

Improving Services for People with HIV and Communities at Risk in North Bay and Area (the Districts of Muskoka, Nipissing, Parry Sound and Timiskaming)—A Community Plan

Final Report

Submitted to the AIDS Bureau of the Ministry of Health and Long-Term Care by the AIDS Committee of North Bay and Area

February 2006

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INTRODUCTION

Background

In the mid 1980s, when little was known about HIV and people died within months of diagnosis, Ontario's response to HIV focused on stopping the spread of HIV and caring for those who were infected. For a time, that strategy was effective. Between 1990 and 1997, the number of new cases of HIV infections diagnosed each year in Ontario dropped by more than 50 per cent, from a high of more than 2,091 to 961¹. Over the same period of time, the treatment of HIV dramatically improved. The number of deaths from AIDS dropped significantly during the mid to late 1990s, and the number of people living with HIV has grown. By the end of 2000, a total of 21,272 people in Ontario had been diagnosed with HIV, and about 14,612 – or about 69 per cent – were still alive.²

Yet, despite this progress, HIV continues to be a serious, unstable, infectious, life-threatening illness. The incidence of HIV in Ontario is still unacceptably high. Over the past three years, there are disturbing signs that the gains in Ontario made in the 1980s and 1990s in preventing HIV have stalled. The epidemic continues and may be getting worse. In 2000, there were indications that the rate of new infections may be increasing in certain populations, in certain parts of the province. For example, about 24 per cent of HIV infections in Northern Ontario compared to 6.2 per cent in Ontario are attributed to injection drug use.

As a result, the Ontario Advisory Committee on HIV and AIDS (OACHA) recommended that each part of the province engage in its own process of community/regional planning, based on the directions outlined in the provincial strategy. The AIDS Bureau of the Ministry of Health and Long-Term Care (MOHLTC) launched a community planning initiative with all AIDS Service Organizations in the province to be completed in 2005. The objectives of this initiative are to

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

In response to the above request, the AIDS Committee of North Bay and Area (ACNBA) worked with two external consultants and several community planning groups in the Districts of Muskoka, Nipissing, Parry Sound and Timiskaming to prepare this report. In addition, a co-champion from each district provided further leadership and guidance as the project unfolded.

This report is a product of a consultative process with communities and is expected to serve as a planning tool for the implementation of better, more efficient services for people with HIV and populations at risk.

The report summarizes the following:

¹ Remis et al. Report on HIV/AIDS in Ontario 2000. Ontario Ministry of Health and Long-Term Care. December 2001.

² Ibid.

- socio-demographic characteristics of the population in the Districts of Muskoka, Nipissing, Parry Sound and Timiskaming;
- prevalence of HIV/AIDS;
- inventory of current services;
- analysis of service gaps and capacities; and
- planning considerations and next steps to assist with the implementation of the report's recommendations.

The purpose of this report is twofold:

1. To describe the planning area, specifically the people and their needs, and the existing services and their capacity;
2. To describe how existing services could be differently organized to meet the needs of people with or at risk of HIV/AIDS.

Process

The activities of this planning process consisted of:

- analyzing data, including census-related and health status information, and AIDS Bureau epidemiological information;
- actively consulting community planning groups;
- identifying co-champions for three of the four districts covered, as well as the ACNBA Executive Director, who also served as co-champion for the overall catchment area
- collecting and analyzing information about service gaps; and
- identifying potential alternative means of improving services in the planning area.

The project benefited from the presence of AIDS Bureau and other resource people at a launch early in April, in North Bay. The launch was well-attended, evaluations from attendees were very positive, and there was considerable interest voiced in the project. Subsequently, face to face and teleconference meetings were conducted with a community planning group established in three of the four districts served. From these consultations, co-champions were identified. Through discussions at these consultations, Terms of Reference were established for the groups (see Appendix A), including following values and goals, developed by the planning groups, further guided the philosophy of this project.

Values

- all people have worth
- all clients should have their needs met
- services should be non-judgmental
- services should be available as close-to-home for the clients as possible
- all clients have a right to self-determination
- all clients have the right to choose to have services and/or treatment external to their home community to protect their confidentiality
- HIV/AIDS affects families and therefore have right to information, education, and support

Goals

- to reduce/eliminate stigma
- to form a parent support group to reflect the unique voice of the individual districts, and the catchment area as a whole

- to actively advocate for a clinic in the North Bay hospital (physician, pharmacists, nurse, counselor)
- to provide outreach/mentoring for GPs (this especially critical for our rural/isolated communities)
- to ensure that alternative points of access to specialized treatment are available to protect confidentiality (given the small nature of so many communities in our area)
- to ensure access to specialized treatment and treatment information
- to maximize the use of technology to ensure access to treatment
- to address the lack of housing as a risk factor for disease progression

Limitations

Any planning exercise of this nature experiences limitations. It is not possible, for example, to make sure that responses to any survey are actually representative of the population surveyed, whether that is a consumer population, or a service provider one. Time, cost, timing, and other factors mitigate against certainty. These surveys, in particular, were not able to use a random sampling of either of their target populations. In addition, because we had no direct access to consumers, or, even more critically, to potential consumers of services, we cannot assume that these data are representative of either the in-need, or the demand population.

That said, it is incumbent on any planning exercise to move ahead with action, based on the data available, with the appropriate caution.

Data

In rural and Northern parts of the province, the stigma attached to HIV/AIDS makes data-gathering extremely difficult. Anonymity is a critical concern for people in small communities, where “everyone knows everyone else’s business”. As well, there is no ~anonymous~ testing available in these district (the closest site to the North is Sudbury). As a consequence, many people go outside the catchment area for testing, and often for treatment. This makes incidence and prevalence rates very difficult to establish, and it is difficult to establish an accurate level of need in the analysis.

Stakeholder Involvement

Also as a function of the rural nature of the catchment area, and the resulting concerns regarding stigma and anonymity, it was exceptionally difficult to attract involvement or input from people with HIV/AIDS, or their families or significant others. Nearly 400 questionnaires, with a small completion incentive, were disseminated to distribution points throughout the four districts; only 61 were returned.

It should also be noted that many of the service providers, particularly those in the health sector, are likely suffering from ‘planning fatigue’. Because health has been so volatile over the last years, many of these agencies have been, and are, involved in a number of planning exercises. One of the local health units has just been split, and its two halves merged with health units from other areas. All mental health and addiction agencies have been involved in extensive planning and restructuring exercises over a period lasting as long as ten years. The restructuring of catchment areas as a result of the establishment of LHINs has split two agencies across two LHINs. None of these planning or restructuring exercises has been accompanied by funding to support the agencies’ involvement; none has resulted in any substantial changes, and none has resulted in any additional funding. It is to the credit of the agencies which responded (and to a very lengthy survey instrument) that they evince

continued commitment to their communities and this population. Some of this 'planning fatigue' has implications for the recommendations that are made in Chapter 5. .

Health Care Reform

During the writing of this report, the MOHLTC was in the process of presenting its Transformation Agenda, which is expected to change the way the health care system works in the province of Ontario. The goal of this reform is to create an integrated system of care through the establishment of Local Health Integration Networks (LHINs). The Ministry received Cabinet approval to proceed with the appointments of Chief Executive Officers and Board chairs for the LHINs by April 2005. The specific details about the LHINs were, at the time of writing this report, still being developed by the Ministry; hence planning the development of a new regional-based service was difficult given the uncertainties created by this health care reform. Nevertheless, a copy of the final report for this project will be provided to the Northeast LHIN, to inform their planning for the region.

Geography

Two significant factors related to geography affected the extent to which service gaps and response could be accurately identified. First, the communities in the four districts are thinly dispersed over a very large landmass. There is, across the North, a lack of secondary service agencies (e.g., population-specific agencies) which might be potential service delivery sites, helping to broaden the base of service accessibility. The existing stakeholder agencies are generally very under-resourced, and have some difficulty serving their mandated populations adequately, making it much less likely that they are able to engage in any partnership which may require use of those scarce resources. Second, the service boundaries between ACNBA and its sister agency in the Northeast are unclear. Additionally, service boundaries among relevant stakeholder agencies (health units, school boards, and so on) overlap frequently. Developing a more effective service continuum requires that significant consideration be given to a number of complex service boundaries, and to the unique demographic and geographical features that distinguish this planning area from other parts of the province, and other urban centres, where centralized programs and services are available.

COMMUNITY PROFILE

The information presented in this section is based on the 2001 Census from Statistics Canada. It describes the area's geography and the socio-cultural and economic factors and their implications on the health of the population and delivery of health care services in the NNCCAC catchment area.

Geography

The Districts of Muskoka, Nipissing, Parry Sound and Timiskaming cover an area of 44, 807 square kilometres, that is approximately 700 kilometres from north to south (Figure 1.0). In practical terms, it is worth noting that it is approximately two and a half hours by road from North Bay to either the top, or the bottom, of this catchment area—in good weather, and without considering road construction or other disruptions. The consequences for ACNBA as a service provider, and for clients who are seeking services, are obvious.

Table 1.0 - Land Mass (km²) Census 2001

Ontario	Northeast	ACNBA Planning Area	Muskoka	Nipissing	Parry Sound	Timiskaming
907,656	279,914	43,457	3,890	17,065	9,222	13,280

Table 2.0 - Population Density (persons per km²) Census 2001

Ontario	Northeast	ACNBA Planning Area	Muskoka	Nipissing	Parry Sound	Timiskaming
12.6	2.2	4.8	13.7	4.9	4.3	2.6

Muskoka District is 3,890 km² and accounts for 9 per cent of the total land mass of the planning area. The population centres are scattered along the Highway 11 corridor and two thirds of the population live in the Towns of Huntsville, Bracebridge and Gravenhurst.

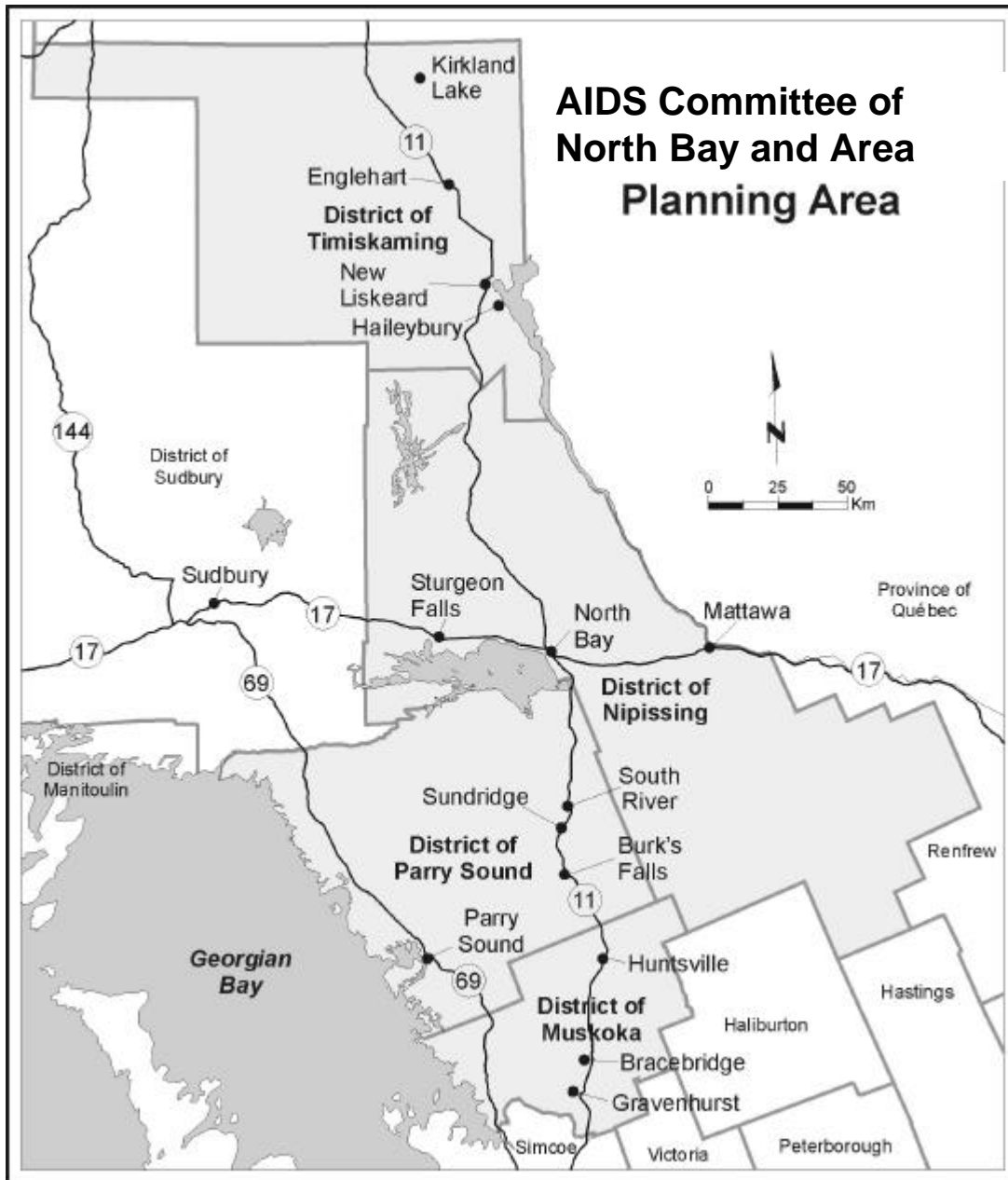
Parry Sound District is 9,222 km² and accounts for 22 per cent of the total land mass of the planning area. In East Parry Sound, the population is concentrated in villages along the Highway 11 corridor at Burk's Falls, Sundridge, South River, Trout Creek, and Powassan. Approximately half of the remaining population lives in rural areas. In West Parry Sound, the Town of Parry Sound is the major community, with most of the remaining population living along the Highway 69 corridor.

Nipissing District is 17,065 km² and accounts for 40 per cent of the total land mass of the planning area. The District of Nipissing can be divided into three main geographic areas based on population concentrations in North Bay, West Nipissing, and East Nipissing. These population clusters lie from east-west along Highway 17, with North Bay at the junction of Highways 11 and 17. The remaining population resides in smaller communities and townships in the northern and southern parts of the district.

Timiskaming District is 13,280 km² and accounts for 28 per cent of the total land mass of the planning area. Timiskaming is divided into three main geographical areas: North, Central, and South Timiskaming. Most of the population resides within relative proximity to Highway 11, with the balance living in small communities and townships in the western portion of the District.

Access to health and social services is limited by the lack of public transportation systems in rural communities and inadequate travel allowances in the budgets of most health and social programs. These factors, as well as poor road conditions and hazardous weather conditions also restrict the availability of services. The area's geography also makes professional development and public education more complicated to deliver.

Figure 1.0 – Map of ACNBA Planning Area



Total Population

Table 3.0 – Total Population and Percentage Population Growth/Decline by District, ACNBA Planning Area, Northeast Region, and Province, Census 2001

	Ontario	Northeast	ACNBA Planning Area	Muskoka	Nipissing	Parry Sound	Timiskaming
Total Population							
2001	11,410,046	604,778	210,123	53,106	82,910	39,665	34,442
1996	10,753,573	632,622	212,987	50,463	84,832	39,885	37,807
1991	10,084,885	629,900	210,134	48,005	84,723	38,423	38,983
1986	9,101,694	606,997	193,382	40,235	79,004	33,828	40,307
Population Change (%)							
1996-2001	6.1%	-4.4%	-1.3%	5.2%	-2.3%	-0.6%	-8.9%
1991-1996	6.6%	0.4%	1.4%	5.1%	0.1%	3.9%	-3.0%
1986-1991	10.8%	3.8%	8.7%	19.3%	7.2%	13.6%	-3.3%

Table 4.0 – Total Adult Population (16 yrs+) by District, ACNBA Planning Area, Northeast Region, and Province, Census 2001

Ontario	Northeast	ACNBA Planning Area	Muskoka	Nipissing	Parry Sound	Timiskaming
9,019,440	484,595	169,418	43,180	66,220	32,535	27,480

MOHLTC-funded programs serve the adult population (defined as 16 years of age and older); therefore, this report focuses on that segment of the population. This is not to suggest that HIV infection is not present, or is not a risk factor, in the younger population but that this particular age group is not addressed in this report, because the majority of relevant services for this age group are the responsibility of the MCYS. Currently, slightly fewer than half a million adults reside in the Northeast with the majority living in the Districts of Sudbury, Algoma, Cochrane and Nipissing.

Since 1990, the number of adult women diagnosed with HIV in Ontario has ranged from 166 to 216 each year. Women account for 20 per cent of new diagnoses. As Table illustrates there are slightly more females in each district of this planning area.

Table 5.0 – Total Male and Female Adult Population (16 yrs +) by District, ACNBA Planning Area, Northeast Region, and Ontario, Census 2001

	Total Population 16 Years +	Male	Female
Muskoka	43,180	21,180	21,995
Nipissing	66,220	31,590	34,635
Parry Sound	32,535	16,080	16,465
Timiskaming	27,480	13,260	14,230
ACNBA Planning Area	169,415	82,110	87,325
Northeast	484,595	235,050	249,515
Ontario	9,019,440	4,351,065	4,668,340

Socio-demographic Factors

There are two important ethnocultural minority groups to consider when planning health services in this planning area – the Aboriginal and Francophone populations.

Aboriginal Population

Table 6 summarizes the proportion of the Aboriginal population by district. These data capture both on-reserve and off-reserve Aboriginal people, although health care service provision for on-reserve Aboriginal people is a federal responsibility. The 2001 Census used the terminology, “Aboriginal identity population” to define the Aboriginal population.³ This is a grouping of the total population into non-Aboriginal or Aboriginal population, with Aboriginal persons further divided into Aboriginal groups, based on their responses to three questions on the 2001 Census form. Included in the Aboriginal population are people who reported identifying with at least one Aboriginal group, that is, “North American Indian”, “Métis” or “Inuit (Eskimo)”, and/or who reported being a Treaty Indian or a Registered Indian, as defined by the Indian Act of Canada, or who reported they were members of an Indian Band or First Nation (Statistics Canada, 2001 Census). It is important to note that many Aboriginal people refuse to complete these questions; consequently the size of the Aboriginal population is likely larger than given.

Table 6.0 – Aboriginal Population by District, ACNBA Planning Area, Northeast Region, and Ontario; Census 2001

Area	Total Population Aboriginal	Percent of Total Population Aboriginal
Muskoka	1,050	2
Nipissing	6,135	7.4
Parry Sound	1,855	4.67
Timiskaming	1,215	3.5
ACNBA Planning Area	10,255	6
Northeast	43,550	8.82
Ontario	188,315	1.7

The population defining itself as “Aboriginal identity” constitutes approximately 6 per cent of the total population in the area. This is significantly higher than the provincial experience (1.7 per cent). The Aboriginal population continues to grow more rapidly than the non-Aboriginal population. Currently, there is a larger proportion of young Aboriginal people compared to the general population in Canada. For example, the proportion of people between the ages of 15 – 24 years in 1996 was greater in the Aboriginal population (18 per cent) than the general population (13 per cent). Children under 15 years in 1996 accounted for 35 per cent of all Aboriginal people, which compared with only 20 per cent of Canada’s total population. Hence, significant increases will occur in the next decade among the Aboriginal youth population between the ages of 15 and 24 years (Northern Shores District Health Council, 2004).

These are important data to consider. Based on data from the provinces that do collect information on ethnicity, Health Canada estimates that Aboriginal people, who make up only 2.8 per cent of Canada’s population, accounted for 19.5 per cent of new HIV infections in 1998, 25.8 per cent in 1999 and 17.7 per cent in 2000. Health Canada also reports that, compared to other populations with HIV, the majority of Aboriginal people with HIV are younger, a larger proportion are women and a larger proportion are injection drug users. Although information from the Ontario testing system does not tell us much about infection among Aboriginal people, data from other sources indicates that this community has been disproportionately affected by HIV. Based on the experience of Aboriginal HIV organizations in Ontario, gay and two-spirited men continue to be the most adversely affected by HIV (which is consistent with overall HIV trends in Ontario). The organizations are also seeing a significant number of women.⁴

In 1993, recognizing the risk of HIV in the Aboriginal population, the province supported the development of the Ontario Aboriginal HIV/AIDS Strategy, which has developed a new strategic plan for the years 2001 to 2006.

Francophone Population

Mother tongue is defined as the first language learned as a child and still understood. Table 7.0 identifies the proportion of the population by mother tongue. Two of the four districts (Nipissing and Timiskaming) are designated under the *French Language Services Act*. ACNBA

⁴ A Strategic Plan for the Years 2001-2006. Ontario Aboriginal AIDS Strategy. February 2002.

is mandated to provide French language services. The *Act* places responsibility on *identified* services funded by the Provincial Government to ensure French language capacity.

Table 7.0 - Population by Mother Tongue, Proportion of the Population by District, ACNBA Planning Area, Northeast Region, and Ontario; Census 2001

Area	Population by Mother Tongue		
	Percent English	Percent French	Percent Nonofficial Languages
Muskoka	94.1	1.4	4.5
Nipissing	70.8	26.1	3.1
Parry Sound	92.6	2.6	4.8
Timiskaming	70.9	25.6	3.4
ACNBA Planning Area	80.9	15.3	3.9
Northeast	71.2	22.3	6.5
Ontario	71.6	4.4	24.0

English is the language first learned and still understood for the majority of the population in the area. In the Districts of Nipissing and Timiskaming, over one quarter of the population reported French as the language first learned and still understood. The language profile in this area is considerably different than that of the province as a whole; it is, therefore, essential that health and social programs have the capacity to provide French language services.

Injection Drug Use and Mental Illness

A significant proportion of people at risk and people living with HIV also have an addiction, substance use or mental health problem that affects their ability to make healthy choices, adhere to treatment regimens or maintain their health. AIDS service organizations report that a larger proportion of their clients now have an addictions problem and/or mental health problems than in the past, and that finding appropriate treatment services is becoming more difficult.

The number and proportion of new infections among the injection drug use population has dropped dramatically in Ontario. This change is due in part to the investment in both prevention and harm reduction programs and treatment services for injection drug users. However, as mentioned previously, the rate of new infections attributed to injection drug use is increasing in Northern Ontario. Compared to the provincial rate (6.2 per cent), approximately 24 per cent of HIV infections in Northern are related to injection drug use.

Residents in this planning area are hospitalized for mental illness and psychotic disorders more frequently than the provincial experience. In the Northeast Region of Ontario, people tend to be hospitalized for mental illness at a rate of 55% higher than elsewhere in the province, and 30% more often for psychotic disorders than the provincial average. In addition, the Northeast Region has a higher rate of hospitalization for suicides, and alcohol and drug dependence when compared to the province (NHIP, 2004).

Education

The determinants of health are inter-related, and do not function in isolation from one another. For example, a shortfall in one determinant, such as education, can have an impact on other determinants, such as employment, income and social status. As illustrated in the following table, the level of education achieved by residents in this planning area is, overall, lower than provincial rates.

Table 8.0 – Total Population 20 Years and Over by Highest Level of Schooling, Census 2001, 20% Sample Data

	Ontario	Northeast	ACNBA Planning Area	Muskoka	Nipissing	Parry Sound	Timiskaming
Total Population 20 Years and Over	8,282,160	442,405	154,140	38,975	60,025	30,140	25,000
Less Than Grade 9	8.7%	11.5%	10.4%	7.0%	10.7%	10.9%	14.2%
Grades 9 to 13	31.1%	35.8%	36.8%	38.7%	33.2%	39.9%	38.8%
Without High School Graduation Certificate	54%	60%	60%	58%	59%	63%	60%
With High School Graduation Certificate	46%	40%	40%	42%	41%	37%	40%
Trades Certificate or Diploma	10.2%	13.9%	13.7%	13.7%	13.8%	13.7%	13.4%
College	23.7%	23.6%	24.0%	23.6%	25.9%	21.8%	22.8%
Without Certificate or Diploma	28%	28%	27%	26%	28%	28%	25%
With Certificate or Diploma	72%	72%	73%	76%	72%	72%	75%
University	26.3%	15.1%	15.1%	17.0%	16.4%	13.7%	10.8%
Without Degree	27%	31%	32%	32%	32%	33%	31%
With Bachelor's Degree or Higher	73%	69%	68%	68%	68%	67%	69%

Employment and Income

A significant proportion of people at risk and those infected with HIV have low incomes. Although Ontario does not routinely collect data on socioeconomic need among people living with HIV or AIDS, there are indicators that poverty is a growing issue. Living longer with a chronic, life-threatening illness creates a range of financial issues. And living with HIV/AIDS in an area with already low income and high unemployment rates (Tables 9.0 and 10.0) increases the risk of poverty, and could exacerbate the disease progression of AIDS.

Table 9.0 – Provincial, Regional and District Labor Force Activity and Employment Statistics for Ages 15+, 15-24 and 25+, Census 2001, 20% Sample Data

	Ontario	Northeast	ACNBA Planning Area	Muskoka	Nipissing	Parry Sound	Timiskaming
Total Population 15 Years and Over by Labour Force Activity	9,048,040	485,365	168,845	42,415	66,135	32,735	27,560
Participation Rate	67.3%	60.2%	59.9%	62.1%	59.9%	58.2%	58.5%
Employment Rate	63.2%	54.6%	55.4%	59.6%	54.5%	54.1%	52.7%
Unemployment Rate	6.1%	9.3%	7.5%	4.0%	9.1%	7.1%	10.0%
Population 15-24 Years by Labour Force Activity	1,479,675	76,600	25,695	6,105	11,160	4,205	4,225
Participation Rate	66.4%	64.2%	65.3%	71.4%	63.2%	65.2%	62.4%

Employment Rate	57.8%	51.8%	54.4%	65.2%	49.7%	55.2%	50.3%
Unemployment Rate	12.9%	19.3%	16.8%	8.7%	21.3%	15.1%	19.5%
Population 25 Years and Over by Labour Force Activity	7,568,360	408,755	143,135	36,310	54,970	28,520	23,335
Participation Rate	67.4%	59.4%	58.9%	60.5%	59.2%	57.2%	57.9%
Employment Rate	64.2%	55.1%	55.6%	58.7%	55.4%	53.9%	53.2%
Unemployment Rate	4.8%	7.2%	5.7%	3.0%	6.4%	5.7%	8.1%

Table 10.0 – Average Employment Income for Total Population (15+ Years) with Employment Income by Gender and Work Activity, Census 2001, 20% Sample Data

	Ontario	Muskoka	Nipissing	Parry Sound	Timiskaming
Total Population 15 Years and Over with Employment Income	6,319,530	28,080	41,435	19,855	16,535
Average Employment Income, \$	35,185	25,949	27,720	24,825	27,184
Average Employment Income, Worked Full Year, Full-Time, \$	47,247	36,661	39,206	35,321	38,842
Average Employment Income, Worked Part Year or Part-Time, \$	20,816	16,551	16,964	15,659	17,481
Males 15 Years and Over with Employment Income	3,311,105	14,535	21,760	10,540	8,750
Average Employment Income, \$	42,719	31,012	33,318	29,327	33,043
Average Employment Income, Worked Full Year, Full-Time, \$	53,923	41,135	44,092	39,356	43,297
Average Employment Income, Worked Part Year or Part-Time, \$	25,139	18,917	20,134	17,418	21,948
Females 15 Years and Over with Employment Income	3,008,425	13,550	19,675	9,315	7,785
Average Employment Income, \$	26,894	20,518	21,528	19,727	20,604
Average Employment Income, Worked Full Year, Full-Time, \$	37,720	29,985	32,092	28,884	31,833
Average Employment Income, Worked Part Year or Part-Time, \$	17,347	14,648	14,255	14,165	13,849

Implications

Socio-demographic and health status indicators (i.e., the determinants of health) for this catchment area are typically less favourable than the regional and provincial averages. These include lower education, employment and income levels, and resulting higher poverty level, than the province as a whole. These factors are also known to influence the population's utilization of health and social services.

Service delivery to a small and diverse population spread over this large geographic area is complicated by the effects of inclement weather for a significant part of the year. There are limited service economies of scale due to geography, distance, isolation, and average organizational size, which may affect each district's ability to achieve provincial costing benchmarks.

Rural communities in general are defined as having a small population base, low population density, distance from any major urban centre, and a dependence on primary-resource-based employment. There are particular difficulties involve in providing any service to a rural population. Residents of rural communities are characterized by

- a tendency to turn to informal help networks in preference to formal, 'institutional' agencies. When the issue is HIV infection, the effectiveness of this typical behaviour is likely to be compromised by the relative lack of awareness and sound information in the general public, and the effects of stigma associated with HIV.
- generally more conservative attitudes, and less tolerance of non-traditional beliefs and behaviours. A good personal reputation is highly valued. As a consequence, people may be more motivated to keep a problem hidden longer.
- great concern about confidentiality, due to the lack of anonymity in small communities and rural areas. This is particularly an issue for people with a high profile in the community. People may be reluctant to be seen going into a building where services for sensitive or stigmatized issues are offered. People may prefer to go outside their home community for service.

There are also a number of challenges associated with the recruitment and retention of qualified health professionals, and maintenance of an appropriate mix of health service professionals in the area's rural communities. The area's low population density also creates the challenge of obtaining adequate levels of funding, and attracting sufficient and appropriate health human resources to a significant number of small communities. Consequently, service providers tend to have heavy client caseloads, be under resourced and have relatively few services to refer to. Access to services is limited by the lack of public transportation systems in rural communities and inadequate travel allowances in the budgets of most health agencies. These factors, as well as poor road conditions and hazardous weather conditions, also restrict the availability of early assessment, treatment and follow-up for this client population that typically lives with significant mobility issues.

TARGET POPULATION

Prevalence

There are distinct geographical differences in the incidence/prevalence of HIV and the populations that are risk of infection. A review of the epidemiological data provided by Dr. Robert S. Remis and Maraki Fikre Merid of the Department of Public Health Sciences University of Toronto (2005), confirms some differences between each of the planning area's districts. (Again, it is important to bear in mind that these data report the district in which testing took place, not necessarily the district of residence of the individual.)

Table 11.0 – Rates of HIV/AIDS per District, Remis et al

Rates of HIV/AIDS	Muskoka and Parry Sound Districts		Nipissing District		Timiskaming District	
HIV Diagnosis Rate per 100,000 Population	39.8		56.3		23.2	
Ranking Among all Public Health Areas in Ontario	16 th		12 th		21 st	
HIV Diagnoses	38	53% MSM	52	42% IDU	< 5	MSM
		18% Heterosexual		21% MSM		IDU, Endemic
AIDS Cases	19	53% MSM	31	48% MSM	9	22% MSM
		21% Heterosexual		16% MSM-IDU		44% Clot/Trans

Notes:

MSM = Men having sex with men

IDU = Injection Drug User

Endemic = country of origin with high levels of HIV/AIDS

Clot/Trans = blood transfusion, other blood products

Heterosexual = transmission through heterosexual contact

The HIV epidemic appears unstable in Muskoka and Parry Sound Districts. HIV diagnoses have doubled since 1996, and HIV diagnoses have increased among injection drug users and in the heterosexual population. In Nipissing, the HIV epidemic appears relatively stable; however, the rate of HIV is increasing among men who have sex with men faster than that for Ontario as a whole, and the proportion of HIV diagnoses is also increasing among men having sex with men. In Timiskaming District, the epidemic in appears generally stable, with HIV diagnoses stable in all exposure categories

Contributing Factors

As noted in the previous section, communities at higher than normal risk of HIV infection have been identified as men having sex with men, injection drug users, Aboriginal people and people from countries where HIV is endemic. However, risk should be viewed more broadly. People in these populations are usually at risk because of other factors, including poverty, mental health issues, self-esteem issues or substance use. Further compounding the incidence and prevalence rates of HIV/AIDS are factors that arise from a lack of some of life's most basic necessities such as affordable housing, adequate income and sound mental health.

A survey conducted by Health Canada confirmed the following determinants of health factors can put people at risk of becoming infected or of more rapid disease progression once infected. These factors include poverty, addictions, mental health problems, marginalization, lack of information, cultural barriers, lack of employment, isolation or lack of social support and lack of safe housing.

Similarly, consumers and service providers in each district highlighted similar risk factors-- specifically, that substance use was the greatest factor associated with becoming infected. Also included in order were ignorance, mental health problems, individual attitudes and poverty. Substance use was also regarded as the risk factor most likely to exacerbate disease progression. It was followed by mental health problems, poverty, lack of education, lack of access to treatment and late testing/diagnosis.

Social inequities that contribute to the HIV/AIDS epidemic can be exacerbated by certain policy decisions; however, the impact is likely that much greater in this planning area given its higher rates of substance use/abuse, mental illness and poorer determinants of health.

Implications For The Future

By and large, the population of the North of the province is declining, and aging. Consequently, it is reasonable to assume that there will be a smaller population at risk, and a smaller infected population, in future years. However, the population that will remain present retains all the risk factors noted above (poverty, low education, under- or un-employment, and, presumably, continued struggles with mental illness and substance abuse problems. Therefore, services should be more targeted to those specific populations. In addition, efforts should be strongly focused on surfacing and diminishing the stigma that is associated with HIV/AIDS and the risk behaviours associated with it.

CAPACITIES, NEEDS AND GAPS

This section describes the methodology and highlights key findings that emerged from a scan conducted for each district of the planning area. Findings were reported to the project's co-champions and they and other members of the community planning groups provided further input. The service needs, capacities, and gaps identified from this process served as the foundation for the development of implementation strategies to improve services for people with HIV and populations at risk. Findings are presented by district, and areas of common concern are also discussed.

Methodology

The following activities were completed as part of the scan:

1. Review literature, pertinent policy documents and epidemiological data.
2. Solicit input from community planning groups.
3. Develop and review a service inventory.
4. Administer consumer and agency surveys.

Sources of data included the following:

- stakeholder comments;
- 2001 Census data;
- 2002 Ontario Advisory Committee on HIV/AIDS Strategy;
- 2000 Ontario MOHLTC Report on HIV/AIDS in Ontario;
- research literature; and
- local survey findings.

Service Inventory

A list of agencies who were identified as potential service points for members of the target population was developed (attached, Appendix D).

It is important to note that it is not possible to connect specific issues related to capacity to individual agencies. In small rural communities, it is extremely easy to identify a particular service provider agency from very little data. In order to obtain the most complete and

accurate data possible from providers, they were assured that data would only be presented at the aggregate level, with all identifying information stripped.

Survey

Two types of questionnaires were mailed to stakeholders throughout the planning area.

One questionnaire was directed to service providers from a wide array of health related service sectors (Appendix D). This agency survey targeted both program managers and front-line staff.

The second questionnaire was directed to anyone who was HIV positive, or at risk of infection, or their family members.

Both surveys were designed to capture qualitative as well as quantitative data, and were intended to:

- confirm the needs in each district;
- identify service gaps and issues; and
- identify the most desirable and effective approaches to planning and implementing strategies to improve services.

Nearly 400 questionnaires, with a small completion incentive, were distributed across the planning area: over 300 to consumers and 54 to agencies. Copies of the instruments are attached (Appendices B and C). Of the 54 agency surveys, 20 (37%) were returned. Of the consumer surveys, 41 (approximately 14%) surveys were returned. Both these return rates are considered to be reasonable for their respective groups.

Consumer Survey Findings

To ensure confidentiality, it was not feasible to have consumers identify their community or District.

Seven respondents skipped the question asking them to identify themselves as having HIV/AIDS, being a family member or significant other person of someone with HIV/AIDS, or being at high risk for HIV/AIDS. Five respondents identified themselves as having HIV/AIDS. Three identified themselves as family members or significant other persons of someone with HIV/AIDS. The majority of respondents (85%) identified themselves as belonging to a high-risk category.

Of the 28 respondents to the question asking them to identify their risk factor, the majority (18) selected having had unprotected sex in last 20 years. Twelve identified as Aboriginal. Seven selected having been a prisoner; three injecting unprescribed drugs, two men having sex with men, none having been from an endemic area. Note that many respondents selected more than one risk factor.

Types of Services Received

Only twenty-two per cent (n=10) responded to the question related to services received from ACNBA. This suggests that a significant proportion of the respondents across the districts may not be aware of the services available by ACNBA. However, of those who responded as having used the services of ACNBA, all reported these services as having been helpful. Services most frequently cited as being used by the respondents included:

- prevention of HIV/AIDS (pamphlets, presentations, counselling);
- HIV/AIDS testing and diagnosis;
- counselling for HIV+ people;
- counselling for family/significant others of HIV+ people;
- spiritual help and support;
- dietary/nutritional supplements;
- ongoing support groups for HIV+ people;
- transportation assistance to medical, legal or other appointments/bus tickets passes or taxi vouchers;
- harm reduction services (condoms, lube etc);
- assistance with completing ODSP, travel grants etc;
- social activity support; and
- referral to other services in the community.

This suggests that consumers who are aware of the ACNBA services are being helped with the above needs. As the following table illustrates, ACNBA services less frequently used by the respondents may reveal service gaps, a lack of awareness of ACNBA services, that needed services are being accessed elsewhere in the community, or that needed services are not part of the ACNBA mandate.

Table 12– Utilization of Services Provided by ACNBA and Other Agencies, ACNBA Planning Area, 2005

Services	Level of Use 3= frequent use 0 = less frequent use # not used n/a not part of ACNBA mandate	
	ACNBA	Other Agencies
Prevention of HIV/AIDS	3	3
HIV/AIDS testing	3	√
Counselling for HIV+ people	3	√
Counselling for family/significant others of HIV+ people	3	√
Counselling for people at high risk	√	√
24-hour crisis response line	√	√
Budget or credit counseling	√	√
Spiritual help and support	3	√
Emergency medical attention only	#	3
Direct medical care/clinical treatment	n/a	3
Housing/assistance to secure housing	√	√
Temporary shelter/homeless services	n/a	√
Meals/soup kitchen	√	√
Vouchers for perishable items	√	√
Food bank	√n/a	3
Dietary/nutrition counseling	√	3
Dietary/nutritional supplements	3	√
Financial support	n/a√	√
Vouchers for clients to help access services	√	√
Ongoing support groups for HIV+ clients	3	√
Transportation assistance	3	3

Services	Level of Use	
	3= frequent use 0 = less frequent use # not used n/a not part of ACNBA mandate	
	ACNBA	Other Agencies
Palliative care/grief counseling	n/a	√
Help with finding employment	√	√
Harm reduction services (Needle Exchange)	√	√
Harm reduction services (condoms lube etc.)	3	√
Legal Services (power of attorney issues)	√	√
Home Care	n/a	√
Relocation assistance or start-up costs	n/a	√
Financial Assistance (direct cash to clients)	n/a	√
Assistive Devices (wheelchair walker eyeglasses hearing aid etc.)	n/a	√
Detox	n/a	√
Inpatient Addiction Services	n/a	√
Outpatient Addiction Services	n/a	√
Clothing Depot	n/a	√
Injection Drug Use support (harm reduction e.g. safer injecting practices)	#	√
Assistance with completing ODSP travel grants etc.	3	√
Social Activity Support (group or individual activities like drop-in centre Christmas party etc.)	3	3
Mental health programs/services	n/a	√
Referral to other services in the community	3	√

It is important to note that some of the services with low or no utilization are only available in the North Bay centre (e.g., vouchers for perishable food items, injection drug use support). In that area, they are well used. It is an indication of the impact of ACNBA's low level of resourcing that these services have not been similarly available throughout its catchment area.

Approximately 40 per cent of the respondents (n=18) indicated they had received HIV/AIDS related services from other sources as well, largely from general health/social service providers. A few indicated that they needed housing or home care but were unable to access these services; the need for specialized Aboriginal services was also identified.

Overall there are a number of services that have low utilization. Of particular concern are the services with low utilization whether provided by ACNBA or other agencies. This may indicate a number of critical service gaps and/or service barriers for people with, or at risk of HIV/AIDS and their significant others. Services provided by either or both ACNBA and other agencies which have overall low utilization include:

- counselling for people at high risk;
- 24-hour crisis response line;
- budget or credit counselling;
- housing/assistance to secure housing;
- meals/soup kitchen;
- vouchers for perishable items;
- financial support;
- vouchers for clients to help access services;
- help with finding employment;

- harm reduction services (needle exchange); and
- legal services (power of attorney issues);

Other services of concern are those where there is no utilization at ACNBA and low utilization at other agencies. These include:

- emergency medical attention only;
- direct medical care/clinical treatment;
- temporary shelter/homeless services;
- palliative care/grief counselling;
- home care;
- relocation assistance or start-up costs;
- financial assistance (direct cash to clients);
- assistive devices (wheelchair walker eyeglasses hearing aid etc);
- detox;
- inpatient addiction services;
- outpatient addiction services;
- clothing depot;
- injection drug use support (harm reduction e.g. safer injecting practices); and
- mental health programs/services.

The low or non-existent level of use of several services is not surprising. Twenty-four hour crisis lines which could appropriately respond to the needs of those with or at risk of HIV infection are not available in the Northern Shores area. The availability of low-cost housing stock is very low throughout the area. Food banks and soup kitchens are generally only available in the urban centres. Addiction and mental health services are in very short supply. Some partners in the various districts, including ACNBA, have been providing harm reduction services including needle exchange, but these are again only available in the urban centres, as are palliative/grief-counseling services.

Helpful Services

Of the respondents who reporting using services from other agencies, approximately half indicated that the following had not been helpful: counselling for people at high risk; budget/credit counselling; housing assistance; vouchers for perishable food items; vouchers to help access services; legal services; home care; relocation assistance or start up costs; and assistive devices.

Services provided by other agencies that were identified as helpful by half of the respondents included prevention of HIV/AIDS; emergency medical attention only; direct medical care/clinical treatment; dietary nutritional counselling; meals/soup kitchen; food bank; transportation assistance; palliative care/grief counselling; harm reduction (needle exchange); harm reduction (condoms, lube etc); detox; inpatient and outpatient addiction services; injection drug use support; the clothing depot; social activities; and referral to other services.

Service Challenges

Overwhelmingly, respondents to the consumer survey identified issues related to geography (e.g., transportation, scarcity of services) as the greatest challenge to service coordination in their area, followed by issues of stigma and confidentiality. The most frequently cited barrier to enhanced service availability was lack of funding. Comments

collected from respondents about services included several references to needing more awareness about HIV/AIDS testing and diagnosis, counselling for people at risk, housing assistance options and temporary shelter/homeless services.

Service Gaps

Only one respondent identified a new service type (HIV/AIDS services specific to First Nations people, both on- and off-reserve); several respondents reported the need for greater availability of services that ACNBA is already providing. Respondents suggested that the formation of partnerships (see Figure 7.1) between agencies was the most appropriate community development strategy for their district to better meet the needs of HIV/AIDS-affected people or communities at risk. Encouragingly, a significant number indicated that they would like to be further involved in this community planning/development initiative

Insight into the service utilization patterns of current services combined with the following additional findings of consumers helped to define a range of possible implementation strategies to address the service gaps identified in this section. The next section presents information collected from agencies.

Agency Survey Findings

The majority of respondents was from mental health and addiction agencies or school boards. Nipissing District had the greatest number of responses (10/24), Parry Sound returned over 50% of its questionnaires (4/7), Timiskaming returned 50% (3/6), and the lowest response rate was from Muskoka District (1/4). Two respondents did not indicate their agency name or district. Many agencies serve more than one district.

The disproportionate response rates across districts, and across service sectors, must be noted when considering the results of the survey.

Most agencies reported that they do not receive funding designated to address HIV/AIDS issues. In addition, most indicated that they were not aware of any current clients who have HIV/AIDS.

Agencies were also asked to indicate the type of client groups that would most often use their agency's services. Again, note that most respondents were from addiction and mental health agencies.

In Muskoka, the groups most commonly identified as requiring services include women at risk and Aboriginal people, followed by a seven-way tie among

- people with substance use problems;
- injection drug users;
- sex trade workers;
- men who have sex with men;
- gay men;
- street-involved people; and
- people who have been incarcerated.

In Nipissing, the group most commonly identified was Aboriginal people followed by a three-way tie among women at risk, people with substance use problems and people with mental health problems. Other frequent selections included

- street-involved people;

- men who have sex with men; and
- people who have been incarcerated.

In Parry Sound, groups most frequently selected included Aboriginal people and women at risk followed by a five-way tie among

- people with substance use problems;
- men who have sex with men;
- gay men;
- street-involved people; and
- people who have been incarcerated.

And in Timiskaming, the majority of the respondents selected people with substance abuse problems, and then equally selected the following groups.

- women at risk;
- infants at risk;
- injection drug users;
- people with mental health problems;
- men who have sex with men;
- gay men;
- street-involved people;
- sexually active people; and Aboriginal people.

Almost half of the respondents indicated that they are not aware of the extent to which their services are being used by people with HIV/AIDS.

Communities at Risk

Agencies who were serving people with HIV/AIDS were asked to identify the populations at risk who were most frequently using their services. The largest single population identified Aboriginal people, followed by a three-way tie between women at risk; people with substance use problems; and people with mental health problems.

The majority of respondents indicated that the greatest risk factor for becoming infected in their district was substance use; this is consistent with the fact that there are increasing numbers of people becoming infected from injection drug use in Northern Ontario. (Note that we use the term injection drug use, rather than intravenous drug use, as steroid use is a significant problem in the area.) Substance use was followed by ignorance, mental health problems, individual attitudes, and poverty.

The following table represents the risk factors that respondents believed increase the risk of infection in each district. The top three factors are bolded.

Table 13– Importance of Risk Factors Associated with an Increased Risk of Infection by Order of Importance and District, 2005

Risk Factor	Muskoka	Nipissing	Parry Sound	Timiskaming
Addictions/drug use	1	1	1	1
Individual attitudes	2	4	3	2
Ignorance/misunderstanding	2	2	2	1
Poverty	2	5	2	3
Marginalization	2	7	4	4

Stigma	3	8	3	4
Lack of self esteem	2	6	3	4
Mental health problems	2	3	1	3
Relationship issues	4	7	5	4
Homelessness	4	8	4	5
Cultural displacement issues	4	8	6	4

Note:

1 – Most Important

10 – Least Important

In addition, respondents were also asked what factors they believed would increase disease progression among infected individuals in their district. Substance use was also noted as being the factor most likely to exacerbate disease progression. Other factors in priority order included mental health problems, poverty, lack of education, lack of access to treatment and late testing/diagnosis. This information is presented in the following table with the top three factors bolded.

Table 14 – Importance of Risk Factors Associated with Disease Progression by Order of Importance and District, 2005

Risk Factor	Muskoka	Nipissing	Parry Sound	Timiskaming
Poverty	1	2	2	2
Lack of affordable housing	2	7	4	-
Stigma/discrimination	2	5	2	3
Language/cultural barriers	4	2	5	5
Mental health problems	3	2	2	4
Drug/alcohol use	2	1	1	1
Lack of family/community support	3	7	5	3
Poor nutrition	3	6	3	2
Health status/coping skills before infection	4	5	4	3
Lack of access to treatment/care	3	4	3	3
Lack of education and information	3	3	2	2
Distance from physician services	2	5	5	2
Late testing/diagnosis	3	4	4	2
Non compliance with medications/fear of treatment	4	8	4	5
Drug resistance/treatment side effects	4	9	7	4
Number of exposures to a number of strains	4	10	7	-

Note:

1 – Most Important

10 – Least Important

Knowledge of HIV/AIDS Services

Overall, the majority of respondents who are not providing services specific to HIV/AIDS issues are nevertheless aware of where to get information on HIV/AIDS and where to refer for services. Only half of the respondents in Parry Sound, however, know where to refer for services. Overwhelmingly, agencies that identified themselves as not providing services or support to HIV/AIDS people indicated the following reasons for this:

- not part of their mandate;
- not part of their funding envelope; and
- people with HIV/AIDS prefer to access services out-of-District.

This last is an interesting finding: most agencies are not providing services to this client population, yet they nonetheless feel that they know that the population seeks services outside of their service area.

One option offered on the questionnaire for agencies to select as the reason that they are not providing service to the in-need population was “a high level of homophobia in my community”. The only respondent to this question in Parry Sound, and one of the three respondents in Nipissing, selected this reason, among others. Insufficient training on issues related to HIV/AIDS and insufficient financial resources to provide services specific to issues related to HIV/AIDS were also selected by the majority of respondents in Parry Sound. Both of these barriers were also selected by respondents in Nipissing but to a lesser degree of frequency.

One agency noted that the increase in numbers of infected persons put an increasing strain on its financial resources. One agency noted that it is developing a program for exotic dancers and trafficked women.

Service Capacity

Most respondents stated that they are operating at full capacity with only a third, however, reporting having a waiting list for the services they offer that have the capacity to respond to people with HIV/AIDS.

Encouragingly, there was some untapped service availability reported which can be pursued in future. Nearly 30 per cent of respondents reported unused capacity in their services (this capacity is not necessarily specific to HIV/AIDS issues).

Most respondents report the need for better linkages and that more information would help to better serve this population. Whether they were already providing services to this population or not, the majority indicated that they foresaw less available service capacity in the future.

As for interaction with ACNBA and other ASOs, most respondents reported the need for more information, materials, training, and population-specific support (women, Aboriginals) in order to improve their services. A small majority had received HIV/AIDS information in the last year from a variety of sources, mostly from ACNBA. Most respondents indicated their interaction with ACNBA in the last year was predominantly for information or referral.

In addition, an overwhelming majority of respondents indicated they believe that it is important to receive any HIV/AIDS related information. Almost a third of the respondents reported not having received any information about HIV/AIDS and HIV/AIDS related programs and service in the past twelve months. Only 44 per cent indicated they received some information at a rate of 1 to 5 times, and 21 per cent indicated they had received some information six or more times. Muskoka and Parry Sound districts reported the highest rates for never having received this information, while more agencies in Nipissing and Timiskaming reported having received such information.

Respondents were also requested to indicate the level of interaction their agency has had with ACNBA in the last twelve months. Not surprising, the highest rate of interaction was reported in Nipissing, but almost a third of the respondents still indicated not having had any interaction. The respondents in Timiskaming reported the lowest rate of interaction with ACNBA.

The vast majority of respondents indicated that their agencies do not have employees or volunteers who work in HIV prevention and/or AIDS related service provision only. Agencies therefore feel unable to devote time, especially in program planning and promotion, to promoting harm reduction practices and to ensuring that individuals are aware of where to access information and services. In this line, it was expressed that Public Health Units in particular needed dedicated funding for staffing to support these activities.

Almost all of the respondents agreed that staff and volunteers should have training to respond to the service needs of people with HIV/AIDS. Respondents also identified training needs.

In Muskoka the following topics were selected:

- general training on sexually transmitted diseases, HIV/AIDS and service intervention practices with HIV/AIDS affected people;
- HIV/AIDS prevention;
- HIV/AIDS case management training; and
- counselling and support for HIV/AIDS clients and their families and significant others.

In addition to these topics, respondents in Nipissing also identified the following training needs:

- conducting HIV/AIDS risk assessments;
- providing HIV/AIDS related services to pregnant women;
- conducting HIV rapid testing and counselling;
- general training on Hepatitis, Hepatitis prevention and service intervention practices; and
- conducting injection drug use interventions;

Those in Timiskaming selected similar topics, but excluded general training on sexually transmitted diseases and conducting injection drug use interventions.

The only training topics identified by respondents in Parry Sound were

- general training on sexually transmitted diseases, HIV/AIDS, service intervention practices with HIV/AIDS affected people and on Hepatitis, Hepatitis prevention and service intervention practices; and
- how to offer counselling and support for families and significant others.

Although the samples are not representative of the training needs in each district, this information does indicate some level of need and interest.

Service Gaps

Most respondents reported being unsure whether any services were missing for people with HIV/AIDS in their districts. Those few who thought more services should be available identified information, information for professionals, anonymous testing, specialist physicians, and a dedicated Aboriginal front-line worker at ACNBA as service gaps. The greatest challenge affecting the level of service delivery in their area was reported as being the scarcity of services, specifically specialist medical services

Only one respondent indicated that their agency should offer programs and services currently not offered for HIV/AIDS affected people and communities at risk. Most respondents indicated that they should not expand their service array to include these services; several more were not sure.

Respondents were asked about the availability of support groups in their district for people with or at risk of HIV/AIDS. All cited ACNBA only.

Some of the greatest service challenges impeding a more coordinated approach to service delivery are associated with the issues around the area's geography. Other significant challenges include the chronic shortage of physicians of any nature, but most particularly specialists.

In addition, there was considerable "catchment confusion" regarding the catchment area of ACNBA and its sister agency in Sudbury. This is not a matter of where clients go for service, as of course there are no boundaries for this. It is an issue of who is responsible for engaging and liaising with the other related stakeholder providers most effectively.

Strategies to Improve Services

Of the options presented to them, an overwhelming majority of respondents indicated that informal networking, referral protocols and interagency training events were their preferred strategies to better meet the needs of HIV/AIDS affected people or communities at risk. There were some slight differences among the districts. In Muskoka, most respondents indicated a preference for informal networking and referral protocols. In Nipissing, informal networking, interagency training events and formal networking and meetings were also selected. In Parry Sound, informal networking, referral protocols and interagency training events were preferred while in Timiskaming referral protocols, planning and service committees and interagency training events were selected.

Type of Participation to Plan and Implement Better Services

Respondents were also asked about choosing the way they would rather participate in helping to plan and implement better services for people with HIV/AIDS. The vast majority indicated their first choice as participating in focus groups only. However, respondents from Timiskaming equally chose the following as top preferences: district planning groups with expenses paid; responding to further requests for information; and discussing partnering with ACNBA. In addition to having selected focus groups the other preferences by district are as follows: in Muskoka, district planning groups with expenses paid; in Nipissing, responding to further requests for information, and discussing partnering with ACNBA; in Parry Sound, district planning group with expenses paid and responding to further requests for information.

The emphasis on district planning groups with expenses paid in both Muskoka and Timiskaming, the districts farthest from the ACNBA location, is interesting, and intuitively logical. This, among other findings, suggests the necessity of finding strategies and implementation processes which are specific to the individual districts.

Strengths to Increase Level of Service Coordination

Respondents were asked about strengths in their district that could increase the level of service coordination for people affected by HIV/AIDS. Strengths include successful protocols with other sectors which could be replicated; past history of interagency collaboration in other service sectors; smaller communities make it easier to network; and the importance of building on the current services available at ACNBA.

Additional Information

In November, ACNBA received separate private funding to pursue rural outreach activities. This project, which will be complete in May 2006, involves a pre- and post-test of awareness of ACNBA services among potential partner agencies outside of the North Bay hub. None of the

agencies surveyed in the pre-test were aware of services available to PHAs and to their own agencies from ACNBA. All agencies were aware of PHAs in their own client population. All agencies agreed to make ACNBA information available to their clients, and all expressed interest in having ACNBA present to their staff and/or clients. These findings support the findings of the Community Planning Initiative's own needs assessments, and emphasize both the need for services and the need for supporting resources to deliver those services throughout the catchment area. Furthermore, the activities of these rural outreach activities are critical to increasing ACNBA's profile in communities that have been historically difficult to serve given the shortage of outreach resources. They also have the capacity to fulfill the development of more formal partnerships and agreements with community agencies as a means of bringing ACNBA's specialized services and supports closer to home.

PLANNING FRAMEWORK

The values and goal statements articulated by the community planning groups should also serve as the foundation for the implementation of a coordinated system in each district. Most notably, the concerns regarding service availability as close to the client's home as possible, access to services outside the client's home area to protect confidentiality, and the need to enhance physician awareness and competence, are borne out by the survey.

Service Availability

In the needs assessment for the provincial strategy, respondents identified the need for greater coordination among organizations that serve people with HIV and/or people at risk. They stressed the need for more networking, partnerships, integration, strategic alliances, and consolidation of organizations as well as a greater effort to place AIDS within a larger social/medical context. It is clear that there are service gaps in the Northern Shores area, as the following table indicates:

Table 15 – Service Availability by District, 2005

Services	Muskoka	Nipissing	Parry Sound	Timiskaming
Prevention of HIV/AIDS (e.g., pamphlets, community presentations)	✓	✓	✓	✓
HIV/AIDS testing & diagnosis	✓	✓	✓	✓
Counselling for HIV+ people	✓	✓	✓	✓
Counselling for family/significant others of HIV+ people		✓		
Counselling for communities at risk		✓		
24-hour crisis response line				
Budget or credit counselling	✓	✓	✓	✓
Spiritual help and support	✓	✓	✓	✓
Emergency medical attention only	✓	✓	✓	✓
Direct medical care/clinical treatment	✓	✓	✓	✓
Housing/assistance to secure housing	✓	✓	✓	✓
Temporary shelter/homeless services		✓		
Meals/soup kitchen	✓	✓	✓	✓
Vouchers for perishable items		✓		
Food bank	✓	✓	✓	✓
Dietary/nutrition counselling	✓	✓	✓	✓
Dietary/nutritional supplements (vitamins, boost, ensure, etc.) or vouchers	✓	✓	✓	✓

Services	Muskoka	Nipissing	Parry Sound	Timiskaming
Financial support	✓	✓	✓	✓
Vouchers for clients to help access services		✓		
Ongoing support groups for HIV+ clients		✓		
Transportation assistance to medical, legal, or other appointments/ bus tickets, passes, taxi vouchers		✓		✓
Palliative Care/Grief	✓	✓	✓	✓
Help with finding employment		✓		
Harm reduction services (Needle Exchange)	✓	✓	✓	✓
Harm reduction services (condoms, lube, etc.)	✓	✓	✓	✓
Harm reduction services (Methadone Maintenance Treatment)	✓	✓	✓	✓
Legal Aid (power of attorney issues)	✓	✓	✓	✓
Home Care	✓	✓	✓	✓
Relocation assistance or start-up costs		✓		
Financial Assistance (direct cash to clients)		✓		
Assistive Devices (wheelchair, walker, eyeglasses, hearing aid, etc.)	✓	✓	✓	✓
Detox		✓		
Inpatient Addiction Services		✓		
Outpatient Addiction Services	✓	✓	✓	✓
Clothing Depot				
Injection Drug Use support (e.g., harm reduction)	✓	✓	✓	✓
Assistance with completing ODSP, travel grants, taxes, etc.		✓		
Social Activity Support (group or individual activities like drop-in centre, Christmas party, e tc.)		✓		
Mental health programs/services	✓	✓	✓	✓
Referral to other services in the community	✓	✓	✓	✓

It must be noted that while many of these services are available in a particular district, they are most often only available in the urban hub of that district.

Gaps and Barriers

As noted earlier, service provision in Northern and rural areas of the province is characterized by a number of barriers:

- provider awareness: service providers who are not familiar with rural life can be insensitive to the local culture. They may be seen as not credible, or they may offer service that is not appropriate to the needs of the client base.
- fewer services: the development of health care services has traditionally been population-based. Because rural communities are smaller, it follows that there are not as many service points.
- less diverse response: as with other health fields, a smaller population base provides fewer opportunities for clinicians to develop and practice new and different approaches.
- less secondary service: again, as a consequence of low population density and historical service delivery practices, secondary service networks are much less likely to be available (e.g., a young person in a large urban centre may not be able to access services in an HIV/AIDS-specific agency or program, but s/he may be able to access a similar service in an agency or program whose primary mandate is to provide a broad range of services to youth). On the hand, clinicians often acquire generalist knowledge and skills that transcend the “speciality” they are associated with--community nurses exchange needles, refer for testing, and counsel patients with HIV/AIDS.
- greater distances: available services tend to be concentrated in core communities which are usually several hours apart. This places a burden of cost on clients who use private

transportation (own vehicle, inter-urban bus or (less likely) train) or depend on friends or family. There may also be a burden of time lost from work, school or home, with its consequences. In addition to geographic and financial isolation, there is an additional level of isolation imposed by greater stigma.

- lack of public transportation: many rural communities have no public transportation services; again, clients who do not have access to a private vehicle are dependent on friends or family, or the cost of private transportation such as taxis.
- lack of telephone access: more rural than urban dwellers do not have phones. Some areas have no telephone coverage at all. Party lines are often the only option available in rural areas, with the consequent loss of confidentiality. Lack of digital phone networks bars access to Internet resources. There is a greater chance that long-distance calls are required to access services.
- Northern experience: the factors noted above are compounded by the fact that roads are generally poorer in the North, and winter weather can make them dangerous, slow, or impassible. Gas is more expensive, which affects clients travelling to services as well as services travelling to clients.

The Organization of the Current System

The lack of coordination and the historical fragmentation in the development and delivery of health services have been identified as main weaknesses of the current system in Nipissing. It is, therefore, helpful to assess the location of the current system along a continuum of coordination and integration. This is illustrated in Figure 7.1

Figure 2.0 - A Continuum of Organizational Arrangements

Entrepreneurial	Coalition	Federation	Integration (amalgamation)
Voluntary participation (in inter-organizational relationships) Ad hoc arrangements (between organizations) Dependent organizing body (i.e., on decisions made by system players)		→ → →	Mandated Formalized Autonomous

The AIDS service system in this planning area is located to the left of the spectrum, beneath the entrepreneurial arrangement. The following defines each coordinating structure displayed in the above figure.

Entrepreneurial

- ✓ minimal structuring of the inter-organizational relationships;
- ✓ organizations act primarily in their own interest, competing with each other for funds and influence, interacting only in a voluntary, ad hoc fashion; and
- ✓ power and authority remain with the individual organization.

Coalition

- ✓ voluntary interaction of organizations with limited degrees of commitment to the coordinating structure;
- ✓ most useful in planning functions;
- ✓ no clear mandate from an external authority;
- ✓ voluntary participation; and
- ✓ lack of power to influence through any other means than persuasion.

Federation

- ✓ usually mandated, with member organizations agreeing to a formal organization to accomplish common goals;
- ✓ the formal coordinating structure is the focus for decision-making, but decisions are subject to ratification by member organizations;
- ✓ moderate level of commitment to the coordinating structure is expected;
- ✓ brings service providers into a stronger relationship with one another without setting up a separate organization;
- ✓ each organization has its own goals and autonomous structure but agrees to participate in a formal relationship;
- ✓ commitment to a central decision-making body and leadership system, the focus of authority remains with the member organizations;
- ✓ major decisions are subject to member ratification; and
- ✓ formal agreements which clarify and state the responsibilities of participating organizations is required.

Integration

- ✓ formation of a super organization which governs the activities of member organizations and has the power to make binding decisions;
- ✓ appear more effective for coordination of direct service and administrative functions; and
- ✓ this structure dramatically changes the power relationships within the existing system.

A review of the literature (academic, Health Services Restructuring Commission and Ministry of Health and Long-Term Care policy) identifies a core set of benefits to be derived from the greater coordination and integration of health programs and organizations. From a system perspective, these include:

- elimination of duplication;
- enhanced information flow and improved ability to communicate across the system (in both clinical and non-clinical areas);
- development of administrative economies of scale and system-wide savings;
- ease of client access to a range of appropriate services;
- development of system-wide human and fiscal resource strategies;
- fixed point of accountability for client outcomes;
- a single information system to enable service and outcome monitoring and evaluation to occur in a timely and effective manner;
- standardization of processes leading to time savings (e.g., assessment and admission procedures); and
- development of a continuum of service and support options which the client can easily access from one point.

Such a continuum should include the following:

Figure 3.0 – Goals and Components of the Ideal Service Continuum

	Health promotion	Primary prevention		Secondary prevention		Tertiary prevention	
		Universal	Selected	Early detection	Harm reduction	Treatment and self-management with selected supports	Intensive long-term treatment
Goal	healthy public policies; healthy physical and social environments	identify and support protective factors; identify and address risk factors	alter susceptibility; reduce exposure	slow disease progression	minimize harm associated with risk behaviours	enhance self-efficacy	minimize suffering, maximize life expectancy
Examples	advocacy	school-based programs	outreach	testing and diagnosis	safer sex education and supports	legal assistance	home care
	partnerships	media literacy	education	counseling for client and family	safer IDU education and supports (e.g., NEP)	financial assistance/ supports, vouchers, clothing, assistance completing ODSP & other forms	palliative care
		public awareness	counseling			spiritual help and support	nursing homes
			24 hour crisis response			transportation assistance/ supports	assistive devices/ supports
						mental health services	respite care
						addictions services	
						employment assistance/ supports, relocation assistance	

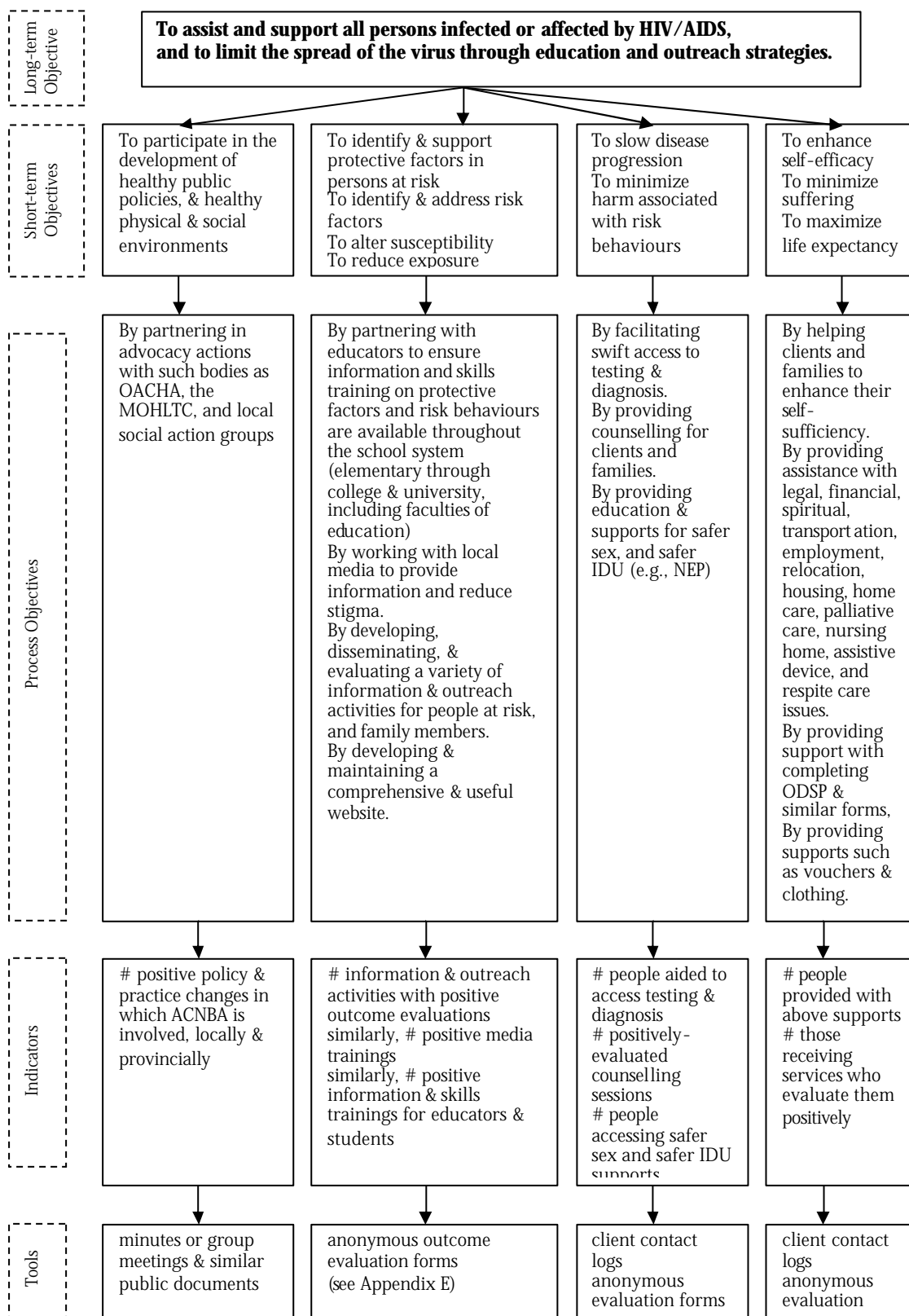
	Health promotion	Primary prevention		Secondary prevention		Tertiary prevention	
		Universal	Selected	Early detection	Harm reduction	Treatment and self-management with selected supports	Intensive long-term treatment
						housing assistance/ supports	
						meals/ soup kitchen/ food bank/ dietary counseling/ dietary supplements	
						social supports and activities	
						specialized physicians	
						emergency and acute medical care	
case management							

All services must be appropriate to the population group. Many service examples can be useful at various points in the continuum (e.g., peer supports). Case management undergirds and runs throughout the entire continuum.

As noted earlier, many of these services are available in the Northern Shores area, however they are not consistently available throughout the four districts.

The logic model and evaluation framework that follow outline a basic, but fairly comprehensive, program designed to articulate the ideal service continuum noted above. It must be noted again that ACNBA's ability to fulfill this program is severely constrained by its lack of resources. Furthermore, the opportunities to 'broaden the base' of services through partnerships with groups and agencies who are serving the same target populations are also limited by the size and geography of the catchment area, and the resources limitations of the potential partners. Ideally, such an approach to service expansion would consider such options as sharing office space, co-location, sharing or seconding staff, referral protocols for joint clients, joint data collection, cross-appointments to boards, and so on. Some of these are possible even within ACNBA's limited resource base, but only at the cost of diverting direct service to clients and family members.

Figure 4.0 – ACNBA Logic Model and Evaluation Framework



Recommendations

MOHLTC

1. That the Ministry be involved in inter-Ministerial work to address social determinants of change in manners specific to this population's needs
2. That the Ministry adjust ACNBA's southern catchment area to reflect the new LHIN boundaries (i.e., remove Muskoka District).
3. That the Ministry increase ACNBA's core funding to reflect the service needs identified in this report, including the extensive challenges involved in serving a geographic area this large and diverse.
4. That the Ministry, in consultation with ACNBA and an Aboriginal advisory group drawn from the revised catchment area, identify and address the needs of all Aboriginal populations in the area, whether status or non-status, on- or off-reserve. This may require negotiation with Health Canada and INAC.
5. That the AIDS Bureau, if it has not already done so, engage with ASOs across the province to develop a strategy whereby ASOs can position the issue of HIV/AIDS with the LHINs, both at the provincial and local level. It is felt that this is a critical issue, in order that HIV/AIDS be considered at all relevant planning and implementation steps that the LHINs engage in. This will broaden the base of HIV/AIDS service delivery most effectively, and ensure that this is not an 'orphan' issue, siloed out of the significant changes in health care service delivery underway in the province.
6. Regarding recommendations 1 and 2 below, that the Ministry ensure that ACNBA's financial resources are adequate to support effective and ongoing partnerships. This will include travel and associated expenses for occasional meetings, supplemented by teleconferences and videoconferences.

ACNBA

1. That ACNBA approach the new LHIN as soon as possible (a copy of the final report of this project may provide an opportune entry). ACNBA's Executive Director should attempt to join any committees or working groups established which address the most relevant health issues and provide opportunities to establish and expand partnerships (e.g., mental health and addictions, primary care). Although ASO funding will not be flowed through the LHINs, given the large geographic area served, the diverse populations and needs in the catchment area, and ACNBA's serious resource limitations at the moment of writing, this approach is the only practicable one to broaden the service base for this population, and incorporate necessary attention throughout the health sector in the area.
2. If this first recommendation is not possible, or does not provide an appropriate venue, that ACNBA establish management-level district and catchment-area working groups to accomplish this goal.
3. Using the gaps/barriers identified in this and other local reports, that ACNBA divide its services equitably across the catchment area. This may involve local recruitment of staff when the opportunity presents (most particularly when and if additional resources are available from the Ministry), and co-location with other compatible agencies in districts outside Nipissing and municipalities outside North Bay.

That consultation with community partners in the outlying areas continue to occur throughout the implementation of the plan presented in this report to continuously monitor needs and relationships between ACNBA and other agencies and groups serving people with or at risk of HIV/AIDS.

5. That ACNBA conduct, with appropriate community partners, an environmental scan or other process to foster a systems approach to address and strengthen service delivery throughout its catchment area. Consideration should be given to the following factors as part of the scan: service system characteristics; geographic/demographic

characteristics; client characteristics; community readiness for change; transitional challenges. When these are considered as part of a scan, there is greater likelihood that the recommended service or system improvements will be appropriate for the communities that they are intended to apply.

6. That ACNBA actively pursue the development of partnerships and formal agreements with agencies as a means of increasing its outreach capacity. A sample interagency service agreement template and guiding principles are located in Appendix F.

IMPLEMENTATION PLAN

	Objective	Task	Timeframe
1	Health Promotion		
a	- Healthy public policy	Executive Director, in consultation with staff, clients, and stakeholders, will provide feedback to any policy initiative undertaken by MOHLTC, OACHA, the Northern ASO caucus, or similar bodies	ongoing; at least annual action
b	- Healthy physical & social environments	ED, and staff as appropriate, will participate in local health and social action groups (e.g., social action planning group, LHIN consultations)	ongoing, at least quarterly
c	- Health linkages	ED will pursue linkages with local LHIN committee/work group structure, to ensure the needs of PHAs and families are included in all relevant health planning and implementation initiatives for the catchment area.	by end of fiscal 2005-6, ongoing thereafter
2	Primary Prevention		
a b	- Protective & risk factors	Staff will examine research on protective factors, and risk factors, among the diverse target populations, and consult with other ASOs, to develop and deliver at least one public information and training session per District per year directed at supporting and strengthening protective factors, and reducing risk factors and behaviours. Sessions will cover elementary, secondary, and post-secondary schools, as well as any access points for out-of-school adolescents and young adults.	ongoing, at least annually

	Objective	Task	Timeframe
		Staff will develop and delivery at least one similar information sessions per District per year with the same goal, covering elementary, secondary, and post-secondary school systems, as well as any access points for out-of-school adolescents and young adults.	ongoing, at least annually
b	- Educating educators	ED, and staff as appropriate, will approach the faculty of education at Nipissing University to investigate opportunities to provide essential HIV/AIDS information and training to student teachers.	by end of fiscal 2006-7; annually thereafter
c	Educating new service providers	As above, approaches to all appropriate programs at Canadore College (e.g., social service worker, drug and alcohol counselor).	by end of fiscal 2006-7, annually thereafter
d	- Educating media	ED, and staff as appropriate, will pursue linkages with local electronic and print media to identify and operationalize mechanisms to provide information to media, and their audiences (through, for example, media briefing kits, community channel shows or presentations)	by end of fiscal 2006-7, semi-annually thereafter
e	- Website	Staff will maintain an effective and current website for the agency and its services.	updated at least quarterly, more often if required
3	Secondary Prevention		
a	- Slow disease progression	In all its literature and presentations, agency staff will include handouts of how to access both anonymous and non-nominal testing and diagnosis services, including pre- and post-testing counseling and support	ongoing
b	- Harm minimization	Within resource constraints, staff will provide supportive counseling services to PHAs and family members and friends.	ongoing
		ED, and staff as appropriate, will investigate the establishment of peer counseling and support groups for PHAs and family members, equitably, in all Districts of the catchment area.	by end of fiscal 2006-7, ongoing thereafter

	Objective	Task	Timeframe
		Agency will continue to provide safer sex and safer IDU services and counseling (i.e., NEP etc.) ACNBA will investigate the utility of forming linkages with other NEPs and safer sex programs/services in the catchment area.	ongoing by end of fiscal 2006-7
4	Tertiary Prevention		
a	- Enhance self-efficacy	Within resource constraints, staff will continue to provide self-efficacy training and supports to PHAs and family members, equitably in all Districts.	ongoing
		Staff will investigate potential resource savings that may be available through peer counseling and support groups for these functions ((a) and (b))	by end of fiscal 2006-7
b	- Assistance	Within resource constraints, staff will continue to provide assistance as noted in above logic model, equitably, in all Districts.	ongoing
c	- Supports	Within resource constraints, staff will continue to provide supports as noted in above logic model, equitably, in all Districts	ongoing
d	- Linkages	ED, and staff as appropriate, will pursue linkages with local agencies who have control of needed resources (e.g., housing), through membership and participation in established work groups (e.g., mental health and addictions work groups)	by end of fiscal 2006-7, ongoing thereafter

EVALUATION PLAN

Through the steps identified above, and within its resource constraints, it is anticipated that ACNBA will attain the following milestones:

31 March 2006

Functional linkages with NE LHIN are established; ACNBA participates in all groups and processes which require attention to the needs of PHAs and family members. Attainment of, or progress towards, this objective will be outlined in the Executive Director's reports to the Board of Directors, and in the report to the AGM.

31 March 2007

Functional linkages with the Faculty of Education at Nipissing University are established. ACNBA information is available at all appropriate places on all campuses; ACNBA staff make at

least one information and training presentation to each class of student teachers. Similar report as noted above.

Similar linkages with Canadore College, all relevant programs (e.g., social service worker, drug and alcohol counselor). Similar report.

Linkages with local print and electronic media are established, including media briefing kits or other needed material. Similar report, including results of satisfaction and outcome questionnaires.

Potential for a cable channel show, alone or in partnership with other companion issue stakeholders, is investigated. Similar report.

Establishment of peer counseling and support groups for PHAs and family members is investigated, to extend ACNBA's scarce resources in provision of services and supports. Similar report, also including results of satisfaction and outcome questionnaires.

Linkages with other NEPs and safer sex programs/services in the catchment area are investigated to establish their potential to positively impact service delivery with accompanying potential to conserve scarce resources. Similar report.

Ongoing

Ongoing activities will continue to be evaluated through established mechanisms and processes.

ACNBA staff will track the impact on their service delivery time of the changes noted above; these data will be reported to the Board, the membership, and the Ministry.

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Appendix A – AIDS Committee of North and Area Community Planning Group - Terms of Reference

Background

The AIDS Bureau of the Ministry of Health and Long -Term Care (MOHLTC) has launched a community planning initiative with all AIDS Service Organizations across Ontario.

Objectives

The objectives of this initiative are to:

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

Terms

The Community Planning Group will be representative of the geography and population of each of the four planning districts: Muskoka, Nipissing, Parry Sound and Timiskaming.

- two Meetings (may be by teleconference)
- Establish terms of reference
- Membership contact list
- Agree on a conflict resolution protocol
- Provide input regarding the needs of people with HIV / AIDS and those at risk in your area
- Knowledge of community and its health / social services
- Participate in certain tasks when required and possible

Common goals and values for the group

Values

- all people have worth
- all clients should have their needs met
- services should be non-judgmental
- services should be available as close-to-home for the clients as possible
- all clients have a right to self-determination
- all clients have the right to choose to have services and/or treatment external to their home community to protect their confidentiality
- HIV/AIDS affects families, who therefore have the right to information, education, and support

Goals

- ✓ to reduce/eliminate stigma
- ✓ to form a parent support group
- ✓ to reflect the unique voice of the individual districts, and the catchment area as a whole
- ✓ to actively advocate for a clinic in the new North Bay hospital (physician, pharmacists, nurse, counselor)
- ✓ to provide outreach/mentoring for GPs (especially critical for our rural/isolated communities)
- ✓ to ensure that alternative points of access to specialized treatment are available to protect confidentiality (given the small nature of so many communities in our area)
- ✓ to ensure access to specialized treatment and treatment information

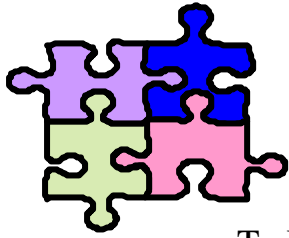
- ✓ to maximize the use of technology to ensure access to treatment
- ✓ to address the lack of housing as a risk factor for disease progression

Members

Members are expected to participate in the consultation process to the greatest extent possible, mindful of the demands of the other parts of their lives. Members bring 'ground wisdom' regarding the local needs, services, and gaps in their areas. Members are expected to support the goals and values of the group, and to be respectfully open regarding any issues that arise, or concerns they may have.

Champions

Community champions bring leadership skills to motivate and involve other community partners, bring people together, and are agents of change in the community. They have networking capabilities (knowledge of the local community service system, and ability to develop effective working relationships with other service providers/organizations), and planning and negotiating skills. They are committed to the principles of integrated services and community planning.



APPENDIX B

Community Planning Initiative To Improve Services for People with, or at risk of, HIV/AIDS in the Districts of Muskoka, Parry Sound, Nipissing and Timiskaming May 2005

Agency Survey

PURPOSE

The overall purpose of this survey is to collect information about services, gaps and issues that will help develop local strategies to better meet the needs of people with HIV/AIDS and communities at risk in the Districts of Muskoka, Parry Sound, Nipissing and Timiskaming.

Specifically this survey will help to

- Describe existing services and their capacity;
- Determine service gaps and unmet needs; and
- Identify opportunities to improve local services for people with HIV and communities at risk.

INSTRUCTIONS

Please complete and submit the survey (**no later than 14 June 2005**) to:
Kathy Kilburn (project consultant)
R.R. #1

Redbridge ON POH 2A0

Should you wish to submit the completed survey electronically, please send it to either Kathy Kilburn at uwuc29@vianet.ca or H el ene Philbin Wilkinson at hpw@sympatico.ca

CONFIDENTIALITY

You have the right to complete, or not to complete, this questionnaire. If you want to be involved in any of the activities noted in question 30, please include your personal information in Section A. If not, just leave these spaces blank.

Only the two consultants, H el ene Philbin Wilkinson and Kathy Kilburn, will have access to the questionnaires. Both consultants will keep these questionnaires secure at all times. They will use the questionnaire information to compile data (i.e., numbers of something) for the final report to ACNBA and the Ministry of Health and Long-Term Care. Neither ACNBA nor the Ministry will have access to the questionnaires, only to the data that is compiled from them. If you are a client of ACNBA, or any other service agency in your area, nothing you tell us on this questionnaire will affect the service you receive in any way—no-one in those agencies will ever know what you have told us.

We do not intend to publish the results of this project in any other form than the final report.

Questionnaires will be kept by H el ene Philbin Wilkinson in a secure container for a period of one year following completion of the project (therefore, until about January 2007). They will then be shredded and burned.

Information gathered through this questionnaire will be used only in aggregate—that is, without any information that could identify a particular individual. For example, the final report on this project will include a mention of the number of HIV/AIDS-affected people who responded to the consumer questionnaire, the District they live in, and the needs they've identified. It will not show names of those people or any other identifying information (address, phone, etc.) Copies of the final report will be available when it is completed—again, if you want a copy, either contact us again in January 2006, or give us your contact information on the questionnaire.

Should you wish to submit the completed survey electronically, please send it to either Kathy Kilburn at uwuc29@vianet.ca or H el ene Philbin Wilkinson at hpw@sympatico.ca

Please direct any questions you have to:

H el ene Philbin Wilkinson
Email: hpw@sympatico.ca

OR

Call the AIDS Committee of North Bay and Area at (705) 497-3560 or leave a message on the Toll Free Number 1-800-387-3701 —Helene will get back to you.

When answering the questions, please use the following definitions:

Communities at risk populations at high risk of HIV infection, including gay men, injection drug users, Aboriginal people and people from countries where HIV is endemic. However, risk should be viewed more broadly. People in these populations are usually at risk because of other factors, including poverty, mental health issues, self-esteem issues or substance use.

AIDS (Acquired Immune Deficiency Syndrome): “Acquired” means you get the condition at some point in your life. “Immunodeficiency” is a weakness in your immune system. “Syndrome” is a combination of symptoms and/or diseases. AIDS is not a disease. It is a syndrome associated with HIV infection, decreased numbers of T4 cells, and one or more opportunistic infections.

HIV (Human Immunodeficiency Virus): The virus believed to cause AIDS. Having HIV is not the same as having AIDS. Some people who have the virus are healthy, and have none or only a few symptoms. A person may have HIV for several years before AIDS-related diseases appear.

District: Any one of the four districts in the Northern Shores catchment area (Muskoka, Nipissing, Parry Sound or Timiskaming).

SECTION A – RESPONDENT INFORMATION

1. Complete the following table.

Organization Name:			
Mailing Address:			
Phone:		Fax :	
Website:			
Respondent's Name			
Title:			
Email:			

SECTION B – SERVICES

2. Indicate (x) which of the following statements best describe your agency (check all that apply).

- Mental Health
- Mental Health consumer/survivor organization
- Addictions
- Public Health Unit
- Physician
- Community Health Centre
- Public Hospital
- Community Care Access Centre
- Palliative Care/Grief
- Services for People with Physical Disabilities
- Advocacy
- Food Bank, Soup Kitchen, Community Garden, etc.
- Ontario Works
- Sexual Assault
- Community Housing
- Legal Clinic
- School Board
- DSSB, ODSP
- Aboriginal-specific (e.g., Indian Friendship Centre, NNADAP worker)
- Designated or identified as per the French Language Services Act
- GLBTQQ services
- Criminal Justice (e.g., jail)
- Other (specify)

3. Indicate (x) your agency's catchment area (check all that apply):

- District of Muskoka
- District of Nipissing
- East Parry Sound
- West Parry Sound
- District of Timiskaming

Other (specify)

4. What is your agency/program's target population?

general public
 particular age group (please specify) _____

particular ethnocultural or linguistic group (e.g., Francophone, Aboriginal - please specify)

particular health issue (please specify) _____

gender-specific (please specify) _____

5. Does your agency have funding designated for HIV/AIDS programs and services?

Yes – please describe the type of funding

No

Don't know

6. In the following list, check (x) all the services that your agency provides, and those services you offer for which you have the capability to respond to people with HIV/AIDS.

Type of Service	Your Agency Provides this Service	Your Agency has the Capability to Respond to People with HIV/AIDS for this Service
Prevention of HIV/AIDS (e.g., pamphlets, community presentations)	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS testing & diagnosis	<input type="checkbox"/>	<input type="checkbox"/>
Counselling for HIV+ people	<input type="checkbox"/>	<input type="checkbox"/>
Counselling for family/significant others of HIV+ people	<input type="checkbox"/>	<input type="checkbox"/>
Counselling for communities at risk (see above)	<input type="checkbox"/>	<input type="checkbox"/>
24-hour crisis response line	<input type="checkbox"/>	<input type="checkbox"/>
Budget or credit counselling	<input type="checkbox"/>	<input type="checkbox"/>
Spiritual help and support	<input type="checkbox"/>	<input type="checkbox"/>
Emergency medical attention only	<input type="checkbox"/>	<input type="checkbox"/>
Direct medical care/clinical treatment	<input type="checkbox"/>	<input type="checkbox"/>
Housing/assistance to secure housing	<input type="checkbox"/>	<input type="checkbox"/>
Temporary shelter/homeless services	<input type="checkbox"/>	<input type="checkbox"/>
Meals/soup kitchen	<input type="checkbox"/>	<input type="checkbox"/>
Vouchers for perishable items	<input type="checkbox"/>	<input type="checkbox"/>
Food bank	<input type="checkbox"/>	<input type="checkbox"/>
Dietary/nutrition counselling	<input type="checkbox"/>	<input type="checkbox"/>
Dietary/nutritional supplements (vitamins, boost, ensure, etc.) or vouchers	<input type="checkbox"/>	<input type="checkbox"/>
Financial support	<input type="checkbox"/>	<input type="checkbox"/>
Vouchers for clients to help access services	<input type="checkbox"/>	<input type="checkbox"/>
Ongoing support groups for HIV+ clients	<input type="checkbox"/>	<input type="checkbox"/>
Transportation assistance to medical, legal, or other appointments/bus tickets, passes, taxi vouchers	<input type="checkbox"/>	<input type="checkbox"/>
Palliative Care/Grief	<input type="checkbox"/>	<input type="checkbox"/>

Help with finding employment	<input type="checkbox"/>	<input type="checkbox"/>
Harm reduction services (Needle Exchange)	<input type="checkbox"/>	<input type="checkbox"/>
Harm reduction services (condoms, lube, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Harm reduction services (Methadone Maintenance Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
Legal Aid (power of attorney issues)	<input type="checkbox"/>	<input type="checkbox"/>
Home Care	<input type="checkbox"/>	<input type="checkbox"/>
Relocation assistance or start-up costs	<input type="checkbox"/>	<input type="checkbox"/>
Financial Assistance (direct cash to clients)	<input type="checkbox"/>	<input type="checkbox"/>
Assistive Devices (wheelchair, walker, eyeglasses, hearing aid, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Detox	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Addiction Services	<input type="checkbox"/>	<input type="checkbox"/>
Clothing Depot	<input type="checkbox"/>	<input type="checkbox"/>
Injection Drug Use support (e.g., harm reduction)	<input type="checkbox"/>	<input type="checkbox"/>
Assistance with completing ODSF, travel grants, taxes, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Social Activity Support (group or individual activities like drop-in centre, Christmas party, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Mental health programs/services	<input type="checkbox"/>	<input type="checkbox"/>
Referral to other services in the community	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>

7. Thinking about the services your agency provides, indicate the extent to which they are currently used by people with HIV/AIDS.

1. None that I am aware
2. Less than 5 clients
3. 6 to 10 clients
4. 11 + clients
5. To the point that we have people with HIV/AIDS on a waiting list
6. Not sure

8. Are the programs/services offered at your agency currently operating at full capacity?

7. Yes
8. No
9. Not sure

Comments:

9. Is there a waiting list for any of the programs/services identified in the table in Question #6?

- Yes – go to Question #9 a)
 No

a) If yes, specify which programs/services, and their average waiting time.

10. If your agency provides services to people with HIV/AIDS, indicate the type of client group(s) that would most often use your agency's services (check all that apply).

- women at risk (injection drug users, sexual partners of injection drug users)
 infants at risk (parent is HIV+ or high-risk)
 people with substance use problems
 injection drug users, including steroids
 sex trade workers

- people with mental health problems
- men who have sex with men
- gay men
- street-involved people
- sexually active young people
- people from endemic countries (Africa, Caribbean)
- Aboriginal People
- people who have been incarcerated
- Other (specify)

SECTION C – SERVICE CAPACITY AND UNMET NEEDS

11. If your agency does not currently provide services or support to anyone who identifies as HIV positive and if someone came to your agency who identified as HIV positive or at risk of HIV, would you know:

a) where to refer for services?

- Yes
- No

b) how to access HIV/AIDS information and resources if you needed them?

- Yes
- No

12. If your agency does not provide services or support to anyone who identifies as HIV positive indicate (x) the reasons you believe your agency does not provide services to this client population (check all that apply).

- Not funded
- Not my agency's mandate
- Location is not accessible because of geography (too far, no transportation, etc.)
- Location is not accessible to all clients because of physical barriers (no elevator, etc.)
- high level of Homophobia in our community
- Services not widely known in our community
- People prefer to access HIV/ AIDS services outside of our community
- Insufficient staff for additional workload associated with providing HIV/AIDS services
- Insufficient knowledge of issues related to HIV/AIDS, including needs of people with HIV/AIDS
- Insufficient training on of issues related to HIV/AIDS, including needs of people with HIV/AIDS
- Insufficient financial resources to provide services specific to issues related to HIV/AIDS
- Stigma associated with HIV/AIDS
- Other barriers (specify)

13. If your agency does not provide any HIV/AIDS prevention or client care

a) Describe how it has been involved in serving people affected by HIV/AIDS?

b) Describe how your agency could further be involved in serving people affected by HIV/AIDS in your community?

14. If your agency does provide HIV/AIDS prevention or client care, indicate (√) the level of capacity you foresee that your agency's programs/services will have in the future.

- Less capacity
- More capacity
- Same capacity
- Not sure

Comments:

15. If your agency does not provide HIV/AIDS prevention or client care, indicate (√) the level of capacity you foresee that your agency's programs/services will have in the future to provide services and/or support to people affected by HIV/AIDS.

- Less capacity
- More capacity
- Same capacity
- Not sure

Comments:

16. Do you believe that it is important for your agency to receive any HIV/AIDS related information?

- Yes – go to Question # 16a)
- No
- Don't know

a) If you believe it is important for your agency to receive HIV/AIDS related information, describe the type of information you would like to receive.

17. In the last 12 months, indicate (x) how many times you have received information about HIV/AIDS and HIV/AIDS related programs and services.

- Never
- 1 – 5 times
- 6 + times
- Don't know

a) Where did this information come from?

18. In the last 12 months, has your agency interacted with the AIDS Committee of North Bay and Area or another HIV/AIDS specific agency, program or service?

- Yes – Please specify which agency and go to Question # 18a)

No – Please explain.

- Don't know
- a) If your agency has interacted with the AIDS Committee of North Bay and Area or another HIV/AIDS specific agency, program or service explain the reasons for, (e.g., referral, training) and the frequency of this contact (e.g., yearly, as required) and whether it's been helpful or not?

19. Are there any programs or services for HIV/AIDS-affected people and communities at risk that are not currently offered by your agency that you think should be?

- Yes – go to Question #19a)
- No
- Not sure

- a) Specify the programs or services for HIV/AIDS-affected people and communities at risk that you think should be offered by your agency.

20. Are there any programs or services for HIV/AIDS-affected people and communities at risk that are not currently offered in your district that you think should be?

- Yes - go to Questions #20a and b)
- No
- Not sure

- a) Specify the programs or services for HIV/AIDS-affected people and communities at risk that you think should be offered in your district.

- b) Is there an existing agency that you think would be most appropriate to offer these services? (Please specify)

21. Are there any local support groups for people affected by HIV/AIDS in your district?

- Yes – go to Question #21a)

- No
- Not sure

a) If there are local support groups for people affected by HIV/AIDS in your district, list their names and contact information, and describe their purpose and location.

22. Thinking of your district and the people who live in your district, indicate (x) which of the following risk factors you believe will increase the risk of becoming infected with HIV/AIDS in your area:

Risk Factors -Check all that apply

- Addictions/drug use
- Individual attitudes
- Ignorance/misunderstanding
- Poverty
- Marginalization
- Stigma
- Lack of self esteem
- Mental health problems
- Relationship issues
- Homelessness
- Cultural displacement issues
- Other (please specify)

a) Of the risk factors you identified in Question #22, list the top three risk factors for your district.

23. Thinking of your district and the people who live in your district, indicate (x) which of the following factors you believe will increase the risk of disease progression related to HIV/AIDS in your area. Check all that apply.

Factor

- Poverty
- Lack of affordable housing
- Stigma/discrimination
- Language/cultural barriers
- Mental health problems
- Drug/alcohol use
- Lack of family/community support
- Poor nutrition
- Health status/coping skills before infection
- Lack of access to treatment/care
- Lack of education and information
- Distance from physician services
- Late testing/diagnosis
- Non-compliance with medications/fear of treatment
- Drug resistance/treatment side effects
- Number of exposures to a number of strains
- Other (please specify)

b) Of the factors you identified in Question #23, list the top three factors for your district.

24. Thinking of your district and the current services available in your district for people affected by HIV/AIDS, describe the challenges that affect the level of service delivery in your area.

25. Does your agency have employees and volunteers who work in HIV prevention and/or AIDS-related service provision only?

- Yes - go to Question #25a and b)
- No

a) Indicate the approximate number of employees and volunteers who work in HIV prevention and/or AIDS-related provision only:

- 1- 3
- 4 - 6
- 6+
- None
- Don't know

b) Indicate the approximate number of employees and volunteers in your agency who have been trained to respond to the service needs of HIV/AIDS –affected people.

- 1- 3
- 4 - 6
- 6+
- None
- Don't know

26. If your agency does not have employees and volunteers trained to respond to the service needs of HIV/AIDS-affected people, do you think they should have training?

- Yes - go to Question #26a)
- No
- Not sure

a) If you think your employees and volunteers in your agency should have training to respond to the service needs of HIV/AIDS -affected people, describe the topics you think would be appropriate and indicate the approximate number of employees and/or volunteers that your agency would agree to have trained.

Topics	Numbers of employees and /or volunteers
General training on sexually transmitted diseases (STD)	
General education about HIV/AIDS	
General education about service intervention practices with HIV/AIDS-affected people	
HIV/AIDS prevention	
HIV/AIDS case management training	
Conducting HIV/AIDS risk assessments	
Providing HIV/AIDS -related services to pregnant women	
Conducting HIV rapid testing	

Conducting HIV/AIDS counselling and testing	
General training on Hepatitis, Hepatitis prevention and service intervention practices	
Conducting IDU (injection drug use) interventions Offering counselling and support for HIV/AIDS clients	
Offering counselling and support for families and significant others	
Other (please specify)	

SECTION D – BUILDING CAPACITY

27. Indicate the type of community development strategy you believe would be appropriate in your district to better meet the needs of HIV/AIDS-affected people or communities at risk. Check all that apply.

Strategy

- Informal networking
- Formal networking and meetings
- Partnerships between agencies
- Service agreements
- Referral protocols
- Integration of services
- Co-location of agencies or programs
- Planning and service committees
- Interagency training events
- Other (please specify)

28. Thinking about your district and the current services available in your district, describe
(a) the most significant challenges that affect the level of service coordination for HIV/AIDS-affected people in your district (e.g., geography, too agencies).

(b) the current strengths in your district that could increase the level of service coordination for people affected by HIV/AIDS (e.g, interagency referral protocols, committees)

29. What services would you add to or expand in your district to better meet the needs of HIV/AIDS-affected people?

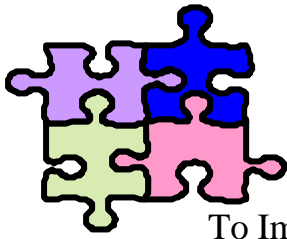
a) Describe any obstacles or challenges that could encumber this process.

30. There are many ways that existing agencies can help to plan and implement better services for people with HIV/AIDS. If you are willing to participate, please indicate your choices below (check all that apply):

- participate in ongoing District planning group (travel expenses paid)
- participate in one or more focus groups
- participate in the development of service/protocol agreements or other interagency agreements to improve service coordination
- respond to further written requests for information
- discuss partnering with ACNBA in any specific service provision initiatives
- Other (please specify):

31. Do you have any other comments?

THANK YOU!



APPENDIX C

Community Planning Initiative To Improve Services for People with, or at risk of, HIV/AIDS

Consumer Questionnaire

PURPOSE

The overall purpose of this survey is to collect information about services, gaps, and issues that consumers have identified, to help develop local strategies to better meet the needs of people with HIV/AIDS and communities at risk in the Districts of Muskoka, Nipissing, Parry Sound, and Timiskaming.

Specifically, this survey will help to

- describe existing services, and their capacity
- determine service gaps and unmet needs, and
- identify opportunities to improve local services for people affected by HIV/AIDS and communities at risk.

INSTRUCTIONS

Please complete and submit the survey, **no later than 14 June 2005**, to
Kathy Kilburn (project consultant)
R.R. #1
Redbridge ON POH 2A0

If you would rather submit the completed survey electronically, please send it to either Kathy Kilburn at uwuc29@vianet.ca, or H el ene Philbin Wilkinson at hpw@sympatico.ca

CONFIDENTIALITY

You have the right to complete, or not to complete, this questionnaire. If you want to be involved in any of the activities noted in question 13, please include your personal information in Section A. If not, just leave these spaces blank.

Only the two consultants, H el ene Philbin Wilkinson and Kathy Kilburn, will have access to the questionnaires. Both consultants will keep these questionnaires secure at all times. They will use the questionnaire information to compile data (i.e., numbers of something) for the final report to ACNBA and the Ministry of Health and Long-Term Care. Neither ACNBA nor the Ministry will have access to the questionnaires, only to the data that is compiled from them. If you are a client of ACNBA, or any other service agency in your area, nothing you tell us on this questionnaire will affect the service you receive in any way—no-one in those agencies will ever know what you have told us.

We do not intend to publish the results of this project in any other form than the final report.

Questionnaires will be kept by H el ene Philbin Wilkinson in a secure container for a period of one year following completion of the project (therefore, until about January 2007). They will then be shredded and burned.

Information gathered through this questionnaire will be used only in aggregate—that is, without any information that could identify a particular individual. For example, the final report on this project will include a mention of the number of HIV/AIDS-affected people who responded to the consumer questionnaire, the District they live in, and the needs they've identified. It will not show names of those people or any other identifying information (address, phone, etc.) Copies of the final report will be available when it is completed—again, if you want a copy, either contact us again in January 2006, or give us your contact information on the questionnaire.

If you have questions about anything in the survey, please contact
H el ene Philbin Wilkinson

email: hpw@sympatico.ca

OR

Call the AIDS Committee of North Bay and Area at 497-3560, or leave a message on the toll-free number: 1-800-387-3701—Helene will get back to you

When answering the questions, please use the following definitions:

Communities at risk populations at high risk of HIV infection, including gay men, injection drug users, Aboriginal people and people from countries where HIV is endemic. However, risk should be viewed more broadly. People in these populations are usually at risk because of other factors, including poverty, mental health issues, self-esteem issues or substance use.

AIDS (Acquired Immune Deficiency Syndrome): “Acquired” means you get the condition at some point in your life. “Immunodeficiency” is a weakness in your immune system. “Syndrome” is a combination of symptoms and/or diseases. AIDS is not a disease. It is a syndrome associated with HIV infection, decreased numbers of T4 cells, and one or more opportunistic infections.

HIV (Human Immunodeficiency Virus): The virus believed to cause AIDS. Having HIV is not the same as having AIDS. Some people who have the virus are healthy, and have none or only a few symptoms. A person may have HIV for several years before AIDS-related diseases appear.

District: Any one of the four districts in the Northern Shores catchment area (Muskoka, Nipissing, Parry Sound or Timiskaming).

SECTION A – RESPONDENT INFORMATION

1. Name (optional)

2. Mailing Address (optional)

3. Phone Number (optional)

4. Fax Number (optional)

5. Email address (optional)

6. Please indicate which of the following group or groups you belong to:
 - I have HIV/AIDS
 - I have a family member or significant other who has HIV/AIDS
 - I belong to the following category/ies of people who are at high risk for HIV/AIDS
 - men who have sex with men
 - have injected drugs not prescribed for me, including steroids
 - sexual partner of someone who has injected drugs, as above
 - have been a prisoner
 - have had unprotected sex (i.e., no condom) in the last 20 years
 - Aboriginal
 - from a country where HIV/AIDS are endemic (Africa, the Caribbean)

SECTION B – SERVICES

7. In the past five years, have you used the services of ACNBA (the AIDS Committee of North Bay and Area), or another agency, for any need related to HIV/AIDS? This could be for any of the following services. (Please note that there are some services which ACNBA does not provide directly (although they may provide referrals); these spaces are blocked off.):

Service	ACNBA (please tick ✓)	Other Agency (please provide agency name)	Was this helpful or not?
Prevention of HIV/AIDS (pamphlets, presentations, counselling)			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
HIV/AIDS testing & diagnosis			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
counselling for HIV+ people			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
counselling for family/significant others of HIV+ people			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
counselling for people at high risk (see above)			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
24-hour crisis response line			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
budget or credit counselling			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
spiritual help and support			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
emergency medical attention only			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:

Service	ACNBA (please tick ✓)	Other Agency (please provide agency name)	Was this helpful or not?
direct medical care/clinical treatment			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
housing/assistance to secure housing			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
temporary shelter/homeless services			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
meals/soup kitchen			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
vouchers for perishable items			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
food bank			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
dietary/nutrition counselling			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
dietary/nutritional supplements (vitamins, boost, ensure, etc.) or vouchers			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
financial support			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
vouchers for clients to help access services			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
ongoing support groups for HIV+ clients			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
transportation assistance to medical, legal, or other			helped <input type="checkbox"/> didn't help <input type="checkbox"/>

Service	ACNBA (please tick ✓)	Other Agency (please provide agency name)	Was this helpful or not?
appointments/bus tickets, passes, taxi vouchers Palliative Care/ Grief Counselling			details: helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
Help with finding employment			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
harm reduction services (Needle Exchange)			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
harm reduction services (condoms, lube, etc.)			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
Legal Services (power of attorney issues)			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
Home Care			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
Relocation assistance or start-up costs			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
Financial Assistance (direct cash to clients)			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
Assistive Devices (wheelchair, walker, eyeglasses, hearing aid, etc.) Detox			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details: helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
Inpatient Addiction Services			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
Outpatient Addiction Services			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:

Service	ACNBA (please tick ✓)	Other Agency (please provide agency name)	Was this helpful or not?
Clothing Depot			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
Injection Drug Use support (harm reduction, e.g., safer injecting practices)			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
Assistance with completing ODSP, travel grants, etc.			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
Social Activity Support (group or individual activities like drop-in centre, Christmas party, etc.)			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
Mental health programs/services			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
Referral to other services in the community			helped <input type="checkbox"/> didn't help <input type="checkbox"/> details:
Other (please describe)			

8. Are there any of the services above that you need, but can't access? Please tell us which ones, and why you can't access them

9. Are there any other services that you need that aren't listed?

10. Do you have concerns about confidentiality that affect how you access local services, such as housing, Ontario Works, ODSP, the dentist, etc.?

Yes (If yes, please go to question 10(a))

No

Not sure

10(a) If yes, how can these concerns be addressed

11. Some people with HIV/AIDS choose to get services and/or treatment outside of their home community. If the service you need or want were made more available locally, would you still prefer to go outside of your home community for these?
- Yes
- No
- Not sure

SECTION D – BUILDING CAPACITY

12. Indicate the type of community development strategy you believe would be appropriate in your district to better meet the needs of HIV/AIDS-affected people or communities at risk.

- Strategy -Check all that apply**
- Informal networking -
- Formal networking and meetings-
- Partnerships between agencies -
- Service agreements-
- Referral protocols -
- Integration of services-
- Co-location of agencies or programs-
- Planning and service committees-
- Interagency training events-
- Other (please specify)

13. Thinking about your district and the current services available in your district, describe

- (c) the most significant challenges that affect the level of service coordination for HIV/AIDS-affected people in your district (e.g., geography, too agencies).
- (d) the current strengths in your district that could increase the level of service coordination for people affected by HIV/AIDS (e.g, interagency referral protocols, committees)

14. What services would you add to or expand in your district to better meet the needs of HIV/AIDS-affected people?

b) Describe any obstacles or challenges that could encumber this process.

15. Would you like to be more involved in the project (be a member of a community planning group, be a member of a focus group, respond to further written requests for information, or give us your opinion confidentially on other issues as the project goes along)? If so, please make sure the contact information in Section A is completed, or, if you'd prefer, please phone ACNBA at 497-3560 or use the toll free number 1-800-387-3701 and leave a name, phone number, and time that we can reach you, or email uwuc29@vianet.ca and leave this information.

16. Anything else you'd like to tell us?

Thank you!

APPENDIX D – Service Inventory

Community Planning Initiative To Improve Services for People with, or at risk of, HIV/AIDS

Organization	District	Note
Nipissing DSSAB and Ontario Works	Nipissing	
CCAC Timiskaming	Timiskaming	
Nipissing -Parry Sound Catholic DSB	Nipissing	
advocate	Nipissing	
North Bay-Parry Sound Health Unit	Nipissing	
Near North Palliative Care Network	Nipissing	
consumer	Nipissing	
Mental Health and Addictions, Timiskaming Health Unit	Timiskaming	
Trillium Lakes DSB, Health and Physical Education/ Science Curriculum Consultant	Muskoka	
Muskoka Parry Sound Sexual Assault Services	Parry Sound	poverty advocate
North Bay Community Housing Initiative	Nipissing	
Sexual Health Program, Simcoe Muskoka District Health Unit	Muskoka	
North Bay Crisis Centre	Nipissing	
ACNBA	all four	
North Bay Jail	Nipissing	
SAIL (sexual assault)	Parry Sound	
Centre de sante Communautaire du Temiskaming	Timiskaming	
Directeur de l'éducation	Timiskaming	no success in contacting this organization
Conseil scolaire de district catholique des Grandes Rivières		
Advocate	Nipissing	
Amelia Rising (sexual assault centre of Nipissing)	Nipissing	
Muskoka/East Parry Sound CCAC	Muskoka	
Metis Nation of Ontario	Nipissing	no success in contacting this organization
ACNBA Board	Nipissing	
District School Board, Ontario North-East	Timiskaming	no success in contacting this organization
Canadian Mental Health Association	Nipissing	
Nipissing First Nation	Nipissing	
Directeur de l'éducation	Nipissing	no success in contacting this organization
Nipissing Detoxification & Substance Abuse Programs	Nipissing	
Harvest Share Community Food Programs	Parry Sound	no success in contacting this organization
Nipissing Legal Clinic	Nipissing	
PEP (People for Equal Partnership in mental health)	Nipissing	
Parry Sound Indian Friendship Centre	Parry Sound	no success in

		contacting this organization
Doreen Potts Health Centre, Temagami First Nation	Nipissing	no success in contacting this organization
former TLC Committee, ACNBA	Nipissing	
Advocate	Parry Sound	
Poverty advocate, Timiskaming Health Unit	Timiskaming	
LIPI (Low Income People's Involvement)	Nipissing	no success in contacting this organization
Near North CCAC	Nipissing	no success in contacting this organization
OPP, Timiskaming	Timiskaming	
Parry Sound DSSAB—Ontario Works	Parry Sound	
Simcoe Muskoka Catholic DSB	Muskoka	no success in contacting this organization
Hospice West Parry Sound	Parry Sound	
Muskoka Parry Sound Community Mental Health Service	Parry Sound	
Directeur de l'éducation	Nipissing	no success in contacting this organization
Parry Sound DSSAB--Ontario Works	Parry Sound	
North Bay Indian Friendship Centre	Nipissing	no success in contacting this organization
physician	Nipissing	
Lawrence Commanda Health Centre	Nipissing	
B'saanibamaadsiwin ~ Native Mental Health	Nipissing	no success in contacting this organization
North Bay Halfway House	Nipissing	
Northeastern Catholic DSB	Timiskaming	no success in contacting this organization
Infectious Diseases Manager	Timiskaming	
Family member	Nipissing	
Near North DSB	Nipissing	no success in contacting this organization
Addiction Outreach Muskoka Parry Sound	Muskoka	
Hospice Muskoka	Muskoka	

APPENDIX E – INFORMATION AND OUTREACH ACTIVITY

Sample Satisfaction QuestionnaireMedia

[date]

Please help us evaluate the usefulness of the media briefing, and any further work that is needed in this area, by completing this brief evaluation before you leave.

For each of the items below, please circle the number from 1 to 5 that best identifies your level of agreement (1 = Strongly Disagree—5= Strongly Agree).

Overview of the presentation

1 = Strongly Disagree / 5 = Strongly Agree

Agree

1	The presentation of the information was clear	1	2	3	4
2	The content of the presentation was useful	1	2	3	4
3	The presentation was just right in length	1	2	3	4
4	The presenter was knowledgeable about the content	1	2	3	4
5	The presenter was able to relate the content to our work	1	2	3	4
6	The presenter was focussed in his/her presentation	1	2	3	4

Other comments: _____

Group Discussion

1 = Strongly Disagree / 5 = Strongly Agree

Agree

11	The facilitator managed the available time well.	1	2	3	4
12	The facilitator kept the discussion on track	1	2	3	4
13	The group discussion was useful	1	2	3	4

Other comments: _____

Other Comments:

14	It was helpful to have this material presented by a knowledgeable person.	1	2	3	4
15	It was helpful for us to get together as a group to speak to the issue of HIV/AIDS in our area.	1	2	3	4
16	The media briefing kit will be a useful resource				

Do you have any suggestions for improving the presentation, or the materials?

Thank you! **Sample Outcome Questionnaire**

Media
[date]

On [date—three months previous], you received a presentation for people working in the media from [presenter] on HIV/AIDS. We need to know if this presentation has improved your knowledge and work on that issue. Please help us to evaluate the usefulness of this presentation, and to identify any further work that is needed in this area, by completing this brief evaluation, and returning it to us [this needs a method that will not reveal the identity of the person completing the evaluation. Completed questionnaires could be mailed to a person or agency external to ACNBA's staff, board, volunteers, or clients, and removed from their envelopes, compiled, and presented to ACNBA for analysis. Or, similarly, emailed or faxed, identifying information such as fax number of sender or email address of sender stripped, forms presented to ACNBA.]

For each of the items below, please circle the number from 1 to 5 that best identifies your level of agreement (1 = Strongly Disagree—5= Strongly Agree).

Impact of the presentation

1 = Strongly Disagree / 5 = Strongly Agree

Agree

1	I am more knowledgeable about issues related to HIV/AIDS as a result of the presentation	1	2	3	4
2	My coverage of issues related to HIV/AIDS has improved as a result of the presentation	1	2	3	4
3	I have used the media briefing kit since the presentation	1	2	3	4
4	I have found the media briefing kit useful when I've referred to it	1	2	3	4
5	I have contacted ACNBA since the presentation	1	2	3	4
6	My contact with ACNBA was useful to my work	1	2	3	4

Other comments: _____

Current Situation

1 = Strongly Disagree / 5 = Strongly Agree

11	I need more information about (content)	1	2	3	4
12	I need to know how to (process, skill)	1	2	3	4

Other comments: _____

Do you have any suggestions for improving the presentation, or the media briefing kit?

Thank you!

Sample Satisfaction Questionnaire
Peer Counselling and Support Group
[date]

Please help us evaluate the usefulness of the peer counseling and support group you've been part of, and any further work that is needed in this area, by completing this brief evaluation. We're interested in your honest opinion, whether it's positive, or negative. Please answer all of the questions. We also welcome your comments and suggestions for improvement. All responses are confidential, and your anonymity is guaranteed. *[need a process for this—e.g., external drop-box].*

1. How would you rate the quality of the service you received in the group?

- Excellent (4) Good (3) Fair (2) Poor (1)

2. Did you get the kind of help you wanted?

- No, definitely not (4) No, not really (3) Yes, generally (2) Yes, definitely (1)

3. To what extent has this group met your needs?

- Almost all of my needs have been met (4) Most of my needs have been met (3)
 Only a few of my needs have been met (2) None of my needs have been met (1)

4. If a friend were in need of similar help, would you recommend this group, or one like it, to him or her?

- No, definitely not (4) No, not really (3) Yes, generally (2) Yes, definitely (1)

5. How satisfied were you with the amount of help you have received?

- Quite dissatisfied (4) Indifferent or mildly dissatisfied (3) Mostly satisfied (2) Very satisfied (1)

6. Has the help you received equipped you to deal more effectively with your problems?

- Yes, they helped a great deal (4) Yes, they helped somewhat (3)
 No, they didn't really help (2) No, they seemed to make things worse (1)

7. In an overall, general sense, how satisfied are you with the help you received through the group?

- Very satisfied (4) Mostly satisfied (3)
 Indifferent or mildly dissatisfied (2) Quite dissatisfied (1)

8. If you were to seek help again, would you come back to this group, or one like it?

- No, definitely not (1) No, I don't think so (3) Yes, I think so (2) Yes, definitely (1)

Do you have any suggestions for improving the group?

Thank you!

Sample Outcome Questionnaire
Peer Counselling and Support Group
[date]

You were or are part of a group to provide peer counseling and support for people with HIV/AIDS, or family members of people with HIV/AIDS (please circle one or the other).

We need to know if these groups are helping the people they're intended to serve. Please help us to evaluate the usefulness of the group, and to identify any changes that are needed, by completing this brief evaluation, and returning it to us [*this needs a method that will not reveal the identity of the person completing the evaluation. Completed questionnaires could be mailed to a person or agency external to ACNBA's staff, board, volunteers, or clients, and removed from their envelopes, compiled, and presented to ACNBA for analysis. Or, similarly, emailed or faxed, identifying information such as fax number of sender or email address of sender stripped, forms presented to ACNBA.*]

For each of the items below, please circle the number from 1 to 5 that best identifies your level of agreement (1 = Strongly Disagree—5= Strongly Agree).

As a result of my participation in the group, ...

1 = Strongly Disagree / 5 = Strongly Agree

1	I am more knowledgeable about issues related to HIV/AIDS	1	2	3	4
2	I am better equipped emotionally to deal with my own/my loved one's HIV/AIDS status and situation	1	2	3	4
3	I have more knowledge about where to access the help I need to deal with my own/my loved one's HIV/AIDS status and situation	1	2	3	4
4	I am more confident about approaching the places that provide the help I need to deal with my own/my loved one's HIV/AIDS status and situation	1	2	3	4
5	I have better skills (communication, positive assertiveness, etc.) to get the help I need to deal with my own/my loved one's HIV/AIDS status and situation	1	2	3	4
6	I have more of what I need of the following	1	2	3	4
	- HIV/AIDS testing & diagnosis	1	2	3	4
	- counseling for HIV+ people	1	2	3	4
	- counseling for family members/significant others of HIV+ people	1	2	3	4
	- 24 hour crisis response line	1	2	3	4
	- budget or credit counseling	1	2	3	4
	- spiritual help and support	1	2	3	4
	- emergency medical attention	1	2	3	4
	- direct medical care/clinical treatment	1	2	3	4
	- help to find or retain housing	1	2	3	4
	- dietary or nutritional counseling	1	2	3	4
	- grief counseling	1	2	3	4
	- help with finding employment	1	2	3	4
	- harm reduction counseling (e.g., safer sex practices, safer injecting practices)	1	2	3	4
	- legal services (e.g., power of attorney)	1	2	3	4
	- home care	1	2	3	4
	- help to relocate	1	2	3	4
	- detox	1	2	3	4
	- addictions treatment	1	2	3	4
	- mental health services				
	- help completing ODSP forms, travel grant applications, etc.	1	2	3	4
	- social activity support	1	2	3	4

- referral to other services	1	2	3	4
- clothing depot	1	2	3	4
- housing/shelter	1	2	3	4
- meals/soup kitchen	1	2	3	4
- vouchers for perishable items	1	2	3	4
- food bank	1	2	3	4
- dietary/nutritional supplements (vitamins, boost, ensure, etc), or vouchers for these	1	2	3	4
- financial support or assistance (direct cash, e.g.)	1	2	3	4
- vouchers to help access services	1	2	3	4
- transportation assistance to medical, legal or other appointments, or bus passes or tickets, taxi vouchers, etc.	1	2	3	4
- palliative care	1	2	3	4
- harm reduction supplies (needle exchange, condoms, lube, etc.)	1	2	3	4
- relocation costs	1	2	3	4
- assistive devices (e.g., wheelchair, walker, eyeglasses, hearing aid, etc.)	1	2	3	4
- other (please specify)				

Other ways that participating in the group has changed your situation?

Any suggestions for changes that would improve the group?

Thank you!

APPENDIX F

Sample Service Agreement

Parties Involved in Agreement

Purpose of the Agreement

Description of Services to be Provided

- What services/support?
- By whom?
- How often – time commitment?
- Where?
- Roles and responsibilities for each of the parties (i.e., what will the client referral process look like and what tools will be used?)

Administrative/Management Responsibilities

- Who has what responsibilities?
- How is staff supervision provided?
- How are decisions made?

Any Financial Terms

- Costs – who pays what costs?
- Staff compensation?

Data/Information Systems

- How and what data is collected?
- Who collects data?
- Who is responsible for managing system?

Clinical Records

- Ownership?
- Where kept?
- Confidentiality?

Other Relevant and Applicable Policies and Procedures

Staffing/Human Resources Plan

Problem Conflict Resolution Process

Process for Review of Agreement

- When?
- Achieved Goals and Objectives

Effective Date of Agreement

Length/Term of Agreement

- Conditions under which agreement can be terminated early

Dated and Signed by Parties Involved

Service Agreement - Guiding Principles (Adapted from OSAB)

Service agreements are designed to enhance services to clients and increase interagency coordination and collaboration. They may range from voluntary agreements between two agencies who clients have a range of problems and require multiple services, to contractual relationships between two agencies regarding the provision of specified services. For example,

- voluntary agreement between two agencies who “share” clients
- voluntary agreement between two agencies with one agency providing services to the other agency (i.e, locate a staff person in the other agency, provide training/consultation) .
- contractual agreement between two agencies for the purchase of certain services. This may involve an outpatient service purchasing special services from an addiction agency as an example
- voluntary agreements between an agency providing direct services to clients and an agency providing services such as health promotion, public information or training.

Service agreements ensure that both parties understand the services that are provided in the other agency, how client referrals can be made, and formalize regular communication between staff of the two agencies to ensure the provision of coordinated services to clients and families.

In a situation where one agency provides services to another, the type of agreement will depend on the nature of the committed resources and the associated responsibilities of each party. For example, ACNBA may agree to co-locate a staff member in a health or social service agency for a fixed number of hours per week or month. A service agreement would need to identify exactly what services that person would provide to the host agency, how clients would be referred to that worker, how the two agencies will coordinate services for “shared” clients. The agreement would also need to describe the services provided by the host agency (e.g. space, telephone, office equipment, staff expectations).

The agreement can also formalize the sharing of client information (with client consent) so that clients do not have to be assessed twice, and to ensure that the follow-up worker has complete information on the client’s progress while in treatment with the specialized service. It is important to ensure that no information is shared without client consent. The consent process should contain appropriate safeguards for clients, such as specific details about what information will be shared, consent is time-limited, client is capable of understanding what he/she is consenting to etc.