OCHART

VIEW FROM THE FRONT LINES 2012

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

April 1, 2011 - March 31, 2012

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

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

OHTN

ACKNOWLEDGEMENTS

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In addition, the AIDS Bureau and PHAC's Ontario Regional Office 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. We would also like to thank Just Becuz for helpful suggestions about strategies for effective data presentation.

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 Regional Office, AIDS Community Action Program

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

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

Jean Bacon
Director, Policy and Knowledge, Translation and Exchange, OHTN

Greg Mitchell
Coordinator, OCHART, Evidence-based Practice Unit, OHTN

Michelle Song
Specialist, Database, OHTN

Maria Hatzipantelis
Coordinator, Evaluation, Evidence-based Practice Unit, OHTN

Diana Campbell
Coordinator, OCASE Evaluation, Evidence-based Practice Unit, OHTN

PREFACE

Welcome to the 7th 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 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:

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

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

THE PURPOSES OF OCHART REPORTING

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.

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, and gives the page where data from that question is discussed.

HOW THE REPORT IS STRUCTURED

1. HIGHLIGHTING SIGNIFICANT CHANGES AND TRENDS

As in last year's report, we are highlighting only data that reveal significant changes or trends; however, data from all OCHART questions is available in a separate document on the OCHART web site.

2. FOCUSING ON THE OUTCOMES OF OUR WORK

Our 2011-12 findings are organized under the four anticipated outcomes of our work as set out in the following logic model, which is a synthesis of the AIDS Bureau and ACAP funding program logic models:

- improved knowledge and awareness
- improved access to services
- enhanced capacity of individuals and organizations
- improved community coordination and collaboration.

The intent is to illustrate how different activities contribute to one or more goals, and to encourage the kind of analyses and reporting that will allow the field to understand and assess the impact (outcomes) of our activities.

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.

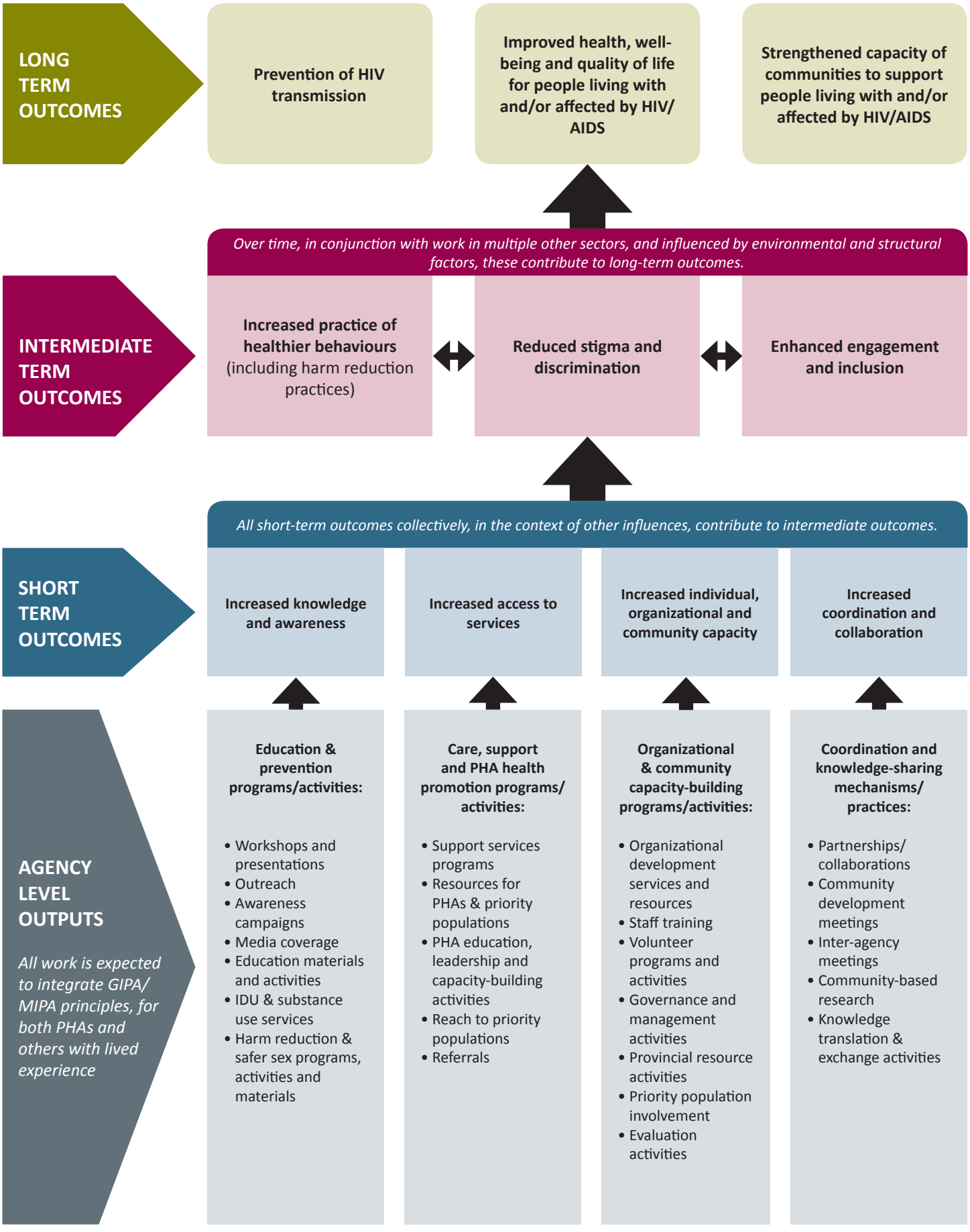
USE OF AGGREGATE DATA

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. We continue to look for ways to express the data that reflect the experience of all agencies.

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.

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



UNDERSTANDING THE LOGIC MODEL

The logic model is a synthesis of both the AIDS Bureau and PHAC logic models, intended to reinforce how the two funding programs are working together to achieve common goals. Because the synthesized logic model represents the work of two funders, not all populations and outputs will apply to all funded programs. It depends on the source(s) of funding for each program. For example, youth at risk are a priority population for ACAP but not the AIDS Bureau, and IDU outreach and harm reduction services are funded by the AIDS Bureau but not ACAP. 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 "key activities" box describes AIDS Bureau, PHAC, OHTN and community agencies' roles, and lists the types of community-based HIV programs in Ontario.
- The "priority populations" box lists the population groups most affected by HIV. These are the ultimate beneficiaries of our work.
- Above the "key activities" and "priority populations" boxes are 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.

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KEY MESSAGES

KEY MESSAGES

THE EPIDEMIC

In 2011, the total number of new HIV diagnoses in Ontario was down about 8% from 2010, yet we continue to see a significant number of new diagnoses in gay men – particularly gay men over age 40. About one of every two new diagnoses are in gay men and one in five are in people in the African, Caribbean and Black communities.

CLIENT DEMOGRAPHICS AND COMMUNITY RESPONSE

Clients of community-based AIDS services continue to face complex health and social needs, including stigma, poverty, unemployment, food insecurity and mental health issues.

Gay men represent more than 50% of new diagnoses and 60% of people living with HIV; however, they account for between 8% and 44% of service users – depending on the type of service (education, outreach or support) and the type of program (AIDS service organizations, community health centres, non-AIDS service organizations and other health care settings). This variation is due in part to the organizations' different mandates. For example, ASOs report that about 44% of support service clients are gay men while CHCs – which primarily serve other populations, such as women or people who use substances – report that only about 8% of support service clients are gay men. In terms of education and outreach, ASOs report that between 30% and 34% of their clients are gay men. It is unclear whether gay men are less in need of these services, are getting these services elsewhere or face barriers accessing these services.

Programs report serving more newcomers than in the past, and working to ensure their services are culturally competent.

Programs report that a significant proportion of their clients – 43% – have substance use issues. Rates are even higher in the Northern, Ottawa, Eastern and South West regions.

Despite a 5% increase in funding from the AIDS Bureau and stable ACAP funding in 2011-12, AIDS service organizations reported an almost $1 million drop in overall funding – largely due to drops in fundraising and cuts in funding from other government sources (e.g., municipal governments, local health integration networks).

INCREASING KNOWLEDGE AND AWARENESS

More programs are recognizing that education is a process and a key component of larger social change. They are working with local partners to link their education programs to broader community development and social justice work that will benefit populations at risk of HIV.

Community-based prevention programs are effective. Between 2001 and 2009, investments in community-based programs contributed to 12,087 averted cases of HIV – infections that did not happen. They also saved the health care system $3.4 billion in direct medical costs. Every $1 invested in HIV prevention saves the health care system $51.

In 2011-12, programs provided fewer general presentations to schools but more outreach and support for LGBT youth – which is consistent with their mission.

Programs reported more requests from service providers for education related to HIV and aging – which is consistent with the "greying" of HIV that we are seeing in terms of the number of people age 40 and older being newly diagnosed and the number of older people seeking support services.

The field's capacity to evaluate education programs is increasing: almost 80% of funded programs now regularly measure changes in knowledge as a result of their education while 60% also measure intent to change behavior.

This report attempts to differentiate between "significant" outreach activities, such as one-on-one conversations with people in bars, bathhouses, and clinics and on the Internet, and "brief" outreach, such as distributing condoms and brochures at community events.

Programs report more demand for outreach services from sex workers, women, trans youth and LGBTTQ youth, First Nations communities, people in detention centres and African, Caribbean and Black men.

The most common locations for outreach continue to be bars and bathhouses. Internet outreach is increasing but is provided primarily by a small number of agencies (7) across the province.

Programs that provide outreach to people who use substances reported that clients are using significantly more practical support services than in the past – including housing, food bank, transportation and employment services.

More contacts with people who use substances were made in drop-in centres and through mobile services than in the past, which suggests that offering these types of services may attract clients. However, more information is required to determine whether these sites are attracting more clients or serving a small number of clients more often.

The number of condoms distributed in 2011-12 was up 26% from the previous year; the distribution of safer injection equipment also increased by 20%. There was also a significant increase in both the number of programs distributing safer inhalation equipment and the amount of equipment distributed.

INCREASING ACCESS TO SERVICES

Programs continue to report providing support services to approximately 14,000 people in each half of the year – most of whom are people living with HIV (70%), people affected (14%) or people at risk (11%).

The number of women and trans people using support services increased slightly in 2011-12 – despite a drop in the number of new diagnoses in women. They represented more than one-third of clients in all regions except Ottawa and Eastern, and more than half the support clients in the Northern and Central East regions. Women may make more consistent use of support services. Given that many women who are infected are likely recent immigrants, their support needs may be more extensive.

The number of new support clients in 2011-12 exceeded the number of new diagnoses, which may indicate that people seek out community-based services as they need them over the course of living with HIV and not necessarily right after being diagnosed. Most people tend to use services on a episodic basis – when and as they need them.

In 2011-12, OCHART asked about the age of new clients: a significant proportion are over age 40 – which is consistent with trends in new diagnoses. At the same time, Ontario continues to have a large number of people aging with HIV. Almost half of all support service clients in all regions are over age 40. To respond to the "greying" of HIV, programs may need to adapt services to focus more on the needs of older clients.

Support service clients use primarily practical assistance, case management and information services as well as referrals and counselling services.

The financial assistance programs provided to clients – a total of $758,680 in 2011-12 – is used mainly for transportation and food. Transportation – including getting to and from medical appointments – continues to be a challenge for many clients, particularly those in more rural and remote areas.

For the first time, programs were also asked about client deaths. They reported a total of 145 deaths; however, as clients may use the services of more than one agency (particularly in Toronto) the actual number of deaths may be slightly lower. Death rates were particularly high in the Northern, South West, and Central East regions.

INCREASING CAPACITY, COORDINATION AND COLLABORATION

Programs continue to provide both paid and volunteer opportunities for people living with HIV, and they continue to attract and retain a significant volunteer workforce – which provides more than $5 million worth of time and skills.

PART I:

TRENDS IN HIV INFECTION IN ONTARIO

BACKGROUND: THE NEEDS AND OUR SERVICES

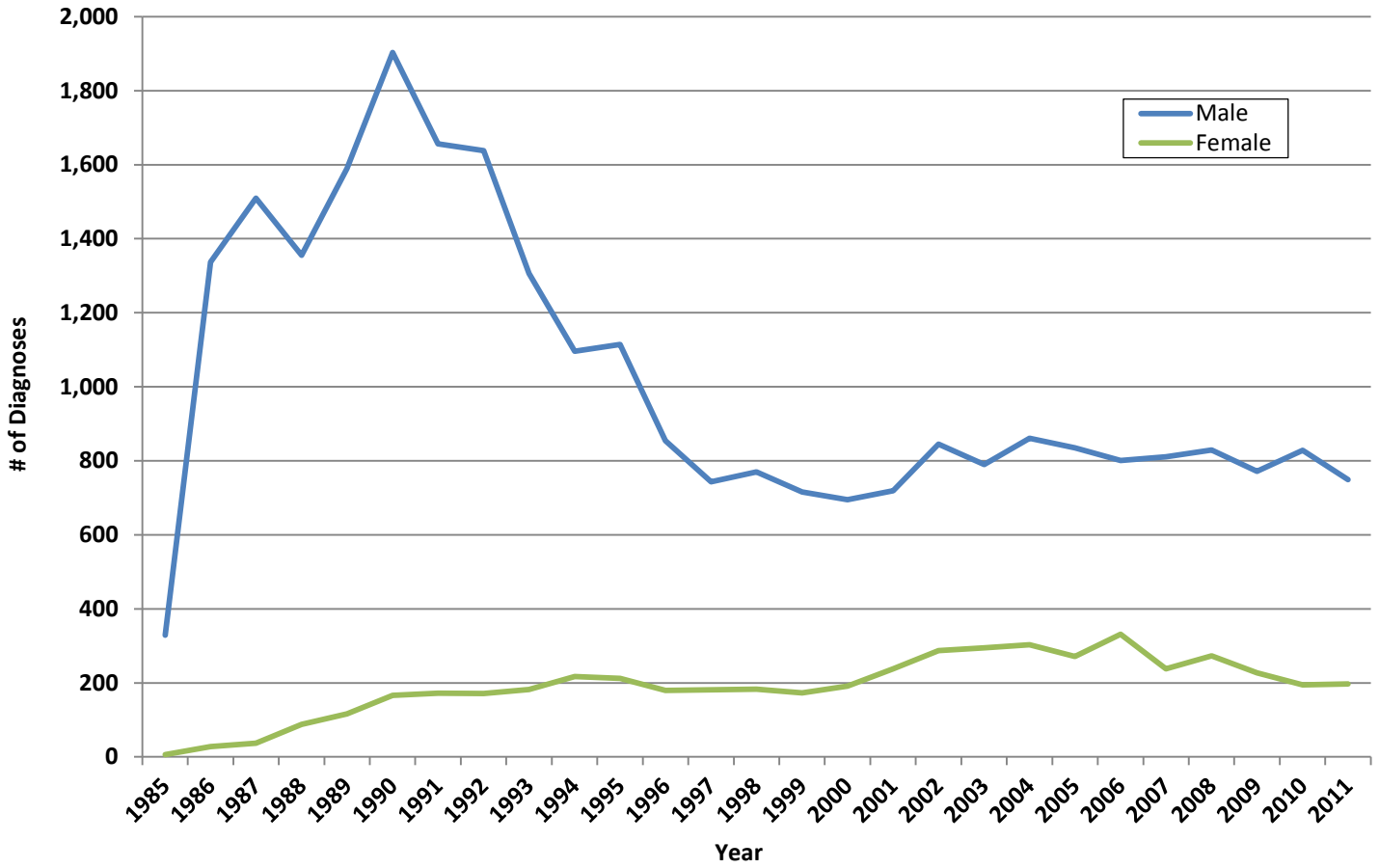
NEW DIAGNOSES DOWN SLIGHTLY IN 2011-12

The Ontario Public Health Laboratory reported 946 new HIV diagnoses in 2011, down about 8% from 1,023 in 2010, and down from 999 in 2009-10. The number of new diagnoses in men (749) was the lowest since 2001 while the number in women (197) remained nearly as low as in 2010 (192), suggesting a possible levelling of after the surge in diagnoses between 2000 and 2009. (Note: the Ontario HIV Epidemiological Monitoring Unit recently updated its HIV diagnoses analysis to remove repeat HIV positive tests, which resulted in a decrease in new diagnoses each year since 1996.)

While these numbers are encouraging, they would have to be sustained over time to be identified as a trend. Even with this promising drop in the number of new diagnoses, we continue to see a sustained, ongoing infection rate that reinforces the importance of prevention programs.

NOTE: HIV diagnoses data show only the number of diagnoses or rate at which people are being diagnosed with HIV/AIDS. They do not include the estimated 20 to 30% of people who are HIV positive but have not been tested or diagnosed, and may not know their HIV status.

Figure 1
Number of HIV Diagnoses (adjusted[1]) Among Males and Females by Year of Diagnosis, Ontario: 1985 - 2011



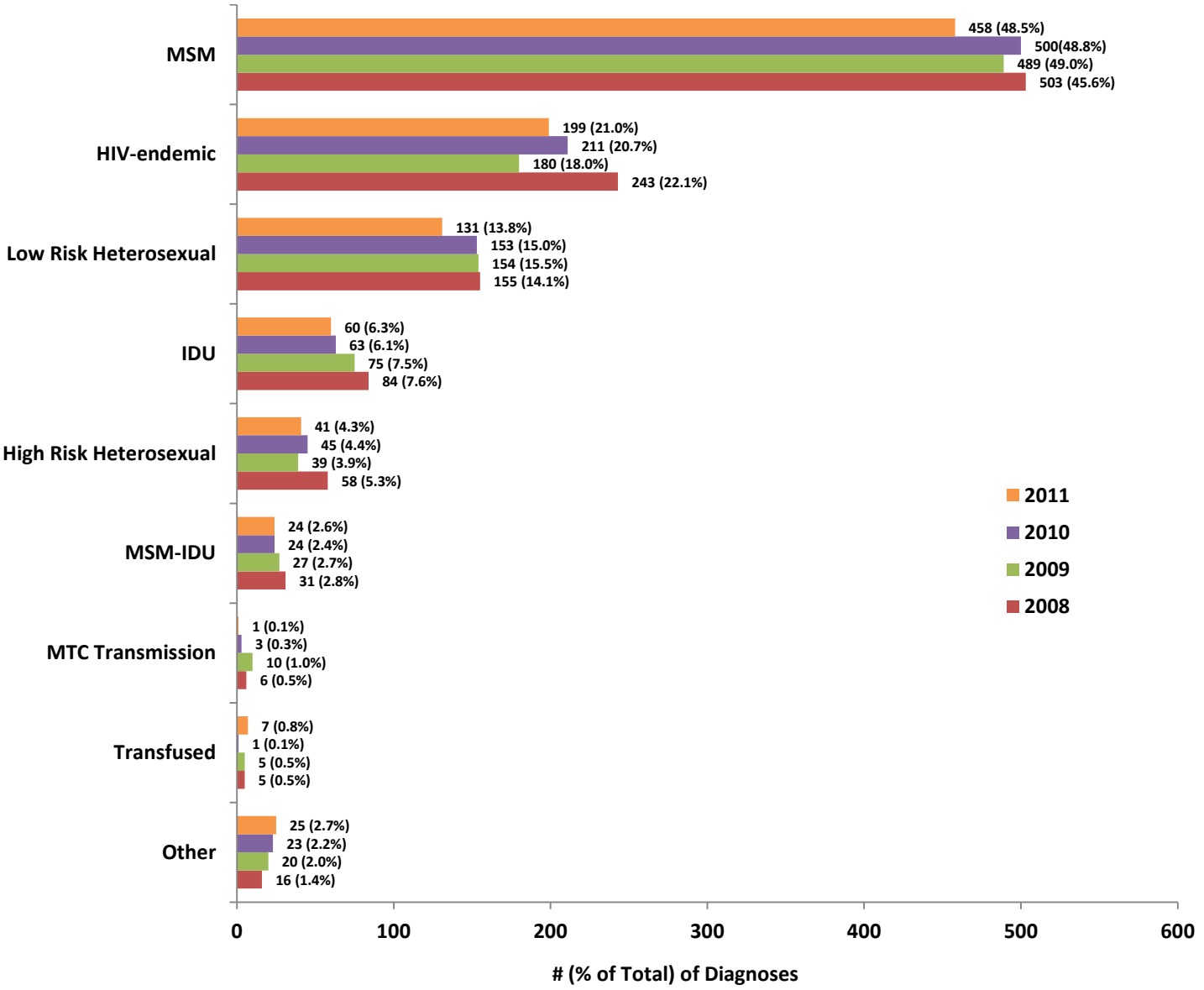
1. Unknown sex assigned according to the distribution of cases with known sex (see Technical Notes); thus, totals may differ due to rounding
Source: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care
From: http://www.phs.utoronto.ca/ohemu/doc/Table1.pdf- accessed June 25, 2012

MEN WHO HAVE SEX WITH MEN CONTINUE TO ACCOUNT FOR >50% OF NEW DIAGNOSES

The populations most affected by HIV in Ontario remain consistent over time. Despite the drop in new diagnoses in men who have sex with men (MSM), this group continues to account for more than half of newly diagnosed infections when we include the MSM-IDU category. In fact, the proportion of new diagnoses in gay men and other men who have sex with men is likely higher than these statistics indicate because – based on Ontario's look-back program – some test requisition forms that indicate "low risk heterosexual", "high risk heterosexual" and "other" are for men who have sex with men.

About 1 in 5 new diagnoses continues to be in people from African, Caribbean and Black communities, and injection drug use continues to be the risk factor for 6 to 7% of new diagnoses.

Figure 2
Number of HIV Diagnoses by Year of Test and Exposure Category: 2008 - 2011

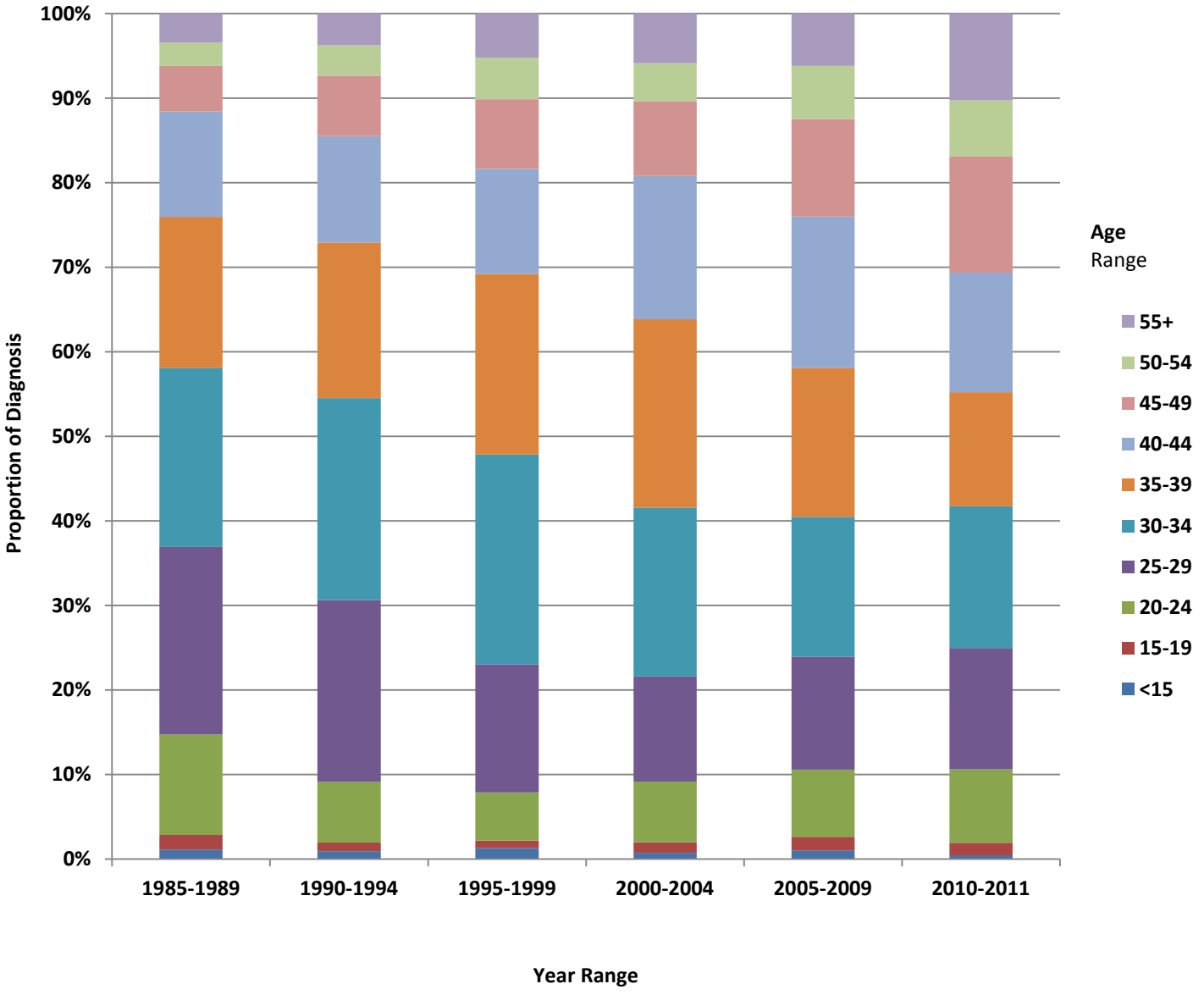


** Data collected on the heterosexual category includes heterosexuals who are at high-risk and at low-risk of acquiring HIV/AIDS. High-risk heterosexual refers to persons reporting a history of sexual contact with a person known to be HIV-infected or at high-risk of HIV infection (e.g., bisexual male [for women only], injection drug user, person from an HIV-endemic region). Low-risk heterosexual includes all other persons who have had sex with a person of the opposite sex, none of whom were reported to be HIV-infected or at increased risk of being HIV-infected; or to have any other risk for HIV infection. (When low-risk heterosexual cases are further analysed, risk taking activity with a person from a high-risk category is often disclosed.)*

45% OF NEW DIAGNOSES ARE IN PEOPLE > AGE 40

Despite a slight increase in new diagnoses in Ontarians between the ages of 20 and 24, the majority of new diagnoses continue to be in older Ontarians, with generally rising rates among those age 40 and older. People over age 40 now account for almost half of new diagnoses. We see the same trends in age at diagnosis in both males and females. However, 61.4% of HIV prevalence amongst males is accounted for by men over the age 40 as compared to 42.3% amongst women.

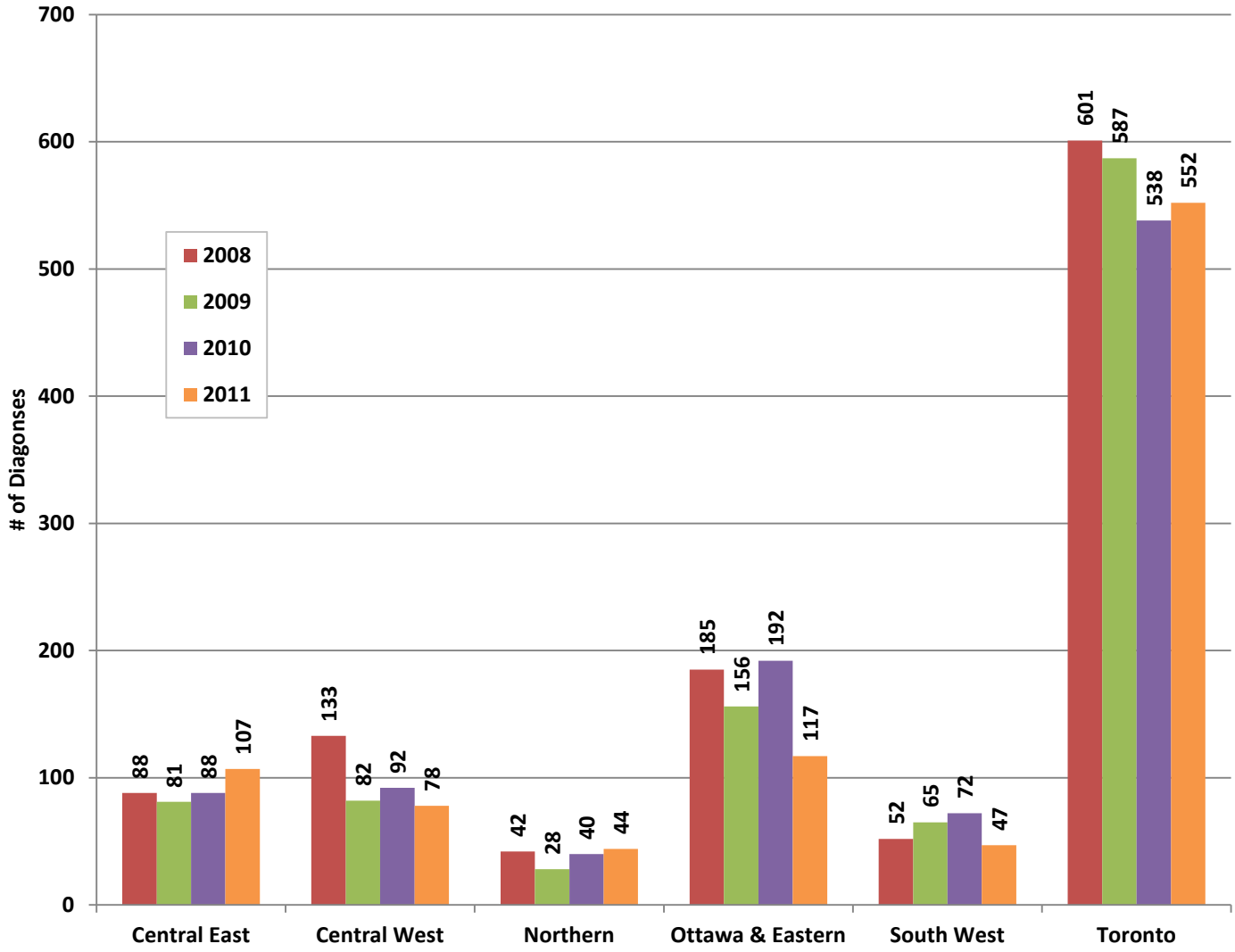
Figure 3
Age at Time of HIV Diagnosis



NUMBER OF NEW DIAGNOSES UP IN CENTRAL EAST AND TORONTO, AND DOWN OR STEADY IN MOST OTHER REGIONS

Toronto and the Northern regions saw a slight increase in new diagnoses in 2011 (4% and 5%), while Ottawa and South West saw a significant drop (39% and 34% respectively) and Central West a slight drop (10%). In 2011, Central East had the largest number of new diagnoses in the past five years (107) – an increase of 18% from 2010.

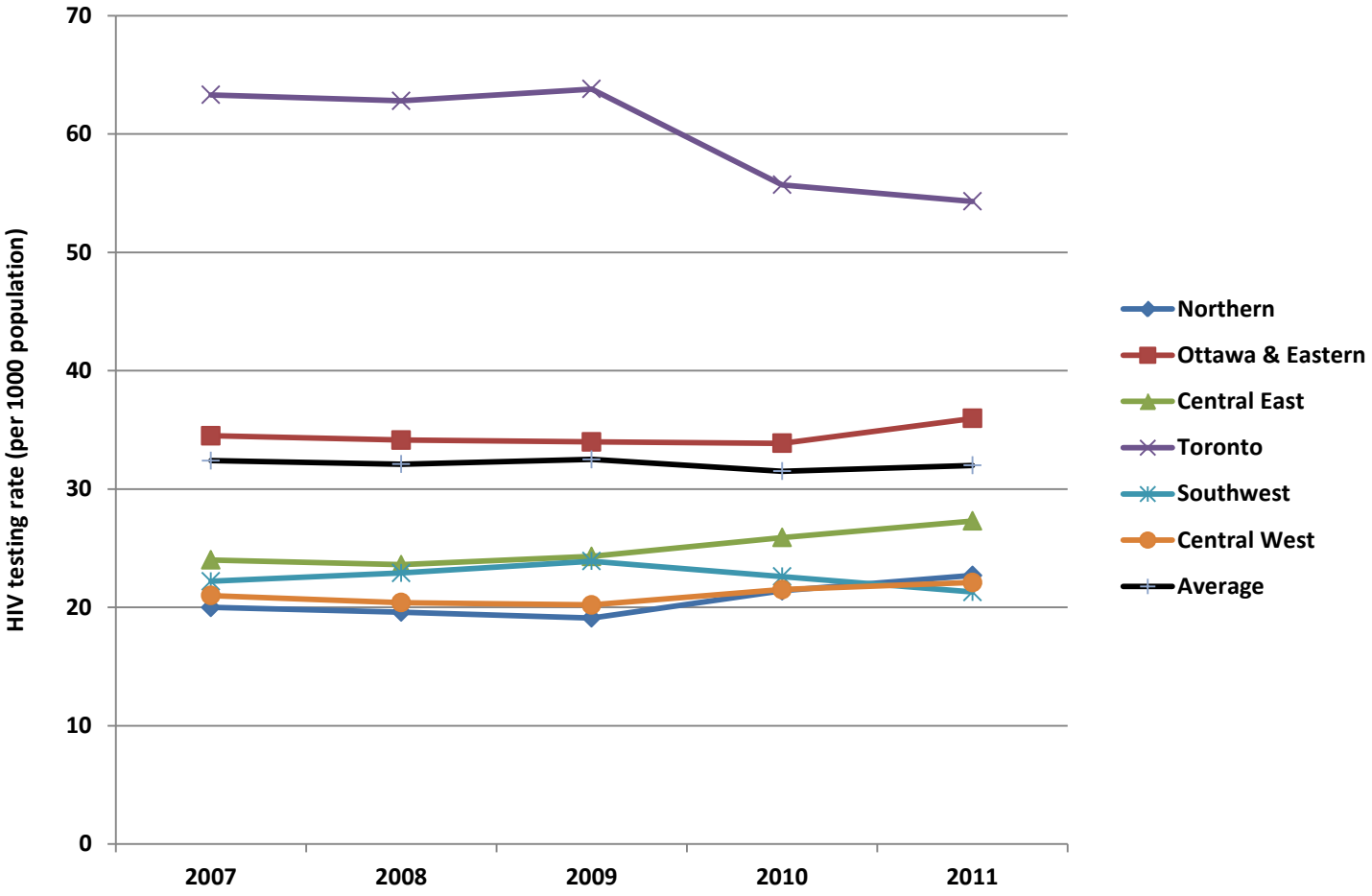
Figure 4
New Diagnoses by Region



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

In terms of testing rates, the number of HIV tests done each year per 1000 population has increased in all regions except Toronto and Southwest (Figure 5). It is interesting to note that Toronto saw an increase in positive tests despite a lower testing rate. This trend may indicate that testing programs are reaching those at highest risk. Central West and Northern, which had increased testing rates in 2011, also had more positive test results; however, that pattern did not hold true for Ottawa, where a higher proportion of the population was tested but there were fewer positive test results.

Figure 5
HIV Testing Rate Per 1000 Population



PART II:

HOW WE WORK

ONTARIO'S COMMUNITY-BASED HIV NETWORK

The View from the Front Lines reflects the activities of 87 community-based programs located within 71 different organizations across the province – including 40 community-based AIDS service organizations (ASOs), 19 non-ASOs, 8 community health centres, and 4 other health care organizations – funded by the AIDS Bureau and ACAP to provide prevention and support services for people with or at risk of HIV, and their partners and families.

Of the 71 organizations:

- 61 are local or regional service programs that provide direct services to clients in their geographic area
- 4 are provincial service organizations that provide direct services to clients across the province
- 6 are provincial resource organizations that provide advice and support to community-based AIDS services organizations and other organizations/providers serving people with HIV.

Some of the provincial organizations – such as OAHAS and Hemophilia Ontario – 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 6
Provincial HIV/AIDS Programs

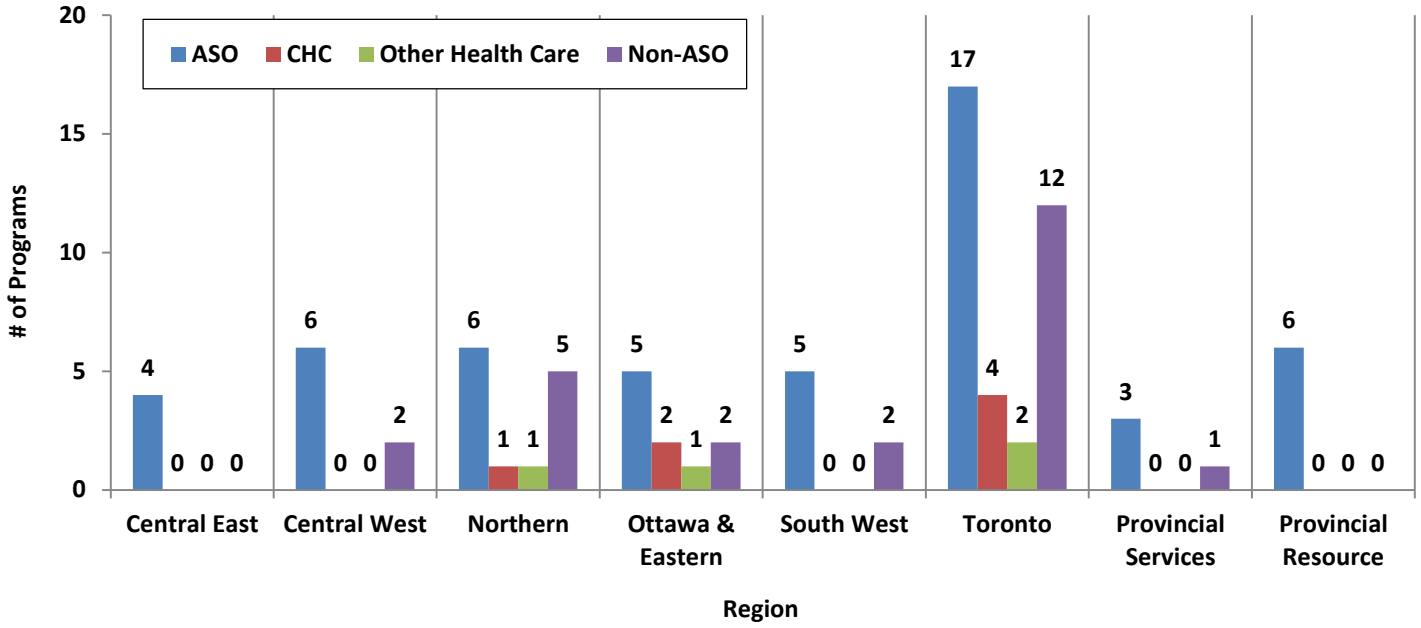
Provincial Programs that Provide Services Directly to Clients	Provincial Programs that are a Resource for Other HIV/AIDS Programs*
HIV & AIDS Legal Clinic (Ontario) (HALCO)	African and Caribbean Council on HIV/AIDS in Ontario (ACCHO)
Ontario Aboriginal HIV and AIDS Strategy (OAHAS)	AIDS Bereavement and 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.*

COMMUNITY-BASED SERVICES ARE LOCATED ACROSS THE PROVINCE

All regions of Ontario have some community-based HIV services, but the majority (including the provincial resource programs) are located in Toronto – where the greatest numbers of HIV cases are concentrated.

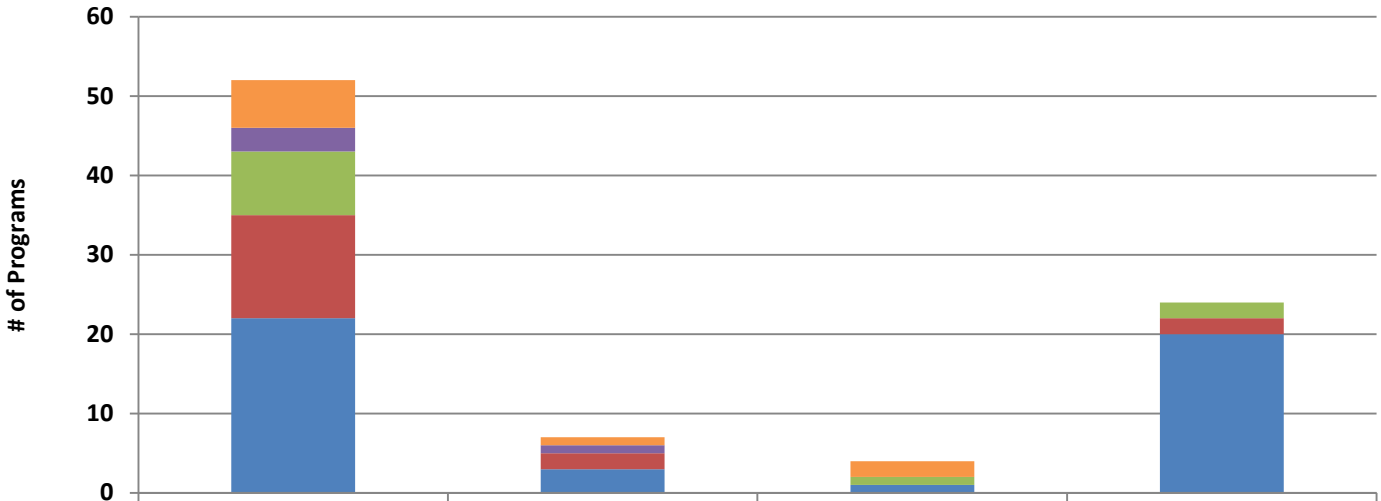
Figure 7
Community-based Services are Located Across the Province



SIZE AND SCOPE OF PROGRAMS VARY

Community-based programs vary significantly in size: over half have five or fewer staff. As would be expected, the larger programs are located in larger urban centres, like Toronto.

Figure 8
Number of Programs by Program Type and Size (by FTE)



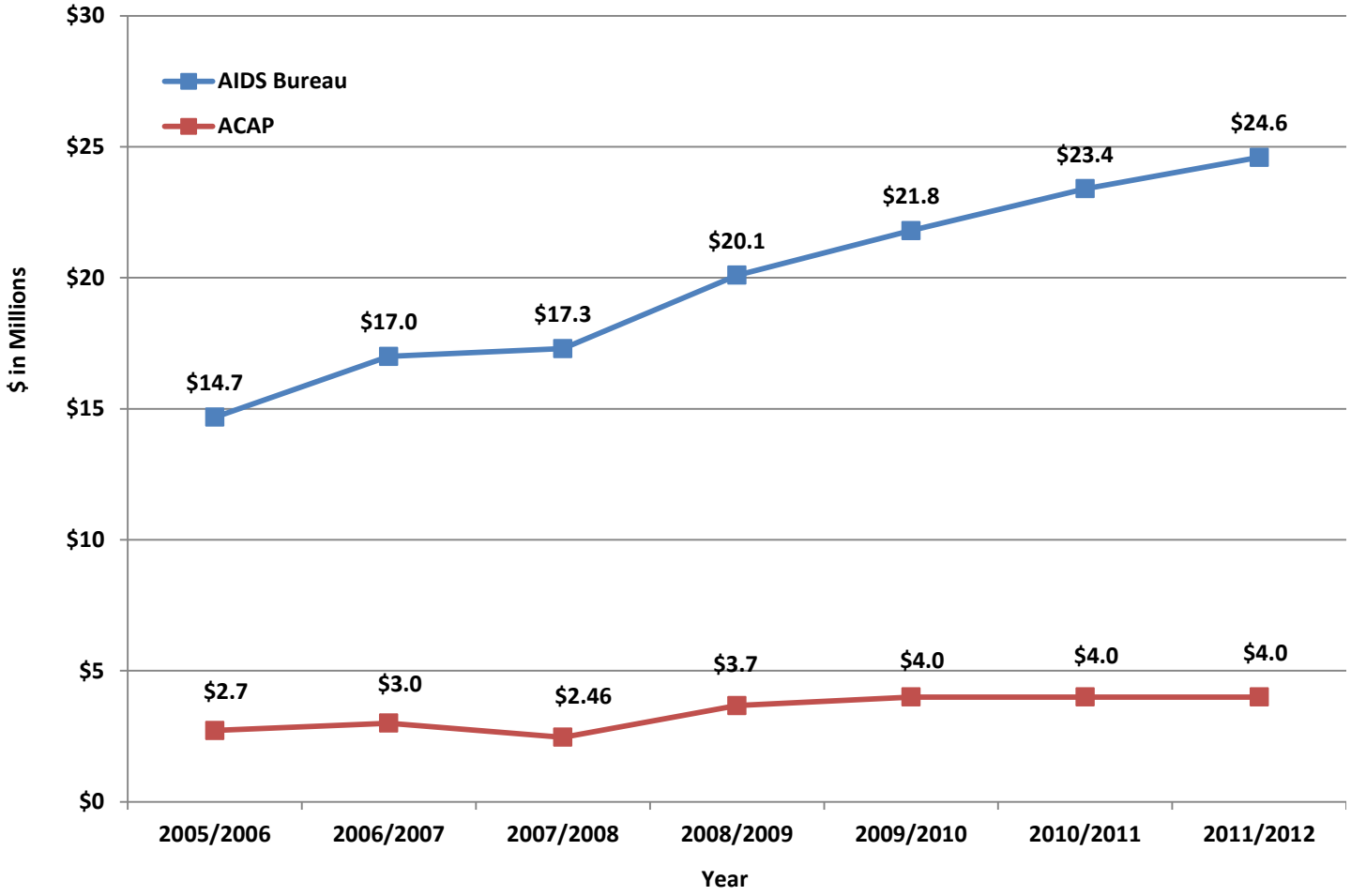
	ASO	CHC	Other Health Care	Non-ASO
>20	6	1	2	
16 to 20	3	1		
11 to 15	8		1	2
06 to 10	13	2		2
01 to 05	22	3	1	20

GOVERNMENT FUNDING FOR COMMUNITY-BASED HIV PROGRAM UP >4% IN 2011

All 87 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 Regional Office) to provide prevention and support services for people with and at risk of HIV.

In 2011-12, the programs received a total of $28.6 million from the AIDS Bureau and PHAC. The following graph shows funding trends over the past seven years. AIDS Bureau funding has increased every year (by 5% in 2011-12) while PHAC funding has remained relatively stable for the past four years.

Figure 9
Annual ACAP and AIDS Bureau Funding as Reported by Funders



FUNDING IS DISTRIBUTED TO REFLECT HIV NEEDS

In terms of distribution of funding across the province, the greatest proportion (47% in 2011-12) is allocated to agencies located in Toronto, which has the largest number of programs and the largest number of people with HIV and at risk. However, all regions have seen steady increases in funding over the past four years.

Many programs located in Toronto also provide either direct client services for people outside Toronto or services for community-based AIDS programs across the province. About 3.5% of the funding received by Toronto-based programs is used to support provincial programs and services.

DEDICATED ASOs DEPEND 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 29 dedicated AIDS service organizations and does not include the funding to non-ASOs, community health centres or programs in other health care settings. This is because we do not have complete information on the full range of funding received by these other organizations.

The 29 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.

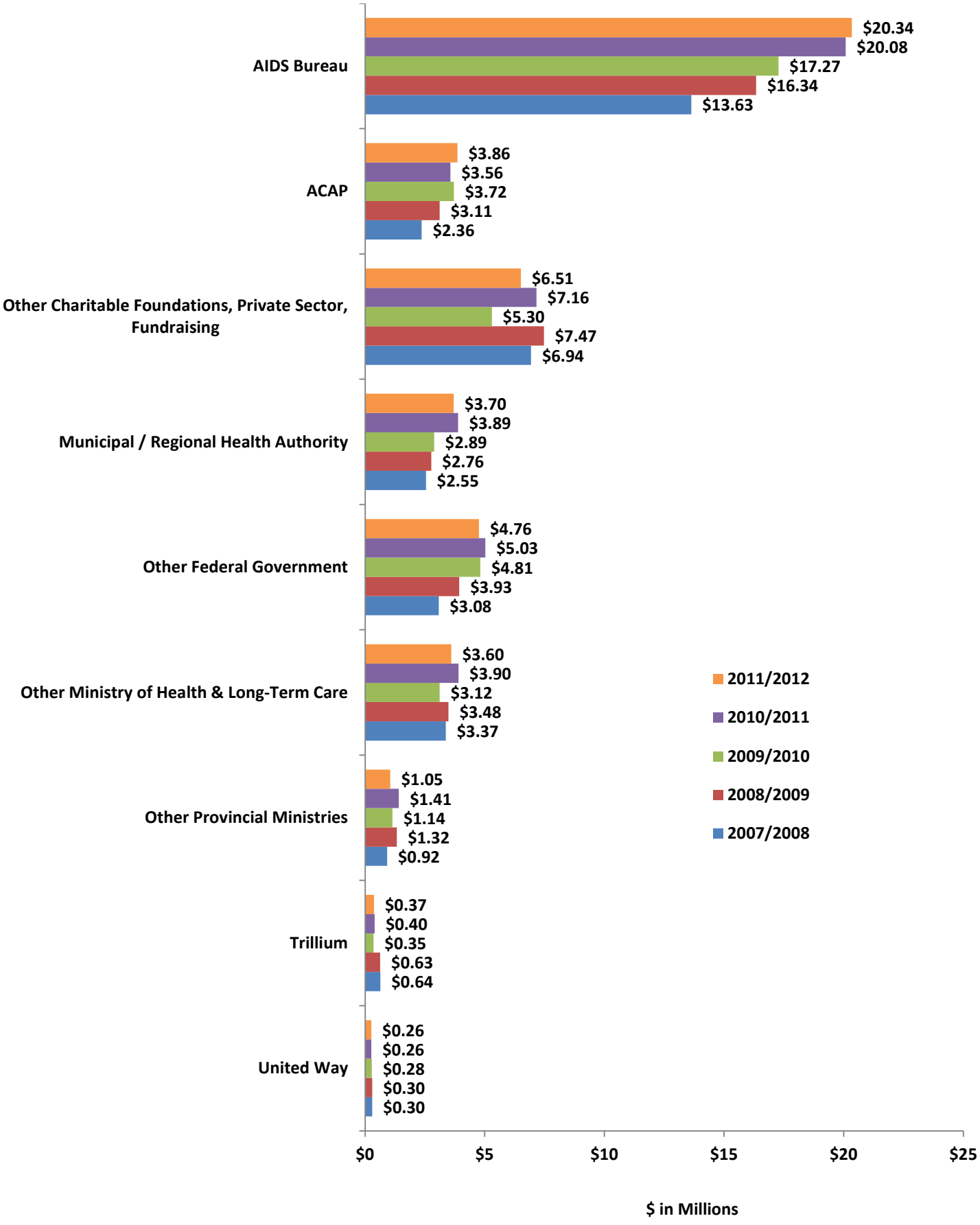
Figure 10
Funding Sources Reported by ASOs

	Source	Amount ($)	%
Government of Ontario	AIDS Bureau	20,338,042.00	43%
	Other Ministry of Health & Long-Term Care	3,598,497.00	8%
	Other Provincial Ministries	1,049,518.36	3%
Federal Government	ACAP	3,859,085.00	8%
	Other Federal Government	4,762,165.00	10%
Local	Municipal / Regional Health Authority	3,696,247.00	8%
Private Sector	Other Charitable Foundations, Private Sector, Fundraising	3,194,259.23	7%
	Fundraising	3,317,337.23	7%
Non-Governmental Funding	Trillium	372,385.05	1%
	United Way	260,434.05	1%
Other	Other	2,574,860.00	5%
	Grand Total	**47,022,829.33**	**100%**
		Highlighted Sources	79%

Despite the 5% increase in funding from the AIDS Bureau, the 29 ASOs reported receiving over $900,000 less in funding in 2011-12 than in 2010-11. In the last year, the ASOs obtained only 7% of their funding from the private sector and fundraising compared to 15% in 2010-11. Fifteen of the 29 AIDS service organizations reported a greater than 10% drop in non-government funding. They also reported receiving less from municipal government and regional health authorities, which are also facing budget pressures.

Note: We investigated the relatively high amount (5% of overall funding) reported in the "other" category. A significant proportion is funding from Local Health Integration Networks or other sources that could have been reported in the private sector or non-government funding categories.

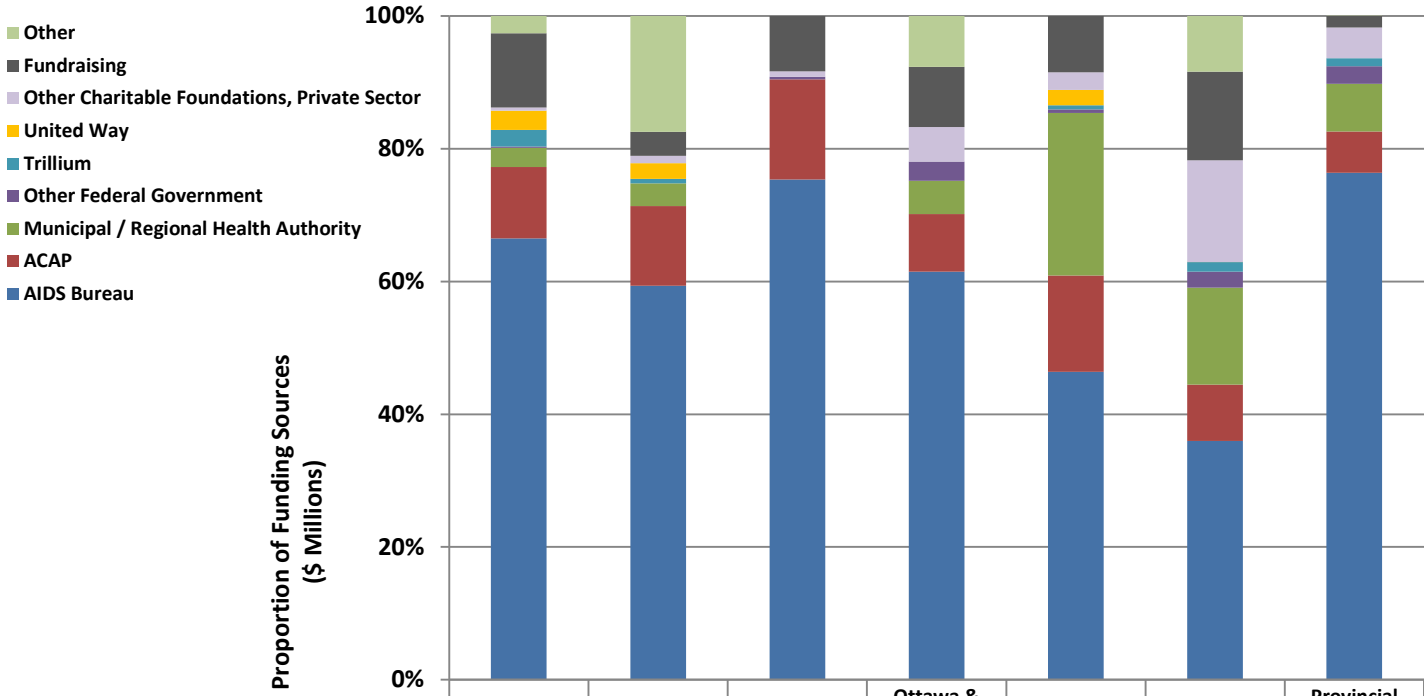
Figure 11
ASO Sources of Funding



SOME REGIONS HAVE MORE CAPACITY TO FUND RAISE

Figure 12 compares the proportion of funding in each region by source of funding. It shows clearly that certain regions, such as Northern, Central East, Ottawa and Central West, are more dependent on AIDS Bureau and ACAP funding than the South West and Toronto regions. The South West and Toronto in particular have been effective in obtaining a significant proportion of their funding from the municipal government and/or regional health authority (LHIN). Figure 12 also highlights the important role of fundraising in most regions. Of all regions, Toronto has been the most effective in obtaining funding through fundraising, charitable foundations and the private sector. This is likely due to the critical mass of people living with HIV, programs and potential donors in a large urban centre.

Figure 12
Sources of Funding by Region – 2011/2012 ($ in millions)



	Central East	Central West	Northern	Ottawa & Eastern	South West	Toronto	Provincial Services
Other	$0.06	$0.88	$0.00	$0.21	$0.00	$1.34	$0.00
Fundraising	$0.25	$0.18	$0.18	$0.25	$0.28	$2.13	$0.05
Other Charitable Foundations, Private Sector	$0.01	$0.06	$0.02	$0.14	$0.09	$2.43	$0.13
United Way	$0.06	$0.12	$0.00	$0.00	$0.08	$0.00	$0.00
Trillium	$0.06	$0.03	$0.00	$0.00	$0.02	$0.23	$0.03
Other Federal Government	$0.00	$0.00	$0.01	$0.08	$0.02	$0.38	$0.07
Municipal / Regional Health Authority	$0.06	$0.17	$0.00	$0.14	$0.81	$2.32	$0.19
ACAP	$0.24	$0.60	$0.33	$0.24	$0.48	$1.35	$0.17
AIDS Bureau	$1.48	$2.98	$1.62	$1.70	$1.52	$5.72	$2.05

EMERGING ISSUES/TRENDS

Funding and financial stability/sustainability continue to be an issue:

1. What do the current trends in fundraising mean for the sector?
2. What strategies are programs using to engage their LHINs?

PART III:

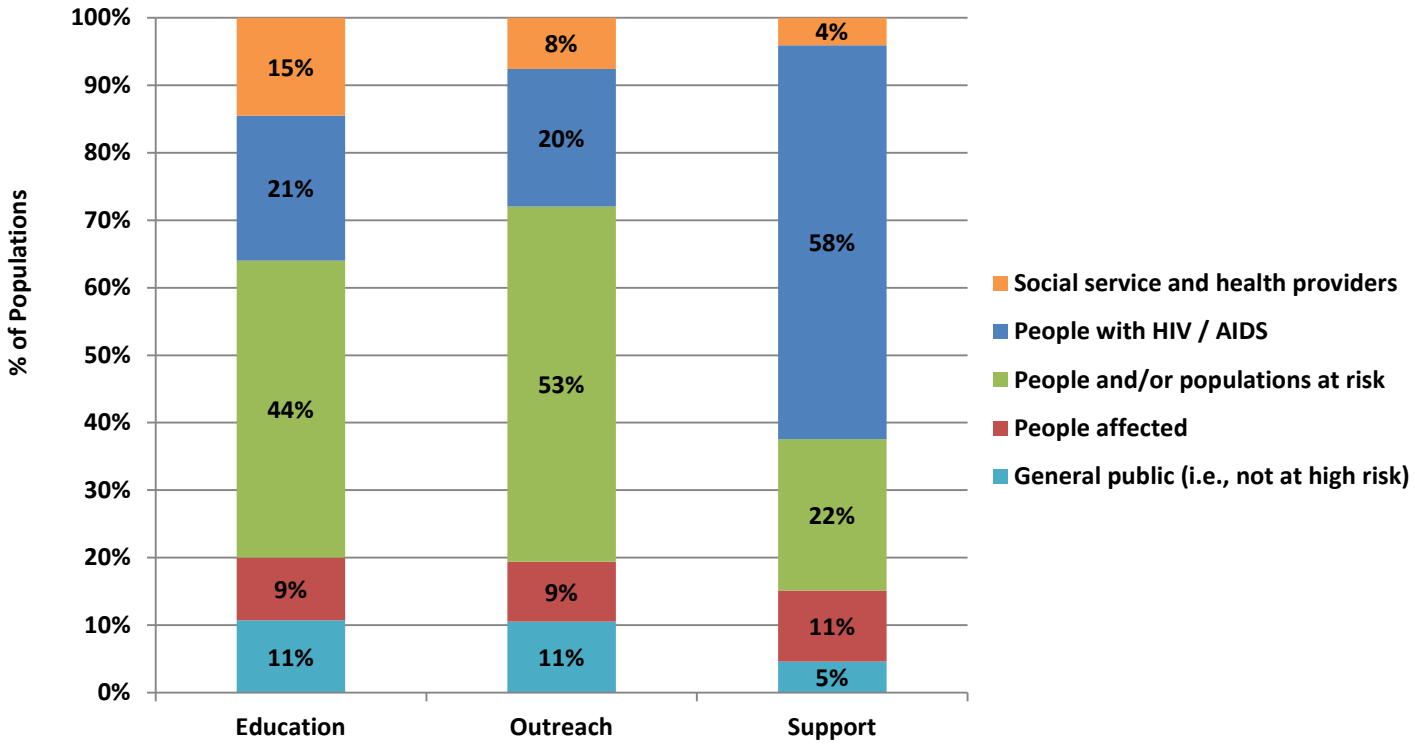
THE PEOPLE WE SERVE

COMMUNITY-BASED HIV SERVICES IN ONTARIO

Ontario's community-based HIV programs report serving primarily people living with or at risk of HIV. They also provide services to people affected by HIV (e.g., partners, families and friends of people with HIV), other agencies that serve people with HIV or populations at risk, and the general public.

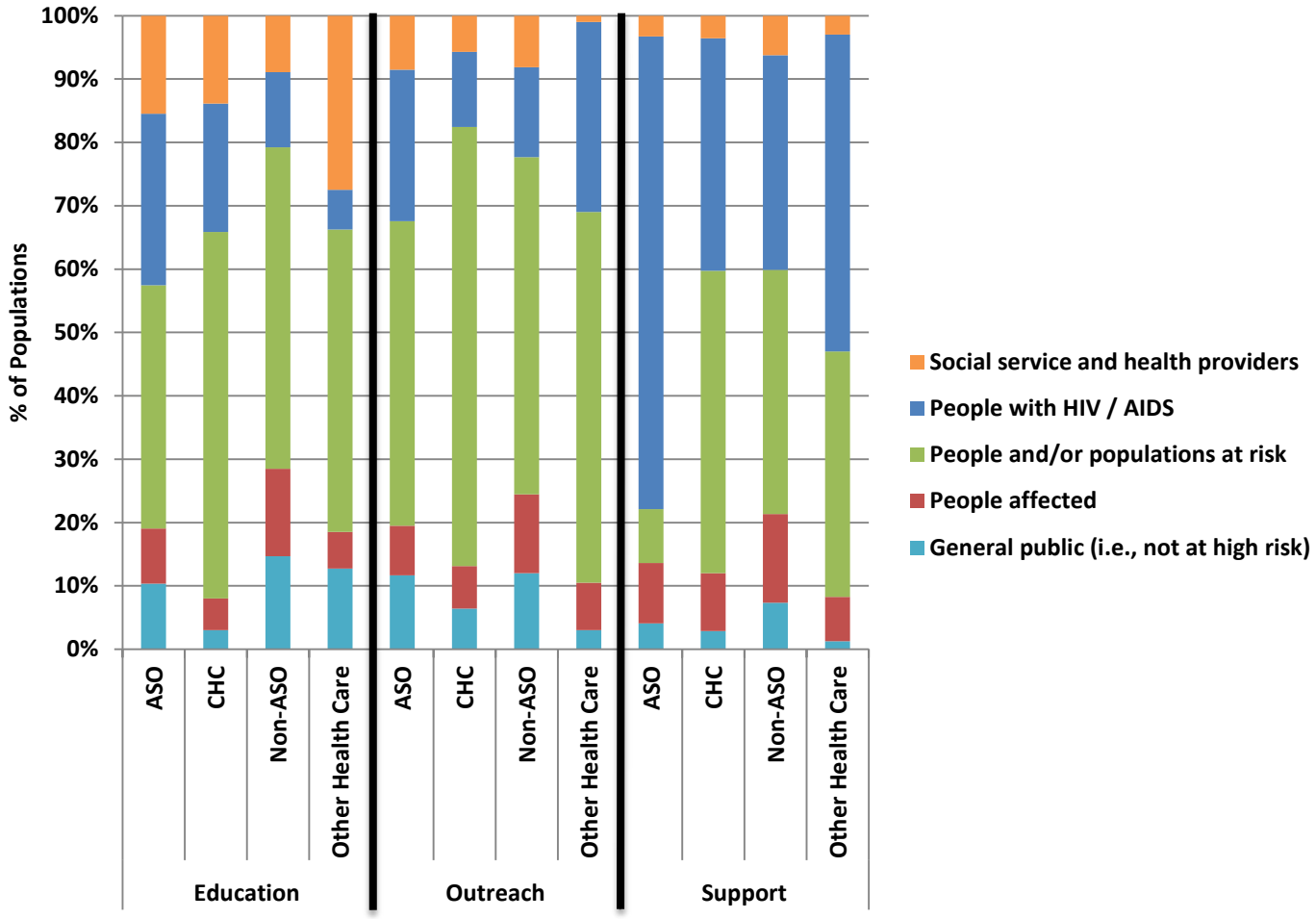
Education and outreach programs are targeted mainly to people at risk, while support programs serve mainly people living with HIV.

Figure 13
Target Populations by Type of Service: 2011/2012 H2



Looking more closely at the target populations for each service by type of agency (Figure 14), it is clear that dedicated ASOs are more focused on serving people living with HIV (dark blue section of the bars), while other organizations are more focused on serving people at risk (green section of the bars). ASOs target more people living with HIV for education and outreach programs than do the other types of agencies, while the other agencies are more likely than ASOs to target support services to people at risk. As noted in last year's report, it is still not clear why any agencies would be providing support services to members of the general public who are not at high risk. This appears to be more of an issue in non-ASOs than in other types of organizations.

Figure 14
Target Populations by Service and by Type of Agency: 2011/2012 H2



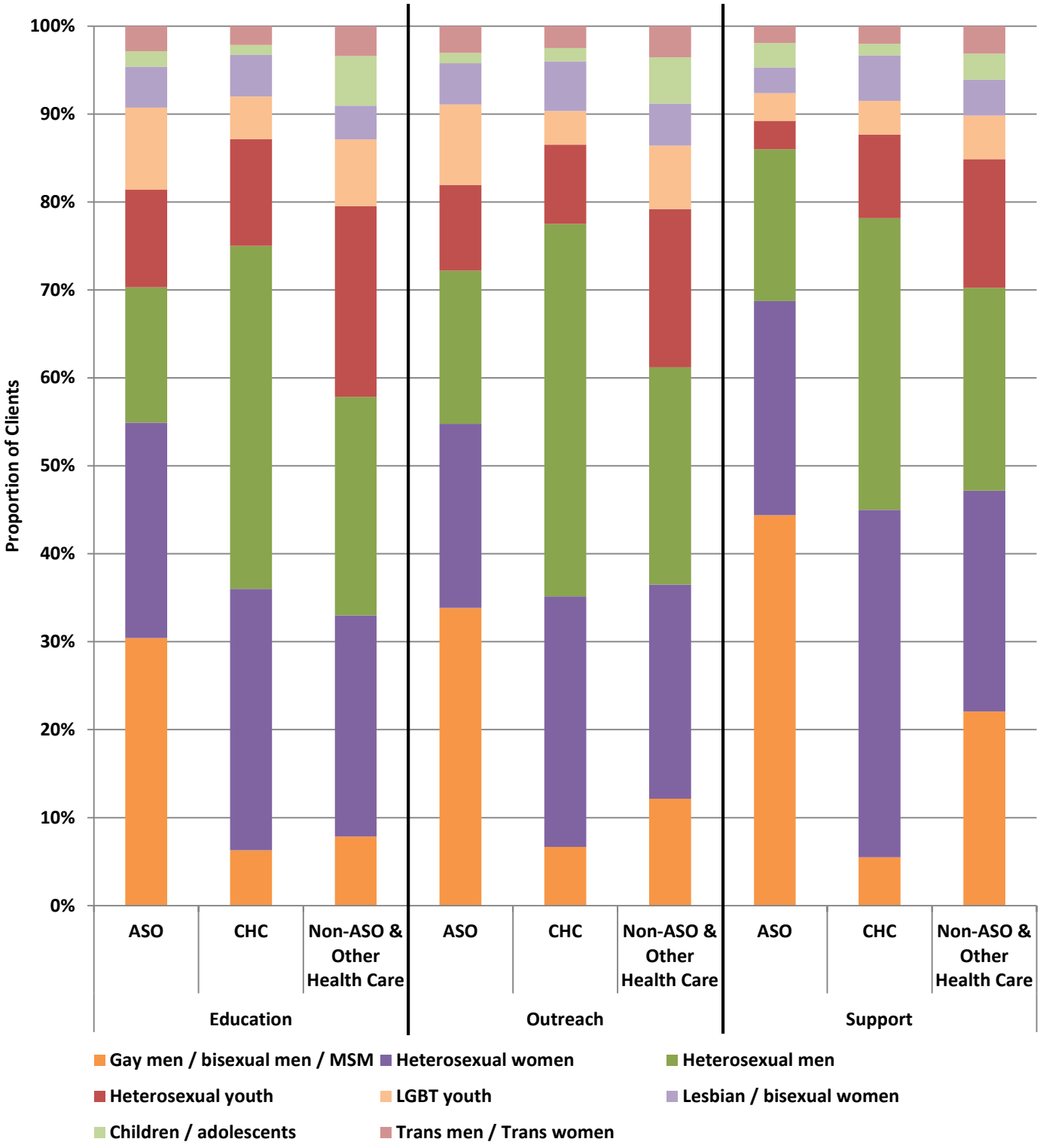
ARE PROGRAMS SERVING THE RIGHT CLIENTS?

Gay men account for over 50% of all new diagnoses and more than 60% of people living with HIV. When asked about their client mix, programs estimated that between 8% and 44% of service users – depending on the type of service (education, outreach or support) and the type of program (AIDS service organizations, community health centres, non-AIDS service organizations and other health care settings) – were gay men and other men who have sex with men. The variation in the proportion of clients who are gay men is due in part to the programs' different mandates. Compared to programs in other settings, ASOs – whose mandate is specifically to serve people with or at risk of HIV – report having a higher proportion of clients who are gay men and other men who have sex with men, and a lower proportion of heterosexual youth clients. On the other hand, the mandate of CHCs is to serve specific populations such as people who inject drugs and use other substances, and African, Caribbean and Black populations, so it makes sense that they would see fewer gay men and more heterosexual women and heterosexual men.

Having said that, a significant proportion of education (15%), outreach (13%) and even support service (8%) clients in all programs are heterosexual youth – more than are LGBT youth. Are these clients at risk (e.g., through drug use, living on the street, part of African, Caribbean and Black communities)? Or are they considered a way to reach gay youth who may not be "out"? Should community-based HIV agencies be providing this much service to heterosexual youth, or are other organizations better able to meet their education and outreach needs?

Gay men account for more than 50% of the epidemic but account for only 30-33% of education and outreach clients within ASOs. The reasons for the gap are unclear. Are gay men less in need of these services? Are they getting their information/services elsewhere? Are there barriers to their using community-based services? Do community-based programs need to work differently to reach gay men and other men who have sex with men?

Figure 15
Proportion of Clients by Agency Type for Education, Outreach and Support: 2011/2012 H2

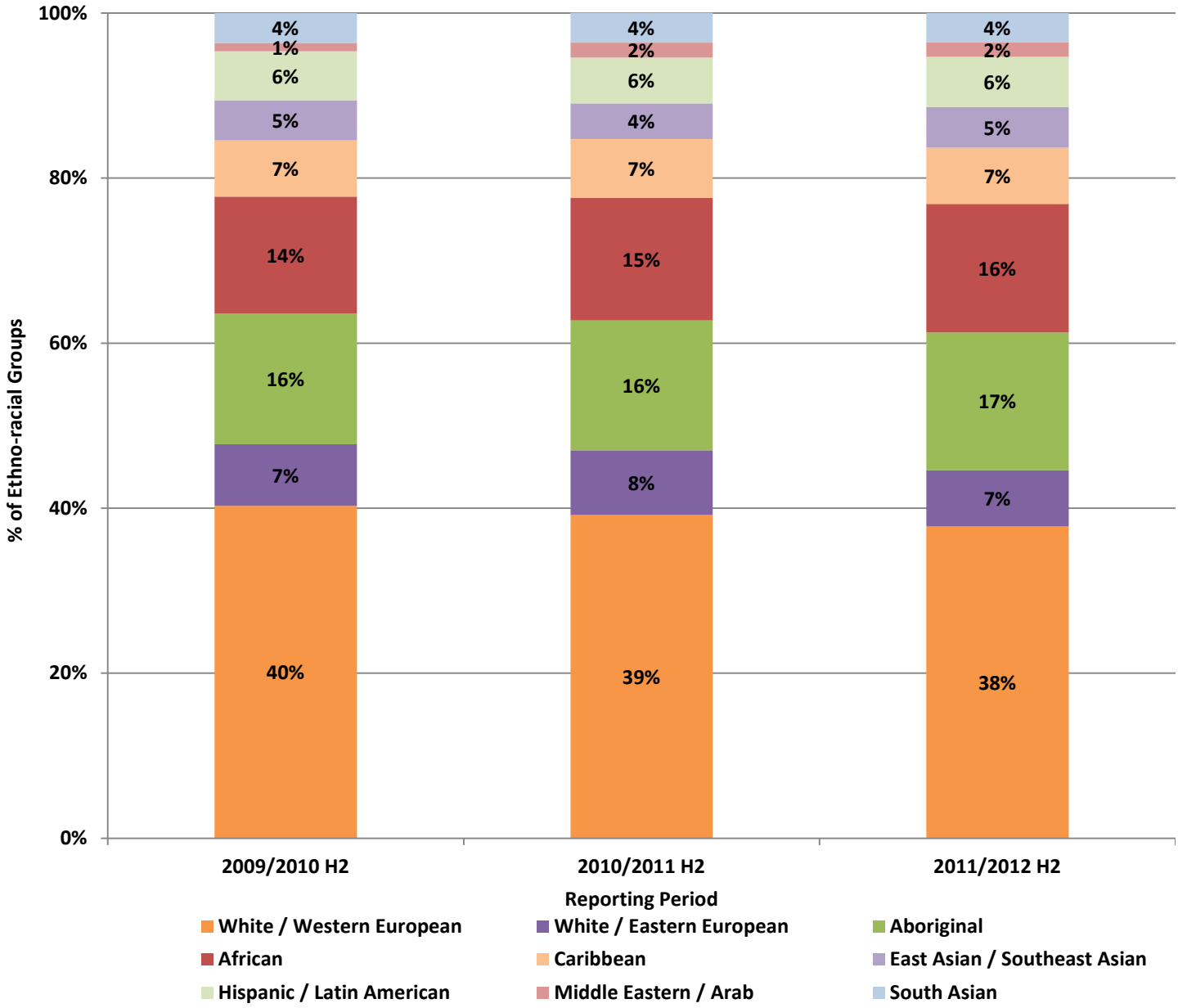


ARE SERVICES CULTURALLY COMPETENT?

In terms of ethnicity, there has been little change in the proportion of clients that programs report serving from different ethno-racial groups. The proportion of White/Western European clients continues to drop slightly while the proportion of Aboriginal and African clients has increased slightly.

Based on what we know about the ethno-cultural groups affected by the epidemic in Ontario, this cultural mix of services appears to be appropriate.

Figure 16
Average Percentage of Services Delivered by Ethno-racial Group



OCHART doesn't ask specifically about the number of newcomers served or programs for newcomers, However, in terms of the need for and the capacity to provide culturally competent services, we were able to obtain some information from the ACAP-funded agencies. In their logic models, they reported more newcomer clients seeking services and more service providers participating in workshops that focus on cultural competence in working with newcomer communities.

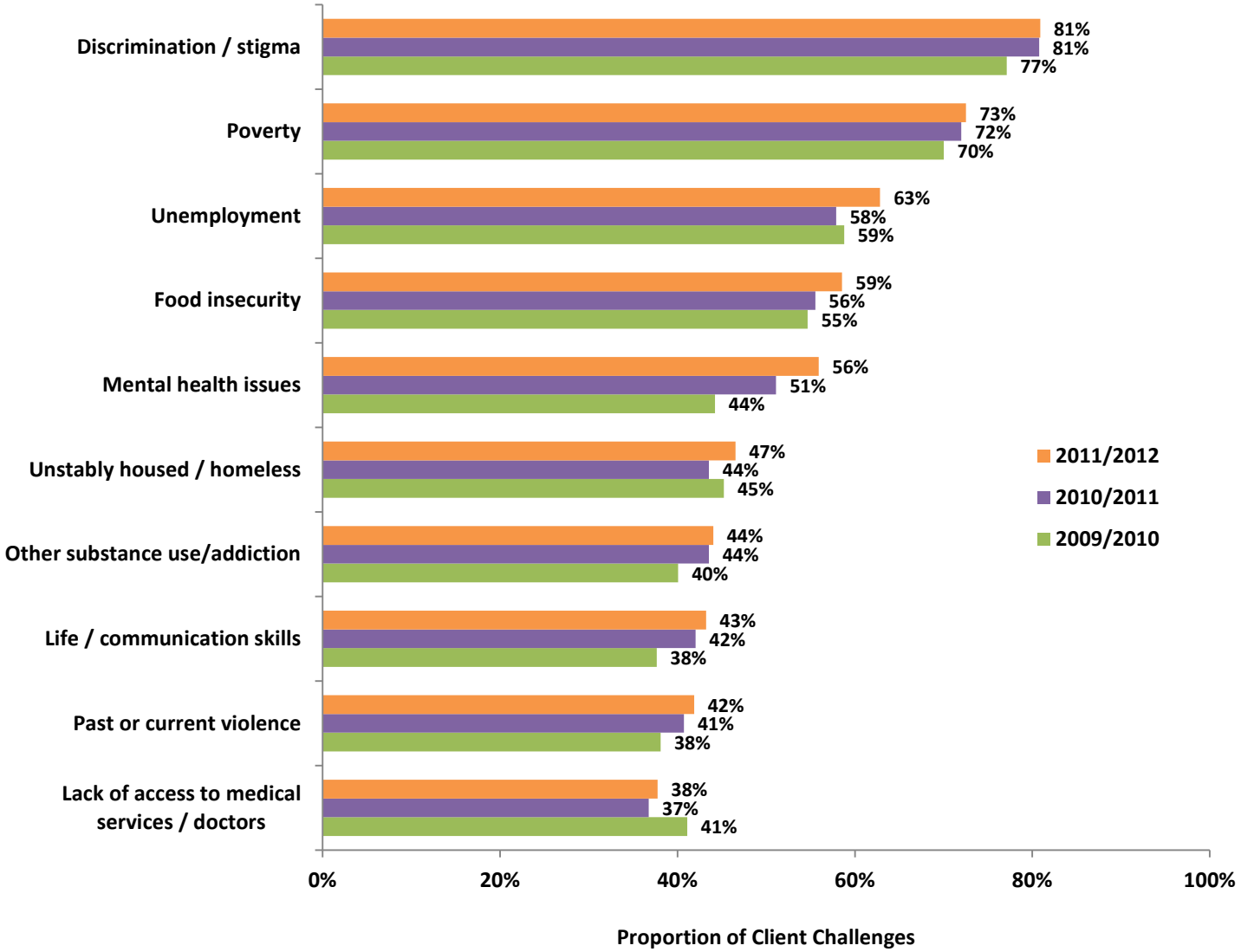
MORE CLIENTS ARE EXPERIENCING UNEMPLOYMENT, FOOD INSECURITY AND MENTAL HEALTH ISSUES

In terms of relative ranking, the health and social challenges facing clients have not changed – however programs report that a larger proportion of people are now struggling with issues such as unemployment, food security, mental health, life skills and violence. Stigma and discrimination continue to be an issue, even more than 30 years into the epidemic. It would be useful to know more about the stigma that clients experience, and how much is due to HIV and how much to other factors such as homophobia, racism and the stigma associated with drug use. Faced with these trends related to the social determinants of health, programs may need to develop different services and/or build stronger partnerships with different agencies in their community. What strategies are agencies using to meet these growing needs?

In terms of access to medical services, almost 40% of clients appear to be facing barriers.

These data are based on estimates provided by the agencies. In the future, we will work to capture more quantifiable data through OCASE, in order to determine how accurate these estimates are.

Figure 17
Proportion of Clients Experiencing Health and Social Challenges: Top 10 Challenges

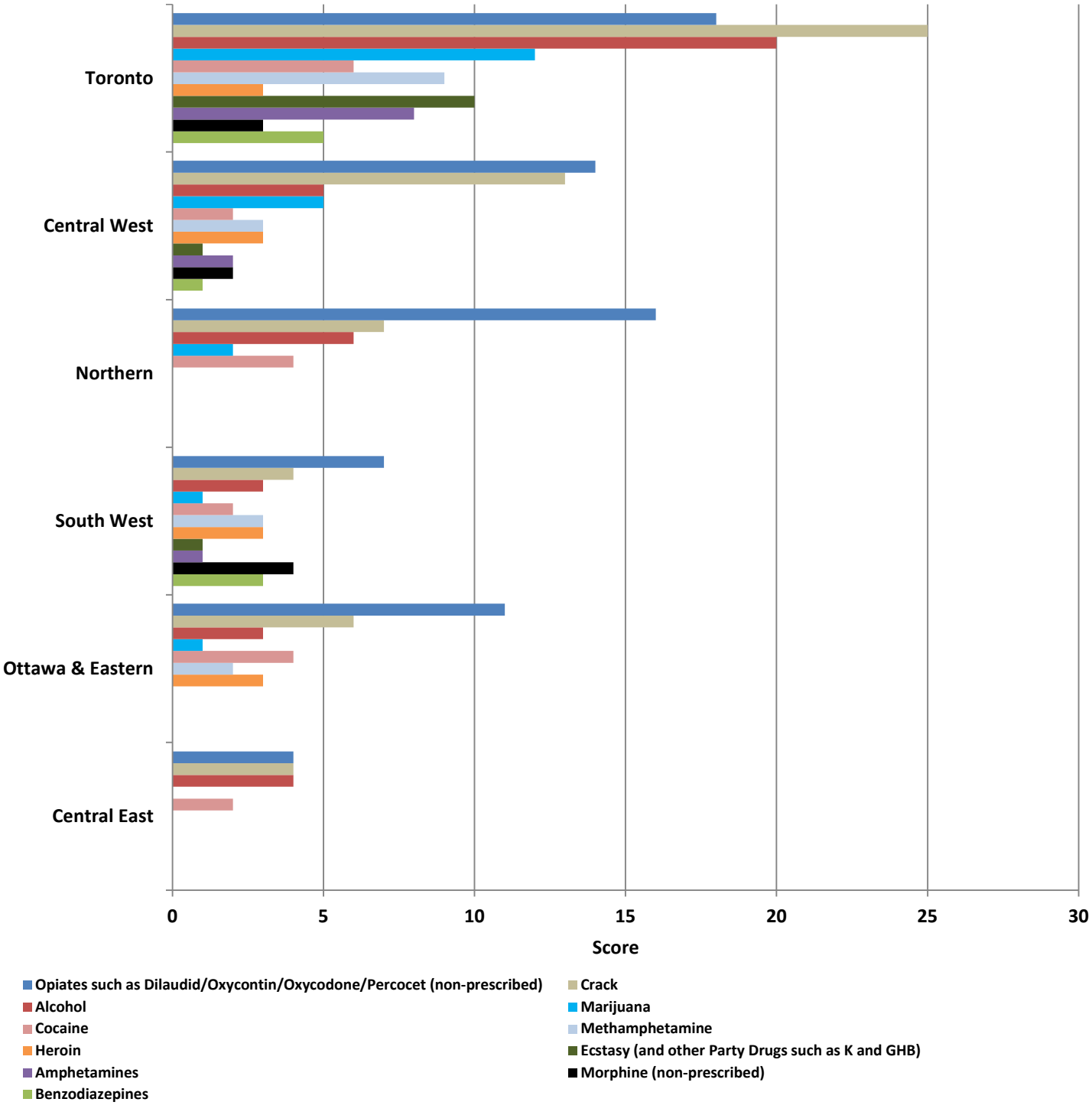


OPIATE, CRACK AND ALCOHOL USE SHAPE SUBSTANCE USE

On average, 43% of clients have substance use issues. That proportion is much higher in certain regions of the province such as Northern (62%), Ottawa and Eastern (56%) and South West (45%).

According to our funded programs, the substances most commonly used by people living with or at risk of HIV are: opiates, crack and alcohol – although substance use patterns vary in different parts of the province. (In Figure 18, the "Score" is determinded as follows: the drug ranked #1 in terms of usage is allocated three points, #2 is allocated two points, and the #3 drug drug receives one point). It remains to be seen whether the discontinuation of Oxycontin and the shift to Oxyneo will have an impact on people's substance of choice (e.g., increased use of heroin) and substance use trends.

Figure 18
Drug Use by Region: 2011/2012 H2



PART IV:

THE IMPACT OF INVESTMENT IN COMMUNITY-BASED HIV/AIDS SERVICES

This section of the report looks specifically at program activities and their impact on our four common goals/ anticipated outcomes:

1. Improving knowledge and awareness
2. Improving access to services
3. Enhancing capacity of individuals and organizations
4. Improving community coordination and collaboration.

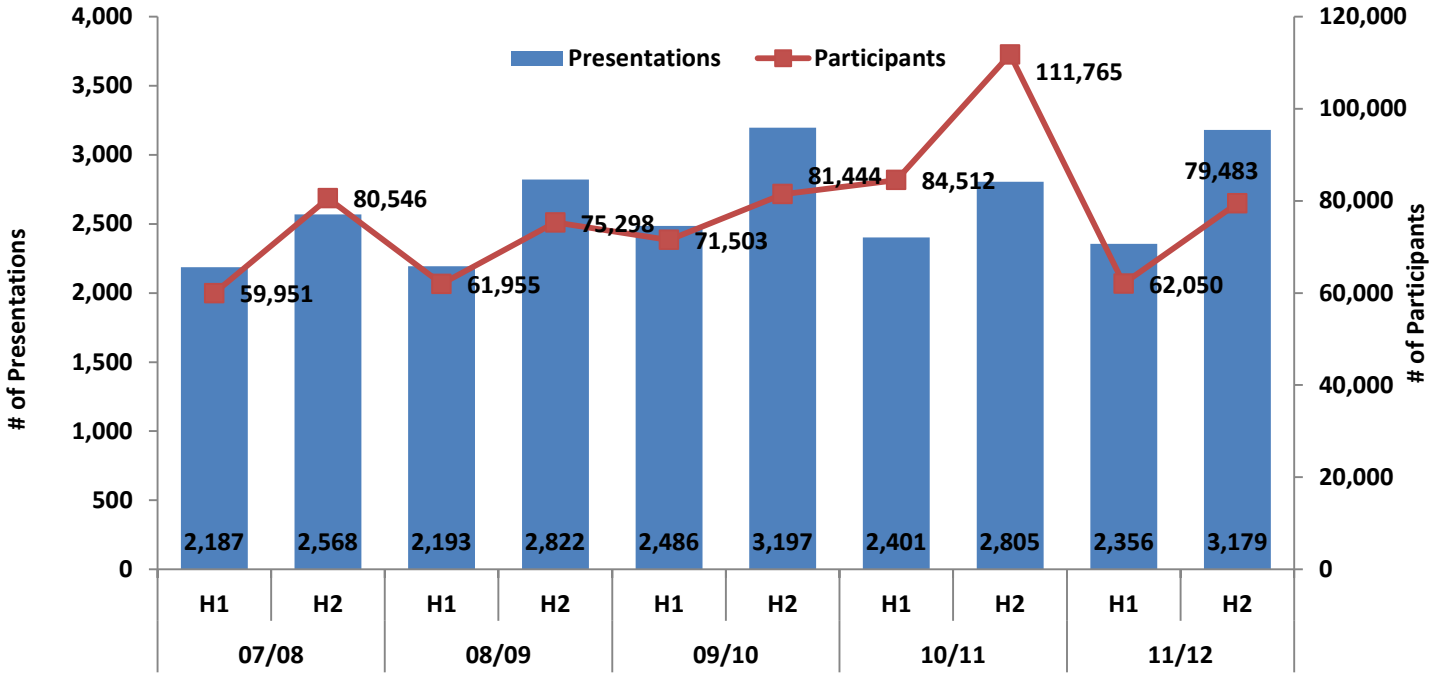
1. IMPROVING KNOWLEDGE AND AWARENESS

One of the key common goals of community-based HIV/AIDS programs is to educate people at risk or living with HIV in order to increase awareness of HIV, the factors that put people at risk of HIV infection or disease progression and the factors that are protective (i.e., can improve health and well-being). Education programs are about more than knowledge. They are also about the skills and resources to use that knowledge to reduce risk, and about developing services that help reduce risk.

PRESENTATIONS FOCUS ON SMALLER GROUPS

Although funded programs gave more education presentations in 2011-12 than in the previous year, they reached fewer participants. A significant proportion of the drop in number of participants was due to one agency that appears to have done fewer presentations to high school students last year. The AIDS Bureau and ACAP see this as a positive trend, as it may mean that other partners in the community (e.g., the schools or public health units) are taking more responsibility for delivering general sexual health education in schools, freeing up resources in ASOs to focus on education, outreach and support for LGBT and other at-risk youth. Overall, agencies reported an increase in demand from schools because of Bill 13: schools are looking for assistance in creating safer spaces for LGBT youth – which is a critical role that community-based agencies are well equipped to fill.

Figure 19
Number of Education Presentations and Participants



In 2011-12, the average number of participants per education session dropped from 38 to 26. Reaching fewer participants is not an indicator of lack of impact. Presentations to smaller groups may, in fact, have more impact than those to large groups because participants may have more opportunities to ask questions and to talk about strategies to reduce risk.

The number of presentations doesn't tell the full story of HIV education programs in Ontario. ASOs are continually adapting and adjusting their education programs to meet evolving needs. In 2011-12, agencies reported an increased demand for:

- women-centred education and support (including women who have sex with men and LGBTTQ)
- education on supporting aging PHAs
- workshops for younger audiences (grades 6-8)
- newcomer support (information/education)
- work with sex workers.

> *"Community members are requesting "Healthy Relationship" workshops. It is a challenge for some community members to maintain relationships and they are requesting help in identifying strategies to make their relationships successful. Requests from the schools are increasing as children in Grade 7 & 8 are beginning to date and there is a concern that they may be pressured into unwanted sexual acts."*

> *"Changing needs of an aging population, increased need for assistance navigating the health care/ social services. The complication of HIV in the aging population presents new concerns to be addressed."*

> *"Increased demand for clear information on disclosure and HIV laws by sex workers and a list of non-judgmental doctors."*

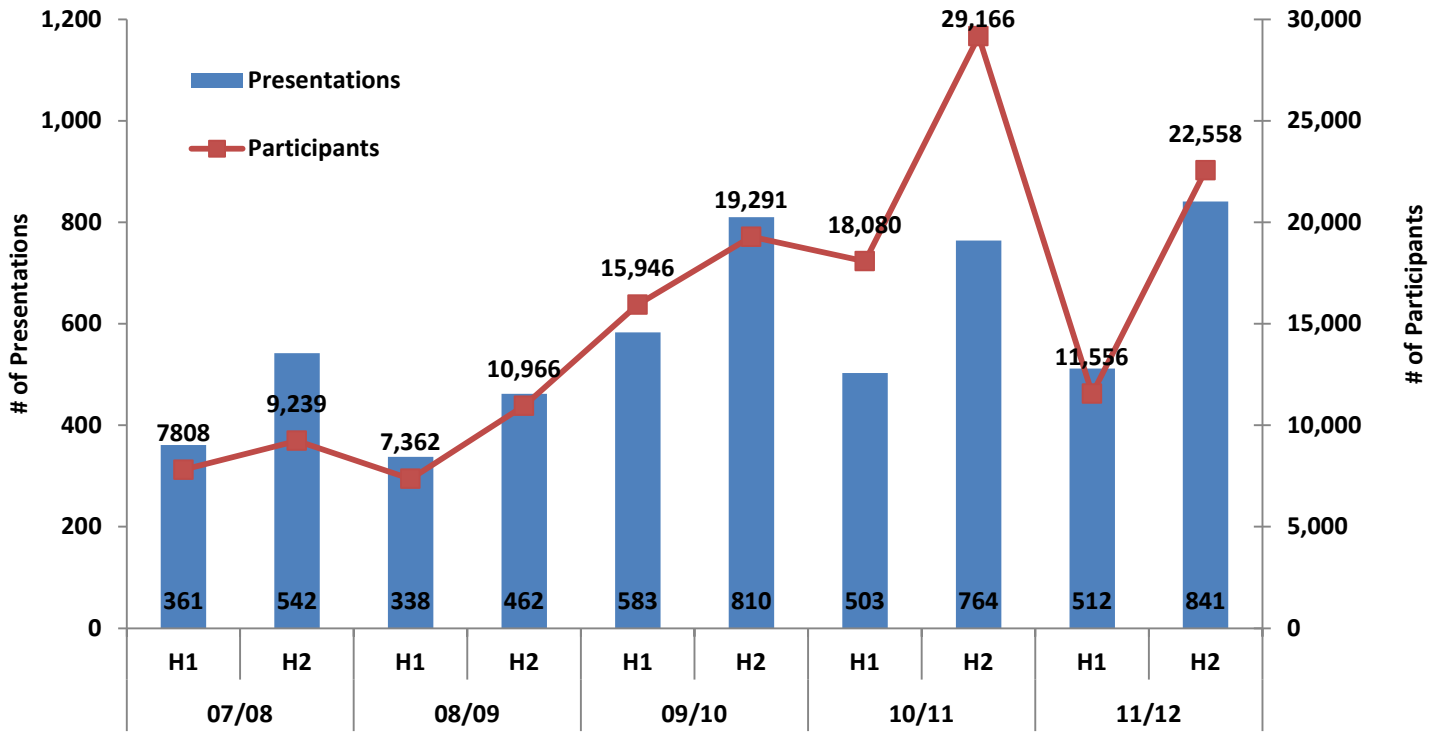
In some cases, new or stronger partnerships with other organizations in the community have resulted in more education requests from groups that had not previously shown an interest in HIV issues, such as long term care homes.

> *"More requests for HIV 101's with Long-Term Healthcare providers as more HIV+ individuals are beginning to enter those residences/programs."*

ACAP FUNDED 24% OF EDUCATION PRESENTATIONS

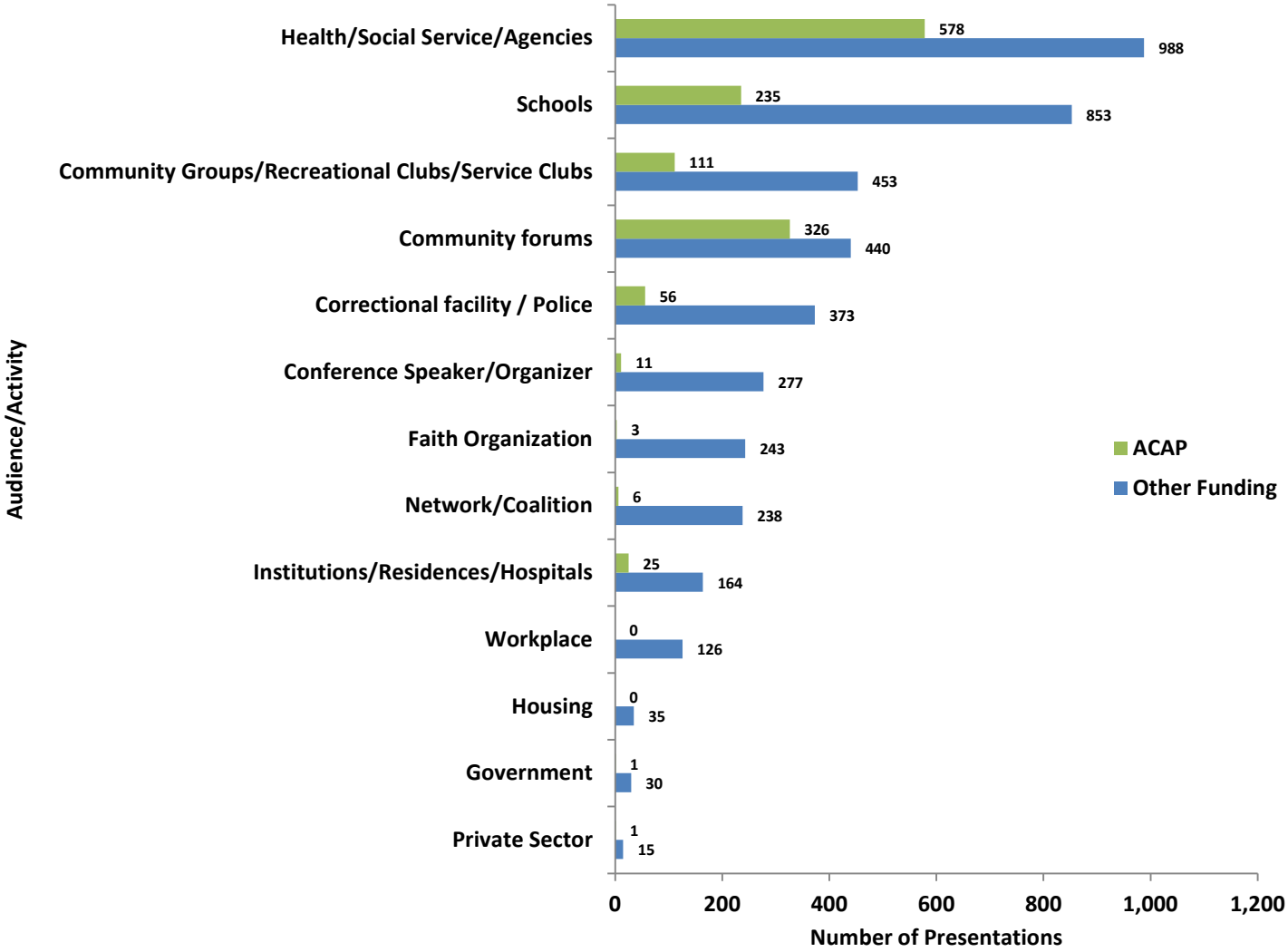
As in previous years, ACAP funded about 1 of every 4 education presentations in the province, which accounted for about 24% of participants.

Figure 20
ACAP Funded Presentations and Participants



Most ACAP-funded presentations were made in five types of locations: health and social service agencies, schools, community groups, community forums and correctional facilities. AIDS Bureau funding also supported presentations in those locations and in several others, such as conferences, faith organizations, institutions and workplaces. A number of agencies report that they are now routinely asked by local organizations for their workshops.

Figure 21
Education Presentations by Funding Source: 2011/2012

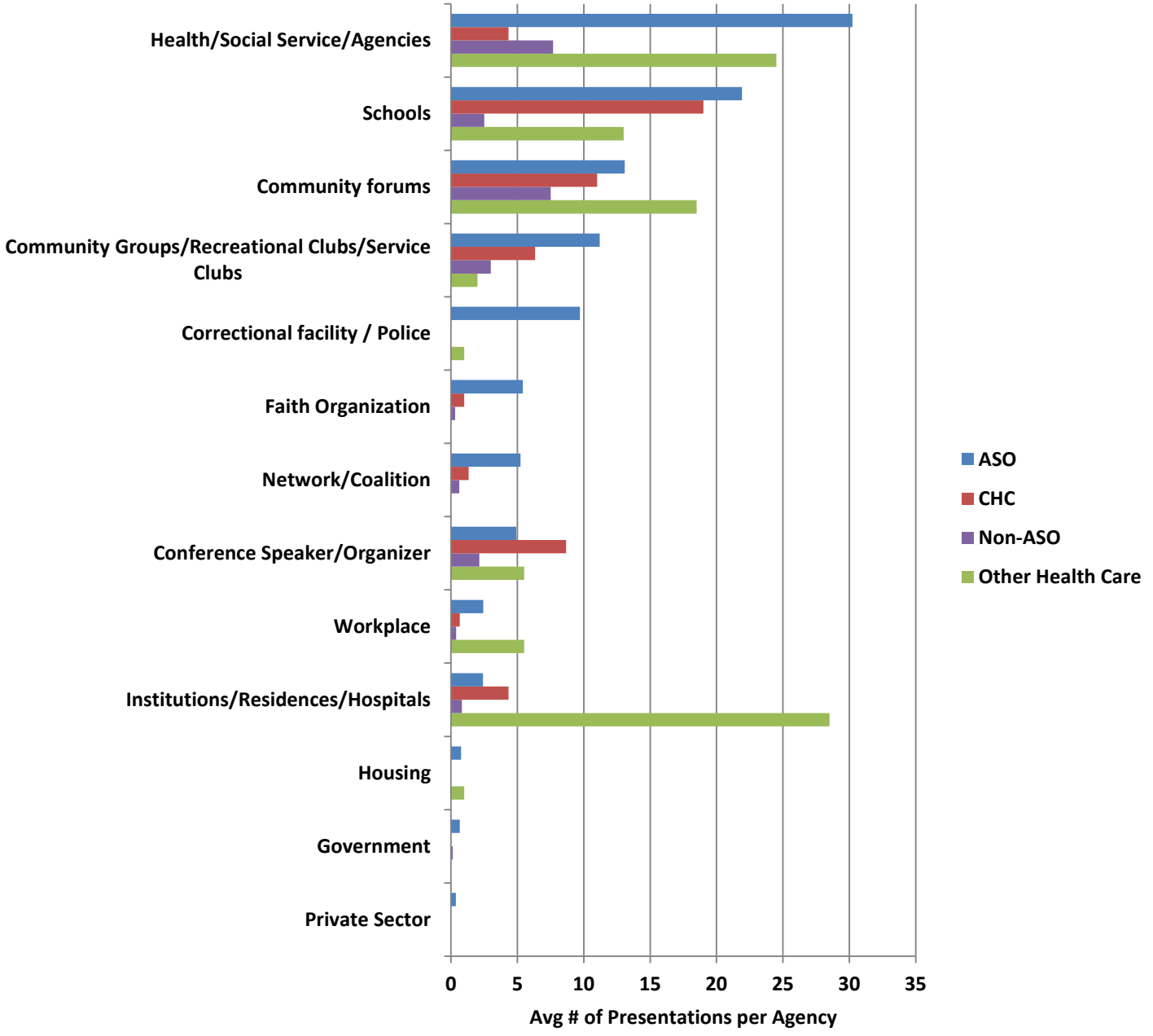


EDUCATION FOCUS VARIES DEPENDING ON THE TYPE OF AGENCY

Education is a larger part of the work in ASOs than in other types of programs. As the following figure shows, ASOs provide on average more presentations than other types of agencies. ASOs are also more likely to provide presentations for health and social services agencies, schools, community groups, correctional facilities and faith organizations – while programs based in other health care settings are more likely to make presentations to service providers, health institutions and – interestingly – workplaces.

Figure 22

Average Number of Presentations by Agency Type: 2011/2012



Different types of agencies also have a different focus in their education. For example, ASOs and non-ASOs deliver more presentations to health and social service agencies than CHCs or other health care institutions. ASOs are also more likely to be involved in education efforts in the correctional services system than programs in other settings.

THE ROLE OF EDUCATION IN SOCIAL CHANGE

A growing number of agencies are recognizing that education is a process (as opposed to a one-time event) and a key component of larger social change. They are making links between their education programs and larger community development and social justice projects, working with their partners to identify different ways to use community resources to meet education needs. Many of these education efforts go beyond HIV education to address other issues that affect risk and health, such as human rights. For example:

> *"We are looking at a systems approach to education and community development, working with those in positions of influence, acknowledging that challenges in our communities are most often based on fear or lack of knowledge; and, working with community partners to define our shared visions and challenge ourselves to address biases that can either hinder or help to achieve our goals."*

> *"This has been a beneficial strategy to build community networks and allies in service areas not directly linked with HIV but important to our clients."*

> *"As a result of our previous work to develop positive working relationships with faith based organizations, we have experienced an increase in demand for program services. These faith based organizations have local leadership which has been very receptive to working with [us]."*

> *"Recently we have begun working within the community to help coordinate a community response to the health and human rights needs of migrant workers in our region."*

> *"Recent increase in challenges related to lack of proper case management support and referrals for ethno-racial and newcomer PHAs as a result of many ASO frontline staff turnover and staff not being adequately trained/oriented to HIV/AIDS, Immigration and service access issues. Increased concerns of new immigration legislations & criminalization on non-disclosure differentially impacting on newcomer PHA communities. Increased unmet need for racialized HIV positive women on issues related to sexual and reproductive health (including birth control, cervical cancer and childbirth) as well as domestic violence. Newcomer PHAs continued to face complex barriers in accessing basic health, settlement and support services, as well as capacity building initiatives to address the many social determinant related challenges they face."*

MORE PROGRAMS ARE ASSESSING THE IMPACT OF THEIR EDUCATION PROGRAMS

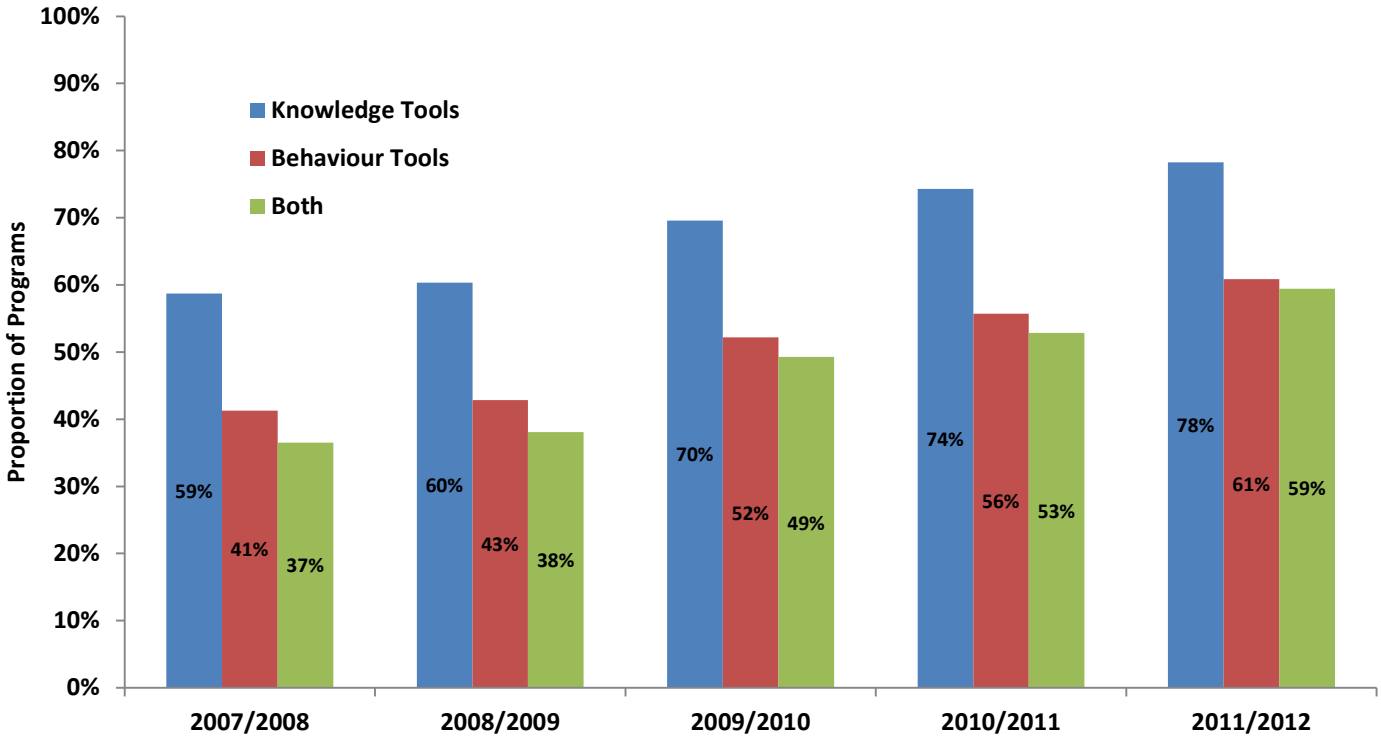
Over the past five years, the proportion of programs using tools to measure changes in knowledge and behavior in their target populations have increased steadily. Almost 80% now regularly measure changes in knowledge, while 60% measure changes in behavior or intent to change behavior and almost 60% measure both.

Among ACAP-funded agencies, both education aimed at people with or at risk of HIV and education aimed at service providers had an impact on both knowledge and the intent to change behavior. However, the proportion of participants who reported an intent to change behaviour varied considerably from between 20% to 80%. In the case of the workshop where only 20% of participants (people from multicultural communities) intended to change behaviour, 73% reported that they were already engaging in safe behaviours. In the case of service providers, they reported they intended to use what they had learned in workshops to provide, for

example, more culturally competent services or to address stigma. In some cases, they also reported that they were confident about referring clients to the ASO.

The next step in evaluation will be to identify which aspects of education presentations or programs have the greatest impact on knowledge and intent to change behaviour. This information will help programs assess the impact of their education efforts and refine them to make them effective.

Figure 23
Tools Used to Measure Changes in Knowledge and Behaviour in the Target Population



EDUCATION MATERIALS AND RESOURCES

Faced with changing education needs, some ASOs report that they are trying to develop new resources that overcome barriers to education, such as distance and stigma.

> *"We are currently developing a series of webinars and e-meetings that can be accessed from any computer/internet connection. This will allow rural residents to more easily access the education and also attend online queer youth group meetings without having to disclose to family members."*

> *"To respond to these emerging trends, we are continually modifying presentation content and format to ensure that the material is age-appropriate for target audiences; we are connecting with existing partners/networks and seeking out new partnerships to fill gaps in experience/knowledge and to make referrals, as necessary; additionally, we are working on an ongoing basis to ensure that the language/format/content of presentations is gender-inclusive (of identities and experiences located within and outside of the M/F gender binary)."*

KEY EDUCATION ISSUES

OCHART education questions have been revised (effective the 2012-13 reporting year) in order to provide a better understanding of who agencies are reaching with their education programs and the topics covered. At this stage in the field's education programs, it would be useful for agencies to discuss the following:

1. Based on increased evaluation, what types of education are most effective?
2. Where should agencies focus their education going forward?
3. Are there opportunities to partner with other organizations to deliver education programs?

EDUCATION RESOURCES

In 2011-12, programs reported developing a number of education resources, including:

	Promotional/Advocacy materials/Awareness Campaigns
Alliance for South Asian AIDS Prevention	Two community information primers: one on HIV and criminalization which was released to our media and volunteer contacts
African and Caribbean Council on HIV/AIDS in Ontario	New online youth campaign to encourage testing: getsexty.com / savoircsexy.com has been advertised online, in public transit and in movie theatres across Ontario
Africans in Partnership Against AIDS	Board Game - ProjectM: On behalf of the Muslim Girl's Project, a very useful, fun learning tool was developed which is the equivalent of a board game which tests basic HIV/AIDS knowledge
AIDS Committee of North Bay	Poster campaign in French for syringe recovery program
AIDS Thunder Bay	Participated in Provincial campaigns - GMSH Get Tested; Syphilis; All the Sex you Want
Hassle Free Clinic	We have also been promoting the HIV/Syphilis Testing Blitz on our website
Ontario Aboriginal HIV/AIDS Strategy - Kingston	Aboriginal specific introduction and explanation of Harm Reduction "Harm Reduction: Keeping Our Circles Strong"
Ontario Aboriginal HIV/AIDS Strategy - London	Aboriginal HIV rapid testing posters developed
	Client Education Resources
AIDS Committee of Toronto	"Planning for the Long-Term" – psycho-educational workshop series for older gay men who are long-term survivors "Making Outreach matter"
AIDS Committee of York Region	HIV Basics Brochure for Men
Casey House Hospice	HIV AIDS and Dementia Workshop
Casey House Hospice	Service Access for PHAs Exiting the Correctional System
Ethiopian Association	HIV/AIDS Prevention brochure that deals with the risks related to alcohol and drug abuse
Family Service Toronto	PowerPoint for Coming Out Later in Life
Hospice Toronto	Men as Caregivers
Hospice Toronto	End of Life package
Ont. Assoc.of the Deaf, Deaf Outreach Program	Two PowerPoint presentations – one for elementary school and one for High School on HIV/AIDS Prevention/Information, Hepatitis A,B & C. and HPV
Women's Health in Women's Hands Community Health Centre	" To Tell or Not to Tell". A guide to HIV disclosure for African, Caribbean and Black women in Canada
	Professional Training Materials
AIDS Committee of North Bay and Area	Street Outreach Training Manual
AIDS Committee of Ottawa	The Toolkit: Ottawa Sex Workers Speak Out. A resource for service providers.
Alliance for South Asian AIDS Prevention	"The best practices" guide for ASO workers
Women's Health in Women's Hands Community Health Centre	Strengthening the capacity of service providers to deliver HIV prevention programs to African, Caribbean and Black communities in Canada: Guide and Toolkit
	Volunteer Training Materials
Africans In Partnership Against AIDS	A pdf training toolkit was developed to train youth volunteers with the HIV Youth Prevention Education Project (HYPE).
AIDS Committee of York Region	My Story - A Speakers Bureau Training Manual Positivity

OUTREACH

Both the AIDS Bureau and ACAP support outreach activities, based on evidence that shows that when people receive education, support and resources (e.g., condoms) in locations where they are making decisions about risk, they are likely to take steps to reduce their risk.[1] [2]

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 this edition of **The View from the Front Lines**, we are trying to distinguish between more significant or intensive outreach activities – such as the conversations that take place in bars, bathhouses, on the Internet and in clinics – and brief outreach – such as the distribution of brochures and condoms that occurs at parades, information booths, health fairs and other community events. Over time, we hope to be able to assess the impact of these different outreach efforts on knowledge and behaviour. Beginning in the 2012-13 reporting year, OCHART questions will help distinguish between significant and brief outreach contacts.

At least two agencies reported that they are now making an effort only to collect data on "significant" outreach contacts – that is, where the worker has had a meaningful conversation about HIV, sexual health or HIV testing or the contact has resulted in a referral. As a result of this shift – which focuses more on the quality of outreach contacts and their potential effect on knowledge and behaviour than the quantity – these agencies reported significantly fewer outreach contacts overall. However, our reasonable inference is that the smaller number of "significant" contacts has more impact.

In terms of demand for outreach services, a number of agencies reported an increase in contacts

- More contacts with sex workers

> *"Since the ruling in the Supreme Court of Canada regarding Sex Trade we have experienced a much greater demand for information from Sex Professionals. They are seeking information on Safer Sex, STI's and HIV transmission and testing."*

- Increased demand to do more outreach with women
- More youth identifying as trans and more outreach to LGBTTQ youth
- Increased capacity to reach difficult-to-reach priority population communities and more demand for outreach to First Nations communities, to people in detention centres, and ACB men.

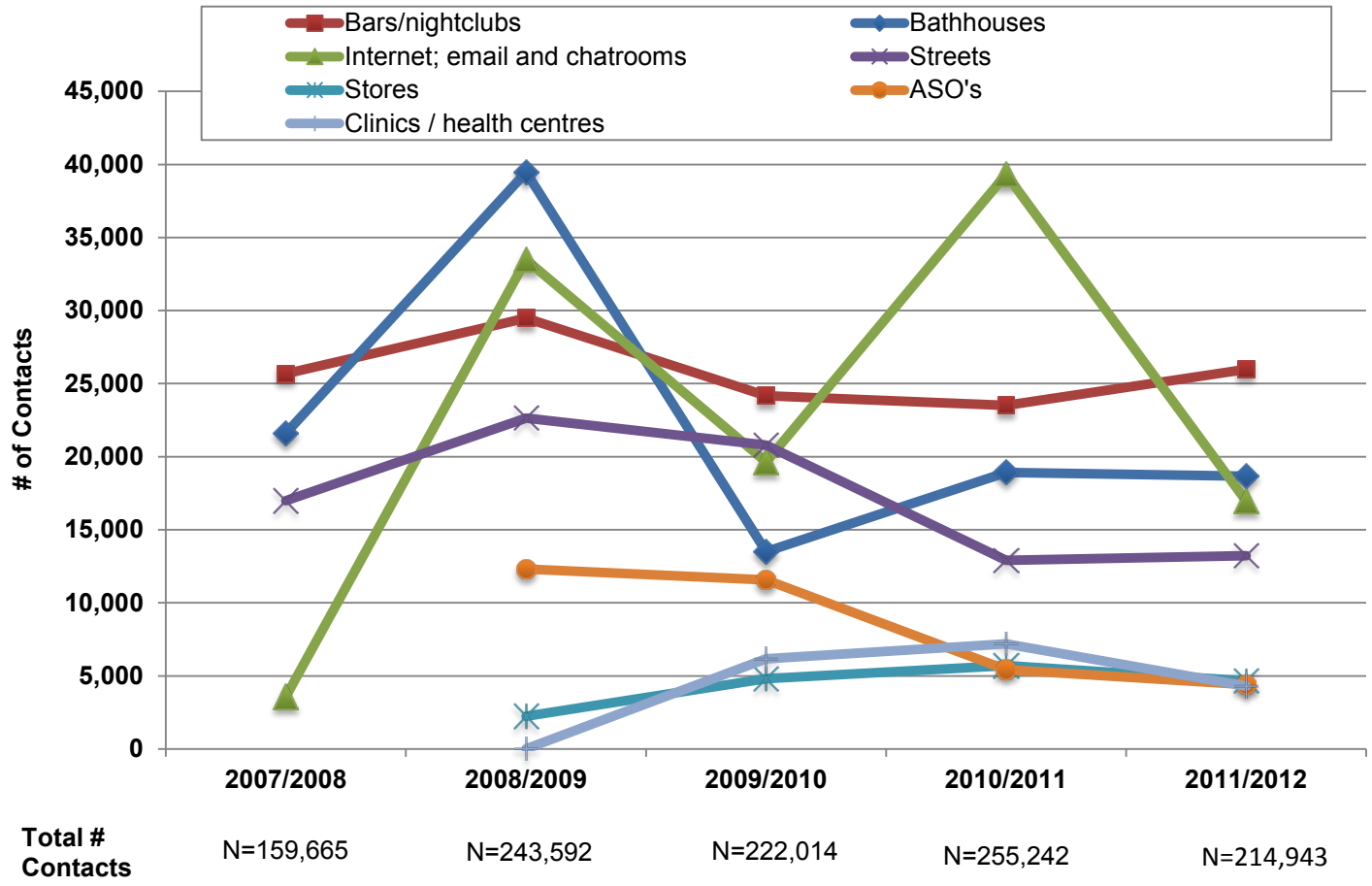
1 *World Health Organization. "Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users," Geneva, Switzerland: World Health Organization; 2004 http://www.unodc.org/documents/hiv-aids/EFA community based outreach .pdf*

2 *Bonell C, Strange V, Allen E, Barnett-Page E. HIV prevention outreach in commercial gay venues in large cities: evaluation findings from London. Health Educ Res. 2006 Aug;21(4):452-64.*

ARE TRADITIONAL OUTREACH LOCATIONS BEING REPLACED BY THE INTERNET?

Figure 24 shows the number of outreach contacts by location. Bars, bathhouses and the streets continue to be the main locations for more intensive outreach services. However, over the past four years, the Internet has become an increasingly important site for outreach, particularly with gay men and other men who have sex with men who are connecting with partners online.

Figure 24
Top Seven Outreach Locations



In 2011-12, 37 agencies reported at least one Internet outreach contact. Overall, the total number of Internet contacts was down, but this may be due to more effective ways to track and count these contacts, rather than a drop in the level of Internet outreach. In terms of geographic locations, there is some Internet activity in all regions; however, agencies in Toronto account for 70% of all Internet activity. Seven organizations – including 3 in Toronto, 1 in Southwest, 1 in Ottawa and Eastern, 1 in Central East and 1 provincial agency – account for 75% of Internet, email and chatroom activity. These findings suggest that the Internet is not replacing traditional outreach methods in most parts of the province, and that the organizations making heavy use of the Internet have either developed effective ways to use it as a tool or better ways of counting those activities.

Programs appear to be finding innovative ways to reach at-risk groups and innovative ways to deliver outreach services. For example:

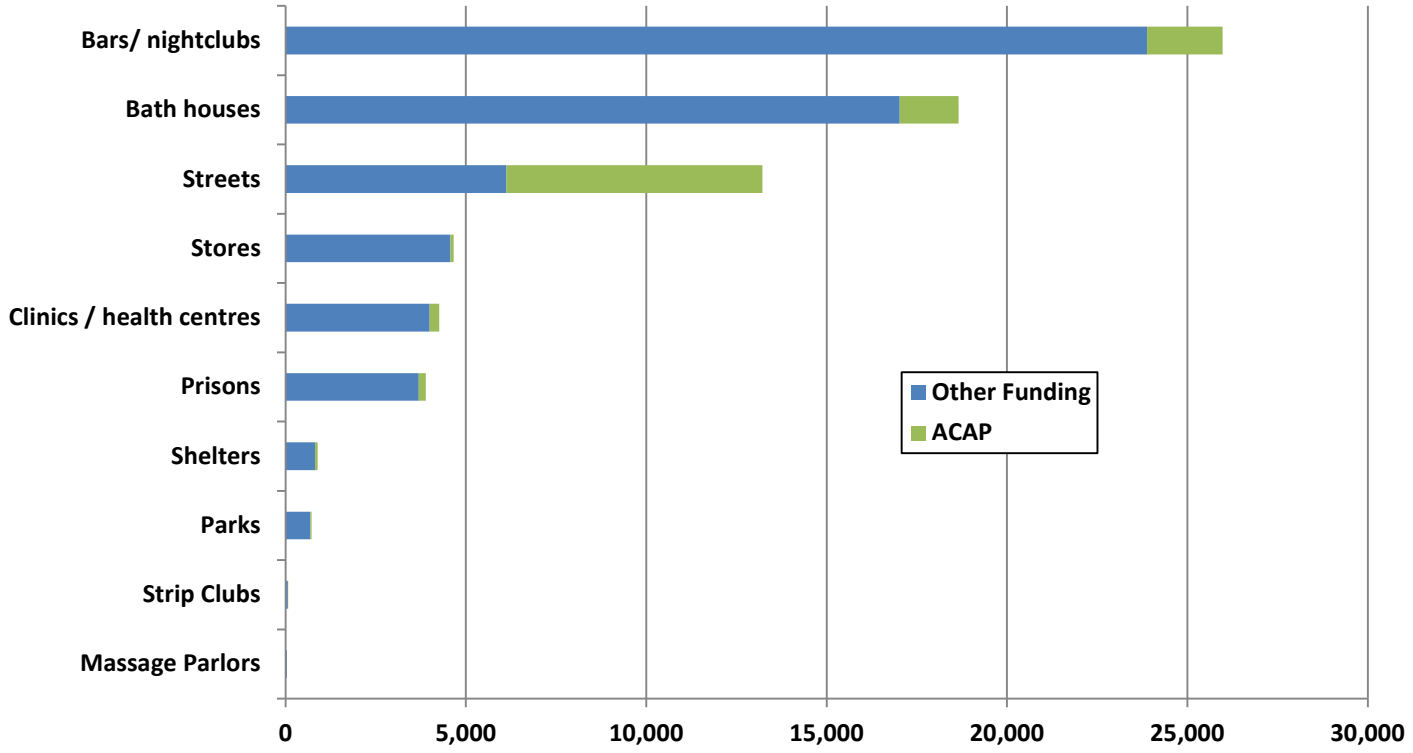
> *"Trained a volunteer at [the] Correctional Centre to present HIV prevention workshop series. Modified series for staff and volunteers who work with women in shelters who have been in prison."*

> *"There is a large LGBTQ seasonal campground that operates 6 months of the year. It was reported that there is a need for MSM outreach support, education and safer sex materials needed for this seasonal community."*

> *"There has been an increase in post-secondary organized events wanting information around safer drug use. There has also been an increase in requests for presentations on the topic of sexual diversity."*

Most outreach work is funded by the AIDS Bureau; however, ACAP-funded programs provided over half the street-based outreach reported through OCHART in 2011-12 and about 8.8% of bar outreach and 9.6% of bathhouse outreach. A total of 26 agencies reported providing street outreach services.

Figure 25
Number of Outreach Contacts by Funder

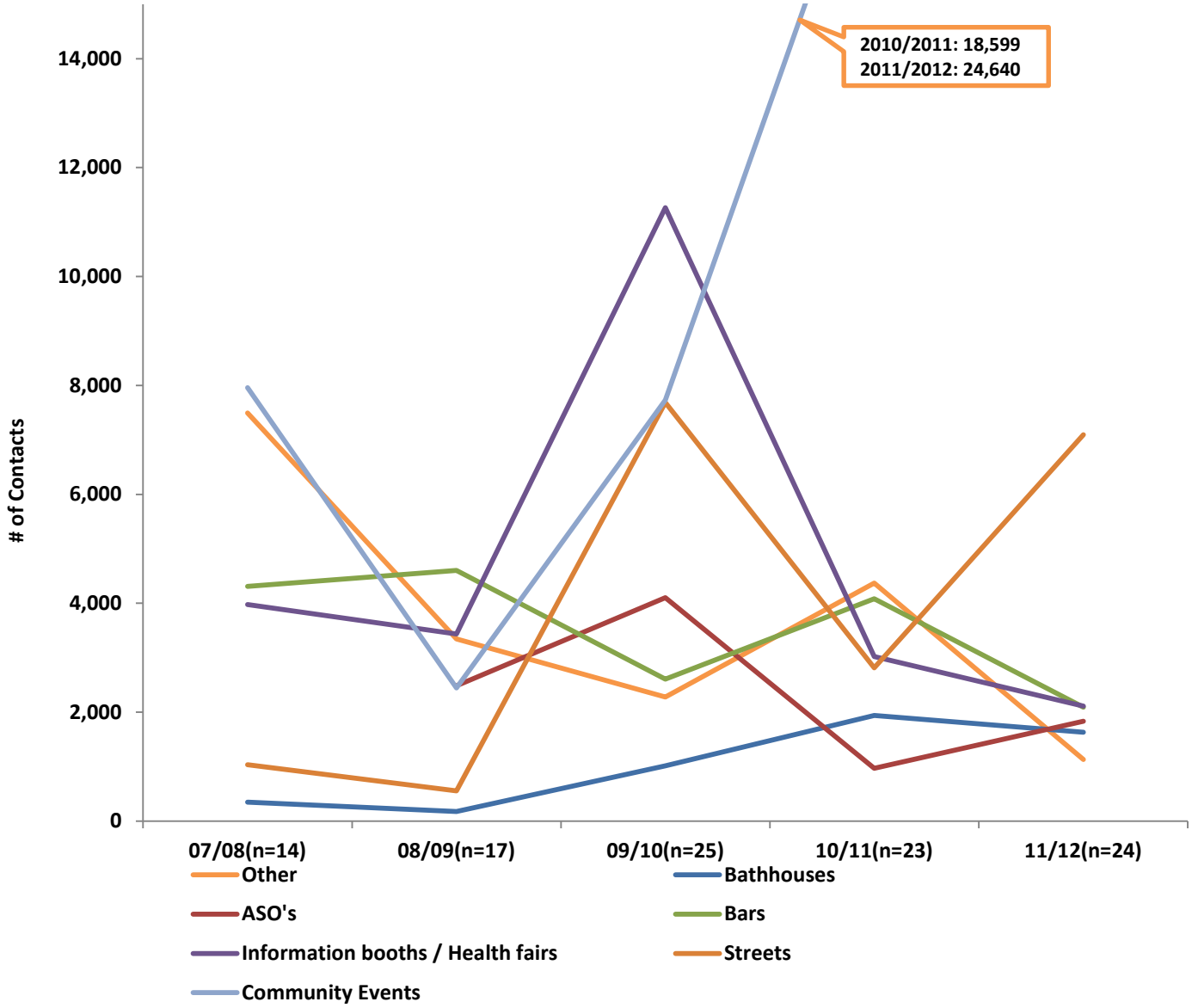


	Massage Parlors	Strip Clubs	Parks	Shelters	Prisons	Clinics / health centres	Stores	Streets	Bath houses	Bars/ nightclubs
Other Funding	40	68	685	821	3,689	3,990	4,567	6,126	17,028	23,884
ACAP	0	2	33	71	200	274	90	7,096	1,633	2,091

ACAP INVESTMENTS LED TO INCREASE IN COMMUNITY EVENTS AND STREET OUTREACH

In 2011-12, ACAP-funded agencies reported a significant increase in brief outreach contacts through community events (up 30% from the previous year) and in significant outreach contacts through street outreach. These increases were due to events such as Pride, other festivals and parties, Afro Fest, and Ethiopian Day. Four of 24 programs reported >1000 brief contacts in 2011 compared to five of 23 programs in 2010.

Figure 26
Top Seven Outreach Activities Reported by Location Over Time ACAP



While these brief contacts may not have the same impact on knowledge and behaviour, they can be a valuable way to fight stigma and to lay the groundwork for more significant contacts. As one ACAP-funded program reported, "In large-scale community events such as cultural festivals, we enjoy broad exposure within specific cultural groups. Our frequent presence at these events, as well as our collaborative work planning events … seems to 'normalize' HIV within these groups and people are becoming more comfortable engaging us, taking supplies/information, and requesting workshops for church groups and community associations."

PROGRAMS CONTINUE TO USE BOTH TRADITIONAL AND NEW MEDIA

Most programs continue to invest in communications as a form of outreach, including communication through the media – and direct communication with clients and target populations through information packages and newsletters.

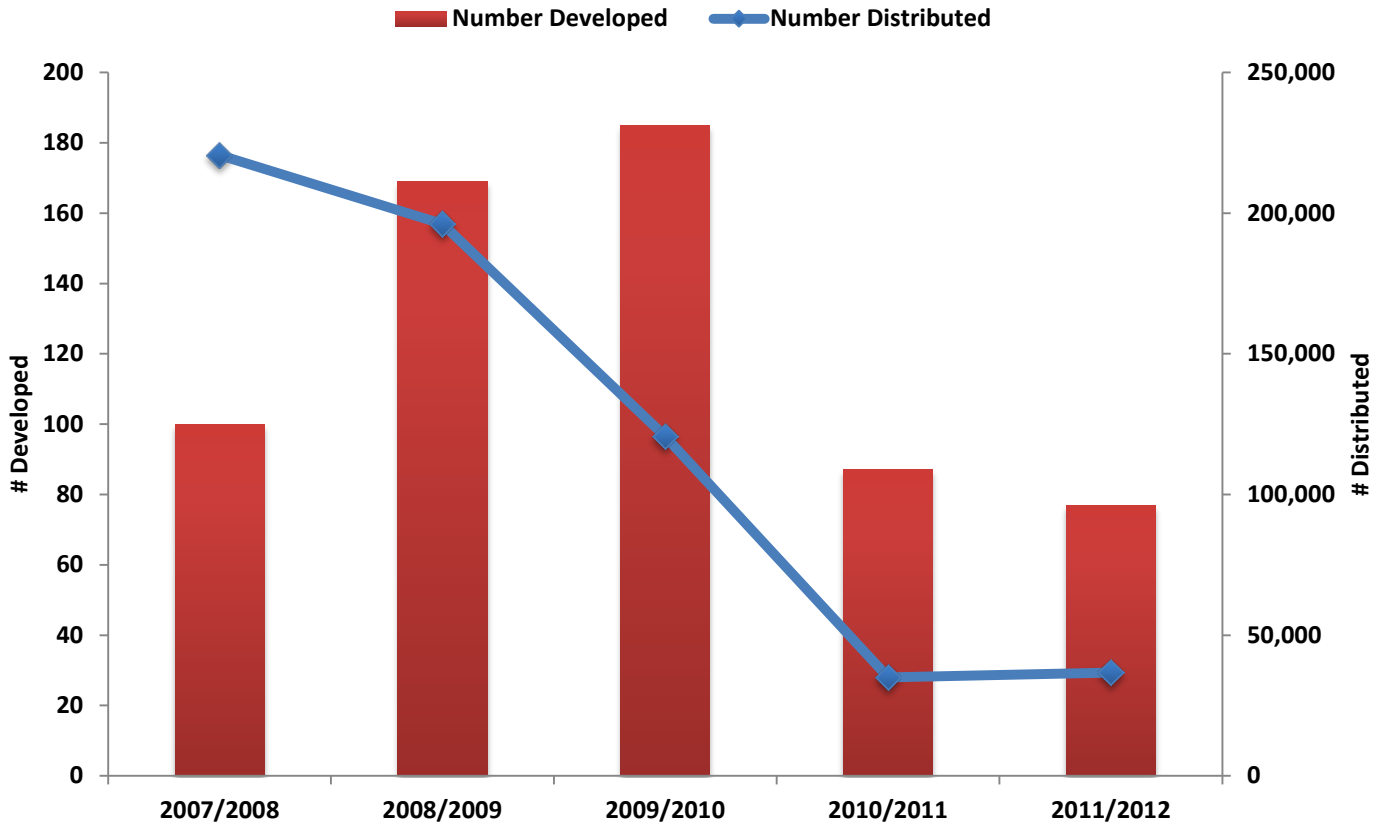
In their narrative reports, ASOs identified a number of trends, including an increase in online presence and use of social media tools, although there is still some uncertainty about how to do Internet-based outreach well and ongoing challenges in tracking and assessing the impact of this work. This is a challenge recognized and shared by funders.

MEDIA USE IS SHIFTING FROM TRADITIONAL OUTLETS TO THE WEB

Over the past few years, there has been a dramatic drop in the number of products both developed and distributed through paid advertising, and a steady increase in web-based media and social marketing. This trend is highly consistent with what is happening beyond our sector.

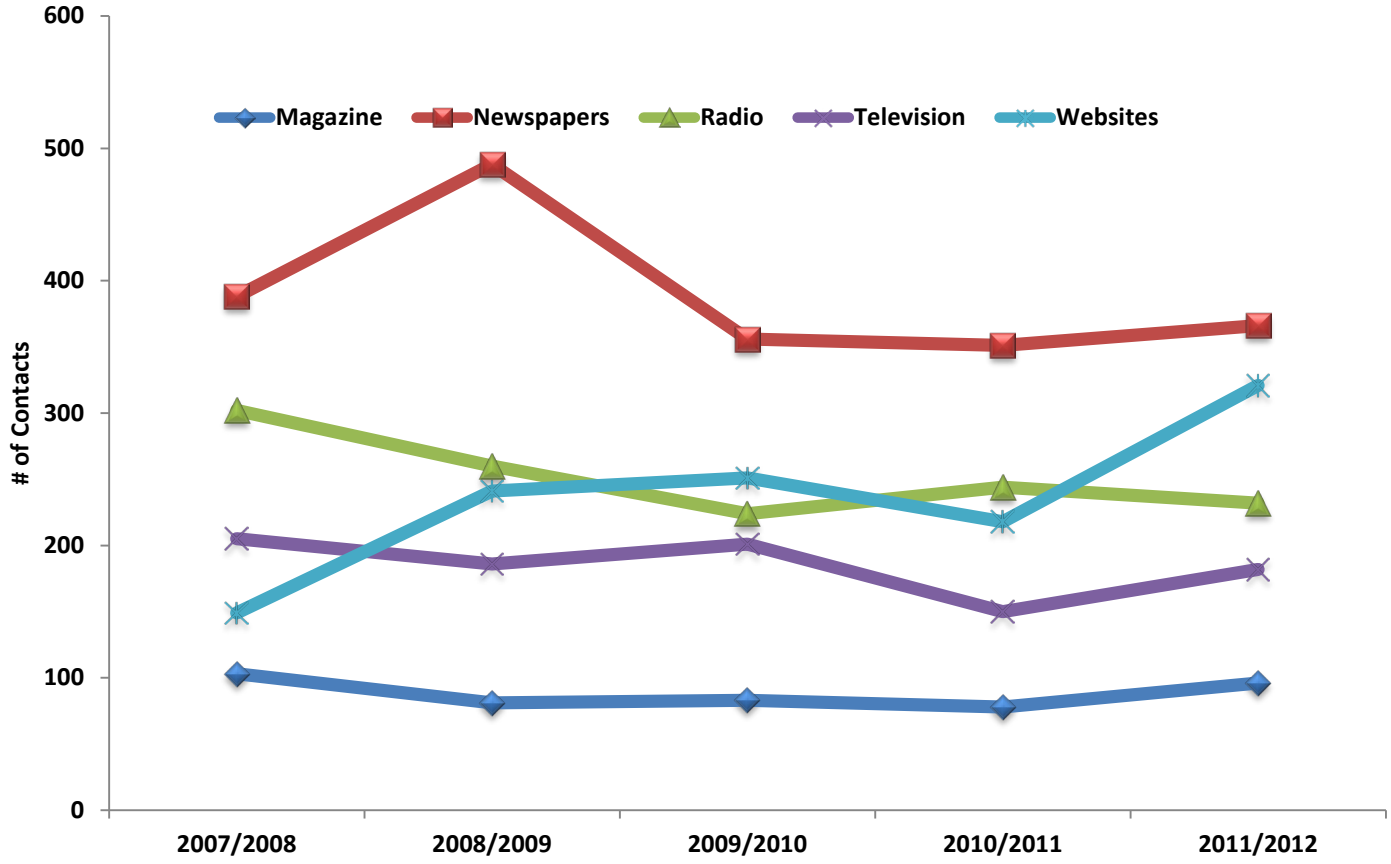
However, while social marketing is an effective way to reach many gay men who use the Internet to connect with people and get information, it is likely less effective in reaching more economically marginalized populations, such as substance users.

Figure 27
Trends in Use of Paid Advertising



Even in non-paid advertising, we are seeing a leveling off in contacts with traditional media and an increase in web-based contacts.

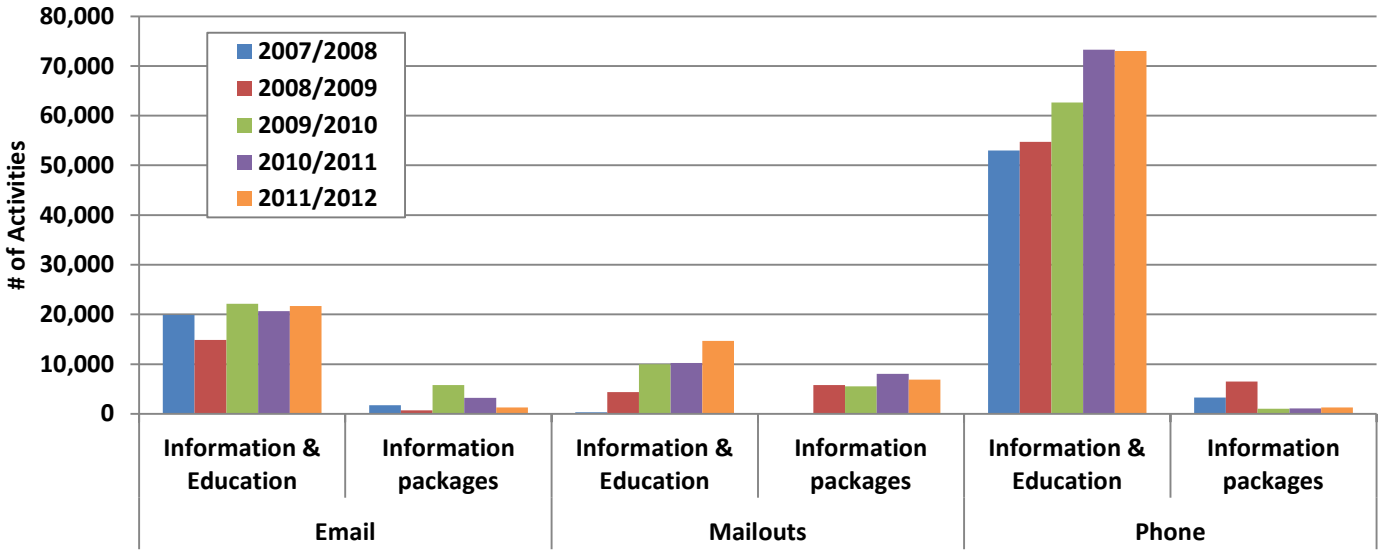
Figure 28
Trends in Media Contacts



PROGRAMS CONTINUE TO USE TRADITIONAL COMMUNICATIONS APPROACHES TO REACH INDIVIDUALS

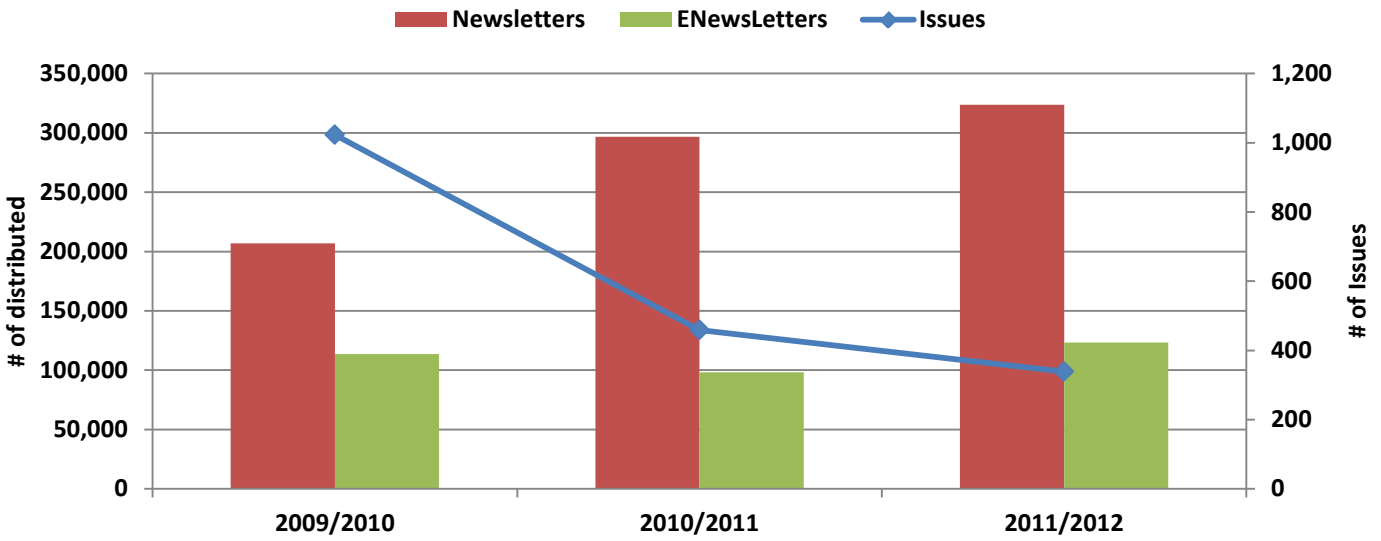
In terms of reaching individuals and responding to individual requests for information and education, programs continue to rely mainly on the telephone, and the number of phone contacts has increased over the past five years. It is not clear from our data whether these phone contacts refer to conversations only, or whether they include other, less traditional uses of the phone to, for example, send texts, tweets and Facebook messages.

Figure 29
Outreach Communication Methods



Programs also continue to make growing use of both traditional and e-newsletters. While the number of issues of newsletters produced has dropped over the past three years, the number distributed has increased – particularly for printed newsletters; however, it may be difficult for agencies to track the number of times an electronic newsletter is downloaded or read.

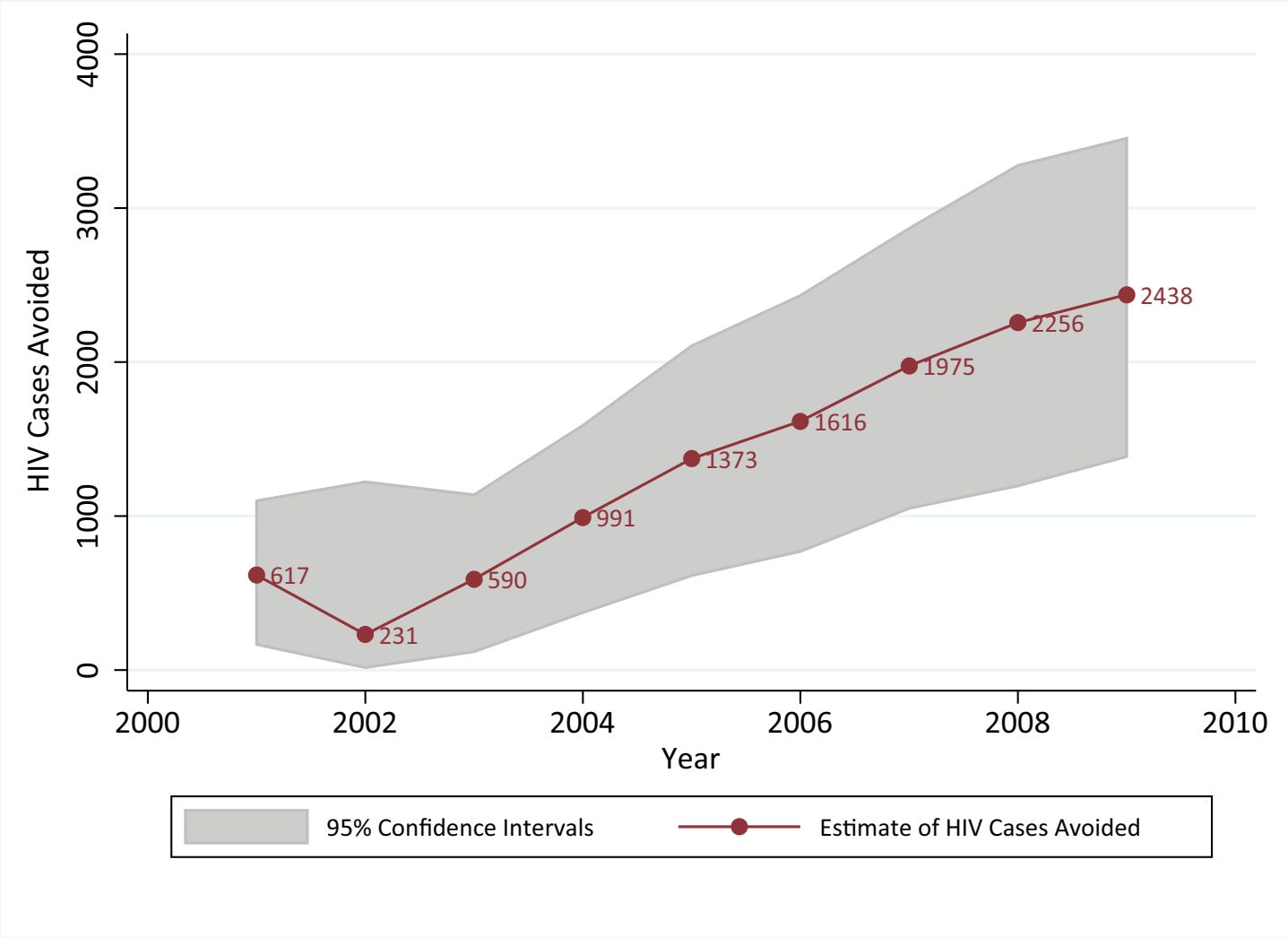
Figure 30
Newsletter Outreach



THE IMPACT OF PREVENTION PROGRAMS

The focus of education and outreach programs is to prevent new HIV infections. A recent analysis, conducted by the OHTN, revealed that the investments in prevention programs in Ontario contributed to 12,087 averted cases of HIV between 2001 and 2009.

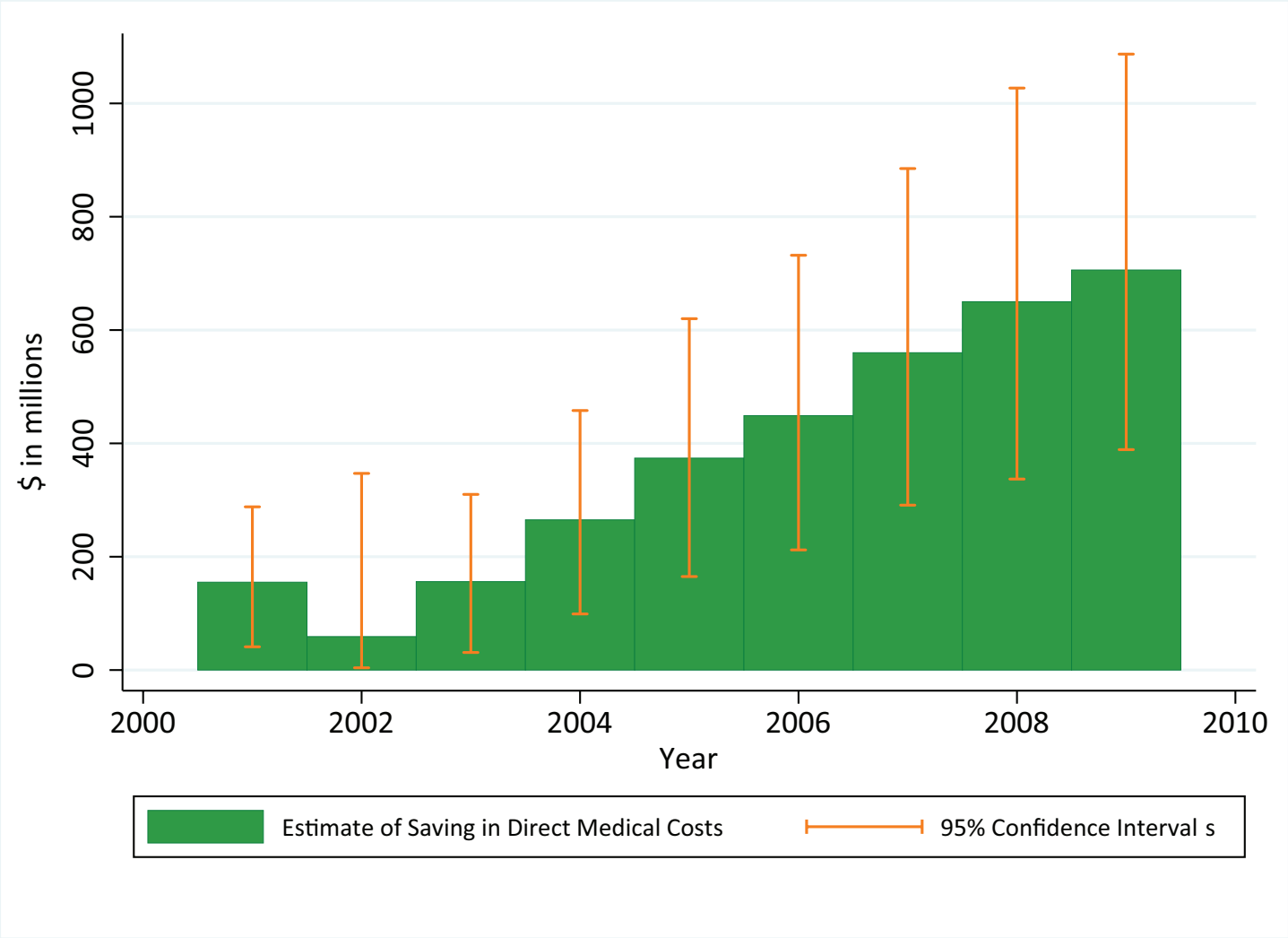
Figure 31 *
Estimates of HIV Cases Avoided (with 95% CI) from 2001-2009



** Rourke, S.B., Choi, S., and Bacon, J. Economic Evaluation and Impact of Community-based HIV Prevention Programs in Ontario from 2001 to 2009. People Policy and Progress, October 16th to 17th, 2012. The Ontario HIV Treatment Network.*

Investments in community-based HIV prevention programs are effective public health policy. They are also an excellent cost saving strategy: between 2001 and 2009, HIV prevention programs saved the health care system $3.4 billion. These figures include only direct medical costs and do not take into account savings related to increased productivity.

Figure 32 *
Estimates of Savings in Direct Medical Costs (with 95% CI) from 2001-2009



** Rourke, S.B., Choi, S., and Bacon, J. Economic Evaluation and Impact of Community-based HIV Prevention Programs in Ontario from 2001 to 2009. People Policy and Progress, October 16th to 17th, 2012. The Ontario HIV Treatment Network.*

Every dollar invested in prevention programs between 2006 and 2009 saved the health care system 51 dollars. Community-based prevention programs are effective. Between 2001 and 2009, investments in community-based programs contributed to 12,087 averted cases of HIV – infections that did not happen. They also saved the health care system $3.4 billion in direct medical costs.

EMERGING OUTREACH ISSUES/TRENDS IN OUTREACH

To enhance our outreach activities, it is helpful for agencies to discuss the following:

1. What types of outreach have the greatest impact?
2. What strategies are agencies using to track and assess the effectiveness of Internet outreach?
3. What resources and skills do agencies need to use social media and do Internet outreach effectively?
4. What are the challenges programs face with communications and media? What proportion of their resources go to these forms of communication, and what impact do they have?
5. What do evaluations tell us about the most effective ways to communicate and to use media?

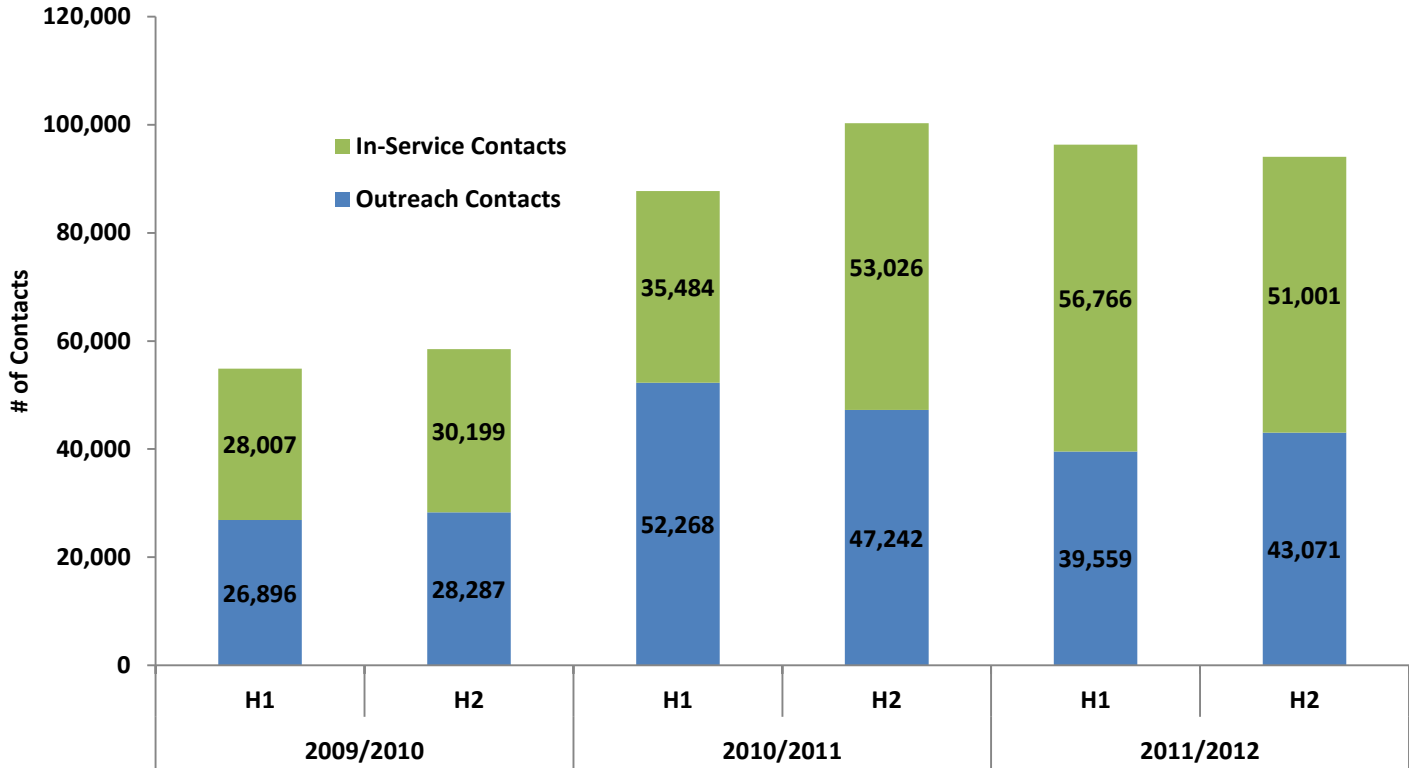
OUTREACH TO PEOPLE WHO USE SUBSTANCES

The AIDS Bureau funds 20 programs – 10 ASOs, 5 CHCs, 4 non-ASOs and 1 other health care institution – to provide outreach services for people who inject drugs or use other substances. In addition to these dedicated programs with dedicated staff positions, 17 other programs report providing outreach to people who use substances.

INCREASE IN IN-SERVICE CONTACTS INDICATES STRONGER RELATIONSHIPS WITH CLIENTS

The total number of outreach plus in-service contacts in 2011-12 is similar to the previous year, but the number of outreach contacts decreased by 16,880 while the number of in-service contacts (i.e., contacts with people who come into the organization for services) increased by 19,257. This trend may indicate that organizations have built trusting relationships with clients who use substances and that clients are more willing to come to the programs for services.

Figure 33
Increase in In-Service Contacts Indicator Stronger Relationships with Clients

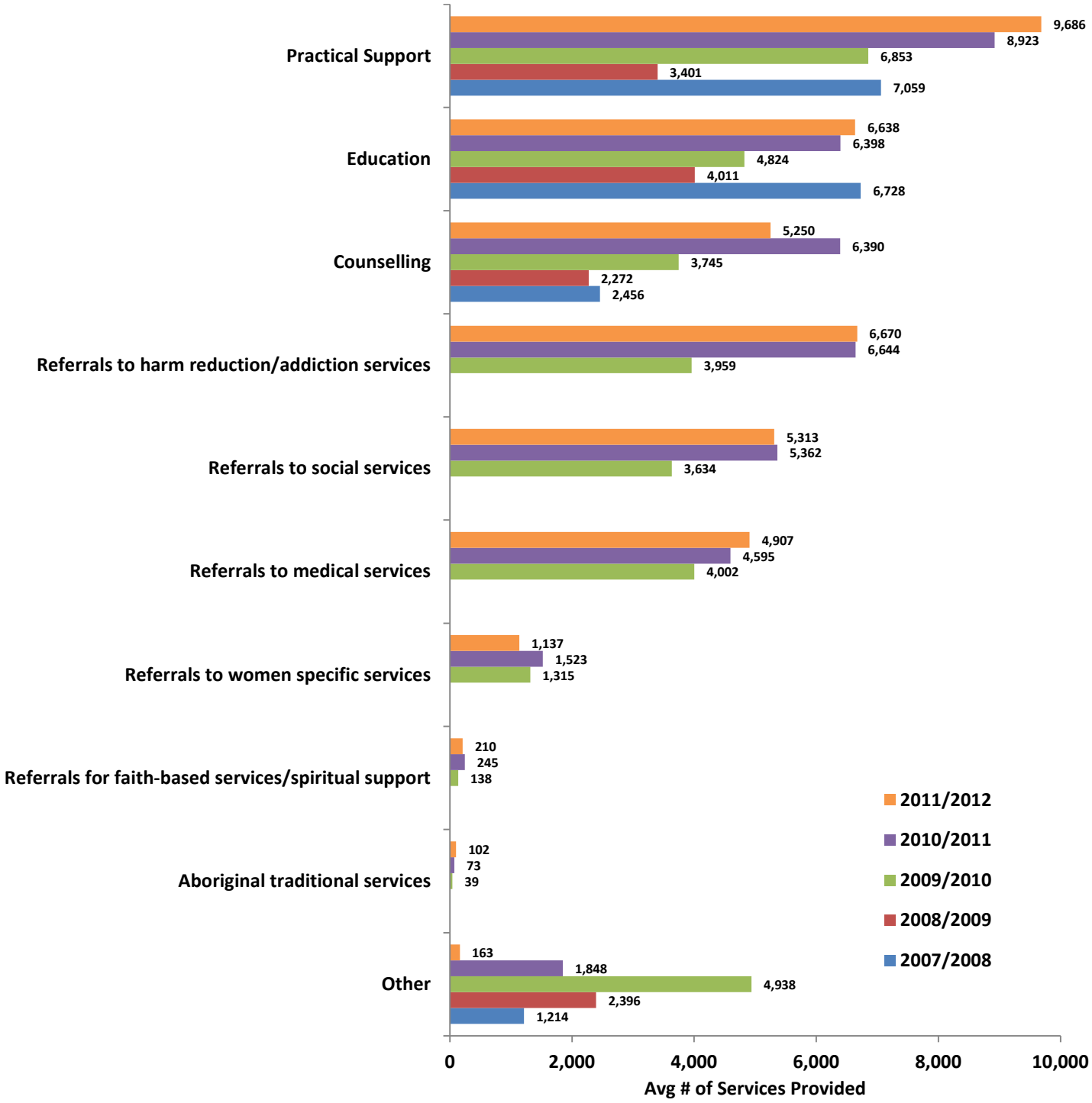


The total number of individual clients served by outreach programs increased by 8% in 2011-12 (24,200) compared to 2009-10 (22,367). Among those who used outreach services, 14,435 (60%) were male, 9,365 (39%) were female and 400 (2%) were trans people.

PEOPLE WHO USE SUBSTANCES ACCESS MORE PRACTICAL SUPPORT SERVICES

In 2011-12, programs reported that people who use substances are using more practical support services – which include housing, food bank, transportation and employment services. Agencies often report anecdotally that helping people who use substances to meet their practical needs can help build trust and lead them to engage in other services. Over the past two years, the number of referrals to harm reduction/addiction services, social services, and medical services remained consistent, while either the demand for counseling services or the capacity to provide them dropped.

Figure 34
Average Number of IDU/Substance Use Services Provided



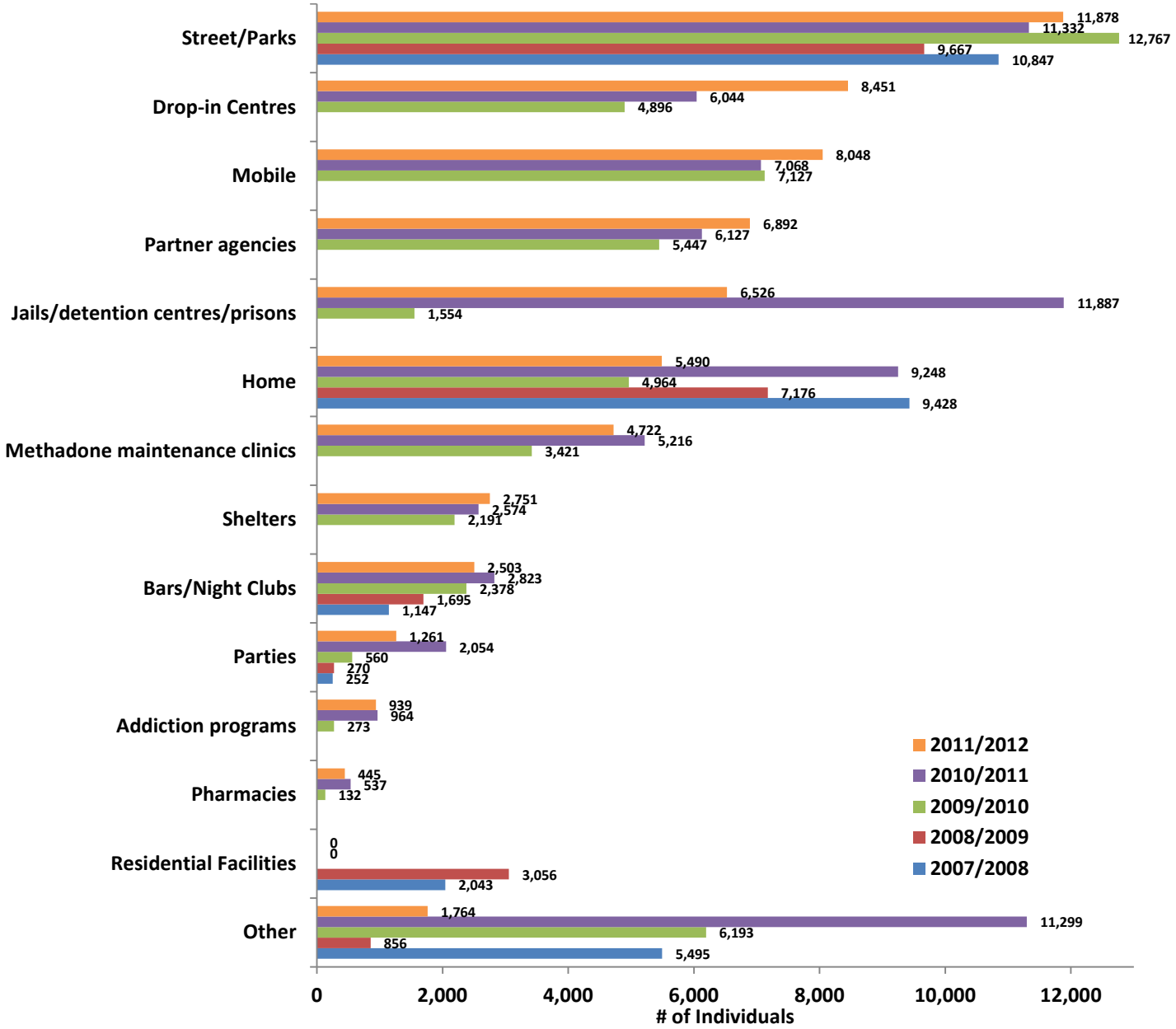
MORE CONTACTS THROUGH DROP-IN CENTRES; FEWER THROUGH JAILS

The increase in the amount of outreach provided through drop-in centres and mobile services may indicate that these types of settings are an effective way to attract people who use substances to services; however, to determine their role in outreach, we need more information about whether these services are serving a large number of clients or a smaller number more often.

> *"[We] partnered with [youth agency] to establish a Harm Reduction drop-in at [youth agency]. The drop-in currently runs one day per week, but the requests for information/ testing indicate that we are reaching this difficult to serve population. Development/ distribution of piercing kits during the drop-in will serve as incentives for street-involved youth to get engaged in program and health. Youth are providing the artwork for the information and reviewing content for appropriate language."*

The significant drop in jail outreach was mainly due to two agencies, which may indicate a change in the focus of their service or perhaps a different way of tracking and counting outreach services.

Figure 35
Outreach Locations

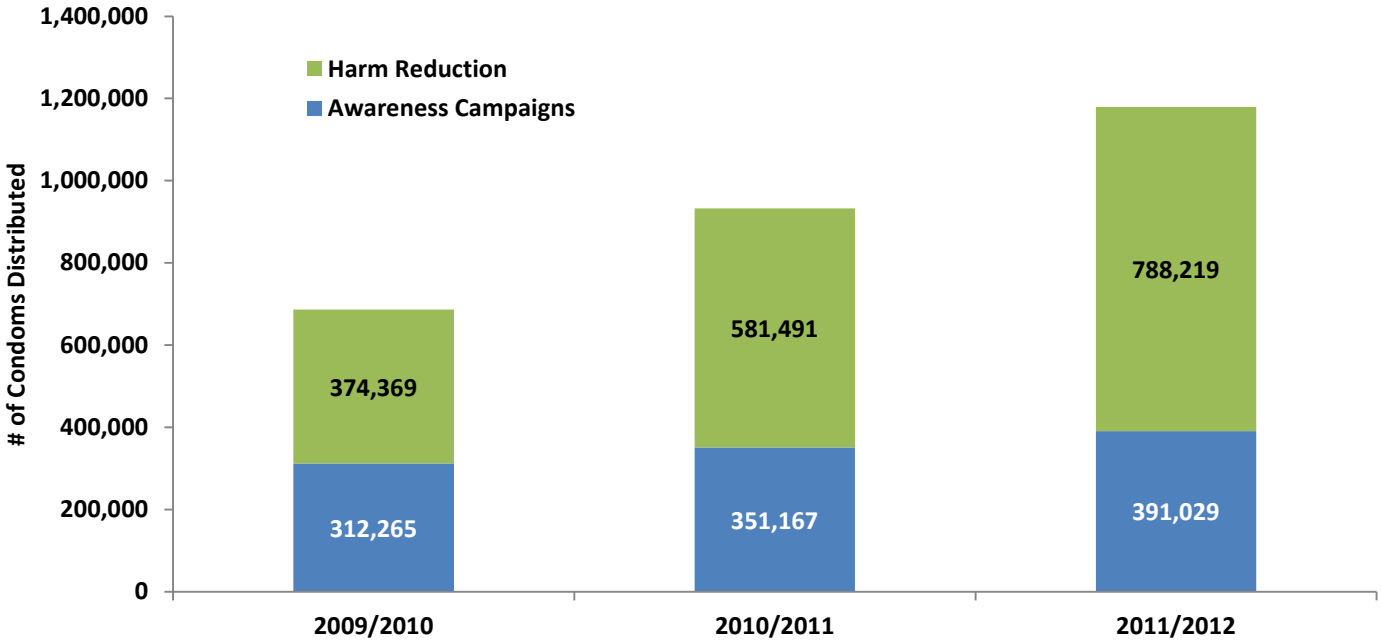


SIGNIFICANTLY MORE PREVENTION AND HARM REDUCTION MATERIALS DISTRIBUTED

In 2011-12, programs reported distributing significantly more prevention and harm reduction resources.

A total of 52 of 87 programs reported distributing condoms, and the number of condoms distributed increased by 26% (from 932,658 to 1,179,248) – primarily due to an increase in one agency. Most of the increase occurred in routine outreach/harm reduction programs as opposed to being part of awareness campaigns.

Figure 36
Number of Condoms Distributed by Activity



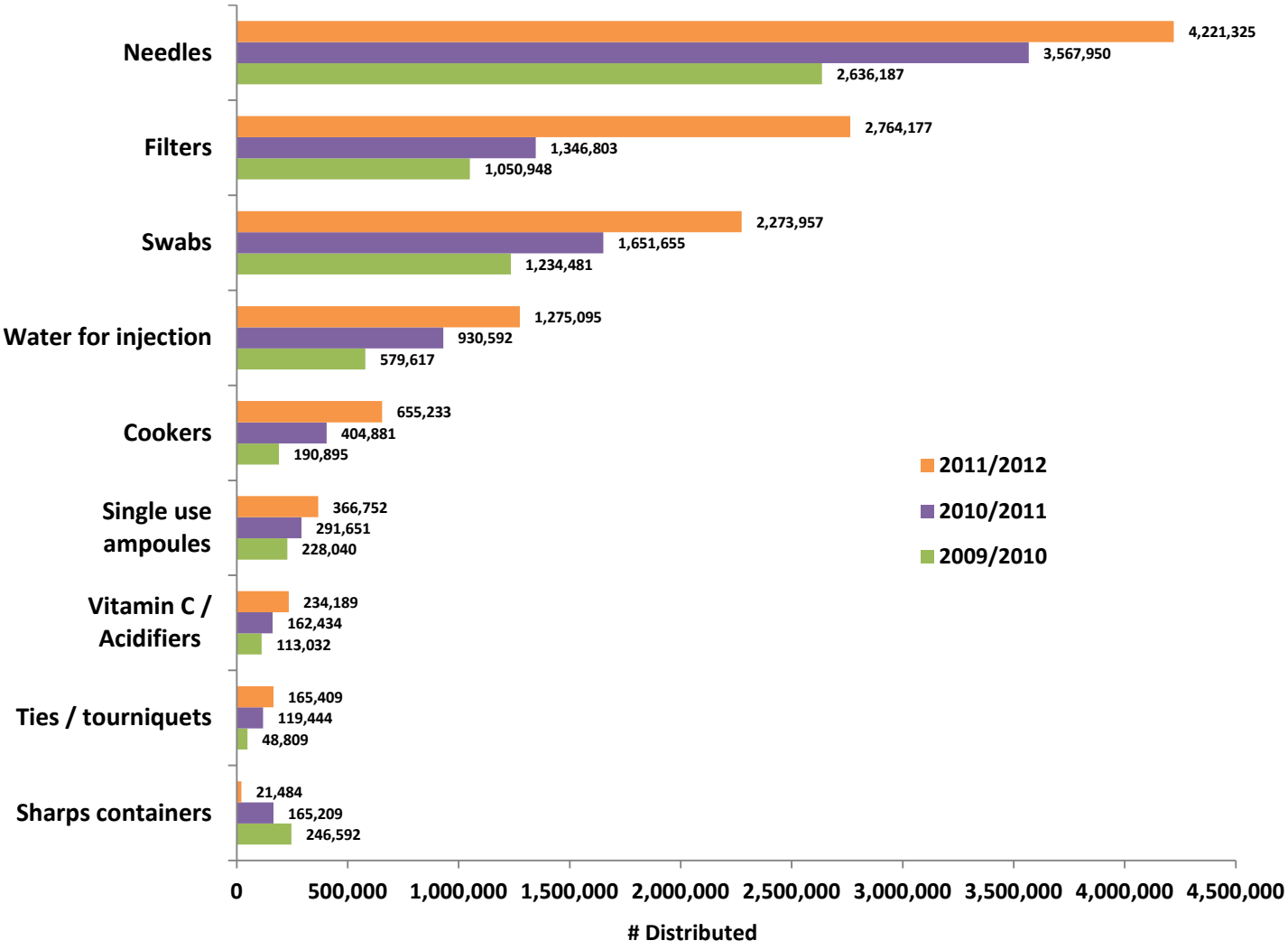
Programs reported some problems with condom distribution programs, particularly related to the brands of condoms. They received complaints about certain types of condoms and more requests for specific condom brands.

> *"More youth have been requesting the Trojan condom brand. Youth report that they prefer the brand because it feels more natural and reliable."*

> *"Historically, we have received a free supply of Lifestyle condoms from Public Health. As a result of the feedback we have received regarding the problems with this product, we anticipate having to purchase Trojan condoms and this may require additional funding for program supplies. There needs to be an analysis of the effectiveness of the Lifestyle and other condoms to ensure that they are safe and effective."*

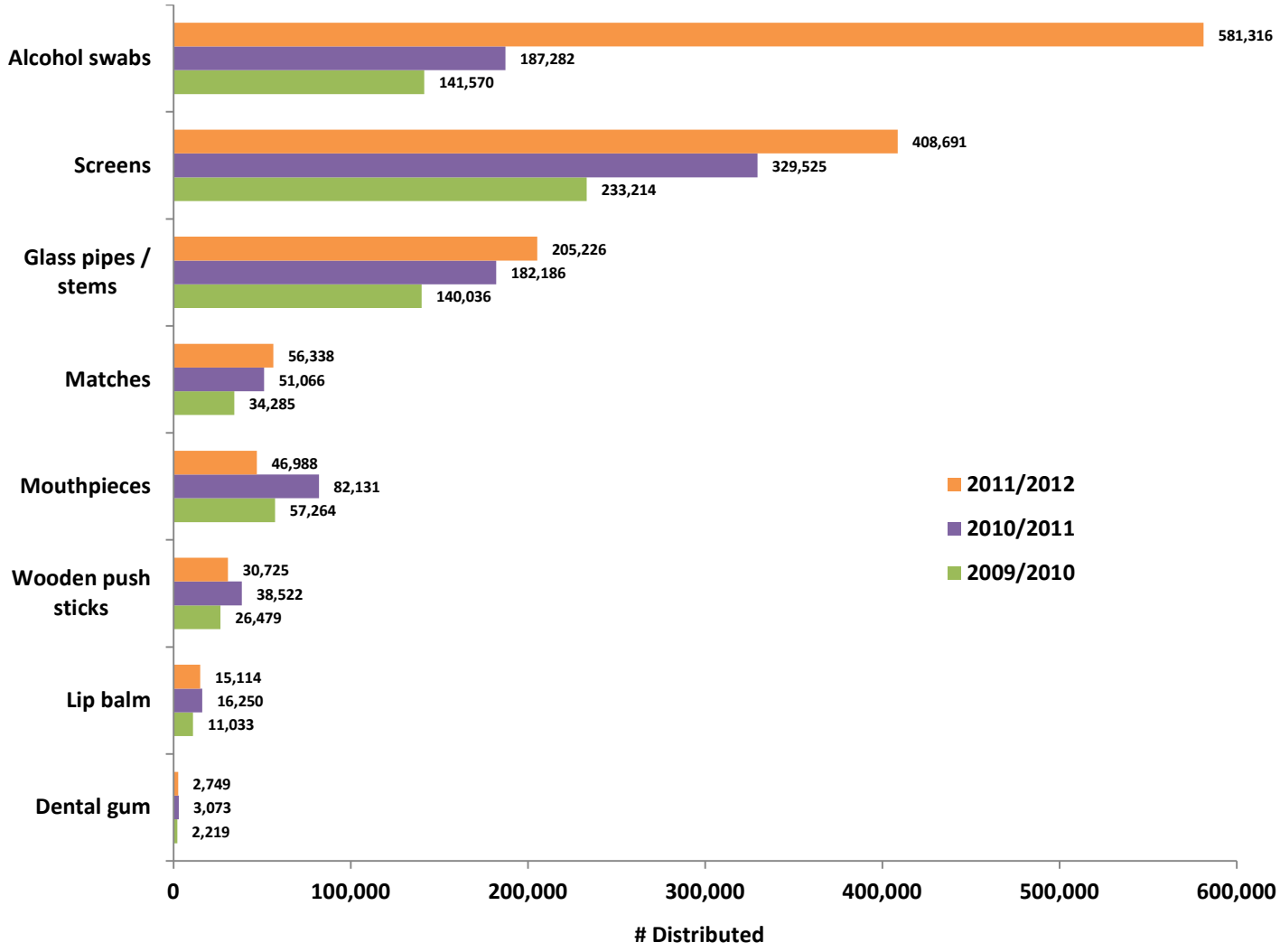
We also saw a significant increase (20%+) in distributing safer injection equipment – despite the fact that three fewer programs were involved in distributing needles than in the previous year.

Figure 37
Total Number of Safer Injection Equipment Distributed



There was also a marked increase in the distribution of safer smoking equipment. The number of programs distributing this equipment increased (to 20), and this equipment is now available in most parts of the province.

Figure 38
Total Number of Safer Inhalation Equipment Distributed



In terms of drug use patterns, programs reported seeing:

- a shift from oxycontin to other drugs of choice, such as heroin, fentanyl, non-prescription street drugs, hydromorphone – the drug of choice tends to be community-specific
- an increase in the street price of opiates since the removal of oxycontin from the drug benefit formulary.

> *"There are reports of people switching to opiods such as Fentanyl and Hydromorphone because of the difficulty in injecting the new formulation of OxyNeo. … as well of heroin use increasing. We remain very concerned about death and injury from accidental overdose, the purity of available substitute substances and the inability to access Naloxone; in addition to the legal, financial and psychosocial consequences this will have for users."*

> *"The trend we are seeing is clients moving away from prescription drugs and towards non-prescription street drugs. This is significant because clients using prescription drugs know what they are taking and what can be expected, while clients using non-prescription street drugs have no way of knowing what they are taking. This can lead to an increase in overdoses and deaths. The increase in Fentanyl users is alarming because of the high risk of overdose when using this drug."*

Programs also reported seeing an increase in younger clients and there is more demand for outreach to sex workers. In terms of the health of their clients, programs are seeing an increase in skin infections, abscesses, and reactions to levamisole tainted cocaine/crack.

There is more demand for:

- safer inhalation kits
- methadone treatment/treatment facilities
- practical assistance (e.g., food, winter clothing, housing, basic needs supplies)
- mental health and concurrent disorder services.

> *"In general, we are noticing an increased demand for needle exchange supplies and outreach services."*

> *"[We] need to re-visit policy for not distributing safer crack use supplies to youth under 18. There was not clear rationale for maintaining this policy so the … community has identified a need to re-visit this by doing a pilot project. Xxx and xxx will collaborate in doing pilot project to reduce the age of access to crack pipes from 18 -16."*

> *"During this reporting period there has been an increased demand for more concurrent disorder programs that use the "housing first model". Since one opened in the past year, the interest in more programs like this has become more evident among our service users."*

To respond to changing needs, agencies are:

- Revising programs / services
- Developing new and strengthening existing partnerships
- Providing more referrals
- Providing more client education
- Providing more education in the community on harm reduction approaches
- Continuing to advocate for access to non-stigmatizing services for their clients.

From anecdotal comments, it is clear that IDU outreach and harm reduction programs are continually assessing demand for their services and seeking out ways to improve services:

> *"During this reporting period we have noticed an increase of needle use through outreach and in-service contacts. This is an indication that our harm reduction clients are feeling more comfortable with the service we provide."*

> *"There is increased interest from other agencies to have a needle exchange at their locations. As well, there has been an increased demand from community members and local businesses for bio-hazard bins and disposal at their locations. This has increased [our agency's] amount of bio hazard disposal and associated cost by 10-15% this year. We continue to be called regularly to pick up used needles reported in parks and other community locations."*

> *"We trained and added two new peer workers to our outreach program this term and this is helping us to reach more clients in need and provide good quality peer information and support about accessing our services."*

> *"We are adjusting and stretching current funding as much as possible in order to meet client need for basic items such as food, clothing and toiletries."*

One program highlighted the service gaps that make it more difficult to serve people who use substances:

> *"There remain gaps in the services provided to clients with concurrent disorders. Attaining assistance from the medical community is difficult, because the client is required to be "clean" for an extended period of time. In turn, it is difficult for the client to become "clean" for an extended period of time without direct assistance with mental health issues."*

> *"Many of our clients are living in housing situations infected with bed bugs."*

EMERGING ISSUES/TRENDS

From the increase in contacts, attendance at drop-ins and demand for practical supports, it appears that programs have developed more trusting relationships with IDU clients. What are the implications of these changes for ongoing services?

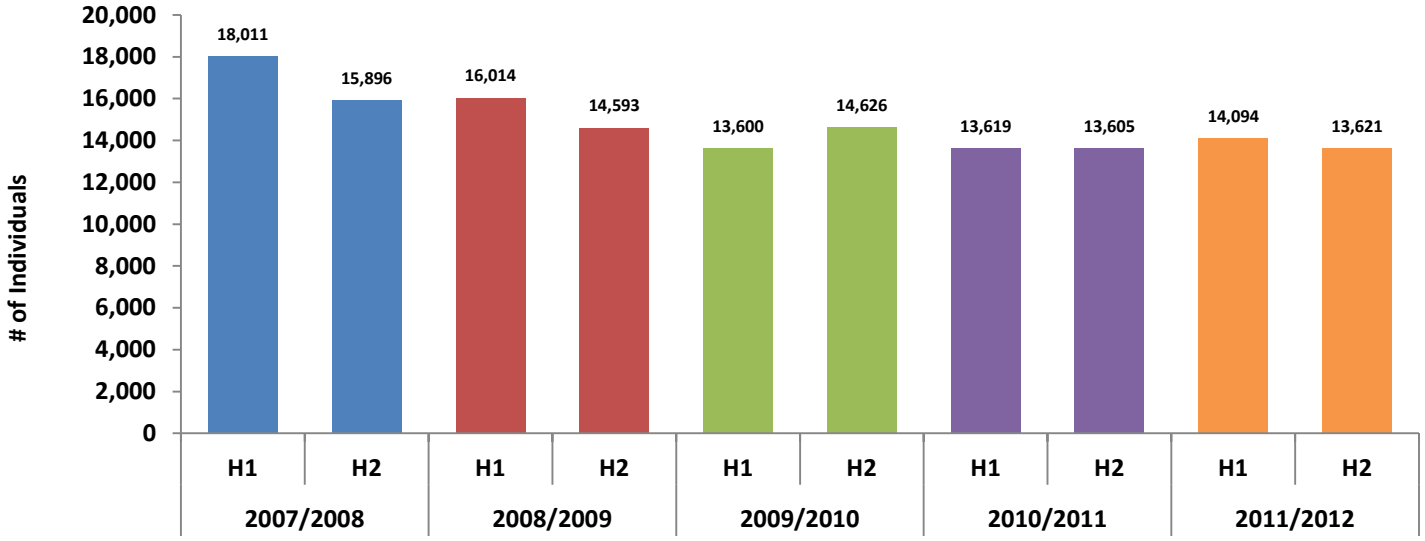
1. Do programs need different skills or resources to respond to changing needs?
2. How can programs balance the increased need for in-service and support with the need to keep doing outreach to the drug using community?
3. What strategies are agencies using to develop working relationships/referral networks with other services, such as mental health and addiction agencies? Primary care services?

2 IMPROVING ACCESS TO SERVICES

Community-based programs funded by the AIDS Bureau and ACAP are expected to improve access to services for people living with and at risk of HIV. A total of 65 of the 88 funded programs provide care and support services.

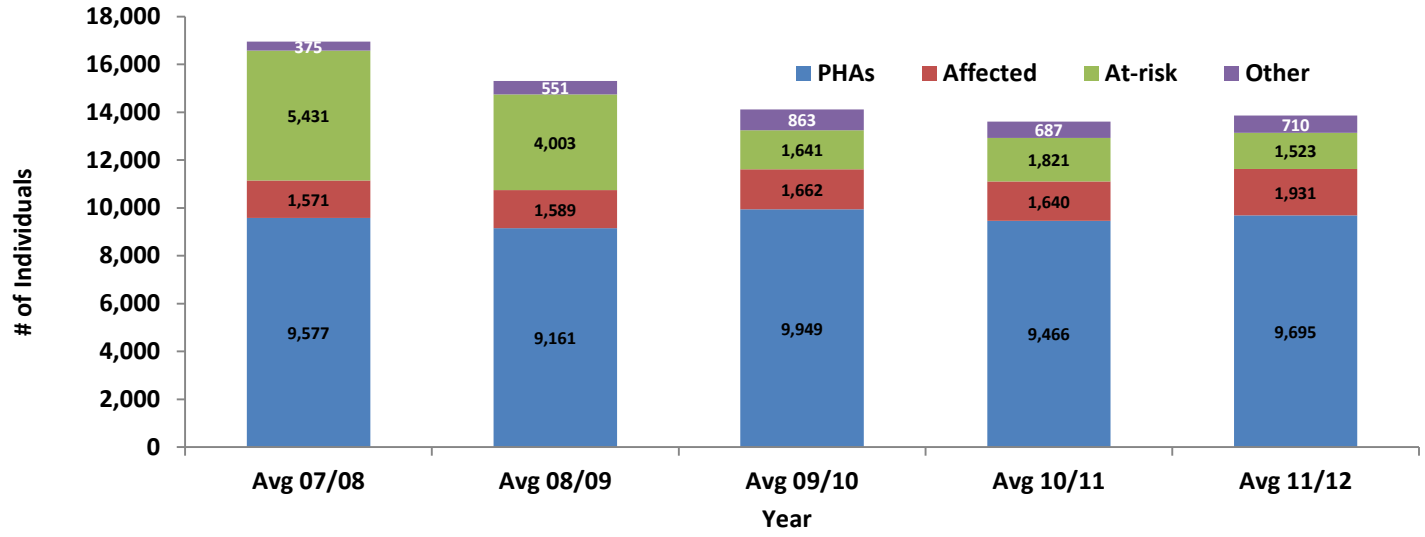
In 2011-12, programs reported serving, on average, 13,858 people in each half of the year. This is slightly higher than the previous year. NOTE: Some individuals may receive services from more than one agency (particularly in Toronto) so some clients may be counted more than once.

Figure 39
Number of Clients who Used Support Services During Each Reporting Period



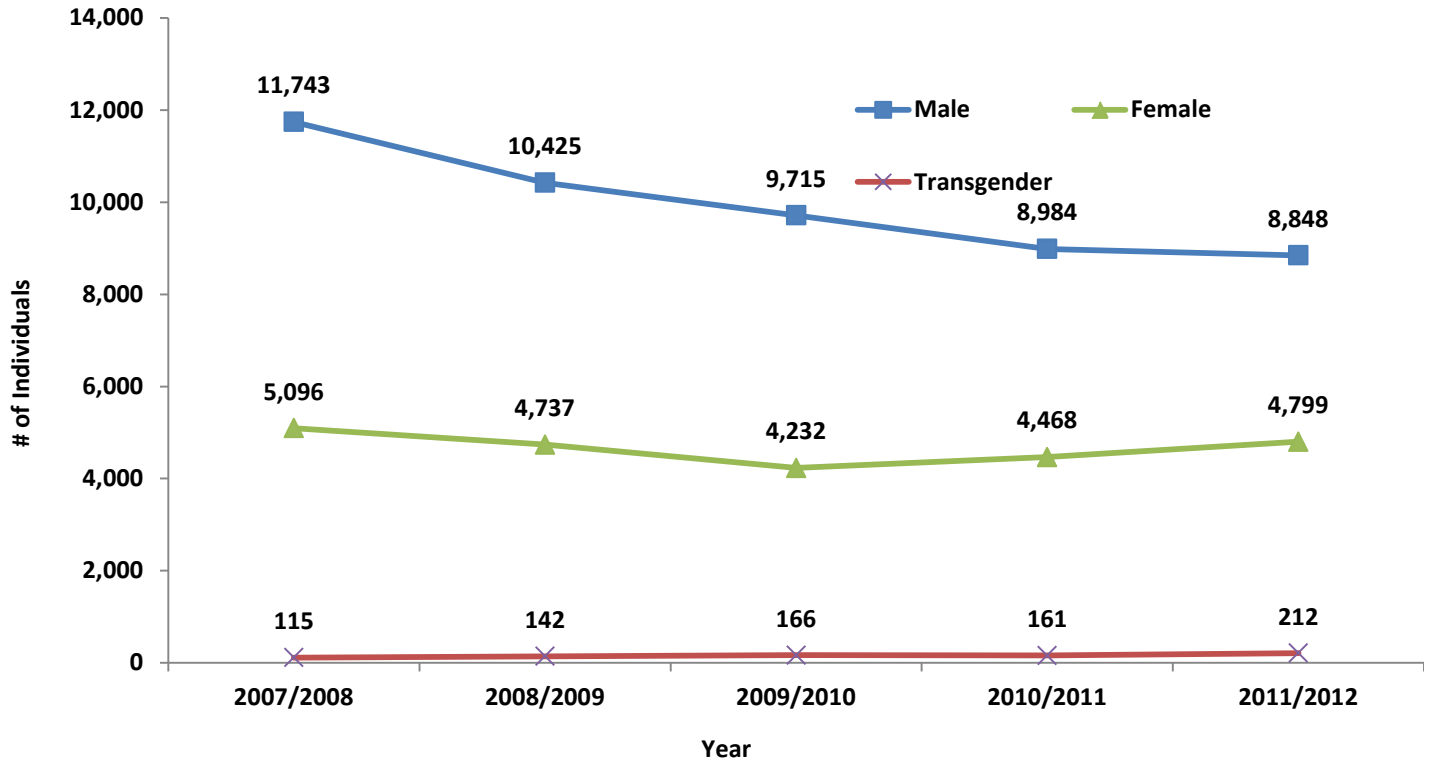
Most users of support services are people living with HIV (70%). In 2011-12, the next highest proportion of users (14%) were people affected (i.e., partners, family, friends of people with HIV), followed by people at risk (11%). Programs reported 5% of users of support services as “other”, which include mainly people with blood disorders, people with hepatitis C and sex workers.

Figure 40
Delivery of Support Services by Client Type



In terms of gender, programs reported serving slightly more females and trans people in 2011-12 and slightly fewer males. The number of females using services has increased steadily over the past three years, despite a drop in the number of new infections in women. This trend may indicate that women make more consistent use of community-based services, or that they have fewer resources and social supports. Given that many women living with HIV are also likely recent immigrants and may have children (some of whom may also be HIV+), their support needs may be more extensive.

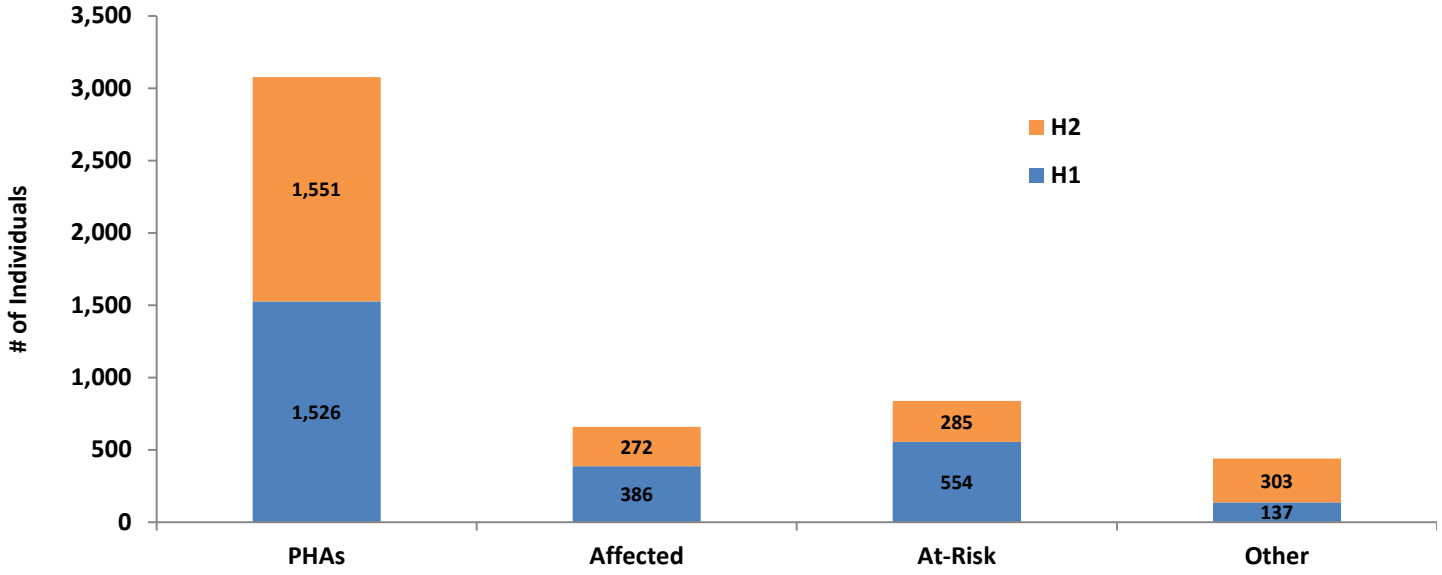
Figure 41
Number of Support Service Users by Gender



INCREASE IN NEW CLIENTS

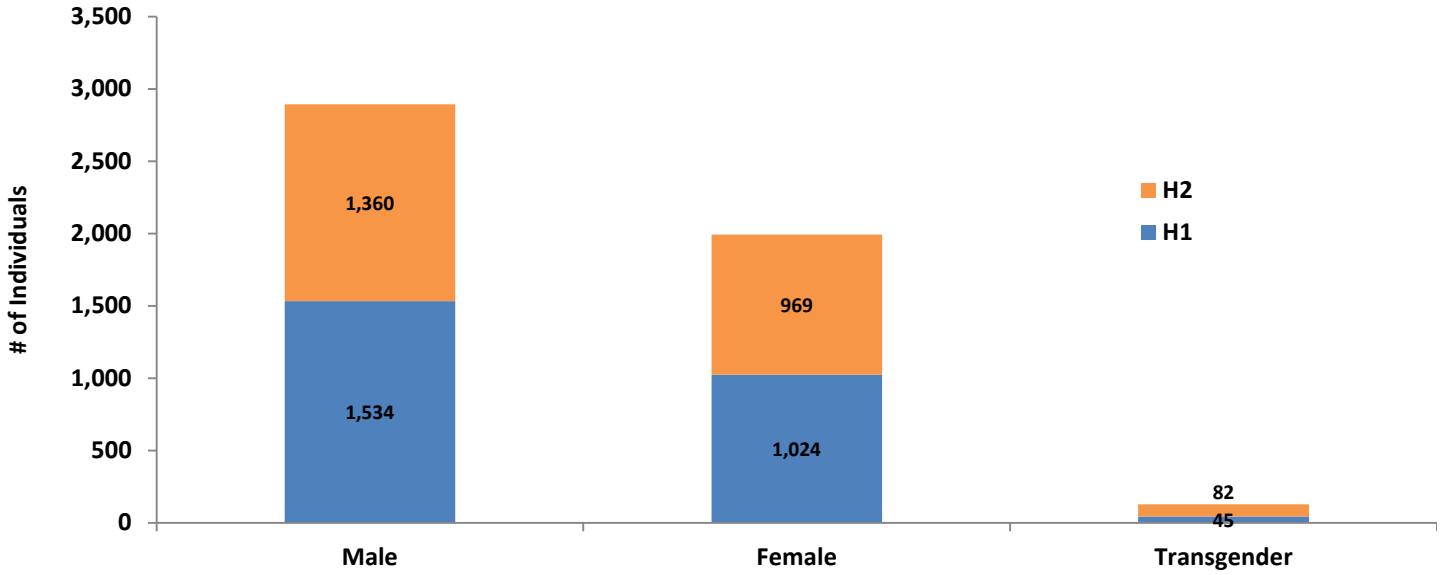
Programs reported a significant number of new clients in each half of the 2011-12 year. Over 3,000 of the people living with HIV served during the year were new clients. As the number of new clients exceeds the number of new diagnoses in 2011-12, it appears that people seek out community-based services as they need them over the course of living with HIV.

Figure 42
Number of New Clients by Client Type: 2011/2012



Programs reported more new male clients than female clients in 2011-12; however, given that women represent <25% of new diagnoses and cumulative diagnoses, they account for a much higher proportion of new clients using community-based services. This is consistent with patterns seen in other parts of the health care system, where women are more likely to use services than men. The three agencies reporting the largest numbers of new clients are all located in Toronto. One provides legal services, one serves the African, Caribbean and Black community, and one serves people living with HIV.

Figure 43
Number of New Clients by Gender: 2011/2012



The majority of males and females using support services are people living with HIV. However, a larger proportion of female clients than male clients are people affected by HIV.

Figure 44
Men Served by Client Type

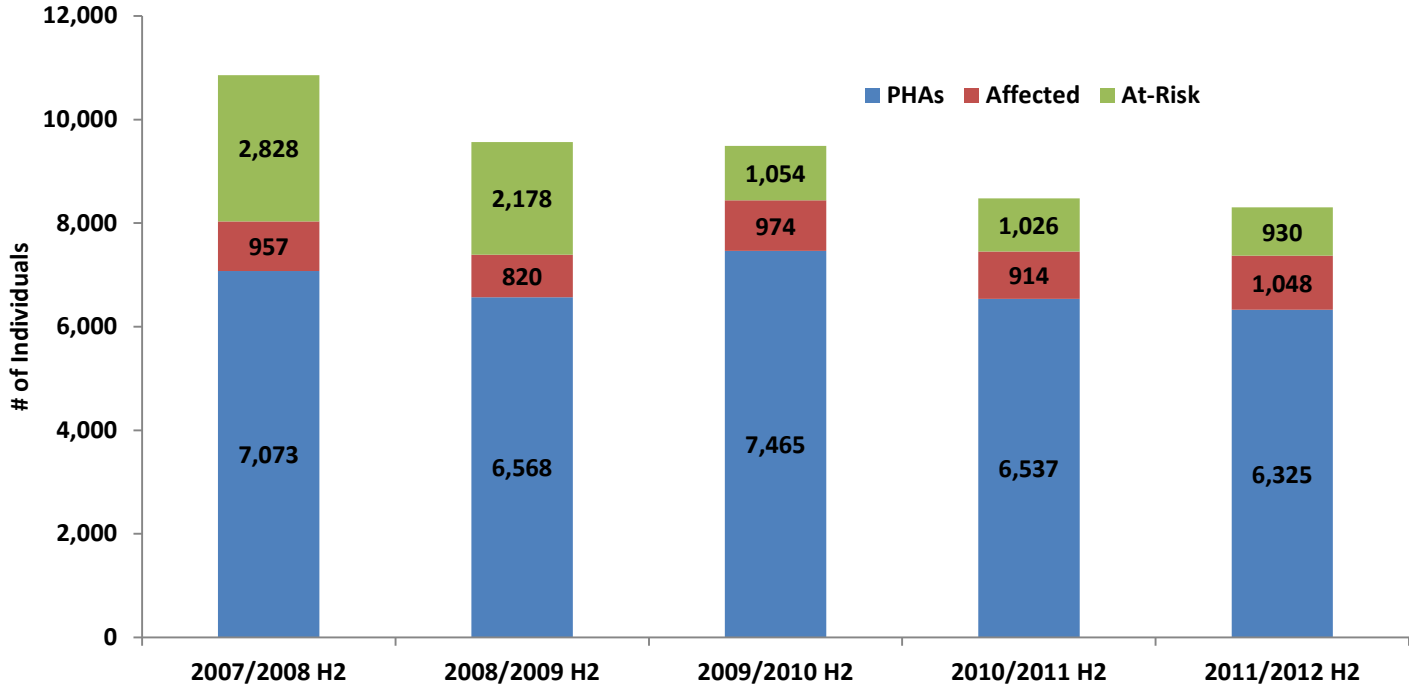
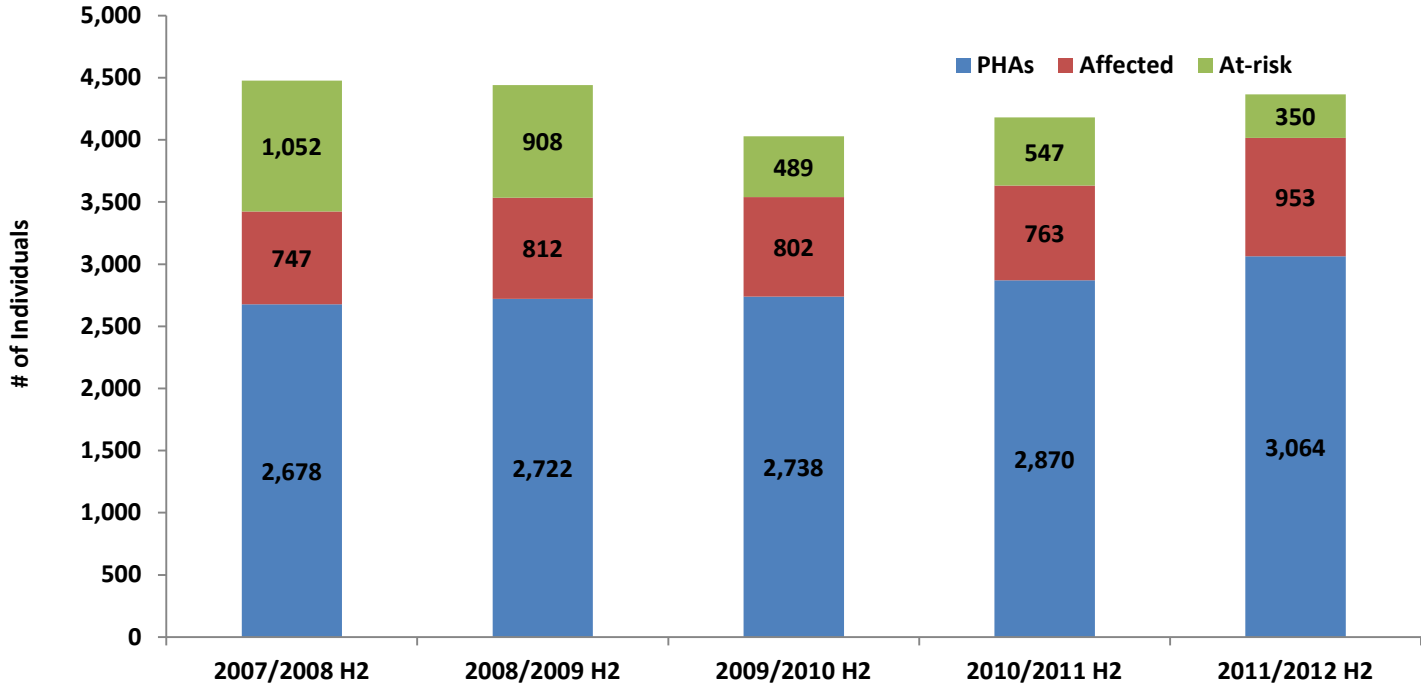


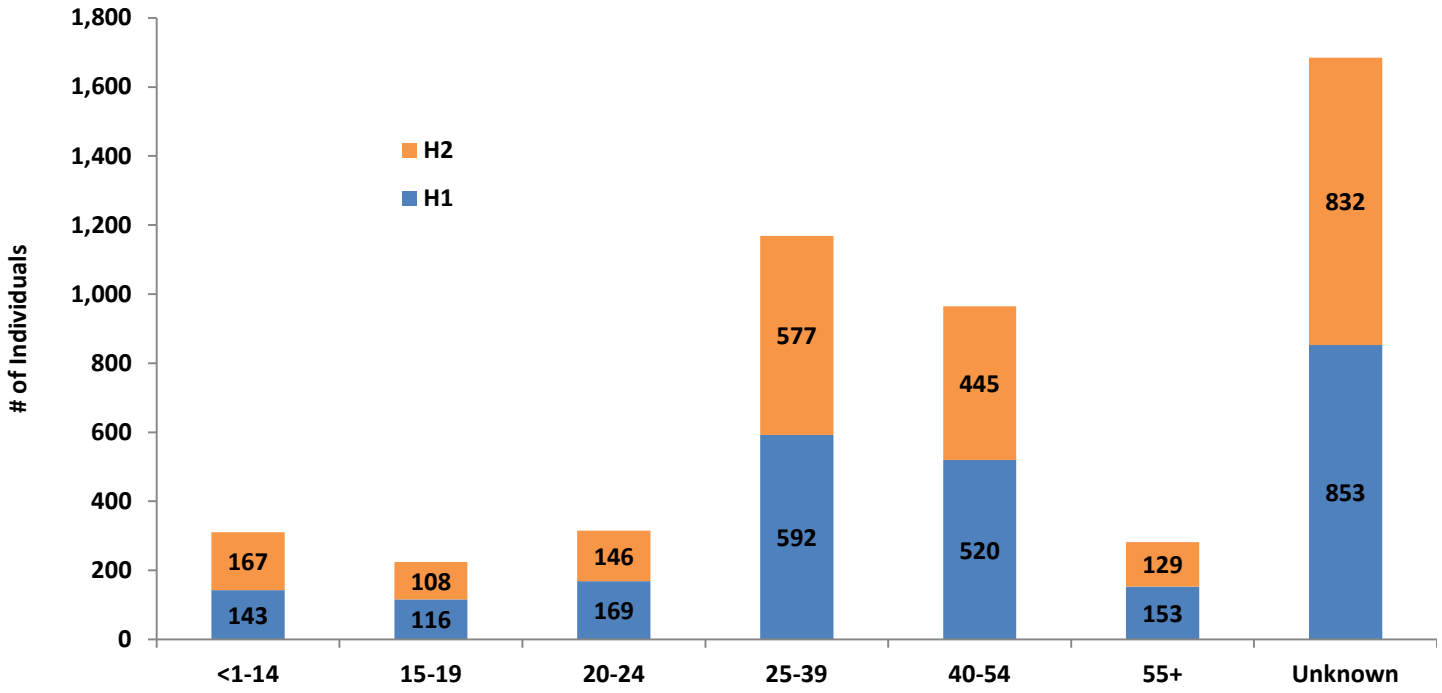
Figure 45
Women Served by Client Type



"GREYING" TREND CONTINUES

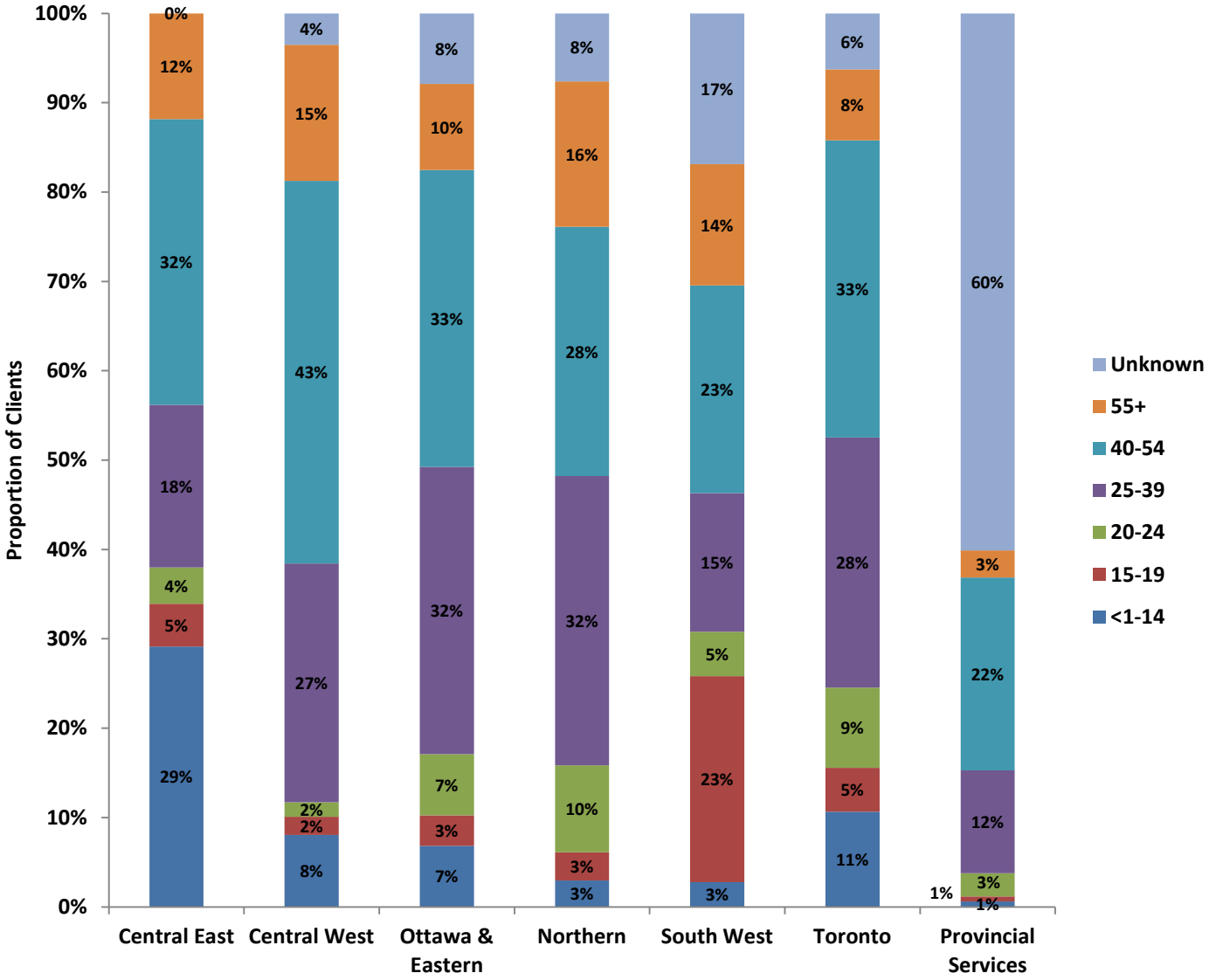
We continue to see the "greying" of HIV. In 2011-12, OCHART asked (for the first time) about the age of new clients. Most new clients (where their age is known) are over age 25 and a significant proportion are over age 40. Of the new clients under age 14, most (250) are affected (i.e., children of people living with HIV) and 15 are living with HIV and were infected perinatally before coming to Canada. Note: the large number of clients whose age is not known is due to one agency, which provides legal advice and doesn't collect data on client age.

Figure 46
Number of New Clients by Age: 2011/2012



When we look at geographic distribution, we see that the greying trend is consistent across the province. Almost half of all clients in all regions are over age 40.

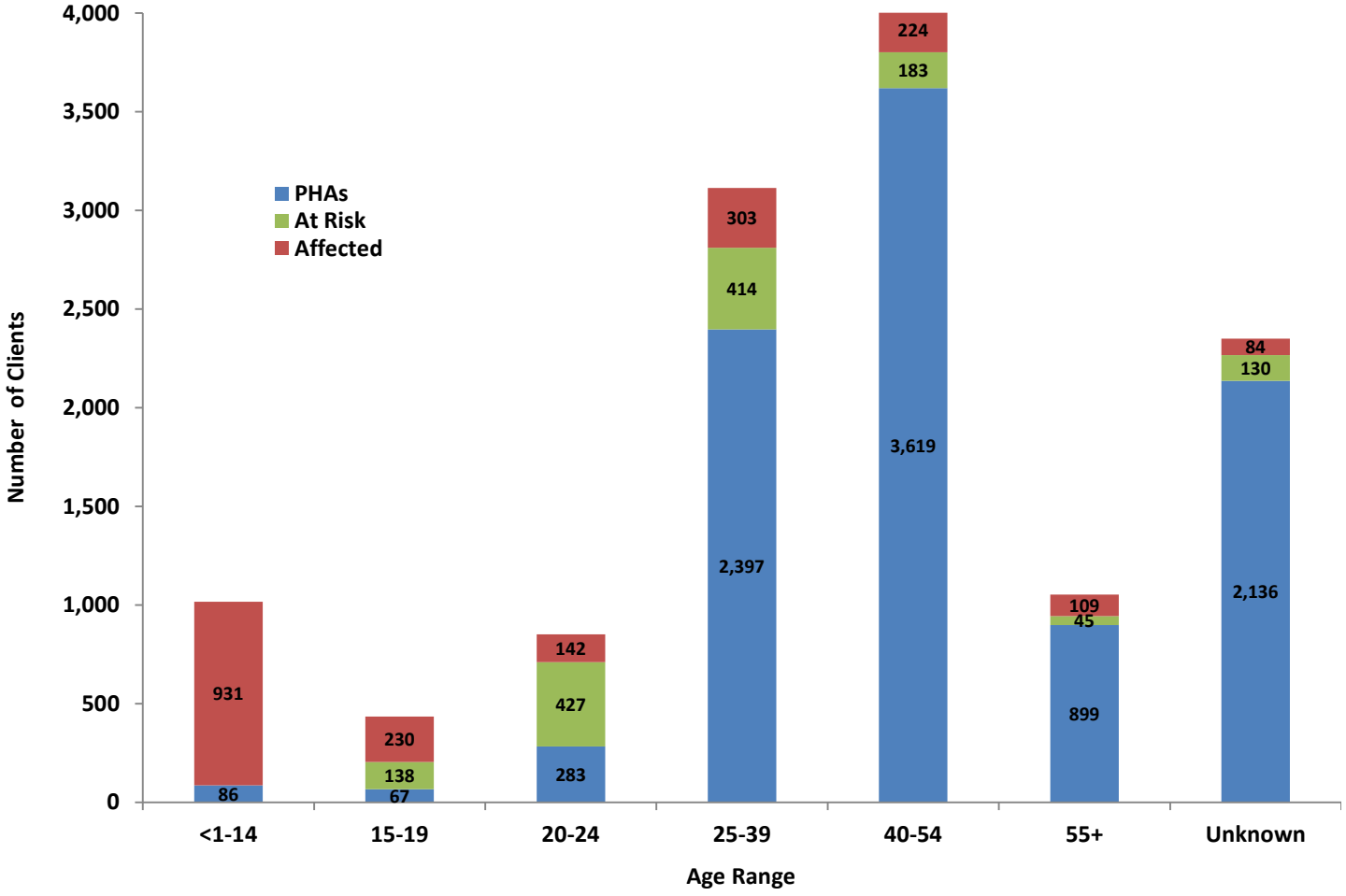
Figure 47
Proportion of Clients Accessing Support Service by Age and Region: H2 2011/12



MOST OLDER SUPPORT SERVICE CLIENTS ARE PEOPLE LIVING WITH HIV

As the following figure illustrates, the majority of older clients using support services are people living with HIV, while a larger proportion of younger clients are people affected or at risk.

Figure 48
Number of Clients access Support Services by Client Type and Age: 2011/2012 H2



ASOs AND OTHER HEALTH CARE SETTINGS SEE OLDER CLIENTS

When we look at the age distribution of clients by type of agency, we see that CHCs and non-ASOs tend to see more younger clients than ASOs or programs based in other health care settings.

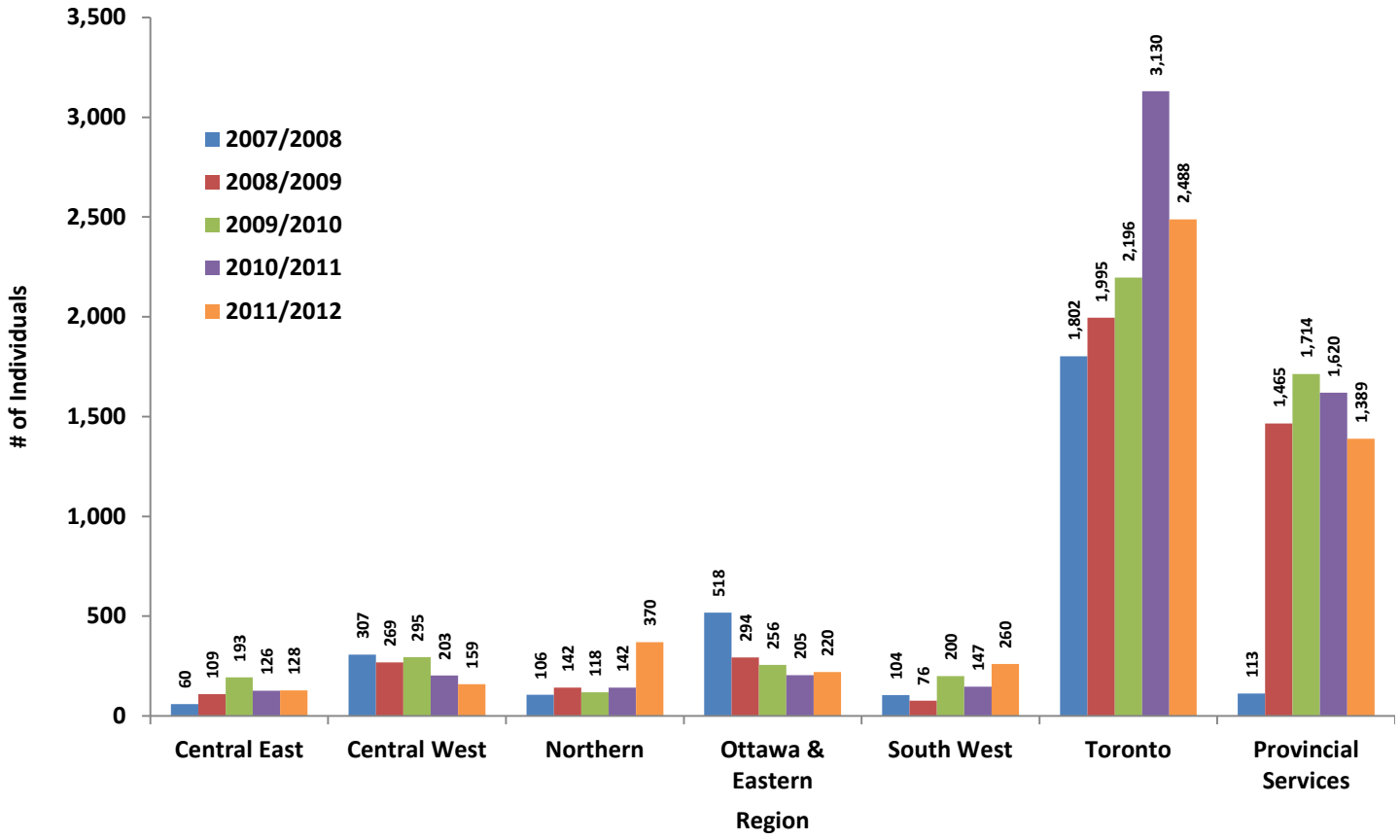
Figure 49
Age Profile by Agency Type (H2 2011)

AgeCategory	ASO	CHC	Non-ASO	Other Health Care	Grand Total
<1-14	8.77%	1.19%	6.12%	0.72%	8.13%
15-19	3.85%	0.00%	9.83%	1.08%	4.35%
20-24	3.68%	5.64%	30.01%	5.05%	6.65%
25-39	22.91%	51.93%	25.37%	20.58%	23.85%
40-54	31.51%	36.20%	18.17%	57.40%	30.70%
55+	8.14%	5.04%	6.93%	14.08%	8.05%
Unknown	21.13%	0.00%	3.57%	1.08%	18.27%
Grand Total	100.00%	100.00%	100.00%	100.00%	100.00%

HIGHER PROPORTION OF NEW CLIENTS IN NORTHERN AND SOUTH WEST REGIONS

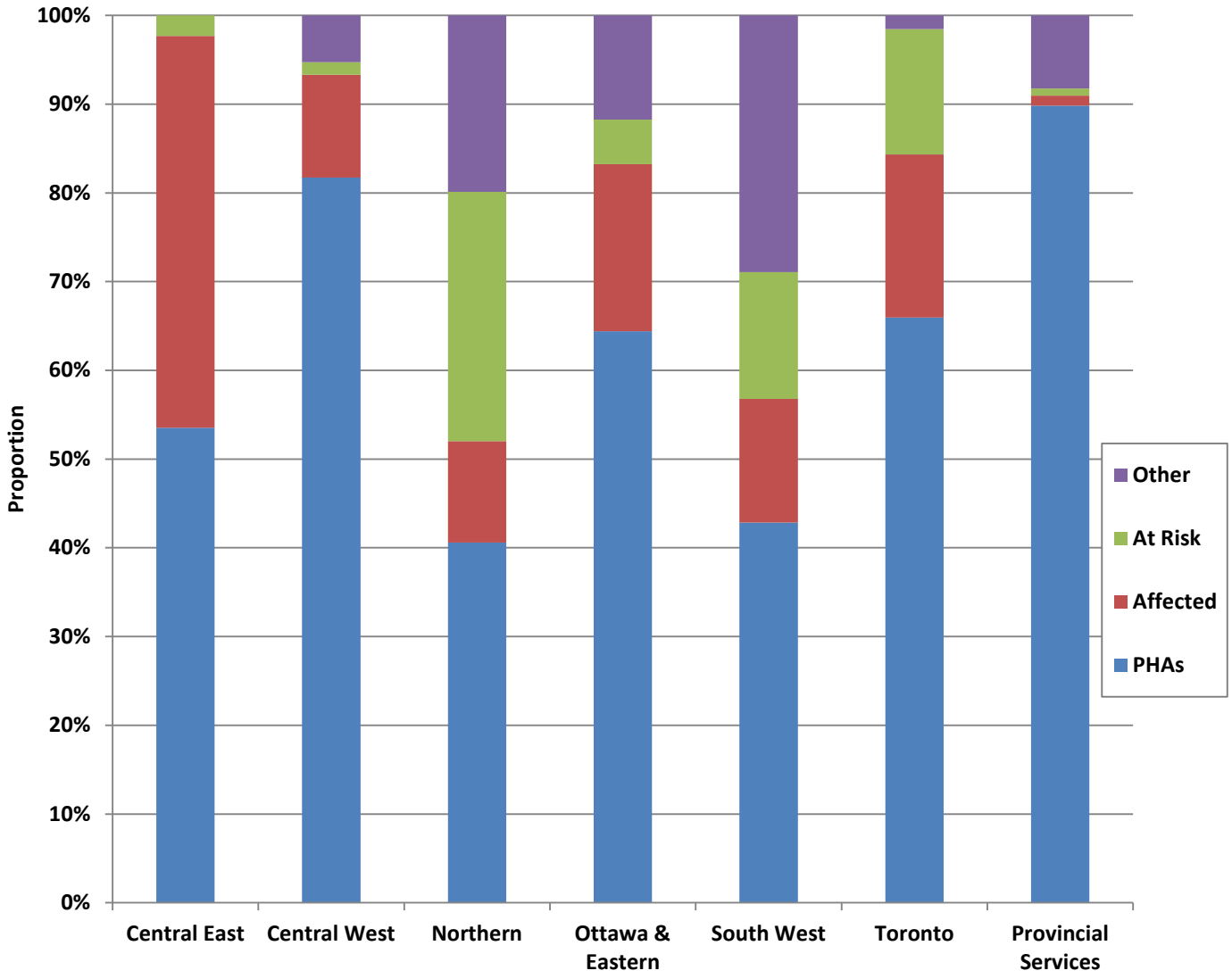
When we look more closely at which programs are reporting new support clients, we see that they are spread across the province. Toronto, which has the majority of the epidemic, has the largest number of new clients – although down from the previous year. (Note: the drop in Toronto was mainly due to the closing of one agency.) In 2011-12, there was a marked increase in new support clients in the Northern and South West regions. In the Northern Region, the increase was mainly in two agencies and consisted primarily of people who are at risk or affected, and may be related to high rates of hepatitis C in that region.

Figure 50
Number of New Clients by Region



In terms of the type of clients served, people living with HIV make up a larger proportion of support service clients in Central West, Toronto, Ottawa and in those provincial agencies that provide direct services. Programs in Central East, Ottawa, and Toronto serve a relatively large proportion of clients who are affected, while the Northern, South West and Toronto Regions serve a relatively large proportion of clients who are at risk. South West, Northern, Ottawa, Central West and the Provincial Services report a large proportion of "other" clients comprising people with blood disorders (55%), people with hepatitis C (22%), and Open Closet Youth (18%). These proportions are similar to the previous year.

Figure 51
Client Type by Region: 2011/2012 H2



145 CLIENT DEATHS IN 2011-12

Figure 52 reinforces that the majority of clients are not new to the programs, but active ongoing clients. We do not yet know how long, on average, or how frequently clients turn to community-based agencies for support services. However, we hope to gain a better understanding of service usage patterns through OCASE.

Figure 52
Number of New and Active Clients by Region: 2011/2012

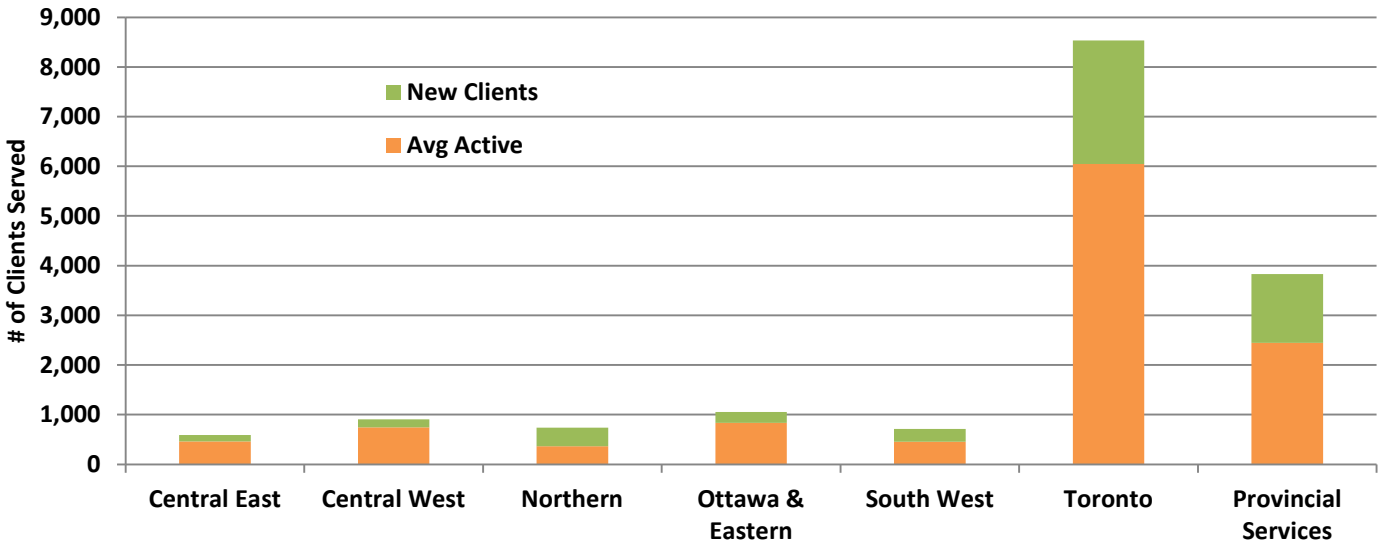


Figure 53 reminds us that despite improvements in care and treatment, HIV is still a life-threatening and life-limiting disease. For the first time in 2011-12, programs were asked to report the number of client deaths a year, and they reported a total of 145 deaths. (Note: Because clients may use the services of more than one agency, particularly in Toronto, the number of deaths reported may be higher than the actual number of people who have died.)

Figure 53
Number of Client Deaths by Region: 2011/2012

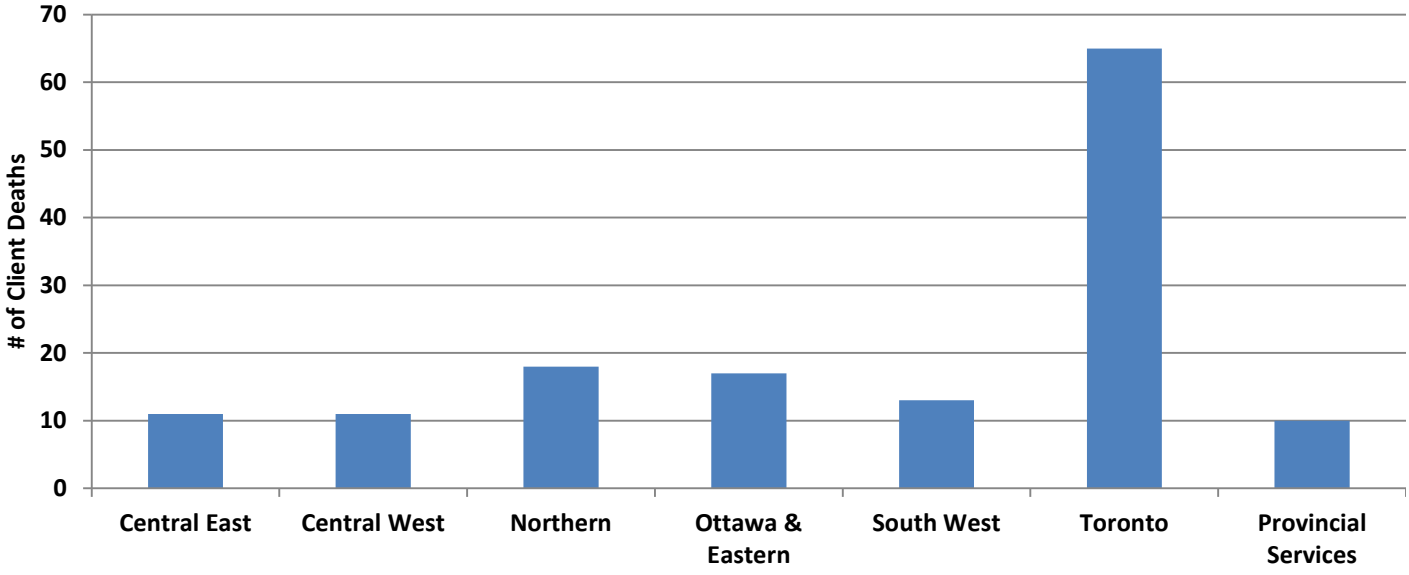
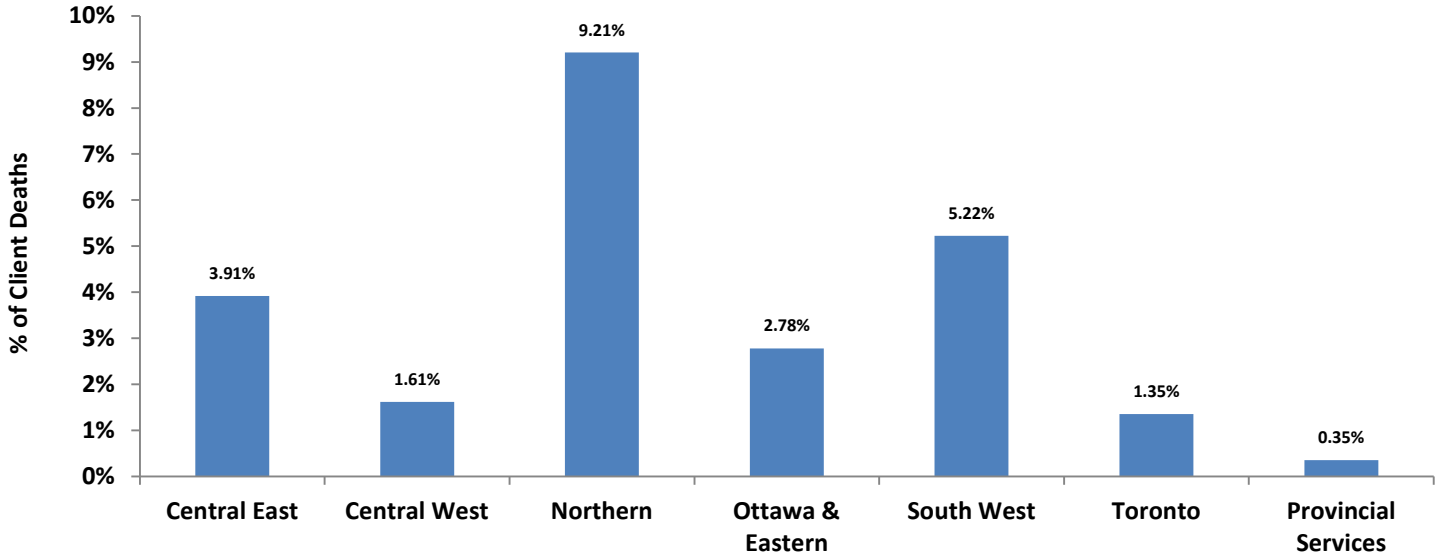


Figure 54 shows the proportion of clients with HIV who died in 2011-12. Programs in Northern Ontario reported that almost 10% of their positive clients died in the last year – while programs in the South West reported that over 5% of their positive clients died. These losses may indicate that people with HIV are more likely to turn to community-based agencies as they age and as their health fails. They may also highlight the problem of late diagnoses among people who inject drugs and Aboriginal people with HIV. Whatever the factors that are leading to high death rates in some regions, these losses are extremely hard on agency staff and other clients, and may argue for the need for more services related to advanced care planning, palliative care and bereavement support.

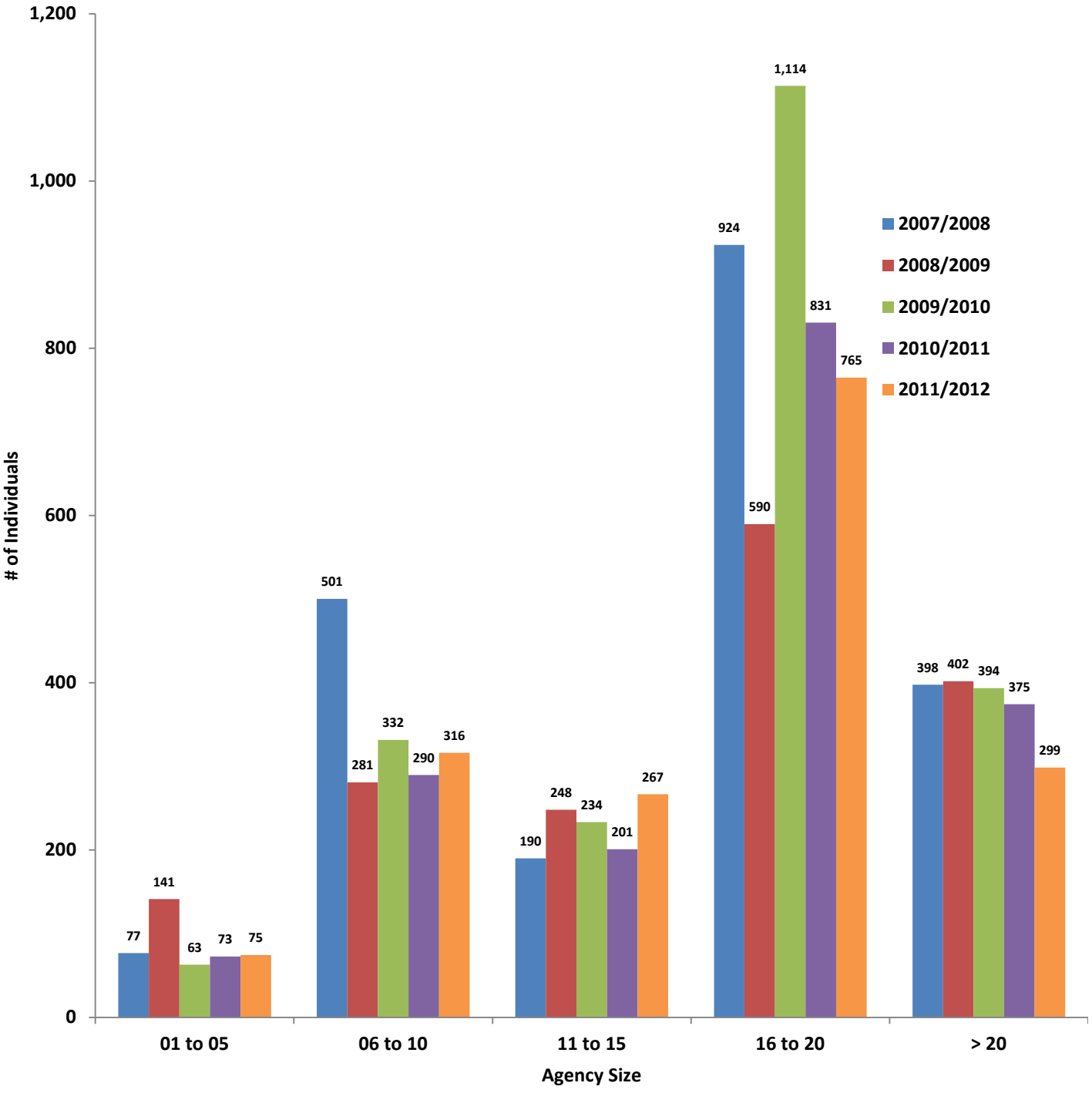
Figure 54
Ratio of Client Deaths to the number of PHA Clients by Region – 2011/2012



AGENCY SIZE IS NOT NECESSARILY A PREDICTOR OF WORKLOAD

It is interesting to note that agency size is not necessarily a predictor of workload. In fact, the programs with between 6 and 10 FTEs serve, on average, more clients than slightly larger agencies – although fewer than agencies with 16 to 20 staff. The relatively large number of clients per agency in the smaller agencies may be because most of the province's dedicated ASOs fall into this size category.

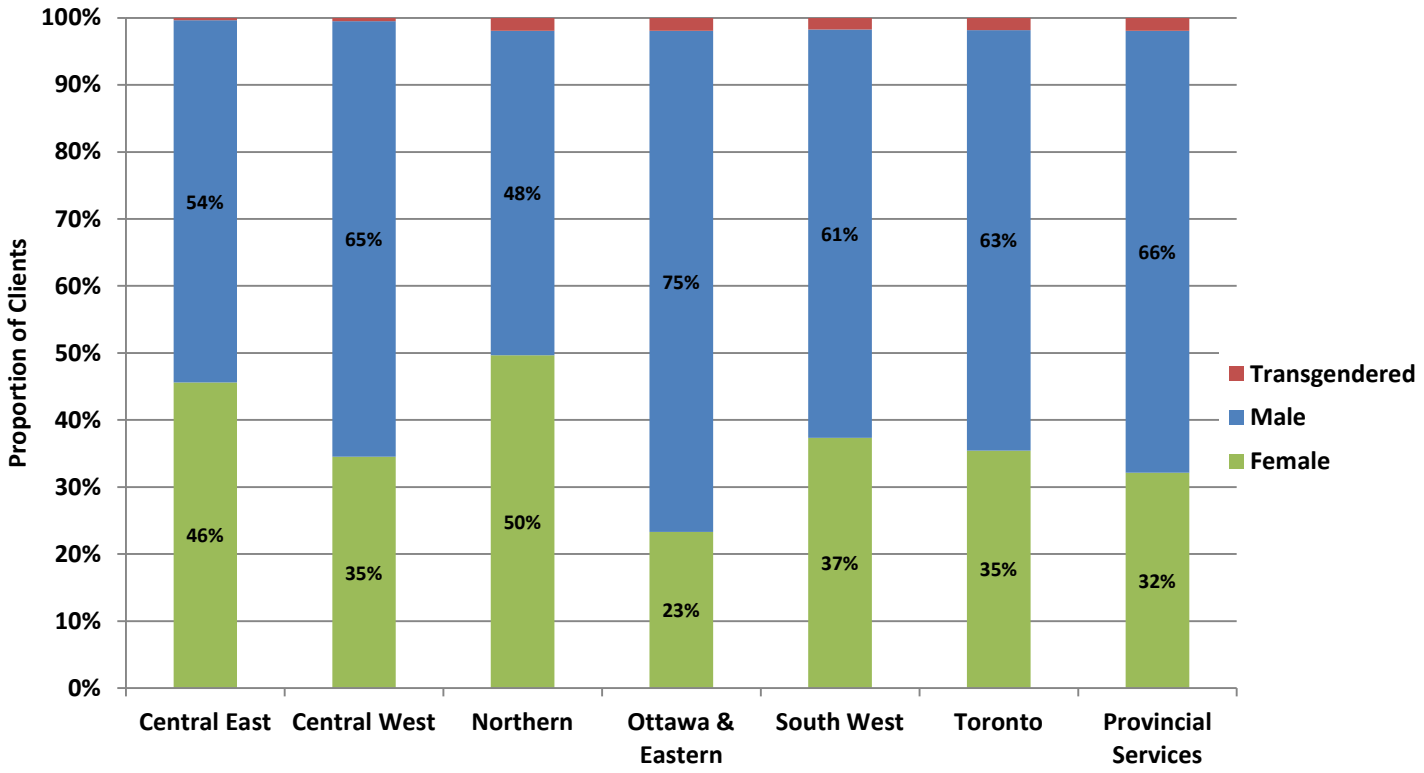
Figure 55
Average Number of Clients Served by Agency Size



PROGRAMS IN ALL REGIONS SERVE WOMEN

Although we often hear concerns that community-based HIV programs are not women-friendly, females represent over one-third of clients in all regions except Ottawa and Eastern – and they represent about half of all support clients in the Northern and Central East regions, despite the fact that they represent only about 20% of new diagnoses.

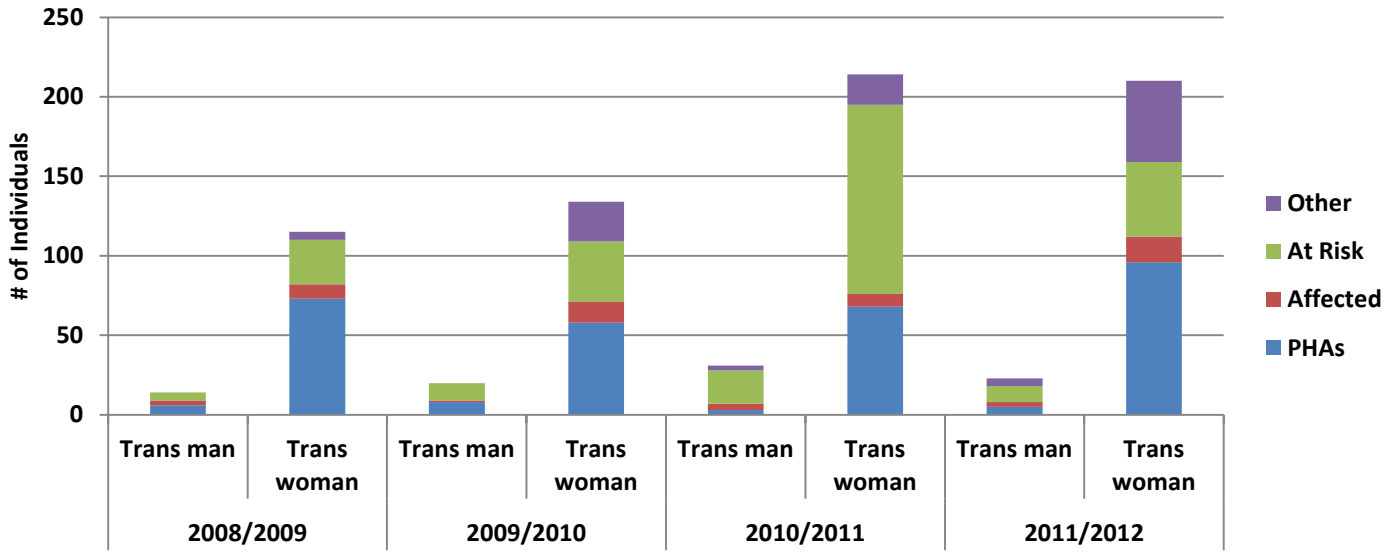
Figure 56
Proportion of Clients accessing Support Services by Region: 2011/2012 H2



PROGRAMS ARE REACHING MORE TRANSGENDERED CLIENTS

Over the past five years, there has been a steady increase in trans people accessing support services – in particular trans people living with or at risk of HIV.

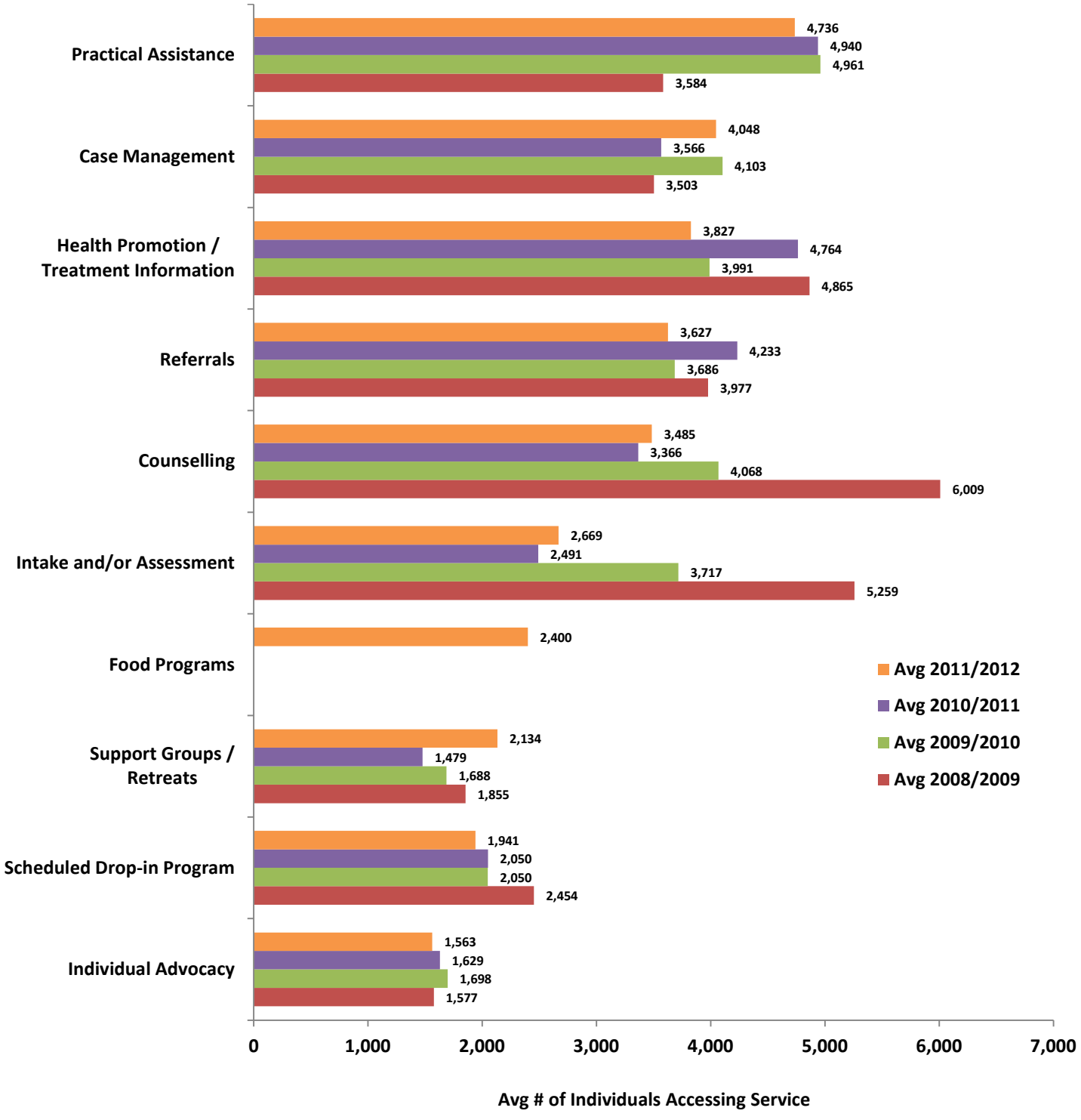
Figure 57
Number of Transgendered Clients accessing Support Services by Population Group



MOST-USED SERVICES REMAIN CONSISTENT

Clients continue to use the same types of services as in the past – with the exception of food programs. 2011-12 was the first year that OCHART asked about food security and the use of food programs. It appears that a significant number of clients have food security issues. A total of 25 agencies – at least one in each region – reported providing food programs. The number of agencies reporting these programs increased from 15 in the first half of 2011-12 to 25 in the second. However, this increase may be due to the fact that agencies began tracking their food programs more closely once they realized OCHART was asking for that specific information. The most heavily used food programs are in Toronto and Ottawa, but there appears to be growing demand for these services in the Central East and Northern regions.

Figure 58
Top 10 (Based on 2011/2012 Number) Support Services Provided



Programs reported receiving more referrals from primary care as well as an increase in the number of youth and women living with HIV accessing their services.

> *"Increase in referrals from MDs in the region of PHAs to [agency's] vitamin bank program led to an increase in new clients who were previously not accessing our services."*

In terms of client needs, programs are seeing more clients with mental health issues and more facing challenges related to aging and complex care issues (e.g., cognitive issues, comorbidities).

> *"Increase in number of clients accessing services who are experiencing significant mental illness combined with addictions who have unstable housing and/or are street involved."*

> *"With 83% of [our] PHA clients over the age of 40, aging and HIV is important to understand and determine the source of health issues. Are symptoms related to HIV or aging? There has been an increase of the number of people living with cancer … one person has become severely diabetic as a result of taking HIV meds, and another person has developed severe heart issues."*

> *"Aging participants continue to access service and require more hands on approach when working through various stages of managing their personal/ medical/financial concerns. Mental health and a variety of other personal/health related afflictions have become more apparent especially with regard to long term health effects of HIV/AIDS and treatments. Affordable housing, transportation, food security, family/relationship issues, and income concerns continue to be high priority issues and demand our response."*

The types of services used varies by client group. As would be expected, people living with HIV and people affected are more likely to use case management services, while people at risk are more likely to use counseling services, support groups and drop-in programs – however, a significant proportion of at-risk clients are also using practical support and referral services. It is interesting to note the high proportion of people affected who use food programs. This likely reflects the needs of the families of people living with HIV.

Programs report seeing an increase in demand for:

- practical assistance (e.g., food, housing, transportation, and financial)
- settlement services
- complementary therapies
- legal information related to non-disclosure

> *"There has been an increase in the need for practical assistance with regard to vitamins and food supplements, food vouchers, bus tickets and transportation to and from medical appointments."*

The demand for food has also been affected by changes in the eligibility criteria for the province's Special Diet Allowance. Many people who are on ODSP have had their diet allowance cut off or reduced and have sought legal help.

> *"We have allocated internal resources to deal with changes in eligibility for the Special Diet Allowance, and have opened in excess of 50 client files for this matter. Our application for funding from the Legal Aid Ontario Innovations Fund was successful. This has allowed us to increase the second Intake Lawyer's number of days worked from three to five per week. He now focuses on immigration matters three days per week."*

In terms of challenges, at least one program reported a lack of space to provide traditional aboriginal services.

Figure 59
Support Services Use by Client Type: 2011/2012 H2

	PHAs		Affected		At Risk	
	#	%	#	%	#	%
Practical Assistance	3645	12.92%	984	21.37%	490	11.57%
Case Management	3435	12.18%	734	15.94%	117	2.76%
Counseling	2389	8.47%	414	8.99%	788	18.61%
Health Promotion / Treatment Information	2695	9.56%	291	6.32%	484	11.43%
Referrals	2558	9.07%	255	5.54%	413	9.75%
Food Programs	2172	7.70%	708	15.38%	26	0.61%
Intake and/or Assessment	2261	8.02%	274	5.95%	188	4.44%
Support Groups / Retreats	1487	5.27%	135	2.93%	643	15.18%
Scheduled Drop-in Program	1085	3.85%	224	4.87%	500	11.81%
Individual Advocacy	1441	5.11%	108	2.35%	89	2.10%
Workshops / Training / Skills Development	1395	4.95%	81	1.76%	84	1.98%
Home & Hospital Visits / Care teams	684	2.43%	73	1.59%	25	0.59%
Complementary therapies	577	2.05%	68	1.48%	24	0.57%
Housing Assistance	494	1.75%	48	1.04%	74	1.75%
Pre/Post Test Counselling	181	0.64%	77	1.67%	233	5.50%
Supportive Housing	456	1.62%	6	0.13%	1	0.02%
Financial Counselling	332	1.18%	16	0.35%	8	0.19%
Bereavement Services	228	0.81%	89	1.93%	25	0.59%
Employment Services	294	1.04%	6	0.13%	17	0.40%
Settlement Services	247	0.88%	4	0.09%	0	0.00%
Interpretation / Translation	108	0.38%	6	0.13%	6	0.14%
Buddy Program	40	0.14%	3	0.07%	0	0.00%

In terms of geographic distribution, there is a significant demand for practical assistance, case management and counselling in all settings – urban, rural/urban mix and northern; however, there is greater use of food programs in larger urban areas and in the North.

Figure 60 reinforces that clients of dedicated ASOs are more likely to receive practical support service than the clients of programs in other types of organizations – while clients of CHCs, non-ASOs and other health care settings are more likely to receive health promotion and treatment information. These service differences are consistent with the different mix of clients in each of these settings.

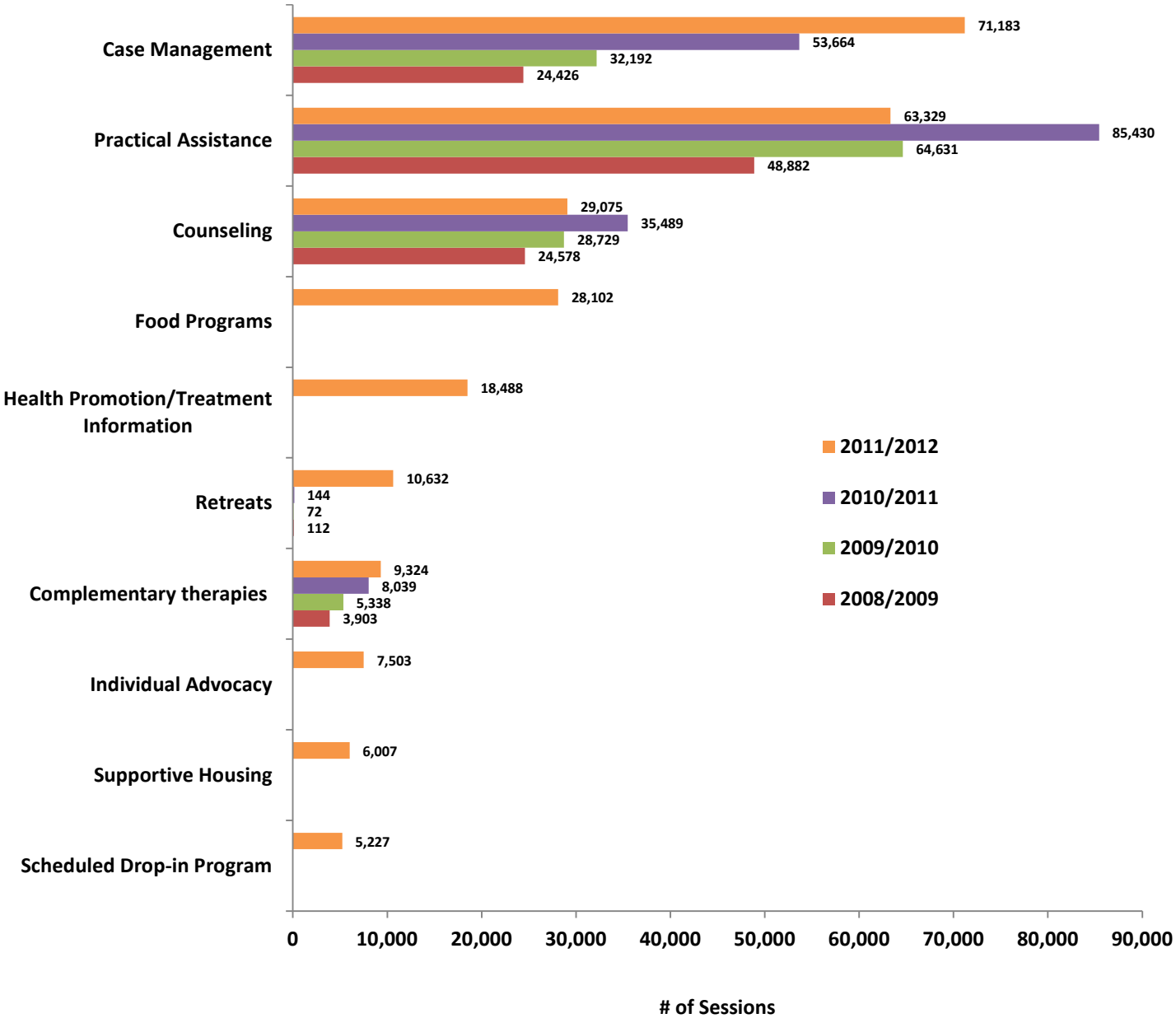
Figure 60
Proportion of Clients Accessing Selected Services by Agency Type: 2010/2011 H2

Service	ASO		CHC		Non-ASO		Other Health Care	
	2010-11	2011-12	2010-11	2011-12	2010-11	2011-12	2010-11	2011-12
Practical Assistance	19%	15%	1%	0%	5%	2%	7%	6%
Case Management	13%	12%	1%	10%	4%	3%	5%	6%
Counseling	9%	9%	6%	2%	12%	19%	7%	4%
Referrals	12%	8%	1%	10%	19%	12%	8%	7%
Health Promotion/Treatment Information	14%	8%	37%	27%	21%	19%	11%	13%
Intake and/or Assessment	8%	8%	12%	1%	9%	8%	2%	1%
Scheduled Drop-in Program	6%	5%	0%	0%	15%	11%	0%	0%

PROGRAMS PROVIDING MORE CASE MANAGEMENT SERVICES

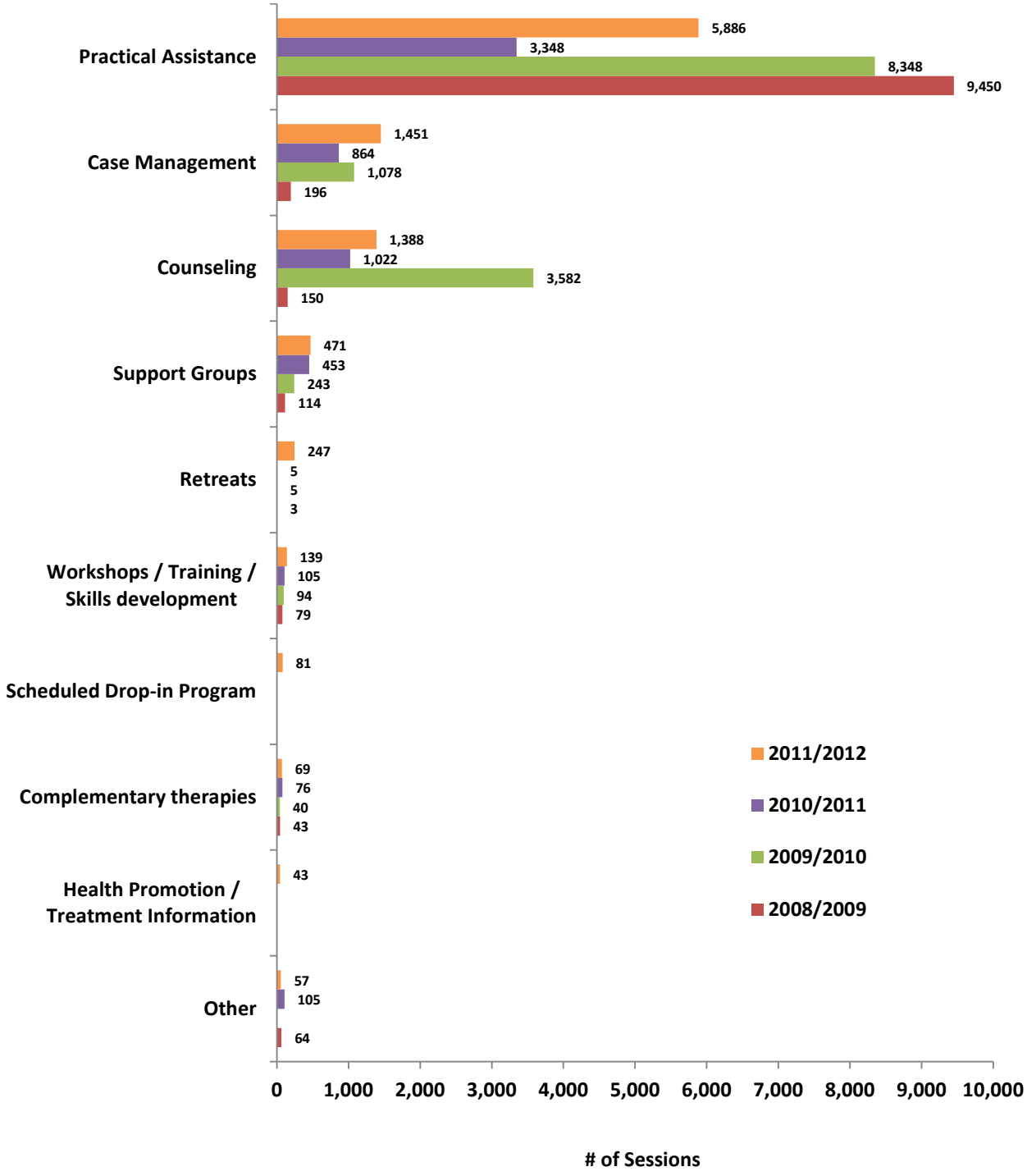
In the last year, there was a marked (33%) increase in case management sessions. However, as different programs define "case management" in different ways, it is difficult to know exactly what that means in terms of the services clients receive. There was also a marked increase in retreat sessions. The drop in practical assistance sessions is due to having added a place to track sessions related to food programs. In the past, programs captured their food program activities under practical assistance. For the first time, programs were also able to track sessions devoted to other activities, such as health promotion and treatment education, advocacy, housing and drop-ins. Over time, this will help us gain a better understanding of support services demands and the skills/capacities organizations need to meet needs.

Figure 61
Top 10 Service Categories by Number of Sessions Provided



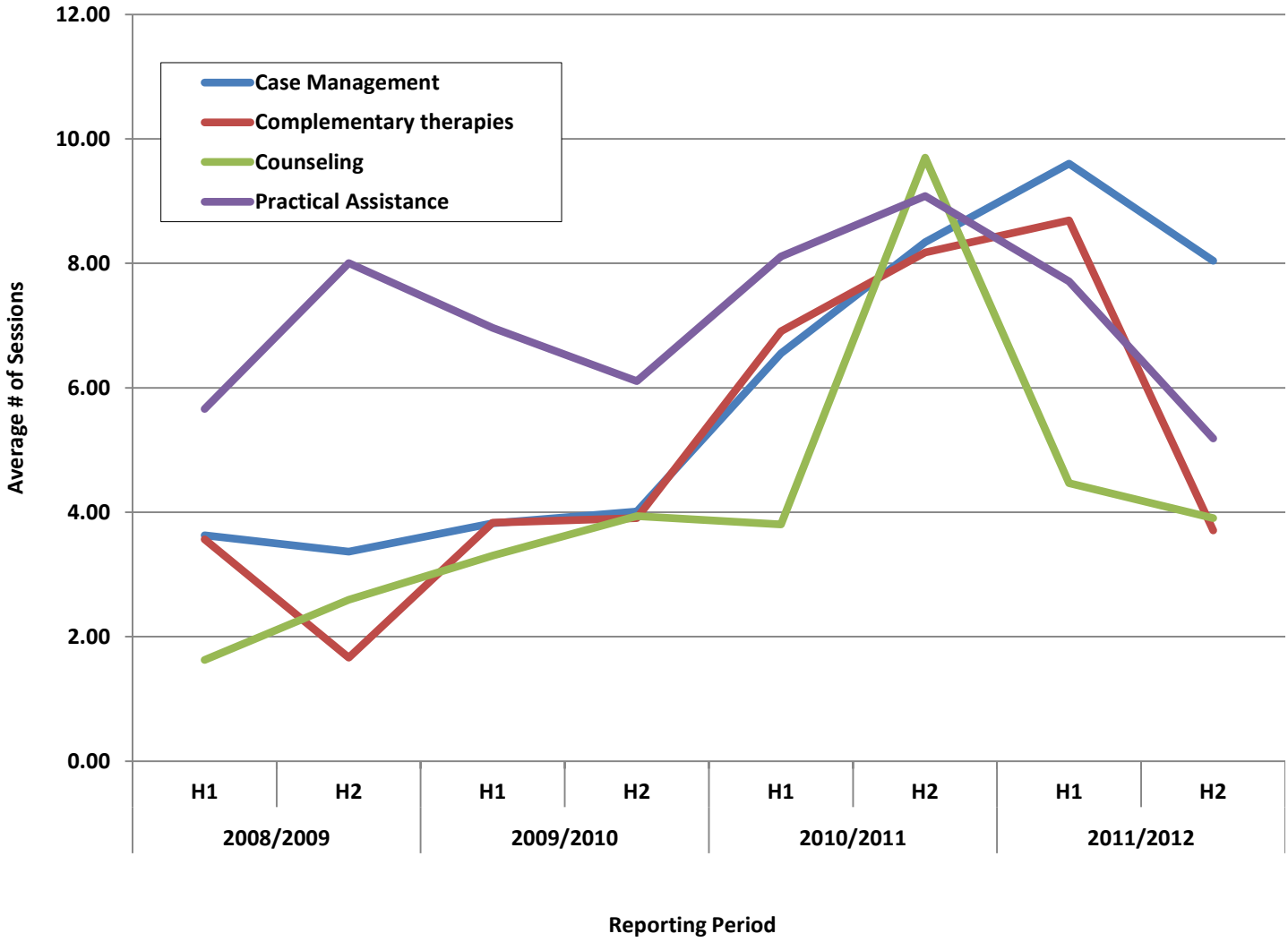
ACAP-funded agencies reported providing more practical assistance, case management and counselling sessions than in the previous year. The increase in the number of practical assistance sessions was mainly due to two agencies. With the increase, ACAP funded about 8% of the practical support provided in 2011-12.

Figure 62
Number of Sessions Provided - ACAP



The average number of sessions per client for the four main services provided dropped in 2011-12. Is this change due to more accurate reporting of number of sessions, to programs trying to be more efficient, or to capacity issues within programs?

Figure 63
Average Number of Sessions per Client for Selected Services



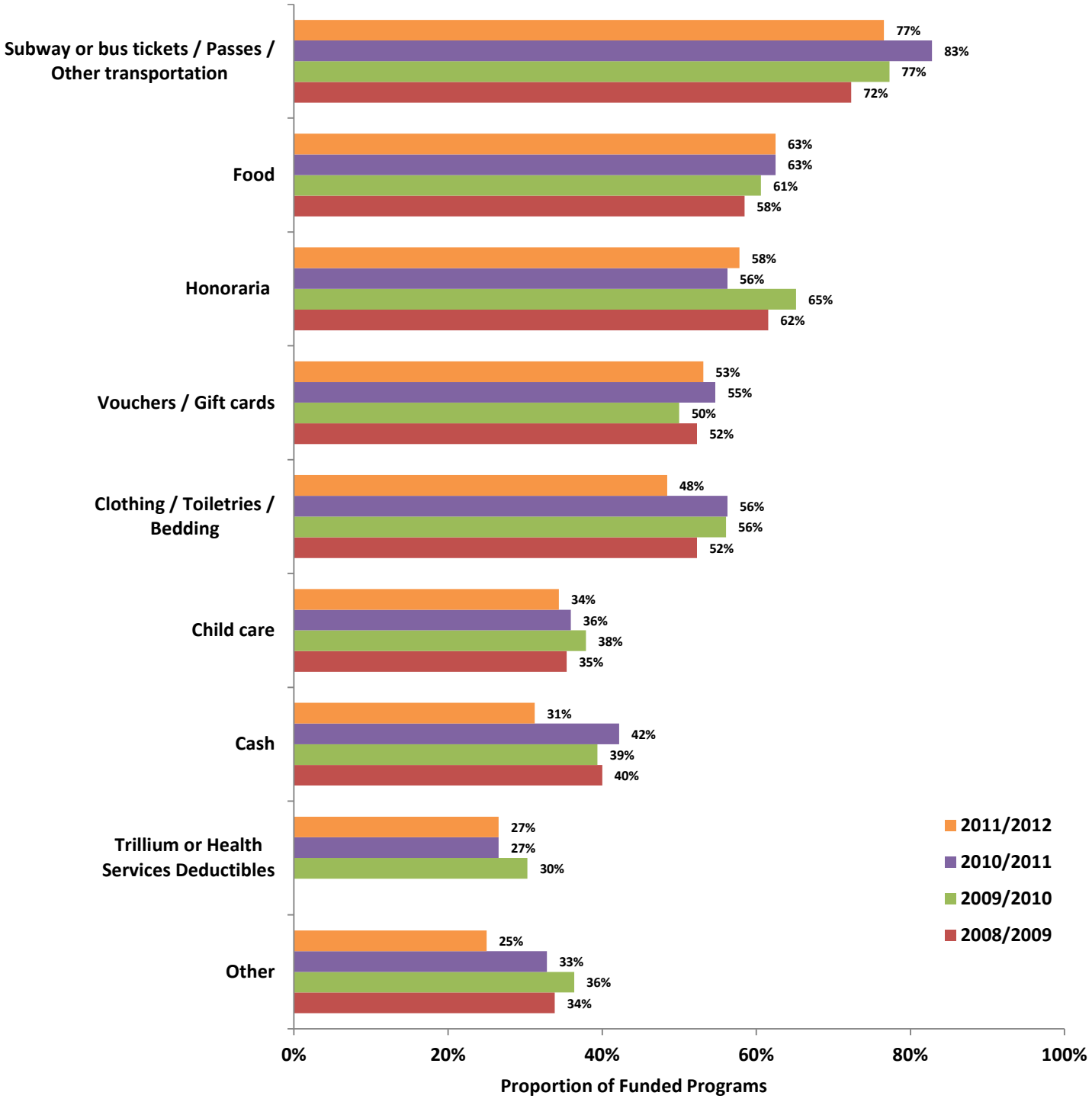
The average number of sessions was lower per client for ACAP-funded programs. Some of this difference is likely due to agencies winding down their ACAP programs at the end of H2 because of the end of that ACAP funding cycle.

FINANCIAL ASSISTANCE USED MAINLY FOR TRANSPORTATION AND FOOD

The cost of transportation continues to be a key issue for many support service clients. Over three-quarters of programs provide assistance with the cost of transportation to attend their services as well as medical appointments. Almost two-thirds provide financial assistance for food, and more than one-half provide vouchers that can be used to purchase items like food and toiletries. Over one-quarter help clients with the cost of their deductible for the Trillium Drug Programs. These financial assistance programs reinforce that a significant proportion of clients do not have the incomes to meet basic needs.

Over half of the funded programs provide honoraria for clients who participate in organizational activities.

Figure 64
Types of Financial and In-Kind Assistance Provided



In their efforts to serve clients with more complex needs, programs are working to develop stronger partnerships and improve collaboration with other agencies in their communities:

> *"[We are] improving our capacity through a community partnership with our local CHC, which provides free primary care, urgent care, phlebotomy, vaccination and immunization services through our treatment room…"*

> *"As service providers we respond to emerging needs by building relationships with other community members via community engagement initiatives and participation with various committees within the health care community. In addition, we continue to foster open communication with our participants and stakeholders via satisfaction surveys, focus groups, and staff educational events which allow us to be continually involved with required direction changes along with our participants."*

> *"We have been responding to those emerging trends by working in partnerships with other ASO's that do offer the services that [we] do not provide."*

Programs are also using technology to try to fill gaps in services. For example:

> *"We service … large counties, and increasingly we use email to communicate with and provide support to our clients."*

> *"We have purchased a PC based TELEMEDICINE system for our office and this is allowing for PHA's to see their HIV Specialist and nurses on a regular basis thus providing better health care. Further to that they will be able to access the services of the clinic social worker as required. It has been an amazing transformation and presently 100% are now in regular care."*

Programs are continually developing new programs and services to meet changing needs:

> *"[We] conducted [a] needs assessment regarding the complementary therapy needs of PHAs in [our]Region, which we created with assistance of the EBPU Evaluation Coordinator at the OHTN; [we] conducted an ongoing recruitment process to engage complementary therapies practitioners in a voluntary CT program which we launched in our treatment room in May (i.e., we will have free Naturopathic Care, Acupuncture and Acupressure services and are in the process of recruiting RMTs as well)."*

> *"… Culturally appropriate programs are being developed to assist newcomers. These programs are aimed at building supportive networks, education on HIV/AIDS and skill building."*

EMERGING SUPPORT ISSUES/TRENDS

To improve support services, agencies should consider the following questions:

1. How is the aging of support service clients affecting the type of support services required? How are agencies responding?
2. How can programs serve transgender clients better?
3. What case management challenges do programs experience? What community partnerships are most useful in meeting clients' service needs?
4. To what extent are programs able to engage clients in meaningful ways in planning and delivering support services (MIPA/GIPA)? What are the challenges of MIPA?

The findings and recommendations from the recent Environmental Scan of Support Services will help inform these discussions.

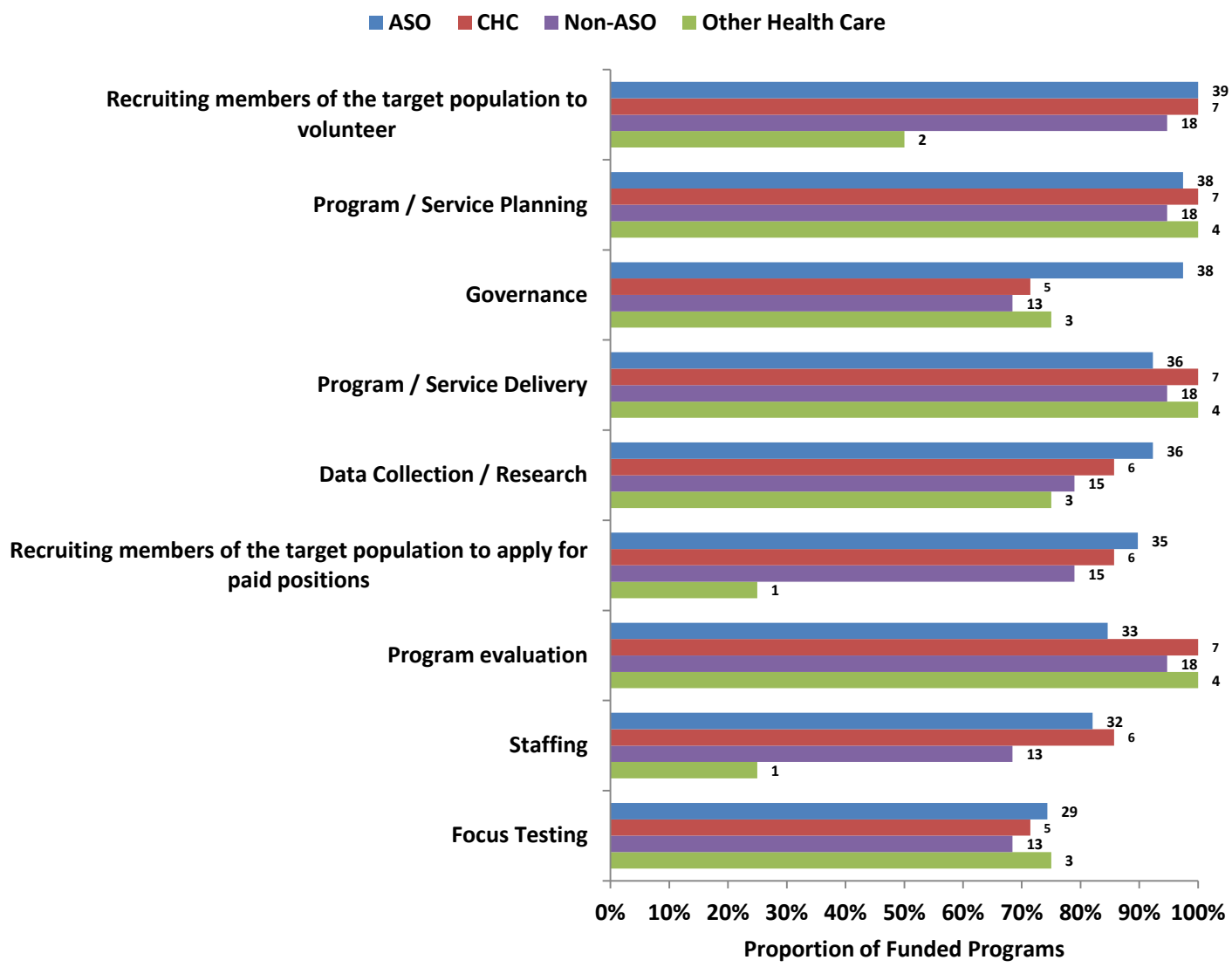
3 ENHANCING CAPACITY

BUILDING INDIVIDUAL CAPACITY

Programs continue to engage people living with and at risk of HIV in their organizations, and to develop opportunities for them to participate in more meaningful ways. In 2011-12, for the first time, 75% of programs reported employing members of their target population, and almost 90% reported having members of their target population involved in governance.

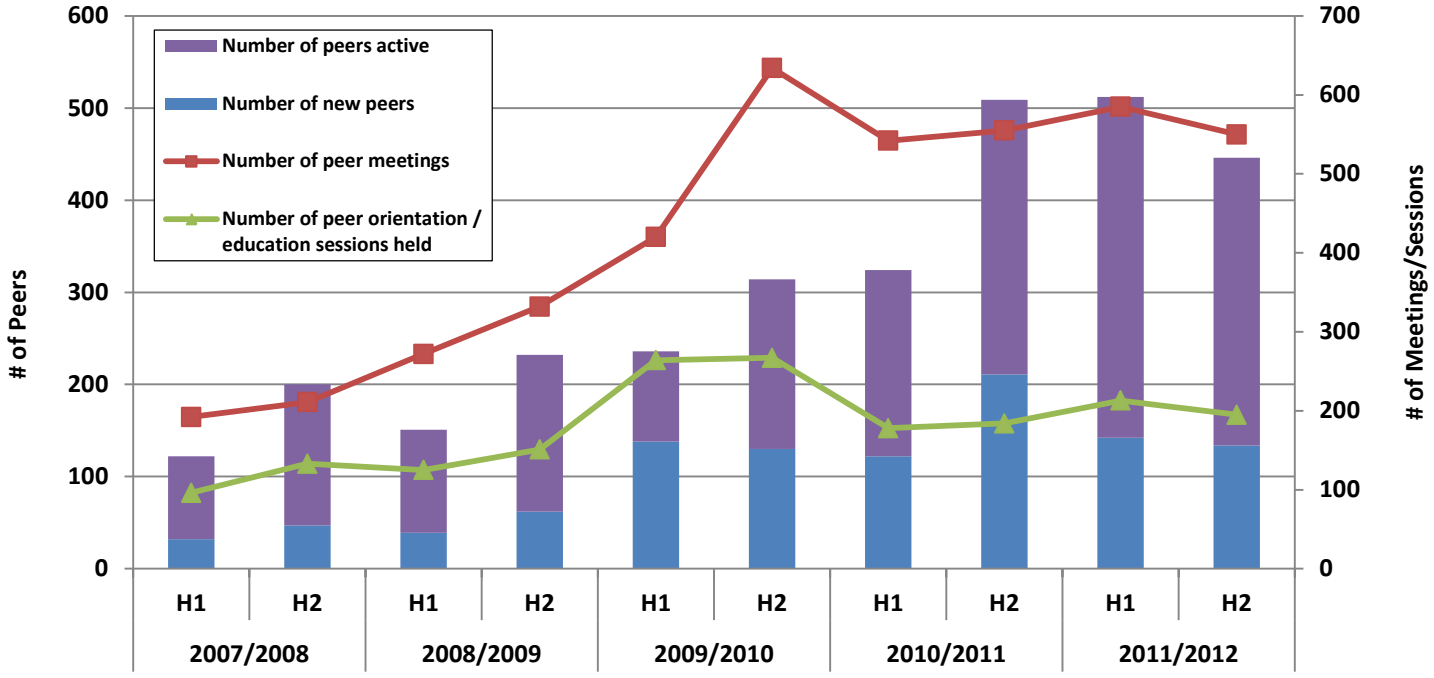
The following figure shows that ASOs are more likely to engage members of their target population in governance than the other settings.

Figure 65
Proportion of Programs Involving Target Populations: 2011/2012



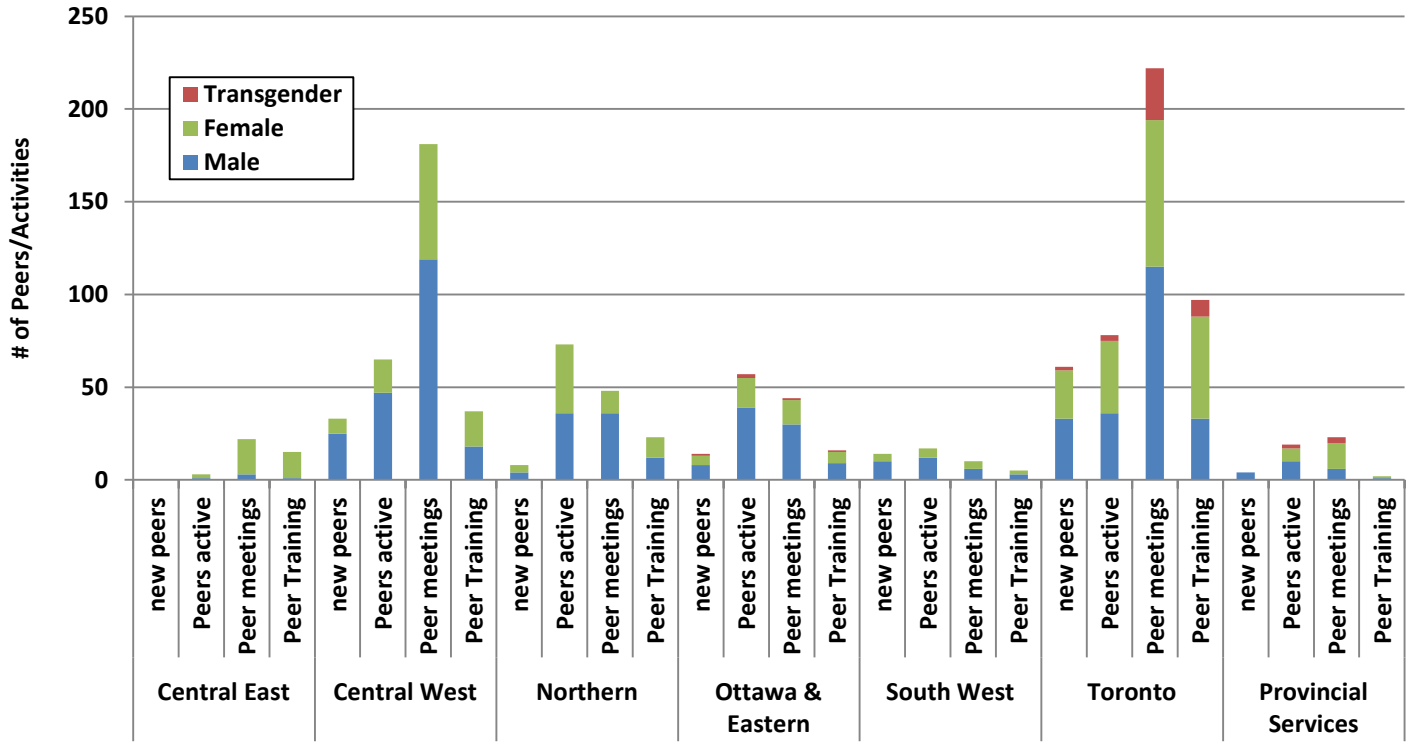
Over the past 18 months, IDU programs have been more successful in both recruiting and retaining peer workers in their programs.

Figure 66
IDU Peer Involvement



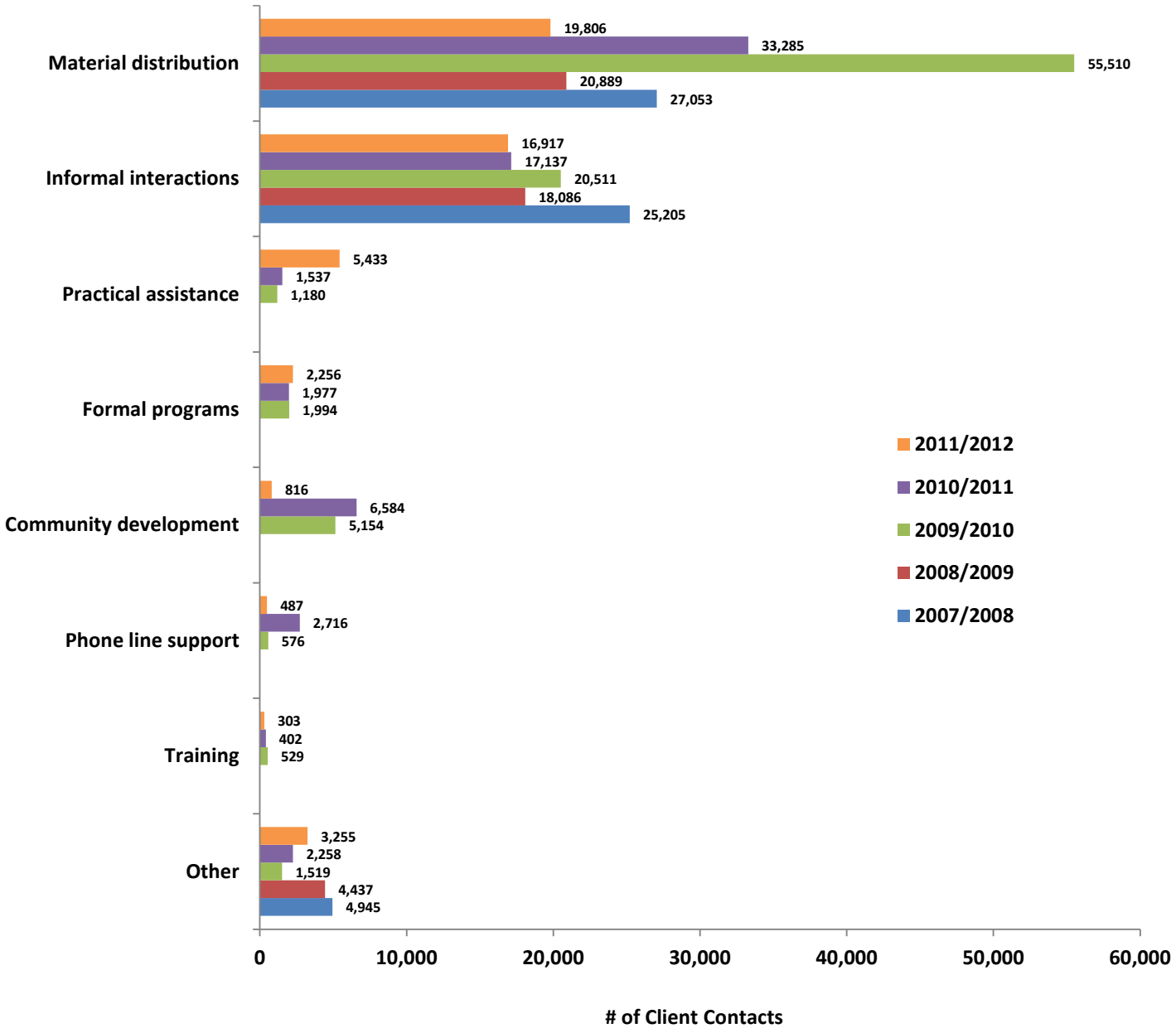
IDU programs across the province have been effective in recruiting both male and female peer workers, and programs in Toronto and Ottawa have made progress in recruiting transgender peers.

Figure 67
IDU Peer Involvement by Gender and Region: 2011/2012 H2



In 2011-12, peers were more active in providing practical assistance than they had been in the past. A number now act as “navigators” helping others access the service system.

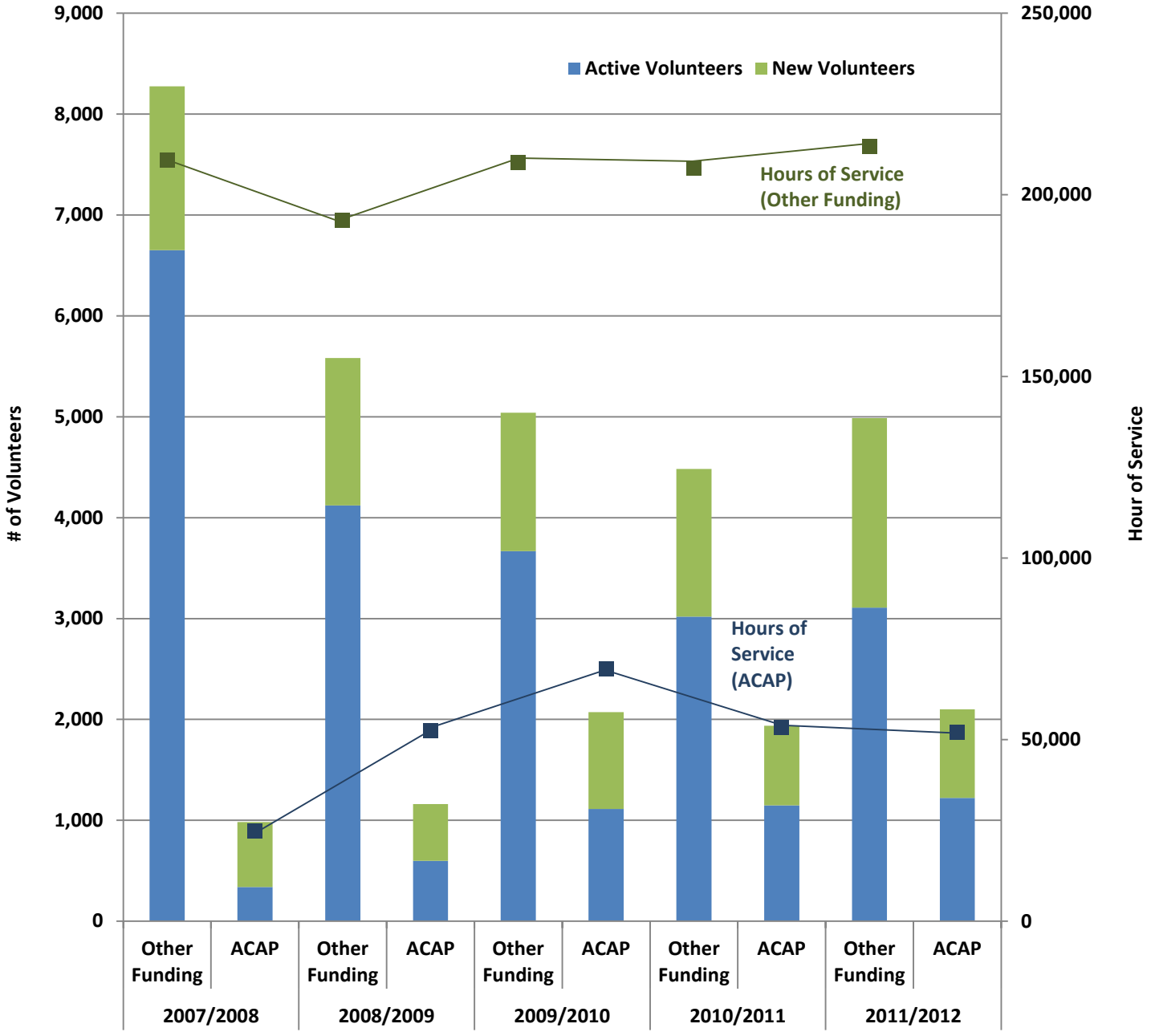
Figure 68
Number of Client Contacts Made by IDU Peers by Activity



ATTRACTING AND RETAINING VOLUNTEERS

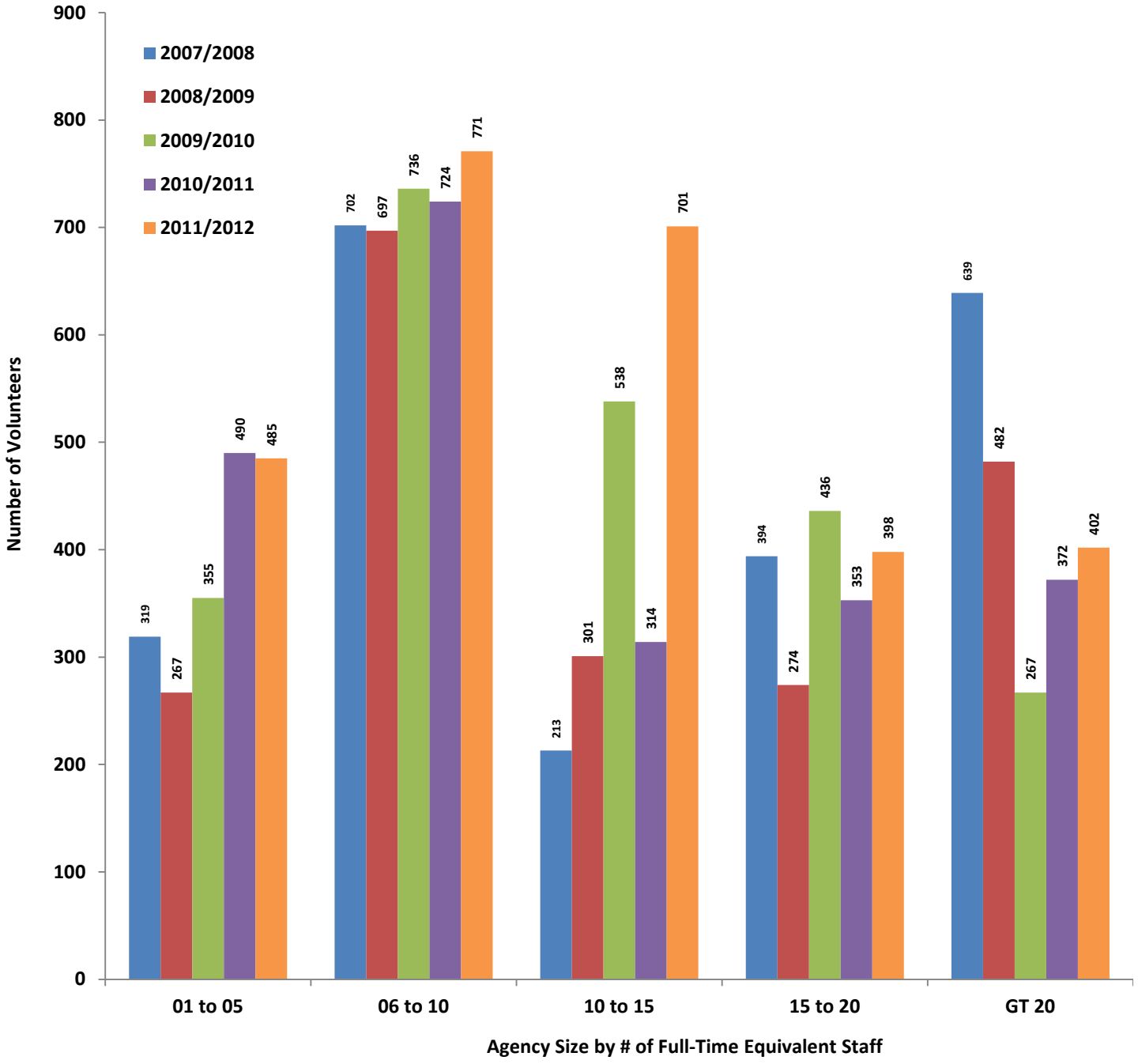
Programs have also been successful in retaining existing volunteers and attracting new ones – in both ACAP and other funded programs.

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



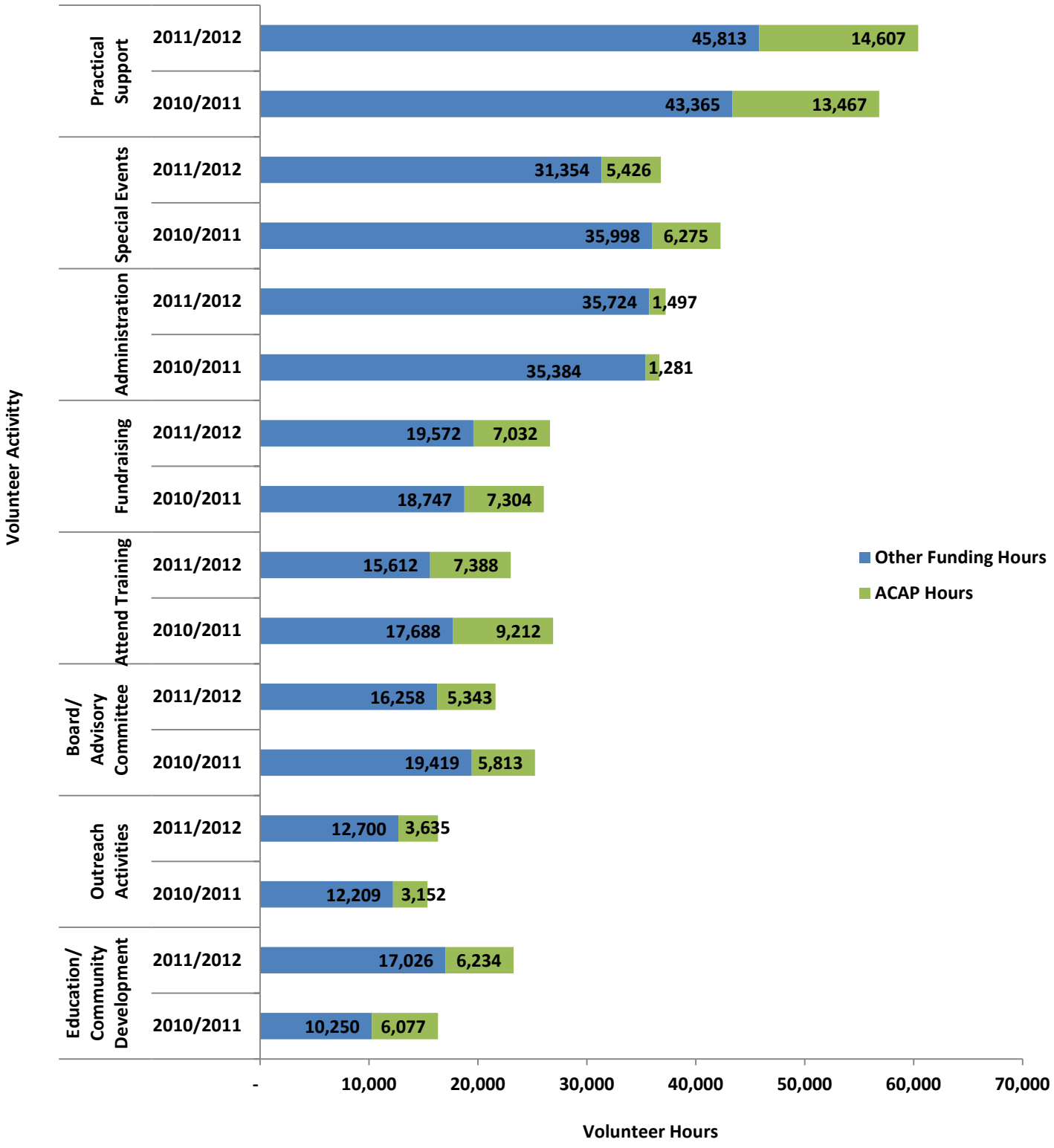
In 2011-12, we saw a marked increase (>100%) in new volunteers in mid-sized agencies, which may indicate that these agencies are turning more to volunteers to enhance their capacity to deliver services. Volunteers continue to be active in providing practical support, organizing special events and fund raising, and in education programs.

Figure 70
New Volunteers Recruited by Agency Size



ACAP-funded volunteers provided a significant proportion of practical support, fundraising and education hours in 2011-12.

Figure 71
For Selected Activities - Total Volunteer Hours by Funding Source: 2010 and 2011



VOLUNTEERS CONTRIBUTE >$5 MILLION WORTH OF TIME

The value of volunteer contributions to our work is indisputable. We calculate, based on national occupation classification data, that volunteers provide more than $5 million worth of service that, without them, would not be available to clients of community-based programs.

Figure 72
Volunteers (Total New and Avg. Active) and Hours of Service: ACAP and Other Funding

	Volunteer Position	OCHART Question	National Occupation Classification (NOC)	Total Number of Volunteer Hours in the Past 12 Months*	NOC Average Hourly Wage Rate Assigned to this Job Type in the past 12 months	Total Volunteer Hours* NOC Average Hourly Wage Rate	Fringe Benefit 12%	Total Value
				(A)	(B)	(C)	(D)	(C+D)
1	Administration (clerical support, reception, etc)	12.2 total # of vol hours for Administration	General office clerk 1411	35,915	$15.25	$547,703.75	$65,724.45	$613,428.20
2	Governance (board of directors, advisory committees etc)	12.2 # of vol hrs for Serve on Board/Advisory Committee	Senior manager – Health, Education, Social and Community Services and Membership Organization 0014	16,493	$39.00	$643,227.00	$77,187.24	$720,414.24
3	Support services (assistance to people living with HIV/AIDS, peer support, etc)	12.2 sum of total # of vol hrs for Practical Support and Counseling	Community and social service workers 4212	63,912	$21.51	$1,374,747.12	$164,969.65	$1,539,716.77
4	Prevention (outreach, targeted education, etc)	12.2 total # of vol hrs for Outreach Activities	Community and social service workers 4212	15,163	$21.51	$326,156.13	$39,138.74	$365,294.87
5	Fundraising (walks, fundraising campaigns, working to secure foundation grants, etc)	12.2 total # of vol hrs for Fundraising	Professional occupation in public relations and communications 5124	25,782	$29.74	$766,756.68	$92,010.80	$858,767.48
6	Public events (public speaking, special events like Pride Day, mall displays, etc)	12.2 sum of total # of vol hrs for Special Events and Education/Comm Devt	General office clerk 1411	57,521	$15.25	$877,195.25	$105,263.43	$982,458.68
7	Human resources	12.2 sum of total # of vol hrs for involvement in hiring process and policies and procedures	Specialists in human resources 1121	2,123	$29.74	$63,138.02	$7,576.56	$70,714.58
8	IT Support	12.2 sum of total # of vol hrs for IT support	Web designers and developers 2175	2,171	$27.78	$60,310.38	$7,237.25	$67,547.63
	Total					**$4,659,234.33**		**$5,080,080.24**

Programs report an increase in demand for volunteer opportunities from students, people doing court mandated community service and newcomers with health professional training who want to gain Canadian experience. There is also more demand from people living with HIV or at risk of HIV for meaningful volunteer opportunities.

> *"We have observed an increased number of Youth volunteers that are involved in the project activities. Most of our volunteers requested information related to job search. Volunteers have shown greater interest in project activities than practical support such as phone calling. We have seen a number of volunteers who are internationally trained with relevant HIV/AIDS and program management experiences."*

In terms of challenges, programs report a shortage of daytime volunteers as well as the need to build volunteer capacity to offset the drop in overall funding (see page 19). Some programs continue to lack capacity to manage volunteers.

> *"More and more volunteers have very restricted availability. Those applying to become volunteers are busy and only have time evenings and weekends to assist. There are volunteer opportunities that can be completed during off peak hours and a new type of volunteer is evolving, virtual volunteers. There is a demand for short term volunteer opportunities as many young people are in transition yet want to be involved in a charitable organization to gain experience and future employment opportunities possibly."*

> *"There remains challenges in finding volunteers for daytime/weekday activities and activities involving meal preparation and delivery. Agency clients are now expressing interest in volunteering with the agency particularly in program delivery and events… Beginning corporate recruitment for group volunteer activities such as our weekend meal programs and one off clean-up/painting at [agency] site."*

> *"I receive numerous requests for volunteer and student placements. But due to lack of staff and time, I am unable to provide these opportunities."*

Programs are using a number of strategies to attract and retain volunteers including:

> *"We are adding new programs and services, resulting in increased requests for placement students to take on program development as their main projects. We have also had increased requests for administrative/fundraising assistance from the Fund Development Department."*

> *"A Volunteer Leadership Program has been developed in order to increase the capacity of volunteers in their facilitation and leadership skills. This will require additional training, and increased collaboration among staff."*

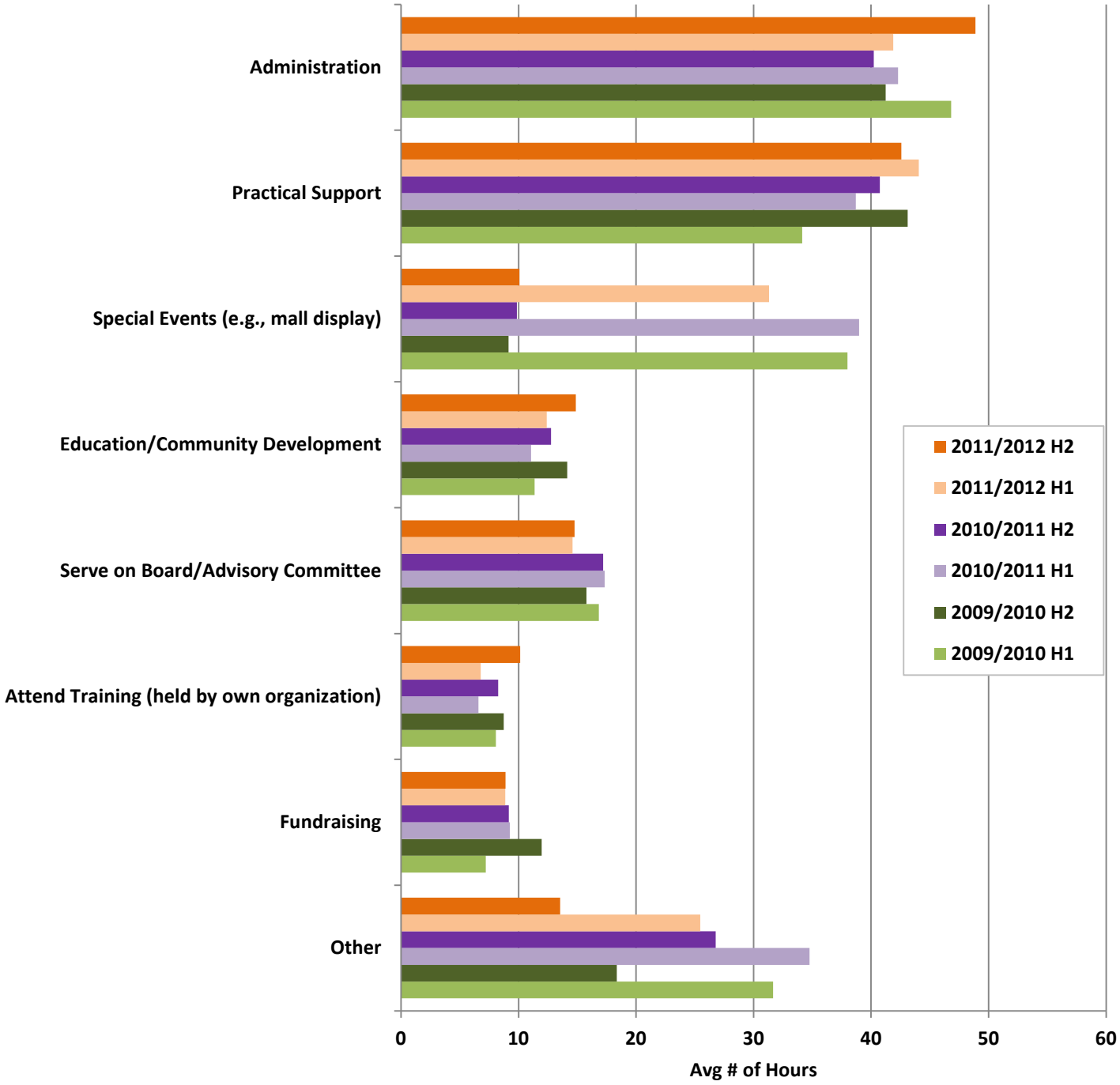
> *"We are tailor making volunteer positions that will give volunteers employment, by supporting them and providing them adequate training as well so they can build their employment skills."*

> *"Volunteers continue to stay longer with the agency and volunteer for multiple volunteer activities - governance, events and programming. The peer PHA programs are increasing our numbers of PHA volunteers in specific program activities."*

"A Volunteer recruitment strategy has been developed to ensure a broader scope of recruitment. The agency will utilize existing networks, such as; cultural and ethnic association, colleges, universities, employment resources centers and professional association in recruiting and attracting new volunteers. Recruitment will also take place during outreach activities by program staff, through community members and [agency] volunteers. Community partners will be asked to encourage community members to review our applications."

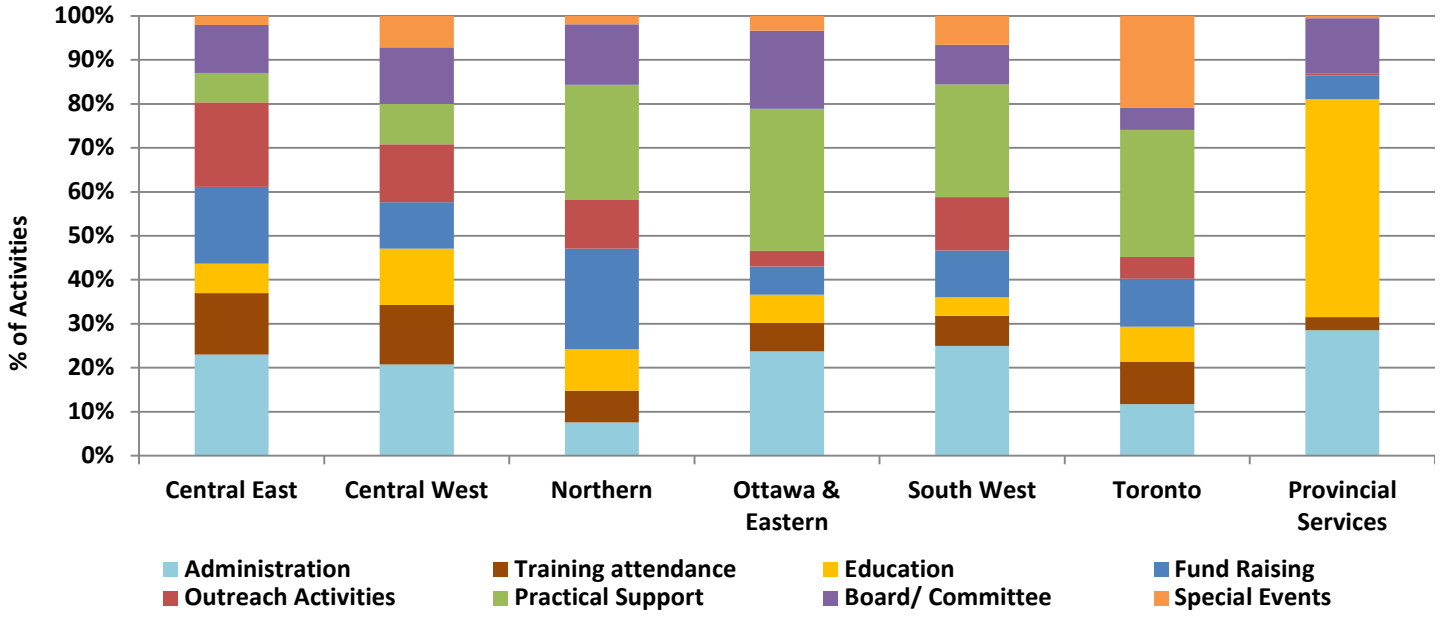
In terms of a time commitment, volunteers give, on average, more time when they are involved in administration and practical support activities.

Figure 73
Average Service Hours per Volunteer



When we look at volunteer activities by region, we see that volunteers in Ottawa & Eastern, Toronto, Northern and South West regions are more likely to be engaged in practical support activities while those in Central East and Central West are more likely to be involved in outreach services.

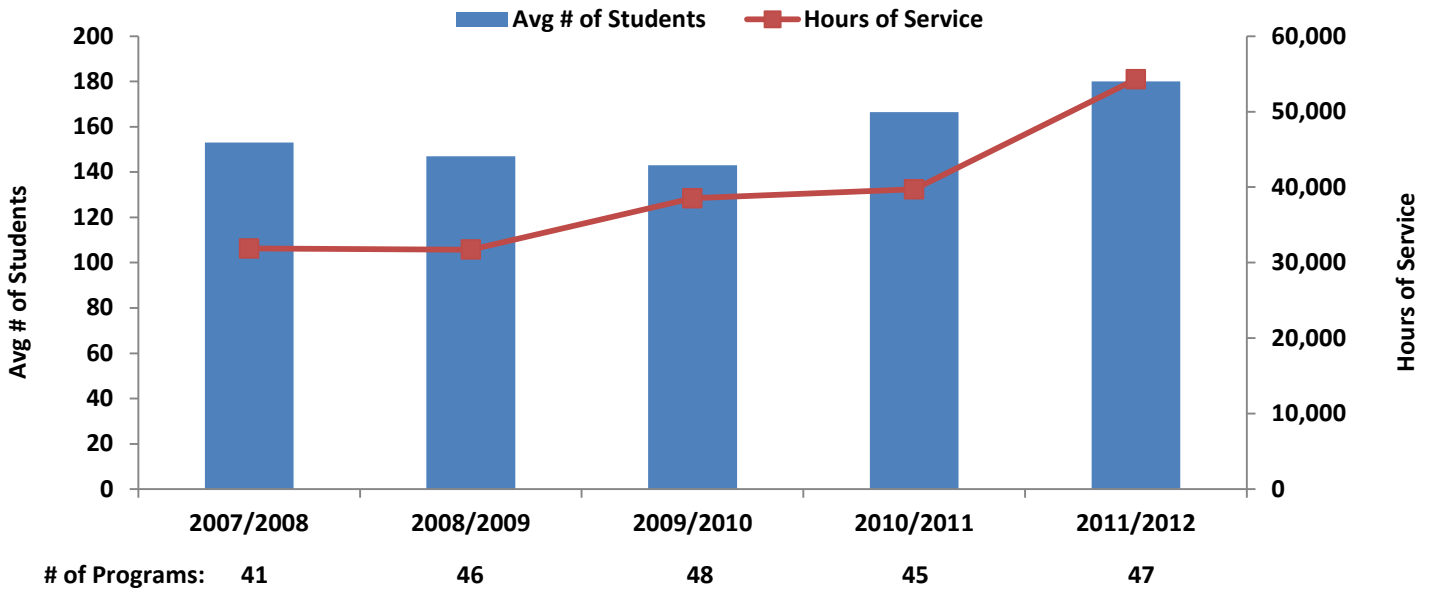
Figure 74
Selected Volunteer Activities and Hours of Service by Region: 2011/2012



Programs continue to make more use of students, who are contributing more hours of services. In some cases, the demand from students for placements affects programs' capacity to retain other volunteers.

> *"The influx of placement students during the school year who need to complete their required hours on street outreach displaces regular and new volunteers who are interested in street outreach. We have developed a relationship with a college addictions program where we have groups of students in on a regular basis to assemble the harm reduction kits."*

Figure 75
Student Placements



EMERGING VOLUNTEER ISSUES

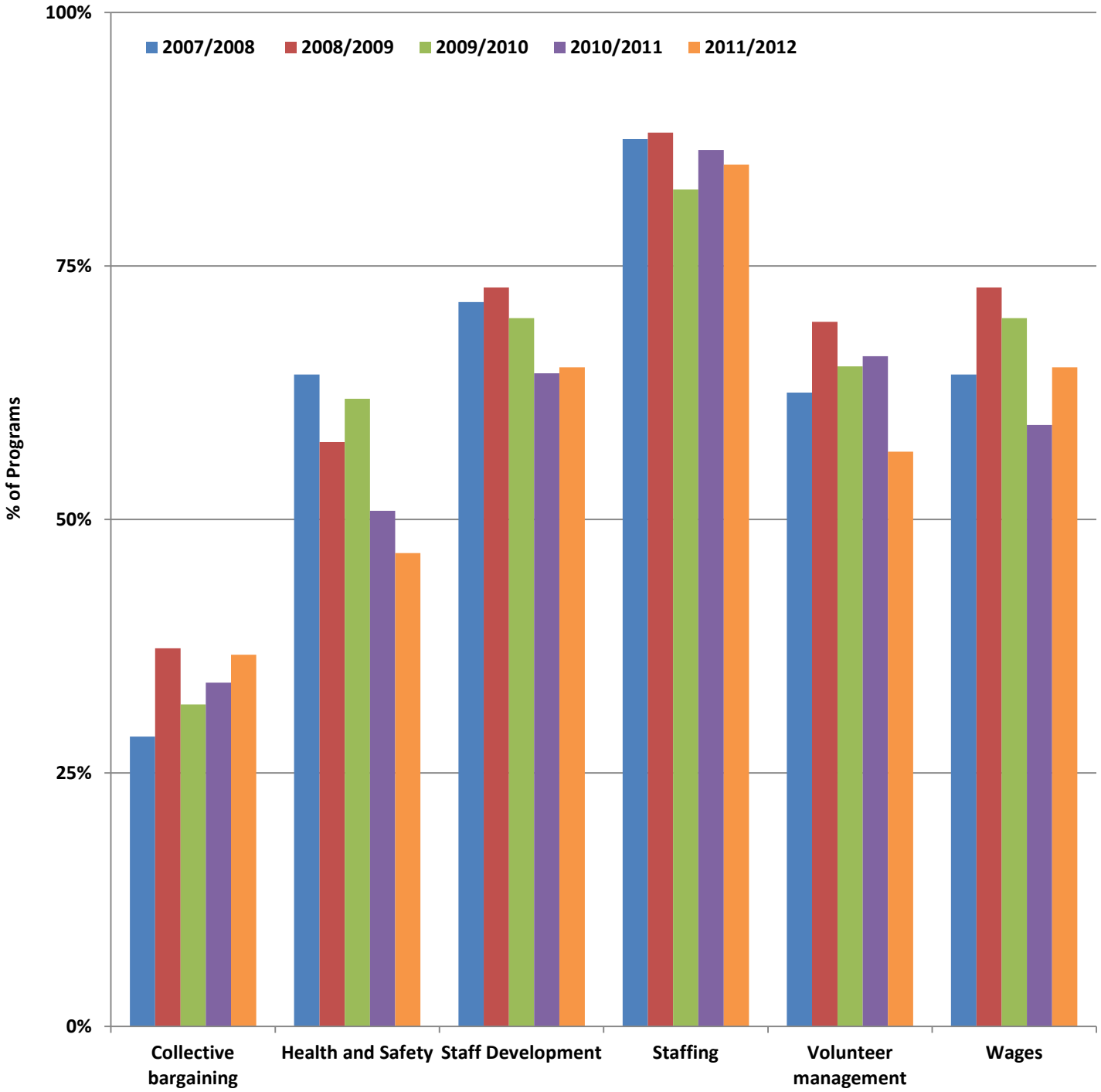
Volunteers continue to be essential to service delivery. To understand and enhance their role, agencies should be discussing the following questions:

1. To what extent are programs relying on volunteers to deliver services?
2. What types of tasks can be delegated effectively to volunteers? Which ones should be limited to paid staff?
3. What are effective volunteer recruitment, training and retention strategies?

ENHANCING STAFF SKILLS AND RETENTION

Programs depend on having skilled staff to provide services. In 2011-12, over 85% of programs reported facing staffing challenges and over half identified wages and staff development issues.

Figure 76
Organizational Human Resource Issues by Fiscal Year

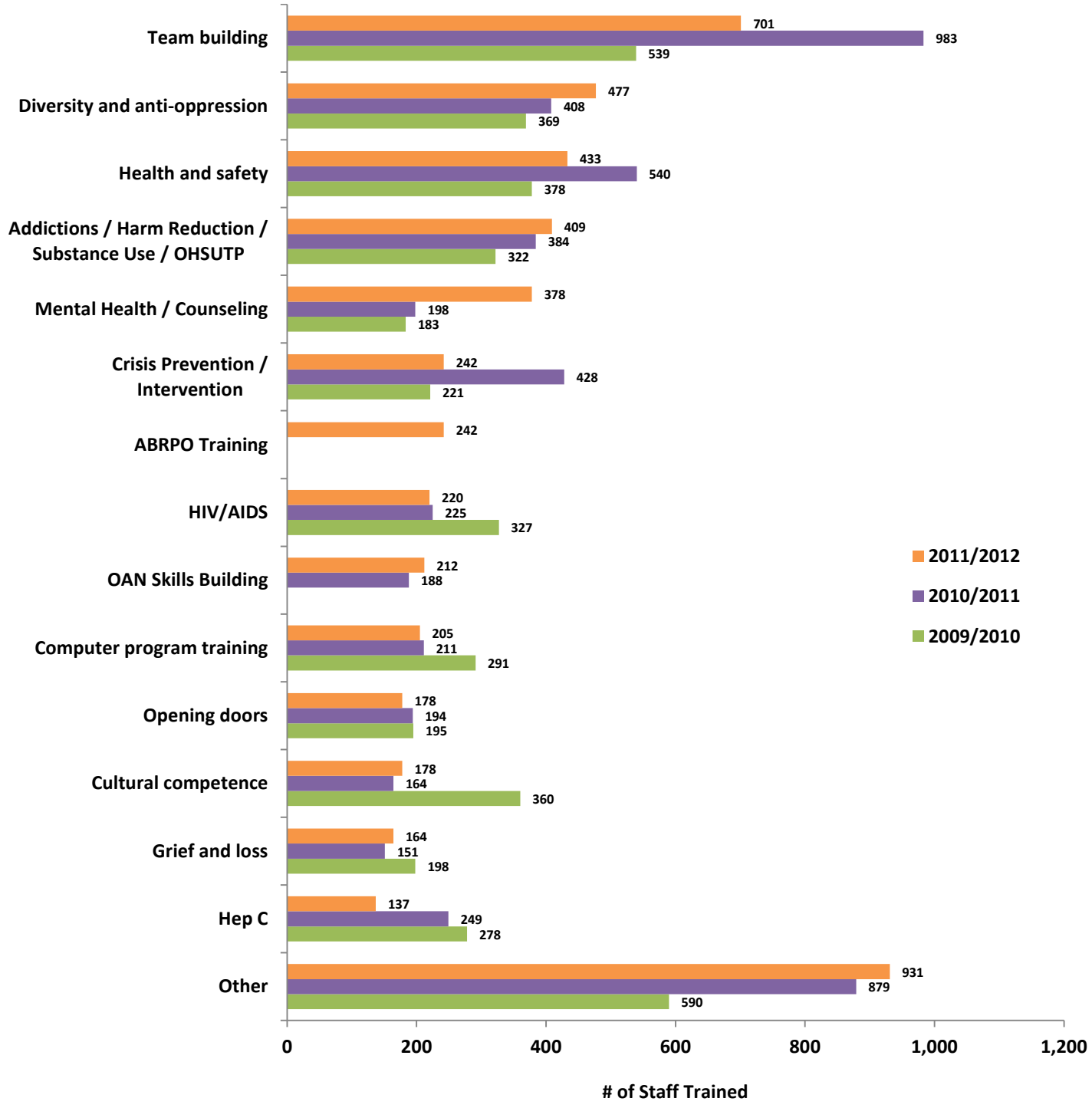


MORE DEMAND FOR MENTAL HEALTH AND ADDICTION TRAINING

Programs reported providing more training for staff in mental health issues and counseling and in addictions, harm reduction and substance use. This highlights the challenges staff face when working with clients with mental health and addiction issues, and is consistent with earlier anecdotal data about the increase in clients with mental health problems.

Note: the "other" category included mainly first aid and CPR training as well as the required training related to the Accessibility for Ontarians with Disabilities Act. Most of this training could have been captured under the category of "health and safety".

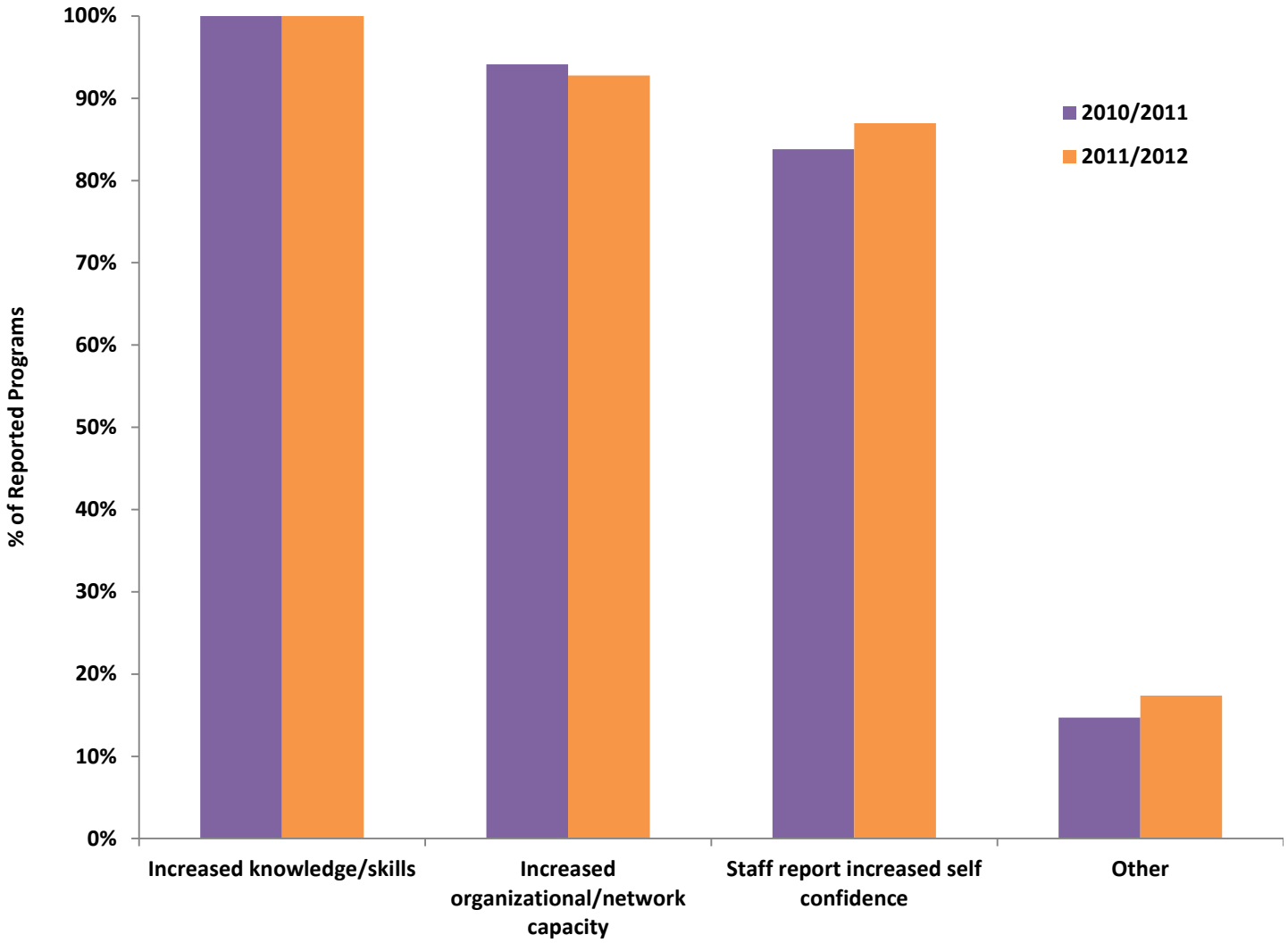
Figure 77
Selected Types of Training Offered to Staff



TRAINING BUILDS KNOWLEDGE AND CONFIDENCE

When asked about the impact of their staff training, programs reported that 100% of staff gain knowledge and skills while more than 85% have more capacity to network and more confidence in their ability to do their job. However, the field does not have a consistent way to assess whether the training leads to improved service provision over time.

Figure 78
Staff Training Contribution: 2010 and 2011

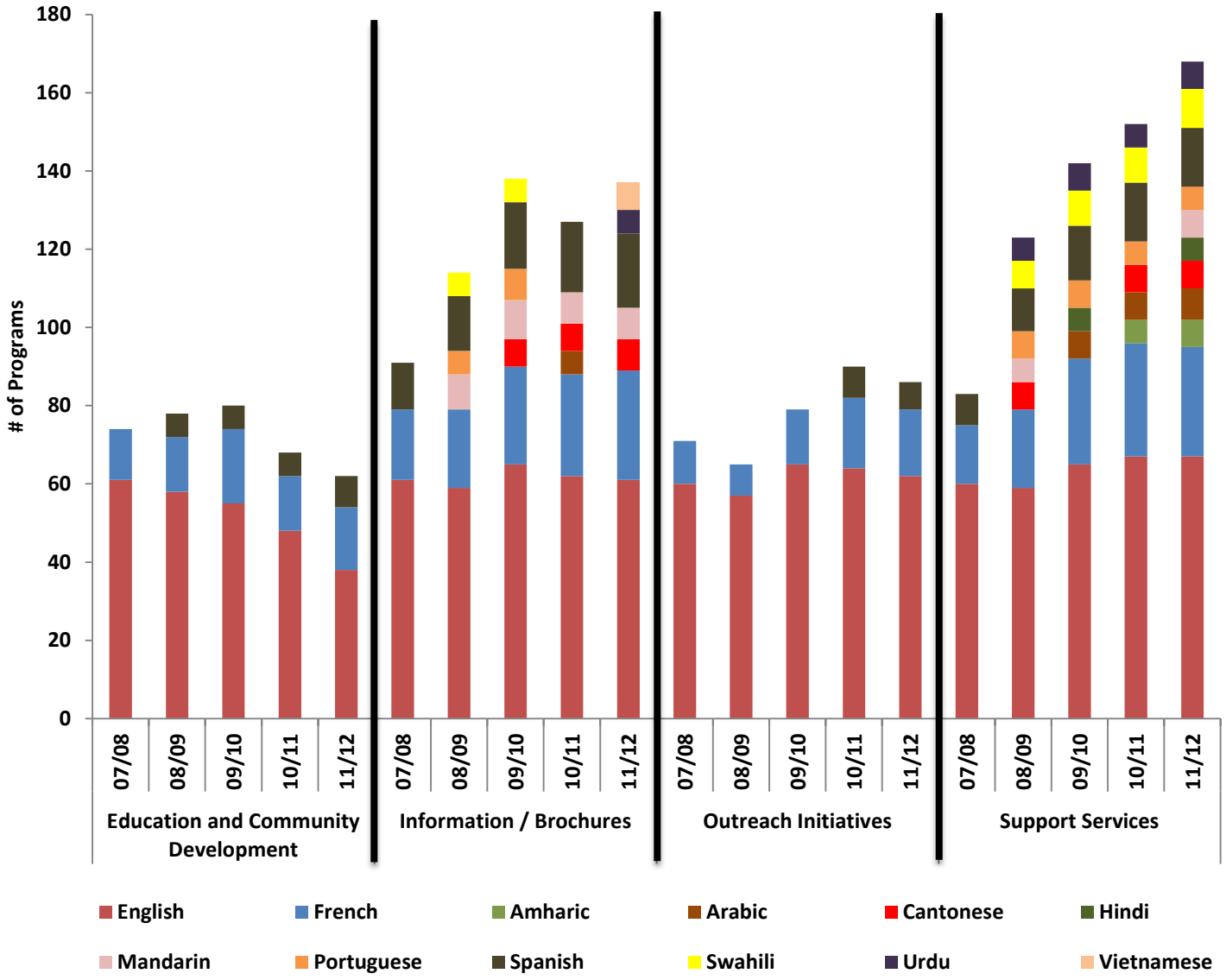


ORGANIZATIONAL CAPACITY

MORE CAPACITY TO PROVIDE CULTURALLY APPROPRIATE SUPPORT SERVICES

Over the past five years, we've seen a steady increase in the number of programs that are able to provide support services in different languages.

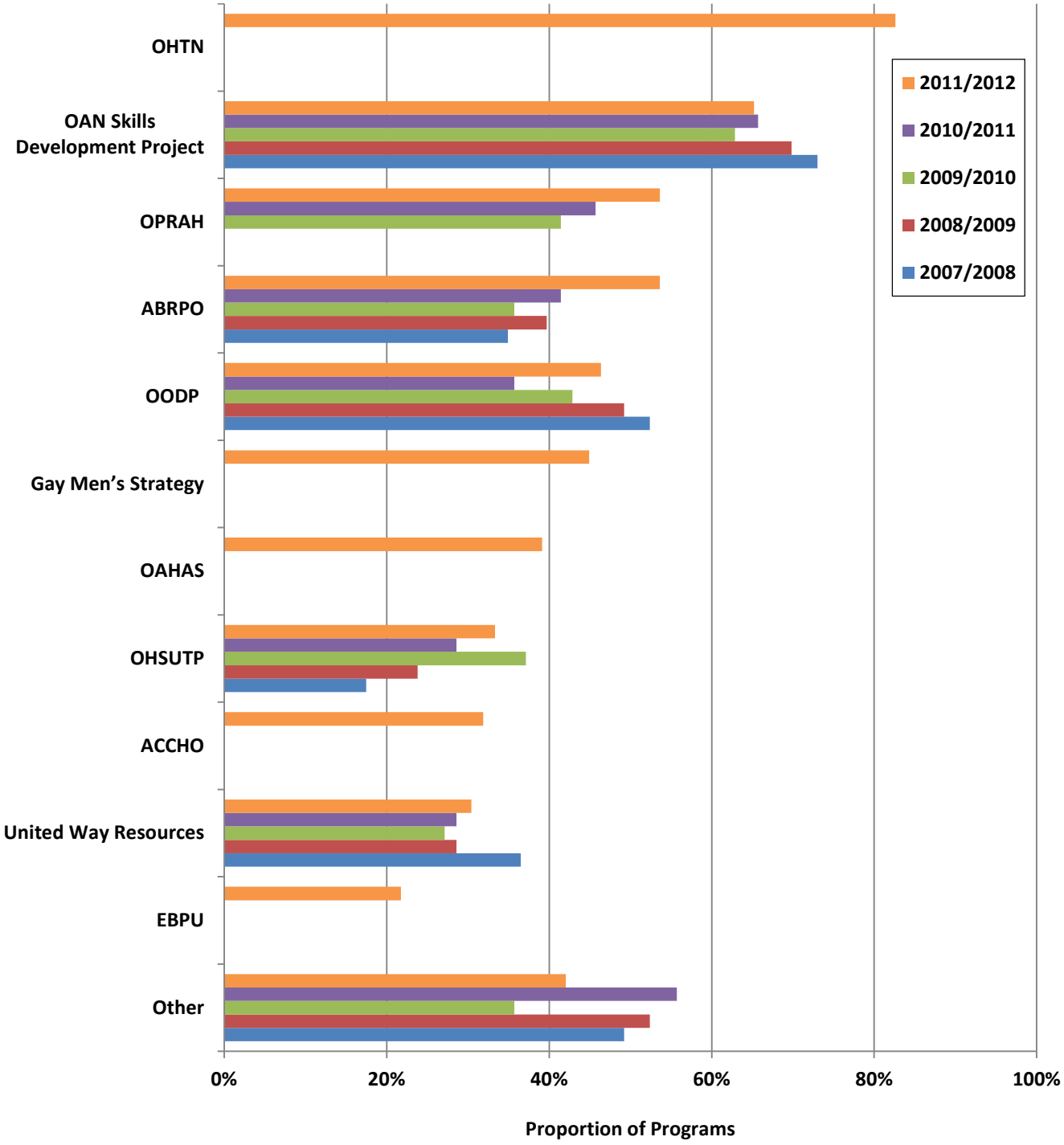
Figure 79
Number of Programs Providing Services by Language and Service Group



PROGRAMS TAKE ADVANTAGE OF ORGANIZATIONAL SUPPORTS

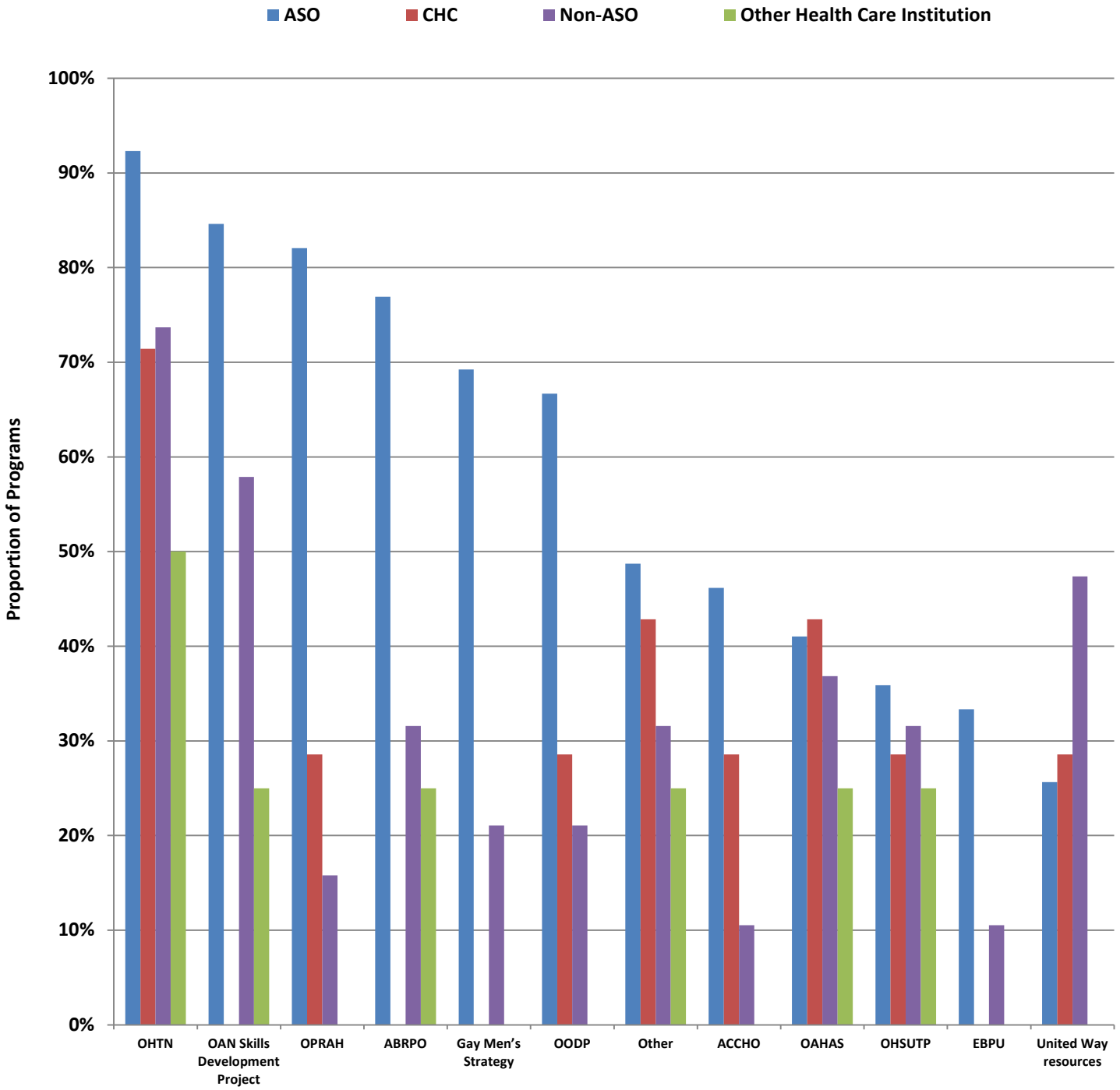
In 2011-12, the list of provincial services and organizational supports that programs can use was expanded to include the OHTN, the Evidence-Based Practice Unit, and the population-specific strategies, including the Gay Men's Health Strategy, the Ontario Aboriginal HIV/AIDS Strategy (OAHAS) and the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO). Over 80% of programs reported using OHTN resources while between 35 and 50% reported using the resources of the population-based strategies.

Figure 80
Proportion of Programs Using Organizational Support by Fiscal Year



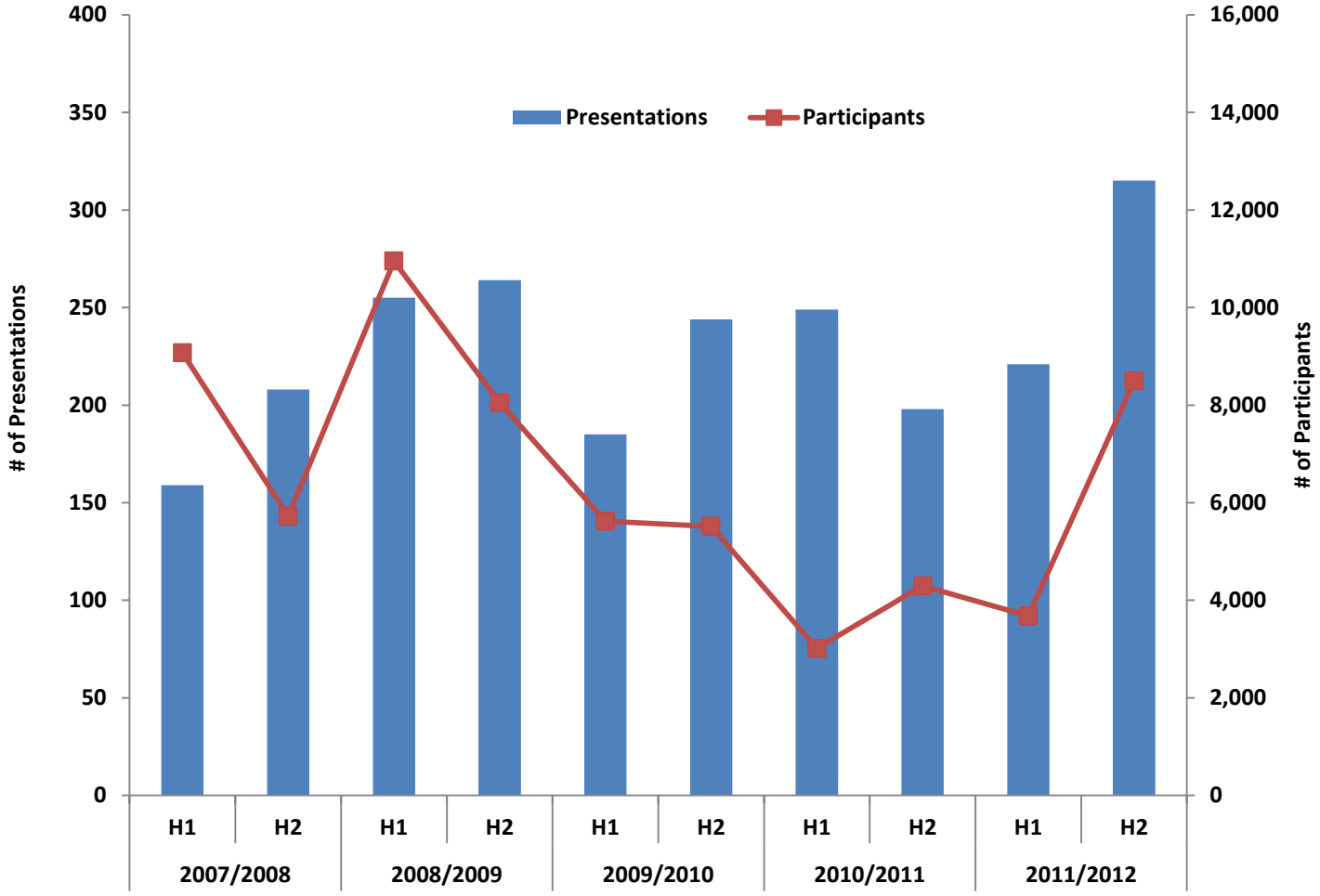
In almost all cases, ASOs are heavier users of these support services than other types of agencies.

Figure 81
Proportion of Programs Using Organizational Support by Agency Type: 2011/2012



The provincial resources organizations contributed to the number of education presentations during the year. The total number of presentations was up considerably, as was the number of participants.

Figure 82
Provincial Resource Programs Education Presentations and Participants



SIZE INFLUENCES CAPACITY

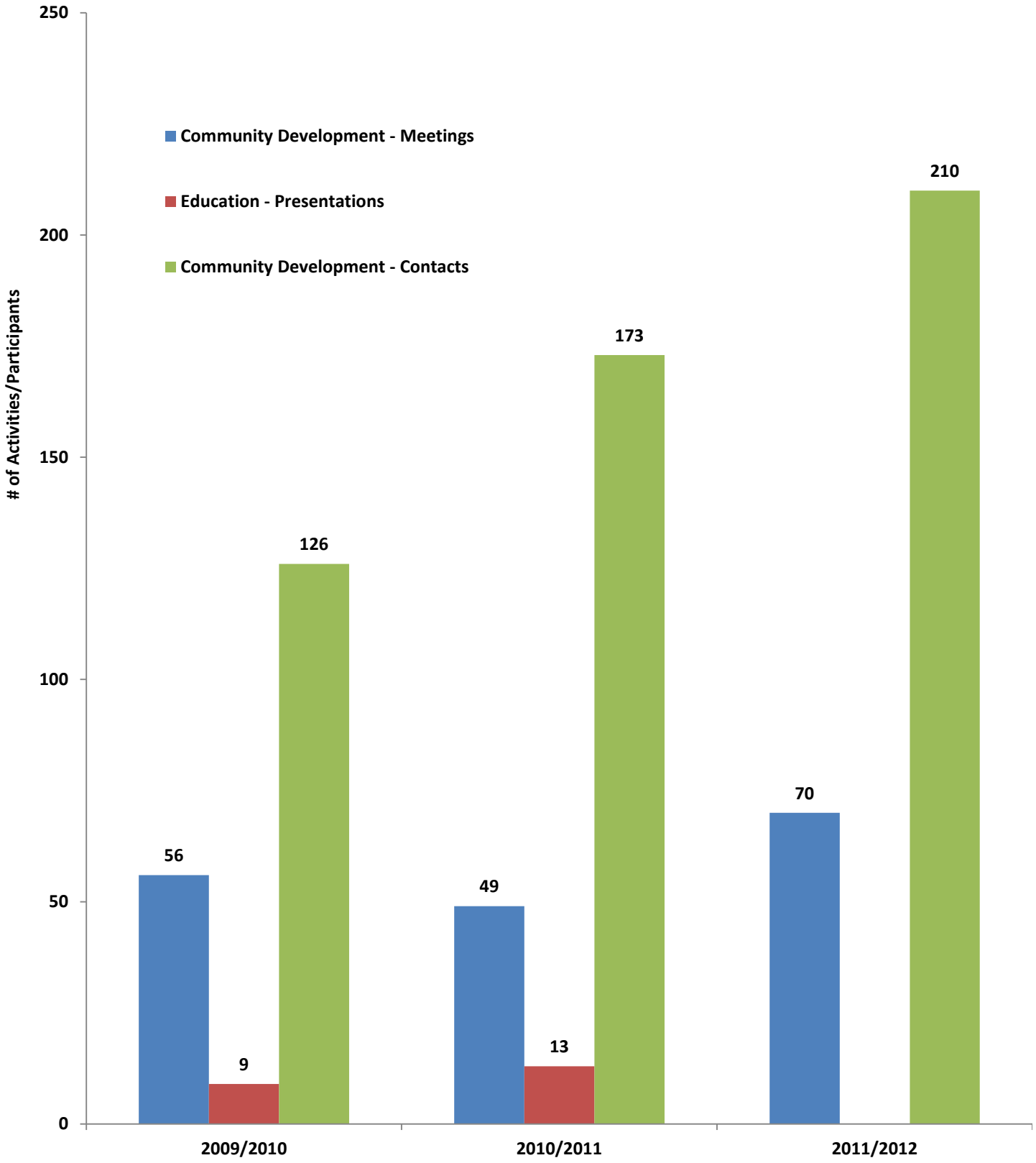
Small (< 5 FTE) programs generally make less use of organizational supports than larger agencies – although about 75% did use OHTN services. This may indicate that smaller agencies don't have the capacity/staff to be able to take advantage of these resources or it may be that the organizational support programs have to package their resources differently to make them more accessible to smaller organizations.

Figure 83
Proportion of Programs Using Organizational Support by Size: 2011/2012

RESEARCH IS PLAYING A LARGER ROLE IN COMMUNITY DEVELOPMENT

Over the past three years, programs have reported holding more community development meetings and education presentations and making more community development contacts related to research. More information is required to know whether these meetings and contacts are related to efforts to conduct research in the community or to share research information and findings that could influence services.

Figure 84
Number of Research-related Presentations/ Meetings/ Contacts



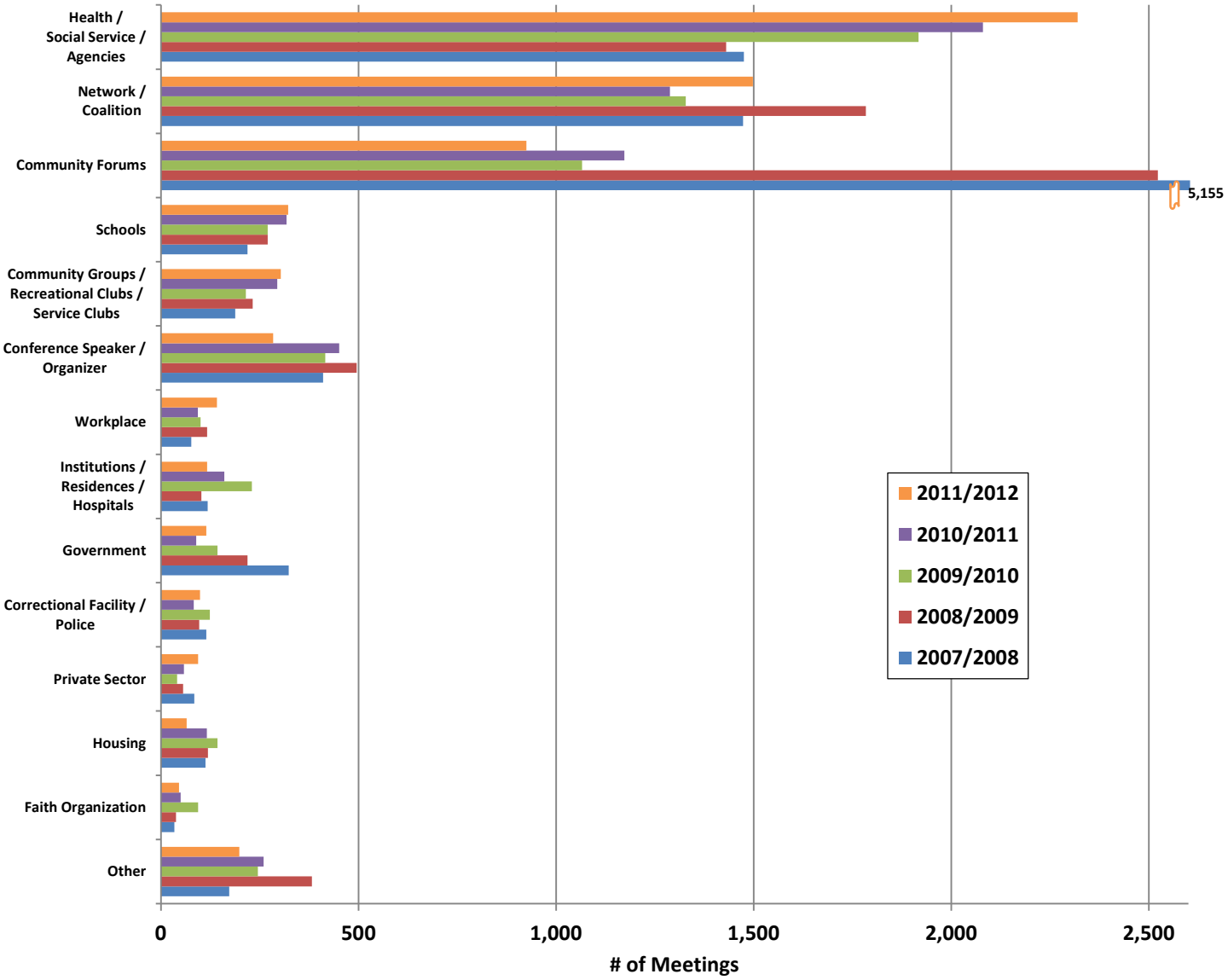
4 IMPROVING COMMUNITY COORDINATION & COLLABORATION

To be effective and achieve their goals, community-based HIV programs must be connected with other services in their communities and develop strong partnerships. They must also work within their communities to create safe, supportive environments for people living with or at risk of HIV.

GENERAL COMMUNITY DEVELOPMENT

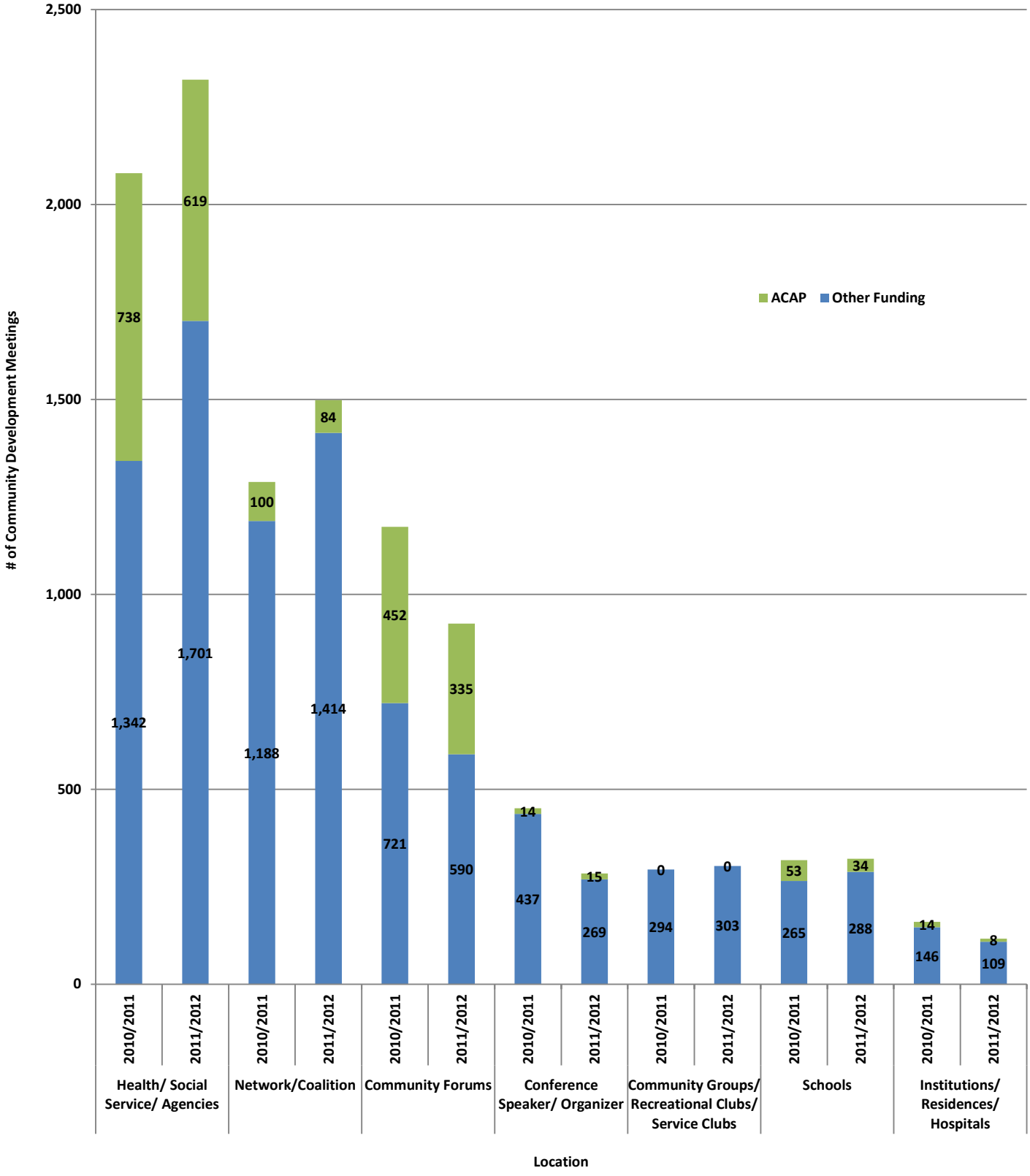
In 2011-12, programs held more community development meetings with health and social service agencies and with service networks in their community.

Figure 85
Community Development - Meetings



ACAP-funded programs were responsible for over one-quarter of the meetings with health and social service agencies.

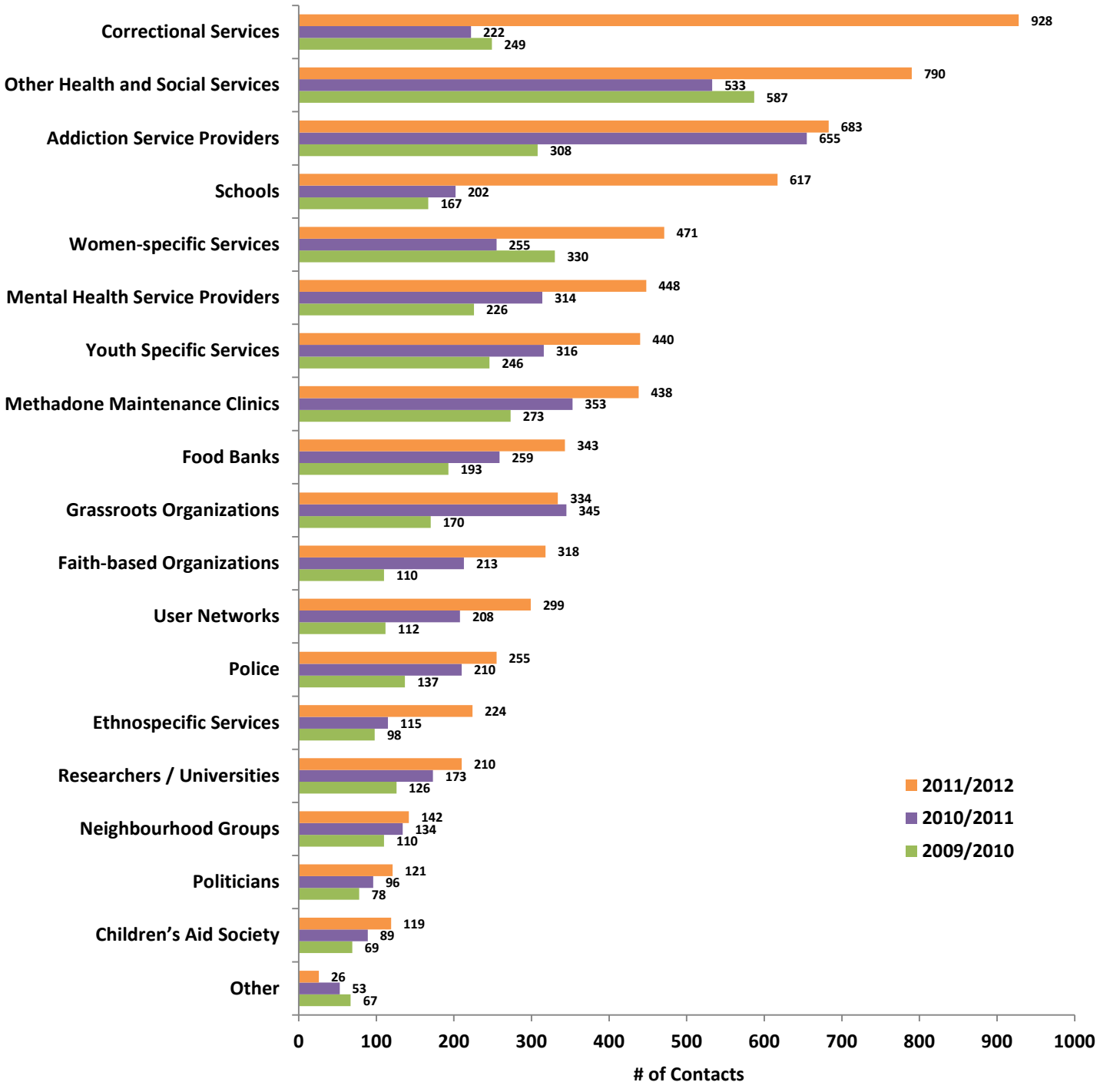
Figure 86
Community Development Meetings by Funding Source: 2010 and 2011



IDU PROGRAMS WORKING WITH CORRECTIONAL SERVICES

In 2011-12, IDU outreach programs reported a more than 400% increase in contacts with correctional services, a three-fold increase in contacts with schools and significant increases in contacts with women-specific services, mental health services, youth-specific services, faith-based organizations and food banks.
The increases in community development contacts with correctional services and schools were due mainly to reporting from one agency. The increases in contacts with health and social services, women-specific services and mental health service providers were also mainly due to reporting from one agency that has some responsibility for delivering a provincial harm reduction program.

Figure 87
Total Number of IDU / Substance Use Community Development Contacts



Provincial resource programs reported a marked increase in community development meetings. As Figure 89 illustrates, most meetings were with health and social service agencies.

Figure 88
Community Development Meetings: Provincial Resource Programs

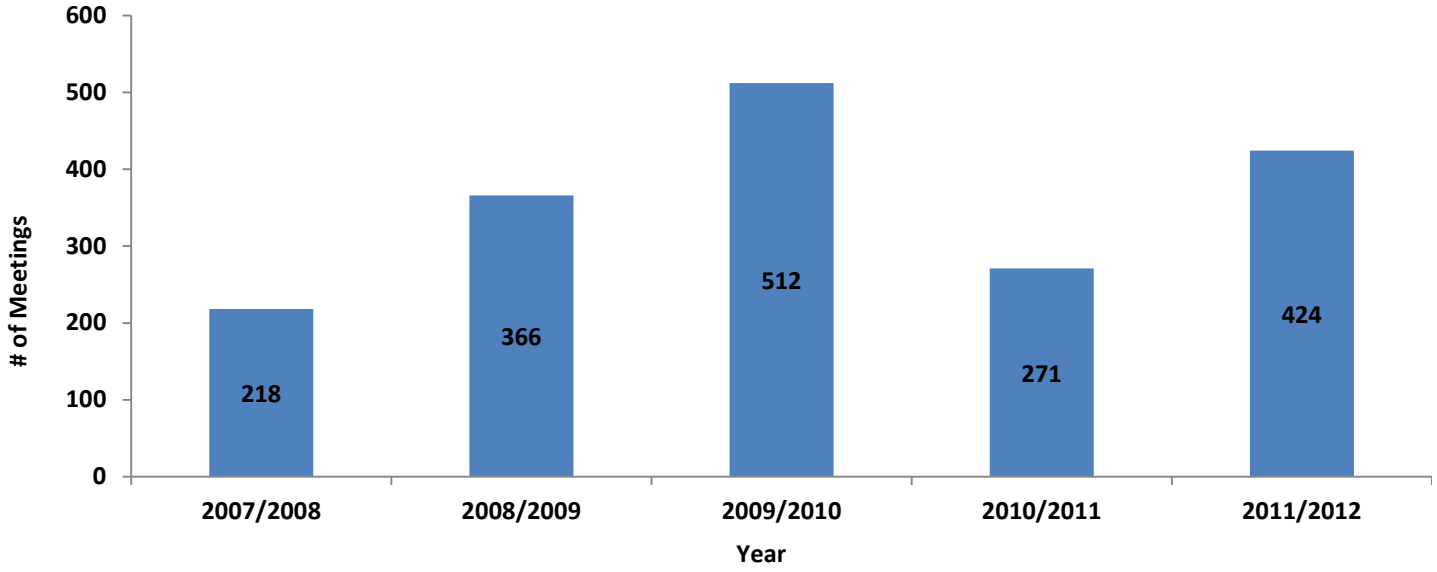
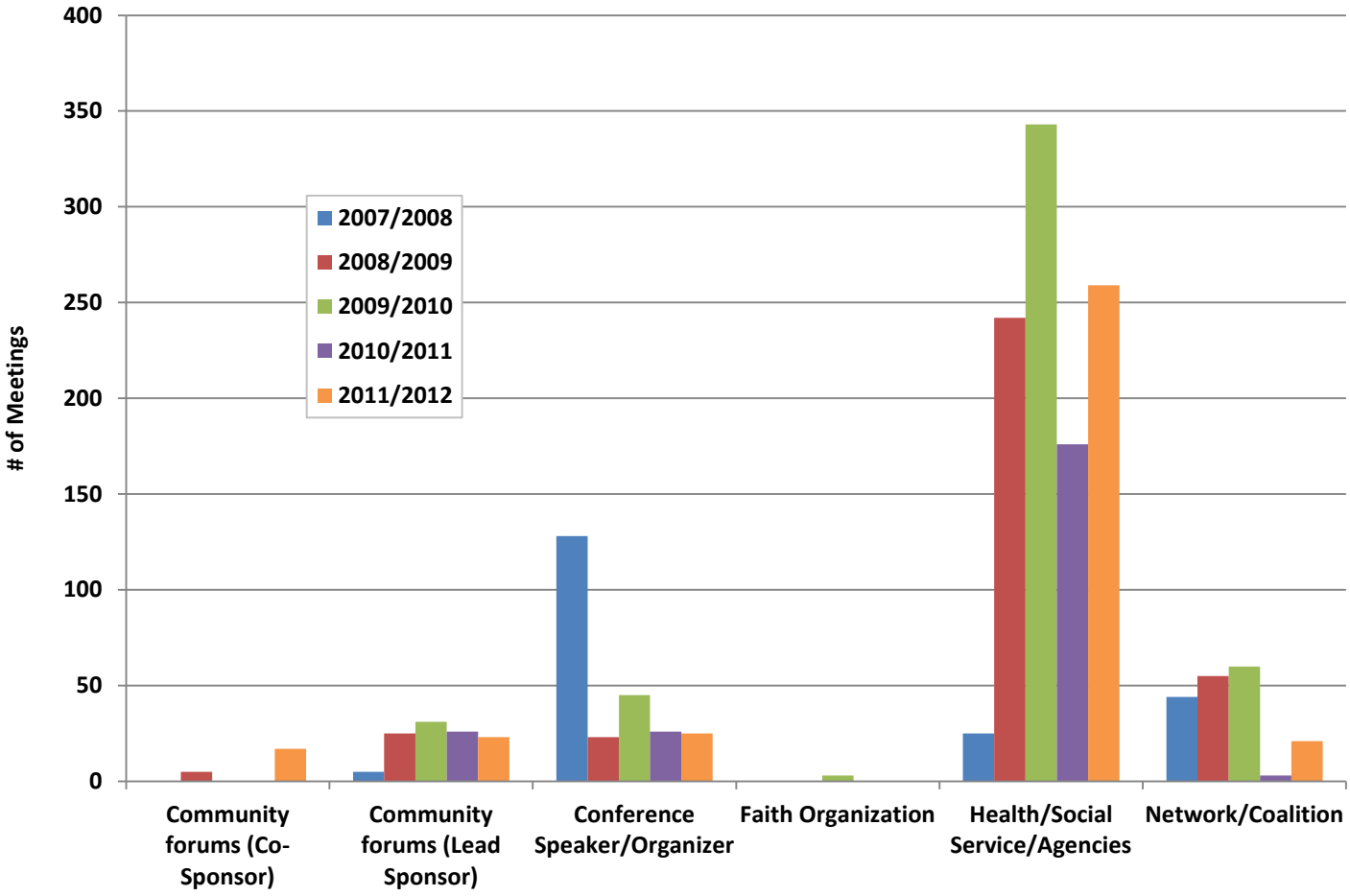


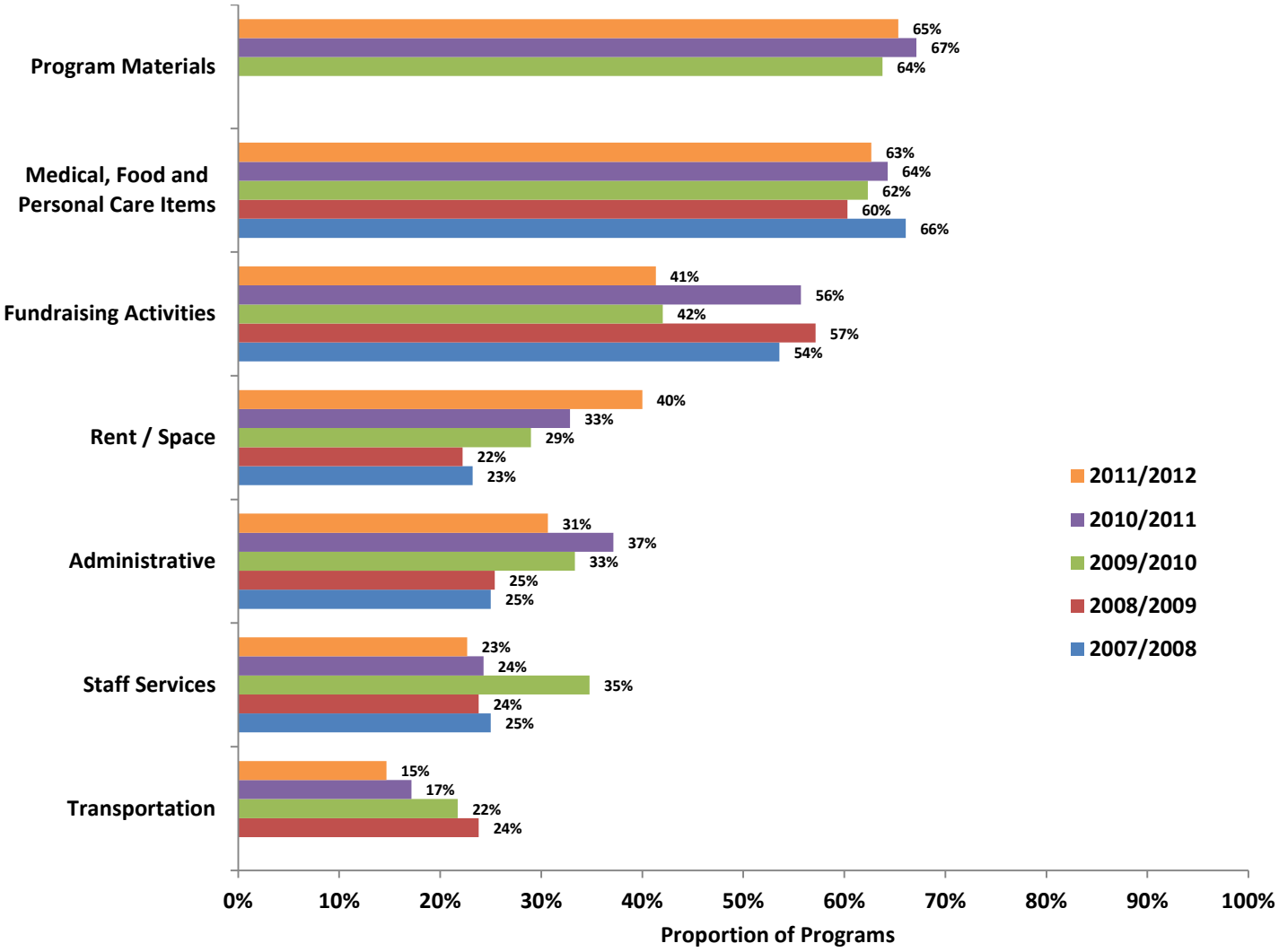
Figure 89
Community Development Meeting by Activity/Location: Provincial Resource Programs



SERVICE PARTNERSHIPS

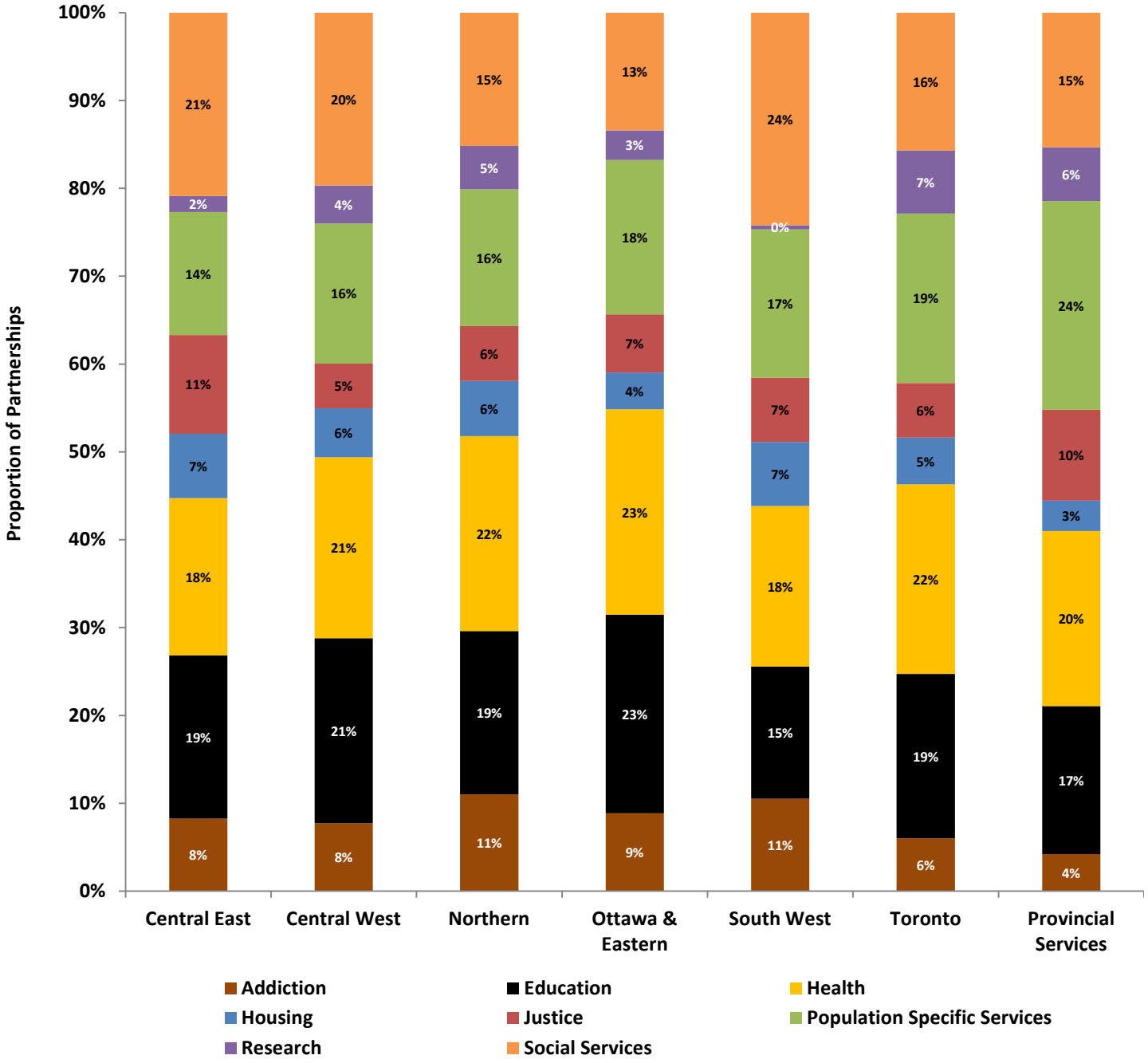
Four in 10 programs are now sharing space with other organizations – an increase of 25% over 2010-11. We consider this a positive sign as the co-locating of services is often associated with better coordination and collaboration and a more client-centred approach to care. However, in some cases this does not seem to lead to sharing staff or administrative resources. The impact may depend on whether the agency is sharing with another organization that serves the same or a similar population.

Figure 90
Proportion of Programs that Report Receiving In-Kind Contributions



The proportion of programs reporting partnerships with other agencies did not change significantly in 2011-12 compared to the previous year.

Figure 91
Partnership Focus by Region: 2011/2012 H2



EMERGING ISSUES IN BUILDING CAPACITY

To assess the role of partnerships in building capacity, agencies should consider the following questions:

1. To what extent do agencies rely on partnerships to deliver services or provide comprehensive services with their clients?
2. What strategies are most effective in engaging partners?
3. What new partnerships are ASOs cultivating to meet clients' changing needs?

APPENDICES

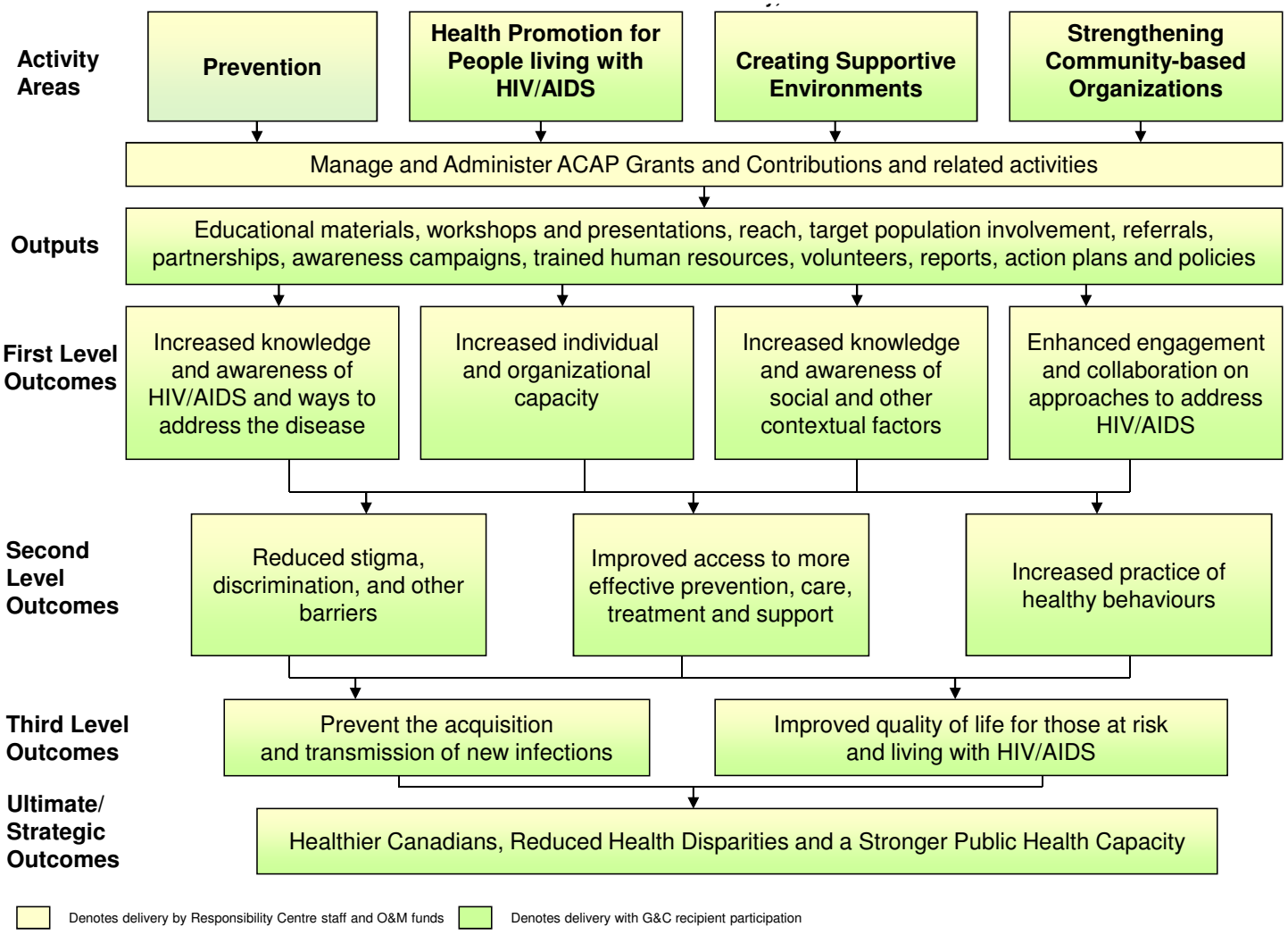
APPENDIX A: LIST OF FUNDED PROGRAMS

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
	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
	Ontario Association 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 and 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 2009-2010

PREVENTION INITIATIVES

Project Number	Project Title	Agency Sponsor
6963-06-2002/2370431	Prison In-Reach Project	Prisoners With HIV/AIDS Support Action Network
6963-06-2002/2370437	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
6963-06-2002/2370440	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	Enhancing Individual and Organizational Capacity
	7.2 Tools used to Measure Knowledge Changes	Enhancing Individual and Organizational Capacity
	7.3 Tools used to Measure Behavioural Changes	Enhancing Individual and Organizational Capacity
	7.4 How Have You Shared Your Knowledge	Enhancing Individual and Organizational Capacity
	7.7 How Does Your Organization Involve Target Populations	Enhancing Individual and Organizational Capacity
	7.8 Involvement in CBR	Enhancing Individual and Organizational Capacity
	7.9 Organizational Barriers	Enhancing Individual and Organizational Capacity
Education	9.2.1 Education Sessions	Improving Knowledge and Awareness
	9.2.1 Education Sessions – Provincial Resource Programs	Enhancing Individual and Organizational Capacity
	9.2.1 Community Development Meetings	Improving Coordination and Collaboration
	9.2.2 Education Resources – Health Promotion and Support Resources	Improving Access to Services
	9.2.2 Education Resources – Planning/Decision Making/Policy and Training Resources	Enhancing Individual and Organizational Capacity
	9.3 and 9.4 Narratives	Improving Knowledge and Awareness
Outreach	10.2 Outreach Contacts by Location	Improving Knowledge and Awareness
	10.3 Awareness Campaigns	Improving Knowledge and Awareness
	10.4 Media Contacts	Improving Knowledge and Awareness
	10.5 Phoneline and Internet Activity	Improving Knowledge and Awareness
	10.5 Phoneline and Internet Activity – Pre/Post Test Counselling and Referrals	Improving Access to Services
	10.6 Safer Sex Supplies	Improving Knowledge and Awareness
	10.7 Newsletter Outreach	Improving Knowledge and Awareness
	10.8 and 10.9 Narratives	Improving Knowledge and Awareness
Support Services	11.1.1 Number of Clients Served by Gender	Improving Access to Services
	11.1.2 New Clients	Improving Access to Services
	11.1.3 Number of Clients Served by Age	Improving Access to Services
	11.2.1 Services Provided	Improving Access to Services
	11.2.2 Sessions Provided	Improving Access to Services
	11.3 Support Groups	Improving Access to Services
	11.4 Financial and In-Kind Support	Improving Access to Services
	11.5 and 11.6 Narratives	Improving Access to Services
Volunteers	12.1 Volunteers and Volunteer Management	Enhancing Individual and Organizational Capacity
	12.2 Volunteer Activities	Enhancing Individual and Organizational Capacity
	12.3 Student Placements	Enhancing Individual and Organizational Capacity
	12.4 Student Activities	Enhancing Individual and Organizational Capacity
	12.5 and 12.6 Narratives	Enhancing Individual and Organizational Capacity

OCHART Section	OCHART Question	VFTFL Goals
IDU/Substance Use Services	13.1.1 Outreach Contacts	Improving Access to Services
	13.1.2 Outreach – Individual Clients	Improving Access to Services
	13.2.1 In-Service Contacts	Improving Access to Services
	13.2.2 In-Service – Individual Clients	Improving Access to Services
	13.3a Services Provided	Improving Access to Services
	13.4 Location of Outreach Services	Improving Access to Services
	13.5 Peer Involvement	Enhancing Individual and Organizational Capacity
	13.6 Peer Activities – Formal Programs, Informal Interactions, Phone Line Support, Practical Assistance	Improving Access to Services
	13.6 Peer Activities – Material Distribution	Improving Knowledge and Awareness
	13.6 Peer Activities - Training	Improving Knowledge and Awareness
	13.7 Community Development Activities	Improving Coordination and Collaboration
	13.8 Community Development Contacts	Improving Coordination and Collaboration
	13.8 Community Development Contacts - Research	Enhancing Individual and Organizational Capacity
	13.9 Drugs of Choice	Improving Access to Services
	13.10 Harm Reduction Resources Distributed	Improving Knowledge and Awareness
	13.11 and 13.12 Narratives	Improving Access to Services

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

The 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 Position	OCHART question	National Occupation Classification (NOC)	Total Number of Volunteer Hours in the Past 12 Months (A)	NOC Average Hourly Wage Rate Assigned to This Job Type in the past 12 months (B)	Total Volunteer Hours NOC Average Hourly Wage Rate (C)	Fringe Benefit 12% (D)	Total Value (C+D)
Administration (clerical support, reception, etc)	12.2 total # of vol hours for Administration	General office clerk 1411	35,915	$15.25	$547,703.75	$65,724.45	$613,428.20
Governance (board of directors, advisory committees etc)	12.2 # of vol hrs for Serve on Board/ Advisory Committee	Senior manager – Health, Education, Social and Community Services and Membership Organization 0014	16,493	$39.00	$643,227.00	$77,187.24	$720,414.24
Support services (assistance to people living with HIV/AIDS, peer support, etc)	12.2 sum of total # of vol hrs for Practical Support and Counseling	Community and social service workers 4212	63,912	$21.51	$1,374,747.12	$164,969.65	$1,539,716.77
Prevention (outreach, targeted education, etc)	12.2 total # of vol hrs for Outreach Activities	Community and social service workers 4212	15,163	$21.51	$326,156.13	$39,138.74	$365,294.87
Fundraising (walks, fundraising campaigns, working to secure foundation grants, etc)	12.2 total # of vol hrs for Fundraising	Professional occupation in public relations and communications 5124	25,782	$29.74	$766,756.68	$92,010.80	$858,767.48
Public events (public speaking, special events like Pride Day, mall displays, etc)	12.2 sum of total # of vol hrs for Special Events and Education/ Comm Devt	General office clerk 1411	57,521	$15.25	$877,195.25	$105,263.43	$982,458.68
Human resources	12.2 sum of total # of vol hrs for involvement in hiring process and policies and proecdures	Specialists in human resources 1121	2,123	$29.74	$63,138.02	$7,576.56	$70,714.58
IT Support	12.2 sum of total # of vol hrs for IT support	Web designers and developers 2175	2,171	$27.78	$60,310.38	$7,237.25	$67,547.63
Total					**$4,659,234.33**		**$5,080,080.24**

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

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