VIEW FROM THE FRONT LINES 2014

OCHART

Annual Summary & Analysis of Data

April 1, 2013 - March 31, 2014

ACKNOWLEDGEMENTS

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

In addition, the AIDS Bureau and PHAC's Ontario Region would like to thank the Ontario HIV Treatment Network (OHTN) for its support of OCHART. This includes developing the web-based OCHART tool, providing ongoing training and support to programs on the use of OCHART, housing the data, extracting the data, and completing the analyses for this report.

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Copies of this report can be found at:
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Data Requests: The OHTN is happy to respond to specific requests for data from community-based organizations. Please contact ochart@ohtn.on.ca.

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This report should be cited in the following manner:

Source of data: Ontario Community HIV and AIDS Reporting Tool (OCHART). The View from the Front Lines, (2014): Annual summary & analysis of data provided by community-based HIV/AIDS services in Ontario. Toronto, ON: AIDS and Hepatitis C Programs, Ontario Ministry of Health and Long-Term Care and the Public Health Agency of Canada, Ontario Region; (2014).

PREFACE

Welcome to the 9th 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 Region, AIDS Community Action Program (ACAP) are required to complete the web-based OCHART.

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

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

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

THE PURPOSES OF OCHART REPORTING

ACCOUNTABILITY

The reports allow the programs, the AIDS Bureau and the Public Health Agency of Canada to check actual activity against program plans and logic models. They also provide information on how resources were used.

PLANNING

The reports may identify trends that can be used to adjust services or develop new services locally and provincially.

QUALITY IMPROVEMENT/EVALUATION

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

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, additional data from OCHART questions is available in a separate document on the OCHART web site.

2. FOCUSING ON THE OUTCOMES OF OUR WORK

Our 2013-14 findings are organized under the four anticipated short-term outcomes of community-based HIV services:

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

DATA LIMITATIONS

ACCURACY AND CONSISTENCY

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

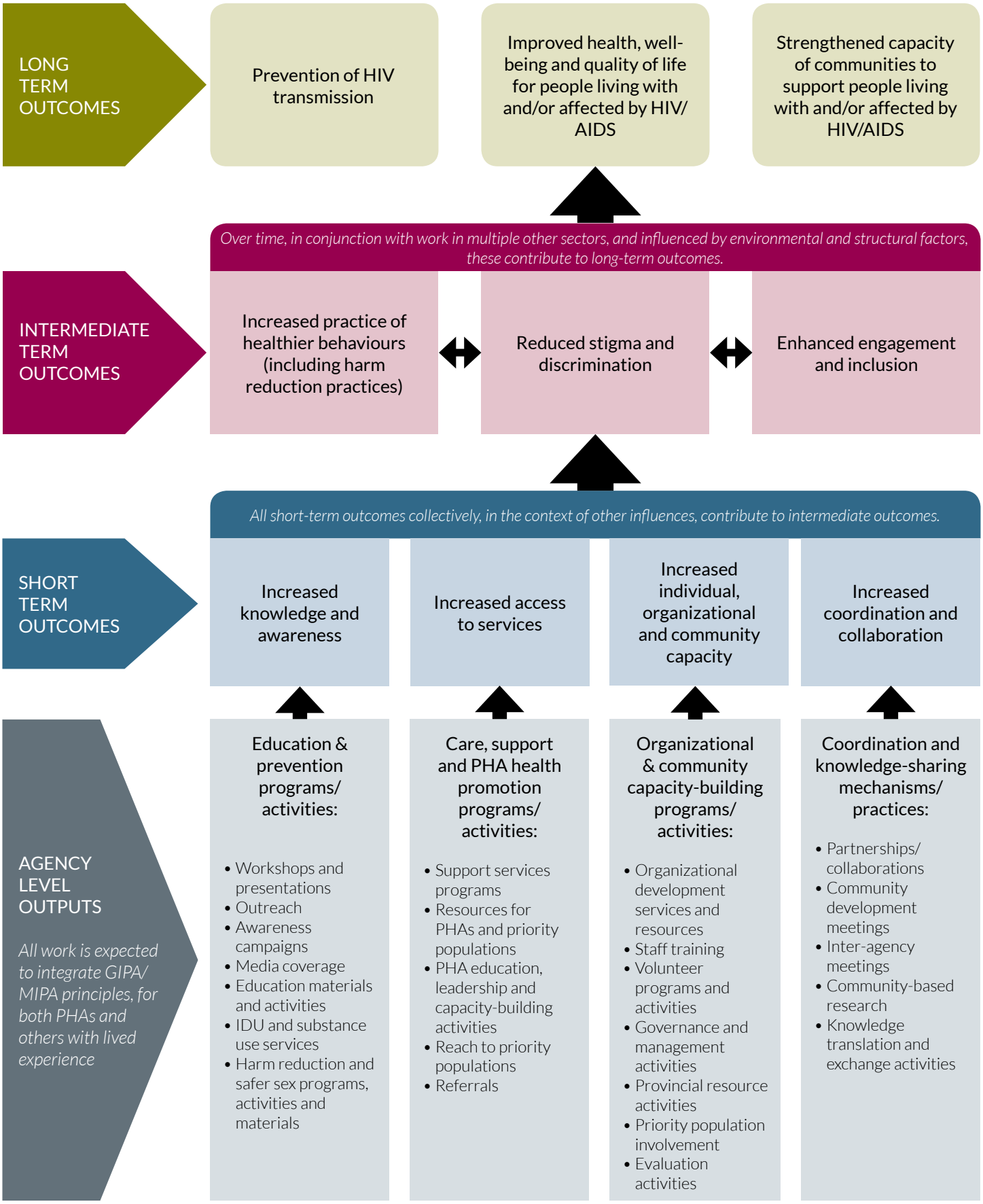
USE OF AGGREGATE DATA

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



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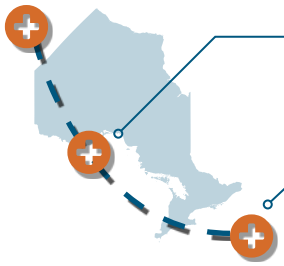
HIV Epidemiology In Ontario

NEW HIV DIAGNOSES

The number of new HIV diagnoses in Ontario have been decreasing over the past three years. In 2013, there were 827 new HIV diagnoses in Ontario — down 7% from 886 in 2012. The data presented in this section is provided by the Public Health Ontario Laboratory.

DIAGNOSES DOWN

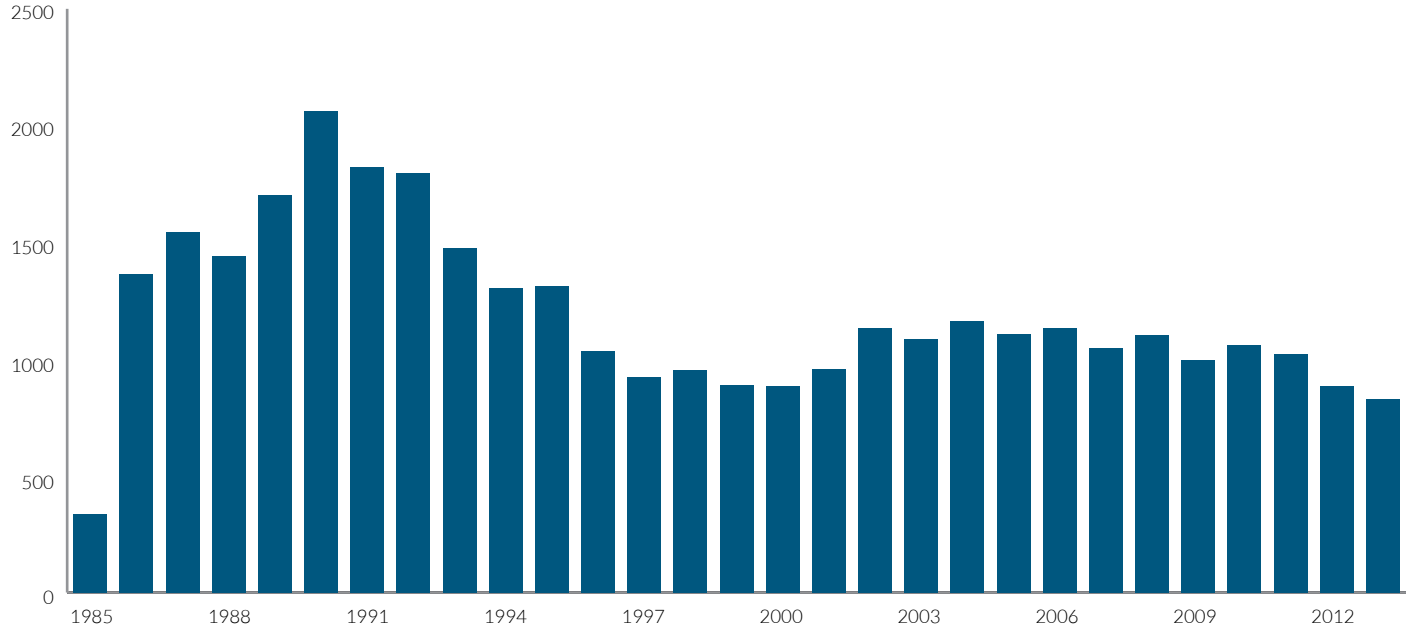


2012: 886 new diagnoses

2013: 827 new diagnoses

A person who is newly diagnosed with HIV may not have a new HIV infection, as diagnosis can occur years after infection. This category also includes people with HIV who have moved to Ontario and have tested for the first time in Ontario.

FIGURE 1
NUMBER OF NEW HIV DIAGNOSES, ONTARIO, 1985-2013



NEW HIV DIAGNOSES BY PRIORITY POPULATION

In terms of the populations most affected by HIV:

- The number of new HIV diagnoses in gay, bisexual and other men who have sex with men decreased slightly in 2013 to 487, and is consistent with a stable long-term trend. However, gay men still accounted for 59% of new diagnoses in 2013 — and have made up an increasing proportion of new diagnoses for the past several years.
- The number of new diagnoses in heterosexual people from countries where HIV is endemic — most of whom are part of African, Caribbean and Black communities in Ontario — has continued to decrease, with 125 new HIV diagnoses in 2013. This group now accounts for a smaller proportion of new diagnoses each year (15% in 2013 compared to 33% in 2006).
- The number and percent of new HIV diagnoses among heterosexual people from non-endemic countries has been stable or slightly decreasing over time. In 2013, 30 heterosexual people diagnosed with HIV were known to have a risk factor for HIV (High Risk, 4% of all new diagnoses in 2013) while 95 people did not (Low Risk, 12%).
- The number of new diagnoses in people who inject drugs (59 in 2013) has decreased over time and accounted for 7% of new diagnoses in 2013.

These numbers are based on adjustments that account for HIV diagnoses where information about priority population is missing.

FIGURE 2
NUMBER OF NEW HIV DIAGNOSES BY PRIORITY POPULATION, ONTARIO, 1985-2013

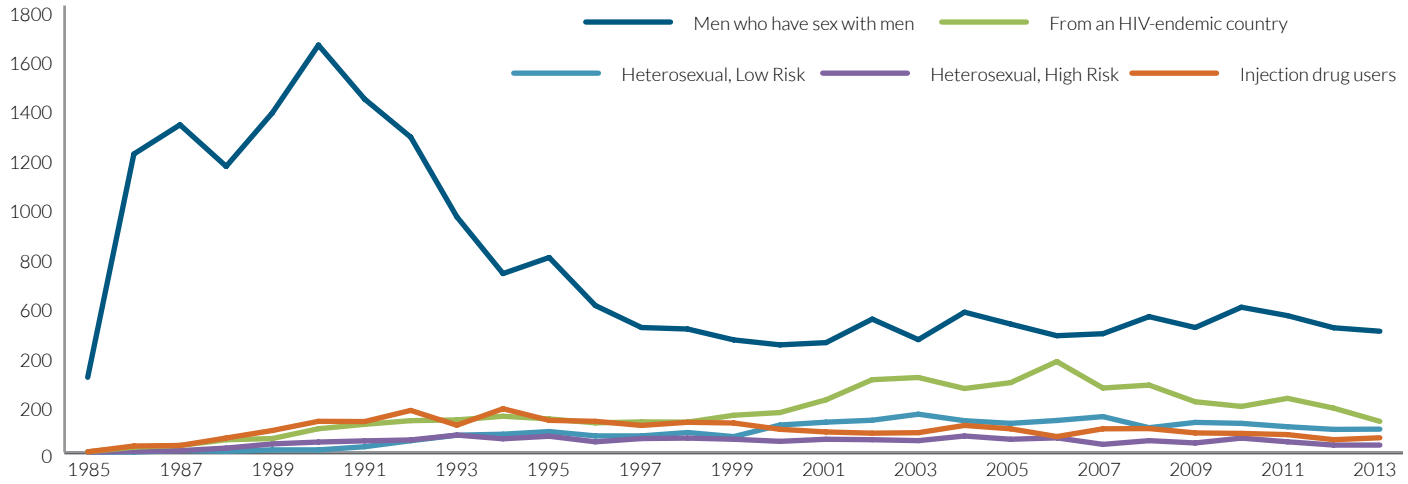


FIGURE 3.
PERCENT OF NEW HIV DIAGNOSES BY PRIORITY POPULATION, ONTARIO, 1985-2013

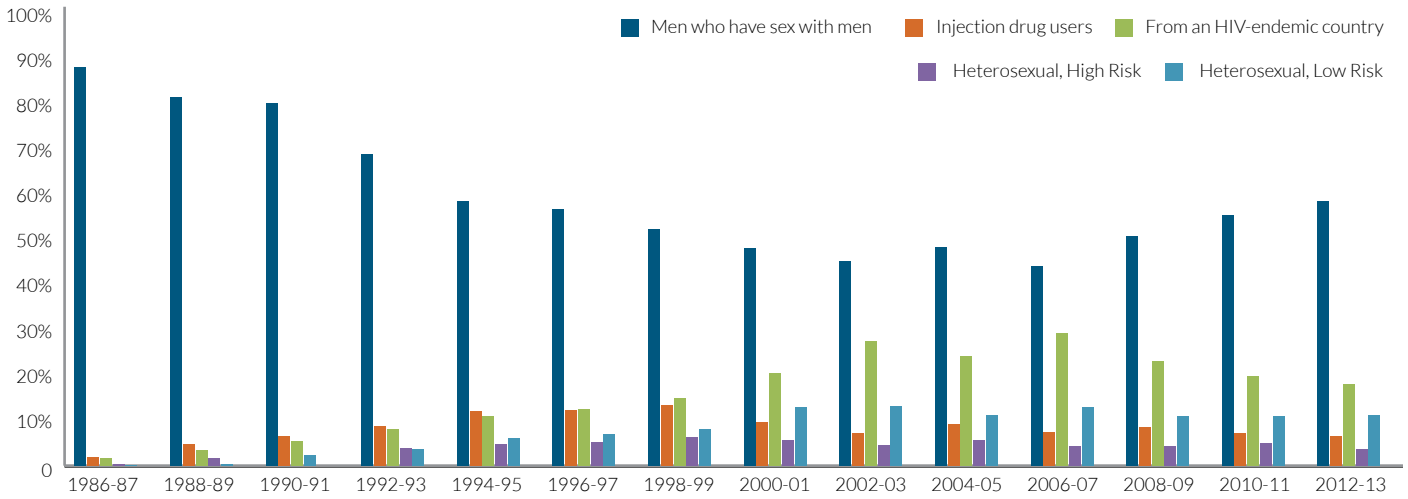


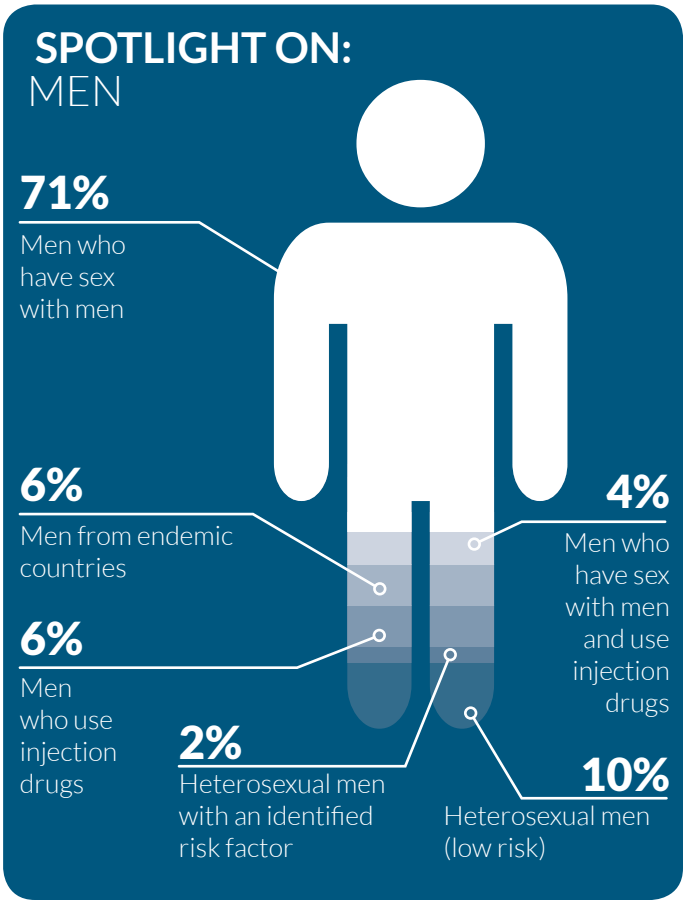
FIGURE 4
NEW HIV DIAGNOSES BY RISK FACTOR AND SEX ONTARIO 2004-2013

NEW DIAGNOSES BY SEX AND RISK FACTOR

In terms of sex:

- In 2013, 686 new diagnoses were in males – similar to the 692 new diagnoses in 2012. Of the 686 new diagnoses, 71% were MSM, 4% were MSM who were also IDU, 6% were males from HIV endemic countries, 6% were IDU, 2% were heterosexual males with an identified risk factor (High Risk), 10% were heterosexual males with no identified risk factor (Low Risk).
- 141 were in females – down 27% from 194 in 2012. Of these 141 new diagnoses, 57% were heterosexual females from HIV endemic countries, 11% were IDU, 12% were heterosexual females with an identified risk factor (High Risk), and 19% were heterosexual females without an identified HIV risk factor (Low Risk).

The largest decrease in new HIV diagnoses was in women. In 2013, women accounted for 17% of new diagnoses (down from 25% in previous years) while men accounted for 83%.



MORE DIAGNOSES IN OLDER AGE GROUPS

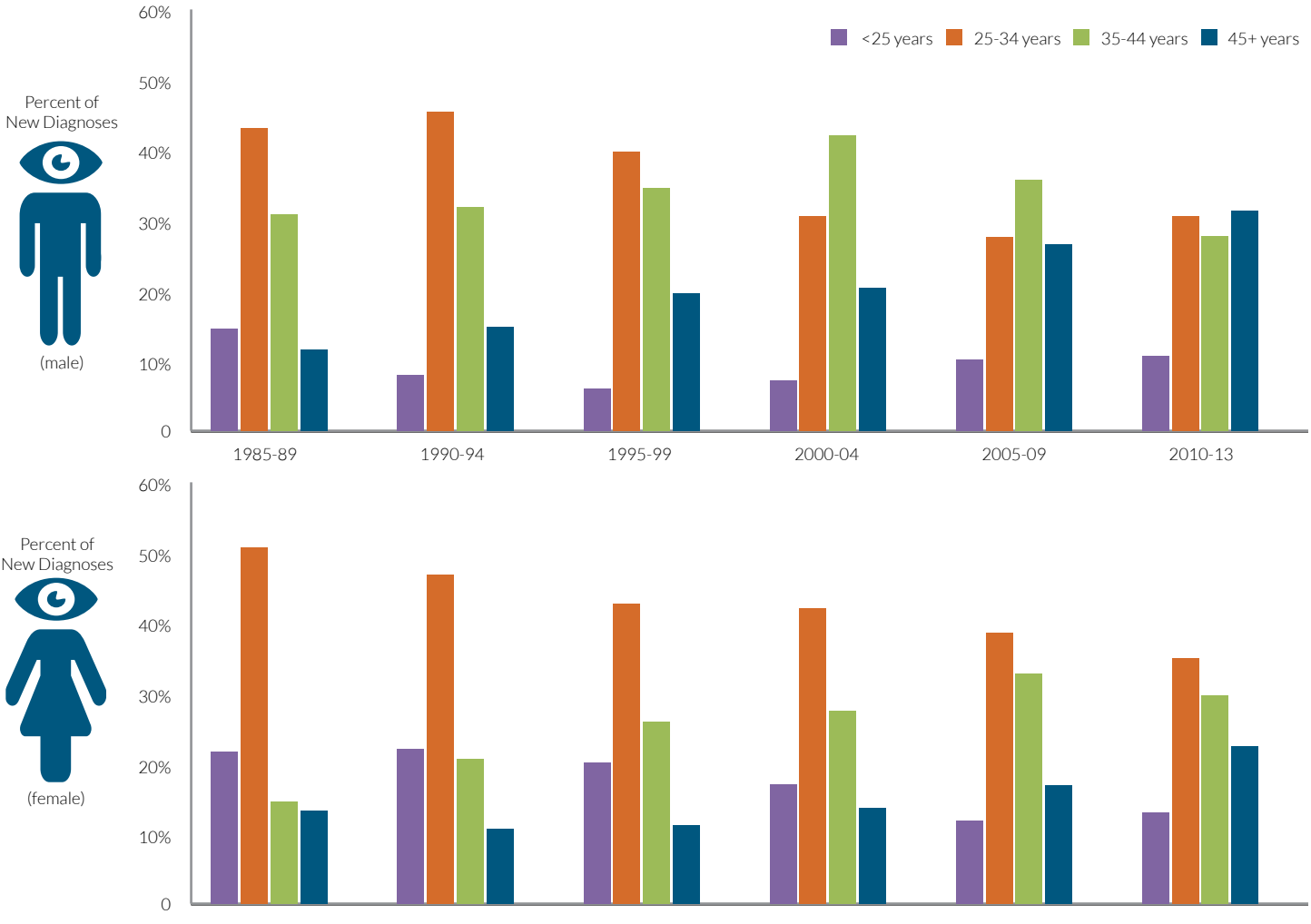
The greatest proportion of new HIV diagnoses each year are among males and females between 25 and 34 years of age (31% for males and 35% for females for 2010-2013). However, as the following charts illustrate, Ontario has seen a steady increase in the proportion of new diagnoses each year among men and women 45 years of age and older.

20% MORE NEW DIAGNOSES AMONG PEOPLE 45 YEARS OLD AND UP

Men: 31

Women: 22

FIGURE 5
AGE AT TIME OF HIV DIAGNOSIS BY SEX, ONTARIO 1985-2013



BREAKDOWN BY ETHNICITY

Information on self-reported ethnicity is available for approximately 60% of new HIV diagnoses each year since 2009. When looking at breakdowns by ethnicity, it is important to keep in mind that breakdowns may be different for the 40% of people diagnosed with HIV whose ethnicity is not known. The following chart summarizes data from the 60% of people where self-reported ethnicity is available over a five year period (2009 to 2013).

Overall in the province of Ontario:

- The majority of new HIV diagnoses between 2009 and 2013 are white (52%), followed by Black (25%).
- The majority of new HIV diagnoses in men follow the same pattern.
- The distribution of new HIV diagnoses among females is different: most are Black (61%) followed by white (25%).
- 3% of the new HIV diagnoses between 2009 and 2013 were in people who self-identified as being Indigenous (2% among males, and 4% among females).

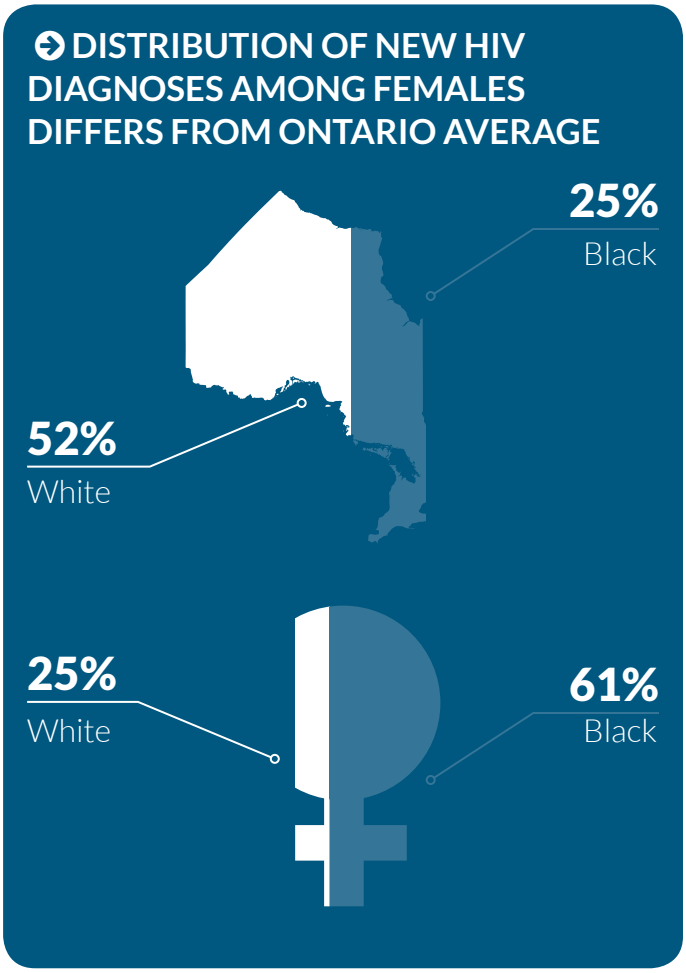
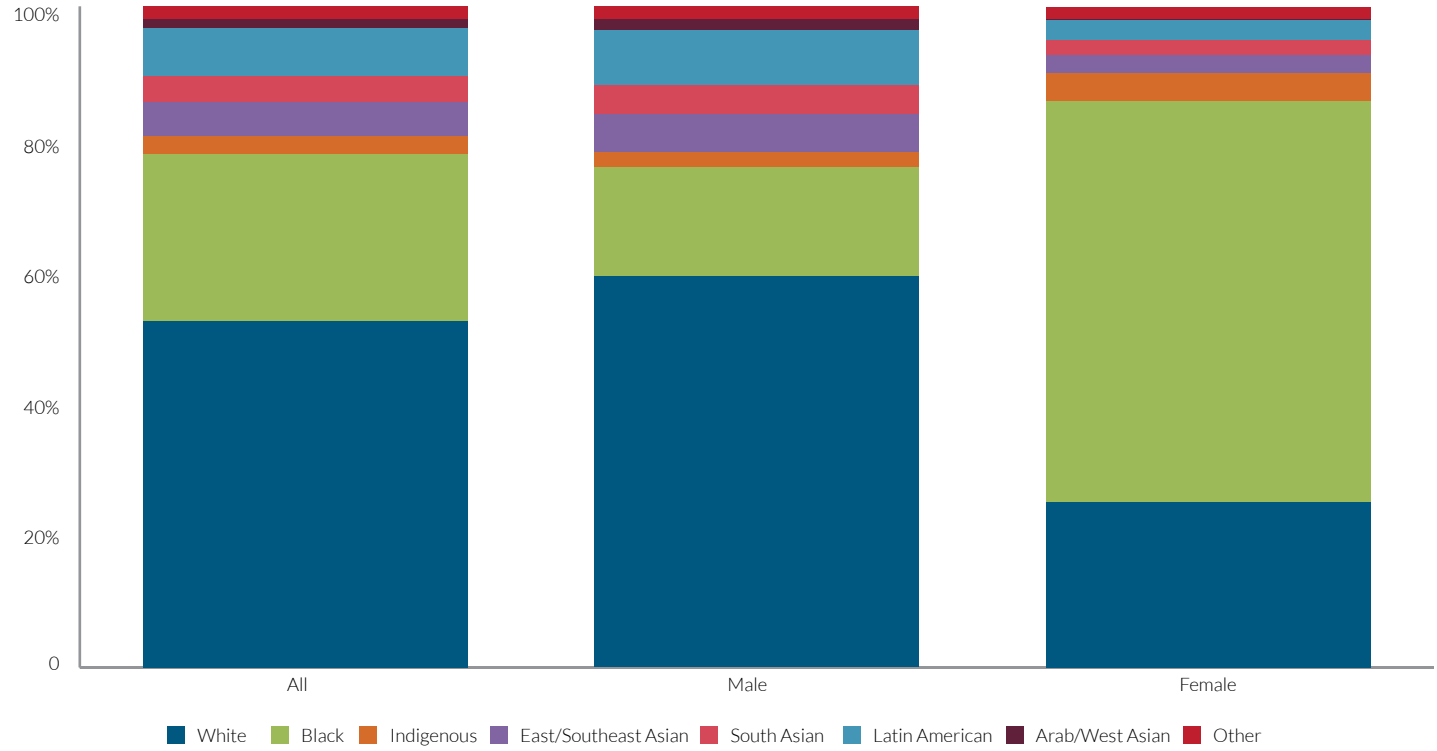
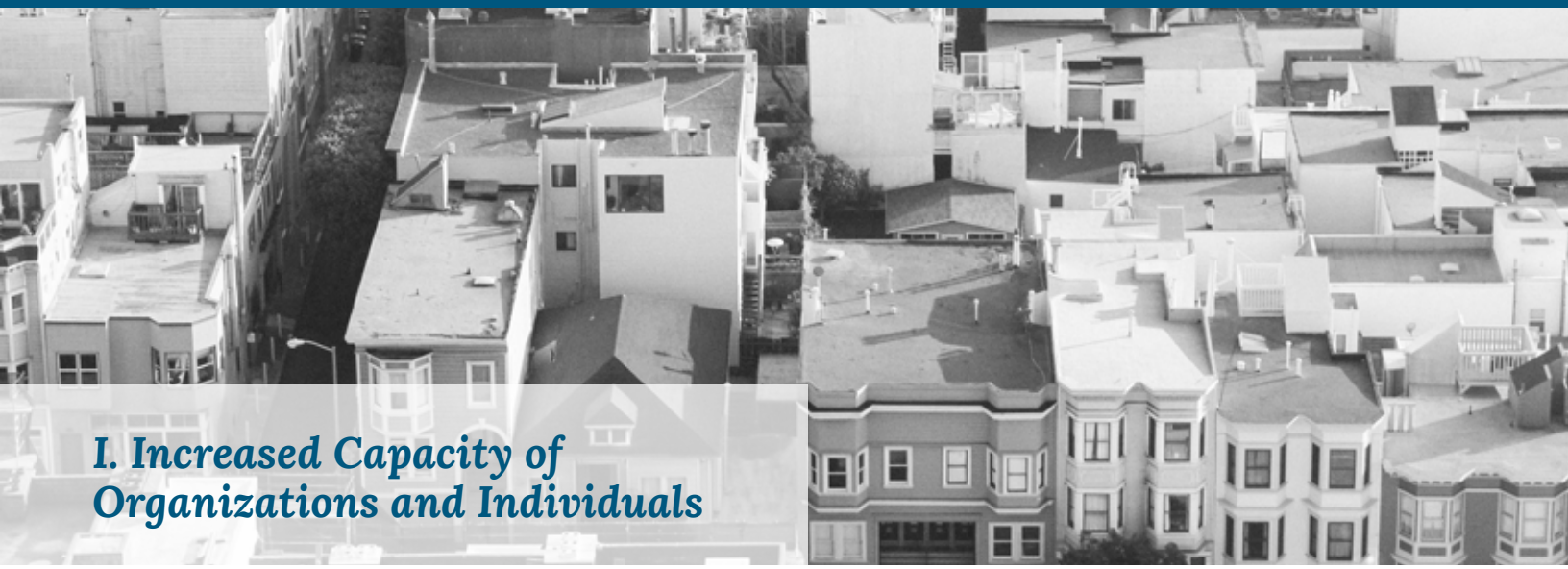


FIGURE 6
PERCENT OF NEW HIV DIAGNOSES BY ETHNICITY AND SEX, ONTARIO 2009-2013





I. Increased Capacity of Organizations and Individuals

In 2013-14, the AIDS Bureau and ACAP funded a total of 89 programs in 73 organizations to provide HIV services.

HIV programs are located across the province (see Figure 7 and Appendices A and C). HIV programs are funded to provide prevention, outreach and support services for people with or at risk of HIV, and their partners and families.

WHO WE ARE AND WHAT WE DO

Although the number of funded HIV programs increased (from 87 to 89), the total number of organizations funded (73) remained the same and included:

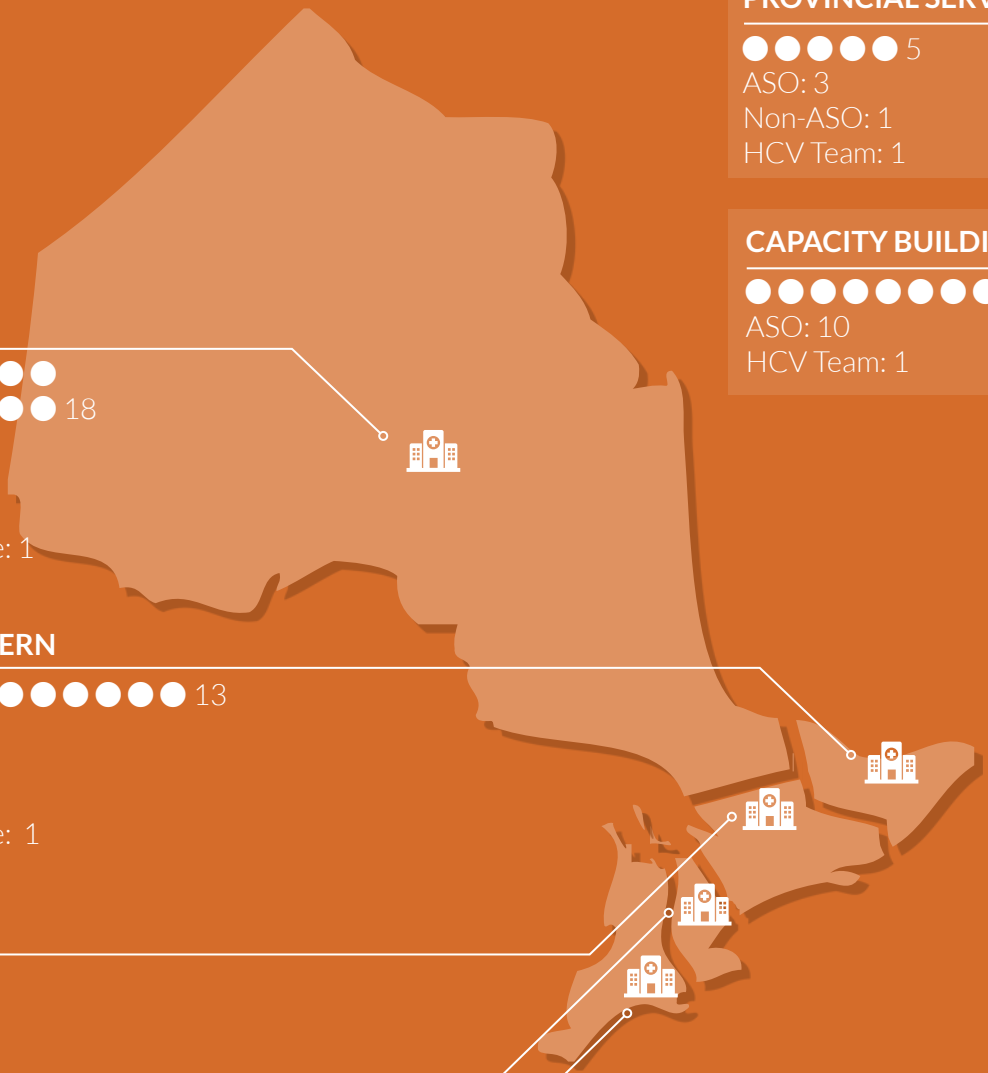
- **40** COMMUNITY-BASED HIV/AIDS ORGANIZATIONS
- **22** NON-AIDS SERVICE ORGANIZATIONS
- **7** COMMUNITY HEALTH CENTRES
- **4** OTHER HEALTH CARE ORGANIZATIONS

For the first time, this View from the Front Lines also includes reporting from 20 Hepatitis C teams funded by the Hepatitis C Secretariat of the Ministry of Health and Long-Term Care. Multidisciplinary and hep C care teams work closely with treating physicians, provide HCV care and treatment, education, outreach, and support services.

Chapters 1 to 5 describe the HIV programs. For information on HCV programs, see Chapter 6. For a list of all funded HIV programs and Hepatitis C teams, see Appendices A, and C.

Of the 73 organizations that provided HIV programs in 2014:

- **59** are local or regional programs that provide direct services to clients in their geographic area
- **14** are provincial programs (see Table 1). Of those:
  - **4** (Hemophilia Ontario, Ontario Aboriginal HIV/ AIDS Strategy [Oahas], PASAN and HALCO) provide direct services to clients across Ontario. Note: because Hemophilia Ontario and Oahas have regional staff/ programs in different locations across the province, we have counted the activities of those programs in the regions where they are delivered. PASAN and HALCO have only one office in Toronto so their activities are counted in that region.
  - **10** provide capacity building — training, information and other services — to support local community-based AIDS services and other organizations. Note: the activities of the provincial office of each population-specific strategy (ACCHO, GMSH, WHAI) are counted under capacity building services.



TORONTO

36
ASO: 14
Non-ASO: 14
CHC: 4
Other Health Care: 2
HCV Team: 2

PROVINCIAL SERVICES

5
ASO: 3
Non-ASO: 1
HCV Team: 1

CAPACITY BUILDING SERVICES

11
ASO: 10
HCV Team: 1

NORTHERN

18
ASO: 6
Non-ASO: 4
CHC: 1
Other Health Care: 1
HCV Team: 6

OTTAWA & EASTERN

13
ASO: 5
Non-ASO: 3
CHC: 2
Other Health Care: 1
HCV Team: 2

CENTRAL EAST

6
ASO: 4
HCV Team: 2

CENTRAL WEST

12
ASO: 6
Non-ASO: 2
HCV Team: 4

SOUTH WEST

8
ASO: 4
Non-ASO: 2
HCV Team: 2

FIGURE 7
LOCATION OF FUNDED PROGRAMS

TABLE 1
CAPACITY BUILDING PROGRAMS

PROVINCIAL ORGANIZATIONS THAT PROVIDE CAPACITY BUILDING SUPPORT
African and Caribbean Council on HIV/AIDS in Ontario (*www.accho.ca)* The African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) provides leadership in the response to HIV/AIDS in African, Caribbean and Black communities in Ontario. This is done through coordination of the implementation of the ACB Strategy, capacity development and community engagement, as well as research and advocacy.
AIDS Bereavement and Resiliency Program of Ontario — ABRPO (sponsored by Fife House) (*www.abrpo.org)* The AIDS Bereavement and Resiliency Program of Ontario (ABRPO) provides community-based AIDS-serving agencies with concrete support in the area of AIDS grief, loss, change and transition. ABRPO is a resource for Ontario groups looking explicitly at the impact of AIDS-related grief and loss. ABRPO helps assess and enhance individual and organizational resiliency in the face of these ongoing losses.
Canadian AIDS Treatment Information Exchange (CATIE) (*www.catie.ca)* CATIE is Canada's source for up-to-date, unbiased information about HIV and hepatitis C. CATIE develops and shares information resources, strengthens community capacity and networks, and connects researchers and service providers to inform each other's work.
Committee for Accessible AIDS Treatment (*www.hivimmigration.ca)* The Committee for Accessible AIDS Treatment (CAAT) is a coalition of affected individuals and organizations from the legal, health, settlement and HIV/AIDS sectors committed to promoting the health and wellbeing of people living with HIV who are facing access barriers related to their status using the tools of education, training, research, service coordination and advocacy.
Gay Men's Sexual Health Alliance (GMSH) (*www.gmsh.ca)* The GMSH is a provincial network made up of front-line workers, researchers, public health, policy makers and community members. Their work aims to respond to the sexual health needs of Ontario's diverse communities of gay, bisexual, and other men who have sex with men, and includes the development of resources, production of campaigns, and striking of working groups.
Ontario AIDS Network (*http://ontarioaidsnetwork.on.ca)* The Ontario AIDS Network (OAN) is a coalition of people with HIV and AIDS (PHAs), AIDS Service Organizations and AIDS Service Programs who work collectively to provide a just, effective response to HIV and AIDS, improve life for people infected with and affected by HIV and AIDS, and prevent the spread of the virus.
Ontario HIV and Substance Use Training Program – OHSUTP (sponsored by Fife House) (*www.ohsutp.ca)* OHSUTP provides training to substance use, mental health and allied service providers in Ontario, in order to increase knowledge of HIV/AIDS and to promote skills development.
Ontario Organizational Development Program (OODP) (*www.oodp.ca)* OODP responds to requests from and provides service to AIDS service organizations (ASOs) and programs for long-term organizational development resources.
Toronto HIV Network (sponsored by the Toronto People With AIDS Foundation) (*www.torontohivaidsnetwork.org)* The Toronto HIV/AIDS Network (THN) facilitates HIV/AIDS planning, collaboration and innovation among organizations in Toronto to improve access to programs and services for people from diverse communities living with, affected by and at risk of HIV/AIDS.
Women and HIV/AIDS Initiative (WHAI) (*www.whai.ca)* WHAI is an answer to community need for a flexible response to HIV/AIDS among women in Ontario that takes into account the structural and societal factors that make women vulnerable to HIV. This initiative, located in 16 AIDS Service Organizations (ASOs) throughout the province, is funded by the AIDS Bureau of the Ministry of Health and Long-term Care.
PROVINCIAL ORGANIZATIONS THAT PROVIDE DIRECT SERVICES TO CLIENTS
Hemophilia Ontario (*www.hemophilia.ca*) Hemophilia Ontario organizes several events annually to raise funds for and awareness of Hemophilia and bleeding disorders.
HIV & AIDS Legal Clinic (Ontario) HALCO (*www.halco.org)* HALCO provides legal services to persons living with HIV/AIDS in Ontario that are relevant to their well-being and that enable them to participate fully in the communities in which they live.
Ontario Aboriginal HIV/AIDS Strategy (Oahas) (*www.oahas.org)* oahas aims to provide culturally respectful and sensitive programs and strategies to respond to the growing HIV epidemic among Indigenous people in Ontario through promotion, prevention, long term care, treatment and support initiatives consistent with harm reduction.
Prisoners with HIV/AIDS Support Action Network (PASAN) (*www.pasan.org)* PASAN provides HIV/AIDS and HCV prevention education and support services to prisoners, ex-prisoners, youth in custody and their families.

FUNDING INCREASED SLIGHTLY IN 2013/14

In 2013/2014, the AIDS Bureau and ACAP invested a total of $29 million in HIV programs. Compared to the previous year, ACAP funding stayed steady at 4.2 million while AIDS Bureau funding increased by $100K. The AIDS Bureau continues to be the primary source of base (operational) funding for community-based HIV programs, providing 49% of total funding for dedicated AIDS service organizations and 37% of funding for other community-based programs in 2013/14. ACAP provides multi-year project funding.

In addition to AIDS Bureau and ACAP funding, organizations report receiving an additional $21.9 million from other sources—both government and non-government (see Figure 9)—down slightly from the previous year.

MORE FUNDING FROM OTHER GOVERNMENT SOURCES

In terms of other government funding sources, municipalities account for about 10% and other ministries and other Ministry of Health and Long-Term Care programs account for 11% of total funding reported by organizations. In 2013/14:

FUNDING FROM THE MINISTRY OF HEALTH AND LONG TERM CARE INCREASED

- ↓ Municipal funding dropped by $500,000; however, this change can be attributed to two non-ASO programs—one in the Eastern region and one in the North—and does not reflect a general decline in municipal funding for HIV programs.
- ↑ Funding from other ministries and other programs within the Ministry of Health and Long-Term Care increased. This trend may be due to community-based organizations developing stronger relationships with their Local Health Integration Networks (LHINs) and with other ministries (e.g. Municipal Affairs and Housing).

FIGURE 8
TRENDS IN AIDS BUREAU AND ACAP FUNDING FOR COMMUNITY-BASED HIV PROGRAMS.

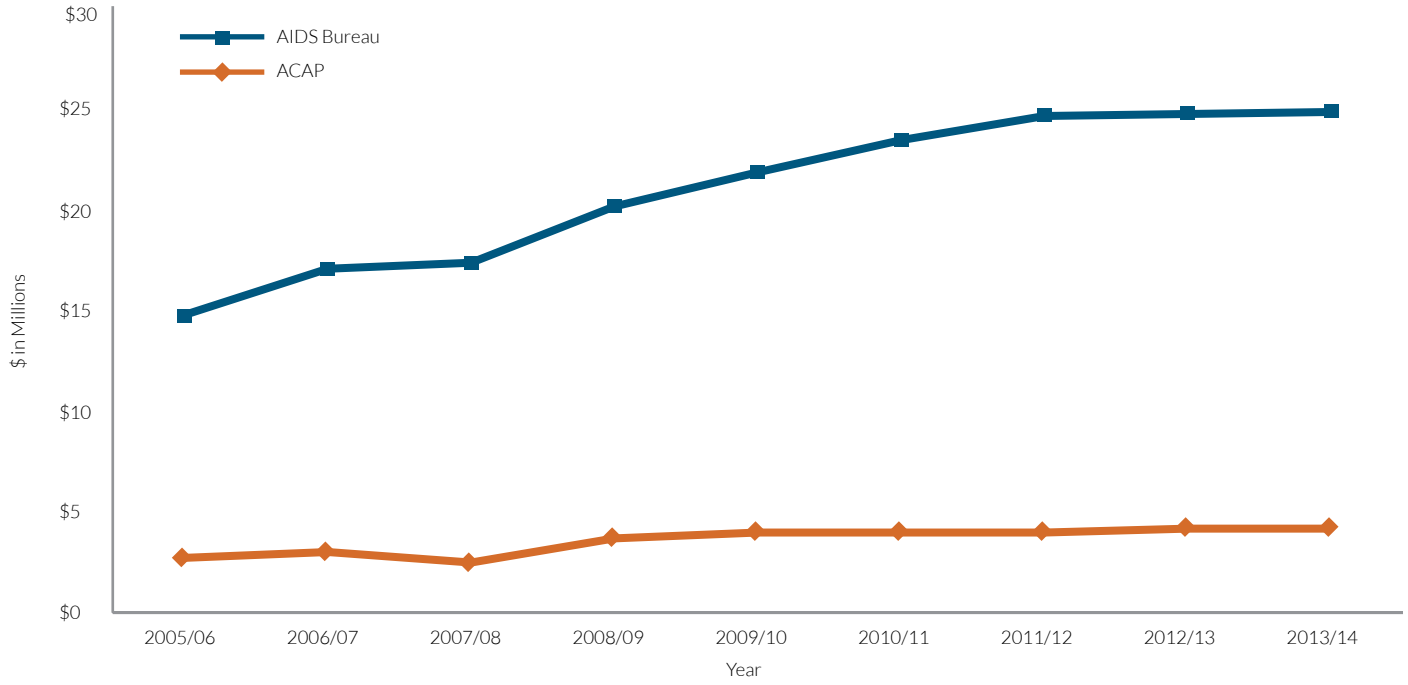
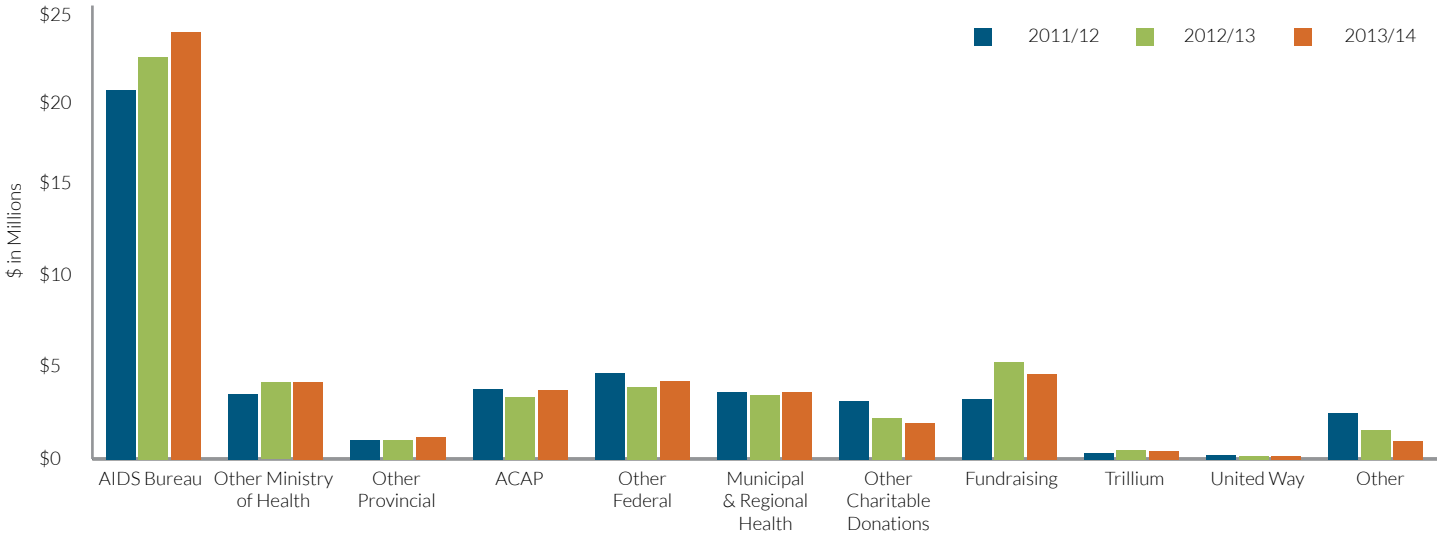


FIGURE 9
ALL SOURCES OF FUNDING 2011/12 - 2013/14



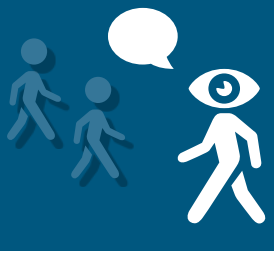
FUNDRAISING DOWN SLIGHTLY

The total of all non-government funding—fundraising, charitable foundations, private sector, Trillium and United Way—was down compared to 2012/13 (by about $750,000), despite the fact that it was a very strong year for fundraising for organizations marking milestone anniversary events. However, fundraising levels were similar to those in 2011/12, so the change may be more a rebalancing than a decline.

The drop in fundraised dollars affects ASOs and non-ASOs because they are more reliant than CHCs and other health care organizations on donations and charitable funding. In general, it appears that non-ASOs are more successful than ASOs in obtaining funding from the United Way while ASOs are more effective in fundraising. The strong United Way support for non-ASOs may reflect the eligibility criteria for United Way funding and these organizations' broader mission.

ALL NON-GOVERNMENTAL FUNDING
$750,000 ↓

HOURS DEVOTED TO FUNDRAISING INCREASED, BUT DID NOT APPEAR TO RESULT IN MORE FUNDS BEING RAISED.



Competition for charitable giving in the community-based sector continues to be fierce. Although organizations reported a significant increase in volunteer hours devoted to fundraising in 2013/14, that investment did not appear to result in an increase in fundraising revenue over the last fiscal year—except in Toronto where the volunteer impact on fundraising appeared to be significant. The sector has been seeing a steady drop in private sector donations over the past three years: a trend that has also been reported by other organizations, such as the Canadian Foundation for AIDS Research, which rely on private sector donations. The drop may be due to the growing perception that HIV is solved or over.

WHO MAKES THE PROGRAMS WORK?

Community-based HIV programs rely on a mix of paid staff and volunteers. They also actively engage peers—people with or at risk of HIV or from the same cultural communities as clients—in their work.

- **445 paid staff**. Most HIV programs are relatively small. More than half have five or fewer staff and only 10 have more than 20 staff.
- **1438 peers** (up from 1,378 in 2012/13). Fifty-two programs reported engaging peers in education and community development activities (e.g. providing outreach [face to face and online], distributing resources, giving presentations and workshops, and developing and delivering awareness campaigns) . Organizations define peers in different ways.

PROGRESS ON GIPA/MIPA

Over the past few years, with the leadership of the OAN, organizations have been more focused on the greater and meaningful involvement of people with or at risk of HIV:

- 77 of the 89 programs reported involving members of their target populations in their work.
- The most common activities were: program/service planning (95%) and recruiting people to volunteer (90%).
- The least common were: focus testing (62%), staffing (66%), recruiting people for paid positions (78%) and governance (79%).
- The proportion of programs reporting having members of target populations on staff has dropped over the past two years.

In some cases, peers are people living with or at risk of HIV. In others, they are people who share characteristics with target population(s), such as culture, language, gender, gender identity, sexual orientation, age or health status.

662 peers engaged in IDU Outreach. Thirty two unique programs (5 ACAP funded) engaged peers in IDU outreach. Although the number of new and active IDU peers was down slightly in 2013/14, they provided significantly more hours of practical assistance, community development, formal support programs and informal interactions with people who use substances. They also had twice as many contacts with people when they were distributing materials compared to the previous year. IDU peers are defined as people with lived experience of using substances.

6,887 volunteers (down from 8,173 in 2012/13) contributed 264,998 hours of service – up from 253,159 in 2012/13. A little over one-quarter of volunteers were recruited through initiatives funded by ACAP. Compared to previous years, volunteers provided more general office and clerical support (administration), fundraising, outreach and education/community development services and fewer hours of support for special events and practical support. Sixty-eight programs reported using volunteers, 30 of which have ACAP funding.

194 students—the highest number since we began tracking the program—provided 52,288 hours of service. Students assisted mainly with education and community development.

SPOTLIGHT: IDU PEERS

662 ACTIVE PEERS
DOWN FROM 697 IN 2012/2013

86 NEW PEERS
DOWN FROM 143 IN 2012/2013

39,258
INFORMAL INTERACTIONS
UP FROM 24,418 IN 2012/2013

52,702
MATERIALS DISTRIBUTED
UP FROM 29,551 IN 2012/2013

IDU PEERS ARE INCREASING CLIENT CONTACTS IN...

COMMUNITY DEVELOPMENT
2,774(2013/14)
2,009 (2012/13)

FORMAL PROGRAMS
2,580 (2013/14)
1,877 (2012/13)

PRACTICAL ASSISTANCE
8,637 (2013/14)
3,677 (2012/13)

(Number of client contacts by peers.)

THE ECONOMIC IMPACT OF VOLUNTEERS

Community-based HIV/AIDS organizations depend on volunteers to fulfill their mission. In 2013/14, volunteers provided $5.1 million of in-kind labour (up slightly from $4.9 million in 2012/13 and similar to the $5.08 million in value reported in 2011/12). To calculate the economic impact of your volunteers, see Appendix D for the formulas.

Note: there may be some overlap in these figures as the definition of "volunteer" is not clear: some agencies may also count students and some peers as volunteers.

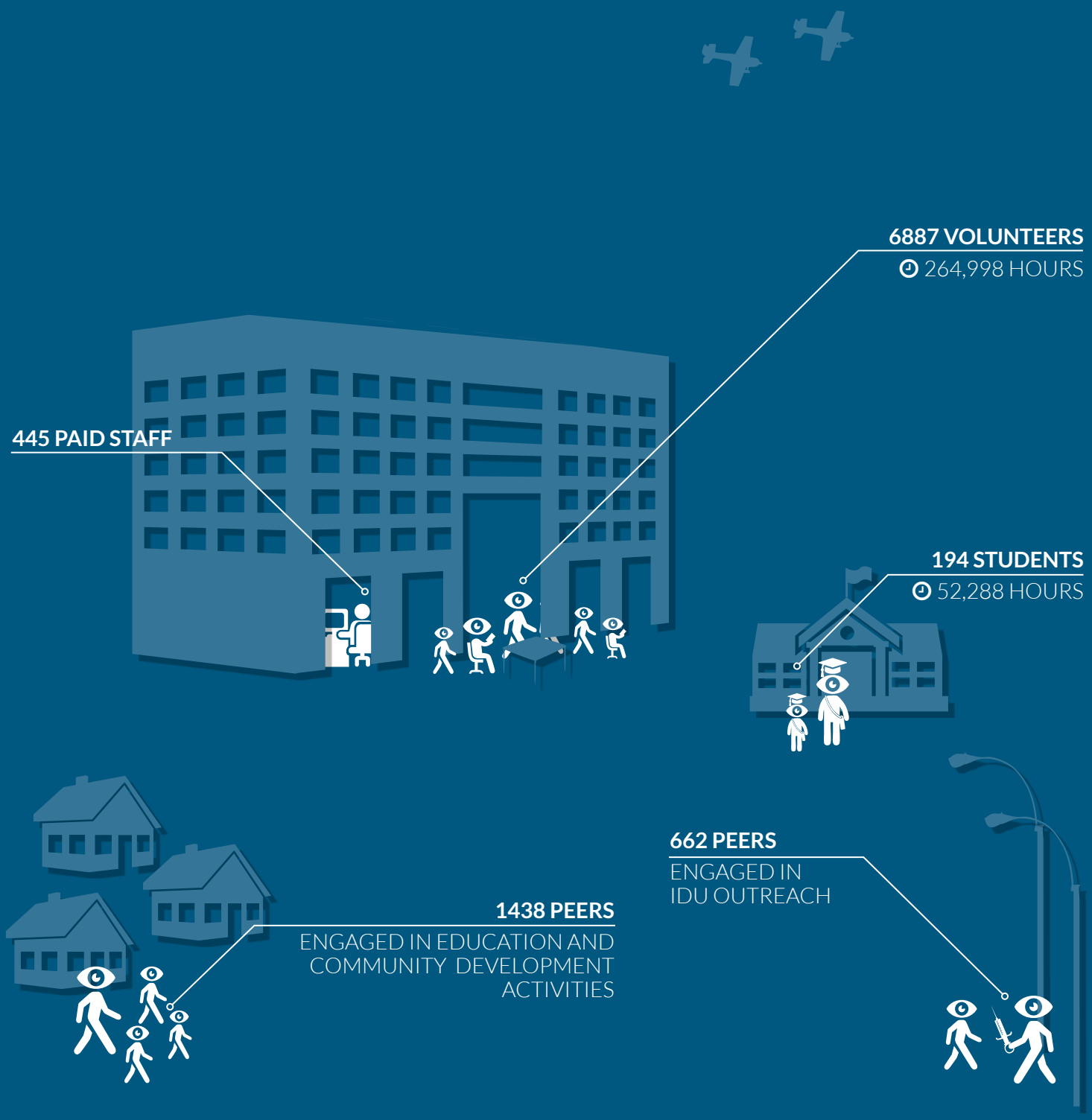
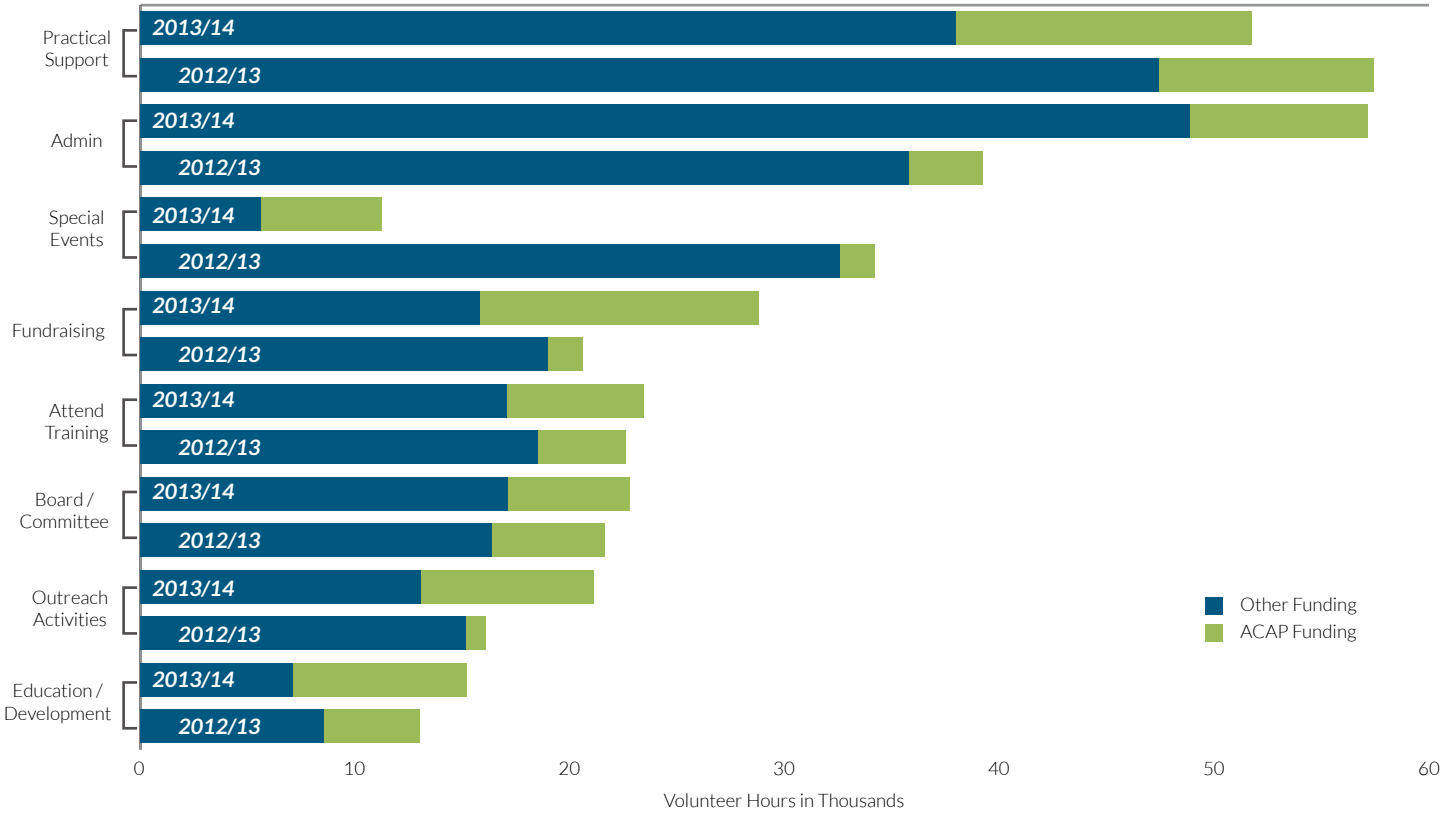


FIGURE 10
WHO MAKES THE PROGRAMS WORK?

FIGURE 11
TRENDS IN VOLUNTEER HOURS/SERVICES
N= 68 UNIQUE PROGRAMS (INCLUDING 30 ACAP FUNDED PROGRAMS)



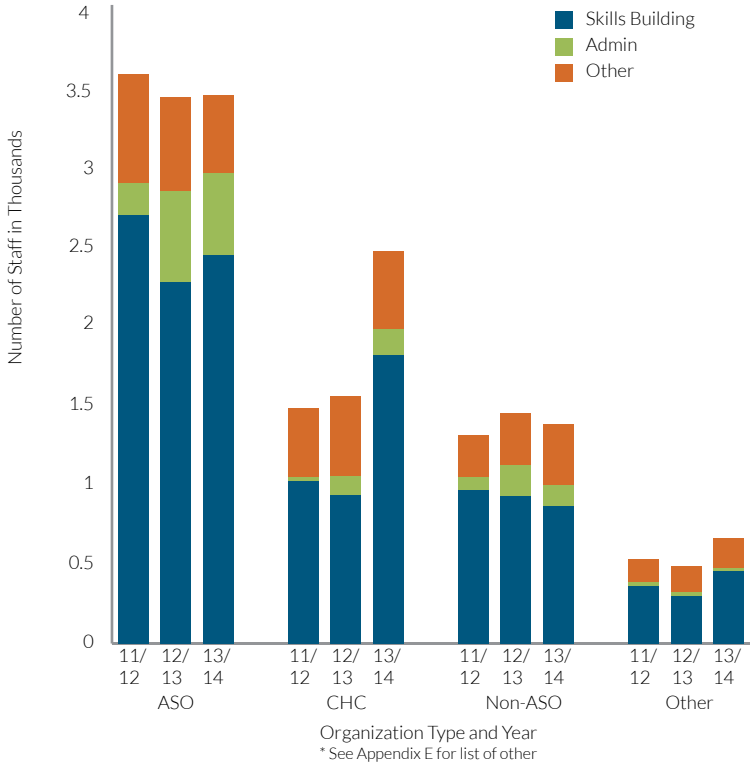
HOW DID WE ENHANCE THE CAPACITY OF THE PEOPLE AND ORGANIZATIONS DELIVERING HIV SERVICES?

To fulfill their missions, community-based organizations must continually enhance their capacity as well as the skills of their staff, volunteers and peers.

Building Staff Skills

When it comes to staff training, funded organizations invest mainly in skills building programs and administrative training. Note: the "other" category includes health and safety training, stress reduction and a wide range of skills building such as: research interviewing training, breastfeeding initiatives, gender identity and clear communications. In terms of skills building, in 2013/14, front-line agencies focused mainly on ensuring staff had more training on addictions, harm reduction and substance use.

FIGURE 12
TRAINING STAFF RECEIVED 2011/12-2013/14:
TOTAL PROGRAMS REPORTING = 89



Challenges to Maintaining and Enhancing Capacity

Organizations told us that building and maintaining capacity is a challenge because of: stigma, lack of funding and other resources, human resources issues (i.e. relatively high turnover in the field), transportation costs, lack of knowledge, competencies and skills, and lack of support from other agencies.

Building Capacity in HIV Programs

Ontario's HIV programs strive to provide effective services and have impact. Ten capacity building programs provide training, information and other services to support local community-based AIDS services and other organizations.

Using Evaluation Findings to Build Capacity

All organizations monitor and evaluate their programs, and use the information to improve services and enhance capacity. The most common ways to assess the programs are informal – staff meetings, informal client feedback and client complaints – followed by routine data collection through service data, client satisfaction surveys and performance reviews. In terms of their education programs, almost 70% of organizations assess their impact on participants' knowledge while just over half assess for any impact on behaviour. It may be that agencies need different evaluation tools or they need to check in with participants several months after the training to be able to assess impact on behaviour.

In 2013/14, as a result of their monitoring and evaluation, organizations reported that they are taking a number of steps to make their programs more effective:

DEVELOPING STRATEGIC PARTNERSHIPS

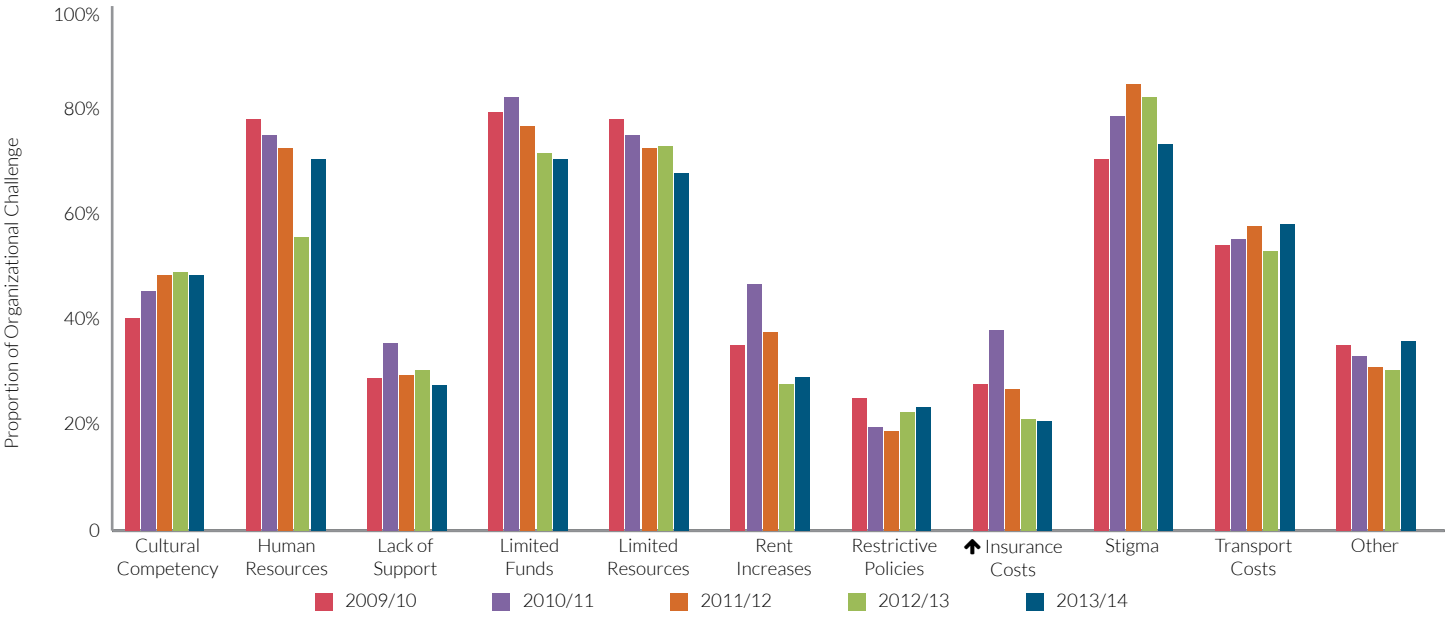
"Based on mental health support needs identified by some clients, we have entered into a new strategic partnership with CMHA in our region to increase our capacity to support mental health issues and to increase CMHA's capacity to address HIV and sexuality issues in their programming."

"The Prevention Program identified a gap in services for heterosexual ACB men in the GTA. We developed partnerships with ASOs, schools and community service providers to deliver programs to young and adult men in schools, community centers and federal male prisons."

"We are organizing more collaborative partnerships around safer sex work and programming for this and next year, with sex workers, service providers and academic partners. Sex workers are contributing to the development of local area specific support material."

"Key areas … are: building partnerships with the long term care and geriatric sectors, the need to expand the number of high support housing beds, develop a common platform for communication of client information, advocate for case management models for people living with HIV who have complex care issues, work with allied community health partners to develop a population health-based model of care and service for all people living with HIV, which embeds a commitment to HIV specific clinical and community knowledge, experience and best practices."

FIGURE 13
REPORTED BARRIERS TO DEVELOPING, MANAGING AND DELIVERING SERVICE
(INCLUDING 30 ACAP FUNDED PROGRAMS)



ENGAGING HARD-TO-REACH POPULATIONS

"After View from the Front Lines indicated an increase in youth seroconverting in the Eastern half of the province, we networked with other agencies serving positive youth, which led to expanding our online programming for youth [our region] (with the funder's consent)."

"We increased outreach to migrant farm workers in English & Spanish after noting significant interest at public festivals."

"We are intensifying our development of French language materials to accommodate our French language clients."

REDESIGNING WORKFLOWS

"We recently completed a four-year evaluation of [program name] [and, as a result] have decreased the number of shifts each week."

"In response to clients dissatisfied with long wait times for service we implemented an extended Intake appointment with all clients close to the time they call in for service. As a result clients are no longer waiting before being able to sit down with a counsellor and identify the concerns bringing them to counselling."

CHANGING SERVICE DELIVERY

"We have many patients who do not have a family physician. Patients feel comfortable here at our clinic and have built trust with our staff so we sought out the services of a physician who will work at our clinic one day a week to provide non-HIV related health care."

"One significant change is a Safe Needle Pick-up [developed] in response to First Nation Communities request for assistance with needles being found in their communities."

"The results of our Bar Outreach Survey indicated that people would prefer accessing sexual health information and resources (i.e. pamphlets/condoms/etc.) in private locations. The survey also indicated that people would prefer not to be approached to discuss sexual health-related topics by ASO staff in bars. Given this, we are focusing our bar outreach activities on community development with bar owners/ managers to develop relationships to support placing materials in bathrooms and other, more discreet locations."

PROVIDING MORE SERVICES FOR TRANS PEOPLE

"Increased support for individuals exploring gender has resulted in increased volunteer-led programming and increased outreach and education with service providers regarding needs of trans individuals within and independent of LGBT community."

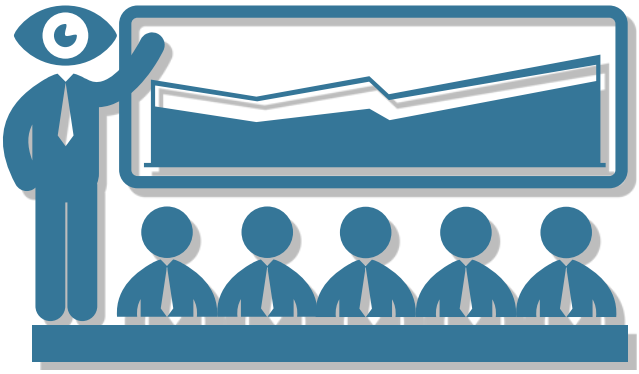
TAKING ADVANTAGE OF CAPACITY BUILDING PROGRAMS

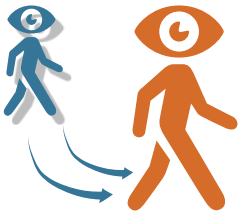
Six capacity building organizations receive ACAP funding. They reported providing 89 presentations (related to capacity building, KTE or mentorship) to a total of 796 participants. Of those, 394 participants reported a change in knowledge and 361 reported changing behaviour based on what they had learned.

Organizations make good use of the province's capacity building programs. Over the past two years, the capacity building organizations themselves reported providing a significant number of capacity building, KTE and mentorship/coaching presentations. Organizations are building skills in dealing with grief and loss, implementing GIPA and MIPA, and boundaries. At the same time, people living with HIV are building leadership skills. (See figure 15.)

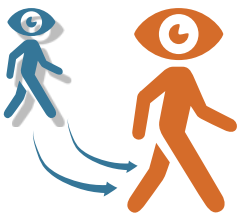
The vast majority of presentations made by the capacity building programs targeted front line workers and executive directors. Some targeted strategy workers and some targeted other (non-HIV) service providers or public health professionals. As would be expected, a significant proportion of leadership presentations targeted people living with HIV.

CAPACITY BUILDING PRESENTATIONS (ACAP)





83%
OR 394 of 471 PARTICIPANTS REPORTED KNOWLEDGE CHANGE



75%
OR 361 of 476 PARTICIPANTS REPORTED BEHAVIOR CHANGE

FIGURE 14
CAPACITY BUILDING PRESENTATIONS AND PARTICIPANTS BY FUNDER 2009/10-2013/14 (INCLUDING 30 ACAP FUNDED PROGRAMS)

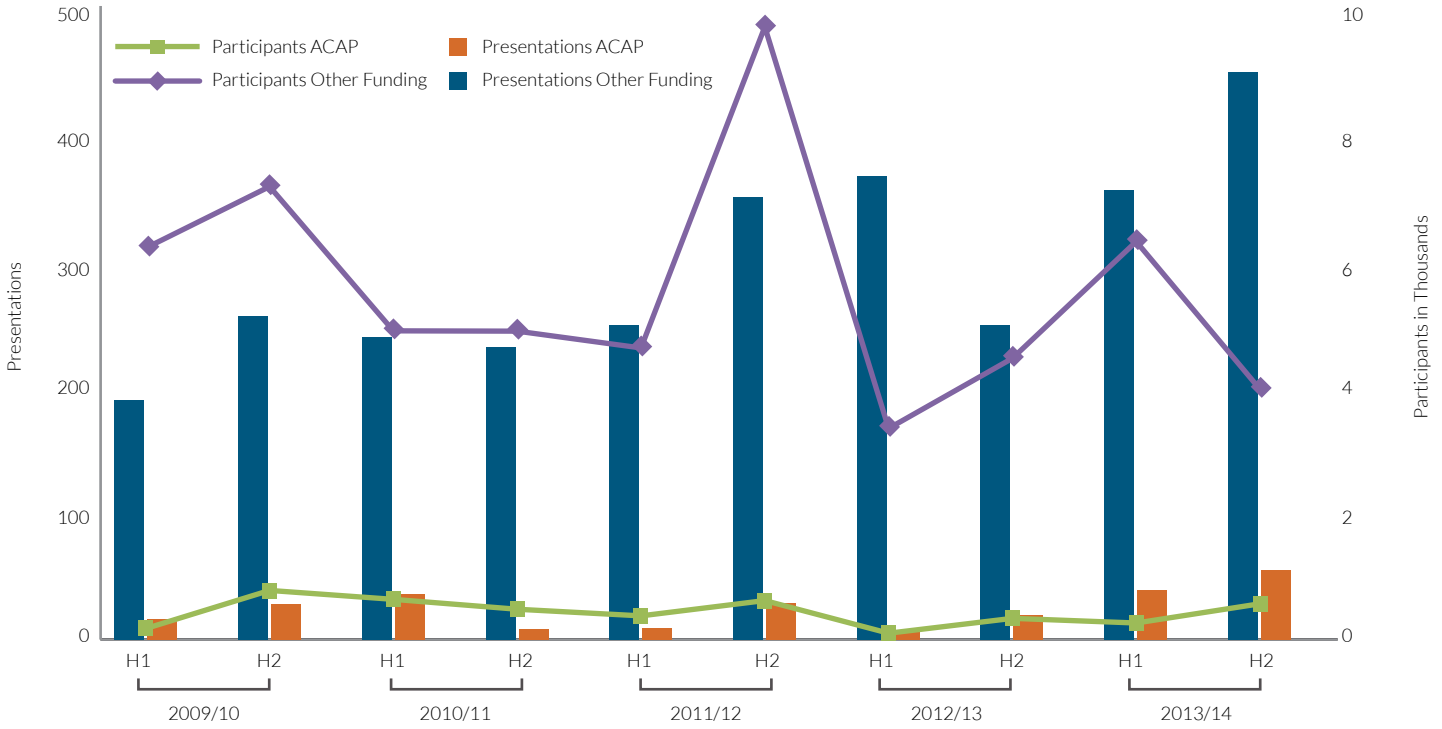
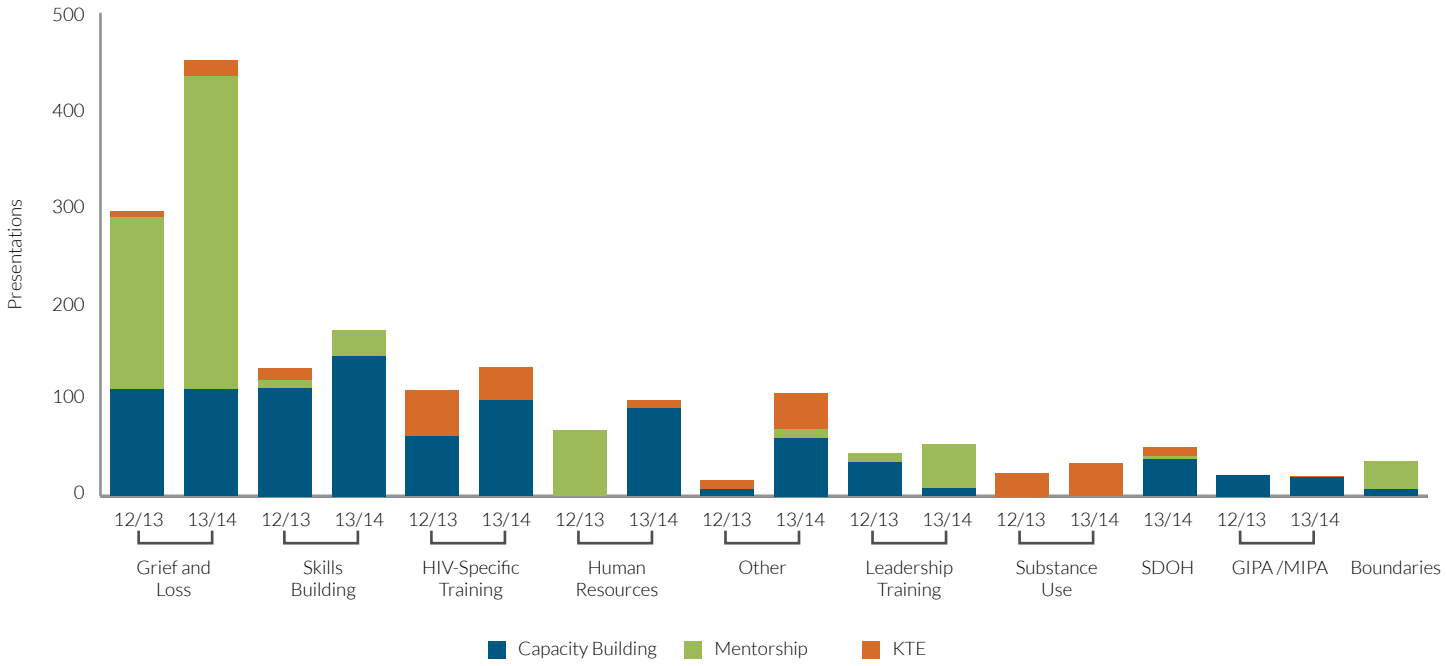


FIGURE 15
FOCUS OF CAPACITY BUILDING PRESENTATIONS

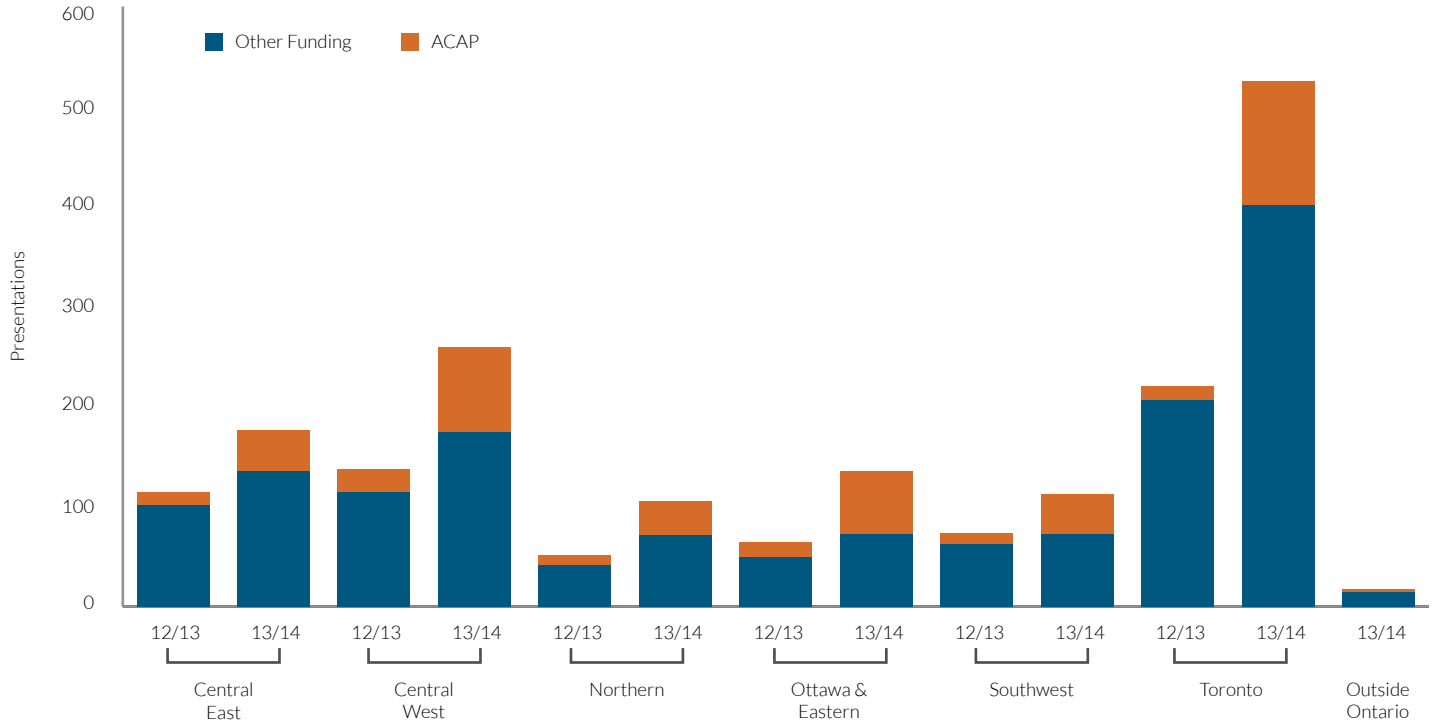


Note: The number of grief and loss presentations is high because the program can do up to 6 sessions per worker.

Capacity Building Occurs Across the Province

Most capacity building workshops and programs take place in Toronto – likely due to the large number of organizations in Toronto and the fact that it is often cheaper to bring participants to Toronto than to travel to smaller centres. Despite that, capacity building events occurred in all LHIN regions in each of the last two years.

FIGURE 16
LOCATION OF CAPACITY BUILDING PRESENTATIONS



CAPACITY BUILDING CONFERENCES AND WORKSHOPS TARGET ADMINISTRATORS AND FRONT LINE WORKERS

Capacity building organizations reported organizing or being involved in 27 conferences and workshops over the year, which reached 1,280 participants. About one-third (9) focused on organizational skills, such as human resources, board skills and fundraising; the rest aimed to improve service delivery skills. Most capacity building workshops were short (under 2 hours) one-time events.

The number of Capacity Building Program-led awareness campaigns decreased from 7 to 6 whereas the number of meetings doubled. The increase in meetings can be attributed to one campaign (GMSHA – Our Agenda).

2012
NUMBER OF CAMPAIGNS: 7
PLANNING MEETINGS: 53

NUMBER OF CAMPAIGNS: 6
PLANNING MEETINGS: 104
2013

BUILDING CAPACITY IN OTHER ORGANIZATIONS

In addition to building their own capacity, HIV organizations work to enhance other organizations' capacity to understand HIV issues and provide culturally appropriate services. They use a number of strategies – presentations, reports, brochures, newsletters and web sites – to share knowledge with other groups, including governments and other community-based organizations.

FIGURE 17
TYPE OF CAPACITY BUILDING PRESENTATIONS 2012/13-2013/14

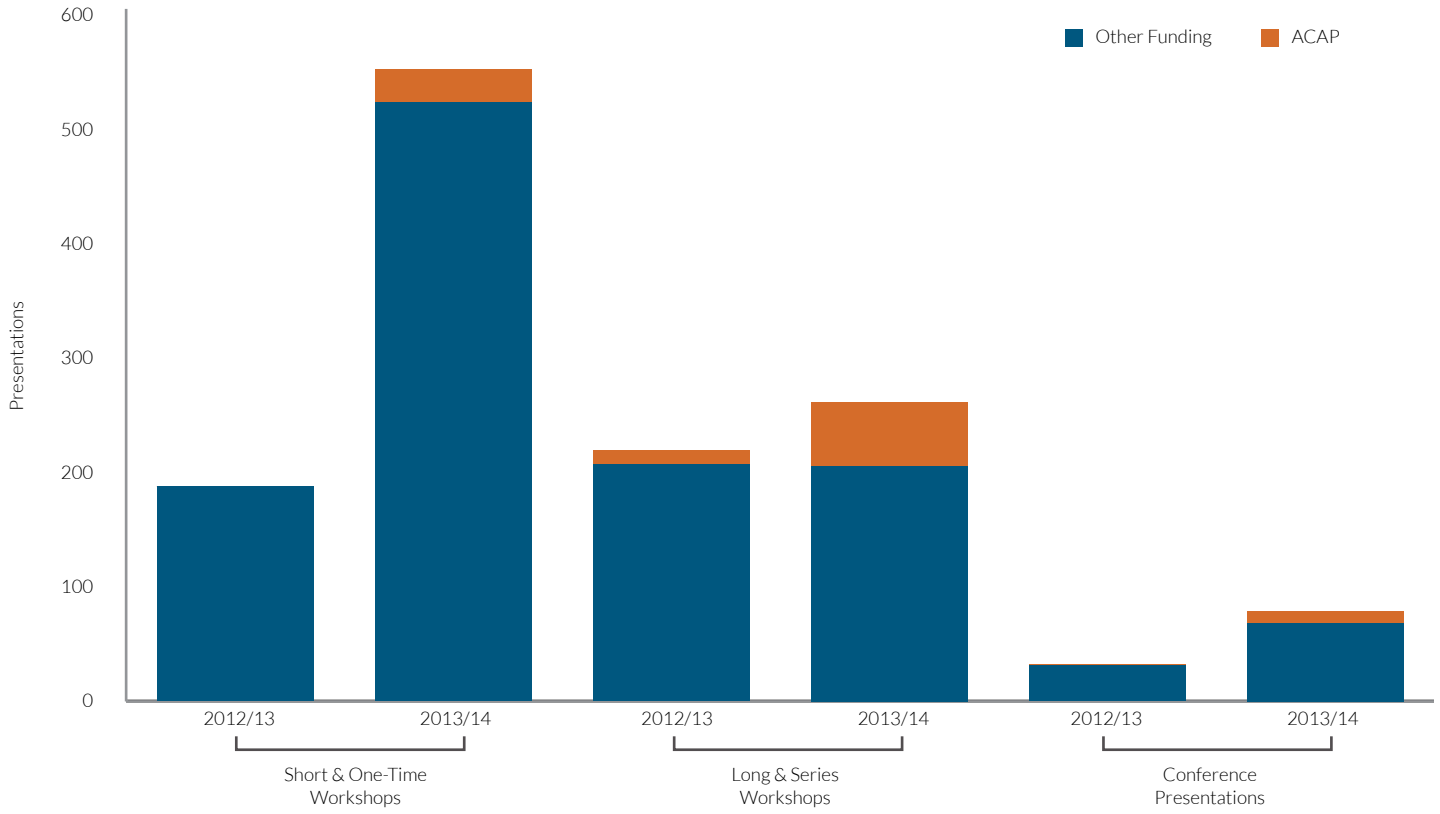


FIGURE 18
HOW KNOWLEDGE IS SHARED WITH OTHER GROUPS

BUILDING CAPACITY WITHIN CAPACITY BUILDING ORGANIZATIONS

The capacity building organizations themselves reported working to enhance their own capacity by, for example, developing new training tools and workshops and different ways of working:

COLLABORATING WITH ONE ANOTHER AND WITH THE HIV PROGRAMS

"We are working on developing the next ACB-specific HIV-related provincial campaign more collaboratively with the agencies and the workers."

"We completed a specific training in partnership with [federal partner] for ethno-specific people with HIV who are working in ASOs. For this training, four [of our] facilitators partnered with four [federal partner] PHAs who had graduated from our previous PHA Facilitator trainings."

RESPONDING TO NEW TRAINING NEEDS

"Due to recent changes in federal immigration and refugee legislation, we're in the process of developing—in partnership with [2 of our partners]—an HIV/AIDS and Immigration Service Access training manual for service providers."

"We have developed and piloted a new workshop on 'self care when working from a harm reduction framework' that participants have positively responded to."

"We have developed a 'train the trainer' resource on the link between gay men's sexual and mental health, which gay men's programs will deliver to mental health services throughout Ontario."

"We were pleased to launch our OSAT Tool pilot project with three ASOs across the province."

WHAT CAPACITY BUILDING ORGANIZATIONS TOLD US ABOUT THEIR CHALLENGES AND SUCCESSES

Challenges:

RESOURCE CONSTRAINTS

"Planning provincial events requires a lot of resources, which is hard to justify for shorter (i.e. half-day or less) events. When we launched [a report/event] there was no other provincial event we could 'piggy back' on, so we hosted a Toronto-based event and invited a limited of [our target population] people living with HIV from across Ontario. We are complementing this event with smaller regional events."

TIME CONSTRAINTS

"It's an ongoing struggle- how to make a difficult challenging topic manageable in short 1/2 day sessions or conference presentations"

STAFF AND PEER TURNOVER

"As we invest in training and building the capacity of our peers, we also face the problem of turnover. When people's life situations change, their engagement and commitment changes. The positive is that our peers have the capacity to move on to better opportunities, the negative is that we lose the peer we have invested in and have to start the process once again."

DEVELOPING MEANINGFUL CONTENT

"It seems that participants don't feel they have a "say" in workshop content even though they are given evaluations at the end of each workshop that asks for future topics. To supplement this, quick email surveys asking for hot topics will be sent to each group prior to the workshops"

Successes:

NEW RESOURCES

"Resource development – [our organisation] collaborated on the development of the CHABAC/HALCO resource "Questions to Ask Your Lawyer" for refugee claimants, which was developed to help support PHAs across the country….[Our organisation] is currently working with HALCO to develop a resource for service providers whose clients have been (or may be) served with deportation orders; this resource should be completed at the beginning of the 2014-2015 fiscal year."

"We created a video resource to document successes of meaningful peer involvement through our Turning To One Another network."

MEANINGFUL ENGAGEMENT

"[Our organisation] completed a series of site visits to agencies. These visits have provided insight into issues that agencies face at a local level."

"We are providing more program planning support to ASOs which reflects their growing capacity to use OCHART data in their planning and to consult with community to ensure their services reflect community needs."

STRONGER RELATIONSHIPS

"Our networking and committee work keeps doors open for training opportunities and builds our reputation as a go-to source for information about HIV, Hep C, substance use and harm reduction."

II. Greater Knowledge and Awareness

Virtually all organizations funded by the AIDS Bureau and ACAP are involved in education, and most offer some outreach services. Over the past few years, community-based programs have been asked to focus their education and outreach programs on the populations most affected by or at risk of HIV.

The goal: to increase knowledge and awareness of HIV, promote healthier behaviours and ultimately prevent the transmission of HIV and/or improve the health, well-being and quality of life for people living with and/or affected by HIV/AIDS.

In 2013/14, organizations reported employing 445 staff, many of whom are involved in education activities.

In addition, the AIDS Bureau also funds three population-specific initiatives that support workers across the province who focus on the education needs of specific populations affected by HIV:

- The Gay Men's Sexual Health Alliance (GMSHA)
- African, Caribbean and Black (ACB) Strategy Workers
- The Women & HIV/AIDS Initiative (WHAI).

The AIDS Bureau also supports two other groups of workers and organizations who provide ecuation services to specific populations:

- Services that focus on Indigenous people including the Ontario Aboriginal HIV/AIDS Strategy (Oahas), Two-Spirited People of the First Nations, Nishnawbe Aski Nation, Association of Iroquois and Allied Indians, Union of Ontario Indians and Waasegiizhig Nanaandawe'iyewigamig.
- 20 organizations that are specifically funded to provide IDU outreach as well as 16 other organizations that report providing IDU outreach services.

TRENDS IN EDUCATION

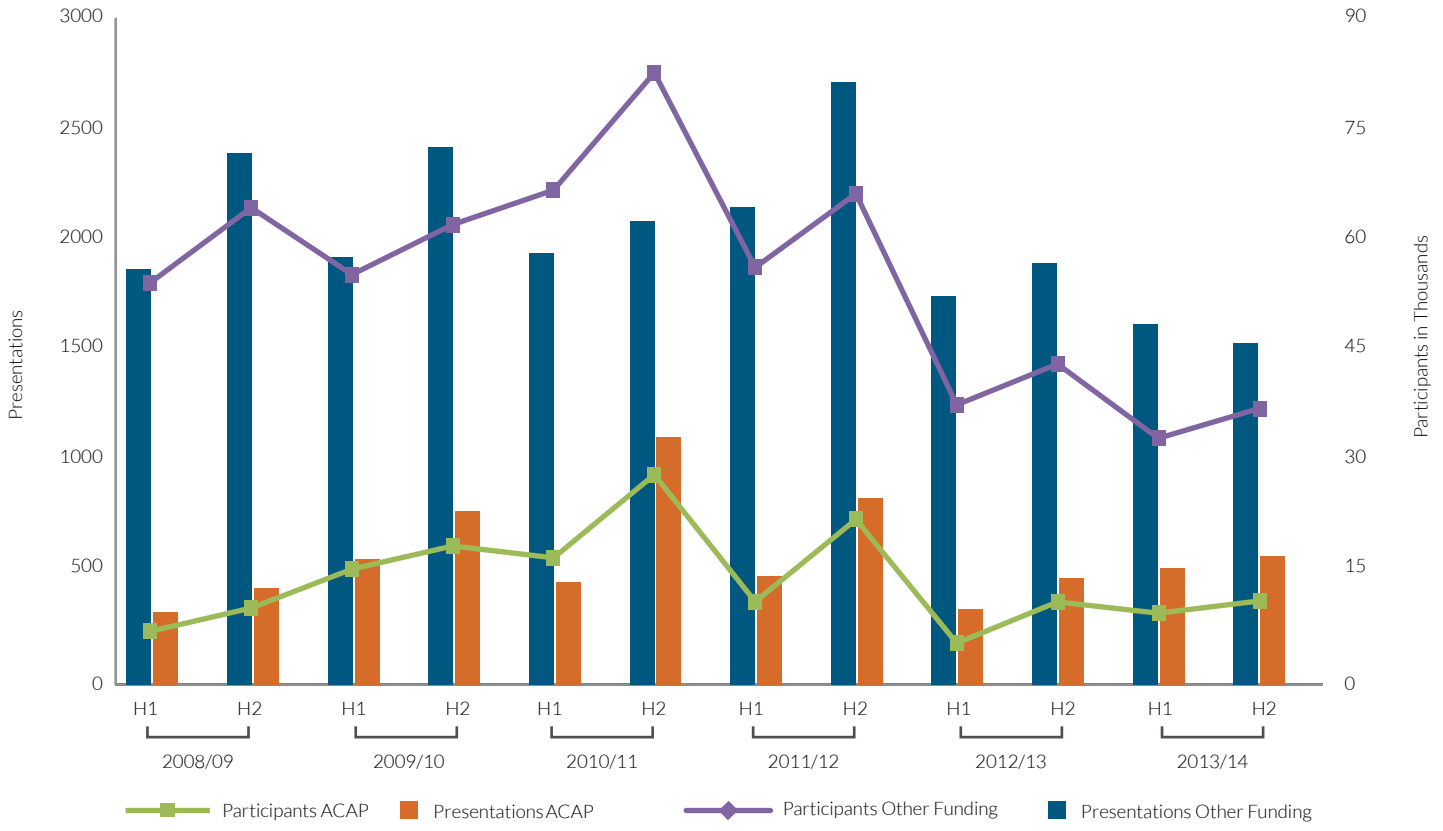
↓486 **TOTAL NUMBER OF PRESENTATIONS**

TOTAL NUMBER OF ACAP-FUNDED PRESENTATIONS **↑280**

PRESENTATIONS 2013/14

- The total number of presentations is down compared to previous years — from 3,646 to 3160 — mainly due to more accurate record keeping at one agency.
- The total number of ACAP-funded presentations is up significantly (from 822 to 1102) – mainly due to the fact that a number of programs funded in 2012/13 are now in their second year.

FIGURE 19
NUMBER OF EDUCATION PRESENTATIONS AND PARTICIPANTS BY FUNDING SOURCE



- The average ratio of participants to presentations is declining over time. Is this because people prefer to receive education through a different medium? Or is this because of the change in focus for education programs (i.e. targeted to people at risk) which may mean smaller groups/audiences?
- Health service agencies and schools are still the most common locations for presentations.
- There were more presentations at faith organisations as a result of the partnership building that ACB strategy workers have been doing in their communities.

WHO ARE WE TALKING TO?

Community-based HIV programs have been asked to focus their education programs on priority populations. Despite that directive, the top three target audiences for AIDS Bureau-funded presentations continue to be: practitioners, professionals and service providers; students; and the general public. Even so, the number of presentations where those groups were the most reported audience dropped significantly in 2013/14. At the same time, we saw an increase in the number of presentations to: people living with HIV; African, Caribbean and Black communities; Indigenous people; and people who use drugs. It therefore appears that organizations are talking more to priority populations.

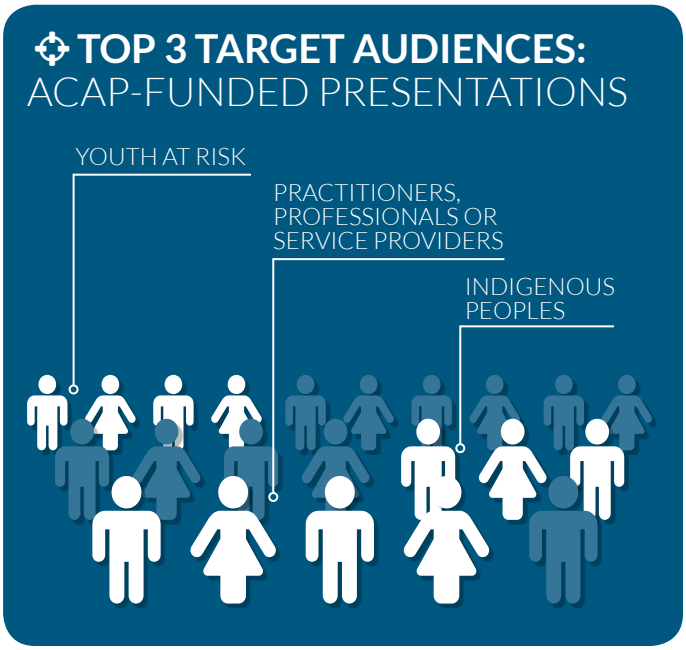
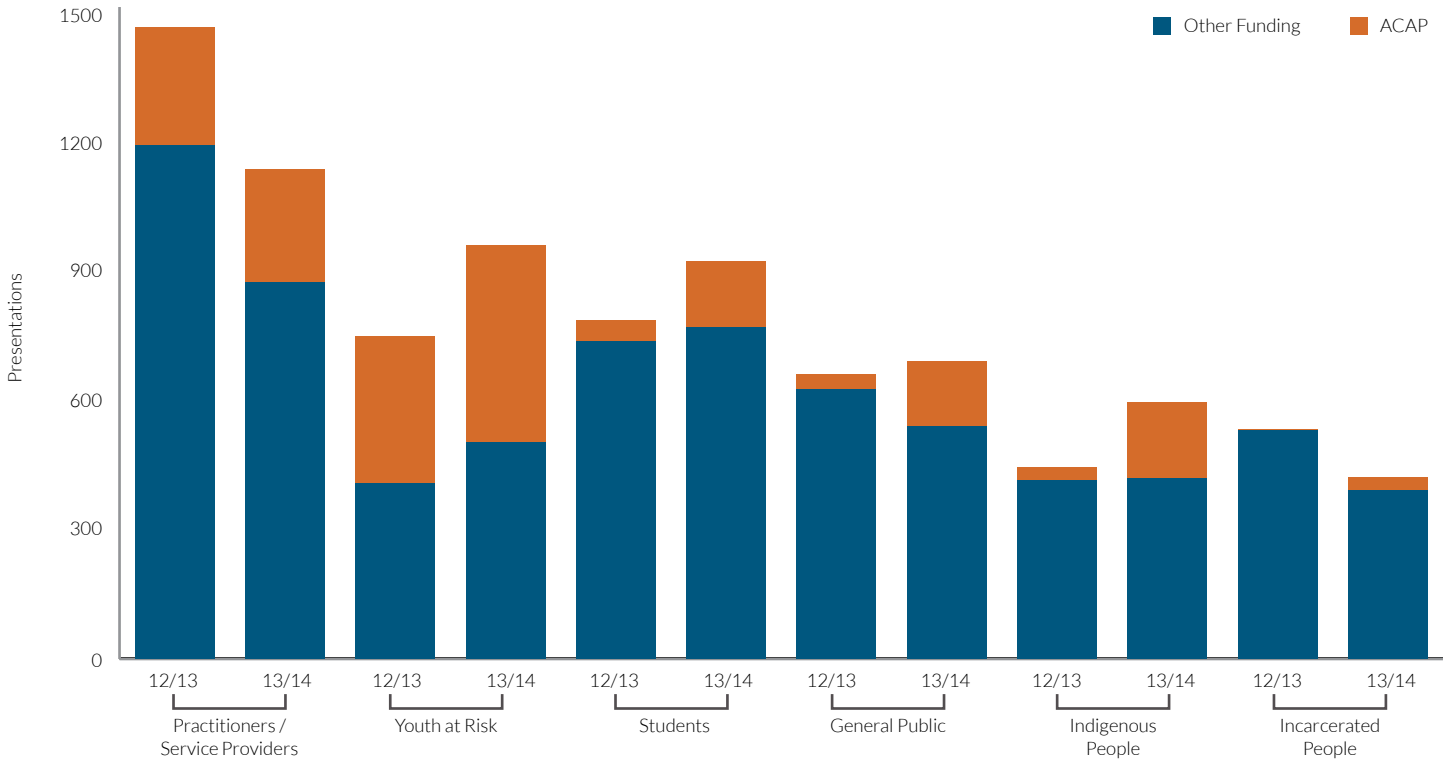


FIGURE 20
INTENDED AUDIENCES 1 AND 2 BY FUNDER FOR TOP FIVE EDUCATION ACTIVITIES

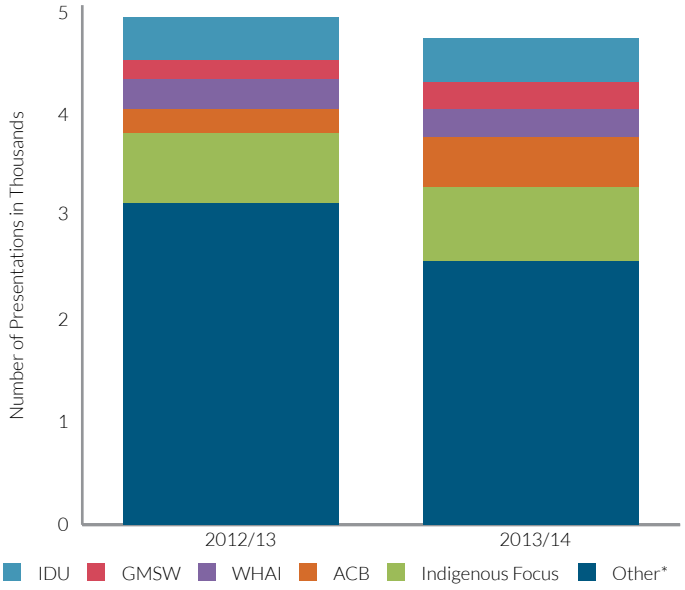


IS RESPONSIBILITY FOR EDUCATION PRESENTATIONS SHIFTING TO STRATEGY WORKERS?

Although most education presentations are still given by general staff in the funded organizations, in 2013/14, we saw a decrease in the number of presentations given by general staff and an increase in the number given by ACB and GMSH workers. A significant proportion of the increase in ACB presentations was due to one Ottawa-based program giving more presentations to students.

The seven Indigenous organizations funded by the AIDS Bureau and ACAP continue to give a substantial number of presentations each year.

FIGURE 21
NUMBER OF PRESENTATIONS BY WORKER TYPE FY 2012-2013

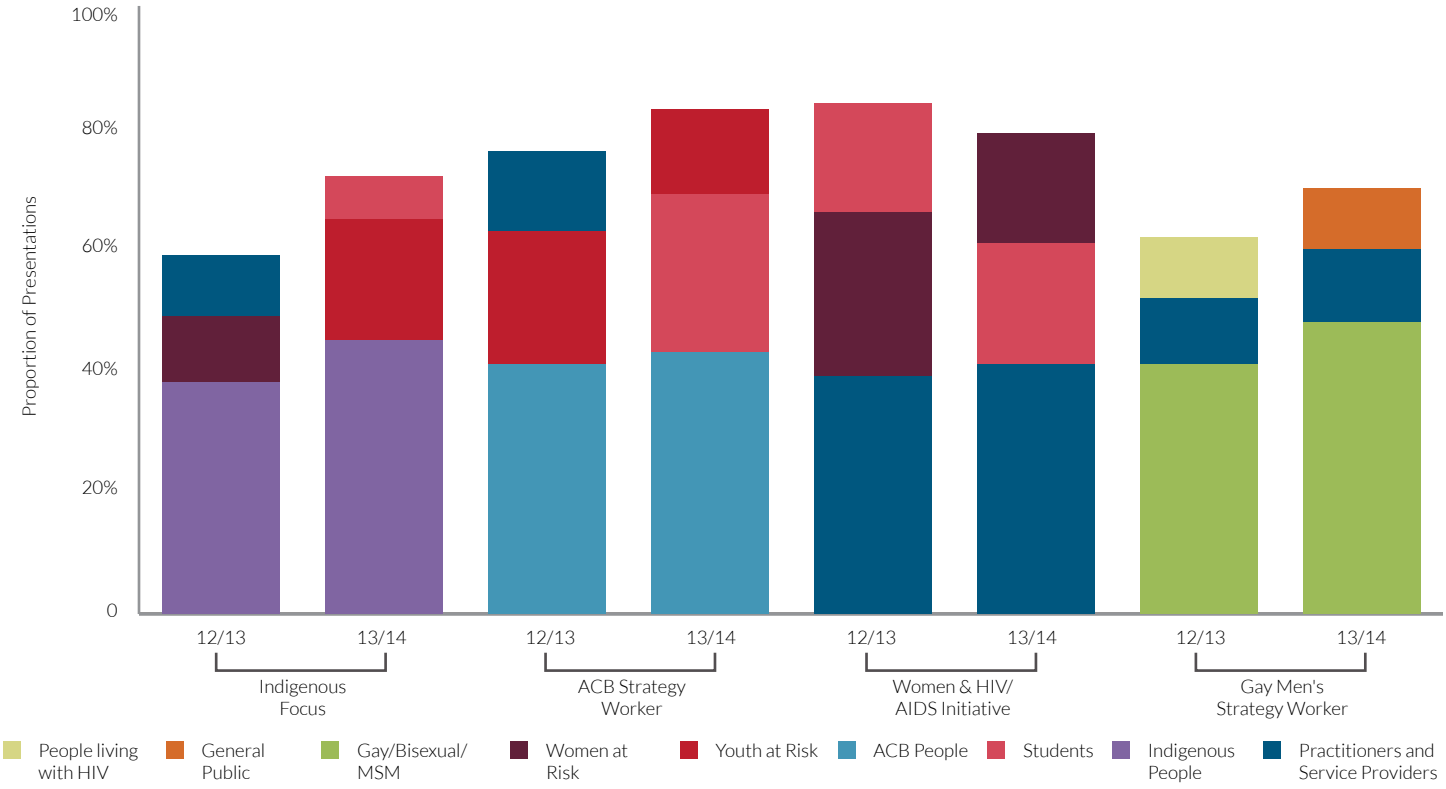


* "Other" includes ACAP-funded presentations.

PRIVACY IMPORTANT TO MEN WHO HAVE SEX WITH MEN

Presenting to gay, bisexual, and other men who have sex with men is challenging in many regions as they lack gathering spaces and/or this population is hidden. One-on-one education and outreach remains a very important activity for Gay Men's Strategy workers.

FIGURE 22
TOP THREE AUDIENCE POPULATIONS REACHED BY POPULATION-SPECIFIC WORKERS



EDUCATION STAFF CONTINUE TO TALK TO PRACTITIONERS – BUT FOCUS IS SHIFTING

To assess the overall impact of presentations given by education staff (i.e. not GMSH, ACB or WHAI strategy workers), we tracked the number of times they selected an audience as "A" or "B" for a presentation. Although most presentations still target practitioners, professionals and service providers, we did see a distinct drop in 2013/14. We also saw a jump in presentations targeting people who use drugs and people living with HIV. However, the large number of presentations to professionals and practitioners may be an indirect way to reach members of priority populations. Connecting with professionals and practitioners who have established relationships or connections with a target population may provide access to priority populations.

STRATEGY WORKERS ARE TALKING TO POPULATIONS AT RISK

Figure 22 shows the top three audiences for each group of strategy workers. Their presentations mainly target the populations they are trying to reach. Of all the strategies, the WHAI workers recorded the largest number of presentations to practitioners, professionals and service providers, which is the WHAI mandate: enhancing the capacity of other organizations to serve women with or at risk of HIV. Note: the shift by ACB workers from service providers to students was driven by one new program in Ottawa and the Eastern Region and may not reflect audience trends in all parts of the province.

WHAT EDUCATION ARE PEOPLE WITH HIV RECEIVING?

People living with HIV play an important role in HIV prevention. To help them reduce the risk of HIV transmission and protect themselves from being co-infected with other sexually transmitted infections (STIs) or blood borne illnesses like hepatitis C, ASOs use a number of different strategies, including education and poz prevention groups.

In 2013-14, organizations reported giving a total of 418 presentations to people living with HIV (up 38% or 117 from 2012-13). Most of this increase occurred in the Toronto region. Presentations were primarily given by general prevention workers, followed by African, Caribbean and Black workers, and Gay Men's Sexual Health workers.

EDUCATION PRESENTATIONS: TOP 4 LOCATIONS

1. **982** HEALTH & SOCIAL SERVICE AGENCIES
2. **805** SCHOOLS
3. **632** ASOs
4. **541** COMMUNITY CENTRES

FOCUS OF EDUCATION FOR PEOPLE LIVING WITH HIV

2012	2013
Population Specific Issues	STIs/Safer Sex
Living with HIV	HIV/AIDS in the Workplace
Other	Population Specific Issues

It is encouraging to the see the focus on STIs and safer sex, given the marked increase in bacterial STIs — particularly in gay men with HIV. It is also encouraging to see the focus on HIV in the workplace, given that most people recently diagnosed with HIV will stay in the workforce.

WHAT ARE WE TALKING ABOUT?

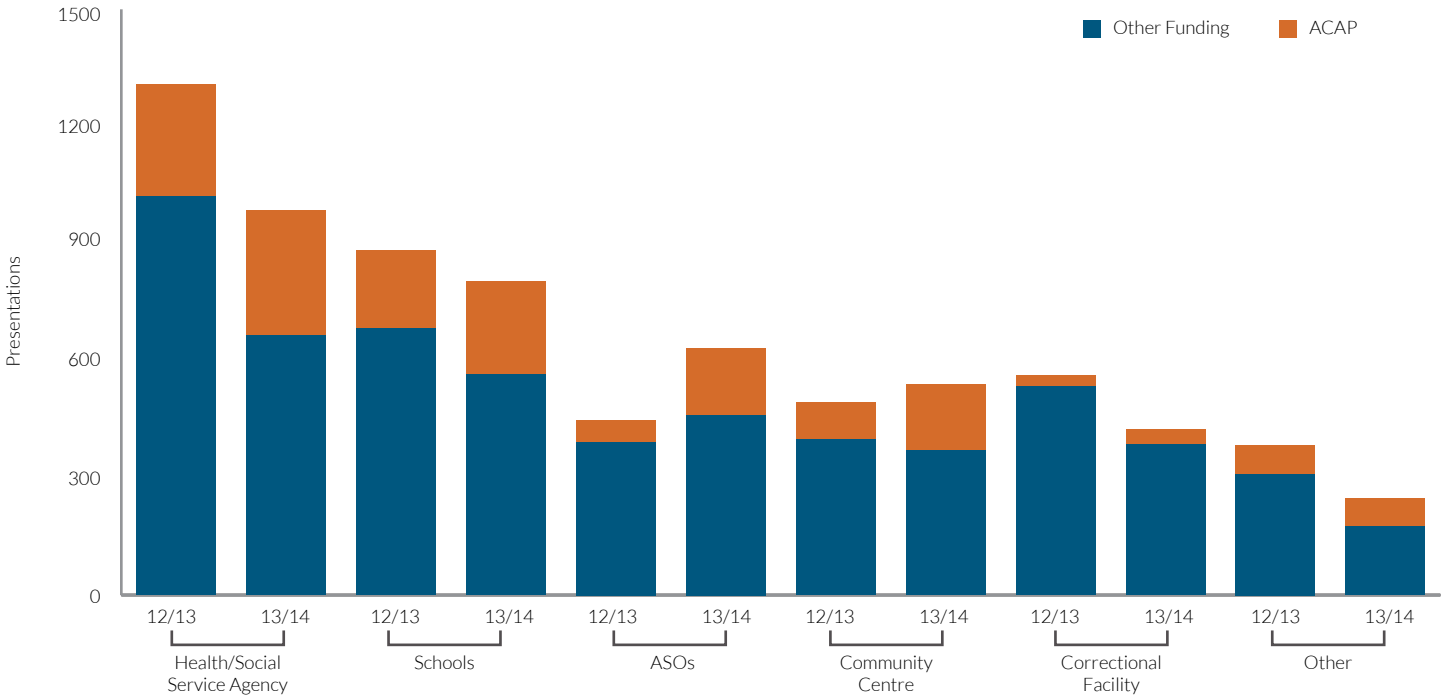
Thirty years into the response to the virus, HIV 101 continues to be the most common topic. Why? Has "HIV 101" become a catch-all for presentations for people at risk? What does it include? Does OCHART provide the right topic options?

The only topics that saw an increase in 2013-14 were stigma/discrimination and diversity, anti-oppression and cultural competence. These increases can be attributed to one Indigenous-focused program and WHAI worker presentations.

WHERE ARE PRESENTATIONS DELIVERED?

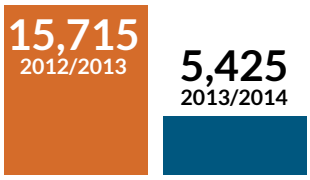
The number of presentations given at health and social service agencies and in schools dropped in 2013-14 while the number delivered at ASOs, community centres and faith organizations increased.

FIGURE 23
TOP SIX PRESENTATION LOCATIONS BY FUNDER 2012/13-2013/14



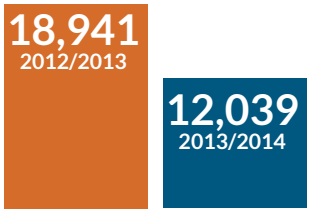
TRENDS IN ONE-ON-ONE IN-SERVICE EDUCATION

Presentations are not the only way to deliver education or to measure the impact of education programs. Workers spend a significant amount of time delivering one-on-one education. Questions about one-on-one education have only been asked for two years so there are still some challenges with reporting. However, in 2013/14:



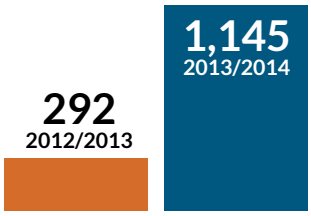
EDUCATION WORKERS

REPORTED MANY FEWER ONE-ON-ONE SESSIONS. MOST WERE WITH PRACTITIONERS AND MEMBERS OF THE GENERAL PUBLIC. THE MAIN TOPIC WAS POPULATION-SPECIFIC ISSUES.



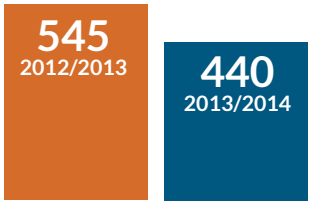
IDU OUTREACH

WORKERS REPORTED FEWER ONE-ON-ONE SESSIONS IN 2013/2014.

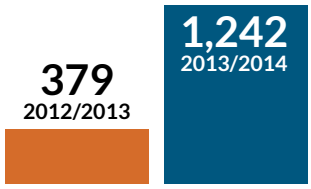


ACB STRATEGY WORKERS

SPENT MORE TIME IN ONE-ON-ONE SESSIONS WITH THEIR COMMUNITIES AND WITH PRACTITIONERS, MAINLY RESPONDING TO POPULATION-SPECIFIC ISSUES AND HIV 101 EDUCATION REQUESTS.

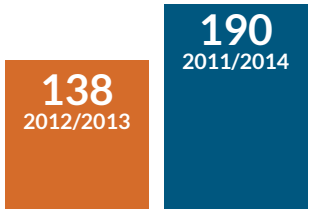


PROGRAMS FUNDED SPECIFICALLY TO WORK WITH **INDIGENOUS PEOPLE** REPORTED FEWER ONE-ON-ONE SESSIONS. STIS/SAFER SEX WAS THE MAIN EDUCATION REQUEST.



GMSH WORKERS

HAD MANY MORE ONE-ON-ONE SESSIONS WITH GAY MEN AND PEOPLE LIVING WITH HIV THAN IN THE PREVIOUS YEAR. THE TOP 3 EDUCATION REQUESTS WERE HIV TESTING, LIVING WITH HIV AND STIGMA AND ANTI-HOMOPHOBIA.



WHAI WORKERS

HAD MORE ONE-ON-ONE SESSIONS WITH PRACTITIONERS, WHERE THEY MAINLY DISCUSSED POPULATION-SPECIFIC ISSUES AND ADDRESSING VIOLENCE.

TOP 3 PRESENTATION AUDIENCES BY WORKER TYPE

GAY MEN'S STRATEGY WORKER

- Gay/bisexual/MSM
- African, Caribbean or Black communities
- People living with HIV

WOMEN & HIV/AIDS INITIATIVE

- Women at risk
- Practitioners, professionals, or service providers
- General public

AFRICAN & CARIBBEAN STRATEGY WORKER

- African, Caribbean or Black communities
- Practitioners, professionals or service providers
- Women at risk

INDIGENOUS FOCUS

- Indigenous peoples
- Practitioners, professionals, or service providers
- General public

TOP 3 ONE-ON-ONE TOPIC REQUESTS BY STRATEGY WORKER

GAY MEN'S STRATEGY WORKER

- HIV Testing
- Living with HIV
- HIV Disclosure

WOMEN & HIV/AIDS INITIATIVE

- Population-specific issues
- Addressing violence
- HIV/AIDS 101

AFRICAN & CARIBBEAN STRATEGY WORKER

- HIV/AIDS 101
- Population-specific issues
- STIs/Safer Sex

ABORIGINAL FOCUS

- STIs/Safer Sex
- HIV/AIDS 101
- Population-specific issues

FIGURE 24
WHO DO DIFFERENT WORKERS EDUCATE, AND ABOUT WHAT?

WHAT YOU TOLD US ABOUT BARRIERS TO EDUCATION AND HOW TO OVERCOME THEM

REACHING HIDDEN POPULATIONS

"[In our region] 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 (i.e. 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 [ASOs] with the help of the OHTN to better understand the needs of this population."

"Other barriers include not wanting to be visible to others when accessing programs in a known ASO."

STIGMA – INCLUDING STRUCTURAL STIGMA

"The idea of HIV being a conspiracy or some sort of population control method can become a barrier to the workshop presentation as it comes up and takes up already limited space in a 90 minute workshop. As it relates to the stigma surrounding the topic, it's not something that can easily be passed off, and so it is important to spend time addressing it when it does arise."

"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 the lay of the land to see if there is any pattern or if we can confidently identify a trend in terms of shifting attitudes towards condom distribution in the local public schools."

"Homogeneity – addressing and naming stereotypes and oppression during workshops, helping youth unlearn oppressive attitudes through critical thinking."

"Another barrier to education is the criminalization of sex work which impacts who is able to provide education and what types of information can be discussed."

"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 "HIV" topic. Screening a video which is educational and entertaining allows us to talk about HIV."

LACK OF RESOURCES

"Limited staff capacity remains a barrier in terms of being able to offer frequent and ongoing education. We are working to revive our Speaker's Bureau and engaging trained volunteers in education efforts."

"Despite the fact that WHAI coordinators are trusted with developing workshops, webinars and providing information directly to service providers, we lack the ability to develop our own resources, which can be tailored to our community's questions, needs, and issues…we need to make sure that the information is not misinterpreted."

DISINTEREST

"HIV is not seen as a "huge issue" in the mind of high-risk youth – seen as treatable, so why take precautions!"

"The Multicultural HIV Prevention Coordinator has found that older generations of ACB community members do not have an interest in discussing HIV/AIDS related topics."

WHAT IS CHANGING ABOUT OUR EDUCATION PROGRAMS? EMERGING TRENDS AND INNOVATIONS

NEW PARTNERSHIPS—SOMETIMES WITH UNLIKELY PARTNERS—HELP PROGRAMS REACH NEW AUDIENCES

"We were able to hold a Clergy Café on the Role of Faith Communities Responding to HIV/AIDS in [our region]. Since the café had 42 attendees, we have had follow-ups with those who attended, to bring workshops and speaks to their faith houses."

"[We held] three HIV/AIDS related presentations at mosques. We are also proud to have 2 Imams who continue to work with us in delivering these educational presentations and who are active members of an advisory group."

"We were able to reach 25 churches and more than 1000 congregation members as a result of our work with faith-based leaders."

"We were asked to present in more [regional] rural communities we have not visited before."

"The Girl Guides contacted the HIV/AIDS department and requested that we provide workshops to their age group of 13 to 17. The leader identified that the Girl Guides were receiving many referrals from the community for youth who were struggling and facing barriers in hopes that the Girl Guides could provide a sense of community membership. As a result, the leaders were faced with challenges that were new to them, including sexual and gender identity, pregnancy and a need to be able to address sexual health needs. The fact that mainstream organizations, when faced with an increase in diversity of youth accessing their services, respond by reaching out toward educators for ways to make services more inclusive, is enormously positive."

INNOVATIVE RESOURCES

"[A] second group of 4 videos will be available in August and includes: HIV and LTC – Mental Health, Substance use and Addiction, Complex Care, and Pharmacy. This project has addressed a gap in HIV and LTC training for frontline staff caring for PLHIV and pre-media launch requests for videos are coming in from across the country from urban centres to remote rural locations."

MORE INTEREST IN DIVERSE TOPICS

"Engaging youth-at-risk in workshops: integrating consent, body image, gender pressure, efficacy into workshop activities and discussions."

"Another success we are seeing is the increased diversity of the presentation topics. The education work is incorporating HIV/AIDS basics as a foundation and coupling it with other topics expanding into social determinants and gender violence."

"There has been increasing interest in topic-specific workshops such as trans training and harm reduction."
"[We] organized a public forum which included a workshop addressing violence against transwomen, 2-spirited people, LGBTQ and sex working women. This event strengthened connections and partnerships with Indigenous, Trans and Two-Spirited communities."

MORE MEANINGFUL PEER INVOLVEMENT

"The digital stories and sharing of personal stories verbally are always a huge success. It is through these stories that workshop participants best increase their understanding of the impact of stigma of people living with and/or affected by HIV/AIDS. Having workshops facilitated by youth peer facilitators allows participants to develop a rapport more easily as the information, although heavy at times, is given to them through someone who is reliable and is seen as similar to them."

"The Young, Poz and Sexy groups along with the Speakers series have effectively engaged PHAs in conversations with one another about the psycho-social aspects of being HIV+."

"More targeted programs, services and resources for newcomers."

"Education to Caribbean migrant workers has led to greater access to public health services by members of this population."

"Many of our workshops in ESL classes were HIV 101, along with recruiting participants for our World AIDS Day event…we secured funding from [regional funding source] to cover printing costs for 4,000 copies of a new Pride Paper Game in advance of World Pride. We believe that these will be useful to facilitate discussion among newcomers, as the focus is on extending the Canadian values of diversity and inclusion to sexually and gender diverse populations."

MORE ENGAGING PROGRAMS AND RESOURCES

"TLC (toys, lube and condoms) Sex Shows – a collaboration between our Education Department and a local sexologist – have continued to demonstrate success in engaging students on campus at [the local university] and also at [the local college]."

"The socialite411 program continues to provide very informative sessions and a space where camaraderie exists."

INROADS WITH THE MEDIA

"We were invited to present to 24 newspaper editors from across Ontario on the topics of HIV stigma as it impacts people living with HIV, and people and populations most affected by the virus. The presentation led to an editorial in our local paper about these issues, and a commitment to do better in regards to coverage of HIV and key populations."

OUTREACH PROGRAMS

Note: This section of OCHART reports non-IDU outreach. *For the activities of the 38 programs that provide outreach services to people who use substances,* *see page 34.*

Significant face-to-face outreach contacts require a two-way, in-person interaction between agency staff/volunteers and a member of the target population. Brief contact does not involve a two-way interaction but may include people taking material like a pamphlet at event booths.

Key Trends:

- 137,923 brief contacts in 2013/14, similar to 2012/13
- More brief contacts through ACAP funded programs (29,653 vs 10,571 last year)
- Gay, bisexual and other men who have sex with men were still the main target for brief outreach but now account for only 30% of contacts (compared to 46% last year)
- 11% more brief contacts with people who use drugs – mainly due to one organization.
- Fewer significant outreach contacts were made with every population however the biggest declines were with people who use drugs and incarcerated people and people living with HIV.

FIGURE 25
TOP 2 BRIEF OUTREACH CONTACTS REPORTED 2013/2014

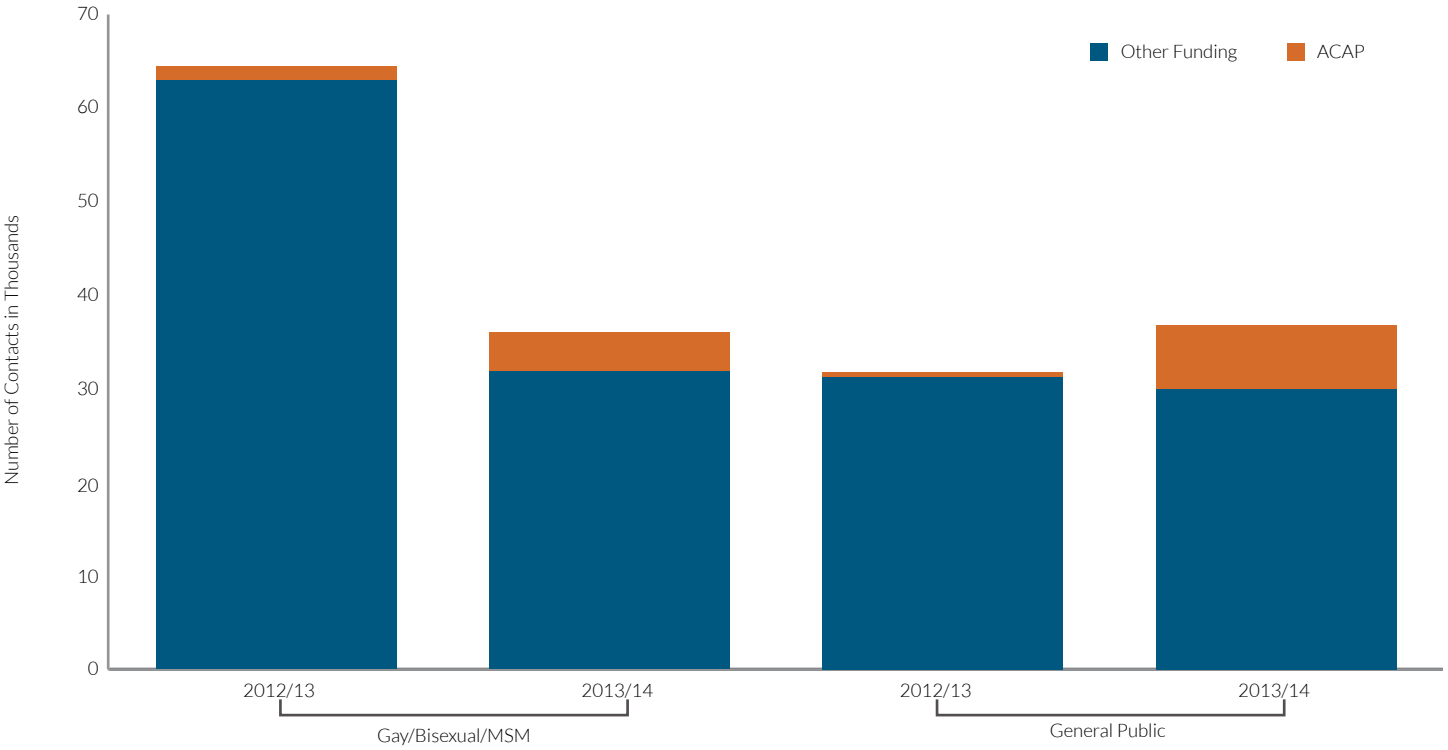
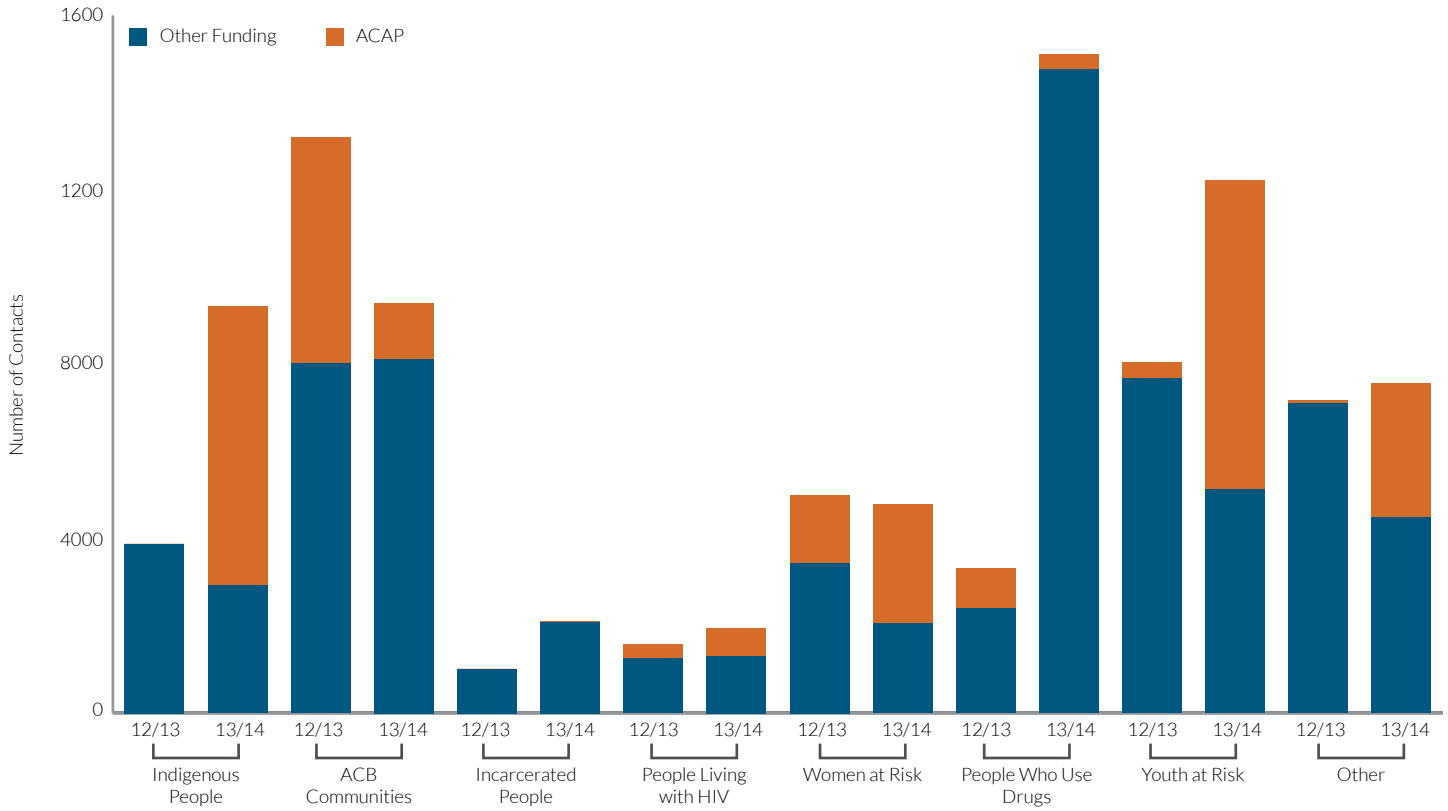
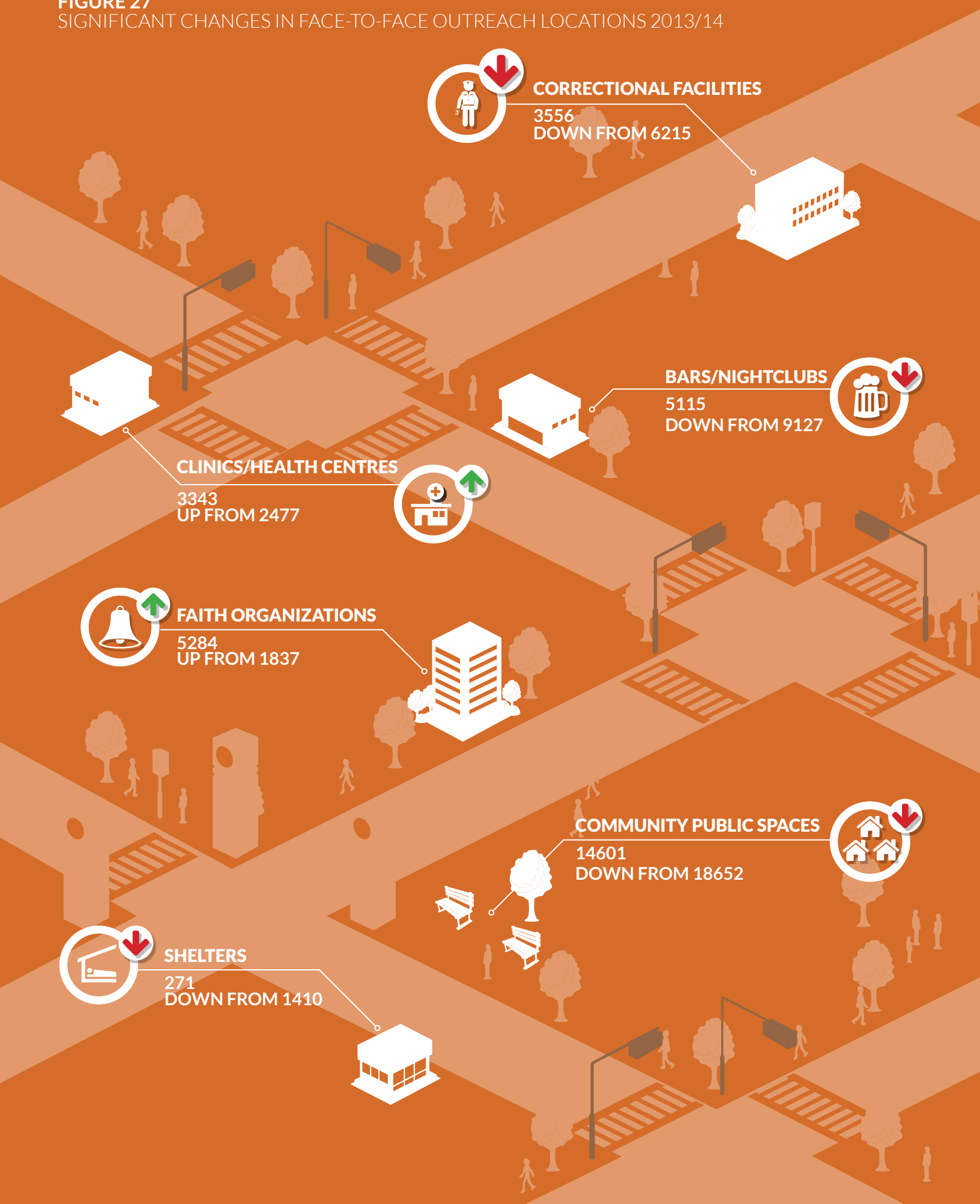


FIGURE 26
BRIEF OUTREACH CONTACTS BY POPULATION 2012/13-2013/14*



*GENERAL PUBLIC AND GAY/BI/MSM NOT INCLUDED — SEE FIGURE 25

FIGURE 27
SIGNIFICANT CHANGES IN FACE-TO-FACE OUTREACH LOCATIONS 2013/14



IS SOCIAL MEDIA WORKING?

Programs are posting YouTube videos on a range of topics including the services they provide, awareness campaigns, speakers bureau and coverage of events such as Taste for Life and World AIDS Day. Although there were more videos posted in 2013, there were dramatically fewer views.

Videos are more economical to produce and disseminate using YouTube. The most-viewed videos were those that had stories involving people — which may be more engaging and are shared more. Examples include: Unlocking HIV Film Documentary (https://www.youtube.com/user/UnlockingHIV) or The River of Healing http://www.youtube.com/watch?v=8867y_9Fnd8) with more than 2,000 views. Videos of services and programs offered, awareness and event highlights were the least viewed. It is unclear whether low viewership is because videos have not been promoted or labelled in an interesting way, or whether YouTube may not be the ideal medium for this type of information.

While the number of Facebook likes and Twitter followers went up in all regions, we still don't have a good sense of who follows ASOs or the impact of their social media. Comprehensive free analytics program for social media are no longer available online. This barrier to information prevents programs and the sector from understanding what works and where to invest their social media resources.

SOCIAL MEDIA: ACTIVITY VS. OUTCOME

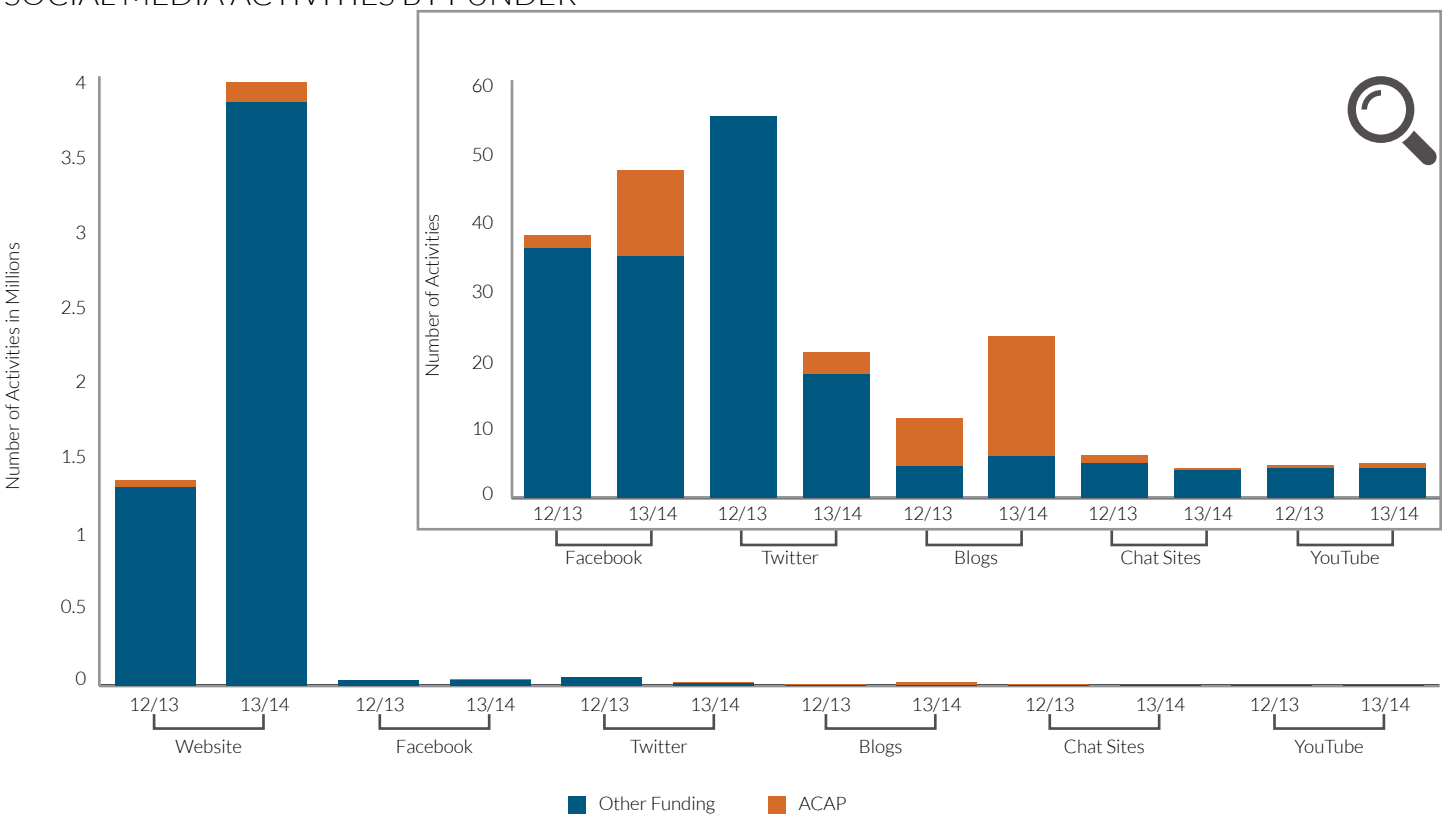
	2012/2013	2013/2014
POSTS	92	325
COMMENTS	58	302
POSTS	10978	12943
INTERACTIONS	**37509**	**43680**
SITES PARTICIPATED IN	128	466
INTERACTIONS	6012	4202
TWEETS	8283	9035
RETWEETS	4623	4885
UPDATES / NEW PGS	840	19879
UNIQUE VISITORS	807434	3336882
VIDEOS POSTED	41	58
VIEWS	53617	19736

MORE PROGRAMS USING SOCIAL MEDIA

The number of programs posting YouTube videos is up 50%; the number in online chatrooms or on dating sites – where outreach is likely to be most effective – increased only slightly.

	PROGRAMS USING MEDIUM IN 2012/2013	PROGRAMS USING MEDIUM IN 2013/2014
Blogs	9	10
Facebook	42	43
Online chatrooms, dating sites, etc.	18	21
Twitter	28	30
Website	31	34
Youtube	14	21

FIGURE 28
SOCIAL MEDIA ACTIVITIES BY FUNDER



YOU TOLD US ABOUT EFFECTIVE OUTREACH STRATEGIES

WORKING WITH TRADITIONAL PARTNERS

"We are working with public health, law enforcement and drop-in/shelter operators to educate service users on proper equipment disposal."

"We are working with the Crystal Meth Coalition."

"[We] will run a pilot project over the summer that engages four youth who will deliver harm reduction information and some supplies to other at risk youth."

"We are continuing to work with the police on education and effectively working together to support our clients."

REACHING OUT THROUGH NEW PARTNERS

"Increased number of ACB-owned small businesses on our outreach list. Opportunities were created to interact with and answer HIV-related questions of shop owners and customers. People reached have been connected to services."

"One of the amazing outcomes of our work with the Muslim community is our ability to cater to the diversity which exists in the Muslim community; we have been able to access ultra-conservative spaces to provide HIV/AIDS outreach (i.e. segregated spaces) as well as super liberal, fringe as well as underground Muslim groups (i.e. LGBTQ Muslims,). This is an indicator that we are being highly inclusive in our work, as well as performing our work with the flexibility which is required depending on the group in question/context."

"Developed a new audience in [our region] with outreach at a faith based meal program once a week. Reaching hundreds of at-risk people we had not seen in the past."

"For the first time, outreach has been established in [a community] on the various farms where Caribbean migrant workers reside. An increase of trust has been achieved with this population, which has led to an increase in the request for education (significant contacts) as well as assistance in obtaining STI testing from the local health unit."

"Increased outreach and partnership development within Indigenous, trans/two-spirit, and migrant worker's rights communities/organizations."

"The Gay Men's Strategy Worker also successfully engaged a couple of male sex workers to help develop connections with community members who might need specific support around HIV prevention in the context of sex work."

TECHNOLOGY AND SOCIAL MEDIA ARE POWERFUL OUTREACH TOOLS

"A success we would like to highlight is the effectiveness of having a strong presence online. I have seen our group for [our target audience] continue to grow in attendance when we facilitate our support sessions, as well as one on one educational requests, because of the online outreach."

"More referral requests via private message(s) through Facebook."

"Online outreach with gay, bi and other MSM has shifted a bit in terms of content and topics discussed. A lot of discussion is being generated through changes in profile information presented. For instance, we have been promoting men's groups a lot more online and this generates a great response that stimulates discussions around relationships, body image and social isolation. There has been a lot more interaction with men that identify as married."

"Promotion of the site and social media with swag; use of text function to engage youth who want to ask questions anonymously; really listening to the youth in terms of feedback for site updates and content to be included."

"Created a "testing awareness campaign" for MSM using two online surveys for community responses that directed the creation of the campaign."

IDU OUTREACH SERVICES

In 2013/14, 38 organizations reported providing IDU outreach services; of those, 20 were funded by the AIDS Bureau specifically for IDU outreach workers and services.

Trends in IDU Outreach Programs

Drug use patterns are changing.

Several programs reported:

- More use of methamphetamines, fentanyl, wellbutrin and heroin.
- More youth using these drugs.
- More need for needles (particularly shorter ones) and pipes.

Outreach contacts down and in-service contacts up

The total number of unique IDU outreach contacts was down again in 2013/14 to 21,468 from 21,862 in 201/13 and 24,199 in 2011/12.. The drop in 2012/13 may have been due to changes in reporting from provincial services; however, how agencies record contacts can have a significant impact on interpreting these numbers.

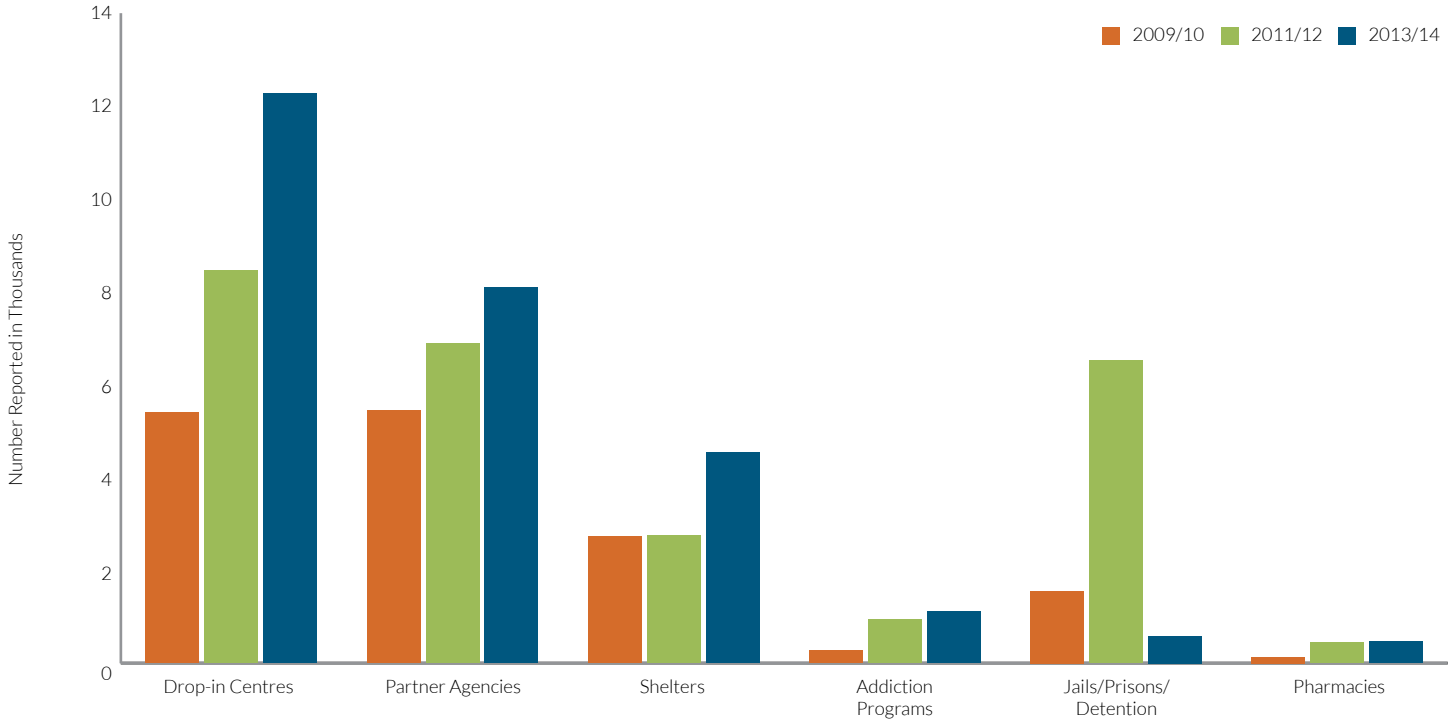
Informally, we are aware that some agencies report interactions instead of clients. If those agencies altered a practice and began recording unique clients, this would explain the decline and be more accurate.

In-service contacts (down in 2012/13) increased in 2013/14 (116,869) to above 2011/12 levels. Two regions — Central East and South West — reported more than double the number of in-service contacts. This increase may be due to the effectiveness of outreach services, which create trust with agencies, or it may be due to less outreach available and clients having to come into the site to access supplies or services.

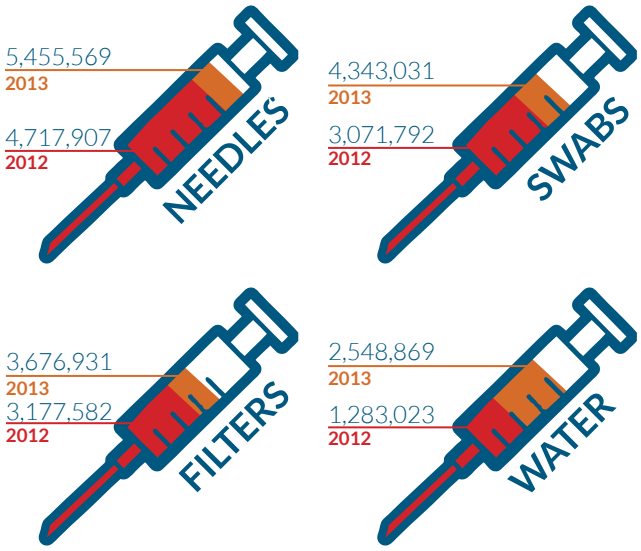
Other agencies becoming common sites for outreach

Overall brief IDU outreach contacts was down to 59,086 in 2013/14 from 61,532 in 2012/13 . There were fewer outreach contacts at parties, in jails or in nightclubs (compared to the previous year) and more through partner agencies, drop-in centres and addiction centres — perhaps due to stronger partnerships with community partners.

FIGURE 29
TOP SIX OUTREACH SITES FROM 2009/10-2013/14



More needles, swabs, filters, water and cookers distributed



Distribution of Safer Inhalation Supplies Varies Across the Province

While most programs reported distributing fewer pipes, several handed out more and reported increased demand for and shortages of safer inhalation equipment. The differences cannot be explained by geography.

More demand for practical assistance

Programs distributed more toiletries, clothing and transit tickets highlighting unmet basic needs of people who use substances.

FIGURE 30
TRENDS IN TOTAL SAFER INHALATION SUPPLIES DISTRIBUTED, 2011/12-2013/14

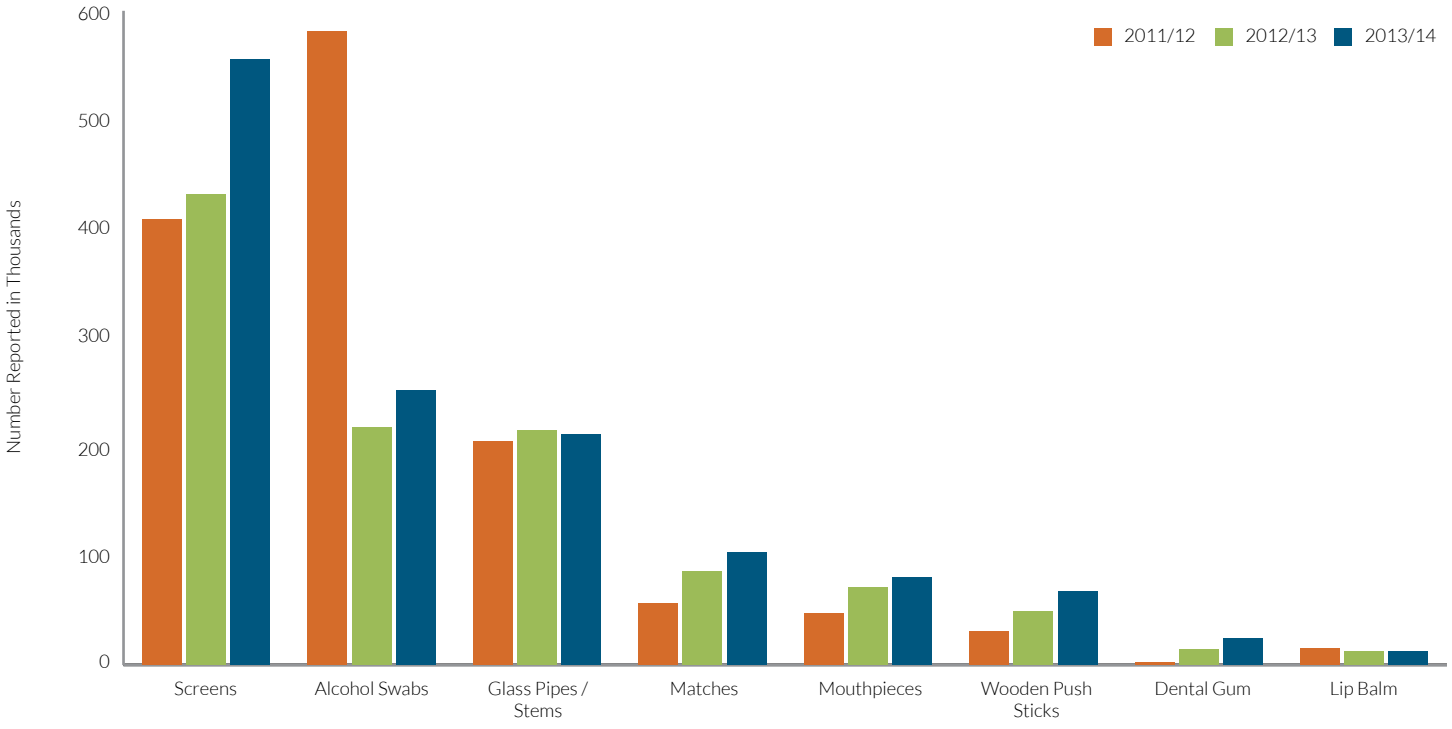
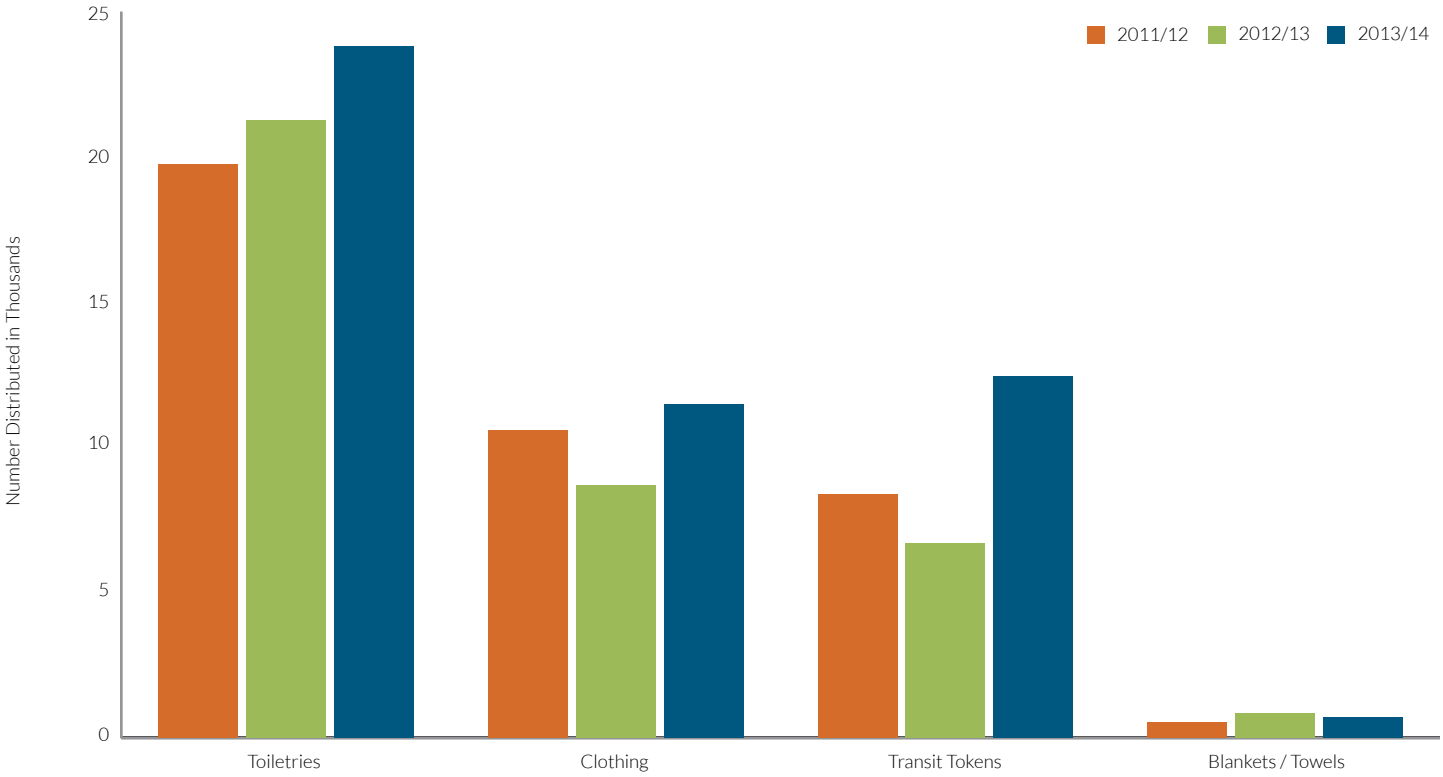


FIGURE 31
TRENDS IN IDU PRACTICAL ASSISTANCE DISTRIBUTION, 2011/12-2013/14



WHAT DID WE LEARN FROM OUR OUTREACH EFFORTS IN 2013/14?

IDU outreach continues to be a key way to reach populations at risk and meet the needs of injection drug users. Agencies provided information on trends in drug use and service.

↑ MORE USE OF CRYSTAL METH, HEROIN AND FENTANYL

"There has been an increased number of service users reporting IDU of crystal methamphetamine, and an increased number of HIV+ individuals associated with IDU. "

"[We've seen a] crystal methamphetamine increase."

"During this reporting period there has been a shift from pharmaceuticals to heroin use. Crystal meth seems to be emerging in [the region]. There have been mystery substances introduced into the Region which has resulted in horrific soft tissue damage for some clients. There have been fewer reports of clients injecting Wellbutrin."

"[There has been an] increase in heroin use and wellbutrin use. Fentanyl is being widely used in [the] Region."

"Clients report seeing an increase in use of both fentanyl and heroin in the region and an apparent co-related increase in overdoses, both fatal and non-fatal."

↑ MORE NEED FOR NEEDLES (PARTICULARLY SHORTER ONES) AND PIPES.

"We've noticed a change in the requests for equipment we've been receiving. Many clients now prefer short tip needles as well as longer pieces of tubing."

"Our syringe distribution is up 33% from the last reporting period. Much of the materials are being accessed through the self serve cupboard at the downtown community health centre which we are stocking daily. There is also an increased demand among users for "short" syringes (30 gauge size). That appears to be an issue as well in the rest of [the region]."

↑ YOUNGER CLIENTS ACCESSING SERVICES AND THE CHALLENGES SERVING YOUTH

"During this reporting period staff has seen a shift in age demographics, we are now seeing younger clients accessing services."

"We continue to see new injection drug use, mostly among youth."

"Ongoing challenges related to publicly-discarded needles and equipment, increase in women and youth accessing services in harm reduction services, increased number of new ID users."

"The Harm Reduction Coordinator created a series of 5 workshops that covered substance use, the criminal justice system, the legal system and the process of navigating these systems. He also partnered with [a social science agency] and with a criminal defense lawyer to deliver this series of 5 workshops. Shortly after the series had been formulated an agreement was struck with Redemption Reintegration Services for the delivery of all 5 workshops, followed by an agreement with [two community partners]. This indicated a need for this type of programming among at risk youth."

STRONGER PARTNERSHIPS

"Staff has worked with public health and the [city] to install a needle kiosk at the local park that the complaints were filed about. Since it has been installed, approximately 300 needles have been recovered from this location. A meeting with the Chief of Police is being planned. StreetWorks Harm Reduction Services implemented a community-based opioid overdose prevention and naloxone distribution program and have trained 6 individuals to date. A quarterly newsletter is distributed to clients and community partners for the purposes of alerting people of dangerous trends, upcoming events, services available to them."

"We continue our partnership with [our partner] in the production of outreach kits and distribution of supplies as well as referring our service users to [our partner] for Naloxone training and access."

"We continue to work with our partners and the OHRDP to provide the most current and relevant information and updates on drugs like fentanyl and wellbutrin including harm reduction strategies. We also work with these partners including police to inform clients of bad/tainted drugs on the street including analog fentanyl ."

III. Improving Access To Support Services

PEOPLE LIVING WITH HIV: BY THE NUMBERS

According to the Ontario HIV Epidemiological Unit at the University of Toronto (2012), about 27,420 people in Ontario are estimated to be living with HIV.

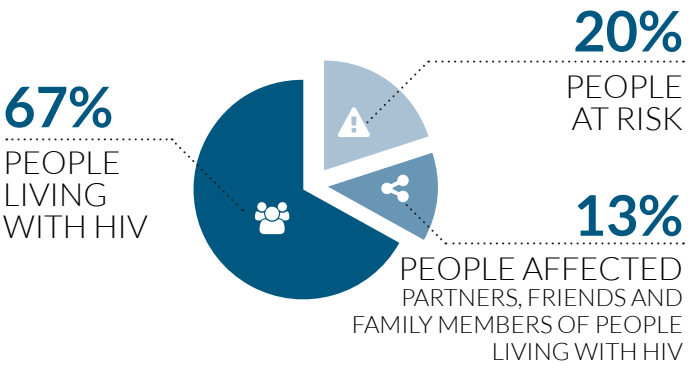
- **Most (55%)** are gay men and other men who have sex with men.
- **19%** are people from countries where HIV is endemic, such as sub-Saharan Africa and the Caribbean.
- **Most (47%)** live in Toronto.

According to modeled estimates, about 35% of people with HIV are unaware they are infected. However, other jurisdictions have recently revised their modeling and significantly reduced their estimates of the number of people infected and not yet diagnosed. For example, the US—which has much higher infection rates than Ontario — now estimates that only about 14% of infections are undiagnosed. The OHTN's new Epidemiology Unit will be reviewing the assumptions underlying Ontario's model and revisiting the estimates.

Not everyone with HIV uses the services of community-based programs. With improvements in treatments, many people with HIV are managing their health well. ASOs are more likely to see the proportion of people living with HIV who have complex health, social and practical assistance needs, including low incomes, mental health and addiction issues, and housing and legal issues. People with HIV tend to use community-based services episodically – that is, when they experience a health crisis or when their health or social needs change.

WHO IS USING SUPPORT SERVICES?

The following data comes from 61 unique programs, 17 of which have ACAP funding.



In 2013/14, the 61* community-based HIV programs that provide support services reported serving an average of 13,412 people in each half of the year. Of those, 2,593 were new clients and 10,990 were ongoing or returning clients. These numbers are within 5% of what was reported the previous year.

	PHAs	Affected	At Risk	New PHAs	New Affected	New At Risk
H1	8225	1419	1709	1331	154	819
H2	7572	1520	1537	1262	232	1045

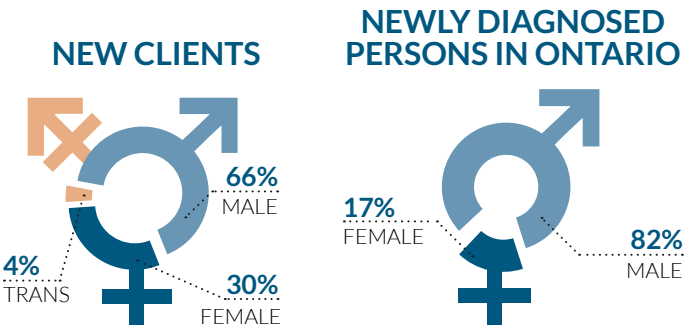
** This includes PASAN, Oahas, and Hemophilia, who provide direct client services.*

Note: because some people with HIV — particularly those in Toronto — may use the services of more than one ASO, some may be counted more than once.

THE GENDER PICTURE

In 2013/14, 66% of new clients were male and 30% were female — although 82% of newly-diagnosed people in Ontario were male and 17% were female.

- Most clients are male.
- Women continue to account for about one-third of people using support services.
- 4% of new clients are trans people but they still represent 1% of all clients.



THE AGE PICTURE

People who access support services tend to be older. In 2013/14, programs reported:

- A 25% increase in clients age 55 and older (from 1,269 in 2012/13).
- A decrease in the number of clients in all younger age groups.
- People with HIV age 55 and older represented 13% of all support service clients and 15.2% of all clients living with HIV.
- Clients living with HIV tended, on average, to be older than those at risk.

Although programs are serving more older clients, they reported fewer deaths in 2013/14: 118 compared to 142 in 2011/12, when OCHART first started to collect this information. While the number of reported deaths was down dramatically in Toronto, the number in the Northern Region almost doubled. The high number of deaths in the North may be due to the fact that many infections are related to drug use and people who use substances tend to have shorter lifespans.

FIGURE 32
NUMBER OF CLIENTS ACCESSING SUPPORT SERVICES BY TYPE AND AGE: 2013/14 H2

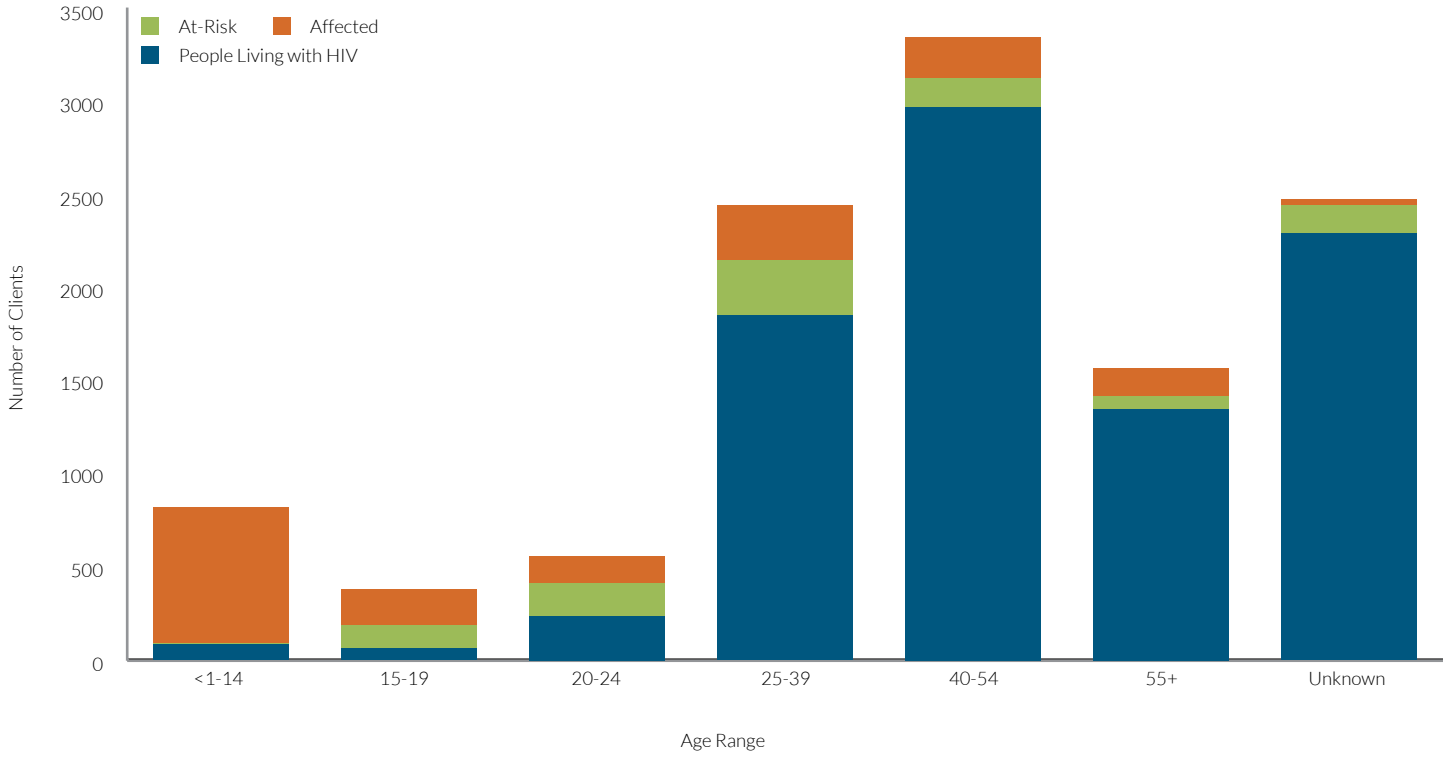
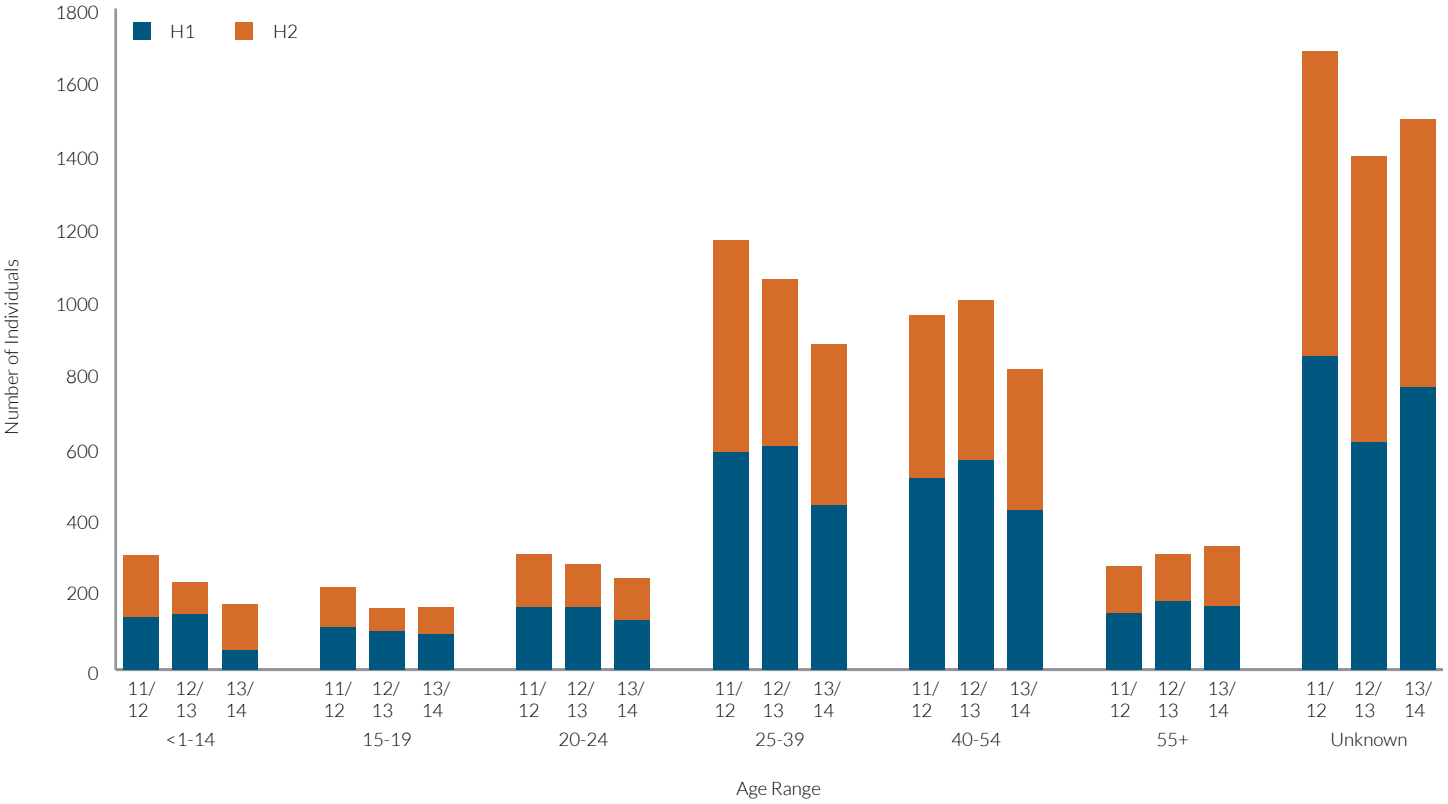


FIGURE 33
NUMBER OF NEW CLIENTS BY AGE RANGE 2011/12-2013/14



IN 2013 THERE WAS A 25% INCREASE IN CLIENTS AGED 55+

CLIENTS AGE 55+ AND OLDER REPRESENT 13% OF SUPPORT CLIENTS

WHAT CHALLENGES DO SUPPORT USERS FACE?

Discrimination/stigma, poverty, unemployment, food insecurity and mental health are the top 5 most reported challenges support users face.

WHICH SUPPORT SERVICES ARE PEOPLE WITH HIV USING?

Practical Assistance continues to be the most commonly used service in 2013/14 (see Figure 34) , followed by case management and food programs. The need for these services reinforces that a significant number of people with HIV who access community-based services are coping with poverty. Services being offered are reflective of client need and partnerships are being made with other organisations to address gaps.

FIGURE 34
NUMBER OF CLIENTS LIVING WITH HIV ACCESSING SERVICES (TOP 10) FOR 2012 AND 2013

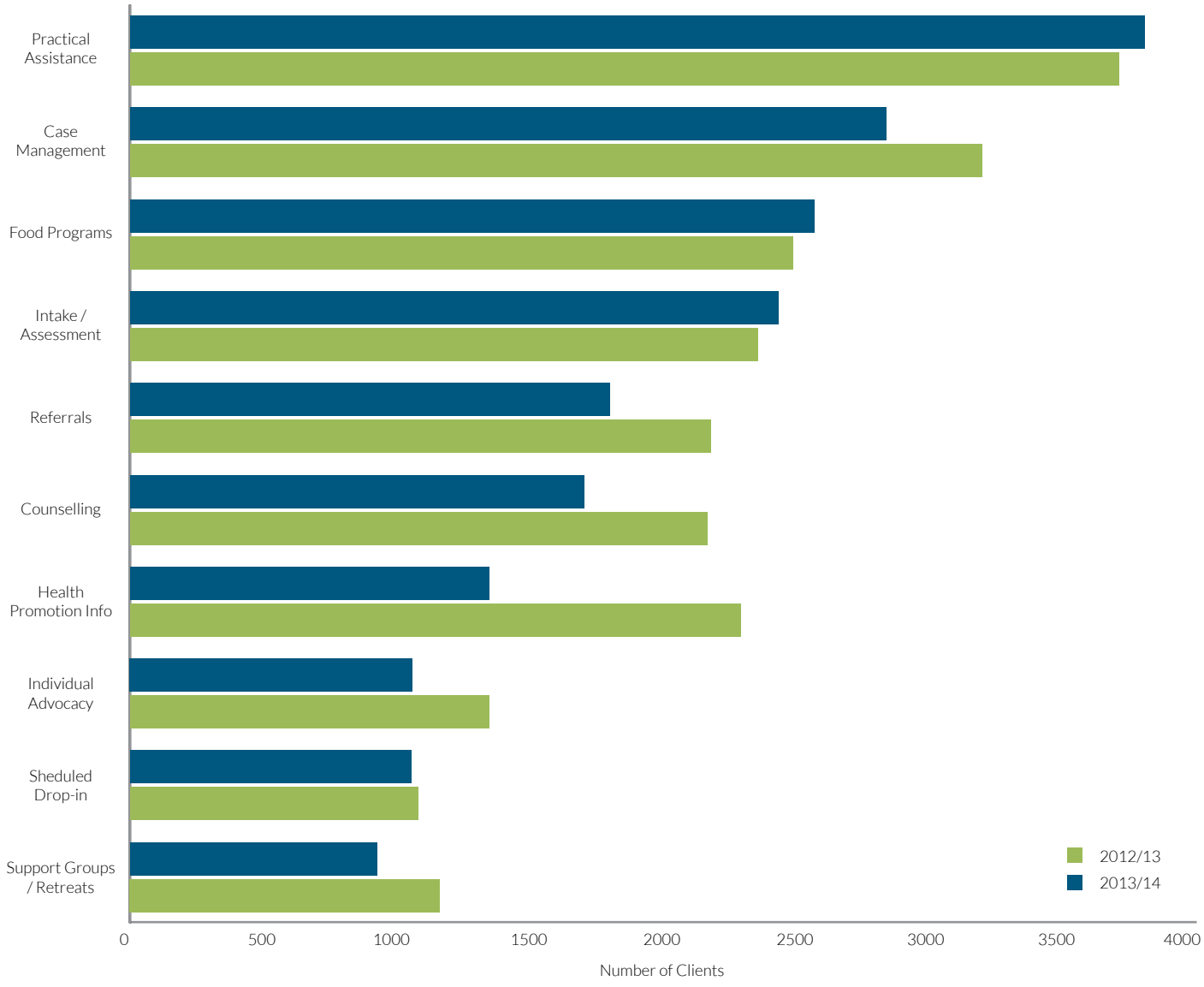
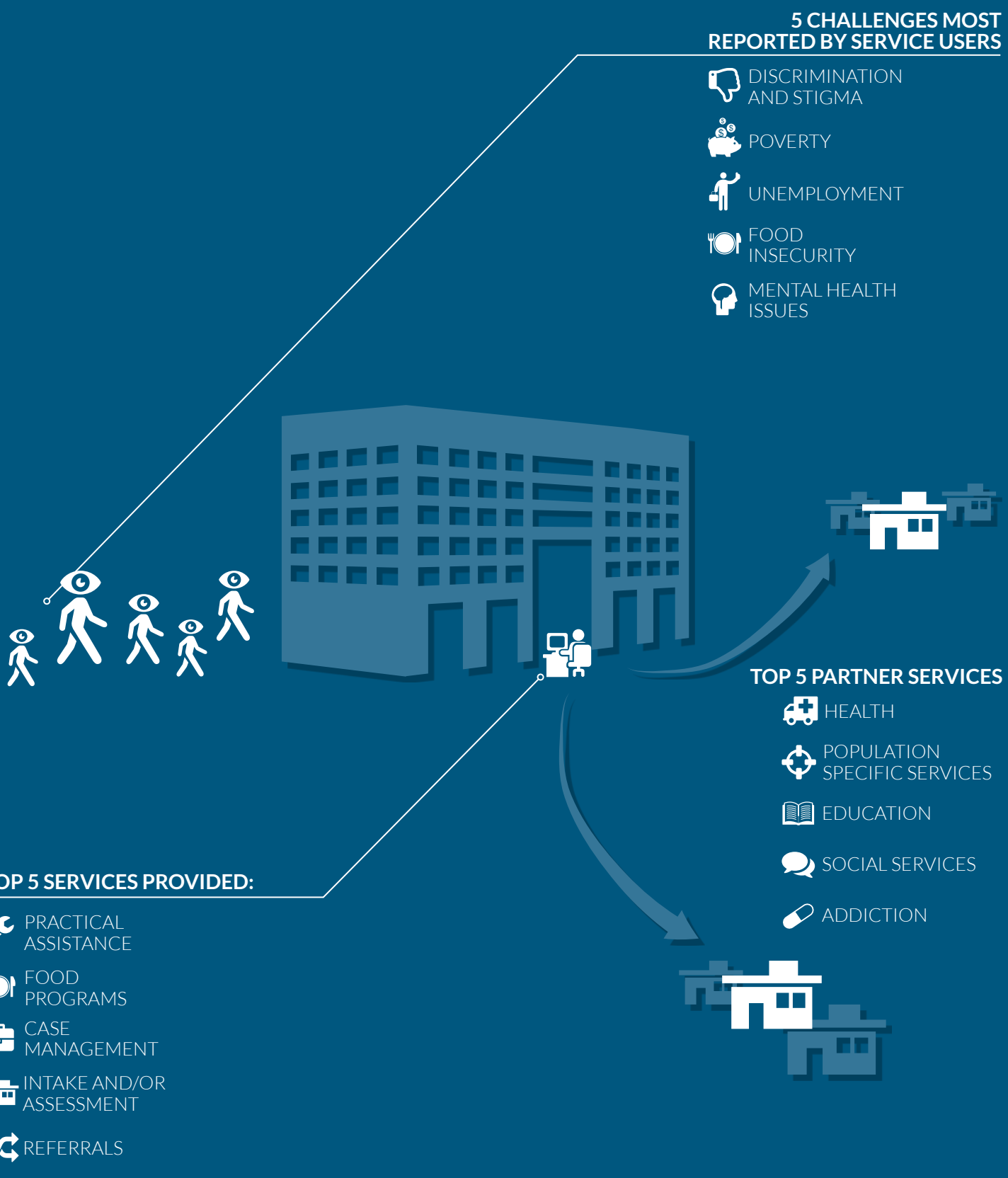


FIGURE 35
SERVICE USERS AND SERVICE PROVIDERS

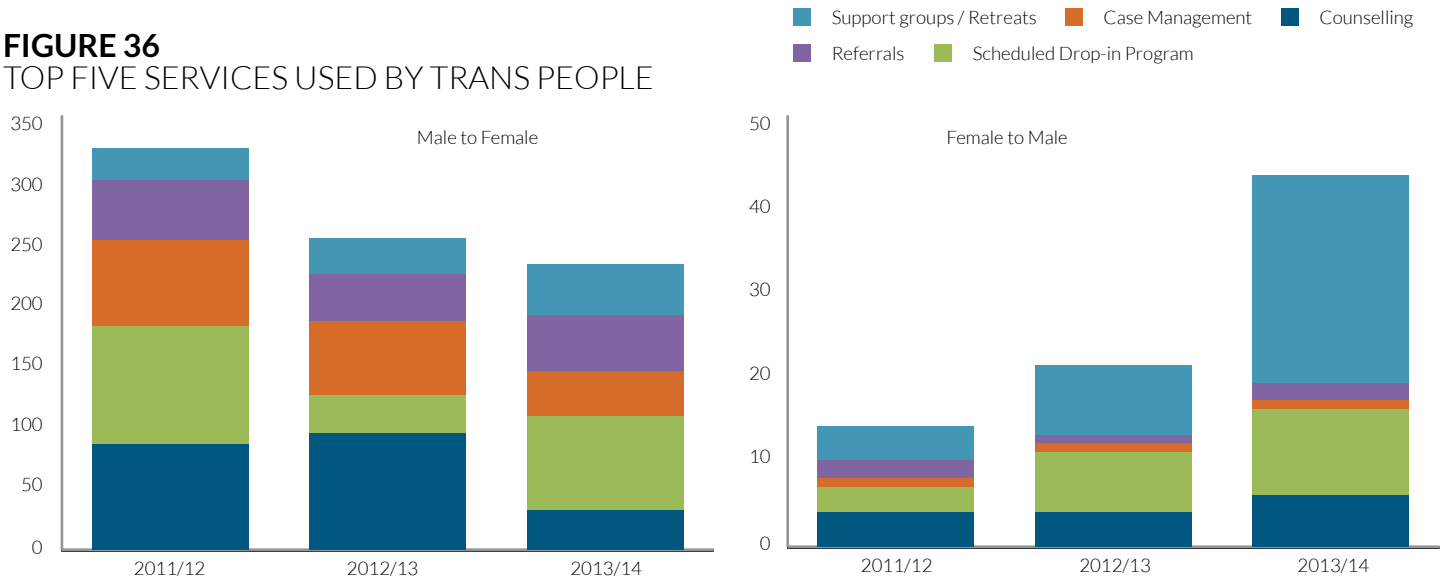


IS THERE A DIFFERENCE IN SERVICE USE BY GENDER?

Both male and female clients use practical assistance, case management, health promotion, food programs and referrals. However, women are more likely than men to use interpretation and settlement services, which suggests that a larger proportion of female clients are newcomers.

Trans people primarily use counselling, drop-in program, case management, referrals and support groups/ retreats. Note: of the 227 trans people using support services: 55% are at risk , 39% are living with HIV and 13% are affected.

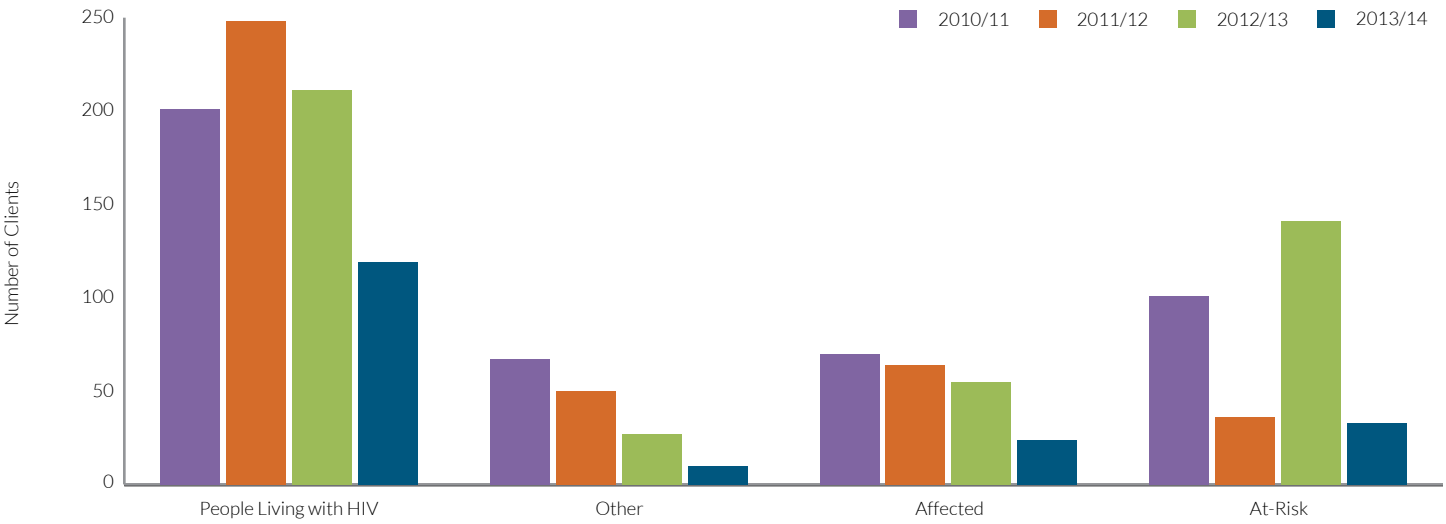
FIGURE 36
TOP FIVE SERVICES USED BY TRANS PEOPLE



WHO PARTICIPATES IN SUPPORT GROUPS?

Overall, the number of support groups dropped in 2013/14 in all participant categories. The majority of support groups were for people living with HIV. As support groups have always been an integral part of support services, it would be interesting to know why there has been such a drop in this type of service. Do clients prefer one-to-one services? Were programs finding that support groups weren't effective or well attended?

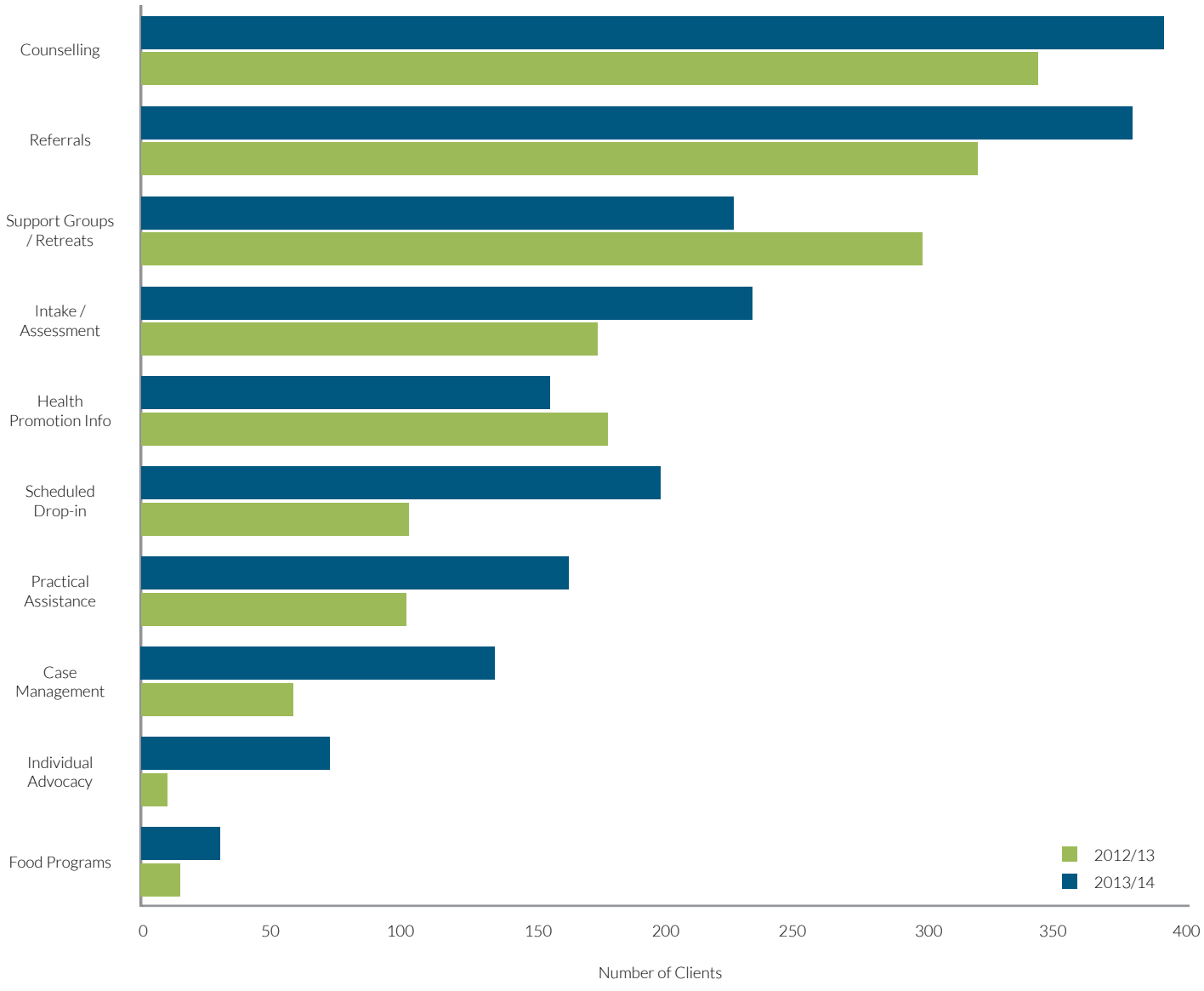
FIGURE 37
SUPPORT GROUPS BY PARTICIPANTS 2010/11-2013/14



WHAT SUPPORT SERVICES ARE PEOPLE AT RISK RECEIVING?

People at risk are using mainly counselling, referral services and support groups. It is interesting to note that, as part of the focus on the HIV cascade, community-based programs in the United States are focusing on providing services that can help people at risk avoid infection, such as housing, mental health services and addiction services. Should Ontario organizations be more aggressive in engaging people at risk in these services?

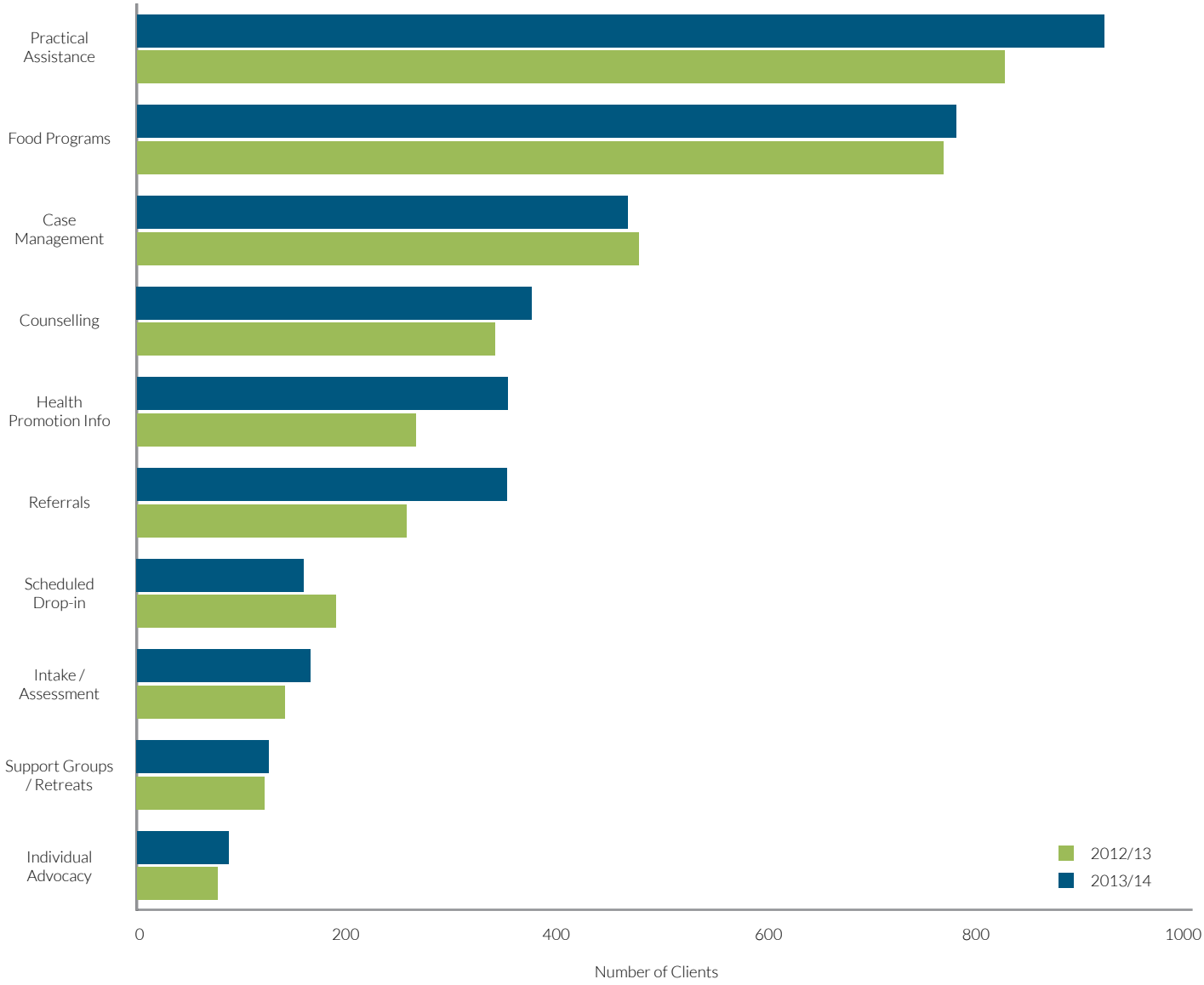
FIGURE 38
NUMBER OF AT-RISK CLIENTS ACCESSING SERVICES (TOP 10) 2012/13 AND 2013/14



WHAT SUPPORT SERVICES ARE AFFECTED PEOPLE RECEIVING?

The service profile of people affected is similar to that of people living with HIV. They mainly use practical assistance and food programs, followed by case management, counselling, health promotion and referral services. The similarity is likely due to the fact that most people affected will be family members of people living with HIV and have the same basic needs.

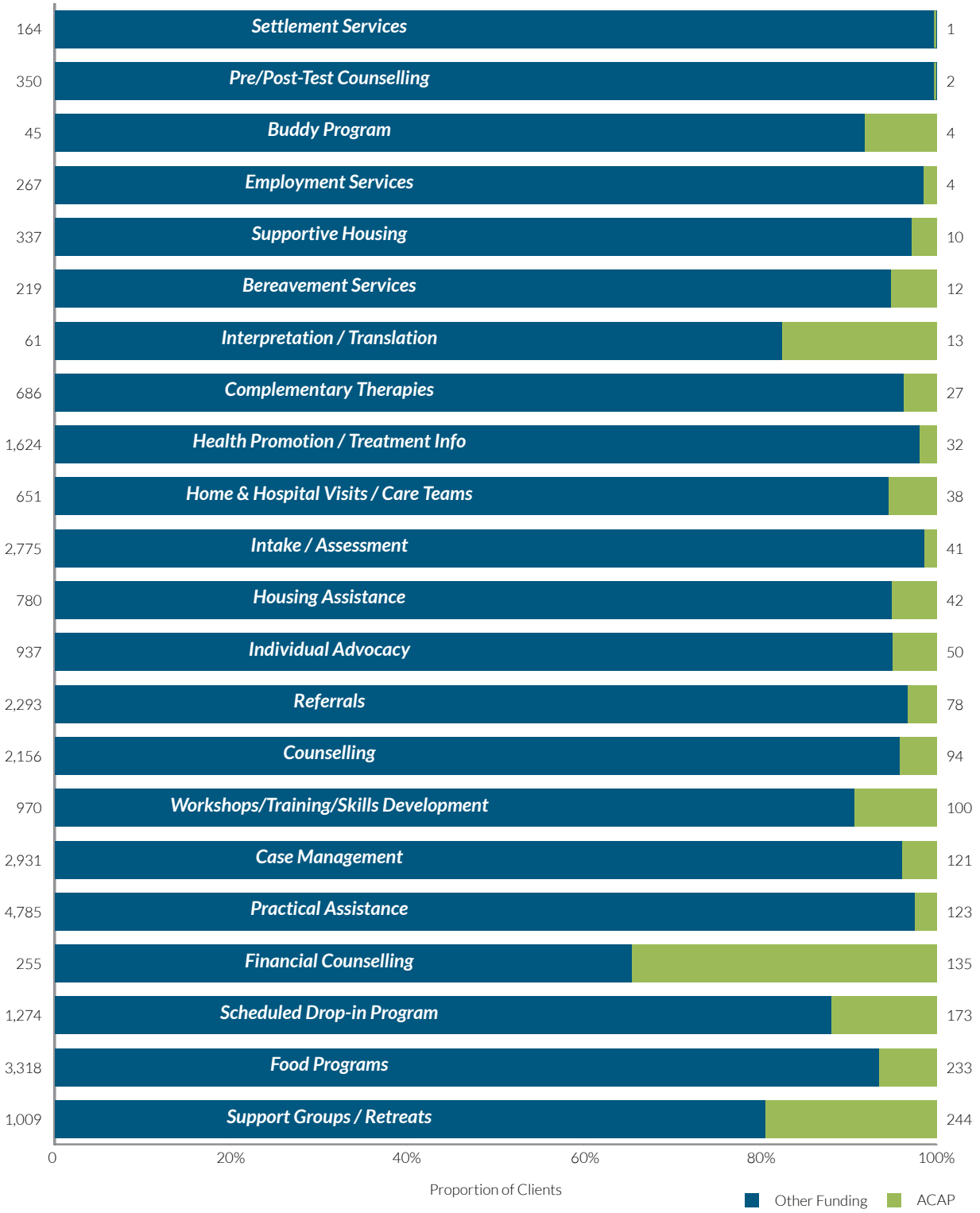
FIGURE 39
NUMBER OF AFFECTED CLIENTS ACCESSING SERVICES (TOP 10) FOR 2012/13 AND 2013/14



ACAP FUNDING SUPPORTS MAINLY FOOD PROGRAMS, SCHEDULED DROP-IN PROGRAMS AND SUPPORT GROUPS

Organizations that receive ACAP funding for support services use that money primarily to provide support to clients through support groups, food programs and scheduled drop-ins programs.

FIGURE 40
ALL CLIENTS ACCESSING SERVICES BY FUNDER 2013/14



WHAT YOU TOLD US ABOUT TRENDS IN SUPPORT SERVICES

↑ MORE CLIENTS FACING POVERTY

"Clients are experiencing challenges staying in care for their HIV treatment and maintaining their medication regimens. Many of our clients who are missing their appointments at the HIV clinic are near or are homeless. The clinic has had challenges contacting these individuals regarding their appointments."

↑ MORE CLIENTS WITH COMPLEX MEDICAL CONDITIONS RELATED TO AGING OR MENTAL HEALTH

"Mental health issues as related to HIV and aging is an identified trend. Client satisfaction surveys conducted this reporting period indicate that 83% of clients prioritize mental health as an area in which they would like more information and services. However, given the stigma [associated with] mental health, clients are more comfortable with naming specific conditions such as depression or cognitive impairment."

↑ MORE NEWCOMERS WHO DO NOT HAVE STATUS IN CANADA

"More individuals that do not have status in Canada are seeking service. Over the last 6 months, we have seen an increase in the number of individuals who are on visitor visas, and individuals who do not have status in Canada seeking assistance to find medical help in the "for fee" service. Most of the individuals are just trying to find a doctor that will meet their medical needs without charging an exorbitant amount of money."

↑ MORE WOMEN WITH HIV SEEKING SUPPORT, MORE PREGNANT WOMEN WITH HIV AND MORE CHILDREN REQUIRING SUPPORT

"During this time there has been an increase in the number of pregnancies and births. Another area where we have noticed a change is in the number from the ACB community who are wishing to go to school and improve their English."

"We've also found that young women under the age of 25 years are seeking more support from the agency. Some of these women were born with HIV and others are young mothers presenting multiple complex needs which includes newly diagnosed, newcomers and single mothers. The number of new PHA mothers continues to rise every year; this has increased demand for counseling and case management service, hospital and home visits. They are presenting with post traumatic stress disorders as a result of the trauma they have experienced in their country of origin and/or being forced to leave their children."

TO RESPOND TO THESE CHANGES, AGENCIES ARE STRENGTHENING OR DEVELOPING PARTNERSHIPS AND ADAPTING CURRENT PROGRAMS

"We have been responding to these emerging trends by continuing to partner with other services organizations to further help them and refer them to the appropriate mental health services."

"We're working more closely with other partners in the Circle of Care Program to support the needs of women living HIV. Recently 4 peers went through a 5-day intensive peer training under the Women Peer Support Program. These peers will reach out to women to provide peer support. Apart from the support women receive from the Circle of Care Program, our Women's Support Program also works with Sick Kids Hospital, Phillip Aziz, WHIWH, and Sunnybrook Hospital to support the needs of women living with HIV. We've also increased the frequency of case management meetings, home and hospital visits."

"Support staff are able to offer more wellness calls and counseling on the telephone and are also engaged in intensive case management to track and record complex health issues. The program also encourages clients to have healthy relationships with their medical providers and specifically released a resource this reporting period outlining strategies that clients can employ to get the most out of their medical appointments and interactions with health service providers. The Peer Navigation program continues to make appropriate and timely referrals in response to client needs. We are also increasing the number of sessions where service providers we trust are connected to clients through education sessions. Client issues are tracked with other service and health care providers via case conferencing."

"At this time we are working with the medical service providers to ensure medical and treatment access for all individuals. As an agency we have developed a relationship with a community doctor that will help with accessing medical and HIV treatment for clients."

"Clients are reminded of their appointments and offered transportation. Clients have also been offered Directly Observed Treatment through our office staff as a few of the clients who are not consistently taking their medication are accessing our office regularly. So far this program has been a success."

IV. Improving Community Coordination and Collaboration

FOSTERING RELATIONSHIPS AND PARTNERSHIPS IN THEIR COMMUNITIES

To reach people at risk and to ensure that people with or at risk of HIV receive comprehensive health and social services, community-based HIV programs are expected to foster relationships, build partnerships and — in some cases — negotiate service agreements with other service providers in their communities. The underlying goal is to develop networks of services that clients can access.

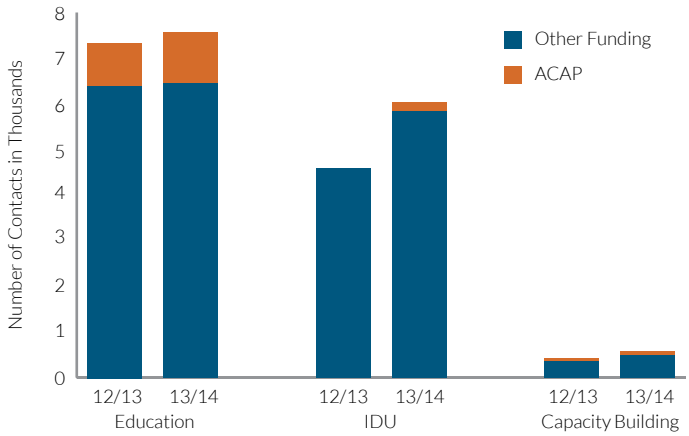
The theme of partnerships runs throughout View from the Front Lines. Programs seek out partners to help them deliver education, outreach and support services. In OCHART, three types of programs — the 1) Education and Outreach; 2) Injection Drug Use; and 3) Capacity Building programs — all report on community development activities.

COMMUNITY DEVELOPMENT MEETINGS UP

1,836 **MORE COMMUNITY DEVELOPMENT MEETINGS**

One way to measure how effective the sector is in creating service networks is to track community development meetings. In 2013/14, programs reported a total of 14,193 community development meetings — up from 12, 347 in 2012/13.

FIGURE 41
COMMUNITY DEVELOPMENT MEETINGS BY TYPE OF PROGRAM AND FUNDER



WHO PROVIDES LEADERSHIP IN EDUCATION AND OUTREACH COMMUNITY DEVELOPMENT?

Community development is a particularly important activity for executive directors, program managers and strategy workers involved in HIV education.

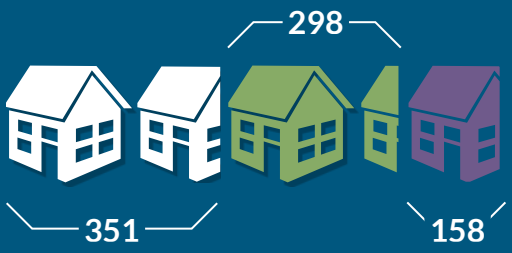
- Executive directors and program managers are more involved in advisory or network meetings, developing new partnerships and in meetings to improve service delivery.
- General prevention workers focus mainly on network meetings, information sharing, new partnerships and improving service delivery.
- Strategy workers are mainly involved in network meetings, community event planning, advisory committee meetings and building relationships.

FIGURE 42
TOP 3 EDUCATION COMMUNITY DEVELOPMENT ACTIVITIES BY ROLE
2012/13 AND 2013/14

GENERAL PREVENTION WORKERS

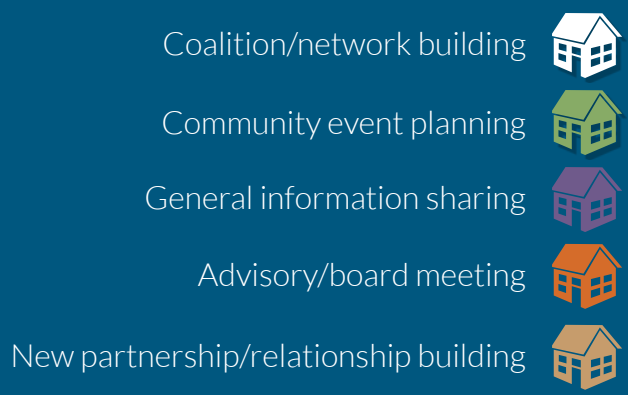
EXECUTIVE DIRECTORS / PROGRAM MANAGERS

WOMEN AND HIV/AIDS INITIATIVE WORKERS



AFRICAN, CARIBBEAN AND BLACK STRATEGY WORKERS

GAY MEN'S SEXUAL HEALTH WORKERS



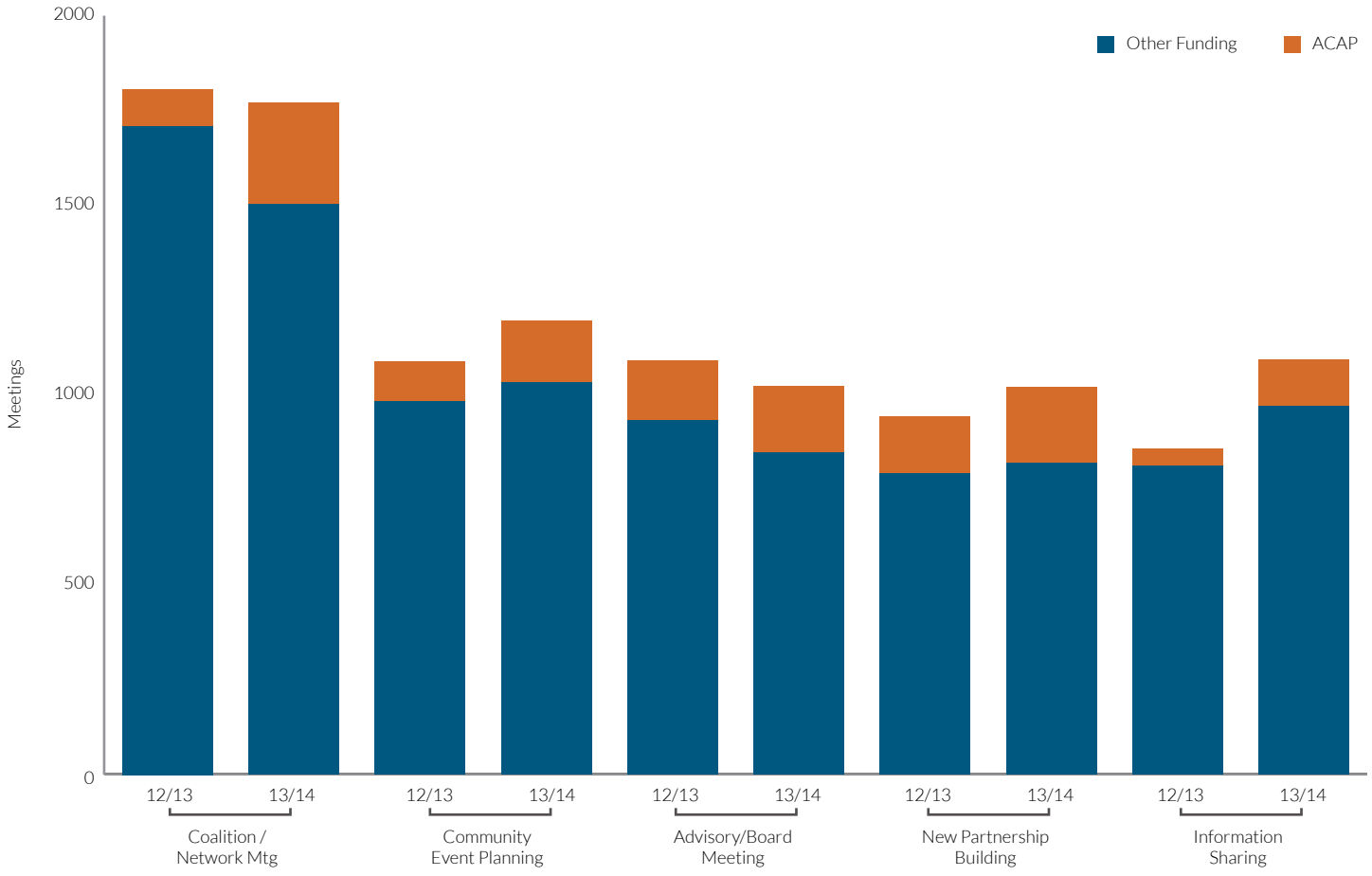
EDUCATION AND OUTREACH COMMUNITY DEVELOPMENT HELPS BUILD NETWORKS

The purpose of education community development meetings is to increase individual, organisational and community capacity. The main reasons for community development meetings were coalition/network building followed by community and event planning.

ACAP & COMMUNITY DEVELOPMENT

ACAP funds just under 20% of community development meetings and the focus of those is similar to the focus of meetings funded by other sources.

FIGURE 43
TOP 5 EDUCATION COMMUNITY DEVELOPMENT ACTIVITIES BY FUNDER



WHO IS INVOLVED IN IDU COMMUNITY DEVELOPMENT ACTIVITIES?

IDU community development activities are targeted mainly to other health and social service providers. In 2013/14, IDU programs made more efforts to engage addiction service providers, mental health service providers and the correctional service system. This is part of broader efforts to meet the complex health and social needs of people who use substances.

PARTICIPATION IN IDU COMMUNITY DEVELOPMENT

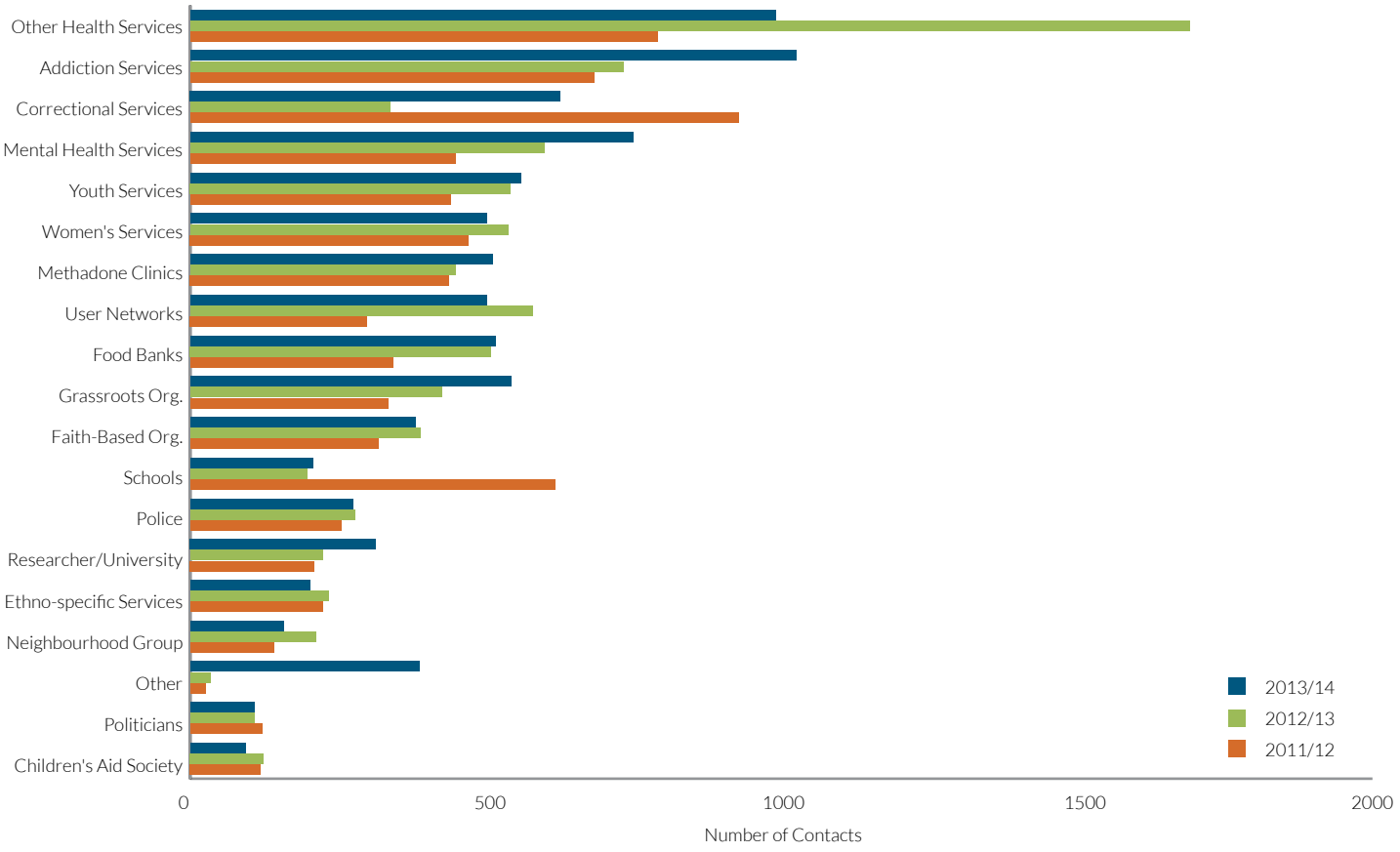
Presentations
2012/13: 8,266
2013/14: 7,817
↳ ACAP-funded: 1,157

Meetings/committees
2012/13: 5,629
2013/14: 8,474
↳ ACAP-funded: 261

Social events
2012/13: 4,005
2013/14: 5,717
↳ ACAP-funded: 508

Agency contacts
2012/13: 4,005
2013/14: 4,649
↳ ACAP-funded: 186

FIGURE 44
IDU COMMUNITY DEVELOPMENT MEETINGS



CAPACITY BUILDING PROGRAMS INVOLVED IN MORE COMMUNITY DEVELOPMENT

The total number of community development meetings reported by capacity building programs increased from 447 in 2012/13 to 586 in 2013/14. Executive directors and board members continue to be the main audience for provincial resource capacity building meetings; however, this past year, gay men's sexual health workers were also a focus, with the number of meetings targeted to GMSH workers increasing from 28 in 2012/13 to 183 in 2013/14. This is most likely due to the Our Agenda campaign and the fact that working groups became a recordable category.

FIGURE 45
NUMBER OF CAPACITY BUILDING COMMUNITY DEVELOPMENT MEETINGS BY TARGET AUDIENCE 2012/13 AND 2013/14

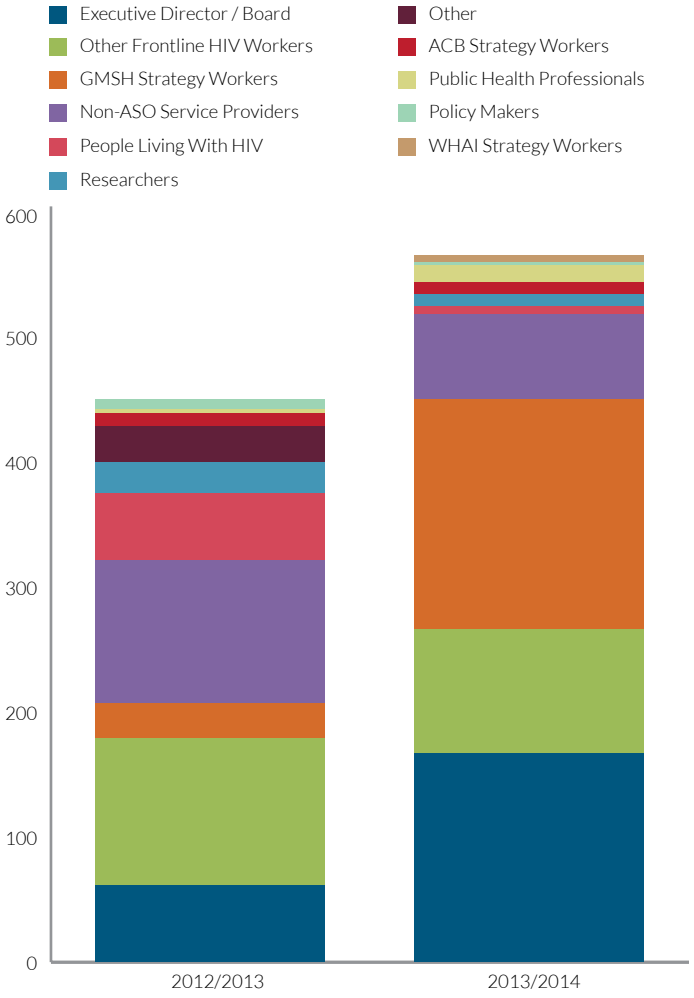
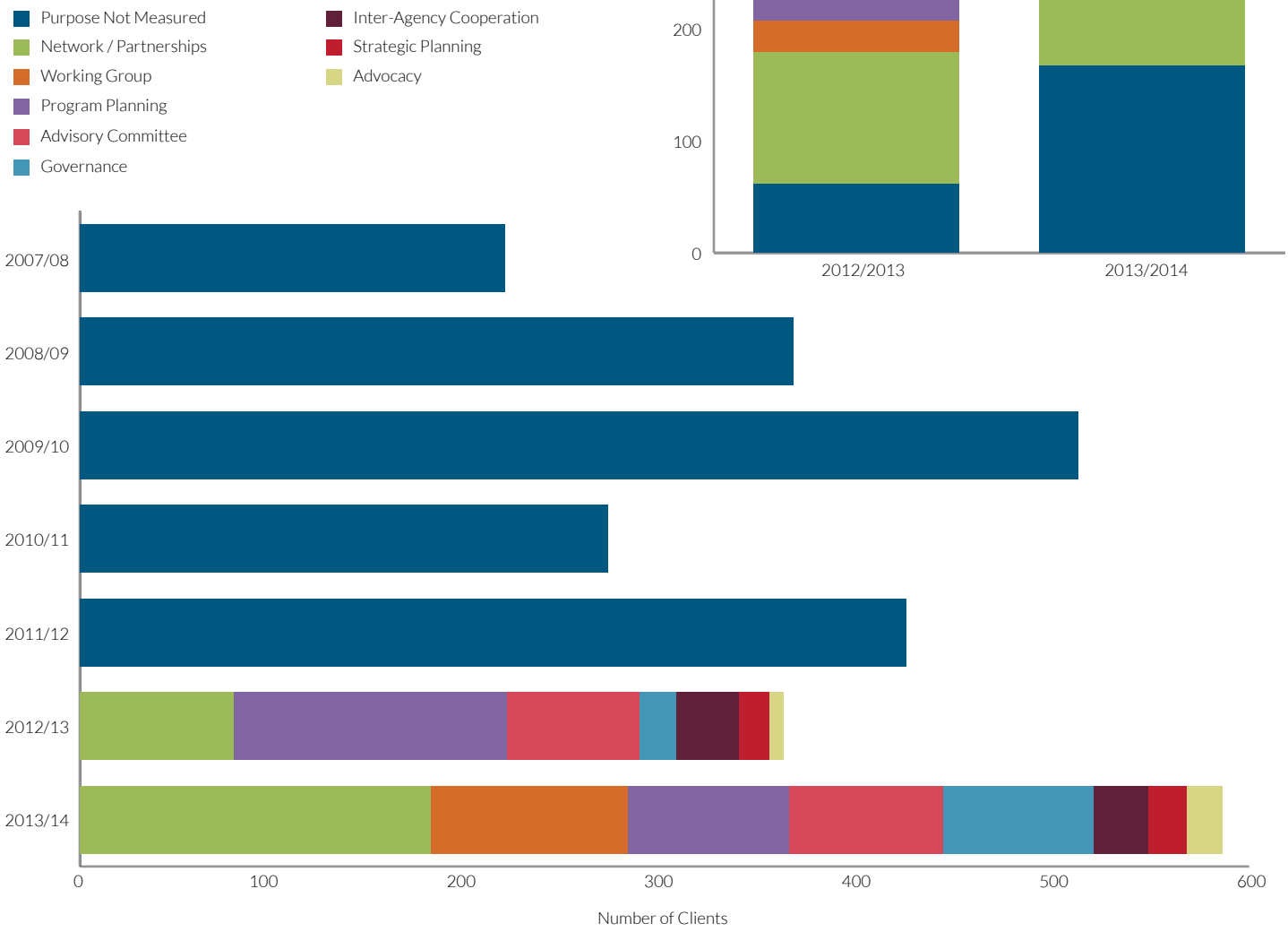


FIGURE 46
PURPOSE OF CAPACITY BUILDING COMMUNITY DEVELOPMENT MEETINGS



OVERCOMING BARRIERS IN COMMUNITY DEVELOPMENT

"Reaching front-line workers outside of the GTA [is a challenge]. The launch of [a new program], with an online learning component aims to reach more people across Ontario and outside of the large urban centres.

"At times, attendance at [our] working group and network meetings has been inconsistent. To address this, [our organisation] is developing MOUs with participating agencies and improving meeting planning processes to ensure that important Alliance meeting and working group meetings are planned/booked for the entire year to ensure greater communication and participation."

SUCCESS IN COMMUNITY DEVELOPMENT

"Our networking and committee work keeps doors open for training opportunities and builds our reputation as a go-to source of information about HIV, Hep C, substance use and harm reduction information. Having [our organisation] representation on boards, working groups, and committees, allows us to be able to bring forward issues and perspectives that may not otherwise get addressed. For example, we have been able to challenge viewpoints of individuals and organizations, allowing them to rethink their approach to issues, and shape the content of conferences and educational sessions. The majority of our training is provided while staff from multiple service providers in one region come together. Participants appreciate the opportunity to come together and network. This also allows for a richer discussion of the issues, as participants get to hear different view points and are able to provide local insights. Additionally, workshop participants have contacted us following workshops requesting the training materials. They use our materials, or adapt them accordingly, for use in their own work, both in educating co-workers and clients they serve."

"[Our organisation] completed a series of site visits to agencies. These visits have provided much insight into issues that agencies are responding to at a local level. Also, the continued investment in working groups has resulted in engagement and strategies to develop resources and training to strengthen agency responses to HIV..."

V. Regional Snapshot

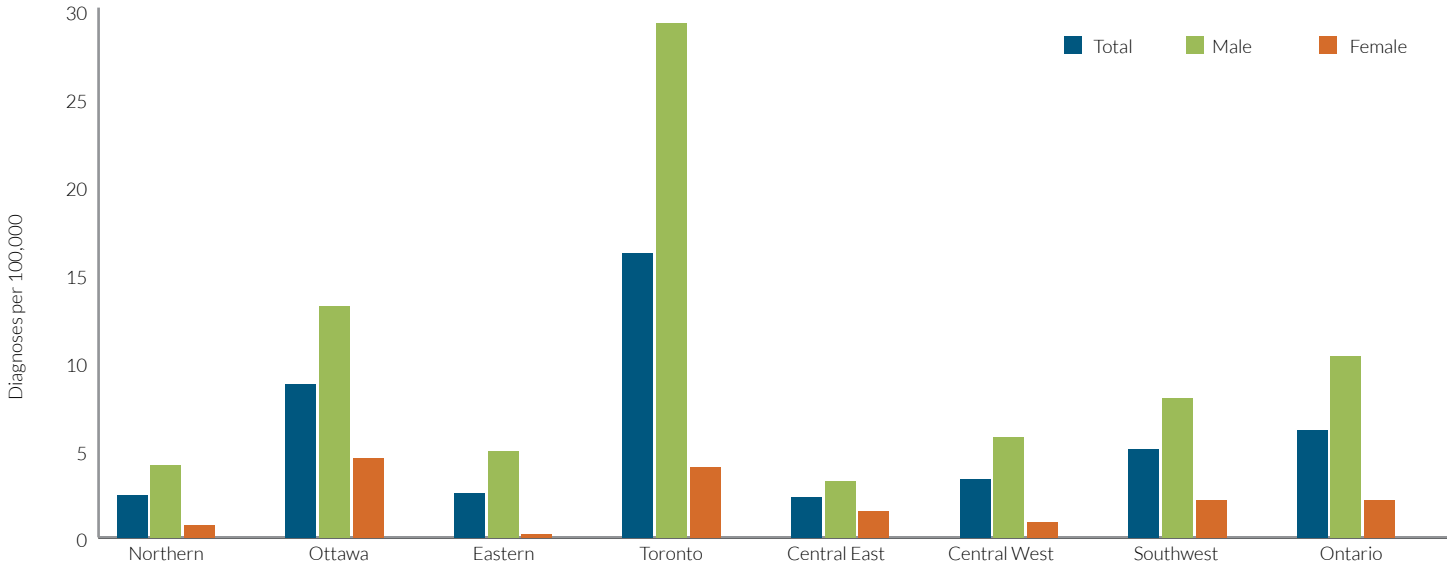
OCHART activities may vary by region, depending on factors such as nature of the epidemic and resources in the region.

A REGIONAL SNAPSHOT

For the province as a whole, there were 6.1 new HIV diagnoses per 100,000 population in 2013: this is known as the rate of new diagnoses. However, the epidemiological picture varies across the province. Different regions have different rates of new diagnoses. For example, Toronto has the highest rate (16.1 per 100,000) while the Central East Region has the lowest rate (2.3 per 100,000).

The rate of new HIV diagnoses in each health region may be in part related to differences in HIV testing between regions, particularly for Toronto and Ottawa health regions which have the highest rates of testing per 1,000 people living in the region.

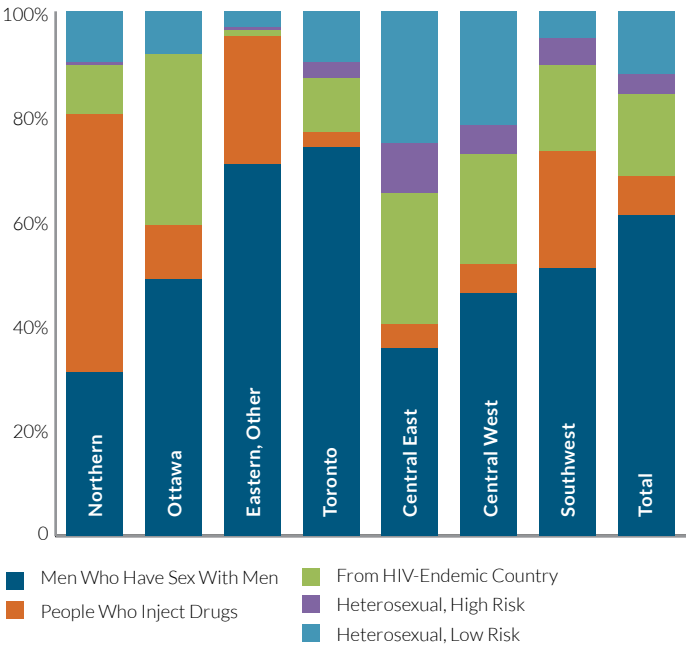
FIGURE 47
RATE OF NEW HIV DIAGNOSES BY HEALTH REGION, 2013



Priority Populations Vary by Region

The distribution of new HIV diagnoses among priority populations also differs by region. For example, the majority of new HIV diagnoses in the Northern Health Region are among people who inject drugs, while most new HIV diagnoses in Toronto and Eastern Health Regions are among gay, bisexual and other men who have sex with men – although the Eastern Region region also has a significant proportion of new diagnoses in people who inject drugs, as does the Southwest Region.

FIGURE 48
PROPORTION OF HIV DIAGNOSIS (ADJUSTED) BY REGION AND RISK FACTOR 2013/14



A REGIONAL SNAPSHOT OF EDUCATION SERVICES

Where are We Talking?

When we break down education presentations by region, we see they're happening across the province. Only two regions — Central West and Ottawa and the Eastern region — reported giving more presentations than in the previous year. These increases can be attributed, in one case, to a worker returning from sick leave and, in the other, to a new program. Within each region, there have been shifts in the target audiences for presentations (see figure 50).

FIGURE 49
TOTAL PRESENTATIONS BY REGION

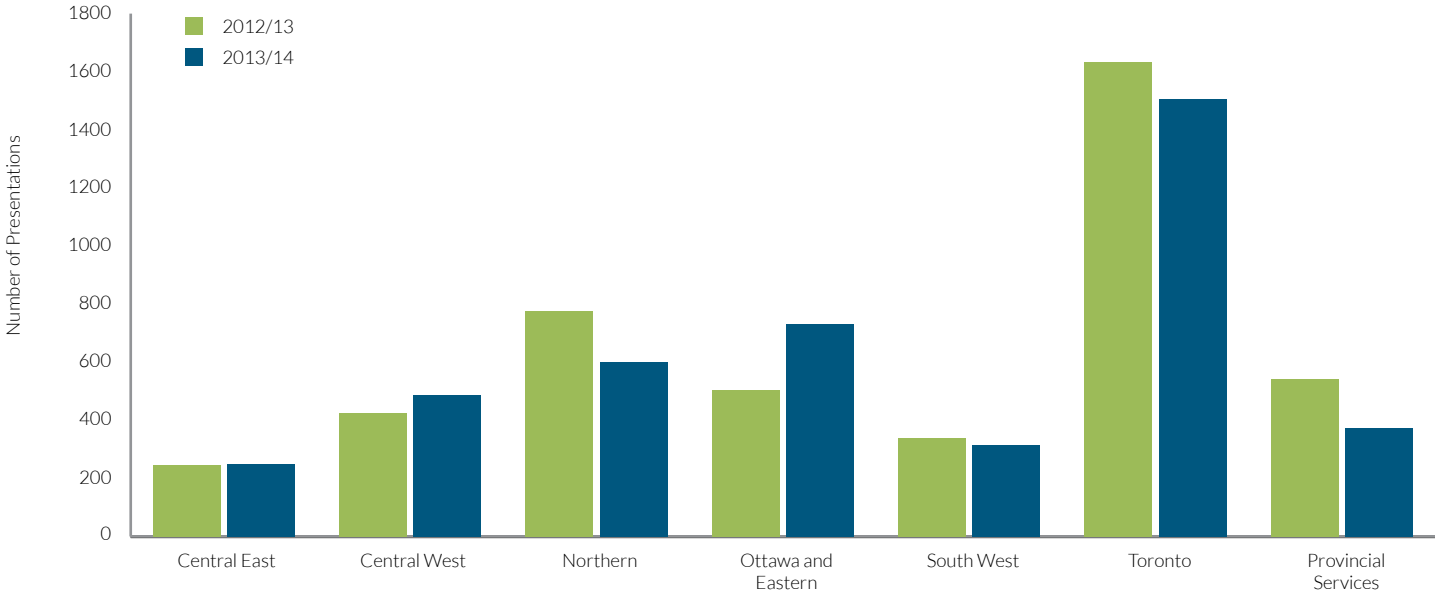
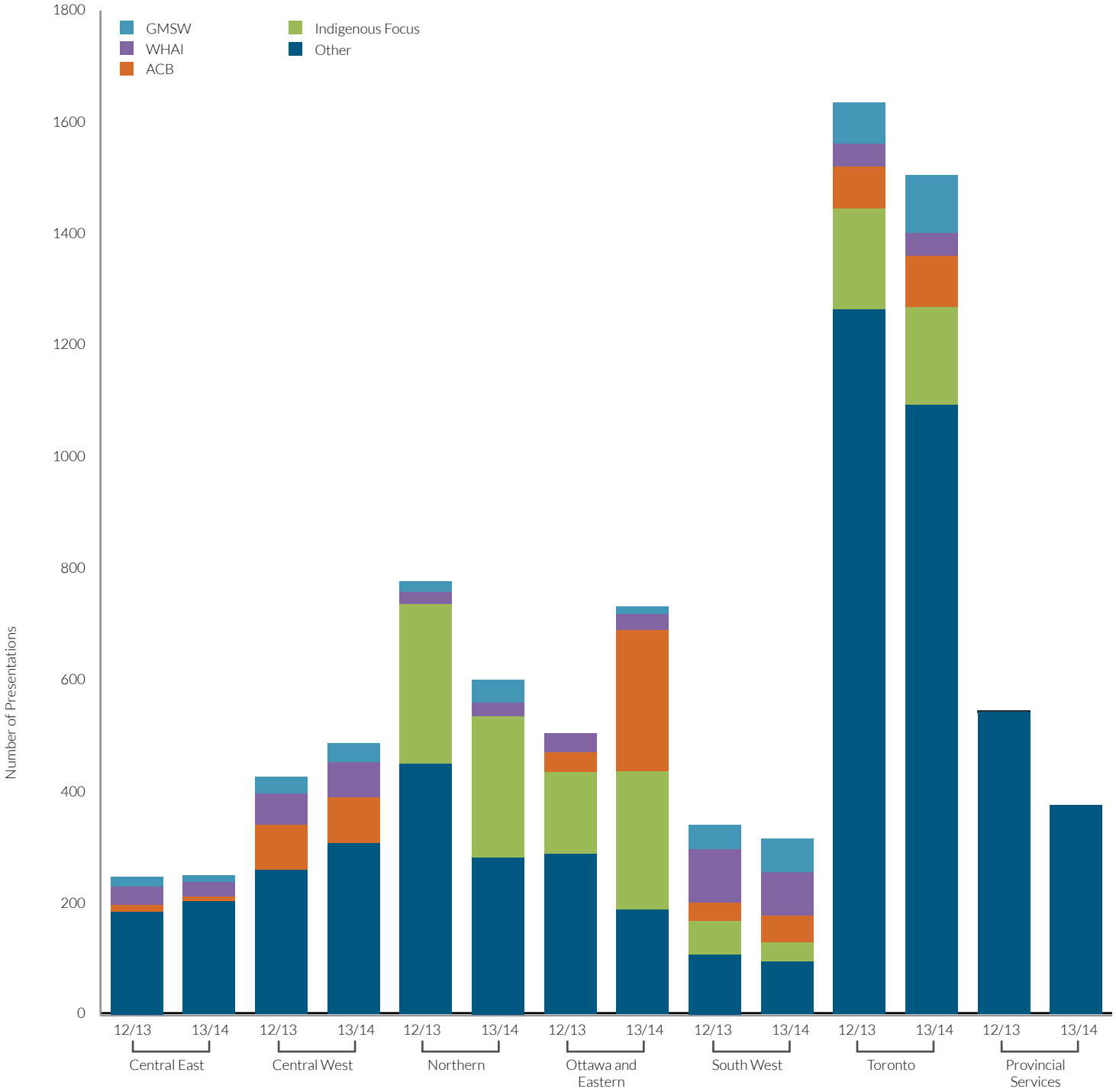


FIGURE 50
TRENDS IN REGIONAL EDUCATION PRESENTATIONS BY AUDIENCE

Who is Delivering Education Presentations in Each Region?

As strategy workers become more established in regions, they seem to take on a larger proportion of presentations. However, most presentations are still delivered by general prevention workers.

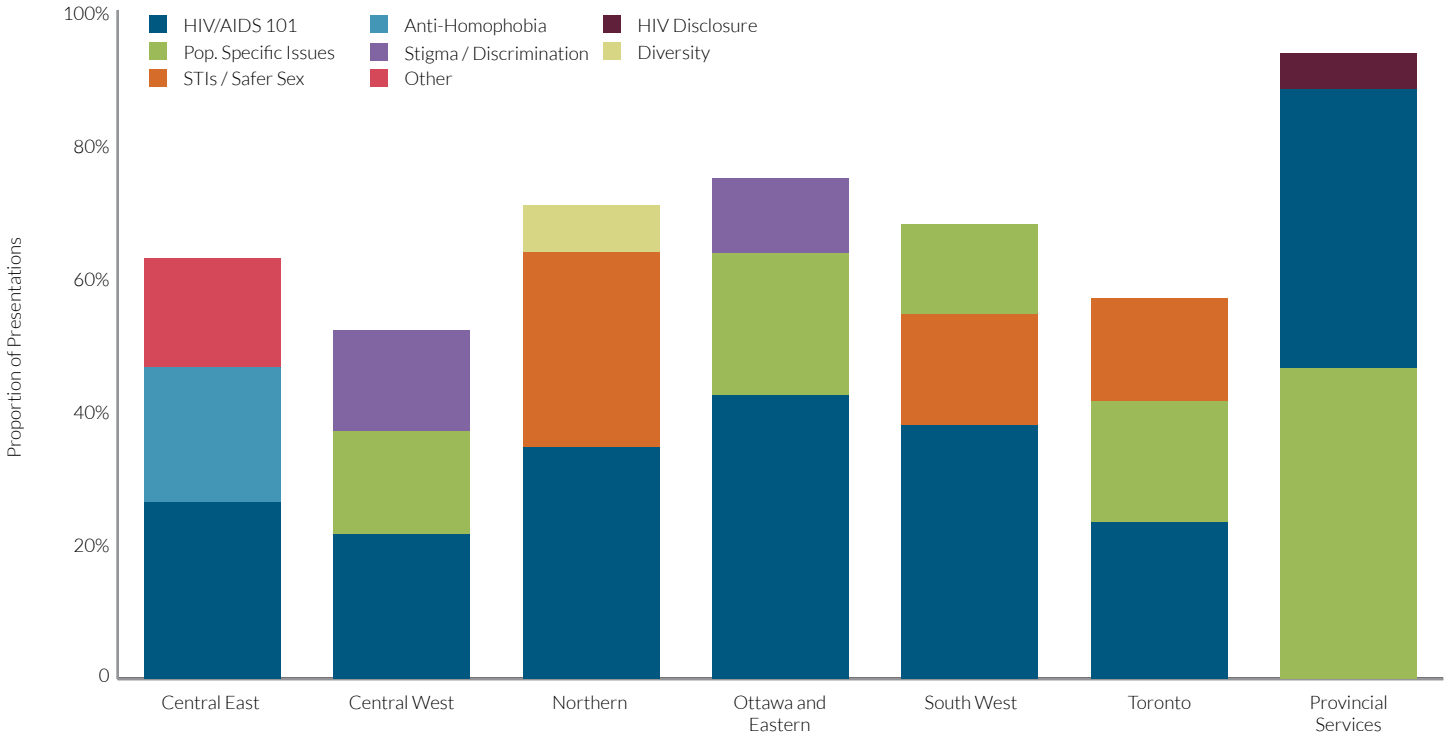
FIGURE 51
NUMBER OF PRESENTATIONS BY REGION AND TYPE OF WORKER 2012/13, 2013/14



What are the Top Topics in Each Region?

Figure 52 illustrates the most common topics in each region. STIs were a popular topic in the Northern, South West and Toronto regions. Stigma was discussed in Central West and Ottawa and in the Eastern region. Anti-homophobia was a key topic in Central East.

FIGURE 52
TOP 3 TOPICS BY REGION 2013/14



Are We Reaching the Right People in Our Regions?

As Figure 48 illustrates, the populations most affected by HIV vary in different regions. For example people who use injection drugs account for 44% of new diagnoses in Northern Ontario while men who have sex with men only account for just over 30% of new diagnoses. In the Southwest Region, men who have sex with men account for over 50% of new diagnoses while people who use drugs account for 22% and people from countries where HIV is endemic account for <20%. This is markedly different from the pattern in Toronto, where men who have sex with men account for over 70% of new infections and people who use drugs account for 3%.

Looking at the top three audiences for education presentations by region, it appears that programs in the Northern Region are devoting a significant amount of their education resources to people who use drugs; however, that is not the case for the Eastern or Southwest Regions, which also have large drug-using populations. At-risk youth are the main target of education in five of the six regions, despite the fact that there are not high rates of new diagnoses in youth. Although there are high rates of new diagnoses in men who have sex with men in most regions, only four regions had this population in their top three audiences, and fewer than 20% of presentations in these regions targeted gay men. Only two regions — Toronto and Eastern — had African, Caribbean and Black populations in their top three audiences.

Youth at risk and practitioners, professionals or service providers make up a bulk of the audiences for ACAP-funded presentations across all regions except for capacity building programs which use funding to reach incarcerated people and people who use drugs.

FIGURE 53
TOP 3 PRIORITY POPULATION EDUCATION PRESENTATION RECIPIENTS (ALL FUNDERS)

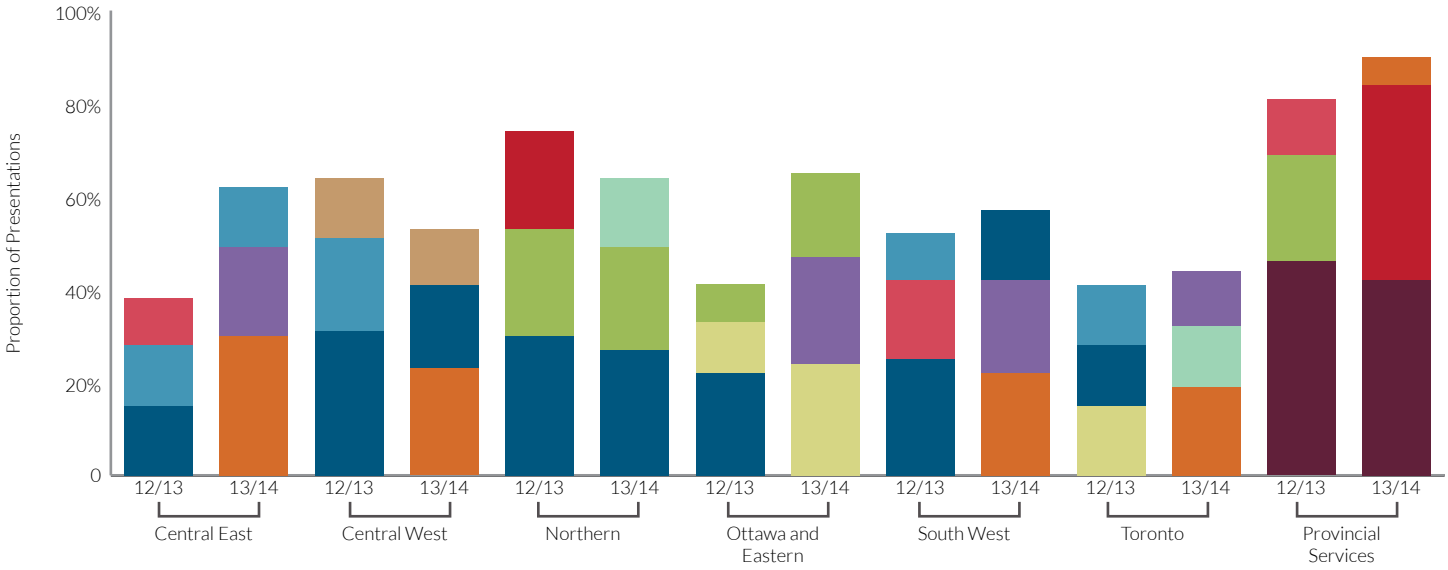
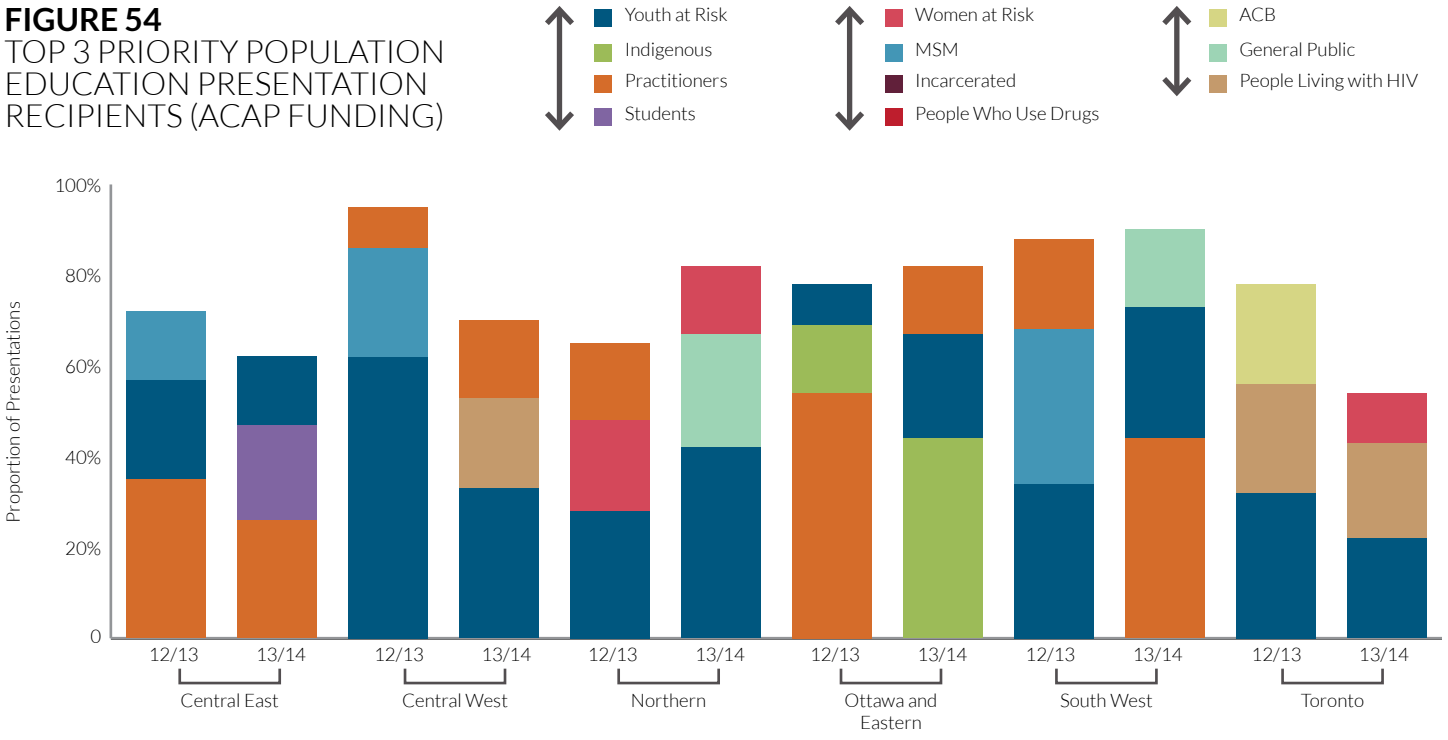


FIGURE 54
TOP 3 PRIORITY POPULATION EDUCATION PRESENTATION RECIPIENTS (ACAP FUNDING)



A REGIONAL SNAPSHOT OF OUTREACH SERVICES

Who are Regions Reaching through Outreach?

- Toronto, Central West, Central East and South West focused on gay, bisexual and other men who have sex with men.
- Ottawa and Eastern region and Central West targeted African, Caribbean and Black populations.
- Northern and South West targeted Indigenous people.
- Central East and Ottawa and Eastern targeted youth at risk.

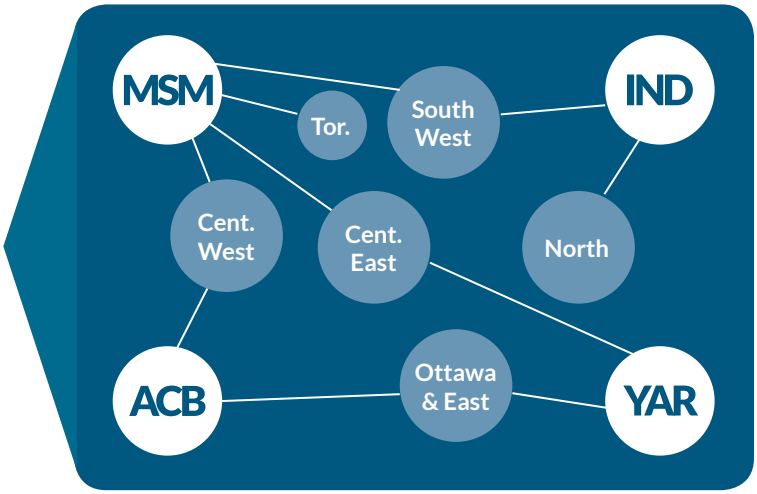
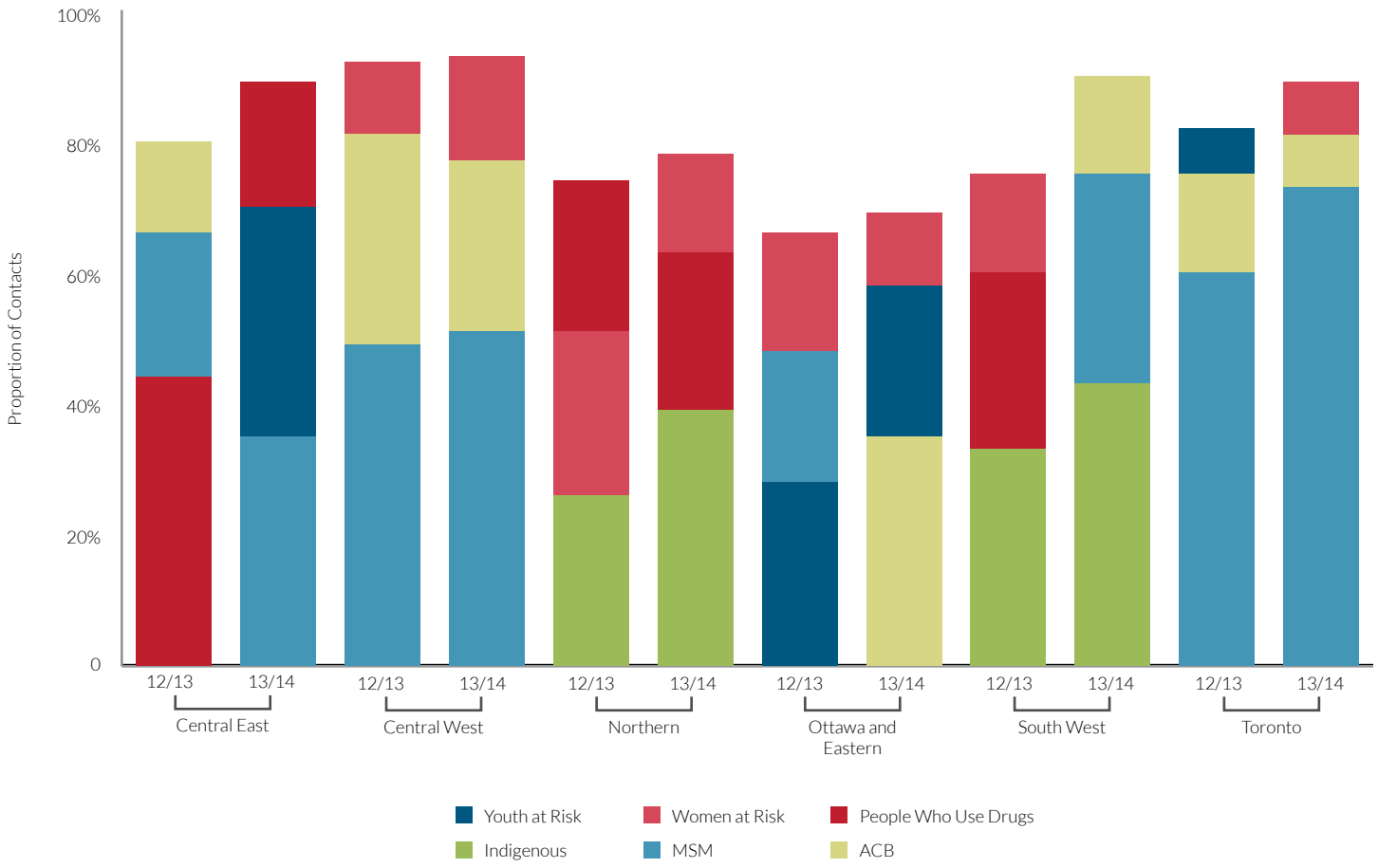


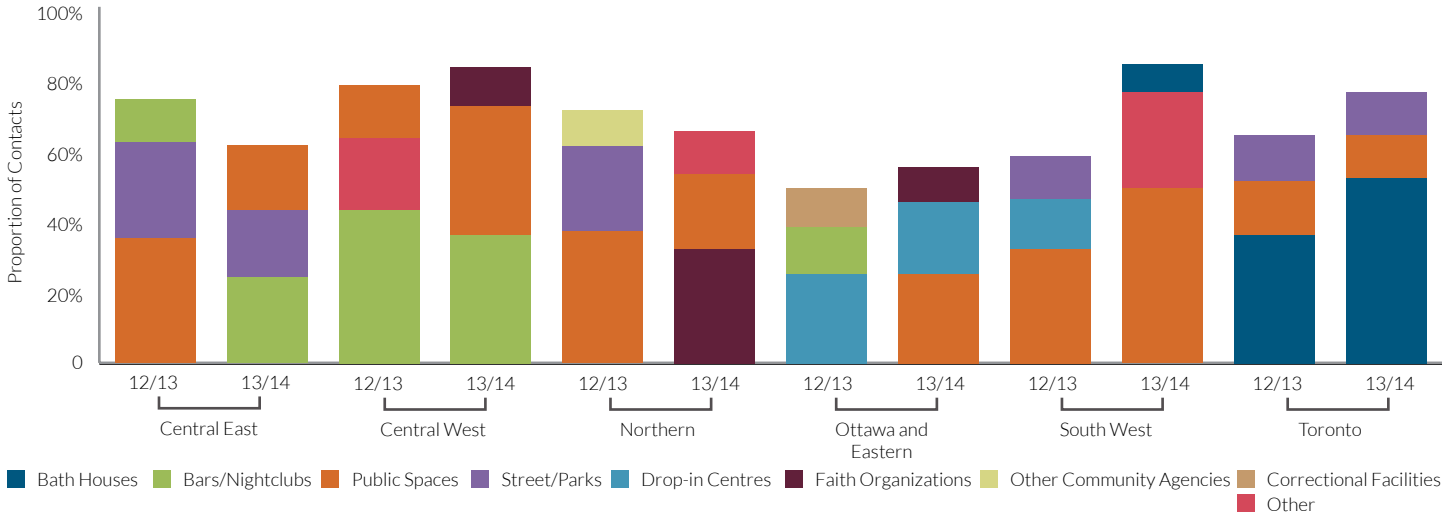
FIGURE 55
TOP 3 SIGNIFICANT OUTREACH CONTACTS BY REGION 2012/13 - 2013/14



Outreach Locations Shifted

While bathhouses are still a key location to reach gay men (in the communities where bathhouses exist), we see a shift to new locations in almost all regions, such as businesses, faith organizations and community public spaces (includes hair salons, community centres, barbershops, restaurants, coffee shops, community kitchens, etc.) Outreach can be affected by factors in the community, such as the closing of a bar (Central West).

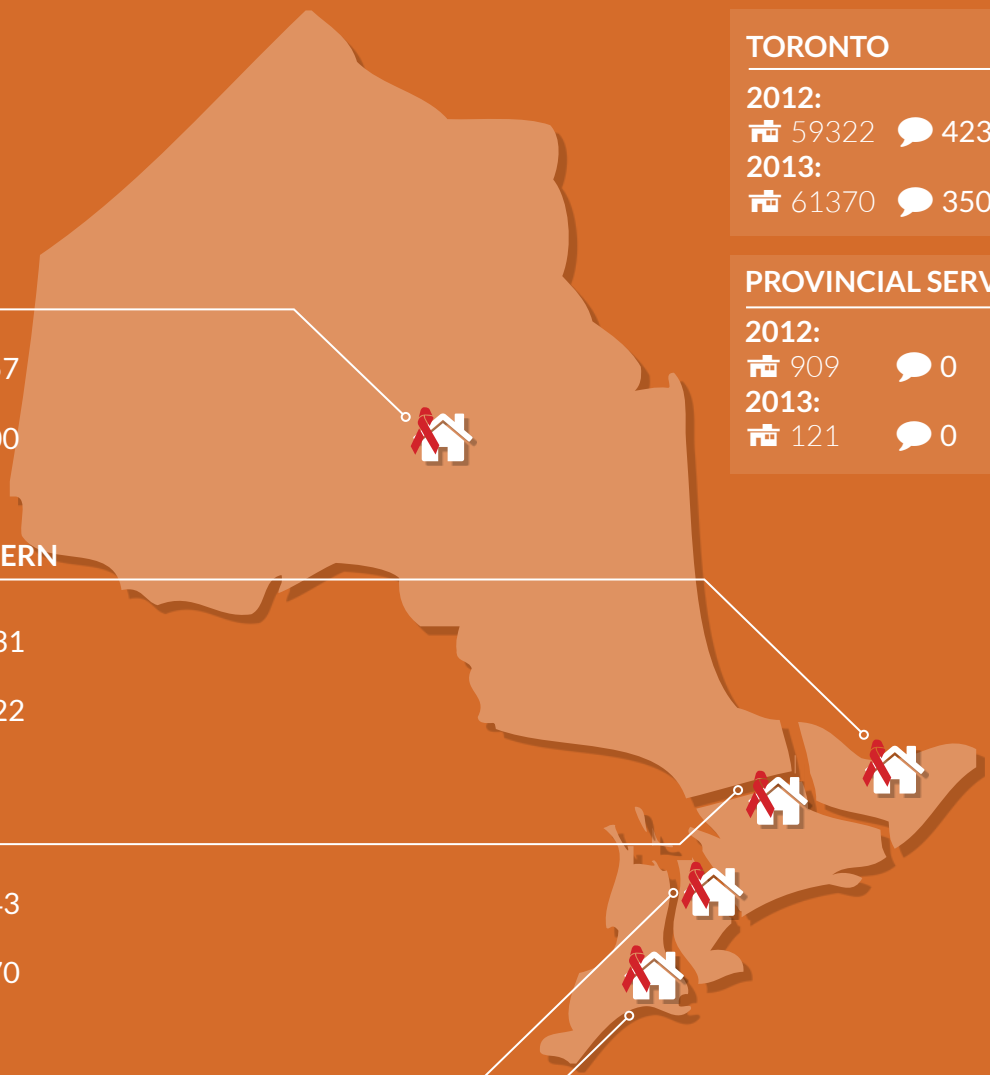
FIGURE 56
TOP 3 OUTREACH LOCATIONS BY REGION



NEW OUTREACH LOCATIONS BY REGION

IN-SERVICE **OUTREACH**

When we look at regional trends in IDU services, we see that the number of outreach contacts (although down overall) increased in Central East, Central West and Ottawa and Eastern Ontario, — however, the number was down significantly in Southwest (>40%), Northern (40%) and Toronto (about 15%). In terms of in-service contacts, the number was up in Southwest (almost 250%), Central East (>100%), Central West (about 30%), Toronto (15%) and Ottawa and Eastern (<10%) and down slightly (5%) in the Northern Region. The increase in inservice contacts in the Southwest region is consistent with the increase in new diagnoses in people who inject drugs.The increase in both outreach and in-service contacts in both Central East and Central West may reflect increased drug use activities in those regions.



TORONTO
2012:
59322 42362
2013:
61370 35014

PROVINCIAL SERVICES
2012:
909 0
2013:
121 0

NORTHERN
2012:
4347 7057
2013:
4194 5700

OTTAWA & EASTERN
2012:
10373 9731
2013:
11180 9922

CENTRAL EAST
2012:
3942 1743
2013:
8957 2270

CENTRAL WEST
2012:
7559 6679
2013:
9791 9452

SOUTH WEST
2012:
8286 9309
2013:
21256 5180

FIGURE 57
REGIONAL SNAPSHOT:
TOTAL IDU OUTREACH AND IN-SERVICE CONTACTS

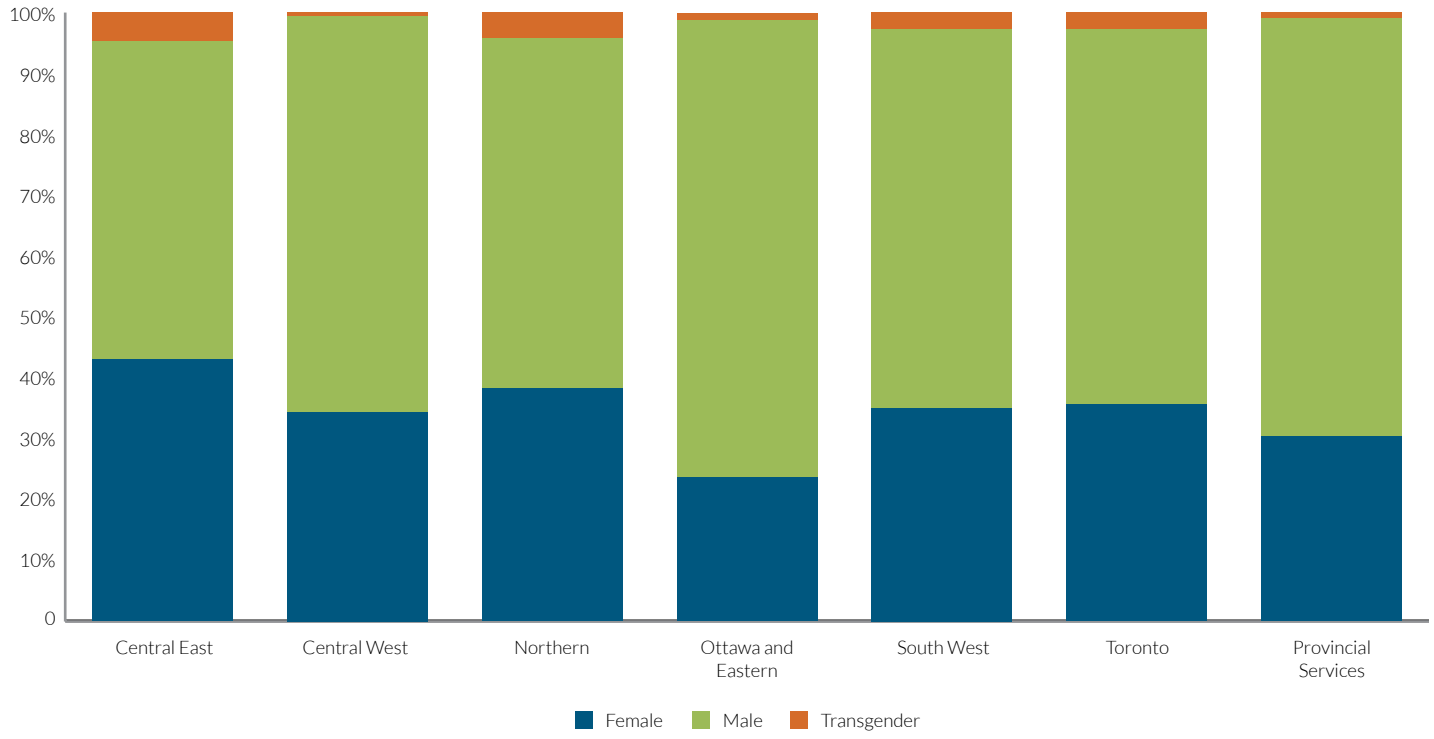
A REGIONAL SNAPSHOT OF SUPPORT SERVICES

Who is using support services?

While males account for about two thirds of support service clients overall, the proportion of men and women accessing support services varies in different regions of the province. For example, programs in Central East report that 43% of support service clients are women — the highest proportion in the province. At the same time, programs in Ottawa and Eastern are mainly serving men. In almost all other regions, men account for two thirds of support service clients and women for one third — which is consistent with the provincial picture.

In terms of whether support service clients are living with HIV, at risk or affected, both the Central East and Ottawa and Eastern regions report providing support services to a larger proportion of clients who are affected (about one third and one quarter, respectively). In the Northern region, about one third of support service clients are people at risk.

FIGURE 58
PROPORTION OF CLIENTS ACCESSING SUPPORT SERVICES BY REGION AND BY GENDER
2012/13 H2



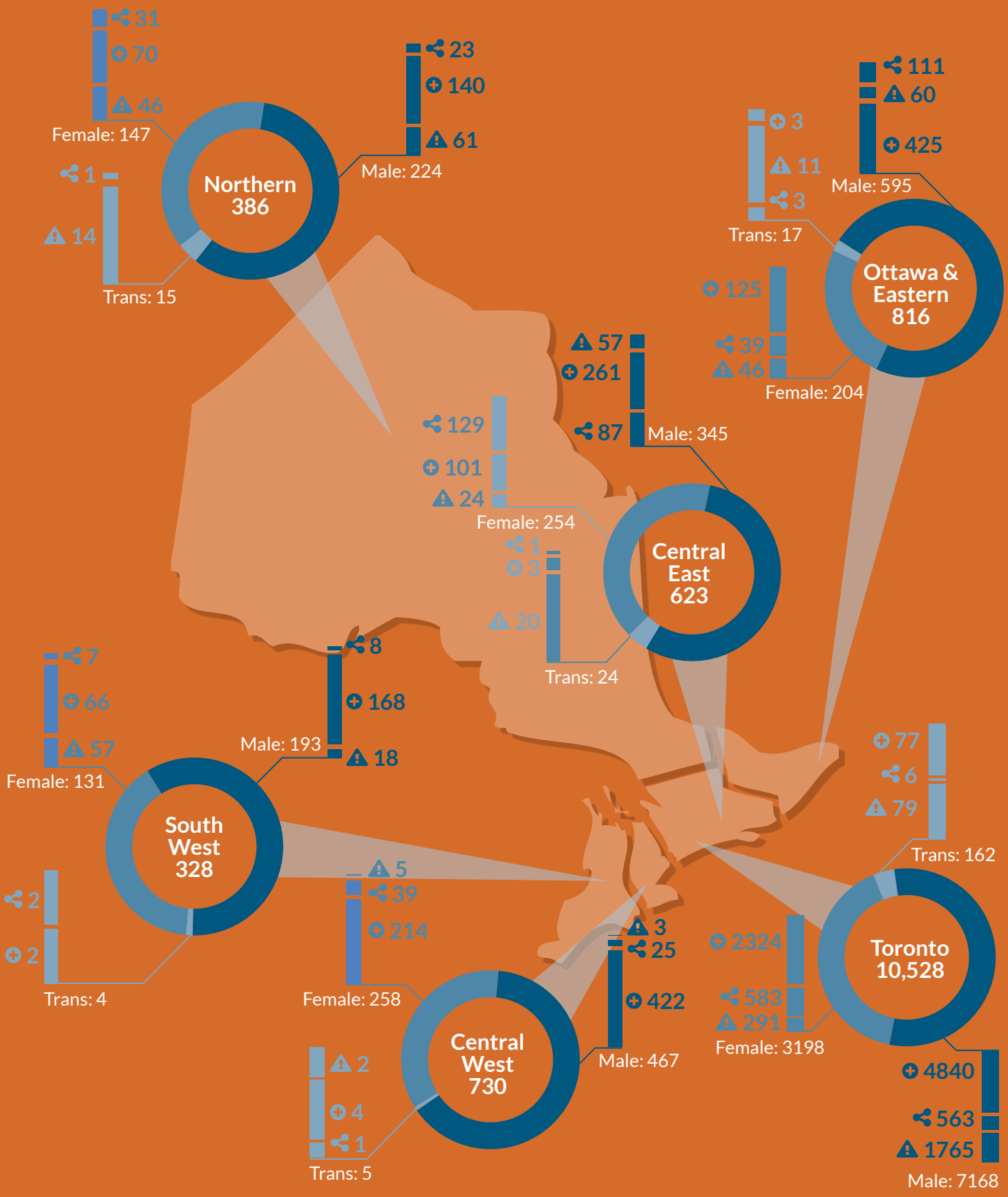
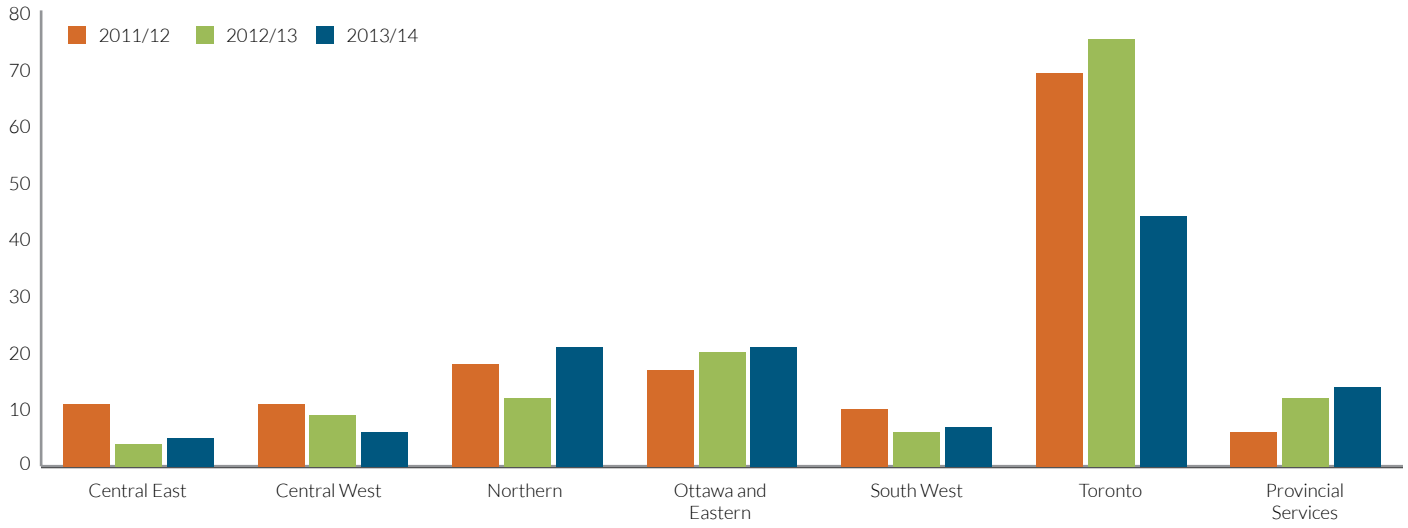


FIGURE 59
REGIONAL DISTRIBUTION OF 13,412 SUPPORT SERVICE CLIENTS BY NEED AND GENDER

Deaths by Region

The number of deaths among people living with HIV was relatively constant in Central East, Ottawa and Eastern and the South West. Deaths dropped dramatically in Toronto and increased in the Northern Region.

FIGURE 60
NUMBER OF CLIENT DEATHS BY REGION 2011/12-2013/14



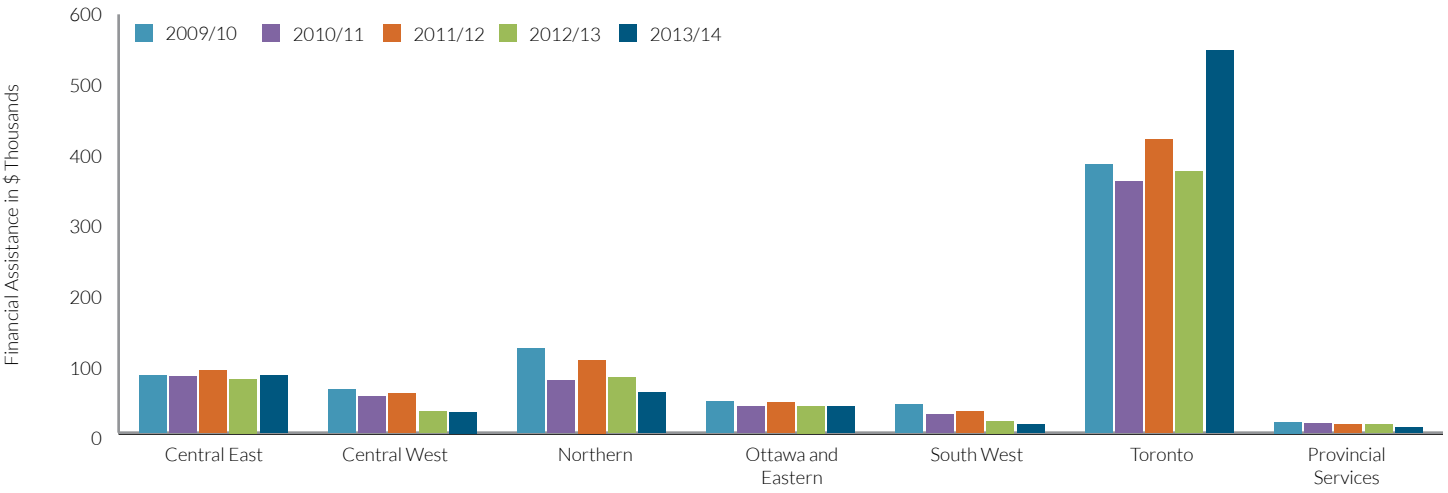
Financial Assistance by Region

When we look at financial assistance, we see that the amount distributed is:

- ↓ down in three regions — Central West, Northern and South West
- ↑ up significantly in Toronto
- → steady in Central East and Ottawa and Eastern

- Although Toronto programs are giving out more money, the number of people receiving financial assistance has increased, so each client is receiving less.
- Ottawa has seen this same trend for the past five years: more people receiving smaller amounts of financial assistance.
- Programs in the Northern and South West regions gave out less money but, on average, gave each client more.

FIGURE 61
FINANCIAL ASSISTANCE GIVEN OUT BY REGION 2009/10-2013/14



VI. Hepatitis C Services

Note: Totals in this section are based on responses to several different questions; not all respondants answered all questions.

In 2013-14, agencies and programs funded by the Hepatitis C Secretariat of the Ministry of Health and Long-Term Care started reporting their activities and services through OCHART. Here is the first snapshot of data provided by the 18 programs that reported in that year.

Hepatitis C case definition: confirmation of a positive anti-HCV antibody result using two enzyme-linked immunoassay (EIA) laboratory tests. If the antibody result is confirmed positive, the case is forwarded to local public health units to investigate/follow-up in accordance with the Ontario Public Health Standards, 2008.

FIGURE 62
NUMBER AND RATE (PER 100,000 POPULATION) OF REPORTED CASES OF HEPATITIS C, ONTARIO, 1992-2010

THE CONTEXT FOR HEPATITIS C SERVICES

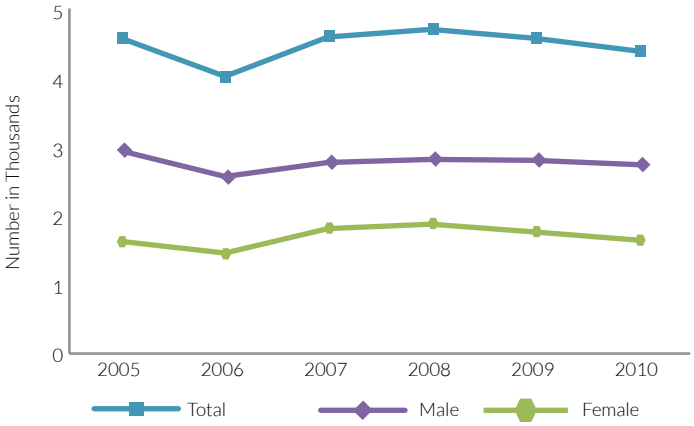
Hepatitis C (HCV) has been reportable in Ontario since October 1991. Between 1992 and 2010, a total of 97,392 cases of hepatitis C were reported in Ontario. Between 4,000 and 5,000 new cases were diagnosed each year between 2005 and 2010.

Hepatitis C is more common in men

Most people diagnosed with hepatitis C are male (62.5% in 2010), but a significant proportion of infections are in women (37.5% in 2010) (See Figure 63).

Most cases are diagnosed in people ages 30 to 60. Hepatitis C is a slow-to-progress disease. It can take many years, even decades, after initial infection for symptoms to develop.

FIGURE 63
REPORTED CASES OF HEPATITIS C IN ONTARIO BY YEAR AND SEX 2005-2010



Injection drug use is the most common known risk factor for hepatitis C

Hepatitis C is primarily a blood borne infection that spreads when blood from a person infected with the hepatitis C virus enters the body of someone who is not infected. The most efficient way to spread the virus is through sharing needles or other equipment to inject drugs. A number of people were also infected through blood transfusions that were obtained before blood donations were screened for hepatitis C (i.e., pre-1992)

Hepatitis C rates are higher in regions with high rates of injection drug use

Rates are higher in the Eastern, Northern and Southwest regions — all parts of the province with high rates of injection drug use.

FIGURE 64
NUMBER OF REPORTED HEPATITIS C CASES BY EXPOSURE CATEGORY AND SEX, ONTARIO 2009

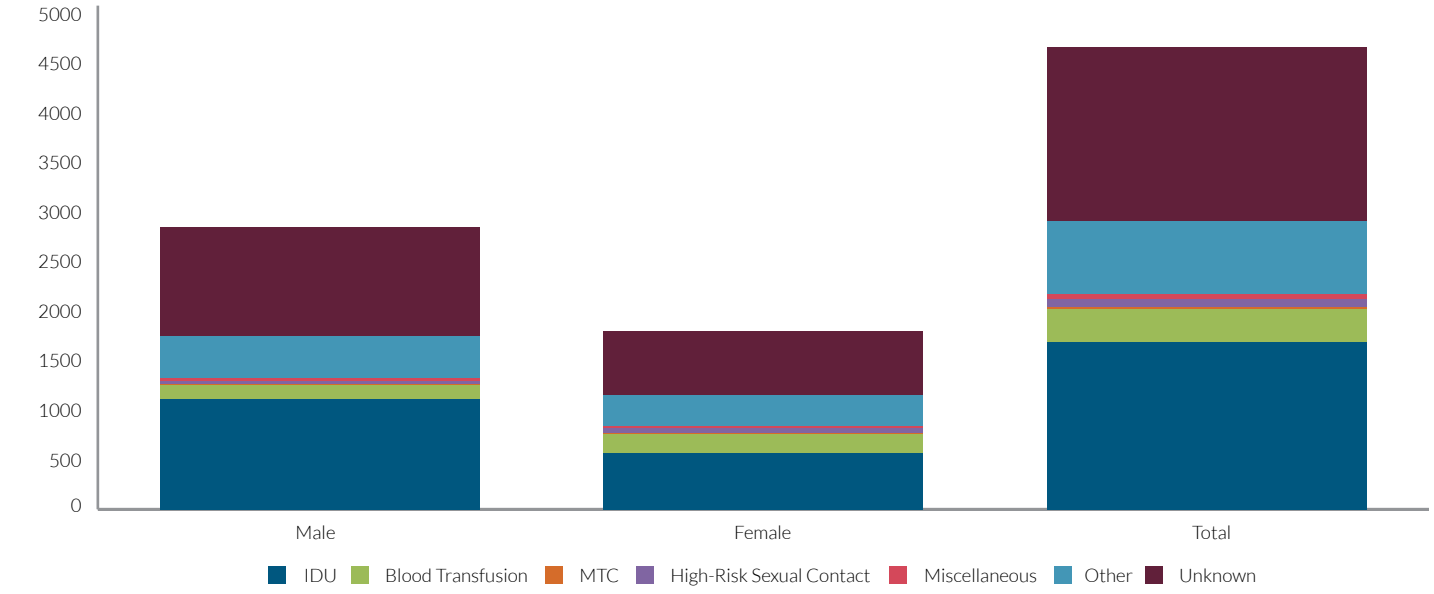
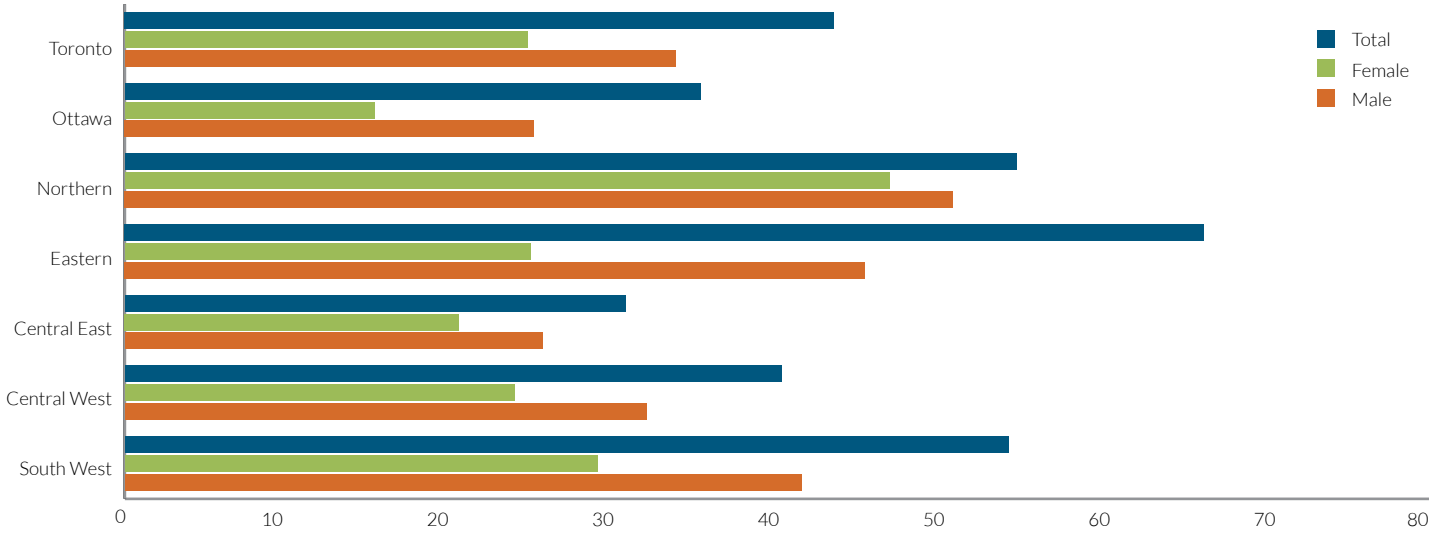


FIGURE 65
HEPATITIS C RATE BY PUBLIC HEALTH REGION AND SEX, ONTARIO 2010



ABOUT ONTARIO'S HEPATITIS C STRATEGY

The key elements of the Strategy include:

Enhanced Services and Supports
Creation of 16 "Hep C Teams" to ensure a coordinated, comprehensive approach to treatment and support of those living with/at risk of acquiring hepatitis C. The Hep C teams consist of HCV outreach workers and community coordinators, additional HCV treatment nurses and access to psychosocial supports.

Education and Outreach
A targeted education and outreach strategy for at risk communities, and a continuing medical education program for physicians and health professionals.

Encourage Prevention
Additional support for the Ontario Harm Reduction Distribution Program.

Better Co-ordination
An inter-ministerial Reference Group to support further collaboration and aid in seamless program integration. The Ministries that have been invited to participate on the inter-ministerial reference group include Aboriginal Affairs, Children and Youth Services, Citizenship and Immigration, Community Safety and Correctional Services, Community and Social Services, Health Promotion and Research and Innovation.

Our HCV Teams

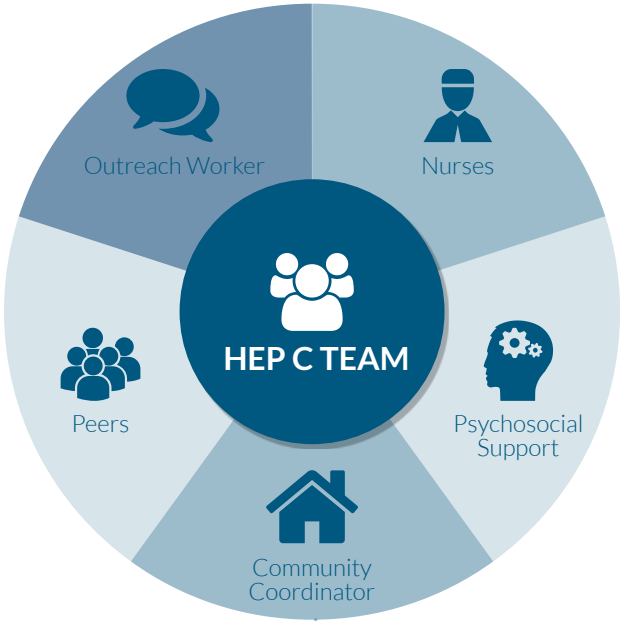
The multidisciplinary Hep C care teams consist of a group of professionals who, working closely and collaboratively with treating physicians, provide HCV care and treatment, education, outreach, and support services in communities across Ontario.

The teams provide care and support services to six priority populations of people living with, at-risk of or affected by HCV:

- People who use drugs
- People involved with the correctional system
- People who are homeless or under-housed
- Aboriginal People
- Street-involved youth
- People with tattoos and/or piercings.

Hep C Teams consist of an outreach worker, peers, nurses, a community coordinator and psychosocial support.

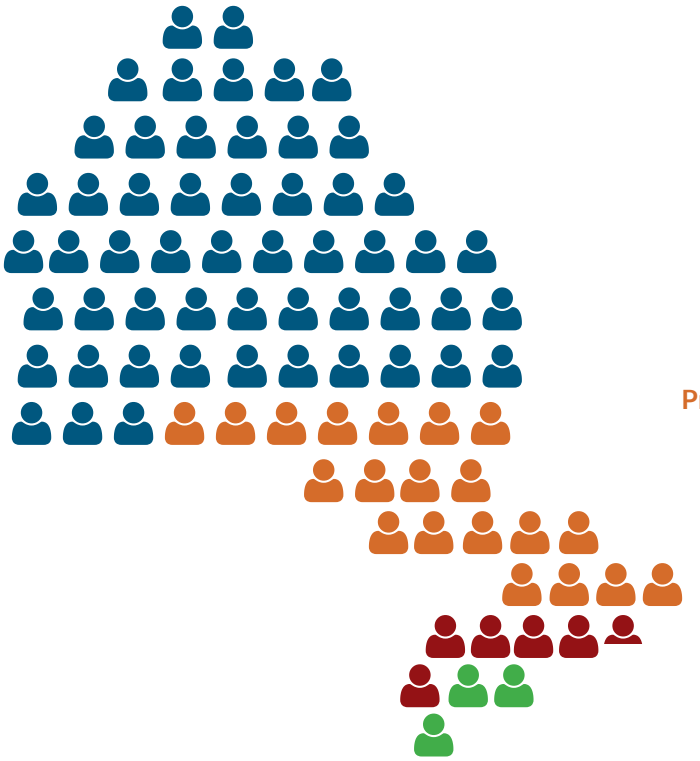
In 2013-14 the Secretariat supported 16 Hep C teams across Ontario as well as: a nurse at Lakeridge Health Centre; a dedicated outreach worker (funded through the Prisoners with AIDS Support Action Network [PASAN]) targeting people who are involved with the correctional system; and an Hep C Case Coordinator (funded through Sioux Lookout First Nations Health Authority) with a focus on providing coordination and support to 31 First Nations communities in Northwestern Ontario.



HEP C CARE TEAMS : A GROUP OF PROFESSIONALS PROVIDING CARE AND TREATMENT, EDUCATION, OUTREACH, AND SUPPORT SERVICES.

A total of 80.5 FTE positions were funded in 2013-14. Two-thirds of these positions focus on providing support services and clinical care, one-quarter provide education and outreach, and the remainder are program managers/administrators.

FIGURE 66
PROGRAM STAFF IN 2013-14



54
Support/Clinical Care

20
Prevention, education, outreach and community development

5.5
Administration

3
Management

TORONTO & PROVINCIAL SERVICES

- Sherbourne Health Centre
- South Riverdale Community Health Centre
- PASAN (Prisoners with HIV/AIDS Support Action Network)

NORTHERN

- AIDS Committee of North Bay and Area
- Elevate NWO
- Algoma Group Health
- Reseau Access Network
- Sioux Lookout First Nations Health Authority
- Timmins Family Health Team

OTTAWA & EASTERN

- Street Health Centre, Kingston Community Health Centres
- The Ottawa Hospital

CENTRAL WEST

- Bramalea Community Health Centre
- Niagara Health System
- Sanguen Health Centre
- Wayside House of Hamilton

CENTRAL EAST

- Lakeridge Health Centre
- Oshawa Community Health Centre

SOUTH WEST

- London Inter-Community Health Centre
- Windsor-Essex Community Health Centre

FIGURE 67
SERVICE MAP BY REGION

OUR SERVICES

Objective 1: To increase access to hepatitis C care and treatment for priority populations in Ontario

Hep C teams provide clinical services related to HCV treatment. They also provide social and psychological support to help clients move successfully through the treatment process — from pre-treatment to post-treatment.

The teams also support people living with HCV who are not currently considering treatment and those who did not clear the virus after completing a previous course of treatment and want to stay engaged with the team.

Clinical services include:

- Intake and assessment
- Health teaching
- Blood work
- Treatment support groups
- Counseling
- Vaccinations
- Pre and post-test counseling
- Follow-up appointments.

Hep C teams also provide other support services as part of holistic case management to address social determinants of health, help clients develop individual support systems and increase access to programs and services they require outside the HCV circle of care.

Case Management services include:

- Referrals
- Practical assistance
- Individual advocacy
- Assistance with forms and applications
- Accompaniment to appointments.

THE PEOPLE WE SERVED IN 2013-14

Ontario's hepatitis C programs serve three client groups:

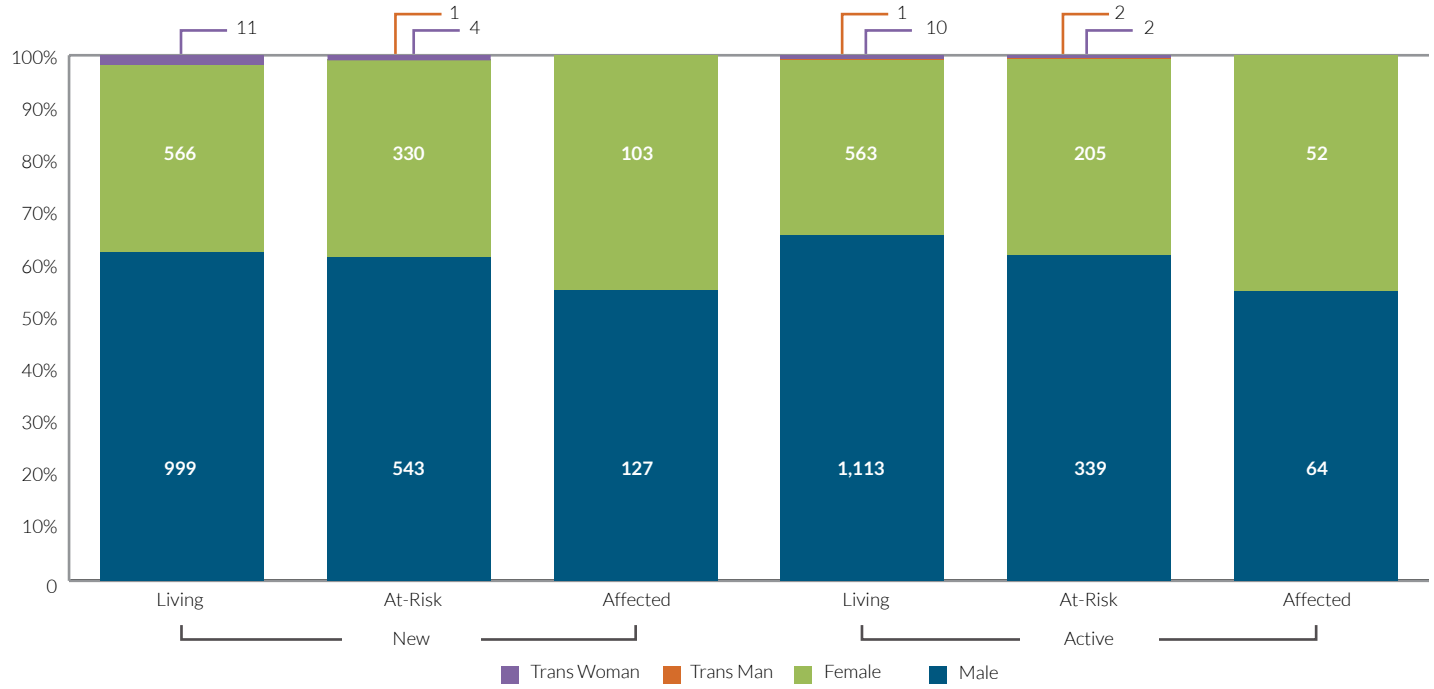
- **People living with HCV:** they have tested positive for either antibody (and require further testing — RNA — to confirm their diagnosis) or are RNA-positive. A person living with HCV can be anywhere on the HCV Treatment spectrum including not contemplating treatment, contemplating treatment, pre-treatment, on treatment or post-treatment. Someone can be counted as "living with HCV" if their health status excludes them from being a candidate for treatment (e.g. end-stage liver disease).
- **People at risk of HCV:** they are HCV-negative and are engaging in risk activities that can lead to HCV infection.
- **People affected by HCV:** they are a support person of someone who is living with HCV such as: a friend, parent, partner or child of someone living with HCV. People can also be considered "affected by HCV" if they have been successfully treated (achieved SVR) and continue to engage with the team's services.

The support services required by people living with HCV vary depending on their stage of the treatment continuum:

- Pre-treatment clients – this group includes clients who have not yet started treatment, but expressed their readiness to consider this option. These clients go through a series of clinical tests and consultations the Hep C team assists clients in accessing drug coverage and provides health teaching to assist the client in preparing to move through the treatment process.
- Clients currently on treatment receive intensive support to assist them in adhering to treatment. Support includes case management, health teaching, skill development and symptom management.
- Post treatment clients are followed by the team for at least six months to determine the outcome of treatment, continue to monitor the health of their liver and to help them address their other health and social needs.
- Clients engaged with HCV support services include people who currently do not qualify for provincial drug coverage, people who decide that treatment is not currently an option for them and people who were previously treated but did not clear the virus. These clients have in common the fact that they are not considering treatment in the foreseeable future. They continue receiving support and case management services focused on helping them lead healthy lives with hepatitis C and stabilizing any mental health, addictions and social issues.

In 2013/14, men accounted for 999 (63% of) new clients living with HIV and 543 new clients at risk of acquiring HCV, served by the program. Woman represented 36% of new clients, 38% of those at risk and 45% of those affected by the virus.

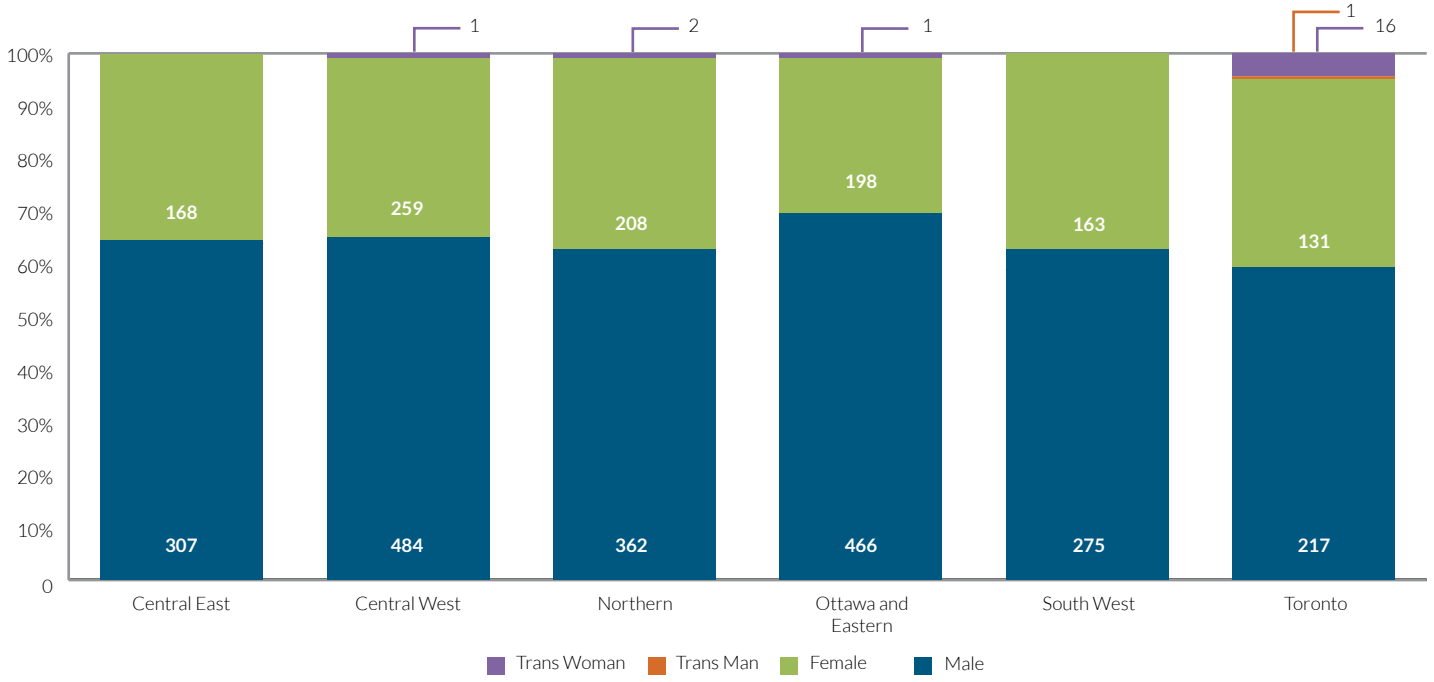
FIGURE 68
TOTAL NEW AND AVERAGE NUMBER OF CLIENTS SERVED



The majority of clients are male

Programs report large regional variations in terms of gender. In some regions, such as Ottawa and Eastern Ontario, 70% of clients were male and 30% were female while, in Toronto, 56% were male, 36% were female and 5% were trans people.

FIGURE 69
GENDER DISTRIBUTION OF CLIENTS BY REGION

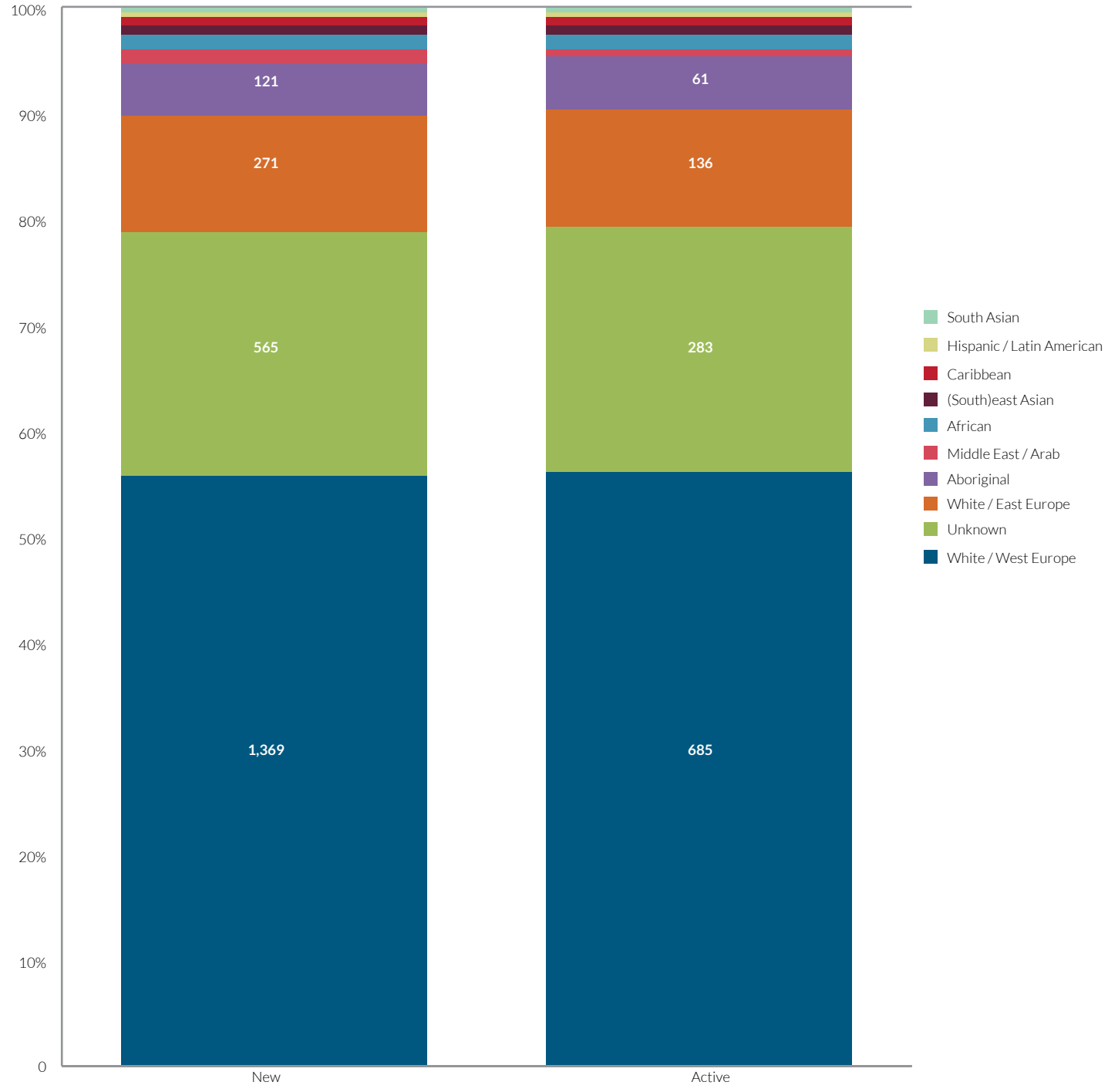


Most new clients (38%) and active clients (34%) were 40 to 54 years old. In 2013-14, younger people — ages 15 to 29 — made up 10% of new clients and 4% of active clients.

Most clients are white Europeans and Indigenous people. About 65% of both new and active clients were white Europeans and 5% were Indigenous people. However we do not have ethnicity information for almost one quarter of clients. In future reports, we hope to close this information gap.

Most clients (88%) speak English at home. About 8% speak French and 2% speak Arabic.

FIGURE 70
ETHNICITY OF NEW AND ACTIVE CLIENTS

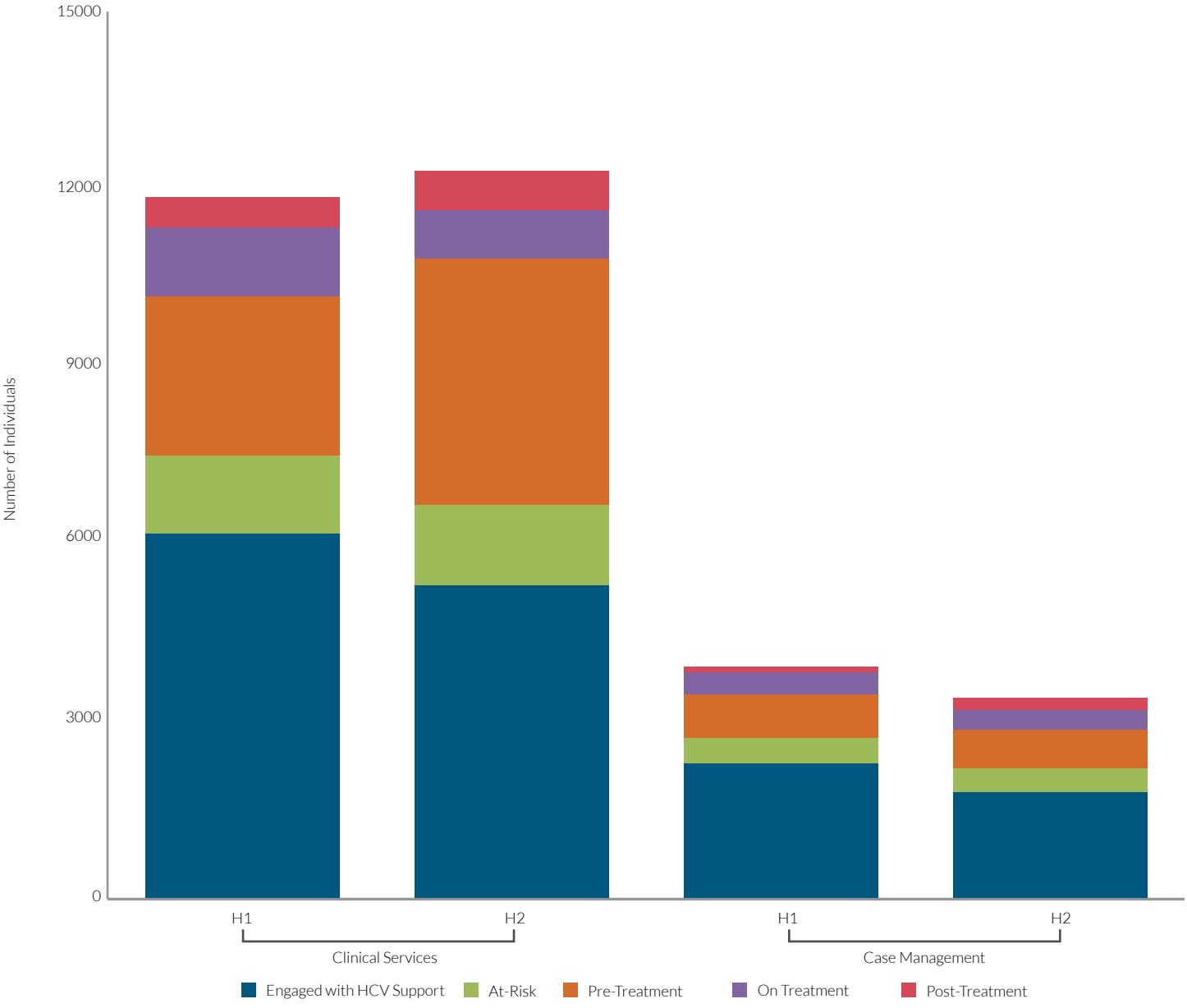


THE SERVICES PROVIDED IN 2013-14

People engaged with HCV teams

The largest group of clients in 2013-14 were people engaged with HCV support. These clients — who either do not qualify for drug coverage under the current criteria for the Exceptional Access Program (EAP) of Ontario Public Drug Programs, or who have chosen to wait until new drug treatments are available through Ontario Public Drug Programs — receive clinical and case management services not directly related to HCV treatment. The large number of people engaged in support but not on treatment is due, in part, to the pending release of new HCV treatments, which will take less time, be more effective and have fewer side effects than current treatments. Because many may be offered treatment in the future, it is important to keep them engaged so they are accessible and able to start treatment when it becomes available.

FIGURE 71
NUMBER OF PEOPLE RECEIVING CLINICAL SERVICES & CASE MANAGEMENT BY TREATMENT STAGE



Clinical Services

Health teaching and treatment information are the most frequently used clinical services among both clients who are currently moving through the treatment process and those not involved with treatment.

In terms of number of service units, people involved in any stage of treatment used a total of 11,235 treatment-related services. Clients appear to be accessing a number of different services as they move through the engagement-treatment cycle.

People at risk also used a range of clinical services — in particular health teaching, treatment information and bloodwork.

Case Management Services

High Demand for Case Management Services

Among people living with HCV, all five case management services are in demand. With the exception of appointment/lab accompaniment, the number of people accessing case management services remained consistent throughout the year and reflected the overall number of clients at each stage of treatment. Most clients accessing case management services access not just one or two services but the whole spectrum of support provided by Hep C teams (See Figure 72).

People at Risk Mainly Access Practical Assistance and Referral Services

Case management services are also available for people at risk. As would be expected, people at risk are more likely to access services that will assist them in remaining HCV-negative, such as practical supports and referrals (See Figure 74).

HCV Testing

Hep C teams provide diagnostic testing for hepatitis C, hepatitis B and HIV (See Figures 75 and 76).

FIGURE 72
CASE MANAGEMENT BY SERVICE CATEGORY AND TREATMENT STAGE

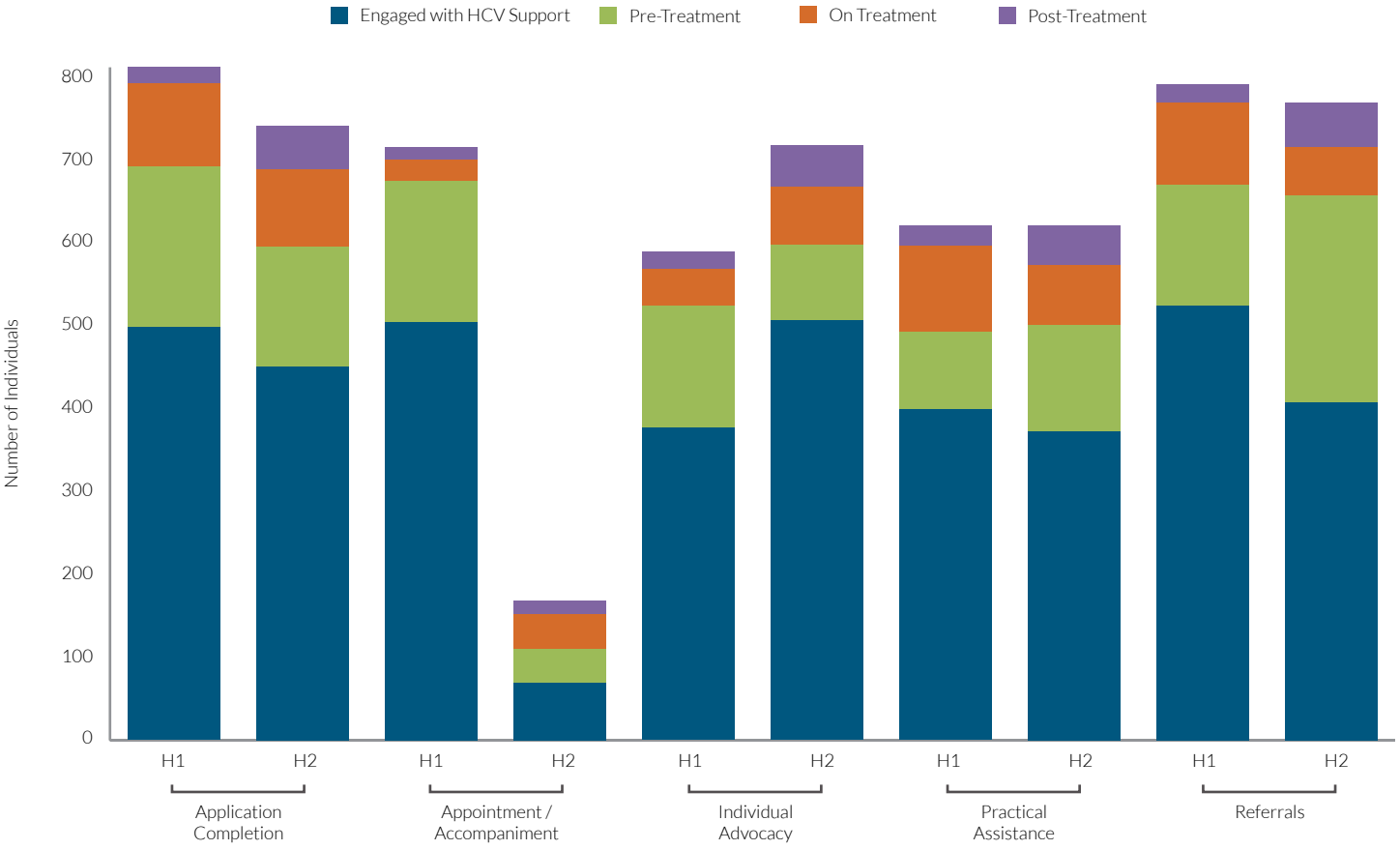


FIGURE 73
CLINICAL SERVICES UTILIZED BY PEOPLE AT RISK OF HCV

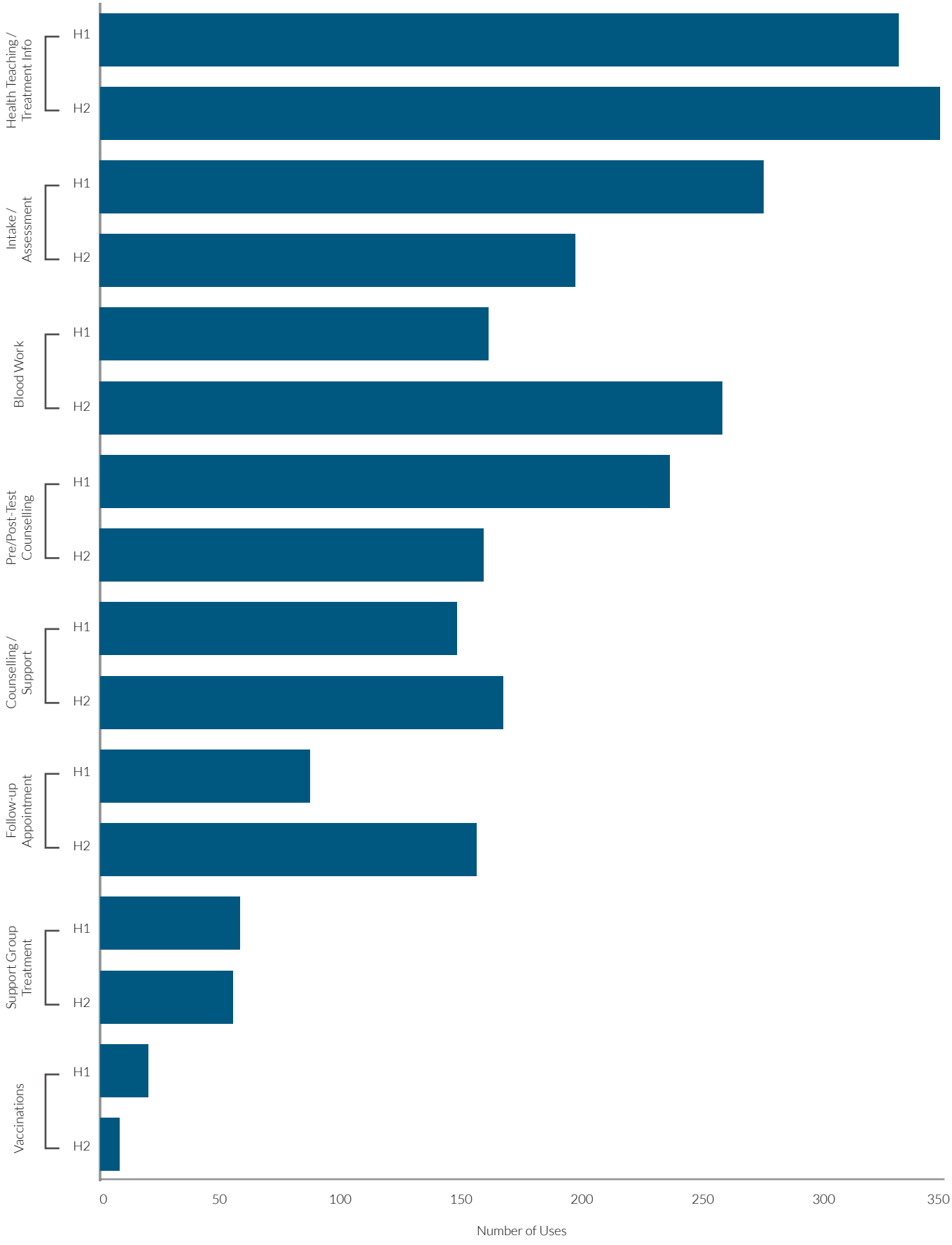


FIGURE 74
CASE MANAGEMENT SERVICES UTILIZED BY PEOPLE AT RISK OF HCV

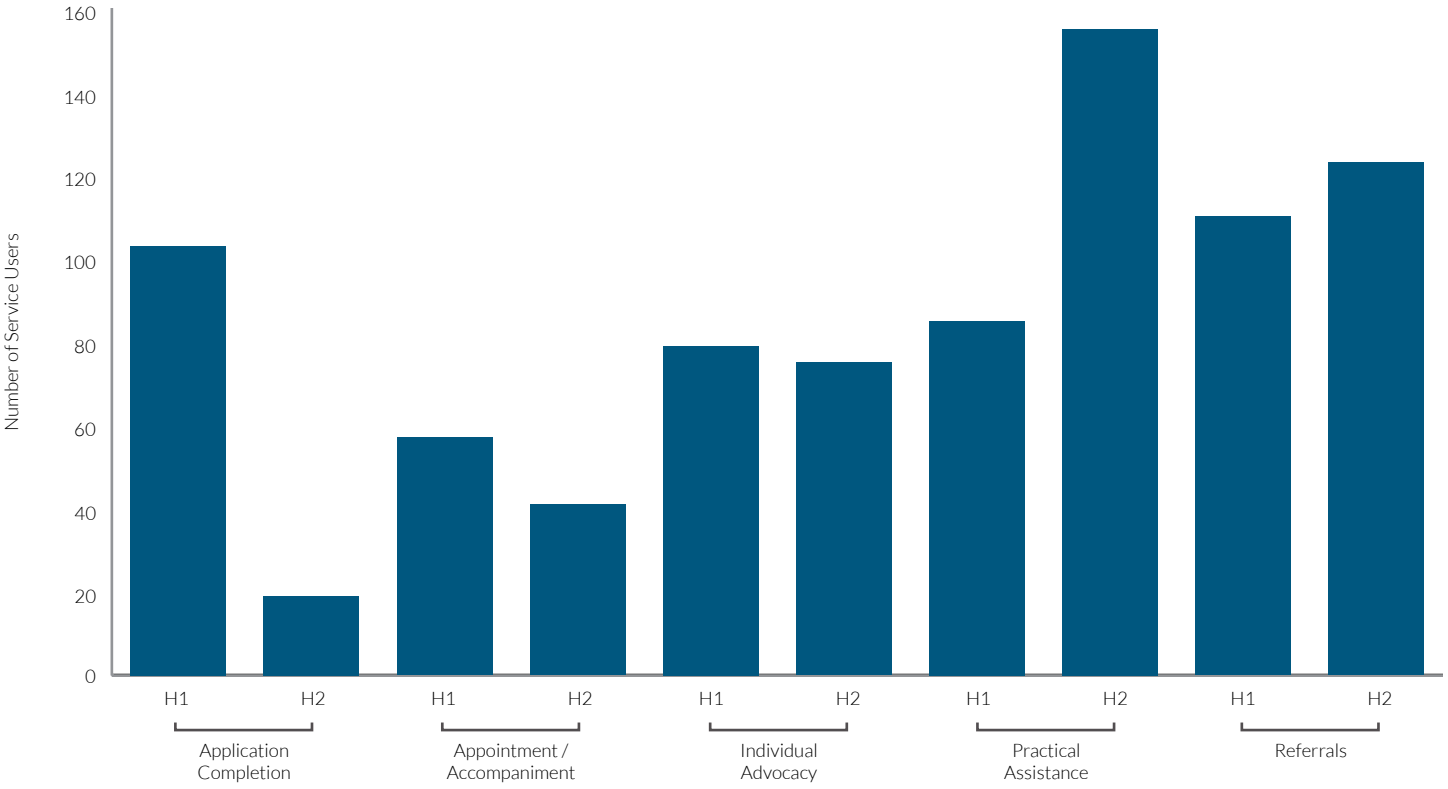


FIGURE 75
NUMBER OF DIAGNOSTIC TESTS BY TYPE

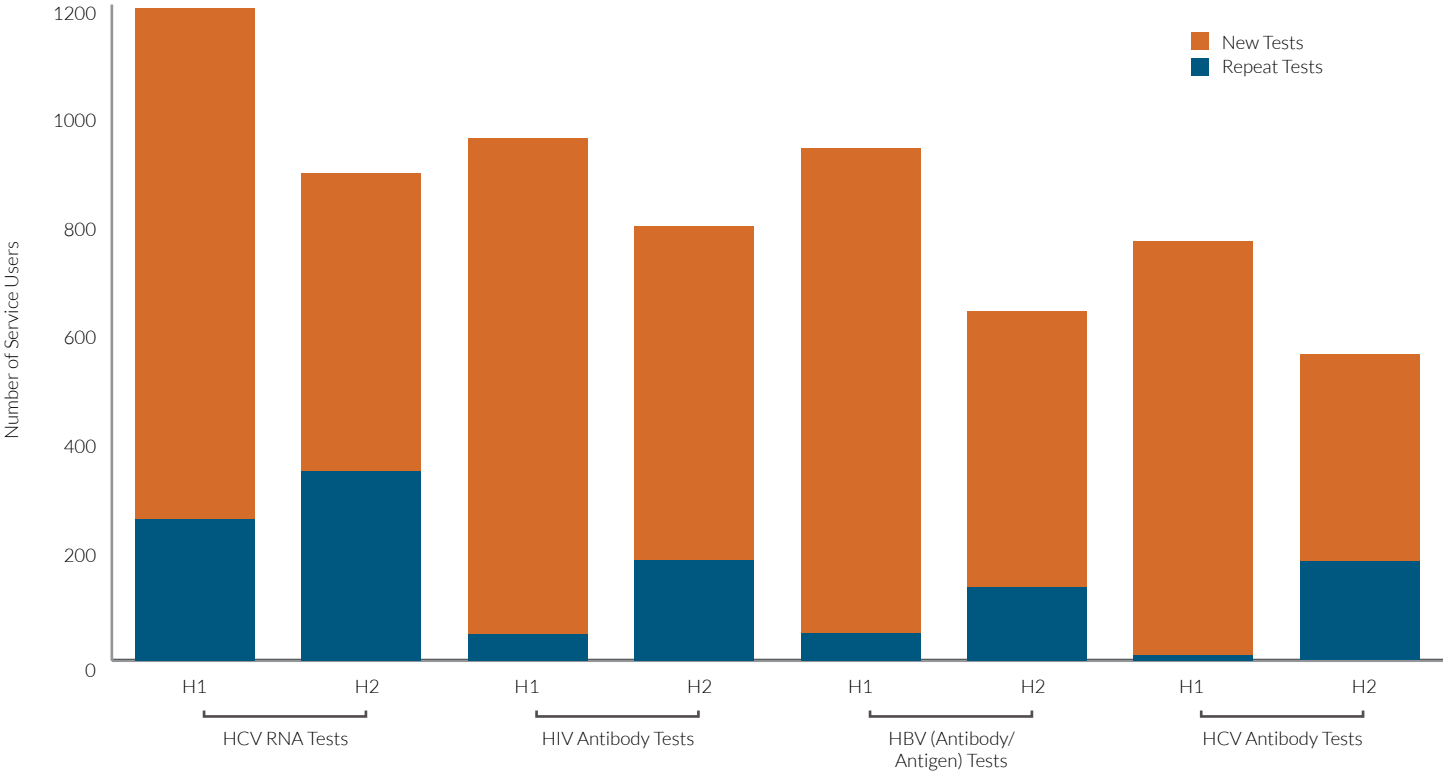


FIGURE 76
NUMBER AND TYPE OF HEPATITIS DIAGNOSTIC TESTS

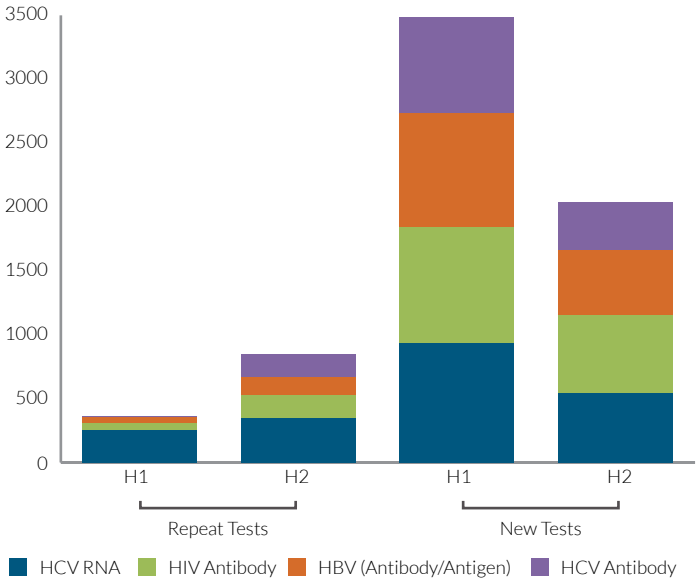
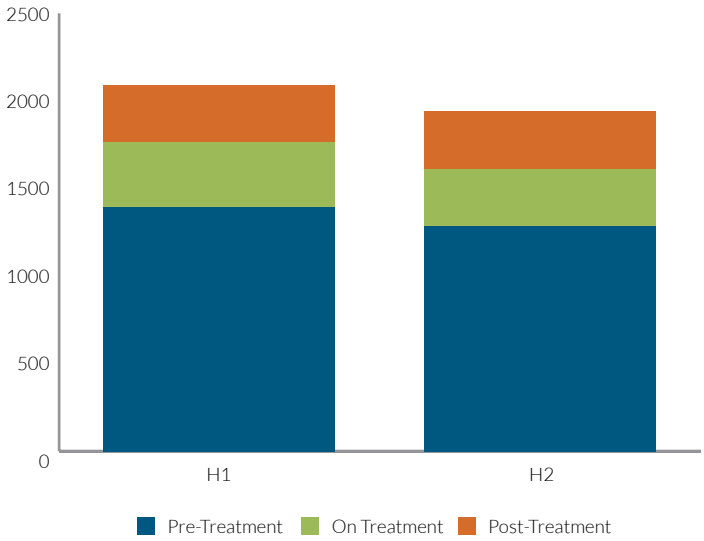


FIGURE 77
NUMBER OF TOTAL CASELOAD MOVING THROUGH VARIOUS STAGES OF HCV TREATMENT PROCESS BY REPORTING PERIOD



In addition to diagnostic testing, HCV teams reported administering 19,996 "other" tests, including various tests related to monitoring treatment outcomes, assessing the stage of the disease and diagnosing sexually transmitted infections. The most common "other" tests were: STI tests, fibrotests, HCV genotype testing and ALT/AST tests.

Outreach

Hep C teams offer HCV outreach testing in various locations. More than 30% of programs reported offering HCV tests in healthcare facilities, drop-in centers and methadone maintenance clinics; and more than 25% of sites offered tests at ASOs and street outreach locations (See Figure 78).

Emerging Trends

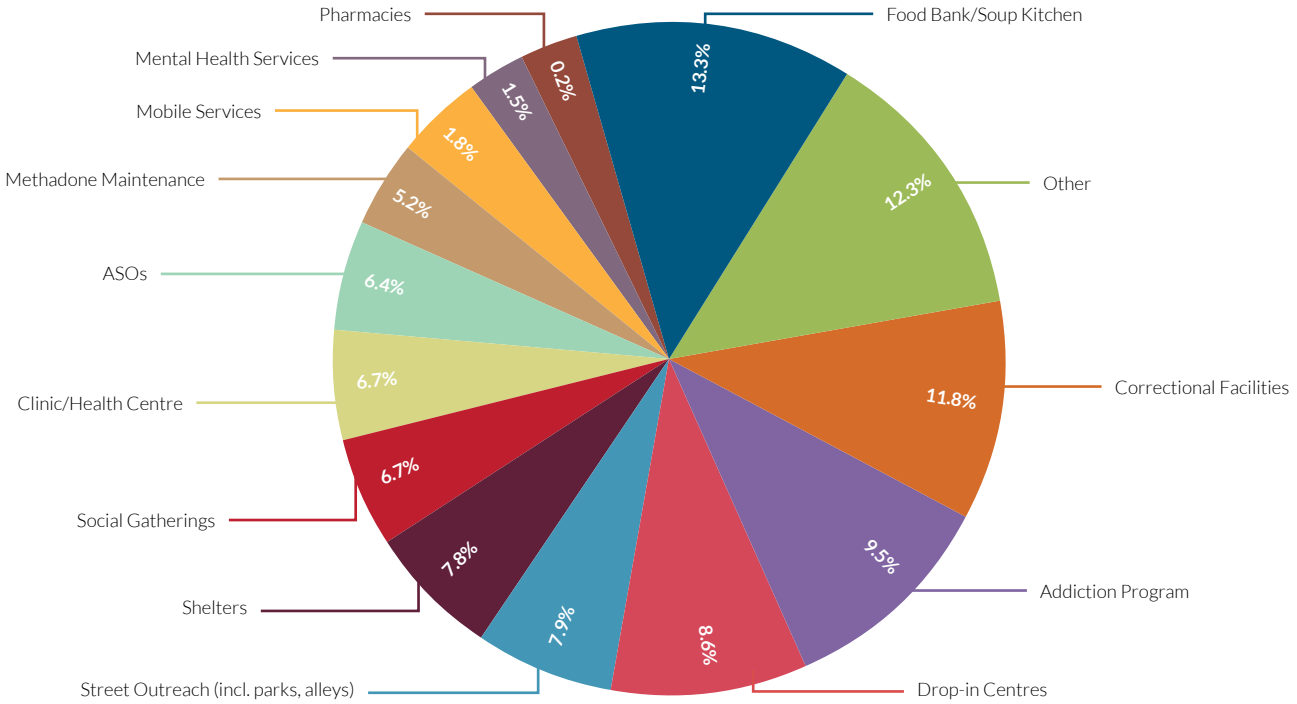
In 2013-14, Hep C teams reported more demand for services. They handled more requests for in- and outbound referrals, more treatment-related inquiries, and more demand for information about new treatment regimens. Seven programs reported their clientele growing in H2 and described this as a key trend. Five programs noticed more young people accessing or asking about support services and treatment.

> "Clients value the model of care, access to interdisciplinary healthcare providers, and the ability to access HCV RN in various locations in the community with/without appointments."

HCV teams often play a vital role in connecting clients with the health care system. When clients who access HCV services have no other medical support, teams provide case management and help them access primary care, addiction services and mental health support. In H2, programs noticed a growing demand from post-treatment clients for mental health services.

Programs also highlighted the importance of non-clinical services, such as practical assistance to stabilize clients on treatment. They also reinforced the need to continually adjust their service models to meet client needs.

FIGURE 78
OUTREACH LOCATIONS



IMPACT: TREATMENT OUTCOMES

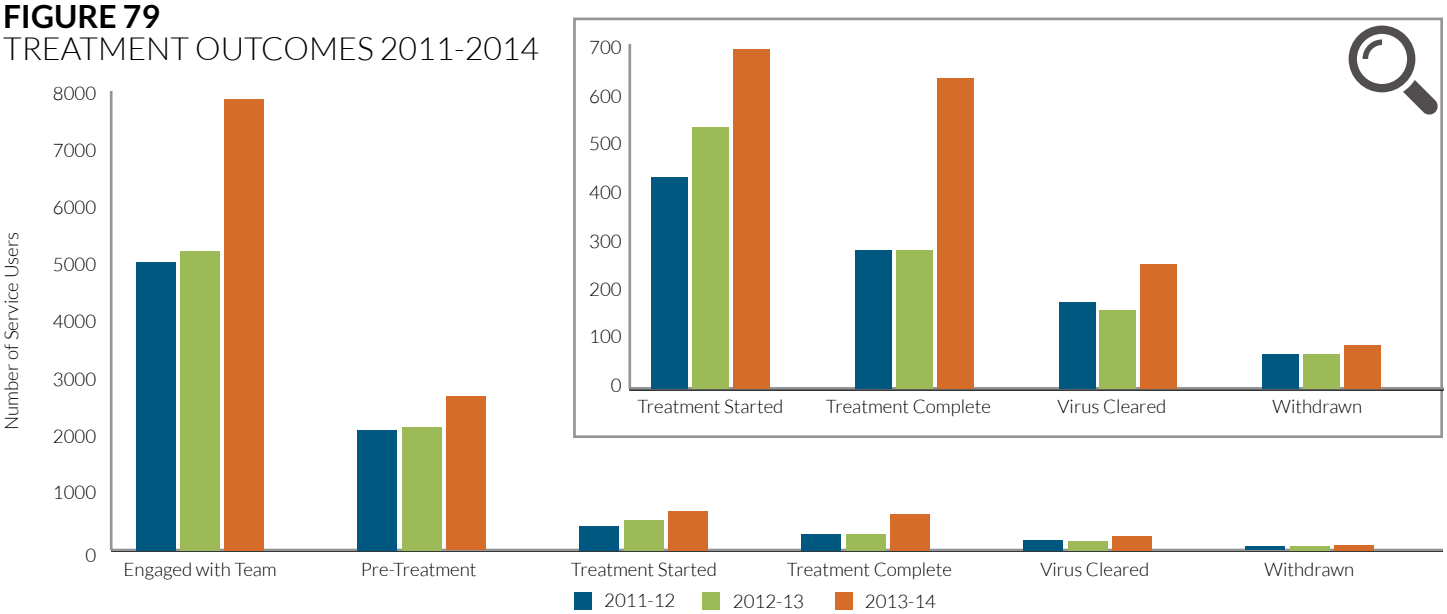
The impact of HCV treatment over the past three years is clear. Significantly more clients were engaged with the Hep C teams in 2013-14, and more were in pre-treatment, had started treatment and had completed treatment. Approximately the same number cleared the virus.

The significant difference between the number of people at the pre-treatment stage and the number of people who complete treatment and clear the virus illustrates how challenging HCV treatment can be.

2013-14 Outcomes

In 2013-14, a significant number of clients remained at the pre-treatment stage, fewer than 200 remained in treatment in each half of the year and fewer still were in the six-month post-treatment follow up period.

FIGURE 79
TREATMENT OUTCOMES 2011-2014



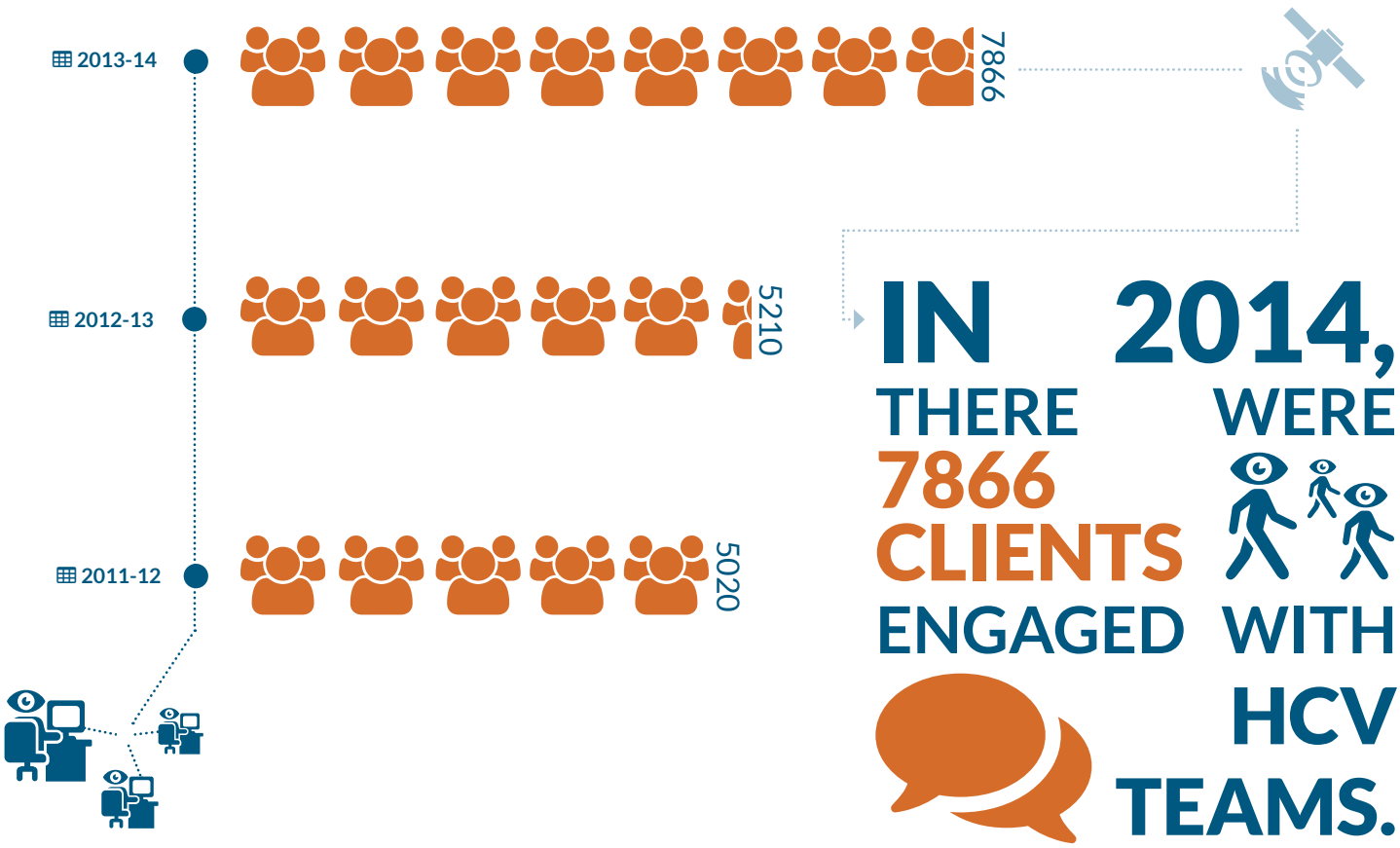
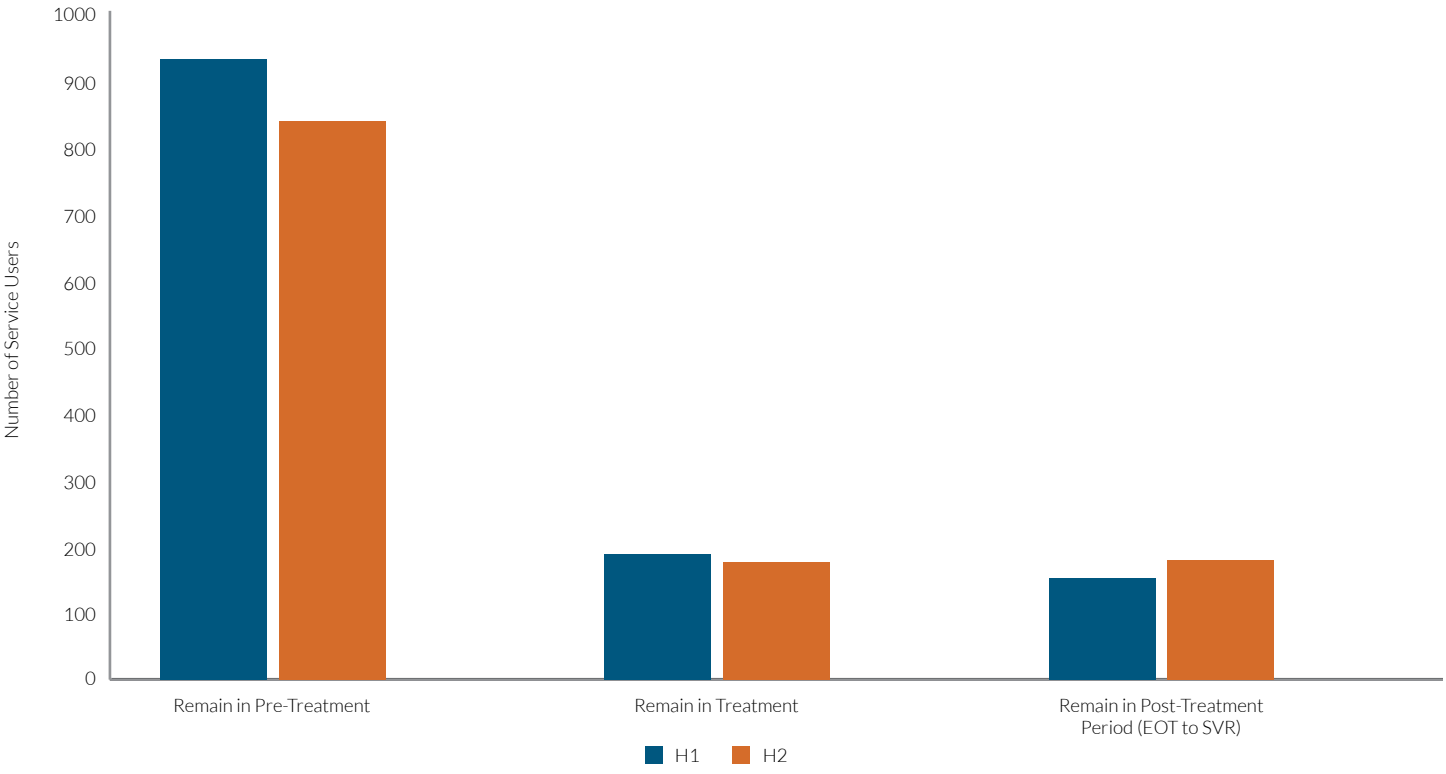


FIGURE 80
H1 AND H2 TREATMENT OUTCOMES 2013-2014



Over the 2013-14 period, 165 and 175 clients successfully completed treatment in each half of the year. Another 252 (154 in H1 and 98 in H2) spontaneously cleared the virus. In total, 241 clients achieved a sustained virologic response (i.e., no relapse) over a six month period.

Treatment Eligibility and Treatment interruptions

One of the reasons that there is such a gap between the number of clients with HCV engaged with treatment and the number who complete treatment, is that a significant number of people are either not eligible for treatment or withdraw before completing treatment. Figure 82 shows the reasons why people are ineligible for treatment as well as the reasons why some people stop treatment.

FIGURE 81
NUMBER OF CLIENTS WHO COMPLETED TREATMENT, CLEARED THE VIRUS AND HAD A SUSTAINED VIRAL RESPONSE

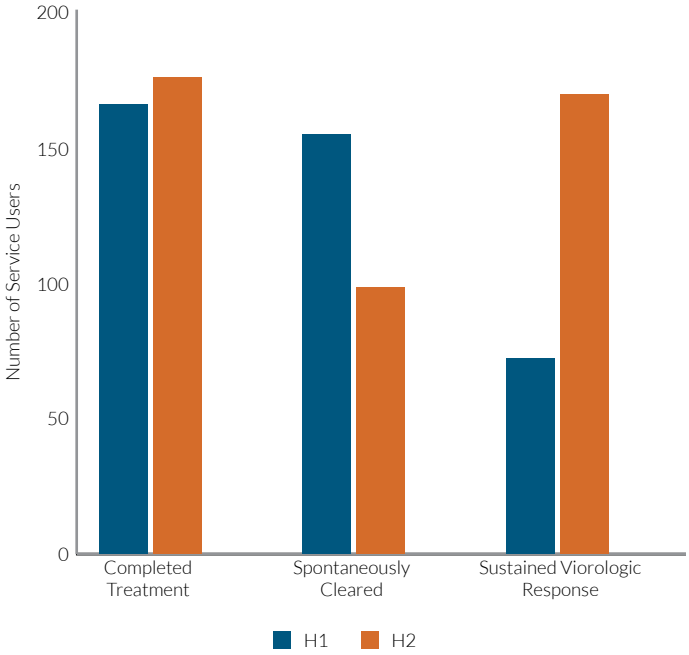
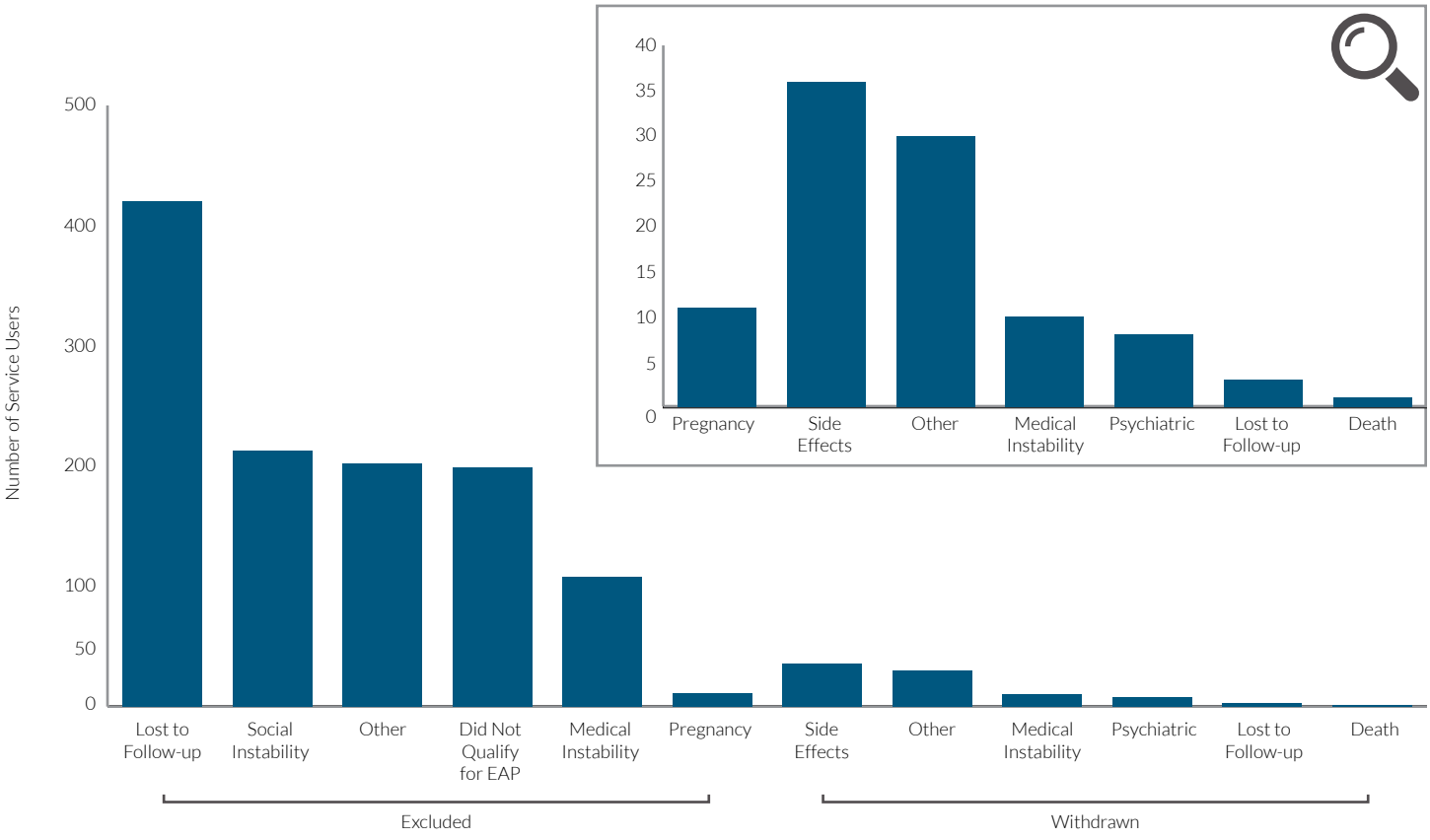


FIGURE 82
REASONS FOR TREATMENT INELIGIBILITY OR INTERRUPTION



More Details on Genotypes and Access to Treatments

Most clients present with genotype 1, 3 or 2. Genotype 1 is the most common genotype in Canada among people who use drugs, which accounts for the high volume of clients with genotype 1 (See Figure 83).

Access to Treatment

Cost can be a barrier to accessing HCV treatment. Not all clients are eligible for the EAP, which covers drugs not included on the Ontario Drug Benefit Plans. In 2013-14, HCV teams reported a total 252 clients (36% of total started on treatment) whose treatment was covered by EAP.

Teams reported that a total of 251 clients were treated using triple therapy, the most most effective HCV treatment regimen in 2013-14.

FIGURE 83
NUMBER OF CLIENTS PRESENTING BY GENOTYPE

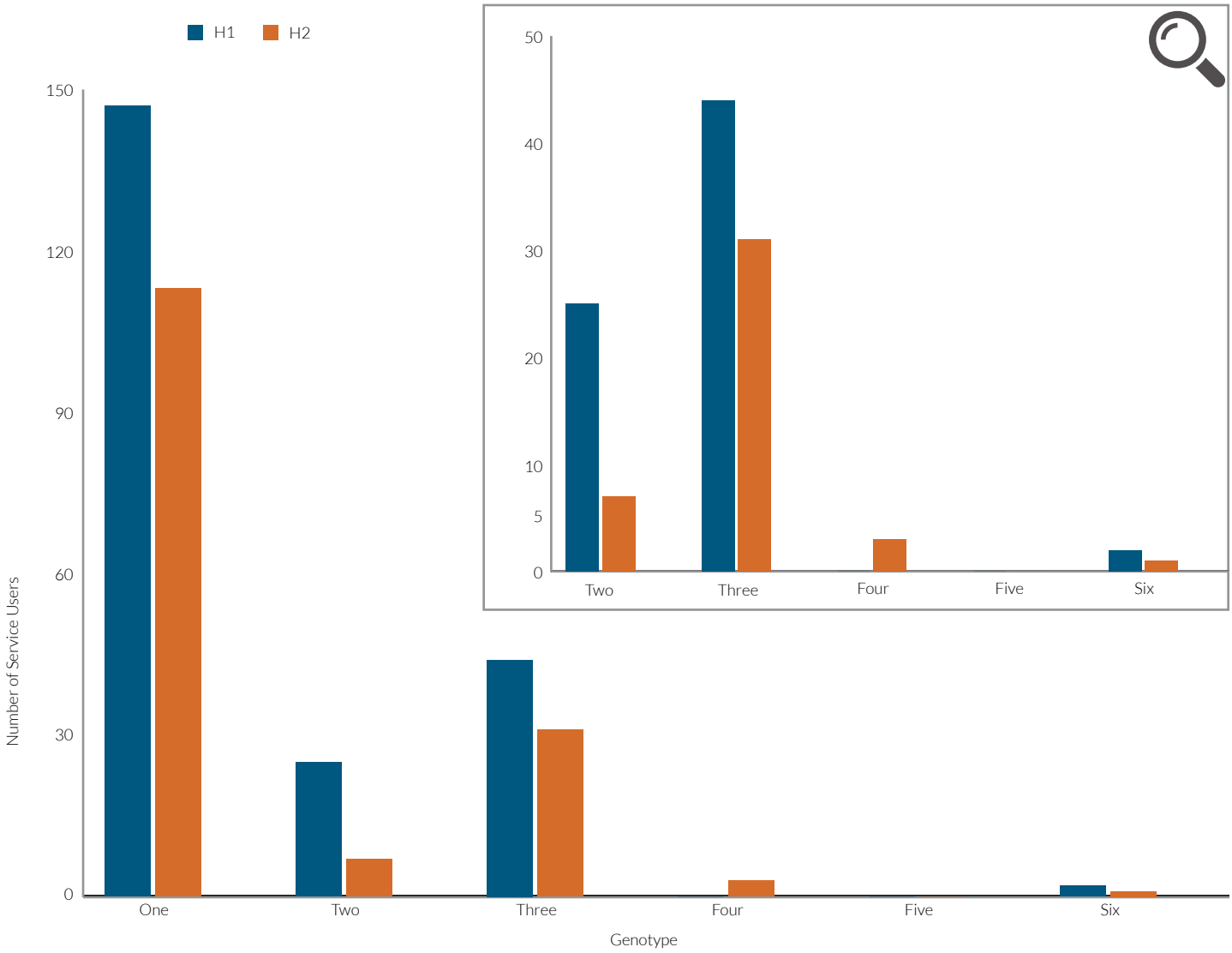


FIGURE 84
CLIENTS ON TREATMENT COVERED BY EAP 2013-14

Cost can be a barrier to accessing treatment. Not all clients are eligible for the EAP.

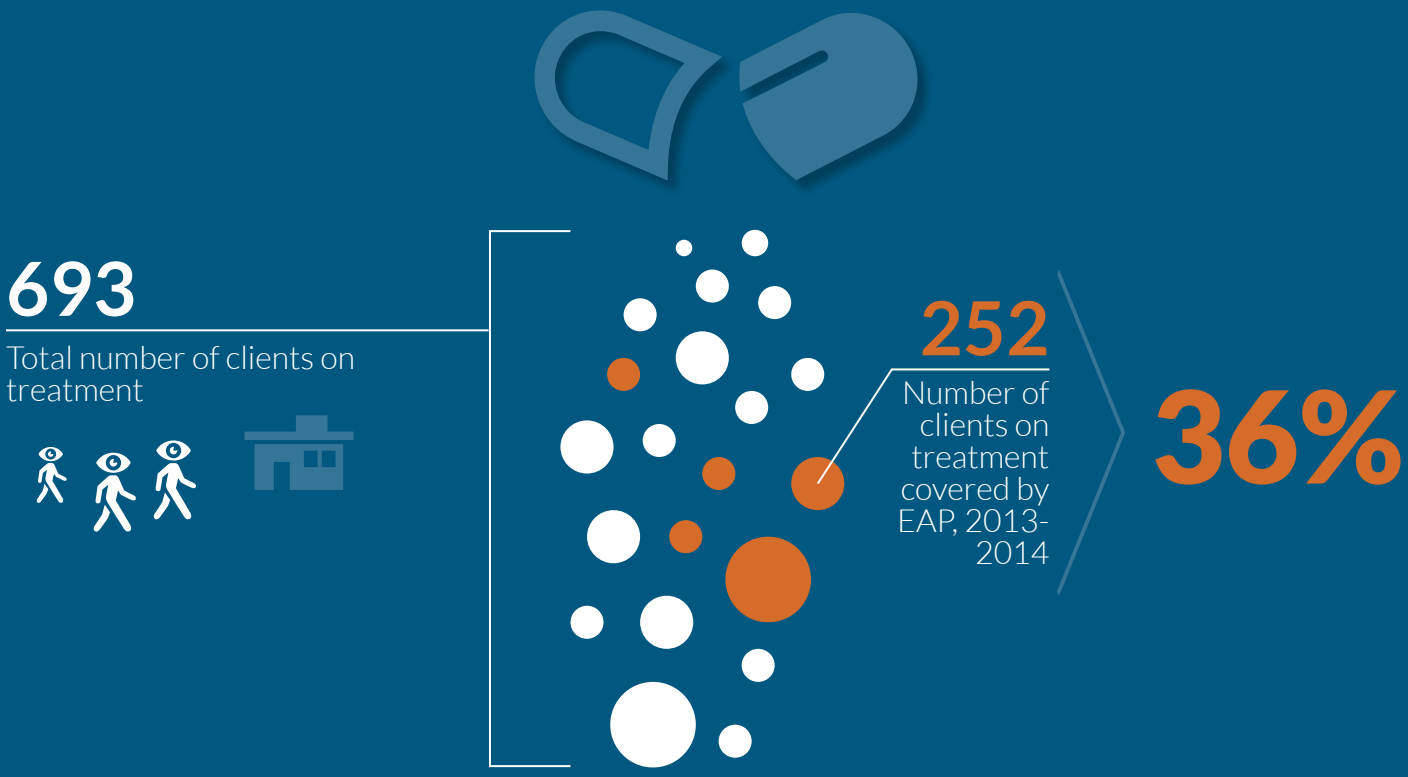
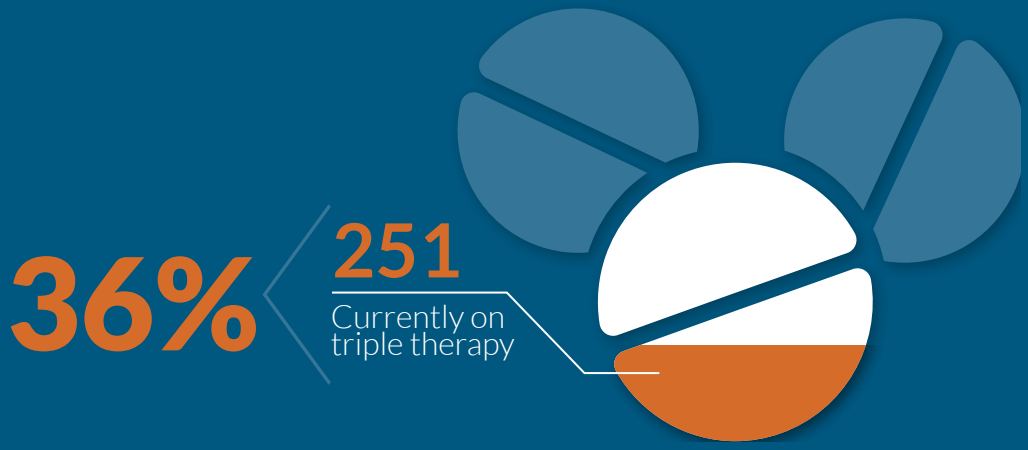


FIGURE X.
CLIENTS CURRENTLY ON TRIPLE THERAPY



Triple therapy was the most most effective HCV treatment regimen in 2013-14.

OBJECTIVE 2: TO INCREASE KNOWLEDGE AND AWARENESS TO PREVENT THE TRANSMISSION OF HCV AMONG PRIORITY POPULATIONS IN ONTARIO

Hep C teams are also responsible for education to increase awareness and prevent HCV transmission — particularly among the six priority populations. They reported a total of 29,016 outreach contacts through a range of settings in the community, and delivered a significant amount of education through food banks and correctional facilities (See Figure 85).

The main locations for outreach/education are other community organizations or events, clinical or health care settings and through mobile services. Sites for outreach vary by region, with South West relying mainly on other community organizations and events, and Central East relying on mobile services and "other" sites (See Figure 86).

FIGURE 85
EDUCATION CONTACTS BY GENDER

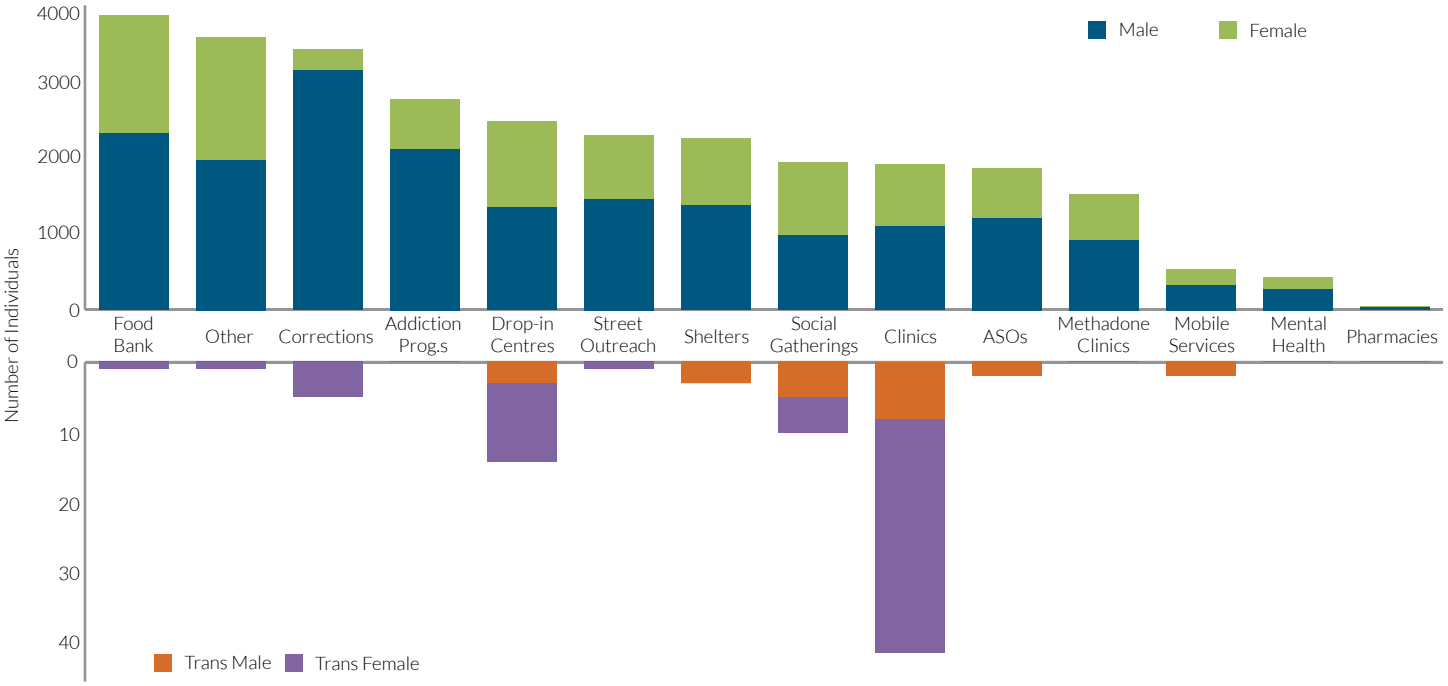
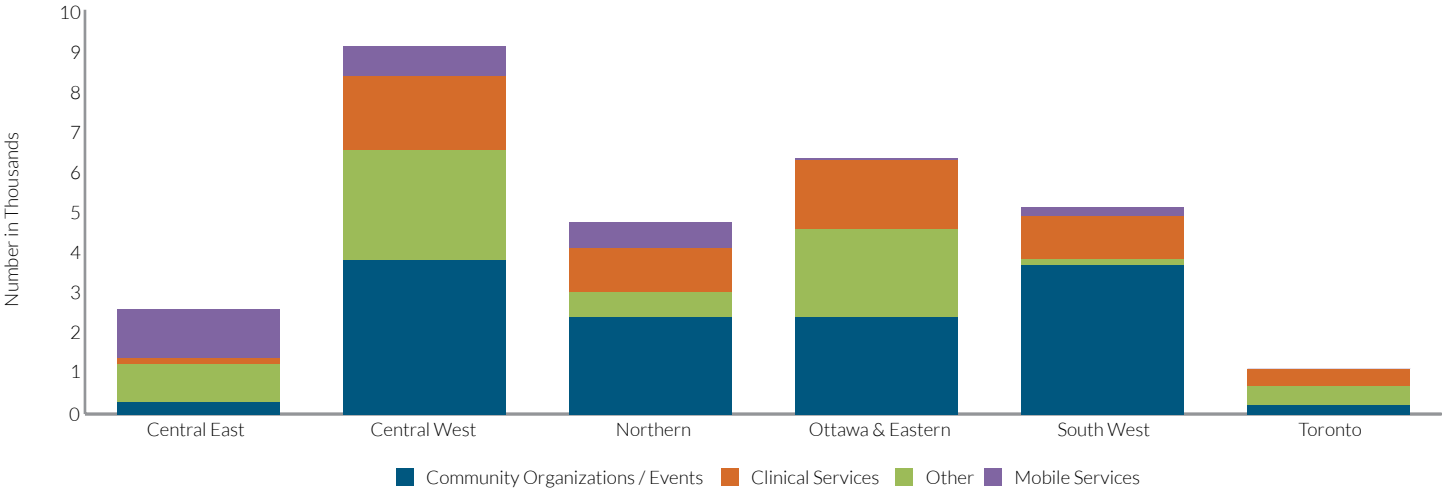


FIGURE 86
EDUCATION CONTACTS BY REGION AND LOCATION



OBJECTIVE 3: TO INCREASE COLLABORATION, COORDINATION AND EVIDENCE BASED PRACTICE ACROSS THE SYSTEM RESPONDING TO HCV

To build stronger networks of services to respond to HCV, HCV teams gave a total of 1,992 presentations throughout their communities and regions. The most common topics were HCV 101, harm reduction/safer drug use and HCV treatment.

Different team members share responsibility for increasing collaboration and coordination, though the majority of the presentations were done by outreach workers and coordinators. Most presentations were made to service providers and professionals, followed by people who use drugs and health care providers.

FIGURE 87
NUMBER OF EDUCATION PRESENTATIONS BY TOPIC AND WORKER

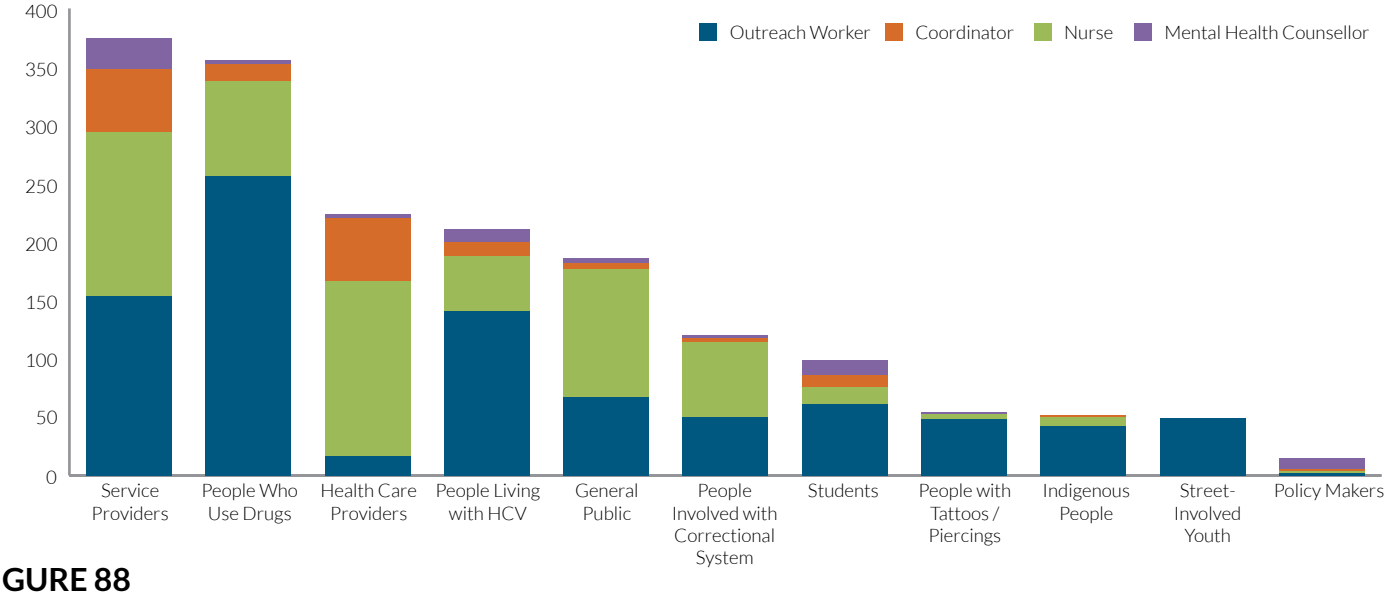
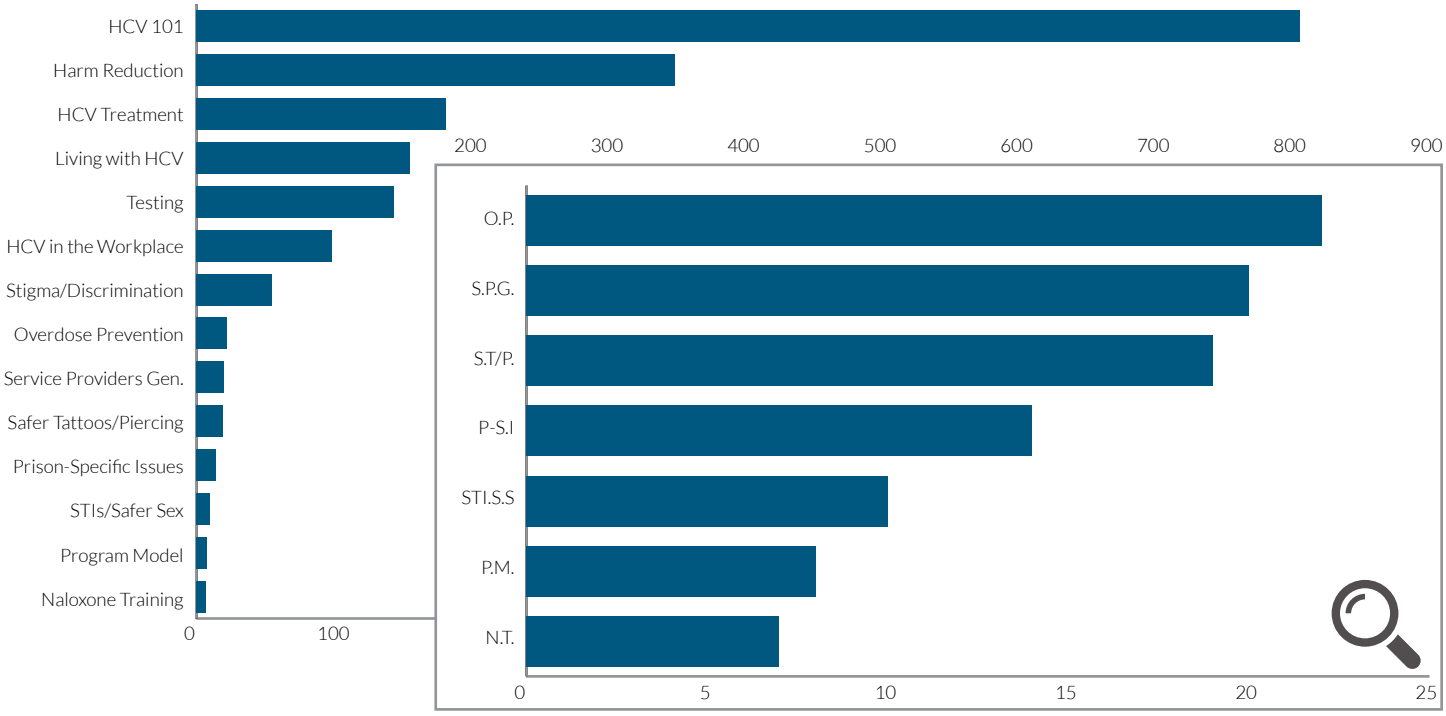


FIGURE 88
MOST COMMON PRESENTATION TOPICS



WHAT HAVE WE LEARNED FROM HEP C PROGRAMS?

PRACTICAL ASSISTANCE AND FOOD PROGRAMS — WHETHER PEER OR STAFF-BASED — ARE IMPORTANT COMPONENTS.

"Our clients on treatment state they really appreciate the weekly grocery card, monthly hygiene kits, vitamin D, multivitamins, meal supplements and bus passes when needed. An extra granola bar and juice is given to individuals who return their used needle supplies and safer inhalation kits."

"Providing small useful items such as personal hygiene kits, hats and mitts is appreciated by participants and further establishes a trusting relationship with the Hep C program."

CLIENTS ARE MORE LIKELY TO USE LOW THRESHOLD AND ONE-STOP SERVICES

Sites reported adjusting staff schedules and roles as well as service hours to provide more opportunities for non-scheduled appointments.

"Counsellor travelled to other agencies where clients may be currently accessing auxiliary services to provide counseling; Outreach in the community with group work is successful in meeting clients 'where they are at'."

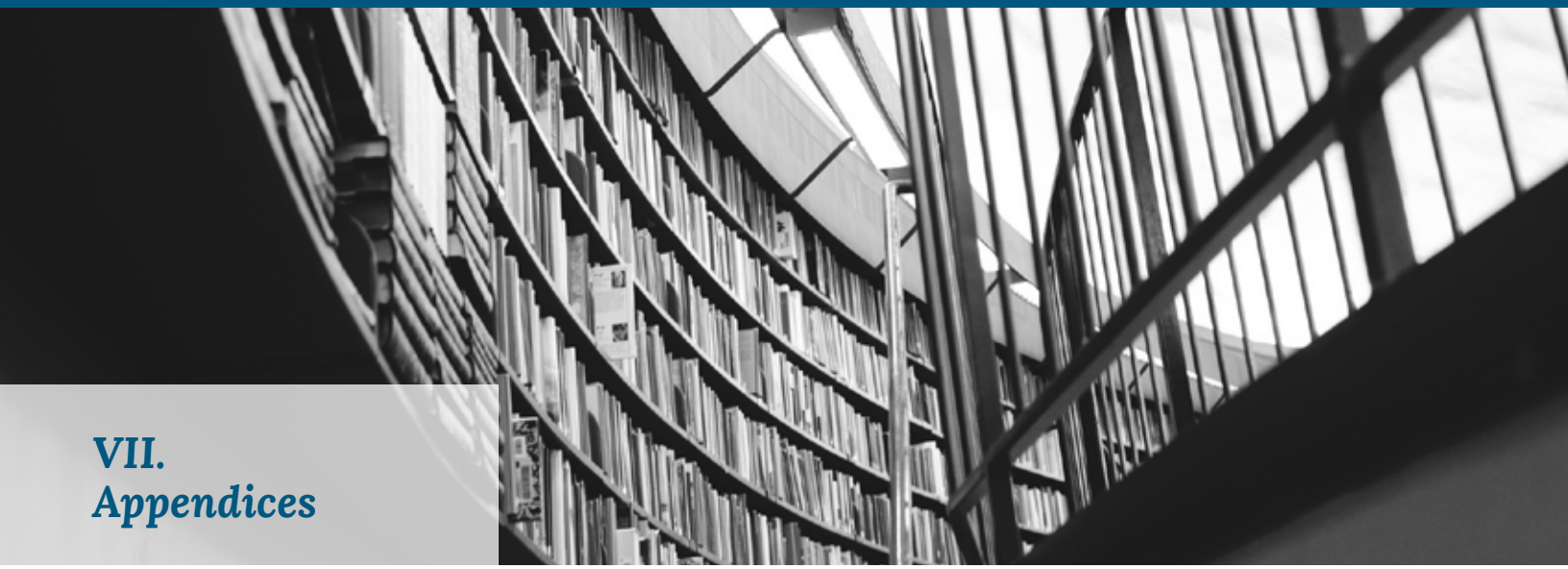
"Organizational policy will be amended to accommodate … staff doing home visits, meeting clients in parks and restaurants."

"Clients value the model of care, access to interdisciplinary healthcare providers and the ability to access HCV RN in various locations in the community with/without appointments."

NEW AND ADAPTED SERVICE MODELS AND NEW PARTNERSHIPS WITH OTHER SECTORS (HOUSING, HIV AND MENTAL HEALTH) IMPROVE ACCESS AND EFFECTIVENESS

"Our Hospital's Patient Experience Team identified 8 care-related dimensions: Access, Continuity and Transition of Care, Emotional Support, Information and Education, Family and Support Person Involvement, Physical Comfort and Respect for Patient Preferences. Our program is designing a new tool to reflect these and other aspects reflecting the patient experience vs. patient satisfaction."

"We have developed a 'Presentation Review' which rates the client's or professional's knowledge of Hep C prior to the presentation. As well, [it] rates their knowledge after the presentation."



VII. *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
	Hamilton AIDS Network	Hamilton Niagara Haldimand Brant
	Hamilton Public Health & Community Services	Hamilton Niagara Haldimand Brant
	Positive Living Niagara	Hamilton Niagara Haldimand Brant
	AIDS Committee of Cambridge, Kitchener, Waterloo and Area	Waterloo Wellington
	HIV/AIDS Resources & Community Health- Clinic	Waterloo Wellington
	HIV/AIDS Resources & Community Health (ARCH)	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
	Elevate NWO	North West
	Nishnawbe Aski Nation	North West
	Ontario Aboriginal HIV/AIDS Strategy - THUNDER BAY	North West
	Waasegiizhig Nanaa-ndawe'iyewi-gamig	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
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
	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 - FFL	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
Provincial	Hemophilia Ontario	Capacity Building
	HIV & AIDS Legal Clinic (Ontario)	Capacity Building
	Ontario Aboriginal HIV/AIDS Strategy	Capacity Building
	PASAN (Prisoners with HIV/AIDS Support Action Network)	Capacity Building
	African and Caribbean Council on HIV/AIDS in Ontario	Capacity Building
	AIDS Bereavement and Resiliency Program of Ontario (sponsored by Fifehouse)	Capacity Building
	Canadian AIDS Treatment Information Exchange	Capacity Building
	Committee for Accessible AIDS Treatment	Capacity Building

	FIFE House - OHSUTP	Capacity Building
	Gay Men's Sexual Health Alliance	Capacity Building
	Ontario AIDS Network	Capacity Building
	Ontario Organizational Development Program	Capacity Building
	Toronto People With AIDS Foundation - THN	Capacity Building
	Women and HIV/AIDS Initiative	Capacity Building

HEP C Programs

Health Region	Organization Name	LHIN
HealthRegion	OrganizationName	LHIN (local Health Integration Network)
Central East	Lakeridge Health Centre	Central East
Central East	Oshawa Community Health Centre	Central East
Central West	Bramalea Community Health Centre	Central West
Central West	Niagara Health System	Hamilton Niagara Haldimand Brant
Central West	Wayside House of Hamilton	Hamilton Niagara Haldimand Brant
Central West	Sanguen Health Centre	Waterloo Wellington
Northern	AIDS Committee of North Bay and Area	North East
Northern	Algoma Group Health	North East
Northern	Reseau Access Network	North East
Northern	Timmins Family Health Team	North East
Northern	Elevate NWO	North West
Northern	Sioux Lookout First Nations Health Authority	North West
Ottawa & Eastern	The Ottawa Hospital	Champlain
Ottawa & Eastern	Street Health Centre, Kingston Community Health Centres	South East
Provincial Resource	Canadian AIDS Treatment Information Exchange	Provincial Resource
Provincial Services	PASAN (Prisoners with HIV/AIDS Support Action Network)	Provincial Services
South West	Windsor-Essex Community Health Centre	Erie St Clair
South West	London Inter-Community Health Centre	South West
Toronto	Sherbourne Health Centre	Toronto Central
Toronto	South Riverdale Community Health Centre	Toronto Central

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
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

APPENDIX B: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.

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.

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	Elevate NWO	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 (Institution-alization) 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: VOLUNTEER WORK

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	57,162	$15.25	$871,723.55	$104,606.83	$976,330.38
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	24,100	$39.00	$939,880.50	$112,785.66	$1,052,666.16
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	54,207	$21.51	$1,165,983.97	$139,918.08	$1,305,902.04
Prevention (outreach, targeted education, etc)	12.2 total # of vol hrs for Outreach Activities	Community and social service workers 4212	21,109	$21.51	$454,054.59	$54,486.55	$508,541.14
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	28,797	$29.74	$856,407.91	$102,768.95	$959,176.86
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	15,875	$15.25	$242,097.56	$29,051.71	$271,149.27
Human resources	12.2 sum to total # of vol hrs for involvement in hiring process and policies and proecdures	Specialists in human resources 1121	1,929	$29.74	$57,353.59	$6,882.43	$64,236.02
IT Support	12.2 sum of total # of vol hrs for IT support	Web designers and developers 2175	608	$27.78	$16,890.24	$2,026.83	$18,917.07
Other (specify)							
Total					$4,604,391.91		$5,156,918.94

* Add the hours from your H1 and H2 OCHART report

Note: these calculations will slightly under-count volunteer hours reported in OCHART, as not all OCHART volunteer activity categories are reflected in this table. This table aligns OCHART volunteer categories with volunteer categories used in ACAP reporting in the rest of Canada, to facilitate rolling up Ontario data with data from other regions

OCHART categoreis excluded from this calculation are: Attended Training (does not align with a paid staff activity); Involved in hiring process; Policies and Procedures; and IT support. These are also the categories in OCHART with the lowerst number of hours, so excluding them from the analysis will have a negligible impact on the total $ value estimate.

APPENDIX E: TRAINING TAXONOMY (REFERENCE TO TRAINING GRAPH FIGURE 12)

Administrative Training	Administrative Computer program training OCASE Training OCHART Training
Skills Building	ABRPO Training Addictions / harm reduction / substance use Addictions / harm reduction / substance use / OHSUTP CAHR conference Change management Crisis Prevention/Intervention Cultural competence Disclosure Diversity and anti-oppression Female condom Fundraising GMHS Grief and loss Hep C HIV and corrections HIV testing (including Point of Care) HIV/AIDS Leadership training LGBTQ-Homophobia Mental Health/counseling OAHAS OAN Skills Building OHSUTP training OHTN conference Opening doors OPRAH Training Prevention and positive prevention Sexual health/STI Suicide prevention Team building Violence (family, women, children, etc.) Volunteer coordinator
Other (from the standard list)	Health and safety Other Stress reduction
Other – free text	Free text values. Main items included Accessibility for Ontarians with Disabilities Training, CPR/First Aid, Social Media Training. Conflict Resolution and Housing training. Many of these items fit within existing categories. With the revision to this question in the future, we strive for clearer questions and accurate reporting. See all free text categories on next page.

Free text training responses (OCHART 4.5)

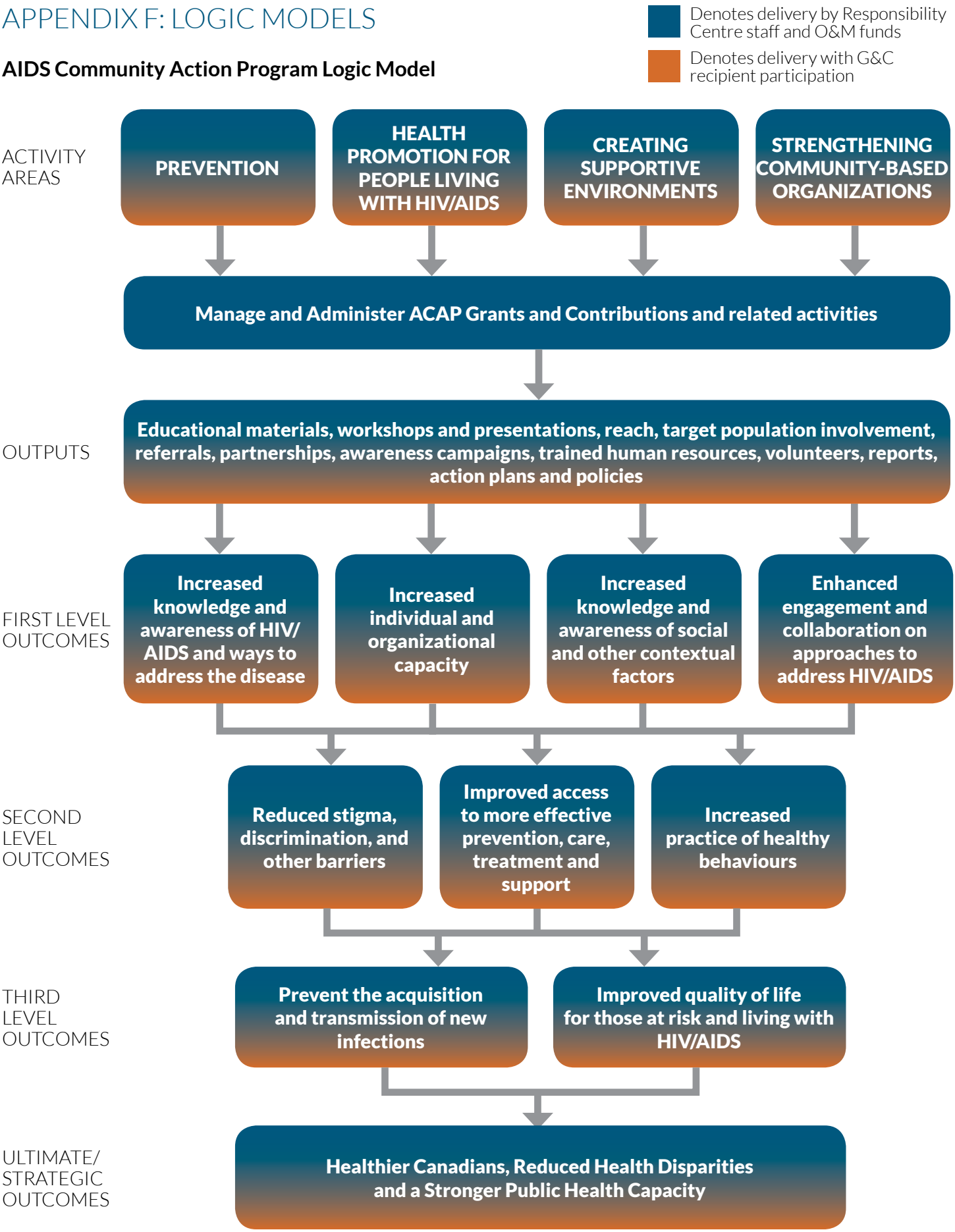
ABI
Aboriginal Issues
ACB Health Symposium
ACCHO
Acquired Brain Injury
Agency tour
Aging
AODA
ASL
Assertiveness Training
Basic Life Support
Best practice standards training
Best Practices: Medication
Blended Learning
Breast Feeding Initiative
CANAC
CATIE Forum
Serodiscordant Couple
Change in Immigration law
Changes to Health Care for Immigrants
Client Records Documentation
Clinical Care
Clinical Supervision
Common Measures Interviewing
Communication Workshop Buzz 1,2
Communications
Community Development
Community Development
Community Engagement Training
Community Leadership
Compassion Fatigue
Conflict in Workplace
Couples Counselling
CPHA conference
CPR/First AID
Creating Health (Nutrition)
Crisis Intervention
CWGHR Conference
Data Analysis (NVivo)
Dealing with Difficult People
Dementia Care
Diabetes
Digital Story Telling Training
ED Peer Learning Circle
Elder Abuse
Elder Helper Work
Episodic Disability Workshop
Ethical CBR with Urban Indigenous Communities
Ethics
Evaluation Framework Dev
Francophone Forum on Mental Health and Addictions

French Language
Gender identity
General Knowledge - HIV/AIDS
GIPA/MIPA
GMSH/OurAgenda-trainer
Guelph Sexuality Conference
Halco
Handwashing/Hygiene
Harvard HIV Update
Health Care Support to Trans
HIV and Aging
HIV Testing Conference
HIV Treatment
Hospice Palliative Care|
Hospice Palliative Care Training
Housing
Human Rights
Human Trafficking
Human Trafficking
IHPREG/pregnancy & motherhood
Immigration
In service: New Elevator Safety and Evacuation Procedures
Income Manager
Infection Control and Prevention
Influenza Vaccine
Inherited Bleeding Disorders
LHIN Rotman Community Health Leadership Training
LHIN Webinars
Life Coaching
Management Skills Building
McMaster field supervisors training
Media Training
Mediation Training
Medical Marijuana
Medication Administration
Medication Training
Methadone Treatment
Middle Management Training
Mindfulness Training
Motivational Interviewing
Naloxone Training
Navigation of New Website
New Technology
Newcomer Issues
Nightingdale On Demand - Super Users
Nursing Skills - Female CPX
Nursing Skills - Lab Results
OCHART KTE Day
Ontario Works
Other Workshops
Outreach
OWS KTE Event — Let's Talk About Us: What Women Have to Say About HIV
Personal Support Worker Certification
Policy & Advocacy
Population Status Report
Positive Supervision
Preparation for ONCA Ontario Non-profit Corporation Act
Privacy
Professional Boundaries and Confidentiality
Program Develop/Evaluation
Program Development
Program Planning
Public relations
Quality of Data Analysis & Research Design
Quantitative Methods in Community Based Research
Rainbow Health Conference
Rainbow Health Ontario
Refugees Sponsorship
Religion, Sexuality & South Asian Youth
Renal Issues with HIV
RHO Public Policy Institute
Risk management
Sex work
Sexual Health Training for People Working with Youth at Risk
Sexual Pleasure
Social Determinants of Health
Social Justice Integration
Social Media and Communications
Social Media Training
Stroke and Brain Injury Workshop
The Science and Clinical Practice Recommendations Around Breast Feeding Practices in Canada
The Works - Job Shadowing
Trans
Trauma
Trauma Informed Care
Trauma training
Trauma-informed Approach
Traumatology Certification
Various: Training on Results-based leadership, creation of social enterprise, Project Management, Francophone Forum on Mental Health and Addictions
Webinars with LHINs
Website & social media
WHAI
WHMIS
Women's Symposium
Women's Voices, Women's Health

Workers Rights
Workplace Wellness
Workshop for Peer Educators
Writing Circle - Research

APPENDIX F: 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

OCHART

Ontario

OHTN

Public Health Agency of Canada

Agence de santé publique du Canada