Building Bridges:

an analysis and summary of the HIV/AIDS community planning initiative in Ontario

AIDS Bureau
Ministry of Health and Long-Term Care
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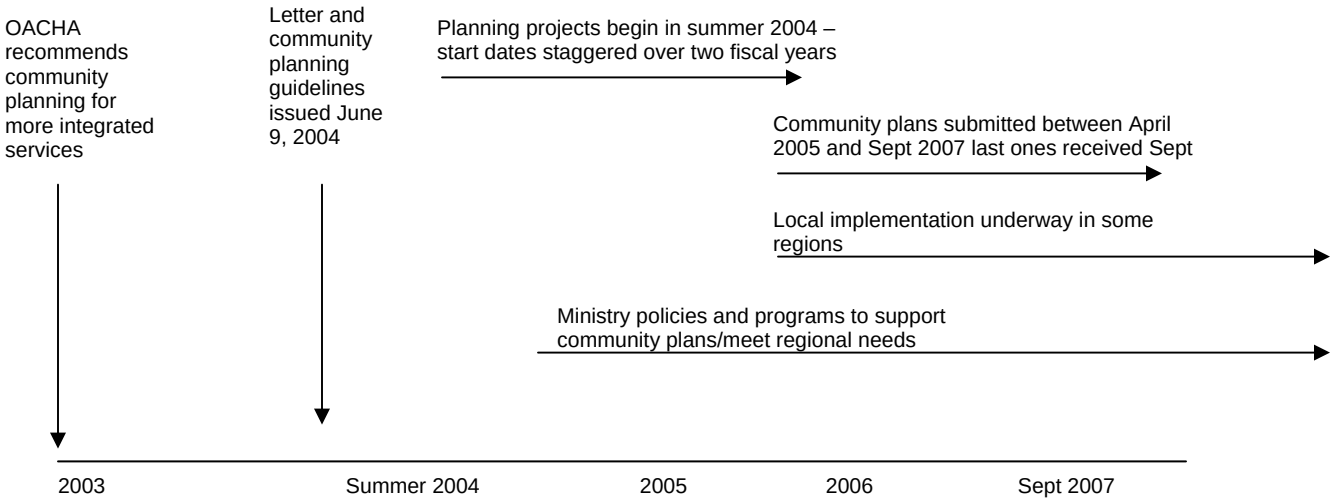
Preface

In June 2004, the AIDS Bureau of the Ministry of Health and Long-Term Care launched an initiative that asked all its funded community-based AIDS service organizations (ASOs) to engage other services in a community planning process designed to improve services for people with HIV and populations at risk. The process took three years from the time the AIDS Bureau issued the June 2004 letter announcing the community planning initiative until the last community plans were submitted in September 2007.



This report summarizes the three-year process, and suggests ways to maintain the momentum. The report includes:

- a summary of key lessons learned
- an overall summary and analysis of the AIDS Bureau community planning initiative, including key findings, common issues or unmet needs identified in a number of different plans, needs distinct to one or two regions, and descriptions of some of the innovative ideas from the plans. The analysis also includes a brief summary of the evaluation results and the next steps, including some of the AIDS Bureau initiatives that support recommendations in the community plans.
- a 2-3 page summary of key information from each community planning report, including the key regional factors driving the plan, the region's proposed approach to integrating services, evaluation results, and any recommendations to the Ministry of Health and Long-Term Care.

Lessons Learned

The key lessons learned from the community planning initiative are:

1. **The community planning process itself was a valuable exercise.**
2. **It was most effective in communities that already have a track record of collaborative planning/service delivery.**
3. **Integrated service planning is easier when all organizations share a common "client".**
4. **Eleven of the 12 reports included plans to either maintain an inter-agency planning group or develop an ongoing planning/information sharing group**.
5. **It may be easier to engage other services in serving people with HIV on an issue-by-issue basis rather than as part of a large ongoing planning group.**
6. **Regions have a better understanding of local needs and resources**.
7. **The process gave the AIDS Bureau a clearer view of service delivery issues throughout the province.**
8. **Community-based AIDS Service organizations are not necessarily aware of the role of provincial organizations or how to work with them.**
9. **The capacity of agencies to deliver on the plans depends, in part, on provincial policies and resources.**
10. **Developing collaborative relationships and integrated services takes time and commitment.**
11. **Funding for community planning was a key success factor.**

For More Information

If you would like more information about the Community Planning Initiative, please contact Joanne Lush, Program Supervisor, at the AIDS Bureau via email: **joanne.lush@ontario.ca**

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Overall Analysis

Background

People living with or at risk of HIV often have complex health and social needs, including substance use and mental health issues, co-infection with hepatitis C or other sexually transmitted diseases, low incomes, and problems finding and maintaining employment and appropriate affordable housing. Many of these needs are beyond the scope or expertise of provincially-funded HIV-specific services, such as community-based AIDS service organizations and HIV clinics. Many people living with or at risk of HIV also come from marginalized groups (e.g., gay men, injection drug users, people from African and Caribbean countries where HIV is endemic, and Aboriginal people) and, because of the stigma and marginalization, may have difficulty accessing the health and social services they need.

Ontario's HIV/AIDS Goals

1. Prevent the spread of HIV
2. Improve the health and well-being of people with HIV and their communities

To help meet the complex needs of people living with or at risk of HIV, the Ontario Provincial Strategy on HIV/AIDS (June 2002) recommended that the province "foster leadership for an integrated approach to HIV prevention, support, care and treatment based on the determinants of health" and "develop effective partnerships and identify opportunities to integrate services to provide more comprehensive, effective care and support … [using] a social justice approach designed to reduce inequities and influence the determinants of health."

Because the HIV epidemic is different in different parts of the province – as are the services available – the AIDS Bureau determined that each region should have the opportunity to develop strategies and plans that respond to local needs. In the fall of 2004, the AIDS Bureau identified 12 community planning regions and asked organizations within those regions to participate in a community planning process. The community planning was done in phases: various regions began in December 2004; others not until April 2005. [After the process began, the AIDS Bureau was approached by organizations with a provincial mandate to establish a provincial planning process.] The AIDS Bureau identified two individuals within each region to champion the planning process (based on nominations from the community) and provided funding to support the community planning process.

In 2005, the AIDS Bureau also asked the agencies with a provincial mandate to undertake a similar planning process.

The goals of the community and provincial plans are to:

- develop a community HIV/AIDS strategy that responds to local needs and reflects provincial goals and directions
- improve access to and co-ordination of services for people living with HIV and populations at risk
- provide more integrated, comprehensive, effective, efficient care and support services
- develop innovative service delivery models.

In addition, the provincial plan is designed to foster and strengthen communities and influence provincial policies.

This report is an analysis and summary of the community plans submitted by the 12 planning regions (see box), as well as the plan prepared by provincial organizations. It also includes the results of an evaluation of the community planning process which was conducted in 10/12 regions.

Community plans included in this report:

Algoma, Cochrane, Manitoulin and Sudbury

Champlain (Ottawa)

Durham, Haliburton, Kawartha and Pine Ridge

Halton, Peel, Simcoe, York

Hamilton, Niagara, Brant, Haldimand and Norfolk

Muskoka, Nipissing, Parry Sound and Timiskaming

Northwestern Ontario

Quinte, Kingston, Rideau (Southeastern Ontario

Thames Valley, Huron, Lambton and Perth (Southwestern Ontario)

Toronto

Waterloo, Wellington, Dufferin and Grey-Bruce

Windsor

Provincial Organizations – [added during process]

Lessons Learned

1. The community planning process itself was a valuable exercise. It brought groups together, raised awareness of HIV among a wide range of health and social agencies, and helped community-based AIDS organizations reinforce and build relationships with other service providers in their communities. As one report noted:

The collaborative community planning process is an effective and meaningful approach to addressing local and regional health care needs. It also encourages and engages participation of a wide range of stakeholders across services, municipalities, communities, organizations and causes. Establishing shared, integrated goals and objectives, and increasing collaboration will present great opportunities to enhance the delivery of HIV/AIDS programs and services. Opportunities exist to enhance current services; to develop and implement new, much needed HIV/AIDS and related care/support programs; and to hire additional human resources and professional services that otherwise would be unattainable by individual organizations and agencies. (Pozitive Living, Pozitive Lives, HIV/AIDS Community Plan, Southwestern Ontario)

At the provincial level, it encouraged networking among provincial organizations, helping them learn more about one another's work, and identify opportunities for collaboration.

2. The planning process was most effective in communities that already have a track record of collaborative planning/service delivery. Communities where AIDS service organizations have already developed effective working relationships with other organizations were able to go much farther with community planning. For example, they tended to involve a wider range of community services, be more successful in getting people to come to the table, be more willing to look at integrated service delivery models such as developing formal service agreements, co-locating services, sharing staff, developing one-stop integrated programs, and sharing resources to enhance services.

The communities that have effective working relationships with other agencies tend to be those with: fewer services over all (and therefore more need for collaboration), and well

established HIV/AIDS services with strong, experienced leaders. These communities tended to use more of a "community development/engagement" approach, bringing organizations together around the table; other communities relied more heavily on surveys of other organizations and did not engage them to the same extent.

3. Integrated service planning is easier when all organizations share a common "client". It appears to work best at the local level where all organizations are involved in direct, front-line service delivery. At the provincial level, organizations differ significantly in their mandate and focus.

4. Eleven of the 12 reports included plans to either maintain an inter-agency planning group or develop an ongoing planning/information sharing group. There is the potential that the community planning exercise will lead to ongoing inter-agency networking, collaboration and service integration.

5. It may be easier to engage other services on an issue-by-issue basis rather than as part of a large ongoing planning group. Other services are interested in being involved when they can make a difference. They appear to be more willing to collaborate to solve a particular problem or need (relevant to their own work), than to serve on an ongoing general planning committee.

6. Regions have a better understanding of local needs and resources. Because community planning involved an assessment of the local epidemic and needs, organizations now have a better understanding of the nature of the HIV epidemic in their area and the most urgent needs, as well as the resources available to meet those needs. Different regions have identified different priorities – particularly in terms of populations with unmet needs. This should lead to more effective programs and services.

7. The process gave the AIDS Bureau a clearer view of service delivery issues throughout the province. In urban centres, community-based agencies are working to develop the capacity to deliver culturally-sensitive programs that can meet the complex needs of highly diverse groups of clients. In smaller communities, community-based AIDS organizations are more dependent on other agencies to help them reach populations at risk and provide the comprehensive range of services required to meet their needs. The community plans help to highlight the challenges that many communities face, particularly in terms of distance from services, stigma, concerns about confidentiality and access to services.

8. Community-based agencies are not necessarily aware of the role of provincial organizations or how to work with them. Community organizations appreciate the services and expertise provided by provincial organizations, but many are unaware of the roles of provincial organizations or when/how to contact them, or they think provincial organizations primarily serve the Toronto area.

9. The capacity of agencies to deliver on the plans will depend on provincial policies and resources. The community planning initiative was not designed as a means to identify the need for more funding: communities were specifically asked to plan within existing resources and to look at how skills and resources within a community could be used differently to have a greater impact.

However, almost all plans identified the need for more resources in order to meet local HIV needs and/or implement some aspects of their plan. Many of the agencies involved in community planning are currently working to capacity. Their long-term commitment and ability to implement collaborative plans will depend to some extent on the direction they receive from the ministry that funds their programs, as well as on overall provincial support for some aspects of their plans. For example, a number of regions identified the need for public education and anti-stigma campaigns as well as efforts to promote testing. In their view, the AIDS Bureau can play a key role in working with other ministries and with other programs within the ministry to support collaborative initiatives. It can also develop provincial HIV education campaigns that communities can build on at the local level.

10. Funding for community planning was a key success factor. Building relationships with other services and agencies, and planning collaboratively takes time. Community-based AIDS organizations report they are working at full capacity – as are many other community-based services. The funding provided by the AIDS Bureau gave the lead agencies the flexibility to hire planners to assist with the process or to free up staff time for the task. Without funding, the planning processes would have been much less manageable and would have had a negative impact on agencies' willingness to participate and on agencies' ability to maintain front-line client services.

Common Themes

In terms of unmet needs and gaps in services, the following were identified fairly consistently in all plans:

- the impact of **stigma and discrimination**, and concerns about confidentiality on people's willingness to obtain prevention information, use harm reduction services, be tested, or to seek out services
- the impact of **geography and transportation issues**. Distance from services and the associated lack of public transportation or cost of transportation are major issues for people living with or at risk of HIV in smaller and rural communities. Services – particularly anonymous testing, needle exchange, primary care and specialist care – are not equitably available in all parts of the province, and communities do not have access to funds to subsidize transportation costs. Many communities highlighted the need to make more effective use of technology to improve access to services across the province.
- the lack of **primary care physicians**. Almost all regions identified problems finding primary care physicians knowledgeable enough to provide care for people living with HIV.
- **waiting lists** for mental health and addiction treatment services. Most communities reported long waits for these key services for their clients.
- the need for more comprehensive **HIV- and health-services for Aboriginal people.** Several parts of the province have large Aboriginal populations and feel they are not adequately addressing their needs. The ability to serve Aboriginal

peoples is complicated by the number of organizations with responsibility for health, including the federal government, Band Councils and the provincial government.

- the need for better access to needle exchange programs, testing and other **services for drug users**.
- the ongoing need for **population-specific prevention programs,** as well as **general education and awareness**. For example, a number of plans stressed the need for prevention and harm reduction services for youth, and a communications strategy that would ensure the public receives accurate HIV/AIDS information.
- the need for innovative integrated approaches to address the practical needs, and the **complex health and social needs** of people living with HIV and populations at risk.

Distinct Themes

Some issues were identified by only one or two communities but are listed here because they may be emerging issues that other areas will soon have to consider:

- the need for **better coordination of services** for people in the **correctional system**
- the need to develop a **continuum of care/housing services** to help people with HIV move from living independently to supportive housing to nursing home and/or palliative care (including long-term and palliative care for Aboriginal people)
- the need for easier access to specialized expertise, such as understanding **social assistance/disability programs, culturally-competent services**, and expertise/assistance in dealing with **legal issues and settlement issues**
- the need to develop services for people with **co-infections or concurrent disorders**
- the potential to use more **nurse practitioners** to enhance both primary and secondary care for people with HIV.
- the potential to make more innovative use of **satellite and outreach services** to improve access to services.
- continued high rates of **staff turnover** in all community-based social service organizations (including ASOs), and the negative impact this has on service continuity for clients.
- the need to **align HIV planning boundaries with LHIN boundaries**, and to link with LHIN planning processes.

Concrete Ideas

There were concrete ideas and/or issues identified for further exploration, such as:

- developing multi-service HIV/AIDS care organizations; co-locating services, particularly outreach workers/teams, and/or developing one access point for services
- establishing regional networks of comprehensive services
- developing a front-line/second-line approach to providing client services, in which ASOs provide front-line services while provincial organizations act as a second-line service, providing expertise, training and support when ASOs do not have the capacity or knowledge to meet a client's needs
- taking a more organized, coordinated approach to advocacy, in which provincial organizations take the leadership to develop policy papers and distribute key messages that all organizations can use
- restructuring or merging organizations
- using a common case management approach to clients
- sharing infrastructure and expertise (e.g., sharing or seconding staff between agencies, shared payroll)
- making changes to physical space to make services more accessible and user-friendly
- extending hours of service
- making more effective use of a wider range of skills (e.g., nurse practitioners)
- making more effective use of technology, particularly the Internet to share information, and deliver education, training and some programs and services
- establishing a multi-sectoral planning and implementation committee (i.e., ASOs and other social/health organizations and programs)
- establishing steering committees to supervise working groups responsible for specific tasks (e.g., housing, inter-agency staff training, infrastructural development)

Evaluation of Community Planning

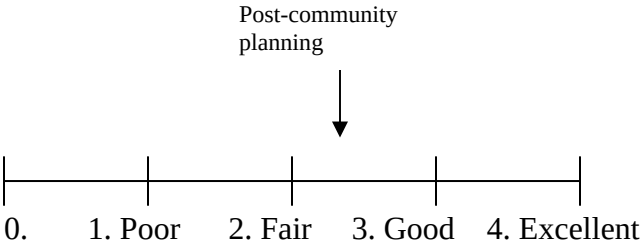
One of the goals of community planning is to give people with HIV and populations at risk access to more integrated health and social services. As part of the initiative, the Community-Linked Evaluation AIDS Resource (CLEAR) Unit at McMaster University evaluated the effectiveness of the community planning process in improving service integration. Ten of the original 12 regions participated in the evaluation. Agency representatives completed a baseline questionnaire and a one year follow-up questionnaire, which were designed to measure two variables:

1. The level of collaboration[1] among the various agencies within a region at the beginning of the planning process and one year later. To determine level of collaboration, researchers looked at nine factors: the decision-making ability of the partnership, synergy, leadership, administration and management, the sharing of non-financial resources, the sharing of financial resources, the benefits and drawbacks of participating in collaborative initiatives, satisfaction with participation, and efficiency (i.e., how well resources were used). Collaboration was ranked on a four point scale from poor to excellent.

2. The level of service integration[2] among the various agencies within a region at the beginning of the planning process and again one year later. Participants were asked to describe their level of integration with other services based on a four-point scale:
   - **Awareness**: discrete programs and services in the community are aware of other programs and services, but they organize their activities solely on the basis of their own program or service mission, and make no effort to do otherwise.
   - **Communication**: programs and services actively share information and community on a formal basis.
   - **Cooperation**: programs and services modify their own service planning to avoid service duplication or to improve links among services, using their knowledge of other services or programs.
   - **Collaboration**: programs and services jointly plan offered services and modify their own services as a result of mutual consultations and advice.

The result indicated that, overall, there was a good level of collaboration among agencies in all regions (2.3 out of 4) after the community planning process.

Figure 1: Level of Collaboration Post-Community Planning

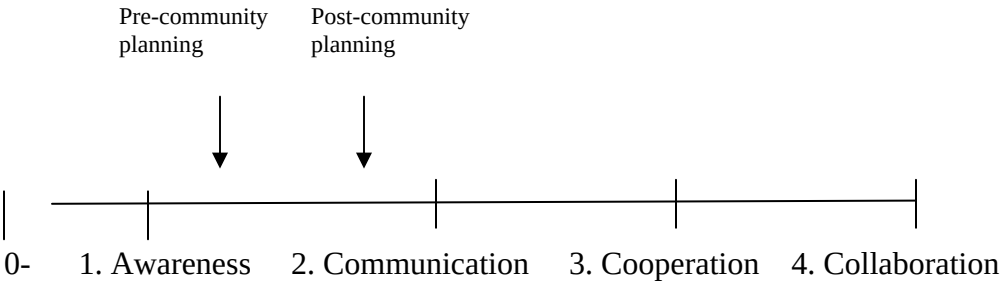


After the community planning process, the level of integration among agencies improved, but most regions are still at the "awareness" level on the integration scale. This reinforces how much time and work is required to develop truly integrated services.

[1] Collaboration was defined as "joint planning, common goals, shared commitment, partnership, collegial relationships, shared resources".

[2] Service integration was defined as "a 'means to an end' that uses collaborative mechanisms to improve the match between single services provided and the multiple needs of clients and families and thus, the effectiveness and efficiency of the system".

Figure 2: Level of Integration Pre and Post Community Planning



The evaluation also included a series of open-ended questions, which demonstrated varying levels of integration across the planning regions.[3]

- Most regions showed knowledge of services available in their respective areas, and agencies expected to communicate and cooperate with each other.
- Most regions had a higher level of integration than they expected at the beginning of the process.
- Integration levels were higher between agencies in close geographic proximity.
- Most ASOs started expecting a high level of integration and, at one year, half reported that they were communicating and cooperating with most of the other agencies.
- Many respondents indicated good synergy among members of the planning group.
- Regions with high quality leadership had high levels of synergy.
- Most respondents were satisfied with their participation in their planning group.

Based on these results, community planning has enhanced the potential for future collaboration among various services.

AIDS Bureau Support for Community Planning

It is clear that it will take more time and ongoing effort to develop truly collaborative, integrated services for people with HIV, and that there are many barriers to overcome. A number of communities are already moving forward on local initiatives identified in plans; others are waiting for funding or other supports from the ministry.

Over the past three years, the AIDS Bureau has already taken steps to develop programs and initiatives that will help organizations implement their community plans and to provide funding to meet needs identified in the community plans, including:

[3] See Evaluation: Community Planning Integration Project: Final Report, March, 2007 for regional details of the evaluation outcome.

1. **Enhancing organizational capacity**

   - increasing base funding for AIDS-Bureau-funded programs by more than 10% over the last three years to allow ASOs to expand/enhance their programs
   - increasing the organizational capacity of ASOs by providing $1.2 million in IT enhancements
   - providing significant increases in operational funding to help stabilize organizations/regions that were identified in community plans as being underserved, including Durham, Simcoe, Sault Ste Marie/Sudbury, Southwestern Ontario (to develop a rural services strategy for Perth and Sarnia), Toronto ethno-specific ASOs and provincial organizations, Peel, Kingston and York Regions **Increases in operational funding in underserved regions ($1M for significant funding increases to 18 agencies)**

2. **Enhancing service capacity and closing gaps**

   - providing funding to support HIV clinical outreach services in areas not served by the existing network of HIV clinics, including Thunder Bay, Guelph, Durham and Peel
   - supporting the development and implementation of the provincial Gay Men's Strategy, including providing additional funding for prevention workers in Durham, Ottawa, Toronto (CSSP, ASAAP, ACAS, Black-CAP), Hamilton, London, and Peel. Also provided funding for a HIV prevention and awareness campaign produced by the Gay Men's Strategy.
   - increasing funding for the Ontario Aboriginal HIV/AIDS Strategy, which has been used to provide additional workers in Toronto, Ottawa, and Thunder Bay
   - providing funding to support the African and Caribbean Council on HIV in Ontario (ACCHO) as well as funding for African and Caribbean prevention workers in London, Toronto (Black-CAP, APPA & ACHS), Ottawa, Hamilton, Niagara and Peel Regions. Also provided funding for a HIV prevention and awareness campaign produced by ACCHO.
   - providing funding for additional IDU outreach workers in Sudbury, Thunder Bay and Ottawa
   - supporting the development of a women and HIV strategy.

3. **Improving access to testing**

   - designating 24 new anonymous test sites across Ontario
   - developing new/updated guidelines for all HIV counselling and testing in Ontario (previous ministry guidelines were only for anonymous test sites), which encourage counsellors to offer hepatitis C and other STI testing as well as HIV testing

- providing point-of-care HIV tests to anonymous test sites, public health sexual health clinics and community health centres that choose to offer point-of-care testing and are able to meet the quality assurance requirements (fall 2007)
- developing targeted campaigns to promote HIV testing to populations at risk.

4. Collaborating with other ministries to address complex needs

- working collaboratively with the ministry responsible for the province's correctional facilities and ASOs that serve prisoners to develop information for prisoners and improve the quality and consistency of services for prisoners
- participating in the community/OHTN-led housing and health initiative (Positive Spaces, Healthy Places) and working with the ministry's supportive housing program to develop policies that will improve access to supportive housing for people with HIV

Next Steps

Other steps the AIDS Bureau is taking to support community planning include working with other parts of government (i.e., Education, MCSS, Municipal Affairs and Housing, Citizenship), with other parts of the ministry and with other levels of government to support more integrated, streamlined services and more support for programs that address the determinants of health.

To identify the next steps in the community planning process, the AIDS Bureau will present the results of the process to date to: the Ontario Advisory Committee on HIV/AIDS (OACHA); to the HIV Clinic Coordinators; and to the Executive Directors of ministry-funded AIDS Service Organizations.

In addition, the AIDS Bureau will:

- identify policy issues and direct them to the appropriate OACHA working group
- continue to monitor resource needs which were identified in the reports.

The final report on the Community Planning Initiative, *Building Bridges: An analysis and summary of the HIV/AIDS community planning initiatives in Ontario*, will be:

- used as reference material by the OACHA sub-group working on the development of the new provincial strategy
- shared with the Local Health Integration Networks (LHINs)
- shared with the AIDS Community Action Program, Public Health Agency of Canada as it identifies gaps and required resources.

ALGOMA, COCHRANE, MANITOULIN, SUDBURY: Summary of Community Plan

Key Regional Factors Shaping the Plan

- Most at-risk populations for HIV are: injection drug users (IDU), men who have sex with men (MSM), MSM-IDU, women, youth, the general public.
- Significant proportion of IDU population is Aboriginal people (32% in Sudbury).
- Small communities spread over large geographic area, which makes it difficult to access specialized service (e.g., Haven clinic in Sudbury).
- Stigma/homophobia is an issue in the communities.
- Services are working to (or over) capacity now – 50% do not have funding specifically allocated for HIV/AIDS services.

Proposed Approach to Integrated Services

This region formed three working groups, each responsible for a specific geographic area, so the recommendations for each area were quite distinct and reflected local needs and existing services.

1. **Increase access to primary and specialist care**. The plan highlights the lack of primary and specialist care in the region. It asks the MOHLTC to use incentives to attract more physicians and to provide funding to hire three IDU outreach workers in the Cochrane and Porcupine District Health Unit area. It asks the Ontario AIDS Network to provide help in educating health care professionals about HIV education, and asks for funding from the MOHLTC to cover travel/accommodation costs to allow Access AIDS Network to share their expertise in HIV prevention and education with other communities. The report also sets out plans to:

- pilot an HIV/AIDS nurse practitioner specialist for the Algoma District
- establish a street outreach nurse initiative in Sudbury (through the public health unit) to provide nursing services to IDUs, street and homeless people
- make the Haven Clinic in Sudbury a traveling training and mentoring centre and use the distance education at Laurentian University to provide training/mentoring
- establish a full-time health promotion position with Rainbow Lodge in Wikwemiking, Manitoulin Island to do HIV and Hep C education/prevention with the community and to provide services to people living with HIV/AIDS and Hep C

2. **Provide more comprehensive services**. As part of the plan, an existing agency has taken on the role of providing ongoing counseling and support for clients on methadone in Sudbury because the methadone clinic did not provide that service. The plan also includes: in Sudbury, expanding an existing supportive housing program to provide supportive housing, home care and a bilingual residential hospice services; in Sault Ste

Marie, securing more safe affordable housing for people at risk and providing workshops on HIV and Hep C in housing complexes.

3. **Address transportation issues and other practical needs.** The cost of travel to and from appointments continues to be a major barrier for PHAs. As part of the plan, the group intends to: advocate with the Northern Travel Grant program to changes its criteria to accommodate PHAs' needs to access specialized care that is not available in their home communities (i.e., providing travel advances instead of reimbursing people after the fact); promote existing transportation services available through the Accessibility Centre in Sault Ste. Marie, which provides transportation assistance to people who need to get to doctor's appointments; and offer a limited number of free bus tickets for people who have to travel within Sault Ste. Marie. Sault Ste Marie has also identified the need to increase the weekly food vouchers for PHAs from $5 to $10 through fund raising and work with the local United Way.

3. Focus on HIV prevention/harm reduction with injection drug users in Sault Ste Marie. The group plans to: increase distribution of clean needles and sterile water (addiction services); target distribution of condoms; promote safer sex and drug use, and give IDUs more opportunities to communicate openly about the issues they face.

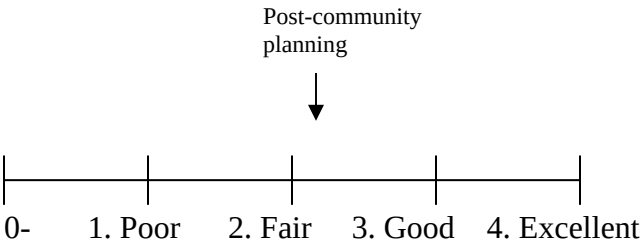
4. **Improve HIV prevention/education for youth**. Community agencies and youth programs will provide more prevention information and support for youth, including making it easier for them to obtain condoms. The organizations have identified principles for success in preventing HIV in youth, and will be working together to develop more effective programs for youth in schools, street youth and other hard-to-reach youth.

5. **Improve support services for PHAs and their families**. In Sault Ste Marie, the group identified the need for more home supports for PHAs (e.g., help with meal preparation, house cleaning and assistance with young children) and a peer support group for PHAs and their families. One of the co-chairs of the planning group also contacted the hospital to provide information about concerns raised by PHAs on community planning surveys about the services they received.

Evaluation Results

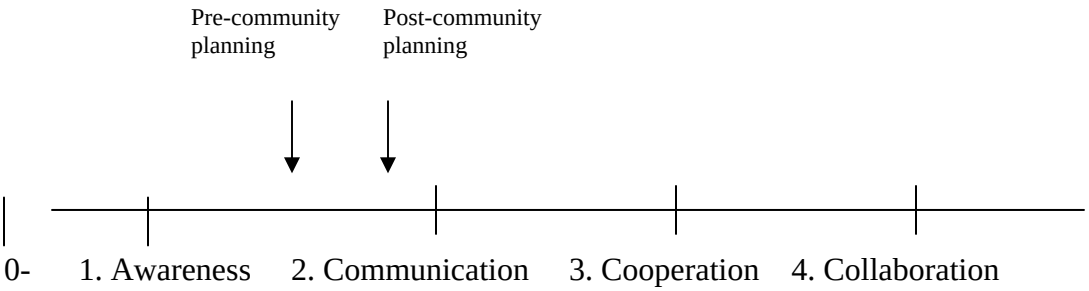
Algoma, Cochrane, Manitoulin and Sudbury region scored an overall 2.21 on collaboration. The region's score was particularly high in the area of collaborative decision making (2.95 out of 4).

Level of Collaboration



The region started with a higher level of integration than other parts of the province (1.5 out of 4). After community planning, the level of integration among agencies in the region improved to 1.8.

Level of Integration Pre and Post Community Planning



Assistance Required from the Ministry of Health and Long-Term Care

To implement its plan and achieve its goals, the region needs the following assistance from the MOHLTC:

- **policy changes** in the Northern Travel Grant Program
- **funding** to support: incentives for physicians, 3 new IDU outreach workers, an HIV/Hep C health promotion worker on Manitoulin Island, transportation costs and human resources to allow the Haven Clinic to provide training and mentoring programs, transportation costs for Access Sudbury to provide HIV prevention training in the region, and more condoms.

The report identifies a number of different programs in the ministry (in addition to the AIDS Bureau) and other organizations to provide funding and support for initiatives. This indicates that the community has a better understanding of the roles and resources of different parts of the health care system – and a willingness on the part of organizations to tap into their networks.

OTTAWA-CARLETON: Summary of Community Plan

Key Regional Factors Shaping the Plan

- increasing rates of HIV: from 10% of Ontario's HIV diagnoses between 1985 and 1995 to 14% between 1996 and 2002
- high prevalence in gay men (45% of cases)
- increase in infections in injection drug users: now represent 23% of people with HIV in the region
- is second only to Toronto in HIV infections in people from countries where HIV is endemic
- a relatively small number of organizations who already have defined roles in HIV/AIDS services (e.g., serving gay men, serving people from countries where HIV is endemic, serving all populations)

Proposed Approach to Integrated Services

1. **One centralized, well-publicized access point for HIV/AIDS information and referrals.** The Ottawa-Carleton Council on AIDS (OCCA) will transform itself into the Ottawa Coalition on HIV/AIDS (OCHA), establish an office located in a community-based AIDS organization, and be responsible for strategic analysis and coordination of the HIV/AIDS system in Ottawa/Carleton. The planning group agreed that there should be one central access point in a community-based AIDS organization and will explore the potential amalgamation of the two existing organizations (i.e., AIDS Committee of Ottawa and Bruce House) – although this resolution did not have unanimous support.

2. **Joint Action Teams**. The region will develop two joint action teams: one focused on services for people from countries where HIV is endemic and one focused on injection drug users. The Joint Action Team on endemic issues will work with the AIDS Committee of Ottawa and the Somerset West Community Health Centre to develop a prevention program.

3. **A larger sustainable HIV/AIDS network**. The group plans to draw in new partners in order to enhance capacity to meet needs and develop a larger network of organizations to focus on HIV/AIDS.

4. **Prevention strategy for gay men**. The AIDS Committee of Ottawa will allocate funds to develop – in collaboration with Pink Triangle Services and the Gay Men's Wellness Initiative – a gay men's prevention strategy.

5. **New housing and counseling services**. To meet the needs of people living with HIV, the community planning group will develop partnerships that will result in new care and support services in the following areas:

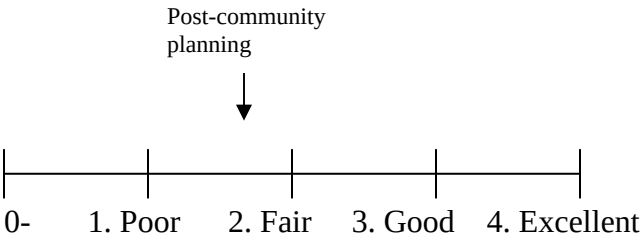
- housing – emergency beds, supportive housing, long-term housing, end-of-life beds

- group and individual counseling – addictions, depression, trauma, bereavement, life skills, sexuality.

Evaluation Results

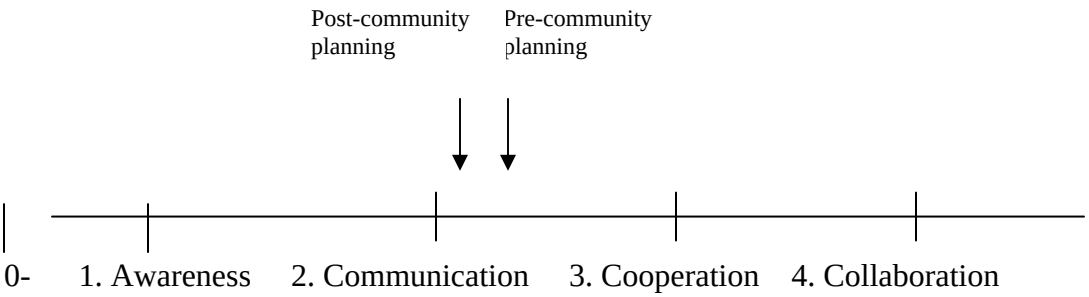
Ottawa Carlton region scored an overall 1.8 on collaboration – lower than the average for all regions. The region's score was particularly high in the area of collaborative decision making (2.48 out of 4).

Level of Collaboration



The region started with a high level of integration compared to the rest of the province (2.3 out of 4). The actual level of integration dropped to 2.1 after the community planning process, but was still higher than that reported by any other region in the province.

Level of Integration Pre and Post Community Planning



Assistance Required from the Ministry of Health and Long-Term Care

The report did not make any specific requests, but it did note that all the proposed initiatives – particularly the gay men and endemic prevention programs – could not be funded solely by reallocating resources from existing agencies and would require new core funding.

DURHAM, HALIBURTON, KAWARTHA & PINE RIDGE: Summary of Community Plan

Key Regional Factors Shaping the Plan

- mix of smaller urban centres and rural areas
- includes four First Nations communities and a large Aboriginal population who have distinct issues and needs – particularly related to testing and treatment
- two prisons in the region: one provincial and one federal; prisoners have distinct needs and issues
- served by three HIV-specific programs or services: Positive Care Clinic (Whitby), AIDS Committee of Durham (Oshawa), and PARN – Your Community AIDS Resource Network (Peterborough)
- people living with HIV who responded to the planning survey have low incomes and are dependent on disability or social assistance (only 15% of those surveyed were employed); 39% are long-term survivors (HIV-positive for more than 16 years)
- many seek services – including testing – in Toronto, where they have greater anonymity/confidentiality
- access to care locally is an issue: 50% of Durham residents receive care locally while only 26% of respondents from other parts of the region access local care
- barriers to service include: stigma (including perceived threats to confidentiality in rural areas and discomfort using services), distance, lack of public transportation and travel costs (return cab fare from Peterborough to Positive Care Clinic is $200), limited hours of operation, lack of primary care providers knowledgeable about HIV, difficulties getting clients into nursing homes, lack of psychology/psychiatry services
- agencies interested in more integrated approaches (e.g., satellites, integrating services)

Proposed Approach to Integrated Services

1**. Inter-agency service agreements**. ASOs, HIV clinics, public health units, needle exchange programs, mental health and addiction services should develop partnerships to address the social determinants of health. ASOs should develop partnerships with methadone clinics in order to enhance the capacity to offer individual DART (directly-observed anti-retroviral therapy) and/or improve PHA adherence with treatment. HIV treatment could also be integrated into other settings that provide culturally-sensitive services for people from countries with high rates of HIV infection. There should also be better coordination between ODSP and AIDS service organizations to resolve the issues associated with travel to medical appointments and other services.

2. **Establish a separate community planning group to address the urgent, complex needs of First Nations and Aboriginal communities and individuals**. The plan should offer options to the current HIV testing reporting system that links test results to status number and provides greater confidentiality.

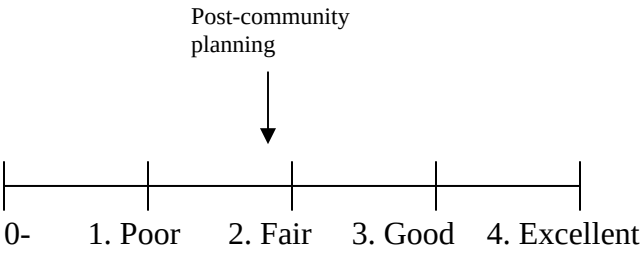
3. **Establish a separate community planning group to address the urgent, complex needs of people in correctional institutions**. Staff from ASOs and/or HIV clinics should work with correctional facilities to develop a variety of harm reduction strategies for prisoners and provide education and treatment that reflect the current standard of care.

4. **Raise awareness of HIV services in the region**. The planning group could provide information to a range of community services including acute care facilities, walk-in clinics, doctors' offices, shelters, services for immigrants, and correctional facilities. HIV organizations can also provide public education that will reduce stigma and discrimination, and lead to more seamless services and supports for people living with HIV.

Evaluation Results

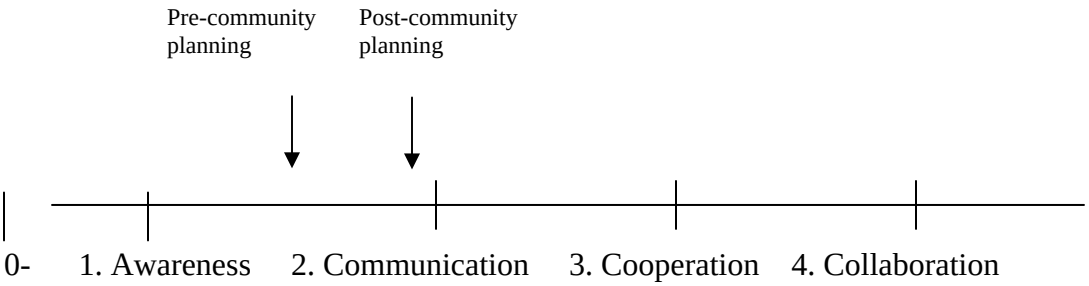
Durham, Haliburton, Kawartha and Pine Ridge region scored an overall 1.86 on collaboration – lower than the average for all regions. The region's highest score was in the benefits of participating in community planning (2.29 out of 4).

Level of Collaboration



Integration improved with community planning. The region scored 1.5 at the beginning of the process and 1.9 at the one-year follow up (higher than the provincial average).

Level of Integration Pre and Post Community Planning



Assistance Required from the Ministry of Health and Long-Term Care

To be able to implement the plan, the planning area needs the following assistance from the Ministry of Health and Long-Term Care:

- **funding for services that is aligned with needs**. The ministry could:
- use a system of workload measurements to assess the complexity and intensity of HIV care, and provide appropriate funding
- designate HIV clinics, staffed with multidisciplinary teams as the "gold standard" for care and provide stable funding for clinics (which will lead to long-term cost savings for individuals and the health care system)
- develop and fund a system of satellite clinics to provide care in underserved, rural and remote areas
- make more effective use of technology to improve access (e.g., interactive web-based information systems, 1-800 numbers for HIV care providers, and partnered programs between local care providers and HIV specialists)

- **supportive public policy to address the determinants of health.** The ministry should work with other ministries and levels of government to address needs such as housing, food, clothing, transportation and employment support for people with HIV

- **promoting and expanding HIV testing**. The ministry could help normalize testing by:
- actively promoting regular HIV testing – with a risk assessment and education -- for everyone (i.e., Know Your Status)
- ensuring access to anonymous and non-nominal testing in all parts of the province

- **incentives**. The ministry could provide:
- supportive programs to help nurses working in HIV train as nurse practitioners and be able to provide primary as well as specialized care
- incentives for integrated services that would offer needle exchange, satellite clinics that provide outreach services, testing, primary care, harm reduction programs, treatment services, and assistance with housing and other needs.

HALTON, PEEL, SIMCOE & YORK: Summary of Community Plan

Key Regional Factors Shaping the Plan

- fast growing region of the province: most health and social service agencies are working at or beyond capacity because of population growth
- large immigrant population from countries where HIV is endemic (Peel, York) who may experience difficulty accessing care and support
- large Aboriginal population in Simcoe country
- low rates of HIV infection compared to other parts of the province, but significant increase in the number of new HIV diagnoses over the past two to three years in York Region and Simcoe County
- because the region is made up of smaller communities, stigma is an issue: people with HIV tend not to disclose their status when seeking services; risk behaviours (e.g., sex trade, drug use) tend to be hidden; and fundraising is more difficult
- extreme shortage of affordable supportive housing in the regions
- shortage of doctors, HIV clinics and dentists willing to treat people with HIV (e.g., doctor:patient ratios in Halton – 1:180, 1:150; in Peel – 1:100, 1:7); many clients travel to Toronto for care, but access to transportation/transportation costs are barriers
- correctional facilities in the region, which creates a demand for treatment for clients with HIV in prison and for effective discharge planning

Proposed Approach to Integrated Services

1. **Multi-service HIV/AIDS care centres**. The plan proposes a phased approach to establish one multi-service centre in each region – including increased access to anonymous testing and maintenance of existing harm reduction programs – using a phased approach:

- year one to two - develop regional AIDS action groups to coordinate services, develop service agreements among public health, AIDS service organizations and other community social and medical services; formulate plans for regional multi-service centres; facilitate training and education for doctors, dentists and health and social service agencies
- year three to four – expand partnerships as required to meet needs; seek funding for multi-service care centres
- year five and beyond – continue development of multi-service centres.

This would reduce the need for people to travel for care and transportation costs, provide access to more comprehensive coordinated care, make more effective use of agency/provider resources, and help reduce the stigma associated with HIV.

2. An AIDS service organization in Halton Region. This region does not currently have an AIDS organization.

3. **More effective use of public health services/expertise.** Many health and social service organizations were unaware of the services available from public health units. Public health expertise should be used to help educate the community as well as health and social service agencies about HIV/AIDS – particularly mental health agencies. (Note: this may require reallocation of resources within health units.)

4. **Designated housing units for people with HIV**. The regional AIDS action groups will consider negotiating with regional housing authorities to designate a number of housing units for clients with HIV/AIDS.

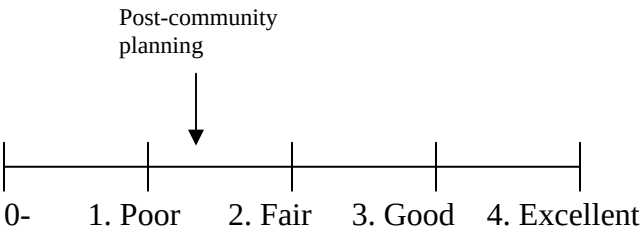
5. **Regional HIV/AIDS awareness campaign**. A regional awareness campaign would help reduce stigma, promote testing and make people aware of the services available.

6. **Links with correctional facilities**. All correctional institutions will have a list of community resources and contact numbers to assist with discharge planning for inmates with HIV.

Evaluation Results

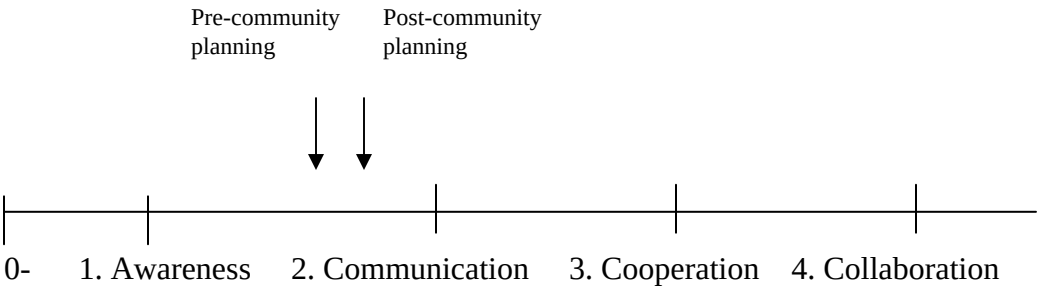
Halton, Peel, Simcoe and York region scored an overall 1.36 on collaboration – lower than the average for all regions. The region's highest score was in the area of non-financial resources (1.94 out of 4).

Level of Collaboration



The region started with a level of integration of 1.6 out of 4, which increased to 1.7 after community planning.

Level of Integration Pre and Post Community Planning



Assistance Required from the Ministry of Health and Long-Term Care

To implement the plan and achieve the goals, the regions need the following assistance from MOHLTC:

- **funding**. Provide funding to develop and maintain multi-service HIV/AIDS centres, to develop an AIDS service organization in Halton Region, and to increase funding for ASOs in the other regions to reflect the growing population demands
- **anti-stigma/public awareness**. Develop a provincial HIV/AIDS awareness campaign that would help address stigma.
- **more care for people with HIV/AIDS**. Develop incentives for doctors and dentists.
- **leadership in addressing social assistance issues**. Negotiate with Ontario Works, Ontario Disability Support Program and the Trillium Drug Programs to fast-track approvals for clients with HIV/AIDS and increase their benefits allowance to reflect the costs associated with treatment

HAMILTON, NIAGARA, BRANT, HALDIMAND & NORFOLK: Summary of Community Plan

Key Regional Factors Shaping the Plan

- a sizable Aboriginal population
- a growing immigrant population: immigrants now account for 85% of population growth in the region
- largest number of refugees entering Canada (Niagara)
- a major destination for migrant farm workers, many of whom come from countries where HIV is endemic
- lower income and education levels across the region than for the province as a whole; low incomes mean many people with HIV do not have access to good nutrition, adequate housing or transportation to participate in social activities
- an increase in HIV diagnoses since 2001 – in gay men, women, people from countries where HIV is endemic, and injection drug users (in Niagara, Brant)
- a significant increase (124%) in HIV diagnoses in 2004 (compared to 2000)
- only a modest increase in HIV testing compared to the rest of the province
- a mix of urban and rural communities: services are more difficult to provide in rural areas because of the lack of affordable public transportation
- shortages of some services: one area (Brant, Haldimand-Norfolk has no community-based AIDS organization, anonymous testing or need exchange program; there is a shortage of family physicians and primary care providers willing to provide care for people with HIV throughout the region
- long waiting lists for services at many mental health agencies, and for other services and supports, such as housing.

Proposed Approach to Integrated Services

1. A regional HIV/AIDS working group. A regional working group will meet regularly to provide a focus for advocacy, a forum for discussion and communication, and an opportunity to review OCHART data in order to identify opportunities for greater collaboration and coordination. Members will include: organizations providing direct service to people living with HIV/AIDS and communities at risk and other key health and social service sectors across the continuum of services required by people with HIV/AIDS. It will also have significant representation of people living with HIV/AIDS. Representatives from service agencies in Burlington will also be invited to participate (this area not included in community planning but group recognized inter-relationships).

2. Formal inter-agency relationships, secondments and co-location of services. Community-based AIDS organizations, mental health, addictions, housing and other agencies will develop formal inter-agency relationships and provide training for staff in

agencies providing services to clients with HIV. Staff of community-based AIDS organizations will be seconded to addictions, mental health, immigration and refugee and other agencies – and vice versa. This will allow organizations to share expertise and avoid duplication of services. Agencies will also consider, where possible, co-locating agencies to provide one-stop shopping for clients.

3. Innovative outreach services. Agencies are considering developing a "health bus" to provide outreach services to clients as well as providing training to organizations working with key populations, such as immigrants, refugees and Aboriginal communities.

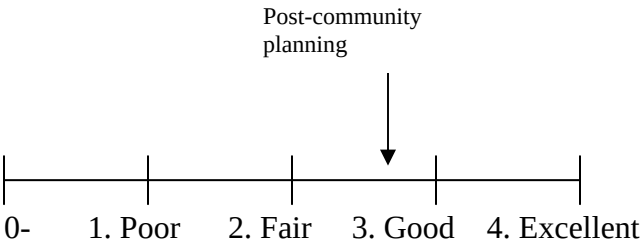
4. A treatment case management strategy. Community-based AIDS organizations, mental health, addictions and other agencies will develop a treatment case management strategy designed to ensure continuity of care across a continuum of services and help clients navigate the broader health and social service system.

5. Service enhancements. All organizations participating in community planning identified opportunities to enhance their services to meet PHA needs including, for example: greater access to anonymous testing, more outreach to at-risk populations, expanded hours at STI clinics, greater access to affordable housing, more comprehensive services for people with hepatitis C and a more comprehensive range of palliative and end-of-life care.

Community Planning Evaluation Results

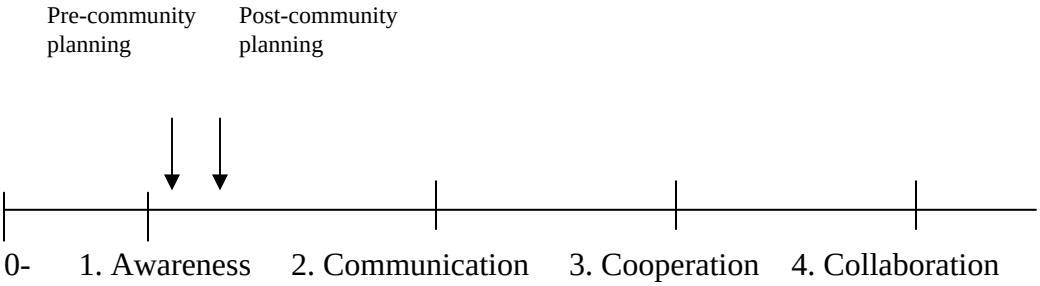
Hamilton, Niagara, Brant, Haldimand and Norfolk region scored an overall 2.65 on collaboration. The region's score was particularly high in the benefits of participating in community planning (3.38 out of 4).

Level of Collaboration



The level of service integration in the region was about 1.1 before community planning, and 1.2 after: a slight increase.

Level of Integration Pre and Post Community Planning



Assistance Required from the Ministry of Health and Long-Term Care

To be able to implement the plan, the planning area needs the following assistance from the Ministry of Health and Long-Term Care:

- **more designated anonymous testings sites**. Brant, Haldimand and Norfolk need access to anonymous testing.

- **funding**. Funding is required to:
- establish a community-based AIDS organization for Brant, Haldimand and Norfolk counties and the Six Nations Reserve
- allow AIDS Niagara and the AIDS Network to enhance social supports, provide services such as chiropractic, massage therapy, homeopathic and nutritional services, expanded outreach programs and peer support programs, and maintain the regional working group
- enhance public health unit sexual health and outreach programs – particularly in Brant and Haldimand-Norfolk (i.e., return to 100% provincial funding for sexual health programs)
- supportive housing for PHAs, using the AIDS Niagara program as a model

- **better access to care**. The region recommends that the ministry:
- develop incentives for primary care physicians to provide services for people with HIV as part of primary care renewal
- provide funding for specially trained nurse practitioners in public health units, community health centres and other primary health care settings – particularly to work with recent immigrants
- work with the academic health science centre in Hamilton and the health system in the region to develop a strategy to improve access to specialist care in the region
- work with the College of Family Physicians and HIV specialists to develop a "shared care" model of care for HIV/AIDS to support family physicians caring for PHAs

- **research.** The service systems requires more information on the impact of multiple risk factors on the increase in HIV diagnoses in the region.

- advocacy with other ministries/levels of government. The ministry should advocate with:
- MCSS to increase ODSP benefits, including access to the nutritional supplement
- Government of Canada to improve Canada Pension Plan benefits and ensure equitable access to drug coverage for people with HIV
- the Public Health Agency of Canada to provide sustained funding for hepatitis C initiatives
- the Ministry of Education to ensure sexual health and HIV/AIDS education is provided in all schools, and that the sexual health curriculum of every school board is available on request
- the Ministry of Municipal Affairs and Housing to develop more affordable housing options

- **public awareness/education.** The ministry should develop a public awareness campaign to provide up-to-date information about HIV/AIDS.
- **professional education**. The ministry should work with the regulatory colleges and professional associations to develop education programs for
- physicians and nurses to provide up to date information about risks and treatments
- obstetricians, family physicians, midwives and nurse practitioners to promote HIV testing in pregnant women
- professionals working in the long-term care sector who are caring for aging and palliative patients with HIV. The program should include education on pain and symptom management for people with HIV-related dementia.

MUSKOKA, NIPISSING, PARRY SOUND & TIMISKAMING: Summary of Community Plan

Key Regional Factors Shaping the Plan

- small communities spread over large land area which tend to be conservative and less tolerant of non-traditional beliefs and behaviours, have less access to service, prefer informal help networks, and are concerned about confidentiality (particularly people who have a high profile in their community) and reluctant to go into a building where services are associated with sensitive or stigmatized issues
- large Aboriginal (6% compared to 1.7% provincially) population – with need for culturally appropriate services
- large Francophone (>25% in Nipissing and Timiskaming) population – with need for education and services in French
- high rates of substance use in the region and approximately 24% of HIV infections associated with drug use (compared to 6.2% for the province)
- higher rates of hospitalization for mental illness (55%) and psychotic disorders (30%) than the provincial average; and higher rates of hospitalization for suicides and alcohol and drug dependence
- lower levels of education, income and employment than provincial average
- a northern/rural area where stigma affects data and information (e.g., difficult to attract people with HIV and their families to participate in the planning: only 41 of 300 questionnaires returned; no anonymous testing in the region so many people go outside for testing)
- problems recruiting and retaining health professionals
- access to services limited by lack/cost of public transportation, poor road conditions and hazardous weather conditions (which also affect professional development and public education)
- lack of secondary services in the region (e.g., population specific services); existing services under resourced
- overlapping service boundaries
- agencies already involved in a number of planning activities/health system changes – usually without funding or any concrete impact (i.e., planning fatigue) – and uncertainty associated with the introduction of LHINs
- agencies need more training to respond to need of people with HIV, including general information on STIs and hepatitis, conducting risk assessments, effective service interventions, case management training, and HIV counseling.

Proposed Approach to Integrated Services

1. **Work with the LHIN to establish and expand partnerships.** The AIDS Committee of North Bay and Area (ACNBA) plans to approach the new LHIN and to join any committees or working groups to build partnerships and ensure health planning addresses the needs of people with HIV and their families. If this approach does not achieve the desired goals, the ACNBA will establish district and catchment area working groups.

2. **Foster a systems approach to strengthen service delivery**. The ACNBA will work with appropriate community partners to conduct an environmental scan to assess service system characteristics, geographic/demographic characteristics, client characteristics, community readiness for change and transitional challenges.

3. **Provide more equitable services across the catchment area**. The ACNBA will work to overcome the barriers and fill the gaps in services identified through the surveys. This may involve recruiting local staff and co-locating services with other compatible agencies, and will continue to consult with community partners in outlying areas to monitor the needs and relationships with other agencies services people with or at risk of HIV/AIDS. Specifically, the ACNBA will:

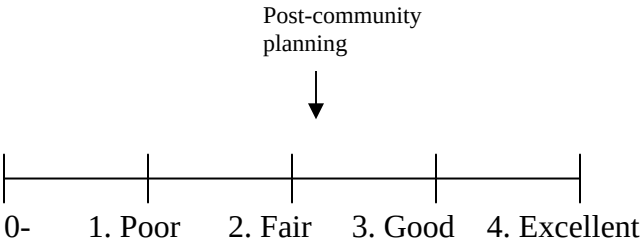
- improve primary prevention by developing public information and professional training sessions as well as other mechanisms (e.g., web site, media briefing kits) designed to help strengthen the protective factors that keep people from becoming infected and reduce the risk factors (e.g., in schools, for student teachers, for new service providers, the media)
- enhance secondary prevention by actively promoting anonymous and non-nominal testing and counselling, providing supportive counselling, establishing peer counselling and support groups for PHAs and family members, and providing safer sex and safer IDU services, including needle exchange programs
- enhance tertiary prevention by providing self efficacy training for PHAs and family members, exploring the potential for peer-led groups, providing assistance with legal, financial, spiritual, transportation, employment, relocation, housing, home care and other services, and pursuing linkages with other agencies (e.g., housing, mental health, addictions)

4**. Develop partnership and service agreements.** The ACNBA will pursue partnerships and formal agreements with agencies as a means of increasing outreach capacity.

Evaluation Results

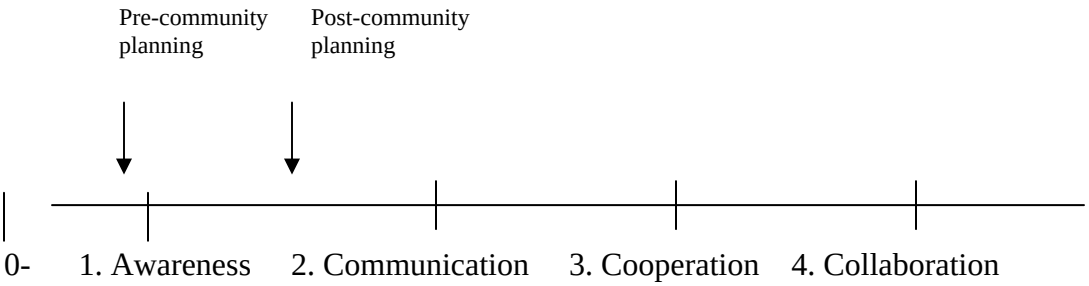
Muskoka, Nipissing, Parry Sound, and Timiskaming region scored an overall 2.18 on collaboration. The region's score was particularly high in the benefits of participating in community planning (3.00 out of 4).

Level of Collaboration



With community planning, the level of service integration increased from just under 1 to 1.5 (out of 4) – one of the most significant increases in the province. Organizations started out not really aware of one another's services but are now knowledgeable about one another's services.

Level of Integration Pre and Post Community Planning



Assistance Required from the Ministry of Health and Long-Term Care

To be able to implement the plan, the planning area needs the following assistance from the Ministry of Health and Long-Term Care:

- **links with LHIN process**. The AIDS Bureau should:
- work with AIDS service organizations to develop a strategy to position HIV/AIDS as an issue for the LHINs, provincially and locally so HIV is not an "orphan" issue
- adjust ACNBA catchment area to reflect the new LHIN boundaries (i.e., remove Muskoka District)

- advocacy within government. The ministry should:
- work with other ministries to address the social determinants of health
- negotiate with Health Canada and INAC to address the needs of all Aboriginal people in the area – status, non-status, on-reserve, off-reserve (in consultation with ACNBA and an Aboriginal advisory group from the catchment area).

- **funding**. The ministry should:
- increase ACNBA core funding to reflect the identified service needs and the demands of serving a large, diverse, northern area
- provide funding to support effective, ongoing partnerships – including travel and meeting costs, teleconferences and videoconferences.

NORTHWESTERN ONTARIO:
Summary of Community Plan

Key Regional Factors Shaping the Plan

- large, sparsely populated, economically depressed geographic area (60% of province; 2.05% of population) – no year-round road access to 2/3 of area – so problems accessing services
- large aboriginal community (21% of population) and related jurisdictional issues (federal-provincial)
- high rates of health risks/problems compared to the rest of the province – particularly in youth (i.e., teen pregnancy, alcohol abuse, Chlamydia, suicide
- high rates of injection drug use
- risk factor for HIV infection: injection drug use (40%); men who have sex with men (32%); high risk heterosexual (23%)

Proposed Approach to Integrated Services

1. **Regional networks of services**. The plan proposes to regional community-based AIDS service organization networks that would consist of centres in Thunder Bay and Dryden linked to satellite sites throughout the region. The satellites would provide flexible (i.e., including evenings and weekends) one-stop shopping for a range of related services that would meet the needs of PHAs and populations at risk including: needle exchange/harm reduction services, anonymous testing, sexual health clinics, access to primary medical care and ASO services. Several key organizations – AIDS Thunder Bay, the Dryden & District AIDS Committee, the Thunder Bay District Health Unit, the Northwestern District Health Unit and Superior Points Harm Reduction Program – would take the lead in developing these regional networks. The intent is to use staff and volunteers from a variety of partner agencies to provide the services, which would enable the network to function with minimal additional funding. It is also the intent of the group to make effective use of Network North (telemedicine service) to help deliver HIV clinical care as well as other services, and reduce the need for people to travel. To ensure that people are aware of the services, the group will create an HIV/AIDS education network to provide: information/education for professionals in the region on harm reduction services; and professional development opportunities for partner agencies. The network will develop a regional resource guide, listing all health and social service agencies and the services they provide, which will be available through all agencies' websites.

2. **A seamless service system for Aboriginal people**. Organizations in the region would like to provide more effective integrated services for Aboriginal people in the region, but are hindered by jurisdictional issues and by lack of good data on the extent of HIV in the Aboriginal community. The plan asks government to take leadership to help remove barriers to better service for Aboriginal people.

3. **Education/harm reduction services for youth**. Given the high rates of risk taking behaviours and health problems in youth in the region, the plan proposes community partnerships among the ASOs, public health units, shelters, drop ins and schools to provide HIV/AIDS prevention, education and harm reduction information and materials targeted to youth.

4. **Strategies to reduce stigma, isolation and fear**. The plan is not specific on this point but notes that stigma, isolation and fear have an impact on "if, when and where individuals seek service" and all plans must take these issues into account so that people feel comfortable accessing service no matter where they live.

Evaluation Results

The Northwestern region did not participate in the community planning evaluation.

Assistance Required from the Ministry of Health and Long-Term Care

To implement its plan and achieve its goals, the region needs the following assistance from the MOHLTC:

- **assistance with data collection**. Revise the anonymous testing form to collect information on the ethnicity, country of origin, risk behaviours, lifestyle and social determinants of health and ensure all testing sites use the same form; and share data collected federally (Health Information System) and provincially (integrated Public Health Information System) so the region can have an accurate picture of who is being tested and of HIV/AIDS in the region
- **assistance in coordinating services for Aboriginal people**. Work with the federal government to clarify the jurisdictional responsibilities for providing services to Aboriginal people to ensure they have access to a seamless service system and fair equitable access to services.
- **support for youth initiatives**. Advocate with the Ministry of Education for more sexual health/harm reduction/prevention/education initiatives and to revive the HIV/AIDS curriculum in elementary and secondary schools
- **assistance in increasing access to anonymous testing**. Designate the Northwestern Health Unit as an anonymous testing site.
- **funding**. Provide funding for an ASO in Dryden (currently an all-volunteer organization) and to support the follow-up and evaluation of the plan's recommendations.

QUINTE, KINGSTON, RIDEAU (Southeast Region): Summary of Community Plan

Key Regional Factors Shaping the Plan

- a relatively small population living in a number of small/rural communities in a relatively large geographic area
- a fairly large Aboriginal community
- 8 federal correctional facilities and one provincial jail in the region
- relatively low and dropping rates of HIV diagnoses in areas surround Kingston
- increasing rates of HIV diagnoses – particularly in injection drug users and people who have identified themselves as low risk heterosexuals – in Kingston area
- one HIV clinic serving the entire region; other HIV specific services (e.g., community-based AIDS organization, anonymous testing) also located in Kingston
- access to services/isolation as well as cost/lack of transportation to services is an issue
- shortages/lack of other services including lack of 24/7 needle exchange programs, long wait lists for mental health and addiction services, community-based services heavily dependent on volunteers, hours of operation not convenient, public and school-based education about HIV including anti-homophobia and addiction as a health problem
- social issues, including lack of affordable housing, poverty, stigma
- a wide range of agencies actively involved in community planning (e.g., violence against women programs, palliative care programs, food banks, organizations that work with prisoners) strong network of agencies in place; holistic approach to service delivery/harm reduction already the norm
- survey of service users indicated that they used the following services: social assistance (82%), primary care physicians (73%), community-based AIDS organization (65%), transportation assistance programs (52%), community health centres (50%), food bank (48%), HIV clinic (47%), mental health services (42%), addictions services (36%), housing services (35%), needle exchange programs (35%), recreation programs (18%), employment services (11%), cultural organizations (11%), women's agencies (10%), and parenting programs (8%)

Proposed Approach to Integrated Services

1. Increase HIV/AIDS education/prevention. The working group has identified the following priorities: consistent HIV/AIDS education in the school, including anti-homophobia education; a multi-media public education plan to address homophobia; prevention education targeted to women; and a prevention education plan for gay men. Local agencies will develop initiatives to support broader provincial awareness

campaigns, including providing in-service education for teachers and agency staff, finding former drug users and GLBTQ people willing to make presentations, working with/through a variety of agencies that serve women (e.g., violence against women programs, parenting groups, the women's health network) to deliver prevention education, and developing initiatives to reach gay men, such as workshops, on-chat groups and bar education

2. Improve access to services by decreasing stigma. The working group plans to develop a campaign to raise community awareness of the issues facing people who are homeless or marginally housed, people living with HIV/AIDS and drug users – and how stigma and discrimination affect access to care. The group will also develop an education plan for the health care and social service system on: alternative healing methods including culturally specific healing methods, and culturally sensitive care for recent immigrants (through consultation with larger urban centres that have more experience in this area).

3. Coordinate services and streamline processes. The regional working group will investigate ways to introduce a single point of entry to service or inter-agency case management, starting by introducing a standard intake assessment for mental health services in the region. The group will also:

- work with Correctional Services Canada to identify ways to coordinate health and social services for people being discharged from the correctional system
- work with Ontario Works and ODSP to develop a coordinated transportation system for clients to reach services, including a charge-back system between agencies to support the system
- work with municipal governments and the Ministry of Community and Social Services to discuss co-locating social assistance programs in order to coordinate financial assistance and provide more efficient service.

4. Improve service accessibility. The working group intends to address barriers to access including:

- altering physical space to make health and social service agencies more accessible for children, women and LGBTQ (similar to the accessibility plans that all municipalities are now required to develop)
- providing more confidential, youth-friendly services, including transportation to medical appointments and tests and the importance of carrying a health card
- advocating with agencies to provide more extended hours of services
- investigating possibility of establishing and promoting a 24/7 mental health crisis line.

5. Make services more user-friendly. Agencies plan to work together to develop more peer-based programs for drug users and people with HIV/AIDS and to build connections with new family health teams and other primary care models. The working group also plans to actively promote a harm reduction approach with all social service agencies and increase the number of needle exchange sites in the region.

6. Advocate for consistent services throughout the region. The working group plans to advocate with:

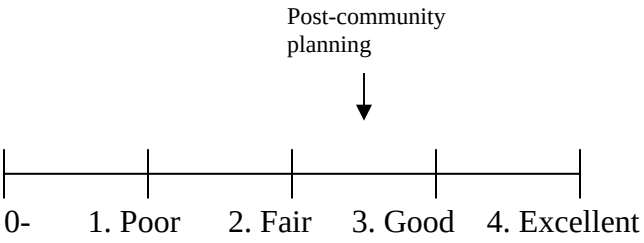
- all pharmacists in the region to provide methadone programs
- all public health units to offer needle exchange programs – including rural programs

7. Increase HIV/AIDS resources. Agencies will collaborate to develop a directory of services for people with HIV and people at risk as well as inter-agency groups that will meet regularly to share information and concerns.

Evaluation Results

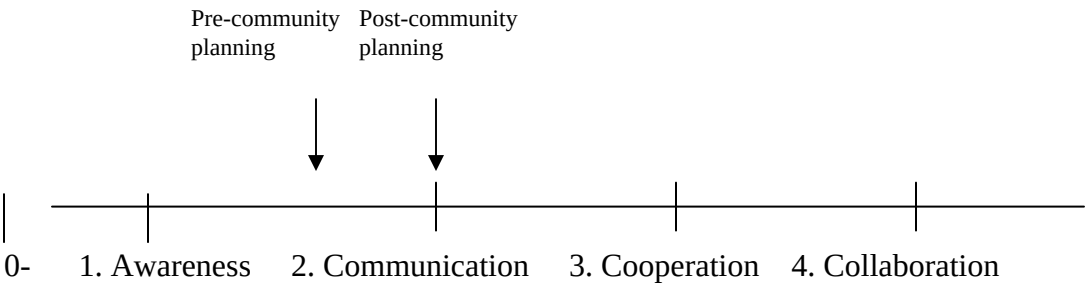
The Quinte, Kingston, Rideau region scored an overall 2.56 on collaboration. The region's score was particularly high in the perceived benefits of participating in community planning (3.56 out of 4).

Level of Collaboration



The region started with a higher level of integration than other parts of the province (1.6 out of 4). After community planning, the level of integration among agencies in the region improved to 2.

Level of Integration Pre and Post Community Planning



Assistance Required from the Ministry of Health and Long-Term Care

To be able to implement the plan, the planning area needs the following assistance from the Ministry of Health and Long-Term Care:

- **advocacy with other ministries**. The ministry should work with:

- the Ministry of Education to ensure delivery of a consistent school curriculum on HIV/AIDS
- the Ministry of Community and Social Services to align the Homelessness Fund Initiative with community planning
- the Ministry of Immigration and Citizenship to jointly fund programs that link AIDS service organizations and immigrant services to provide culturally appropriate education services

- **advocacy with other health programs.** The ministry should hold all health units accountable for providing mandatory programs, such as needle exchange programs (based on best practices)

- **public awareness/education.** The ministry should develop a public awareness campaign to reduce stigma and discrimination against gay men, and coordination of distribution of prevention/education materials through health units, AIDS service organizations and health care providers.

- **funding.** More funding is required to support transportation services for clients and to support the ongoing implementation of community planning (i.e., funds for a staff person to coordinate an inter-agency steering commitment and implement strategies).

Note: many agencies also identified ongoing funding issues (e.g., dependence on short-term funding, not enough funding to meet current demands for services).

SOUTHWESTERN ONTARIO: Summary of Community Plan

Key Regional Factors Shaping the Plan

- Mixture of small urban centres and rural areas, with conservative attitudes to sexuality
- Services and people with HIV concentrated in London, fewer services in smaller urban centres or rural counties – so transportation is an issue
- Highest HIV prevalence in gay men (13.4% -- third highest in Ontario after Toronto and Ottawa), followed by people who reported as heterosexual
- Increasing rates of HIV infection in youth and women
- People living with/affected by HIV tend to lack financial resources
- Lack of access to family physicians, mental health services, transportation to services, accurate information, needle exchange and other harm reduction services, affordable housing and addiction services
- Ongoing stigma association with HIV/AIDS – particularly in rural communities
- Providers report "over demand" for services, increasing case loads, more complicated service needs, and little or no duplication
- The AIDS Committee of London, HIV Care Programme, ,Options Clinic and Middlesex-London Health Unit have track record of collaboration with excellent outcomes for HIV/AIDS community in London; same benefits not available to people in more rural parts of planning region
- Recent collaboration and use of internet to target youth have enhanced service delivery.

Proposed Approach to Integrated Services

1. **Establish a task force to lead/sustain community planning**. The task force or council will include representatives from key organizations, services and geographic areas – including those not yet involved in community planning.

2. **Adopt a case management model of service delivery**. Programs and services will create a centralized "clearinghouse" for service delivery, based on agreements among partners, based on the existing case management approach used by the HIV Care Programme as well as best practices from case studies funded by the OHTN. They will integrate care and co-locate services wherever possible, and share information, helping PHAs navigate the system.

3. **Increase access to comprehensive HIV/AIDS medical and related services**. The region will establish a pilot HIV/AIDS health care team, made up of a variety of health professionals (e.g., medical, mental health, social), apply for funding for more nurse practitioners, educate service providers about PHA needs, provide orientation programs

for people newly diagnosed with HIV and their families/friends, increase access to services that support healthy living (e.g., nutrition, housing, alternative therapies), and advocate for specialized education courses for health care and social work professionals.

4. **Restructure or integrate the AIDS Committee of London and AIDS Action Perth**. Explore restructuring these community-based services in order to provide more service in rural parts of the region.

5. **Develop an integrated funding and fund raising strategy for HIV-related programs in the region**. The agencies plan to contract with a professional/experienced grants writer on an as-needed basis to prepare applications to foundations.

6. **Address rural needs**. The task force will establish a comprehensive outreach program for PHAs in rural areas that will address issues such as transportation, support services, information and access to anonymous testing.

7. **Develop an action plan to address youth needs**. Organizations will establish a six-county Youth Working Group to address the information and education needs of youth and build alliances with youth-serving agencies. The plan will use the Internet to provide information and will give youth greater access to harm reduction materials and information. ASOs and public health units will work together to engage district school boards and teachers in delivering consistent HIV/AIDS education.

8. **Develop an action plan to address women's needs.** The task force will establish a six-county women's issues working group to develop an awareness campaign to promote pre-natal testing and build partnerships with agencies that serve women.

9. **Develop an action plan to address gay men's needs**. The task force will use link with the provincial Gay Men's Strategy, and use research findings to improve prevention initiatives for gay men as well as men who have sex with men but do not self-identify as gay.

10. Develop an appropriate, affordable housing strategy. The task force will identify housing opportunities, and develop a continuum of care for PHAs from independent living to supported living and palliative care. The group will also consider lobbying the government for subsidies to enable PHAs to remain in their current housing or secure market-rate accommodation.

11. **Increase access to harm reduction information and services**. The group plans to increase condom distribution and expand needle exchange programs.

12**. Launch integrated, dynamic support and social groups for PHAs, families and friends**. In an effort to de-stigmatize HIV, the task force will organize inclusive (rather than population specific) groups that will be together people with HIV, and evaluate their impact.

13. Expand access to services. The region will use different strategies to improve access to services, including co-locating HIV and related services, extending hours of service, and using needle exchange programs to promote other programs and services.

14. **Develop a comprehensive communications strategy**. The goal is to ensure the community has accurate, timely information on HIV/AIDS and available programs and services. The strategy will include: issues management, electronic communications, media and community relations, event management and relationship development.

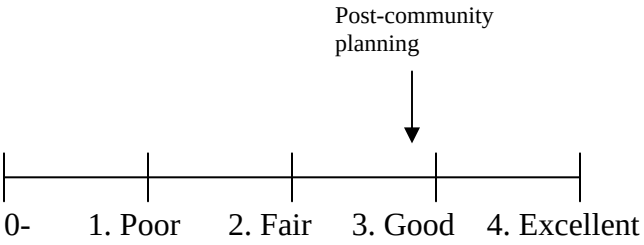
15**. Develop education and sensitivity training for service providers**. The task force will develop training materials for providers and professionals working in agencies or organizations that serve people with HIV – including government departments, such as Corrections Canada and Immigration Canada.

16. **Establish a government affairs subcommittee to advocate for supportive public policy.** The group would advocate for supportive policies, such as stable, long-term funding for HIV/AIDS services, more subsidized housing, cross-agency collaboration, and harmonization of Ontario Works, ODSP and Trillium Drug Program.

Evaluation Results

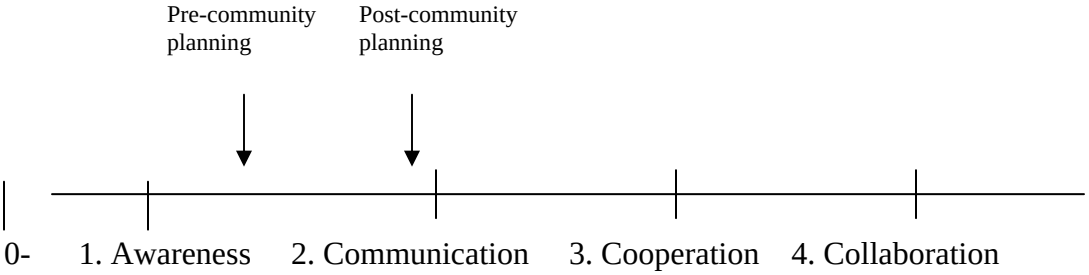
Algoma, Cochrane, Manitoulin and Sudbury region scored an overall 2.9 on collaboration – higher than the average for all regions. The region's score was particularly high in the area of benefits of participating in collaborative planning (3.50 out of 4).

Level of Collaboration



After community planning, the level of integration among services improved from 1.4 to 1.9 (out of 4): the largest increase of any region.

Level of Integration Pre and Post Community Planning



Assistance Required from the Ministry of Health and Long-Term Care

To be able to implement the plan, the planning area needs the following assistance from the Ministry of Health and Long-Term Care:

- advocacy with other parts/levels of government. The ministry should:
- work with other ministries/governments to increase subsidized housing
- work with the Ministry of Community and Social Services to harmonize the procedures and rules for Ontario Works, OSDP and the Trillium Drug Program

- work with the Ministry of Education to harmonize public policy
- **address misleading information.** The ministry should monitor and address misleading HIV/AIDS drug therapy claims and misleading advertising.

TORONTO: Summary of Community Plan

Key Regional Factors Shaping the Plan

- large urban centre with culturally diverse population that needs culturally competent, accessible services
- highest rates of HIV infection in Ontario (62% of Ontarians diagnosed with HIV live in Toronto)
- majority of people living with HIV in Toronto are gay men
- increasing rates of HIV infection in women, particularly Aboriginal women and women from countries where HIV is endemic
- stable infection rates among injection drug users, but risk levels high
- increasing homelessness and povery
- almost 2000 health and human service organizations, of which 30 are dedicated to providing HIV prevention, care, treatment and/or support services and more that provide HIV-related programs
- most services located in downtown core
- desire within the service system to maintain diversity of organizations, give clients choice and, at the same time, make effective use of resources
- almost all services involved in informal partnerships with some other agencies but no real "system" of services for people with HIV or populations at risk
- waiting lists for support groups, buddying, harm reduction programs, long-term care and palliative care services
- lack of services for long-term survivors/aging PHAs, women, Aboriginal people, recent immigrants, former prisoners, people with concurrent disorders and coinfections, and children growing up with HIV
- transformation and restructuring of the health system in which many services will be planned and funded by and accountable to the Local Health Integration Network (LHIN)
- increasing public apathy/misinformation about HIV.

Proposed Approach to Integrated Services

1. An Ongoing Multi-Sectoral HIV/AIDS Planning and Implementation Committee. A committee should be established to: oversee the implementation of the Plan; encourage continued coordination, planning and information sharing among ASOs and related organizations and programs; and promote a system-wide approach to addressing gaps. In addition, a number of working groups should be formed to address specific issues.

2. A Coordinated and Accessible HIV/AIDS Service Information System. A centralized system should be established, building on existing tools, to ensure clients and

service providers have access to up-to-date information (in different formats and languages) about HIV/AIDS and related services in Toronto (e.g., calendar of services and events in multiple languages).

3. Integrated, Innovative and Targeted Prevention/Education Strategies. A Prevention Working Group should be established to advocate for adequately resourced harm reduction programs, involve agencies that serve marginalized populations in HIV prevention education planning and delivery, and facilitate communication and collaboration between groups and networks working on targeted provincial prevention education initiatives and their local implementation.

4. More Responsive Health and Social Services. To ensure PHAs have access to responsive services from the broader health and social service system, the community should use a five-fold approach:

- build inter-sectoral partnerships between HIV/AIDS organizations/programs and broader health and social service organizations
- train organizations in the broader health and social service sectors (e.g., hospitals, primary health care, emergency health, long term care, housing, immigration, income support, shelter, mental health and addictions services) about HIV/AIDS;
- train HIV/AIDS organizations and programs about the broader service system, access process and system pressures
- develop coordinated advocacy efforts (HIV/AIDS organizations/programs and partners in other services) about the need for changes to policies and practices affecting PHAs and people at risk of HIV/AIDS
- develop more coordinated approaches to service delivery, such as "shared care/case management" models that involve greater coordination by different service provider organizations.

5. Enhanced Capacity to Serve Diverse Communities. To address the needs of an increasingly diverse population, the Planning and Coordination Committee should use a three-pronged approach:

- advocate for increased funding for population-specific ASOs and programs
- train and providing ongoing support/resources for staff and volunteers of HIV/AIDS organizations and programs to increase their cultural competency, using an anti-racist anti-oppression framework
- pursue partnerships to respond to concrete needs, such as having staff from a population-specific HIV/AIDS organization provide services at a more general HIV/AIDS organizations and vice versa, developing inter-agency and intersectoral partnerships to eliminate practical barriers such as transportation (e.g., ASOs providing services in the space of other organizations that serve non "downtown" neighbourhoods), expanding or altering hours of services, and offering services in more "neutral" settings to address concerns about privacy and inadvertent disclosure of HIV status.

6. Improved Access to Affordable, Appropriate Housing. To improve access to affordable appropriate housing (including shelters and long-term care homes, the TCPI Housing Working Group should:

- develop relationships with other community groups (e.g., mental health agencies) involved in housing issues, including those developing innovative housing access models
- focus on policy advocacy initiatives related to housing supply and access
- develop a Users' Guide to Affordable Housing using peer involvement.

7. Address Income and Employment-Related Needs. To address income and employment-related issues, the ongoing planning committee, along with the Education and Training Working Group, should:

- participate in provincial and federal level advocacy initiatives on matters related to income and employment
- reinforce the importance of employment programs in HIV/AIDS organizations/programs tailored to the needs of PHAs
- educate general employment programs about the needs of PHAs (e.g., the importance of flexibility and supports)
- build strategic alliances with key collaborators (e.g., unions, employers).

8. A Coordinated Training Strategy. The Education and Training Working Group should develop and coordinate a training strategy to meet the self-identified training needs of people living with HIV/AIDS, and support consistent levels of service across HIV/AIDS organizations and programs in Toronto.

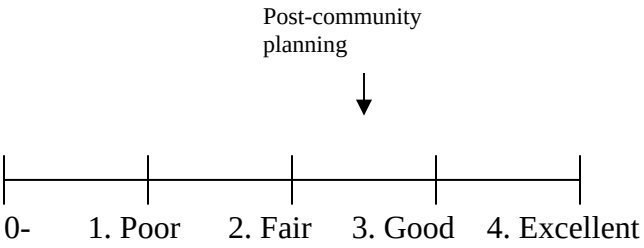
9. Infrastructure Partnerships. Toronto should build on the shared infrastructure pilot projects currently underway in Toronto's HIV/AIDS organizations and programs, such as the human resource initiative. The planning group can play a key role in documenting, monitoring and disseminating the lessons learned from existing projects, promoting new initiatives and developing a staff and volunteer retention strategy for the HIV/AIDS sector.

10. Coordination with Local Health Integration Networks (LHINs), Provincial HIV/AIDS Strategies and Other Emerging Initiatives. Given the changes occurring within the health care system, it will be important for HIV/AIDS programs to have a profile within the LHIN structure so they can advocate for broader system planning that addresses any gaps or barriers faced by PHAs, and to maintain their distinct funding through the AIDS Bureau. The ongoing committee should also be responsible for actively supporting implementation of provincial strategies and collaborating with other strategy or system restructuring initiatives that may affect services for the people living with HIV and populations at risk.

Evaluation Results

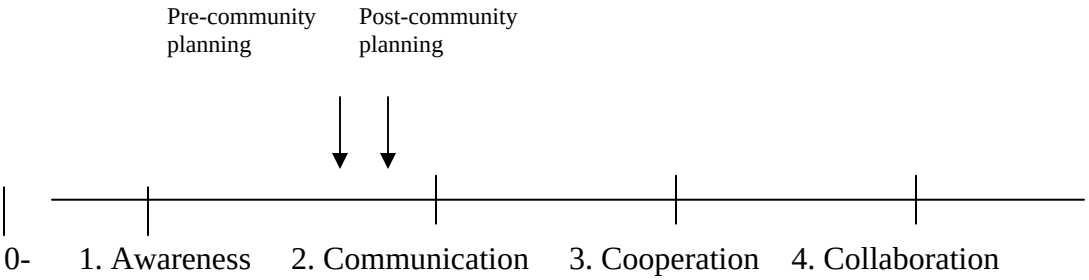
Toronto scored an overall 2.57 on collaboration. The region's score was particularly high in the area of sharing non-financial resources, such as skills, expertise and data (2.92 out of 4).

Level of Collaboration



The region started with a higher level of integration than other parts of the province (1.64 out of 4). After community planning, the level of integration among agencies in the region improved to 1.79 but, like other regions, remains at the "awareness" level.

Level of Integration Pre and Post Community Planning



Assistance Required from the Ministry of Health and Long Term Care

- Funding to support implementation of major recommendations.

WATERLOO, WELLINGTON, DUFFERIN & GREY BRUCE: Summary of Community Plan

Key Regional Factors Shaping the Plan

- relatively low incidence of HIV, but number of new diagnoses has risen sharply in Guelph and Waterloo in recent years
- increase in infections in people from countries where HIV is endemic
- low diagnoses in region – particularly rural areas – may understate real rates as people may leave the region to be tested/diagnosed
- steady increase in Chlamydia over past five years; low incidence of syphilis and gonorrhoea but rates have increased slightly in recent years
- increase use of cocaine and crystal meth among drug users, which increase risk by removing sexual inhibition and increasing libido
- reports of safer sex fatigue – less consistent safer sex practices
- more sexual activity at young ages (i.e., high school), increase in multiple partners

Proposed Approach to Integrated Services

1. **More effective prevention programs**. Organizations in the region (e.g., public health, community-based AIDS organizations, Planned Parenthood, schools, other community agencies) will collaborate to improve youth-oriented prevention education, planning together, and sharing innovative practices and materials. To ensure that education will not only build knowledge but have an impact on behaviour, it will be integrated into broader psycho-social and sexual health education. The region will also establish peer education programs. To improve prevention programs for hard-to-reach, at-risk communities, the region will collaborate to plan outreach programs, share best practices and make changes that will make programs more accessible (e.g., more sites, more flexible hours).

2. **Regional HIV clinic**. Gueph's Masai Centre will address some of the key needs identified by PHAs and service providers by bringing a range of services together under one roof, including clinical services, pharmacy services, counseling, alternative therapies and the community-based AIDS organization. An advisory committee with representatives from throughout the planning area will help ensure the clinic promotes a regional vision and acts as a conduit, solidifying connections among HIV-related services. The clinic will also explore the potential to address transportation issues by providing field clinics in smaller centres using traveling multi-disciplinary clinic teams and by providing mobile outreach services.

3. **Social supports for isolated people with HIV**. Community-based AIDS organizations will work with other community agencies to hold events that meet general needs (e.g., poverty, friendship, multiculturalism). The region is also exploring the potential to provide information and advocacy services to help PHAs navigate the

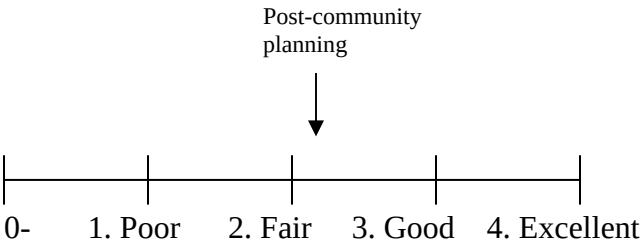
housing and ODSP systems, and obtain assistance with transportation and emergency financial support.

4. **More** i**ntegrated, comprehensive care and support**. Service providers will come together each year for an annual networking conference to learn about each other's programs and exchange information, materials and experiences. The region will also create an inventory of community services that can be accessed by individuals and case managers. Some communities are planning to establish inter-agency teams for collaborative case planning and case management (e.g., Waterloo); others plan to establish shared office space for outreach workers (i.e., HIV/AIDS, community mental health, addictions, street youth)

Evaluation Results

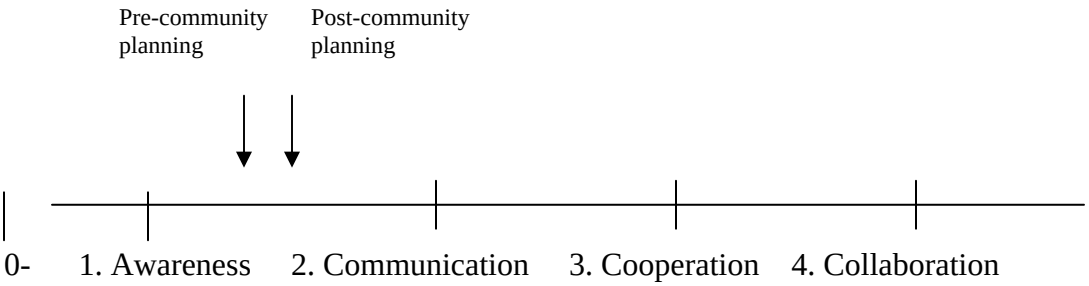
Waterloo, Wellington, Dufferin and Grey Bruce region scored an overall 2.23 on collaboration. The region's score was particularly high in the area of collaborative decision making (2.89 out of 4).

Level of Collaboration



After community planning, the region's level of integration increased from 1.4 to 1.5 (out of 4), which was slightly slower than the average for all regions.

Level of Integration Pre and Post Community Planning



Assistance Required from the Ministry of Health and Long-Term Care

- The report did not make any specific requests for assistance, but it did note that community-based AIDS organizations may be seeking funding to allow them to dedicate more time to developing collaborative relationships (i.e., the "champion" role).

WINDSOR-ESSEX & CHATHAM-KENT: Summary of Community Plan

Note: The plan is based on interviews with people with HIV/AIDS (PHAs) and service providers in the Windsor-Essex and Chatham-Kent area. It identifies partnerships to address specific problems/needs in the region rather than setting out a comprehensive plan.

Key Regional Factors Shaping the Plan

- large group of older PHAs and long-term survivors
- significant proportion of PHAs on ODSP, Ontario Works and CPP benefits, and use food banks or food co-op programs
- high rates of risk behaviour in youth aged 15 to 29 including reusing needles, unsafe sex, sharing sex toys, tattooing and piercing
- under-served GLBT community
- under-served prison population
- region served by one HIV Care Program and one community-based AIDS organization (although AIDS Support Chatham-Kent has its own name, most of its staff are paid through and work out of the AIDS Committee of Windsor)
- service providers in the region unable to commit time to serve on a planning group but willing to be involved in improving services
- some tension in the region over distribution of services between Windsor and the county
- shortage of primary care physicians so PHAs tend to rely on emergency departments and walk-in clinics
- long waiting lists for subsidized and supportive housing, and for addiction treatment services
- high turnover rates within social service agencies, which affect continuity of care.

Proposed Approach to Integrated Services

1. Defined partnerships with other agencies to meet needs. HIV-specific services in the region – that is, the AIDS Committee of Windsor, AIDS Support Chatham-Kent and the HIV Care Program – will work collaboratively with other services providers in the community to fill gaps in services and meet the needs of people living with HIV and those at risk. For example, the AIDS programs will work with:

- seniors' groups to develop more opportunities for social support for older PHAs
- the Homeless Coalition to advocate for more affordable housing and to explore the potential to provide supportive housing
- Youth and Family Resource Network Food Co-op to develop a food co-op that will give PHAs greater access to fresh fruit, vegetables and meat
- a travel agency to develop information to help PHAs make travel decisions

- the GLBT Resource Centre, Pride groups and the Metropolitan Community Church to meet the needs of the GLBT community
- social service providers and public health to develop STI prevention education for women on social assistance/in shelters
- public health and medical staff in the jails to advocate for on-site HIV testing and STI education/prevention programs for prisoners
- addiction agencies to increase access to treatment.
- Windsor Pride and QBarter to improve PHA access to complementary therapies, such as chiropractic services and massage therapy.

2. Collaboration with health care providers to reduce stigma and improve quality of care. A number of PHAs reported experiencing stigma in their encounters with the health care system. To reduce stigma, the AIDS committees will provide education for health care workers in settings such as walk-in clinics, emergency departments and laboratory services.

3. Service enhancements. The AIDS-specific services identified a number of ways to enhance services for PHAs, including providing more opportunities for social support and for meaningful work and volunteering, providing more information on health care for aging PHAs, providing a transportation service to appointments and developing a service to notify people living with HIV when friends have been hospitalized.

4. Prevention program for youth. The AIDS programs will work with public health and school boards to develop an STI/HIV prevention program that targets youth.

5. Public education to reduce stigma. Ensemble, a community group that addresses issues of discrimination of prejudice in Windsor-Essex, will develop strategies that can be adapted for Chatham-Kent.

6. Advocacy to improve the adequacy and continuity of social assistance programs. Current social assistance programs are complex to access and use, and do not provide adequate incomes for PHAs who are unable to work. Organizations in the region will advocate for policy changes that make the services easier for people to use, higher levels of assistance, and more funding to reduce staff turnover.

Evaluation Results

Windsor-Essex did not participate in the evaluation of community planning.

Assistance Required from the Ministry of Health and Long Term Care

The report did not request any specific support from the Ministry of Health and Long Term Care; however it did identify the need for more research on the needs of prisoners and for programs that would meet the needs of middle-aged PHAs whose health does not allow them to participate in activities of others who are the same age.

Provincial Organizations: Summary of Plan

Key Factors Shaping the Plan

- Provincial organizations are highly diverse: some serve specific populations (e.g., Aboriginal groups, Prisoners with HIV/AIDS Support Action Network, Voices of Positive Women); some were established specifically to support community-based AIDS organizations (e.g., Ontario Organizational Development Program, AIDS Bereavement Project of Ontario, Ontario AIDS Network); and some provide technical expertise (e.g., HIV/AIDS Legal Clinic [Ontario], Ontario HIV Treatment Network). One – the Canadian AIDS Treatment Information Exchange (CATIE) – is a national organization funded by the province to provide certain services.
- Most are located in Toronto, which makes it easier for them to collaborate but also means there is a risk their services will be Toronto-centric or more easily accessed by organizations in the GTA.
- Most are well-established – some have been in place for 20 years -- which makes change more difficult; while a small number are recent.
- Community-based AIDS organizations are highly satisfied with the services/support they receive from some provincial organizations; however, they see opportunities for provincial organizations to work in different ways.

Proposed Approach to Integrated Services

Based on the feedback from community-based AIDS organizations as well as their own assessment of the strengths and weaknesses of the way provincial services are organized and delivered now, the provincial organizations developed the following four-pronged strategy:

1. Provide leadership on emerging issues. Provincial organizations will lead efforts to advocate on emerging issues, and provide information and support to help community-based organizations meet clients' changing needs.

2. Adopt a client-centred approach to help serve clients with complex needs. Provincial organizations recognize that community-based organizations are dealing with clients with increasingly complex needs. Provincial organizations will take a more client-centred, determinants of health approach – rather than issue or population specific approach – to providing services. They will collaborate in organizing training sessions and workshops, ensuring they cover a range of issues relevant to clients and front-line service providers. Those provincial organizations that provide direct client services will take a shared care approach with community-based organizations that makes the best use of all skills and resources (i.e., provincial organizations will act as a second line service in communities that have local organizations, providing expertise as required, and as a front-line service in parts of the province that are unserved).

3. Use technology to share knowledge. Provincial organizations will develop more efficient effective ways to use technology to mobilize knowledge and exchange information with community-based organizations and others. They will also support community-based organizations in their efforts to use technology to deliver information and services.

4. Strengthen organizations. Provincial organizations will provide help and support for community-based organizations with a goal of enhancing their capacity to run effective efficient organizations and deal with the key challenges and issues they face. The plan is to focus initially on issues identified by community-based organizations: human resources management and program monitoring and evaluation.

5. Establish an ongoing provincial service integration planning group and engage other services. Provincial organizations will continue to meet at least twice a year as a full group and more often in working groups to implement this plan, and monitor its effectiveness. They will also identify effective ways to engage other services at the provincial level, to assist in advocacy and developing cross-sectoral policies and services to meet the needs of people living with HIV and populations at risk.

Evaluation Results

The provincial organizations did not participate in the community planning evaluation.

Assistance Required from the Ministry of Health and Long Term Care

The plan does not specifically request any help or assistance from the Ministry of Health and Long-Term Care; however, in the surveys conducted to develop the plan, provincial organizations reported that they are working to full capacity now and may need more resources to implement all aspects of this plan. The group has also asked the ministry for some logistical support (e.g., space for meetings).