2013

OCHART

VIEW FROM THE FRONT LINES

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

April 1, 2012 - March 31, 2013

A collaborative project of the AIDS Bureau, Ontario Ministry of Health and Long-Term Care and the Public Health Agency of Canada, Ontario Regional Office

Ontario

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

OHTN

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PREFACE

Welcome to the eighth annual OCHART (Ontario Community HIV and AIDS Reporting Tool) report: **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.

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.

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.

HOW THE REPORT IS STRUCTURED

1. HIGHLIGHTING SIGNIFICANT CHANGES AND TRENDS

The **View from the Front Lines** highlights significant trends from the OCHART data; however, data from all OCHART questions is available in a separate document on the OCHART website.

2. FOCUSING ON THE OUTCOMES OF OUR WORK

Our 2012-13 findings are organized under the four anticipated short-term outcomes of community-based HIV services:

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

DATA LIMITATIONS

ACCURACY AND CONSISTENCY

This report relies on self-reported data provided by agencies. Data is collected by a number of staff in the agencies, and there is always the potential for inconsistency (i.e., different definitions, different interpretations). 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.

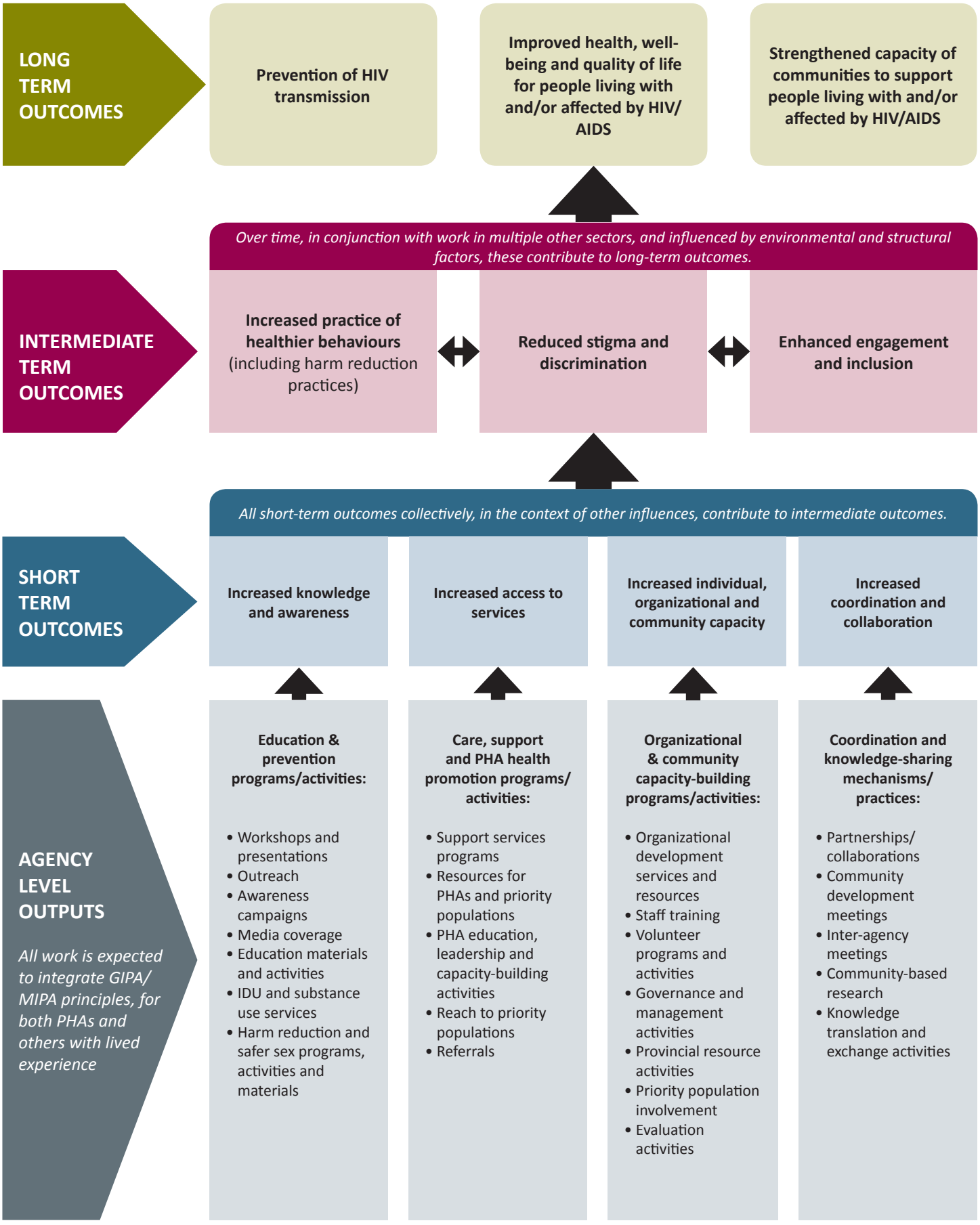
USE OF AGGREGATE DATA

Throughout the report, we use aggregate data – rolling up 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 reports from one or two large organizations to skew the data. Aggregate or average results may not 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 OCHART logic model – a synthesis of both the AIDS Bureau and PHAC logic models – reinforces 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. 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.

HOW TO READ THE LOGIC MODEL

The box at the top of the logic model describes the long-term outcomes or goals of our work. The rest of the logic model explains how our work contributes to achieving these outcomes. To read the logic model, start at the bottom of the page:

- The outputs list the activities or services of community-based HIV programs, which are a means to an end.

- The end is the desired change or "outcomes" that we expect to see. For reporting purposes, we linked each output to just one short-term outcome; however, in practice, outputs can contribute to more than one outcome. For example, "workshops and presentations" contribute to the outcome "increased knowledge and awareness" but they can also contribute to other outcomes, such as increased access to services or increased organizational capacity.

- There are different 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 outputs and outcomes. These are the areas where funded agencies have the strongest influence, and where change can be most directly attributed to their work.

    - Outcomes become more complex to measure as we move up the logic model. Intermediate and longer-term outcomes take more time to achieve, and depend more on the work of other programs and sectors. Funded agencies contribute, along with other community and government initiatives, to achieving these outcomes.

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KEY FINDINGS

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A total of 73 organizations reported through OCHART in 2012-13. Fifty new ACAP projects began in April 2012 and their previously funded projects ended. These new ACAP projects were in the start-up phase so had less to report.

HIV Diagnoses in Ontario in 2012

- The number of new diagnoses in 2012 – 843 – was the lowest since the beginning of the epidemic. New diagnoses were down in all risk groups except African, Caribbean and Black women and low risk heterosexual men:
- The number of new diagnoses in gay men and other men who have sex with men dropped 6% (from 517 to 484) while the number of new diagnoses in men who have sex with men and use injection drugs dropped 4% (from 25 to 24) – however gay men still accounted for 73 to 76% of new HIV diagnoses in men in 2012.
- The number of new diagnoses in people from countries where HIV in endemic (e.g., Africa, the Caribbean) increased in women (from 107 to 116) but decreased in men (from 91 to 55).
- Among people who inject drugs, the number of new diagnoses dropped 22% (from 38 to 29).
- Among people who reported their risk factor as high risk heterosexual activity, the number of new diagnoses dropped 14% in men (from 12 to 10) and 15% in women (from 19 to 17).
- The number of new diagnoses in people who reported low risk heterosexual activity as a risk factor increased 9% in men (from 55 to 60) and decreased 23% in women (from 36 to 27). Note: past enhanced surveillance programs have found that most new cases originally reported as “low risk heterosexual” have a high risk contact (e.g., unprotected sex with someone at high risk, sharing needles).

We do not know about changes in diagnoses among Aboriginal people because being Aboriginal is not one of the risk factors on the HIV test requisition form. The OHTN is continuing to work with partners (the Ontario Aboriginal HIV/AIDS Strategy, Two-Spirited People of the 1st Nations, the HIV Studies Unit, Public Health Agency of Canada and the AIDS Bureau) on the development of a special Situation Report to better understand HIV in Aboriginal communities in Ontario.

We continue to see a steady increase in new diagnoses in people age 40 and older - 44% of all new diagnoses in 2012 of which there were 285 males and 69 females. This is particularly reflected in men, of which 40% were MSM, 3% IDU, 1% HIV-endemic, 7% Low-Risk Hetero, and the remaining 49% with No Identifiable Risk (this 49% needs follow-up to determine risk factors – further analysis is pending).

1. IMPROVING KNOWLEDGE AND AWARENESS

EDUCATION

Most education presentations in 2012-13 were short, one-time workshops or talks that focused on basic HIV information and population-specific issues. Should organizations be striving to offer more in-depth workshops or to develop a series of workshops that would help move beyond HIV 101? Or is the focus on HIV 101 necessary to keep educating younger generations and to compensate for turnover in other agencies?

Community-based programs use different education strategies to reach different audiences. For example, organizations mainly used resources and materials to reach gay, bisexual and other men who have sex with men. This may indicate that organizations find it easier to reach out to this population with information than to bring them to education presentations. Organizations relied heavily on films and DVDs to reach the African, Caribbean and Black communities, workshops to reach Aboriginal peoples, and brochures to reach women at risk.

Condom distribution was up 47% in 2012-13 – due in part to organizations capturing and reporting this information more accurately.

Organizations are using a range of innovative strategies to deliver education, including working with community media, arts-based programs, youth programs, building community relationships and developing targeted education for professionals.

The key barriers to HIV awareness continue to be: stigma, the complex needs of clients (i.e., HIV may not be a priority), language and cultural barriers, the challenges of working with other sectors (e.g., corrections) and organizational issues (e.g., staff turnover, lack of resources).

OUTREACH

Non-IDU brief outreach initiatives target mainly gay, bisexual and other men who have sex with men (46%) followed by the general public (22%) and African, Caribbean and Black communities (9%). ACAP funding supported about 7% of significant and 8% of brief outreach contacts, the vast majority of which (>4500) were in Toronto and in African, Caribbean and Black populations, women at risk, gay men and people who use drugs.

Programs report greater use of social media as part of their outreach, and note that they believe it is effective in helping them increase their interactions with specific populations, awareness and discussions. It would be worthwhile having a broader discussion about which types of social media are most effective in terms of outreach. For example, a blog may not be as widely read as a Facebook post but it may provide more in-depth information/discussion and lead to a stronger outreach connection.

Barriers to outreach include: stigma, lack of spaces to conduct outreach, language and cultural barriers, lack of technical skills with social media and organizational issues (e.g., distance to cover, challenges in engaging peers and volunteers in outreach, and resource issues).

IDU OUTREACH

Programs reported an increase in demand for in-service supports, such as practical support, education, referrals and counselling – which indicates that they are forming trusting relationships with drug users in their community, who then engage in care.

IDU outreach programs have built strong relationships with partner agencies that also serve people who use drugs, and work with them to provide a continuum of services.

In 2012-13, there was a 12% in the number of needles and a 6% increase in the amount of safer inhalation equipment distributed across the province.

Barriers faced by IDU outreach programs include: the impact of changes in drugs and drug use (e.g., reformulation of Oxy led to an increase in use of heroin, Fentanyl and Dilaudid), more demand for needles from people using them to inject steroids and hormones, an increase in overdoses and deaths, and an increase in youth using drugs, particularly in the North. Strategies to overcome these issues include: relationship building, providing more care for abscesses, overdose training programs and campaigns that target youth.

2. IMPROVING ACCESS TO SERVICES

SUPPORT SERVICES

Organizations reported serving almost 13,000 clients in 2012-13. (Note: because clients may use services from more than one organization, these may not all be unique clients.) Most clients who use community-based support services are male (62%); one in three are female and 2% are trans.

There was a 150% increase in trans people accessing community-based HIV programs between the years 2008-09 and 2012-13.

In 2012-13, women accounted for 38% of new clients and between 25 and 41% of clients in all regions – although they make up only 20 to 24% of people living with HIV. It may be that women are more likely than men to seek services or they may be more vulnerable and more in need of support services.

Most clients using support services are age 40 and older. This trend likely reflects the aging of people who have been living with HIV for some time, the fact that more people newly diagnosed with HIV are older, and the impact of better treatments, which may mean that younger people diagnosed with HIV may be better able to maintain their health, employment, income and social networks and may not need support services.

Organizations reported an increase in practical assistance last year, as well as more clients using food programs – which may be an indicator that more clients are struggling with poverty.

In 2012-13, programs distributed less in financial assistance, but that amount was shared among more people. There appears to be an increasing demand for financial assistance but less capacity to provide that service.

Organizations reported increasing demand for: immigration services, navigation services, practical assistance, transportation and services to help people cope with the image of aging and complex needs.

3. ENHANCING CAPACITY

VOLUNTEERS

In 2012-13, volunteers contributed $4.9 million worth of service – down slightly from $5.08 million in 2011-12.

Agencies that have large numbers of volunteers – that is, more than 100 – are more likely to involve a large proportion of those volunteers in fundraising, practical support and outreach activities. On the other hand, agencies with a smaller number of volunteers are more likely to engage those volunteers on the Board, in community development and in administration.

STUDENTS

Attracting students is not just a benefit for the program over the short-term; it is an effective way to expose young people to this sector who may then consider HIV work when planning their careers.
Community-based HIV programs have capitalized on the student volunteer requirements that are now part of the Ontario secondary school curriculum. In 2012-13, programs attracted more students; however, those students gave fewer hours.

PEERS

IDU outreach programs were significantly more effective in 2012-13 in attracting and retaining peers. Areas with larger drug-related HIV epidemics – such as Toronto, Ottawa and the North – are more successful in attracting peers.

IDU programs seem to be putting more emphasis on the potential for peers to interact with people who use substances, provide education and support, and connect them to agency and other health services. This is a positive trend as the IDU evaluation indicated that word-of-mouth from someone who has had a similar life experience (i.e., a peer) is how most people who use substances develop enough confidence and trust to connect with services.

ORGANIZATIONAL CAPACITY BUILDING

Provincial resource organizations reached 8,000 people in 2012-13 with their workshops and presentations – mainly front-line workers, other service providers and people living with HIV.

4. IMPROVING COMMUNITY COORDINATION AND COLLABORATION

COMMUNITY DEVELOPMENT

In 2012-13, the number of community development meeting increased by 22%, and organizations reported more meetings with faith organizations, workplaces and housing providers than in the past. This trend is encouraging given the importance of housing and employment to health, and the role that faith organizations can play in providing support and reducing stigma.

In 2012-13, IDU programs more than doubled the number of meetings held with other health and social services in their communities. The number of meetings with addiction service providers, mental health providers and service user networks also increased. These activities may reflect the growing move in many communities to establish harm reduction networks that work together to meet the needs of people who use substances.

Partnerships with other services are important because they result in: more effective services, greater capacity to meet clients' complex needs and stronger networks.

I. A SNAPSHOT OF THE COMMUNITY-BASED SECTOR IN 2012-13

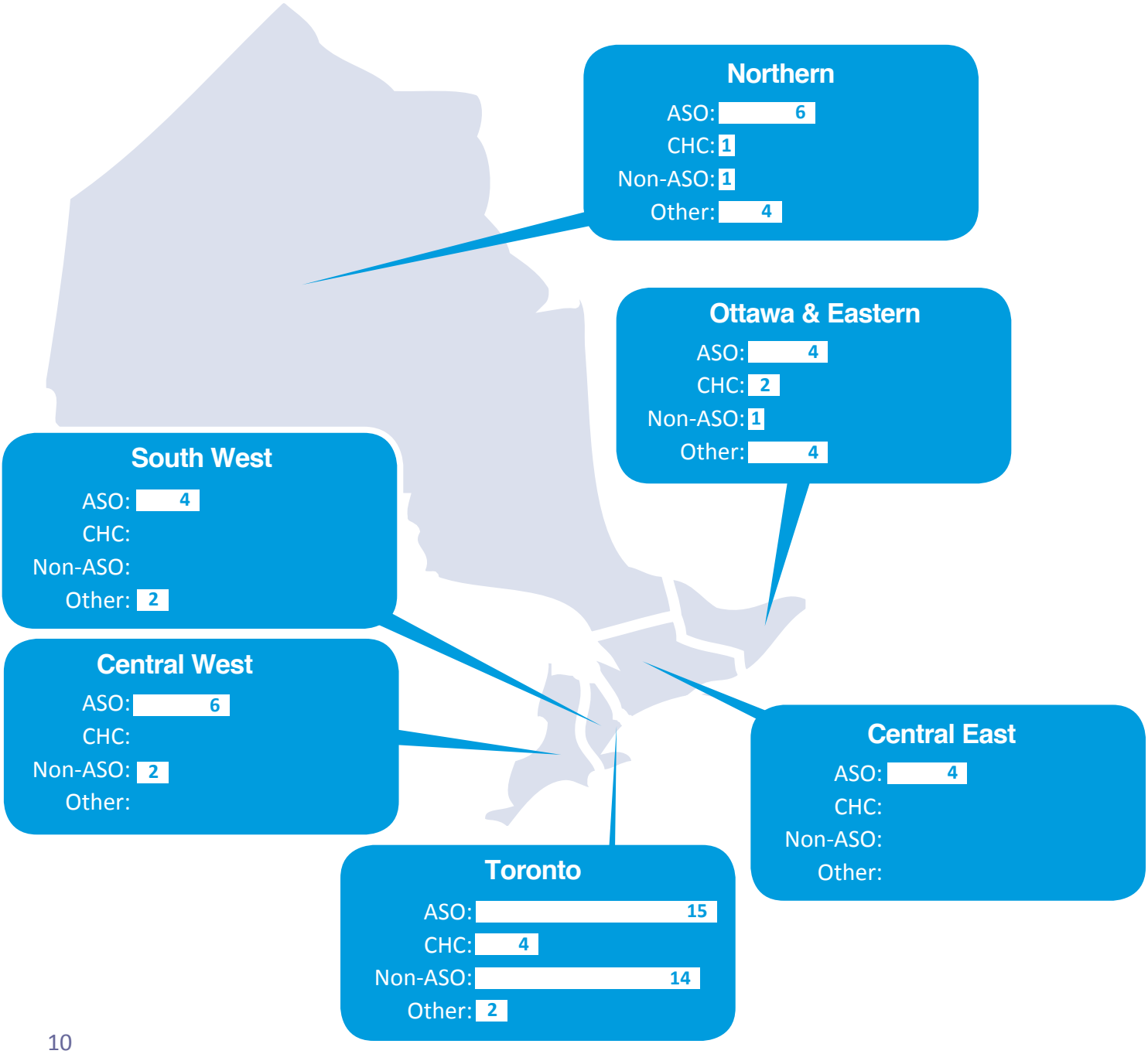
A SNAPSHOT OF THE COMMUNITY-BASED SECTOR IN 2012-13

In 2012-13, the AIDS Bureau and ACAP funded a total of 87 programs in 73 organizations, including:

- 40 community-based HIV/AIDS organizations
- 22 non-AIDS service organizations
- 7 community health centres
- 4 other health care organizations.

These programs, located across the province (see Figure 1), are funded to provide prevention, outreach and support services for people with or at risk of HIV, and their partners and families.

Figure 1. Where Are Ontario's Community-Based HIV Services?



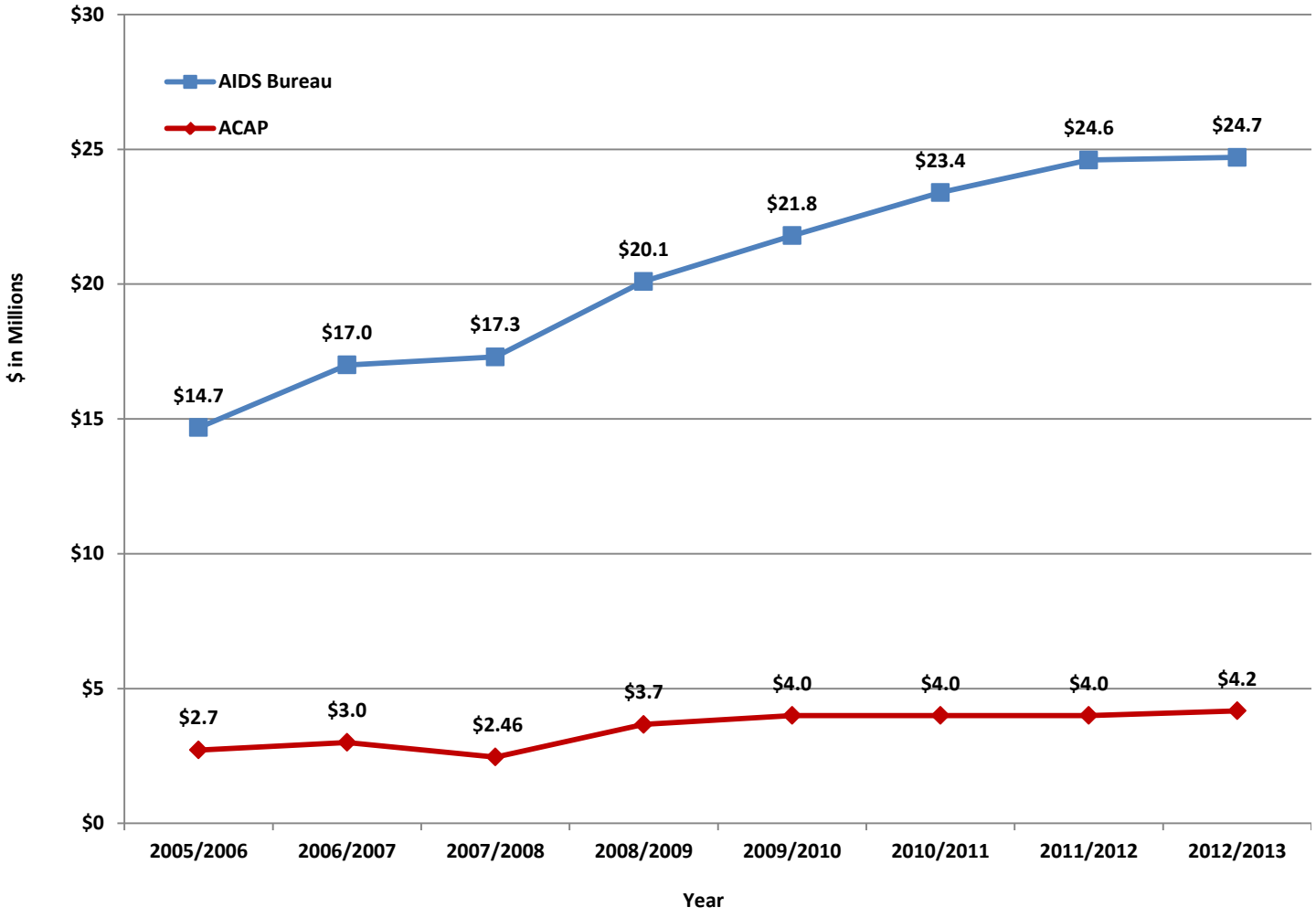
Of the 73 organizations:

- 62 are local or regional service programs that provide direct services to clients in their geographic area
- 11 are provincial organizations responsible for managing programs for the entire province. Of these 11 provincial organizations: four provide direct **services** to clients across the province and seven are provincial **resource** organizations that provide training, information and other services to enhance the capacity of community-based AIDS services and other organizations (see Table 2). Two provincial organizations – OAHAS and Hemophilia Ontario – are based in Toronto but have regional staff/ programs located across the province. We have counted the activities of those programs in the regions where they are delivered. Note: Two of these regional programs did not have any activity in H2 of 2012-13 due to staff transition (OAHAS Kingston and Hemophilia Ontario – North Eastern Ontario Region).
- Most funded programs are relatively small. More than half have five or fewer staff and only 10 have more than 20 staff.

GOVERNMENT FUNDING FOR HIV SERVICES REMAINS STABLE

In 2012-13, community-based programs received $28.9 million in funding from the AIDS Bureau and ACAP (based on information provided by the funders).

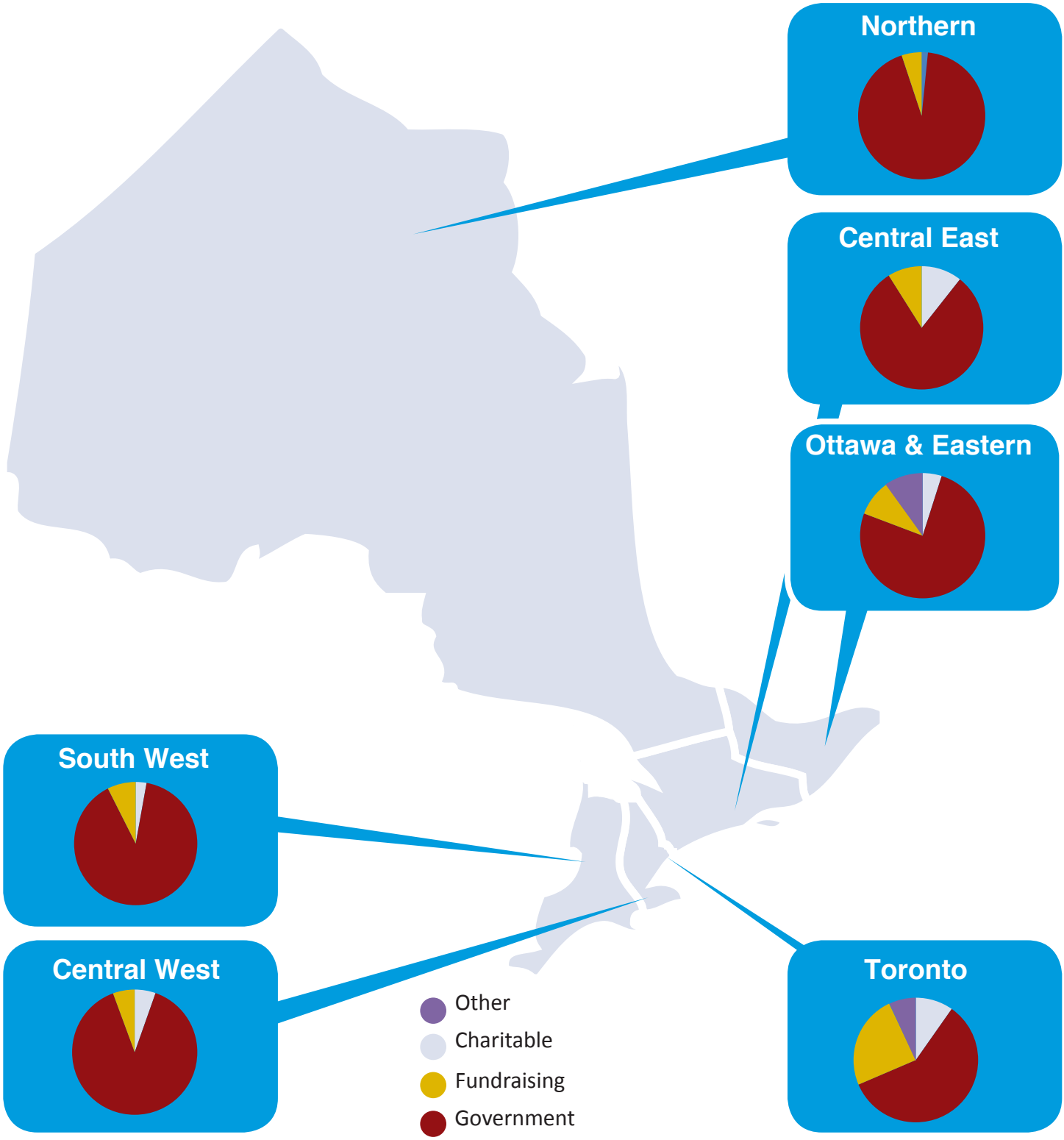
Figure 2. Annual ACAP and AIDS Bureau Funding as Reported by Funders



ORGANIZATIONS CONTINUE TO RELY ON GOVERNMENT FUNDING

The AIDS Bureau provides operational funding for community-based HIV programs and is their primary source of funding. AIDS Bureau funding accounted for 45% of the total funding reported by organizations in 2012-13: up from 43% in 2011-12. Programs also reported a 1% increase in the proportion of their funding that came from other parts of the Ontario Ministry of Health and Long-Term Care.

Figure 3. Who Funds Programs in Ontario?



FUNDRAISING UP IN 2012-13

Based on figures reported by the community-based organizations, overall funding for community-based programs increased by just over $3 million compared to the previous year.

Programs also reported more fundraising revenue than in the past. As a proportion of total funding, fundraising accounted for 16% of agency funding – up from 14% in 2011-12 and 15% in 2010-11. However, almost all the increase in fund-raised dollars was reported by agencies in Toronto ($5.5 million compared to $4.5 in the previous year). Only two other regions saw an actual increase in fundraised money: Central West and Ottawa/Eastern.

Some regions have more capacity than others to obtain funding from a variety of sources. Two regions – Central West and the Northern region – as well as provincial services, rely on the AIDS Bureau and ACAP for more than 80% of their funding.

FIFTY NEW ACAP-FUNDED PROJECTS START UP IN 2012-13

ACAP provides time-limited funding. In March 2012, the projects that had been funded by ACAP in previous years ended. In April 2012, ACAP began funding 50 new projects. Because these projects were in the start-up, planning and development phase for part of the year, they did not have as many ACAP-funded activities to report as in previous years.

II. HIV IN ONTARIO IN 2012-13

II. HIV IN ONTARIO IN 2012

FEWER NEW DIAGNOSES DESPITE HIGH TESTING RATES

NUMBER OF NEW HIV DIAGNOSES DOWN >10%

All-time low.

In 2012, HIV diagnosis rates in Ontario reached their lowest point since the beginning of the epidemic.

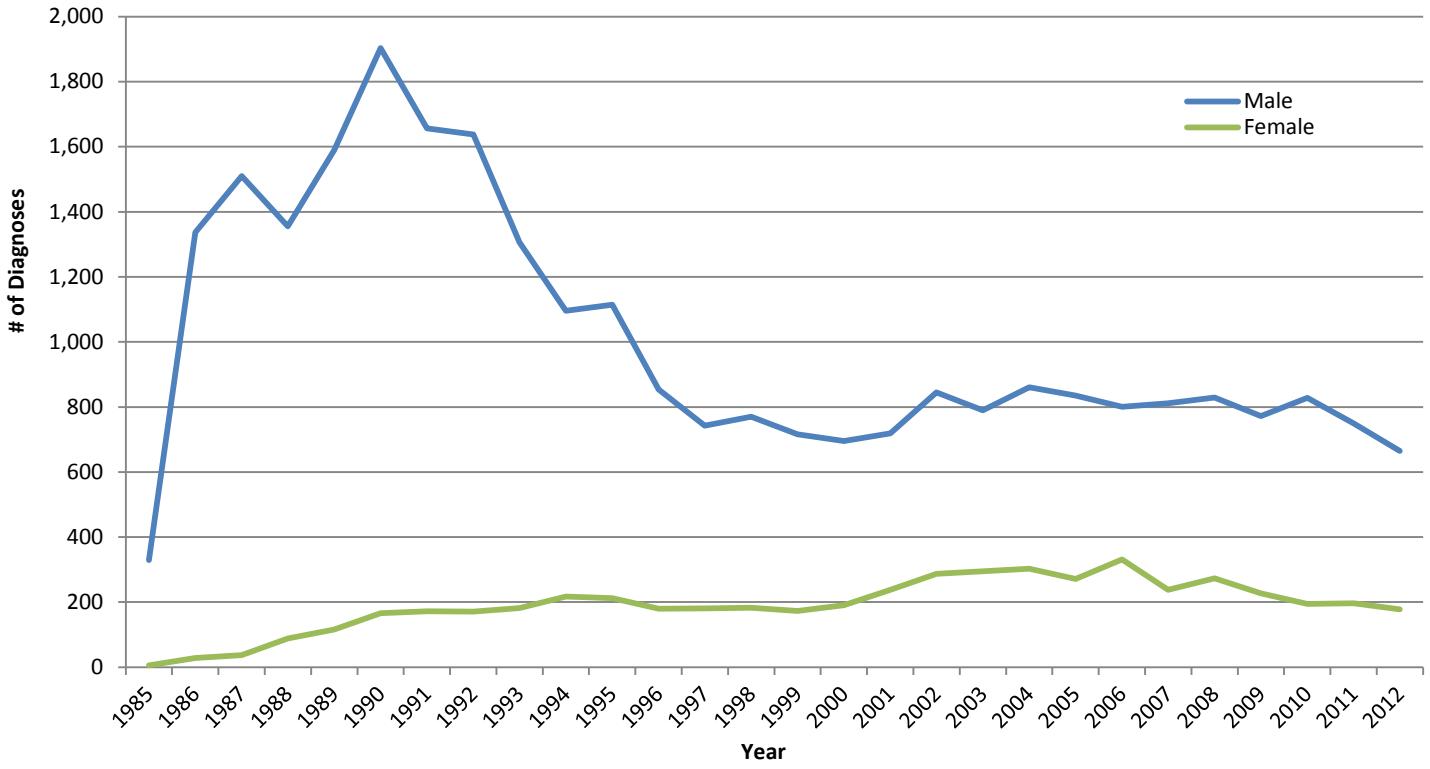
843

New diagnoses reported in 2012.

In 2012, Ontario saw a significant drop in new diagnoses: down 11% in men and 10% in women from the previous year (2011-12).

Over 2011 and 2012, there was almost a 20% drop in the number of new diagnoses among men.

Figure 4. Number of HIV Diagnoses (adjusted[1]) Among Males and Females by Year of Diagnosis, Ontario: 1985 - 2012



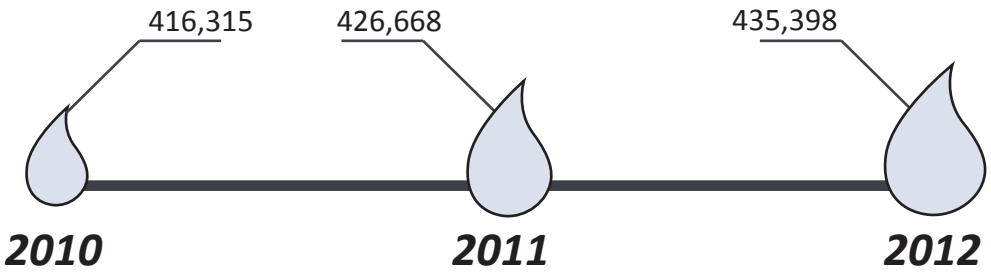
1. Unknown sex assigned according to the distribution of cases with known sex (see Technical Notes); thus, totals may differ due to rounding. Source: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care From: http://www.phs.utoronto.ca/ohemu/doc/Table1.pdf- accessed June 25,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

IS THE DROP IN NEW DIAGNOSES "REAL" OR AN ARTIFACT OF TESTING?

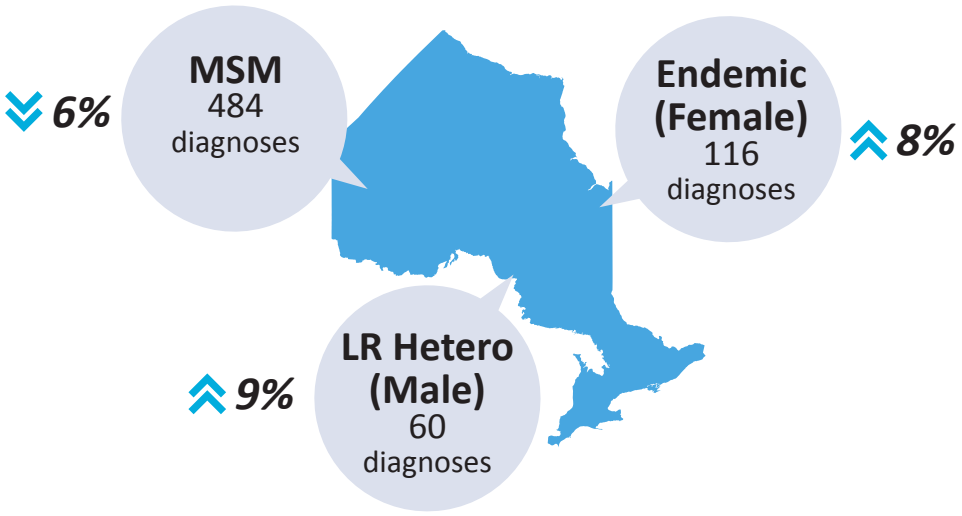
The drop in new diagnoses begs the question: are there fewer infections or fewer people being tested? The total number of HIV tests in 2012 was up from previous years. The question then becomes: are our testing programs reaching the right people or are there, in fact, fewer new or undiagnosed infections?

Testing's up.

The drop can't be explained away by lack of HIV testing, which has risen steadily over the past three years.



NUMBER OF NEW DIAGNOSES DOWN IN EVERY RISK CATEGORY EXCEPT AFRICAN, CARIBBEAN AND BLACK WOMEN AND LOW RISK HETEROSEXUAL MEN



Who's getting tested?

At left are the three groups with the greatest number of new infections.

Note: Past enhanced surveillance programs have revealed that most cases originally reported as "low risk heterosexual" have a high risk contact (e.g., unprotected sex or sharing needles with someone at risk).

Figure 5. Number of New HIV Diagnoses by Gender and Risk Category (2011 and 2012)

Male		2011	2012	% Change
MSM	No	517	484	-6%
	%	69.0%	72.7%	
MSM-IDU	No	25	24	-6%
	%	3.4%	3.6%	
IDU	No	38	29	-22%
	%	5.0%	4.4%	
Endemic	No	91	55	-39%
	%	12.1%	8.3%	
HR Hetero	No	12	10	-14%
	%	1.6%	1.5%	
LR Hetero	No	55	60	9%
	%	7.4%	9.0%	
Clot Factor Transfused Other	No	3	0	-100%
	%	0.39%	0.00%	

Female		2011	2012	% Change
IDU	No	27	17	-39%
	%	14.0%	9.4%	
Endemic	No	107	116	8%
	%	54.7%	65.2%	
HR Hetero	No	19	17	-15%
	%	9.9%	9.3%	
LR Hetero	No	36	27	-23%
	%	18.2%	15.4%	
Clot Factor Transfused Other	No	6	1	-82%
	%	3.2%	0.7%	

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

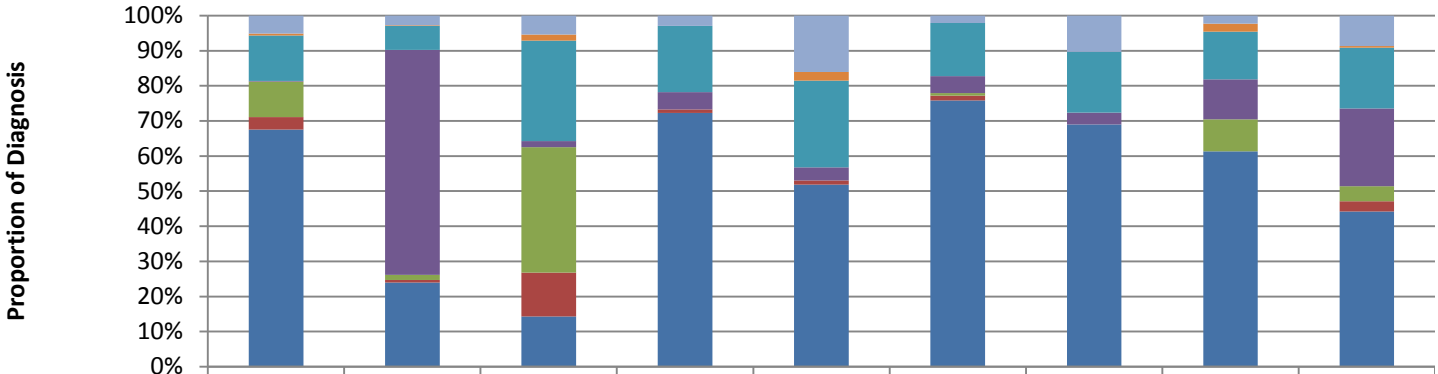
Although there was a significant drop in the number of new diagnoses in gay men and other men who have sex with men, they made up a larger proportion of the men newly diagnosed in 2012: 73% or 76% if we include MSM-IDU.

HIV DIAGNOSES BY ETHNICITY

Ontario's Lab Enhancement Program seeks to obtain more complete information on HIV risk factors and, since 2009, on ethnicity, country of birth and date of arrival in Canada. The program sends a questionnaire to a number of physicians each year, asking for more information on an HIV positive test result.

As Figure 6 illustrates, between 2009 and 2012, the Lab Enhancement Program found that a majority of people diagnosed with HIV were White (53%) and their most common risks were reported as: men having sex with men, heterosexual contact and injection drug use. In terms of ethnicity, the second most affected group was Black (26%) and their most common risks were being from a country where HIV is endemic (64%) and men having sex with men (24%). It is interesting to note that the third largest affected group by ethnicity is people from the Middle East/North Africa and their most common reported risk factors were men having sex with men and heterosexual contact.

Figure 6. Number of HIV Diagnoses by Ethno Racial and Risk Category 2009-2012



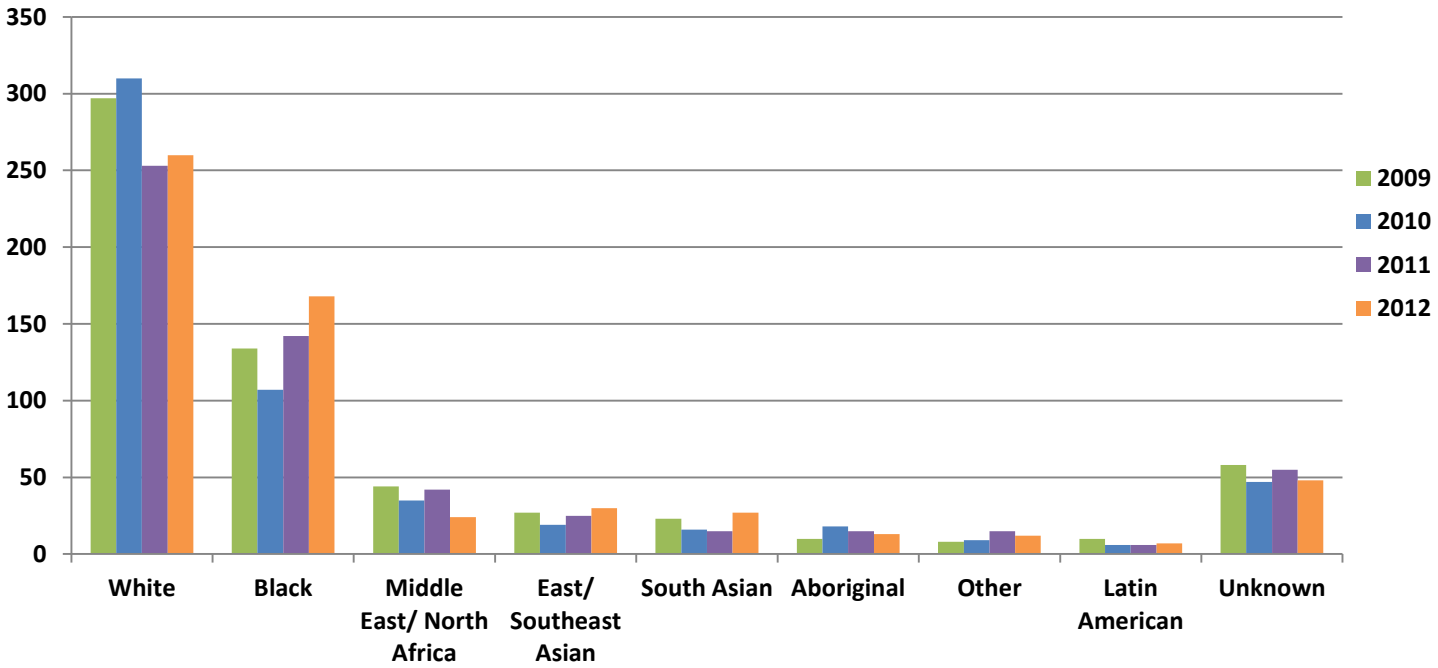
	White	Black	Aboriginal	East/South east Asian	South Asian	Middle East/North Africa	Latin American	Other	Unknown
Unknown	57	15	3	3	13	3	3	1	18
Other	6	1	1	0	2	0	0	1	1
Heterosexual	145	38	16	19	20	22	5	6	36
HIV Endemic	2	353	1	5	3	7	1	5	46
IDU	114	8	20	0	0	1	0	4	9
MSM-IDU	40	4	7	1	1	2	0	0	6
MSM	756	132	8	73	42	110	20	27	92
Total	**1,120**	**551**	**56**	**101**	**81**	**145**	**29**	**44**	**208**

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

ARE WE SEEING ANY TRENDS IN TERMS OF ETHNICITY?

Based on the Lab Enhancement Program data, there appears to be an increase in infections among people of Black and Asian ethnicity.

Figure 7. Number of HIV Positive Diagnoses by Ethno Racial Category

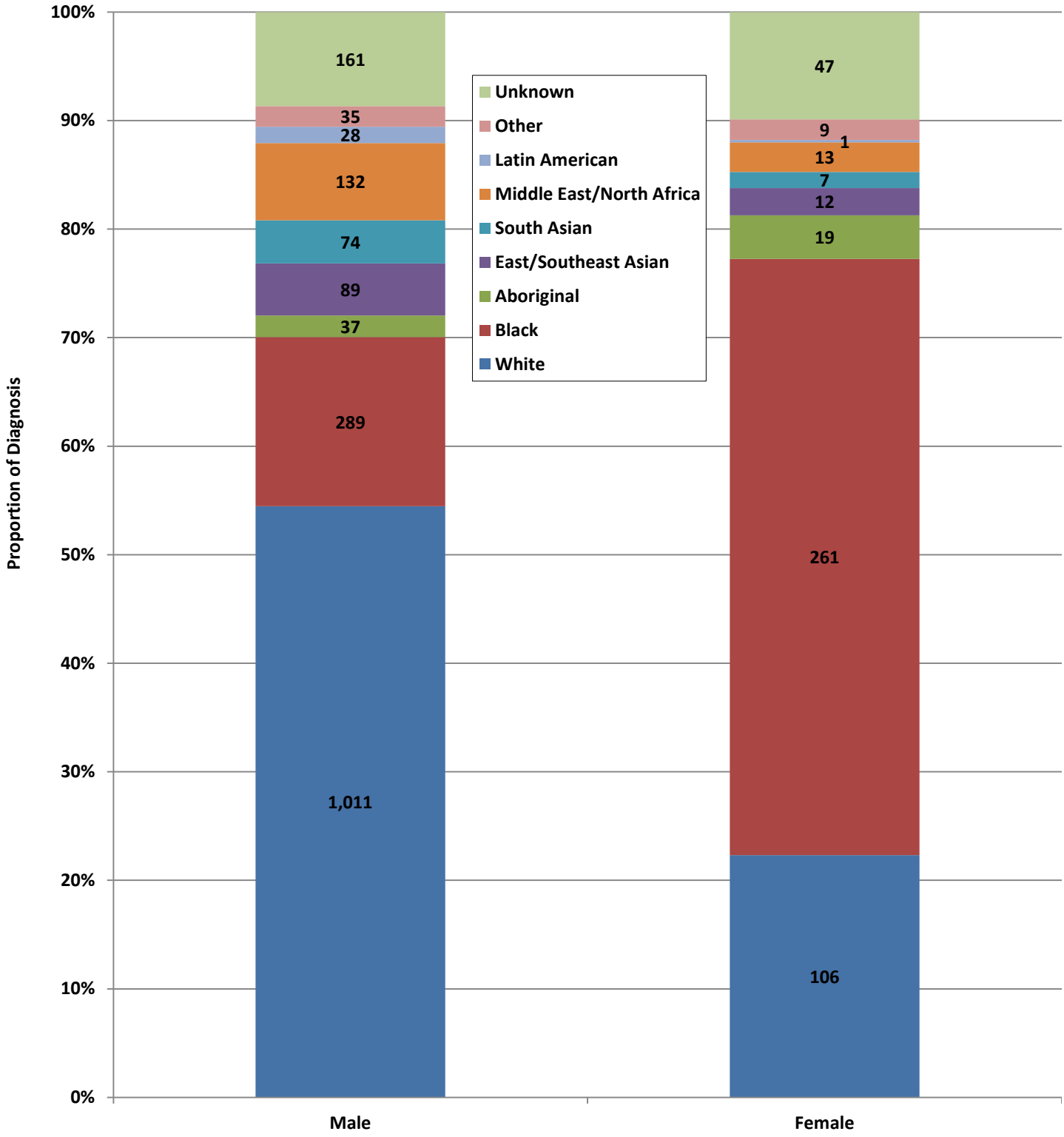


Source: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care

ETHNICITY BY GENDER

In terms of gender, most men diagnosed with HIV were White while most women were Black (African, Caribbean).

Figure 8. Number of HIV Diagnoses by Gender and Ethno Racial Category 2009 - 2012

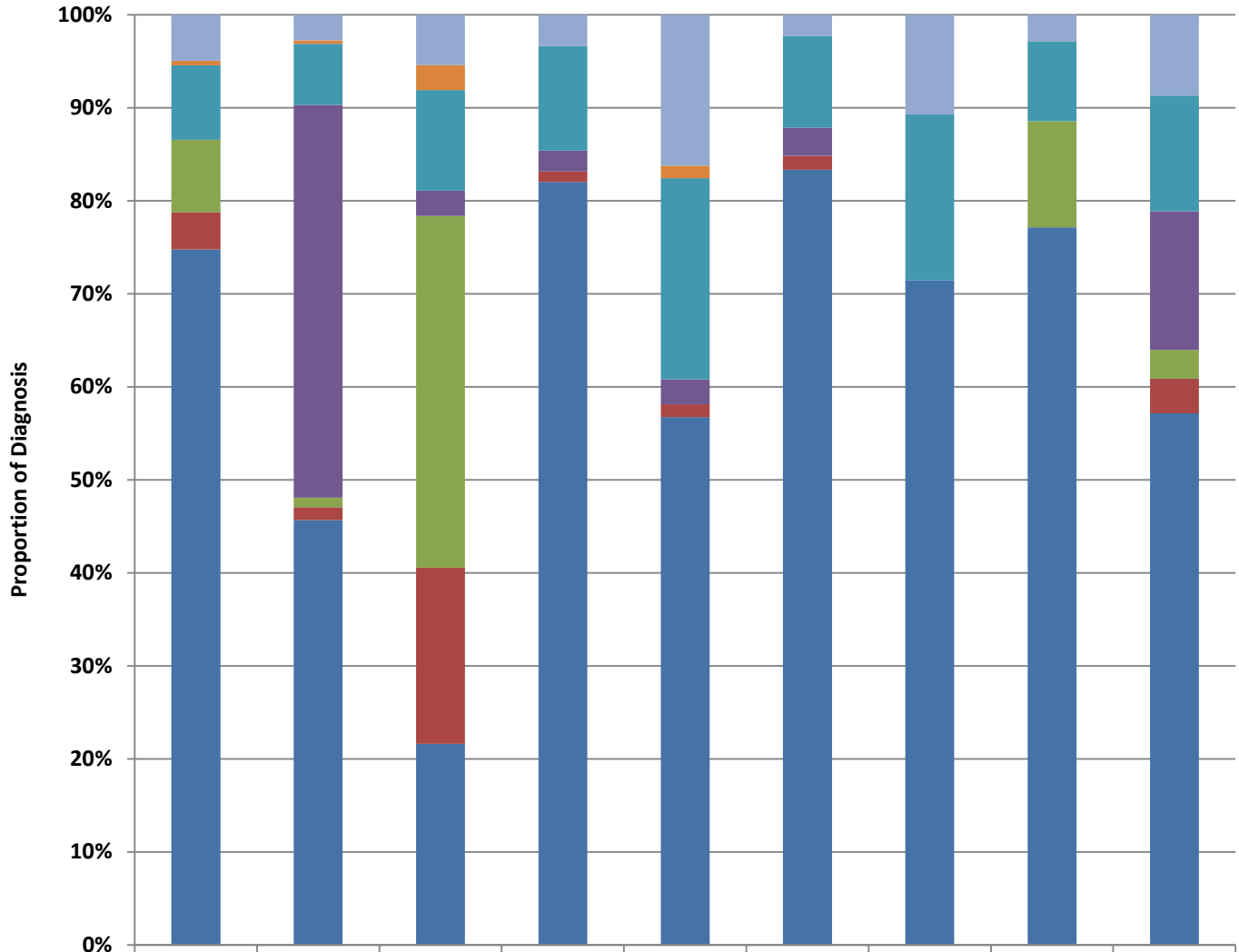


Source: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care

ETHNICITY, GENDER AND RISK

Looking across males with different ethnicities, men having sex with men was the most common risk factor for men who were White, Asian, Latin American and from the Middle East or North Africa. Aboriginal men were more likely to have been infected from injection drug use. For Black men, there were two main risks: men having sex with men and being from a country where HIV is endemic.

Figure 9. Ethnicity by Risk Category – Male 2009 - 2012

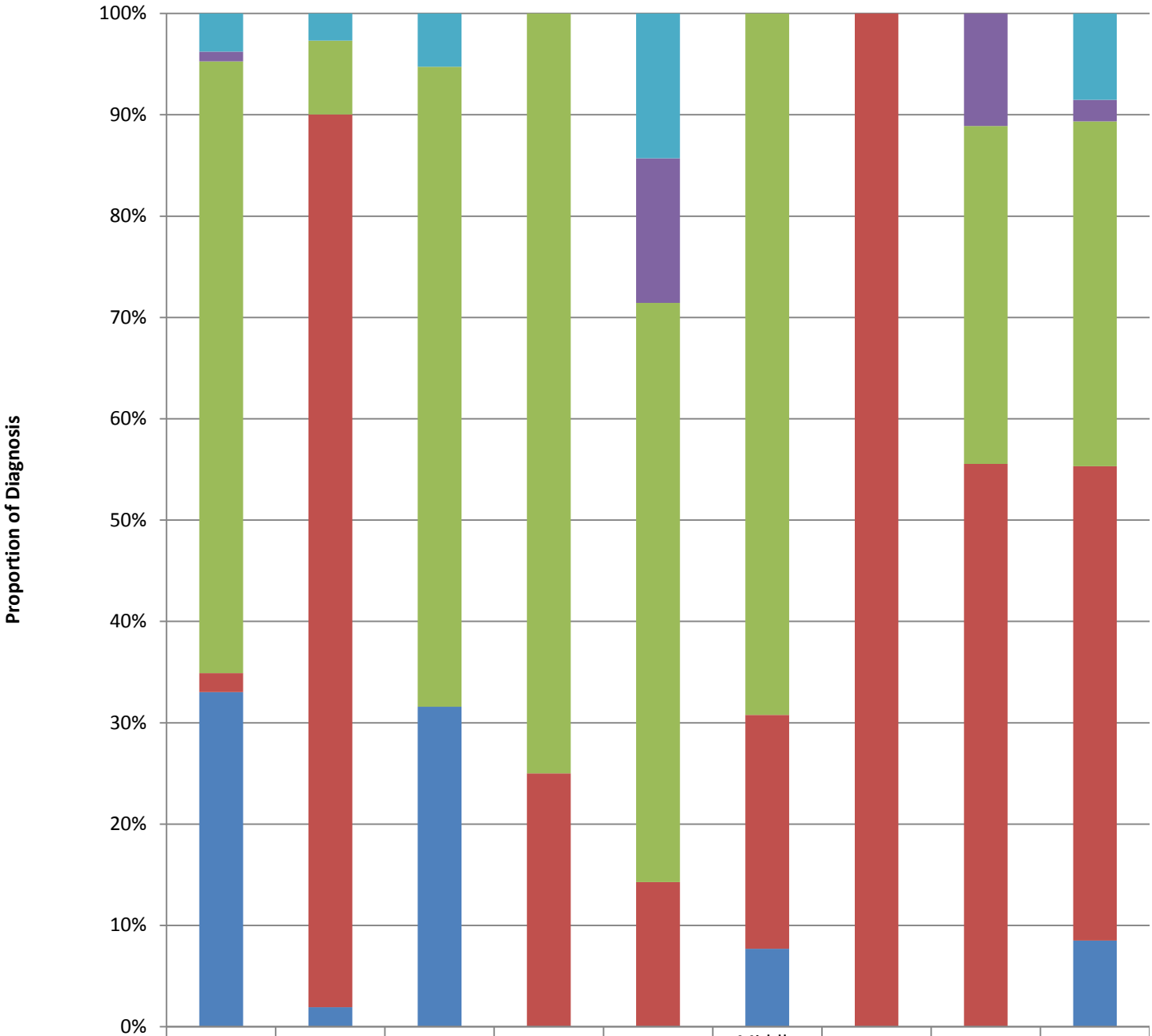


	White	Black	Aboriginal	East/South east Asian	South Asian	Middle East/North Africa	Latin American	Other	Unknown
Unknown	50	8	2	3	12	3	3	1	14
Other	5	1	1	0	1	0	0	0	0
Heterosexual	81	19	4	10	16	13	5	3	20
HIV Endemic	0	122	1	2	2	4	0	0	24
IDU	79	3	14	0	0	0	0	4	5
MSM-IDU	40	4	7	1	1	2	0	0	6
MSM	756	132	8	73	42	110	20	27	92
Total	1,011	289	37	89	74	132	28	35	161

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

For women, the most common risk factor in most ethnicities was reported as heterosexual activity. However, in Black women the most common risk was being from a country where HIV is endemic. Drug use was also a significant risk factor for White and Aboriginal women.

Figure 10. Ethnicity by Risk Category – Female 2009 - 2012



	White	Black	Aboriginal	East/South east Asian	South Asian	Middle East/North Africa	Latin American	Other	Unknown
Unknown	4	7	1	0	1	0	0	0	4
Other	1	0	0	0	1	0	0	1	1
Heterosexual	64	19	12	9	4	9	0	3	16
HIV Endemic	2	230	0	3	1	3	1	5	22
IDU	35	5	6	0	0	1	0	0	4
Total	**106**	**261**	**19**	**12**	**7**	**13**	**1**	**9**	**47**

NEW DIAGNOSES DOWN IN ALL REGIONS EXCEPT SOUTH WEST ONTARIO

All regions except South West Ontario saw a drop in new diagnoses in 2012 compared to the previous year; however, even in the South West the number of new diagnoses in 2012 was lower than in 2009 and 2010.

Figure 11. New Diagnoses are Down in Most Regions

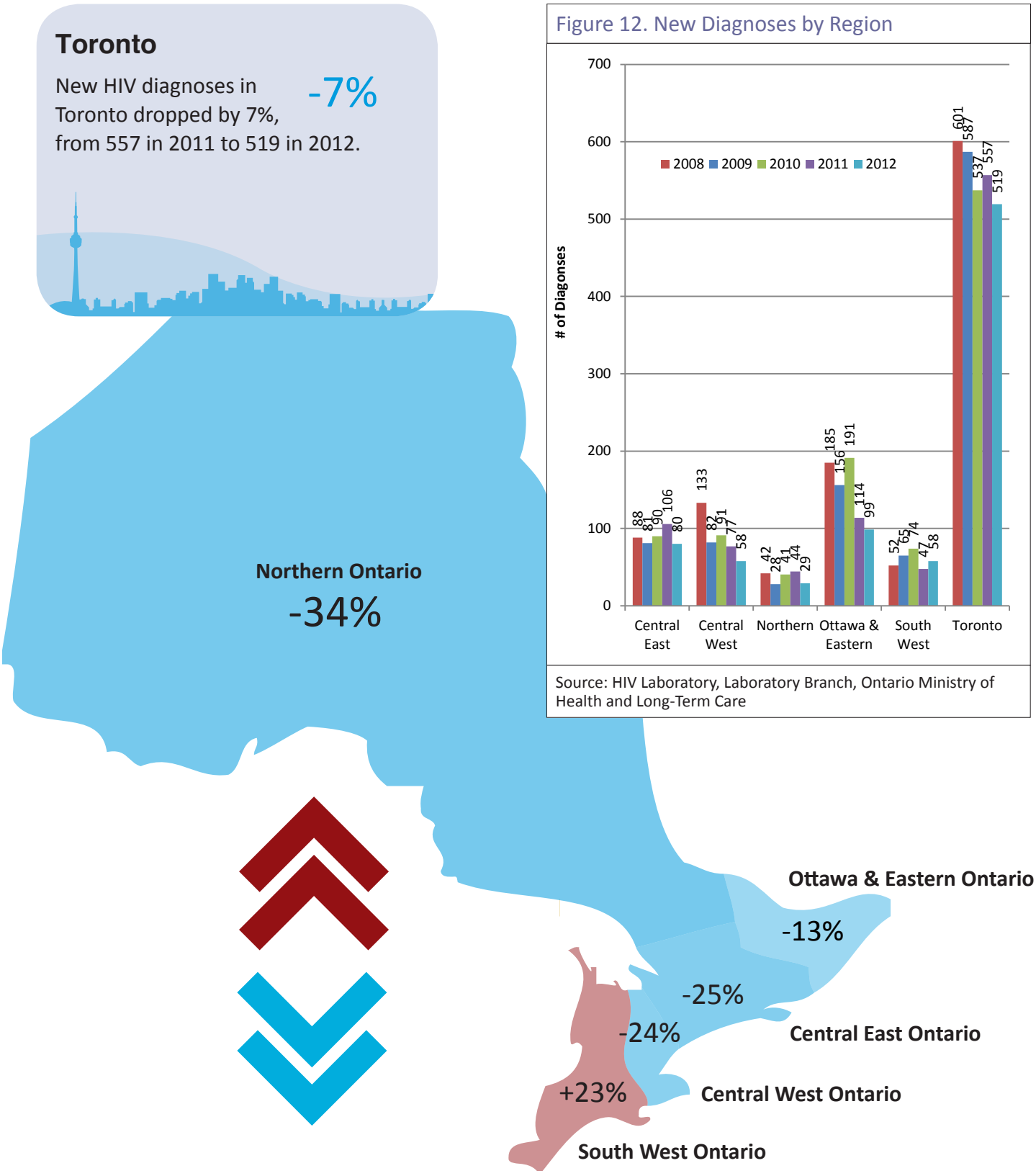


Figure 12. New Diagnoses by Region

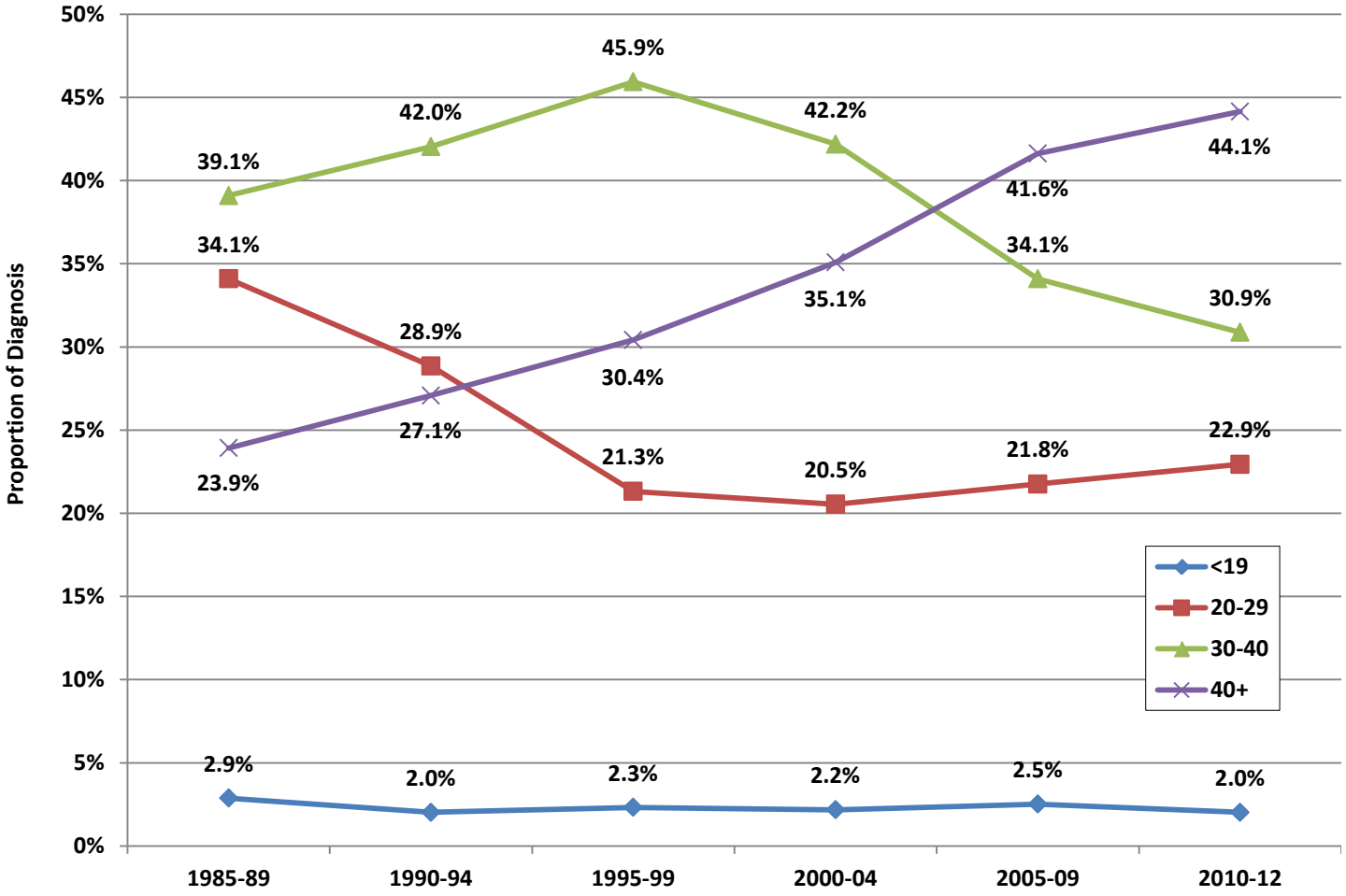
Source: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care

MORE NEW DIAGNOSES IN OLDER ADULTS

IS HIV BECOMING A DISEASE OF OLDER AND YOUNG ADULTS?

We continue to see an aging trend in new HIV diagnoses. Over the past 10 years, people age 40 and older have accounted for a steadily increasing proportion of new diagnoses (almost 45% in 2012). There's also been a slight increase in the proportion of new diagnoses in people between the ages of 20 and 29 – while the proportion of diagnoses in people between the ages of 30 and 40 has dropped. These trends in age at diagnosis argue for prevention programs that target people in specific age groups.

Figure 13. Age at Time of HIV Diagnosis



THE RISK FOR OLDER ADULTS IS MAINLY AMONG GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN

A closer look at the data on new diagnoses in people 40 and older revealed that 81% (285) are male and 19% (69) are female. The most common risk factor for infection among men was having sex with men, while the most common risk factor for women was low risk heterosexual.

III. OCHART ACTIVITIES

1. IMPROVING KNOWLEDGE AND AWARENESS

Activities that contribute mainly to improving knowledge and awareness include education and outreach, as well as IDU outreach services. For the first time in 2012-13, we have more detailed data on organizations' education and outreach initiatives and their impacts.

EDUCATION PRESENTATIONS

STRATEGY WORKERS ENHANCE CAPACITY TO DELIVER EDUCATION THAT TARGETS POPULATIONS AT RISK

The AIDS Bureau funds four initiatives that support 58 population-specific workers in different parts of the province based on the epidemic:

- the Gay Men's Sexual Health Alliance (GMSH)
- African and Caribbean Strategy Workers
- the Ontario Aboriginal HIV and AIDS Strategy (OAHAS)
- the Women & HIV/AIDS Initiative (WHAI).

Their role is to enhance the capacity of community-based programs to reach people at risk of HIV.

In addition to the strategy-specific workers, community-based programs employ another 88 individuals specifically to do education work. These positions are funded either through AIDS Bureau operational funding, ACAP time-limited funding or other operational funding, many of which also target their programming to population specific strategies. Programs also report that others in the agency besides education workers (e.g., executive directors, support workers) are involved in education activities, such as presentations.

EDUCATION PRESENTATIONS TARGET PEOPLE AT RISK

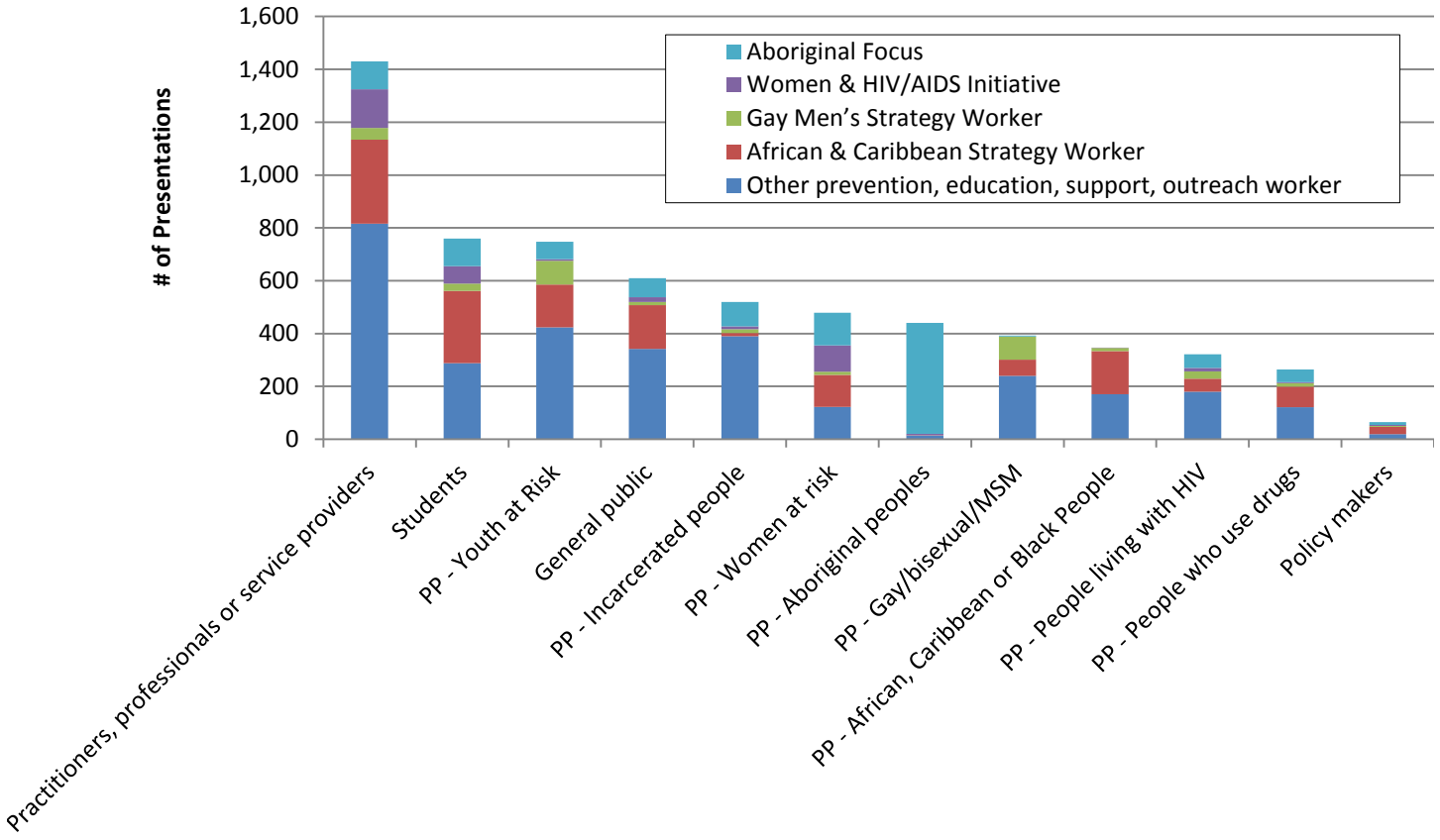
Community-based HIV education programs focus primarily on reaching populations most at risk, which include:

- gay men and other men who have sex with men
- African, Caribbean and Black communities
- Aboriginal peoples
- people who use substances
- people living with HIV
- women at risk
- youth at risk
- people who are incarcerated.

Education programs try to reach populations directly and indirectly (i.e., through other professionals and organizations that serve high risk populations).

OCHART asks organizations to identify the type of worker who delivered the presentation and the target audiences for their presentation. The following chart shows the number of presentations, who made them and the top two target audiences.

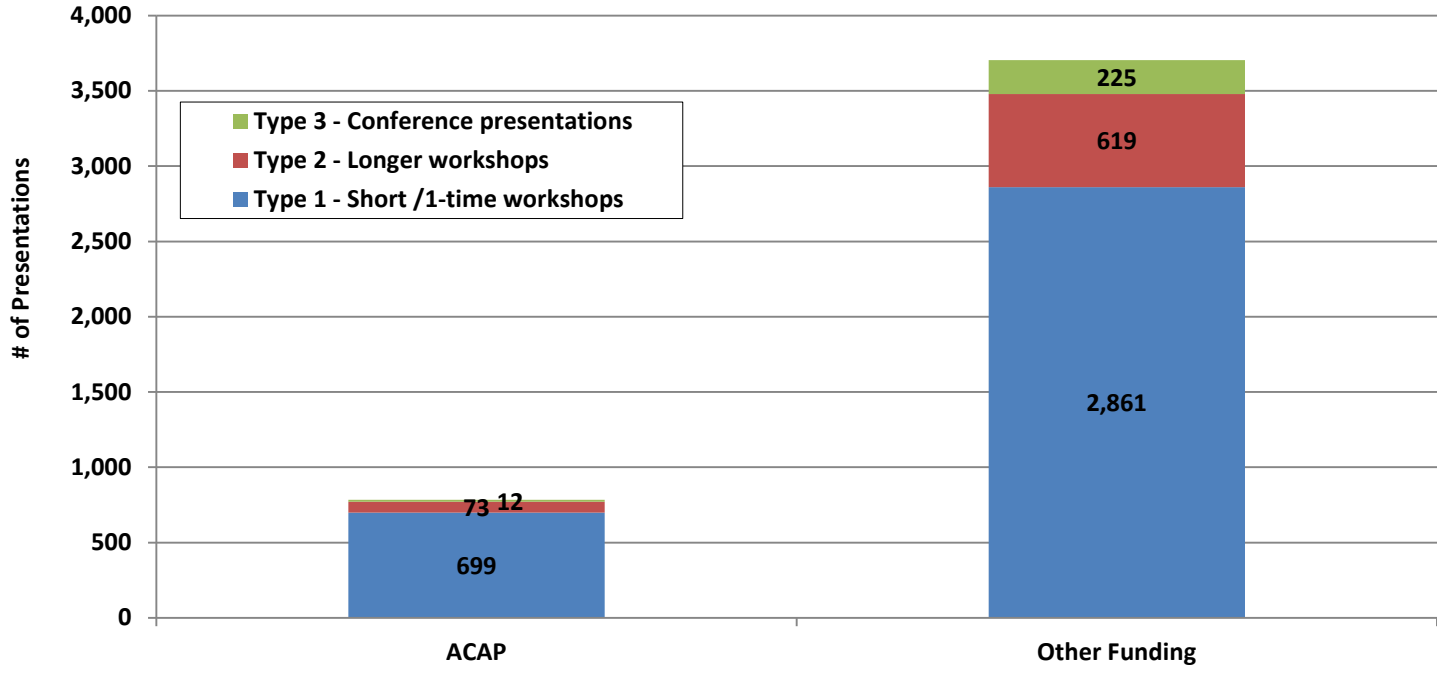
Figure 14. Number of Presentations by Worker Type and Audience 2012/2013



MOST PRESENTATIONS ARE SHORT, ONE-TIME WORKSHOPS

The majority (79%) of education presentations given by community-based organizations are short, one-time workshops – brief talks given to different audiences, while 15% are longer, more in-depth workshops and 5% are presentations at conferences.

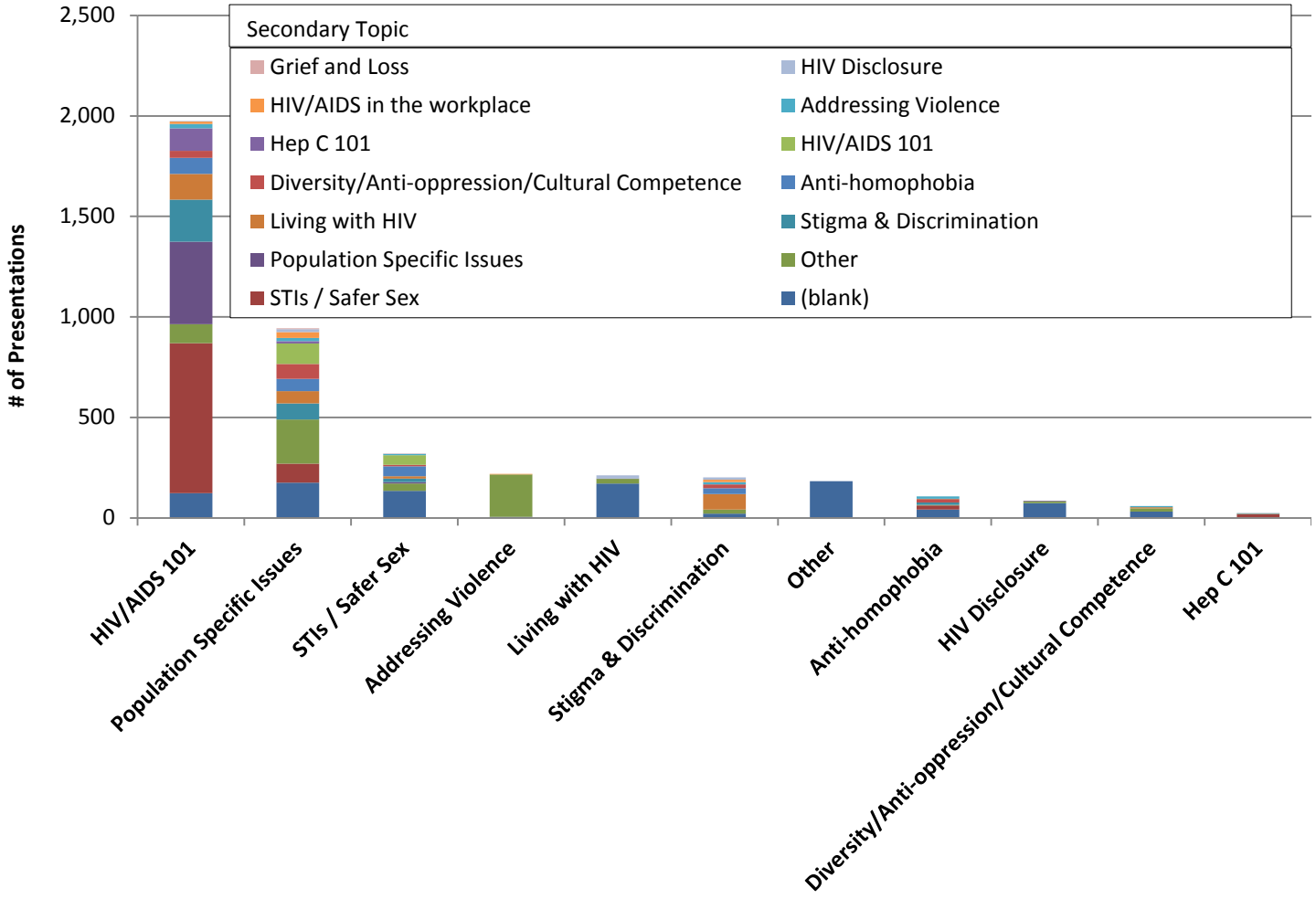
Figure 15. Number of Presentations by Type and Funder



PRESENTATIONS FOCUS ON BASIC KNOWLEDGE AND POPULATION-SPECIFIC ISSUES

As the following graphic illustrates, most education presentations continue to focus on basic HIV knowledge and awareness, followed by population-specific issues, STIs and safer sex. The focus on basic HIV information makes sense, given the large number of short, one-time presentations the organizations provide. In terms of achieving the outcome of improving knowledge and awareness, the one-time presentations are likely effective at raising awareness but may not be as successful as longer workshops in helping people develop knowledge and skills. Should organizations be striving to offer more in-depth workshops or to develop a series of workshops that would help move beyond HIV 101? Or is the focus on HIV 101 necessary to keep educating younger generations and to compensate for turnover in other agencies?

Figure 16. Number of presentations by Focus 2012/2013

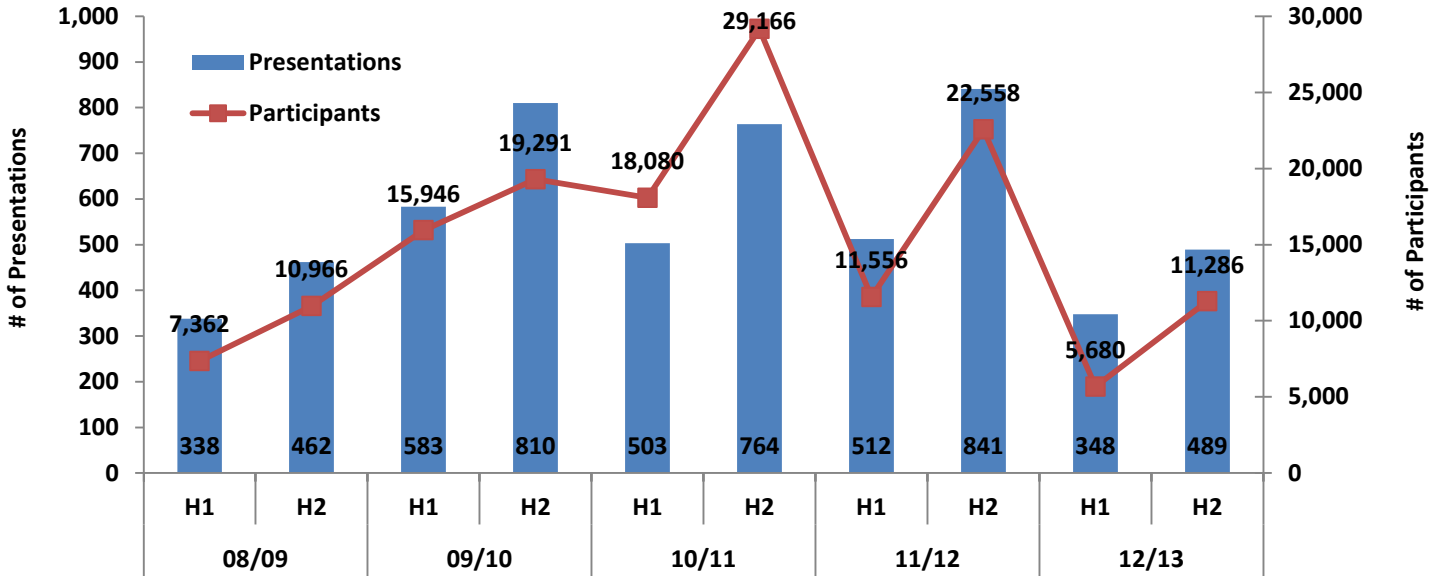


The most common audience for presentations continues to be other service providers. Following that, presentations tend to focus on youth – including both youth at risk and students – and the general public. Among priority populations or populations at risk, there are more presentations to incarcerated people and women than there are to gay, bisexual and other men who have sex with men or to African, Caribbean and Black communities. It is encouraging to see that the investments in gay men's strategy workers and African & Caribbean Strategy workers are contributing significantly to the number of presentations targeting these populations. The large number of presentations that target people who are incarcerated is likely due to the fact that the AIDS Bureau funds a provincial organization dedicated to working with prisoners as well as several community programs in regions with prisons.

FEWER ACAP FUNDED PRESENTATIONS BECAUSE OF LAUNCH OF NEW PROGRAMS

As noted on page 13, ACAP began funding 50 new programs in 2012-13 and previously funded programs ended. Because the new programs were in the start-up phase, there were fewer ACAP-funded presentations to fewer participants than in the previous three years.

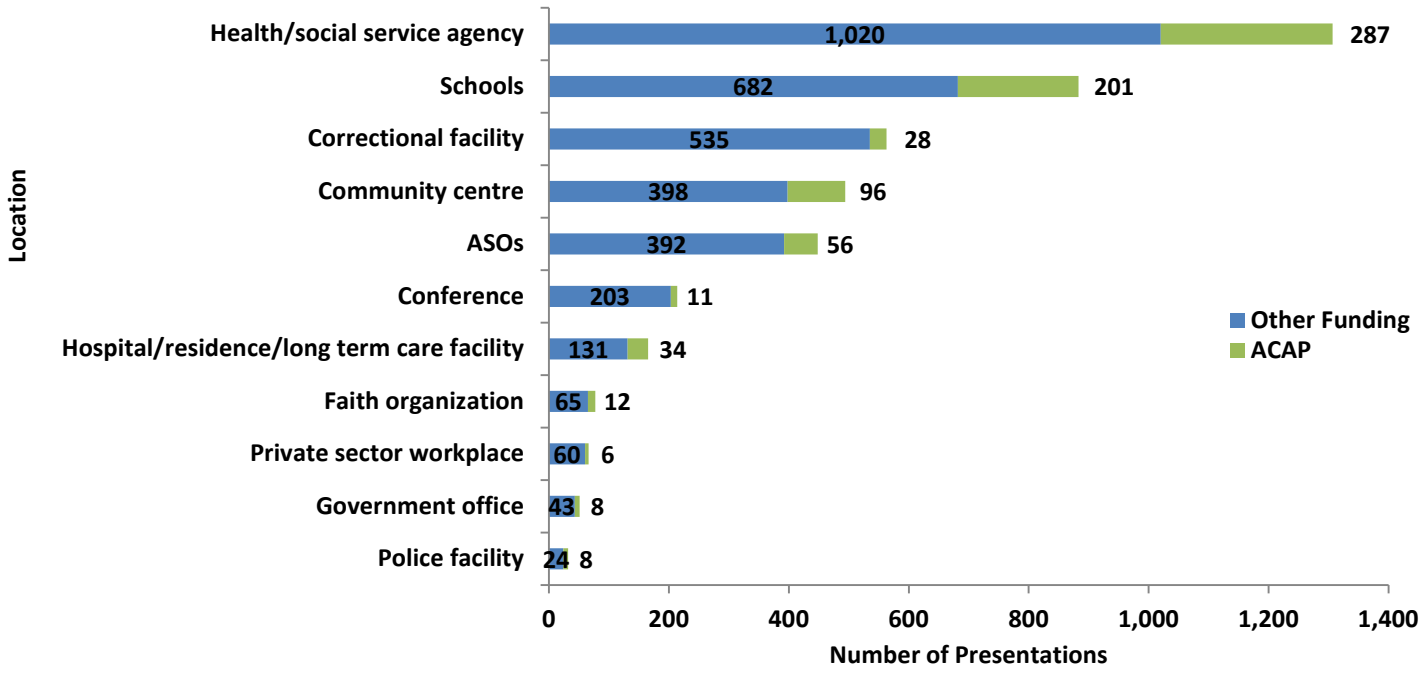
Figure 17. ACAP Funded Presentations and Participants



MOST PRESENTATIONS ARE HELD IN HEALTH, EDUCATION AND SOCIAL SERVICE SETTINGS

Although programs report that most of their presentations are targeted to people with or at risk of HIV, presentations are predominantly held in health, education and social service settings; a much smaller number are held in public settings, such as community centres, faith organizations and workplaces. In some cases, particularly correctional facilities, these settings may be the only way to reach the target population.

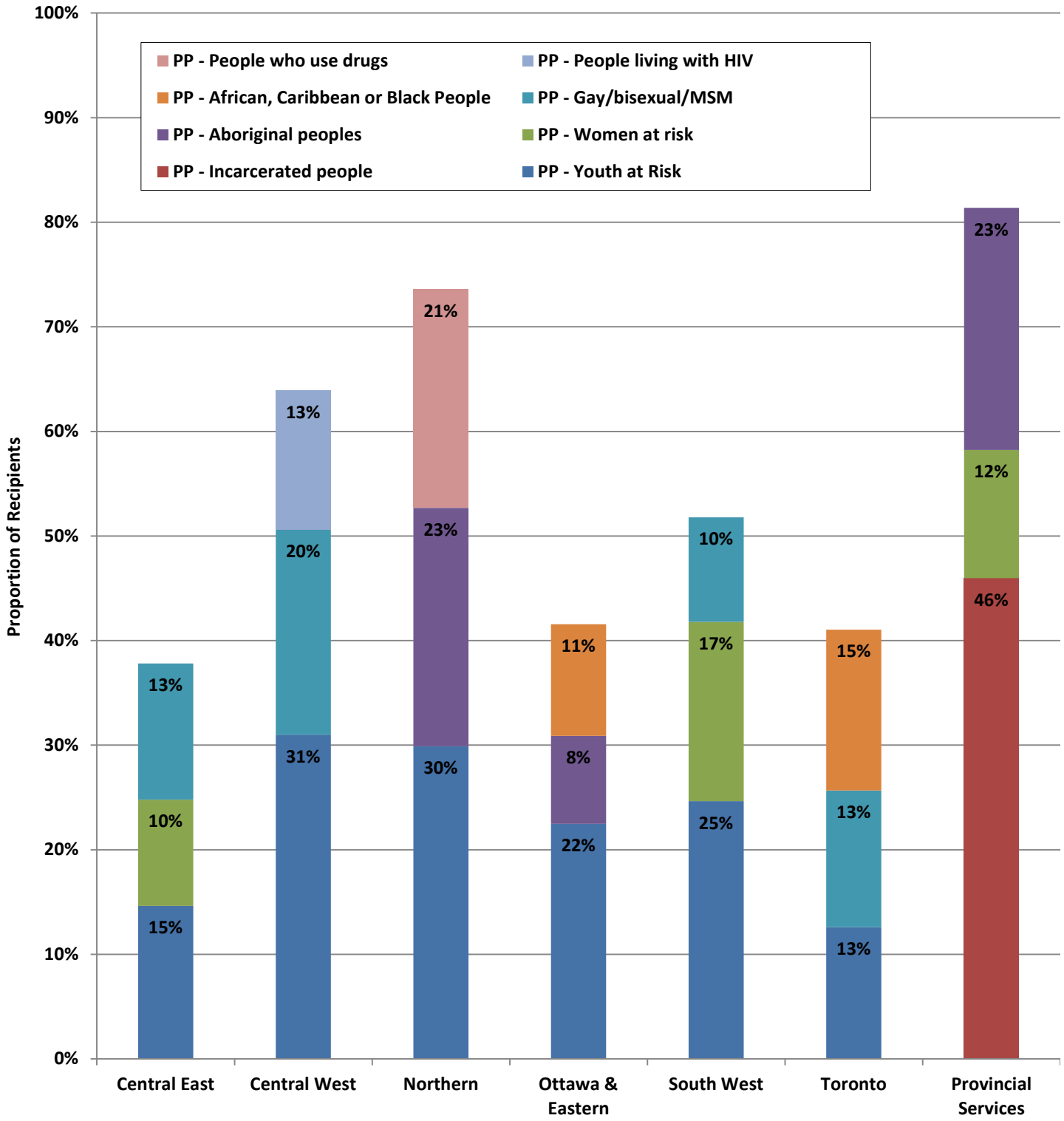
Figure 18. Location of Education Presentations by Funding Source: 2012/2013



DO TARGET AUDIENCES AND TOPICS REFLECT THE EPIDEMIC IN EACH REGION?

The populations targeted and the focus of presentations varies by region. The following figure shows the three main populations targeted for education in each region. For example, more than 70% of education presentations in the Northern Region were to youth, Aboriginal peoples and people who use drugs – which is consistent with the HIV epidemic in the North. The large proportion of presentations related to incarceration reported by provincial services are the result of one organization that focuses on serving current and former prisoners.

Figure 19. Top three Priority Population Education Presentation Recipients Fiscal Year 2012/2013



2012-13 EDUCATION PRESENTATIONS AT A GLANCE

Figure 20. Presentations: Who, What, When and Where

Most presentations are:

79%
Less than two hours and one-time-only.

80%
Held in health, education and social service settings.

45%
Focused on HIV/AIDS 101.

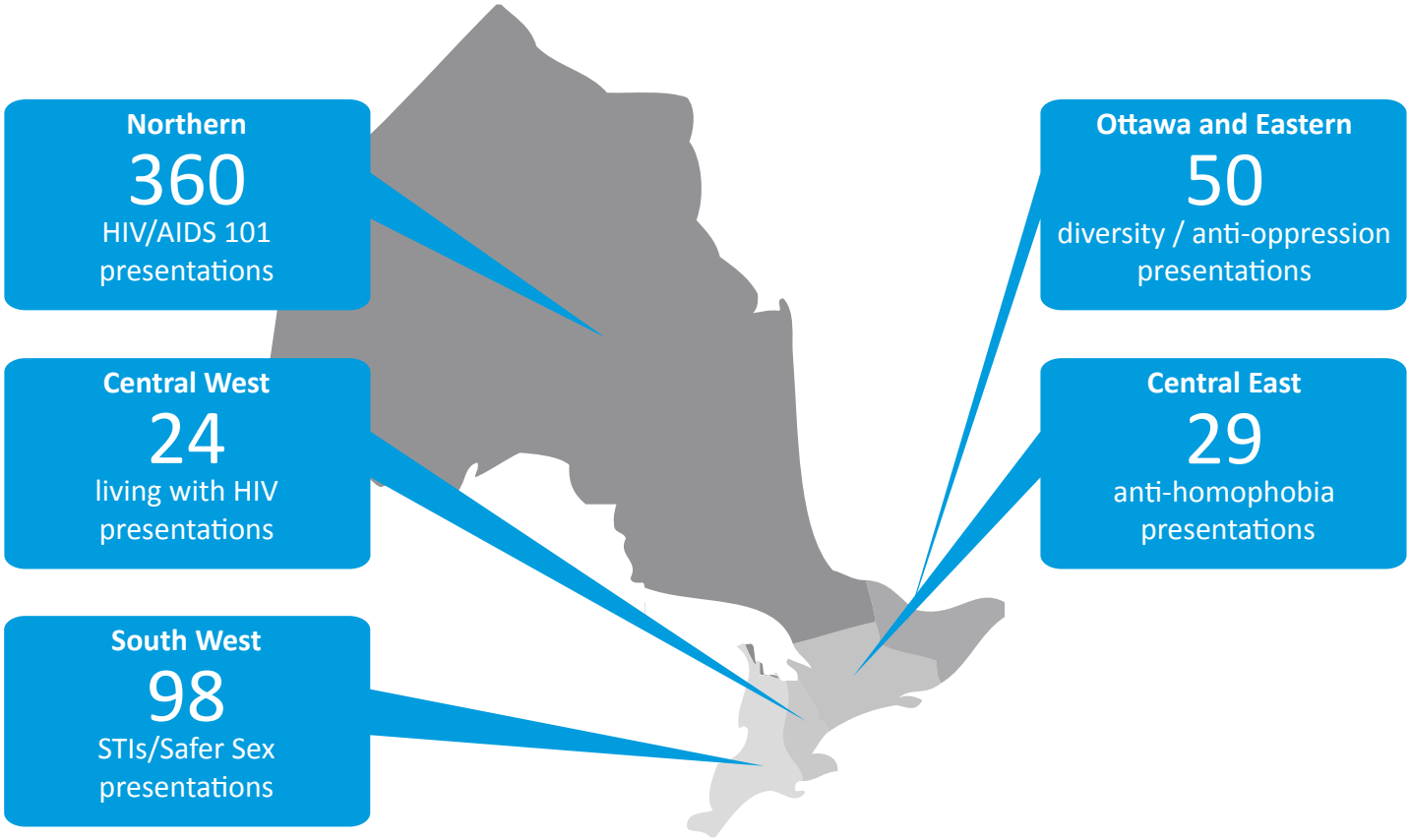
Other key topics.

20%
Population-specific issues

7%
STIs/Safer Sex

5%
Addressing violence

Regional highlights.



RESOURCES

ORGANIZATIONS PRODUCED A SIGNIFICANT NUMBER OF EDUCATION RESOURCES IN 2012-13

Community-based agencies use different education resources to reach different populations. Looking only at the target audiences for presentations may not adequately convey the extent or impact of community-based education efforts. The following graphic shows the number and type of resources targeted to different at-risk populations. It appears that organizations use different resources to reach different populations. For example, organizations used mainly resources and materials to reach gay, bisexual and other men who have sex with men. **This may indicate that organizations find it easier to reach out to this population with information than to bring them to education presentations.** Organizations relied heavily on films and DVDs to reach the African, Caribbean and Black communities, workshops to reach Aboriginal peoples, and brochures to reach women at risk.

Figure 21. Which Populations Receive Educational Resources?

This year, people living with HIV received...

61,338 newsletters and news articles.

32,786 agency promotion brochures.

12,802 health information or support resources.

Gay/bisexual/MSM...

...received **39,188** prevention education brochures.

Women at risk...

94% of resources received by women at risk were prevention education brochures.

African/Caribbean/Black...

...populations received **698** films/DVDs.

Aboriginal people...

...received **304** workshop presentations.

VIDEOS PRODUCED IN 2012-13

Organizations reported producing 20 videos. They are listed here, along with the agency that produced them, in case other agencies would like to see or use these resources.

Figure 22. Videos Produced in 2012-13

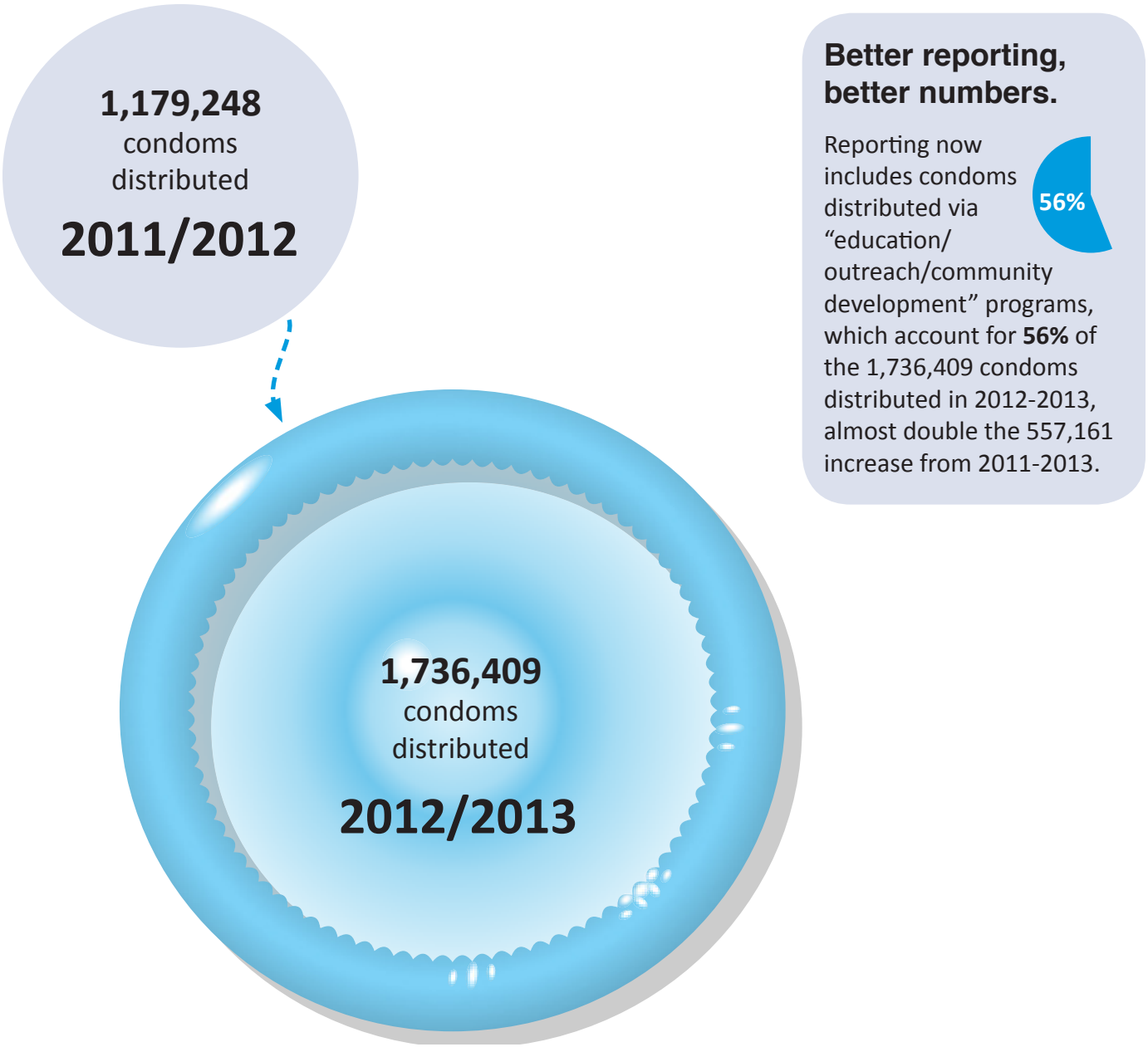
Resource Name	Target Audiences	Organization Name
Burdz n da Beez	Incarcerated people; Youth at Risk	Ontario Aboriginal HIV/AIDS Strategy - SUDBURY
Every Woman Matters A report on accessing primary healthcare for Black women and women of color in Ontario	Women at risk; Practitioners, professionals or service providers	Women's Health in Women's Hands Community Health Centre
HIV/AIDS and Bedside Care for Long term Care Providers	Practitioners, professionals or service providers; Students	Casey House Hospice
HIV/AIDS and Cognitive Concerns for Long Term Care	Practitioners, professionals or service providers; Students	Casey House Hospice
Pilot Video - HIV/AIDS Care for Long Term Care Providers	Practitioners, professionals or service providers; Students	Casey House Hospice
Positive Women - Exposing Injustice	Practitioners, professionals or service providers	"AIDS Committee of Guelph and Wellington County Hamilton AIDS Network"
Protect Your Love	Gay/bisexual/MSM	Alliance for South Asian AIDS Prevention
River of Healing	Aboriginal peoples; Practitioners, professionals or service providers	Union of Ontario Indians
Strong Woman Song	Aboriginal peoples; People who use drugs	Ontario Aboriginal HIV/AIDS Strategy - SUDBURY
Strong Woman's Song. French and English	African, Caribbean or Black People; People living with HIV	AIDS Niagara
Strong Women Song	Aboriginal peoples; Women at risk	Ontario Aboriginal HIV/AIDS Strategy - SUDBURY
Take Back the Night - "Sin by Silence"	General public; Women at risk	AIDS Committee of Windsor
The River of Healing	People who use drugs; Practitioners, professionals or service providers	Ontario Aboriginal HIV/AIDS Strategy - SUDBURY
The Woman I have Become	General public; Practitioners, professionals or service providers	Women's Health in Women's Hands Community Health Centre
The Woman I have Become	African, Caribbean or Black People; Practitioners, professionals or service providers	AIDS Committee of Cambridge, Kitchener, Waterloo and Area
The woman I have become DVD and users guide	People living with HIV; Practitioners, professionals or service providers	Women's Health in Women's Hands Community Health Centre
Tumaini Video - update statistics & edit according to community members suggestions.	African, Caribbean or Black People; Practitioners, professionals or service providers	Somerset West Community Health Centre
Two Spirit Women	Practitioners, professionals or service providers	Ontario Aboriginal HIV/AIDS Strategy - SUDBURY
Understanding how to sign with correct information like interpreters	General public; Practitioners, professionals or service providers	Ont. Assoc.of the Deaf, Deaf Outreach Program
We developed a short film which addresses issues of HIV infection, prevention, disclosure, treatment, stigma and support.	African, Caribbean or Black People; Practitioners, professionals or service providers	Somerset West Community Health Centre

CONDOM DISTRIBUTION UP SIGNIFICANTLY – LIKELY DUE TO BETTER REPORTING

In the revised OCHART, programs now report the number of condoms distributed through three different programs: education and outreach programs, awareness campaigns, and the IDU outreach program (38 programs reported providing IDU outreach; 20 are specifically funded to provide this program).

According to 2012-13 reports, 71 programs distributed a total of 1,736,409 condoms – up significantly (47%) from the previous year. Most of the increase came from education and outreach programs, which indicates that agencies may not have been capturing this information fully in the earlier version of OCHART, or that condoms previously counted under awareness campaigns are now being counted as part of education and outreach. A significant proportion of the increase in the number of condoms distributed is due to several agencies that now have more effective ways to track the number of condoms they distribute across their initiatives.

Figure 23. Condom Distribution Up By 47% Likely Due To Better Reporting



INNOVATION LEADS TO IMPACT

In OCHART, organizations were enthusiastic about their ability to develop a range of innovative education initiatives and resources that are making a difference in their communities.

Figure 24. How Do Education Initiatives Reach Audiences?

Agreements with community media

"We reached an agreement with Regent Park Radio Group... to run radio talks every saturday for half an hour."

A community library:

"Our library collection highlights issues around HIV/AIDS focusing on the South Asian context... subjects [include] sexuality, gender discrimination, and holistic health."

Innovative arts-based exhibitions

"Partnering with the Guelph Lite Theatre... allowed us to reach a new audience conducting anti-homophobia education."

Professional education

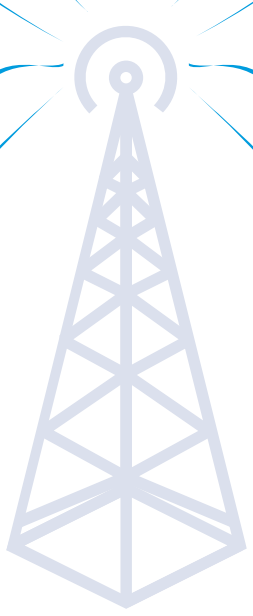
"An educational series of videos has been developed targeted at long-term care professionals and service providers."

Community relationships and visibility

"Presenting at the Aboriginal School in Kingston was incredible. The honesty of the questions and the witty rapport with students was excellent!"

Harm reduction workshops

"We significantly expanded our harm reduction program... [a large increase in the number of educational sessions we provide to at-risk substance users.]"



More languages

"We were able to conduct HIV/AIDS workshops in Somali, Tigray, Trgrayna, Ahmaric and Swahili."

Youth programs

"[There was] a significant increase in youth participation in our bi-weekly Socialite BMSM sexual health drop-in."

BARRIERS TO EDUCATION AND STRATEGIES TO OVERCOME THEM

Organizations continue to encounter barriers and challenges in their education work, including:

- **Stigma** related to living with HIV, harm reduction and homophobia. Because of stigma, many people who could benefit from education are hidden or hard to reach.

"Stigma continues to be a barrier. We have to introduce our training in other ways without mentioning HIV as people get put off by the topic. Screening a video which is educational and entertaining as well allows us to talk about HIV."

- **Clients' complex needs**

"Delivering educational health-positive programming to a marginalized population who are struggling often with concurrent issues of substance abuse, mental health and chronic pain can be challenging. Relationship building with these clients with staff and peer workers allows us to deliver key information in person when people are receiving their supplies."

- **Language and cultural barriers** connecting with different communities, including the lack of suitable, culturally appropriate environments for education

"There is a lack of local relevant information on gay/bisexual/MSM populations. This is a hidden population – the barriers include lack of dedicated space where men congregate (e.g., no designated bars, bath houses), diversity of group with age and interests, secrecy of MSM and hidden nature of the population. The agency continues to be a part of the GMSH's working group of rural men's outreach and network with ASOs and outreach workers with similar barriers. The agency is also exploring undertaking research with other Northern Ontario ASOs (Sudbury, North bay, Simcoe) with the help of the OHTN to better understand the needs of this population."

- **Engaging with other human service providers** such as staff in correctional facilities and school staff who are resistant to more comprehensive education that includes safer sex.

"We have experienced some challenges in the public school board re: distributing safer sex resources (condoms) of late. We have encountered this type of resistance in the separate school board (Catholic board), however such resistance has been exceptional in the public board...At this juncture we will continue to monitor to see if there is any patterning or if we can identify a trend in terms of shifting attitudes towards condom distribution in local public schools." – RHAC

- **Organizational issues**. Many of the organizations are small and struggle with issues such as staff turnover and limited resources for education (i.e., human resources, ethno-specific resources)

"Our staff capacity is limited, and so we provided training for our Speaker's Bureau this quarter in order to use their volunteer support in helping with some of the educational components."

OUTREACH PROGRAMS

Note: This section of OCHART reports specifically on program activities that are non-IDU outreach related. The activities of the 38 programs that report IDU outreach services to people who use substances (i.e. harm reduction) are reported elsewhere – see page 48.

GAY MEN, BISEXUAL AND OTHER MEN WHO HAVE SEX WITH MEN ARE THE MAIN TARGETS OF OUTREACH PROGRAMS

In 2012-13, about one-third of all significant outreach contacts – that is, face-to-face outreach – were with gay, bisexual and other men who have sex with men, and most of those contacts occurred in bathhouses and bars. In addition to the specific IDU Outreach activities reported on page 48, a number of programs also reported a significant number of outreach contacts with people who use drugs in this section. That outreach occurred mainly in the streets, through mobile outreach services and in clinics and health centres (which would be important outreach locations for community health centres).

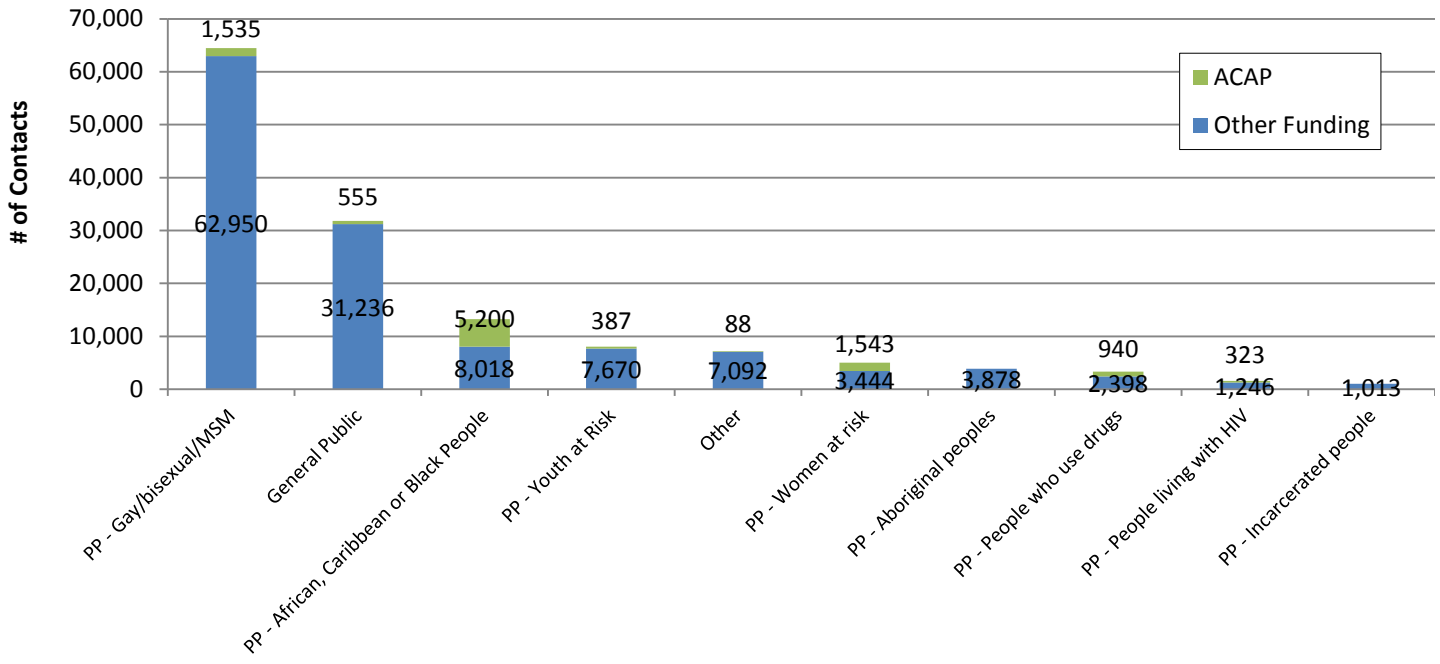
Organizations reported a total of 139,516 brief outreach contacts – usually group contacts at health fairs, street fairs or events like PRIDE.

More than 62,000 (46%) were with gay, bisexual and other men who have sex with men and more than 30,000 of these brief contacts (22%) were with the general public.

Outreach involves workers going out to where people with, or at risk of, HIV socialize or congregate. OCHART now makes a distinction between **significant outreach contacts** – that is, face-to-face, one-to-one outreach – and **brief outreach** – that is, distributing information or answering questions at a health fair or community event.

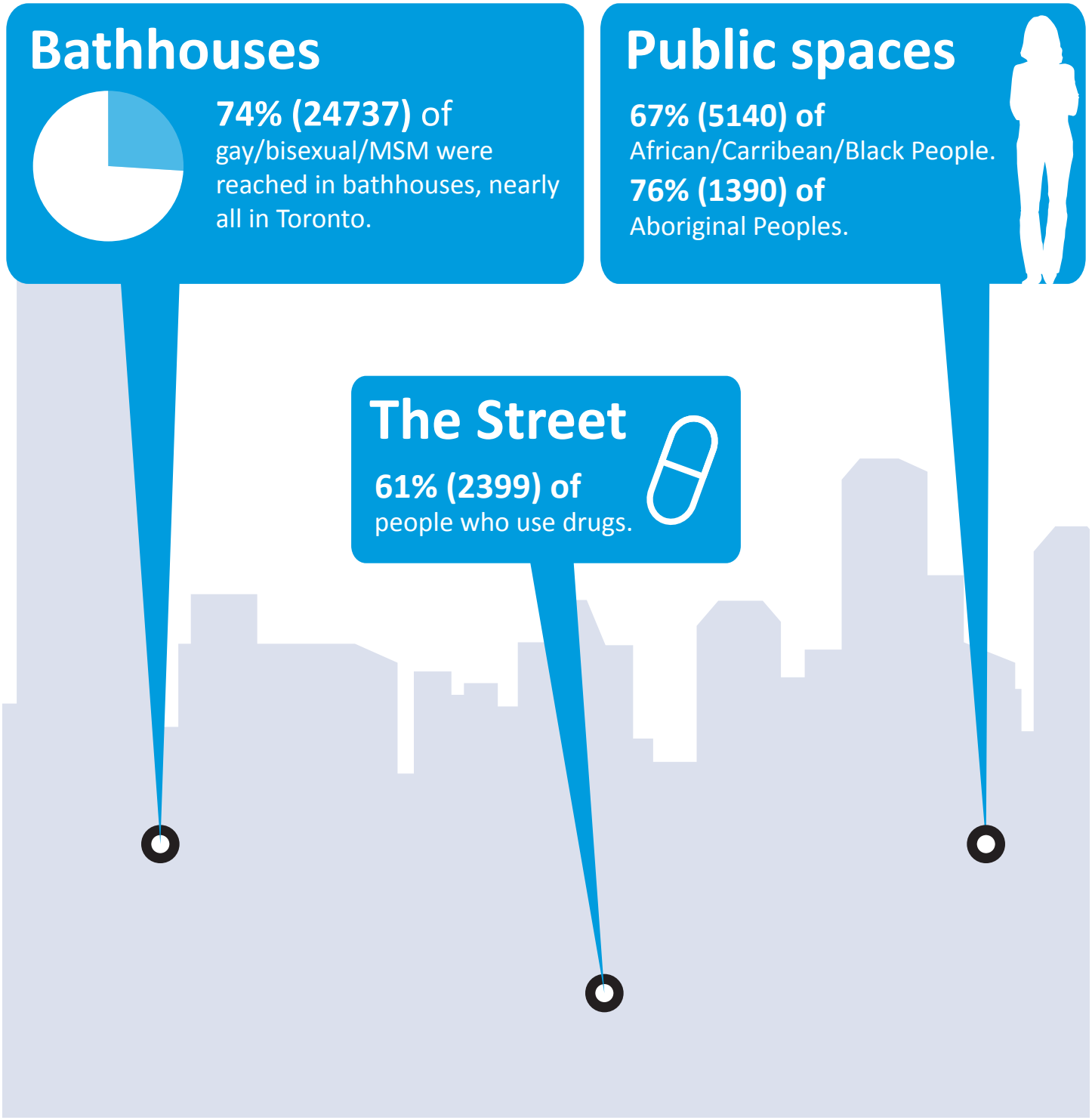
In 2012-13, ACAP funded a total of 18 organizations to deliver outreach services, primarily to distribute health promotion and HIV prevention information to priority populations. ACAP funding supported about 7% of significant outreach and 8% of brief outreach contacts – the vast majority of which (>4500) were in Toronto. The majority of brief contacts funded by ACAP (10,571 in total) were with the African, Caribbean and Black population, women at risk, gay men and people who use drugs.

Figure 25 Number of Brief Outreach Contacts by Population 2012/2013



Community public spaces and other community spaces are also common locations for outreach – particularly for outreach to African, Caribbean and Black communities and Aboriginal people. Outreach to women at risk seems to occur most in drop-in centres, community public spaces, streets, shelters and women's centres.

Figure 26. Where are Clients Reached, and Which Clients?



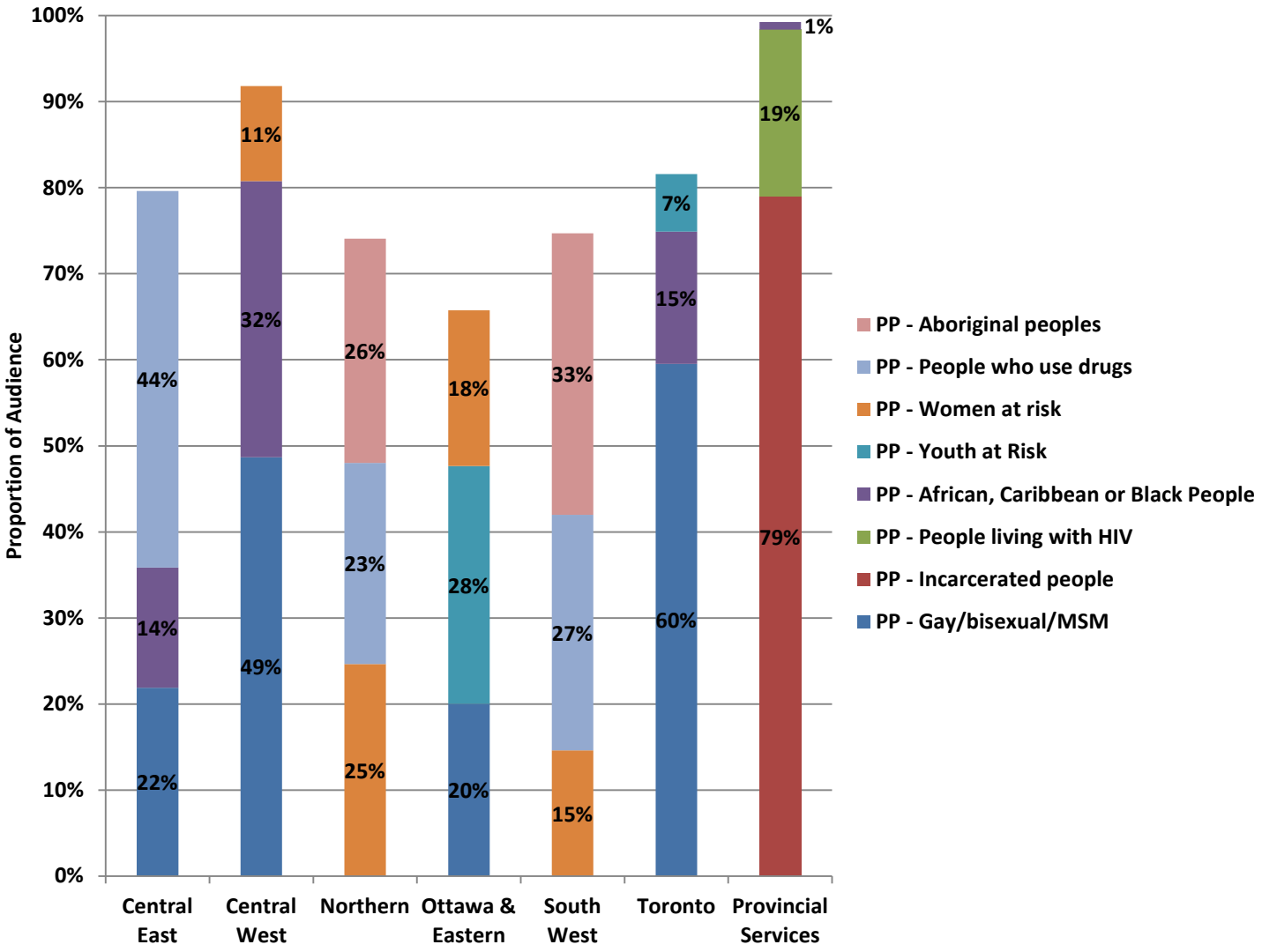
Almost 14,000 significant outreach contacts were with members of the general public. More information is required to understand the purpose and impact of these contacts. Most of the contacts reported as "other" populations were with sex workers.

REGIONS TARGET DIFFERENT POPULATIONS FOR OUTREACH

In terms of the target audience for outreach, there is a great deal of variety across the province, which is likely due to the epidemic in each region and whether there are places in the community where populations at risk, such as gay men or people who use drugs, congregate. Outside larger centres, at-risk populations may be more hidden and harder to reach.

Given the large gay population in Toronto, the prevalence of HIV in that population, and the existence of bathhouses and gay bars, it makes sense that gay men make up 45% of significant outreach contacts in that region. Similarly, it makes sense that over 30% of contacts in Central West are with African, Caribbean and Black communities, given the focus of their programs and that the region has a large ACB community.

Figure 27. Significant Outreach Contacts by Region and Target Audience FY 2012/2013



The large proportion of outreach contacts with incarcerated people reported by provincial services reflects the work of one program whose mandate is to serve that population.

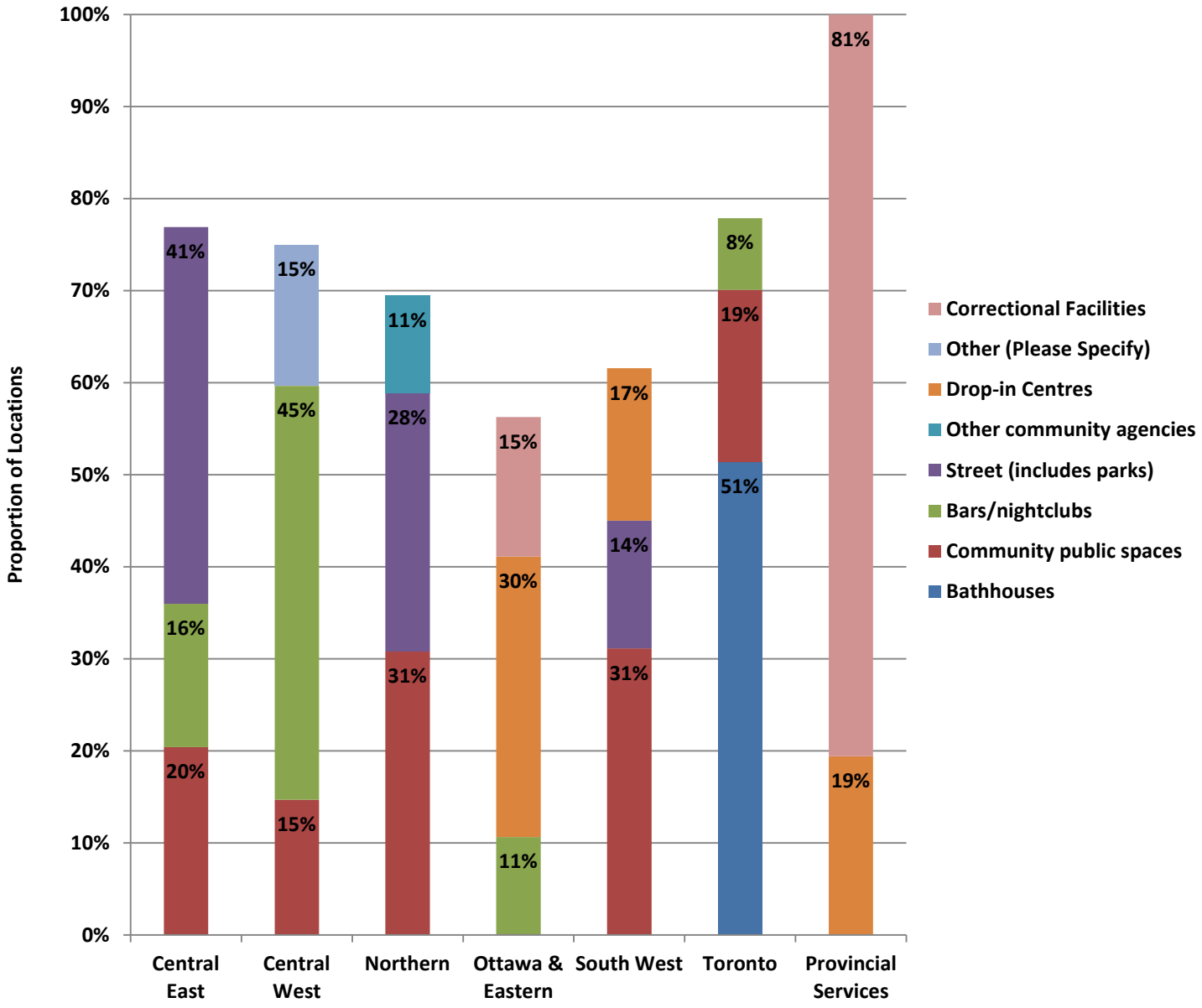
Note: There was no OAHAS worker in the North for part of 2012-13, which may mean that the number of outreach contacts with Aboriginal people do not reflect usual practice.

SMALLER URBAN CENTRES USE A RANGE OF COMMUNITY SETTINGS TO DELIVER OUTREACH SERVICES

Figure 28 reinforces the importance of shaping outreach programs to take advantage of local opportunities. In a city like Toronto that has several bathhouses, a significant amount of outreach can be delivered there. However, in other communities, outreach workers have to rely more on other settings, such as community public spaces (Central East, Northern and South West), drop-in centres (Ottawa & Eastern, South West) and streets (Central East, Northern, Southwest). Mobile services seem to be increasingly important in Central West, Central East and Ottawa.

> *"The success of [our] drop-in in reaching a diverse population within the LGBTQ+ youth is a significant highlight, especially when considering evidence that LGBTQ+ youth who experience additional barriers such as race or physical disabilities are especially vulnerable to HIV. Youth have informed staff that attending [our drop-in] was the highlight of their week."*

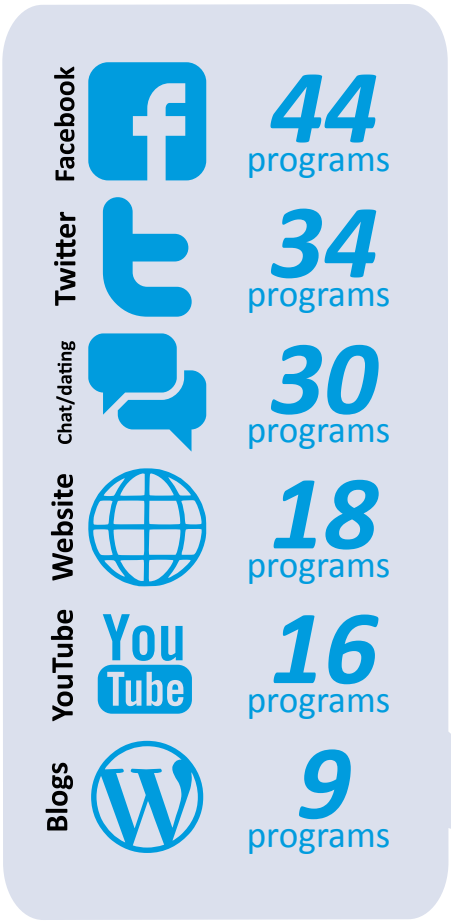
Figure 28. Significant Outreach Contacts by Region and Location FY 2012/2013

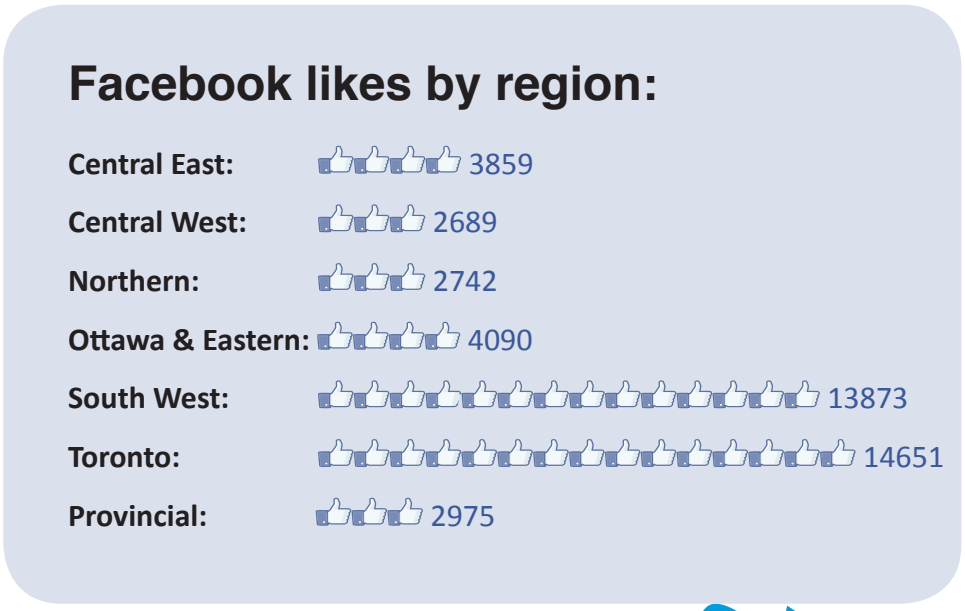


AGENCIES LOOK TO SOCIAL MEDIA TO REACH TARGET POPULATIONS

In 2012-13, a total of 50 programs reported using at least one form of online and social media outreach with 24 reporting using all six forms. The most common social media outreach was through Facebook and the organizations' web sites.

Figure 29. Who's Using Social Media and How?





538003
Website views

37906
Facebook interactions

4681
Re-tweets

"As more gay men switch to 'app'-based social/sexual networking sites (e.g. Grindr, Scruff), we have moved to doing outreach on these platforms."

DOES SOCIAL MEDIA OUTREACH WORK?

Although only 34 programs reported using their website for outreach, those websites appear to be quite active, with a significant number of returning visitors. However, there is no analysis on who those visitors are or what they are viewing or accessing from the websites.

Several organizations described the impact of their social media outreach in more detail:

> *"Social media such as Twitter and Facebook have greatly increased our interactions with specific populations [and they help us] to keep communities informed."*

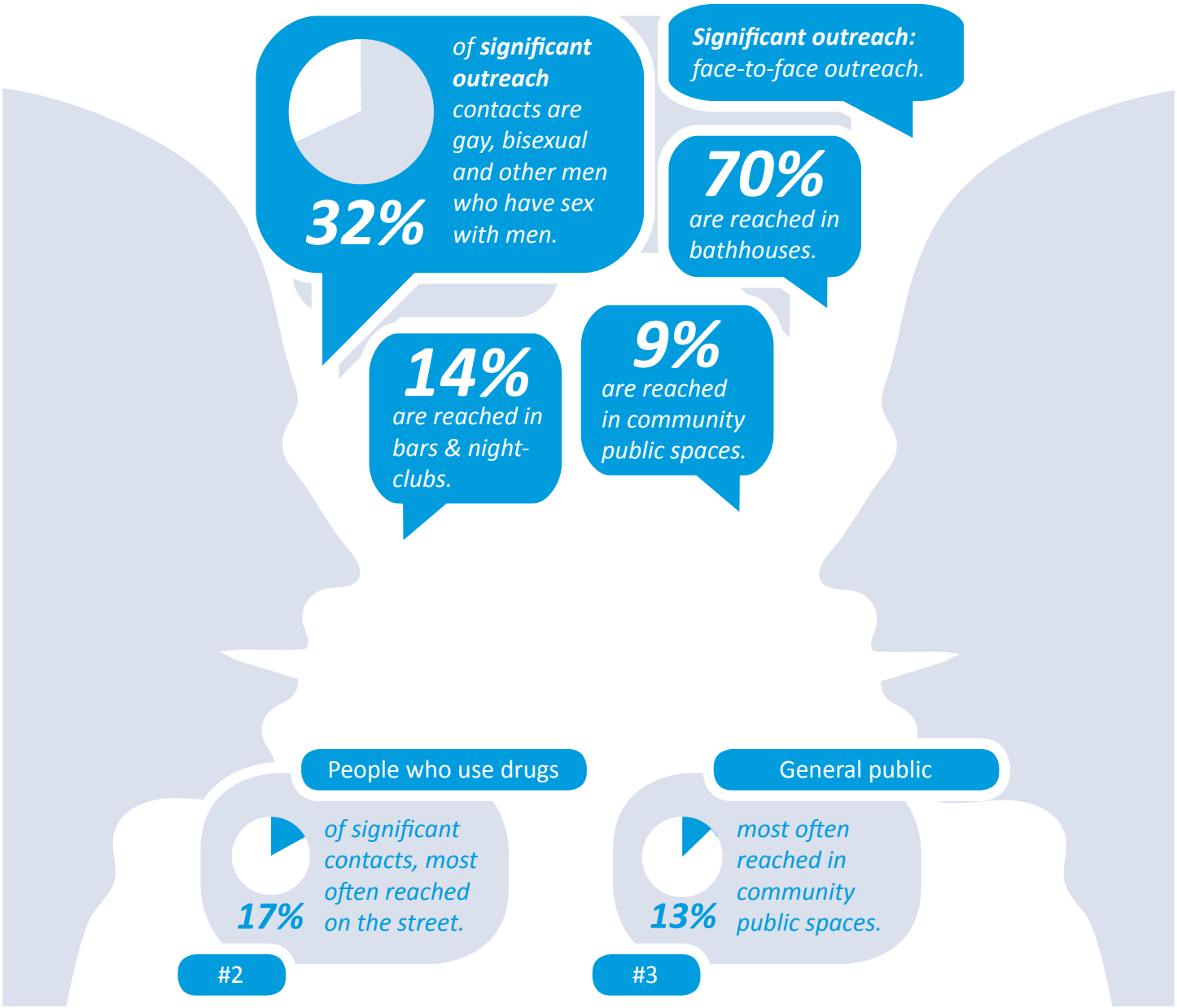
> *"We have begun to use social media a lot more to keep our communities informed. Using blog postings and Twitter feeds to engage with our community and other service providers. We have seen an increase in online engagement and awareness of our agency and our services."*

> *"Online or app based outreach has proven to be an effective way to reach and converse with MSM in particular. This has led to greater awareness and discussion of HIV/AIDS, STIs, and testing options."*

It would be worthwhile having a broader discussion about which types of social media are most effective in terms of outreach. For example, a blog may not be as widely read as a Facebook post but it may provide more in-depth information/discussion and lead to a stronger outreach connection.

2012-13 OUTREACH SERVICES AT A GLANCE

Figure 30. Gay Men Are The Number One Group Targeted For non-IDU Outreach



THE IMPACT OF OUTREACH SERVICES

In addition to the impacts described above, organizations discussed the advantages of outreach as a way to:

- **Link people to services**

"The PHA bathhouse outreach workers are making a lot of referrals for people who are interested in getting tested for HIV and STIs and engaging with people by disclosing their HIV status. They are also highly knowledgeable about connecting with people and peer education. People are thanking us for the outreach work."

- **Reach ethno-specific groups**

"Two main printed outreach materials were developed during this period that helped our program reach a vast number of audiences specifically Spanish speaking at special events and in bars and bathhouses to engage them in our program services."

- **Engage with hard-to-reach populations**

"We have been connecting with more at-risk individuals through our partnership with the local needle exchange program [which] has brought more feedback about how we can better serve the needs of this target population."

- **Increase awareness of the organization and its services**

"Over this reporting period we have also organized a team of volunteers that conduct street outreach on a weekly basis and during this outreach one individual is responsible for carrying a sign that mentions the agency's logo which has led to many discussions about what we do and how we support our community. These interactions have led to new outreach opportunities for the agency."

"The videos on our YouTube channel continued to receive many views throughout the reporting period. The videos allow a wide audience to learn about The Teresa Group and the work that we do, as well as hear about living in a family affected by HIV from the children, youth, and their families."

- **Recruit volunteers**

"As a result of outreach efforts, several members of local ACB communities have expressed interest in volunteering with the agency, and the majority of those interested have followed through... by taking part in the agency's volunteer training process."

BARRIERS TO OUTREACH AND STRATEGIES TO OVERCOME THEM

Organizations are actively working to overcome the challenges and barriers to effective outreach, including:

- **Stigma**, including fear of criminalization, prevents people at risk from engaging with outreach workers

"Stigma in our communities is still very present and affects the engagement of potential volunteers. We are still working on a strategy to address this through our situational assessment. Due to stigma and discrimination in the community and within self (PHA) – valuable stories of PHAs, which have been proven to change community perception of who is living with HIV and participants reporting they will change behaviour regarding safer sex, are not being represented."

"Fear of criminalization is a barrier to people discussing HIV. We are conducting forums and information sessions on criminalization [to try to reduce the fear]."

"Our primary barrier is the criminalization of sex work and the possession of condoms. Over the years our efforts in reaching sex workers has had limited success. However, we hope that persistence will pay off and that our new condom packaging (to look like menstrual pads) will reassure women that the police will not identify packages as condoms."

- **Community issues**, such as the lack of spaces where programs can conduct outreach, the decline in venues catering to the LGBTQ population, and the fragmentation of populations

"Restricted access to community space has been an ongoing barrier to the Community Outreach Program. Gatekeeper mentality has been consistently present across the city sometimes making it extremely challenging to reach targeted populations, especially those within the ages 30-45. In an effort to address these issues, the program lead, with the support of management, have recruited an Adult Peer Educator who will help to bridge some of the gaps as well as support social media aspect of outreach where we are hoping to connect with these individuals."

"Gay, Bi, and MSM bar-related outreach has become more and more challenging in London. It can be difficult to significantly engage gay, bi, and MSM at any venue in the city owing to stigma, the social organization of the local GBMSM community, and the city's generally conservative sociopolitical climate. In addition, the declining number of venues that cater to LGBT communities in London challenges traditional outreach efforts...To try and address these barriers, we are currently trying to pair our outreach activities with events that are already taking place..."

- **Language and cultural barriers**

"Latin American or Spanish speaking MSM still have a strong internalized homophobia that we're trying to address with cultural competence while we approach them. We developed a new concept of sexual health approaches to provide self-esteem and pride while coming out, or when living with HIV is the issue. The approach is basically to think the same way as the Latin American "Man" thinks when facing sexual desires for another "Man" and not assume that coming out doesn't need to be a feminine thing."

"Some of the challenges in our outreach work have been around language needs of those we are outreaching to and not having staff members who can speak every language. We have been addressing this by outreaching to local cultural and neighbourhood groups so they can support linguistic and translation needs when we are doing outreach. We have also been building our volunteer team in language skills and currently have 29 languages represented on our team."

- **Lack of technical skills** required to manage successful social media outreach.

"One of the challenges internally has been building shared understanding around the use and power of social media. We are developing a more relevant technology policy and educating staff."

- **Organizational issues**, such as the vastness of the areas some organizations cover, human resources and the challenges of engaging volunteers and peers in outreach work

"Again, due to the small staff numbers we are not always able to be out in the community but work to make sure that outreach opportunities that are the most valuable to our target population are attended by at least one team member."

"Region is very vast, there are still many areas that are not covered. We are working with our volunteers and student placements to increase our outreach. We are also ensuring to participate in many community events in order to increase our reach."

IDU OUTREACH SERVICES

A total of 38 organizations reported providing IDU outreach services; of those, 20 are funded by the AIDS Bureau specifically for IDU outreach workers and services.

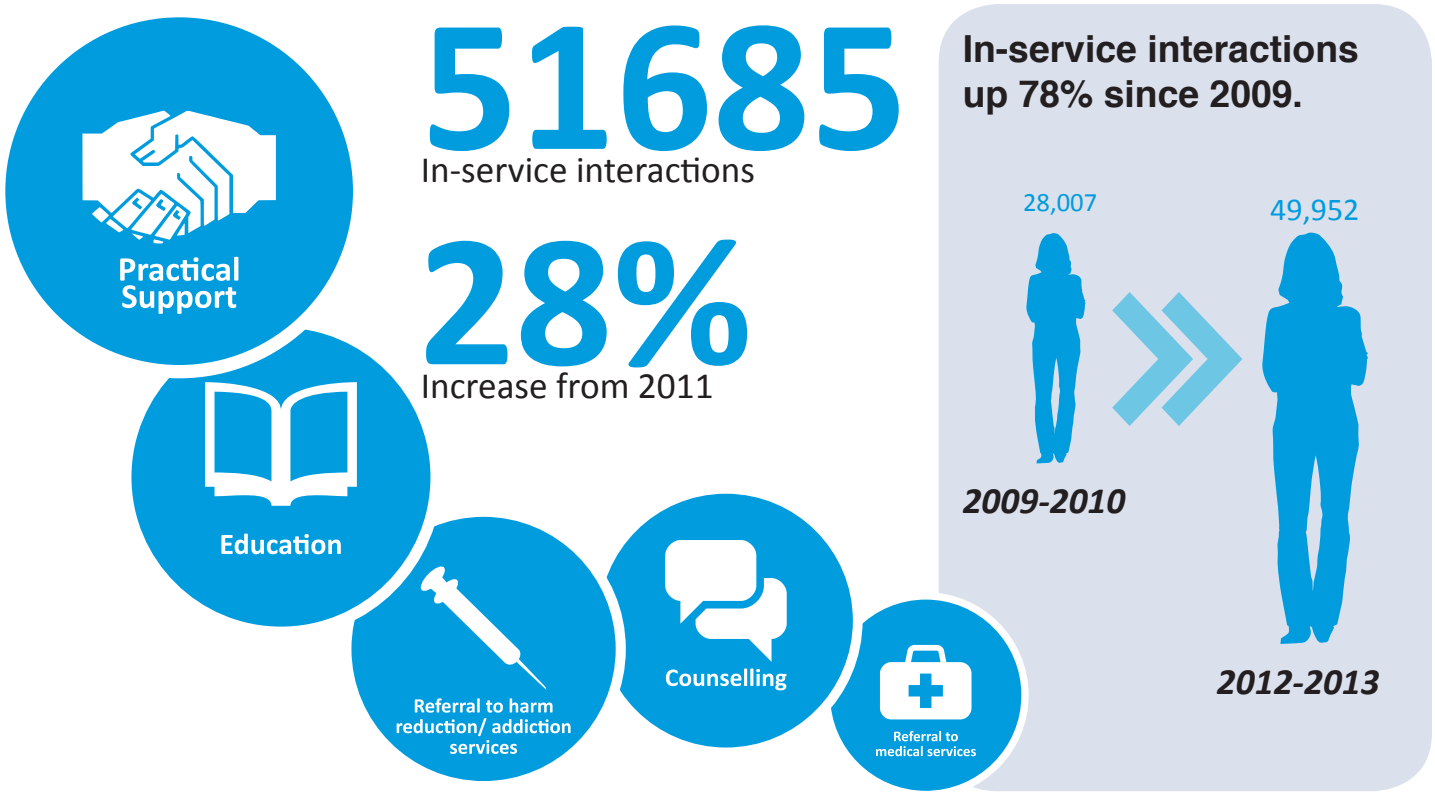
DRUGS OF CHOICE CONTINUE TO BE MAINLY OPIATES, CRACK AND ALCOHOL

Substance use continues to be a driver in Ontario's epidemic. It contributes to new infections through sharing of drug use equipment and through the disinhibiting effects of substances on sexual behaviour. Patterns of drug use vary slightly across the province, however, in general, organizations report the most commonly used substances continue to be opiates, crack and alcohol. In 2012-13, three regions – Northern, South West and Ottawa & Eastern – saw a significant increase in the use of morphine (non-prescribed). Four regions – Toronto, Northern, Ottawa & Eastern and Central West – reported increased use of methamphetamine.

MORE PEOPLE ARE ACCESSING IDU SERVICES – MAINLY FOR PRACTICAL SUPPORT

IDU outreach programs reported fewer client interactions in 2012-13 (76,881) than in the previous year (83,133), as more of their clients accessed services in their agencies. In particular, programs saw an increase in demand for practical support, education, referrals and counselling – which indicates that they are forming trusting relationships with drug users in their community, who are then better able to engage in care.

Figure 31. More In-Service Interactions for Practical IDU Support



IDU SERVICES NURTURE RELATIONSHIPS WITH PARTNER AGENCIES

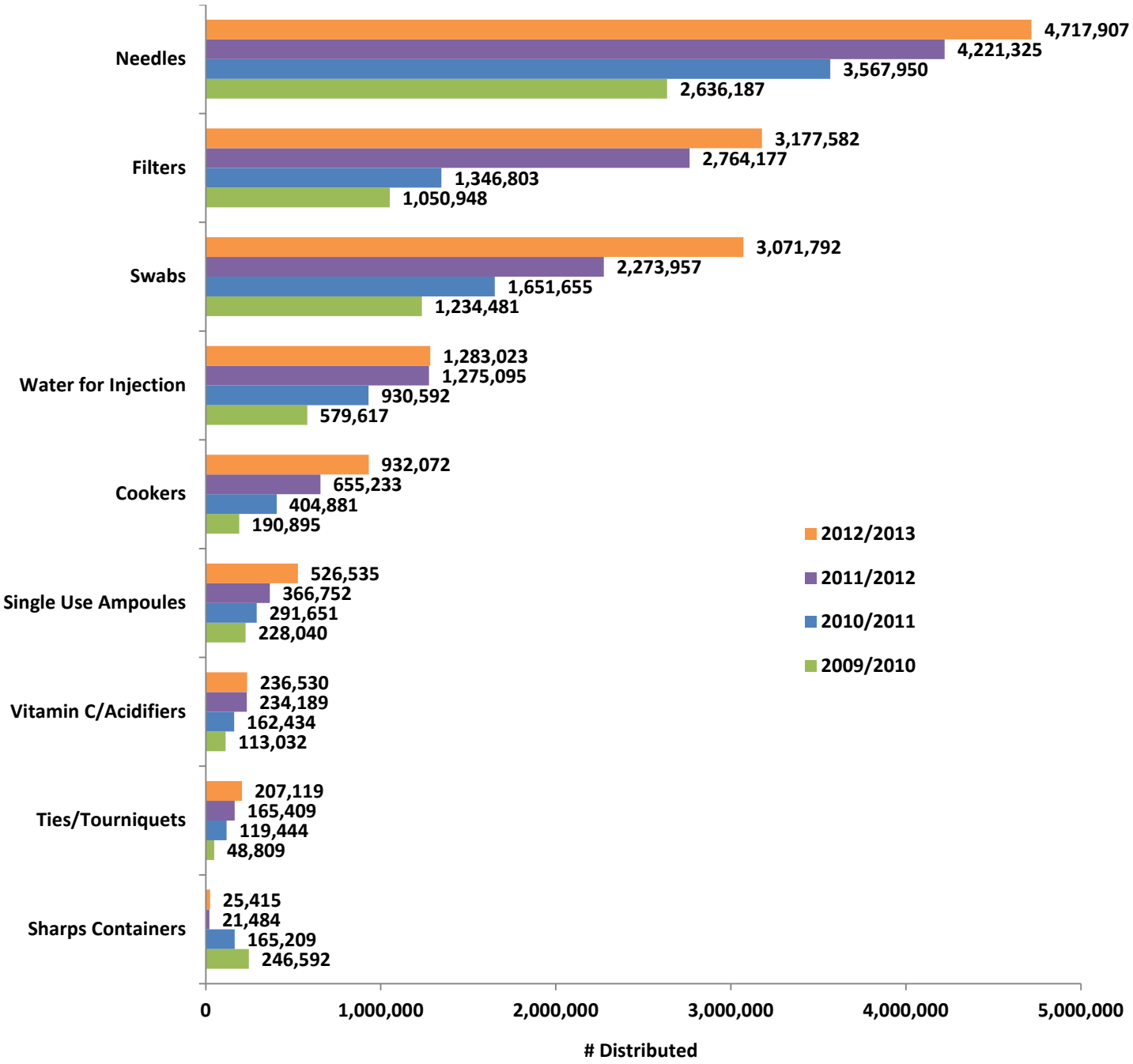
The locations to reach people who use substances are similar to those used for general outreach: streets, parks and public places, other community agencies and through mobile services. Programs also reach clients through methadone maintenance clinics and shelters. In fact, the programs put particular emphasis on developing strong partnerships with other agencies that either do or can serve people who use drugs.

MORE HARM REDUCTION MATERIALS DISTRIBUTED

As part of their harm reduction services, programs distribute safer injection and safer inhalation equipment. In 2012-13, there was a marked increase (+12%) in the number of needles distributed as well as comparable increases in the number of filters and swabs. This was due to increases across a number of agencies, particularly in southern Ontario. Over the same period, Ontario saw a marked drop in new HIV diagnoses among people who inject drugs (-22% in men and -39% in women).

Programs also reported about a 6% increase in the number of screens, pipes and matches distributed to encourage safer inhalation practices; 34 programs are now distributing safer inhalation equipment compared to 33 in 2011-12.

Figure 32: Total Number of Safer Injection Equipment Distributed



CHALLENGES TO IDU OUTREACH AND STRATEGIES TO OVERCOME THEM

Organizations highlighted a number of challenges in their harm reduction work, including:

- **Changes in drugs and drug use and their impact**

"The change in the formulation of Oxy has led to an increase in heroin, Fentanyl, and Dilaudid."

"Due to the change in Oxy formulation, there has been an increase in clients suffering from abscesses."

"The introduction of Oxyneo increased prices, pushed people to stronger opioids (hydromorph), created a market for heroin and led to a huge increase in crystal meth. This has led to vein damage/ neck injection, abscesses, ER visits, increased overdoses and has reduced people's overall stability."

- **More demand related to injecting steroids and hormones**

"More transgender persons want to inject their own hormones, looking for more information on safer injecting."

"Steroid users and trans persons using hormone replacements are engaging with IDU outreach for safer injection materials."

- **More demand for safer inhalation kits**

"We saw high demand for safer inhalation kits. 1500 were donated."

- **More overdoses and deaths**

"There has been an increase in overdoses directly relating to the use of Fentanyl and heroin."

"There have been several fatal overdoses over the last several months that have been linked to heroin use."

- **More youth using drugs – particularly in the North**

"We continue to see an increase in younger people engaging in injection drug use. This is a significant change. In the past the majority of IDU clients were between 20-30 and now we notice an increase of approximately 50% between the ages of 13-20."

"Again this reporting period we are noticing that there is a large amount of clients under the age of 25 accessing needle exchange services for the first time. We are also noticing that clients are coming and seeking advice on proper care for injection related wounds, like abscesses."

In 2012-13, organizations used a number of strategies to overcome barriers and improve access to services for people who use drugs, including:

- **Relationship building**

"We are continuing to work with the substance using community to build a trusting relationship to increase client comfort levels in accessing services. We have our weekly drop-in/advisory committee that has had a steady increase in the number of attendees. Many clients bring new clients in through this group."

"We are working on finding more money to get the supplies needed to get through to the end of year and help with next year's budget. We have requested an increase from our Health Unit for more funding for next year's budget."

- **Care for abscesses**

"We began to create abscess kits for those who needed sterile bandages and were not accessing medical care, and increased the amount of resources available for abscess prevention and care."

"We are continuing to engage community service providers in new partnerships including a Nurse Practitioner, wound care specialist on site once a week to address abscess care."

- **Overdose training programs**

"We are in the process of implementing a community based Naxolone training and distribution program in Niagara in response to clients who particularly are using Fentanyl and heroin of unknown quality, and the younger demographic who are inexperienced and at high risk of overdose."

- **Resources and programs for steroid users**

"In partnership with CATIE, [we have] developed a national resource for distribution to steroid users."

- **Campaigns and programs directed at youth**

"We have shifted our marketing campaigns to appeal to a younger audience and have developed a new youth engagement program to work specifically with youth at risk."

2. IMPROVING ACCESS TO SERVICES

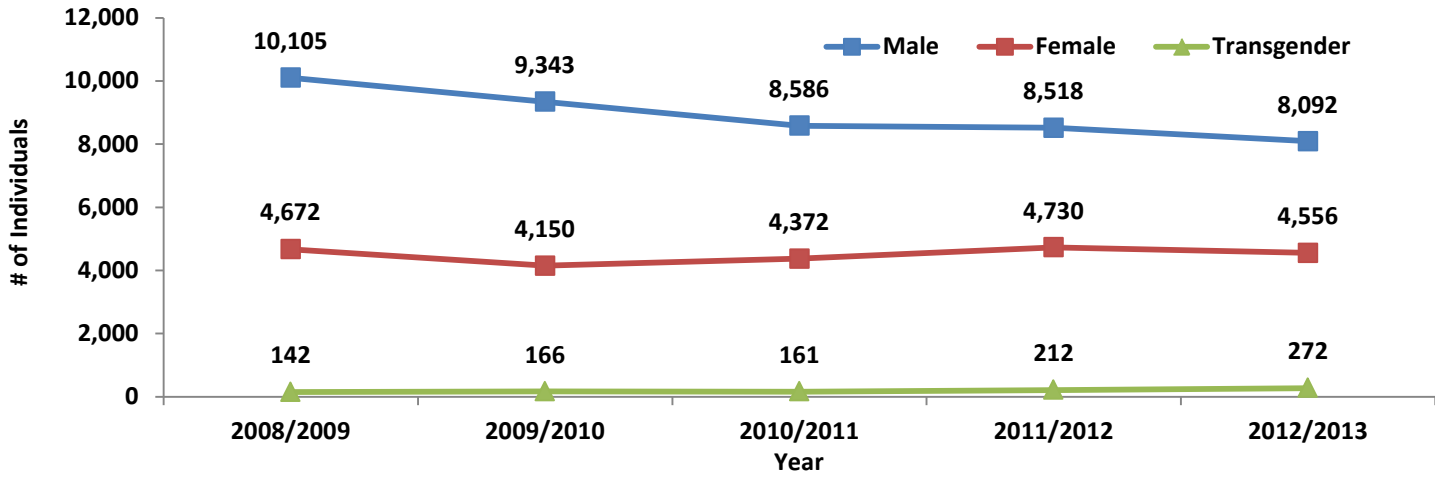
Activities that contribute mainly to improving access to services include support services and IDU outreach services.

SUPPORT SERVICES

DEMAND FOR COMMUNITY-BASED SUPPORT SERVICES REMAINS HIGH

Organizations reported serving almost 13,000 clients in 2012-13. (Note: because clients may use services from more than one organization, these may not all be unique clients.) Most clients who use community-based support services are male (62%); one in three is female and 2% are trans. **Note**: The slight drops in the number of male (<5%) and female (<4%) clients using support services in 2012-13 was due primarily to more accurate tracking and reporting (i.e., less inadvertent double counting of clients within agencies).

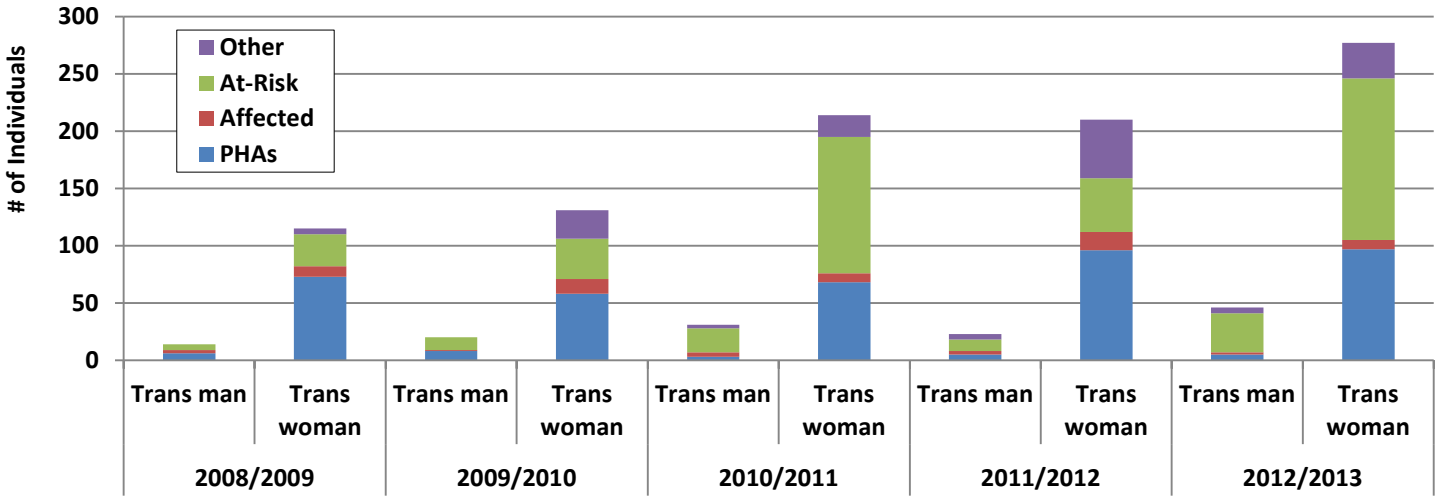
Figure 33. Number of Clients Accessing Support Services by Gender



MORE TRANS PEOPLE ACCESSING SUPPORT SERVICES

The increase in the number of trans clients is an extremely positive sign as this population has been under-recognized and underserved. The majority of trans clients are either living with HIV or at risk.

Figure 34. Number of Transgendered Clients Accessing Support Services

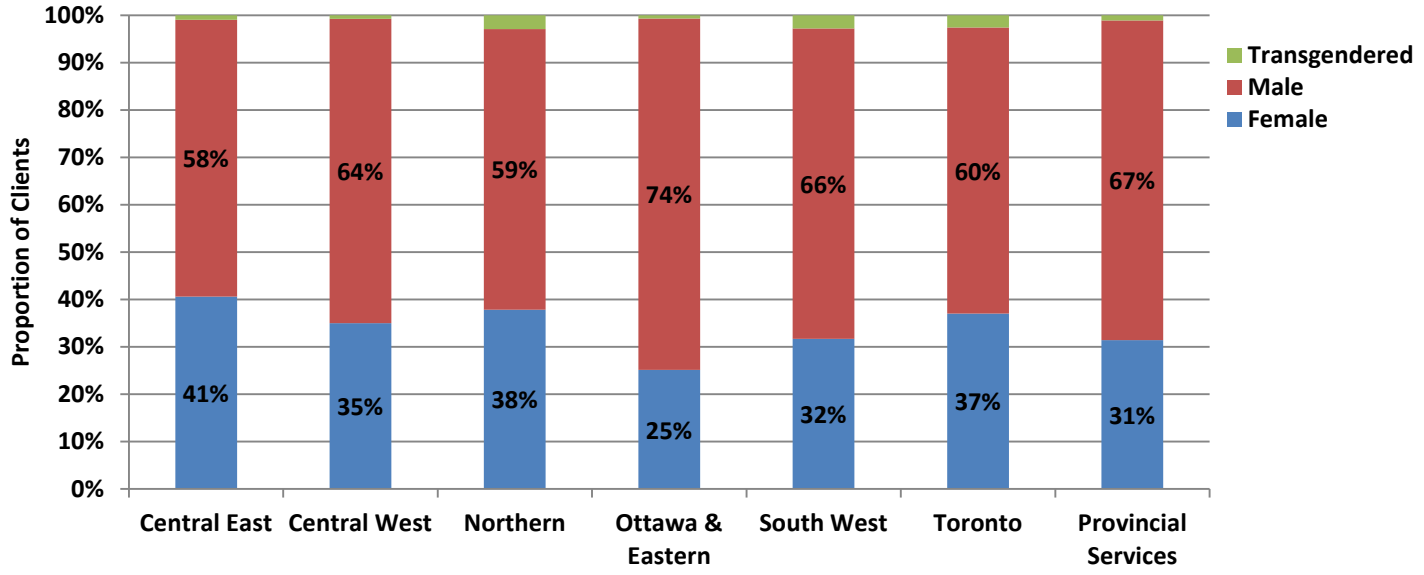


WOMEN ACCOUNT FOR 38% OF NEW CLIENTS AND BETWEEN 25 AND 41% OF ALL CLIENTS IN ALL REGIONS

Agencies reported 2,354 new clients in the first half of the year and 2,056 new clients in the second half (down slightly from the previous year); however, as noted earlier, these may not be unique clients as people may use the services of more than one agency, particularly in Toronto.

In terms of gender, women accounted for 38% of new clients in both halves of the year – which is higher than the 20 to 24% of people with HIV who are women. This difference may indicate that women are more likely to seek services than men, or that the women infected with HIV are more vulnerable and more in need of support services. Women make up a significant proportion of support services clients in all parts of the province.

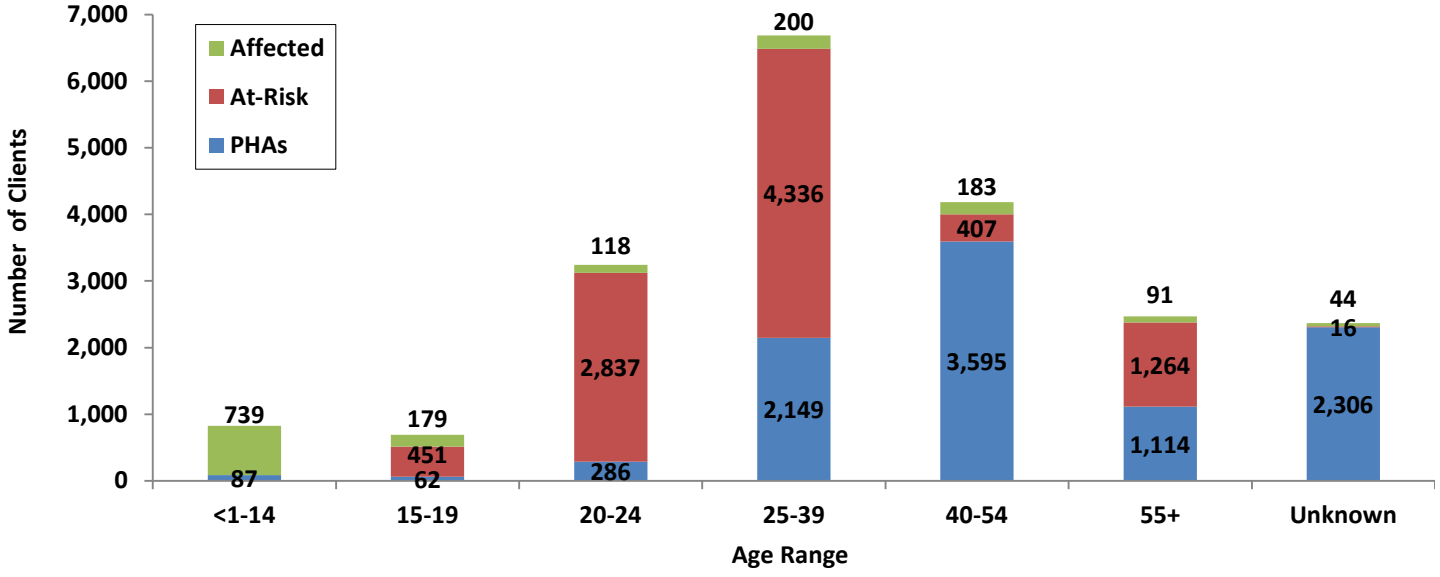
Figure 35. Proportion of Clients Accessing Support Services by Region and By Gender: 2012/2013 H2



SUPPORT SERVICE CLIENTS ARE AGING

Organizations – particularly those that serve families – report serving a number of children whose parents have HIV. However, in general, community-based programs tend to serve older clients.

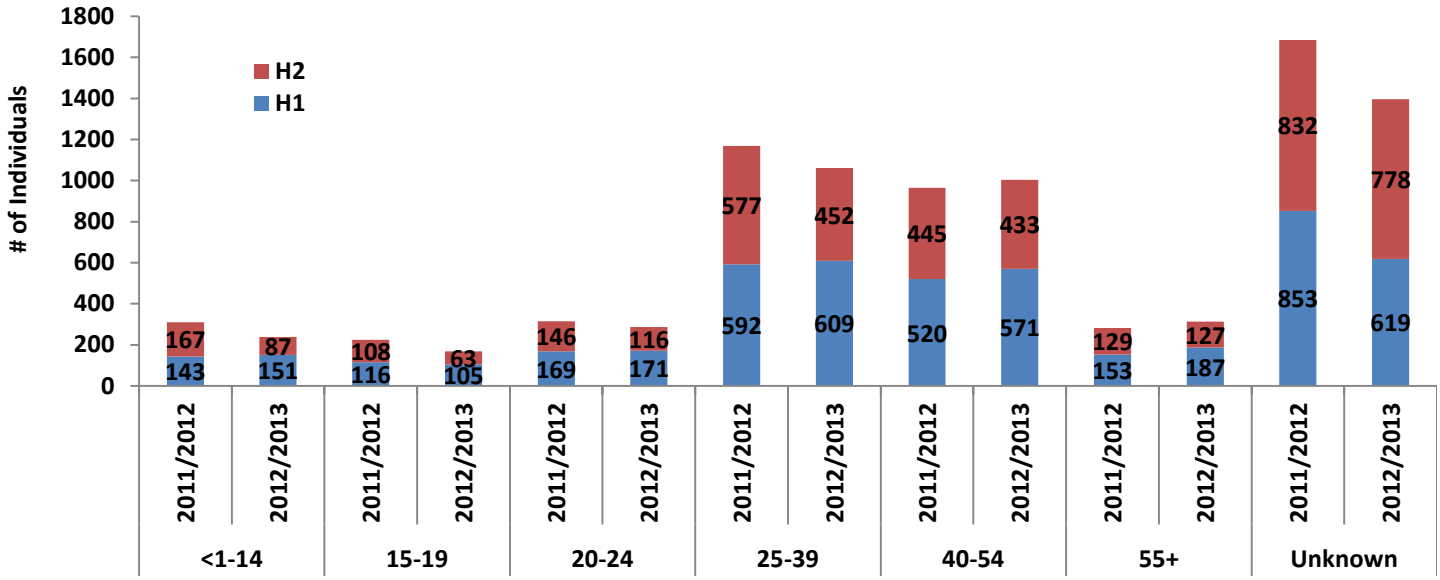
Figure 36. Number of Clients Accessing Support Services by Client Type and Age: 2012/2013 H2



Client age is not simply a function of people diagnosed in the past (i.e., aging with HIV) who are receiving services over time. Community-based programs are seeing an increasing number of new clients who are over age 40 and over 55. This is consistent with the increase in new diagnoses in older age groups.

This trend likely reflects the aging of people who have been living with HIV for some time, the fact that more people newly diagnosed with HIV are older, and the impact of better treatments, which may mean that younger people diagnosed with HIV may be better able to maintain their health, employment, income and social networks and may not have the same need for services.

Figure 37. Number of New Clients by Age Range

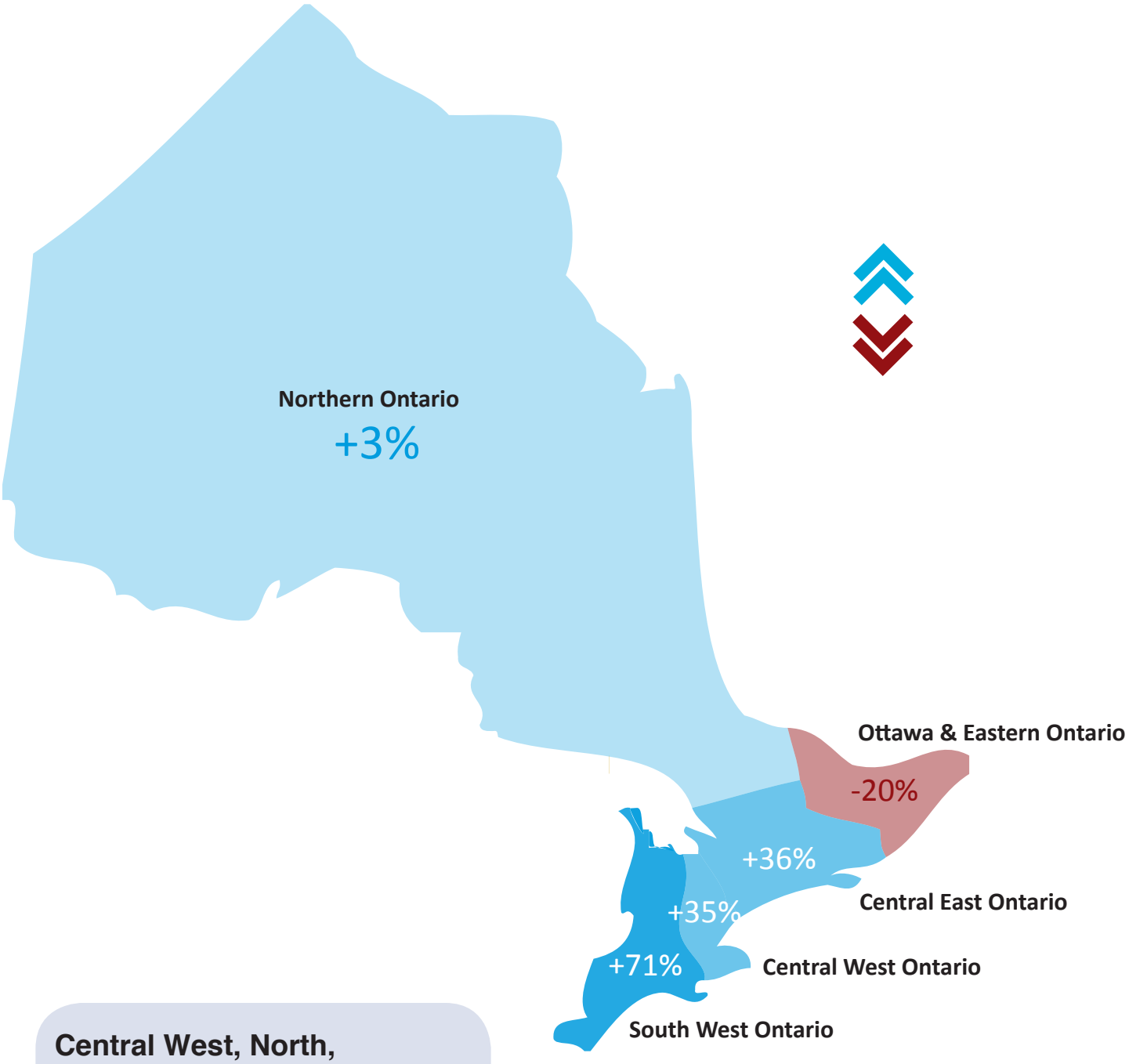


Note: The large number of clients whose age is unknown is due to one service that provides legal services that does not collect data on client age.

ALL REGIONS ARE SEEING OLDER CLIENTS

All regions except Ottawa and Eastern Ontario reported an increase in clients over age 55. Even though Ottawa and Eastern Ontario reported a 20% decrease in the number of support service clients who are age 55 or older (from 90 to 72), more than half their clients are age 40 or older. The drop in the number of older clients in that region may be related to the increase in deaths (see Figure 39). In South West, the number of clients over 55 increased from 52 to 89 (71%). In Central West, there was a 35% increase compared to the previous year (67 to 91). A significant proportion of these changes appear to be due to the aging of existing clients. Although the number of clients over age 55 in Toronto increased by 5% (from 603 to 661), they still represent only 8% of support service clients in that region. The majority are between the ages of 25 and 54.

Figure 38. Almost All Regions Report More Clients Over 55



Central West, North, Ottawa/Eastern

In 2012-2013, more than 50% of support service clients in Central West and the North were age 40 and older. The only regions that saw an increase in younger clients was Ottawa/Eastern.

Toronto

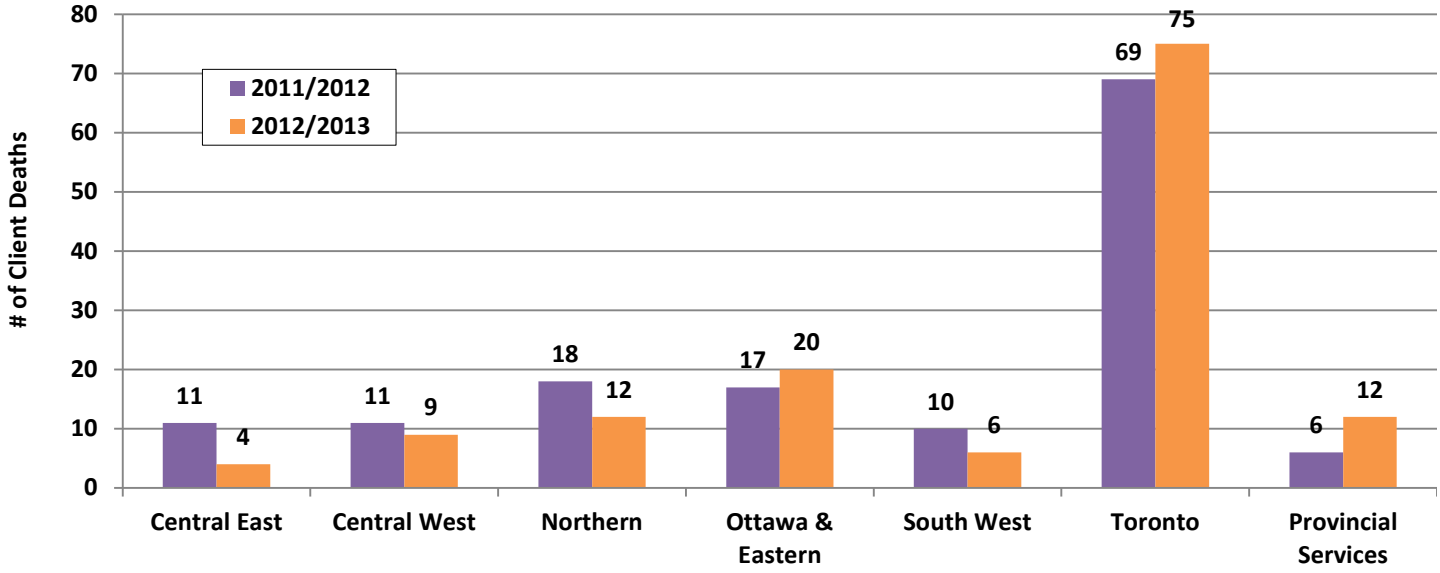
Toronto's +55 client base increased by **5%**. Clients +55 represent **8%** of the city's clients, the lowest of any region.

+5%

MORE DEATHS

With the aging of people living with HIV, Ontario continues to see more deaths. Programs reported that a total of 138 clients had died in 2012-13 (although some of those deaths may be double counted if people were receiving services from more than one program). Compared to the previous year, Toronto and Ottawa & Eastern saw an increase in deaths.

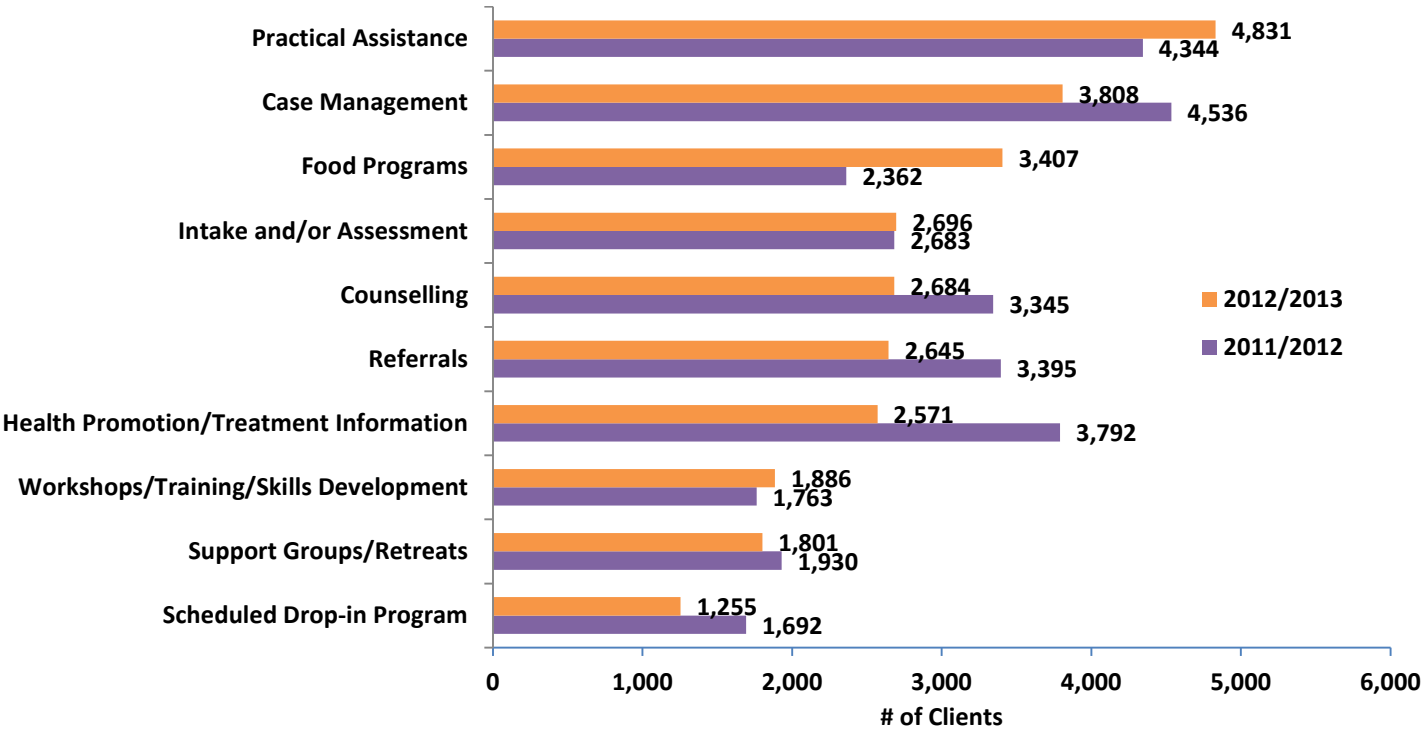
Figure 39. Number of Client Deaths by Region: 2012/2013



MORE DEMAND FOR PRACTICAL ASSISTANCE AND FOOD PROGRAMS IN 2012-13

Organizations reported an increase in practical assistance services last year, as well as more clients using food programs – which may be an indicator that more clients are struggling with poverty.

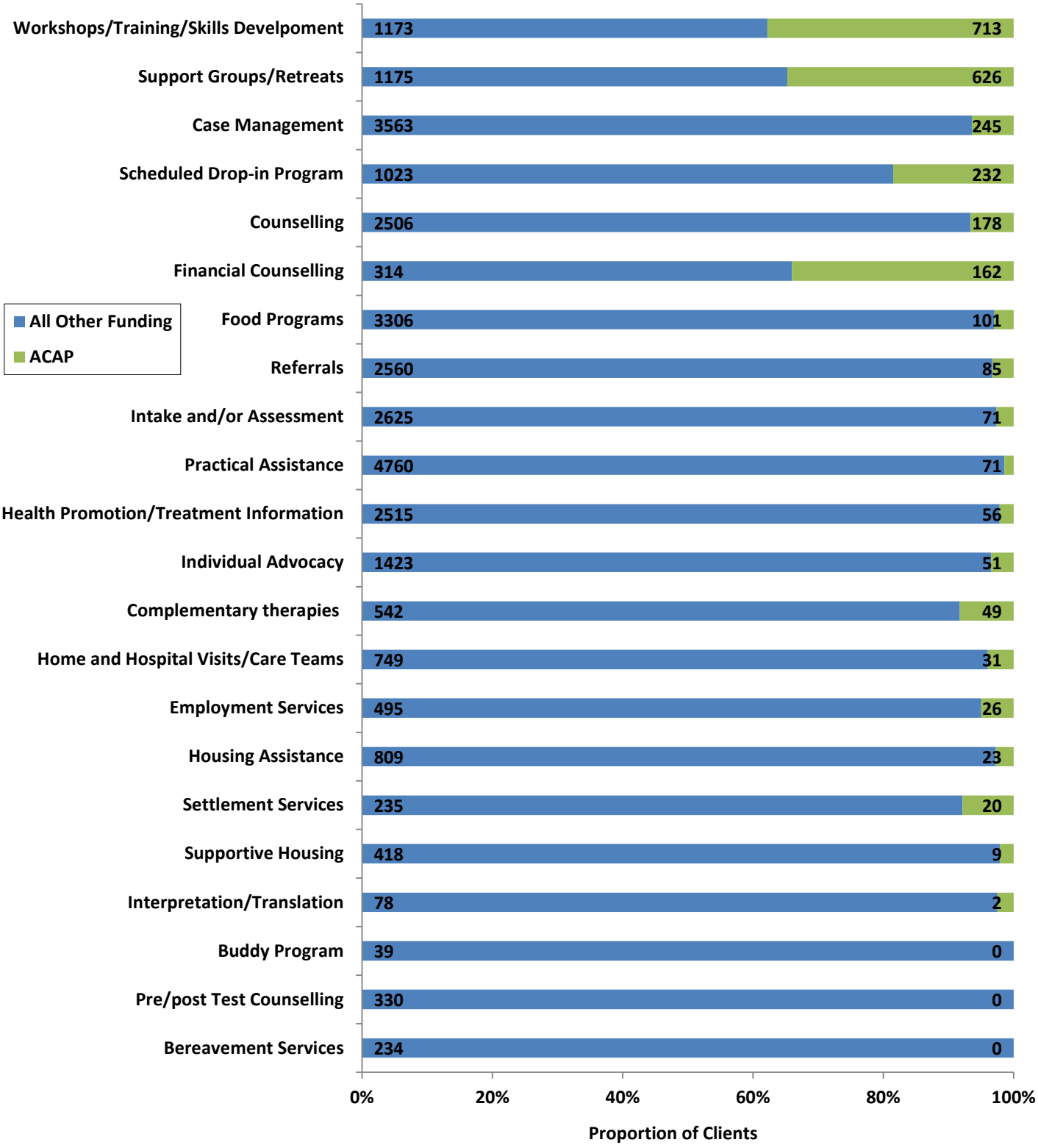
Figure 40 Number of Clients Accessing Services (Top 10) for 2011 and 2012



ACAP FUNDING SUPPORTS MAINLY FINANCIAL COUNSELLING, TRAINING, SUPPORT GROUPS, DROP-INS AND SETTLEMENT SERVICES

Organizations that received ACAP funding for support services used that money primarily to enhance their capacity to provide training workshops, support groups, case management, scheduled drop-in programs, counselling and financial counselling.

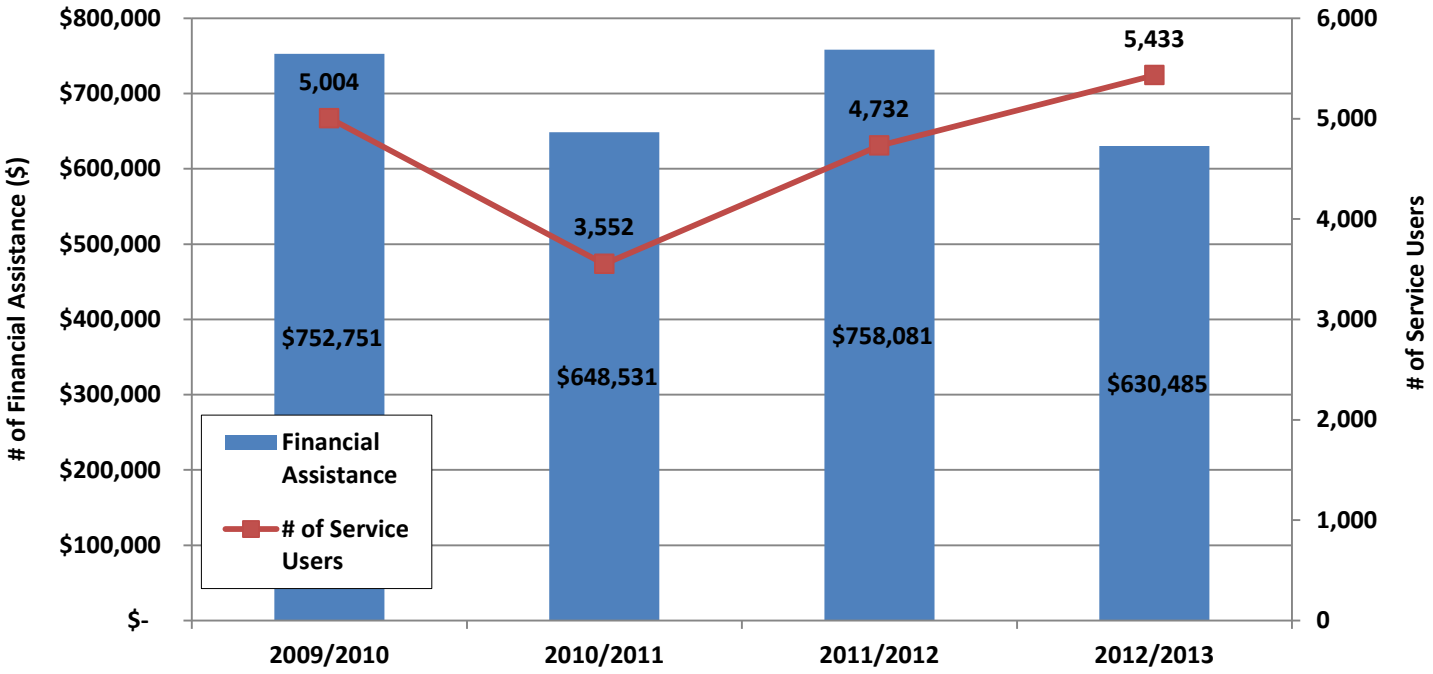
Figure 41. Proportion of Clients Accessing Services by Funder H2 2012/2013



MORE CLIENTS IN NEED, LESS FINANCIAL ASSISTANCE

In 2012-13, programs distributed less in financial assistance, but that amount was shared among more people. There appears to be an increasing demand for financial assistance but less capacity to provide that service.

Figure 42. Financial Assistance



The amount of financial assistance varies considerably across the province, driven largely by the size of the epidemic in each region and the local capacity to provide financial support. The greatest drops in 2012-13 occurred in Toronto, South West and Central West; however, every region provided less financial assistance than it had the previous year.

Figure 43. Financial Assistance Given Out by Region

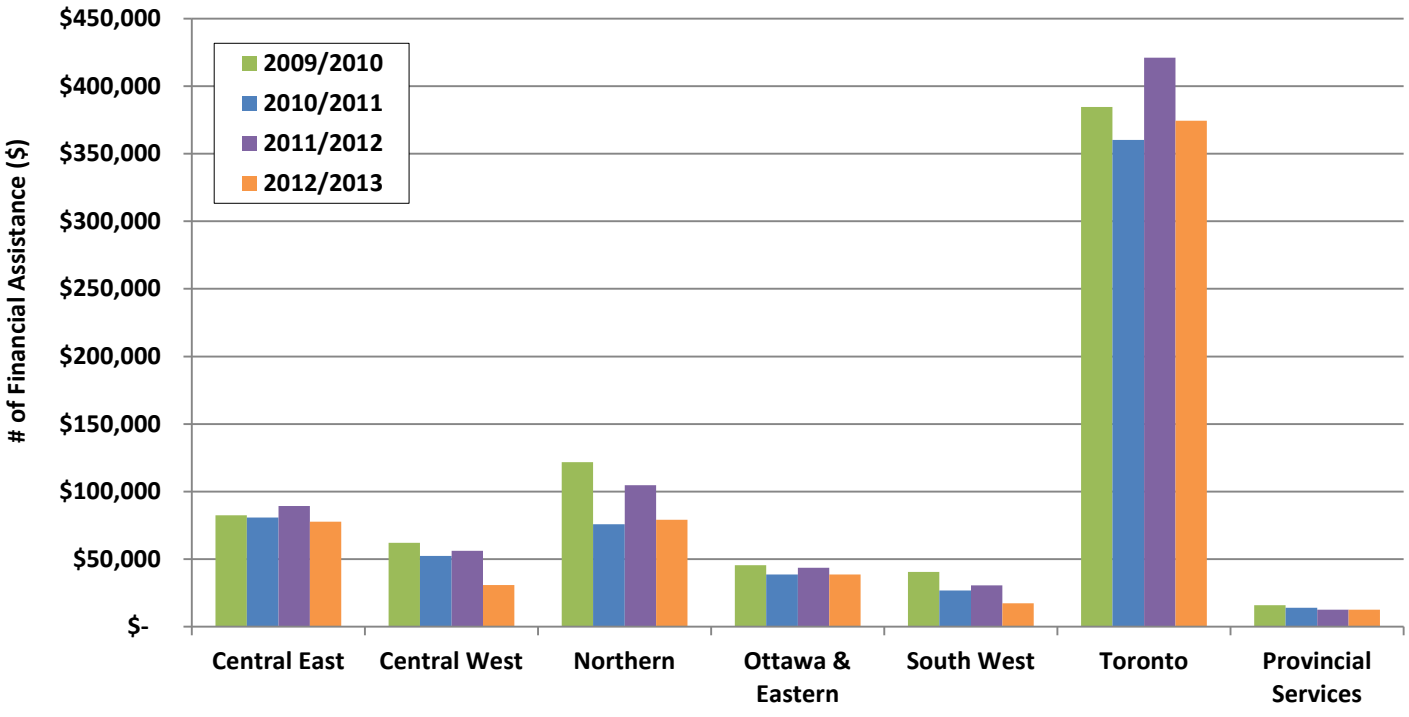
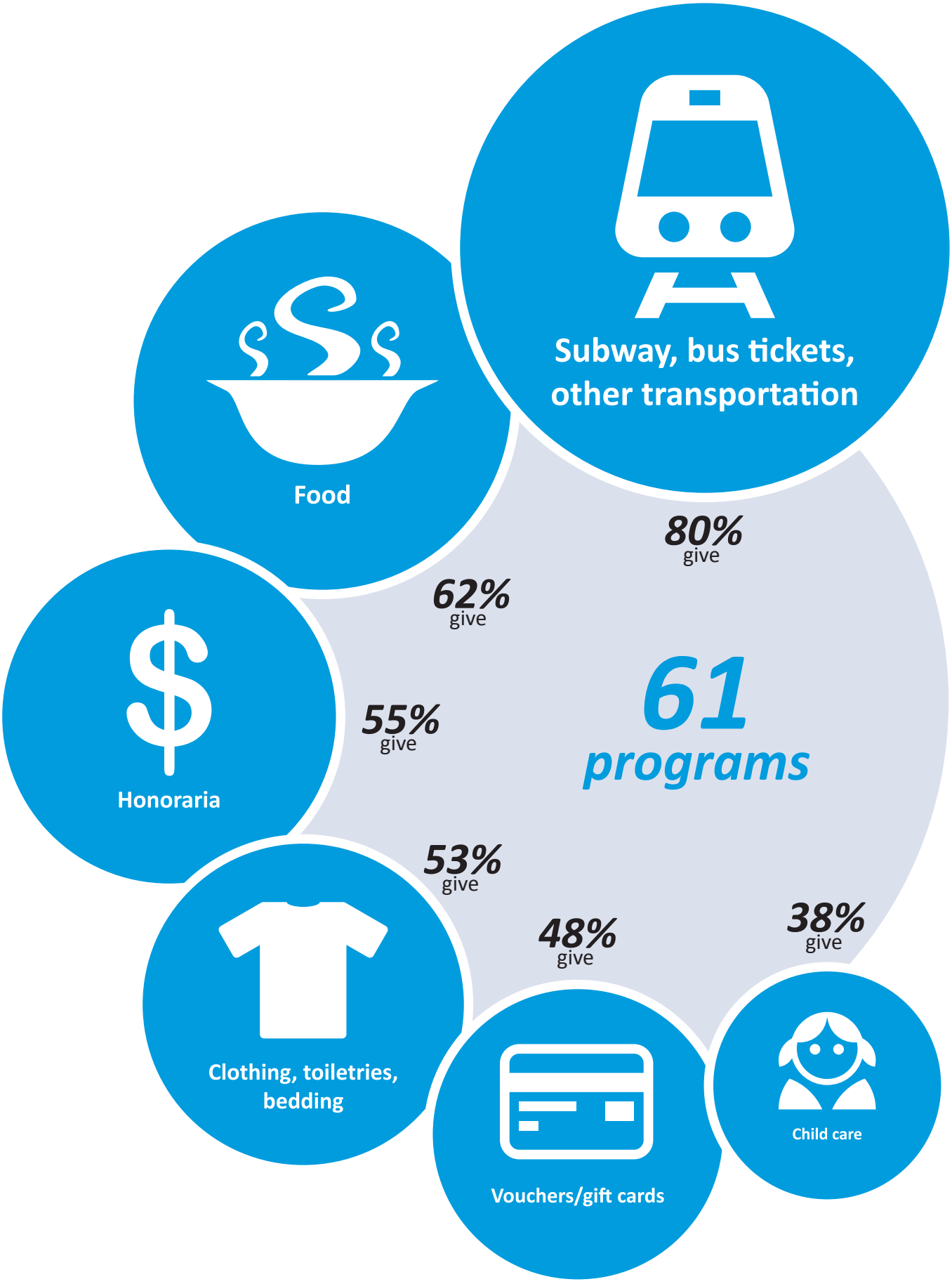


Figure 44. What Kind of Financial Assistance Do Clients Receive?



BARRIERS TO SUPPORT SERVICES AND STRATEGIES TO OVERCOME THEM

Organizations identified a number of challenges to providing effective, consistent support services, including:

- **Immigration services**: there was a dramatic increase in immigration support services being requested by newcomers.

"We are working closely with immigration lawyers and CBSA to assist clients on their H&C application process or their deportation process; making sure they know where to access resources in their home countries."

- **Complex needs**: there has been a marked increase in concurrent addiction and mental health issues.

"Responding to emerging trends; In order to meet the above mentioned demands, the support department has established new partners and continues working in collaboration with other service providers providing services to people living with HIV/AIDS to offer holistic support. We refer clients to McEwan House, Fred Victor, Fife House, Casey House, Women's Health in Women's Hands for housing, addiction and mental health support. Clients are referred to Sherbourne Health Centre for complementary therapy services. PWA continues providing food stuff to clients. The support coordinator accompanies clients with adherence issues to their doctor's appointment and develops a case management plan with the client."

- **Navigation services**: people need help navigating complex health and benefit systems.

"The Peer Navigator role has been a very effective model with which to meet increased demands in service access and immigration. Partnerships with agencies such as HALCO and SALCO (South Asian Legal Clinic of Ontario) has proved invaluable. More linkages are also being made with specialists, physicians, psychotherapists and settlement services. Support staff have been accessing appropriate training and professional development opportunities surrounding emerging themes mentioned above and previous years such as aging and treatment adherence."

- **Practical assistance**: demand is increasing.

"We are providing the necessary systems to support women effectively including development of trauma informed interventions. A pro bono lawyer comes once a month to help women file immigration papers. We also refer women to HALCO for support. A housing worker comes once a week to help women with issues of housing"

- **Criminalization**: the requests for guidance and support surrounding criminalization have spiked.

"As noted above, there are also a number of clients who are concerned about their relationships concerning the criminalization of non-disclosure of their HIV status. In response, we are planning a number of information sessions to increase PHA knowledge of the changing requirements of the law and its detrimental impact on women and members of racialized communities."

- **Aging with HIV**: requests for support relating to HIV and aging issues continues to increase.

"A Long Term Survivor Group is reported to be addressing some of the needs for individuals who participate. They have engaged in a "life review" of their journeys with HIV. Out of this "story telling" the group identified issues for future discussions like – financial planning, disclosure, power of attorney and wills, and aging with HIV. Practical discussions with clients have included preparing for or coping with weather related issues – power outages, mobility issues and social isolation."

- **Transportation issues**

"We are in negotiations with APH and are working towards having a nurse attend at our office on a regular basis to provide POC testing. This is an important step as we are located in the downtown core of the city. We have reserved Thursday mornings as clinic days. Clients/patients see their HIV specialist in Sudbury from the comfort of our own office. It has eliminated travel and has resulted in substantial monetary savings in Northern Travel Grants. The MOHLTC Northern Travel Grant when travelling from Sault St Marie to Sudbury return is $309.10. The savings as of October 1, 2012 is approx. $13,000.00. The improved health of clients/patients adds to the savings and their quality of their lives."

3. ENHANCING CAPACITY

Activities that contribute to enhancing capacity include those that help both individuals and organization develop skills. Individual capacity building initiatives include peer programs. Those that enhance the capacity of organizations include volunteer programs as well as the training and other services provided by provincial resource organizations.

VOLUNTEERS

COMMUNITY-BASED HIV SECTOR IN ONTARIO HIGHLY DEPENDENT ON VOLUNTEERS

In 2012-13, volunteers contributed $4.9 million worth of services – down slightly from $5.08 million in 2011-12.

There is increasingly fierce competition among non-profits and arts institutions for volunteer time; therefore community-based HIV programs must continue to offer opportunities that will attract and retain volunteers. In general, programs were able to attract more volunteers in 2012-13 and those individuals volunteered more hours. There was a drop in the ACAP funding volunteer programs, which was due to the end of some funded volunteer programs in March 2012.

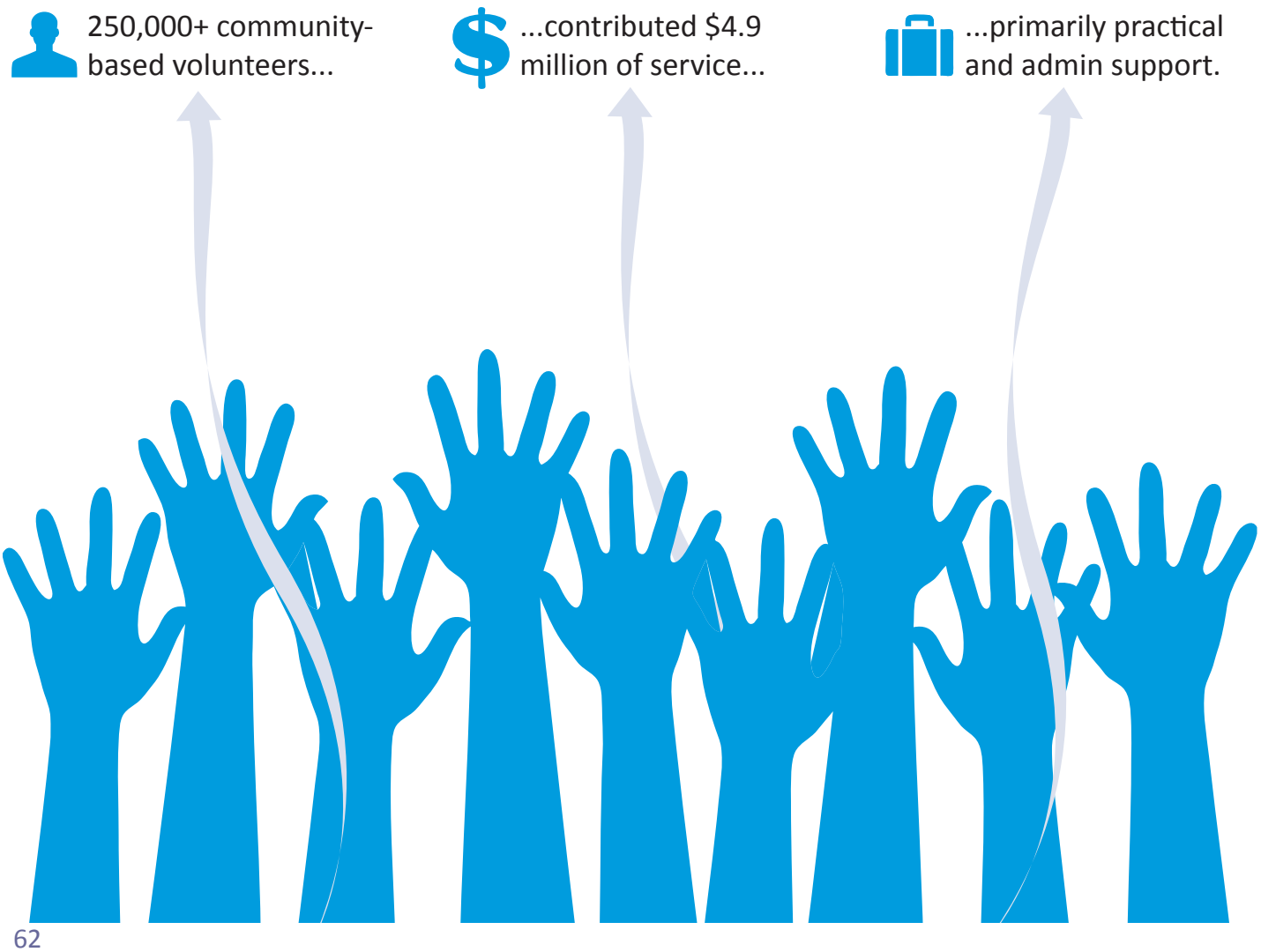
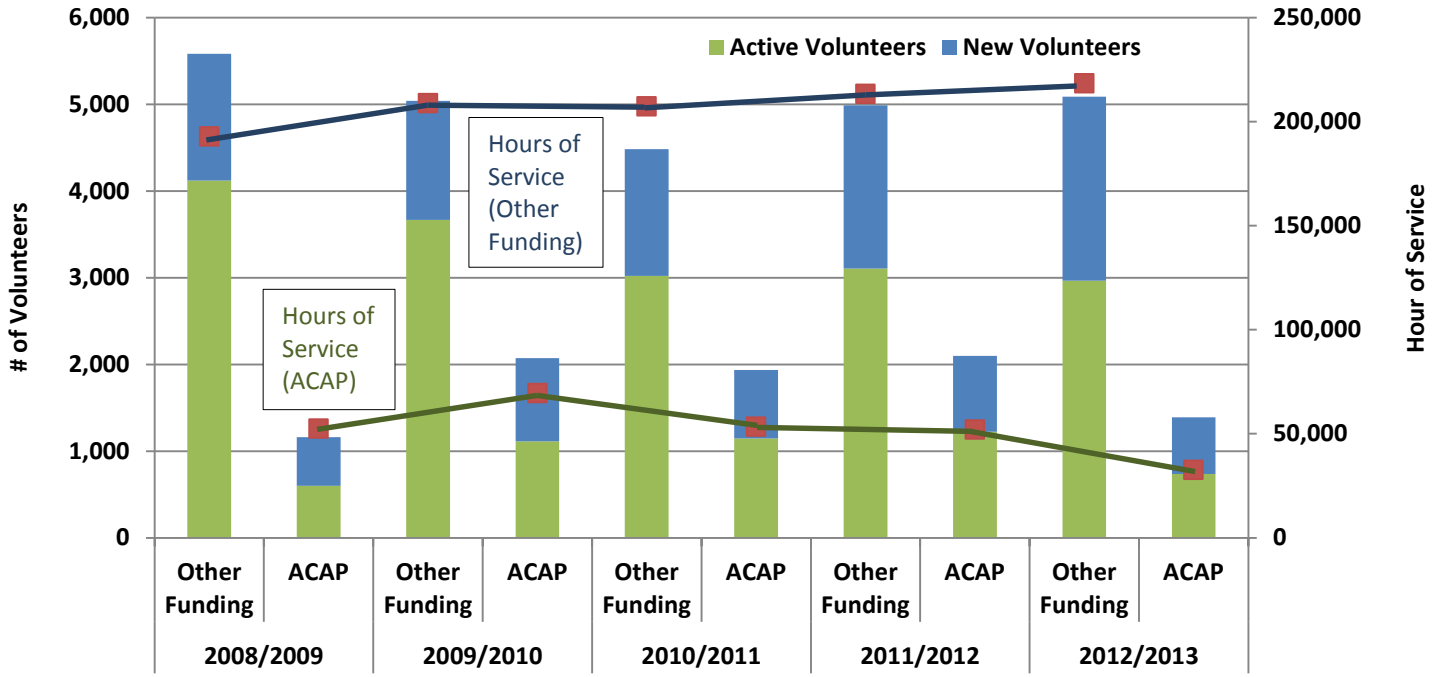


Figure 45. Volunteers and Equivalent Dollar Benefit

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	38,369	$15.25	$585,127.25	$70,215.27	$655,342.52
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	20,331	$39.00	$792,899.25	$95,147.91	$888,047.16
Support services (assistance to people living with HIV/AIDS, peer support, etc)	12.2 sum of total # of vol hrs for Practical Support and Counselling	Community and social service workers 4212	60,226	$21.51	$1,295,461.26	$155,455.35	$1,450,916.61
Prevention (outreach, targeted education, etc)	12.2 total # of vol hrs for Outreach Activities	Community and social service workers 4212	15,667	$21.51	$336,997.17	$40,439.66	$377,436.83
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	20,231	$29.74	$601,669.94	$72,200.39	$673,870.33
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	46,316	$15.25	$706,319.00	$84,758.28	$791,077.28
Human resources	12.2 sum to total # of vol hrs for involvement in hiring process and policies and proecdures	Specialists in human resources 1121	1,610	$29.74	$47,881.40	$5,745.77	$53,627.17
IT Support	12.2 sum of total # of vol hrs for IT support	Web designers and developers 2175	535	$27.78	$14,862.30	$1,783.48	$16,645.78
Total					**$4,381,217.57**		**$4,906,963.68**

* Add the hours from your H1 and H2 OCHART report

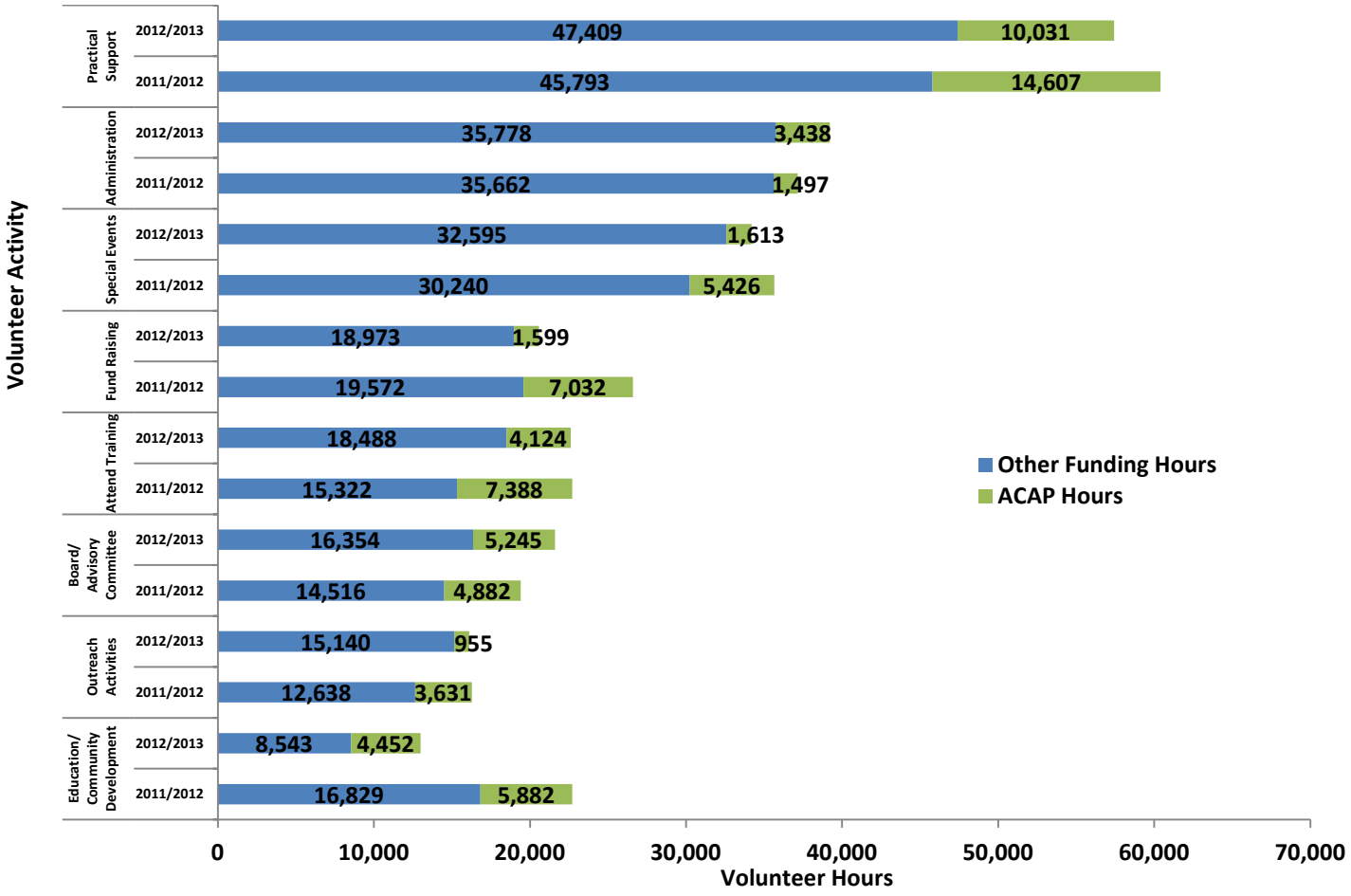
Figure 46: Volunteers (Total New and Avg. Active) and Hours of Service: ACAP and Other Funding



VOLUNTEERS KEY TO PRACTICAL SUPPORT, ADMINISTRATION AND SPECIAL EVENTS

Volunteers appear to give the greatest number of hours to providing practical support, assisting with administration and special events.

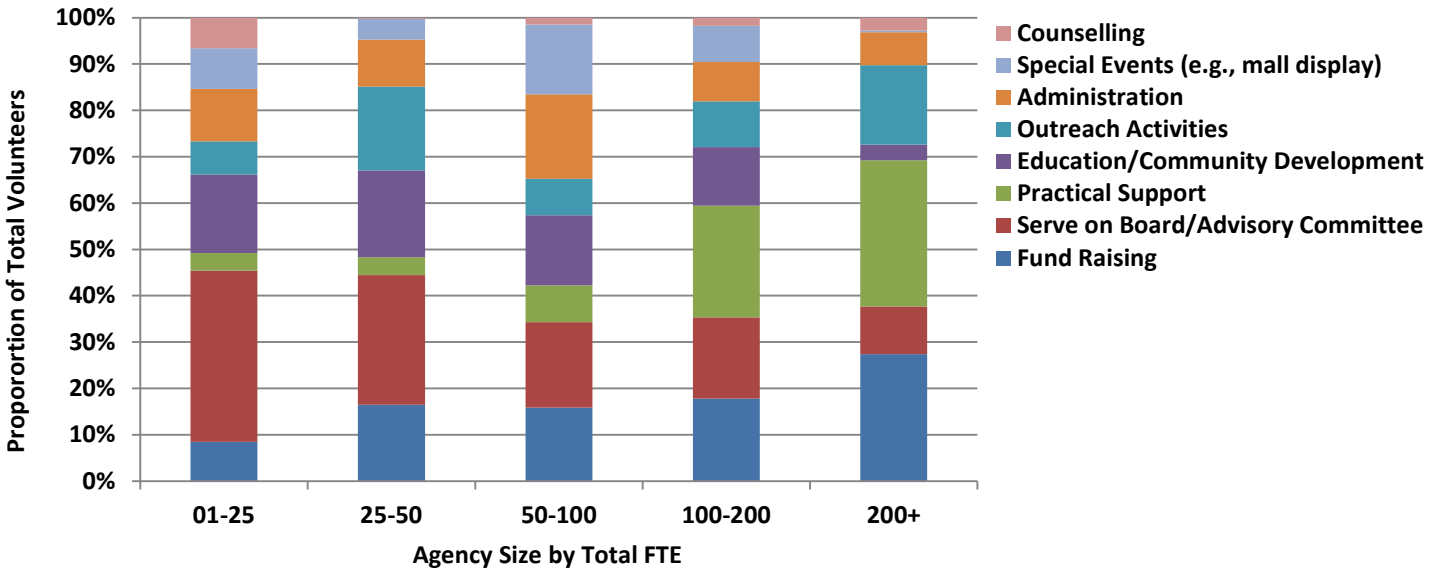
Figure 47. For Selected Activities - Total Volunteer Hours by Funding Source: 2010 and 2011



DOES HAVING MORE VOLUNTEERS CHANGE HOW YOU PROVIDE SERVICES?

Agencies that have large numbers of volunteers – that is, more than 100 – are more likely to have a large proportion of those volunteers involved in fundraising, practical support and outreach activities. On the other hand, agencies with a smaller number of volunteers are more likely to engage those volunteers on the Board, in community development and in administration. Agencies with large numbers of volunteers do not seem to need volunteers to help with IT support, policies and procedures or hiring – perhaps because they have the capacity through paid staff in their organizations to do those tasks.

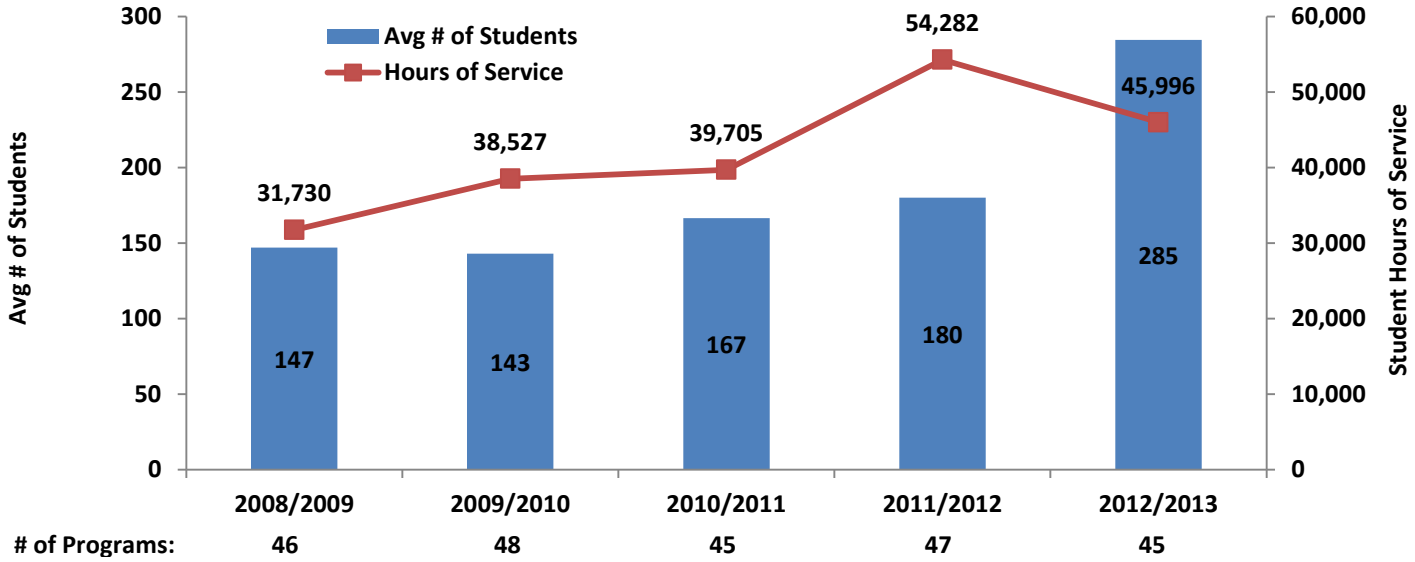
Figure 48. Proportion of Volunteers Involved in Activities (Selection) by Size of Agency Volunteer Work Force



MORE STUDENTS VOLUNTEERING, BUT GIVING FEWER HOURS

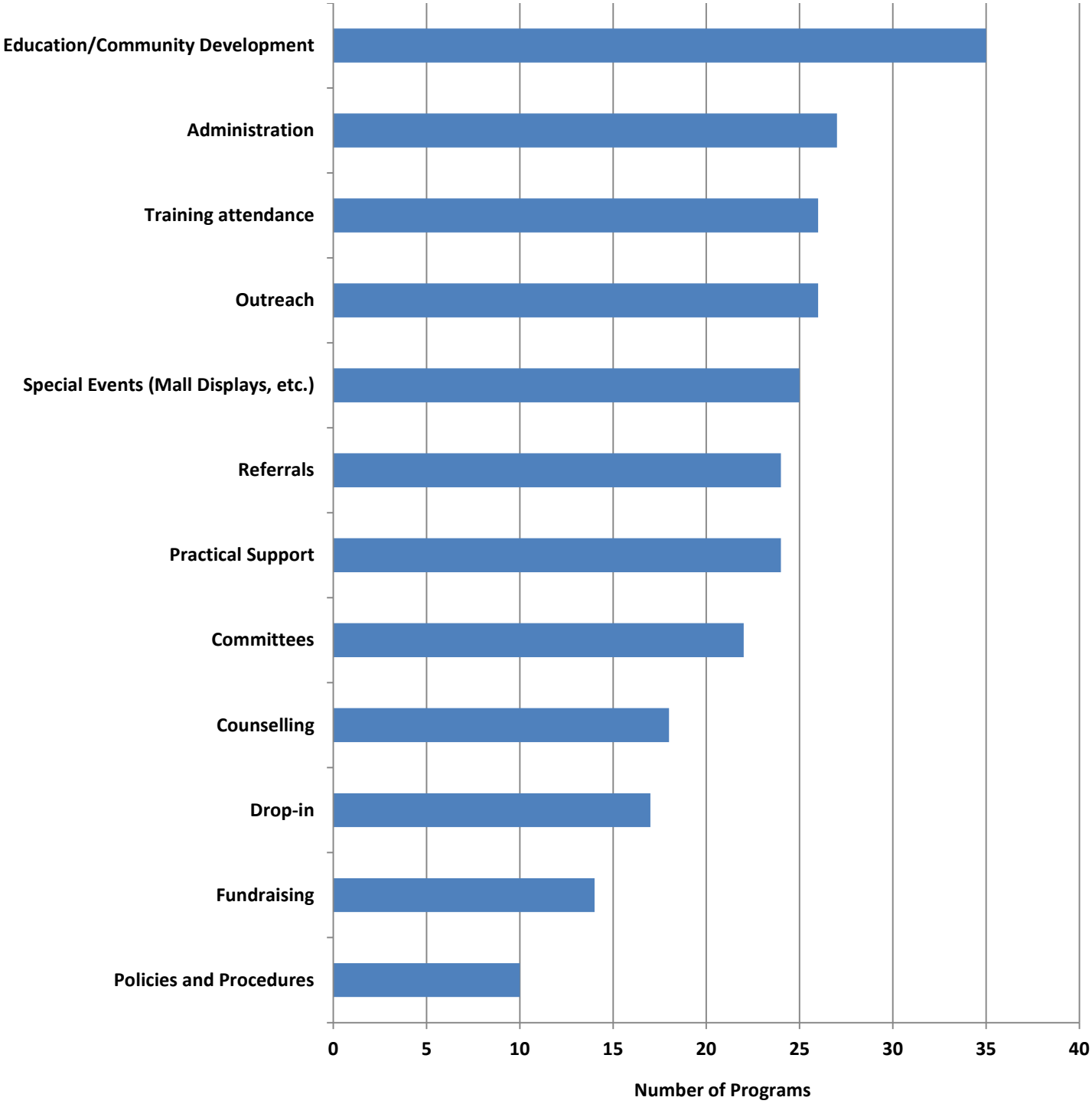
Community-based HIV programs have been extremely successful in taking advantage of the student volunteer requirements that are now part of the Ontario secondary school curriculum. In 2012-13, programs attracted more students; however, those students gave fewer hours. Attracting students is not just a benefit for the program over the short-term; it is an effective way to expose young people to this sector who may then consider HIV work when planning their careers.

Figure 49: Student Placements



In terms of activities, agencies engage students in a wide range of activities, with a particular focus on education and community development.

Figure 50. Number of Programs reporting Student Activity H2 2012



PEER PROGRAMS

Although all community-based organizations involve people living with or at risk of HIV in their programs and services, only the IDU outreach programs are required to involve peers and to report specifically on peer involvement.

Figure 51. Peer Involvement In IDU Outreach Is On The Rise

Central East Ontario

11

57

Most areas have a mix of male and female peers, but peers appear to be predominantly female in Central East.

Northern Ontario

2011-2012: 81

2012-2013: 139

Northern Ontario experienced a surge of new and active peers in 2012-2013, amounting to a jump of over 71%.

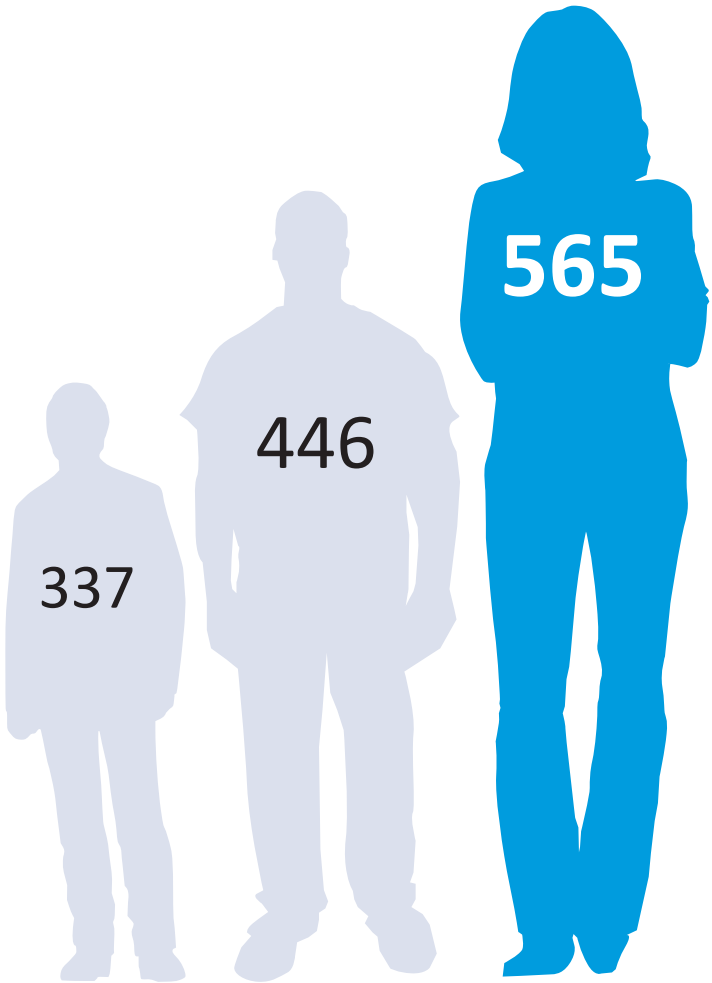
Toronto

Toronto and Ottawa are now addressing the issue of drug use in the trans community, accounting for 15% of peer meetings.

2012-2013 H2

733 Peer meetings

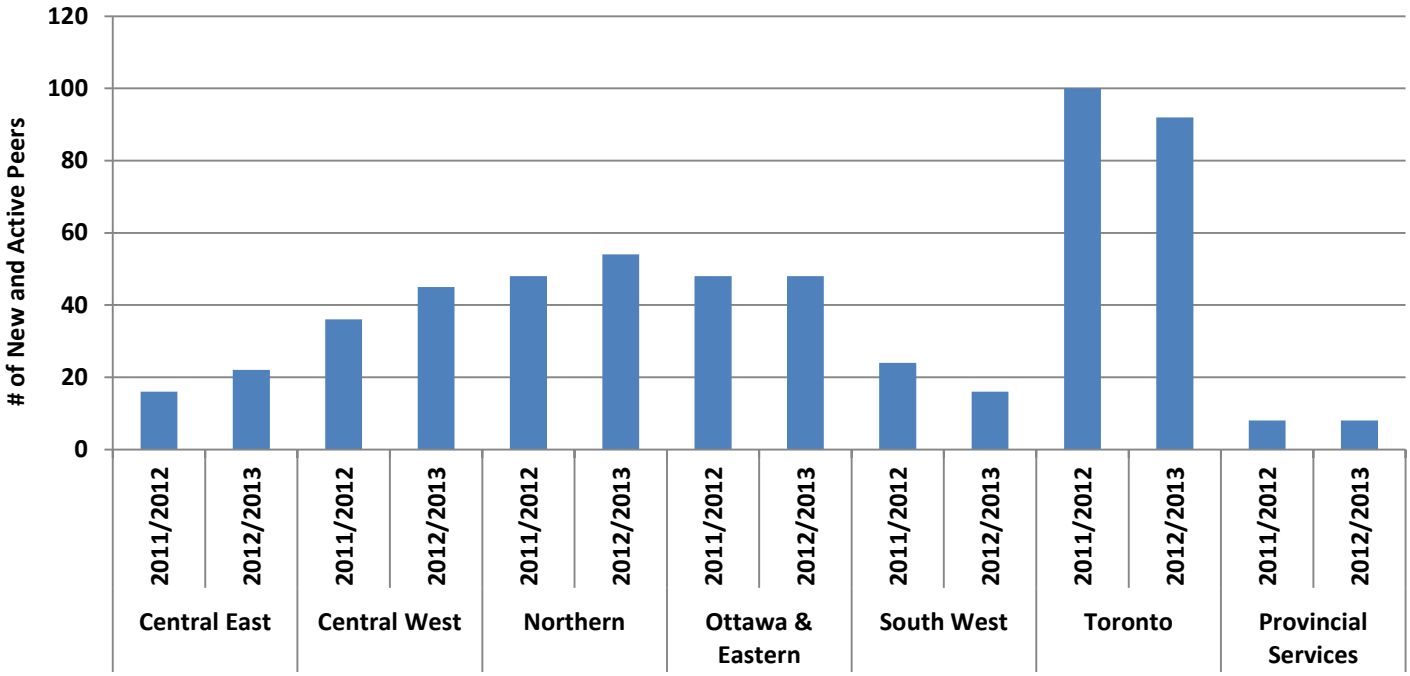
282 Orientation / education sessions



IDU OUTREACH PROGRAMS ATTRACT AND RETAIN MORE PEERS

A closer look at the data on peers in IDU programs shows that those areas with larger drug-related HIV epidemics – such as Toronto, Ottawa and the North – are more successful in attracting peers.

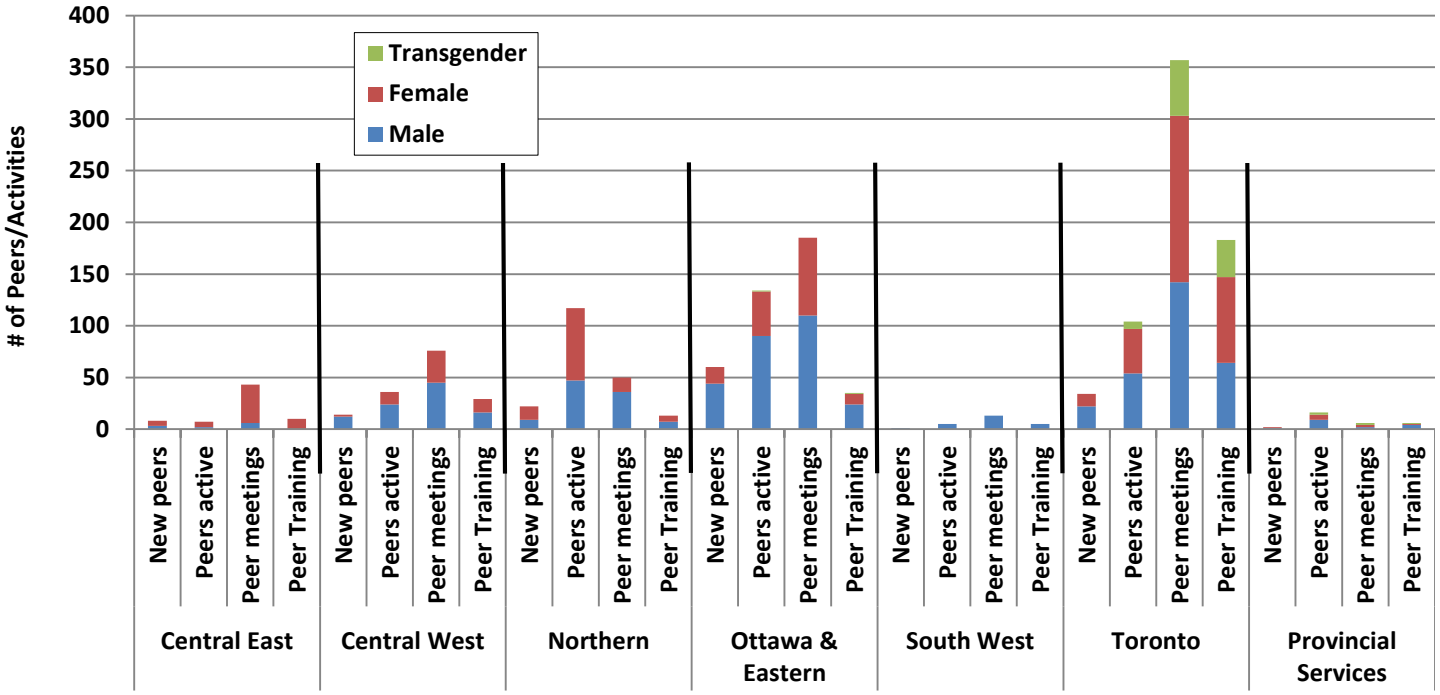
Figure 52. Number of New and Active Peers by Region H2 2011/2012 and 2012/2013



IDU PROGRAMS ATTRACT A MIX OF MALE AND FEMALE PEERS

All regions except the South West have a mix of male and female peers. In Central East, the peers appear to be mainly women. It is interesting to note that both Toronto and Ottawa are now addressing the issue of injection in the trans community.

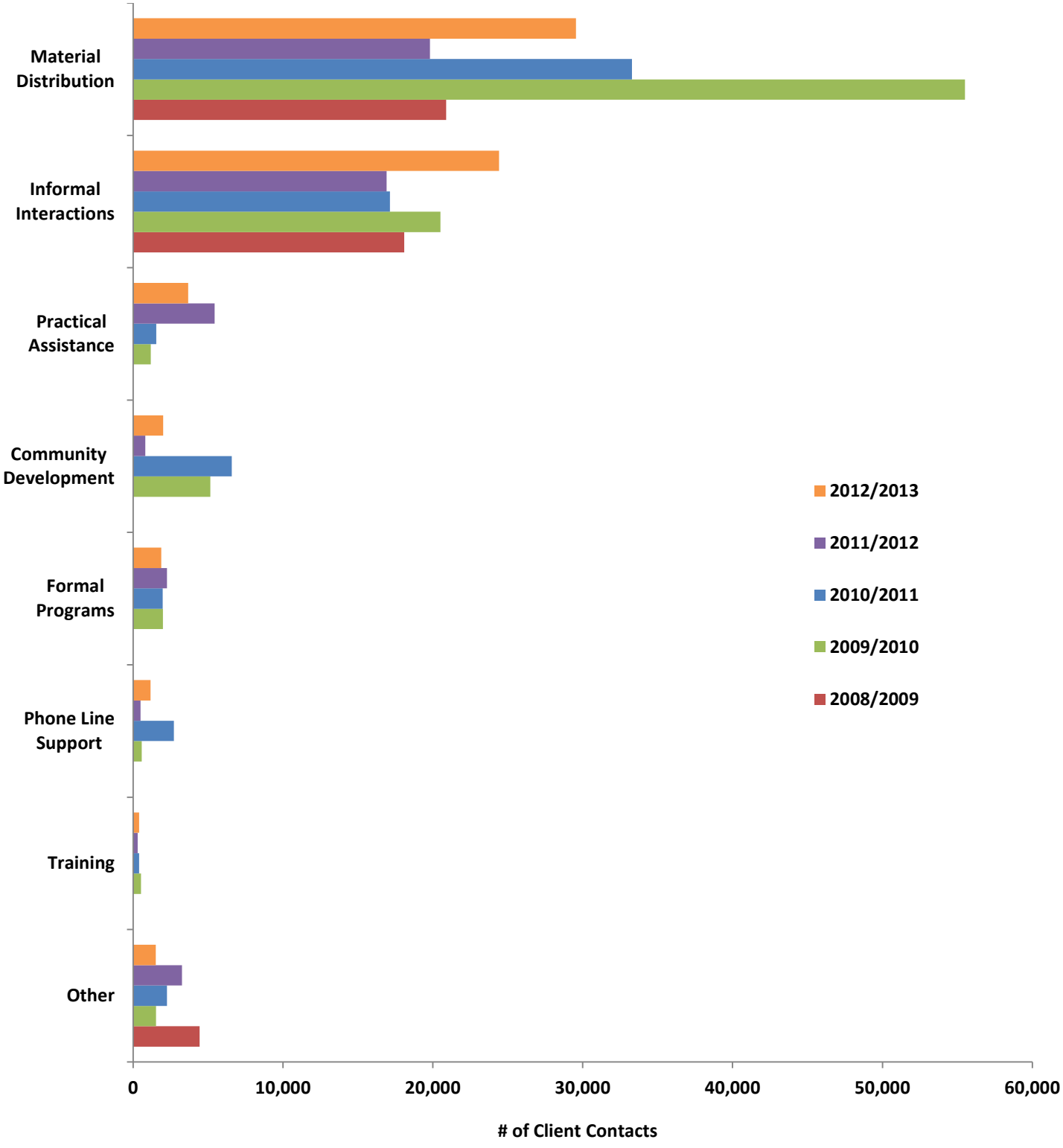
Figure 53. IDU Peer Involvement by Gender and Region: 2012/2013 H2



IDU PEERS MORE INVOLVED IN INFORMAL INTERACTIONS WITH CLIENTS

IDU programs seem to be putting more emphasis on the potential for peers to interact with people who use substances, provide education and support, and connect them to agency and other health services. This is a positive trend as the IDU evaluation indicated that word-of-mouth from someone who has had similar life experiences (i.e., a peer) is how most people who use substances develop enough confidence and trust to connect with services.

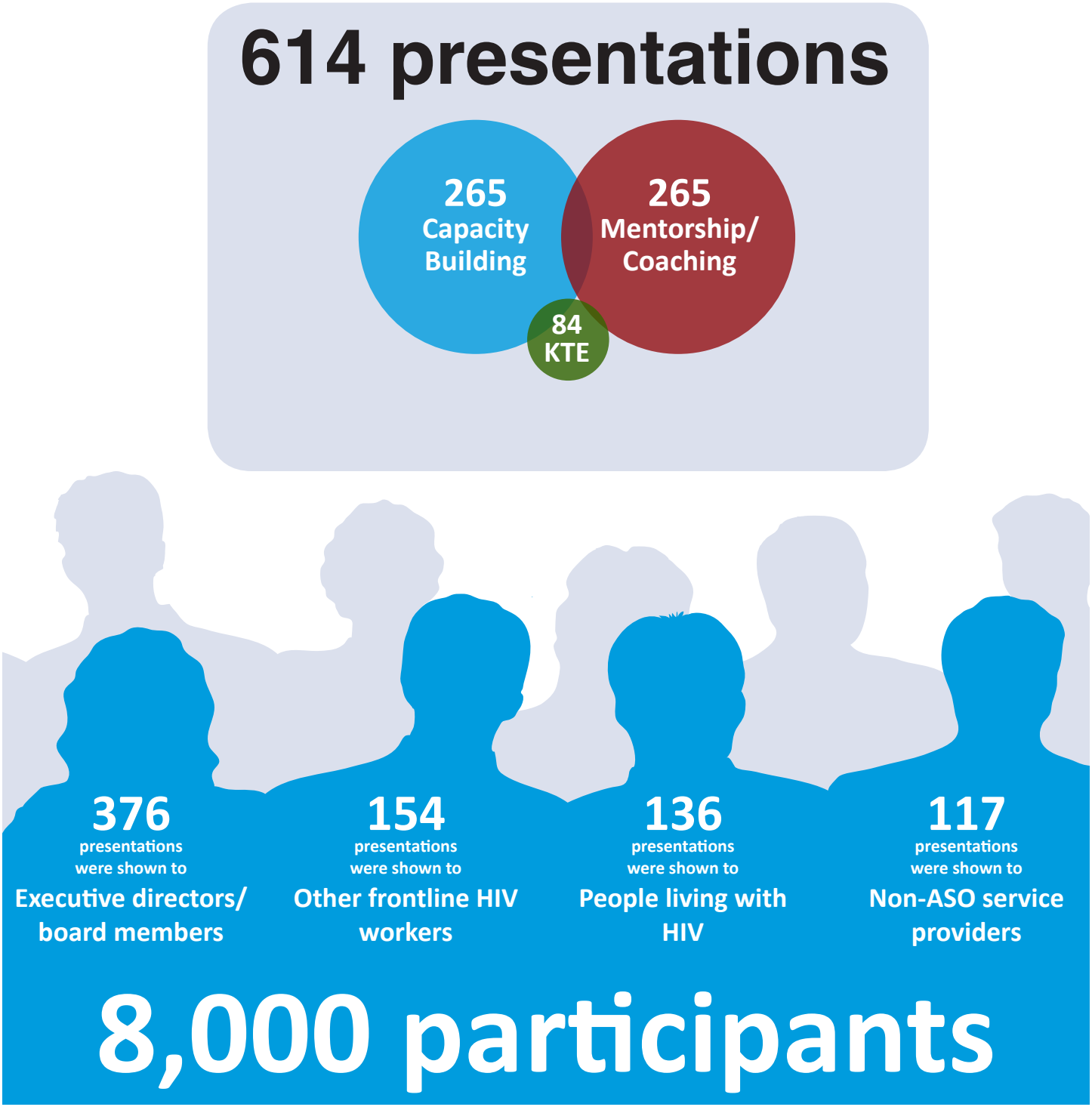
Figure 54. Number of Client Contacts Made by IDU Peers by Activity



ORGANIZATIONAL CAPACITY BUILDING

Provincial resource organizations reached 8,000 people – mainly front-line workers, other service providers and people living with HIV.

Figure 55. Who Did Provincial Resource Organizations Reach?



In terms of the skills gained, provincial presentations for front-line staff focused on dealing with grief and loss, boundaries and other HIV-specific skills; while those that targeted executive directors were more focused on organizational development, GIPA/MIPA and Anti-Racism Anti-Oppression (ARAO). In 2012-13, a significant number of KTE presentations were focused on harm reduction.

4. IMPROVING COMMUNITY COORDINATION AND COLLABORATION

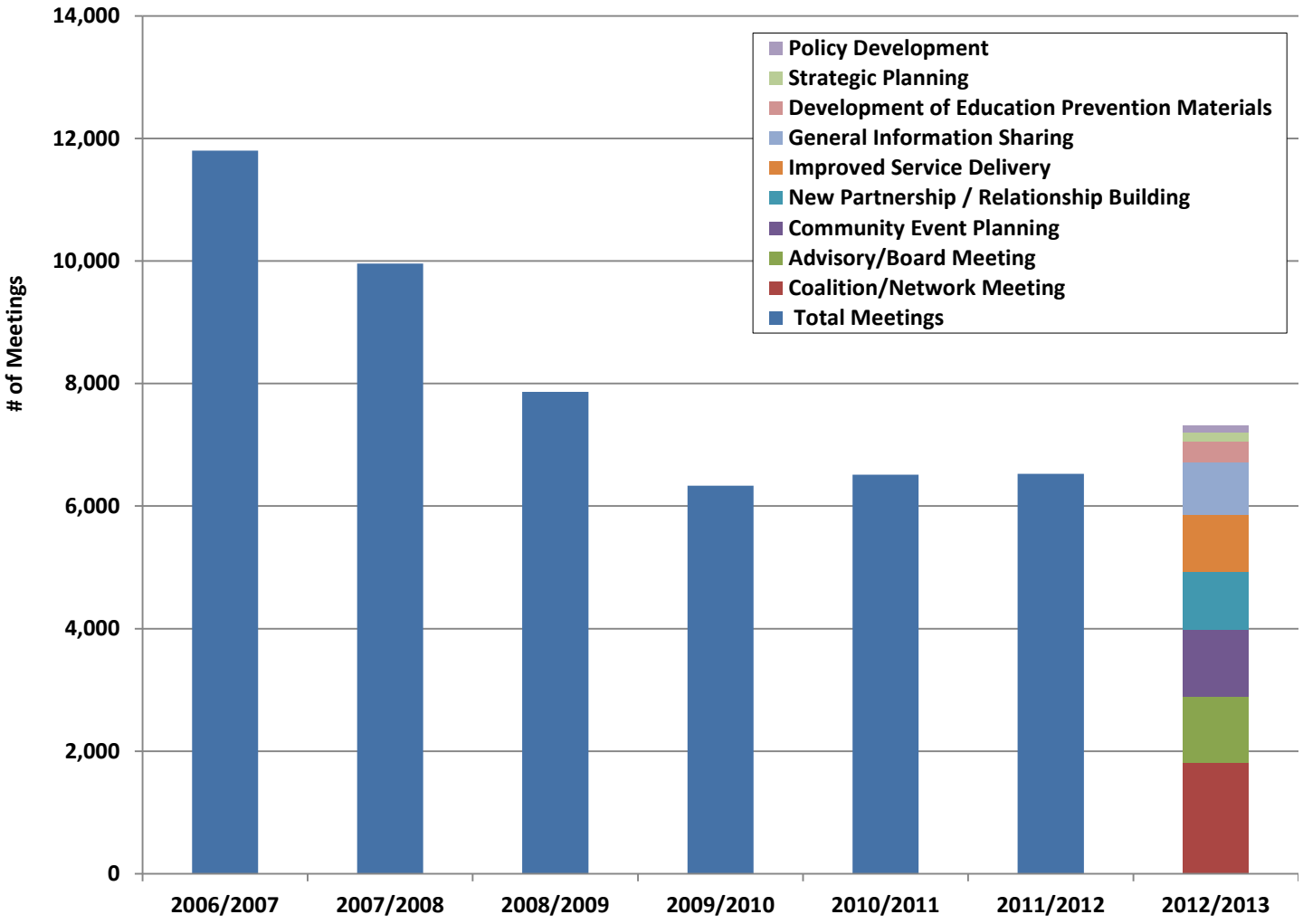
To serve clients well, community-based HIV programs must be connected with other services in their communities and collaborate to provide a continuum of health and social services, and to create safe welcoming environments for people with or at risk of HIV. The main activities that contribute to community coordination and collaboration are community development meetings, networking and partnership-building with other agencies in the community.

In 2012, OCHART changed the way community development meetings are tracked to capture not just the number of meetings but also their purpose.

MORE ENGAGEMENT WITH FAITH ORGANIZATIONS, WORKPLACES AND HOUSING PROVIDERS

In 2012-13, the number of community development meetings increased by 22%, and organizations reported more meetings with faith organizations, workplaces and housing providers than in the past. This trend is encouraging given the importance of housing and employment to health, and the role that faith organizations can play in providing support and reducing stigma.

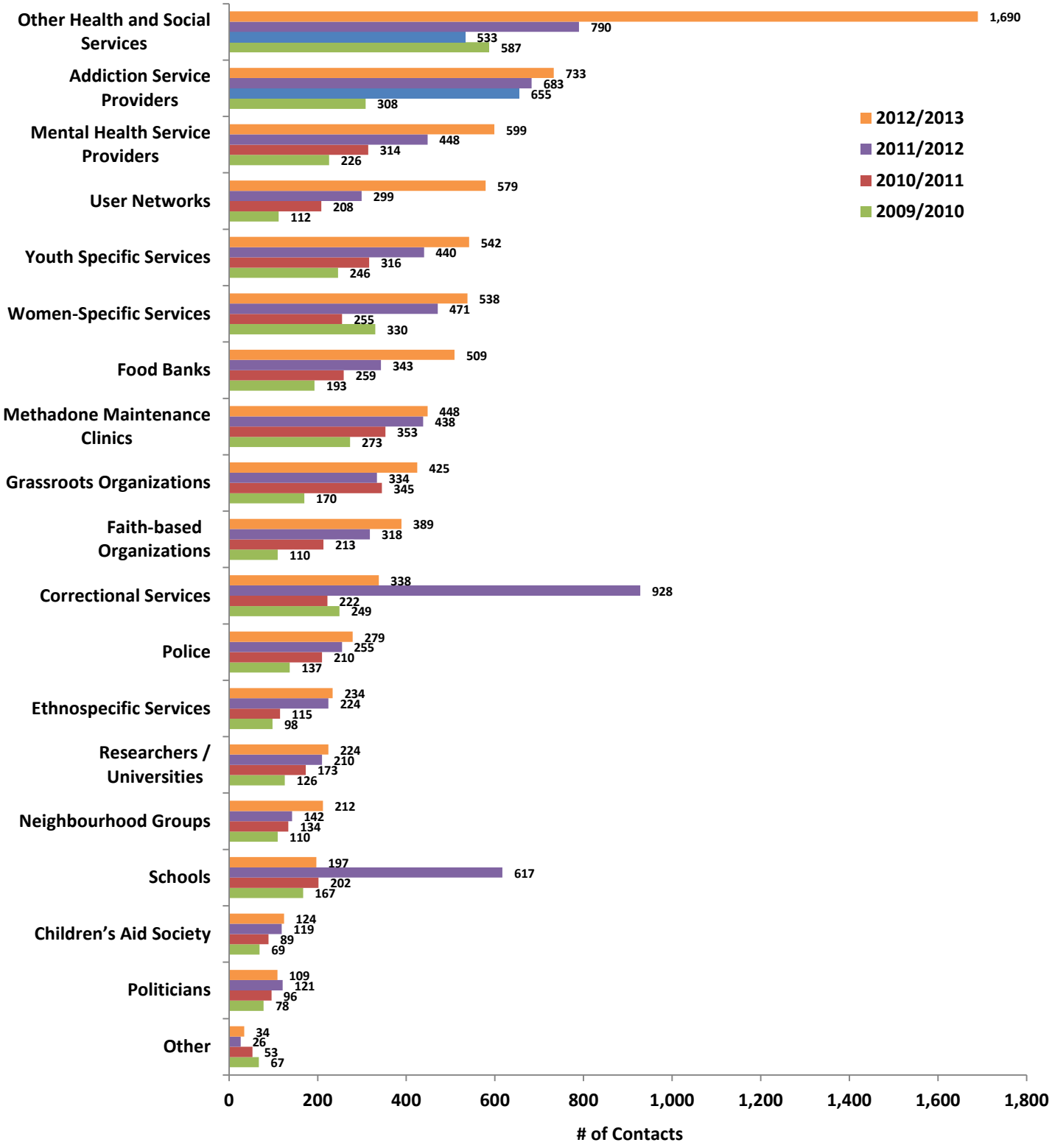
Figure 56. Community Development - Meetings



IDU PROGRAMS BUILDING RELATIONSHIPS WITH OTHER COMMUNITY SERVICES

In 2012-13, IDU programs more than doubled the number of meetings held with other health and social services in their communities. The number of meetings with addiction service providers, mental health providers and service user networks also increased. These activities may reflect the growing move in many communities to establish harm reduction networks that work together to meet the needs of people who use substances.

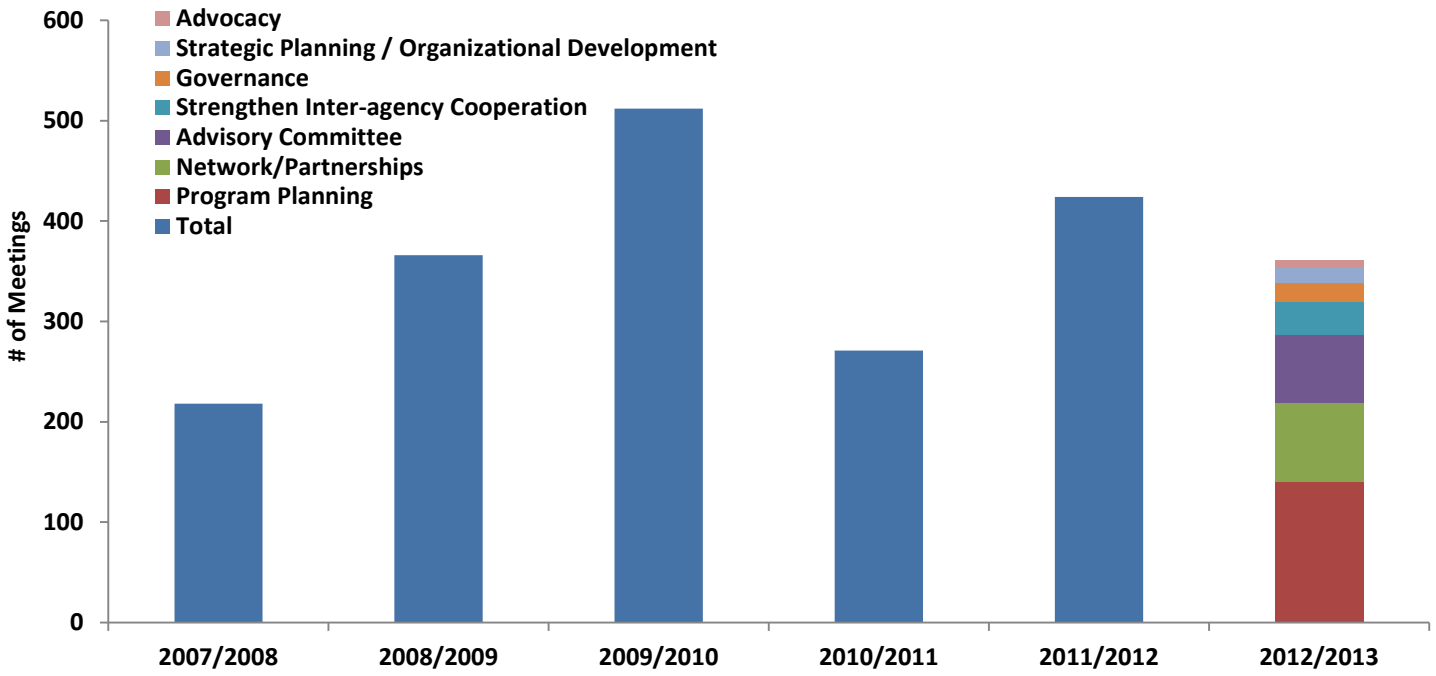
Figure 57. Total Number of IDU / Substance Use Community Development Contacts



PROVINCIAL RESOURCE PROGRAMS FOCUS ON PROGRAM PLANNING AND BUILDING NETWORKS

Community development meetings organized by provincial resource programs were mainly for the purpose of program planning and building networks and partnerships. It may be that these organizations are looking for ways to link their services and provide more integrated supports for community agencies.

Figure 58. Community Development Meetings: Provincial Resource Programs



UNDERSTANDING THE IMPACT OF SERVICE PARTNERSHIPS

We know that community-based HIV programs nurture partnerships with other organizations in their communities – both in the HIV sector and in related sectors, such as mental health, addictions, housing, and (increasingly) long-term care. We are still working to find effective ways to gather meaningful information on partnerships and their impact on the health and well-being of people with or at risk of HIV.

In this report, we focus on comments from organizations that describe the importance and impact of service partnerships:

- **More effective services**

"Effective service provision is not possible without our community partners. 65% of all [our organization's]programming is now joint programming with other agencies – particularly our youth programming."

"Successful collaborations continue to improve access to care for PHAs and access to HIV/AIDS education for frontline healthcare, long term care and ASO service providers. As partnerships develop a level of service is created that supplements existing services both for [our organization] and our partners, creating broader service capacity."

Strong partnerships and coalitions close gaps in services, increase knowledge of individuals and organizations, increase appropriate and responsive services available to people living with , affected by, or at risk of HIV.

- **Ability to meet clients' complex needs**

"Clients with multiple challenges and the most marginalized including homeless and health instability, receive intensive case management with all partner resources immediately to facilitate comprehensive rapid goal focused services resulting in housing, health stabilization, access to medical care, and having basic needs met including a sense of community where diversity is embraced."

"Partnerships support us to access and provide services within underserviced, high priority and at-risk communities within Toronto's Black, African, and Caribbean communities with multiple and complex needs. This includes adult men and women from countries where HIV is endemic, youth and adult MSM, LGBT newcomers, adults and youth living with and/or affected by HIV, transgender/transsexual women and WSW. Partners play a significant role in providing holistic and supportive services to clients."

- **Stronger networks**

"The partnerships have created a more holistic network of education, support, outreach and prevention, as well as joint advocacy and activism on important issues, e.g. Criminalization of HIV Non-Disclosure."

"Strategic partnerships are key in enabling [our agency's] staff and volunteers to reach our target populations and provide relevant services that recognize the complexity of people's lives."

"They also allow us the ability to address individual and systemic barriers faced by our clients and reduce stigma and risk for marginalized populations."

IV. APPENDICES

APPENDIX A: LIST OF FUNDED PROGRAMS

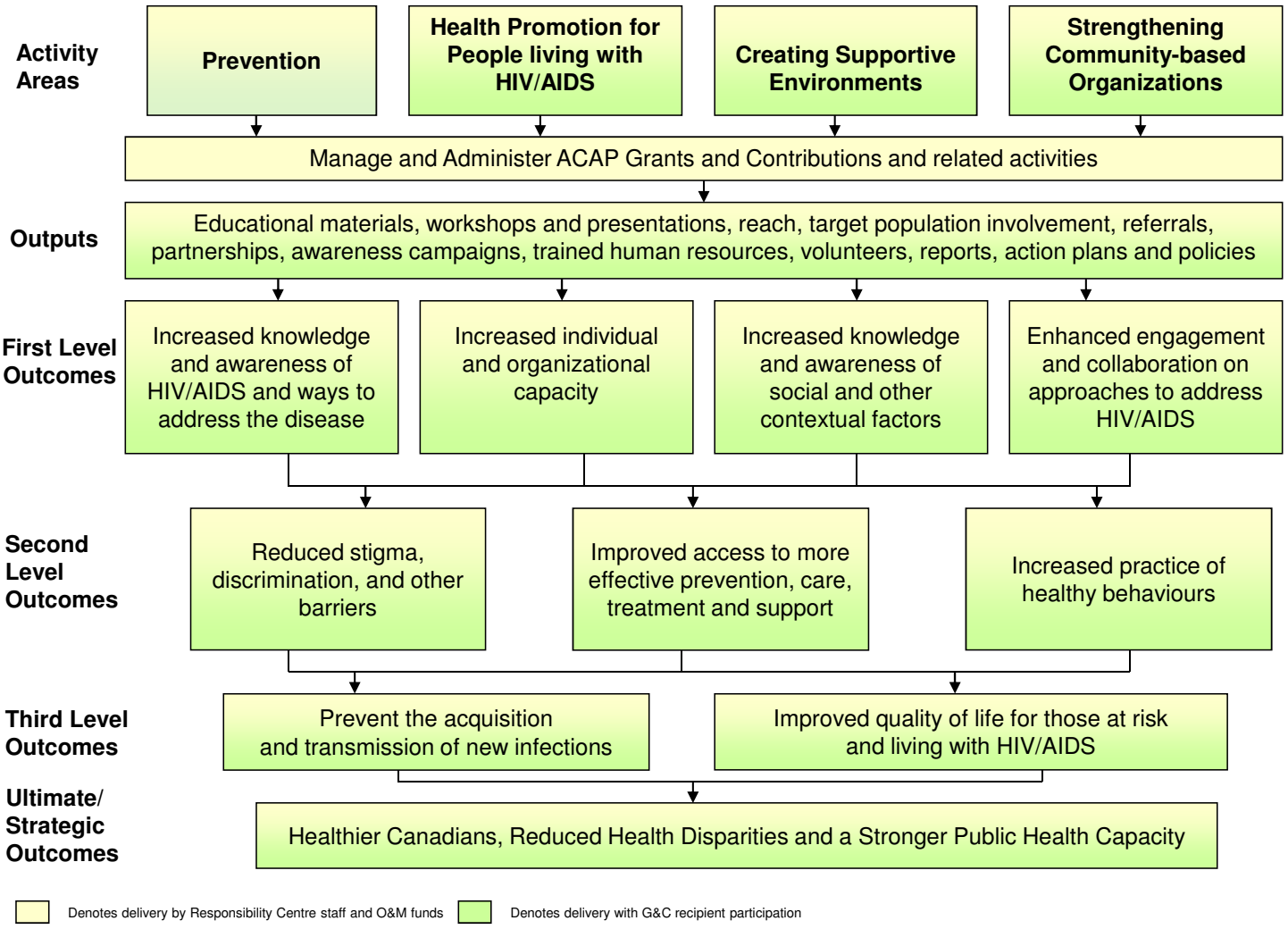
Health Region	Organization Name	LHIN
Central East	AIDS Committee of York Region	Central
	AIDS Committee of Durham Region	Central East
	Peterborough AIDS Resource Network	Central East
	AIDS Committee of Simcoe County	North Simcoe Muskoka
Central West	Hemophilia Ontario - CWOR	Central West
	Peel HIV/AIDS 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	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
	Reseau Access Network	North East
	Sudbury Action Centre For Youth	North East
	Union of Ontario Indians	North East
	AIDS Thunder Bay	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
	Wabano Centre for Aboriginal Health Inc	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

Health Region	Organization Name	LHIN
South West	AIDS Committee of Windsor	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
Toronto	2-Spirited People of the First Nations	Toronto Central
	Action Positive	Toronto Central
	Africans In Partnership Against AIDS	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
	Circle of Care (Sponsored by TPWAF)	Toronto Central
	Committee for Accessible AIDS Treatment	Toronto Central
	Elizabeth Fry Society of Toronto	Toronto Central
	Ethiopian Association	Toronto Central
	Family Service Toronto	Toronto Central
	Fife House	Toronto Central
	Hospice Toronto	Toronto Central
	LOFT Community Services	Toronto Central
	Maggie's: The Toronto Prostitutes' Community Service Project	Toronto Central
	Ont. Assoc.of the Deaf, Deaf Outreach Program	Toronto Central
	Passerelle Integration et Developpement Economiques	Toronto Central
	Planned Parenthood Toronto	Toronto Central
	Reseau des Chercheures (RECAF) Africaines	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 HIV/AIDS Counselling, Testing and Support Program	Toronto Central
	The Teresa Group	Toronto Central
	The Works, City of Toronto Public Health	Toronto Central
	Toronto People With AIDS Foundation - RFAC	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

Health Region	Organization Name	LHIN
Provincial Services	Hemophilia Ontario	Provincial Services
	HIV & AIDS Legal Clinic (Ontario)	Provincial Services
	Ontario Aboriginal HIV/AIDS Strategy	Provincial Services
	PASAN (Prisoners with HIV/AIDS Support Action Network)	Provincial Services
Provincial Resource	African and Caribbean Council on HIV/AIDS in Ontario	Provincial Resource
	AIDS Bereavement and Resiliency Program of Ontario (sponsored by Fifehouse)	Provincial Resource
	Canadian AIDS Treatment Information Exchange	Provincial Resource
	FIFE House - OHSUTP	Provincial Resource
	Gay Men's Sexual Health Alliance	Provincial Resource
	Ontario AIDS Network	Provincial Resource
	Ontario Organizational Development Program	Provincial Resource

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

Operational Projects

Project Number	Sponsor	Project Title
6963-06-2012/4480524	Bruce House	Expanding and Strengthening Volunteer Supports to Improve Quality of Life for People Living with HIV/AIDS
6963-06-2011/4480510	Réseau Access Network	Fostering Diversity and greater access to HIV/AIDS information within Educational Institutions
6963-06-2011/4480512	The AIDS Committee of Cambridge, Kitchener, Waterloo and Area	Youth Sexual Health Program
6963-06-2011/4480513	The AIDS Committee of York Region Inc.	Community HIV Engagement Project
6963-06-2011/4480509	The Teresa Group - Child and Family Aid	Volunteer Support Program Enhancement
6963-06-2011/4480516	Regional HIV/AIDS Connection	GBMSMT2SY and HIV Initiative-Community Development and Knowledge Transfer Exchange
6963-06-2012/4480535	AIDS Bereavement and Reslilency Program of Ontario Sponsored by Fife House Foundation Inc.	Nuts and Bolts: Developing Organizational Tools to Build Effective Working Relationships with PHAs in Multiple Roles
6963-06-2011/4480517	AIDS Committee (Durham)	HYPE - HIV & Youth Peer Engagement Program
6963-06-2011/4480507	AIDS Committee of Guelph and Wellington County	Regional Rural Education Project
6963-06-2012/4480526	AIDS Committee of Simcoe County	Bridging HIV Prevention to men who sex with men (MSM) and their female partners
6963-06-2012/4480522	AIDS Committee of Toronto	Promoting the health of gay men and women living with HIV/AIDS
6963-06-2012/4480523	AIDS Thunder Bay	PHA Mobilization and Organizational Integration Program (PHA MOIP)
6963-06-2012/4480532	Committee for Accessible AIDS Treatment Sponsored by Toronto People With AIDS Foundation	Walk with us: Investing & inspiring collective empowerment for PHAs and affected communities (Legacy 2)
6963-06-2012/4480530	Fife House Foundation Inc.	Buddies for Life and Volunteer Recruitment 2.0
6963-06-2012/4480525	Hamilton AIDS Network for Dialogue and Support (HANDS)	Gay Men's HIV Prevention Program
6963-06-2011/4480508	Ontario AIDS Network	Living PHA Leadership in our lives and in the communities we serve
6963-06-2012/4480539	Ontario AIDS Network	Increasing Capacity: Group Based Intervention for Gay and Bisexual Men
6963-06-2012/4480531	Peel HIV/AIDS Network Inc.	Empowerment and Transformation of People living and affected by HIV/AIDS in the Region of Peel
6963-06-2012/4480534	Peterborough AIDS Resource Network	Normalizing HIV: Building on individual and community assets to address determinants of health vulnerabilities.
6963-06-2012/4480537	Regional Food Access Committee Sponsored by Toronto People With AIDS Foundation	Community Food Access Project
6963-06-2012/4480520	The Ontario Organizational Development Program Sponsored by Regional HIV/AIDS Connection	The Creation and Delivery of HIV/AIDS Specific Organizational Development Resources to HIV/AIDS Organizations in Ontario

6963-06-2012/4480536	Toronto People with AIDS Foundation	Dreaming & Opportunities Project
6963-06-2012/4480527	AIDS Committee of Niagara	Community Development and Education Program
6963-06-2011/4480514	HIV/AIDS Regional Services (HARS)	HARS Prevention and Education Outreach Program
6963-06-2013/4480540	AIDS Committee of Windsor	Gay/MSM Sexual Health Program
6963-06-2012/4480538	Alliance for South Asian AIDS Prevention	Connecting to Care: South Asian PHA Peer Leaders Supporting Each Others
6963-06-2012/4480521	Asian Community AIDS Services	Volunteers' Capacity Building & Community Engagement Project
6963-06-2011/4480511	Prisoners with HIV/AIDS Support Action Network	Prison Support & Health Promotion Project
6963-06-2012/4480533	The Black Coalition for AIDS Prevention of Metropolitan Toronto	Health and Social Determinants Support Program
6963-06-2012/4480529	AIDS Committee of North Bay and Area/Comite du SIDA de North Bay et de la Region	Extending the Reach: HIV Regional Outreach and Education
6963-06-2012/4480528	Africans in Partnership Against AIDS	"Taruwan Maza" Heterosexual men gathering together

Time Limited Projects

Project Number	Sponsor	Project Title
6963-06-2011/6420458	AIDS Committee of Cambridge, Kitchener, Waterloo and Area	Gay Men's Sexual Health Program
6963-06-2011/6420473	Planned Parenthood of Toronto	Youth HIV Project: Prevention, Engagement, Action and Knowledge (PEAK)
6963-06-2011/6420455	Réseau Access Network	"Surviving Sex Trade" an Education and Prevention Program
6963-06-2011/6420457	The Elizabeth Fry Society, Toronto Branch	Work Safe – Trans and High Risk Sex Workers Outreach Project
6963-06-2011/6420459	Regional HIV/AIDS Connection	Enhancing Regional Service Delivery for PHAs and at Risk Populations in Six Counties
6963-06-2011/6420474	Wabano Centre for Aboriginal Health Inc.	Respecting the Earth, Fire and Ourselves
6963-06-2011/6420456	AIDS Committee of Guelph and Wellington County	Project ATTACH- Art, technology, theatre addressing community health
6963-06-2011/6420463	AIDS Committee of Toronto	Positive Youth Outreach (PYO)
6963-06-2011/6420468	Fife House Foundation Inc.	HIV/AIDS Complex Care Pilot Project: Developing a Continuum of Enhanced Community Care and Housing
6963-06-2011/6420467	Hamilton AIDS Network for Dialogue and Support (HANDS)	Connecting Regional PHAs in Haldimand, Norfolk and Brant to Care and Support
6963-06-2011/6420477	Toronto People with AIDS Foundation	Holistic Engagement
6963-06-2011/6420460	Sault Ste. Marie and District Group Health Association	Community Education and Prevention Project
6963-06-2011/6420471	The Centre for Spanish-Speaking Peoples	INFO plus: intervention to reduce HIV/STI's infection among Latino gay men in Toronto
6963-06-2011/6420461	AIDS Committee of Windsor	Volunteer Leadership Program

6963-06-2011/6420464	Ethiopian Association in the Greater Toronto Area and Surrounding Regions	HIV/AIDS Prevention and Education Program
6963-06-2011/6420466	Somerset West Community Health Centre	African and Caribbean Community Development and HIV Health Initiative
6963-06-2011/6420476	Women's Health in Women's Hands	Intervention on Disclosure of HIV +ve Status for ACB Women: Organizational Integration (Institutionalization) of Intervention
6963-06-2011/6420469	Passerelle Intégration et Développement Économiques	Outils de prévention du VIH pour immigrants francophones de pays où le VIH est endémique
6963-06-2011/6420475	Réseau des chercheures africaines (RECAF)	Trajectoires intersectionnelles de la sexualité et du VIH-Sida chez les femmes immigrantes francophones

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 your 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, Outreach and Community Development -	9-10 Education Sessions	Improving Knowledge and Awareness
	9-10.5 Community Development Meetings	Improving Coordination and Collaboration
	9-10.7 Education Resources	Improving Knowledge and Awareness
	9-10.8, 9-10.9 and 13.10 Safer Sex Supplies	Improving Knowledge and Awareness
	9-10.9 Awareness Campaigns	Improving Knowledge and Awareness
	9-10.10 Outreach Contacts by Location	Improving Knowledge and Awareness
	9-10.11 Social Media	Improving Knowledge and Awareness
	9-10.12 Peer Involvement	Enhancing Individual and Organizational Capacity
	9-10 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
Provincial Resource Programs -	14.1 Education Sessions	Enhancing Individual and Organizational Capacity
	14.4 Community Development Meetings	Improving Coordination and Collaboration
	14 Narratives	Improving Coordination and Collaboration

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	38,369	$15.25	$585,127.25	$70,215.27	$655,342.52
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	20,331	$39.00	$792,899.25	$95,147.91	$888,047.16
Support services (assistance to people living with HIV/AIDS, peer support, etc)	12.2 sum of total # of vol hrs for Practical Support and Counselling	Community and social service workers 4212	60,226	$21.51	$1,295,461.26	$155,455.35	$1,450,916.61
Prevention (outreach, targeted education, etc)	12.2 total # of vol hrs for Outreach Activities	Community and social service workers 4212	15,667	$21.51	$336,997.17	$40,439.66	$377,436.83
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	20,231	$29.74	$601,669.94	$72,200.39	$673,870.33
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	46,316	$15.25	$706,319.00	$84,758.28	$791,077.28
Human resources	12.2 sum to total # of vol hrs for involvement in hiring process and policies and proecdures	Specialists in human resources 1121	1,610	$29.74	$47,881.40	$5,745.77	$53,627.17
IT Support	12.2 sum of total # of vol hrs for IT support	Web designers and developers 2175	535	$27.78	$14,862.30	$1,783.48	$16,645.78
Total					**$4,381,217.57**		**$4,906,963.68**

* Add the hours from your H1 and H2 OCHART report

APPENDIX F: ACRONYMS

Acronym	Name
ABRPO	AIDS Bereavement and Resiliency Project Program of Ontario
ACAP	AIDS Community Action Plan
ACB	African, Caribbean and Black
ACCHO	The African and Caribbean Council on HIV/AIDS in Ontario
ACT	AIDS Committee of Toronto
ACTG	AIDS Clinical Trials Group
AGM	Annual General Meeting
APH	Algoma Public Health
APAA	African in Partnership Against AIDS
ARAO	Anti-Racism Anti-Oppression
ASO	AIDS Service Organization
ATB	AIDS Thunder Bay
Avg.	Average
BLACKCAP	Black Coalition For AIDS Prevention
CAAT	Committee for Accessible AIDS Treatment
CAHR	Canadian Association of HIV Research
CAMH	Centre for Addiction and Mental Health
CATIE	Community AIDS Treatment Information Exchange
CBAESP	Community Based AIDS Education & Support Program
CBAO	Community Based AIDS Organization
CBR	Community Based Research
CBSA	Canada Border Services Agency
CHC	Community Health Centre
CMHA	Canadian Mental Health Association
CTAC	Canadian Treatment Action Council
EBPU	Evidence Based Practice Unit
FTE	Full Time Equivalent
GIPA	Greater Involvement of People Living with HIV/AIDS
GMSH	Gay Men's Sexual Health Alliance
H&C	Humanitarian and Compassionate Leave Application
H1	April to September Reporting Period
H2	October to March Reporting Period
HALCO	HIV/AIDS Legal Clinic Ontario
HCV	Hepatitis C Virus
HR	Human Resources
HR hetero	High risk heterosexual
IDU	Injection Drug Use
IT	Information Technology
KTE	Knowledge Transfer and Exchange
LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer, Questioning
LHIN	Local Health Integration Network
LR hetero	Low risk heterosexual
MIPA	Meaningful Involvement of People Living With HIV/AIDS
MOHLTC	Ministry of Health and Long Term Care
MSM	Men who have Sex with Men
OACHA	Ontario Advisory Committee on HIV/AIDS
OAHAS	Ontario Aboriginal HIV/AIDS Strategy
OAN	Ontario AIDS Network
OCASE	Ontario Community AIDS Services and Evaluation

OCHART	Ontario Community AIDS Reporting Tool
OCS	OHTN Cohort Study
OCSGC	OHTN Cohort Study Governance Committee
ODB	Ontario Drug Benefit
OHSUTP	Ontario HIV and Substance Use Training Program
OHTN	Ontario HIV Treatment Network
OODP	Ontario Organizational Development Program
OPRAH	Ontario Provincial Resource for ASOs in Human Resources
PARN	Peterborough AIDS Resource Network
PASAN	Prisoners with HIV/AIDS Support Action Network
PHA	Persons with HIV or AIDS
PHAC	Public Health Agency of Canada
PHIPA	Personal Health Information Protection Act
POC	Point of Care Testing
PP	Priority Populations
PSAs	Public service announcements
PWA	Toronto People With AIDS
RHAC	Regional HIV/AIDS Connection
STI	Sexually Transmitted Infection
WHAI	Women & HIV/AIDS Initiative
WHIWH	Women's Health in Women's Hands
WSW	Women who have Sex with Women

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