2017 View from the Front Lines

OCHART

Annual summary and analysis
April 1, 2016 to March 31, 2017

View from the Front Lines

OCHART

ONTARIO
HIV TREATMENT
NETWORK

Ontario

Acknowledgements

The AIDS Bureau would like to thank the programs that provided data used to create this report. The funders acknowledge the time and care taken to collect data and complete the Ontario Community HIV and AIDS Reporting Tool (OCHART). The AIDS Bureau would also like to thank all the individuals who worked during the year to improve the OCHART questions and the accuracy of the resulting OCHART data.

In addition, the AIDS Bureau wishes to thank the Ontario HIV Treatment Network (OHTN) for its continued support of OCHART, which includes:

- Developing the web-based OCHART tool
- Providing ongoing training and support to programs on the use of OCHART
- Housing OCHART data
- Extracting OCHART data; and
- Completing the analyses and final design of this report.

We look forward to continued excellence in data reporting, analysis and delivery.

For more information about completing OCHART forms or to request program-specific data and reports, please contact:
416-642-6486 x2303 or ochart@ohtn.on.ca

ONTARIO
HIV TREATMENT
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Copies of this report can be found at http://www.ohtn.on.ca/ochart

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Contents

Preface

Preface

Welcome to the 12th annual Ontario Community HIV and AIDS Reporting Tool (OCHART) report: **View From the Front Lines 2016-17.**

Focusing our efforts

In 2017, the HIV/AIDS Strategy to 2026, *Focusing Our Efforts: Changing the Course of HIV, Prevention, Engagement and Care Cascade* in Ontario was officially launched.

A copy of this strategy can be found online at: **http://www.health.gov.on.ca/en/pro/programs/hivaids/oach_strategy.aspx**

The strategy challenges all HIV-related programs and services to focus their efforts in order to:

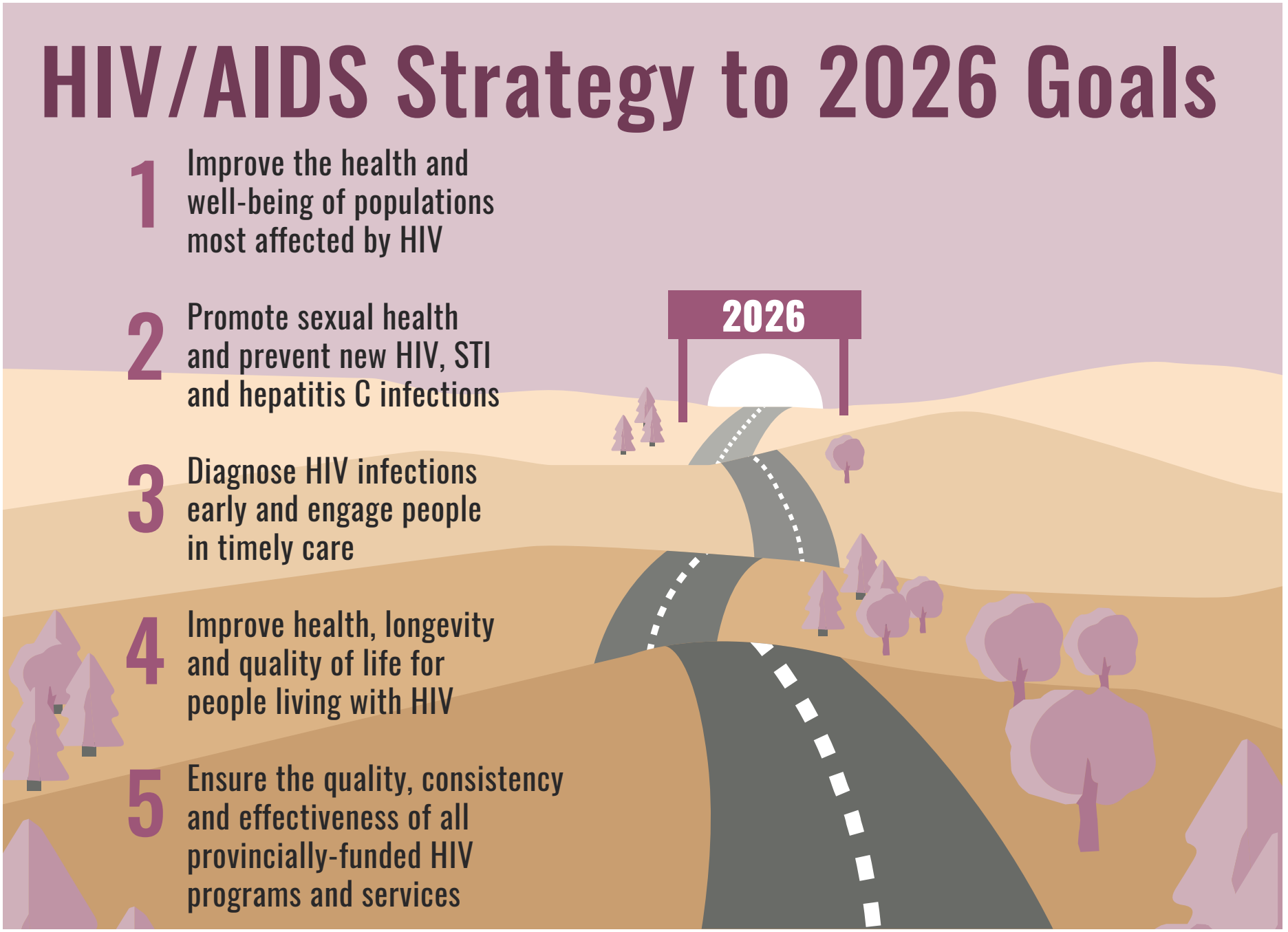
- Take a systems approach, integrating HIV services with other health and social services
- Engage populations most affected by HIV
- Meet the needs of people at each stage of the prevention, engagement and care cascade, including:
  - Those at risk of acquiring HIV
  - Those recently exposed to HIV, so they can be tested early and linked to services that will either help them prevent HIV seroconversion or transmission, or, if they test positive, provided with care
  - Those living with HIV, so they stay engaged in care and improve their health

Agencies began preparing for the launch of the strategy well in advance and have expanded and enhanced their programs. In 2016-17, the OCHART questions were also revised to reflect this new strategy.

> People who acquire HIV in their 20s and are diagnosed early, remain engaged in care and receive treatment to suppress the virus (as well as high-quality care for other health issues) can expect to live into their early 70s.
>
> We can and must do better to end new HIV infections and continue to improve care for all in Ontario living with HIV.

HIV/AIDS Strategy to 2026 Goals

1. Improve the health and well-being of populations most affected by HIV
2. Promote sexual health and prevent new HIV, STI and hepatitis C infections
3. Diagnose HIV infections early and engage people in timely care
4. Improve health, longevity and quality of life for people living with HIV
5. Ensure the quality, consistency and effectiveness of all provincially-funded HIV programs and services



About this report

This report highlights key service trends of programs funded by the AIDS and Hepatitis C Programs, Ministry of Health and Long-Term Care including:

- **69** community-based HIV/AIDS programs (including programs in AIDS services organizations and non-AIDS organizations, including community health centres
- **4** provincial organizations that provide direct services to clients:
  - Hemophilia Ontario
  - Ontario Aboriginal HIV/AIDS Strategy (Oahas)
  - Prisoners with HIV/AIDS Support Action Network (PASAN)
  - HIV & AIDS Legal Clinic Ontario (HALCO)
- **11** capacity-building programs including:
  - 7 provincial organizations that provide training, information and other services to support local community-based AIDS services and other organizations
  - 3 priority population networks (PPNs) which each have a provincial office and network members based mainly in the AIDS service organizations (ASOs) throughout the province
    - Gay Men's Sexual Health Alliance (GMSH)
    - African & Caribbean Council on HIV in Ontario (ACCHO)
    - Women's HIV and AIDS Initiative (WHAI)
  - The Ontario HIV Treatment Network (OHTN) which acts a knowledge exchange organization that uses data to drive change.
- **8** anonymous testing programs
- **5** community-based HIV clinics
- **15** hepatitis C teams, which work closely with physicians, providing HCV care and treatment, education, outreach and support services.

OCHART data collection tools and support

Organizations collect their OCHART data in a number of different ways. Some use tracking tools developed by OCHART and others have developed their own systems to record and track their activities. A small number of organizations (29) also use a case management tool, Ontario Community-based AIDS Services and Evaluations (OCASE), where they record information specifically on support services for clients. The OCASE team at the OHTN works closely with OCASE agencies to help them pull data from OCASE for their OCHART reports. In the process, agencies have been able to improve the quality and completeness of their data and have more accurate counts of unique clients accessing services.

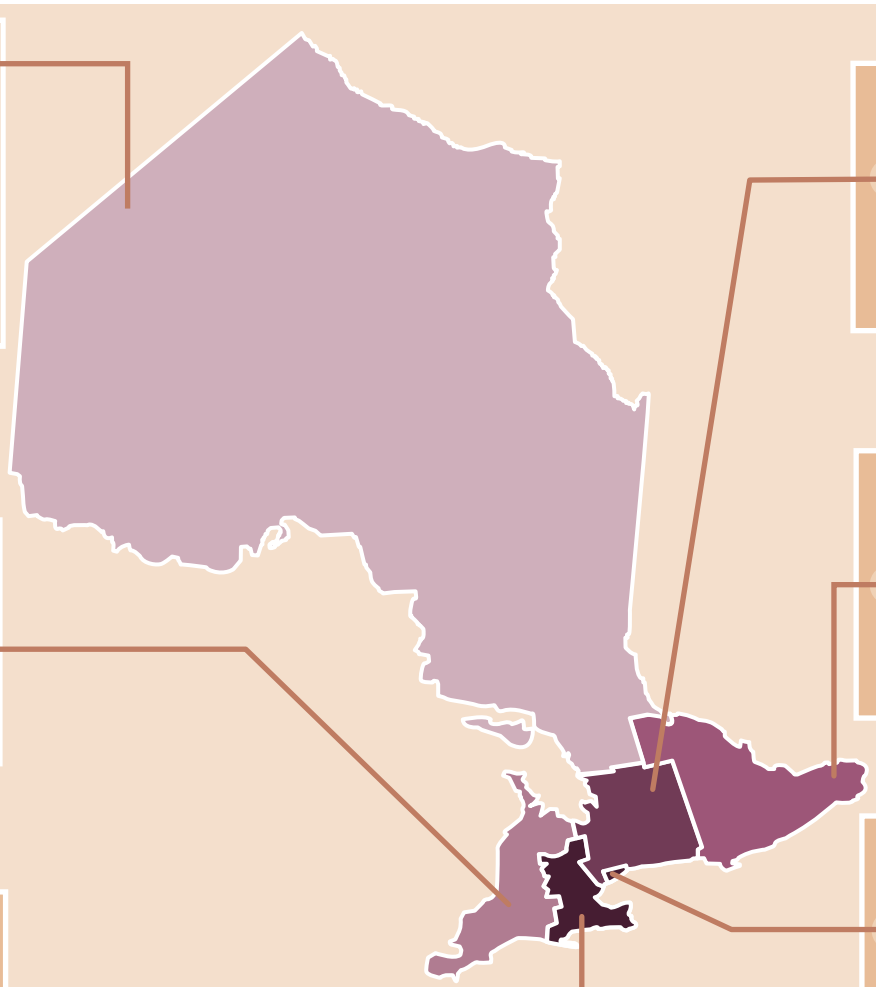
How OCHART data is used

OCHART data is used to:

1. document the range of community-based HIV services provided each year in Ontario
2. identify emerging issues, trends and client needs
3. inform planning
4. account for use of public resources.

For data limitations, please see Appendix B.

Programs providing HIV and hepatitis C services across the province, by region and service type



Northern

ASO	3
HCV team	4
Anonymous testing	2
Clinical services	1
HCV position	1
Non-AIDS service organization	5
Direct services provincial	4

Central East

ASO	4
HCV team	1
Anonymous testing	1
Clinical services	1
HCV position	1

Ottawa and Eastern

ASO	3
HCV team	2
Anonymous testing	1
Non-AIDS service organization	4
Direct services provincial	3

South West

ASO	2
HCV team	2
Anonymous testing	2
Non-AIDS service organization	1
Direct services provincial	3

Toronto

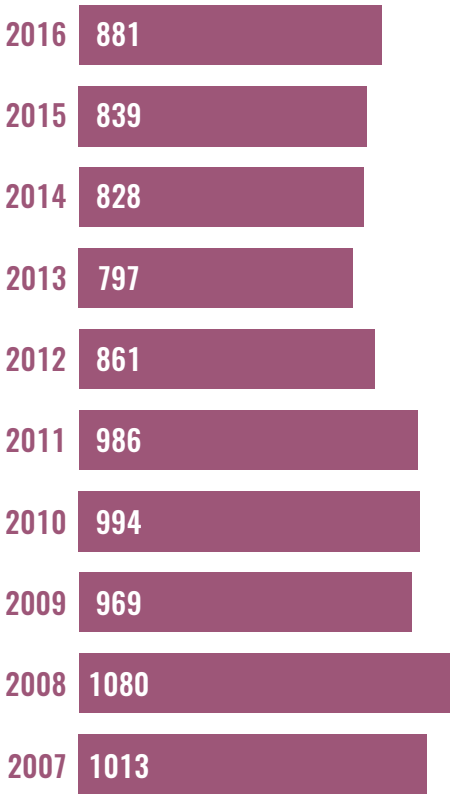
ASO	11
HCV team	2
Anonymous testing	1
Clinical services	1
HCV position	1
Non-AIDS service organization	19

Central West

ASO	5
HCV team	4
Anonymous testing	1
Clinical services	2
Direct services provincial	1

HIV epidemiology in Ontario

Number of new HIV diagnoses in Ontario, 2007-2016



Note: Data provided by the Public Health Ontario Laboratory

HIV epidemiology in Ontario

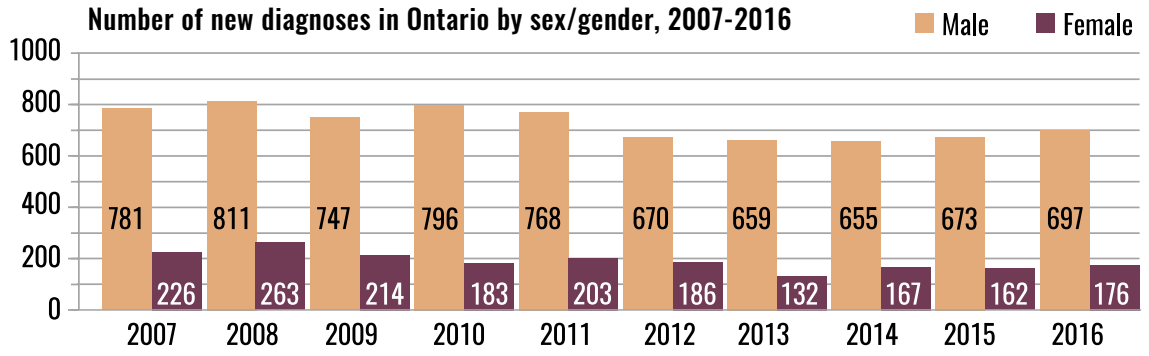
In 2016, there were **881** new HIV diagnoses in Ontario.

Over the past five years, Ontario has had between 800 to 900 new HIV diagnoses each year—down from the approximately 1,000 diagnoses a year between 2007 and 2011, but still equal to more than two new diagnoses each day.

Despite an overall decrease in the number of new diagnoses over the past decade, there has been a slight increasing trend since 2013 when there was a low of 797 diagnoses. This trend may be due to an increase in new HIV infections, but it may also be partly due to other factors, such as the 19% increase in the number of tests during this same time period. Migration could have also played a role, as new diagnosis numbers include people who acquired HIV outside Ontario and moved to the province and were tested here.

By sex/gender

In 2016, four of every five people newly diagnosed in Ontario (676 or 80%) were male and one in five were female (176 or 20%). Sex/gender was unknown for 8 diagnoses.



Note: Data provided by the Public Health Ontario Laboratory

By priority population

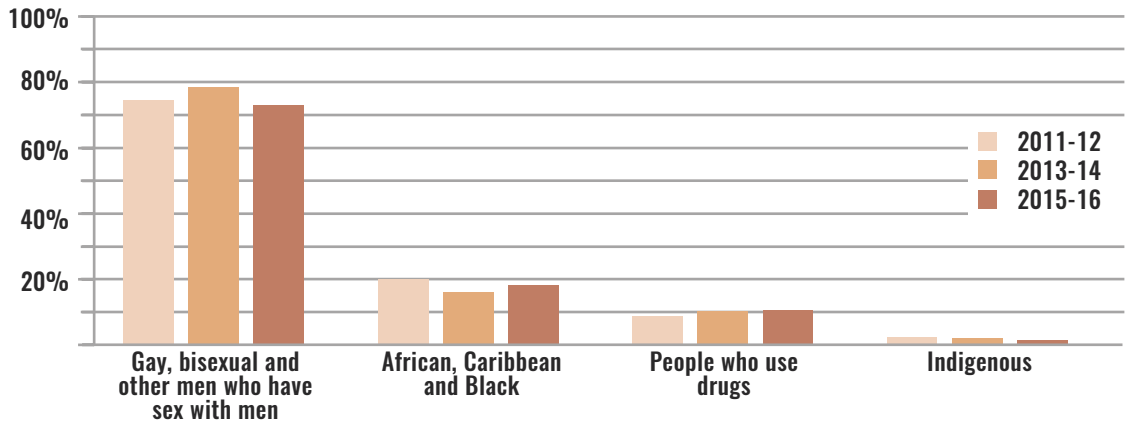
In 2015 and 2016 (combined), most new HIV diagnoses were in gay, bisexual and other men who have sex with men (59%), followed by individuals from African, Caribbean or Black communities (25%), at-risk women (19%), people who use injection drugs (13%) and Indigenous men and women (3%).

Information on priority population was unknown for about a third of new diagnoses and therefore was excluded from the data below. Percentages do not add to 100 because people can be recorded in more than one priority population (e.g., a gay man who injects drugs) and not all diagnoses fit within one of these priority populations.

What are the priority populations?

- People living with HIV/AIDS
- Gay, bisexual, and other MSM, including trans men (GBMSM)
- African, Caribbean and Black communities (ACB)
- Indigenous men and women
- People who use drugs, including people who use injection drugs (PWID)
- At-risk women, including trans women

Percentage of new male HIV diagnoses by priority population (where known), Ontario, 2011-2016



Note: Data provided by the Public Health Ontario Laboratory

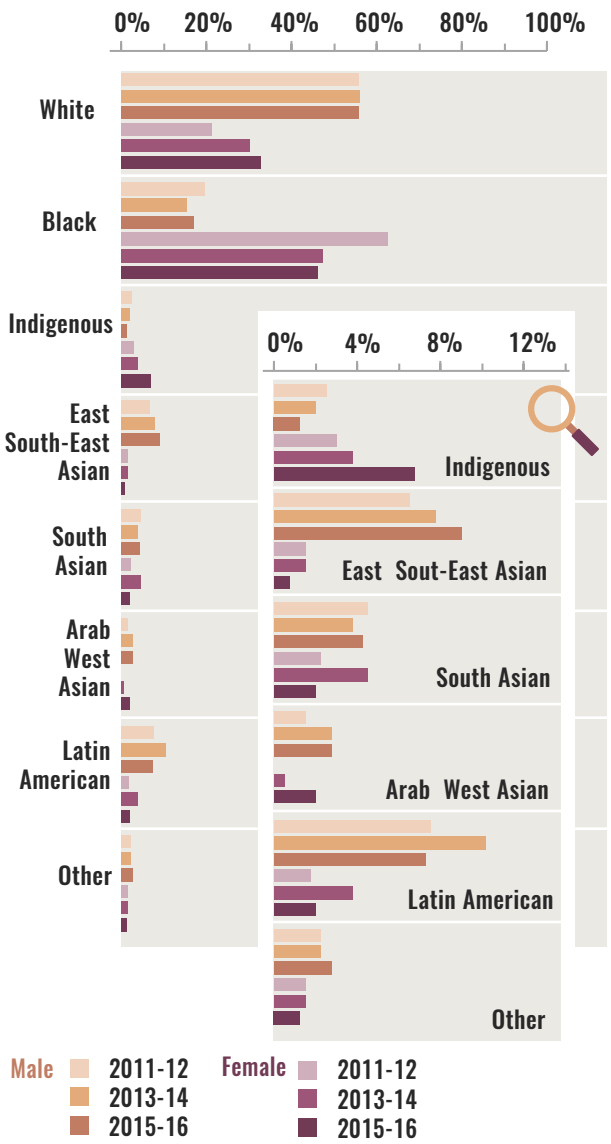
Snapshot: Most **women** diagnosed with HIV were African, Caribbean or Black (51% in 2015-2016) and between the ages of 30-34 (16% in 2016).

Trends over time: The number of women diagnosed each year has generally decreased over the past decade but has increased since 2013.

Snapshot: Most **men** diagnosed with HIV in 2016 were white (56% in 2015-2016), gay, bisexual or other men who have sex with men (73% in 2015-2016) and between the ages of 25-29 (19% in 2016).

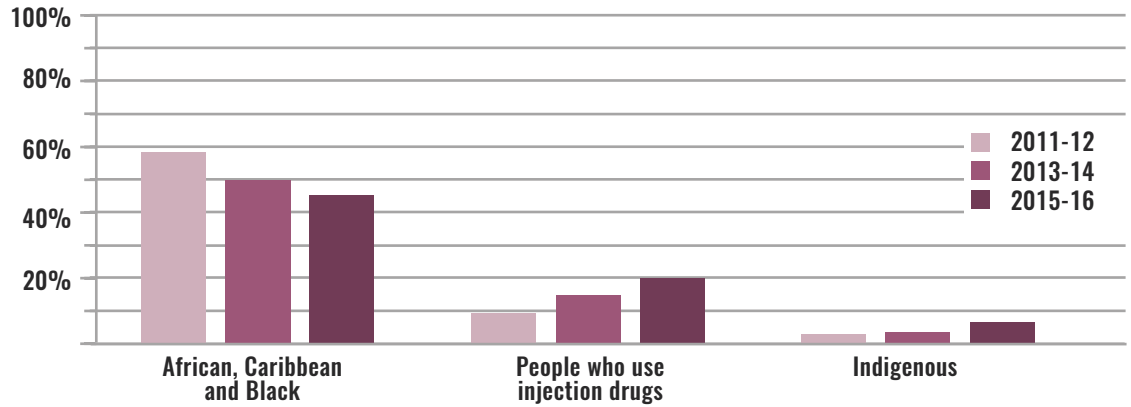
Trends over time: The number of men diagnosed with HIV each year has generally decreased over the past decade. However, the number of diagnoses in 2016 was higher compared to each of the past 4 years (2012 to 2015).

Percent of male and female HIV diagnoses by ethnicity (where known), Ontario, 2011-2016



Note: Data provided by the Public Health Ontario Laboratory

Percentage of new female HIV diagnoses by priority population (where known), Ontario, 2011-2016



Note: Data provided by the Public Health Ontario Laboratory

By race/ethnicity

In 2015 and 2016 combined, most new HIV diagnoses were among white (52%), followed by Black (23%), East/Southeast Asian (7%) and Latin American (6%) peoples.

Race/ethnicity was unknown for about a third of new diagnoses and thus are excluded from the data below.

Differences by sex/gender

The most common races/ethnicities in 2015-2016 differed by sex/gender. For men, it was white (56%), Black (17%), East/Southeast Asian (9%) and Latin American (7%). For women, it was Black (49%), white (34%) and Indigenous (7%).

Trends over time

Among men, between 2011-2012 and 2015-2016, the percentage of new diagnoses increased among East/Southeast Asian (from 6% to 9%) and Arab/West Asian (1.5% to 3%) people. Among women, the percentage of new diagnoses increased among white (from 23% to 34%) and Indigenous people (from 3% to 7%) and decreased among Black women (from 66% to 49%).

By age

In 2016, most new diagnoses among men were in people aged 25 to 29 and for women, were in people aged 30 to 34. However, in both men and women, about four of every ten new diagnoses were in people age 40 or older.

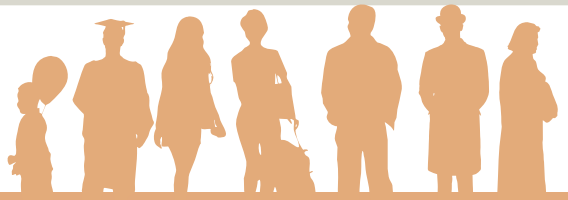
While the percent of new diagnoses were relatively similar for men and women in many age categories, the number of diagnoses was much higher for men in most categories.

Regional snapshot

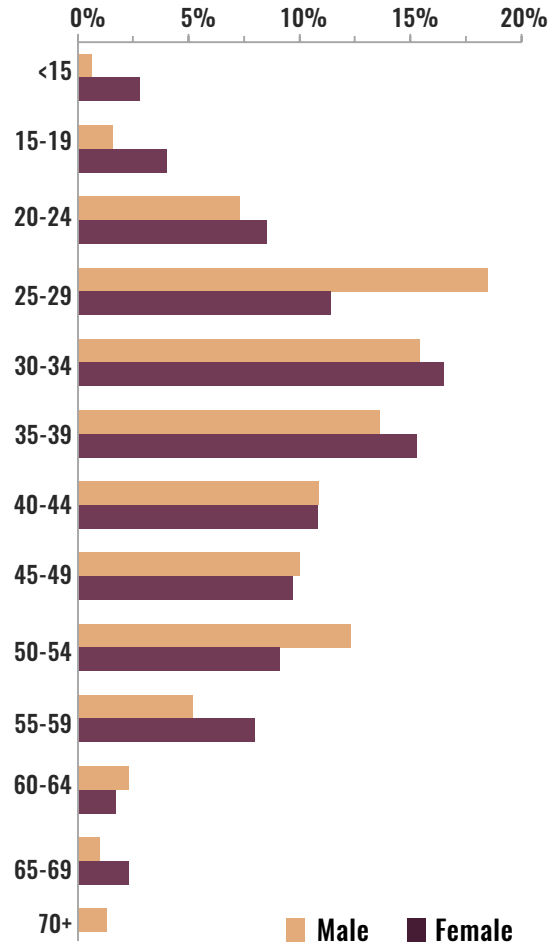
In 2016, there were more than 400 new diagnoses in the Toronto region (accounting for 49% of all diagnoses), followed by approximately 100 new diagnoses in each of the Central West, Central East and South West health regions.

But numbers of new diagnoses don't tell the whole story. When we also look at the rate of new diagnoses—that is, the number of new diagnoses per 100,000 population—we see that some regions with a smaller or similar number of diagnoses compared to other regions actually have higher rates of diagnosis. For example, while Ottawa had a slightly lower number of diagnoses than Central East, Central West and South West, their rate of diagnoses was quite a bit higher. This means that a larger proportion of their population may be infected and that HIV is more of an issue based on the size of the population.

Overall, compared to 2015, the number of new HIV diagnoses in 2016 increased in the Ottawa, Eastern, Central West and South West regions and decreased in the Northern, Toronto and Central East regions.

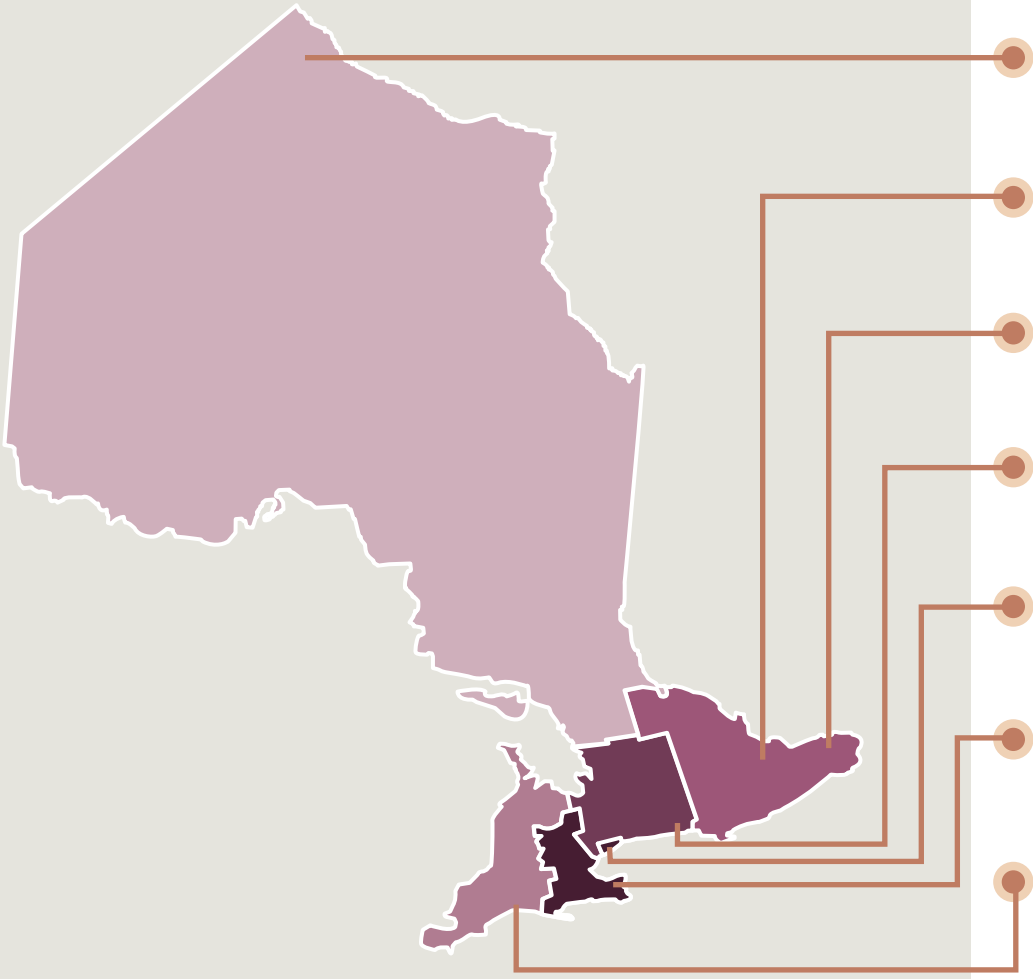


Percent of new HIV diagnoses by sex/gender and age, Ontario, 2016



Note: Data provided by the Public Health Ontario Laboratory

Number and rate of new HIV diagnoses by health region, Ontario, 2015 and 2016



	Number of new HIV diagnoses	Rate of HIV diagnoses per 100,000
Northern		
2015	29	3.6
2016	24	3.0
Ottawa		
2015	59	6.2
2016	86	8.8
Eastern		
2015	13	1.5
2016	26	3.1
Central East		
2015	105	2.6
2016	97	2.3
Toronto		
2015	462	16.3
2016	432	15.0
Central West		
2015	81	3.1
2016	108	4.0
South West		
2015	79	4.9
2016	97	6.0

HIV services in Ontario

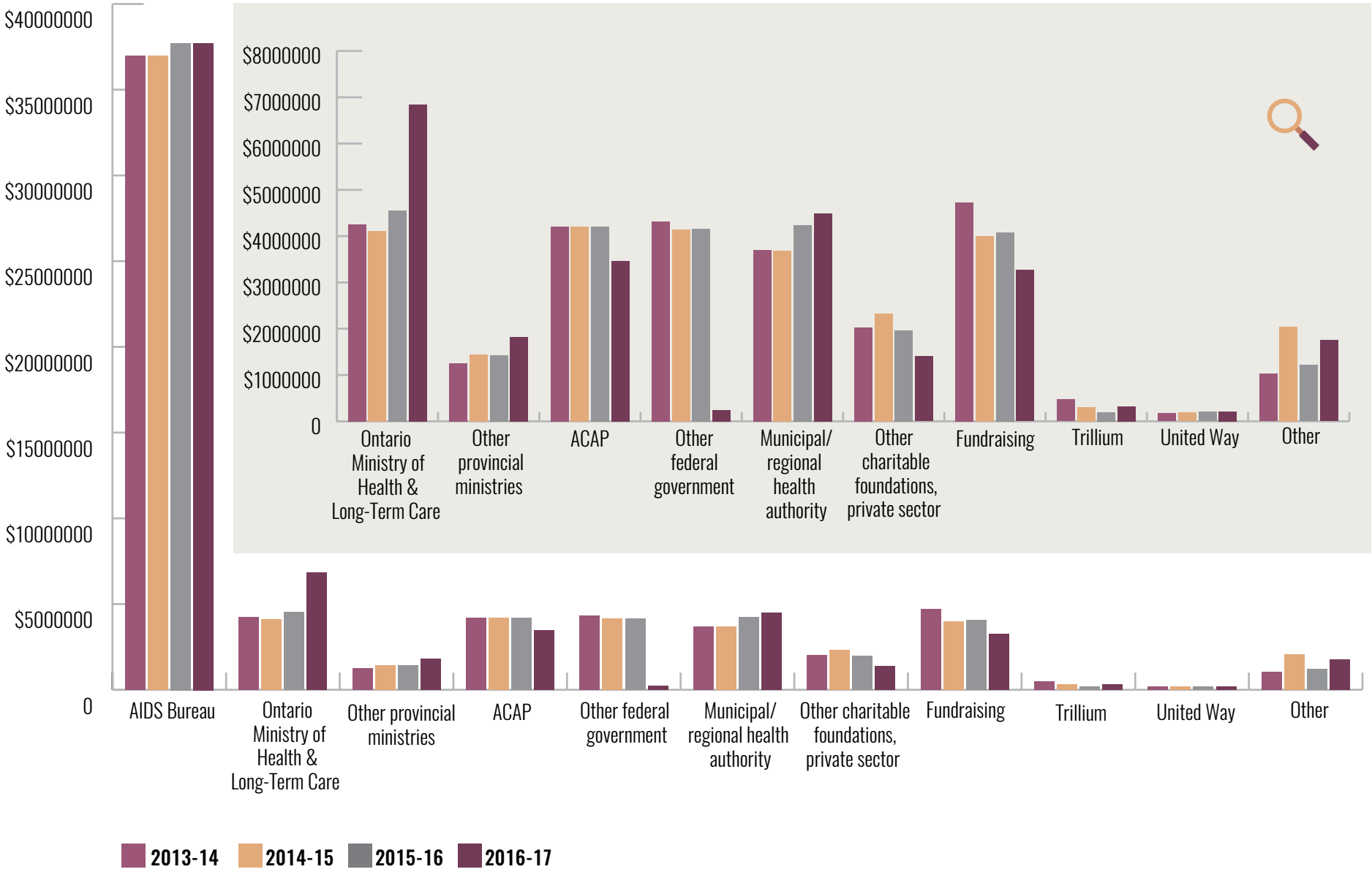
HIV services in Ontario

Funding in 2016-17

In 2016-17, the sector reported both funding gains and losses. The sector reported an increase of $2.3-million-dollar from the Ministry of Health and Long-Term Care and a combined increase of $1.3 million from other provincial ministries, municipal/regional health authority, Trillium, United Way and other sources. Over the same period, programs reported receiving a total of $5.2 million less from the following sources: $750,000 in ACAP funding due to changes in that program, $3.9 million from other federal government sources (primarily one program), $820,000 in fundraising and $560,000 in private sector funding.

	2013-14	2014-15	2015-16	2016-17
AIDS Bureau	$37,000,000	$37,000,000	$37,700,000	$37,700,000
Ontario Ministry of Health & Long-Term Care	$4,258,142	$4,117,141	$4,552,044	$6,841,742
Other provincial ministries	$1,253,361	$1,442,933	$1,423,908	$1,821,327
ACAP	$4,200,000	$4,200,000	$4,200,000	$3,462,780
Other federal government	$4,312,151	$4,137,443	$4,160,439	$249,374
Municipal/regional health authority	$3,702,316	$3,691,507	$4,244,011	$4,492,194
Other charitable foundations, private sector	$2,026,199	$2,330,015	$1,968,980	$1,405,113
Fundraising	$4,722,148	$3,998,472	$4,085,264	$3,265,425
Trillium	$470,781	$301,032	$194,368	$320,300
United Way	$173,198	$186,752	$203,315	$212,073
Other	$1,024,762	$2,046,847	$1,214,308	$1,750,300
Total	**$63,143,058**	**$63,452,142**	**$63,946,636**	**$61,520,627**

Community-based sector funding 2013-17



People who make the sector work

Staff	379	AIDS Bureau funded
	75	HCV funded
	145	designated peer positions
Volunteers	5,738	
Students	284	
Peers that are living with HIV	540	
Peers engaged in IDU Outreach	616	

More paid staff and students; fewer volunteers

Programs reported a small increase of 2% in the paid workforce and 53% increase in students—but a decrease of 8% in the number of volunteers.

While the sector gained 10 full time employees (FTE) in paid staff, it lost the equivalent of 21 FTE in volunteer hours. This is the second year that programs reported fewer volunteers and hours. The change may be due, in part, to the fact that ACAP is no longer funding volunteer coordinators.

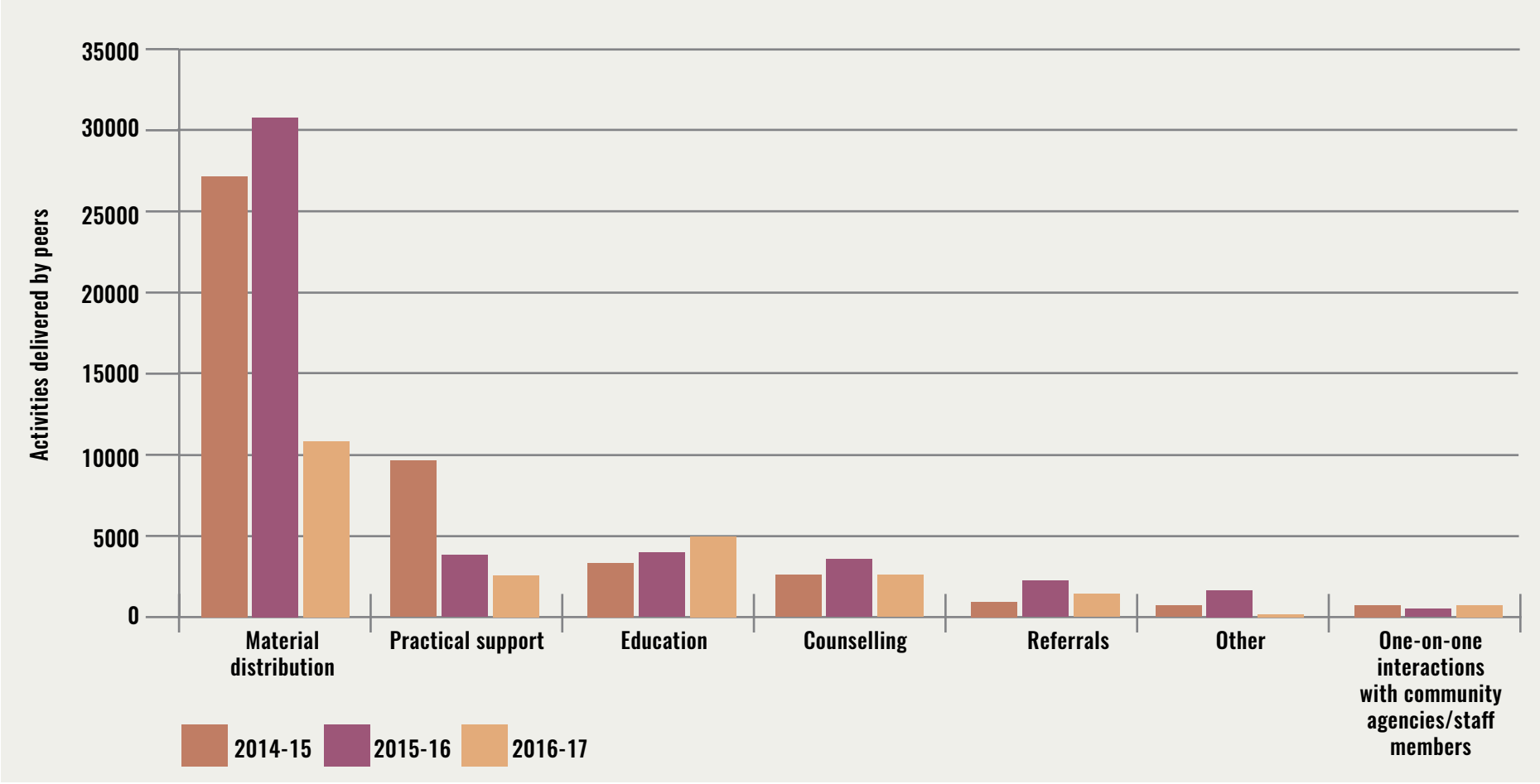
In 2016-17, volunteers invested **164,392** hours of time valued at **$4,792,533**. This is equivalent to each volunteer donating an average of **$835** annually to the prevention of HIV and improving the lives of people living with HIV.

Fewer IDU peers and shifts in activities

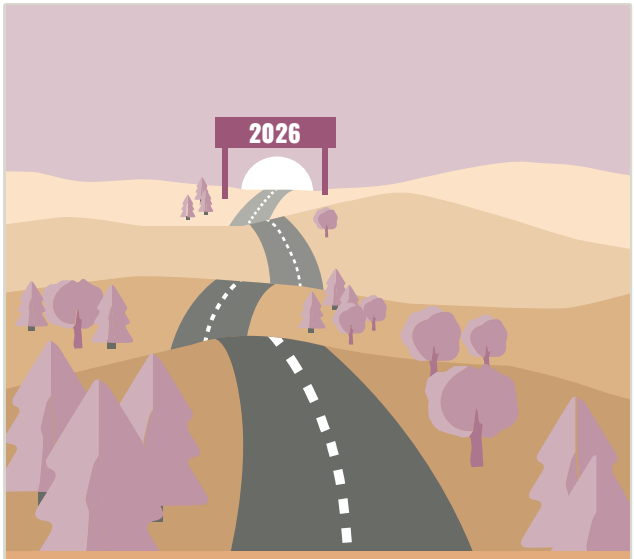
There was a 77% year-over-year decrease in the number of IDU peers from **1,089** in 2015-16 to **616** in 2016-17. This drop is due, in part, to a handful of agencies changing the way they defined and reported IDU peers as well as the fact that several programs that typically report large number of peers were unable to report on peer activities for 2016-17.

Peers provided a mix of one-on-one, referral, counseling, education and practical support services. They were also involved in distributing materials.

IDU clients served by peers 2014-15 to 2016-17



Prevention education and outreach



HIV/AIDS Strategy to 2026 Goals

1. Improve the health and well-being of populations most affected by HIV
2. Promote sexual health and prevent new HIV, STI and hepatitis C infections
3. Diagnose HIV infections early and engage people in timely care
4. Improve health, longevity and quality of life for people living with HIV
5. Ensure the quality, consistency and effectiveness of all provincially funded HIV programs and services

Prevention education and outreach

For the 2016-17 fiscal year, 54 programs that deliver prevention education, outreach and community development services tracked their activities using the OCHART tracking tool. An additional four programs did not use the tracking tool. Data is now being collected in two streams: activities targeted to service users and activities targeted to service providers. Activities are also linked to priority populations targeted.

Prevention work focused on Ontario's HIV priority populations

The Priority Population Networks (PPNs) are focused on the specific needs of some of Ontario's priority populations, which include:

GMSH Gay Men's Sexual Health Alliance

ACCHO African and Caribbean Council on HIV/AIDS in Ontario

WHAI Women & HIV/AIDS Initiative

Of the 58 programs that reported prevention education, outreach and community development work, 34 were ASOs and 24 were non-ASOs. Most ASOs work with all population groups, whereas non-ASOs seem to have a more targeted audience. This may reflect the context of smaller HIV programs being funded to deliver activities to reach specific populations.

Programs working with Priority Population Networks (PPNs):

- 32 organizations reported a total of 208 prevention activities delivered across the province that were linked to a PPN campaign and/or used PPN materials.
- 28 organizations reported participating in awareness campaigns reaching an estimated **300,000 contacts**.
- 20% of all campaign activity was directly linked to a PPN campaign.
- 88% of all campaign activity was reported by ASOs.

Safer sex supplies

Programs reported distributing almost 30% more safer sex supplies in 2016-17 (1,941,956) up from 1,525,115 in 2015-16. Lubricant distribution drove this increase with almost a doubling of distribution year over year. Fewer insertive condoms and dental dams were distributed in 2016-17 than 2015-16.

Alignment of education and outreach activities with provincial strategy goals

More than two-thirds (69%) of all activities targeted to service users were linked to Goal 1 and Goal 2, while the remaining one-third (31%) of activities aligned with Goal 3 and Goal 4.

It appears that certain types of activities were delivered more frequently to help achieve certain goals. In 2016-17, programs were more likely to use structured interventions to improve the lives of people living with HIV and more likely to use brief outreach to promote sexual health and help prevent new HIV, STI and hepatitis C infections.

Education to service providers

In 2016-17, programs reported:

- 943 education events attended by 24,011 service providers
- 193 activities linked to a PPN campaign (WHAI: 100, GMSH: 53 and ACCHO: 40)
- 4,083 meetings with connections to 18,626 community partners
- ASO participation in 75% of all community development meetings and 86% of all partnerships.

These activities aligned with the approaches outlined in the HIV Strategy to 2026 for Ontario to strengthen local collaborations as well as service and referral networks.

Top three reasons for community development meetings attended by ASOs:

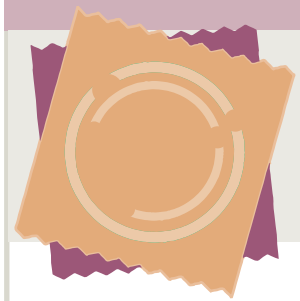
- coalition/network meeting
- community event planning
- general information sharing.

Number of programs focused on Ontario's HIV priority populations

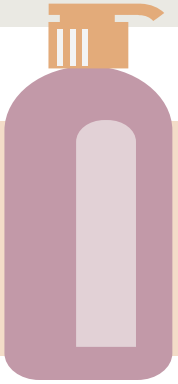
Priority population	ASO	Non-ASO
African, Caribbean & Black communities	18	10
Other populations at risk for HIV*	64	25
Indigenous peoples	23	12
People who use drugs	28	12
Gay/bisexual/MSM	33	13
Women at risk	33	15
People living with HIV	34	22

* includes incarcerated people, sex workers and other populations.

Increase in the distribution of safer sex supplies

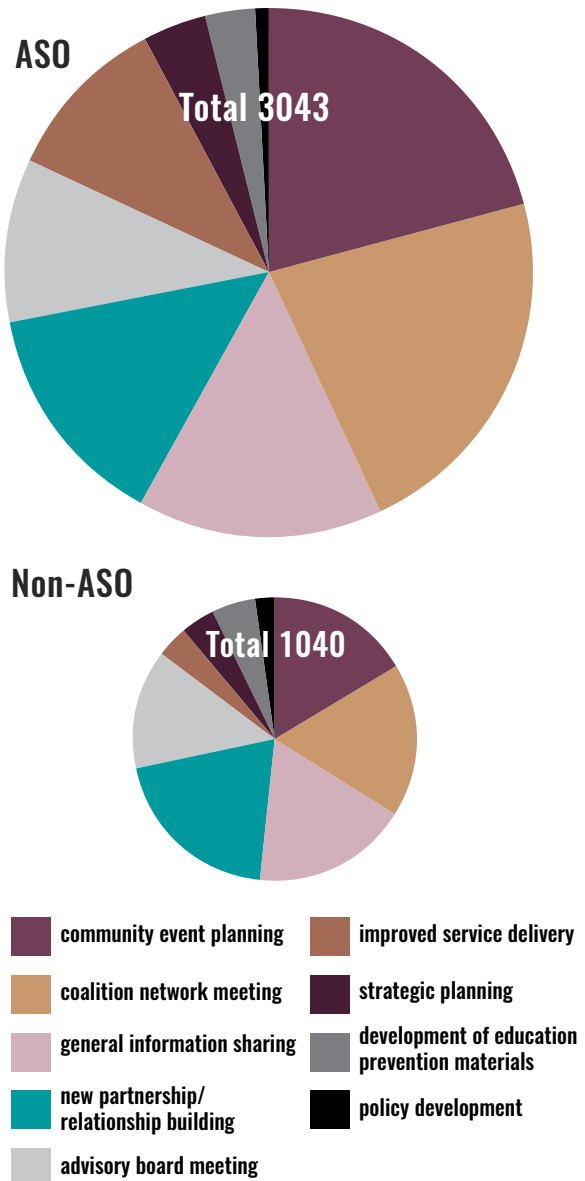


Traditional condoms
2015–16: 1,003,597
2016–17: 1,084,520



Lubricant
2015–16: 451,029
2016–17: 820,686

Community development meetings by purpose and agency type



Top three reasons for community development meeting for non-ASOs:

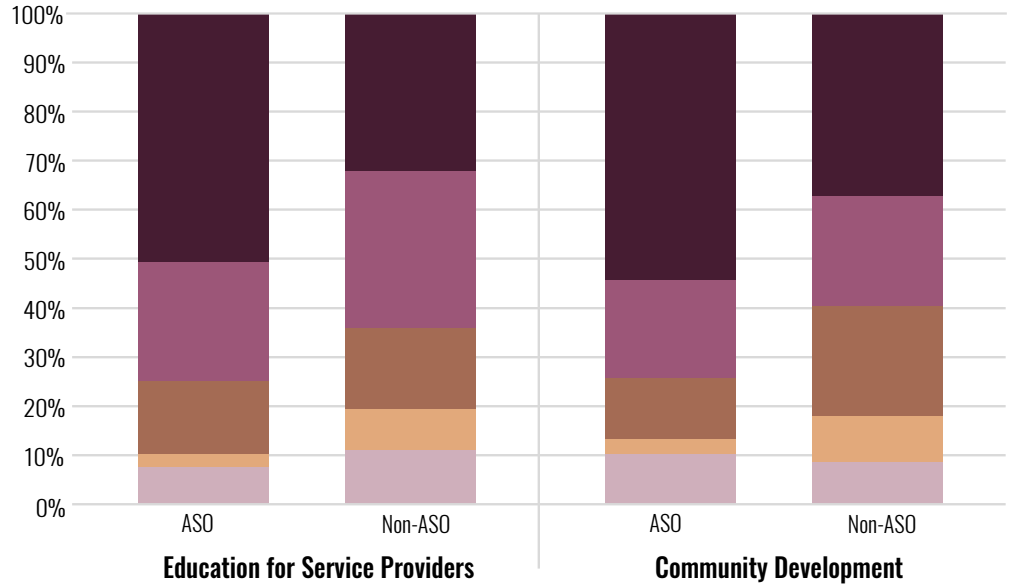
- community event planning
- advisory/board meeting
- new partnership/relationship building.

More than 60% of all meetings for both ASOs and non-ASOs discussed well-being, social supports, living with HIV and risk of HIV. The least discussed topic was food security—yet it accounts for a bulk of the practical support services ASOs deliver to clients.

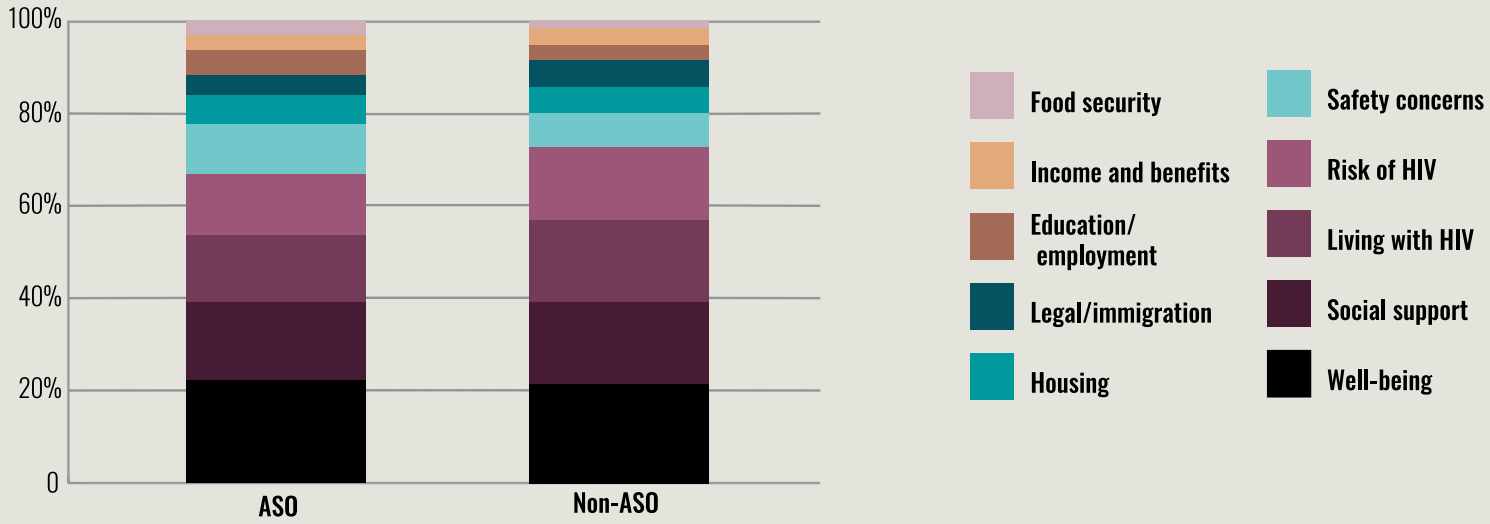
More than 70% of ASO community development activities are linked to Goals 1 and 2 of the strategy; non-ASOs focus on the first 3 Goals.

Education activity type	GOAL 1 Improving the health and well-being of populations most affected by HIV	GOAL 2 Promoting sexual health and preventing new HIV, STI and Hepatitis C infections	GOAL 3 Diagnosing HIV infections early and engage people in timely care	GOAL 4 Improving health, longevity and quality of life for people living with HIV
Education presentations/ workshops	36%	35%	13%	16%
Structured interventions	23%	20%	23%	34%
One-on-one education activities	28%	23%	26%	23%
Significant outreach contacts	33%	36%	11%	20%
Brief outreach contacts	35%	45%	12%	9%

Proportion of education activities by goals to service providers 2016-17



Proportion of community development meetings by issues discussed 2016-17



Reported community development, by goal

Goal 1: Improve the health and well-being of populations most affected by HIV

We expanded education and support to reduce isolation, to foster a sense of connectedness and well-being for service providers and community members and to increase access to traditional medicines and teachings. These are inclusive practices that contribute to a sense of belonging, purpose and well-being. We increased number of partnerships to reach Indigenous populations.
— Ontario Aboriginal HIV/AIDS Strategy, Sudbury

Between April and September 2016, we have contacted potential partners for our Mental Health Navigation System. These intakes and tailored referrals and follow-ups will have an impact on the well-being of gay, bisexual and other men who have sex with men.
— Ottawa Gay Men's Wellness Initiative

We work to increase service providers' awareness about PEP and PrEP and their capacity to deliver respectful, appropriate and supportive care to members of priority populations. This involved increasing service providers' awareness about the social determinants of health, HIV acquisition and related issues.
— Regional HIV/AIDS Connection

Goal 2: Promote sexual health and prevent new HIV, STI and hepatitis C infections

The African, Caribbean and Black Program provided five HIV 101 workshops to Language Instruction for Newcomers (LINC) classes at the Multicultural Council of Windsor-Essex Inc during the period. Approximately 150 new immigrants were trained in safer sex practices and were given resources information to access HIV/STI testing locally.
— AIDS Committee of Windsor

Gay Zone offers an opportunity for our men's team to host weekly sexual health information and workshops as well as access to safer sex supplies. Our strong relationship with Ottawa Public Health has allowed us to promote and refer people to testing and information for STIs due to their syphilis campaign and a workshop we hosted in partnership with them to promote HPV awareness and vaccine program through Gay Zone. Through our connection with the LGBT2Q+ new immigrants group, our staff have had the opportunity to provide sexual health information and resources to people new to the Ottawa area.
— AIDS Committee of Ottawa

Partnering with CATIE ensured that we have access to up-to-date HIV and STBBI resources. Community Health Ambassadors continued to partner with other organizations to deliver sexual HIV and STI education in various locations where African, Caribbean and Black populations reside.
— Womens Health in Women's Hands

Goal 3: Diagnose HIV infections early and engage people in timely care

A point of care testing event on Manitoulin Island encouraged community members from five First Nations to get tested.
— Union of Ontario Indians

Hosted a rapid HIV testing drive and delivered HIV 101 at Barrie Pride. Service users that were involved included gay, bisexual and other men who have sex with men as well as substance users. We collaborated with the David Busby Centre (harm reduction services) and Public Health to deliver this event.
— The Gilbert Centre

Our rapid testing clinics with both Hassle Free Clinic and Queen West Community Health Centre have proven to be very successful over the last reporting period. Our Hassle Free dates at 260 Augusta Ave have been very popular with gay, bisexual and other men who have sex with men. We have increased the number of Hassle Free clinics to accommodate the higher demand by our priority populations. The success of these clinics can be attributed to the promotion of these services and the quality of care delivered.

— St. Stephen's Community House

Goal 4: Improve health, longevity and quality of life for people living with HIV

We provide an environment for people living with HIV to feel welcome and safe to say or to do their work and to participate in our different activities. Here, they can develop their skills and improve their quality of life. They come for prayer every Friday: one prayer for Muslims and one prayer for Christians at different times.

— Africans in Partnership Against AIDS

We partnered with Vaughan Community Health Centre to create pathways to primary care and access for AIDS Committee of York Region's most vulnerable service users. We developed stronger relationships with frontline staff and management at community agencies such as the Canadian Mental Health Association, Addictions Services for York Region and Housing Help to support coordinated case management goals for service users in greater need of support. We also formed partnerships with Peel HIV/AIDS Network and Gilbert Centre (Simcoe/Muskoka) to plan the annual Central Opening Doors conference for capacity-building of service providers working with people living with HIV in Peel, Simcoe and York regions.

— AIDS Committee of York Region

Goal 5: Ensure the quality, consistency and effectiveness of all provincially funded HIV programs and services

We have engaged with Africans in Partnership Against AIDS to offer a support group for French-speaking people living with HIV. We intend to invite other ASOs to join us, to provide good coordination of services between agencies and to reduce duplication.

— Centre francophone de Toronto

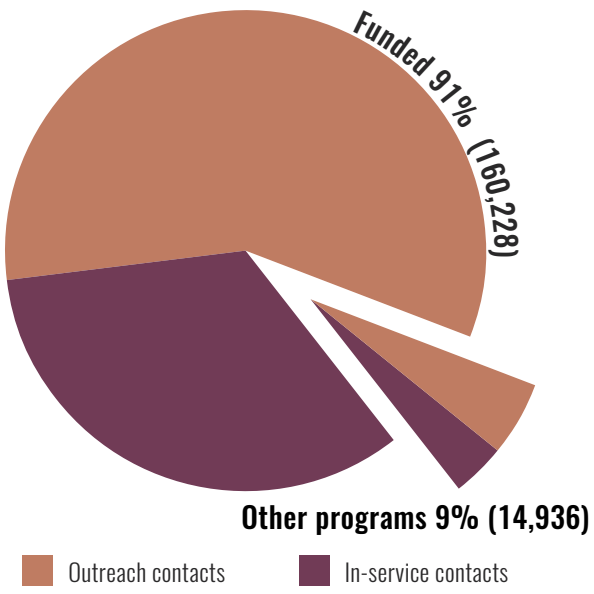
One of our community partners (Palliative Education and Care for the Homeless) asked if we could have our hospice volunteers support a survey of shelter residents around their health care needs. Engaging them in a community development process, we reached over 12 volunteers at various shelters across the city over the course of three weeks. Volunteers got to know the residents and staff at the shelter during this time and also were able to make informal linkages to various services for those with declining health and were able to connect them to a hospice social worker to explore community options.

— Hospice Toronto

Funded IDU Outreach Programs

Year	Total organizations funded	Other programs that reported
2013-14	21	16
2014-15	21	16
2015-16	22	12
2016-17	22	11

Harm reduction programs report 175,000+ client interactions



IDU outreach services

Investment in programs aligned with epidemic

Providing outreach services to people who use drugs has become an increasing area of focus for Ontario's HIV and HCV programs. Between 2011-2012 and 2015-16, the percent of people who inject drugs diagnosed with HIV increased from 8.7% to 10.8%[1]. In 2016-17, the AIDS Bureau funded 22 IDU outreach programs.

Funded IDU outreach programs and other programs that reported in section 6 of OCHART for 2016-17

Funded IDU outreach program

- AIDS Committee of Durham Region
- AIDS Committee of Windsor
- Central Toronto Community Health Centres
- City of Ottawa Public Health
- Elevate North Western Ontario
- Hamilton Public Health & Community Services
- HIV/AIDS Resources & Community Health (ARCH)
- Ontario Aboriginal HIV/AIDS Strategy
- Peel HIV/AIDS Network
- Peterborough AIDS Resource Network
- Positive Living Niagara
- Regional HIV/AIDS Connection
- Réseau ACCESS Network
- Sandy Hill Community Health Centre (OASIS)
- Somerset West Community Health Centre
- South Riverdale Community Health Centre
- Street Health Centre, Kingston Community Health Centres
- Sudbury Action Centre for Youth
- Syme-Woolner Neighbourhood and Family Centre
- The Works, City of Toronto Public Health
- Unison Health and Community Services
- Warden Woods Community Centre

Other IDU outreach programs that reported

- 2-Spirited People of the First Nations
- AIDS Committee of Cambridge, Kitchener, Waterloo and Area
- AIDS Committee of North Bay and Area
- AIDS Committee of Ottawa
- Algoma Group Health
- Black Coalition for AIDS Prevention
- St. Stephen's Community House
- The Gilbert Centre
- Toronto People With AIDS Foundation
- Waasegiizhig Nanaandawe' -iyewigamig
- Youth Services Bureau of Ottawa

1 New HIV diagnoses in Ontario: Preliminary update, 2016. Ontario HIV Epidemiology and Surveillance Initiative.

In addition, eleven other programs reported providing outreach services to people who use drugs during the same time period. Here is a look at the data by IDU-funded and "other" funded programs, to better understand how services are being provided and utilized. Non-ASO programs were mainly run by community health centres or regional public health agencies.

Harm reduction programs report 175,000+ client interactions

In 2016-17 programs reported a total of 175, 164 (N=33) IDU client interactions. Programs specifically funded to deliver harm reduction programs account for 91% of all interactions. Outreach contacts account for 39% (67,965) of all interactions. The remaining 61% (107,199) of interactions reported were in-service.

Education and counselling services provided to people who use drugs

In 2016-17, there was a 15% increase in services provided to people who use drugs. While practical support and education remained the top two services provided over a three-year period, education services increased by 150% since 2014-15. This trend is being driven by IDU-funded non-ASO programs who reported 6,158 unique clients in 2014-15, 10,233 unique clients in 2015-16 and 17,372 unique clients in 2016-17 receiving education services (e.g. informal verbal and/or written harm reduction information, health teaching, etc.). In 2016-17, counselling services which included brief, focused, crisis interventions or could include more formal counselling more than doubled compared to the previous year (25,322: 2016-17 vs. 11,496 2015-16) while referrals to other harm reduction/addiction programs decreased by roughly the same amount (12,276 in 2015-16 vs 6908 in 2016-17).

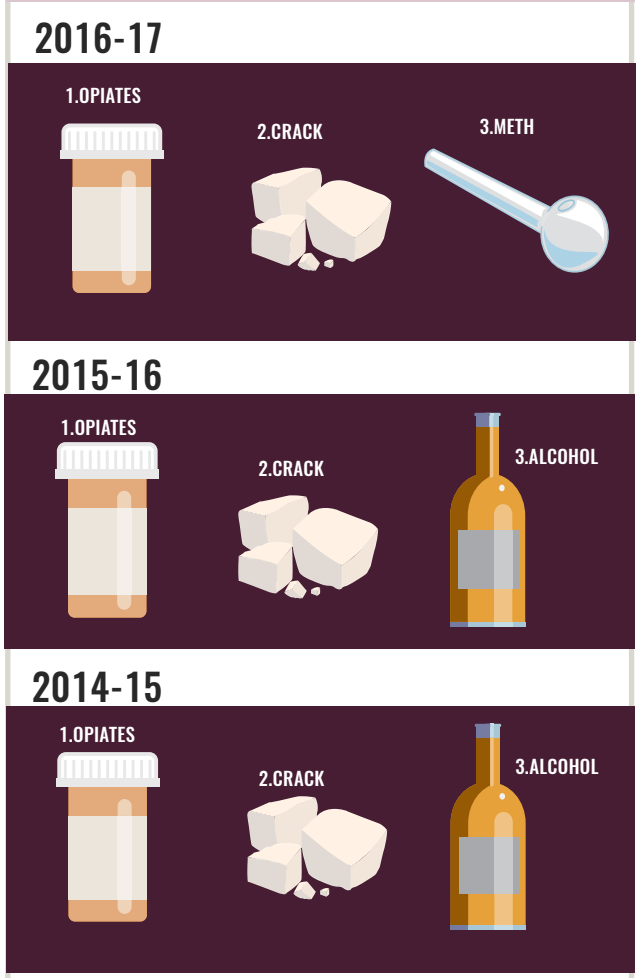
Programs provided 39% fewer referrals to medical services for clients in 2016-17 (6,094; N=28 programs reporting) compared to 2015-16 (10,065; N=31 programs reporting), but the total number of clients receiving medical referrals in 2016-17 remains 80% higher than 2014-15 (3,386; N=37 programs reporting).

Outreach service locations

In 2016-17 the majority of the outreach took place in community agencies/services, residences and street/parks and has been a consistent trend since 2014-15. In addition, outreach in residences (e.g. client homes, apartment/house, friend's place, place where

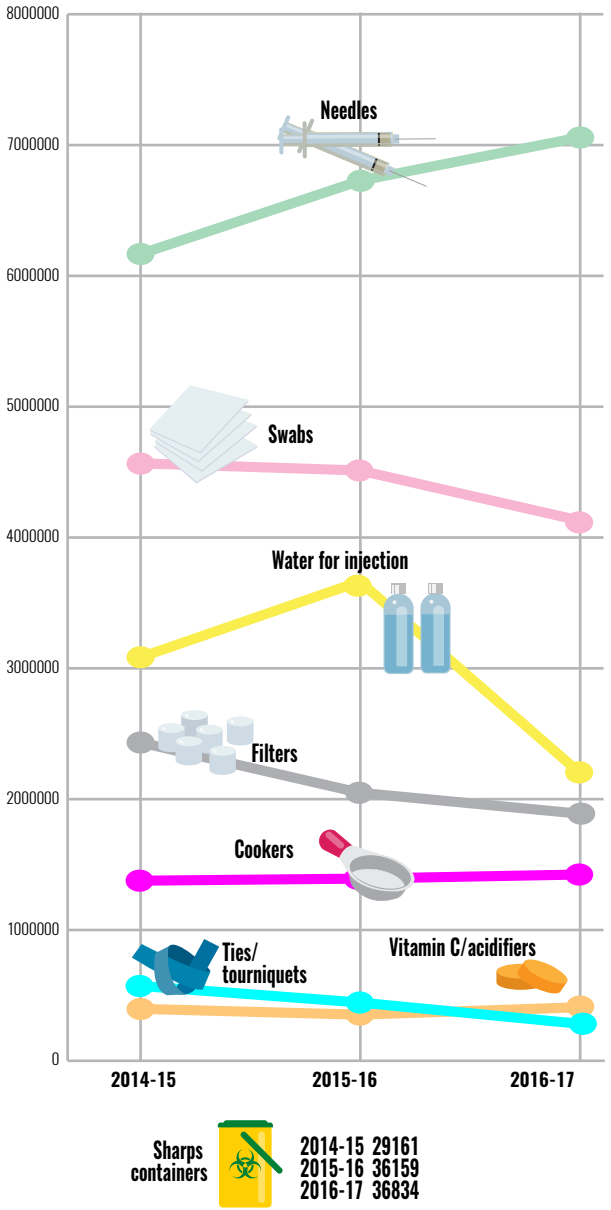
Opiates remain top substance used by clients.

Methamphetamine surpassed alcohol in top 3 substances used by clients.



Note: Ranking based on scores assigned to top three reported substances per program.

Trends in safer injection supplies distributed



client resides), more than doubled to 23,543 client interactions in 2016-17 from 9,696 in 2015-16. This increase may reflect more targeted outreach efforts to meet people where they live/gather or better data reporting practices. Funded programs reported more than a 100% increase in outreach to pharmacies in 2016-17 (7,263) from 2015-16 (3,564). This increase was largely driven by the efforts of one program. The proportion of outreach interactions reported in "other" locations dropped from 18% in 2015-16 to 1% in 2016-17, which may also reflect better data reporting or more targeted outreach strategies.

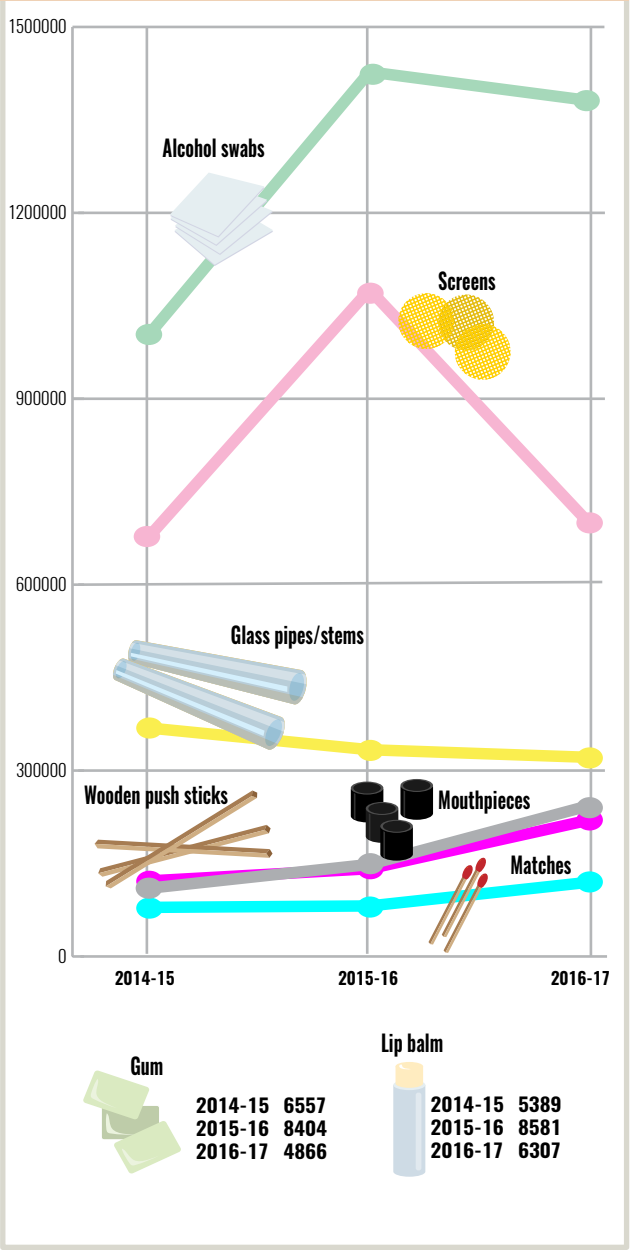
Unique clients receiving IDU services	2014-15		2015-16		2016-17	
	Funded program	Other program	Funded program	Other program	Funded program	Other program
Indigenous traditional services	322	42	337	44	248	46
Referrals for faith-based services/spiritual support	276	33	394	22	409	13
Other	284	10	648	37	1251	–
Referrals to women specific services	859	399	769	69	1891	62
Referrals to social services	5877	591	5932	397	4863	183
Referrals to medical services	2875	511	9716	349	5607	488
Counseling	7760	1622	10866	630	24974	348
Referrals to harm reduction/ addiction services	3511	426	11929	346	6410	499
Education	8281	1903	15293	1961	24188	1689
Practical supports	10854	1852	25767	2219	26092	1480

Increase in harm reduction supplies distributed

Programs distributed more than 20 million units of safer injection/inhalation equipment in 2016-17: Over 17 million safer injection supplies and just under three million safer inhalation supplies; overall a slight increase from the previous year. ASOs distributed 66% of all safer injection supplies and non-ASOs distributed 74% of all safer inhalation supplies.

Number of IDU outreach client interactions by location	2014		2015		2016	
	Funded program	Other program	Funded program	Other program	Funded program	Other program
Parties/raves	40	—	—	—	9	46
Jails/detention centres/ prisons	365	524	187	516	1250	556
Addiction programs	938	194	658	873	1251	—
Methadone maintenance clinics	1043	120	1395	85	1411	54
Bars/night clubs	642	2314	351	792	468	745
Pharmacies	3317	6	3564	8	7263	3
Streets/parks	1569	2401	8683	4711	24974	348
Community public spaces	867	3433	961	20	864	—
A residence	6822	1157	9067	629	23387	156
Mobile	9227	16	8627	563	8444	442
Other	7033	3158	14992	859	727	393
Community agencies/ services	24106	11016	26281	4801	21701	4814

Trends in safer inhalation supplies distributed



Wait times and lack of access to other health and social services

Programs continued to report a number of challenges to client care including:

- long wait times for housing and mental health services
- lack of mental health and addiction services in their communities
- reluctance of physicians to take on clients with complex mental health needs
- client reluctance to engage in care where they may feel stigmatized or having to wait for services given the precariousness of their current life context. There are still long wait lists for addiction, mental health services and subsidized and supportive housing. Many clients require supportive housing, but are forced to take market rent rooming houses which has negative impacts on health and risk of homelessness.
  — **Peel HIV/AIDS Network**

> Mental health services in the community still have ongoing extended wait time access issues. With the current mental health reorg in the community, clients have had to wait 36 months to see an intensive counsellor or psychiatrist externally.
> — **Kingston Community Health Centres**

> There is no detox in Guelph/ Wellington. Clients have to find their own transportation to access detox in Kitchener.
> — **HIV/AIDS Resources & Community Health (ARCH)**

> We do not have appropriate detox services for crystal meth withdrawal.
> — **Regional HIV/AIDS Connection, London**

> Several clients report being 'ignored until they leave' from local ER and report poor treatment if being seen for an overdose or abscess/wound care.
> — **AIDS Committee of Windsor.**

> Service users are reluctant to access services that have waiting lists as the nature of their lives may be unstructured or chaotic.
> — **Peterborough AIDS Resource Network**

> Physicians are reluctant to take on new patients with complex mental health addiction and chronic pain challenges.
> — **HIV/AIDS Resources & Community Health (ARCH)**

Shifts in demand

The most notable trends reported in harm reduction programs for 2016-17 were an increase in meth and heroin use resulting in increased demand for safer inhalation kits and sterile syringes. Many organizations reported that they were concerned by the rise in fatal and non-fatal overdoses. Due to the sharp increase in use of fentanyl, clients requested naloxone kits and training as well as drug testing. With the rise of a known drug in a community, there was a concurrent plea for relevant supplies, yet staff reported being undersupplied and overwhelmed during this period of increasing demand.

Increase in overdoses

This year we have seen an increase in overdose and overdose deaths. We are hearing that fentanyl is being cut into heroin, coke, crack and pills like Xanax. There has been an increase in agencies wanting overdose prevention training and materials for staff and clients. We have seen increased participation in the Peel Harm Reduction Committee and agencies wanting to adopt more of a harm reduction approach.
— Peel HIV/AIDS Network

The primary change we have seen is an increased demand for harm reduction equipment. We have also seen higher rates of overdose resulting in greater demand for naloxone and overdose prevention education.
— South Riverdale Community Health Centre

We have noted a positive shift in our city to support harm reduction work more than in the past from our city council and public members. We are seeing drugs of use include crystal meth and "popcorn", which contains fentanyl with subsequent overdoses and deaths. The IDU outreach worker distributes naloxone kits with teaching as part of her role. Demands for mobile van needle outreach is exceeding our available hours, and we are turning clients away from the service.
— Hamilton Public Health & Community Services

There is a notable increase in fatal and non-fatal drug overdoses in our region. There are daily requests for safer meth smoking supplies, which we do not currently have the funding to purchase and provide. We continue to wait for access to naloxone to distribute to our folks. We have seen tremendous growth in the amount of interactions we have experienced over the winter compared to previous years.
— AIDS Committee of Cambridge, Kitchener, Waterloo and Area

Increasing demands

We see more frequent episodic psychosis with female identified meth users, many of whom then become vulnerable to violence, sexual assault, wasting, and conflict with housing authorities or police.
— Maggies: The Toronto Prostitutes Community Service Project

We have seen the demand for services and harm reduction supplies steadily increasing over time. This has made it more difficult for us to meet the demand and provide comprehensive services to our clients. The demand is increasing in the areas outside the downtown core and there is little capacity for services to provide harm reduction services.
— The Works, Toronto Public Health

There appears to be more acceptance of harm reduction efforts within the general population, which can possibly be attributed to the increased media exposure and the continued efforts of harm Reduction workers to further educate the community to better understand the need for these types of programs and services.
— Warden Woods Community Centre

Our syringe outreach has increased considerably. We know that service users are injecting crystal meth and heroin. Services users are still utilizing our safe inhalation kits, speculatively for smoking crystal meth and also crack cocaine. Our peers have indicated that the age of injecting drug users is quite young.
— Ontario Aboriginal HIV/AIDS Strategy

Responding to emerging trends

Adaption and innovation

We have developed overdose prevention materials to make available to agencies and clients. Conduct trainings on OD prevention. Advocate for wider naloxone distribution. Applying for funding to start the process of creating a region wide drug strategy to address issues related to drug use.
— Peel HIV/AIDS Network

We have increased our supply orders and provided more OD education and distributed more naloxone. We continue to advance our plans to integrate supervised injection services and anticipate funding approval in the coming weeks. To help us with bereavement we have had a number of support events, including a healing circle with Indigenous teachers, and the support of the AIDS Bereavement & Resiliency Program on Ontario.
— South Riverdale Community Health Centre

Increased efforts have been made to refer individuals at high risk of overdose to be trained in how to deliver naloxone. In addition, staff have been alerting clients of any new developments regarding potentially dangerous drugs being sold in the city. Increased access to naloxone to priority populations by allowing the Outreach Coordinator (HIV) to participate in the training and distribution of naloxone would increase access to individuals seeking training.
— Réseau ACCESS Network

To meet community demands for drug analysis and quality services, ACO began offering postuse urine based fentanyl testing strips as a service where community members had a free and anonymous way to find out if they had recently been exposed to fentanyl. We continue to pursue onsite drug checking and analysis services.
— AIDS Committee of Ottawa

We were able to purchase more crystal meth pipes to distribute for the spring and summer via donated funds. Loss of clients due to fatal overdoses has weighed heavily on the team this past year and we will be following up with some grief counselling. IDU outreach worker and Street outreach worker participated in a training of 120 local social service providers on Opiates and Fentanyl in March which most workers identified gave them a broader knowledge base to do their work.
— HIV/AIDS Resources & Community Health (ARCH)

We continue to make naloxone as available as possible and are providing overdose training as much as staffing will allow to staff and clients at external community agencies. We have obtained funding for 4 new staff who will assist in the naloxone distribution to our clients and overdose training for community and City of Toronto operated agencies.
— The Works, Toronto Public Health

Partnership and hard work

We have developed a new partnership with the City of Kingston, and have introduced a proposal to assist them in having bio hazard drop boxes in all the local parks and walks in the city. The IDU outreach worker and peers will ensure the bins are monitored and emptied weekly.

— Street Health Centre, Kingston Community Health Centres

We have a great relationship with Loving Spoonful (food program) and they have increased the amount of food that they bring to us on a daily basis. We have been engaging the local Addictions and Mental Health services more.

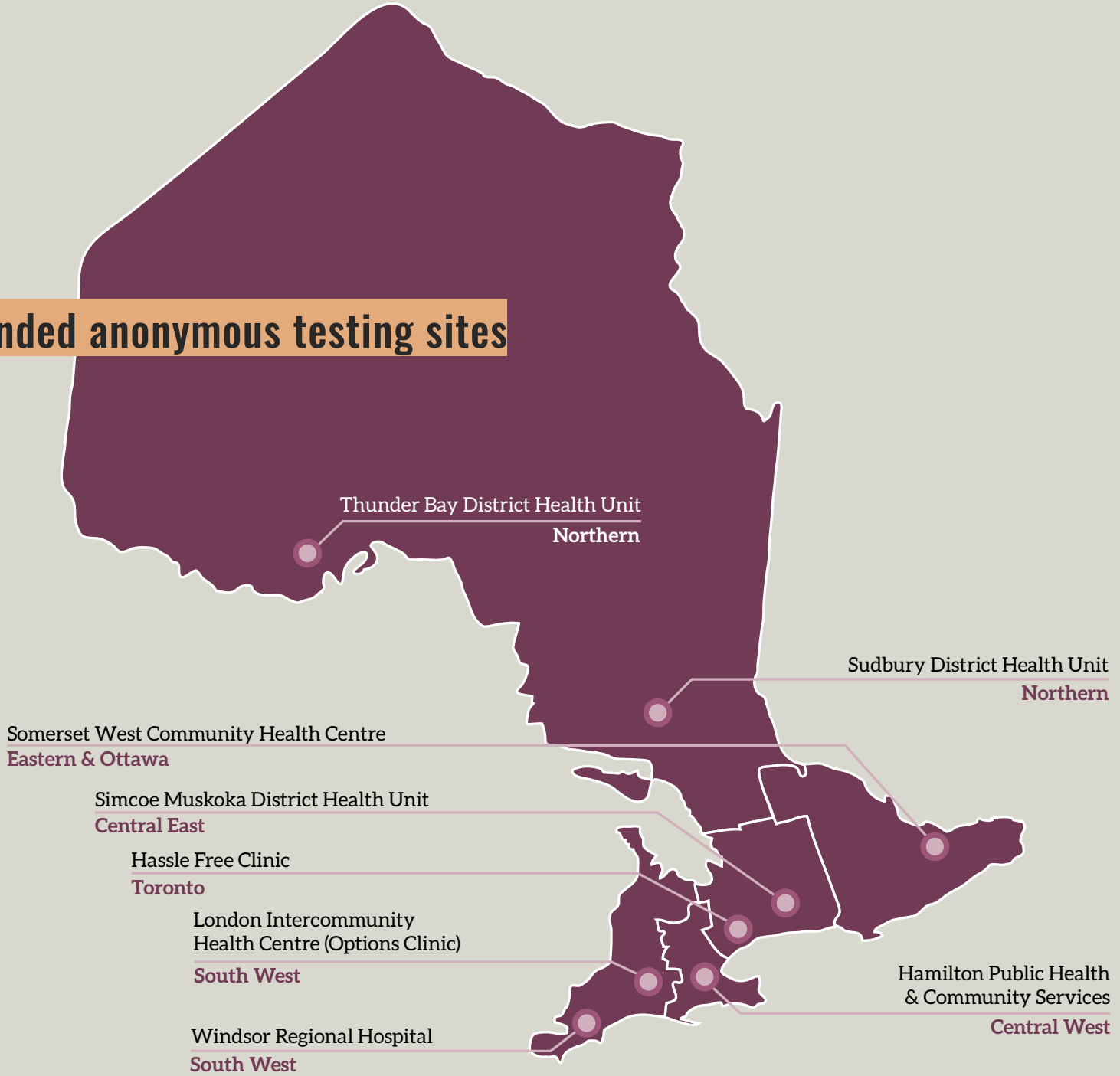
— HIV/AIDS Regional Services

Launched a multipronged approach to enhance overdose prevention and naloxone access in Ottawa: raising awareness with the public, service providers and people at higher risk about the increased risk of overdose, illicit fentanyls and naloxone availability/access through the development of a widespread awareness campaign, print resources and webpage. Working with local pharmacies to build capacity and expand access to the Ontario Pharmacy take-home Naloxone Program. Expanding access to naloxone for clients at higher risk (including people who inject drugs and the incarcerated population). Expanding access to naloxone for first responders in Ottawa. Exploring naloxone access for community partners integrating with individuals at increased risk of overdose. Enhanced access to harm reduction services and increasing meaningful peer engagement have been identified as top priorities to meet the needs of people who use drugs in the community.

— City of Ottawa Public Health

Anonymous testing

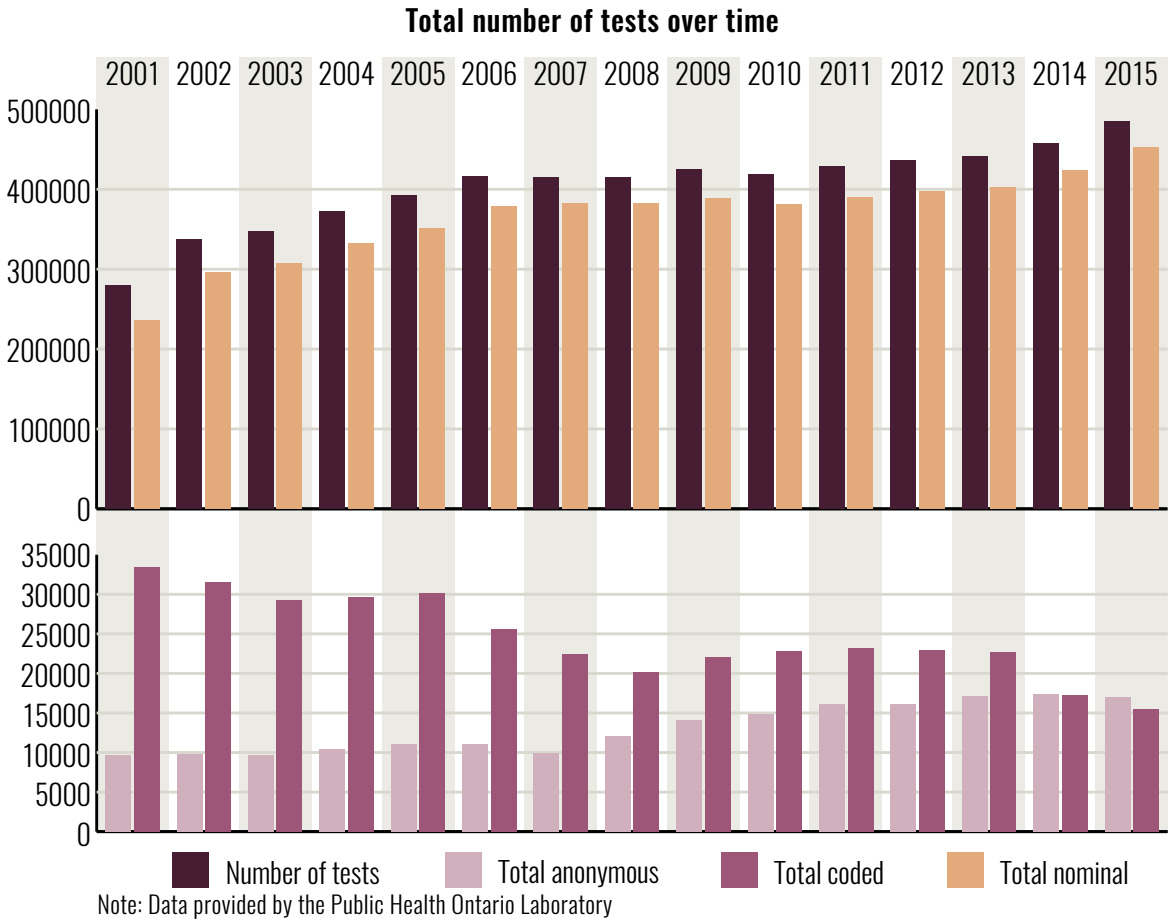
Locations of funded anonymous testing sites



Anonymous testing

Eight of the 50 organizations designated under the Health Protection and Promotion Act to provide anonymous HIV testing are funded by the AIDS Bureau and report through OCHART.

A snapshot of HIV testing in Ontario (nominal, coded and anonymous)



Note: Data provided by the Public Health Ontario Laboratory

Types of HIV testing offered in Ontario

Standard blood testing: blood is drawn from a person's arm and processed by the Public Health Ontario Laboratories (PHOL). It can take up to one week to get the final results.

Rapid/point-of-care-testing (POCT): is done on-site and results are immediate; if someone has a reactive point-of-care test, a standard blood draw test must be ordered for confirmatory testing by PHOL to verify whether or not the test is positive.

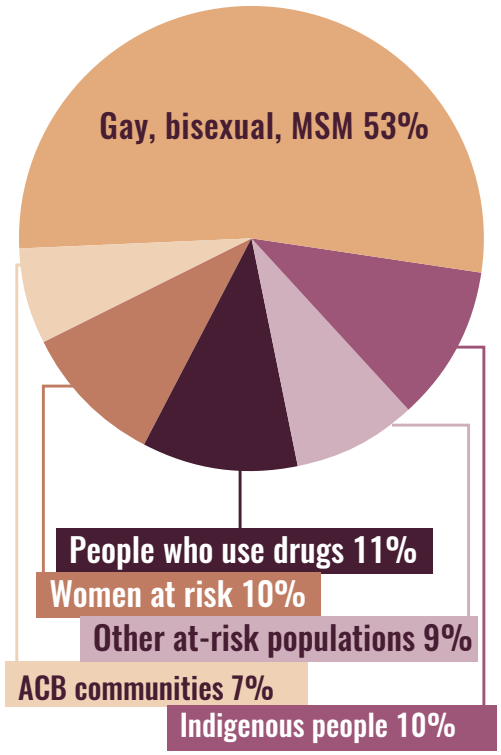
Nominal testing: the health care practitioner orders the HIV test using the name of the person being tested.

Non-nominal or coded testing: the health care practitioner has the client's name on file but uses a unique code instead of their name to order the HIV test.

Anonymous testing: the health care practitioner uses a code that appears on the anonymous test requisition form to order the HIV test and does not collect the client's name or any identifying information. The code cannot be linked to a client's identity.

The above three types of testing are offered in combination with either standard blood-draw or rapid/point-of-care testing.

Percentage of outreach to targeted priority populations



525,544 HIV tests were done in Ontario in 2016, of which 881 were positive, equivalent to a 0.17% positivity rate. The total number of HIV tests continues to increase each year.

Testing sites may offer different types of testing. Of the 10,773 total tests done by the eight funded anonymous testing sites in 2016-17:.

Taking testing to people at risk

The majority of anonymous tests (6,384 of 10,773, or **59%**) were done at the testing programs' main sites. However, in an effort to reach more people at risk, seven of the eight programs provided testing in locations in the community, including local AIDS service organizations (ASOs) and other agencies, community health centres (CHCs), community centres, bathhouses and shelters.

Targeting priority populations

The anonymous testing programs reported that a little over half of their outreach (53%) was to gay, bisexual and other men who have sex with men, while the rest was divided fairly evenly among the other priority populations.

> The in-clinic services, including HIV testing for gay, bisexual and other men who have sex with men, are primarily promoted by word of mouth and we are generally at capacity. Our off-site services targeted to this group are promoted through social media. All off-site testing is by drop-in, so we promote it to the clinic overflow patients.
> **— Hassle Free Clinic**

Outreach strategies

The anonymous testing sites used a number of strategies to reach populations at risk. Some highlights included:

Gay and other men who have sex with men

- offering point-of-care testing during Pride Week, at a local LGBT2Q+ campground and at other LGBTQ2+ events and community fairs
- collaborating with the MSM outreach worker at the local ASO who promoted the testing dates/events through web, posters and social media
- offering a monthly evening men's clinic at the health unit and a bi-monthly evening men's clinic at the local ASO
- connecting with a weekly Transhealth clinic to offer education and testing
- using social media outreach (Squirt, Grindr, Scruff, Hornet, Craigslist, Twitter) to promote testing.

African, Caribbean and Black communities

- establishing relationships with universities and colleges that focused on the ACB student groups
- doing outreach during summer festivals (Carivibe, Jamaica Day, Multiculturalism Day)
- providing HIV testing 101 to volunteers of the in-house ACB HIV Prevention Program
- participating in the ASO's ACB health forum, World AIDS Day outreach and presentation to the River Jordan Church, Black History Month outreach and an ACB HIV Awareness Day – multifaith event
- developing an information campaign to be utilized at multicultural centres, offering educational seminars throughout the year and investigating the opportunity to provide testing at these sites.

> We work with the local ASO but the community is not yet ready to engage in structured testing events/promotions. We will continue to liaise and support local efforts.
> **— Hamilton Public Health & Community Services**

Indigenous people

- developing a new brochure and buttons specifically to target Indigenous populations
- promoting outreach for Indigenous testing events on Facebook
- offering a monthly testing event at a local ASO
- training public health nurses to deliver point-of-care testing in areas with large Indigenous populations
- offering services on outreach nursing van and at local corrections facilities.

> No specific structured testing events or clinics occurred targeted to Indigenous people during this period. Clients do attend our general sexual health clinic sites for testing.
> **— Hamilton Public Health & Community Services**

> We did one mailing, with a personalized (to each organization) letter and hours slips, to all health and social service organizations in Toronto who identify as Indigenous and/or who serve Indigenous communities. We would very much like to work with Indigenous providers of health services, led by Indigenous leaders, to do appropriate and effective outreach to these communities.
> **— Hassle Free Clinic**

People who use injection drugs

- promoting services through street health clinics
- offering a monthly testing clinic to people coming to needle syringe site
- addition of naloxone information to a regular newsletter given to needle exchange clients
- doing outreach to methadone clinics, shelters and other locations

where people who use drugs gather
- hosting a fixed-site needle exchange program at the sexual health clinic site and offering anonymous testing as well as other sexual health services to people who come for the needle exchange
- developing a strategy to work with the local ASO to continue to engage this population.

Women at risk

- working with ASO women's workers to provide education and testing services at a local YWCA transitional housing program
- attending women's shelter site to increase future testing uptake
- providing education sessions and promoting testing to the female population at the detention centre
- establishing a relationship with the Street Level Women and Risk Program and offering outreach information and testing to street level sex workers both at the health centre as well as at the women's community house, safer space and My Sister's Place support services
- offering outreach testing through street nursing and attending nights at women's drop in center
- organizing a quarterly "girls night out" event with other community partners focused on women at risk.

> Although we ask about risks, we don't probe too much. The risk assessment question would be something like "do you have any particular concerns about male partners, i.e. bisexual, drug use, part of communities where there is lots of HIV?" If a client says no, we won't ask about racialized partners, which would be offensive and probably illegal, so we may be under reporting the number of at-risk women we are testing.
> **— Hassle Free Clinic**

Others at risk

- offering weekly testing to at-risk youth who often use drugs or engage in survival sex work in a homeless shelter
- attending monthly workshops at a local detention centre to provide sexual health and harm reduction education sessions for women
- conducting weekly outreach to sex workers
- using the mobile van to distribute condoms, harm reduction supplies and encourage health-seeking behaviour
- working with a CHC that hosted refugee health clinic offering information and supports to government-assisted refugees.

> We engage with youth at their meal time to increase their awareness of our services and to build a relationship with them.
> **— Hamilton Public Health & Community Services**

Changing demands for services

When asked about shifts or trends in services, the testing programs reported the following:

> Sexual health clinics are very busy, some have had to limit the number of tests they can deliver during operating hours. Full screens at sexual health clinics tended to be nominal bloodwork. Women at risk, Indigenous people and those from African, Caribbean & Black communities remained difficult to reach specifically for testing. IDU and MSM clients have been easier to reach through harm reduction and outreach activities.
> **— Hamilton Public Health & Community Services**

> Advertising opportunities for anonymous HIV testing have increased the uptake.
> **— Sudbury Health Unit**

In 2016, the Middlesex London Health Unit declared an HIV epidemic in London with rising rates specifically among the street-involved people who inject drugs. There is a need to increase testing with this population and with women who engage in street work. They are working hard to reach this population with information and harm reduction supports as well.
— London Inter-Community Health Centre

We have noticed an increase in demand for anonymous HIV testing during our weekly anonymous HIV testing clinics. In 2015, there were a total of 68 appointments at the weekly anonymous testing clinics. In 2016, we reached the same number of appointments by October.
— Simcoe Muskoka District Health Unit

More men who have sex with men are requesting window period serology. Many clients accessing rapid anonymous HIV testing at outreach clinics ask the anonymous testing worker for additional STI testing—specifically syphilis testing.
— Somerset West Community Health Centre

It appears we are on track to have more HIV positive tests than in 2015. A lot of our new diagnoses are coming from outreach testing sites. Our sex worker drop-in testing has been successful but the drop-in population is very stable, so the suggestion has been to offer another cycle over the winter when workers might need retesting or new clients are attending.
— Hassle Free Clinic

There was an increase in clients requesting HIV testing and more clients choosing nominal testing.
— Thunder Bay Health Unit

To meet the growing demand for services, the testing sites reported the following activities:

- collaborating and creating partnerships with other agencies to improve testing and links to care/treatment for high-risk priority populations
- training internal staff to support testing with the street-involved populations including a staff member who is primarily based out of the needle exchange program in London
- assigning additional nurses to anonymous testing clinics as needed
- offering window period serology more often to MSM who have had high risk exposure(s)
- working with community partners to access Indigenous people in the community
- exploring other opportunities to reach MSM/bi/trans men
- shifting schedules to allow for a few more evening shifts at sites where testing is in greater demand
- providing more outreach services to reach at-risk clients who may not be presenting to the clinic for testing services.

Clients who test positive for syphilis should be treated where they received testing. However, individuals who live outside of our CHC catchment area cannot access medical services at our clinic due to provincial billing protocol. Syphilis treatment and follow-up is complex and requires a medical service provider experienced in sexual health to interpret syphilis test results, provide a positive diagnosis and provide appropriate treatment and follow-up. AIDS Bureau guidance and financial support would be required for this initiative to fund a part-time nurse practitioner position to assist with test result interpretation, diagnosis, treatment and follow-up.
— Somerset West Community Health Centre

Community-based clinical services

Total active and new clients by client group, 2016-2017

Male	ACT	NEW	Total
People living with HIV	1174	190	1364
Affected	NR	NR	14
At risk	23	183	206
Total	1200	384	1584

Female	ACT	NEW	Total
People living with HIV	289	44	333
Affected	NR	NR	NR
At risk	17	147	164
Total	307	199	506

Trans	ACT	NEW	Total
People living with HIV	NR	NR	16
At risk	NR	NR	111
Total	—	—	128

Total	ACT	NEW	Total
	1507	583	2217

*NR = Not reported due to low numbers.

Community-based clinical services

Ontario has 20 HIV clinics across the province: 15 hospital-based and five multidisciplinary community-based clinics. The five multidisciplinary community-based clinics are funded by the AIDS Bureau and required to report through OCHART.

Community-based HIV clinics

- Bloom Clinic, Bramalea CHC, Brampton (Central West Region)
- Elevate NWO, Thunder Bay (Northern Region)
- HIV/AIDS Resources and Community Health Clinic (ARCH Clinic), Guelph (Central West Region)
- Lakeridge Health Centre , Oshawa (Central East Region)
- Health Centre at 410 Sherbourne St., St. Michael's Hospital (Toronto Region)

Key highlights in 2016-17

- The number of clients continued to increase.
- Gay, bisexual and other men who have sex with men continued to be the priority population most likely to access clinical HIV services.
- Female clients increased for the third year.
- Trans clients were retained in care.
- More clients faced stigma and parenting and childcare issues (Central West, primarily).
- Fewer clients had health insurance issues (Central West).
- There were increased linkages made to mental health services and community-based addiction/harm reduction services.
- There were fewer education activities and participants, and fewer health care professionals attended conferences and nursing updates.

Women and trans clients using clinical services

Over the past three years, the clinics have seen a steady increase in the number of both male and female clients. Between 2014 and 2016, the number of female clients more than doubled, while the number of male clients increased by 52%—however, males still accounted for 71% of the clients served.

In the previous year, the five clinics saw a large increase in the number of new trans clients accessing clinical services. Many of those clients were retained in care and became repeat clients during the 2016-17 year.

Age group	14-17	18-25	26-35	36-45	46-55	56-65	66-75	Over 75	TOTAL
Male	23	71	226	350	505	305	81	19	1582
Female	19	57	75	141	118	63	27	—	502

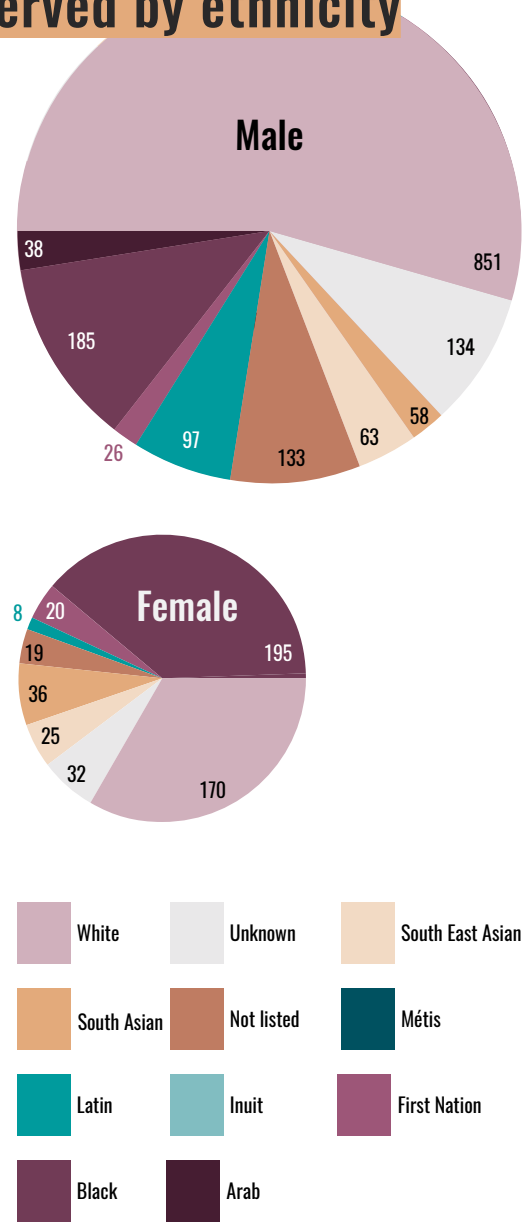
Note: Trans men and women were not reported due to low client numbers

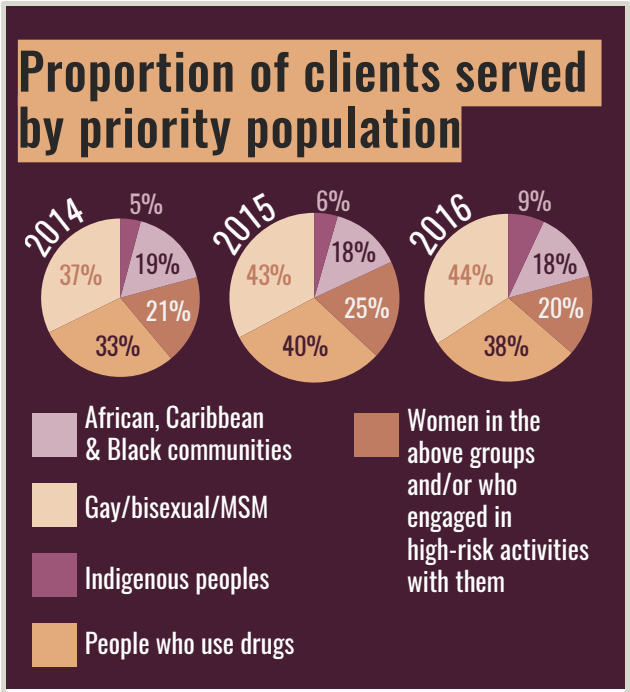
Age, ethnicity and language

In the 2016-17 OCHART report, client age was recorded using different age ranges than in previous years. Over 51% of clients were between the ages of 46 and 65. The number of trans clients was too small to report; however, similar to last year, trans clients were younger than cisgender clients: 77% of cisgender clients were 35 years of age and older, with 30% being between the ages of 46 and 55; 79% of trans clients were younger than 35 with most (58%) being between 15 and 25 years old. Among cisgender clients, the majority of female clients were 36 to 45 years old (28%) and the majority of males were 46 to 55 years old (32%). In 2016-17, where ethnicity and first language spoken was reported:

- Ethnicity data was reported for 92% of clients
- 55% of clients were white
- 19% were Black
- 5% were South East Asian or South Asian
- 91% spoke English as a first language—however, data on first language spoken was only available for 64% of all clients.

Proportion of clients served by ethnicity





Clients were most likely to be white for all sex/gender groups except females, who were most likely to be Black.

Who accesses services?

Similar to last year, gay, bisexual and other men who have sex with men and people who use drugs continued to represent the majority of clients accessing clinical HIV services at the five clinics. Overall, the proportion of priority population clients accessing services remained relatively stable. However, the proportion of clients identifying as Indigenous increased from last year while the proportion of at-risk women decreased.

Challenges clients faced this past year

Similar to previous years, discrimination/stigma (80%), poverty (61%), mental health issues (60%), and unemployment (48%) remain the five most common challenges faced by clients accessing services at these five clinics. More clients reported experiencing racism/racial discrimination at all five clinics (29% up from 18% last year). Bramalea reported more clients facing childcare issues (50% vs 3% last year) and Lakeridge had more clients facing challenges with life/communication skills (50% vs 3% last year). Meanwhile, ARCH reported significantly fewer clients with challenges related to the lack of health insurance.

Regionally, Central West and Central East clients reported discrimination/stigma as being a more significant issue than those in the North or Toronto. Poverty was an important issue in all regions, but especially so for the North and Central West regions, which also faced higher rates of other poverty-related challenges such as unemployment and food insecurity.

Shift in services used by clients

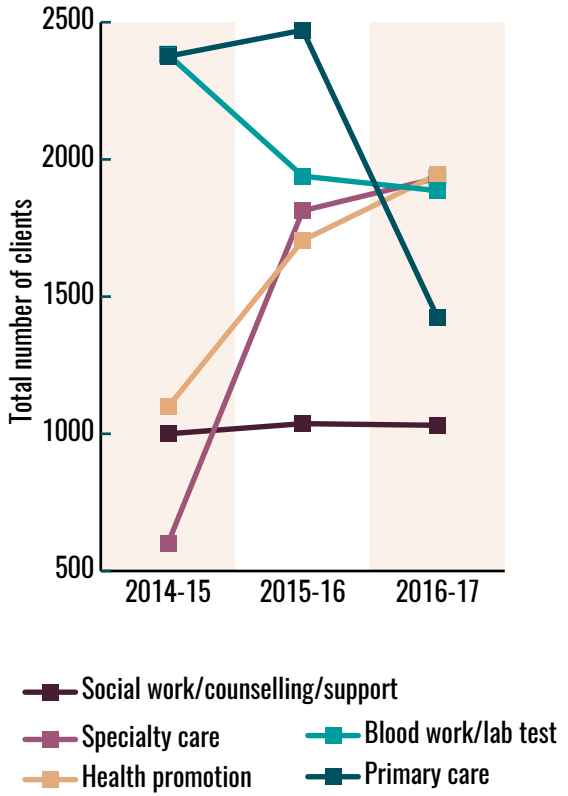
Overall, clinics reported clients using far fewer primary care services than in previous years. The largest clinic accounted for most of that decrease, which was partially offset by an ongoing increase in health promotion and specialty care services.

Continuing trends from last year, clients were using more intake/assessment and pharmacy services, but fewer treatment information and mental health services.

The decline in some services may be attributed to changes in guidelines for how often clients were seen and linked to services within the clinics' external referral networks. Changes to guidelines meant that some clients may have been seen only half as often as before depending on their healthcare needs, coming for regular check-ups only once per year. Guidelines also recommend that clinics focus on HIV-related care, meaning that clients may have been increasingly linked to other providers for general primary care and other services.

Client services	2014-15	2015-16	2016-17
Primary care	2376	2471	1425
Blood work/lab test	2382	1939	1886
Health promotion	1098	1705	1945
Specialty care	602	1813	1932
Social work/counselling/support	1000	1037	1031
Treatment information	940	761	546
Pharmacy services	454	644	783
Intake and assessment	502	622	679
Adherence support	684	502	605
Sexual health counselling	544	455	452
Pre-/post-test counselling (STIs)	503	456	456
Mental health services	817	361	99
Nutritional services	208	208	251
Application support	228	151	173
Addiction services	31	104	96
Reproductive health services	48	31	25

Top 5 client services



Links to clinical and community/social services

Clinics advocate and intervene on behalf of clients to make sure they are linked to the services they need. Linking clients to services means actively making and following up on referrals made to other local clinics or community organizations to manage clinical comorbidities or social determinants of health.

While the total number of referrals decreased by 13% to 2,241 in 2016-17, it was still an increase of 37% from 2014-15. In 2015-16, clinics reported a **57%** increase in the number of referrals in 2015-16 compared to the previous year. The trend toward increased referrals is consistent with the approach promoted in the HIV Strategy to strengthen partnerships and regional referral networks.

Clinics made more links to community-based addiction services and mental health services. A large decrease in the number of links made to medical specialists and an increase in primary care referrals occurred in 2016-17. When combined, these two services remained relatively stable from one year to the next (3% decrease). Meanwhile, links to HIV specialists (27% decrease), ASOs (37% decrease) and housing services (97% decrease) all declined. The majority of these decreases can be attributed to one high volume clinic that changed its reporting practices.

Links to services	2014-15	2015-16	2016-17
Medical specialists	787	1232	723
HIV specialist	215	463	340
Primary care (GP)	159	192	661
Clinical mental health services	119	186	109
AIDS service organization	126	122	77
Mental health services (community)	59	84	114
Housing services	79	118	3
Community-based addiction services	—	—	172
Clinical addiction services (detox/ rehab)	45	52	40
Legal services	22	78	2
Community-based addiction services	5	27	—
Settlement services	16	7	—
Employment services	4	10	—
Local hospital/service network	10	47	24
Opening Doors conference/event	26	18	16

Fewer education events, network meetings and professional development

In 2016-17, the clinics reported delivering approximately half of the number of education events (55) than in 2015-16 (114). While each education category had at least one-third fewer events, conference presentations declined the most (85%). Similarly, the number of participants at the educational events declined by 70% in 2016-17 (560) compared to 2015-16 (1850). This decrease is likely owing to better data reporting from one specific clinic.

In terms of average attendance, each HIV Round was attended by approximately half as many participants (9 per event compared to 17 in 2015-16) and community presentations were attended by approximately a quarter fewer participants (15 per event compared to 22 in 2015-16). However, conference presentations reached more people on average (13 per event compared to 10 in 2015-16).

In 2016-17, clinics reported approximately half as many community development meetings with local hospitals/service networks (24) than in 2015-16 (47). The number of meetings held in 2016-17 with the Ontario HIV Outpatient Clinic Network (OCN), Local HIV Planning Networks and Opening Doors Conferences decreased slightly from 2015-16 but remained relatively stable.

Clinic staff participated in fewer professional development activities in 2016-17 (42) compared to 2015-16 (69). Overall, they attended 55% as many conferences and 18% as many nursing updates.

Education event	2014-15	2015-16	2015-16
HIV rounds			
Number of participants	507	1023	343
Number of events	28	61	40
Community presentations			
Number of participants	585	541	167
Number of events	15	25	11
Conference presentations			
Number of participants	268	286	50
Number of events	16	28	4

Community development meetings	2014-15	2015-16	2016-17
HIV clinic coordinator network	18	23	18
Local HIV planning network	8	12	10
Local hospital/service network	10	47	24
Opening Doors conference/event	26	18	16
Total	**62**	**100**	**68**

Professional development activities	2014-15	2015-16
CME/CPD or post-secondary course (or other professional development course)	18	19
Conference	31	17
Nursing update/RPNAO/RNAO course	17	3
Other official college requirement	3	3

Shifts in demand

Managing HIV as a chronic illness

> With improved treatments, supports to adherence and healthy lifestyles, clients living with HIV are living longer. These clients can have some increased health care needs related to chronic disease management and natural aging as well as to isolation.
> **— Bramalea Community Health Centre**

> We are experiencing increasing challenges with managing our aging HIV population that have multiple co-morbidities.
> **— 410 Sherbourne at St. Michaels Hospital**

Increased demand, especially MSM

> We have had a significant increase in new patients. This is a combination of new diagnoses primarily consisting of MSM and ACB patients, with some transfers of care along with new immigrant/new diagnoses. We continue to see several syphilis diagnoses. We witnessed several client deaths this reporting period. We have cared for several pregnant patients.
> **— HIV/AIDS Resources & Community Health Clinic**

> Over the last 18 months we have noticed an increase in the number of gay men who are living with HIV accessing services.
> **— Elevate NWO**

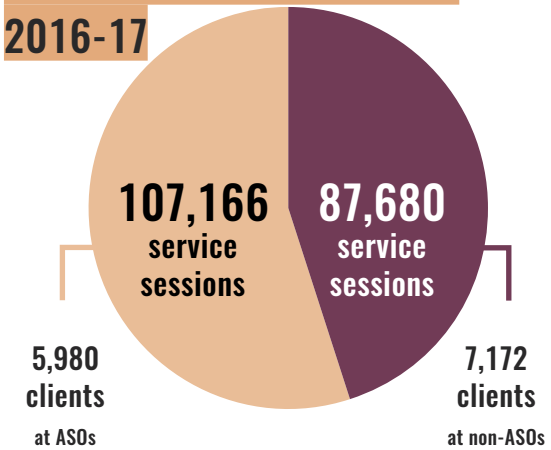
Treatment engagement

> Attendance has improved over the last few months. Clients are both attending their appointments and getting their blood work done.
> **— Elevate NWO**

> As we have implemented new standards, stable clients are seen less frequently, with fewer registered visits within the reporting period. It is more difficult to determine if/when clients become lost to follow-up given the reduced frequency of booked visits. This trend may complicate engagement/re-engagement strategies as it becomes more difficult to identify when clients are not following up as outlined in the plan of care or if the client's health or social situation has changed unexpectedly.
> **— Lakeridge Health Centre**

Support services

Service sessions delivered 2016-17



Client group by age

Age group	People living with HIV	Affected	At-risk
Under 18	55	529	40
18-25	169	115.5	173
26-35	855	115	547
36-45	1450	191	439
46-55	1851	97	450
56-65	968	57	191
66-75	225	12	42
Over 75	27	NR	NR

*NR = Not reported due to low numbers.

Support services

Who is using support services?

This year, 54 community-based HIV programs—36 ASOs (which includes seven satellite Oahas sites) and 18 non-ASOs—provided support services to **13,152** people[1] (on average).

Of these, 5,980 accessed services at ASOs and **7,172** accessed services at non-ASOs. The total number of people accessing community-based programs is up slightly from **12,343**, recorded in 2015-16.

In 2016-17:

- **194,846** total service sessions provided
- **107,166** service sessions to **5,980** clients (45% of total clients) provided by ASOs
- **87,680** service sessions to **7,172** clients (55% of total clients) provided by non-ASOs.

Client group by age and ethnicity

Programs provide support services for people living with HIV, people at risk of infection and people affected by HIV (e.g. partners, family members). When looking at type of client by age (with age data provided in 96% of service users), the majority of clients were between the ages of 36 and 65. People living with HIV were more likely to be older (46-55 years old) than those at risk (26-35 years old) or those affected by HIV (over 18 years old). Male clients tended to be older (46-55 years old) than female clients (36-45 years old). Trans clients were not included in the analysis because of low numbers reported. Year-over-year age and ethnicity analysis was not possible as new categories were introduced in 2016-17.

1 The 13,152 clients may not be unique individuals as some may receive services from more than one organization.

Are there differences in the type of clients served by type of agency?[2] Yes.

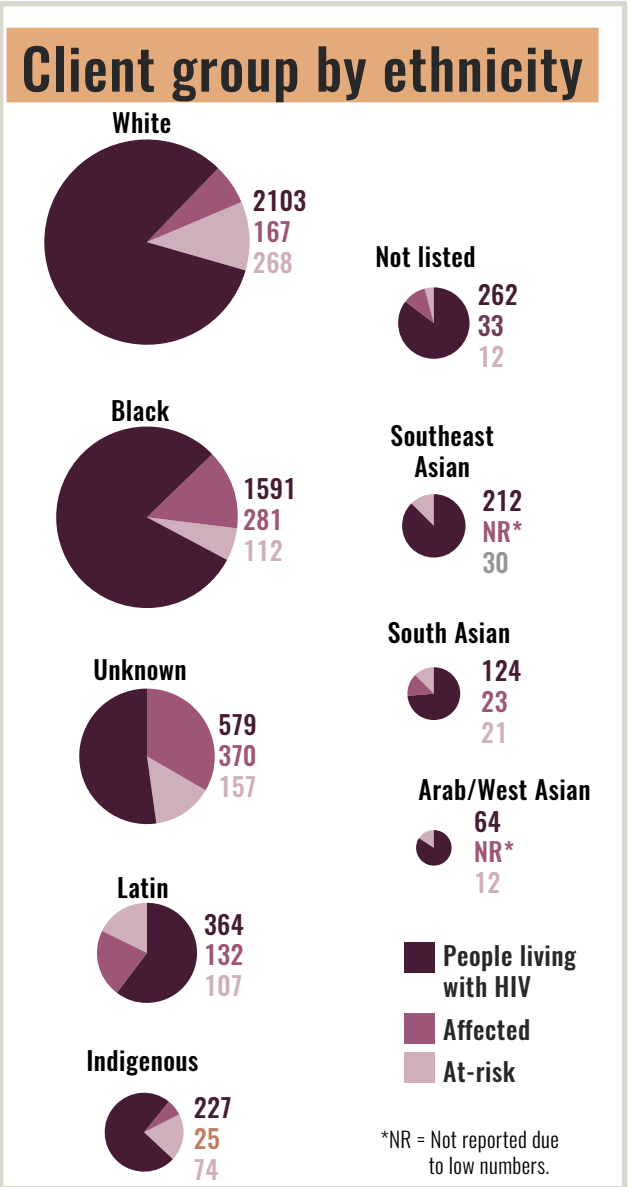
- 85% of people who received support services at the 36 designated ASOs (including the seven satellite sites) were living with HIV
- 42% of people receiving support services at the non-ASO agencies were living with HIV; while 52% were considered at-risk.

These differences are not surprising given ASO mandates and mandates of smaller HIV programs at non-ASO agencies, funded to work with specific HIV priority populations.

ASOs had ethnicity data on 85% of their clients while non-ASOs had ethnicity data on only 20% of their clients. This may be because non-ASOs do not typically require this information for the services they deliver. Organizations that did not provide any ethnicity data for their clients were removed from the ethnicity analysis.[3]

Overall, where ethnicity was known, service users were mainly white (41%), followed by Black (32%), and Latin American (10%). This was consistent for people living with HIV and at-risk client groups; however, clients affected by HIV were most likely to be Black, followed by white and Latin American. First Nations, Inuit and Métis were combined to include a broader Indigenous populations group.

Overall, two out of every three clients (66%) accessing service during 2016-17 were men. Women made up 32% of service users and trans women accounted for 1%. Trans men and service users with an unlisted gender accounted for less than 1% of total service users in 2016-17. When ethnicity was examined more closely by gender, Indigenous women accounted for 6% of female clients and 14% of trans female clients.



Support service clients living with HIV

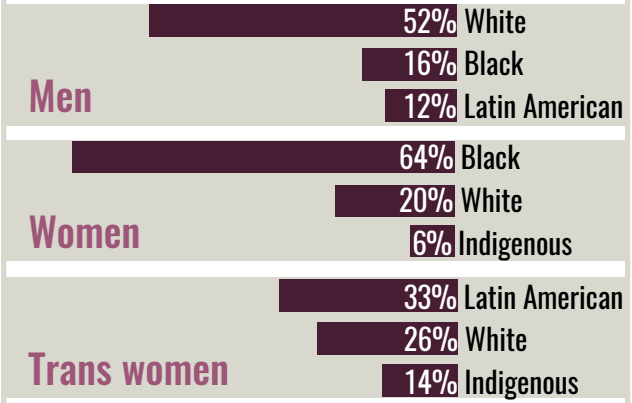
37% 2748 have a primary care physician

45% 3277 have an HIV specialist

2 As this question was new in 2016-17, it is likely these numbers will increase next reporting period as agencies are able to better collect and report this data.

3 One organization was removed from gender analysis and two organizations were removed from age or ethnicity analyses because they do not collect information on clients. One additional organization was also removed from ethnicity analysis because this information was not collected, but was included in the age analysis.

Top 3 ethnicities by gender



Note: Trans men were not reported due to low client numbers

Number of clients accessing support services	ASO	Non -ASO
Community/social services	4812	4010
Practical assistance	6543	633
Intake	616	2212
Case management	434	258
Support within housing	170	13
Traditional services	26	57

Clients by priority population

In terms of clients living with HIV (for both ASOs and non-ASOs) most were reported as gay, bisexual and other men who have sex with men, followed by African, Caribbean and Black and people who use drugs.[4]

Although ASOs provide support services to people living with HIV in all priority populations, their at-risk clients were most likely to be gay, bisexual and other men who have sex with men (including trans men) and people who use drugs. The majority of affected clients were reported by one ASO that works primarily with African, Caribbean and Black clients and one non-ASO that works mainly with gay, bisexual and other men who have sex with men.

Types of services

In 2016-17, the most frequently used services were community/social services and practical assistance. ASOs served a greater proportion of returning clients. The bulk of intake services (78%)— which are more likely to be offered to new clients—were provided by non-ASO agencies. Questions about the types of services clients accessed changed from the previous year, limiting year-over-year comparisons.

The broad service areas of community and social services and practical assistance included the following types of services:

Community/social services

- General support
- Support groups
- Clinical counselling
- Employment services
- Financial counselling services
- HIV pre-/post-test counselling
- Managing HIV
- Settlement services
- Bereavement services

4 The women at-risk priority population was removed from the people living with HIV client category because a woman living with HIV cannot be at-risk of HIV by definition.

Practical assistance

- Complementary therapies
- Transportation
- Financial
- Food programs
- Other

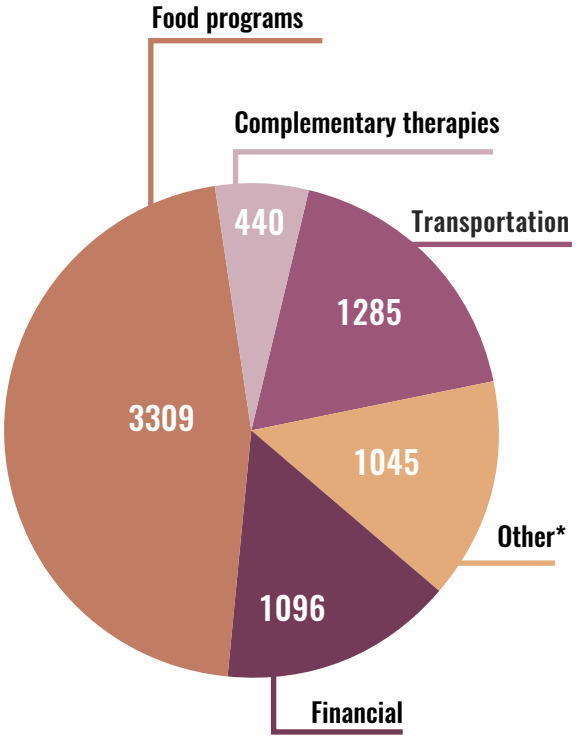
Overall, ASOs delivered 91% of the practical support services provided to all client groups. 7,176 clients received practical support in 2016-17, which typically relied on fundraised dollars. Food programs—the most used form of practical support—accounted for 46% of all practical assistance services. This highlights the high proportion of people living with HIV facing challenges with income and food security. Transportation, financial and other types of practical assistance each accounted for 15% to 18% of practical assistance services and complementary services make up the remaining 6% of practical assistance services.

ASOs provided 55% of community/social support services—delivering services to 8,822 clients. The most common type of community/social support service delivered was general support for both ASO (43%) and non-ASO (66%) agencies. The top community/social services differed slightly between ASOs and non-ASOs. It makes sense that non-ASOs, which serve more at-risk people than ASOs, would be providing more test counselling services.

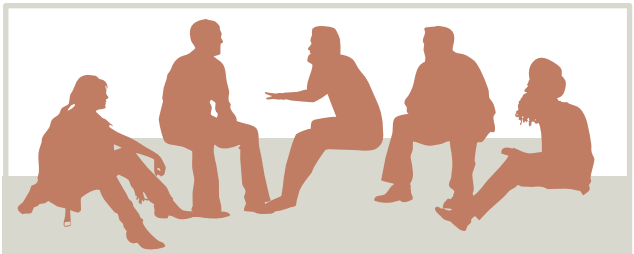
	People living with HIV		At risk		Affected	
	ASO	Non-ASO	ASO	Non-ASO	ASO	Non-ASO
Gay, bisexual and other men who have sex with men	1,568	346	219	217	15	94
African, Caribbean and Black	981	414	79	24	351	11
People who use drugs	606	187	137.5	1,070	25	–
Other	677	68	15.5	2,221	–	–
Indigenous	232	11	68	–	–	–
Women at risk	–	–	66	–	14	18

Note: The women-at-risk priority population was removed from the people living with HIV client category because a woman living with HIV cannot be at risk of HIV by definition.

7,176 clients accessed support services for practical assistance



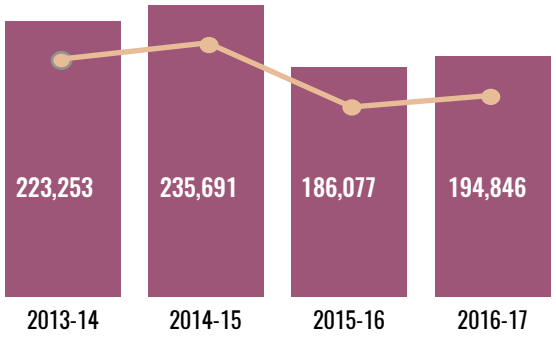
*Other practical assistance included assistance with completing identification, insurance, legal forms and providing household items and clothing.



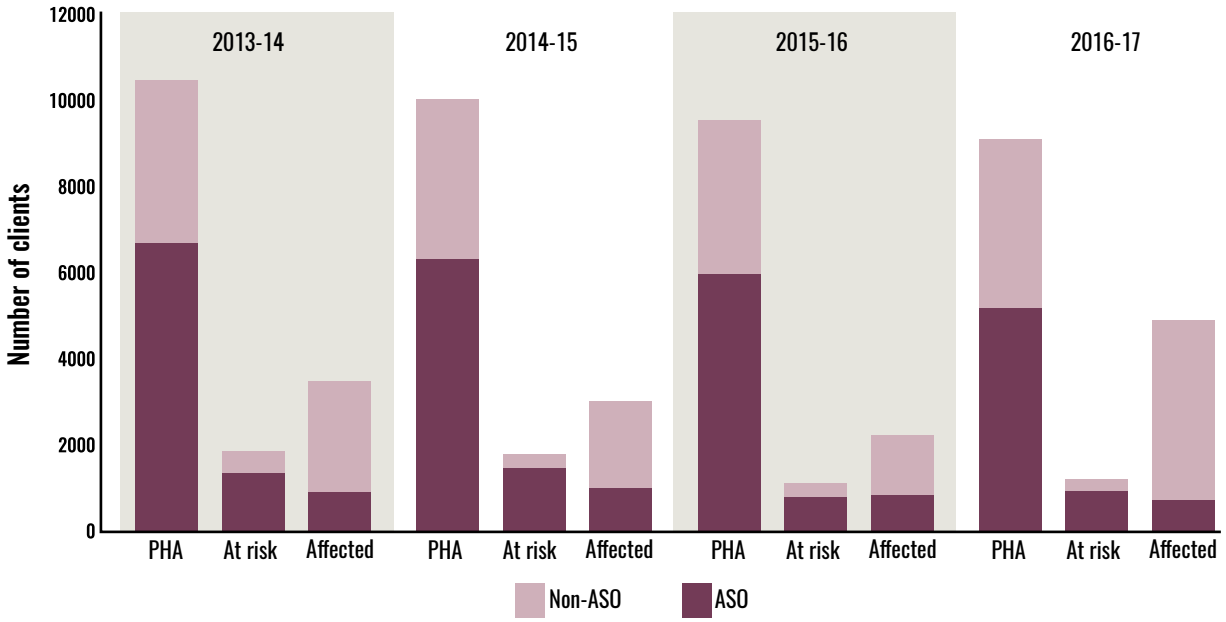
Top community/social support services delivered by ASO and non-ASO agencies 2016-17

50,184	General support
9,497	Support groups
4,763	Managing HIV
4,359	Clinical counselling
2,224	Financial counselling services
1,725	Settlement services
1,684	Employment services
740	Bereavement services
388	HIV pre-/post-test counselling

Total number of service sessions



Total clients by client group 2013-14 to 2016-17



More service sessions delivered

Programs delivered **194,846** service sessions in 2016-17—up from **186,077** in 2015-16. When analyzed by gender, women were more likely to utilize practical assistance programs and case management services, while men were more likely to make use of intake services and support within housing.

91% of these sessions were delivered by ASOs and 89% of these sessions were delivered to people living with HIV. Of the remaining 9% of service sessions delivered by non-ASOs, 61% of their support sessions were delivered to people living with HIV.

People living with HIV and at-risk clients mainly used community/social services, practical assistance, and support within housing. HIV affected clients mainly used practical assistance, community/social services and intake services.

Community/social services comprise nine different services. Of the **75,564** service sessions reported, two-thirds (5,0184) were for general support, followed by 13% (**9,497**) for support groups.

Referrals

In 2016-17, agencies made a total of **9,045** referrals to other clinical and community services. The most common referrals were to:

- other community-based service providers—**3,864**
- non-HIV specific clinical service providers—**1,670**
- mental health services providers—**900.**

ASOs were more likely to refer clients to other community-based service providers, both HIV-specific and non-HIV specific. Other community-based service providers included organizations providing social and legal services, housing, settlement and community supports and population-specific services such as women's organizations. Non-ASO agencies were more likely to refer clients to all other types of services, including other clinical services, mental health services, harm reduction/addiction services and HIV/STI testing.

Referral type	ASO	Non-ASO
Other community-based service providers	2430	1434
Clinical service providers: non-HIV specific	796	874
Mental health service providers	283	617
Community-based service providers—HIV care and support	431	401
Addiction services	71	450
Clinical service providers: HIV care	175	256
Harm reduction services	28	399
HIV/STI testing	36	364

Number of sessions for top 3 services delivered by client group in 2016-17

People living with HIV

1. Community/social services (64,153)
2. Practical assistance (55,028)
3. Support within housing (42,766)

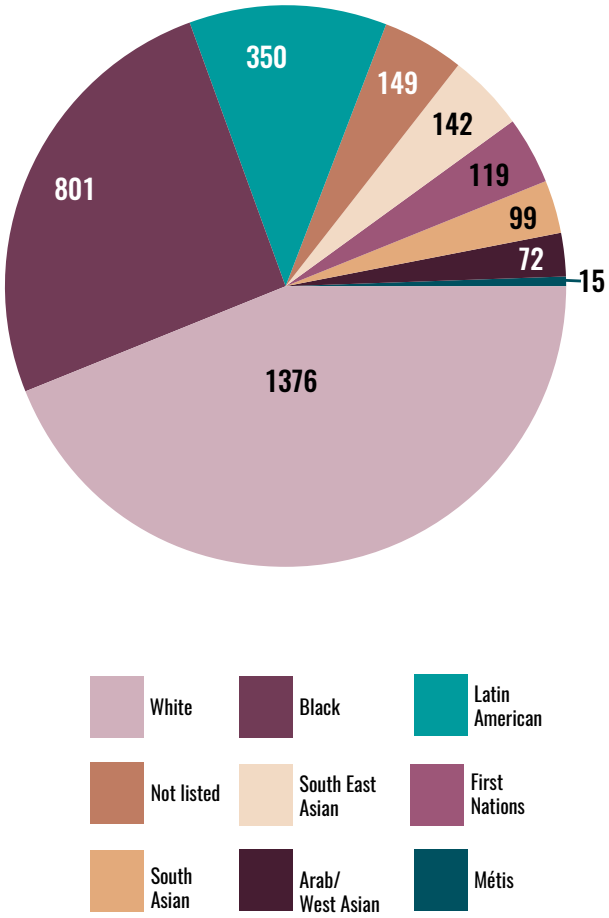
At risk

1. Community/social services (8,755)
2. Practical assistance (1,334)
3. Support within housing (982)

Affected

1. Practical assistance (6,293)
2. Community/social services (2,656)
3. Intake (159)

New client demographics by ethnicity



Two thirds of new clients living with HIV are male

Non-ASOs: **2,741** new clients

ASOs: **1,779** new clients

Most new clients (61%) were reported at non-ASOs. This trend is expected given the nature of non-ASO agencies (e.g. legal services, end-of-life care).

Most new clients (58%) were people living with HIV, while 35% were considered at-risk and 6% were considered affected.

Where gender was reported—in 81% of new clients—68% of new clients living with HIV were men, 30% women and 2% trans. Women account for about 20% of new diagnoses, but 30% of new support service clients. It appears that women are more likely than men to use support services. The majority (96%) of clients where gender is unknown (19%) were at-risk clients reported by one agency.

New clients by gender

	Men	Women	Trans women	Not listed
People living with HIV	1804	779	48	NR*
ASO	795	298	15	–
Non-ASO	1009	481	33	617
Affected	150	112	NR*	NR*
ASO	82	88	–	–
Non-ASO	68	24	–	–
At risk	591	137	21	841
ASO	389	74	–	–
Non-ASO	202	63	–	–

NR = Not reported due to low numbers.

New client demographics

Ethnicity was reported for 53% of new service users. Regardless of client group or agency type, the top three ethnicities were white, Black and Latin American, which is consistent with provincial epidemiological data. These three ethnicities have historically been the most commonly reported ethnicities of newly diagnosed individuals in provincial epidemiological data. However, in 2015-16, East/Southeast Asian displaced Latin American as the third most commonly reported ethnicity for newly-diagnosed individuals.

Programs reported age for 66% of new clients. Most clients with an unknown age (94%) were reported by non-ASOs that do not require this information for the services they deliver. Where age was known, new clients tended to be older: they were more likely to fall into the 36-45 year old age category for both men and women. This may reflect the episodic nature of HIV where people's need for services changes or indicate that people who are newly diagnosed at a younger age may either be in less need of services or wait to access services until a later date.

When looking at new service users by client group, people living with HIV were more likely to be older (46-55 years old) than at-risk (26-35 years old) or affected clients (less than 18 years old). However, it was not possible to link the data for new clients with their length of diagnosis or age at diagnosis.

Client group	under 18	18-25	26-35	36-45	46-55	56-65	66-75	Over-75
People living with HIV	114	179	579	741	768	349	115	12
Affected	96	19	35	64	25	NR	NR	NR
At risk	NR	115	201	146	106	51	19	NR

New clients by priority population

Priority populations	ASO	Non-ASO	Number of new clients	Percentage of new clients
Gay, bisexual and other men who have sex with men	892	416	1308	35%
African, Caribbean and Black	430	96	526	14%
People who use drugs	290	127	417	11%
Indigenous people	89	6	95	3%

Challenges faced by new clients

- 19% Legal/immigration
- 15% Well-being
- 14% Social support
- 11% Living with HIV
- 10% Income and benefits
- 9% Housing
- 7% Food security
- 6% Education/employment
- 4% Risk of HIV/STI
- 4% Current safety concerns

New clients by priority population

In terms of priority populations, new clients were mainly gay, bisexual and other men who have sex with men, followed by African, Caribbean and Black individuals, people who use drugs and Indigenous people. The percentage of new clients who were people who use drugs (11%) and/or Indigenous (3%) closely mirrors the provincial epidemiological data[5].

New at-risk clients were mainly gay and other men who have sex with men (63%), people who use drugs (19%) and Indigenous people (3%), suggesting a focus from agencies on engaging these priority populations in prevention programs.

Challenges faced by new clients

In 2016-17, the top five challenges reported by new clients were legal/immigration issues, well-being, social support, living with HIV and income and benefits. The top five challenges shifted across client category groups.

Top five presenting issues for all new clients by client group in 2016-17

People living with HIV	At risk	Affected
1. Legal/immigration	1. Social support	1. Social support
2. Living with HIV	2. Well-being	2. Well-being
3. Well-being	3. Legal/immigration	3. Food security
4. Income and benefits	4. Risk of HIV/STI	4. Legal/immigration
5. Social support	5. Housing	5. Current safety

5 One agency was removed from the priority population analysis as all of their clients were reported as 'other priority population'.

Shifts in support service demands at agencies

Complex care, especially mental health and substance use

> Clients that are accessing service continue to be very complex. A number of the newer clients are experiencing severe trauma.
> — **Peel HIV/AIDS Network**

> Addictions continue to be a concern, causing some clients to fall out of care.
> — **AIDS Committee of North Bay and Area**

> Concerns coming forward include housing, HIV-related illness and aging, financial security and healthy sexuality. Also on the rise seems to be mental health matters within our client group, in addition to complex cases requiring supports in housing, mental health, employment, addiction and social isolation resulting from struggles in all of these areas.
> — **Regional HIV/AIDS Connection**

Online and social media support

> More and more clients use social media to reach out and fewer access face-to-face interventions. With videos in ASL that are about HIV and AIDS, more clients are able to confidently seek treatment, discuss with doctors and make a better sexual health decisions.
> — **Ontario Association of the Deaf**

> We have a new website with updated and current information, utilizing social media more.
> — **AIDS Committee of Windsor**

> There's more need for one-on-one support through text messaging, emails and Facebook.
> — **The Gilbert Centre**

> Due to the stigma and discrimination associated with HIV, some women prefer using web-based resources and support systems.
> — **Women's Health in Women's Hands Community Health Centre**

More financial support, especially with housing

> Individuals are having difficult times with housing, food and finding ways to make it through the month, so we are constantly looking at various options to assist them.
> — **HIV/AIDS Regional Services**

> We have seen an increase in requests for settlement services, presenting issues of substance use, affordable housing, HIV non-disclosure, food insecurity and poverty.
> — **Les Africains en Partenariat contre le SIDA**

> Housing instability is on the rise among our most vulnerable clients and we are referring more clients to housing workers, housing programs and emergency shelters than in previous reporting periods.
> — **AIDS Committee of Durham Region**

> There continues to be a trend in clients and their families having difficulty in accessing affordable housing. Given the housing crisis in Toronto and its impact on people living in poverty, much more of our work is focused on supporting clients to find affordable housing. Many families and individuals come from shelters and have to enter an apartment paying market value rent.

This makes it challenging to balance bills and access food and puts them at risk for homelessness. There are more referrals to food and clothing banks and more urgency for clients to work to have a better income to afford their basic living costs.
— Black Coalition for AIDS Prevention

Aging with a chronic illness

There is an increase in complex care needs as the HIV positive population ages.
— AIDS Committee of Cambridge, Kitchener, Waterloo and Area

We have noticed an increase in serious complications of comorbidities (e.g. diabetes-related amputation and kidney failure). Despite the fact that there are decreased side effects with new ARVs, long-term survivors continue to deal with chronic effects of HIV and early ART.
—AIDS Committee of Durham Region

A greater number of clients are identifying issues around HIV and aging and the impacts on them as individuals.
— Bruce House

We are dealing with more aging issues in our client base and connecting them to support services in our community.
— Positive Living Niagara

More trans clients

We have seen an increase in gender non-conforming and non-binary clients. Also, we have seen increases in trans women of diverse sexual orientations and increases in questions regarding hormone treatments for trans folks.
— Centre for Spanish Speaking Peoples

We continue to see a growing number of trans clients who are accessing services from us. We are working on creating partnerships to better meet the needs of this population.
— LOFT Community Services

We've seen an increase in trans men who engage in sex with other men (including other trans men) accessing services and the MSM clinic. The primary priority population (outside of the MSM clinic) continues to be individuals who struggle with issues of addiction and mental health.
— Réseau ACCESS Network

Provincial capacity-building

Provincial capacity-building

Provincial capacity-building programs (HIV Resources Ontario)

HIV Resources Ontario (HRO) is a group of **11** Ontario-based programs, brought together to support greater capacity within community-based HIV/AIDS organizations, through resource-sharing and the utilization of the strengths and expertise of each member agency.

These five programs provide organizational expertise:

- The **Ontario Organizational Development Program (OODP)** provides mentoring and capacity-building services that help community-based organizations build management and board skills and manage organizational issues.
- The **AIDS Bereavement and Resiliency Program of Ontario (ABRPO)** provides workshops and training programs that help community-based organizations build resilience and cope with AIDS-related losses or changes.
- The **Ontario AIDS Network (OAN)** is a network of community-based HIV organizations, which provides training programs for frontline workers, managers and executive directors, as well as leadership training for people living with HIV.
- **CATIE**, as a national source for HIV and hepatitis C information, provides information, webinars and events about evidence-based programs and practices that community-based organizations use in their prevention and support programming.
- The **Toronto HIV Network (THN)** works to improve access to and coordination of programs and services for people living with, affected by and at risk of HIV/AIDS in Toronto.

These six HRO member agencies focus on helping community-based organizations meet the needs of populations most affected by HIV:

- The **Gay Men's Sexual Health Alliance (GMSH)** supports a network of gay men's workers based in ASOs across the province, and acts as an information hub for gay and bisexual men's sexual health. It also delivers webinars and workshops that help ASOs build the skills to work effectively with gay, bisexual men and other men who have sex with men, including trans men.

- The **African and Caribbean Council on HIV in Ontario (ACCHO)** supports a network of ASO workers across the province, providing leadership and resources for use in response to HIV in African, Caribbean and Black communities.

- The **Women and HIV/AIDS Initiative (WHAI)** supports a network of workers in ASOs across the province, specializing in the support of women with or at risk of HIV. WHAI workers focus on community development with organizations that serve women to help them integrate HIV into current programs and build their knowledge and skills.

- The **Ontario HIV Substance Use Training Program (OHSUTP)** delivers training to substance use, mental health and allied service providers to develop the knowledge and skills needed to provide quality services for people living with HIV across the province.

- The **Committee for Accessible AIDS Treatment (CAAT)** provides education, research, service coordination and advocacy to increase service access for people with HIV who are immigrants and refugees.

- The **Ontario HIV Treatment Network (OHTN)** provides data and evidence to support and improve prevention and treatment efforts.

Educational sessions 2016-17

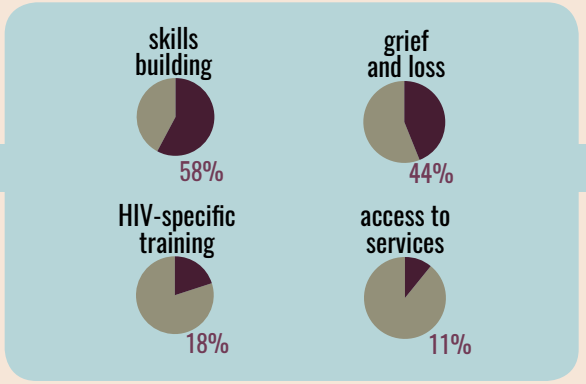
771 educational sessions in 2016-17 were delivered to 7,301 participants

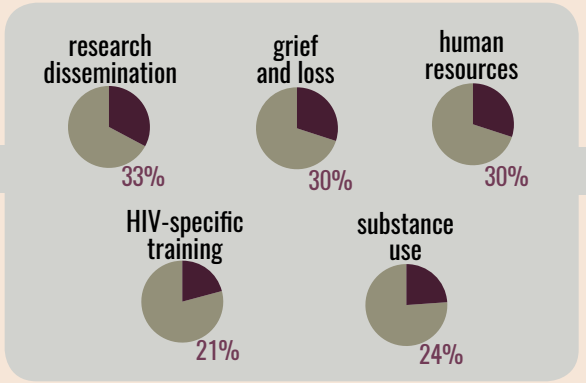
239 capacity-building sessions delivered to 4,214 participants

456 mentorship & coaching sessions delivered to 229 participants

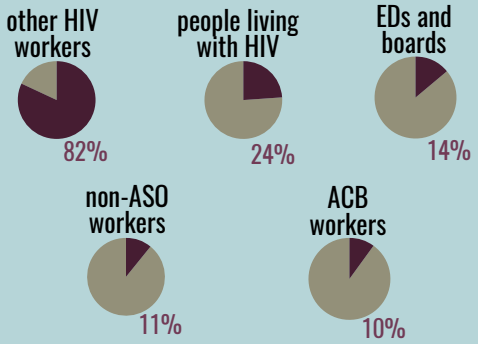
76 KTE sessions delivered to 2,858 participants

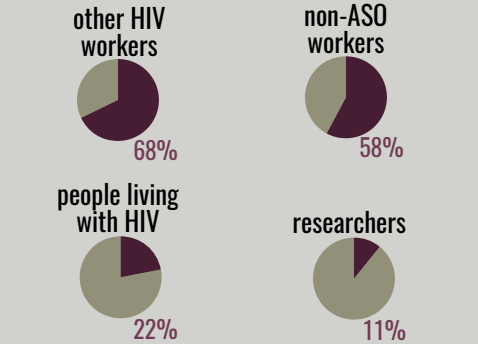
Topics





Audiences





Priority populations sessions

63 sessions for 868 participants

WHAI 5 sessions for 72 participants
GMSH 17 sessions for 131 participants
OHSUTP 3 sessions for 116 participants
CAAT 34 sessions for 487 participants
ACCHO 4 sessions for 62 participants

14 sessions for 26 participants

CAAT 14 sessions for 26 participants

52 sessions for 1,667 participants

WHAI 3 sessions for 41 participants
GMSH 5 sessions for 410 participants
OHSUTP 20 sessions for 394 participants
CAAT 24 sessions for 822 participants

Organizational support sessions

176 sessions for 3,346 participants

OODP 27 sessions for 158 participants
ABRPO 104 sessions for 1,562 participants
CATIE 40 sessions for 1,554 participants
THN 5 sessions for 72 participants

442 sessions for 203 participants

OODP 192 sessions for 32 participants
ABRPO 143 sessions for 64 participants
OAN 107 sessions for 107 participants

24 sessions for 1,191 participants

ABRPO 23 sessions for 1,156 participants
THN 1 sessions for 35 participants

Focus on mentorship, community development, and knowledge exchange

In 2016-17, the provincial capacity-building programs delivered a total of **771** presentations, workshops or sessions to a total of 7,301 participants. Compared to previous years, while there were fewer mentorship and coaching sessions and fewer presentations held, organizations were able to reach more participants.

The programs work in different ways to achieve their goals. Some focus more on mentoring and coaching while others provide more capacity-building workshops. KTE sessions, in general, reach a larger number of participants, while mentorship and coaching sessions, which often involve repeated one-on-one meetings with individuals, reach a much smaller number.

Targeting education to meet different needs

The provincial capacity-building organizations target their education efforts to meet different needs. For example, in 2016-17, a quarter of the topics covered in presentations to executive directors and board members focused on organizational development, whereas half of the topics covered in presentations to researchers focused on research dissemination. Education for frontline workers covers a range of topics, such as healthy sexuality, substance use and harm reduction, immigration, social determinants of health, skills-building and dealing with grief and loss.

In 2016-17, there was also more focus on training related to substance use and harm reduction which may reflect the need to increase the capacity of community organizations to effectively respond to the risk of opioid overdoses in their regions. One percent of presentations overall focused on anti-racism, GIPA/MIPA or legal issues around disclosure.

Education successes

When asked to report on successes, provincial programs mentioned:

- Creation of new tools and resources, such as Resilient Group Practice Framework (ABRPO)
- Greater demand for information and education about PrEP (CATIE)
- Training on non-violent communication, incorporated into Ethnoracial Treatment Support Network (ETSN), empowering people living with HIV (CAAT)
- Targeted education to enhance capacity of law, nursing and social work students to address racism, oppression and stigma when they are in the workforce (CAAT)
- Greater engagement of community partners who use harm reduction programming who wish showcase their work and put a face to their services (OHSUTP)
- Efficient transfer of trainings created by Toronto Public Health to the Toronto Harm Reduction Alliance, including the development of a decision-making process that helped manage the large number of players wanting control over the training design (OHSUTP)
- Greater interest from typically non-GMSH audiences due to creation of regional meetings to support the roll out of The Sex You Want (GMSH)
- Almost double the number of coaching requests for both executive directors and board chairs, due to the rate of changeover in these positions; increase in requests for HIV Disclosure Policy Development and Support, while the disclosure tool was downloaded 47 times in June and 39 times in August (OODP)

- Engagement and appreciation from attendees of the Guided Learning Opportunity for Support Workers (a new initiative in collaboration with the OHTN and the HIV Endgame conference for HIV clinicians) along with greater opportunity to connect with clinicians (OAN)
- Revision/Update of Volunteer Core HIV Training Program, rolled out in the fall (THN)
- Engagement of expertise within the WHAI network to model capacity building from a community development perspective by emphasizing strategies to engage cis and trans women with different backgrounds and learning styles, fostering communication with executive directors and with managers who support WHAI workers (WHAI)
- Greater collaboration in training inititatives amongst provincial capacity-building organizations. (THN)

Challenges

- Competing priorities—especially when trying to organize meetings with workers across a number of organizations and keeping community members engaged in committees and working groups (ACCHO, THN)
- Staff turnover in ASOs (ABRPO, CAAT, GMSH)
- Adequate time/resources required to manage network initiatives (e.g. keeping contact lists up to date) and to do community development work (OHSUTP, WHAI)
- Lack of resources (OODP)
- Inconsistent understanding of the meaning of community development amongst agencies with workers (WHAI)

Conferences and events

In 2016-17, six of the ten provincial capacity-building programs reported organizing or participating in a total of 17 conferences or events that involved **910** participants.
The conferences and events included Opening Doors, the GMSH Symposium, the ACB Strategy Symposium, an Excutive Director Symposium, and an HR workshop for managers.

What impact did these events have? Here are some examples:

> The Symposium—a partnership between Casey House, ACCHO, APAA, BlackCAP and WHIWH, aimed to assist service providers in understanding some of the issues faced by members of ACB communities related to HIV, racism and service access. It also highlighted the importance of service providers making connections to each other to help clients have optimal health outcomes.
> **— African and Caribbean Council on HIV/AIDS in Ontario**

> Neon Lights was organized by CATIE and Oahas in Timmins. Participants included frontline workers in HIV organizations, other organizations, public health and corrections from Timmins, Cochrane, North Bay and First Nations communities.
> The agenda included HIV and hepatitis C, cultural safety, and HIV and criminalization.
> **— CATIE**

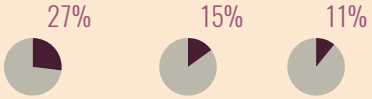
> This conference-based learning opportunity helped support workers learn more about clients' health needs and care options. They developed a better understanding of the challenges in HIV care that have implications for their work. They also were able to network with one another and with clinical care providers.
> **— Ontario AIDS Network**

Popular training and education topics by audience type

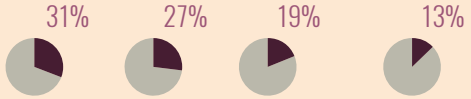
GMSH workers

policymakers

EDs and board members

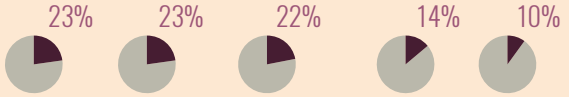


other HIV workers



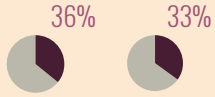
WHAI workers

non-ASO workers

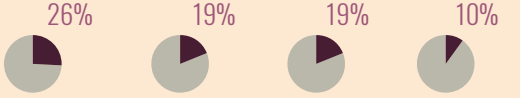


ACB network workers

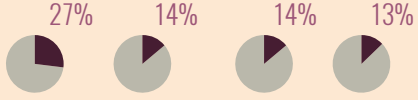
people living with HIV



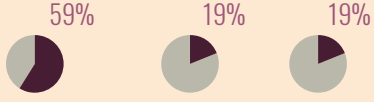
Public Health professionals



volunteers



researchers



Nineteen faith and spiritual leaders, referred by ACB strategy workers, participated in It Takes Courage. The conference helped them build welcoming communities and understand the role they can play in eliminating stigma in their congregations.
— African and Caribbean Council on HIV/AIDS in Ontario

Community development

Community development takes many forms: being part of a strategic planning exercise, advisory committee or working group or strengthening inter-agency cooperation and networks. In 2016-17, the total number of community development activities was **586**, up 40% compared to the previous year. Provincial organizations were involved in fewer strategic planning activities and more network/partnership activities and working groups than in 2015-16.

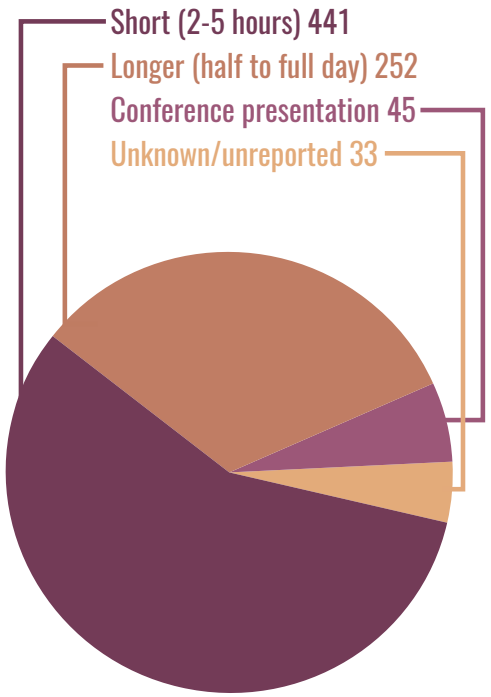
Most community development activities (almost half) were with the executive directors and front-line staff of other organizations.

Successes

The success of the Injection Drug Use Outreach Network (IDUON): there has been more use of the network, i.e. more members using the network to ask questions and get support from each other. In addition, for the first time, there was almost 100% attendance at this past year's face to face with only two people not able to attend. ...The chair has been getting requests from workers all over the province to join the network.
— Ontario HIV and Substance Use Training Program

For the It Takes Courage strategy: The Faith & Spiritual Leader Handbook, consultation was done with a group of faith and spiritual leaders to garner their input and ensure relevance.
—African and Caribbean Council on HIV/AIDS in Ontario

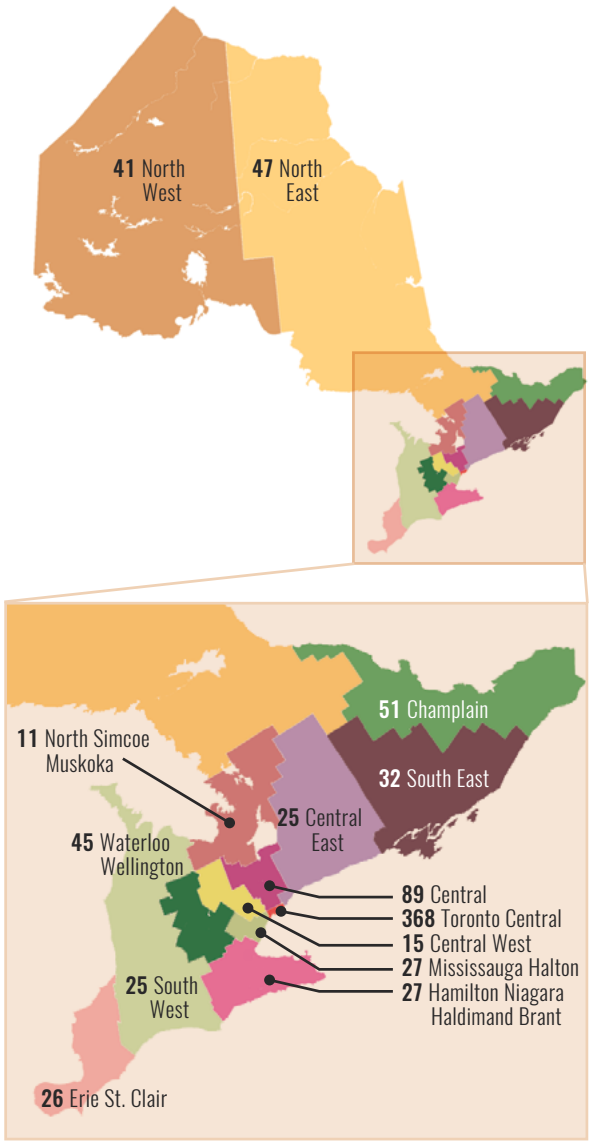
Length of education sessions



586 community development initiatives

187 networks and partnerships
127 working groups
66 initiatives to strengthen inter-agency cooperation
66 governance initiatives
55 program planning initiatives
40 advisory committees
33 strategic planning and organizational development initiatives
12 advocacy initiatives

Number of presentations and sessions reaching workers by LHIN



The ACB KTE Forum Planning Committee now has a formal partnership agreement. The partnership with Casey House led to greater awareness for service providers in the HIV sector and across the social determinants of health, of issues related to HIV faced by ACB communities.
– African and Caribbean Council on HIV/AIDS in Ontario

Our ongoing efforts to prioritize and develop work plans help us achieve more and more every period.
– African and Caribbean Council on HIV/AIDS in Ontario

Our collaboration with the OHTN produced PRA video resource teaching peers about our Essential Tools for Support and Stability material.
– AIDS Bereavement and Resiliency Program of Ontario

There have been a significant number of deaths of well known activists in this period. Through our partnerships and networks built over time, we were able to quickly set up and offer community closures/debriefings for ASO workers and peers connected to those who had died.
– AIDS Bereavement and Resiliency Program of Ontario

Partnership with Elevate NWO and local the Indigenous community in that region has resulted in an OjiCree translation of the Resiliency Map (or Story Telling Blanket as the community has named it).
– AIDS Bereavement and Resiliency Program of Ontario

WHAI did a lot of community development work in this period. We modeled strong community development and community engagement practices, developed tools that are accessible to people with a range of learning styles and are research-based while also being innovative and have been participatory in development.
– Women and HIV/AIDS Initiative

HIV Resources Ontario (HRO) has come together to produce the HRO portal under the direction of the OHTN and the OAN. CATIE will use this to house resources to assist ASOs and other Ontario organizations working in HIV.
– CATIE

Planned and implemented a three-day Ethnoracial Treatment Support Network (ETSN) training in Ottawa attended by 25 people. Newcomer PHAs successfully applyed for funding as an alliance from PHAC.
— Committee for Accessible AIDS Treatment

The co-director sat on a working committee to help transfer the Harm Reduction 101 trainings offered by Toronto Public Health to be facilitated by the Toronto Harm Reduction Alliance (THRA) and involve people with lived substance use experience in a meaningful way.
— Ontario HIV and Substance Use Training Program

Alliance and Working Group meetings continue to be well evaluated by participants. Having a greater focus on The Sex You Want campaign vs multiple projects has had a positive impact.
— Gay Men's Sexual Health Alliance

Being part of the Scope of Practice working group of the Support Services Advisory Committee provides an opportunity to try and help support workers be more focused in their work rather than "being everything to everybody" which too often leads to burnout.
— Ontario AIDS Network

We have supported two ASO board merger discussions this year and have helped three ASOs develop formal partnership agreements with community partners. Mergers and partnerships can strengthen organizational capacity and improve service delivery.
— Ontario Organizational Development Program

Our new governance workshop continues to receive positive feedback and we are mostly combining governance and board work planning together as a single consult. We are also offering more program planning and strategic planning supports.
— Ontario Organizational Development Program

Groupe de Travail Francophones en Matière de VIH/SIDA (GTFMVT)/Toronto Francophone HIV/AIDS Working Group developed a common interagency referral form.
— Toronto HIV Network

Volunteer HIV Core Training Program moved from a pilot project to a program.
— Toronto HIV Network

Challenges

Competing priorities sometimes prevent us from making progress on some initiatives. Scheduling meetings is sometimes challenging, given that fact that many committee/working group members have other commitments.
— African and Caribbean Council on HIV/AIDS in Ontario

Keeping community members engaged in committees and working groups remains a challenge. More concerted efforts will be made to consult with them regarding how they want to engage, as well as what means of communication and timing work best for them.
— African and Caribbean Council on HIV/AIDS in Ontario

Staff turnover affects the momentum of shared projects/ collaborations.
— AIDS Bereavement and Resiliency Program of Ontario, Gay Men's Sexual Health Alliance

It can be a challenge dealing with multiple players who all want control over designing the training instead of taking a team player role. To deal with this, the working committee took the time to develop a decision-making process that everyone agreed to.
— Ontario HIV and Substance Use Training Program

Managing the Injection Drug Use Outreach Network (IDUON) is taking more time and resources than anticipated. However, this is also good news as it demonstrates the network's success.
— Ontario HIV and Substance Use Training Program

Being a member of HIV Resources Ontario (HRO) often highlights the need for collaborative efforts between members regarding training opportunities and so as a member, we have increased our collaboration with other members who provide similar training.
— Ontario AIDS Network

Our only barrier is resource limitations. Although we have not turned any consult requests away, we are sometimes not able to provide the level of support needed. We recently began sending a Tips and Tools newsletter to ASO executive directors and board chairs to focus in on specific topics like planning and to highlight tools we have available for support. About 50% are reading it and going to the website to see the tools we are promoting.
— Ontario Organizational Development Program

THN has been challenged by multiple issues, priorities and projects. Strong support for direction and problem solving is provided by steering committee/co-chairs. For example participation by steering committee members is increasing: steering committee has booked quarterly meetings for the program year.
— Toronto HIV Network

Community development work, by nature, requires process, engagement and time. Since both provincial WHAI staff started approximately a year ago, much of this reporting period (and last) were dedicated to meeting and learning about the work people in the sector are doing and learning about existing or potential partnerships.
—Women and HIV/AIDS Initiative

We are finding that we have limited time for staff to attend meetings or other events which might offer additional community development opportunities and connections helpful to THN's work.
— Toronto HIV Network

Challenges have included varying understandings of what community development means in context of WHAI, varying approaches in different regions and staff changes.
— Women and HIV/AIDS Initiative

Role of peers

Depending on the focus of their work, provincial organizations define peers differently. They include people living with HIV, people living with hepatitis C, long-term HIV survivors and multiple loss survivors (without having HIV), people with previous experience of drug use, members of populations at risk e.g., gay, bisexual and other men who have sex with men; women from African, Caribbean, Black and Indigenous communities; women and men who use drugs.

All organizations engage peers in their community development and other work. Peers may:

- Be staff, board members and volunteers
- Serve on working groups
- Help delivery workshop presentations
- Help plan campaigns
- Give conference presentations.

The amount of time that peers are involved varies depending on the role of the organization.

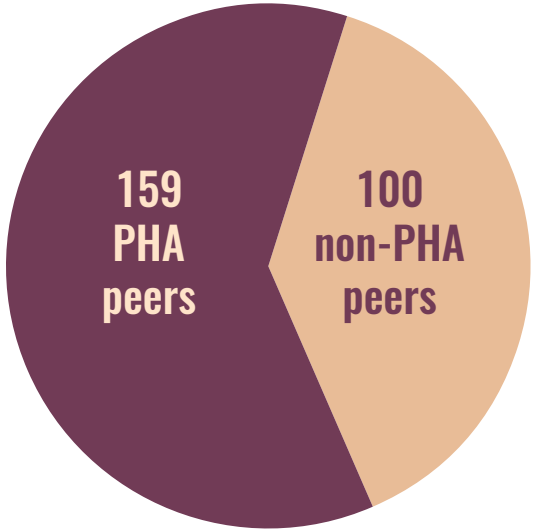
Resources

In 2016-17, the organizations developed and revised several resources and distributed a total of 267,973 copies, which is down from previous years—likely due to the ongoing shift to online resources.

CATIE, whose primary role is to develop educational resources, distributed most of the total number of items: **239,669**. However, all organizations produced resources during the year. Most resources were distributed to or through frontline service providers, to people living with HIV and to members of the organizations themselves.

259 peers

organization	PHA peers	non-PHA peers	Total number of peers
ACCHO	24	62	86
WHAI	7	4	11
THN	5	1	6
GMSH	49	28	77
OHSUTP	5	1	6
CAAT	65	—	65
OAN	2	—	6
CATIE	2	—	2



Below are a selection of resources developed in 2016-17 that are shareable across the sector and will be available through the HIV Resources Ontario (HRO) website:

- Board self-assessment tools and staff workplan guides from the Ontario Organizational Development Program (OODP)
- *Trans 101 with HIV Risks and Harm Reduction* (OHSUTP)
- New toolkits, including *Women, HIV & Stigma: A Toolkit for Creating Welcoming Spaces,* from the Women and HIV/AIDS Initiative (WHAI)
- Resources to help reduce HIV/AIDS stigma in faith/spiritual communities, such as *It Takes Courage*, from the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO)
- *Supporting PHAs employment preparedness: Lessons learnt from the Legacy project* from the Committee for Accessible AIDS Treatment (CAAT)
- A resiliency framework from the AIDS Bereavement and Resiliency Program of Ontario (ABRPO).

Seven awareness campaigns in 2016-17

- **World Hepatitis Awareness Day** (CATIE)
- **Aboriginal HIV/AIDS Awareness** (CATIE)
- **ACB Canadian HIV Awareness Day** (CATIE)
- **World AIDS Day** (CATIE)
- **The Sex You Want** (GMSH)
- **It Takes Courage** (ACCHO)
- **State of the HIV Sector 2016** (OAN)

Digital and social media

The ten provincial organizations reached a total of **736,460** unique visitors through their digital and social media efforts. Some, particularly CATIE, which is responsible for broad public education, rely on online resources and social media to deliver education. CATIE was responsible for **93%** of all online and social media activity. The GMSH, with its The Sex You Want campaign, was responsible for more than **5%** of online activity.

The Ontario HIV Treatment Network (OHTN)

The OHTN, one of the provincial HIV Resources Ontario (HRO) organizations funded by the AIDS Bureau, focuses specifically on research and evidence that can be used to strengthen all HIV programs and services in Ontario. The OHTN gathers that research and evidence in different ways:

- by funding and conducting relevant research
- by synthesizing research/evidence developed by others
- by gathering and analyzing data on HIV in Ontario related to the epidemiology of HIV, clinical care and outcomes of people living with HIV and the prevention, care and support services provided by community-based organizations.

The OHTN also provides backbone supports for Ontario's HIV sector, including providing a rapid response/knowledge synthesis service, assisting HIV programs and services with evaluation, funding a residency program for physicians who want to specialize in HIV care, supporting the Ontario HIV Outpatient Clinic Network (OCN) and the network of HIV pharmacists and organizing knowledge sharing events and opportunities (e.g. conferences, webinars, education days).

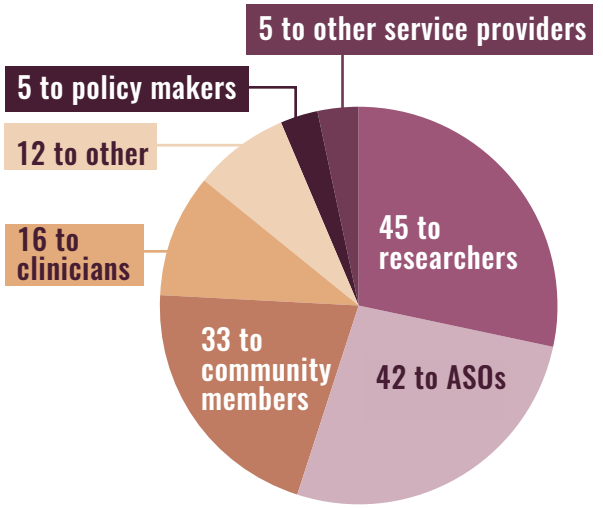
Presentations

The OHTN's presentations consisted mainly of information sessions, consultations, capacity-/skills-building sessions and networking sessions for individuals and organizations actively involved in providing HIV services in Ontario.

Presentation delivery by department

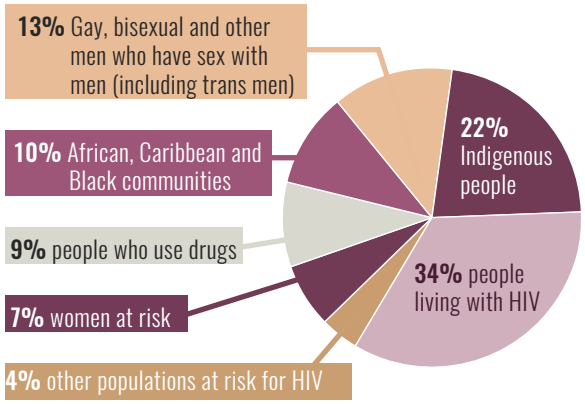
- research funding program (46)
- evidence-based practice unit (29)
- in-house research program (23)
- education and training (22)
- applied epi unit (15)
- OCS (14)
- KTE (9)

158 presentations delivered by the OHTN



Presentation topics

Working with priority populations



Goals of the HIV/AIDS Strategy to 2026

1. Improve the health and well-being of populations most affected by HIV
2. Promote sexual health and prevent new HIV, STI and hepatitis C infections
3. Diagnose HIV infections early and engage people in timely care
4. Improve health, longevity and quality of life for people living with HIV
5. Ensure the quality, consistency and effectiveness of all provincially funded HIV programs and services

Number of presentations/trainings/meetings by primary focus

	GIPA	EBP	Social determinants of health	Engagement in care	HIVCLIN	Program science
Information sessions	16	9	19	19	8	2
Consultations	4	17	5	2	4	6
Skills building	11	3	2	7	1	1
Network meetings	3	2	4	–	3	3
Total in 2016-17	34	31	30	28	16	12

Priority populations

Almost all OHTN presentations, trainings, consultations and network meetings were relevant to at least one priority population:

- 34% people living with HIV
- 22% Indigenous people
- 13% Gay, bisexual, and other men who have sex with men (includes trans men)
- 10% African, Caribbean and Black communities
- 9% people who use drugs
- 7% women at risk
- 4% other populations at risk for HIV

Strategy goals

158 presentations by goal:

- Goal 1 (60)
- Goal 2 (2)
- Goal 3 (18)
- Goal 4 (43)
- Goal 5 (35)

Education and training

The OHTN produces and promotes a number of online education modules.

In 2016-17 **694** users completed an OHTN online education module:

- 320 ASO service providers
- 181 researchers/academics
- 157 community members (i.e. service users, people living with HIV, people at risk)
- 16 clinical service providers
- 20 other (non-HIV) service providers

In 2016-17, the OHTN developed and/or updated 21 modules including:

- OCHART section updates (5)
- OCHART tracking tools (3)
- OCASE reports (10)
- OCS section updates/reports (3)

In 2016-17 707 people received training from the OHTN on the use of various data tools:

- 445 ASO service providers
  - 183 in OCHART
  - 199 in OCASE
  - 63 in HIV View
- 236 other service providers—all in OCHART
- 26 others—mainly OCS data collectors

Data cuts

The OHTN is the steward of several key HIV databases—HIV epidemiological data, OHTN Cohort Study (OCS), Ontario Community-Based AIDS Service and Evaluation (OCASE), HIV View, OCHART—and regularly received requests from programs for data they used to inform their services, make presentations to their boards and complete their OCHART reports.

In 2016-17, the OHTN received **364** requests for data.

The OHTN cohort study (OCS)

In 2016-17, the OHTN Cohort Study (OCS) actively followed:

3,407 people living with HIV receiving care in one of nine clinics across the province:

- St. Joseph's Hospital, London
- Maple Leaf Medical Clinic, Toronto
- Ottawa General Hospital, Ottawa
- Sunnybrook Hospital, Toronto
- St. Michael's Hospital, Toronto
- Sudbury Regional Hospital, Sudbury
- University Health Network, Toronto
- University of Ottawa Health Services, Ottawa
- Windsor Regional Hospital, Windsor

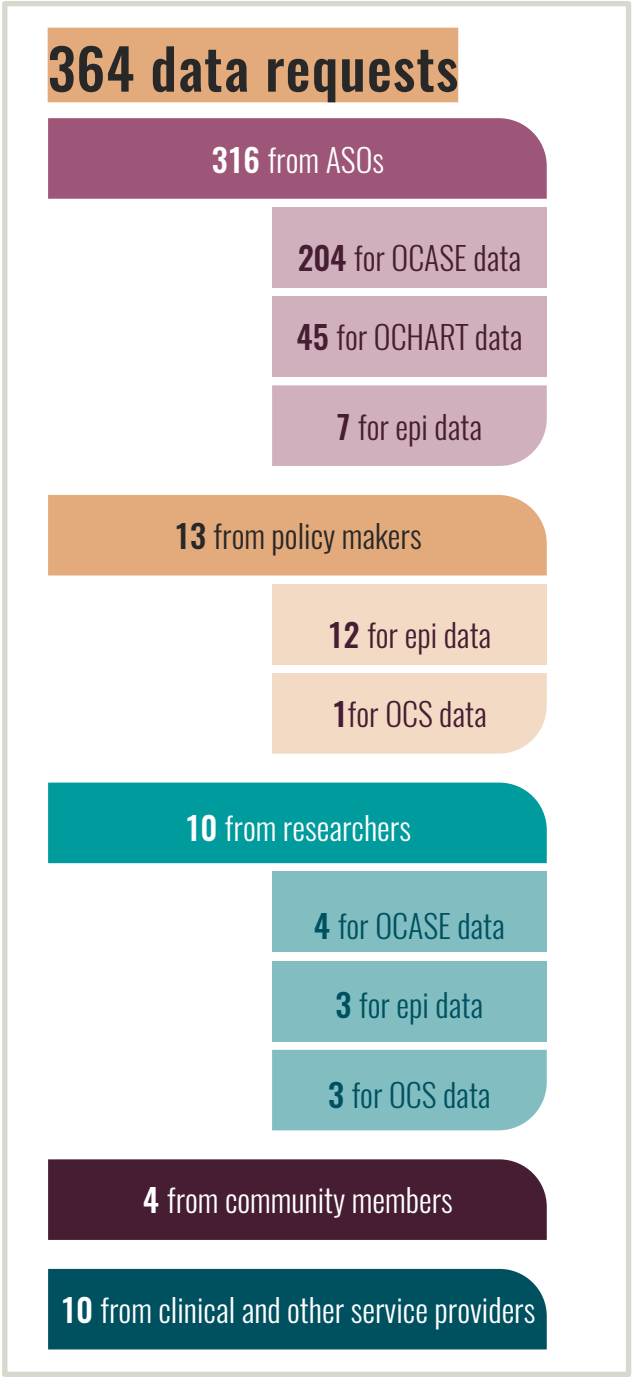
Of those:

- 3,207 were existing members of the cohort
- 155 were new
- 2,747 were male (includes trans men)
- 615 were female (includes trans women)
- 2,291 were men who have sex with men
- 654 were African, Caribbean or Black
- 222 were people who use drugs
- 281 were Indigenous

2,233 completed the OCS interview questionnaire.

Percentage of OCS participants in each region who completed the interview in 2016-17:

- 62% Toronto
- 70% South Western Ontario
- 81% Ottawa
- 57% Northern



Research initiatives by goal and priority population targeted

	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5
People living with HIV	5	4	–	32	11
Gay/bisexual/ MSM (includes trans men)	6	16	2	4	5
ACB communities	7	10	2	–	10
Indigenous people	2	–	–	1	3
People who use drugs	3	–	2	4	2
Women at-risk (includes trans women)	4	2	–	1	3

Funded research

In 2016-17 the OHTN invested approximately **$3,000,000** in 77 research grants. In addition, 19 grants were completed and 20 researchers received salary support.

77 grants, by priority population:

- People living with HIV (30)
- Men who have sex with men (19)
- African, Caribbean and Black (15)
- People who use drugs (6)
- women at risk (4)
- Indigenous communities (3)

In terms of the strategy goals, the majority of the research projects were focused on

- Goal 4—improving the health, longevity and quality of life of people living with HIV
- Goal 5—ensuring the quality, consistency and effectiveness of HIV services,
- Goal 2—enhancing sexual health and reducing new infections and
- Goal 1—improving the health and well-being of populations most affected by HIV.

A relatively small proportion of research projects look at testing and diagnosis: a gap that should be addressed in future years.

KTE materials and resources

193 KTE products created, 2016-17

- 59 tools
- 52 peer-reviewed publications
- 45 reports
- 20 fact sheets
- 17 rapid responses

Target audiences

- ASOs
- Researchers
- Community (people living with HIV, people at risk, service users)
- Clinical service providers
- Other service providers
- Policy makers

Focus

- Evidence-based practice
- HIV clinical care
- Social determinants of health
- Engagement in care
- HIV prevention
- GIPA/MIPA
- Program science

Goals

KTE materials and resources were designed to ensure consistency and effectiveness of services (Goal 5), improve health, longevity and quality of life for people living with HIV (Goal 4) and enhance the overall health and well-being of populations at risk (Goal 1).

Social media

In 2016-17, the OHTN contributed to traditional and online media 3,200 times and reported **126,573** engagements. Engagements account for sharing, comments and/or retweets from social media followers and website users while contributions account for new materials posted by the OHTN across platforms.

More than three-quarters of all social media activity (77%) was designed to share knowledge or promote events/ opportunities, while less than one-quarter (23%) was intended to promote the OHTN.

Conferences and retreats

866 participants attended conferences, retreats and other OHTN-organized KTE events:

- 234 researchers
- 202 ASOs
- 118 service users/community groups
- 108 clinicians
- 70 other service providers
- 26 policy makers
- 108 others

Of those, **665** attended one of the two HIV Endgame conferences. These conferences focused specifically on the priority populations and on interventions across the prevention, engagement and care cascade.

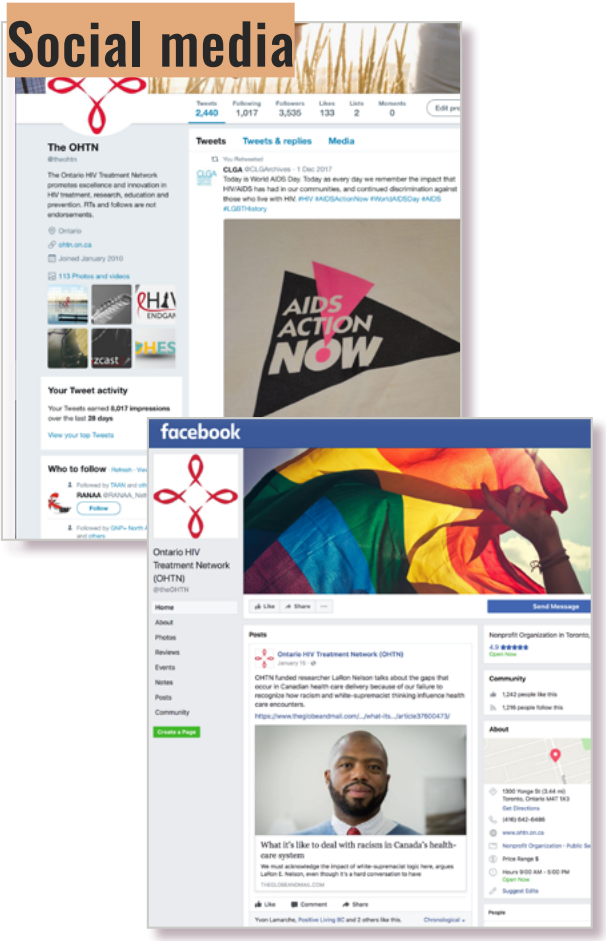
Impact of OHTN initiatives

OCHART KTE day

94% of evaluation respondents rated OCHART KTE day as having achieved its objective to provide an overview of the key highlights from View From the Frontlines as 'very' or 'extremely' well.

Attendees reported they intended to take the following actions after the KTE Day to share what they learned with colleagues and change agency practices by:

- sharing the View From the Frontlines report with colleagues;
- providing an overview of the key data presented at staff meetings;
- sharing the OCASE Priority Populations Key Definitions FAQ with all staff at the agency/team;
- sharing the link to the Provincial HIV Strategy with staff/colleagues;
- integrating the OCASE intake/client profile exercise and handout as part of the staff training process;
- encouraging consistent use of the OCHART prevention tracking tool to improve data quality.



Social media platform	Engagements	Contributions
OHTN website	103,455	456
Monthly newsletter	8,200	55
Facebook	850	202
Twitter	6,500	1,670
YouTube	7,568	817

HIV Endgame I: Closing the gaps in the care cascade

- **84%** of clinically-focused attendees identified that the conference was relevant to their practice.
- **92%** agreed/strongly agreed that the conference enhanced their knowledge.
- **90%** agreed/strongly agreed that the conference included the latest information about HIV prevention and treatment strategies and promising interventions to improve health outcomes for people living with HIV.
- **82%** agreed/strongly agreed that the conference highlighted the roles that clinicians, service providers, policy makers and community members can play in a coordinated cross-sector effort to end HIV.
- **98%** agreed/strongly agreed that the conference featured research that impacts the lives of people living with/at risk for HIV.
- **84%** agreed/strongly agreed that the conference encouraged them to think about practical applications of research findings.
- **81%** agreed/strongly agreed that they can apply what they learned at the conference to their life/work.

Furthermore, the conference impacted other knowledge exchange events as three conference scholarship applicants applied to attend the Tools for CBR online course offered from the OHTN Education and Training Unit. Also, Gary Bloch, who presented on the Poverty Clinical Tool for Primary Care Providers later presented to the members of the Ontario HIV Outpatient Clinic Network (OCN) quarterly meeting, along with providing his presentation. Clinics are now using the screening tool and it has been included in the Provincial Guidelines for HIV Care.

HIV Endgame II: Stopping the Syndemics that Drive HIV

- **93%** of attendees agreed/strongly agreed that the conference featured research that impacts the lives of people living with/at risk for HIV
- **87%** agreed/strongly agreed the conference enhanced their knowledge
- 84% agreed/strongly agreed the conference highlighted interventions and approaches that can be used to lessen the impact of syndemics on health and strengthen efforts to combat HIV.

In addition, the conference featured a memorial room dedicated to former Peer Research Associates, some of whom had passed away quite recently. A community debriefing circle for multiple losses was held. It was a time to reflect on the impact that these losses have had and on conference attendees' processes of saying goodbye. It was also a time to consider ways to honour their contributions.

OHTN's ongoing development of Indigenous Research Initiatives (IRI) was highlighted by the coordination of an Indigenous People Living with HIV panel. Indigenous and decolonizing practices were supported to highlight successes and challenges in communities in Ontario.

Hepatitis C in Ontario

Reported rates of hepatitis C by public health unit of residence

Rates of hepatitis C infection per 100,000 population

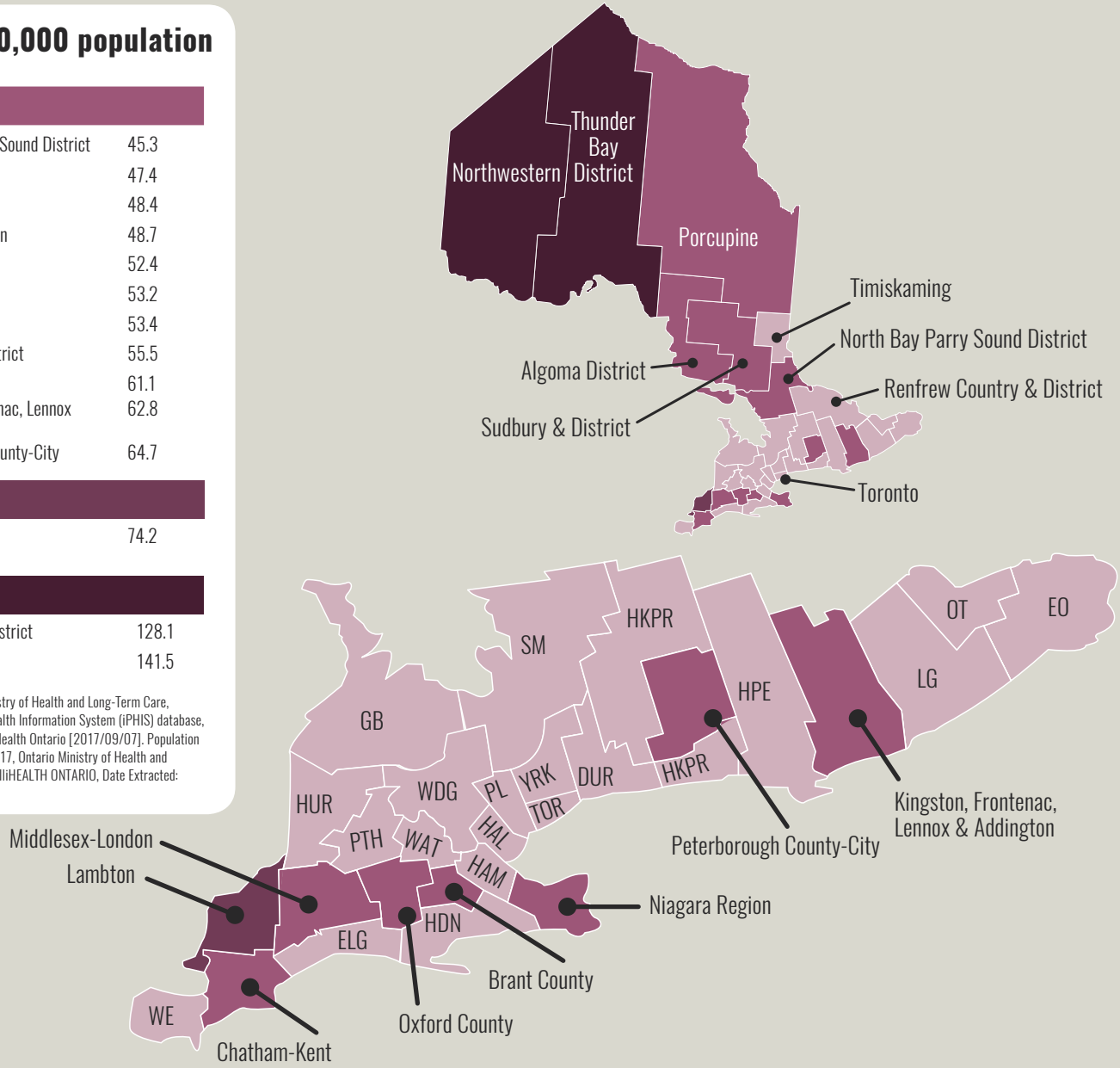
14.1 – 41.4		
DUR	Durham Region	23.3
EO	Eastern Ontario	15.6
ELG	Elgin-St. Thomas	31.9
GB	Grey Bruce	21.4
HDN	Haldimand-Norfolk	32.6
HKPR	Haliburton, Kawartha, Pine Ridge	40.3
HAL	Halton Region	16.8
HAM	City of Hamilton	41.2
HPE	Hastings-Prince Edward	39.7
HUR	Huron County	37.8
LG	Leeds, Grenville & Lanark District	38.3
OT	City of Ottawa	22.6
PL	Peel Region	23.5
PTH	Perth District	20.4
RF	Renfrew	33
SM	Simcoe Muskoka District	35.6
TOR	Toronto	17.7
TSK	Timiskaming	22
WAT	Waterloo Region	21.1
WDG	Wellington-Dufferin-Guelph	25.7
WEC	Windsor-Essex County	35.3
YRK	York Region	13.6

41.5 – 68.7	
North Bay Parry Sound District	45.3
Chatham-Kent	47.4
Brant County	48.4
Middlesex-London	48.7
Porcupine	52.4
Oxford County	53.2
Niagara Region	53.4
Sudbury and District	55.5
Algoma District	61.1
Kingston, Frontenac, Lennox & Addington	62.8
Peterborough County-City	64.7

68.8 – 96.0	
Lambton County	74.2

96.1 – 141.5	
Thunder Bay District	128.1
Northwestern	141.5

Source: Ontario Ministry of Health and Long-Term Care, integrated Public Health Information System (iPHIS) database, extracted by Public Health Ontario [2017/09/07]. Population Projections 2016-2017, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [2017/02/01].



Hepatitis C in Ontario 2016

Through the Ontario Ministry of Health integrated Public Health Information System (iPHIS) database, Public Health Ontario extracts annual counts of hepatitis C cases by age and health region.

In 2016, there were **4,346** reported confirmed cases of hepatitis C in Ontario: an increase of 83 cases (2%) from 2015.

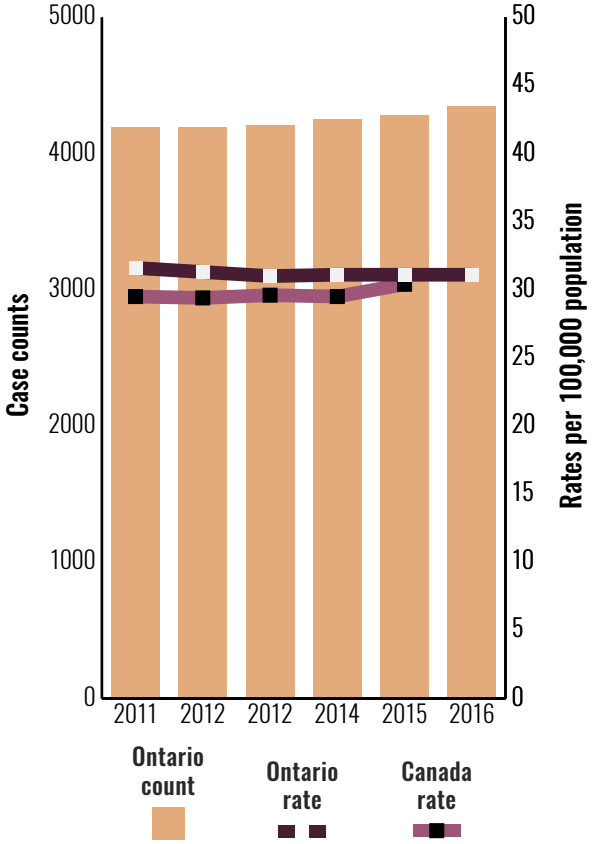
More than 8 out of every 10 (84%) people diagnosed with hepatitis C reported at least one risk factor:

- 1,970 (54%) reported injection drug use.
- 573 (16%) reported high risk sexual activity.
- 247 (7%) reported having a blood transfusion.
- Many more reported having other possible risks, such as being born in a country where HCV is endemic, occupational exposure, mother to child transmission, 'other' sexual activity or receiving an organ transplant.

The number of hospitalizations also increased from 28 in 2015 to 34 in 2016. The number of deaths remained stable.

Rates of hepatitis C were highest in North Western, followed by Thunder Bay; Lambton County; Peterborough County-City; Kingston, Frontenac, Lennox and Addington; Algoma District; Sudbury District; Niagara Region; Oxford County.

Number of reported rates of confirmed hepatitis C cases by year: Ontario and Canada, 2011-2016



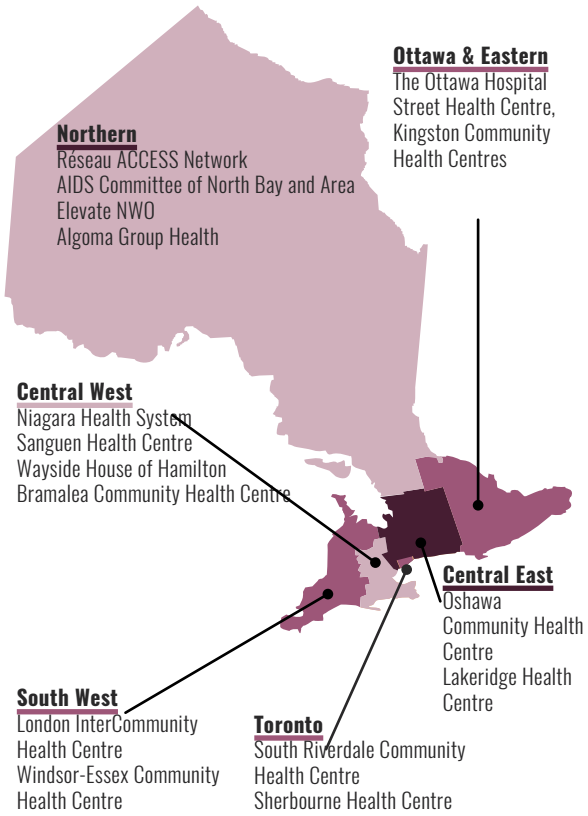
4346 hepatitis C cases in Ontario

34 hospitalizations (0.8%)

19 deaths (0.4%)

Note : Data provided by the Public Health Ontario Laboratory

HCV team locations



HCV care cascade

At risk	Screened for HCV antibody	Tested for RNA	Engaged in care	Pre-treatment	On treatment	Post-treatment	Affected
People at risk who receive education and case management services to reduce their risk	People who are screened for HCV antibody either by blood draw or HCV point of care test (POCT)	People who tested HCV antibody positive (or HCV POCT reactive) and have received an HCV RNA test to confirm active HCV infection	People with HCV who receive clinical and case management services	People who are being worked up for treatment (yet to start treatment) and require pre-treatment care	People who are on treatment	People who have completed treatment	People who are partners, friends or family members of people with HCV who receive education and support services

Ontario's hepatitis C teams

In 2016-17, the AIDS and hepatitis C programs funded:

- 15 hepatitis C teams with a total of 75 full-time positions—down from 85 in 2015-16
- 1 nurse at Lakeridge Health in Oshawa
- 1 dedicated outreach worker at the Prisoners with AIDS Support Action Network (PASAN) who connects with people involved in the correctional system
- 1 case coordinator at the Sioux Lookout First Nations Health Authority who coordinates supports for 31 First Nations communities in Northwestern Ontario
- hepatitis C education and mentoring for HCV Team members, to be provided by CATIE and University Health Network.

HCV teams work collaboratively with physicians to provide HCV care and treatment, education, outreach and support services to people living with or at risk of HCV. The services clients use vary based on where they are along the HCV care cascade. HCV teams offer a range of engagement, case management and clinical services. The most intense users of services are clients living with HCV, followed by those who are pre-treatment or

at risk. As people move through the care cascade, they require fewer services. This is likely due to improvements in treatment, which now only takes 12 weeks for most people.

Who did we serve in 2016-17?

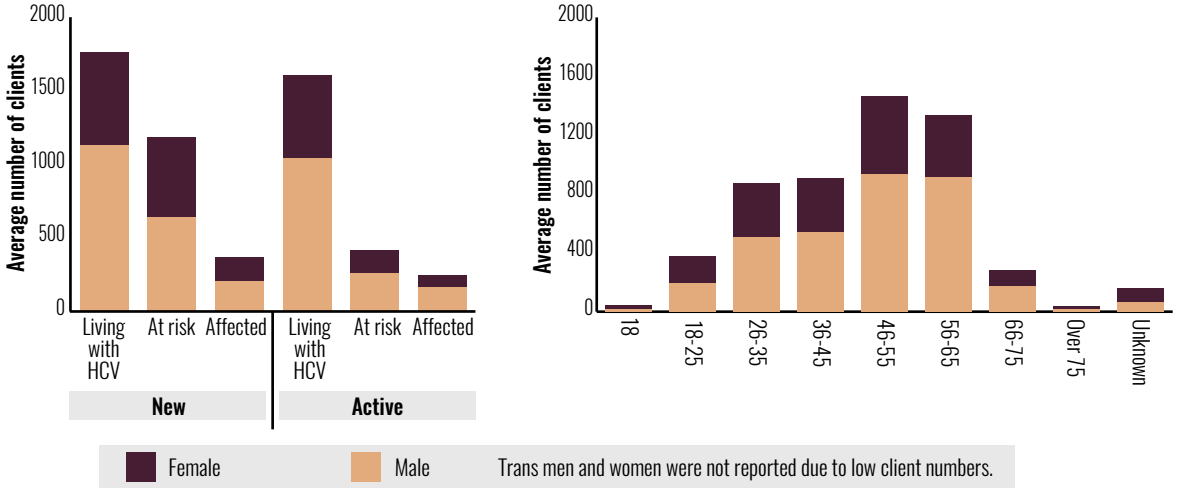
In 2016-17, the HCV programs served about **5,618** unique clients—down about 18% from 6,881 unique clients served in 2015-16.

Although people living with HCV still account for 60% of all clients, that proportion is dropping while the proportion at risk is increasing. This is likely due to the growing number of people with HCV who have received and completed treatment, as well as the increased focus on prevention and testing. The trend of HCV teams seeing more people at risk is particularly clear looking at new clients where 35% were at risk compared to existing clients where 18% were at risk.

Age

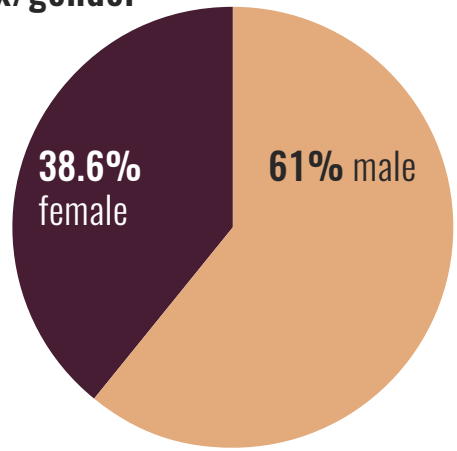
53% of clients (55% of males and 45% of females) are between the ages of 46 and 65.

Average number of new vs active clients served by sex/gender and client types, 2016-17

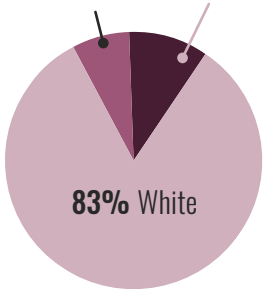


Clients served

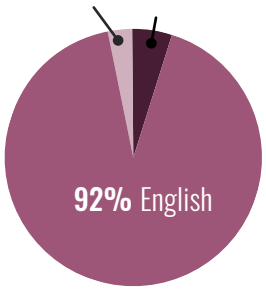
Sex/gender



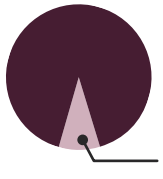
Ethnicity



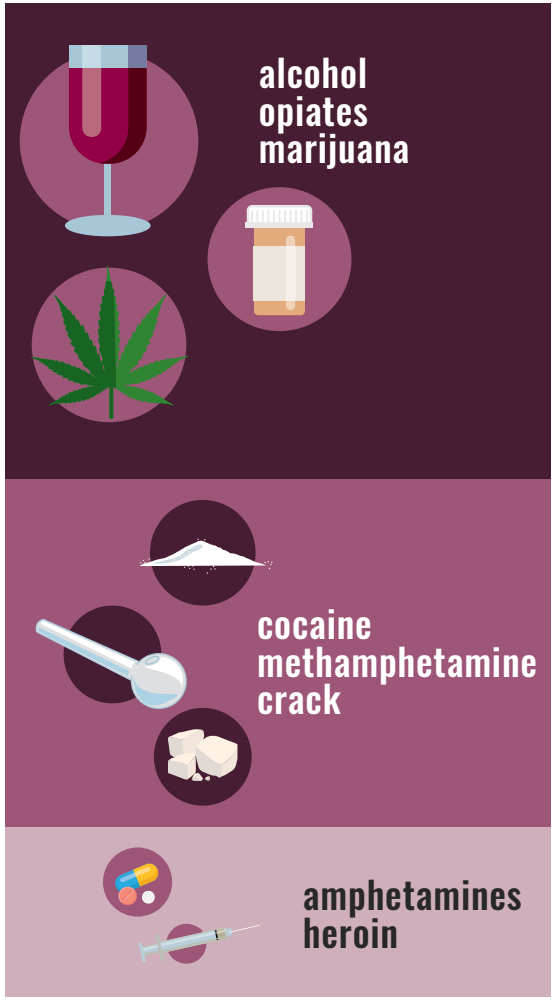
First language



Birthplace



Used substances Commonly reported *



* Rankings based on scores assigned to the top three reported substances per program.

Co-infections

26% fewer clients were co-infected with HIV this year over last (78 in 2015-16 to 58 in 2016-17) but this year, more are co-infected with hepatitis B. The increase in reported hepatitis B co-infections (from 3 to 25 or 833%) is likely due to increased precautionary testing because of concerns that new direct-acting HCV antivirals may reactivate HBV.

Substance use

The most commonly used drugs reported by clients were: alcohol, opiates and marijuana. While alcohol, opiates and marijuana were the top three reported substances in agencies across Ontario, for a few agencies, cocaine, methamphetamines, crack or heroin were the most reported substances.

What services did clients use?

Overall, the most used services are: health teaching, follow-up appointments, testing (blood work), intake/assessment and counselling.

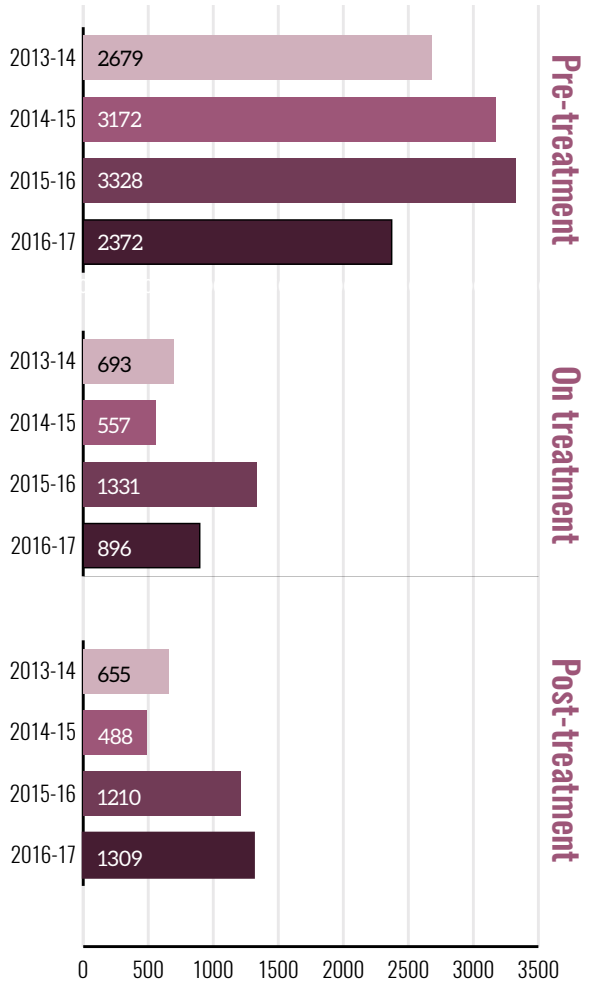
In 2016-17:

- **At-risk clients** mainly used counselling, assessment, health teaching and testing services.
- **Clients living with HCV** mainly used health teaching, appointments, testing, assessment and practical assistance services.
- **Pre-treatment clients** mainly used assistance to apply for treatment as well as referral, counselling, assessment, testing and health teaching services.
- **Clients in treatment** mainly used appointment, health teaching and testing services.
- **Post-treatment clients** mainly used follow up appointments, health teaching, testing and counselling services.
- **Affected clients** mainly used counselling, practical assistance and referral services.

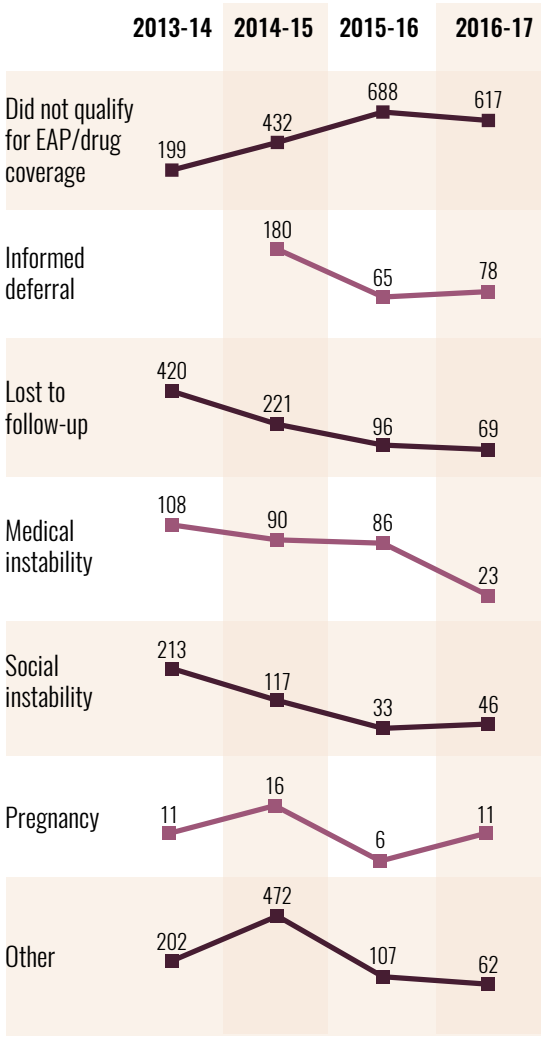
Number of services used by stage of care

Services	At-risk	Pre-treament	Living with HCV	On treatment	Post-treatment
Support groups treatment	64	89	209	64	116
Vaccinations	76	166	187	87	42
Appointment/lab accompaniment	33	144	343	64	53
Individual advocacy	88	219	446	116	115
Application completion	35	549	421	323	99
Referrals	332	623	668	161	88
Practical assistance	302	398	841	168	180
Counselling/support	444	791	945	265	186
Pre-/post-test counselling	1215	851	1178	251	251
Intake and/or assessment	1012	1157	1447	227	137
Blood work	965	1274	1497	538	494
Follow-up appointment	759	1210	1781	680	585
Health teaching/ treatment information	1079	1913	2465	663	566
Total	6404	9384	12428	3607	2912

Total number of clients by treatment continuum stage



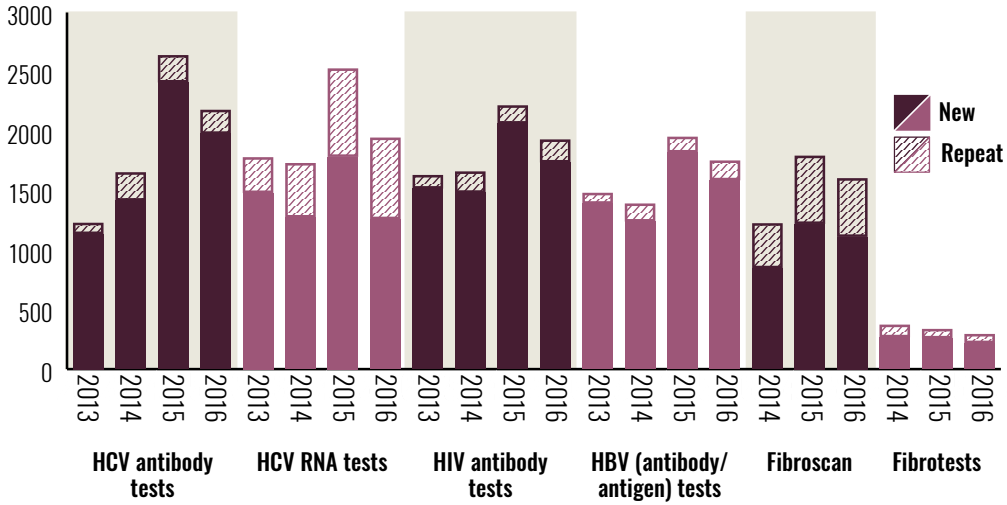
Reason for not receiving treatment



This year over previous years, the trend shows a reduction in systemic barriers due to greater access and improvements to medications.

Fewer tests

While teams described being involved in more HCV testing initiatives and partnerships, they reported fewer total tests in 2016-17 than in previous years. Five agencies reported a reduction in testing of 40% or more this year over last. Some of these teams reported having vacant positions during the year, which would have affected the number of tests. Some teams also talked about putting more focus on partnerships and outreach to address the opioid crisis, which may mean that more testing was done by partner agencies and, therefore, not reported by the teams themselves. The most significant decreases were in HCV antibody tests and HCV RNA tests.



Smaller caseloads

All but one HCV team reported smaller caseloads in 2016-17 than in the previous year, with four teams accounting for the majority of the caseload reduction. The large drop in those teams may be due to vacant positions. With newer medications and more people now eligible for treatment, the time between diagnosis and initiation of treatment appears to be much shorter—fewer people are remaining at the pre-treatment stage—and therefore move through the care cascade faster.

Fewer clients lost to follow up/more clients completing treatment

Over the past four years, there has been a marked decrease in the number of clients lost to follow up (69 in 2016-17 compared to 420 in 2013-14) and in the number who withdraw from treatment (27 in 2016-17 compared to 88 in 2013-14). These trends are likely due to shorter wait times from diagnosis to treatment and the newer treatments with fewer side effects. With the shorter wait times for treatment and short treatment cycle (12 weeks for most people), it is easier for clients whose lives are unstable to stay in care. Fewer side effects mean that clients are less likely to withdraw from treatment.

Fewer clients medically and socially unstable

In terms of the reasons why clients do not receive treatment, fewer clients were medically or socially unstable than in past years.

Where are programs providing outreach?

The HCV teams continue to do active outreach to engage people at risk or living with HCV in prevention, testing and treatment services.

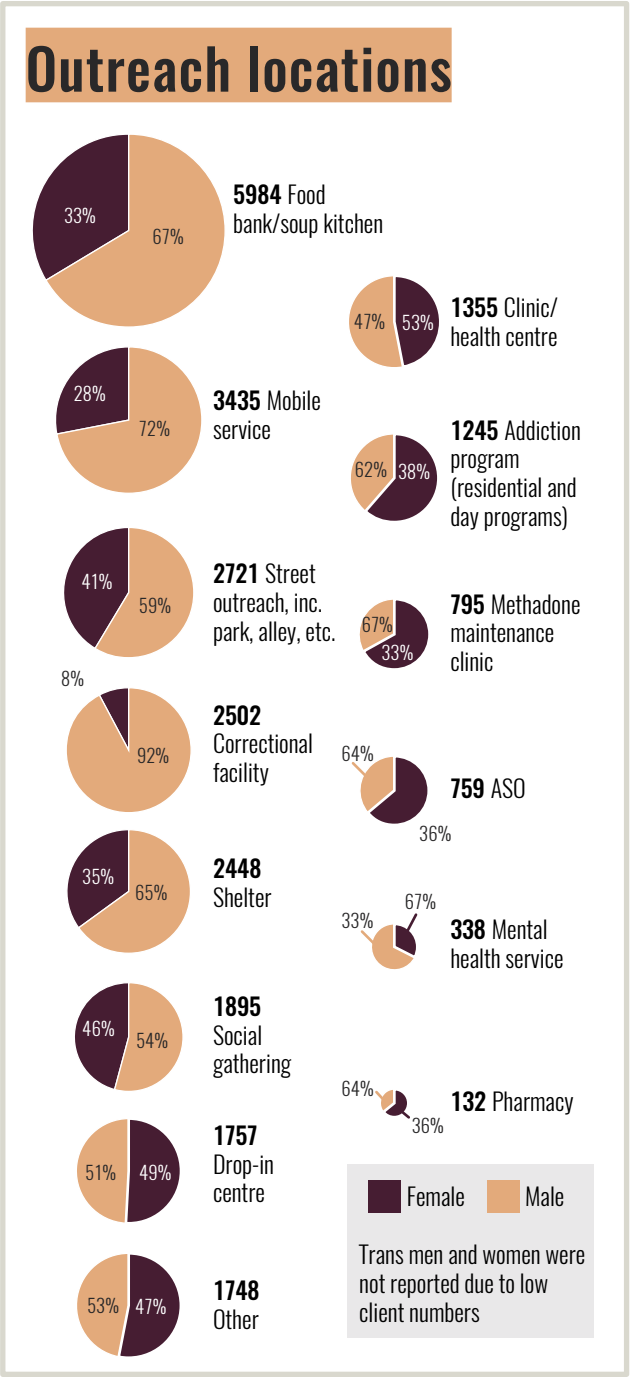
In 2016-17, the most common locations for outreach were:

- foodbanks/soup kitchens
- mobile services (e.g. vans)—the increase was due mainly to one agency that introduced a new mobile service)
- street outreach
- correctional facilities
- shelters
- social gatherings.

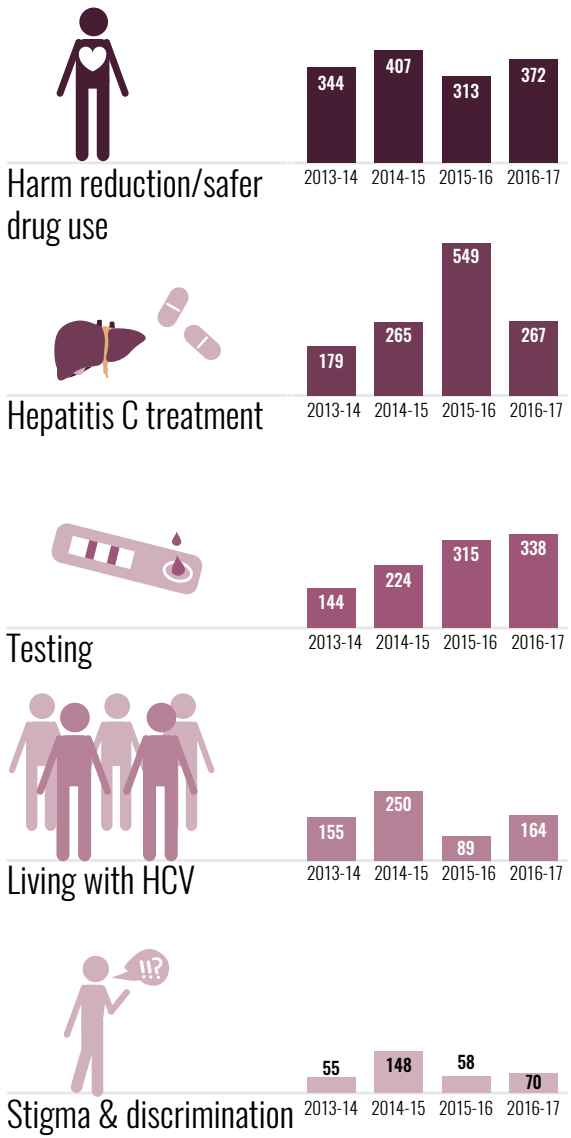
Compared to previous years, programs reported fewer outreach contacts through addiction programs, clinics/health centres and drop-in centres.

Who are they reaching?

64% of all outreach contacts are male.



Common education topics



Providing education

As part of their prevention and education efforts, HCV teams mainly present to drug users, service providers and people living with HCV. They delivered a total of **762** presentations to 10,999 participants in 2016-17 down from **831** presentations to **13,994** participants in 2015-16.

Total number of presentations, 2016–17

Population targeted	Harm reduction/ safer drug use	Testing	Hepatitis C treatment	Other	Living with HCV	Stigma & discrimination	Co-infection	STIs/ safer sex	Safer tattooing/ piercing
People who use drugs	280	262	155	74	105	27	4	7	2
Service providers, professionals	226	119	160	85	24	33	7	1	–
People living with HCV	38	130	51	19	89	26	2	1	1
People involved with the correctional system	39	14	19	32	24	5	–	–	3
Health care providers	17	19	44	20	3	4	3	–	
General public	12	24	23	28	9	4			1
Indigenous people	22	15	17	21	10	6	3	4	
People who have tattoos and/or piercings	29	32	4	3	1	1	–	–	1
Students	16	3	7	12	5	10	–	–	2
Policy makers	12	–	–	15	6	3	–	–	–
Total number of presentations	**691**	**618**	**480**	**309**	**276**	**119**	**19**	**13**	**10**

How do the HCV teams engage peers?

HCV teams actively engage people with lived experience (peers) in delivering their services. In 2016-17, 519 peers were involved across all programs. Compared to the previous year, peers were more involved in providing outreach, planning/delivering awareness campaigns and developing/delivering resources. These shifts are likely due to the intense focus on distributing naloxone and providing training as a response to the alarming increase in overdoses and overdose deaths related to fentanyl.

Successes

Better process and programs

> We have changed our process. A new client meets with our social worker before meeting our nurses. This allows us to better support our clients right from the start. We provide naloxone education in the North Bay Jail. Staff and prisoners have said they appreciate this service.
> **— AIDS Committee of North Bay and Area**

> We continue to engage at-risk or known HCV antibody-positive individuals in locations where they are already receiving other services and in collaboration with community partners (e.g. methadone clinic, Canadian Mental Health Association (CMHA), nurse practitioner-led clinic). We accept self-referrals to reduce barriers to care, especially for more vulnerable populations. Healthcare service is adapted as necessary and more formal collaborations in the community for outreach will be initiated during the second half of this fiscal year to improve access.
> **— Lakeridge Health Centre**

> The outreach worker is now accessible weekly to one men's shelter and one co-ed shelter providing education and support to Indigenous-specific transitional housing.
> **— Niagara Health System**

Number of peers per activity type

81	Face to face outreach
69	Awareness campaign delivery
65	Resource distribution
63	Participation with group facilitation
59	Awareness campaign planning
49	Resource development
29	Community development meetings
28	Longer workshops/workshop series
28	Short/one-time education presentations
23	One-on-one in-service education
18	Patient advisory board member
7	Conference presentations

The successful roll out of the testing event games have promoted future peer involvement in these HCV educational materials. The game was promoted in the last copy of the CATIE Exchange online newsletter.
— Réseau ACCESS Network

Recruitment and treatment of five clients within the SIMPLIFY Study—a clinical trial of sofosbuvir/velpatasvir conducted with the University of New South Wales, Australia—is now complete though follow-up will continue for two years. Enrollment in our third clinical trial—the D3FEAT Study—is complete and treatment for three clients will take place over the next 10 to 12 weeks. Enrollment in the TCHCP Adherence Study to measure outcomes and predictors of adherence for the new interferon-free hepatitis C medications for clients in our program is ongoing and there are currently 73 people enrolled in the study. Preliminary results were recently presented at [an international] conference where audience members remarked on our strong adherence rates.
— Sherbourne Health Centre

The hepatitis C program has found particular success in visiting one of our local methadone providers to engage clients in testing. We aim to grow to additional methadone sites for the next reporting period. Increased community partnerships with local shelters and the women's correctional institution has broadened our outreach access to clients living at risk of hepatitis C.
— London InterCommunity Health Centre

Recently, we have begun providing naloxone training in partnership with our co-located pharmacy. We attend agencies and provide all-staff training then have the staff each recruit three clients from the at-risk population and provide them with training. To date, this has been very successful with over 100 people having received the training.
— Elevate NWO

We continue to host regular free-of-charge fibroscan clinics to minimize the barriers to care. We plan to expand our nurse outreach by partnering/sharing space with a pharmacy, a mental health and addiction service and the Ontario drug treatment and mental health court and expanding screening/testing at the AIDS Committee of Durham Region.
— Lakeridge Health Centre

Our solution to low drop-in numbers in winter has been to use an off-site neighbourhood resource centre. We hope our continued presence will encourage an increase in attendance. Clients are more apt to make contact with outreach programming if it is presented in a non-clinical, benign way.
— Algoma Group Health

Our stronger peer program has been invaluable in connecting with the community. We will proceed with specialized peer training and mentoring in the upcoming reporting period.
— Bramalea Community Health Centre

We encourage clients to complete intakes upon first meeting in person (or by phone) if they have time, rather than giving them a contact card with an invite to call or a later date for an intake. If not possible, we set up an appointment for when they have other medical appointments in Sioux Lookout or offer a telephone appointment.
— Sioux Lookout First Nations Health Authority

Ongoing evaluation and quality improvement

Client feedback [on the Sanguen Health Centre Mobile Outreach Program] continues to be overwhelmingly positive. Sanguen has used client feedback to shape service delivery such as van routes and supplies to be offered on the van.
— Sanguen Health Centre

Environmental scans identified the need for increased presence in shelters, Indigenous communities and correctional facilities; more available appointments and clinics with the physician at the St. Catharines satellite and Niagara Falls clinic location; more fibroscans in different clinic locations; more nursing clinics at the Fort Erie satellite. Recommendations are being implemented as part of ongoing program planning.
— Niagara Health System

We conducted an evaluation of our peer program to create a more robust program that engages our peers and also keeps them accountable to meeting our objectives. We are finalizing the details of this new peer program and will be rolling this out with the onboarding of our new peers. We also conducted an analysis of the multiple support groups offered around the region. Based on our results, we will be streamlining the number of groups offered as well as restructuring the format of these groups.
— Oshawa Community Health Centre

Feedback from service providers confirms stronger community partnerships and overall awareness of program services which continues to facilitate patient referrals.
— Algoma Group Health

Our "Hep C Basics and Treatment" presentation has been proven to increase knowledge of hepatitis C while the peer program successfully engages people living with, at risk or affected by hepatitis C. Peers report that involvement in outreach has had a significant impact on their personal journey and self-awareness.
— London InterCommunity Health Centre

The west end education sessions at a drop-in program for groups of women/transwomen who identify as injection drug users or sex workers have been well received. The nurse has been asked to return for more regular education sessions. The west end nurse is also in the process of connecting with the healthcare team based at a women/transwomen's drop-in centre to discuss how we might work together for better circles of care, and to offer a clinical HCV education 101 workshop for their staff. At the shared west end HCV group, they have brought in the diabetes education team to do talks on subjects aimed to support people while on treatment as many in the group also have diabetes.
— South Riverdale Community Health Centre

We have become well known in the communities we serve through consistency, reliability and our peer program.
—Bramlea Community Health Centre

The team received feedback and changed our services accordingly to reflect these, including: providing venipuncture, distributing naloxone, providing onsite testing after our presentations, identifying effective strategies to recruit and retain peers and creating a visual menu showing how clients can purchase 17 healthful items from Walmart for under $22. The patients were shocked that they could actually afford to buy healthy food and many reported eating healthier since then.
— Wayside House of Hamilton

Treatment initiation rates have picked up considerably with the expanded eligibility criteria and availability of Epclusa for public funding. With the emergence of Epclusa, St. Michael's Hospital has also begun a slow and steady rollout of treatment starts (about 34 patients/week). The stagger starts ensures that the sicker patients are able to be followed closely and more frequently.
— South Riverdale Community Health Centre

Peers have indicated that they would like to do more outreach work. We are creating more outreach opportunities which will include peers. Peers will be required to do training before they can begin outreach.
— AIDS Committee of North Bay and Area

We are evaluating the best amount of materials to include in our safer injection and safer inhalation kits. We have started consulting with partnering agencies for feedback.
— Elevate NWO

We have implemented a recall process for clients who miss appointments through telephone, referring physician, text or mail. We will continue this practice having noted a decrease of approximately 55% in the number of clients lost to follow-up between H1 and H2.
— Windsor-Essex Community Health Centre

Regular contact with leaders within Indigenous communities increases attendance, engagement and participation at various events and presentations as they will actively promote the HCV services. The increase in detention centre referrals indicates that consistently scheduled in-reach services improve client follow-through upon release.
— Windsor-Essex Community Health Centre

We continue to work with our rural community health centres on improving and strengthening our partnerships with them. Nurse assessment clinics are a successful initiative which decreased our wait time to see a specialist to eight to ten weeks. Further efficiency was found by: prebooking the appointment with the specialist; revising the nurse assessment tool to align with OCHART data requirements; and revising the blood work requisition package. Unfortunately, with the nursing vacancy, these clinics will be on hold. We are looking at doing these clinics monthly during times when there are physician clinic cancellations in order to keep the workload manageable. Treatment start templates have been successfully implemented to standardize documentation. The template is also used for follow-up appointments for patients on treatment. Data collection for OCHART is now on Excel; it was collected on paper by previous coordinator.
— The Ottawa Hospital

Our hepatitis C 101/triage group, which began last year, continues to have an average of about 5 people attending per cycle. It is now exclusively run by one of our community support workers with support from the program coordinator and case manager. Originally run in a more didactic style, the group has evolved into a responsive discussion based on the weekly group composition. This still allows for necessary HCV education to be conveyed but with a flexibility that is more client-centred.
— South Riverdale Community Health Centre

A partnership with local gastrointestinal specialists was reinitiated. These two specialists are providing a half day of client services once per month at Street Health Centre. This has eliminated the referral process and wait time to access hospital services. [We are] working with community partners (e.g. mental health agencies, hospital staff, shelter staff) to break down barriers to referrals and make our program known to the community. Five peers are currently being mentored and supported by our team and have had access to a number of training opportunities.
— Street Health Centre, Kingston Community Health Centres

Providing peers with meaningful opportunities to connect with various individuals or groups through sharing of their lived experience has contributed to increased uptake of testing and seeking walk-in services onsite. We will build upon this practice.
— Windsor-Essex Community Health Centre

Outreach clients value the increased consistency. More people are engaging with our outreach worker. Each client now has a dedicated nurse. This has reduced confusion and duplication among the nurses.
— AIDS Committee of North Bay and Area

Challenges

Processes

Re-engaging with clients who have been lost to follow-up due to treatment deferral has been a challenge as we attempt to reconnect with them and assess them with the new treatment eligibility criteria. It would be helpful to be informed of what the next year looks like (i.e. will fibrosis score continue to be a criterion for treatment?) so that clients are not further discouraged if they continue to be ineligible. A clear timeline from the province for further elimination of restrictions on access to treatment agents would help with patient engagement and retention in care. Nurse practitioner prescribing under Limited Use would increase the number of people that can be managed on treatment.

— South Riverdale Community Health Centre

Now that blood spot testing can be accepted at public health unit labs, we have begun to explore options for low barrier outreach testing. Possibilities include the training of community support workers and other harm reduction workers and the use of our harm reduction satellite sites. We are also developing a plan to address fibrotest barriers: St. Michael's Hospital is currently in discussions with Gilead to contract a mobile fibroscan device and to have a nurse provide fibroscans to clients in the community, potentially integrated with hepatitis C 101 programming.

— South Riverdale Community Health Centre

We need to continue to build stability and trust with new partners in the Region of Peel in order to find more HCV positive clients. We can expand further to include more frequent street outreach. We continue to pursue opportunities to support the Indigenous community and look forward to some further relationship strengthening collaboration with activities including education, screening and treatment.

— Bramalea Community Health Centre

The changing nature of clients' needs in the era of new HCV medication (i.e. less investment required in the preparation phase) has led to potentially changing the focus of our support group.

— Réseau ACCESS Network

Clients have identified sometimes they wait longer than they wish to get a return call back from the nurses. We have a retired nurse volunteer who comes in to triage the voice mails from clients. The volunteer will call people back with appointments if that is what the clients are seeking. This has helped the nurses tremendously … [and] clients get quicker responses.

— AIDS Committee of North Bay and Area

We have been partnering with a local shelter and drop-in space to provide outreach testing but have had minimal testing opportunities. However, our staff continues to engage in conversations about HCV, testing and harm reduction with service users. We are hopeful that the new OCHART tracking tool will better reflect the true nature of our outreach testing. A monthly outreach testing partnership with our local ASO has recently been put back into place. We are striving to better engage our Indigenous community. We have recently made some progress with offering services on the Tyendinaga Mohawk Territory and have been invited to participate in a community meeting. Although this is taking some time, we consider this invitation to be a large step forward.

— Street Health Centre, Kingston Community Health Centres

London is experiencing an outbreak of both HCV and HIV among people who use injection drugs. A leadership team has convened to develop more clearly defined pathways to testing, treatment and support for at-risk populations. Both partner agencies of the hepatitis C program—London InterCommunity Health Centre and Regional HIV/AIDS Connection (RHAC)—are active participants. We have made a commitment to ensure that we have the resources needed to do outreach testing and engagement given this concerning community situation.
— London InterCommunity Health Centre

We aim to implement an internal team process to track our activities more efficiently in tandem with the new online tracking tool that was launched this fiscal year.
— Oshawa Community Health Centre

We have ongoing concerns about crystal meth use and complex mental health issues … [We plan to] enhance our discharge planning process by further engaging the expertise of the social worker participating in the local community drug and alcohol strategy and developing partnerships with mental and public health services.
— London InterCommunity Health Centre

We are continuing to try and improve our outreach testing numbers. Our nurses have been engaging weekly with clients at a local shelter. Consistency will likely be the key to the success of this initiative. We are currently working on a more extensive outreach testing plan.
— Street Health Centre, Kingston Community Health Cente

External factors

Our HCV Support Group has been put on a temporary hold. Our team has been working with peers to redesign this group. Attendance has significantly dropped since our move to our new building in the summer of 2016. A number of building-related issues had to be addressed to make this group as accessible as possible. We are planning on relaunching the group this upcoming summer.
— Street Health Centre, Kingston Community Health Centres

Accessibility of our building continues to be a difficulty in service. The elevator is often not functional. The landlord continues to fix it and is looking into putting in a new elevator in 2018.
— AIDS Committee of North Bay and Area

During the past year, there were an extraordinary number of lockdowns preventing the delivery of many programs. Staff are often not aware that there will be a lockdown until they arrive at the institution. When staff are unable to deliver their programs, they meet one-to-one with clients to provide information regarding HCV prevention, testing and treatment.
— PASAN (Prisoners with HIV/AIDS Support Network)

Resources

St. Michael's Hospital has had issues with slow Employee Assistance Program (EAP) approvals, as well as almost every application being returned with queries. The hospital is currently only applying to Harvoni for genotype 1 and this is the drug that EAP has been very slow to approve. SMH also had many genotype 3 and 4 patients deferred for treatment as we wait for EAP access to Epclusa.
— South Riverdale Community Health Centre

Patients are experiencing barriers to treatment for F1F0. Some are able to participate in Dr. Cooper's clinical investigations when there are research studies underway. There are few treatment options available for groups that are co-infected, genotype 3 or people who use injection drugs. In the meantime, we continue to advocate for the right to treatment for these groups.
— The Ottawa Hospital

We do not have evaluations for this reporting period. We hired the Provincial HCV Program Coordinator position in November after it was vacant for two months and she spent the first few months establishing clearance in the correctional institutions were she will be delivering programming. Due to delays that are inherent in the correctional system, she was able to carry out one presentation from which we did not receive enough evaluation data to answer this question for this reporting period.
— PASAN (Prisoners with HIV/AIDS Support Network)

The west end program recently learned that it will not be receiving the Public Health Agency of Canada (PHAC) funding that supported their HCV group and case management components. It is likely that the group will not be able to continue after this fiscal year and, as a result, treatment uptake and completion may be challenging to maintain. The social support provided by the PHAC hepatitis C coordinator and peer support workers will not be available in the west end either. The resulting lack of support and case management will likely lead to a slower rate of treatment readiness as many of the barriers to treatment were addressed by these positions including: inadequate or lack of housing, identification, health care accompaniment. We are working with our community health centre partners in the west end to explore options to increase support and spread of the program.
— South Riverdale Community Health Centre

Since launching the Mobile Outreach Van Project, we have seen our outreach numbers increase steadily. Nightly contacts have increased from 20 to 75 to 100 individual client contacts. One of the pieces we are trying to address is working to balance staffing resources within our clinics and the mobile outreach initiative without any more staffing resources. We are currently looking to build partnerships with other local agencies such as Waterloo Public Health, the Working Centre, local ASOs and CMHA to augment staffing for the van.
— Sanguen Health Centre

Geography/transportation

The clinic physician will now travel to the Niagara Falls and St. Catharines clinic locations on a regular basis to conduct fibroscan clinics and meet with clients. Client transportation barriers will be greatly reduced by Dr. Kuhn making himself available at the different locations across the region. This will also be extremely valuable for those clients who struggle to attend appointments at the Port Colborne Site. There are still clients that require the services of clinic-paid taxis for them to attend their appointments.
— Niagara Health System

Communication and data systems

Internal communication continues to be a challenge. With activities and services occurring so rapidly it is difficult to keep everyone informed. We are updating our website to allow more user-friendly apps. We are also starting to vet internal communication tools like Slack and Basecamp as a means of improving timely communication with staff.
— Elevate NWO

Our program does not have an online or social media presence, within or outside our organization. We will be working on getting this started over the next reporting period. We are now able to use the Ontario Telehealth Network (OTN) at our

discretion as we have telemedicine capability in our office. We will be looking into using this technology for our local outreach patients who cannot make it to the hospital.
— The Ottawa Hospital

[We are] continuously working to integrate data among Regional Wellness Response Program's (RWRP) hepatitis C support and treatment service, the electronic data system used by the treating physicians and the system used by community nurses to ensure there is effective communication between the entire HCV team.
— Sioux Lookout First Nations Health Authority

There could still be better connection to people who use drugs in order to get up-to-date information on their needs and provide information about available services. As we roll out our mobile outreach unit, we will better be able to engage with even more people at the street level.
— Elevate NWO

Appendices

Appendix A. Programs

Central East health region

Organization name	LHIN
AIDS Committee of Durham Region	Central East
AIDS Committee of York Region	Central
Lakeridge Health Centre	Central East
Oshawa Community Health Centre	Central East
Peterborough AIDS Resource Network	Central East
Simcoe Muskoka District Health Unit	North Simcoe Muskoka
The Gilbert Centre	North Simcoe Muskoka

Central West health region

Organization name	LHIN
AIDS Committee of Cambridge, Kitchener, Waterloo and Area	Waterloo Wellington
Bramalea Community Health Centre	Central West
Hamilton Public Health & Community Services	Hamilton Niagara Haldimand Brant
Hemophilia Ontario - CWOR	Central West
HIV/AIDS Resources & Community Health-Clinic	Waterloo Wellington
HIV/AIDS Resources & Community Health (ARCH)	Waterloo Wellington
Niagara Health System	Hamilton Niagara Haldimand Brant
Peel HIV/AIDS Network	Central West
Positive Living Niagara	Hamilton Niagara Haldimand Brant
Sanguen Health Centre	Waterloo Wellington
The AIDS Network	Hamilton Niagara Haldimand Brant
Wayside House of Hamilton	Hamilton Niagara Haldimand Brant

Northern health region

Organization name	LHIN
AIDS Committee of North Bay and Area	North East
Algoma Group Health	North East
Elevate NWO	North West
Hemophilia Ontario - NEOR	North East
Ontario Aboriginal HIV/AIDS Strategy - COCHRANE	North East
Ontario Aboriginal HIV/AIDS Strategy - SUDBURY	North East
Ontario Aboriginal HIV/AIDS Strategy - THUNDER BAY	North West
Réseau ACCESS Network	North East

Organization name	LHIN
Sioux Lookout First Nations Health Authority	North West
Sudbury Action Centre For Youth	North East
Sudbury Health unit	North East
Nishnawbe Aski Nation	North West
Thunder Bay District Health Unit	North West
Union of Ontario Indians	North East
Waasegiizhig Nanaandawe'iyewigamig	North West

Ottawa and Eastern health region

Organization name	LHIN
AIDS Committee of Ottawa	Champlain
Bruce House	Champlain
City of Ottawa Public Health	Champlain
Hemophilia Ontario - OEOR	Champlain
HIV/AIDS Regional Services	South East
Ontario Aboriginal HIV/AIDS Strategy - KINGSTON	South East
Ontario Aboriginal HIV/AIDS Strategy - OTTAWA	Champlain
Ottawa Gay Mens Wellness Initiative	Champlain
Sandy Hill Community Health Centre (OASIS)	Champlain
Somerset West Community Health Centre	Champlain
Street Health Centre, Kingston Community Health Centres	South East
Youth Services Bureau of Ottawa	Champlain
The Ottawa Hospital	Champlain
The Ottawa Hospital Research Institute	Champlain

South West health region

Organization name	LHIN
AIDS Committee of Windsor	Erie St Clair
Association of Iroquois and Allied Indians	South West
Hemophilia Ontario - SWOR	South West
London Inter-Community Health Centre	South West
Ontario Aboriginal HIV/AIDS Strategy - LONDON	South West
Ontario Aboriginal HIV/AIDS Strategy - WALLACEBURG	Erie St Clair
Regional HIV/AIDS Connection	South West
Windsor Regional Hospital	Erie St.Clair
Windsor-Essex Community Health Centre	Erie St Clair

Toronto health region

Organization name	LHIN
2-Spirited People of the First Nations	Toronto Central
Action Positive	Toronto Central
Africans In Partnership Against AIDS	Toronto Central
AIDS Committee of Toronto	Toronto Central
Alliance for South Asian AIDS Prevention	Toronto Central
Asian Community AIDS Services	Toronto Central
Barrett House - Good Shepherd Ministries	Toronto Central
Black Coalition for AIDS Prevention	Toronto Central
Casey House Hospice	Toronto Central
Central Toronto Community Health Centres	Toronto Central

Organization name	LHIN
Centre for Spanish-speaking Peoples	Toronto Central
Centre francophone de Toronto	Toronto Central
Family Service Toronto	Toronto Central
Fife House	Toronto Central
Hassle Free Clinic	Toronto Central
Hospice Toronto	Toronto Central
LOFT Community Services	Toronto Central
Maggie's: The Toronto Prostitutes' Community Service Project	Toronto Central
Ont. Assoc.of the Deaf, Deaf Outreach Program	Toronto Central
Sherbourne Health Centre	Toronto Central
South Riverdale Community Health Centre	Toronto Central
St Michael's Hospital	Toronto Central
St. Stephen's Community House	Toronto Central
Syme-Woolner Neighbourhood and Family Centre	Toronto Central
The Teresa Group	Toronto Central
The Works, City of Toronto Public Health	Toronto Central
Toronto People With AIDS Foundation - RFAC	Toronto Central
Toronto People With AIDS Foundation - FFL	Toronto Central
University Health Network	Toronto Central
Unison Health and Community Services	Toronto Central
Warden Woods Community Centre	Toronto Central
Women's Health in Women's Hands Community Health Centre	Toronto Central

Provincial

Organization name	LHIN
Hemophilia Ontario	Capacity Building
HIV & AIDS Legal Clinic (Ontario)	Capacity Building
Ontario Aboriginal HIV/AIDS Strategy	Capacity Building
PASAN (Prisoners with HIV/AIDS Support Action Network)	Capacity Building
African and Caribbean Council on HIV/AIDS in Ontario	Capacity Building
AIDS Bereavement and Resiliency Program of Ontario (sponsored by Fifehouse)	Capacity Building
Canadian AIDS Treatment Information Exchange	Capacity Building
Committee for Accessible AIDS Treatment	Capacity Building
FIFE House - OHSUTP	Capacity Building
Gay Men's Sexual Health Alliance	Capacity Building
Ontario AIDS Network	Capacity Building
Ontario Organizational Development Program	Capacity Building
Toronto People With AIDS Foundation - THN	Capacity Building
Women and HIV/AIDS Initiative	Capacity Building
The Ontario HIV Treatment Network	Capacity Building

Appendix B. Data limitations

Accuracy and consistency

This report relies on self-reported data provided by agencies. A number of staff in the agencies collect data, and there is always the potential for inconsistency (i.e., different definitions, different interpretations, different tools for tracking activities) as with any data collection systems. OCHART staff work closely with agencies to validate their data and identify data errors. In cases where we errors are discovered, they are corrected for the current year and – where applicable – for past years.

Use of aggregate data

Throughout the report we use aggregate data – rolling up responses from all contributing agencies to make inferences about overall levels of activity and trends; however, because of the different sizes of organizations, it is possible for reports from one or two large organizations to slant the data. Aggregate or average results may not reflect the experience of all agencies.

Risk of residual disclosure

A privacy review changed reporting standards for this report. Totals of 11 or less are no longer reported owing to client identification risks; therefore, client groups or activities with few number were not reported and unable to be compared to previous years.

Changes in number of funded programs

The number of programs that submit OCHART reports change from year to year: some programs are only funded for a certain number of years and some may close or cease to offer HIV-related services. However, in those cases, the funding for community-based AIDS services is not lost to the system: it is reallocated to other programs.

Changes in questions and reporting system

This was first year data was collected using a redesigned online portal and user interface. The system two important differences compared to the past data collection system: a redesigned user interface and a shift to reporting some activities on a daily basis using 'tracking tools'. The redesigned interface was implemented to increase user friendliness; however, it is possible that the redesigned interface could have impacted the way some data were reported compared to previous years. The implementation of tracking tools to facilitate daily tracking of education, outreach and community development activities within the OCHART system rather than biannually only changed the processes used to track these activities at organizations and affected how data is tracked and reported on these activities.

Appendix C. What is a PPN

Ontario's HIV **priority populations** are those populations that are most affected by HIV in Ontario. In Ontario, we strategically tailor the HIV service response to key populations to increase access to HIV and other health and social services for people at high risk of HIV infection and poorer health outcomes when living with HIV. These key populations include: people living with HIV/AIDS, gay, bisexual and other men who have sex with men (including trans men), African, Caribbean and Black communities, Indigenous people, people who use drugs, and women at risk (include trans women).

The Priority Population Networks (PPN) are focused on the specific needs of some of Ontario's priority populations, including:

Gay Men's Sexual Health Alliance (GMSHA) www.gmsh.ca

- A provincial based organization (five staff people) with a mandate to support local ASO workers who focus their work on gay men's sexual health (prevention/education, outreach, community development and support).
- The provincial office provides this capacity building through training and education of local ASO workers.
- In addition, the provincial office develops provincial campaigns and accompanying resource materials for use by local ASO workers and other service providers who work with gay/bisexual and other men who have sex with men.

Women and HIV/AIDS Initiative (WHAI) www.whai.ca

- A provincial-based organizations (two staff people) with a mandate to support local ASO workers (WHAI coordinators) who focus on using a community development approach to strengthen the capacity of communities to support women living with and/or affected by HIV/AIDS. Local workers achieve this goal by:
    - raising awareness and informing local community organizations and groups that serve women about HIV/AIDS and the need for women's HIV-related services
    - working with local community organizations and groups to promote the integration of HIV/AIDS into their current programs, services, and policies/procedures
    - working with staff at community organizations to build their knowledge and capacity to respond to women's HIV-related needs.
- The provincial office provides capacity-building through training and education to local ASO workers.
- In addition, the provincial office helps to develop provincial resources that can be used by local ASO workers in their work (e.g. presentations with consistent messages) as well as resources that local ASO workers can share with the agencies with whom they interact (e.g., policy development tools).

African Caribbean Council on HIV/AIDS in Ontario (ACCHO) www.accho.ca

- A provincial based organization (six staff members) with a mandate to support local ASO workers who focus their work on the health of African, Caribbean and Black communities (prevention/education, outreach and community development).
- The provincial office provides capacity-building through training and education to local ASO workers.
- In addition, the provincial office develops provincial campaigns and accompanying resource materials for use by local ASO workers and other service providers that work with communities.

Priority Population Network Members are ASOs (and other HIV programs that reside within organizations whose mandate is broader than only HIV) that employ staff whose focus is on one of the priority populations supported by the PPNs.

Appendix D. Economic impact

The View From the Front Lines data on the dollar value of volunteer work is calculated using an adapted version of a tool developed by Yang Cui, a graduate student in the PHAC Manitoba/Saskatchewan regional office, in August 2009. For detailed instructions on how to use this tool in your project, please contact the OHTN.

Limatations of this tool

Information from this tool needs to be interpreted carefully. It can only give an estimate of the value of some types of volunteer work. Several factors can affect the accuracy of the estimated dollar value of this work.

Like any tool, the quality of data this tool produces depends on the quality of data that is entered into it. If volunteer hours have not been carefully tracked, or are recorded in the wrong OCHART categories, the estimated value of volunteer work will not be accurate.

This tool uses average wages for Ontario from National Occupation Classification (NOC) data. These averages may be higher or lower than average wages in some communities. This may result in over- or under-estimates of the dollar value of volunteer work.

Not all types of volunteer work are included in this tool. For example, volunteer hours reported in the "other" category cannot be assigned a dollar value with this tool. Also, the OCHART volunteer activity "Attend training" is not included in this tool. Attending training is not itself a job, so this activity cannot be assigned a wage.

Some volunteer work in each volunteer category may not align well with the associated wage category. For example, fundraising volunteer hours are calculated using the average wage for a professional occupation in fundraising or communications. However, some volunteer work counted in the fundraising category may not require a professional skill set (e.g. stuffing envelopes or being a marshal in a fundraising walk). The dollar value of this work may therefore be over-estimated.

Finally, the value of volunteers goes well beyond the financial impact of their work. This is only one dimension of the important impact volunteers have on community-based HIV work.

The tool uses data from two places:

- OCHART 12.2 data on the total number of volunteer hours, by category of work, in the last fiscal year (H1 + H2)
- National Occupation Classification (NOC) data, which tells you the average Canadian, provincial and regional wages for various occupations.

Volunteer Position	OCHART question	National Occupation Classification (NOC)	Total Number of Volunteer Hours in the Past 12 Months* (A)	NOC Average Hourly Wage Rate Assigned to This Job Type in the past 12 months (B)	Total Volunteer Hours × NOC Average Hourly Wage Rate (C)	Fringe Benefit 12% (D)	Total Value (C+D)
Administration (clerical support, reception, etc)	12.2 total #of vol hours for Administration	General office clerk 1411	39,190	$20.23	$792,813.70	$95,137.64	$887,951.34
Governance (board of directors, advisory committees etc)	12.2 # of vol hrs for Serve on Board/ Advisory Committee	Senior manager-Health, Education, Social and Community Services and Membership Organization 0014	17,804	$46.65	$830,556.60	$99,666.79	$930,223.39
Support services (assistance to people living with HIV/AIDS, peer support, etc)	12.2 sum of total # of vol hrs for Practical Support and Counselling	Community and social service workers 4212	44,665	$21.51	$960,744.15	$115,289.30	$1,076,033.45
Prevention (outreach, targeted education, etc)	12.2 total # of vol hrs for Outreach Activities	Community and social service workers 4212	15,699	$21.51	$337,685.49	$40,522.26	$378,207.75
Fundraising (walks, fundraising campaigns, working to secure foundation grants, etc)	12.2 total # of vol hrs for Fundraising	Professional occupation in public relations and communications 5124	19,404	$30.33	$588,523.32	$70,622.80	$659,146.12
Public events (public speaking, special events like pride day, mall displays, etc)	12.2 sum of total # of vol hrs for Special Events and Education/ Comm Devt	General office clerk 1411	28,504	$20.23	$576,635.92	$69,196.31	$645,832.23
Human resources	12.2 sum to total # of vol hrs for involvement in hiring process and policies and procedures	Specialists in human resources 1121	1,539	$34.95	$53,788.05	$6,454.57	$60,242.62
IT Support	12.2 sum of total # of vol hrs for IT support	Web designers and developers 2175	991	$27.78	$27,529.98	$3,303.60	$30,833.58
Total					**$4,168,277.21**		**$4,668,470.48**

Notes

Data tables

Preface

Programs providing HIV and hepatitis C services across the province, by region and service type

Health region	Service type	Number
Northern	ASO	3
Northern	HCV team	4
Northern	Anonymous testing	2
Northern	Clinical services	1
Northern	HCV position	1
Northern	non-AIDS service organization	5
Northern	Direct services provincial	4
Central West	ASO	5
Central West	HCV team	4
Central West	Anonymous testing	1
Central West	Clinical services	1
Central West	Direct services provincial	1
South West	ASO	2
South West	HCV team	2
South West	Anonymous testing	2
South West	non-AIDS service organization	1
South West	Direct services provincial	1
Toronto	ASO	11
Toronto	HCV team	2
Toronto	Anonymous testing	1
Toronto	Clinical services	1
Toronto	HCV position	1
Toronto	non-AIDS service organization	17
Central East	ASO	4
Central East	HCV team	2
Central East	Anonymous testing	1
Central East	Clinical services	1
Ottawa and Eastern	ASO	3
Ottawa and Eastern	HCV team	2
Ottawa and Eastern	Anonymous testing	1
Ottawa and Eastern	non-AIDS service organization	4
Ottawa and Eastern	Direct services provincial	3

HIV epidemiology in Ontario

Number of new HIV diagnoses in Ontario, 2007-2016

Year	Number of new HIV diagnoses
2007	1,013
2008	1,080
2009	969
2010	994
2011	986
2012	861
2013	797
2014	828
2015	839
2016	881

Note: Data provided by the Public Health Ontario Laboratory

Number of new diagnoses in Ontario by sex/gender, 2007-2016

Year	Number of new HIV diagnoses — males	Number of new HIV diagnoses — females
2007	781	226
2008	811	263
2009	747	214
2010	796	183
2011	768	203
2012	670	186
2013	659	132
2014	655	167
2015	673	162
2016	697	176

Note: Data provided by the Public Health Ontario Laboratory

Percentage of new male and female HIV diagnoses by priority population (where known), Ontario, 2011-2016

Year and gender	Gay, bisexual and other men who have sex with men	African, Caribbean and Black	People who use injection drugs	Indigenous	At-risk women
Males, 2011-2012	74.5%	20.1%	8.7%	2.6%	–
Males, 2013-2014	78.4%	16.1%	10.4%	1.9%	–
Males, 2015-2016	72.9%	18.3%	10.8%	1.5%	–
Females, 2011-2012	–	65.8%	10.5%	3.5%	100%
Females, 2013-2014	–	56.2%	16.8%	4.3%	100%
Females, 2015-2016	–	50.9%	22.4%	7.3%	100%
Overall, 2011-2012	58.6%	29.7%	9.0%	2.8%	21.1%
Overall, 2013-2014	65.3%	22.8%	11.5%	2.3%	16.6%
Overall, 2015-2016	58.8%	24.6%	13.1%	2.7%	19.3%

Note: Data provided by the Public Health Ontario Laboratory.

Percent of male and female HIV diagnoses by ethnicity (where known), Ontario, 2011-2016

	White	Black	Indigenous	East/Southeast Asian	South Asian	Arab/West Asian	Latin American	Other
Overall, 2011-2012	48.6%	29.4%	2.7%	5.4%	4.0%	1.2%	6.4%	2.2%
Overall, 2013-2014	52.2%	21.0%	2.4%	6.8%	3.9%	2.3%	9.3%	2.2%
Overall, 2015-2016	51.6%	23.1%	2.5%	7.4%	4.0%	2.7%	6.4%	2.4%
Males, 2011-2012	55.7%	19.5%	2.6%	6.5%	4.4%	1.6%	7.6%	2.2%
Males, 2013-2014	55.9%	15.4%	2.1%	7.7%	3.8%	2.6%	10.3%	2.3%
Males, 2015-2016	55.6%	17.0%	1.3%	9.0%	4.4%	2.8%	7.3%	2.6%
Females, 2011-2012	22.5%	66.4%	3.3%	1.6%	2.5%	0.0%	2.0%	1.6%
Females, 2013-2014	32.1%	50.3%	4.2%	1.8%	4.8%	0.6%	4.2%	1.8%
Females, 2015-2016	34.6%	48.8%	7.4%	0.9%	2.3%	2.3%	2.3%	1.4%

Note: Data provided by the Public Health Ontario Laboratory.

Percent of new HIV diagnoses by sex/gender and age, Ontario, 2016

Age	Percent of new HIV diagnoses (males)	Percent of new HIV diagnoses (females)
<15	0.6%	2.8%
15-19	1.6%	4.0%
20-24	7.3%	8.5%
25-29	18.5%	11.4%
30-34	15.4%	16.5%
35-39	13.6%	15.3%
40-44	10.9%	10.8%
45-49	10.0%	9.7%
50-54	12.3%	9.1%
55-59	5.2%	8.0%
60-64	2.3%	1.7%
65-69	1.0%	2.3%
70+	1.3%	0.0%

Note: Data provided by the Public Health Ontario Laboratory.

Number and rate of new HIV diagnoses by health region, Ontario, 2015 and 2016

Health Region	Year	Number of new HIV diagnoses	Rate of new HIV diagnoses per 100,000
Northern	2015	29	3.6
Northern	2016	24	3.0
Ottawa	2015	59	6.2
Ottawa	2016	86	8.8
Eastern	2015	13	1.5
Eastern	2016	26	3.1
Toronto	2015	462	16.3
Toronto	2016	432	15.0
Central East	2015	105	2.6
Central East	2016	97	2.3
Central West	2015	81	3.1
Central West	2016	108	4.0
South West	2015	79	4.9
South West	2016	97	6.0

HIV services in Ontario

People who make the sector work

People who make the sector work	Total people
Staff	• 379 AIDS Bureau funded • 75 HCV funding • 145 designated peer positions
Volunteers	5,738
Students	284
Peers that are living with HIV	540
Peers engaged in in IDU Outreach	616

IDU clients served by peers 2014-15 to 2016-17

IDU clients served by peers 2014-15 to 2016-17	Total	Clients served in 2014	Clients served in 2015	Clients served in 2016
One-on-one interactions with community agencies/staff members	1,931	728	482	721
Other	2,511.5	693.5	1,647	171
Referrals	4,574.5	928	2,239	1,407.5
Counseling	8740	2,577	35,63.5	2,599.5
Education	12,255	3,322	3,978	4,955
Practical Support	15,998.5	9,639	38,01.5	2,558
Material distribution	68,791.5	27,178	30,787	10,826.5
Total	**114,802**			

Prevention, education and outreach

Number of programs focused on Ontario's HIV priority populations

Priority population	ASO	Non-ASO
African, Caribbean & Black communities	18	10
Other populations at risk for HIV*	64	25
Indigenous peoples	23	12
People who use drugs	28	12
Gay/bisexual/MSM	33	13
Women at risk	33	15
People living with HIV	34	22

Increase in the distribution of safer sex supplies

Supplies	2015–16	2016–17
Traditional condoms	1,003,597	1,084,520
Lubricant	451,029	820,686

Community development meetings by purpose and agency type

Community development meetings by purpose and agency type

Meeting purpose	ASO	Non-ASO	Total
Community event planning	642	196	838
Coalition/network meeting	671	144	815
General information sharing	459	154	613
New partnership/relationship building	424	155	579
Advisory/board meeting	303	176	479
Improved service delivery	312	120	432
Strategic planning	117	32	149
Development of education prevention materials	91	45	136
Policy development	24	18	42
Total	3043	1040	4083

Proportion of education activities by goals to service providers 2016-17

Proportion of education activities by goals to service providers 2016-17

	Contacts	Events	Total
Capacity-building workshops	13,013	441	13,454
ASO	9,188	324	9,512
Non-ASO	3,825	117	3,942
Consultations	2,348	187	2,535
ASO	1,488	111	1,599
Non-ASO	860	76	936
Information sessions	8,650	315	8,965
ASO	6,451	214	6,665
Non-ASO	2,199	101	2,300
Total	24,011	943	24,954

Proportion of community development meetings by issues discussed 2016-17

	ASO	Non-ASO	Total
Well-being	22.25%	21.49%	22.04%
Social support	16.99%	17.58%	17.15%
Living with HIV	14.39%	17.93%	15.36%
Risk of HIV	13.17%	15.62%	13.83%
Safety concerns	10.99%	7.48%	10.03%
Housing	6.08%	5.49%	5.92%
Legal/immigration	4.50%	6.02%	4.92%
Education/employment	5.23%	3.22%	4.68%
Income and benefits	3.26%	3.63%	3.36%
Food security	3.13%	1.55%	2.70%

Harm reduction programs report 175,000+ client interactions

	Total outreach contacts	Total in-service contacts	Total client interactions	
Funded (N=22)	58,889	101,339	160,228	91%
Other (N=11)	9,076	5,860	14,936	9%
Total	67,965	107,199	175,164	—

Top 3 substances used by clients

2014-15	2015-16	2016-17
1. Opiates	1. Opiates	1. Opiates
2. Crack	2. Crack	2. Crack
3. Alcohol	3. Alcohol	3. Methamphetamine

Note: Ranking based on scores assigned to top three reported substances per program.

Trends in safer injection supplies distributed

Safer injection supplies	2014-15	2015-16	2016-17
Needles	6,167,218	672,6951	7,057,798
Swabs	4,566,917	4,512,544	4,130,269
Water for injection	3,084,426	3,663,558	2,204,732
Filters	2,433,196	2,048,929	1,889,363
Cookers	1,376,906	1,392,462	1,423,912
Ties/tourniquets	572,079	445,530	283,248
Vitamin C/acidifiers	397,061	352,729	409,076
Sharps containers	29,161	36,159	36,834
Total	**18,626,964**	**19,178,862**	**17,435,232**

Trends in safer inhalation supplies distributed

Safer inhalation supplies	2014	2015	2016
Alcohol swabs	1,004,627	1,427,494	1,381,103
Screens (single)	678,379	1,076,223	698,253
Glass pipes/stems	368,646	333,602	321,298
Mouthpieces	110,158	148,574	243,617
Wooden push sticks	121,953	141,573	220,306
Matches	79,208	81,511	119,882
Lip balm	5,389	8,581	6,307
Dental gum	6,557	8,404	4,866
Total	**2,374,917**	**3225962**	**2,995,632**

Anonymous testing

Locations of funded anonymous testing sites

Region	Testing site
Northern	Thunder Bay District Health Uni
Northern	Sudbury District Health Unit
Eastern and Ottawa	Somerset West Community Health Centre
Central East	Simcoe Muskoko District Health Unit
Toronto	Hassle Free Clinic
South West	London Intercommunity Health Centre (Options Clinic)
South West	Windsor Regional Hospital
Central West	Hamilton Public Health and Community Services

Percentage of outreach to targeted priority populations

African Caribbean and Black communities	7%
Gay/bisexual/and other men who have sex with men	54%
Indigenous people	11%
Other at-risk populations	9%
People who use drugs	11%
Women at risk	10%

Total number of tests over time

Year	Number of tests	Total nominal	Total anonymous	Total coded
2001	279,491	236,454	9,637	33,377
2002	336,800	295,411	9,813	31,536
2003	346,720	307,816	9,627	29,269
2004	372,871	332,844	10,436	29,588
2005	392017	350,832	11,070	30,114
2006	415,562	378,871	11,120	25,560
2007	414,494	382,208	9,890	22,381
2008	414,926	382,728	12,049	20,147
2009	425,312	389,152	14,059	22,090
2010	418,369	380,588	14,905	22,831
2011	428,628	389,317	16,142	23,169
2012	436,272	397,263	16,117	22,891
2013	441,815	401,900	17,177	22,734
2014	457,916	423,286	17,393	17,231
2015	485,250	452,681	17,048	15,519

Community-based clinical services

Total active and new clients by client group, 2016-2017

Client group and gender	Active	New	Total
People living with HIV (male)	1,174	190	1,364
Affected (male)	NR	NR	14
At risk (male)	23	183	206
People living with HIV (female)	289	44	333
Affected (female)	NR	NR	NR
At risk (female)	17	147	164
People living with HIV	NR	NR	16
At risk	NR	NR	111
Total	**1,200**	**384**	**1584**

*NR = Not reported due to low numbers.

Age group

Age group	Male	Female
14-17	23	19
18-25	71	57
26-35	226	75
36-45	350	141
46-55	505	118
56-65	305	63
66-75	81	27
Over 75	19	—
TOTAL	**1,582 male**	**502 female**

Note: Trans men and women were not reported due to low client numbers

Proportion of clients served by priority population

Proportion of clients served by priority population	2014	2015	2016
Indigenous peoples	5%	6%	9%
African, Caribbean and Black communities	19%	18%	18%
Women in the above groups and/or who engaged in high-risk activities with them	21%	25%	20%
People who use drugs	33%	40%	38%
Gay/bisexual/MSM	37%	43%	44%

Proportion of clients served by ethnicity

Ethnicity	Male	Female	Trans man	Trans woman
White	851	170	49	59
Unknown	134	32	0	3
South East Asian	36	25	2	0
South Asian	58	36	1	0
Not listed	133	19	0	4
Métis	1	0	0	0
Latin	97	8	5	1
Inuit	1	0	0	0
First Nation	26	20	0	0
Black	185	195	1	3
Arab	38	2	0	2

Note: Trans men and women were not reported due to low client numbers

Support services

Service sessions delivered, 2016-17

	Number of service sessions	Number of clients
ASOs	107,166	5,980
Non-ASOs	87,680	7,172

Client group by age

Age group	People living with HIV	Affected	At-risk
Under 18	55	529	40
18-25	169	115.5	173
26-35	855	115	547
36-45	1,450	191	439
46-55	1,851	97	450
56-65	968	57	191
66-75	225	12	42
Over 75	27	NR	NR

*NR = Not reported due to low numbers.

Client group by ethnicity

Client group	People living with HIV	Affected	At-risk
White	2,103	167	268
Black	1,591	281	112
Latin American	364	132	107
South Asian	124	23	21
Southeast Asian	212	NR	30
Arab/West Asian	64	NR	12
Unknown	579	370	157
Not listed	262	33	12
Indigenous	227	25	74

Top 3 ethnicities by gender

Men	White (52%)	Black (16%)	Latin American (12%)
Women	Black (64%)	White (20%)	Indigenous (6%)
Trans women	Latin American (33%)	White (26%)	Indigenous (14%)

Number of clients accessing support services

Service	ASO	Non -ASO
Community/social services	4,812	4,010
Practical assistance	6,543	633
Intake	616	2,212
Case management	434	258
Support within housing	170	13
Traditional services	26	57
Total	**12,601**	**7,183**

Clients accessing support services for practical assistance

Practical assistance	Number of clients
Complementary therapies	440
Food programs	3,309
Financial	1,096
Other*	1,045
Transportation	1,285
Total	**7,176**

*Other practical assistance included assistance with completing identification, insurance, legal forms and providing household items and clothing.

Top community/social support services delivered by ASO and non-ASO agencies 2016-17

Community/social service 2016-17	Number of service sessions
General support	50,184
Support groups	9,497
Managing HIV	4,763
Clinical counselling	4,359
Financial counselling services	2,224
Settlement services	1,725
Employment services	1,684
Bereavement services	740
HIV pre/post-test counselling	388

Total number of service sessions

Year	Number of service sessions
2013-14	223,253
2014-15	235,691
2015-16	186,077
2016-17	194,846

Total clients by client group 2013-14 to 2016-17

People living with HIV/AIDS	2013-14	2014-15	2015-16	2016-17
ASO	6,697.5	6,334	5,928.5	5,101.5
Non-ASO	3,794	3,716	3595	3,849.5
Total people living with HIV/AIDS	**10,491.5**	**10,050**	**9,523.5**	**8951**

Affected	2013-14	2014-15	2015-16	2016-17
ASO	1,366.5	1,476	791	919
Non-ASO	489	318.5	344.5	272
Total affected	**1,855.5**	**1,794.5**	**1,135.5**	**1,191**

At risk	2013-14	2014-15	2015-16	2016-17
ASO	926.5	1,004.5	859.5	707.5
Non-ASO	2,560.5	2,010.5	1,378	4,122.5
Total at risk	**3487**	**3015**	**2237.5**	**4830**

Referrals

Referral type	ASO	Non-ASO
Other community-based service providers	2,430	1,434
Clinical service providers: non-HIV specific	796	874
Mental health service providers	283	617
Community-based service providers—HIV care and support	431	401
Addiction services	71	450
Clinical service providers: HIV care	175	256
Harm reduction services	28	399
HIV/STI testing	36	364

Number of sessions for top 3 services delivered by client group in 2016-17

People living with HIV	At-Risk	Affected
1. Community/social services (64,153)	1. Community/social services (8,755)	1. Practical assistance (6,293)
2. Practical assistance (55,028)	2. Practical assistance (1,334)	2. Community/social services (2,656)
3. Support within housing (42,766)	3. Support within housing (982)	3. Intake (159)

New client demographics by ethnicity

Ethnicity	Number of new clients served
White	1,376
Black	801
Latin American	350
Not Listed	149
Southeast Asian	142
First Nations	119
South Asian	99
Arab/West Asian	72
Métis	15

Client group by age

Client group	People living with HIV	Affected	At risk
under 18	114	96	NR
18-25	179	19	115
26-35	579	35	201
36-45	741	64	146
46-55	768	25	106
56-65	349	NR	51
66-75	115	NR	19
Over-75	12	NR	NR

New clients by priority population

Priority population	ASO	Non-ASO	Number of new clients	Percentage of new clients
Gay, bisexual, and men who have sex with men	892	416	1,308	35%
African, Caribbean, and Black	430	96	526	14%
People who use drugs	290	127	417	11%
Indigenous people	89	6	95	3%

Challenges faced by new clients

Challenge	Percent of new clients reporting challenge
Legal/immigration	19%
Well-being	15%
Social support	14%
Living with HIV	11%
Income and benefits	10%
Housing	9%
Food security	7%
Education/employment	6%
Risk of HIV/STI	4%
Current safety concerns	4%

Provincial capacity-building

Educational sessions 2016-17

Session type	Number of educational sessions sessions	Number of participants
capacity-building	239	4,214
mentorship & coaching sessions	456	229
KTE	76	2,858
Total	**771**	**7,301**

Educational sessions topics

	Skills building	Grief and loss	HIV-specific training	Access to services	Leadership training	Organizational development	Human resources	Research dissemination	Substance use
capacity-building	58%	44%	18%	11%	–	–	–	–	–
mentorship & coaching sessions	–	31%	–	–	42%	23%	23%	–	–
KTE	–	30%	21%	–	–	–	30%	33%	24%

Educational sessions audiences 2016-17

	Other HIV workers	People living with HIV	EDs and boards	Non-ASO workers	ACB workers	researchers
capacity-building	82%	24%	14%	11%	10%	–
mentorship & coaching sessions	31%	34%	66%	–	–	–
KTE	68%	22%	–	58%	–	11%

Priority population capacity-building sessions

Organization	Number of sessions	Number of participants
WHAI	5	72
GMSH	17	131
OHSUTP	3	116
CAAT	34	487
ACCHO	4	62
Total	**63**	**868**

Organizational support capacity-building sessions

Organization	Number of sessions	Number of participants
OODP	27	158
ABRPO	104	1,562
CATIE	40	1,554
THN	5	72
Total	**176**	**3,346**

Priority population mentorship and coaching sessions

Organization	Number of sessions	Number of participants
CAAT	14	26
Total	**14**	**26**

Organizational support mentorship and coaching sessions

Organization	Number of sessions	Number of participants
OODP	192	32
ABRPO	143	64
THN	107	107
Total	**442**	**203**

Priority population KTE sessions

Organization	Number of sessions	Number of participants
WHAI	3	41
GMSH	5	410
OHSUTP	20	394
CAAT	24	822
Total	**52**	**1,667**

Organizational support KTE sessions

Organization	Number of sessions	Number of participants
ABRPO	23	1,156
THN	1	35
Total	**24**	**1,191**

Popular training and education topics by audience type

Audience type	HIV-specific training	Healthy sexuality	Organizational development	Human resources	Grief and loss	Skills-building	Change leadership	Research dissemination	Substance use	Anti-racism	GIPA	Policy	Access to serivces
GMSH workers	18%	15%	—	—	—	—	—	—	—	—	—	—	
Policy-makers	50%	—	—	—	—	—	—	—	—	—	—	—	
EDs and board members	—	11%	27%	15%	—	—	—	—	—	—	—	—	
Other HIV workers	19%	—	—	13%	31%	27%	—	—	—	—	—	—	
WHAI workers	—	—	17%	—	—	12%	22%	16%	—	—	—	—	
non-ASO workers	22%	—	—	23%	23%	14%	—	—	10%	—	—	—	
ACB network workers	94%	—	—	—	—	—	—	—	—	—	—	—	
People living with HIV	—	—	—	—	36%	33%	—	—	—	—	—	—	
Public Health professionals	19%	—	—	—	—	—	—	26%	19%	10%	—	—	
Volunteers	—	—	—	—	—	27%	—	—	14%	—	14%	13%	
Researchers	59%	—	—	—	—	19%	—	—	—	—	—	—	

Length of education sessions

Length of session	Number of sessions
Short (2-5 hours)	441
Longer (half to full day)	252
Conference presentation	45
Unknown/unreported	33

Community development initiatives

Type of community development initiative	Number of sessions
networks and partnerships	187
working groups	127
initiatives to strengthen inter-agency cooperation	66
governance initiatives	66
program planning initiatives	55
advisory committees	40
strategic planning and organizational development initiatives	33
advocacy initiatives	12
Total	**586**

Number of presentations and sessions reaching workers by LHIN

Toronto Central	368
Central	89
Champlain	51
North East	47
Waterloo Wellington	45
North West	41
South East	32
Mississauga Halton	27
Hamilton Niagara Haldimand Brant	27
Erie St Clair	26
Central East	25
South West	25
Central West	15
Outside Ontario	14
North Simcoe Muskoka	11

Number of capacity-building peers

organization	PHA peers	non-PHA peers	Total number of peers
ACCHO	24	62	86
WHAI	7	4	11
THN	5	1	6
GMSH	49	28	77
OHSUTP	5	1	6
CAAT	65	—	65
OAN	2	—	6
CATIE	2	—	2
Total	**159**	**100**	**259**

Presentations delivered by the OHTN

Audience	Number of presentations
researchers	45
ASOs	42
community members	33
clinicians	16
other	12
other service providers	5
policy makers	5
Total	**158**

Working with priority populations

Priority population	% of relevant presentations
people living with HIV	34%
Indigenous people	22%
Gay, bisexual, and other men who have sex with men (includes trans men)	13%
African, Caribbean and Black communities	10%
people who use drugs	9%
women at risk	7%
other populations at risk for HIV	4%

OHTN data requests

	Total number of requests	Epidemiology data	OCASE data	OCHART data	OCS data
ASOs	316	7	204	45	—
policy makers	13	12	—	—	1
Researchers	10	3	4	—	3
Community members	4	—	—	—	—
Service providers	4	—	—	—	—
Total number of requests	364	22	208	45	4