The View from the Front Lines

Summary and Preliminary Analysis of Data Provided by Community-based HIV/AIDS Services in Ontario 2001/02 to 2005/06

A Collaborative Project of the
AIDS Bureau, Ministry of Health and Long-Term Care
Public Health Agency of Canada, Ontario Region
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Background

The AIDS Bureau of the Ministry of Health and Long-Term Care and the Ontario Region of the Public Health Agency of Canada (PHAC) AIDS Community Action Program (ACAP) fund a variety of community-based organizations in Ontario to provide prevention and support services for people living with HIV and people at risk. The AIDS Bureau provides ongoing operational funding and occasional one-time grants to community-based AIDS organizations, public health units, community health centres and other organizations. ACAP provides two streams of funding: 3 to 4 year operational funding for AIDS service organizations and 1 to 2 year time-limited funding for voluntary, non-profit and non-governmental organizations addressing HIV. This funding is used to support activities consistent with the priorities of *Federal Initiative to Address HIV/AIDS in Canada* (2004), and *Leading Together: Canada Takes Action on HIV/AIDS* (2005). (For more information on funding, see section 1.3. For a list of funded agencies, see Appendix A.)

The purposes of collecting and reporting data on community-based HIV/AIDS services are:

- **Accountability**: the reports allow the organizations, the AIDS Bureau and the Public Health Agency of Canada to check actual activity against program plans. They also provide information on how resources were used.
- **Planning**: the reports may identify trends that can be used to adjust services or to develop new services locally and provincially.
- **Quality Improvement/ Evaluation**: the reports may provide information that organizations can use to improve their services.

Community-based agencies that receive AIDS Bureau and PHAC funding are expected to provide information on the clients they serve and the services they provide. This information is used to monitor changing needs, plan effective programs and services, and ensure accountability.

When both the provincial and federal governments were developing new HIV/AIDS strategies, community-based organizations identified two issues with the funding and reporting process:

- reporting requirements were onerous – agencies were spending a disproportionate amount of time filling out separate forms, required at different times, and providing similar information to the two funders
- information gathered by the funders was not always useful and it was not available to the agencies to help them improve their programs and services.

The *Ontario Provincial Strategy on HIV/AIDS* (2003), the *Federal Initiative to Address HIV/AIDS in Canada*, and *Leading Together: Canada Takes Action on HIV/AIDS* (2005), the Pan-Canadian HIV/AIDS strategy all recommended that funders simplify reporting requirements and reduce the administrative burden on community-based agencies. They also recommended that the system enhance its capacity to gather data that can be used to monitor, evaluate and improve services, and to identify emerging trends.

Over the past two to three years, the AIDS Bureau and PHAC have been working closely together with community-based organizations to simplify and improve data collection and reporting. In March 2005, the two funders introduced a joint reporting tool: the Ontario Community HIV/AIDS Reporting Tool or OCHART. Unlike the previous reporting forms (i.e., AIDS Bureau quarterly activity reports that had to be completed four times a year and PHAC semi-annual narrative reports), OCHART only has to be completed and submitted twice a year (April and October). It combines data required by both the AIDS Bureau and PHAC in one reporting tool. It also allows community-based organizations and funders to gather more information about emerging trends and needs that can be used to improve services.

About This Report

This report is a summary and analysis of the data collected during the first year of OCHART's use (i.e., 2005/06). It also includes data collected during the previous four years using the AIDS Bureau quarterly activity reports (which included PHAC-funded activities).

The analysis is designed to help the AIDS Bureau, PHAC and funded agencies understand the demand for services and identify any shifts or emerging trends. The analysis provides a general picture of HIV/AIDS prevention, care and support activity in the province. It indicates the types of services that community-based organizations are providing, and whether they are changing over time.

Data Limitations

The data in this report should be interpreted with caution. It is difficult to draw conclusions because of the potential for error in data entry – particularly in the first two years of the AIDS Bureau quarterly activity reports and with the shift to OCHART. Different agencies may have interpreted data requests in different ways or used different definitions.

Data quality and consistency are improving over time. OCHART includes more precise data definitions, and reports are being monitored to ensure greater consistency across agencies.

It is important to note that organizations provide program level – rather than client level – data. As a result, it is possible to identify the type and number of services provided, but not the exact number of people served or the mix of services that each person used.

Acknowledgements

The AIDS Bureau and the Ontario Region of PHAC would like to thank the community-based AIDS organizations in Ontario who provided the data used in this report. It takes time to collect data and complete activity reports and OCHART, and the funders appreciate the attention that agencies give to completing the forms.

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Jennifer Major
416-642-6486
jmajor@ohtn.on.ca

Key Findings and Trends

1. **The network of community-based HIV/AIDS organizations is concentrated in larger urban areas, but covers most of the province.** The AIDS Bureau of the Ministry of Health and Long-Term Care and the Public Health Agency of Canada, Ontario Region fund a network of 74 community-based organizations, which provide a range of education, prevention, outreach and support services for people with HIV, populations at risk and the general public. Most organizations are small (50% have <5 staff) and concentrated in large urban centres, such as Toronto, but there are programs and services operating in most parts of the province.
2. **Funding for community-based HIV/AIDS organizations has increased**. Between 2003/04 and 2005/06, AIDS Bureau and PHAC funding increased about 35%.
3. **The HIV epidemic in Ontario continues to vary by region**. While organizations in Toronto see clients with a wide range of risk factors and cultural backgrounds, those in northern and more rural regions primarily see gay men, injection drug users and Aboriginal people. Overall, agencies are serving more people with injection drug or substance use and more culturally diverse clients.
4. **The age and gender mix of clients is shifting**. In terms of support services, most clients are between the ages of 25 and 54, and two-thirds are men – although the proportion of women and transgendered clients has more than doubled in recent years.
5. **People living with HIV and populations at risk have complex health and social needs, and community-based organizations continue to adapt services to meet needs.** The major issues that people living with HIV and populations at risk faced in 2005/06 were: unemployment, mental health problems, food insecurity, homelessness/being underhoused, substance use/addiction, a history of abuse and domestic violence. These findings reinforce the need for comprehensive programs and services that meet clients' health, psychosocial, social and economic needs – which community-based organizations are working to provide. For example, organizations are providing more practical assistance – including food banks and income support, advocacy, case management services, housing assistance, supportive housing, skills development, and employment counselling. In addition, organizations are providing more home and hospital visits: an indication that more clients may be failing on treatment and becoming ill.
6. **Income stability is an issue for many clients**. In 2005/06, just over 60% of organizations provided almost $680,000 in financial assistance to 5,766 clients for items such as bus tickets, food vouchers, honoraria for participating in meetings and focus groups, and child care. The growing need for this type of financial assistance indicates that income programs like social assistance and ODSP are not providing enough income support to allow people with HIV to manage their health.

7. **Organizations are developing partnerships with other health and social service agencies**. To meet clients' increasingly complex needs, HIV/AIDS organizations must work closely with one another and with other health and social service agencies. The regions that have been most effective in building collaborative partnerships outside the HIV sector tend to be those with relatively few HIV organizations; however, all organizations are working to develop links with other health and social service agencies.
8. **Outreach contacts – in both community-based and IDU programs -- increased significantly in 2005/06.** Most of the increase in community-based programs was due to greater use of the Internet and chat rooms. Organizations continue to be highly innovative in their efforts to reach their targets populations, seeking out new venues for outreach such as parties, prisons, shelters, and, in the case of IDU outreach, treatment programs.
9. **Increased use of the Internet in outreach, education and support programs is changing the way services are delivered**. In addition to using the Internet for outreach, organizations also reported more use of web-based media, electronic newsletters and other Internet-based technologies to deliver prevention, education and support services. Increasing reliance on the Internet highlights the need to develop different skills and strategies while, at the same time, maintaining other forms of outreach and service delivery for clients who do not have access to computers. It also raises issues of geography, as many organizations report providing services on the Internet, such as counselling, to people outside their traditional catchment areas.
10. **Organizations are distributing a wider range of prevention and education materials**. As part of their prevention, education and outreach programs, organizations are distributing a wider, more varied range of materials that reflect clients' complex needs, such as brochures, condoms, lubricant, needles, crack cocaine kits, health or hygiene kits, vitamins and food.
11. **More organizations are involving clients in services.** People living with HIV and people at risk are most likely to be involved in planning, service delivery and evaluation. Over two-thirds of organizations report that they actively recruit members of their target populations to volunteer and/or apply for paid positions. In IDU Outreach Programs, peers are mainly involved in distributing information and materials, and in informal interactions with other drug users.
12. **Community-based HIV/AIDS organizations continue to be very successful in attracting volunteers.** The number of active volunteers increased significantly in 2005/06 – although volunteers appear to be giving fewer hours, and volunteering for shorter periods of time. Both trends may be due to the large number of high school students required to do community service. As a result of these trends, organizations are continually recruiting and training volunteers.

13. **Organizations are committed to monitoring, evaluating and improving their services.** Community-based organizations reported using a variety of tools to monitor their programs including service data, program reviews, client satisfaction surveys, performance reviews and focus groups. They use this information to refine their programs and services.

14. **Emerging trends include:**
    - an increase in demand for education and community development services – particularly from other community organizations and schools
    - an increase in the need for outreach services for recent immigrants, injection drug users and women
    - an increase in crack/cocaine and crystal methamphetamine use, and an increased demand for needles, safer cocaine kits and other drug-related supplies
    - more people from countries where HIV is endemic and more long-term survivors seeking services
    - greater need for financial and other practical assistance, culturally and linguistically appropriate services (including assistance dealing with immigration issues), mental health services, case management and complementary therapies

1. The Context

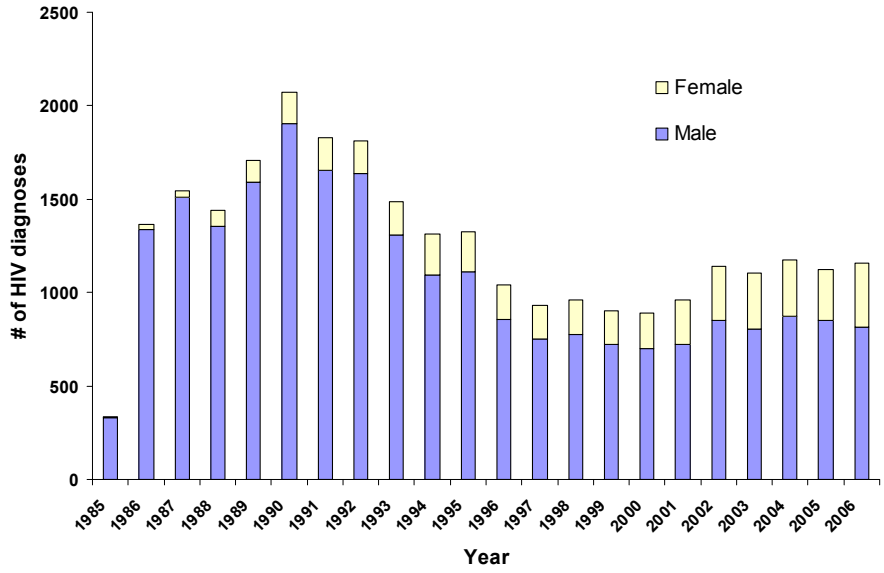
1.1 Trends in HIV Infection

More Ontarians are being diagnosed with HIV

As of the end of 2006, a total of 27,621 Ontarians had been diagnosed with HIV. From 1990 to 2000, the number of newly diagnosed HIV infections in Ontario each year declined but, beginning in 2001, started to increase again (Figure 1). Because HIV is a slow acting disease, a number of people who are infected have not yet been diagnosed, so these figures understate the actual number of new infections each year as well as the total number of people infected.

Most people diagnosed with HIV are men (85%), but women now account for a larger proportion of new diagnoses each year (30% in 2006).

Figure 1: HIV Diagnoses in Ontario



More Ontarians are living with HIV

With the increase in new HIV diagnoses and more effective treatments for HIV, the total number of people in Ontario living with HIV has increased. According to statistical modeling, by the end of 2004:

- 32,037 people in Ontario had been infected with HIV
- 8,267 had died
- 24,251 were living with HIV.

This likely means that funded organizations are providing services for more people over a longer period of time; however, because we collect program rather than client data, we do not know exactly how many people are using community-based HIV prevention, care and support services or how long they receive services.

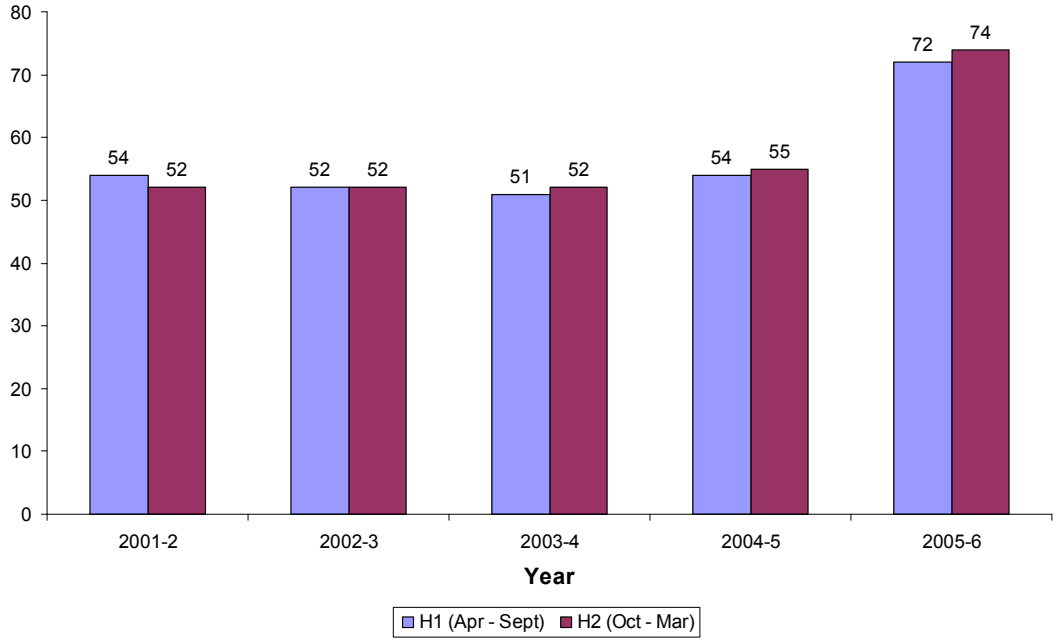
1.2 Funded Organizations

Over 70 community-based organizations receive funding to provide HIV services

Between 2001/02 and 2004/05, the number of organizations funded by the AIDS Bureau remained relatively stable. With the introduction of OCHART, the number of organizations funded by the AIDS Bureau and/or the Public Health Agency of Canada increased from 54 to 72 in the first half of 2005/06 and to 74 in the second half of the fiscal year. The increase is due to:

- 16 Injection Drug Use (IDU) Outreach Programs, which are now included instead of being counted separately
- Organizations funded by PHAC under the new ACAP funding cycle for time-limited projects, which began April 1, 2005
- Additional organizations funded by the AIDS Bureau during 2005/06.

Figure 2a: Number of Funded Community-based Organizations



Of the 74 organizations funded in the second half of 2005/06: 30 received funding from *both* the AIDS Bureau and PHAC; 40 from the AIDS Bureau; and 4 from PHAC. (Note: organizations also received funding from other sources. See page 12.)

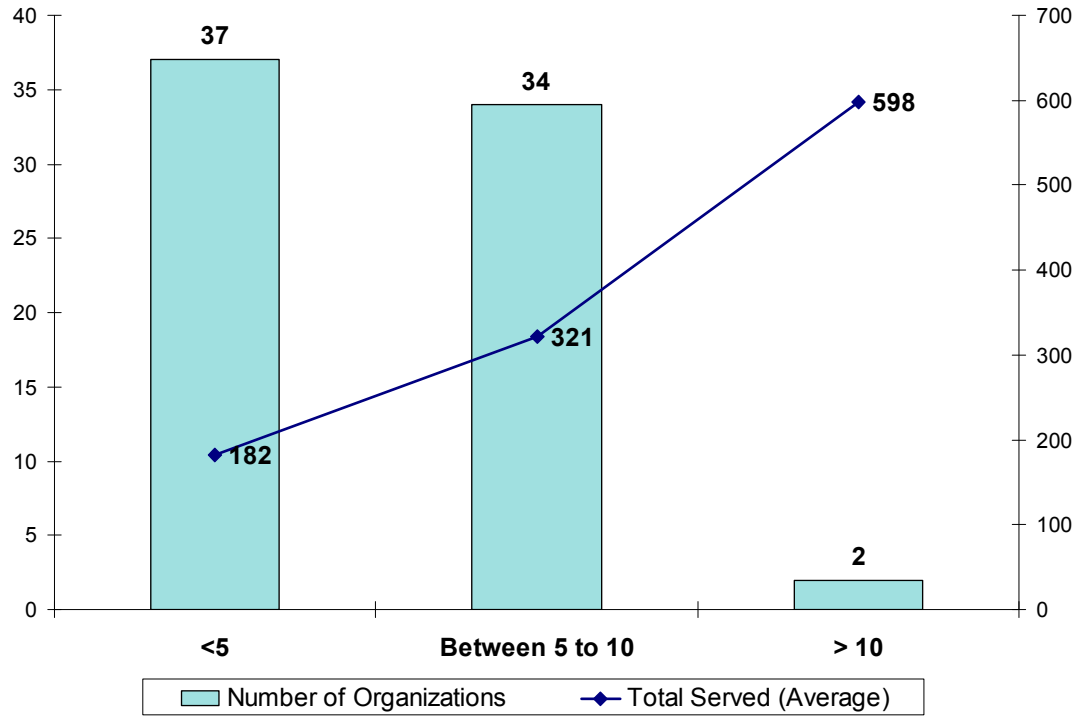
Although 74 organizations were funded in the last half of 2005/06, this report includes data from only 73. For the list of funded organizations that provided information for this report, please refer to Appendix A.

97% of funded organizations have 10 or fewer staff

Most funded programs are relatively small (see Figure 2b): in the last half of 2005/06, about half (37) had fewer than five staff, 34 had between five and 10 staff, and only two had more than 10 staff. As would be expected, the larger the number of staff, the higher the number of clients served (i.e., with support services): in the second half of 2005/06, agencies with fewer than five staff served an average of 182 clients, agencies with five to 10 staff served an average of 321 clients, and agencies with more than 10 staff served an average of 598 clients.

In addition to providing support services for individual clients, many funded agencies provide HIV education and prevention services for the population in their catchment areas.

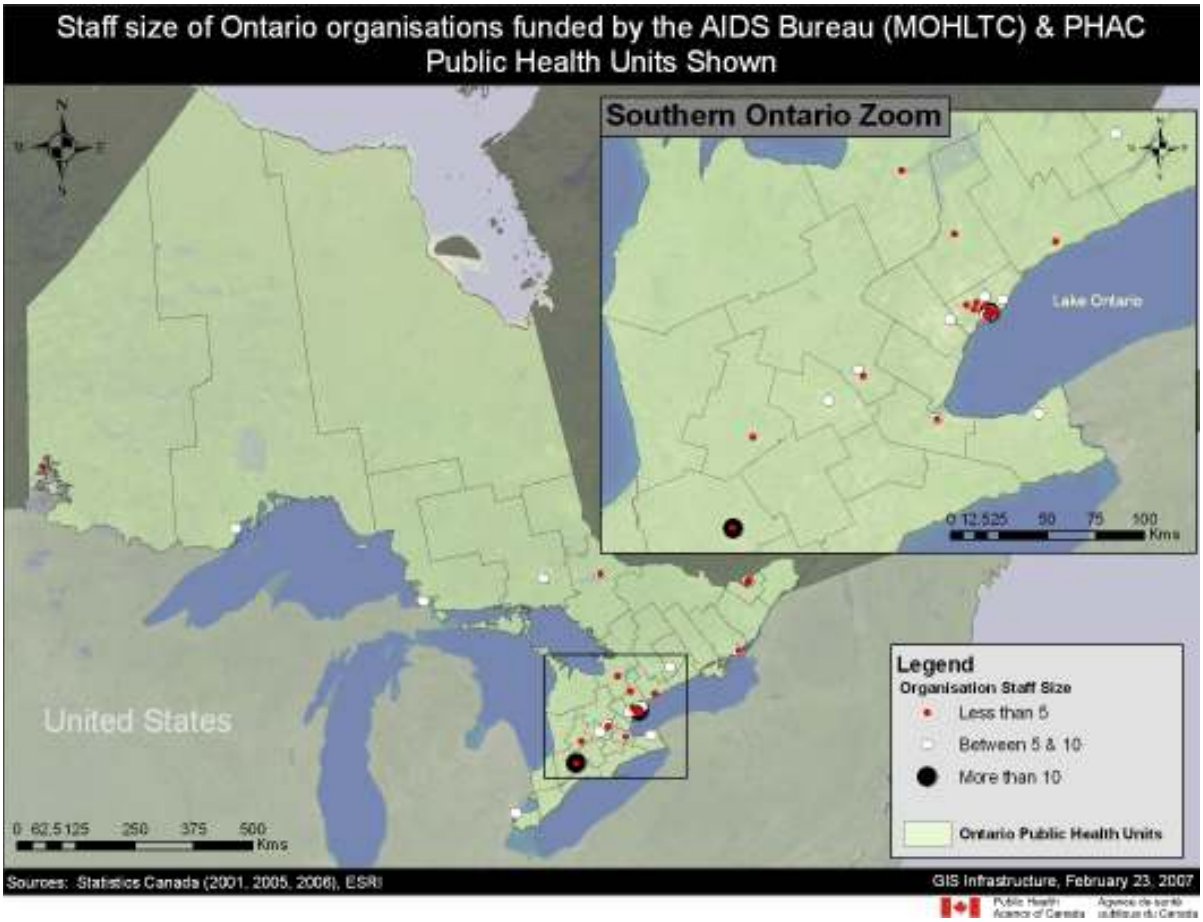
Figure 2b: Size of HIV Programs (# of staff) and Clientele Served



Organizations are located across the province – mainly in urban centres

Figure 3a shows where the funded organizations are located across the province. Most agencies are clustered in larger urban areas. Over half are located in and around the Greater Toronto Area; however, some of these agencies (e.g., OAN, PASAN, CATIE) provide services for the entire province.

Figure 3a: Location and Staff Size of Community-based Organizations



Most organizations in the Greater Toronto Area are located in the downtown core (Figure 3b).

Figure 3b: Location and Staff Size of Organizations in the Greater Toronto Area

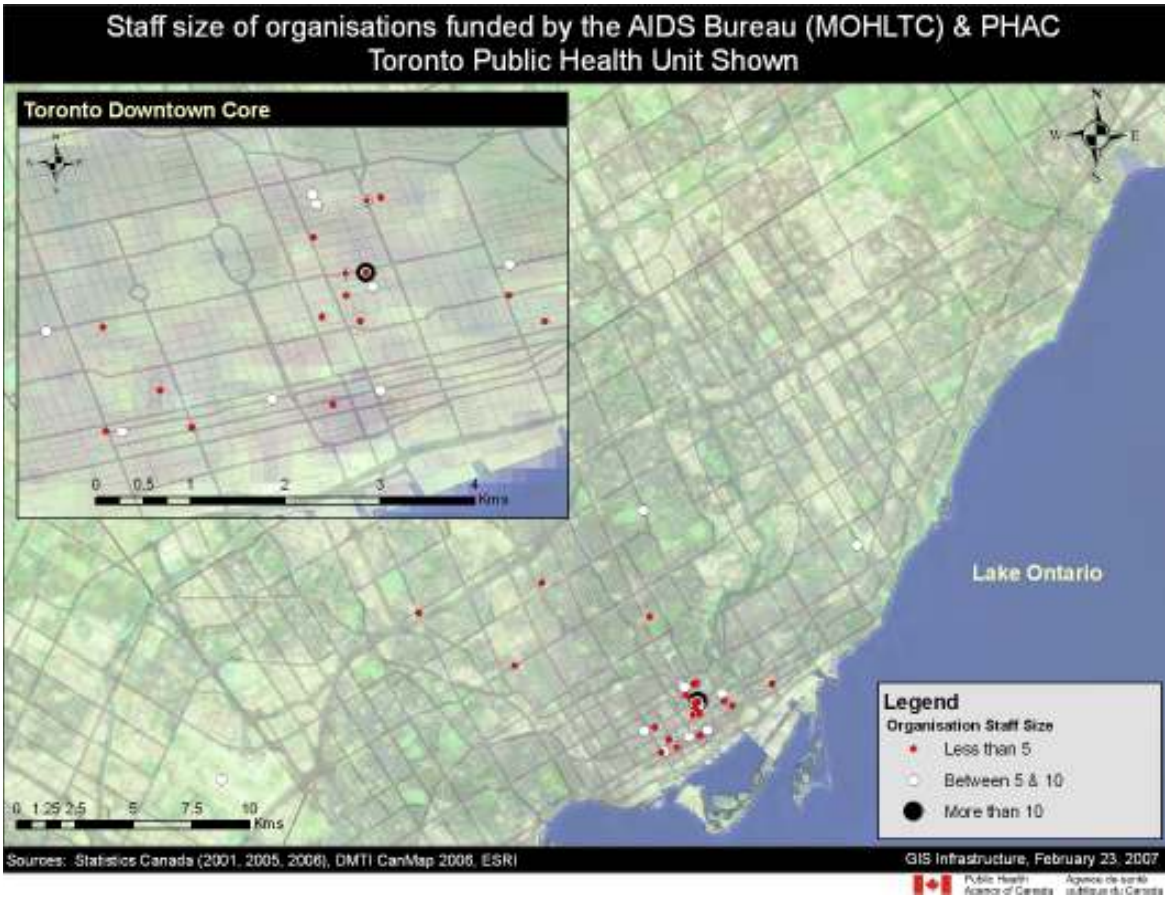
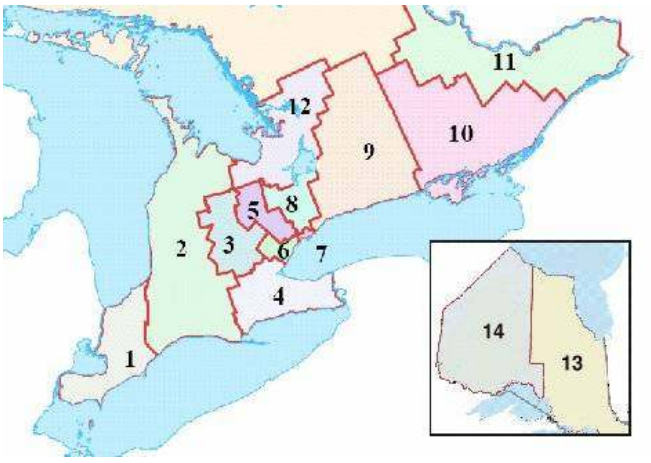


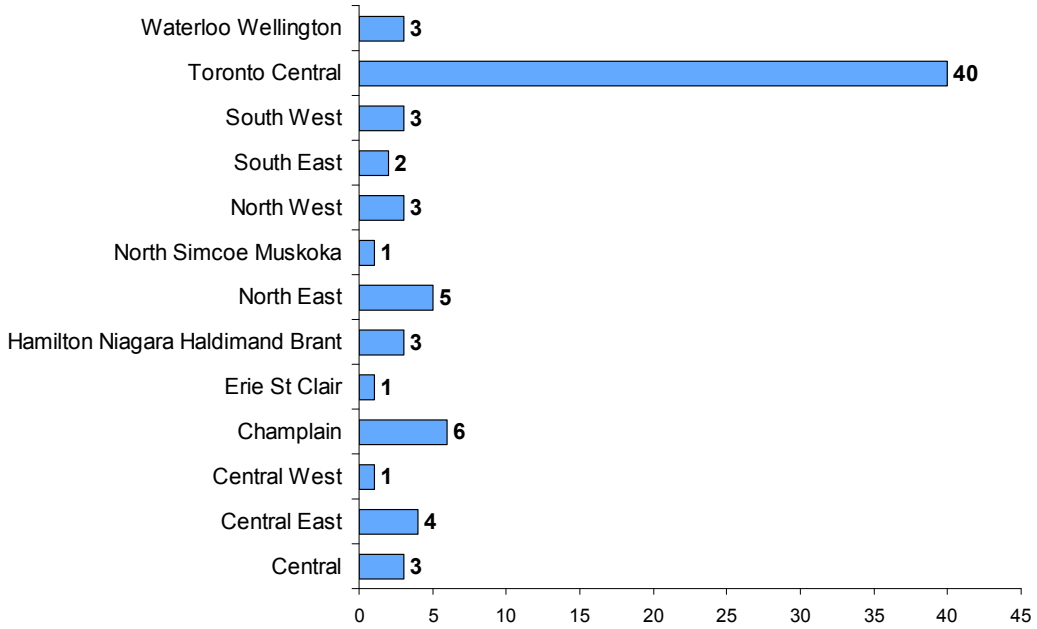
Figure 3c shows the geographic planning areas for each of the province's Local Health Integrated Networks, and Figure 3d indicates the number of funded organizations in each LHIN.

Figure 3c: Ontario's Local Health Integration Networks (LHINs)



1. Erie St. Clair
2. South West
3. Waterloo, Wellington
4. Hamilton, Niagara, Haldimand, Brant
5. Central West
6. Mississauga, Halton
7. Toronto Central
8. Central
9. Central East
10. South East
11. Champlain
12. North Simcoe, Muskoka
13. North East
14. North West

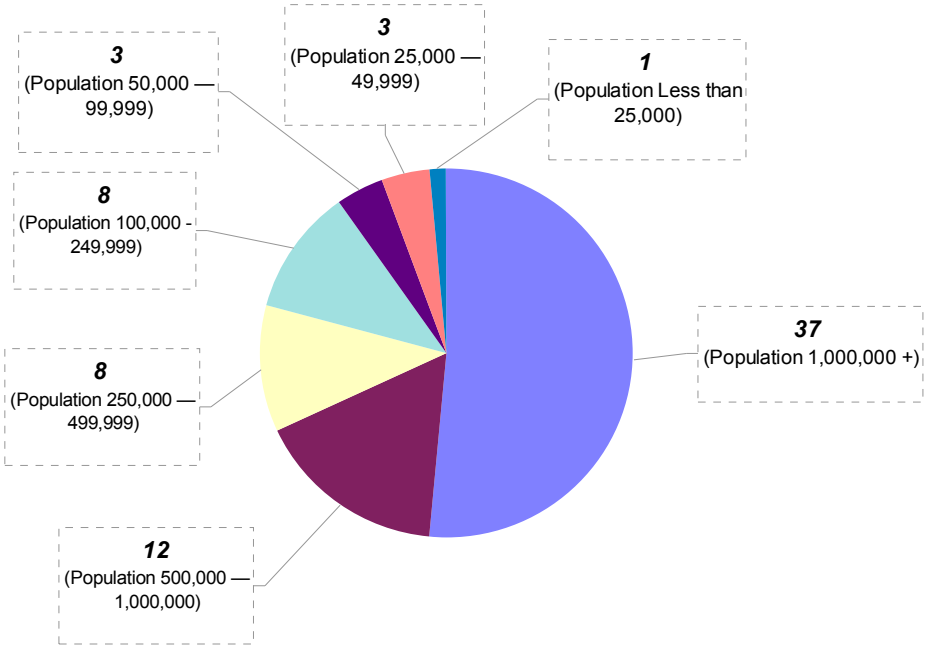
Figure 3d: Number of Funded Organizations by LHIN



Geography affects the demand for services

The organizations vary significantly in the size of the population in their catchment area (Figure 3f), which ranges from fewer than 25,000 to over a million. Organizations also vary in the size of their catchment area (see Figure 3b). A significant number of smaller agencies serve large, sparsely populated areas, which has implications for program delivery.

Figure 3e: Number of Organizations within Specific Catchment Populations

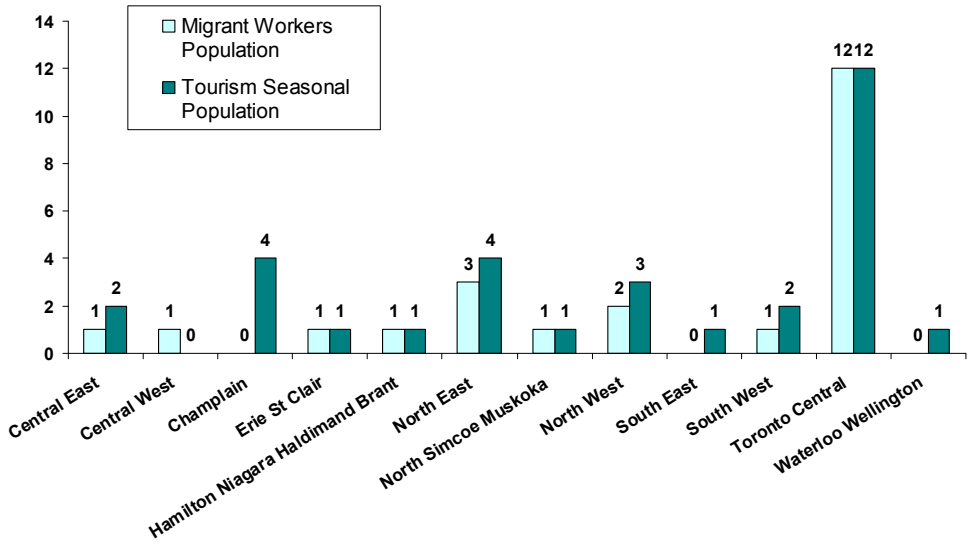


A number of organizations serve migratory and seasonal populations

Because of where they are located in the province, some community-based organizations serve a population that will vary or shift over the year. In the second half of 2005/06, over 40% of agencies reported serving seasonal populations, while almost one-third serve a migrant population, and just over 20% are facing border-related issues (e.g., clients from other provinces or the US, large immigrant or refugee populations).

As Figure 3f illustrates, there are agencies in almost all LHIN areas that serve shifting populations. Organizations with large seasonal or migrant populations will see surges in demand at certain times of the year, and may need different program and staffing strategies to meet client needs.

Figure 3f: Number of Organizations Serving Migratory & Seasonal Populations by LHIN

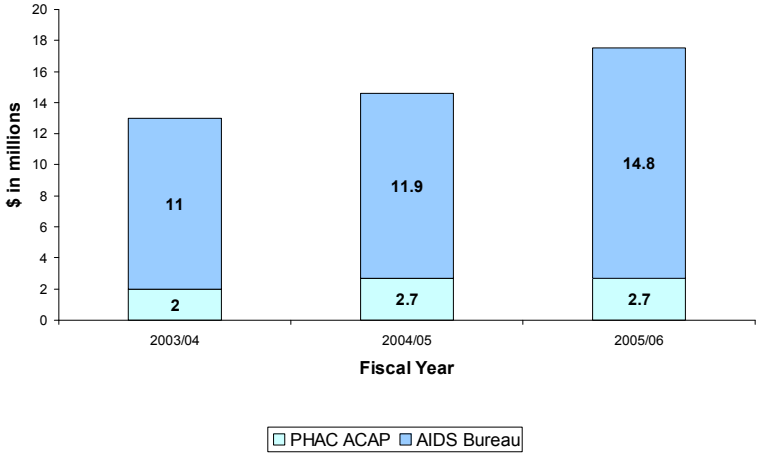


1.3 Funding Levels and Sources

AIDS Bureau and PHAC funding increased between 2003/04 and 2005/06.

Figure 4a illustrates the total amount of funding provided by the AIDS Bureau and the Ontario Region of PHAC ACAP program each year from 2003/04 to 2005/06. Over that period, both PHAC and AIDS Bureau funding increased by about 35%. In the case of the AIDS Bureau, funding increased from $11 million to $14.8 million a year, while PHAC funding increased from $2 million to $2.7 million a year.

Figure 4a: Annual AIDS Bureau and PHAC Funding



Almost all organizations funded by the AIDS Bureau and/or Ontario Region of PHAC receive funding from other sources (e.g., Trillium, United Way, fundraising). According to a 2004 report developed by the Ontario AIDS Network[1] (OAN), between 1995 and 2002, the proportion of funding from sources other than the AIDS Bureau and ACAP increased steadily. Based on data collected by the OAN, agencies received as much of their funding from fundraising in 2002 as they did from the base operating grants provided by the AIDS Bureau.

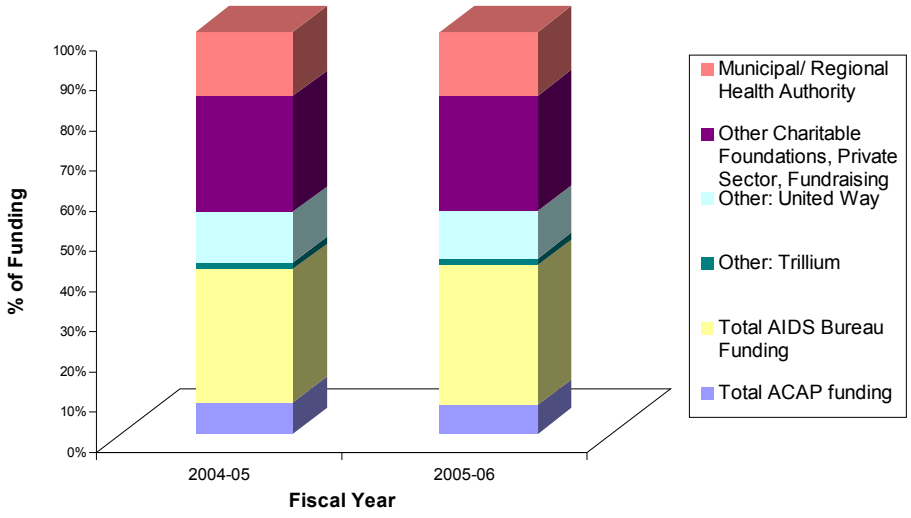
This funding trend may be a strength: having stable base funding allows organizations to leverage money from other sources. It may also be a weakness: according to the OAN report, agencies are now spending a disproportionate amount of time on fundraising and are more reliant on unstable sources of funding (e.g., fundraising, short-term project grants). This affects their capacity to deliver front-line services. The growing competition among non-profit organizations for fund-raised dollars is also an issue: organizations are reporting that it is becoming more difficult to sustain the levels of private donations they received in the past.

In an effort to understand funding trends and assess their impact on programs and services, OCHART asked funded organizations to provide information about funding sources and the amount of funding they receive from each source.

Figure 4b indicates the proportion of funding that organizations reported receiving from various funding sources in 2004/05 and 2005/06. Despite an almost 35% increase in funding from the AIDS Bureau in 2005/06, organizations continue to receive more than half their funding from other sources. However, when funding from municipal and regional health authorities is taken into account, at least 61% of organization funding in 2005/06 came from government sources. This means that fundraising accounts for slightly less than 40%. In 2004/05 and 2005/06 respectively, organizations reported over $14.3 and $14.8 million in fundraised dollars, compared to $21.3 and $23.6 in funding from government sources.

(Note: Figure 4b does not include significant additional funding that some organizations – such as community health centres – receive from other provincial and federal government programs to support other activities.)

Figure 4b: Proportion of Total Organization Funding by Source



[1] Ontario AIDS Network. *Stemming the Tide: The Case for More Investment in Community-based HIV/AIDS Prevention and Support.* January 2004.

1.4 Who Are We Serving?

OCHART requested funded organizations to identify the type of risks that their target populations faced during the reporting period. The risk categories used in OCHART are the categories used in epidemiological data reports and on the HIV test requisition form. The AIDS Bureau and PHAC are aware that these categories are not widely used in the community; however, they are used here so OCHART reports can be compared with epidemiological data to determine whether services are reaching people living with HIV and populations at risk.

Organizations report serving people with a wide range of risk factors

Figure 5a indicates the number of organizations in each OCHART reporting period who reported serving clients with particular risk factors for HIV. About 80% of funded organizations reported serving gay men, high risk heterosexuals, and injection drug users. A smaller proportion (approximately 60%) reported serving low risk heterosexuals, people from countries where HIV is endemic, and MSM/IDU. During 2005/06, there was an increase in the number of organizations reporting serving clients with almost every risk factor – the increase was most significant for injection drug or substance use and for people from countries where HIV is endemic. Part of the increase may be due to more agencies responding to this question in the second half of the year, while part may be due to changing client mix.

Figure 5a: Populations Served by Risk Factor

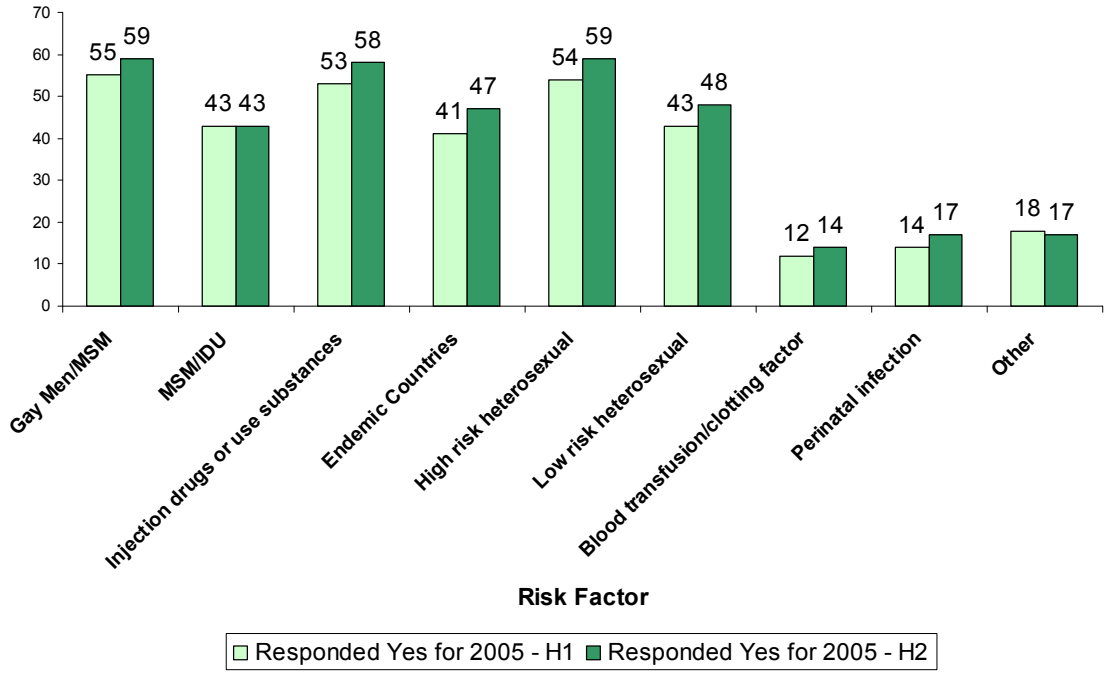
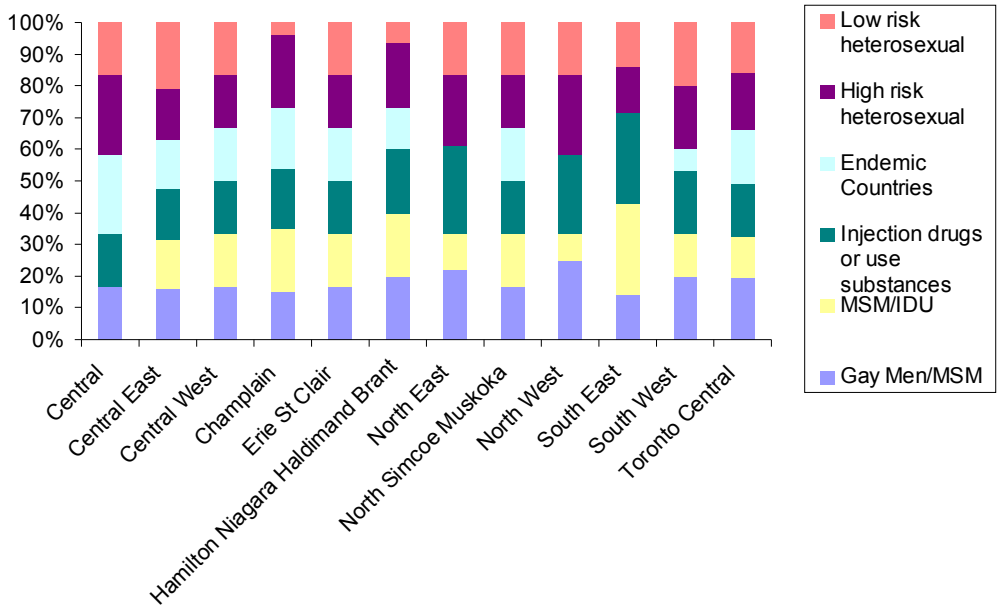


Figure 5b shows the relative mix of risk factors clients faced in each LHIN region (see Figure 3d) – among the organizations that indicated they serve particular target populations (5a). (Note: the number of clients with transfusion-related or perinatal risk factors is so small; these risk factors do not appear on the graph.)

Figure 5b: Proportion of Risk Factor Prevalence by LHIN



As would be expected given the regional differences in Ontario's HIV epidemic, injection drug use is a significant risk issue for organizations in the north, while organizations serving large urban centres in the southern part of the province see more clients from countries where HIV is endemic. It is difficult to draw conclusions about the relative prevalence of risk factors in each region or the extent to which all target populations are being served because not all organizations responded to this question.

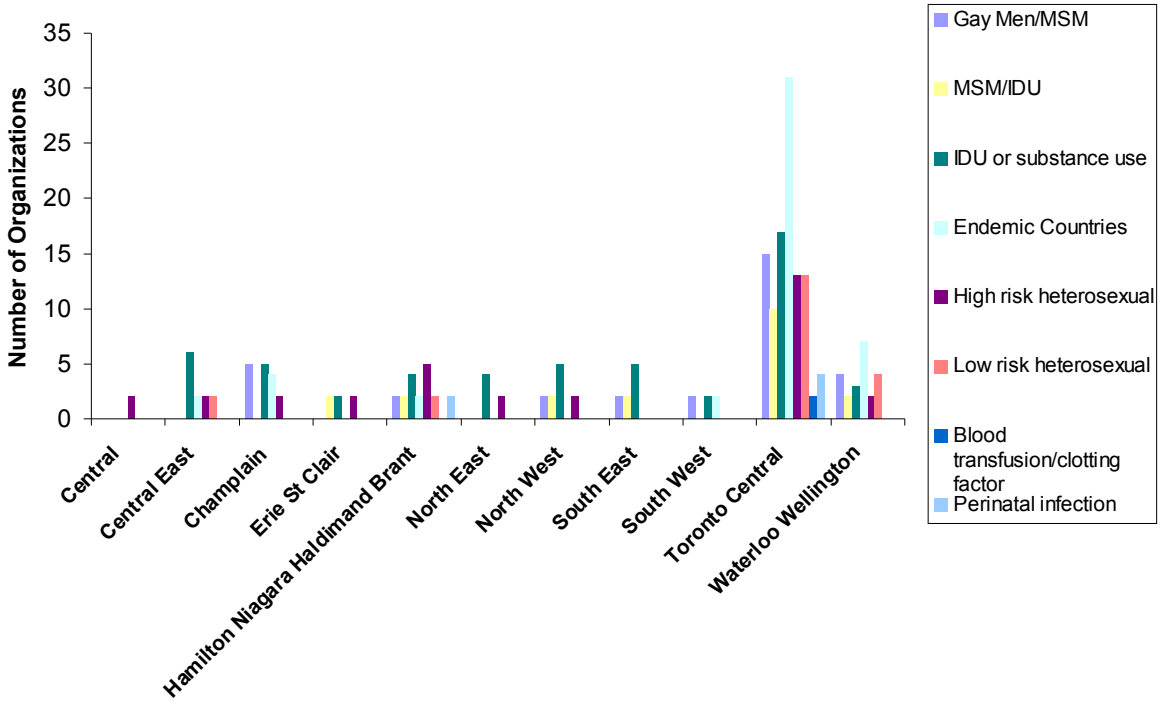
Organizations are seeing an increase in clients who use substances, people from countries where HIV is endemic and gay men

Organizations were also asked to indicate whether they observed any changes in risk factors. Over 30% reported increases in clients who use substances, more than one-quarter reported increases in clients from countries where HIV is endemic, and 20% reported increases in clients who are gay men.

Figure 6 illustrates the risk factors that increased during the year by LHIN. For example, organizations in the South East region reported a significant increase in injection drug or substance use, and moderate increases in men who have sex with men (MSM) and MSM/IDU. Central Region reported an increase only in high risk heterosexuals, while organizations in Toronto Central reported increases in almost

all the populations served. Across all regions, the most consistent increase appears to be in clients who inject drugs or use other substances. This may be due to more people who use substances seeking services/support from community-based organizations. It should be noted that these data reflect increases in people using services as opposed to increases in new infections.

Figure 6: Changes in Risk Factors by LHIN

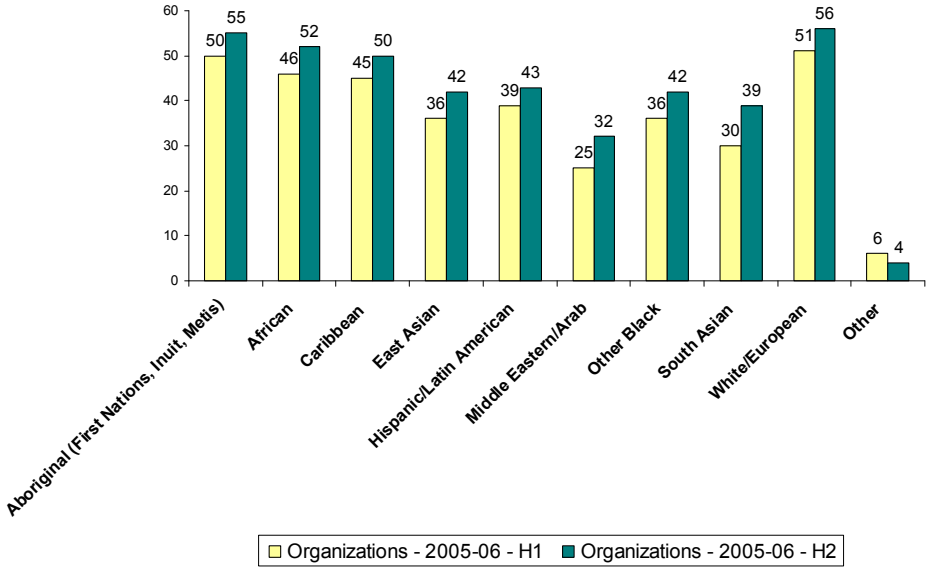


Organizations are serving more culturally diverse clients

Community-based organizations are serving culturally diverse populations (see Figure 7a).

For example, over half of funded agencies are serving clients from all ethnic groups, except Middle Eastern/Arab. Between the first and second halves of 2005/06, the number of agencies providing services increased for all races. The most

Figure 7a: Race/Ethnicity of Populations Served



significant increases occurred in the number of agencies seeing South Asian (30%) and Middle Eastern/Arab clients (28%). There was also an increase (14%) in the number of organizations serving black populations (i.e., African, Caribbean and other black). Some of the increase may be due to the recent increase in the number of ethno-specific organizations receiving funding; however, it appears that more community-based organizations are serving people from a variety of ethnic backgrounds. It should be noted that data on race and ethnicity are based on the agencies' subjective assessment: more detailed, consistent client-level data would be required to confirm where people with HIV and people at risk are being served.

Figure 7b shows the number of organizations in each LHIN that report serving each racial/ethnic group. As would be expected, organizations in regions that include large urban centres like Toronto and Ottawa are serving a more ethnically diverse client group than those in northern and more rural regions.

Figure 7b: Race/Ethnicity of Clients Served by LHIN

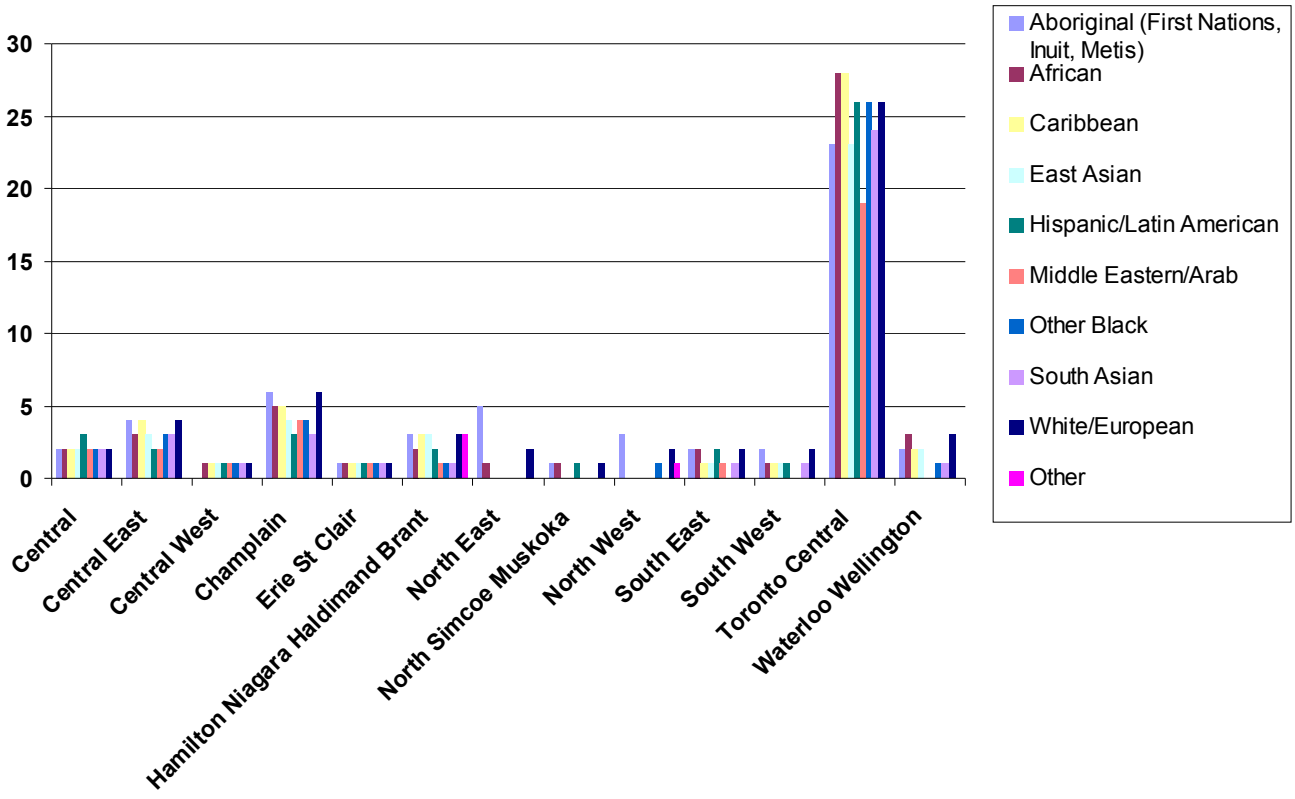
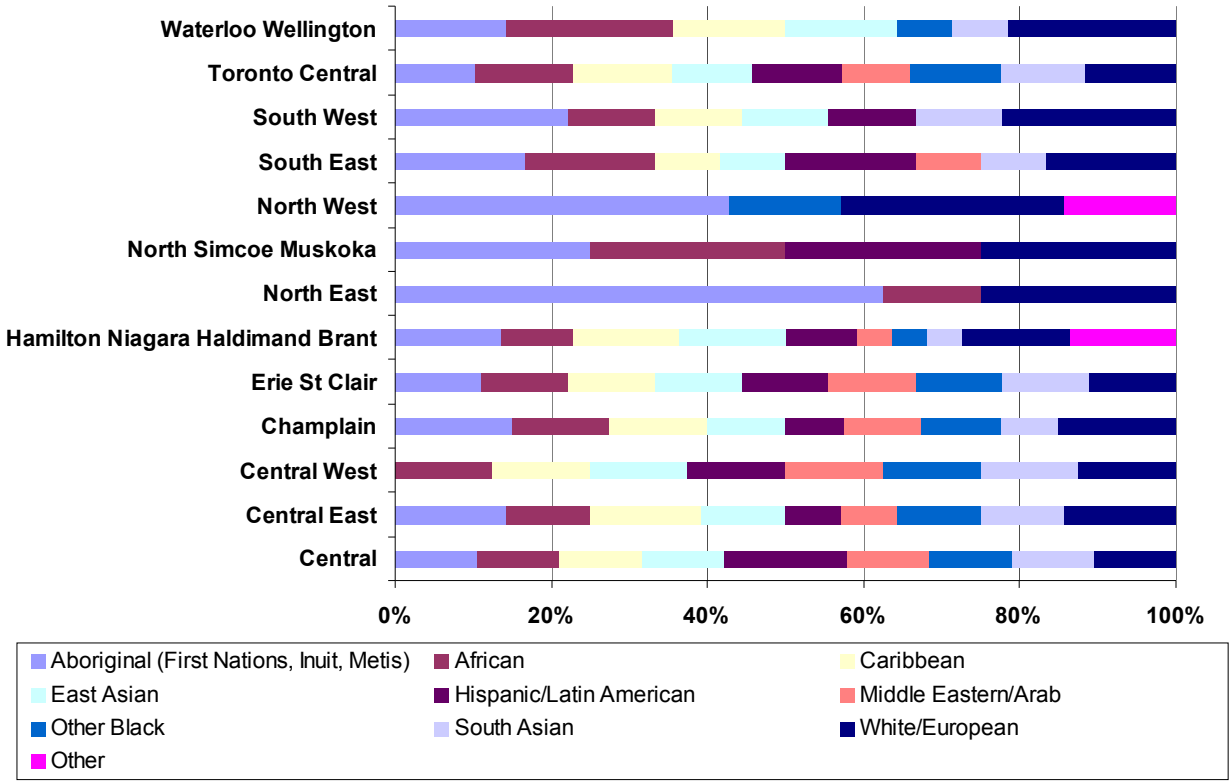


Figure 7c illustrates the mix of racial/ethnic groups served within each region.

Figure 7c: Proportion of Ethnic Groups Served by LHIN



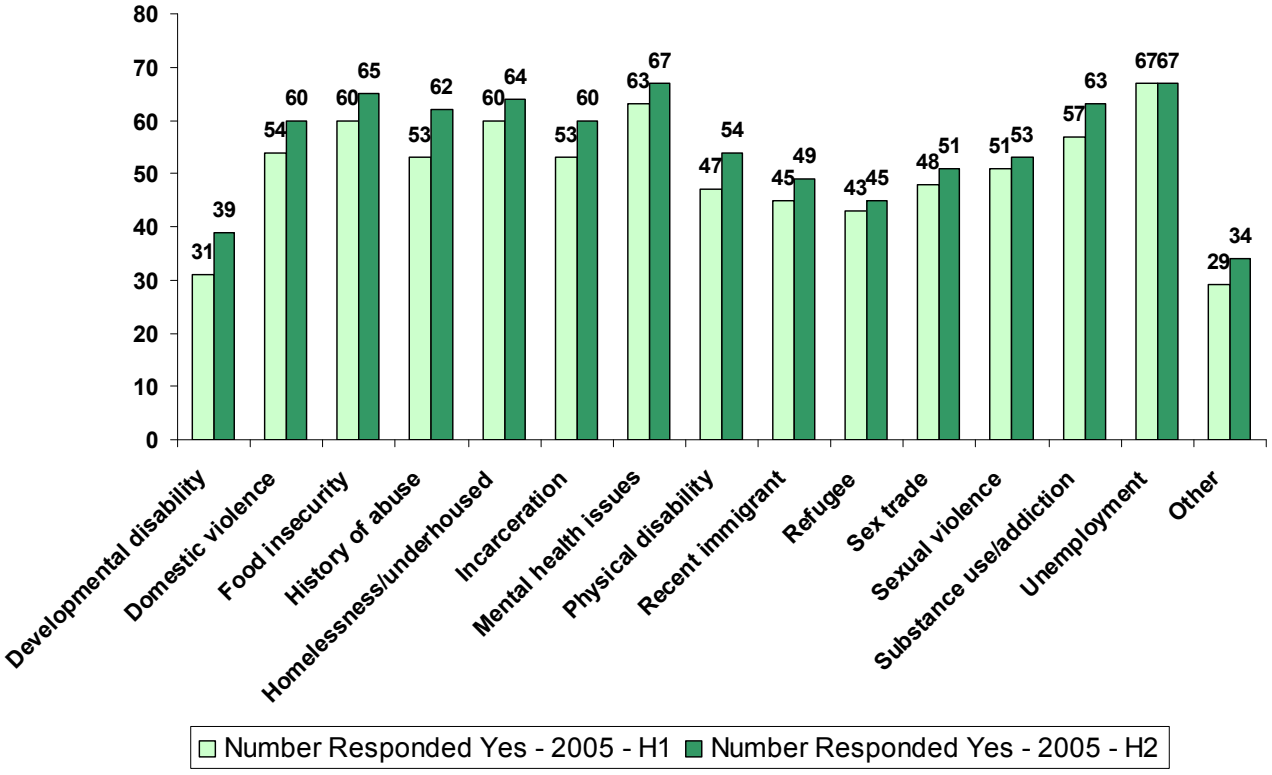
Organizations are serving clients with complex health and social needs

OCHART also asked organizations to identify the health and social issues that their clients/target populations faced during the reporting period. The health and social factors mentioned by the greatest number of organizations in the second half of 2005/06 included: unemployment (89%), mental health issues (89%), food insecurity (87%), homelessness/being underhoused (85%), substance use/addiction, history of abuse (83%) and domestic violence (80%) (see Figure 8).

Between the first and second half of 2005/06, the number of agencies reporting these issues increased for every issue except unemployment – and they increased significantly for those reporting clients with a history of abuse, domestic violence or incarceration, and clients with a physical or developmental disability. The increase may reflect an increase in clients with these issues or the fact that provincial and federal HIV/AIDS strategies (as well as OCHART reporting) are encouraging organizations to take a determinants-of-health approach to HIV prevention and support, and identify client's broader health and social needs. Regardless of the

reason for the increase, it reinforces the need for comprehensive programs and services that meet people's health, psychosocial, social and economic needs.

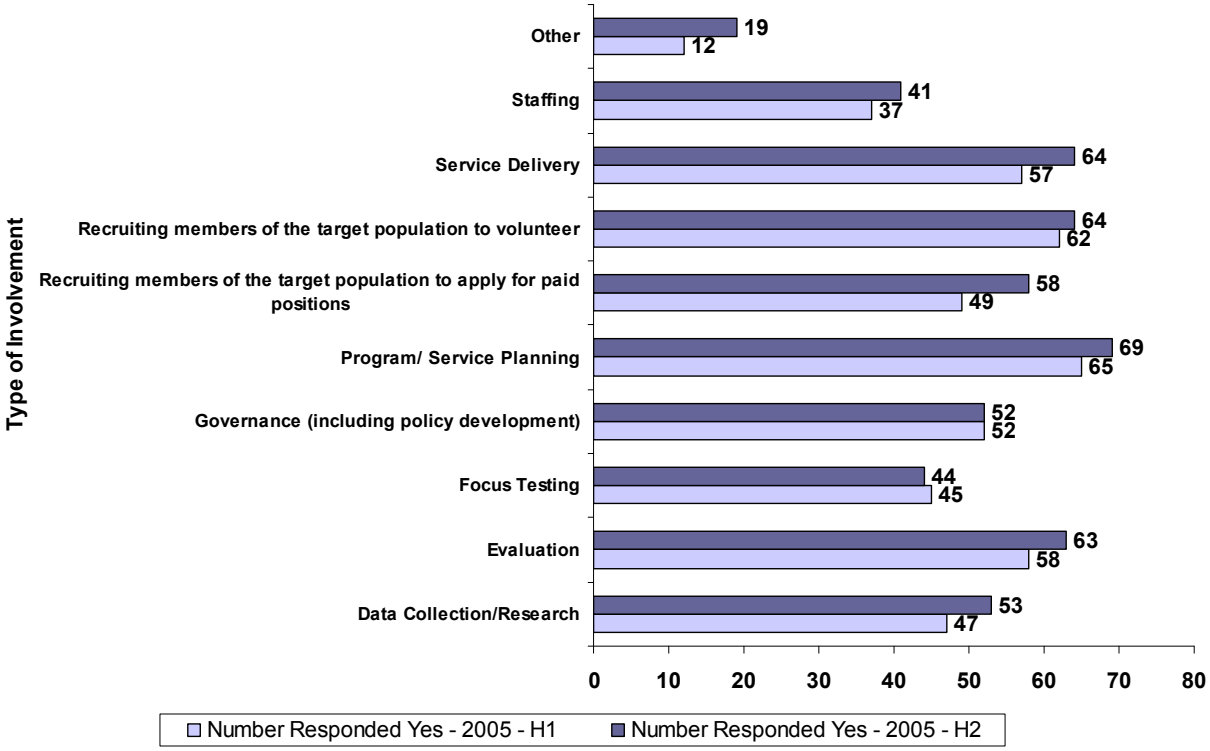
Figure 8: Health and Social Factors Affecting Target Populations



More organizations are involving clients in services

One of the goals of the provincial, federal and the pan-Canadian strategies is greater involvement of people living with HIV/AIDS (GIPA) and populations at risk in planning and delivering services. OCHART requested organizations to indicate how they are involving their target populations. As Figure 9 illustrates, community-based organizations are most likely to involve members of their target populations in planning, service delivery, and evaluation. Over two-thirds of organizations actively recruit members of their target populations to volunteer and/or to apply for paid positions, and almost two-thirds involve members of their target population in governance. Over half have people on staff who are members of their target population.

Figure 9: Target Population Involvement



Over the two OCHART reporting periods, the number of agencies involving their target populations either remained stable or increased for all activities. It may be that asking this type of question and explicitly suggesting ways to involve people has encouraged more organizations to re-assess their practices.

1.5 Partnerships

Community-based HIV/AIDS organizations are expected to develop and maintain partnerships with other organizations that will enhance services for people living with HIV and populations at risk. OCHART defines three types of partnerships:

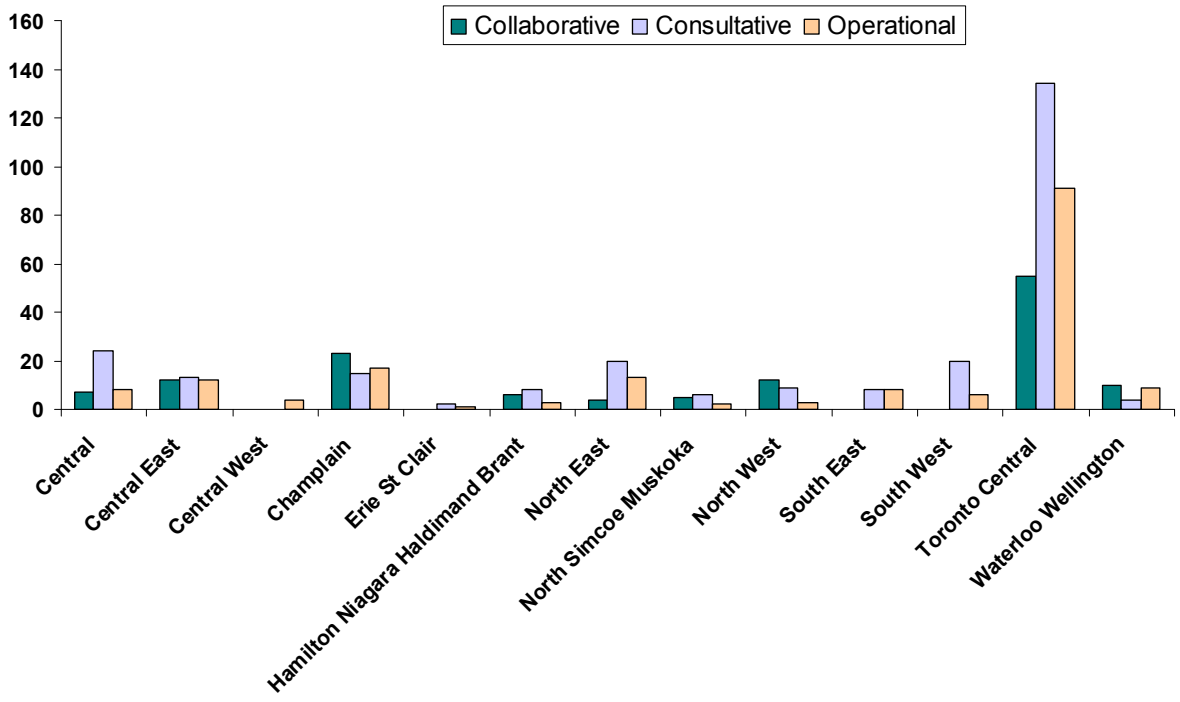
- Consultative -- Organizations share information. Activities include providing information, resources, referrals or skills development.
- Operational -- Organizations share work as well as financial and other support, and work together to achieve common goals and objectives. Activities include sharing meeting space, joint fundraising events, and joint management of support groups
- Collaborative -- Organizations share decision making. Partners develop consensus and share responsibility for outcomes.

During the OCHART reporting year, virtually all organizations were involved in the community planning initiative, which was designed to help them develop new partnerships and strengthen existing ones.

Organizations are sharing resources to achieve common goals

Figure 10 is a summary of the number and type of partnerships among organizations reported by LHIN region. The most common type of partnership is operational: organizations sharing resources to provide programs and services.

Figure 10: Number of Partnerships by Type and by LHIN

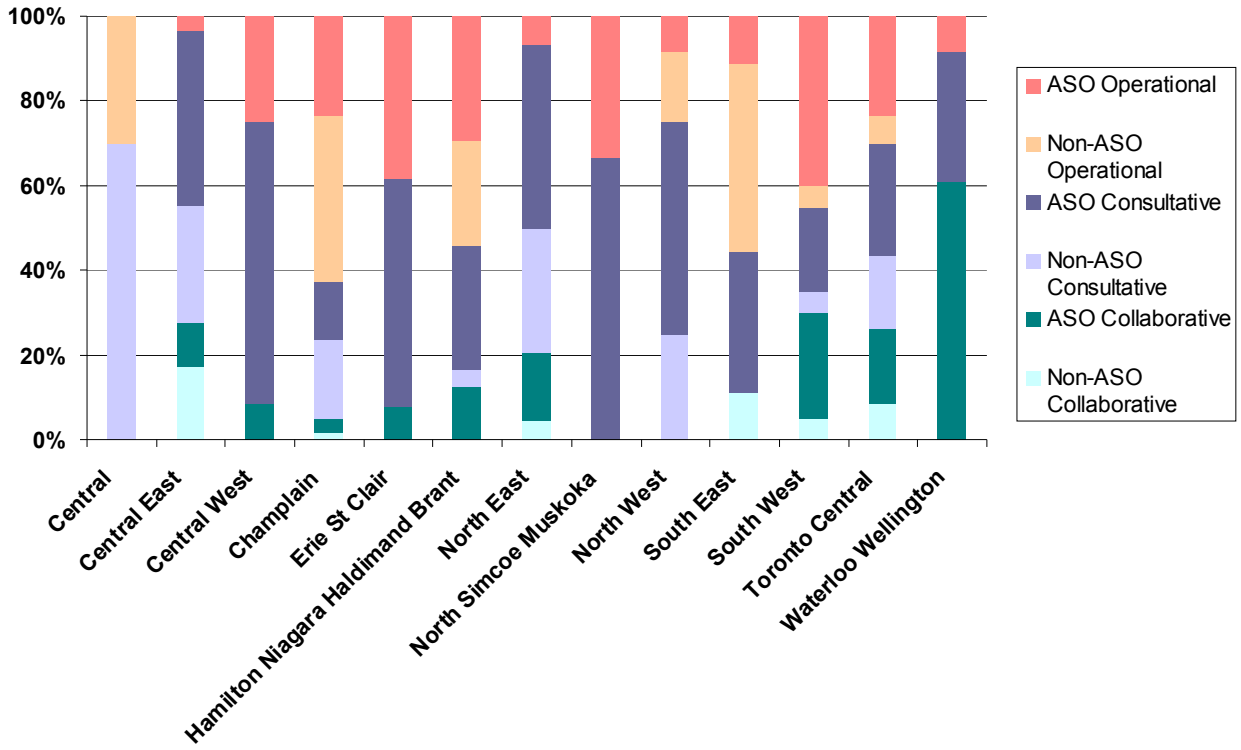


As would be expected, more partnerships are reported in Toronto Central because there are a greater number of organizations in that region. It will be interesting to track responses over time to see whether organizations gradually develop more collaborative partnerships. It will also be interesting to assess the impact of the type of partnership on services provided and client outcomes.

Figure 11 illustrates the proportion of partnerships reported in each LHIN region with other HIV/AIDS organizations and with non-AIDS organizations by type of partnership (i.e., operational, consultative, collaborative). According to the 2005/06 reports, the majority of partnerships are consultative partnerships with other HIV/AIDS organizations. The LHIN regions that have been most effective in building partnerships outside the HIV sector are Central East, North East, Toronto Central and South West. In some cases, this may be due to the small number of HIV organizations within a geographic area; in others, it may be due to a commitment to

provide integrated services for clients. Over time, these data can be tracked to determine whether HIV/AIDS programs are able to develop more partnerships with non-AIDS organizations and whether these partnerships lead to better services for clients.

Figure 11: Proportion of Partnerships by Type of Partner

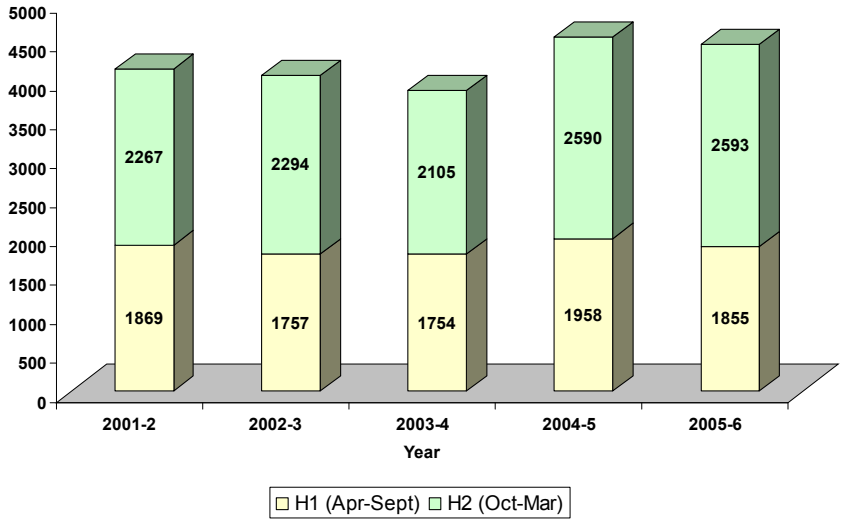


2. Education and Prevention Activities

Organizations are giving more education presentations

A significant proportion (85%) of funded organizations completed the OCHART questions on prevention and education programs. Figure 12 shows the trend in the number of education presentations given by funded organizations over the past five years. The total number of presentations given each year ranged from a low of 3,859 in 2003/04 to a high of 4,548 in 2004/05. As would be expected, fewer presentations are given in the first half of the fiscal year (April to September) than in the fall or winter.

Figure 12: Number of Education Presentations Given by Funded Organizations



The drop in the total number of presentations in 2003-04 may be due to a number of factors, including the outbreak of SARS in Toronto, which limited many activities. It may also reflect the lack of capacity within agencies and high rates of staff turnover. According to a 2003 Ontario AIDS Network survey of community-based AIDS organizations, at least 50% reported that they had cut back their prevention and education programming, as well as other services, in order to manage their limited resources.

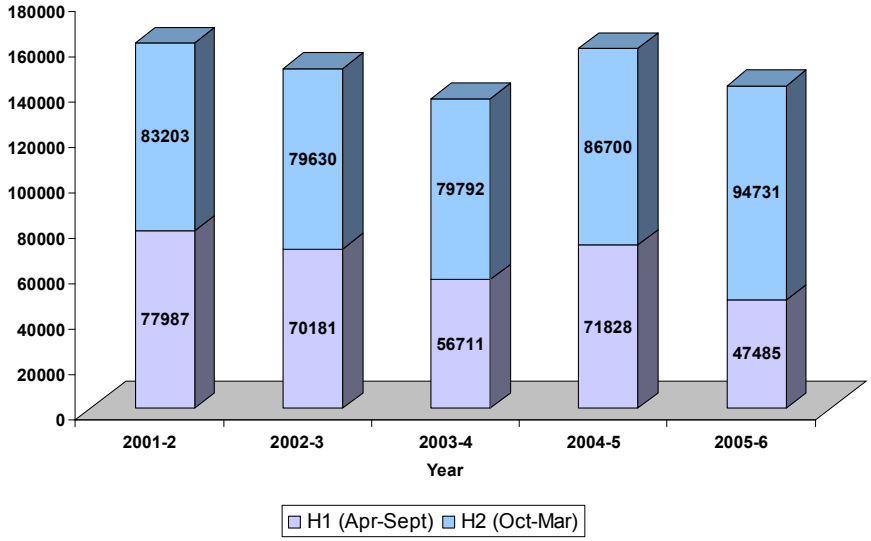
The increase in 2004/05 may reflect the impact of the increase in PHAC funding for prevention programs. It may also reflect the AIDS Bureau's renewed focus on prevention. The slight drop in activities in 2005/06 (4,448) – despite the increase in the number of agencies being funded – is likely due to the shift to the new OCHART reporting tool[2] and the fact that many of the "new" agencies are IDU outreach programs, which do not traditionally report on education presentations.

The total number of people participating in or reached by education presentations ranged from a low of 136,503 in 2003/04 to a high of 161,190 in 2001/02 (see Figure 13). Although funded organizations provided more presentations in 2004/05 and in 2005/06 than in 2001/02, they reached fewer people (158,528 and 137,131 compared to 161,190).

[2] When agencies reported quarterly, there was greater risk of activities being double counted; also, the OCHART training may have provided a clearer definition of the activities to be included in education presentations.

According to organizations that reviewed the data, the 2001/02 numbers may reflect inconsistencies in how organizations were documenting activities and may have overstated the number of people reached. Over the past three years, funded organizations have gained experience with data collection and developed better activity tracking systems, so the recent numbers are likely more accurate.

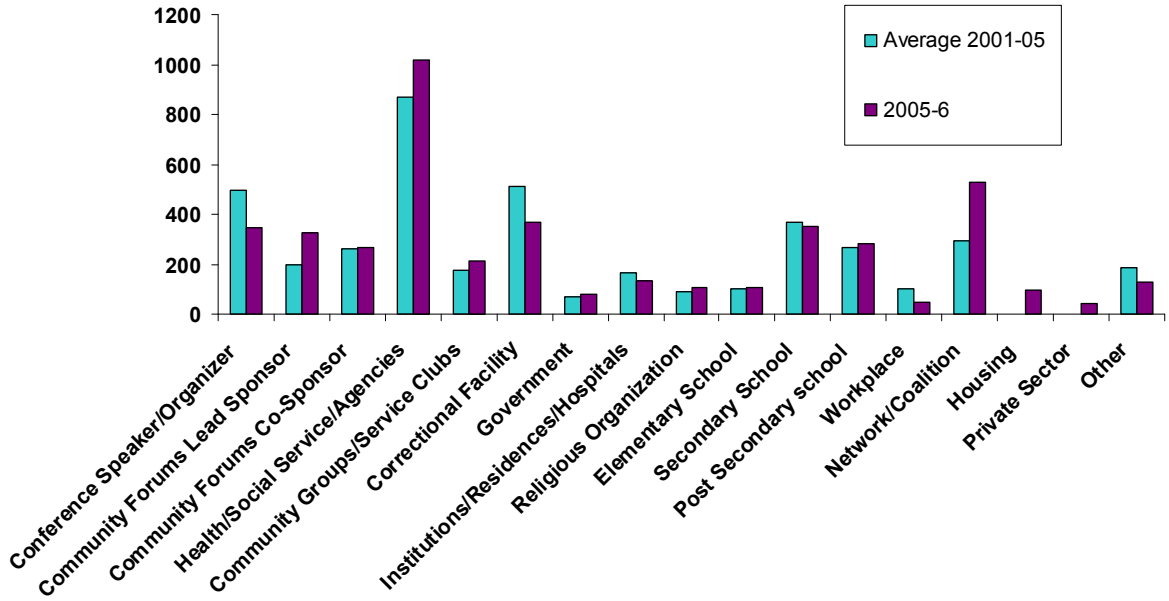
Figure 13: Total Number of People Participating in Education Presentations



Organizations are targeting health and social service agencies

The difference in the number of people reached by education presentations may also be due to changing trends in the target audience/location for presentations. As Figure 14 shows, HIV/AIDS programs gave more presentations to health and social service organizations and to networks/coalitions in 2005/06 than they had in previous years. In these settings, they are likely to be addressing a smaller number

Figure 14: Location of Education Presentations



of people than, for example, workplace presentations.

The increase in presentations to health and social service organizations and to housing groups may reflect the increased emphasis on service coordination for people with HIV and populations at risk, as well as the realization that community-based AIDS organizations cannot meet growing client needs on their own. The 2005/06 increase in presentations to networks/coalitions coincides with the community planning initiative, an AIDS Bureau initiated process that asked all funded organizations to work with other service providers within a defined geographic area to develop networks of services for people with HIV and populations at risk.

Organizations are organizing fewer community development meetings

According to OCHART reports, organizations held or participated in significantly fewer community development meetings in 2005/06 (see Figure 15). This may be a function of the change in reporting. It may also reflect the impact of the community planning initiative: instead of holding a large number of one-to-one meetings with individual agencies, organizations may have held a smaller number of meetings that brought together a range of services in the community to coordinate services for people with HIV and populations at risk.

Figure 15: Number of Community Development Meetings

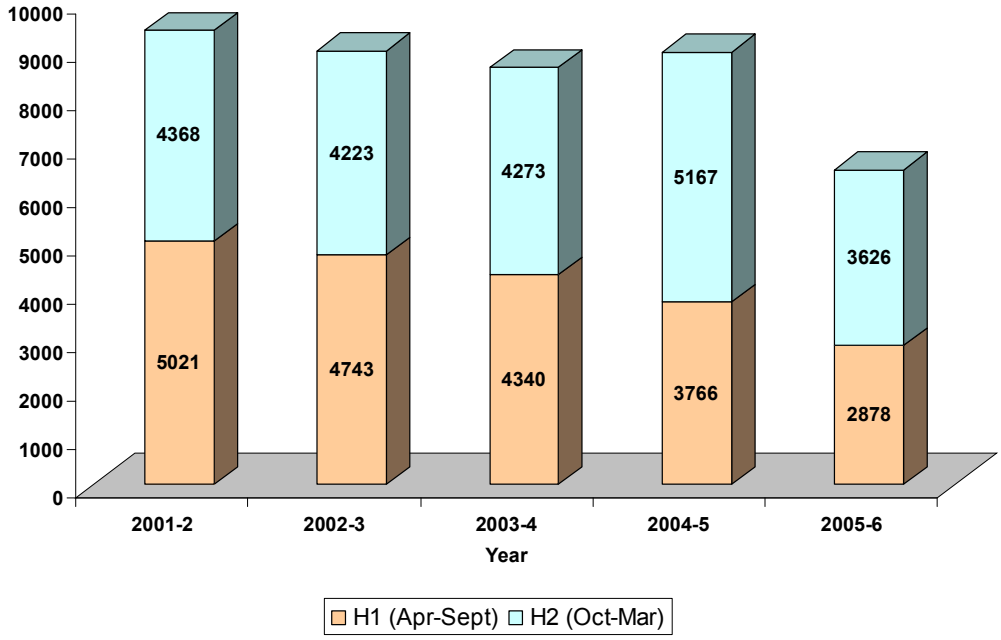
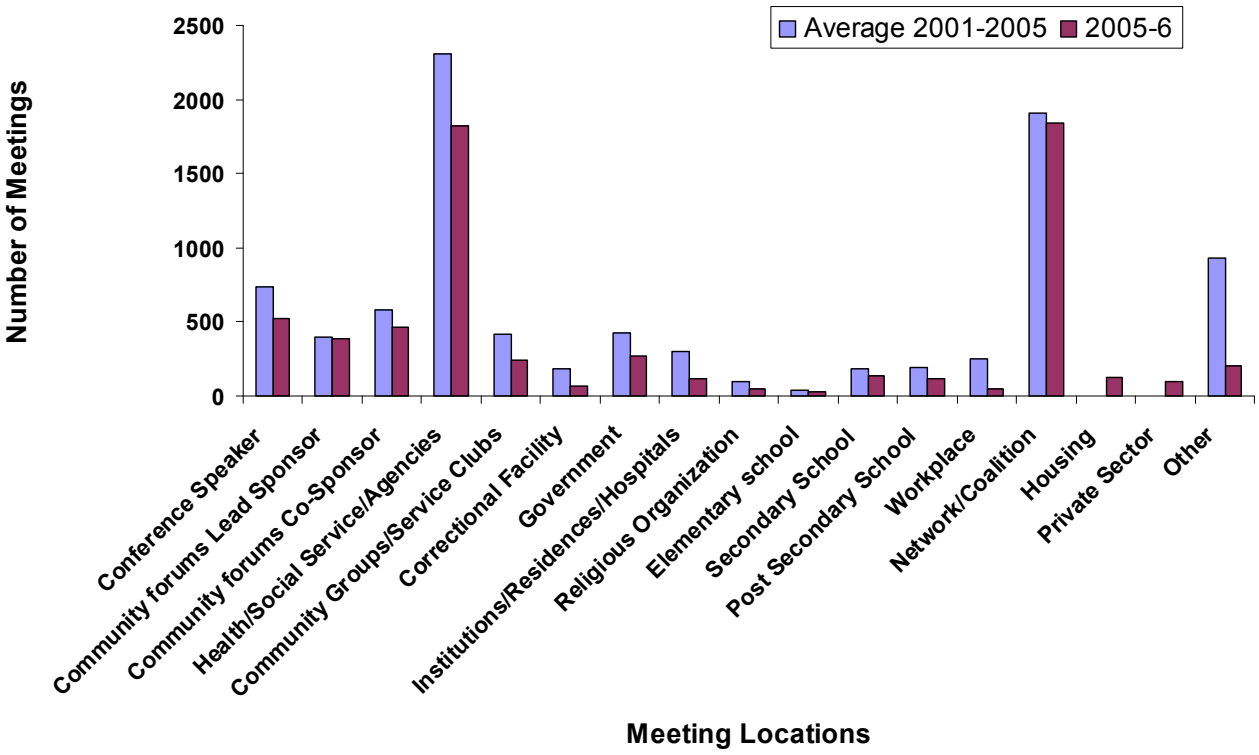


Figure 16: Location of Community Development Meetings



As Figure 16 shows, the majority of community development meetings are held with health and social service agencies and local networks and coalitions – again, likely related to the community planning initiative and ongoing efforts at service coordination.

3. Outreach Initiatives

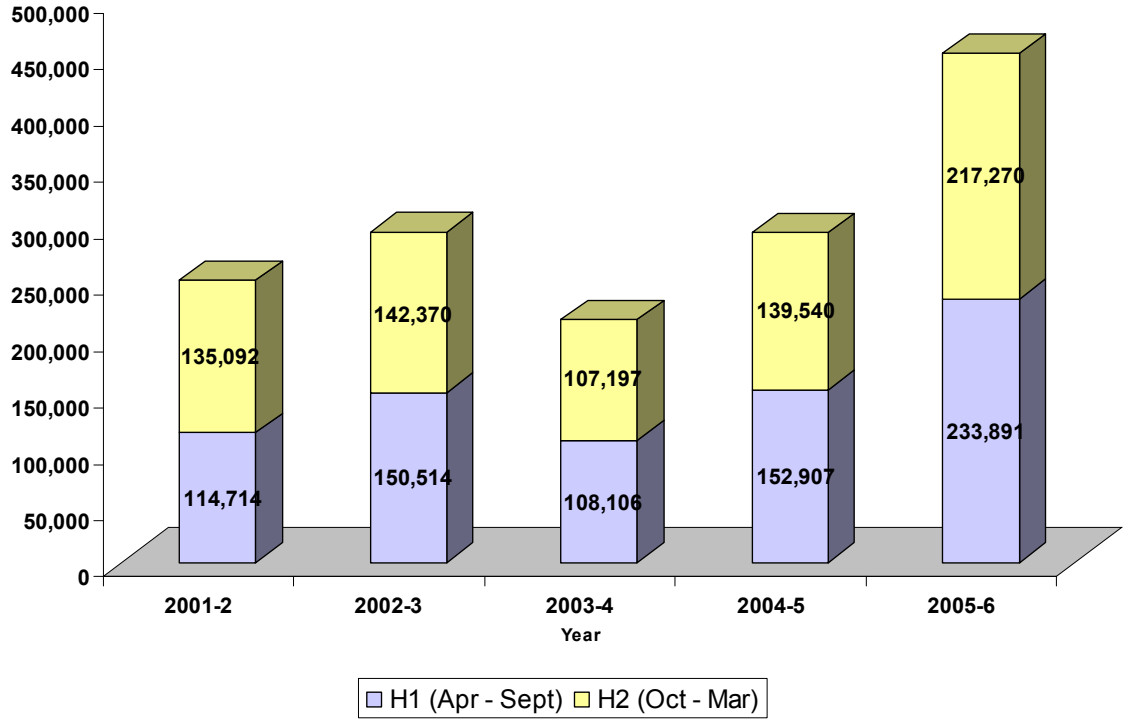
(Note: this section does not include IDU outreach services. Their activities are reported separately in section 6 of this report.)

Organizations funded to provide HIV prevention and education often offer outreach services for populations at risk. This section of the report summarizes data on their outreach activities.

Outreach contacts increased significantly in 2005/06

Over the past five years, the total number of outreach contacts ranged from a low of 215,303 in 2003/04 to 449,663 in 2005/06 (Figure 17).

Figure 17: Total Number of Outreach Contacts



The dramatic increase in outreach contacts in 2005/06 may be due to:

- More effective ways of tracking and counting outreach contacts
- The new organizations funded in that year and their mandate
- A shift in focus by organizations consistent with the focus in both the provincial and federal strategies on vulnerable or at risk populations
- The increased use of Internet technologies in outreach programs.

Locations for outreach prevention programs are changing

The main locations where outreach contacts are made appears to be shifting away from more "traditional" settings, such as steam baths and bars (see Figure 18a), to settings like parties as well as Internet chatrooms, information booths and health fairs (see Figure 18b).

Given the significant number of contacts now being made through the Internet, it will be important to define Internet outreach and identify best practices in providing effective outreach services on-line.

Figure 18a: Number of Outreach Contacts by Location

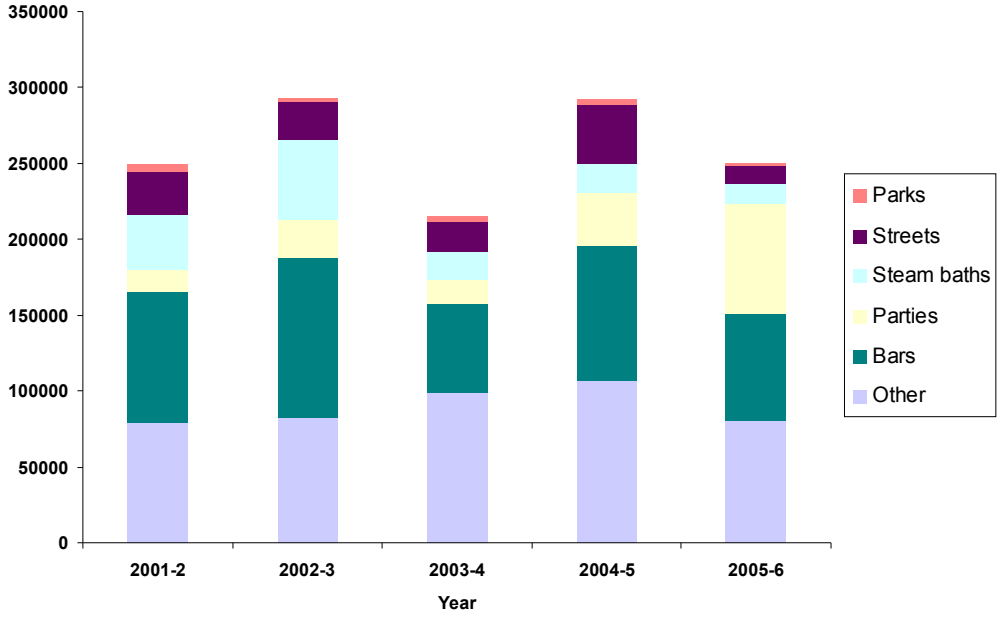
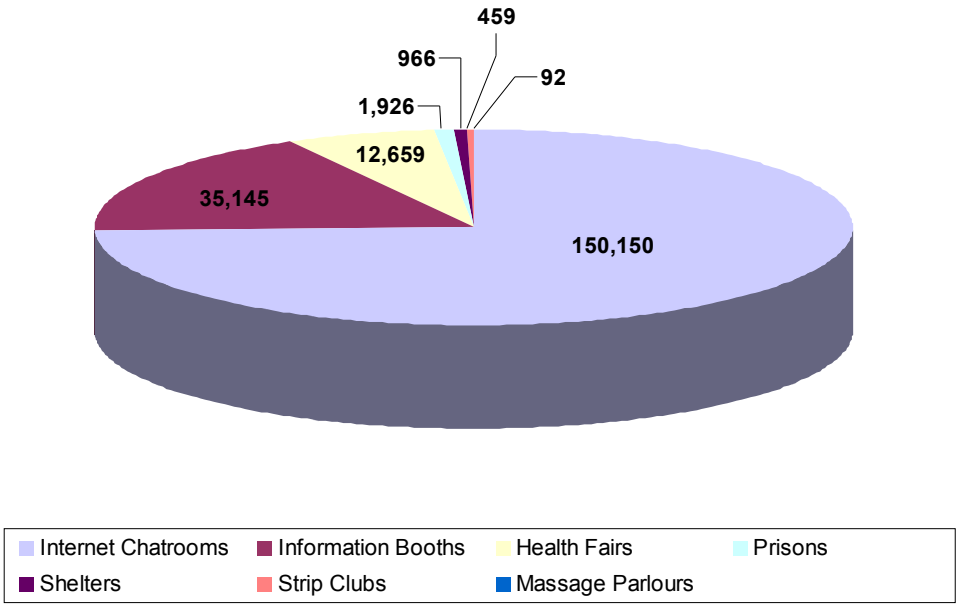


Figure 18b: "Other" Locations for Contacts 2005-06



It will also be important to assess the impact on service networks, as Internet outreach can reach clients outside an organization's traditional catchment area. A number of agencies report that they are providing online outreach services to people in other parts of the province and even outside Ontario. The issue then becomes the organization's capacity to serve a large Internet client as well as its ability

to help Internet contacts connect with the local services they may need.

To be able to monitor new outreach trends more closely over time, OCHART gives organizations a wider range of outreach locations than the previous activity reports (Figure 18b). It will be interesting to see whether some newly identified locations, such as shelters and massage parlours, become more common targets for outreach services. "Other" locations where organizations make outreach contacts (Figure 18a) include: Internet cafes, a health bus, local businesses, other health agencies (e.g., hospital, clinics), and settlement agencies (i.e., agencies that offer services for recent immigrations).

Targets of outreach programs vary by organization

Figure 19a indicates the populations that organizations listed as their top three priorities for outreach programs by LHIN region.

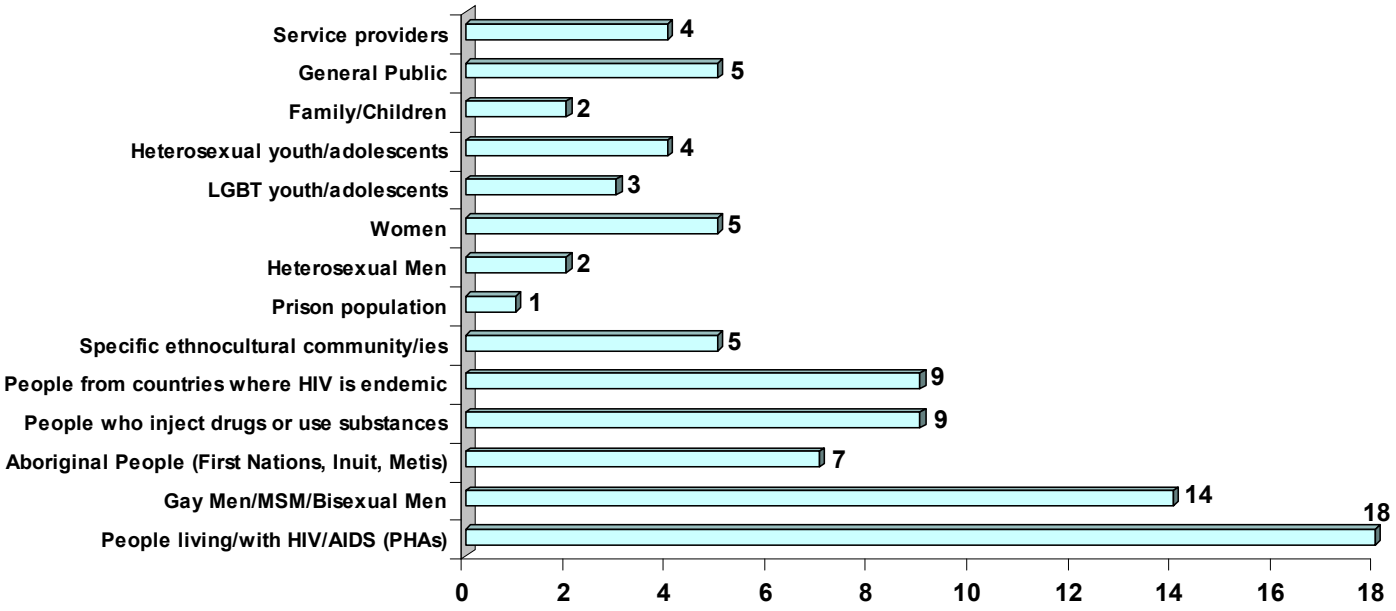
Figure 19a: Priority Populations for Outreach Services

	People living with HIV/AIDS (PHAs)	Gay Men/MSM /Bisexual Men	Aboriginal People (First Nations, Inuit, Metis)	People who inject drugs or use substances	People from countries where HIV is endemic	Specific ethnocultural community/ies	Prison population	Heterosexual Men	Women	LGBT youth/adolescents	Heterosexual youth/adolescents	Family/Children	General Public	Service providers
Central	1.4%	4.2%	16.8%	9.8%	7%	6.3%	19.6%	5.6%	4.9%	3.5%	2.8%	8.4%	2.1%	7.7%
Central East	3.6%	7.1%	13%	1.2%	5.9%	8.3%	11.2%	8.3%	4.7%	4.7%	4.7%	11.8%	8.3%	7.1%
Champlain	4.1%	1.6%	6.5%	4.9%	8.1%	6.5%	8.1%	9.8%	8.1%	4.9%	8.9%	11.4%	9.8%	7.3%
Erie St Clair	3.8%	2.9%	9.5%	1%	10.5%	11.4%	8.6%	4.8%	1.9%	6.7%	7.6%	12.4%	5.7%	13.3%
Hamilton Niagara Haldimand Brant	4.8%	5.3%	10.6%	1%	7.2%	13.5%	11.6%	2.9%	3.9%	6.8%	5.3%	13.5%	8.7%	4.8%
North East	2.2%	2.2%	4.4%	3%	20.7%	19.3%	7.4%	9.6%	4.4%	3%	7.4%	10.4%	1.5%	4.4%
North Simcoe Muskoka	1%	2.9%	5.7%	4.8%	12.4%	13.3%	9.5%	7.6%	1.9%	3.8%	11.4%	6.7%	8.6%	10.5%
North West	2.2%	8.7%	1.1%	9.8%	15.2%	14.1%	13%	5.4%	4.9%	4.9%	4.3%	3.3%	6.5%	6.5%
South East	3.4%	3.4%		20.7%			24.1%			17.2%	6.9%		13.8%	10.3%
South West	1.4%	1.4%	7.9%	2.1%	5.7%	17.1%	15.7%	12.9%	11.4%	2.9%	5.7%		7.1%	8.6%
Toronto Central	3.2%	4.8%	8%	8%	4.8%	4.8%	16%	10.4%	3.2%	6.4%	4.8%	14.4%	6.4%	4.8%
Waterloo Wellington	11.1%	4.8%	4.8%	1.6%	12.7%	11.1%		6.3%	4.8%	6.3%	4.8%	15.9%	4.8%	11.1%

LHINs with a small number of organizations, such as Erie St Clair and North Simcoe Muskoka tend to target a smaller number of priority populations than LHINs with a large number of organizations with different missions, such as Toronto Central. Some of variation among LHINs may be due to organizations interpreting the question differently: some listed populations in order of priority; others listed several populations as having the same priority.

Figure 19b indicates the number of organizations that identified each population as its highest priority. Each population is the top priority for at least one organization and, with the exception of the general public and service providers, the distribution tends to reflect the level of risk for each population (i.e., people living with HIV followed by gay men, IDUs, people from countries where HIV is endemic and Aboriginal people). The only exception may be the prison population; however, the prison population was identified as a relatively high priority for a number of organizations.

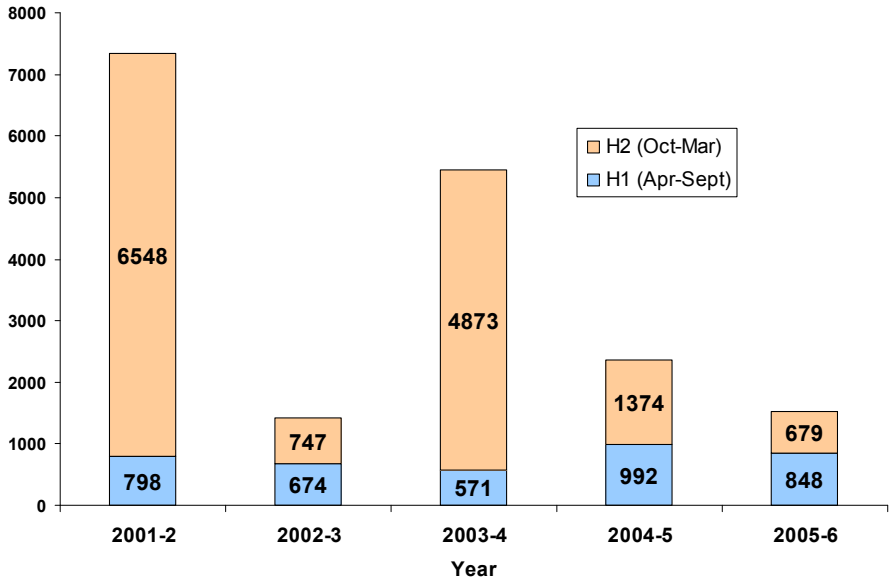
Figure 19b: Number of Organizations Identifying a Particular Population as their Highest Priority



Organizations are making more effective use of web-based media to deliver their messages

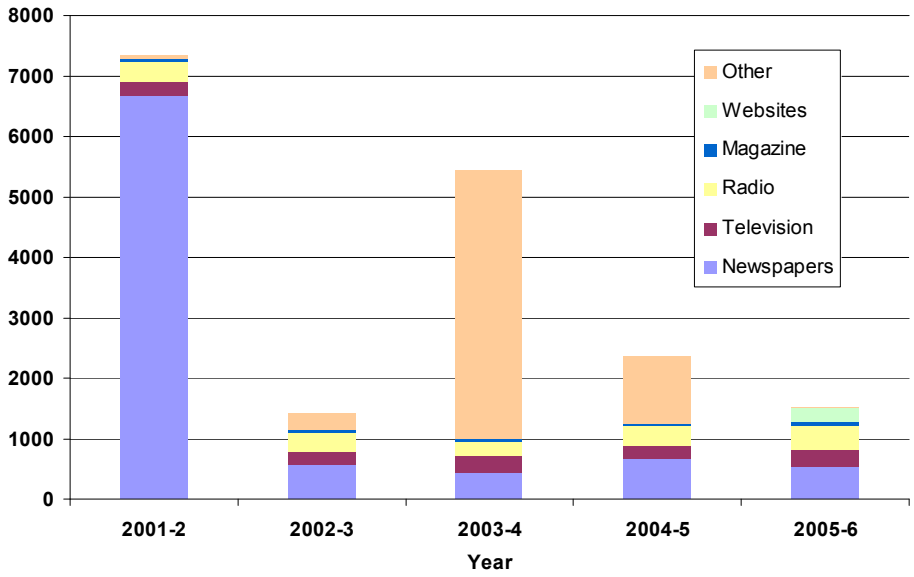
The number of media contacts reported has varied widely over the past five years (Figure 20a). The high numbers in 2001/02 and 2003/04 may be due to a misinterpretation of the intent of the question on the reporting form: some organizations appear to have counted each time an ad appeared in a local newspaper, as opposed to focusing on media interviews or media stories. This reporting error was corrected in subsequent years.

Figure 20a: Number of Media Contacts



Over time, funded agencies have maintained relatively consistent levels of media contacts through newspaper, television, radio and magazines (Figure 20b). The field is seeing an increase in web-based media contacts. This reflects the growing role of the Internet in communication, and may highlight the need to develop different skills and strategies to take full advantage of this medium. (Note: the high proportion of "other" contacts in earlier years was a reporting error.)

Figure 20b: Number of Contacts per Year by Type of Media



Organizations use a mix of phone, email, chatroom/website and mail services to deliver prevention services

The number of services provided by telephone and Internet increased dramatically in 2005/06 (Figure 21a). A significant proportion of the telephone and Internet contacts in 2005/06 came from three organizations: CATIE (472,707 web hits), the AIDS Committee of London (14,580 unique web hits) and Toronto PWA Foundation (2,855 phone calls in the second half of 2005/06). It is difficult to determine from the reporting forms whether all funded agencies are counting total or unique web hits. Unique web hits would give a better sense of the actual number of people who are accessing information or services via the Internet.

Figure 21a: Number of Telephone and Internet Contacts/Services

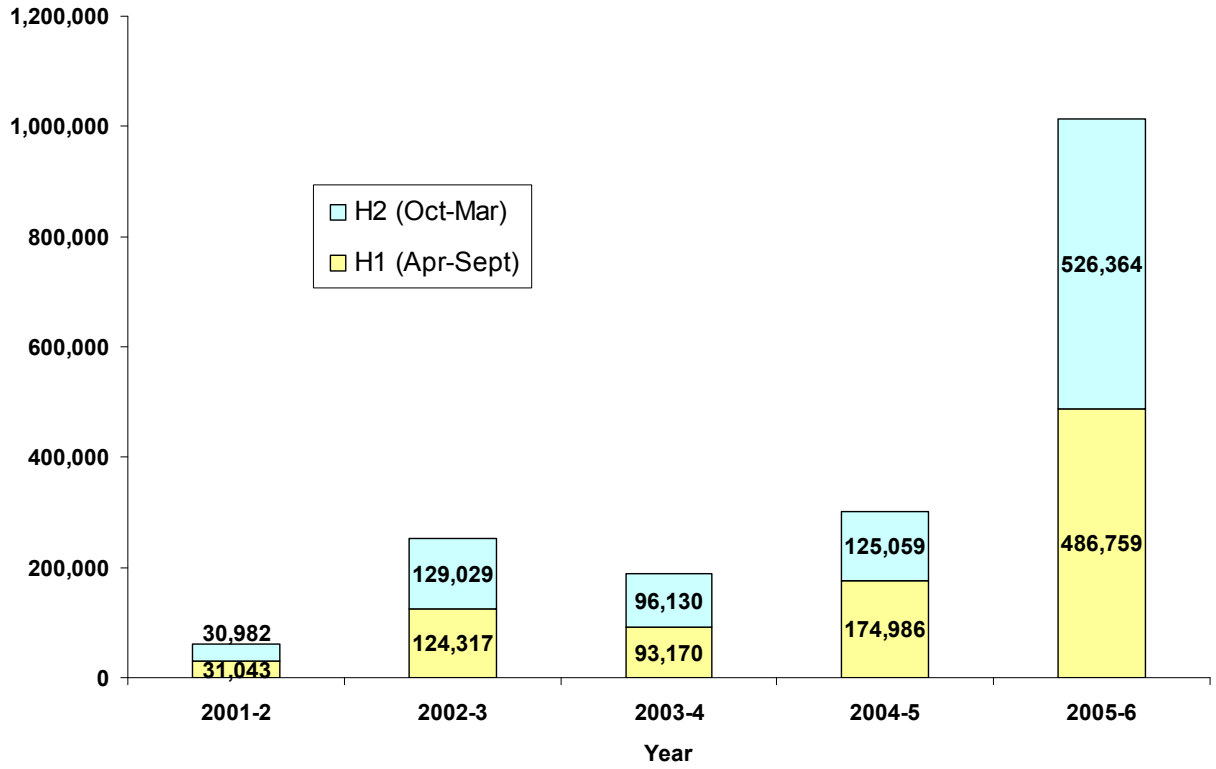


Figure 21b illustrates the type and proportion of services provided by phone, email, chatroom and mail in 2005/06.

Figure 21b: Type of Services Provided by Type of Media

2005/06	Phone	Email	Chatroom/ Website	Mailouts
Information & Education	30,116	24,662	924,242	11,963
Pre/post Test Counselling	3,766	270	18	46
Referrals	9,109	2,855	50	180
Information packages	1,366	698	35	4,564
Other	843	189	15,627	2,553

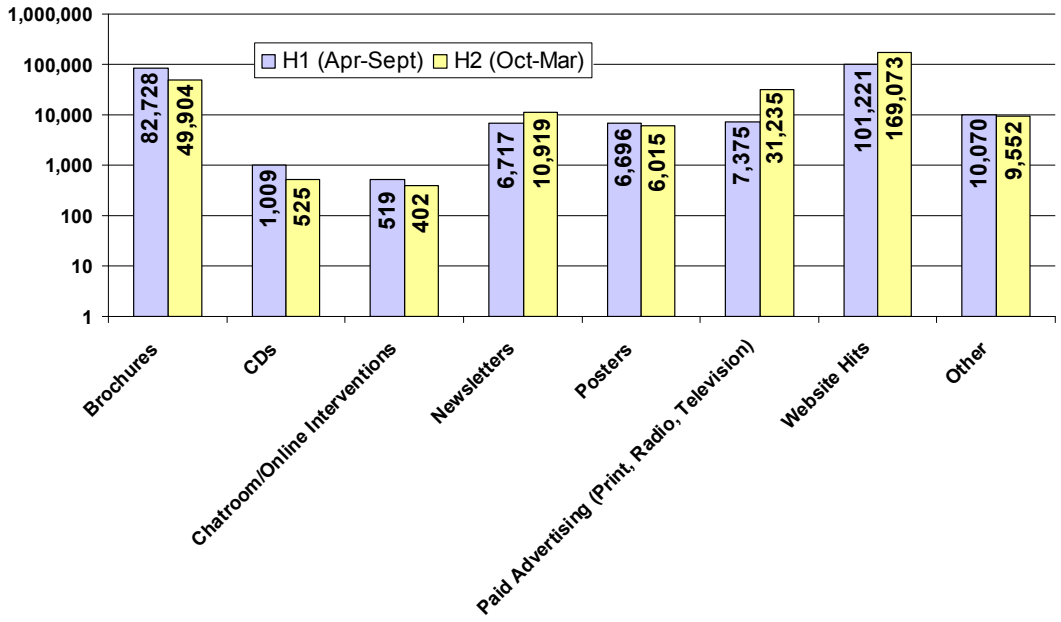
No comparable information is available from previous years. This information will provide a baseline for comparison with future OCHART reports.

Over time, it may be helpful to analyze how services differ depending on how they are delivered, and whether electronic modes of service delivery are extending the reach of organizations – either geographically or into populations that may not previously have used their services.

Organizations use different strategies to deliver awareness campaigns

In 2005/06, organizations were asked for the first time about the types of materials they use to deliver awareness campaigns. As Figure 22 illustrates, the media that organizations used most often were: website hits, paid advertising, brochures, and newsletters. Some are also experimenting with other media, such as CDs and chatrooms.

Figure 22: Number of Awareness Campaign Materials by Type



The "other" category included materials such as:

- direct mail-outs to health care providers
- condom packs
- t-shirts
- press releases
- unpaid advertising

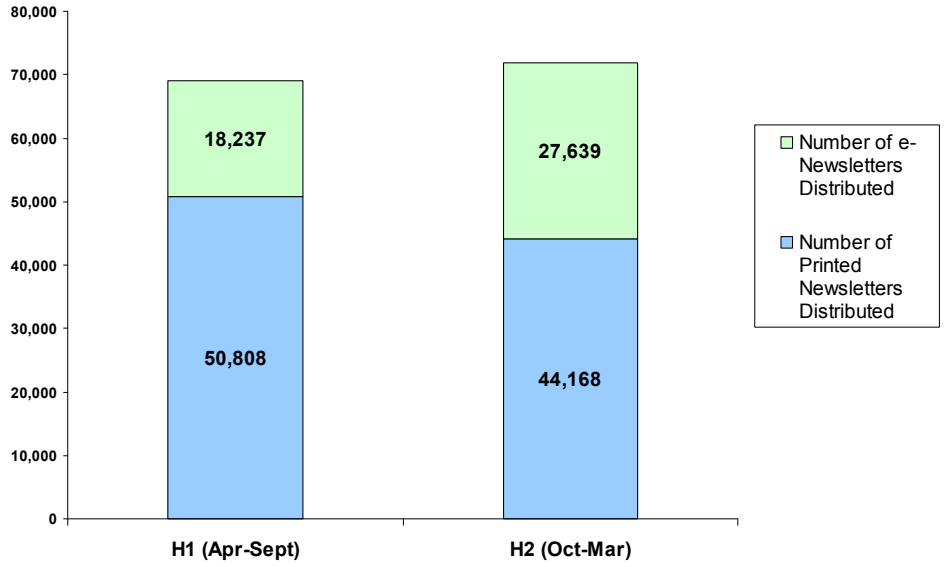
A number of items including in "other" should have been captured in other categories (e.g., fact sheets and pamphlets would be included with "brochures".

Organizations are creating and distributing more e-newsletters

The Internet trend continues in the production and distribution of newsletters. With OCHART, organizations are asked to distinguish between print and e-mail newsletters. In the second half of 2005/06, organizations distributed about 12% fewer print newsletters and 50% more e-newsletters than in the first half of the year (see Figure 23).

This trend is consistent with greater use of the Internet to provide both information and services.

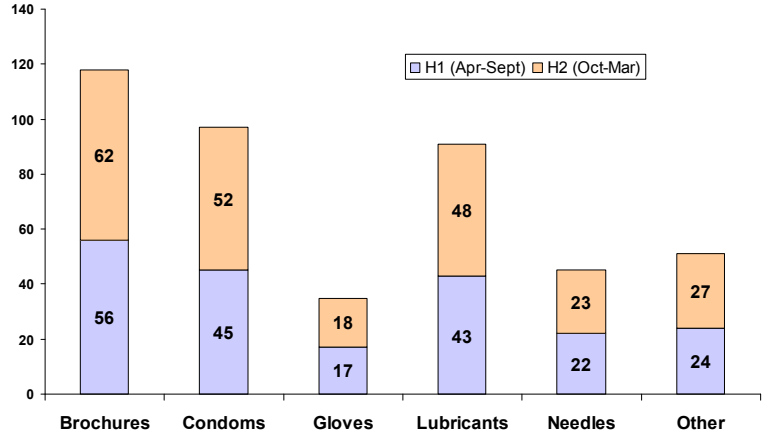
Figure 23: Newsletter Distribution for 2005/06



70% of organizations distribute condoms, 31% distribute needles

With OCHART, organizations were asked for the first time about the types of prevention resources they distribute regularly. Figure 24 indicates the number of organizations that distribute each type of resource.

Figure 24: Number of Organizations Distributing Prevention Resources



The most common is brochures, followed by condoms and lubricants. It is interesting to note that the number of organizations distributing resources increased in the second half of 2005/06.

The "other" category included crack cocaine kits and other drug-related equipment such as filters, cookers, swabs and tourniquets, female condoms, dental dams, latex gloves, safe piercing kits as well as items such as health kits, vitamins, food hampers and baby supplies. Given recent efforts to increase distribution of other drug use equipment, future versions of OCHART should likely track these items and define prevention resources more explicitly.

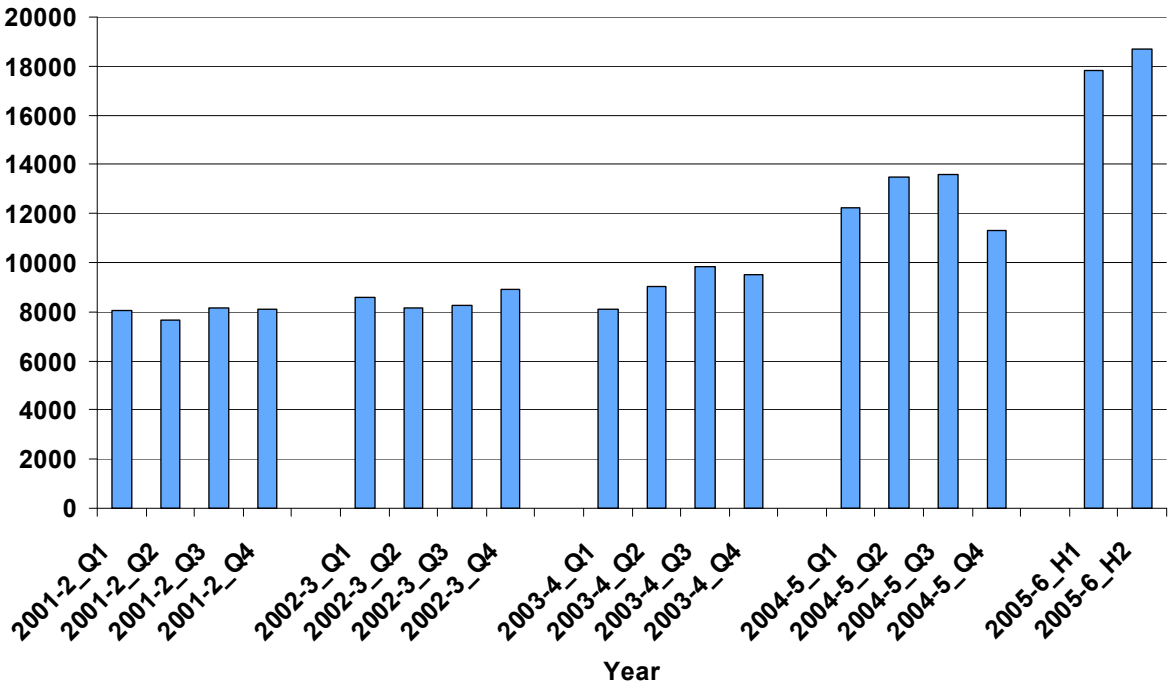
4. Support Services

Fifty-six organizations (or 76% of the organizations that provided data) completed the OCHART section on support services in 2005/06 (e.g., counselling, practical support, referrals to other services) for people living with HIV, family/friends, people affected by HIV (i.e., populations at risk) and others.

Organizations appear to be serving more unique clients than previously thought

Figure 25 indicates the number of clients served each quarter between 2001/02 and 2004/05, as well as the number of clients served each half of the year in 2005/06.

Figure 25: Number of Service Users

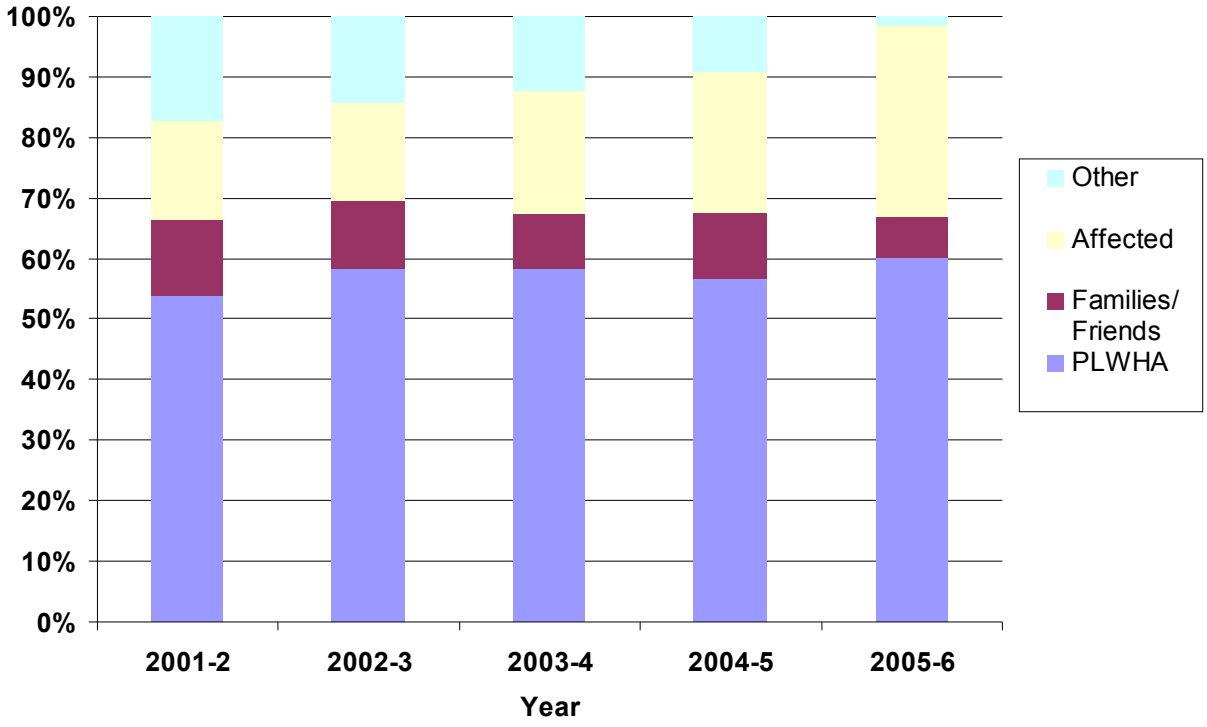


Because the same client may receive services in more than one quarter or one half, this information cannot be used to determine the total number of individual clients served, but it can give a sense of the average number of clients served within a given period. It is clear from this chart that reporting twice a year reduces some duplicate counting; it also indicates that organizations may be serving a greater number of unique clients at a given time than previously thought. The chart also indicates a marked increase in the number of people using services in 2004/05. From the data that is collected, it is not possible to determine what proportion of clients are new, ongoing or returning services users each year.

Organizations are serving more people at risk

According to their reports, funded organizations serve primarily people living with HIV along with a growing number of people at risk and family and friends (Figure 26). The OCHART form clearly lists "people at risk" in the "affected" category, and this change seems to have significantly reduced the "other" category.

Figure 26:
Proportion of Support Services Provided by Client Type



The increase in support services for people at risk is consistent with the provincial, federal and pan-Canadian strategies, which advocate for services that help reduce factors that put people at risk (e.g., substance use, lack of affordable housing, stigma, and poverty).

The types of services used most frequently by people living with HIV in 2005/06 were:

- counselling
- practical assistance
- case management
- health promotion
- referrals

The types of services used most frequently by people at risk were:

- health promotion
- counselling

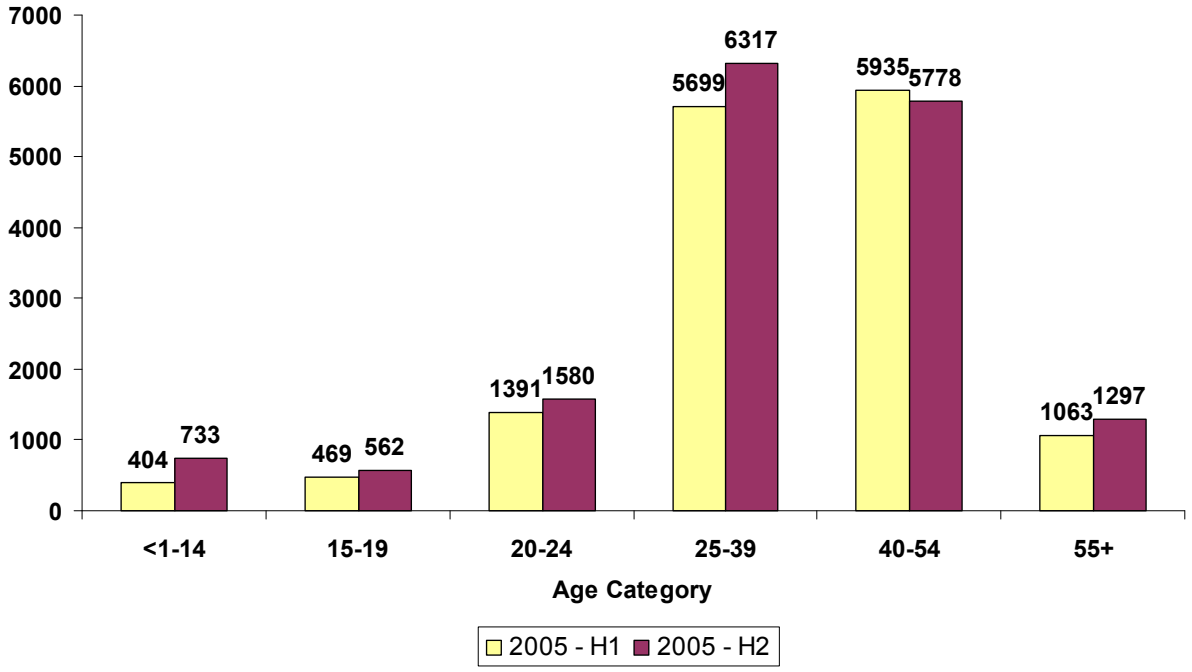
Families and friend were more likely to access:

- counselling
- practical support
- health promotion

Most clients are between the ages of 25 and 54

In the second half of 2005/06, there was a slight increase in the number of clients in all age categories except 40 to 54 year olds; however, the majority of clients served were between the ages of 25 and 39 (Figure 27a).

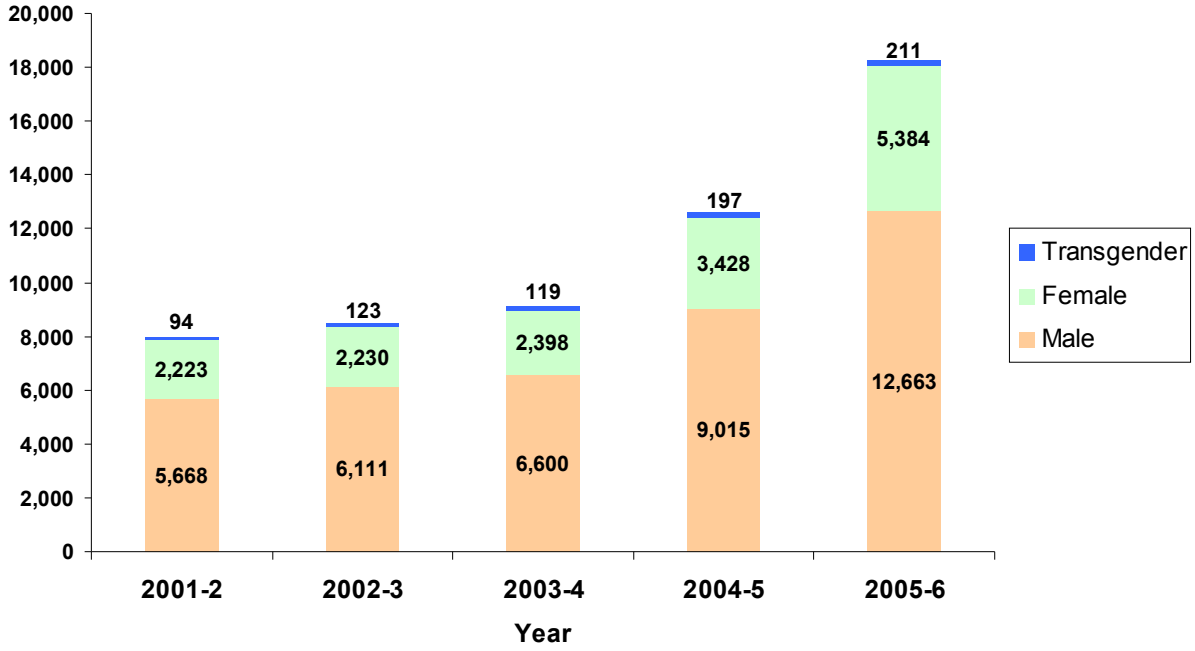
Figure 27a: Number of Clients Served by Age Category



By tracking the age distribution of clients over time, it may be possible to assess the effectiveness of both prevention and treatment programs. Having an aging client base in support programs indicates that both treatment and prevention programs are working.

Figure 27b indicates the average number of clients served by those agencies that provide support programs by gender over the past five years. Because women are more likely to use other types of health services than males (e.g., physician services), the chart may not reflect the actual gender distribution of people infected and affected by HIV.

Figure 27b:
Average Number of Service Users per Year by Gender



Over the past five years, there has been a 142% increase in the average number of women being served each year by community-based organizations (i.e., from 2,223 in 2001/02 to 5,384 in 2005/06). Over that same period, the average number of males using services each year increased by 123% (i.e., from 5,668 to 12,663). The average number of transgendered clients also increased by 124% (i.e., from 94 to 211). The greatest increase has occurred within the last two years, perhaps as a result of greater outreach to the transgendered community.

Organizations are providing more support services

Organizations are required to track the total number of services provided. This information gives a sense of the level of activity (Figure 28a). The number of services increased steadily through 2004/05 but dropped slightly in 2005/06. The decline may be due, in part, to the shift to OCHART reporting. Because the services are not clearly defined (i.e., is a counselling session 15 minutes or 1 hour?), it is difficult to interpret these numbers.

Figure 28a: Number of Support Services Used by Year

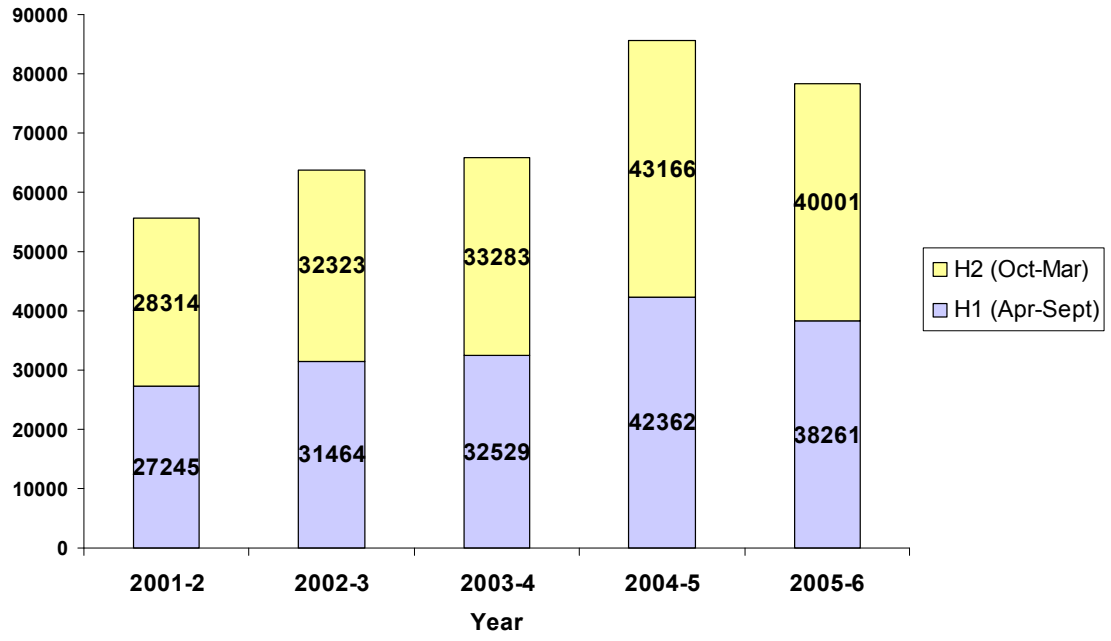


Figure 28b illustrates the proportion (percent) of different types of support services provided each year:

Support Service	2001-2	2002-3	2003-4	2004-5	2005-6
Intake & Assessment	9.4	10.3	9.3	6.3	6.7
Counselling	21.6	23.2	21.3	20.2	15.4
Health Promotion	16.6	14.2	14	13.2	10.8
Drop-in-Center	3.8	5.3	5.3	7.1	11.9
Practical assistance	19.9	21.8	20	21.5	12.3
Support groups	4	3.9	4.8	5	2.3
Pre/Post Counselling	2	1.7	1.8	1.3	1.9
Buddy Programs	0.7	0.4	0.5	0.4	0.2
Financial Counselling	6	5.4	6.5	7.2	7.4
Bereavement Counselling	1.5	1.1	1.7	2.2	1.3
Referral	10.8	10.7	12	12.9	10.2
Other service users	3.7	2	2.9	2.9	1.4
Employment Counselling					0.7
Workshops/Training/Skills Development					1.3
Housing Assistance					1.5
Individual Advocacy					6.6
Supportive Housing					0.8
Settlement Services					0.2
Interpretation/ Translation					0.2
Complementary Therapies					1.5
Case Management					4.6
Home & Hospitals Visits/Care Teams					0.9

Figure 28b: Types and Proportion (%) of Support Services Provided

With OCHART, organizations were offered a larger range of service choices, which more accurately reflect the mandate of all the funded agencies. It is interesting to note the relatively high demand for services such as individual advocacy, case management, housing assistance and supportive housing, skills development, home and hospital visits and employment counselling (reporting options not available in previous years). These data highlight the complex needs of people living with HIV as well as people at risk. They illustrate the ongoing client need for practical assistance (including food banks, income support). They also reinforce two recent and different trends reported anecdotally by community-based organizations: clients who are managing well on medications and who need help with employment counselling; and clients who are becoming ill and need assistance with care.

Based on the data collected, we do not know how many clients are using multiple services or the mix of services individual clients use. We also cannot distinguish between short-term or occasional clients (i.e., those who come to an organization for a particular service and then are able to manage without further assistance) and those who require long-term support.

Figure 28c is an analysis of the type of services provided by LHIN region.

LHIN	Intake and Assessment	Case Management	Counselling	Health Promotion/ Treatment Information	Scheduled Drop In Program	Practical Assistance	Home & Hospitals Visits/Care Teams	Support Groups/Retreats	Pre/post Test Counselling	Buddy Program	Financial Counselling	Bereavement Services	Referrals	Employment Counselling	Workshops/Training/ Skills Development	Housing Assistance	Individual Advocacy	Supportive Housing	Settlement Services	Interpretation/Translation	Complementary Therapies	Other
Central	6	13	19	13		9	3	14	1		3		10	1		2	1			6		
Central East	1	2	19	28	15	3		3	12		1		14				2					1
Central West	11	8	15	3	7	10		7	5	1	16		12			1					1	2
Champlain	1		54	15	3	3		3	3				9		2			1			2	2
Erie St Clair	11	18	15	15		8		4	2		3	1	9	2		5	5	1			2	
Hamilton Niagara Haldimand Brant	4	17	19	8	2	13		2	4	1	3	1	11	1	1	3	5	2		1	3	
North East	11	5	15	11	1	19	1	11	3		2	3	9	1	2	2	3				1	
North Simcoe Muskoka	1	8	13	15	7	12	1	6	1		5		10	1	1	2	6	1			9	
North West	3	6	16	10	2	29	7				5	1	8		5	2	6					
South East	4	6	15	13		14	1		2		7	9	12	1		5	8	1			2	
South West	6	6	12	6	5	12	2	10	2	1	3	1	11	2	2	5	4	1	1			9
Toronto Central	9	5	7	9	14	15	1	3	1		9	1	9	1	1	1	8	1			1	2
Waterloo Wellington	7	11	13	13	4	12	2	1			1	1	9	1	3	1	5				3	12

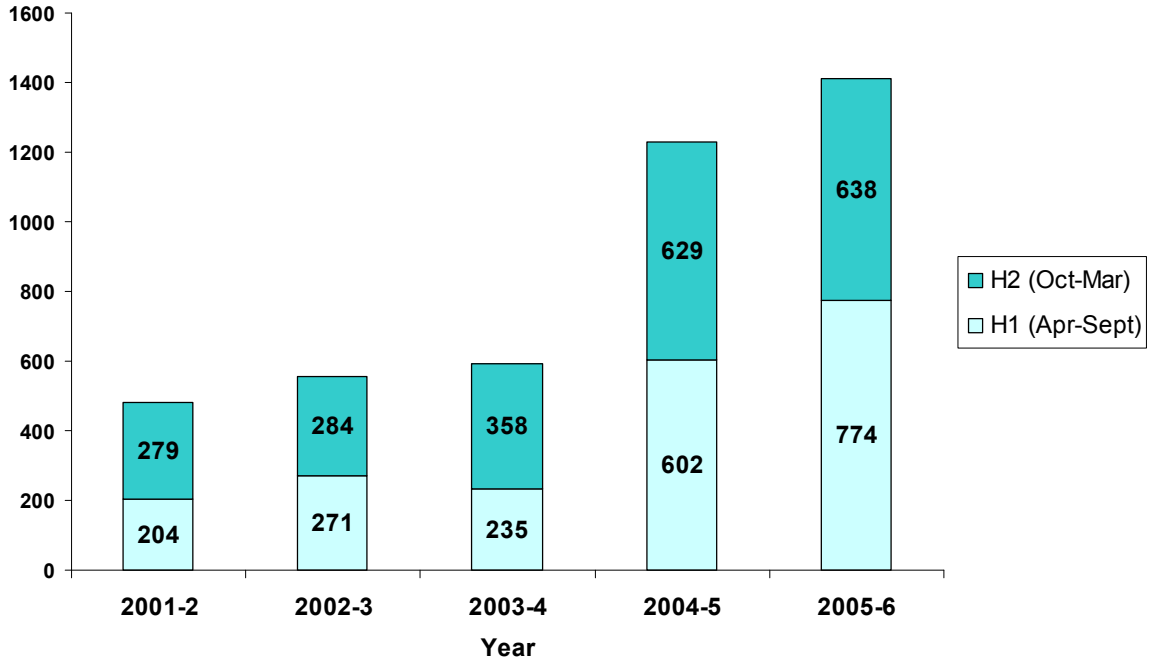
Figure 28c: Types and Proportion (%) of Support Services Provided by LHIN Region

Practical support appears to be particularly important in the North West and North East – perhaps due to geography and the shortage of other services in those regions. Organizations in Champlain provide primarily counselling services and those in Central East provide more health promotion and treatment information. The proportion of referrals is surprisingly consistent across all LHINs. This may indicate that community-based organizations are playing an important role in linking clients to other services. More analysis is required to understand the factors that affect the mix of services provided (e.g., client need, availability of other services in the community, staff skills).

There has been an increase in support groups

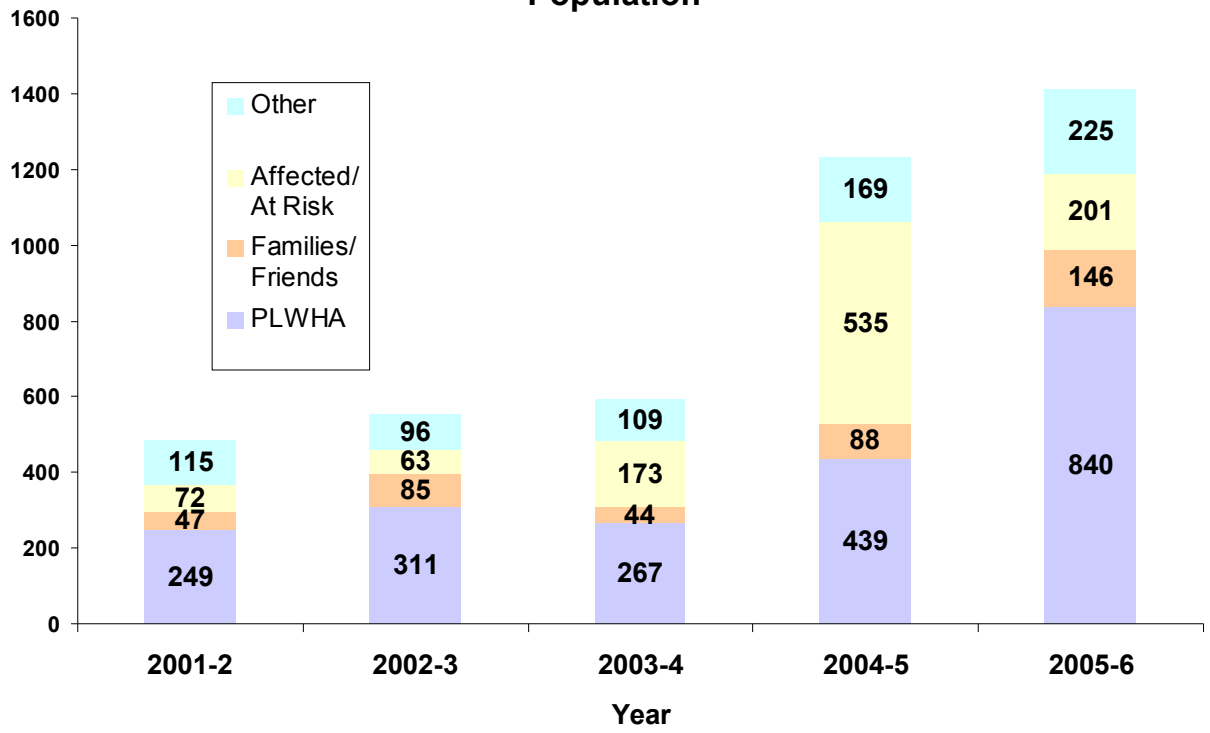
Over the past two years, there has been a marked increase in the number of support groups provided by community-based organizations (Figure 29a).

Figure 29a: Number of Support Groups by Year



While there was a slight increase in the number of support groups for people living with HIV in 2004/05, the most significant increase was in support groups for people who are affected or at risk (Figure 29b). In 2005/06, the groups seemed more focused on people living with HIV.

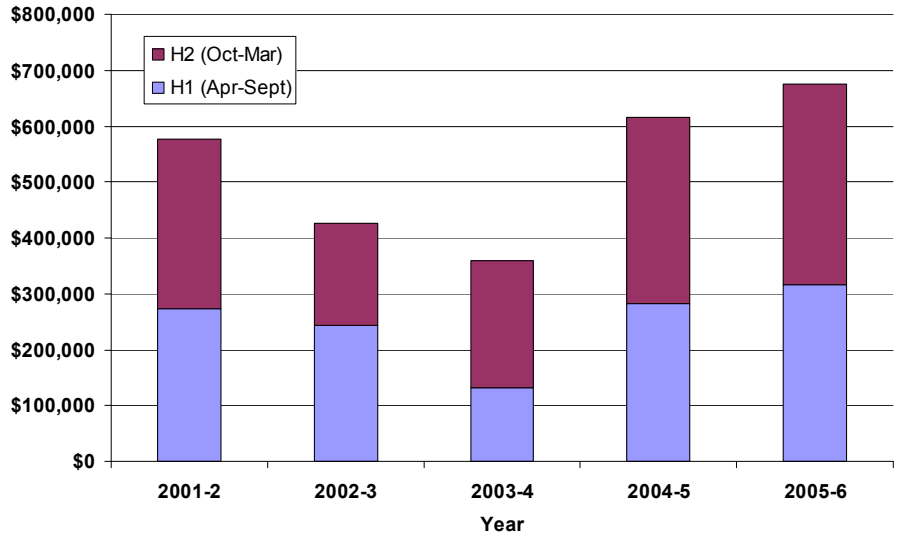
Figure 29b: Number of Support Groups per Year by Population



Clients do not have adequate incomes to meet health needs

OCHART questioned organizations about the amount of financial assistance they provide to clients. This information provides a way to assess clients' financial stability and identify gaps in other services, such as social assistance. The questions about financial assistance are voluntary, but 61% of organizations provided this information in the first half of 2005/06 and 62% in the second half.

Figure 30a: Financial Assistance Provided by Year



Those organizations provided a total of almost $680,000 in financial assistance to clients in 2005/06 – an increase of almost 10% over the previous year (Figure 30a). In the first half of the year, 2,611 people received financial assistance, in the second half, 3155 received assistance. More financial assistance was provided in the second half of the year $$358,000 compared to $317,000 in the first half. This may be due to increased costs associated with the winter months or increased capacity on the part of organizations to provide funds in the second half of the fiscal year. Many of the funds used to support financial assistance programs are generated through events like the annual AIDS walk, which takes place in the fall.

Figure 30b: Number of People who Received Financial Assistance by LHIN

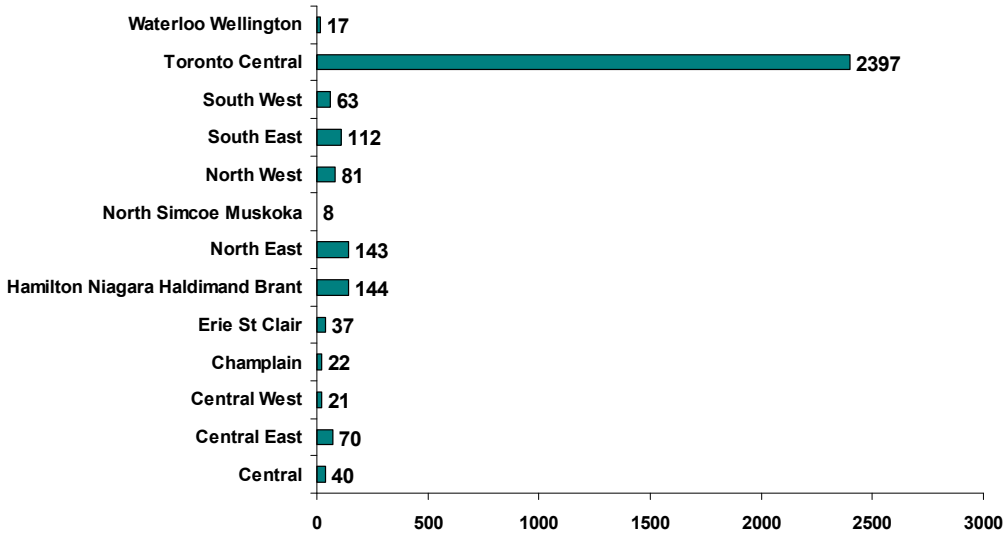


Figure 30b shows the number of people who received financial assistance by LHIN region.

The vast majority were in Toronto Central; however, all regions were providing some financial assistance to clients.

Figure 30c: Total Amount of Financial Assistance Provided by LHIN (2005-06)

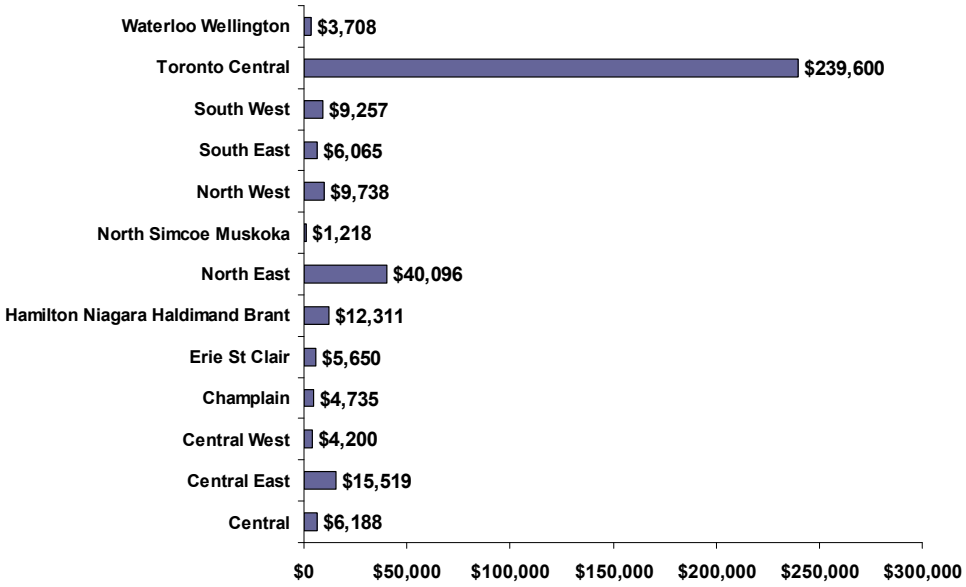


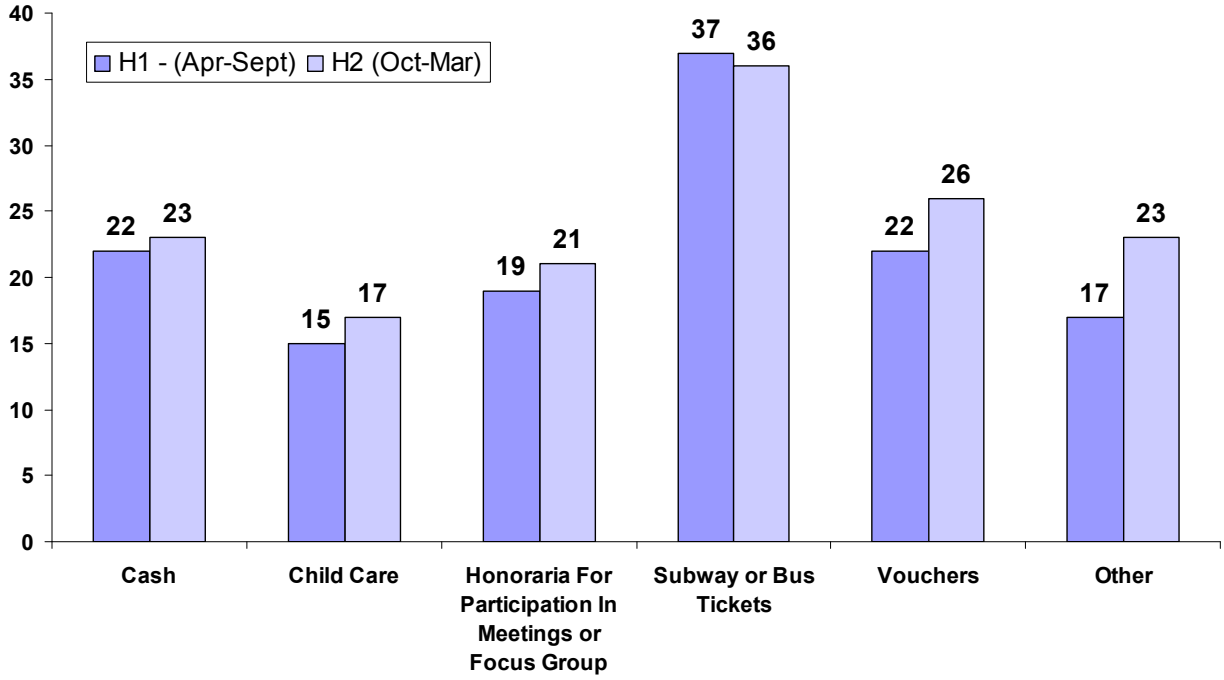
Figure 30c indicates the amount of financial assistance provided by LHIN.

Although Toronto Central distributed the largest amount of money to the largest number of people, organizations provided an average of just less than $100

per person, which is less than the $280 per person distributed in the North East LHIN or the $221 per person in Central East.

Figure 30d illustrates the number of organizations (of those that answered these questions) providing different types of financial assistance.

Figure 30d: Number of Organizations Providing Different Types of Financial Assistance



The most common type of assistance is subway or bus tickets (i.e., assistance with transportation costs), followed by vouchers and cash. The high demand for assistance with transportation is consistent with many community plans, which identified transportation as a serious unmet need.

The need for all the types of financial assistance listed in Figure 30d indicates that income stability is an issue for many clients, and that income programs like social assistance and ODSP are not providing enough income to allow people with HIV to manage their health (e.g., attend appointments, have adequate food).

5. Use of Volunteers and Students

Organizations continue to attract volunteers

Community-based HIV/AIDS organizations are highly dependent on volunteers to assist with many of the programs and activities, and the number of active volunteers has tended to increase each year. Figure 31a shows the average number of volunteers per half year.

The dramatic jump in the number of volunteers in the first half of 2005/06 may be associated with the AIDS Walk and other short-term episodic events that require large numbers of volunteers – or it may be a reporting error related to the shift to OCHART.

Figure 31a: Number of Active Volunteers per Half-Year

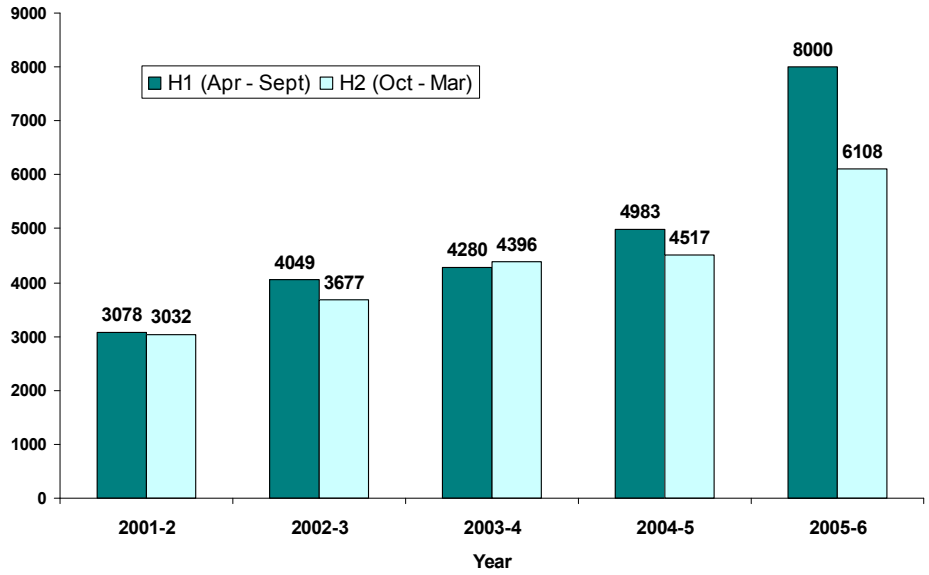
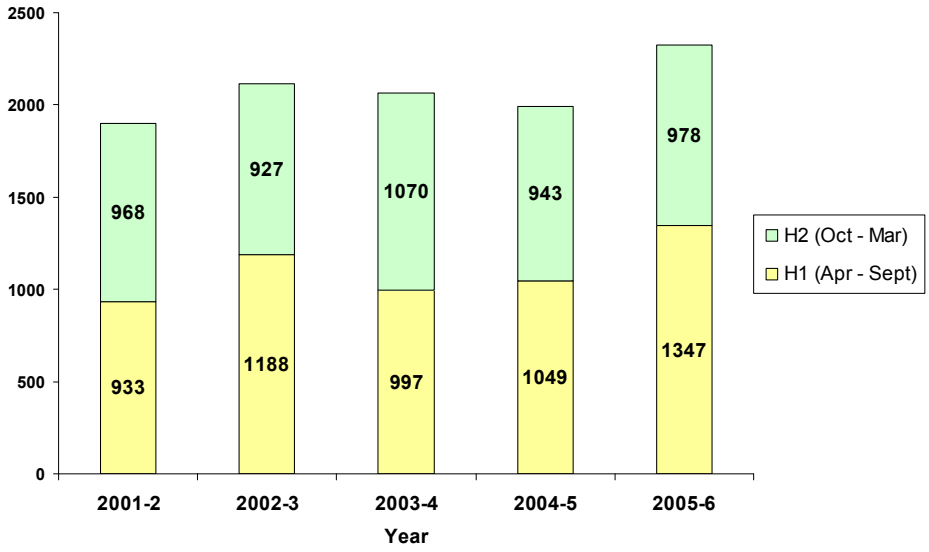


Figure 31b: Number of New Volunteers Each Year



As Figure 31b indicates, about 16% of volunteers in 2005/06 were new.

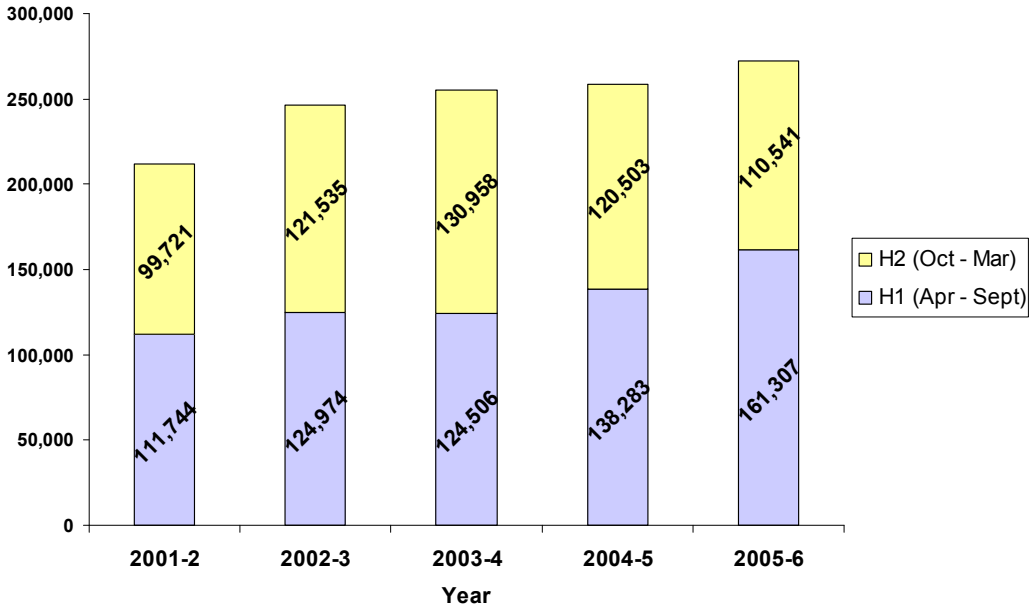
In fact, a significant proportion of the volunteer workforce is new each year. This means that community-based organizations must put significant ongoing effort and resources into recruiting and training new volunteers. As the OAN report, *Stemming the*

Tide, noted, there is increasing competition among non-profit organizations for volunteers, so this may continue to be an issue for organizations in the future.

Volunteers provided more than 250,000 hours of service

The number of hours of service provided by volunteers has tended to increase steadily over the years (Figure 32a).

Figure 32a: Number of Volunteer Service Hours per Year

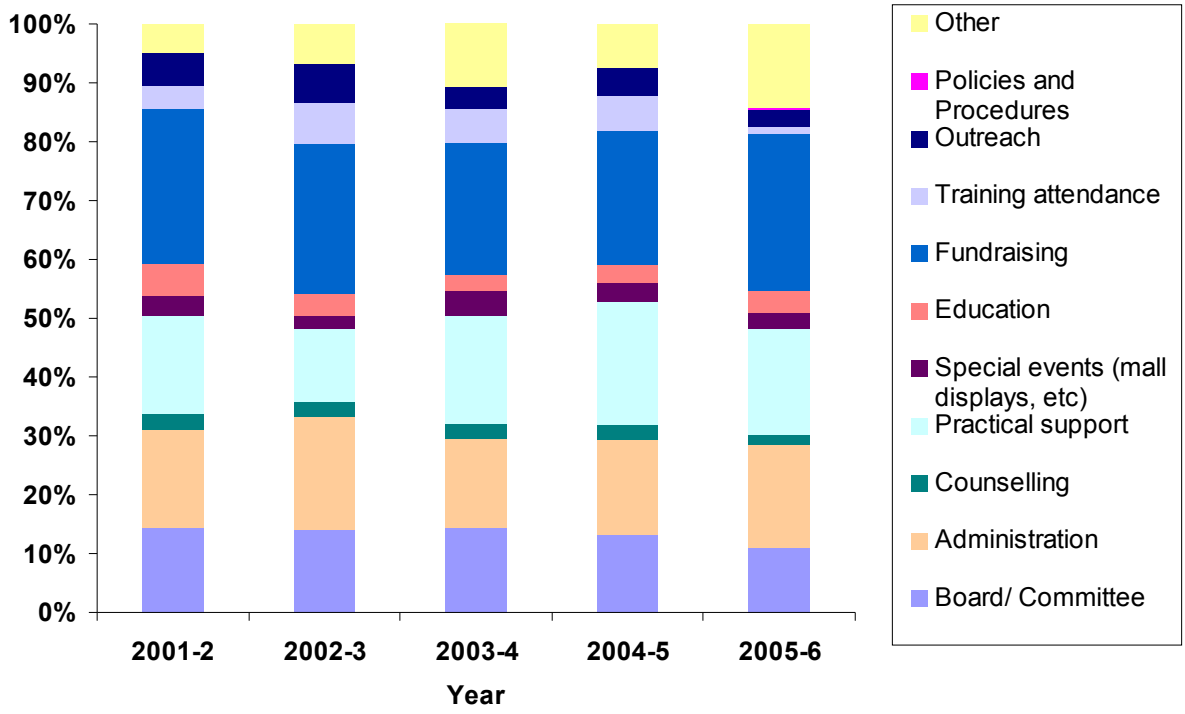


Volunteers continue to provide a significant amount of service and enhance the capacity of community-based organizations. In 2005/06, they provided more than 250,000 hours of service – or the equivalent of over 140 full-time staff. It is interesting to note that the large increase in the number of active volunteers in 2005/06 did not translate into a proportional increase in the number of volunteer hours, which may indicate either an error in reporting the number of volunteers, or the fact that volunteers give less time than they have in the past. If the latter is the case, organizations have to recruit more volunteers to maintain the same level of volunteer services.

Volunteers play a key role in fundraising, practical support and administration

Volunteers are involved in a range of activities (Figure 32b). Over the past five years, the mix of activities have remained relatively stable – although in 2005/06 volunteers seem to have been less involved in direct service delivery, such as outreach or education, than they were in the past. Volunteers play a key role in fundraising, providing practical support, administration and serving on boards and committees.

Figure 32b: Mix of Volunteer Activities

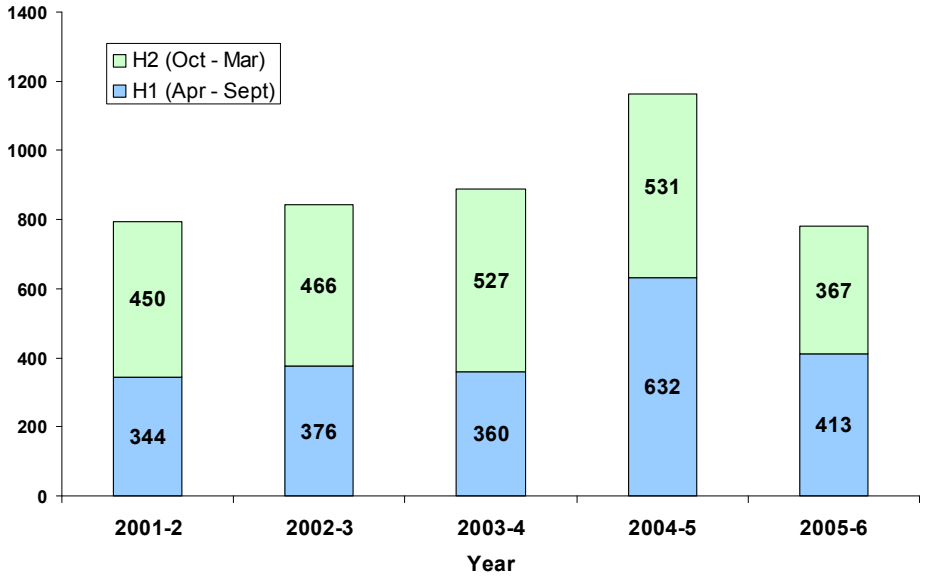


Volunteer Training and Recognition

There is evidence that volunteer training and recognition programs are an effective way to increase volunteer satisfaction, retain volunteers, reduce recruitment costs and improve the quality and consistency of the services provided by volunteers.

The number of volunteer training programs provided by HIV/AIDS organizations increased steadily from 2001/02 to 2004/05, but dropped in 2005/06 – despite an overall increase in the number of active and new volunteers (Figure 33a).

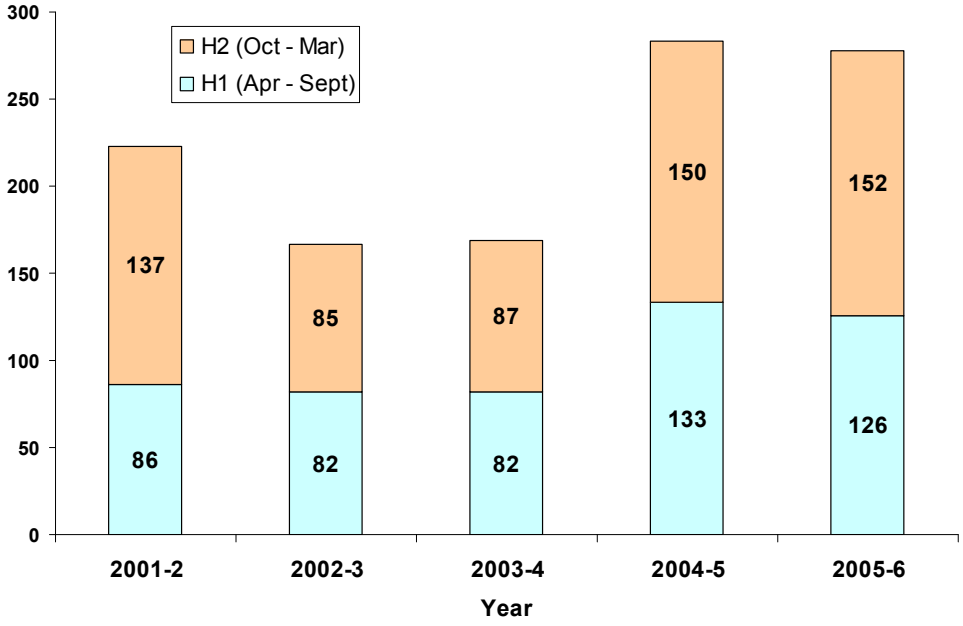
Figure 33a: Number of Volunteer Training Sessions per Year



This anomaly may be due to the shift to OCHART reporting (e.g., some training programs may have been double counted in past years) or it may reflect changes in how training programs are being organized and delivered.

The drop in training programs is particularly interesting given that the number of recognition events for volunteers remained relatively stable over the past two years (Figure 33b).

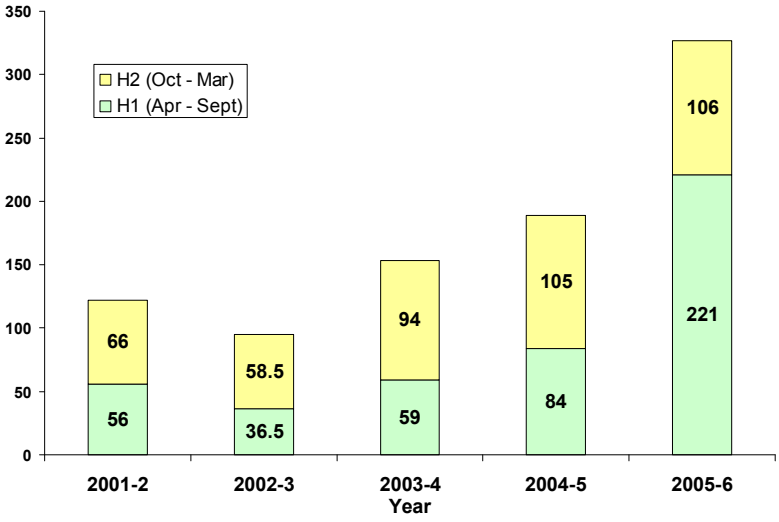
Figure 33b: Number of Volunteer Recognition Events by Year



Organizations are offering more student placements

Over the past four years, community-based organizations have provided placements for increasing numbers of students studying in relevant professions (e.g., social work, counselling). Agencies also report providing more placements for high school students looking for ways to meet their community service requirements. This activity increases the skills available to organizations; it may also play a role in recruiting graduates to the field.

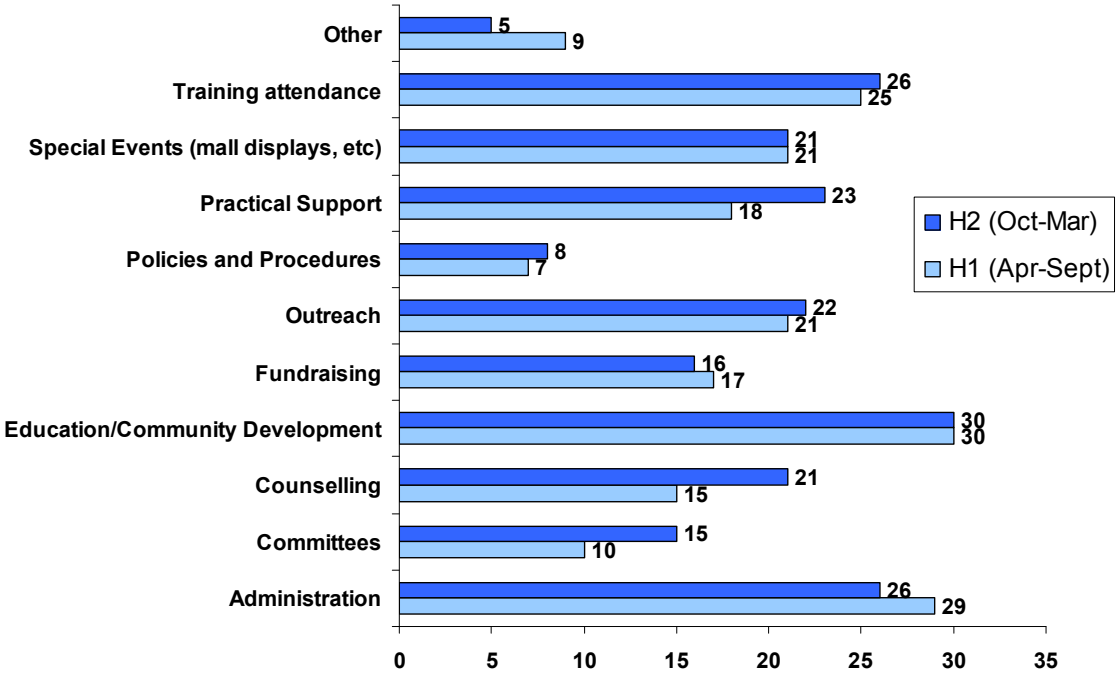
Figure 34a: Number of Student Placements per Year



The average number of students doing placements during each half year ranged from a low of 37 in 2002/03 to a high of 221 in 2005/06. The significant increase in 2005/06 may be due to reporting errors with the shift to OCHART, or it may indicate that organizations provide more unique placements for students in a year than previously thought (in past years, it was assumed that the same students were counted in different quarters). It is interesting to note there were almost twice as many students doing placements in the first half of 2005/06 than in the second half. This is not consistent with trends in previous years, and may require a review of the data.

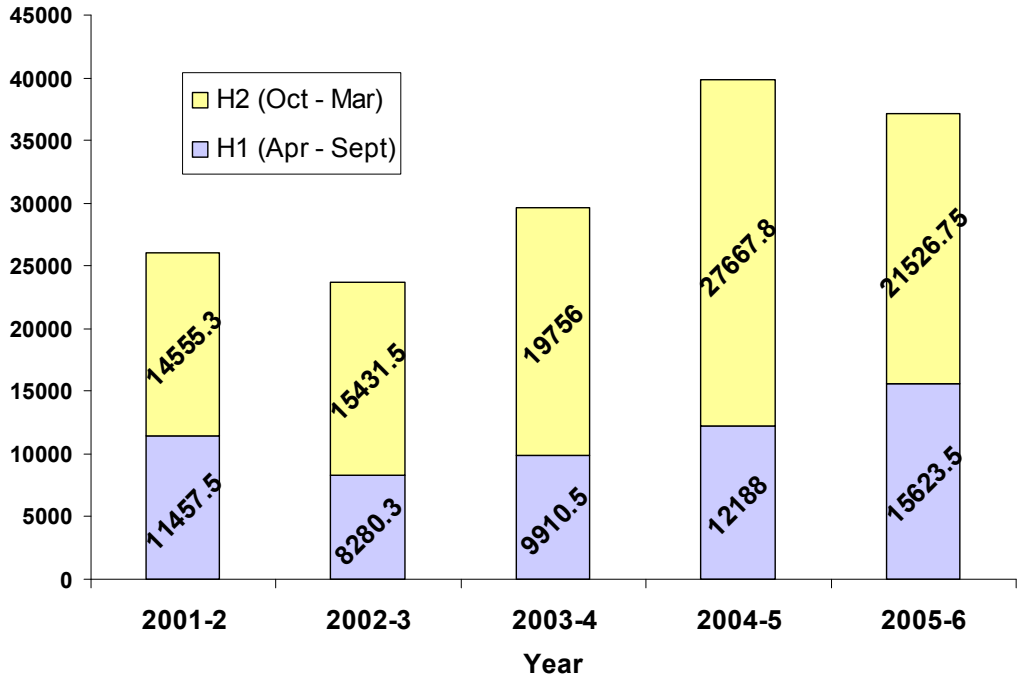
Organizations involve students in a range of activities, including education, administration, training and practical support (Figure 34b).

Figure 34b: Number of Organizations using Students by Type of Activity for 2005-06



It is interesting to note the increase in the number of organizations using students to assist with practical support, counselling and committees between the first and second half of 2005/06. This may indicate that organizations are attracting more college and university students with skills in these areas.

Figure 34c: Number of Hours of Service Provided by Students per Year



Over the past five years, the total number of hours of service provided by students per year has ranged from a low of 23,712 in 2002/03 to a high of 39,856 in 2004/05. The hours of work provided by students were the equivalent of between 14 and 23 full time staff. The fact that the dramatic increase in the number of students reported in 2005/06 did not result in an increase in student hours requires further investigation.

6. IDU (Injection Drug Use) Outreach Programs

The AIDS Bureau of the Ontario Ministry of Health and Long-Term Care funds 16 HIV and IDU (Injection Drug Use) Outreach Programs. The goal of these programs is to reach injection drug users and link them to prevention/harm reduction services, such as needle and syringe exchange programs, and/or to testing and treatment services.

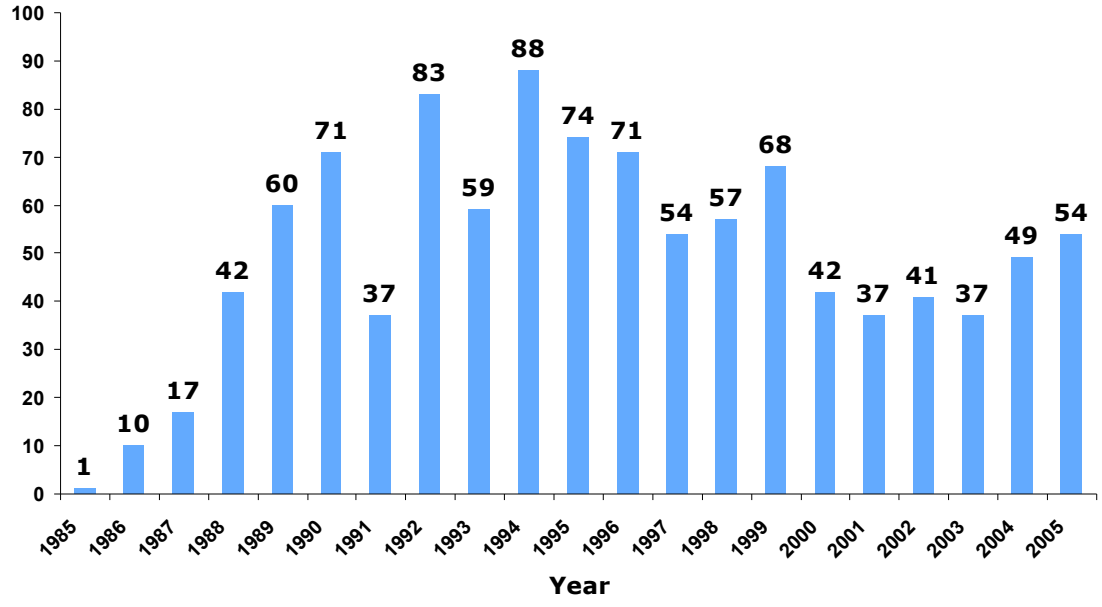
The following is a summary and analysis of their activities between 2001/02 and 2005/06. It also includes some IDU outreach activities reported by two other organizations, which may indicate that more agencies are developing services to respond to the needs of this population.

Trends in HIV Infection in IDUs

Between 2000 and 2003, the number of newly diagnosed HIV infections in people who inject drugs or other substances remained relatively low; however, 2004 and 2005 saw an increase (Figure 35). Between 1985 and 2005, a total of 1,468 men and 632 women were diagnosed with HIV infection related to injection drug use (Remis, R. HIV Infection in Ontario).

The drop in new infections was likely due to the increased investment in both prevention/harm reduction programs (needle and syringe exchange programs, IDU outreach, counselling) and treatment services for IDUs over the past few years. The recent increase may be due to more drug users seeking testing or changes in drug use patterns (i.e., increase in cocaine and crystal methamphetamine use) that may be affecting people's harm reduction strategies.

Figure 35: Number of Diagnosed Infection - Risk Factor Injection Drugs or Substance Use

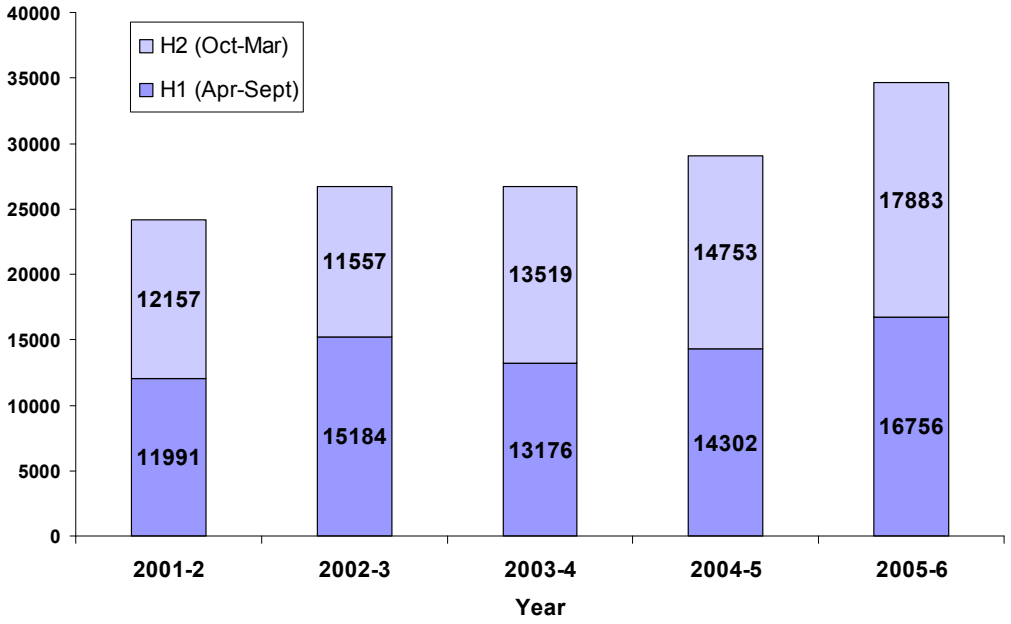


Outreach and inservice contacts increased in 2005/06

The IDU Outreach Programs do not collect client-specific data, so they cannot provide information on the actual number of people served, but the programs do track the number of contacts they have each quarter.

Figure 36a illustrates the total number of contacts – from both outreach and inservice activities for each half year. Over that five-year period, both the total number of contacts and the average number of contacts per reporting period have increased.

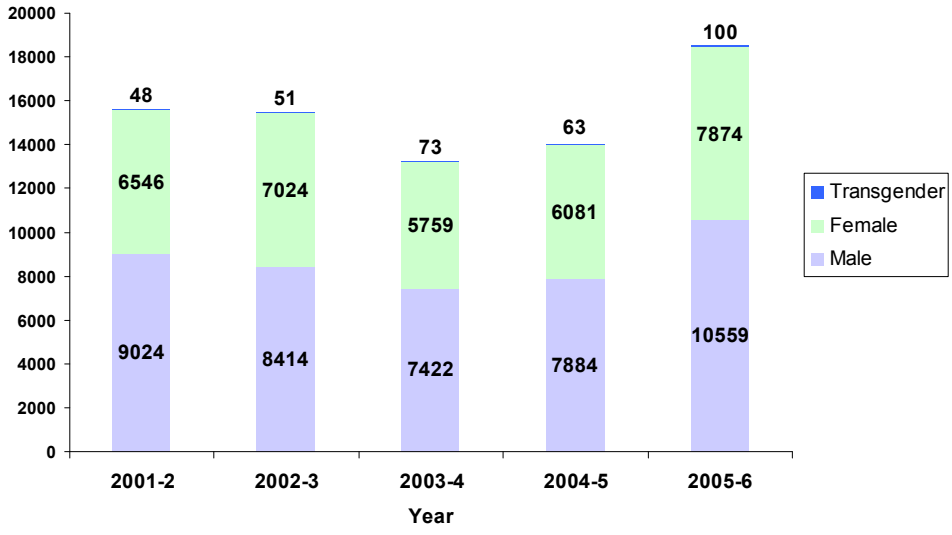
Figure 36a: Total Number of Contacts per Year



Women are more frequent users of outreach services than men

The IDU outreach programs consistently have more outreach contact with males than females – however, given that male IDUs tend to outnumber female IDUs by about three to one[3], women account for a larger proportion of contacts with outreach services (Figure 36b). It appears that women may be more frequent users of outreach services than men. As Figure 36b

Figure 36b: Number of Outreach Contacts (New & Repeat) by Gender



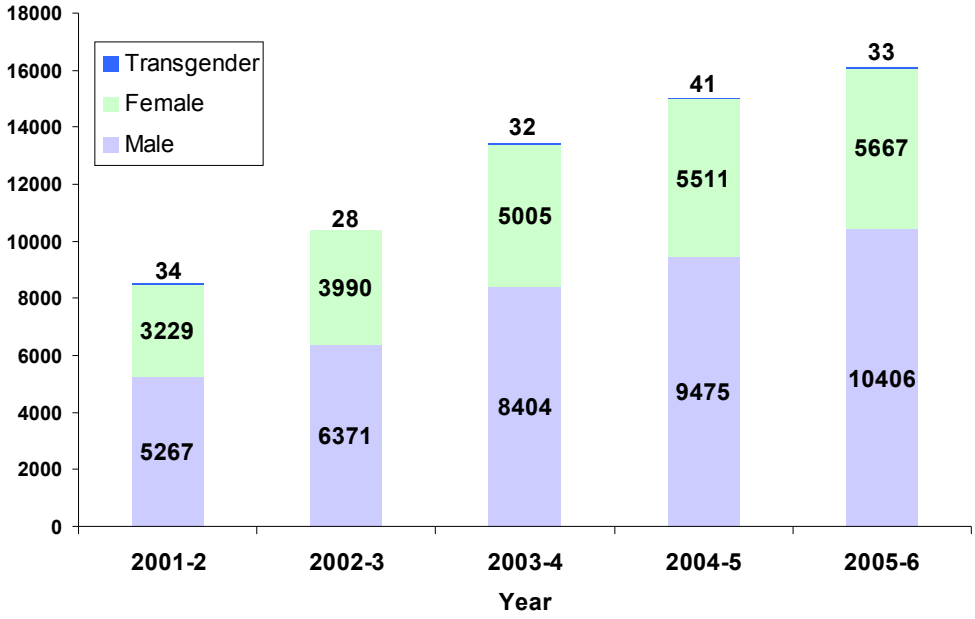
[3] Health Canada. Injection Drug Use and Services in Ontario. An Environmental Scan. May 2003.

indicates, the total number of outreach contacts dropped in 2003/04 and 2004/05 but rose again in 2005/06 – likely due to an increase in funding for IDU outreach programs.

Unlike outreach contacts, inservice contacts (Figure 36c) have increased steadily each year for the past five years.

Women account for a smaller proportion of inservice contacts than outreach contacts. The proportion of men and women using inservice supports more closely match the proportion using injection drugs.

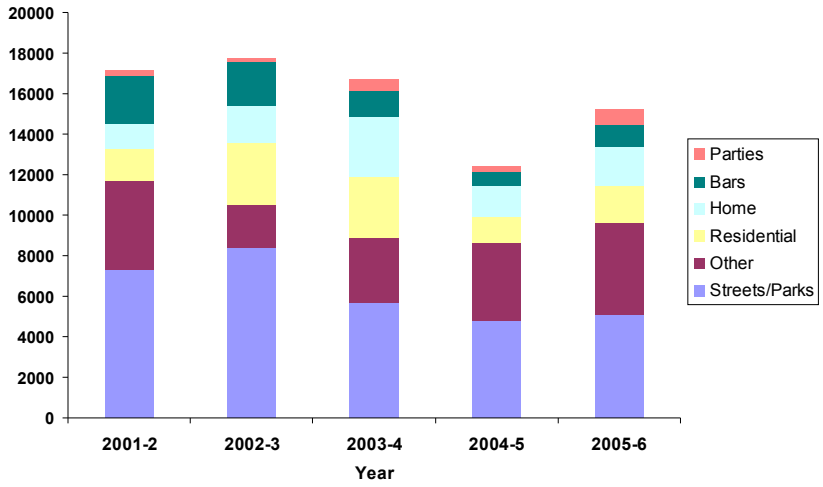
Figure 36c: Number of Inservice Contacts (New & Repeat) by Gender



Outreach programs are seeking out different locations to deliver services

Over the past five years, there has been a shift in the locations where IDU outreach services are provided. Initially they were provided mainly on the streets, in parks or in bars. While streets and parks are still the most common location, more outreach services are being provided in homes, residential programs (i.e., treatment programs) and parties. This trend indicates that programs are being proactive in their efforts to go where clients are.

Figure 36d: Location and Number of Outreach Contacts by Year



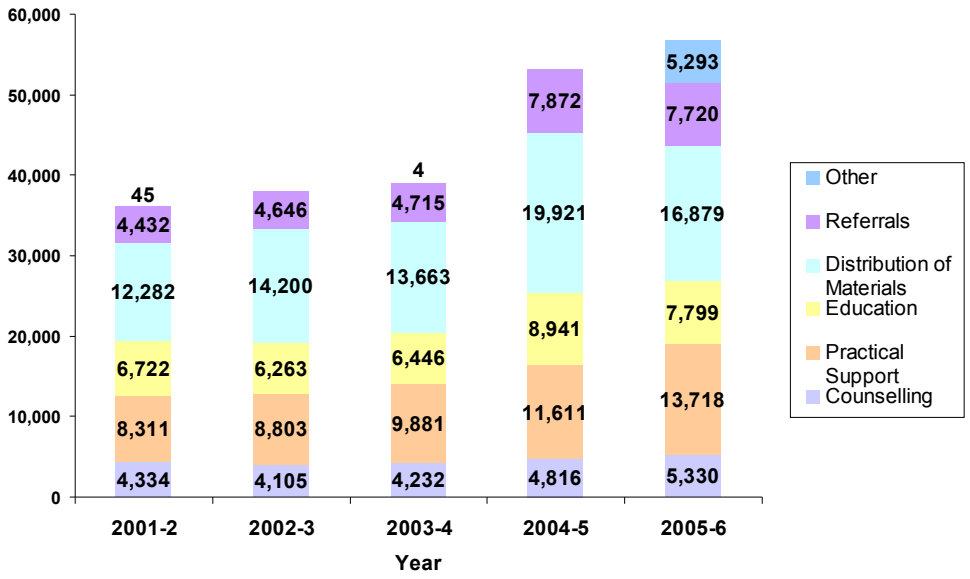
IDU outreach programs are providing more services

IDU outreach programs provide a range of services, including:

- counselling
- practical support
- education
- distribution of materials
- referrals

The total number of services – including both outreach and inservice activities – provided by the IDU programs increased significantly in 2004/05 (up 37% from the previous year) and in 2005/06 (Figure 37a).

Figure 37a: Number and Type of Service Provided per Year



Programs reported providing more of all types of services, but the increase was particularly marked in practical support. This is likely due to the complex needs of people who use injection drugs who – because of their addiction and/or other health and social issues -- often need assistance with income, food and housing. Organizations reported making fewer referrals in 2005/06 compared to 2004/05. "Other" activities in 2005/06 included: operating a health bus, distributing hygiene kits, providing transportation, and providing access to telephone services.

Figure 37b: Mix of Services Provided by Year

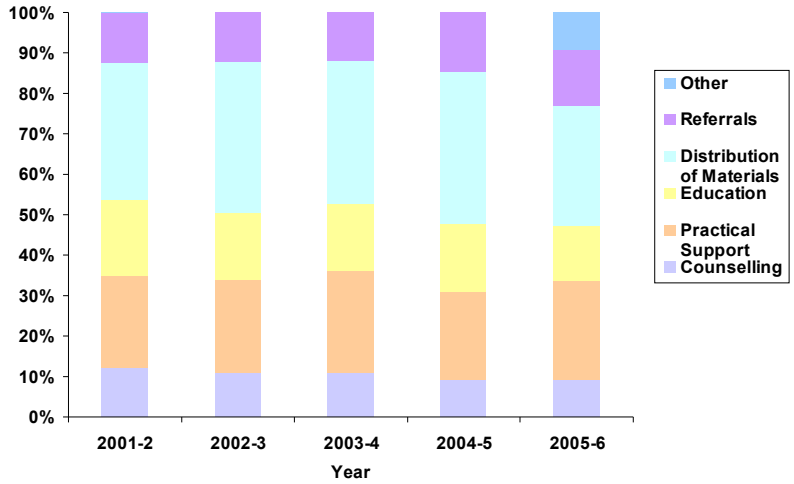
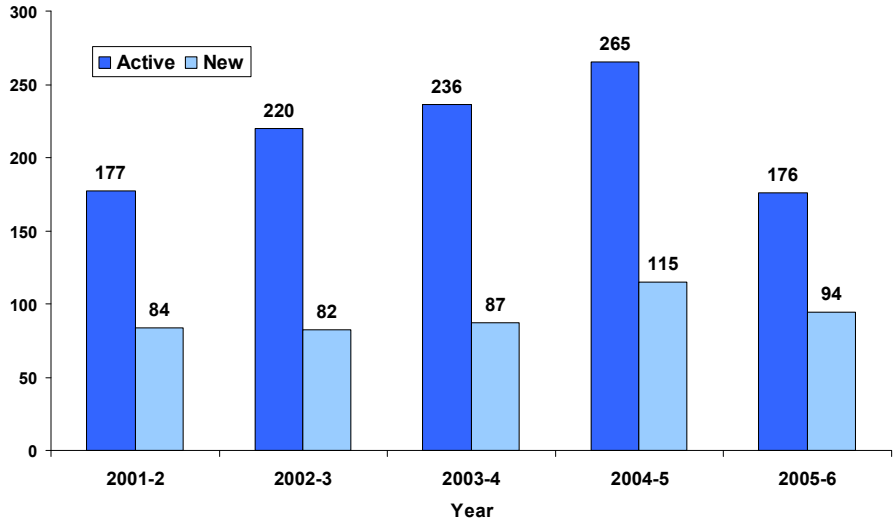


Figure 37b illustrates the proportion of each type of service provided: programs seem to be putting less focus on distributing materials and education, and more on practical support and referrals. This may reflect a more long-term relationship with some clients who have developed trust with the service providers and are using the outreach programs to connect with other services.

Peer Activities

All IDU Outreach Programs are required to have a strong peer component. They are expected to recruit clients to help reach other injection drug users, and to provide training and support.

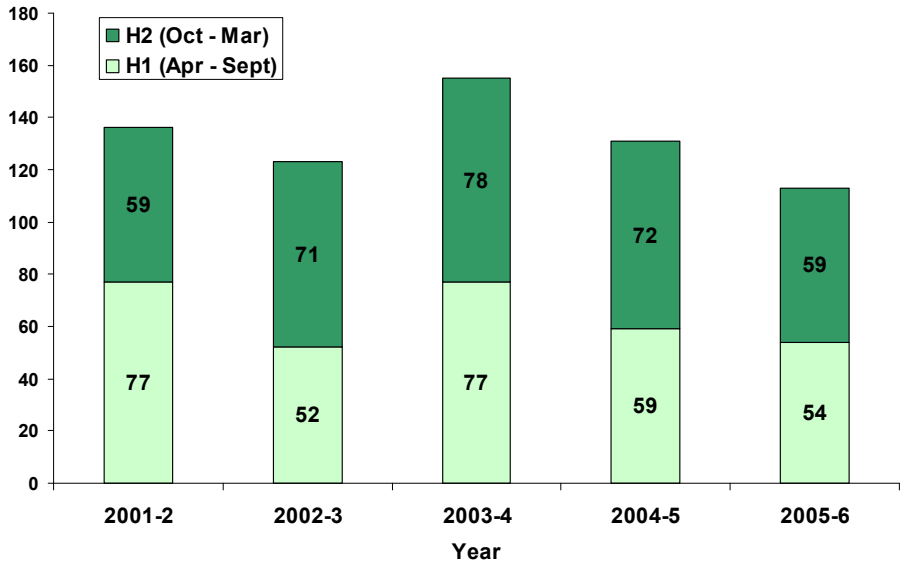
Figure 38a: Number of Peers (Active & New) per Year



The programs have consistently recruited a relatively consistent number of new peers each year (Figure 38a). The significant drop in the number of active peers in 2005/06 may be due to the change in reporting through OCHART. It is possible that, in reporting by quarter in previous years, active peers were double counted. More analysis is required to determine what proportion of peers remain active in the program and for how long.

As part of their peer programs, IDU outreach programs provide orientation and education sessions. The number of sessions held each has remained relatively consistent (Figure 38b): the drop in 2005/05 may be a function of the change in reporting rather than an actual change in activity. The sessions also appear to be held throughout the year, which indicates that peers are receiving consistent support.

Figure 38b: Number of Peer Orientation & Education Sessions per Year



As part of their peer programs, IDU Outreach Programs are expected to hold regular reporting/feedback sessions with peers, to monitor their activities, provide support and learn from their contacts with other injection drug users.

As Figure 38c illustrates the number of reporting sessions held per year seemed to drop substantially in 2005/06. It is unclear whether there was an actual drop or whether this due to the change to OCHART or of reporting errors with the previous quarterly activity reports.

Peers are mainly involved in distributing information and materials, and in informal interactions with other drug users. Figure 38d illustrates the number of peer contacts by LHIN by type of activity.

Figure 38c: Number of Peer Reporting Sessions per Year

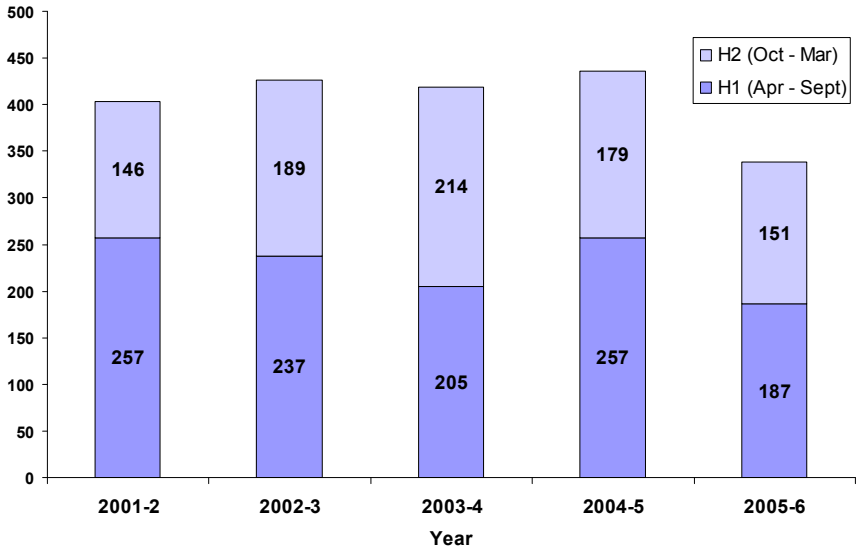
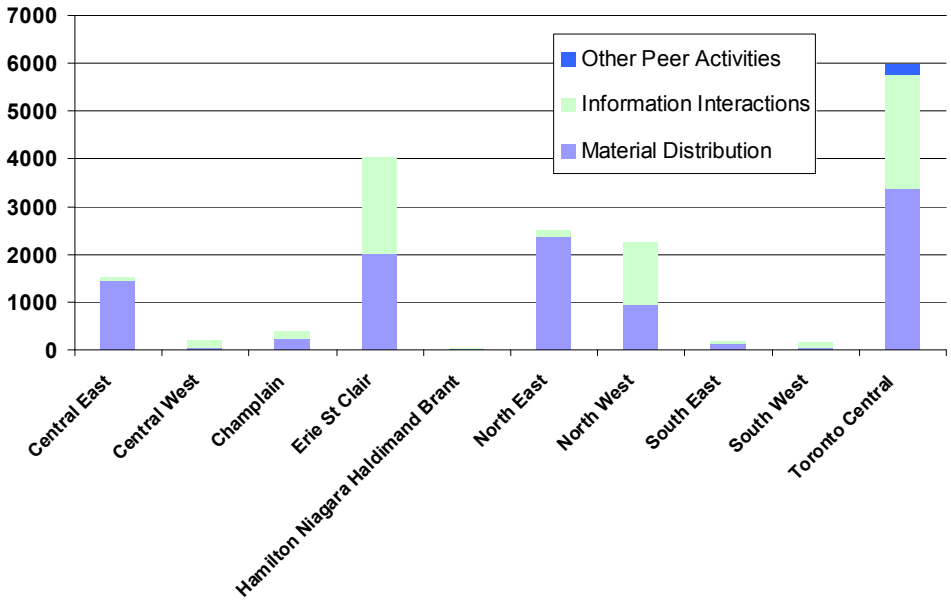


Figure 38d: Number and Type of Peer Activities by LHIN



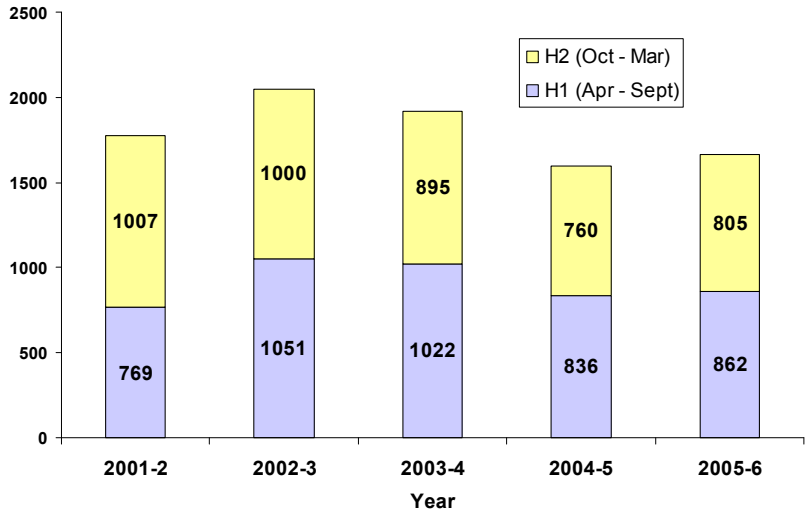
Peers appear to be particularly active in Toronto Central, Erie St. Clair, the North East and the North West. Peers also appear to be more involved in informal interactions with other drug users in Toronto Central, Erie St. Clair and the North West.

Community Development

Community development includes activities designed to help the program become integrated with other services. They are also designed to create a supportive social environment for the program and overcome any public concerns about services for people with addictions. Both staff and peers can be involved in community development, and the data includes the activities of both groups.

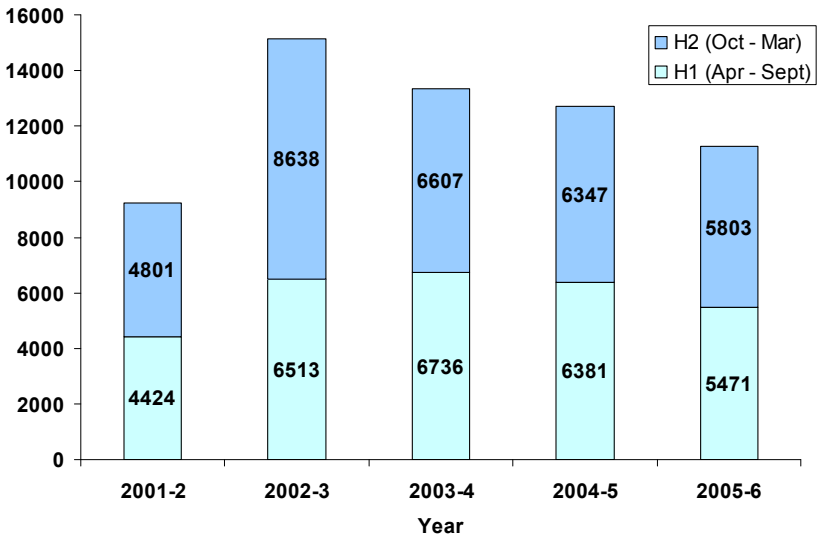
The total number of community development activities – which include contacts with other agencies, making presentations about the program, and attending community meetings – peaked in 2002/03, and remained relatively constant in 2004/05 and 2005/06 (Figure 39a).

Figure 39a: Number of Community Development Activities per Year



The number of people participating in these meetings has also dropped (Figure 39b).

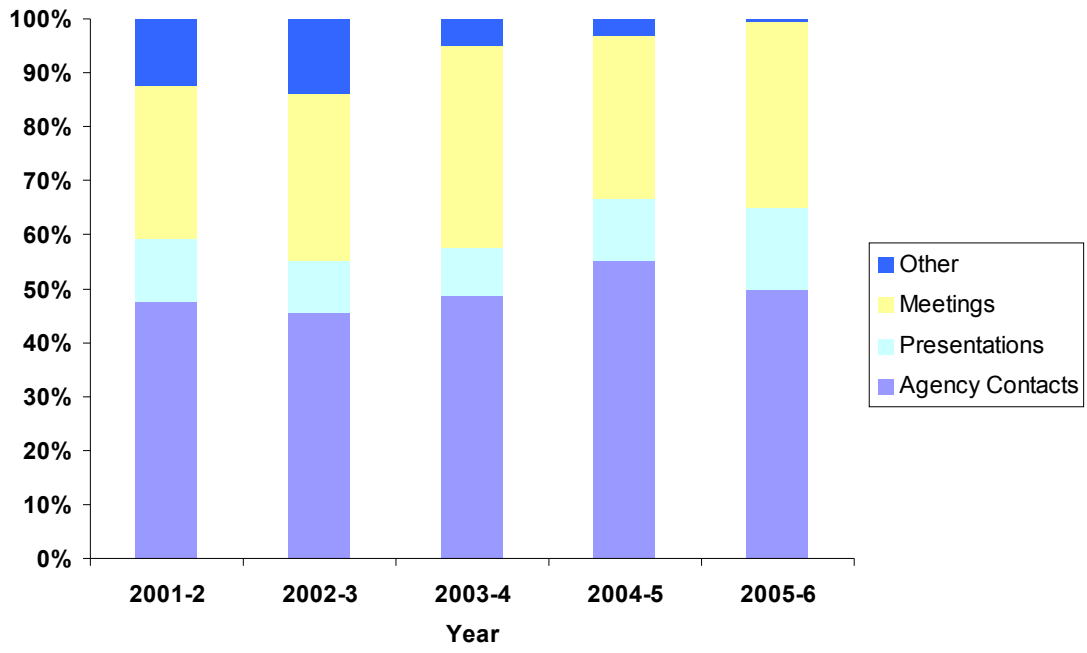
Figure 39b: Number of Participants in Community Development Activities per Year



This trend may reflect the fact that IDU outreach programs are now well established and more accepted in their communities. They have developed their referral networks, and may not have to put the same effort into community development.

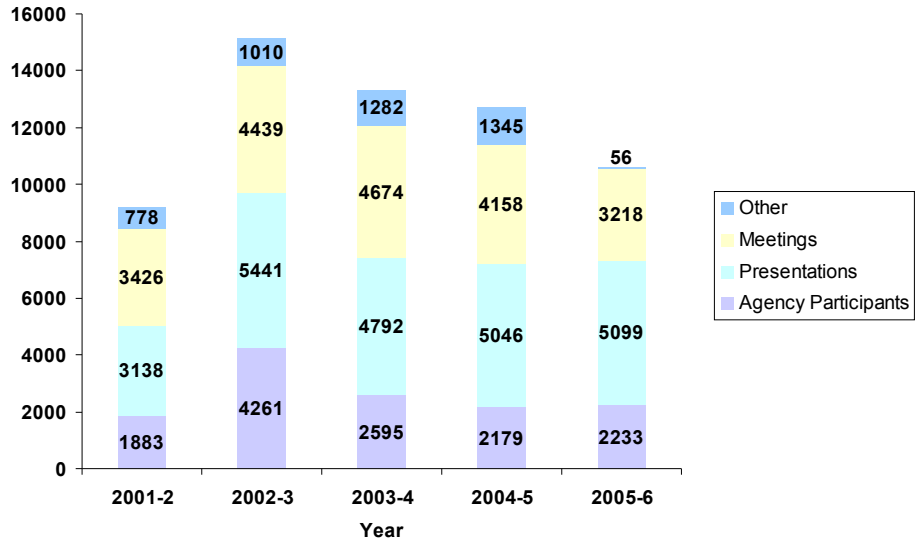
As Figure 39c illustrates, the most common community development activities continue to be contacts with other agencies and community meetings.

Figure 39c: Mix of Community Development Activities by Year



As would be expected, some types of activities reach more people than others (Figure 39d).

Figure 39d: Number of Participants by Activity and Year



For example, the programs reach a smaller number of people through agency contacts than they do when making presentations or attending meetings. However, the agency contacts are likely to lead to more effective services for IDUs, and may have a greater impact on their health and quality of life.

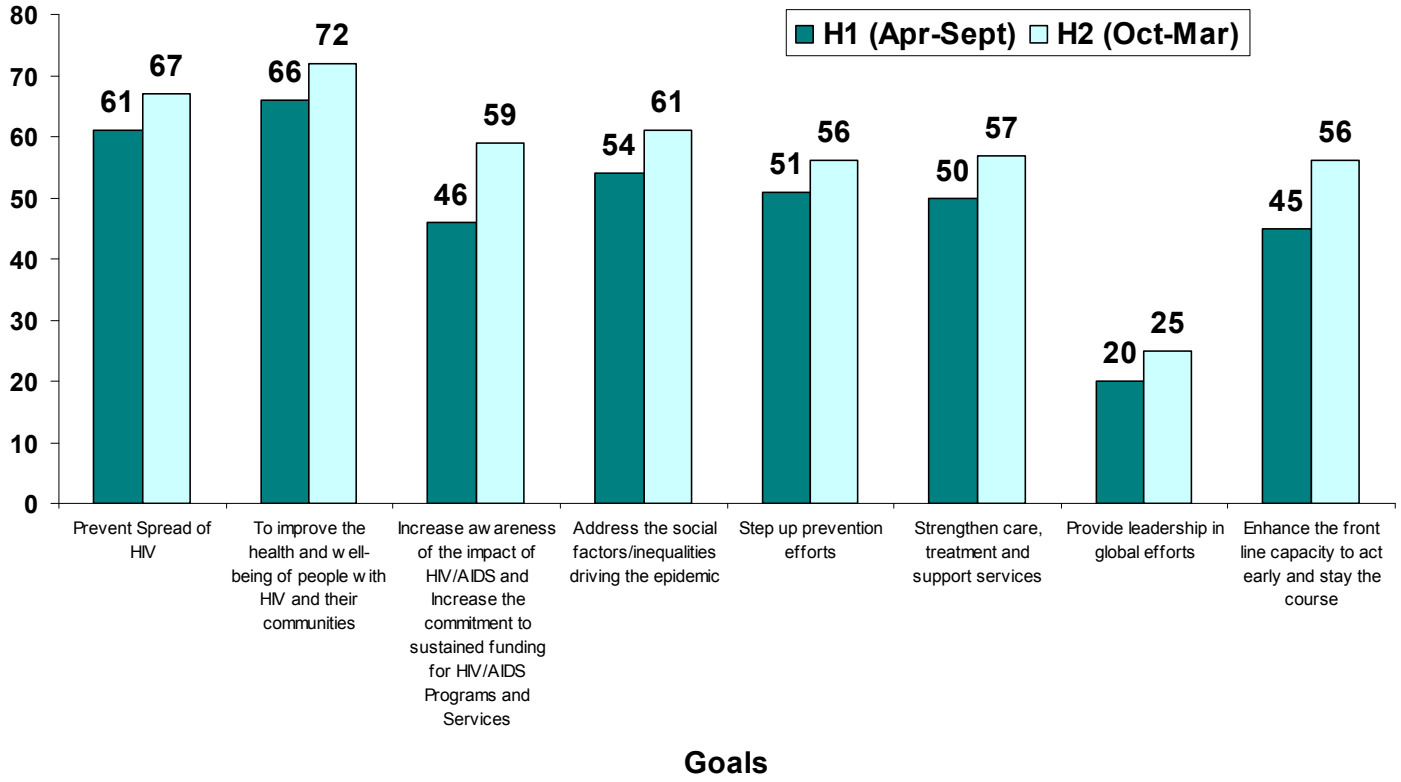
7. Program Planning and Evaluation

Organizations funded by the AIDS Bureau are required to submit program/service plans, and to monitor the effectiveness and impact of their services. Organizations funded by PHAC are required to complete program logic models, and monitor their ability to achieved outputs and outcomes in their logic models. OCHART requested organization to report how they are monitoring services, describe the lessons they have learned, and how they are using that information to refine their programs.

Organizations' goals are consistent with provincial and federal strategies

As Figure 40a indicates, funded organizations share most of the goals of the Ontario HIV/AIDS strategy and Leading Together. There is closer alignment with the provincial goals (i.e., prevent the spread of HIV and improve the health and wellbeing of people with HIV and their communities) than some of the pan-Canadian goals (e.g., provide leadership in global efforts). This is consistent with their role as local front-line organizations.

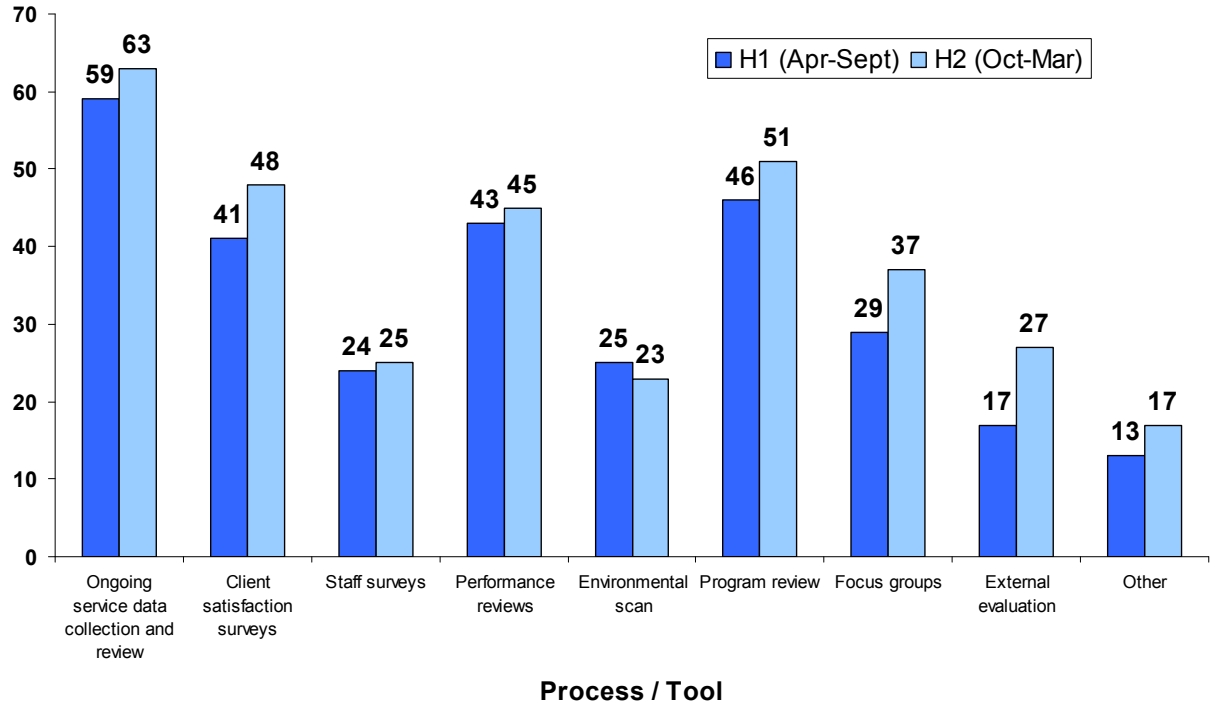
Figure 40a: Number of Organizations Aligned with Provincial and Pan-Canadian HIV/AIDS Strategies (2005-06)



Organizations use a variety of tools to monitor their programs

Figure 40b indicates the types of processes and tools that organizations are using to monitor their programs.

Figure 40b: Monitoring Processes and Tools (2005-06)



The most common are the ongoing collection and review of service information, program reviews, client satisfaction surveys, and performance reviews. During 2005/06, a significant proportion (26% in the first half of the year and 33% in the second half) reported being involved in an external evaluation.

In the "other" category, organizations reported using data from interviews with people living with HIV conducted as part of community planning, data sources in their community (i.e., surveys), feedback from their community advisory committees, participatory evaluation, "chat" meetings, campaign testing, their intake process and informal observations with clients.

Lessons learned from monitoring and evaluations

Organizations reported that, in general, clients are very satisfied with the services they receive. They also have identified a number of "lessons learned" that can be used to strengthen programs:

- the changing health and social needs of clients
- the importance of structures and opportunities to involve target populations
- the types of presentations and training sessions that score high with participants
- ways to improve programs and materials
- many clients continue to experience stigma and discrimination when accessing health services
- the need to provide services over longer hours and in more sites
- the importance of outreach services to reach vulnerable and underserved populations
- outreach models that work in downtown urban areas are not always transferable to other communities
- the need for more information on illicit drug interactions
- how to be more innovative in using resources
- the need to address misperceptions about HIV transmission and risks
- the importance of having administrative structures that allow organizations to adapt programs to meet needs (e.g., changing priorities, reallocating staff and resources, retraining staff and volunteers)
- how to use complementary services to provide comprehensive support for clients
- how to create safe environments for clients and safer working environments for staff
- the need for easy-to-use data collection and monitoring tools
- sharing office space or co-locating programs leads to stronger relationships among agencies and increased consultation to meet client needs
- the value of partnerships to meet client needs
- the importance of training volunteers appropriately, and ensuring they have meaningful opportunities
- the need to be aware of and anticipate the impact of changes in health or other policies on client needs.

Organizations use evaluation information to refine programs and services

As a result of their monitoring and evaluations, organizations reported making the following type of changes to their programs and services:

- creating structures (e.g., offering honorariums, providing agency ID) to allow more members of target populations to be involved
- developing new community partnerships
- finding ways to hire more outreach staff
- developing new programs and services
- adapting existing programs and services to meet needs
- reallocating resources to meet changing client needs
- implementing regular program reviews; developing work plans for staff

- implementing a case management approach
- reviewing and updating strategic plans
- providing more staff and volunteer training.

Over half of community-based organizations participate in community-based research

Community-based research is one means to assess the impact and/or effectiveness of programs and services.

In 2005/06, over half (40 of 74) of the organizations funded by the AIDS Bureau and/or PHAC reported being involved in community-based research. Two others indicated that they intended to be more involved in community-based research within the next year.

The type of involvement included:

- working with researchers on a particular study/program evaluation (e.g., providing information, recruiting participants, providing office space) (27 organizations)
- being a co-investigator in a community-based research project (5 organizations)
- having an ongoing relationship/partnership with an academic centre (4 organizations)
- conducting funded studies/developing programs that include a research component (12 organizations)
- incorporating research findings into practice/capacity building (2 organizations)
- helping organizations conduct community-based research (1 organization).

(Note: organizations may be involved in different ways in different research projects.)

Community-based organizations predominantly play a supportive role in community-based research, helping to recruit participants or provide sites for academic researchers; however, a growing number of organizations are successfully competing for research funding and playing more of an active role in planning and conducting studies. A relatively small number of organizations made specific reference to activities related to translating research knowledge into practice.

Organizations value the opportunity to participate in community-based research, but one respondent noted that the involvement comes at a certain cost: "A number of large mainstream AIDS service organizations request that we provide research participants for their studies but do not provide budgets for translation or coordination activities … [as a result, staff] find it stressful to support the work."

8. Emerging Trends

Emerging Trends

OCHART asked all funded organizations to identify any emerging trends in their programs. Because the questions were open-ended, it is not possible to do a quantitative analysis. The following pages provide a summary of the types of changes and shifts identified by organizations as well as the steps they have taken to respond to changing needs.

8.1 Education and Community Development Services

In 2005/06, 47 organizations reported changes – usually increases – in demand for education and community development services. The greatest increases occurred in education provided to other community organizations, including other health agencies, and schools.

As Table 8.1 illustrates, the types of services requested varied considerably across organizations, depending on their role or mandate. There were no obvious provincial trends in the changes in activities.

In general, the response to any increase in demand for education or community development is to provide more services and/or to develop partnerships with other organizations to meet needs; however, a handful of organizations noted that they did not have the resources to respond to some requests.

Table 8.1: Emerging Trends in Education and Community Development

Shift/Trend	Organization/s	Response
In groups requesting education and community development services		
↑ health agencies	North East Waterloo Wellington Champlain Hamilton Niagara Haldimand Brant Toronto Central	• organized workshop for drug and addiction workers and women's community agencies • working with other agencies to develop programs that meet client needs • offering workshops to a wider range of groups • providing education to long term care facilities who are receiving more admissions of people with HIV
↑ other community organizations	North East Central East Toronto Central Central West	• created strong relationships with police, drop-in centre and ODSP workers • preparing harm reduction information packages increased partnerships and training for speakers' bureau • considering hosting monthly meeting with agencies serving adolescents and women • developing an FAQ sheet for

Shift/Trend	Organization/s	Response
		community agencies about a housing development • providing train the trainer workshops for ASOs working with prisoners • developing partnerships to address determinants of health and social justice • delivering workshops to Toronto Hydro
↑ faith based and other community organizations related to global impact of HIV/AIDS	Waterloo Wellington South West	• used volunteers from Canada World Youth (India and Canada) to target secondary schools
↑ elementary and secondary schools	Erie St Clair Central East North West	• trying to reassign staff to meet demand from schools • providing more presentations about STIs in schools and providing age appropriate pamphlets
↓ from secondary schools (despite – as one organization reported -- efforts to solicit interest)	South West	• working with Teachers College, health unit and school board to develop age appropriate activities/learning sessions • had summer student develop four lesson plans for grades 7 and 8
↑ women, women's organizations	Toronto Central Hamilton Niagara Haldimand Brant	• providing workshops on HIV/AIDS and STI awareness, as well as related health issues such as cervical cancer • collaboration with a women's organization to develop more programming for Aboriginal women
↑ gay community	Toronto Central (related to party drugs, crystal meth) Erie St Clair	• has received funding to provide education about crystal methamphetamine
↑ ethnocultural communities	Toronto Central	• collaborating with another agency to organize workshops for men to discuss their prejudices and own HIV/AIDS discrimination • providing treatment information in additional languages (e.g., Tamil, Punjabi, Swahili) • making presentations
↑ youth	South West Toronto Central North East	• providing more displays and information sessions • developing updated web site for youth • providing training for parents to provide support groups (related to two deaths in the hemophilia community) • planning a Summit where

Shift/Trend	Organization/s	Response
		hemophiliac youth can discuss their concerns and needs • involving youth in presentations to First Nations communities
In types of services requested		
↑ informal in-home sessions	Champlain	•
↑ women specific workshops (e.g., family planning)	Toronto Central	• working collaboratively with other organizations to develop workshops
↑ speakers to present at social service clubs	Toronto Central	• responding to requests
↑ harm reduction information on hep C transmission through inhalant drugs	Waterloo Wellington	•
↑ interest in Kondoms and Karaoke program	Champlain	• working with community agencies locally and across Canada to facilitate program • starting a support group for youth
↑ demand for information in certain formats	Toronto Central	• learned that their target audience responds better to quizzes, ice breakers and certain visual tools
↑ organizational loss	Toronto Central	• reworking existing materials to speak to various audiences
↑ integrating treatment information into existing services	Toronto Central	• hiring a consultant to develop and deliver train-the-trainer materials • strengthening regional networks of treatment information providers
↑ advocacy with government	Toronto Central	• held four meetings with MPPs and government representatives to reinforce that HIV/AIDS is a health, economic, cultural and educational issue
↑ information on rapid testing	Toronto Central	• responding to requests for information and training on use of the rapid test

8.2 Outreach Programs

Thirty-five organizations reported shifts or changes affecting outreach services. Table 8.2 summarizes the emerging trends in populations needing outreach and in the types of services requested.

Over the past year, organizations have identified more need for outreach services for newcomers, injection drug users and women. Agencies have seen increases in requests for needles, safer cocaine kits and other drug related supplies, and condoms as well as for more information for culturally diverse communities and more information on STIs.

There can be some danger involved in providing outreach services, particularly to drug using and street involved populations – including sex workers. Two organizations discussed the impact of safety issues on their ability to deliver outreach services.

Table 8.2: Emerging Trends in Outreach Services

Shift/Trend	Location of Organizations (by LHIN)	Response
In populations needing outreach services		
↑ people from countries where HIV is endemic – including youth, refugees	Hamilton Niagara Haldimand Brant Toronto Central Central West	• increasing outreach to these communities • providing more training for staff and volunteers on immigration issues • doing monthly outreach to Chinese businesses (e.g., beauty salons, bars, video stores)
↑ injection drug users – particularly those wanting access to methadone, treatment, testing or other health services or access to stable housing	Erie St Clair Hamilton Niagara Haldimand Brant Toronto Central	• referring more clients to physicians and addiction treatment • providing more training for staff and volunteers
↑ young women	North East Central West Toronto Central	• restructuring the young women's support group • develop an outreach plan to young women's communities • hiring a women's outreach worker
↑ gay men – particularly young gay men	South West Champlain	• working with health unit to reach the MSM community • providing training for bath house staff • meeting with local bars to improve access to HIV prevention materials • doing outreach with Pink Triangle Youth
↑ escorts, massage parlours; Aboriginal sex workers	Toronto Central	• reduced drop-in hours and dedicated more time/ resources to outreach – beginning with phone outreach to escort services • initiated outreach in new locations in the city • providing practical assistance (e.g., assistance with child care, financial planning, harm reduction)

Shift/Trend	Location of Organizations (by LHIN)	Response
		• hiring an Aboriginal outreach worker
↑ schools and youth serving agencies (requesting presentations, workshops and information) – including agencies serving ethnocultural and Aboriginal youth	Champlain Toronto Central Central East	• working to address issues of Aboriginal and newcomer youth • working with schools to develop AIDS modules and provide training for teachers and workshops for students
↑ other community organizations	Hamilton Niagara Haldimand Brant Toronto Central Central East	• providing more presentations at shelters and soup kitchens • meeting with local police to address community concerns about drug use and sex trade; advocating for a coordinated response using the four pillars approach developed by Vancouver
In services requested		
↑ needles, safer cocaine kits and supplies	Waterloo Wellington (increase in demand for glass stems instead of needles) Erie St Clair Hamilton Niagara Haldimand Brant Toronto Central Central East	• meeting with health unit/other agencies to develop new partnerships to distribute safer crack cocaine kits and other supplies • advocating with health units to expand needle exchange program • working with new harm reduction distribution program offered through the Hep C secretariat • using outreach team to distribute tools and supplies • changing outreach route to mach client needs (e.g., more clients now in Internet cafes because of cold weather)
↑ culturally appropriate materials	Central West Hamilton Niagara Haldimand Brant	• partnering with ethnically diverse groups • hiring staff from the African and Caribbean communities
↑ condoms	North East Hamilton Niagara Haldimand Brant Toronto Central	• doing more outreach in barbershops and bathhouses to reach young people
↑ women's condoms and gloves	Central West Hamilton Niagara Haldimand Brant	•
↑ information on STIs	Toronto Central	• promoting information on STIs • distributing information and referring clients to clinics for STI testing
↑ treatment information and distance learning	Toronto Central	• developing publications and workshops on HIV/HCV co-infection, the treatment experienced PHA, HIV and aging, information for vulnerable populations starting treatment, structured treatment interruptions, HAART and drug side effects
↑ legal advice	Toronto Central	• developed partnership with local legal office

Shift/Trend	**Location of Organizations (by LHIN)**	**Response**
↑ door to door prevention services	Toronto Central	• is starting to provide door to door outreach services, targeting young people
In organizational issues		
↑ safety issues for street workers	Toronto Central	• pairing workers when they are providing services in new areas or starting new projects
agency policy requiring outreach volunteers to be accompanied by staff ensure safety and avoid liability issues but hampers outreach activities	Waterloo Wellington	• identifying activities and locations where volunteers, working in pairs, can work with the least danger

8.3 Support Services

Forty-four organizations provided information on shifts or changes in clients seeking support services and/or the type of support services they need. The most significant changes in client demographics appear to be an increase in people from countries where HIV is endemic and an increase in long-term survivors seeking services.

The most significant increases in support needs were for:

- financial and other practical assistance – in particular, assistance with transportation. The cost of bus tickets and other forms of travel to appointments continues to be a major barrier for many clients
- culturally and linguistically appropriate services for newcomers and people from countries where HIV is endemic, including assistance dealing with immigration issues
- mental health services
- case management
- complementary therapies.

Table 8.3: Emerging Trends in Support Services

Shift/Trend	Location of Organization/s	Response
In client demographics		
↑ people from countries where HIV is endemic	South West Toronto Central Hamilton Niagara Haldimand Brant Champlain	• submitted proposals for funding African/Caribbean support worker (South West)
↑ long-term survivors/clients over age 55	Waterloo Wellington Hamilton Niagara Haldimand Brant Toronto Central	• starting a dying with dignity fund, purchasing a headstone for a group cemetery plot
↑ women	Champlain Hamilton Niagara Haldimand Brant Toronto Central	• planning workshops for women • developing support group for HIV+ women
↑ injection drug users	Champlain Toronto Central	• developing partnerships with other organizations (e.g., public health) to provide needle and pipe exchange
↑ people in rural areas	South East	•
↑ men	Waterloo Wellington Toronto Central	•
↓ heterosexual males with addiction issues	Hamilton Niagara Haldimand Brant	• taking steps to manage difficult clients with substance use issues (e.g., no trespassing notices on clients using or dealing on site)
↑ certain groups of sex workers: dancers and escorts and Aboriginal sex workers	Toronto Central	• developing a resource guide for dancers • creating a guide for Aboriginal sex workers
↓ GBLT group	Central East (likely due to increase in Gay Straight Alliance Groups in region)	• supporting GSA groups and planning quarterly events for queer youth
In support needs		

Shift/Trend	**Location of Organization/s**	**Response**
↑ FInancial assistance, food banks, grocery vouchers, bus tickets/cab service/Northern Travel Grants, assistance with phone bills/ utilities, assistance accessing Trillium Drug coverage	North East Waterloo Wellington Central East Waterloo Wellington South West (up 68% since 04/05) Erie St Clair Central Hamilton Niagara Haldimand Brant Toronto Central Champlain Toronto Central South East Central West North West	• increasing value of weekly food voucher • changing current financial assistance programs • doing more fundraising • working with ODSP and Ontario Works to help clients access monthly bus passes • developing an emergency transportation fund/driving program • advocating locally and provincially to increase social assistance, minimum wage and end clawback of national child care tax credit • planned a session on Ontario Works/ODSP supports at Opening Doors conference • encouraging clients to use other resources (e.g., city food banks, local drop in programs) • developing partnerships with local food bank • offering a money management workshop • providing information/helping clients apply to long-term disability, Trillium, Northern Health Travel Grant and other assistance programs
↑ Services for newcomers (e.g., translation services, ethnic foods in food hampers, support groups that respect need for confidentiality)	Waterloo Wellington Central Erie St Clair Toronto Central	• developing workshops and projects that focus on ethnocultural issues • hiring an ethnocultural worker • finding people from other communities to act as translators (to address confidentiality/disclosure issues) • working with other organizations • developing plan to provide translation services by speaker phone • translating brochures • recruiting volunteers who can speak certain languages
↑ Legal services including Immigration services/costs	Waterloo Wellington Toronto Central Central West	• forming partnerships with agencies that can help with immigration issues • assisting clients with immigration issues • providing training and workshops for staff • offering some immigration/legal services
↑ Health services for clients without health cards	Waterloo Wellington Central West	• working with local pharmacist to address refugee issues
↑ Mental health services/support groups on depression, stress, grief	Waterloo Wellington Toronto Central North West	• ACT/PWA partnership to provide holistic wellness services • providing depression support groups for PHAs • linking with CMHA • incorporating an HIV psychiatrist into services • developed an expressive arts program to help PHAs deal with anticipatory grief • working with Mt. Sinai hospital to develop

Shift/Trend	**Location of Organization/s**	**Response**
		culturally appropriate mental health tools
↑ Case management/health needs	Waterloo Wellington South West North East (health kits) North West Central East	• hired case manager/support worker on 3-month contract to help meet demand for services • considering doing outreach to physicians to promote HIV testing of pregnant women (several women recently diagnosed after childbirth – North West) • considering educating and building partnerships with child protection workers • restructuring service hours • providing health kits monthly instead of every two months
↑ Complementary therapies (e.g., chiropractic, massage, nutrition services, yoga)	Waterloo Wellington North West Toronto Central	• developed partnership with local chiropractor • made contact with a life coach • created partnership with a registered massage therapist • searching for funding to bring in a nutritionist (Masai Clinic) • partnering with other organizations to provide vitamin supplements
↑ Affordable housing	Hamilton Niagara Haldimand Brant Central East (for IDUs)	• establishing partnerships with local Access to Housing
↑ Supportive counselling	Champlain	•
↑ Complex pre-release planning for prison population	Toronto Central South East	• working with other organizations to address needs of ex-prisoners from the African and Caribbean community
↑ Counselling	Waterloo Wellington Central East Toronto Central Champlain	• developing a partnership with the Childen's Hospital of Eastern Ontario • offering tutoring program for children between the ages of 8 and 14
↑ Advocacy	South West Central East (for IDUs) Toronto Central	
↓ Safety planning for people who are homeless	Toronto Central	• accessing agencies with expertise in mental health • working with clients of the Homeless Outreach Program to develop a safety plan • making referrals to other agencies

8.4 Volunteer Programs/Services

Thirty-two organizations reported some shifts or changes in their volunteer programs. In general, agencies are working with more students and youth volunteers. Those in large urban areas are also seeing more newcomer volunteers. In both cases, the volunteers' commitment is often short-term: long enough to fulfill high school requirements or to gain work experience. This means that organizations are continually recruiting and training. A number of organizations also noted that volunteers want opportunities that allow them to develop new skills or do meaningful work.

As Table 8.4 illustrates, organizations have identified a range of roles for volunteers, depending on their mandate or focus.

Table 8.4: Emerging Trends in Volunteer Services

Shift/Trend	Organization/s	Response
In volunteer demographics		
↑ youth/student volunteers due to high school requirements, student placements – although some students not available during business hours and many do not stay on after they have completed their required hours	North East Toronto Central Toronto Central South West Hamilton Niagara Haldimand Brant South East Champlain North West	• providing positive experiences so youth continue to volunteer after they meet their academic requirements • creating specific volunteer opportunities for students who are not available during working hours • developing new partnerships • mentoring 5 people from Pro Bono Students Canada
↑ older volunteers/retirees	Hamilton Niagara Haldimand Brant Toronto Central Champlain	
↑ PHA volunteers (as health allows); more clients interested in developing/delivering Positive Youth Outreach services	Toronto Central Hamilton Niagara Haldimand Brant Champlain	• developing PHA Support Volunteer Training workshop • developing meaningful opportunities for clients to develop skills to address HIV issues
↑ newcomers (often short-term to gain Canadian work experience)	Hamilton Niagara Haldimand Brant Toronto Central	• ensuring a positive experience so volunteers stay longer • collaborating with PWA Speaker's Bureau to train South Asian PHA volunteers • adapting core volunteer training to meet needs of newcomer volunteers • implementing outreach strategies in Spanish, East Indian, African and Asian communities • expanding volunteer opportunities to provide meaningful work for highly skilled volunteers
↑ volunteers from re-training programs	Toronto Central	
In role of volunteers/volunteer services required		
Change in organization's	Champlain (more targeted gay men's prevention	• assessing volunteer needs • developing partnerships with organizations

Shift/Trend	Organization/s	Response
services/priorities	through online and park/bar/bath house outreach) Toronto Central (more work in endemic communities) Hamilton Niagara Haldimand Brant Champlain	working with people from countries where HIV is endemic • developing training programs to give volunteers skills to work in priority areas • assessing potential to use volunteers on AIDSline • developing a brief skills/ experience matching assessment • matching volunteers to specific client needs
↑ services for youth	Champlain North East North West	• creating partnerships to start programming for positive youth • recruiting youth to participate in educational workshops on reserve • recruiting youth from schools and involving youth in peer teaching
↑ speakers	Toronto Central Hamilton Niagara Haldimand Brant	• develop a training program for youth with HIV and youth allies in education, media relations and public speaking • revising standard volunteer training to focus on prevention education
↑ IT support (web site, network)	Toronto Central	•
↑ fundraising	North East Toronto Central	•
↑ special events planning	Champlain	•
↑ program development and delivery	Toronto Central Toronto Central	• revitalize Positive Youth Outreach and involve group in program development
↑ administrative tasks	Toronto Central Waterloo Wellington	•
↑ assisted daily living/practical support for clients	Hamilton Niagara Haldimand Brant Champlain Toronto Central	• developed Peer Educators/ Mentors/Advocates Program and worked with CCACs to meet needs • designing assisted daily living tracking and assessment documents to improve client care as well as communication with volunteers • examining mileage rate to attract more volunteers willing to drive • starting new buddy program
↑ tutors for school age children	Theresa Group	• partnering with community programs such as JUMP
↓ practical support for clients	Waterloo Wellington	• assessing client needs to determine how best to use volunteers
↑ "virtual" volunteers to test computer applications	Toronto Central	• recruiting diverse group of volunteers • inviting existing volunteers to participate in Internet projects
In volunteer recruitment and training		
↑ need to recruit/develop volunteers to avoid volunteer burnout	North East Toronto Central	• placing ads in newspapers • identifying role for volunteers in recruiting and mentoring new volunteers • submitting a grant application to Trillium • securing funding through partnerships with Ontario: Canadian Volunteerism Initiative

Shift/Trend	Organization/s	Response
		to increase recruitment activities • providing incentives for peers to volunteer
Lack of staff time to coordinate volunteers and/or space for volunteers	Waterloo Wellington Toronto Central	• considering staff development • identifying a volunteer who can assist with volunteer coordination
↑ volunteers wanting to develop new skills (e.g., computer skills, knowledge about HIV)	Toronto Central	• staff focus on volunteer training • developing a brief skills/ experience matching assessment • creating specific projects with clear descriptions for each volunteer • using other organizations that provide volunteer trainings that are either cost effective or free • creating new volunteer training materials • increasing number of orientation sessions

8.5 IDU Outreach Programs

In the 2005/06 OCHART reports, 14 IDU outreach programs noted some changes or shifts in client needs. Table 8.5 summarizes both the emerging trends and the strategies programs are using to meet changing needs. The trends highlight the complex health and social needs of people who use substances, as well as the impact that changes in the broader environment – such as police procedures and the opening of methadone clinics – can have on clients and on the outreach programs.

In general, programs are seeing an increase in crack/cocaine and crystal methamphetamine use as well as an increase in the number of youth and women using their services. They are responding with education, new or modified outreach programs and collaboration with other agencies to meet the needs of these populations.

Table 8.5: Emerging Trends in IDU Outreach Services

Shift/Trend	Organization/s	Response
In drug use		
↑ cocaine or crack use/injection drug use	North East Toronto Central South East North West Central East	• dedicating one store-front window to safer injection information • training program staff and peers how to work with cocaine users • meeting with clients/developing trust to find out where new shooting galleries are • increasing outreach to clients living on the streets • becoming better educated about issues
↑ crystal methamphetamine use – some direct use/some other drugs cut with crystal meth	South East Toronto Central North West Central East	• gathering information about crystal meth, preparing handouts and making presentations • adapting information developed by the AIDS Committee of Toronto • becoming better educated about issues
↑ clients on	North East	

Shift/Trend	Organization/s	Response
methadone, which is associated with more cocaine use/problems related to prescription opioids	North West Erie St Clair	
In client demographics		
↑ youth – in one case due to specific outreach to young men 16 to 24 years	Toronto Central South East Central West North East	• adding an outreach program for youth and consulting with youth to guide the program • hiring a part-time outreach worker to target youth • using ties with youth in youth drop in centres • developing relationships with other agencies that provide addiction counselling, referrals and HIV/AIDS supports
↑ women	Toronto Central	• co-facilitating a bi-weekly women's group with the Sexual Assault Centre
↑ clients who are transgendered (related to hormone use)	Central West	
In health problems		
↑ sores associated with crystal meth use	North West	
↑ serious infections at injection sites related to using vinegar to cut cocaine	North West	• providing information on the risks of using vinegar with cocaine – and researching safer cocaine use methods, such as distributing powdered ascorbic acid
↑ co-infection/concurrent diagnoses (e.g., hepatitis C, mental health issues) – which means that clients require "longer interactions" and "complex referrals and supports	Toronto Central	• working with the York and North York Harm Reduction Coalition to make more effective referrals and provide more comprehensive support
↑ health problems related to injection drug use	Erie St Clair	
In social/environmental issues (determinants of health)		
↓ IDUs on the streets (now in more hidden venues, such as crack houses and bush areas	North East	• working through escort services to reach IDUs •
↑ police activity which makes it more difficult for agencies to reach people at risk	South West Central	• planning in-service education for the local police force on HIV/HCV transmission, harm reduction and the agency's outreach programs • modifying outreach to crack houses
↑ street sex trade beyond the usual locations	North West	• increasing peer outreach to sex trade workers
↑ privately run methadone clinics which increase the number of people on methadone	North West	

Shift/Trend	Organization/s	Response
but do not provide the counselling and support services that lead to effective methadone management		
↑ violence in the community, making it harder to reach people at risk and increasing the need for support services	Toronto Central	• developing a community radio show with a university radio station, targeting youth and violence issues • requesting funding from the City to increase peer program that addresses violence
↑ infections among people in prison who reported sharing needles when inside; ↓ of harm reduction services in prison	Toronto Central	• developing a new program to deliver harm reduction services to jails • offering help with advocating for needle exchange programs for prisoners • providing information on how to survive in the Canadian penal system • encouraging clients coming out of the prison system to be tested for HIV and hepatitis C • providing outreach to men in prison
↓ lack of needle exchange programs in First Nations communities	North West	• creating training opportunities for community workers on counselling • bringing issues to the attention of community leaders
In demand for services		
↑ requests for sterile water, cookers, cocaine kits, education, supplies, condoms	North East Toronto Central Central Central East Erie St Clair	• reviewing the feasibility of adding safer cocaine kits to harm reduction programs • distributing safer inhalation kits • increasing the number of cocaine pipes distributed each month
↑ requests for needles	Central West Toronto Central	• making extra deliveries of needles to certain sites
↑ requests for social support, support groups	Hamilton Niagara Haldimand Brant	• developing support groups • contacting hep C support network to develop a group and other supports
↑ requests for addiction counselling and/or treatment	Toronto Central Central East	• making links with withdrawal management and other addiction services
↑ requests for nutritional supplements, warm clothes, sleeping bags, housing, outreach to shelters, help advocating with medical and social service providers	Toronto Central Hamilton Niagara Haldimand Brant South East	• making more effective referrals and working with other agencies to support clients more effectively • approaching businesses to provide warm clothing and hygiene products • developing relationships with mental health programs
↑ requests for harm reduction presentations from other community-based agencies	Erie St Clair	• planning joint "roadshow" with Needle Exchange Program to take harm reduction information to rural communities • using the Best Practice Guidelines for Needle Exchange Programs to help build community/political support for harm reduction programs

Appendix A: Alphabetical List of Funded Organizations

Organization	LHIN
2-Spirited People of the 1st Nations	Toronto Central
Access AIDS Network - Sault Ste. Marie	North East
Access AIDS Network - Sudbury	North East
AIDS Committee of Cambridge, Kitchener, Waterloo and Area	Waterloo Wellington
African and Caribbean Council on HIV/AIDS in Ontario	Toronto Central
African Community Health Services	Toronto Central
Africans In Partnership Against AIDS	Toronto Central
AIDS Action Committee of Perth County	South West
AIDS Bereavement Project of Ontario-sponsored by Fife House Foundation, Inc	Toronto Central
AIDS Committee of Guelph & Wellington County	Waterloo Wellington
AIDS Committee of Guelph and Wellington County - HIV Outpatient Clinic	Waterloo Wellington
AIDS Committee of London	South West
AIDS Committee of North Bay and Area	North East
AIDS Committee of Ottawa	Champlain
AIDS Committee of Simcoe County	North Simcoe Muskoka
AIDS Committee of Toronto	Toronto Central
AIDS Committee of Toronto – Positive Youth Outreach	Toronto Central
AIDS Committee of Toronto - VIVER	Toronto Central
AIDS Committee of Windsor	Erie St Clair
AIDS Committee of York Region	Central
AIDS Niagara	Hamilton Niagara Haldimand Brant
AIDS Thunder Bay	North West
Alliance for South Asian AIDS Prevention	Toronto Central
Asian Community AIDS Services	Toronto Central
Association of Iroquois and Allied Indians	South West
Barrett House - Good Shepherd Ministries	Toronto Central
Black Coalition for AIDS Prevention	Toronto Central
Bruce House	Champlain
Canadian AIDS Treatment Information Exchange	Toronto Central
Casey House Hospice	Toronto Central
Central Toronto Community Health Centres	Toronto Central
Centre for Spanish-speaking Peoples	Central
Centre Francophone de Toronto	Toronto Central
City of Ottawa Public Health	Champlain
Family Service Association of Toronto	Toronto Central
Fife House	Toronto Central

FIFE House - OHSUTP	Toronto Central
Hamilton AIDS Network	Hamilton Niagara Haldimand Brant
Hassle Free Clinic	Toronto Central
Health and Social Supports Branch of Community Services	Hamilton Niagara Haldimand Brant
Hemophilia Ontario	Toronto Central
HIV & AIDS Legal Clinic (Ontario)	Toronto Central
HIV/AIDS Regional Services	South East
Hospice Toronto	Toronto Central
Kingston Community Health Centres, Street Health Centre	South East
Lawrence Heighs Community Health Centre	Toronto Central
LOFT Community Services	Toronto Central
Maggie's: The Toronto Prostitutes' Community Service Project	Toronto Central
Nishnawbe Aski Nation	North West
Ont. Assoc.of the Deaf, Deaf Outreach Program	Toronto Central
Ontario Aboriginal HIV/AIDS Strategy	Toronto Central
Ontario AIDS Network	Toronto Central
Ontario Organizational Development Program	South West
PASAN (Prisoners with HIV/AIDS Support Action Network)	Toronto Central
Peel HIV/AIDS Network Inc	Central West
Peterborough AIDS Resource Network	Central East
Pink Triangle Services	Champlain
Regent Park Community health Centre	Toronto Central
Somerset West Community Health Centre	Champlain
South Riverdale Community Health Centre	Toronto Central
St. Stephen's Community House	Toronto Central
Sudbury Action Centre For Youth	North East
Syme-Woolner Neighbourhood and Family Centre	Central
The AIDS Committee of Durham Region	Central East
The Ontario Organizational Development Program	Toronto Central
The Teresa Group	Toronto Central
The Works, City of Toronto Public Health	Toronto Central
Toronto People With AIDS Foundation	Toronto Central
Union of Ontario Indians	North East
Voices of Positive Women	Toronto Central
Warden Woods Community Centre	Central East
Wassay Gezhig Na Nahn Dah We Igamig	North West
Women's Health in Women's Hands	Toronto Central
Youth Services Bureau of Ottawa	Champlain
YOUTHLINK Inner City	Central East