

## **Introduction**

This document represents the work of the Strategic Planning Committee in identifying the future strategic direction of the AIDS Committee of Ottawa. Since last spring we have been engaged in a process of research and consultation about the strategic issues facing ACO. We have produced a number of documents summarizing our work. This report represents our work on the final area, proposing a new direction for the agency. The decision about what direction to take belongs to the Board. We hope that this document will help provide a common understanding of the task in front of us.

The report is made of a number of parts:

1. Our sense of the problems we need to face.
2. The criteria that we developed to evaluate the best solutions.
3. What we heard in the client and community consultations.
4. The proposed strategic direction.
5. Next steps and challenges

## **1. Why Do We Need a Strategic Plan?**

The strategic planning process underway with the community about the ACO is the final step in the process of answering the question of what is ACO's role in the provision of HIV/AIDS programs and services within the City of Ottawa. It has been preceded by several other attempts to answer this question dating at least as far back as 1998. While this current initiative was begun as an internal exercise, it now has been formally requested by the AIDS Bureau and by the Ottawa-Carleton Council on AIDS (OCCA), essentially as a response to the OCCA Strategic Plan of 2002, and continuing dissatisfaction on the part of community partners and PHA's alike with both ACO's efforts in some areas and perceived lack thereof in others.

Over time a host of contributing factors have impinged on ACO's ability to effectively deal with the challenges it faces. Some of these are listed below:

1. The changing face of the disease over time means that there are more clients representing many more communities than were affected in the 1980's and early 1990's. This fact led to expectations that ACO address the totality of need across all populations. In turn, attempting to respond to these expectations actually has resulted in meeting few of them adequately.
2. The array of organizations dealing with HIV/Aids has grown over the past ten to fifteen years, as the public health sector became increasingly involved.
3. OCCA's Strategic Plan provided a catalogue of local organizations, programs and services available to PHA's, endangered populations and the general public. This

study identified areas where there is duplication of effort as well as some constituencies that are not adequately served.

The time has come to define a unique role for ACO if it is to continue to be relevant in the fight against HIV/Aids and in the provision of unique services to the community. The type of role that ACO could take on ranges from:

- Unaddressed constituencies
- Unaddressed local planning capacity
- PHA agency
- No role - dissolution.

In the elaboration of its new role, ACO will have to identify those things that it will no longer do or offer, as well as define those that it will.

## **2. Criteria**

The committee reflected on the criteria that would we would use to make our recommendations. We identified the following list. It is by no means an exhaustive list.

- Reflect and respond to the need of PHA's
- Be flexible to future needs
- Maximize the reach and effectiveness of the organization
- Remain true to our mission statement
- Maintain our charitable status
- Contribute to the health and well-being of the city overall
- Be realistic
- Be aware of the political context
- Be clear about outcomes so we know if we are succeeding.

## **3. What Did We Hear?**

In the interests of brevity we will focus most on the client and community partner feedback. Most board members were able to attend the community consultation.

### **Service Users**

There was striking uniformity in the comments from service users. They were alarmed at the prospect of losing the Living Room. They believed that the services provided by the Living Room need to be enhanced and represented a unique service. They valued the opportunity to meet face-to-face and share their experiences of living with HIV/AIDS with each other. They wanted to talk with others who knew what it was like to be on medication. They missed the practical things that the Living Room had provided in the past such as massage therapy, vouchers and toiletries. They were much less interested in the services provided by ACO outside of the Living Room. Some commented favourably

on the support they had received from staff. Others felt that the loss of volunteers particularly PHA volunteers meant that relationships with staff were too disciplinary or limiting.

None of the options presented to them attracted substantial support. Option 3 – Working with PHA’s attracted the most support. There was some interest in a stronger capacity for case-management.

### Community Partners

Some community partners doubt the ability of ACO to provide service. They expressed concern that the name and baggage of ACO would hold the agency back. Some expressed support for a merger with Bruce House (Option 4); others favour a role in system leadership (Option 2) and working with PHA’s (Option 3).

## **4. The Proposed Model: PHA Empowerment**

### Rationale for New Model

Interviews with service users and community consultations revealed that there has been a growth of services for PHA’s over the past two decades. When ACO was founded very few services were specifically targeted to PHA’s and it was difficult for PHA’s to access general community services because of homophobia and stigma about the disease. ACO was founded as a community response to the epidemic and worked from a peer and community-based approach. Things have since changed for the better. Medical and social services have increasingly become available in other agencies. However these agencies often use traditional social service delivery models of “professionals” offering services to “clients”. There remains a need for a PHA vehicle, an organization that works to ensure that PHA’s play a meaningful role in shaping the systems designed to help them. Despite the fact that PHA’s are drawn from diverse populations there is a common experience of being HIV-positive. An organization of PHA’s directed by PHA’s can fill a much-needed void in Ottawa today.

Serving as a voice for PHA’s means that we have to bring them together. To bring them together we need to meet their needs. Service users spoke eloquently of the need for an environment where PHA’s could engage in peer-to-peer interaction speaking to one another about the experience of medication, the difficulties of coping with the stigma of the diagnosis and sharing strategies for enhancing their mental, physical and spiritual well-being. Many service users told us that could best be done in the Living Room, which offers a friendly and supportive space. The Living Room is a service that is offered nowhere else and has in the past offered a wide range of practical supports that were highly valued and sorely missed. The most commonly cited example was the Complementary Therapies program.

The strength of the Living Room was its ability to mobilize tremendous energy and commitment from volunteers including PHA's. Despite having a relatively small paid staff the Living Room was able to offer a range of practical services and open at night and over the weekend. This model is consistent with other successful organizations, such as Pink Triangle Services, and Egale that rely on a small paid staff and a large group of volunteers.

### Revitalized Living Room

The proposal is to restructure ACO to primarily provide services to enhance the well being of PHA's through an expanded Living Room Program. The New Living Room will be a place that is home-like and open to ALL PHA's and those closely affected. The centre will be open extended hours and on the weekends to accommodate those who are working full time. It will be a welcoming place where people can gather on an informal basis to talk to others who share many of the same life experiences that they are. People who are newly diagnosed will be able to talk those who have lived with the disease for several years and learn about things such as side effects of drugs, experiences with relationships, how to access services provided by other agencies etc. A small staff and a large contingent of volunteers will provide a broad range of practical services.

The following is a partial list of services to be provided by the New Living Room:

- Hot meals will be available at lunch and dinner times
- Facilitated and informal men's and women's social gatherings.  
(e.g. games night, new drug update sessions, resume preparation workshops, healthy cooking/nutrition classes, and movie night)
- Community Kitchen with access to an emergency food bank
- YM/YWCA day pass to encourage maintaining or improving physical well-being.
- Volunteer personal trainer, Pilates classes)
- Massage therapist
- Arts and craft activities
- Donated clothing facility
- Spring and fall clothing exchange days
- Hairdresser at the Living Room one day per week.
- Home/hospital visits for those who are not able to come to the Living Room.
- Referral service to other community resources
- PHA Speakers' Bureau to aid with prevention initiatives

### How is this Different?

In recent years the variety and availability of services once offered by the Living Room has decreased due to a several factors including lack of funding, and the restriction of hours. Yet the need has not diminished. The Living Room currently provides a women's and gay men's social groups, a community kitchen, grocery program and "Meet and Eat"

gatherings for PHA's to share a meal and talk in a social atmosphere. These services have been cut to restricted hours that have made it impossible for some to participate. Several services that were provided in the past are no longer offered. These would include massage therapy, clothing exchange, provision of toiletries, haircuts and style, arts and crafts etc. In most instances volunteers provided these services.

The organization would also self-consciously act to empower PHA's and emphasize peer interactions. In terms of staffing and governance the expectation would be that PHA's would direct the agency. Non-PHA's would continue to play an important role in a range of capacities where necessary.

### Services to be Transferred to Other Organizations

Activities such as prevention education for the wider community and counselling which are presently provided by ACO will be moved to other organizations that are better suited to administer these activities. This will allow ACO to focus on one aspect of service to the PHA community and not scatter the limited resources. Instead of doing many things at a mediocre level of service ACO will be able to provide the highest level of service by focusing on one crucial aspect of PHA care. These changes would need to be phased in and other community agencies would need to take these services on.

### How Would This Be Funded?

The New Living Room will require a space such as presently exists with minor modifications, a core staff consisting of a Director, Office manager, Volunteer coordinator, and several staff to supervise the living room and volunteers. We hope that funding for this facility will come from government funding as well as both corporate and individual donations, as well as public funding. Currently ACO presently about 65% of its funding from the provincial government, about 7% from the City of Ottawa and currently receives no federal funding.

### Next Steps

1. Board approves strategic direction in late March
2. Strategic Plan is written up in late March.
3. Membership considers and approves strategic plan early April.
4. Strategic Plan is submitted to OCCA for consideration on April 13.
5. We begin negotiations with community partners to consider taking on prevention and counselling programs in spring.
6. OCCA makes recommendations to the provincial Ministry of Health regarding our plan and local services in general in summer.
7. Ministry of Health decides whether it will fund our plan while we pursue alternate sources of funding in summer.

## Next Challenges

### **Getting Membership Approval**

While the recommended strategic plan reflects the overwhelming sentiment expressed in the recent consultations change is difficult. There may be opposition. The decision to phase out counselling at ACO may provoke some concerns from clients of our counselling services. It will take time to implement this recommendation.

### **Implementing the Plan**

Coming up with the plan was a lot of work but once it is approved the challenge will be implementing it. The Board will need to develop an implementation plan which will operationalise what needs doing and when it can be done.

### **Staff Participation**

Once the strategic plan is adopted we will embark on a transition period of implementing the plan. This is on top of the prolonged uncertainty staff have already experienced from our loss of executive directors. We may have difficulty retaining our staff even as we try to transition to the new model.

### **Community Partners**

For our strategic plan to receive Ministry of Health funding it will need support from other community agencies. The last few months have revealed a great deal of unhappiness with ACO from other agencies working in the field. Our perennial organizational woes, staff turnover, concerns about program delivery and failure to resolve basic strategic issues have all played a role. The other big issue is money. ACO receives over \$500,000 in government grants. Shrinking ACO or eliminating it altogether represents an opportunity for other agencies to get more money. Several of our partner agencies are running big deficits. Others are looking to dramatically increase their role and need a lot of money to make this work. The provincial Ministry of Health has instructed Ottawa agencies to reach a consensus about how its AIDS money gets spent. This will be complicated and will involve a lot of political manoeuvring.

### **Government Funding**

Even if a consensus plan is reached in Ottawa, the AIDS Bureau of the Ontario Ministry of Health will still need to agree to fund it. They have the same concerns about our organizational capacity that our sister agencies have. The City of Ottawa will likely share the same concerns. We will need to pursue alternate funding sources in case we cannot rely on current funders.

### **Conclusion**

ACO began this process of strategic planning a year ago. Our previous efforts to undertake this process have failed to get off the ground.

That it has reached this point despite the enormous challenges of the past year is a major accomplishment. The Strategic Planning Committee wanted to ensure that it listened to the voices of PHA's, staff, and the wider community. The model we propose represents our response to that feedback.