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

To the End of Fiscal Year 2007-08

A Collaborative Project of
the AIDS Bureau, Ministry of Health and Long-Term Care and
the Public Health Agency of Canada, Ontario Region
December 2008

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Preface

In 2007-08, 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) provided a mix of ongoing operational funding and time-limited project funding to 77 community-based organizations – including AIDS service organizations (ASOs), community health centres and other organizations – to support a wide range of HIV/AIDS prevention and support services.

All the organizations that receive AIDS Bureau and ACAP funding are required to complete the online Ontario Community-based HIV and AIDS Reporting Tool (OCHART) twice each fiscal year – in April and October. In addition, the 28 organizations that receive ACAP funding are each required to complete an online logic model that is directly linked to the OCHART. The online logic model maps out the work to be completed within each fiscal year by recording the "planned" outputs /deliverables into the logic models. During the reporting, the "actual" outputs/ deliverables are inputted into the logic models (and transferred into OCHART).

The OCHART reports give the funders the information they need to be accountable for public resources. They also give funders and organizations valuable information about client needs and services that can be used to improve existing programs and plan new ones.

This report is a summary of the aggregate data reported through OCHART and the logic model tool in 2007-08, a comparison with data from previous years, and an analysis of provincial trends.

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 and logic models. They also provide information on how resources were used.
- **Planning**: the reports may identify trends that can be used to adjust services or to develop new services locally and provincially.
- **Quality Improvement/ Evaluation**: the reports may provide information that organizations can use to strengthen their services.

Data Limitations

The data in this report should be interpreted with caution. This is only the third year that organizations have reported using OCHART and the second year that organizations have used the online logic model. The tools are continually being refined, and organizations are still working to ensure that they take a consistent approach to interpreting questions, collecting data, and defining services and activities. OCHART now includes more precise data definitions, reports are being monitored to ensure greater consistency, and data quality is improving over time.

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

How Data are Aggregated, Organized and Reported

As noted earlier, this report provides aggregate data rather than agency specific data. To ensure the anonymity of individual agency data, information is aggregated and reported at three different levels depending on the source:

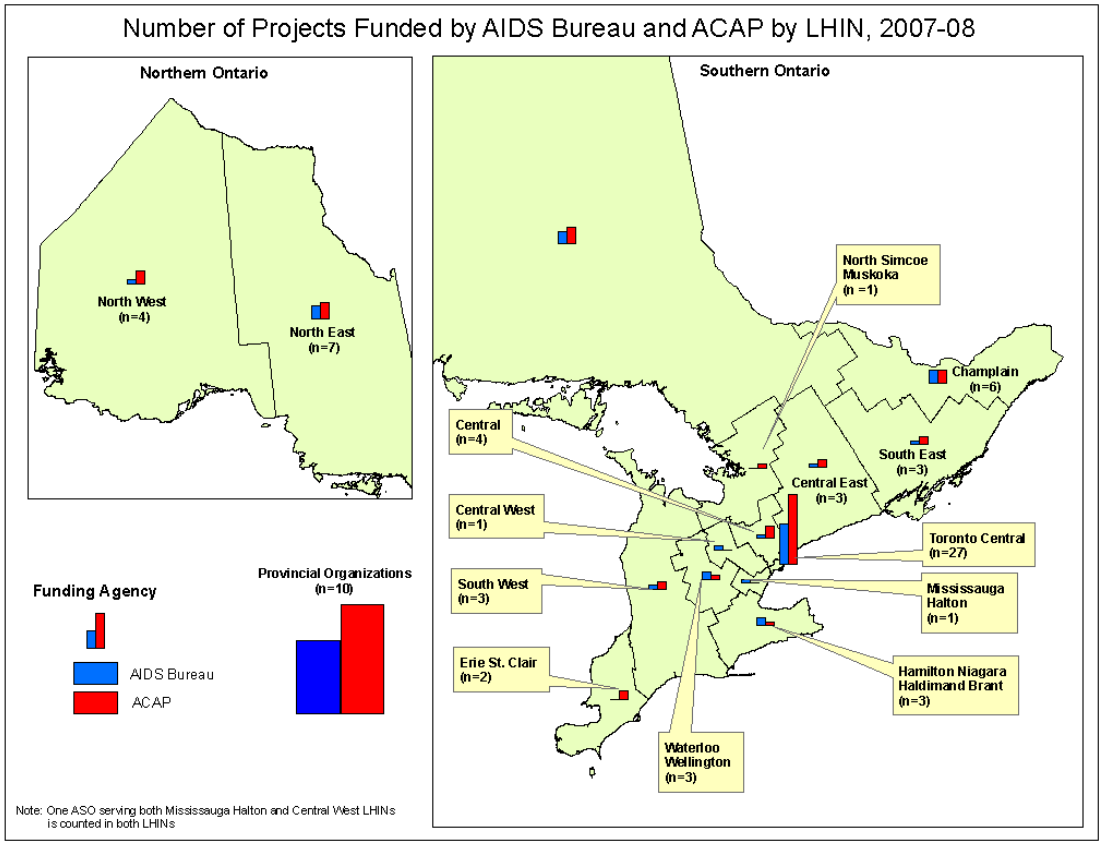
- provincially (i.e., all organizations)

- by the seven regions used to report epidemiological data on HIV cases in Ontario
- by the 14 Local Health Integration Network regions (i.e., all organizations that provide services within a LHIN region).

Most health services in Ontario, including hospital services, home care, long-term care homes, community health centres, and mental health and addiction services, are now planned, coordinated and funded by the LHINs. Whenever possible – while still protecting the anonymity of individual agency data – this report will provide data by LHIN, in order to help identify and understand any regional or geographic trends or differences.

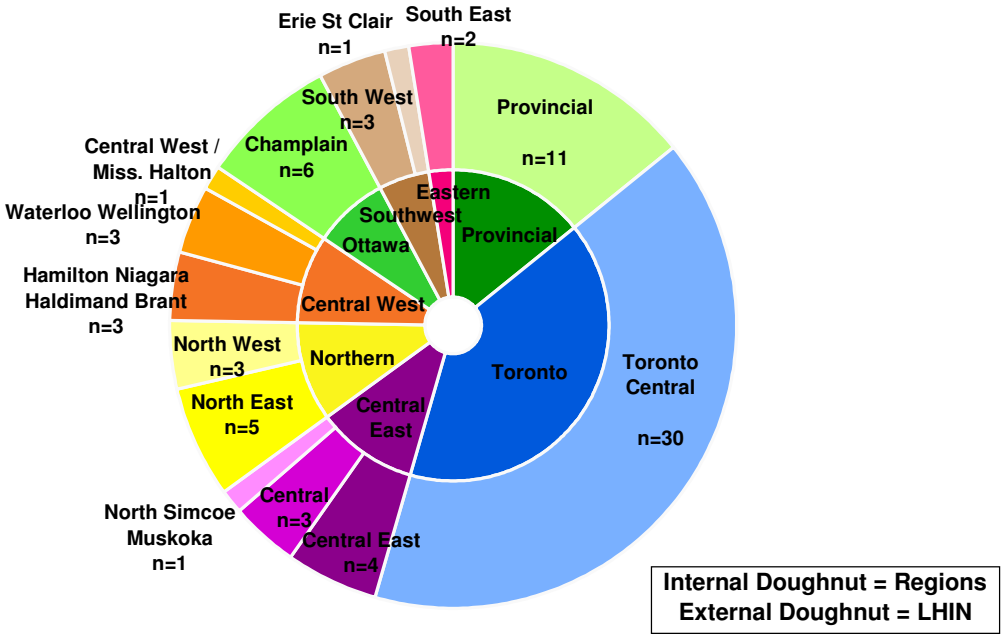
The map below shows the LHIN regions, and the number of projects funded by the AIDS Bureau and ACAP in each LHIN.

Although ASOs are not funded through the LHINs – and some provide services in more than one LHIN region – ASOs should be aware of LHIN plans and priorities for other services that clients may use, such as housing, mental health, addiction and hospital services.



The figure below illustrates the relationship between the LHINs and the regions used to report epidemiological data. It lists the number of funded organizations within each LHIN and the LHINs in each region. For example, in the Northern region, there are two LHINs – North West and North East – with four and seven organizations, respectively, funded by the AIDS Bureau and/or ACAP to provide HIV-related services. Although most provincial organizations – that is, organizations funded to provide services across the province – are located in Toronto, they are treated as a separate group to avoid distorting the amount of service provided in Toronto.

LHIN Distribution Across Regions



Note: for purposes of this report and analysis, two LHIN regions that are served by one community-based organization – Central West and Mississauga Halton – have been combined into one.

How the Report is Organized

The 2007-08 View from the Front Lines is organized in five sections. To help community-based organizations understand the link between the information in this report and the data they provide through OCHART, the report generally follows the same order as the OCHART form.

Section	Contents
Part I: Context – Trends in HIV Infection	Epidemiological data and information on how the data are aggregated and presented
Part II: How We Work	Information on the organization, governance, funding, staffing, planning, evaluation and partnerships of community-based organizations, taken from OCHART sections 1 through 5, 7 and 8
Part III: Who We Serve	Information on the catchment area and populations community-based organization service, taken from OCHART section 6
Part IV: What We Do	Information on the programs and services provided by funded organizations, taken from OCHART sections 9 through 13
Part V: ACAP Report	A separate summary of the programs and services funded by the Public Health Agency of Canada AIDS Community Action Program

The report also includes a discussion of emerging trends and other issues identified by community-based organizations in narrative comments submitted through OCHART.

PLEASE NOTE: Figures are numbered to correspond with the relevant OCHART question/s.

Acknowledgements

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

The AIDS Bureau and PHAC would also like to thank the advisory group who provided advice on effective ways to present the data:

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Le-Ann Dolan, AIDS Committee of Toronto

Llana James, Peel HIV/AIDS Network

Kathleen Jodouin, AIDS Committee of North Bay and Area

Murray Jose, People with AIDS Foundation, Toronto

Brian Lester, AIDS Committee of London

Randi Reynolds, St. Stephen's House

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Michael Sobota, AIDS Thunder Bay

Darien Taylor, CATIE

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Jason Zigelstein, Fife House

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

For more information about completing OCHART forms or to request organization-specific data and reports, please contact:

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Key Findings and Trends in 2007-08

Trends in Client Needs

Mental health and substance use are key issues facing clients. For the first time since organizations began reporting through OCHART, mental health and substance use issues were ranked as having more effect on clients than unemployment and housing problems. This shift may reflect epidemiological reports, which indicated that there were fewer new HIV diagnoses than in previous years and fewer diagnoses in women in Ontario, but more diagnoses in people who reported injection drug use and among men who have sex with men who use injection drugs.

Organizations are receiving more requests for education for youth, women and newcomers, and for information on criminalization and disclosure, the biology of the virus, trends in drug use and point-of-care testing.

Organizations continue to attract new clients and more women. Almost one out of every five support service clients was new to the organization. About one-third of clients are women – about 60% of whom have HIV (up from 42% in the previous year).

Support service clients are getting older. The proportion of clients over age 55 doubled in 2007-08, while the proportion between the ages of 15 and 24 was down. This is in contrast to the growing number of youth seeking education and harm reduction services.

Trends in Service Delivery

More outreach is being provided by Internet and phone, and through websites. The Internet now accounts for the greatest number of contacts – particularly in efforts to reach gay men. In terms of face-to-face outreach, there was a marked increase in bar, bathhouse and park outreach. A growing number of organizations are making efforts to reach sex workers.

More aggressive policing is limiting outreach and education opportunities. A number of organizations reported that changes in policing practices are making it more difficult for them to find clients on the street.

Although unemployment was identified as a key factor affecting client health, organizations provided relatively few employment-related services. Housing was also identified as a key issue, and there was an increase in the amount of housing assistance and supportive housing services provided. This may be due to increased capacity or increased awareness of housing issues, related to the Positive Spaces Healthy Places study.

Organizations continue to attract more volunteers. However, volunteers are giving fewer hours and organizations are having to adapt to changing volunteer needs. Volunteers are looking for flexible and meaningful/challenging opportunities. As was the case in 2006-07, volunteers involved in practical support give more time than those involved in fundraising or administrative activities. Having a volunteer coordinator has a significant impact on volunteer recruitment, retention and number of hours of volunteer services. In terms of who is volunteering, organizations are seeing more professionals, women, and youth as well as more ethnically diverse volunteers.

Peers in IDU outreach programs are providing more service. In the past, peers mainly distributed materials and information. They are now more involved in informal interactions with other drug users, and in facilitating harm reduction groups and other education programs.

Attitudes of drug users and the public are having an impact on program effectiveness. Programs are concerned about growing apathy on the part of clients who use substances (i.e., message fatigue) as well as less public support/tolerance for harm reduction programs. These trends may indicate the need for different service delivery models and approaches. There may also be a link between changes in attitudes and epidemiological reports, which indicated that there were fewer new HIV diagnoses than in previous years and fewer diagnoses in women, but more diagnoses in people who reported injection drug use and among men who have sex with men who use injection drugs.

The need for flexibility and new programming approaches. Several organizations reported lack of interest in some long-standing programs (e.g., support groups, community development meetings) from both clients and partners in the community. Some are working to adjust their programs and develop new approaches to meet changing needs.

Organizational Issues

More organizations are recruiting and employing people with HIV or at risk. The number of organizations reporting people with HIV on staff increased. This trend may be due in part to the impact of the OAN Leadership Development Program, which began in March 2006 and had 130 PHA alumni. Providing opportunities for paid employment is particularly important given that unemployment was identified as one of the key social factors affecting clients. While organizations see the value of hiring people with HIV, they also reported some challenges – including being flexible enough to accommodate extended health-related leaves of absence.

Organizations experienced high rates of staff turnover and vacancies. At least 36 organizations reported dealing with staff turnover during the year, and it appears that more than 70 new staff were hired within the system over the year. This trend highlights the need for ongoing recruitment and training, and for strategies to fill gaps and manage workloads.

More organizations are involved in research. There was a marked increase in the number of organizations that reported being involved in developing a research question and implementing research findings. This indicates a growing commitment to evidence-informed practice.

Part I: Context
Trends in HIV Infection in Ontario

The main goals of the programs/organizations funded by the AIDS Bureau and ACAP are:

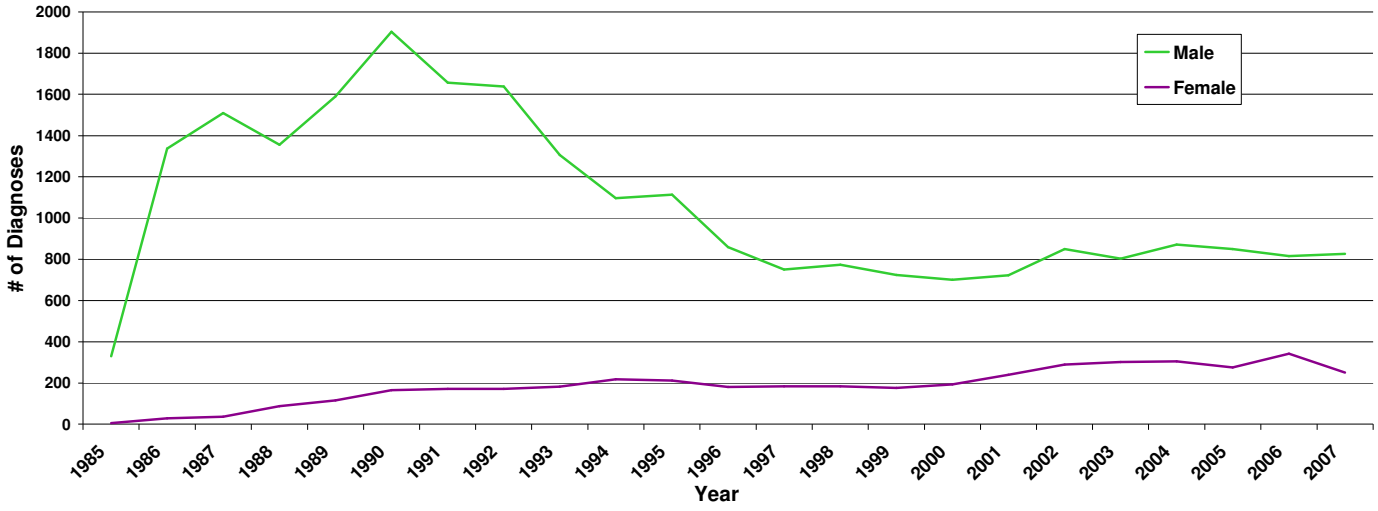
- to prevent the spread of HIV, and
- to improve the health and well-being of people with HIV and their communities.

The programs and services are designed to respond to the needs of the organizations' respective communities, and are shaped by the nature of the epidemic in their regions.

Fewer new HIV diagnoses in 2007

According to the Ontario Epidemiologic Monitoring Unit at the University of Toronto, which is responsible for HIV surveillance, there was a 7% decrease in new HIV diagnoses (i.e., first-time positive test results) in 2007 (1,076 new diagnoses) compared to 2006 (1,158): in fact, in 2007, Ontario had the lowest number of new diagnoses in a single year since 2001.

Number of HIV Diagnoses (adjusted[1]) Among Males and Females by Year of Diagnosis, Ontario, 1985 to 2007



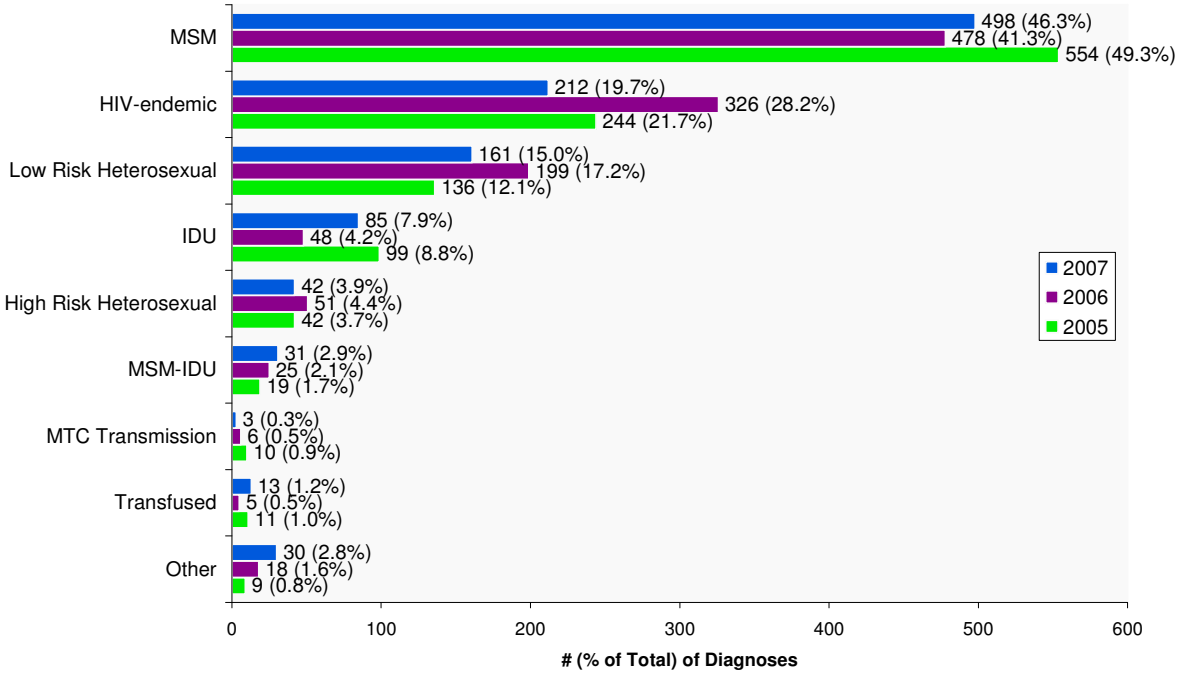
1 Unknown sex assigned according to the distribution of cases with known sex (see Technical Notes); thus, totals may differ due to rounding
Source of data: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care
From: http://www.phs.utoronto.ca/ohemu/doc/Table1.pdf - accessed August 8, 2008

In 2007, 77% of new diagnoses were in men and 23% were in women, compared to 70% and 30%, respectively, in 2006. In terms of actual number of cases, there were 12 more men diagnosed in 2007 than in 2006 (827 compared to 815) and 96 fewer women diagnosed (249 compared to 343). These gender trends in new HIV diagnoses remained consistent in the first two quarters of 2008 (i.e., 77% of cases in men and 23% in women); however, it is too early to say whether we are seeing a long-term downward trend in infections in women – particularly given the fact that women are often diagnosed later in HIV infection than men. (Mugavero, Castellano, Edelman & Hicks, 2007).

In terms of risk factors (figure below), there was a decrease in new cases among people from countries where HIV is endemic (i.e., Africa and the Caribbean), and in those who reported either high risk or low risk heterosexual activity as a risk factor compared to 2006. There was an increase in cases among people who inject drugs and among men who have sex with men and inject drugs.

Men who have sex with men (MSM) and men who have sex with men/injection drug use (IDU) continue to account for about 50% of new HIV diagnoses each year; injection drug use alone accounted for 8% of new diagnoses, while the proportion of new diagnoses in people from communities where HIV is endemic accounted for 20% of cases – down from 28% in 2006.

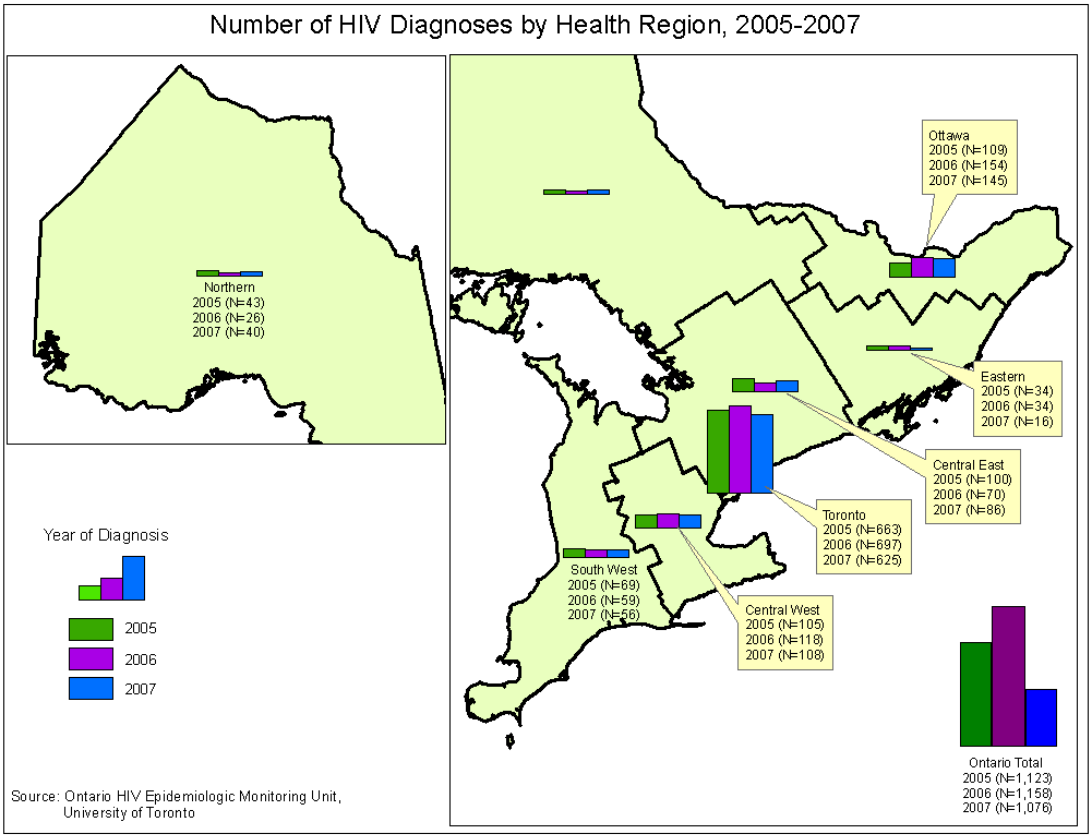
Number (adjusted[1]) of HIV diagnoses by Year of Test and Exposure Category - 2005 to 2007



1. Source: HIV Laboratory, Laboratory Branch, Ontario Ministry of Health and Long-Term Care. MSM = men who have sex with men; HIV-endemic = people from countries where HIV is endemic, such as Africa and the Caribbean; IDU = injection drug use; MTC = mother-to-child transmission.

New diagnoses up in Northern and Central East Regions, but down elsewhere

While the overall number of HIV diagnoses decreased in 2007, this trend was not consistent across all regions of the province (map below).



The number of new diagnoses was up in the Northern and Central East regions, down over 50% in the East and down slightly in the Toronto (10%), Central West (8%), Ottawa (6%), and Southwest (5%) regions. In terms of the rate of new HIV diagnoses (i.e., number of HIV tests by 1000 population), the epidemiology of the epidemic continues to vary by region, with Ottawa and Thunder Bay having more infections related to injection drug use, and Toronto having more infections in gay men and people from African and Caribbean communities.

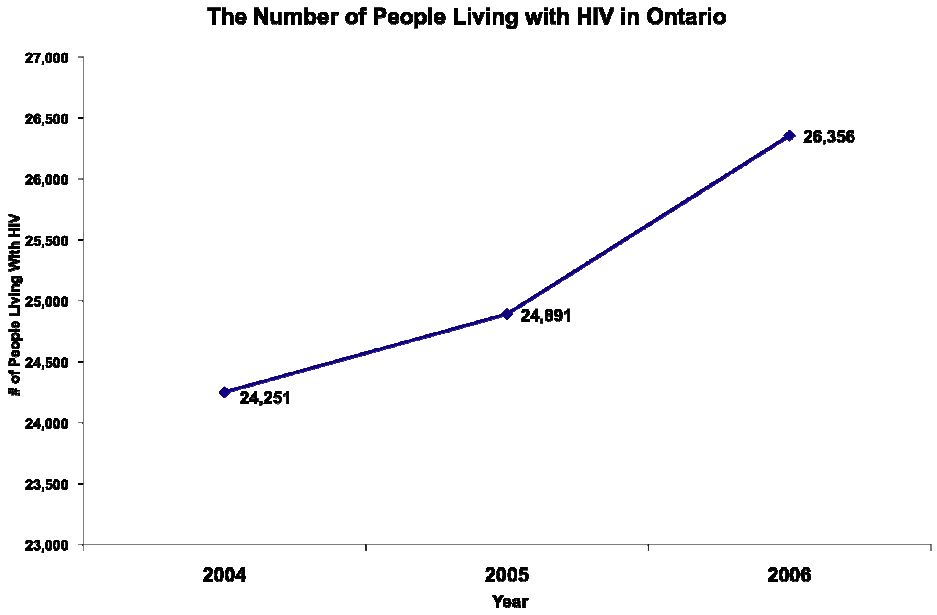
The overall decrease in the number of new diagnoses does not appear to be due to lack of HIV testing. In 2007, 410,262 HIV tests were done Ontario – down slightly from the 413,079 tests in 2006 but up from the number of tests done in all previous years.

Number of Ontarians with HIV continues to rise

Because of more effective treatments for HIV, the number of people with HIV in Ontario continues to increase. According to statistical modeling done by the Ontario HIV Epidemiologic Monitoring Unit, by the end of 2006 (the most recent year these data are available):

- 34,983 people in Ontario had been infected with HIV (not all of whom have been diagnosed)
- 7,880 had died of AIDS and 1,228 had died of causes other than AIDS
- 26,356 were living with HIV/AIDS.

The number of people thought to be living with HIV in Ontario has increased steadily over the past few years: 24,251 in 2004, 24,891 in 2005 and 26,356 in 2006.*



As the number of people with HIV continues to grow, funded organizations are likely providing services for more people over a longer period of time. However, because OCHART collects program rather than client-level data, it is not possible to determine exactly how many people are using community-based HIV prevention, care and support services; how long or how often they receive services; or whether their service needs change the longer they live with HIV.

*** For more information on epidemiological data for Ontario, see (http://www.phs.utoronto.ca/ohemu/mandate.html).**

Part II: How We Work

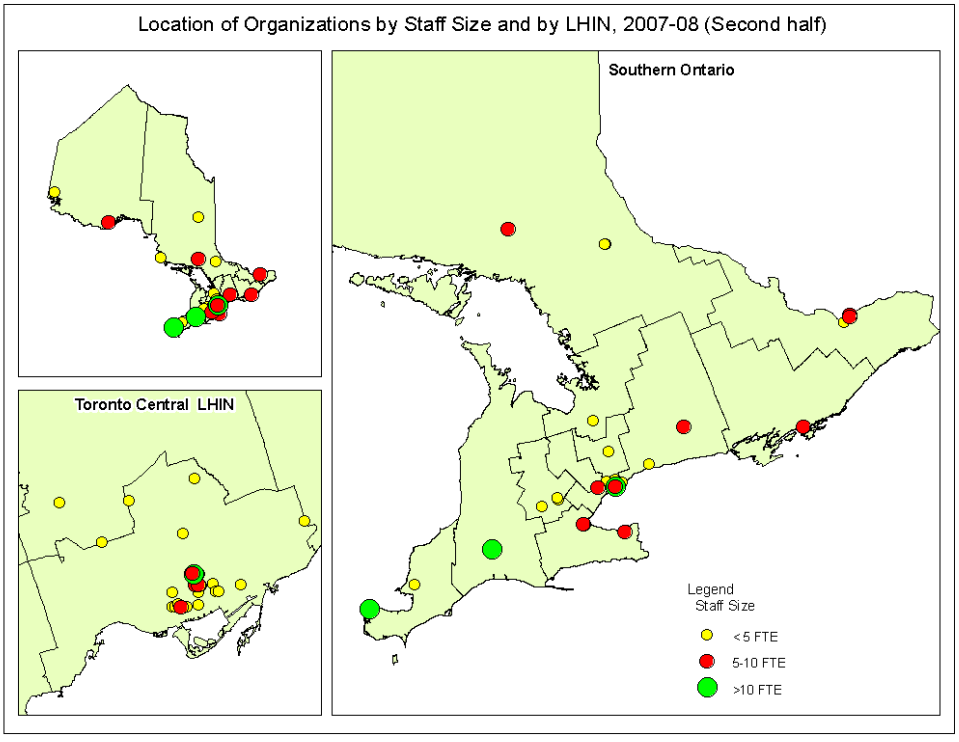
The following summarizes responses to OCHART sections 1 through 5, 7 and 8.

At the end of 2007-08, 77 organizations/programs were receiving funding from the AIDS Bureau and/or ACAP – one more than in 2006-07. However, some funded organizations changed. Six that had received funding in 2006-07 were not funded in 2007-08[1]. Two of the six were time-limited ACAP projects that ended in 2006-07. (Ten other ACAP time-limited projects also ended in 2006-07, but they were sponsored by organizations that continued to receive ongoing funding from the AIDS Bureau and/or ACAP, so did not affect the total number of organizations funded.) In addition, the Ontario Aboriginal HIV/AIDS Strategy (OAHAS), which in the past had reported as one organization, now submits eight reports: one for the provincial office and one for each of the seven regional programs. They are counted as eight reporting programs for purposes of this analysis. As a result of these changes, there are now three fewer organizations reporting in Toronto and three more reporting in Northern Ontario. With the types of changes that have occurred (i.e., several organizations no longer funded, one existing organization reporting differently) it would not be surprising to see a decrease in overall activity. For the list of funded organizations that provided information for this report, please see Appendix A.

Size and Location of Services

Services are located across the province

As the map illustrates, funded organizations are located across the province. Although most agencies are located in urban centres, many provide services for large geographic areas. In 2007-08, the 77 funded organizations provided services from 103 different sites which enhanced their capacity to serve their communities.



[1] African Community Health Services, AIDS Action Committee of Perth County, Pink Triangle Services, Centre Francophone de Toronto, Tumivut Youth Shelter, and Women's Health in Women's Hands Health Centre.

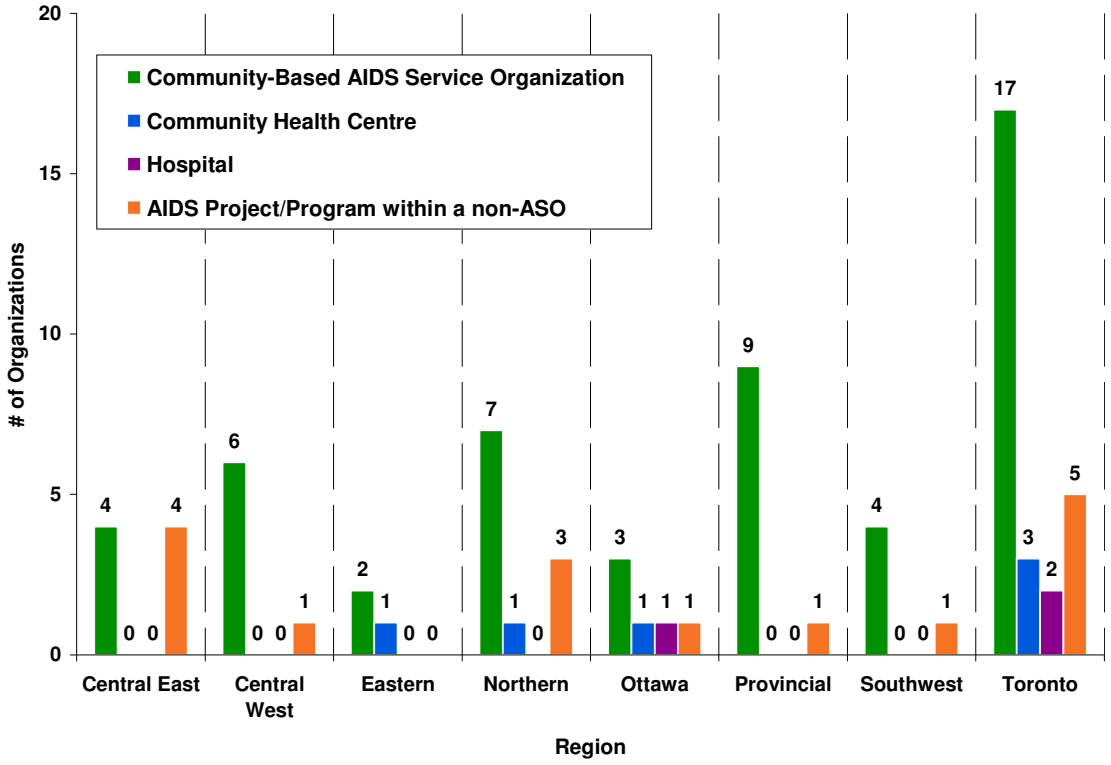
Governance

70% of funded organizations are AIDS Service Organizations

Of the 77 organizations whose data are included in this report, the majority (54 or 70%) are AIDS service organizations (ASOs). The remainder are community health centres, hospitals or non-ASOs that offer some HIV/AIDS programming. (Note: some organizations report as being in more than one category.)

Figure 3.1b shows the mix of types of organizations funded in each region in 2007-08. There are community-based AIDS organizations in all regions, and at least three funded organizations in each region.

3.1b: Number of Organizations by Type and Region



Most organizations have policies in place

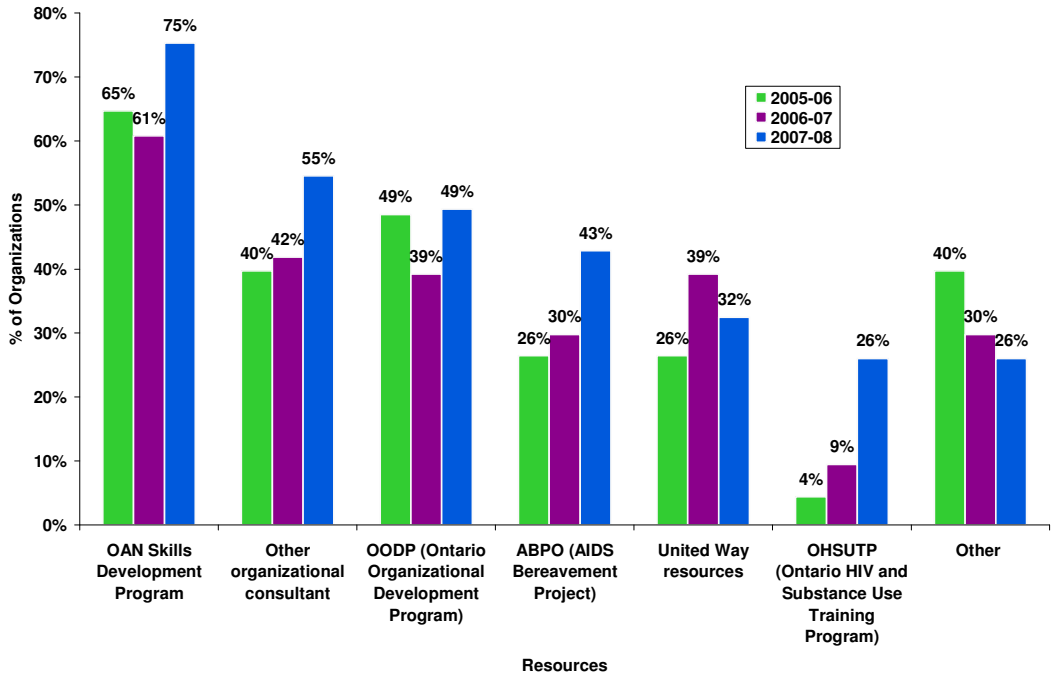
OCHART asks organizations about a range of policies that well-run organizations should have. In terms of governance, over 99% have a Board of Directors and HR/operating policies. Compared to 2006-07, a larger proportion of organizations now have policies on conflict of interest (97% vs 95%), equity/discrimination (95% vs 91%) and PHA/target population involvement (87% vs 80%). This indicates that organizations are putting in place the mechanisms they need to operate effectively and provide client-centred programs and services. The proportion of organizations reporting that they have policies in place has increased steadily since the introduction of OCHART, which may indicate that the OCHART questions have stimulated work in this area –

although other factors, such as time and maturity of the organizations and the active promotion of the GIPA principle, may also contribute to policy development.

Most are committed to improving knowledge, skills and capacity

A number of programs and resources have been developed to help organizations enhance their capacity to operate stable effective organizations, including skills building programs offered by the Ontario AIDS Network (OAN), and the services of organizational development consultants provided by the Ontario Organizational Development Program (OODP). In fact, the primary role of most provincial organizations funded by the AIDS Bureau and/or ACAP is to enhance the capacity of local organizations. Funded organizations can also access expertise and resources through other non-HIV specific organizations, such as the United Way.

3.9: Organizational Resources Used by Agencies - 2005 - 2007



During 2007-08, 74 (96%) organizations reported using the resources of at least one of the capacity building programs listed in OCHART (Figure 3.9), up from 69 (93%) in 2006-07.

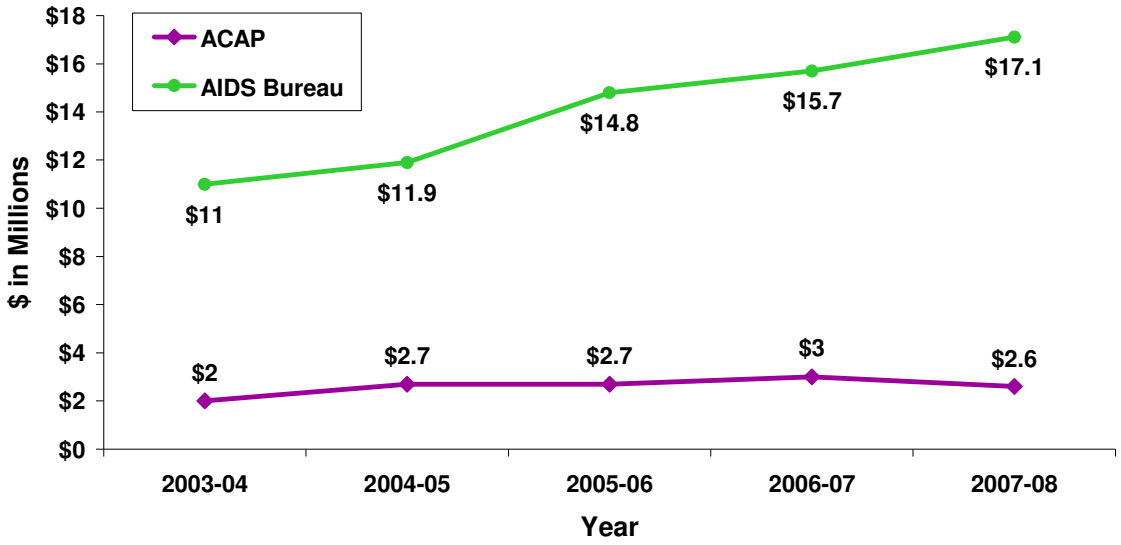
The most frequently used capacity building resources in 2007-08 were the OAN Skills Development Program, other organizational consultants and the OODP. There was also an increase in the use of the Ontario HIV and Substance Use Training Program (OHSUTP), which coincided with that program once again being fully staffed and active. Organizations continue to make use of non-HIV specific resources, such as the United Way and other organizational consultants.

Funding

AIDS Bureau and ACAP funding increased 5% in 2007-08

Figure 5.2/5.3 illustrates the total amount of funding that organizations reported receiving in OCHART from the AIDS Bureau and the Ontario Region of PHAC ACAP program each year from 2003-04 to 2007-08.

5.2 and 5.3: Annual ACAP and AIDS Bureau Funding as Reported by Organizations



Organizations are funded in different ways to provide different services.

Table 3 lists the number of organizations that received funding from the AIDS Bureau and ACAP in 2007-08. Note: it is possible for one organization to receive two or more types of funding.

In 2007-08, the AIDS Bureau introduced two new funding initiatives: one to support the African and Caribbean Strategy and one to support the provincial Gay Men's HIV Prevention Strategy. This funding is consistent with the provincial AIDS strategy (Provincial HIV/AIDS Strategy to 2008), which recommends prevention efforts targeted to populations at highest risk of HIV infection. At the end of 2006-07, most of the one to two-year (time-limited) projects funded by ACAP ended; the few that continued to receive funding in 2007-08 are not included in the analysis.

Table 3: Organizations Reporting Different Funding Types

	Funding Source	2006 - H2	2007 - H2
AIDS Bureau	Community-based AIDS Education and Support Program (CBAESP)	63	66
	HIV/IDU Program	15	16
ACAP	Operational	29	29

ASOs continue to rely on fundraising for one-third of their budgets

Almost all organizations funded by the AIDS Bureau and/or ACAP receive funding from other sources (e.g., Trillium, United Way, fundraising). Some, such as CHCs, hospitals and Fife House, receive the majority of their funding from other parts of the Ministry of Health and Long-Term Care and/or other provincial ministries (e.g., Municipal Affairs and Housing).

The capacity of organizations to attract funding from other sources is a strength – unless organizations are spending a disproportionate amount of time/resources on fundraising or are becoming increasingly dependent on unstable sources of funding (e.g., time-limited grants) to support core programs and services.

Figure 5.4 looks at the sources of funding only for ASOs that consider the AIDS Bureau their main funder.

5.4: AIDS Service Organizations: Selected Sources of Funding

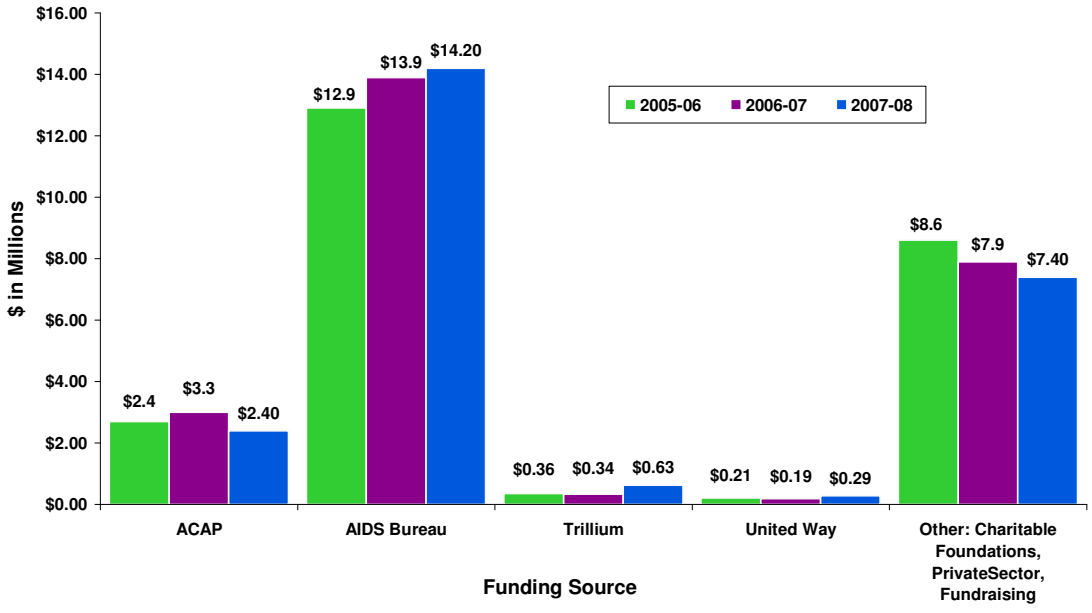


Figure 5.4 illustrates that, compared to previous years, organizations generated less income from private sector fundraising – although the funding they received from Trillium and the United Way

increased in 2007-08. It is not clear whether the 13% drop in funding from other charitable foundations and fundraising over the past two years is because organizations are finding it more difficult to raise funds or whether – with the increase in AIDS Bureau funding – it was less necessary for them to fundraise. However, based on OCHART comments, it appears that fundraising is becoming increasingly difficult.

Organizations received $1,902,704.74 in in-kind contributions

In 2007-08, a consistent number of organizations (28) reported receiving in-kind contributions in both reporting periods (in the past the number varied from 17 to 35 organizations). Organizations that reported receiving in-kind contributions in 2007-08 estimated their value as $1,902,704.74. The most common types of in-kind contributions were:

- rent/space
- staff services
- administrative support
- medical, food and personal care items, such as vitamins, toiletries, food/gift certificates, clothing and food supplements (i.e., Ensure)
- fundraising, including items donated for auction or resale.

Other in-kind contributions included:

- printing services
- Internet Services and website hosting
- laptop computer
- bus tickets
- building supplies
- machinery
- furniture
- CDs
- publicly traded securities
- diapers/incontinence pads.

Organizations also received in-kind donations of risk/harm reduction resources, such as:

- condoms, female condoms, personal lubricant
- needles, sterile water, tourniquets, injection filters, alcohol swabs, abcess kits, sharps containers, Vitamin C, ascorbic acid
- safer crack kits, safer inhalation equipment, cookers, chopsticks, ziplock bags, disposable crack pipes, matches, stem kits, push sticks, screens, filters
- brochures/pamphlets
- gloves.

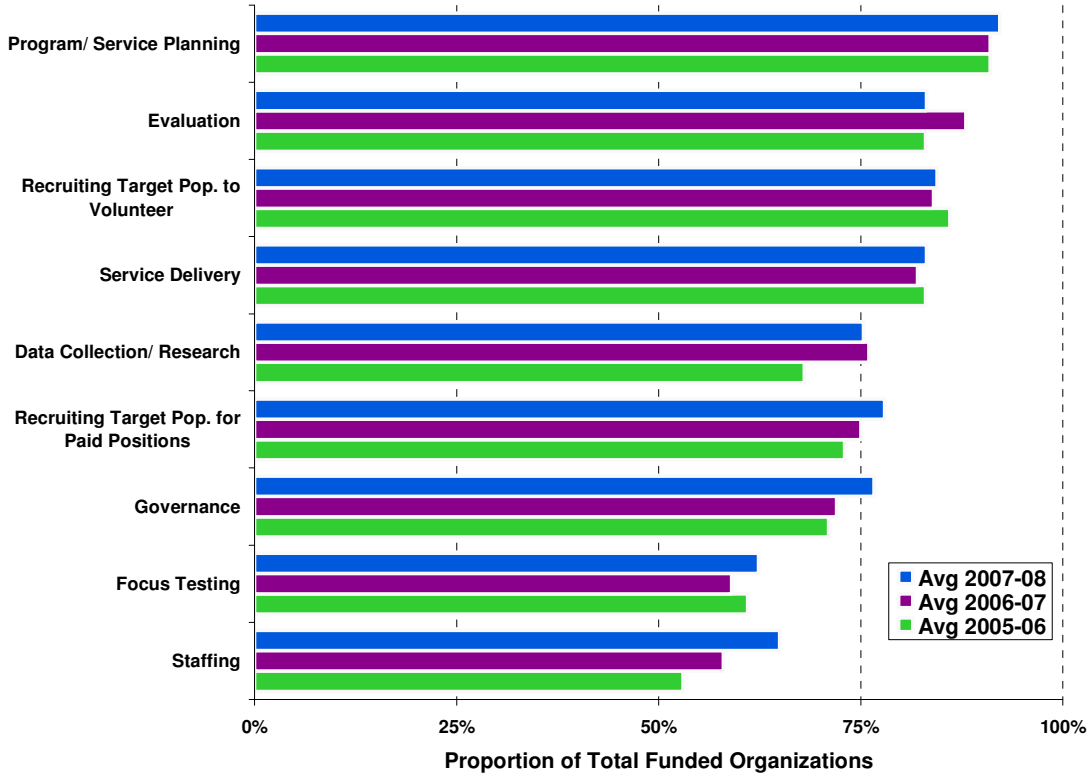
Human Resources

More organizations are recruiting and employing people with HIV or at risk

One of the goals of the provincial, federal and the pan-Canadian strategies is Greater Involvement of People with HIV/AIDS (GIPA) as well as the greater involvement of populations at risk in their services. Figure 7.7 compares how organizations involved members of their target populations over the past three years. It is encouraging to see an increase in the past year in the number of organizations who are recruiting people with HIV/AIDS or people at risk, involving them on the board and having them in paid positions. These initiatives are particularly important

given OCHART data that indicates that unemployment is one of the most common social problems facing clients.

7.7: Organizations Reporting Involvement of Target Populations in Organizational Activities



In addition to the categories listed in Figure 7.7, organizations reported that they made other efforts to involve people with HIV or at risk, including:

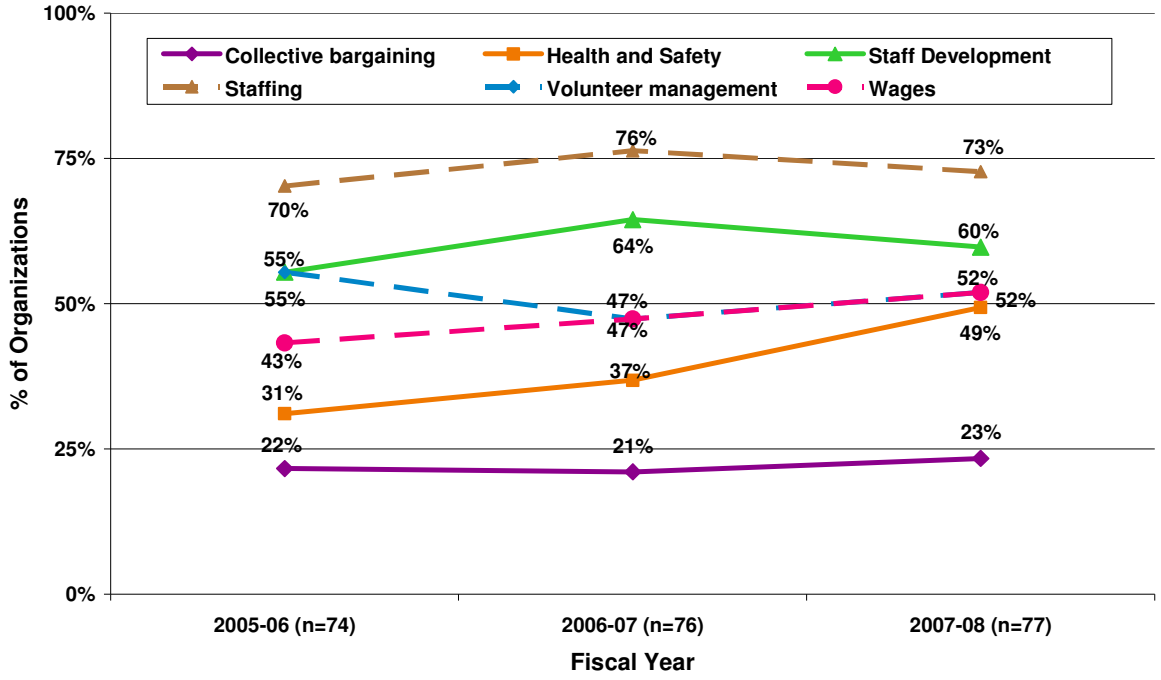
- involving them on working groups and advisory committees
- changing board policies that limited the ability to recruit people with HIV into permanent staff positions
- holding regular forums and monthly "chats" with clients to get their feedback on programs and activities.

More organizations dealing with staffing, staff development, wage, volunteer, and health and safety issues

Most funded organizations are small, community-based organizations that have historically faced some challenges recruiting and retaining staff. Frequent staff turnover has a negative impact on organizations' ability to deliver consistent, high quality programs, and increases recruitment and training costs. Through OCHART, the AIDS Bureau and ACAP try to identify the human resource issues facing funded organizations, which can be used to help organizations develop effective recruitment and retention policies and strategies.

During the last half of 2007-08, a growing proportion of organizations reported that they were actively dealing with issues related to staffing, staff development, wages, volunteer management and health and safety. The most significant increase occurred in the area of health and safety and wages.

4.1: Organizational Human Resource Issues



In addition to the quantitative data on HR issues, organizations provide qualitative information. The main human resource challenge identified by organizations is workforce instability, which is related to a number of factors, including the commitment to GIPA and hiring people with HIV, workload, and wage rates/lack of funding.

At least three organizations reported having staff members on extended medical leave with no definite return date, which creates uncertainty and makes it difficult to recruit contract people to fill in (i.e., length of contract is uncertain).

At least 36 organizations reported dealing with staff turnover during the year, and it appears that more than 70 new staff have been hired within the system over the year. Five organizations

reported receiving resignations during the year, others reported management or organizational restructuring changes, one terminated a position, and some have had vacancies in key positions (e.g., executive director, board members) for several months. Some are considering contracting with consultants to fill gaps.

Workload is an issue in many organizations and a factor in staff turnover. Several organizations noted increased demands on support staff from growing numbers of clients, many of whom are long-term survivors who require significant staff time or have complex needs. One organization highlighted the challenges of having only one support worker to serve a large geographic area. Another noted that workload on existing programs increased when the funding from the federal Hepatitis C program (which had supported a worker to provide services for people who are co-infected) ended in 2007. Recruitment and retention of volunteers is also a challenge – although one organization reported that its youth engagement program has "generated extensive interest and volunteer involvement from youth."

Organizations are using a number of strategies to fill gaps and manage workloads, including: trying to recruit more staff to respond to the increased demand for services; using more student interns (highschool, college and university) to deliver key programs, including harm reduction services, fundraising, reception, surveys and other activities; and brainstorming more effective ways to use volunteers and students.

Wages and remuneration continue to be an issue. Six organizations reported that they consistently have problems recruiting and retaining qualified staff at current wage rates, and most organizations do not have the financial flexibility to increase wages. One organization reported a significant increase in benefit costs. The *per diem* available for consultants hired to work with community-based organizations is lower than that of the private market, which makes it difficult to recruit consultants. One organization noted that it had developed a staffing contingency plan to respond to potential cuts in federal funding.

A number of organizations reported providing training for staff, board members and volunteers during 2007-08. The wide range of training topics reported during the year – including multiple loss, communication, computer skills, time management, Life Skills training, accounting, mediation, crisis intervention, anti-oppression training and yoga – highlight the wide variety of skills that staff working in small support organizations are expected to have. In terms of training needs and issues, organizations noted that volunteers need better training related to the GIPA principles, board governance and direct service work. The main barrier to ongoing staff development is time: when organizations are short staffed or have large workloads, it is difficult for staff to take the time away from the office to attend training programs.

In terms of health and safety and other staff management issues, organizations identified the following:

- revising policies and procedures
- reviewing and revising health and safety policies
- reviewing the performance evaluation system for all staff.

Program Planning and Evaluation

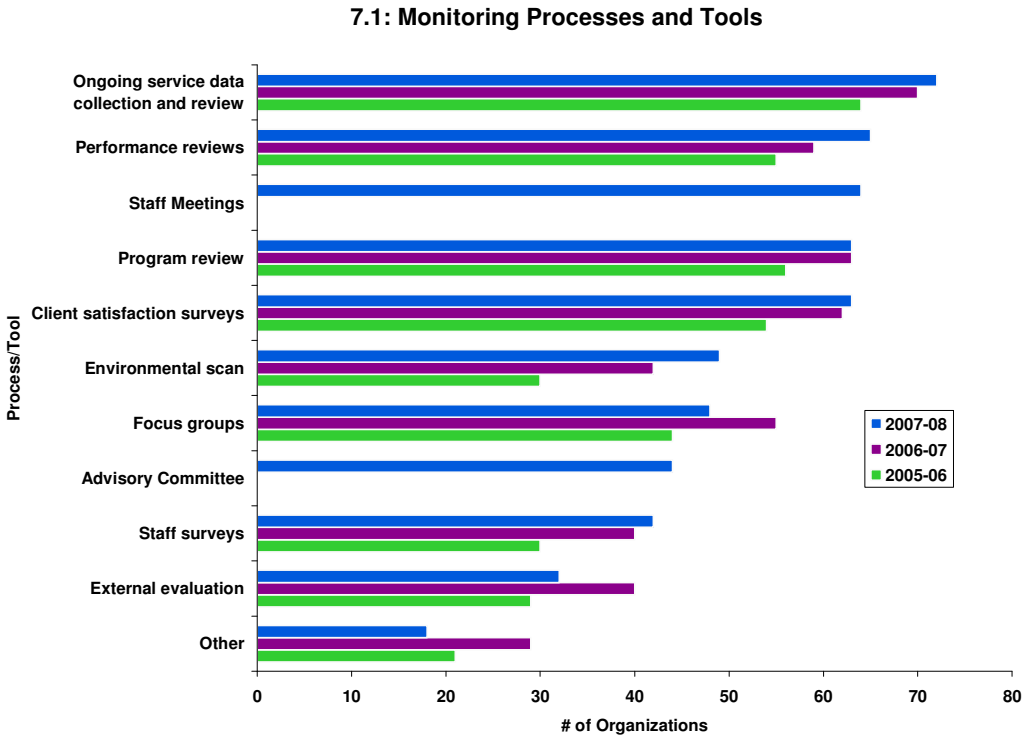
Organizations funded by the AIDS Bureau are required to submit program plans and monitor the effectiveness and impact of their services. Organizations funded by ACAP are required to complete online program logic models, and use these logic models and evaluation plans to monitor their ability to achieve outputs, produce deliverables and achieve outcomes. Through OCHART, organizations report: the methods used to monitor services, the lessons learned, and how they are using that information to refine their programs.

Number of organizations monitoring programs continues to increase

ASOs are continuing to develop an evaluation/quality improvement culture. More organizations are using service data, performance reviews and environmental scans to monitor their programs (Figure 7.1). In 2007-08, OCHART added two monitoring tools noted by organizations in the "other" category in previous years: staff meetings and advisory committees. Over 90% of organizations use staff meetings as a way to monitor and improve their programs and services: this is good practice because it ensures that staff members are an integral part of quality improvement. Over half the funded organizations have also established advisory committees to help guide their programs.

Fewer organizations reported having external evaluations in 2007-08; however, as organizations would only be expected to have external evaluations once every three to five years in conjunction with a strategic planning process, this decrease is appropriate. In general, funders are seeing a strong commitment on the part of organizations to evaluate and improve their programs and services. Organizations want to know if what they are doing is working, and the field is developing an evaluation and quality improvement culture. In addition to the categories in the OCHART form, organizations identified other processes and tools that they use to monitor their programs, including:

- a word-of-mouth survey
- verbal feedback from clients/client meetings
- interviews with participants and community members
- written evaluations after various group activities
- monthly staff reports that detail activities (including workshops, outreach, meetings, community activities) in monthly reports that are then discussed during both individual supervision meetings and team meetings, and which also provide a basis for program evaluation and planning
- a strategic planning process that includes a review of core activities and their "vitality" (i.e., where we had an impact, why that was significant, what that impact has meant over time).



Measuring the impact of programs on knowledge and behaviour

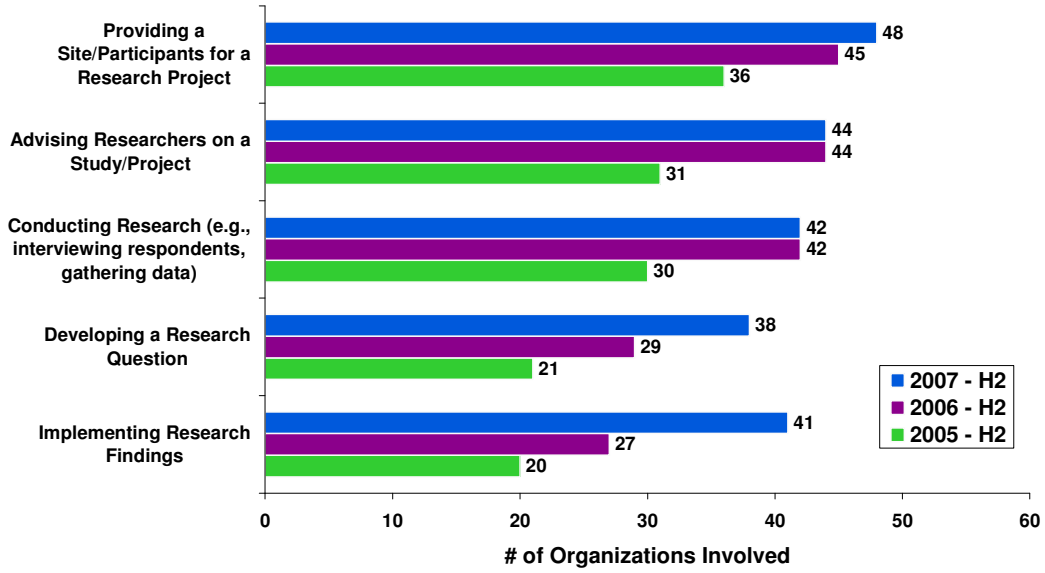
Most program evaluation activities measure client satisfaction with service, but not the impact of education or prevention programs on knowledge and/or behaviour. In 2007-08, OCHART asked organizations for the first time about whether they attempt to measure any changes in client knowledge and/or behaviour as a result of the services they have received. Forty-six (46) organizations reported using tools such as pre- and post-activity surveys that try to assess changes in client knowledge, and 32 organizations reported using other tools to try to collect information on/measure changes in behaviour.

More organizations are actively involved in research

In 2007-08, there was a marked increase in the number of organizations that reported being involved in developing a research question, which indicates that organizations are involved early in the stages of planning research and are having more influence on the type of research that is being done (Figure 7.8). It is also encouraging to see a 50% increase in the number of organizations that are implementing research findings. This indicates a growing trend towards evidence-informed practice. It also reinforces that, when organizations are involved in planning and conducting research, they are more likely to integrate the findings into their policies and practices.

In addition to the research activities listed in Figure 7.8, organizations reported greater involvement in research partnerships with a university, ultimately increasing capacity for community-based research. A number of organizations reported being co-investigators on research proposals and studies, or being involved in developmental work for a larger research project. Some reported having a stronger role in disseminating research findings, preparing

7.8: Organizational Involvement in Community-Based Research

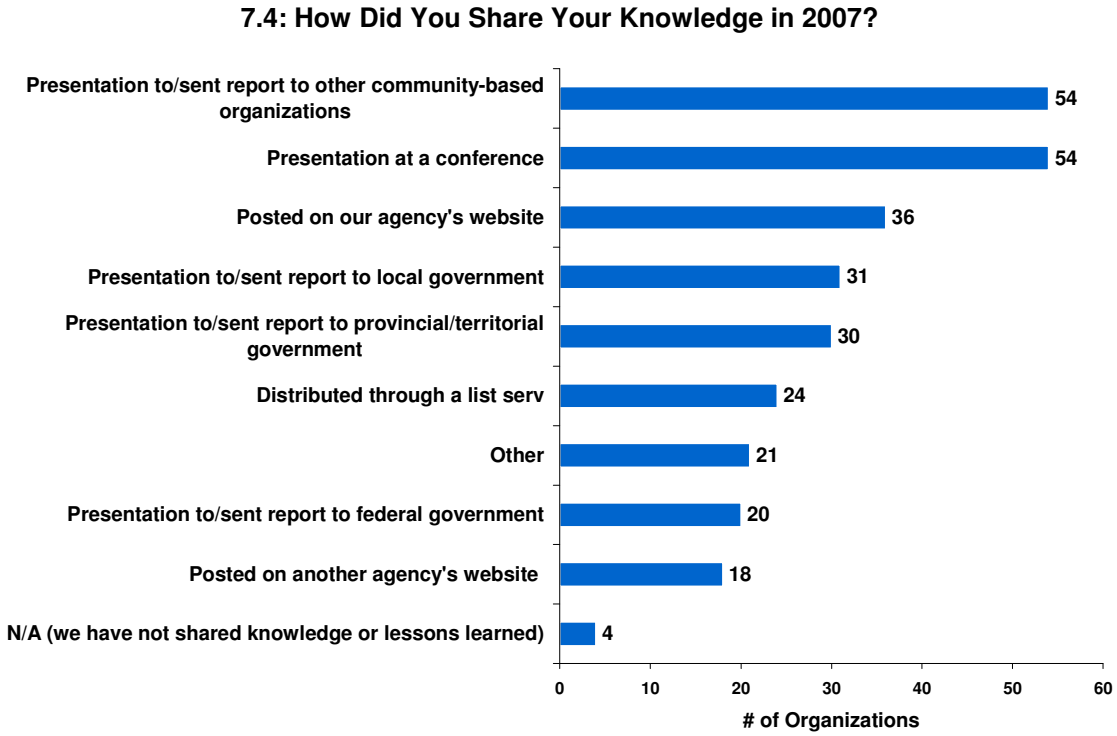


articles and creating reports. One organization has developed an evaluation tool that will be used to gather information on the challenges front-line workers experience in maintaining their own well-being and resiliency in HIV work. A number of organizations are now organizing workshops or research days to share information.

Organizations are sharing knowledge

In the process of developing, delivering and evaluating their programs and services, organizations gain insight and learn lessons that can help advance the field. In the view of the AIDS Bureau and ACAP, best practices are the result of a combination of research and the wisdom of front-line experience. Evidence-based practice requires practice-based evidence. For organizations to benefit from their collective wisdom, they need mechanisms to share their knowledge. For the first time, the 2007-08 OCHART asked organizations about the extent to which they share their knowledge. Figure 7.4 indicates the number of organizations that have used various mechanisms, such as conferences, web sites and reports, to share knowledge and try to shape policy and practice. It is encouraging to see the large number of organizations (70%) that have prepared reports or made presentations. This indicates that the HIV field in Ontario is committed to learning and improving practice.

It is interesting to note that organizations are more likely to communicate with one another than with local, provincial or federal levels of government whose policies may influence their programs. A total of 41 organizations – including all 10 provincial organizations – indicated that they are sharing information with some level of government.



Lack of resources main service barrier

In 2007-08, organizations were asked to identify the main barriers to providing services. The top three all related to resources, including funding, other resources and human resources. Just over 79% of organizations believe that limited funds are a barrier to providing more effective services.

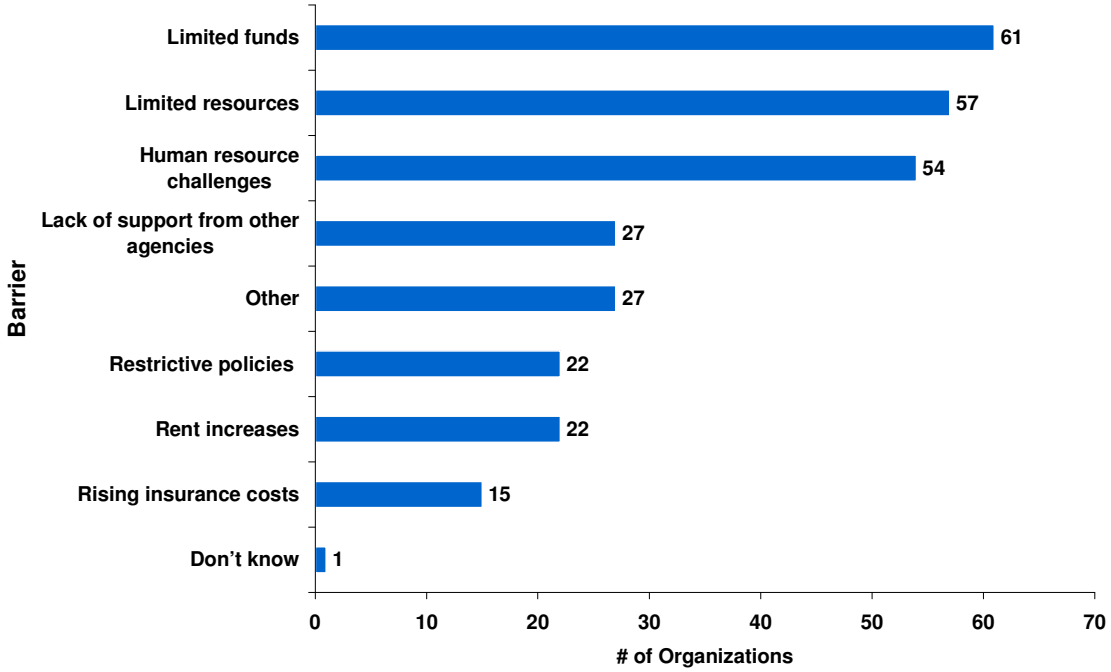
Twenty-seven organizations mentioned the lack of support from other organizations in their communities. In their comments, organizations noted shortages or lack of access to family physicians, specialists, dental practitioners, supportive and transitional housing, and traditional Aboriginal healers/healing.

A significant number also mentioned rent increases (28%) and insurance costs – factors that can make it necessary for organizations to change locations or cut programs and services. Other barriers related to operating an organization include lack of space, higher utility costs and high transportation costs for the organizations that serve large geographic areas.

Over one-quarter of the funded organizations also identified restrictive policies as a barrier, including:

- law enforcement policies that do not support harm reduction
- board policies that prohibit clients from becoming paid staff of an organization
- health unit policies that restrict access to needle exchange and safe inhalation programs and the politicization of harm reduction
- policies and procedures of various boards of education, other educational facilities, and employment training programs and apprenticeship programs that inhibit access for young people.

7.9: Number of Organizations Reporting Service Barriers in 2007



In addition to the barriers included on the form, a number of organizations mentioned:

- stigma, including homophobia and AIDSphobia
- lack of services for women and South Asian populations
- poverty (i.e., clients are often struggling with other issues so health is a low priority).

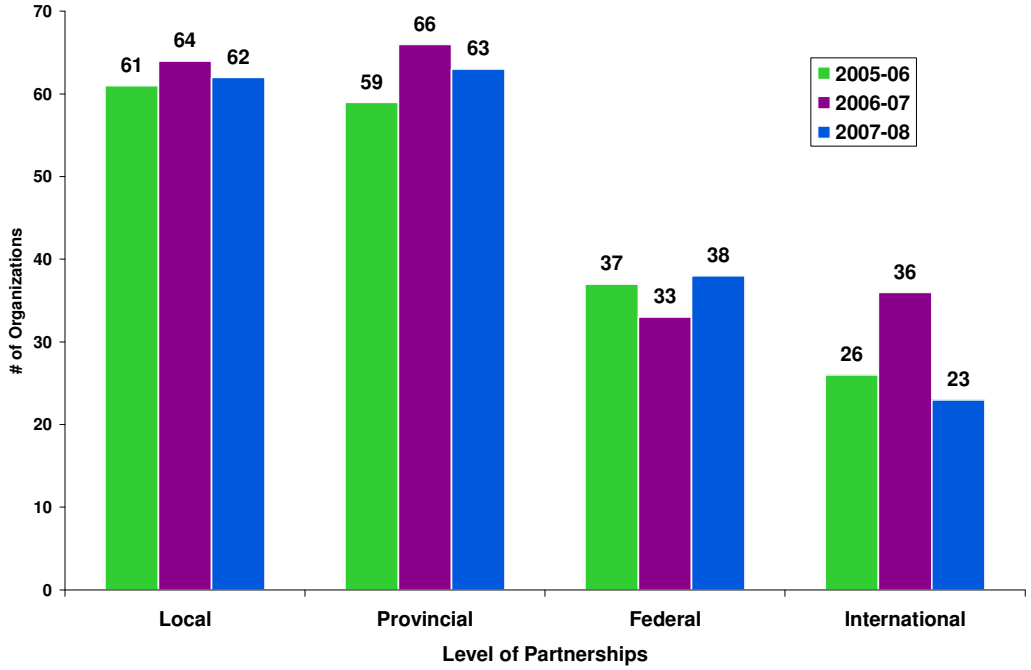
Partnerships

Community-based HIV/AIDS organizations are expected to develop and maintain partnerships with other organizations in order to provide enhanced, coordinated services for people with HIV and populations at risk. As noted above, lack of support from other organizations can create barriers for clients. Partnerships are an effective way to overcome those barriers and ensure more support from other organizations.

Organizations continue to develop/maintain partnerships

Figure 8.1 shows the extent to which community-based organizations are involved in partnerships (i.e., for planning, policy and decision-making) locally, provincially, nationally and internationally. The number of organizations with local and provincial partnerships has remained consistently high.

8.1: Organizations Reported Partnerships in Different Levels



When asked about new initiatives, organizations mentioned, for example:

- participating in working groups established by the AIDS Bureau, including Living and Serving II, the Gay Men's Sexual Health Alliance, and HIV and Corrections
- participating in networks such as the Suicide Prevention Coalition and End-of-Life Care, the Ontario First Nations HIV/AIDS Education Circle, and the Black Diaspora initiative
- serving on the Community Advisory Panel for a hospital.

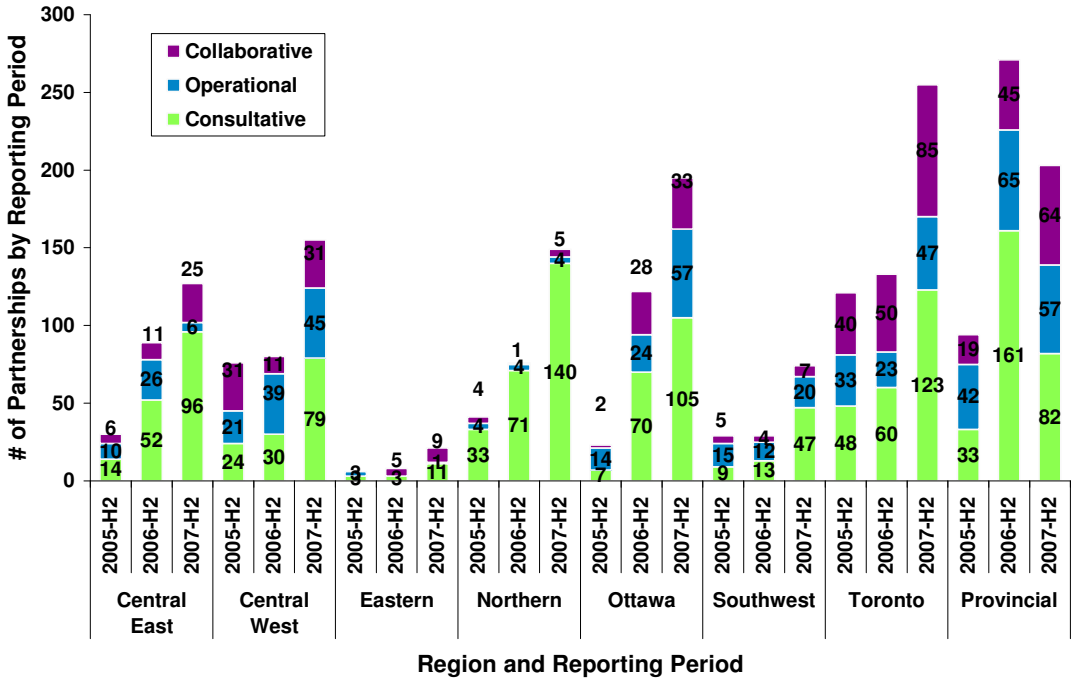
HIV organizations are developing more collaborative partnerships

Figure 8.2a is a comparison of the number and type of partnerships between and among HIV/AIDS organizations by region from 2005-06 through 2007-08. In all regions, there was an increase in the number of partnerships with other HIV organizations or programs. The decrease in

the number of partnerships reported by provincial organizations in 2007-08 was likely due to the regional OAHAS programs reporting as part of their regions, rather than provincially.

In all regions, there was a marked increase in the number of collaborative partnerships, which indicates that HIV organizations are finding more effective ways to work together.

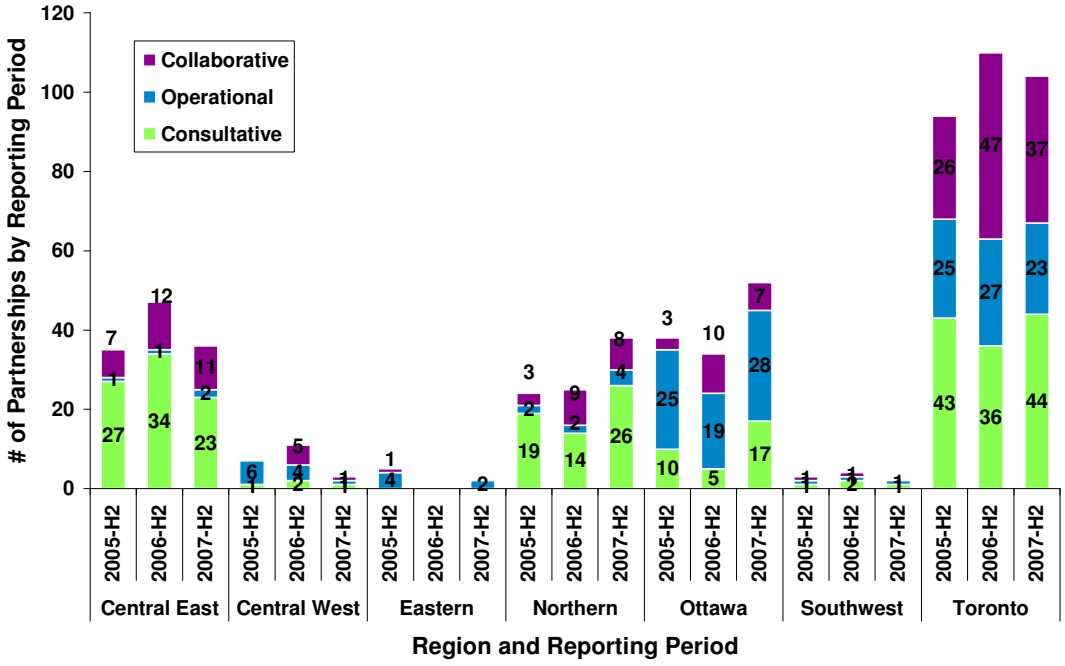
8.2a: AIDS Service Organizations: Partnerships by Region



Partnerships with non-AIDS organizations focus on clients' practical needs

Figure 8.2b is a comparison of the number and type of partnerships between HIV/AIDS organizations/programs and non-AIDS specific organizations (e.g., mental health providers, housing providers) by region between 2005-06 and 2007-08. With the exception of the Northern and Ottawa regions, there was a decrease in the number of partnerships with non-AIDS service organizations in most regions. This decrease may be due, in part, to more accurate reporting of partnerships or to focusing on a smaller number of non-AIDS organizations as partners. The 2007-08 OCHART data do not reveal an increase in collaborative partnerships with non-AIDS organizations, reinforcing how difficult it continues to be to work across sectors.

8.2b: Non-AIDS Service Organizations: Partnerships by Region



While organizations may have reported fewer partnerships with non-AIDS organizations, they are continuing to develop working relationships with diverse organizations, and the partnerships that do exist have the potential to lead to more and better services for clients. For example, community-based organizations reported working with:

- police on joint education about drug use and sex work
- several NGOs across Canada to create a strategic plan on HIV/AIDS for black, African and Caribbean communities in Canada
- organizations to develop a joint drop-in program
- the Canadian Hearing Society and the Canadian National Institute for the Blind to develop and deploy HIV 101 and STI/Harm Reduction educational materials in audio and video formats (using ASL interpreters in the video presentations) as well as developing educational resources in large print and Braille
- youth organizations on education programs
- the John Howard Society and the police services to provide educational support and diversity training to the staff, new recruits, and clients
- the Alzheimer Society, ALS Society, Hospice, Palliative Care & Pain Management, and the Cancer Clinic to develop a conference on caregiving
- the corporate sector
- a variety of local and provincial organizations to address the systemic issues facing people with HIV/AIDS including substance use/addictions/harm reduction; physical and mental health; underhousing; income security; palliative care and services to First Nations
- a collaborative partnership for a joint HIV testing initiative
- the Social Justice Committee of the Anglican diocese
- community partners to provide services for under-represented communities (i.e.,using a satellite liaison worker service model, ASO staff deliver services in locations where community members feel comfortable accessing services).

Part III: Who We Serve

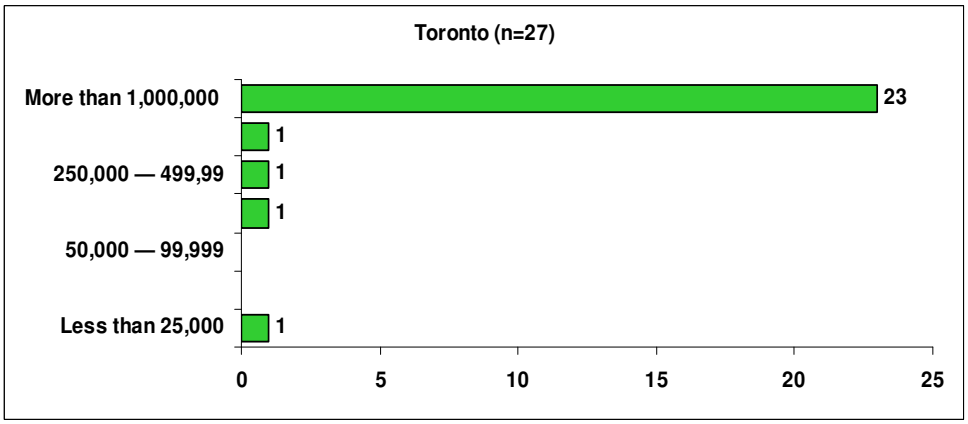
The types of programs and services provided by each organization are shaped, in part, by the characteristics of their catchment areas and the communities/people they serve.

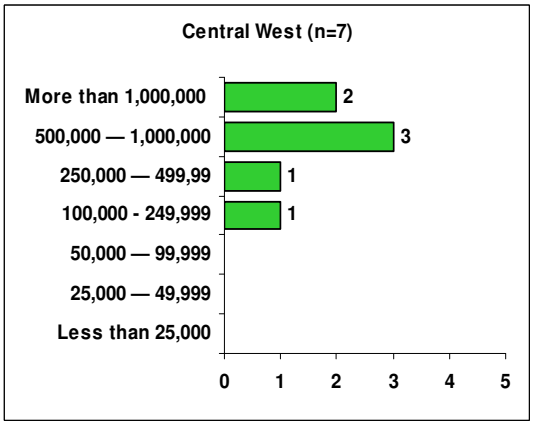
In the north and rural areas, organizations are serving relatively small populations spread across large geographic areas.

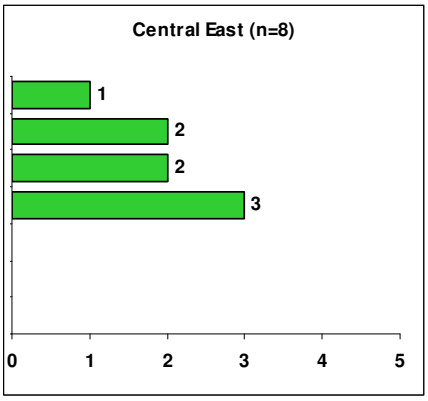
Figure 6.2 shows the number of organizations in each region that report serving populations of different sizes. Twenty-seven organizations (23 in Toronto, 2 in Central West, 1 in Ottawa and 1 in the Northern Region) report serving populations of more than one million people: they consider the entire population as part of their target groups. On the other hand, several organizations located in highly populated areas have a mandate to serve particular target groups and report serving a smaller number of people.

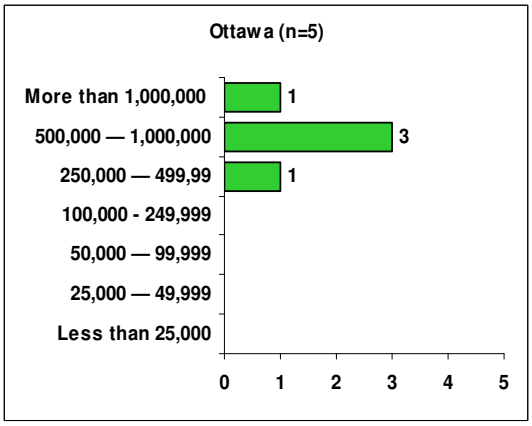
The most rapid population growth has occurred in Central West, which has fewer organizations relative to the size of its population – and a lower incidence of HIV – compared to the other regions. In fact, the number of new diagnoses in Central West dropped in 2007-08 – although the lower number of cases in Central West may be due, in part, to its close proximity to Toronto. People in Central West may go to Toronto for testing, and their cases would be recorded there.

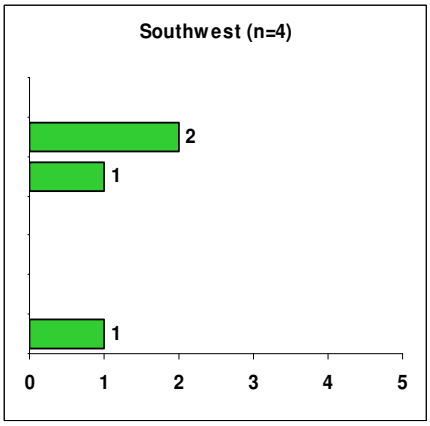
6.2: Number of Organizations per Population Size by Health Region

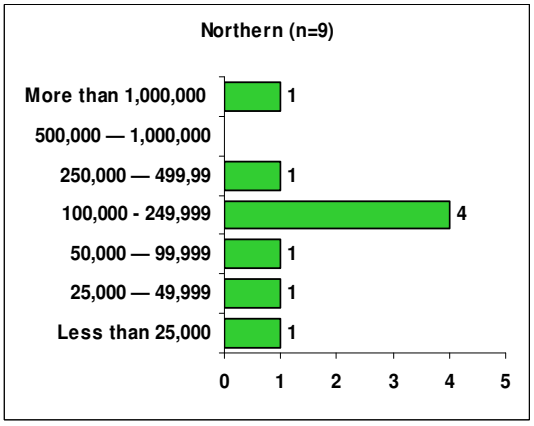


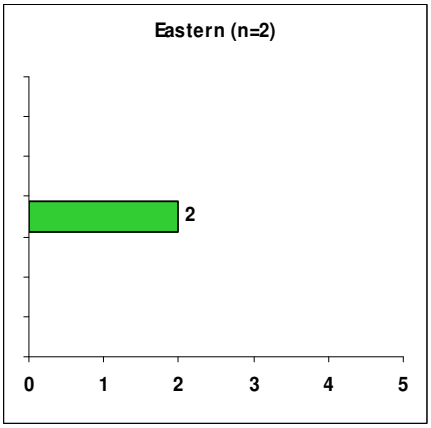












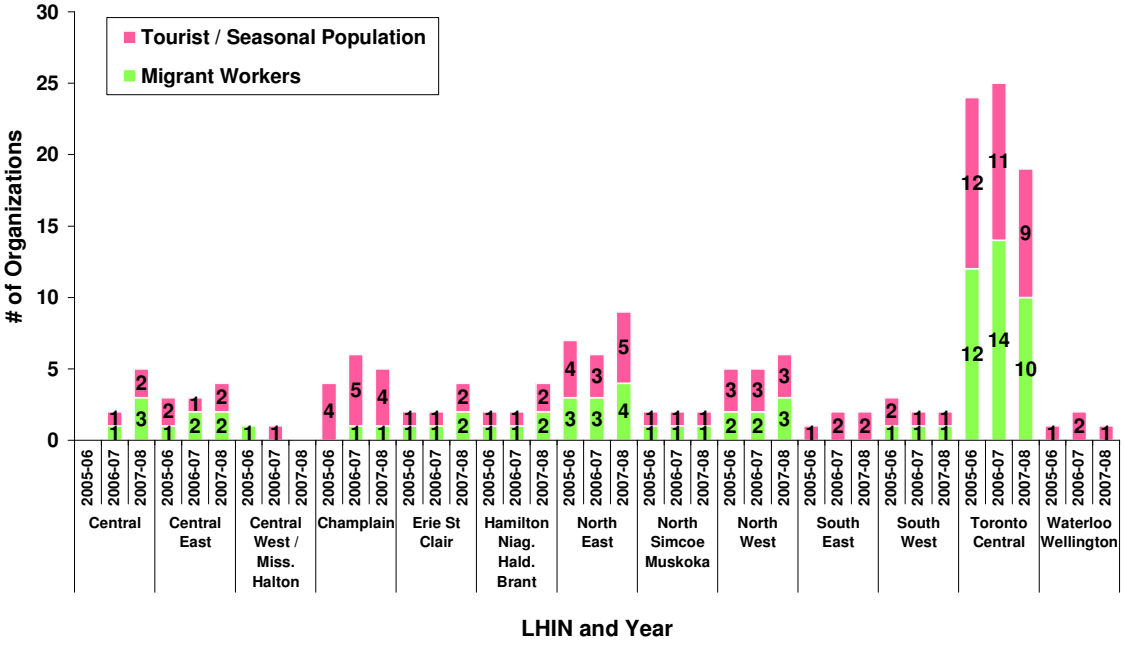
More organizations report serving migrant populations

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 2007-08, 29 organizations in 10 of the province's LHIN regions reported serving migrant populations (Figure 6.3) – up from 27 in 2006-07 and 23 in 2005-06. A number of organizations noted a recent increase in migrant workers from Mexico. Other organizations highlighted the impact of Aboriginal migration within Ontario: a growing number of Aboriginal people live in urban centres but return to their home communities for education, work, meetings, cultural events, sports events, religious events, and medical care. Migration allows for the possibility of HIV transmission to remote communities, and can create education and prevention issues for organizations serving regions with First Nations communities.

Thirty-two organizations in 12 LHINs reported serving seasonal populations (Figure 6.3); this number has remained relatively constant over the past three years. Organizations with seasonal populations experience surges in demand at certain times of the year, and may need different program and staffing strategies to meet client needs.

Organizations continue to point out other trends in their communities (besides the movement of people) that affect HIV risk, such as serving a catchment area where there is a large concentration of sex workers, having a large crack cocaine community, working to meet Francophone and First Nations needs, serving a large homeless/underhoused community, and trying to meet the needs of growing numbers of clients with hepatitis C.

6.3: Organizations Serving Migrant or Tourist / Seasonal Populations by LHIN

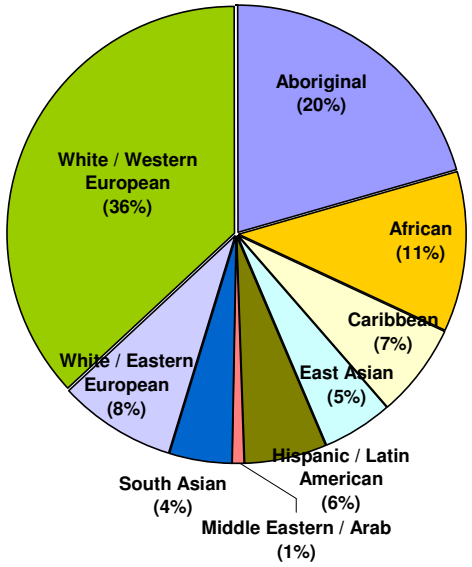


A clearer picture of racial and cultural diversity

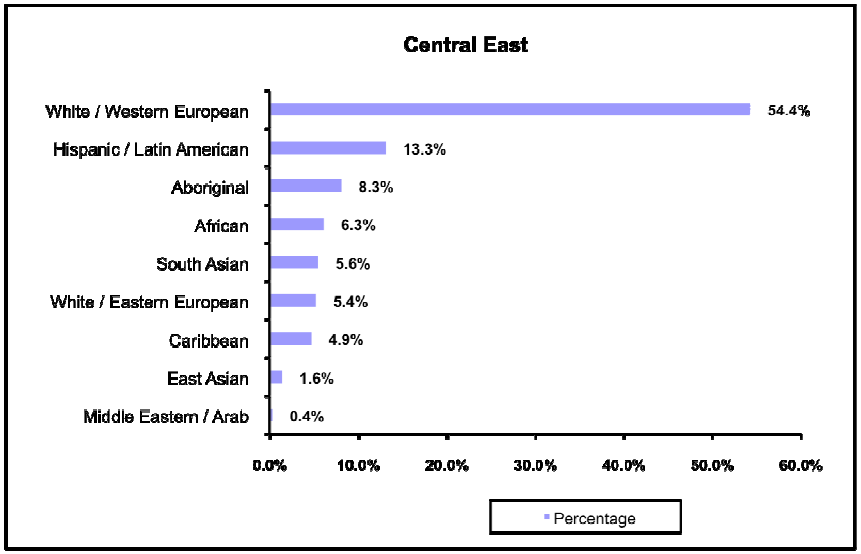
In previous years, OCHART simply asked organizations to indicate the race/ethnicity of the clients they serve, based on the ethnic categories established by Statistics Canada. To gain a clearer picture of who is using community-based AIDS services, in 2007-08, OCHART asked organizations to indicate the proportion of their clients in each racial/ethnic group. Funders are aware that this reporting is still subjective (i.e., most organizations do not collect data on race/ethnicity) but this data does provide a better sense of the extent of ethnic and cultural diversity as well as the need for culturally sensitive programs.

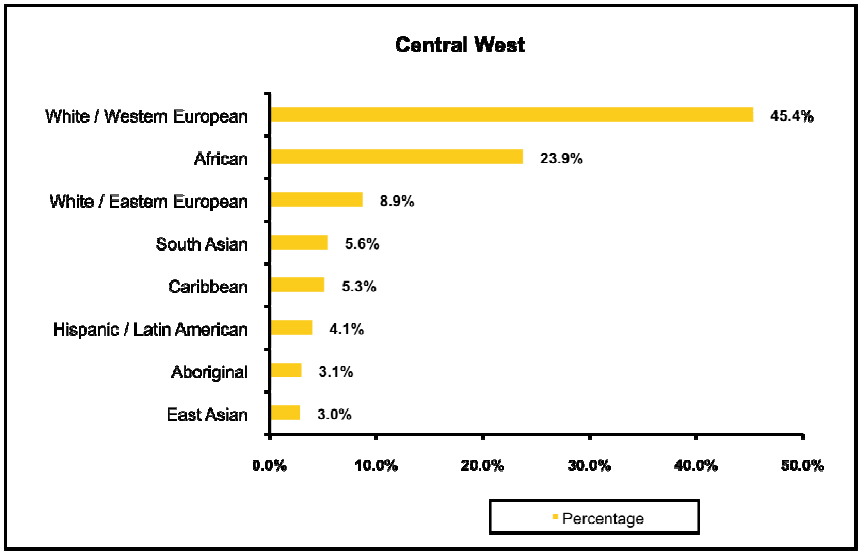
It appears that the epidemic in Ontario continues to be concentrated in white/western European, Aboriginal and African populations – although the proportion serving Asian, Latin American and white/eastern European populations appears to be growing. Six of eight regions report that most of their clients are white or western European, and two (Northern and Southwest) report that the majority of their clients are Aboriginal.

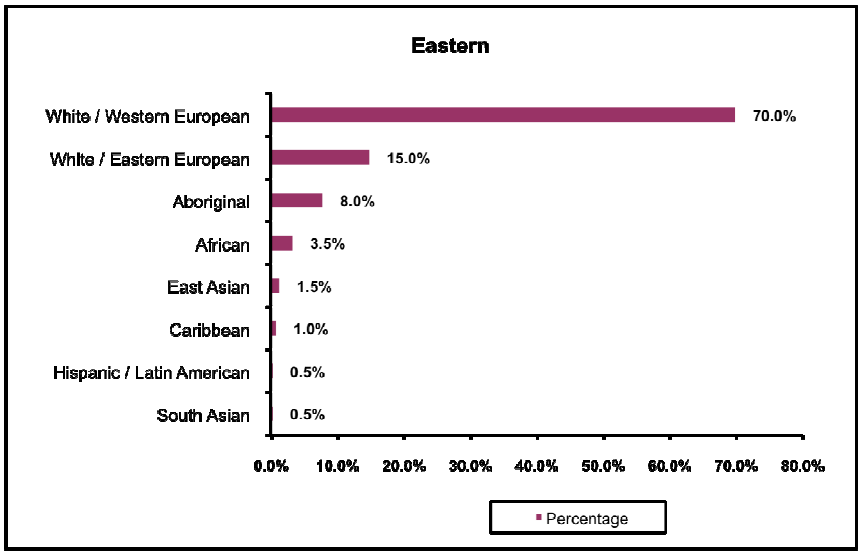
6.4b: Average Percentage of Services to Each Ethno-racial Group, 2007-08 H2

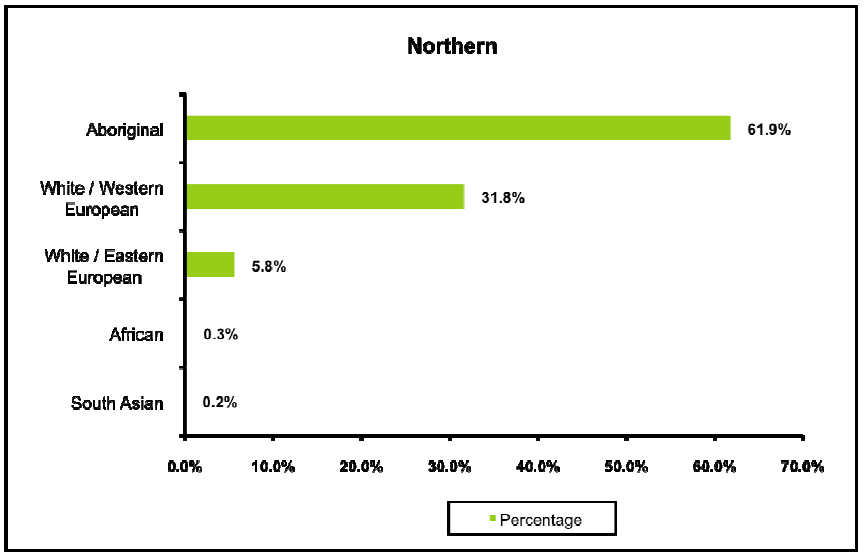


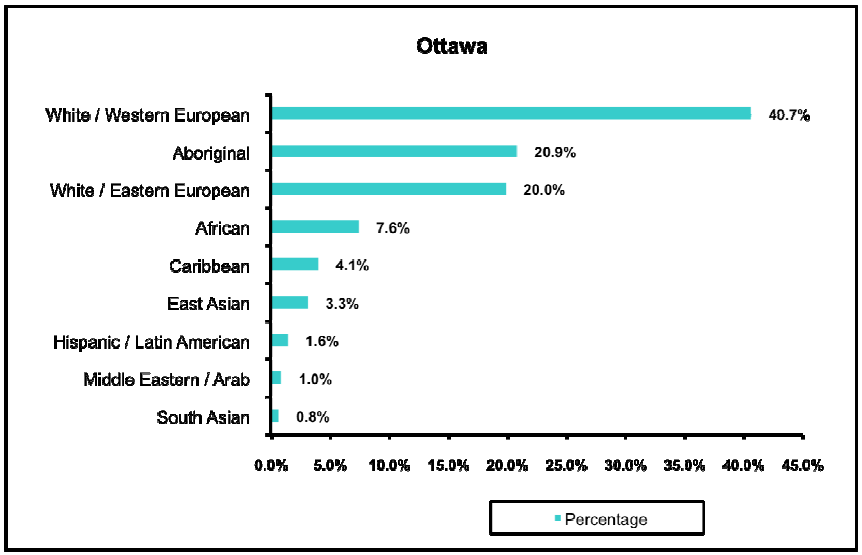
6.4a: Percent of Clients Served of Different Races/Ethnicities by Region

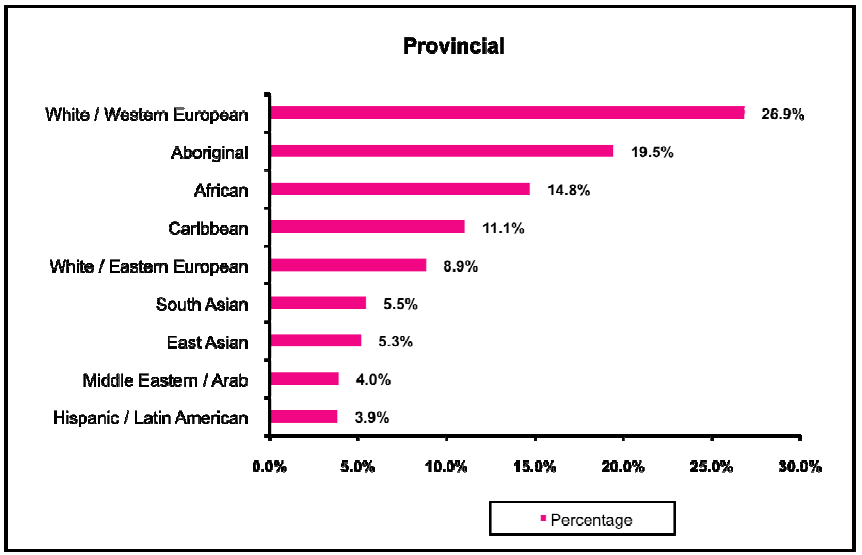


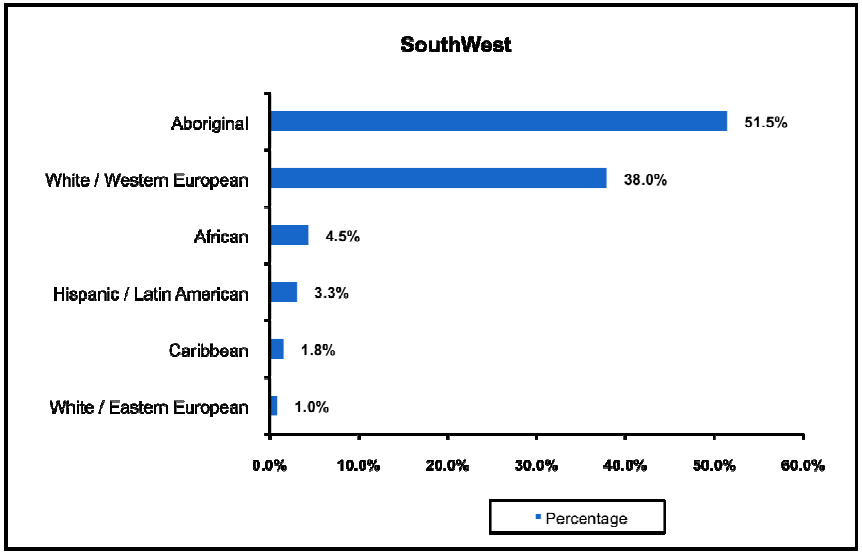


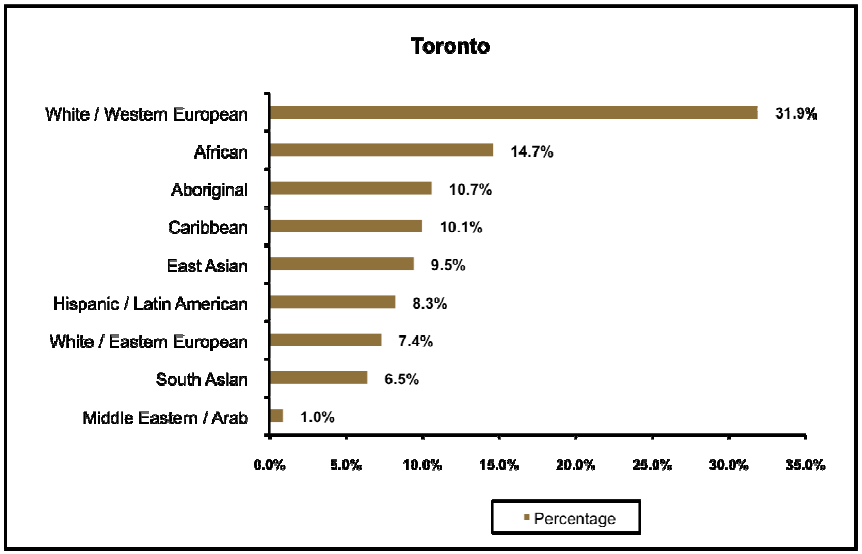





Ottawa
White / Western European
Aboriginal
White / Eastern European
African
Caribbean
East Asian
Hispanic / Latin American
Middle Eastern / Arab
South Asian
40.7%
20.9%
20.0%
7.6%
4.1%
3.3%
1.6%
1.0%
0.8%
0.0% 5.0% 10.0% 15.0% 20.0% 25.0% 30.0% 35.0% 40.0% 45.0%
Percentage

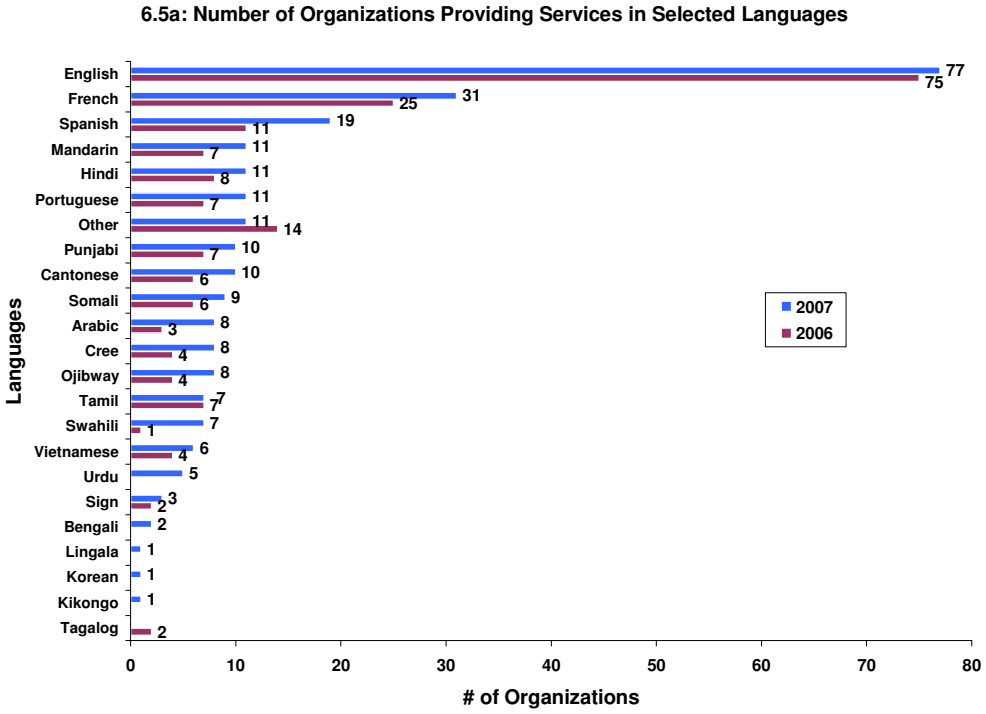

Provincial
White / Western European
Aboriginal
African
Caribbean
White / Eastern European
South Asian
East Asian
Middle Eastern / Arab
Hispanic / Latin American
26.9%
19.5%
14.8%
11.1%
8.9%
5.5%
5.3%
4.0%
3.9%
0.0% 5.0% 10.0% 15.0% 20.0% 25.0% 30.0%
Percentage


SouthWest
Aboriginal
White / Western European
African
Hispanic / Latin American
Caribbean
White / Eastern European
51.5%
38.0%
4.5%
3.3%
1.8%
1.0%
0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0%
Percentage


Toronto
White / Western European
African
Aboriginal
Caribbean
East Asian
Hispanic / Latin American
White / Eastern European
South Asian
Middle Eastern / Arab
31.9%
14.7%
10.7%
10.1%
9.5%
8.3%
7.4%
6.5%
1.0%
0.0% 5.0% 10.0% 15.0% 20.0% 25.0% 30.0% 35.0%
Percentage

More organizations providing services in different languages

In 2007-08, there was an increase in the number of organizations providing services in certain languages, including Spanish, Portuguese, French, First Nations languages, Arabic, Asian languages and African languages.

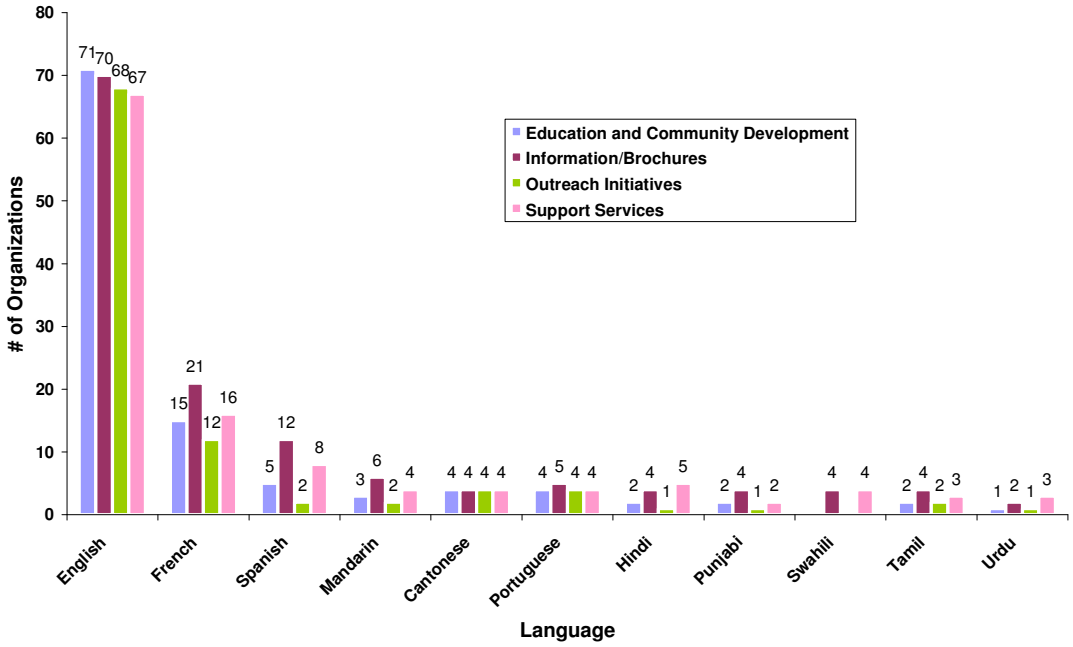


The increase in the number of organizations reporting that they deliver services in Aboriginal languages (e.g., Cree, Ojibway) is likely due to the fact that the Ontario Aboriginal HIV/AIDS Strategy is now reporting as separate programs in each region.

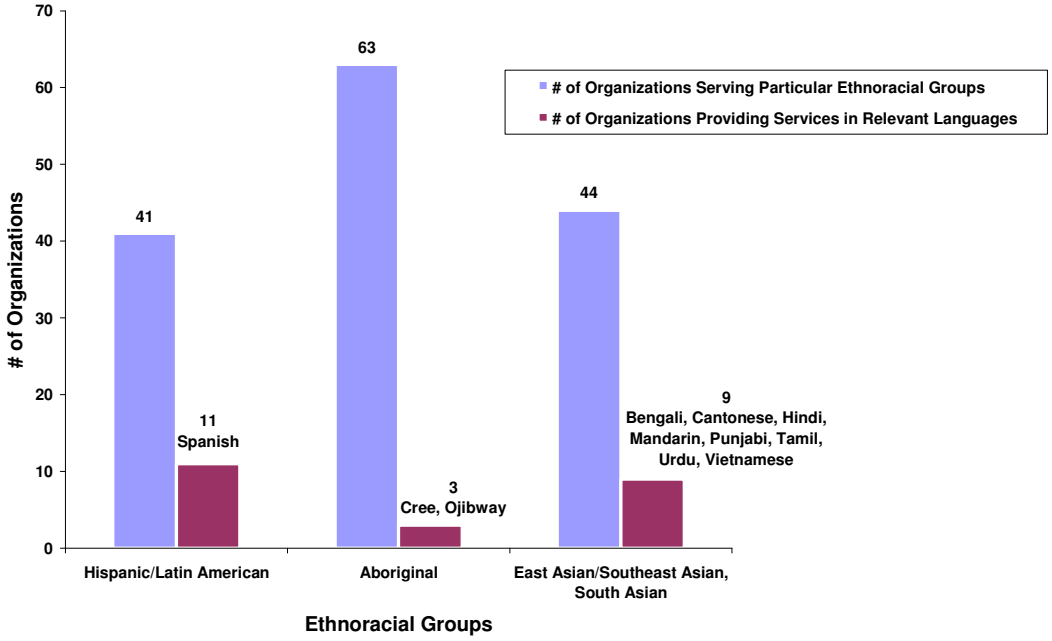
Previous versions of OCHART gathered information on the number of organizations with the capacity to provide services in different languages, but not on the actual services that clients could receive in each language. For example, does the organization distribute brochures in various languages or does it have the capacity to counsel clients in their mother tongue? In 2007-08, OCHART asked for more detailed information on the types of services available in languages other than English.

As Figure 6.5b indicates, most organizations provide services in English and a relatively small number provide services in other languages. Those that do provide services in other languages are more likely to provide information/brochures than to deliver outreach or support services. As Figure 6.5c illustrates, only a small proportion of organizations that report serving particular cultural groups are providing services in their languages (e.g., only 11 of the 41 organizations that report having Hispanic or Latin American clients have the capacity to provide outreach or support services in Spanish).

6.5b: Languages in which Five or More Organizations Reported Offering Services - 2007-08 H2

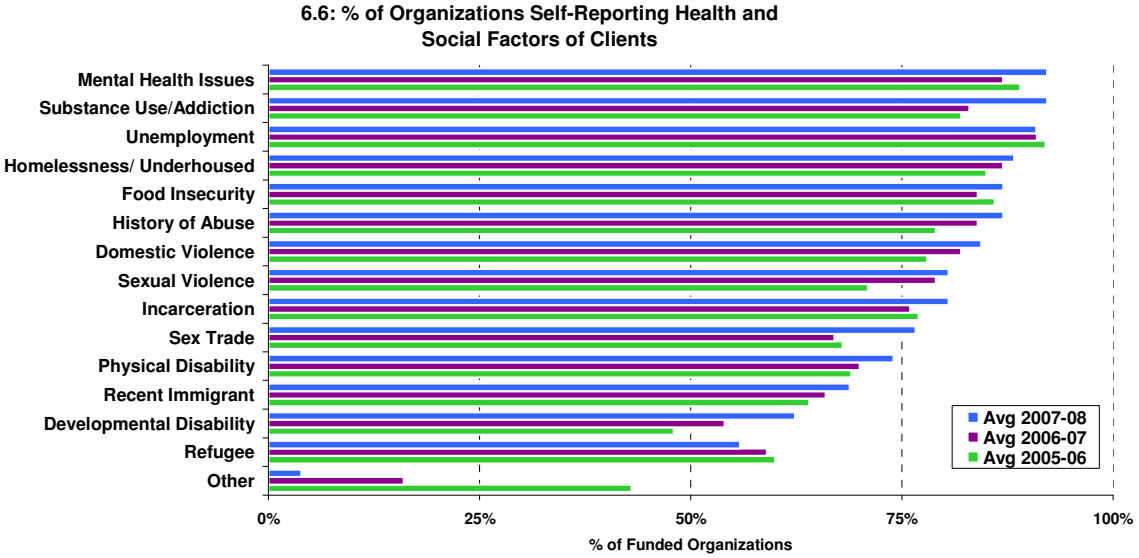


6.5c: Number of Organizations that Report Serving Particular Ethnoracial Groups and Number that Provide Services in Relevant Languages - 2007-08 H2



More clients face issues associated with substance use, mental health problems, sex work and disability

In 2007-08, the proportion of organizations that reported serving clients who are dealing with issues related to substance use and mental health problems increased significantly. For the first time since organizations began reporting through OCHART, these issues are more prominent than those related to unemployment or unstable housing – although they are probably factors in people's ability to find and maintain both housing and employment. These trends are consistent with the increase in HIV diagnoses among people who use injection drugs.



Organizations also reported an increase in the proportion of clients dealing with issues related to sex work, developmental or physical disabilities, and incarceration. The fact that more organizations are seeing people with sex work issues may be related to the larger number of women seeking services, or to substance use. Many people turn to sex work to support an addiction. The increase in organizations providing services for people who are incarcerated may be due to efforts over the past year to develop more collaborative relationships between ASOs and health services within the province's correctional facilities to ensure that prisoners are linked with services in the community. As noted in the 2006-07 OCHART report, the increase in clients with developmental disabilities may be related to changes in the social services system, including the closing of residential programs. It may also be due to organizations recognizing that this group is at risk and targeting them for services.

Once again in 2007-08, there was an increase in the number of organizations serving clients with a history of abuse or problems related to domestic or sexual violence. This increase is likely due to a combination of factors, including more clients who are women, more Aboriginal clients, and more clients with substance use and sex work issues, which may put them at higher risk of experiencing violence. In their comments, organizations mentioned specifically exposure to gun violence and gangs, as well as the long-term impact of residential schools. There is also likely growing recognition on the part of organizations that a history of abuse is a determinant of health and puts people at higher risk of substance use and HIV infection.

In addition to the factors listed on OCHART, organizations identified other social issues that affect clients' health including:

- stigma (i.e., homophobia, racism, discrimination, systemic oppression, ageism)

- poverty
- lack of access to medical services
- language and literacy barriers
- isolation
- body image and self-esteem issues
- lack of formal education or training
- lack of life skills
- Hepatitis C co-infection
- child care and parenting issues
- conflict with parents and family.

The complex, multiple issues that clients face reinforce the importance of comprehensive programs and services that meet people's health, psychosocial, social and economic needs, and the importance of taking a broad determinants of health approach to both HIV prevention and support. Ontario will not be able to stop the spread of HIV until it addresses the factors that put people at risk.

Part IV: Our Programs and Services

Organizations funded by the AIDS Bureau and ACAP provide a wide range of programs and services, which are grouped into five categories for reporting purposes. The categories are: education and community development programs; outreach initiatives; support services; volunteer and student programs; and outreach programs for injection drug users. This part of the View from the Front Lines describes the type and level of service provided in each category as well as emerging trends.

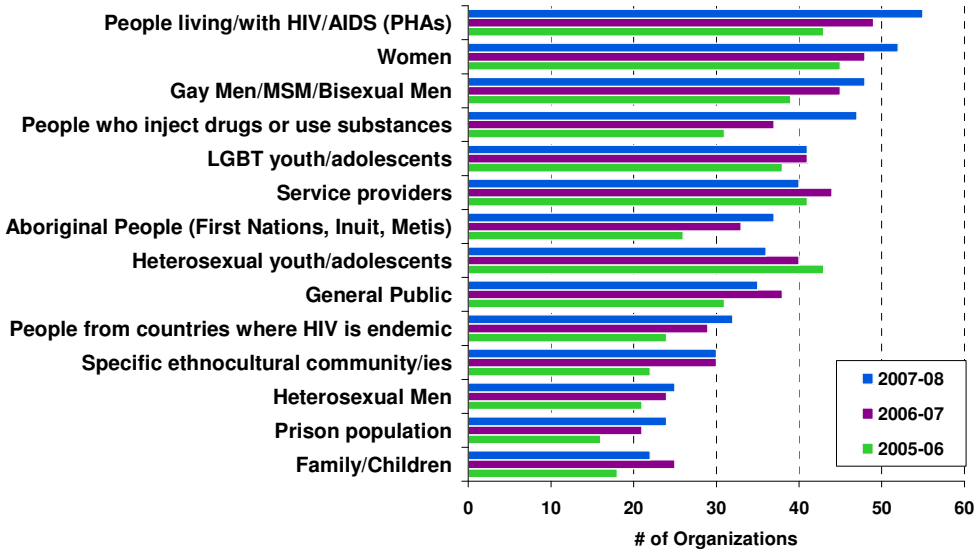
Education and Community Development

During the second half of 2007-08, 64 organizations were funded by the AIDS Bureau and/or ACAP to provide education and community development services – up from 60 in the first half of the year. Of the 64 organizations, 25 were funded by the AIDS Bureau only, 5 by ACAP only and 29 by both the AIDS Bureau and ACAP.

More organizations target priority populations

OCHART asks organizations to rank the populations they target in order of priority.[2] Over the past three years, there has been a steady increase in the number of organizations targeting their education programs towards priority populations, including people with HIV, women, gay men, people who use injection drugs, Aboriginal peoples, people from African and Caribbean communities (i.e., countries where HIV is endemic), and the prison population. Over the same period, fewer organizations report giving high priority to education for heterosexual youth or the general public.

9.1: Organizations Selecting Specific Populations as Priority #1 to #6 for Education and Community Development

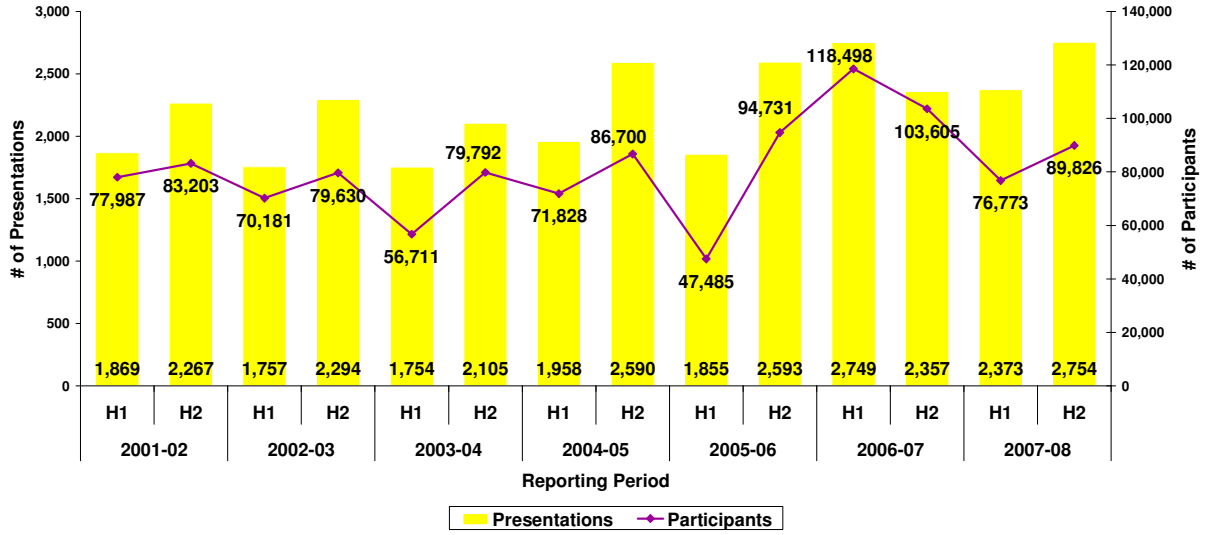


[2] Because there are no rules on how organizations answer this question, some rank populations from 1 to 10; others identify a number of different populations as their number 1 priority. This makes it difficult to analyze or display the data. Because of data problems, this question is not part of the 2008-09 OCHART.

Fewer education presentations than 2006-07 but more than previous years

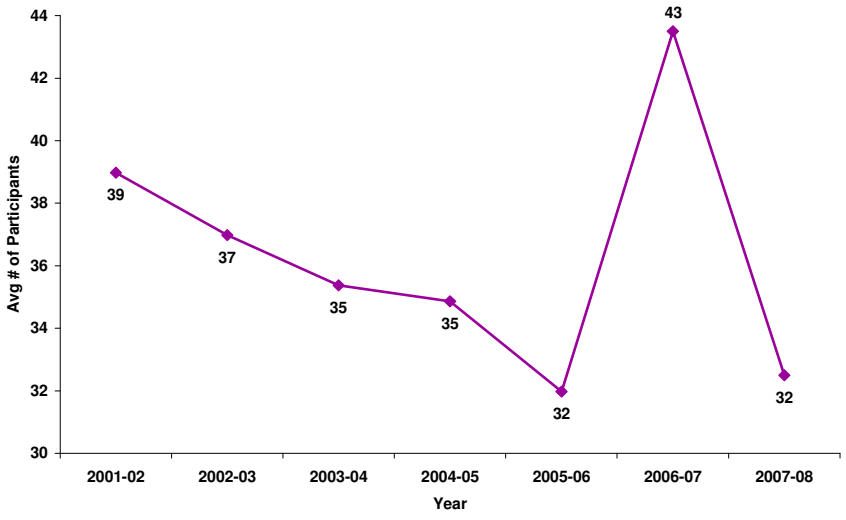
As Figure 9.2.1a shows, organizations gave a total of 5,127 education presentations (indicated by the yellow bars for H1 and H2 in 2007-08) to a total of 166,599 participants in 2007-08 (indicated by the red line). Although they gave about the same number of presentations as in 2006-07 (the year of the International AIDS Conference), there were about 25% fewer participants. However, compared to 2005-06, both the number of presentations and participants increased (by 15% and 17% respectively). Despite the growing sense that HIV is no longer a high profile public issue, organizations continue to find and create opportunities for education. The trend to provide more presentations in the second half of the year (i.e., fall and winter) has remained consistent across all years except 2006-07 when the International AIDS Conference was held in the summer.

9.2.1a: Number of Education Presentations and Participants by Reporting Period



With the exception of 2006-07 (the year of the International AIDS Conference), the average number of participants per presentation has gradually declined over the past six years, and this likely reflects a more targeted approach to HIV prevention and skills building.

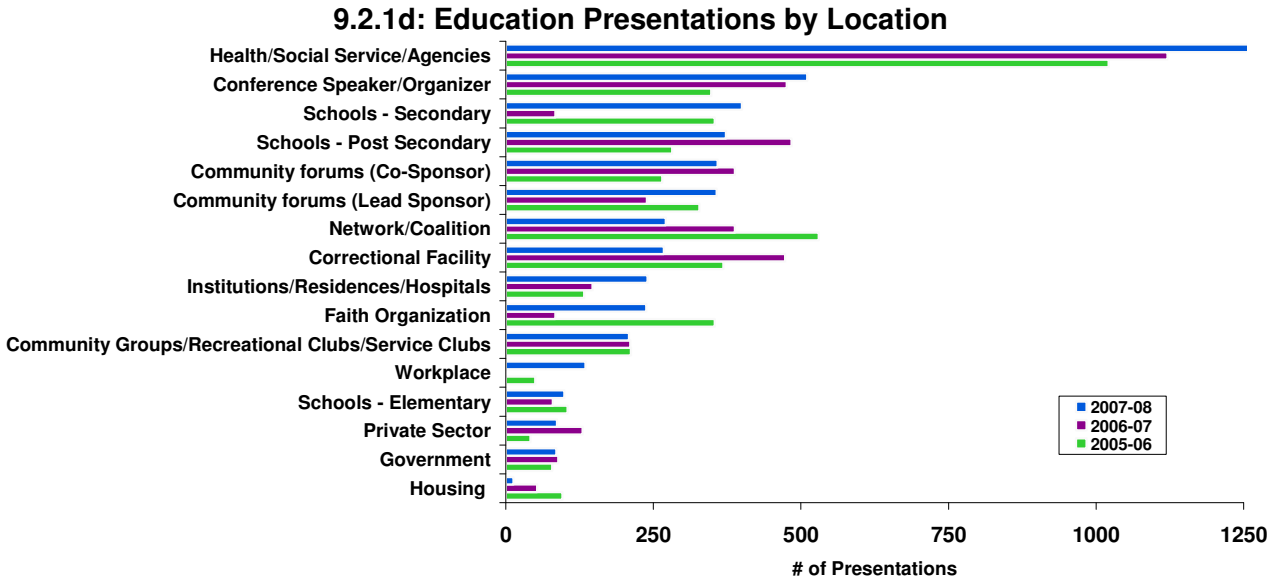
9.2.1b: Average[1] Number of Participants per Education Presentation 2001-2007



[1] Averages were calculted by dividng the total number of participants (H1+H2) by the number of presentations.

More presentations to health and social services agencies, schools, workplaces and institutions

Although service providers are not identified as a high priority by many organizations (see Figure 9.1), the majority of education presentations are given to service providers. This may reflect efforts on the part of community-based AIDS organizations to build a network of services, and improve access to other services and supports, for their clients.



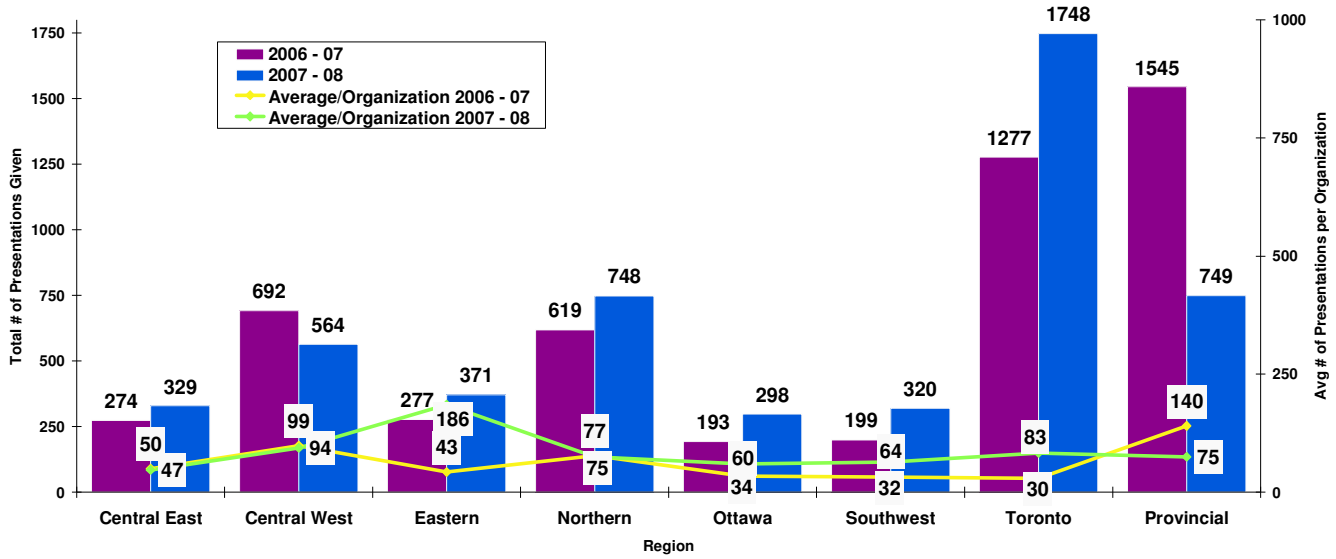
A fairly large proportion of education presentations were also given in school settings, which can be an effective way to reach higher risk youth (e.g., LGBT, racialized minority and Aboriginal youth).

In 2007-08, there was a marked increase in the number of education presentations in the workplace, which is consistent with the finding that employment issues are a priority for people with HIV. There were also more presentations to institutions, residences and hospitals than in previous years. Given the fact that housing is still identified as a key unmet need, it is interesting to see a significant drop in the number of presentations to housing organizations/providers.

Presentations increase significantly in Ottawa and Toronto

Figure 9.2.1e shows the number of education presentations given by region in 2007-08 and the average number of presentations per organization in each region.

9.2.1e: Total and Average[1] Number of Presentations by Region for 2007-08



1 The average number of presentations made was calculated by dividing the total number of presentations for the fiscal year by the number of organizations that reported making presentations.

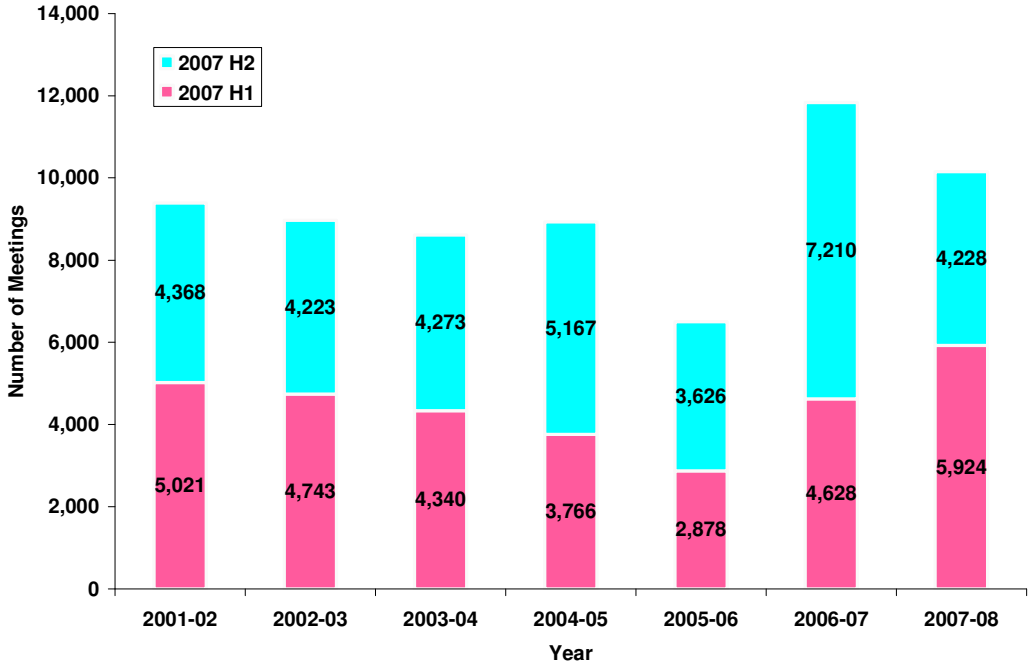
There was an increase in both the number of presentations given in almost all regions as well as in the average number of presentations per organization in each region. The increase was significant in Ottawa (54%) and Toronto (37%). The larger number of presentations in Ottawa was likely due to efforts to raise awareness about the benefits of harm reduction programs for people who use drugs – particularly the safer inhalation program run by the department of public health, which was shut down because of a political decision by municipal council.

The marked decrease in the number of presentations given by provincial organizations is likely due in part to the fact that all activities of regional staff of the Ontario Aboriginal HIV/AIDS Strategy (OAHAS) are now counted in their regions, rather than as part of the provincial numbers – in order to provide a better understanding of the level of activity in each region.

Community development meetings down from 2006-07 but up from previous years

Organizations held or participated in fewer community development meetings in 2007-08 (10,152) than in 2006-07 (11,838), but more than in previous years (average: 8,481). As noted in the 2006-07 View from the Front Lines, the high number of community development meetings that year was likely due to the International AIDS Conference as well as meetings held to disseminate information from the conference.

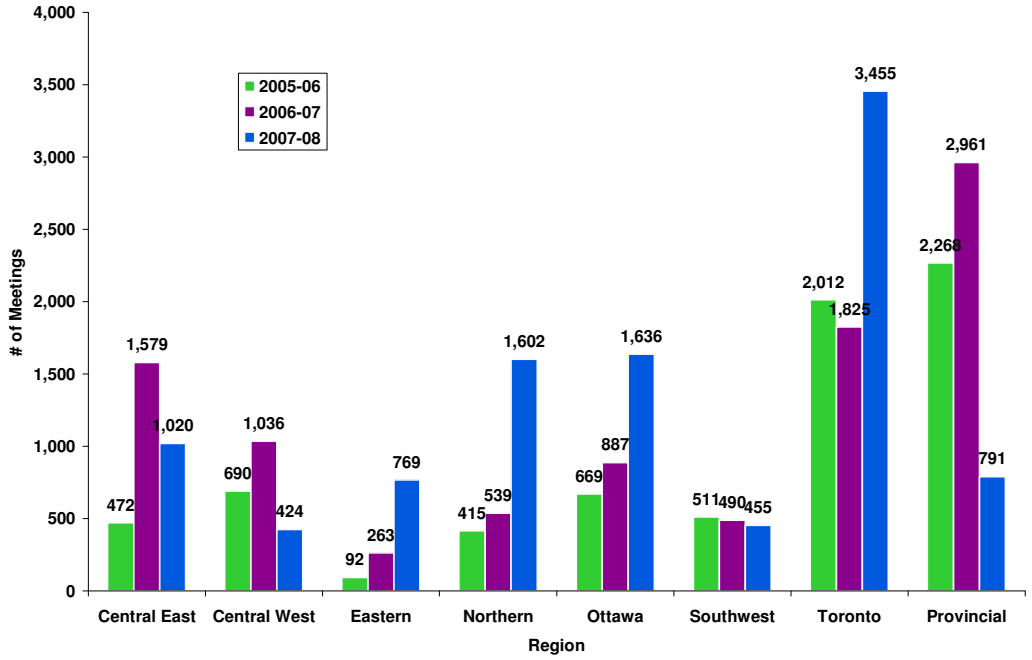
9.2.1f: Community Development Meetings Held by Reporting Period



Community development activities up significantly in four regions

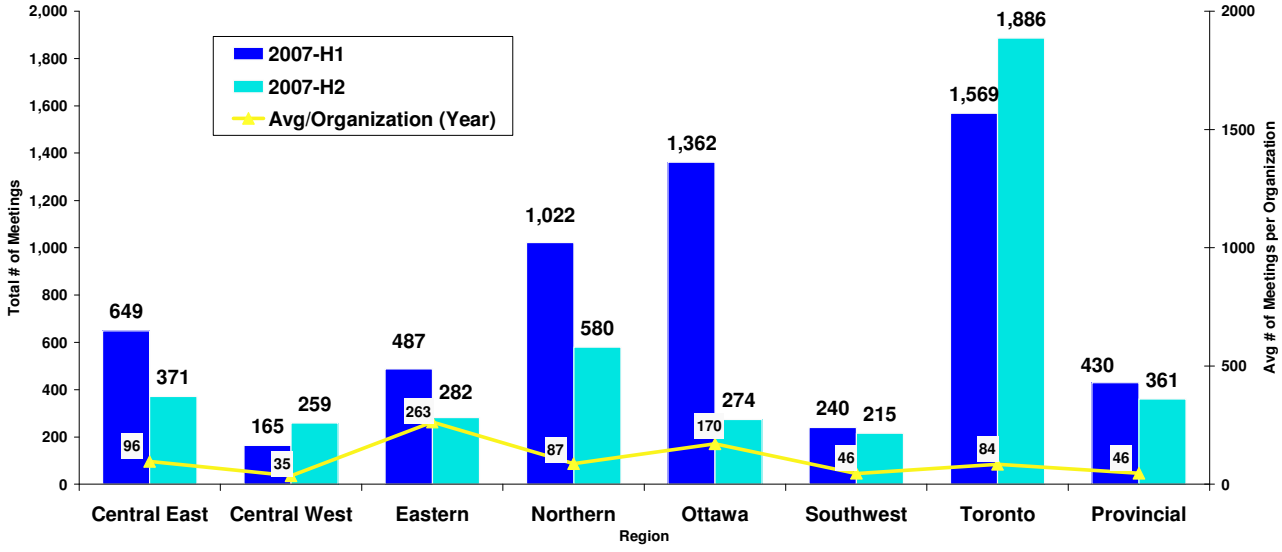
Four regions – Eastern, Northern, Ottawa and Toronto – reported significantly more community development meetings in 2007-08 than in previous years. As noted earlier, the increase in Ottawa and Eastern Ontario may be related to the efforts to save the Safer Inhalation Program and to advocate for harm reduction programs in general.

9.2.1g: Community Development Meetings by Region



The average number of presentations per organization increased significantly in Toronto (from 46 to 84), Ottawa (from 99 to 170), Eastern Ontario (from 132 to 263) and in Northern Ontario (from 39 to 87). Some of this change may be related to how the data are being reported.

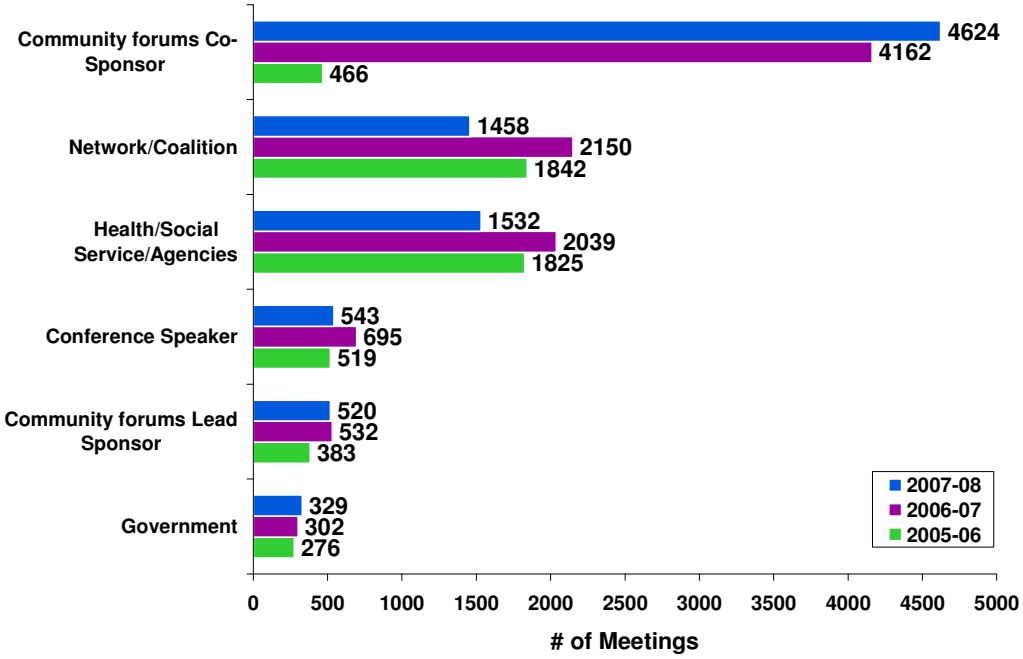
9.2.1h: Total and Average[1] Number of Community Development Meetings by Region for 2007-08



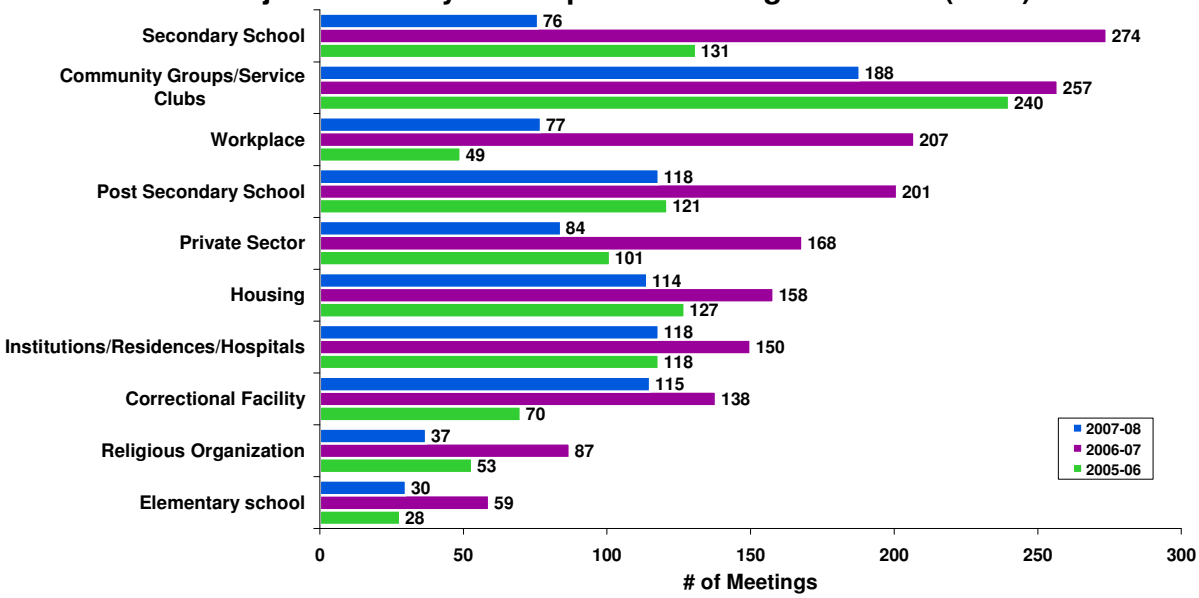
More community forums and more focus on correctional facilities and workplaces

During 2007-08, the number of community development meetings was down in all locations except community forums and government. This reflects the focus on integration and working with other organizations in the community to improve care and services. It also reflects an increase in advocacy with government.

9.2.1i: Community Development Meeting Locations (>300)



9.2.1j: Community Development Meeting Locations (<300)



Although the number of community development meetings was down in all locations compared to 2006-07 (International AIDS Conference), they were up from 2005-06 in two key locations: correctional facilities and workplaces. The increase in community development efforts with correctional facilities may be due to the AIDS Bureau and Ministry of Community Safety and Correctional Services efforts to link the health nurses in correctional facilities with community-based AIDS organizations. This initiative is designed to ensure greater continuity of services for prisoners inside correctional settings and when they are released back into the community. The focus on workplaces is consistent with earlier findings that employment is one of the key issues facing people with HIV. It indicates that organizations are trying to address employment, stigma and social support issues.

Emerging Trends in Education and Community Development

Organizations reported the following emerging trends in education and community development.

More sensitivity training for service providers

Service providers requesting more information and sensitivity and other training in:

- working with Aboriginal and African/Caribbean communities
- working with lesbian, gay, bisexual and transgender (LGBT) youth
- reducing homophobia and transphobia
- being sex-positive
- harm reduction, including the distribution of safer inhalation kits
- issues facing sex workers
- intersecting issues, such as HIV, violence and Aboriginal people
- providing HIV testing
- HIV/AIDS for palliative care providers
- providing care for people with HIV in long-term care homes.

One organization noted that its services and messaging are changing to reflect the diversity of its clients as well as the changing nature of HIV and the fact that, for many clients, it is becoming a chronic illness.

More information and services for youth

A number of organizations reported more requests for youth-based programming that includes healthy sexuality for youth; and support for schools, universities and social service agencies that are developing gay straight alliances, groups for LGBT youth or working with at-risk youth.

More information and services for women

In 2007-08, there were more requests for prevention education for young women; information on women's health and sexuality; information about Hep C (both mono-infection and co-infection) for women who are incarcerated; and information for women who have sex with women.

More information for newcomers and different ethnoracial groups

Organizations report receiving more requests for education and community development for newcomers and different ethnoracial groups related to immigration issues; social and market housing systems; and services for specific cultural groups, including Latino PHAs, African and Caribbean women, First Nations (on reserve) communities, Portuguese and Spanish communities.

Hot topics

ASOs also reported receiving more requests for information on the following topics:

- criminalization of HIV, the legal requirements of people with HIV, and disclosure
- biological information on the virus itself, including the relationship between viral load and risk of transmission, the role of STIs and circumcision in HIV transmission, and genotyping and phenotyping
- drugs, including the types of street drugs currently in use (i.e., crack cocaine, oxycontin) and treatments for IDUs
- point-of-care testing
- health promotion and nutritional information for people with HIV
- mental health issues for people with HIV
- dating with HIV (i.e., healthy relationships)
- how to understand and interpret the statistics used in HIV reports and research
- body mapping (i.e., a visual story-telling technique that depicts that impact of HIV on one's relationships and health)
- HIV and aging.

Responding to Emerging Trends

To respond to emerging education and community development needs, organizations report that they are:

- revamping/refocusing existing programming
- developing new programming/materials/resources/workshops/training sessions (including peer education programs) and providing new training for staff
- distributing their resources more widely
- developing/strengthening partnerships with other ASOs, the city, faith-based organizations, schools, and ethnospecific communities
- making more effective use of peers and peer training
- hiring staff with the knowledge and skills to serve specific populations, such as youth and particular cultural groups
- planning research
- requesting funding.

Outreach Initiatives

Organizations funded to provide HIV prevention and education often offer outreach services for people with HIV and populations at risk.

(Note: this section does not include the outreach services provided by organizations that are specifically funded under the AIDS Bureau IDU Outreach initiative: their activities are reported separately, beginning on page 93 of this report. However, it does include outreach to injection drug users by organizations that are NOT funded under the IDU Outreach initiative.)

Priority populations for outreach services vary geographically

Some populations or communities are at a high risk of HIV. The pie chart on the following page (Figure 10.1) shows the number of organizations that identified certain populations as their highest priority for outreach services. In 2007-08, there was an increase in the number and proportion of organizations that identified people with HIV as their highest priority (29% compared to 25% in 2006-07). A larger proportion of organizations also identified men who have sex with men (18% compared to 17%) and Aboriginal communities (10% compared to 7%) as their highest priority, while fewer identified African and Caribbean communities (6% compared to 9%), ethnocultural communities (6% compared to 9%) and injection drug users (6% compared to 8%). (Note: the number and proportion of organizations identifying injection drug users may be low because this section does NOT include the IDU outreach programs). In 2007-08, 9% of funded organizations identified women as their highest priority for outreach services.

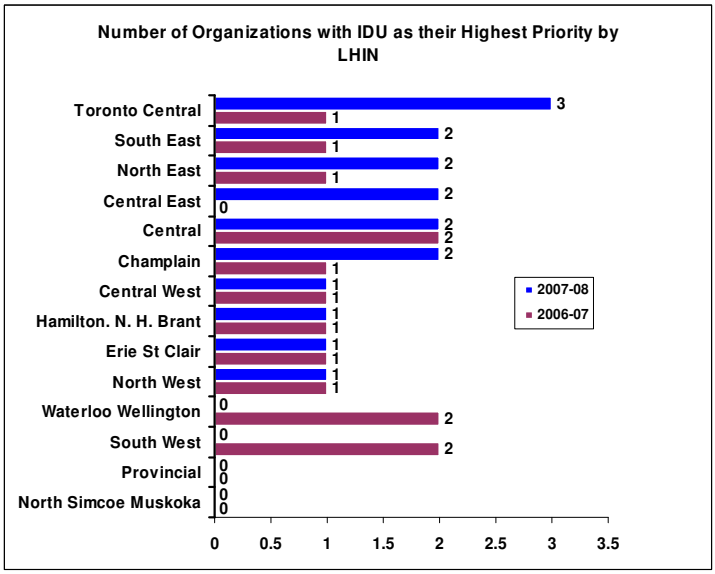
The bar graphs in Figure 10.1 compare the number of organizations in each LHIN region that prioritize each population. The number of organizations whose highest priority is people with HIV increased in Toronto, the North East and the North West LHINs – perhaps reflecting the increase in HIV diagnoses in the North. Seven LHINs had an increase in the number of organizations selecting gay men as a priority in outreach programs. This could be a result of the Gay Men's Sexual Health Alliance.

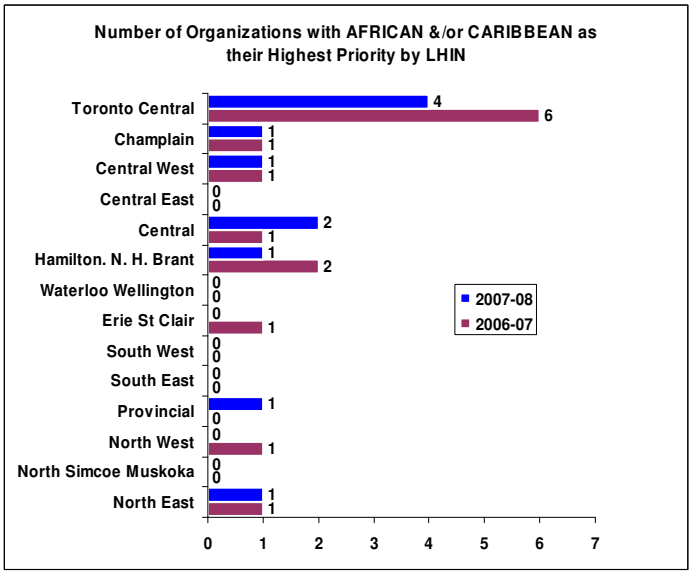
The increase in the number of organizations giving high priority to Aboriginal peoples across nine LHINs reflects the fact that the Ontario Aboriginal HIV/AIDS Strategy (OAHAS) regional workers and their programs and services are now counted in their regions rather than as part of a provincial organization. However, even given that change, the number of organizations giving high priority to Aboriginal peoples has increased in Toronto, the North West, the North East and the South East. This trend is consistent with the growing concern that Aboriginal peoples are particularly vulnerable to HIV.

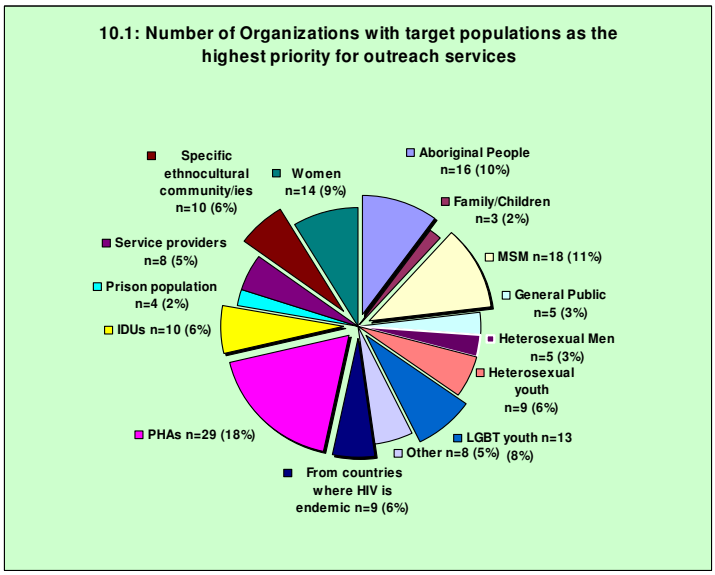
Organizations also identified other priority populations for outreach services, including:

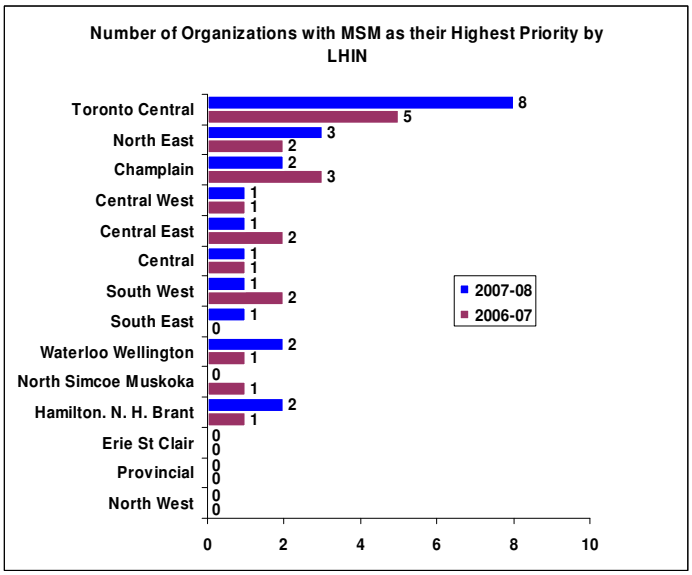
- sex workers and escort drivers
- prisoners.

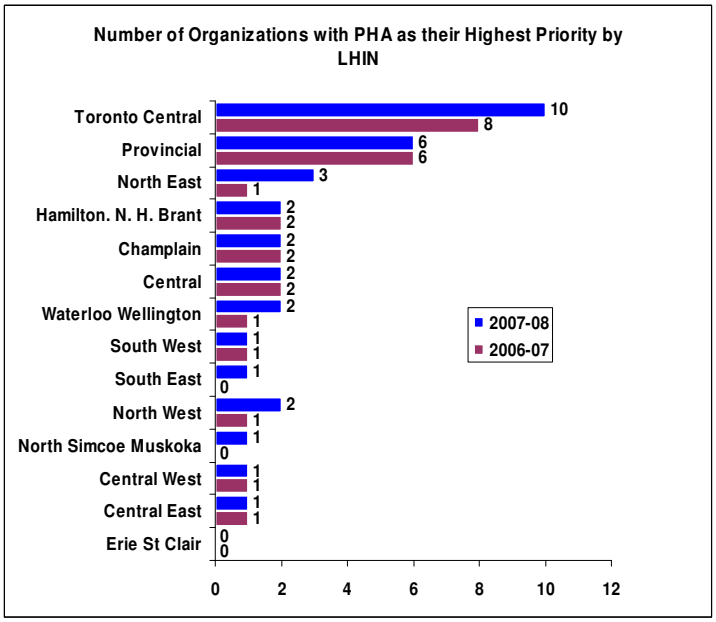
10.1: Number of Organizations Prioritizing Different Target Populations

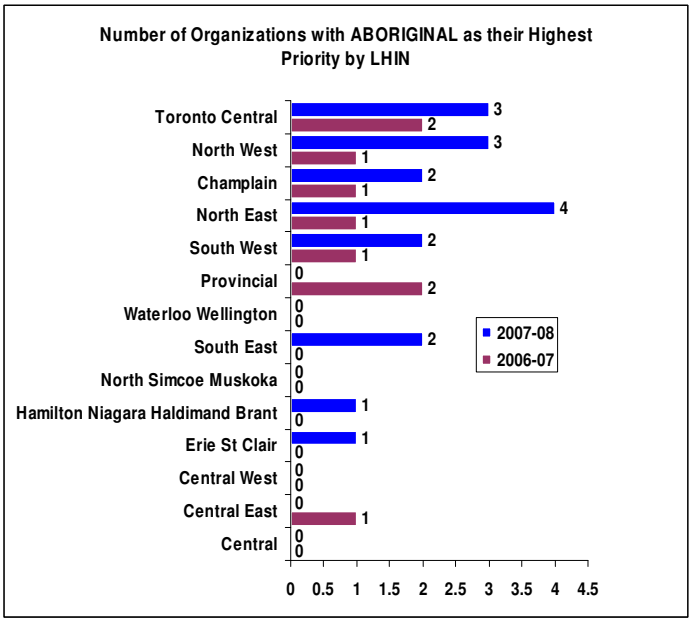






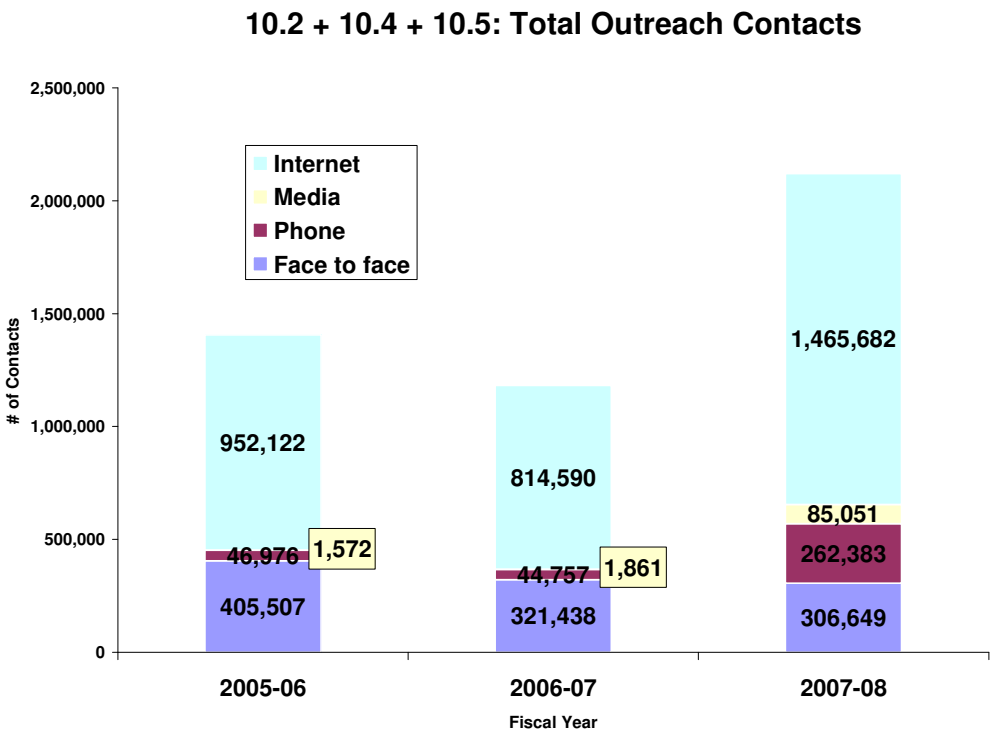






Face-to face outreach down, but Internet, phone and media contacts up

Figure 10.2/.4/.5 shows the total number of outreach contacts by funded organizations through traditional face-to-face outreach, Internet and phone outreach and media contacts. While the total number of face-to-face outreach contacts by funded organizations – in all locations – has dropped, the number of Internet, phone and media contacts increased significantly in 2007-08.

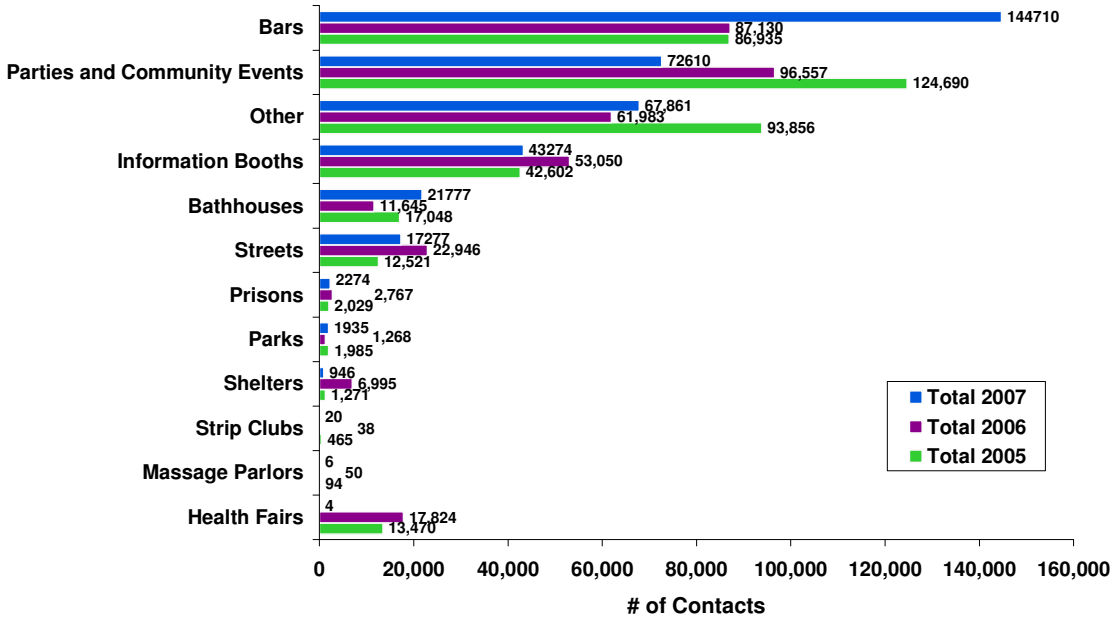


Locations for face-to-face outreach shifting

Figure 10.2b compares the location of "face-to-face" outreach contacts over the past three years. There was a slight increase in the total number of face-to-face outreach contacts in 2007-08 compared to the previous year; however, the number is still lower than in 2005-06.

During 2007-08, the number of contacts made at parties and events continued to drop, but there was a marked increase in bar contacts (+66%), bathhouse contacts (+87%) and park outreach (+53%). This trend may be related to the Gay Men's Sexual Health Alliance, and the concerted effort to reach gay men. The drop in contacts made at shelters and health centres is due to the fact that a shelter program and several community health centres funded in 2006-07 were not funded in 2007-08.

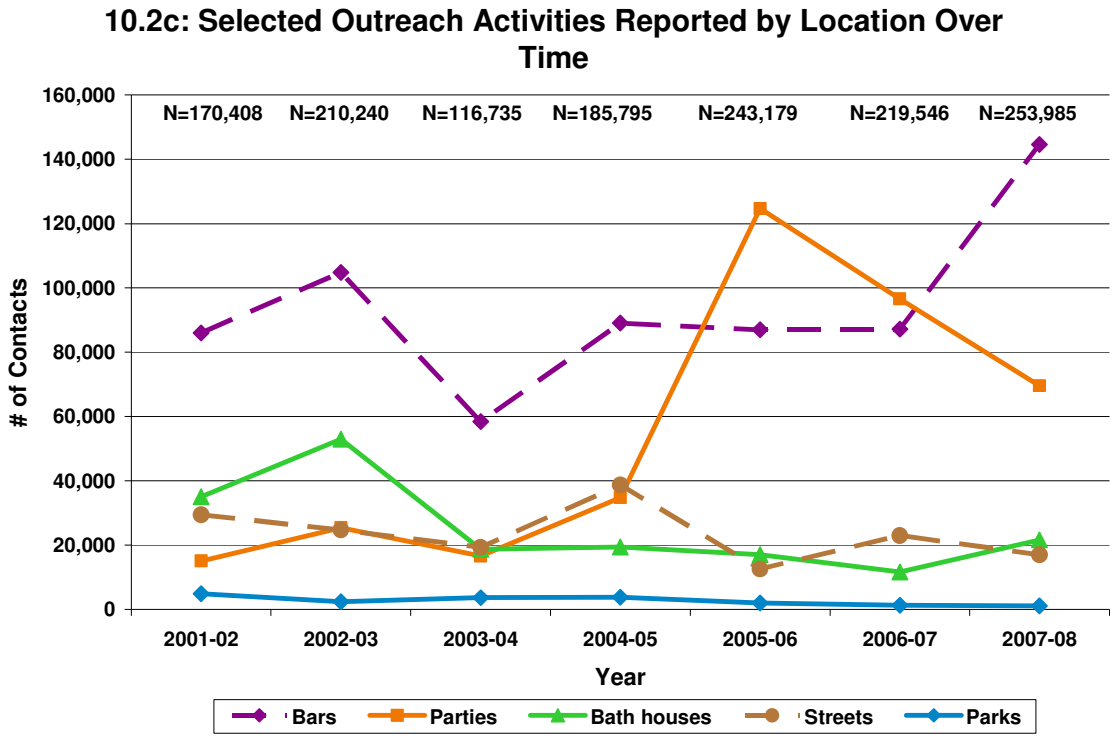
10.2b: Number of Outreach Contacts by Location



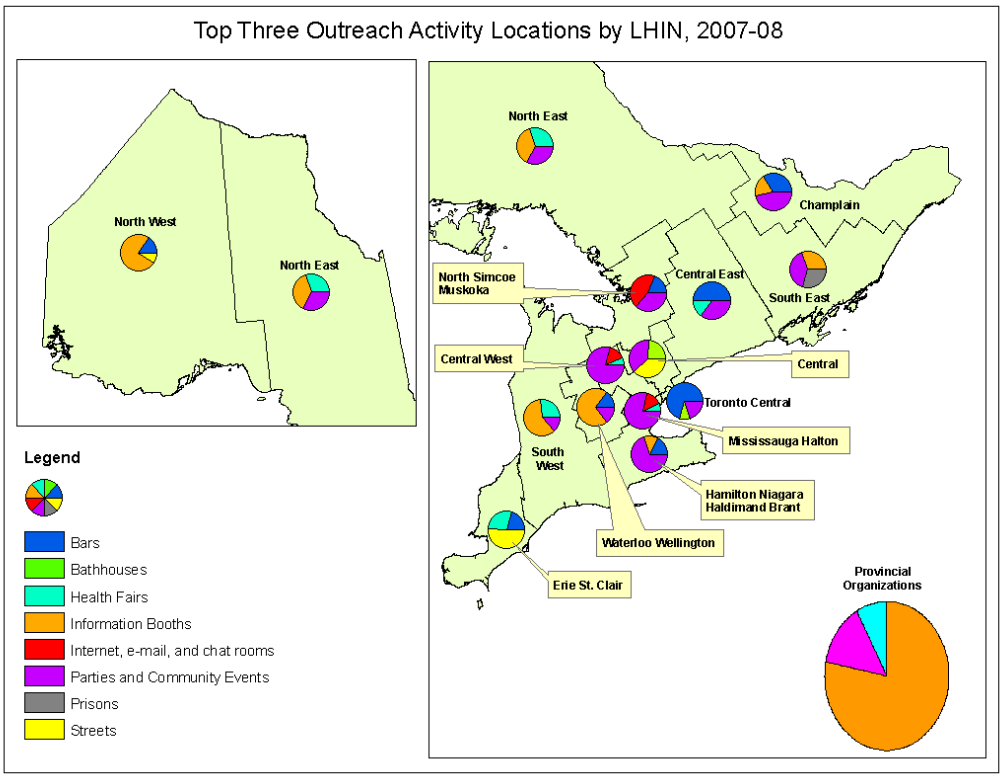
In addition to the locations listed on the charts, organizations reported using a number of other venues for outreach, including:

- withdrawal management programs
- drop-in programs
- food stores and shopping malls
- community sites, such as coffee shops, libraries and community events (e.g., Nuit Blanche, Caribana)
- treatment centres and health buses
- youth groups.

Figure 10.2c shows the shift in outreach locations over time. Ontario has seen a resurgence in bar outreach in the last year, and a decrease in party outreach. Despite the increase in bathhouse outreach in 2007-08, the number of contacts in that setting is lower than it was seven years ago. Street outreach is down over time, as is park outreach. As noted earlier, recent increases in bar and bathhouse outreach may be related to the Gay Men's Sexual Health Alliance.



The map illustrates the top three locations for delivering outreach services by LHIN. The differences across the province reflect local needs and target populations as well as organizational capacity and resources. For example, bars are the most common outreach location in Toronto and Central East, while parties are a more common location in Champlain, South East, Central

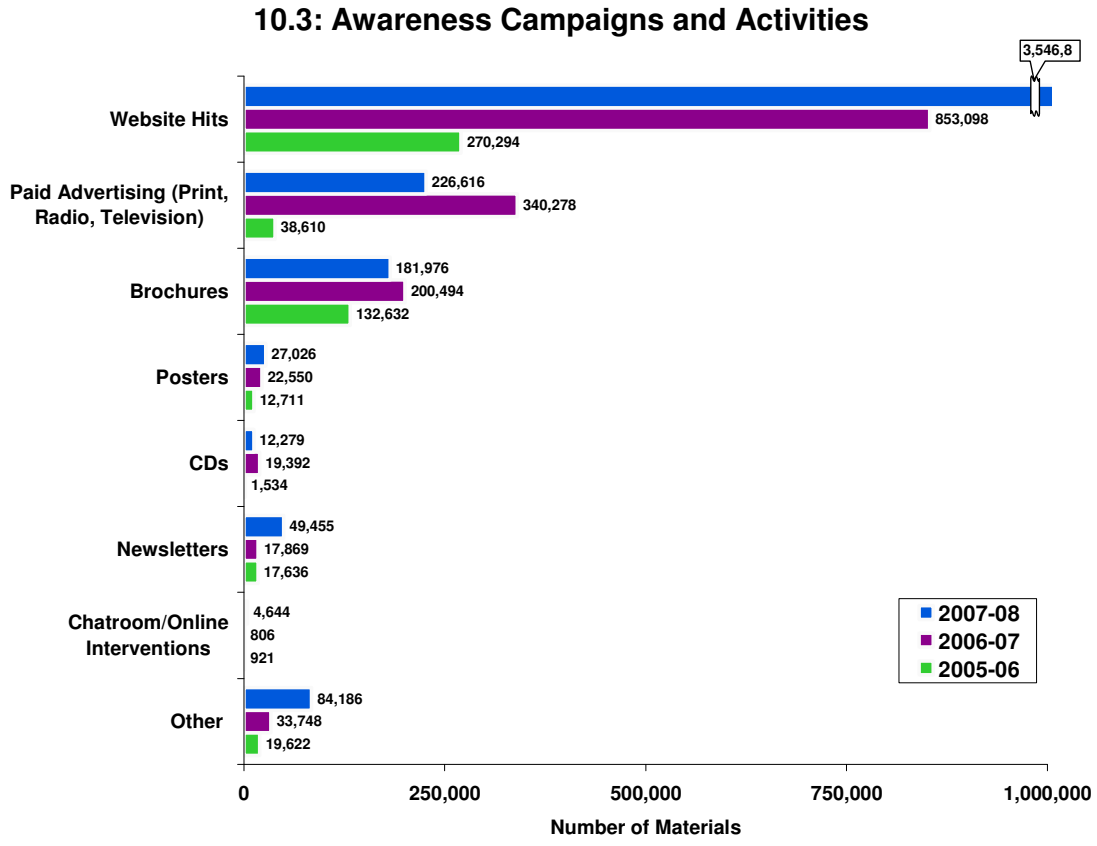


West and the Hamilton Niagara Haldimand Brant LHIN. Erie St. Clair and the Central regions focus on street outreach. Internet outreach is the most common form of outreach in North Simcoe Muskoka, while both the North West and North East LHINs continue to rely primarily on information booths.

In communities with outreach services that target gay men, the most common locations for outreach will depend in part on whether the communities have openly gay populations. In large urban centres with openly gay populations, outreach is more likely to occur in bars, while in smaller and more remote communities, it is more likely to occur at parties, on the Internet or through information booths and health fairs.

Use of websites to raise awareness continues to grow

In 2007-08, the trend of using the Internet to raise awareness continued. At the same time, there was a drop in the use of paid advertising and brochures, and an increase in the use of newsletters (many of which were electronic).



Note to chart: The number of web site hits in 2007-08 was so high that the graph uses a cut bar so the value of other categories can still be seen.

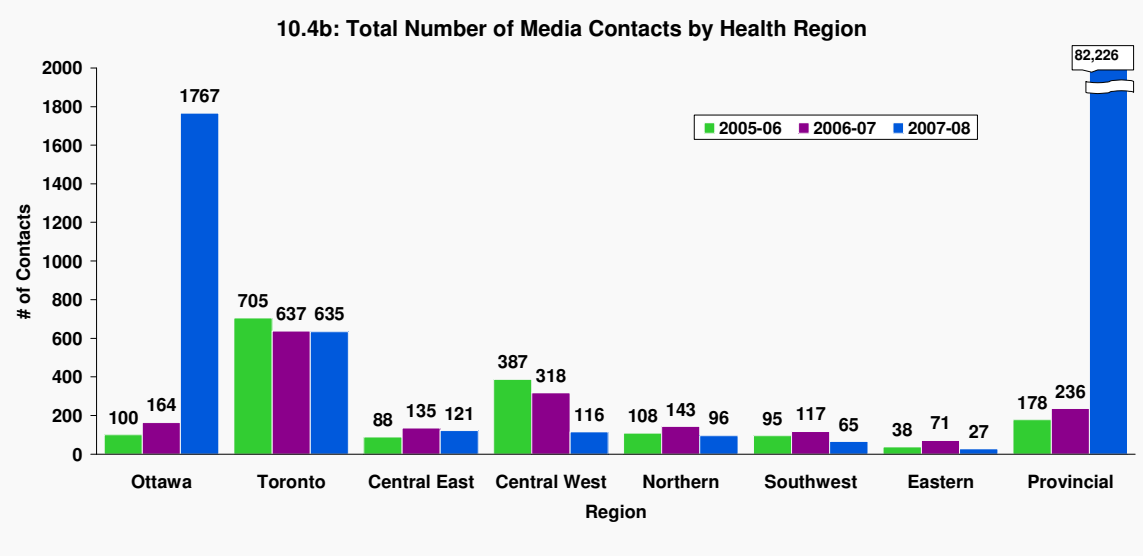
Other awareness activities included:

- mailouts of condoms/condom packages/brochures with inserted condoms/walk-ins for condoms
- postcards, buttons and stickers
- playing cards

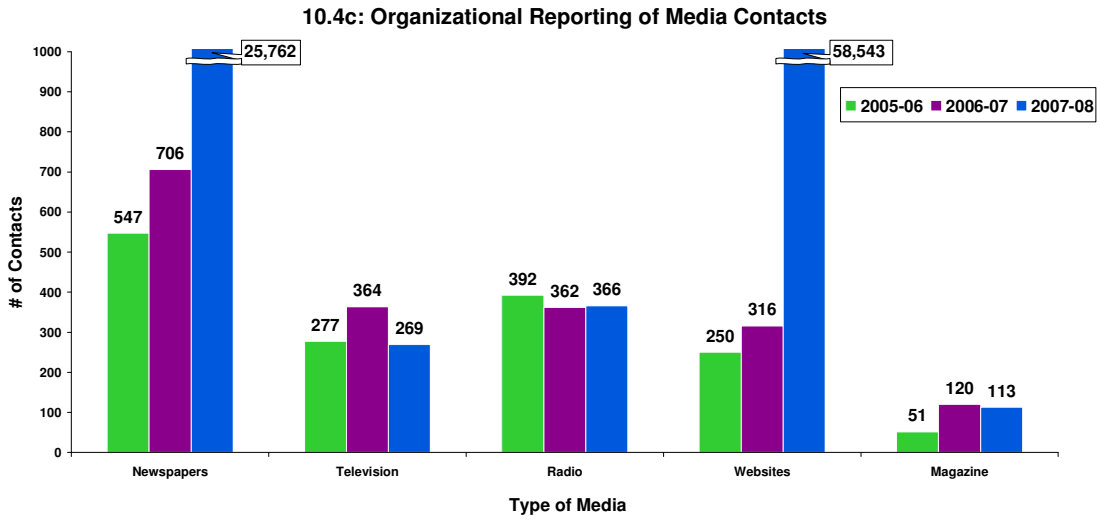
- Facebook pages
- videos/DVDs/CD ROMs
- anonymous testing cards
- billboards
- workshops/presentations.

More media contacts provincially and in Ottawa

Both provincial organizations and organizations in Ottawa reported a dramatic increase in media contacts. This may have been due to changes in federal funding levels and to the City of Ottawa's decision to not allow the public health unit to distribute safer crack kits. Most other regions saw a drop in media contacts over the year.



Note to chart: The number of media contacts reported by provincial organizations in 2007-08 was so high that the graph uses a cut bar so the value of other categories can still be seen.

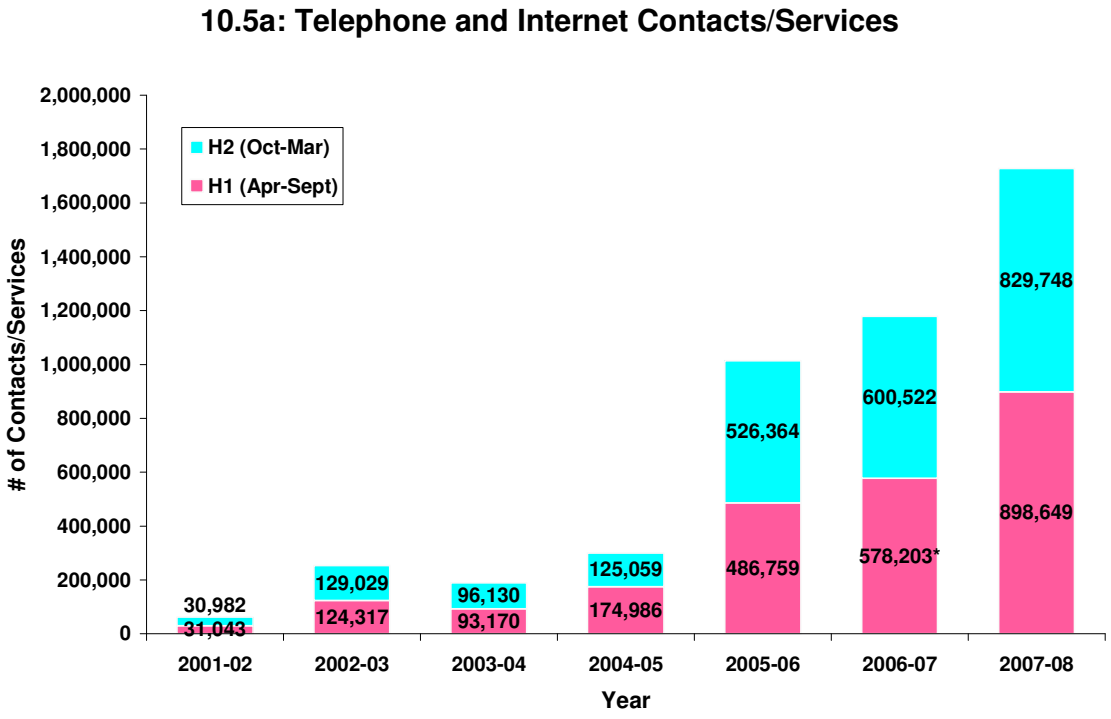


Note to chart: The number of newspaper and website contacts in 2007-08 were so high that the graph uses cut bars so the value of other categories can still be seen.

Organizations reported significantly more media contacts and/or media coverage through web-based media and newspapers than in the previous year (Figure 10.4c). In addition to these media outlets, some organizations reported producing films that were aired on television and programs through the media, and business-sponsored media events to promote a DVD. One organization organized press conferences at international meetings and conferences, and one is involved with a program for journalists in training.

Phone and internet outreach services continue to grow

The number of services provided by telephone and Internet increased significantly (47%) in 2007-08. This is primarily due to an increase in Internet contacts.



*Total in 2006-07 H1 estimated due to reporting

Figure 10.5b shows the distribution of Internet and phone contacts by region. Some regions, such as Central West, Ottawa and Toronto, appear to be making more use of Internet outreach than others – however, Internet and phone outreach is increasing in all parts of the province.

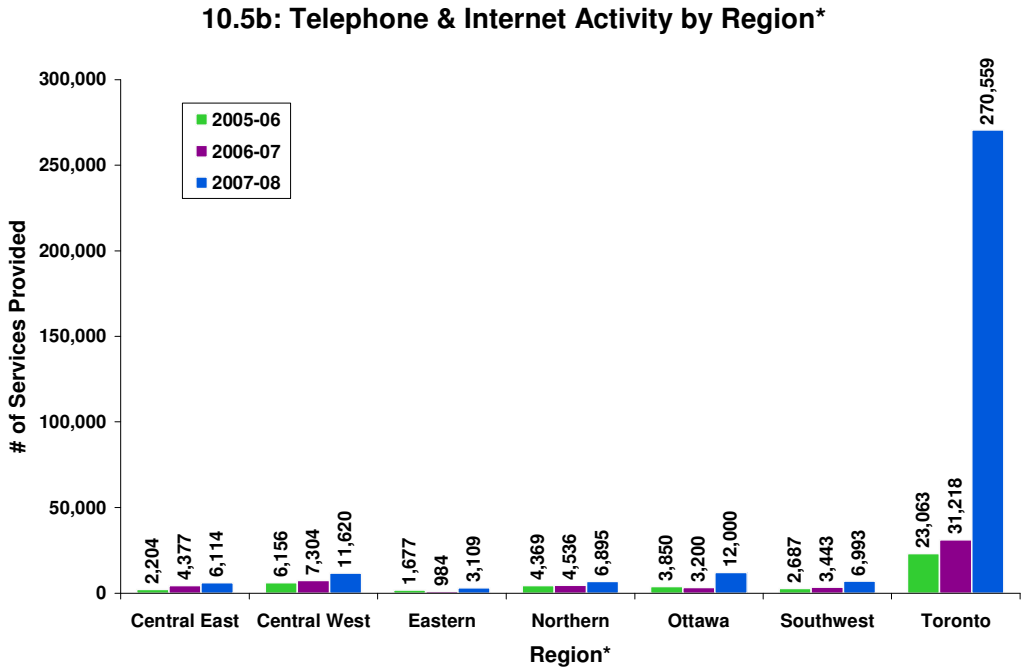
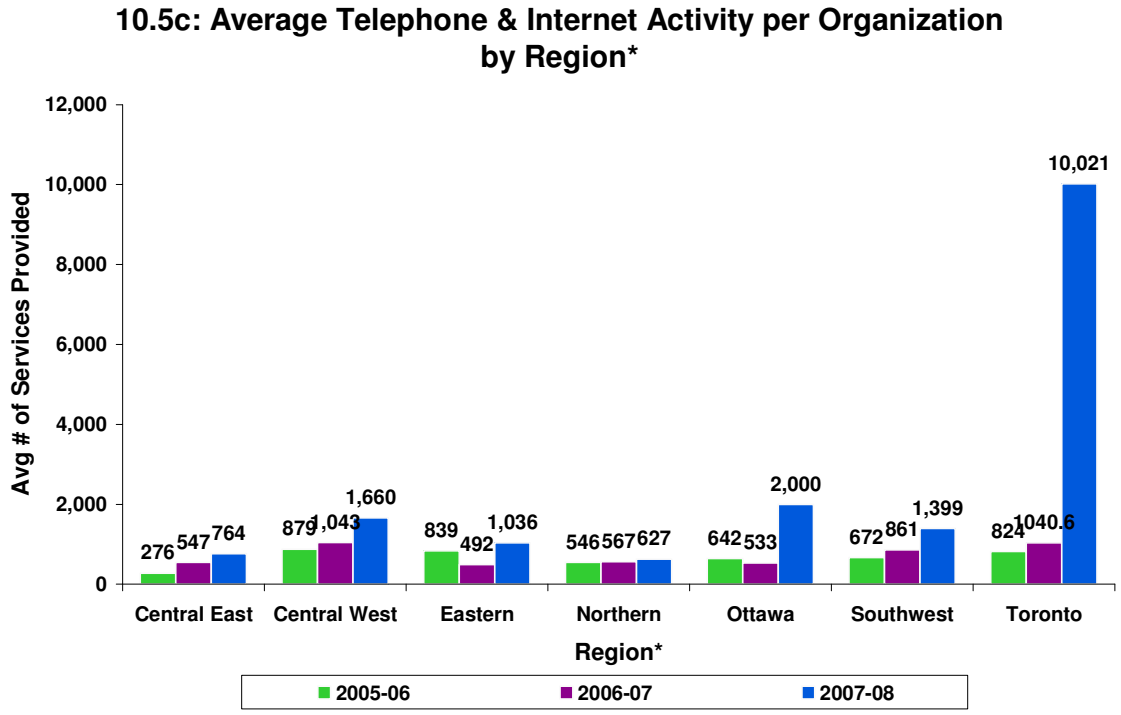


Figure 10.5c shows the average number of Internet and phone contacts per organization in each region. The variation in average telephone/Internet use over time is likely due to organizations trying to find more effective ways to monitor and count these contacts (e.g., unique web site hits versus all hits) or errors in reporting.

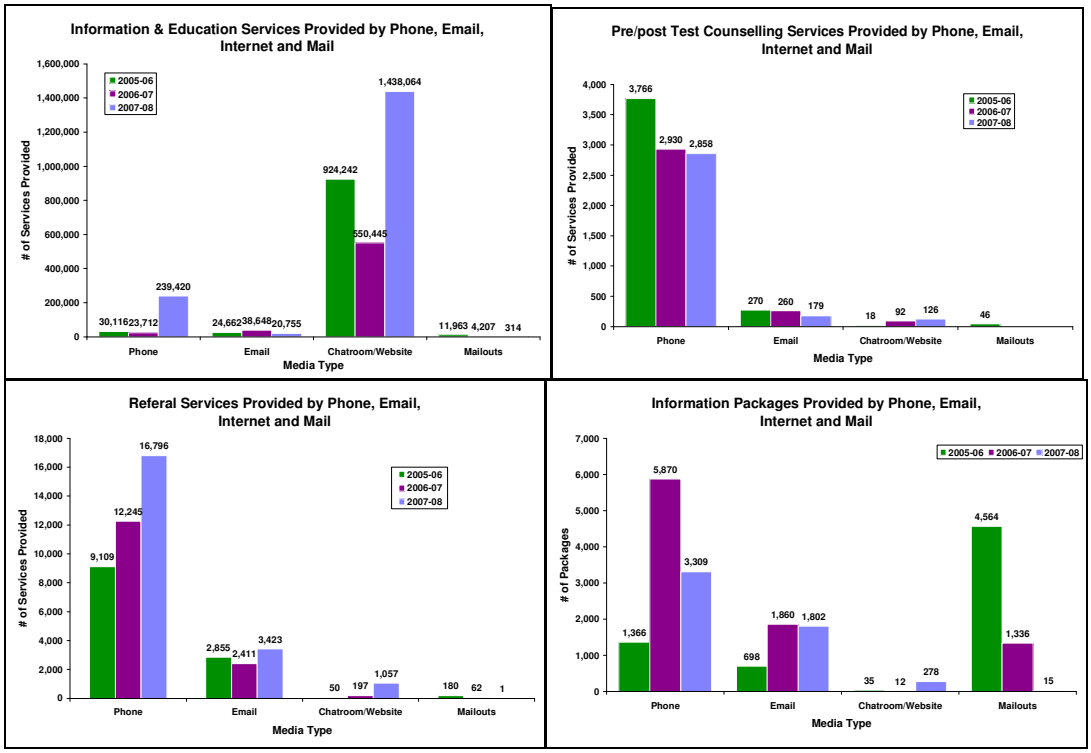


* Provincial data removed to show more data for other regions

There has been an increase in the use of the Internet to provide all types of services

The following series of charts (Figure 10.5d) shows how organizations are using phone, email, the Internet and mailouts to deliver different types of services. Although there was an increase in the use of the Internet to deliver all four services, organizations still deliver more personal services, such as referrals and pre- and post-test counselling by phone.

10.5d: Outreach Approaches to Deliver Different Types of Services

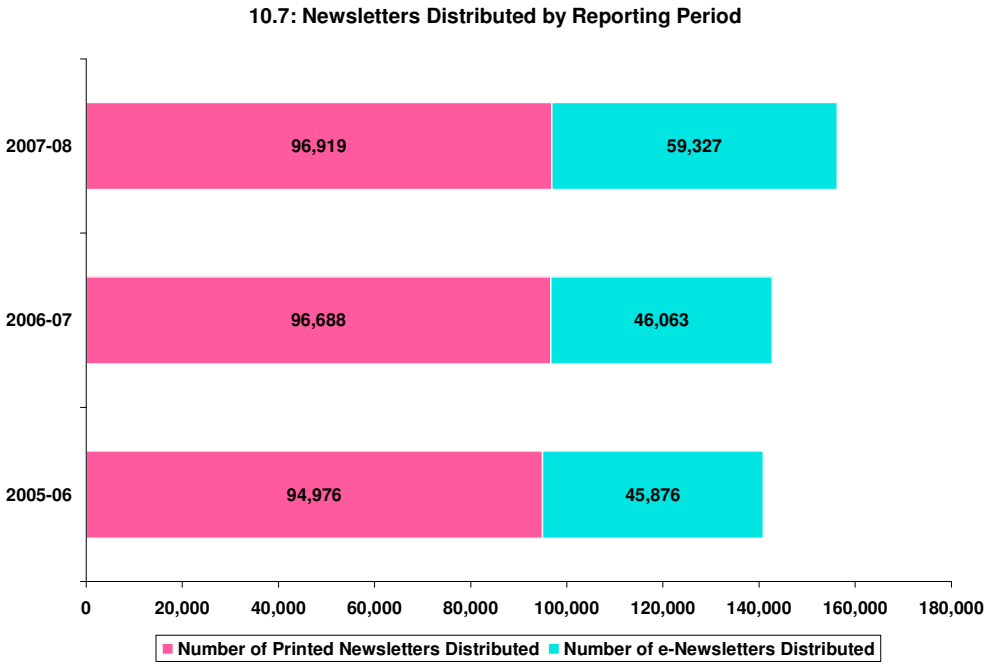


In addition to these services, organizations reported using phone and Internet to provide:

- counselling and support services
- positive prevention programs
- drive-to-care programs (i.e., transportation to medical and other care appointments).

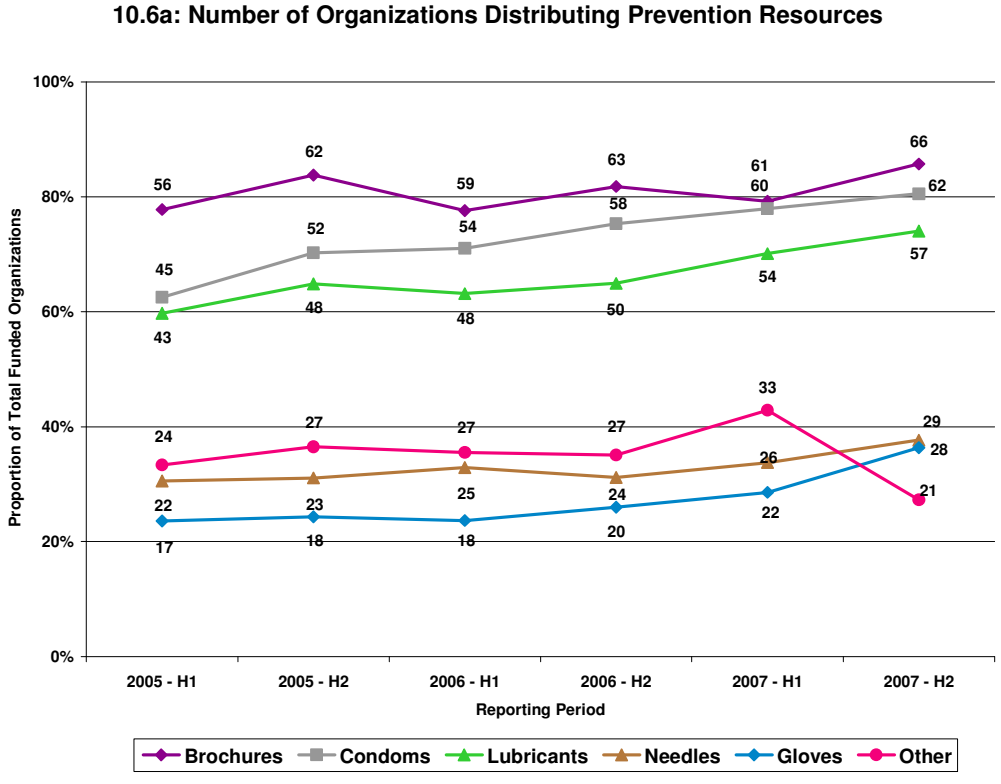
More newsletters distributed

Organizations distributed 9% more newsletters in 2007-08 than in 2006-07 (Figure 10.7). In the second half of 2007-08, there was a marked increase in the number of newsletters distributed electronically. This trend is likely to continue as more people come to use the Internet to obtain information and more organizations look for ways to reduce their environmental impact. Using e-newsletters also reduces production and distribution costs, making it possible for organizations to produce more information.



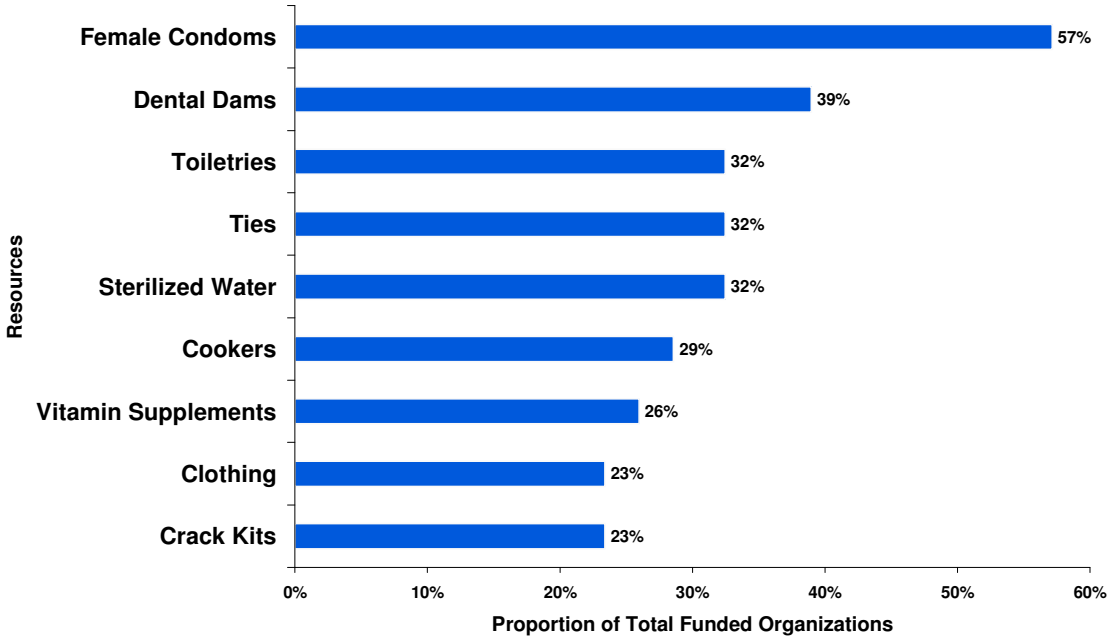
More organizations distributing all prevention resources

In 2007-08, there was an increase in the number of organizations delivering all prevention resources (except "other"). Just over 80% of all funded organizations now distribute condoms, and 38% distribute needles – up from 75% and 31%, respectively, in 2006-07.



In 2007-08, organizations were also asked whether they delivered a number of other prevention resources (see Figure 10.6a) that had been captured in the past in the "other" category. In fact, 57% distribute female condoms, 39% distribute dental dams, about one-third distribute sterile water, ties, toiletries and cookers, and almost one-quarter distribute vitamin supplements, crack kits and clothing.

10.6b: Number of Organizations Distributing Prevention Resources that were Newly Added to OCHART in 2007 H2



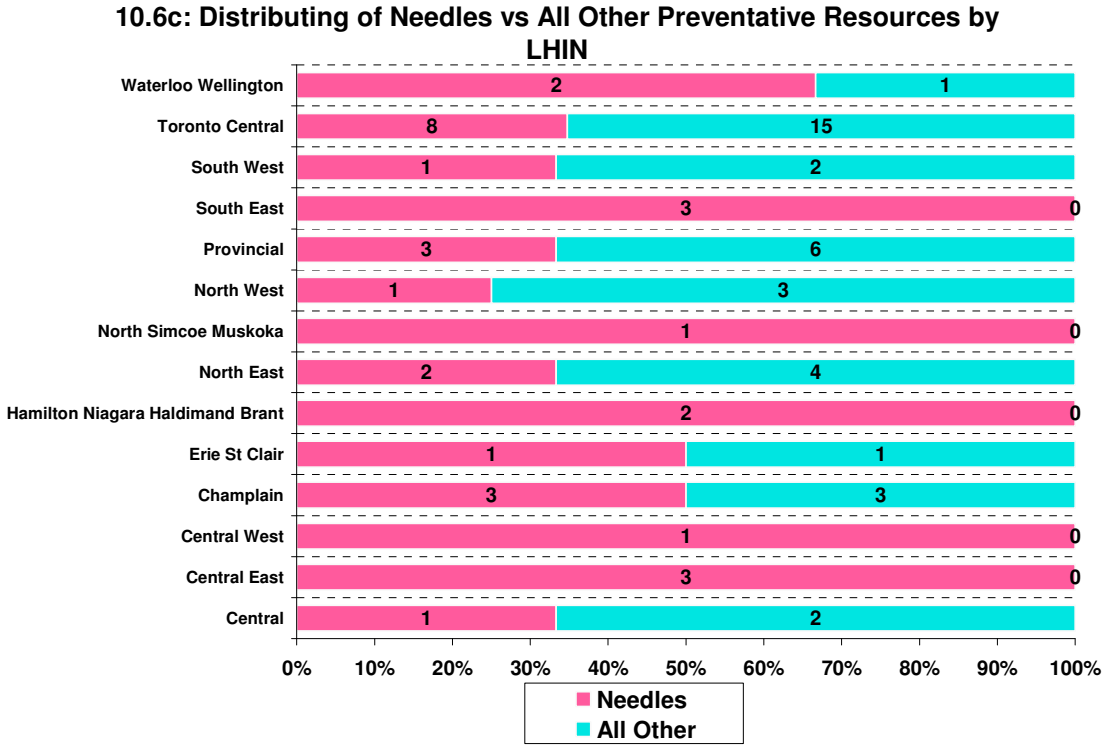
"Other" prevention resources that organizations provide include:

- alcohol swabs (7 organizations)
- filters (5 organizations)
- safer inhalation equipment (3 organizations)
- sharps containers (3 organizations)
- other harm reduction supplies, mouth pieces, stems, glass tubes, matchbooks, safe piercing kits, tourniquets and acidifiers (8 organizations)
- medical supplies to reduce infections associated with injection drug use, such as antibacterial gel, abscess kits, and vein cream (3 organizations).

Consistent with Ontario's social determinants of health approach, many organizations also distribute food and food supplements (10), blankets and bedding (6), transit tickets, and pet supplies. At least 11 organizations also reported distributing promotional items as well as other health information (e.g., STI fact sheets, legal information).

Access to needles increasing

Given the high risk of HIV infection from sharing needles, the AIDS Bureau is particularly interested in access to needles and other drug equipment. Figure 10.6c shows the number of organizations in each LHIN that distribute needles (in addition to the IDU outreach programs, which report in a separate section of OCHART). In 2007-08, the number of organizations distributing needles increased in four regions: Toronto (from 5 to 8), South East (from 1 to 3), Hamilton (from 1 to 2), and Central (from 0 to 1).



Emerging Trends in Outreach Services

During 2007-08, organizations reported changes in drug use, clients and their needs, and the policy environment.

In terms of drug use, some organizations reported more crack use and therefore more demand for safer inhalation equipment, while others reported less crack use and more use of opiates. Drug use appears to vary across the province. In addition, organizations reported more drug use in rural areas, where there was an increase in demand for needle exchange services.

Ottawa City Council decided to cancel the safer inhalation initiative offered by the public heath unit. The affected programs reported a significant decrease in service encounters. However, the decision did lead to a significant amount of advocacy and media coverage, which raised public awareness of the issues.

In terms of clients, organizations reported increases in many of the same groups identified in 2006-07:

- more women, including women involved with the justice system or fleeing violence, women with young children, women from countries where HIV is endemic, street-active women, and women involved in the sex trade
- more youth (i.e., needle exchange clients are younger) including more transgendered youth, African and Caribbean youth (14 – 26 years old), young men and women from the Portuguese community, international students in their 20s and 30s (Japanese and Korean)
- more newcomers between the ages of 22 and 35
- more clients with complex needs, such as street-involved with limited money, dual diagnosis and Von Willbrand disease
- more families with children.

In addition to information, safer sex and drug use equipment and practical support, clients are looking for more flexible, client-centred services including:

- more ethno and gender specific services (e.g., volunteers who speak Korean, Vietnamese and Chinese)*
- more online outreach, particularly to gay men and youth*
- more outreach into the Asian and South Asian communities
- more mobile services for women
- more support, resources and education for transgender youth and greater engagement of GLBTTQ youth
- more education for service providers on issues facing transgender youth
- training in negotiating condom use
- information on hepatitis C*
- more mental health services
- information on settlement, immigration and other health services
- outreach services on weekend nights
- in-house service delivery initiatives
- new programming
- more workshops
- outreach at organizations that serve street-involved and homeless people
- more jail visits
- more information on both harm reduction and abstinence-based services for people who use substances
- more education sessions for youth (e.g., schools, community centres, Boys and Girls clubs)

(*indicates also requested in 2006-07)

ASOs also received more requests for information from other organizations in their communities, including:

- bars and health fairs
- faith-based organizations
- hospices and long-term care facilities
- social service organizations for queer-positive education
- organizations serving women
- the media, looking for clients with HIV who are willing to share their stories.

Responding to Emerging Trends in Outreach

Organizations report using a number of strategies to respond to emerging trends in outreach services.

Increasing Services

Several organizations reported increasing their outreach services, including mobile services, and developing more partnerships with other organizations to meet client needs. In addition, individual organizations reported that they had:

- worked with other organizations to provide anonymous testing at more sites in their community
- opened a new needle exchange site or formed a committee to look at establishing sites in outlying areas
- implemented a safe inhalation program or contracted to distribute safer crack kits
- provided more consultations, referrals and health promotion days
- increased their presence at youth events, in bars, at health fairs, and at evening and weekend events
- increased the frequency of their outreach services.

Changes in staffing/staff development

A number of organizations report providing more training and recruiting more volunteers for outreach programs. Other staffing changes included:

- hiring more staff
- investigating effective online interventions
- training volunteers to conduct online outreach
- increasing the diversity of the outreach team
- forming a transgender working group to develop resources and skills.

Changes in programming/evaluation

Changes in programming include:

- increased programming
- targeting youth, ethno-specific communities, women, street-active women, organizations that serve sex workers, jails, libraries and rural areas
- providing more culturally sensitive services
- providing more resources on the organization's website
- providing more information and supplies in relevant languages
- providing more information on issues, such as the potency of heroin, safe working tips for sex workers, legal and health information, and hepatitis C prevention
- creating a youth-friendly film
- monitoring client needs through questionnaires and feedback.

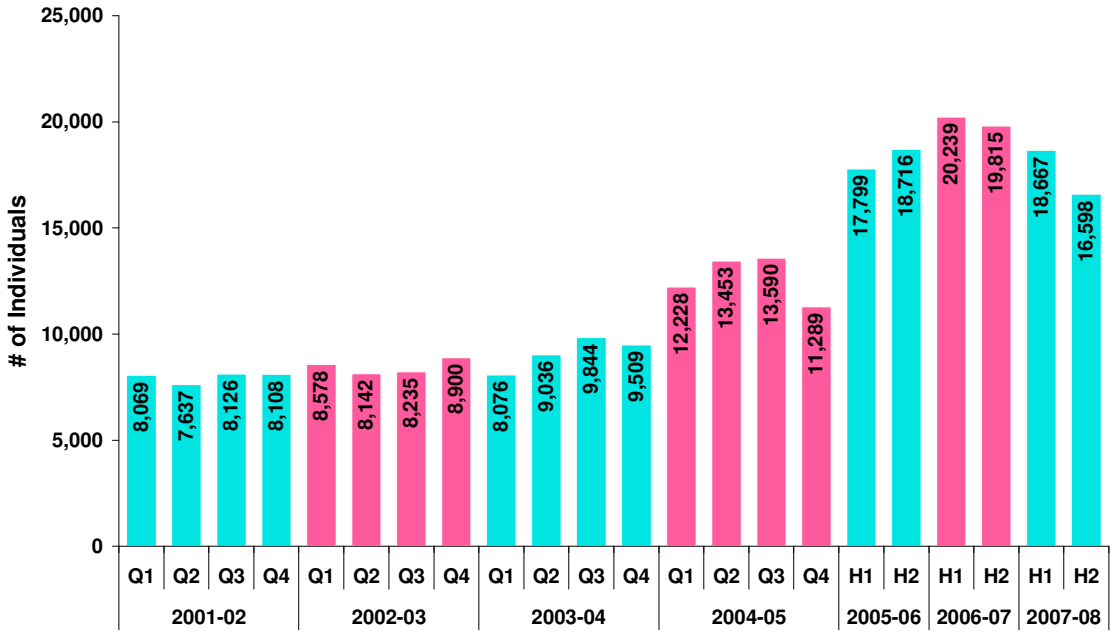
Support Services

In 2007-08, 61 organizations completed the OCHART section on support services, which included counselling, practical support, and referrals to other services for people with HIV, their family and friends, people affected by HIV (i.e., populations at risk) and others – compared to 64 in the previous year.

Fewer people using support services

As Figure 11.1.1a indicates, organizations reported a lower number of clients receiving support services than in the previous year (-8% in H1 and -16% in H2). The decrease is due to a number of factors, including: more accurate counting of clients (i.e., less double counting of clients who use more than one service; not counting everyone who attended a vigil as a client) and the temporary closure of some services – usually due to staff shortages or changes. (Note: because the same client may receive services in more than one reporting period, it is not possible to determine the total number of clients served in a given year, or what proportion of clients received services in both halves of the year.)

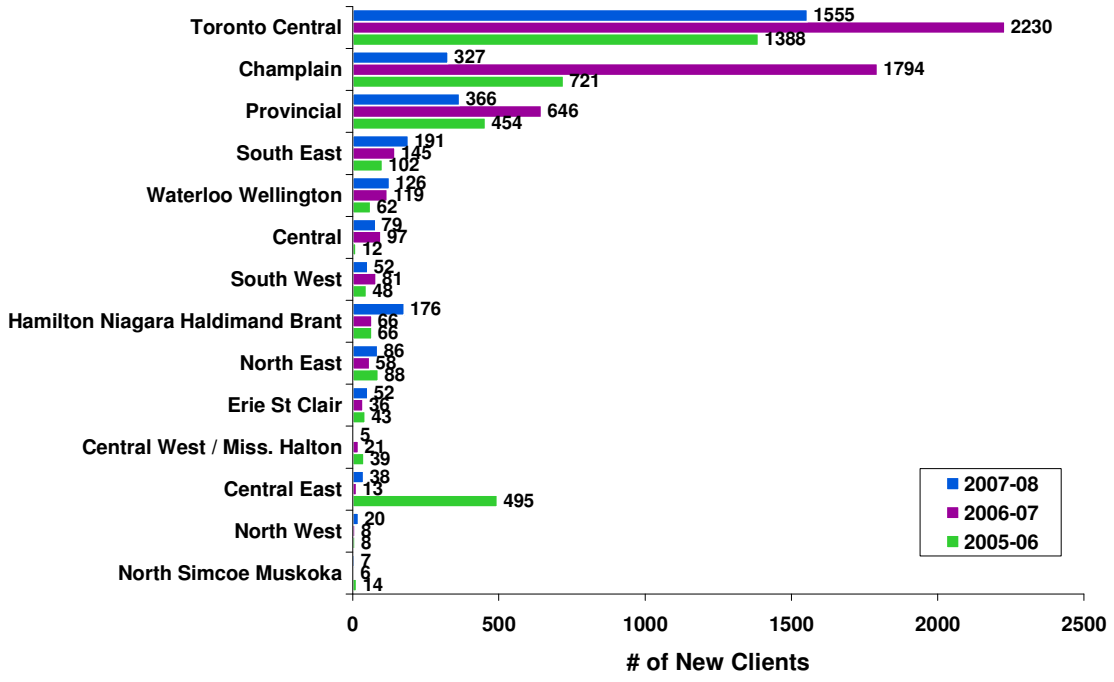
11.1.1a: Number of Clients who Used Support Services During Each Reporting Period



Organizations continue to attract new clients

Of the average 17,633 people served in each half of the year, 3,080 (17% – or almost one in five) were new to the organizations. LHINs that had more new clients than in previous years were South East, Hamilton Niagara Haldimand Brant, Erie St Clair, the North West and Waterloo Wellington.

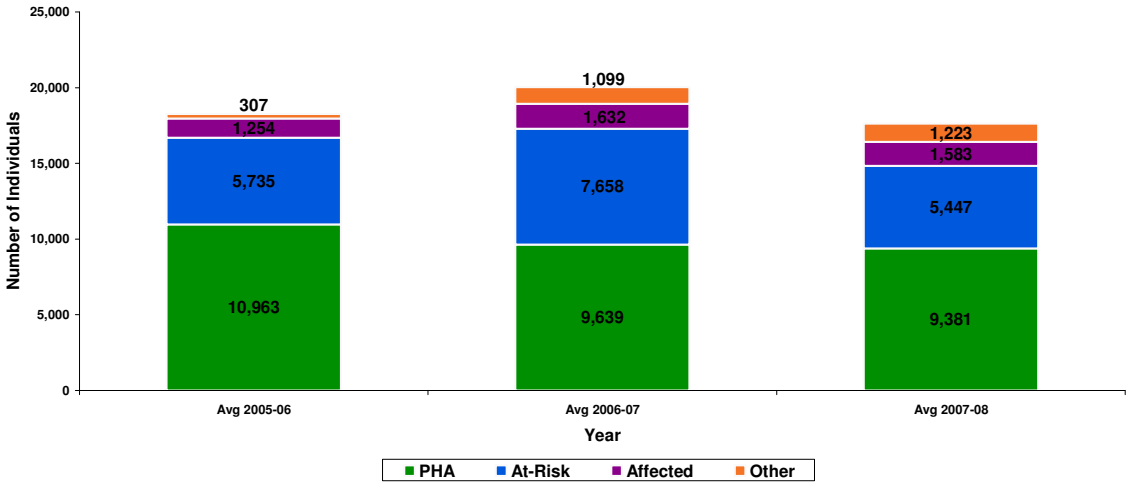
11.1.2: New Support Service Clients Reported by LHIN



Primary users of support services are people with HIV and people at risk

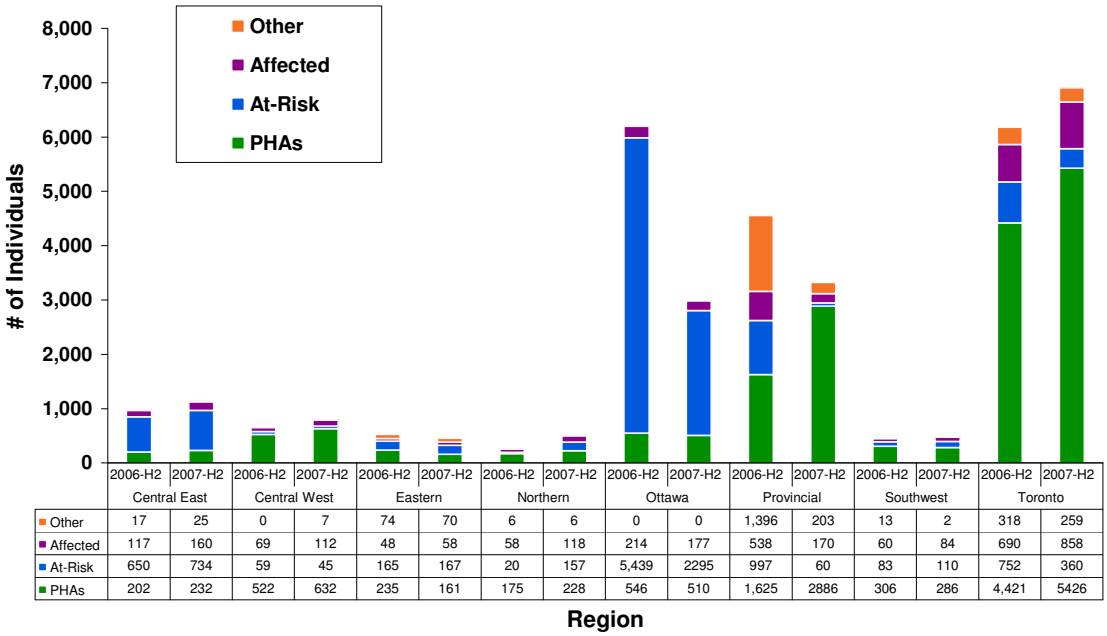
Although the average number of clients living with HIV and clients at risk in each half year was down (3% and 29% respectively), they continue to be the main users of support services. (Figure 11.1.1b) The number of "other" clients continues to increase – largely due (according to information provided by the funded organizations) to people with hepatitis C (but not infected with HIV) who are unable to access comprehensive support services from other sources.

11.1.1b: Delivery of Support Services by Client Type



In terms of a regional breakdown, Central East, Ottawa and the Eastern Region report serving mainly people at risk, while most other regions report serving mainly people with HIV.

11.1.1c: Distribution of Clients Using Support Services by Region (2006 - H2 and 2007 - H2)



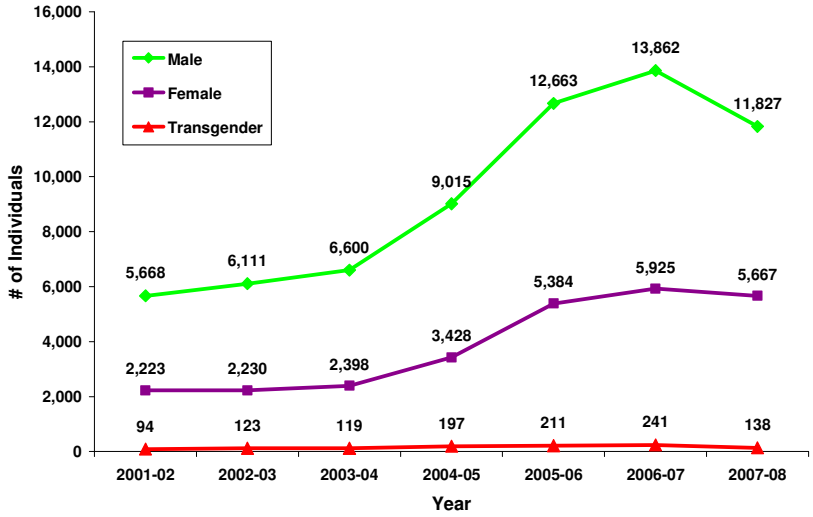
	2006-H2	2007-H2	2006-H2	2007-H2	2006-H2	2007-H2	2006-H2	2007-H2	2006-H2	2007-H2	2006-H2	2007-H2	2006-H2	2007-H2	2006-H2	2007-H2
	Central East		Central West		Eastern		Northern		Ottawa		Provincial		Southwest		Toronto	
Other	17	25	0	7	74	70	6	6	0	0	1,396	203	13	2	318	259
Affected	117	160	69	112	48	58	58	118	214	177	538	170	60	84	690	858
At-Risk	650	734	59	45	165	167	20	157	5,439	2295	997	60	83	110	752	360
PHAs	202	232	522	632	235	161	175	228	546	510	1,625	2886	306	286	4,421	5426

Region

About one-third of clients are women

In 2007-08, the average number of male clients in each half year was down about 20%, while the number of female clients fell only 9%. Women now account for about one-third of all support service clients. The number of transgender clients dropped in 2007-08, but this is due mainly to reporting errors in 2006-07 and is a more accurate count of the number of transgender clients.

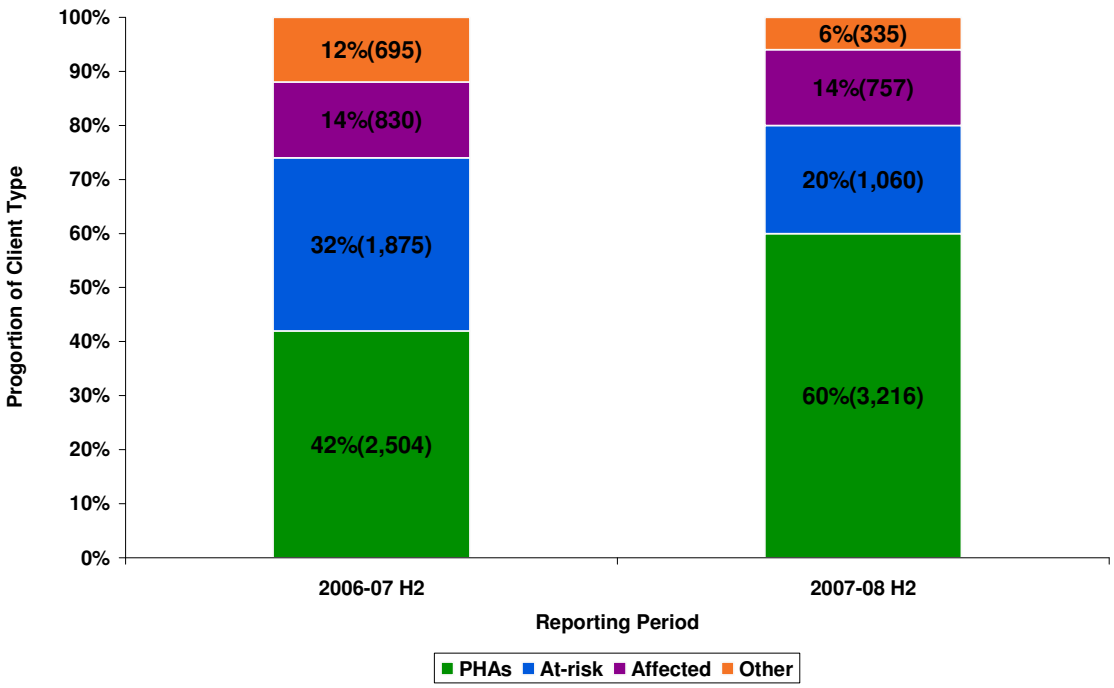
11.1.1d: Average Number of Support Service Users by Gender



Among the 5,368 women served in the last half of 2007-08:

- 3,216 (60%) were PHAs (compared to 2,504 or 42% in 2006-07)
- 1,060 (20%) were at-risk (compared to 1,875 or 32% in 2006-07)
- 757 (14%) were affected (family, friends, partner) (compared to 830 or 14% in 2006-07)
- 335 (6%) were other (compared to 695 or 12% in 2006-07).

11.1.1: Women Served by Client Type - 2006-07 and 2007-08, H2

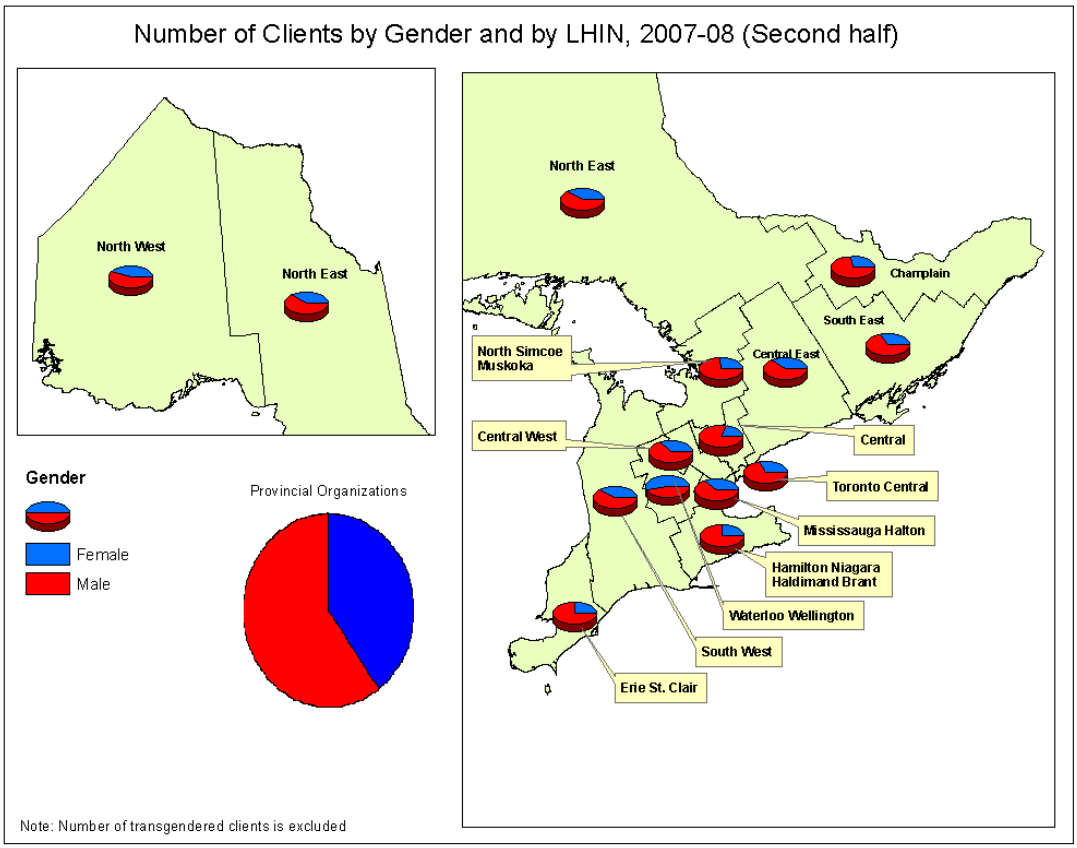


This means that a significantly larger number and proportion of women seeking services from ASOs were living with HIV than was the case in the previous reporting year.

Organizations in all parts of the province are serving women

Every LHIN in Ontario has at least one organization that reports providing HIV support services to women.

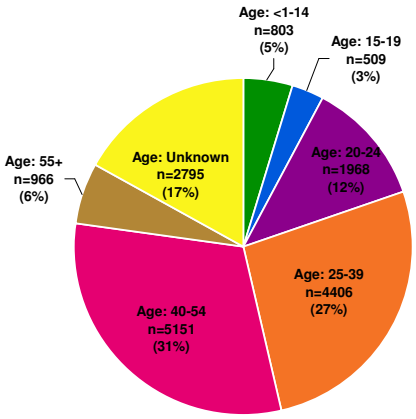
The map below shows the proportion of support service clients in each LHIN region who are male and female (note: numbers of transgendered clients is too small to show on chart). The LHINs serving the largest number of women with HIV are: Toronto Central, Champlain Ottawa, South East, and Waterloo Wellington; however, LHINs serving the largest *proportion* of women clients are: Waterloo Wellington, North West, North East and South West.



Support service clients are getting older

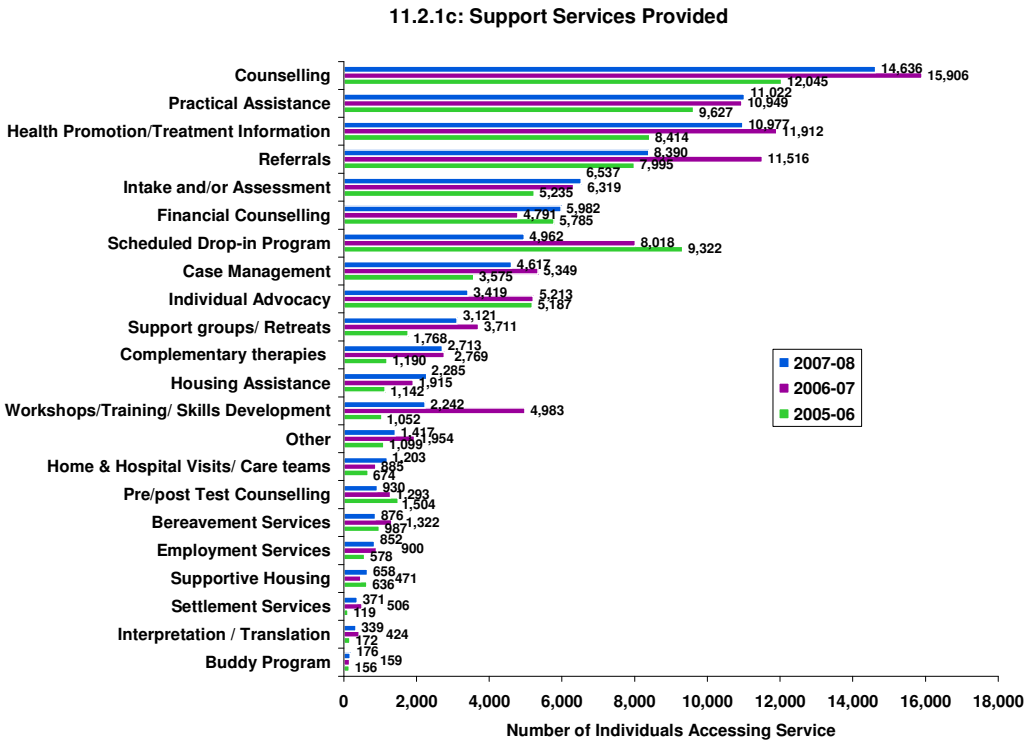
Most services users (58%) in 2007-08 were between the ages of 25 and 54 (compared to 47% in 2006-07), while 15% were between the ages of 15 and 24 (down from 20%). The proportion of clients over age 55 doubled from 3% to 6%. (Figure 11.1.3).

11.1.3: Support Services Provided by Age: 2007 - H2



Slight shifts in demand for services

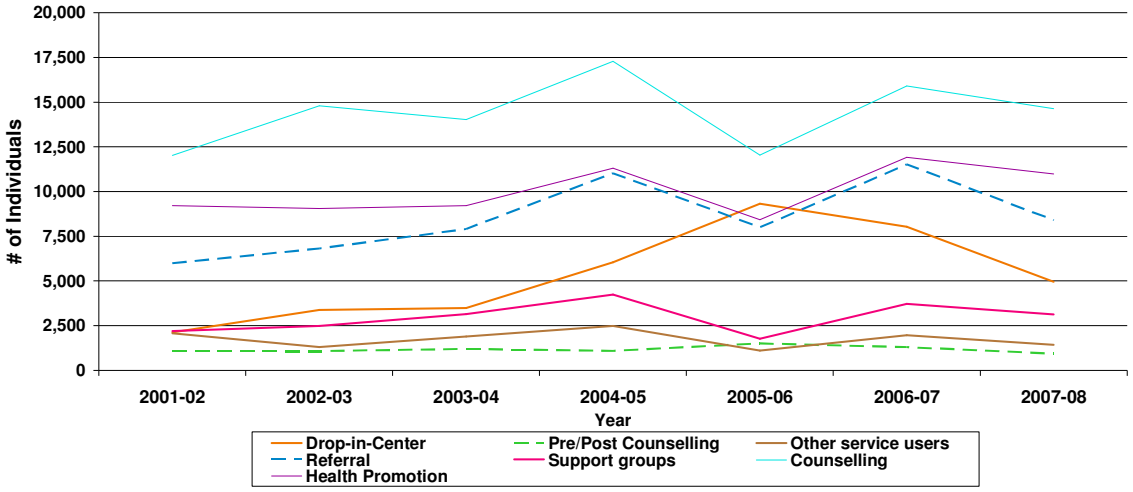
The demand for support services continues to change over time, although the changes were relatively small over the past year.



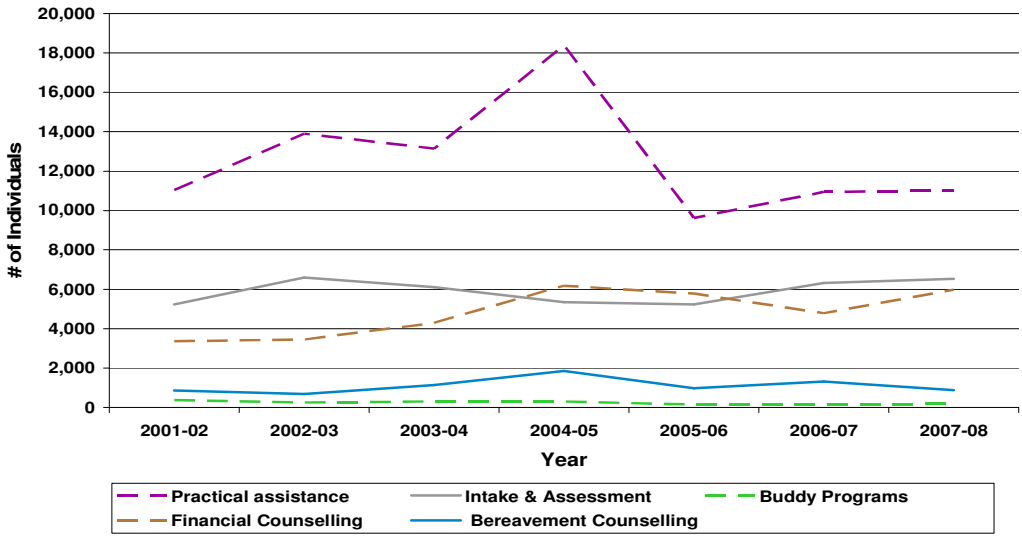
During 2007-08, organizations provided more financial counselling, housing assistance/ supportive housing, home/hospital visits and practical assistance than in 2006-07, reinforcing both the poverty associated with HIV and the fact that more people with HIV are becoming ill. The increase in housing services may represent an increase in demand and/or an increase in the awareness and capacity of ASOs to help clients find and keep housing, and the impact of the Positive Spaces Healthy Places study.

Figure 11.2.1a identifies which support services were in less demand in 2007-08 than in previous years, and Figure 11.2.1b identifies which services were in greater demand. It is difficult to see consistent trends over time in most support services; instead they appear to vary over time depending on individual client needs. The marked decrease in drop-in services was because some programs did not operate in 2007-08. Despite the decreases in 2007-08, more clients are accessing referral, health promotion and counselling services than in 2001-02.

11.2.1a: Support Services that Decreased Between 06-07 and 07-08



11.2.1b: Support Services that Increased Between 06-07 and 07-08



People with HIV are most likely to use practical assistance

In terms of the types of services used most frequently by different types of clients, organizations reported that, in 2007-08:

- people with HIV were more likely to use practical assistance, health promotion/treatment; information, and counselling services
- people at risk were more likely to use counselling services
- family and friends were more likely to use practical assistance.

Slight differences between services used by women and men

When the services used are analyzed by gender (men and women), the top eight services for both men and women are the same, with only slight differences in the order of most-used services. The

only major difference in the ten most used services was that men sought out "individual advocacy" services, while women sought out complementary therapies.

The services most often used by women were:

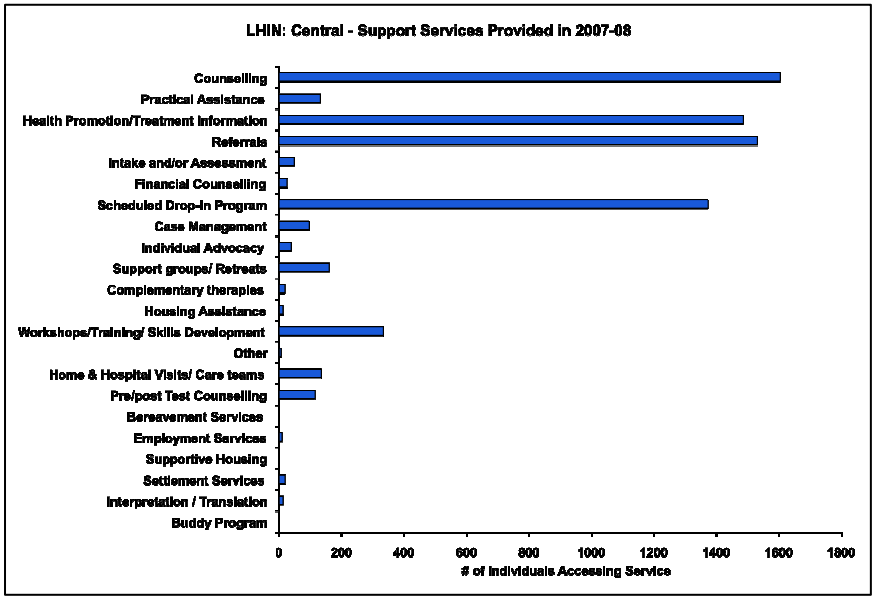
- counselling
- health promotion and treatment information
- practical assistance
- referrals
- intake and assessment services
- financial counseling
- drop-in services
- case management
- support groups/retreats
- complementary therapies.

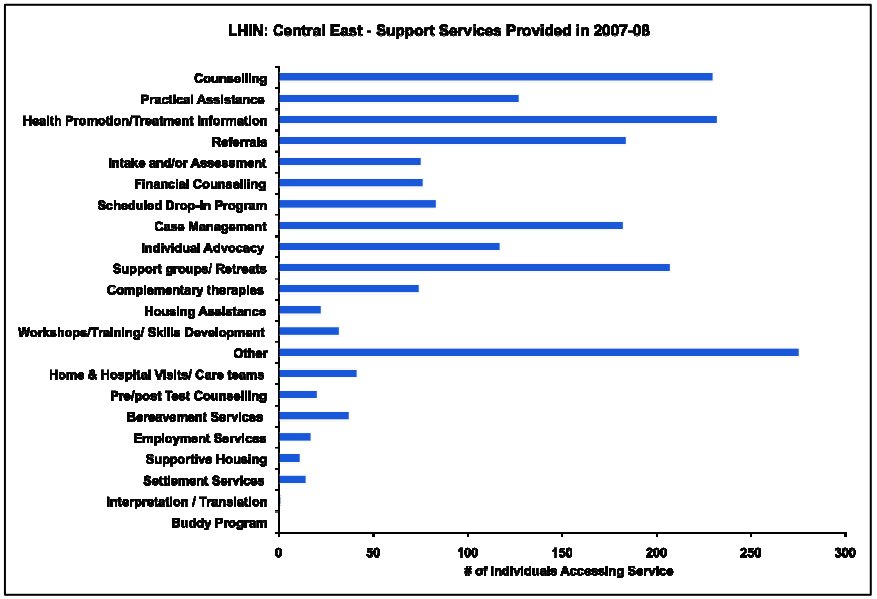
The services most often used by men were:

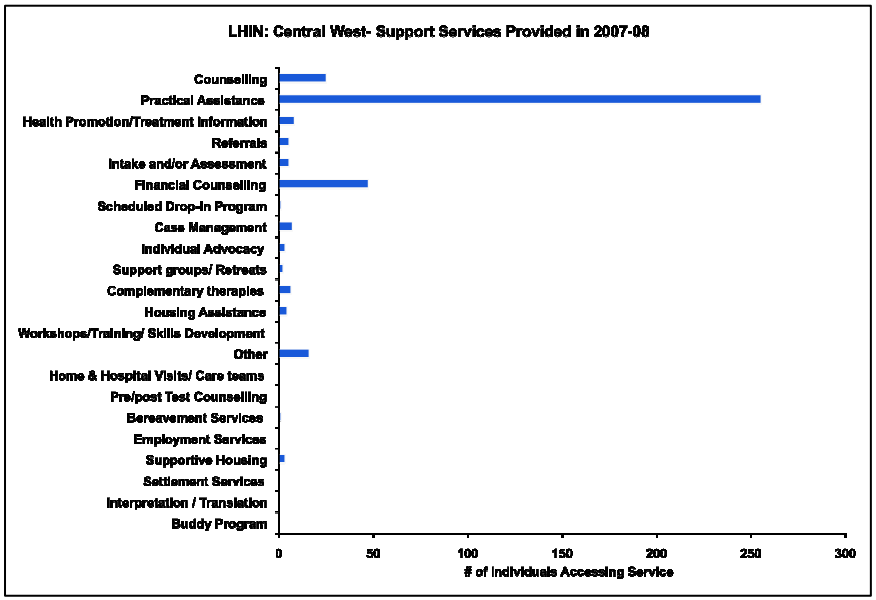
- counselling
- practical assistance
- health promotion and treatment information
- referrals
- intake and assessment services
- financial counselling
- drop-in services
- case management services
- individual advocacy
- support groups/retreats.

Regional variations in support services

It is possible to use OCHART data to examine and compare the mix of services provided in different parts of the province. As the following graphs indicate, within some LHINs there is more focus on counselling, while in others there is more emphasis on case management and practical assistance. The range of services provided within each LHIN also varies. The differences may be due to the nature of the epidemic and clients in each LHIN, and the size/capacity of the organizations. These charts highlight the weaknesses of using only aggregate data to characterize services across the province.


LHIN: Central - Support Services Provided in 2007-08
Counselling
Practical Assistance
Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Financial Counselling
Scheduled Drop-In Program
Case Management
Individual Advocacy
Support groups/ Retreats
Complementary therapies
Housing Assistance
Workshops/Training/ Skills Development
Other
Home & Hospital Visits/ Care teams
Pre/post Test Counselling
Bereavement Services
Employment Services
Supportive Housing
Settlement Services
Interpretation / Translation
Buddy Program
0
200
400
600
800
1000
1200
1400
1600
1800
# of Individuals Accessing Service


LHIN: Central East - Support Services Provided in 2007-08
Counselling
Practical Assistance
Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Financial Counselling
Scheduled Drop-In Program
Case Management
Individual Advocacy
Support groups/ Retreats
Complementary therapies
Housing Assistance
Workshops/Training/ Skills Development
Other
Home & Hospital Visits/ Care teams
Pre/post Test Counselling
Bereavement Services
Employment Services
Supportive Housing
Settlement Services
Interpretation / Translation
Buddy Program
0
50
100
150
200
250
300
# of Individuals Accessing Service


LHIN: Central West- Support Services Provided in 2007-08
Counselling
Practical Assistance
Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Financial Counselling
Scheduled Drop-In Program
Case Management
Individual Advocacy
Support groups/ Retreats
Complementary therapies
Housing Assistance
Workshops/Training/ Skills Development
Other
Home & Hospital Visits/ Care teams
Pre/post Test Counselling
Bereavement Services
Employment Services
Supportive Housing
Settlement Services
Interpretation / Translation
Buddy Program
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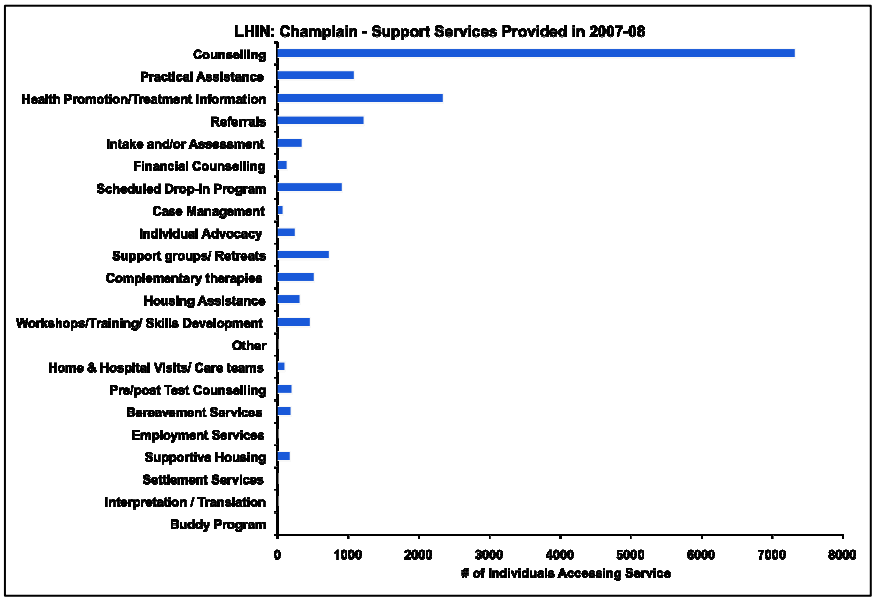
# of Individuals Accessing Service


LHIN: Champlain - Support Services Provided in 2007-08
Counselling
Practical Assistance
Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Financial Counselling
Scheduled Drop-In Program
Case Management
Individual Advocacy
Support groups/ Retreats
Complementary therapies
Housing Assistance
Workshops/Training/ Skills Development
Other
Home & Hospital Visits/ Care teams
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Bereavement Services
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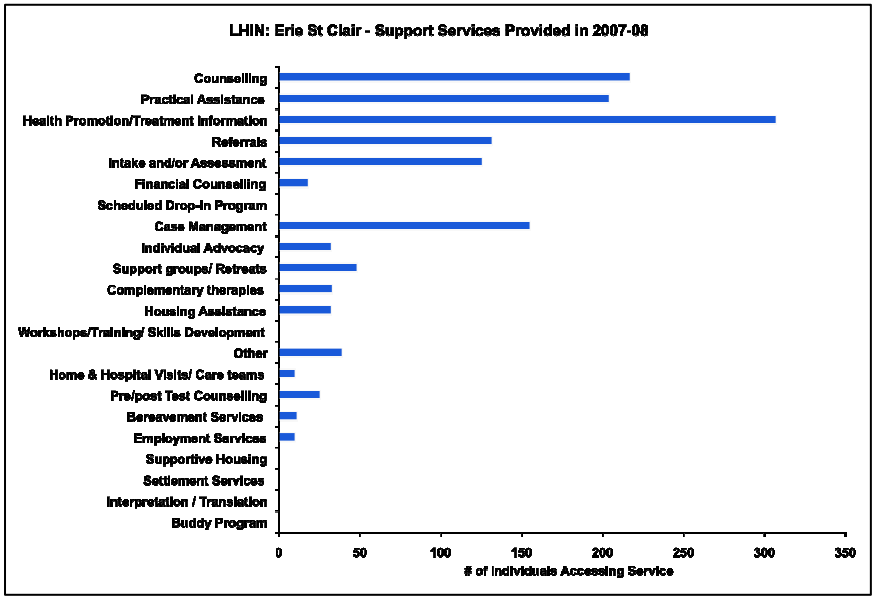
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Counselling
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Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Financial Counselling
Scheduled Drop-In Program
Case Management
Individual Advocacy
Support groups/ Retreats
Complementary therapies
Housing Assistance
Workshops/Training/ Skills Development
Other
Home & Hospital Visits/ Care teams
Pre/post Test Counselling
Bereavement Services
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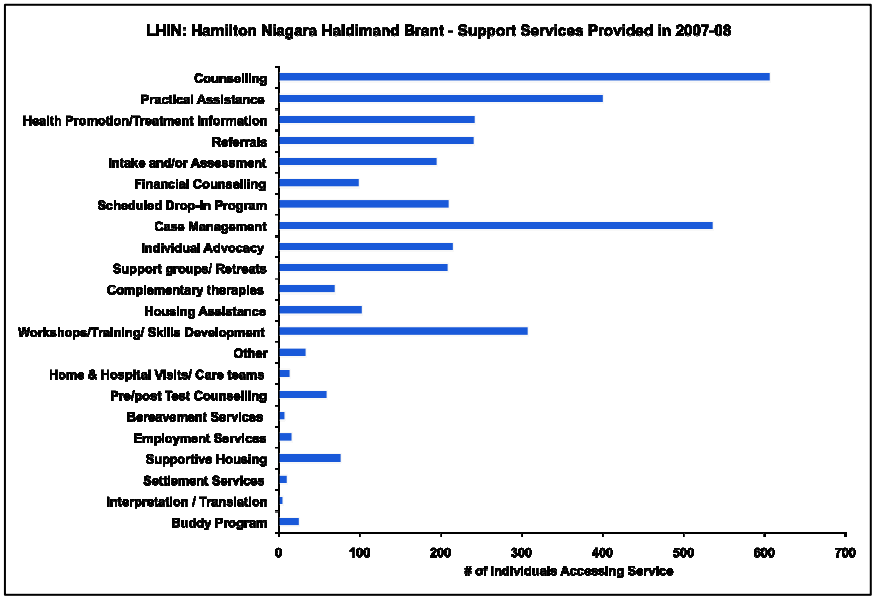
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Counselling
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Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Financial Counselling
Scheduled Drop-In Program
Case Management
Individual Advocacy
Support groups/ Retreats
Complementary therapies
Housing Assistance
Workshops/Training/ Skills Development
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Home & Hospital Visits/ Care teams
Pre/post Test Counselling
Bereavement Services
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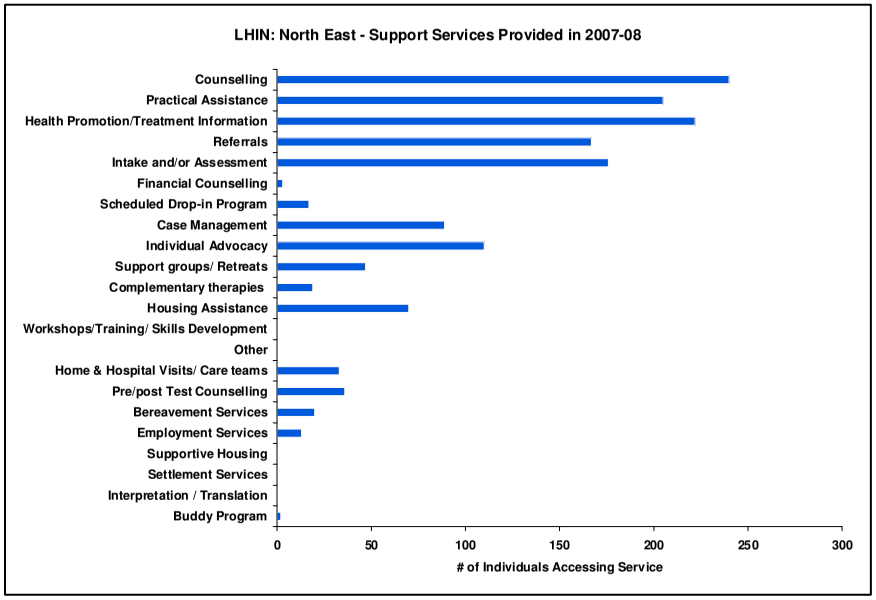
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Counselling
Practical Assistance
Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Financial Counselling
Scheduled Drop-in Program
Case Management
Individual Advocacy
Support groups/ Retreats
Complementary therapies
Housing Assistance
Workshops/Training/ Skills Development
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Pre/post Test Counselling
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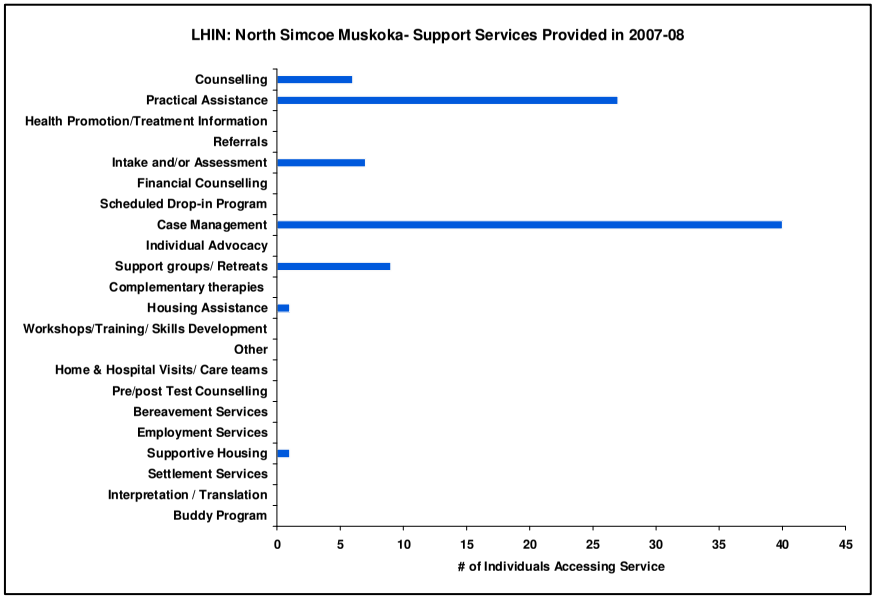
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Counselling
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Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Financial Counselling
Scheduled Drop-in Program
Case Management
Individual Advocacy
Support groups/ Retreats
Complementary therapies
Housing Assistance
Workshops/Training/ Skills Development
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Home & Hospital Visits/ Care teams
Pre/post Test Counselling
Bereavement Services
Employment Services
Supportive Housing
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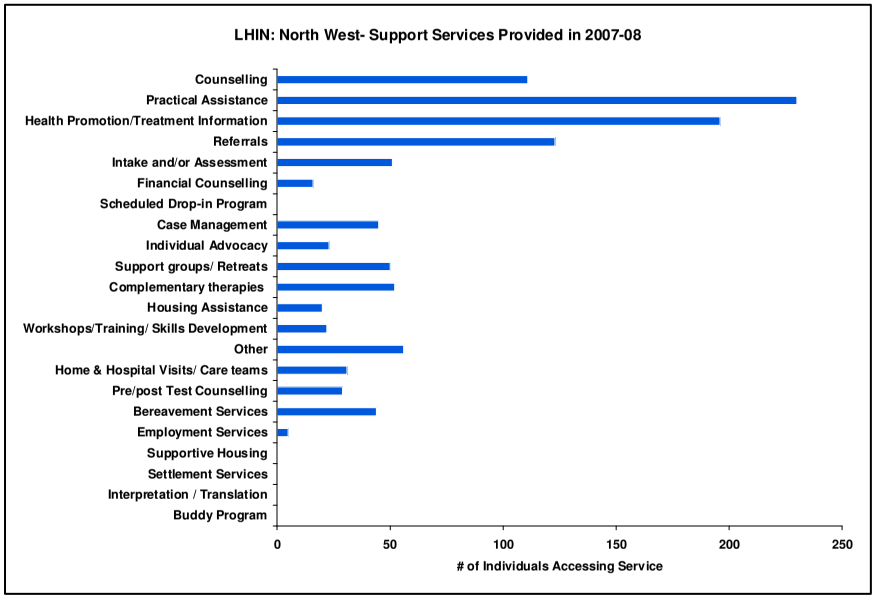
LHIN: North West- Support Services Provided in 2007-08
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Practical Assistance
Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Financial Counselling
Scheduled Drop-in Program
Case Management
Individual Advocacy
Support groups/ Retreats
Complementary therapies
Housing Assistance
Workshops/Training/ Skills Development
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Home & Hospital Visits/ Care teams
Pre/post Test Counselling
Bereavement Services
Employment Services
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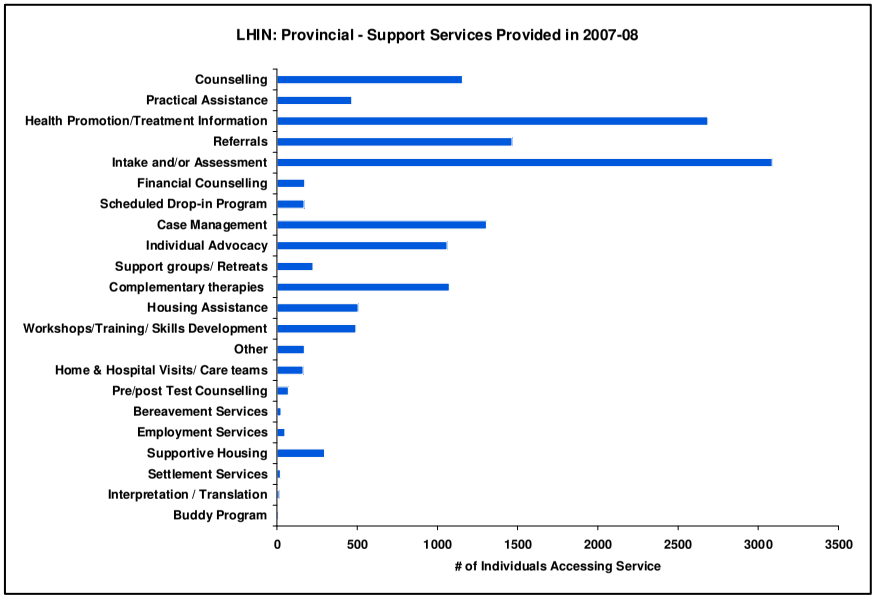
LHIN: Provincial - Support Services Provided in 2007-08
Counselling
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Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Financial Counselling
Scheduled Drop-in Program
Case Management
Individual Advocacy
Support groups/ Retreats
Complementary therapies
Housing Assistance
Workshops/Training/ Skills Development
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Bereavement Services
Employment Services
Supportive Housing
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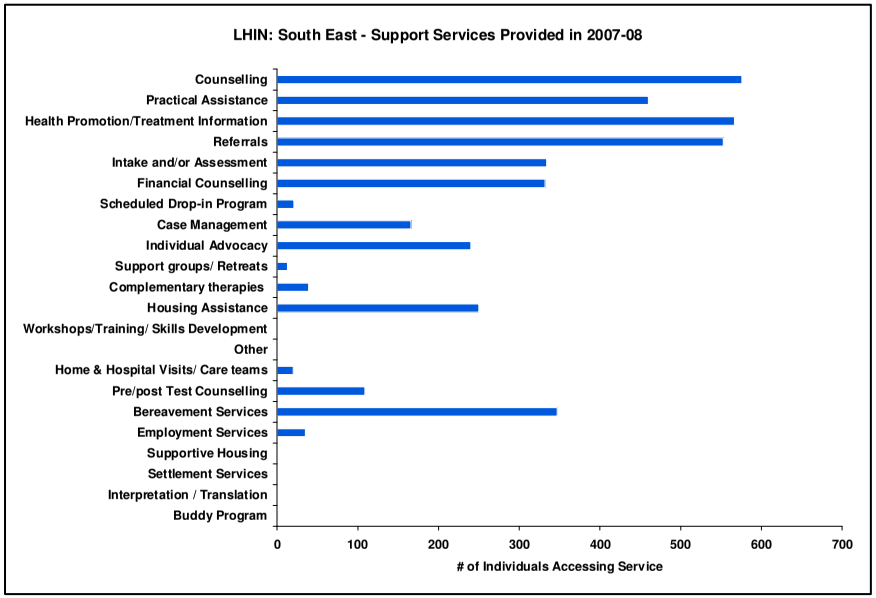
LHIN: South East - Support Services Provided in 2007-08
Counselling
Practical Assistance
Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Financial Counselling
Scheduled Drop-in Program
Case Management
Individual Advocacy
Support groups/ Retreats
Complementary therapies
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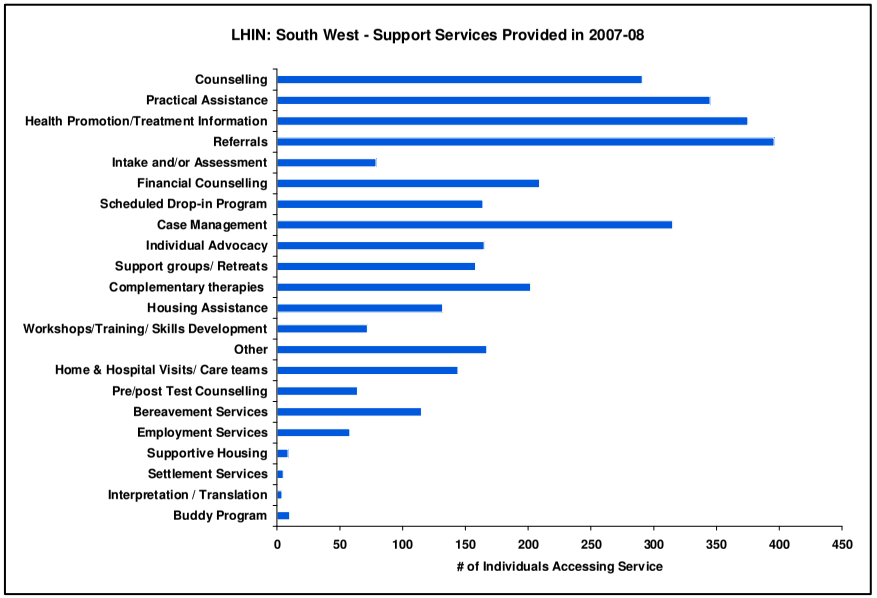
LHIN: South West - Support Services Provided in 2007-08
Counselling
Practical Assistance
Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Financial Counselling
Scheduled Drop-in Program
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Individual Advocacy
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Complementary therapies
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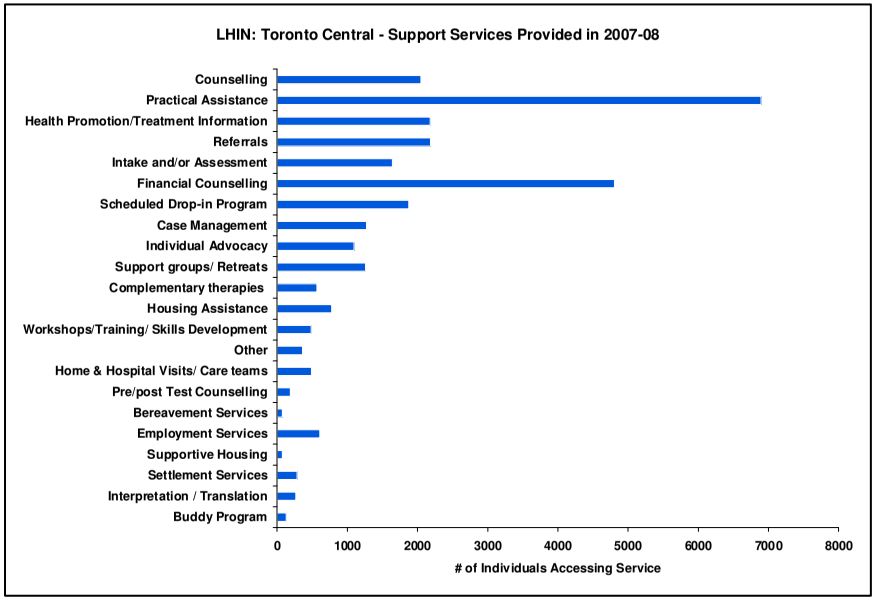
LHIN: Toronto Central - Support Services Provided in 2007-08
Counselling
Practical Assistance
Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Financial Counselling
Scheduled Drop-in Program
Case Management
Individual Advocacy
Support groups/ Retreats
Complementary therapies
Housing Assistance
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Pre/post Test Counselling
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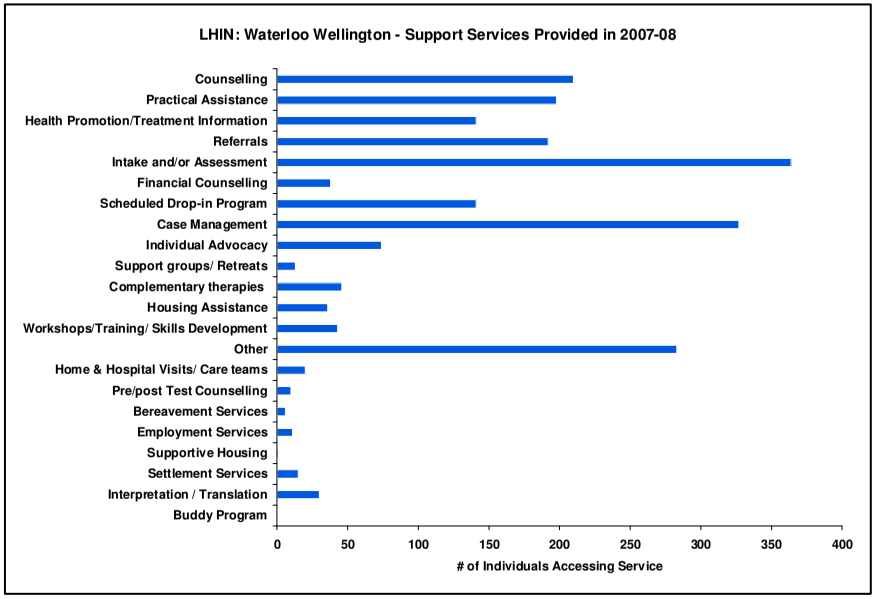
LHIN: Waterloo Wellington - Support Services Provided in 2007-08
Counselling
Practical Assistance
Health Promotion/Treatment Information
Referrals
Intake and/or Assessment
Financial Counselling
Scheduled Drop-in Program
Case Management
Individual Advocacy
Support groups/ Retreats
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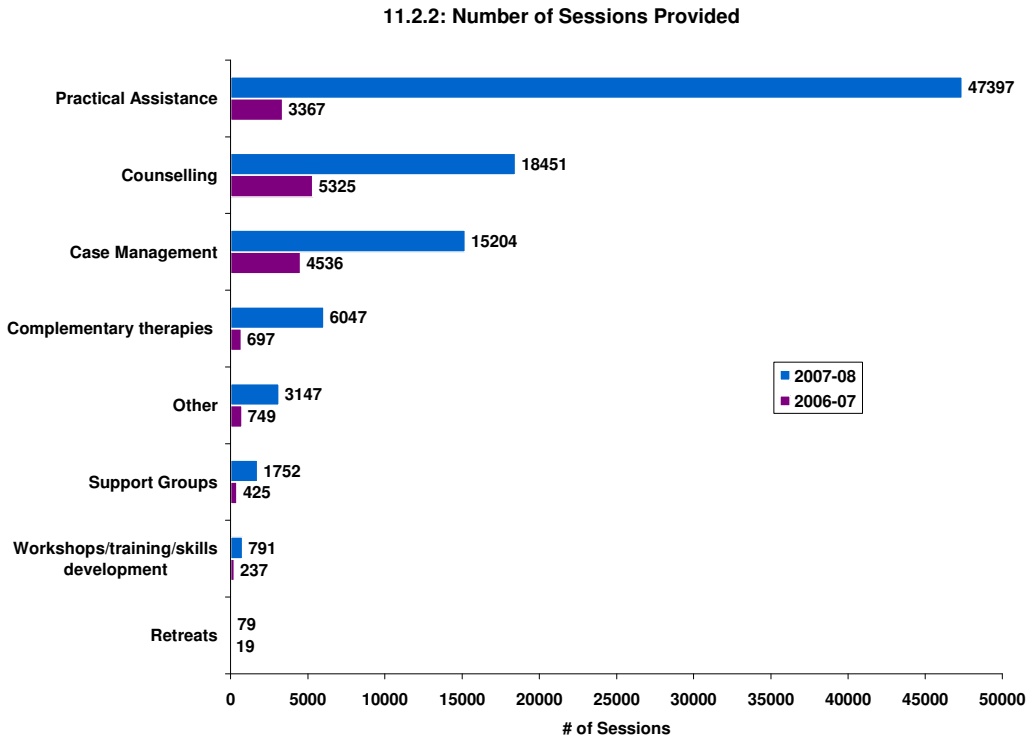
Sessions focus on practical assistance

In terms of overall number of sessions of service provided (rather than number of clients who used services), organizations reported providing over twice as many practical assistance sessions as any other type of service. This indicates that – although fewer clients used practical support services than counselling services – those who did used an intensive amount of service.

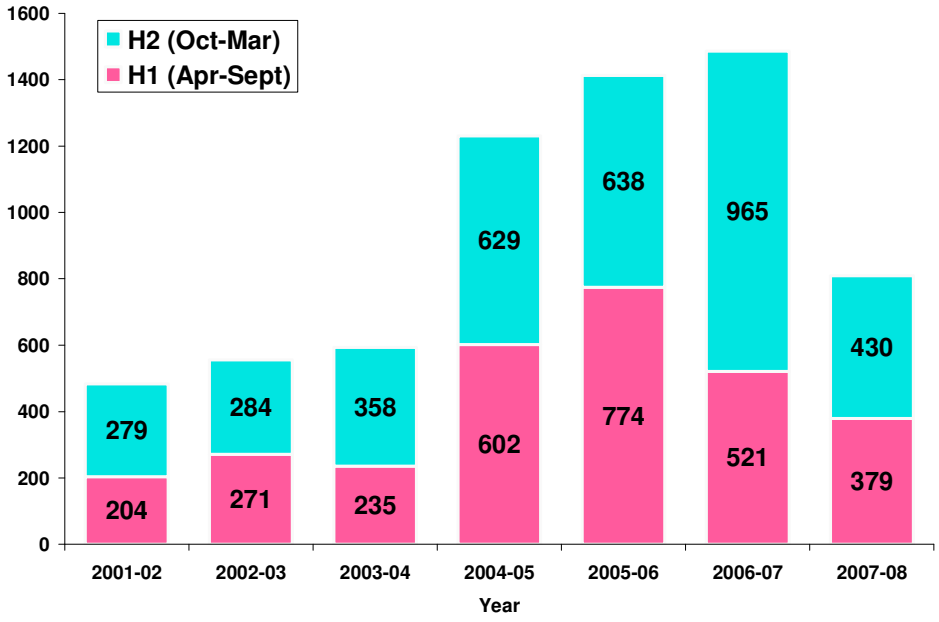


Note: the relatively low number of sessions reported in 2006-07 compared to 2007-08 is likely due to the fact that it was the first year organizations were asked for this information and many may not have had mechanisms in place to track and count number of sessions.

Decrease in support groups

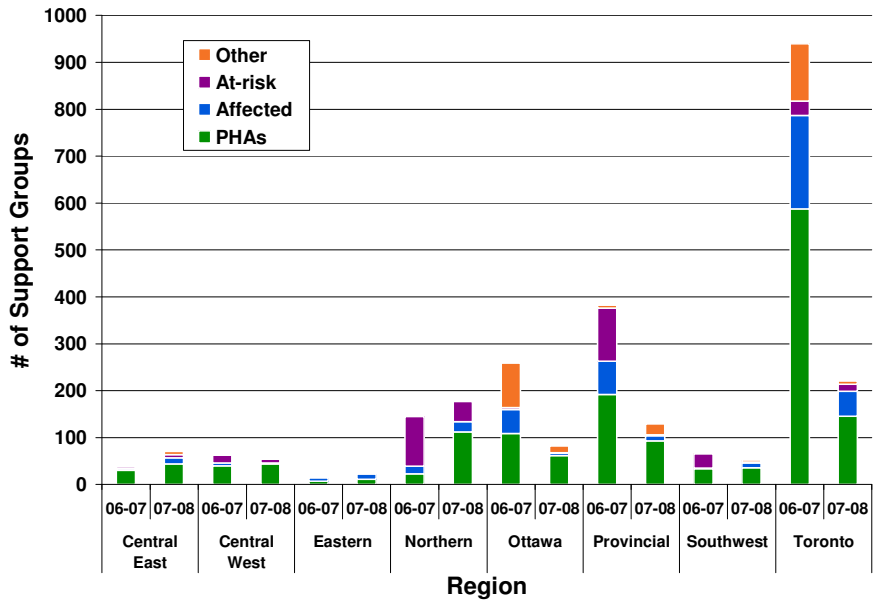
In 2007-08, there was a significant drop in the number of support groups reported. This may be due to errors in reporting in previous years (i.e., one support group may meet 15 times over a year and organizations may have been counting the number of sessions or meetings rather than the number of groups). Some organizations also reported holding fewer groups because of staff vacancies and turnover, or because clients preferred to network rather than hold a support group.

11.3a: Number of Support Groups for Service Users



The majority of support groups in almost all regions were for PHAs.

11.3b: Support Groups Reported by Client Type and Region (2006-07 to 2007- 08)

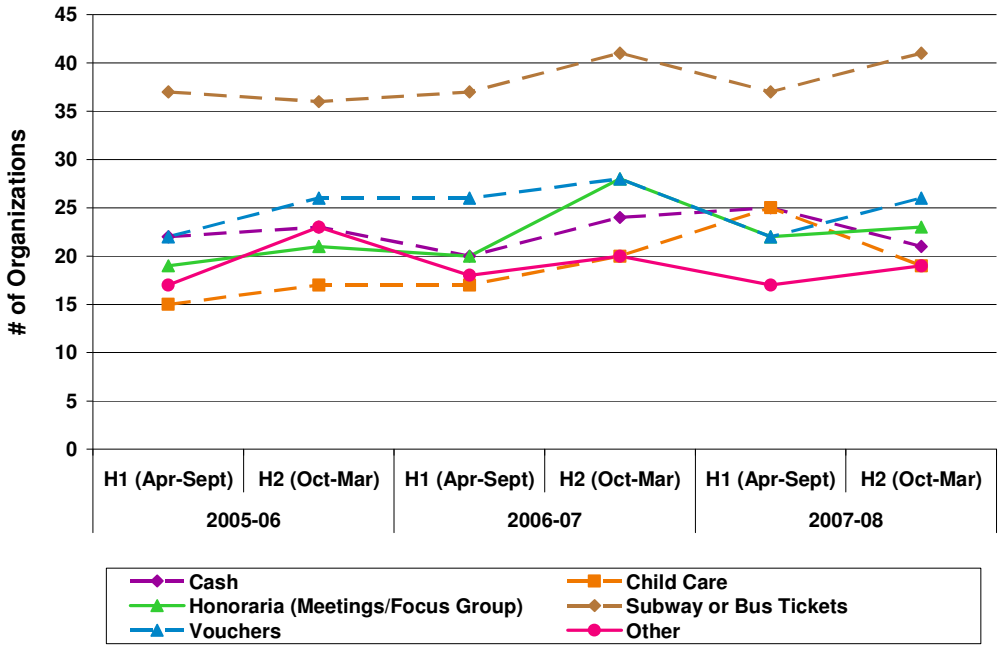


Increase in assistance with transportation

OCHART asks organizations whether they provide financial assistance to clients, and the type of financial assistance they provide. This information provides a way to assess clients' financial stability and identify gaps in other services, such as social assistance. About 75% of organizations indicated that they provided financial assistance in the first and second halves of 2007-08, similar to the rates in each reporting period in 2006-07 (70% and 78%) (Figure 11.4a) .

Financial assistance can be provided in different forms, such as cash, vouchers and bus tickets. The most common forms of assistance in 2007-08 were subway or bus tickets, vouchers and honoraria.

11.4a: Number of Organizations Providing Different Types of Financial Assistance



In addition to the items listed above, organizations reported providing financial assistance in the form of:

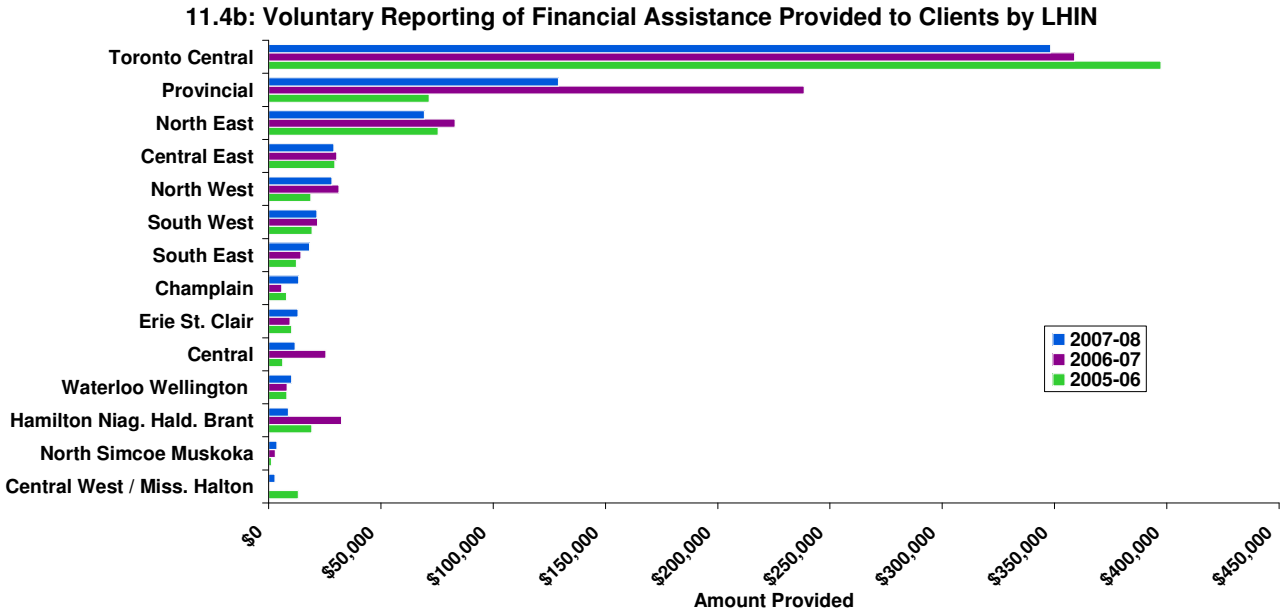
- basic necessities, such as food, nutritional supplies, baby supplies, clothing, child's car seats, winter clothes, socks, work clothes, hygiene products
- assistance with housing, rent, utilities, and moving costs
- assistance with health care costs, such as prescription co-pay amounts and Trillium deductibles, complementary and alternative therapies, dental costs and glasses
- equipment such as orthotics, helmets, knee pads, crutches, medical supplies, wheel chairs, medical alert bracelets and other assistive devices
- parking costs, telephone and television costs during hospital stays
- items that enhance quality of life, such as gift cards, phone cards, Christmas hampers and camp fees.

The growing need for financial assistance indicates that income stability is an issue for many clients. It also indicates that income programs like social assistance and ODSP are not providing enough income to allow people with HIV to properly manage their health (e.g., attend appointments, have adequate food).

Financial assistance decreases

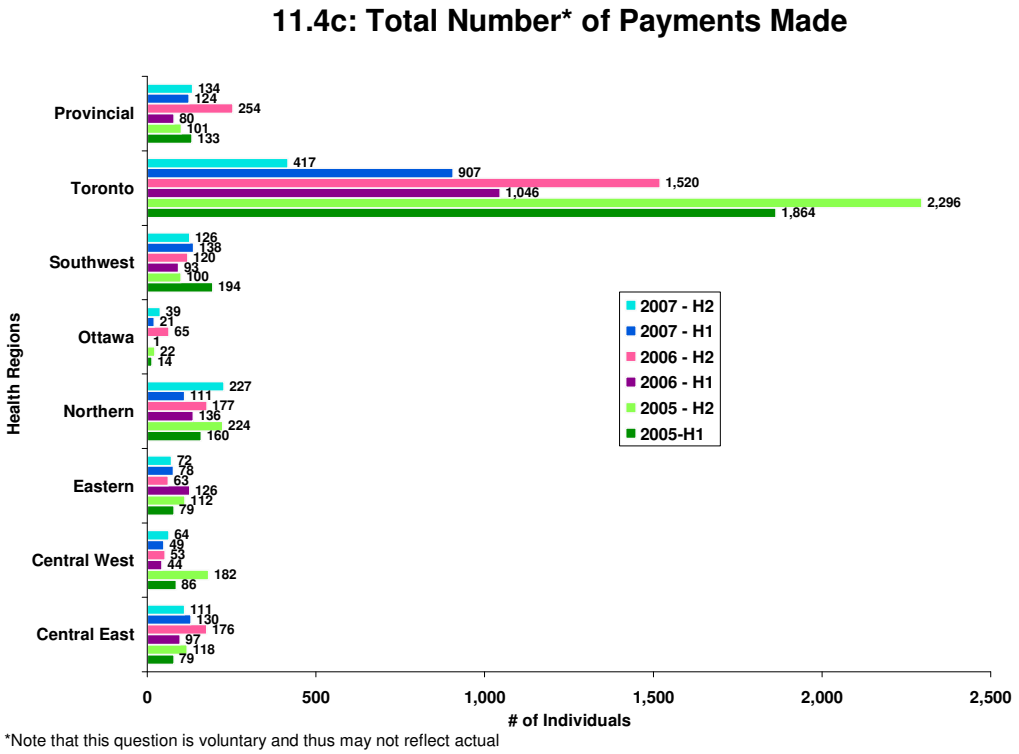
OCHART also asks organizations about the value of the financial assistance they provide and the number of clients who receive financial assistance. The questions were voluntary*; 25 organizations responded in H1 and 26 in H2 of 2007-08, compared to 42 in the first half of 2006-07 and 50 in the second half. Because the questions are voluntary, it is difficult to know whether fewer organizations are providing financial assistance or fewer are reporting it. Based on the information provided by organizations, it appears that the amount of financial assistance provided to clients in 2007-08 decreased by 18% from 2006-07, to $707,232.43 -- but this drop may be due more to lack of reporting than a real change in the amount of financial assistance.

The amount of financial assistance provided was down in all LHINs except South East, Champlain, Erie St. Clair, Waterloo Wellington and North Simcoe Muskoka.



The total number of payments made in 2007-08 (2,694) was also lower than in previous years – primarily because of changes in organizations within Toronto, which reported 1,242 fewer payments (although the average value of each payment increased).

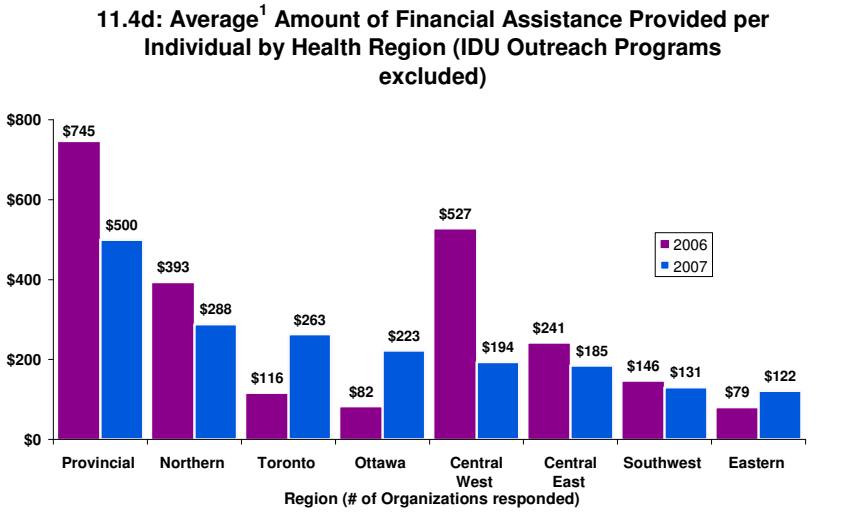
Note: Beginning in 2008-09, questions about financial assistance became mandatory so OCHART should have more accurate data in the future.



*Note that this question is voluntary and thus may not reflect actual

Financial assistance per person

On average, clients who obtained financial assistance from ASOs (not including provincial organizations) received between $122 and $288 during the year, and there appears to be less variation than in the previous year. The amount per person is still higher in the North where costs for items such as travel and fresh food are higher, and in large urban areas such as Toronto and Ottawa, where the cost of living is high.



1 Averages were calculated by dividing Amount of Financial Assistance Given Out by Number of Service Users (section 11.5). This information is not required by organizations and is only provided on a voluntary basis. Thus, the data only represents the organizations that provided information in this section (30 organizations).
Note: Ottawa and Eastern regions are grouped together due to a n=1 issue. Since they are in the same geographic regions, it is deemed appropriate.

Emerging Trends in Support Services

During 2007-08, organizations reported the following trends:

- more demand for counselling and mental health services, including bereavement support and other support groups (12 organizations). “An increasing number of clients are talking about feeling depressed, anxious and suicidal”
- increasing problems with food security (9 organizations). There is more demand for food vouchers, greater use of food banks, and more need for nutrition supplements and vitamins. As one agency noted, clients are unable to “afford dietary supplements or the vegetables and fruit to meet their dietary needs"
- more demand for services to meet the needs of newcomers (9 organizations), including interpretation and translation services, help obtaining OHIP coverage, and help accessing health services, employment and language training
- more clients with substance use issues (7 organizations)
- "an increase in the number of people seeking financial assistance” (6 organizations), including help to purchase basic clothing and furniture, or help accessing programs such as Ontario Works and the Ontario Disability Support Program
- more demand for bus tickets and assistance with transportation to access their programs and services (6 organizations)
- “more families experiencing crises, such as housing”: more clients needing affordable, safe housing and supportive housing services (6 organizations, 4 LHINs)
- greater need for prison support (5 organizations, 4 LHINs)
- more clients with co-infections (4 organizations), including hepatitis C, kidney disease and dementia
- more interest in information on complementary therapies and other treatments (3 organizations).

A smaller number of organizations reported clients who needed more hospital care, and more pre- and post-natal care (i.e., “Babies with HIV are being born due to lack of prenatal care.”) Two saw more clients – including men in same-sex relationships – who are experiencing domestic abuse. Two had more involvement with the court system either because of custody issues or criminal charges against a client for not disclosing. Two reported a higher rate of deaths among long-term survivors – not from HIV but from related conditions, such as heart attacks and cancer.

In terms of client groups, seven organizations reported more demand from youth, seven reported more demand from women or women and children, four reported more long-term survivors (so more need for services related to aging with HIV), three reported more demand from African and Caribbean clients, and two reported more trans clients. Two urban organizations reported serving more clients from surrounding rural areas.

Responding to Emerging Trends

To respond to emerging trends in support services, organizations are using a number of strategies, including:

Education and Training

- training front-line staff so they can meet clients’ needs (e.g., harm reduction, domestic violence, aging and HIV, mental health issues)
- teaching other service providers in the community about the impact of HIV on people’s lives
- organizing training programs for clients on issues of interest to them, such as naturopathy, immigration issues, addiction issues

Expanding services and/or hours

- increasing the weekly food program
- allowing clients to join support programs in mid-session
- offering longer hours or adjusting hours to provide more counselling services
- providing more consistent case management services
- making services more flexible for clients who use substances
- planning testing blitzes aimed at youth
- adding services in other languages (e.g., Shona, Ndebele)
- providing more food and transportation services.

New/extended programs

- starting grief and bereavement services
- organizing gender specific activities
- developing groups and other supports for newly diagnosed youth
- distributing safer crack kits
- developing services for newcomers
- developing effective ways to provide services in rural areas
- establishing an interactive website that allows sex workers to contact the ASO for supplies
- initiating new programs and services, such as a Buddy program, a dental program, long-term survivors support group, a community kitchen, and on-site testing
- extending hours into the evenings and weekends
- reviewing and refining programs.

Changes in staffing

- applying for more funding, fundraising and hiring new staff
- making more effective use of volunteers (e.g., to provide child care, translate materials, serve clients in rural areas, support PHAs in hospital or at home, or to serve as drivers)
- involving more peers in support services.

Referrals and partnerships

- working more closely with needle exchange programs
- developing partnerships with hospitals and other health services
- connecting with a furniture bank
- partnership with pharmacies to improve access to meal supplements and vitamins
- working with youth agencies
- partnerships with agencies to address abuse issues
- working more closely with prisons, detention centres and parole officers
- working with cultural and settlement agencies to improve services for newcomers
- connecting with social workers, psychologists and a psychiatrist at a local family practice clinic
- meeting with city councilors and social service workers to increase access to affordable and supportive housing
- strengthening relationships with prenatal groups
- working with faith-based organizations

Seeking funding

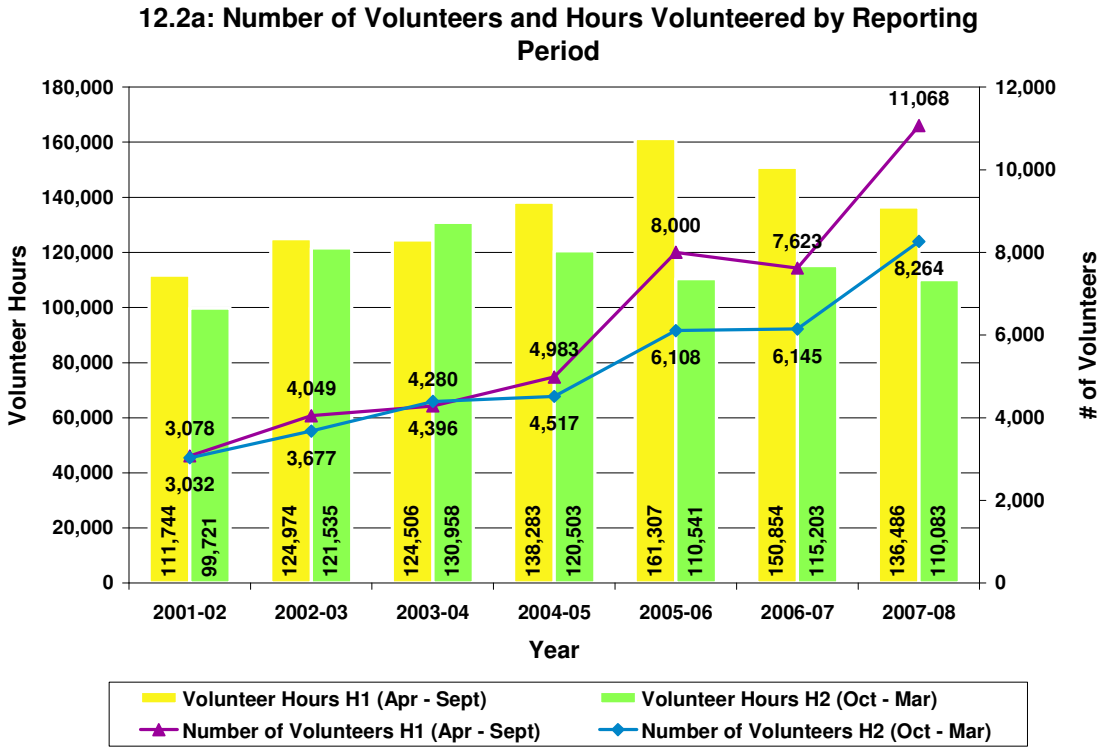
- applying for grants (9 organizations) from government, foundations and pharmaceutical companies
- increasing fundraising efforts (4 organizations).

Use of Volunteers and Students

In 2007-08, 65 organizations reported using volunteers and 45 reported using students.

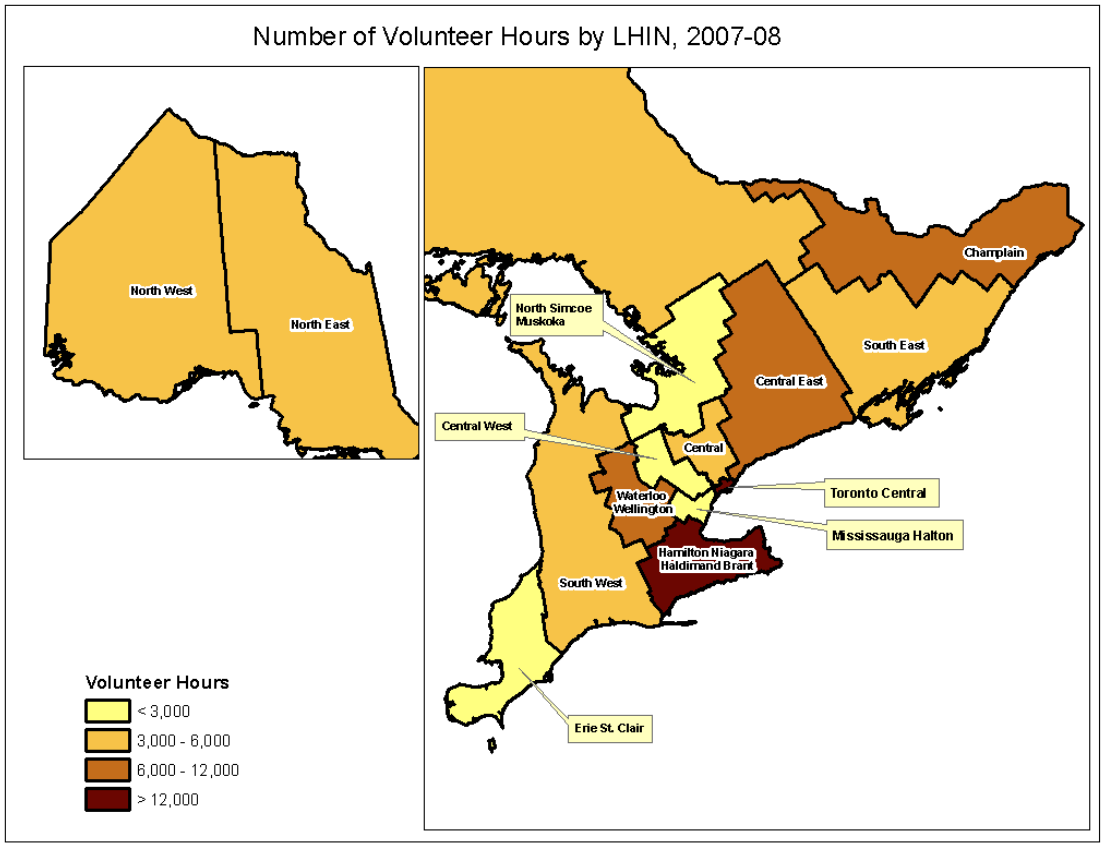
More volunteers, fewer volunteer hours

Although the number of active and new volunteers increased significantly in each half of 2007-08 (45% and 34% respectively), the number of volunteers hours declined slightly. Some of the increase in number of volunteers may be due to organizations doing a better job of collecting information on one-time volunteers or to some volunteers being counted twice (i.e., both as new and as active volunteers). It is encouraging to see such an increase in the number of people volunteering in the year after AIDS 2006 (the International AIDS Conference).



Volunteers contributed about 247,000 hours or the equivalent of 136 full-time staff – down from 266,000 hours in the previous year and 272,000 in 2005-06. This is consistent with a pattern seen across most organizations that rely on volunteers: people who volunteer are not able to give as much time as they did in the past. As one organization noted, "the volunteer position has to be flexible due to their busy schedule, the time commitment is short term and they seek opportunities that will give them the satisfaction they are making a difference."

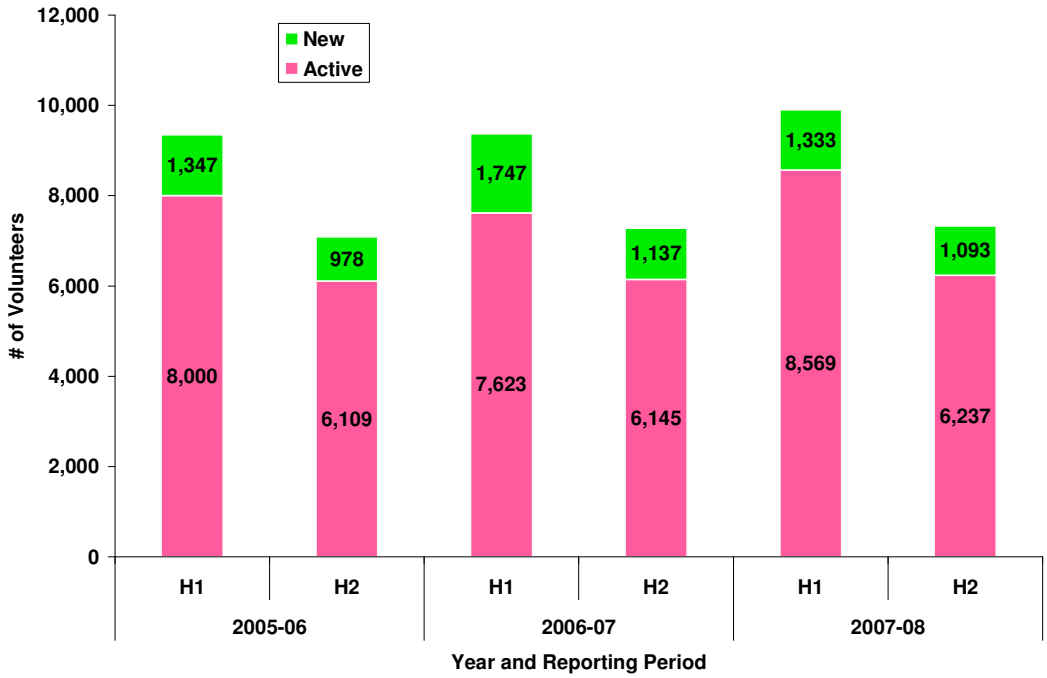
The map below illustrates the number of volunteer hours of service by LHIN. As would be expected, the large urban centres, such as Toronto and Hamilton, reported the largest number of volunteer hours. Perhaps more surprising is the higher number of volunteer hours in more sparsely populated northern LHIN regions compared to LHIN regions in the south. The number of volunteers is also strongly influenced by the number of organizations in each LHIN.



Better retention of volunteers

As Figure 12.1a indicates, about 16% of volunteers in the first half of the year and 13% in the second half were new volunteers, compared with 23% and 19% in 2006-07. Given that there was an increase in the overall number of volunteers, this means that organizations were retaining about 85% of their volunteers from year to year. The more volunteers who can be retained, the less organizations have to invest in recruiting and training new ones.

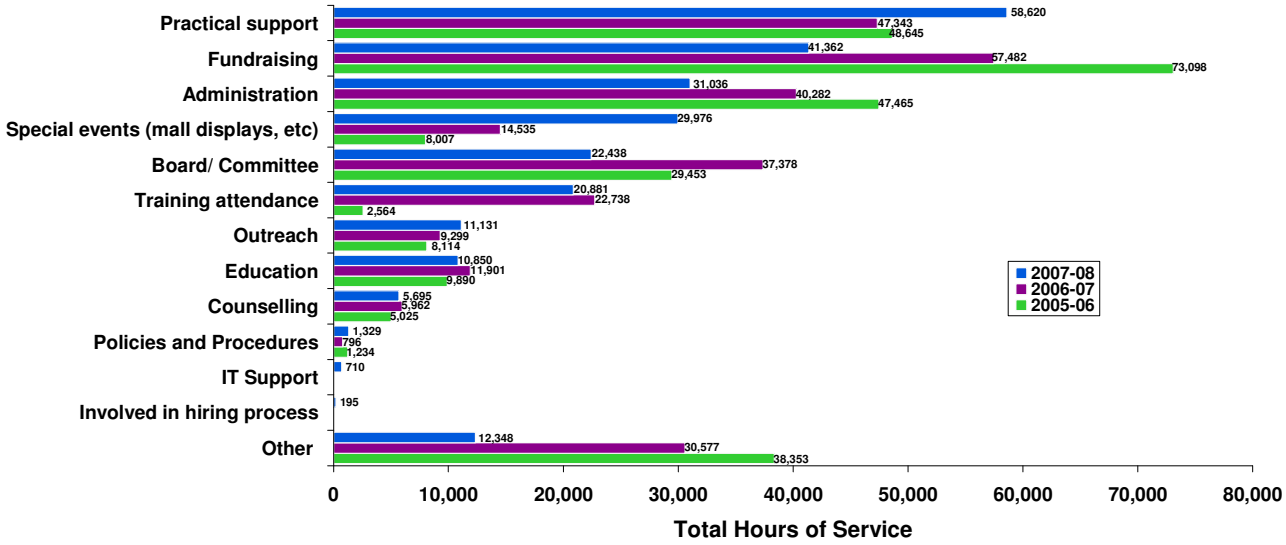
12.1a: Number of New and Active Volunteers by Half Year



Volunteer roles shift

Over the past three years, there has been a steady decrease in the number of volunteer hours devoted to fundraising and administration, and an increase in volunteer hours devoted to practical support, special events and outreach (Figure 12.2b).

12.2b: Hours of Service Provided by Volunteers for Different Organizational Activities

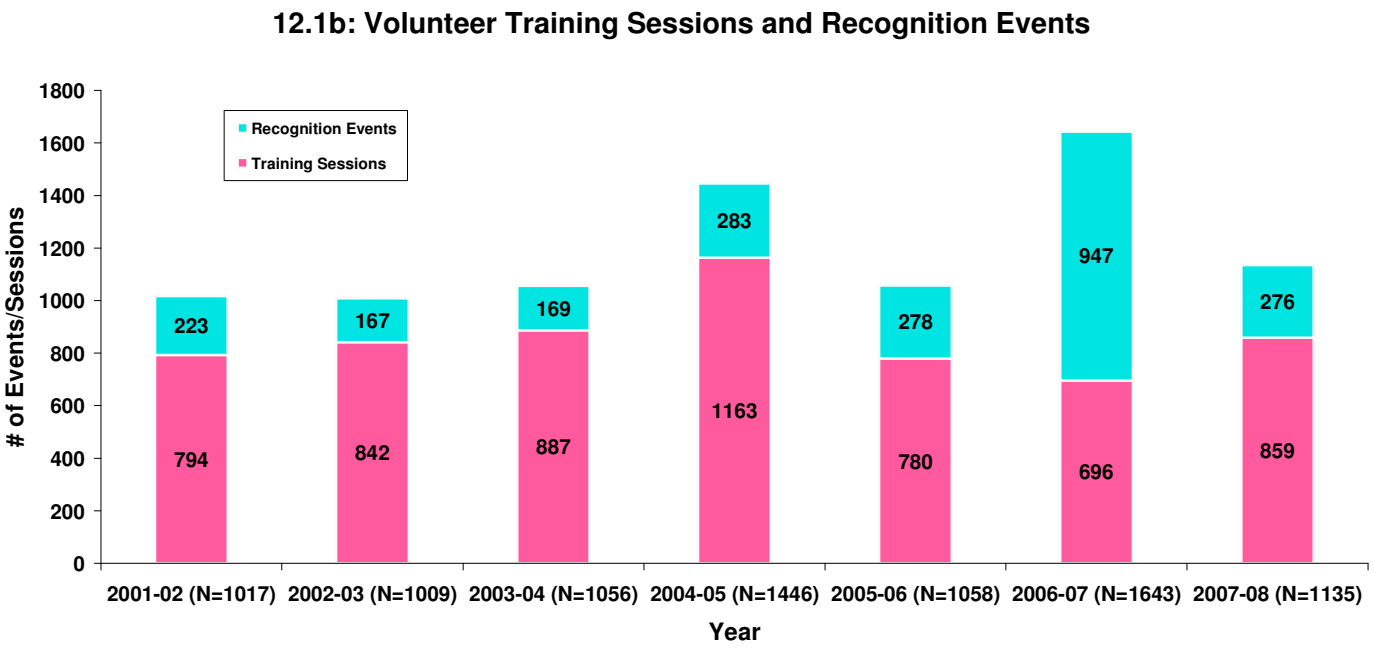


Other volunteer activities in 2007-08 included:

- providing technical and computer skills and support
- developing materials, such as newsletters, graphic designs and red ribbons
- stuffing condom packages
- staffing the drop-in program
- working in the library
- working in the food bank
- providing legal advice or other professional expertise
- assisting with strategic planning.

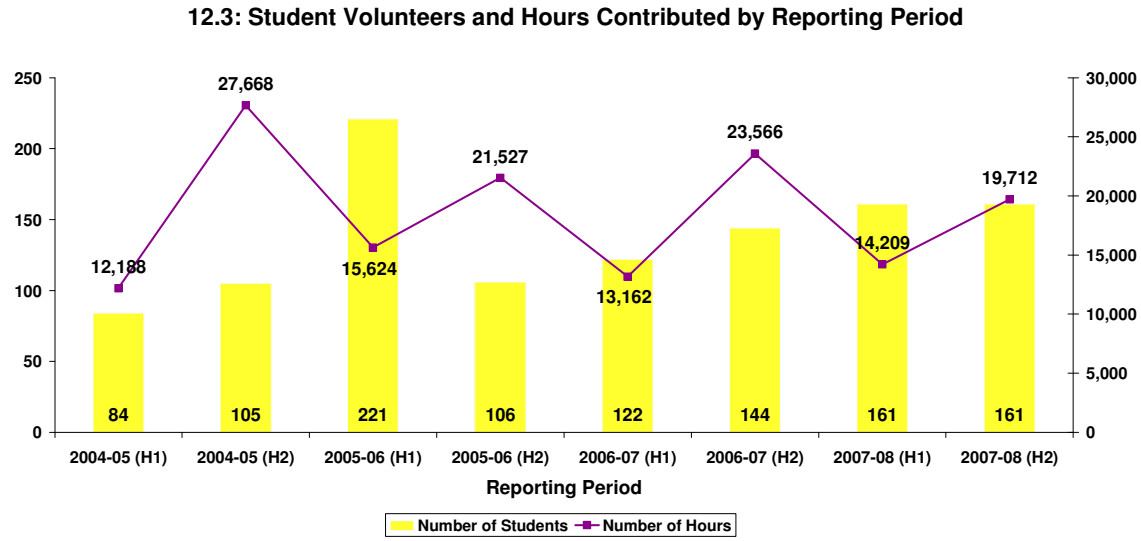
More volunteer training

Training and recognition programs are effective ways to recruit and retain volunteers, increase volunteer satisfaction, reduce recruitment costs and improve the quality of volunteer services. Organizations held fewer volunteer recognition events and more training events in 2007-08 – despite the fact that they had fewer new volunteers than the year before and better retention of volunteers. This change may reflect a number of factors: volunteers tend to be more interested in training than in volunteer recognition – they value the additional skills they develop in these training sessions, the training opportunity and the skills attained make them feel recognized and valued. The relatively low number of volunteer recognition events is surprising given the large increase (about 40%) in the number of volunteers. The high number of volunteer recognition events in 2006-07 may be due to AIDS 2006, data errors, or both.



More students giving fewer hours

In 2007-08, 45 organizations reported using the services of students. Those organizations reported an increase (32% in H1 and 12% in H2) in the number of students volunteering or doing placements at ASOs (compared to 2006-07). Overall, students gave fewer hours (88 per student in H1, 122 per student in H2) than they had the previous year (164 in H1 and 107 in H2). However, the total hours of work provided by students during the year were the equivalent of about 18 staff.

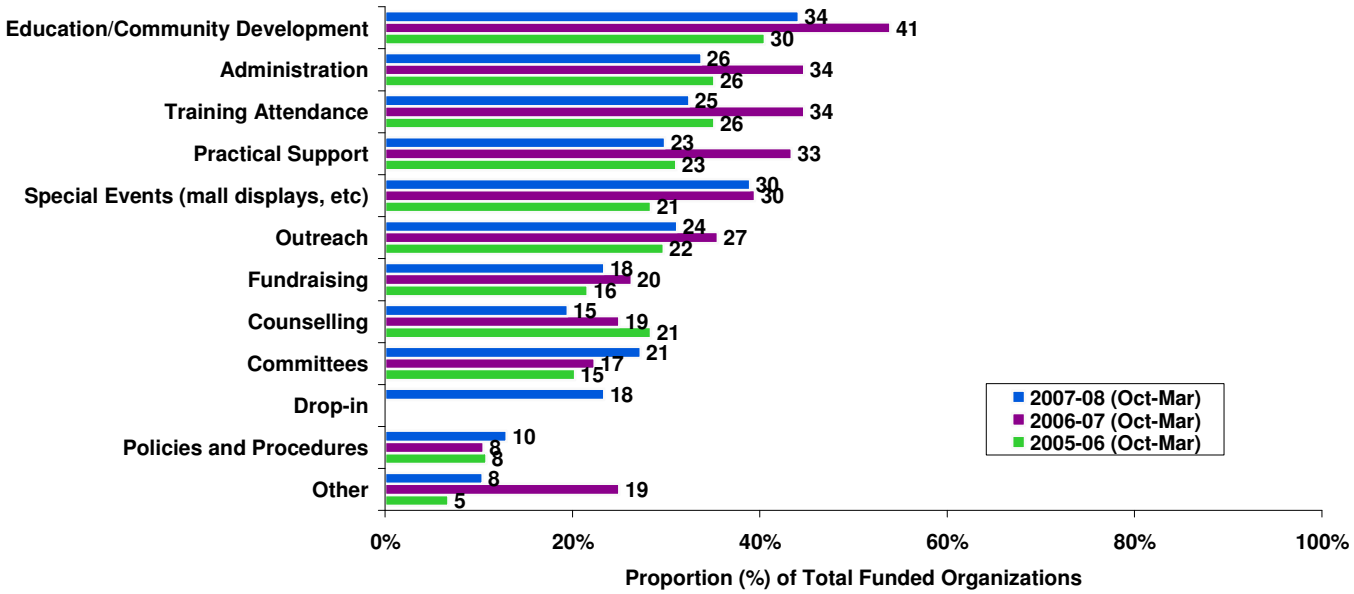


The number of students and hours likely varies based on whether the students are in high school and trying to meet requirements for community service, or in post-secondary programs and completing placements.

More students involved in education and special events

Organizations involve students in a wide range of activities. In 2007-08, organizations that had students reported using them primarily to assist with education/community development (34% of organizations), special events (30%), administration (26%), training (25%), outreach (24%) and practical support (23%) (Figure 12.4). The focus on education and outreach and drop-in services may reflect efforts by ASOs to reach/work with youth (i.e., focus on peer education and outreach).

12.4: Student Volunteer Involvement in Organizational Activities



Organizations also reported that students were involved in other activities, such as:

- conducting and analyzing surveys, evaluating programs and other research activities
- assisting physicians, providing care (medical students)
- assisting with support services such as intake interviews, expressive arts therapy groups, and legal services
- developing newsletters and other materials
- providing interpretation services
- organizing a conference.

Emerging Trends in Volunteer Services

In terms of emerging trends in volunteer services, organizations identified a greater need for volunteers to assist with the following activities:

- medical and other visits, direct support, chores and transportation for clients who are ill (8 organizations)
- events and activities (e.g., Caribana, PRIDE, homophobia forum, conferences, AIDS Walk for Life, third party events)
- translation and interpretation services
- fundraising and in-kind donations coordination
- outreach activities – particularly rural outreach

- media, marketing and advocacy activities
- educational/training support and tutoring.

The increase in the number of volunteers may be due to staff turnover in some organizations and to changing demands on staff (i.e., greater need for volunteers). A number of organizations reported relying more on volunteers to compensate for lack of staff (e.g., no receptionist) or to cover for staff who have to be out of the office because of other demands on the organization. The growing number of volunteers looking for "short-term" opportunities is a challenge for organizations. They need to identify discrete tasks that can be done in a short period of time, which has led to more research and special event oriented tasks for shorter term volunteers.

The need for volunteers and the ability to manage them are affected by other factors. For example, one organization reported needing and using fewer volunteers when one of their programs (i.e., meal replacement) was reduced. Another noted that the lack of a volunteer coordinator affected its ability to recruit and manage volunteers.

In terms of who is volunteering, organizations reported having and needing:
- more professionals, including internationally educated health professionals trying to establish their careers in Canada
- more women, including health professionals and women who live on the street (to help with outreach and harm reduction materials)
- more youth ("80% of the volunteers recruiting in this period were between the ages of 16 and 24") – including recent university graduates
- more ethnically diverse volunteers.

In terms of volunteer development, organizations report that volunteers want to develop specific job skills and have innovative, challenging opportunities. They also want to learn more about trans needs and issues, facilitating groups, and other support and outreach skills. Barriers that organizations face in using volunteers effectively include: volunteers who do not have cars and who have to use public transit to provide support services, the time it takes to provide training and support, and problems accessing volunteers in rural communities who would like to be involved with the organization.

Responding to Emerging Trends in Volunteer Services

Organizations are using the following strategies to respond to emerging volunteer trends:

Training

- providing more training
- developing a volunteer training manual
- involving PHAs in volunteer training
- establishing a volunteer development committee
- using other organizations (e.g., Alliance Hospice) to provide volunteer training.

Recruitment

- actively recruiting volunteers
- developing a targeted recruitment strategy to attract volunteers with the right skills/ availability (e.g., professionals, people who can volunteer during business hours, people with specific language skills, medical students, business people)
- doing community outreach through libraries, schools, faith-based groups, professional bodies and community committees.

Creating new volunteer positions/approaches/partnerships

A number of organizations are adjusting their programs and partnerships to accommodate volunteers, including:

- developing new support and leadership roles for volunteers, such as practical support positions, drop-in coordinator, and roles in theatre groups; and expanding volunteer program activities to take advantage of their skills
- revising and creating job descriptions
- developing partnerships with local organizations so they will take over tasks formerly done by volunteers, such as stocking displays
- partnering with a local employment centre that provided volunteers
- shortening the intake and training procedure for volunteers to make opportunities more attractive for those who want short placements
- shortening the time commitment required
- providing/arranging transportation for volunteers.

IDU (Injection Drug Use) Outreach Programs

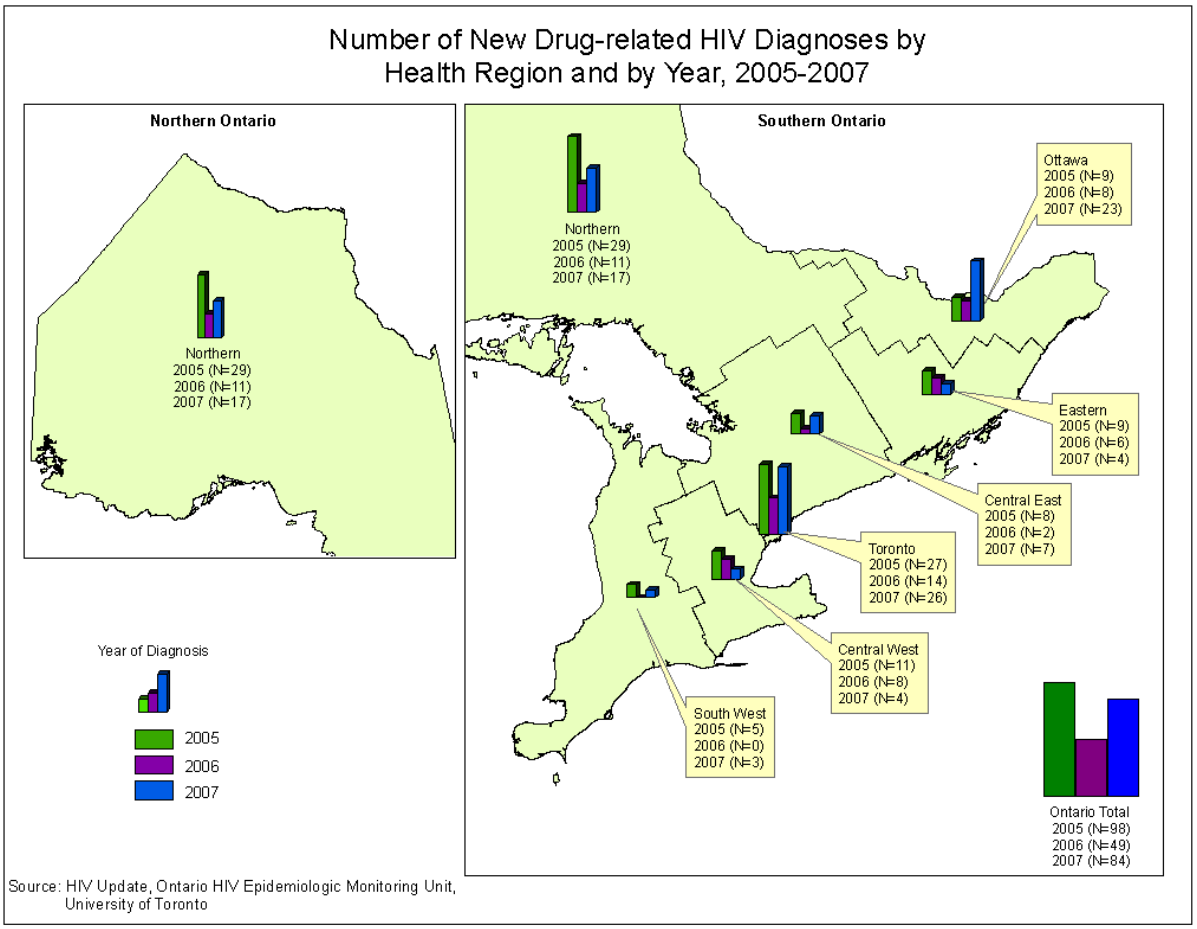
In 2007-08, the AIDS Bureau funded 16 HIV and IDU (Injection Drug Use) Outreach Programs (the same number as in 2006-07). The goal of these programs is to reach injection drug users and link them to prevention/harm reduction services, such as needle and syringe exchange programs, and/or testing and treatment services.

The following is a summary and analysis of their activities.

Trends in HIV Infection in Drug Users

The number of new HIV diagnoses among people who inject drugs increased in 2007, and represented 8% of new diagnoses in that year.

The map below illustrates the number and location of new diagnoses in each region from 2005 through 2007. Cases continue to be concentrated in the Toronto, Ottawa, and Northern regions.

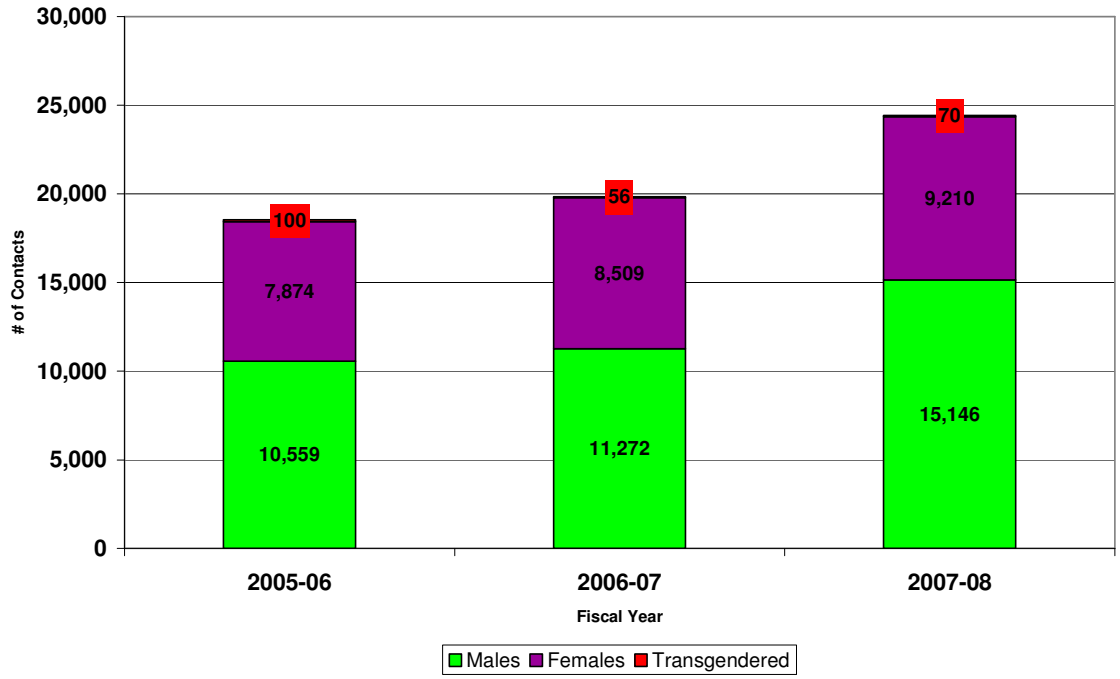


Number of outreach and In-service contacts increases

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 outreach and in-service contacts during each reporting period.

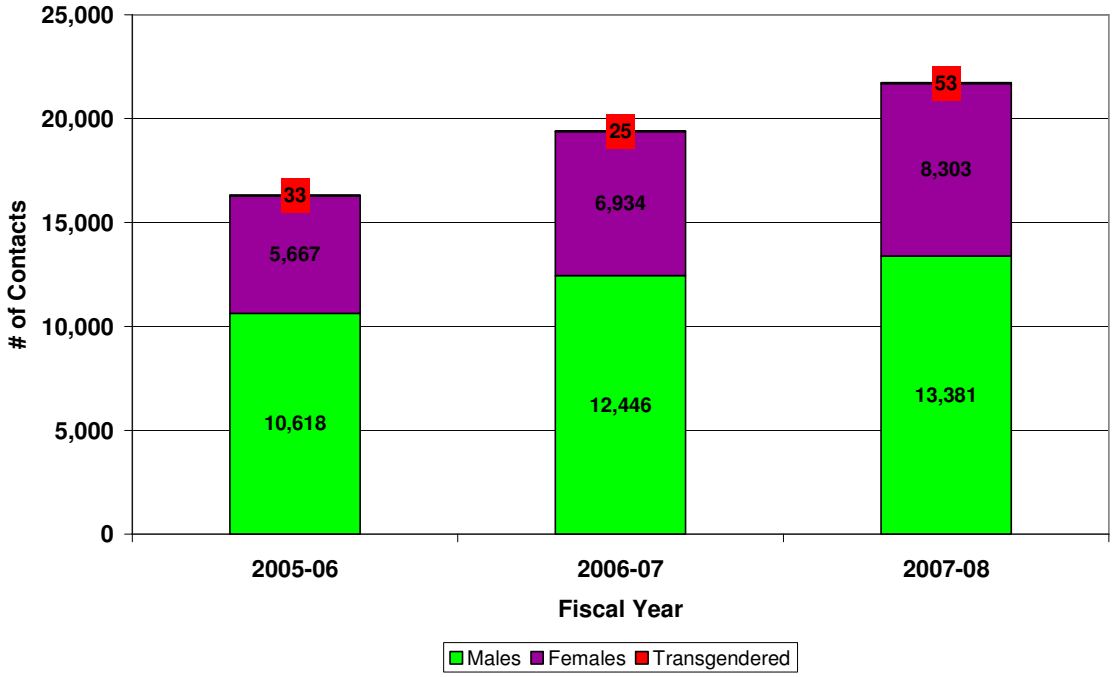
In 2007-08, both outreach and in-service contacts increased for both men (34% and 8%) and women (8% and 20%). The total number of contacts is likely higher than stated because of a reporting problem in one program.

13.1: Number of Outreach Contacts(New & Repeat) by Gender



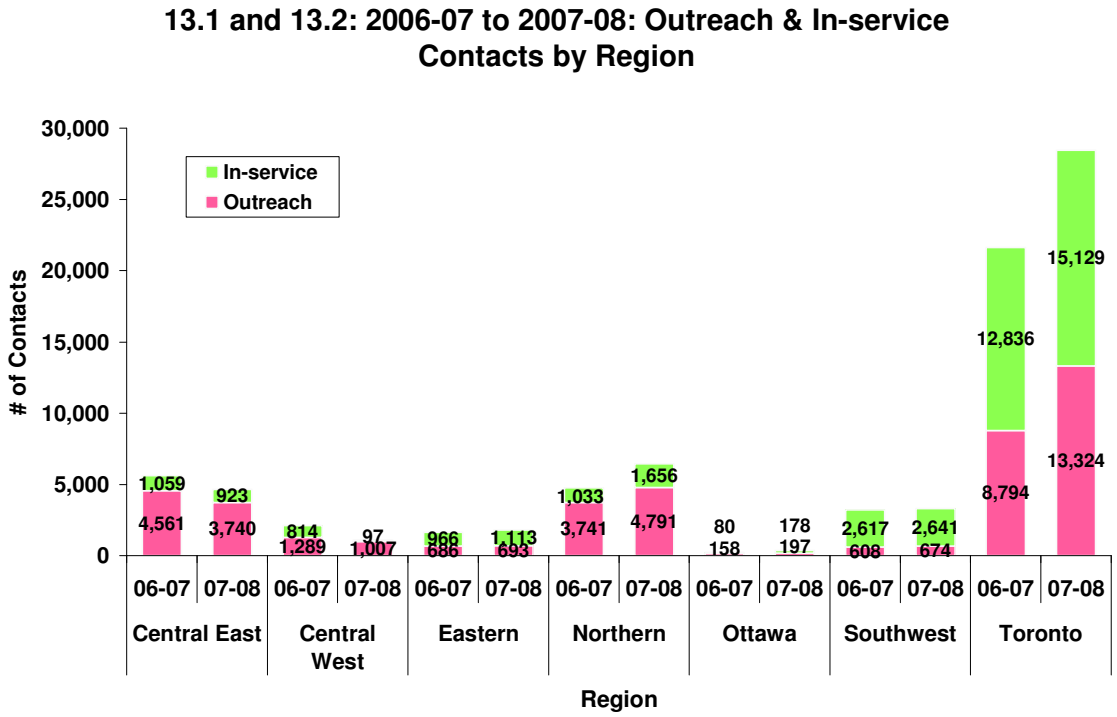
Of the 24,426 total outreach contacts in 2007-08, 19,606 were contacts with repeat clients and 4,820 were contacts with new clients. Of the 21,737 in-service contacts in 2007-08, 18,663 were with repeat clients and 3,074 were with new clients.

13.2: Number of In-Service Contacts(New & Repeat) by Gender



Strategies to reach clients vary by region

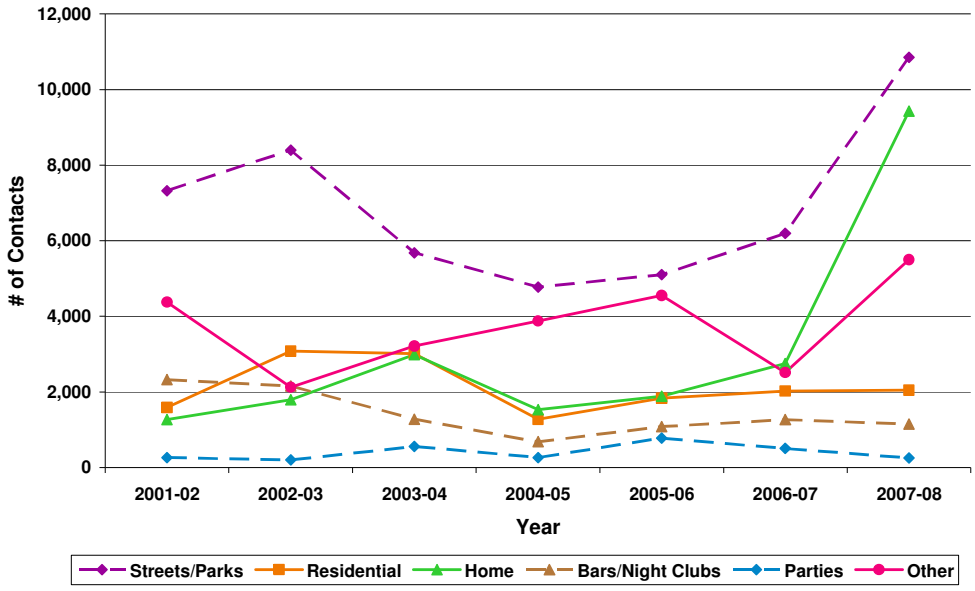
Some regions, such as Central East, Central West, and Northern, rely on outreach programs to connect with clients while regions such as Toronto, Southwest and Eastern reached the majority of their clients though in-service contacts. This pattern has been consistent over the past two reporting years.



Homes, streets and parks main locations for outreach contacts

In 2007-08, there were significant increases in home outreach and in street and park outreach (Figure 13.4). The increase in home outreach may be due to changes in policing practices in some cities, which are moving substance users out of public areas, making it harder for organizations to reach them. There was also an increase in outreach in “other” locations, including shelters, drop-in centres, coffee shops, barber shops, and video stores.

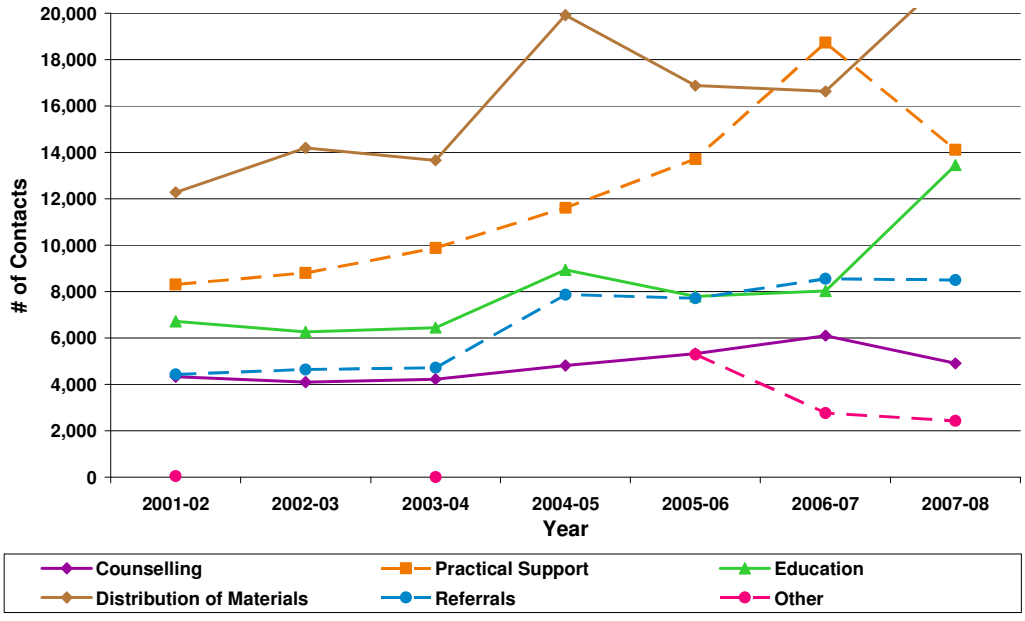
13.4: IDU: Outreach Contacts Made by Location



More emphasis on distributing hard reduction materials

In 2007-08, IDU outreach programs reported distributing more materials and providing more education than in the previous two years. They also reported providing less practical assistance than in 2006-07, as well as less counselling.

13.3: IDU: Number and Types of Services Provided

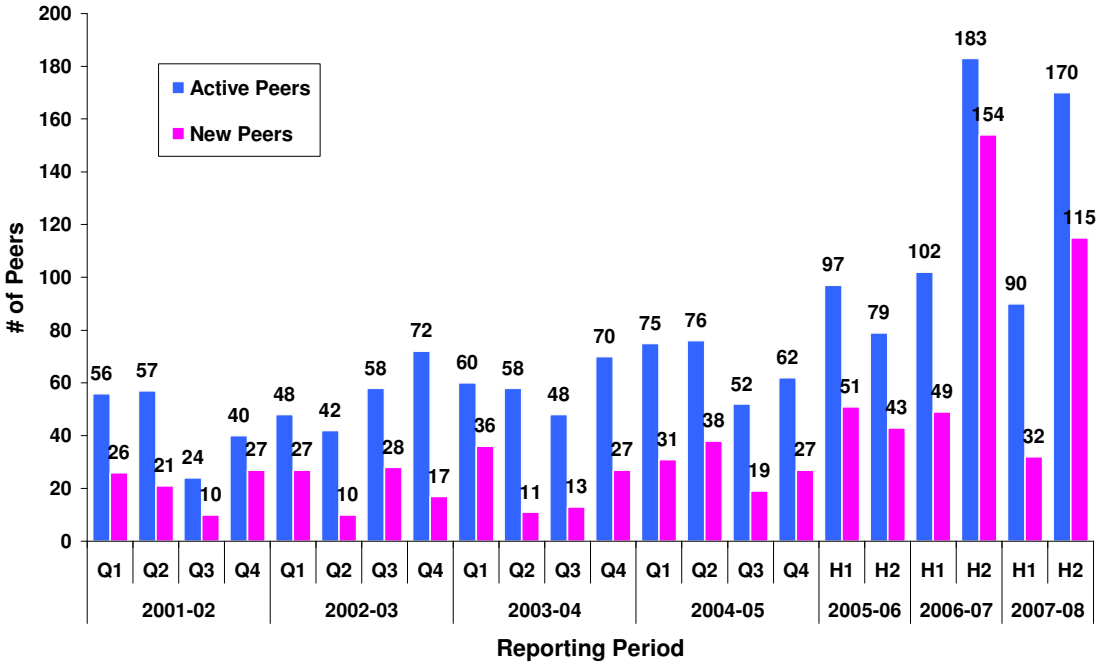


IDU Outreach Programs also reported providing other services in 2007-08, including hygiene kits, food, medical care and telephone services.

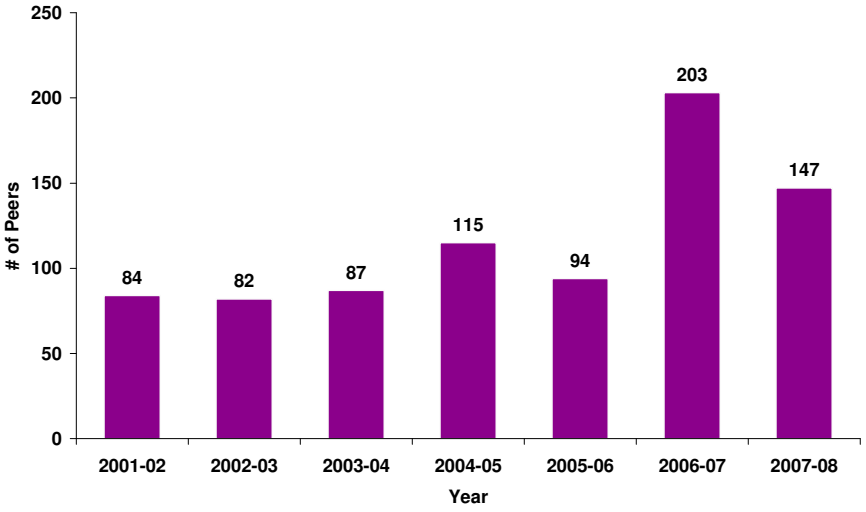
Peer Activities

All IDU Outreach Programs are required to have a strong peer component. They are expected to recruit peers to help reach other injection drug users, and to provide training and support. In 2007-08, programs reported a slight decrease in active peers in both halves of the year and a drop in new peers (compared to 2006-07) – however, the overall numbers are still significantly higher than in previous years.

13.5a: Peer Involvement (New and Active) by Reporting Period



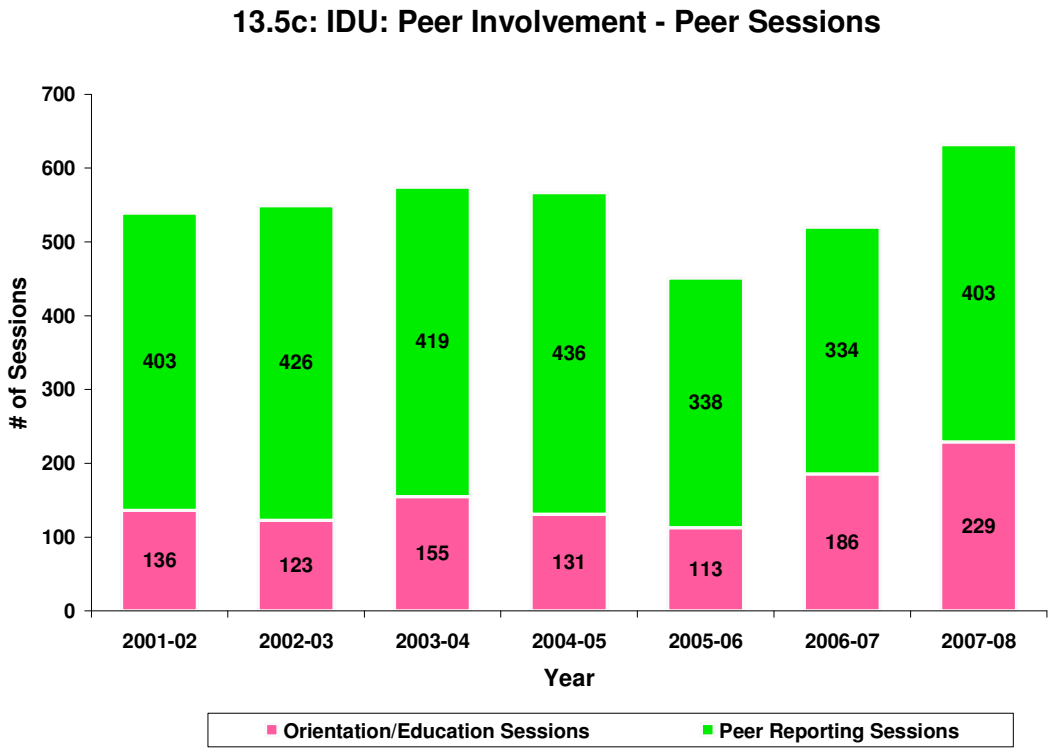
13.5b: Total New Peers by Year



More orientation/education for peers

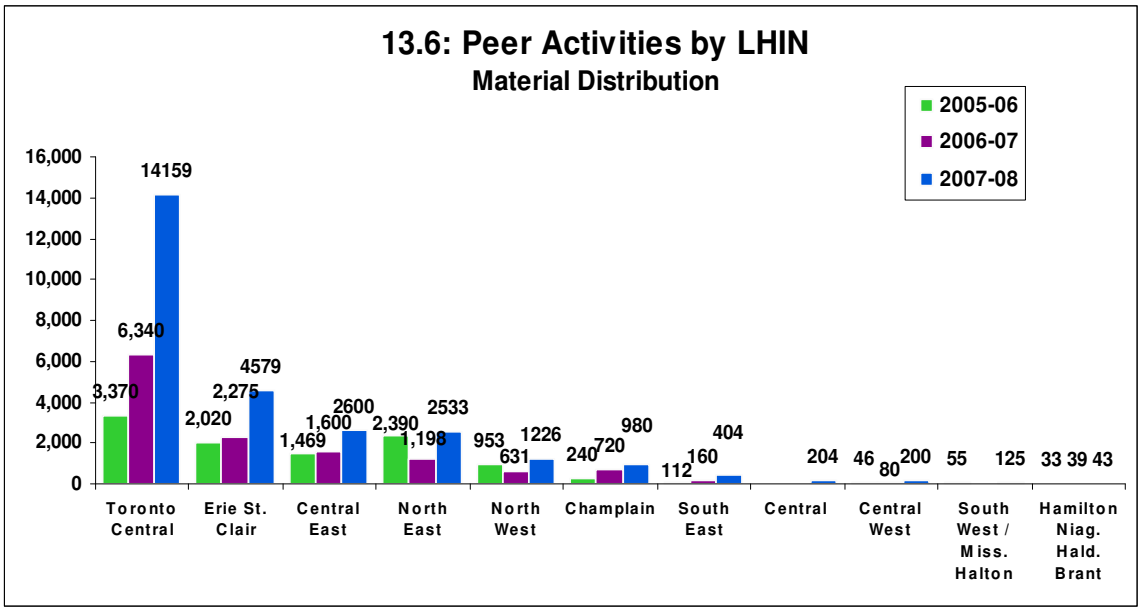
As part of their peer programs, IDU outreach programs provide orientation and education sessions. In 2007-08, IDU outreach programs reported a 23% increase in orientation and education sessions for peers compared to 2006-07 – despite having fewer peers and fewer new peers. This may highlight the need for ongoing training to maintain peer networks.

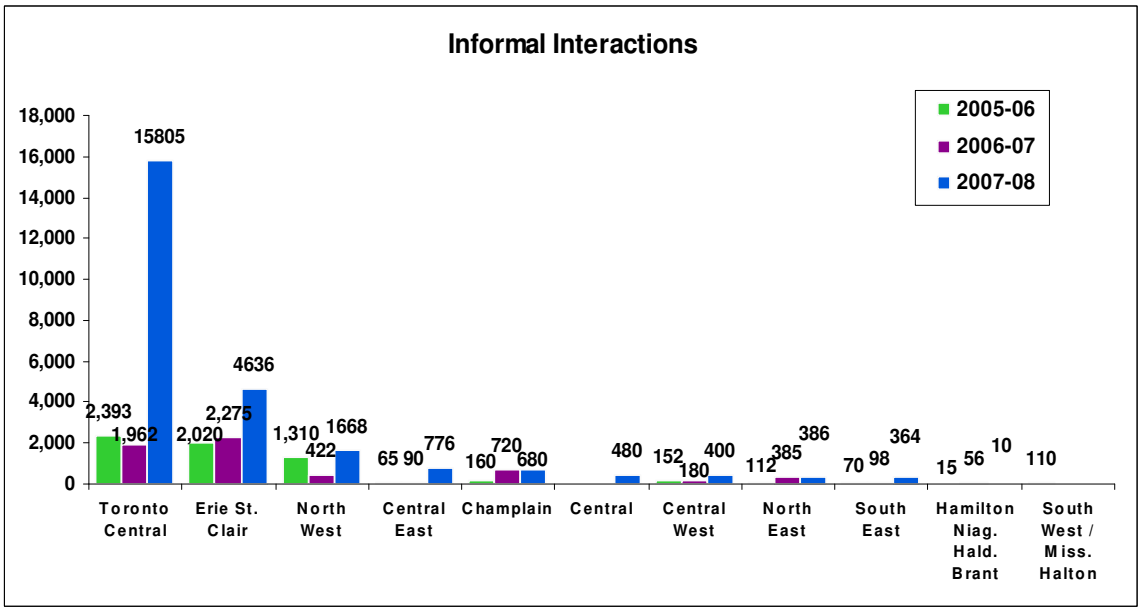
IDU Outreach Programs are expected to hold regular reporting/feedback sessions with peers in order to monitor their activities, provide support, and learn from their contacts with other injection drug users. The number of peer reporting sessions increased by 21% in 2007-08 compared to 2006-07, but was still lower than in most pre-OCHART years.



Peers more active in providing services

Although programs reported having fewer peers in 2007-08, peers provided significantly more service than in previous years. Peers are mainly involved in distributing information and materials, as well as in informal interactions with other drug users. Almost every LHIN saw an increase the number of these activities delivered by peers.



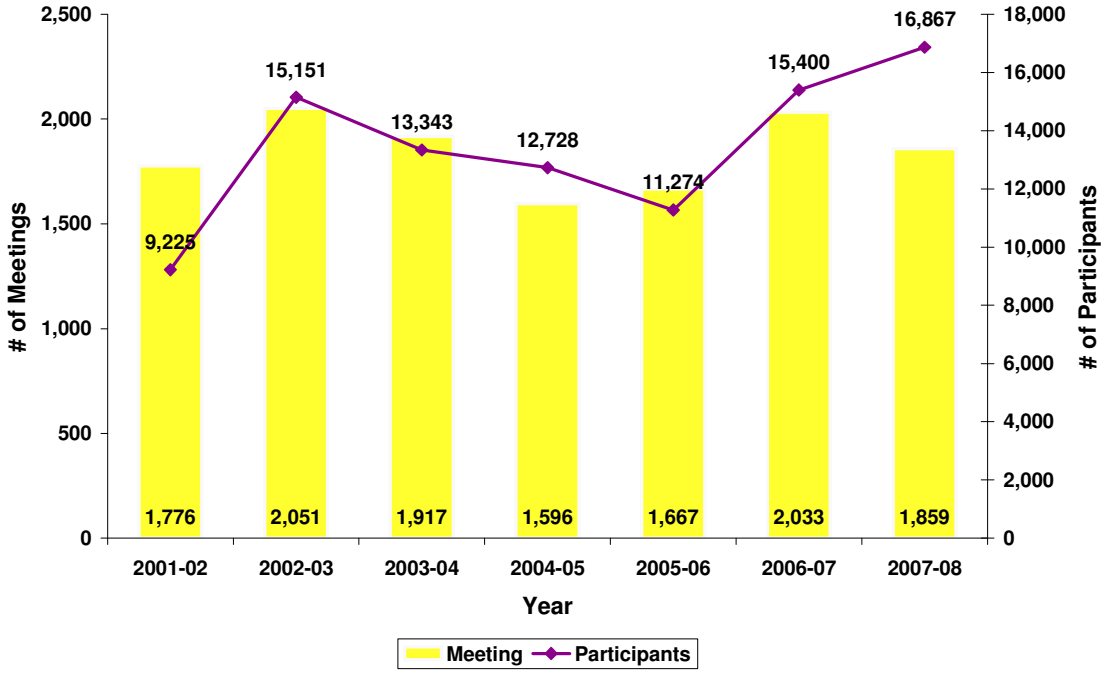


Programs also reported peers being involved in meetings, facilitating harm reduction groups, staffing satellite and other education programs, accompanying clients to OHIP, Ontario Works and other government offices, and other education activities.

More community development

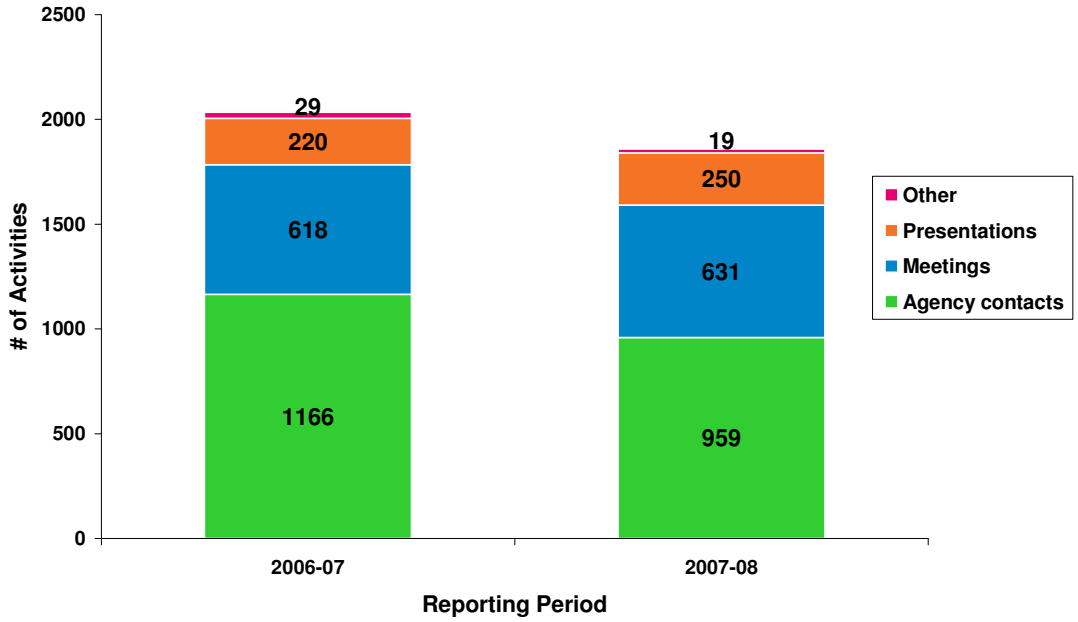
For IDU outreach programs, community development includes activities designed to help the program become integrated with other services. Such activities include making contacts with other organizations, making presentations about the program, and attending community meetings. These activities are intended to help create a supportive social environment for the program and its clients, and to 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 (Figure 13.7a). In 2007-08, IDU programs were involved in fewer community meetings, but had contact with almost 10% more participants, than in 2006-07.

13.7a: Total Number of Community Development Activities



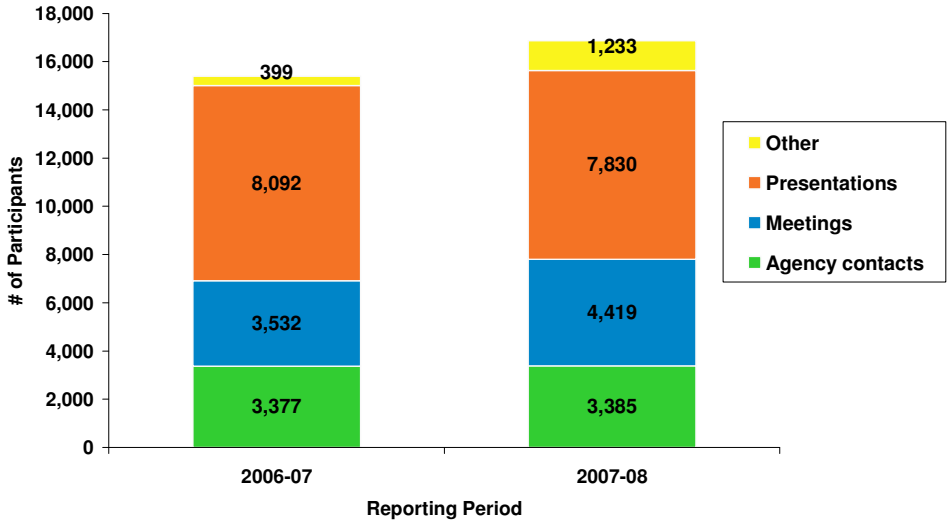
In 2007-08, programs engaged in fewer community development meetings with other organizations, and more meetings and presentations.

13.7b: Number of Community Development Activities by Type



Of the 16,867 participants in community development meetings, half were engaged in presentations and over one-quarter were engaged through meetings. "Other" community development activities included a community clean-up, a barbeque, a memorial and sensitivity training for the local police force.

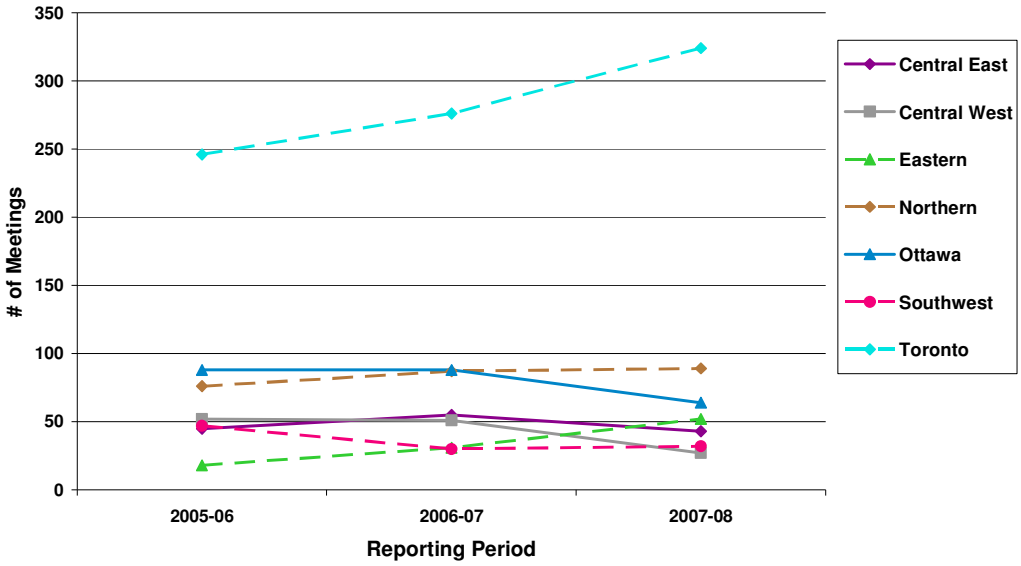
13.7c: Number of Participants by Community Development Activity



Although programs reported fewer agency contacts in 2007-08, they reached more people through those contacts.

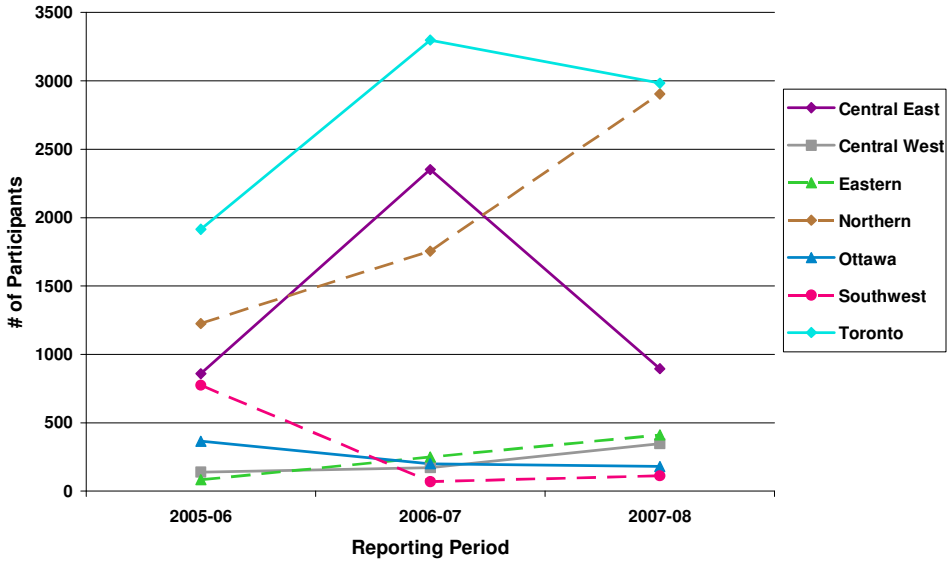
When the number of community development meetings is analyzed by region (Figure 13.7d), organizations in the Toronto Region reported holding significantly more meetings than any other region.

13.7d: Community Development Meetings by Region



While IDU Outreach Programs in the Northern region reported fewer community development meetings than those in Toronto, they reported involving a comparable number of participants. (see Figure 13.7e)

13.7e: Number of Participants at Presentations by Region



Emerging Trends in IDU Outreach

The IDU Outreach Programs identified a number of social and environmental changes that are affecting their clients and their work, including shifts in drug use, more youth using drugs, changes in attitudes, and the need for more and different services.

Changing Drug Use

In terms of drug use, programs are seeing:

- more crack cocaine use
- more injection drug users coming out of prison
- an increase in the practice of injecting pills (i.e., morphoine, oxycontin) – particularly among young people – which leads to an increase in infections
- greater use of fentanyl patches
- unexpected effects from cocaine that are more consistent with the use of crystal meth (i.e., staying much higher for much longer) and the use of cocaine that has additives that could lead to stroke or heart attack
- a shift in drug use due to the cancellation of a city-run safe inhalation program.

Changing Clients

Programs are seeing some shifts in clients:

- Four organizations (in Toronto and the North) reported seeing many more youth: "The age of clients is getting younger on the streets. They are hard to reach because they don't want to admit to anyone that they are using injection drugs. They have little knowledge about how to use safely"
- Programs in Ottawa and Toronto reported providing services to more women involved in sex work: "Girls as young as 16 have come up and asked for kits. After getting to know some of them, [we found] many more are needing our services … They can't always get out to meet us. We need to start going to them"
- One organization reported an increased demand for service from older community members
- One organization reported more clients with hepatitis C.

Changing Attitudes

Programs are concerned about possible signs of message fatigue and apathy from some service users, including:

- lack of concern about acquiring hepatitis C
- visible evidence of unsafe practices occurring (e.g., increase in abscesses and other infections) – and people are reluctant to seek medical attention for these issues
- more people unhappy with methadone replacement therapy who are returning to using
- individuals using needles out in the open
- clients attempting to get used needles from sharps containers to exchange them
- needles being found in abstinence-based shelters.

These attitudes may indicate the need for different approaches.

Programs also reported changes in public attitudes such as the decision by one community to close down a safer inhalation program and the concern expressed in another by local doctors about the benefit of low threshold harm reduction services and easy access to materials.

Changing Service Needs

Programs report increased demand for:

- harm reduction materials including syringes, crack kits, other safer inhalation equipment and condoms (12 programs)
- toiletries, winter clothing and nutritional items (e.g., meal replacements, power bars)
- detox/treatment services
- treatment services outside the city so clients can remove themselves from their drug using environment
- services for women
- education and information (e.g., HCV)
- peer opportunities including employment, volunteer and social activities
- assistance with housing and social assistance programs
- support in dealing with police.

Responding to Emerging Trends

In response to these trends, programs are adjusting their education, outreach, support and supply services, and developing new partnerships.

Education

Programs have launched new education programs including:

- warnings about additives in cocaine (e.g., be cautious, do a "tester")
- one-to-one discussions and written information about unsafe injecting practices
- educating nurses and detox centre staff about how to engage and establish trust with drug users
- organizing peer-led forums on HCV co-infection, safer injection, smoking and sex and body piercing practices
- weekly groups to encourage proper disposal of needles
- educating clients and the community
- using peers to reach young users
- more peer training.

Outreach

Programs are using different strategies to reach clients including:

- surveying clients about where they should focus their efforts
- coordinating with other outreach programs to provide outreach to youth living in makeshift squats
- seeking out locations where youth may be injecting and taking a more youth-oriented approach
- adding a mobile van services (which reduces the number of times the outreach worker must return to the agency for more supplies)
- supporting the IDU outreach worker who visits a local shelter daily by having two other workers visit the shelter once a week to promote harm reduction practices
- having a peer target the buildings and strolls where women in the sex trade work
- considering renting a motel room at certain times of the week to be able to reach sex trade workers.

Support

To provide more support for clients, programs are:

- holding discussions with clients to identify new intervention strategies (e.g., support group), because available treatments (e.g., methadone) are not have an impact on the overall use of cocaine and opiates in the community
- advocating with the police, landlords, and social assistant programs on behalf of clients
- developing new programs for women who use drugs and engage in sex work
- offering more harm reduction groups
- making referrals to other services.

Supplies

In terms of supplies, programs report that they are:

- delivering Chapstick to at-risk clients to help with cracked lips – which creates an opportunity to provide more support
- creating hygiene kits for homeless pill injectors (i.e., gauze pads, sterile water and paper, information on health/hygiene issues)
- doing routine checks of neighbourhoods to pick up used needles
- doing research on and pricing safer inhalation supplies
- considering purchasing wall-mounted disposal containers for used needles.

Partnerships

Programs report working with different partners to try to improve services for injection drug users including:

- the Drug and Alcohol Treatment Registry (DART) to investigate providing safer crack kits (i.e., assessing benefits, challenges, community reaction)
- social service providers, including youth programs
- shelters to encourage the installation of sharps containers in the washrooms
- churches to provide support for peers
- a police liaison officer to reduce the pressure on clients.

In addition, six programs reported they are actively seeking funding/grants from other sources, such as their municipality.

To respond to any change or hardening in public attitudes, at least one program is evaluating its practices and preparing for any media/public backlash against harm reduction services.

Part V: ACAP Report

The Ontario Region of the Public Health Agency of Canada (PHAC) AIDS Community Action Program (ACAP) funds a variety of community-based organizations to provide HIV/AIDS prevention and support services. According to OCHART data, during 2007-08, ACAP provided approximately $2.6 million through two streams of funding - Operational and Time Limited.

Operational Programs

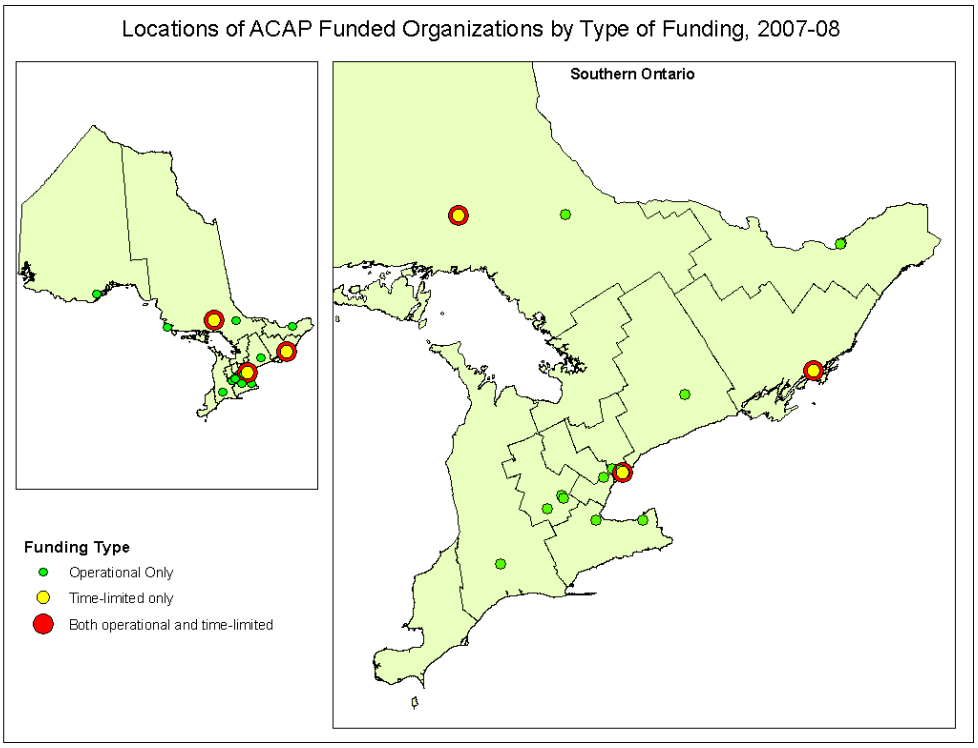
The purpose of Operational funding is to fund AIDS Service Organizations whose mandate is specific to addressing HIV/AIDS in Ontario. This includes funding for key programming, overhead and administrative costs. In 2007-08, ACAP funded 29 Operational programs. This report focuses on the data provided by these programs.[3]

Time Limited Projects

Time Limited Project funding is available to voluntary, non profit, non-governmental organizations actively dealing with HIV/AIDS issues. This funding is for specific, time-limited activities to address unmet HIV/AIDS needs and priorities – not for ongoing work. Examples of time-limited initiatives are: pilot projects, projects to develop best practice models, and the development of a common intake and assessment form.

Sixteen time-limited projects began in 2006 and ended on March 31, 2007. Information on these projects was included in the 2006-07 *View from the Front Lines* report, so the data are not provided in this report. A new cycle of time-limited funding began in March 2008: four 12-month projects, which will end March 31, 2009, were funded. Their data will be captured in the 2008-09 OCHART report.

The map shows the location of ACAP-funded projects by type of funding.



[3] Note: the 2006-07 report included data from the time-limited projects, so some of the differences in 2007-08 may be due to the fact that fewer programs were submitting data.

Criteria/Focus of ACAP-Funded Programs/Projects

To meet the criteria for ACAP funding, ACAP projects and programs must support one or more of the four Funding Approaches:

1. Prevention Initiatives
2. Health Promotion for PHAs
3. Strengthening Community-Based Organizations
4. Creating Supportive Environments.

During 2007-08:

- 11 programs reported being involved in Prevention Initiatives, such as working with at-risk populations, offering prevention workshops and providing peer outreach programs
- 11 programs were funded for activities related to Health Promotion for PHAs, such as improving environments and services for immigrant, refugee and minority populations (e.g., translating resources, developing peer education and outreach campaigns) and conducting health promotion activities (e.g., leadership development workshops for PHAs, educating and networking with health care providers about the needs of PHAs)
- 7 were funded to Strengthen Community-Based Organizations by, for example, maintaining strong volunteer programs and strengthening capacity of organizations
- all programs that receive ACAP funding are expected to be involved in activities to Create Supportive Environments, including community strengthening their relationships with other sectors (e.g., mental health, settlement/immigration, media, and faith communities) and developing media campaigns to reduce homophobia and promote healthy sexuality.

All ACAP funded programs are required to complete annual logic models, which map the anticipated project activities for the fiscal year. At the beginning of the fiscal year (April 1st), projects and programs enter their "planned" outputs/deliverables and the logic model. On October 31st and April 30th organizations input their "actual" outputs/deliverables into their on-line logic models. The online logic model links their data directly to the on-line OCHART. If there are variances between planned and actual outputs/deliverables, organizations are given the opportunity to provide explanations and revise their activities as necessary.

ACAP now has two years of logic model data, which are included in this report.

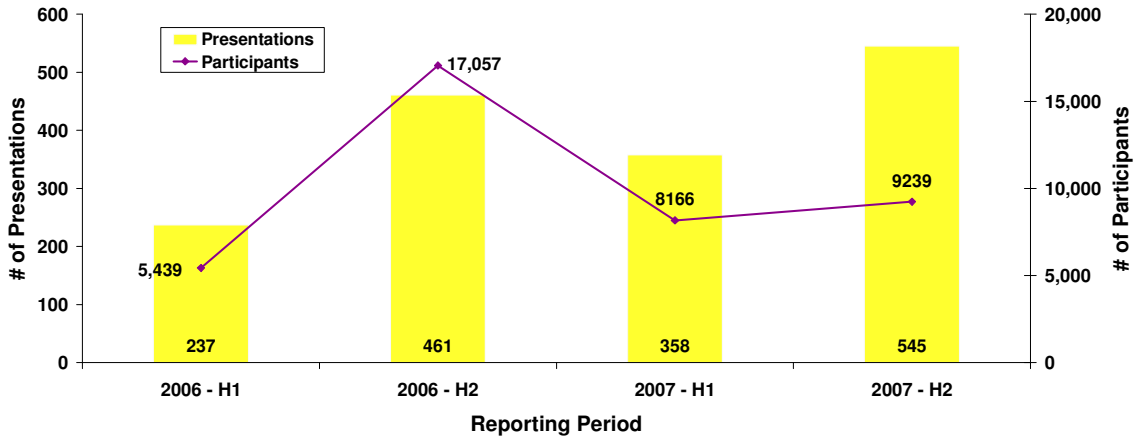
1. Prevention Initiatives

Prevention initiatives funded by ACAP include education presentations, the development of resources, outreach programs, awareness campaigns, and Internet and media contacts.

Education Presentations Increase

In 2007-08, the 11 programs funded by ACAP to provide education and community development services gave a total of 903 presentations, which reached a total of 17,407 participants – or an average of 19 participants per presentation (see Figure 9.2.1a). Compared to 2006-07, this represents a 29% increase in the number of presentations and a 22% decrease in the number of participants. The higher average number of participants per presentation in the previous year is likely due to AIDS 2006, the International AIDS Conference held in Toronto, and the lower number of participants per presentation in 2007-08 may also reflect a more targeted approach to prevention education. It is encouraging to see that ACAP-funded projects were able to increase the number of presentations in 2007-08 because that was not the case across all organizations. The total number of education presentations reported by the organizations that complete OCHART dropped in 2007-08 (compared to 2006-07). As a result, ACAP operational funding accounted for 18% of all presentations in 2007-08, compared to 14% in the previous year.

9.2.1a: Total Number of ACAP Funded Education Presentations and Participants

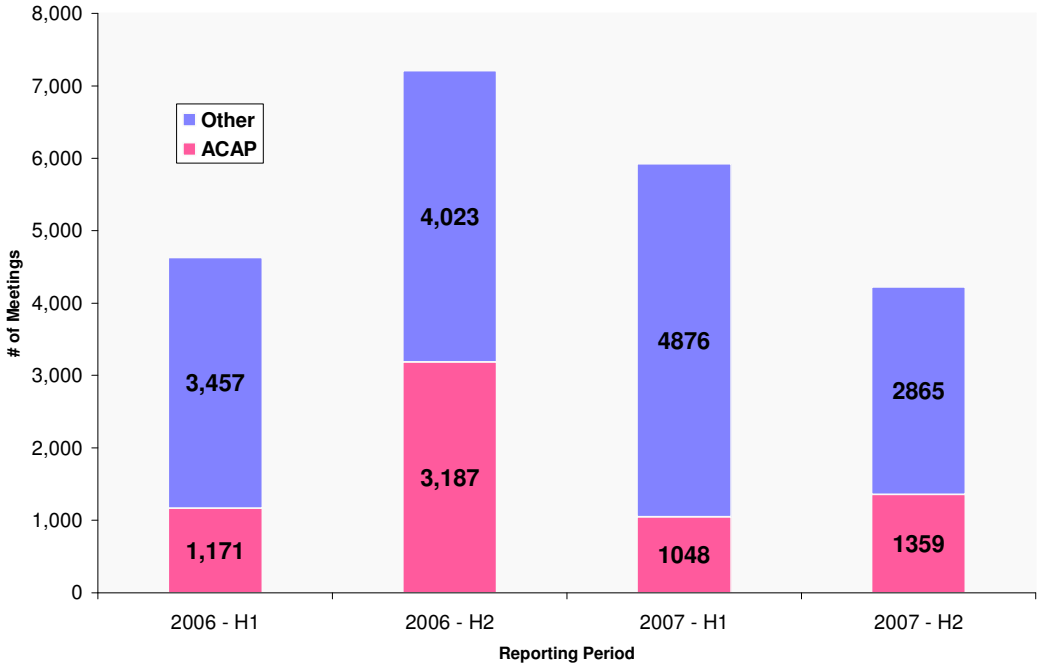


Community Development Meetings Down

As noted earlier, all ACAP-funded organizations are expected to be involved in activities that Create Supportive Environments for people with HIV and populations at risk, such as community development meetings.

ACAP-funded organizations were responsible for a total of 2,407 community development meetings in 2007-08, down 45% from the previous year. ACAP funding supported about 24% of the community development meetings during the year, down from 37% in 2006-07. The decreases are likely due to the fact that, with the end of the 16 time-limited projects, there were fewer projects reporting.

9.2.1b: Community Development Meetings - ACAP and Other Funding

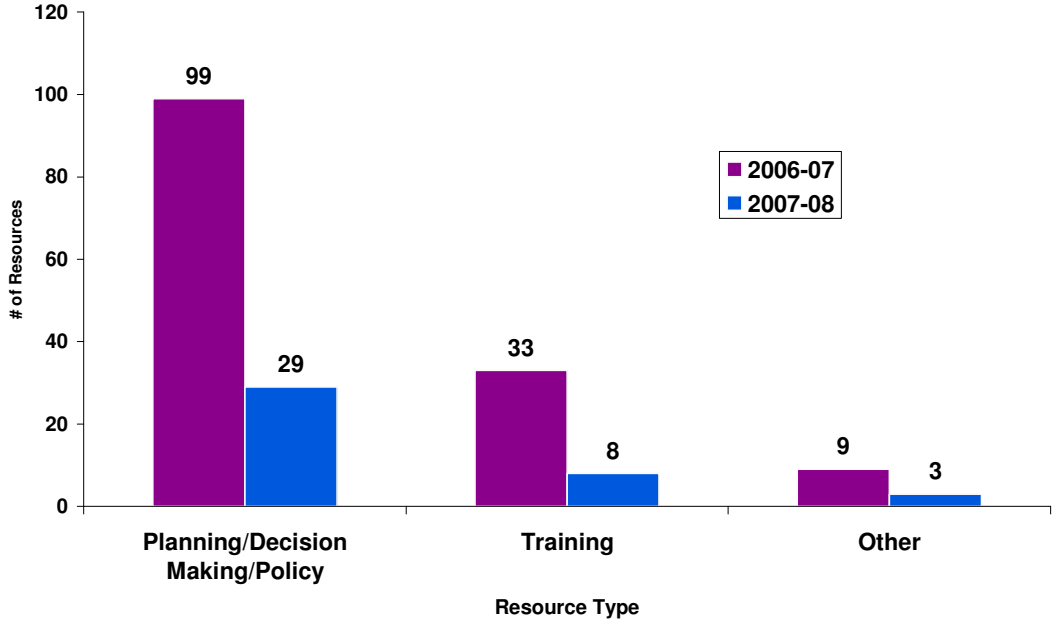


In terms of their logic model planning, ACAP-funded organizations significantly exceeded their total education targets for number of presentations, participants and community development meetings. Among the 4 programs and projects that did not meet their education/community development targets, the most common explanations were staff turnover, transitions and vacancies, as well as no-shows and lack of interest from target groups. In some cases, organizations identified barriers that could be addressed, such as lack of transportation. In one case, the organization completely changed its approach, shifting from trying to organize meetings with bar owners to discuss education campaigns (which were not well attended) to one-to-one visits to each bar, giving the owner the opportunity to select from a number of different education messages and customize the message for the venue and clientele. This reinforces the need for programs and organizations to be flexible, and to continue to look for new ways to deliver education and achieve their goals.

Fewer Resources Developed

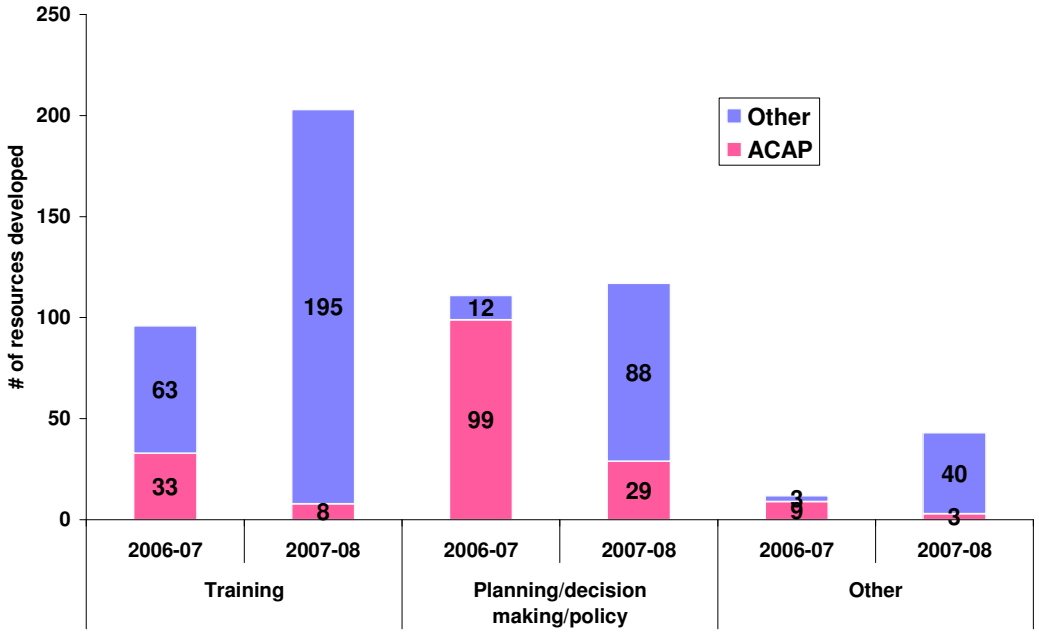
Organizations funded by ACAP are also asked to report on the number of resources they develop to support community development activities (Figure 9.2.2a). In 2007-08, the organizations developed a total of 40 resources: 29 planning/decision making/policy documents (compared to 99 in 2006-07) and 8 training resources (compared to 33).

9.2.2a: Number of Resources Developed by Type of Resource



In terms of contribution to the overall development of resources, ACAP-funded materials accounted for 25% of planning and policy resources and 4% of training in 2007-08, compared to 89% and 34% in 2006-07).

9.2.2b: Education and Community Development - ACAP and Other Funded Organizations



For detailed descriptions of funded programs and their resources, please go to:

http://www.phac-aspc.gc.ca/aids-sida/about/reg_ontario_e.html

ACAP-Funded Programs Maintain Party, Bar and Street Outreach

In 2007-08, ACAP funding supported a total of 14 programs to provide 18,357 outreach contacts, compared to 16 programs and 18,604 contacts in 2006-07, and 24 programs and 40,307 contacts in 2005-06. Overall, the average number of outreach contacts per funded program dropped from 1,681 in 2005-06 to 1,311 in 2007-08, but the average in 2007-08 was higher than in 2006-07 (1,162).

10.2a: ACAP Funded Organizations: Total # of Outreach Contacts and Average # of Outreach Contacts Per Funded Program

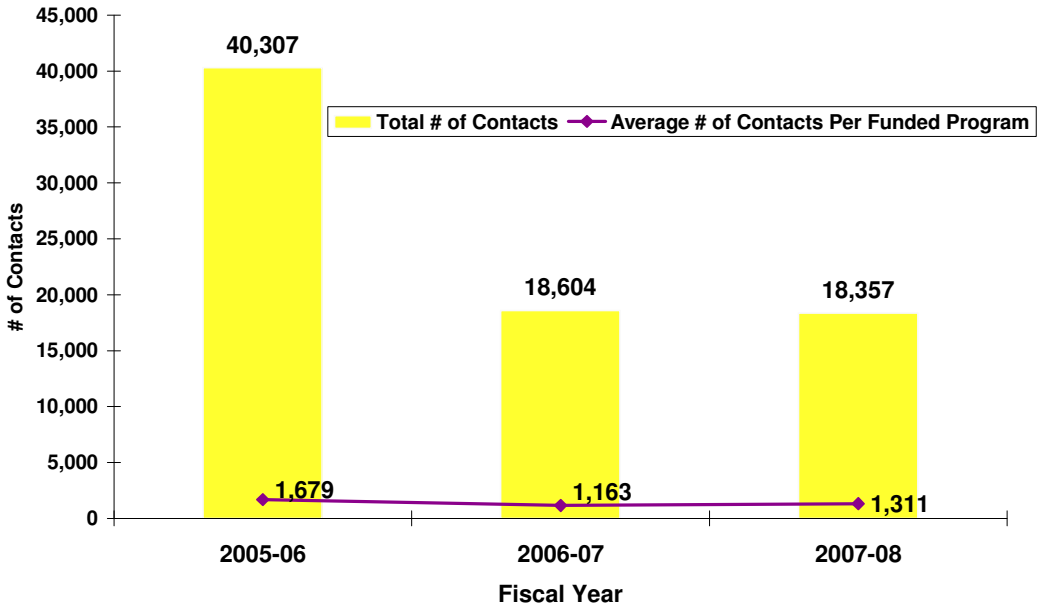
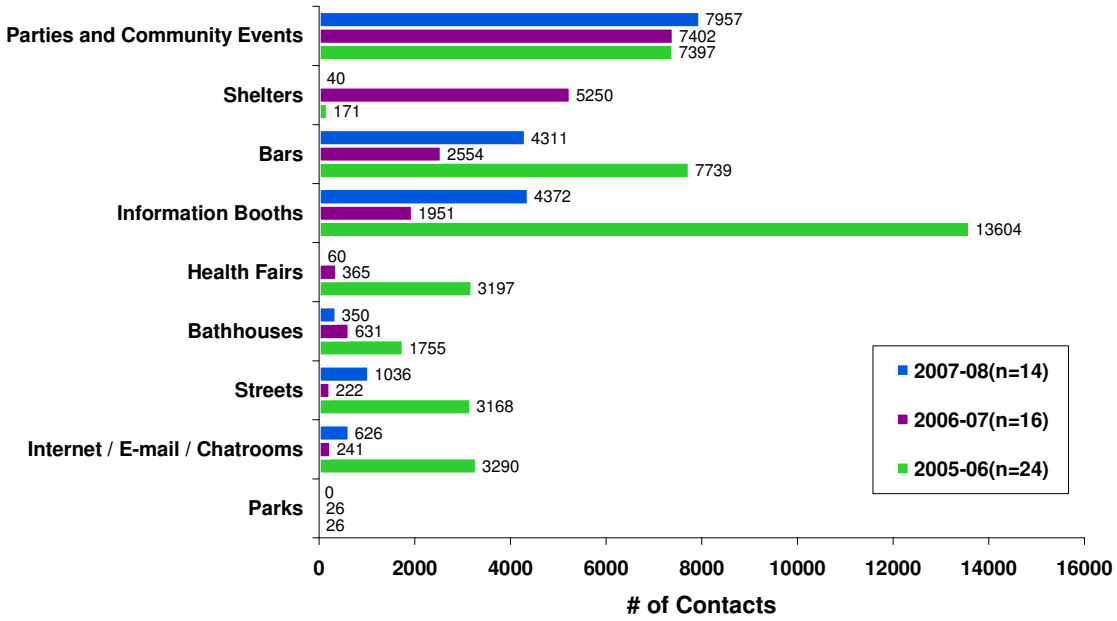


Figure 10.2b shows the location of ACAP-funded outreach activities over the past three years as well as the number of contacts in each location. The significant drop in the number of outreach contacts in shelters in the most recent year is due to the fact that a shelter program funded in 2006-07 was not funded in 2007-08.

Given that about half as many programs were funded for outreach in 2007-08 as in 2005-06, the programs appear to be doing a good job of maintaining levels of bar, party and street outreach.

10.2b: ACAP Funded Organizations: Outreach Activity Contacts by Location



In total, funded programs exceeded their planned outreach contacts by 72%. The three programs that did not reach their target reported a number of limiting factors including: problems recruiting and training enough volunteers (particularly for bath outreach) and a strong police presence keeping men away from cruising areas. To address these problems, programs are advertising to increase peer volunteers and are working with other organizations to increase outreach.

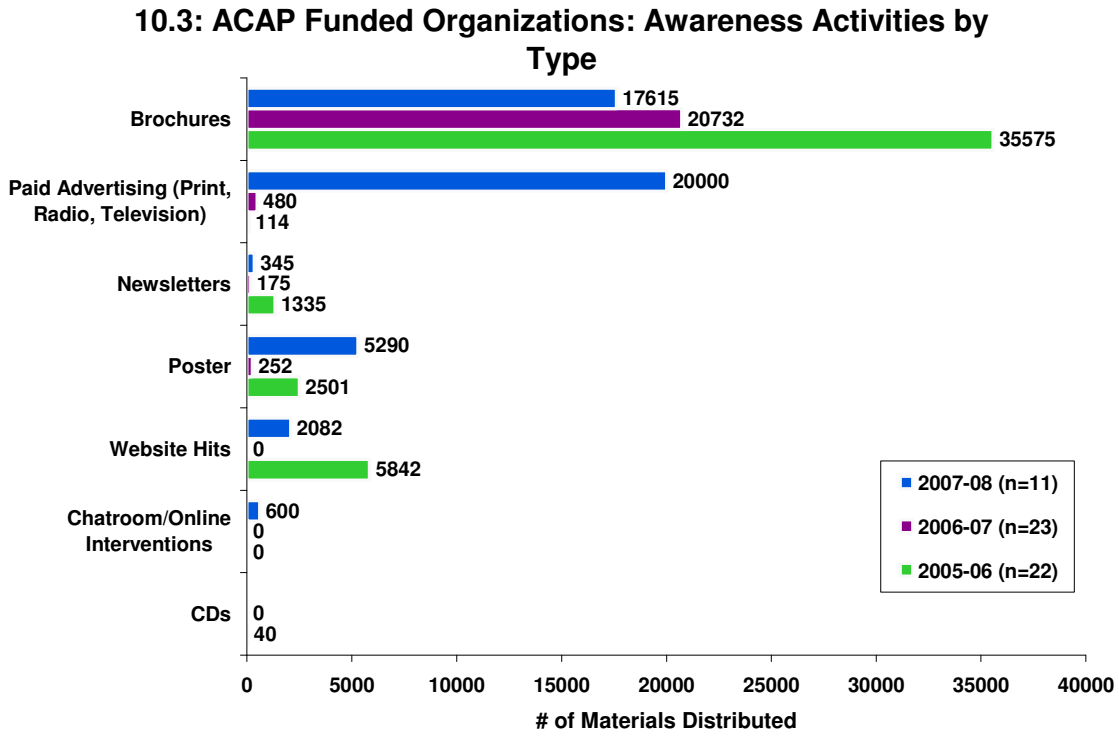
Awareness Focuses on Paid Advertising, Posters and Website

ACAP funded 11 programs for awareness activities in 2007-08 (down about 50% from the two previous years). The drop in the number of funded programs over the three-year period may explain the decrease in the number of brochures, website hits and newsletters.

In 2007-08, funded programs reported using ACAP funding primarily to support paid advertising, brochures and posters. The significant increase in paid advertising and posters was due primarily to the activities of one organization, which reported the circulation numbers for a publication rather than the number of ads. (Although OCHART now specifically asks organizations to indicate the number of newsletters, brochures and posters developed as well as the number distributed, organizations continue to confuse the two questions in their reporting – an issue that is being addressed in 2008-09 reporting).

One organization also reported a significant increase in online interventions, which are difficult to "count" – particularly with the increasing use of social networking sites, such as Facebook. As the organization noted, an e-blast on a social networking site might reach as many as 300 people, but there is no way to confirm that.

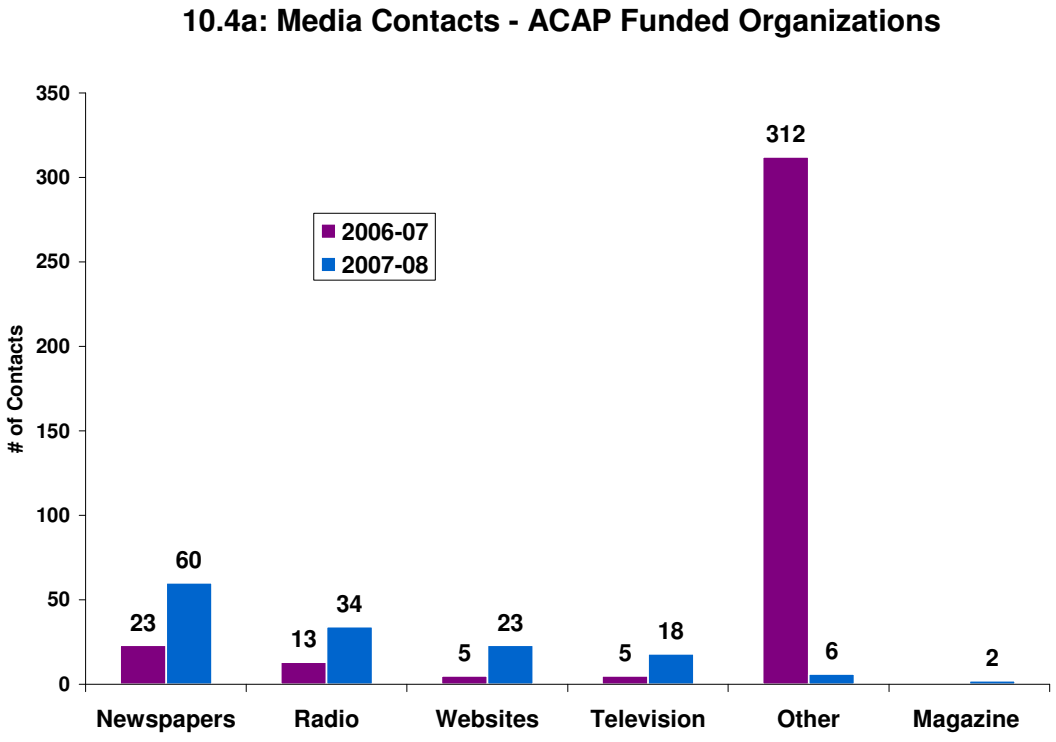
Compared to overall awareness campaigns and activities in 2007-08 (see Figure 10.3 in main OCHART report), ACAP funding supported a relatively small proportion: 9% of paid advertising, and 10% of brochures.



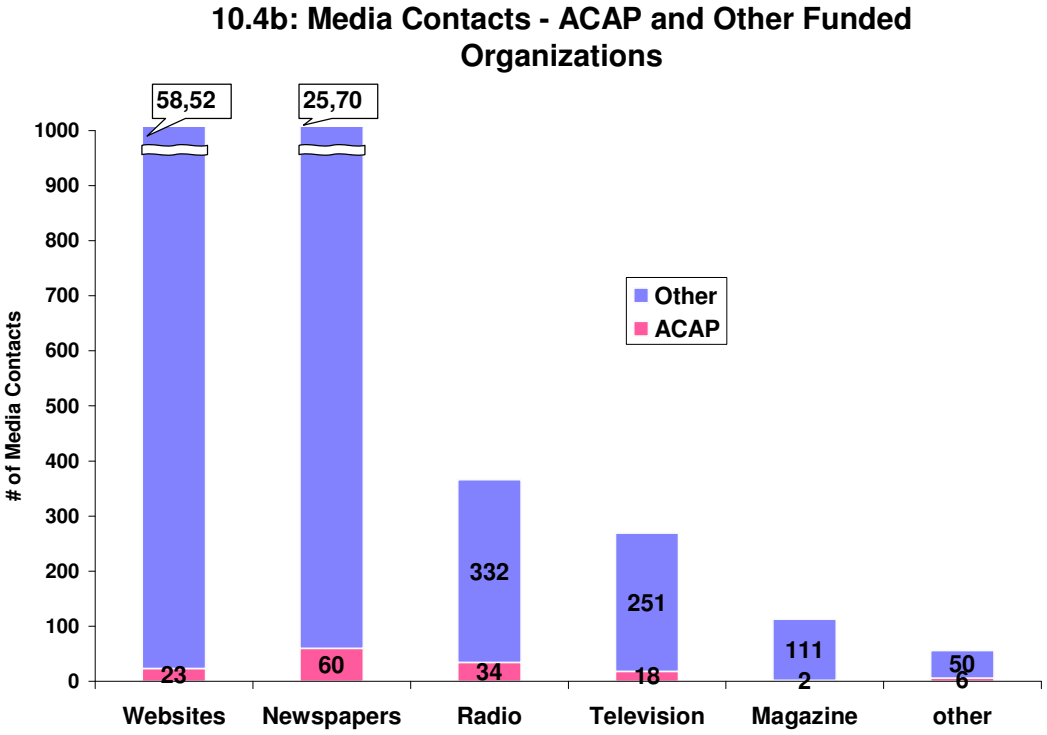
In total, ACAP-funded organizations far exceeded their targets for awareness activities, but nine programs fell short of their projected targets. Several reported that their planned campaigns had been delayed and were behind schedule. Some identified reporting errors due either to computer problems (making it impossible to predict or count web hits), or staff turnover and new workers being unaware of the need to track awareness activities (e.g., number of brochures distributed). In one case, the organization was able to fill all spaces in its program by word of mouth, so it was not necessary to advertise.

Traditional Media Contacts Up

Six ACAP-funded programs reported a total of 143 media contacts in 2007-08. Although that represents a drop from the 358 media contacts in 2006-07, it is almost twice as many as planned in their logic models – Of note: there was an increase in all media categories except “other”. It appears that programs are engaging in more active media strategies.

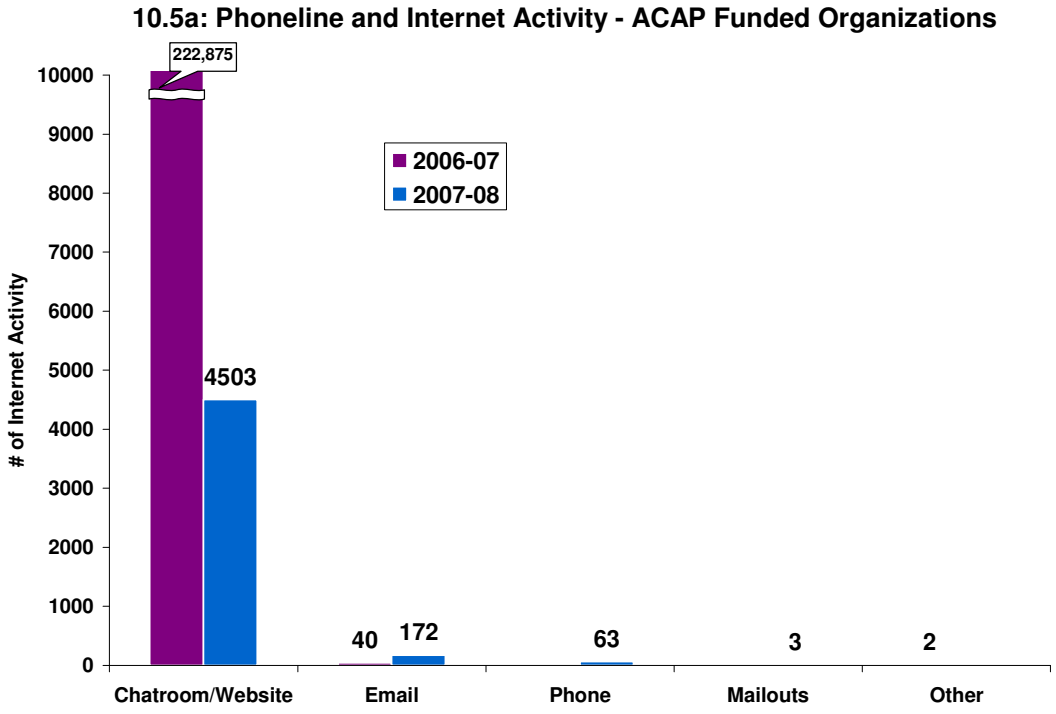


The higher number of "other" media contacts in 2006-07 may have been due to AIDS 2006 and/or reporting errors. ACAP funding accounts for a relatively small proportion of media contacts.

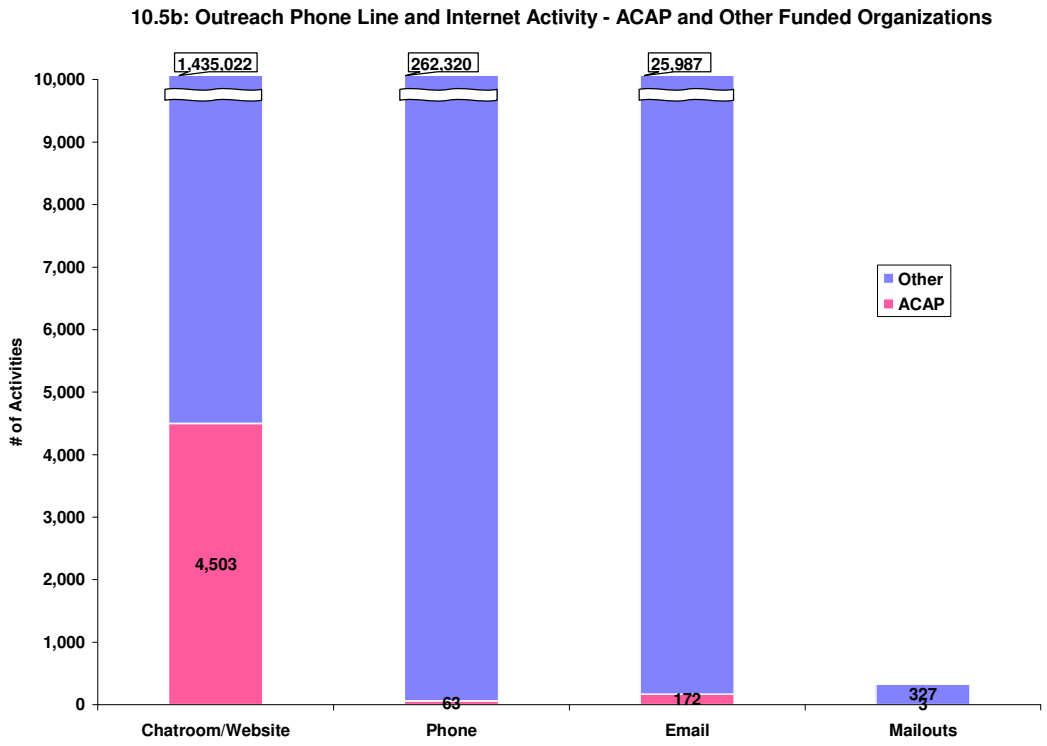


Website and Chatroom Activity Down But Exceeds Target

Nine programs received ACAP funding to support Phone and Internet outreach in 2007-08. Funding was used primarily to support chatroom, website and email contacts (Figure 10.5a). Although there was a drop in the number of chatroom/website contacts compared to the previous year, only three of the nine programs fell short of their targets, and the group as a whole exceeded their target by about one-third. The drop in chatroom activity between 2006-07 and 2007-08 was due to one program, which had accounted for the majority of the contacts in the previous year and – because of staff changes and the loss of a key outreach worker – had virtually no Internet outreach contacts in the current year. Another program reported having no trained volunteers to assist with chatroom and web outreach. The high number of contacts in 2006-07 was also likely an error in reporting.

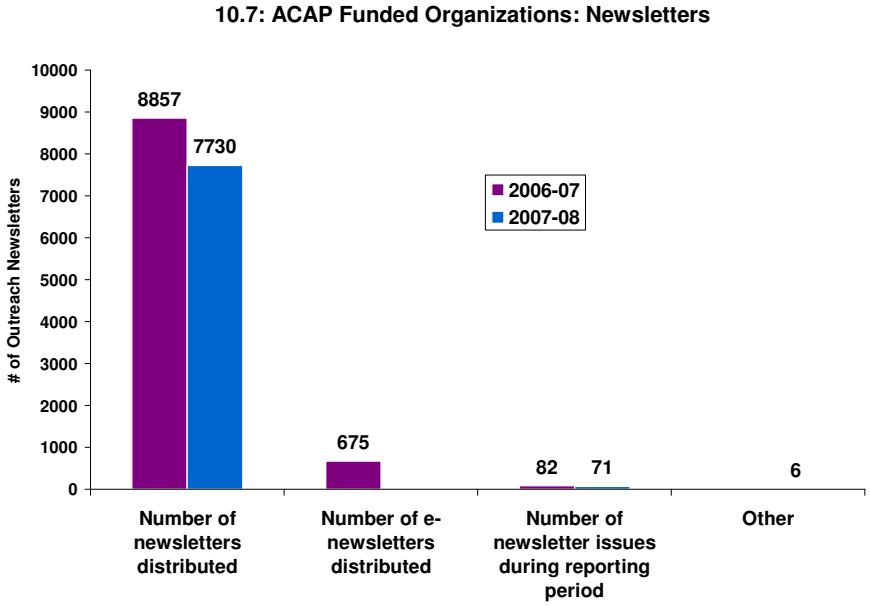


ACAP funding accounts for about 0.3% of total phone and Internet activity reported by all funded organizations (not including mailouts). (Note: scale of chart has been adjusted to compensate for the wide variations in numbers).



Fewer Newsletters

The 12 programs funded for newsletter outreach in 2007-08 produced 71 newsletter issues, and distributed 7730 newsletter in either hard copy or electronically. Six of the 12 fell short of their targets for newsletter outreach. The main reasons for the gap were staff turnover, reductions in the number of issues produced during the year and changes in format (a colour issue instead of two black and white issues).



ACAP-funded programs were responsible for just over 1% of the newsletter issues produced by all funded organizations in 2007-08 and 8% of the newsletters distributed.

2. Health Promotion for People with HIV/AIDS

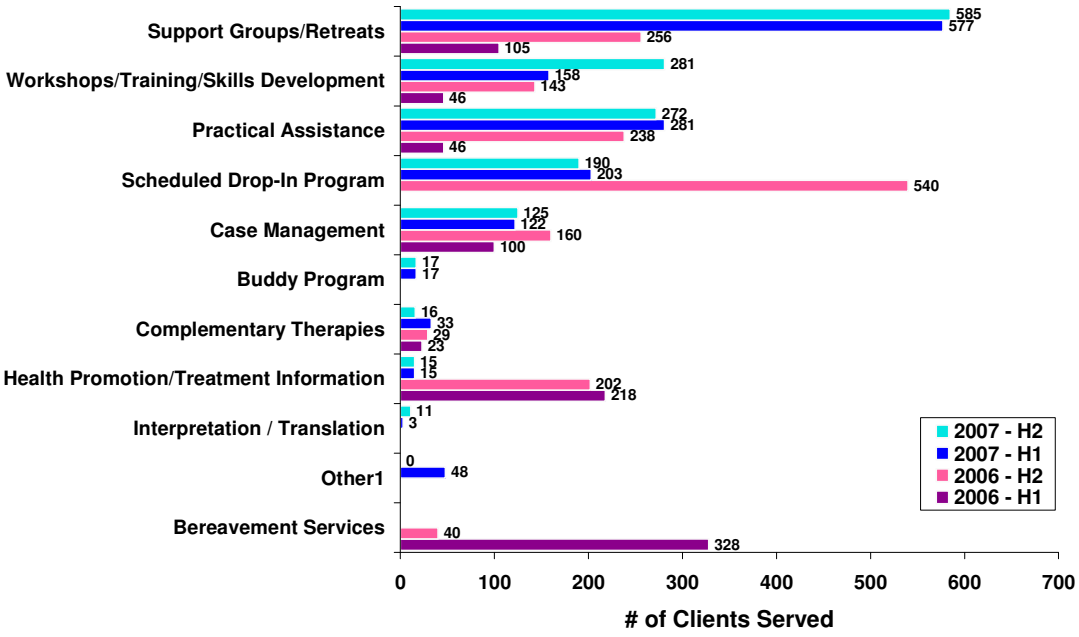
In 2007-08, ACAP funded 11 programs to provide health promotion programs for people with HIV (compared to 15 in 2006-07); however, a total of 15 programs reported using ACAP funding to provide support services to clients. This is due to the fact that some ACAP Funding Approaches overlap.

Number of Clients in Support Groups Increases +300%

In 2007-08, programs funded by ACAP to provide health promotion for people with HIV used that funding primarily to give more clients access to support groups and retreats, skills workshops and practical assistance. In fact, compared to the previous year, the number of clients who participated in ACAP-funded support groups and retreats more than tripled, the number who participated in skills workshops more than doubled, and almost twice as many clients received practical support. Fewer clients received drop-in and bereavement services, but that shift is mainly due to changes in two programs between the two years.

The categories of "buddy program" and "interpretation/translation" services were added in 2007-08 based on programs reporting an increased demand for these services.

11.2.1: Number of Clients Served by Type of Support Service and by Reporting Period - ACAP Funded Organizations

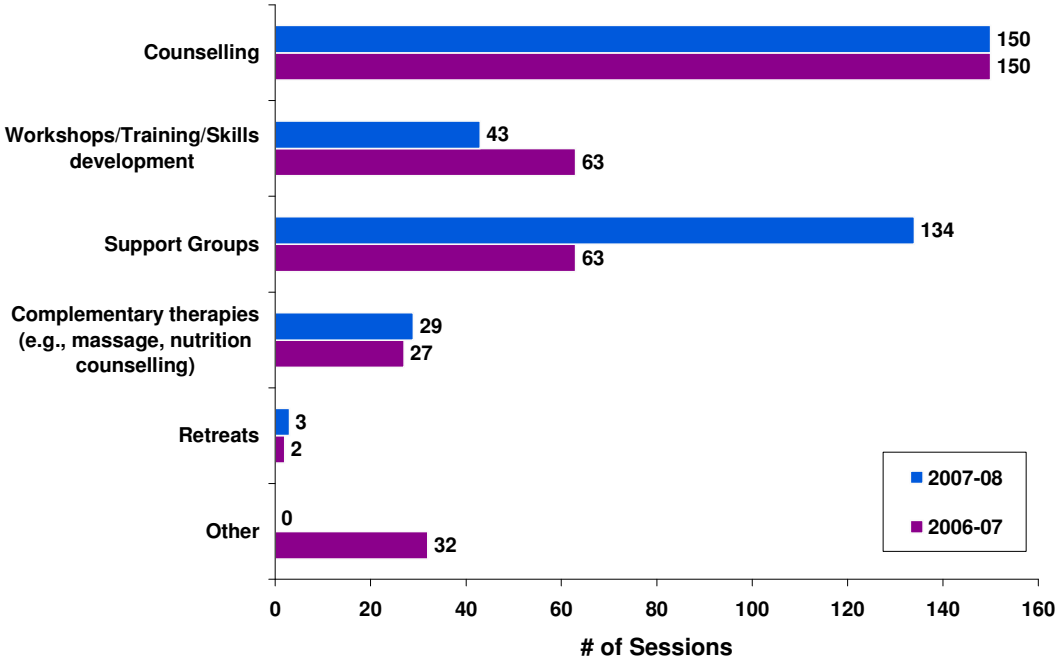


Seven of the 15 programs providing support services met or exceeded their logic model targets. The eight that did not identified the following reasons: lack of interest in the community (i.e., cancellations, no-shows); scheduling changes; aging of clients (i.e., not as much demand for youth programming); and lack of transportation.

More Support Groups

Figure 11.2.2 lists the number of sessions reported by the 11 programs that received ACAP funding in the Health Promotion for PHA approach. Over the two years, the number of sessions devoted to counselling and complementary therapies remained constant, the number devoted to skills training/workshops decreased, and the number to support groups more than doubled. (Note: in 2006-07, the "other" sessions were primarily monthly drop-in sessions for young people with HIV/AIDS and weekly ones for all individuals with HIV/AIDS offered by an agency that did not receive funding in 2007-08.)

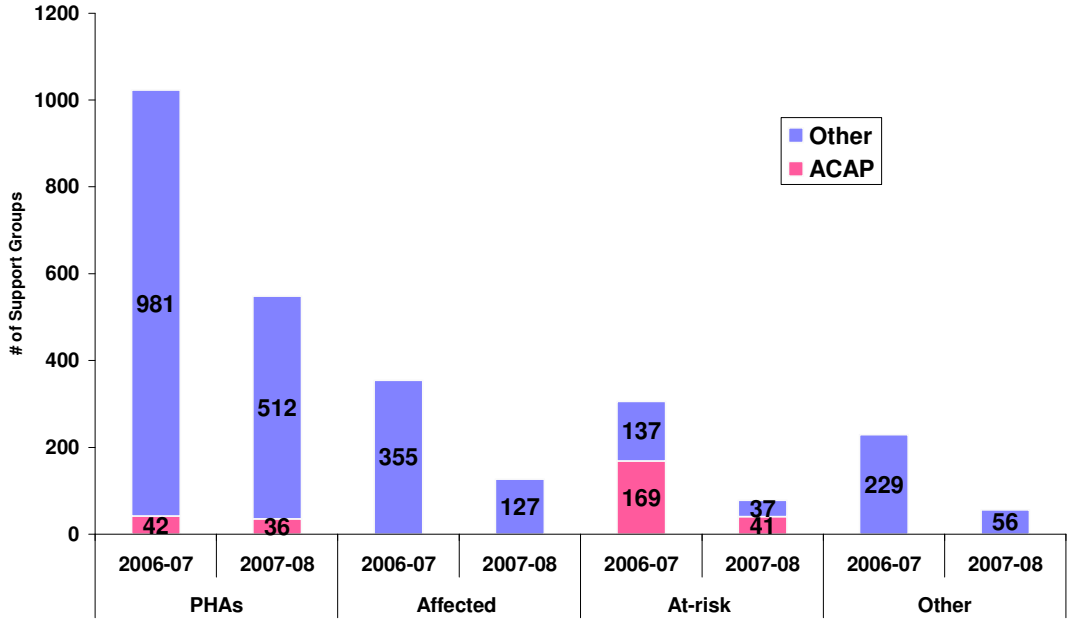
11.2.2: Sessions Provided by ACAP Funded Organizations



Despite a 25% drop in the number of funded programs, there was actually a slight (3%) increase in the number of sessions held in 2007-08. Six of the 11 programs met or exceeded their logic model targets for number of sessions. The five that did not reported the following limiting factors: inclement weather, lack of interest, staffing changes and scheduling changes.

ACAP funding accounted for 7% of the total number of support groups for PHAs and 53% of the groups for populations at risk provided by all funded organizations over the year.

11.3: Number of Support Groups Held – ACAP and Other Funded Organizations

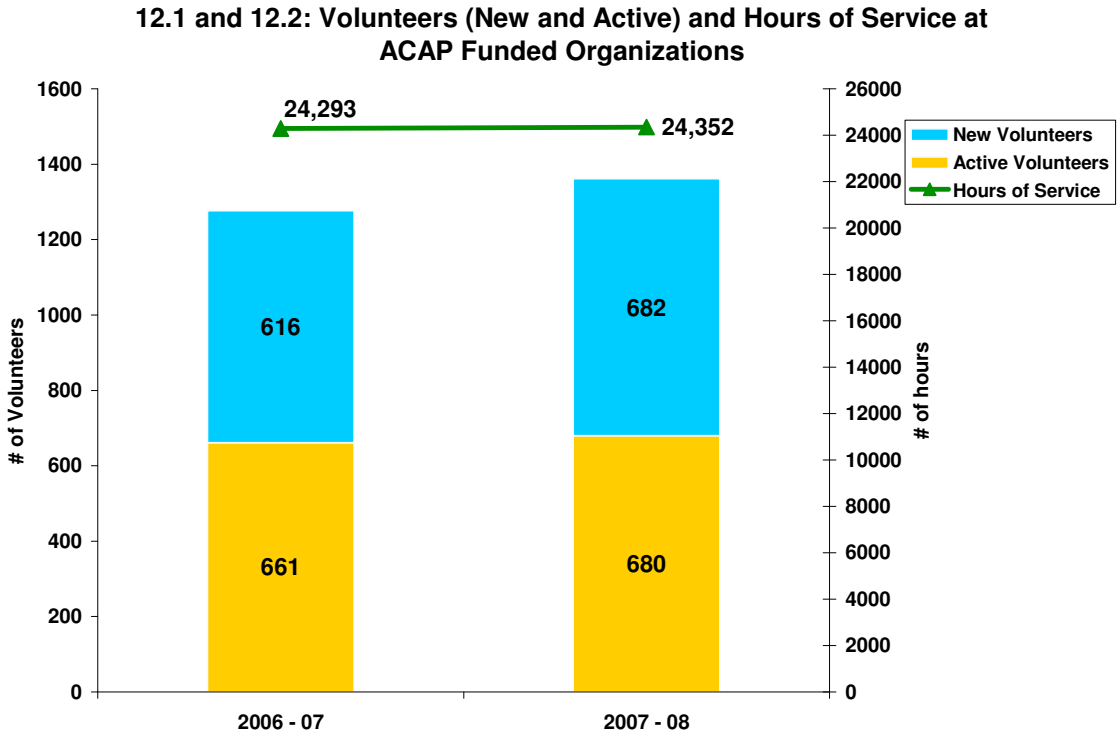


3. Strengthening Community-based Organizations

Number of Volunteers Increases

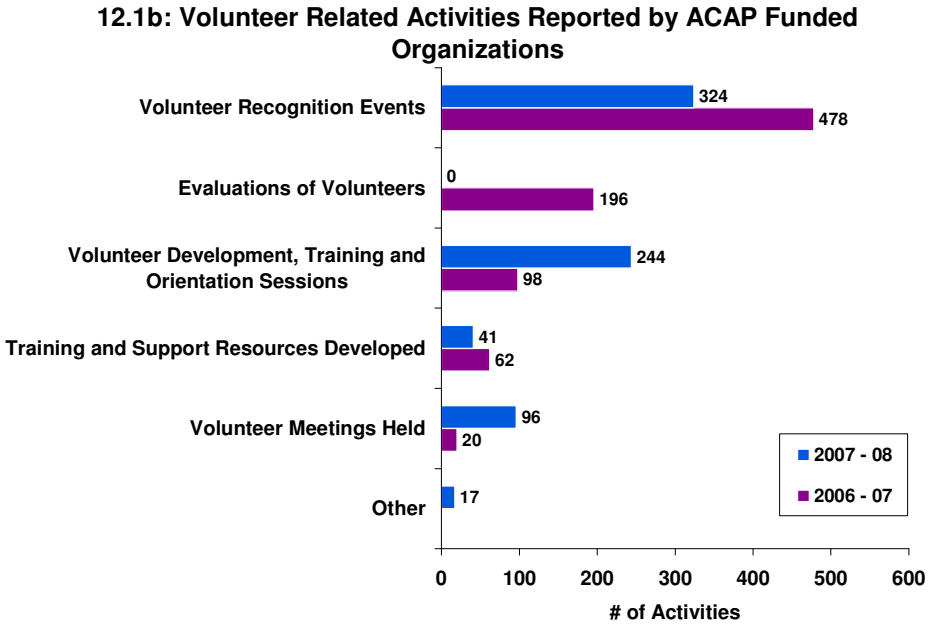
In 2007-08, ACAP provided funding for six volunteer programs. In addition, another 10 programs reported using ACAP funding to support volunteer activities. All 16 set targets for volunteer services, but only 13 reported data on new and active volunteers. Programs that did report had a total of 773 volunteers in the first half and 589 in the second half (compared to 709 and 568 in the previous year). It is encouraging to note that these programs were able to attract even more volunteers in 2007-08 than in 2006-07 when AIDS 2006 created a lot of interest and demand for volunteers. Over time, ACAP-funded organizations appear to maintain a solid core of active volunteers, while continuing to attract new ones – although a number did report lack of volunteers limiting their outreach efforts.

During 2007-08, volunteers in ACAP-funded programs and projects provided a total of 24,352 hours of services (compared to 24,282 in 2006-07) – or the equivalent of approximately 14 full-time staff.



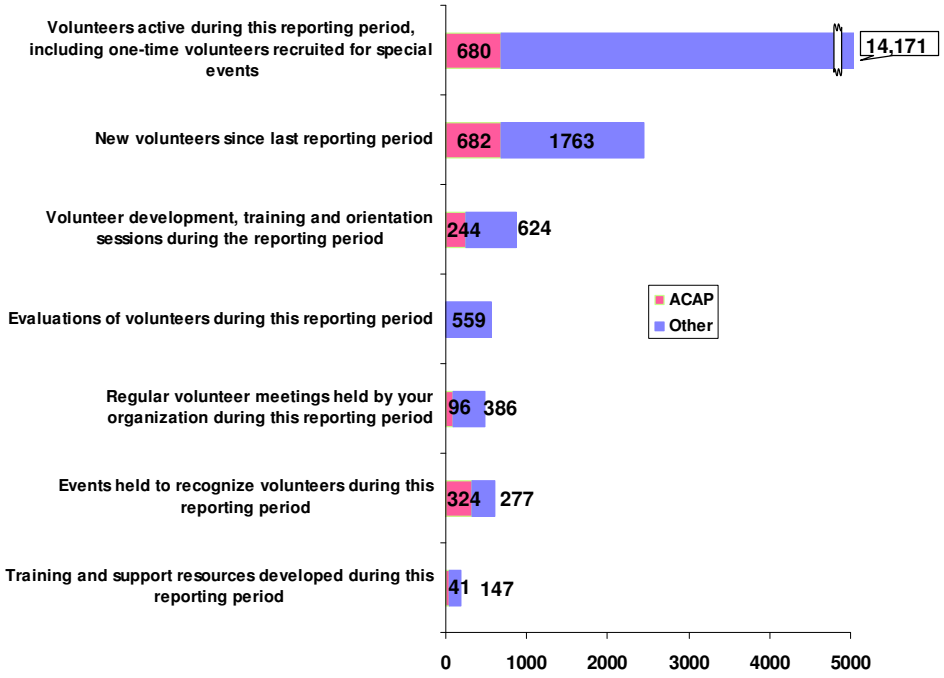
Fewer Volunteer Recognition Events, More Volunteer Training

ACAP-funded programs held fewer volunteer recognition events and completed fewer volunteer evaluations in 2007-08 than in the previous year, but they provided more volunteer training and held more volunteer meetings. Programs that did not meet their targets for volunteer evaluation and recognition reported problems such as staff illness, volunteer coordinator leaving, low registration and scheduling changes.

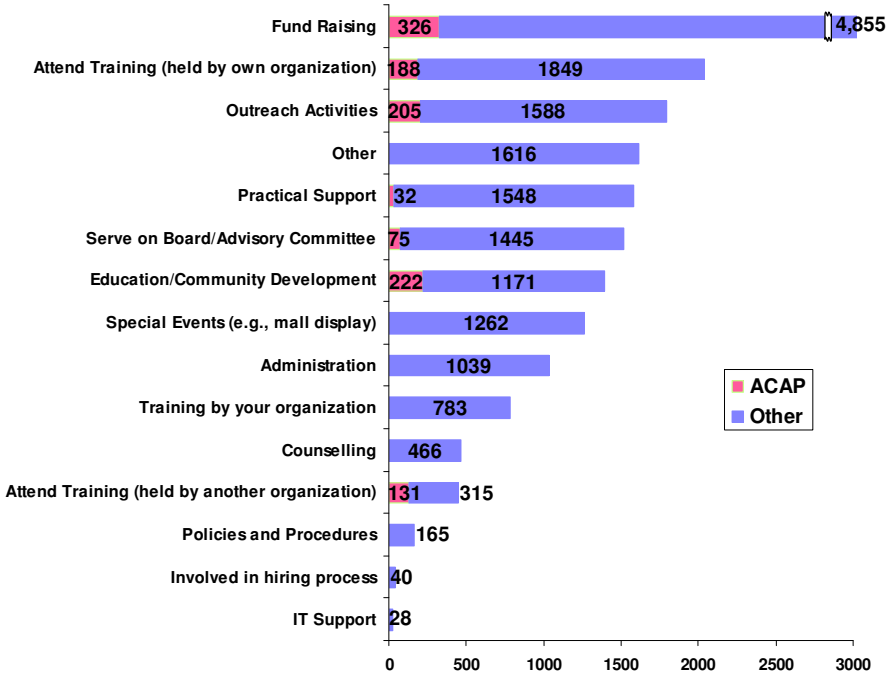


The following figures illustrate the impact of ACAP funding on total volunteer activities in the sector. ACAP funded organizations recruited over one-quarter of new volunteers.

12.1c: Volunteer Management - ACAP and Other Funded Organizations

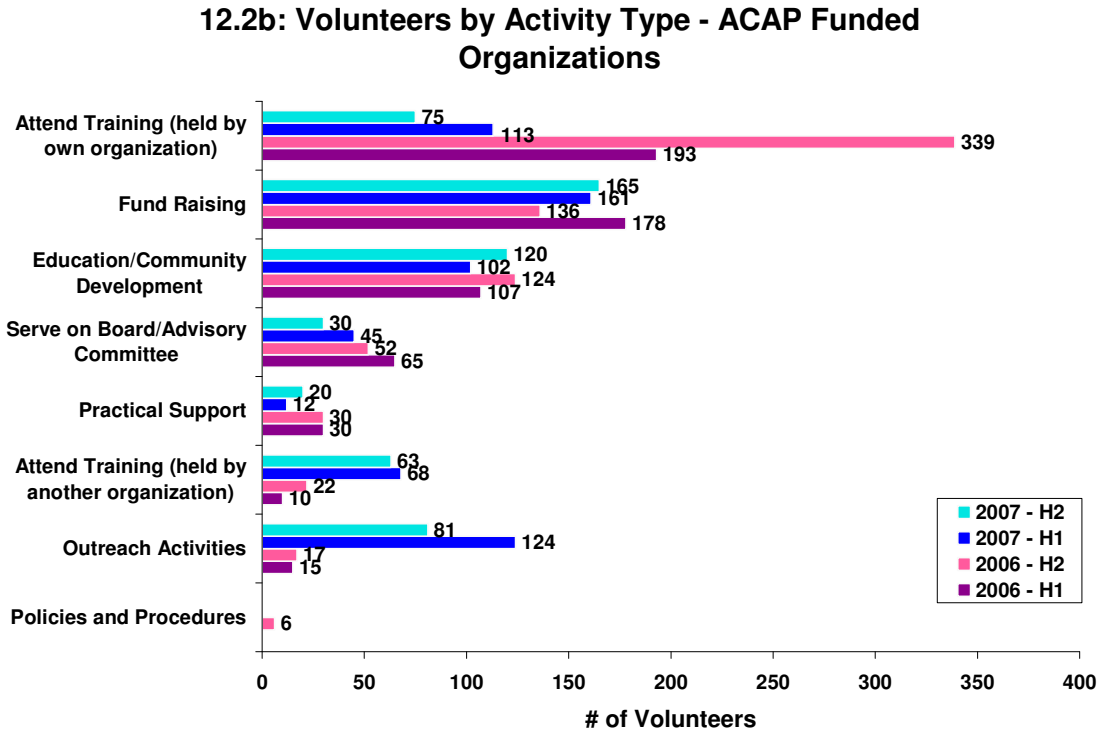


12.2a: Volunteer Activities - ACAP and Other Funded Organizations



More Volunteers Involved in Outreach

In 2007-08, there was a change in how volunteers were being used. Significantly more were involved in delivering outreach services than in the previous year. Volunteers continued to play a key role in fundraising, education and community development. Fewer were involved in training held by the AIDS organization and more were involved in training with other organizations.

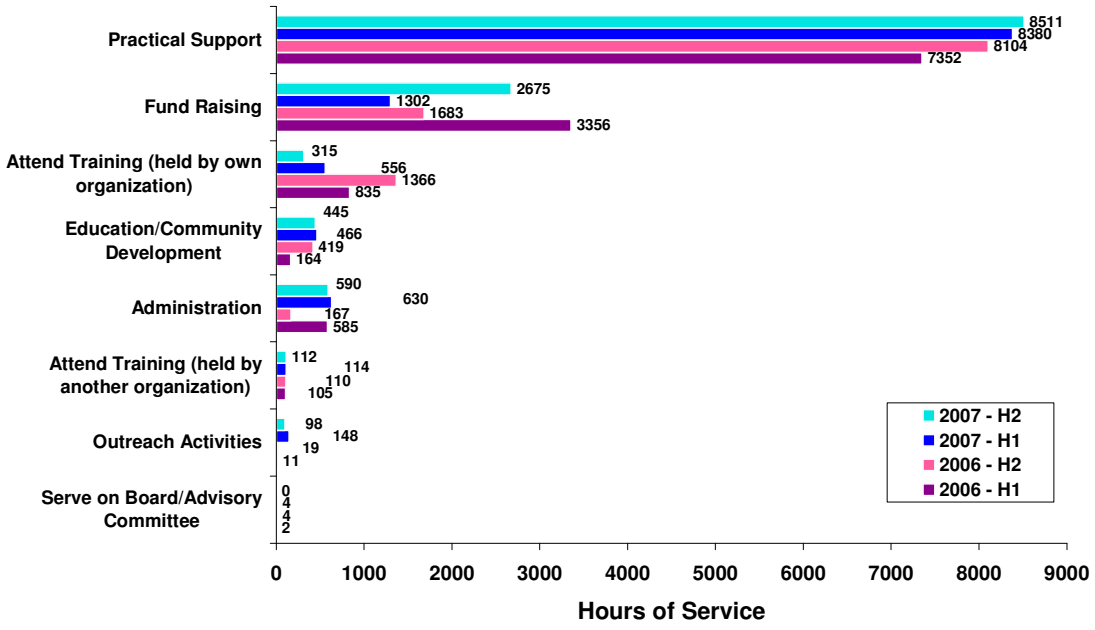


Six programs met or exceeded their targets for volunteer services. Those that did not reported limitations such as problems recruiting volunteers for particular tasks/roles, and scheduling changes that reduced the need for volunteers.

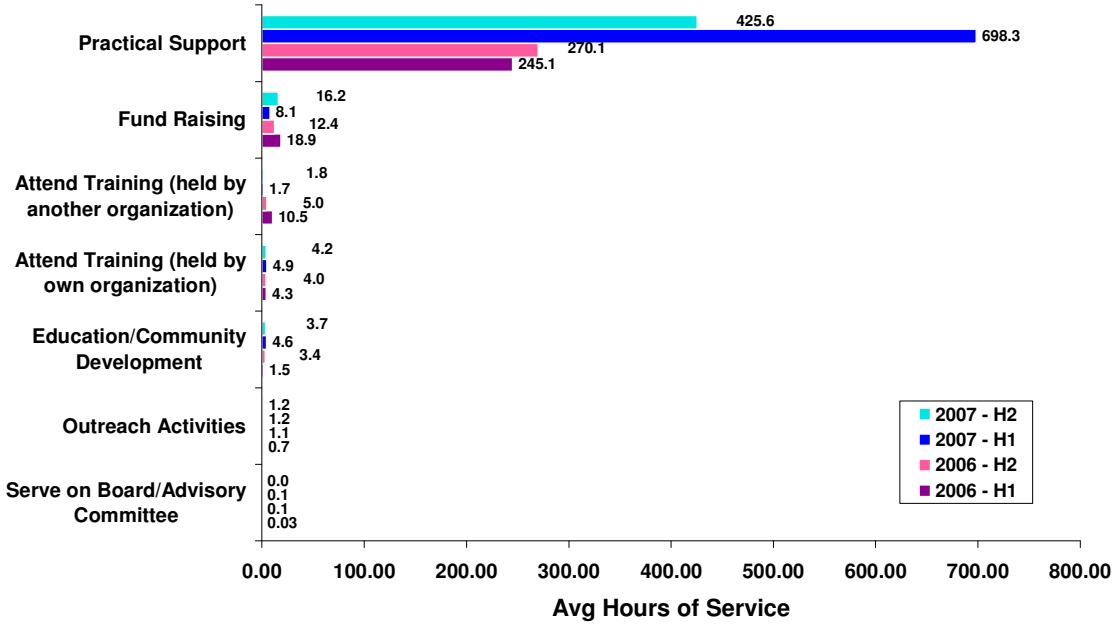
More Hours Devoted to Practical Support

The data showed the same trend in terms of volunteer intensity in 2007-08 as in 2006-07: the relatively small number of people who volunteer to assist with practical support provide significantly more volunteer hours than those who volunteer for fundraising or education: on average about 425 hours each every six months, compared to about 16 hours provided by each fundraising volunteer, and 3.7 hours by each education and community development volunteer.

12.2c: Hours of Volunteer Service by Activity Type - ACAP Funded Organizations



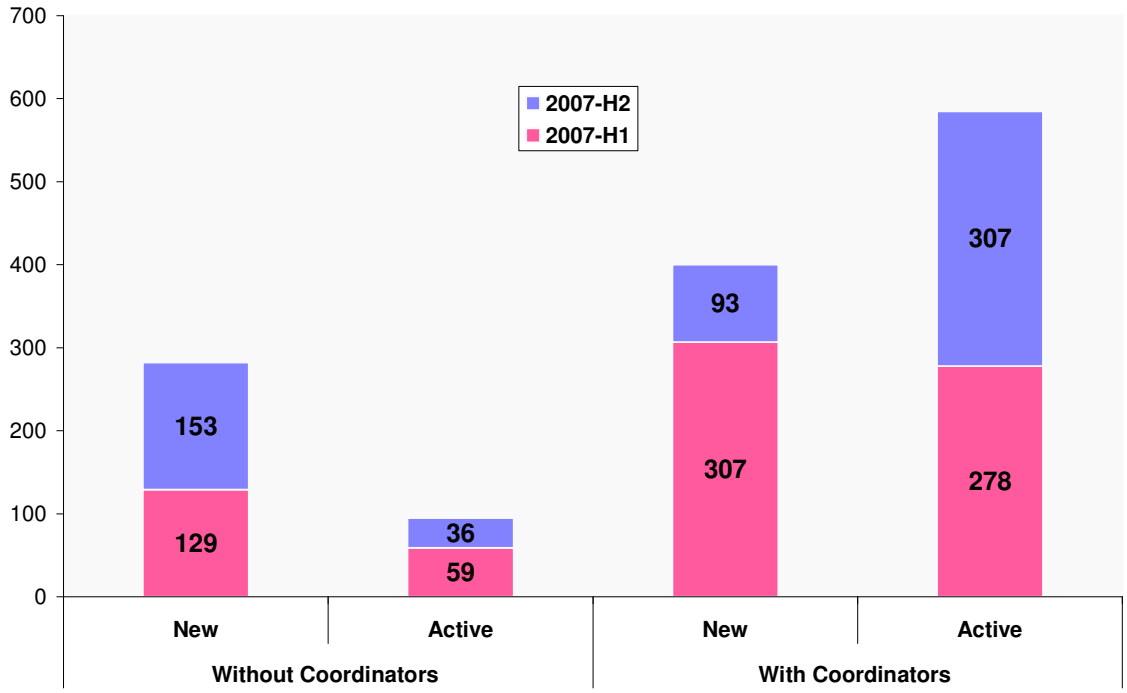
12.2d: Average Hours of Service per Volunteer by Activity - ACAP Funded Organizations



Volunteer Coordinators Influence Volume of Volunteer Activities

During 2007-08, ACAP funded four unique volunteer coordinators within organizations. According to OCHART data, funded volunteer coordinator positions result in an increase in volunteer activity. The programs that have funding for coordinator positions reported significantly more volunteers and volunteer activity than programs not funded for a coordinator (see Figure 12.1d).

12.1d: Number of Volunteers in Organizations With and Without a Volunteer Coordinator (2007-08)



ACAP Operational Programs

PREVENTION INITIATIVES

Program Number	Program Title	Agency Sponsor
6963-06-2002/2370431	Prison In-Reach Project	Prisoners With HIV/AIDS Support Action Network
6963-06-2002/2370438	Healthy Sexuality Program	ACCESS AIDS Network
6963-06-2002/2370445	HIV Prevention Services for Gay, Bisexual and MSM	AIDS Committee of London
6963-06-2002/4480430	PARN HIV Education Program - Building Our Community Response	Peterborough AIDS Resource Network
6963-06-2002/4480432	Prevention & Education Program	HIV/AIDS Regional Services
6963-06-2002/4480434	Community HIV Prevention and Education Program	AIDS Niagara
6963-06-2002/4480438	HIV Education Services Program	AIDS Committee of North Bay and Area
6963-06-2002/2370437	Community Education and Prevention Program	Access AIDS Network
6963-06-2002/2370442	Gay Men's Health and Wellness Project	AIDS Committee of Ottawa
6963-06-2002/4480433	Community Education Program	AIDS Committee of Cambridge, Kitchener, Waterloo and Area
6963-06-2002/4480444	Wellington & Grey-Bruce Rural Prevention/ Outreach Program	AIDS Committee of Guelph and Wellington County

HEALTH PROMOTION FOR PHAs

Program Number	Program Title	Agency Sponsor
6963-06-2002/2370428	Peer Network Community Collaboration Program	Voices of Positive Women
6963-06-2002/2370434	Ontario AIDS Network PHA Program	Ontario AIDS Network
6963-06-2002/2370441	VIVER: Portuguese-Speaking Community Development	Sponsored by AIDS Committee of Toronto
6963-06-2002/2370446	Health Promotion for PHAs	AIDS Committee of Toronto
6963-06-2002/2370447	Positive Youth Outreach: Health Promotion and Outreach to HIV-Positive Youth	Sponsored by AIDS Committee of Toronto
6963-06-2002/4480433	South Asian PHA Program/Volunteer Program	Alliance for South Asian AIDS Prevention
6963-06-2002/4480435	Food For Life	Sponsored by Toronto People with AIDS Foundation
6963-06-2002/4480445	Enhancing Healthy Options Program (EHOP)	AIDS Thunder Bay
6963-06-2002/2370435	PHA Resource Program	Hamilton AIDS Network
6963-06-2002/2370436	Health Promotion for People living with and Affected by HIV/AIDS	Peel HIV/AIDS Network
6963-06-2004/4480463	VIVER: Portuguese-Speaking Case Management	Sponsored by the AIDS Committee of Toronto

STRENGTHENING COMMUNITY-BASED AIDS ORGANIZATIONS

Program Number	Program Title	Agency Sponsor
6963-06-2002/2370432	Creating and Sustaining Healthy and Effective Communities / Volunteer Development Program	Asian Community AIDS Services
6963-06-2002/2370440	Volunteer Support Program	Bruce House
6963-06-2002/2370444	Ontario Organizational Development Program	Sponsored by AIDS Committee of London
6963-06-2002/4480431	Fife House Volunteer Services	Fife House
6963-06-2002/4480433	South Asian PHA Program/Volunteer Program	Alliance for South Asian AIDS Prevention
6963-06-2002/4480437	Volunteer Program	Toronto People with AIDS Foundation
6963-06-2002/4480449	Volunteer Support Program	The Teresa Group

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

ACAP Time-Limited Projects
2007 - 2008

Program Number	Program Title	Agency Sponsor
6963-06-2007/6420466	Black PHA Prevention Project	Black Coalition for AIDS Prevention
6963-06-2007/6420468	« SIDA : Ulbuntu / Komipesa / Angajmant Kominoté / Engagement communautaire »	Centre francophone de Toronto
6963-06-2007/6420470	Operation Hairspray Phase2 : HIV/AIDS Prevention in Ottawa's African and Caribbean Communities	Somerset West Community Health Centre
6963-06-2007/8890459	« Despierta Comunidad Latina » Raising Awareness among HIV+ and – Men (Gay, Bisexual and MSM)	Centre for Spanish Speaking Peoples

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

Appendix A: Alphabetical List of Funded Organizations

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

Centre Francophone de Toronto	Toronto Central	Toronto
City of Ottawa Public Health	Champlain	Ottawa
Family Service Association of Toronto	Toronto Central	Toronto
Fife House	Toronto Central (Provincial)	Provincial
Fife House – OHSUTP	Toronto Central	Toronto
Hamilton AIDS Network	Hamilton Niagara Haldimand Brant	Central West
Hassle Free Clinic	Toronto Central	Toronto
Hamilton Public Health & Community Services	Hamilton Niagara Haldimand Brant	Central West
Hemophilia Ontario	Toronto Central (Provincial)	Provincial
HIV & AIDS Legal Clinic (Ontario)	Toronto Central (Provincial)	Provincial
HIV/AIDS Regional Services	South East	Eastern
Hospice Toronto	Toronto Central	Toronto
Kingston Community Health Centres, Street Health Centre	South East	Eastern
LOFT Community Services	Toronto Central	Toronto
Maggie's: The Toronto Prostitutes' Community Service Project	Toronto Central	Toronto
New Heights Community Health Centre	Toronto Central	Toronto
Nishnawbe Aski Nation	North West	Northern
Ontario Association of the Deaf, Deaf Outreach Program	Toronto Central (Provincial)	Provincial
Ontario Aboriginal HIV/AIDS Strategy	Toronto Central (Provincial)	Provincial
Ontario AIDS Network	Toronto Central (Provincial)	Provincial
Ontario Organizational Development Program	Toronto Central (Provincial)	Provincial
Ottawa Public Health	Champlain	Ottawa
PASAN (Prisoners with HIV/AIDS Support Action Network)	Toronto Central (Provincial)	Provincial
Peel HIV/AIDS Network Inc.	Central West / Mississauga Halton	Central West
Peterborough AIDS Resource Network	Central East	Central East
Regent Park Community Health Centre	Toronto Central	Toronto
Somerset West Community Health Centre	Champlain	Ottawa
South Riverdale Community Health Centre	Toronto Central	Toronto
St. Stephen's Community House	Toronto Central	Toronto
Sudbury Action Centre For Youth	North East	Northern
Syme-Woolner Neighbourhood and Family Centre	Central	Central
The Teresa Group	Toronto Central	Toronto
The Works, City of Toronto Public Health	Toronto Central	Toronto
Toronto People With AIDS Foundation	Toronto Central	Toronto
Union of Ontario Indians	North East	Northern
Voices of Positive Women	Toronto Central (Provincial)	Provincial

Warden Woods Community Centre	Central East	Central East
Wassay Gezhig Na Nahn Dah We Igamig	North West	Northern
Women's Health in Women's Hands	Toronto Central	Toronto
Youth Services Bureau of Ottawa	Champlain	Ottawa
YOUTHLINK Inner City	Central East	Central East

* Note that for the purposes of this report, “Provincial” was added as both a LHIN and Region to distinguish data between organizations mandated to serve the entire province (or country in the case of CATIE) and those mandated to serve a specific area of Ontario.

** Note that there were six organizations who reported during the period covered in the report (2005 to 2007-08) that either no longer exist or are no longer funded. Their historical data has been included/maintained in order to reflect actual activity.