OCHART

View from the Front Lines 2011

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

April 1, 2010 - March 31, 2011

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

Ontario
Ontario Ministry of Health and Long Term Care
Ministère de la santé des soins longue durée de l'Ontario

Public Health Agency of Canada
Agence de santé publique du Canada

OHTN

VIEW FROM THE FRONT LINES

2011

ACKNOWLEDGEMENTS

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

In addition, the AIDS Bureau and PHAC's Ontario and Nunavut ARO would like to thank the Ontario HIV Treatment Network (OHTN) for its support of OCHART. 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
416-642-6486 x2303
gmitchell@ohtn.on.ca

CONTRIBUTORS

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

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

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

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

Jean Bacon
Director, Policy and Knowledge, Translation and Exchange, Ontario HIV Treatment Network

Charles Shamess
Director, Evidence-based Practice Unit, Ontario HIV Treatment Network

Greg Mitchell
Manager, OCHART

Michelle Song
Data Analyst, OCHART

PREFACE

Welcome to the 6th 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 Regional Office, 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:

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

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.

WHAT'S DIFFERENT ABOUT THIS YEAR'S REPORT?

We have made two major changes to this year's report.

1. HIGHLIGHTING SIGNIFICANT CHANGES AND TRENDS

In past reports, we included data on almost every OCHART question. This year, we are highlighting only data that reveal significant changes or trends; however, data from all OCHART questions will be available in a separate document on the OCHART web site.

2. FOCUSING ON THE OUTCOMES OF OUR WORK

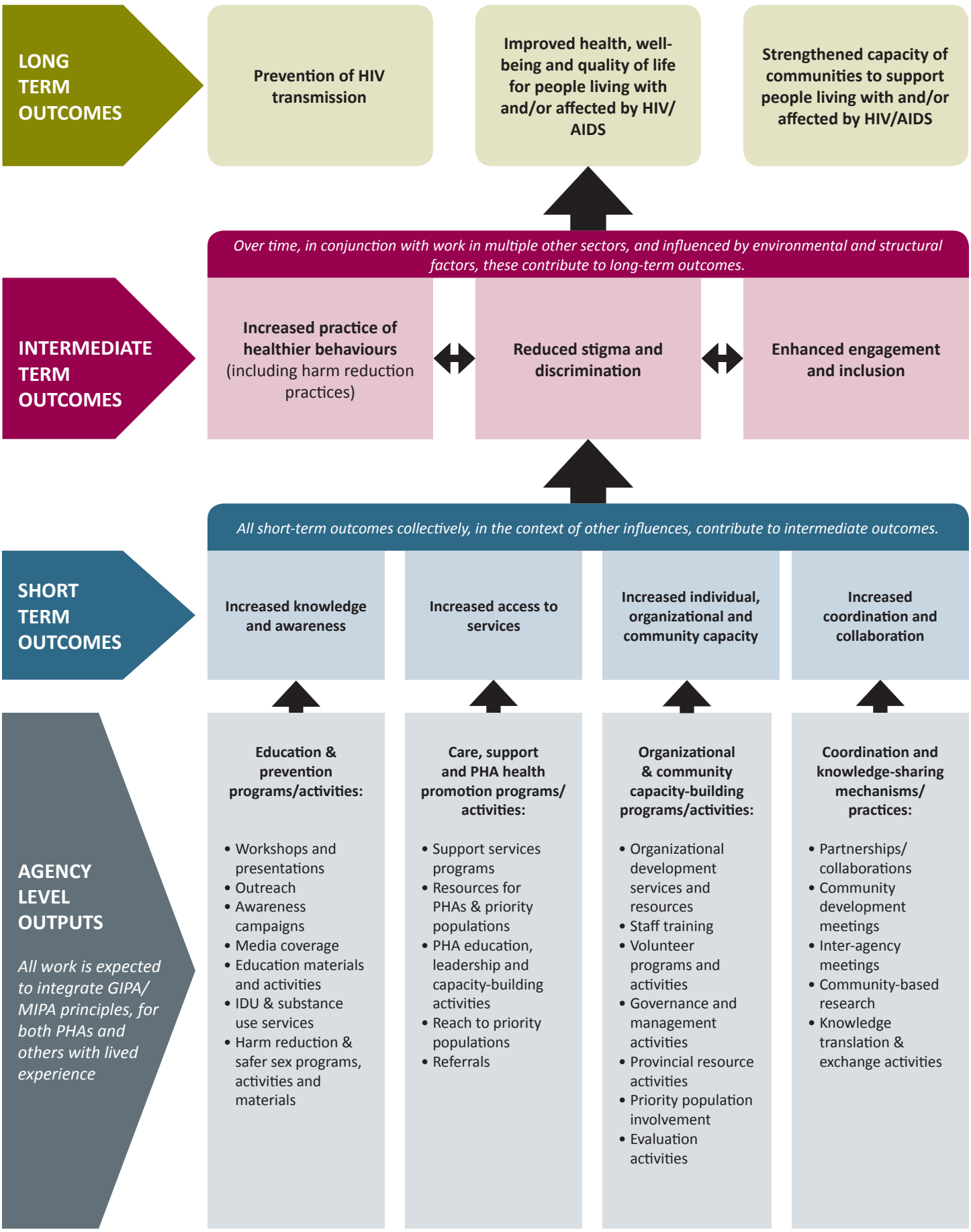
In past reports, data were presented in the same order as the OCHART questions themselves. This structure made it easy to see the connection between the OCHART questions and the resulting data – but harder to understand how the work contributes to achieving our common goals.

In this year's report, we have organized the data to reflect the activities that funded organizations undertake to achieve our common goals as illustrated in the following logic model, which is a synthesis of both the AIDS Bureau and ACAP funding program logic models.

This new structure reinforces how different activities contribute to one or more goals. It also begins to shift us away from simply reporting on activities (outputs) to understanding and assessing their impact (outcomes). For 2010-11, OCHART data is reported under the following four anticipated outcomes of our work:

- increasing knowledge and awareness
- increasing access to services
- increasing individual, organizational and community capacity
- increasing coordination and collaboration.

SYNTHESIZED LOGIC MODEL FOR COMMUNITY-BASED HIV/AIDS FUNDING PROGRAMS IN ONTARIO



UNDERSTANDING THE LOGIC MODEL

PHAC has always used logic models to explain the relationship between the key activities, outputs and expected outcomes of community-based HIV funding. With the recent development of a logic model for the AIDS Bureau Funding Program, a synthesized logic model was developed. It takes core pieces of both the AIDS Bureau and PHAC logic models together to reinforce how the two funding programs are working to achieve common goals. Because the combined logic model represents the work of two funders, not all outputs will apply to all funded programs. It depends on the source(s) of funding for each program. The logic model captures all the work of the two funding programs; individual agencies and funded projects aren't expected to carry out all the activities or reach all the populations included in the logic model.

HOW TO READ THE LOGIC MODEL

The box at the top of the logic model describes the long-term outcomes or ultimate goals of our work. The rest of the logic model explains how our work contributes to reaching these goals.

To read the logic model, start at the bottom of the page:

- The logic model begins with four pillars that list the outputs associated with each community-based HIV program. Outputs are tangible goods or services produced by programs. These tangible items or outputs are a means to an end.

- That end is the desired change or "outcomes" that we expect to see. For reporting purposes, we linked each output to a single short-term outcome where there is the closest logical link; however, we know that, in practice, outputs can contribute to more than one outcome. For example, we have linked the output "workshops and presentations" to the outcome "increased knowledge and awareness" since change in knowledge is usually the most direct, immediate result of workshops. But we know that workshops can also contribute to other outcomes, like increased access to services or increased organizational capacity.

There are three levels of outcomes in the logic model, based on time and reach. Short-term outcomes generally occur first, and are where we can see the clearest cause-effect relationship between the outputs produced by agencies and the outcomes we see in the community. These outcomes are the areas where funded agencies have the strongest influence, and where we can most directly attribute change specifically to the work of funded agencies and projects. Outcomes become more complex to measure as we move up the logic model. Intermediate and longer-term outcomes take more time to achieve, and are more dependent on the work of other programs and sectors. Funded agencies can make a contribution, along with other community and government initiatives, to achieving these outcomes, but they are influenced by many factors beyond the control of both community agencies and funders.

MAPPING OCHART QUESTIONS TO ACTIVITIES

For those seeking information on a specific OCHART question, see Appendix D. It shows how we mapped the OCHART questions to the four outcomes discussed in this report.

DATA LIMITATIONS

ACCURACY AND CONSISTENCY

This report relies on self-reported data provided by agencies. Data are collected by a number of staff in the agencies, and there is always the potential for inconsistency (i.e., different definitions, different interpretations). Those agencies that have strong systems to track their activities are better able to complete OCHART accurately. Over the past few years, OCHART staff have worked closely with agencies to validate their data and identify data errors. We are confident that the data is becoming more accurate each year. In cases where we have discovered reporting mistakes, we've corrected them for the current year and – if applicable – for past years.

USE OF AGGREGATE DATA

In many cases throughout the report we use aggregate data – rolling up the responses from all contributing agencies to make inferences about overall levels of activity and trends; however, because of the different sizes of organizations, it is possible for the results from one or two large organizations to skew the data. For example, one or two agencies may have had a large increase in on-line education, while most other agencies had a drop but the provincial trend would still appear to be increasing. Aggregate or average results may not reflect the experience of all agencies. To reduce that effect, this year we looked at the range of responses from agencies and tried to present a more accurate picture.

CHANGES IN NUMBER OF FUNDED PROGRAMS

The number of programs that submit OCHART reports can change from year to year: some programs are only funded for a certain number of years and some may close or cease to offer HIV-related services. However, in those cases, the funding for community-based AIDS services is not lost to the system: it is reallocated to other programs, so OCHART provides a picture of how the total amount of provincial and ACAP funding has been used each year.

THE PURPOSES OF OCHART REPORTING

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 develop new services locally and provincially.

QUALITY IMPROVEMENT/EVALUATION

The reports may provide information that programs can use to strengthen their services.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

KEY FINDINGS

THE EPIDEMIOLOGY

HIV continues to be a serious, persistent problem in Ontario. There were 1,018 new diagnoses in 2010. Of those, more than 50% were in gay men and other men who have sex with men, 20% were in members of the African, Caribbean and Black communities, and 6% were in people who reported using injection drugs.

A growing number of men who have sex with men newly diagnosed with HIV are age 40 and older. There was also an increase in new diagnoses in gay men between the ages of 25 and 29. Between 2005 and 2009 those age 40 and older accounted for 38% of new diagnosis in MSM, while those between 20 and 29 accounted for 29%. Almost half of all new diagnoses in 2010 were outside Toronto. Ottawa (24%), Central East (16%) and South West (10%) had the largest increases in diagnoses.

CLIENT MIX

Community-based HIV/AIDS programs appear to be reaching at-risk women: agencies estimate that between 25 and 28% of clients using education, outreach and support services are heterosexual women which reflects the epidemiology of the epidemic. Agencies may be less effective in reaching gay men and other men who have sex with men, who account for only 20 to 35% of clients using education, outreach and support services (slightly higher if we include LGBT youth) but over 50% of new diagnoses and over 60% of people living with HIV.

SOCIAL DETERMINANTS OF HEALTH

The people who use community-based HIV/AIDS services continue to have highly complex social and health challenges, including discrimination, poverty, unemployment, food insecurity, mental health and substance use issues, and violence.

1. IMPROVING KNOWLEDGE AND AWARENESS

One of the key goals of community-based HIV/AIDS programs is to educate people with or at risk of HIV and raise awareness of the factors that put them at risk as well as the factors that can improve their health and well-being.

Overall, there were fewer presentations and workshops in 2010-11 than in 2009-10 but more participants. The information provided through OCHART does not include details on the type of education, the people or populations being reached or the impact on knowledge and awareness. It is likely that different types of education activities, such as one-time presentations to large groups and a six-week small group workshop, will have different impacts. A growing number of organizations (75%) are now using tools to measure knowledge and behaviour change among people who participate in education programs. According to results from evaluations reported in ACAP logic models, these activities are achieving at least short-term changes in knowledge and awareness.

In general, organizations are seeing increasing demand for education on stigma, GIPA/MIPA, new prevention technologies, poz prevention, co-morbidities, long-term care, health promotion, healthy sexuality and resilience. They are also receiving more requests for culturally competent education and for education for youth – particularly LGBT youth, sex workers, transmen and transwomen, people in rural areas and Aboriginal people.

Both the number of general outreach contacts and outreach to people who use substances increased in 2010-11. Contacts vary in intensity: some are brief contacts with large numbers of people attending a health fair or community event, while others are intense one-to-one conversations that occur in higher risk settings, such as bathhouses, streets/parks and bars. In the future, it might be helpful to distinguish between brief and more significant contacts to be able to assess their impact on knowledge, awareness and behaviour.

According to community-based agencies, the location of outreach is key to success, as are good working relationships with the owners of the outreach sites and having the right resources to distribute. Among outreach clients, there appears to be a high need for practical assistance and referrals to other services, which indicates that outreach plays a valuable role in helping to link people to services. To meet the needs of the diverse communities affected by HIV, programs plan to deliver outreach in more diverse locations, adapt resources to ensure they are culturally competent and develop partnerships with other organizations, such as Aboriginal organizations, faith-based groups, housing groups, youth groups and cultural organizations.

A relatively small number of organizations are involved in online outreach (<10 in any one reporting period) and most delivered fewer than 200 chatroom interventions in a six-month period. Given that this type of virtual service can be provided from anywhere, it might be interesting for the sector to discuss whether there is any benefit in concentrating this type of intervention in a small number of organizations.

Organizations distributed 36% more condoms, 35% more needles and almost 30% more glass pipes/stems in 2010-11 than in the previous year.

2. IMPROVING ACCESS TO SERVICES

Providing access to comprehensive, integrated, culturally competent support services is a core part of the work of community-based HIV programs. Improving access to these services will help achieve the outcome of "improved health, well-being and quality of life for people living with or affected by HIV".

Organizations reported providing support services to more than 13,600 people in each half of 2010-11 – the majority of whom are people living with HIV; of those, about 39% were new clients. However, these numbers may underestimate the actual number of people served. The 26 organizations that use the OCASE case management system had 7,695 active clients between April 2010 and September 2011 and it seems likely that the other 37 organizations would have more than 6,000 over the year.

Although males (including both men who have sex with men and heterosexual men) are at high risk of HIV and make up the majority of new diagnoses (80%) and people living with HIV (80%), only 66% of support service users are male and the number of men receiving services declined by 7% in 2010-11. Over the same period, the number of women using support services increased slightly. This trend may reflect the impact of the new Women and HIV/AIDS Initiative, which is working to enhance the capacity of community-based services to respond to women with HIV. The number of transgender clients also increased in 2010-11.

The most used services in 2010-11 were practical assistance, health promotion/treatment information services, referrals, case management and counselling services. In terms of the actual number of clients using services, there was a drop in most categories. It may be worthwhile investigating whether this trend is due to more accurate counting of service use, capacity issues in the organizations or a change in client needs.

Although the total number of clients using case management and counselling services in 2010-11 went down, the actual number of sessions increased. This may indicate that a relatively small number of people are intense users of community-based services. If this is the case, the sector may want to focus on identifying effective ways to serve this high needs group and assessing whether the use of community-based services reduces their use of other, more costly health services, such as inpatient and emergency care.

Agencies reported that the types of support services required vary with age: older clients are more concerned about meeting basic needs, managing other chronic conditions and financial security while younger clients are looking for services related to reproductive health and relationships.

When asked about unmet needs, organizations identified a number of gaps in support services including: supports for aging clients, services to counter stigma, discrimination and social isolation, translation and other services for newcomers, support for prisoners, support for women, and services for men who have sex with men. Strategies being used to fill these gaps include: recruiting more volunteers, pursuing funding for new and expanded programs, building partnerships with other services and expanding outreach and other services that reduce social isolation.

3. ENHANCING INDIVIDUAL, ORGANIZATIONAL AND COMMUNITY CAPACITY

Community-based programs are expected to enhance the capacity of people, organizations and communities to respond to HIV.

The sector is committed to the greater and more meaningful involvement of people living with HIV (GIPA/MIPA). Between 70 and 95% of organizations reported that they actively try to involve members of their target populations in their work. Although 80 to 90% of agencies recruit people with or at risk of HIV to paid positions, only about 70% have a member of a target population on staff – down slightly from the previous year. It should be noted that GIPA and MIPA does not need to be confined to the HIV sector: many people with HIV are engaged in their communities in other ways. Barriers to GIPA and MIPA continue to be: lack of training for people with HIV, their health circumstances which can affect their ability to work consistently and financial circumstances such as the impact of employment on their ability to access disability benefits based on current ODSP rules.

In 2010-11, there was a significant increase in the number of peers involved in IDU outreach programs – particularly in activities such as community development, phone line support and practical assistance.

Community-based HIV programs continue to be highly dependent on volunteers. In 2010-11, they benefited from the equivalent of 222,223 volunteer hours or approximately $4,605,878 worth of services. During that year, organizations reported fewer volunteers (14% drop) than in previous years and fewer volunteer hours of service (6% drop). Fewer volunteers appear to be doing more work. Smaller organizations appear to be more effective than larger ones at recruiting and retaining volunteers, which may be due to the fact that they are more dependent on volunteers or are able to develop stronger relationships with them. Strategies that appear to be effective in recruiting volunteers include: more outreach to potential volunteers, mentoring programs, more meaningful and independent projects for volunteers, targeting volunteers with specific skills and providing training opportunities. The role of the volunteer coordinator also seems to be key in attracting and retaining volunteers.

As part of their efforts to improve services and retain employees, organizations are investing in staff training in areas such as team building, change management, computer training, health and safety, culturally competent care and client services such as crisis prevention, addictions, violence and mental health.

Agencies continue to make use of provincial resource programs designed to enhance organizational capacity. Almost 70% participated in skills building programs offered by the Ontario AIDS Network. About 60% used "other" resources, such as external consultants and the supports provided by HALCO and the OHTN. Almost half used the services of OPRAH, the program that provides assistance with HR issues, and the AIDS Bereavement and Resiliency Project of Ontario, which introduced a new resiliency training program and the Ontario Organizational Development Program. Over 80% of organizations also reported that they participated in some way in community-based research.

4. IMPROVING COORDINATION AND COLLABORATION

The effectiveness of community-based HIV organizations depends on their ability to coordinate and collaborate with other services in their community. Organizations continue to participate in community development efforts and link with other sectors.

In 2010-11, agencies that provide services for people who use substances reported more community development contacts with addiction service providers, methadone maintenance clinics, grass roots organizations, youth services, mental health service providers, food banks, faith-based organizations, police and user networks.

Over the same period, more agencies reported service partnerships that involve sharing administrative resources and space but fewer reported sharing staff resources.

Organizations reported having partnerships across a range of sectors, which should lead to more effective, comprehensive services for people living with or at risk of HIV.

CONCLUSION: THE LINK BETWEEN ACTIVITIES AND OUTCOMES

This is the first OCHART report that has organized and reported on activities under the four logic model outcomes. In its current form, OCHART does not necessarily provide enough information to assess whether the activities are having the desired impact. However, reporting in this way should reinforce the importance of developing programs and services that will help achieve the desired outcomes. It should also lead to the development of evaluation tools that will help assess the impact and effectiveness of community-based HIV programs and services.

PART 1:

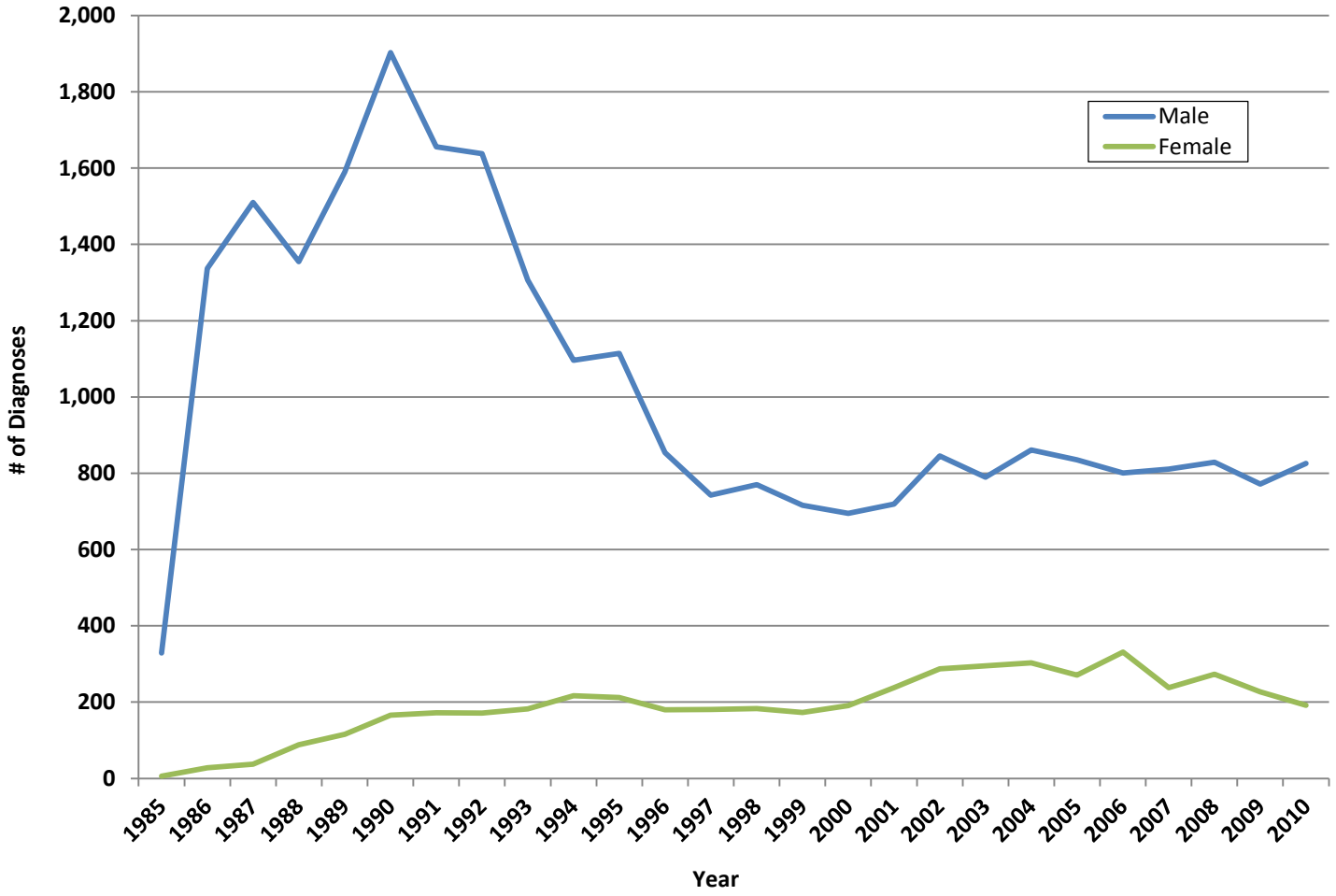
TRENDS IN HIV INFECTION

TRENDS IN HIV INFECTION IN ONTARIO

1,018 NEW HIV DIAGNOSES IN 2010

HIV continues to be a serious, persistent problem in Ontario. In 2010, 826 men and 192 women were newly diagnosed with HIV: a total of 1,018 new HIV diagnoses – up from 999 in 2009. The number of new diagnoses in men has remained at over 800 a year (range: 772 to 861) for the past nine years. Women still account for about 1 in 5 new diagnoses although the number of new diagnoses in women has declined by over one-third since its high in 2006. The number of new diagnoses each year – in both men and women -- reinforces the ongoing need for effective prevention programs.

Figure 1
Number of HIV Diagnoses (adjusted1) Among Males and Females by Year of Diagnosis, Ontario: 1985 - 2010

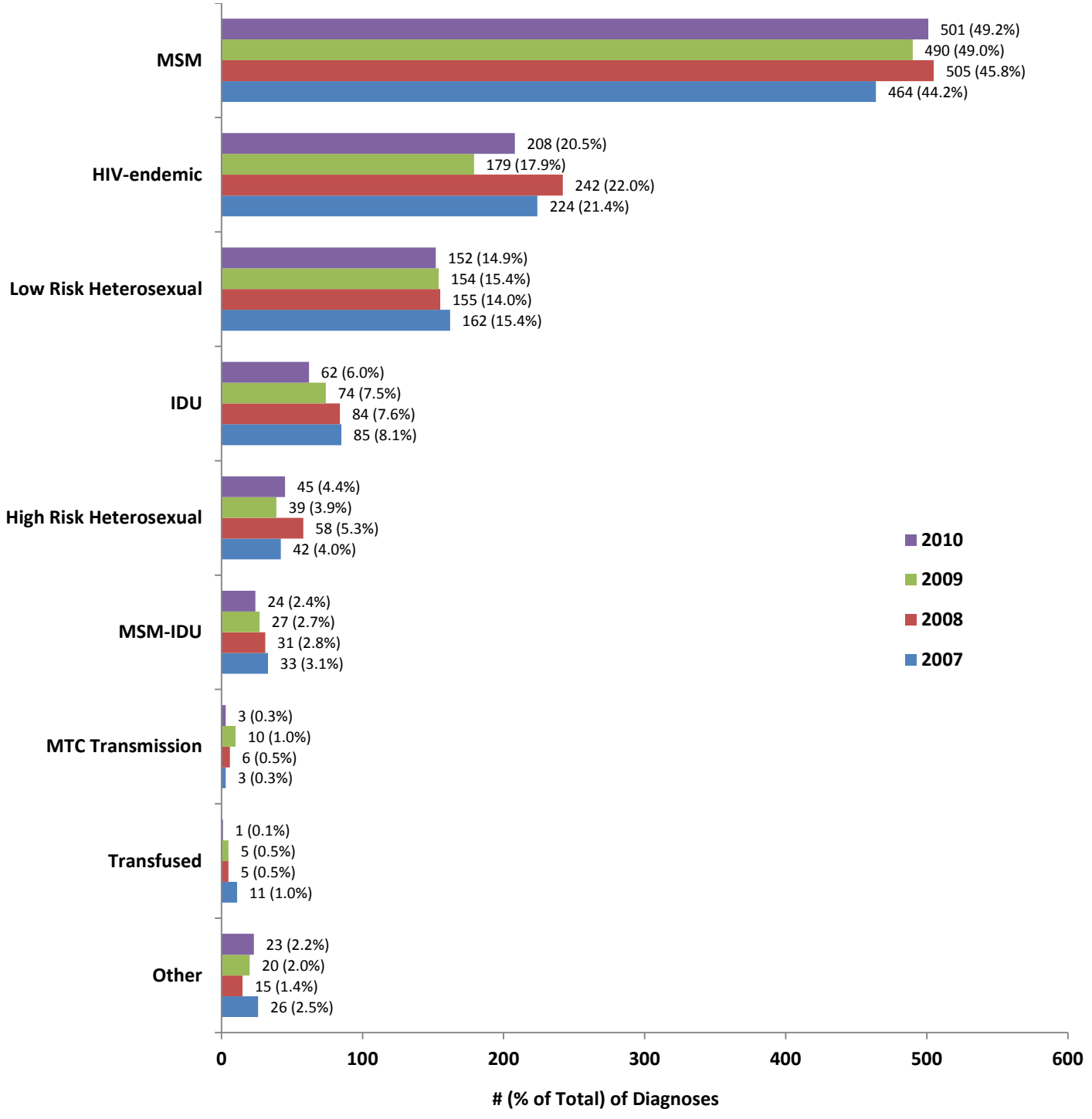


1. Unknown sex assigned according to the distribution of cases with known sex (see Technical Notes); thus, totals may differ due to rounding
Source: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care
From: http://www.phs.utoronto.ca/ohemu/doc/Table1.pdf - accessed February 13,2012

MORE THAN 50% OF ALL NEW DIAGNOSES IN GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN

In 2010, the number of new diagnoses in men who have sex with men (MSM) increased. Combined with MSM who also report injection drug use, men who have sex with men accounted for 1 of every 2 new diagnoses in Ontario (51%). One of every five people newly diagnosed (20%) was from a country where HIV is endemic – that is, Africa or the Caribbean – and one in every 16 reported injection drug use as a risk factor (6%). In 2010, the number of new diagnoses in people who report injection drug use as a risk factor continued to decline – likely due to effective harm reduction programs. The number of new diagnoses in people from countries where HIV is endemic increased in 2010 but was still lower than in 2007 or 2008.

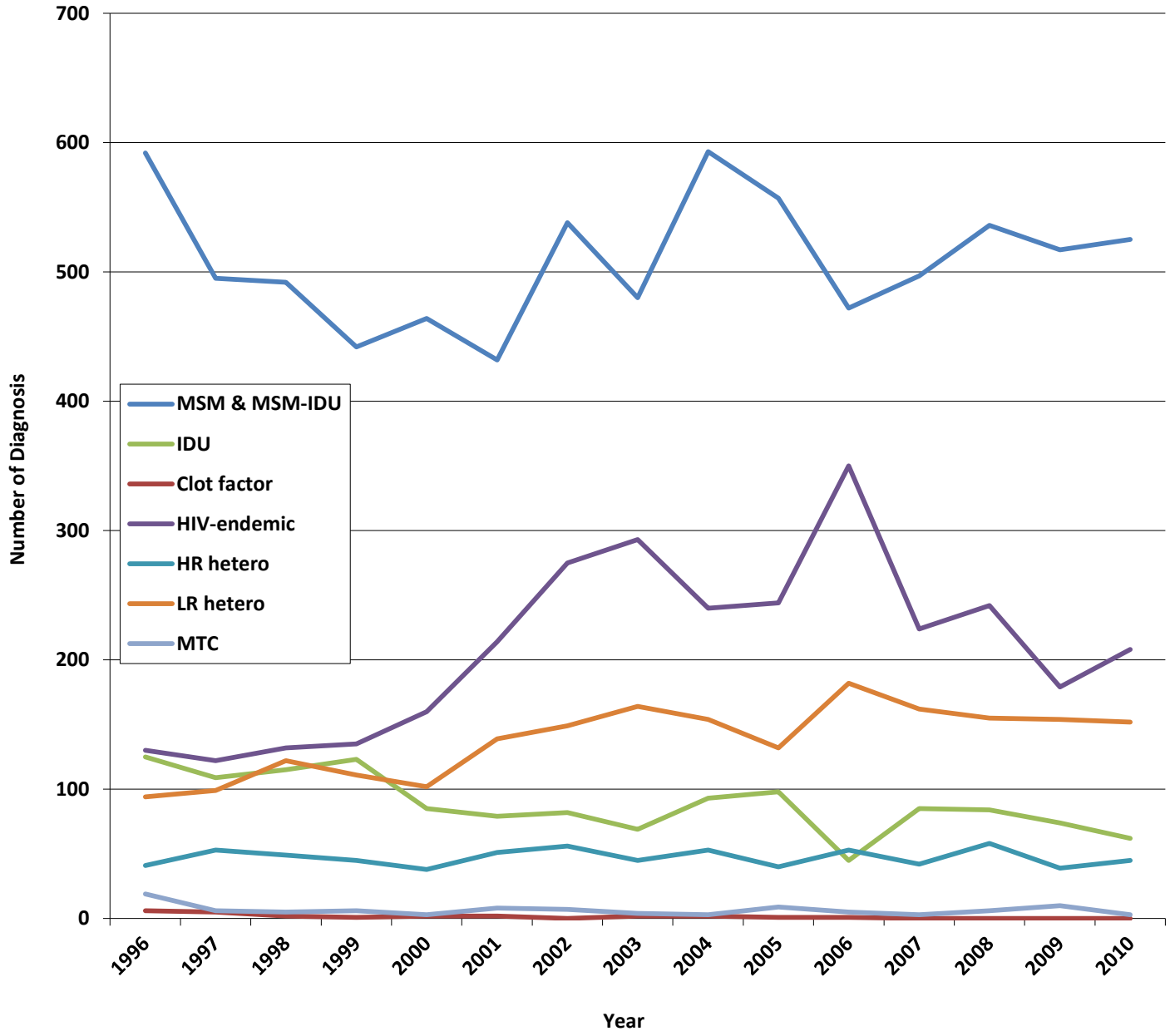
Figure 2
Number of HIV Diagnoses by Year of Test and Exposure Category: 2007 - 2010



Source: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care

The number of people reporting low risk heterosexual activity has remained consistent for the past four years; however, based on research with this group most are not low risk and do, in fact, have a risk factor for infection. Figure 3 shows the trends in new diagnoses by risk factor over the past 15 years. Men who have sex with men are the only category to see a steady increase in new diagnoses since 2006.

Figure 3
Number of HIV Diagnosis by Exposure Category: 1996 - 2010

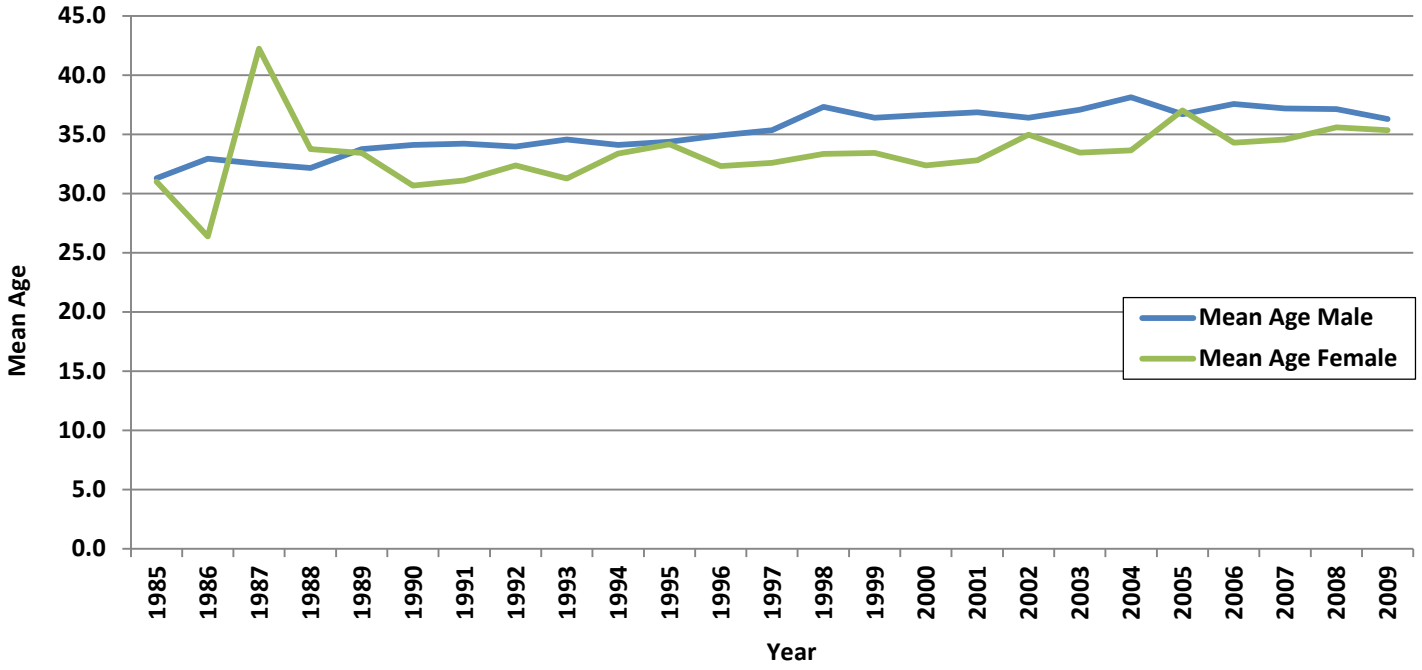


Source: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care

MOST NEWLY DIAGNOSED PEOPLE ARE IN THEIR 30S AND 40S

Figure 4 shows the mean age of people at diagnosis, which is increasing over time in both males and females.

Figure 4
Mean Age at HIV Diagnosis by Gender by Year of Diagnosis



Among men who have sex with men, there's been an increase in the number of new diagnoses in gay men age 40 and older and between the ages of 20 and 29. Those over the age 40 represent 38% of new diagnosis in MSM between 2005 and 2009; while gay men between 20 and 29 represent 29%. These data reinforce the need for prevention programs/strategies tailored to reach these groups of men.

Figure 5
Proportion of HIV Diagnosis by Age at Diagnosis and Year of HIV Diagnosis

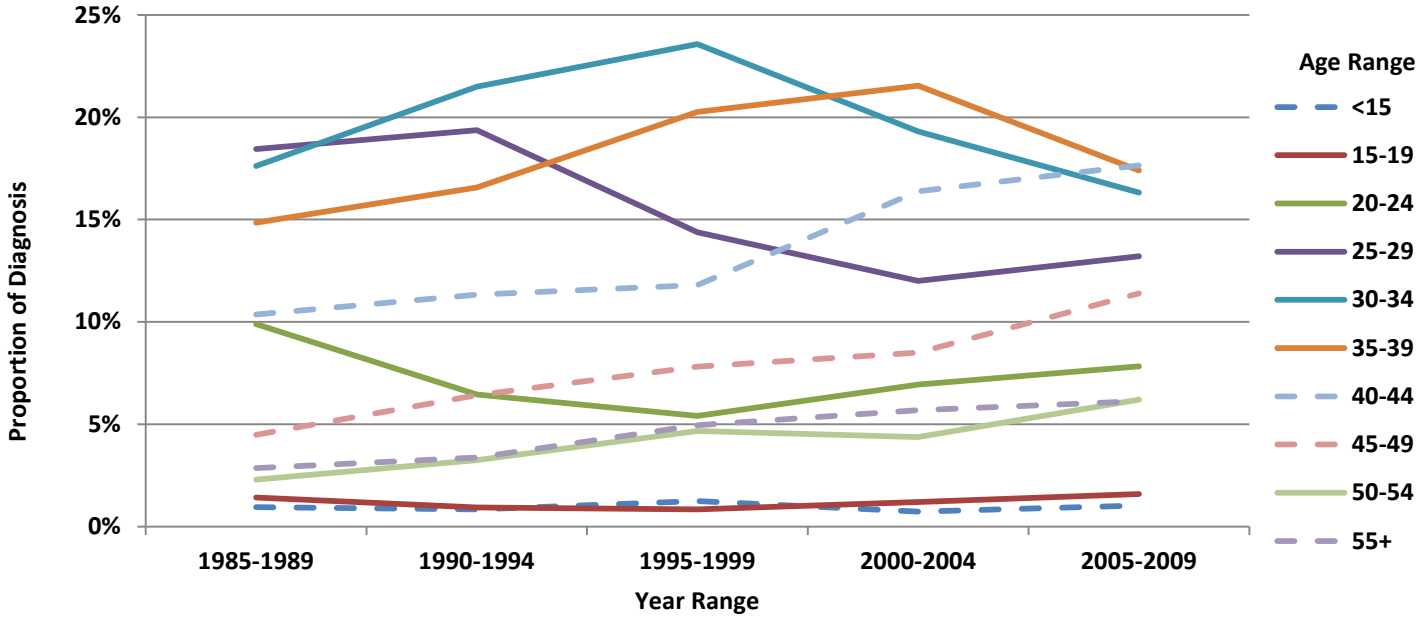
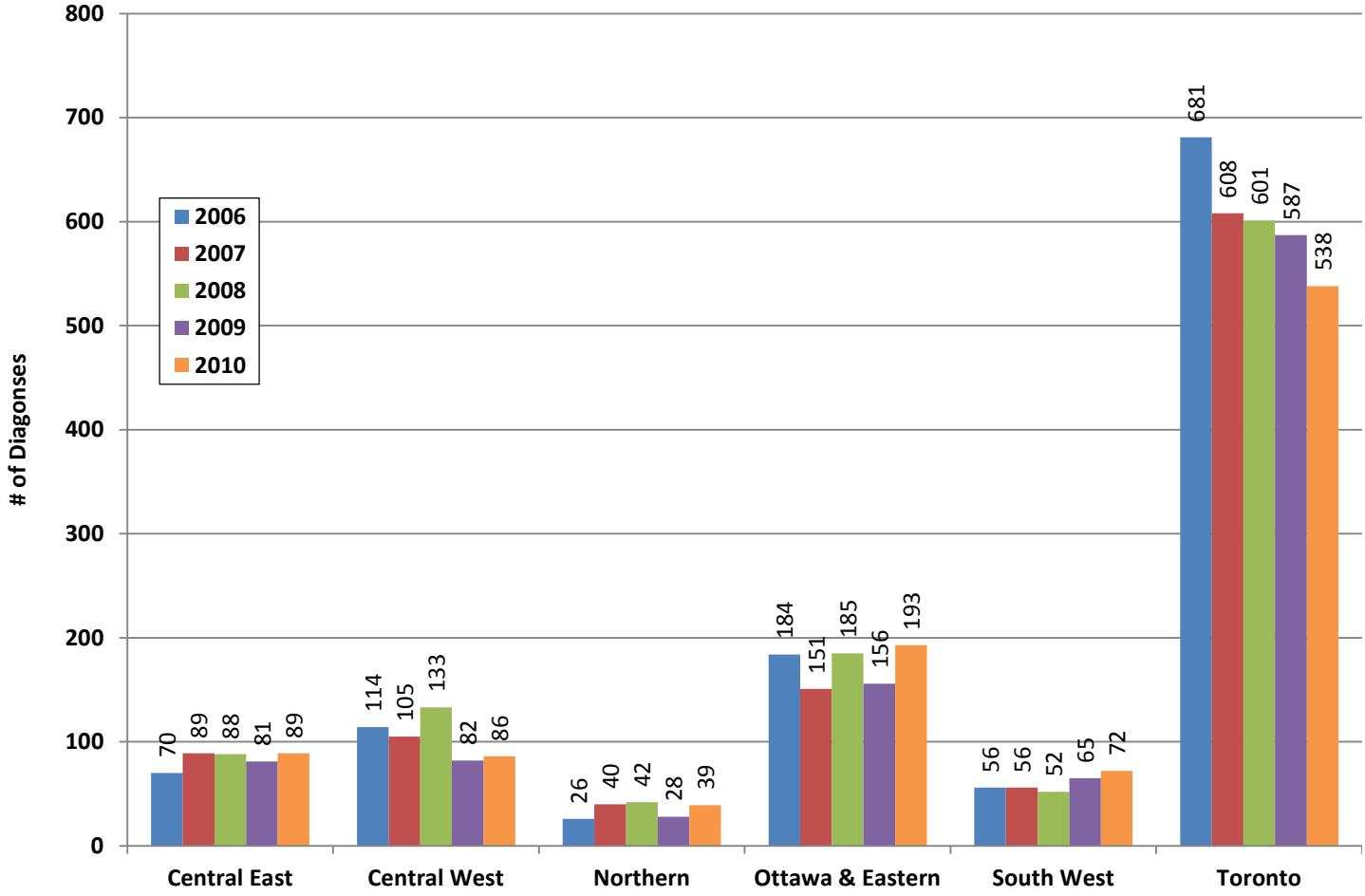


Figure 4 & 5 - Source: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care

ALMOST HALF OF ALL NEW DIAGNOSES OUTSIDE TORONTO

Although Toronto still has the largest number of new diagnoses each year, that number has been dropping steadily for the past five years – while the number of new diagnoses per year has been increasing in other parts of the province. In the last year alone, there was an increase in new diagnoses in South West (10%), Central East (10%), and Ottawa and Eastern (24%). Each of those parts of the province had its largest number of diagnoses in a single year in 2010.

Figure 6
New Diagnoses by Region

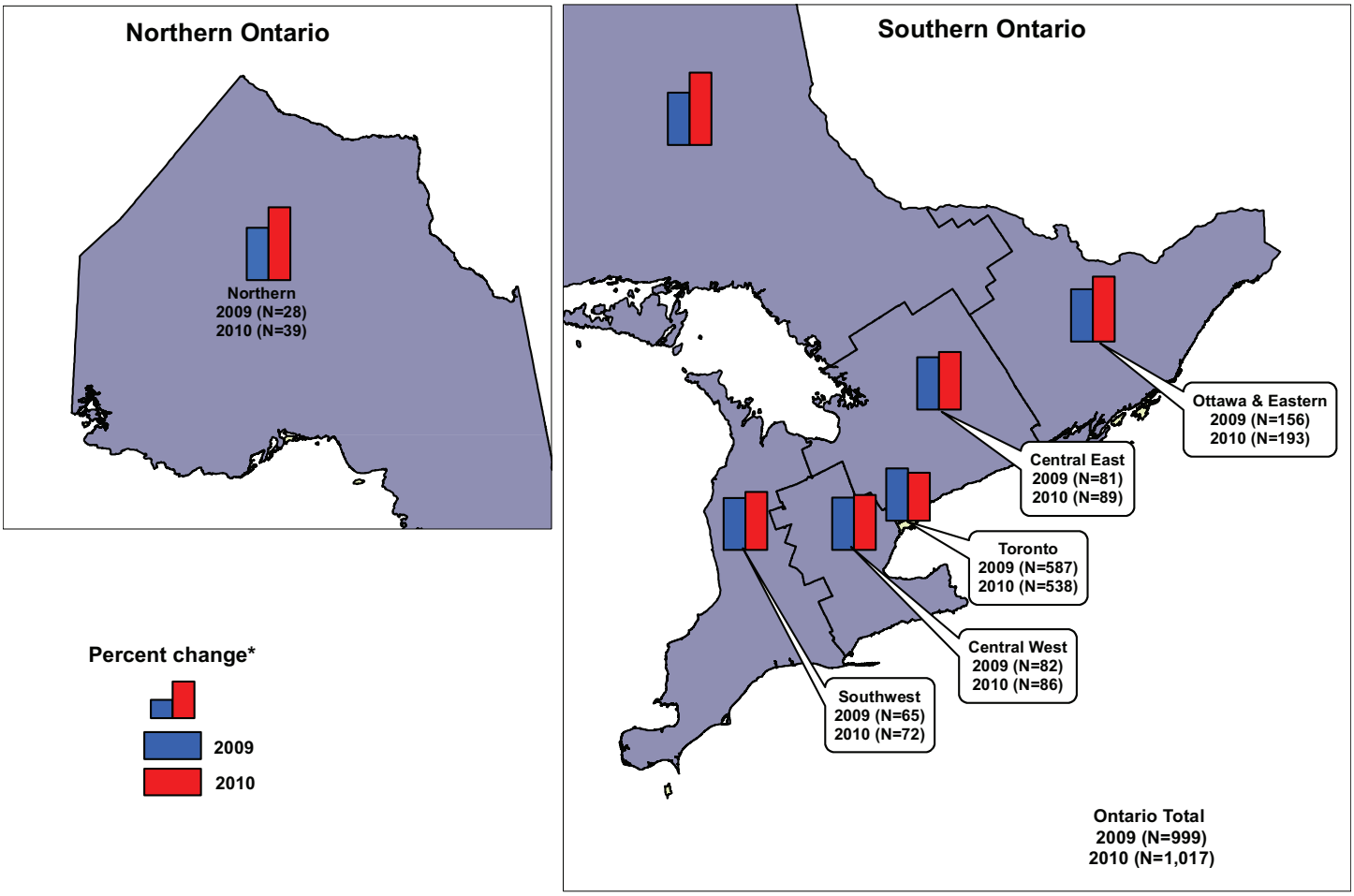


Source: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care

NEW DIAGNOSES BY REGION

The following map illustrates the number of new diagnoses in each region over the past two years. All showed an increase over the previous year – except Toronto. In the South West region, all the increase was in the "men who have sex with men" category. In Central East, the increase was in the "injection drug use" and "endemic" categories. In Ottawa, the increase was in the "endemic", "high risk heterosexual" and "low risk heterosexual" categories. These data reinforce the need for prevention programs tailored to the epidemiology of HIV in each region.

Figure 7
Percent of Diagnoses and Percent Change by Health Region



** The bars show percent change in 2010 compared with 2009*
Source: HIV Update, HIV Epidemiologic Monitoring Unit, University of Toronto

PART 2:

HOW WE WORK

COMMUNITY-BASED HIV SERVICES IN ONTARIO

This report reflects the work of 88 community-based programs located within 72 different organizations across the province – including 40 community-based AIDS service organizations (ASOs), 20 non-ASOs, eight community health centres, and four other health care organizations – that are funded to provide prevention and support services for people with or at risk of HIV, and their partners and families.

Of the 72 organizations, 62 are local or regional service programs that provide direct services to clients in their geographic area, four are provincial service organizations that provide direct services to clients across the province and six are provincial resource organizations that provide advice and support to community-based AIDS service organizations and other organizations/providers serving people with HIV. Some of the provincial organizations are based in Toronto but have regional staff/programs located in across the province. We have counted those regional programs separately so we can capture their services in the regions where they are delivered.

Figure 8
Provincial HIV/AIDS Programs

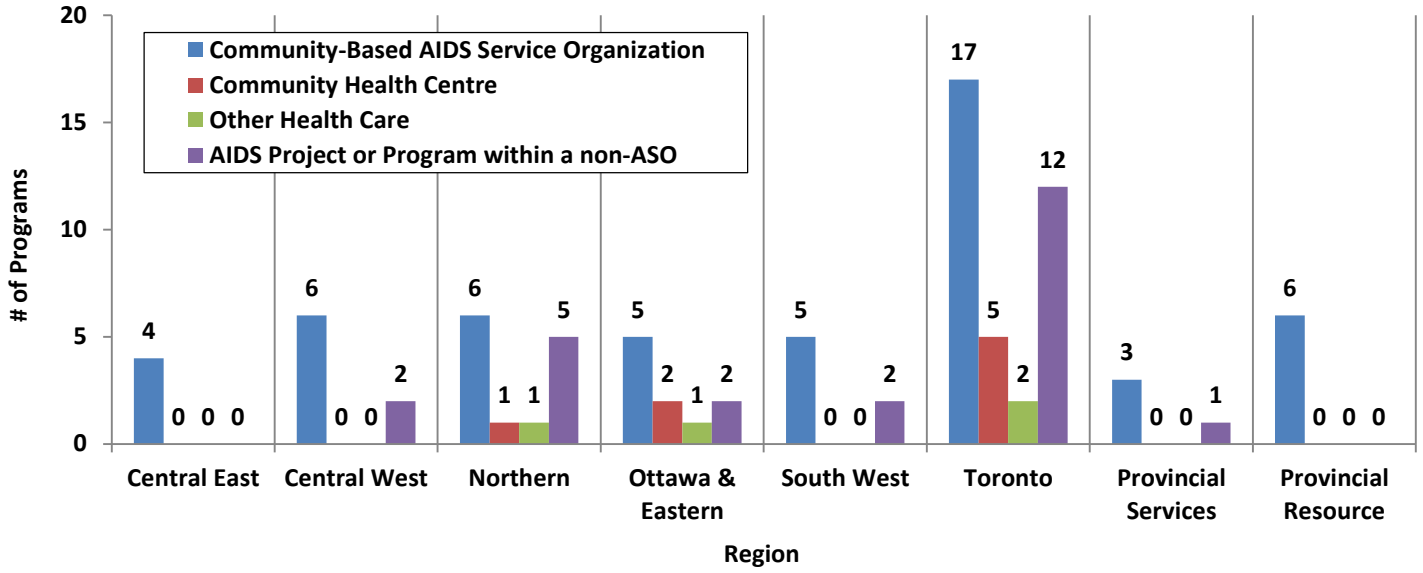
Provincial Programs that Provide Services Directly to Clients	Provincial Programs that are a Resource for Other HIV/AIDS Programs*
HIV & AIDS Legal Clinic (Ontario) (HALCO)	African and Caribbean Council on HIV/AIDS in Ontario (ACCHO)
Ontario Aboriginal HIV and AIDS Strategy (OAHAS)	AIDS Bereavement and Resiliency Project of Ontario (ABRPO)
Hemophilia Ontario	Canadian AIDS Treatment Information Exchange (CATIE)
Prisoners' HIV/AIDS Support and Action Network (PASAN)	Ontario AIDS Network (OAN)
	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.*

PROGRAMS ARE LOCATED ACROSS THE PROVINCE

There are community-based programs in all parts of the province. More than half (46 including the provincial services and resource organizations) are located in Toronto.

Figure 9
Number of Programs by Type and Region



SIZE AND SCOPE OF PROGRAMS VARY

Programs vary in size and in the range of services they provide: the vast majority (66 or 77%) have fewer than 10 staff – in fact, more than half (45) have fewer than six staff, while only eight (9%) have more than 20 staff. As would be expected, the larger programs are located in larger urban centres, like Toronto.

Figure 10
Number of Programs by Program Type and Size (by FTE)

	ASO	CHC	Other Healthcare Institutions	Non-ASO
> 20	5	1	2	
15-20	3	1		
10-15	7		1	2
6-10	15	2		4
1-5	12	4	1	14

Program Type

The range and scope of services provided depend on a number of factors, including:

- size/skills/capacity of the program
- the focus of the program (i.e., some specifically serve people living with HIV or who are part of a particular cultural or ethno-racial group; some focus on a particular type of service, such as housing)
- local needs (i.e., in a community with a small number of people living with HIV, the program will focus more on prevention with populations at risk)
- links to other services available in their communities (i.e., programs may provide a broader range of services, such as food banks or housing supports, if these services either do not exist in the community or are not easily accessible to clients because of location or stigma).

Although the type and extent of services provided by each program or organization may vary, all are using similar strategies to achieve common goals:

1. Prevent HIV transmission
2. Improve the quality of life for people living with and at risk of HIV
3. Strengthen the capacity of communities to support people living with or at risk of HIV/AIDS

PART 3:

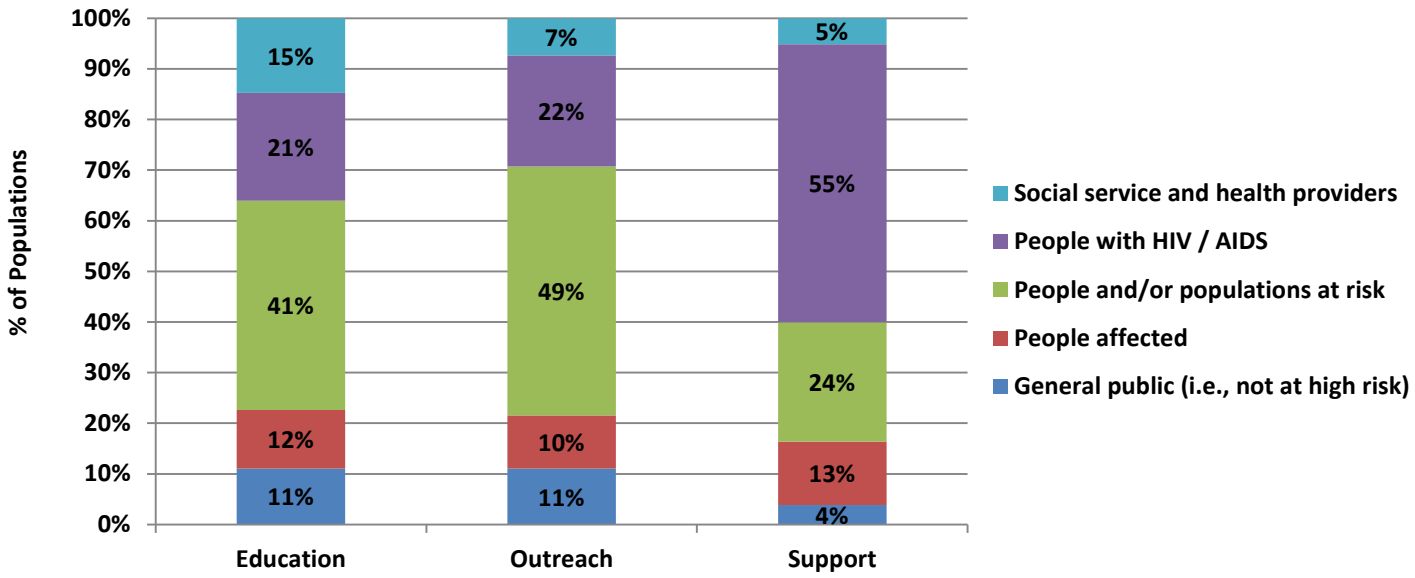
THE PEOPLE WE SERVE

Through OCHART, we try to understand who uses community-based services and how well the programs reach people who need their services.

PROGRAMS MAINLY SERVE PEOPLE AT RISK AND PEOPLE LIVING WITH HIV

OCHART asks programs to identify what proportion of education, outreach and support services they provide to different populations. As would be expected, education services target primarily people at risk, people living with HIV and other health and social service providers, and outreach services target primarily people at risk and people with HIV. Programs continue to devote about 10% of their resources to reaching the general public and another 10% to providing education or outreach services for people affected (e.g., partners, families and friends of someone with HIV).

Figure 11
Proportion of Target Populations by Service Type: 2010/2011 H2

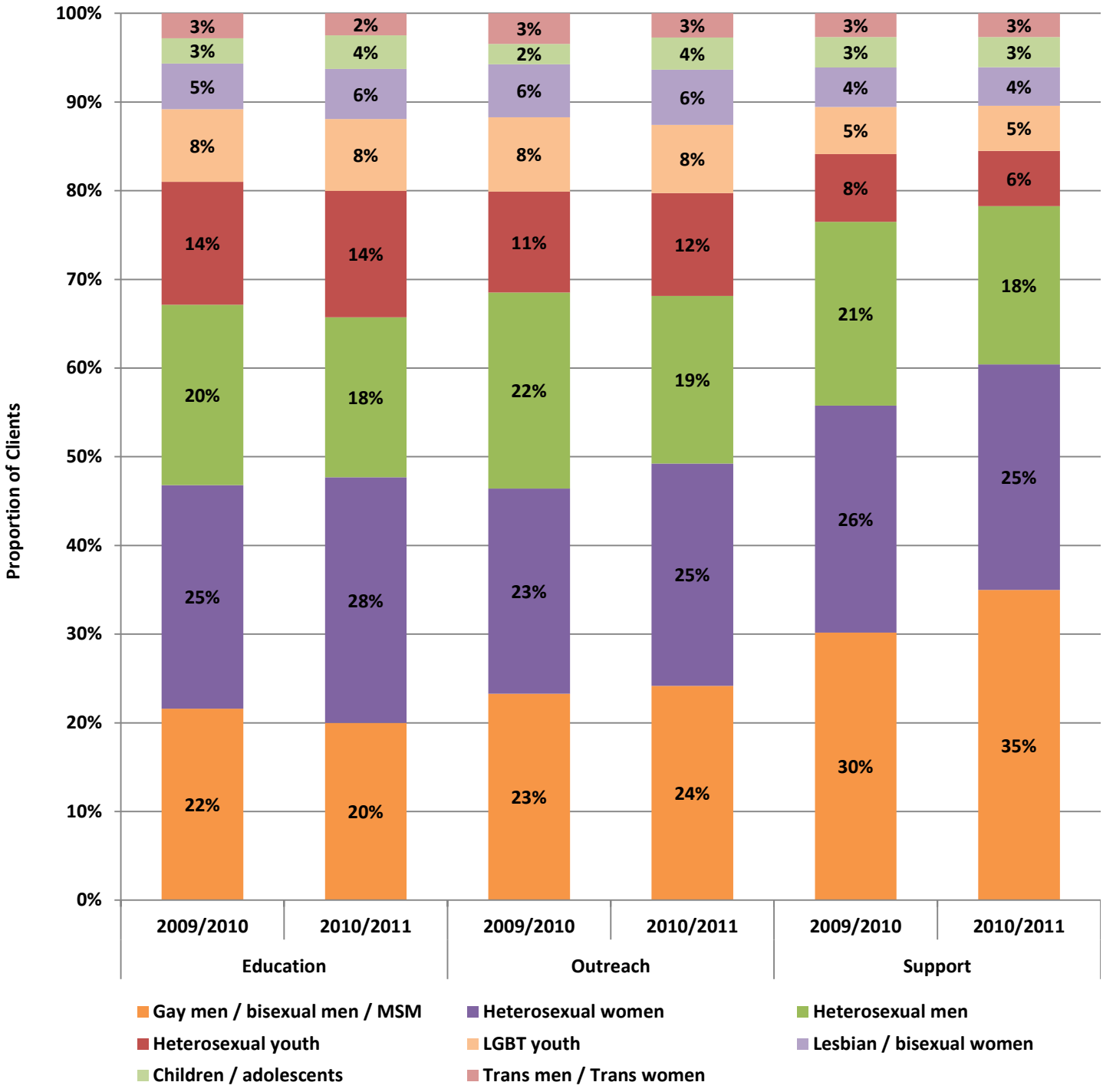


As would also be expected, the biggest users of support services are people with HIV, people at risk and people affected. It is somewhat surprising that 28 programs reported providing support services to the general public and 40 reported providing support services to health and social service providers. The support to other providers may be related to coordinating services for clients or making referrals. However, it is less clear why community-based programs would be providing support services to members of the general public who are not at high risk. There may be an issue in how some organizations are defining "support services". It may be that any services provided for the general public and service providers should be captured in other programs, such as education. Some of these anomalies may be resolved when provincial organizations have their own questions in OCHART.

CLIENT MIX MAY NOT REFLECT THE EPIDEMIC

Programs report that 25% to 28% of clients are heterosexual women, which reflects the epidemiology of the epidemic in Ontario, which is good news. The same is not true of gay, bisexual and other MSM. Although this population accounts for 52% of new diagnoses and more than 60% of people living with HIV, programs report that only 20-35% of education, outreach and support services clients are gay, bisexual and other MSM (28-40% if we include LGBT youth). These figures may indicate that programs are either not reaching men at risk or that some gay men are accessing support services in other settings (e.g., clinics, other agencies, through their own personal support networks). It may be useful for programs to look at the epidemiology of HIV in their region to ensure that their programs strive to reach populations most at risk.

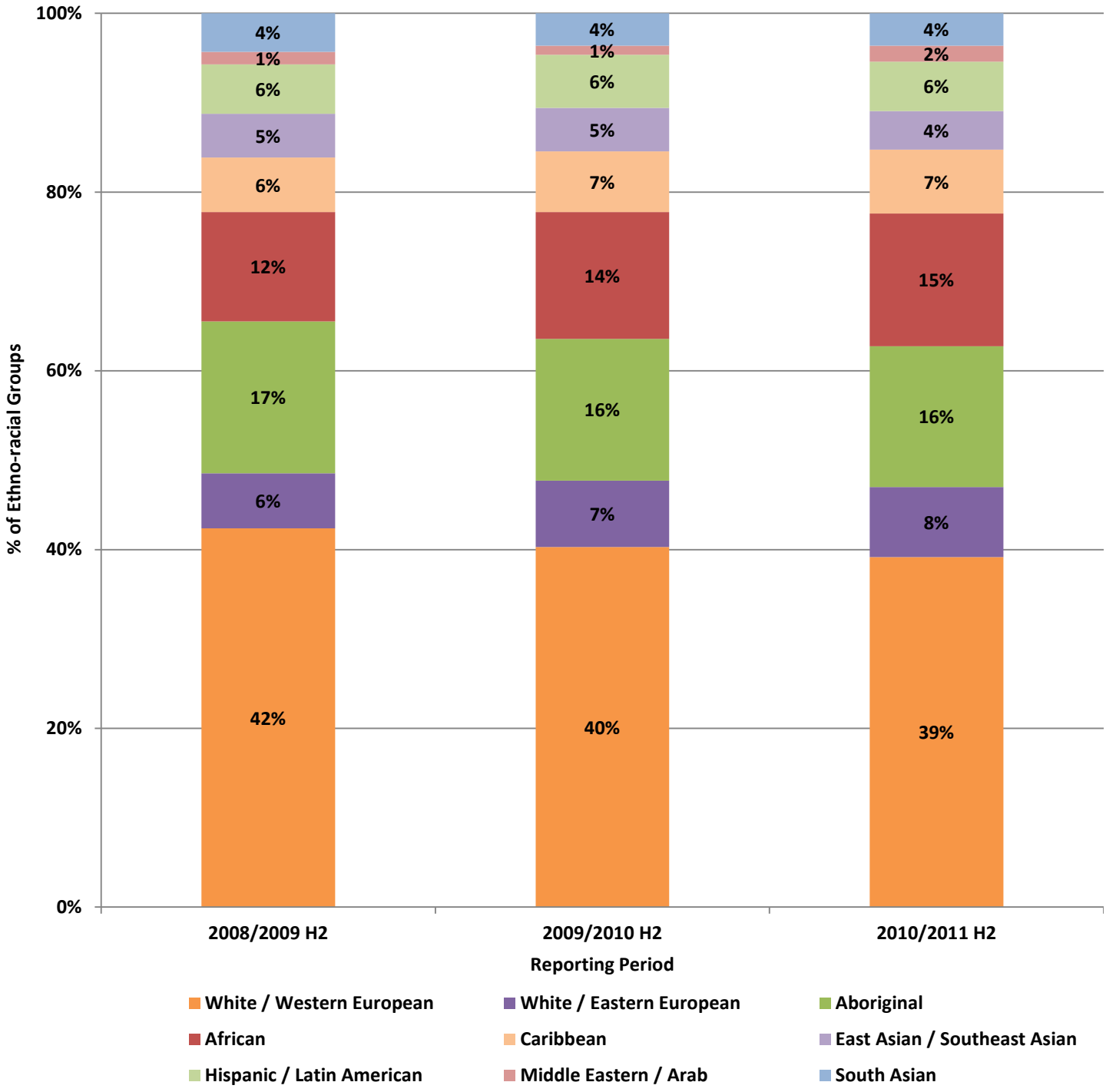
Figure 12
Proportion of Clients by Service Type: 2009/2010 and 2010/2011 H2



CLIENTS ARE MORE ETHNICALLY DIVERSE

Programs are reporting some increase in ethnic diversity among their clients, with fewer white/western European clients and more African, Caribbean and Black (ACB), Hispanic and Middle Eastern clients. This shift is consistent with epidemiological data on the increasing rates of HIV in ACB communities and in Hispanic men – most of whom are recent immigrants to Canada.[1]

Figure 13
Average Percentage of Services Delivered by Ethno-racial Group

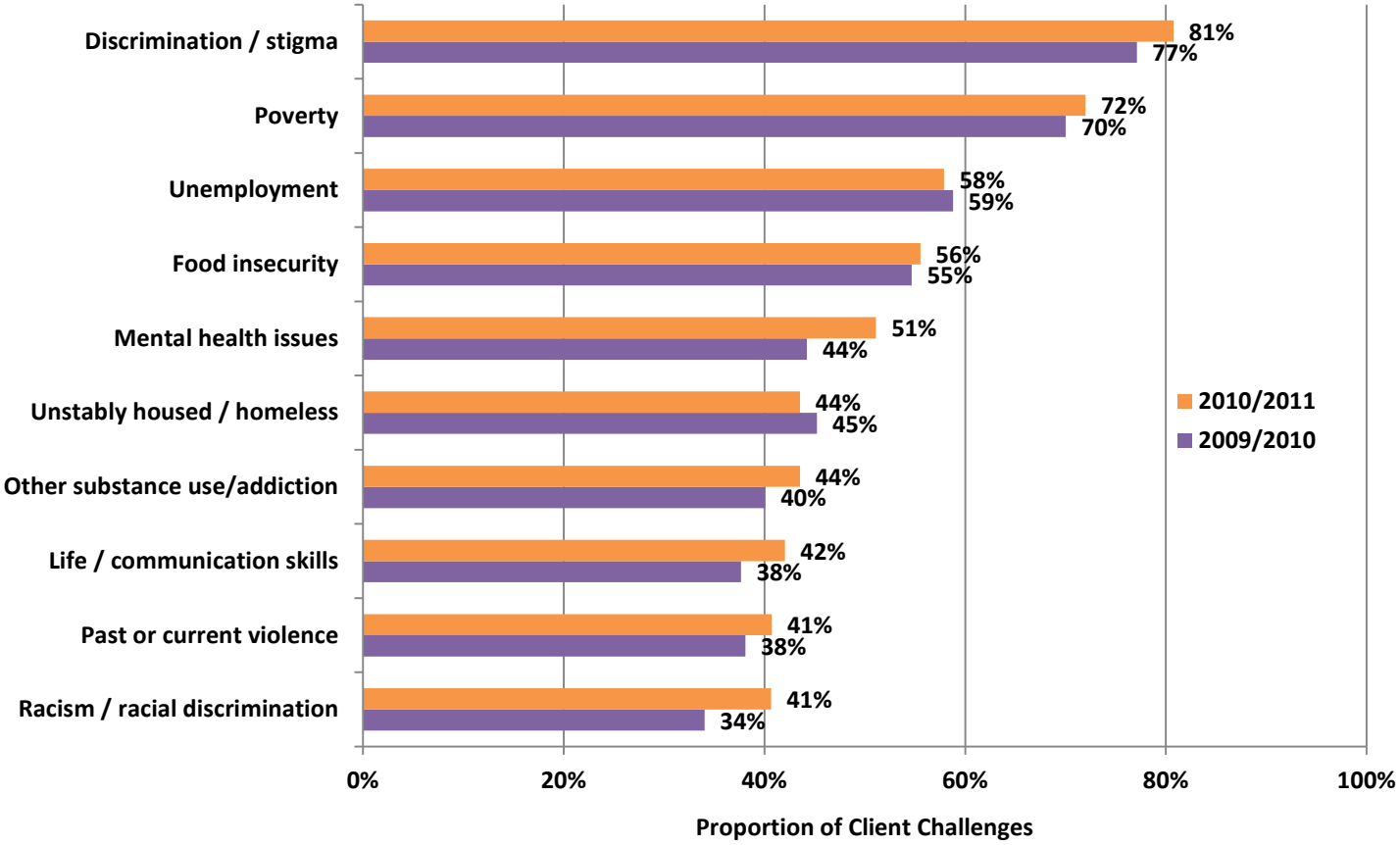


1. Liu J, Remis R, Myers T, Husbands W. (2009). Special report: Ethnicity analysis in the Lambda Survey of men who have sex with men, Ontario 2007.

SOCIAL DETERMINANTS OF HEALTH CONTINUE TO AFFECT CLIENT WELL-BEING

The people we serve continue to have complex social and health issues, including discrimination, poverty, unemployment, food insecurity and mental health challenges. Clients are also coping with rates of violence much higher than in the general population.[1, 2]

Figure 14
Proportion of Clients Experiencing Health and Social Challenges: Top 10 Challenges



When we look at regional breakdowns, agencies in one region that saw a marked increase in diagnoses (South West) reported that a larger proportion of clients were experiencing discrimination. Only one region (Central East) reported a smaller proportion of clients experiencing stigma compared to the previous year.

Programs outside Toronto reported a higher proportion of clients experiencing mental health challenges, which may be due to the lack of mental health services and supportive communities (i.e., isolation) in smaller urban centres and rural areas compared to Toronto.

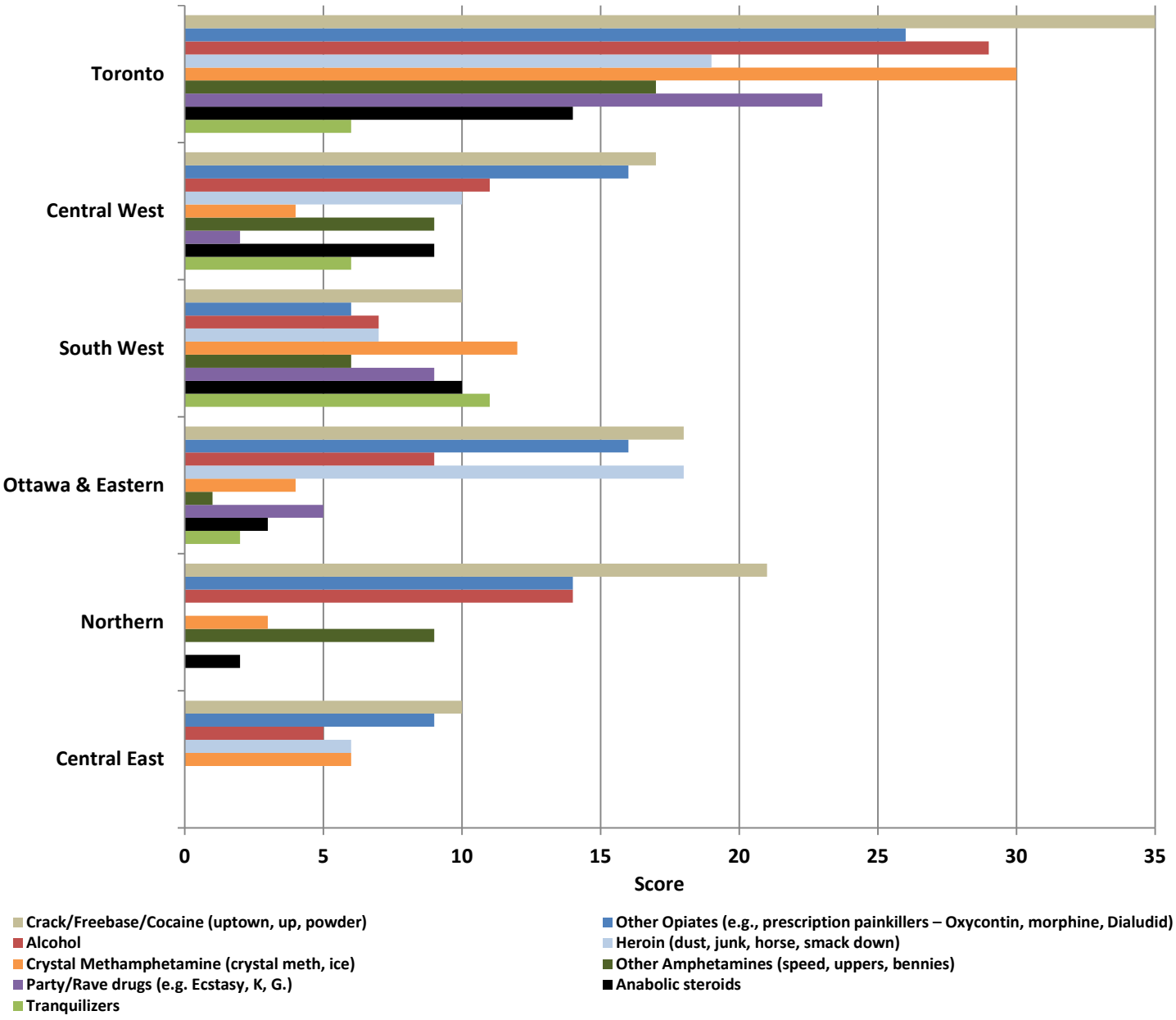
1. Ramachandran S, Yonas MA et al. (2010). Intimate partner violence among HIV-positive persons in an urban clinic. AIDS Care 22(12):1536-1543.

2. DiStephano AS and Cayetano RT. (2011). Health care and social service providers' observations on the intersection of HIV/AIDS and violence among their clients and patients. Qualitative Health Research 21(7):884-889.

SUBSTANCE USE AND DRUGS OF CHOICE AFFECT SERVICE NEEDS

Programs estimate that about 40% of people who use their services experience challenges related to substance use/addiction (provincial average), with some regions reporting that substance use is an issue for 55% (South West) to more than 60% (Northern, Ottawa and Eastern) of the people they serve.

Figure 15
The Ranking of Drug Use by Region: 2010/2011 H2



As part of OCHART, programs are asked to identify the substances most commonly used by people with or at risk of HIV. Drugs of choice can vary across the province, often based on available supply; however, the reports indicate generally high use of crack/cocaine, opiates (including heroin) and growing use of crystal methamphetamine. Alcohol use also continues to be an issue for many people. Agencies should use the information on trends in substance use to drive prevention, harm reduction, support and treatment programs.

PART 4:

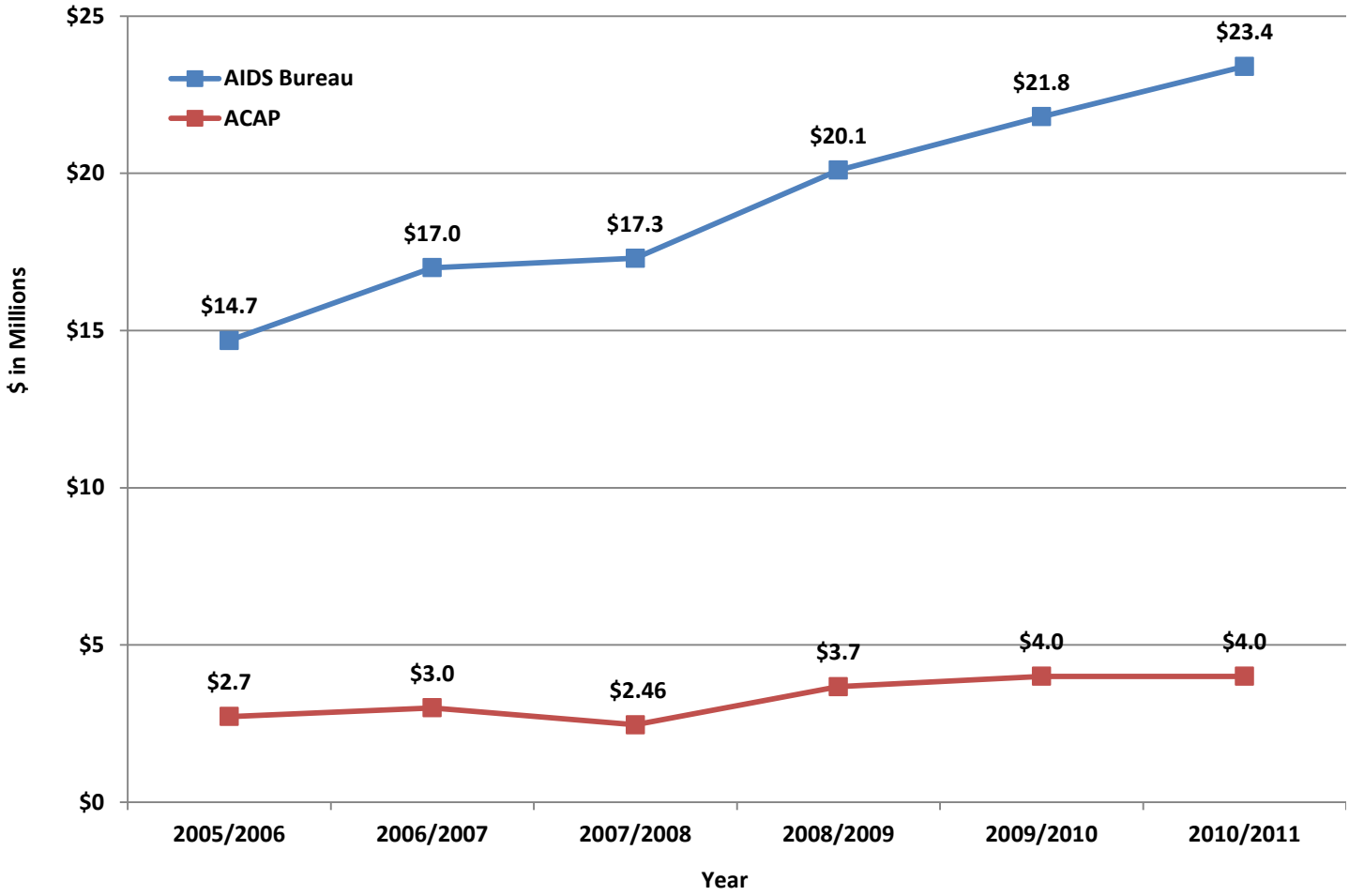
FUNDING FOR COMMUNITY-BASED HIV SERVICES

FUNDING FOR COMMUNITY-BASED HIV SERVICES

All 88 programs included in this year's report are funded by the AIDS Bureau and/or ACAP (through the Public Health Agency of Canada (PHAC) Ontario and Nunavut Agency Regional Office) to provide prevention and support services for people with and at risk of HIV.

In 2010-11, the programs received a total of $27.4 million from the AIDS Bureau and PHAC. The following graph shows funding trends over the past six years. AIDS Bureau funding has increased every year while PHAC funding has remained relatively stable for the past three years.

Figure 16
Annual ACAP and AIDS Bureau Funding as Reported by Funders



FUNDING FOLLOWS THE EPIDEMIC

In terms of distribution of funding across the province, the greatest proportion (47% in 2010-11) is spent in Toronto, which has the largest number of programs. All regions have seen steady increases in funding over the past four years.

Figure 17
AIDS Bureau and ACAP Funding by Region as Reported by Funders

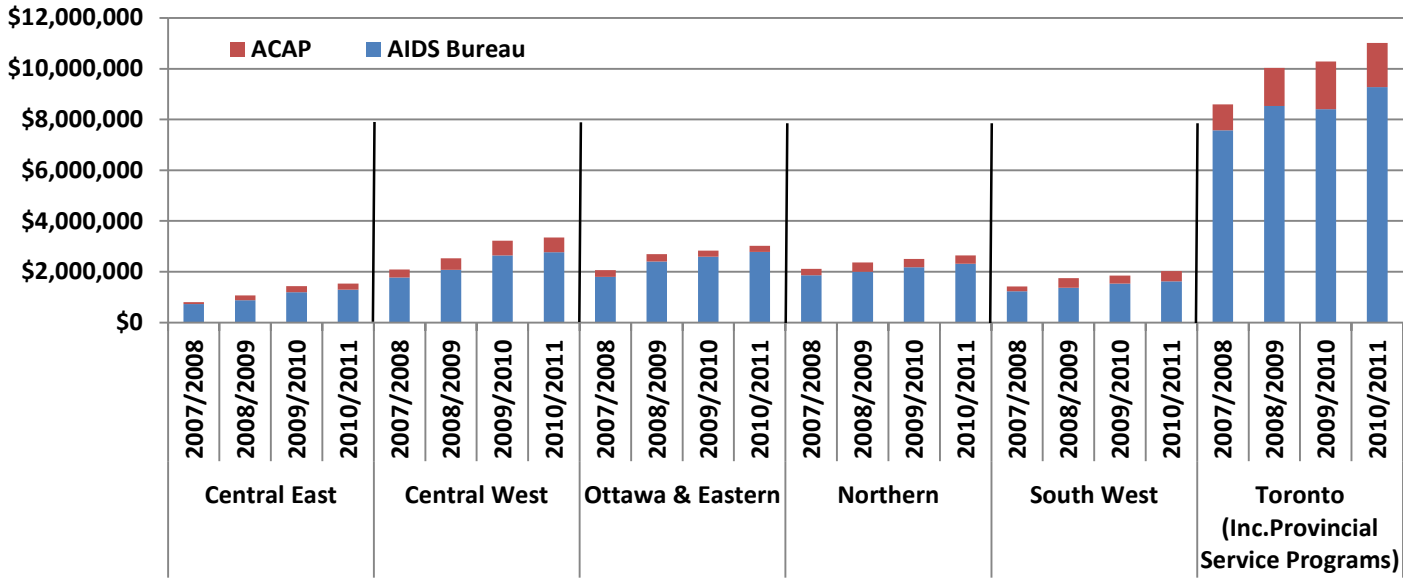
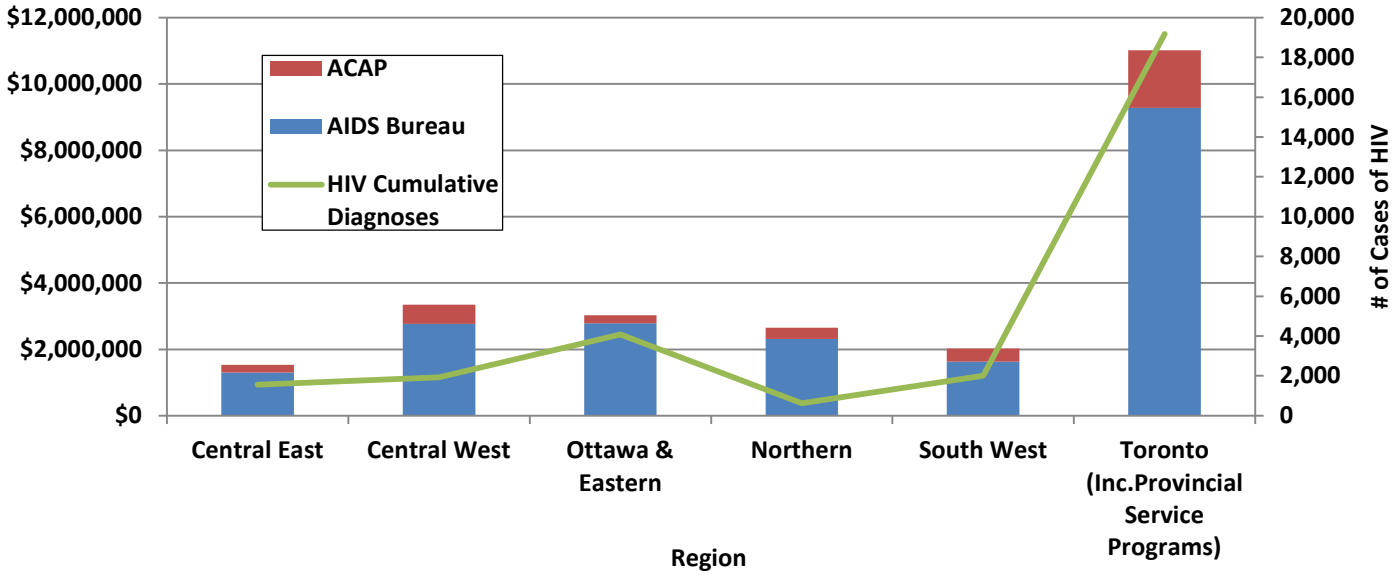


Figure 18
AIDS Bureau and ACAP Funding as Reported by Funders (2010/2011) vs HIV Cumulative Diagnoses (1985-2009) by Region



ASOS RELY ON GOVERNMENT FUNDING

Note: the following funding information is based on the OCHART reports submitted by the agencies, rather than the funders' records. It reflects only the funding to the province's 40 dedicated AIDS service organizations and does not include the funding to non-ASOs, community health centres or programs in other settings. This is because we do not have complete information on the full range of funding received by these other organizations.

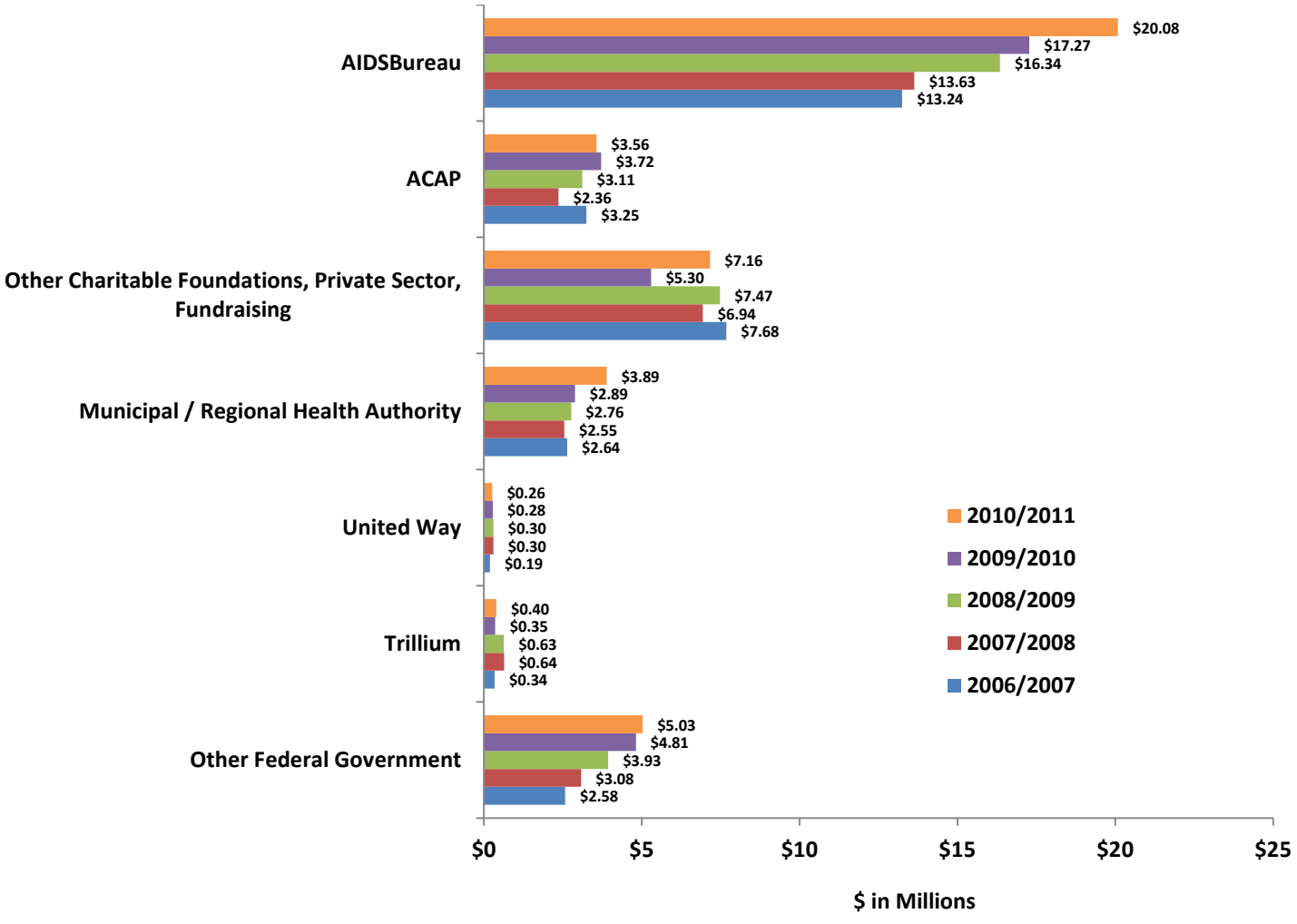
The 40 dedicated AIDS service organizations report that they continue to rely heavily on government funding. The AIDS Bureau, the PHAC ACAP program, municipal/regional governments and other federal government programs account for 79% of the total funding that programs report receiving in 2010-11.

Figure 19

	Source	Amount ($)	%
Government of Ontario	AIDS Bureau	20,083,701.00	42%
	Other Ministry of Health & Long-Term Care	3,900,196.00	8%
	Other Provincial Ministries	1,409,291.36	3%
Federal Government	ACAP	3,564,936.00	7%
	Other Federal Government	5,027,115.00	10%
Local	Municipal / Regional Health Authority	3,886,758.87	8%
Private Sector	Other Charitable Foundations, Private Sector, Fundraising	7,161,206.87	15%
Non-Governmental Funding	Trillium	395,391.30	1%
	United Way	264,788.00	1%
Other	Other	2,303,852.69	5%
	Grand Total	**47,997,237.09**	**100%**
		Highlighted Sources	79%

Fundraising (including money obtained from the United Way or the Trillium Foundation) accounted for 17% of the total funding that ASOs received – a significant increase from the previous year.

Figure 20
AIDS Service Organizations: Sources of Funding as Reported by Programs

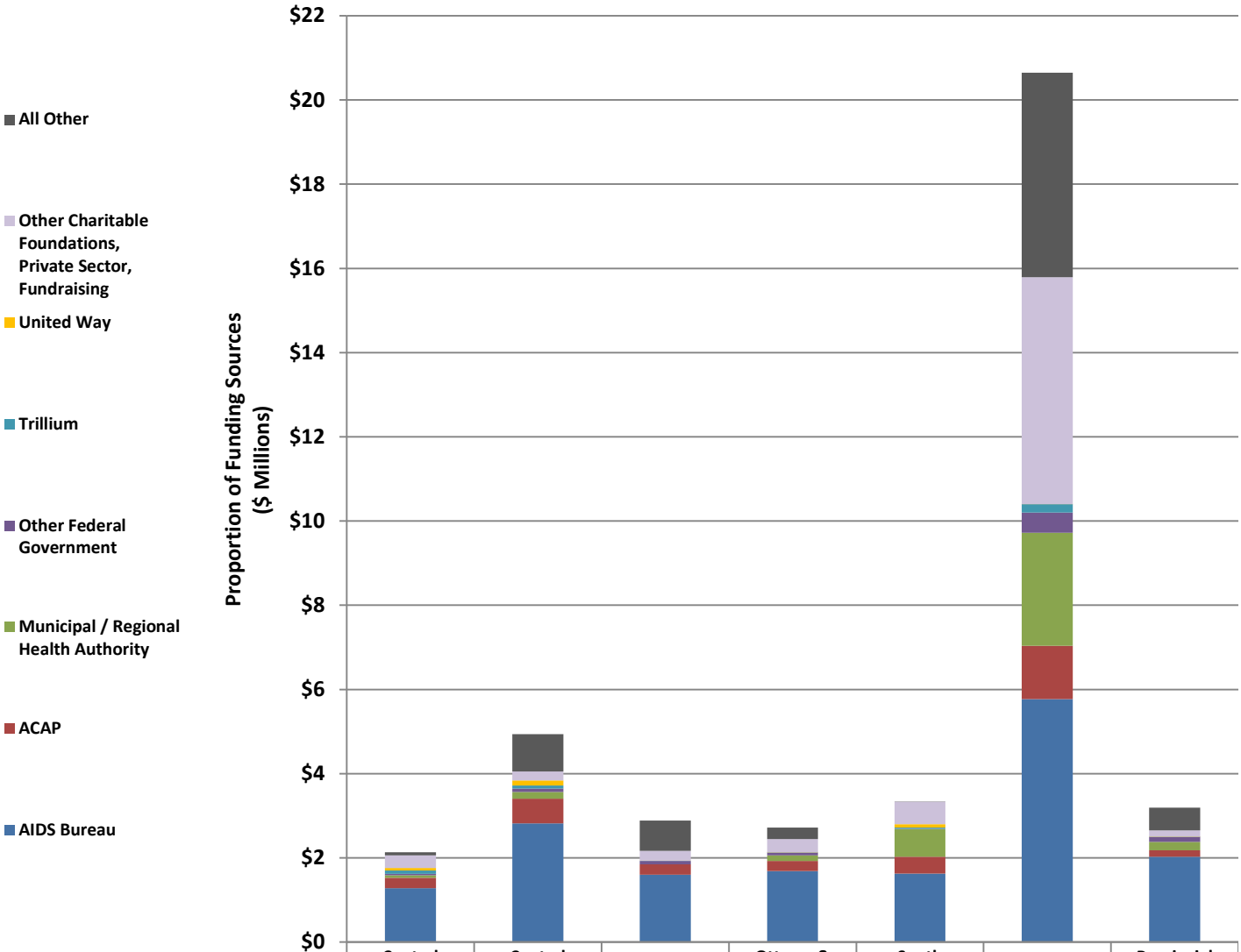


REGIONAL FUNDING PATTERNS

Funding patterns for ASOs are similar across the province with the AIDS Bureau being the primary funder. The ASOs in each region report receiving comparable amounts of funding from ACAP as they do from charitable foundations and fund raising.

ASOs in Toronto have a much greater capacity to fund raise than those in smaller urban or rural settings: government funding accounts for only 44% of their funding compared to 65% to 70% in most other parts of the province. Even within Toronto, the capacity to fundraise varies among organizations. Some larger organizations have extremely effective fundraising programs while others rely almost exclusively on government funding.

Figure 21
Sources of Funding by Region - 2010/2011 ($ in Millions)



	Central East	Central West	Northern	Ottawa & Eastern	South West	Toronto	Provincial Services
All Other	$0.08	$0.89	$0.72	$0.27	$0.00	$4.85	$0.54
Other Charitable Foundations, Private Sector, Fundraising	$0.30	$0.21	$0.23	$0.31	$0.53	$5.39	$0.15
United Way	$0.06	$0.12	$0.00	$0.00	$0.08	$0.00	$0.00
Trillium	$0.08	$0.07	$0.00	$0.00	$0.03	$0.20	$0.00
Other Federal Government	$0.03	$0.08	$0.08	$0.07	$0.00	$0.48	$0.12
Municipal / Regional Health Authority	$0.06	$0.16	$0.00	$0.13	$0.66	$2.68	$0.20
ACAP	$0.25	$0.59	$0.25	$0.24	$0.40	$1.27	$0.15
AIDS Bureau	$1.28	$2.82	$1.60	$1.69	$1.63	$5.77	$2.03

PART 5:

THE IMPACT OF THE INVESTMENT IN COMMUNITY-BASED AIDS SERVICES

5.1 INCREASING KNOWLEDGE AND AWARENESS

One of the key goals of community-based HIV/AIDS programs is to educate people at risk, raising awareness of HIV, the factors that put them at risk (of either HIV infection or – if they are already infected – of disease progression) and the factors that can help them improve their health and well-being.

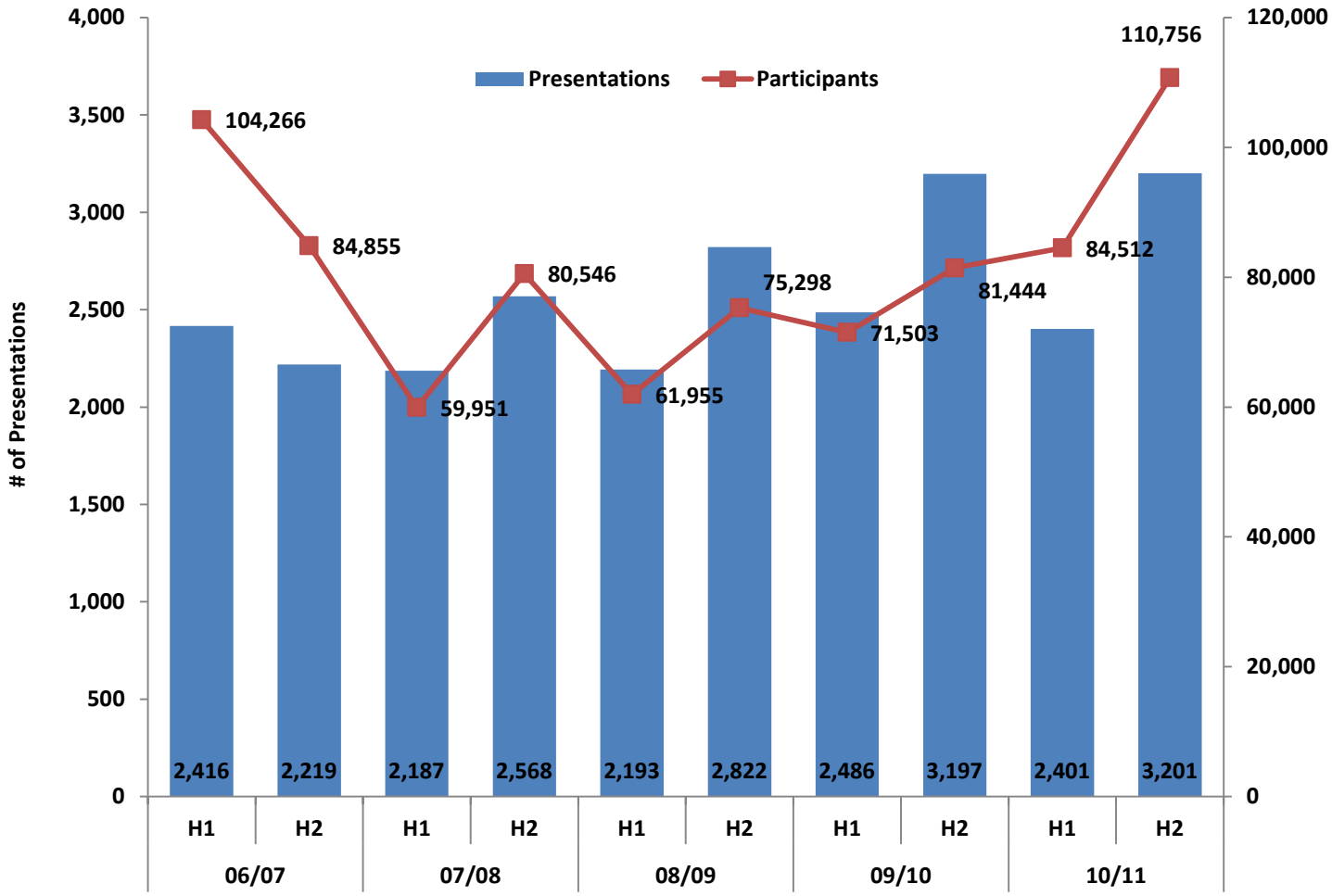
> *"Participants gain and share knowledge on the risks associated with introduction of new drugs/methods (ie Levamicoke in cocaine, fentanyl patches)."*

5.1.1 EDUCATION

REACHING 28% MORE PEOPLE WITH EDUCATION

In 2010-11, funded programs held a total of 5,602 education presentations/workshops (down from 5,683 in 2009-10) and reached 28% more participants (196,304) than in the previous year (152,947). The average number of participants at each presentation was 33 (up from 27 in the previous two years).

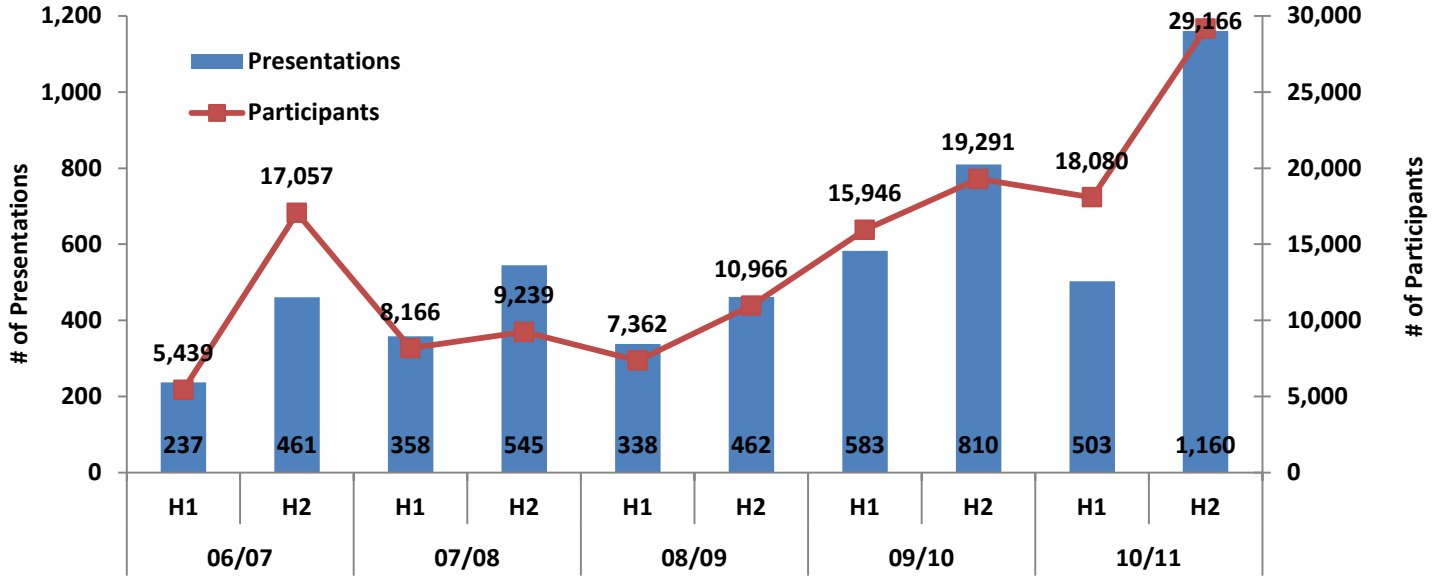
Figure 22
Number of Education Presentations and Participants by Reporting Period



1 IN 4 PRESENTATIONS FUNDED BY ACAP

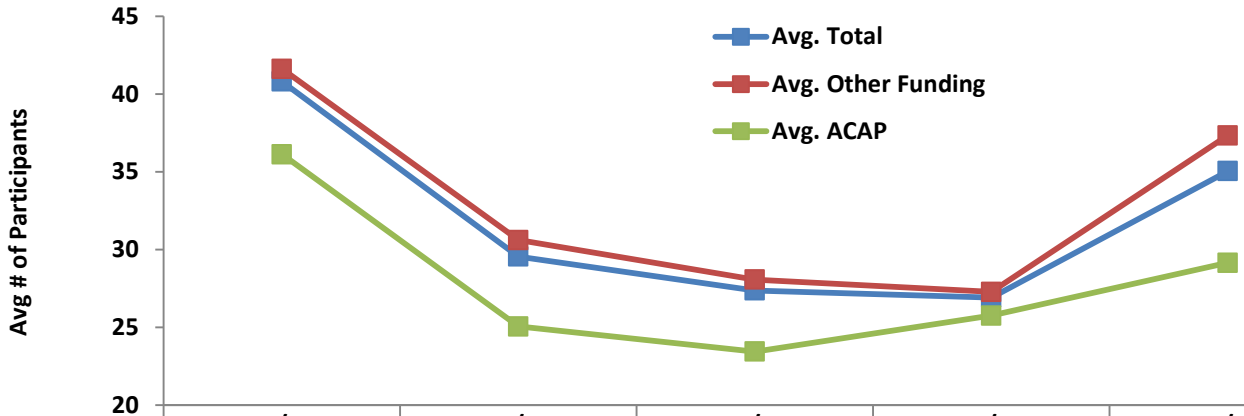
Of those 5,602 presentations, 29% (1,663) were funded by ACAP. Those ACAP presentations reached a total of 45,847 participants (24%).

Figure 23
Education Presentations and Participants: ACAP Funded Projects



The average number of participants at ACAP funded presentations was slightly lower (29), perhaps reflecting the focus on community forums and workshops instead of presentations in ACAP-funded programs (Figure 24).

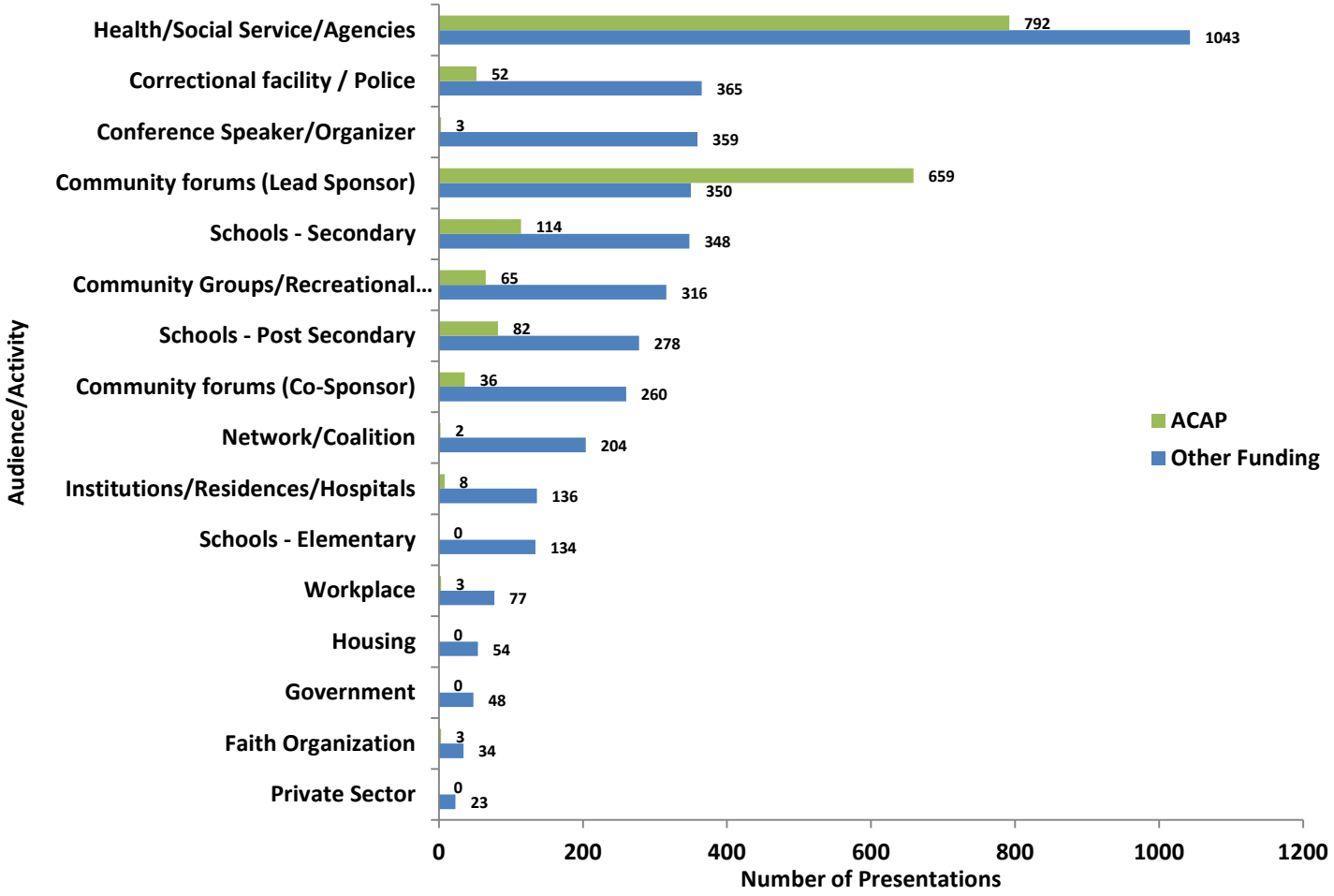
Figure 24
Average Number of Participants per Education Presentation: 2006/2007-2010/2011
(Averages were calculted by dividng the total number of participants (H1+H2) by the number of presentations.)



	2006/2007	2007/2008	2008/2009	2009/2010	2010/2011
Avg. Total	41	30	27	27	35
Avg. Other Funding	42	31	28	27	37
Avg. ACAP	36	25	23	26	29

In terms of the target or focus of education, ACAP funded projects reported a larger proportion of community forums and fewer conference presentations or presentations in other settings, such as schools, correctional facilities or other institutions.

Figure 25
Education Presentations by Funding Source: 2010



VARIATION ACROSS ORGANIZATIONS

The number of education presentations/workshops per organization varies considerably. In fact, overall 47% of programs reported more presentations than in the previous year and 50% reported fewer.

Of the 72 organizations that reported through OCHART, 15 reported between 1 and 20 presentations over the year and 14 reported between 61 and 80 presentations. The difference may be a function of size and capacity, or it may be part of a conscious decision by a program to focus more or less on education than on other activities.

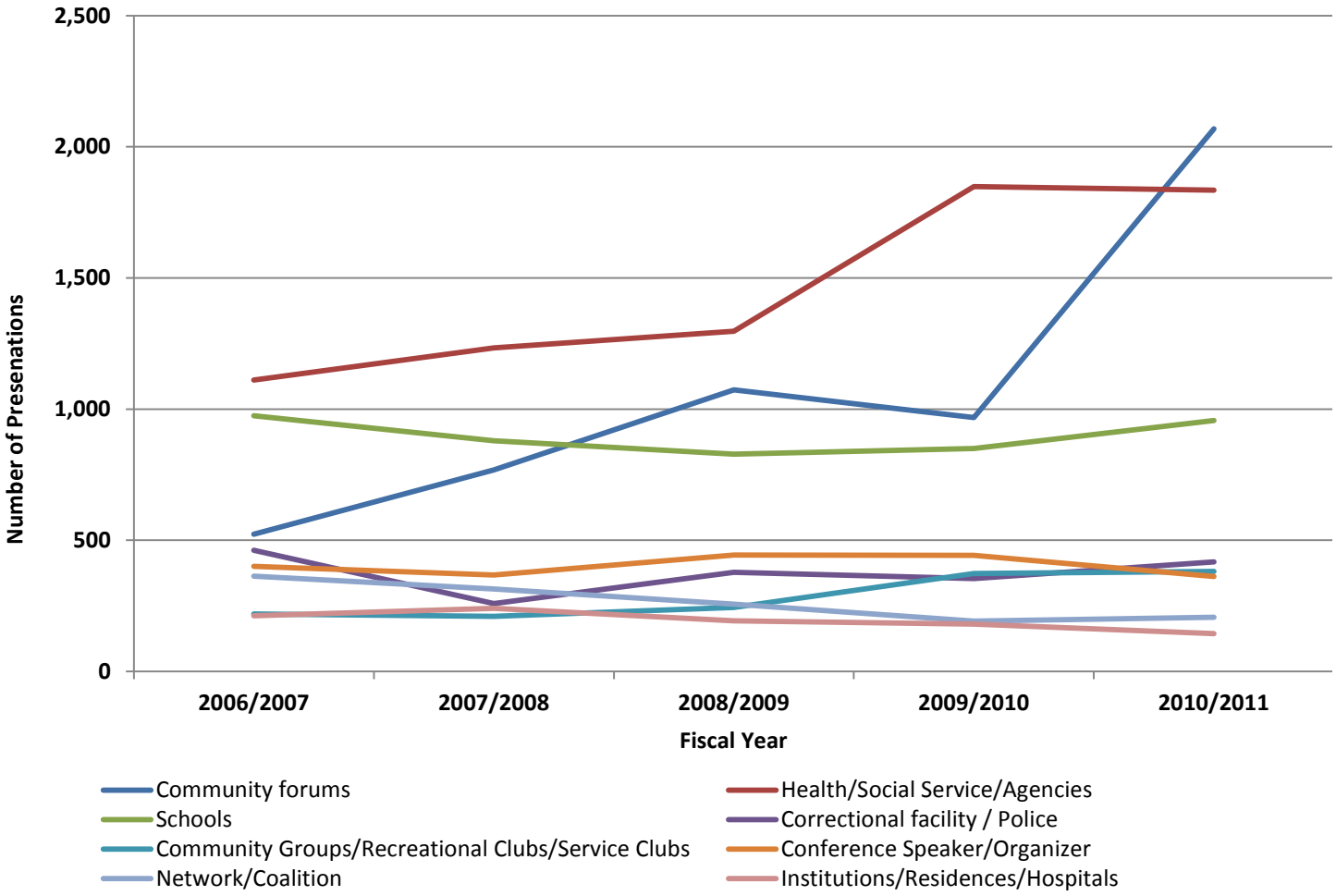
EDUCATION TARGETED TO HEALTH AND SOCIAL SERVICE PROVIDERS

Health and social service providers continue to be one of the main targets of community-based education presentations for both AIDS Bureau and ACAP-funded programs. This education is designed to ensure other providers understand the needs of people with HIV and increase access to stigma-free services, and to reach clients of other organizations.

> *"We received numerous requests to provide education to service providers on how to better serve sex workers and dispel commonly held myths. We have also been asked to provide more education around HIV and women and HIV and non-status PHAs."*

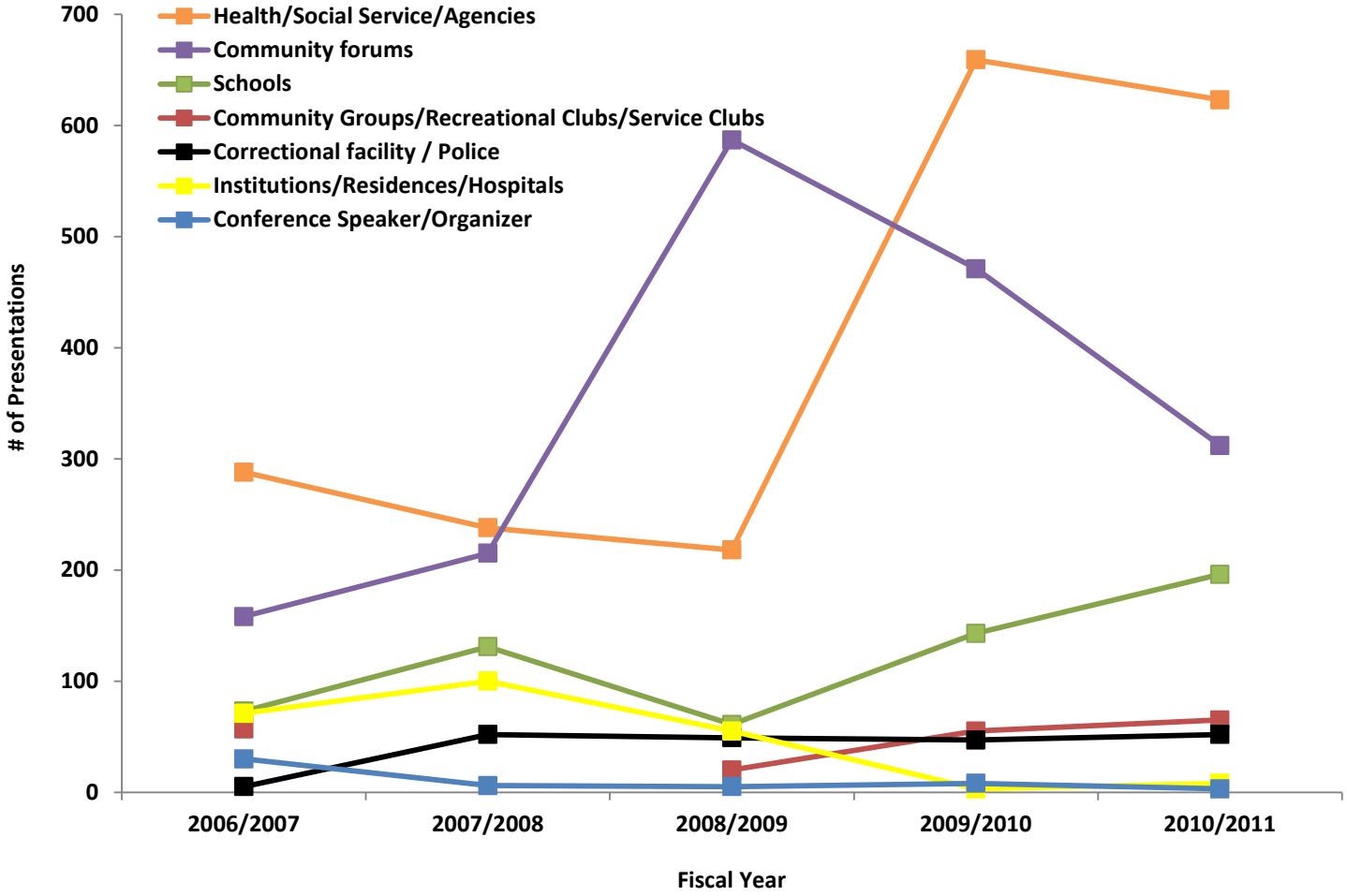
The number of presentations in community forums and schools has also remained relatively high over the past five years.

Figure 26
Education Presentations for Selected Locations



> *"The increase in the number of STIs in the younger population in the Sudbury District has increased requests for school presentations."*

Figure 27
Education Presentations for Selected Locations: ACAP Funded Projects



WHAT KIND OF ACTIVITIES? WHAT WORKS?

At the current time, OCHART information is not detailed enough to be able to understand the type of education being provided, the people or populations being reached or impact of the education on knowledge and awareness. OCHART is now working with organizations to identify ways to gather more useful information on education activities. It is reasonable to expect that education presentations contribute to increasing knowledge and awareness. However, different types of education activities, such as one-time presentations to large groups and a six-week small group education workshop, will have different impacts on knowledge and awareness.

Organizations funded by ACAP provide some information on the nature and impact of their education activities in their logic model reports. For example, in 2010-11, education activities included: harm reduction conferences, youth groups including queer youth events, presentations about HIV in schools, anti-bullying and anti-homophobia workshops in schools, training for service providers, Pride events, and safer sex workshops.

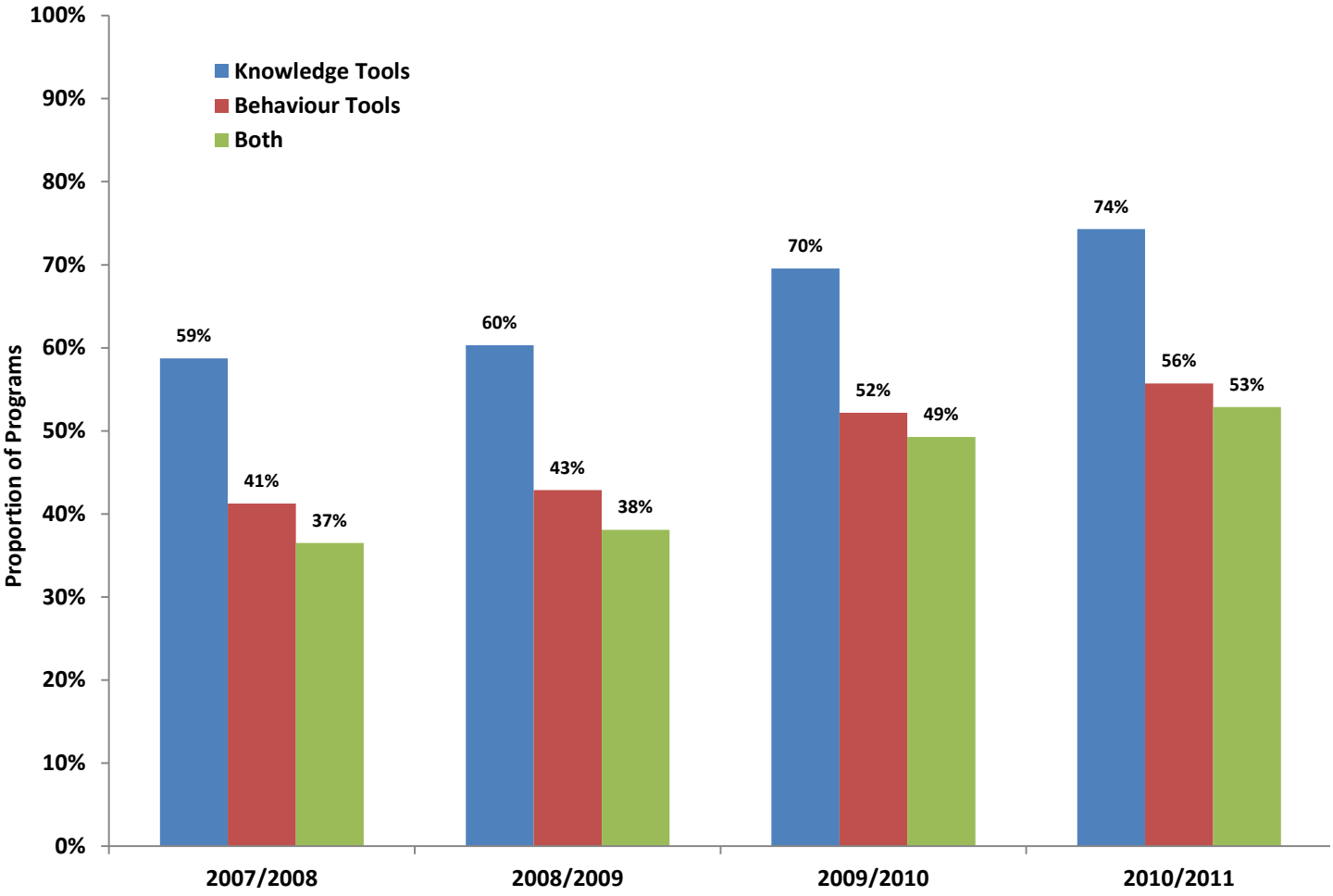
Not all education activities are evaluated but, according to results from evaluations reported in ACAP logic models, these activities are effective in achieving at least short-term change in knowledge and awareness. Different types of evaluation would be needed to determine whether these changes are sustained over time. Immediately after workshops, participants generally reported a change in knowledge, change in attitudes (i.e., less likely to stigmatize people with HIV) and the intention to change behaviour. For example:

> *"After the [Gender and HIV/AIDS] workshop, we surveyed 10 participants to assess the effectiveness … and to measure knowledge change. 9 out of the 10 respondents said their knowledge about HIV/AIDS increased after attending various HIV awareness activities presented by our Program. … the majority reported that they have learned how women are specifically prone to HIV infections and how HIV is transmitted and can be prevented. They reported that they learned how they can protect themselves and their children from HIV and other sexually transmitted infections and expressed their commitment to share the lessons they got about healthy sexuality and openness to their family members."*

> *"89.2% of those completing evaluations indicated a change in knowledge."*

Through OCHART, organizations report on their efforts to measure the impact of their education efforts. Over the past four years, there has been a steady increase in the proportion of programs using tools to measure knowledge and behaviour change among people who are targets for their education programs: 3 out of 4 programs now measure changes in knowledge, over half use tools to measure reported changes in behaviour and just over half measure both knowledge and behaviour. This type of information is essential to assess the effectiveness and impact of programs and services.

Figure 28
Tools Used to Measure Changes in Knowledge and Behaviour in the Target Population



EMERGING TRENDS: MORE DEMAND FOR INFORMATION ON AGING, ON SUBSTANCE USE/HARM REDUCTION AND FOR YOUTH

Programs reported more interest in education and workshops on:

- aging with HIV
- harm reduction
- sexually transmitted infections (STIs)
- immigration
- other socio-legal issues – including disclosure and criminalization.

> *"We have seen a change in demand for education and awareness raising opportunities within schools, community and governmental organizations, as well long term care facilities and supportive housing."*

> *"[There is] more demands by PHA members for education around ageing and the complexities of HIV/AIDS and ageing."*

> *"[We] identified a greater demand for NEP education among users to address trends and risks of purchasing drugs in the syringe … [and] for education to the community to safe response of needle retrieval"*

A number of communities reported an increasing interest in education for youth (including LGBT youth) on topics ranging from safer sex to anti-bullying to resilience. Several programs reported more requests for education with Aboriginal peoples, and for culturally competent and culturally specific education. They also received more requests for information on topics such as: stigma, GIPA, new prevention technologies, poz prevention, co-morbidities particularly hepatitis C, long-term care, health promotion, healthy sexuality and resilience. Programs identified several populations with specific education needs, including sex workers, transmen and transwomen, youth, and people in rural areas. Meeting the needs of these communities may require new education models.

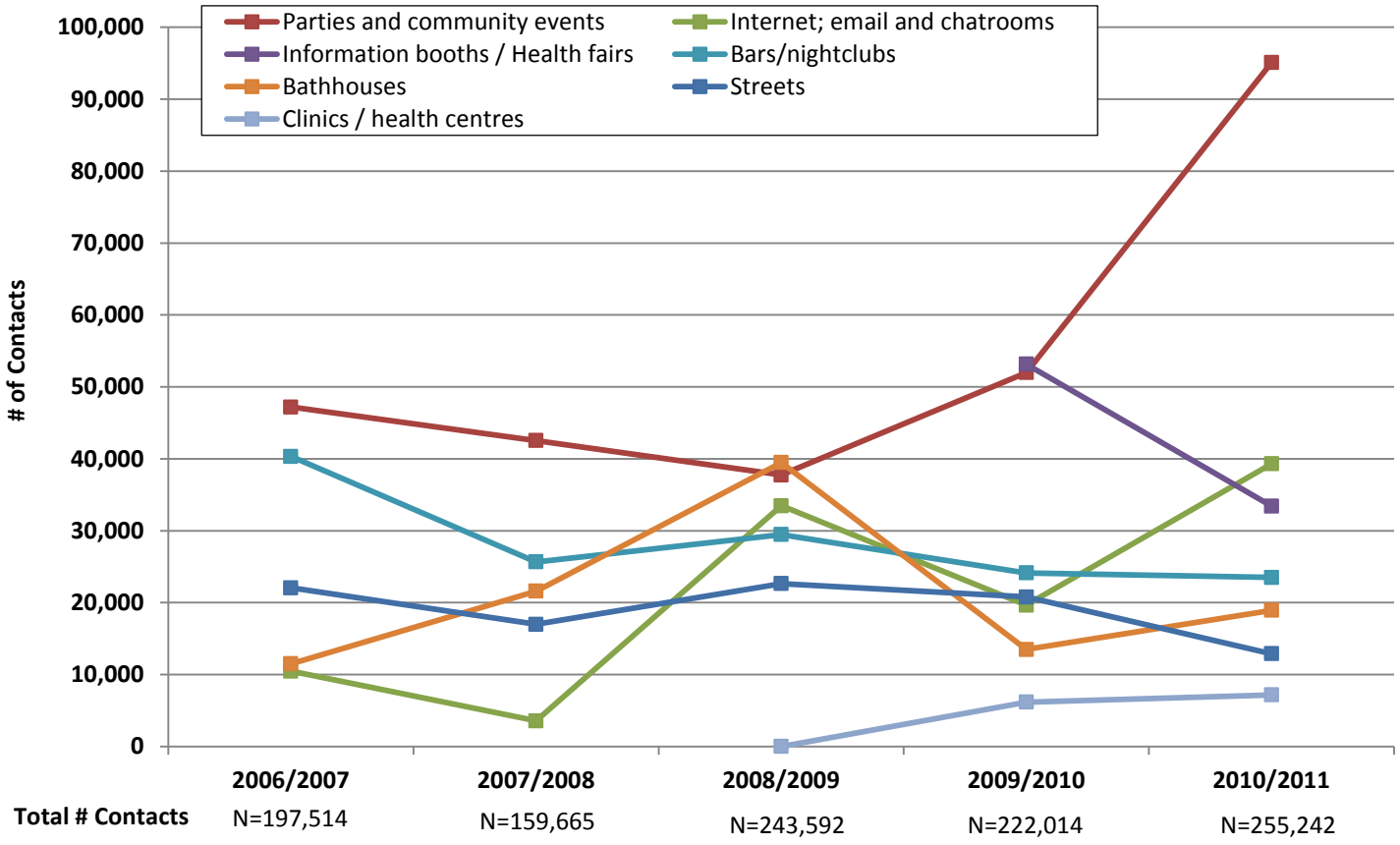
Several programs reported an increased demand for presentations and workshops while others reported a decline. One program noted that by planning and providing more events – particularly targeting gay youth and gay/straight alliances -- it was seeing increasing interest and participation.

The strategies that programs are using to respond to emerging trends include:

- Expanding existing programs, particularly those for gay men and other men who have sex with men, people in rural areas, Aboriginal communities, peer-led programs
- Developing/enhancing partnerships – for example, with cultural communities, LGBT groups, sex workers, and others – to enhance their capacity to reach these audiences and meet their needs
- Developing education resources
- Tailoring education programs and workshops to meet specific needs (e.g., for Aboriginal communities, faith based leaders, prisoners, migrant workers, women, youth) and to focus on key issues such as self-esteem, immigration, and health literacy
- Providing professional development for staff.

5.1.2 OUTREACH

Figure 29
Top Seven Outreach Activities Reported by Location Over Time (w/o one program for Bars and Community Events Outreach)



OCHART defines "outreach" as "Reaching out to people by going to places where community members socialize, gather, or casually walk in." Outreach is distinct from education presentations in that it involves non-structured interactions. Outreach is defined as direct meaningful contact with the target population, and does not include activities such as media campaigns and mass mail outs.

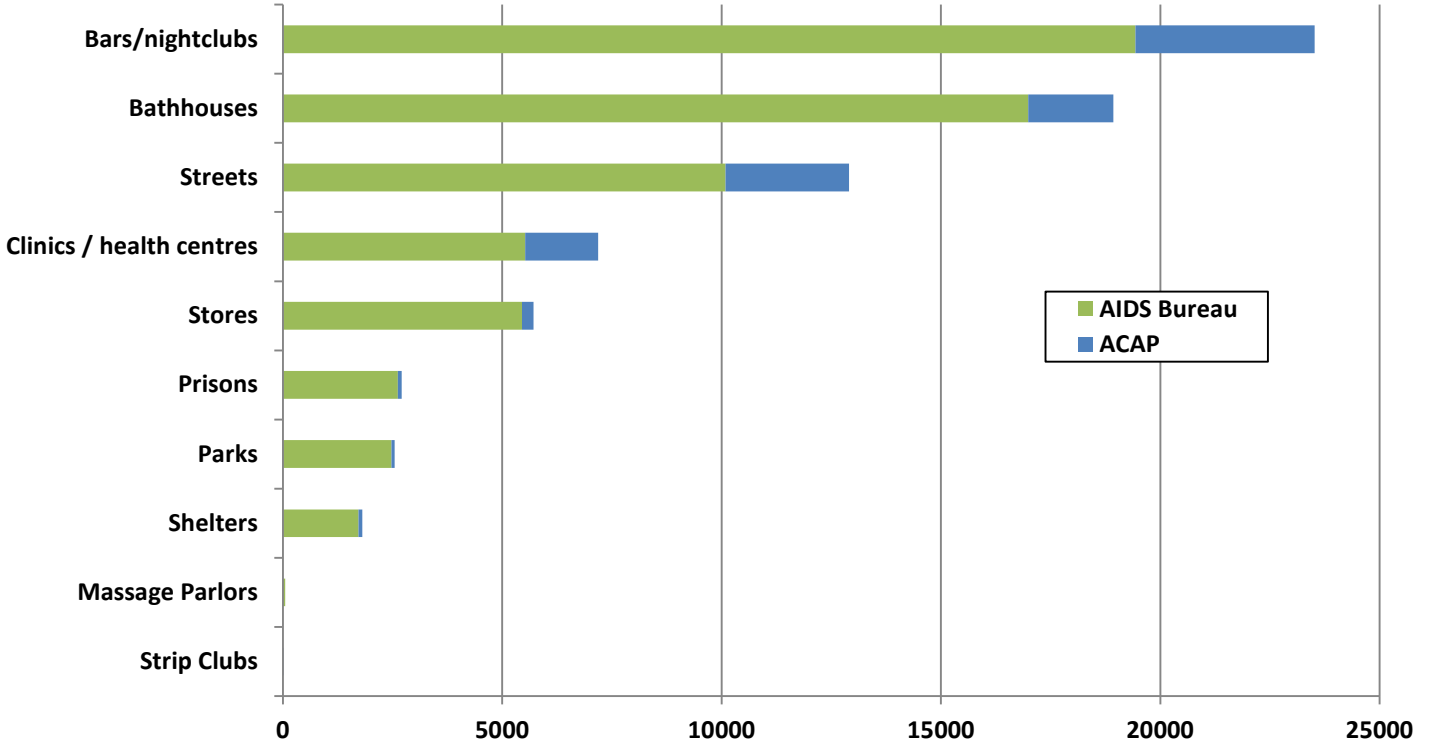
In 2010-11, there was increase in the number of outreach contacts reported, largely in the category of "community events" and mainly based on reports from three agencies. The increases were so great that they may be due to reporting issues, or they may reflect the fact that some agencies were doing outreach for the first time at large ethnocultural events other than Pride and Caribana.

OUTREACH CONTACTS VARY IN INTENSITY

There is wide variation in the nature of outreach contacts depending on where and how they occur. For example, many of the outreach contacts reported in OCHART are people who attended a community event or obtained information at a booth at a health fair, while some will have had a more in-depth one-to-one contact or conversation with a worker or volunteer from one of the funded programs. Comments submitted as part of the ACAP logic model highlight the range of activities currently captured under outreach:

> *"This includes 605 significant contacts involving one-on-one peer sexual health consultations (averaging 20-30 min) and approximately 1210 brief contacts [in a bathhouse setting]."*

Figure 30
Number of (Non-Event) Contacts by Funder: Fiscal Year 2010/2011



	Strip Clubs	Massage Parlors	Shelters	Parks	Prisons	Stores	Clinics / health centres	Streets	Bathhouses	Bars/nightclubs
AIDS Bureau	0	52	1726	2476	2623	5452	5526	10090	16993	19434
ACAP	20	0	87	76	90	261	1660	2813	1939	4084

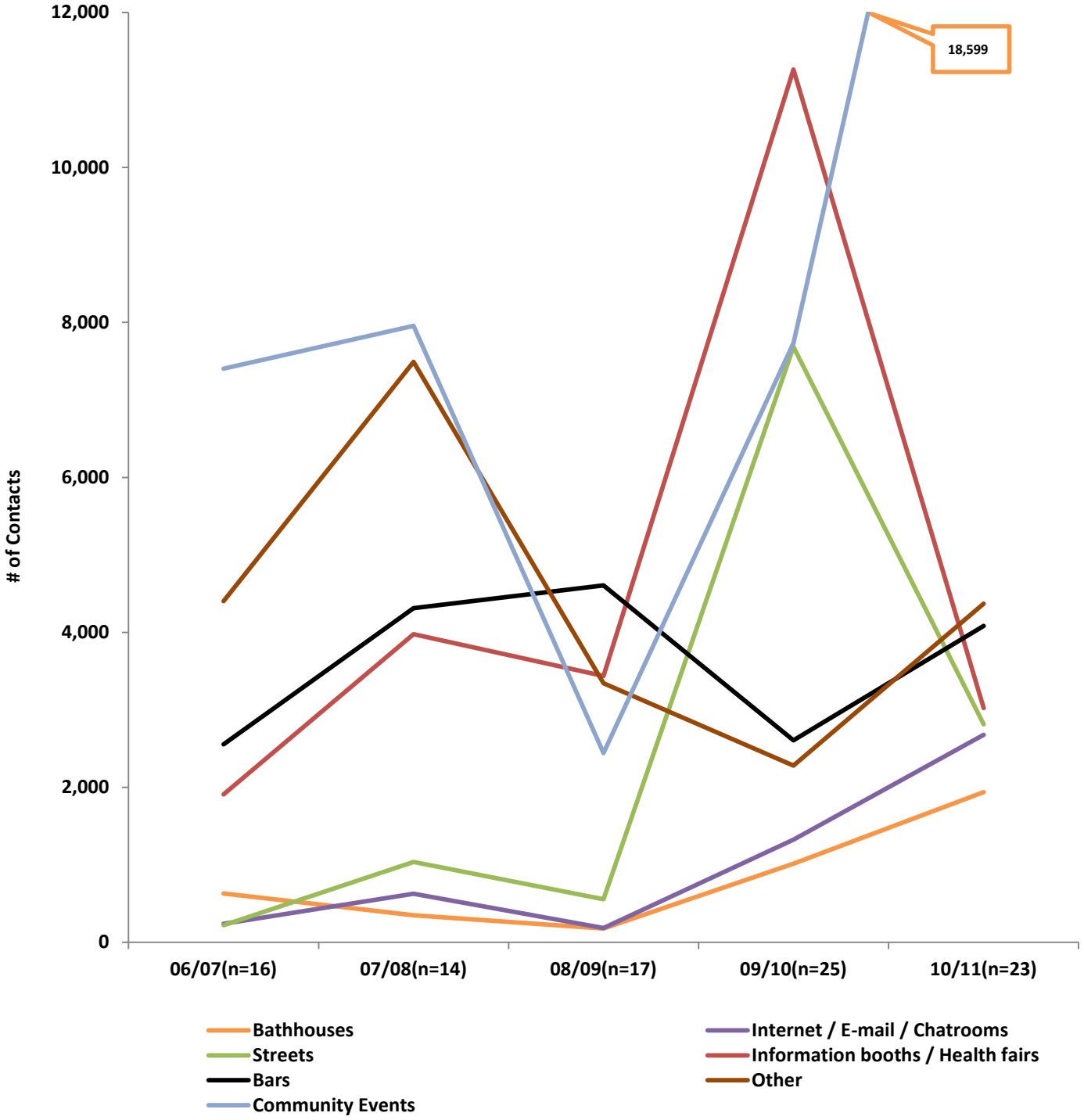
"With attendance of close to 20,000 people every year, [this] celebration offered an opportunity to reach out to about 4,000 people. Our booth at the event was visited by thousands of people. Our activities, including the fashion show served us a purpose to educate our community members. We displayed our … campaign materials and condoms for pick up in an attractive manner. In addition to these, leaders of different faith organizations, addressed the crowd with HIV awareness messages."

In future revisions to OCHART, it may be helpful to distinguish between significant and brief contacts, and to assess the impact of different types of contacts.

Of the 258,656 total outreach contacts reported in 2010-11, 75,402 were "non-event" contacts -- that is, they were more likely to be one-on-one or significant contacts.

ACAP-funded initiatives accounted for 40,368 or 15% of the total outreach contacts. Most of those occurred at community events (Figure 31). There has also been a steady increase in Internet-based outreach contacts in ACAP-funded programs over the past two years.

Figure 31
Top Seven Outreach Activities Reported by Location Over Time (w/o one program for Bars and Community Events Outreach)



WHAT AFFECTS THE EFFECTIVENESS OF OUTREACH?

Programs reported that location of outreach is key to success. A couple of programs that switched locations – primarily to reach their target populations – reported greater success. A number of programs benefited by taking advantage of events that were already occurring in their communities or going to sites such as drop-in centres. Other critical success factors include: good working relationships with the owners/operators of sites, such as bars, bathhouses, shelters and prisons, and having the right resources to distribute.

> *"We are reaching more workers in Massage Parlours, as we now go to 12 sites monthly and are adding more regularly."*

> *"With staff change in program we are rebuilding relationships with bar owners and thus we have been able to increase our presence at the local gay bars."*

> *"Because of our good working relationship with … night clubs …, we were able to reach out to our community members with HIV/AIDs awareness resources. The two night clubs we visited host a number of community members each weekend and at some special events. According to feedback from our volunteers, the venues are effective ways to reach the youth community members."*

The types of barriers that programs reported included: people not being interested in HIV information, potential danger to staff in some sites, not being able to access certain populations in certain sites (e.g., one program reported that shelters were not a good location to reach sex workers), and transportation and child care issues that prevent people from attending events.

> *"We have faced some challenges getting into the facilities because of safety reasons. [We are] currently re-evaluating our strategy."*

> *"Contacts at the local Friendship Centres are consistently low despite efforts to advertise workshops and groups due to lack of transportation, remote locations of the centres themselves and little to no child care."*

EMERGING TRENDS: INCREASING DIVERSITY IN COMMUNITY OUTREACH

A significant number of programs reported an increased demand for outreach from communities they had not previously worked with, including African, Caribbean and Black communities, migrant workers, newcomers, trans people, and Aboriginal peoples.

> *"There are more African MSM frequenting the bathhouses than before."*

The issues reported to be of interest to outreach clients are similar to those identified by education participants: aging, chronic disease, harm reduction, and disclosure/criminalization. Among outreach clients, there is more demand for practical assistance and referrals to other services.

To meet the needs of different communities, programs report that they plan to:

- Deliver outreach programs in more diverse locations in the community
- Develop multi-lingual resources and examine ways to adapt outreach programs to be culturally competent
- Identify ways to improve access to safer sex materials
- Develop partnerships (e.g., Aboriginal organizations, faith organizations, housing groups, youth groups, cultural organizations/services) to respond more effectively to needs of specific groups.

5.1.3 OUTREACH TO SUBSTANCE USERS

Now that other organizations – in addition to those that are specifically funded to deliver IDU services – are reporting activities in section 13 of OCHART, there has been an increase in reported outreach to substance users. Most of the increase in in-service contacts in 2010-11 was due to two community health centres, which may reflect new programs or initiatives at those centres.

Figure 32
Total Outreach & In-Service Contacts

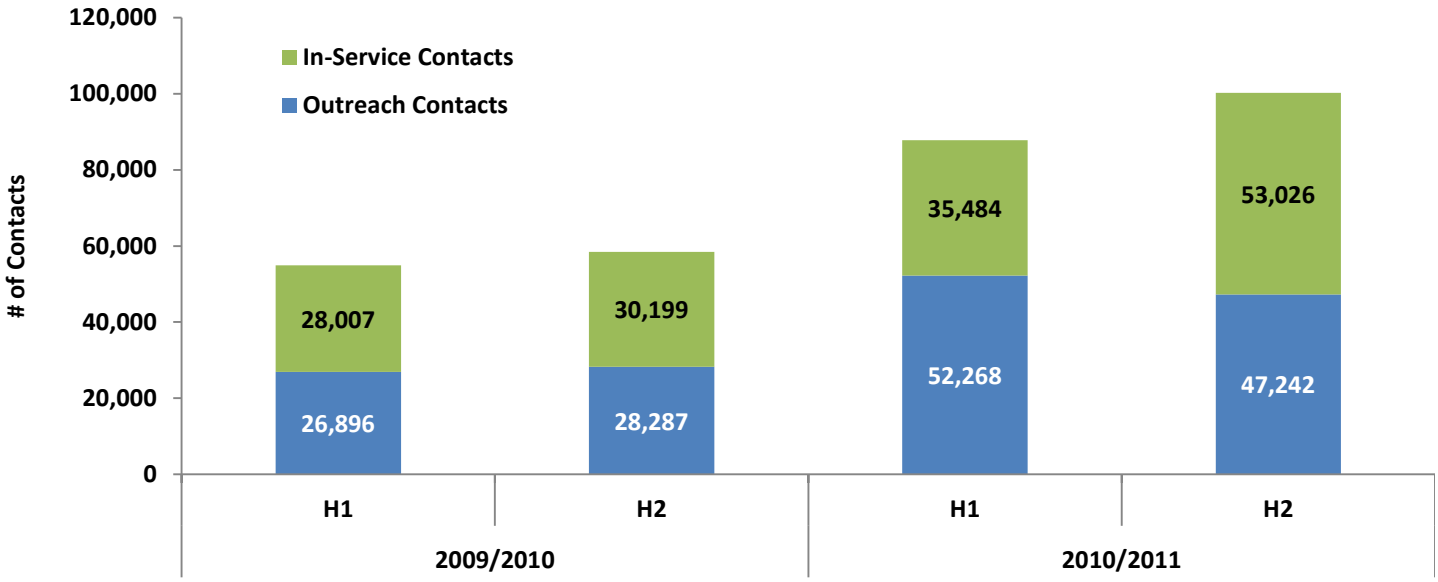
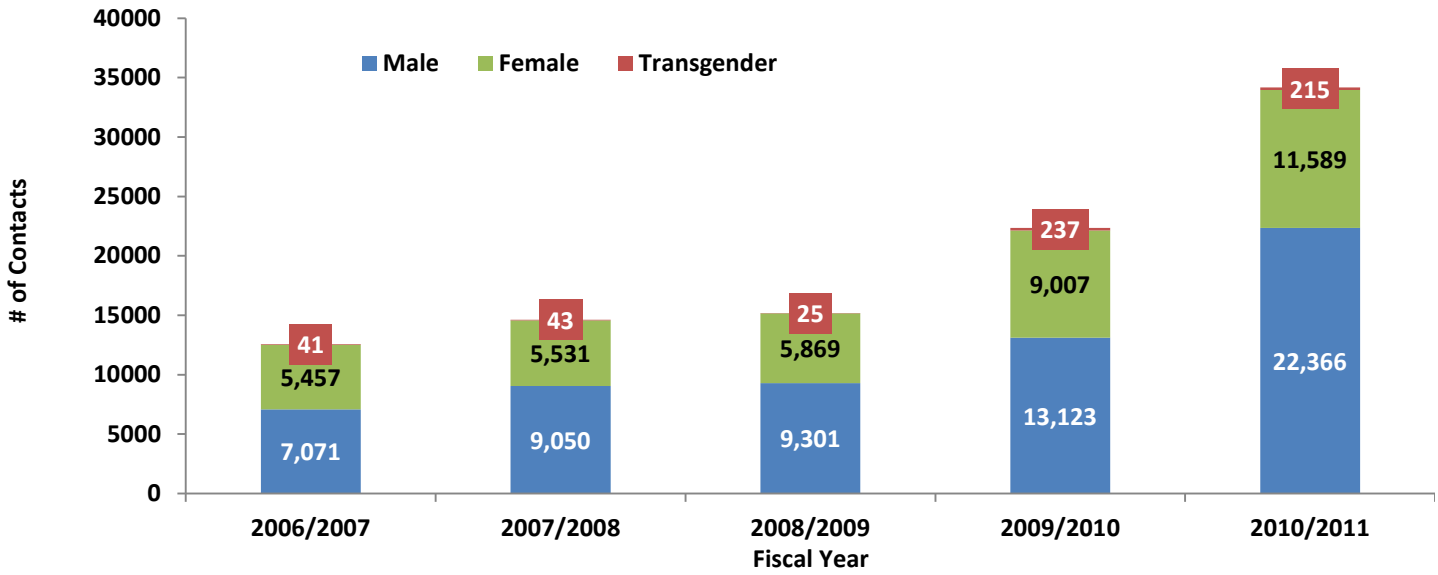


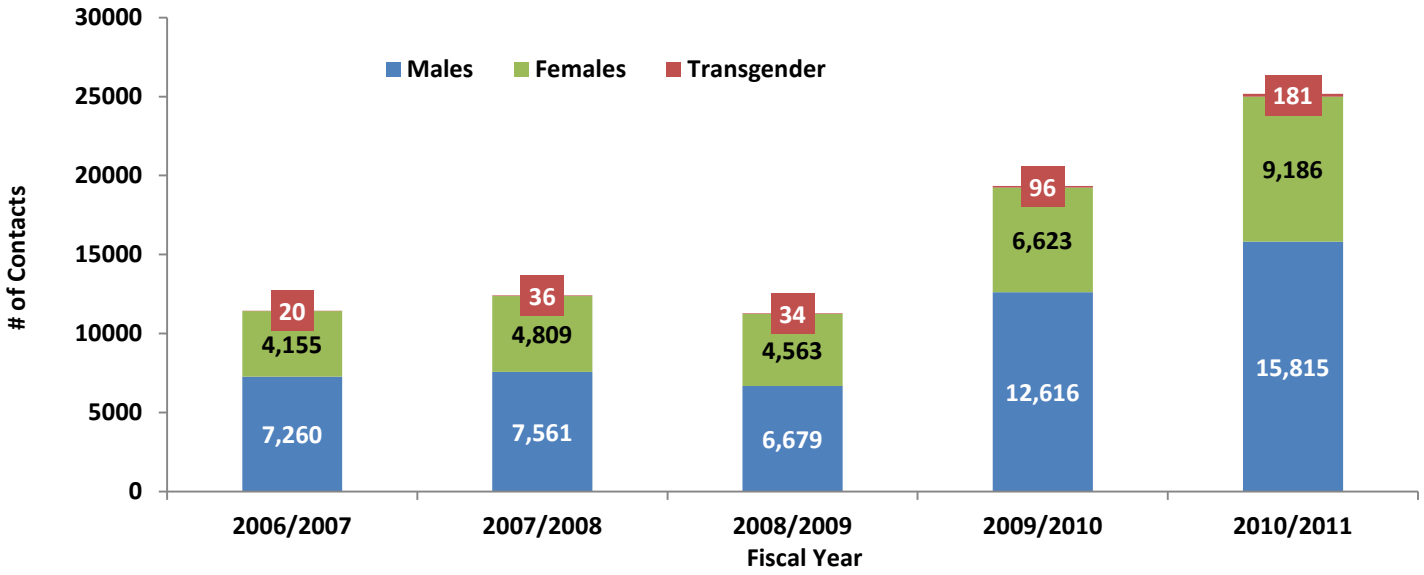
Figure 33 lists the number of unique clients who were IDU outreach contacts during 2010-11. With the additional agencies reporting, there was a marked increase in both the number of males and females receiving IDU outreach services; however, the majority of outreach clients continue to be male.

Figure 33
Number of Outreach Contacts (Total New & Average Repeat) by Gender



There was also a marked increase in the number of clients using in-service programs.

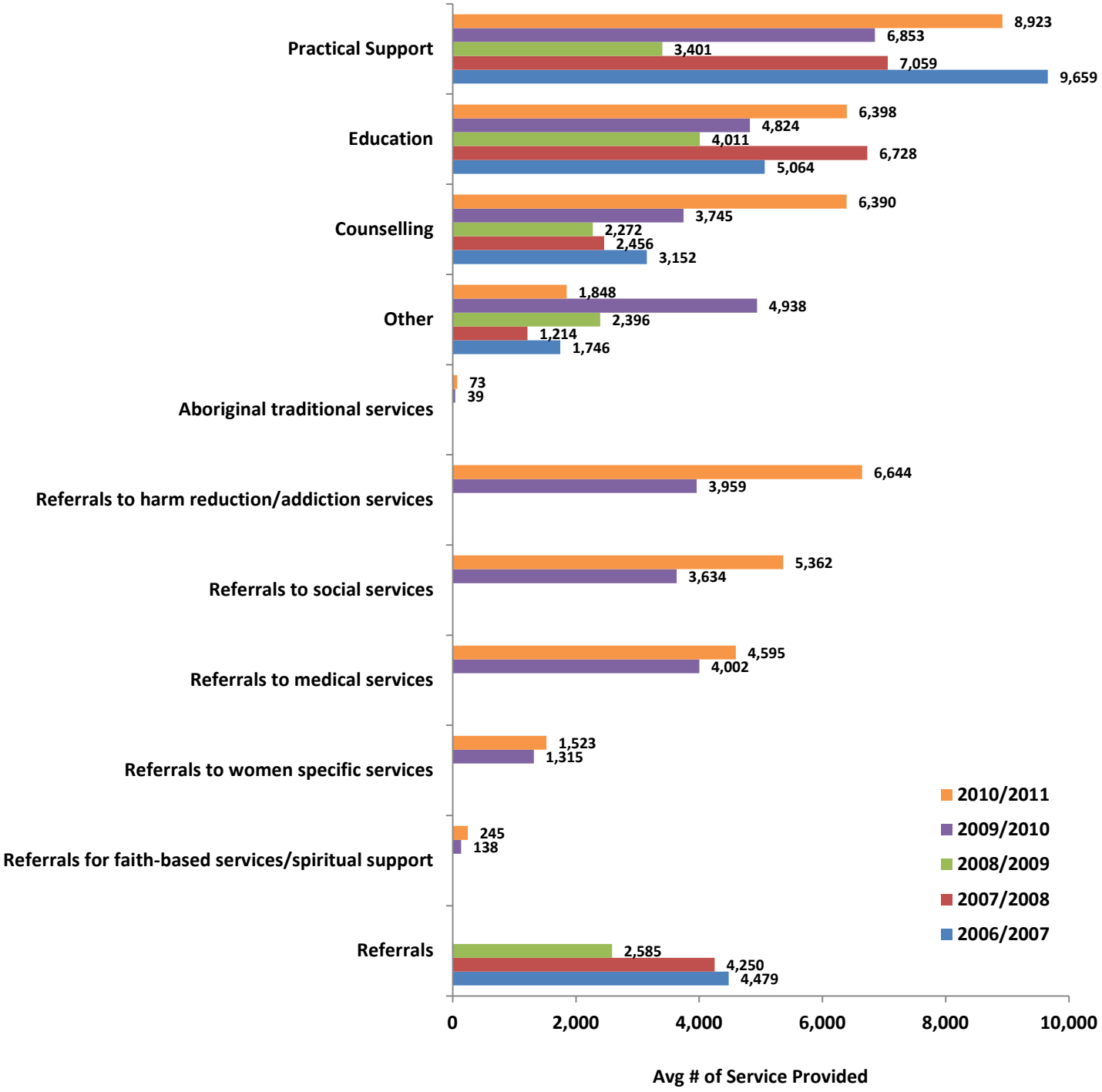
Figure 34
Number of In-Service Contacts(Total New & Average Repeat) by Gender



OUTREACH FOR SUBSTANCE USERS FOCUS ON PRACTICAL SUPPORT, EDUCATION REFERRALS

Organizations providing education and outreach for people who use substances provided significantly more practical support, counselling and referrals than in previous years – and these increases were across all organizations. They may reflect a maturing of their relationships with substance users, which allow the organization to move beyond education to connecting people with services. It would be interesting to know what organizations have learned to be able to improve access to services for people who use drugs and what, if anything, they are doing differently.

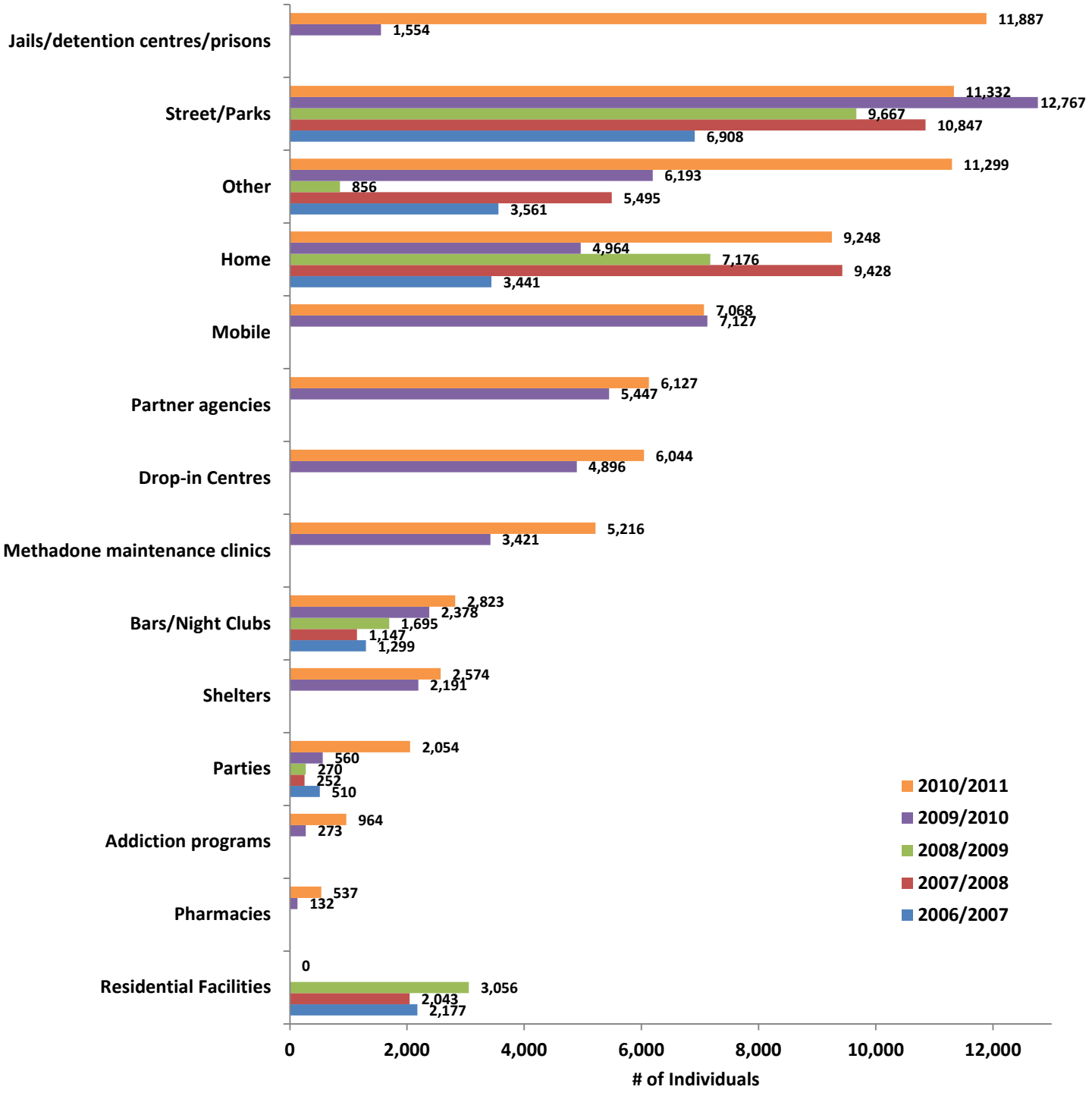
Figure 35
Average Number of Service Provided



MORE IDU OUTREACH IN PRISONS AND "OTHER" LOCATIONS

The significant reported increase in prison outreach was due mainly to one organization that now reports in this section. A wide range of agencies continue to provide street and park outreach, as well as outreach in people's homes and in other settings in the community, such as through partner agencies, drop-in centres and methadone maintenance clinics. The "other" category, which increased significantly in 2010-11 included: barber shops and hair salons (4338 contacts), satellite sites (3980 contacts) and food programs (1022 contacts). The marked increase in outreach in "other" locations suggests that programs are going to more diverse settings to reach people who use substances, and may indicate that the OCHART location categories should be revised to capture activity more accurately.

Figure 36
Outreach Locations



EMERGING TRENDS IN SUBSTANCE USE AND OUTREACH SERVICES

Programs report new trends in substance use, including injecting crystal meth, fentanyl and ketamine and use of crack cut with levamisole. Demand for harm reduction services and safe places to inject or smoke continues to grow; long wait times for other community services also continues to be a challenge. Programs also report that they are seeing more youth, more women and more sex workers – who need a range of services including justice, protection from violence and counselling.

> *"Younger clients, and more women, are coming to the needle exchange for IDU services."*

> *"We have seen a dramatic increase in the number of people accessing our needle exchange program. We are seeing an increase in younger individuals who are seeking information about the exchange and were unaware the program existed."*

> *"We are noticing higher reports of Fentanyl use, and have had an increase in youth between the ages of 20-29 accessing our needle exchange services."*

> *"We continue to see a rise in injection drug use in our youth population as well as increased requests for safer injection kits on outreach and in the office."*

> *"There are more injection opiate users. Actually, over 50% of our service users have told us that they are also injecting opiates."*

In addition to educating clients about the risks associated with different substances and how they are being used, programs are working to expand outreach programs to different areas, provide more harm reduction and counselling services, and to develop partnerships with police and others in the community to reduce the risks – including the risk of violence – for people who use substances. All of these shifts help to increase access to services and improve client health and well-being.

One program reported that it changed the location of its needle exchange program to make it more accessible to users. This is a concrete example of how programs adjust in order to meet the outcome of increased access to services in our communities.

> *"We have seen a marked increase in the number of safer inhalation kits that have been accessed over the last 2 to 3 months. This may primarily be due to a shift to a temporary fixed location as we have not been able to distribute supplies at our main office location since Aug 1 2010."*

Agencies credit some of the increase in use of needle exchange programs to their ability to provide a wide range of other, practical supports and build a trusting relationship with clients.

> *"...we have seen tremendous activity, mainly due to, to be honest, us giving out more stuff, like food, matches, health kits, which resulted in increased activity in needle exchange."*

> *"There was a significant increase in repeat outreach clients because we began offering more in the way of practical support."*

> *"Our overall distribution of Safer Injection Kits has increased substantially in the last reporting period and that is all of the items that increased. This increase is due to increased volunteers, increased staff on the street and a larger amount of peers. The peers are the main reason."*

> *"Because of the consistency of our program over the last two years, clients have now developed the confidence that this program will be able to meet their needs now and in the future. Because of this consistent service provision, we are able to see more clients in the community who trust us."*

One agency highlighted the challenges of helping clients who use substances access other services in the community:

> *"While most organizations recognize the basic principles of harm reduction, the policies that govern these organizations continue to contravene the principles; and as such many clients are denied services. A primary example is the local shelters in the area. In addition, there continues to be a no smoking policy in place at addiction service providers, and access to mental health services is very challenging. The no-smoking policies at the addiction service providers have proven to be an obstacle in accessing these services."*

5.1.4 EDUCATION MATERIALS AND RESOURCES

As part of OCHART, organizations report on the education/awareness materials and resources they develop, including brochures, posters, reports and training materials. Some of the resources developed in 2010-11 included:

- Guide for Service Providers working with Sex Workers
- Speakers Bureau Training Guide
- Guides for Living with HIV/AIDS
- Guides on Outreach
- Volunteer Training Manuals
- Strategic planning resources
- Resource Lists
- Criminals and Victims - The Impact of the Racialization of the Criminalization of HIV Non-disclosure on African, Caribbean and Black Communities in Ontario
- The PHA Learning Portal: a web portal for people living with HIV/AIDS to be able to self manage information on capacity building programs – developed with the assistance of the OHTN in partnership with PWA Toronto, OAN, ABRO< THN (Toronto HIV Network), ACCHO and CAAT.
  See http://www.phalearning.org/

5.1.5 ONLINE ACTIVITIES

Organizations continue to explore effective ways to the use the Internet and new social media for education and outreach, and to count their online activities.

> *"We have seen increased demand in online services. More people feel comfortable in accessing services via email the website and chat sites due to the fact that it makes accessing services easier and more anonymous."*

The number of organizations involved in chatroom interventions remains relatively small (fewer than 10 in any given reporting period). Most of those delivered fewer than 200 chatroom interventions in a six-month period – although there now appears to be a small group of three or four organizations focusing more on chatroom interventions. The number of agencies involved in this type of intervention appears to fluctuate and may depend on the interest and skill of individual staff. Given that this type of "virtual" service can be provided from anywhere, it might be interesting for the field to discuss whether there is any benefit in concentrating expertise in these types of interventions in a small number of agencies.

As would be expected, a larger number of organizations – 23 to 24 in 2010-11 -- are using websites as part of their education and awareness initiatives. However, only about half report a significant number of hits every six months and hits may be counted differently by different organizations. For this reason, it is difficult to assess the impact of web-based education and outreach.

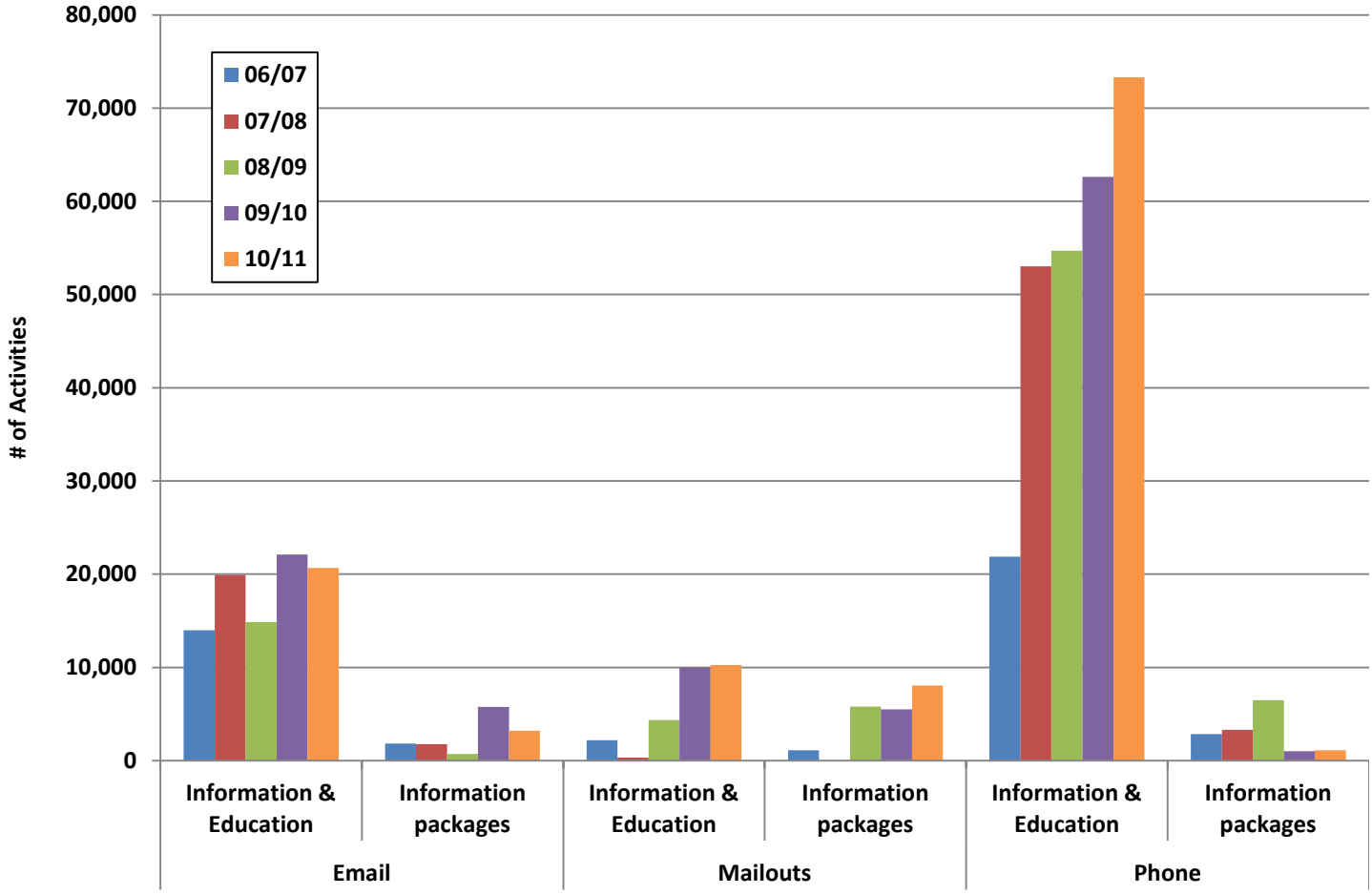
5.1.6 PHONELINE AND INTERNET INFORMATION

Organizations continue to provide information and to respond to both phone and email requests for information. The marked increase in requests for phone information is due to one organization and those calls are related to more clinical information. As more information becomes available on-line, we may see a drop in both phone and email requests, as well as in the number of mail outs.

5.1.7 USE OF MEDIA

The media can be an important ally in improving HIV knowledge and awareness. In OCHART, organizations are asked to what extent they use "paid" and "unpaid" media – doing interviews, making appearances and submitting articles – in their education program. There are still inconsistencies in the way that agencies report media contacts, so more work is required to ensure contacts are defined and counted consistently. There is a relationship between paid and unpaid media coverage, particularly in community media, as community newspapers are more likely to run stories from places that are paying for advertising. In general, organizations are less likely to buy paid advertising than they were a few years ago, and that has led to fewer of their "unpaid" articles being picked up by community newspapers. There may be opportunities for agencies to discuss more effective ways to use media and to get their messages out.

Figure 37
Outreach Communication Methods on Information/Education and Information Packages



WHAT WORKS IN MEDIA RELATIONS?

Comments from the ACAP logic model provide some insight into media practices. Effective use of the media depends on factors such as having someone who has skills in this field on staff or as a volunteer, maintaining good relationships with local television and radio stations, and capitalizing on a wide range of media, including ethnocultural and other community-specific media.

> *"The number of participants for this year's Annual Alcohol and HIV Forum was more than we anticipated. We got more participants because we advertised the event aggressively in a variety of print and electronic media including social network, word of mouth, text messages, e-mails, newspapers and radio advertisements."*

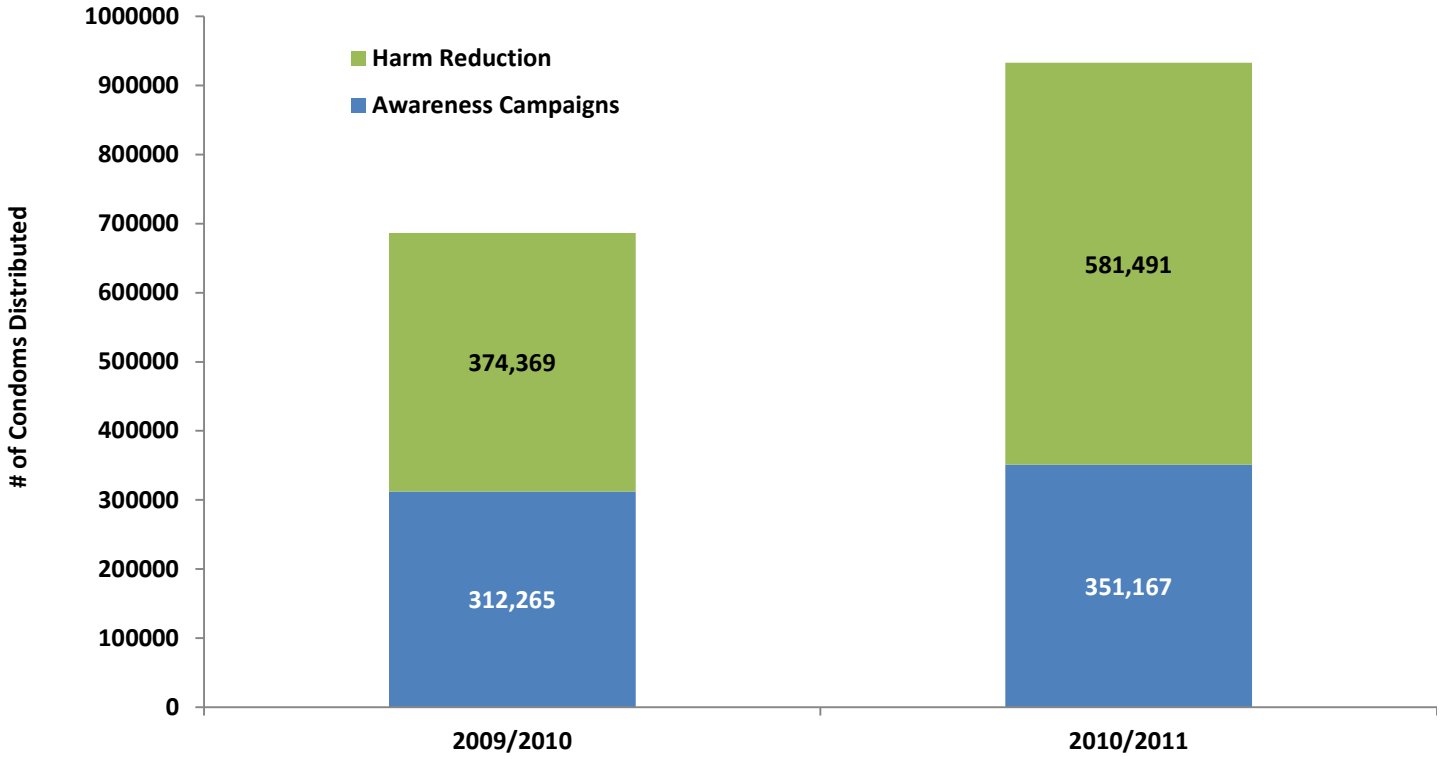
5.1.8 DISTRIBUTING SAFER SEX AND DRUG EQUIPMENT AND OTHER PREVENTION RESOURCES

To prevent transmission of HIV, people need easy access to condoms and lubricant, new needles, safe inhalation equipment and other prevention/harm reduction resources. They also need information and education about how to correctly, consistently use and safely dispose of these resources.

MORE CONDOMS DISTRIBUTED

In 2010-11, programs reported distributing 351,167 condoms through their awareness programs and 581,491 condoms through harm reduction programs – an increase of 36% in the number of condoms distributed compared to 2009-10. Over the past few years there has also been a significant increase in the number and proportion of funded programs that distribute condoms. Only six of the 72 funded organizations did NOT distribute condoms – mainly because they were provincial resource programs that do not serve clients (e.g., CATIE, Ontario AIDS Network) or are specialized services (e.g., Hospice Toronto).

Figure 38
Number of Condoms Distributed by Activity



In terms of trends related to condom distribution, agencies reported the following:

> *"As a result of increased community outreach along Dundas Street West, where there are a lot of community stores, businesses and bars, we have seen an increase in demand for condom and lubricant packages."*

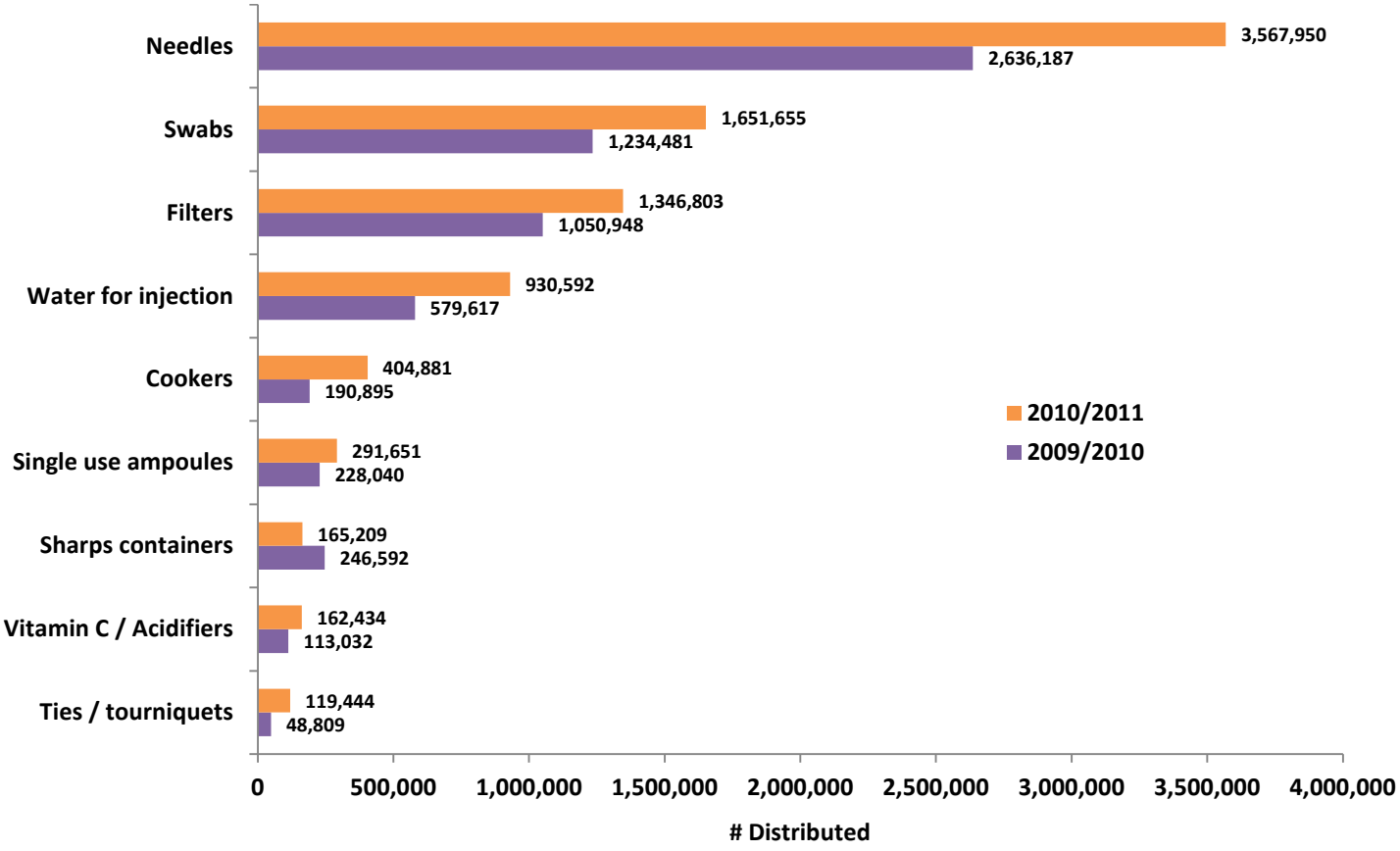
> *"[We are seeing an] increased need for female/insertive condoms and these are being ordered in bulk."*

MORE NEEDLES AND OTHER SAFER INJECTION EQUIPMENT DISTRIBUTED

In 2010-11, 31 organizations reported distributing safer injection equipment. They distributed 35% more needles (3,567,950 compared to 2,636,187) than in 2009-10: this reflects a 13% increase among those agencies that reported in 2009-10 plus the additional resources distributed by programs that are not funded specifically to provide IDU outreach services and only started reporting in this section of OCHART in 2010-11. The number of needles distributed by different organizations varied considerably from a high of 1,537,499 needles to a low of 61 needles. The number of needles distributed largely depends on the need in each community, the number of other exchange sites in the community, and on the organization's capacity to distribute needles. It is also affected by the role of the organization. Some are the sites of funded needle exchange programs, so they would be expected to distribute more needles.

Programs also reported distributing more of all other safer injection equipment except sharps containers.

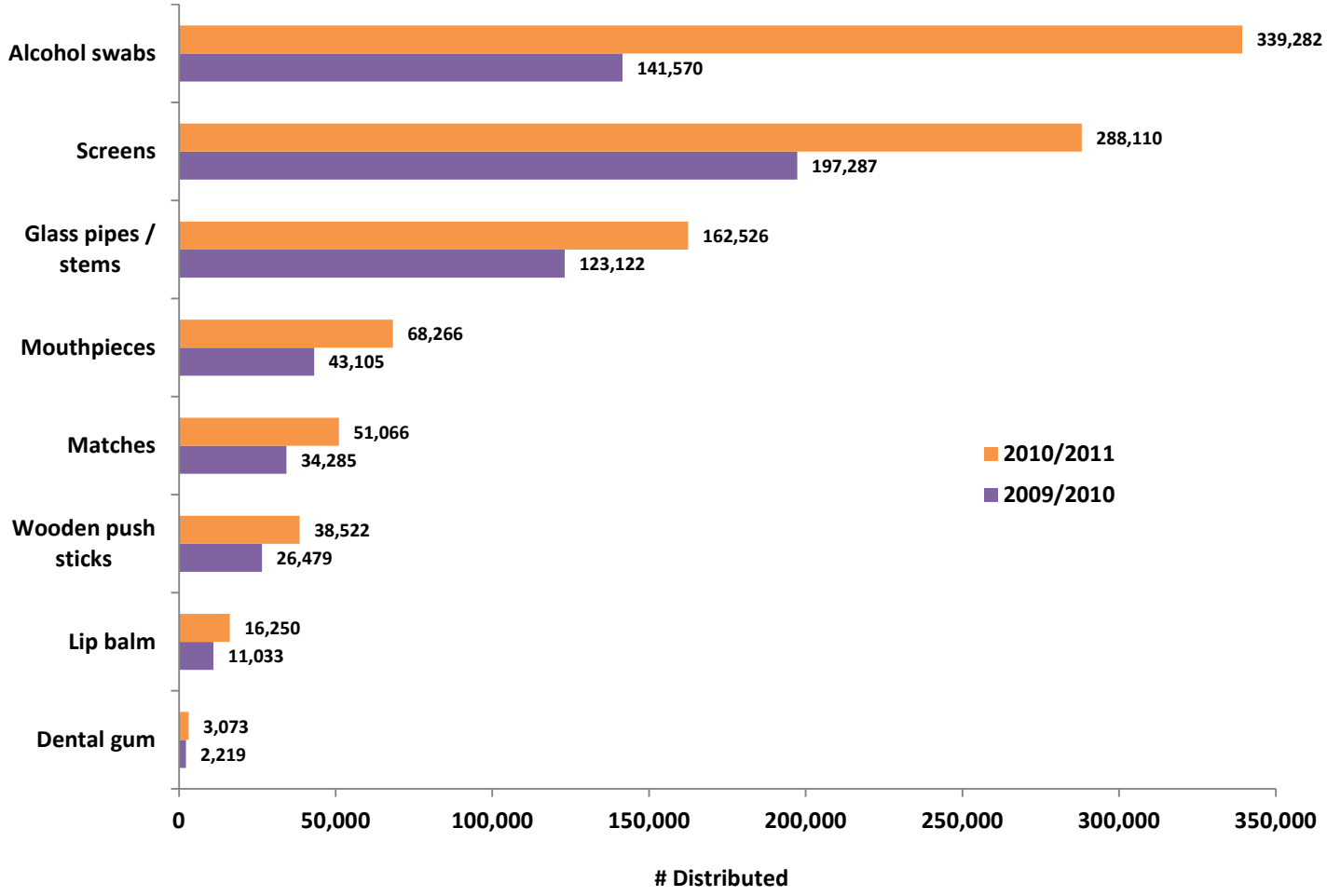
Figure 39
Total Number of Safer Injection Equipment Distributed



MORE SAFER INHALATION EQUIPMENT DISTRIBUTED

Twenty-nine organizations reported distributing safer inhalation equipment in 2010-11, and the number of items distributed increased significantly.

Figure 40
Total Number of Safer Inhalation Equipment Distributed



5.2 INCREASING ACCESS TO SERVICES

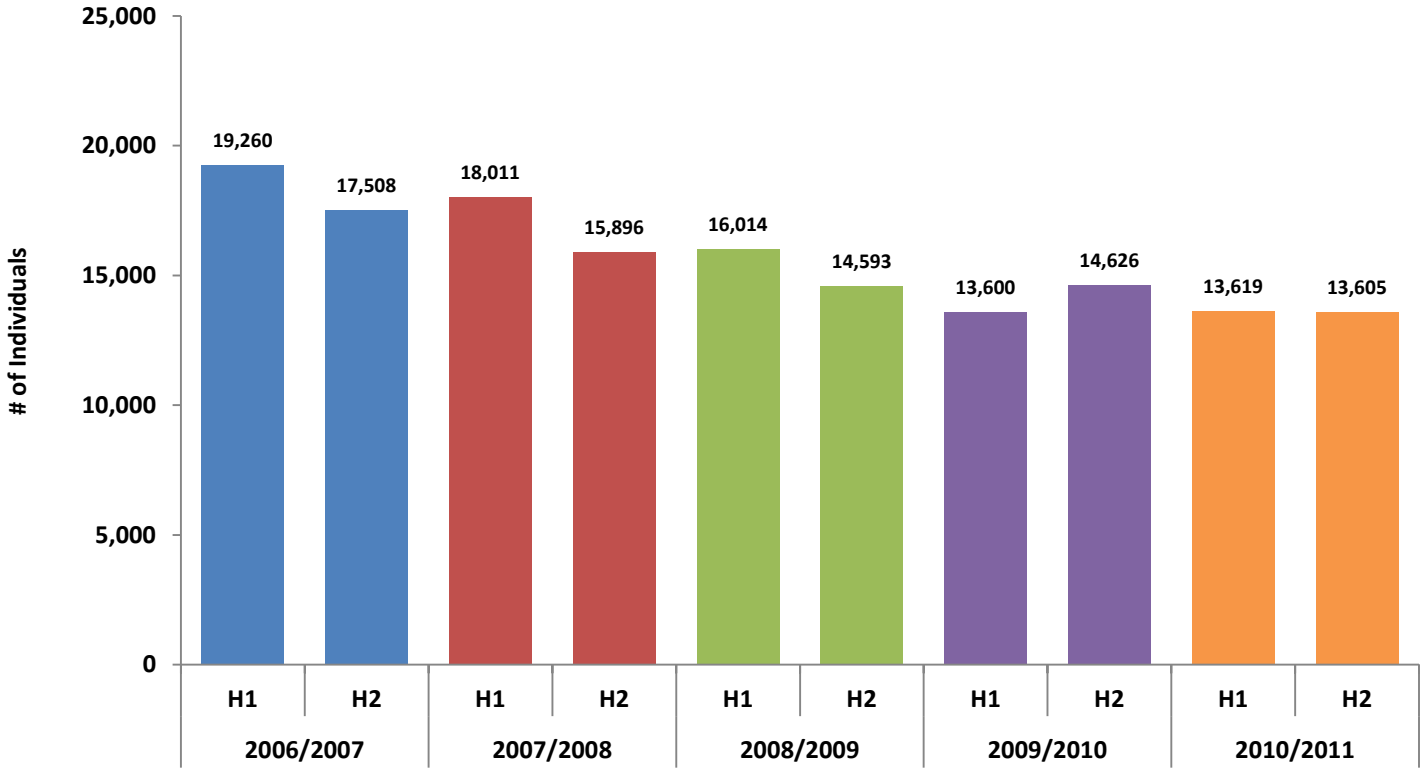
Providing access to comprehensive, integrated, culturally competent, support services is a core part of the work of community-based HIV programs. Improving access to services will help achieve the outcome of improved health, well-being and quality of life for people living with or affected by HIV/AIDS.

In 2010-11, 64 of the 88 community-based programs reported providing support services for people living with or at risk of HIV.

5.2.1 NUMBER OF CLIENTS INCREASINGLY CONSISTENT

Over the past two to two and a half years, the total number of clients that organizations report serving in each half year has remained between 13,600 and 14,626. The decrease from previous years is due to more accurate reporting and less double counting of clients using more than one service with an agency. However, it appears that the numbers programs report for each half year through OCHART may understate the actual number of clients served within a given year. When these numbers were compared with the total number of active clients reported by the 26 organizations that use OCASE (a client/case management system for community-based ASOs), we found that the 26 organizations alone had 7,695 active clients between April 1, 2010 and March 31, 2011. It seems likely that the remaining 37 organizations would have more than 6,000 clients over the year. As more organizations move to using their OCASE data to support their OCHART reporting, client numbers should become even more accurate. However, it's important to note that – especially in communities in Toronto that have a number of different organizations serving people with HIV – these may not all be unique clients. Clients may go to different organizations to access different services, and may be counted more than once.

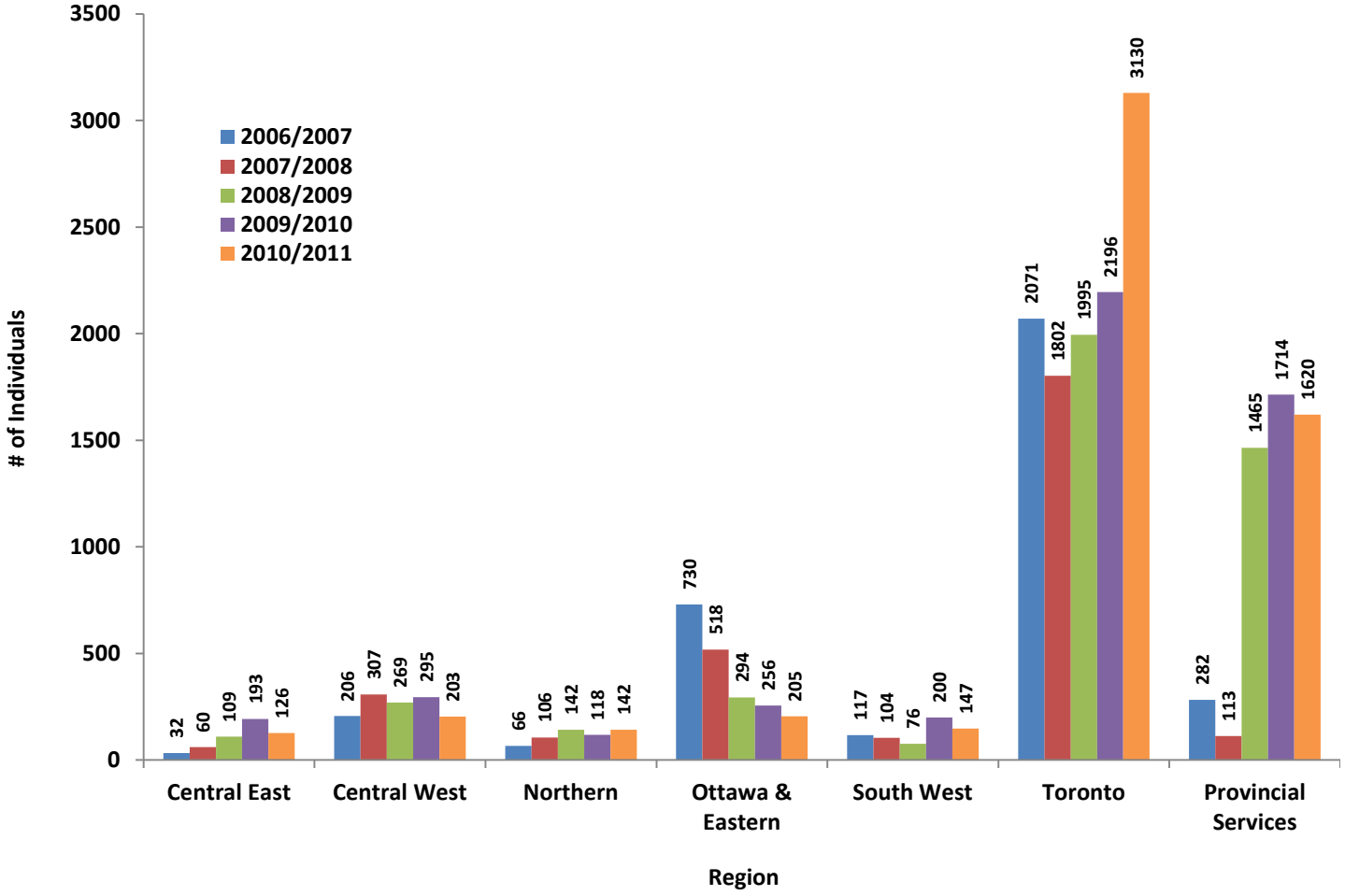
Figure 41
Number of Clients who Used Support Services During Each Reporting Period



It is interesting to note that the number of clients has remained relatively constant over the past five reporting periods despite the fact that there are around 1,000 new infections diagnosed in Ontario each year and more people living with HIV. This trend may be due to a number of factors: the episodic way that people with HIV use community-based services, the drop in the number of people at risk who are being served (see below) and the capacity of community-based programs.

Figure 42 reinforces the episodic nature of support services. Organizations report a significant number of "new" clients each year (although some may be returning clients): 5,368 or 39% of clients in 2010-11. This would appear to indicate that some people use the services of community-based organizations on an as-needed basis (e.g., when first diagnosed, when facing a change in the health status, when faced with a problem with income or housing) rather than on an ongoing basis. (Note: the increase in clients using provincial services is due to the fact that one provincial resource agency that does provide direct client services only started reporting clients in 2008-09).

Figure 42
Number of New Clients by Region

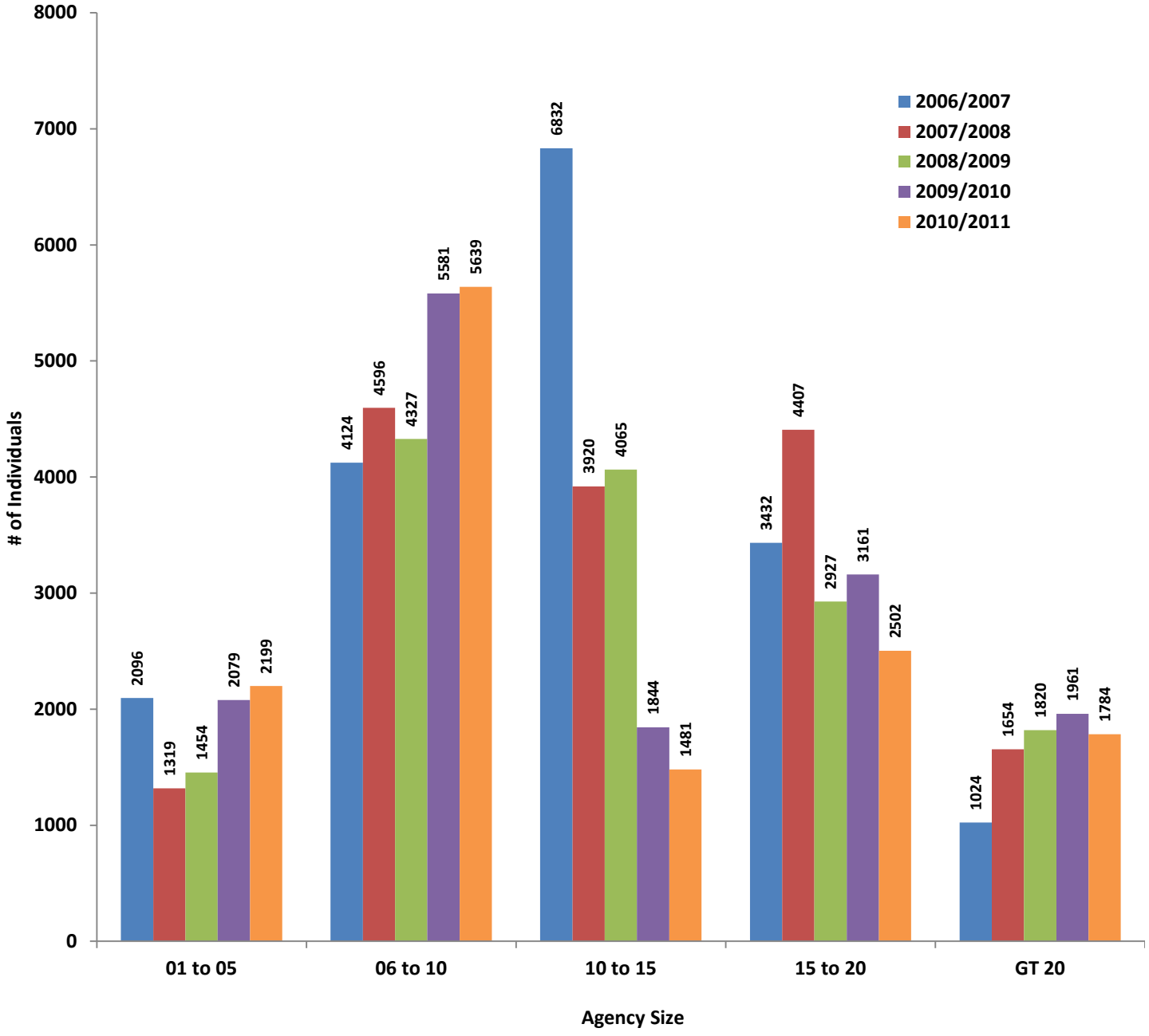


"New service users, who have been newly diagnosed have been in the 60+ age range. This population has presented with unique challenges such as comorbid diagnoses (e.g., diabetes, physical disability, cardiac and lung disorders etc) and difficulty obtaining accessible and affordable housing, as well as accommodations that provide assisted living services."

MOST CLIENTS SERVED BY SMALLER AGENCIES

Most community-based programs that provide support services are relatively small: 49 of the 64 that provide support services (76%) have fewer than 10 staff and only 5 (8%) have more than 20 staff. As Figure 43 illustrates, most clients (7950 or 58%) receive services from programs with 10 or fewer staff.

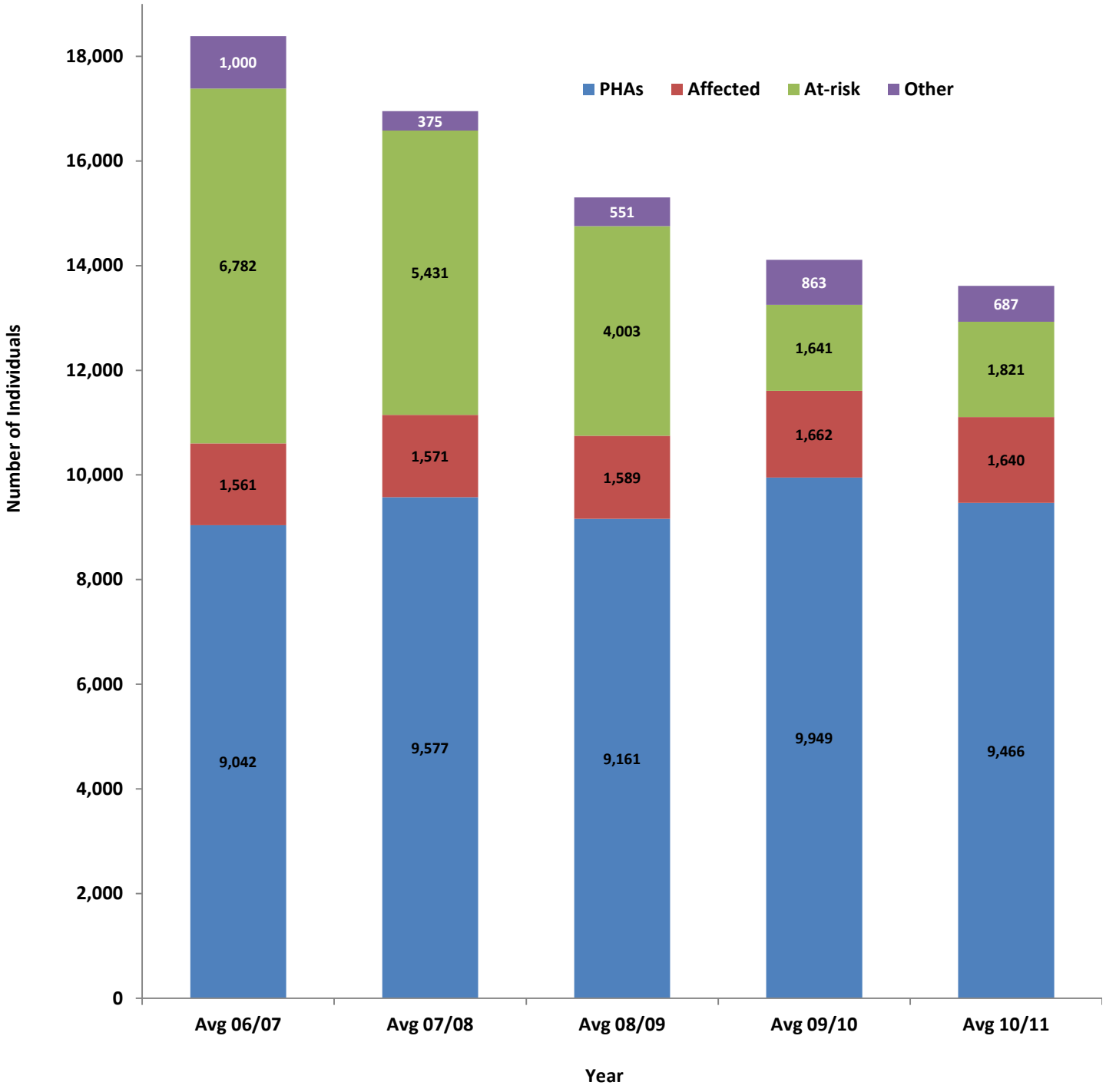
Figure 43
Clients Served by Agency Size



5.2.2 MOST SUPPORT SERVICE CLIENTS ARE LIVING WITH HIV

Most clients using support services are people living with HIV, and the number of people with HIV using services has remained relatively consistent over the past five years. The significant drop in the number of at-risk clients being served over the past few years is likely due to two reporting trends: more consistent definitions for support services and more agencies reporting services for clients who use substances in the IDU outreach section of OCHART instead of the support service section.

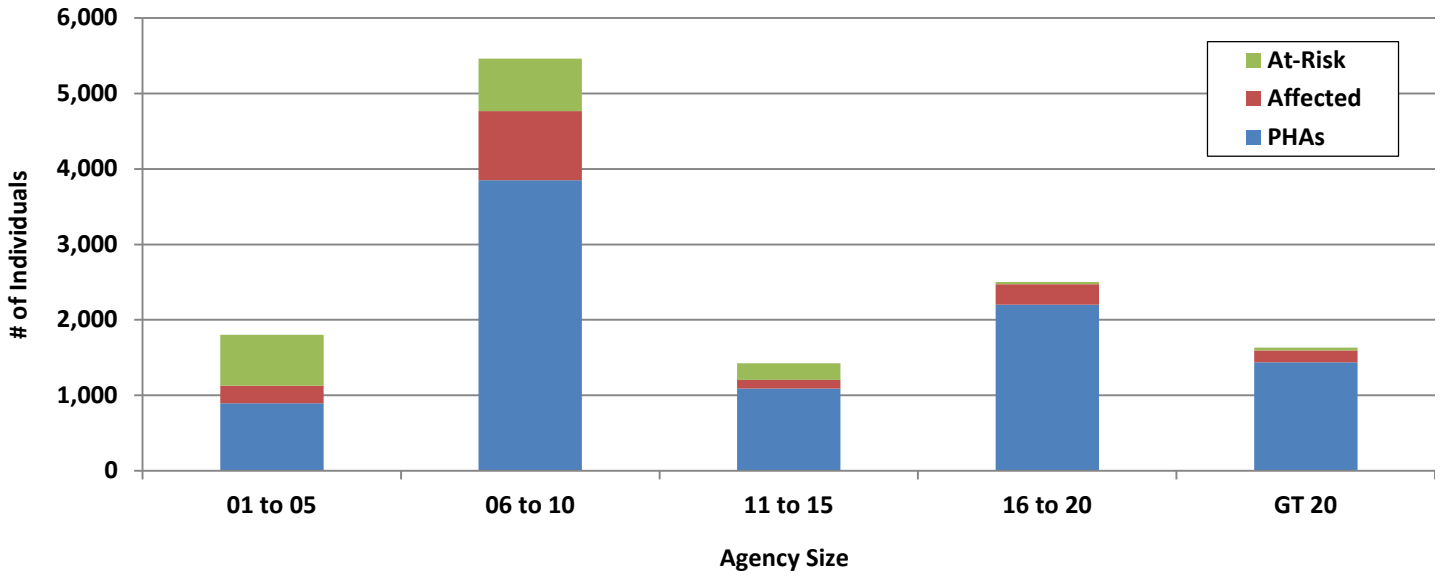
Figure 44
Delivery of Support Services by Client Type



SMALLER ORGANIZATIONS MORE LIKELY TO SERVE PEOPLE AFFECTED

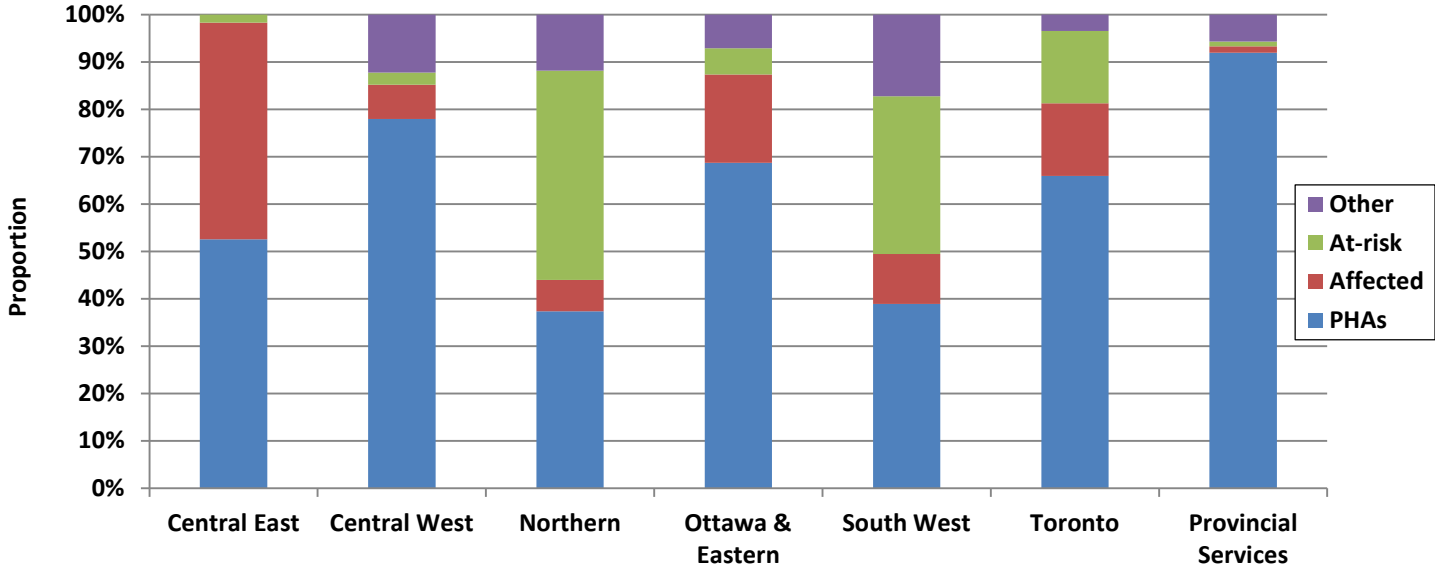
It appears that smaller organizations (i.e., 10 or fewer staff) serve a larger proportion of people who are at risk or affected (i.e., partners and family members of people living with HIV), while larger organizations focus almost completely on people living with HIV and their partners/families. A significant amount of the support services for people affected are provided by the small number of programs/organizations whose mission is to serve families.

Figure 45
Client Served by Client Type and Agency Size: 2010/2011 H2



There is significant regional variation in the mix of clients using support services. Organizations in the Northern, South West and Toronto regions are more likely to provide support services for people at risk, while organizations in Central East, Ottawa and Toronto regions are more likely to provide services for people who are affected. As would be expected, those provincial organizations that provide direct client services focus almost exclusively on people living with HIV.

Figure 46
Proportion of Clients who Used Support Services by Client's Type and Region: 2010/2011 H2

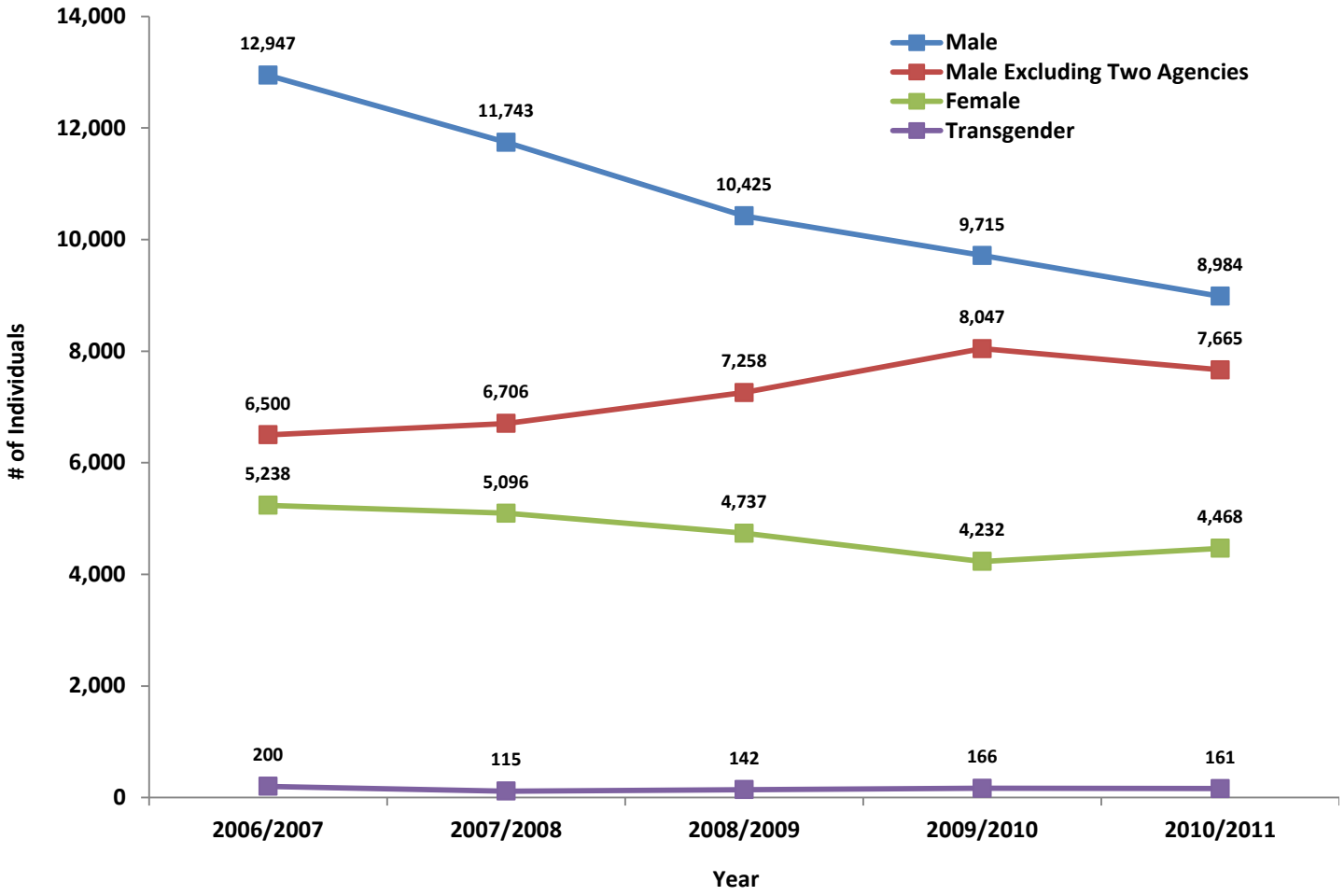


5.2.2 GENDER MIX

FEWER MEN SERVED IN 2010-11

Despite the fact that men account for 80% of new diagnoses, only 66% of support service users are male and the number of men receiving support services declined by 7% in 2010-11. The drop in the number of male clients occurred across agencies but was particularly marked in three agencies, which may mean it is due to more accurate counting.

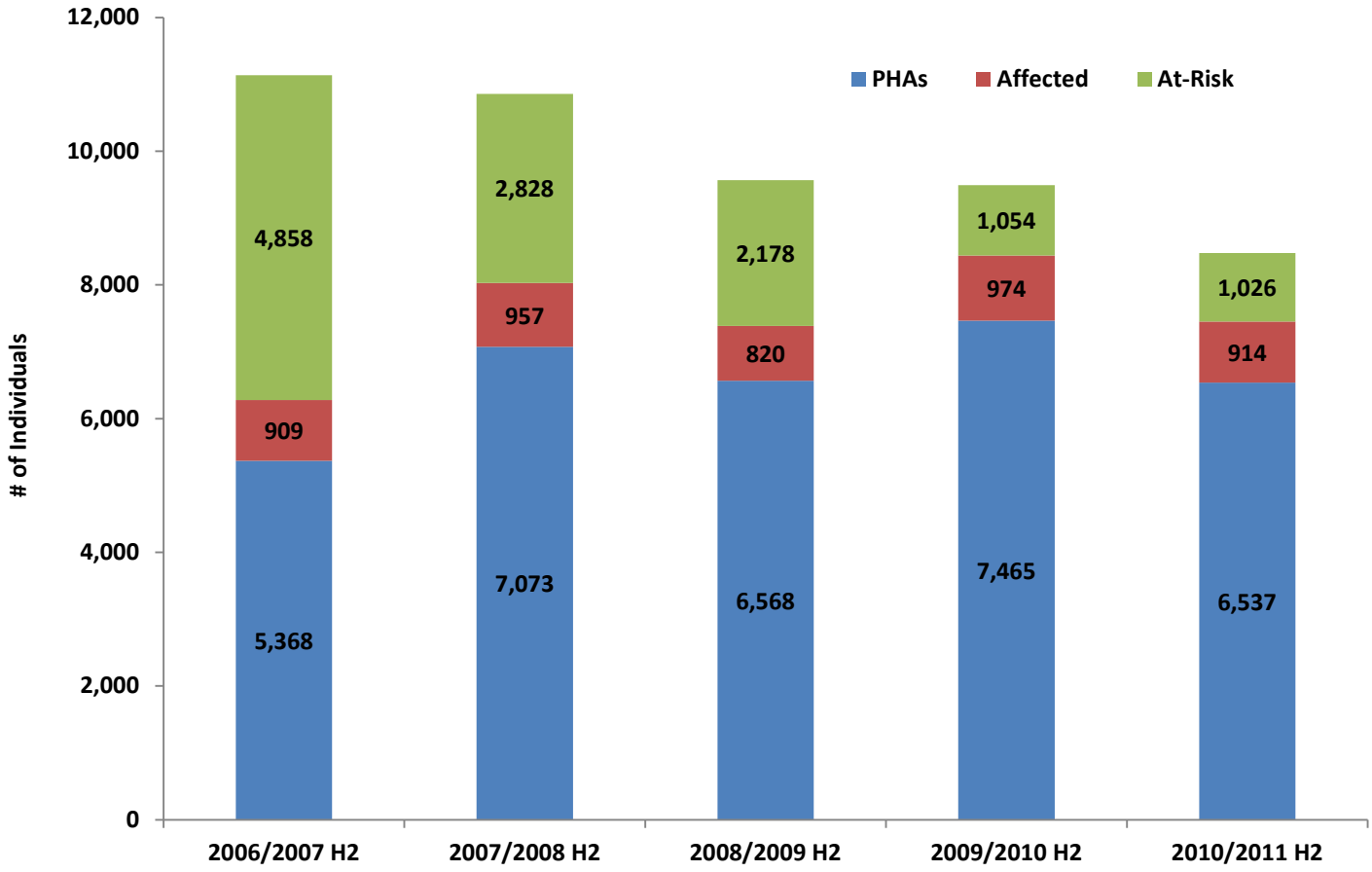
Figure 47
Average Number of Support Service Users by Gender



Please note that the chart includes two lines showing male clients: one includes data from all agencies and one excludes data from two agencies. This was done to show that the drop in the number of male clients in previous years was due to more accurate counting at one agency (i.e., less double counting of the same clients using different services) and to the fact that another agency that used to have a large number of clients no longer provides support services. As the line excluding the two agencies illustrates, throughout most of the system, there was a steady increase in the number of male clients between 2006 and 2010, and a decrease in 2010/11.

Of the 66% of male support service users, most (73%) are men living with HIV and the remainder are men who are at risk or affected.

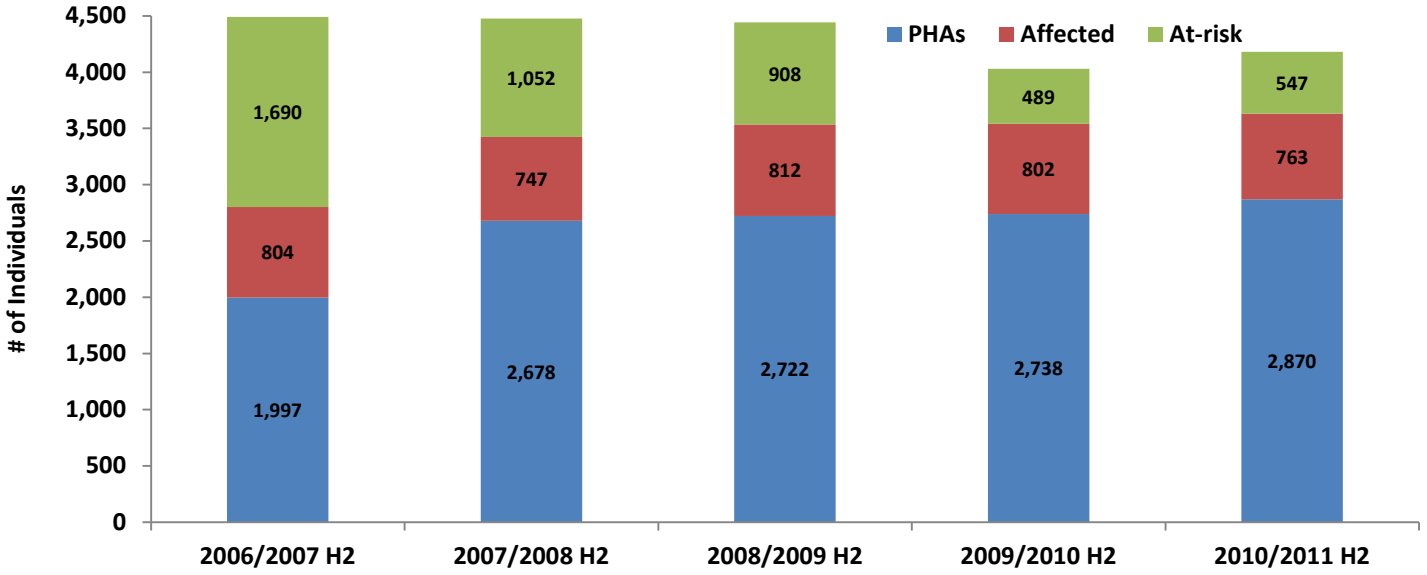
Figure 48
Men Served by Client Type



MORE WOMEN SERVED IN 2010-11

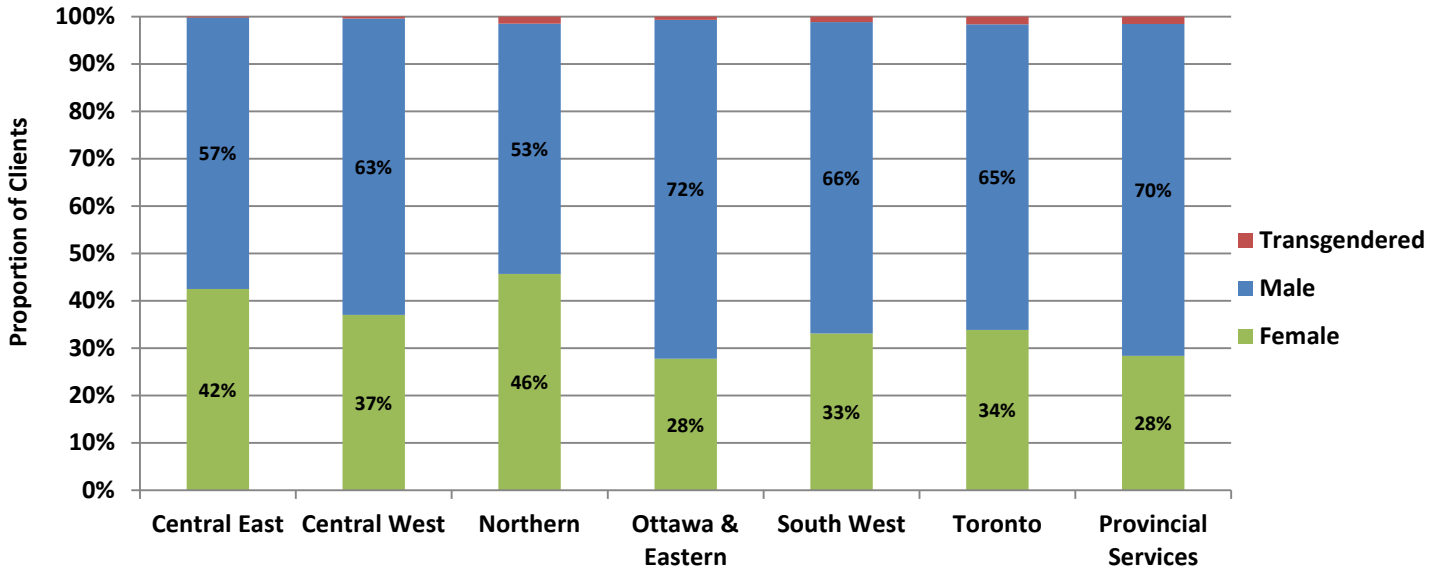
At the same time, the number and mix of female clients has remained relatively consistent – up slightly in 2010-11 -- over the past three years. It is interesting to see this trend in number of women served even though data from an agency that used to serve women and ceased operation in 2010-11 has been removed from the analysis. This may indicate that women served by that agency were able to make the transition to other organizations. It may also reflect the impact of the new Women and HIV/AIDS Initiative, which is working to enhance the capacity of community-based health and social service organizations to respond to women and HIV.

Figure 49
Women Served by Client Type



In terms of regional variations, organizations in the Northern, Central East and Central West regions serve a larger proportion of female clients – which reflects the nature of the epidemic in those regions.

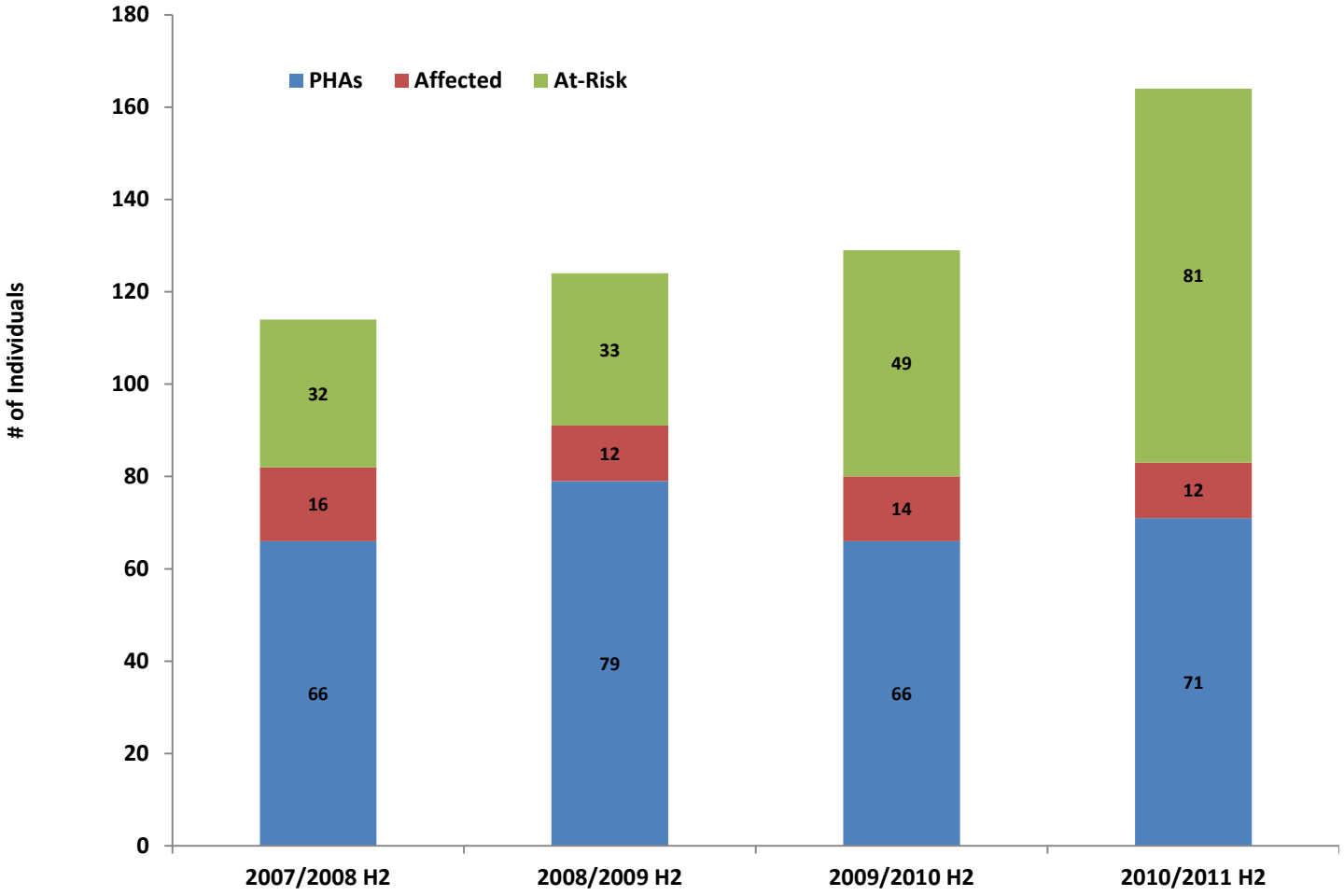
Figure 50
Proportion of Clients accessing Support Services by Region: 2010/2011 H2



NUMBER OF TRANS CLIENTS INCREASES

Of the 64 organizations that report providing support services, 63 serve female clients, 62 serve male clients and 30 serve trans clients. The number of trans clients – particularly people affected – has increased over the past two years. This is likely due to program efforts to reach out to the trans community.

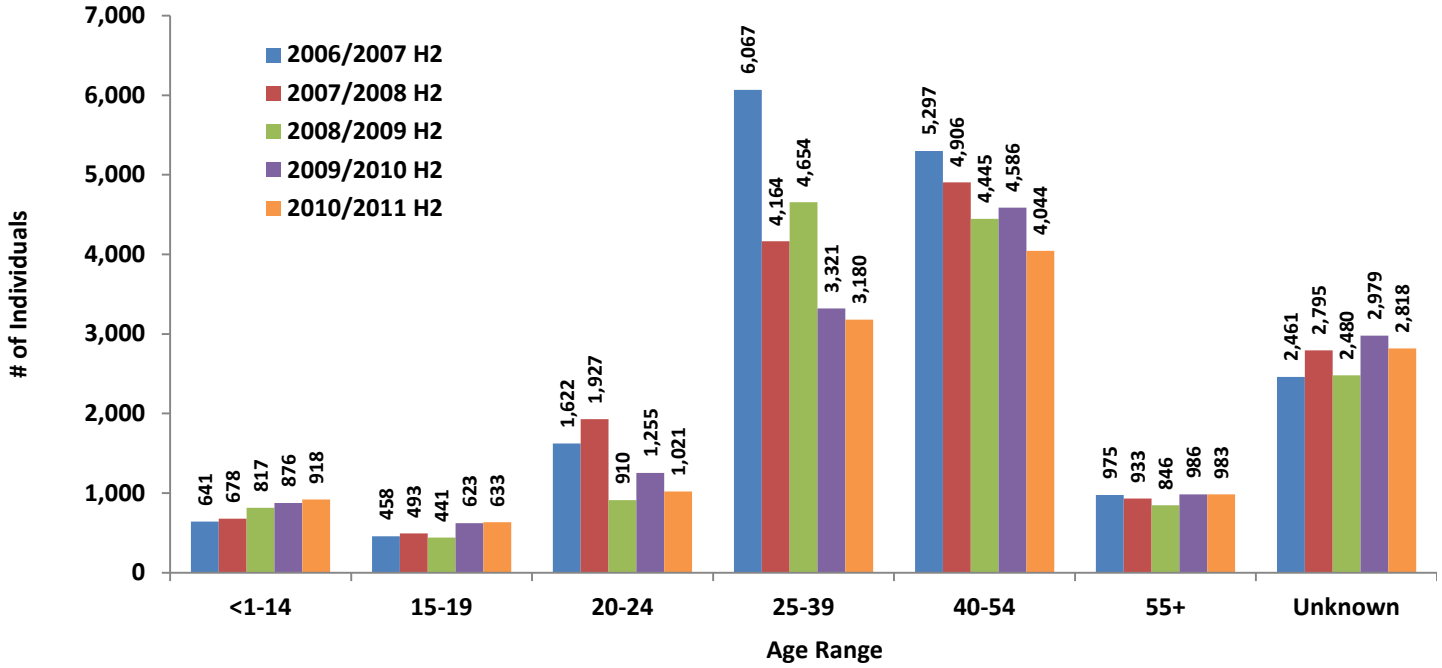
Figure 51
Transgender Clients Served by Client Type



5.2.3 MOST CLIENTS BETWEEN 25 AND 54

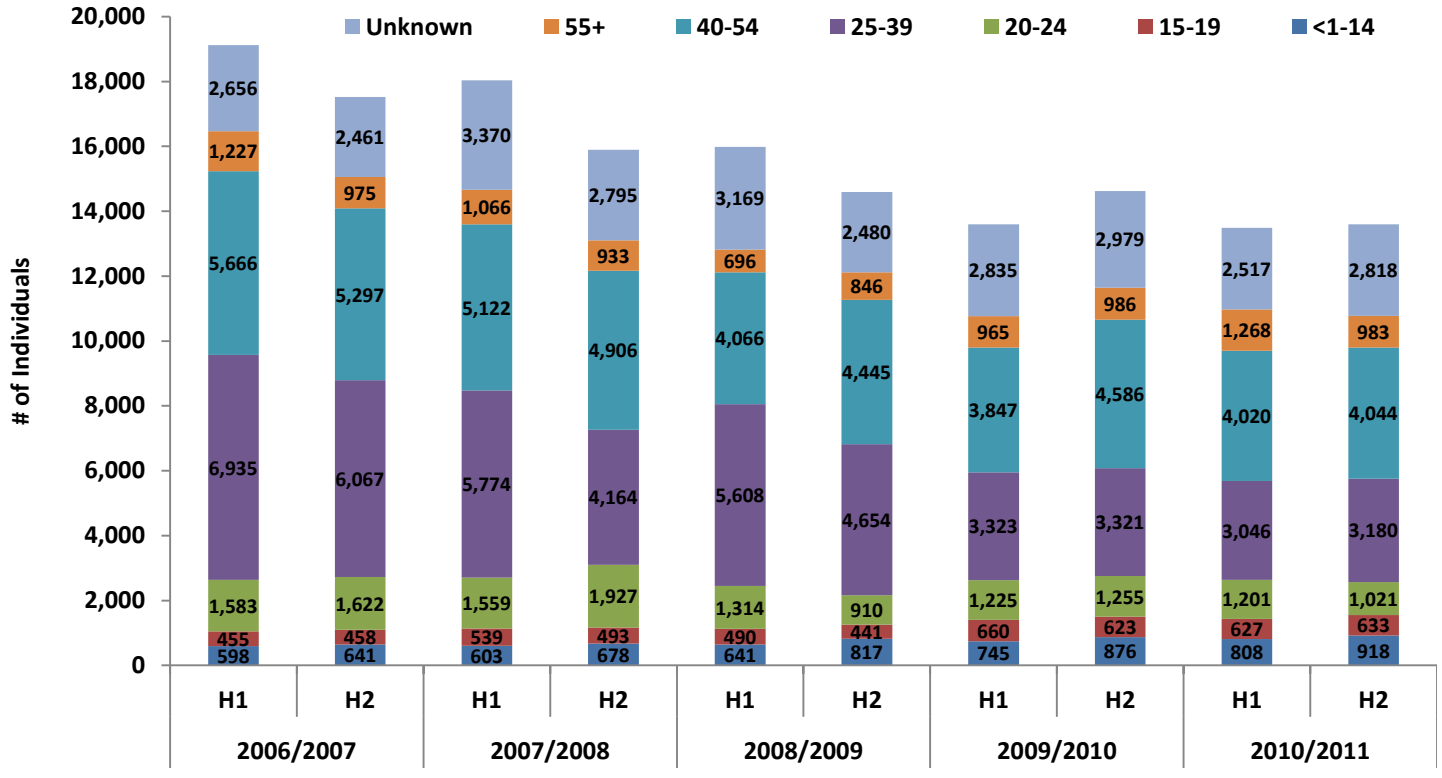
Most people using support services continue to be between the ages of 25 and 54, and that pattern holds true across all regions.

Figure 52
Clients Accessing Support Services by Age



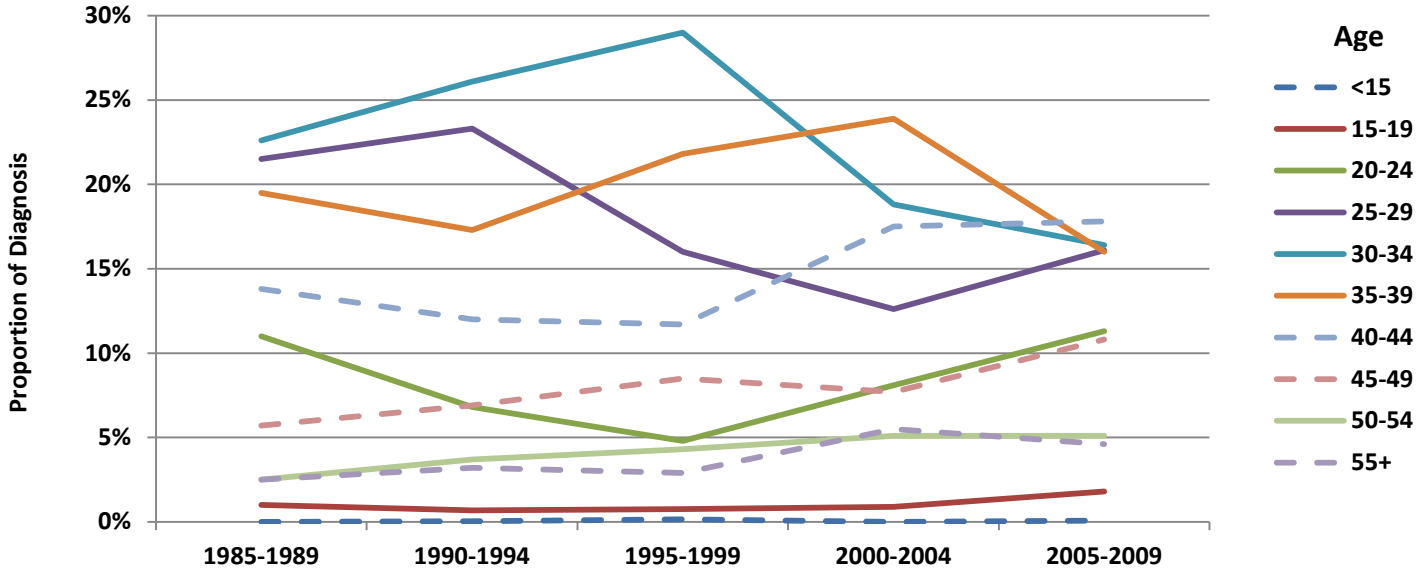
The age mix of people using support services has remained relatively consistent over time.

Figure 53
Clients Accessing Support Services by Age and Reporting Period



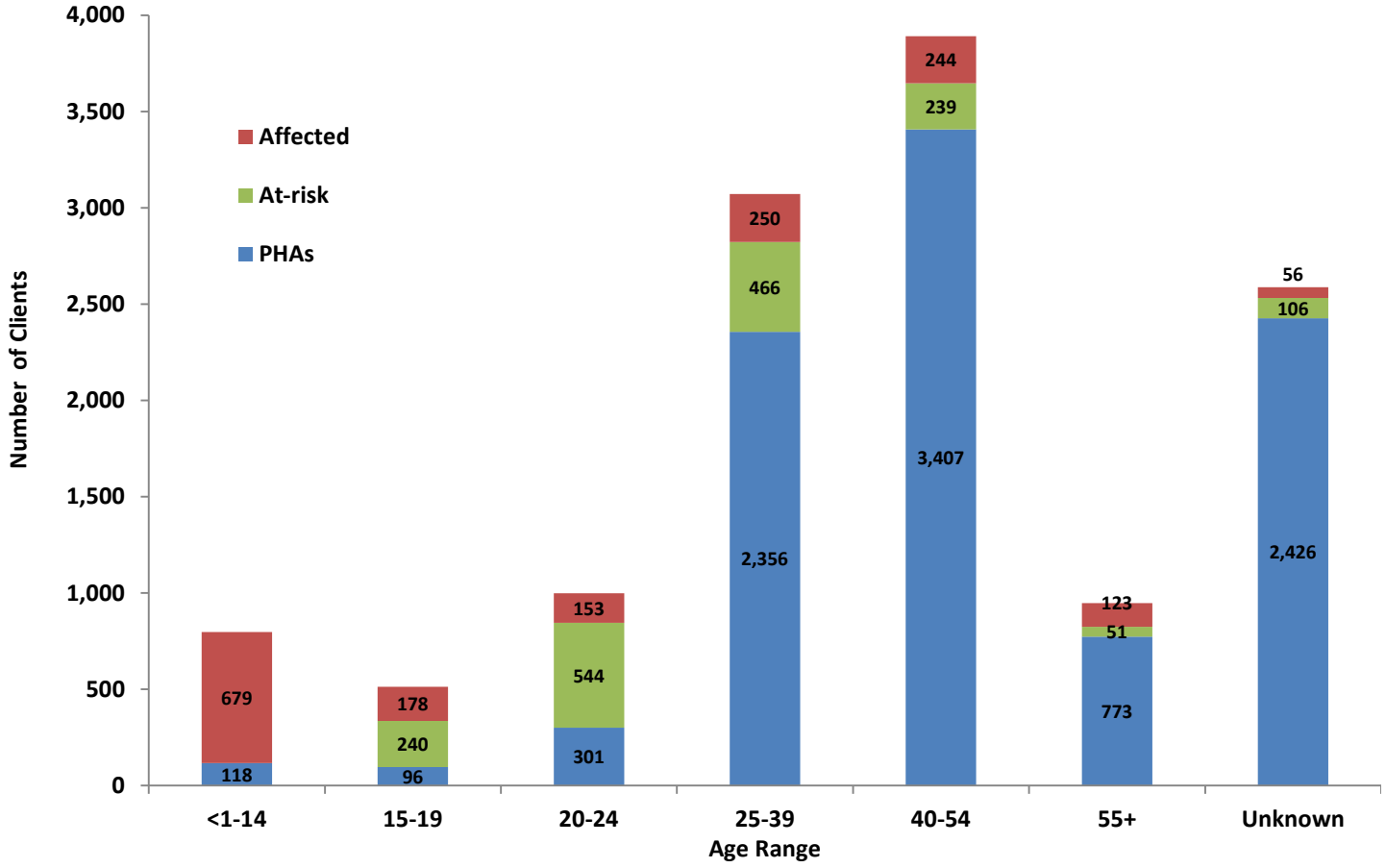
These age trends are consistent with the epidemiology of HIV in Ontario.

Figure 54
Proportion of HIV diagnosis by age at diagnosis and year of HIV diagnosis: MSM
Source: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care



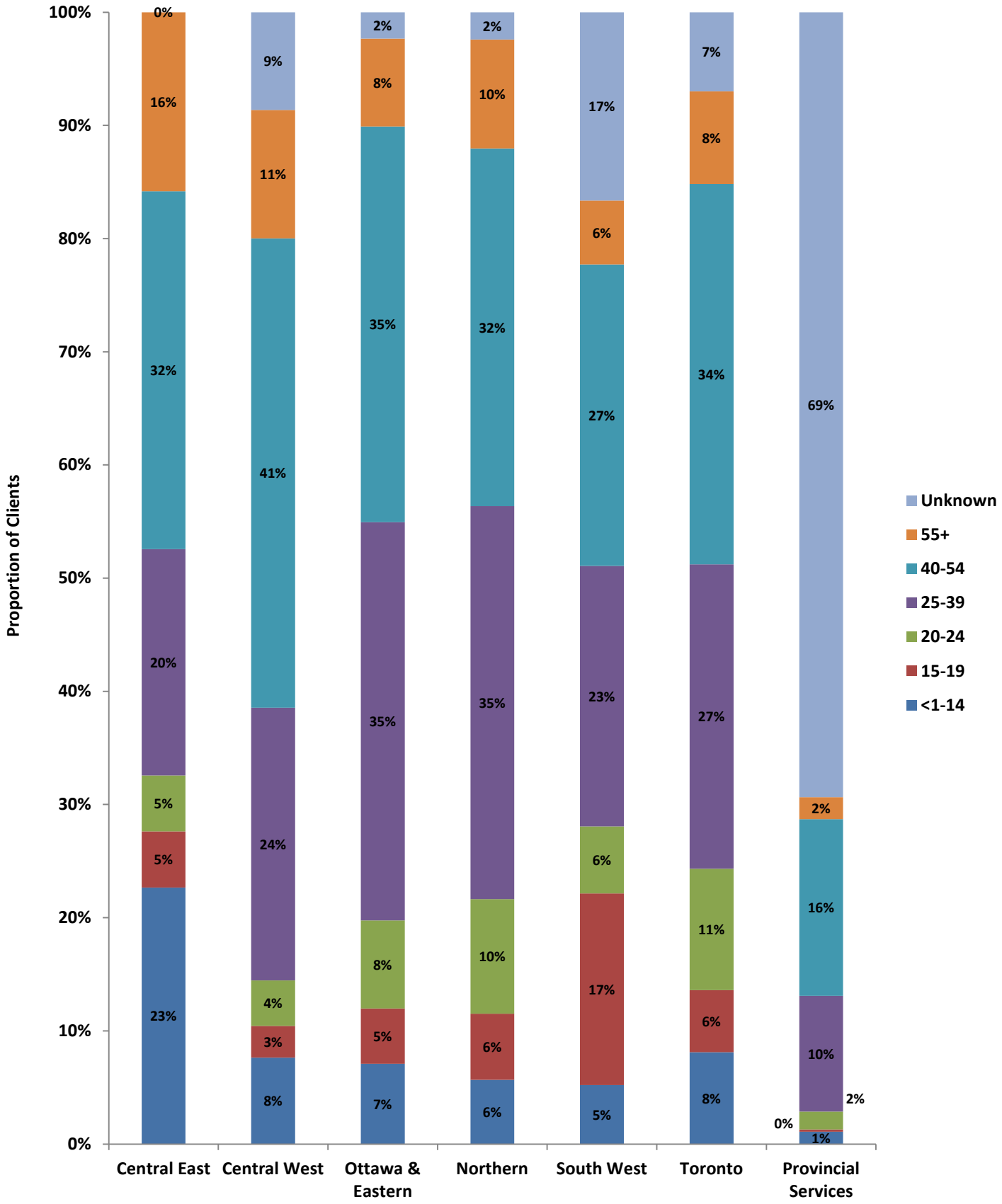
The people over age 25 accessing support services are much more likely than younger people to be living with HIV.

Figure 55
Number of Clients access Support Services by Client Type and Age: 2010/2011 H2



When we analyze the age of clients by region, we find that a larger proportion of clients in Central West and Central East regions are 40 years of age or older, compared to other regions.

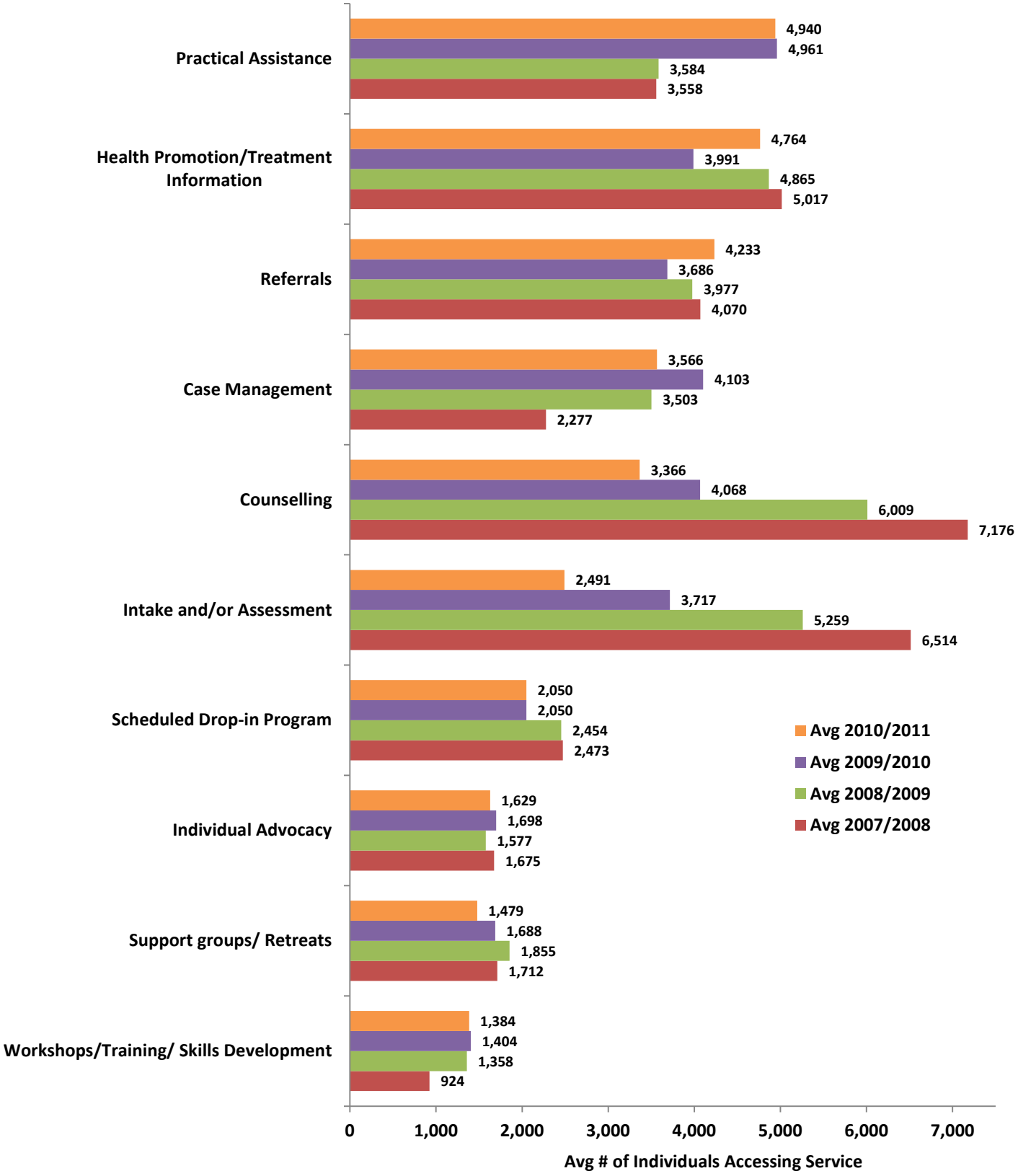
Figure 56
Proportion of Clients Accessing Support Service by Age and Region: H2 2010/11



5.2.4 PRACTICAL ASSISTANCE, HEALTH INFORMATION AND REFERRALS ARE MOST USED SERVICES

As Figure 57 illustrates, clients continue to turn to community-based programs mainly for practical assistance, information and referrals – followed by case management and counselling services.

Figure 57
Top 10 (Base on 2010/2011 Number) Support Services Provided

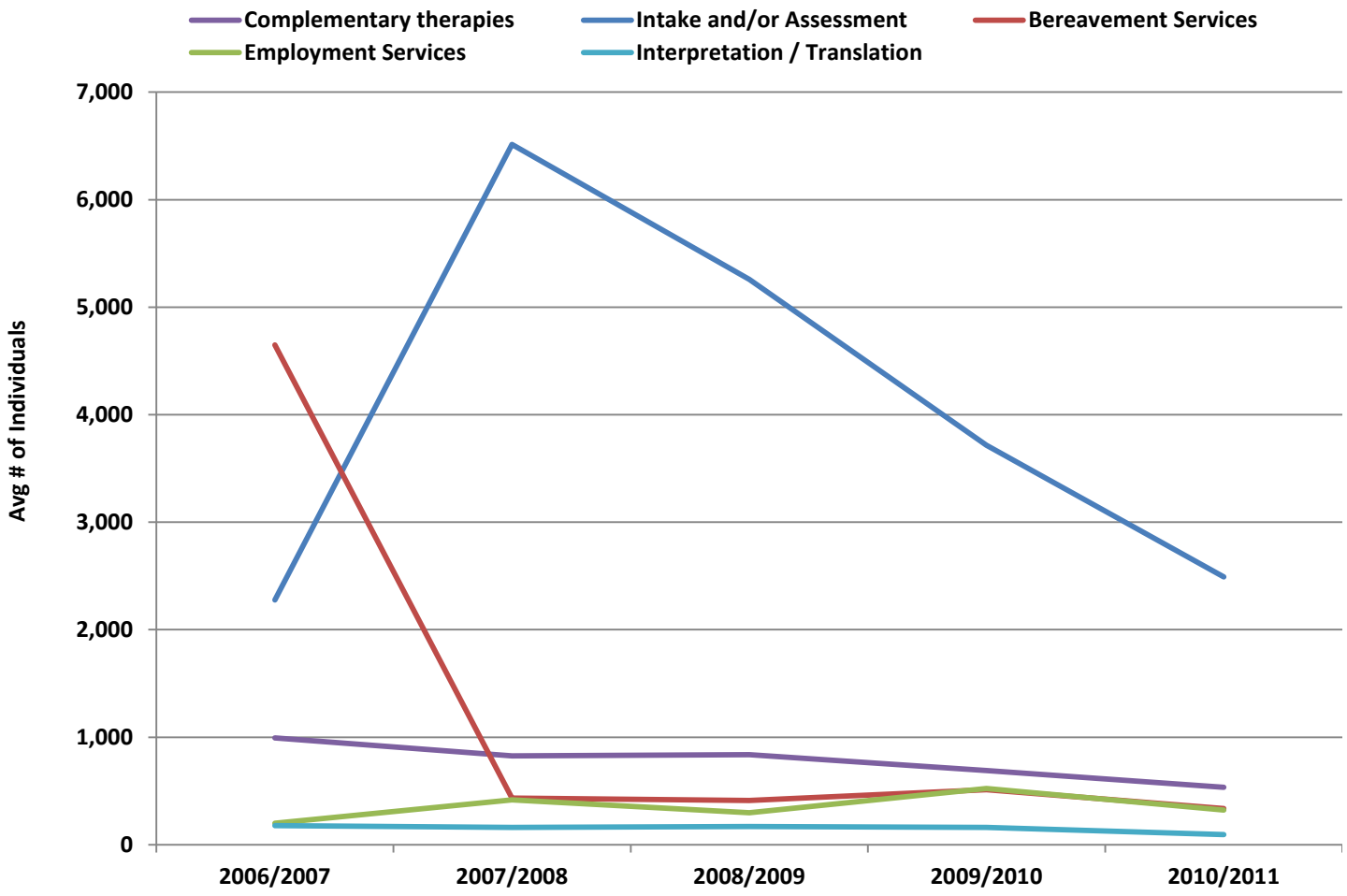


It was somewhat surprising to see a significant drop in intake and/or assessment services over the last year – particularly given the fact that 39% of clients were "new".

In terms of the actual number of clients using services, there was a drop in almost every category except health promotion/treatment information, referrals, settlement services and "other" services. (Note: services reported in the "other" category included activities such as arranging doctor's appointments, food programs and income tax clinics – many of which could have been captured in existing categories.) This likely reflects more accurate counting and recording of the number of clients using each service. However, it would be worthwhile investigating whether there are any capacity issues in the programs or whether clients are requesting/needing fewer services.

The five services that each decreased by 20% in 2010-11 were complementary therapies, intake and/or assessment, bereavement services, employment services and interpretation/translation services – although in terms of actual number of clients using the services, the only truly significant drops were in intake and/or assessment and bereavement services.

Figure 58
Support Services that Decreased between more than 20% between 2009/2010 and 2010/2011



ASOS FOCUS MORE ON PRACTICAL ASSISTANCE THAN NON-ASOS

There is a distinct difference in the types of services offered by ASOs compared to non-ASOs. ASOs are significantly more likely to provide practical assistance and case management services, while non-ASOs are more likely to provide information, referrals and drop-in services.

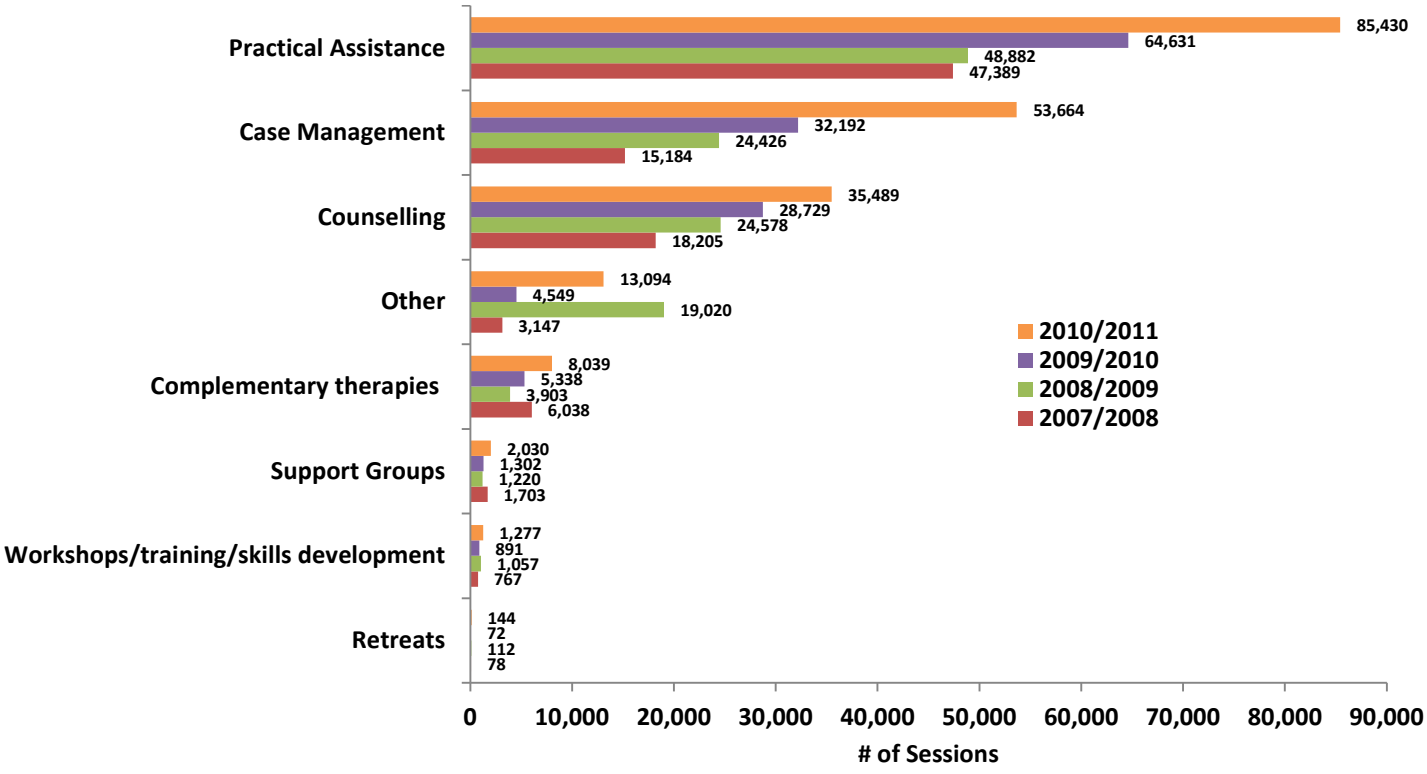
Figure 59
Proportion of Clients accessing Selected Services by Agency Type: 2010/2011 H2

Service	ASOs	CHC	Non ASO	Other Healthcare Institutions
Practical Assistance (e.g., accompany to appointments)	18.77%	0.56%	4.88%	6.54%
Health Promotion/Treatment Information	14.25%	37.42%	21.32%	10.90%
Referrals	12.05%	0.89%	18.71%	7.51%
Case Management	13.22%	1.11%	4.10%	5.08%
Counselling	9.24%	6.12%	12.31%	7.26%
Intake and/or Assessment	7.92%	12.25%	9.28%	1.94%
Scheduled Drop-in Program	5.69%	0.00%	15.12%	0.00%

FEWER CLIENTS USE MORE CASE MANAGEMENT AND COUNSELLING SESSIONS

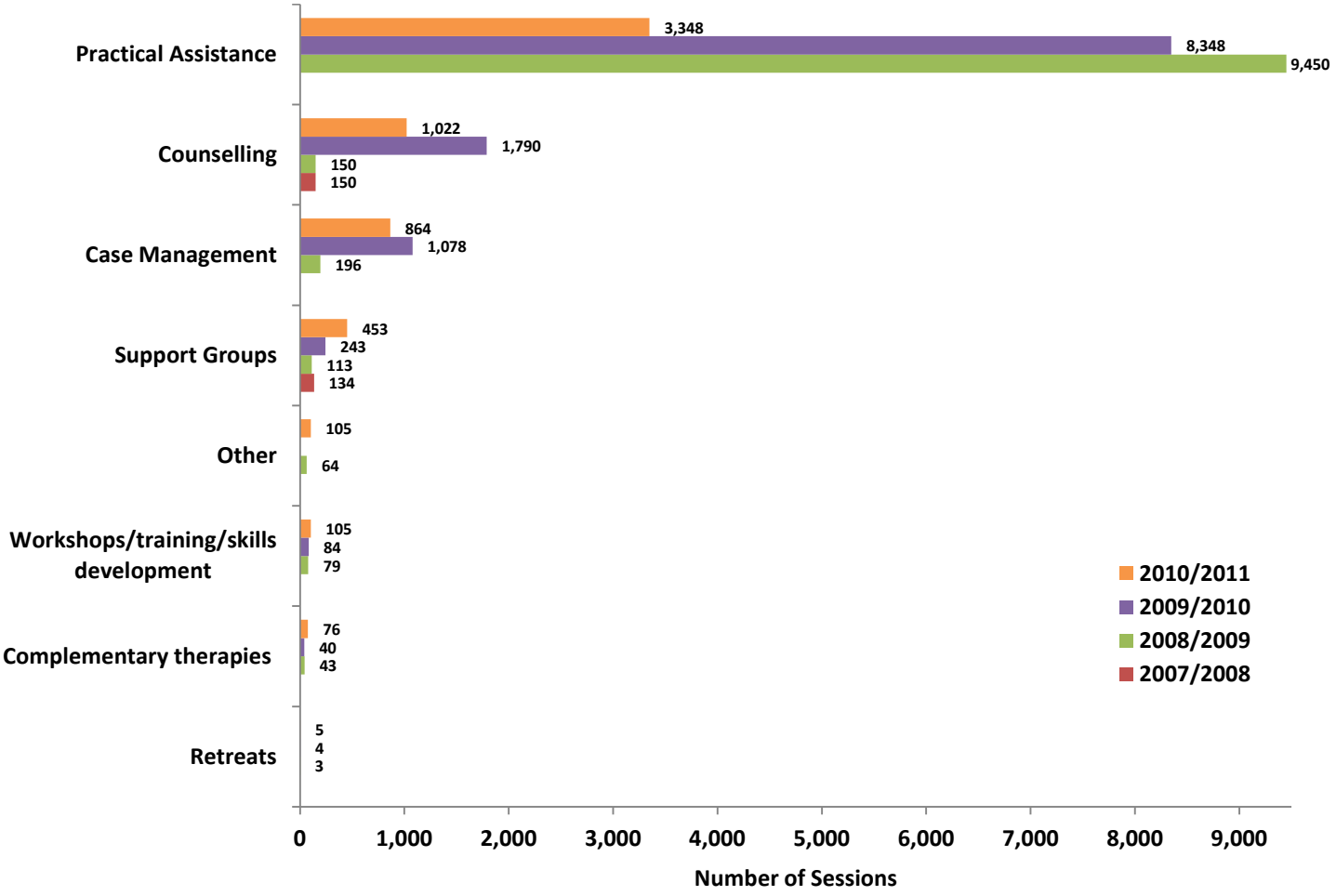
Although the total number of clients using services such as case management and counselling dropped in 2010-11, the actual number of sessions increased. Most of the increase in the number of case management sessions – in fact, 48% of all case management sessions -- can be attributed to three agencies and may be related to their model of service. It may also indicate that a small number of clients are resource intensive. The number of practical assistance sessions also increased significantly – mainly due to the reports from two organizations.

Figure 60
Number of Sessions Provided



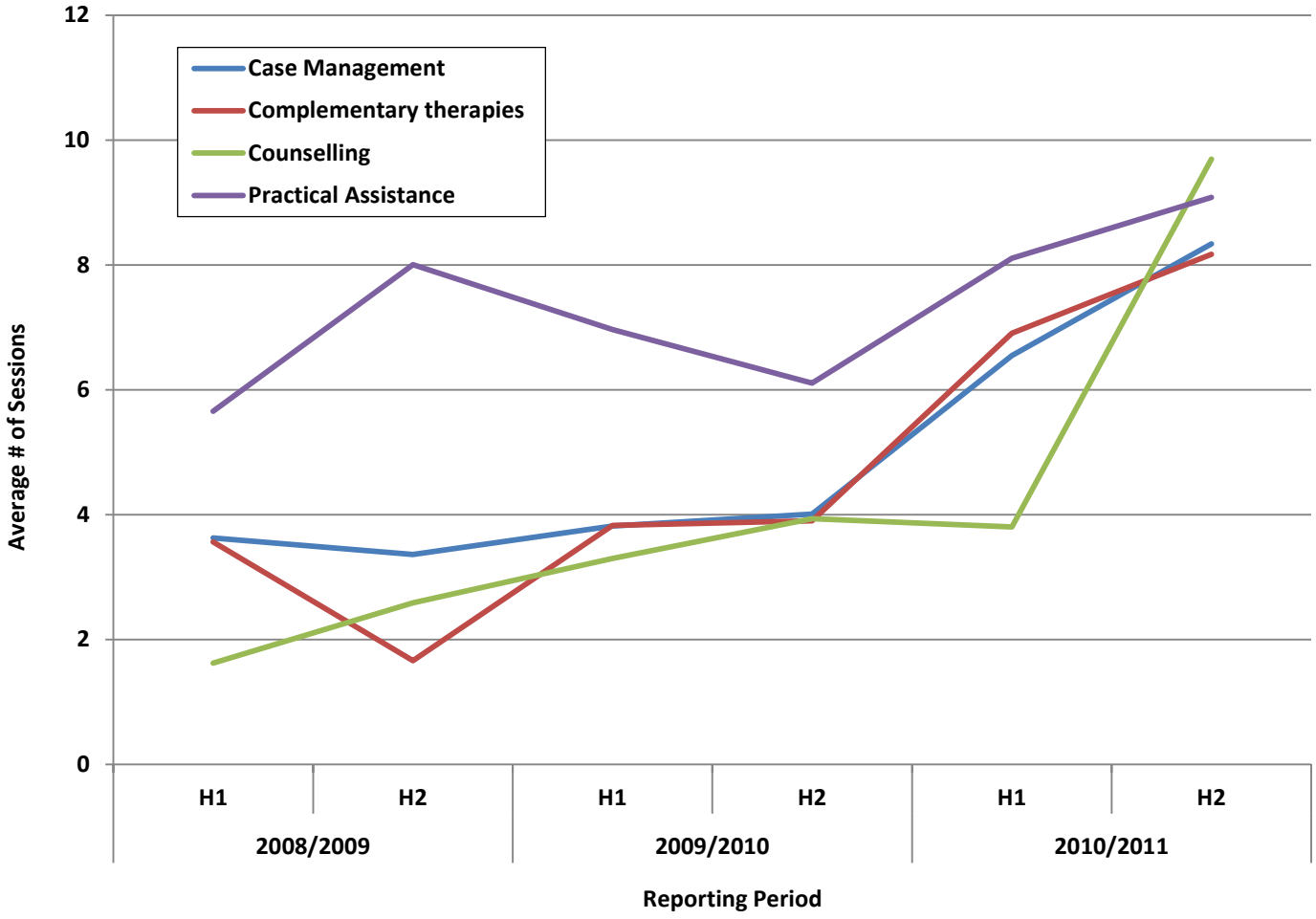
In 2010-11, ACAP-funded agencies reported providing fewer practical assistance and counselling services than in the past, but almost twice as many support groups.

Figure 61
Number of Sessions - ACAP



The number of sessions per client increased across the board. It would be interesting to know whether this change was based on specific client needs, better record keeping, or models of care or interventions being used by a small number of organizations.

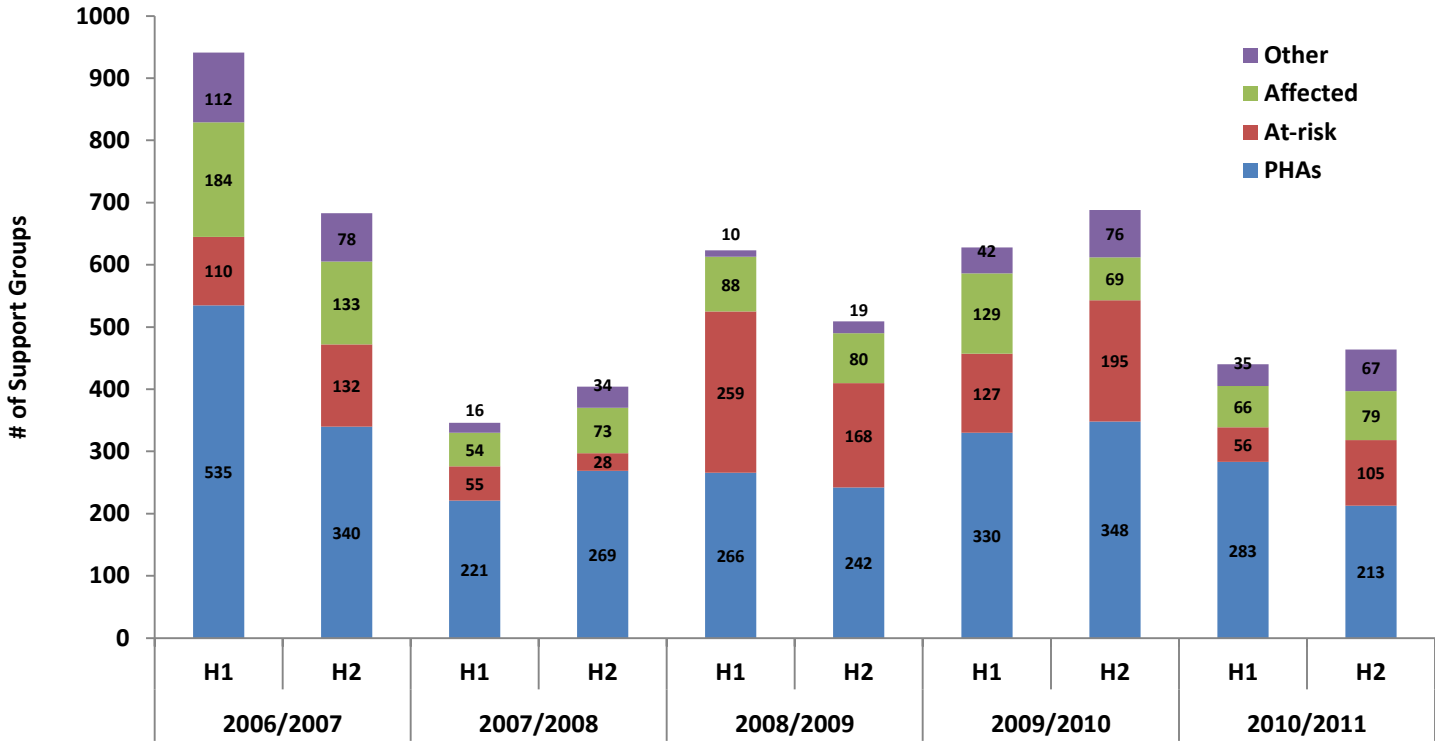
Figure 62
Average number of sessions per client for selected services



FEWER SUPPORT GROUPS IN 2010-11

With the exception of some ACAP-funded programs, organizations reported offering significantly fewer support groups for people living with and particularly for people at risk of HIV than in the previous year. It would be interesting to know whether this reflects a lack of interest on the part of clients in support groups, a change in client needs, a change in service models/definitions and/or a capacity issue on the part of the organizations.

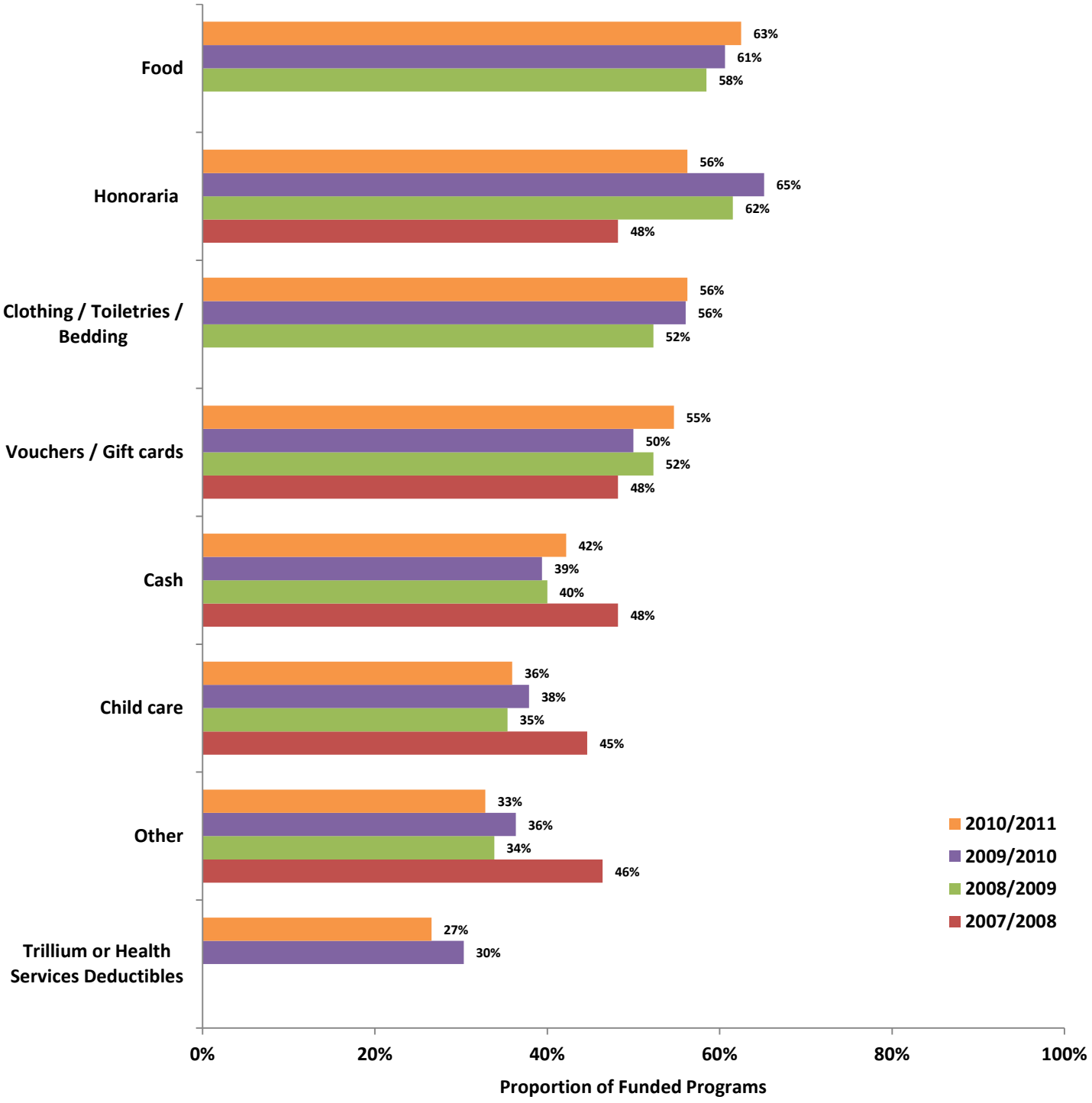
Figure 63
Number of Support Groups by Service User



5.2.5 FINANCIAL ASSISTANCE FOCUSES ON PRACTICAL NEEDS

Almost two-thirds of organizations reported providing financial assistance to help clients with one of the basic necessities of life – food – and over half provided money for items such as clothing, bedding and gift cards at stores where clients can get basic, practical items. One quarter of programs also provided financial assistance with health services or medications, which may indicate that other medical assistance funds are not fully meeting clients' needs, or that clients of these community-based programs experience barriers in accessing other medical assistance funds.

Figure 64
Types of Financial Assistance and In-Kind Provided



5.2.6 WHAT ARE THE TRENDS AND UNMET NEEDS IN SUPPORT SERVICES? HOW CAN WE RESPOND?

Support services gaps and needs vary across the province. However, some of the common gaps identified were: supports for aging clients, services to counter stigma, discrimination and social isolation, translation services and other services for newcomers, support for prisoners, supports for women – including trans women and women experiencing violence, and services for men who have sex with men. Agencies report that support services vary with age, with older clients more concerned about managing basic needs, other chronic conditions and financial needs while younger clients are looking for support around reproductive health, parents and relationships.

> *"We continue to see more and more older gay male PHAs who are long-term survivors."*

> *"Our client base is aging with the highest brackets being 40-55 and 55 and over. [We have] seen a steady increase [in clients] presenting with more long-term basic needs including financial concerns, mental health issues, as well as medical coverage concerns."*

> *"Issues surrounding aging and retirement for our poz clients continue to be a priority."*

> *"We continue to see an increased number of intakes with women and children, particularly women with histories of street involvement, substance use and mental health issues and women from African and Caribbean countries and their children."*

> *"New service users who have been newly diagnosed have been in the 60+ age range. This population has presented with unique challenges such as comorbid diagnoses (e.g., diabetes, physical disability, cardiac and lung disorders) and difficulty obtaining accessible and affordable housing, as well as accommodations that provide assisted living services."*

> *"We've experienced an 18% and a 17% increase in the number of women we are working with. We believe this is a result of two factors, the closure of [another agency] and the increased visibility of our agency."*

> *"Due to the economy we are seeing an increase in requests for financial assistance as well as requests for more social events to be put together."*

> *"The majority of the clients accessing our services are between 25 and 39 years old. This is an important consideration as many require support in the areas of reproductive health, parenting, sexual health and navigating relationships. Issues discussed with this age range were mostly around pregnancy, safer sex, condom use, the disclosure process and the criminalization of HIV non-disclosure."*

Strategies that programs are using to fill these gaps in services include: recruiting more volunteers who are living with HIV (GIPA), pursuing funding for new and expanded programs, building partnerships with other services including legal, immigration, settlement, mental health, addiction and palliative care services, developing multi-lingual resources, and expanding outreach and other services that reduce social isolation.

> *"Most of our clients are aging and … for most of the aging clients there are other illnesses to manage (e.g., diabetes, hypertension, arthritis). Their HIV is well managed but the other illnesses are not and so [there is a] need for more workshops and treatment information on how to manage/self care when you have other illnesses."*

> *"[We] successfully engaged more men to consistently attend workshops. This was largely due to the topics and whether or not they received support from their partners. We received positive feedback from their evaluations that the topics were informative and empowering. We have received requests to continue creating workshops on the same topics from deeper perspectives (e.g., how to disclose to your children)."*

> *"We have changed the method with which we connect with Aboriginal sex workers. As a result we have had three talking circles with high numbers of participants for a longer period of time."*

Agencies identified ongoing barriers to clients accessing support services:

> *"Clients in the 40 to 54 age group are mostly reluctant to access services partly because they have other cultural beliefs and taboos about HIV disclosure. They are also reluctant to discuss sex and sexuality as they feel that it is not appropriate at their age. Generally when they do identify areas for support, it is usually for emotional support related to living with HIV, disclosure of their status in current or new relationships and concerns about their health (e.g., long term care, medication, support)."*

5.3 INCREASING INDIVIDUAL, ORGANIZATIONAL AND COMMUNITY CAPACITY

One of the key expected outcomes of community-based HIV programming is enhancing the capacity of individuals, organizations and communities.

5.3.1 BUILDING INDIVIDUAL CAPACITY

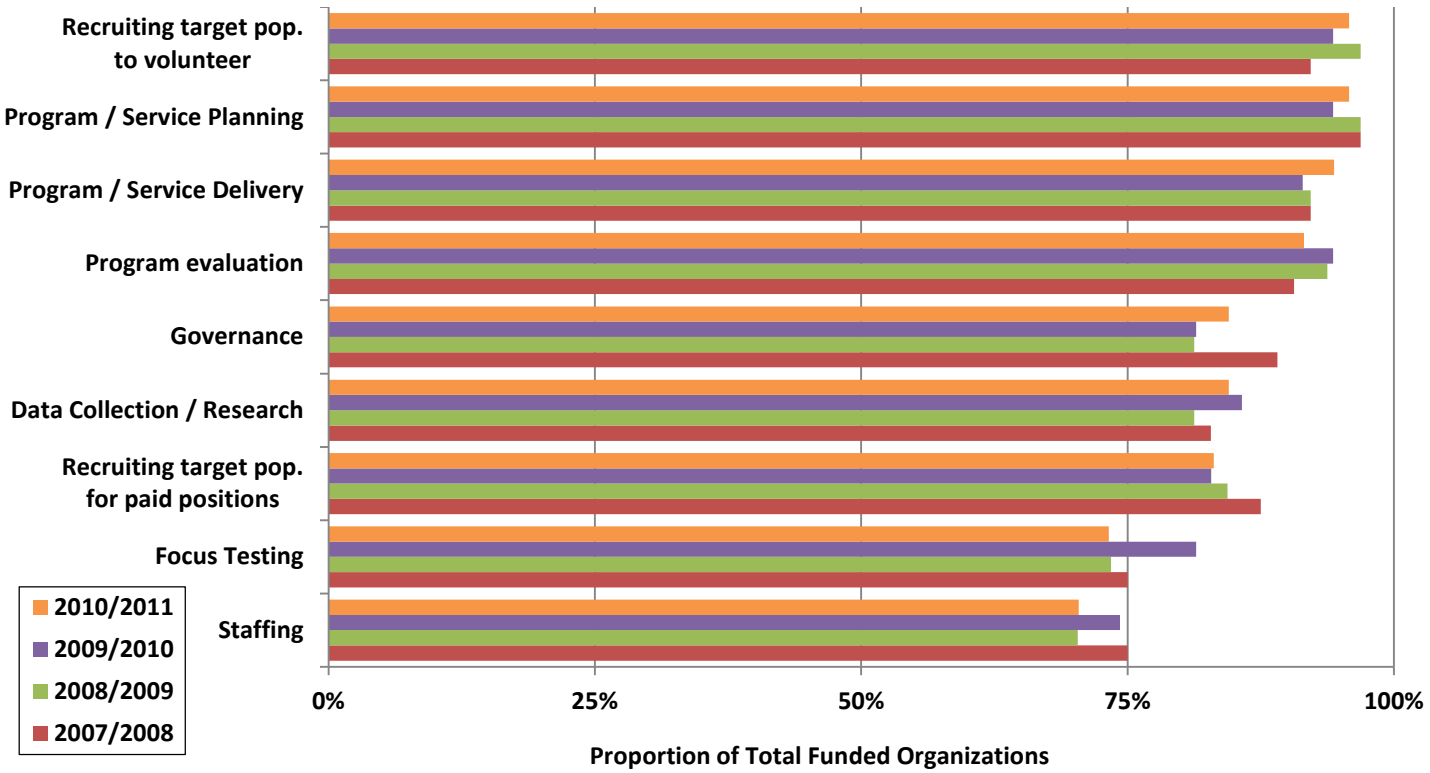
At the individual level, organizations work to build capacity of the people they serve, volunteers and staff.

ENGAGING PEOPLE WITH OR AT RISK OF HIV

Ontario HIV programs are committed to the greater involvement of people with HIV/AIDS (GIPA) and the more meaningful involvement of people with HIV/AIDS (MIPA). GIPA and MIPA strategies can enhance the capacity of people living with HIV to participate in their communities – which can improve their health and well-being and strengthen the capacity of those communities to respond to HIV. These strategies can also enhance the capacity of organizations to provide peer-led programming and to integrate PHAs and members of other target populations into all aspects of organizational management and program development.

Between 70 and 95% of organizations report that they actively try to involve members of their target populations in their work. The focus is still strongly on recruiting people to volunteer. Although between 80 and 90% of organizations report they recruit people with or at risk of HIV to paid positions, only about 70% report having a member of their target population on staff – down slightly from the previous year. Because OCHART just asks organizations whether or not they involve members of their target populations (i.e., a yes or no question), it is impossible to assess the extent or intensity of the involvement from this question. For example, one organization may employ just one person with HIV or just one person from a population at risk on an advisory committee while another may have several people on staff or serving on committees.

Figure 65
Organizations Reporting Involvement of Target Populations in Organizational Activities



Although organizations are committed to GIPA and MIPA, there are individual, social, environmental, organizational and broader systemic barriers that make it more challenging to involve people with or at risk of HIV. Barriers reported by programs to engaging and/or employing people with or at risk of HIV include: lack of training/skills, health circumstances (i.e., because of the episodic nature of HIV, some people are not able to work consistently), and financial circumstances (e.g., concerns about the impact of employment on individuals' ability to access disability benefits, based on current ODSP rules.

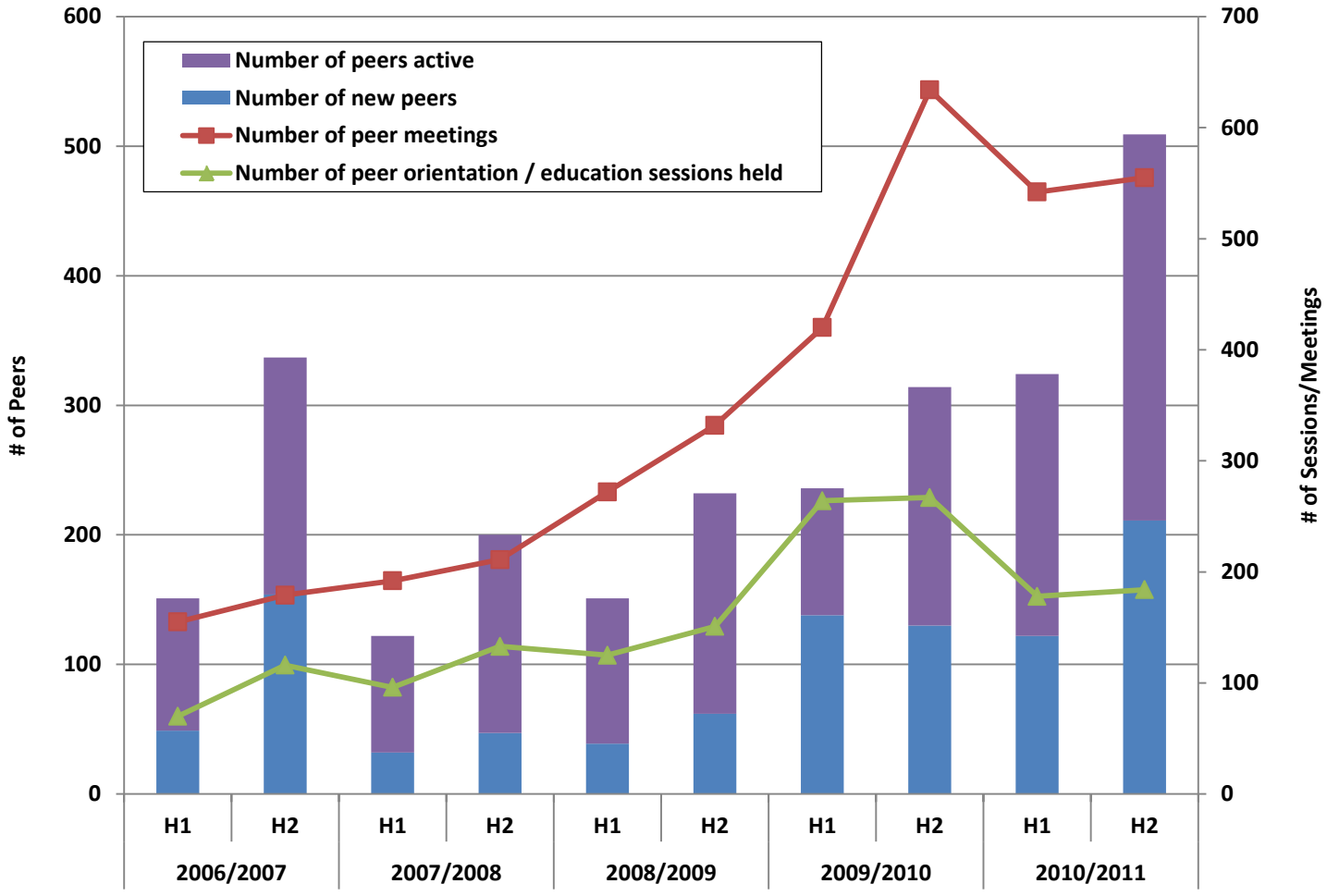
It is also important to note that GIPA and MIPA does not need to be confined to the HIV sector. Many people with HIV are leading full lives and choose to engage with the community in other ways, such as working, volunteering on boards of non-HIV agencies or pursuing other interests.

ENGAGING PEERS IN IDU OUTREACH

Ontario's IDU outreach programs promote a peer-based model, and actively engage peers in their activities. Peer involvement in IDU outreach can strengthen the leadership capacity of people who use substances, as individuals and as a community; it can also improve the capacity of IDU-serving agencies to connect with populations that can sometimes be difficult for service providers to reach.

Figure 66 illustrates that the number of peers involved increased significantly in the second half of 2010-11. This increase was across the board, not the result of changes in only one or two agencies. It also appears that the programs are retaining existing peers as well as attracting new peers.

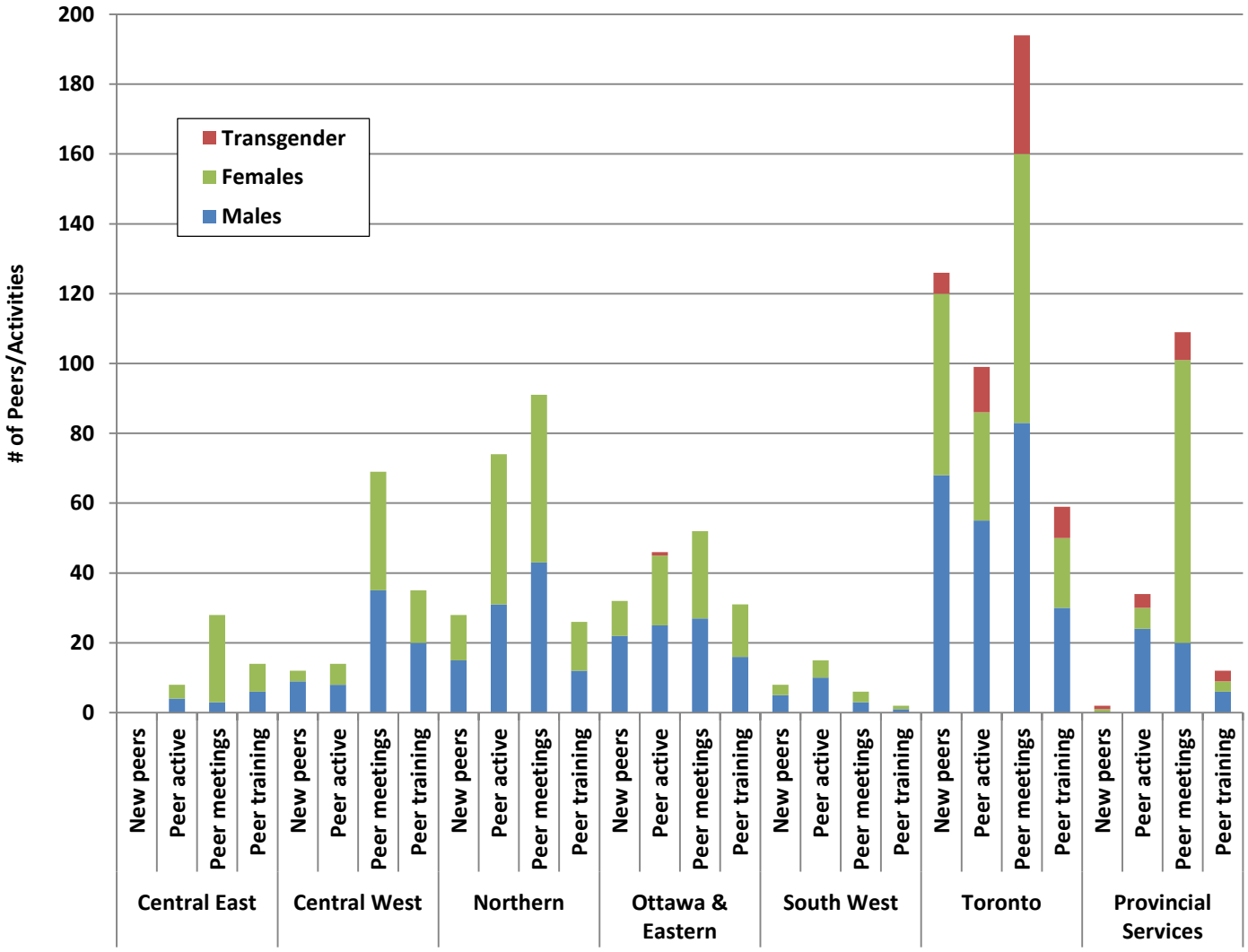
Figure 66
Peer Involvement



While 18 of the 36 programs that reported involving people who use substances account for 75% of the peers, 36 of the 38 programs report at least one peer. The size of an organization has an impact on the number of peers. For example, organizations with five or fewer staff tend to have on average five peers, while organizations with more than 20 staff have, on average, 17 peers.

Geography also has an impact on number of peers. Peers are highly concentrated in Toronto, and in regions that report high rates of substance use, including the Northern, Ottawa and Eastern, and South West regions. All regions except South West make heavy use of peer meetings as a way to manage and sustain their involvement.

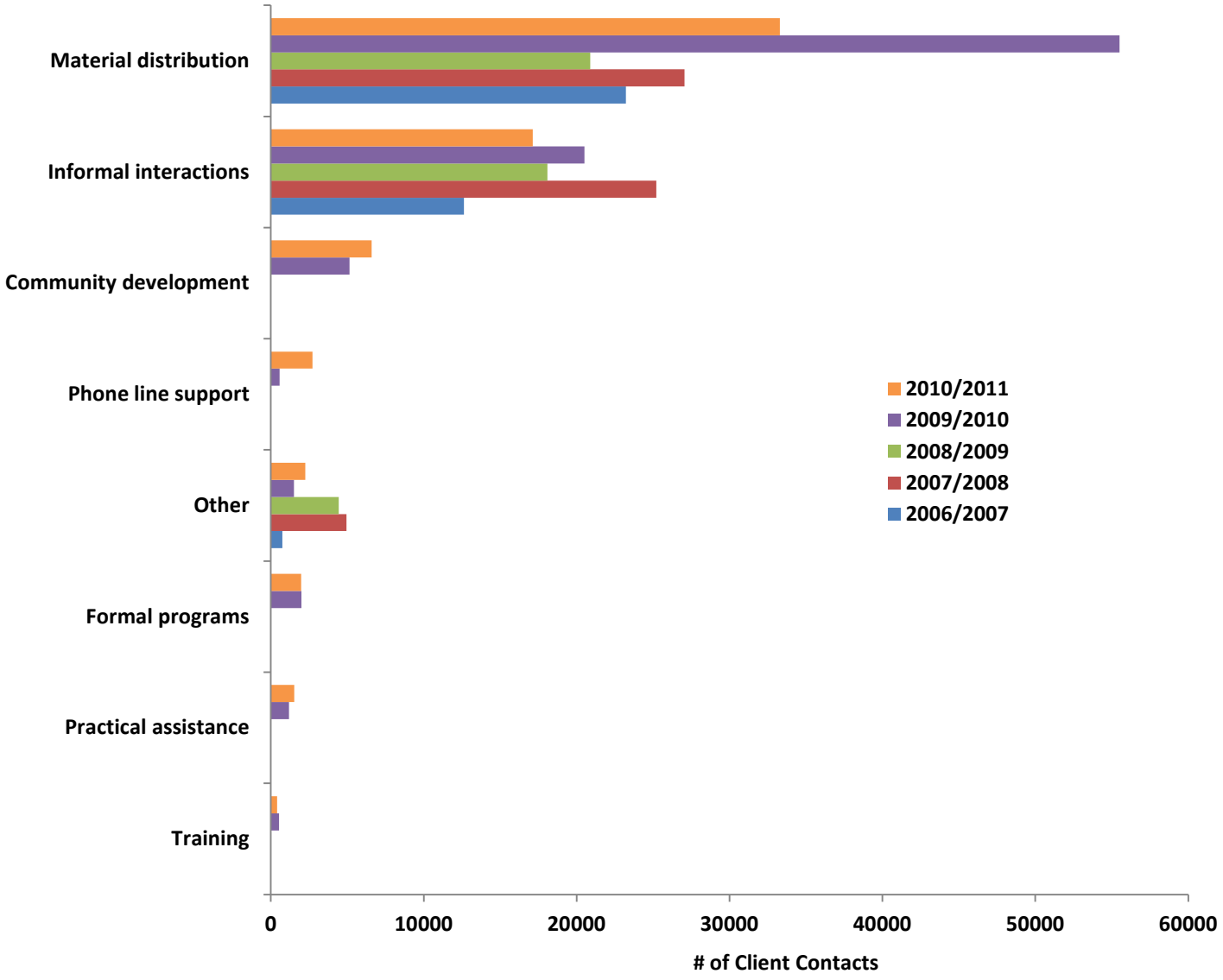
Figure 67
Peer Involvement by Region: 2010/2011 H2



IDU PEERS MORE INVOLVED IN FORMAL OUTREACH ACTIVITIES

The following chart illustrates trends in IDU peer outreach. It appears that peers are becoming more involved in organized outreach activities, such as community development, phone line support and practical assistance – rather than just being involved in informal interactions and distributing materials. This may indicate that peers are receiving the training and support to be involved in more meaningful ways with the work.

Figure 68
Number of Client Contacts Made by Peers by Activity



Eight of the 38 agencies involved in IDU outreach reported that peers did not distribute materials while 13 reported fewer than 100 peer contacts a year that involved distributing materials. At the other end of the spectrum, seven organizations reported their peers had over 800 contacts a year related to distributing materials.

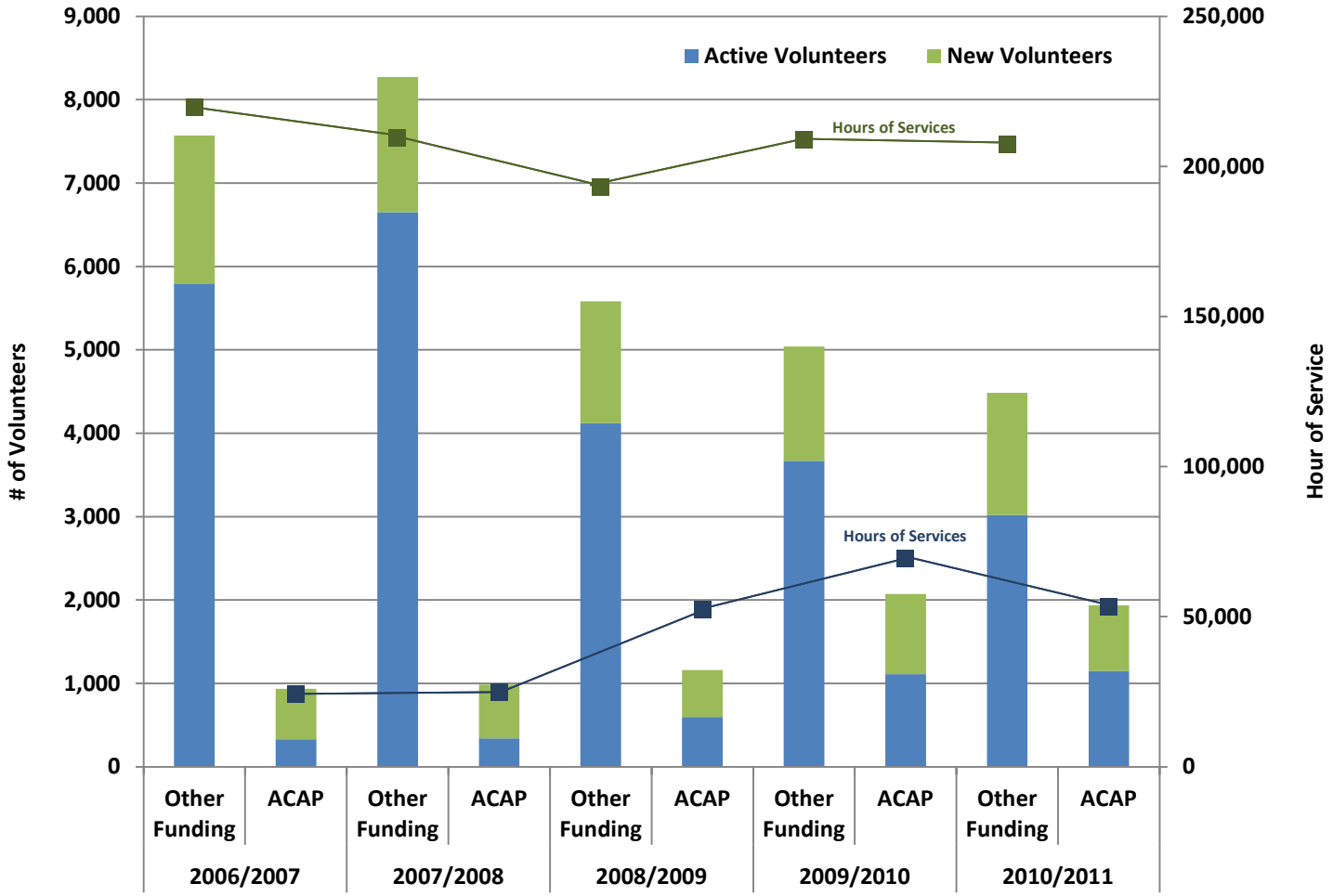
5.3.2 ATTRACTING AND RETAINING VOLUNTEERS

Community-based HIV programs continue to be highly dependent on volunteers. Volunteers play a crucial role in strengthening organizational capacity: their voluntary services represent time and labour that agencies would otherwise need to pay for or do without; their administrative, clerical, support and paraprofessional work can free the time of paid professional staff to provide specialized services directly to clients. As board members, they provide strategic vision, guidance and oversight that contributes to organizational stability. Volunteer contributions improve the reach of agencies, and help reduce the cost of program administration, management and delivery. In 2010-11, community-based HIV programs benefited from the equivalent of 222,223 volunteer hours or approximately $4,605,878 worth of service (see Appendix E for the template for the calculation). ACAP recognizes the important role that volunteers play by providing funding to some organizations specifically to support volunteer programs.

DROP IN VOLUNTEERS

In 2010-11, organizations reported fewer volunteers than in the previous four years, and fewer volunteer hours of service. In general, almost all organizations reported a drop in existing volunteers – although a significant part of the change was due to one organization that reported 535 fewer volunteers in this reporting year, which appears to be due to a combination of an actual drop and reporting errors in the previous years.

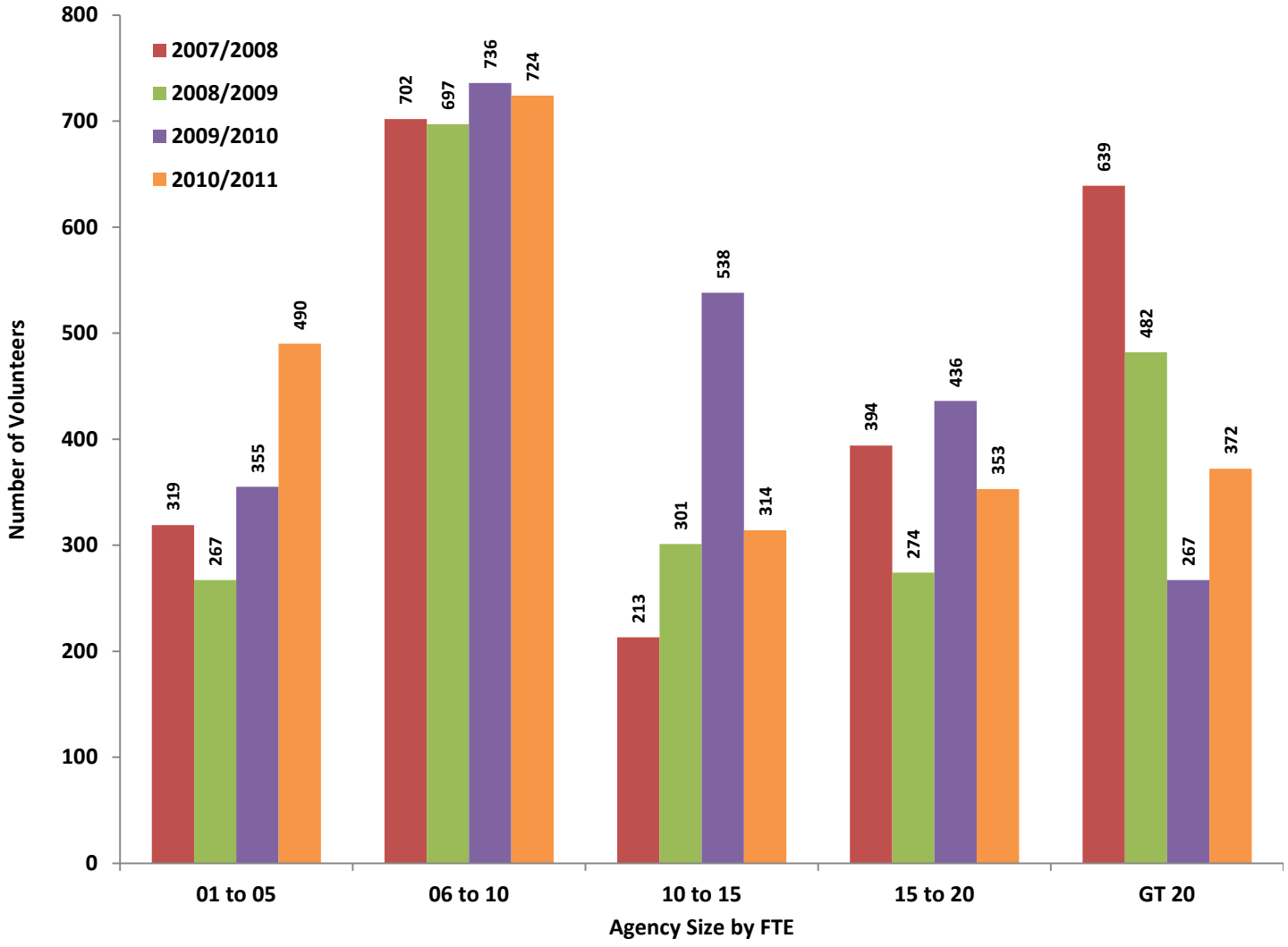
Figure 69
Volunteers (Total New and Avg Active) and Hours of Service: ACAP and Other Funding



The data reinforce the need to continually recruit new volunteers. For example, one of the largest organizations in the province lost 374 of its active volunteers in 2009-10, but was able to recruit 266 new volunteers, which helped offset the loss. Four programs across the province – two in Toronto, one in Central East and one in South West -- were able attract over 100 new volunteers in 2010.

Although the actual total number of volunteers dropped by 14% in 2010-11, the number of hours of services declined by only 6%. This translates to an average of 40 hours per volunteer per year compared to 37 in 2009-10. It appears that fewer people are doing more work. This may indicate that organizations are involving a smaller number of volunteers in activities that are of greater interest to the volunteers so they are willing to give more time. This shift may have implications for volunteer programs over the longer term.

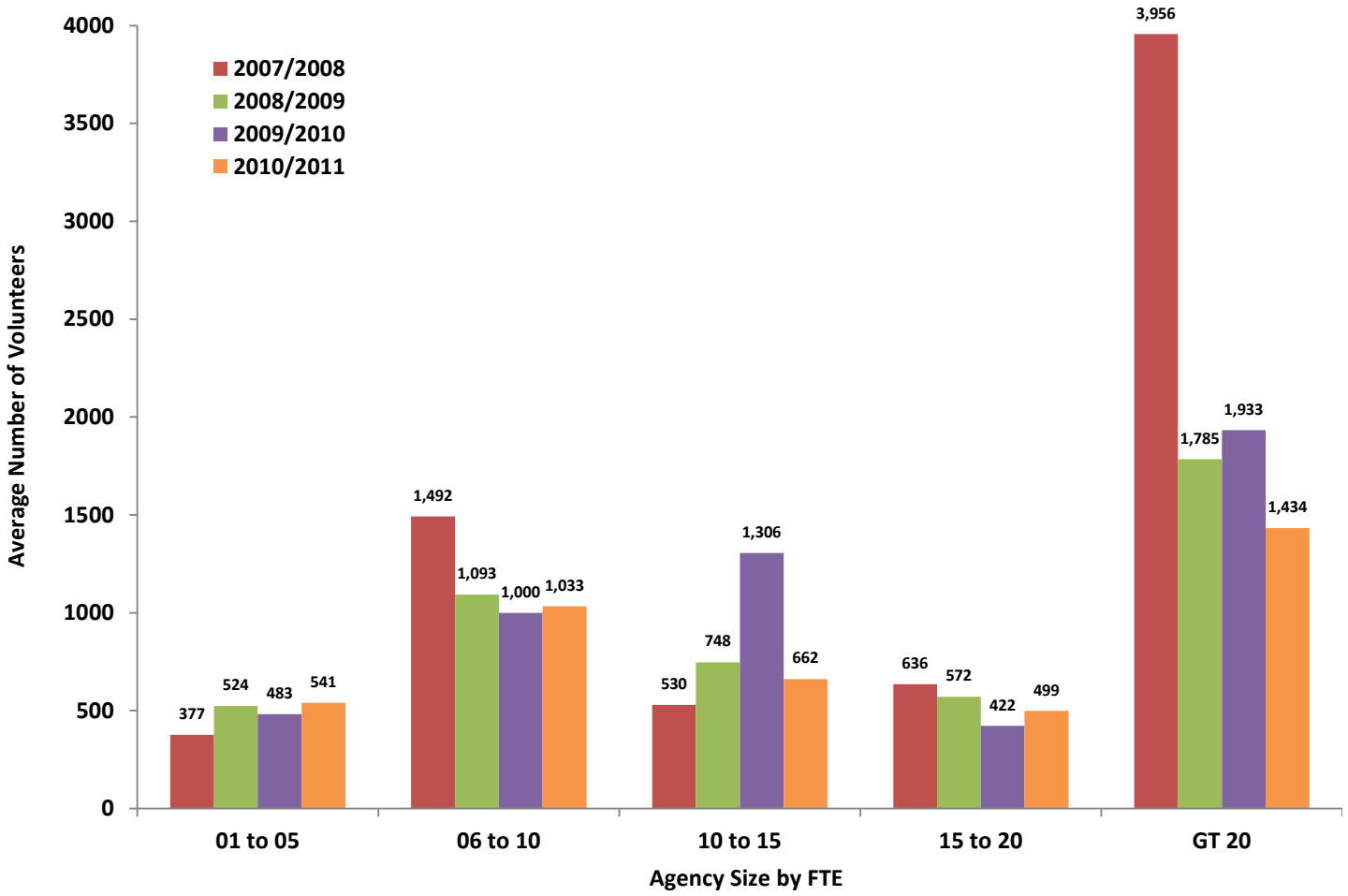
Figure 70
New Volunteers Recruited by Agency Size



SMALLER AGENCIES BETTER AT RECRUITING AND RETAINING VOLUNTEERS

In terms of size, smaller organizations (<15 FTEs) appear to be more consistent in their ability to attract new volunteers over time (Figure 70) and to retain a high proportion of volunteers to staff (compared to larger organizations). This may be due to the fact that smaller organizations have a wider range of opportunities for volunteers, are much more dependent on volunteers to do their work or are able to develop stronger relationships with their volunteers, which leads to great volunteer commitment.

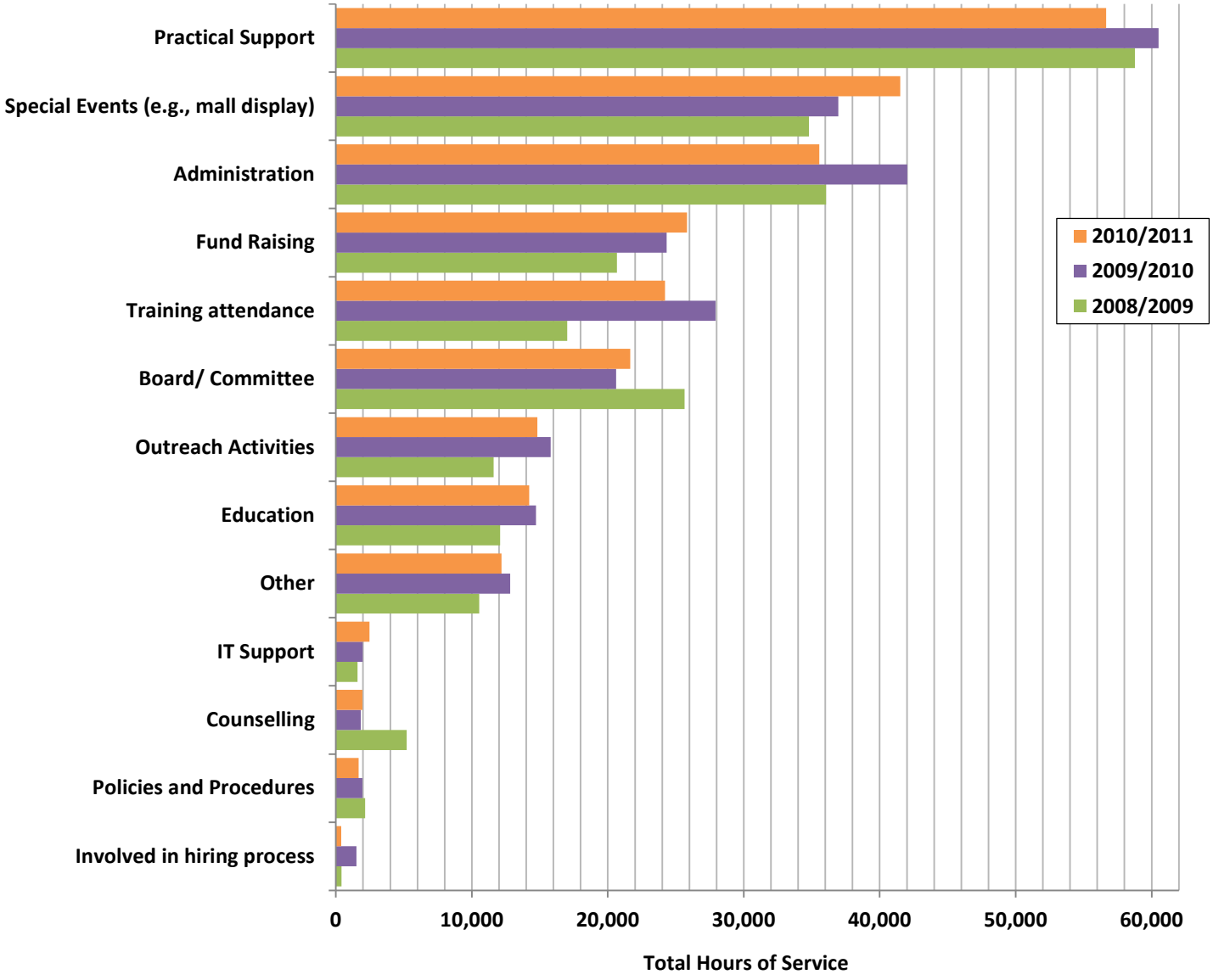
Figure 71
Average Number of Active Volunteers by Agency Size by Fiscal Year



VOLUNTEERS PLAY KEY ROLE IN PRACTICAL SUPPORT, SPECIAL EVENTS, ADMIN AND FUND RAISING

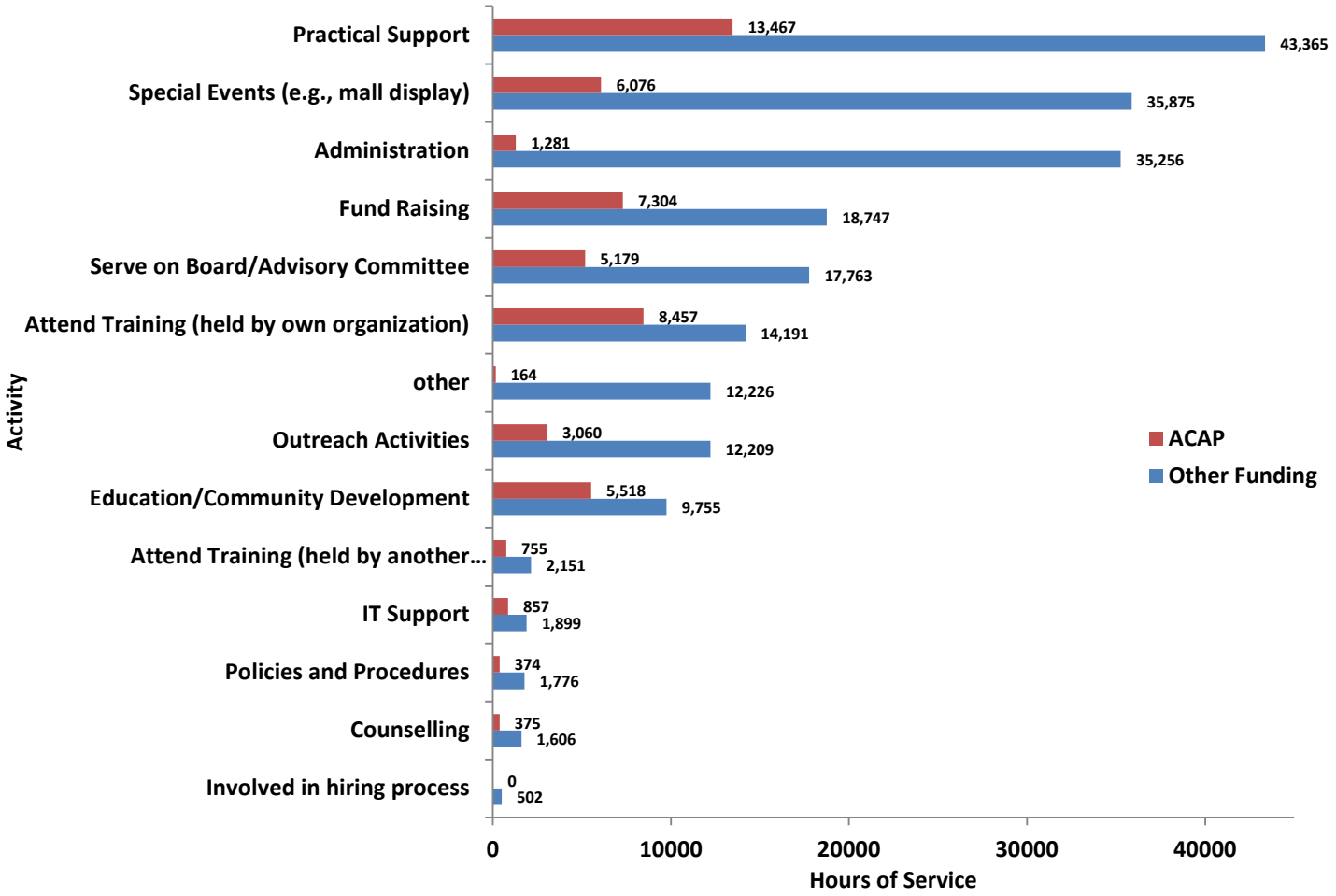
Volunteers provide practical support and assist with special events, administration and fund raising. In 2010-11, three organizations accounted for almost 38% of the total volunteer hours for practical support. The increase in volunteer hours for special events was driven almost entirely by one event organized by one organization, which accounted for 75% of total special event volunteer hours.

Figure 72
Volunteer Activities and Hours of Service: Other Funding



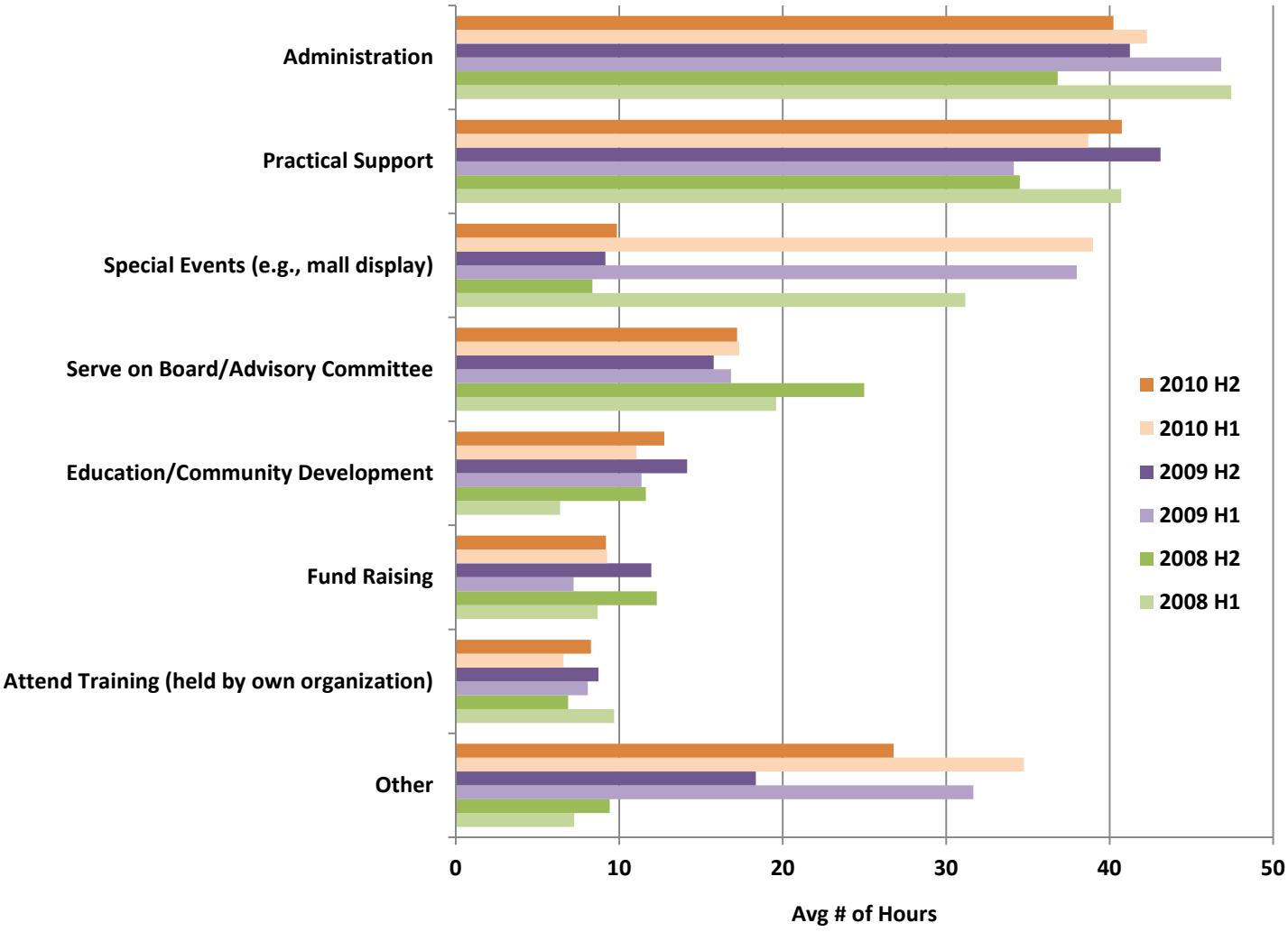
Comparing volunteer activities between ACAP-funded and other organizations, it appears that volunteers in ACAP-funded programs are more likely to be involved in education and community development and less likely to take on administrative roles.

Figure 73
Total Volunteer Hours by Funding Source: 2010/2011



In terms of time, the average number of hours that volunteers spend on different activities has shifted significantly, with volunteers spending fewer hours on practical support and more on fundraising. This may be due, in part, to better systems to track volunteer hours and to a renewed focus on fundraising.

Figure 74
Average Service Hours per Volunteer

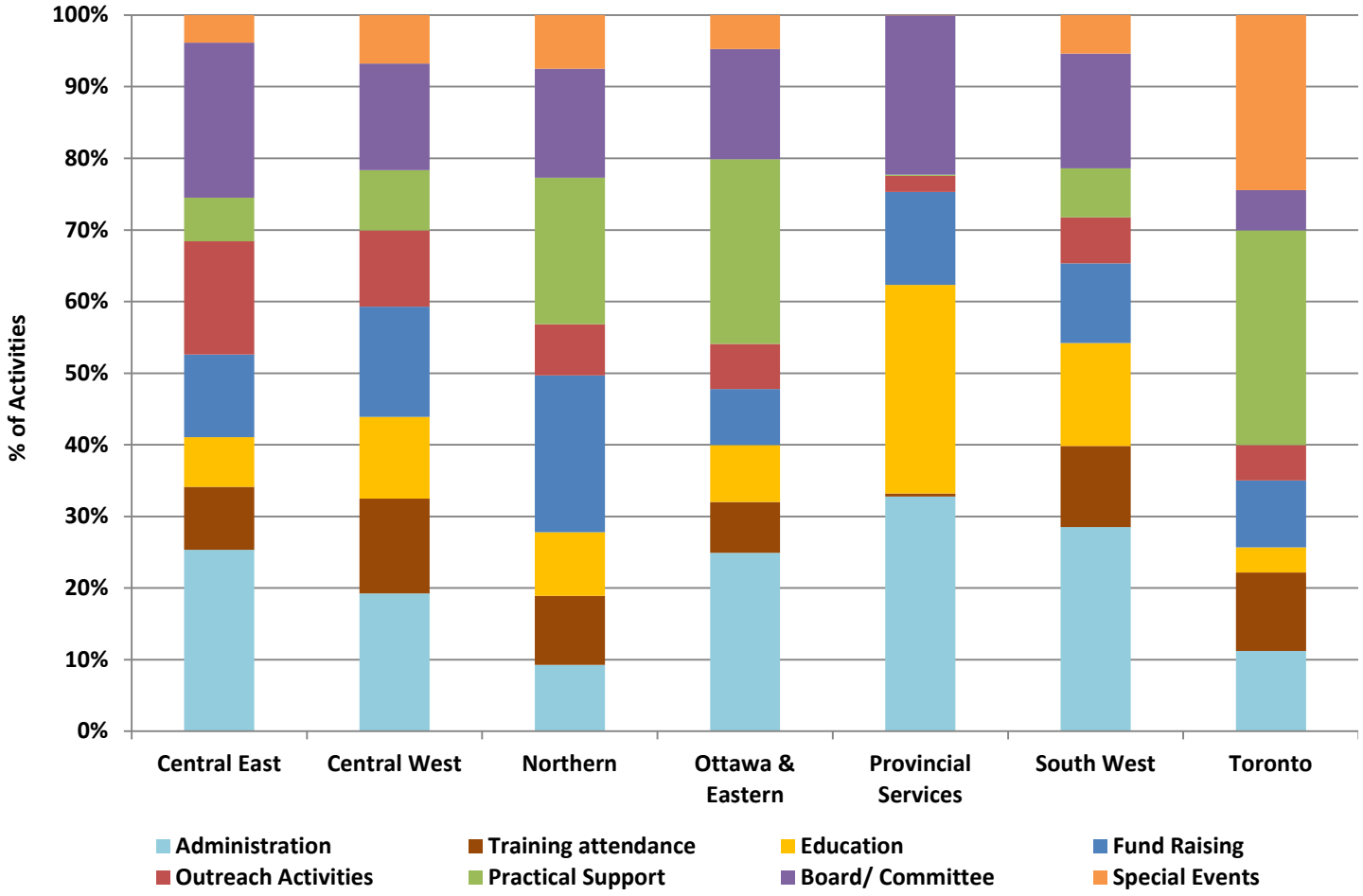


In terms of size of agency, volunteers in smaller organizations (<10 staff) spend more hours serving on boards and committees, administration and fund raising (i.e., around 50% of their time) than they do on practical support and other activities, while those who volunteer with larger organizations spend more hours (i.e., 75% of their time) on practical support and fund raising. This may be due to the fact that smaller organizations have, in general, fewer clients and therefore may require more help with administrative tasks than services.

REGIONS DIFFER IN USING VOLUNTEERS

As the following regional graphs illustrate, three parts of the province – Toronto, Ottawa and the Eastern Region and Northern Ontario – are much more likely to engage volunteers in providing practical support than other regions. In Toronto and Ottawa, this trend may be due simply to the number of people with HIV who are long-term survivors being supported in those regions. In the North, it may be due to close working relationships between the ASOs and the clinics, as well as the lack of other services in their communities or the complex needs of the population there.

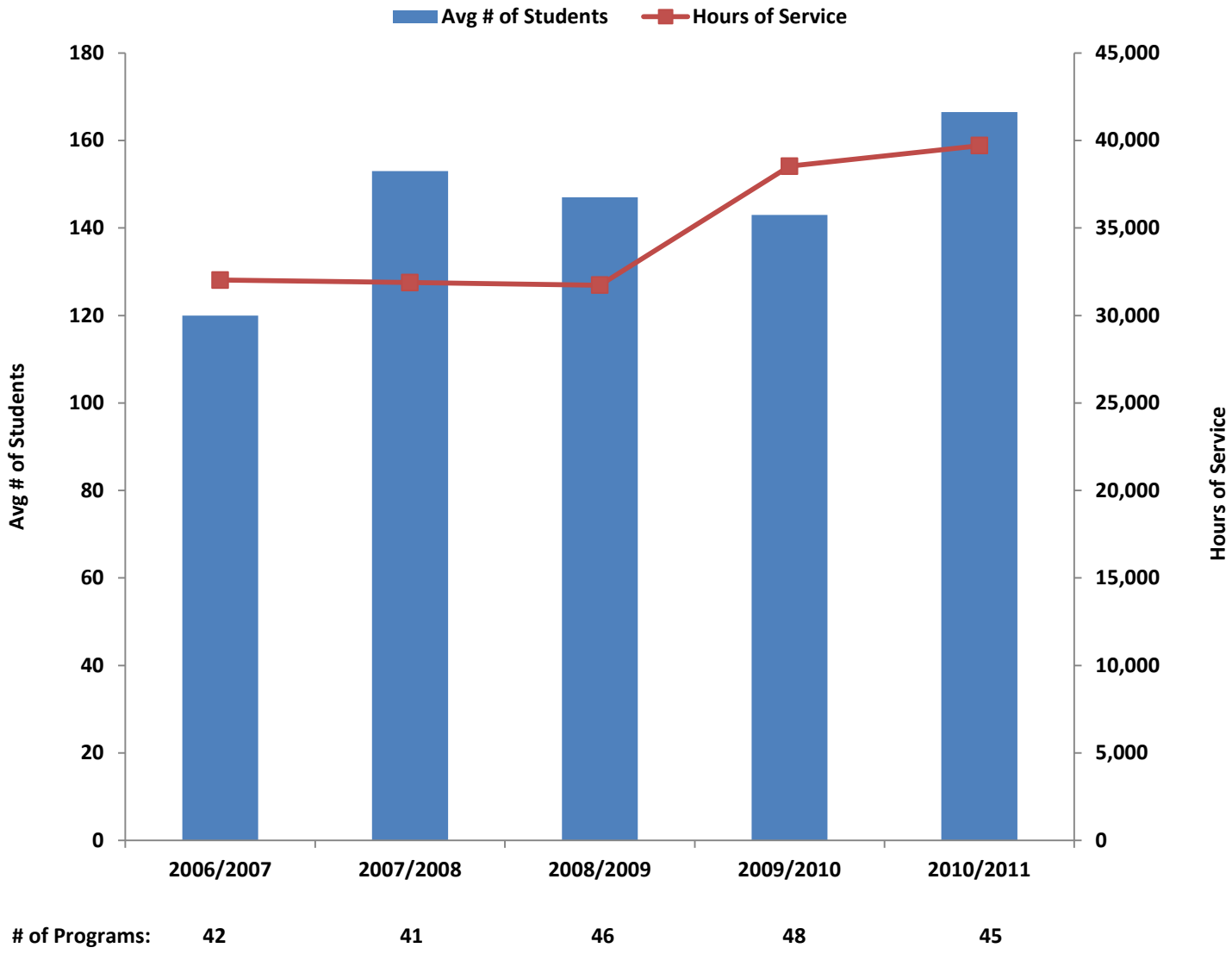
Figure 75
Selected Volunteer Activities and Hours of Service by Region: 2010/2011



5.3.3 MORE STUDENTS: MORE HOURS

Organizations reported having more students doing placements and those students are providing more hours of service. In general, the same number of organizations reported using students as in the previous year, but they have more students. This may indicate that once organizations develop the capacity to take on and support students, they see the benefits and are willing to provide more student placements.

Figure 76
Student Placements



Organizations deploy student volunteers in different ways. Smaller organizations are more likely to use students to assist with education and community development, administration and special events while larger organizations are more likely to use students to help with practical support and outreach programs.

5.3.4 IMPROVING VOLUNTEER RECRUITMENT AND RETENTION: WHAT WORKS?

TRENDS IN VOLUNTEERS

In their comments in OCHART, agencies reinforced the volunteer trends discussed above: more students and more newcomers volunteering.

> *"We are seeing students applying for placements from more varied programs than in past reporting periods, (e.g., addictions and mental health counselling, community service worker, extended language training programs, marketing and public relations). We are also receiving more referrals from agencies that serve New Canadians who have high levels of skill, but lack Canadian work experience."*

> *"We are seeing an influx of professional newcomers especially females who are interested in volunteering opportunities within the agency."*

> *"We have noted an increased interest within our youth involvement with programming and fundraising."*

VOLUNTEER STRATEGIES

Recruiting and retaining volunteers – particularly volunteers with the right skills -- is an ongoing challenge. Programs are particularly aware that they must continually improve their capacity to recruit and retain volunteers -- including people living with HIV -- from ethnocultural communities.

The strategies that appear to be effective in recruiting volunteers include:

- more outreach to potential volunteers
- mentoring programs for volunteers
- more meaningful and independent projects for volunteers
- targeting volunteers with specific skills
- providing training opportunities for volunteers.

> *"Staff are requesting volunteers with specific experience and skill sets (e.g., graphic design, policy and procedure creation, mobile app. creation)."*

> *"Staff are tailoring volunteer assignments based on skill sets and expertise of volunteers, calling on them on a project basis (graphic artists, writers, researchers, translators) to assist teams in achieving their mission."*

A number of agencies reinforced the key role of the volunteer coordinator:

> *"Having a full-time Volunteer Coordinator on staff has led to staff thinking more about how they can make use of volunteers in their programs."*

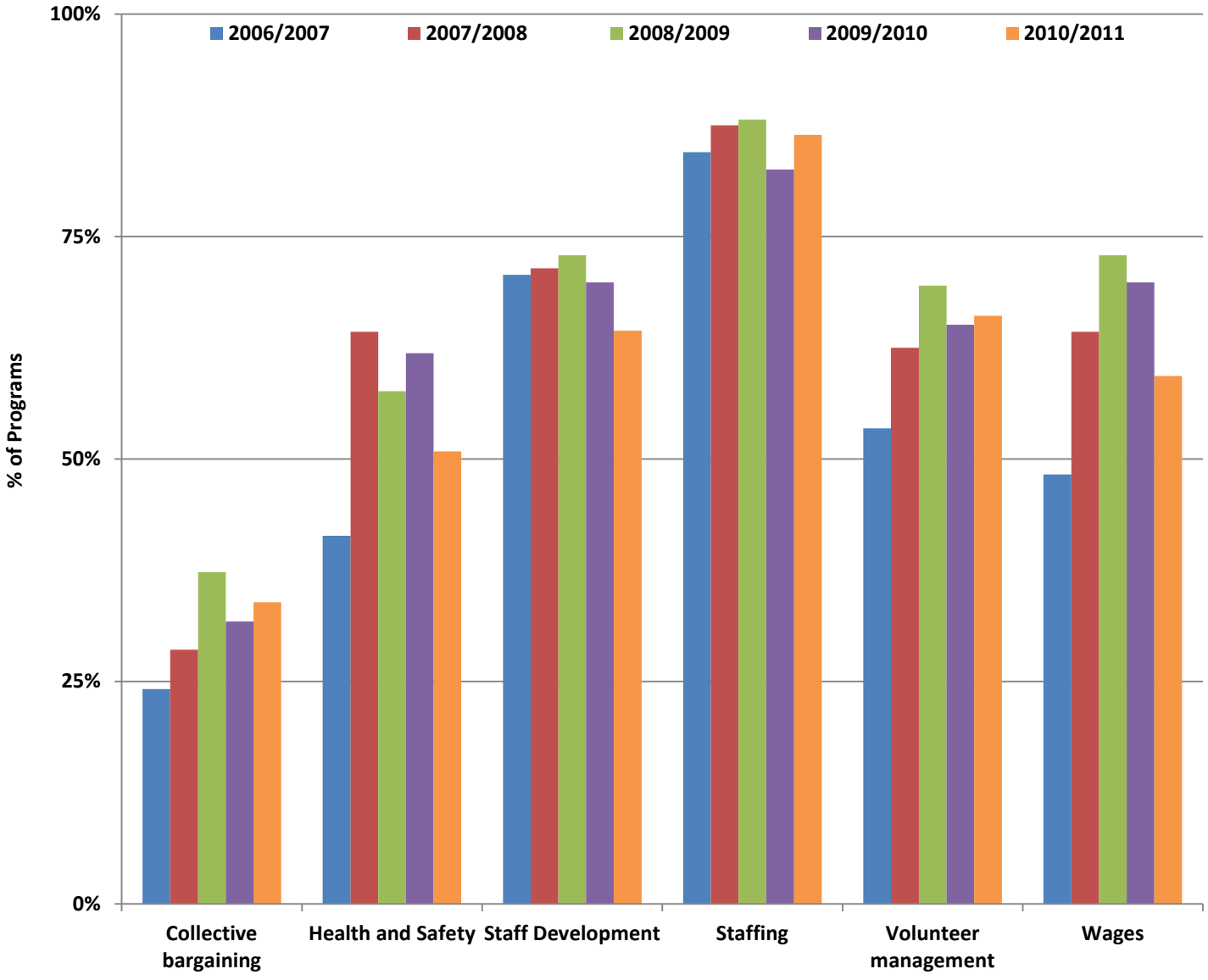
> *"We continue to see a number of individuals who want to volunteer at [our agency] in many capacities. This has been due to the re-organizing and the new volunteer co-ordinator."*

> *"There are a growing number of women from our targeted populations interested in volunteering or doing their student placement at [our agency]. Since we don't have a volunteer coordinator, we are unable to meet this growing demand."*

5.3.5 ENHANCING STAFF SKILLS AND RETENTION

When asked about key human resource (HR) challenges, organizations consistently identify staffing and staff development. In terms of HR, the sector is a mix of very long-term employees with newer/younger people who tend not to stay as long. Because of its active volunteer programs, the sector is often a "first" employer for newcomers and others who use the experience they gain in ASOs to pursue careers in other parts of the health and social service system. Retention continues to be an issue because wages in this sector -- like those in the community mental health sector -- lag behind those in other parts of the health care system (e.g., community health centres). All of this can affect organizational capacity.

Figure 77
Organizational Human Resource Issues



In 2010-11, organizations identified the following HR issues and trends. As part of their efforts to improve services and retain employees, organizations are actively involved in staff training. As Figure 78 illustrates, a growing number of staff participate in types of training that can help staff work well in increasingly flexible work environments, such as team building, change management and computer training. (Note: two CHCs accounted for most of the team building training.) Training also seems to focus on health and safety issues, on skills that staff need to respond effectively to clients' complex needs including crisis prevention, addictions, violence, hepatitis C and mental health, and on the need for culturally competent care (e.g., diversity and anti-oppression).

Figure 78
Selected Types of Training Offered to Staff

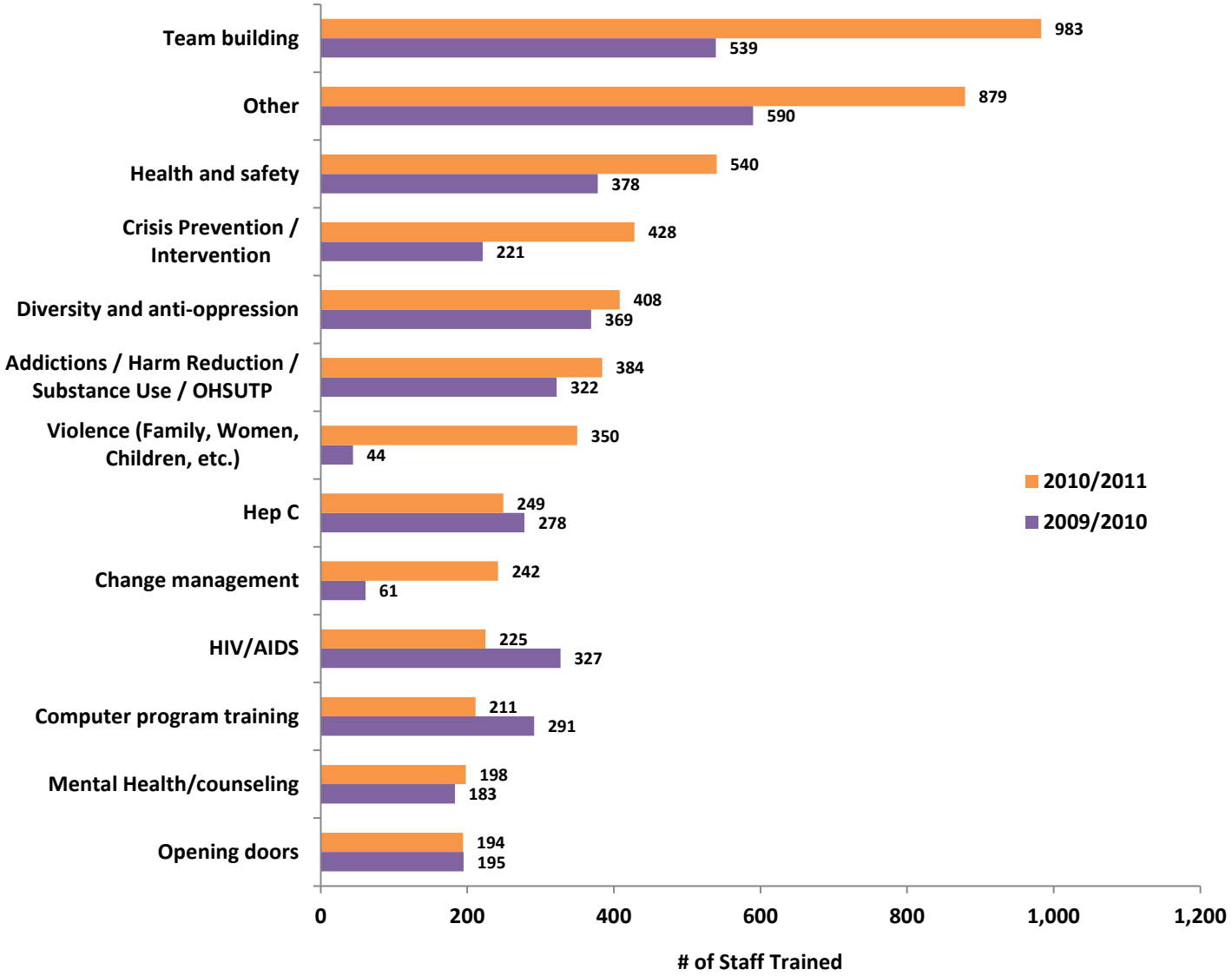


Figure 79 shows the top 10 training topics by size of agency; the coloured cells represent the top five.

Figure 79
Top 10 Training Topics by Size of Agency

01 to 05	06 to 10	10 to 15	15 to 20	GT 20
Team building	Team building	Team building	Team building	Crisis Prevention/ Intervention
Diversity and anti-oppression	Addictions / harm reduction / substance use / OHSUTP	Grief and loss	Crisis Prevention/ Intervention	Health and safety
Violence (family, women, children, etc.)	Health and safety	Health and safety	Addictions / harm reduction / substance use / OHSUTP	Addictions / harm reduction / substance use / OHSUTP
Health and safety	OAN Skills Building	Opening doors	Diversity and anti-oppression	Violence (family, women, children, etc.)
Change management	Opening doors	Violence (family, women, children, etc.)	Change management	Diversity and anti-oppression
Hep C	Computer program training	Computer program training	Health and safety	Computer program training
LGBTQ-Homophobia	Crisis Prevention/ Intervention	Diversity and anti-oppression	Disclosure	Mental Health/ counseling
HIV/AIDS	Diversity and anti-oppression	HIV testing (including Point of Care)	Grief and loss	Team building
Crisis Prevention/ Intervention	HIV/AIDS	Hep C	OHSUTP training	Cultural competence
Cultural competence	LGBTQ-Homophobia	OAN Skills Building	HIV/AIDS	HIV/AIDS

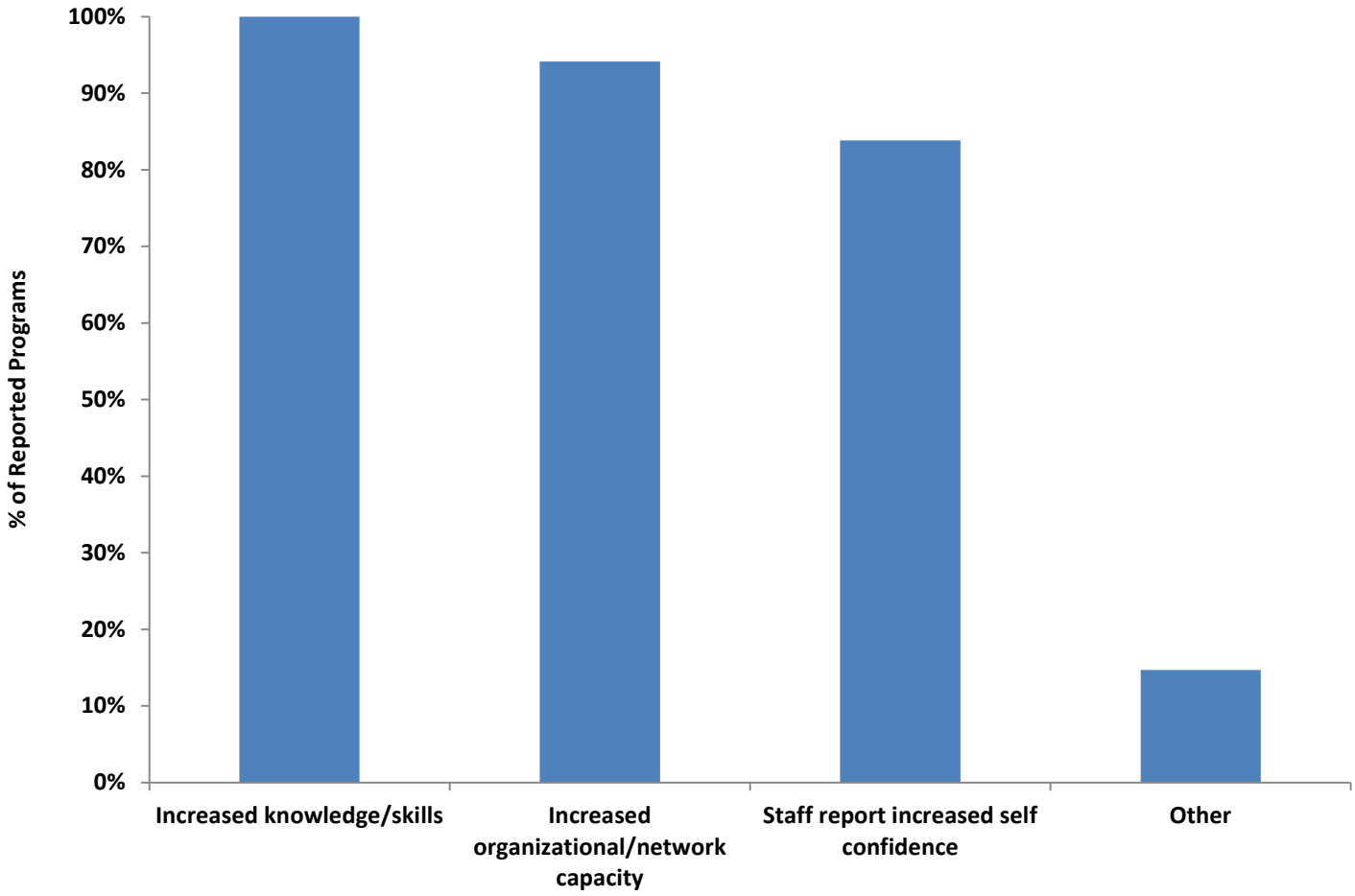
According to the organizations, staff training builds capacity by increasing knowledge and skills, enhancing the organization's ability to function and increasing staff confidence in their ability to do their work well. However, training requires a commitment of time and resources.

> *"The agency continues with staff development strategies in areas of cultural competency, transgender training, grief and loss awareness, crisis prevention intervention, first aid, etc. At times this requires a fair amount of staff and management time along with training costs to ensure management and front line staff are adequately trained to support the process."*

> *"Staff have been undertaking a training on conflict resolution/boundaries/professional conduct. The purpose of this training is to help staff members a) build their capacity to deal conflict now that they are all working under one roof, b) get to know each other better, and c) learn to work together and collaborate better."*

> *"The last six months reflect staff changes with increased need for staff development and education. With a new team and increased participation on agency issues staff feel more connected to the organization. Education and training initiatives are underway with the intention to develop a culture of learning within the organization."*

Figure 80
Staff Training Contribution: 2010/2011

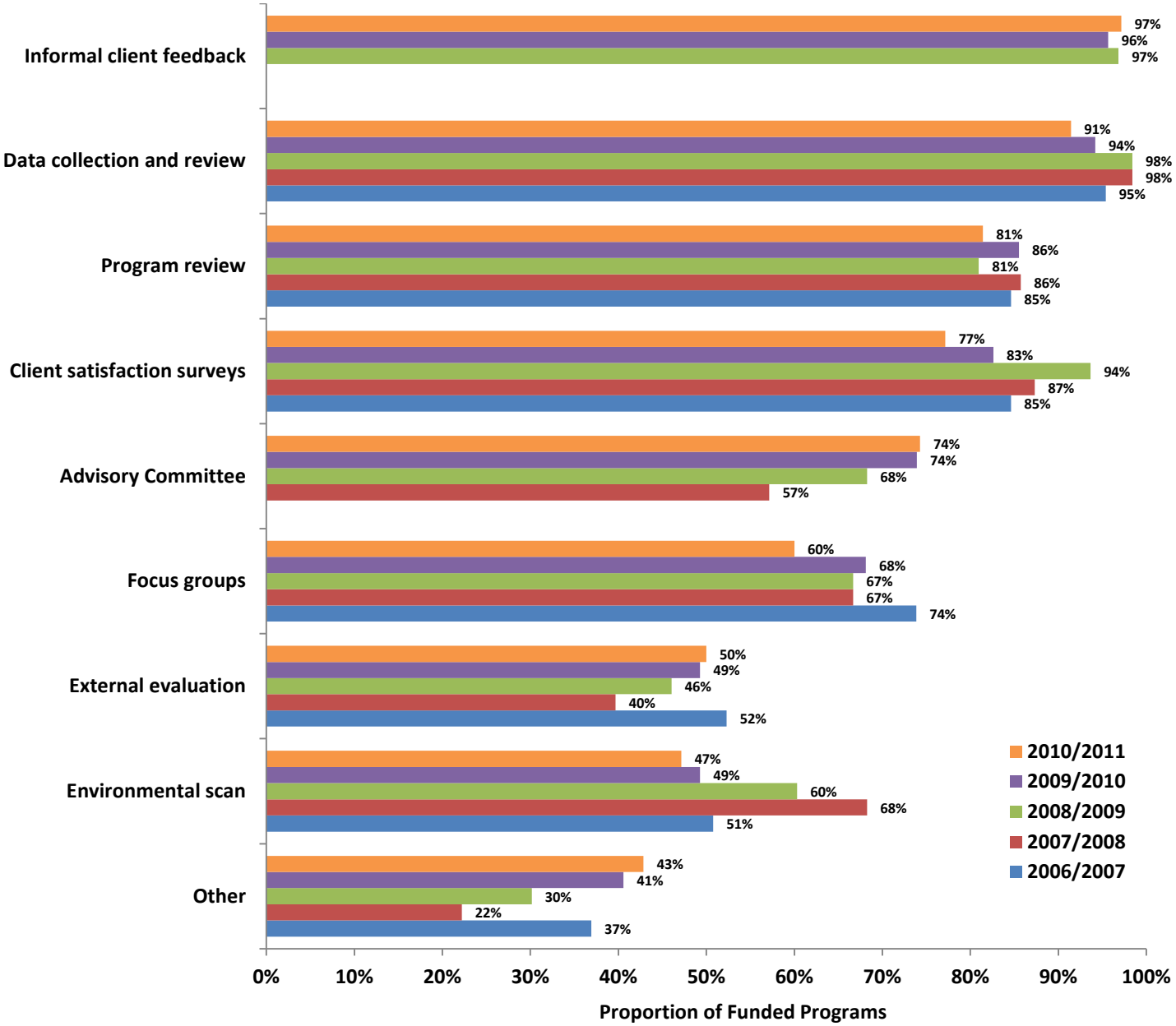


5.3.6 BUILDING ORGANIZATIONAL CAPACITY

To ensure funded organizations have the capacity to provide sustained, high-quality programs and services that are responsive to community needs, OCHART tracks the systems they have in place to ensure the organizational integrity and stability required to support program delivery. There has been a steady increase in the proportion of organizations that have appropriate policies in place.

It is interesting to note that the proportion of organizations using certain types of monitoring processes and tools (e.g., client satisfaction surveys, focus groups, environmental scans) decreased over the past year – which may indicate that they are relying more on informal client feedback.

Figure 81
Monitoring Processes and Tools



CAPACITY ISSUES

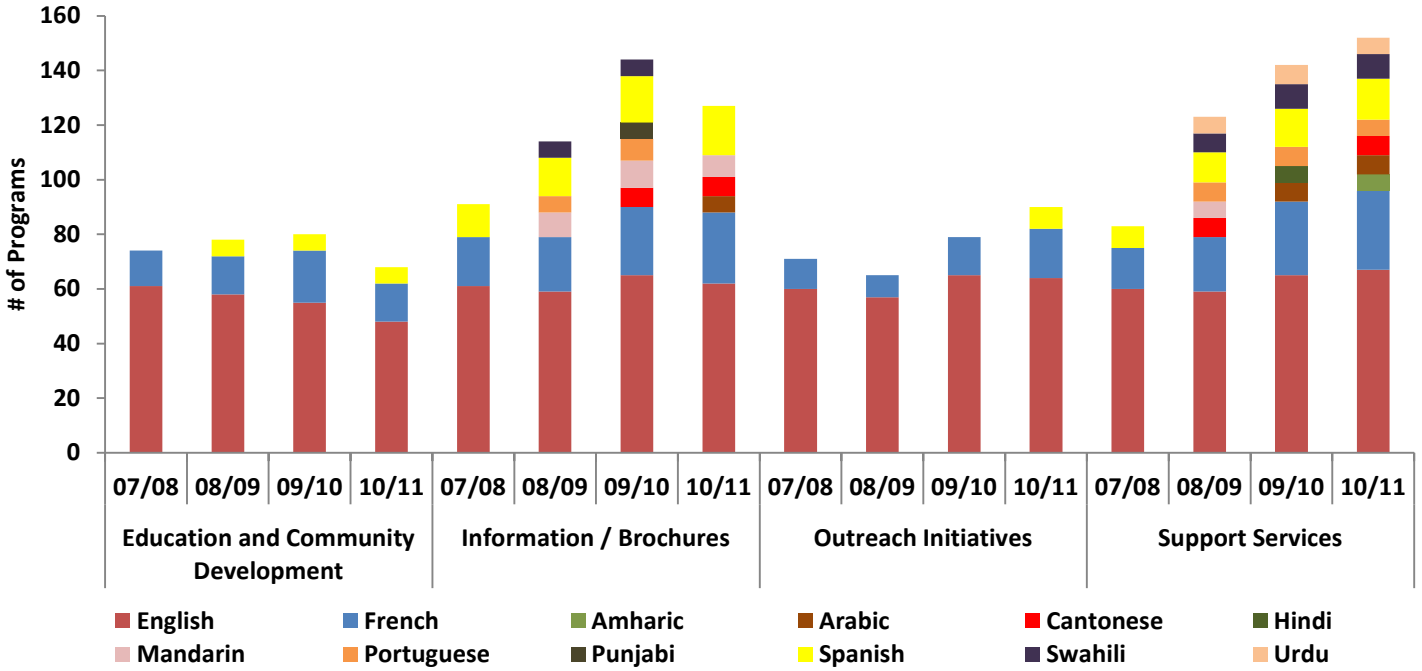
Organizations identified a number of barriers that affect their ability to deliver effective programs and services, including: stigma, limited funds and other resources, HR challenges – including lack of cultural competency and increasing costs.

PROGRAMS MAY EXPERIENCE CHALLENGES DELIVERING CULTURALLY COMPETENT CARE

To be effective and achieve their outcomes, community-based HIV programs must be able to provide culturally competent prevention, education, care and support for all their clients – including services that are appropriate for people based on their race, ethnicity, sexual identity, gender identity, substance use and experience of incarceration. Meeting the needs of the wide range of people with or at risk of HIV-- including gay and other men who have sex with men, people who use substances, African, Caribbean and Black people, people from countries where HIV is endemic (including migrant workers, immigrant, refugee and undocumented populations), Aboriginal people, sex workers, prisoners and transmen and transwomen – is challenging. The AIDS Bureau is now supporting workers whose role is to provide education and support to agencies across the province and to help them enhance their capacity to provide culturally competent services.

In terms of language – which is only one aspect of culturally competent services – ACAP has a commitment to support community-based HIV programming in both official languages, and funds some projects specifically to deliver services in French. Recognising the linguistic diversity in the province, a number of agencies are also funded to deliver services in other languages including Spanish, Portuguese, Urdu and ASL. Beyond these programs, most other agencies operate in English – although some may have the capacity (usually dependent on one or two staff) to provide services in another language(s). In general, organizations are better able to provide information (brochures) and support services in multiple languages – while most education and outreach continues to be provided mainly in English.

Figure 82
Number of Programs Providing Services by Language and Service Group

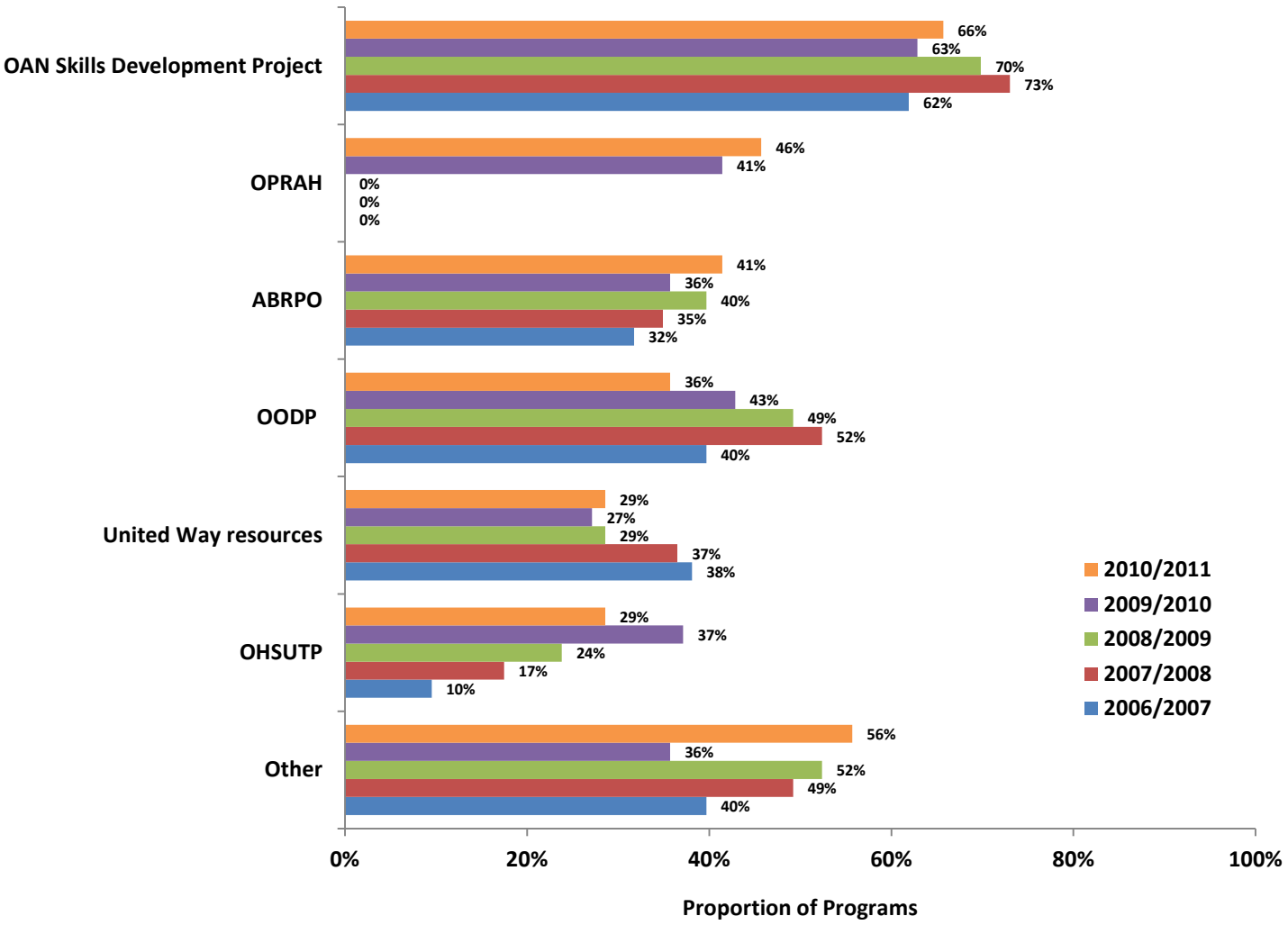


FOCUS ON ORGANIZATIONAL SKILLS

Most community-based programs funded by the AIDS Bureau and ACAP are in relatively small, independent organizations that do not necessarily have the resources or infrastructure of larger organizations, such as hospitals, public health units or community health centres. To enhance their capacity to provide quality programs and services, the AIDS Bureau funds a number of provincial resource programs. Organizations can also take advantage of other resources in the community, such as those provided by the United Way.

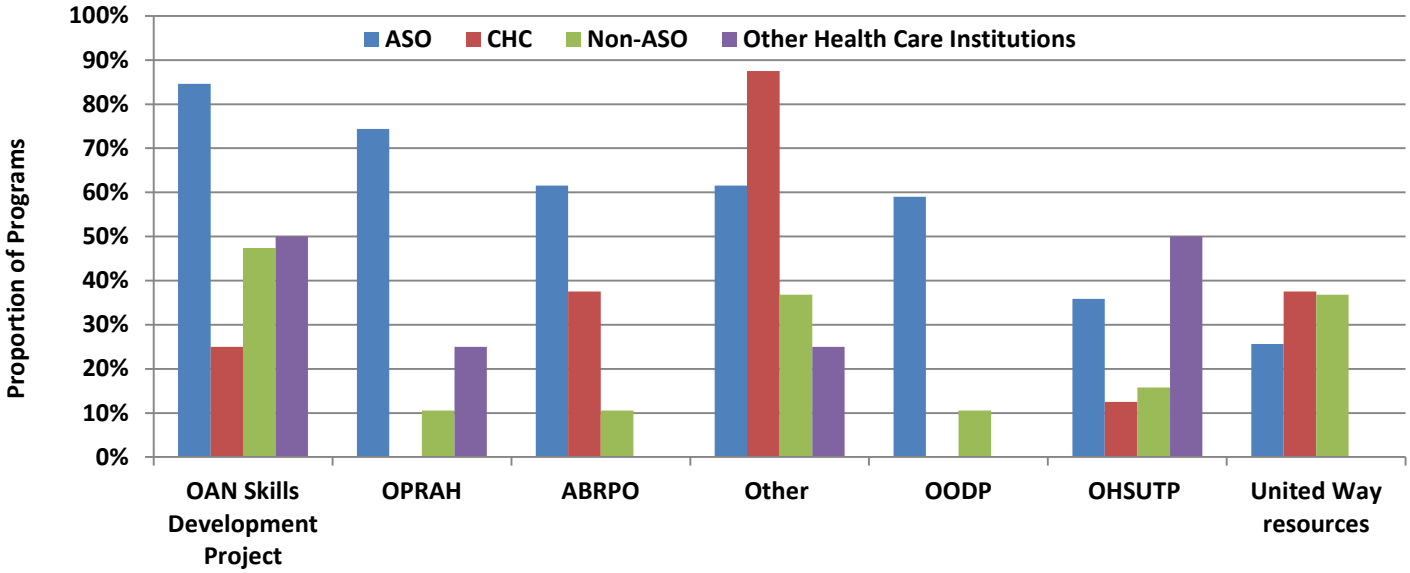
As Figure 83 illustrates, in 2010-11, almost 70% of organizations participated in skills building programs offered by the Ontario AIDS Network (OAN). In 2010-11, organizations reported greater use of OPRAH, the program that provides assistance with HR issues, and of the AIDS Bereavement and Resiliency Project of Ontario (ABRPO), which introduced a new training program designed to promote resilience within community-based HIV organizations. About 60% of organizations used "other" organizational resources – in particular external consultants – on topics such as strategic planning, organizational reviews, program reviews, reviews of HR training, policy and procedures, branding and first aid/CPR. In the "other" category, a number of organizations reported that they used supports provided by HALCO and the OHTN.

Figure 83
Proportion of Program Using Organizational Support



As would be expected, ASOs were more likely to use the resource services funded by the ministry while CHCs and non-ASOs were more likely to use the United Way and other resources.

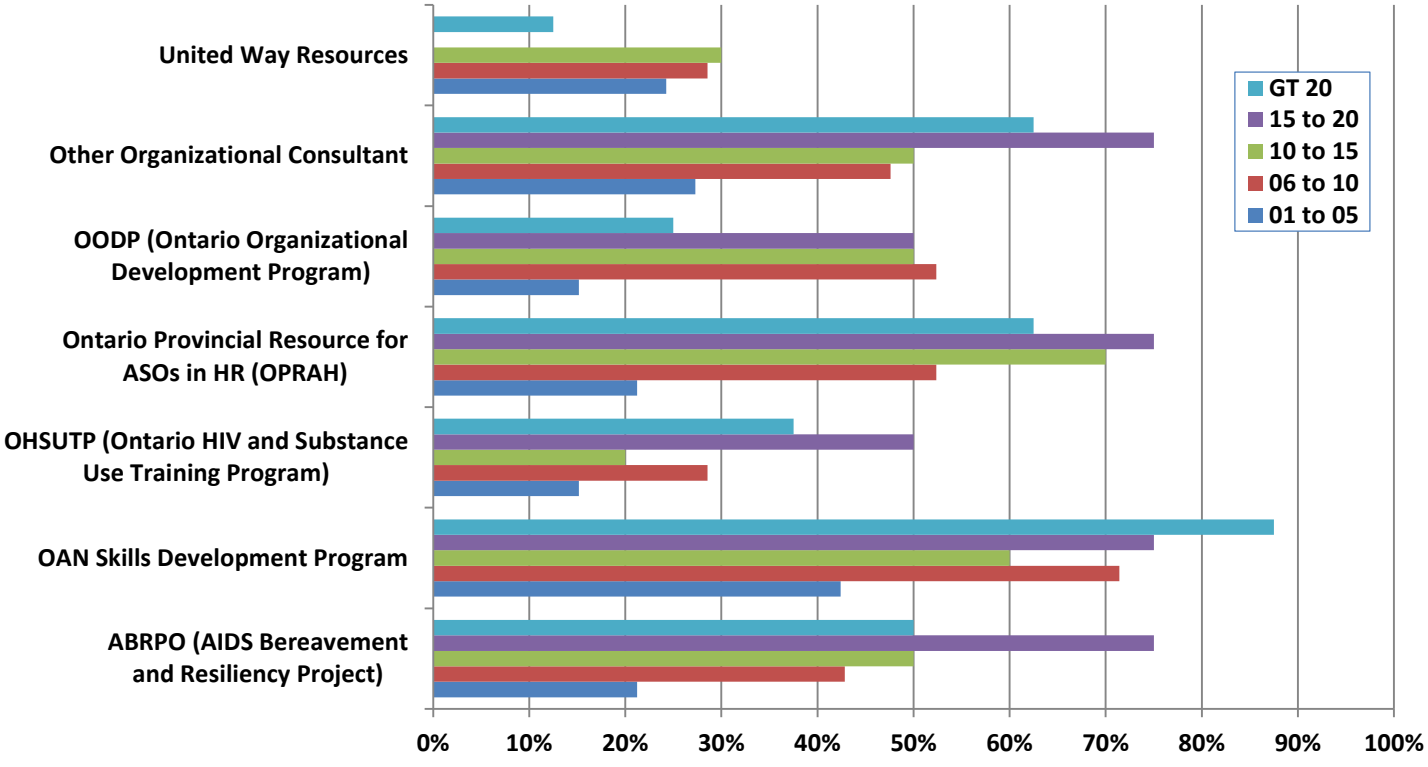
Figure 84
Proportion of Program Using Organizational Support by Agency Type: 2010/2011



SIZE INFLUENCES CAPACITY

As Figure 85 shows, a large proportion of mid-sized organizations used organizational consultants, OODP, OPRAH and ABRPO; while a relatively small proportion of small organizations (<30%) used any one organizational support program. Smaller ASOs and non-ASOs may not have the staff or resources to participate in these programs – although, because of their size, they may potentially benefit most from these supports.

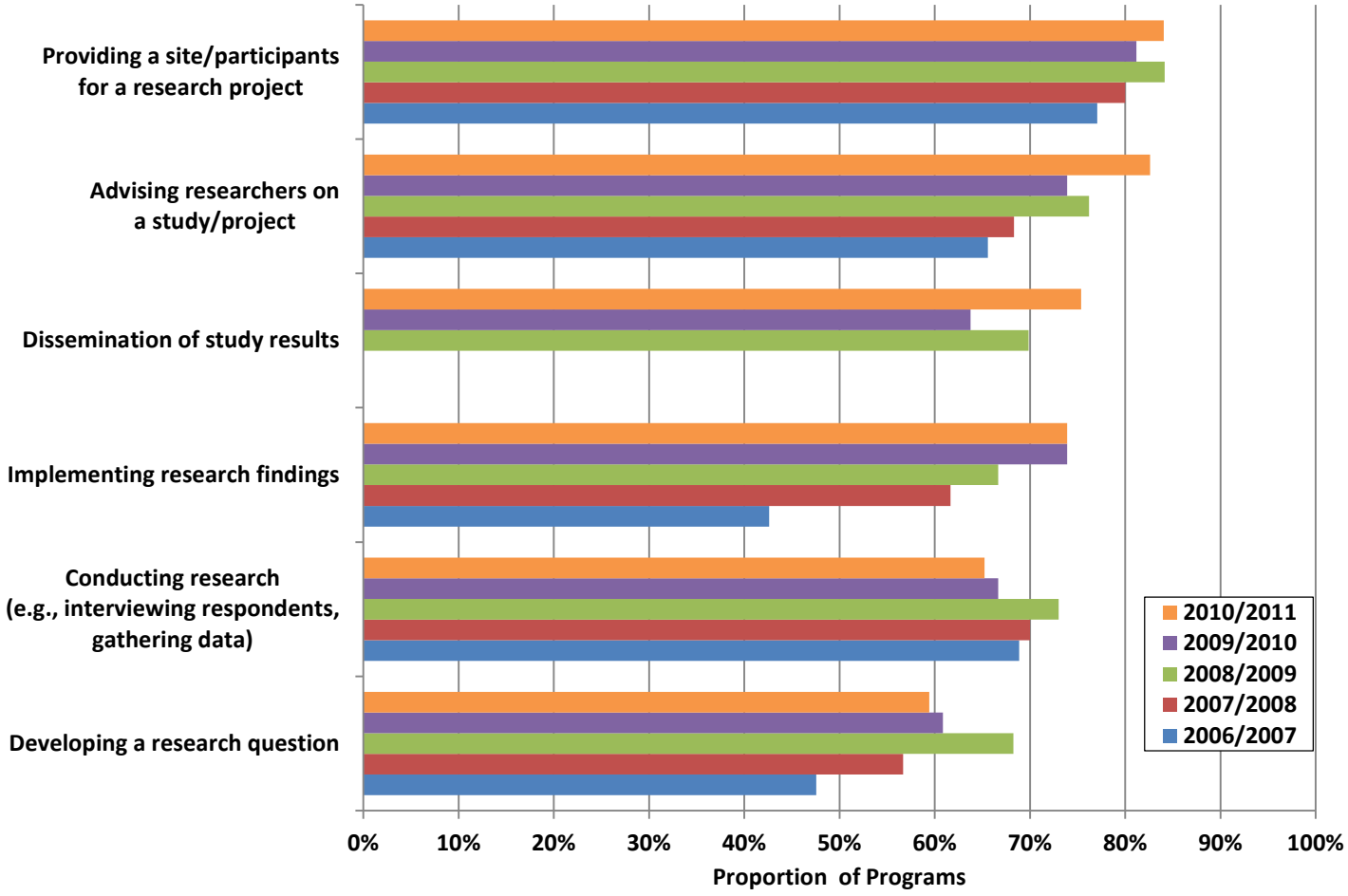
Figure 85
Proportion of Program Using Organizational Support by Agency Size: 2010/2011



PROVIDING ADVICE AND PARTICIPATING IN RESEARCH

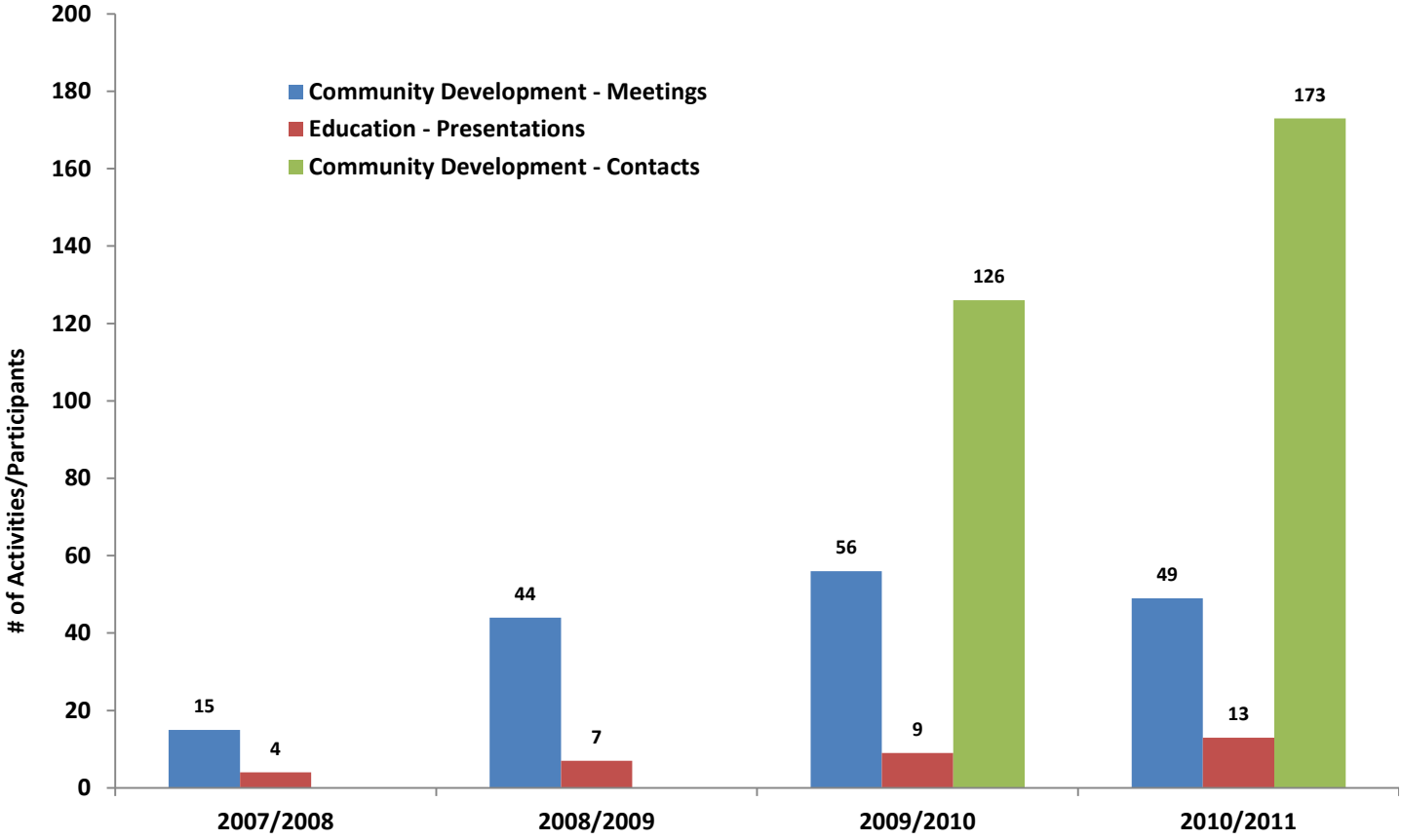
Almost 90% of organizations are involved in research in some way – in particular advising researchers, providing a site or participants for a research project, disseminating results and implementing findings. This level of interest and participation in research is encouraging as it reinforces the field's commitment to evidence-based practice. It is also encouraging to see that involvement in most aspects of community-based research appears to be increasing over time. This trend may indicate that organizational capacity to participate in or support research has become stronger. It may also reflect improved capacity of researchers to involve community-based organizations in their research projects.

Figure 86
Proportion of Programs Involved in Community-based Research



In 2010-11, organizations that provide outreach programs for injection drug users – particularly the CHCs and large needle exchange programs – reported more contact with researchers and universities. This trend may have been driven by increased interest in harm reduction and safe consumption sites and the need for research and data to inform ongoing political debates on the health and social value of these services.

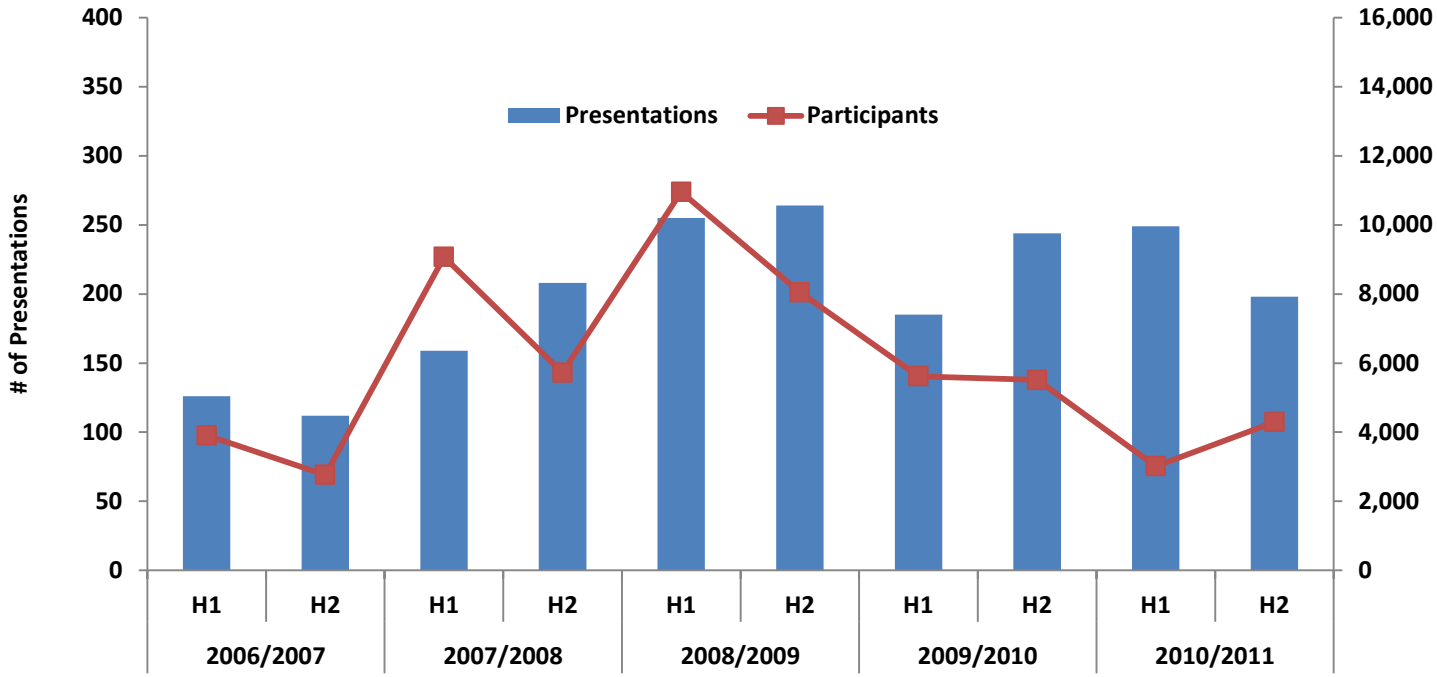
Figure 87
Number of Education Presentations / Meetings / Contacts - Other re: Research & Study



5.3.7 TRACKING PROVINCIAL RESOURCES

In 2010-11, OCHART began discussion on collecting distinct information from provincial resource programs that will help create a clearer picture of their work to strengthen the capacity of community-based programs. These organizations reported more presentations in 2010-11 than in 2009-10 but fewer participants.

Figure 88
Education Presentations and Participants Provincial Resource Programs



We are also starting to collect information on the number of resources developed that are designed to help funded programs with organizational development. A fairly significant number of resources have been developed over the past five years – both for planning and for training. The challenge now is to ensure those resources are widely distributed and used. Examples of resources produced include:

- ACCHO's Capacity Building Guide for Working with African, Caribbean and Black Canadian People
- The Ontario Black Gay Men's Summit full report and issues report
- Provision of HIV/AIDS Services and Support for African, Caribbean and Black Populations: Capacity Assessment Tool
- Criminals and Victims? The Impact of the Racialization of the Criminalization of HIV Non-disclosure on African, Caribbean and Black Communities in Ontario
- TTOA Handbook; developed TTOA training module for workers; developed a new Survive to Thrive Retreat agenda using PHAs as peer facilitators; multiple loss journey in Spanish being distributed
- Positive Change Makers (from the Positive Leadership Development Institute) HR compensation and benefits survey unionized agencies summary of trends within the HIV sector
- GIPA Workshop; Change Workshop and the Boundaries Workshop was revamped to relate to new ASOs.

5.4. INCREASING COORDINATION AND COLLABORATION

The effectiveness of community-based HIV organizations depends on their ability to coordinate and collaborate with other services in their community to enhance education, care and support for people with and at risk of HIV. Effective coordination and partnerships can help agencies learn from each others' experiences, provide appropriate referrals to their clients, support community development and intersectoral responses to HIV, and provide a network of comprehensive programming with fewer gaps and duplication in services.

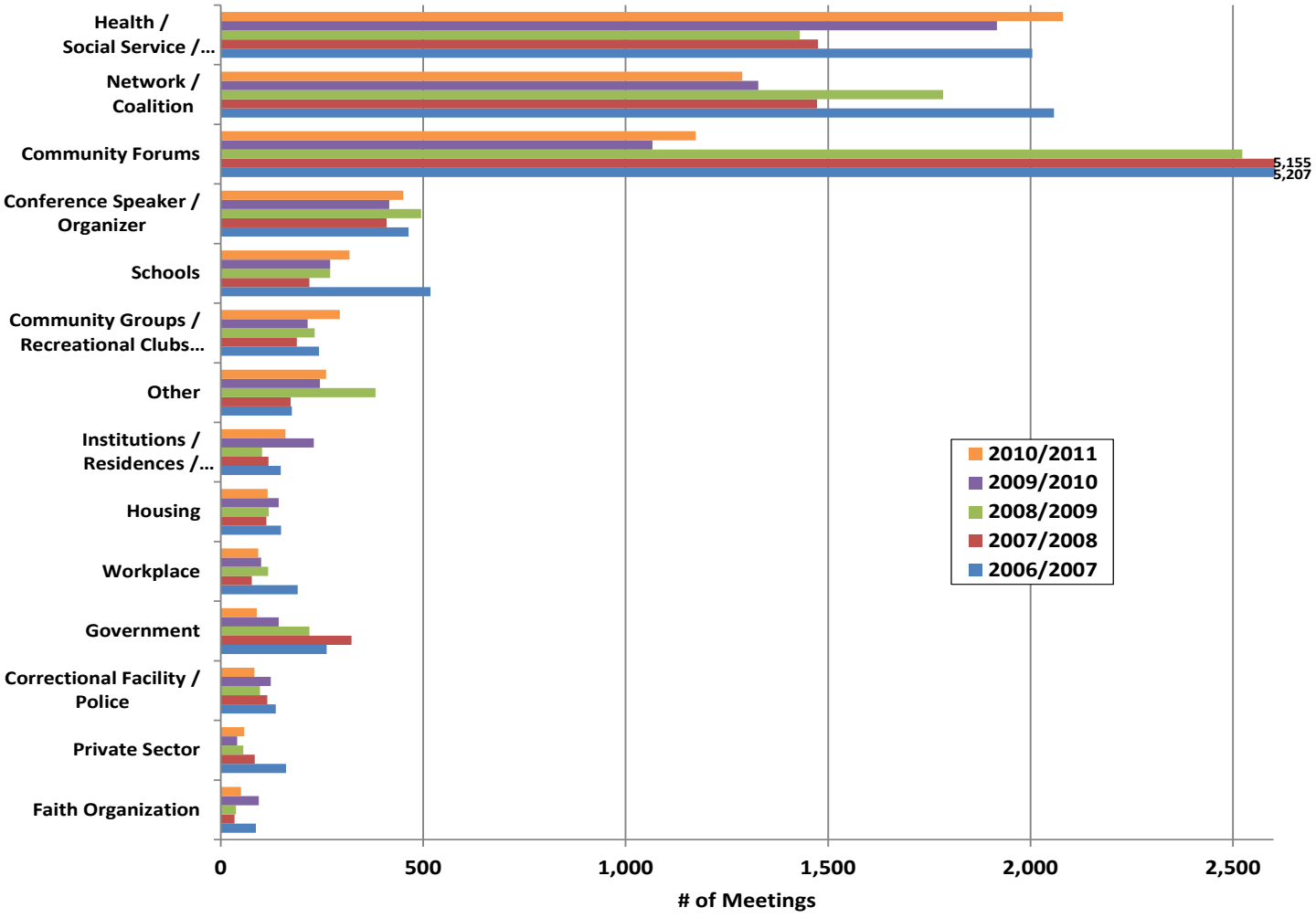
5.4.1 COMMUNITY DEVELOPMENT

OCHART tracks the community development efforts of education/outreach programs, IDU specific outreach program (including community development by peers) and provincial resource organizations.

GENERAL COMMUNITY DEVELOPMENT

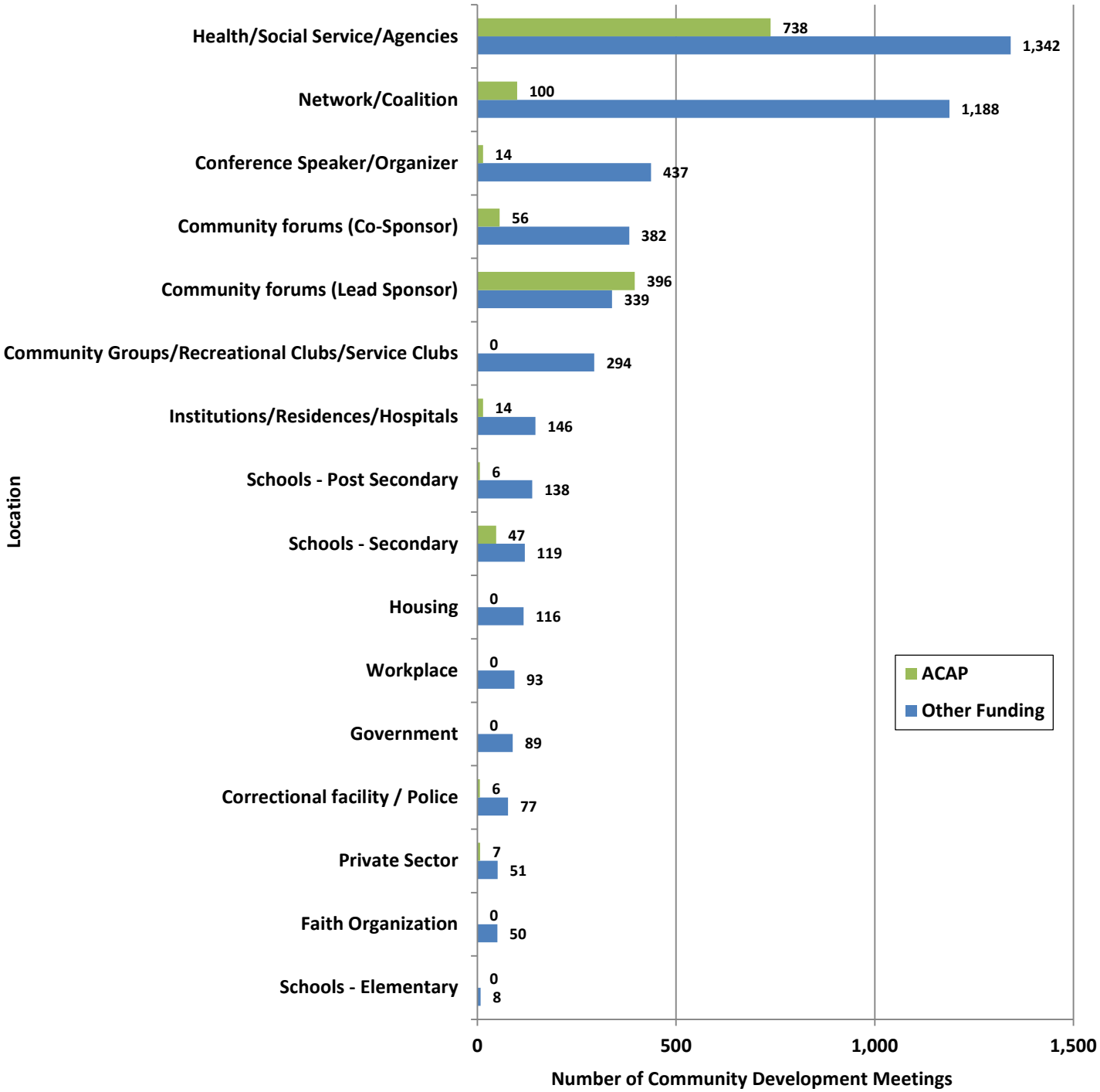
In 2010-11, only 66 of the 88 funded programs reported organizing community development meetings and those 66 accounted for a total of 6,253 meetings. Most were held with other health and social service agencies and networks/coalitions. A much smaller proportion were with schools, community groups, hospitals, employers or the police. (Note: the high number of community forums reported in 2006-07 and 2007-08 are a reporting error.)

Figure 89
Community Development - Meetings



In looking at the number of ACAP-funded community development meetings compared to those funded through other sources, ACAP funded one third of all community development meetings with health and social service agencies and over half the community forums where programs were a lead sponsor. On the other hand, ACAP funding was not used to support any meetings with elementary schools, faith organizations, government, workplace, or housing agencies.

Figure 90
Community Development Meetings by Funding Source: 2010



General community development activities included: advisory committee meetings, planning meetings for larger events such as harm reduction conferences and Opening Doors sessions, meetings with community leaders including faith leaders in different ethno-cultural and racialized communities, and involvement in community action on poverty and housing issues. Organizations report that these meetings are valuable because they help provide advice on education and often lead to other activities in the community. For example:

> *"[The focus of one advisory committee meeting with volunteers and other professionals … [was to obtain] inputs on preparing a brochure on HIV/AIDS and alcohol/drug abuse. Most participants acknowledged that there is a wide spread abuse of alcohol in our community that caused undesirable behaviour patterns including unprotected sexual encounters, low self esteem, crime and suicide. They also commented that we should focus on dealing with a stimulant leaf commonly known as khat in the community. They commented that the substance abuse emanated from different factors including stress due to isolation. Most participants suggested the brochure should be simple in format, use plain language, include cartoons and include statistics."*

> *"The purpose of the meeting was to gather necessary inputs for the HIV/AIDS awareness activities planned for the period. Accordingly, participants of the discussion provided inputs on the contents, nature and methods of the activities. They suggested relevant sites of outreach to … community members. These outreach locations effectively provided to us links to various partners in the community including faith-based institutions."*

> *"[As a result of our meetings,] the [faith] leaders in Toronto passed on their messages to their respective congregations …. The spiritual leader called on the faithful to stop stigma gossip and discrimination on people living with HIV/AIDS."*

Community development activities also help develop the integrated services that clients need.

> *"[We've] been involved in community development to address issues of community versus Sex Trade Workers. The meetings have involved the police, the crown, partners and sex trade workers."*

> *"[The] University has had a partnership with [the agency] for years where our clients go to their … campus for the 1st year MD students to practice their interviewing skills. This year, [the university] asked to increase the number of PHAs in this opportunity, which was a success. We have noticed a considerable lack of HIV-related knowledge among medical professionals in our region, particularly around HIV counseling and testing (for instance, individuals have been called at work to be informed of their HIV status, with no further counseling or follow-up)."*

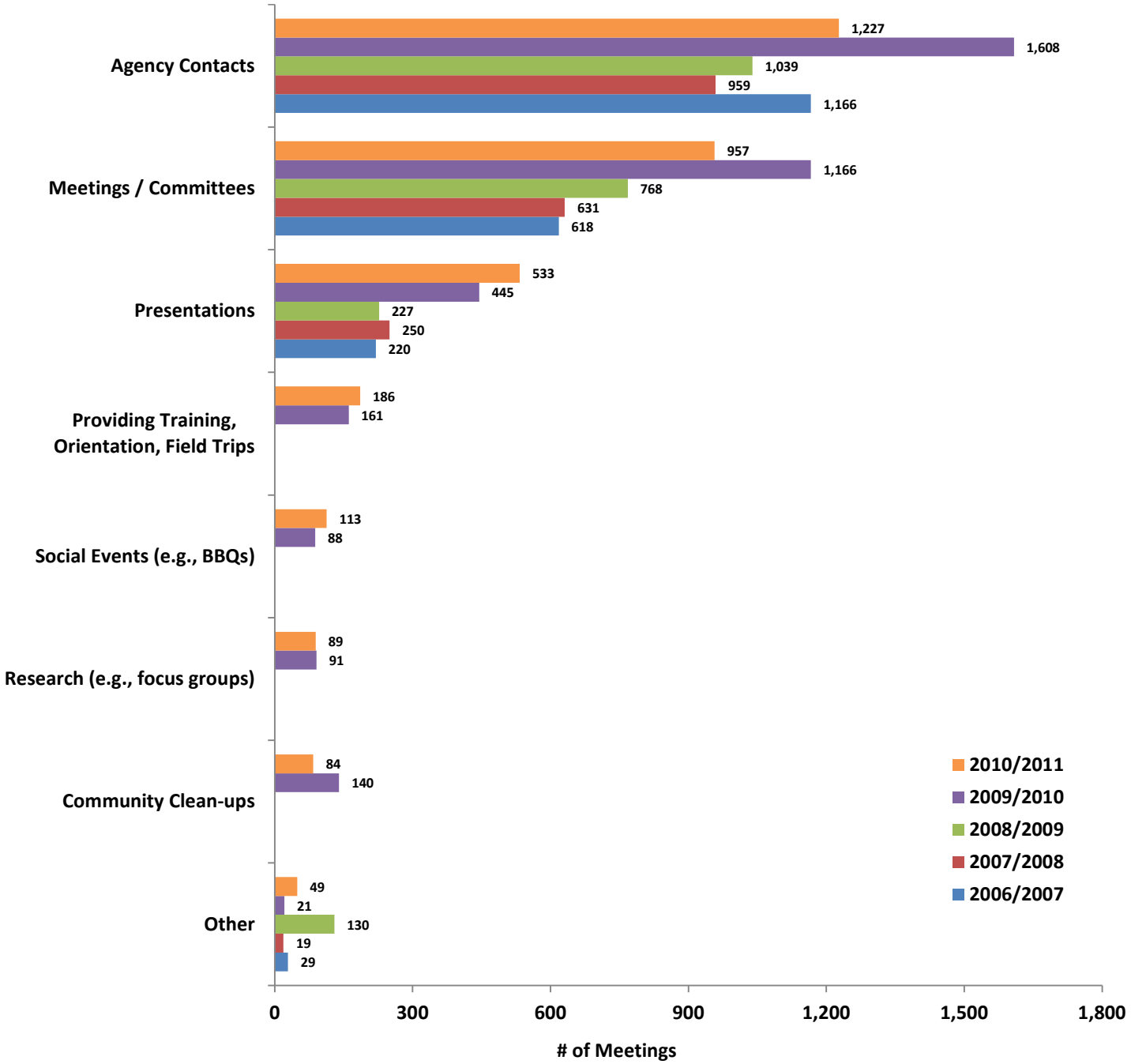
> *"During this reporting period there has been an increased demand for education, information and community development for the Migrant Worker population as this population has little to no access to services and information and are at high risk for HIV and other STIs."*

> *"Cultural groups including Bengali, Filipino and Tamil groups and networks were very keen to have access to the knowledge and also making contributions around cultural information."*

IDU OUTREACH COMMUNITY DEVELOPMENT

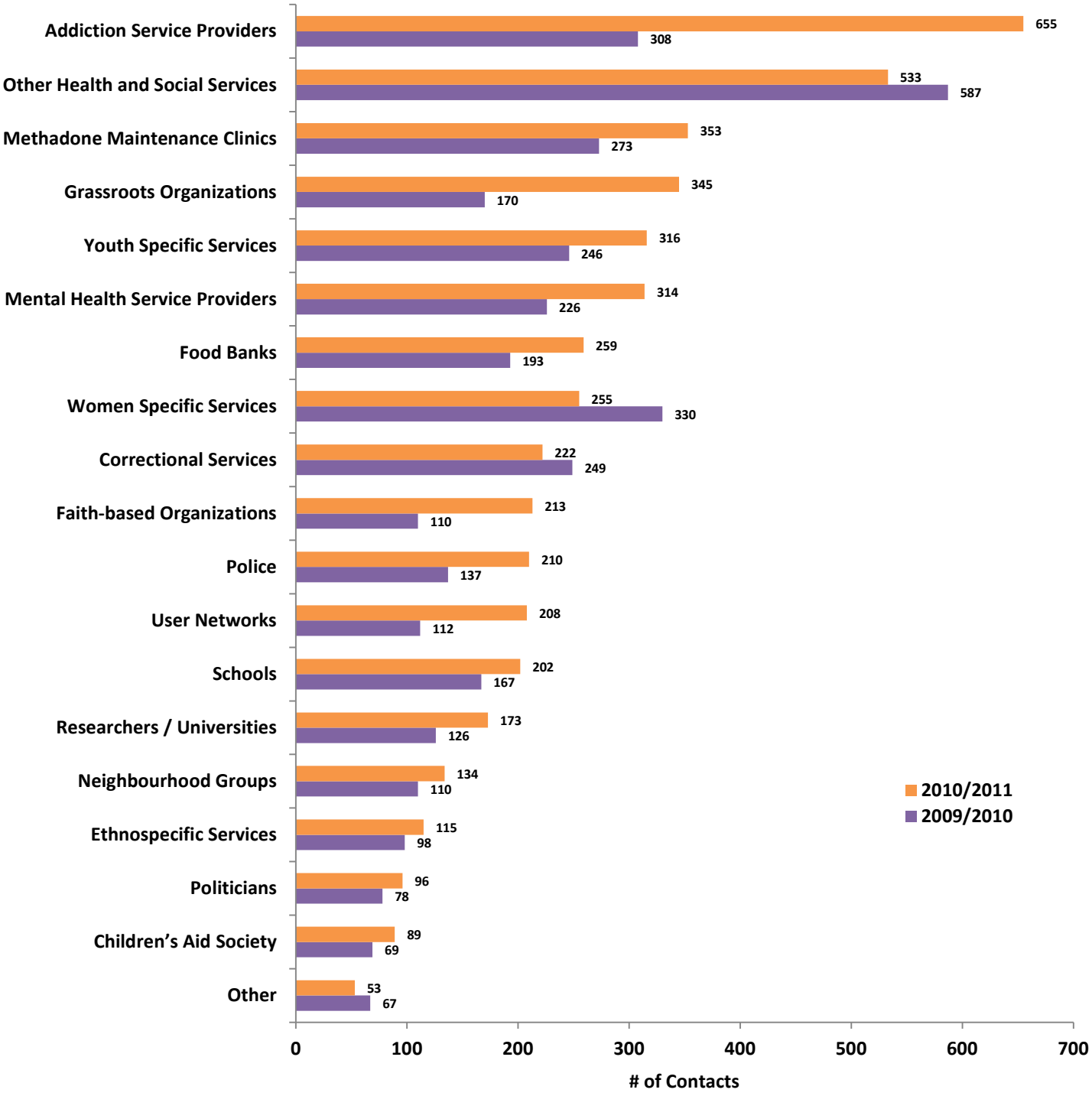
The province's IDU outreach services are expected to undertake community development activities designed to help create more supportive communities for people who use substances. In 2010-11, the 38 programs that report community development related to IDU outreach/harm reduction mainly met with other agencies and committees, and did presentations in the community or provided training or field trips for people who wanted to know more about harm reduction.

Figure 91
Community Development Activities



In terms of community development contacts, IDU outreach programs reported a total of 4,712 contacts in 2010-11, connecting mainly with addiction service providers, other health and social services, methadone clinics and grassroots organizations.

Figure 92
Total Number of Community Development Contacts

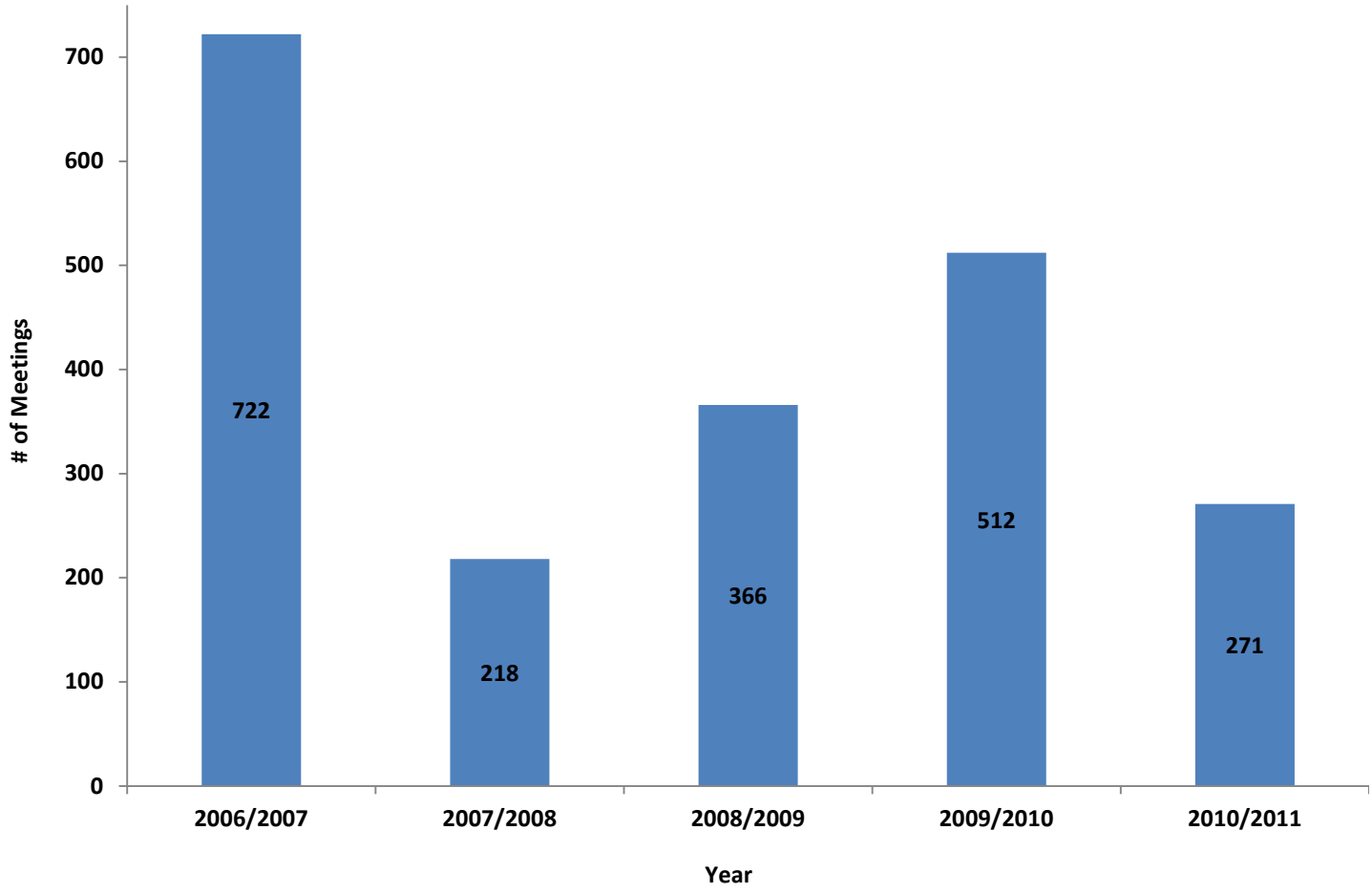


The doubling of contacts with addiction service providers was not due to any one agency; it occurred across the board, and may be related to the consultation and collaboration that was part of the development of the provincial mental health strategy as well as the need to link with these agencies to improve access to services for people who use substances. It likely also reflects the additional agencies that now report their substance use activities in section 13 of OCHART.

PROVINCIAL RESOURCE AGENCY COMMUNITY DEVELOPMENT

Provincial resource agencies – particularly four organizations -- reported significantly fewer community development meetings in 2010-11.

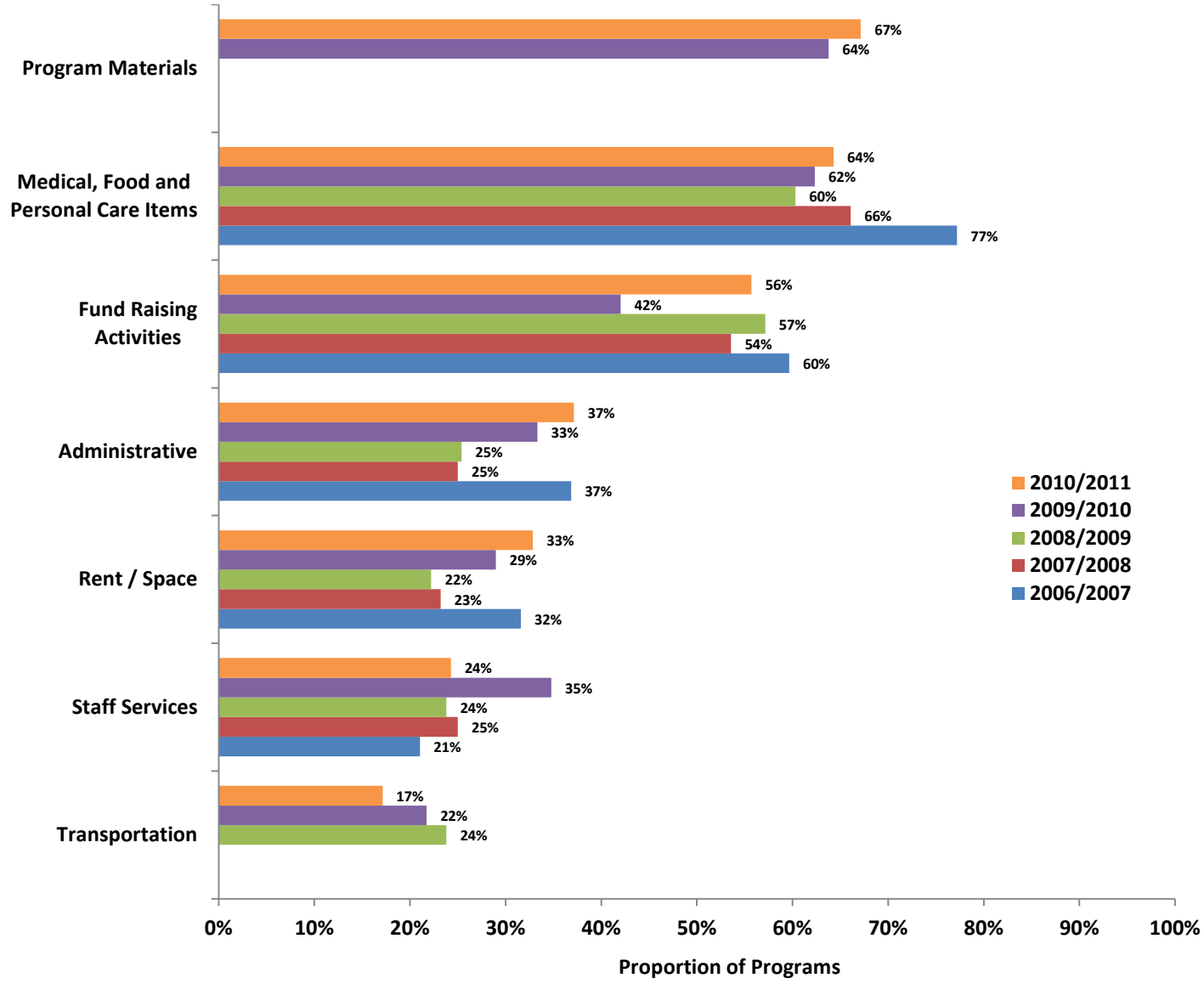
Figure 93
Community Development Meetings: Provincial Resource Programs



5.4.2 SERVICE PARTNERSHIPS

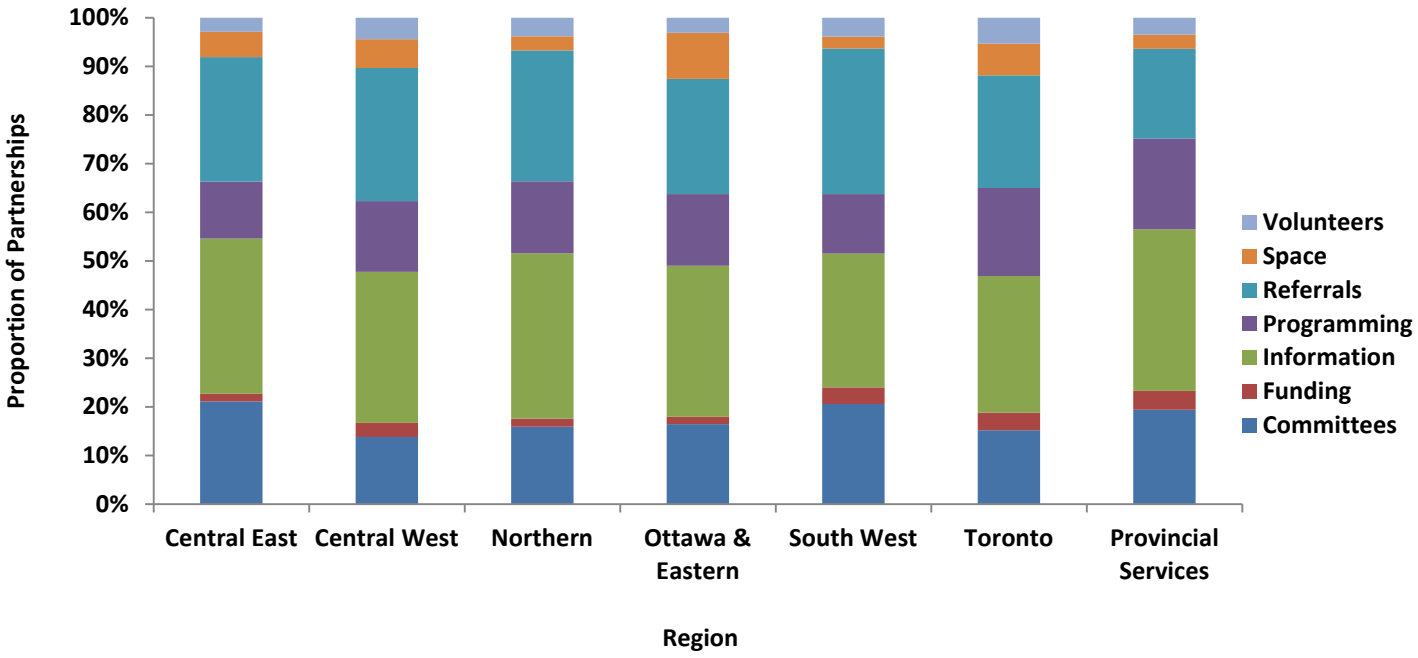
Collaborations between community-based HIV organizations and other organizations are intended to lead to and support service partnerships that enhance prevention, care and support for people with and at risk of HIV. To measure the extent of collaboration among agencies, OCHART asks for information on in-kind contributions and the sharing of resources. As Figure 94 shows, a larger proportion of organizations reported receiving program materials and medical or other items from partners in 2010-11, and more reported sharing administration resources and space. However, fewer reported sharing staff resources.

Figure 94
Proportion of Programs that Report Receiving In-Kind Contributions



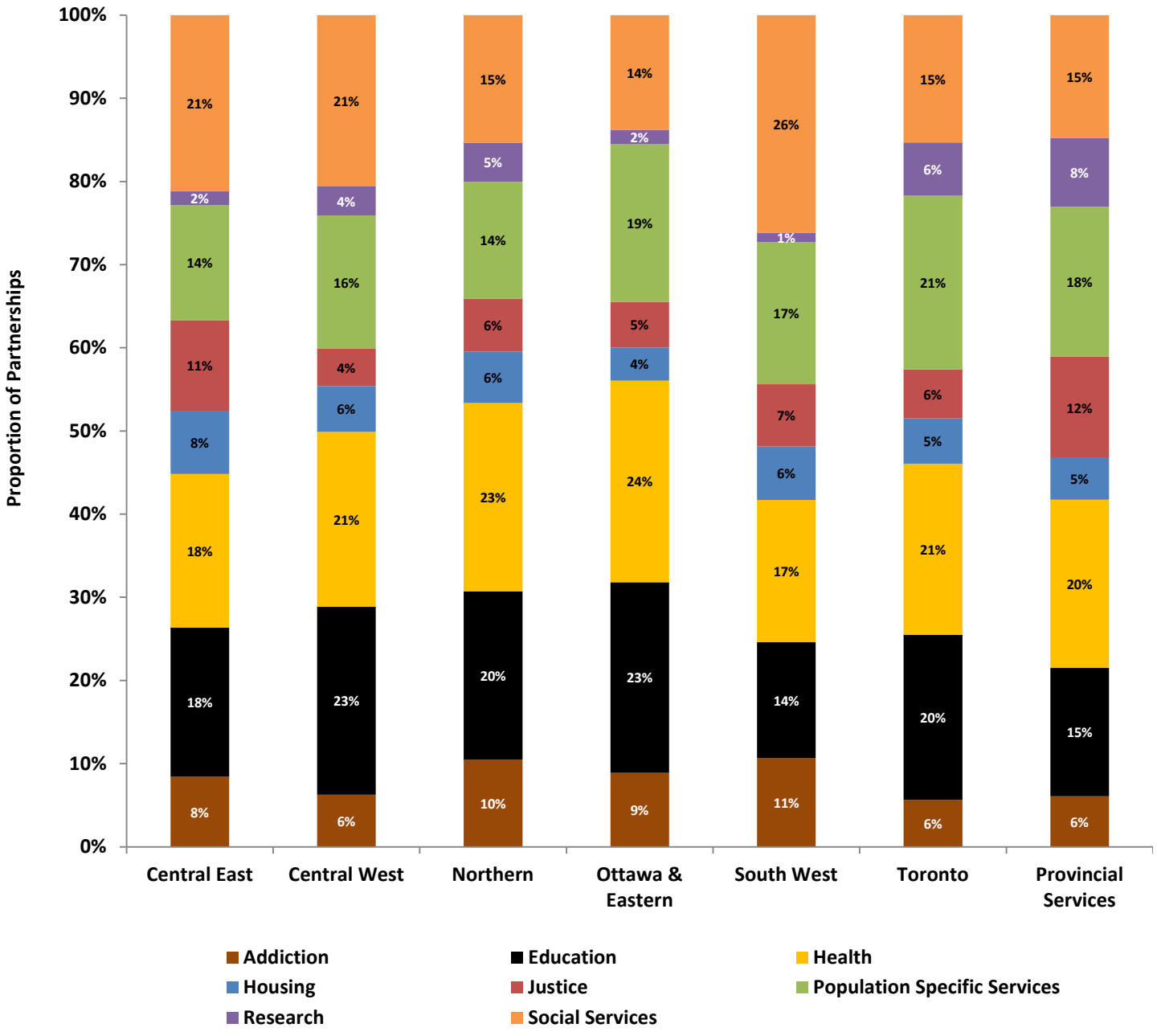
It is interesting to note that the larger the organization, the more likely they are to share resources. This may be a function of capacity: larger organizations may be better positioned to share staff and/or positions. Smaller organizations are likely to be in smaller communities and may not have many organizations with which to partner. In terms of regional differences, organizations are more likely to share space in Ottawa, Toronto and Central West, and more likely to jointly fund initiatives in Toronto, South West and at the provincial level.

Figure 95
Partnership Activity by Region: 2010/2011 H2



The focus of partnerships varies slightly by region. For example, organizations in South West and Central East report a greater proportion of partnerships with social service organizations. In general, all regions report partnerships across a range of sectors, including population-specific services, health, education, housing and justice, which reinforces that organizations are committed to collaboration and working intersectorally to meet client needs.

Figure 96
Partnership Focus by Region: 2010/2011 H2



APPENDICES

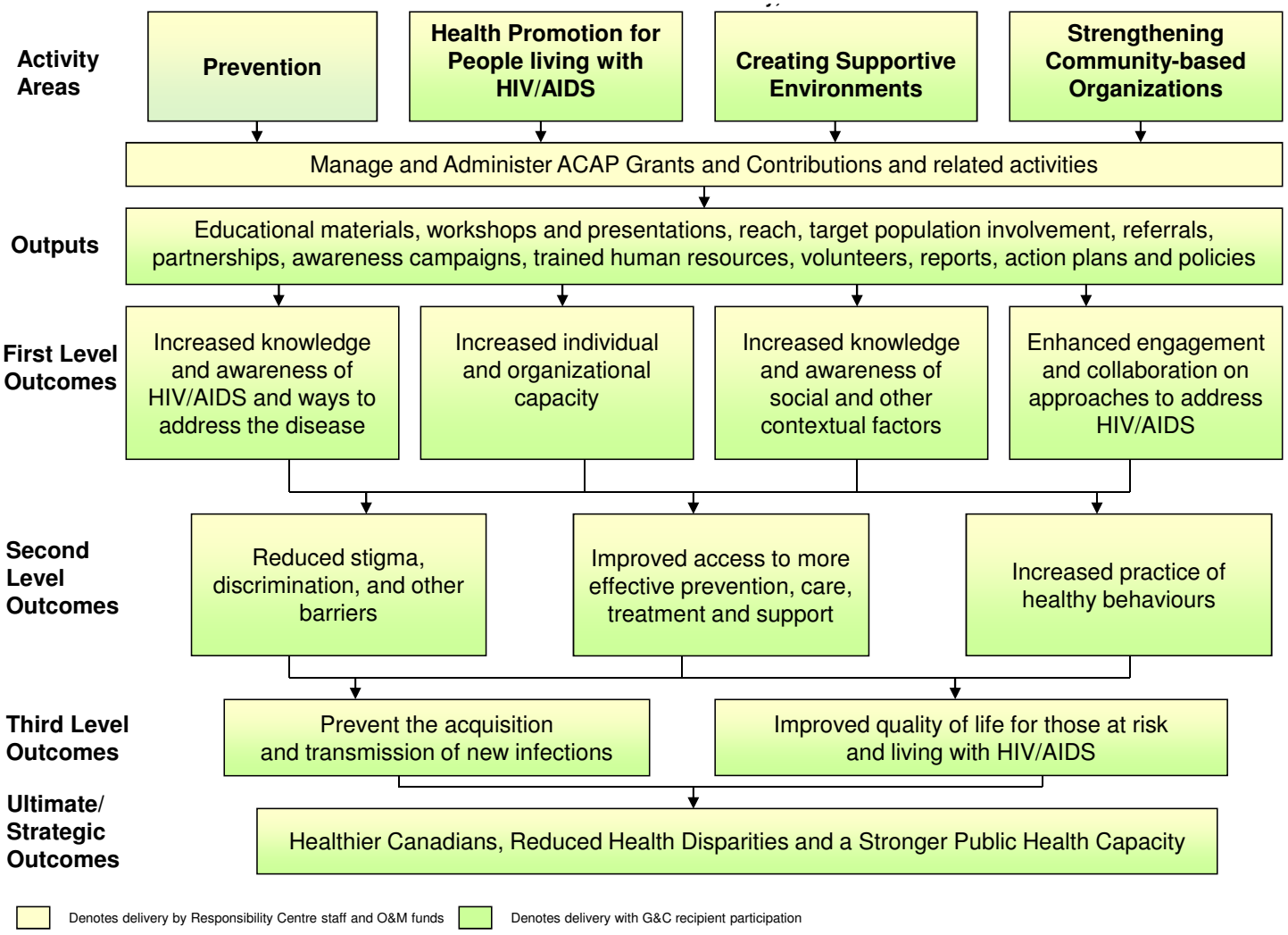
APPENDIX A: LIST OF FUNDED PROGRAMS

Health Region	Organization Name	LHIN
Central East	AIDS Committee of York Region	Central
	AIDS Committee of Durham Region	Central East
	Peterborough AIDS Resource Network	Central East
	AIDS Committee of Simcoe County	North Simcoe Muskoka
Central West	Hemophilia Ontario - CWOR	Central West
	Peel HIV/AIDS Network	Central West
	AIDS Niagara	Hamilton Niagara Haldimand Brant
	Hamilton AIDS Network	Hamilton Niagara Haldimand Brant
	Hamilton Public Health & Community Services	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
Northern	Access AIDS Network - Sudbury	North East
	AIDS Committee of North Bay and Area	North East
	Algoma Group Health	North East
	Hemophilia Ontario - NEOR	North East
	Ontario Aboriginal HIV/AIDS Strategy - COCHRANE	North East
	Ontario Aboriginal HIV/AIDS Strategy - SUDBURY	North East
	Sudbury Action Centre For Youth	North East
	Union of Ontario Indians	North East
	AIDS Thunder Bay	North West
	Hemophilia Ontario - NWOR	North West
	Nishnawbe Aski Nation	North West
	Ontario Aboriginal HIV/AIDS Strategy - THUNDER BAY	North West
	Waasegiizhig Nanaandawe'iyewigamig	North West
Ottawa & Eastern	AIDS Committee of Ottawa	Champlain
	Bruce House	Champlain
	City of Ottawa Public Health	Champlain
	Hemophilia Ontario - OEOR	Champlain
	Ontario Aboriginal HIV/AIDS Strategy - OTTAWA	Champlain
	Somerset West Community Health Centre	Champlain
	Youth Services Bureau of Ottawa	Champlain
	HIV/AIDS Regional Services	South East
	Ontario Aboriginal HIV/AIDS Strategy - KINGSTON	South East
	Street Health Centre, Kingston Community Health Centres	South East
South West	AIDS Committee of Windsor	Erie St Clair
	AIDS Support Chatham-Kent	Erie St Clair
	Ontario Aboriginal HIV/AIDS Strategy - WALLACEBURG	Erie St Clair
	Association of Iroquois and Allied Indians	South West
	Hemophilia Ontario - SWOR	South West
	Ontario Aboriginal HIV/AIDS Strategy - LONDON	South West
	Regional HIV/AIDS Connection	South West

Health Region	Organization Name	LHIN
Toronto	2-Spirited People of the First Nations	Toronto Central
	Africans In Partnership Against AIDS	Toronto Central
	AIDS Committee of Toronto - Action Positive	Toronto Central
	AIDS Committee of Toronto - PYO	Toronto Central
	AIDS Committee of Toronto - VIVER	Toronto Central
	AIDS Committee of Toronto	Toronto Central
	Alliance for South Asian AIDS Prevention	Toronto Central
	Asian Community AIDS Services	Toronto Central
	Barrett House - Good Shepherd Ministries	Toronto Central
	Black Coalition for AIDS Prevention	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
	Elizabeth Fry Society of Toronto	Toronto Central
	Ethiopian Association	Toronto Central
	Family Service Toronto	Toronto Central
	Fife House	Toronto Central
	Hassle Free Clinic-HIV/AIDS Counselling & Support Program/Women	Toronto Central
	Hospice Toronto	Toronto Central
	LOFT Community Services	Toronto Central
	Maggie's: The Toronto Prostitutes' Community Service Project	Toronto Central
	Ont. Assoc.of the Deaf, Deaf Outreach Program	Toronto Central
	Planned Parenthood Toronto	Toronto Central
	South Riverdale Community Health Centre	Toronto Central
	St. Stephen's Community House	Toronto Central
	Syme-Woolner Neighbourhood and Family Centre	Toronto Central
	The Teresa Group	Toronto Central
	The Works, City of Toronto Public Health	Toronto Central
	Toronto People With AIDS Foundation - CAAT	Toronto Central
	Toronto People With AIDS Foundation - FFL	Toronto Central
	Toronto People With AIDS Foundation	Toronto Central
	Unison Health and Community Services	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	Hemophilia Ontario	Provincial
	HIV & AIDS Legal Clinic (Ontario)	Provincial
	Ontario Aboriginal HIV/AIDS Strategy	Provincial
	PASAN (Prisoners with HIV/AIDS Support Action Network)	Provincial
Provincial Resource	African and Caribbean Council on HIV/AIDS in Ontario	Provincial
	AIDS Bereavement and Resiliency Program of Ontario (sponsored by Fifehouse)	Provincial
	Canadian AIDS Treatment Information Exchange	Provincial
	FIFE House - OHSUTP	Provincial
	Ontario AIDS Network	Provincial
	Ontario Organizational Development Program	Provincial

APPENDIX B: LOGIC MODELS

AIDS Community Action Program Logic Model



AIDS Bureau Funding Program - Logic Model

AIDS Bureau Funding Program

Ontario Government Goal -To build a patient-centered health care system that delivers quality, value and evidence based care in Ontario.
Objective -Preventing Injury and Illness: Managing Disease

Program Description

Program provides transfer payment funding to support an evidence informed, community-based response to HIV/AIDS in Ontario through the provision of such services and programs as: prevention education and awareness, harm reduction, HIV testing, support and care, community mobilization, and research.

Objectives	Strategies	Inputs/Resources	Outputs
To increase knowledge and awareness to prevent the transmission of HIV/AIDS within priority populations in Ontario.	• Increase knowledge and awareness of HIV/AIDS through prevention programming for priority populations • Increase awareness and provision of HIV testing options among priority populations • Provide harm reduction services • Promote integration of GIPA/MIPA principles, including the involvement of PHAs and others with lived experience	• Provincial HIV/AIDS Strategy • Base & One Time Funding • Program Guidelines and Strategies • Program materials, staffing, administrative and management costs	• Education, Prevention and Outreach Programs • HIV Testing Initiatives • Harm Reduction Programs • Peer based programming • Prevention programming to address stigma, marginalization & discrimination such as homophobia, racism, HIV stigma, etc… • Includes such funded strategies as: GMSH, ACCHO, IDU Outreach, OAHAS
To increase access to services for people living with and/or affected by HIV/AIDS.	• Support organizations and communities in providing services to people living with and/or affected by HIV/AIDS • Provide support to reduce gaps in service for people living with and/or affected by HIV/AIDS • Provide support services for Ontario's priority populations • Promote integration of GIPA/MIPA principles, for both PHAs and others with lived experience	• Provincial HIV/AIDS Strategy • Base & One-Time Funding • Program Guidelines and Strategies • Program materials, staffing, administrative and management costs	• Care and Support for PHAs • Health Promotion and capacity-building programs for PHAs • Support programming to address stigma, marginalization & discrimination such as homophobia, racism, HIV stigma, etc… • Care and Support for those affected by HIV/AIDS
To increase capacity of organizations and communities to effectively respond to HIV/AIDS.	• Promote system effectiveness, transparency, and responsiveness • Support leadership capacity and coordination of communities, organizations, staff, volunteers, and PHAs • Foster supportive and engaged communities • Build capacity of the wider health and social service sector to meet the needs of people living with HIV/AIDS • Promote integration of GIPA/MIPA principles, for both PHAs and others with lived experience	• Provincial HIV/AIDS Strategy • Base & One-Time Funding • Program Guidelines and Strategies • Program materials, staffing, administrative and management costs	• Organizational development programs • Volunteer and Staff Capacity Development programs • Includes funded strategies: WHAI, ACCHO, GMSH, OAHAS • Established referral network of allied service providers • Community development programming to address stigma, marginalization & discrimination such as homophobia, racism, HIV stigma, etc…
To increase coordination, collaboration and evidence based practice across the system responding to HIV/AIDS.	• Support opportunities for relevant and high quality research • Provide opportunities for knowledge translation and exchange across sectors • Provide opportunities to integrate evidence into practice • Build capacity of the wider health and social service sector to meet the needs of people living with HIV/AIDS • Promote integration of GIPA/MIPA principles, for both PHAs and others with lived experience	• Provincial HIV/AIDS Strategy • Base & One-Time Funding • Program Guidelines and Strategies • Program materials, staffing, administrative and management costs	• Partnership and service coordination programs • CBR, Clinical and Other Research including Epidemiological Monitoring • Knowledge Translation and Exchange to increase evidence based practice • Data collection, input and analysis to increase evidence based and informed practice

Health Outcomes

- Reduced transmission of HIV/AIDS in Ontario
- Improved health and well-being of people living with HIV/AIDS (PHAs)
- Strengthened community capacity to respond to people living with, affected by &/or at-risk of HIV/AIDS

Priority Populations in Ontario

- People living with HIV/AIDS
- Gay, bisexual and other MSM
- Aboriginal peoples
- People who use drugs
- African, Caribbean and Black Ontarians
- Women in the above groups &/or who engage in high-risk activities with them

Activities	Data Measures	Short-term Outcomes
• Education sessions/workshops • Community development • Social marketing campaigns • Resource Distribution • HIV Prevention counseling • Outreach activities • Distribution of harm reduction materials • Harm reduction counseling with service users • HIV Testing Initiatives – POC testing, Anonymous HIV Testing, Prenatal HIV Testing; and partner notification	• Total funding contributed to each objective • OCHART reporting (Sect 9, 10 & 13) including such things as # presentations, # education participants, # community development meetings, # resources distributed, # outreach contacts, # harm reduction supplies, etc… • Other data measures including # HIV tests & other HIV testing data • Program evaluations, reviews or environmental scans	• Increased knowledge and awareness of HIV/AIDS prevention and harm reduction for priority populations in Ontario • Increased capacity for individuals to use harm reduction practices • Increased awareness and provision of HIV testing options, and number of people tested for HIV, among priority populations in Ontario • Integration of GIPA/MIPA principles, for both PHAs and others with lived experience
• Counseling and Case Management for PHAs, affected and those at-risk • Referrals for allied services • Practical Assistance and Other Supports • PHA peer led programming • PHA Health Promotion and capacity-building activities	• Total funding contributed to each objective • OCHART reporting (Sect 11) including such things as # clients, client gender & age, # new clients, type of services accessed, financial assistance distributed, # clients receiving financial assistance • Program evaluations, reviews or environmental scans	• Increased access to services for people living with &/or affected by HIV/AIDS • Integration of GIPA/MIPA principles, for both PHAs and others with lived experience
• Provincial resources to support community-based HIV sector: ie: OAN, ACCHO, GMSH, OODP, ABRPO, OHSUTP, OPRAH, CATIE • WHAI Programming • Opening Doors conferences • Knowledge Transfer and Exchange Days/ Activities • Organizational development programming • Volunteer management activities • Staff development • Peer involvement in the Organization or Program development or delivery	• Total funding contributed to each objective • OCHART reporting (Sect 3,4, 12 & 7) including such things as provincial resources accessed, # activities by provincial resource programs, # staff attending trainings, # volunteers, # student placements, # peers involved including PHAs, IDU peers, & other priority population involvement • Program evaluations, reviews or environmental scans	• Strengthened community and organizational capacity to respond to HIV/ADS • Integration of GIPA/MIPA principles, for both PHAs and others with lived experience
• Knowledge Development & Research • Knowledge Resource Dissemination • Ontario HIV Treatment Network programming • Evidence-based Practice Unit – OCHART, OCASE, and evaluation supports • Partnerships and collaborations • Community development activities • Evaluation activities	• Total funding contributed to each objective • Total funding for research & KTE related activities • OCHART reporting (Sect 13, 5, & 8) including such things as partnerships, # community development meetings • Other data measures including # research reports, KTE events, data collection activities, # requests for evaluation support, etc… • Program evaluations, reviews or environmental scans	• Increased coordination, collaboration and evidence based practice in responding to HIV/AIDS • Increased system effectiveness, transparency, and responsiveness. • Integration of GIPA/MIPA principles, for both PHAs and others with lived experience

APPENDIX C: ACAP-FUNDED PROJECTS BY TYPE AND FUNDING APPROACH

ACAP Operational Projects 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	Community Education and Prevention Program	Sponsored by Réseau Access Network
6963-06-2002/2370438	Healthy Sexuality Program	Réseau Access Network
6963-06-2002/2370445	HIV Prevention Services for Gay, Bisexual and MSM	Regional HIV/AIDS Connection
6963-06-2002/4480430	PARN HIV Education Program - Building Our Community Response	Peterborough AIDS Resource Network
6963-06-2002/4480432	Regional Prevention & Education Program	HIV/AIDS Regional Services
6963-06-2002/4480443	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	AIDS Committee of Toronto
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
6963-06-2002/2370440x	Volunteer Support Program	Bruce House
6963-06-2002/2370444	Ontario Organizational Development Program	Sponsored by Regional HIV/AIDS Connection
6963-06-2002/4480431	Fife House Volunteer Services Program	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	Turning to One Another – AIDS Service Organizations Bringing the "Greater Involvement of People Living with HIV/AIDS" Principle to Life	AIDS Bereavement and Resiliency Program 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 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 in the GTA and the Surrounding Regions
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	Africans in Partnership Against HIV/AIDS

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	AIDS Bereavement and Resiliency Program of Ontario Sponsored by Fife House Foundation
6963-06-2008/4480473	The Positive Prevention Project: Developing Youth-led Strategies Supporting a Common Approach to HIV, Hepatitis C and STI Prevention	Planned Parenthood Toronto
6963-06-2008//4480484	HIV/AIDS Regional Coordination and Integration Plan – Connecting Regional Persons Living with HIV/AIDS to Care and Support	Regional HIV/AIDS Connection

STRENGTHENING COMMUNITY-BASED ORGANIZATIONS

Project Number	Project Title	Project Sponsor
6963-06-2008/4480482	The "Aht Fra" Project: Accessibility through Interpreter Project for People with HIV/AIDS)	AIDS Committee of Cambridge Kitchener, Waterloo and Area (ACCKWA)
6963-06-2008/4480490	Program Infrastructure Development Project for Improving HIV Prevention)	Hamilton AIDS Network

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

APPENDIX D: OCHART QUESTIONS

OCHART Section	OCHART Question	VFTFL Goals
Program Planning and Evaluation	7.1 Processes/tools used to evaluate services	5.3 Increasing Individual and Organizational Capacity
	7.3 Tools used to measure behavioural changes	5.3 Increasing Individual and Organizational Capacity
	7.4 How have your shared your knowledge	5.3 Increasing Individual and Organizational Capacity
	7.7 How does your organization involve target populations	5.3 Increasing Individual and Organizational Capacity
	7.8 Involvement in CBR	5.3 Increasing Individual and Organizational Capacity
	7.9 Organizational barriers	5.3 Increasing Individual and Organizational Capacity
Education	9.2.1 Education Sessions	5.1 Increasing Knowledge and Awareness
	9.2.1 Education Sessions – provincial resource programs	5.3 Increasing Individual and Organizational Capacity
	9.2.1 Community Development Meetings	5.4 Increasing Coordination and Collaboration
	9.2.2 Education Resources – Health promotion and support resources	5.2 Increasing Access to Services
	9.2.2 Education Resources – Planning/decision making/policy and training resources	5.3 Increasing Individual and Organizational Capacity
	9.3 and 9.4 Narratives	5.1 Increasing Knowledge and Awareness
Outreach	10.2 Outreach Contacts by Location	5.1 Increasing Knowledge and Awareness
	10.3 Awareness Campaigns	5.1 Increasing Knowledge and Awareness
	10.4 Media Contacts	5.1 Increasing Knowledge and Awareness
	10.5 Phoneline and Internet Activity	5.1 Increasing Knowledge and Awareness
	10.5 Phoneline and Internet Activity – Pre/post test counselling and referrals	5.2 Increasing Access to Services
	10.6 Safer Sex Supplies	5.1 Increasing Knowledge and Awareness
	10.7 Newsletter Outreach	5.1 Increasing Knowledge and Awareness
	10.8 and 10.9 Narratives	5.1 Increasing Knowledge and Awareness
Support Services	11.1.1 Number of Clients Served by Gender	5.2 Increasing Access to Services
	11.1.2 New Clients	5.2 Increasing Access to Services
	11.1.3 Number of Clients Served by Age	5.2 Increasing Access to Services
	11.2.1 Services Provided	5.2 Increasing Access to Services
	11.2.2 Sessions Provided	5.2 Increasing Access to Services
	11.3 Support Groups	5.2 Increasing Access to Services
	11.4 Financial and In-Kind Support	5.2 Increasing Access to Services
	11.5 and 11.6 Narratives	5.2 Increasing Access to Services
Volunteers	12.1 Volunteers and Volunteer Management	5.3 Increasing Individual and Organizational Capacity
	12.2 Volunteer Activities	5.3 Increasing Individual and Organizational Capacity
	12.3 Student Placements	5.3 Increasing Individual and Organizational Capacity
	12.4 Student Activities	5.3 Increasing Individual and Organizational Capacity
	12.5 and 12.6 Narratives	5.3 Increasing Individual and Organizational Capacity

OCHART Section	OCHART Question	VFTFL Goals
IDU/Substance Use Services	13.1.1 Outreach Contacts	5.2 Increasing Access to Services
	13.1.2 Outreach – Individual Clients	5.2 Increasing Access to Services
	13.2.1 In-Service Contacts	5.2 Increasing Access to Services
	13.2.2 In-Service – Individual Clients	5.2 Increasing Access to Services
	13.3a Services Provided	5.2 Increasing Access to Services
	13.4 Location of Outreach Services	5.2 Increasing Access to Services
	13.5 Peer Involvement	5.3 Increasing Individual and Organizational Capacity
	13.6 Peer Activities – Formal Programs, informal Interactions, phone line support, practical assistance	5.2 Increasing Access to Services
	13.6 Peer Activities – Material Distribution	5.1 Increasing Knowledge and Awareness
	13.6 Peer Activities - Training	5.1 Increasing Knowledge and Awareness
	13.7 Community Development Activities	5.4 Increasing Coordination and Collaboration
	13.8 Community Development Contacts	5.4 Increasing Coordination and Collaboration
	13.8 Community Development Contacts - Research	5.3 Increasing Individual and Organizational Capacity
	13.9 Drugs of Choice	5.2 Increasing Access to Services
	13.10 Harm Reduction Resources Distributed	5.1 Increasing Knowledge and Awareness
	13.11 and 13.12 Narratives	5.2 Increasing Access to Services

APPENDIX E: CALCULATING THE DOLLAR VALUE OF VOLUNTEER WORK IN YOUR ACAP- OR AIDS BUREAU-FUNDED PROJECT

View From the Front Lines data on the dollar value of volunteer work is calculated using an adapted version of a tool developed by Yang Cui, a graduate student in the PHAC Manitoba/Saskatchewan regional office, in August 2009. For detailed instructions on how to use this tool in your project, please contact the OHTN.

Limitations of this tool

Information from this tool needs to be interpreted carefully. It can only give an estimate of the value of some types of volunteer work. Several factors can affect the accuracy of the estimated dollar value of this work.

Like any tool, the quality of data this tool produces depends on the quality of data that is entered into it. If volunteer hours have not been carefully tracked, or are recorded in the wrong OCHART categories, the estimated value of volunteer work will not be accurate.

This tool uses average wages for Ontario from National Occupation Classification (NOC) data. These averages may be higher or lower than average wages in some communities. This may result in over- or under- estimates of the dollar value of volunteer work.

Not all types of volunteer work are included in this tool. For example, volunteer hours reported in the "other" category cannot be assigned a dollar value with this tool. Also, the OCHART volunteer activity "Attend training" is not included in this tool. Attending training is not itself a job, so this activity cannot be assigned a wage.

Some volunteer work in each volunteer category may not align well with the associated wage category. For example, fundraising volunteer hours are calculated using the average wage for a professional occupation in fundraising or communications. However, some volunteer work counted in the fundraising category may not require a professional skill set (e.g. stuffing envelopes or being a marshal in a fundraising walk). The dollar value of this work may therefore be over-estimated.

Finally, the value of volunteers goes well beyond the financial impact of their work. This is only one dimension of the important impact volunteers have on community-based HIV work.

The tool uses data from two places:

- OCHART 12.2 data on the total number of volunteer hours, by category of work, in the last fiscal year (H1 + H2)
- National Occupation Classification (NOC) data, which tells you the average Canadian, provincial and regional wages for various occupations.

Volunteer Categories for Calculating Volunteer Values: *	OCHART Volunteer Categories	Number of Volunteer Hours (Sum Of H1 and H2 Totals)	NOC Title, Code and Average On Wage for this Job in the Last 12 Months	Estimated Dollar Value of Work (Hours X Average Wage)
Administration (includes clerical support, reception, etc.)	12.2 total #of vol hours for Administration	36,537	• General office clerk • NOC code: 1411 • Wage: 17.31	$632,455
Governance (includes board of directors, advisory committees, etc.)	12.2 total # of vol hrs for Serve on Board/Advisory Committee	22,942	• Senior manager-Health, Education, Social and Community Services and Membership Organization • NOC code: 0014 • Wage: 30.95	$710,055
Support services (includes assistance to people living with HIV/AIDS, peer support, etc.)	12.2 sum of total # of vol hrs for Practical Support and Counselling	58,812	• Community and social service workers • NOC code: 4212 • Wage: 19.81	$1,165,066
Prevention (includes outreach, targeted education, etc.)	12.2 total # of vol hrs for Outreach Activities	15,259	• Community and social service workers • NOC code: 4212 • Wage: 19.81	$302,281
Fundraising (includes walks, fundraising campaigns, work to secure foundation grants, etc.)	12.2 total # of vol hrs for Fundraising	26,051	• Professional occupation in public relations and communications • NOC code: 5124 • Wage: 25.53	$665,082
Public events (includes public speaking, special events like pride day, mall displays etc.)	12.2 sum of total # of vol hrs for Special Events and Education/Community Development	57,224	• General office clerk • NOC code: 1411 • Wage: 17.31	$990,547
Human resources	12.2 sum of total # of vol hrs for Involved in Hiring Process and Policies and Procedures	2,652	• Specialists in human resources • NOC code: 1121 • Wage: 27.02	$71,657
IT support	12.2 total # of vol hrs for IT support	2,756	• Web designers and developers • NOC code: 2175 • Wage: 24.94	$68,735
TOTAL ESTIMATED DOLLAR VALUE OF WORK:		**222,233**		**$4,605,878**

** This tool was developed by PHAC as a way to calculate ACAP volunteer hours. For this reason, it mainly uses the volunteer categories used in ACAP reporting in the rest of the country, not the OCHART volunteer categories used in Ontario.*

ACKNOWLEDGEMENTS

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

In addition, the AIDS Bureau and PHAC's Ontario and Nunavut ARO would like to thank the Ontario HIV Treatment Network (OHTN) for its support of OCHART. 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
416-642-6486 x2303
gmitchell@ohtn.on.ca

CONTRIBUTORS

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

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

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

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

Jean Bacon
Director, Policy and Knowledge, Translation and Exchange, Ontario HIV Treatment Network

Charles Shamess
Director, Evidence-based Practice Unit, Ontario HIV Treatment Network

Greg Mitchell
Manager, OCHART

Michelle Song
Data Analyst, OCHART

Ontario
Ontario Ministry of Health and Long Term Care
Ministère de la santé des soins longue durée de l'Ontario

Public Health Agency of Canada
Agence de santé publique du Canada

OHTN