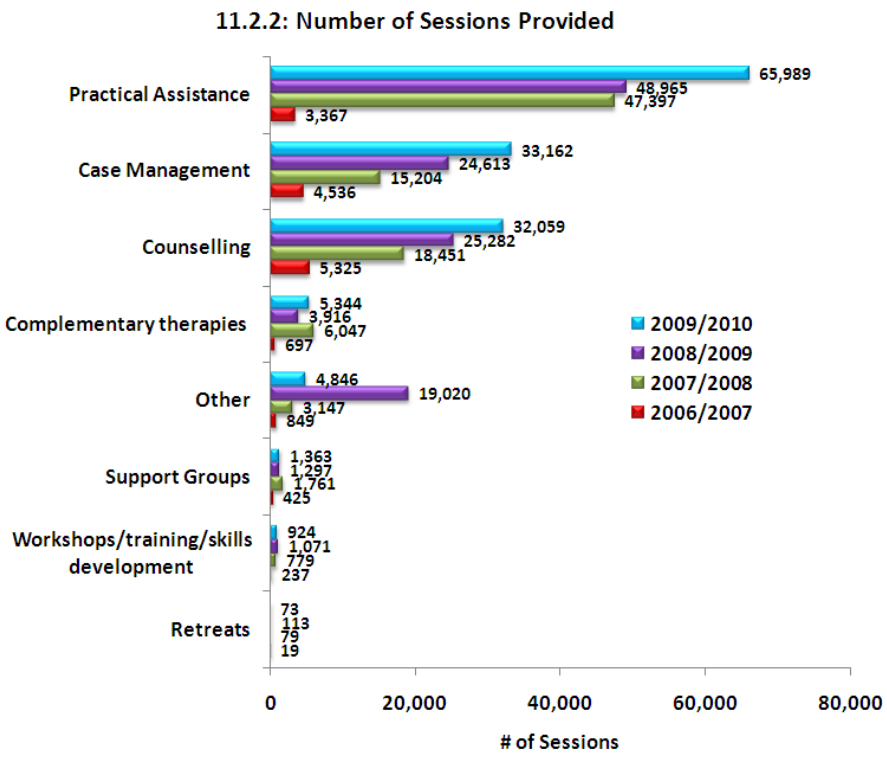
The "top 10" support services (see Figure 11.2.1e) provided tends to vary by type of program. ASOs are more likely to provide practical assistance, health promotion and case management services, while provincial programs are more likely to provide intake/assessment and referral services. Other community-based programs focus more on health promotion, counselling and referrals, while hospital-based programs offer mainly home and hospital visits. These variations are consistent with the different mandates of the funded programs.

The following graph shows the support services that increased between 2005-06 and 2009-10: the most dramatic increase was in case management services followed by practical assistance and training and skills development. Again, this is likely a reflection of better data collection and use of OCASE. It would be helpful to track the types of training and skills development that are taking place and the impact of those, over time, on both engagement in paid and volunteer work as well as the quality of life for clients.

11.2.1b: Support Services that Increased More Than 20% Between 08/09 and 09/10



In an effort to measure not only the type of services but the intensity of services provided, programs were asked about the number of sessions of certain types of services. As Figure 11.2.2 illustrates, the capacity for programs to track the number of sessions is improving over time as indicated by the drop in the "other" category. The high number of "other" sessions in 2008-09 was mainly due to one agency capturing their food bank data in the "other" rather than the "practical assistance" category.

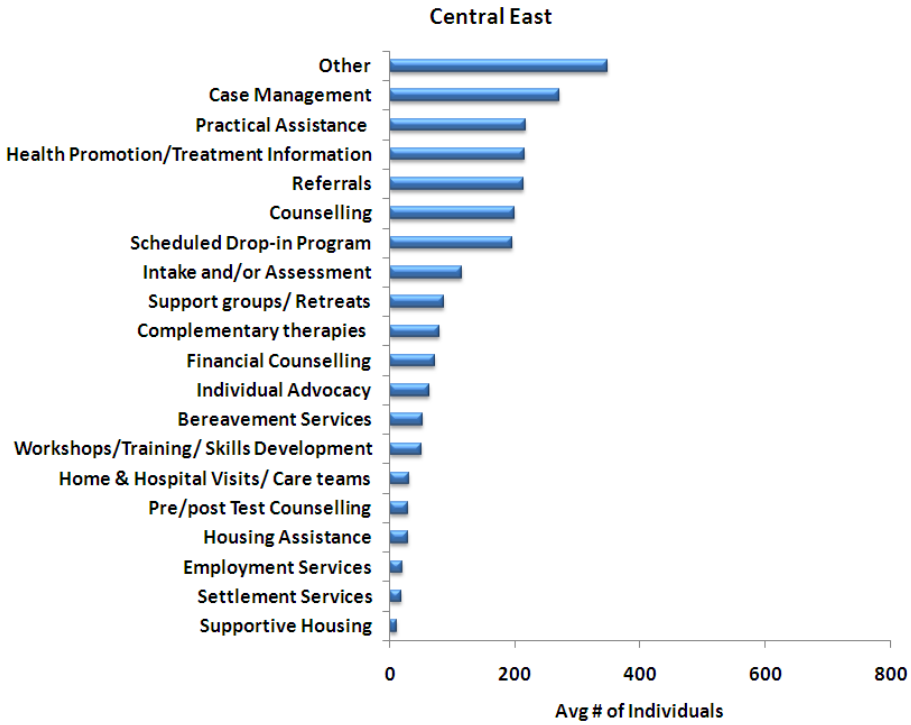


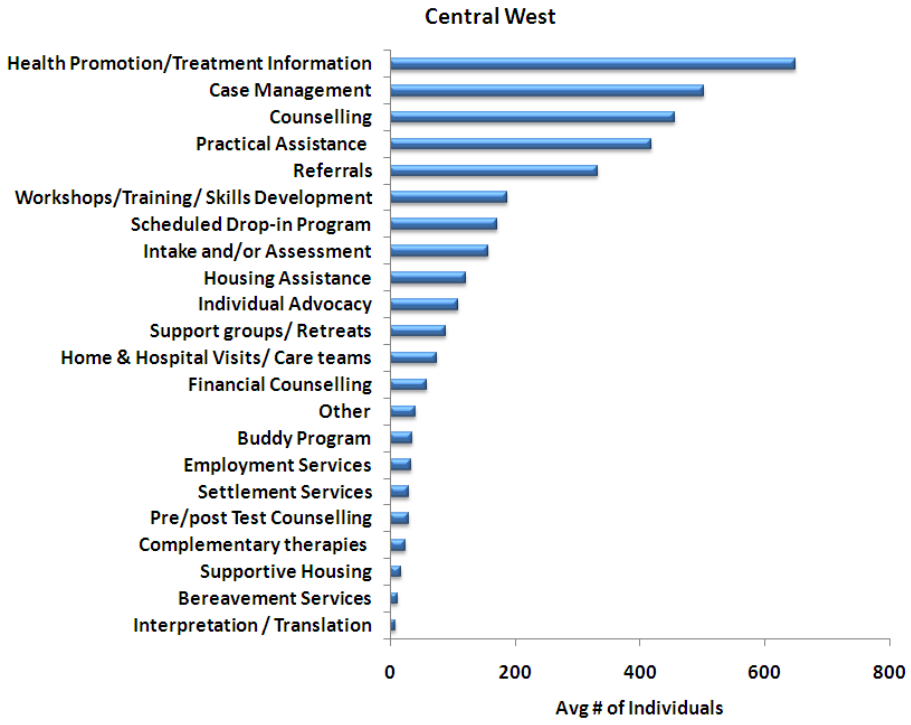
Availability of Services Varies by Region

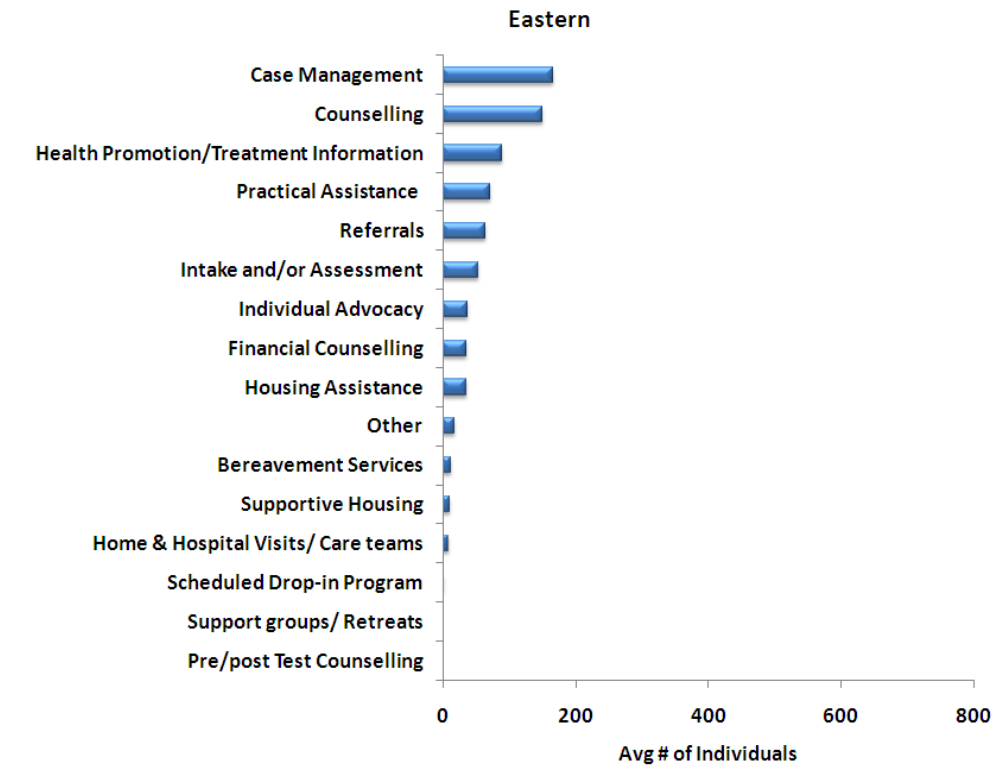
The types of support services provided and used vary across the province although health promotion and treatment information, case management, counselling, practical assistance and referrals are the top five services in almost all regions (See Regional Breakdowns 11.2.1d). Central East reported a significant number of "other" services, largely due to one agency counting their food bank and needle exchange activity in this category, which will change in the next reporting period. Ottawa and Central East also have scheduled drop-in programs that are attracting a lot of clients. Provincial programs are more likely than other programs to report providing intake and/or assessment services and this is largely due to one program that provides a significant number of phone assessments.

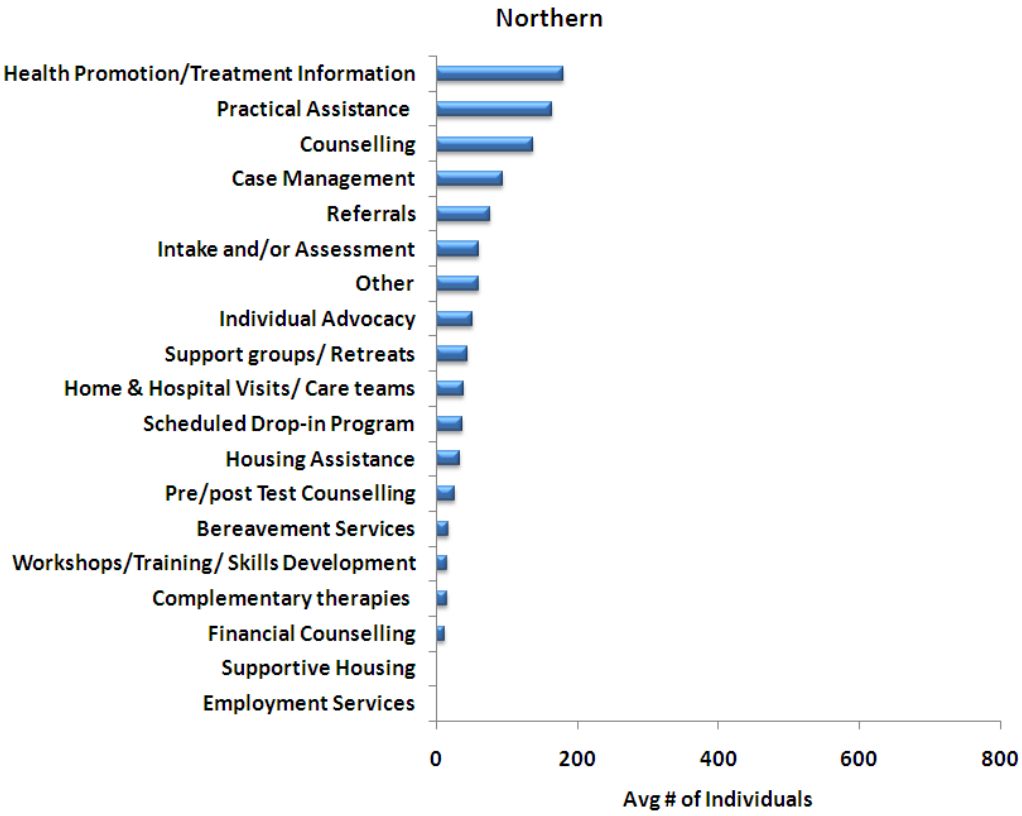
Regional Breakdown – Chart 11.2.1d

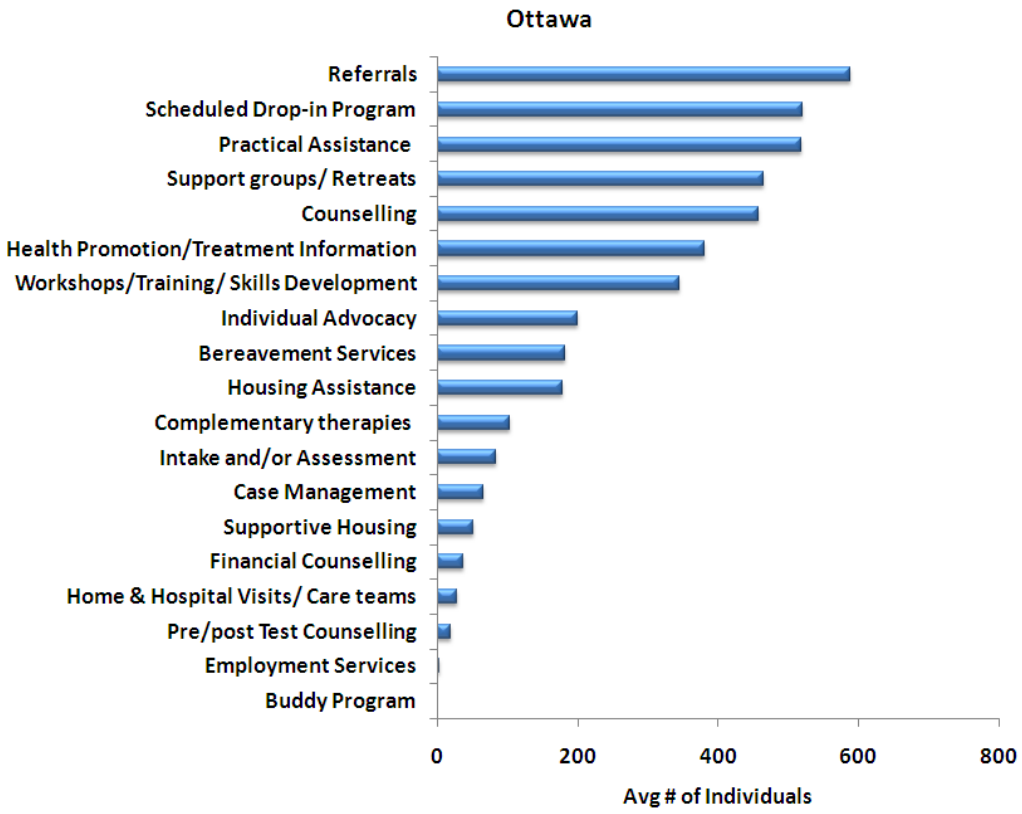
Please Note: The Avg # of Individuals scale at the bottom of the Toronto and Provincial Services charts differs from the others due to the number of clients they serve.

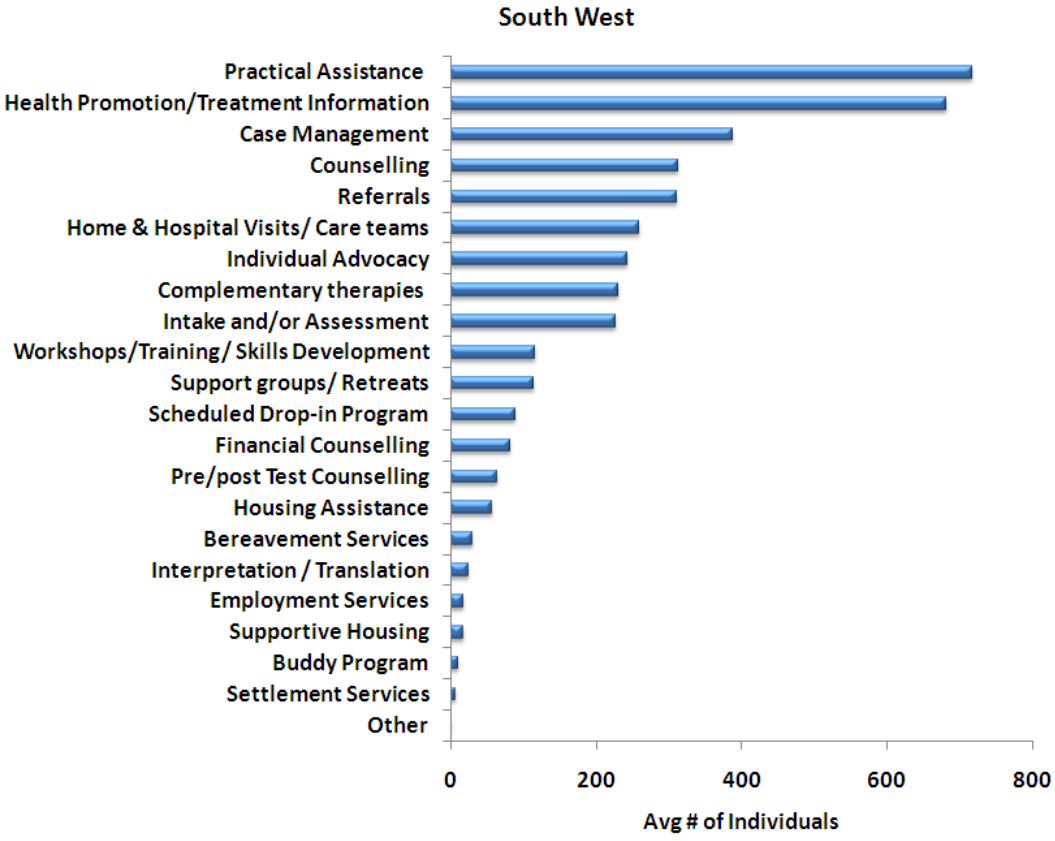


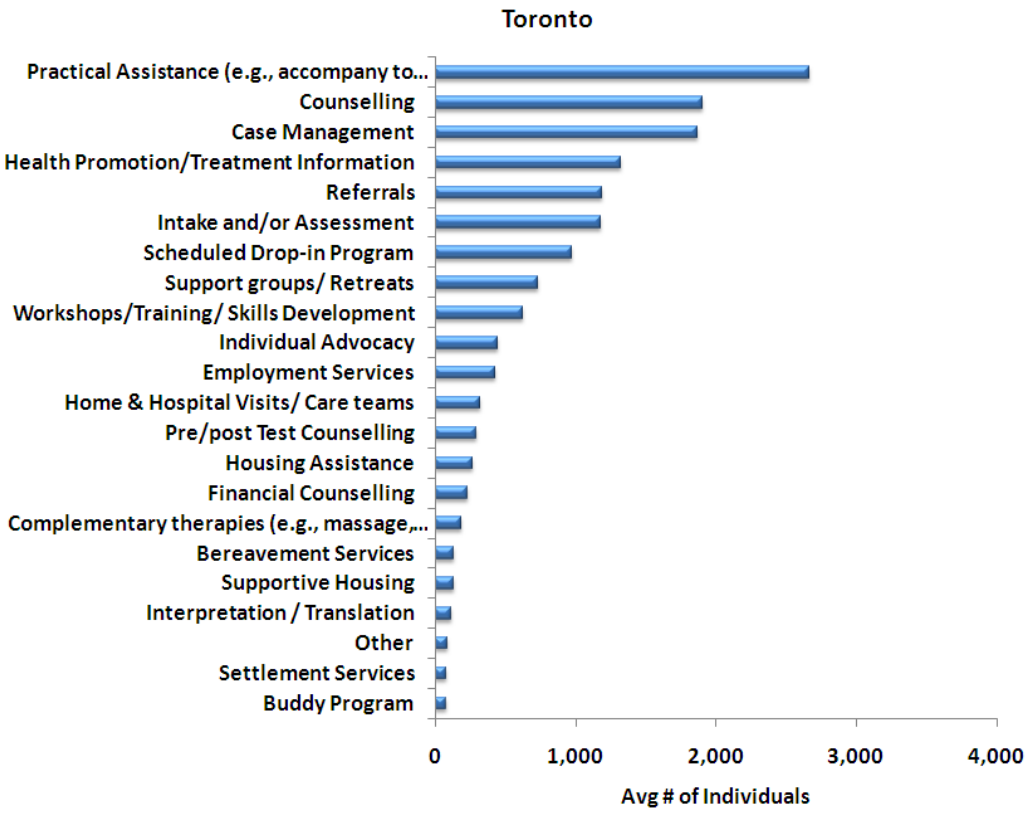


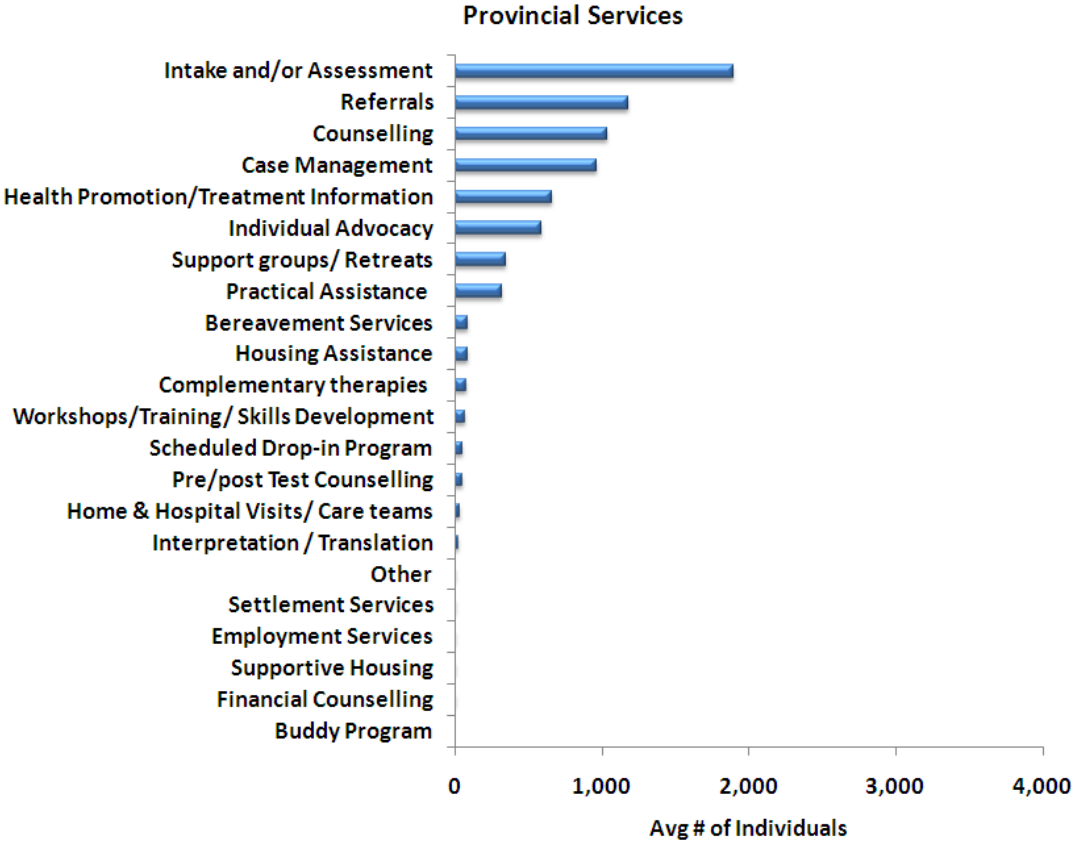

Eastern
Case Management
Counselling
Health Promotion/Treatment Information
Practical Assistance
Referrals
Intake and/or Assessment
Individual Advocacy
Financial Counselling
Housing Assistance
Other
Bereavement Services
Supportive Housing
Home & Hospital Visits/ Care teams
Scheduled Drop-in Program
Support groups/ Retreats
Pre/post Test Counselling
0
200
400
600
800
Avg # of Individuals


Northern
Health Promotion/Treatment Information
Practical Assistance
Counselling
Case Management
Referrals
Intake and/or Assessment
Other
Individual Advocacy
Support groups/ Retreats
Home & Hospital Visits/ Care teams
Scheduled Drop-in Program
Housing Assistance
Pre/post Test Counselling
Bereavement Services
Workshops/Training/ Skills Development
Complementary therapies
Financial Counselling
Supportive Housing
Employment Services
0
200
400
600
800
Avg # of Individuals


Ottawa
Referrals
Scheduled Drop-in Program
Practical Assistance
Support groups/ Retreats
Counselling
Health Promotion/Treatment Information
Workshops/Training/ Skills Development
Individual Advocacy
Bereavement Services
Housing Assistance
Complementary therapies
Intake and/or Assessment
Case Management
Supportive Housing
Financial Counselling
Home & Hospital Visits/ Care teams
Pre/post Test Counselling
Employment Services
Buddy Program
0
200
400
600
800
Avg # of Individuals


South West
Practical Assistance
Health Promotion/Treatment Information
Case Management
Counselling
Referrals
Home & Hospital Visits/ Care teams
Individual Advocacy
Complementary therapies
Intake and/or Assessment
Workshops/Training/ Skills Development
Support groups/ Retreats
Scheduled Drop-in Program
Financial Counselling
Pre/post Test Counselling
Housing Assistance
Bereavement Services
Interpretation / Translation
Employment Services
Supportive Housing
Buddy Program
Settlement Services
Other
0
200
400
600
800
Avg # of Individuals


Toronto
Practical Assistance (e.g., accompany to...
Counselling
Case Management
Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Scheduled Drop-in Program
Support groups/ Retreats
Workshops/Training/ Skills Development
Individual Advocacy
Employment Services
Home & Hospital Visits/ Care teams
Pre/post Test Counselling
Housing Assistance
Financial Counselling
Complementary therapies (e.g., massage,...
Bereavement Services
Supportive Housing
Interpretation / Translation
Other
Settlement Services
Buddy Program
0
1,000
2,000
3,000
4,000
Avg # of Individuals

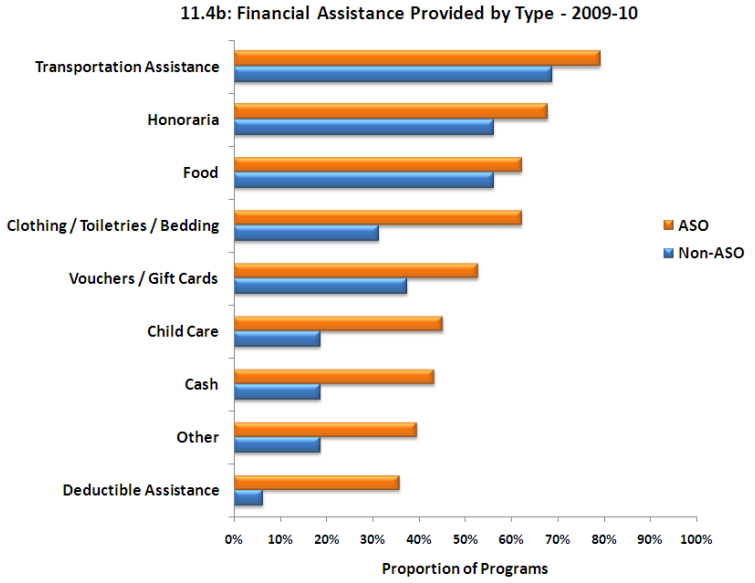

Provincial Services
Intake and/or Assessment
Referrals
Counselling
Case Management
Health Promotion/Treatment Information
Individual Advocacy
Support groups/ Retreats
Practical Assistance
Bereavement Services
Housing Assistance
Complementary therapies
Workshops/Training/ Skills Development
Scheduled Drop-in Program
Pre/post Test Counselling
Home & Hospital Visits/ Care teams
Interpretation / Translation
Other
Settlement Services
Employment Services
Supportive Housing
Financial Counselling
Buddy Program
0
1,000
2,000
3,000
4,000
Avg # of Individuals

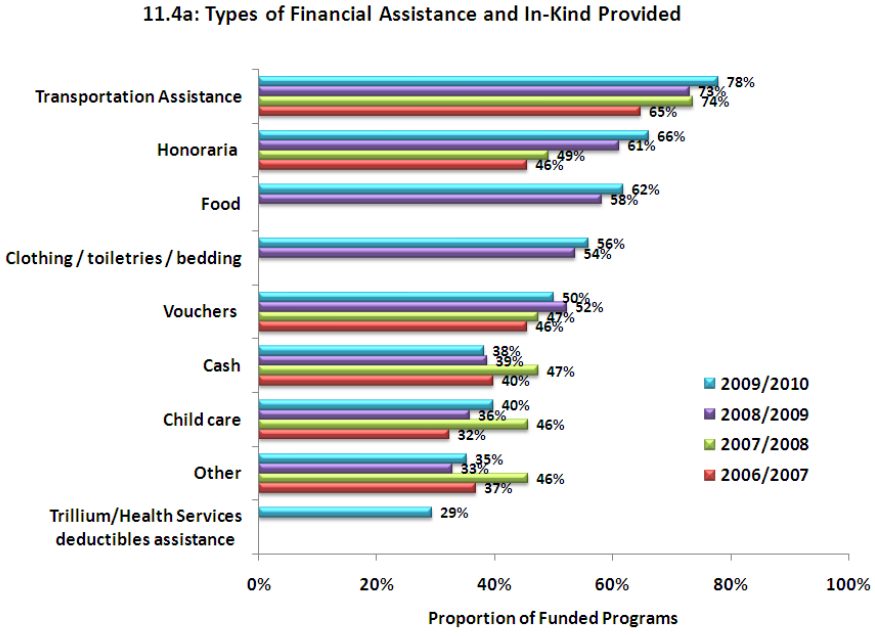
Growing Demand for Financial and In-Kind Assistance

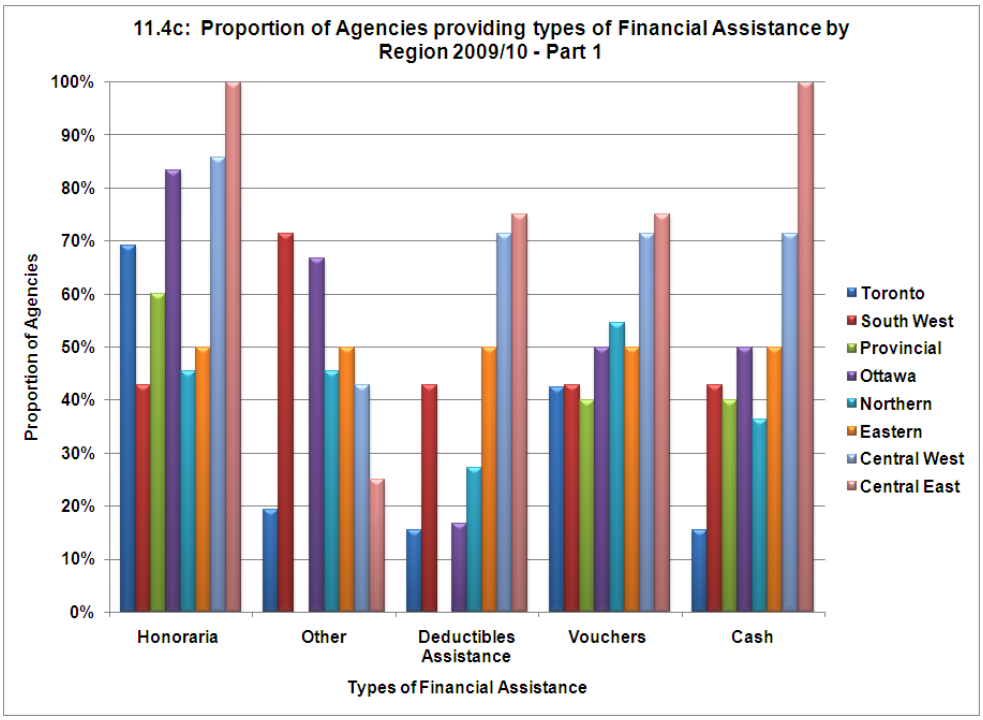
OCHART question 11.4: Financial Support - What other assistance do you provide?

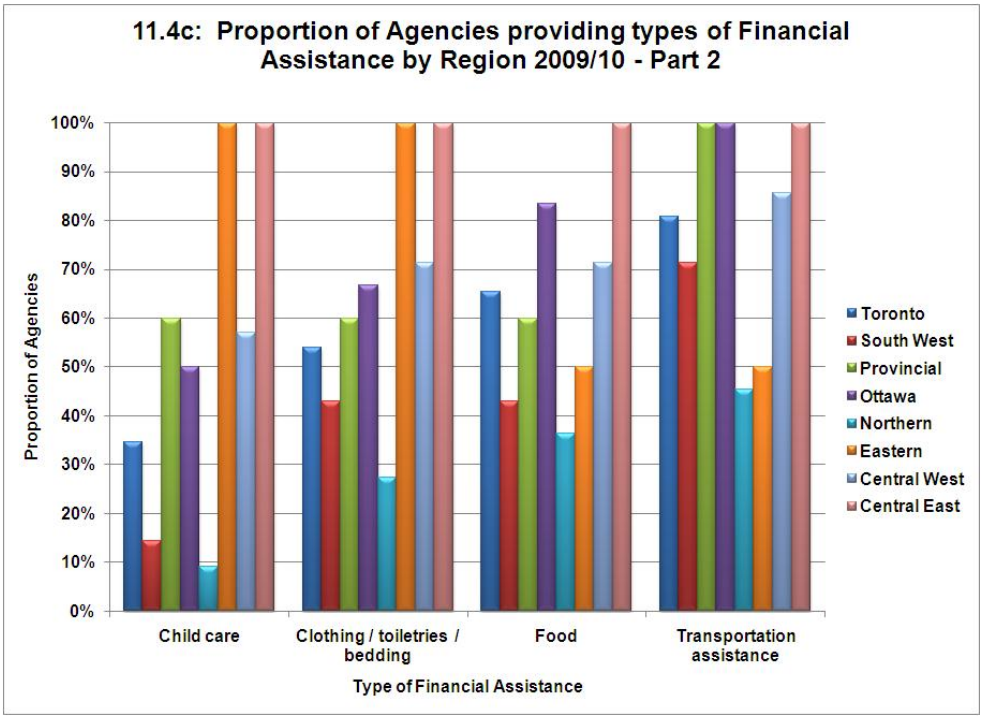
More programs are providing financial and in-kind assistance for clients, primarily in the form of transportation assistance, honoraria for speaking engagements, food, clothing and vouchers (see Figures 11.4a, 11.4b and 11.4c). The total amount of financial assistance reported by programs is $740,801 to 4,773 clients. There may be some double-counting of clients across the two reporting periods. In the future, we will review this question to consider how this data can be more accurately reported.

There is regional variation in the types of financial and in-kind assistance provided by programs. This is affected by the number of clients served, the services offered by the program, fundraising and other services providers in the region.






11.4c: Proportion of Agencies providing types of Financial Assistance by Region 2009/10 - Part 1
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Proportion of Agencies
Honoraria
Other
Deductibles Assistance
Vouchers
Cash
Types of Financial Assistance
Toronto
South West
Provincial
Ottawa
Northern
Eastern
Central West
Central East


11.4c: Proportion of Agencies providing types of Financial Assistance by Region 2009/10 - Part 2
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Proportion of Agencies
Child care
Clothing / toiletries / bedding
Food
Transportation assistance
Type of Financial Assistance
Toronto
South West
Provincial
Ottawa
Northern
Eastern
Central West
Central East

Regional Shifts in Demand for Support Services and Responses to Emerging Trends

Central East Region

- Increased need to fundraise to provide more practical assistance (food bank, vouchers, basic needs) for clients and newcomers (mostly women).
- Concerns about where newcomer men were accessing support in the region since most services were accessed by women.
- More support for clients related to disclosure of HIV status and criminalization.

Central West Region

- More family-friendly and immigration/settlement related support services to newcomers and children affected/infected.
- More partnerships with housing agencies to make referrals for clients.
- More clients wanting information on becoming pregnant.
- More complex support needs of clients with mental health and addiction issues.
- An aging client population that requires new supports such as visitation, house cleaning, and massage services.

Eastern Region

- More need for advocacy and assistance with new pain relief methods for clients with Hepatitis C, which programs met by enhancing co-operation with local agencies.

Northern Region

- Hired a support worker to address women's issues.
- Gathered input from clients about their changing needs (e.g., mental health, meal services).
- Advocated for clients with mental health/substance use issues to receive palliative care by networking with hospice staff.
- More need for support services for male clients who experience violence in same-sex relationships as well as education for service providers and the police on creating safety plans.

Ottawa Region

- More diverse support services to newcomers including immigration, housing, mental health, trauma, and health care.
- Greater need for support groups for English-speaking as well as French-speaking newcomer women.

South West Region

- More need for financial assistance to help clients pay for medication.
- More support with Hepatitis C claims, applying for funding to support co-infected clients.

- More staff time spent attending testing appointments with clients.
- More clients who self-refer as at-risk and want to work with an Aboriginal service provider.

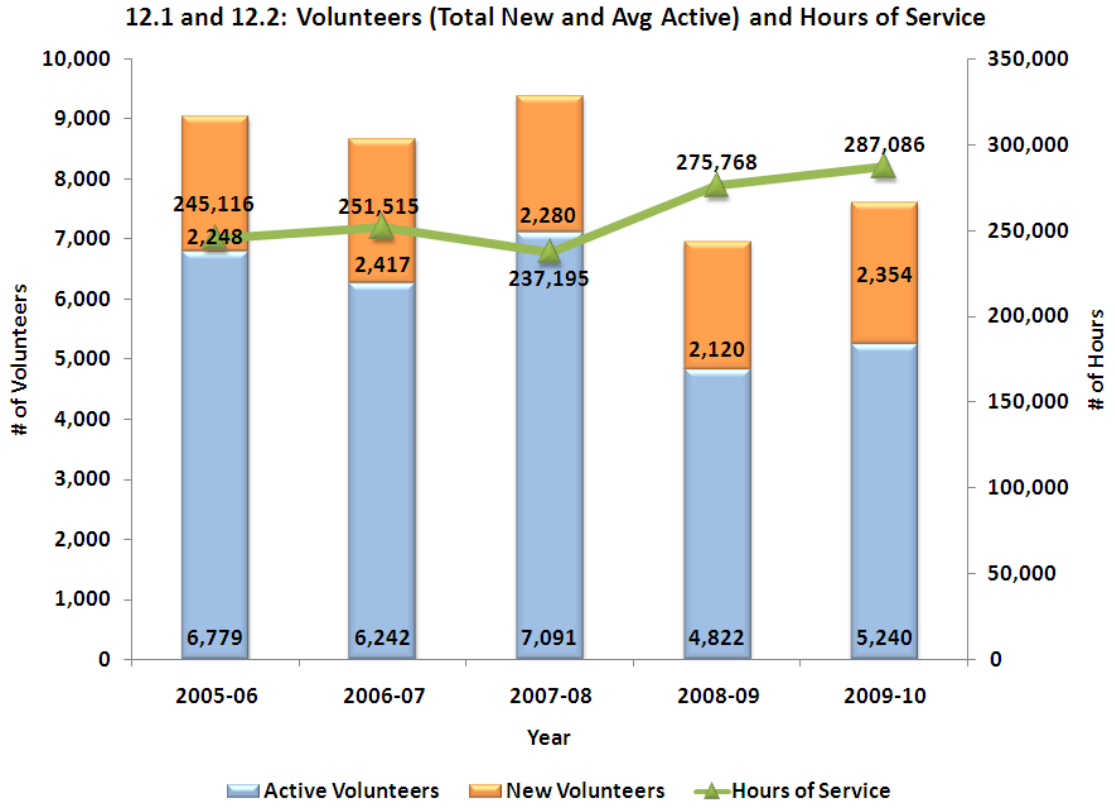
Toronto Region

- More need for advocacy for housing, immigration/settlement issues, complex needs (mental health, substance use, poverty), disclosure, supports for aging clients including medical support/hospitalization support, clients with dementia, caregiver support, services for clients involved in sex work and education to service providers, and legal services.
- More demand for workshops on how to disclose to a partner in addition to the traditional resources on disclosure/criminalization.
- More clients attending conferences/workshops who require psycho-social support to participate fully.
- More need to advocate for access to Ontario Disability Support Program (ODSP) and provide support with power of attorney designation.
- Successful use by one program of a new intake tool FARM (Frail At-Risk and Marginalized) Assessment to provide support to clients who are homeless.

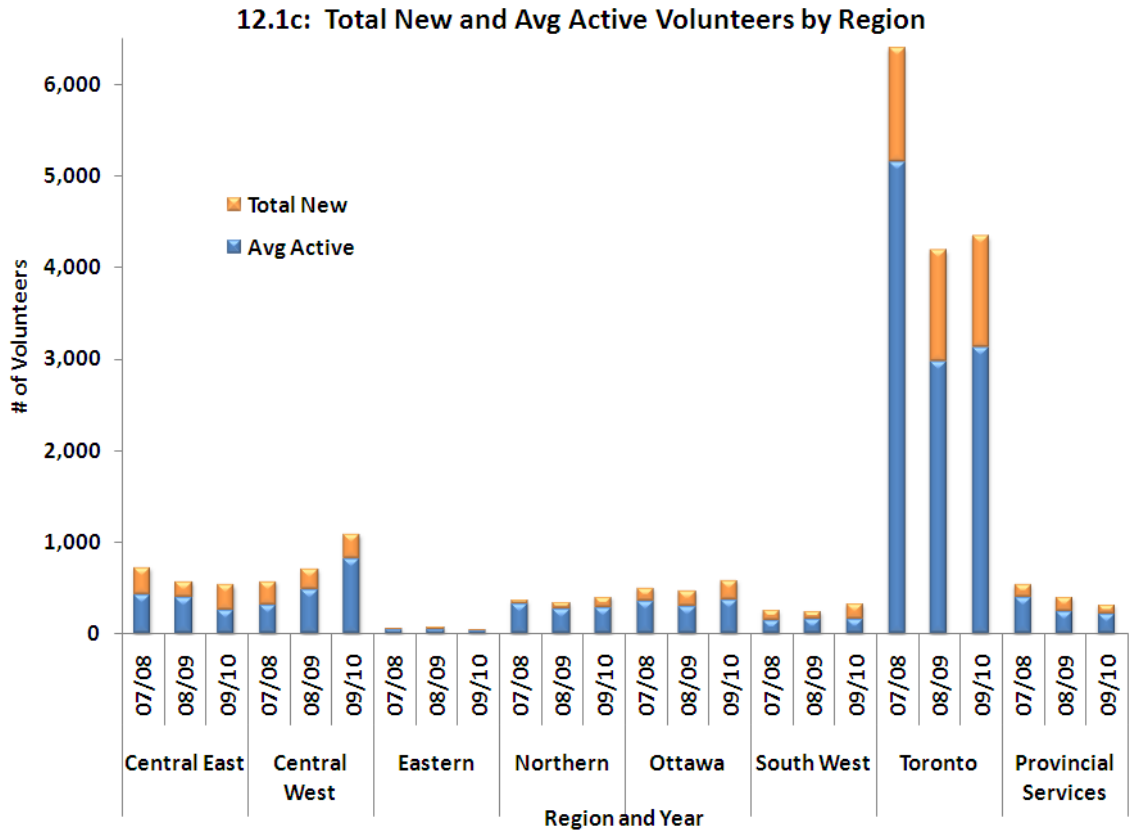
4.4 Use of Volunteers

OCHART questions 12.1 Volunteers and Volunteer Management and 12.2 Volunteer Activities

The total number of volunteers and the hours they contributed to community-based HIV services increased in 2009-10 after a drop in 2008-09 (see Figure 12.1 and 12.2). Once again, as programs use systems to better collect and track volunteer activity, we will have a more accurate picture of their impact on our services.



An estimate of the dollar value of the volunteer hours contributed to HIV programs around Ontario, based on an ACAP formula used to determine the value of ACAP volunteer contributions across the country, shows the approximate value of volunteers in our sector is a staggering $4.7 million. The obvious benefits to the programs of this volunteer work are tremendous but there is also the added benefit of almost 8,000 people having a better understanding of the challenges of living with HIV and the resiliency of many of the people facing HIV and related issues. It also would be of interest to understand the impact of volunteers on fundraising as there are significant numbers involved in that activity.



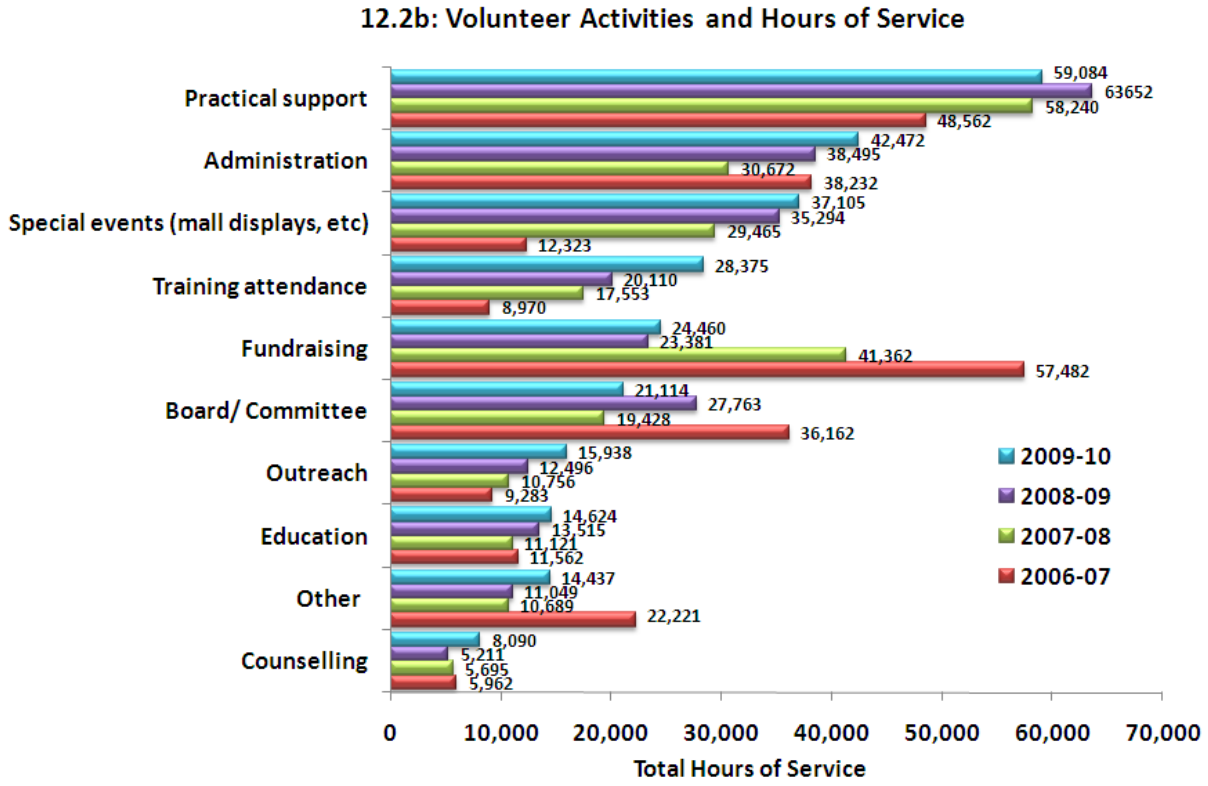
	Central East			Central West			Eastern			Northern		
	07/08	08/09	09/10	07/08	08/09	09/10	07/08	08/09	09/10	07/08	08/09	09/10
Avg. Active	418	397	256	310	472	818	36	36	25	321	265	287
Total New	301	165	272	258	227	263	19	31	17	38	69	112

	Ottawa			South West			Toronto			Provincial Services		
	07/08	08/09	09/10	07/08	08/09	09/10	07/08	08/09	09/10	07/08	08/09	09/10
Avg. Active	345	301	364	138	158	157	5,135	2,958	3,119	389	237	216
Total New	151	162	216	113	82	162	1,258	1,227	1,216	142	157	96

Volunteers more involved in direct service delivery

In 2009-10, organizations reported more volunteer hours spent delivering services such as administrative duties, special events, training and fundraising. As well, volunteers spent more time delivering training and education sessions. One program uses peer volunteers as mentors and delivers counselling through these peers. It would be very helpful to track the time and activities of peers to better understand the involvement and impact of both those living with HIV and other peers such as gay men and people from ethno-specific communities.

The hours spent on particular activities will shift year to year as programs change their approaches to better serving clients and those at-risk.



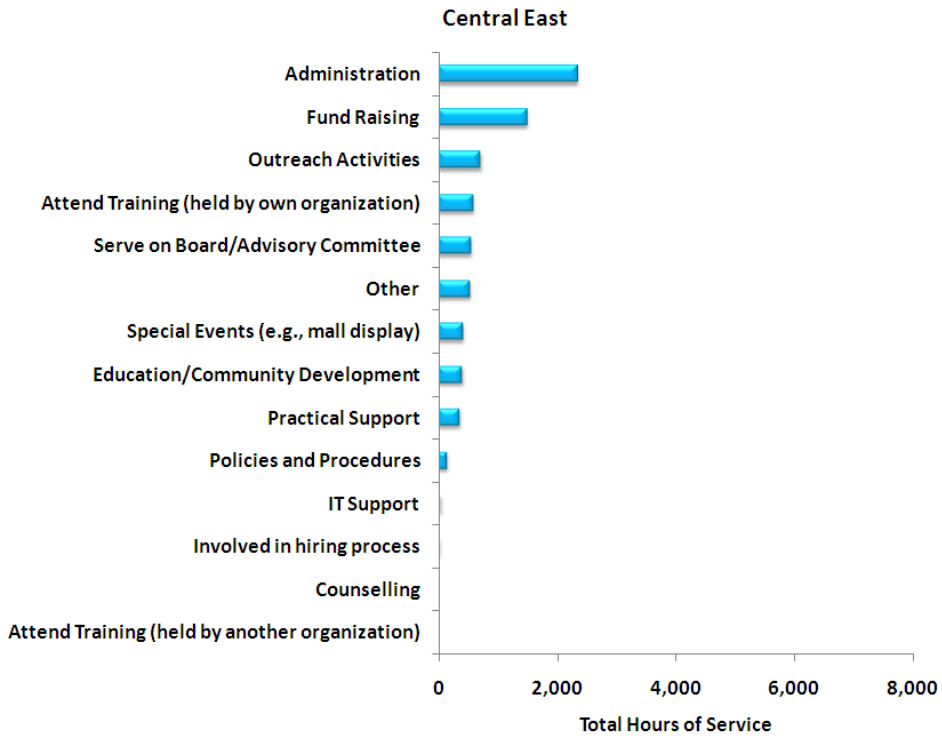
Note: In the following regional charts (Chart 12.2b) the Total Hours of Service numbers on the bottom are different depending on the total number in each region.

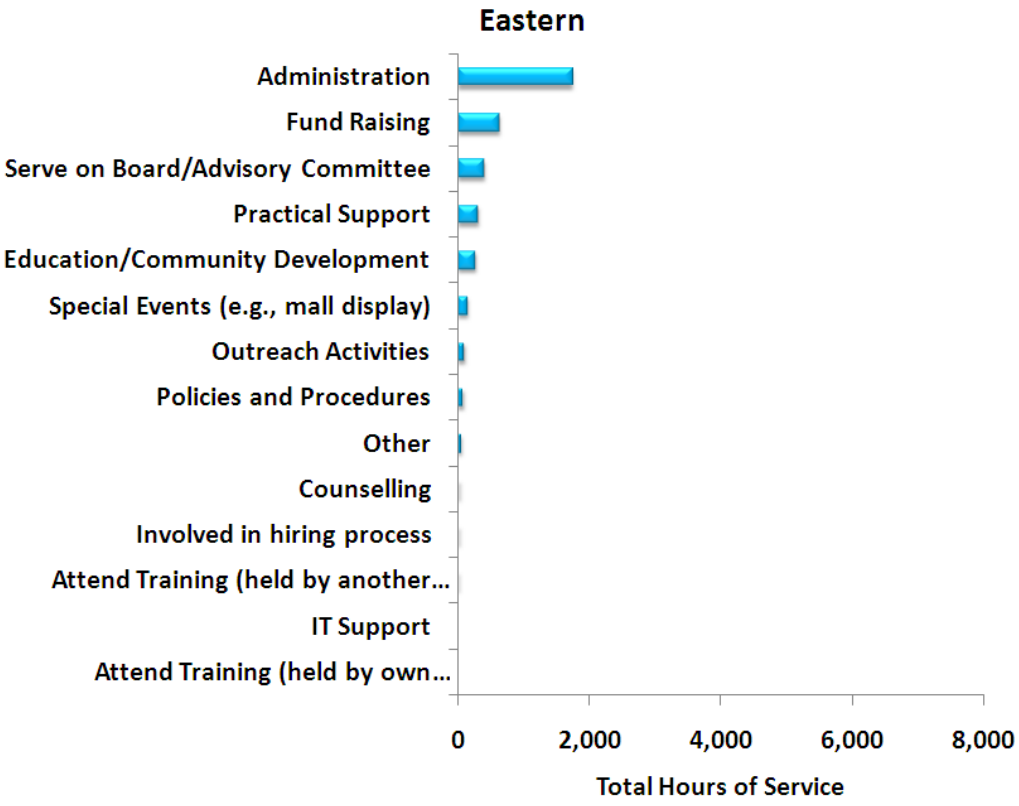
Volunteers in Ottawa, Toronto and Central West spent most of their time on practical support while those in Central East, Eastern and South West provided time on administrative activities.

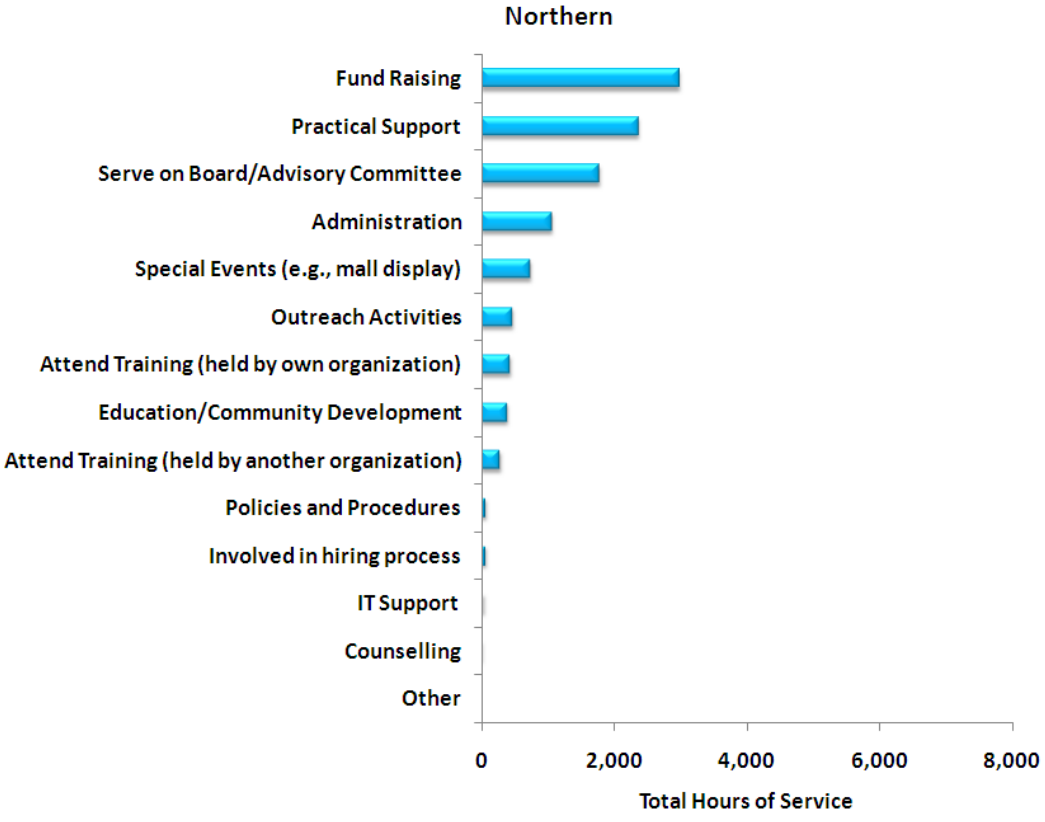
The Northern region used volunteers most in fundraising and this is of interest as the Northern region also has some of the lowest amounts of fundraised dollars. Perhaps the amount of time spent fundraising is greater in Northern communities and requires more effort to achieve, or the type of fundraising activity is more labour intensive than in other regions?

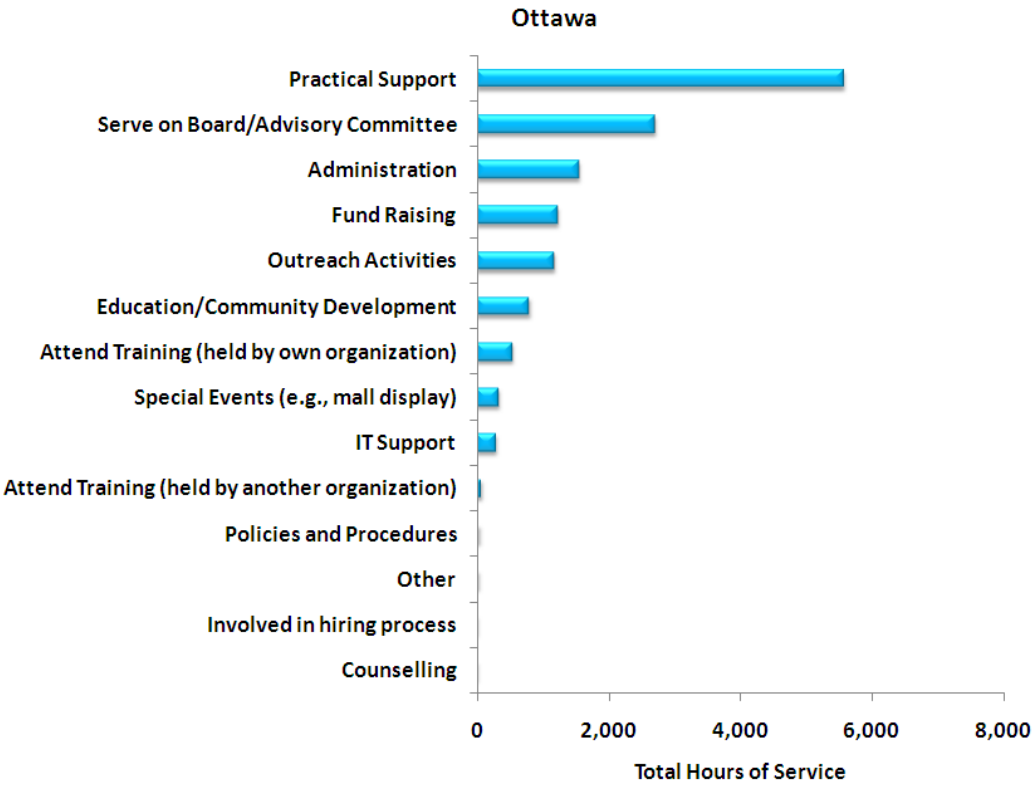
As noted above, one provincial organization engages peers in mentoring and counselling and that was the largest amount of time spent in the provincial category.

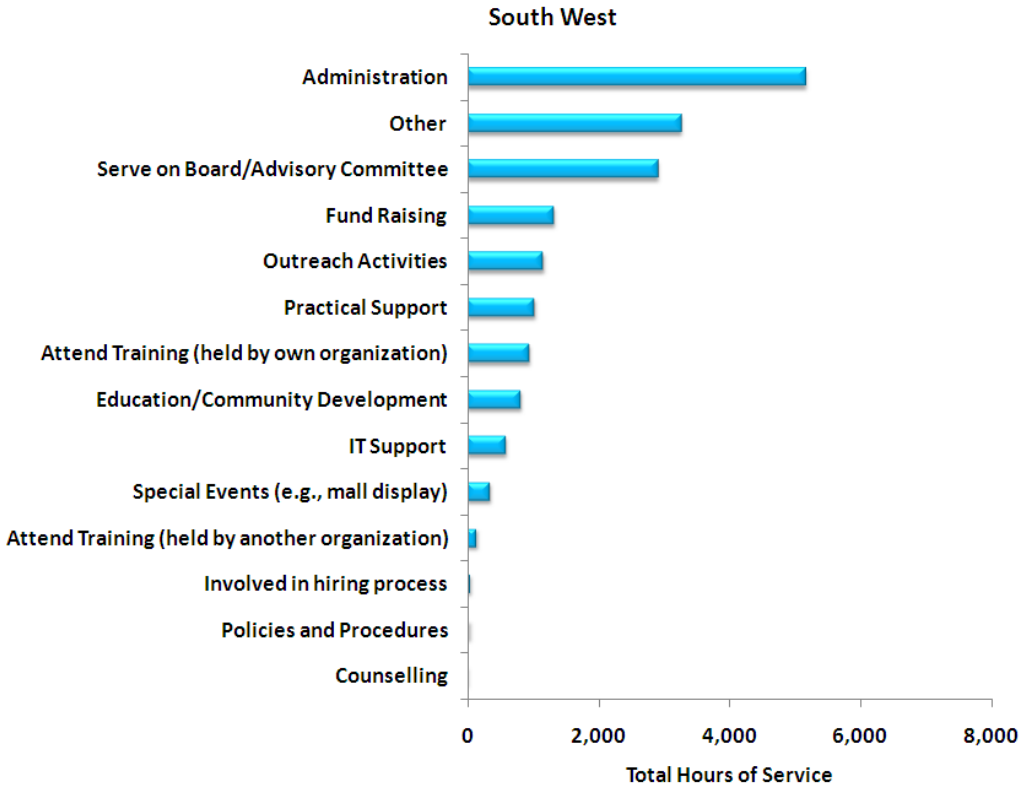
Regional Breakdown – Chart 12.2b

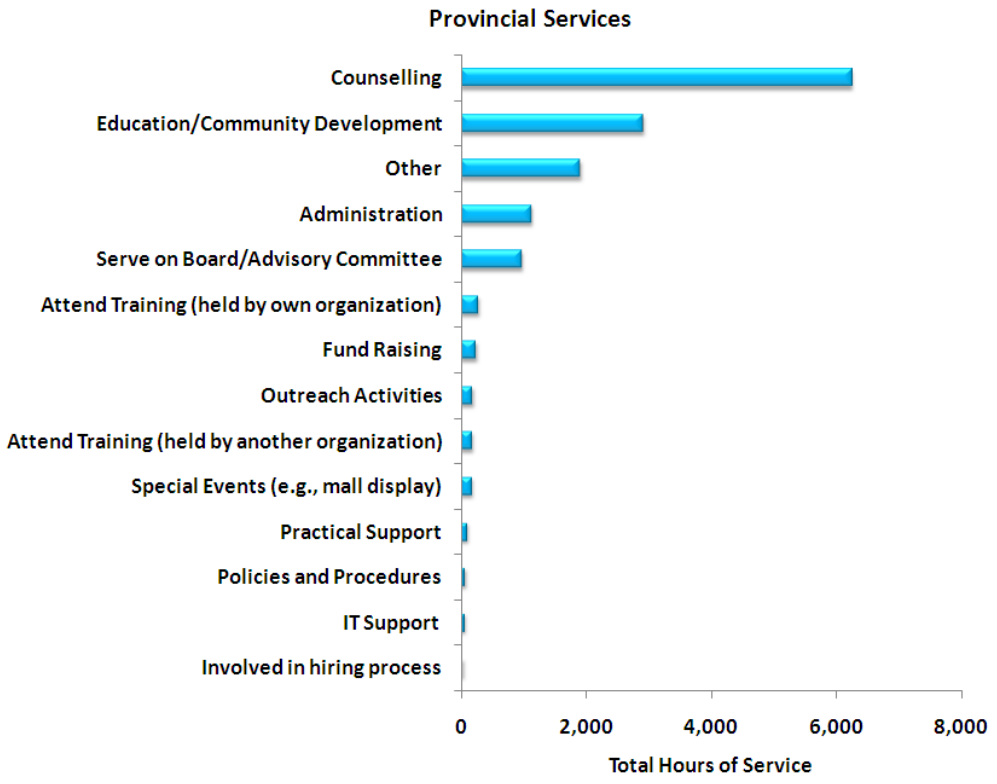


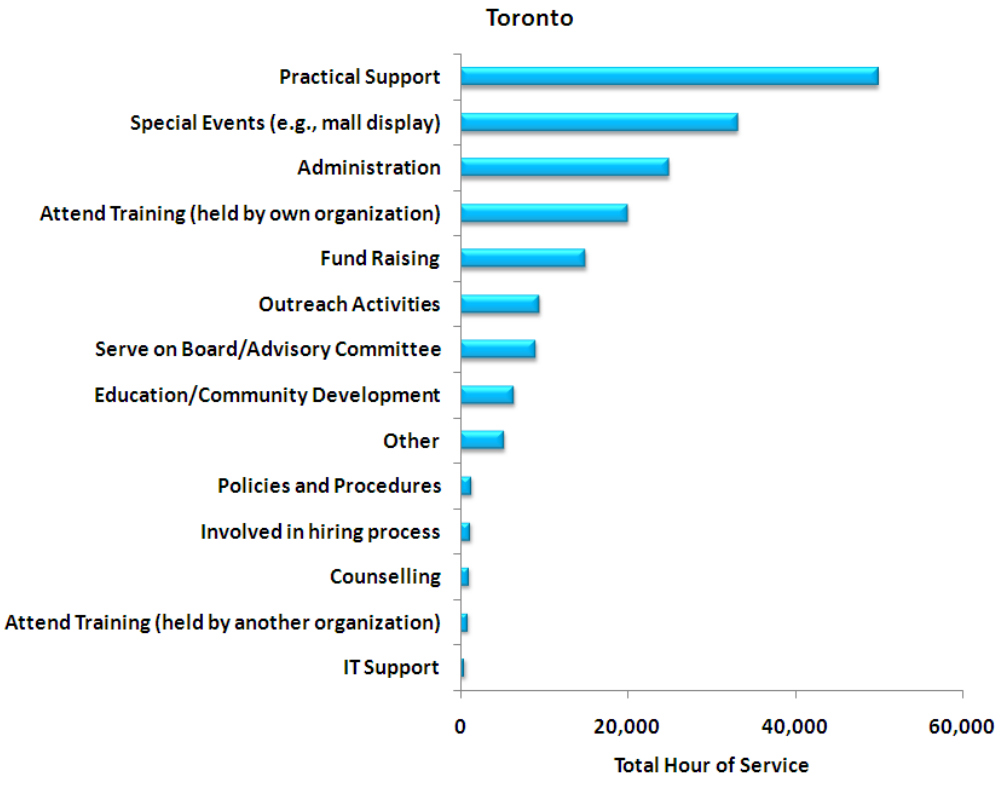

Eastern
Administration
Fund Raising
Serve on Board/Advisory Committee
Practical Support
Education/Community Development
Special Events (e.g., mall display)
Outreach Activities
Policies and Procedures
Other
Counselling
Involved in hiring process
Attend Training (held by another...
IT Support
Attend Training (held by own...
0
2,000
4,000
6,000
8,000
Total Hours of Service


Northern
Fund Raising
Practical Support
Serve on Board/Advisory Committee
Administration
Special Events (e.g., mall display)
Outreach Activities
Attend Training (held by own organization)
Education/Community Development
Attend Training (held by another organization)
Policies and Procedures
Involved in hiring process
IT Support
Counselling
Other
0
2,000
4,000
6,000
8,000
Total Hours of Service


Ottawa
Practical Support
Serve on Board/Advisory Committee
Administration
Fund Raising
Outreach Activities
Education/Community Development
Attend Training (held by own organization)
Special Events (e.g., mall display)
IT Support
Attend Training (held by another organization)
Policies and Procedures
Other
Involved in hiring process
Counselling
0
2,000
4,000
6,000
8,000
Total Hours of Service


South West
Administration
Other
Serve on Board/Advisory Committee
Fund Raising
Outreach Activities
Practical Support
Attend Training (held by own organization)
Education/Community Development
IT Support
Special Events (e.g., mall display)
Attend Training (held by another organization)
Involved in hiring process
Policies and Procedures
Counselling
0
2,000
4,000
6,000
8,000
Total Hours of Service


Provincial Services
Counselling
Education/Community Development
Other
Administration
Serve on Board/Advisory Committee
Attend Training (held by own organization)
Fund Raising
Outreach Activities
Attend Training (held by another organization)
Special Events (e.g., mall display)
Practical Support
Policies and Procedures
IT Support
Involved in hiring process
0
2,000
4,000
6,000
8,000
Total Hours of Service


Toronto
Practical Support
Special Events (e.g., mall display)
Administration
Attend Training (held by own organization)
Fund Raising
Outreach Activities
Serve on Board/Advisory Committee
Education/Community Development
Other
Policies and Procedures
Involved in hiring process
Counselling
Attend Training (held by another organization)
IT Support
0
20,000
40,000
60,000
Total Hour of Service

New Approaches to Recruiting and Retaining Volunteers

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

Central East Region programs report several issues including:

- The need to hire a volunteer coordinator in order to recruit and retain participation of volunteers, including on the Board.
- An increase in the need for volunteers who are multi-lingual.
- A need to recruit volunteers for their reception area as it can be challenging to find people available during the day for regular shifts.

Central West Region programs report:

- Several note an increase in the need for volunteer drivers and for Board members.
- Two made note of the need for fundraising and to attend community events.

Eastern Region is struggling with the absence of a volunteer coordinator and so is dealing with retention and training issues.

Northern Region programs report:

- An increase in fundraising and outreach activities has led to an increased need for volunteers.
- One program wants to train volunteers to help with support services and to help at community events.
- One program reports an increase in the number of seniors wanting to volunteer and they are shifting their orientation program to accommodate these requests.
- Again, one program reports an increased need for volunteer drivers.

Ottawa Region programs report:

- Requests from volunteers for enhanced creative opportunities.
- Requests from other organizations to manage their volunteer recruitment.
- Concerns about an aging volunteer base and how to retain them through innovative means such as online volunteering.
- One program reported an opportunity to train volunteers with another organization and this may be a way to reduce time and increase partnerships by sharing both the training and the activities of volunteers.

South West Region programs report:

- Volunteer are more interested in project-based activities and leadership opportunities and so they are identifying individual projects to be assigned to volunteers and are creating volunteer roles with greater responsibility and leveraging volunteer skills to provide meaningful service.

- In response to more requests for youth speakers, one program has created a YouTube channel featuring members of their Youth Speakers Bureau delivering speeches at various local events which helps them to showcase the skills of their youth while also helping to foster a sense of accomplishment and pride.

- One agency has revamped their volunteer program by modeling after agencies in their community with more successful programs.

- One program has recruited Aboriginal youth to develop tools and strategies for a peer group that has been developed to meet the needs of young Aboriginal people at-risk for HIV.

Toronto Region programs report:

- One program has developed partnerships with other Aboriginal organizations to fill requests for volunteers.

- One has developed an emergency response volunteer team and it would be interesting to see when and how these volunteers are used.

- Many programs use peer-volunteer positions and one is utilizing peers to plan and lead a retreat.

- Another has established stronger partnerships with ethno-specific ASOs to ensure volunteer competency and sensitivity to newcomers.

Provincial programs report:

- One program is developing a volunteer opportunities database that reflects requests for volunteers and allows for better matching.

- Another program is training PHAs to provide peer support to other PHAs and to collaborate on presentations at various events, such as Opening Doors and PHA Retreats.

- One is looking to provide more challenging and skill building opportunities for volunteers and is developing plan that will help mothers to volunteer in their free time.

- Two programs identified a need for volunteers to help with fundraising strategies and so are actively recruiting through other volunteer programs to increase their capacity.

4.5 IDU Outreach Programs

In 2009-10, 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. This section of OCHART includes their data as well as data from 27 other HIV programs not specifically funded by the AIDS Bureau to do IDU outreach, but who offer services such as needle exchange or other harm reduction activities.

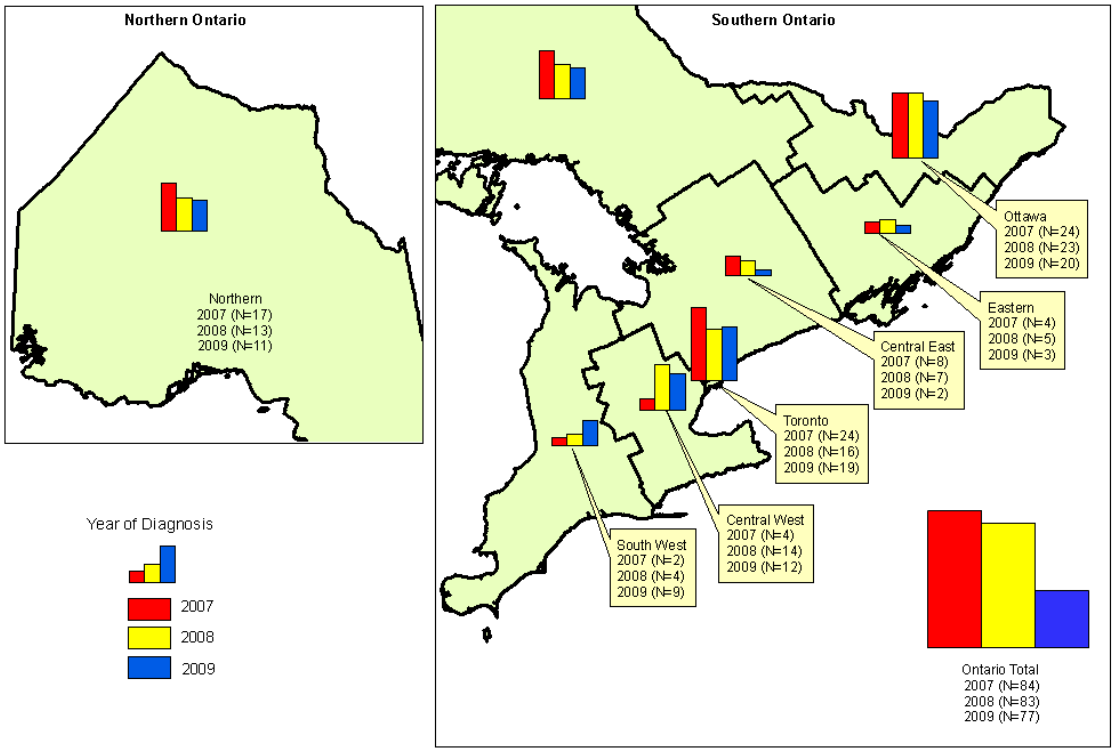
This section does not include data from ACAP funded projects. In the future, this OCHART section will be adapted so that ACAP-specific data can be collected.

An ongoing challenge in tracking outreach and in-service programs for people who use substances is that programs do not record or report data in a consistent way, and it is difficult to collect data on services delivered through outreach to this group of clients. The use of OCASE and other case management systems will improve monitoring but it would be helpful if programs agreed on ways of collecting and tracking client activity.

Trends in HIV Infection in People Who Use Injection Drugs

The number of new HIV diagnoses in people who use substances dropped slightly again this year in most regions in 2009; however, there was a marked increase in IDU-related diagnoses in South West region and a slight increase in Toronto (see Figure 9 below).

Figure 9. New Injection Drug-related HIV Diagnoses by Health Region and Year, 2007-2009

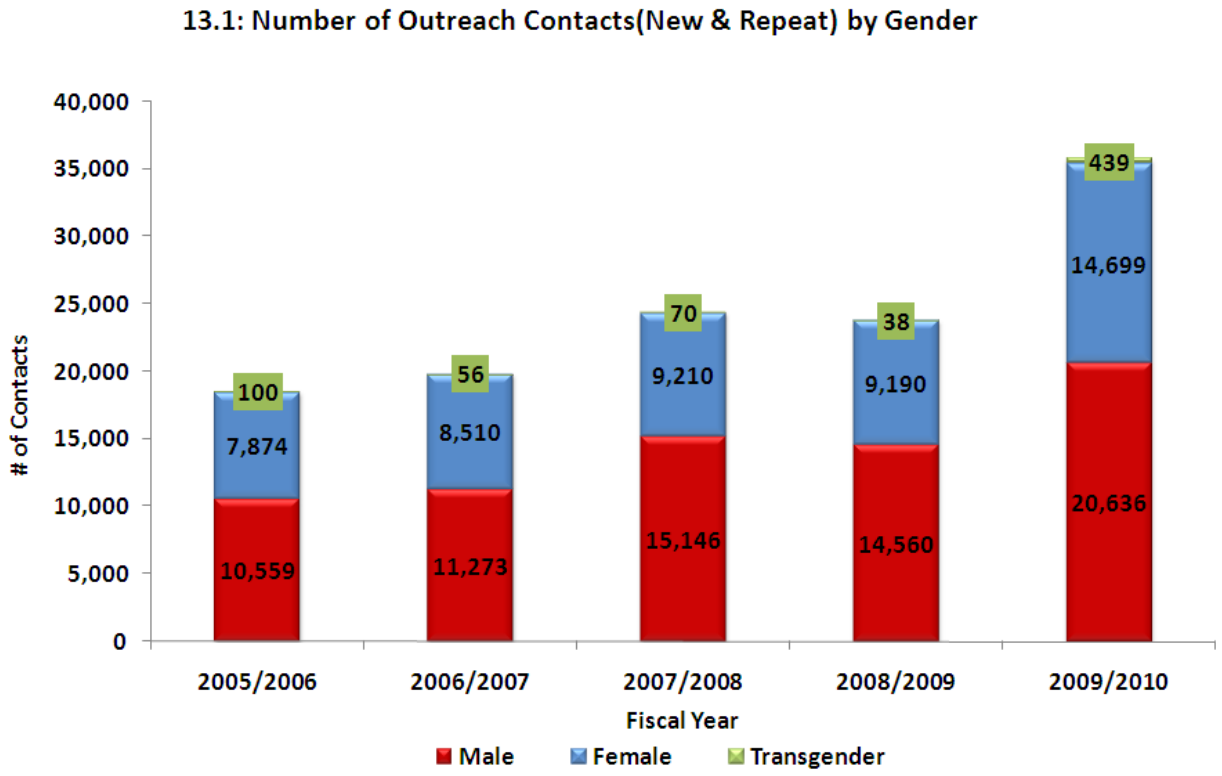


Source: HIV Update, Ontario HIV Epidemiologic Monitoring Unit, University of Toronto

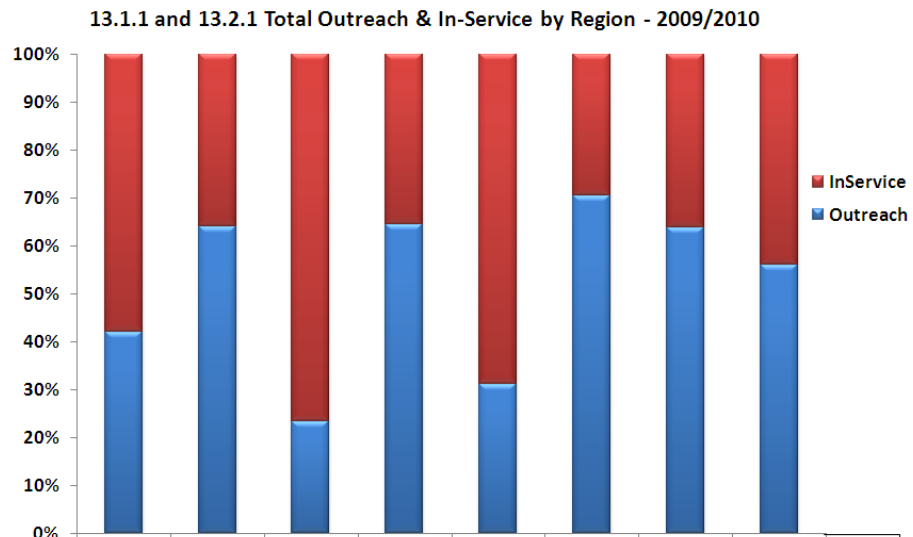
Significant Increase in Outreach Contacts

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 IDU-related outreach and in-service contacts were up significantly compared to 2008-09 as was expected with the inclusion of data from 27 other programs newly reporting in this section (see Figure 13.1). Of note is the new data from the Ottawa region which has significant outreach and on-site programming for people who inject substances.



The mix of in-service and outreach services depends on the resources available in the region (see Figure 13.1.1 and 13.2.1). Some programs have dedicated mobile services and cover large urban and rural areas while others rely on satellite needle exchanges in pharmacies or other social service agencies. There are also significant differences in the resources attached to these programs by the public health units that have primary responsibility for funding of needle exchanges across the province.

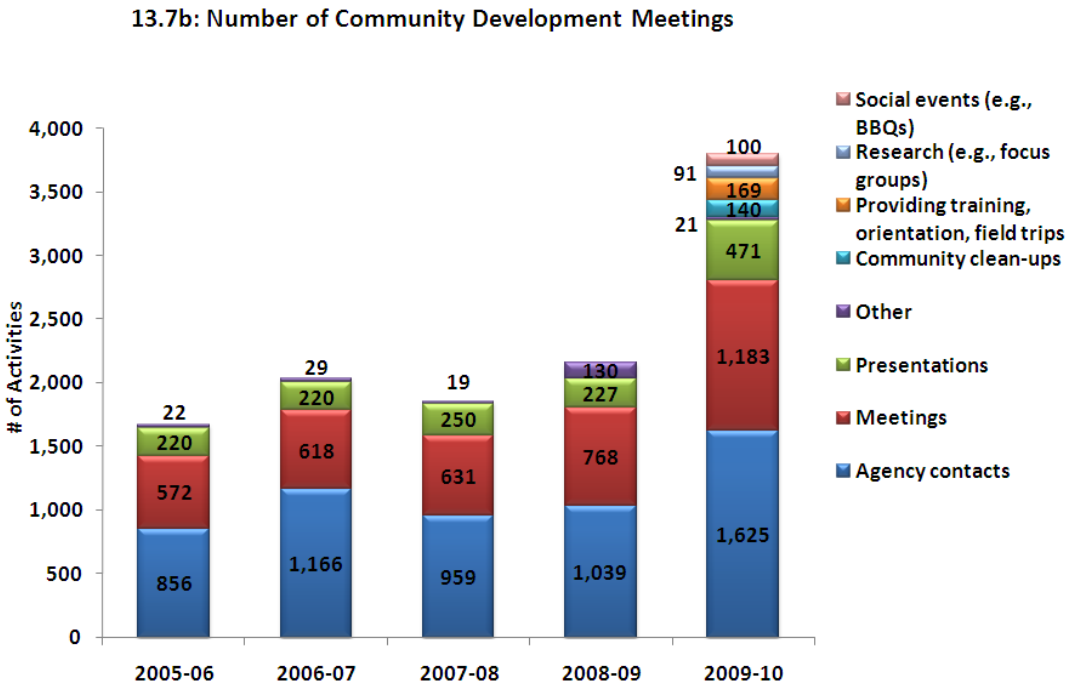


	Central East	Central West	Eastern	Northern	Ottawa	South West	Toronto	Provincial Services	Total
InService	1,017	3,094	5,439	2,376	12,208	1,993	31,467	1,912	59,506
Outreach	735	5,520	1,654	4,314	5,550	4,781	55,719	2,442	80,715
Total	1,752	8,614	7,093	6,690	17,758	6,774	87,186	4,354	140,221

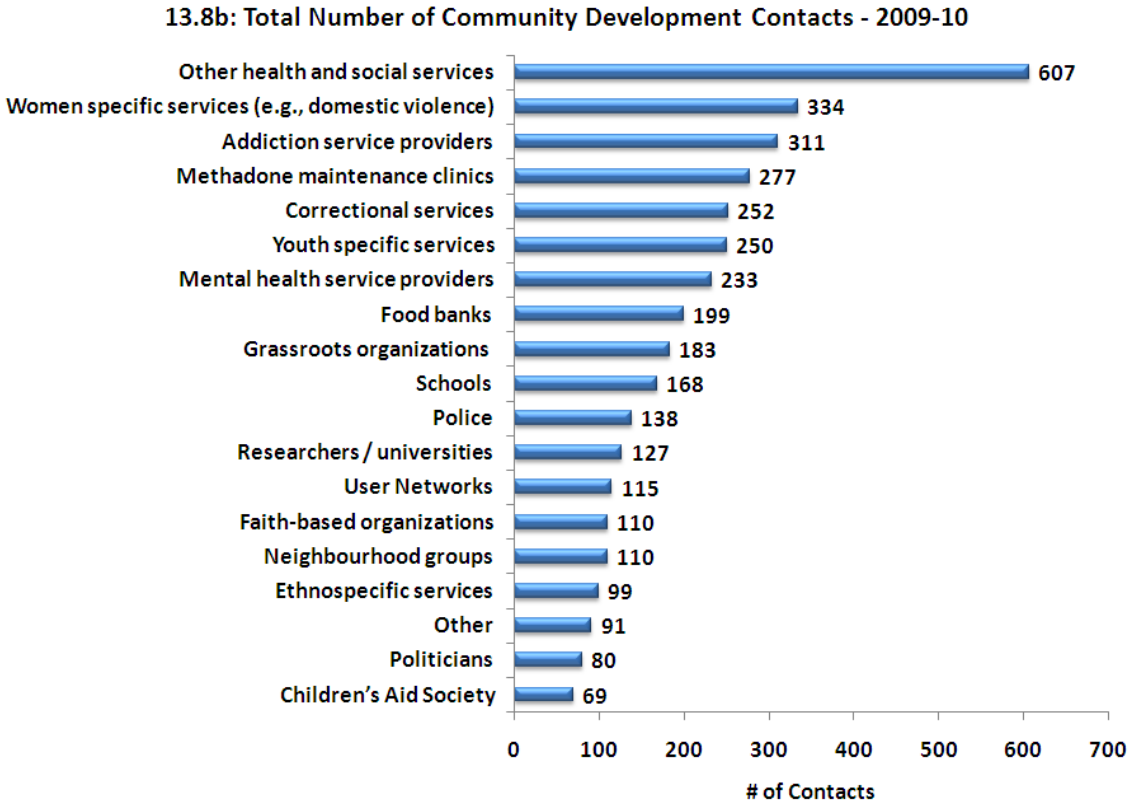
Increase in Community Development Activities

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 2008-09 and 2009-10 – largely due to the 27 additional programs



providing data for this section of OCHART (see Figure 13.7b).



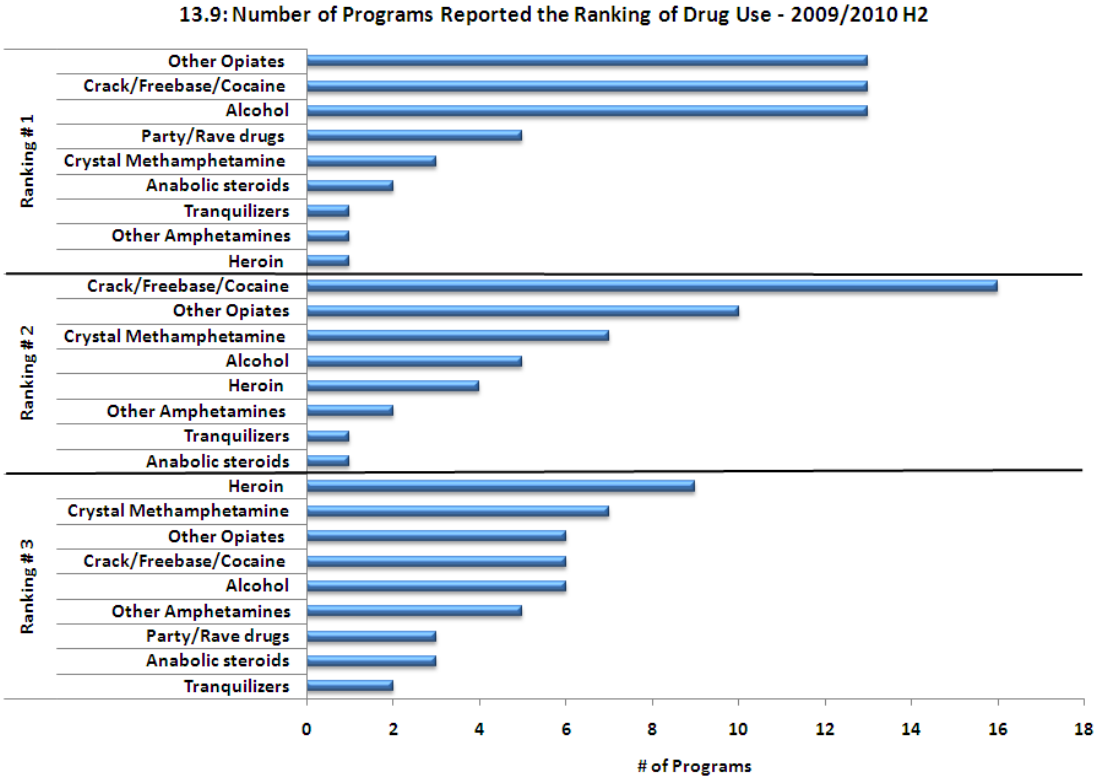
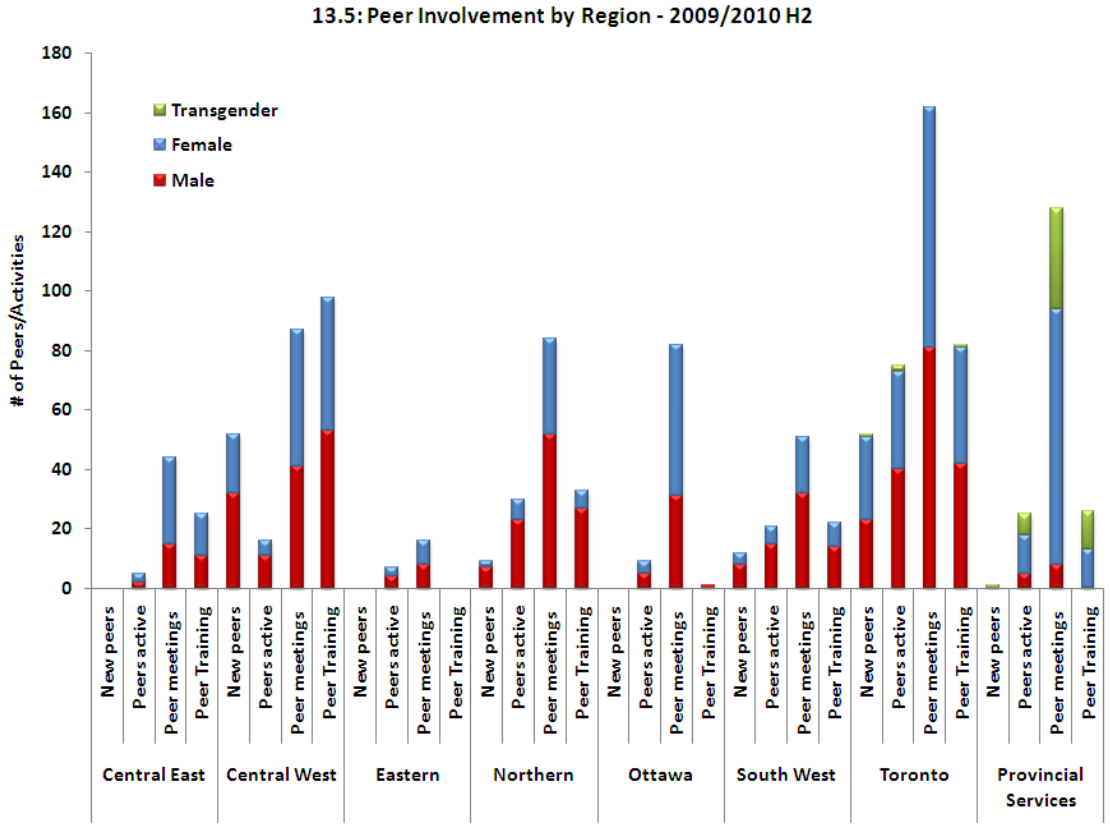


Figure 13.9 shows the number of programs ranking the use of specific substances used by their clients. The categories and names of the substances above will be reviewed and may change to be more consistent with current use and other research in the province.

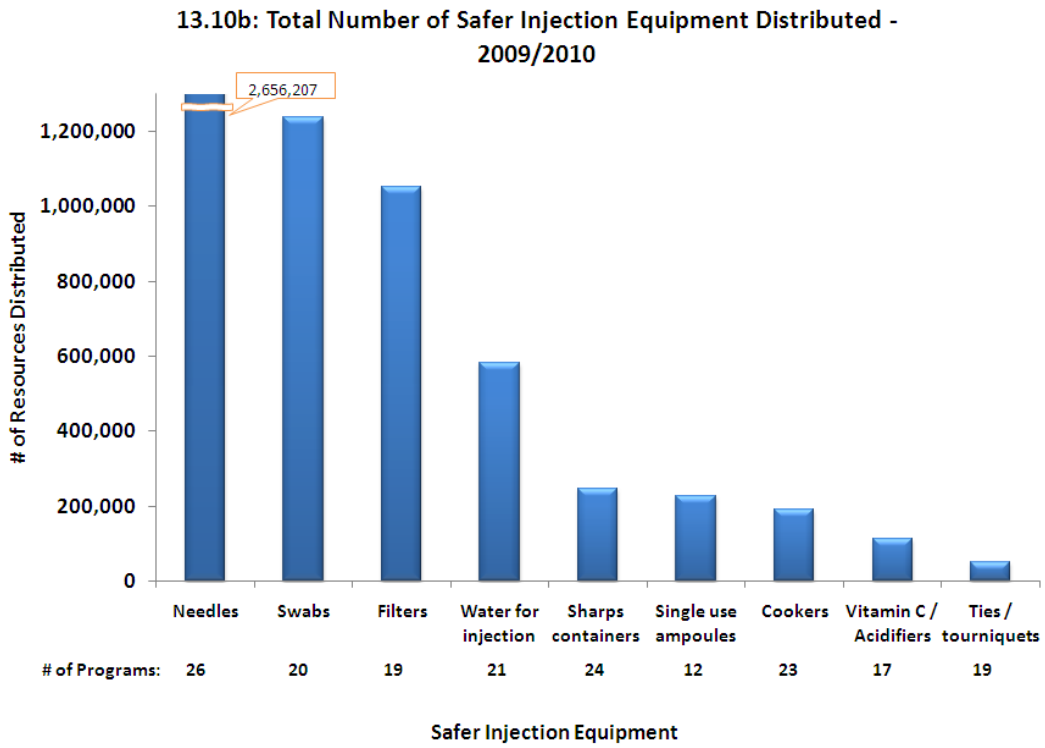
Peers stay active in outreach programs

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

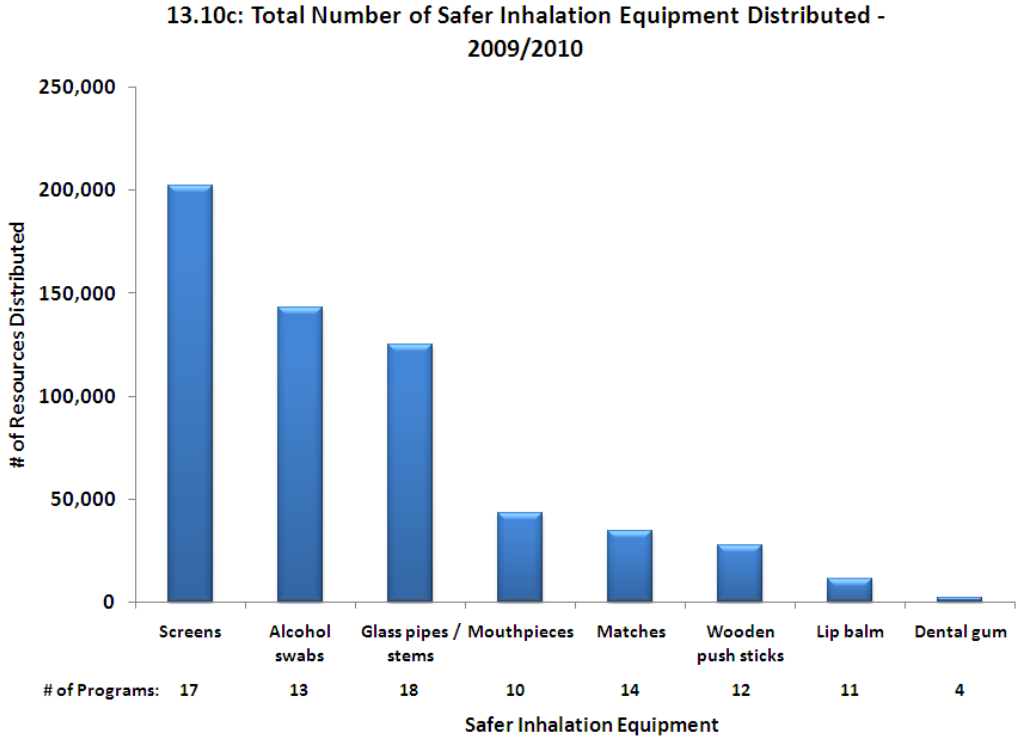
When we look at peer involvement (see Figure 13.5), we see a significant number, of all genders, of them involved in all regions. IDU outreach programs appear to be effective in involving peers in training and meetings although a smaller number remain active over the year. It would be interesting to see what impact volunteering has on quality of life over time. There seems to be a number of training initiatives for peers so that may be an area to examine to assess the impact of the education and skill development they receive.



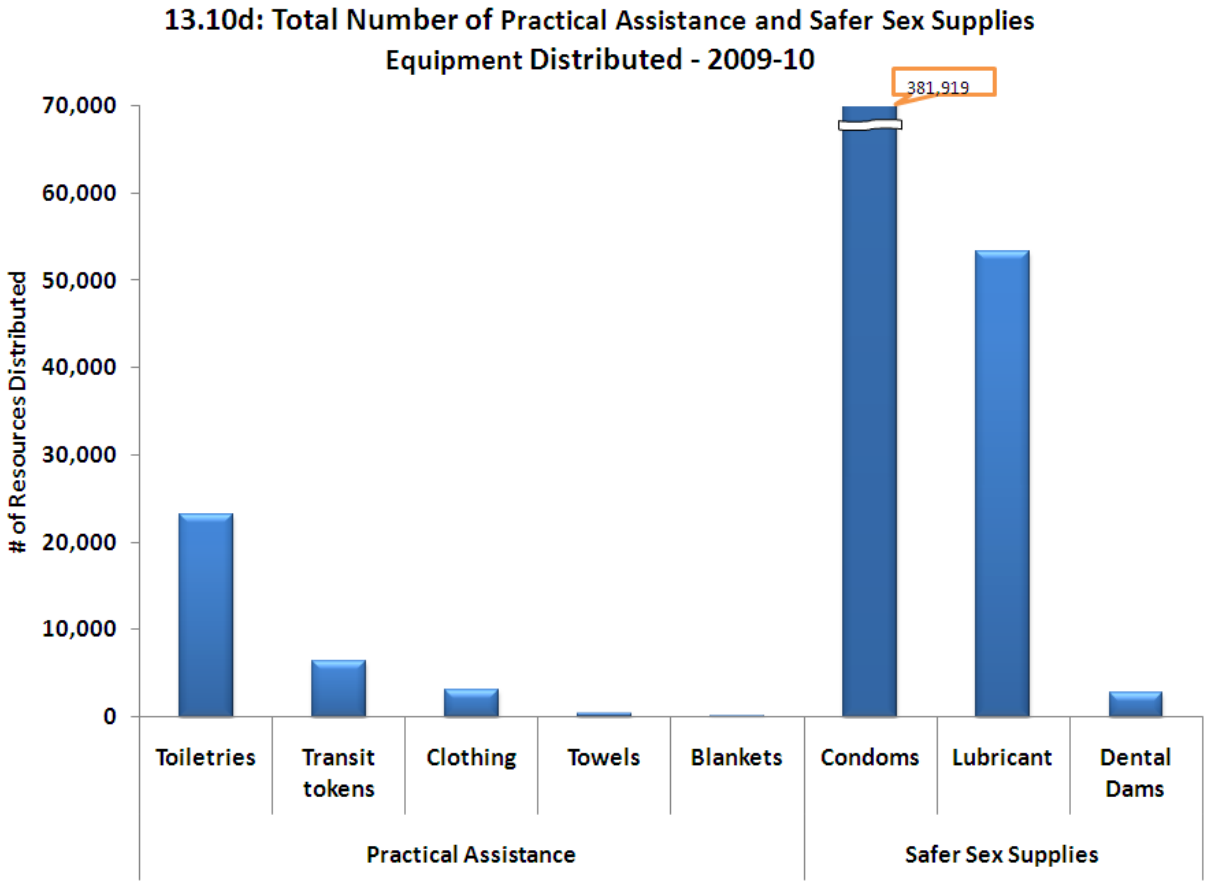
There are 38 programs that distribute safer injection equipment (see Figure 13.10b) around the province through needle exchange programs. The equipment other than needles and sharps containers is distributed through the Ontario Harm Reduction Distribution Program, funded by the Hepatitis C Secretariat (AIDS & Hep C Programs, Provincial Programs Branch, Ontario Ministry of Health and Long-Term Care). This program is tracking the uptake of this new equipment through on-site research and it would be helpful to analyze those results against the data collected through the needle exchange programs that report in OCHART. This may give us more insight into the outcomes and impact of harm reduction education and peer outreach.



Safer inhalation equipment is distributed by 36 programs around the province (see Figure 13.10c). The smoking of crack cocaine is commonplace in virtually every area of the province and many needle exchange programs see clients who both inject and smoke.



A significant amount of practical assistance and safer sex supplies are distributed through IDU outreach programs (see Figure 13.10d). It would be helpful to better track the number of individuals through these programs although it is a challenge to do so in the context of brief and anonymous outreach services. Some needle exchange programs are using unique, anonymous codes and it will be useful to know how successful they are and if those practices can be adopted around the province.



Emerging Trends in IDU Outreach

The South West, Central East, Ottawa and Northern regions all reported an increase in the use of fentanyl (patches attached to the skin that release strong narcotic pain-killers over time) and the need to provide education to clients about the associated risks. In addition, each region reported the following:

Central East Region:
Increasing services provided in rural areas due to increased demand as well as new partnerships with rural agencies. The AIDS service organization is working with the municipality to help them understand the need for these harm reduction services.

One program is seeing its Harm Reduction Coalition revitalized and re-building a partnership with police.

Eastern Region:
Developing new partnerships with other youth providers to increase youth outreach and looking to extend funding for youth program.

Central West Region:
Some programs are seeing younger clients using injection drugs.

Some are seeing more crack laced with meth and an increased use of crystal meth in rural areas, which seems to be leading to more arrests.

More clients have addiction and mental health concerns so the program hosted a symposium on these related issues.

Increased requests for safer inhalation kits.

One program is developing a partnership with another provider to start a support group for people with hepatitis C.

One program reports that other service providers are not embracing harm reduction principles so clients are less able to access services.

Northern Region:
They have had an increase in requests for safer inhalation equipment and are conducting a community survey to better understand the need for safer inhalation kits.

More Aboriginal women are involved in sex work so programs are making more referrals to agencies serving women and conducting female-focused outreach.

One community reports a more community-minded police force and better relationships being maintained through the community drug strategy and the Oxycontin Task Force.

One program is lobbying other service providers for more timely access to mental health and methadone treatment as well as more detox beds.

There are more requests for education and referrals from other agencies, which resulted in an on-site needle exchange program being implemented in another community-based service.

The return rate of needles has increased, which has created more trust and opportunities for educating clients.

Ottawa Region:
One program is hearing of policing issues from clients and has initiated more direct communication with police and become a member of the Overdose Prevention Working Group.

One program is receiving more calls to its mobile van services from people in outlying areas and is travelling to meet people outside the downtown core and extending their nightly routes to provide more access.

Another program identified the need to develop a position statement on youth and harm reduction and to initiate discussions with partners on decreasing the age limits for access to safer inhalation equipment.

South West Region:
One program is seeing more youth and is developing partnerships with agencies serving youth.

Another has seen more requests for methadone treatment and is trying to develop partnerships with methadone treatment providers outside of the community to reduce wait times.

One program has seen an increase in clients needing supports to get housing and has opened an account with a local rental agency to make referrals and provide clients with more timely information.

Toronto Region:
One program has seen an increased police presence and reported that their van and peer worker feeling targeted by police when doing outreach. To help alleviate this, the program is now represented on community committees / meetings, has given peer workers ID cards to show police, is conducting harm reduction training for local police platoon and has developed a police relations working group of service agencies. They are also approaching police to form a youth advisory board.

Another program reports more youth using crack cocaine so they are recruiting new youth peers. One program reported an increased level of trust with sex trade workers. It is working with other service providers to ensure sex trade workers receive harm reduction supplies.

Provincial programs:
Because of an increase in requests from sex trade workers, one program has developed a partnership with Maggie's and is expanding outreach to the local transgender community.

Another program is trying a unique approach using a peer-based theater production to educate service providers about women who use substances. This program is also developing a peer training to educate the community about the risk of HIV and HCV through injection drug use.

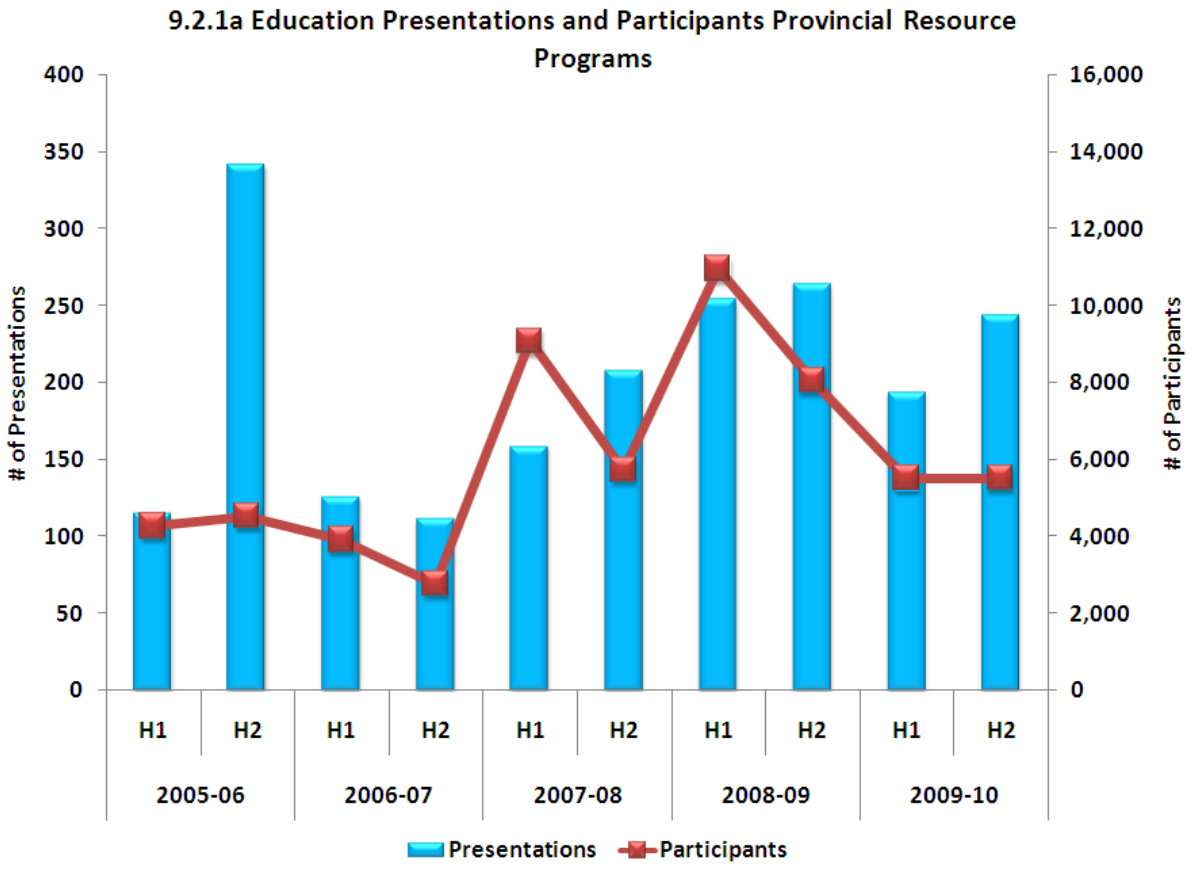
4.6 Provincial Resource Programs

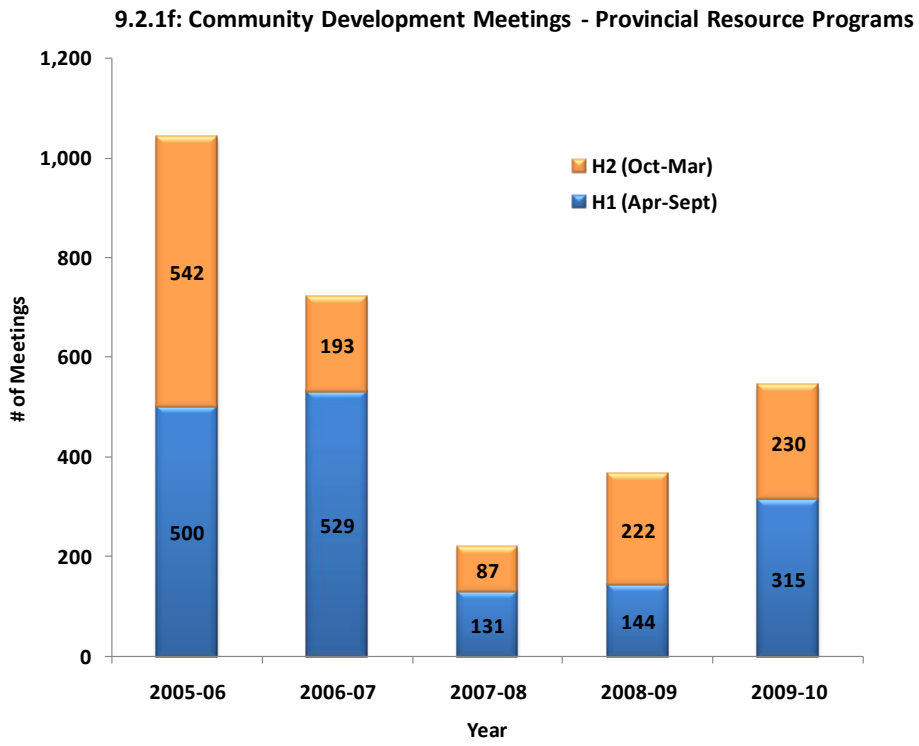
Six of the programs funded by the AIDS Bureau and PHAC's Ontario and Nunavut ARO are provincial programs that act as "resources" for other programs rather than providing outreach or support services directly to people with HIV or at-risk.

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 roll up or compare their data. Some of these programs are now using OCASE to collect their data and this may allow us to undertake more meaningful analysis and understand the impact of their activities.

Presentations

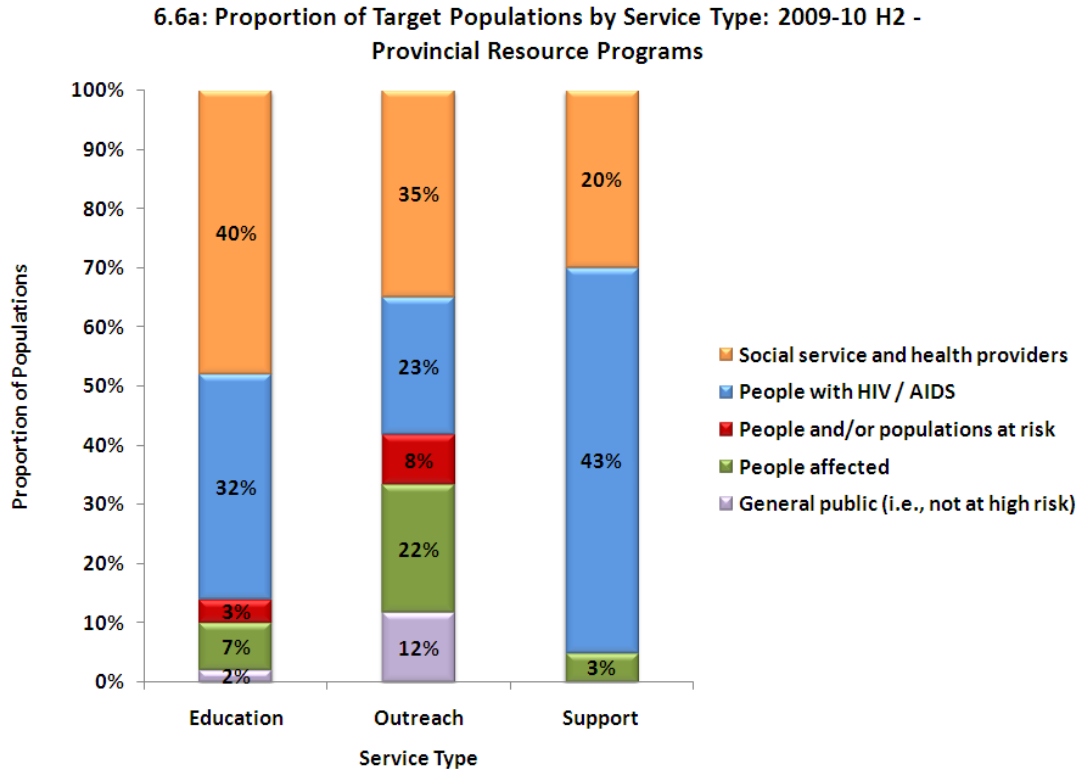
In 2009-10, provincial resource organizations reported a slight decrease in the number of education presentations and fewer participants over the past year (see Figure 9.2.1a). However, they also reported more community development meetings – which often lead to opportunities for more presentations so we may see an increase in those next year.





Provincial Services Target Mostly Other Service Providers and People with HIV

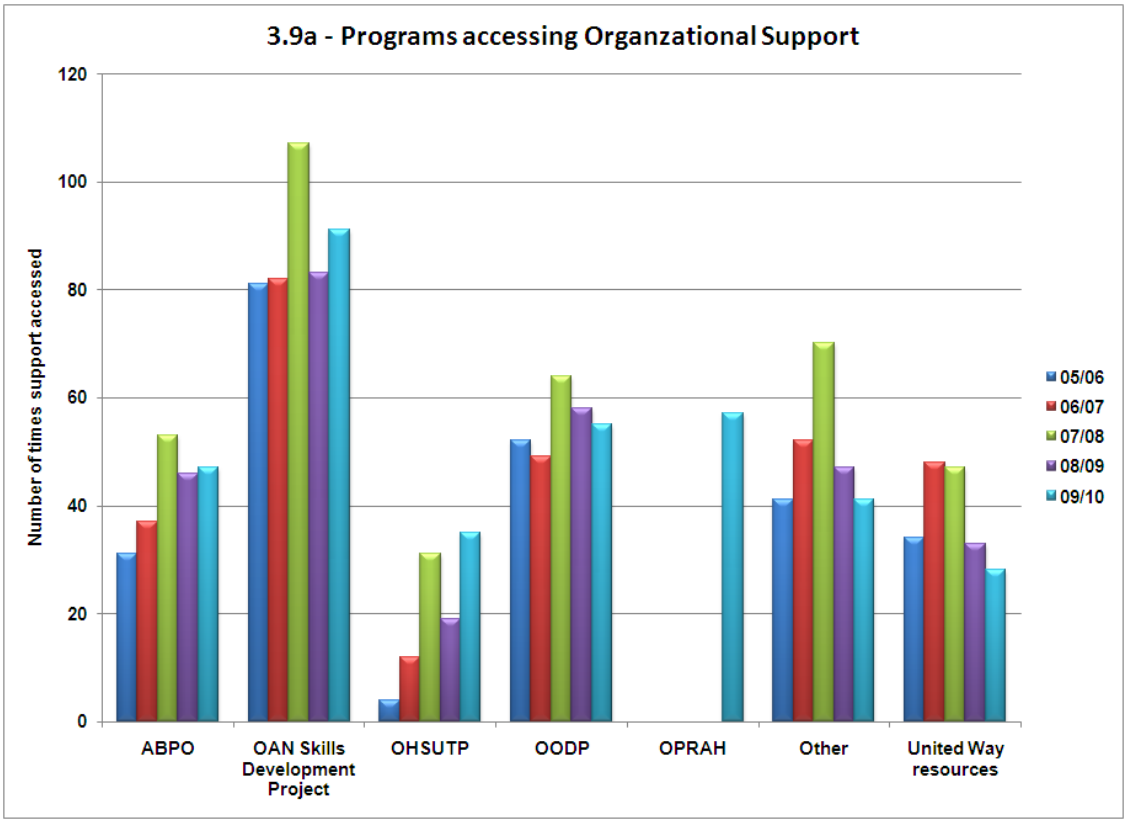
The goal of provincial programs is generally to increase access to other services for those living with or at-risk of HIV. Most of their services are directed at people living with HIV and other service providers though outreach services target those affected as well (see Figure 6.6a).



Provincial Programs Designed to Meet Culturally Diverse Needs

It appears that provincial resource programs are targeting the full range of populations with and at-risk of HIV in Ontario.

Note: The Ontario Aboriginal HIV/AIDS Strategy is a provincial organization that provides direct client support so its activities are counted in the earlier sections of the report, which explains the relatively low proportion of Aboriginal peoples served by provincial resource programs -- although the proportion has increased over the last three years.



Provincial resources programs provide services to other community-based AIDS service organizations.

Figure 3.9a shows the number of times HIV programs used provincial resources each year for the past five years.

Note: There is an omission in this section as the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) was not included as an option in the OCHART form for programs to select. ACCHO is made up of organizations and individuals committed to HIV prevention, education, advocacy, research, treatment, care and support for African and Caribbean communities in Ontario and offer support and training to the various outreach workers in Ontario working with these communities. ACCHO will be included in future OCHART reports so that we can better track the use of this provincial resource.

Note: The Ontario Provincial Resource for ASOs in Human Resources (OPRAH) is a new human resource service available to programs, which was well utilized in its first year.

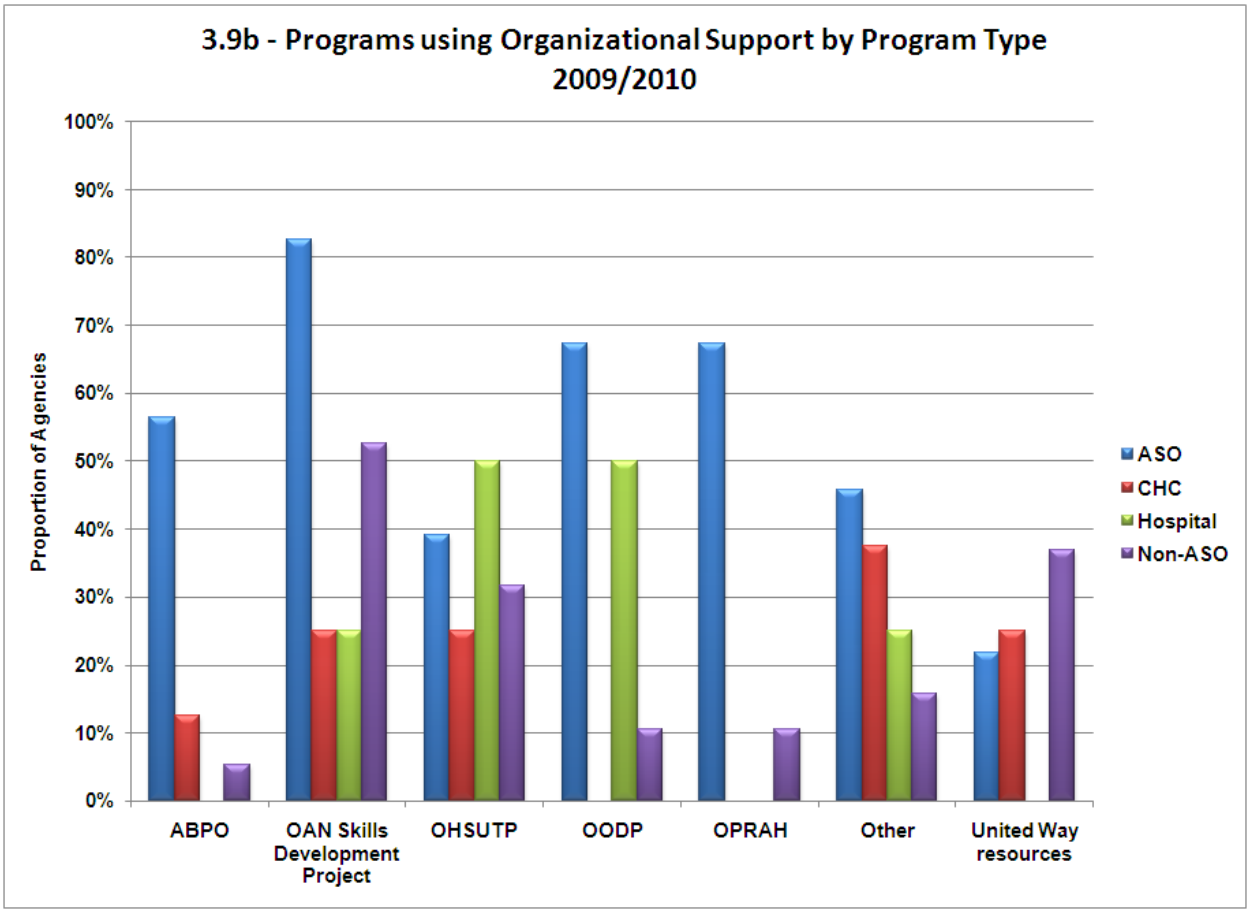


Figure 3.9b shows the proportion of provincial services used by the type of program. As would be expected, use of these services is highest by community-based AIDS programs as well as non-AIDS programs and less by CHC or hospital-based programs, which would have access to many of these services (e.g., education, training, HR, organizational development) within their home organization.

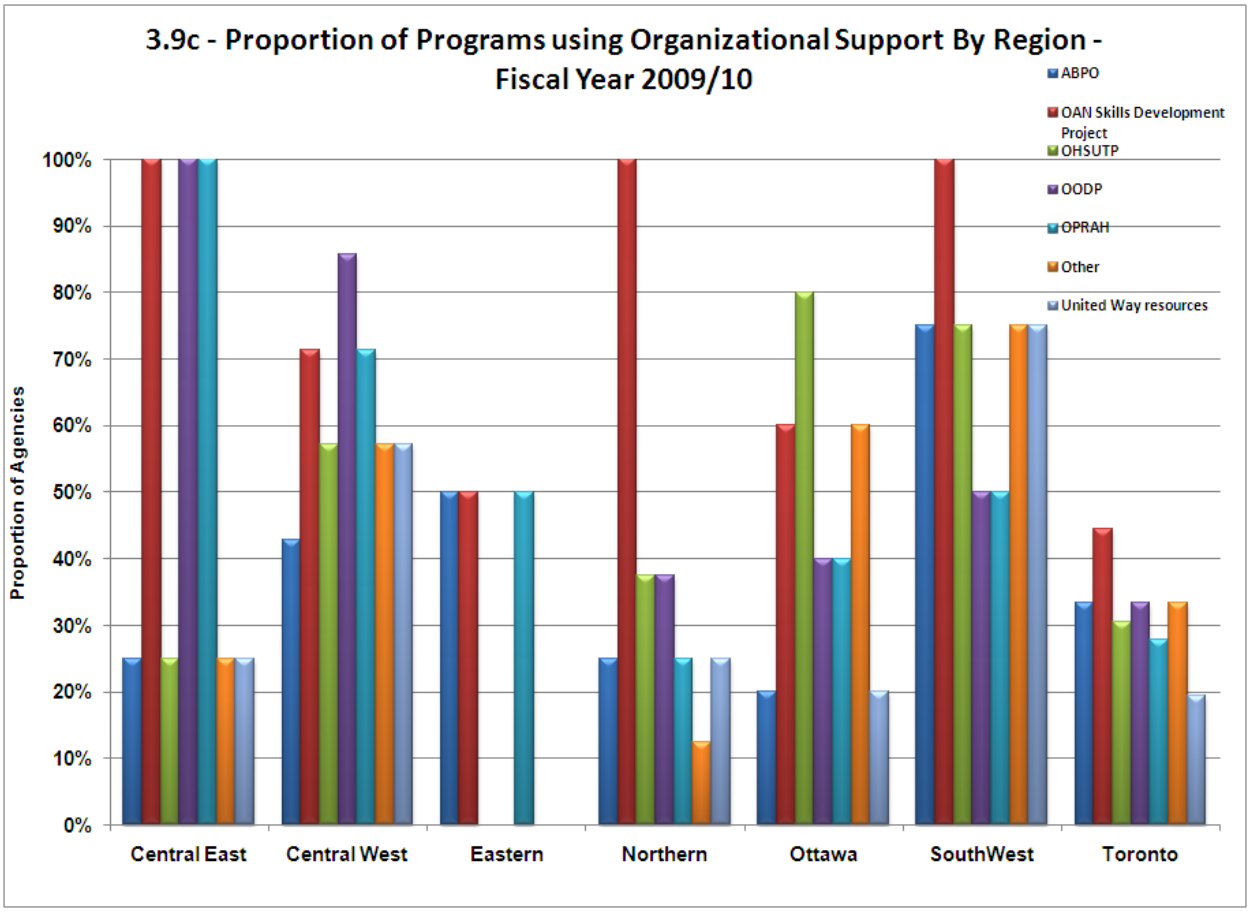


Figure 3.9c looks at the use of these services by region. It appears that programs outside of Toronto access provincial services more than those in Toronto. This may be a function of the smaller size of agencies outside Toronto and the fact that those in Toronto may have more capacity or more access to these services from other agencies.

What's Working Well in Provincial Resource Organizations

Effectively providing resources to program staff across Ontario

Partnerships

One program identified their success in brokering effective partnerships with multiple stakeholders as important to helping them support staff members that are on the frontline. This also supported them to implement strategy work and provide better services to community members through the integration of culturally appropriate services.

Effective Team Collaboration

Two of the organizations highlighted their team dynamic, practices, and ability to work together as factors contributing to their success in providing resources to other programs.

Incorporating GIPA Principles
One provincial resource organization identified the inclusion of PHAs in providing service across the province as one element that was working well in their service delivery.

Emerging Trends in Requests for Education Services by Provincial Resource Organizations
Provincial resource organizations identified numerous trends in requests for services from programs across Ontario. The following are some main highlights of service requests.

Information on HIV and Aging
Three of the six resource organizations identified the issue of HIV & aging as a primary topic for information (including neuro-cognitive impairments, mental health, chronic conditions). Provincial resource organizations are responding to this identified need by:

- Delivering workshops on dignity as we age
- Delivering workshops on HIV & aging as part of capacity-building initiatives
- Conducting additional research to be able to respond to these requests for information and services
- Revising existing materials to include these topics
- Developing a new brochure on HIV & aging

Information on HIV Disclosure and Criminalization
Programs continue to request accurate, up-to-date information on HIV and the law, disclosure, and the recent criminalization cases. Provincial resource organizations continue to meet this need by:

- Maintaining and strengthening partnerships with other provincial organizations to deliver workshops
- Revising materials and making these readily available
- Delivering panel presentations at skills-building sessions
- Participating in research to inform evidence-based policies

Information on Hepatitis C and Co-infection with HIV
Programs across Ontario are increasingly requesting more information about Hepatitis C and co-infection. To fill this need, one provincial resource program reported they are expanding their HCV website to include detailed and easily accessible information on treatment, testing, financial assistance, and services specific to each province and territory, including Ontario.

Need for Anti-Oppression Training
More programs across the province are requesting anti-oppression training. One resource program is responding to this need by working with agencies individually to deliver training. For those programs that do not have strategy workers, new partnerships are being developed to help address training needs.

More Services Requested to Strengthen Governance and Management Roles

Provincial resource organizations are providing services to support programs' reviews of their management of staff, primarily focusing on staff benefits, analysis of compensation packages, unionization, and general training in human resources. In addition, programs are requesting more governance related services, focusing on policy development, strategic planning, work plan development, and clarifying roles and responsibilities. Resource organizations are responding by using consistent materials in their training workshops and linking programs together for sharing of policy documents.

Part V: ACAP Report

About ACAP

The AIDS Community Action Program (ACAP) of the Public Health Agency of Canada (PHAC) is a community-based funding component of the Federal Initiative to Address HIV/AIDS in Canada. ACAP uses a community development model of intervention to reach people and communities at-risk of or living with HIV/AIDS. Its goals are to prevent the acquisition and transmission of new infections; to slow the progression of the disease and improve quality of life; and to reduce the social and economic impact of HIV/AIDS. In 2009-10 ACAP provided $4 million in funding to support community-based HIV/AIDS projects in Ontario.

ACAP Funding Streams and Approaches

ACAP has two funding streams: operational and time-limited. Operational funding supports AIDS Service Organizations (ASOs) whose main mandate is specific to addressing HIV/AIDS in Ontario. This funding stream supports ongoing, operational and core programming activities. Examples of operational funding include volunteer programs, and health promotion for people living with HIV/AIDS (PHAs). Time-limited funding is available to voluntary, non-profit and non-governmental organizations that are actively dealing with HIV/AIDS issues, but whose mandate is not specific to HIV. This funding is for specific, time-limited activities that address unmet HIV/AIDS needs and priorities. Examples of time-limited initiatives include pilot projects to develop best practice models, and education and awareness campaigns.

ACAP has four funding approaches. All ACAP funded projects support one or more of the four funding approaches:

- *Prevention Initiatives*: This funding approach supports community-based prevention initiatives for populations known to be vulnerable to HIV infection. Examples of this work might include peer outreach programs, or education workshops.

- *Health Promotion for People Living With HIV/AIDS*: This approach supports activities that increase the capacity of PHAs to manage their health and wellness. Examples of this work include activities that improve access to services, treatment, care, and social support, or that strengthen the leadership capacities of PHAs.

- Stre*ngthening Community-based Organizations*: This approach supports activities to increase the skills, abilities and capacity of people and organizations at all levels of the community-based AIDS movement. Examples include staff training, organizational development, or volunteer programs.

- *Creating Supportive Environments:* This funding approach supports initiatives to reduce or eliminate social barriers that prevent people living with HIV or AIDS, those at-risk, and those affected, from accessing health care and/or social services. Activities under this funding approach help to reduce discrimination, poverty, illiteracy, homophobia, and the fear and stigma associated with HIV/AIDS-related issues.

2009-10 Funded Projects By Stream and Approach

In 2009-10, ACAP funded 40 operational projects. Sixteen of these had a primary focus on prevention, 14 were focused on health promotion and 10 focused on strengthening community-based organizations. ACAP also funded 17 time-limited projects. Six of these had a primary focus on prevention, 7 were focused on health promotion and 4 focused on strengthening community-based organizations. All ACAP projects contribute to the creation of supportive environments.

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	Stre*ngthening Community-based Organizations*
Operational	16	14	10
Time-limited	6	7	4
Total*	22	21	14

** Note: One time-limited project's data was not included in this report; therefore, while there are 57 ACAP projects in Ontario, data in this report are from only 56 of these projects.*

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

ACAP Logic Model: Expected Outputs and Outcomes

ACAP has a program logic model that explains the relationship between the activities supported by the fund and the expected outputs and outcomes. Please refer to Appendix B for the ACAP logic model.

ACAP projects in all four funding approaches are expected to produce outputs (deliverables). Outputs are the tangible materials or services that funded projects produce. These include education materials, workshops and presentations, policies, and reports.

Outputs, in turn, are expected to contribute to outcomes. Outcomes are the ultimate impact or desired results of activities and outputs. ACAP outcomes are organized into short, intermediate and long term outcomes. Outcomes become more complex to measure as one moves down the logic model, because contributions become more dependent on the work of other programs and sectors. Funded projects contribute most directly to short term outcomes. Examples of these outcomes include increased knowledge about HIV, and increased individual capacity. Intermediate and long term outcomes require broader participation, take more time to achieve, and are affected by multiple factors beyond the control of individual projects. Therefore, ACAP initiatives can make only a contribution, along with other community and government initiatives, to realizing these outcomes. Intermediate outcomes include reduced stigma, and increased practice of healthy behaviours. Long term outcomes include improved quality of life and reduction in HIV incidence.

Data Submission Process

All ACAP funded projects submit annual project logic models that map their planned activities for the year. At the beginning of the fiscal year (April 1st), projects enter their planned activities, expected outputs (deliverables) and expected outcomes into their online project logic model.

At the end of each reporting period, organizations enter their actual outputs into their online logic models. This information is then linked directly to the relevant OCHART questions. If, as is often the case, there are variances between planned and actual deliverables, organizations provide explanations and revise their activities and budgets as necessary. Once information is entered into OCHART and the online logic models, it is validated (checked for accuracy) by PHAC and OHTN staff. This ensures that funded projects, funders and communities have the most accurate information possible about the work that ACAP supports, and the impact of this work.

OCHART Data Reported by ACAP Projects

To reflect the ACAP logic model, data in this section are organized by the activities and outputs associated with each funding approach, while taking into consideration that some activities and outputs associated with different funding approaches may overlap.

The analysis includes comparisons between projects' planned activities and actual outputs. In analyzing this information, we recognize that there are many good reasons why planned and actual activities and outputs may differ. Comparing planned and actual numbers does not imply that funders require planned numbers to be reached, and this is not how the quality of project work should be measured. Falling short of planned numbers does not mean failure, nor are higher numbers or exceeded targets necessarily better. However, when planned and actual deliverables are similar, this means that projects' planned budgets, staffing and resource allocations do not need to be significantly revised. This is helpful for organizational planning and stability.

In general, this year's OCHART data shows that there was an increase in ACAP activities and deliverables in 2009-10. This was largely due to a new funding cycle that saw 17 new time-limited and 10 operational projects funded.

To assist with interpreting data in the graphs, this year's report includes tables below each graph that show the number of projects reporting data in each fiscal year. This helps us to understand significant increases or decreases in the number of activities, products or services reported. Where graphs show significant increases or decreases in reported work from one fiscal year to the next, by looking at the tables, we can see whether such increases or decreases are due to a change in the number of projects, or whether the same number of projects are doing substantially more, or less, work.

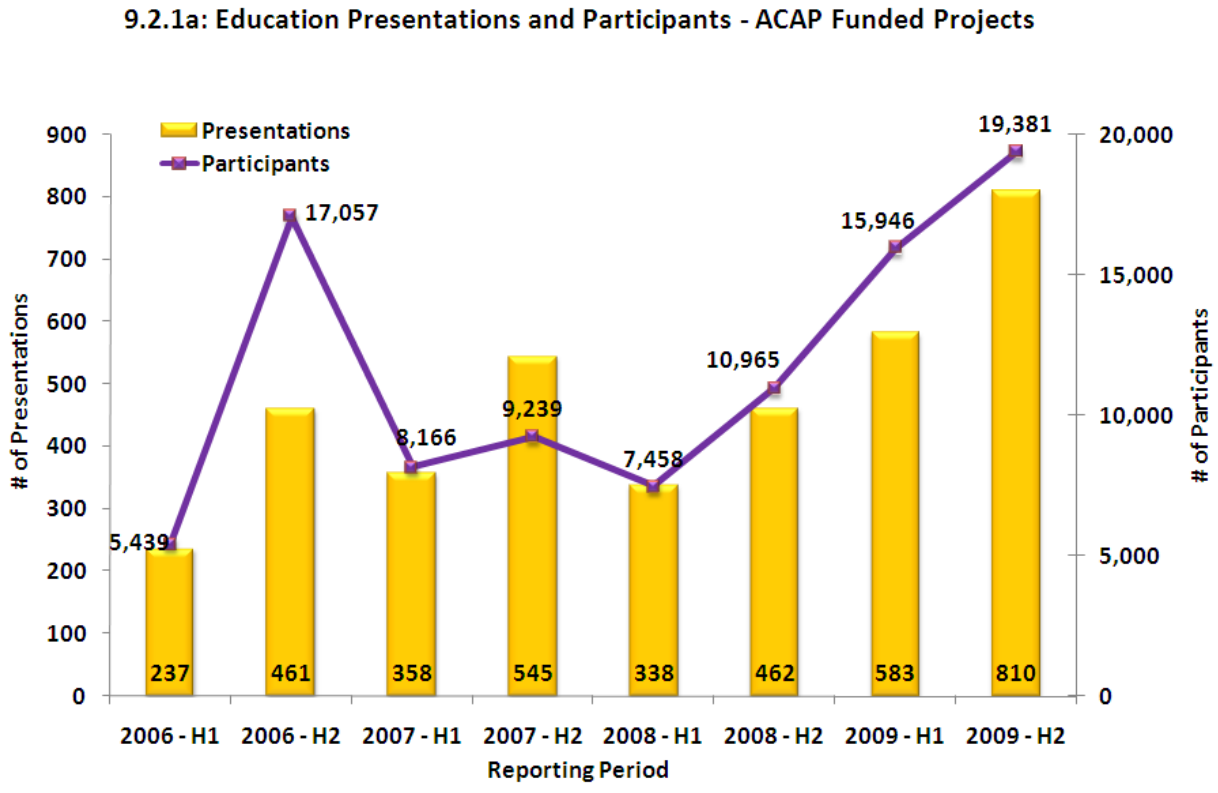
1. Prevention Initiatives

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

More 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 2009-10, 54 ACAP-funded projects reported providing education and community development services. Of those, 43 projects gave a total of 1,393 presentations (up from 800 in 2008-09), which reached a total of 35,327 participants (up from 18,423 in 2008-09) – or an average of 25 participants per presentation (see Figure 9.2.1a). Compared to 2008-09, this represents a 74% increase in the number of presentations, and a 92% increase in the number of participants; both increases are largely due to the new projects. In terms of targets, 26 of the funded projects met or exceeded their combined targets for presentations (1,139) and 28 met or exceeded their targets for participants (20,360). Several did not meet their targets due to staff turnover, and two mentioned their planned activities with Public Health Units were interrupted by H1N1 planning in the second reporting period.



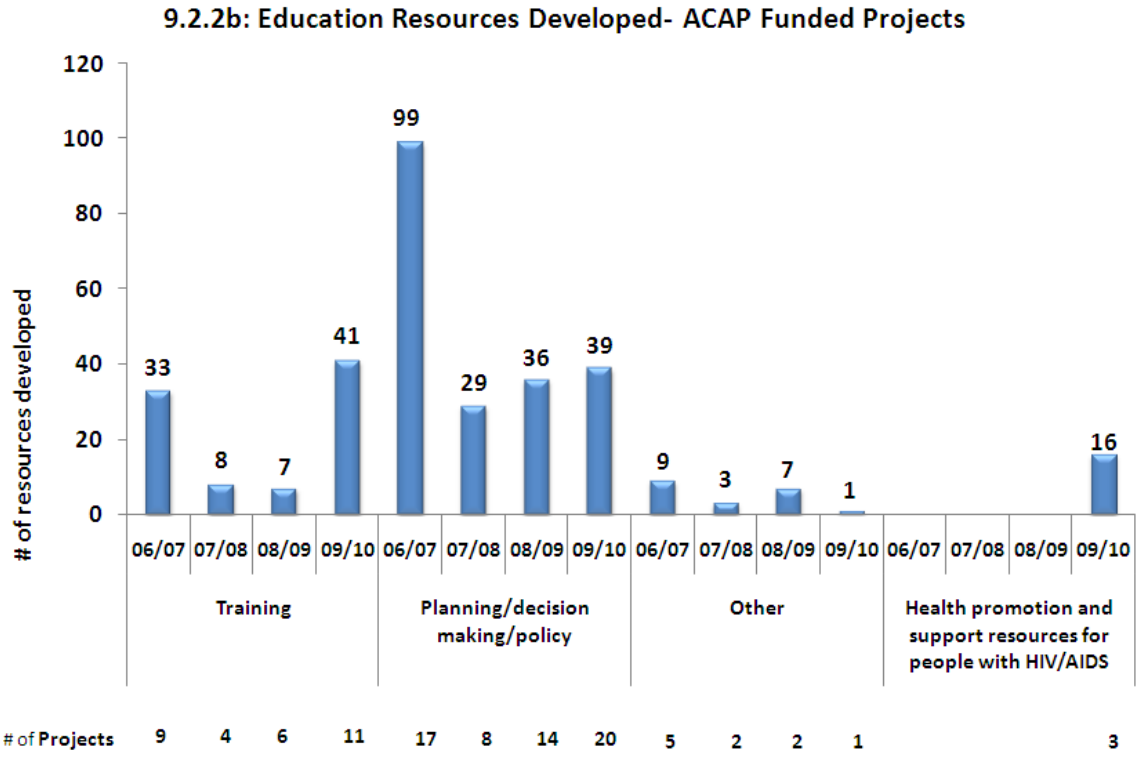
Number of projects reporting by year.

2006/2007	2007/2008	2008/2009	2009/2010
40	27	29	51

Thirty nine ACAP-funded projects were responsible for a total of 1,407 community development meetings in 2009-10, down from the previous year (2,679). This number was lower than their overall target of 1,908 community development meetings. The number of these meetings is likely to fluctuate as new projects develop partnerships and networks to enhance their services.

Resources Developed

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

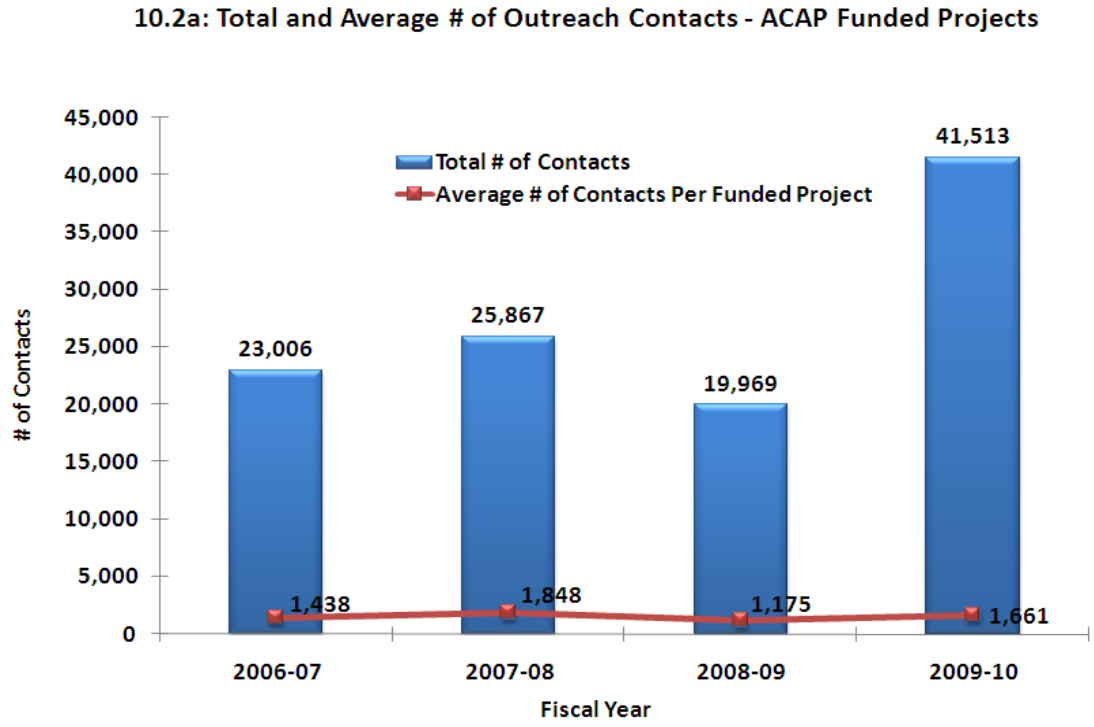


ACAP-funded projects are asked to report on the number of resources they develop to support their activities (Figure 9.2.2b). In 2009-10, the organizations developed a total of 80 resources (up from 50 in the previous year). The greater number of resources developed compared to 2008-09 was likely due to the fact that there were 27 new projects. Newly tracked in 09/10 were health promotion resources created especially for people living with HIV. The high number of resources in the Planning section for 06/07 is likely a reporting error. As well, this question may need to be reviewed as some projects are uncertain as to what data to report.

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 Significantly Increase Outreach

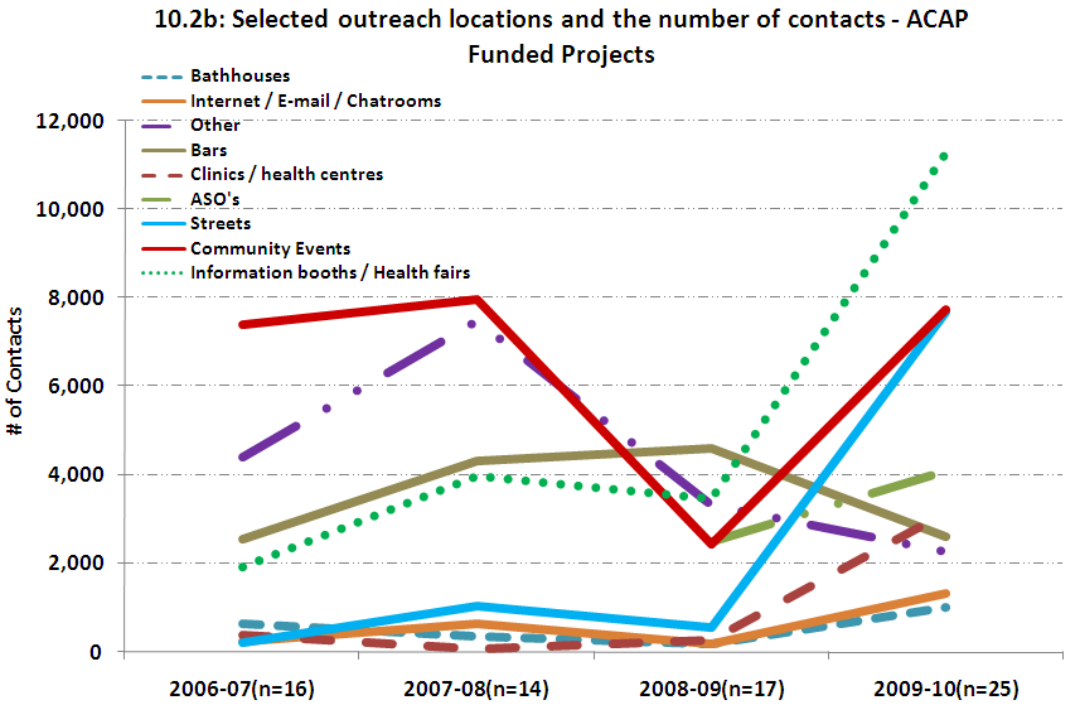
OCHART question 10.2: Indicate the outreach activities undertaken during the reporting period.



Number of projects reporting by year.

2006/2007	2007/2008	2008/2009	2009/2010
16	14	17	26

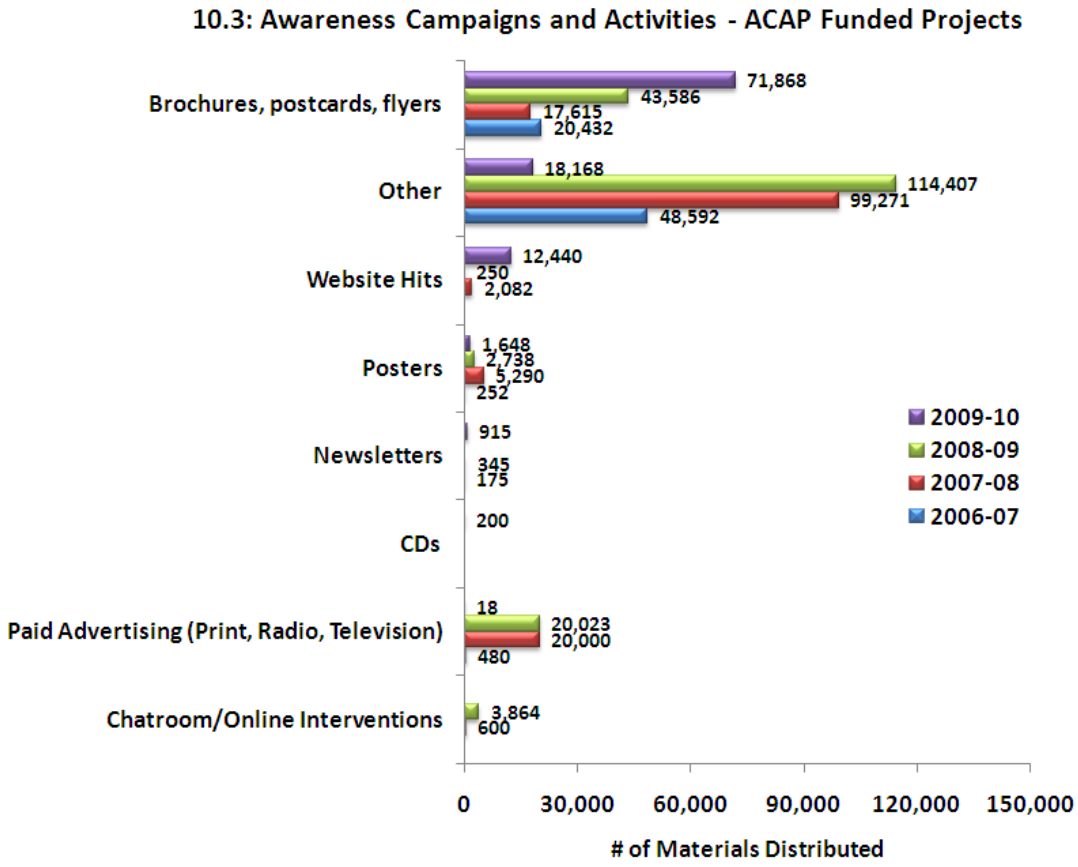
In 2009-10, ACAP funding supported a total of 26 projects to provide 41,513 outreach contacts – an average of 1,537 contacts per project. The total number of outreach contacts exceeded the target of 17,994. Twenty projects met or exceeded their targets. In addition to the increase in the overall number of programs, other reasons for the increase in the number of outreach contacts included doing outreach in new locations (music festivals and online), and at several large youth events and Pride events. The top 5 outreach locations were information booths/health fairs, community events, streets, ASOs, and clinics which, together, accounted for 82% of total contacts (see Figure 10.2b). It appears as though significant contacts are being made at community events and health fairs although the counting of those contacts can be challenging depending on how a 'contact' is defined.



Awareness Focuses on Distribution of Information and Website Development

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

ACAP funded 32 projects for awareness activities in 2009-10, and the total number of awareness activities, 167, was higher than the target of 127. The number of resources distributed (96,309) was just short of the target of 96,764. The majority of programs (23) met or exceeded their targets. Projects reported using their ACAP funding primarily to support the creation and distribution of awareness products such as brochures and other information materials. The second highest category was 'Other' which included providing condoms and lube, and training packages. During 2009-10, there was also a significant increase in newsletters distributed as well as online health promotion and website development. In future, this area of OCHART will be re-developed in order to more accurately and meaningfully capture these activities.



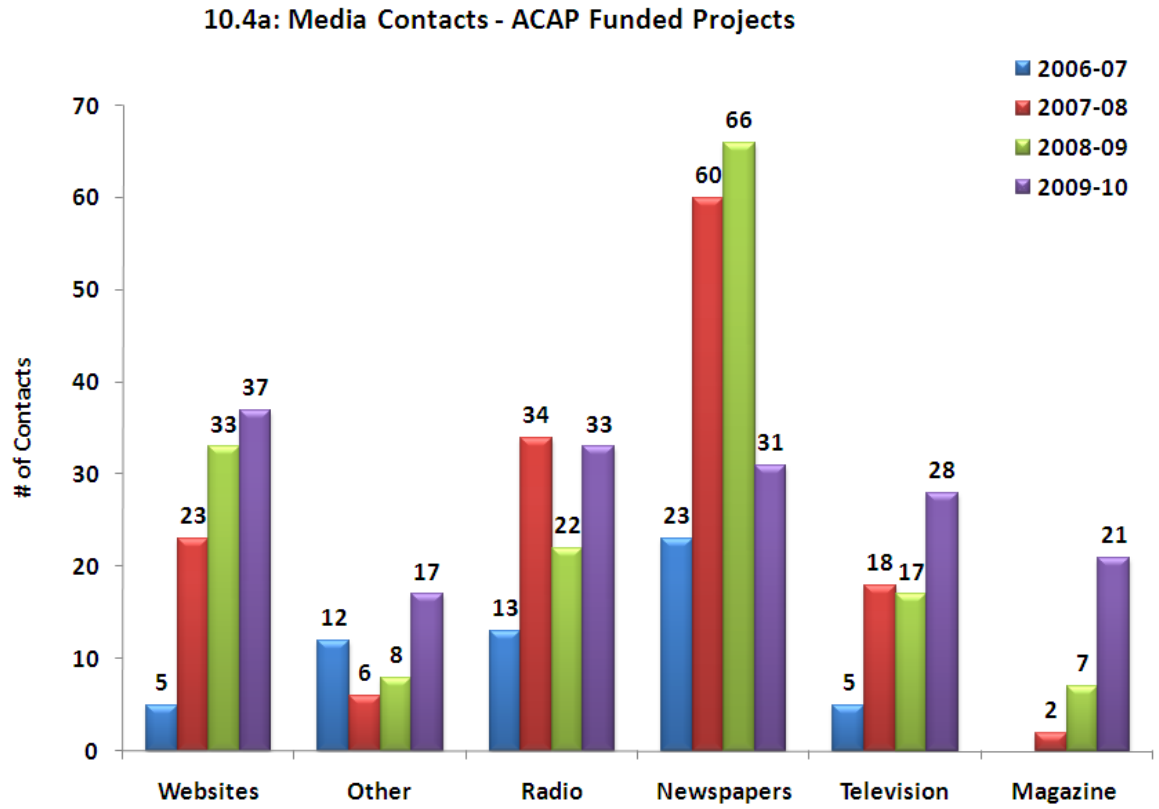
Number of projects reporting by year.

2006/2007	2007/2008	2008/2009	2009/2010
15	12	18	35

Media Contacts Up

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

ACAP-funded projects reported a total of 113 media contacts in 2009-10 – down slightly from the previous year. Over the past three years, these projects have reported steady increases in new media (website) contacts. A number reported increased requests this past year from media sites online as well as from community and college papers. Several reported more requests from ethno-specific radio and television programs.



Number of projects reporting by year.

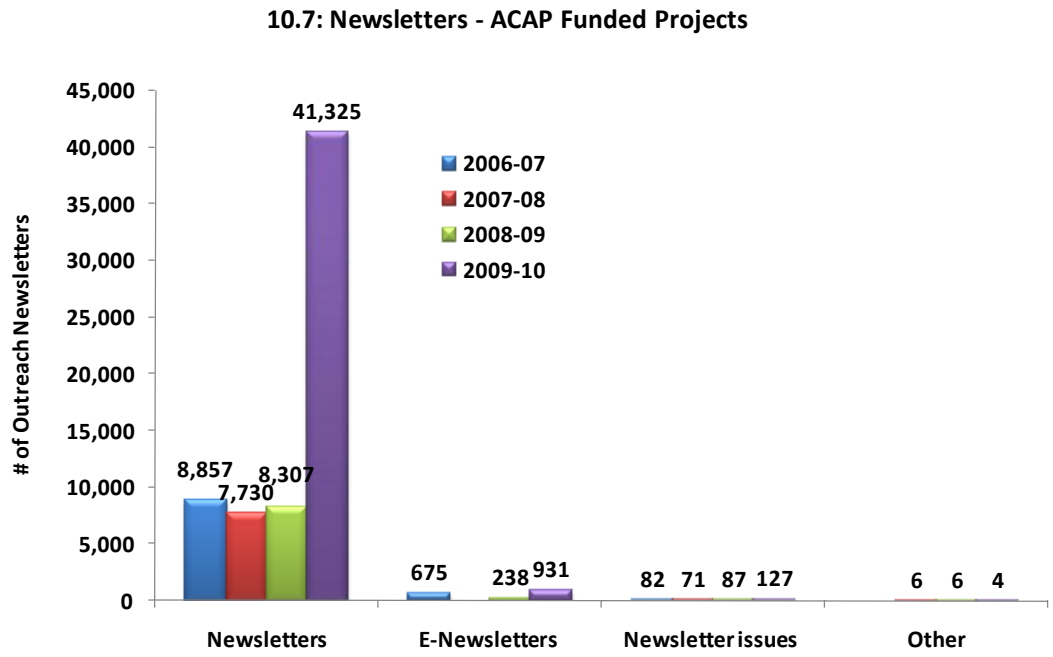
2006/2007	2007/2008	2008/2009	2009/2010
8	6	12	10

Website and Chatroom Activity Down, but Exceeds Targets

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

In 2009-10, 10 projects reported being involved in activities that involved phone or internet outreach. A number of projects have created a Facebook and/or Myspace page and it will be interesting to see how awareness activities adapt to social networks over time. We should consider more specifically counting the types of online outreach whether through chatrooms, social networking sites, emails, texting, etc., as some appear to be more passive in nature while others are quite active in how they attempt to reach their particular at-risk group. As has been noted elsewhere, we will continue to try and find the best ways to track, collect and analyze outreach and activity that occurs on the internet.

In terms of newsletter production, there were 16 projects that developed/distributed e-news/newsletters in 2009. One hundred and twenty-seven issues were developed and 41,325 distributed, although 25,000 were distributed by one project through a community newspaper. There were 931 e-newsletters distributed.



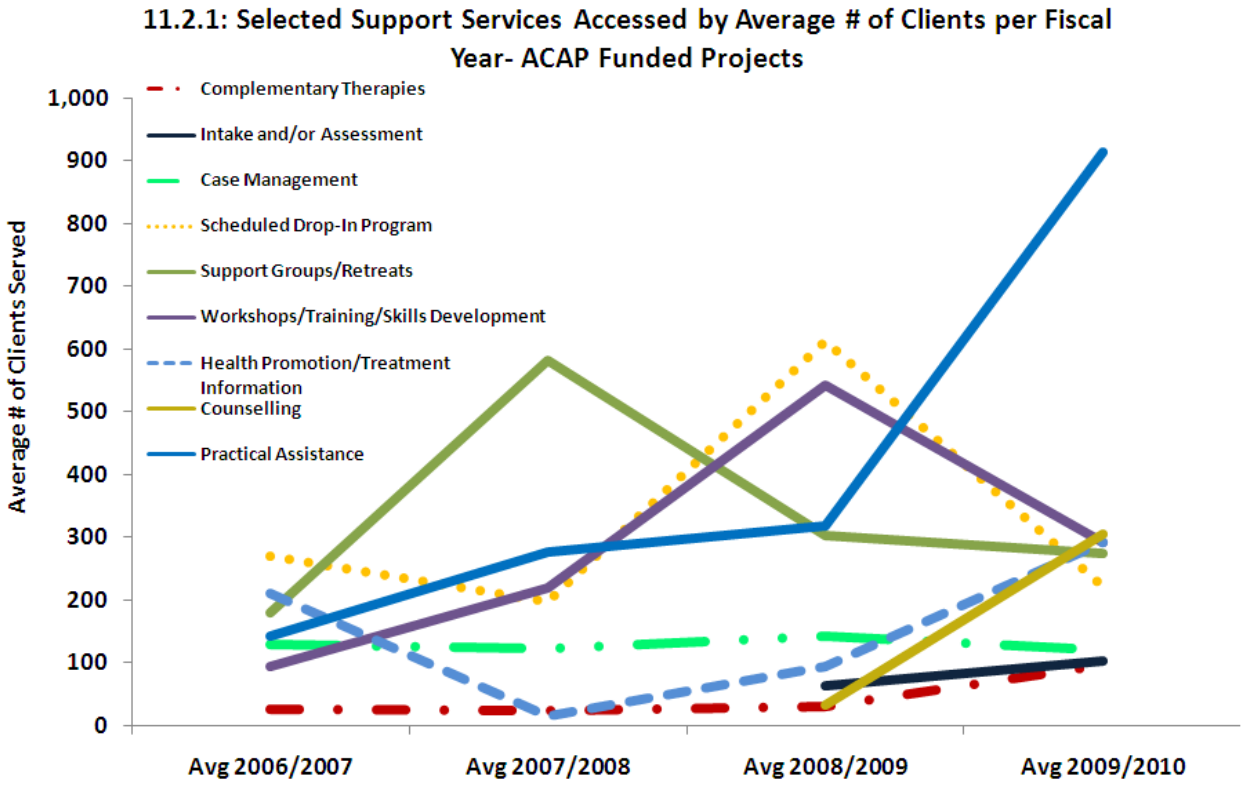
2. Health Promotion for People with HIV/AIDS

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 services were accessed.

In 2009-10, ACAP funded 21 projects whose primary objective was to provide health promotion for people with HIV. However, 25 ACAP-funded projects reported using this funding to provide support programming 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 program such as counselling as part of that project (i.e., there is some overlap between approaches). Of these 25 projects, 15 provided health promotion activities, 8 were prevention initiatives and 2 focused on strengthening community-based organizations.

Significant Increases in Practical Assistance, Counselling and Home Visits

Health promotion activities by projects provided more practical assistance, health promotion, counselling and treatment information. Practical assistance sessions were by far the largest category with 8,348 sessions in 09-10. Given there were 10 new projects focusing on Health Promotion, we would expect significant increases in this area. The drop in Scheduled Drop-In activity is due to two projects that stopped providing this service in 2009.



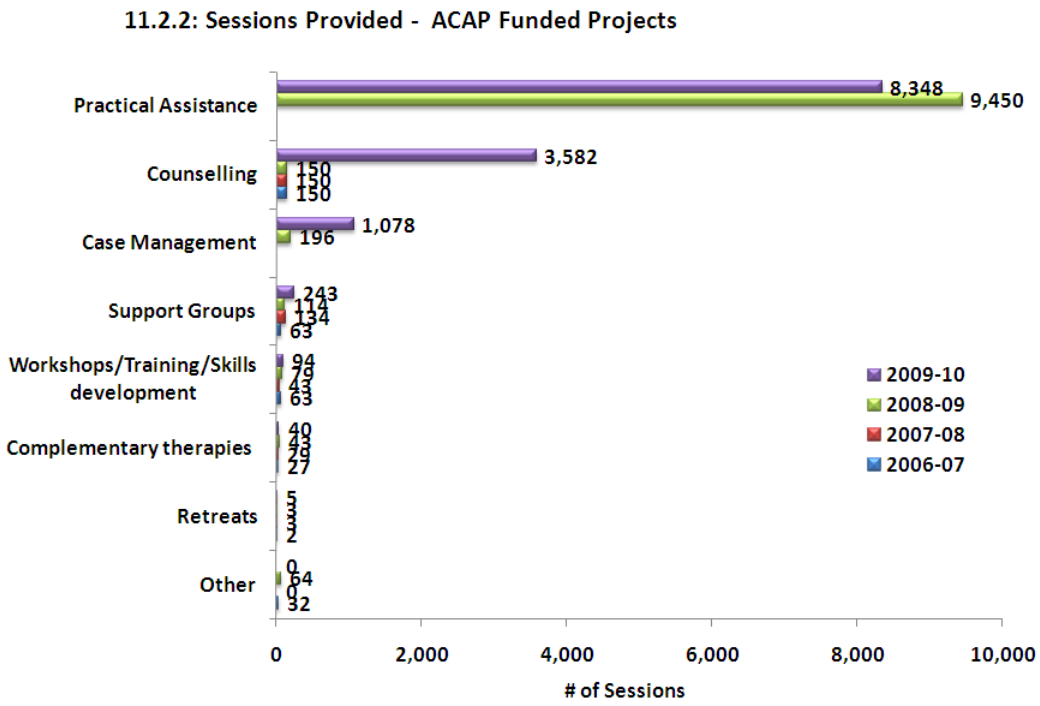
Number of projects reporting by year.

2006/2007	2007/2008	2008/2009	2009/2010
14	15	14	25

The total number of health promotion activities delivered to clients in 2009-10 (6,171) was 40% higher than in 2008-09 (4,407).

Efforts to Measure Intensity of Service

Figure 11.2.2 lists the number of support sessions reported by ACAP-funded projects. There has been a significant increase in the number of support sessions provided due to the 10 new projects that are serving PHAs. Two in particular are using a case management model and have seen the intensity of their services increase.



3. Strengthening Community-Based Organizations

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

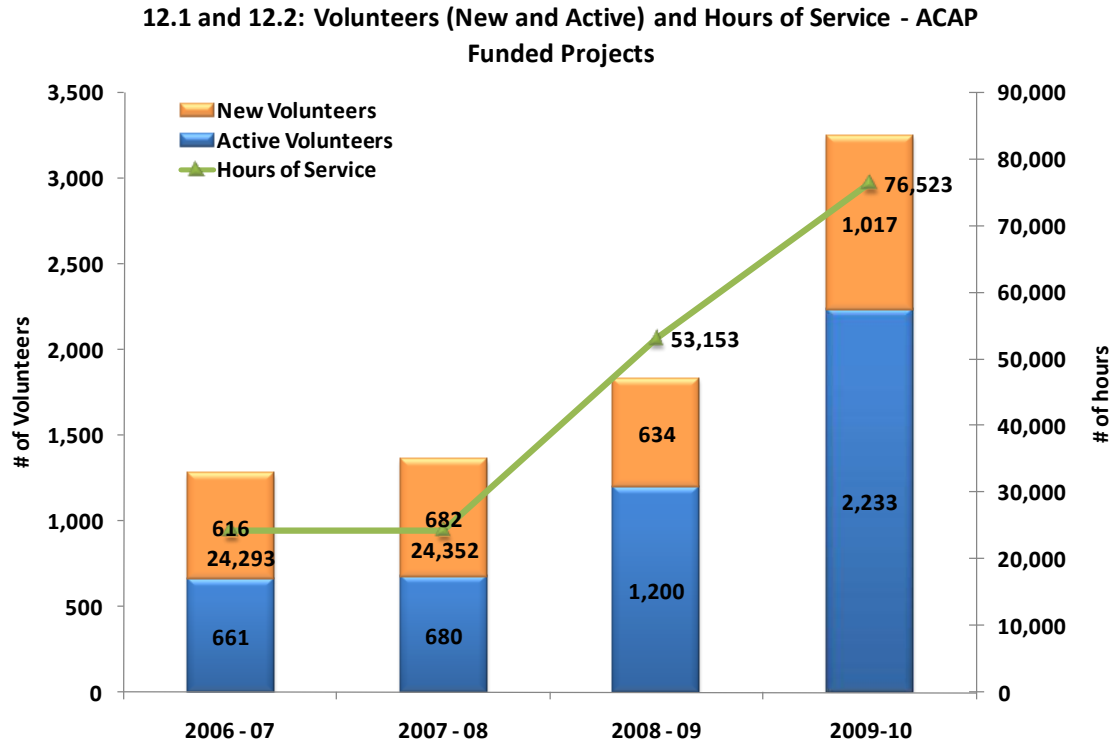
ACAP supports activities that increase the skills and abilities of the people who work at all levels of the community-based AIDS movement: board members, staff and volunteers. ACAP also supports initiatives that provide training for staff and volunteers in areas such as community development, fundraising,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

Significant Increase in the Number of Active and New Volunteers and Hours of Service

In 2009-10, 48 ACAP-funded projects reported having activities that involve volunteers. The number of active volunteers increased significantly over the past year, partly due to the new funded projects.

During 2009-10, volunteers in ACAP-funded projects and projects provided a total of 76,523 hours of service, up about 24% over last year. Volunteers provided over 22,000 hours of practical assistance alone. The impact of this volunteer service is tremendous, both for the health of organizations and their ability to provide service. It also helps to raise the profile of the projects in the broader community. Again, it would be of interest to know how many of these volunteers are PHAs or peers in order to better understand the greater involvement of people infected or affected.

These projects reported a total of 3,250 volunteers during the year, which slightly exceeded their overall target of 3,015, but the actual number of hours of service was slightly lower than the target.



Number of projects reporting by year.

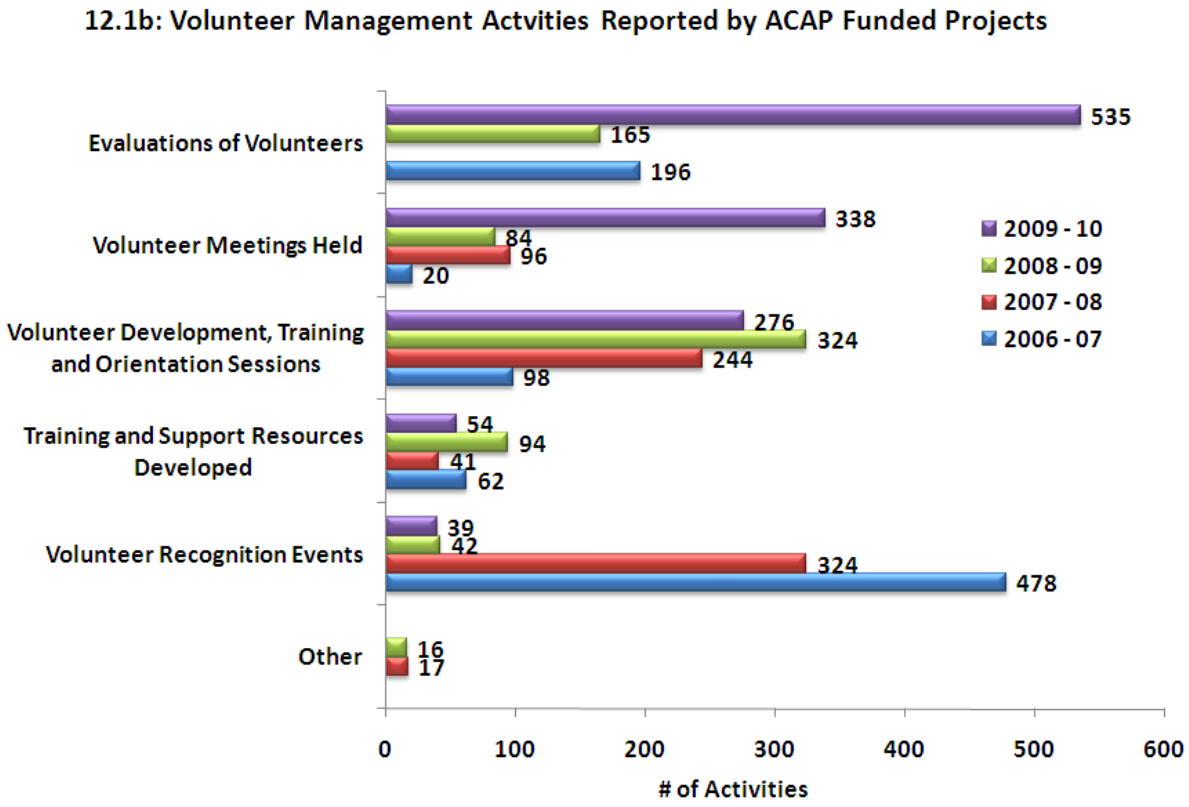
2006/2007	2007/2008	2008/2009	2009/2010
23	18	26	48

Average Hours per Volunteer.

2006/2007	2007/2008	2008/2009	2009/2010
19.02	17.88	28.98	26.55

In the past, volunteer numbers have been inconsistently reported in ACAP online logic models. In particular, some projects that report volunteer activities and hours have not reported the total number of new and active volunteers in each reporting period. ACAP is working on strategies to improve the accuracy and completeness of volunteer data that is reported in the online logic models, to ensure that we are fully capturing the valuable contribution that volunteers make. ACAP project staff can assist with these efforts by making sure that, if they are reporting volunteer activities, their logic model data provides answers to all questions in the volunteer section of OCHART.

Focus on Evaluations of Volunteers



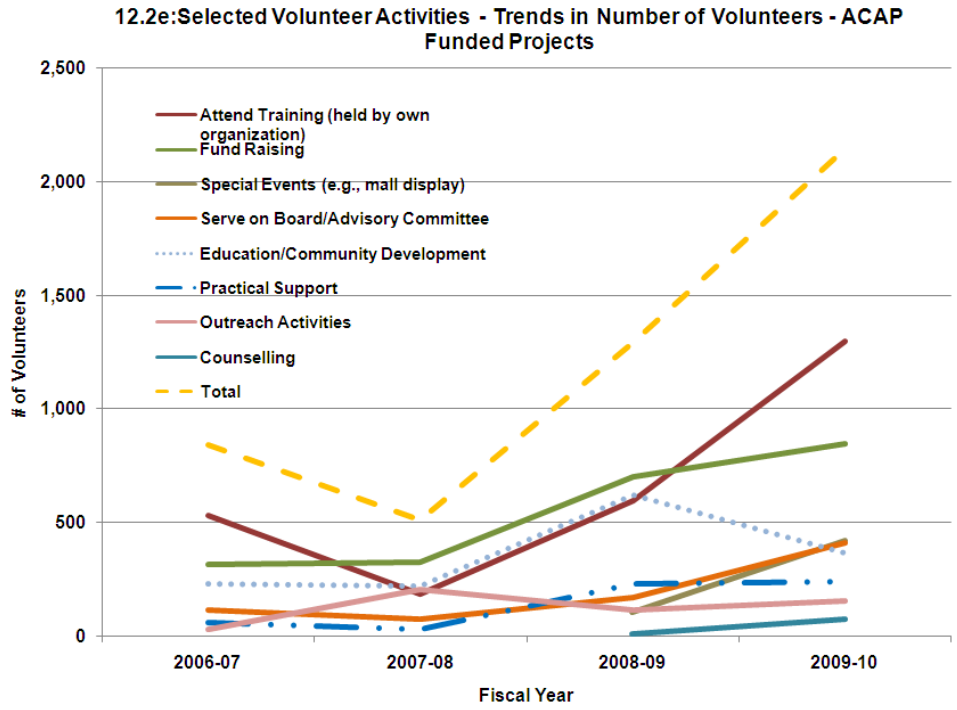
Over the past three years, ACAP-funded projects have focused on training, meetings and in this past year, evaluations. It would be of great interest to know the results of these evaluations and, as more programs make use of OCASE, we may be able to understand what helps to attract and maintain volunteers to our work. Evaluations of volunteers increased due to two projects that reported a large number of evaluations, but also because there were 4 new agencies reporting. This is another area in OCHART that may need to be changed as the questions seem to be producing ambiguous results. The number of volunteer meetings also increased; again, the increase is due to the number of new agencies reporting, which went from 8 to 18.

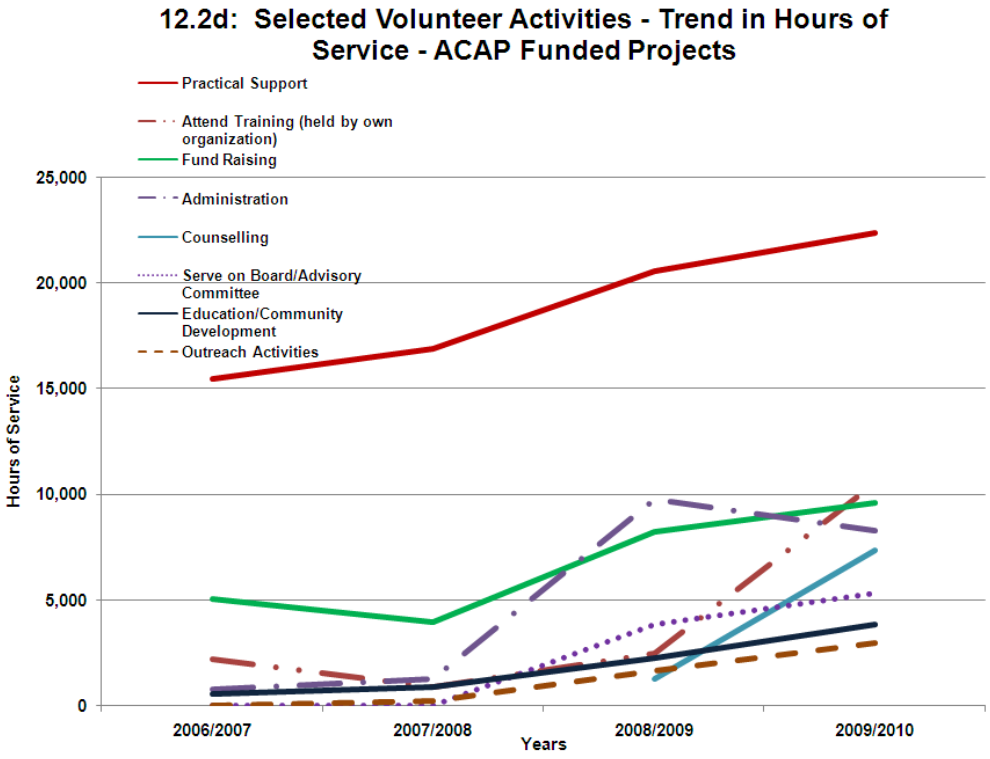
More Volunteers Involved in Fundraising, Special Events and Serving on Boards

Figure 12.2e lists the type of volunteer activities in ACAP-funded projects in 2009-10. Volunteers in these organizations were more active in fundraising than the non-ACAP project volunteers who were more active in practical support and administration. Of great interest is the number of programs reporting attracting volunteers to serve on boards and committees. This is often a challenge for projects and can have significant benefits to the overall health of an organization. It would be helpful to know if there is any link between the increase in evaluation of volunteers and their respective board or committee activity.

Of the 48 ACAP-funded projects that reported providing volunteer services, 26 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.

There was a significant increase in volunteers attending training, as would be expected with an increase in the number of ACAP funded projects. Special events, board and committee work and fundraising also saw large increases in the number of volunteers providing service.

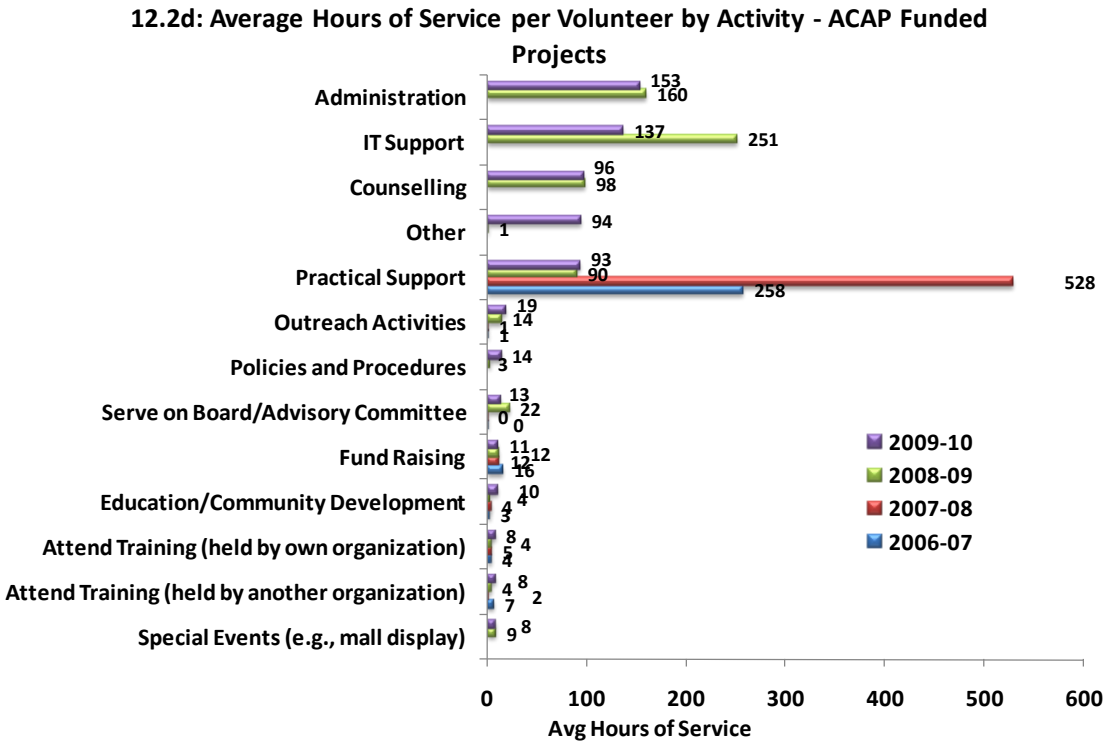




Number of projects reporting by year.

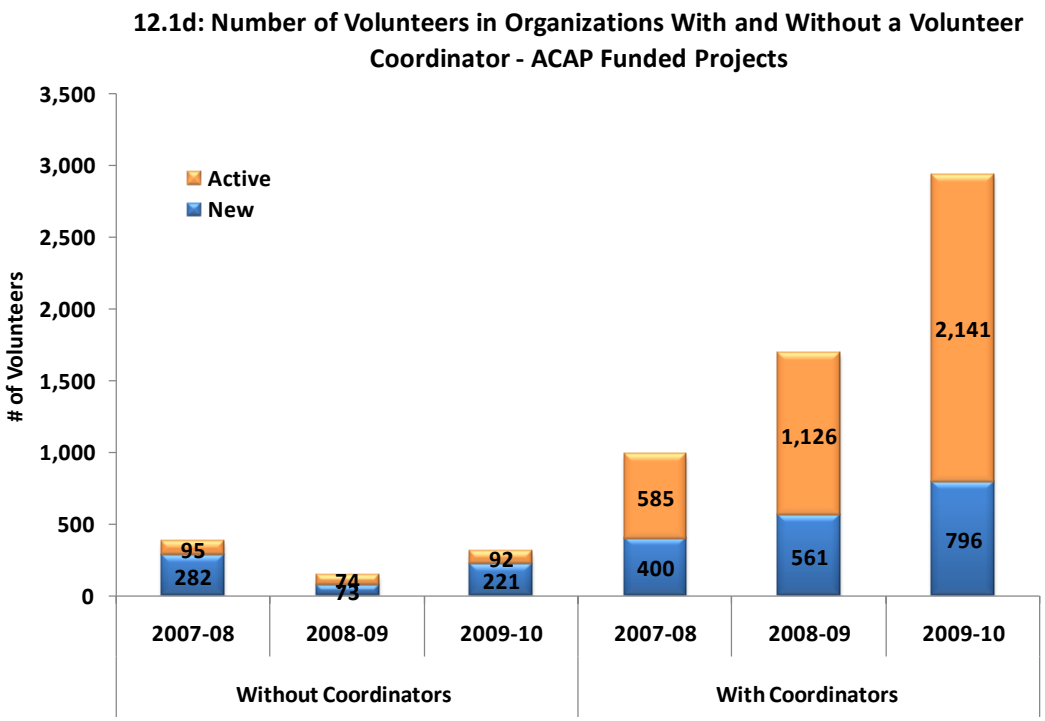
2006/2007	2007/2008	2008/2009	2009/2010
16	14	24	47

Although practical support is still the activity with the greatest number of volunteer hours, there have been significant increases in hours spent on counselling, education and committee work. As well, there was a large increase in time spent on training of volunteers and it will be interesting to see if this results in greater retention of volunteers or changes in the services they provide. The average number of hours spent per activity is still greatest in administration and IT support though a significant amount of volunteer time is devoted to counselling and practical support. It will be interesting to follow the trends of these activities over the next few years as the number of new volunteers has increased significantly. Once again, the increased number of volunteers and volunteer activities is largely due to the increased number of projects.



Volunteer Coordinators Influence Volume of Volunteer Activities

During 2009-10, ACAP funded 11 unique volunteer coordinator positions within projects. Investment in volunteer coordinators continues 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).



In 2009/10, there were 11 ACAP projects that had a volunteer coordinator and 13 that did not. 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. Key accomplishments this year include:

- With the funding of 27 new projects, the activities funded by ACAP have increased significantly in many areas.
- Compared to last year, ACAP projects almost doubled the number of education presentations and participants.
- Outreach to at-risk populations and people living with HIV doubled from last year. There are innovative activities being developed to increase outreach, especially the use of online outreach through social networking sites.
- Case management services are reaching a significant number of PHAs through partnerships among AIDS Service Organizations (ASOs) and ACAP funded projects.
- Volunteers provide excellent return on investment in volunteer programs. In 2009-10 they provided over 80,000 hours of service through special events, board and committee work and fundraising and helped to reduce project expenses by providing practical support and administration activities.

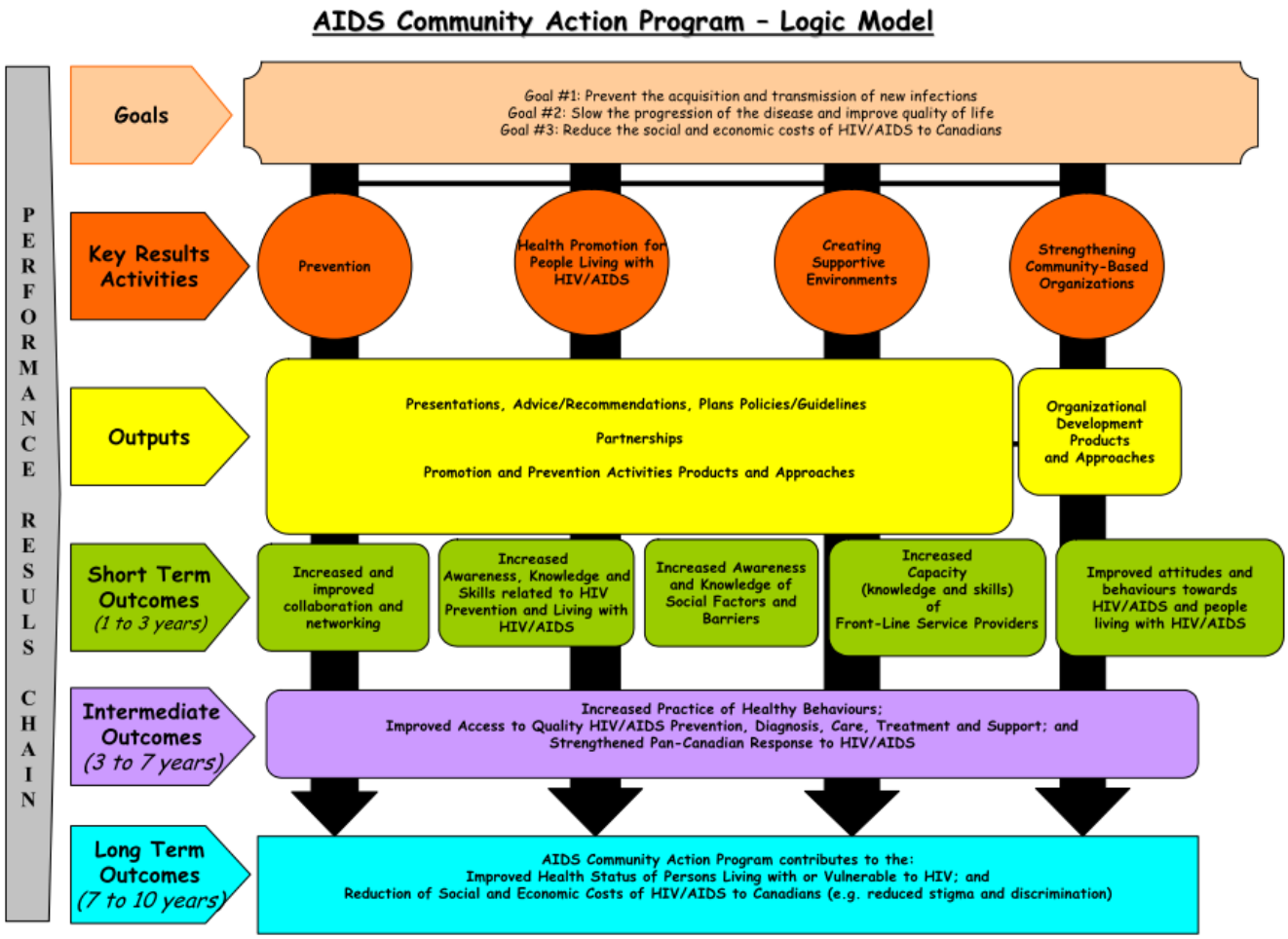
The new funding provided by ACAP has contributed to a significant increase in prevention, support and education activities. This work is contributing to measurable outcomes in terms of increased awareness, knowledge and skills related to HIV prevention. It is also reasonable to expect that the presence of 27 new projects has contributed to increased access to risk reduction resources, support programs and social support for the populations targeted by funded projects.

Appendix A: Funded Programs by Health Region

HealthRegion	OrganizationName	LHIN
Central East	AIDS Committee of York Region	Central
	Peterborough AIDS Resource Network	Central East
	AIDS Committee of Durham Region	Central East
	AIDS Committee of Simcoe County	North Simcoe Muskoka
Central West	Hemophilia Ontario - CWOR	Central West
	Peel HIV/AIDS Network	Central West
	Hamilton AIDS Network	Hamilton Niagara Haldimand Brant
	Hamilton Public Health & Community Services	Hamilton Niagara Haldimand Brant
	AIDS Niagara	Hamilton Niagara Haldimand Brant
	AIDS Committee of Cambridge, Kitchener, Waterloo and Area	Waterloo Wellington
	AIDS Committee of Guelph and Wellington County - Masai	Waterloo Wellington
	AIDS Committee of Guelph and Wellington County	Waterloo Wellington
Eastern	Ontario Aboriginal HIV/AIDS Strategy - Kingston	South East
	HIV/AIDS Regional Services	South East
	Street Health Centre, Kingston Community Health Centres	South East
Northern	Sudbury Action Centre For Youth	North East
	Union of Ontario Indians	North East
	Ontario Aboriginal HIV/AIDS Strategy - Cochrane	North East
	Ontario Aboriginal HIV/AIDS Strategy - Sudbury	North East
	Hemophilia Ontario - NEOR	North East
	Algoma Group Health	North East
	Access AIDS Network - Sudbury	North East
	AIDS Committee of North Bay and Area	North East
	Hemophilia Ontario - NWOR	North West
	Ontario Aboriginal HIV/AIDS Strategy - Thunder Bay	North West
	Nishnawbe Aski Nation	North West
	AIDS Thunder Bay	North West
	Wassay Gezhig Na Nahn Dah We Igamig	North West
Ottawa	Youth Services Bureau of Ottawa	Champlain
	Somerset West Community Health Centre	Champlain
	Bruce House	Champlain
	City of Ottawa Public Health	Champlain
	Ontario Aboriginal HIV/AIDS Strategy - Ottawa	Champlain
	Hemophilia Ontario - OEOR	Champlain
	AIDS Committee of Ottawa	Champlain
South West	AIDS Support Chatham-Kent	Erie St Clair
	Ontario Aboriginal HIV/AIDS Strategy - Wallaceburg	Erie St Clair
	AIDS Committee of Windsor	Erie St Clair
	Association of Iroquois and Allied Indians	South West
	Hemophilia Ontario - SWOR	South West
	Ontario Aboriginal HIV/AIDS Strategy - London	South West
	AIDS Committee of London	South West
Toronto	AIDS Committee of Toronto - PYO	Toronto Central
	AIDS Committee of Toronto - VIVER	Toronto Central
	AIDS Committee of Toronto	Toronto Central
	Africans In Partnership Against AIDS	Toronto Central
	2-Spirited People of the First Nations	Toronto Central
	Elizabeth Fry Society of Toronto	Toronto Central
	Planned Parenthood Toronto	Toronto Central
	AIDS Committee of Toronto - Action Positive	Toronto Central
	Ethiopian Association	Toronto Central
	Barrett House - Good Shepherd Ministries	Toronto Central
	Black Coalition for AIDS Prevention	Toronto Central
	Alliance for South Asian AIDS Prevention	Toronto Central
	Asian Community AIDS Services	Toronto Central

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

Appendix B: ACAP Logic Model



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

ACAP Operational Projects 2009-2010

PREVENTION INITIATIVES

Project Number	Project Title	Agency Sponsor
6963-06-2002/2370431	Prison In-Reach Project	Prisoners With HIV/AIDS Support Action Network
6963-06-2002/2370437	Algoma Group Health: Community Education and Prevention Program	Sponsored by ACCESS AIDS 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
6963-06-2002/4480433	Community Education Program	AIDS Committee of Cambridge, Kitchener, Waterloo and Area
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
6963-06-2002/2370442	Gay Men's Health and Wellness Project	AIDS Committee of Ottawa
6963-06-2002/4480444	Wellington & Grey-Bruce Rural Prevention/ Outreach Program	AIDS Committee of Guelph and Wellington County
6963-06-2008/4480492	African Peer Speakers Bureau Project	Africans in Partnership Against AIDS
6963-06-2008/4480497	Aboriginal Youth Peer Prevention Project	Ontario Aboriginal HIV/AIDS Strategy
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	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
6963-06-2002/2370435	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
6963-06-2002/2370441	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
6963-06-2004/4480463	VIVER: Portuguese-Speaking Case Management	Sponsored by the AIDS Committee of Toronto
6963-06-2008/4480491	Legacy Project: Structured Mentorship Support to Promote Community Collaboration, Succession, and Meaningful Participation of People with HIV/AIDS	Committee for Accessible AIDS Treatment sponsored by the Toronto People with AIDS Foundation
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
6963-06-2008/4480495	Case Management for Black, African and Caribbean People with HIV/AIDS	Black Coalition for AIDS Prevention

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
6963-06-2008/4480493	Community Volunteer Program	AIDS Committee of York Region
6963-06-2008/4480496	AIDS Bereavement Project of Ontario: Turning to One Another – AIDS Service Organizations Bringing the "Greater Involvement of People Living with HIV/AIDS" Principle to Life	AIDS Bereavement Project of Ontario Sponsored by Fife House Foundation

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

ACAP Time-Limited Projects 2009-2010

PREVENTION INITIATIVES

Project Number	Project Title	Project Sponsor
6963-06-2008/4480468	Work Safe: Sex Worker's HIV/AIDS, Hepatitis C and STI Prevention and Support Project	Elizabeth Fry Society of Toronto
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
6963-06-2008/4480470	People living with HIV/AIDS (PHA) Capacity Building to Increase Community Engagement	Ontario AIDS Network
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
6963-06-2008//4480484	HIV/AIDS Regional Coordination and Integration Plan – Connecting Regional Persons Living with HIV/AIDS to Care and Support	AIDS Committee of London

STRENGTHENING COMMUNITY-BASED ORGANIZATIONS

Project Number	Project Title	Project Sponsor
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
6963-06-2008/4480482	The "Aht Fra" Project: Interpreter Services for People with HIV/AIDS	AIDS Committee of Cambridge Kitchener, Waterloo and Area (ACCKWA)
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