2016

View from the Frontlines

OCHART

Annual summary and analysis
April 1, 2015 to March 31, 2016.

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Acknowledgements

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For more information about completing OCHART forms or to request program-specific data and reports, please contact:
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Copies of this report can be found at:
www.ochart.ca/reports

Data requests
The OHTN is happy to respond to specific requests for data from community-based organizations. Please fill out a data request form at:
www.ohtn.on.ca/evidence-based-practice-unit

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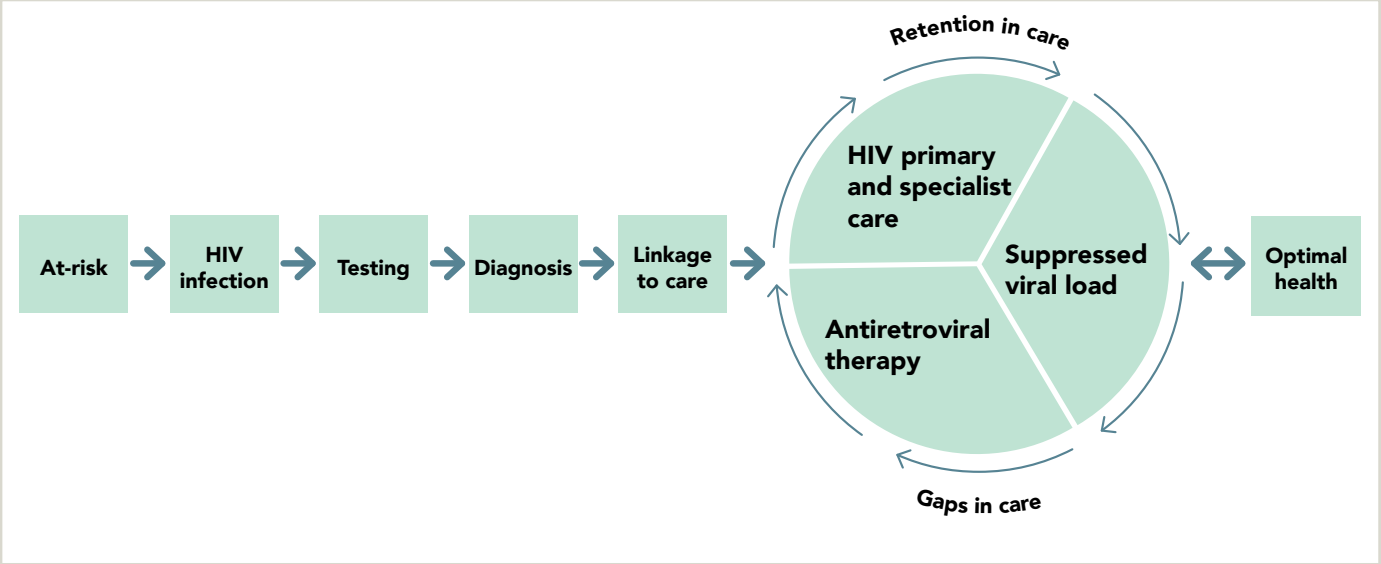
Preface

Welcome to the 11th annual OCHART (Ontario Community HIV and AIDS Reporting Tool) report: **View From the Front Lines for 2015-16**.

Context: the new HIV strategy to 2026

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



That strategy challenges all HIV-related programs and services to shift and adapt their services to:

- focus on populations most affected by HIV
- meet the needs of people at each stage of the prevention, engagement and care cascade, including:
  - ◊ people at-risk to help them stay uninfected
  - ◊ people who may have been exposed to HIV so they can be tested early and linked to services that will either help them stay negative or, if they test positive, provided with care
  - ◊ people living with HIV to help them stay engaged in their care and improve their health
- take a systems approach, integrating HIV services with other health and social services.

In 2015-16, funded programs were working with a logic model developed before the new strategy (see Appendix B), but they were already starting to work towards achieving the goals of the new strategy:

> By 2026, new HIV infections will be rare in Ontario and people with HIV will lead long healthy lives, free from stigma and discrimination.

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 the key service trends of 119 programs funded by the AIDS and Hepatitis C Programs, Ministry of Health and Long-Term Care, including:

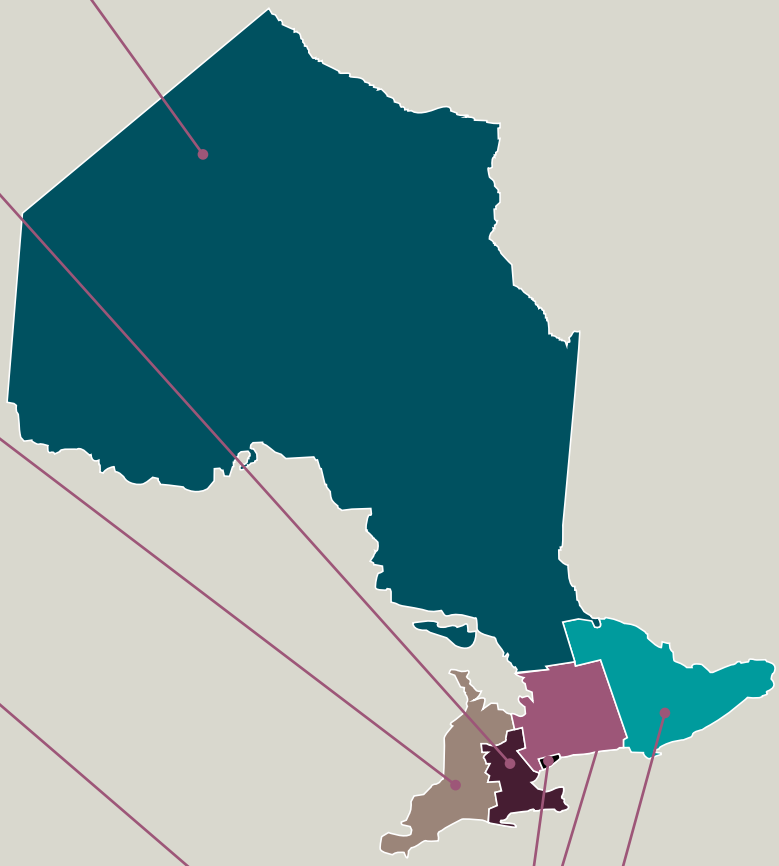
- 64 community-based HIV / AIDS programs, including programs in AIDS service organizations and non-AIDS organizations, such as community health centres
- 4 provincial organizations that provide direct services to clients — Hemophilia Ontario, which has a main office plus 4 regional offices that report individually; the Ontario Aboriginal HIV / AIDS Strategy (Oahas), which has a main office plus 7 workers who report individually; Prisoners with HIV / AIDS Support Action Network (PASAN); and 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) — the Gay Men's Sexual Health Alliance (GMSH), the African and Caribbean Council on HIV and AIDS in Ontario (ACCHO) and the Women's HIV and AIDS Initiative (WHAI) — which each have a provincial office and network members based mainly in AIDS service organizations (ASOs) throughout the province[1]
  - ◊ the Ontario HIV Treatment Network — a research and knowledge exchange organization
- 8 anonymous testing programs
- 5 community-based HIV clinics
- 16 hepatitis C teams, which work closely with treating physicians, providing HCV care and treatment, education, outreach and support services.

NOTE:
In the past, OCHART was a joint reporting initiative between the AIDS Bureau and the Public Health Agency of Canada (PHAC) AIDS Community Action Program (ACAP). In April 2015, PHAC changed its reporting requirements for all ACAP funded programs in the province and implemented a national reporting system that took effect in the spring of 2016. This means that View from the Front Lines will no longer include comprehensive data on PHAC-funded programs in Ontario. However, where possible, we have included data provided by PHAC to create a more complete picture of the work being done in the province.

1 The AIDS and Hepatitis C Programs also support other organizations that provide services to specific populations: the Ontario Aboriginal HIV / AIDS Strategy (Oahas), Two-Spirited People of the First Nations, Nishnawbe Aski Nation, Association of Iroquois and Allied Indians, Union of Ontario Indians and Waasegiizhig Nanaandawe'iyewigamig that provide services for Indigenous people; and 21 community-based organizations funded to provide harm reduction outreach services.

FIGURE 1 HIV programs and Hepatitis C teams span the province

Northern	**20**
Anonymous testing	2
ASO	3
Clinical services	1
Direct services provincial	4
HCV position	1
HCV team	4
non-AIDS service organization	5
Central West	**13**
Anonymous testing	1
ASO	5
Clinical services	2
Direct services provincial	1
HCV team	4
South West	**10**
Anonymous testing	2
ASO	2
Direct services provincial	3
HCV team	2
non-AIDS service organization	1
Toronto	**38**
Anonymous testing	1
ASO	11
HCV position	1
HCV team	2
non-AIDS service organization	23
Central East	**8**
Anonymous testing	1
ASO	4
Clinical services	1
HCV team	2
Ottawa & Eastern	**13**
Anonymous testing	1
ASO	3
Direct services provincial	3
HCV team	2
non-AIDS service organization	4



For a complete list of funded organizations, please see Appendix A.

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, OCASE, where they record information specifically on support services for clients. The OCASE team at the Ontario HIV Treatment Network (OHTN) has worked 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, reduce double reporting and have more accurate counts of unique clients accessing services.

Four expected short-term outcomes of these services in 2015/16:

- increased capacity of organizations and individuals
- greater knowledge and awareness
- improved access to services
- increased community coordination and collaboration.

How OCHART data are used

OCHART data are 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 D.

How this report is structured

I. HIV programs and services

This section is divided into 8 parts:

1. HIV in Ontario — trends in new diagnoses to help guide services
2. A description of HIV services in Ontario — including funding and human resources (staff and volunteers)
3. Prevention, education and outreach services — including IDU outreach — provided by community-based programs
4. Anonymous HIV testing services
5. Community-based HIV clinical services
6. Support services
7. Capacity-building and community development activities.

II. Hepatitis C teams

This section is divided into 4 parts:

1. HCV epidemiology in Ontario
2. A description of the hepatitis C teams and who they serve
3. HCV prevention services
4. HCV engagement and treatment services.

III. Appendices

The appendices provide more detailed information about the programs that report through OCHART including:

- logic models
- data limitations
- priority population network information
- the economic impact of volunteers.

Contents

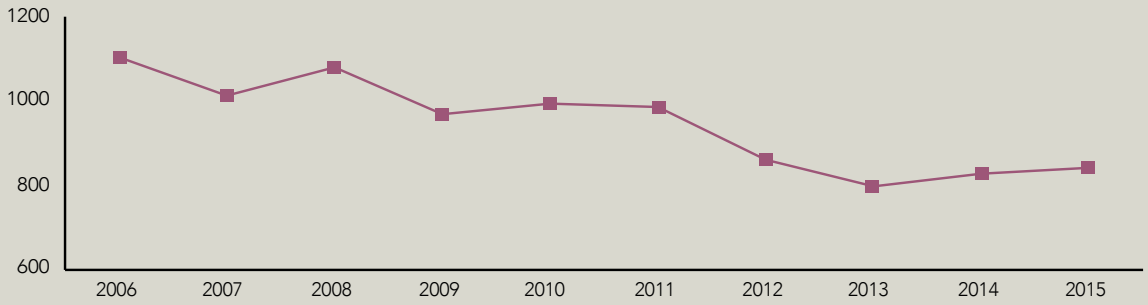
HIV programs and services

New diagnoses

In 2015, there were 842 new HIV diagnoses in Ontario.

Over the past four years, Ontario has had about 830 new HIV diagnoses each year – down about 17% from the approximately 1,000 diagnoses a year between 2006 and 2011, but still equal to more than 2 new diagnoses each day. New diagnosis numbers include people newly infected as well as those who have been infected for years but have only recently been tested. They may also include people who acquired HIV outside Ontario and moved to the province and were tested here.

FIGURE 2 Number of new HIV diagnoses in Ontario, 2006-2015

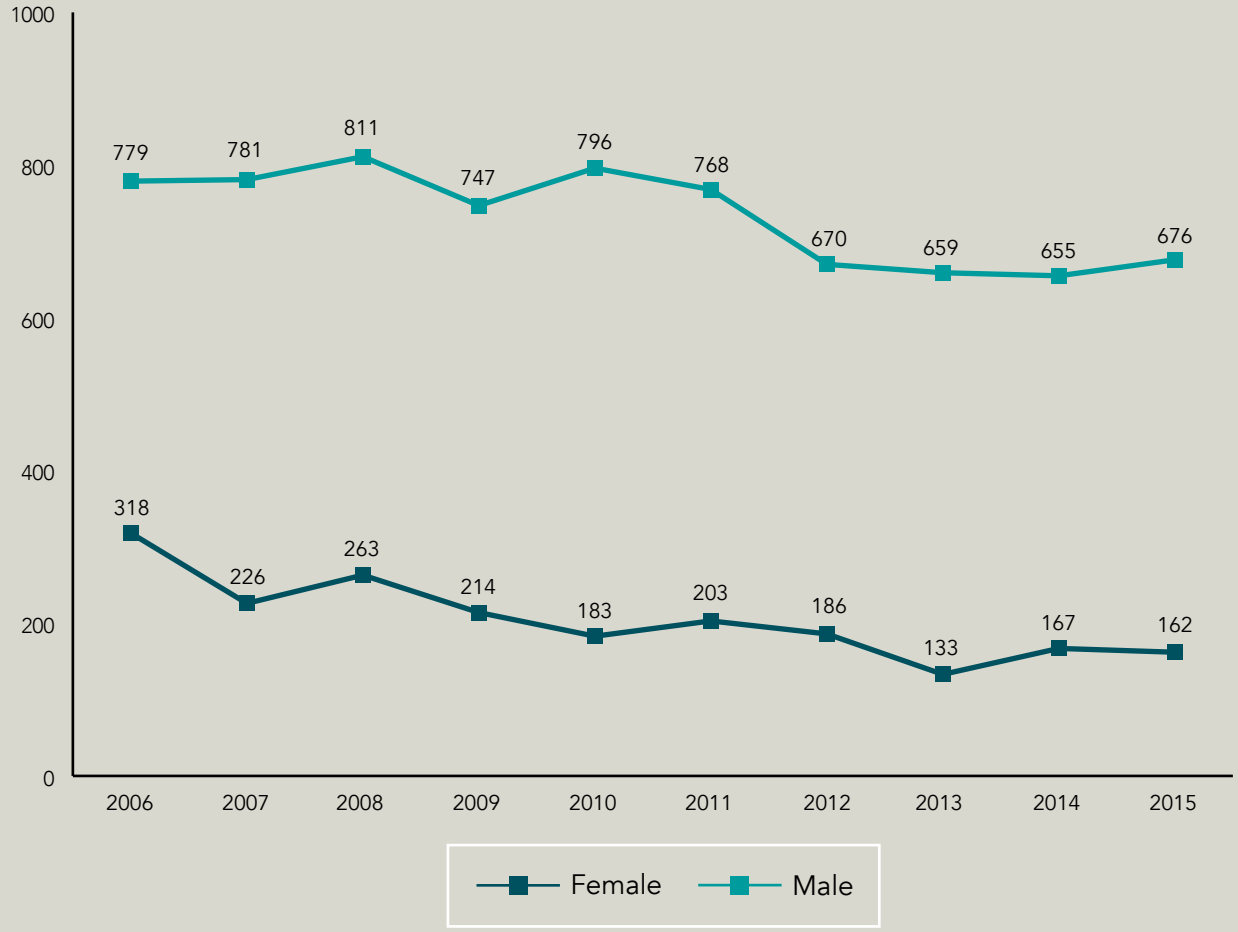


By sex/gender

In 2015, four of every five people newly diagnosed in Ontario (676 or 81%) were male and about one in five were female (162 or 19%).

Female	Male
Snapshot: Most women diagnosed with HIV were African, Caribbean, or Black (54% in 2014-2015), and between the ages of 30-34 (19% in 2013- 2015).	Snapshot: Most men diagnosed with HIV were White (55% in 2014-2015), gay, bisexual or other men who have sex with men (77% in 2014-2015).
Trends over time: The number of women diagnosed each year has generally been decreasing. It dropped by 20% between 2011 and 2015.	Trends over time: The number of men diagnosed with HIV each year dropped 13% in 2012 and has remained steady since then.

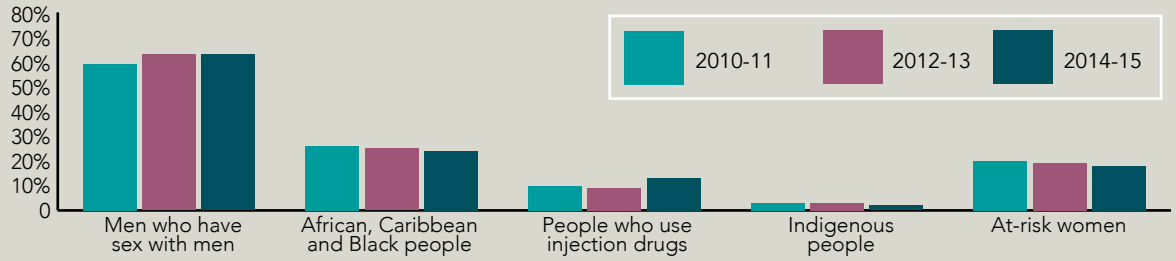
FIGURE 3 Number of new HIV diagnoses in Ontario by sex/gender, 2006-2015



By priority population

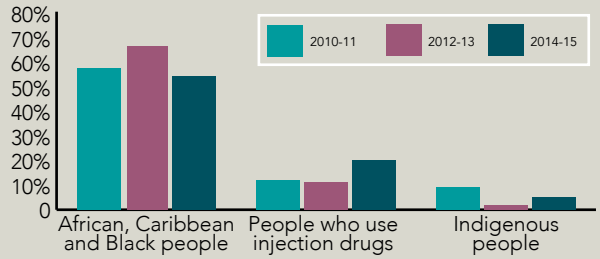
In the last two years (2014 and 2015 combined), most new HIV diagnoses were in gay, bisexual and other men who have sex with men (63%), followed by individuals from the African, Caribbean or Black (24%) communities, at-risk women (18%), people who use injection drugs (13%), and Indigenous men and women (2%). Note: Percentages do not add to 100 because people can be in more than one priority population (e.g., a gay man who injects drugs).

FIGURE 4 Percent of HIV diagnoses by priority population (where known), male and female, Ontario, 2010-2015



Trends over time: For women, there was an increase in the proportion of new diagnoses attributed to injection drug use (from 11% in 2012-2013 to 20% in 2014-2015).

FIGURE 5 Percent of female HIV diagnoses by priority population (where known), Ontario, 2010-2015



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 injection drugs (PWID)
- At-risk women

By ethnicity

In the last two years (2014 and 2015 combined), most new HIV diagnoses were in White (51%), followed by Black (23%) and East/Southeast Asian (7%) and Latin American (7%) people.

Differences by sex/gender

The most common ethnicities differed by sex/gender. For men it was White (55%), Black (17%), East/Southeast Asian (8%) and Latin American (8%). For women it was Black (51%), White (32%) and Indigenous (5%).

Trends over time

The proportion of new diagnoses in men of White ethnicity has been decreasing while both the proportion and number of new diagnoses has increased in: 1) East/Southeast Asian populations—from 45 or 5% of new diagnoses in 2010 and 2011 (combined) to 74 or 8% of new diagnoses in 2014 and 2015 (combined); and 2) Arab/West Asian populations — from 12 in 2010 and 2011 (combined) to 28 in 2014 and 2015 (combined).

FIGURE 6 Percent of total HIV diagnoses by ethnicity (where known), Ontario, 2010-2015

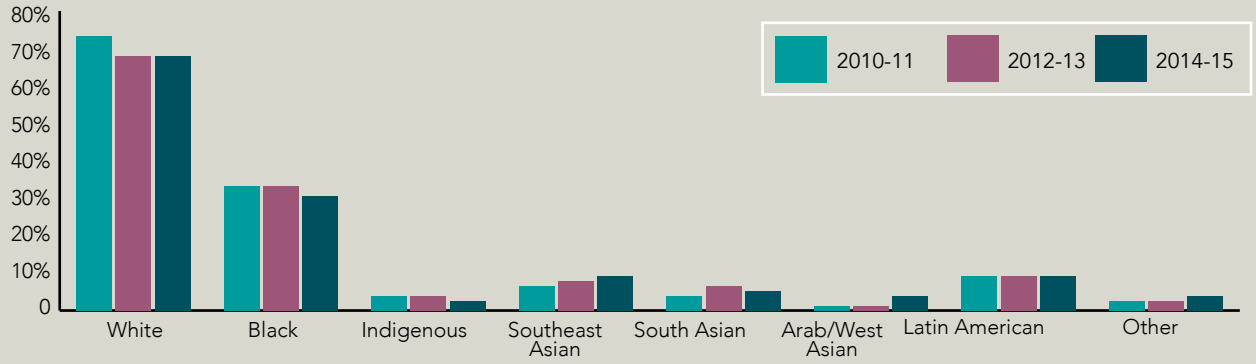


FIGURE 7 Percent of male HIV diagnoses by ethnicity (where known), Ontario, 2010-2015

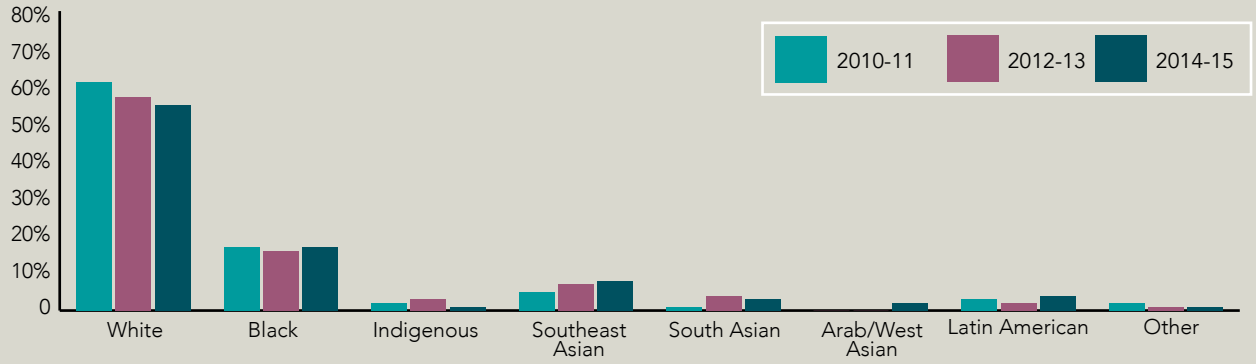
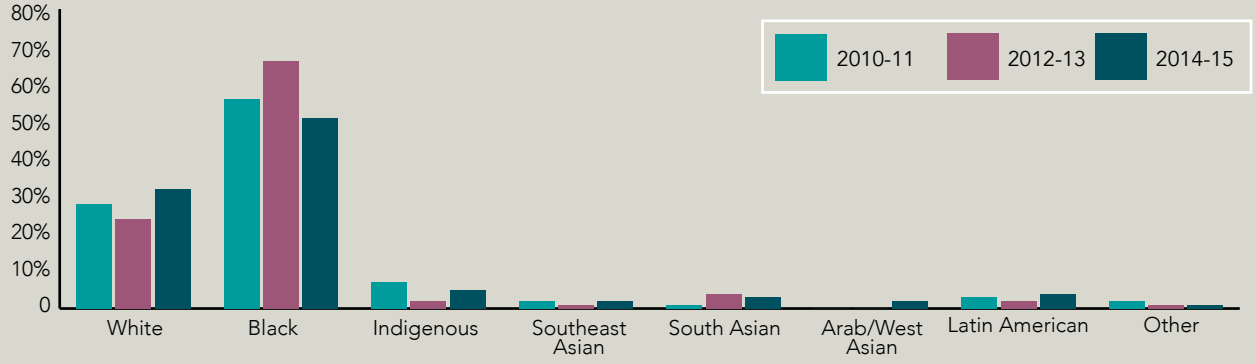


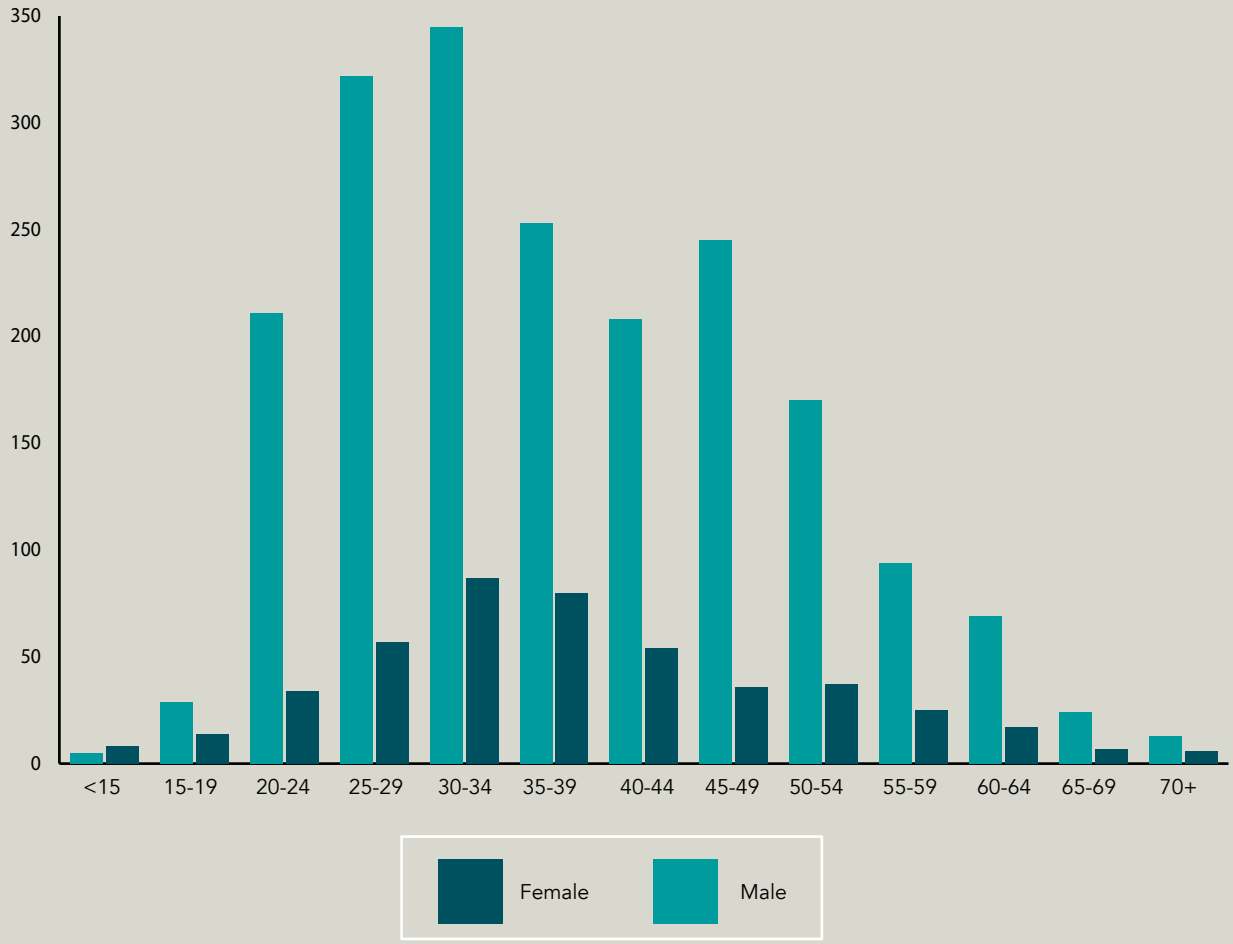
FIGURE 8 Percent of female HIV diagnoses by ethnicity (where known), Ontario, 2010-2015



By age

In the three years from 2013 through 2015, most new diagnoses—for both men and women—were in people aged 30 to 34. However, about four of every 10 new diagnoses—in both men and women—were in people age 40 or older and about 25% of new diagnoses in women and 28% in men were in those under age 30.

FIGURE 9 Number of new HIV diagnoses by sex/gender and age, Ontario 2013-2015



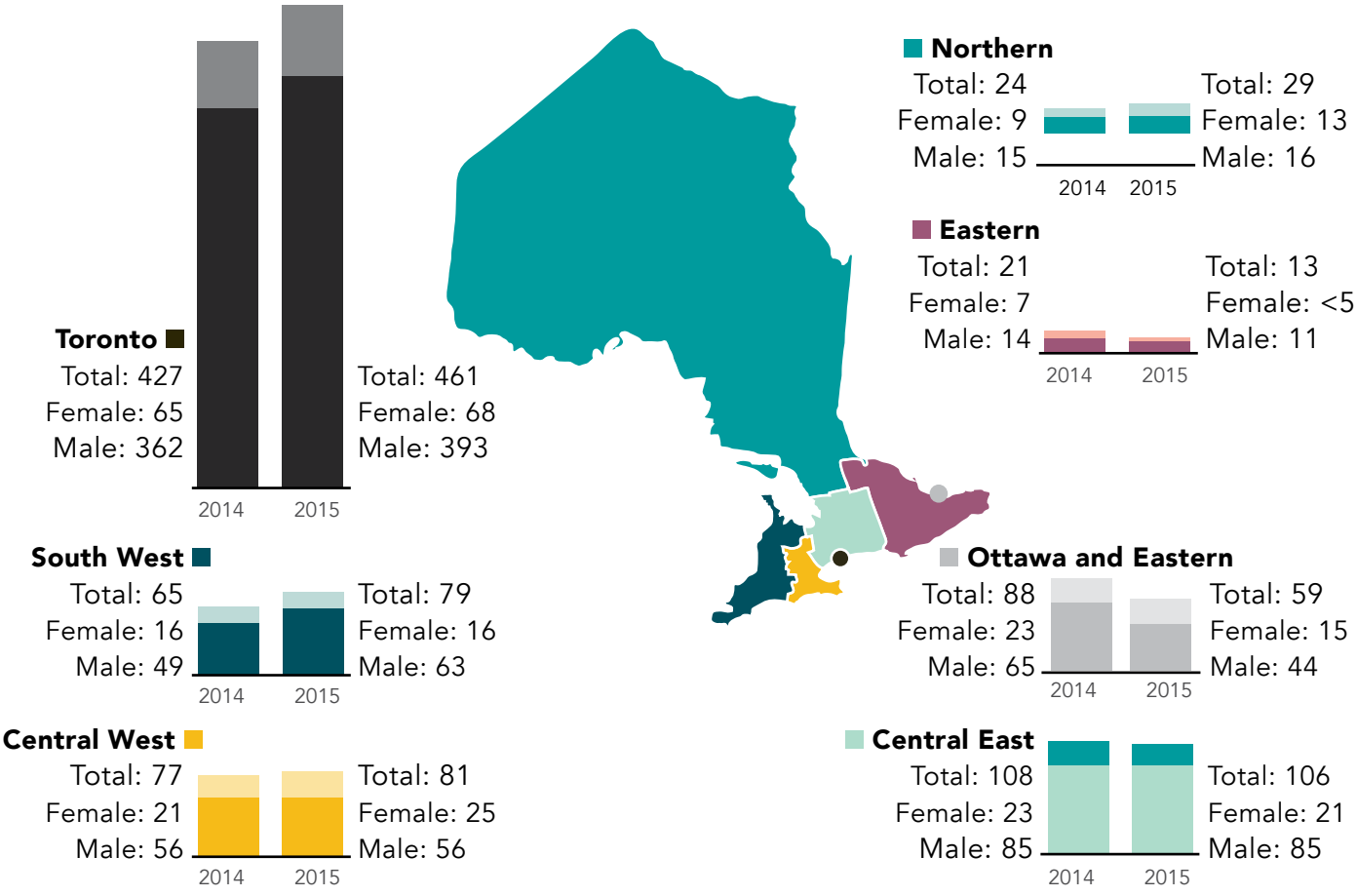
Female	Male
Trends: More women are being diagnosed at age 40 or older.	**Trends**: More men are being diagnosed at older ages — mainly due to the aging of men born in the 1960s, the group that has historically made up the largest proportion of people living with HIV. Over the past 10 years, there has also been a shift to more gay men under age 30 being diagnosed.

Regional snapshot

More than half of all new diagnoses were in people in the Toronto region, followed by Central East, Central West and South West – however, there were new diagnoses in all regions of the province.

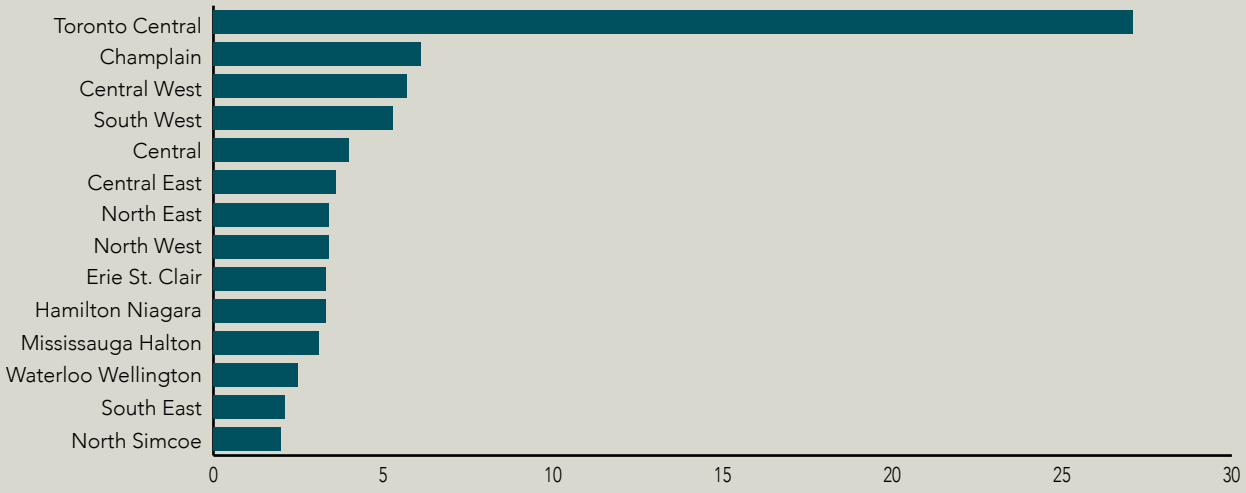
Overall, the number of new HIV diagnoses in 2015 increased in the Toronto, Central West, Northern and South West regions and decreased in the Ottawa and Eastern regions (compared to 2014). A significant proportion of the new diagnoses in both South West and the Northern regions were related to injection drug use. Between 2009 and 2015, 32% of new diagnoses in the South West and 53% of those in the Northern Regions were in people who inject drugs.

When we look at new diagnoses by region and by sex/gender, we see an increase in men in Toronto and the South West and a slight increase in women in Toronto, the North and Central West.



But numbers don't tell the whole story. When we look at the rate of new diagnoses – that is, the number of new diagnoses per 100,000 population – we see that some regions that have a smaller number of diagnoses than other LHIN regions, such as Central West and South West, actually have higher rates of diagnosis. This means that a larger proportion of their population is infected and HIV is more of an issue in their communities.

FIGURE 10 Number of new HIV diagnoses by LHIN, Ontario 2013-2015



HIV services in Ontario

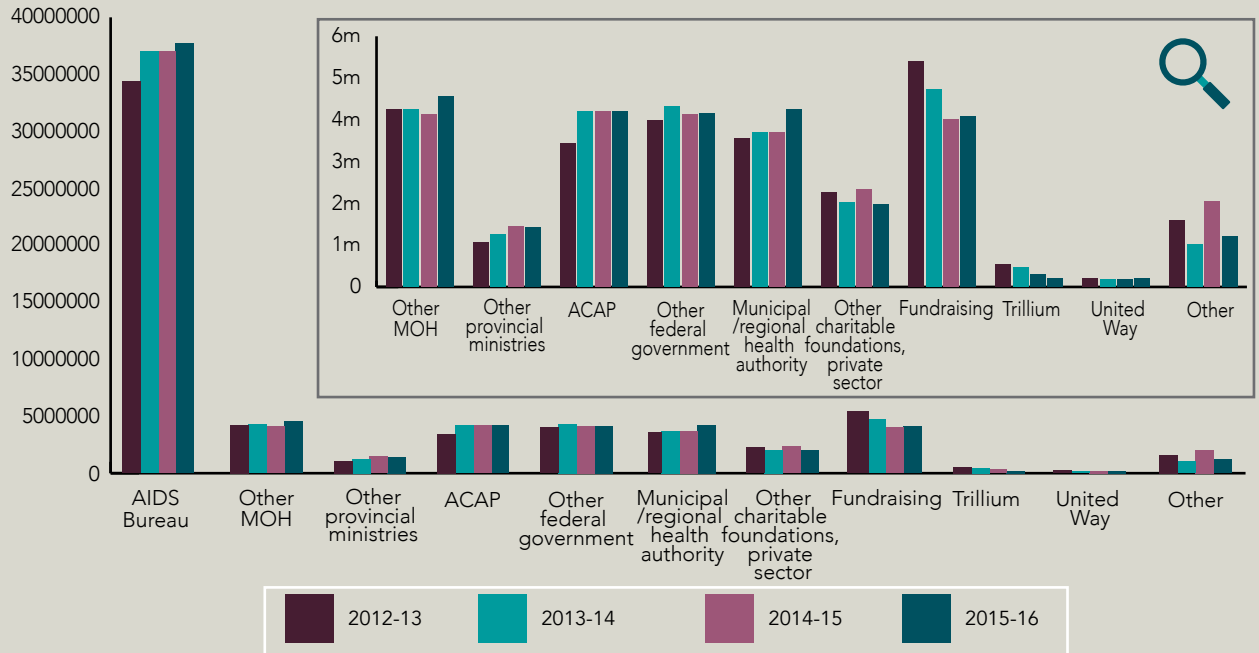
To do their work, community-based HIV organizations rely on funding from government sources (largely from the AIDS Bureau, but also from municipal and federal governments) as well as grant and fundraised dollars. They also need the people and skills to deliver effective programs and services.

The funding landscape in 2015-16

Key Trends

- Overall funding to the sector remained stable.
- More funding was reported from the AIDS Bureau, other Ministry of Health & Long-Term Care funding programs and municipal governments and regional health authorities (local health integration networks – LHINS).
- Less funding came from Trillium or other charitable foundations/private sector.
- Fundraising appears to have plateaued over the past two years at a level that is significantly lower (down 24%) than in 2012-13.

FIGURE 11 All sources of community-based AIDS organisations funding 2012-13 to 2015-16 (OCHART q. 5.1, 5.2, 5.3)



*NOTE: AIDS Bureau & ACAP funding was underreported in program submissions. FIGURE 11 has been adjusted to reflect actual dollars invested.

More paid staff and fewer volunteers and students

In 2015-16 volunteers invested 208,842 hours of time valued at $4,729,000.

That is an average of each volunteer donating $9,400 to the prevention of HIV and improving the lives of people living with HIV.

In 2015-16, programs reported 9 more FTEs working in prevention services than in 2014-15 – a small increase of 2% in the paid workforce – but a decrease in volunteers and students.

While the sector gained 9 FTEs in paid staff, it lost the equivalent of 15 FTEs in volunteer and student hours.

- Programs reported having fewer volunteers and students in 2015-16 – down 6% and 8% respectively.
- The number of peers remained stable.
- Existing volunteers and students gave fewer hours of time: 265,707 in 2015-16 compared to 295,926 in 2014-15.
- Although there were fewer volunteer hours overall, programs reported that more volunteer hours were devoted to practical support and administration and significantly fewer were spent on special events and fundraising or on providing other types of support (not shown on graph).
- Staff participated in a total of 5,678 training opportunities. More than 60% of all training was related to general capacity building and service delivery.

FIGURE 12 Who makes programs work? (OCHART q. 2.2, 9.13a, 12.1, 12.3, 13.5a)

FIGURE 13 Trends in top 8 volunteer activities 2013-14 to 2015-16 (OCHART q. 12.2)

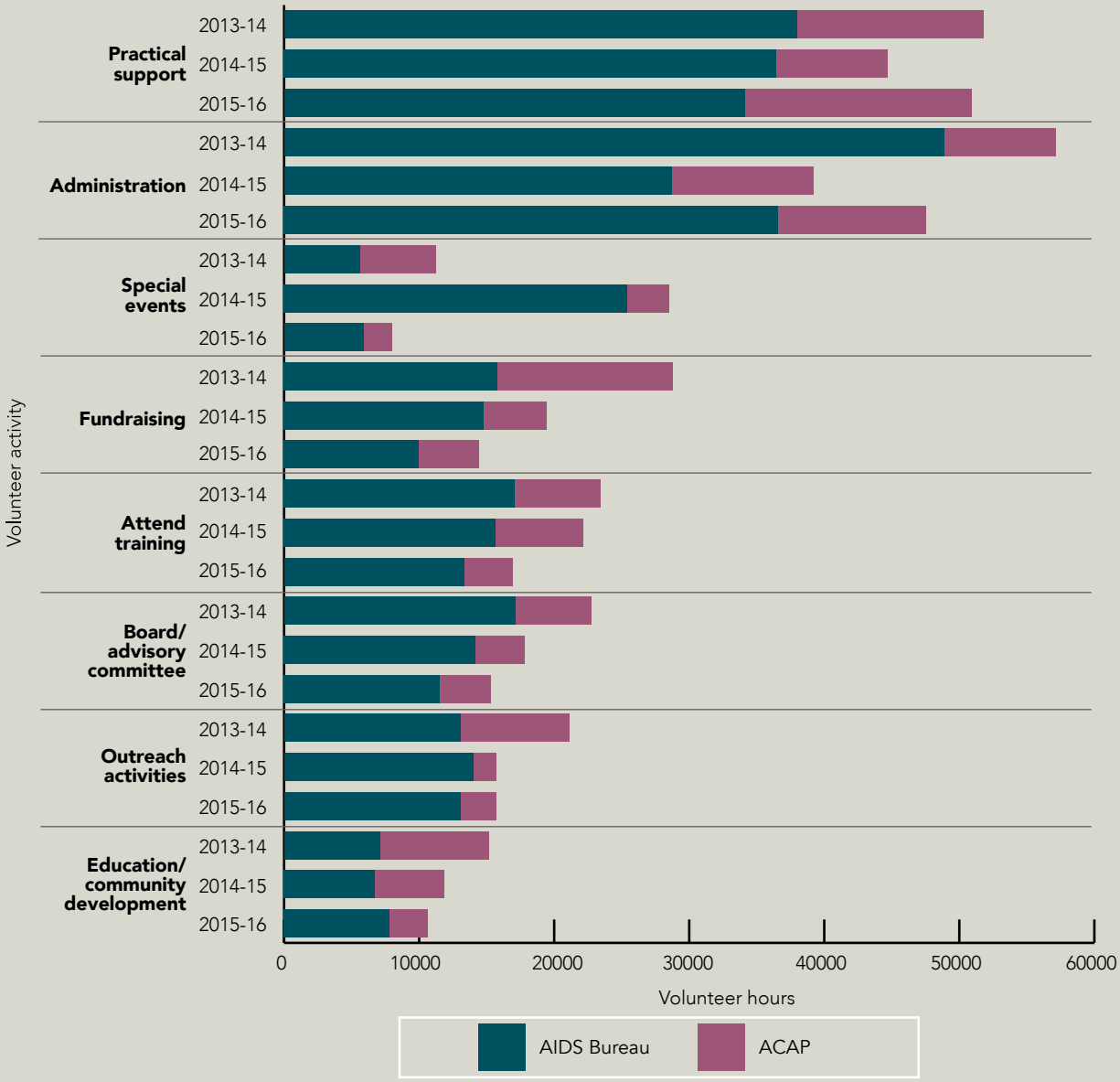
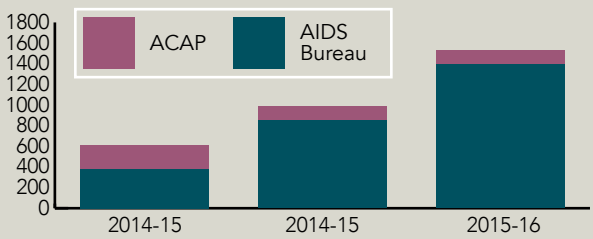


FIGURE 14 Volunteers giving more IT support 2013-14 – 2015-16



Although IT support is not one of the top 8 volunteer activities, it is the one growing at the greatest pace. This is the only activity that has increased for three consecutive years and the numbers have more than doubled in 2 years, suggesting that (as with administration), programs are seeking out volunteers with particular skills to help their organizations.

The challenges: Matching volunteer skills to program needs and fulfilling volunteer expectations

Despite the large number of volunteers and volunteer hours, several programs reported challenges recruiting volunteers with the right skills to meet their service needs – particularly related to outreach, administration (front-desk), transportation, buddies and specialized roles. Programs also noted that it was becoming more difficult to meet volunteer expectations: volunteers often want specific time-limited roles as well as a fulfilling experience.

Agency need		Volunteer needs
We needed to have more volunteers to help in our outreach activities as well as volunteers in IT services. — Action Positive		Volunteers are looking for more opportunities that have a start - finish date in sight due to heavy workloads often through work / school or other life engagements. — HIV/AIDS Resources & Community Health (ARCH)
Less administrative students so higher need for volunteers in this area [and we] require more support in fundraising activities from volunteers and students. — AIDS Committee of Cambridge, Kitchener, Waterloo and Area		Volunteers are looking for roles that have direct interactions with clients. Volunteers are coming with more experience and education in specific areas such as nursing, social work and education. — The AIDS Network
Desperately need more drivers since the Positive Care Clinic moved back to Whitby, but they remain elusive to current recruitment strategies. Increased desire from staff to have volunteers better reflect the priority populations we serve. — AIDS Committee of Durham Region	vs	More students would like to do their school practicum(s) but we are unable to accommodate their requests due to lack of resources (staff/ workers). —Ontario Aboriginal HIV/AIDS Strategy, Sudbury
We are seeing an increased need for volunteers with the following skills: program volunteers, administrative assistants, volunteers who have ASL and peer volunteers (e.g. folks living with HIV and/or knowledge/experience with substance use). — AIDS Committee of Toronto		There has been a growing number of volunteers who come with difficult histories and current challenges who are juggling school, work and mental health challenges. — Peterborough AIDS Resource Network
Increased demand for longer-term volunteers and student placements in order to fulfill specific program requirements [and a] need for specific recruitment methods to fulfill volunteer needs in Chatham office. — AIDS Committee of Windsor		Volunteers are requesting specific roles and departments; unfortunately, due to issues of confidentiality and privacy, we cannot meet all of their demands. — Women's Health in Women's Hands Community Health Centre
We are beginning to see more PHAs asking for "buddies" again. We have had a higher number of requests for transportation from the rural areas. — HIV/AIDS Regional Services		

Agencies are responding to these challenges by changing their recruitment and onboarding methods

Our Black African Caribbean Community Outreach Coordinator rather than our Volunteer Coordinator recruited young Black Caribbean men to specifically work on rural outreach where ACB workers went to shop and relax to encourage them to attend the Durham Migrant Worker Network's Health Fairs. These young men also became ambassadors at multiple ACB Festivals across the region over the summer. In the meantime, our Volunteer Coordinator referred some of our Spanish speaking volunteers to the network to volunteer as translators. This has proved beneficial in other ways as Black Churches find it easier to begin conversations about HIV through this lens furthering our broader prevention work with ACB communities.
— AIDS Committee of Durham Region

Volunteer engagement has now become an ongoing topic of discussion at staff meetings so that we can work together to address the increased demand for volunteer opportunities. We've also started engaging with volunteers via social media since we have such a large service area and want to maintain a connection with our volunteers.
— AIDS Committee of Simcoe County

Increasing recruitment strategies through post-secondary educational institutions to bring students on board as volunteers. Most students are able to make a longer-term commitment due to being unemployed or looking for skills-building opportunities, networking and professional references. This allows us to skills-match students with specific roles for a win-win situation for both the agency programs and the student.
— AIDS Committee of Windsor

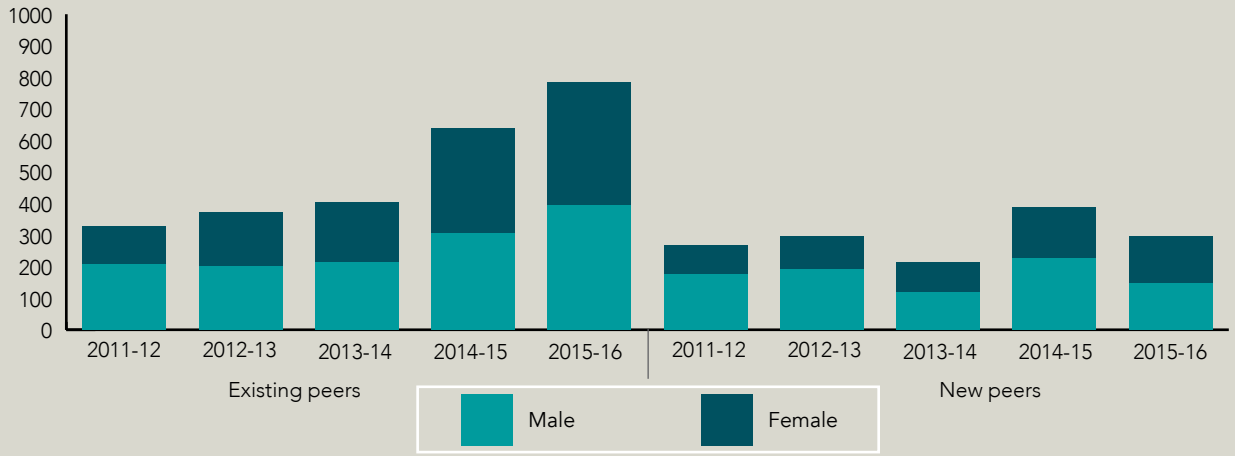
Developed job descriptions and have built in realistic capacity for each program to handle a specific number of volunteers so that we don't have a high number of volunteers with little work for them to do. We have also had to tighten up policies as we expand the nature of volunteer engagement with the Support Program.
— Alliance for South Asian AIDS Prevention

We are adding more information in the initial contact with people so that they know right from the beginning what is needed, how long of a commitment and how important the volunteer tasks are to us. We are considering implementing some kind of written agreement. We are asking up front what their plans are and if they are not going to be available in four months, we are not signing them up.
— Positive Living Niagara

More peers involved in IDU services

Over the past few years, the number of peers involved in IDU services has increased by 80% (from 599 in 2012-13 to 1,079 in 2015-16). Although women accounted for only 35% of IDU clients in 2015-16, they made up 50% of new and existing peers (see FIGURE 15).

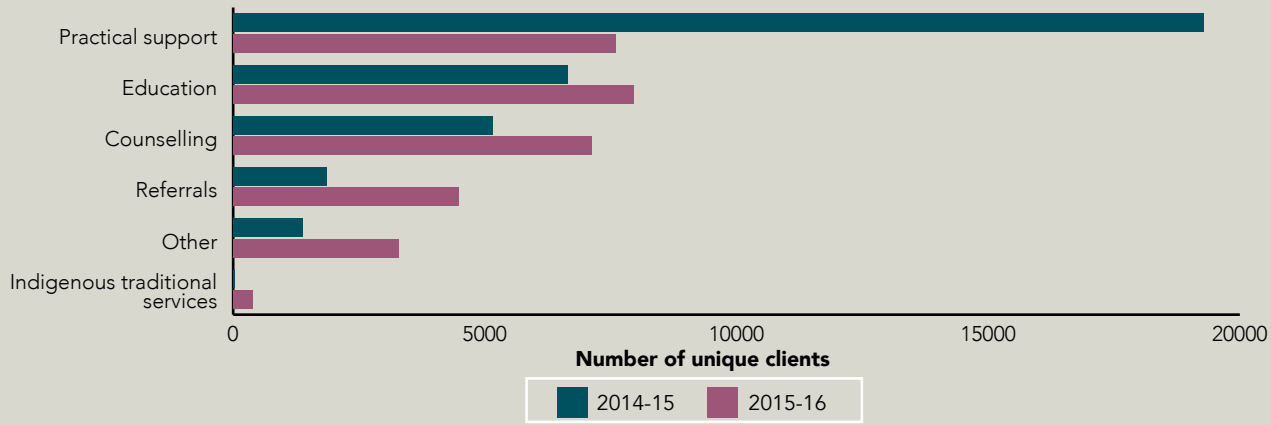
FIGURE 15 Total IDU peers by sex/gender (OCHART q. 13.5)



IDU peers involved in more meaningful work with clients

IDU outreach programs have traditionally recruited peers to assist in distributing materials. In 2015-16, peers appeared to be more involved than in the previous year in providing direct client services, including education, counselling, referrals and traditional Indigenous services. There is good evidence that clients are more likely to follow through on referrals and to act on education and counselling information when peers are involved.

FIGURE 16 IDU peer activities 2014-15—2015-16 (OCHART q. 13.6)



Prevention, education and outreach services including IDU outreach

The goal of these services is to:

1. increase knowledge and awareness of HIV
2. promote healthier behaviours and ultimately prevent the transmission of HIV, and/or
3. improve the health, well-being and quality of life for people living with or affected by HIV/AIDS.

All funded community-based organizations provide education to service users and service providers. Most also offer outreach services.

For the purposes of OCHART, education activities are divided into two main categories: presentations given to groups and one-on-one education provided to individuals.

Key trends

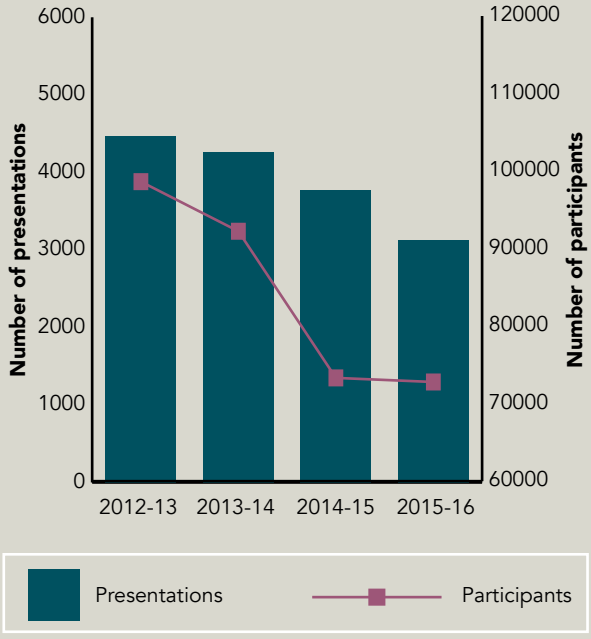
- AIDS Bureau funded presentations reached more participants.
- Programs gave more presentations focused on priority populations.
- Programs reported more targeted outreach to priority populations.
- Outreach programs made more use of online tools including social media to connect with people at-risk.

Fewer prevention presentations but same number of people reached

In 2015-16, community-based programs delivered 3,122 prevention presentations. Although the number of presentations was down 17% from 2014-15 (3,777), the number of people reached decreased by only 1% (from 73,321 to 72,793).

The reduction in the total number of presentations was due in part to changes in the federal government's AIDS Community Action Program, which has traditionally funded prevention activities, including presentations.

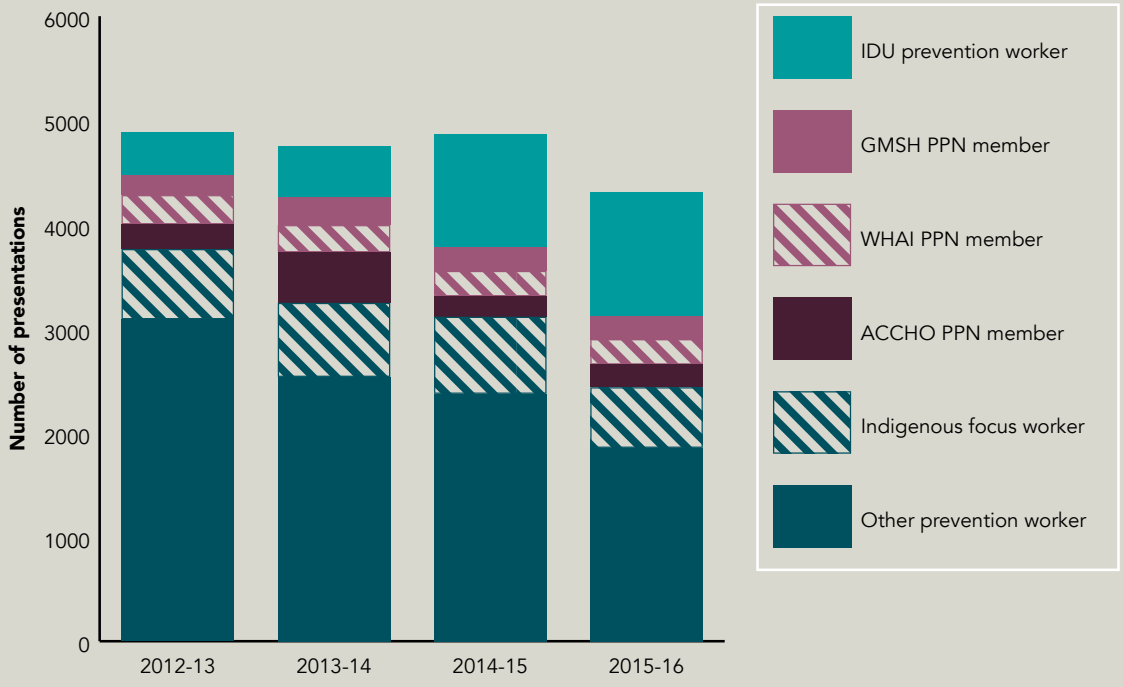
FIGURE 17 Number of education presentations and participants (OCHART q. 9.1.a)



Population-specific workers – particularly IDU outreach workers – delivered more presentations

In 2012-13 and 2013-14, general or "other" prevention workers delivered most education presentations (63% and 53% respectively). However, over the past two years, population-specific workers have delivered a larger portion of presentations (51% in 2014-15 and 57% in 2015-16). The most significant increase was in presentations given by IDU outreach workers. In 2015-16, they delivered 28% of all presentations compared to 9% in 2012-13. The increase in 2015-16 was due mainly to four agencies: two in Ottawa, one in Toronto and one in Northwestern Ontario.

FIGURE 18 Number of presentations by worker type 2012-13 – 2015-16 (OCHART q. 13.7 and 9.1.a)



General prevention education workers focus on service providers

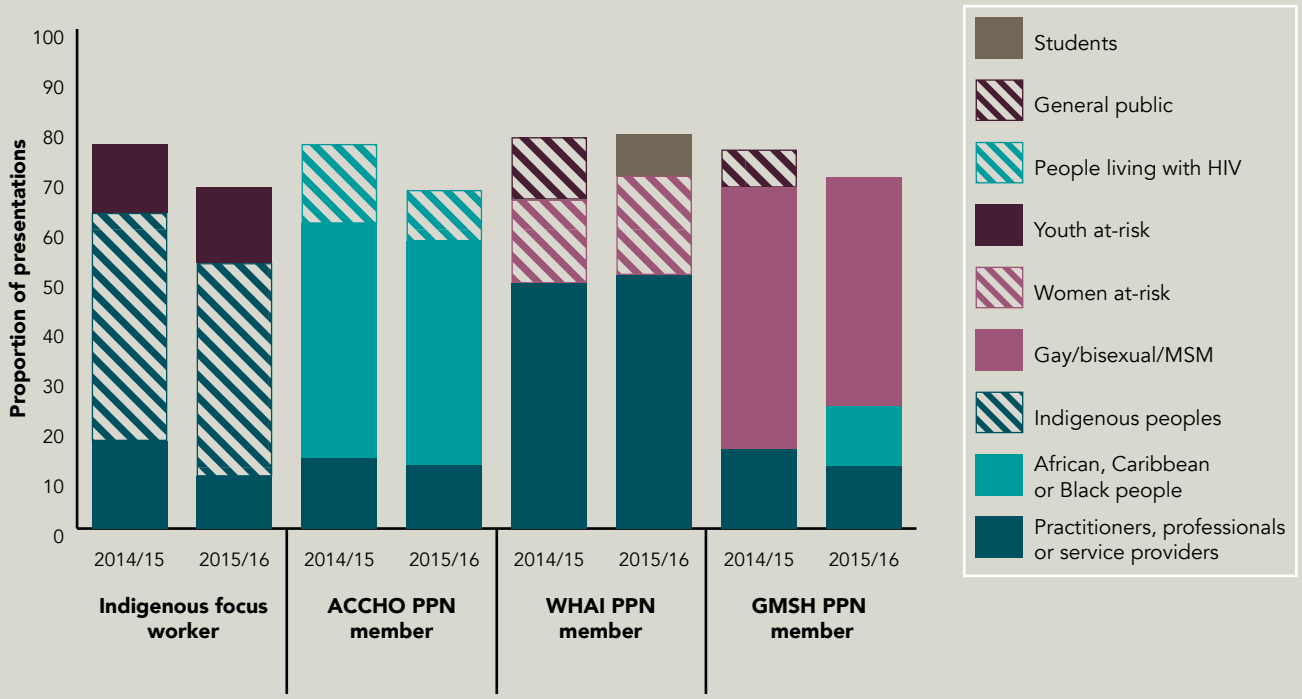
General prevention education workers gave fewer presentations in 2015-16; however, practitioners, professionals or service providers continue to be their primary audience. The drop in the number of presentations to students may reflect the fact that fewer organizations are doing presentations in schools.

FIGURE 19 Top 6 intended audiences for education presentations by general prevention education staff 2013-14 – 2015-16 (OCHART q. 9.1.a)

Population-specific workers focus on priority populations

FIGURE 20 shows the top three audiences for prevention education presentations by worker type. As would be expected, the population-specific workers focused on their populations. In 2015-16 almost half of all presentations delivered (46%) by the Indigenous focused workers were to Indigenous peoples, while 45% of all presentations delivered by ACCHO PPN members were to ACB communities. For all population-specific workers except the GMSH workers, the top three audiences were consistent over the past two years. In 2015-16, 12% of all presentations by GMSH workers were to ACB communities.

FIGURE 20 Top 3 audiences reached by population-specific workers 2014-15 – 2015-16 (OCHART q. 13.7 and 9.1.a)



Increase in population-specific one-on-one education

In addition to delivering structured education presentations, workers also provide one-on-one education, which includes responding to requests for information over email and phone as well as in-person conversations. The number of requests for one-on-one education dropped 19% in 2015-16 compared to 2014-15; however, the number of requests to population-specific workers increased across all populations except Indigenous. The drop in the number of requests to Indigenous focused workers was due mainly to a shift in programming at one agency that no longer reports presentations through OCHART.

FIGURE 21 One-on-one in-service education requests by worker type 2014-15 – 2015-16 (OCHART q. 9.10.2)

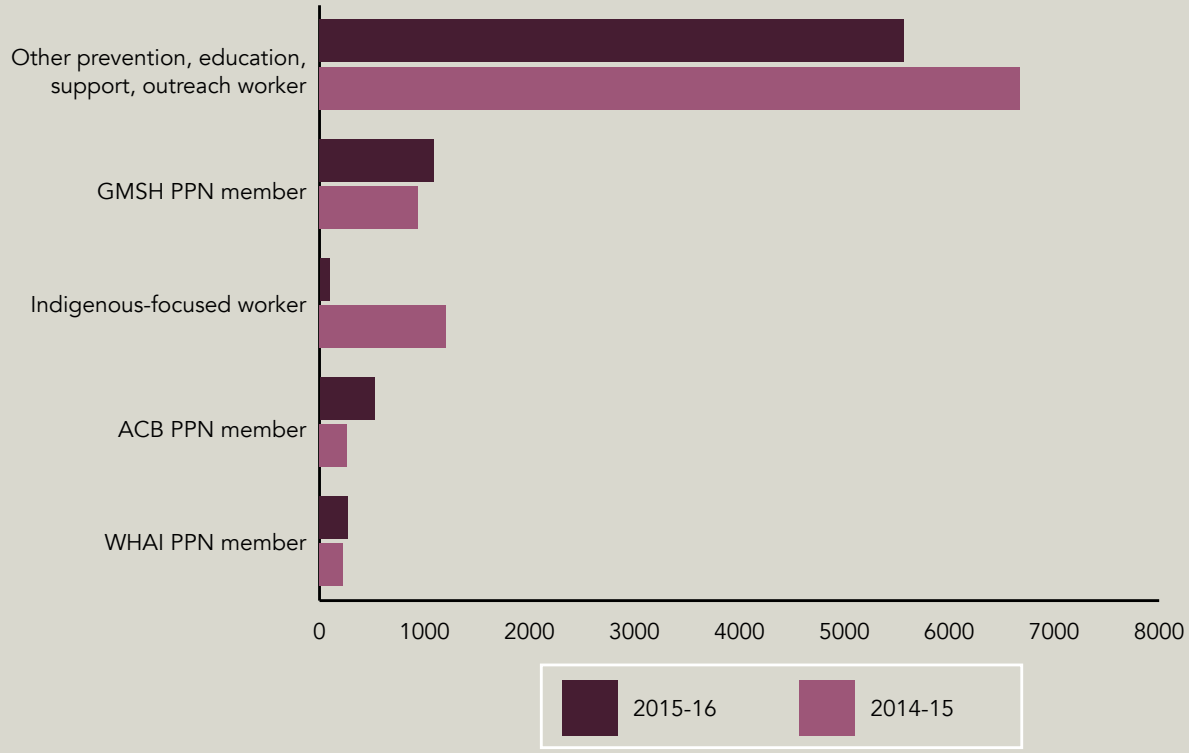


FIGURE 22 Top 3 one-on-one education requests by worker type (OCHART q.9.2)

Other prevention, education, support, outreach worker
Population-specific issues
STIs/safer sex
HIV/AIDS 101

GMSH PPN member
STIs/safer sex
HIV testing
Population-specific issues

ACB PPN member
Population-specific issues
Living with HIV
HIV/AIDS 101

Indigenous-focused worker
Population-specific issues
HIV/AIDS 101
STIs/safer sex

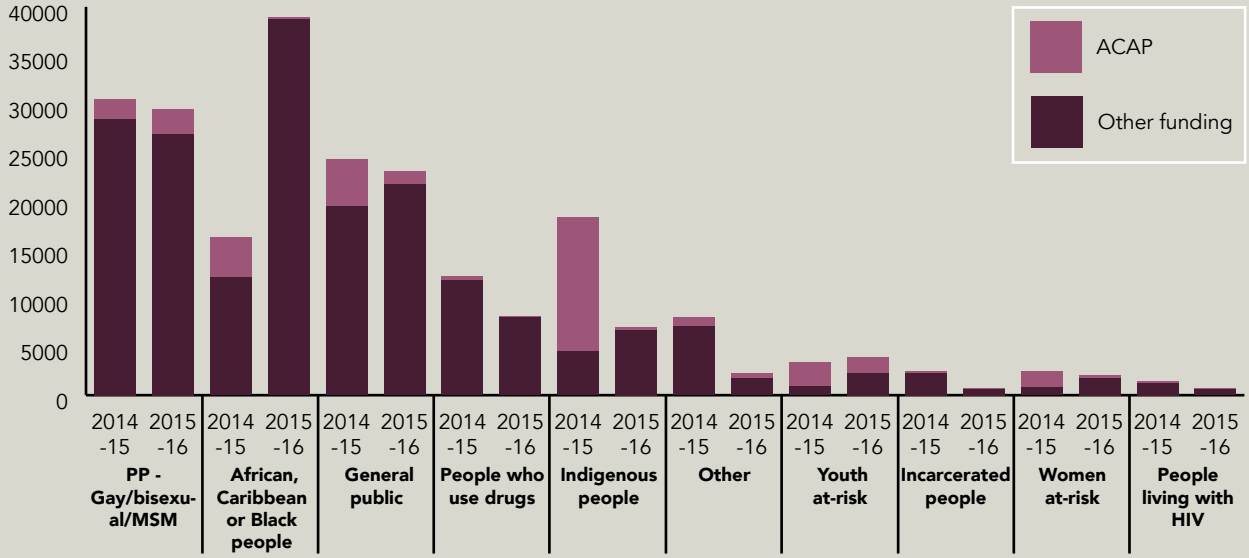
WHAI PPN member
Population-specific issues
Addressing violence
Diversity/anti-oppression/cultural competence

Outreach focused on priority populations

Compared to 2014-15, outreach programs reported fewer brief and significant outreach contacts in 2015-16. While the number of overall outreach contacts is down, the number of brief outreach contacts in African, Caribbean or Black communities more than doubled in 2015-16 – mainly due to three programs.

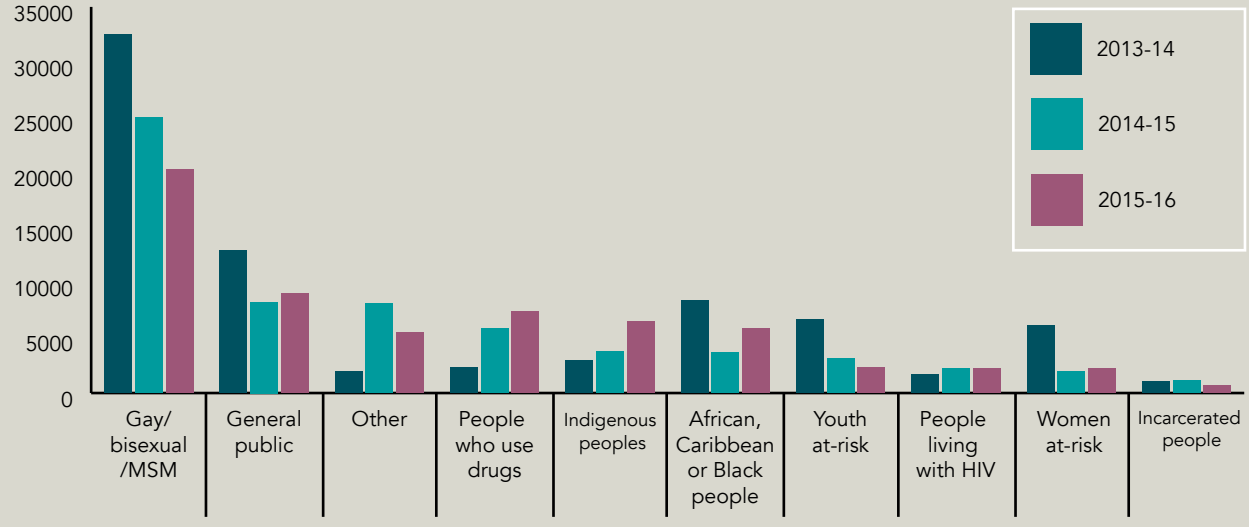
Brief contacts do not involve a two-way interaction and may include people taking material (e.g., a pamphlet) at event booths.

FIGURE 23 Number of brief outreach contacts by population reached and funder 2015-15 — 2015-16 (OCHART q 9.10b)



Over the past three years, there has been a steady increase in significant outreach contacts with people who use drugs and with Indigenous peoples (see FIGURE 24).

FIGURE 24 Number of significant outreach contacts by population 2013-14 – 2015-16 (OCHART q. 10a)



Shifts in location for significant outreach interactions

Over the past three years, programs have reported large fluctuations in the locations of significant outreach contacts. The largest shift reported in 2015-16 was a 66% increase in the number of significant outreach contacts made at "other" locations. The most commonly reported "other" locations were: special events, restaurants and educational institutions. Fewer contacts were made through outreach in bars/nightclubs (13,121 in 2015-16 compared to 15,206 in 2014-15). There was also a substantial decrease in the number of contacts made at faith-based organizations, which was due to one program no longer reporting outreach contacts in OCHART. Changes in outreach locations can be expected over time depending on trends in the priority populations and program capacity/resources.

TABLE 1 Largest shifts in significant face-to-face outreach contacts by location (OCHART q.9.10a)

Location	2013-14 (programs reported)	2014-15 (programs reported)	2015-16 (programs reported)
Bathhouses	27,998 (22)	13,923 (9)	15,653 (11)
Other (please specify)	4,754 (22)	7,921 (33)	13,121 (34)
Bars/nightclubs	5,115 (22)	15,206 (17)	10,041 (17)
Drop-in centres	3,556 (22)	1,944 (11)	3,838 (19)
Street (includes parks)	7377 (13)	3,647 (16)	3,755 (25)
Other community agencies	2354 (24)	2,386 (26)	3,443 (24)
Clinics/health centres	3343 (25)	3,411 (24)	1,676 (24)
Faith organizations	4,284 (11)	4,790 (10)	481 (12)
Massage parlors	293 (3)	212 (2)	434 (2)
Shelters	367 (10)	1,133 (7)	277 (10)
Mobile	561 (12)	551 (8)	230 (3)

Programs report using online tools for outreach

In addition to doing outreach in physical locations in their communities, programs are reaching out online. The data on online contacts was difficult to interpret; however, programs provided anecdotal reports about the effectiveness of online outreach.

Having a new website, increasing our tweeting capacity and posting more information on our Facebook page help to reach out more diverse populations.
— Action Positive

We have seen huge requests for online media from African refugees and newcomers. APAA Facebook and Twitter, which encourage people to know their HIV status, have seen participation from all Africans who contribute their opinion and comments.
— Africans In Partnership Against AIDS

Onsite testing campaign increased contact with men I haven't been able to reach in the past.
— AIDS Committee of Durham Region

We have made a conscious effort to encourage meaningful engagement on social media. Our audience has grown significantly on Facebook and Twitter thanks to regular, engaging posts.
— The Gilbert Centre

Online outreach continues to evolve, and has grown its volunteer base during this reporting period. The gay men's team has also been providing support to the bathhouses around GHB overdose prevention. The outreach conversations continue to deepen, as people (of all ages) seem to have comfort in speaking about HIV, and the conversation has evolved to topics of testing guidelines and PrEP.
— AIDS Committee of Toronto

The ACB program has used web-based and social media platforms to engage target populations and promote our activities within the program more during this period. The ACB HIV testing day on February 7th was posted on CHABAC's web page. We shared this on our Twitter and Facebook pages and we also wrote an article about our regional efforts around our agency's annual HIV Testing campaign for CATIE's Prevention in Focus Spring 2016 edition.
—AIDS Committee of Windsor

Our online outreach efforts have been continually growing and we have seen greater engagement with at-risk groups through emails and phone calls. We are consistently referring people to our sexual health clinics for testing through the online outreach program.
—AIDS Committee of York Region

The Casey House website has allowed for greater and more timely awareness of the information on the site. It has been helpful to mix useful HIV related 'advice,' related news posts, client stories and posts about Casey House activities.
— Casey House Hospice

Challenges in outreach

Stigma and discrimination

We work closely with progressive leaders in the community and focus our efforts on building trust.
— Africans In Partnership Against AIDS

We continue to recruit and support people living with HIV as ambassadors for communication and education to facilitate the voice of people living with HIV and demonstrate they are not alone.
— Casey House Hospice

Cost of advertising

Facebook is by far the platform on which ACT has the most traction and achieves the most engagement. Facebook is also increasingly a paid platform. We do not have a significant budget to promote our posts on Facebook and as a result our posts are not reaching the number of people we were once seeing. It would be really nice to have more of a budget to promote specific programs and services on Facebook to those target audiences.
— AIDS Committee of Toronto

Have gotten free 'not for profit' advertising from Scruff. I am also using Craigslist, Facebook and Twitter.
— AIDS Committee of Durham Region

IDU outreach services

In 2015-16, the AIDS Bureau funded 22 IDU outreach programs and, in addition, another 12 to 16 programs reported providing IDU outreach services in 2015-16. (Note: Over time, the number of "other" agencies — that is, not specifically funded for IDU outreach services — has ranged from 12 to 18 and they do not always report consistently.) To get a better sense of trends, we looked at the data reported by both the funded and other programs as a whole as well as some breakdowns of services.

TABLE 2 Funded IDU outreach programs and other programs that reported in section 13 for 2015-16

Funded IDU Outreach Program

- AIDS Committee of Durham Region
- AIDS Committee of Windsor
- Elevate North Western Ontario (NWO)
- Central Toronto Community Health Centre
- City of Ottawa Public Health
- 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 Centre
- 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 Programs*

- AIDS Committee of Cambridge, Kitchener, Waterloo and Area
- AIDS Committee of North Bay and Area
- AIDS Committee of Ottawa
- The Gilbert Centre
- Algoma Group Health
- Black Coalition for AIDS Prevention
- The AIDS Network (Hamilton)
- HIV/AIDS Regional Services
- Ontario Aboriginal HIV/AIDS Strategy - Sudbury
- Toronto People With AIDS Foundation
- Waasegiizhig Nanaandawe'iyewigamig
- Youth Services Bureau of Ottawa**

*Between 2010-11 and 2014-15, at least 10 other programs (not listed above) reported in section 13 of OCHART.
**reported in H1 only

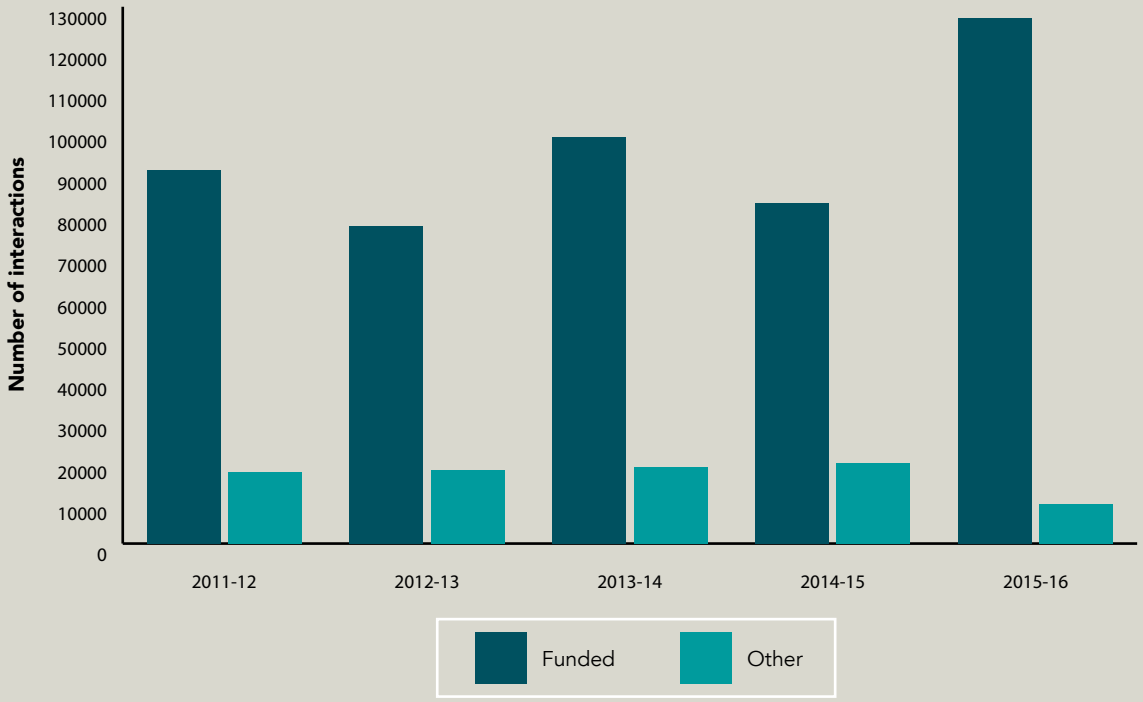
Key Trends

- IDU funded programs reported more in-service and outreach interactions.
- Other funded programs reported fewer interactions.
- Community agencies are the most popular location for IDU outreach.
- Men make up 65% of all clients and use 60% of all services.

IDU programs report 34% more interactions

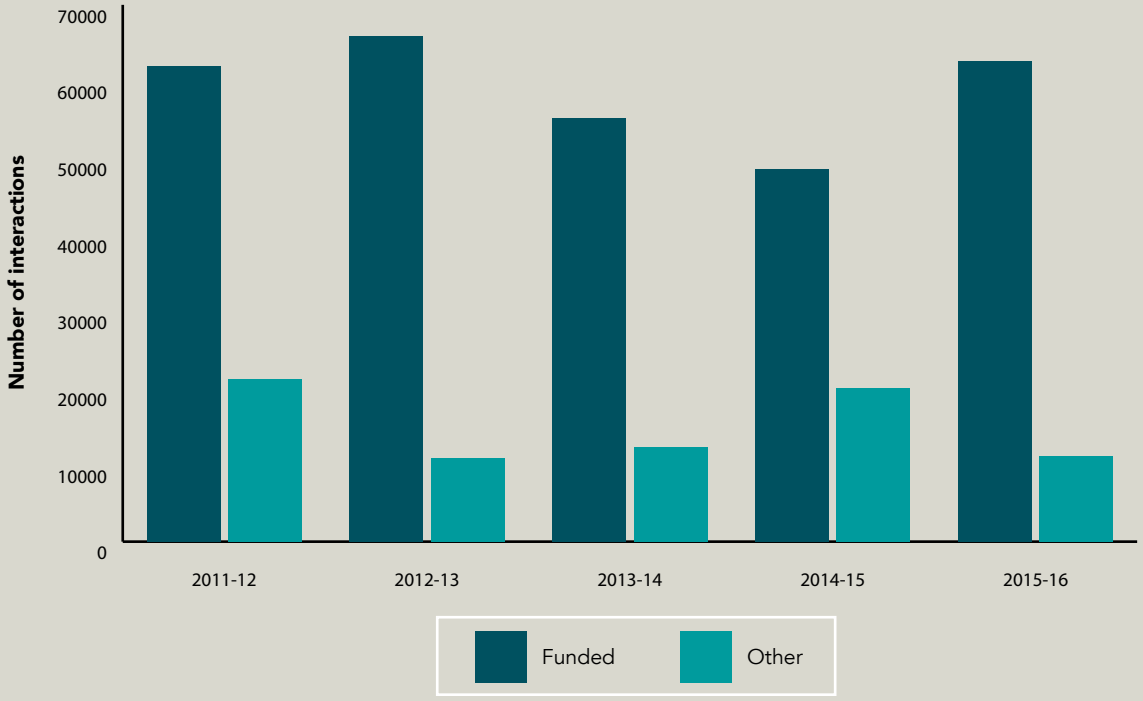
Overall, IDU programs reported a 34% increase in in-service interactions (see FIGURE 25). Funded IDU outreach programs are driving this trend: they reported a 46% increase in in-service interactions (120,178 in 2015-16 compared to 82,562 in 2014-15) while other programs reported 14% fewer interactions.

FIGURE 25 Total number of IDU in-service interactions by funded IDU outreach programs and other programs 2011-12 – 2015-16 (OCHART q. 13.21)



As FIGURE 26 shows, IDU programs reported an overall 8% increase in outreach interactions. This increase was driven by the funded programs: they reported a 29% increase in the number of outreach interactions while other programs reported a 44% decrease. The drop in both in-service and outreach interactions among other programs is likely due to the fact that two fewer programs reported in OCHART in 2015-16.

FIGURE 26 Total number of IDU outreach interactions by funded IDU outreach programs and other programs 2011-12 – 2015-16 (OCHART q. 13.1.1)



Community agencies are the most popular location for IDU outreach

Community agencies and services were the most popular outreach location reported by all programs followed by "other" locations. While streets/parks and a residence were common locations for both types of programs, funded programs reported more mobile outreach and outreach at pharmacies (see FIGURE 27), whereas other programs reported more outreach at bars/night clubs (see).

FIGURE 27 Total number of outreach interactions in the top 6 outreach locations for funded IDU outreach programs 2014-15 – 2015-16 (OCHART q. 13.4)

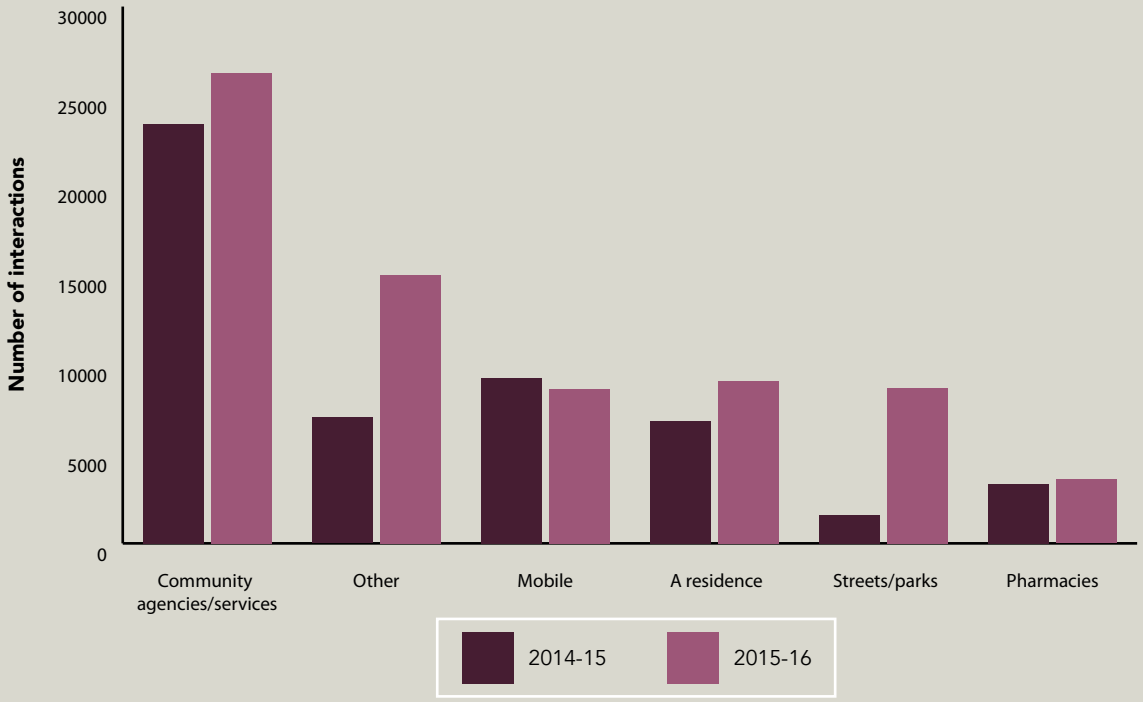
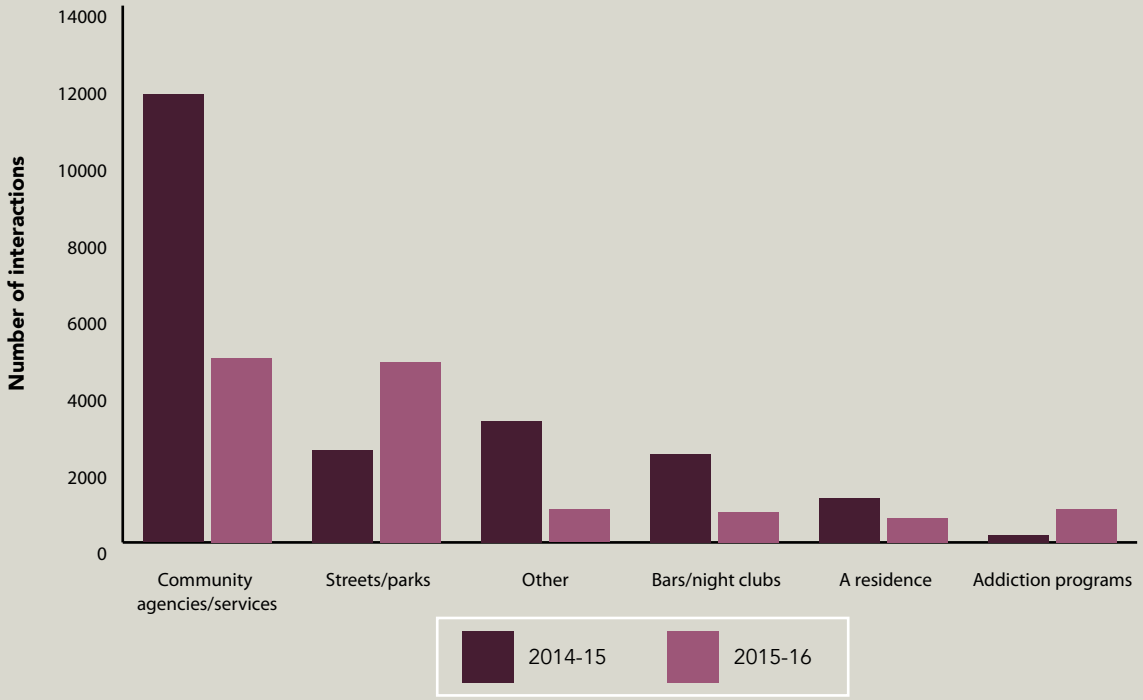


FIGURE 28 Total number of outreach interactions in the top 6 outreach locations for other IDU outreach programs 2014-15 – 2015-16 (OCHART q. 13.4)

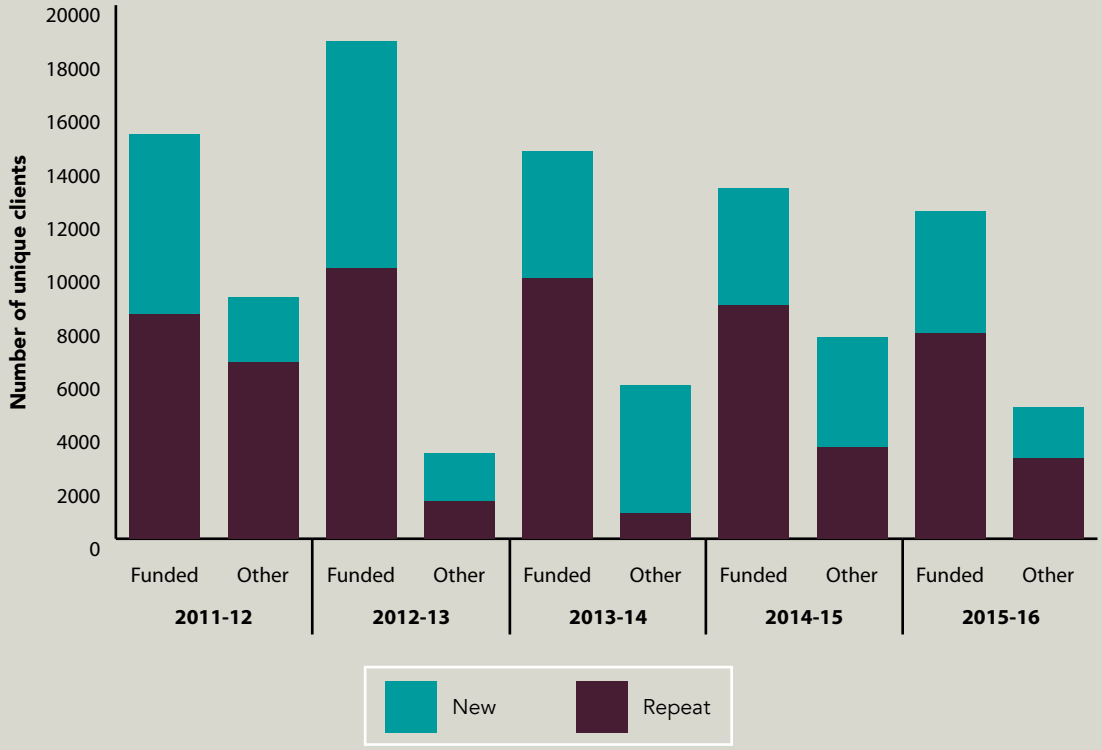


Unique outreach clients

OCHART asks IDU programs to report the number of unique clients they serve (in addition to total number of contacts); however, some agencies do not have the ability to track unique clients. As a result, the numbers reported tend to fluctuate over time and may not accurately represent the actual number of unique people accessing services.

The total number of unique outreach clients reported by IDU programs in 2015-16 was down 17% compared to 2014-15 (see FIGURE 29). Funded IDU outreach programs reported more new (+5%) and fewer repeat (-12%) unique outreach clients, while other programs reported 54% fewer new unique outreach clients and 13% fewer repeat outreach clients.

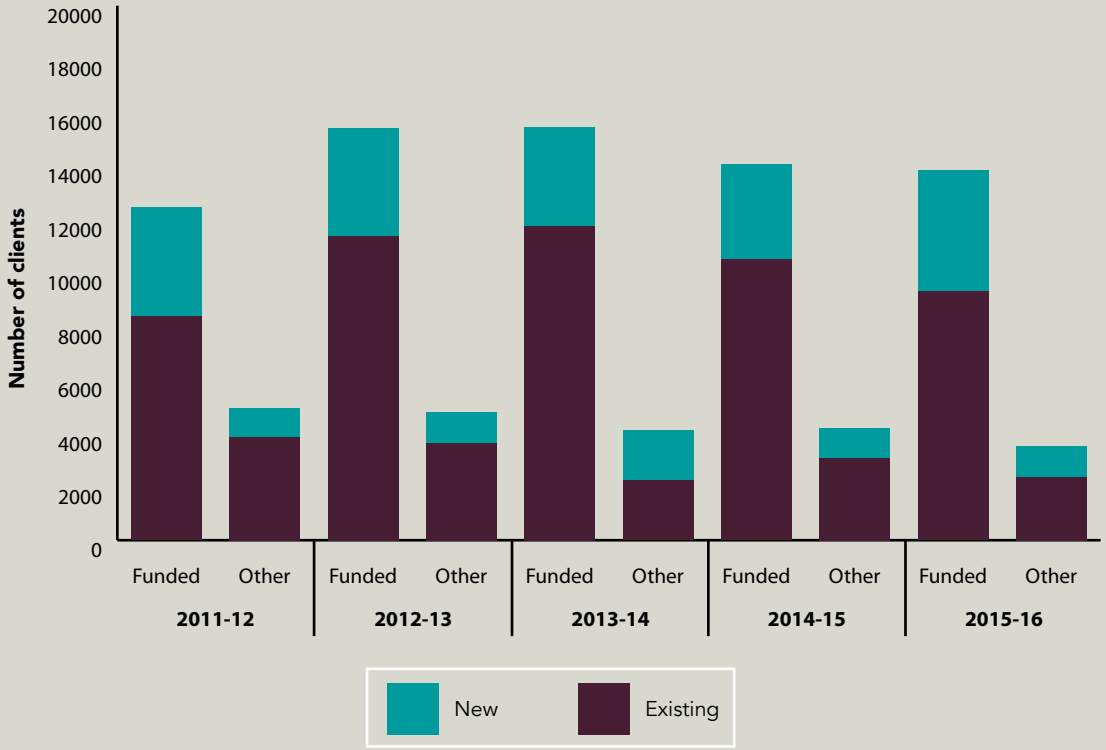
FIGURE 29 Total number of unique outreach clients reported by funded IDU outreach programs and other programs 2011-12—2015-16 (OCHART q. 13.1.2)



Unique in-service clients

For funded programs, the number of new unique in-service clients increased by 28% while other programs reported a smaller increase of 4%. Both funded and other programs reported slightly fewer in-service contacts. Funded programs reported serving over 13,000 unique individuals, while other programs reported between 4,000 and 5,000 unique in-service clients.

FIGURE 30 Total number of unique in-service clients reported by funded IDU outreach programs and other programs 2011-12 to 2015-16 (OCHART q. 13.2.2)



Most IDU service users are male

	Male	Female	Trans woman	Trans man
Outreach clients, 2015-16	10,825	6,263	73	53
In service clients, 2015-16	11,597	5,638	81	63

Clients access more IDU services and referrals

Both funded and other IDU programs reported large increases in the number of clients accessing:

- practical support — +121%
- education — +69%
- referrals to medical services — +197%
- referrals to harm reduction/addictions services — +>200% (20,130 in 2015-16 vs 7,873 in 2014-15)
- referrals to faith-based services/spiritual support — +35% (831 in 2015-16 vs. 617 in 2014-15).

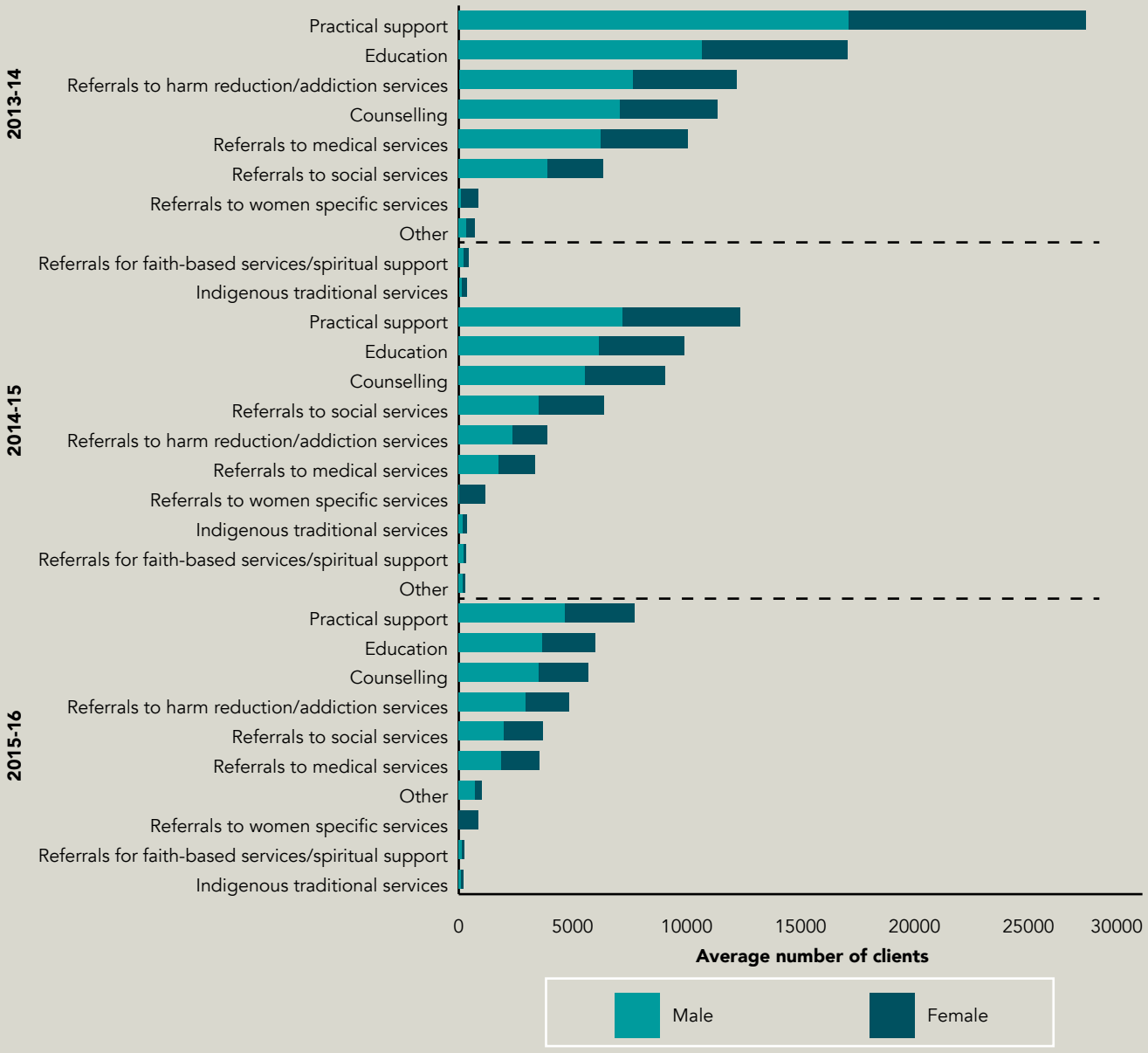
These trends may indicate that programs are becoming more effective at linking people to the services they need and retaining people in care.

FIGURE 31 Top 4 IDU services provided over 3 years by type of program (OCHART q. 13.3a)

Most IDU service users are men

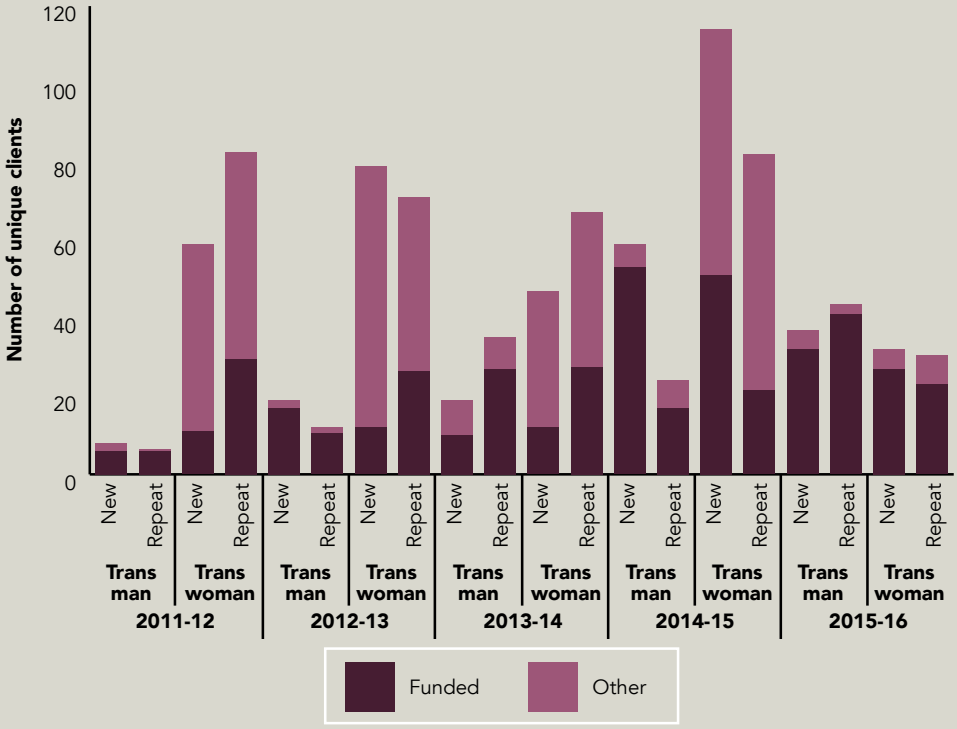
Men made up 65% of all IDU service clients in 2015-16 and used 60% of the services provided. Women made up 35% of all clients and used 40% of all services. (Fewer than 1% of clients were trans people.) With the exception of referrals to women-specific services, there were no differences in the types of services used by sex/gender.

FIGURE 32 Use of IDU support services by sex/gender 2013-14 – 2015-16 (OCHART q. 9.13.3a)



The number of trans people reported to be served by programs has fluctuated primarily due to inconsistent reporting. With the exception of one program in Toronto, most programs reported serving fewer than 5 trans clients. In terms of services, trans people mainly used practical support.

FIGURE 33 Total number of unique in-service trans clients over 5 years by program type (OCHART q. 13.2.2)*

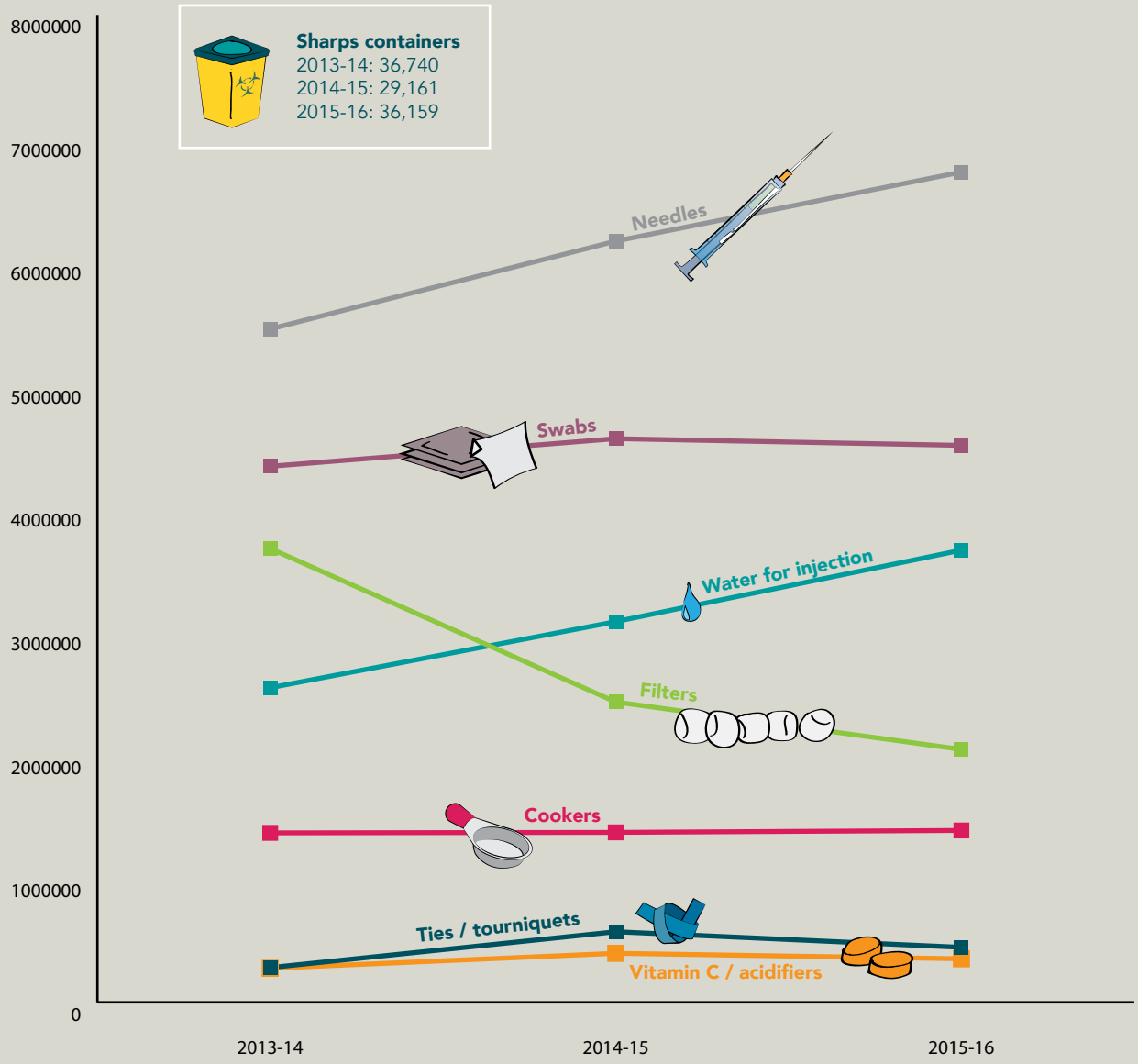


*2 other programs removed from analysis due to inconsistent reporting

Programs distributed more than 19 million units of safer injection supplies

In 2015-16, more than 19 million units of safer injection supplies were distributed. Over the past three years, more needles, filters, water for injection and vitamin C/acidifiers were distributed. For the third year in a row, fewer filters were distributed.

FIGURE 34 Trends in safer injection supplies distributed 2013-14—2015-16 (OCHART q. 13.10a)



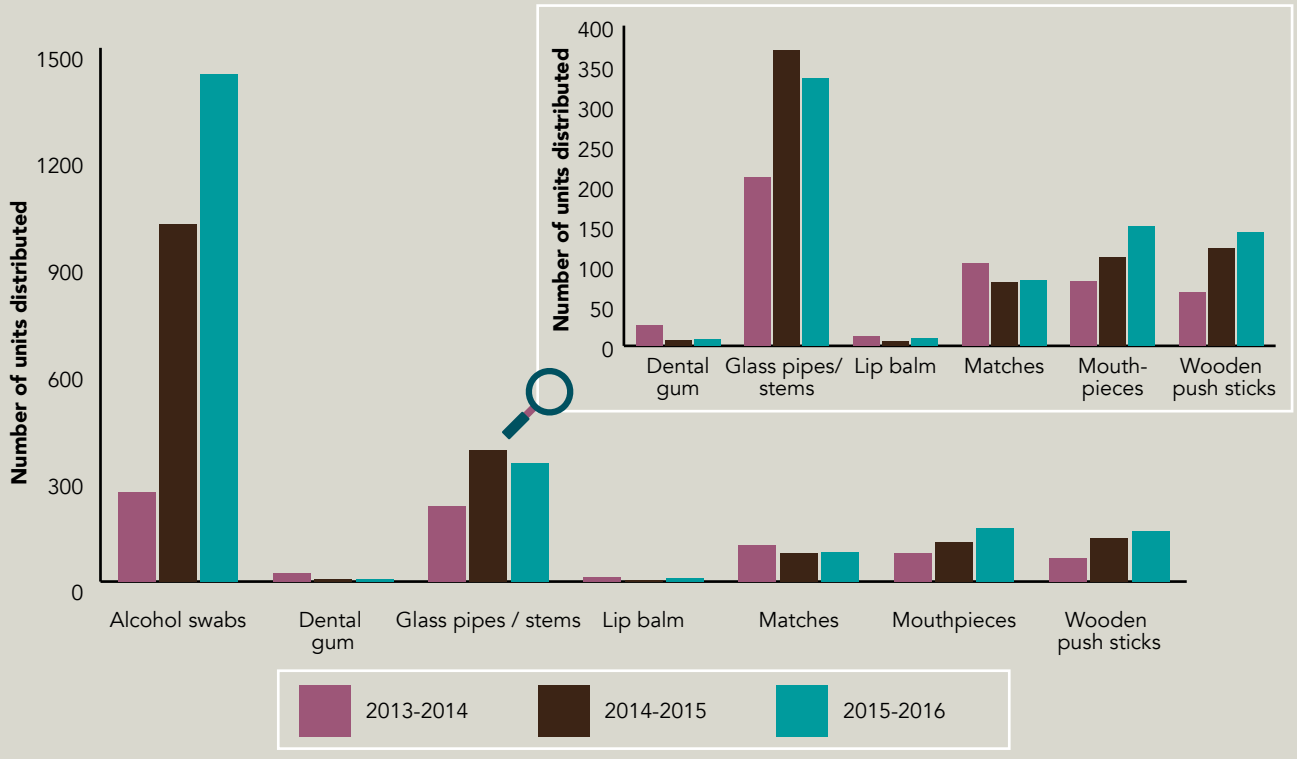
Despite the increase in the number of needles distributed, programs still report a gap between need and supply:

We have been limited to the number of needles we are being given by the needle exchange to carry out our outreach duties and shifts throughout the year. This doesn't allow us to follow best practices and give the amount of needles that our community members sometimes request as we will run out of needles by the end of the month. We were told that this is due to the budget the Health Unit has set out for our needle exchange. This has become a difficult challenge.
— Réseau ACCESS Network

Stable distribution of safer inhalation supplies

In 2015-16, programs distributed a total of 2,150 safer inhalation supplies with alcohol swabs accounting for 66% of the total. Programs reported they had more access to swabs which accounts for the 27% increase in swab distribution. All other supply categories remained stable.

FIGURE 35 Trends in safer inhalation supplies distributed 2013-14 – 2015-16 (OCHART 13.10a)



Crystal meth on the rise

Crystal Meth is becoming more prevalent in the region, and there are reports that people are adapting the safer inhalation kits to smoke meth.
— Positive Living Niagara

Clients are reporting that they are using the safe inhalation pipes to inhale crystal meth "hot railing".
— Regional HIV/AIDS Connection

There has been a shift to people using methamphetamine in our area [and] an increase in people requesting access to meth pipes, which we currently cannot accommodate.
— AIDS Committee of Cambridge, Kitchener, Waterloo and Area

Slight increase in reported crystal meth amphetamine use.
— AIDS Committee of Durham Region

We have had many requests for equipment related to smoking crystal methamphetamine. We have been unable to directly respond due to difficulty sustaining the service related to financial cost.
— AIDS Committee of Ottawa

While it does not show up in top three drug of choice statistics, we have seen an increase in methamphetamine and crystal meth in the past few months. More are coming in looking for information and resources for safer snorting and safer smoking related to this trend.
— AIDS Committee of North Bay and Area

Crystal meth is now being seen in Thunder Bay. Although there is still not a strong uptake in the drug, with its low cost it may be a matter of time before we begin to see a higher rates of use.
— Elevate NWO

We have had some anecdotal reports from clients and peers about crystal meth being cut with fentanyl and an increase in synthetic drugs available through local head shops. While crystal meth has been in circulation for many years in London, we are starting to really see the health impacts of long term use.
— Regional HIV/AIDS Connection

Increase in overdoses

We have noticed that there has been an increase in the number of overdose incidents with our street population, mainly as a result of other substances such as fentanyl being duplicated as heroin on the streets.
— Black Coalition for AIDS Prevention

We continue to have reports of high rates of overdose in the community impacted by changes in drug availability and inconsistency of potency/altered drugs.
— City of Ottawa Public Health

We have heard of more reports of non-fatal and fatal overdose due to an increase in fentanyl use related to fentanyl being sold as heroin. This has resulted in our agency providing more naloxone kits and doing more education and support regarding overdose prevention.
— The Works, City of Toronto Public Health

Responding to changes via programming

Operating a naloxone program. Increase in meth information pamphlets.
— AIDS Committee of Windsor

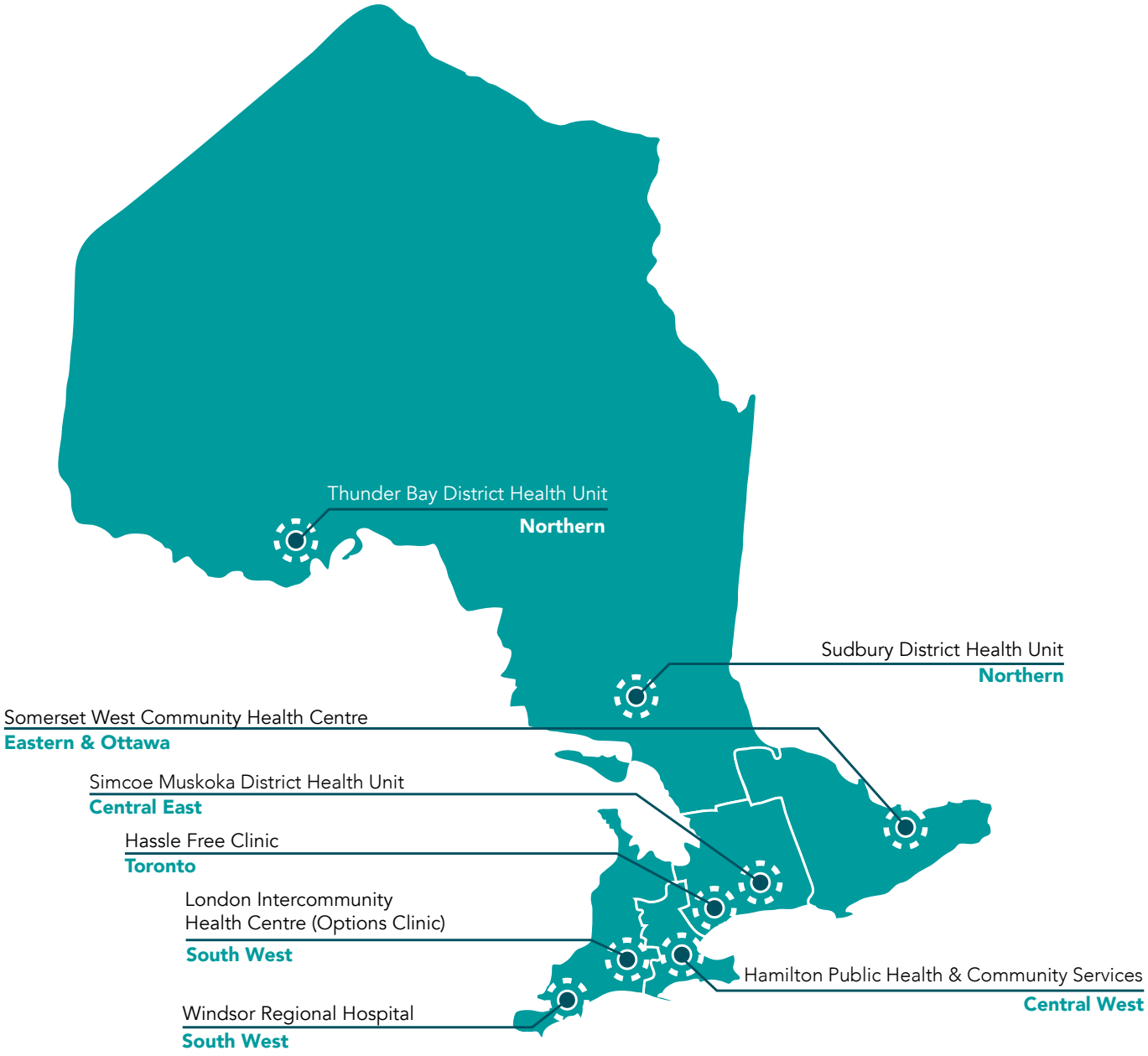
Continuing to advocate for naloxone distribution to enhance our overdose prevention training here at ACCESS.
— Réseau ACCESS Network

Two satellite sites have been added to our program to increase access to supplies.
— Positive Living Niagara

Anonymous testing

Fifty organizations across Ontario that offer HIV testing are designated (under the Health Protection and Promotion Act) to provide anonymous HIV testing. Eight of these organizations are funded by the AIDS Bureau. This is the second year these eight sites have reported their testing services in OCHART.

FIGURE 36 AIDS Bureau funded anonymous HIV testing sites by public health region



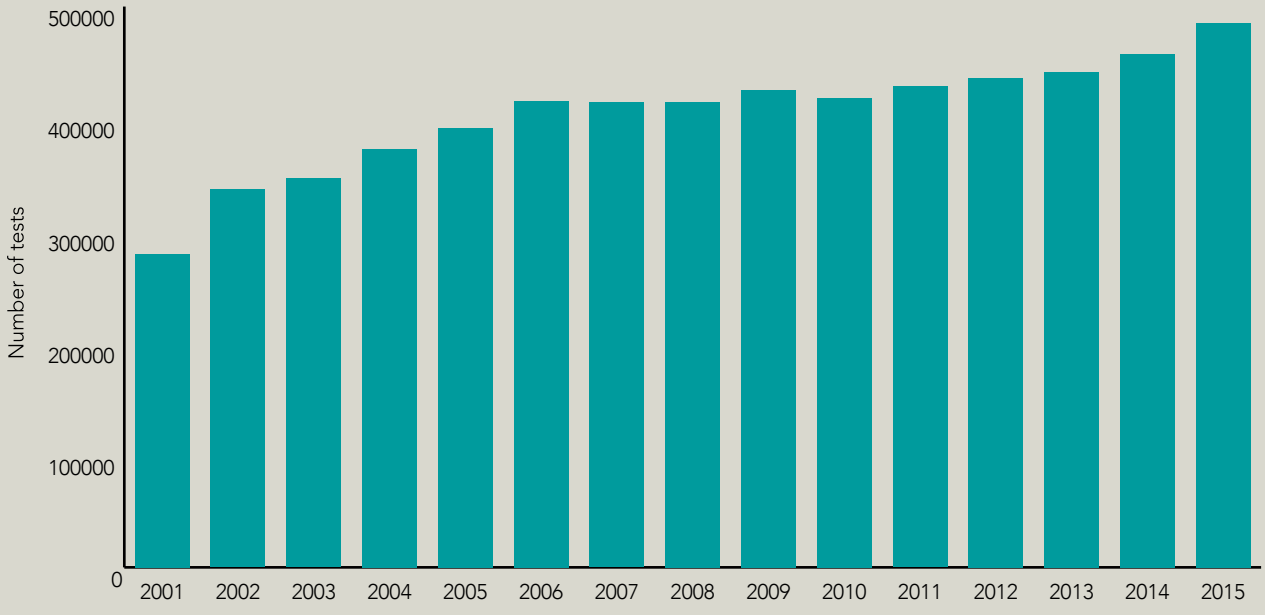
HIV testing in Ontario at a glance

- In 2015, a total of 485,250 HIV tests were conducted in Ontario (not including prenatal tests).
- The number of HIV tests conducted each year in Ontario has been increasing since 2010 — largely driven by an increase in nominal testing and testing among men who have sex with men.
- Historically, HIV tests can be done in three ways: nominally, non-nominally (coded) and anonymous. The vast majority of HIV tests in Ontario are conducted nominally. The number of non-nominal tests has decreased since 2000.
- The number of anonymous HIV tests began increasing in 2007 with the expansion of anonymous HIV testing sites in Ontario, but has stabilized recently – likely due to these sites having reached capacity.
- The number of HIV tests has increased more rapidly among males than females. Overall and for both sexes, positivity rates have decreased over time (as the number of HIV tests has increased).
- Among all HIV tests, the positivity rate has consistently been higher in males than females and in people tested anonymously than in those tested nominally or non-nominally.

Number of HIV tests up over time

Quick breakdown: In 2015, a total of 485,250 HIV tests were conducted in the province (not including prenatal tests). The positivity rate (the proportion of tests that are HIV-positive) was 0.17%.
Trends over time: Between 2000 and 2006, there was a large increase in the total number of HIV tests conducted each year. Since 2010, there has been a slight but steady increase in the number of HIV tests each year.

FIGURE 37 Number of HIV tests, Ontario, 2001-2015



Most tests ordered nominally

Quick breakdown: In 2015, 452,68 were nominal, 15,519 were non-nominal and 17,048 were anonymous.

Trends over time:

- Since 2010, the number of nominal tests has increased each year.
- Between 2007 and 2013, the number of anonymous tests increased – due to the expansion of anonymous testing sites in Ontario – but has stabilized in recent years (likely due to the sites being at capacity).
- The number of non-nominal or coded tests has decreased over time.

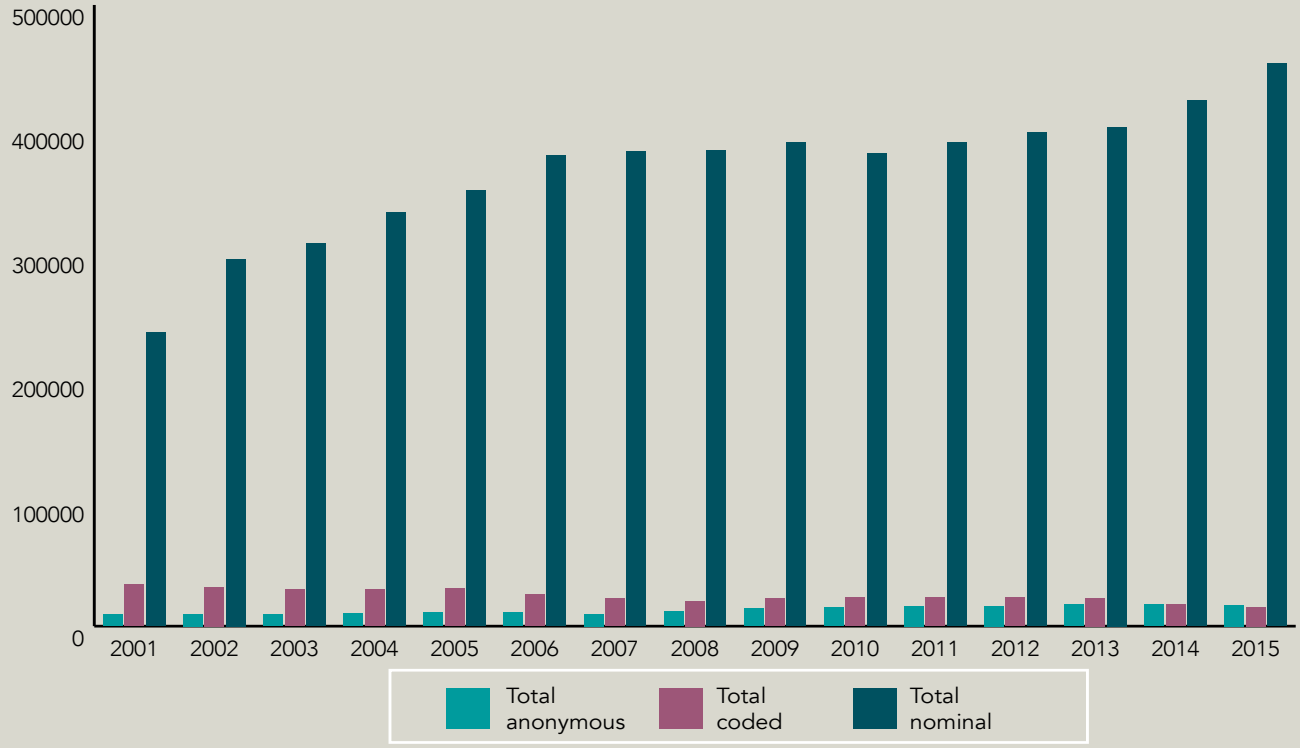
Types of HIV Testing

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 person's name on file but uses a unique code, instead of the person's 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 person's name or any identifying information. The code cannot be linked to the patient's identity.

FIGURE 38 Number of HIV tests by submission type, Ontario, 2000-2014

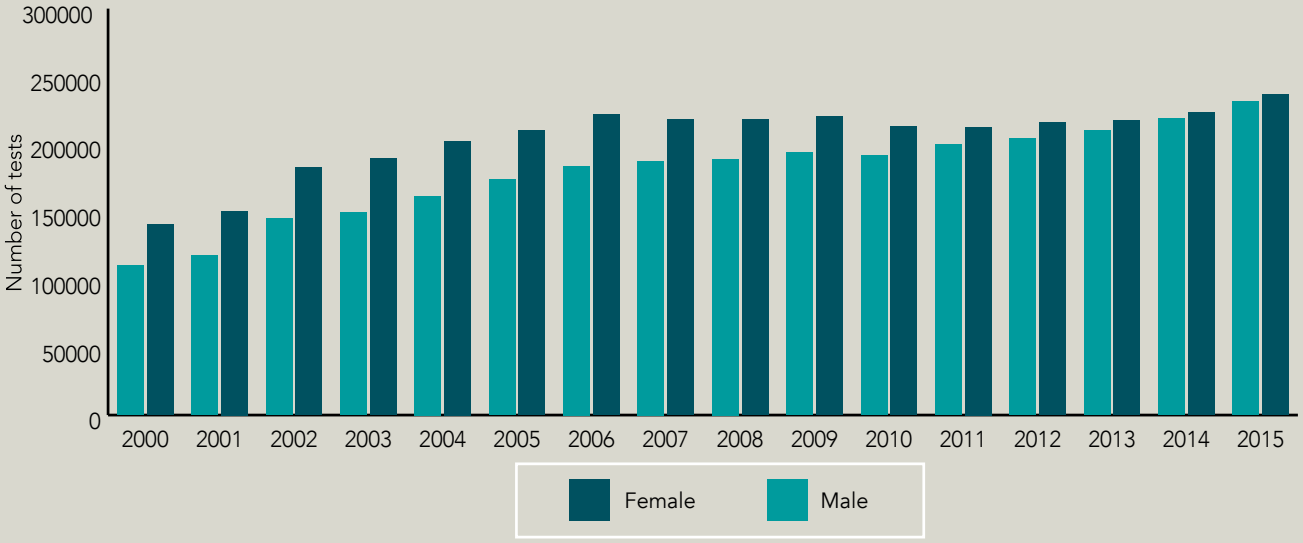


Testing increasing in males

Quick breakdown: In 2015, 49% of the people who had HIV tests were male and 51% were female.

Trends over time: Since 2010, the number of males being tested has increased more rapidly than females.

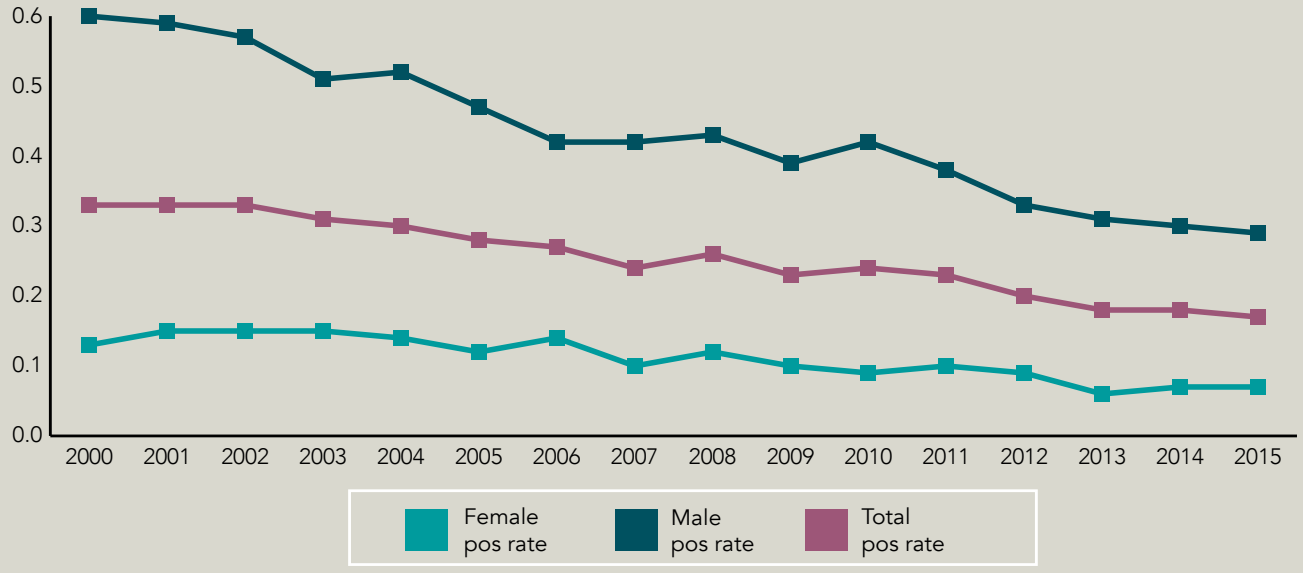
FIGURE 39 Number of HIV tests by sex, Ontario, 2000-2015



Positivity rates down but still higher in men than women

As the number of HIV tests has increased, the positivity rate has decreased in both males and females. However, the positivity rate is 4 times higher in males than females.

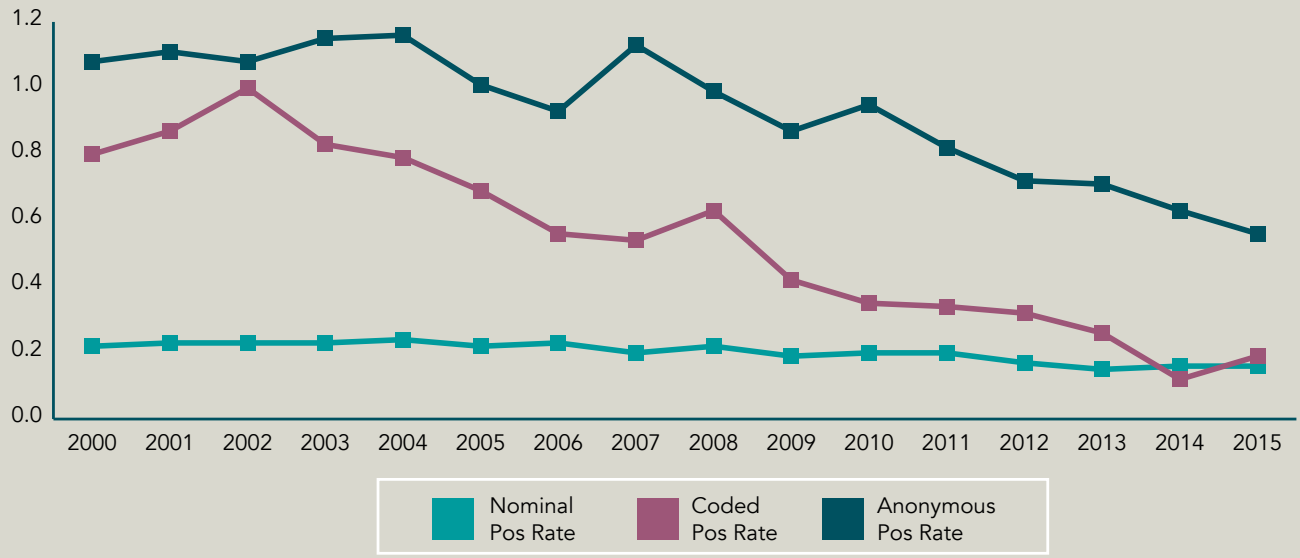
FIGURE 40 HIV positivity rate, Ontario, 2000-2015



Positivity rates higher among people who test anonymously

In 2015, the positivity rate for people who test anonymously was about 3 times higher than for people who tested nominally or non-nominally (coded).

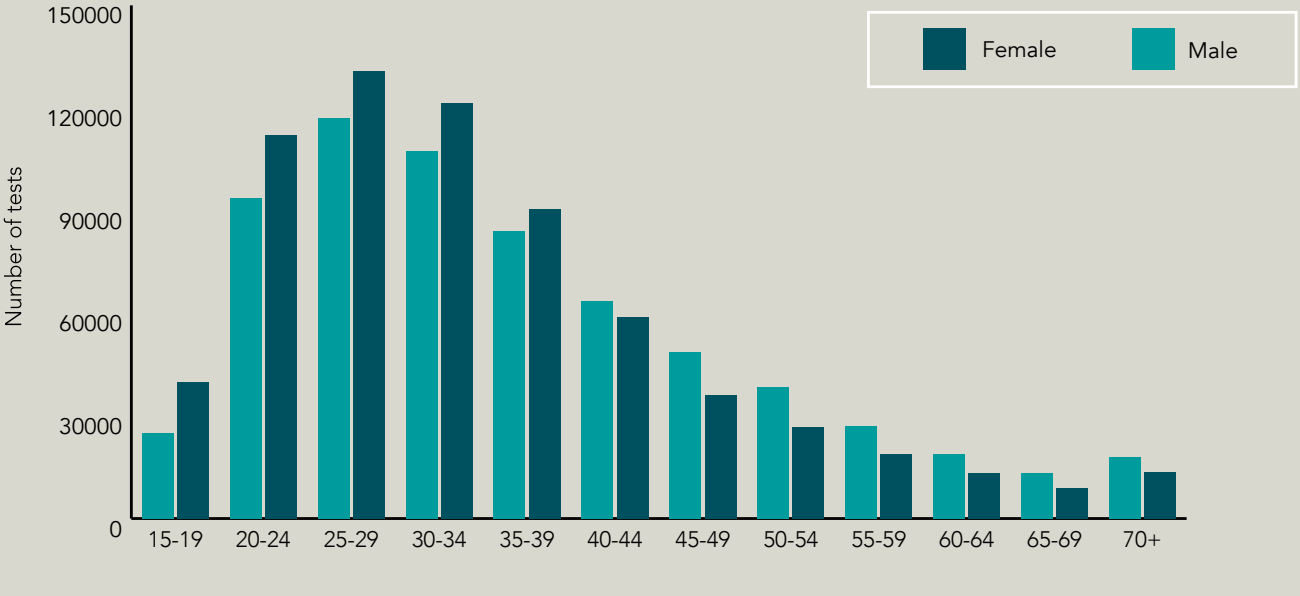
FIGURE 41 HIV positivity rate by submission type, Ontario, 2000-2015



Testing most common in 25 to 29 year olds

Quick breakdown: From 2013 to 2015, Ontarians aged 25 to 29 accounted for the greatest number of HIV tests for both males and females.

FIGURE 42 Number of HIV tests by age and sex, Ontario, 2013-2015



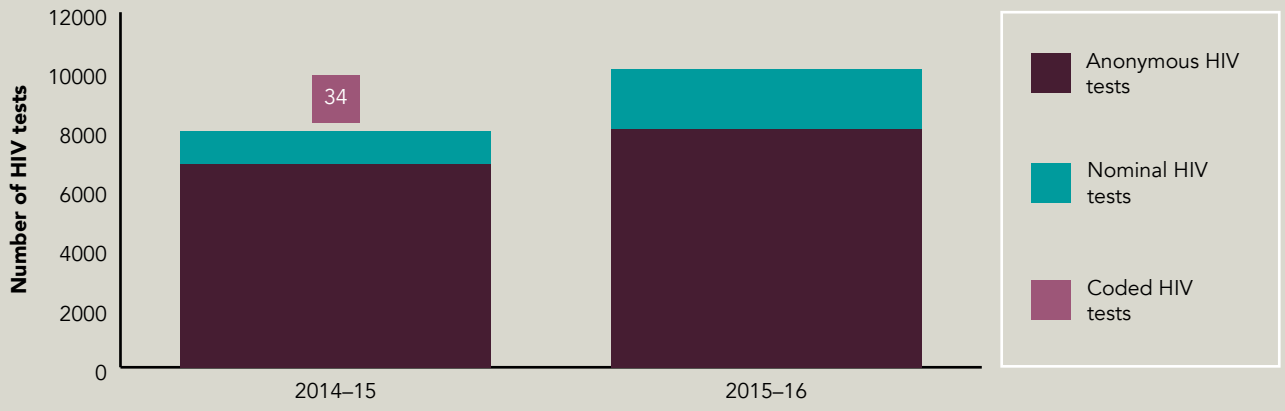
Trends over time: For both males and females, there has been a slight decrease in the proportion of tests in people under age 25 and a slight increase in people over 45.

The work of the AIDS Bureau funded anonymous testing sites

More tests provided

- In 2015-16, the eight testing sites administered 10,068 HIV tests (anonymous and nominal) using either a rapid or standard blood draw testing method – up 25% from 2014-15. However, a smaller proportion of the tests were anonymous: 80% (8,050) anonymous tests in 2015-16 compared to 86% (6,875) in 2014-15.
- Note: the total number of tests does not include the blood tests that are used to confirm a reactive rapid test.

FIGURE 43 Total number of HIV tests conducted (OCHART q8.1a)



More people diagnosed in 2015-16

In 2015-16, the eight sites diagnosed a total of 78 individuals with HIV (includes nominal and anonymous HIV tests) – 23 more people than in 2014-15. However, these positive diagnoses were concentrated in four of the eight clinics. Only four sites reported a positive test result in 2015-16 compared to seven sites in 2014-15.

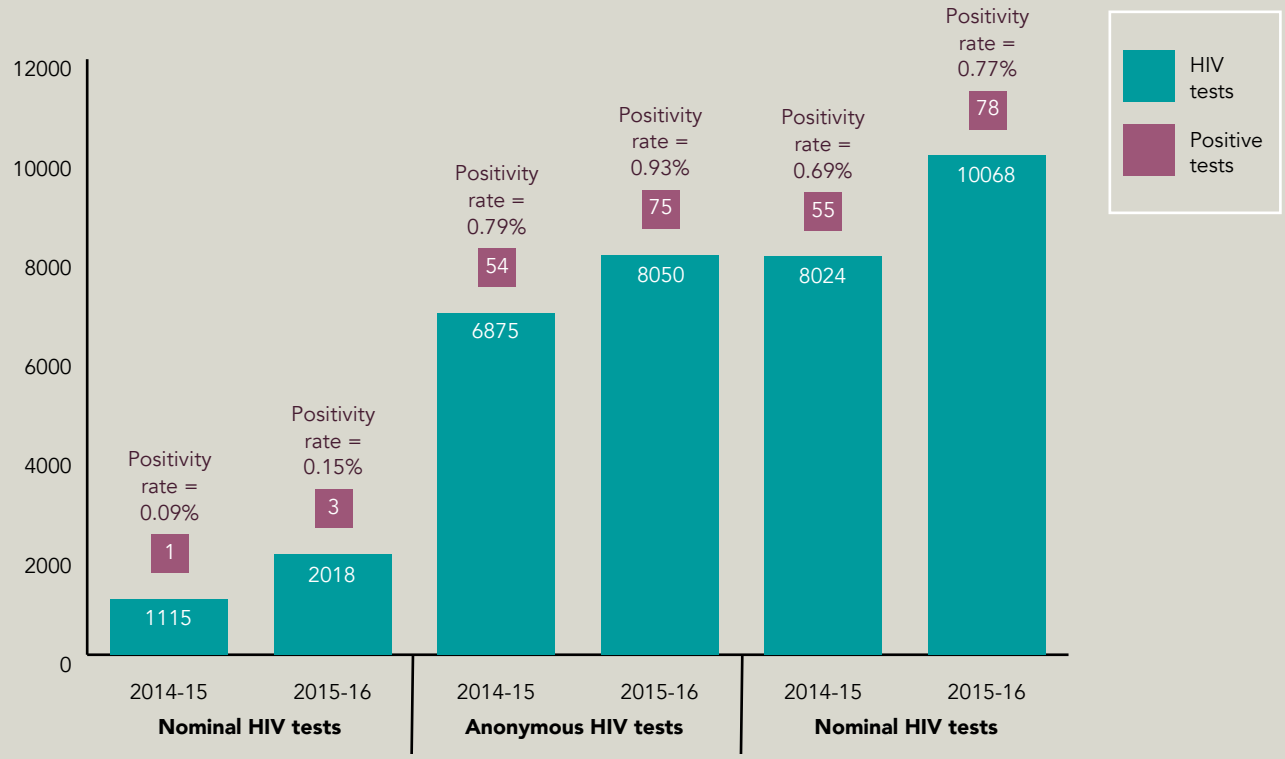
Higher positive rate in 2015-16

While the overall positivity rate from HIV testing was down in 2015-16, it was up among those who tested at the eight sites that report through OCHART.

The positivity rate among the 10,068 nominal and anonymous tests at the eight sites was 0.77% (78/10,068) – up from 0.69% (55/8,024) in 2014-15. However, the positivity rate was much higher among those who tested anonymously: 0.93% (75/8,050) – up from 0.79% (54/6,875) in 2014-15. The positivity rate among those who tested nominally was 0.15% (3/2,018) in 2015-16 – up from 0.09% in 2014-15.

Higher positivity rates may be due to the fact that the eight sites are using more targeted testing strategies to reach people most at-risk for HIV.

FIGURE 44 Number of HIV tests by test type and positivity rate (OCHART q8.1a)

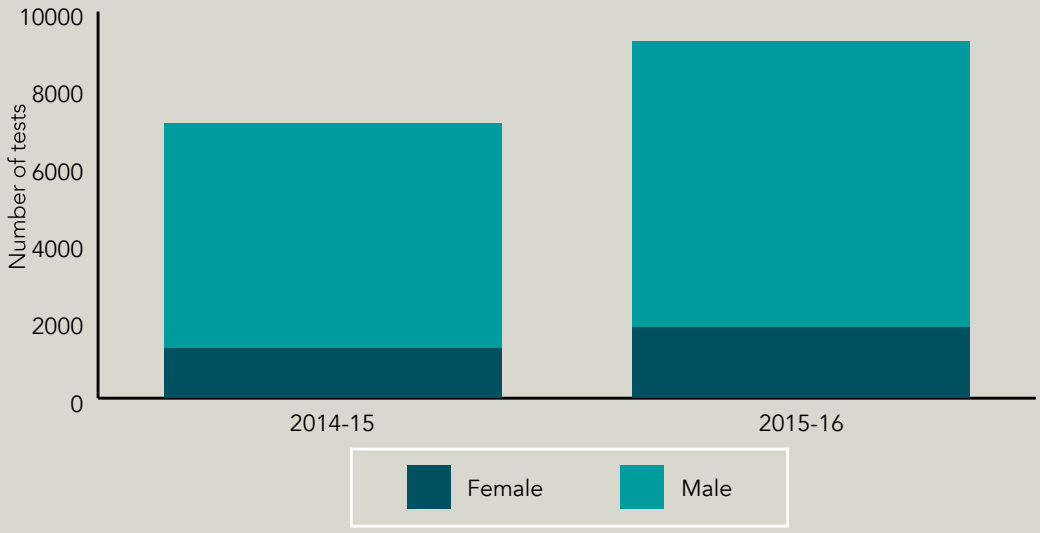


Men account for four of every five tests

In 2015-16, men accounted for 80% (7,394/9,281) of all HIV tests administered by the eight sites and women accounted for 20% (1,833/9,281). This is similar to the sex/gender breakdown reported by the sites in 2014-15 and consistent with the overall rate of new diagnoses in Ontario.

Note: Data on sex/gender was available for 92% of all HIV tests in 2015-16 (9,281/10,068) at these eight sites.

FIGURE 45 Number of HIV tests by sex/gender (OCHART q8.1b)

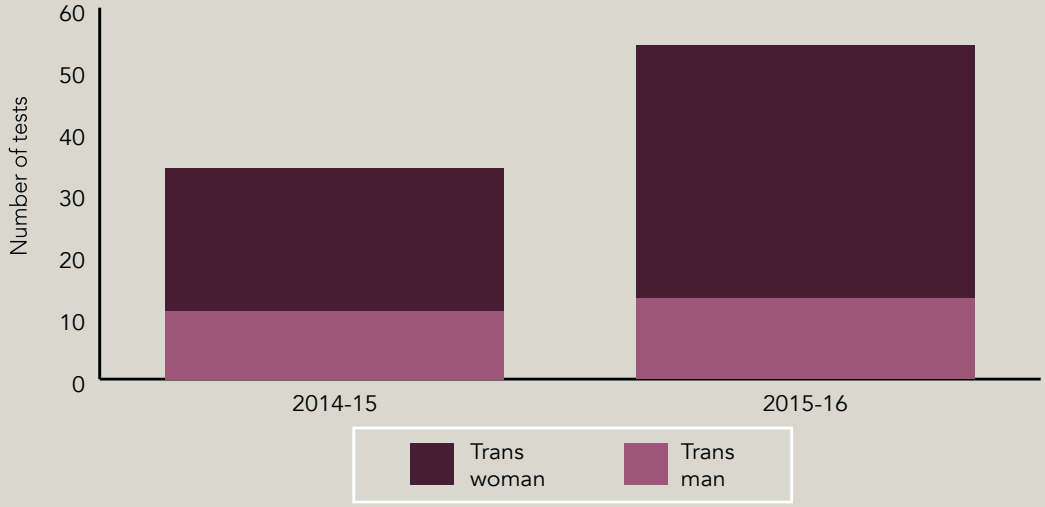


(N = 7, 157 HIV tests in 2014-15 and 9,281 HIV tests in 2015-16)

More trans women tested

Compared to 2014-15, there was a 78% increase in the number of trans women tested for HIV: 41 in 2015-16 compared to 23 in 2014-15. Fewer than 1% (54/9,281) of all HIV tests were for trans people.

FIGURE 46 Number of HIV tests by sex/gender (OCHART q8.1b)



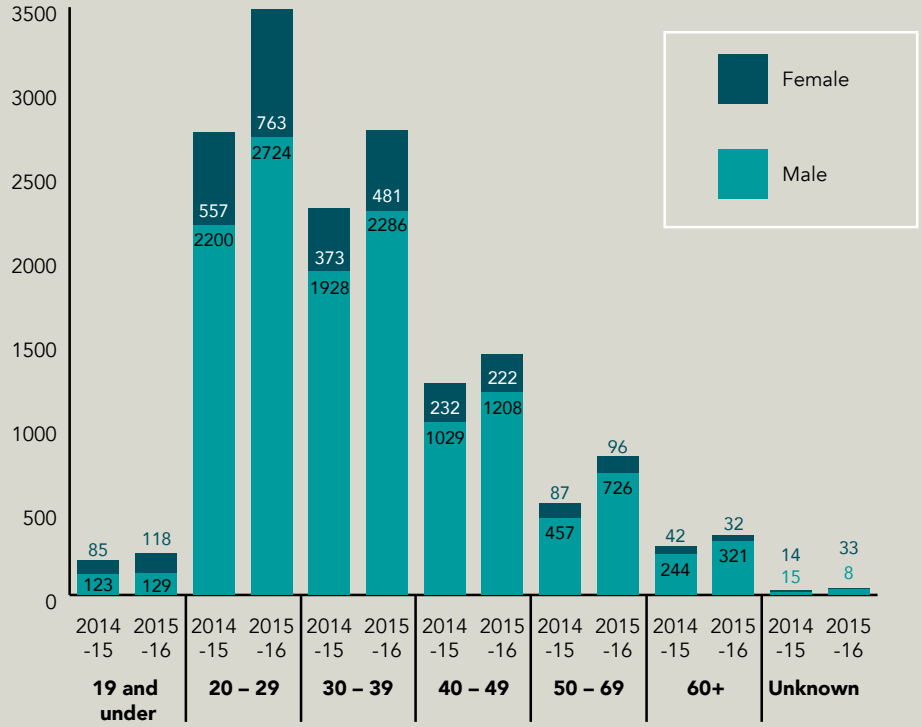
Most people testing were between the ages of 20 and 49

Similar to 2014-15, 84% of all HIV tests at the eight sites in 2015-16 were for people between the ages of 20 and 49. Most (68%) were for individuals ages 20-39.

In 2015-16, across all age ranges, the highest proportion of females tested (44%) were age 20-29 and 28% were age 30-39. Similarly, for men, 37% were age 20-29 and 31% were age 20-29.

Note: Data on age was reported for 91% of all HIV tests conducted at the eight sites in 2015-16 (9,199/10,068). Of these tests with age reported, fewer than 1% reported the age as unknown.

FIGURE 47 Number of HIV tests by age and sex/gender (OCHART q8.1d)



Trans people made up less than 1% of those tested across all age ranges: 75% of trans people who tested across all age ranges were trans women. Most trans women who tested (75%) were age 20-39.

FIGURE 48 Number of HIV tests with trans people by age (OCHART q8.1d)

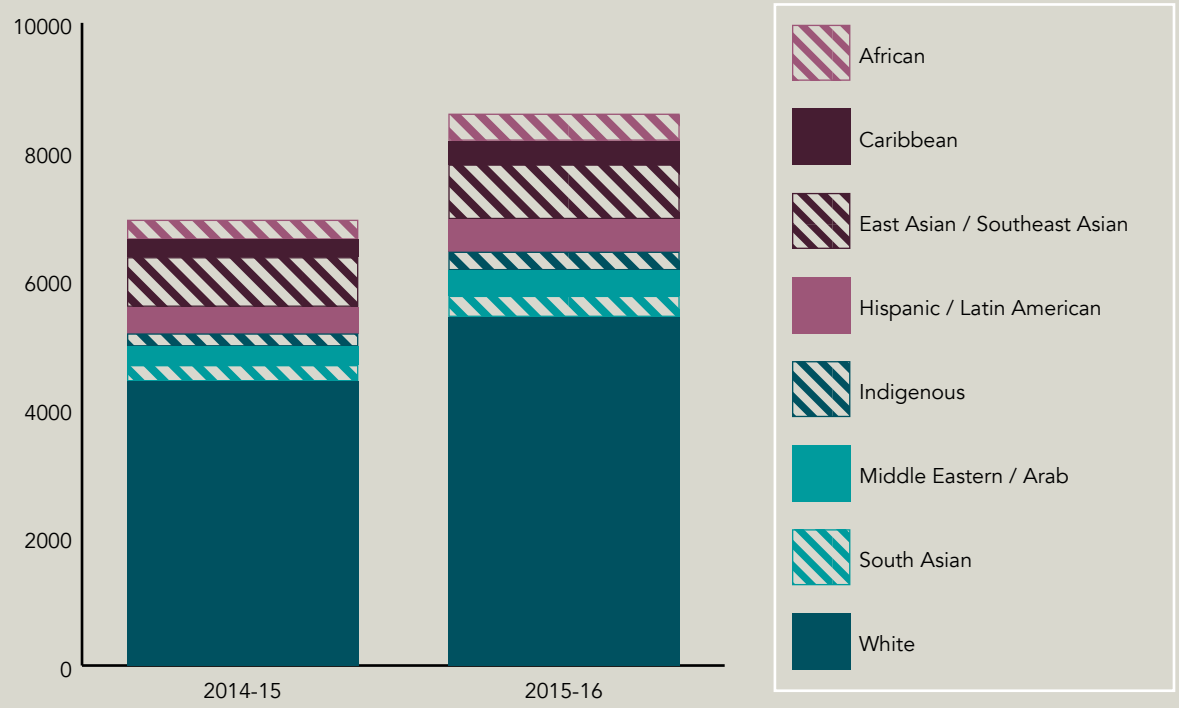
(n = 38 HIV tests with trans people in 2014-15 and 52 HIV tests with trans people in 2015-16; total HIV tests in 2014-15 is 7,424 and 9,199 HIV tests in 2015-16)

(Trans people includes trans men and trans women)

Most testers are White

Similar to the testing pattern in 2014-15, 63% of people who tested were White (includes Western and Eastern European), 10% were East Asian/Southeast Asian, 9% were African or Caribbean and 3% were Indigenous.

FIGURE 49 Number of HIV tests by ethnicity (OCHART q8.1c)



Note: Ethnicity data was reported for 85% of HIV tests conducted in 2015-16 (8,588/10,068) at these eight sites.

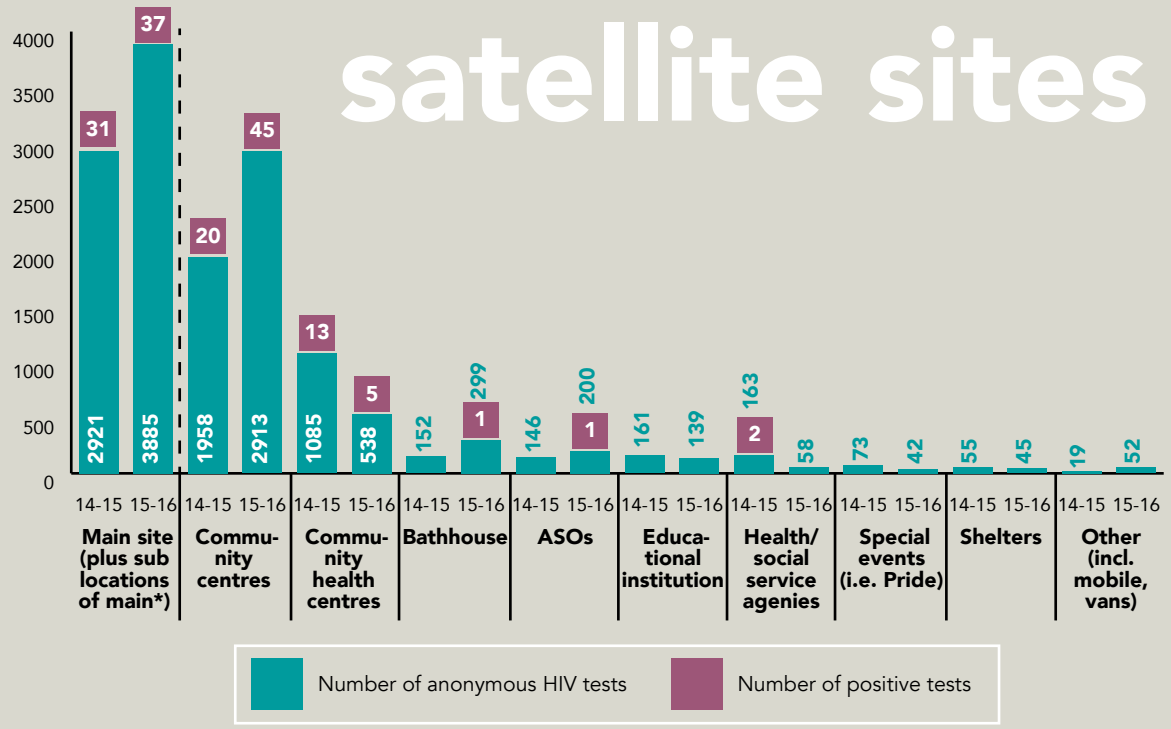
Testing done at main sites and satellites

In 2015-16, almost all anonymous HIV tests (90%) were administered at the sites' main location and through satellite sites at community centres and community health centres.

Nearly half of anonymous HIV tests (48%) were delivered at the testing agencies' main sites and sub-locations. The remaining tests were delivered at satellite locations in the community. The most frequently used satellite locations for anonymous HIV testing were community centres (up to 36% from 29% in 2014-15), community health centres (down to 7% from 16% in 2014-15) and bathhouses which accounted for 4% of tests in 2015-16. The remaining satellite locations—such as ASOs, health/social service agencies, shelters, testing at special events such as PRIDE and mobile outreach (e.g., vans)—each accounted for approximately 1-2% of all anonymous HIV tests.

For 2015-16, the highest positivity rates were reported at the most common locations where anonymous HIV tests were conducted: satellite sites at community centres (1.54%), main sites (0.95%) and satellite sites at community health centres (0.95%). This is a slight change from 2014-15 where the highest positivity rates were reported at satellite locations at health/social service agencies (1.23%) and community health centres (1.20%) followed by the main site (1.06%). Due to how data are reported, we are unable to link these positive tests with client demographics.

FIGURE 50 Number of anonymous HIV tests by location (OCHART q8.2a)

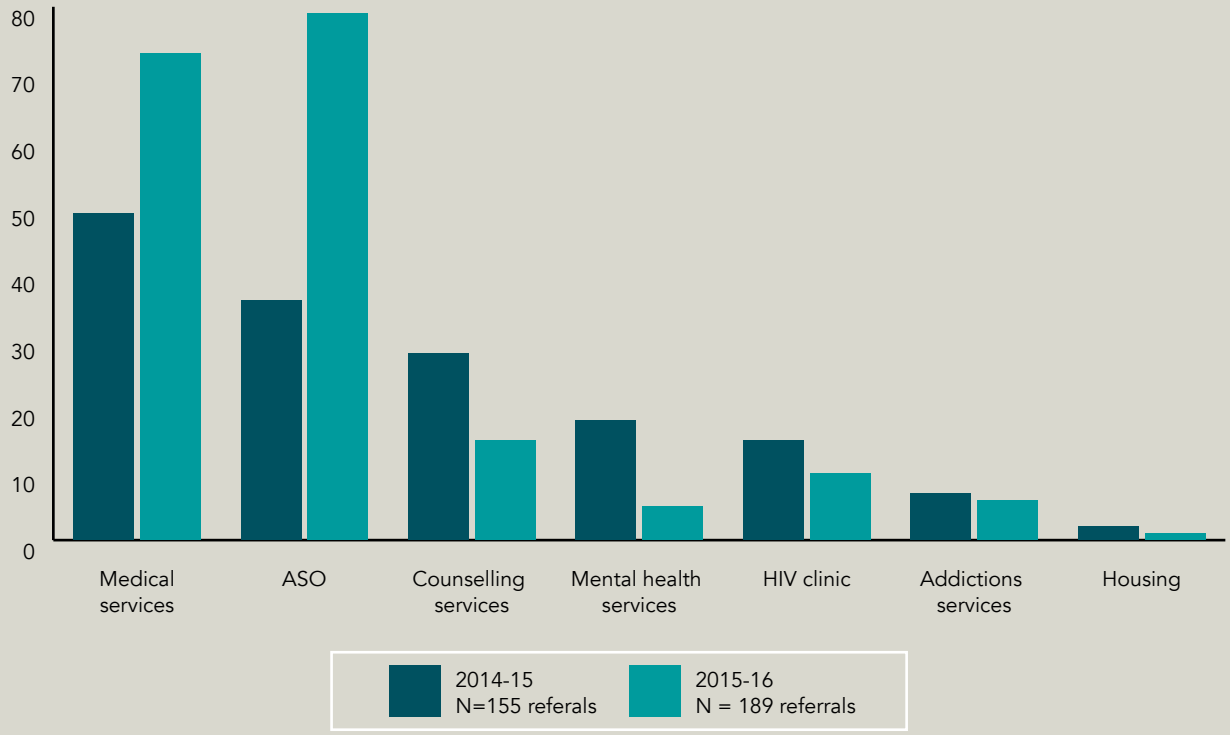


People who test positive referred to medical and other services

The four sites that diagnosed the 78 individuals in 2015-16 provided 189 referrals to additional services – up from 155 in 2014-15.

The top three referrals in 2015-16 were to medical services, ASOs and counselling services. While the number of overall referrals increased, the number of referrals to ASOs more than doubled and those to medical services increased by approximately by 50%. These referral patterns are consistent with the new provincial strategy's focus on quickly linking people with HIV to health care services and other social supports through ASOs.

FIGURE 51 Referrals made for HIV positive clients (OCHART q8.3)



Community-based clinical services

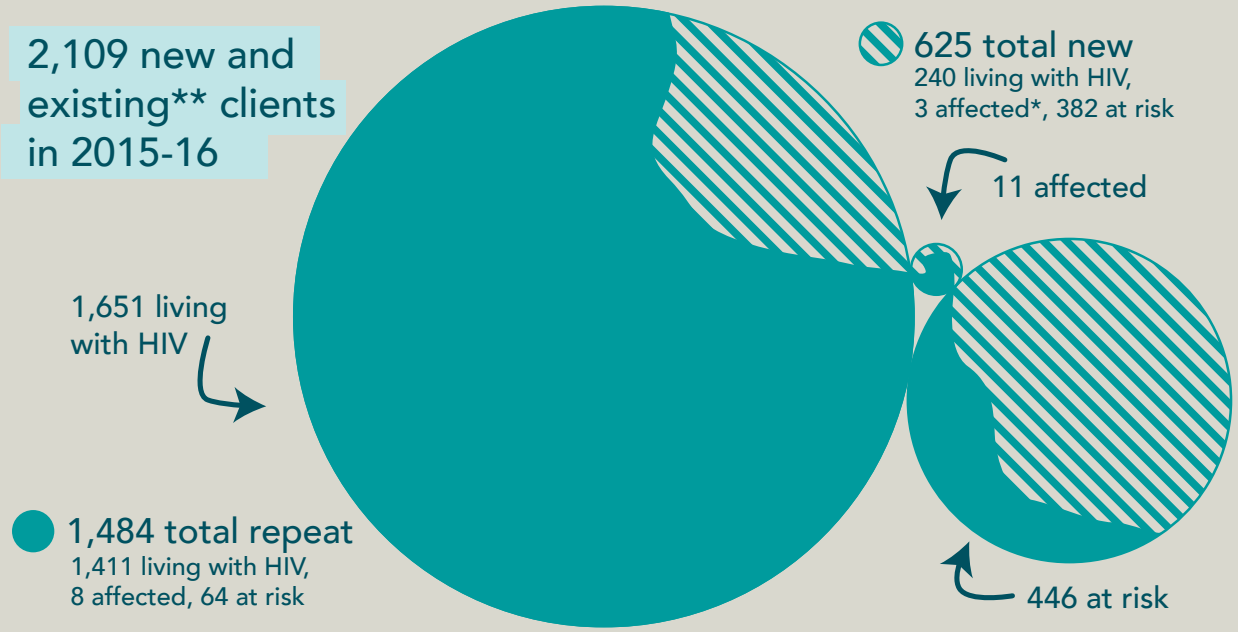
1. **Bloom Clinic**, Bramalea CHC (Brampton, Central West)
2. **Elevate NWO** (Thunder Bay, Northern)
3. **ARCH Clinic HIV/AIDS Resources & Community Health Clinic** (Guelph, Central West)
4. **Positive Care Clinic**, Lakeridge Health Centre (Oshawa, Central East)
5. **Health Centre** at 410 Sherbourne St. (St. Michael's Hospital, Toronto)

Ontario has 21 HIV clinics across the province: 16 hospital-based and 5 community-based clinics. The five multidisciplinary community-based clinics are funded by the AIDS Bureau and required to report through OCHART.

Key highlights in 2015–16

- More women and trans clients using clinical services than in previous year.
- More clinical and social service referrals than in previous year.
- Community-based HIV clinical service providers did more presentations, networked more and engaged in more professional development activities.
- More health care professionals and service providers were engaged in education.

FIGURE 52 Total clients served in 2015-16



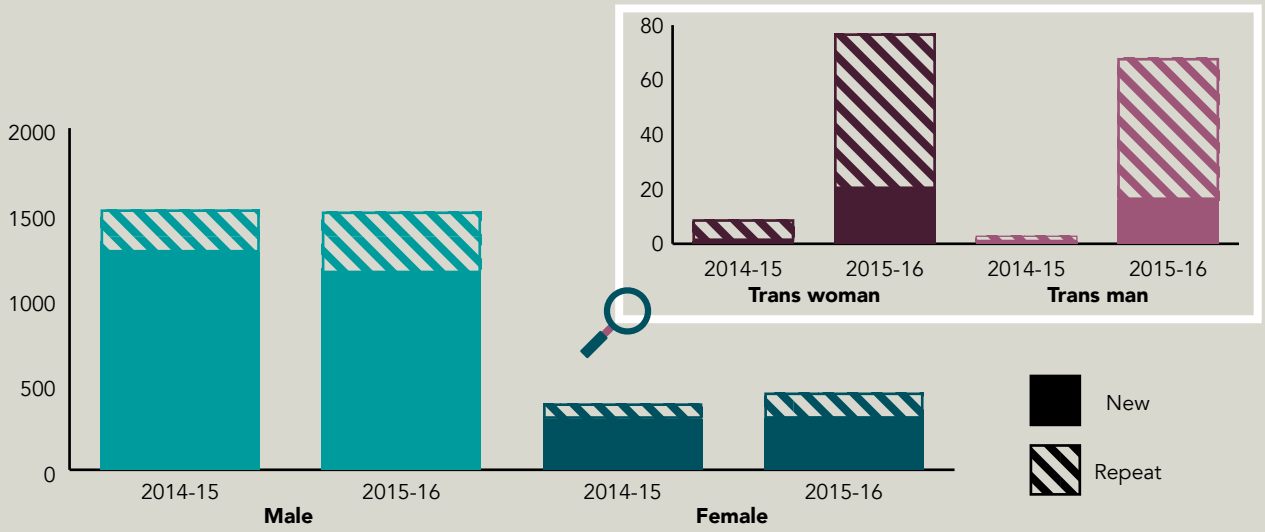
*3 of the 5 clinics have the ability to track client type and can report on the number of clients who are at-risk and affected
** (averaged)

More women and trans clients using clinical services

The sex/gender distribution of clients receiving clinical services at the five clinics shifted in 2015-16. All clinics reported an increase in female clients, and one clinic that began offering a trans health clinic in 2015-16 reported serving more trans clients.

> **Doctor and nurse have attended transgender healthcare courses and conferences for improved knowledge and education.**
> ***— HIV/AIDS Resources & Community Health Clinic, Guelph***

FIGURE 53 Number of new and repeat (averaged) clients served by sex/gender (OCHART q.7.1a)



Trans clients younger than cisgender clients

The majority of cisgender clients served in 2015-16 (76%) were between the ages of 30 and 59 while most trans clients were between the ages of 20 and 29.

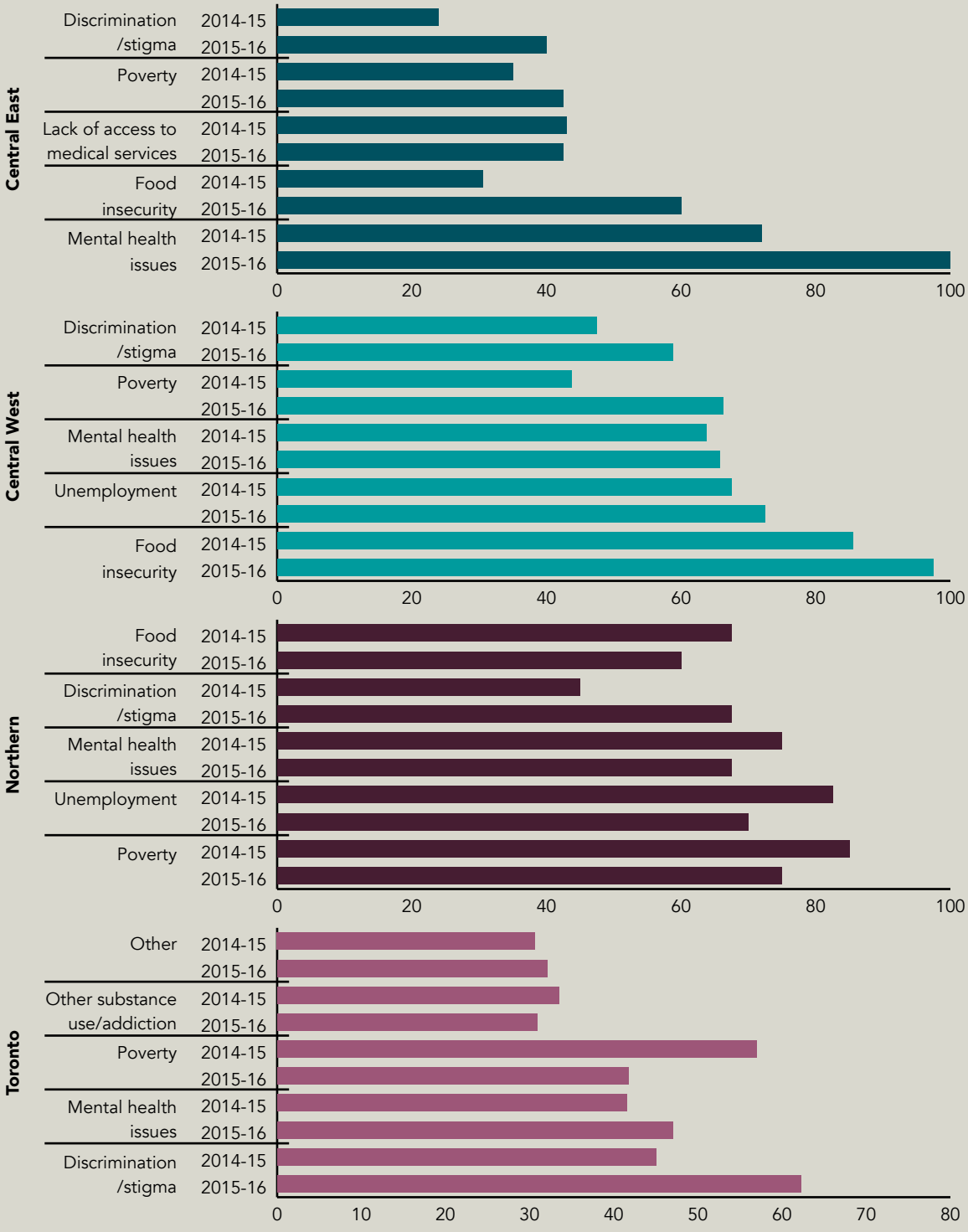
FIGURE 54 Number of clients by age and sex/gender 2015-16 (OCHART 7.1b)*

*new clients and average number of existing clients

Clients face different challenges regionally

As FIGURE 55 illustrates, clinics in Central East, Central West and Toronto reported a larger proportion of clients experiencing discrimination/stigma than those in the Northern Region. Poverty was a challenge in all regions.

FIGURE 55 Top 5 challenges facing clients by region (OCHART q.7.1f)



What services do clients use?

Clinics report on four categories of services: allied health care, engagement (intake and assessment), HIV treatment and care, and sexual and reproductive health. Consistent with 2014-15, the most commonly used services were primary care (because two of the clinics – including the largest one – are primary care clinics) and blood work/lab testing.

> **Clinic coordinator now books the HIV clinic appointment and the blood work appointment on the same day so that client has a ride and support automatically coordinated for both events.**
> ***— Elevate NWO***

More links made to clinical and community/social services

The clinics advocate and intervene on behalf of clients to make sure they get the services they need. Referrals involve actively linking clients to appropriate clinical services in the local hospital or community to help them manage clinical co-morbidities. In 2015-16, the clinics reported 2,125 clinical referrals or links: up 60% from 2014-15 (1,325). The most common clinical referrals were to medical specialists and HIV specialists.

Community-based HIV clinics also link individuals to appropriate health, legal and/or social service agencies that can help the person address social determinants of health. As with clinical referrals, these are active and involve much more than just providing a client a referral contact number to call. In 2015-16, clinics reported making 446 referrals to community/social service referrals – up 43% from 2014-15 (311). The two most common referrals were to housing services and AIDS service organizations; however, compared to 2014-15, the clinics made more referrals to legal services, community-based mental health services and community based addiction services (see FIGURE 56).

FIGURE 56 Number of clients linked to clinical services (OCHART q. 7.3)

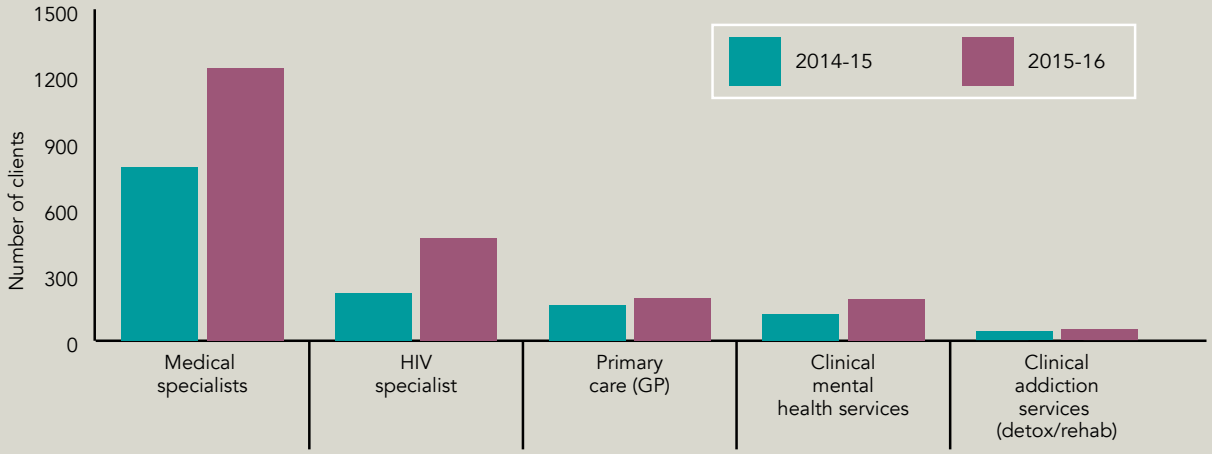


FIGURE 57 Number of clients linked to community services (OCHART q. 7.3)

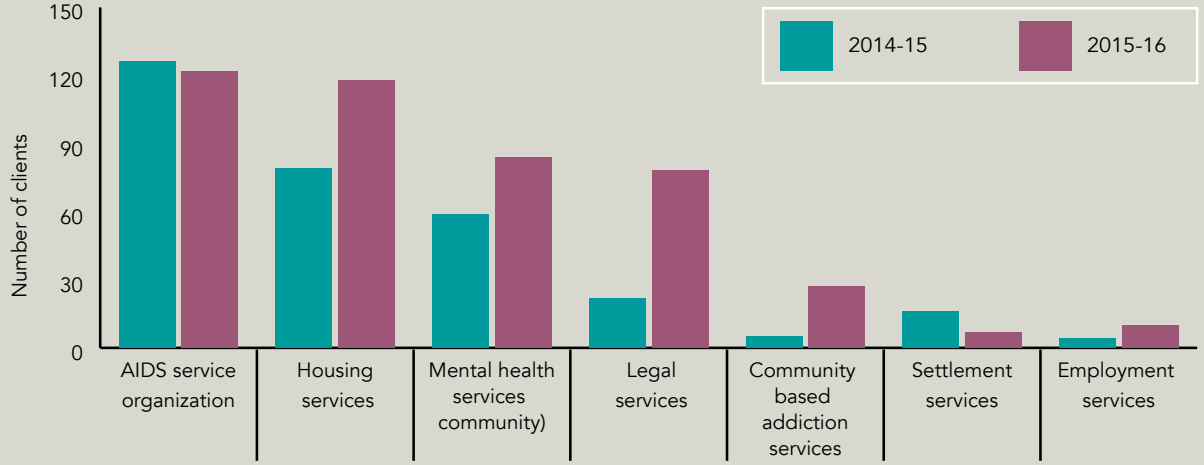
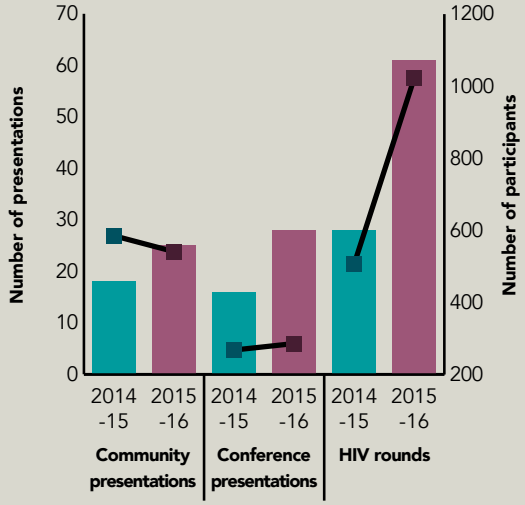


FIGURE 58 Number of education presentations and participants by education activity type (OCHART q.7.4a)



Engaging more health care professionals and service providers in education

In 2015-16, the clinics reported delivering double the number of education events (114) than in 2014-15 (62). While there were increases in all education categories, the number of HIV Rounds activities doubled (61 in 2015-16 compared to 28 in 2014-15). Overall, more people participated in education activities; however, the increase was mainly due to increased attendance at HIV Rounds and there were fewer participants at community and conference presentations (see FIGURE 58).

To maintain their competencies, clinic staff participated in professional development activities:

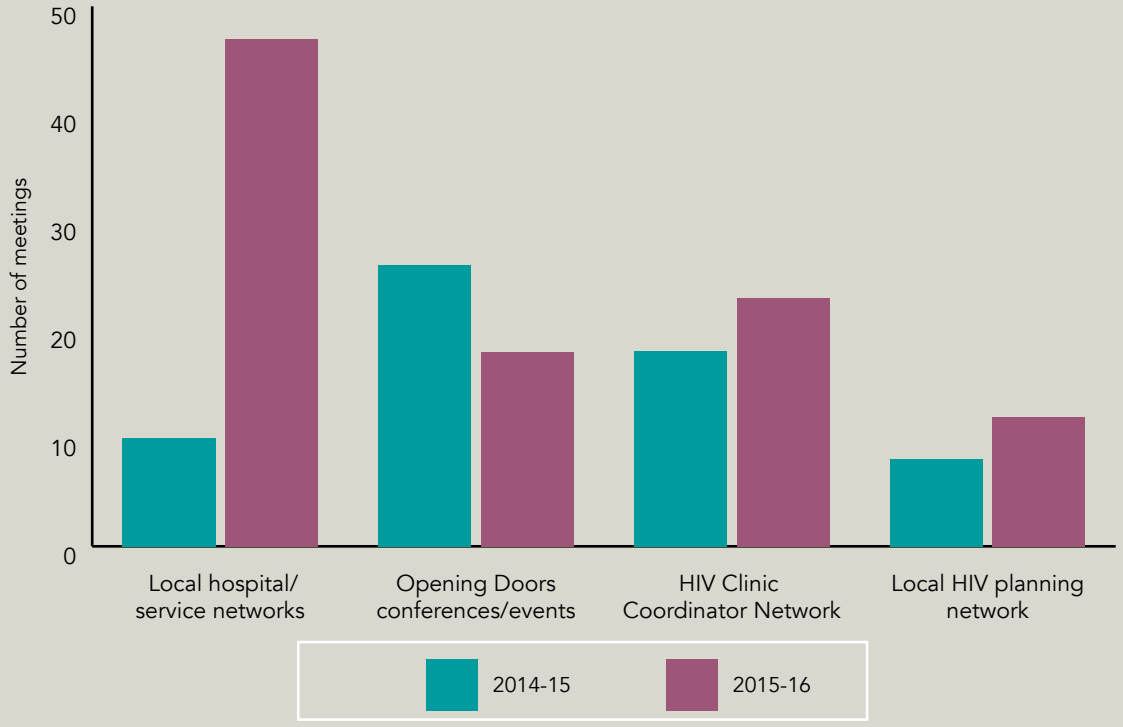
- 31 staff attended conferences
- 18 attended continuing medical education (CME) or post secondary courses
- 17 completed nursing updates
- 3 attended other courses required by a professional college.

Increase in network meetings

To provide excellent clinical care, providers must share knowledge, network with other providers/professionals and stay current in their field. Clinic staff reported that, in 2015-16, they networked more and engaged in more professional development activities.

In 2015-16, clinics reported triple the number of meetings with local hospital/service networks, as well as attending more meetings with the Ontario HIV Outpatient Clinic Network (OCN) and their Local HIV Planning Network. These meetings help build and nurture partnerships and expand the clinics' referral networks (see FIGURE 59).

FIGURE 59 Community development meetings by type (OCHART q.7.4b)



Support services

New clients are clients who are receiving service for the first time. While they are new to the program, they are not necessarily newly diagnosed.

Key trends

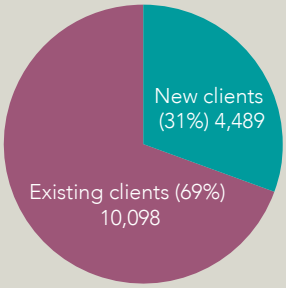
Populations we serve align with the epidemic in Ontario

- Community-based organizations provided support services to an average of 14,585 people over the year, the majority of whom (65%) were people living with HIV.
- The sex/gender, ethnicity and age of new clients were consistent with the trends we see in new diagnoses, even though new clients are not necessarily people who are newly diagnosed.
- Programs are making more referrals for at-risk clients and providing fewer direct support services.
- Referrals are linked to social determinants of health, engaging and retaining clients in care.

Who is using support services?

In 2015-16, 57 community-based HIV programs (in 46 agencies) reported providing support services to an average of 14,585 people over the year. Of those, 4,489 were new clients (31%) and 10,098 (69%) were ongoing or existing clients.

FIGURE 60 Total clients (averaged) accessing support services in 2015-16 (OCHART q.11.1.1)



The number of clients reported as being served has been declining over the past two to three years. This does not mean fewer clients are receiving services. Instead, the numbers being reported are more accurately reflecting the services delivered (i.e., less double counting of clients within agencies).

Note: the 14,585 people served may not be unique clients or new to the system as some people (particularly those in Toronto) may be receiving support services from more than one community-based agency.

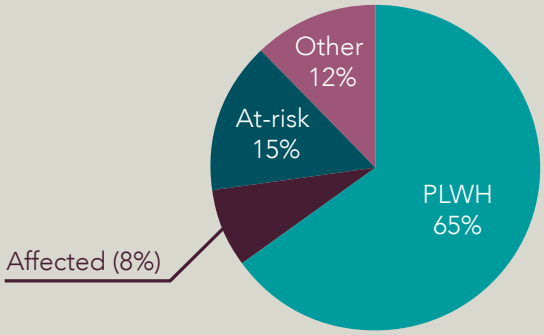
Of all clients who used support services in 2015-16:

- 65% (9,524) were people living with HIV (PLWH)
- 15% (2,238) were people at-risk
- 8% (1,136) were people affected, such as partners, friends and family members of people living with HIV
- 12% (1,689) were recorded as "other". When we looked at what was entered as "other", it appears that most should have been captured as at-risk (e.g., people with hepatitis C, sex workers, men who have sex with men).

Of new clients, 56% were people living with HIV, 30% were at-risk and 18% fell into the "other" category. At-risk clients tend to use services once whereas people living with HIV tend to use multiple services and engage in a service plan.

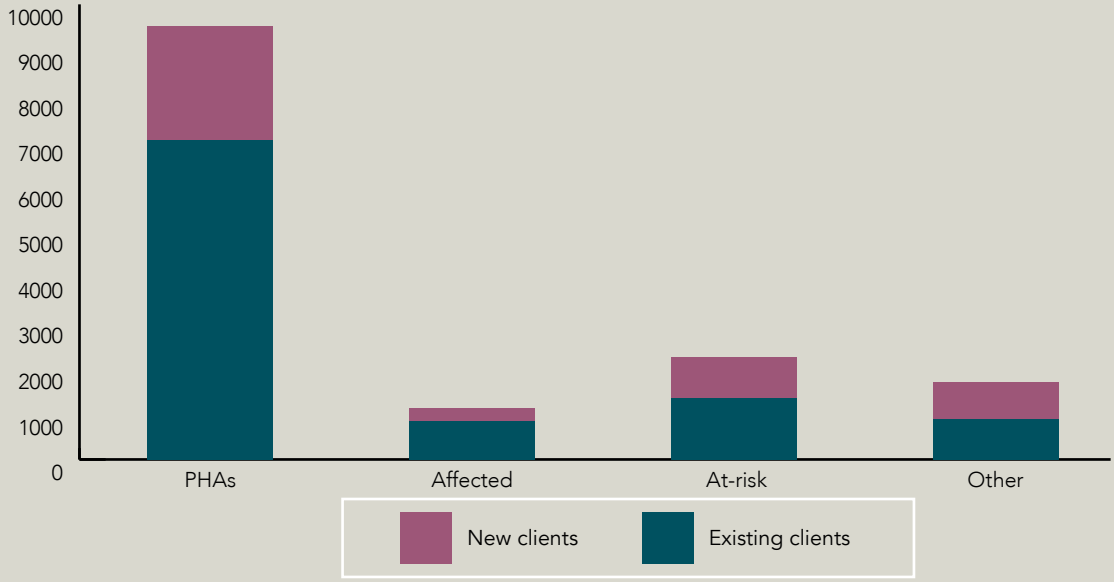
In 2015-16, most support services were accessed by people living with HIV and those affected.

FIGURE 61 Who is using support services 2015-16 (OCHART q. 11.1.1)



Not everyone with HIV uses the services of community-based programs. With improvements in treatment, many people with HIV are managing their health well. ASOs are more likely to see people living with HIV who have complex health, social and practical assistance needs, including low incomes, mental health and substance use issues, and housing and legal issues. People with HIV tend to use community-based services episodically – that is, when they experience a health crisis or when their health or social needs change.

FIGURE 62 Clients accessing support services by client group — 2015-16 (OCHART q. 11.1.1)



When it comes to the type of support services used by members of each group:

- People living with HIV mainly used services that meet basic needs, such as practical assistance, food programs and counselling.
- People at-risk mainly used food programs, drop-in programs and referrals to other services. Compared to the previous year, more people at-risk accessed referrals and fewer used practical assistance and case-management. This shift may be a result of agencies focusing on meeting the needs of people living with HIV and referring at-risk clients to appropriate services in their communities.
- People affected mainly used food programs, counselling and practical assistance.

FIGURE 63 Top 10 services being accessed by people living with HIV (OCHART q. 11.2.1)

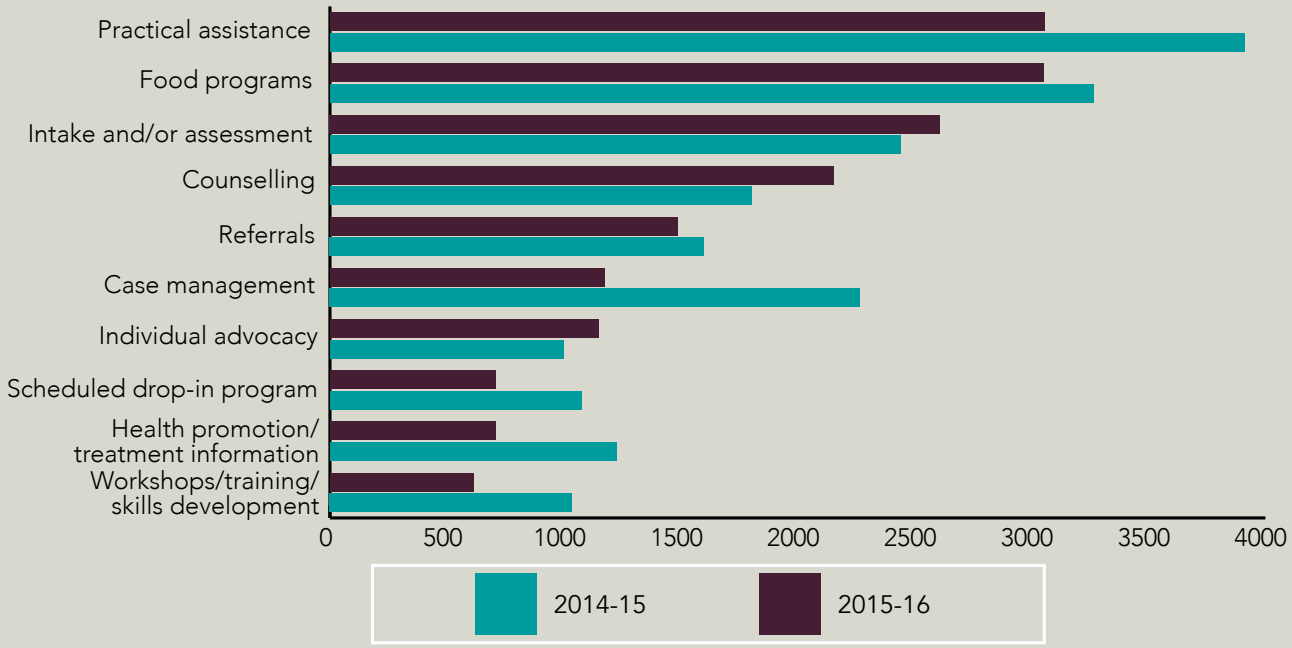


FIGURE 64 Top 10 services being accessed by at-risk clients (OCHART 11.2.1)

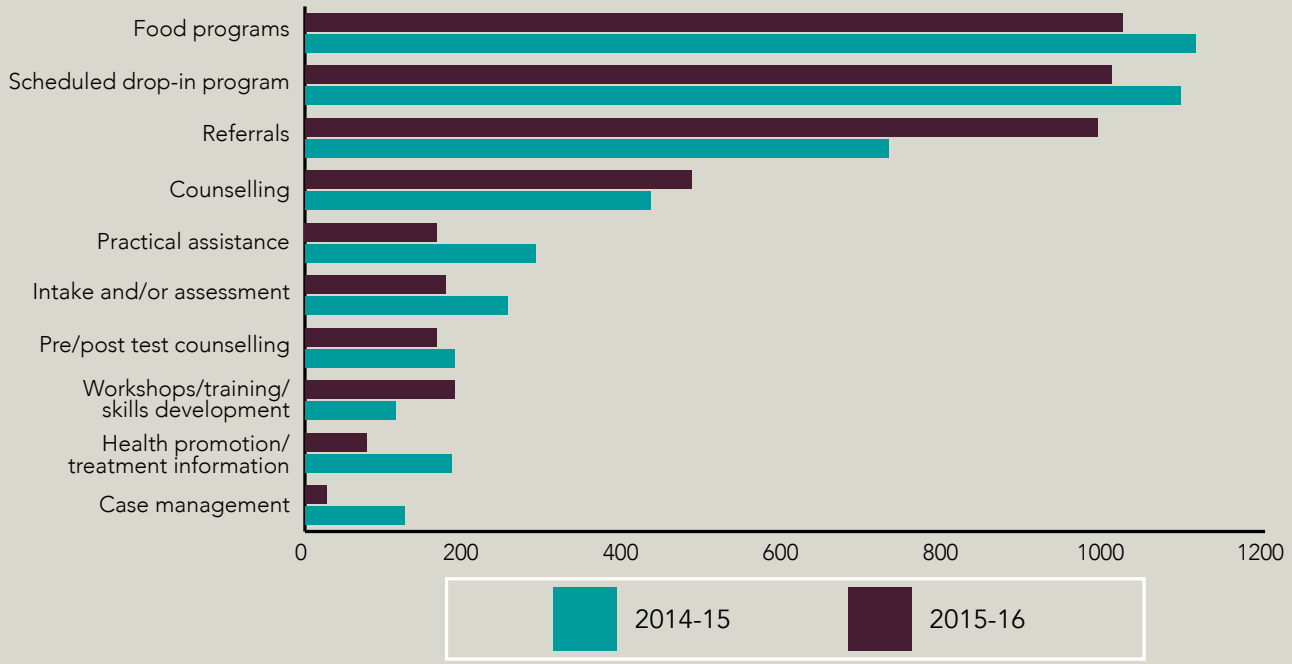
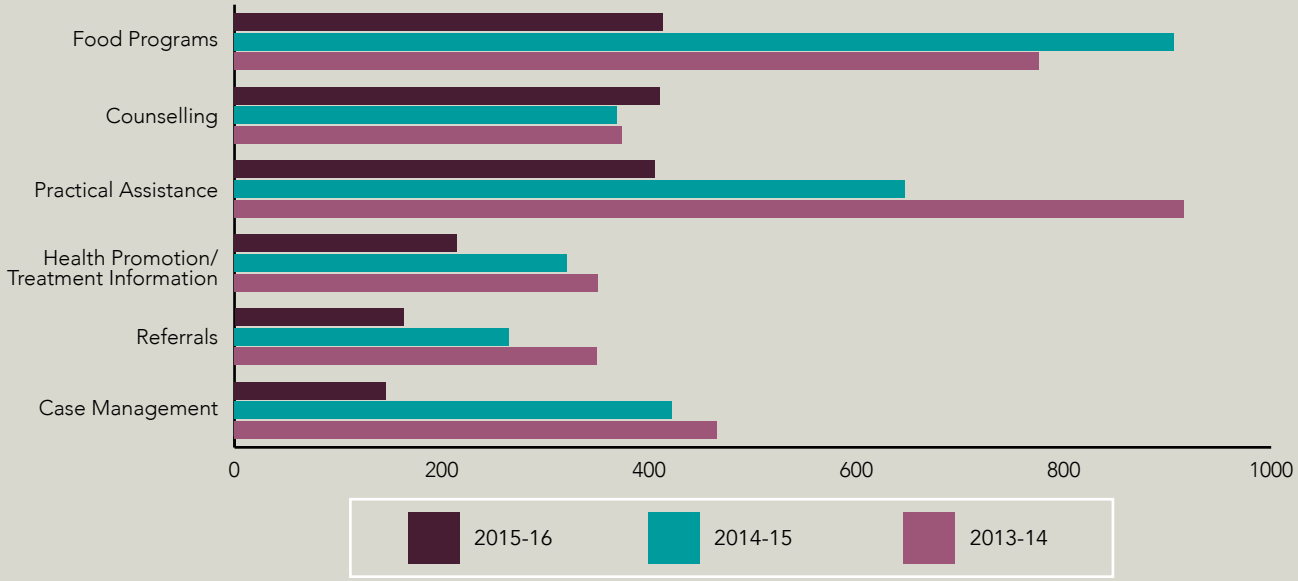


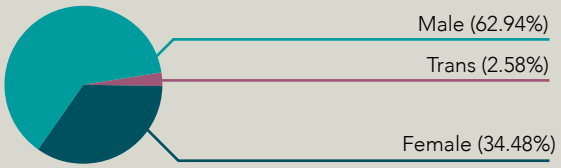
FIGURE 65 Top 5 services being accessed by affected clients (OCHART 11.2.1)



Women more likely to use support services than men

Since 2010, men account for 3 of every 4 new diagnoses (78-83%) while women account for 1 in 4 (17-22%), yet men account for 62-66% of new clients (2 of 3) and women 32-36% (1 of 3) of new clients. In terms of all support service clients (new plus returning) 63% are male, 34% are female and 3% are trans in 2015-16. These data indicate that women may be more likely than men to seek out community-based support services.

FIGURE 66 Breakdown of new clients living with HIV using support services by sex/gender (OCHART q. 11.1.1)



Both male and female clients use practical assistance, food programs and referrals. However, women are more likely than men to use interpretation and settlement services, which suggests that a larger proportion of female clients are newcomers.

TABLE 3 Top 5 services accessed by sex/gender in 2015-16

Cis Man	Cis Woman	Trans Woman	Trans Man
1. Food programs	1. Practical assistance	1. Counselling	1. Practical assistance
2. Practical assistance	2. Food programs	2. Referrals	2. Referrals
3. Counselling	3. Referrals	3. Practical Assistance	3. Scheduled drop-in program
4. Intake and/or assessment	4. Scheduled drop-in	4. Intake and/or assessment	4. Counselling
5. Referrals	5. Intake and/or assessment		5. Health promotion/ treatment information

Trans people primarily use drop-in programs, practical assistance and referrals. There is some variation in the services used by trans men and trans women. Trans men appear to access more services than trans women; however, the number of services used by trans men is too low to draw conclusions.

FIGURE 67 Top five services used by trans women (OCHART q. 11.2.1)

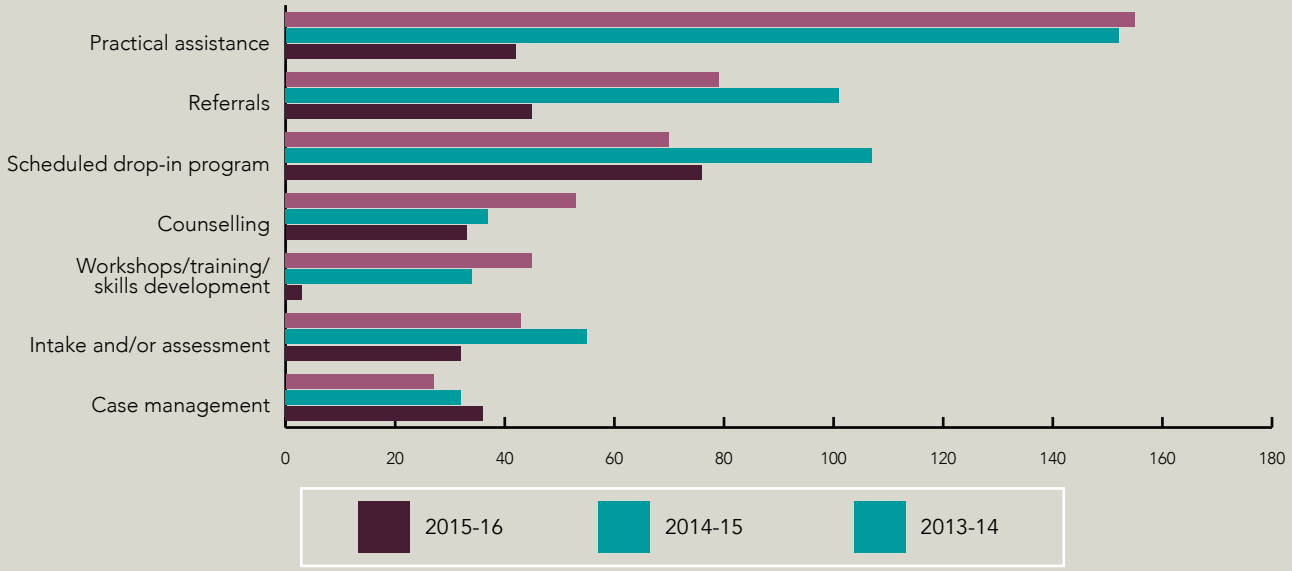
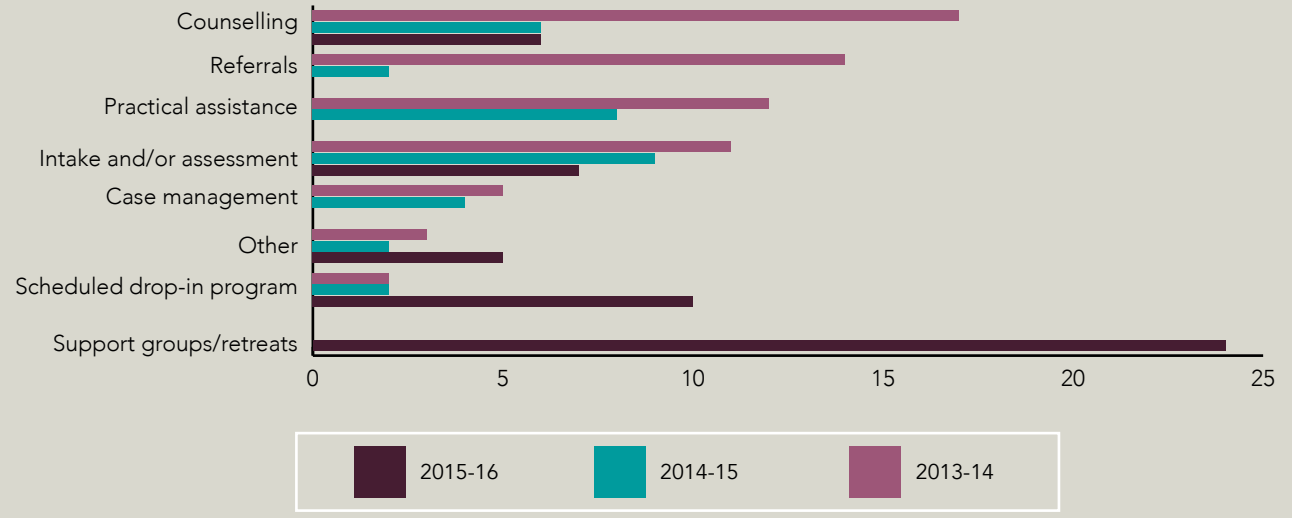


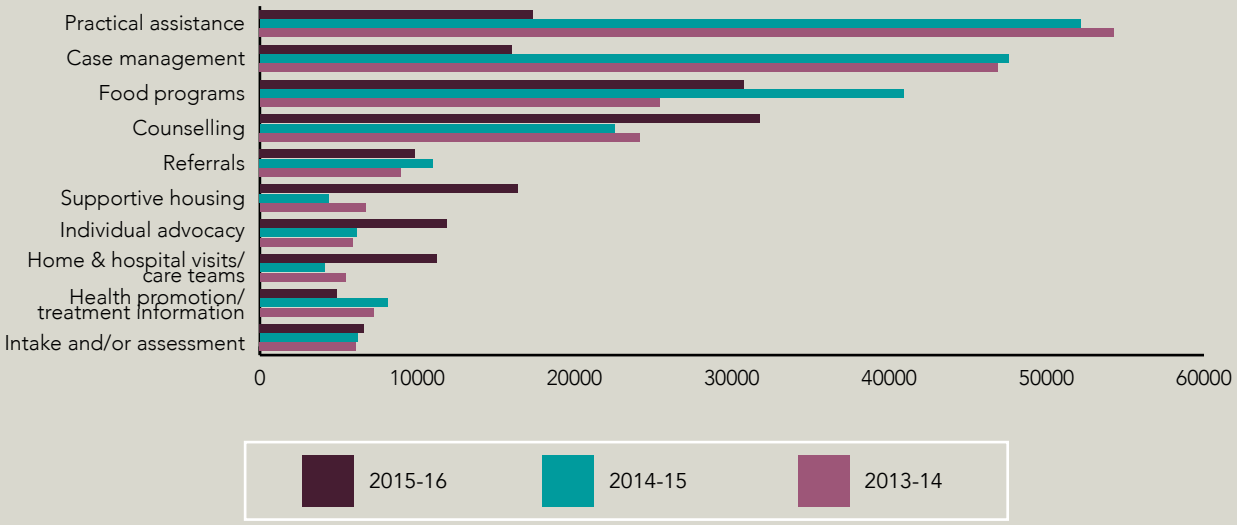
FIGURE 68 Top five services used by trans men (OCHART q. 11.2.1)



Increase in client visits, counselling and individual advocacy

In 2015-16, programs reported an increase in home and hospital visits, individual advocacy, supportive housing and counselling. They reported fewer sessions devoted to case management, practical assistance and food programs. The decline in the number of case management sessions is likely due to efforts within the sector (currently underway) to define case management as being a service for clients with more complex and intensive needs. The decrease in the number of practical assistance sessions is due to a change in how practical assistance is defined, particularly for those agencies that use OCASE. There is now a standard definition for practical assistance services across the province. The decrease in food bank sessions or services is also due to a change in reporting. For example, in the past if a client received both a food basket and a gift certificate for food at the same appointment, that would have been counted as two services but is now counted as one.

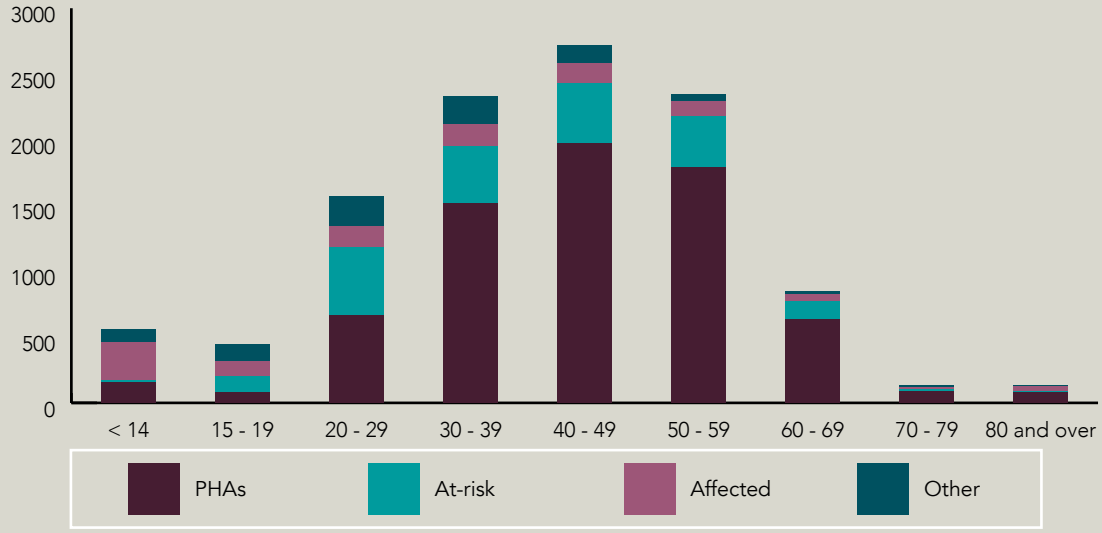
FIGURE 69 Total number of support sessions 2013-14 – 2015-16



More than half of all support service clients are between the ages of 30 and 59

Where the age of clients is reported, more than half of all clients accessing support services in 2015-16 were between the ages of 30 and 59—which is consistent with the age of people diagnosed with HIV.

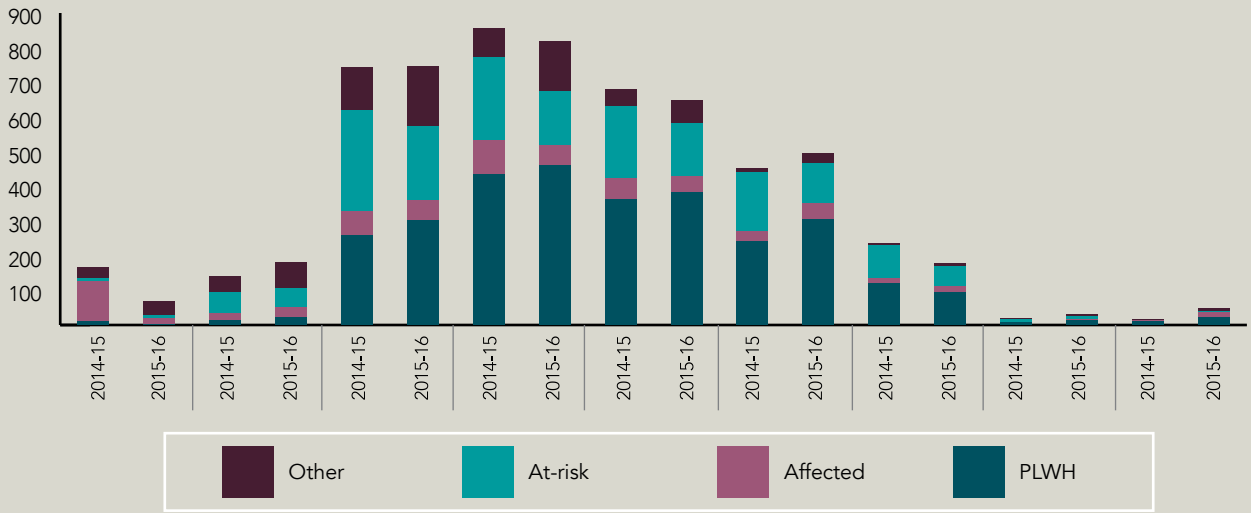
FIGURE 70 Total number* of clients accessing support services by client type and age**: 2015-16 (OCHART q. 11.1.3)



* New and existing (averaged)
** Age was unreported for 3,512 clients primarily from 2 programs.

When we look only at new clients, we see that a significant proportion are between the ages of 20 and 29, which may reflect the increase in new diagnoses in this age group.

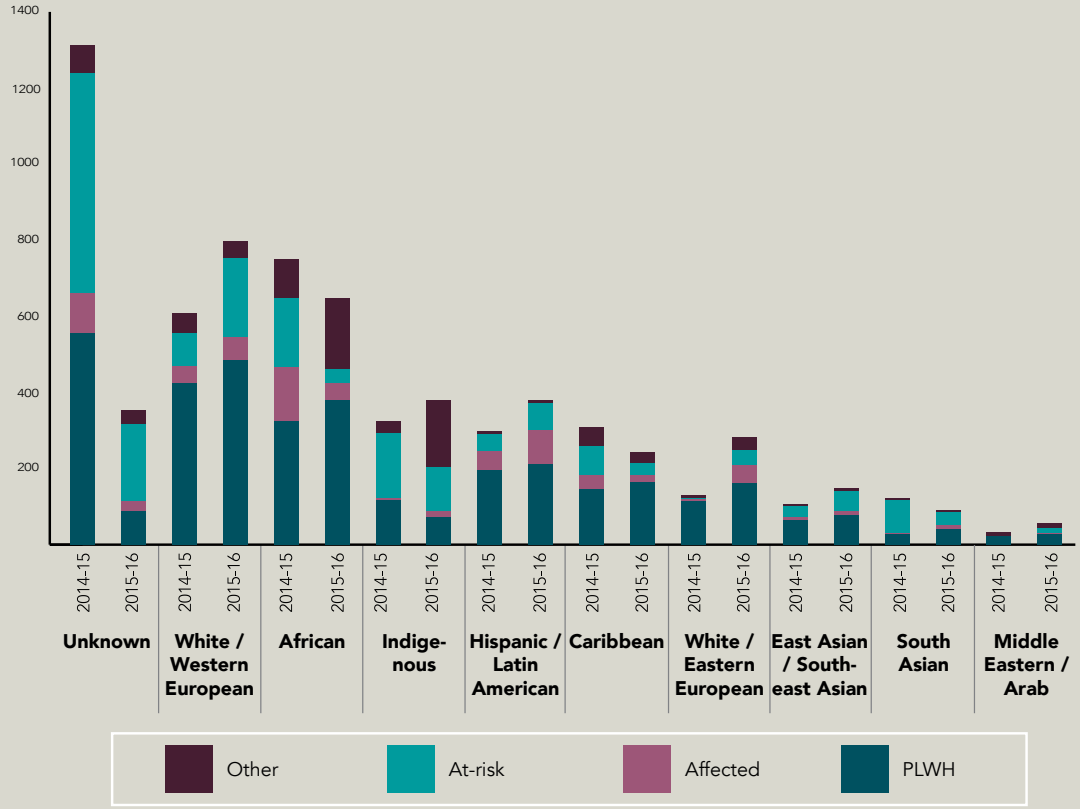
FIGURE 71 Number of new clients by age and client type 2014-15 – 2015-16 (OCHART q. 11.1.3)



Client ethnicity consistent with provincial epi data

Information on the ethnicity of people who use support services has improved greatly in the past year, thanks to more complete reporting by community-based organizations. More complete and accurate information on ethnicity helps agencies identify the need for culturally competent services; it also helps the sector get a sense of whether certain ethnic groups are at-risk and need more focused prevention interventions.

FIGURE 72 Number of new clients by ethnicity and client type 2014-15 – 2015-16 (OCHART q. 11.1.4)



* One program was removed from 2014-15 and 2015-16 since it does not collect ethnicity data.

Clients face discrimination, poverty and unemployment

Clients continue to face challenges associated with the social determinants of health. In the past, we relied on agency estimates of the proportion of clients dealing with each issue. With recent improvements to OCASE, we now have more accurate data on the number of clients who reported each of these presenting issues. FIGURE 73 shows that:

- almost 3 in 4 clients have experienced stigma / discrimination
- almost 7 in 10 live in poverty
- more than 6 in 10 are unemployed
- more than 5 in 10 are dealing with food insecurity
- just over half reported mental health issues
- almost 4 in 10 have experienced violence and almost 3 in 10 reported past or current sexual abuse
- more than 3 in 10 report substance use.

FIGURE 73 Challenges faced by clients (proportional) 2015-16 (OCHART q. 11.1.6)

Referrals critical in engaging and retaining clients in care

In 2015-16, programs reported a total of 12,670 referrals: 5,794 to clinical services and 6,876 to community / social services. For cis gender clients, the majority of community referrals were to basic social supports including social service funding, housing and food banks while the most common clinical referrals were to health care professionals, counselling services and community mental health agencies. For trans clients, the most common community referrals were to population-specific services, other ASOs and social services; the most common clinical referrals were to testing programs, including STI, HIV and HCV testing.

FIGURE 74 Number of unique clinical and community referrals by sex/gender (male and female) 2015-16 (OCHART q. 11.2.1b)

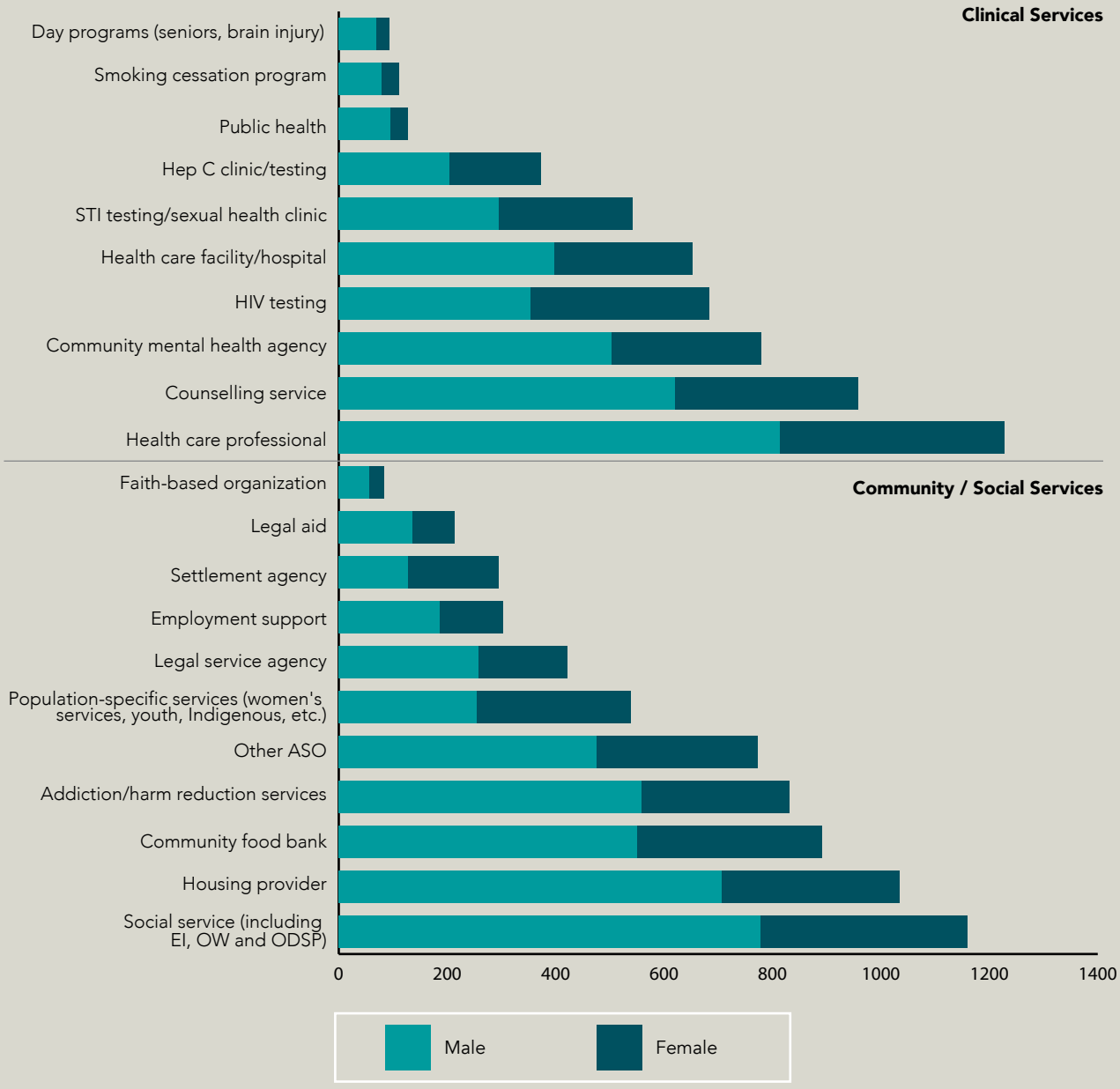
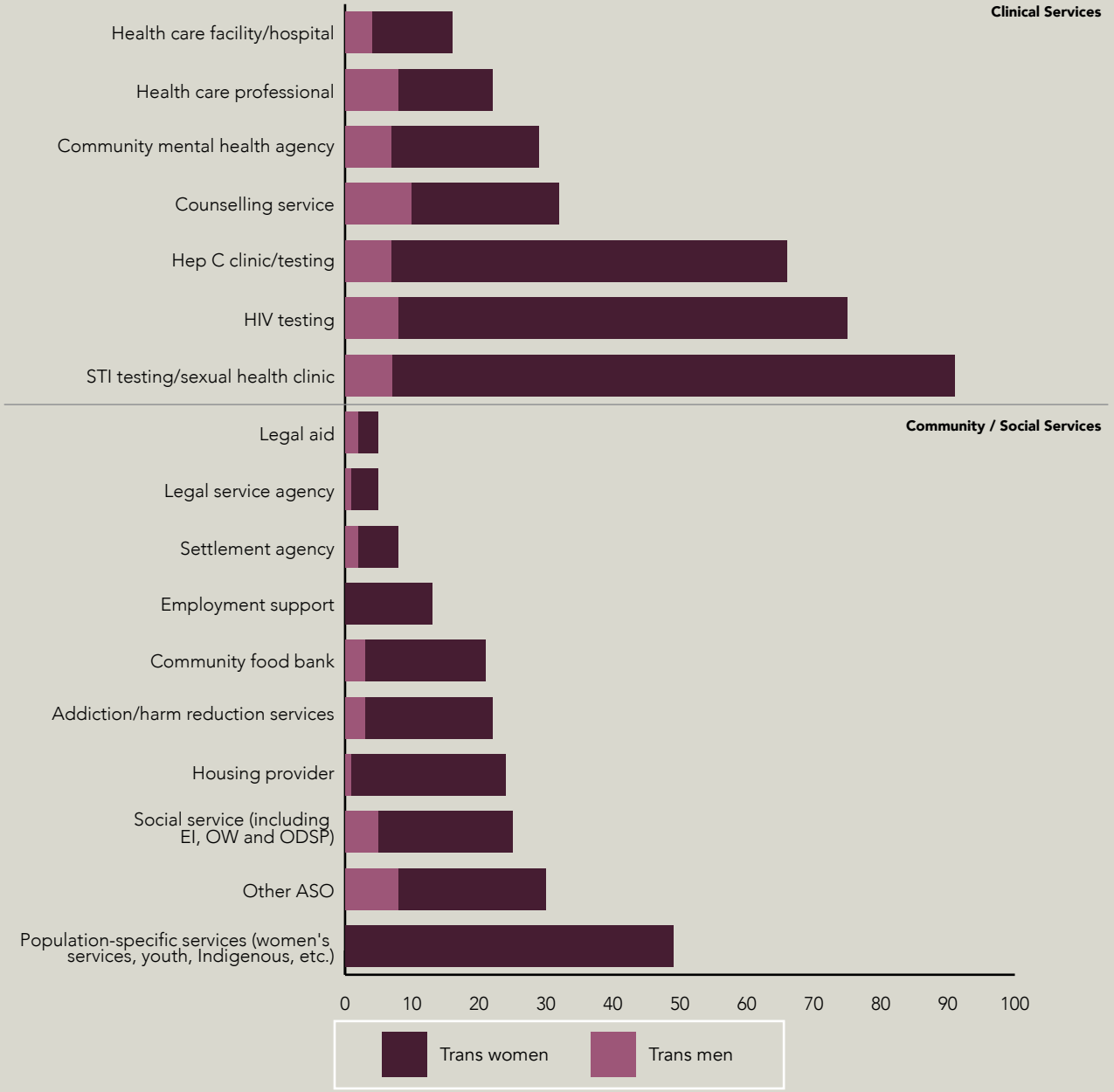


FIGURE 75 Number of unique clinical and community referrals by sex/gender (trans men and trans women) (OCHART q. 11.2.1b)



What programs told us about shifts in the demand for support services

Shift in demand	Examples of shifts
Housing and supports	We have observed an increase in single adult males experiencing homelessness and housing instability who are the primary users of the agency daily drop in programs…. Male clients needing support, advocacy and referrals for housing and income disability support [are] presenting bed bug infestations as one of their primary concerns impacting their quality of life and mental health, and also regarding cost concerns with the lack of affordability of hydro and heat, and safety concerns in local buildings and neighborhoods in subsidized and affordable housing units, including higher end social support housing options. — The AIDS Network Challenges with poor housing conditions – infestation and those who are on subsidized housing wait lists. — Hospice Toronto More clients looking for affordable and appropriate family housing. Increase in supporting parents with decisions around disclosure to children. — The Teresa Group The new policies around accessing furniture from the furniture bank has created greater financial demands for clients as they can no longer make their own arrangements to pick up furniture. Everyone now has to pay the delivery fee once they have visited and selected furniture. — Black Coalition for AIDS Prevention
Mental health issues	Increased number of clients in need of counseling and mental health services, especially in addiction/harm reduction. — Action Positive There is an increase in clients presenting mental health issues, e.g. depression, schizophrenia, bipolar disorder and addictions issues (alcohol, smoking, drugs). — Africans in Partnership Against AIDS Noticing more and more clients dealing with mental health issues who are not linked into mental health services as well as larger numbers of folks abusing prescription pain medications. — AIDS Committee of Cambridge, Kitchener, Waterloo and Area

Shift in demand	Examples of shifts
Immigration (complex refugee issues)	Increased number of PHAs, especially among new immigrants who have complex challenges due their refugee status. — Action Positive The request for financial assistance (immigration fee costs, e.g. permanent residence, humanitarian, etc.) continue to increase. — Africans In Partnership Against AIDS There are growing demands created by the increased number of refugee clients being served by the agency. Many require quick follow up appointments and intense attention to help them be fully prepared for their refugee hearing. —Black Coalition for AIDS Prevention There has been a 50% increase in immigrant population requests for services and support. We expect this to be a growing trend with the influx of students coming to the city for both university and college programs. This coincides with an increase in the French-only speaking population who need some translation services and supports. — Réseau ACCESS Network

Responding to emerging trends

Trend	Examples
Strengthening partnerships and referral network	We have increased our partnerships and developed MOUs with many to make roles and responsibilities clear and streamline processes….Increased number of referrals to mental health services in and outside the Region [and] increased referrals to Fife House as there are limited options here in Durham. — AIDS Committee of Durham Region We sit on various committees to build partnerships with agencies that can collaborate with us in supporting the needs of our service users. ACYR's support services staff have also informed our education, outreach, and community development efforts so that we can build service provider capacity around issues of HIV and immigration and population specific needs. — AIDS Committee of York Region The HIV/AIDS Complex Care Project has partnered and linked with a new project led by Fife House, the Coordinated Access for HIV Housing and Supports Initiative. This new initiative developed a new central intake and assessment tool for all HIV related supportive housing and case management supports. The Project is a partnership of 8 housing providers and is also linked and aligned to The Access Point (Central Intake and Assessment for all Mental Health & Addictions Supportive Housing and Case Management Services). Partnering with the new Coordinated Access Project allows eligible clients for the Complex Care project to be streamlined into supportive housing wait lists and other support services, at the same time as being assessed and referred to services within the Complex Care Project. —Fife House We have increased our annual "Country Cupboard" budget and built a relationship with a local butcher who has since begun providing a higher quality product with more diverse options, including ground beef, chicken and pork. Furthermore, we are once again developing a community garden plot which will serve not only as an activity for PHAs should they wish to contribute but also provide fresh produce when harvested. Note: participation is not necessary in order to receive fresh goods. — Regional HIV/AIDS Connection
Adapting practice	Participating in coordinated care plans with multi-disciplinary teams to address care for complex clients. — LOFT Focusing on the case management and engaging more case coordination which will allow more wrap around service for individual clients and their families. — Peel HIV/AIDS Network
Building internal capacity	We have offered additional training to volunteers and staff to gain better awareness for mental health/homeless/disabilities and have adapted the training. — Hospice Toronto

Capacity-building & community development

This section of OCHART summarizes the capacity building and community development activities undertaken by both provincial capacity building programs and local ASOs.

Provincial capacity-building programs

The AIDS Bureau funds 11 provincial capacity-building programs to help front-line community-based programs develop new skills and implement evidence-informed practices and programs. The work of these organizations generally falls into three categories: capacity-building, skills development and mentoring. Three of these provincial programs are population-specific.

TABLE 4 Provincial capacity-building organizations

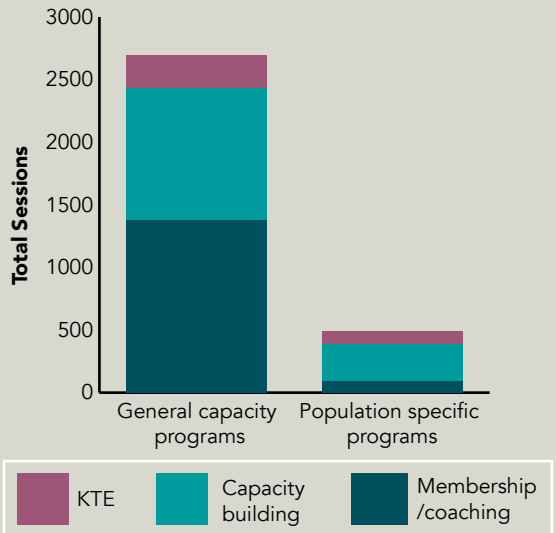
Organization Name	Description of services
Population specific programs	
African and Caribbean Council on HIV/AIDS in Ontario - ACCHO	ACCHO provides leadership in response to HIV/AIDS in African, Caribbean and Black communities in Ontario. This is done through coordination of the implementation of the ACB Strategy, capacity development and community engagement, as well as research and advocacy.
Gay Men's Sexual Health Alliance – GMSH	The GMSH is a provincial network made up of front-line workers, researchers, public health experts, policy makers and community members. They act as an information hub for gay & bisexual men's health in Ontario.
Women and HIV/AIDS Initiative - WHAI	WHAI is a community-based response to HIV and AIDS among cis and trans women in Ontario that takes into account the structural and societal factors that increase women's risk factors for HIV.
General capacity building programs	
AIDS Bereavement and Resiliency Program of Ontario – ABRPO	ABRPO provides community-based AIDS-serving agencies with concrete support in the area of AIDS grief, loss, change and transition. ABRPO is a resource for Ontario groups looking explicitly at the impact of AIDS-related grief and loss. ABRPO helps assess and enhance individual and organizational resiliency in the face of these ongoing losses.
Committee for Accessible AIDS Treatment – CAAT	CAAT is a coalition of individuals and organisations from the legal, health, settlement and HIV/AIDS sectors committed to promoting health and wellbeing in which all individuals living with HIV/AIDS have the information and tools they need to access health, social and legal services that are welcoming, inclusive, and respectful regardless of their immigration status.
Canadian AIDS Treatment Information Exchange – CATIE	CATIE is Canada's source for up-to-date, unbiased information about HIV and hepatitis C. CATIE develops and shares information resources, strengthens community capacity and networks, and connects researchers and service providers to inform each other's work.

Organization Name	Description of services
Ontario AIDS Network – OAN	The OAN unites and supports those working in HIV prevention, treatment and care in Ontario. They pursue knowledge exchange, advocacy and capacity building for people living with HIV and member organizations who are challenging stigma, fighting for social justice, and confronting HIV in Ontario communities.
Ontario HIV and Substance Use Training Program – OHSUTP (sponsored by Fife House)	OHSUTP provides training to substance use, mental health and allied service providers in Ontario, in order to increase knowledge of HIV/AIDS and to promote skills development.
Ontario HIV Treatment Network - OHTN	The OHTN funds and conducts HIV research and provides education, capacity building, evaluation services, data collection and monitoring for HIV services in Ontario.
Ontario Organizational Development Program – OODP	The Ontario Organizational Development Program (OODP) provides e-resource tools, one-on-one coaching for executive directors and board chairs, workshops, planning support, group facilitation and consulting support for customized consults upon request.
Toronto HIV Network - THN (sponsored by the Toronto People With AIDS Foundation)	The Toronto HIV/AIDS Network facilitates HIV/AIDS planning, collaboration and innovation among organizations in Toronto to improve access to programs and services for people from diverse communities living with, affected by and at risk of HIV/AIDS.

Key Trends

- More demand for leadership and change leadership coaching.
- More investment in provincial data management and reporting systems.

FIGURE 76 Number of presentations or sessions by type 2015-2016 (OCHART q.14.1a)



Responding to the sector's changing needs

In 2015-16, the general capacity-building organizations reported providing significantly more coaching and mentoring sessions and fewer presentations. This shift is consistent with a sector-wide effort to review the capacity and training needs of HIV funded programs. Provincial capacity-building programs have developed a committee (HIV Resources Ontario - HRO) to determine how to make capacity-building resources more accessible and effective. We expect to see more changes in the type and focus of capacity-building services as this process continues.

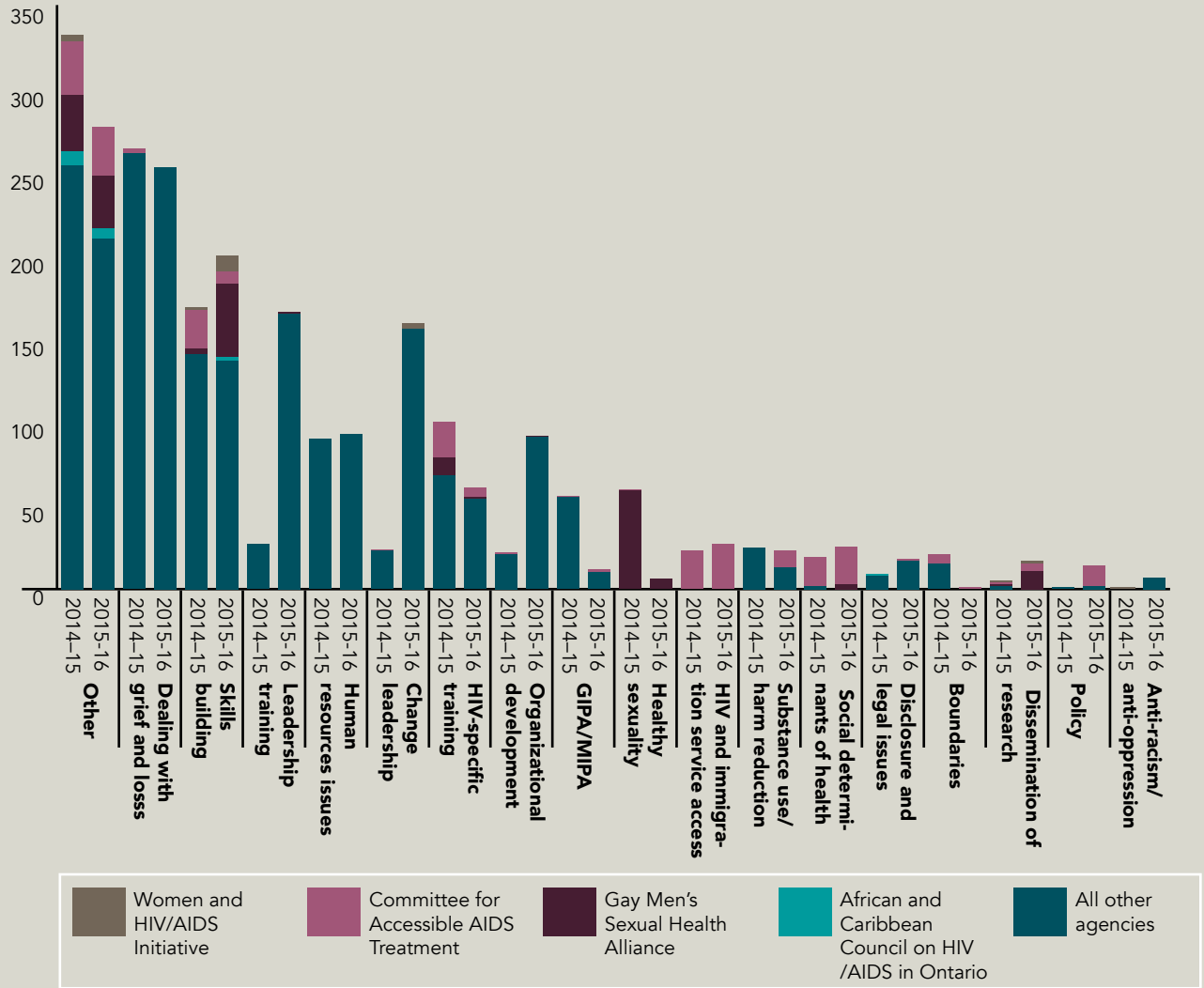
The population specific programs – particularly GMSH, WHAI and ACCHO – concentrated their efforts on building the capacity of other workers in the sector through capacity-building and disseminating research. CAAT provides mentorship as well as these other activities.

In terms of the focus of presentations/sessions, the largest category was "other". More than half of the "other" presentations were delivered by ABPRO to front line workers and people living with HIV on topics such as people living with HIV having multiple roles, one-to-one mentoring, coaching and assessment.

In response to demand from the sector, the general provincial capacity-building organizations reported a 500% increase in activities related to leadership training and change leadership as well as a 300% increase in organizational development activities – including support with both structural and procedural change as well as work plans. Most leadership trainings were primarily coaching sessions delivered by the Ontario Organizational Development Program.

All provincial capacity-building programs reported fewer presentations/sessions in 2015-16 related to HIV specific training, GIPA/MIPA, healthy sexuality and boundaries.

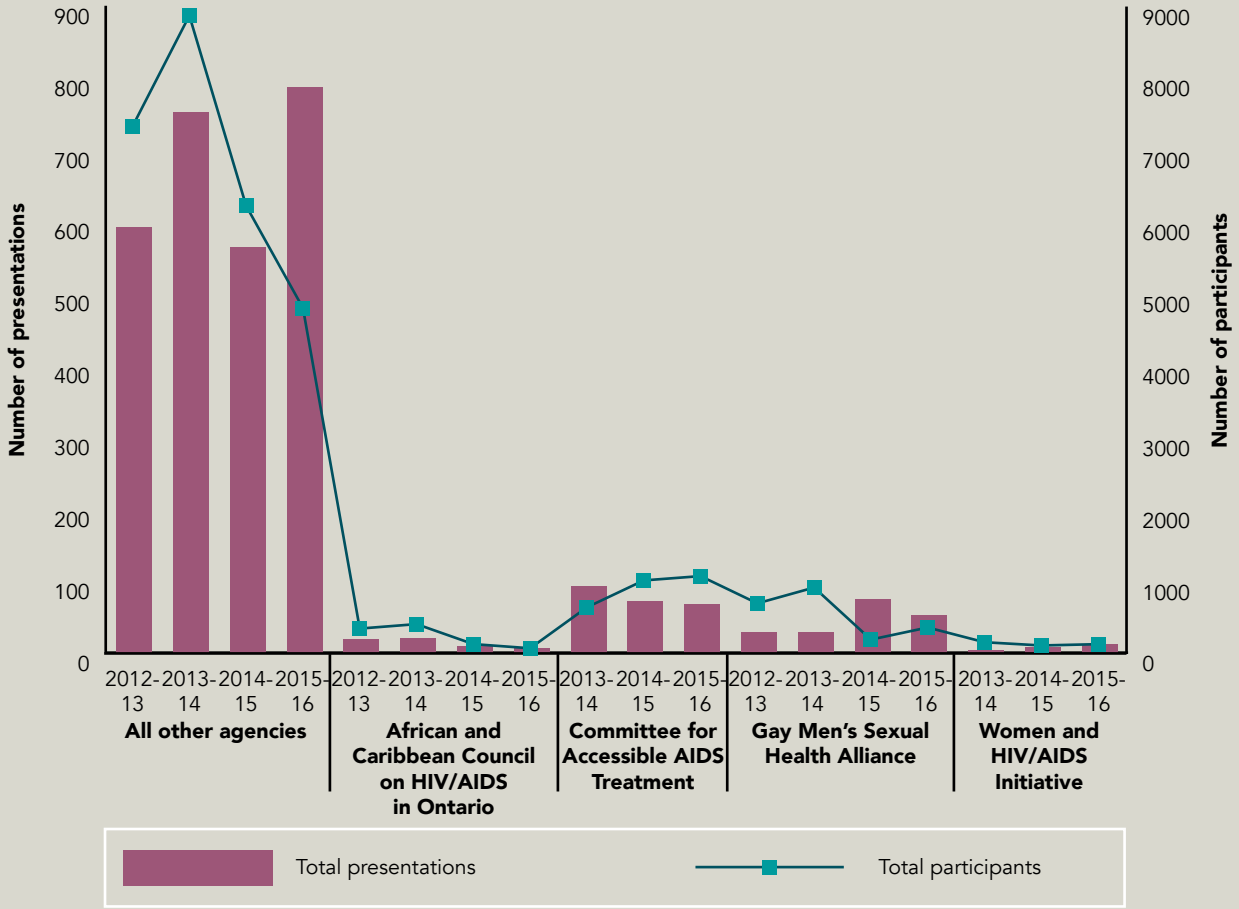
FIGURE 77 Number of capacity building events by focus and organization (OCHART q. 14.1.a)



Population-specific capacity building organizations were more likely than the general organizations to offer presentations and sessions related to immigration, social determinants of health, policy and cultural sensitivity training.

Although the number of capacity-building sessions increased in 2015-16, the number of participants dropped. This trend reflects the shift away from general presentations to mentoring and coaching sessions.

FIGURE 78 Capacity-building presentations and participants (OCHART q. 14.1a)



Provincial campaigns

Several provincial capacity-building organizations are responsible for developing campaigns that can be used by community-based organizations. In 2015-16, there was a significant increase in the number of campaigns and related planning meetings – largely due to the maturing of the priority population networks.

TABLE 5 Capacity-building program-led campaigns and planning meetings (OCHART q.14.7b)

Year	Number of campaigns	Planning meetings
2012-13	7	53
2013-14	6	104
2014-15	6	58
2015-16	11	83

Resources

Capacity-building organizations are also responsible for developing resources that can be used across the system. The following chart shows the total number of resources distributed during 2015-16.

TABLE 6 Resources distributed by capacity building organizations (OCHART q. 14.6b)

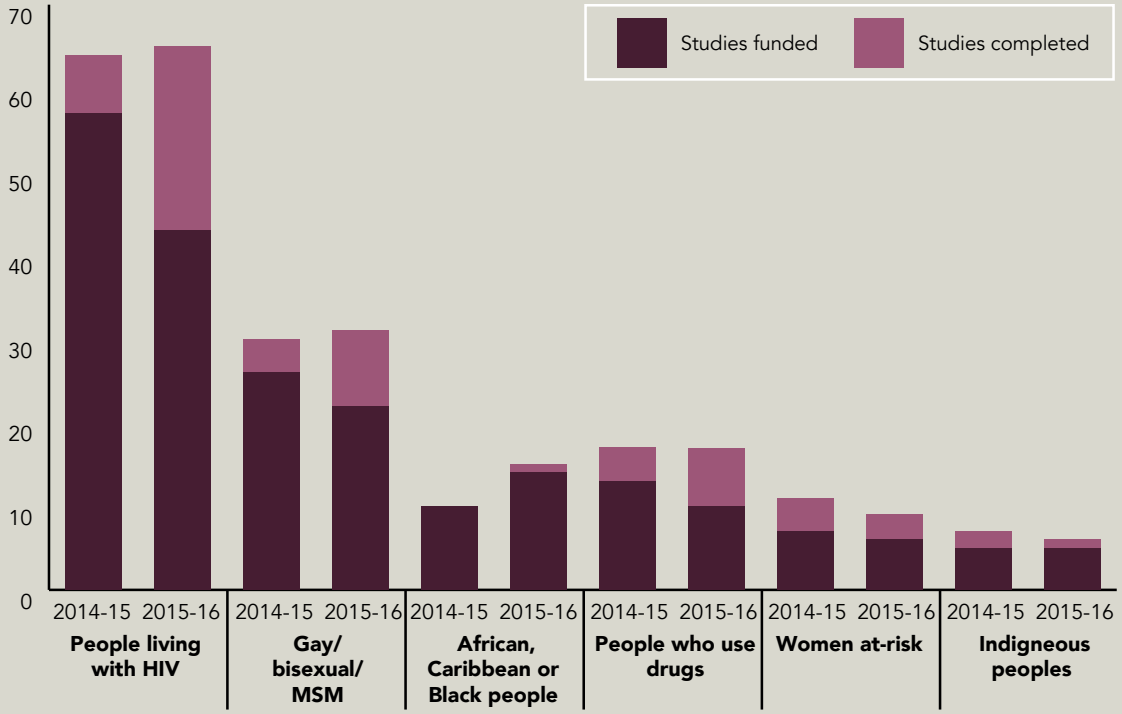
Resource distributed	2012-13	2013-14	2014-15	2015-16
PHA health information or support resources	256,914	188,587	273,556	283,553
Newsletter or news article	113,223	41,958	51,468	51,746
Other (please specify)		12,192	80	78
Brochures, posters, flyers or pamphlets – agency promotional materials	75	560	10,043	50
Brochures, posters, flyers or pamphlets – prevention/ education		1,737	1,660	5,347
Manuals/training kits	1578	497	185	294
Workshop presentation materials (includes templates, PowerPoint, handouts, etc.)	1496	200	52	702
Strategic planning, decision making, policy or organizational development tools	188	145	20	145
Research summary or evaluation report	1	2	67	40
Film/DVD		13		
Grand total	**373,475**	**245,891**	**337,131**	**341,955**

Promoting research and evidence-based practice

The OHTN continues to fund research focused on priority populations and the prevention, engagement and care cascade. In 2015-16:

- the OHTN funded 100 research grants (4 new and 96 ongoing) – 12 of which went to new (never funded before) researchers. The funded research projects engaged 361 trainees (283 reported in H1 and 78 reported in H2) (5d). Trainees include mentees and other individuals who participate in the research projects.
- 43 studies / grants were completed.
- Funded studies can focus on one or more priority populations. In 2015-16, there was a significant increase in the number of research projects relevant to African, Caribbean and Black communities while the others remained relatively similar.

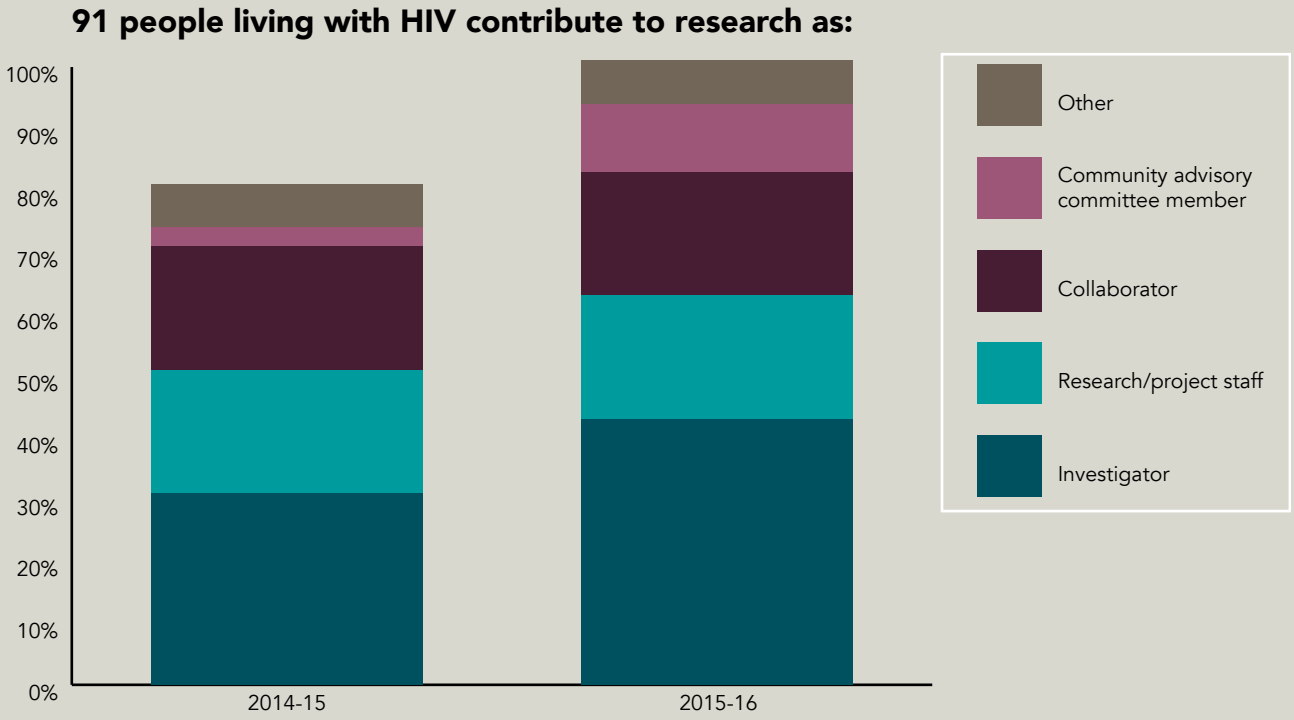
FIGURE 79 Number of research studies by priority population (OCHART q. 6.5b)



More people living with HIV were investigators on studies

Funded research projects reported involving 91 people living with HIV — up from 75 in 2014-15. (**Note**: some people living with HIV may be involved in more than one study so there may not be 91 unique individuals involved.) There was a significant increase in the proportion of people living with HIV who were investigators, which indicates an increasing level and depth of involvement as well as the fact that a growing number of people with HIV are pursuing research careers.

FIGURE 80 Contributions to research from people living with HIV by role (OCHART q. 6.5d)



In 2014-15, OHTN scientists and staff participated in more than 10 research projects and produced a range of resources and products including:

OHTN Scientists produced	2014-15	2015-16
Peer-reviewed articles	21	24
Grey literature publications	10	16
Resources (including newsletters and study support pieces)	21	29

OHTN Cohort Study

The OHTN Cohort Study (OCS) is a nine-site research study that has collected clinical and socio-behavioural data on over 6,000 people living with HIV in Ontario — 3,700 of whom actively complete a questionnaire at least once a year. OCS data are used to understand the health needs of people living with HIV and improve care.

In 2015-16, the OCS enrolled more than twice as many new participants (1,208) than in 2014-15 (435) of whom: 30% were men who have sex with men, 11% were African, Caribbean or Black individuals, 4% were people who use drugs, 8% were women at-risk and 2% were Indigenous people.

TABLE 7 OCS Key Findings – 2015 - 16

Key finding	Why this is important
Ontario clinics are successfully engaging people with HIV in care and providing sustained, effective treatment. By 2011, 87% of OCS participants were engaged in care and 76% had a suppressed viral load.	When people living with HIV engage and stay in care and adhere to antiretroviral medication, their health improves and the risk of HIV transmission is reduced.
Shorter mental health screening instruments (PHQ-9, CES-D 10 & K-10) can accurately diagnose depression among people living with HIV.	Depression often goes unrecognized among people living with HIV. Shorter screening instruments have the potential to improve depression screening and diagnosis rates at busy HIV clinics.
Syphilis rates among HIV-positive men who have sex with men are rising. Over the study period (2006-2010), rates were 300 times higher among HIV-positive men than in the general population.	Having syphilis or another STI increases the risk of HIV transmission. Syphilis may go undetected for quite some time so it is important for HIV-positive men who have sex with men to test for syphilis more often. Novel syphilis control strategies are needed for HIV-positive men.
People living with HIV-HCV co-infection and a history of injection drug use are significantly less likely to receive regular liver, kidney and metabolic tests despite being at higher risk for cirrhosis and kidney disease.	People living with HIV-HCV co-infection who have a history of injection drug use and who are not regularly tested for liver and kidney function may develop comorbidities that could have a negative impact on their health and wellbeing.

OCS data were cited more in publications. OCS staff delivered more presentations and completed more data scans. (see FIGURE 81).

FIGURE 81 Ways OCS data was used (OCHART q 6.4)

	2014/15	2015/16
Data scans completed (Internal)	4	7
Number of presentations by OCS Staff	21	28
Number of project proposals received	7	3
Number of publications containing OCS data	6	18
Project proposals approved	4	3
Studies completed using link to ICES (Internal)	0	0

Moving evidence into practice

In 2015-16, to help move evidence into practice, the OHTN knowledge synthesis team completed 11 literature reviews — including 5 systematic reviews — as well as 9 rapid responses. The rapid response service, which provides research summaries in response to questions from community-based HIV / AIDS organizations in Ontario, is designed to help support evidence-informed programs, service delivery and advocacy.

TABLE 8 Table 10. OHTN summarizes research evidence via systematic reviews and rapid responses

11 Literature reviews

Topics for literature reviews are often identified by researchers and policy makers

1. HIV/STI prevention interventions for people living with HIV in high income settings*
2. Using community-based participatory research approaches in HIV: Case studies from three countries
3. Benefits and challenges of community-academic partnerships in HIV-related research*
4. Patient support and education for promoting adherence to highly active antiretroviral therapy for HIV/AIDS*
5. Factors associated with retention in HIV care*
6. Examining the associations between HIV-related stigma and health outcomes in people living with HIV/AIDS*
7. HIV/HCV harm reduction services specific to Indigenous women who use drugs and other substances
8. Models and services that have been shown to be effective in improving linkage to care for people living with HIV
9. Machine learning and text mining for knowledge synthesis
10. Mobile apps and self-management of chronic conditions
11. Interventions addressing intimate partner violence among Ontario's priority populations

9 Rapid responses

Topics identified by community

1. HIV-related stigma in relation to health care professionals in Canada
2. Reminder systems for people living with HIV
3. Transitioning from adolescent to adult care in HIV
4. Impact of community-based organizations for people living with HIV
5. Knowledge of HIV and related best practices among non-HIV specific health care providers
6. What factors affect the health and well-being of lesbian, gay and bisexual Asian youth?
7. Mobile apps and sexual risk behaviours among men who have sex with men
8. Epidemiology of hepatitis C virus infection among men who have sex with men
9. The role of nurse practitioners in HIV care

* denotes systematic review

Helping community-based programs with data and evaluation

This past year, the Evidence-Based Practice Unit of the OHTN (EBPU) invested in the development and upgrading of its OCASE and OCHART data systems. As part of this process, all ASO executive directors and OCASE leads were invited to attend a one-day Data Summit on data systems, data integrity and how the data systems are being aligned with the provincial strategy. The EBPU also continued to support the province's HIV sector with data management, reporting, program development and evaluation services.

In 2015-16, the EBPU responded to 46% fewer data requests (195) than in the previous year (364). The drop in requests can be attributed to more automated features in OCASE, the implementation of a new request tracking system and more emphasis on user training. With these changes, users are able to query and manipulate their own data and no longer need to submit as many requests.

FIGURE 82 OCHART and OCASE training in 2015-16 (OCHART q. 6.7a)

FIGURE 83 OCHART and OCASE data analysis requests in 2015-16 (OCHART q. 6.7b)

Talking research

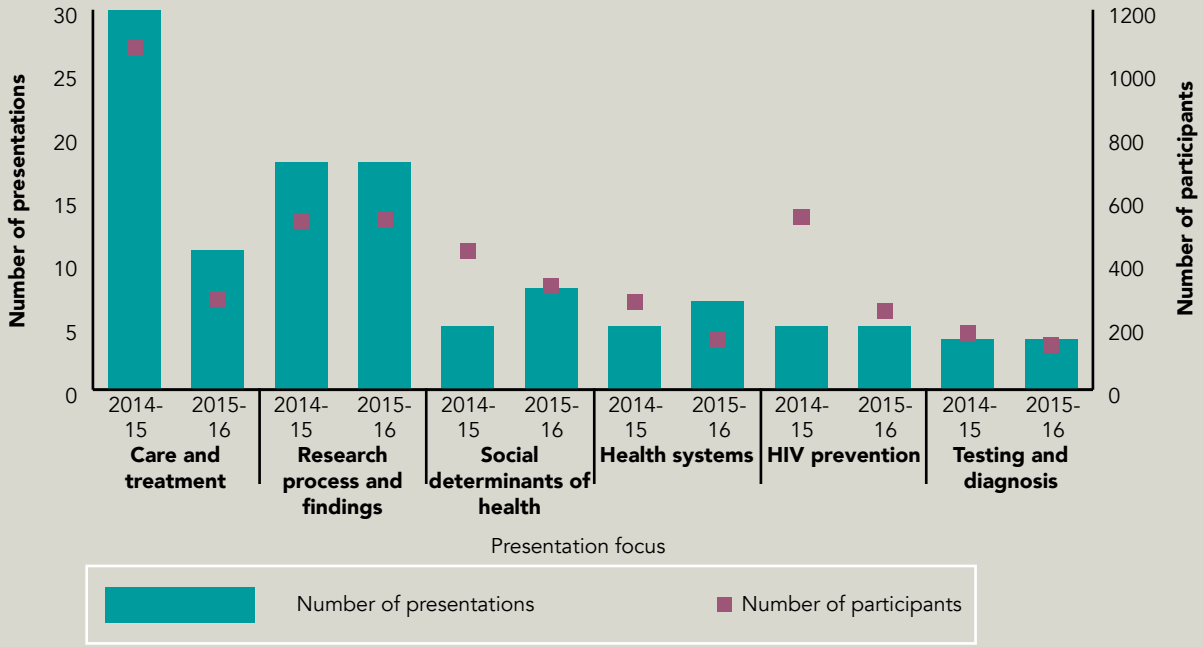
The OHTN reported delivering 53 presentations to a total of 1,696 participants. Overall the number of presentations and participants decreased (-21% and -44% respectively) due to OHTN scientists making fewer conference presentations. Research and findings were the main focus of many of the presentations followed by care and treatment and the social determinants of health.

TABLE 9 Total OHTN presentations and participants in 2015-16 by target audience (OCHART q. 6.1a)

	ASO service providers	HIV care providers	Multiple stakeholders	Non-ASO service providers	Policy makers
Capacity-building					
14 presentations, 285 participants	86%		14%		
KTE					
14 presentations, 316 participants	50%	36%	7%		7%
Researchers/academic (incl. students)					
25 presentations, 1095 participants	20%	60%	16%	4%	

The top 3 presentation venues in 2015-16 were consistent with those in 2014-15: conferences, community-based AIDS organizations and university/hospitals.

FIGURE 84 Total number of presentations and participants by presentation focus 2014 - 2015 – 2015-16 (OCHART q. 6.1a)



Local community development initiatives

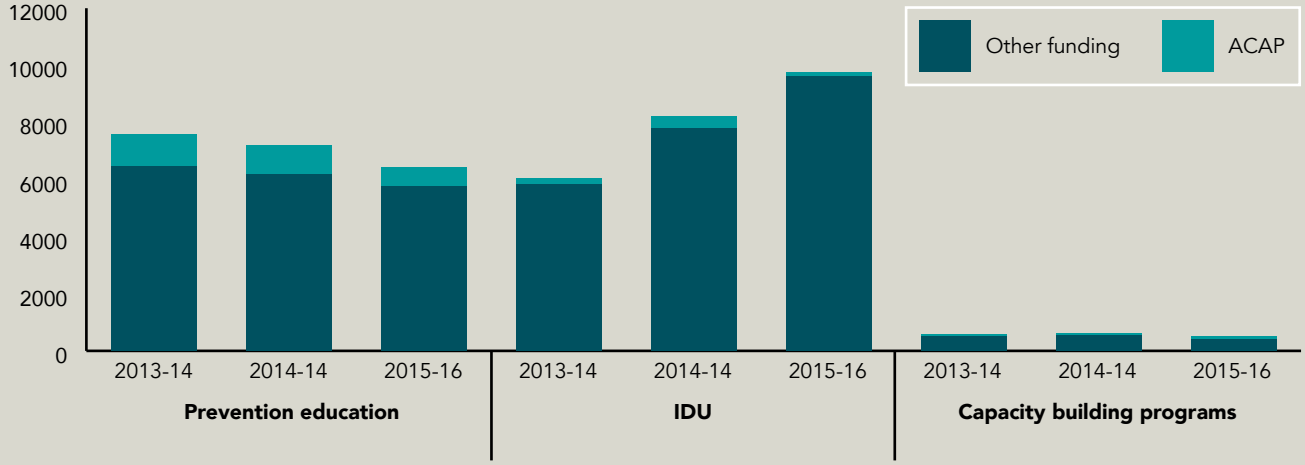
Strengthening capacity of communities to support people living with HIV

To reach people at-risk and to ensure that people with or at-risk of HIV receive comprehensive health and social services, programs seek out partners to help them deliver education, outreach and support services. As well, programs seek to create safe spaces and increase the cultural competence of other service providers providing service to people living with HIV. In OCHART, three types of programs — 1) prevention (education and outreach); 2) injection drug use outreach; and 3) provincial capacity-building programs — all report on community development activities.

IDU programs increasing community development efforts

By tracking community development meetings, the sector continues to demonstrate its commitment to building strong service networks. In 2015-16, programs reported a total of 16,678 community development meetings — up from 16,078 in 2014-15. The increase in meetings for the past two years is primarily attributed to IDU community development.

FIGURE 85 Community development meetings by funder and program type (OCHART q. 9.5 and 13.7 and 14.4)



Community development helps build networks

The purpose of prevention (education and outreach) community development meetings is to increase individual, organizational and community capacity.

Top 5 community partners:

1. Community agency/group/members
2. AIDS service organizations
3. Population specific services
4. Community health centres
5. Community advisory groups

The main goals of the meetings are to develop coalitions/networks and plan community events (see FIGURE 86). Within organizations, managers, education workers and priority population members all participate in network building activities (see FIGURE 87).

FIGURE 86 Top 5 community development meetings by purpose and funder (OCHART q. 9.5)

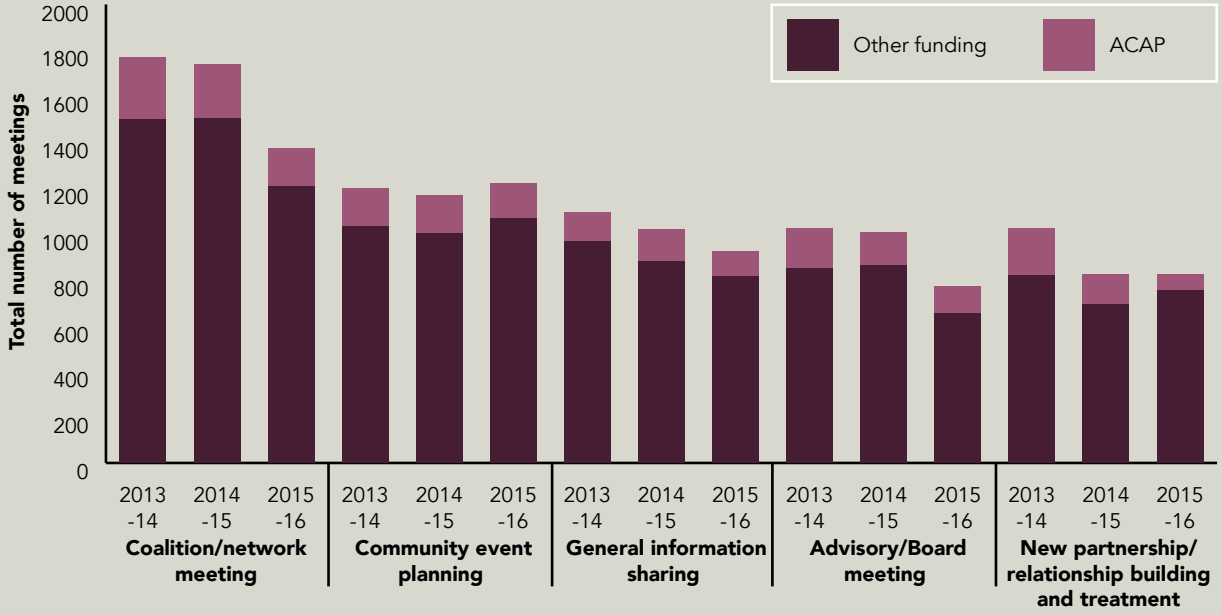
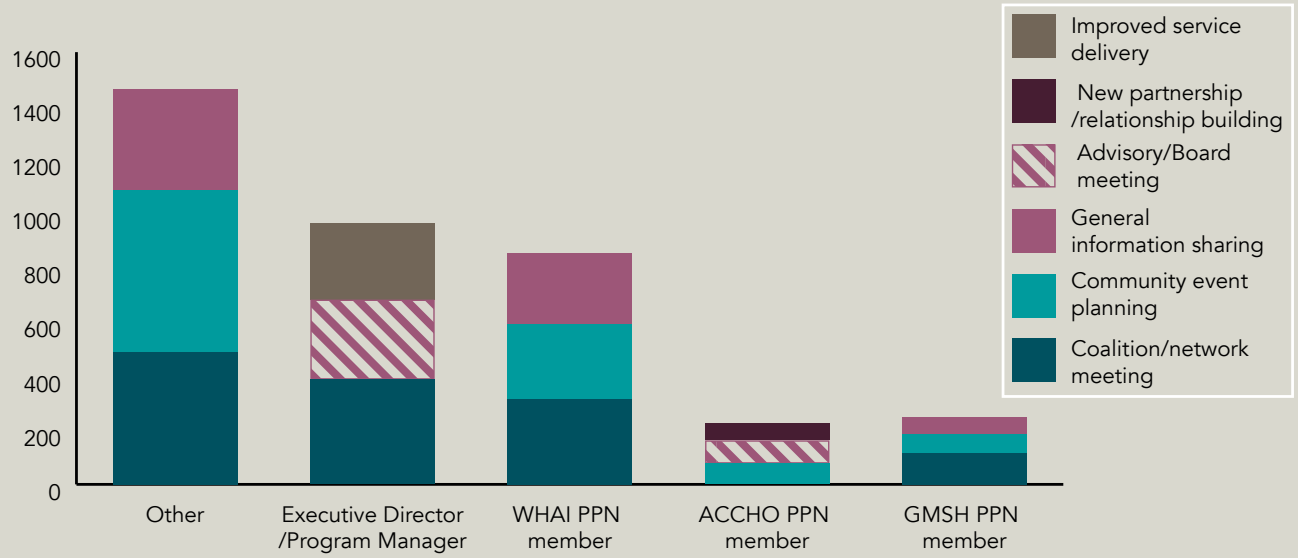


FIGURE 87 Community development meetings (top 3) by meeting purpose and worker role 2015-16 (OCHART q. 9.5)



Who is involved in IDU community development activities?

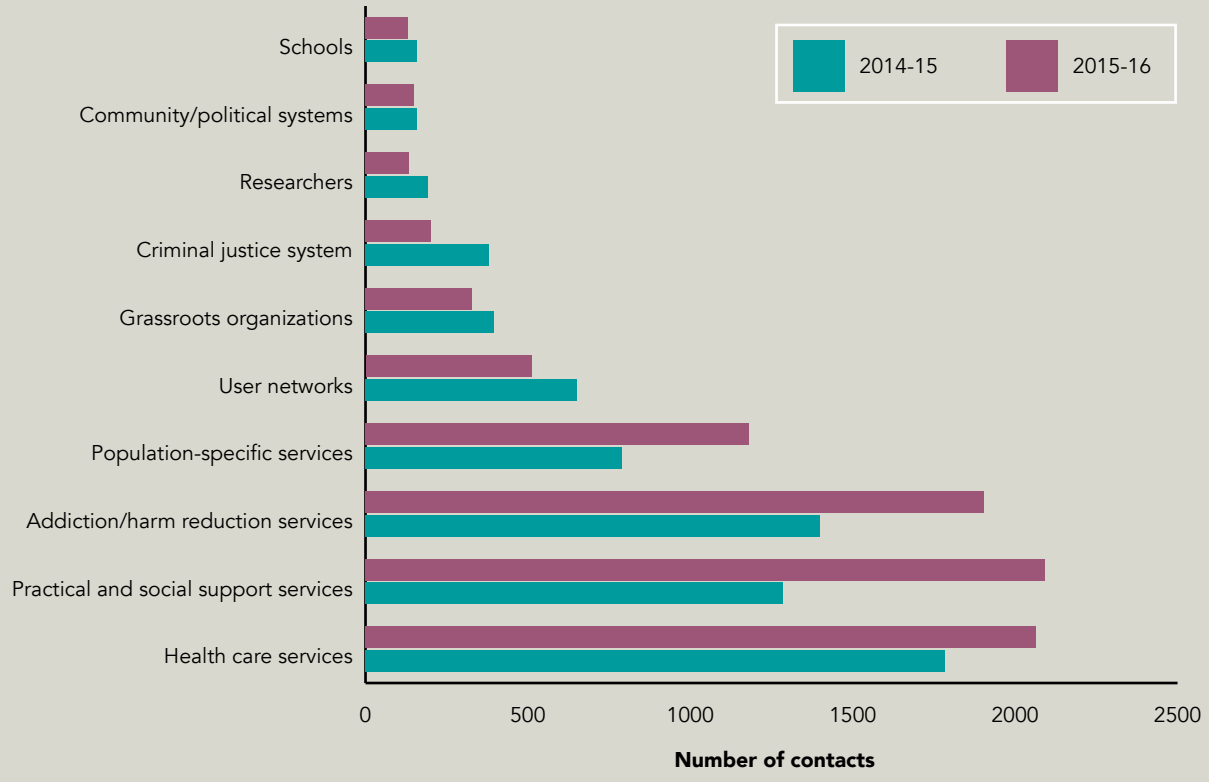
In 2015-16, IDU community development efforts engaged the largest number of participants through education presentations/formal programs, most of which were targeted to health care services, social support services and addiction/harm reduction services.

TABLE 10 Number of IDU community development activities by type and participants 2015 - 16 (OCHART 13.7)*

	Committee/ network/ coalition meetings	Community clean-ups	Community events	Education presentations / formal programs	Research
Number of meetings/ contacts	722	174	257	1,189	84
Number of participants	5,118	341	10,825	11,066	517

*includes ACAP funding

FIGURE 88 IDU community development contacts by agency type 2015-16 (OCHART 13.8)



Hepatitis C teams

Key trends

In 2015-16:

1. Ontario's hepatitis C (HCV) teams served 6,883 clients – up 16% from the previous year and 15% since 2013-14. Of these, 2,319 – or more than 1 in 3 -- were new clients.
2. In 2015-16, the number of clients accessing HCV treatment services (i.e. pre-treatment, treatment, post-treatment services) increased by 39% compared to 2014-15. While there was a slight increase in pre-treatment clients, the number of clients on treatment and in post treatment more than doubled (139% and 148% respectively).
3. HCV testing also increased. The program provided 59% more HCV antibody tests (to determine if someone has come in contact with the hepatitis C virus) and 46% more HCV RNA tests (to detect current HCV infection). Most clients tested (86%) were new; the remainder (14%) were repeat testers.
4. Thanks to shorter treatment regimens (=/-12 weeks instead of up to 48 weeks) clients are getting into treatment sooner (420 clients in 2015-16 compared to 221 in 2013-14) and fewer clients are being lost to follow up.
5. More than twice as many clients (1,210) completed treatment than in 2014-15 (488).

What we have learned from HCV teams, their clients and partners

1. **Outreach is key.** As part of their outreach efforts HCV teams nurture partnerships with other organizations — public health providers, community service organizations, methadone clinics and local pharmacies — to access and engage their priority population. Programs offer HCV testing and treatment at outreach sites. One program reported successful use of a mobile "Outreach Van" and plans to replicate this practice in other areas in the future.
2. **Practical assistance improves engagement in care.** Clients who received assistance with travel (e.g., bus passes or tokens) were more likely to attend appointments consistently. Having food available at appointments also increased attendance. In addition, clients responded well to reminder calls or text messages about upcoming appointments.
3. **Fibroscan clinics improve engagement in care.** Many HCV teams found fibroscan clinics are an effective tool in keeping clients engaged. One program uses a roving fibroscan machine to reach remote communities.
4. **Client evaluations improve services.** HCV teams continue to use comprehensive evaluation tools – including client satisfaction surveys, community partner surveys, and service provider satisfaction surveys -- to improve their services. Some teams also use focus groups, interviews and case reviews to gather evaluative feedback on their services. Client feedback reinforced the importance of providing opportunities to connect with peers. In response, programs continue to invest in peer training and are integrating peer volunteers into program delivery (e.g. offering peer-led support group sessions).

HCV Epi

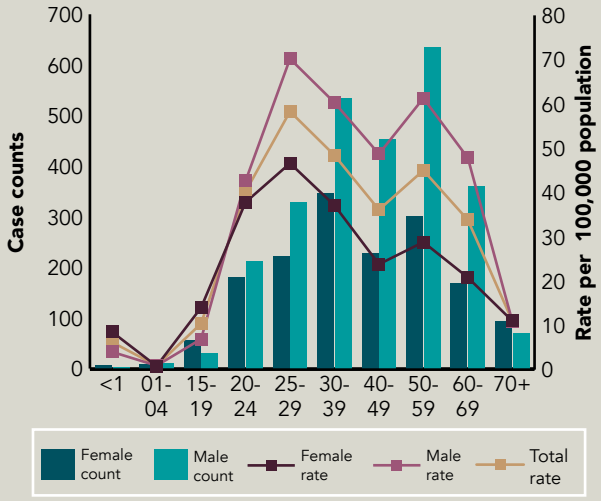
Hepatitis C is the most infectious agent in Ontario. Through the Ontario Ministry of Health integrated Public Health Information System (iPHIS) database, Public Health Ontario extracts annual counts by age group and health region.

In 2015, there were 4,263 reported cases, 28 hospitalizations and 18 deaths. HCV is a blood-borne infection. People who test positive for HCV often report more than one possible risk factor. For example, 3,472 of the 4,263 people diagnosed with HCV in 2015 (81%) reported at least one risk factor:

- 54% (1,875) reported injection drug use
- 519 (15%) reported high risk sexual activity
- 298 (9%) reported having had a blood transfusion (before testing for HCV was available)
- many more reported having had other possible risks, such as being born in a country where HCV is endemic, occupational exposure, other sexual activity and organ transplants.

HCV continues to predominantly affect men. Almost two of every three cases in 2015 (62%) were in males and most men were diagnosed between the ages of 30 and 59.

FIGURE 89 Confirmed case counts and reported rates of hepatitis C by age and gender: Ontario, 2015



4,263	Reported cases of Hep C
28	Hospitalizations
18	Deaths

**Kingston had the highest rate of hospitalizations*

Cases and rates increasing in Southwestern Ontario

In 2015, the number of confirmed cases of hepatitis C reported in Ontario (4,263) remained relatively stable – despite a significant increase in HCV testing.

Rates of HCV (i.e. number of cases per 100,000 population) continue to be high in Northwestern Ontario and Thunder Bay District; however it is very encouraging to note that HCV rates dropped in the Sudbury region. Less encouraging, rates were up in Southwestern Ontario.

FIGURE 90 Reported cases and rates of hepatitis C

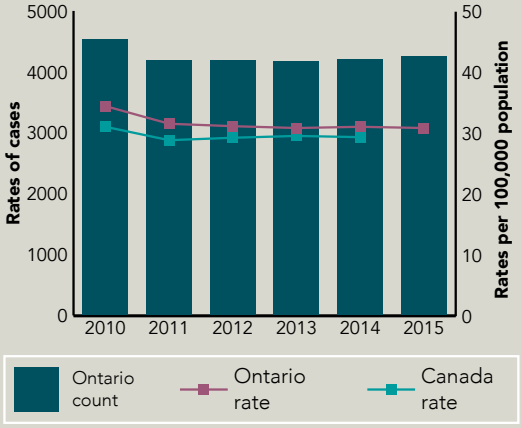
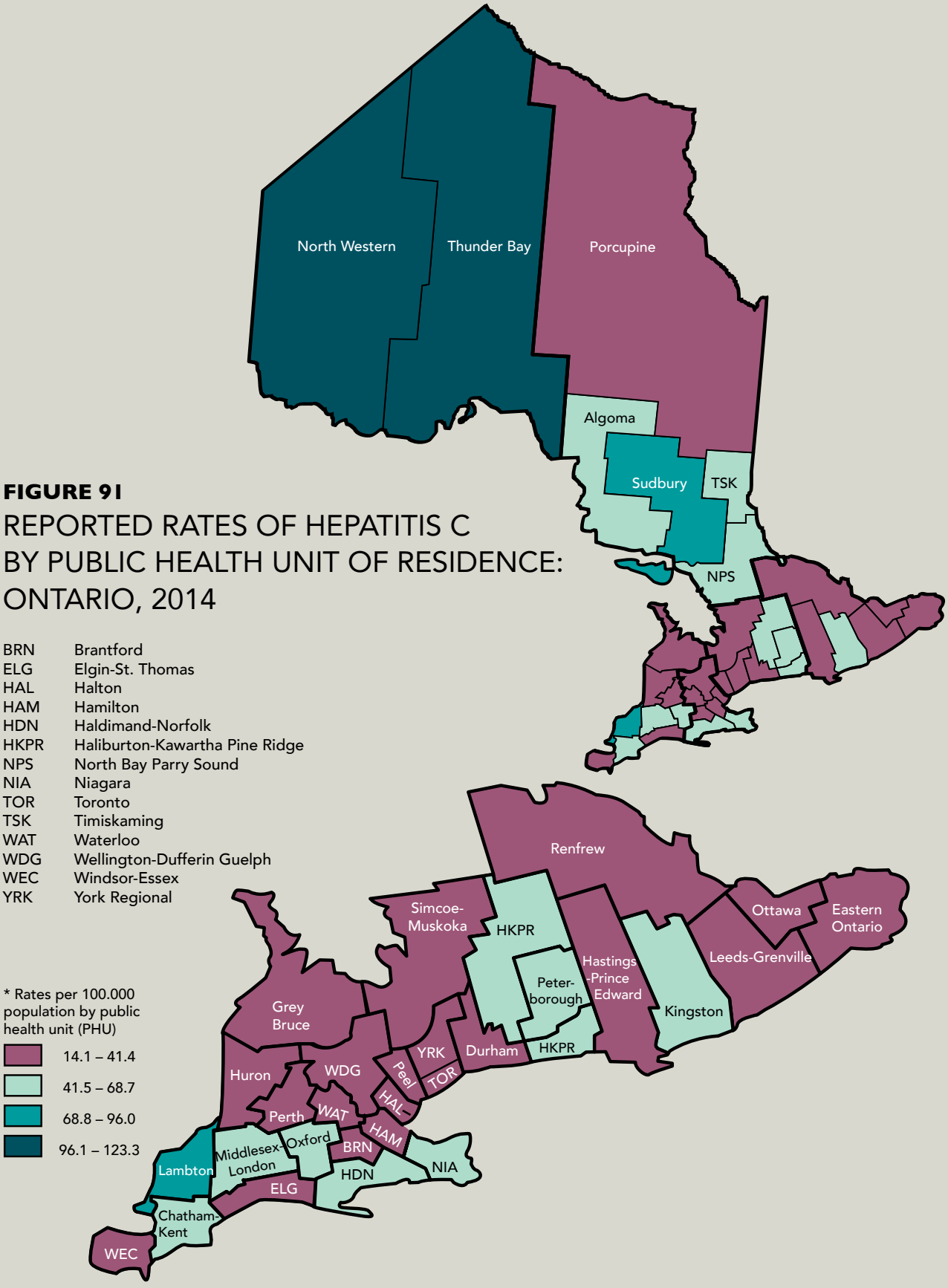


FIGURE 91

REPORTED RATES OF HEPATITIS C BY PUBLIC HEALTH UNIT OF RESIDENCE: ONTARIO, 2014



BRN Brantford
ELG Elgin-St. Thomas
HAL Halton
HAM Hamilton
HDN Haldimand-Norfolk
HKPR Haliburton-Kawartha Pine Ridge
NPS North Bay Parry Sound
NIA Niagara
TOR Toronto
TSK Timiskaming
WAT Waterloo
WDG Wellington-Dufferin Guelph
WEC Windsor-Essex
YRK York Regional

* Rates per 100.000 population by public health unit (PHU)

- 14.1 – 41.4
- 41.5 – 68.7
- 68.8 – 96.0
- 96.1 – 123.3

HCV teams and their services

Who delivers HCV services?

In 2015-16, the Hepatitis C Secretariat funded a total of 84 FTE positions across 16 teams.

HCV teams provide interdisciplinary care. Each team includes: an outreach worker, peers, nurses, a community coordinator and psycho-social support. Teams work corroboratively with treating physicians to provide HCV care and treatment, education, outreach and support services.

In addition, the Secretariat funded:

- a nurse at Lakeridge Health Centre in Oshawa
- a dedicated outreach worker at the Prisoners with AIDS Support Action Network (PASAN) who connects with people involved with the correctional system
- a case coordinator at the Sioux Lookout First Nations Health Authority to coordinate supports to 31 First Nations communities in Northwestern Ontario.

The teams have been reporting their activities through OCHART for three years.

FIGURE 92 Hep C funded positions by role (H2 only) (OCHART 2.3)

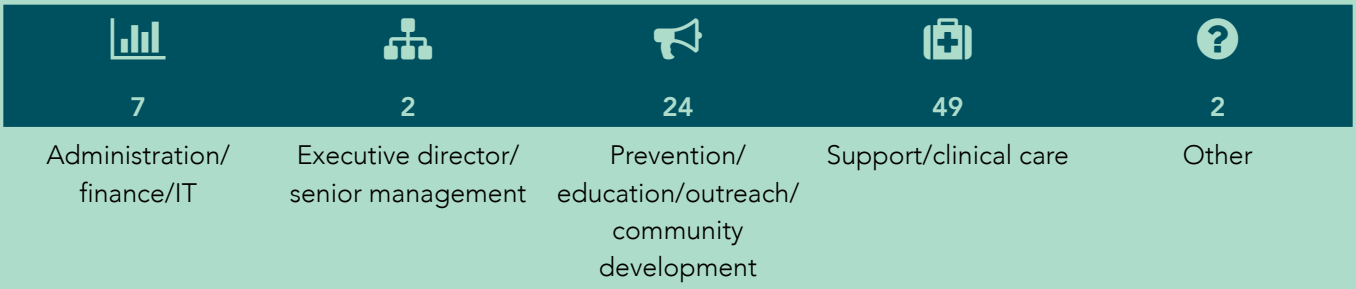
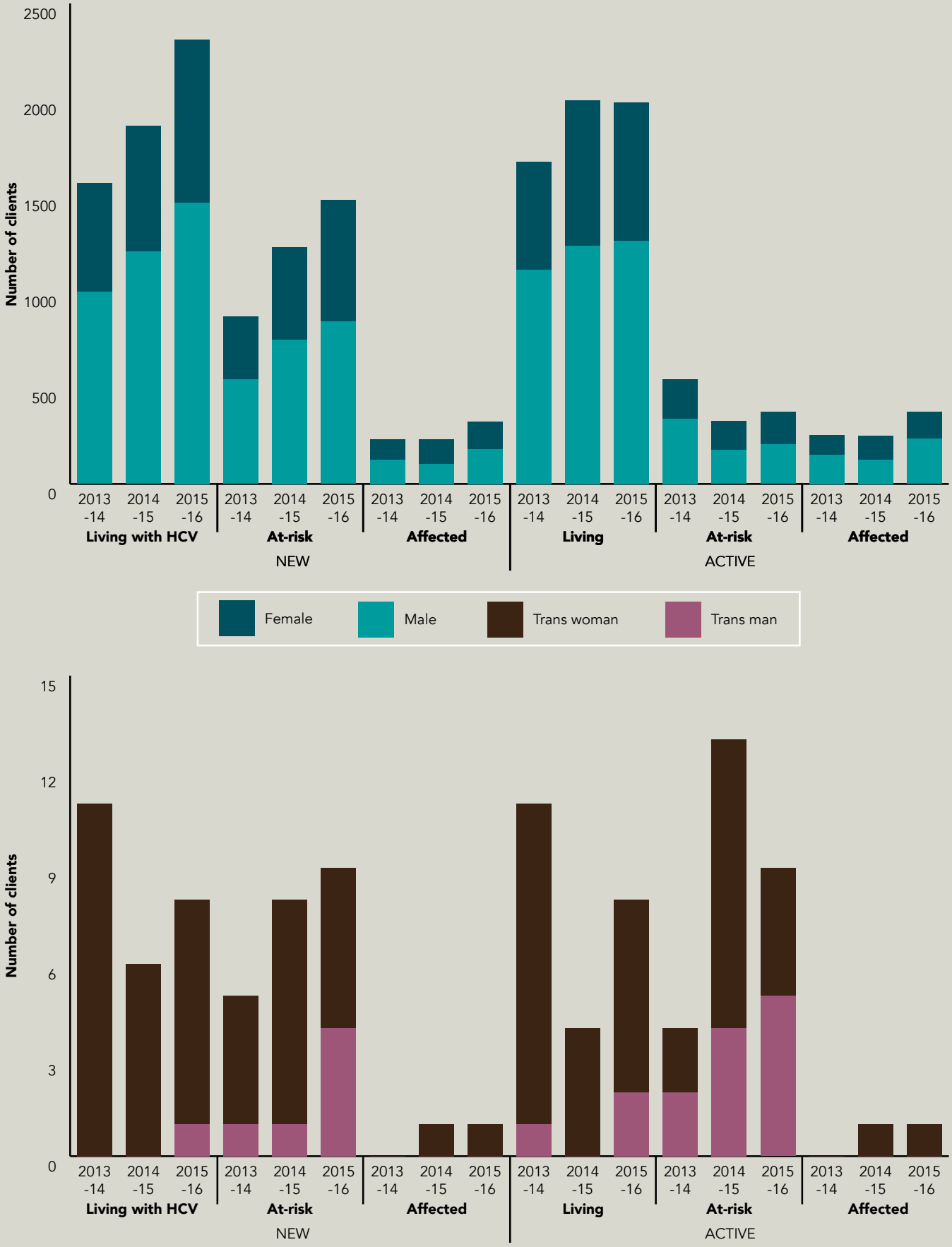


FIGURE 93 Total number of new/active clients served by sex/gender and client type 2013-14 – 2015-16 (OCHART q. 15.1a)



Serving clients across the care continuum

HCV teams and workers provide a mix of prevention, testing, treatment and support services. Clients fall into one of six categories depending on where they are along the prevention, engagement and care continuum.

FIGURE 94 HCV Prevention, Engagement and Care Continuum

At risk	Engaged with HCV care	Pre-treatment	On treatment	Post treatment	Affected
People at risk of acquiring HCV because of injection drug use, who can receieve education and case management services to help reduce their risk.	Clients with HCV who do not yet qualify for drug coverage under current treatment criteria but who can receive clinical and case management services not directly related to HCV treatment.	People who meet or are near meeting treatment criteria but who have not yet started treatment and who will require close monitoring.	People who are on treatment.	People who have completed treatment. complicated treatement.	People who are partners, friends, or family members of people with HCV who receive education and support services.

Note: A person living with HCV can be anywhere on the HCV treatment continuum from engaged with HCV services to post-treatment. Clients are counted as "living with HCV" even when they are not a candidate for treatment (e.g., have end-stage liver disease).

The people we served in 2015-16

In 2015-16, programs served an average of 6,883 unique clients – up 16% from 2014-15:

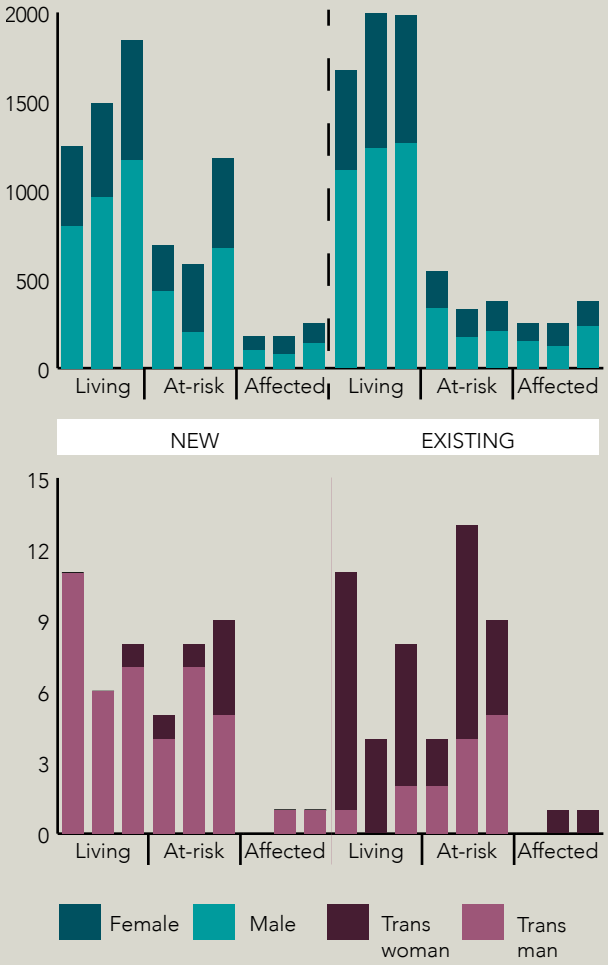
- 1,872 were at-risk clients — up 19%. At risk clients are people involved in activities that put them at risk of HCV infection.
- 4,311 were clients living with HCV – of whom 2,319 were new clients (up 24%) and 1,992 were existing or ongoing clients (down 0.3%). People living with HCV have either tested HCV-antibody positive and require RNA testing to confirm their diagnosis or are RNA positive. Of those:
  - ◊ 1,376 were engaged with HCV teams
  - ◊ 2,935 were receiving treatment services (up from 2,109 (39%) in 2014-15).
- 700 were affected clients – up 45%. Affected clients are the friends, parents, partners or children of people living with HCV who support them through their treatment. People who have been successfully treated for HCV and continue to use the team's services are also considered "affected". This increase is likely attributed to those who have been cured of HCV but continue to engage with the team for ongoing medical monitoring

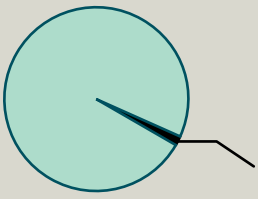
Most existing and new clients were male – although more women accessed services in 2015-16 than in the previous two years.

Trans people made up a small proportion of service users but the absolute number of trans clients increased by 3 compared to 2014-15.

In 2015-16 more trans people were reported to be living with HCV and fewer were reported to be at risk. Most trans clients were trans women although the number of trans men increased in 2015-16 compared to 2014-15.

FIGURE 95 Total number of new clients served by gender and client type 2013-14 – 2015-16 (OCHART q.15.1a)





Total number of clients: 6,883
Total number trans clients: 100

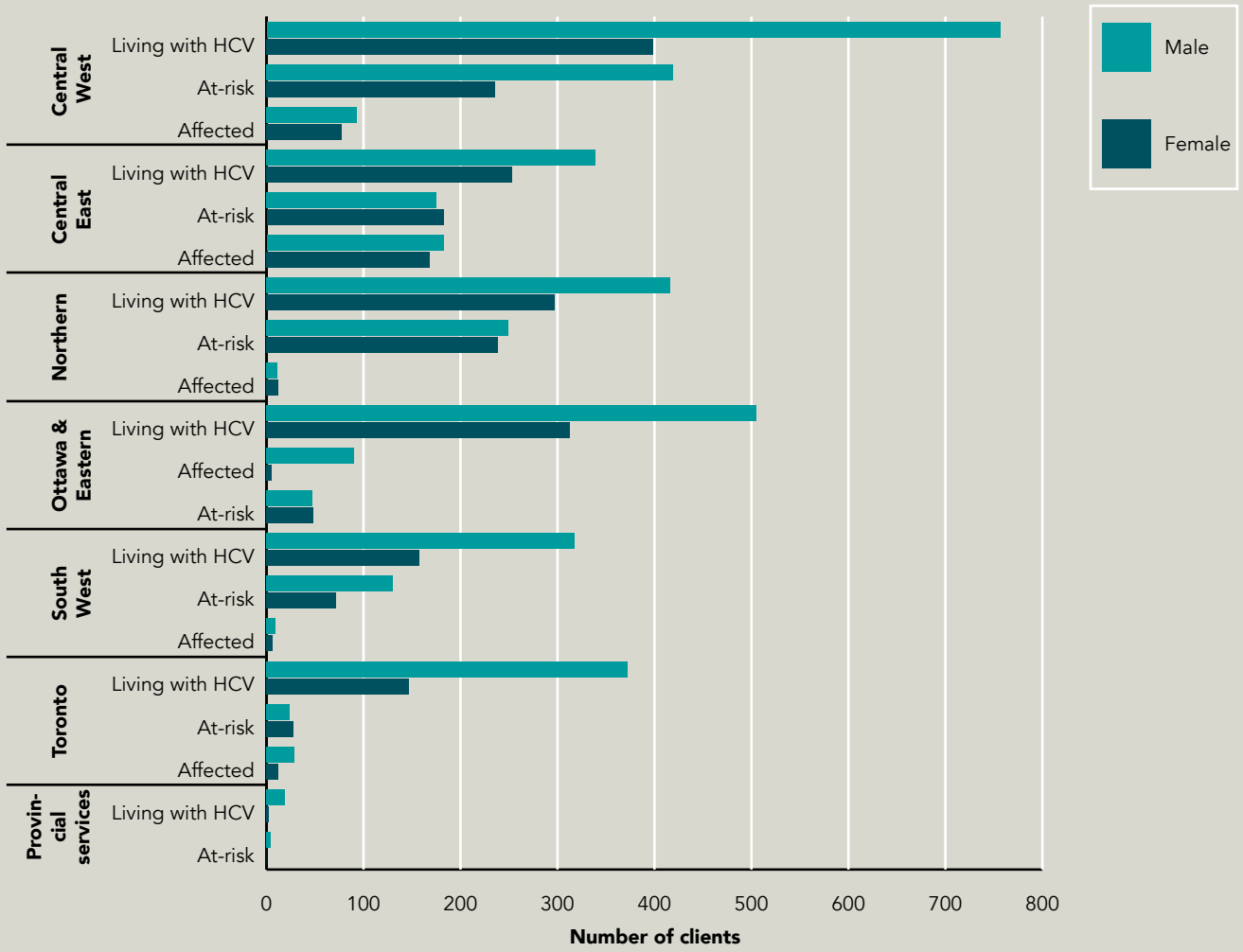
A regional snapshot of HCV services

When we look at service users by region, we see that the Central West, Northern and Central East regions have seen steadily more clients each year for the past two years.

As in past years, about two-thirds of clients in the Ottawa and Eastern and Central West regions were male; in the Central East and Northern regions a larger proportion of clients (45-56%) were female.

When it comes to trans clients, most sought services in Toronto, but all regions served as least one trans woman and Central West, Central East and Ottawa and Eastern reported having clients who were trans men.

FIGURE 96 HCV clients by sex/gender, client type and region (OCHART q. 15.1a)



Prevention Services

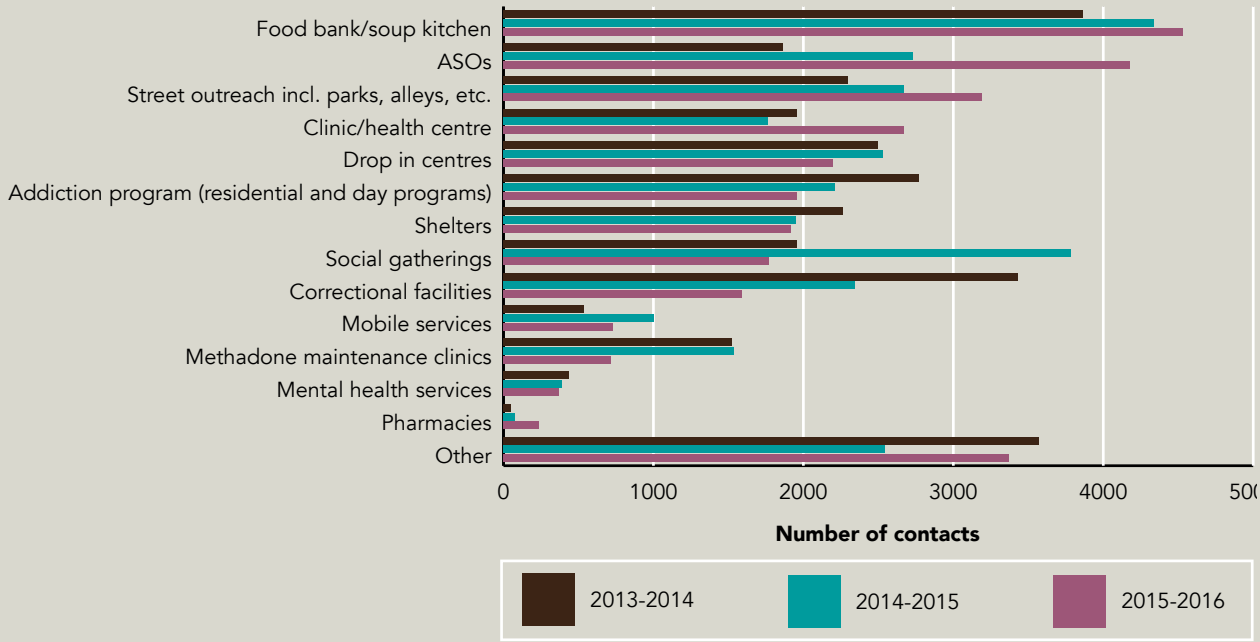
HCV teams undertake a range of activities – including outreach programs, education/presentations and peer programs — designed to help prevent new infections.

OBJECTIVE: To increase knowledge and awareness to prevent the transmission of HCV among priority populations in Ontario.

Outreach

HCV teams do outreach services to reach people at risk of HCV – to provide both prevention/education and testing services. Since 2013-14, HCV teams report making the most contacts through food banks/soup kitchens. Over the past two years, the number of contacts through ASOs has more than doubled while contacts through street outreach increased by 39%. HCV teams also reported more contacts at clinic/health care centres and pharmacies, but fewer through methadone maintenance clinics, correctional facilities and social gatherings. This shift may be due to the fact that pharmacies and health care clinics now dispense methadone and workers continue to face barriers accessing people in correctional facilities.

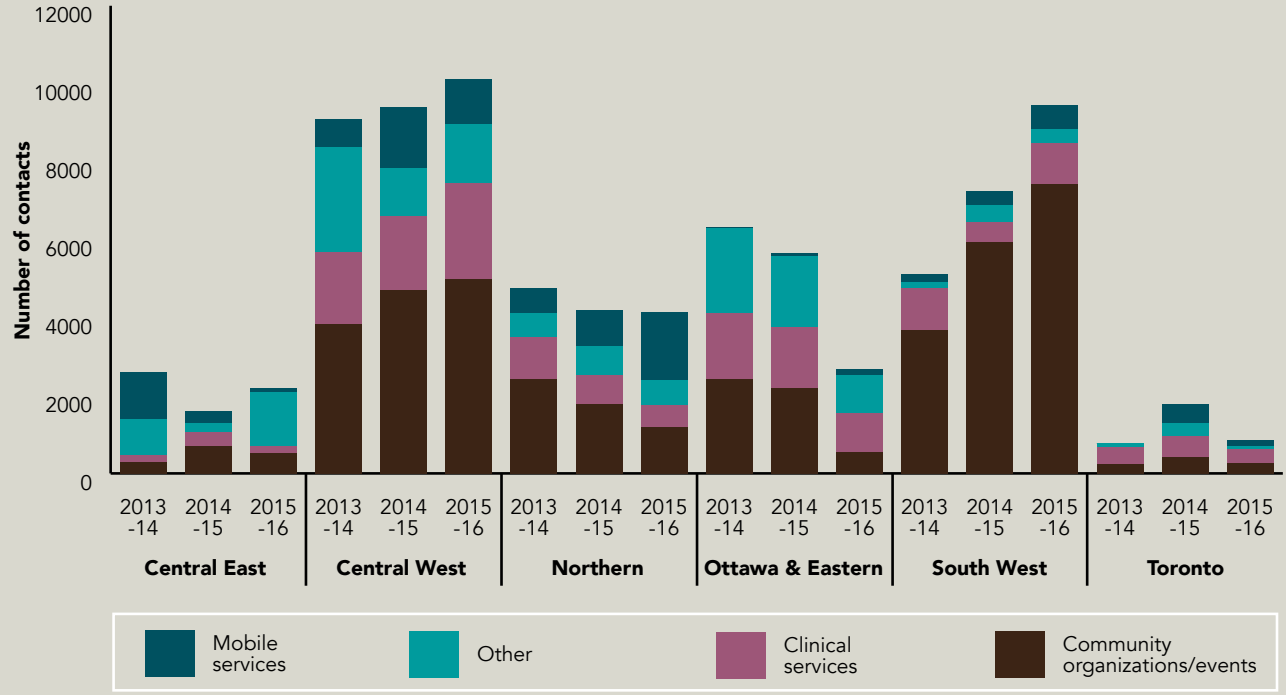
FIGURE 97 Outreach contacts by location (OCHART q. 15.4a)



Regional differences

While the total number of outreach contacts through mobile services decreased overall, it grew in the North. South and Central West reported the largest increase in outreach contacts, most of which were made at community organizations and events. Toronto and Ottawa & Eastern reported fewer outreach contacts.

FIGURE 98 Outreach contacts by region and location (OCHART q.15.4a*)



*Please see Appendix A for category groupings

Education/presentations

One of the most common ways to deliver HCV prevention and education is through presentations – to people who use drugs, service providers/professionals and people living with HCV.

In 2015-16, HCV teams delivered a total of 831 presentations to a total of 13,994 participants. These presentations may include two presentation topics. The most common topics were HCV treatment, testing and harm reduction/safer drug use, and the most common audiences were people who use drugs, service providers/professionals and people living with HCV.

Most presentations to service users are delivered by outreach workers while coordinators give most presentations to health care professionals and to people involved with the corrections system.

Peer involvement

HCV teams actively engage people with lived experience (peers) in delivering education and outreach services. In 2015-16, peers were also more involved in awareness campaigns and in distributing resources.

FIGURE 99 Top 5 education topics (OCHART q. 15.4c)

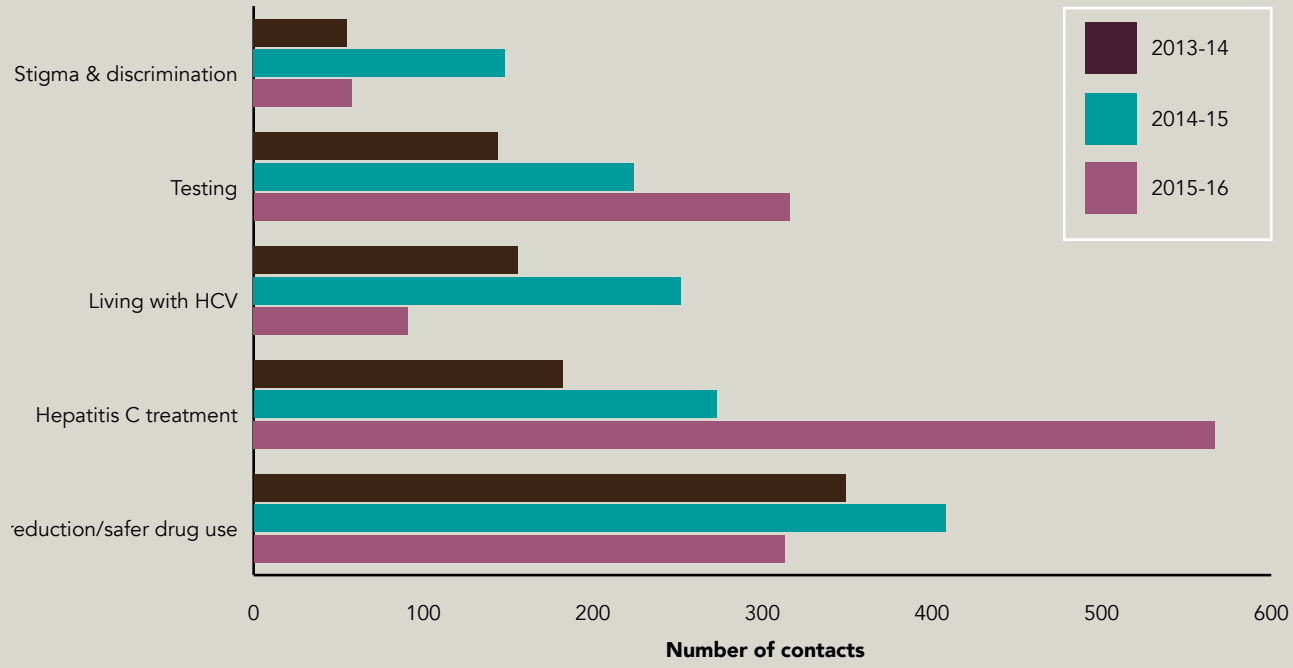


FIGURE 100 Number of peers involved in delivering HCV services (OCHART q. 15.4d)

Engagement and treatment services

Objective: To increase access to hepatitis C care and treatment for priority populations in Ontario

HCV teams provide both case management and clinical services for clients at each stage of the prevention, engagement and care continuum (see TABLE 111 for types of service by treatment stage). FIGURE 101 shows the proportion of clients who received services at each stage of the continuum for each of the past three years.

In 2015-16, teams provided a larger proportion of clinical services to at-risk clients. The increase is partly due to better reporting of services for people at-risk (some teams did not report these data in the past), more outreach testing and the fact that teams now offer Naloxone training, which makes it easier for them to engage more people at-risk and offer them clinical services such as wound care and immunizations.

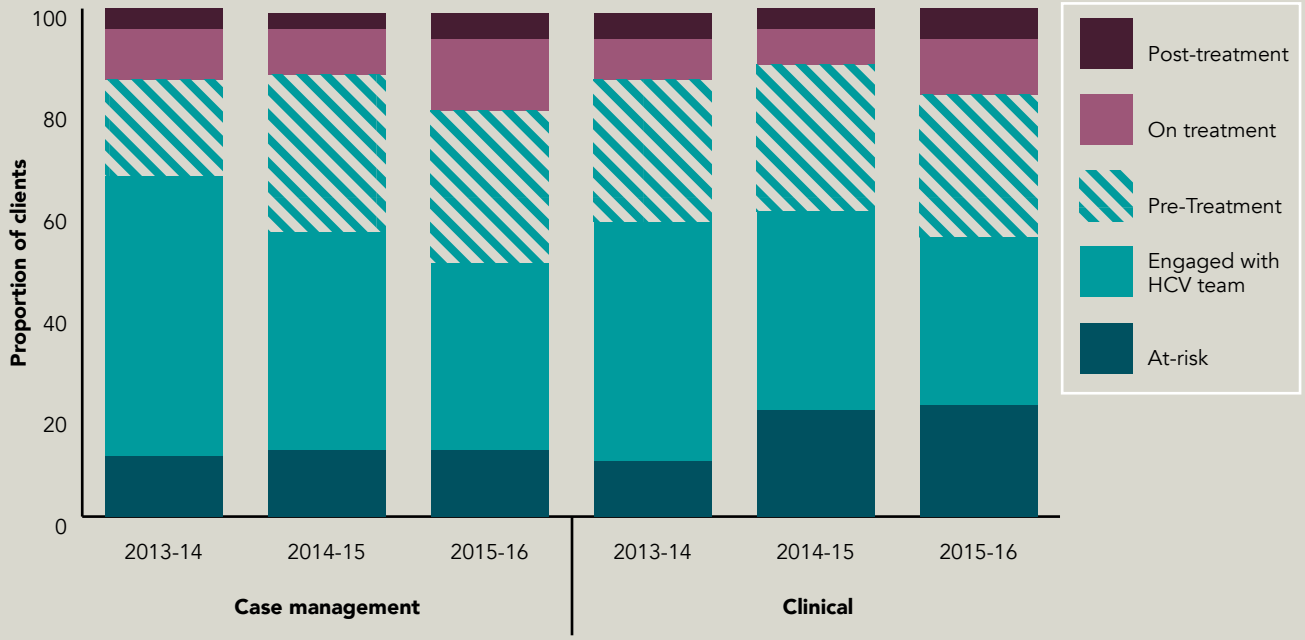
With the increase in the people accessing services [we] reviewed intake procedures and will be making adjustments in an effort to continue to deliver services quickly [with the goal of the intake process taking] no longer than one week from the time of referral [un]till the time that they are accepted into and receiving services. — *Elevate NWO*

Although people engaged with HIV teams and those in the pre-treatment phase still make up more than half of all service users, they are using a smaller proportion of both case management and clinical services. This shift is largely due to the fact that, with new treatments, clients are moving more quickly to the treatment phase and, therefore, do not require case management and clinical services for as long a time. More than twice as many clients were in the treatment and post-treatment stages (up 139% and 148% respectively) in 2015-16 than in 2014-15.

TABLE 11 Types of clinical services delivered by treatment stage

Stage	Services
At-risk	Testing, access to harm reduction materials and naloxone (participating organizations), practical support, prevention/education, vaccinations.
Engaged with team	This could be any service user who has registered with the team and is accessing at least one service pertinent to their service user type, such as: follow up/ongoing testing, practical support, counselling, stabilization of social issues, vaccinations, peer support, ongoing medical monitoring, appointment accompaniment, application completion, support groups, and individual advocacy.
Pre-treatment	Counselling, practical support, application completion (e.g. EAP, Trillium), stabilization of social issues such as addictions and mental health.
On treatment	Testing, medical monitoring (e.g. treatment monitoring), peer support/support group, counselling.
Post-treatment	Testing, medical monitoring (e.g. for SVR at 6 months post treatment and ongoing monitoring for hepatocellular carcinoma), practical support, peer support leader/engagement, counselling.

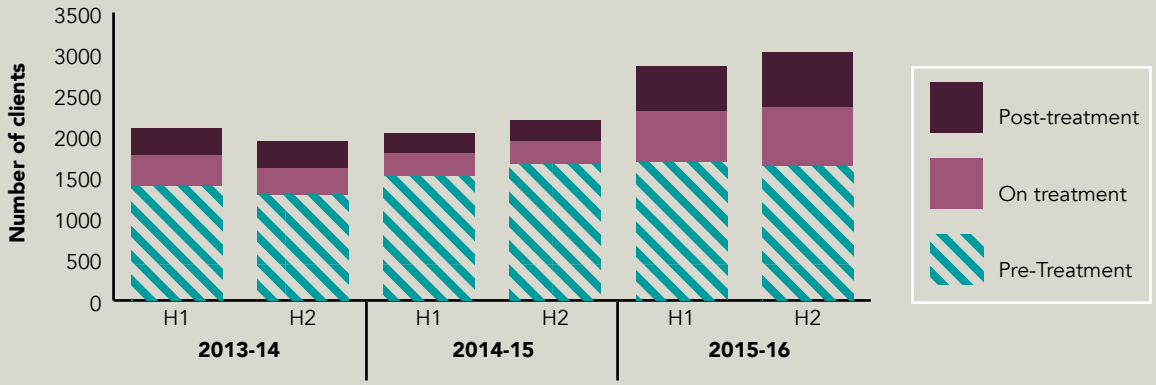
FIGURE 101 Proportion of clients receiving clinical and case management services by treatment stage 2013-14 – 2015-16 (OCHART q. 151f)



Implications for workload

Looking just at clients who were in the pre-treatment, on treatment and post-treatment stages, we see a significant increase in caseload for the HCV teams in 2015-16 – particularly for clients in the treatment and post-treatment stages. Although team members are supporting more clients, they are supporting them for shorter periods of time: with the new HCV drugs, treatment regimens are shorter and side effects are rare. In the past, a client in these stages would require services for up to 48 weeks; today the average is 12 weeks.

FIGURE 102 Total caseload by treatment stage by reporting period 2013-14 – 2015-16 (OCHART q. 15.1f)

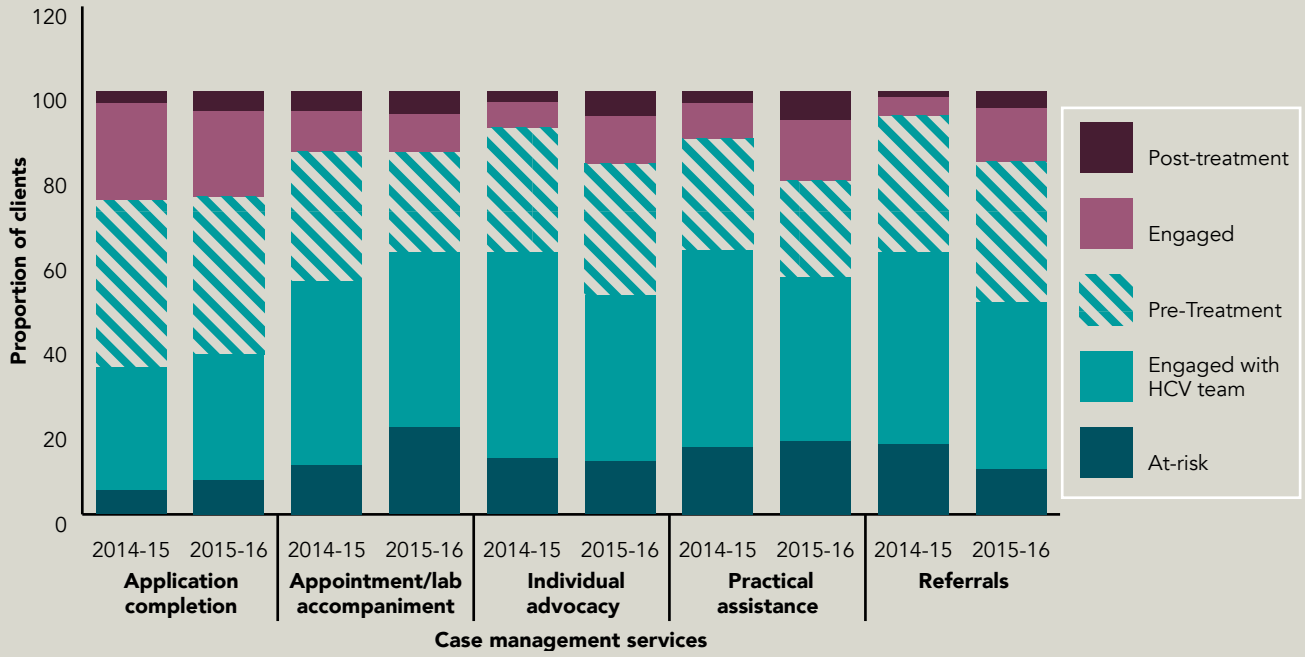


What services do clients use?

Case management services

Clients at all stages of the prevention, engagement and care continuum accessed case management services. Since most clients are either engaged with HCV teams or in the pre-treatment phase, it makes sense that they used a larger proportion of case management services.

FIGURE 103 Case management services accessed by client group 2014-15 – 2016-17 (OCHART q. 151f)

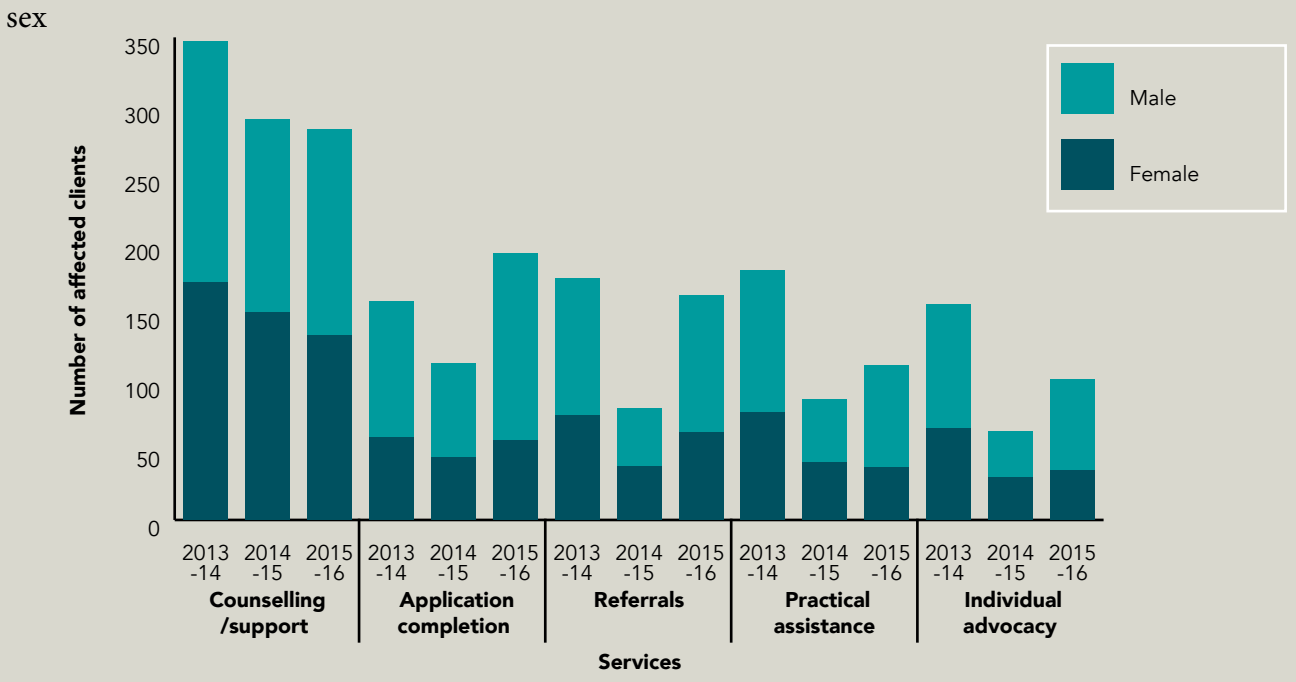


This increased need in client support has resulted in an internal transfer of responsibility, wherein new referrals and intake to the HCV team are followed up by the program coordinator. This has reduced the time frame between referral and first contact with the team.
— Windsor-Essex Community Health Centre

Affected clients use counselling and support services

Although the number of affected clients increased in 2015-16 (back close to 2013-14 levels), they used fewer services than in the past – with the exception of assistance in completing applications. In general, affected clients are more likely to use counselling and support services. Men accounted for 61% of affected clients who used services compared to 51% in 2014-15.

FIGURE 104 Affected client service utilization by sex/gender 2013-14 – 2015-16 (OCHART q. 15.1f)



Shift in service usage by client type

While people engaged with HCV teams continue to represent the largest client group accessing services, they accounted for a smaller proportion of service usage in 2014-15 and 2015-16 (48% in 2013-14, 39% in 2014-15 and 33% in 2015-16). Over the same two-year period, the at-risk and on-treatment client groups used a larger proportion of services than in the past. Despite this shift, the types of services being accessed have remained relatively constant (see FIGURE 105). Health teaching and education still remain the number one services accessed while vaccinations and support groups are the least accessed services.

FIGURE 105 Clinical services accessed by group 2013-14 – 2015-16 (OCHART q. 151f)

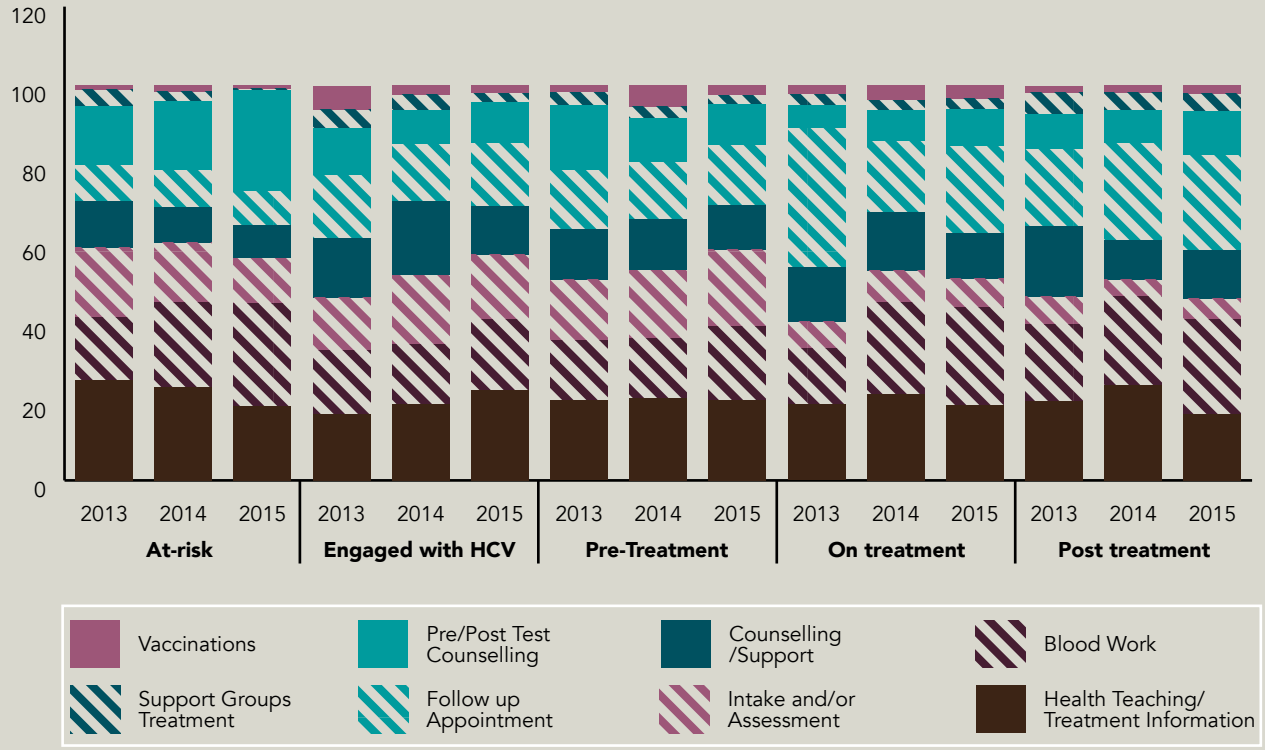
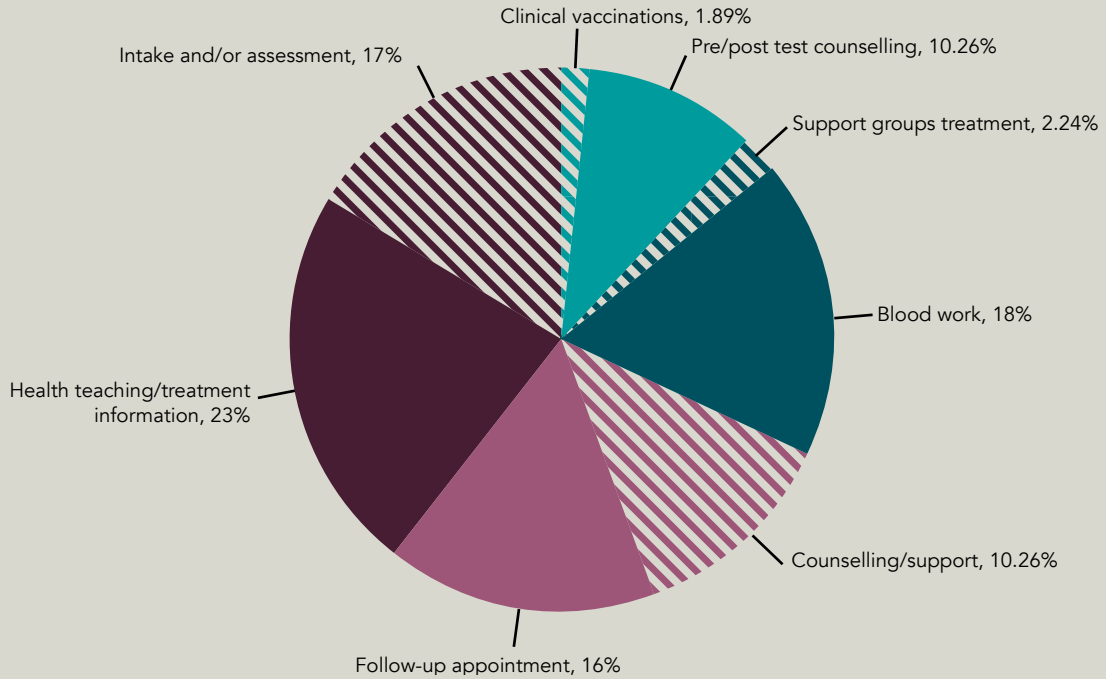


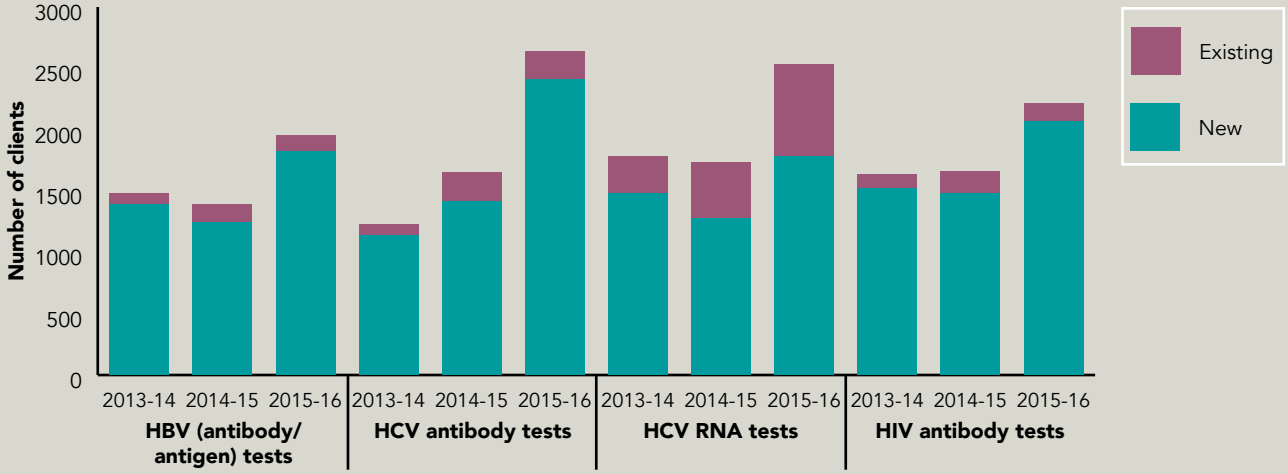
FIGURE 106 Proportion of clinical services accessed 2015-16 (OCHART q. 151f)



HCV testing on the rise

In 2015-16, HCV teams actively promoted testing and provided significantly more tests. Programs tested a total of 2,642 people — 89% of whom were new clients. HCV antibody tests were up 59% and HCV RNA tests were up 46%.

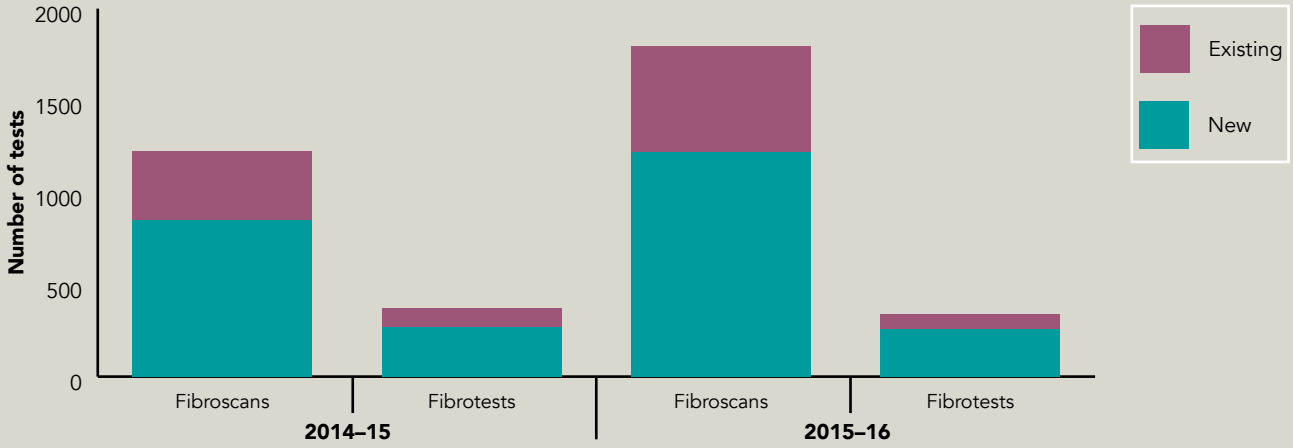
FIGURE 107 Number of clients tested by diagnostic test type (OCHART q. 15.2a)



More fibroscans

To be eligible for publicly funded HCV treatment, clients must have a fibroscan that shows their disease has reached a certain phase. Fibroscan tests are also an effective way to keep clients engaged with the HCV team. Teams reported providing a total of 339 fibroscan tests — up 46% from the previous year.

FIGURE 108 Number of fibroscans and fibrotests provided in 2014-15 (OCHART q.15.2a)



A coordinated plan is being drafted between the partnership sites to ensure that there is adequate resource distribution and testing throughout the City of Toronto [and to] reduce duplication...
— Sherbourne Health Centre

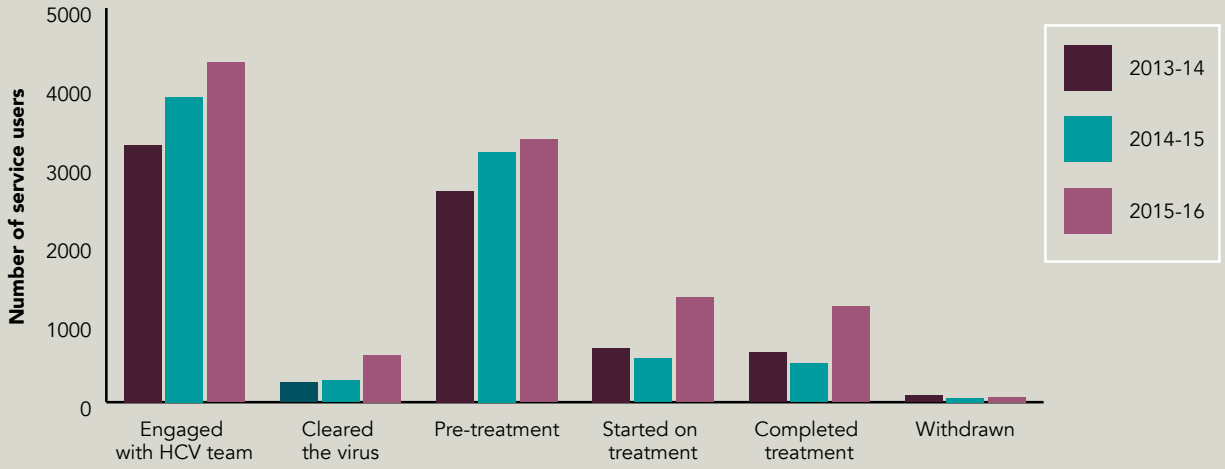
More clients receiving and completing treatment

HCV teams reported large increases in the number of clients who started and completed treatment, and the number who had a sustained virologic response to treatment. Positive treatment outcomes are due to shorter and better tolerated treatment regimens as well as the wrap-around services the teams provide.

In 2015-16:

- 3,328 clients were in the pre-treatment phase – compared to 3,172 in the previous year (5% ↑)
- 309 spontaneously cleared the virus, up from 218 (42% ↑)
- 1,337 were started on treatment, up from 557 (140% ↑)
- 1,210 completed treatment, up from 488 (148% ↑)
- 598 clients had a sustained virologic response
- 77 clients were reported to be co-infected with HIV, up from 55 in 2014/15.
- 66 clients withdrew from treatment (a slight increase over the 54 last year). This number is small given the relative increase in number of clients on treatment.

FIGURE 109 Treatment outcomes 2013-14 – 2015-16 (OCHART 15.3b & 15.3c)



Fewer clients being lost to follow up

The most common reason for clients engaged with teams to not move into treatment is that they do not have private drug coverage and do not qualify for the Exceptional Drug Access program (FIGURE 110). Other reasons included social instability and being lost to follow up. In the past, some clients did not receive treatment because their lives were not stable enough to complete the long and difficult drug treatment. In other cases, the long wait times meant more people were lost to follow-up.

In 2015-16, the number of clients not receiving treatment due to social instability declined for the second consecutive year as did the number of clients lost to follow up. These shifts are due to the shorter treatment cycle (+/-12 weeks), which makes it easier for clients — even those facing challenging stability issues — to stay connected with care. That being said, being lost to follow up and instability continue to account for most treatment interruptions (FIGURE 111).

FIGURE 110 Reasons for clients not receiving treatment 2013-14 – 2015-16 (OCHART q. 15.3c)

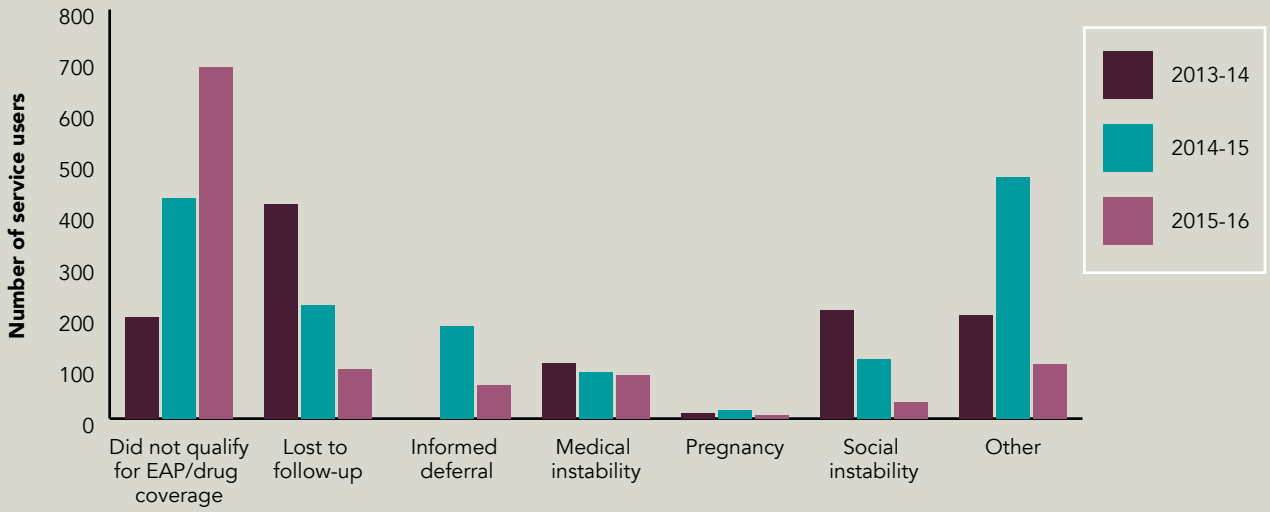
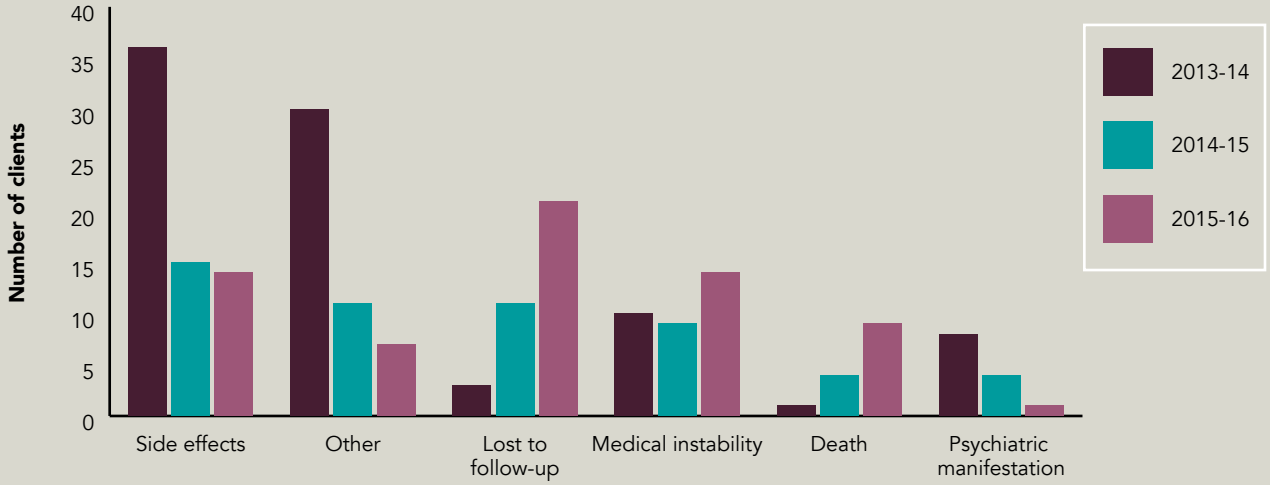


FIGURE 111 Reasons for treatment interruptions 2013-14 – 2015-16 (OCHART 15.3b)



More clients had access to treatment

In 2015-16, Exceptional Access Program (EAP) grew its coverage of drugs including Harvoni, Holkira Pak and Solvadi. As a result, five times as many clients (601 compared to 128 in 2014-15) could access treatment. The total number of clients on treatment increased by 780 — 45% of whom had EAP coverage, compared to 23% last year. The total number of clients who completed treatment also grew by 722. Changes to EAP coverage helped reduce barriers to HCV treatment.

List of figures

Appendices

Appendix A. Programs

Health Region	Organization Name	LHIN
Central East	AIDS Committee of York Region	Central
	AIDS Committee of Durham Region	Central East
	Lakeridge Health Centre	Central East
	Oshawa Community Health Centre	Central East
	Peterborough AIDS Resource Network	Central East
	AIDS Committee of Simcoe County	North Simcoe Muskoka
	Simcoe Muskoka District Health Unit	North Simcoe Muskoka
Central West	Bramalea Community Health Centre	Central West
	Hemophilia Ontario - CWOR	Central West
	Peel HIV/AIDS Network	Central West
	Hamilton AIDS Network	Hamilton Niagara Haldimand Brant
	Hamilton Public Health & Community Services	Hamilton Niagara Haldimand Brant
	Niagara Health System	Hamilton Niagara Haldimand Brant
	Positive Living Niagara	Hamilton Niagara Haldimand Brant
	Wayside House of Hamilton	Hamilton Niagara Haldimand Brant
	AIDS Committee of Cambridge, Kitchener, Waterloo and Area	Waterloo Wellington
	HIV/AIDS Resources & Community Health- Clinic	Waterloo Wellington
	HIV/AIDS Resources & Community Health (ARCH)	Waterloo Wellington
	Sanguen Health Centre	Waterloo Wellington
Northern	AIDS Committee of North Bay and Area	North East
	Algoma Group Health	North East
	Hemophilia Ontario - NEOR	North East
	Ontario Aboriginal HIV/AIDS Strategy - COCHRANE	North East
	Ontario Aboriginal HIV/AIDS Strategy - SUDBURY	North East
	Reseau Access Network	North East
	Sudbury Action Centre For Youth	North East
	Sudbury Health unit	North East
	Union of Ontario Indians	North East
	Elevate NWO	North West
	Nishnawbe Aski Nation	North West

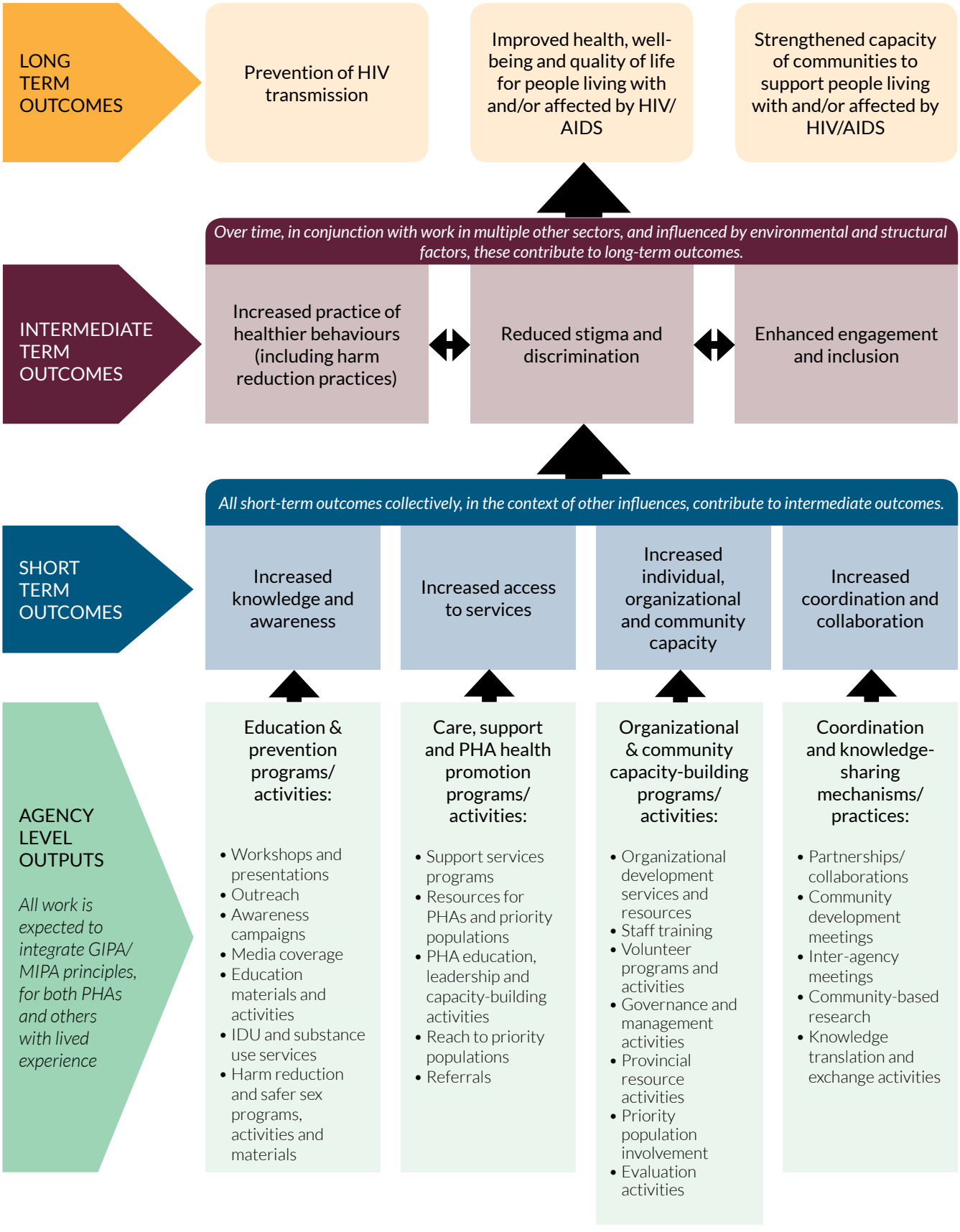
Health Region	Organization Name	LHIN
Northern cont'd	Ontario Aboriginal HIV/AIDS Strategy - THUNDER BAY	North West
	Sioux Lookout First Nations Health Authority	North West
	Thunder Bay District Health Unit	North West
	Waasegiizhig Nanaandawe'iyewigamig	North West
Ottawa & Eastern	AIDS Committee of Ottawa	Champlain
	Bruce House	Champlain
	City of Ottawa Public Health	Champlain
	Hemophilia Ontario - OEOR	Champlain
	Ontario Aboriginal HIV/AIDS Strategy - OTTAWA	Champlain
	The Ottawa Hospital	Champlain
	Somerset West Community Health Centre	Champlain
	Wabano Centre for Aboriginal Health Inc	Champlain
	Youth Services Bureau of Ottawa	Champlain
	HIV/AIDS Regional Services	South East
	Ontario Aboriginal HIV/AIDS Strategy - KINGSTON	South East
	Street Health Centre, Kingston Community Health Centres	South East
South West	AIDS Committee of Windsor	Erie St Clair
	Ontario Aboriginal HIV/AIDS Strategy - WALLACEBURG	Erie St Clair
	Windsor-Essex Community Health Centre	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
	Options Clinic	South West
	Regional HIV/AIDS Connection	South West
	Windsor Regional Hospital	Erie St.Clair
Toronto	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

Health Region	Organization Name	LHIN
Toronto cont'd	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
	Centre for Spanish-speaking Peoples	Toronto Central
	Elizabeth Fry Society of Toronto	Toronto Central
	Ethiopian Association	Toronto Central
	Family Service Toronto	Toronto Central
	Fife House	Toronto Central
	The HIV/AIDS Counselling, Testing and Support Program	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
	Passerelle Integration et Developpement Economiques	Toronto Central
	Planned Parenthood Toronto	Toronto Central
	Reseau des Chercheures (RECAF) Africaines	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 HIV/AIDS Counselling, Testing and Support Program	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

Health Region	Organization Name	LHIN
Provincial	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
Hep C Programs		
Central East	Lakeridge Health Centre	Central East
	Oshawa Community Health Centre	Central East
	Bramalea Community Health Centre	Central West
	Niagara Health System	Hamilton Niagara Haldimand Brant
	Wayside House of Hamilton	Hamilton Niagara Haldimand Brant
	Sanguen Health Centre	Waterloo Wellington
Northern	AIDS Committee of North Bay and Area	North East
	Algoma Group Health	North East
	Reseau Access Network	North East
	AIDS Thunder Bay	North West
	Sioux Lookout First Nations Health Authority	North West
Ottawa & Eastern	The Ottawa Hospital	Champlain
	Street Health Centre, Kingston Community Health Centres	South East
	Canadian AIDS Treatment Information Exchange	Provincial Resource
Provincial Services	PASAN (Prisoners with HIV/AIDS Support Action Network)	Provincial Services

Health Region	Organization Name	LHIN
South West	Windsor-Essex Community Health Centre	Erie St Clair
	London Inter-Community Health Centre	South West
Toronto	Sherbourne Health Centre	Toronto Central
	South Riverdale Community Health Centre	Toronto Central
Anonymous Testing		
South West	Options Clinic	South West
Central East	Simcoe Muskoka District Health Unit	North Simcoe Muskoka
Northern	Thunder Bay District Health Unit	North West
	Sudbury Health unit	North East
South West	Windsor Regional Hospital	Erie St.Clair
Toronto	The HIV/AIDS Counselling, Testing and Support Program	Toronto Central
Ottawa & Eastern	Somerset West Community Health Centre	Champlain
Central West	Hamilton Public Health & Community Services	Hamilton Niagara Haldimand Brant
HIV Clinical Services		
Toronto	St Michael's Hospital	Toronto Central
Central West	Bramalea Community Health Centre	Central West
	HIV/AIDS Resources & Community Health- Clinic	Waterloo Wellington
Northern	Elevate NWO	North West
Central East	Lakeridge Health Centre	Central East

Appendix B. Synthesized Logic Model



Appendix C. 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.

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.

Regional vs provincial data

The *View from the Front Lines* provides data for the province as a whole. It also provides some information by region. Some of the capacity building programs have provincial offices as well as staff or members located in different regions of the province. Their data is handled as follows:

- For Hemophilia Ontario and Oahas, which have regional staff/programs in different locations across the province, the activities of those programs are counted in the regions where they are delivered.
- For each priority population network (PPN) - GMSH, ACCHO, WHAI – the activities of the provincial office are counted under capacity building services but the activities of each network member is counted in his or her region.

Appendix D. 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:

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 AIDS service organizations (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.

Gay Men's Sexual Health Alliance (GMSH) 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).

Appendix E. 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.

Limitations 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.

Note: these calculations will slightly under-count volunteer hours reported in OCHART, as not all OCHART volunteer activity categories are reflected in this table. This table aligns OCHART volunteer categories with volunteer categories used in ACAP reporting in the rest of Canada, to facilitate rolling up Ontario data with data from other regions

OCHART categoreis excluded from this calculation are: Attended Training (does not align with a paid staff activity); Involved in hiring process; Policies and Procedures; and IT support. These are also the categories in OCHART with the lowerst number of hours, so excluding them from the analysis will have a negligible impact on the total $ value estimate

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 proecdures	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**

Data tables

FIGURE 1 HIV programs and Hepatitis C teams span the province

Region and Program	Number
Central East	**8**
Anonymous testing	1
ASO	4
Clinical services	1
HCV team	2
Central West	**13**
Anonymous testing	1
ASO	5
Clinical services	2
Direct services provincial	1
HCV team	4
Northern	**20**
Anonymous testing	2
ASO	3
Clinical services	1
Direct services provincial	4
HCV position	1
HCV team	4
non-AIDS service organization	5
Ottawa & Eastern	**13**
Anonymous testing	1
ASO	3
Direct services provincial	3
HCV team	2
non-AIDS service organization	4

Region and Program	Number
Provincial Resource	**12**
Capacity-building program	11
HCV position	1
Provincial Services	3
Direct services provincial	2
non-AIDS service organization	1
South West	**10**
Anonymous testing	2
ASO	2
Direct services provincial	3
HCV team	2
non-AIDS service organization	1
Toronto	**38**
Anonymous testing	1
ASO	11
HCV position	1
HCV team	2
non-AIDS service organization	23

FIGURE 2 Number of new HIV diagnoses in Ontario, 2006-2015

Year	Number of diagnosis
2006	1,104
2007	1,013
2008	1,080
2009	969
2010	994
2011	986
2012	861
2013	798
2014	828
2015	842

FIGURE 3 Number of new HIV diagnoses in Ontario by sex/gender, 2006-2015

Year	Male diagnosis	Female diagnosis
2006	779	318
2007	781	226
2008	811	263
2009	747	214
2010	796	183
2011	768	203
2012	670	186
2013	659	133
2014	655	167
2015	676	162

FIGURE 4 Percent of HIV diagnoses by priority population (where known), male and female, Ontario, 2010-2015

Priority Population	2010-11	2012-13	2014-15
Men who have sex with men	59	63	63
African, Caribbean and Black people	26	25	24
People who use injection drugs	10	9	13
Indigenous people	3	3	2
At-risk women	20	19	18

FIGURE 5 Percent of female HIV diagnoses by priority population (where known), Ontario, 2010-2015

Priority population	2010-11	2012-13	2014-15
African, Caribbean and Black people	57	66	54
People who use injection drugs	12	11	20
Indigenous people	9	2	5

FIGURE 6 Percent of total HIV diagnoses by ethnicity (where known), Ontario, 2010-2015

Ethnicity	2010-11	2012-13	2014-15
White	55	51	51
Black	25	25	23
Indigenous	3	3	2
Southeast Asian	5	6	7
South Asian	3	5	4
Arab/West Asian	1	1	3
Latin American	7	7	7
Other	2	2	3

FIGURE 7 Percent of male HIV diagnoses by ethnicity (where known), Ontario, 2010-2015

Ethnicity	2010-12	2012-13	2014-15
White	61	57	55
Black	17	16	17
Indigenous	2	3	1
Southeast Asian	5	7	8
South Asian	1	4	3
Arab/West Asian	0	0	2
Latin American	3	2	4
Other	2	1	1

FIGURE 8 Percent of female HIV diagnoses by ethnicity (where known), Ontario, 2010-2015

Ethnicity	2010-12	2012-13	2014-15
White	28	24	32
Black	56	66	51
Indigenous	7	2	5
Southeast Asian	2	1	2
South Asian	1	4	3
Arab/West Asian	0	0	2
Latin American	3	2	4
Other	2	1	1

FIGURE 9 Number of new HIV diagnoses by sex/gender and age, Ontario 2013-2015

Age	Male diagnosis	Female diagnosis
<15	5	8
15-19	29	14
20-24	211	34
25-29	322	57
30-34	345	87
35-39	253	80
40-44	208	54
45-49	245	36
50-54	170	37
55-59	94	25
60-64	69	17
65-69	24	7
70+	13	6

FIGURE 10 Number of new HIV diagnoses by LHIN, Ontario 2013-2015

LHIN	Number of new HIV diagnosis
Toronto Central	27.1
Champlain	6.1
Central West	5.7
South West	5.3
Central	4
Central East	3.6
North East	3.4
North West	3.4
Erie St. Clair	3.3
Hamilton Niagara	3.3
Mississauga Halton	3.1
Waterloo Wellington	2.5
South East	2.1
North Simcoe	2

FIGURE 11 All sources of community-based AIDS organisations funding 2012-13 to 2015-16 (OCHART q. 5.1, 5.2, 5.3)

		2012-13	2013-14	2014-15	2015-16
Government of Ontario	AIDS Bureau	$34,387,984.00	$37,000,000.00	$37,000,000.00	$37,700,000.00
	Other Ministry of Health & Long-Term Care	$4,237,608.00	$4,258,142.00	$4,117,141.00	$4,552,044.00
	Other provincial ministries	$1,073,804.00	$1,253,361.00	$1,442,933.00	$1,423,908.00
Federal Government	ACAP	$3,436,180.45	$4,200,000.00	$4,200,000.00	$4,200,000.00
	Other federal government	$3,997,281.00	$4,312,151.00	$4,137,442.92	$4,160,439.00
Local	Municipal / regional health authority	$3,555,399.03	$3,702,316.00	$3,691,506.81	$4,244,010.92
Private Sector	Other charitable foundations, private sector	$2,264,300.06	$2,026,199.25	$2,330,015.18	$1,968,979.91
	Fundraising	$5,390,831.37	$4,722,147.59	$3,998,471.91	$4,085,264.05
Non-Governmental Funding	Trillium	$532,413.00	$470,781.02	$301,032.20	$194,368.00
	United Way	$213,582.79	$173,197.96	$186,751.91	$203,315.00
Other	Other	$1,601,824.15	$1,024,761.53	$2,046,846.83	$1,214,307.52
	Grand Total	$48,491,207.85	$49,305,406.35	$63,452,141.76	$63,946,636.40

FIGURE 12 Who makes programs work? (OCHART q. 2.2, 9.13a, 12.1, 12.3, 13.5a)

People	Note
501 Paid staff	361 AIDS Bureau, 57 ACAP, 83 HCV Funding
6,191 Volunteers	208,842 hours
186 Students	56,860 hours
1,668 Peers	Engaged in education and community development activities
1,089 Peers	Engaged in IDU outreach

FIGURE 13 Trends in top 8 volunteer activities 2013-14 to 2015-16 (OCHART q. 12.2)

	Year	AIDS Bureau	ACAP	Total
Edu./ Comm. dev.	2013-14	7,101	8,097	15,198
	2014-15	6,728	5,086	11,813
	2015-16	7,823	2,803	10,626
Outreach activities	2013-14	13,056	8,053	21,109
	2014-15	13,992	1,707	15,699
	2015-16	13,058	2,630	15,688
Board/ Adv. comm.	2013-14	17,120	5,670	22,790
	2014-15	14,175	3,629	17,804
	2015-16	11,522	3,752	15,274
Attend training	2013-14	17,070	6,342	23,412
	2014-15	15,660	6,472	22,132
	2015-16	13,308	3,641	16,949
Fundraising	2013-14	15,787	13,010	28,797
	2014-15	14,782	4,622	19,404
	2015-16	9,983	4,404	14,387
Special events	2013-14	5,605	5,644	11,249
	2014-15	25,393	3,111	28,504
	2015/16	5,865	2,133	7,998
Administration	2013-14	48,873	8,259	57,132
	2014-15	28,703	10,487	39,190
	2015-16	36,573	10,966	47,539
Practical support	2013-14	37,957	13,816	51,773
	2014-15	36,440	8,225	44,665
	2015-16	34,097	16,836	50,933

FIGURE 14 Volunteers giving more IT support 2013-14 – 2015-16

Year	AIDS Bureau	ACAP
2013	380	228
2014	852	139
2015	1394	138

FIGURE 15 Total IDU peers by sex/gender (OCHART q. 13.5)

	Male	Female	Grand Total
Existing peers			
2011-12	207	123	330
2012-13	202	170	372
2013-14	214.5	187.5	402
2014-15	306	332	638
2015-16	394	389	783
New peers			
2011-12	175	94	269
2012-13	192	103	295
2013-14	118	98	216
2014-15	226	162	388
2015-16	148	147	295

FIGURE 16 IDU peer activities 2014-15 – 2015-16 (OCHART 13.63)

Peer activity	2014-15	2015-16	
Practical support	82	78	26881
Education	140	149	14600
Counselling	496	387	12,281
Referrals	1,856	4,478	6,334
Other	1,387	3,294	4,681
Indigenous traditional services	32	390	422

FIGURE 17 Number of education presentations and participants (OCHART q. 9.1.a)

	Presentations	Participants
2012-13	4,468	98,633
2013-14	4,262	92,236
2014-15	3,777	73,321
2015-16	3,122	72,793

FIGURE 18 Number of presentations by worker type 2012-13 – 2015-16 (OCHART q. 13.7 and 9.1.a)

	Other prevention worker	Indigenous focused worker	ACCHO PPN member	WHAI PPN member	GMSH PPN member	IDU prevention worker
2012-13	3,090	675	237	281	185	422
2013-14	2,537	711	485	262	267	494
2014-15	2375	740	196	244	222	1094
2015-16	1856	582	218	244	222	1189

FIGURE 19 Top 6 intended audiences for education presentations by general prevention education staff 2013-14 – 2015-16 (OCHART q. 9.1.a)

	Other funding	ACAP	Grand Total
Practitioners, professionals or service providers	**2,622**	**790**	**3,412**
2013-14	867	259	1,126
2014-15	1,000	380	1,380
2015-16	755	151	906
Youth at-risk	**1,374**	**963**	**2,337**
2013-14	498	455	953
2014-15	507	333	840
2015-16	369	175	544
Students	**1,638**	**531**	**2,169**
2013-14	762	152	914
2014-15	485	218	703
2015-16	391	161	552
Indigenous peoples	**1,344**	**436**	**1,780**
2013-14	416	173	589
2014-15	482	258	740
2015-16	446	5	451
Women at-risk	**1,016**	**282**	**1,298**
2013-14	297	112	409
2014-15	355	145	500
2015-16	364	25	389
Gay/bisexual/MSM	**1,094**	**198**	**1,292**
2013-14	332	67	399
2014-15	445	89	534
2015-16	317	42	359
Grand Total	9,088	3,200	12,288

FIGURE 20 Top 3 audiences reached by population-specific workers 2014-15 – 2015-16 (OCHART q. 13.7 and 9.1.a)

		Practitioners, professionals or service providers	African, Caribbean or Black people	Indigenous peoples	Gay/bisexual/MSM	Women at-risk	Youth at-risk	People living with HIV	General public	Students
Indigenous focused worker	2014-15			46%			14%			
	2015-16	10%		43%			15%			
ACCHO PPN member	2014-15	14%	47%					16%		
	2015-16	13%	45%					10%		
WHAI PPN member	2014-15	49%				17%			13%	
	2015-16	51%				20%				8%
GMSH PPN member	2014-15	16%			52%				8%	
	2015-16	13%	12%		46%					

FIGURE 21 One-on-one in-service education requests by worker type 2014-15 – 2015-16 (OCHART q. 9.10.2)

	2014-15	2015-16	Grand Total
WHAI PPN member	223	267	490
ACB PPN member	265	524	789
Indigenous focus	1,205	95	1,300
GMSH PPN member	937	1,091	2,028
Other prevention education worker	6,673	5,570	12,243

FIGURE 22 Top 3 one-on-one education requests by worker type (OCHART q.9.2)

Worker type	Topics
Other prevention education, support, outreach worker	Population specific issues STIs/safer sex HIV/AIDS 101
GMSH PPN member	STIs/safer sex HIV testing Population specific issues
ACB PPN member	Population specific issues Living with HIV HIV/AIDS 101
Indigenous-focused worker	Population specific issues HIV/AIDS 101 STIs/safer sex
WHAI PPN member	Population specific issues Addressing Violence Diversity/anti-oppression/ cultural competence

FIGURE 23 Number of brief outreach contacts by population reached and funder 2015-15 — 2015-16 (OCHART q 9.10b)

	Other funding	ACAP
Gay/bisexual/MSM	55,370	4,534
2014-15	28,465	1,965
2015-16	26,905	2,569
African, Caribbean or Black people	**50,959**	**4,260**
2014-15	12,149	4,086
2015-16	38,810	174
General public	**41,250**	**6,070**
2014-15	19,533	4,763
2015-16	21,717	1,307
People who use drugs	**19,939**	**440**
2014-15	11,834	378
2015-16	8,105	62
Indigenous people	**11,350**	**13,980**
2014-15	4,628	13,741
2015-16	6,722	239
Other	**8,975**	**1,334**
2014-15	7,182	843
2015-16	1,793	491
Youth at-risk	**3,258**	**4,074**
2014-15	970	2,441
2015-16	2,288	1,633
Incarcerated people	**2,938**	**202**
2014-15	2,295	181
2015-16	643	21
Women at-risk	**2,641**	**1,886**
2014-15	871	1,640
2015-16	1,770	246
People living with HIV	**1,961**	**187**
2014-15	1,265	109
2015-16	696	78

FIGURE 24 Number of significant outreach contacts by population 2013-14 – 2015-16 (OCHART q. 10a)

	2013-14	2014-15	2015-16
Gay/bisexual/MSM	32,503	25,005	20,277
General public	12,890	8,250	9,022
Other	1,993	8,124	5,523
People who use drugs	2,353	5,859	7,354
Indigenous peoples	2,937	3,726	6,454
African, Caribbean or Black people	8,351	3,642	5,869
Youth at-risk	6,699	3,143	2,335
People living with HIV	1,670	2,220	2,197
Women at-risk	6,116	1,963	2,186
Incarcerated people	1,046	1,122	704
Grant Total	**76,558**	**63,054**	**61,921**

FIGURE 25 Total number of IDU in-service interactions by funded IDU outreach programs and other programs 2011-12 – 2015-16 (OCHART q. 13.2.1)

	Total number of in-service interactions
2011-12	107,767
Funded	90,455
Other	17,312
2012-13	94,738
Funded	77,006
Other	17,732
2013-14	116,869
Funded	98,397
Other	18,472
2014-15	101,976
Funded	82,562
Other	19,414
2015-16	136,821
Funded	127,267
Other	9,554

FIGURE 26 Total number of IDU outreach interactions by funded IDU outreach programs and other programs 2011-12 – 2015-16 (OCHART q. 13.1.1)

	Total number IDU Outreach interactions
2011-12	83,133
Funded	62,001
Other	21,132
2012-13	76,881
Funded	65,978
Other	10,903
2013-14	67,538
Funded	55,275
Other	12,263
2014-15	68,647
Funded	48,627
Other	20,020
2015-16	73,811
Funded	62,672
Other	11,139

FIGURE 27 Total number of outreach interactions in the top 6 outreach locations for funded IDU outreach programs 2014-15 – 2015-16 (OCHART q. 13.4)

Location and Year	Number of interactions
Community agencies/ services	**49,723**
2014-15	23,442
2015-16	26,281
Other	**22,025**
2014-15	7,033
2015-16	14,992
Mobile	**17,854**
2014-15	9,227
2015-16	8,627
A residence	**15,889**
2014-15	6,822
2015-16	9,067
Streets/parks	**10,252**
2014-15	1,569
2015-16	8,683
Pharmacies	**6,881**
2014-15	3,317
2015-16	3,564

FIGURE 28 Total number of outreach interactions in the top 6 outreach locations for other IDU outreach programs 2014-15 – 2015-16 (OCHART q. 13.4)

Location and Year	Number of interactions
Community agencies/ services	**16,481**
2014-15	11,680
2015-16	4,801
Streets/parks	**7,112**
2014-15	2,401
2015-16	4,711
Other	**4,017**
2014-15	3,158
2015-16	859
Bars/night clubs	3,106
2014-15	2,314
2015-16	792
A residence	1,786
2014-15	1,157
2015-16	629
Addiction programs	1,067
2014-15	194
2015-16	873

FIGURE 29 Total number of unique outreach clients reported by funded IDU outreach programs and other programs 2011-12—2015-16 (OCHART q. 13.1.2)

	Repeat Clients	New Clients	Grand Total
2011-12	**15,048**	**9,151**	**24,199**
Funded	8,424	6,736	15,160
Other	6,625	2,415	9,040
2012-13	**11,579**	**10,283**	**21,862**
Funded	10,162	8,499	18,661
Other	1,417	1,784	3,201
2013-14	**10,749**	**9,526**	**20,275**
Funded	9,779	4,753	14,532
Other	970	4,773	5,743

	Repeat Clients	New Clients	Grand Total
2014-15	**12,260**	**8,438**	**20,698**
Funded	8,787	4,352	13,139
Other	3,474	4,086	7,560
2015-16	**10,760**	**6,454**	**17,214**
Funded	7,735	4,555	12,290
Other	3,025	1,899	4,924

FIGURE 30 Total number of unique in-service clients reported by funded IDU outreach programs and other programs 2011-12 to 2015-16 (OCHART q. 13.2.2)

	Repeat Clients	New Clients	Grand Total
2011-12	**12,260**	**5,142**	**17,402**
Funded	8,399	4,070	12,469
Other	3,861	1,072	4,933
2012-13	**15,056**	**5,145**	**20,201**
Funded	11,388	4,015	15,403
Other	3,669	1,130	4,799
2013-14	**14,021**	**5,530**	**19,551**
Funded	11,757	3,686	15,443
Other	2,264	1,844	4,108
2014-15	**13,606**	**4,629**	**18,235**
Funded	10,537	3,525	14,062
Other	3,069	1,104	4,173
2015-16	**11,709**	**5,668**	**17,377**
Funded	9,348	4,515	13,863
Other	2,362	1,153	3,515

FIGURE 31 Top 4 IDU services provided over 3 years by type of program (OCHART q. 13.3a)

	Unique clients/interactions		
	Funded	Other	Grand total
Practical support	**86,042**	**10,912**	**96,954**
2013-14	12,801	2,770	15,571
2014-15	21,708	3,704	25,412
2015-16	51,533	4,438	55,971
Education	**56,375**	**10,538**	**66,913**
2013-14	9,227	2,812	12,039
2014-15	16,562	3,805	20,367
2015-16	30,586	3,921	34,507
Counselling	**46,019**	**7,160**	**53,179**
2013-14	8,768	2,657	11,425
2014-15	15,519	3,244	18,763
2015-16	21,732	1,259	22,991
Referrals to medical services	**31,380**	**2,592**	**33,972**
2013-14	6,613	457	7,070
2014-15	5,335	1,437	6,772
2015-16	19,432	698	20,130

FIGURE 32 Use of IDU support services by sex/gender 2013-14 – 2015-16 (OCHART q. 9.13.3a)

Year and service	Services used by males	Services Used by females	Total services used by cisgender persons
2013-14	**19,603**	**14,109**	**33,712**
Indigenous traditional services	80	112	191
Referrals for faith-based services/spiritual support	127	98	225
Referrals to women specific services	3	859	862
Other	738	273	1,011
Referrals to medical services	1,858	1,664	3,522
Referrals to social services	1,984	1,704	3,688
Referrals to harm reduction/addiction services	2,940	1,882	4,822
Counselling	3,518	2,171	5,688
Education	3,687	2,310	5,997
Practical support	4,671	3,039	7,709
2014-15	**27,135**	**19,822**	
Other	192	101	293
Referrals for faith-based services/spiritual support	193	115	308
Indigenous traditional services	188	169	356
Referrals to women specific services	39	1,115	1,154
Referrals to medical services	1,738	1,582	3,319
Referrals to harm reduction/addiction services	2,368	1,498	3,865
Referrals to social services	3,533	2,852	6,385
Counselling	5,544	3,495	9,039
Education	6,138	3,744	9,882
Practical support	7,204	5,154	12,358
2015-16	**53,427**	**33,321**	**86,748**
Indigenous traditional services	153	220	373
Referrals for faith-based services/spiritual support	221	192	413
Other	313	371	684
Referrals to women specific services	104	728	832
Referrals to social services	3,896	2,423	6,319
Referrals to medical services	6,218	3,812	10,030
Counselling	7,078	4,259	11,337
Referrals to harm reduction/addiction services	7,661	4,542	12,203
Education	10,675	6,381	17,056
Practical support	17,109	10,394	27,503

FIGURE 33 Total number of unique in-service trans clients over 5 years by program type (OCHART q. 13.2.2)*

Year and service	Services used by trans males	Services used by trans females	Total services used by trans people
2013-14	**47**	**202**	**248**
Indigenous traditional services		8	8
Referrals for faith-based services/spiritual support		2	2
Referrals to women specific services		26	26
Other	2	5	7
Referrals to medical services	2	12	14
Referrals to social services	4	19	22
Referrals to harm reduction/addiction services	2	44	46
Counselling	6	19	25
Education	8	15	23
Practical support	24	53	77
2014-15	**156**	**1,173**	**1,329**
Other	1	1	2
Referrals for faith-based services/spiritual support		1	1
Indigenous traditional services	3	5	8
Referrals to women specific services	5	100	105
Referrals to medical services	8	60	67
Referrals to harm reduction/addiction services	21	51	72
Referrals to social services	5	79	84
Counselling	46	297	343
Education	32	270	302
Practical support	38	310	348
2015-16	**656**	**317**	**973**
Indigenous traditional services	3	5	8
Referrals for faith-based services/spiritual support	1	3	3
Other	1		1
Referrals to women specific services		6	6
Referrals to social services	5	6	10
Referrals to medical services	28	8	36
Counselling	85	74	159
Referrals to harm reduction/addiction services	59	13	72
Education	162	37	198
Practical support	315	168	483

FIGURE 34 Trends in safer injection supplies distributed 2013-14—2015-16 (OCHART q. 13.10a)

Safer Injection Supply	2013-14	2014-15	2015-16
Cookers	1,373	1,377	1,392
Filters	3,677	2,433	2,049
Needles	5,456	6,167	6,727
Sharps containers	37	29	36
Swabs	4,343	4,567	4,513
Ties / tourniquets	281	572	446
Vitamin C / Acidifiers	276	397	353
Water for injection	2,549	3,084	3,664

FIGURE 35 Trends in safer inhalation supplies distributed 2013-14 – 2015-16 (OCHART 13.10a)

Resource	2013-14	2014-15	2015-16
Alcohol swabs	252	1,005	1,427
Dental gum	25	7	8
Glass pipes / stems	211	369	334
Lip balm	12	5	9
Matches	103	79	82
Mouthpieces	80	110	149
Wooden push sticks	67	122	142

FIGURE 36 AIDS Bureau funded anonymous HIV testing sites by public health region

Health Region	HIV testing sites
Northern	Thunder Bay District Health Unit Sudbury District Health Unit
Toronto	Hassle Free Clinic
Central West	Hamilton Public Health & Community Services
South West	London Intercommunity Health Centre (Options Clinic)
	Windsor Regional Hospital
Central East	Simcoe Muskoka District Health Unit
Ottawa & Eastern	Somerset West Community Health Centre
Central East	Simcoe Muskoka District Health Unit
Ottawa & Eastern	Somerset West Community Health Centre

FIGURE 37 Number of HIV tests, Ontario, 2001-2015

Year of Test	Number of tests
2001	279,491
2002	336,800
2003	346,720
2004	372,871
2005	392,017
2006	415,562
2007	414,494
2008	414,926
2009	425,312
2010	418,369
2011	428,628
2012	436,272
2013	441,815
2014	457,916
2015	485,250

FIGURE 38 Number of HIV tests by submission type, Ontario, 2000-2014

Year of Test	Total Anonymous	Total Coded	Total Nominal
2001	9,637	33,377	236,454
2002	9,813	31,536	295,411
2003	9,627	29,269	307,816
2004	10,436	29,588	332,844
2005	11,070	30,114	350,832
2006	11,120	25,560	378,871
2007	9,890	22,381	382,208
2008	12,049	20,147	382,728
2009	14,059	22,090	389,152
2010	14,905	22,831	380,588
2011	16,142	23,169	389,317
2012	16,117	22,891	397,263
2013	17,177	22,734	401,900
2014	17,393	17,231	423,286
2015	17,048	15,519	452,681

FIGURE 39 Number of HIV tests by sex, Ontario, 2000-2015

Year of Test	Males	Females
2000	110,687	140,600
2001	117,763	150,668
2002	144,791	182,862
2003	149,232	189,357
2004	161,730	202,300
2005	173,675	210,186
2006	183,877	222,146
2007	187,529	217,998
2008	188,990	218,195
2009	193,933	220,661
2010	191,533	212,962
2011	199,637	212,607
2012	203,963	216,072
2013	209,724	217,428
2014	218,878	223,237
2015	231,292	236,316

FIGURE 40 HIV positivity rate, Ontario, 2000-2015

Year of Test	Total Pos Rate	Male Pos Rate	Fem Pos Rate
2000	0.33%	0.60%	0.13%
2001	0.33%	0.59%	0.15%
2002	0.33%	0.57%	0.15%
2003	0.31%	0.51%	0.15%
2004	0.30%	0.52%	0.14%
2005	0.28%	0.47%	0.12%
2006	0.27%	0.42%	0.14%
2007	0.24%	0.42%	0.10%
2008	0.26%	0.43%	0.12%
2009	0.23%	0.39%	0.10%
2010	0.24%	0.42%	0.09%
2011	0.23%	0.38%	0.10%
2012	0.20%	0.33%	0.09%
2013	0.18%	0.31%	0.06%
2014	0.18%	0.30%	0.07%
2015	0.17%	0.29%	0.07%

FIGURE 41 HIV positivity rate by submission type, Ontario, 2000-2015

Year of test	Anonymous Pos Rate	Coded Pos Rate	Nominal Pos Rate
2000	1.08%	0.80%	0.22%
2001	1.11%	0.87%	0.23%
2002	1.08%	1.00%	0.23%
2003	1.15%	0.83%	0.23%
2004	1.16%	0.79%	0.24%
2005	1.01%	0.69%	0.22%
2006	0.93%	0.56%	0.23%
2007	1.13%	0.54%	0.20%
2008	0.99%	0.63%	0.22%
2009	0.87%	0.42%	0.19%
2010	0.95%	0.35%	0.20%
2011	0.82%	0.34%	0.20%
2012	0.72%	0.32%	0.17%
2013	0.71%	0.26%	0.15%
2014	0.63%	0.12%	0.16%
2015	0.56%	0.19%	0.16%

FIGURE 42 Number of HIV tests by age and sex, Ontario, 2013-2015

	Male tests	Female Tests
15-19	24,854	39,914
20-24	93,566	112,190
25-29	117,138	130,685
30-34	107,483	121,507
35-39	83,995	90,388
40-44	63,556	58,999
45-49	48,574	36,230
50-54	38,492	26,850
55-59	26,925	18,860
60-64	18,897	13,267
65-69	13,202	8,859
70+	17,858	13,731

*Unknowns and less than 15 not shown

FIGURE 43 Total number of HIV tests conducted (OCHART q8.1a)

Test type	2014-15	2015-16
Coded HIV tests	34	0
Nominal HIV tests	1,115	2,018
Anonymous HIV tests	6,875	8,050

FIGURE 44 Number of HIV tests by test type and positivity rate (OCHART q8.1a)

	Coded HIV tests		Nominal HIV tests		Anonymous HIV tests		All HIV tests	
	2014-15	2015-16	2014-15	2015-16	2014-15	2015-16	2014-15	2015-16
HIV tests	34	0	1115	2018	6875	8050	8024	10068
Positive tests	0	0	1	3	54	75	55	78
Positivity rate			0.089686	0.148662	0.785455	0.93167702	0.685444	0.774732

FIGURE 45 Number of HIV tests by sex/gender (OCHART q8.1b)

	Male	Female	Grand Total
2014-15	5,834	1,289	7,123
2015-16	7,394	1,833	9,227

FIGURE 46 Number of HIV tests by sex/gender (OCHART q8.1b)

	Trans man	Trans woman	Grand Total
2014-15	11	23	34
2015-16	13	41	54

FIGURE 47 Number of HIV tests by age and sex/gender (OCHART q8.1d)

Age	Year	Male	Female
19 and under	2014-15	123	85
	2015-16	129	118
20 - 29	2014-15	2,200	557
	2015-16	2,724	763
30 - 39	2014-15	1,928	373
	2015-16	2,286	481
40 - 49	2014-15	1,029	232
	2015-16	1,208	222
50 - 59	2014-15	457	87
	2015-16	726	96
60+	2014-15	244	42
	2015-16	321	32
Unknown	2014-15	15	14
	2015-16	33	8

FIGURE 48 Number of HIV tests with trans people by age (OCHART q8.1d)

Age range	Year	Total
29 and under	2014-15	20
	2015-16	21
30 - 39	2014-15	13
	2015-16	19
40 - 69	2014-15	5
	2015-16	12

FIGURE 49 Number of HIV tests by ethnicity (OCHART q8.1c)

	2014-15	2015-16
White	4,422	5,424
South Asian	254	330
Middle Eastern / Arab	289	396
Indigenous	203	290
Hispanic / Latin American	413	506
East Asian / Southeast Asian	774	851
Caribbean	272	368
African	310	423
Grand Total	**6,937**	**8,588**

FIGURE 50 Number of anonymous HIV tests by location (OCHART q8.2a)

	Number of anonymous HIV tests	Number of positive tests
Main site (plus sub locations of main*)		
14/15	2,921	31
15/16	3,885	37
Community centres		
14/15	1,958	20
15/16	2,913	45
Community health centres		
14/15	1,085	13
15/16	538	5
Bathhouse		
14/15	152	0
15/16	299	1
ASOs		
14/15	146	0
15/16	200	1
Educational institution		
14/15	161	0
15/16	139	0
Health/social service agencies		
14/15	163	2
15/16	58	0
Special events (i.e. Pride)		
14/15	73	0
15/16	42	0
Shelters		
14/15	55	0
15/16	45	0
Other (incl. mobile, vans)		
14/15	19	0
15/16	52	0

FIGURE 51 Referrals made for HIV positive clients (OCHART q8.3)

	2014-15	2015-16
Medical services	49	73
ASO	36	79
Counselling services	28	15
Mental health services	18	5
HIV clinic	15	10
Addictions services	7	6
Housing	2	1

FIGURE 52 Total clients served in 2015-16

	Repeat	New	Total
Total (all client categories)	1,484	625	2,109
Living with HIV	1,411	240	1,651
At-risk*	64	382	446
Affected*	8	3	11

*3 of the 5 clinics have the ability to track client type and can report on the number of clients who are at-risk and affected

FIGURE 53 Number of new and repeat (averaged) clients served by sex/gender (OCHART q.7.1a)

	Repeat	New	Total
Male	**2,422**	**615**	**3,037**
2014-15	1,272	253	1,525
2015-16	1,150	362	1,512
Female	**597**	**245**	**842**
2014-15	298	91	389
2015-16	299	154	453
Trans woman	**21**	**65**	**86**
2014-15	1	8	9
2015-16	20		
Trans man	**17**	**54**	**71**
2014-15	1	2	3
2015-16	16	52	68

FIGURE 54 Number of clients by age and sex/gender 2015-16 (OCHART 7.1b)*

Age	Male	Female	Trans Man	Trans Woman	Grand Total
< 14	9	12			**21**
15 - 19	12	14	10	13	**49**
20 - 29	148	53	39	40	**278**
30 - 39	293	107	10	9	**418**
40 - 49	434	133	<5	10	**576**
50 - 59	457	113	<5	6	**575**
60 - 69	163	21	<5	<5	**183**
70 - 79	31	<5			**31**
80 and over	5				**5**
Unknown	5	6			**11**

FIGURE 55 Top 5 challenges facing clients by region (OCHART q.7.1f)

Region	Challenges	Year	Percentage
Central East	Mental health issues	2014-15	24
		2015-16	40
	Food insecurity	2014-15	35
		2015-16	43
	Lack of access to medical services / doctors	2014-15	43
		2015-16	43
	Poverty	2014-15	31
		2015-16	60
	Discrimination/stigma	2014-15	72
		2015-16	100
Central West	Food insecurity	2014-15	48
		2015-16	59
	Unemployment	2014-15	44
		2015-16	66
	Mental health issues	2014-15	64
		2015-16	66
	Poverty	2014-15	68
		2015-16	73
	Discrimination/stigma	2014-15	86
		2015-16	98
Northern	Food insecurity	2014-15	68
		2015-16	60
	Discrimination/stigma	2014-15	45
		2015-16	68
	Mental health issues	2014-15	75
		2015-16	68
	Unemployment	2014-15	83
		2015-16	70
	Poverty	2014-15	85
		2015-16	75
Toronto	Other	2014-15	31
		2015-16	32
	Other substance use/addiction	2014-15	34
		2015-16	31
	Poverty	2014-15	57

Region	Challenges	Year	Percentage
		2015-16	42
	Mental health issues	2014-15	42
		2015-16	47
	Discrimination/stigma	2014-15	45
		2015-16	62

FIGURE 56 Number of clients linked to clinical services (OCHART q. 7.3)

	2014-15	2015-16
Care Linkages - Clinical Services	1,325	2,125
Medical specialists	787	1,232
HIV specialist	215	463
Primary care (GP)	159	192
Clinical mental health services	119	186
Clinical addiction services (detox/rehab)	45	52

FIGURE 57 Number of clients linked to community services (OCHART q. 7.3)

	2014-15	2015-16
Care Linkages – Community/Social Services	**311**	**446**
AIDS service organization	126	122
Housing services	79	118
Mental health services (community)	59	84
Legal services	22	78
Community based addiction services	5	27
Settlement services	16	7
Employment services	4	10

FIGURE 58 Number of education presentations and participants by education activity type (OCHART q.7.4a)

	Number of presenta-tions	Number of participants
Community presentations	**43**	**1126**
2014-15	18	585
2015-16	25	541
Conference presentations	**44**	**554**
2014-15	16	268
2015-16	28	286
HIV Rounds	**89**	**1530**
2014-15	28	507
2015-16	61	1023

FIGURE 59 Community development meetings by type (OCHART q.7.4b)

	2014-15	2015-16	Total
Local hospital/service networks	10	47	57
Opening Doors conferences/events	26	18	44
HIV Clinic Coordinator Network	18	23	41
Local HIV planning network	8	12	20

FIGURE 60 Total clients (averaged) accessing support services in 2015-16 (OCHART q.11.1.1)

Client type	Total
Existing	10,098
New	4,489

FIGURE 61 Who is using support services 2015-16 (OCHART q. 11.1.1)

Client category	Percentage
PLWH	65%
Affected	8%
At-risk	15%
Other	12%

FIGURE 62 Clients accessing support services by client group — 2015-16 (OCHART q. 11.1.1)

	Existing	New	Total
PHAs	7,019	2,505	9,524
Affected	839	297	1,136
At-risk	1,349	889	2,238
Other	891	798	1,689

FIGURE 63 Top 10 services being accessed by people living with HIV (OCHART q. 11.2.1)

	2013-14	2014-15	2015-16
Workshops/training/skills development	983	1,035	616
Health promotion/treatment information	1,347	1,224	707
Scheduled drop-in program	1,055	1,074	709
Individual advocacy	1,059	997	1,150
Case management	2,834	2,267	1,173
Referrals	1,799	1,600	1,487
Counselling	1,703	1,802	2,153
Intake and/or assessment	2,431	2,442	2,609
Food programs	2,567	3,266	3,052
Practical assistance	3,804	3,913	3,056

FIGURE 64 Top 10 services being accessed by at-risk clients (OCHART 11.2.1)

	2014-15	2015-16
Case management	124	27
Health promotion/treatment information	184	77
Workshops/training/skills development	113	187
Pre/post test counselling	187	164
Intake and/or assessment	254	176
Practical assistance	288	165
Counselling	432	483
Referrals	730	990
Scheduled drop-in program	1,095	1,008
Food programs	1,113	1,022

FIGURE 65 Top 5 services being accessed by affected clients (OCHART 11.2.1)

	2013-14	2014-15	2015-16
Case Management	465	422	146
Referrals	350	265	163
Health Promotion/Treatment Information	351	321	215
Practical Assistance	916	647	406
Counselling	374	369	410
Food Programs	776	906	413

FIGURE 66 Breakdown of new clients living with HIV using support services by sex/gender (OCHART q. 11.1.1)

Sex/Gender	Percent
Female	34.48%
Male	62.94%
Trans	2.58%

FIGURE 67 Top five services used by trans women (OCHART q. 11.2.1)

	2013-14	2014-15	2015-16
Case management	36	32	27
Intake and/or assessment	32	55	43
Workshops/training/skills development	3	34	45
Counselling	33	37	53
Scheduled drop-in program	76	107	70
Referrals	45	101	79
Practical assistance	42	152	155

FIGURE 68 Top five services used by trans men (OCHART q. 11.2.1)

	2013-14	2014-15	2015-16
Support groups/retreats	24		
Scheduled drop-in program	10	2	2
Other	5	2	3
Case management		4	5
Intake and/or assessment	7	9	11
Practical assistance		8	12
Referrals		2	14
Counselling	6	6	17

FIGURE 69 Total number of support sessions 2013-14 – 2015-16

	2013-14	2014-15	2015-16
Intake and/or assessment	6,109	6,178	6,618
Health promotion/treatment information	7,229	8,095	4,880
Home & hospital visits/care teams	5,446	4,098	11,217
Individual advocacy	5,910	6,118	11,884
Supportive housing	6,724	4,392	16,368
Referrals	8,965	11,006	9,860
Counselling	24,156	22,532	31,748
Food programs	25,400	40,908	30,720
Case management	46,903	47,578	16,025
Practical assistance	54,284	52,142	17,357
Grand Total	**191,126**	**203,047**	**156,677**

FIGURE 70 Total number* of clients accessing support services by client type and age**: 2015-16 (OCHART q. 11.1.3)

Age	PLWH	At-risk	Affected	Other	Grand Total
< 14	161	11	296	92	559
15 - 19	86	123	115	124	447
20 - 29	668	519	159	223	1,569
30 - 39	1,523	427	174	209	2,332
40 - 49	1,976	460	150	131	2,716
50 - 59	1,792	391	111	53	2,346
60 - 69	640	133	59	20	851
70 - 79	95	12	15	11	133
80 and over	87	6	32	7	131
Unknown	2,502	158	33	811	3,504
Grand Total	**9,528**	**2,237**	**1,141**	**1,680**	**14,585**

FIGURE 71 Number of new clients by age and client type 2014-15 – 2015-16 (OCHART q. 11.1.3)

Age	PLWH	Affected	At-risk	Other	Grand Total
< 14	4	17	7	40	68
15 - 19	25	27	56	75	183
20 - 29	304	57	214	172	747
30 - 39	461	60	154	143	818
40 - 49	385	47	151	64	647
50 - 59	308	44	115	27	494
60 - 69	94	20	56	8	178
70 - 79	16	4	6	5	31
80 and over	23	15	3	6	47
Unknown	897	11	127	257	1,292
Grand Total	**2,517**	**302**	**889**	**797**	**4,505**

FIGURE 72 Number of new clients by ethnicity and client type 2014-15 – 2015-16 (OCHART q. 11.1.4)

	PLWH	Affected	At-Risk	Other	Total
Unknown	**645**	**132**	**782**	**107**	**1,666**
2014-15	556	106	579	71	1,312
2015-16	89	26	203	36	354
White / Western European	**912**	**107**	**290**	**96**	**1,405**
2014-15	426	45	85	52	608
2015-16	486	62	205	44	797
African	**705**	**189**	**217**	**286**	**1,397**
2014-15	324	144	180	101	749
2015-16	381	45	37	185	648
Indigenous	**190**	**24**	**286**	**203**	**703**
2014-15	117	7	170	29	323
2015-16	73	17	116	174	380
Hispanic / Latin American	**409**	**140**	**115**	**13**	**677**
2014-15	196	51	44	6	297
2015-16	213	89	71	7	
Caribbean	**312**	**54**	**111**	**76**	**553**
2014-15	147	36	78	49	310
2015-16	165	18	33	27	243
White / Eastern European	**280**	**52**	**40**	**41**	**413**
2014-15	116	6	1	7	130
2015-16	164	46	39	34	283
East Asian / Southeast Asian	**147**	**15**	**83**	**9**	**254**
2014-15	67	6	29	3	105
2015-16	80	9	54	6	149
South Asian	**69**	**15**	**121**	**10**	**215**
2014-15	28	4	86	5	123
2015-16	41	11	35	5	92
Middle Eastern / Arab	**52**	**1**	**13**	**21**	**87**
2014-15	22			10	32
2015-16	30	1	13	11	55

FIGURE 73 Challenges faced by clients (proportional) 2015-16 (OCHART q. 11.1.6)

Challenge	Percentage (averaged)
HCV mono-infection	5%
Developmental disability	6%
Refugee/non-status	8%
Involved in sex work	9%
Incarceration	10%
Recent immigrant	14%
Parenting and child care issues	14%
HIV HCV co-infection	16%
Language barriers	18%
Physical disability	18%
Injection drug use	18%
Lack of access to medical services/doctors	22%
Past or current sexual abuse	28%
Unstably housed/homeless	28%
Life/communication skills	31%
Racism/racial discrimination	33%
Other substance use/addiction	33%
Past or current violence	37%
HIV mono-infection	49%
Mental health issues	52%
Food insecurity	55%
Unemployment	63%
Poverty	69%
Discrimination/stigma	73%

FIGURE 74 Number of unique clinical and community referrals by sex/gender (male and female) 2015-16 (OCHART q. 11.2.1b)

	Male	Female	Total
Clinical services	**3,435**	**2,112**	**5,547**
Day programs (seniors, brain injury)	69	24	93
Smoking cessation program	80	32	112
Public health	96	31	127
Hep C clinic/testing	205	168	373
STI testing/sexual health clinic	295	247	542
Health care facility/hospital	397	255	652
HIV testing	354	329	683
Community mental health agency	504	275	779
Counselling service	621	338	959
Health care professional	814	413	1,227
Community / social services	**4,091**	**2,454**	**6,545**
Faith-based organization	57	27	84
Legal aid	136	77	213
Settlement agency	129	166	295
Employment support	187	117	304
Legal service agency	257	164	421
Population-specific services (women's services, youth, Indigenous, etc.)	255	283	538
Other ASO	476	297	773
Addiction/harm reduction services	559	273	832
Community food bank	550	341	891
Housing provider	706	328	1,034
Social service (including EI, OW and ODSP)	779	381	1,160

FIGURE 75 Number of unique clinical and community referrals by sex/gender (trans men and trans women) (OCHART q. 11.2.1b)

	Trans men	Trans women	Total
Clinical services	**51**	**280**	**331**
Health care facility/hospital	4	12	16
Health care professional	8	14	22
Community mental health agency	7	22	29
Counselling service	10	22	32
Hep C clinic/testing	7	59	66
HIV testing	8	67	75
STI testing/sexual health clinic	7	84	91
Community / social services	**25**	**177**	**202**
Legal aid	2	3	5
Legal service agency	1	4	5
Settlement agency	2	6	8
Employment support		13	13
Community food bank	3	18	21
Addiction/harm reduction services	3	19	22
Housing provider	1	23	24
Social service (including EI, OW and ODSP)	5	20	25
Other ASO	8	22	30
Population-specific services (women's services, youth, Indigenous, etc.)		49	49

FIGURE 76 Number of presentations or sessions by type 2015-2016 (OCHART q.14.1a)

	Mentorship/ Coaching	Capacity Build-ing	KTE	Total
General Capacity Programs	1,381	1,047	267	2,695
Population Specific Programs	89	302	102	493

FIGURE 77 Number of capacity building events by focus and organization (OCHART q. 14.1.a)

	All Other Agencies	African and Caribbean Council on HIV/AIDS in Ontario	Gay Men's Sexual Health Alliance	Committee for Accessible AIDS Treatment	Women and HIV/AIDS Initiative	Total
Other	**464**	**14**	**66**	**61**	**4**	**609**
2014-15	254	8	34	32	4	332
2015-16	210	6	32	29		277
Dealing with grief and loss	**514**			**3**		**517**
2014-15	261			3		264
2015-16	253					253
Skills building	**278**	**2**	**47**	**30**	**12**	**369**
2014-15	141		3	23	2	169
2015-16	137	2	44	7	10	200
Leadership training	**192**		**1**			**193**
2014-15	27					27
2015-16	165		1			166
Human resource issues	**183**					**183**
2014-15	90					90
2015-16	93					93
Change leadership	**179**			**1**	**3**	**183**
2014-15	23			1		24
2015-16	156				3	159
HIV-specific training	**122**		**12**	**27**		**161**
2014-15	68		11	21		100
2015-16	54		1	6		61
Organizational development	**112**		**1**	**1**		**114**
2014-15	21			1		22
2015-16	91		1			92
GIPA/MIPA	**65**			**3**		**68**
2014-15						56
2015-16	10			2		12
Healthy sexuality			**65**	**1**		**66**
2014-15			59	1		60
2015-16			6			6

	All Other Agencies	African and Caribbean Council on HIV/AIDS in Ontario	Gay Men's Sexual Health Alliance	Committee for Accessible AIDS Treatment	Women and HIV/AIDS Initiative	Total
HIV and immigration service access				**50**		**50**
2014-15				23		23
2015-16				27		27
Use/harm reduction	**38**			**10**		**48**
2014-15	25					25
2015-16	13			10		23
Social determinants of health	**2**		**3**	**39**		**44**
2014-15	2			17		19
2015-16			3	22		25
Disclosure and legal issues	**25**	**1**		**1**		**27**
2014-15	8	1				9
2015-16	17			1		18
Boundaries	**15**			**7**		**22**
2014-15	15			6		21
2015-16				1		1
Dissemination of research	**2**		**12**	**5**	**3**	**22**
2014-15	2		1	1	1	5
2015-16			11	4	2	17
Policy	**3**			**12**		**15**
2014-15	1					1
2015-16	2			12		14
Anti-racism/anti-oppression	**7**				**1**	**8**
2014-15					1	1
2015-16	7					7

FIGURE 78 Capacity-building presentations and participants (OCHART q. 14.1a)

	Total presentation	Total participants
All Other Agencies	**2695**	**27241**
2012	592	7334
2013	752	8874
2014	564	6227
2015	787	4806
African and Caribbean Council on HIV/AIDS in Ontario	**54**	
2012	19	346
2013	20	408
2014	9	130
2015	6	72
Committee for Accessible AIDS Treatment	**230**	**2734**
2013	92	642
2014	71	1016
2015	67	1076
Gay Men's Sexual Health Alliance	**185**	**2168**
2012	29	697
2013	29	917
2014	75	193
2015	52	361
Women and HIV/AIDS Initiative	**24**	**396**
2013	4	156
2014	8	111
2015	12	129

FIGURE 79 Number of research studies by priority population (OCHART q. 6.5b)

	Studies funded	Studies completed
People living with HIV	**100**	**29**
2014-15	57	7
2015-16	43	22
Gay/bisexual/MSM	**48**	**13**
2014-15	26	4
2015-16	22	9
African, Caribbean or Black people	**24**	**1**
2014-15	10	0
2015-16	14	1
People who use drugs	**23**	**11**
2014-15	13	4
2015-16	10	7
Women at-risk	**13**	**7**
2014-15	7	4
2015-16	6	3
Indigneous peoples	**10**	**3**
2014-15	5	2
2015-16	5	1

FIGURE 80 Contributions to research from people living with HIV by role (OCHART q. 6.5d)

	Investigator	Research/ project staff	Collaborator	Community Advisory Committee member	Other	Total
2014-15	31%	20%	20%	23%	7%	**100%**
2015-16	43%	20%	20%	11%	7%	**100%**

FIGURE 81 Ways OCS data was used (OCHART q 6.4)

	2014-15	2015-16
Data scans completed (Internal)	4	7
Number of presentations by OCS Staff	21	28
Number of project proposals received	7	3
Number of publications containing OCS data	6	18
Project proposals approved	4	3
Studies completed using link to ICES (Internal)	0	0

FIGURE 82 OCHART and OCASE training in 2015-16 (OCHART q. 6.7a)

	Training sessions	People trained
OCHART	38	229
OCASE	89	173

FIGURE 83 OCHART and OCASE data analysis requests in 2015-16 (OCHART q. 6.7b)

	Data requests
OCHART	43
OCASE	152

FIGURE 84 Total number of presentations and participants by presentation focus 2014 - 2015 – 2015-16 (OCHART q. 6.1a)

	Number of presentations	Number of participants
Care and treatment	**41**	**1366**
2014-15	30	1078
2015-16	11	288
Research process and findings	**36**	**1069**
2014-15	18	534
2015-16	18	535
Social determinants of health	**13**	**764**
2014-15	5	438
2015-16	8	326
Health systems	**12**	**434**
2014-15	5	277
2015-16	7	157
HIV prevention	**10**	**795**
2014-15	5	545
2015-16	5	250
Testing and diagnosis	**8**	**320**
2014-15	4	180
2015-16	4	140

FIGURE 85 Community development meetings by funder and program type (OCHART q. 9.5 and 13.7 and 14.4)

	Other Funding	ACAP	Total
Prevention education	**18,362**	**2,862**	**21,224**
2013-14	6,444	1,128	7,572
2014-15	6,173	1,038	7,211
2015-16	5,745	696	6,441
IDU	**23,247**	**763**	**24,010**
2013-14	5,831	204	6,035
2014-15	7,791	448	8,239
2015-16	9,625	111	9,736
Capacity building programs	**1,448**	**267**	**1,715**
2013-14	495	91	586
2014-15	535	93	628
2015-16	418	83	501

FIGURE 86 Top 5 community development meetings by purpose and funder (OCHART q. 9.5)

	Other Funding	ACAP	Total
Coalition/network meeting	**4,220**	**664**	**4,884**
2013-14	1,503	269	1,772
2014-15	1,507	233	1,740
2015-16	1,210	162	1,372
Community event planning	**3,108**	**477**	**3,585**
2013-14	1,033	164	1,197
2014-15	1,006	164	1,170
2015-16	1,069	149	1,218
General information sharing	**2,668**	**368**	**3,036**
2013-14	971	124	1,095
2014-15	882	136	1,018
2015-16	815	108	923
Advisory/Board meeting	**2,368**	**432**	**2,800**
2013-14	849	174	1,023
2014-15	863	143	1,006
2015-16	656	115	771
New partnership/relationship building	**2,268**	**400**	**2,668**
2013-14	821	202	1,023
2014-15	692	130	822
2015-16	755	68	823

FIGURE 87 Community development meetings (top 3) by meeting purpose and worker role 2015-16 (OCHART q. 9.5)

	Coalition/network meeting	Community event planning	General information sharing	Advisory/ Board meeting	New partnership/relationship building	Improved service delivery
Other	491	596	377			
Executive Director/ Program Manager	388			296		283
WHAI PPN member	315	276	265			
ACCHO PPN member		77		86	62	

FIGURE 88 IDU community development contacts by agency type 2015-16 (OCHART 13.8)

	2014-15	2015-16
Schools	158	130
Community/political systems	159	150
Researchers	192	134
Criminal justice system	381	203
Grassroots organizations	396	329
User networks	651	511
Population-specific services	791	1,182
Addiction/harm reduction services	1,398	1,905
Practical and social support services	1,285	2,092
Health care services	1,783	2,063

FIGURE 89 Confirmed case counts and reported hepatitis C by age and gender: Ontario 2015

	<1	01-04	15-19	20-24	25-29	30-39	40-49	50-59	60-69	70+
Female Count	6	8	57	180	222	347	228	302	168	93
Male Count	3	10	30	212	328	534	453	635	360	71
Female Rate	8.5	0.8	14.0	37.8	46.6	37.1	23.8	28.8	20.8	11.0
Male Rate	4.0	0.9	6.9	42.6	70.2	60.3	48.7	61.3	47.8	10.9
Total Rate	6.2	0.9	10.4	40.2	58.3	48.4	36.1	45.0	33.8	11.0

FIGURE 90 Reported cases and rates of hepatitis C

	2010	2011	2012	2013	2014	2015
Ontario Count	4532	4189	4191	4185	4214	4263
Ontario Rate	34.5	31.6	31.2	30.9	31.1	30.9
Canada Rate	31.1	28.9	29.3	29.6	29.4	

FIGURE 91 Reported rates of hepatitis C by public health unit of residence: Ontario 2014

Health Unit	Rates per 100,000
North Western	96.1 - 123.3
Thunder bay	96.1 - 123.3
Porcupine	14.1 - 41.4
Algoma	41.5 - 68.7
Sudbury	68.8 - 96.0
TSK Timiskaming	41.5 - 68.7
NPS North Bay Parry Sound	41.5 - 68.7
Eastern Ontario	14.1 - 41.4
Ottawa	14.1 - 41.4
Leeds-Grenville	14.1 - 41.4
Renfrew	14.1 - 41.4
Kingston	41.5 - 68.7
Hastings-Prince Edward	14.1 - 41.4
HKPR Haliburton-Kawartha Pine Ridge	41.5 - 68.7
Peterborough	41.5 - 68.7
Simcoe-Muskoka	14.1 - 41.4
YRK York Regional	14.1 - 41.4
Durham	14.1 - 41.4

Health Unit	Rates per 100,000
TOR Toronto	14.1 - 41.4
Peel	14.1 - 41.4
HAL Halton	14.1 - 41.4
HAM Hamilton	14.1 - 41.4
BRN Brantford	14.1 - 41.4
WAT Waterloo	14.1 - 41.4
WDG Wellington-Dufferin Guelph	14.1 - 41.4
Grey Bruce	14.1 - 41.4
Huron	14.1 - 41.4
Perth	14.1 - 41.4
NIA Niagara	41.5 - 68.7
HDN Haldimand-Norfolk	41.5 - 68.7
Oxford	41.5 - 68.7
Middlesex-London	41.5 - 68.7
ELG Elgin-St. Thomas	14.1 - 41.4
Lambton	68.8 - 96.0
Chatham-Kent	41.5 - 68.7
WEC Windsor-Essex	14.1 - 41.4

FIGURE 92 Hep C funded positions by role (H2 only) (OCHART 2.3)

Positions by role	Total
Administration/finance/IT	7
Executive director/senior management	2
Prevention/education/outreach/community development	24
Support/clinical care	49
Other	2

FIGURE 93 Total number of new/active clients served by sex/gender and client type 2013-14 – 2015- 16 (OCHART q. 15.1a)

	Male	Female	Trans woman	Trans man
LIVING WITH HIV				
New				
2013-14	999	566	11	0
2014-15	1,208	657	6	0
2015-16	1,462	849	7	<5
Active				
2013-14	1,113	563	10	<5
2014-15	1,238	757	<5	0
2015-16	1,265	719	6	<5
AT-RISK				
New				
2013-14	543	330	<5	<5
2014-15	752	479	7	<5
2015-16	844	635	5	<5
Active				
2013-14	339	205	<5	<5
2014-15	176	152	9	<5
2015-16	205	170	<5	5
AFFECTED				
New				
2013-14	127	103	0	0
2014-15	103	130	<5	0
2015-16	181	142	<5	0
Active				
2013-14	152	102	0	0
2014-15	125	126	<5	0
2015-16	235	140	<5	0

FIGURE 94 HCV Prevention, Engagement and Care Continuum

At risk	Engaged with HCV care	Pre-treatment	On treatment	Post treatment	Affected
People at risk of acquiring HCV because of injection drug use, who can receieve education and case management services to help reduce their risk.	Clients with HCV who do not yet qualify for drug coverage under current treatment criteria but who can receive clinical and case management services not directly related to HCV treatment.	People who meet or are near meeting treatment criteria but who have not yet started treatment and who will require close monitoring.	People who are on treatment.	People who have completed treatment. complicated treatement.	People who are partners, friends, or family members of people with HCV who receive education and support services.

FIGURE 95 Total number of new clients served by gender and client type 2013-14 – 2015-16 (OCHART q.15.1a)

	Male	Female	Trans woman	Trans man
Living				
2013-14	999	566	11	0
2014-15	1208	657	6	0
2015-16	1462	849	7	<5
At-risk				
2013-14	543	330	4	<5
2014-15	752	479	7	<5
2015-16	844	635	5	<5
Affected				
2013-14	127	103	0	0
2014-15	103	130	<5	0
2015-16	181	142	<5	0

FIGURE 96 HCV clients by sex/gender, client type and region (OCHART q. 15.1a)

	Female	Male
Provincial Services	**2**	**24**
At-risk		5
Living with HCV	2	19
Toronto	**186**	**425**
Affected	12	29
At-risk	28	24
Living with HCV	147	372
South West	**237**	**457**
Affected	7	9
At-risk	72	130
Living with HCV	158	318
Ottawa & Eastern	**366**	**643**
At-risk	48	47
Affected	6	91
Living with HCV	313	505
Northern	**549**	**677**
Affected	12	11
At-risk	239	249
Living with HCV	298	417
Central East	**604**	**698**
Affected	169	183
At-risk	183	176
Living with HCV	253	340
Central West	**712**	**1,269**
Affected	78	94
At-risk	236	419
Living with HCV	399	757

FIGURE 97 Outreach contacts by location (OCHART q. 15.4a)

	2013-14	2014-15	2015-16
Food bank/soup kitchen	3,864	4,340	4,530
ASOs	1,867	2,729	4,179
Street outreach incl. parks, alleys, etc.	2,300	2,670	3,190
Clinic/health centre	1,955	1,764	2,672
Drop in centres	2,495	2,533	2,195
Addiction program (residential and day programs)	2,769	2,208	1,956
Shelters	2,262	1,950	1,915
Social gatherings	1,958	3,786	1,771
Correctional facilities	3,431	2,344	1,593
Mobile services	535	1,007	729
Methadone maintenance clinics	1,521	1,539	715
Mental health services	438	393	372
Pharmacies	49	74	236
Other	3,572	2,544	3,368

FIGURE 98 Outreach contacts by region and location (OCHART q.15.4a*)

	Community organizations/ events	Clinical Services	Other	Mobile Services
Central East	**1527**	**677**	**2571**	**1581**
2013-14	302	165	928	1193
2014-15	697	353	244	286
2015-16	528	159	1399	102
Central West	**13525**	**6188**	**5441**	**3463**
2013-14	3825	1843	2699	733
2014-15	4704	1901	1224	1580
2015-16	4996	2444	1518	1150
Northern	**5394**	**2359**	**2006**	**3315**
2013-14	2414	1086	607	645
2014-15	1781	719	768	915
2015-16	1199	554	631	1755
Ottawa & Eastern	**5161**	**4245**	**4975**	**246**
2013-14	2416	1696	2172	50
2014-15	2188	1555	1831	62
2015-16	557	994	972	134

	Community organizations/ events	Clinical Services	Other	Mobile Services
South West	**17034**	**2648**	**920**	**1178**
2013-14	3687	1065	146	214
2014-15	5930	519	421	364
2015-16	7417	1064	353	600
Toronto	**935**	**1317**	**506**	**648**
2013-14	240	439	96	
2014-15	431	514	350	470
2015-16	264	364	60	178

FIGURE 99 Top 5 education topics (OCHART q. 15.4c)

Presentation Topic	2013-14	2014-15	2015-16
Stigma & discrimination	55	148	58
Testing	144	224	316
Living with HCV	156	252	91
Hepatitis C treatment	182	273	567
Harm reduction/safer drug use	349	408	313

FIGURE 100 Number of peers involved in delivering HCV services (OCHART q. 15.4d)

Activity	2014-15	2015-16
1 on 1 in-service education	21	16
Awareness campaign delivery	44	46
Awareness campaign planning	34	26
Community development meetings	19	11
Conference presentations	8	7
Face-to-face outreach	35	31
Longer workshops/workshop series	13	8
Participation with group facilitation	38	32
Patient advisory board member	18	15
Resource development	39	16
Resource distribution	51	38
Short one-time education presentations	28	17

FIGURE 101 Proportion of clients receiving clinical and case management services by treatment stage 2013-14 – 2015-16 (OCHART q. 151f)

	Fiscal year	At-risk	Engaged with HCV team	Pre-Treatment	On treatment	Post treatment
Case management	2013-14	12%	55%	19%	10%	4%
	2014-15	13%	43%	31%	9%	3%
	2015-16	13%	37%	30%	14%	5%
Clinical	2013-14	11%	47%	28%	8%	5%
	2014-15	21%	39%	29%	7%	4%
	2015-16	22%	33%	28%	11%	6%

FIGURE 102 Total caseload by treatment stage by reporting period 2013-14 – 2015-16 (OCHART q. 15.1f)

	Pre-treatment	On treatment	Post-treatment
2013-14	**2,679**	**693**	**655**
H1	1,393	372	323
H2	1,286	321	332
2014-15	**3,172**	**557**	**488**
H1	1,512	279	236
H2	1,660	278	252
2015-16	**3,328**	**1,331**	**1,210**
H1	1,690	614	543
H2	1,638	717	667

FIGURE 103 Case management services accessed by client group 2014-15 – 2016-17 (OCHART q. 151f)

	Fiscal year	At-risk	Living with HCV	Pre-Treatment	On treatment	Post treatment
Application completion	2014-15	6%	29%	39%	23%	3%
	2015-16	8%	30%	37%	20%	5%
Appointment/lab accompaniment	2014-15	12%	43%	31%	9%	5%
	2015-16	21%	41%	24%	9%	6%
Individual advocacy	2014-15	13%	49%	29%	6%	3%
	2015-16	12%	39%	31%	11%	6%
Practical assistance	2014-15	16%	46%	26%	8%	3%
	2015-16	17%	39%	23%	14%	7%
Referrals	2014-15	17%	45%	32%	4%	1%
	2015-16	11%	39%	33%	13%	4%

FIGURE 104 Affected client service utilization by sex/gender 2013-14 – 2015-16 (OCHART q. 15.1f)

	Female	Male
Counselling/support	**456**	**465**
2013-14	172	176
2014-15	151	140
2015-16	134	150
Application completion	**163**	**303**
2013-14	60	99
2014-15	46	68
2015-16	58	136
Referrals	**179**	**241**
2013-14	76	99
2014-15	39	42
2015-16	64	100
Practical assistance	**158**	**224**
2013-14	78	104
2014-15	42	46
2015-16	38	75
Individual advocacy	**133**	**190**
2013-14	66	91
2014-15	31	34
2015-16	36	66

FIGURE 105 Clinical services accessed by group 2013-14 – 2015-16 (OCHART q. 151f)

	Health Teaching/ Treatment Informa-tion	Blood Work	Intake and/or As-sessment	Coun-selling/ Support	Follow up Appoint-ment	Pre/Post Test Coun-selling	Support Groups Treatment	Vaccina-tions
Engaged with HCV	**20%**	**16%**	**16%**	**15%**	**16%**	**10%**	**4%**	**3%**
2013	17%	16%	13%	15%	16%	12%	5%	6%
2014	19%	15%	18%	19%	15%	8%	4%	2%
2015	23%	18%	16%	12%	16%	10%	2%	2%
At-risk	**22%**	**23%**	**14%**	**9%**	**9%**	**21%**	**2%**	**1%**
2013	25%	16%	18%	12%	9%	15%	4%	1%
2014	24%	21%	15%	9%	9%	17%	2%	2%
2015	19%	26%	11%	8%	9%	25%	0%	1%
Pre-Treatment	**20%**	**17%**	**18%**	**12%**	**15%**	**12%**	**3%**	**3%**
2013	20%	15%	15%	13%	15%	16%	3%	2%
2014	21%	15%	17%	13%	15%	11%	3%	5%
2015	20%	19%	20%	11%	15%	10%	2%	2%
On treatment	**20%**	**22%**	**7%**	**13%**	**25%**	**8%**	**3%**	**3%**
2013	19%	14%	7%	14%	35%	6%	3%	2%
2014	22%	23%	8%	15%	18%	8%	3%	4%
2015	19%	25%	7%	11%	22%	9%	3%	3%
Post treatment	**20%**	**22%**	**6%**	**13%**	**23%**	**10%**	**5%**	**2%**
2013	20%	20%	7%	18%	20%	9%	6%	2%
2014	24%	23%	4%	10%	25%	8%	4%	2%
2015	17%	24%	5%	12%	24%	11%	4%	2%

FIGURE 106 Proportion of clinical services accessed 2015-16 (OCHART q. 151f)

	2015-16
Pre / post test counselling	10%
Support groups treatment	2%
Blood work	18%
Counselling / support	12%
Follow-up appointment	16%
Health teaching / treatment information	23%
Intake and / or assessment	16%
Vaccinations	2%

FIGURE 107 Number of clients tested by diagnostic test type (OCHART q. 15.2a)

	New	Repeat
HBV (antibody/antigen) tests	**4,454**	**379**
2013-14	1,391	93
2014-15	1,241	153
2015-16	1,822	134
HCV antibody tests	**4,964**	**566**
2013-14	1,136	96
2014-15	1,417	240
2015-16	2,411	231
HCV RNA tests	**4,541**	**1,506**
2013-14	1,481	302
2014-15	1,275	459
2015-16	1,785	745
HIV antibody tests	**5,066**	**451**
2013-14	1,518	116
2014-15	1,483	181
2015-16	2,065	155

FIGURE 108 Number of fibroscans and fibrotests provided in 2014-15 (OCHART q.15.2a)

	New	Repeat
2014-15	**1,115**	**487**
Total number of fibroscans	848	380
Total number of fibrotests	267	108
2015-16	**1,479**	**656**
Total number of fibroscans	1,221	575
Total number of fibrotests	258	81

FIGURE 109 Treatment outcomes 2013-14 – 2015-16 (OCHART 15.3b & 15.3c)

	2013-14	2014-15	2015-16
Engaged with HCV team	3,263	3,869	4,310
Cleared the virus	252	278	598
Pre-treatment	2,681	3,172	3,328
Started on treatment	689	557	1,331
Completed treatment	631	488	1,210
Withdrawn	88	54	66

FIGURE 110 Reasons for clients not receiving treatment 2013-14 – 2015-16 (OCHART q. 15.3c)

	2013-14	2014-15	2015-16
Did not qualify for EAP/drug coverage	199	432	688
Lost to follow-up	420	221	96
Informed deferral		180	65
Medical instability	108	90	86
Pregnancy	11	16	6
Social instability	213	117	33
Other	202	472	107

FIGURE 111 Reasons for treatment interruptions 2013-14 – 2015-16 (OCHART 15.3b)

	2013-14	2014-15	2015-16
Side effects	36	15	14
Other	30	11	7
Lost to follow-up	3	11	21
Medical instability	10	9	14
Death	1	4	9
Psychiatric manifestation	8	4	1

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