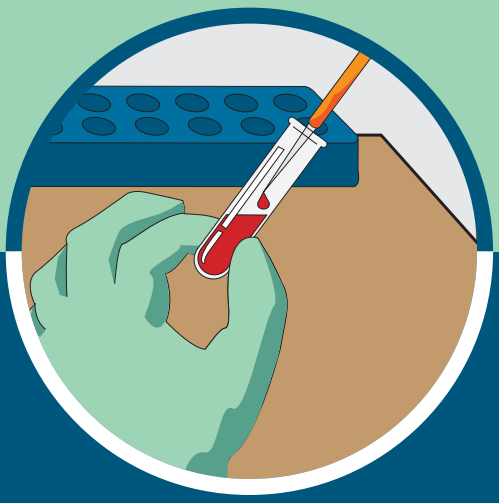
2015 *View from the Frontlines*



OCHART

Annual summary
and analysis of data
April 1, 2014 to
March 31, 2015

2015
View from the Frontlines

OCHART
ONTARIO HIV TREATMENT NETWORK
Public Health Agency of Canada
Agence de santé publique du Canada
Ontario

Acknowledgements

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In addition, the AIDS Bureau and PHAC's Ontario Region would like to thank the Ontario HIV Treatment Network (OHTN) for its support of OCHART. This includes maintaining the web-based OCHART tool, providing ongoing training and support to programs on the use of OCHART, housing the data, extracting the data, and completing the analyses for this report.

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:
http://www.ohtn.on.ca/evidence-based-practice-unit

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Preface

Welcome to the 10th annual OCHART (Ontario Community HIV and AIDS Reporting Tool) report: ***View from the Front Lines***. This year's report marks two significant changes.

1. More programs and services

Reports from 109 programs in 91 organizations are included in this report — up from 99 programs in 85 organizations in 2013/14.

The increase is mainly due to different HIV programs now reporting through OCHART. In addition to reporting on the activities of:

- 69 **community-based HIV/AIDS programs** (including programs in AIDS services organizations and non-AIDS organizations, such as community health centres) funded by the Ontario Ministry of Health and Long-Term Care AIDS Bureau and the Public Health Agency of Canada (PHAC) Ontario Region AIDS Community Action Program (ACAP) to provide prevention, outreach and support services for people living with or at risk of HIV and HCV, and their partners and families.
- 4 **provincial organizations that provide direct services to clients** — Hemophilia Ontario, Ontario Aboriginal HIV/AIDS Strategy (Oahas), Prisoners with HIV/AIDS Support Action Network (PASAN), and HIV & AIDS Legal Clinic Ontario (HALCO).
- 10 **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)[1] — which each have a provincial office and network members based mainly in AIDS service organizations (ASOs) throughout the province.

The 2014/15 *View from the Front Lines* includes for the first time the activities of three other types of community-based services funded by the AIDS Bureau:

- 8 **anonymous testing programs**
- 5 **community-based HIV clinics**
- the **Ontario HIV Treatment Network** — a research and knowledge exchange organization (included with capacity building programs – bringing the total number to 11).

The 2014/15 *View from the Front Lines* also includes, for the second year:

- 16 **Hepatitis C Teams** funded by the Ontario Ministry of Health and Long-Term Care Hepatitis C Secretariat, which work closely with treating physicians, providing HCV care and treatment, education, outreach and support services (included for the first time last year).

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

1 The AIDS Bureau also supports two other groups of workers and organizations that provide services to specific populations: services that focus on Indigenous people including 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; and 21 community-based organizations funded to provide harm reduction outreach services.

FIGURE 1

HIV PROGRAMS AND HEPATITIS C TEAMS SPAN THE PROVINCE

Northern

AIDS service organizations:	7
Non-AIDS service organizations:	5
Community-based HIV clinical services:	1
Anonymous testing programs:	2
HCV teams:	4
Total number of funded programs:	19

Ottawa and Eastern

AIDS service organizations:	6
Non-AIDS service organizations:	6
Anonymous testing programs:	1
HCV teams:	1
Total number of funded programs:	14

Central East

AIDS service organizations:	4
Community-based HIV clinical services:	1
Anonymous testing programs:	1
HCV teams:	1
Total number of funded programs:	7

Central West

AIDS service organizations:	6
Non-AIDS service organizations:	1
Community-based HIV clinical services:	2
Anonymous testing programs:	1
HCV teams:	4
Total number of funded programs:	14

South West

AIDS Service organizations:	5
Non-AIDS service organizations:	1
Anonymous testing programs:	2
HCV teams:	2
Total number of funded programs:	10

Toronto

AIDS service organizations:	6
Non-AIDS service organizations:	22
Community-based HIV clinical services:	1
Anonymous testing programs:	1
Capacity-building programs:	11
HCV teams:	4
Total number of funded programs:	45

Total number of funded programs in Ontario

AIDS service organizations:	34
Non-AIDS service organizations:	35
Community-based HIV clinical services:	5
Anonymous testing programs:	8
Capacity-building programs:	11
HCV teams:	16
	109

2. The new provincial HIV strategy to 2025

During 2014/15, many of the HIV programs that report through OCHART were encouraged to shift their services to reflect the strategic approach set out in the new provincial strategy:

- change the course of the HIV prevention, engagement and care cascade
- focus on populations most affected by HIV
- take a systems approach (i.e. integrating HIV services with other health and social services).

Although funded programs were working with a logic model developed before the new strategy (see Appendix B), they were also aware of and starting to work towards achieving the goals of the new strategy:

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.

> By 2025, new HIV infections will be rare in Ontario and people with HIV will lead long healthy lives, free from stigma and discrimination.

3. How OCHART data are used

The data and information provided through OCHART give funders the information they need to:

1. review the range of services provided
2. identify emerging issues and trends
3. inform planning
4. account for use of public resources.

OCHART data analyses and reports also give community-based programs information about services, trends and client needs that they can use to improve existing services and plan new ones. For data limitations, please see Appendix D.

The purpose of OCHART reporting

Accountability

The reports allow the programs, the AIDS Bureau and the Public Health Agency of Canada to check actual activity against program plans and logic models. They also provide information on how resources were used.

Planning

The reports may identify trends that can be used to adjust services or develop new services locally and provincially.

Quality improvement/evaluation

The reports may provide information that programs can use to strengthen their services.

4. How the report is structured

I. Highlights

This section summarizes significant changes and trends in the 2014/15 OCHART data.

II. HIV programs and services

This section is divided into 8 parts:

1. HIV epidemiology in Ontario — which provides a better understanding of how and where we need to focus HIV programs and 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 testing services — funded by the AIDS Bureau
5. Community-based HIV clinical services — funded by the AIDS Bureau
6. Support services - provided by community-based programs
7. Capacity-building and community development activities
8. A regional snapshot.

Four expected short-term outcomes of these services in 2014/15:

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

III. Hepatitis C teams

This section is divided into 3 parts:

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

IV. Appendices

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

- priority population network information
- detailed funding dollar amounts
- the economic impact of volunteers.

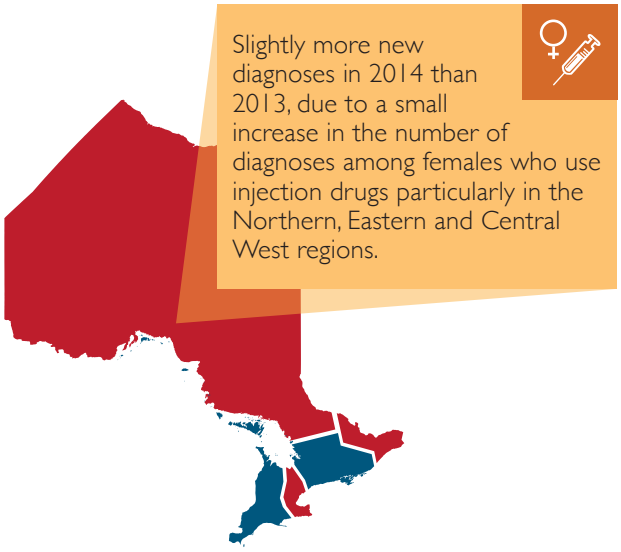
Contents

I. Highlights

A total of 91 organizations (109 programs) reported through OCHART in 2014/15. Here are the highlights and key take home messages from those reports.

HIV in Ontario in 2014

- The number of new HIV diagnoses has been declining over the past decade.
- The number of new diagnoses in 2014 was slightly higher than in 2013, due to a small increase in the number of diagnoses among females who use injection drugs particularly in the Northern, Eastern and Central West regions. This increase may reflect year-to-year variation or be due to other factors such as increased testing.
- The percent of new HIV diagnoses by risk factor/population in 2013 and 2014 for the province is consistent with longer-term trends: increasing in men who have sex with men (MSM) and MSM who inject drugs (MSM-PWID), stable in people who inject drugs (PWID) and decreasing in HIV-endemic and heterosexual populations.
- The peak age at HIV diagnosis for both males and females was 30-34 years, with a shift towards both sexes being diagnosed at older ages. Among males, this shift appears to be related to the aging of males born in the 1960s, who have experienced a higher burden of HIV diagnoses over the past 20 years.
- Over the past 10 years there has been an increase in diagnoses among younger men who have sex with men.



The community-based HIV sector

The community-based HIV services included in this report were provided by a mix of:

- 492 paid full-time equivalent staff
- 1,709 peers involved in education and support programs
- 1,042 peers involved in IDU outreach programs
- 6,112 volunteers.

Prevention, education and outreach services

Practitioners, professionals and service providers continue to be the main target of education presentations as programs work to create culturally sensitive networks of services that are able to serve people with or at risk of HIV.

Education programs target priority populations

The sector is successfully shifting its focus to populations most affected by HIV.

Fewer presentations were targeted to the general public or to students, and more were targeted to three priority populations: Indigenous people, gay, bisexual and other men who have sex with men, and women at risk.

There was a drop in the number of presentations to and for African, Caribbean and Black communities, however, this change was due to staff vacancies as opposed to a lack of interest or focus.

Within community-based AIDS organizations, a larger proportion of education presentations are now being given by staff whose work is focused on a particular population, such as IDU workers, Indigenous-focused workers and local workers who are part of the priority population networks (as opposed to general prevention workers) — the Gay Men's Sexual Health Alliance (GMSH), the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) and the Women HIV and AIDS Initiative (WHAI).

One-on-one education responds to requests for information

Workers spent a significant amount of time delivering one-on-one education — mainly in response to individuals seeking information. The most common requests for one-on-one education were for information about population specific issues and STIs. For the GMSH priority population network members, the most common requests were for information on HIV testing, living with HIV and stigma. In African, Carribean and Black communities, the most common requests were for information on population-specific issues, HIV 101 and living with HIV.

From education to engagement: connecting people with other services

In 2014/15, OCHART asked programs to report any referrals made through their education, outreach and online/social media activities. The types of referrals education workers made in 2014/15 highlighted the complex health and social needs of people who seek services through community-based programs:

- two-thirds were to clinical services such as HIV and other STI testing/sexual health clinics, counselling services, a health care professional or facility and public health
- one-third were to community services such as another ASO, community food banks, population-specific services, social services, addiction programs, employment programs, housing programs and settlement services.

Outreach

In 2014/15, programs reported 12% fewer brief outreach contacts (e.g. handing out pamphlets at a community event) and 18% fewer significant face-to-face contacts — although contacts with individuals from Indigenous and ACB communities increased significantly. Some of the decrease may be due to more accurate reporting. More programs reported using social media for outreach; however, it is difficult to measure the impact of social media initiatives.

IDU outreach

Two different groups of programs report on IDU outreach services: 21 IDU outreach programs that are funded by the AIDS Bureau specifically to provide these services; and between 14 and 16 other programs that also serve the IDU population. For the first time in 2014/15, we looked at the experience of these two groups of programs separately.

The 21 funded IDU outreach programs reported fewer outreach and in-service contacts while other programs that also work with injection drug users reported significantly more outreach contacts and slightly more in-service contacts. However, even with these trends, the funded IDU outreach programs provide the majority of services to this population.

Programs reported making more contacts with people who inject drugs through community agencies/services. More contacts were also made through pharmacies and fewer at methadone clinics. This change is likely due to more pharmacies dispensing methadone.

Programs are effective in retaining clients over time, as well as in attracting new clients. In the Toronto region, a sizeable portion of the increase in unique IDU clients was due to more trans women accessing services. This change is most likely the result of two new program initiatives targeting the trans community.

While most IDU clients are men, female clients tend to use more services. Male clients are more likely to use practical support, education and counselling, but less likely to access referrals to other health and social services.

Over the past three years, programs serving people who use substances distributed about five million more units of safer injection equipment.

"Our GMSH team has had a record high period for online outreach, with 130 online outreach contacts during this reporting period. 88 of those contacts were classified as significant, meaning at least one sexual health related question was asked to the worker. From these contacts, we have made many referrals to HIV/STI testing, community programming and counselling services." – AIDS Committee of Cambridge, Kitchener and Waterloo Area

Anonymous testing services

In 2014/15, eight agencies and programs funded by the AIDS Bureau Ministry of Health and Long-Term Care to provide anonymous HIV testing started reporting their activities and services through OCHART.

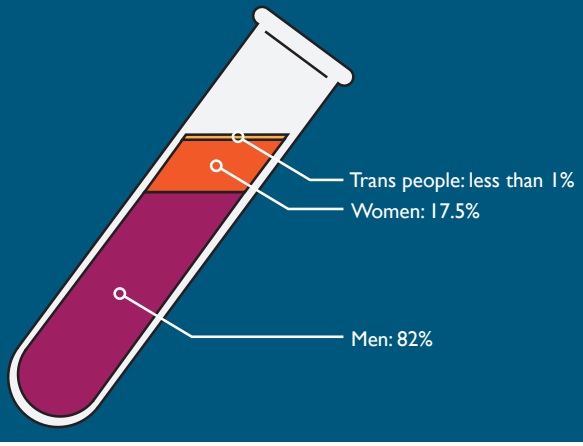
In 2014/15, the eight testing sites administered 8,024 HIV tests (anonymous, nominal, coded) using either a rapid or standard blood draw testing method. Most — 6,875 (86%) — were anonymous tests.

Overall, men accounted for 82% of all HIV tests administered by the eight sites in 2014/15, women for 17.5% and trans people for less than 1%. In 2014/15, 86% of all HIV tests at the eight sites were administered to individuals between the ages of 20 and 49. Most (68%) were for individuals aged 20 to 39. It appears that men – and particularly younger men — seek out anonymous testing.

The eight sites diagnosed 55 HIV infections (0.69% positivity rate). If we look at type of tests administered at these eight sites, anonymous testing resulted in a 0.79% positivity rate, nominal tests a 0.09% positivity rate and non-nominal tests a 0.0% positivity rate. It appears that HIV anonymous testing attracts people who are at risk/undiagnosed.

FIGURE 2
TESTING SERVICES

***8** sites administered **8,024** HIV tests of which **86% (6,875)** were anonymous tests.*



Community-based HIV clinical services

In 2014/15, five community-based HIV clinical services reported for the first time in OCHART. The five clinics served a total of 1,629 people living with HIV (148 new and 1,481 repeat clients). All of the clinics noted that a significant number of clients were people who inject drugs — possibly because people with a history of drug use are more comfortable accessing care in community-based than hospital-based clinics.

Eighty-two percent of clinic clients were male and 18% were female. Most clients were between the ages of 30 and 59, while a quarter of new clients were between the ages of 20 and 29.

The challenges facing clients varied from region to region. Food security, unemployment and poverty were bigger issues for clients in the North than in Toronto, while stigma and mental health were bigger issues in Central West.

The most commonly used services at the clinics were primary care and blood work/lab testing services. Most referrals were to medical specialists followed by HIV specialists. Although clinics reported that 48% of clients were experiencing mental health challenges, only 119 clients were referred to mental health services. This gap might be due to some of the clinics having in-house mental health care available.

Support services

In 2014/15, 61 community-based HIV programs in 47 agencies reported providing support services to an average of 16,323 people, 29% of whom were new clients. Practical assistance continued to be the most commonly used community-based service among people living with HIV, followed by food programs and case management. The need for these services underscores the fact that a significant number of people with HIV who use community-based services are living in poverty and dealing with food insecurity and other social determinants of health.

Among people at risk of HIV, programs reported seeing substantially more demand for scheduled drop-in services, food programs and referrals. Among people affected by HIV, the most commonly used services were food programs, practical assistance, case management, counselling, and referral and health promotion services.

Female clients were more likely than male clients to use interpretation and settlement services, suggesting that a larger proportion of female clients are newcomers. The main services used by trans people were drop-in programs, practical assistance and referrals. With two Toronto-based agencies offering services to trans women sex workers, there were more trans women seeking practical assistance and referrals in 2014/15.

Capacity-building and community development

Capacity-building and community development activities occur at both the provincial and the local level.

At the provincial level, 11 capacity building programs provided a total of 727 KTE, mentorship/coaching and capacity-building sessions in 2014/2015 – down 19% from 2013/14. However, this change is likely due to a shift in how some capacity-building sessions are now being delivered (i.e., in a group rather than a one-to-one format). Although there were fewer capacity-building sessions, the number of people trained in 2014/15 is similar to previous years.

Provincial capacity-building organizations reported moving away from HIV-specific training and toward the social determinants of health, disclosure and legal issues. They gave more presentations focused on healthy sexuality, boundaries and GIPA/MIPA.

There were more community development meetings in 2014/15 (628) than in 2013/14 (586), and more of these meetings were held with front-line workers, rather than executive directors and board members. While meetings continued to address issues such as program planning and network building, there were more meetings related to governance, inter-agency cooperation and strategic planning.

In terms of impact, five provincial capacity-building organizations that received ACAP funding in 2014/15 reported providing 163 presentations to a total of 534 participants. Of those: 464 were asked about knowledge change — of which 379 (80%) reported a change as a result of the capacity-building presentation or workshop; and 350 were asked about behaviour change — of which 279 (71%) reported changing how they delivered services based on what they had learned.

In 2014/15, the OHTN reported for the first time in OCHART as one of the 11 provincial capacity-building organizations. Of the 119 active research projects funded by the OHTN in that year, 118 were focused on at least one priority population. Almost half were focused on people living with HIV, almost a quarter on gay men and the remainder on people who use drugs, African, Caribbean and Black populations, women at risk and Indigenous people.

OHTN staff organized more than 173 education and training events that reached a total of 2,150 people, trained more than 30 peer researchers and posted 110 research-based videos that were viewed by 11,681 visitors. OHTN scientists participated in more than 10 research projects and produced 21 peer-reviewed articles, 10 publications in the grey literature and 40 resources. The OHTN's knowledge synthesis and knowledge exchange teams developed 14 rapid responses on topics that ranged from case management to PTSD among people living with HIV to the impact of crystal methamphetamine on the risk behaviours of gay men. OHTN staff also gave 67 presentations to a total of 3,052 participants who were mainly ASO service providers, HIV clinical care providers, people at risk, non-ASO service providers and policy makers.

Staff of the OHTN Cohort Study, which follows more than 5,000 people living with HIV in Ontario, enrolled 425 new participants in 2014/15, gave 21 presentations and contributed data for a number of studies and articles.

At the local level, community-based HIV programs worked to enhance the capacity of their communities to serve people with or at risk of HIV. The number of community development meetings were up – mainly due to more meetings organized by IDU outreach programs.

A significant portion of local capacity-building is done by executive directors and program managers — who nurture partnerships with other health and social services — and by the priority population networks (WHAI, GMSH, ACCHO).

Community development activities help to build coalitions and networks, plan community events, share information and create new partnerships. Most of these activities involve other agencies in the community, other ASOs, population-specific services and social service agencies. In particular, programs reported an increase in meetings/partnerships with population-specific services.

Hepatitis C services

About 4,214 confirmed hepatitis C cases were reported in Ontario in 2014 — similar to the previous three years. The number of new cases was highest and rising in the North, specifically the Northwestern, Thunder Bay District and Sudbury and District public health units. About 60% of hepatitis C cases overall are in people who are current or past users of injection drugs and 20% are in people from countries where hepatitis C is endemic. In Northern Ontario, at least 88% of new cases were in people who inject drugs.

Men accounted for 62.2% of new hepatitis C cases. Most new cases were in people between the ages of 25 and 29.

The province's hepatitis C teams served an average of 5,932 clients — up 15% from the previous year. Of these clients:

- 1,871 were new clients living with HCV — up 19%
- 1,998 were active clients with HCV — up 18%
- 1,579 were at-risk clients — up 11%
- 484 affected clients

Most clients were over age 40 — and 32% of active clients were over age 55 — up 12% from 2013/14.

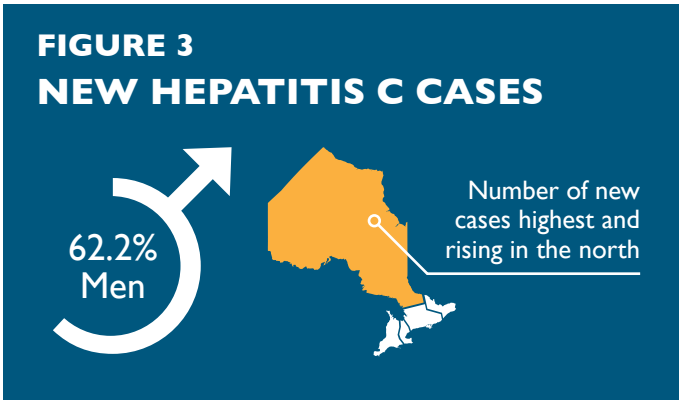
With the introduction of new, shorter and better tolerated HCV treatments, HCV teams reported the following treatment outcomes in 2014/15:

- 3,869 people engaged with the HCV teams
- 3,172 clients in the pre-treatment phase – 493 more than the previous year
- 218 spontaneously cleared the virus
- 557 clients started on treatment
- 488 completed treatment
- 54 clients withdrew from treatment (39% fewer than in the previous year). Fifteen of the 54 withdrawals were due to side effects from the treatments.

With the new treatment regimens, some clients moved through all three treatment stages within a 6-month reporting period.

The large gap between the number of clients engaged with treatment and the number who completed treatment in 2014/15 is mainly due to the fact that many were not yet eligible for drug coverage. However, because of the work of the HCV teams, far fewer clients were lost to follow-up (-52%) or experienced treatment interruption due to social instability (-55%).

HCV teams actively engage people with lived experience in delivering education and outreach services. Peers provided a wide spectrum of services and were actively involved in distributing resources, and planning and implementing awareness campaigns and outreach activities. On average, 345 peers delivered services in each half of 2014/15.



II. HIV programs and services

1. HIV epidemiology

Key trends for 2014

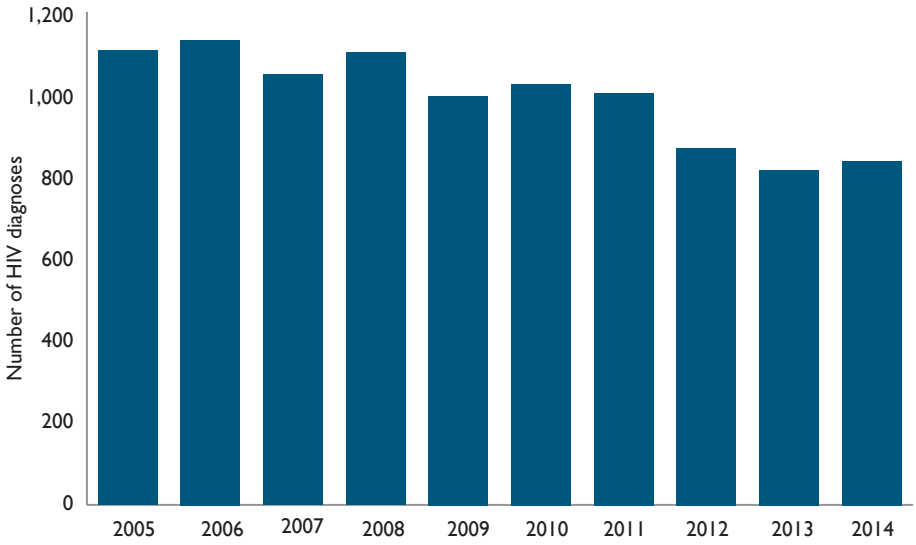
- The number of new HIV diagnoses has been declining over the past decade.
- The number of new diagnoses in 2014 was slightly higher than in 2013, due to a small increase in the number of diagnoses among females who use injection drugs particularly in the Northern, Eastern and Central West regions. This increase may reflect year-to-year variation or be due to other factors such as increased testing.
- The percent of new HIV diagnoses by risk factor/population in 2013 and 2014 for the province is consistent with longer-term trends: increasing in men who have sex with men (MSM) and MSM who inject drugs, stable in people who inject drugs and decreasing in HIV-endemic and heterosexual populations.
- The peak age at HIV diagnosis for both males and females was 30-34 years, with a shift towards both sexes being diagnosed at older ages. Among males, this shift appears to be related to the aging of males born in the 1960s, who have experienced a higher burden of HIV diagnoses over the past 20 years.
- Over the past 10 years there has been an increase in diagnoses among younger men who have sex with men.

The epidemiological data is for the 2014 calendar year, while the data on activities is for the 2014/15 fiscal year.

New HIV diagnoses

Quick breakdown: In 2014 there were 837 HIV diagnoses in Ontario.

FIGURE 4 Number of new HIV diagnoses in Ontario, 2005-2014



Are new HIV infections decreasing? A decreasing trend in new HIV diagnoses may mean that the rate of new HIV infections in Ontario is decreasing — but we cannot say for sure. A new HIV diagnosis is not the same as a new HIV infection: some people can be infected for years before being diagnosed, and trends in diagnoses may be related to changes in HIV testing patterns.

Also, new HIV diagnoses include people who became HIV positive outside Ontario, but moved to the province and were tested for the first time here.

Trends over time

The number of new HIV diagnoses in 2014 was higher than the 815 in 2013, but still lower than most years in the past decade when there were generally more than 1,000 HIV diagnoses each year.

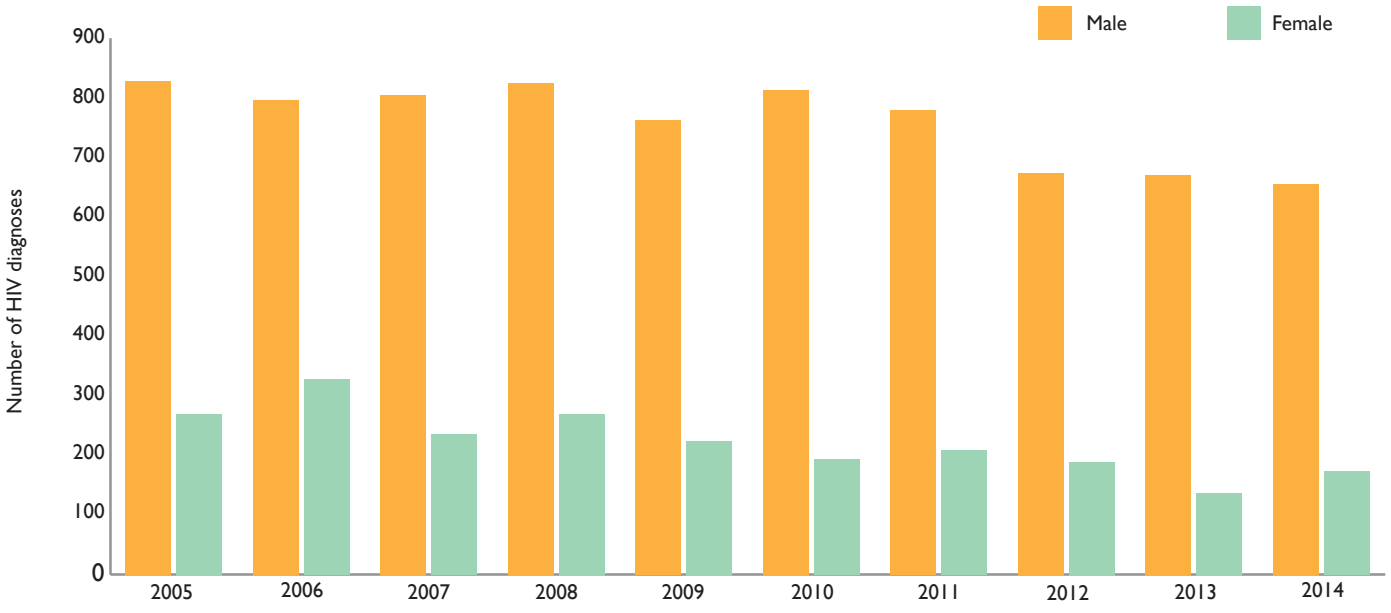
By sex/gender

Quick breakdown: In 2014, 656 (79%) diagnoses were in males and 174 (21%) in females in Ontario (sex/gender was unknown for 7 diagnoses).

Missing data: The only current options on HIV testing forms are male and female. If someone newly diagnosed with HIV identifies with a gender other than male or female (for example, transgender), this information is not currently collected. Revisions to the testing form to gather more information on gender and ethnicity are currently underway. Please see page 13 for more information.

Females	Males
Snapshot: Women diagnosed with HIV were most commonly Black (51%), from an HIV-endemic country (48%) and between the ages of 30-34 (21%).	**Snapshot:** Men diagnosed with HIV were most commonly White (56%), men who have sex with men (73%), and between the ages of 30-34 (17%).
Trends over time: The number of new HIV diagnoses among females has generally decreased over the past decade. The number of new HIV diagnoses in 2014 (174) was higher than in 2013 (138) — although still lower than most years in the past decade.	**Trends over time:** The number of new HIV diagnoses among males has generally decreased over the past decade. This trend continued in 2014 (656) compared to 2013 (671).

FIGURE 5 Number of new HIV diagnoses in Ontario by sex/gender, 2005-2014



Exposure category or population? Each new HIV diagnosis in Ontario is assigned to what is known as an exposure category. In this report we refer to these categories as populations. Populations include men who have sex with men (MSM), people who inject drugs (PWID), MSM who are also PWID (MSM-PWID), HIV-endemic (born or lived in a country where HIV is endemic), people who acquired HIV through heterosexual sex and other. If a new HIV diagnosis belongs to more than one population, a set of rules are used to assign the diagnosis to a single population. Therefore, these populations are mutually exclusive.

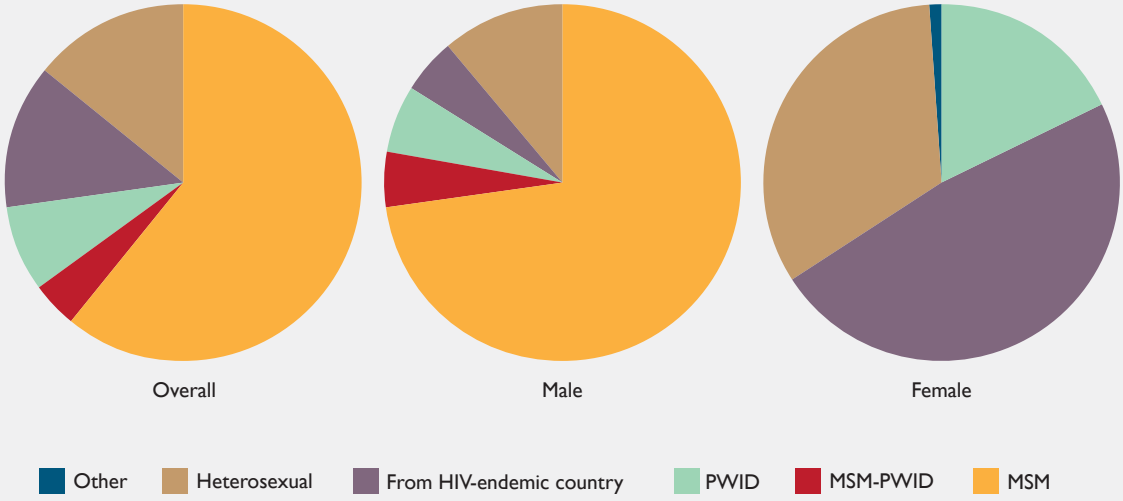
Missing data: In 2014, information on population was missing for about 25% of new HIV diagnoses, which was similar to previous years.

By population

Quick breakdown: In the last two years (2013 and 2014 combined), the majority of new HIV diagnoses were among men who have sex with men (61%), followed by HIV-endemic (14%) and heterosexual contact (13%).

Differences by sex/gender: The most commonly affected populations differed by sex/gender. For males it was men who have sex with men (73%) and heterosexual contact (11%) and for females it was HIV-endemic (48%), heterosexual contact (33%) and people who inject drugs (18%).

FIGURE 6 Percent of new HIV diagnoses attributed to different populations (where known), overall and by sex/gender, 2013 and 2014 (combined)



Trends over time: The percent of new HIV diagnoses attributed to certain populations in 2013-2014 is generally consistent with trends observed over the past decade: increasing among men who have sex with men (MSM) as well as men who have sex with men and also use injection drugs (MSM-PWID), remaining stable among people with injection drug use (PWID) and decreasing among HIV-endemic and heterosexual populations.

These overall time trends were observed for both males and females (Figures 5 and 6) — with a couple of exceptions among females: the percent of new female diagnoses attributed to heterosexual contact has varied, while the percent attributed to people who inject drugs increased slightly in the last two years (2013 and 2014 combined).

FIGURE 7 Percent of new *male* HIV diagnoses attributed to different exposure categories (where known), 2005-2014

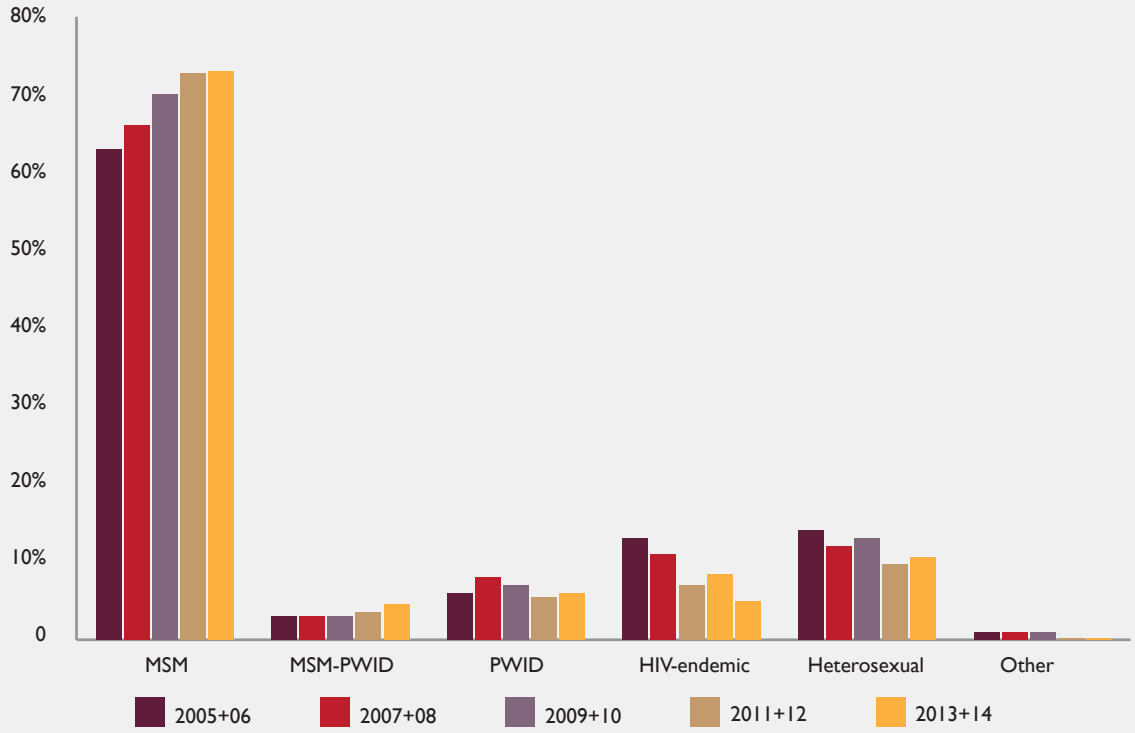
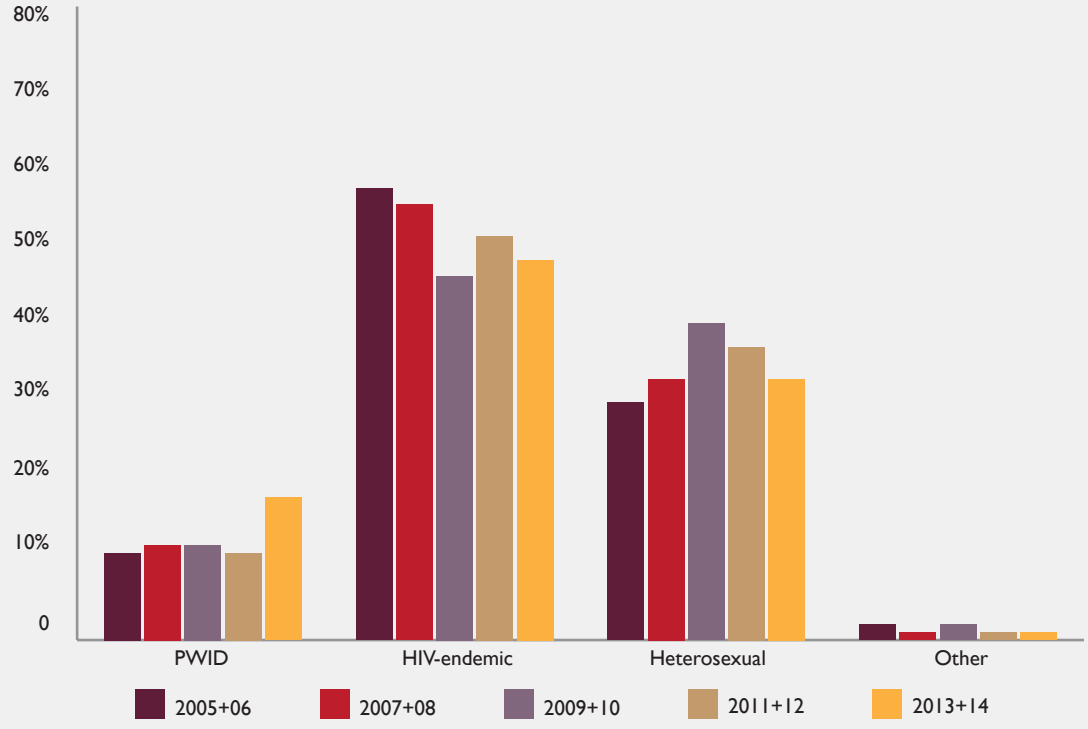


FIGURE 8 Percent of new *female* HIV diagnoses attributed to different exposure categories (where known), 2005-2014



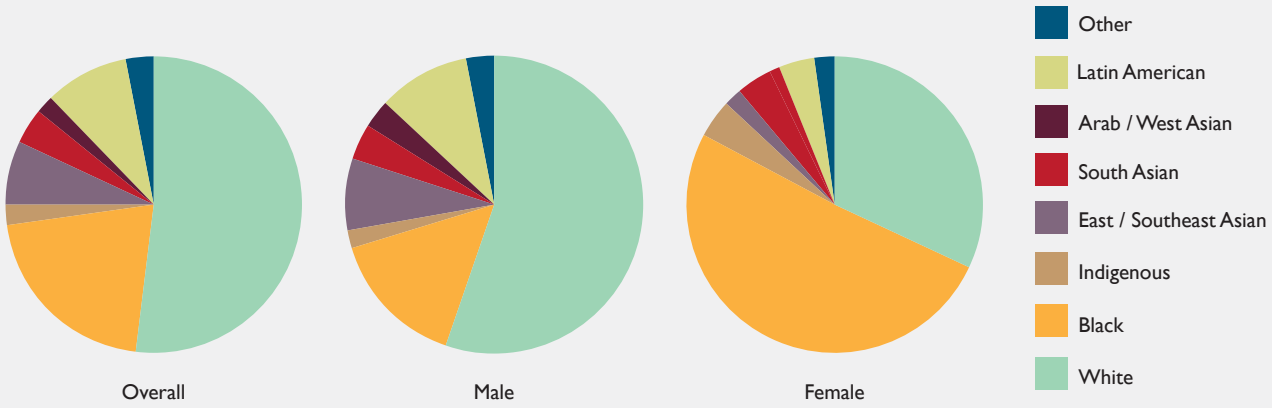
By ethnicity

Quick breakdown: In the last two years (2013 and 2014 combined), the majority of new HIV diagnoses were among white people (52%). The next most common ethnicity was Black (21%). Overall, 2% of new HIV diagnoses were among people who identified as Indigenous.

Differences by sex/gender: The most common ethnicities differed by sex/gender. For males it was White (56%), Black (15%) and Latin American (10%). For females it was Black (51%), White (32%) and Indigenous, South Asian and Latin American (all 4%).

Missing data: In 2014, information on ethnicity was missing for about 40% of new HIV diagnoses. The proportion of diagnoses with missing ethnicity data has been relatively constant since 2009 when ethnicity started to be collected.

FIGURE 9 Percent of HIV diagnoses attributed to different ethnicities (where known), overall and by sex, 2013 and 2014 (combined)



Trends over time: Since 2009, trends in the proportion of new HIV diagnoses attributed to different ethnicities have varied. This is true for both males and females (Figures 8 and 9).

FIGURE 10 Percent of new *male* HIV diagnoses attributed to different ethnicities (where known), 2009-2014

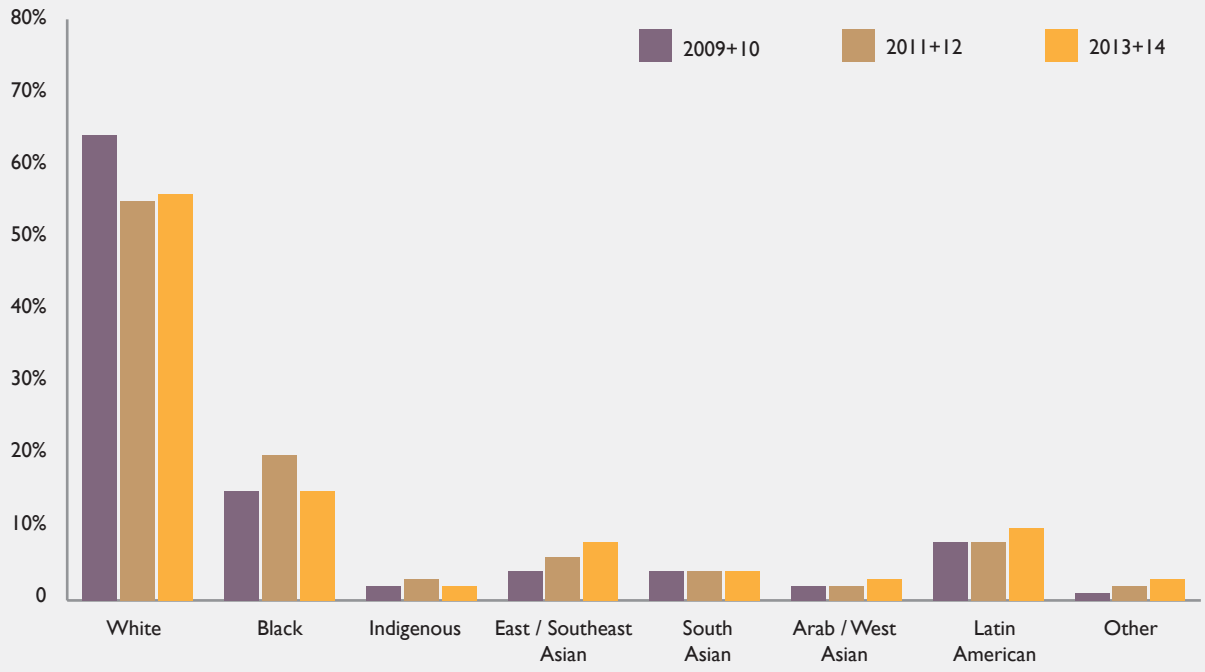
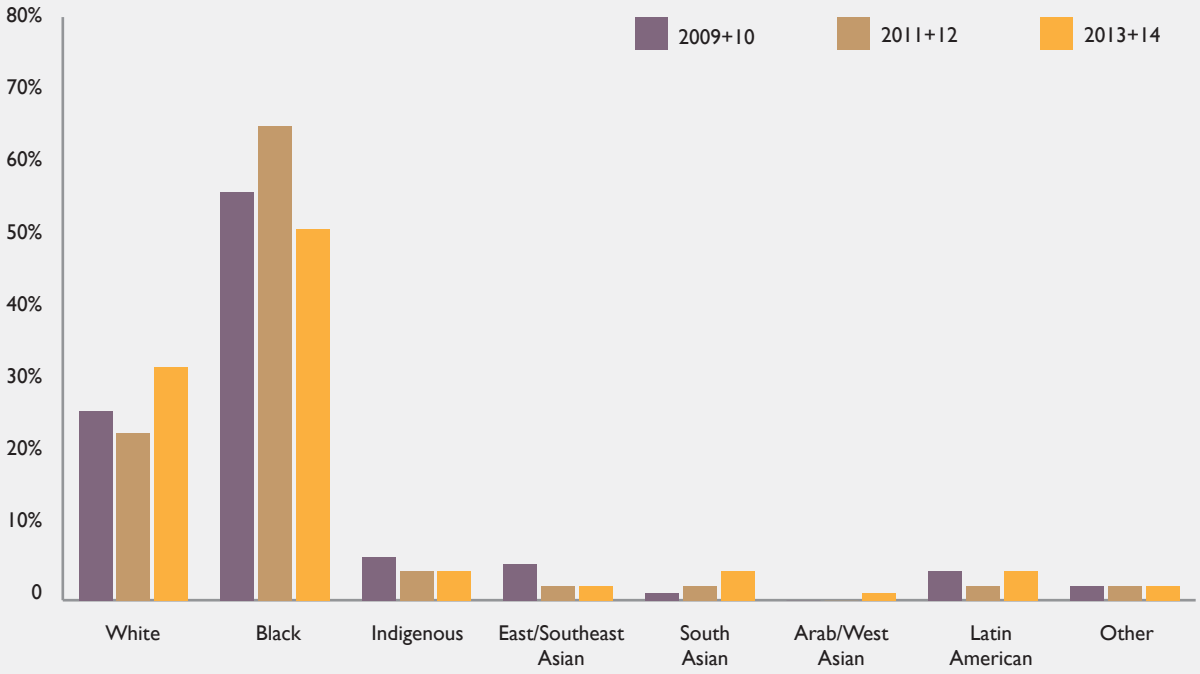


FIGURE 11 Percent of new *female* HIV diagnoses attributed to different ethnicities (where known), 2009-2014



By age

Quick breakdown: From 2012 through 2014 combined, 18% of diagnoses were in people between the ages of 30 and 34 — for both males (17%) and females (21%).

Differences by sex/gender: Age at diagnosis was generally younger for males and older for females. This trend did not extend to the 45-49 age category (people born in the 1960s), where there were more diagnoses in males than female.

FIGURE 12 Percent of new HIV diagnoses attributed to different age groups, by sex/gender, 2012 to 2014 (combined)

Trends over time: By comparing the proportion of new HIV diagnoses by age group for different five-year time periods, we can see the following trends by sex/gender:

Females	Males
Trend: There has been a shift towards older age at diagnosis, with females aged 40+ accounting for an increasing percentage of diagnoses. Despite this shift, the peak age has remained at 30-34 years over the past two decades.	**Trend**: There has been a shift towards older age at diagnosis – mainly due to the aging of men born in the 1960s, who have experienced a higher burden of HIV diagnoses over the past two decades. Over the past 10 years there has also been a shift towards younger age at diagnosis, primarily among men who have sex with men.

Generational trends. While the trend among men born in the 1960s was present for males both known and not known to be MSM, the shift towards younger age at diagnosis was only seen for MSM. The most recent time period (2012-2014) is the first where HIV diagnoses were not most common among men born in the 1960s. These generational trends may be related to differences in attitudes and beliefs, HIV prevalence, HIV risk behaviours, and/or rates of HIV testing.

Future directions

The AIDS Bureau, Public Health Ontario, the Public Health Agency of Canada and the OHTN — the agencies involved with the Ontario HIV Epidemiology and Surveillance Initiative (OHESI) — are taking steps to improve the description of HIV trends in Ontario. This includes:

- Changing HIV testing forms to collect data on gender identity (e.g. transgender identities), ethnicity and test history (e.g., first or repeat positive test).
- Moving from exposure categories to priority populations. Currently, each new HIV diagnosis is assigned to one mutually exclusive exposure category (referred to as a population in this report). Future reports will present HIV data according to the priority populations identified in the provincial HIV strategy, where individuals can be counted more than once if applicable (e.g. men who have sex with men and who come from a country where HIV is endemic).
- Developing new statistical methods for dealing with missing data to provide better estimates of trends.

Sources of information

This report uses information provided by the Public Health Ontario Laboratory to OHESI.

Whenever someone gets an HIV test in Ontario, the health care provider conducting the test fills out an HIV testing form which is sent to Public Health Ontario. This form collects information on the individual getting tested for HIV, including age, sex and risk factors. If an individual has a positive HIV result, the Public Health Ontario Laboratory sends a second form to the health care provider who ordered the test which also collects this information. Data from both forms are combined and used to describe trends in HIV diagnoses in Ontario.

OHESI
Ontario HIV Epidemiology and Surveillance Initiative

What is the Ontario HIV Epidemiology and Surveillance Initiative (OHESI)?

OHESI is a new collaboration between the AIDS Bureau, Public Health Ontario, Public Health Agency of Canada, and the Ontario HIV Treatment Network.. This initiative is being led by the Applied Epidemiology Unit at the OHTN. The main objective of OHESI is to understand, monitor and translate the epidemiology of HIV in the province of Ontario.

To find out more and to sign up for updates, visit www.ohesi.ca.

What are the priority populations?

1. People living with HIV/AIDS
2. Gay, bisexual, and other MSM, including trans men
3. African, Caribbean, and Black communities, including people from HIV-endemic countries
4. Indigenous men and women
5. Men and women who use drugs
6. At risk women, including trans women.

2. HIV services in Ontario

Who we are and what we do

The HIV programs and services funded by the AIDS Bureau and the Public Health Agency of Canada work across the HIV prevention, engagement and care cascade.

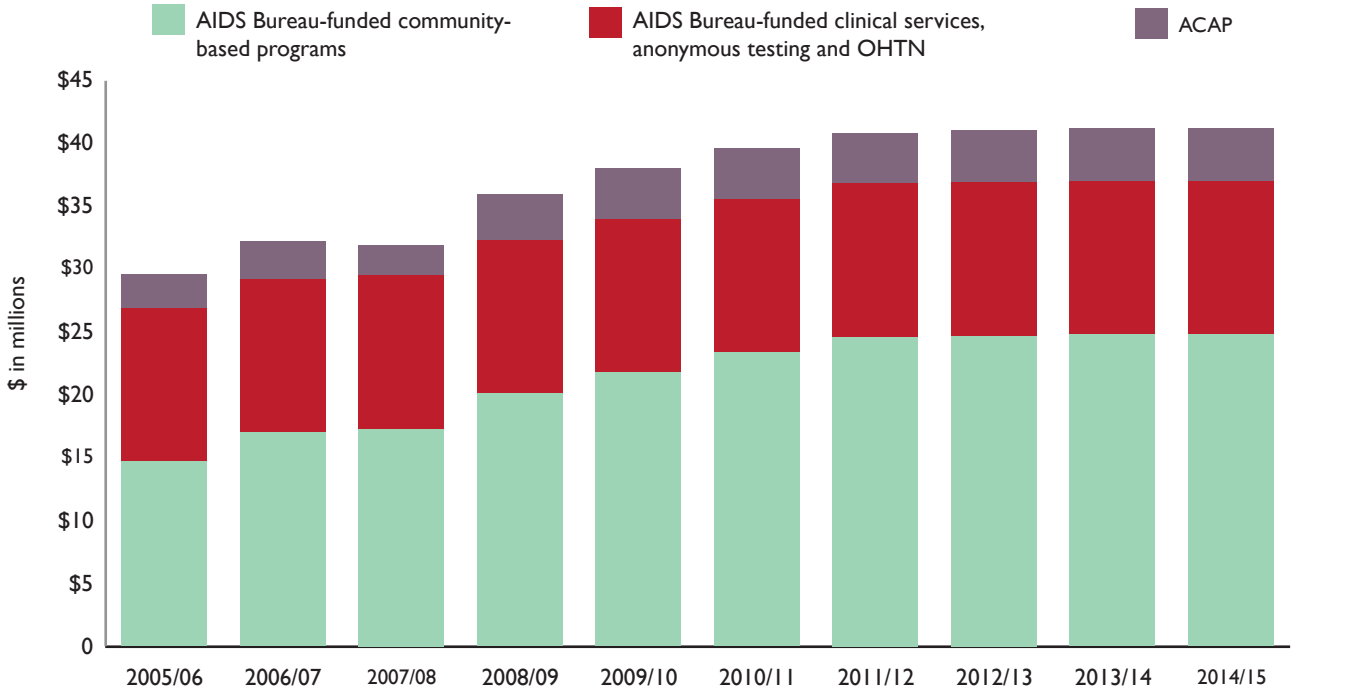
The funding landscape in 2014/15

Key trends

- AIDS Bureau and ACAP funding for education, outreach and support services has remained stable at $29 million over the past two years.
- Programs have been successful in leveraging other provincial government funding.
- Fundraising was down in 2014/15 but a number of programs found other sources of funding.

Figure 15 shows the funding amounts allocated by the AIDS Bureau and ACAP over the past 10 years. It includes — for the first time — the $12.2 million the AIDS Bureau invests each year in anonymous testing services, community-based HIV clinical services and the OHTN.

FIGURE 13 Annual AIDS Bureau and ACAP funding as reported by funders 2005/06 – 2014/15



Funding for education, outreach and support services

Figure 17 illustrates the different sources of funding reported by community-based programs that provide education, outreach and support services (AIDS service organizations and non-AIDS organizations). Taken together, the AIDS Bureau and ACAP account for 56% of these programs' funding. The AIDS Bureau continues to be the primary source of core (operational) funding, providing 48% of total funding (45% of total funding for dedicated AIDS service organizations and 37% of funding for other community-based programs) whereas ACAP provides multi-year project funding that accounts for 8% of funding.

In addition to AIDS Bureau and ACAP funding, these organizations reported receiving an additional $22.6 million from other sources in 2014/15 — both government and non-government — up slightly from the previous year (see Figure 16).

In terms of other government funding sources:

- municipalities accounted for 8% — similar to last year
- other government ministries and other Ministry of Health and Long-term Care funding accounted for 12% — up from the previous year.

The total of all non-government funding — fundraising, charitable foundations, private sector, Trillium, United Way and "other" — was up by about $450,000 compared to 2013/14. However, most of that increase was due to 35 agencies reporting "other" funding – several for the first time, while most traditional charitable sources of funding (i.e. fundraising, Trillium) declined last year. "Other" funding increased by 100% ($1.2 million) with one program reporting a four-fold increase in their "other" funding.

This is the second consecutive year the amount of fundraised dollars has declined, highlighting the challenges agencies face persuading donors that HIV is still an issue. 2012/2013 was a record year for fundraising (largely due to an important anniversary for one annual fundraising event). Numbers reported this fiscal are higher than 2011/12, so the change may be a return to pre-2012/13 levels. For actual dollar amounts over the past four years, see Appendix E.

FIGURE 14 Annual additional funding as reported by funded programs

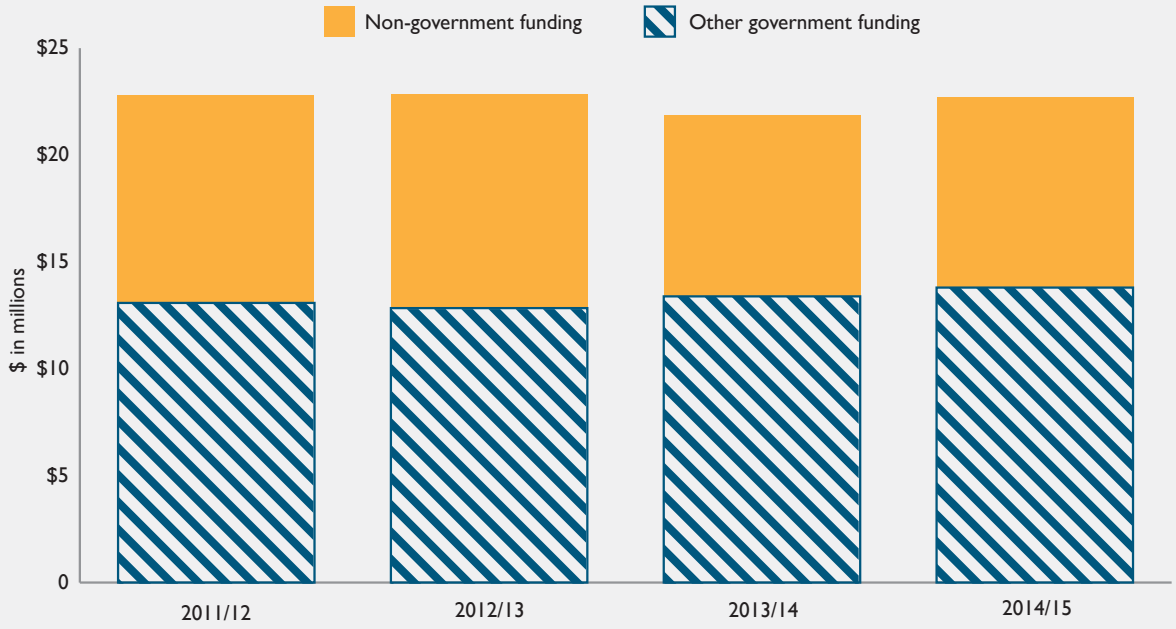
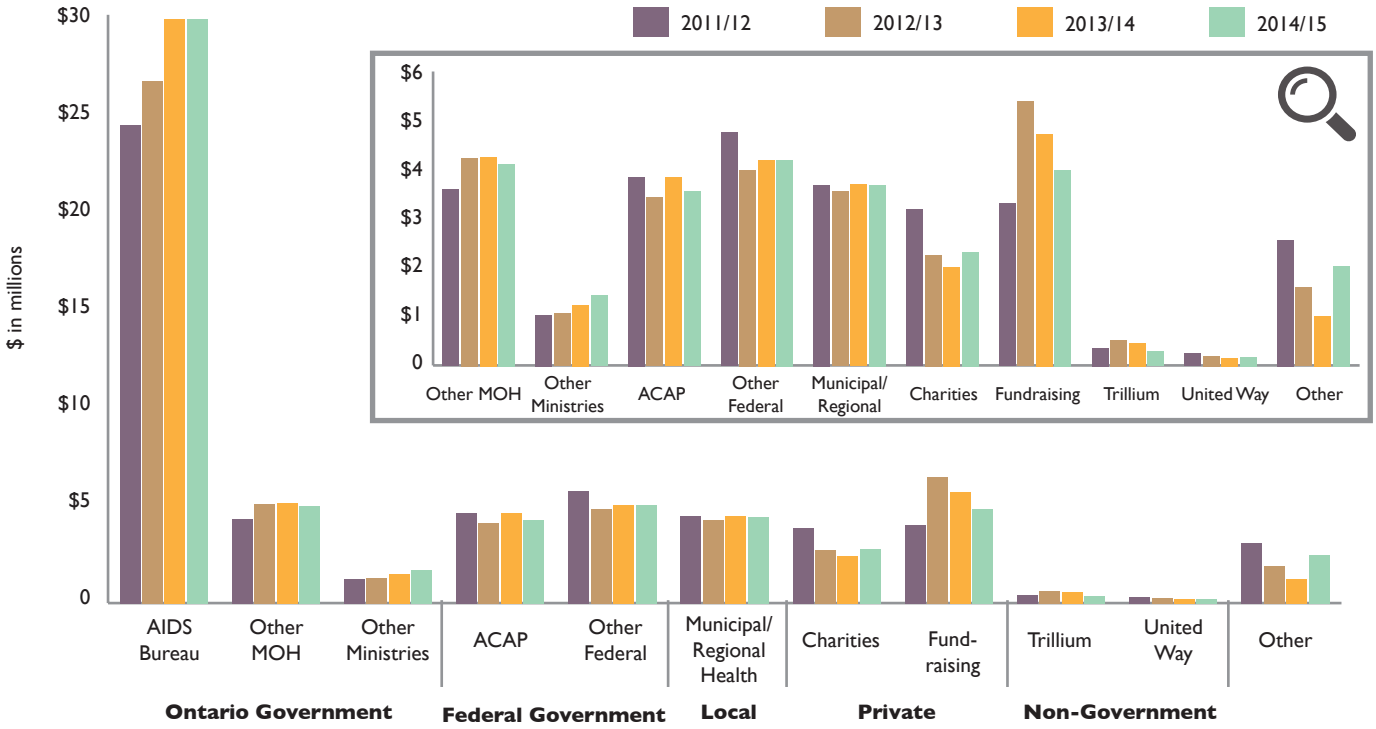


FIGURE 15 All sources of community-based AIDS organisations funding 2011/12 – 2014/15
(OCHART q. 5.1, 5.2 and 5.3)



* NOTE: ACAP and AIDS Bureau funding was underreported in program submissions. Figures 15 and 17 have been adjusted to reflect actual dollars invested.

Who makes the programs work?

Key trends

- Number of paid staff consistent with 2013/14.
- Number of volunteers up almost 10% but number of volunteer hours down by 13%.
- 39% increase in the number of peers involved in IDU outreach programs – mainly due to two organizations.
- Highest number of students since OCHART began tracking student involvement.
- Key challenges to enhancing staff capacity include: changing client demographics in some communities, changing client needs, human resource issues (e.g. turnover) and costs associated with training.
- Despite these challenges, programs reported that 492 paid staff participated in a total of 6,387 training opportunities.

Programs that provide education, outreach and support services rely on a mix of paid staff and volunteers. They also actively engage peers in their work. Peers are defined as people with or at risk of HIV and/or as people who share characteristics with the program's target population(s), such as culture, language, lived experience, gender identity and sexual orientation, age or health status. This year's numbers include people engaged in anonymous testing sites, community-based HIV clinical services and the OHTN, which rely mainly on paid staff.

Progress on GIPA/MIPA

"We have increased the number of PHA peers who volunteer with us over the past 4 years from 7 active to 65 this past fiscal year."
— Fife House

"We have seen an increase in volunteers who want to work with the coordinator in providing speaks and assisting with outreach."
— HIV/AIDS Regional Services

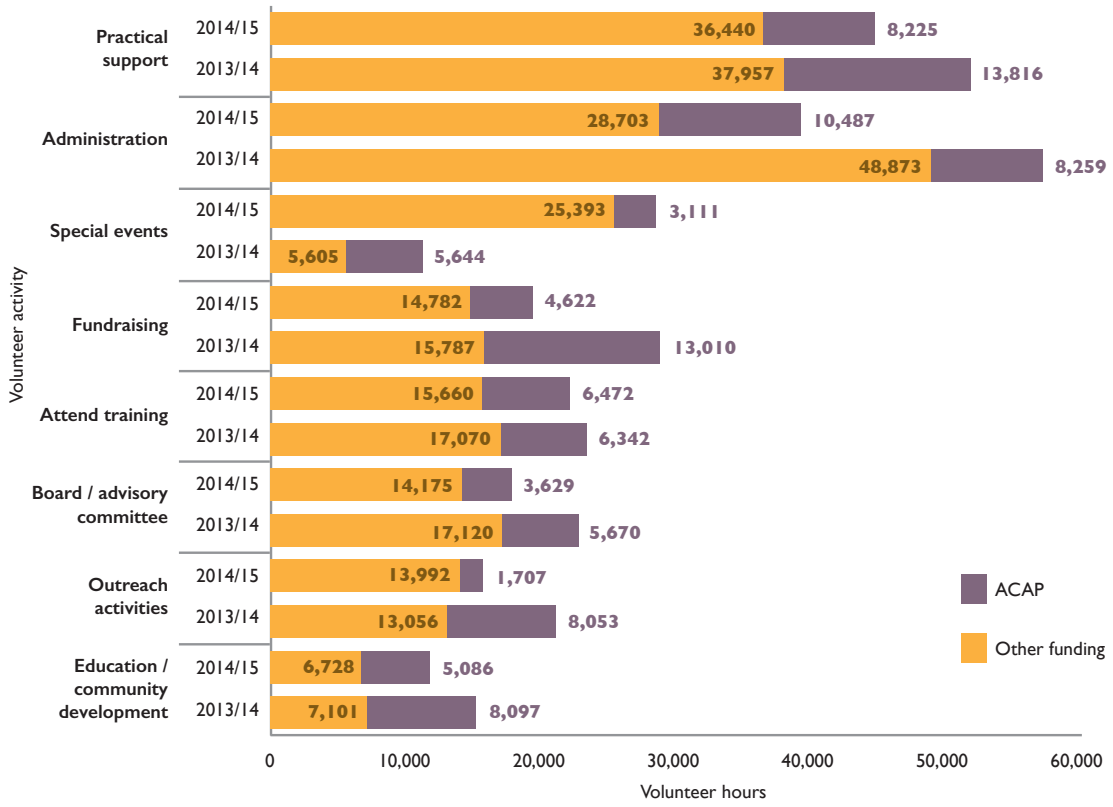
- Funded programs reported having 492 **paid full-time equivalent staff (FTEs)** in the second half of the fiscal year (H2), including the 64 FTEs reported by anonymous testing sites, community-based HIV clinical services and the OHTN. When these programs are removed from the analysis, community-based HIV programs reported 1 fewer FTE than in 2013/14.
- 55 unique programs — up three from last year — reported having engaged a total of 1,709 **peers** (up from 1,438 in 2013/14) in prevention and education activities (i.e., providing face-to-face and online outreach, distributing resources, giving presentations and workshops, and developing and delivering awareness campaigns).
  Note: organizations define peers in different ways. In some cases, peers are people living with or at risk of HIV. In others, they are people who identify as a member of a priority population.
- 33 unique programs — five of which have ACAP funding — reported engaging 1,042 **peers in IDU outreach**: an increase of 39% over the previous year. Most organizations reported a slight increase and two organizations account for most of the increase. IDU peers are defined as people with lived experience of using substances. These peers provided significantly more hours of service than last year, distributing materials and providing practical support than in the previous year.
- 67 unique programs — 27 of which have ACAP funding — reported engaging 6,112 **volunteers** (up from 5,907 in 2013/14) who contributed 230,216 hours of service — down from 264,998 in 2013/14. Over a third of volunteers were recruited through initiatives funded by ACAP. Compared to previous years, fewer volunteer hours were reported in every category except special events, which saw a 150% increase in hours — likely due to World Pride activities in Toronto.
- 201 **students** — the highest number since OCHART began tracking students — provided 65,709 hours of service. Students assisted mainly with education and community development.

Note: there may be some overlap in these numbers as the definition of "volunteer" varies. Some agencies may also count students and some peers as volunteers.

FIGURE 16

WHO MAKES THE PROGRAMS WORK?

FIGURE 17 Trends in volunteer hours/services (OCHART q. 12.2)



Trends in volunteer activities

Africans in Partnership Against AIDS

In this reporting period, we observed larger number of volunteers and volunteer hours. APAA's massive outreach activities during the past year and our close relationship with newcomer shelters, universities, colleges and high schools assisted us to attract a more diverse volunteer force.

2-Spirited People of the First Nations

Yes, there has been an increase in non-Aboriginal people who wish to volunteer due to the amount of outreach at other organizations.

MORE INTEREST IN VOLUNTEERING

MORE MEMBERS OF PRIORITY POPULATIONS

HIV/AIDS Regional Services

As the gay men's program is taking off we have seen an increase in gay men wanting to get involved.

Peterborough AIDS Resource Network

We have seen an increase in requests to work specifically with our WHAI, Rainbow Youth and Harm Reduction initiatives.

Ontario HIV and Substance Use Training Program OHSTUP

During this reporting period we have seen a dramatic increase in requests to deliver trainings on drug stigma, substances 101, women-specific harm reduction workshops, and trainings on reserves. As the program trainings evolve based on community's needs, we have moved towards seeking out and utilizing peers who have former or current substance using experience so that they may speak about stigma they experienced and share their personal knowledge of drug use.

The economic impact of volunteers

Community-based HIV/AIDS organizations depend on volunteers to fulfill their mission. In 2014/15, volunteers provided $4.7 million in in-kind labour (down slightly from $5.1 million in 2013/14). To calculate the economic impact of your volunteers, see Appendix G for the formulas.

> The number of volunteers may not be increasing at a high rate, but the quality of work being done is increasing. This is mainly due to the volunteers becoming more passionate about the work we do, and finding ways to become engaged on a higher level, which involves attending workshops and training opportunities.
> — AIDS Committee of Windsor

> During the H2 Reporting period there was a significant increase in response to the AIDS Awareness Week Red Scarf Project, with total scarves knitted by volunteers increasing by 140% over the previous year. A conservative 3689 volunteer hours were logged with 1220 scarves being knitted and distributed by volunteers."
> — Regional HIV/AIDS Connection

OLDER AND YOUNGER VOLUNTEERS

AIDS Committee of Cambridge, Kitchener, Waterloo & Area

The average age of volunteer applicants has been trending lower.

Women's Health In Womens Hands

Older women were interested in volunteering, and getting involved in community education.

Asian Community AIDS Services

Volunteers have been younger (ages 20 to 25) as they are looking to connect with their peers and community.

NEW VOLUNTEER PROGRAMS

AIDS Committee of Durham Region

Spring March Break "Camp" targeting at-risk youth was developed; 12 youth enrolled from group homes and alternative schools, most identified as trans, queer or questioning or were street involved.

Regional HIV/AIDS Connection

We are developing a process and system for a year-round Volunteer program focused on the Red Scarf project (AIDS Awareness) in the six counties served.

Teresa Group

We have been participating in the Toronto HIV Network volunteer project to partner with other ASOs and offer joint basic training modules for volunteers and are excited that the pilot training should be up and running soon.

Women's Health In Women's Hands

We are also developing culturally appropriate workshop resources for volunteers to use when conducting community outreach and education.

Committee for Accessible AIDS Treatment

During this reporting period we mentored and supported 4 of our peers to develop a mental health group mentoring program that will support our peers with mental health and addiction issues. We also supported 5 peers to help facilitate employment preparedness training.

Africans in Partnership Against AIDS

We capitalized on the linguistic competency of our ACB volunteers to engage them in designing HIV awareness resources in various languages. For instance, with the help of our volunteers, we translated APAA's Islam and HIV Brochure into French and 2 more African languages. APAA volunteers provided close to 8,000 volunteer hours.

Peel HIV/AIDS Network

Volunteers have been increasing their leadership in programming over the last year and taking greater ownership of activities along with planning and implementation.

MORE VOLUNTEER CAPACITY (ACAP)

Asian Community AIDS Services

Volunteers involved at World AIDS Day (WAD) event to raise awareness of AIDS and also a mini-fundraising event at TTC subway stations. Volunteers enjoyed interacting with the public during the WAD event.

Centre for Spanish Speaking Peoples

Our volunteers have been working on technology issues, such as making the radio shows recorded on site and … available online.

HIV/AIDS Regional Community Health

Regional Rural Education Project: Pride & Prejudice in Guelph and many education projects (such as in-school presentations and outreach activities) have been successful as a result of volunteer involvement.

VOLUNTEERS INVOLVED IN INNOVATIVE PROJECTS

AIDS Committee of Windsor

We also work with WEAVA to showcase and recognize volunteer engagement across the community through channels such as the Windsor Star.

NEW VOLUNTEER RECOGNITION STRATEGIES

AIDS Committee of Durham Region

Our Youth Outreach Coordinator hosted a placement student from Centennial College's Community Development Program. Her main project was to develop and implement a 3 day March Break Camp for High school students based on HIV/AIDS Education.

AIDS Committe of Windsor

This past 6 months we have had 4 student placements in Chatham and 7 in Windsor, which has enhanced the community partnership between ourselves and the local educational institutions.

Fife House

We continue to have many students on placement with us, including some who are PHAs, and we have hired some of them into our Relief pool after their placement.

Ontario AIDS Network

PLDI had 5 graduates who received 50 hours of life coaching combined. PLDI uses the View from the Front Lines to show our participants how meaningful and valuable volunteering is.

MORE STUDENTS (ACAP AGENCIES)

3. Prevention, education and outreach services including IDU outreach

Virtually all community-based organizations funded by the AIDS Bureau and ACAP (ASOs and non-ASOs) are involved in education, and most offer outreach services. Over the past few years, community-based programs have focused their education and outreach programs on the populations most affected by HIV.

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.

The goal of these services is:

1. to 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 and/or affected by HIV/AIDS.

Key trends

- Programs reported giving a total of 3,733 presentations, down 14% from 4,262 in 2013/14. While most agencies reported fewer presentations, three agencies that did not have a full complement of staff during the year accounted for most (65%) of the decline.
- The total number of ACAP-funded presentations was down 5% from 1,102 to 1,044.
- The number of participants reached by presentations was also down in 2014/15 due mainly to programs trying to connect with hard-to-reach populations and one agency reporting serious issues accessing prison populations (often related to labour issues within the correctional system). The number of participants in ACAP-funded presentations remained stable – perhaps because those initiatives have specific objectives with a more defined target population.
- Most referrals from education programs are to HIV testing, STI testing or counselling services.
- Most presentations are given at health service agencies, schools and community centres, regardless of funding source.
- Programs reported fewer presentations to the general public (from 684 to 418), which is not considered a priority population.

Trends in education presentations

Who delivers education presentations?

Education presentations are given by: general education workers and other program staff; local ASO staff who are members of the priority population networks (PPNs) (for more information see Appendix F); regional population-focused workers who are part of the Ontario Aboriginal HIV/AIDS Strategy (Oahas); Hemophilia Ontario; and IDU outreach programs. In 2014/15, all of these workers reported giving more presentations either targeted to or related to priority populations.

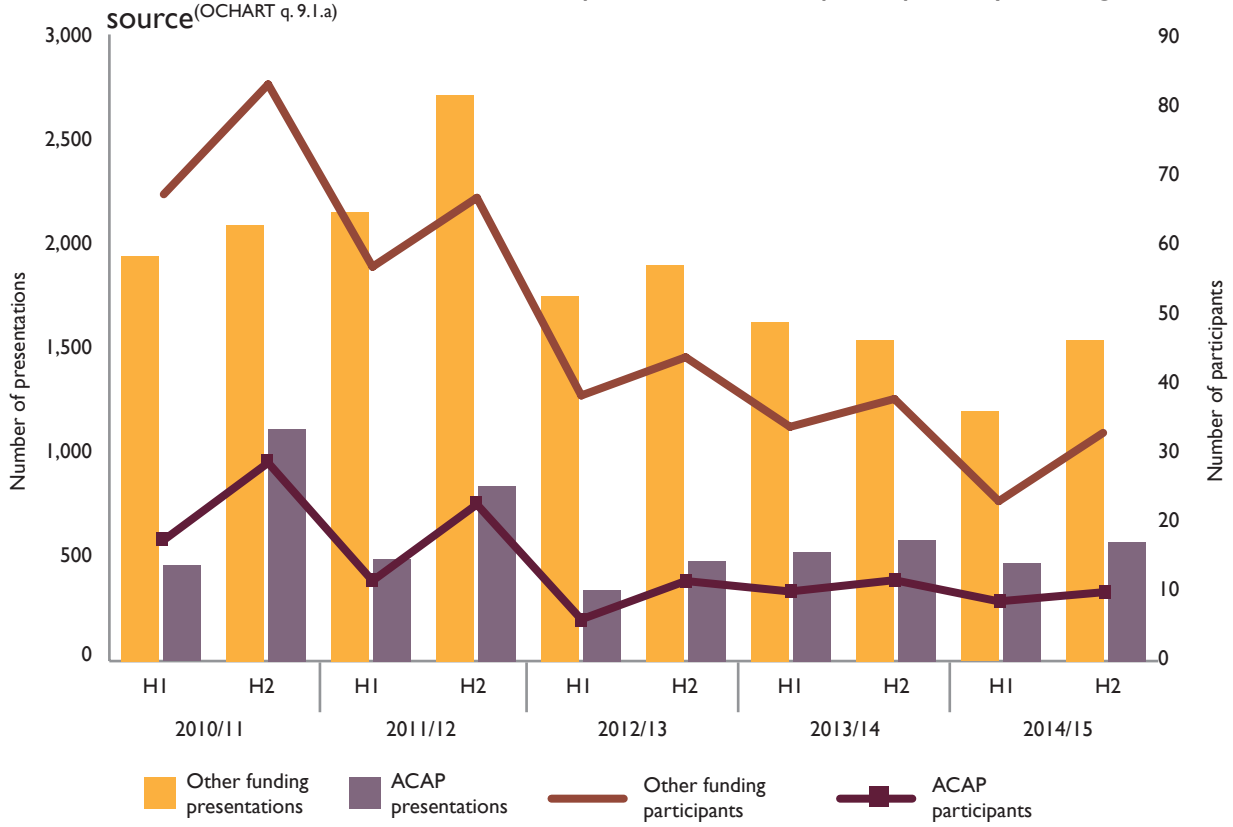
Population-specific workers playing larger role

Year over year, the PPN members and other population-focused workers are giving a larger proportion

of education presentations. In 2014/15, the number of presentations targeting injection drug use more than doubled (494 to 1,094) — however this is largely due to a change in the way the question is asked in OCHART. It now captures more agency activity than in previous years. In addition, the increase is also attributed to more peer volunteers at two agencies giving presentations. Members of the Gay Men's Priority Population Network also reported giving more presentations. The decline in presentations targeting ACB communities was due to one agency having reduced staffing capacity.

Most presentations continue to be to practitioners, professionals or service providers. In fact, the number targeting these groups increased in 2014/15 — mainly due to focused efforts by WHAI, GMSH and Indigenous workers to reach service providers. Educating other service providers can be an effective way to ensure that people at risk have access to culturally sensitive prevention services across health and social services systems.

FIGURE 18 Number of education presentations and participants by funding source(OCHART q. 9.1.a)



Presentations more focused on priority populations

To support the implementation of the provincial HIV strategy, community-based HIV programs are focusing their education activities on priority populations. In 2014/15, programs reported a significant drop in the number of presentations to the general public (from 684 to 418), which is not considered a priority population.

Across all workers providing education:

- the number of presentations to Indigenous people, gay, bisexual and other men who have sex with men, and women at risk increased
- there were fewer presentations to ACB communities – mainly due to an unfilled position at one agency. However, ACB communities were still one of the top six intended audiences for education
- almost 50% fewer people in prison attended presentations in 2014/15 — due to issues that one agency faced accessing prisons.

FIGURE 19 Number of presentations by worker type 2014/15 (OCHART q. 13.7 and 9.1.a)

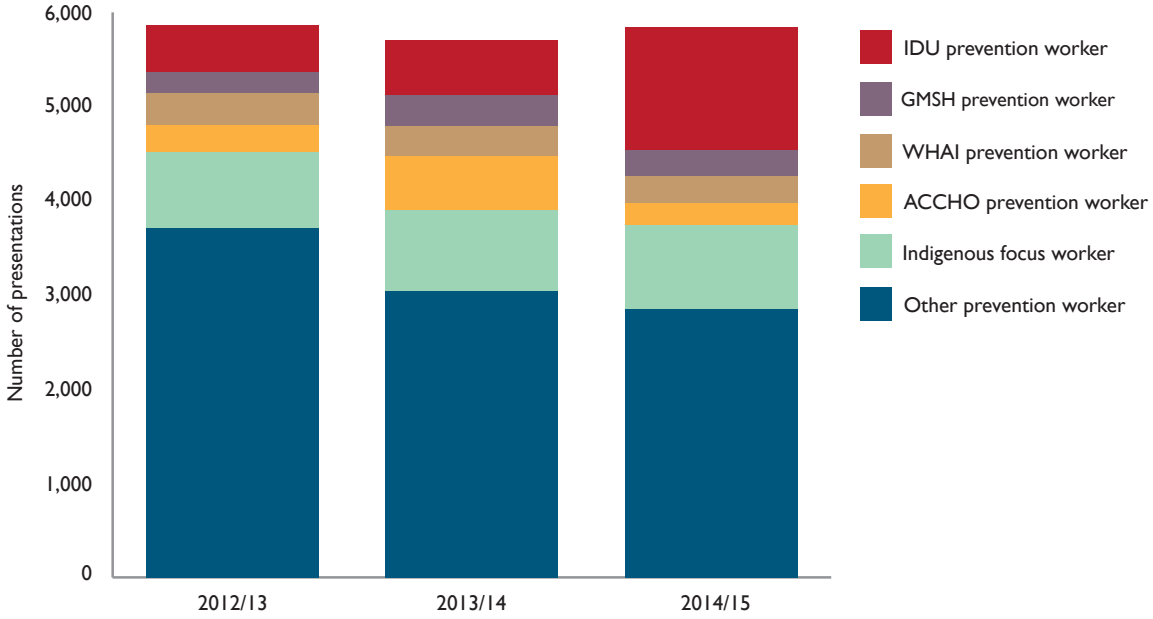


FIGURE 20 Top 6 intended audiences for education presentations by general education staff
(OCHART q. 9.1.a)

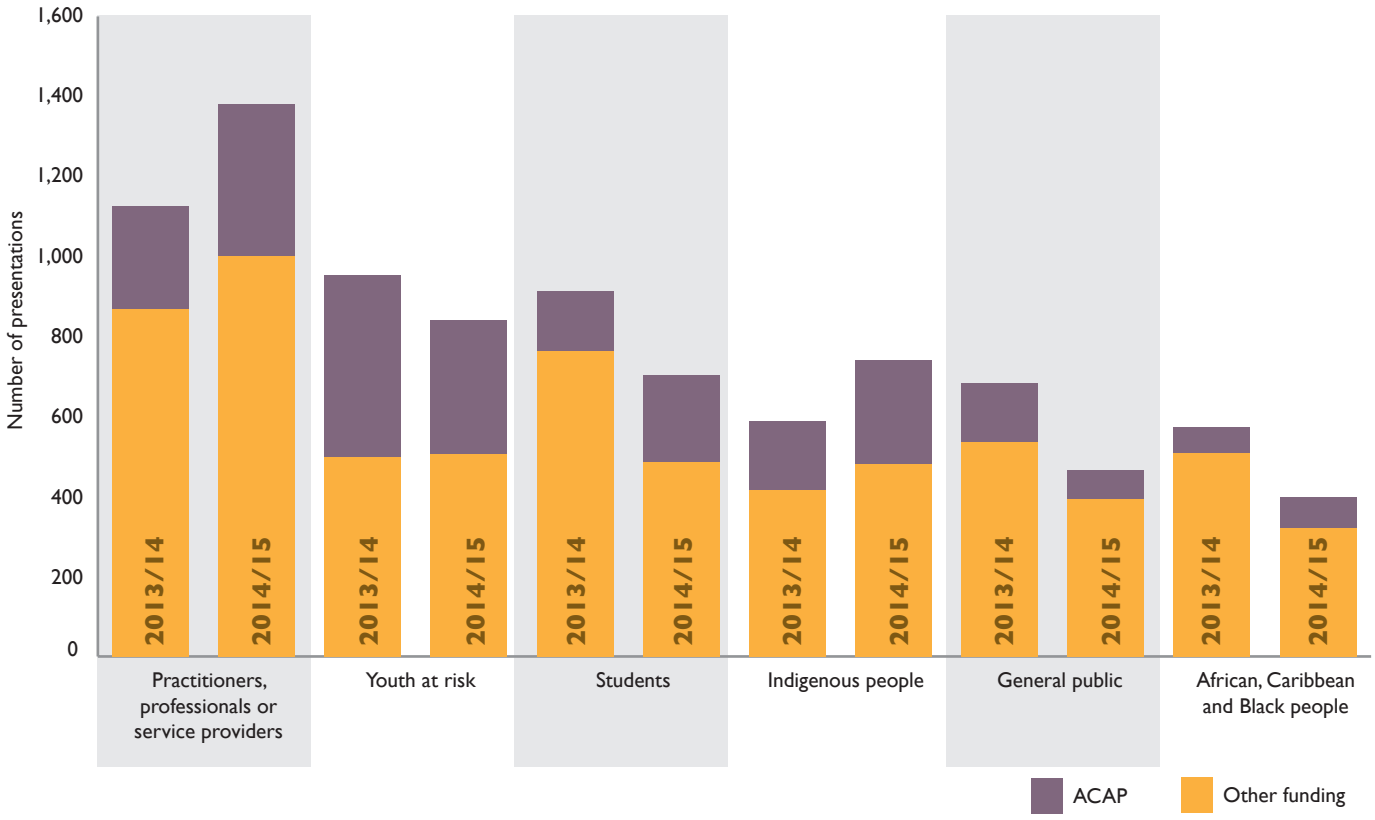


FIGURE 21
TOP 3 TARGET AUDIENCES FOR ACAP-FUNDED PRESENTATIONS

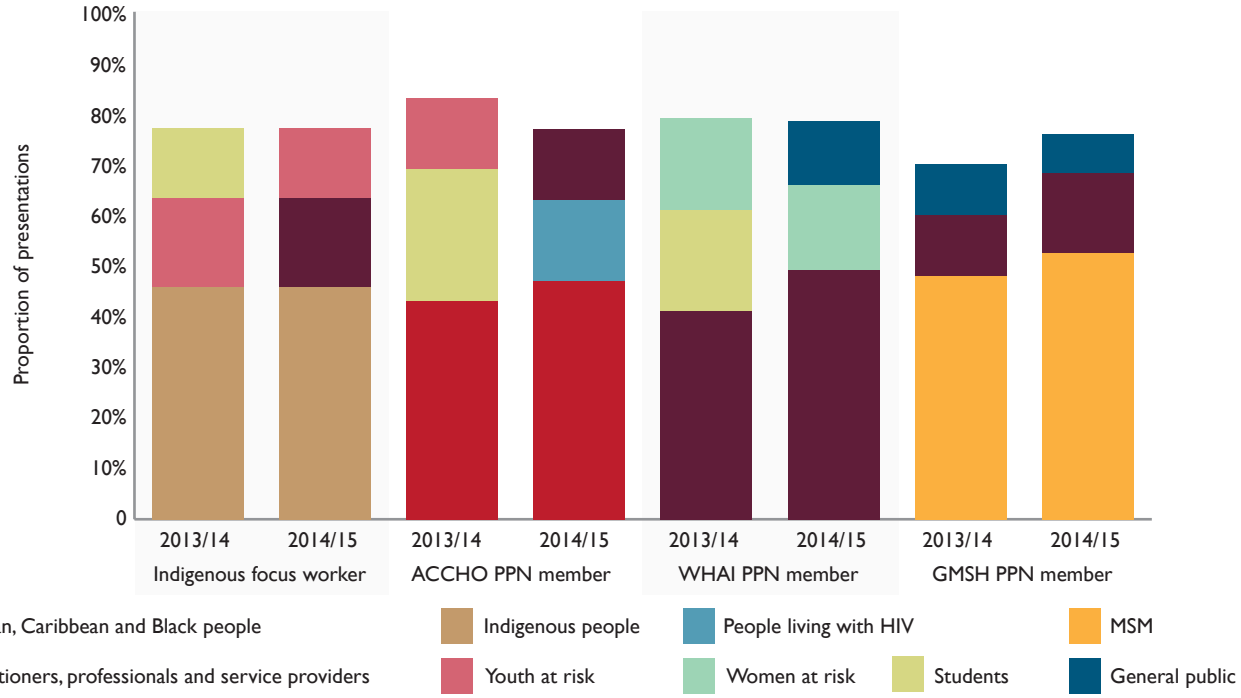
Population-specific workers connecting to priority populations

Figure 26 shows the top three audiences for prevention education by worker type. All PPN members reported more success reaching their primary priority audience as well as practitioners, professional or service providers. Consistent with the focus on priority populations, ACCHO PPN members, WHAI PPN members and Indigenous focused workers all reported fewer presentations targeting youth/ students.

Reaching gay, bisexual and other men who have sex with men

Presenting to gay, bisexual and other men who have sex with men is challenging in many regions as they lack gathering spaces and/or the population is hidden. Workers rely instead on one-on-one education and outreach to provide education for gay and other men who have sex with men.

FIGURE 22 Top 3 audience populations reached by population-specific workers
(OCHART q. 13.7 and 9.1.a)



Note: Current OCHART questions do not capture the full range of education activities. Questions are currently being revised to ensure the data accurately represents the work that programs are doing. These new questions will be introduced in April 2016.

What education are people with HIV receiving?

People living with HIV play an important role in HIV prevention. To help reduce the risk of HIV transmission and prevent co-infections with other sexually transmitted or bloodborne illnesses (like hepatitis C), ASOs use a number of different strategies, including education and poz prevention groups.

In 2014/15 organizations reported giving a total of 383 presentations to people living with HIV (down 8% or 35 from 2013/14). Presentations were primarily given by general prevention workers, followed by ACCHO PPN members and GMSH PPN workers.

Table 1. Most common focus of presentations to people living with HIV

2012/13	2013/14	2014/15
Population-specific issues	STIs/safer sex	HIV 101
Living with HIV	HIV/AIDS in the workplace	Living with HIV
Other	Population-specific issues	Stigma

Over the past three years there has been some shift in the content of presentations that target people living with HIV. It is curious to see, 30 years into the epidemic, that HIV 101 is still the most common focus in 2014/15. Reasons for this are unclear. Is HIV 101 not clearly defined within OCHART? Are prevention workers discussing poz prevention and recording it as HIV 101? Is HIV 101 part of the context in most presentations? Do volunteers, who deliver a significant proportion of presentations, focus on HIV 101 while staff, who give fewer presentations, provide more complex or advanced information?

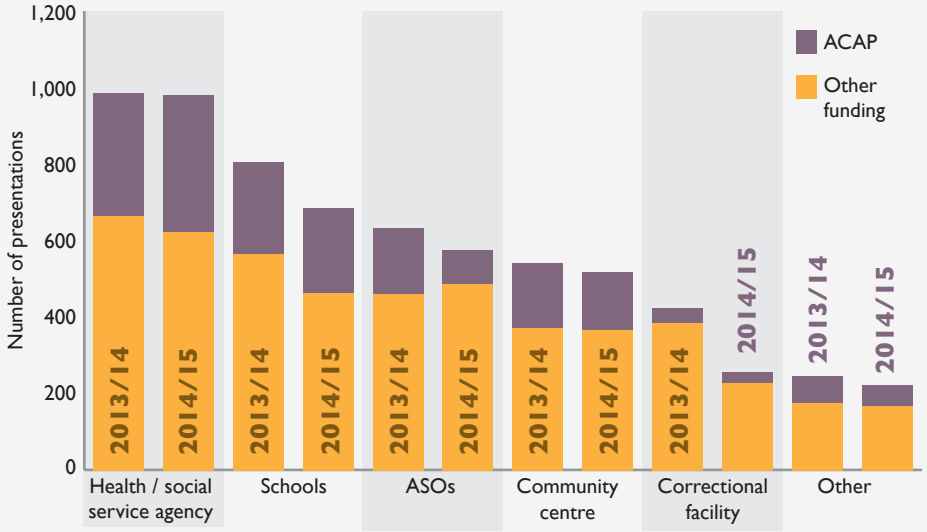
In 2014/15, programs reported more presentations on diversity/anti-oppression/cultural competence – mainly due to the WHAI workers. Presentations on population-specific issues, stigma and discrimination remain in high demand.

Where are presentations delivered?

The main locations for presentations were the same as in the previous year — although the number delivered in schools and correctional facilities dropped significantly. These new trends were mainly due to:

- a shift from general presentations to youth to more focused presentations related to priority populations
- issues accessing correctional facilities, particularly provincial institutions.

FIGURE 23 Top 6 presentation locations by funder
(OCHART q. 9.1c)



Trends in one-on-one in-service education

Presentations are not the only way to deliver education or to measure the impact of education programs. Workers spend a significant amount of time delivering one-on-one education — mainly in response to individuals seeking information. The information reported here helps paint a picture of the issues important to people with or at risk of HIV.

FIGURE 24 One-on-one in-service education requests

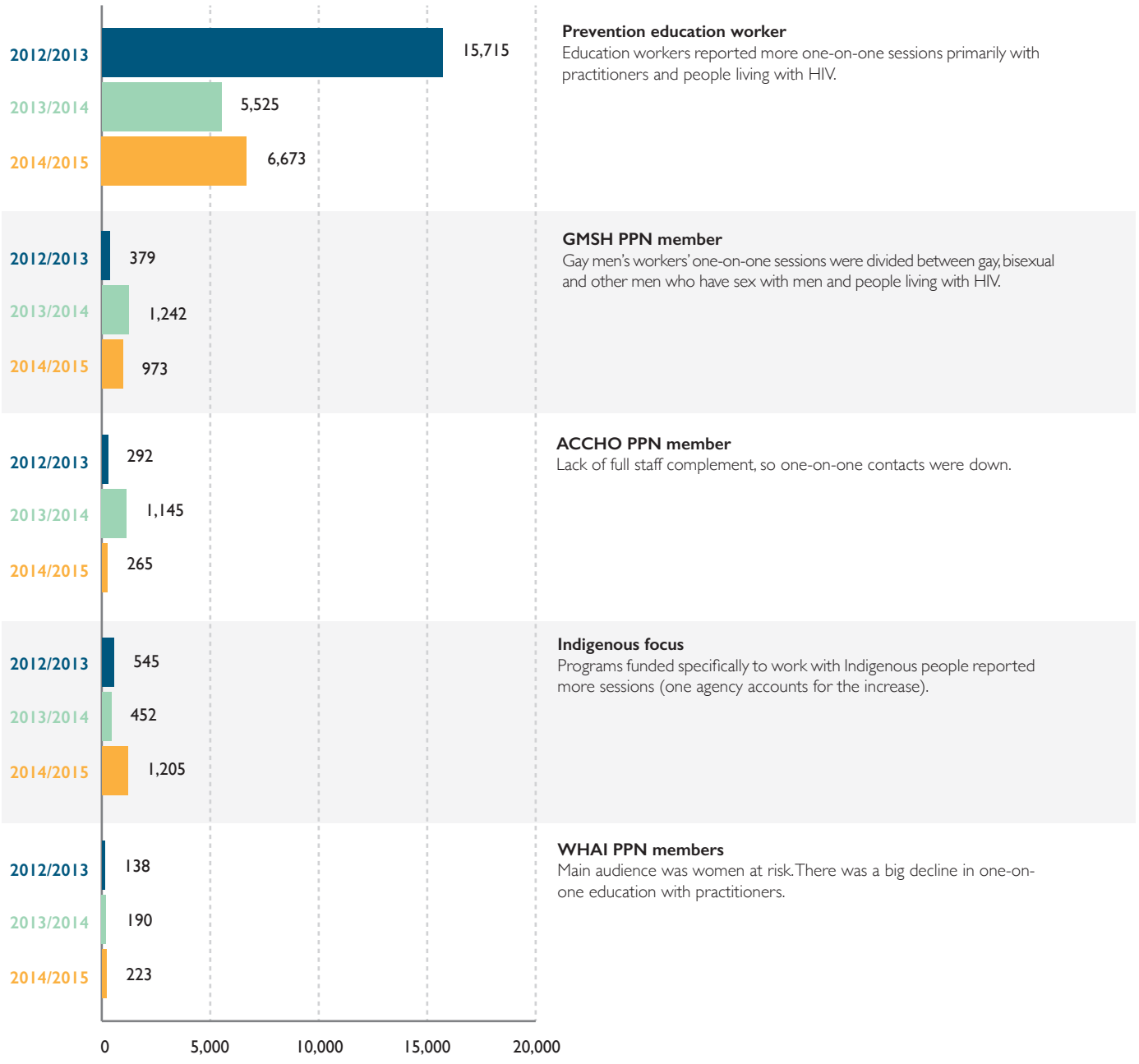


FIGURE 25

TOP 3 ONE-ON-ONE TOPIC REQUESTS BY WORKER TYPE

Prevention Education Worker

1. Population-specific issues
2. Sexually-transmitted infections
3. HIV 101

Gay Men's Sexual Health PPN

4. HIV testing
5. Living with HIV
6. Stigma

African and Caribbean Council on HIV/AIDS in Ontario PPN

1. Population-specific issues
2. HIV 101
3. Living with HIV

Indigenous-focused

4. HIV testing
5. Sexually-transmitted infections
6. Living with HIV

Women and HIV/AIDS Initiative PPN

1. Population-specific issues
2. Sexually-transmitted infections
3. Addressing violence

From education to engagement: connecting people with other services

In 2014/15, OCHART asked programs to report any referrals made through their education, outreach and online/social media activities. Although it is not possible to determine whether people follow-through on these referrals, making referrals is more likely to engage people in the services they need. The types of referrals education workers made in 2014/15 highlighted the complex health and social needs of people who seek services through community-based programs:

- two-thirds were to clinical services such as HIV and other STI testing/sexual health clinics, counselling services, a health care professional or facility and public health
- one-third were to community services such as another ASO, community food banks, population-specific services, social services, addiction programs, employment programs, housing programs and settlement services.

What programs told us about barriers to education and how to overcome them

Challenge	Overcoming challenge
Accessing service providers for training	**Shorter presentations and clever partnerships** "WHAI: One barrier is getting [other health and social service] organizations to give enough time to do presentations to their staff. One way to address this is by doing shorter presentations to service providers, often as lunch-n-learns. This provides an opportunity to familiarize service providers with HIV and women's risk, as well as some of the services available through ARCH. This way, they have contact information to get more information and are better able to refer their clients to ARCH. Several referrals and contacts have come as a result of these short presentations." — HIV/AIDS Resources and Community Health "Women and HIV Program has established a new ongoing educational partnership with the University of Windsor Nursing program. We will be part of an annual panel discussing diverse populations and stigma within the health care system. In a collaborative effort the WHAI, GMSH, and ACCHO coordinators have begun planning an educational forum for physicians and nurses. A success so far has been getting five prominent health care organizations to attend planning committee meetings." — AIDS Committee of Windsor
At-risk population reluctant to discuss sensitive/taboo topics	**Utilizing peers to share knowledge and prevention messages** "Barriers around perception of risk while engaging in risky behaviours continues to be an issue within the populations we work with. Although some are aware of the risks that they take, they are more likely to engage in what's socially acceptable within their peer groups. Therefore engaging in safer sex practices or conversations about it can actually be perceived as taboo, and deters those from taking the steps needed to ensure that they are making the safest most informed choices. We've addressed these issues by involving peers in the development, delivery and evaluations of all educational workshops." — Black Coalition for AIDS Prevention "Three presentations were provided by the Sex Trade Peer Development Coordinator … An additional three presentations were provided by sex working peers at a conference organized by SWANS - Sex Workers Advisory Network Sudbury. SWANS was developed out of our agency." — Réseau Access Network

Challenge	Overcoming challenge
Geography a barrier in large rural areas	**Innovative use of technology and incentive programs** "Another barrier … is the limited resources in rural areas. Doing workshops in these areas can be challenging because strategies for change are not always easily implemented. Referrals, follow-ups, connecting agencies with other rural agencies and more education helps with these barriers, but has not eliminated them." — HIV/AIDS Resources and Community Health "Providing the same level of education services to outlying communities. Agency has begun to look into technology strategies to provide an alternative venue for education." — AIDS Committee of North Bay and Area "Large geographical area limits participation by members. Offering gas cards to help offset the cost of travel helps encourage participation." Hemophilia – Northern
Lack of resources	**Leveraging volunteers and exploring other funding opportunities** "Increased financial capacity to provide consistent honorariums to Spectrum leaders would greatly assist in retention of highly skilled youth volunteers. The HIV/AIDS program does its best to creatively fund raise and to stretch dollars to utilize revenues. A grant was written to the United Way last April seeking increased revenues for this services; unfortunately, this was not successful. The HIV/AIDS program will continue to seek opportunities to apply for grants for this program." — Youth Services Bureau of Ottawa "Over the past six months due to high work volumes and less resources — both financial and human — to continue to offer as many educational sessions. We continue to explore opportunities to offer train-the-trainer sessions where possible and offer as many educational and outreach sessions to the community. We continue to leverage volunteers, students and community members in opportunities to provide support more informally when possible. We continue to explore new funding avenues in the hopes of being able to offer more educational opportunities and/or partnerships." — Hospice Toronto

Outreach programs

Note: The information on outreach programs in this section refers to non-IDU outreach. For the activities of the 37 programs that provide outreach services to people who use substances, see page page 48.

Key trends

- A total of 119,339 brief contacts in 2014/15 — down 12% from the previous year.
- ACAP-funded programs reported about the same number of brief contacts (30,147). However, their outreach to Indigenous populations and ACB communities more than doubled, while outreach to gay, bisexual and other men who have sex with men, people living with HIV and youth at risk declined.
- More outreach to ACB communities — particularly through events such as Jambafest and Scotiabank Caribbean Carnival Toronto.
- A significant increase in outreach to Indigenous communities in 2014/15 — largely due to eight more programs reporting brief contacts with Indigenous people, which may be a result of agencies focusing their efforts on this population.
- Two fewer programs reported brief outreach contacts with gay, bisexual and other men who have sex with men and the total number of contacts with this priority population dropped by 15% in 2014/15. However, gay men were still the main target for brief outreach, followed by the general public, Indigenous people and ACB communities.
- Three fewer programs reported significant outreach contacts than in the previous year. Of all the programs that did report significant contacts, all but one reported having made fewer contacts

Number of both brief and significant outreach contacts drop in 2014/15

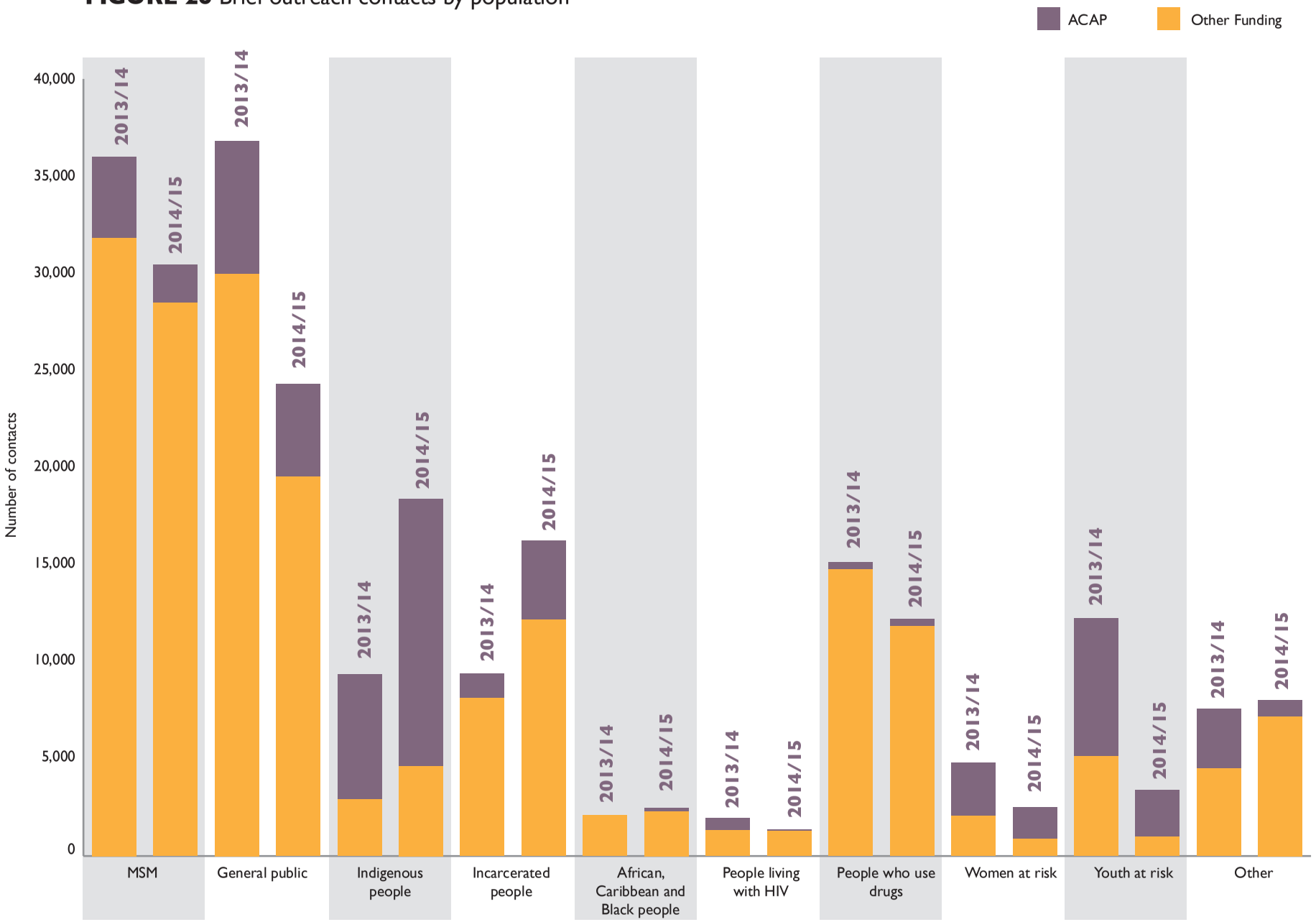
Significant face-to-face outreach contacts requires a 2-way, in-person interaction between agency staff/ volunteers and a member of the target population.

Brief contacts do not involve a 2-way interaction and may include people taking material (e.g., a pamphlet) at event booths.

Although the overall number of brief contacts was 12% lower in 2014/15, contacts with Indigenous and ACB communities increased significantly across at least four agencies. Only a few agencies reported working with people who inject drugs in this section of OCHART; see page 48 for information on outreach and education with this population.

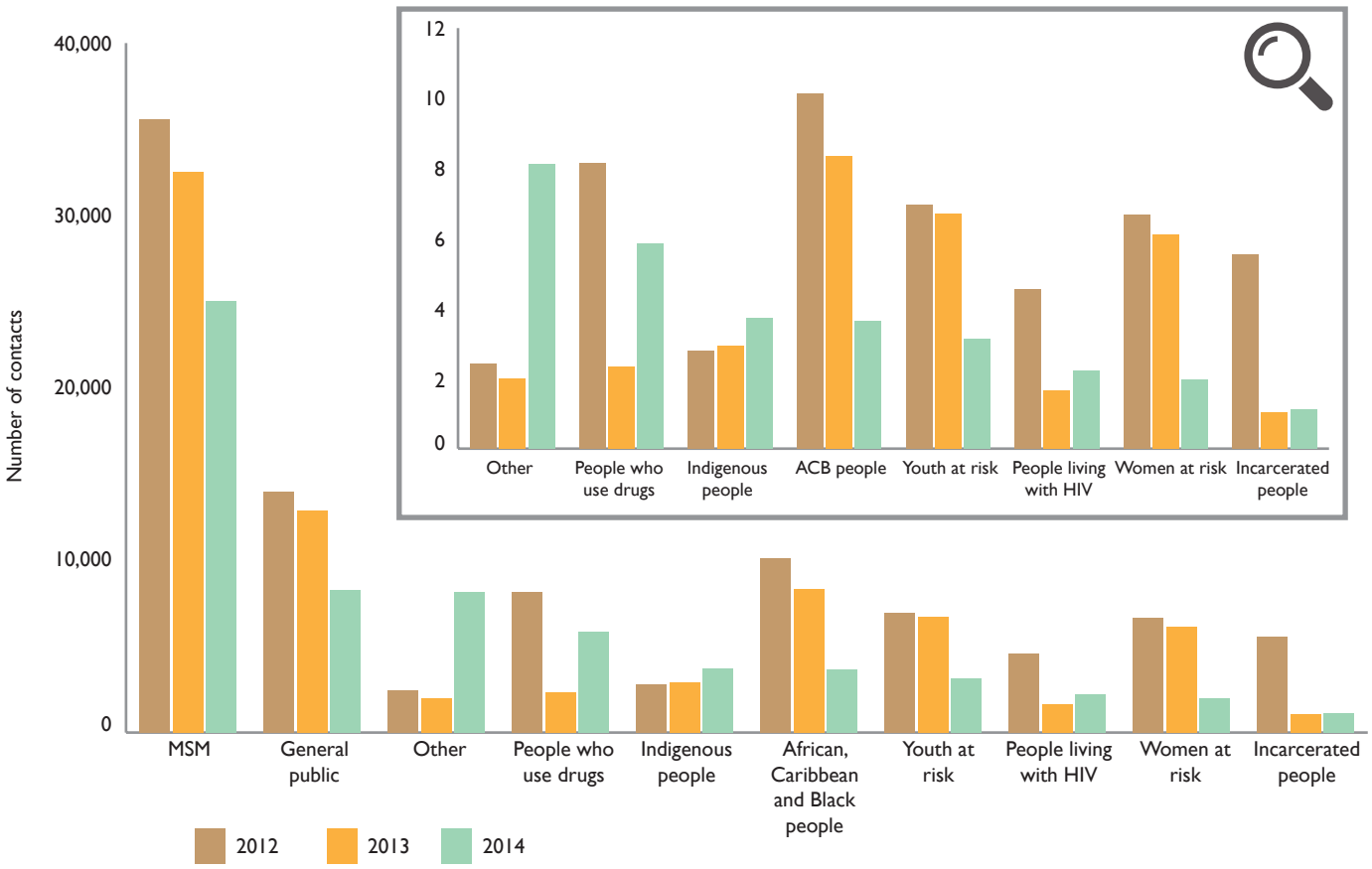
The number of reported significant face-to-face contacts was down 18% in 2014/15. Through conversations with agencies, we learned that some of the decrease is likely due to more widespread use of tracking tools and more accurate reporting. The number of contacts was down across all populations except people who use drugs, Indigenous people and "other."

FIGURE 26 Brief outreach contacts by population (OCHART q 9.10b)



Note: "other" includes a mix of service providers, students, the general public and sex workers

FIGURE 27 Number of significant face-to-face contacts by population type(OCHART q. xx)



Number and locations for significant outreach shifting

More significant face-to-face outreach contacts occurred in bars and shelters than in the past – even though fewer programs reported doing outreach in these locations. Substantially fewer significant contacts occurred in bathhouses, community public spaces or on the street.

Three agencies that had large numbers of contacts in some locations in the past, such as bathhouses, reported none in 2014/15 and two others reported substantial decreases. These changes were due to a combination of changes in how contacts were tracked (e.g., counting people rather than the number of condoms distributed), staff vacancies and shifts in the focus of programming during the year. In the case of street outreach, more programs reported providing it but the larger number of programs involved had fewer contacts.

Table 2. Largest shifts in significant face-to-face outreach contacts by location(OCHART q. 9.10.a)

Location	2013/14	# of programs reporting	2014/15	# of programs reporting
Bars/nightclubs	5,115	22	15,206	17
Bathhouses	27,998	11	13,923	9
Community public spaces	12,577	35	5,305	38
Shelters	367	10	1,133	7
Street (includes parks)	7,377	13	3,647	16
Strip clubs	216	3	55	2

Using social media as an education/outreach tool

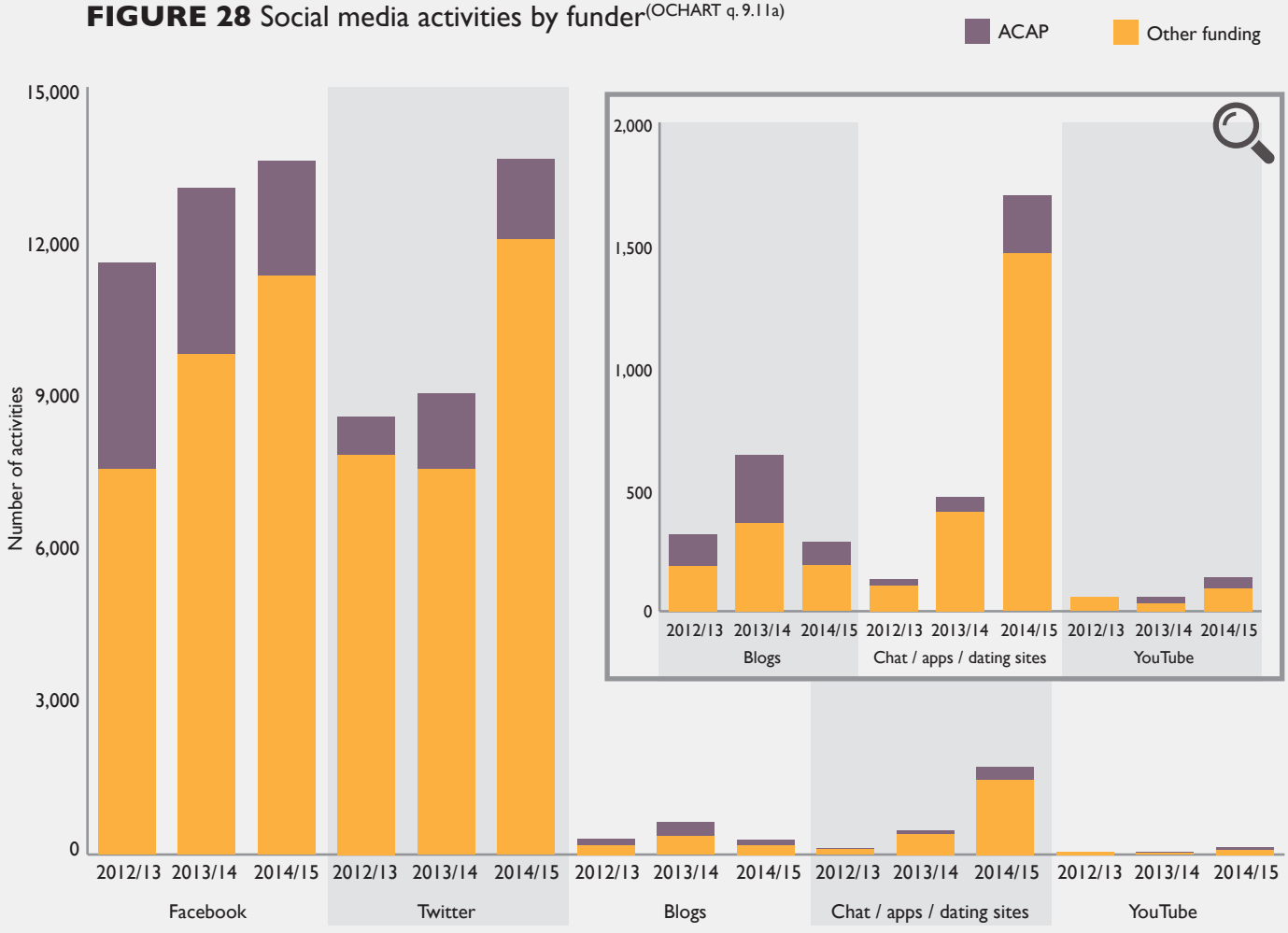
More programs are reporting using social media for education and outreach and being more active on social media (54 programs in 2014 vs. 46 in 2012).

In general, programs seem to be relying more on Facebook and Twitter, and less on blogs to connect with people online.

Table 3. Number of organizations using different types of social media(OCHART q. 9.11.a)

	2012/13	2013/14	2014/15
Blogs	9	10	10
Facebook	42	43	50
Chatroom/apps	18	21	22
Twitter	28	30	34
Websites	31	34	39
YouTube	14	21	20

FIGURE 28 Social media activities by funder(OCHART q. 9.11a)



However, we still don't have a good sense of the impact of these online efforts. Comprehensive free analytics programs for social media are no longer available, and these analytics are better suited to measuring discrete activities or campaigns and are difficult to aggregate across a variety of activities over a six-month period. At the current time, we only know whether social media activities have resulted in some type of response, such as a comment, share or retweet – but not whether they had an impact on knowledge, behaviour or skills. Without information on impact the sector is unable to understand what works and where best to invest social media resources. The way these activities are reported in OCHART also does not make it clear what proportion were used to promote the agency as opposed to providing prevention messaging and outreach.

The capacity-building programs are also making greater use of social media. They reported a 275% increase in their use of social media but only a 5% increase in their reach.

OCHART tracks "reach" in terms of items disseminated. Currently programs do not have consistent, accurate ways to measure electronic distribution, which may explain why use of social media is up but reach is down.

Programs continue to post YouTube videos. This is one of the few media where analytics are accessible. Over time we see more videos being posted and a decline in the video-to-viewer rate. This may be due to the success of a few videos in previous years such as the *Unlocking HIV Film Documentary*[1] or *The River of Healing*[2], which each had more than 2,000 views at the time of reporting.

Websites:

Recent changes to OCHART reporting for website activities make it hard to compare with previous years but, in 2014/15:

- 3, 584 updates or new pages
- 912, 620 visitors

FIGURE 29
SOCIAL MEDIA: ACTIVITY AND OUTCOME (OCHART Q. 9.11A)

	Blogs	Facebook	Chatrooms / apps	Twitter	YouTube
2012/13	Posts: 92 Comments: 58	Posts: 10,978 Shares: 37,509	Sites participated in: 128 Interactions: 6,012	Tweets: 8,283 Retweets: 4,623	Videos posted: 41 Views: 53,617
2013/14	Posts: 325 Comments: 302	Posts: 12,943 Shares: 43,680	Sites participated in: 466 Interactions: 4,202	Tweets: 9,035 Retweets: 4,885	Videos posted: 58 Views: 19,736
2014/15	Posts: 283 Comments: 38	Posts: 13,552 Shares: 13,757	Sites participated in: 1,702 Interactions: 2,959	Tweets: 13,596 Retweets: 11,826	Videos posted: 136 Views: 23,145

1 https://www.youtube.com/user/UnlockingHIV

2 http://www.youtube.com/watch?v=8867y_9Fnd8

ACAP FUNDED PROGRAMS REPORT INNOVATIVE AND EFFECTIVE USE OF SOCIAL MEDIA AND APPS

AIDS Committee of York Region

We have seen far more engagement on our social media activities in terms of post views, likes, shares and follows (especially on Facebook) since we made an intentional shift in posting content around sexual health promotion focusing on social determinants of health and key impacted populations.

HIV/AIDS Resource Community Health

Our Halt Homophobia & HIV app was downloaded 86 times in approx 11 different countries. We also added updates to the app to include information on STIs, how to report a hate crime, condom negotiation skills, as well as a map locator for free condoms and harm reduction supplies in our catchment area.

AIDS Committee of Cambridge, Kitchener, Waterloo & Area

"Our anonymous text service (part of Doin' It) has proved invaluable in reaching youth at risk who are experiencing a number of barriers (transportation, mandatory programming, internalized shame and homophobia/transphobia, etc.) that prevent them from benefiting from outreach or in-service programming that we offer. Most of the conversations have been about safer sex, specifically: testing (who, what, where, when, how), pregnancy prevention and safer sex options. A number of the conversations have spanned over several hours, and the youth shared information that may not have been shared in person, and asked follow-up questions (e.g. How do I tell my partner I am not comfortable doing something?, I feel like I am letting them [parents] down).

GREAT SUCCESS WITH ONLINE APPS TARGETING GAY/B/MSM

AIDS Committee of Cambridge, Kitchener, Waterloo & Are

The GMSH team has had a record high period for online outreach, with 130 online outreach contacts during this reporting period. 88 of those contacts were classified as significant, meaning at least one sexual health related question was asked to the worker. From these contacts, we have made many referrals to HIV/STI testing, community programming and counselling services.

AIDS Committee of Windsor

Online outreach continues to be an effective tool for HIV testing awareness and has resulted in an increase in the amount of gay men utilizing our testing nights here at the agency.

More focused awareness campaigns

Awareness campaigns, which may include social media, can be an effective way to educate, raise awareness and reach people at risk. However, awareness campaigns can be complicated and costly to develop – and are beyond the scope of small programs. To make the best use of resources, a significant amount of responsibility for developing campaigns and evaluating their impact has shifted to priority population networks, particularly ACCHO and GMSH. Materials are developed provincially and then used/adapted by programs for their communities.

In 2014/15, programs reported fewer awareness campaigns and meetings associated with campaigns. This shift can be explained by a smaller number of more focused campaigns. The number of awareness campaign meetings organized by capacity building programs, including PPNs, returned to 2012/2013 levels in 2014/2015. The large number of planning meetings in 2013/14 was related to the GMSH Our Agenda campaign.

Table 4. 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

Shifts in developing and distributing materials

In general, the number of education/outreach resources and materials, such as infographics, developed by the sector increased by 74% in 2014/15. However, most were electronic and front-line programs do not have the capacity to track how many were distributed. The capacity building programs do seem to be able to track resource distribution and reported a 27% increase, mainly attributed to WHAI and CATIE. (see Table 7)

Table 5. Resources distributed by capacity building organisations (OCHART q. 14.66)

Resources distributed	2012/13	2013/14	2014/15
PHA health information or support resources	256,914	188,587	273,556
Newsletter or news article	113,223	41,958	51,468
Brochures, posters, flyers or pamphlets – agency promotional materials	75	560	100,043
Brochures, posters, flyers or pamphlets – prevention/ education	N/A	1,737	1,660
Manuals/training kits	1,578	497	185
Other (please specify)	N/A	12,192	80
Research summary or evaluation report	1	2	67
Workshop presentation materials (includes templates, PowerPoint, handouts, etc.)	1,496	200	52
Strategic planning, decision making, policy or organizational development tools	188	145	20
Film/DVD	0	13	0
GRAND TOTAL	**373,475**	**245,891**	**337,131**

What you told us about outreach successes

AIDS Committee of Durham Region

Also,
successful cross-promotions
with other provincial strategy workers
resulting in greater regional interest for events
in Durham.

Action positive VIH/SIDA

Using
a new strategy
to promote our website has
increased the number of likes
and people who visit it.

NEW OUTREACH STRATEGIES AND PARTNERSHIPS TO ENGAGE THE COMMUNITY

AIDS Committee of Ottawa

In terms of
SPOT, we are now working with Queer
Mafia, Fever, Swizzles, Mr. Leather Ottawa and HUMP. We have
recruited and trained more SPOT volunteers to work events, which will be beneficial
over the spring and summer. Working closer with Ottawa Public Health, we will (eventually)
be getting mobile testing kits for chlamydia and gonorrhea for our men's team outreach.
GayZone volunteers have become more engaged than ever, and because of their amazing
work our outreach numbers have increased at Gay Zone which means more
gay men and MSM are being contacted.

ENGAGING GAY/ BISEXUAL/MSM COMMUNITIES

AIDS Committee of Toronto

Play Safely (World Cup condom and
lube packs) The Portuguese Speaking Men's Outreach
program developed condom and lube packs written in
Portuguese to be distributed during the World Cup soccer
tournament in target populations and areas of the city that
are frequented by the Portuguese community.

AIDS Committee of Toronto

Gay
Men's Online Outreach
developed a new relationship with
Dudesnude.com at a time when ACT was the only
sexual health outreach program registered on the entire
site. Dudesnude (a gay men's hookup site) then went
on to promote sexual health links from the
ACT website on their website.

AIDS Committee of Cambridge, Kitchener/Waterloo & Area

Our
bar outreach quiz board,
increased online outreach contact frequency,
and the installation of condom dispensers in our
region's newest gay bar "The Order."

Africans in Partnership Against AIDS

We developed an activity to reach people from marginalized countries that are identified as HIV/AIDS endemic countries, such as sub-sabra African nations and Caribbean Islanders.

AIDS Committee of York Region

We were invited for the very first time to have a table at the Black History Month celebration hosted by the Markham African Caribbean Canadian Association (MACCA) thus allowing us access to many members of the African, Caribbean and Black (ACB) community that we have struggled to reach in the past.

ENGAGING AFRICAN, CARIBBEAN AND BLACK COMMUNITIES

Elevate NWO

Our Outreach BBQS had over 200 in attendance at each location. The event was held at two local shelters. On site testing was provided by public health with support from Elevate Staff. It resulted in 17 people being tested. Additionally four new intakes in Elevate services occurred as a result of this outreach.

HIV & AIDS Legal Clinic Ontario

We are very proud of the Trans* Legal Needs Assessment project which we launched in June 2014. Goals of the project include documenting the need for legal services among trans* people in Ontario, identifying barriers to access to legal services through a series of focus groups and a province-wide survey, and formulating strategies to address those barriers. The project will draw on the knowledge and experience of trans* people and communities, legal service providers, and other stakeholders, to ensure that contextualized, meaningful, and actionable information is available to achieve the project goals.

ACCESSING HARDER TO REACH POPULATIONS

Youth Services Bureau Ottawa

Spectrum, the HIV/AIDS drop-in for queer and trans youth, has registered 208 unique clients. A mental health worker who specifically works with LGBTQ+ youth attends once per month and reports that 25% of this worker's clients are registered at Spectrum. It is noticed that approximately 35% of the youth who attend Spectrum would identify within the broad spectrum of trans; as the Population Specific HIV/AIDS status report for women (PHAC, 2008, p. 33) states that 27.7% of trans women are living with HIV, the HIV/AIDS program believes that creating ways to be inclusive to the trans population is a priority. Additionally, attendees include multiple populations within the LGBTQ+ youth community including street-involved youth, racialized youth, and youth who use walkers and/or wheelchairs.

Réseau Access Network

Peers involved in the Surviving Sex Trade program are becoming much more confident and involved in peer-to-peer support and education. I currently have three peers involved who are committed to regularly doing peer outreach and support on a weekly basis. Peers are also doing outreach in their own work settings — for example, one peer is currently working in the strip clubs and regularly doing outreach support and education with her peers.

ACCESSING AFRICAN, CARIBBEAN AND BLACK COMMUNITIES

Africans in Partnership Against AIDS

We successfully reached significant number of African, Caribbean and Black communities in the Greater Toronto Area. We have also successfully launched ACB youth forum with other partner organizations. We have reached most ACB venues, for example, barber shops, restaurants, ethnic business shops, coffee shops and on major intersections of the Greater Toronto streets.

AIDS Comittee Windsor

Working with hard to reach at-risk populations like ACB Migrant workers has been a success as we have been able to provide condoms, create greater access to primary health care through advocacy and system navigation support with other service providers outside of the HIV sector.

ACCESSING WOMEN AT RISK

HIV/AIDS Resource Community Health

The women's health alliance teamed up to do community outreach this summer. We created an obstacle course on barriers to women's health and had a resource table. We got a lot of traffic and a lot more people learned/heard about the women's health alliance.

The AIDS Network

During this same reporting period, the WHAI Coordinator was successful in developing a relationship with a new women's drop-in centre for marginalized women (most homeless or very unstably housed and involved in street based sex work and actively using substances) based out of a local shelter space. This new centre adopted a suggested name for the drop-in as offered by the WHAI Coordinator (Willow's Place) and the WHAI Coordinator replenishes resources and materials on HIV related issues, including testing, safer sex practices, harm reduction and women specific materials through having an unstaffed outreach resource display in their space available to all who attend the drop-in (which provides programming including free shower, coffee, meals, lounge, etc).

INNOVATIVE PREVENTION ACTIVITIES

AIDS Committee of Windsor (ACW)

Spinwheel is a great tool for education: questions lead to deeper conversations, contacts identified that they learned something new, particularly around transmission and stigma. Youth-specific resources (flipbooks, fortune tellers, happy packs), giveaway items, and peer volunteers assisted with effectiveness of outreach.

Deaf Outreach Program

…more people are using social media to have access to information about HIV/AIDS and STIs. Having video logs helps a lot for access to information in American Sign Language about our updates.

What you told us about overcoming outreach barriers

Challenge	Overcoming challenge
Stigma and discrimination	**Subtlety and solidarity** It is challenging locating and reaching young poz people because of stigma, homophobia, and cultural and religious norms in some communities, as well as the wide spread location of individuals in the city. We are trying to reach a population that is largely hidden, and are therefore continually strategising new locations, how, where and when to do outreach to reach this population. To overcome these barriers we outreach in different communities and at events in neighbourhoods that are not typically LGBTQ associated or focused. Furthermore, as part of the program's 25th Anniversary, we are promoting the benefits, take-a-ways and positive impacts of being involved with the program so there is a need and want for the program. — AIDS Committee of Toronto People living with HIV face stigma, discrimination and isolation. We continue to recruit and support PLHIV as ambassadors for communication and education to facilitate the PLHIV voice and demonstrate to PLHIV that they are not alone. — Casey House Continue to encounter/identify barriers engaging in community outreach work with any identifying symbols/logos/language/reference to HIV, AIDS or the red ribbon or the agency logo. The team is actively working to address this issue by often ensuring that there is no visible indicator of any of these HIV services in resource and table displays, in materials, and other approaches that would result in community members not even approaching or engaging in conversation if it is perceived as an "HIV/AIDS" affiliation. This is particularly relevant for all ACCHO activities; and for regional outreach, but also experienced widely both in Hamilton and Halton as well. Stigma and related fears are still very present in outreach work. — The AIDS Network
Resource constraints: technology	**Innovation and skill development** There have been some challenges in navigating the social media aspect of online outreach and education. To gain a better grasp of how to better improve interactions online and increase the agency profile, I've attended a webinar on social media referred through ACCHO. — Africans in Partnership Against AIDS The lack of ability to do online social media outreach has continued to make connecting with the MSM population specifically difficult. Workers have developed a comprehensive online outreach plan, which we are assured we will be able to implement during this coming reporting period. — Algoma Group Health

Challenge	Overcoming challenge
Resource constraints: accessing target/priority populations	**Offering incentives and challenging perceptions** We discovered a gap in our capacity to respond to the needs of racialized GBMSM online. As a result, steps have been put into motion on the provincial level with the establishment and participation in the Alliance of Aboriginal, Racialized Men of Ontario Region. — AIDS Committee of Cambridge, Kitchener, Waterloo & Area Black LGBTQ in positions of power not living in region are resistant to helping with creating outreach strategies outside of 'paid' time. Addressing this through daytime-limited outreach to racialized LGBTQ people in these post-secondary environments. — AIDS Committee of Durham Region The cycles of increased police presence creates barriers to mobility for people who use drugs, and therefore either our ability to reach them or their ability to reach us. — AIDS Committee of Ottawa Lack of LGBT friendly spaces in the area means accessing that population is more challenging. The same issue is found in the ACB community. There is a pervasive concern among our outreach workers that HIV is not an issue or a big issue in this community. This requires our outreach workers to focus first on changing a person's perception of risk before they can then focus on changing a person's behaviours. — Positive Living Niagara Because of the shame surrounding sex in our society, compounded with issues of peer pressure and self-esteem in adolescence, youth are often wary of approaching our outreach booth or taking brochures/safer sex materials. We have found that bringing music speakers to play music, inviting them to the booth with our array of "free stuff!" as well as swag items to promote the Doin' It website breaks down some of the barriers that can make our booth intimidating. — AIDS Committee of Cambridge, Kitchener, Waterloo & Area

IDU outreach services

In 2014/15, the AIDS Bureau funded 21 IDU outreach programs — up from 20 in previous years. In addition, another 14-16 programs provided IDU outreach services in 2014/15 and their work is also reported in this section (Note: over time, the number of "other" agencies — that is, not specifically funded for IDU outreach services — has ranged from 16 to 19 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 1. Funded IDU outreach programs and other programs that reported in section 13 for 2014/15

Funded IDU Outreach Programs	Other Programs*
AIDS Committee of Durham Region (ACDR)	AIDS Committee of Cambridge, Kitchener, Waterloo and Area (ACCKWA)
AIDS Committee of Windsor (ACW)	AIDS Committee of North Bay and Area
Central Toronto Community Health Centres	AIDS Committee of Ottawa (ACO)
City of Ottawa Public Health	AIDS Committee of Simcoe County
Elevate NWO	AIDS Committee of Toronto (ACT)
Hamilton Public Health & Community Services	Algoma Group Health
HIV/AIDS Resources & Community Health (ARCH)	Black Coalition for AIDS Prevention (Black CAP)
Ontario Aboriginal HIV/AIDS Strategy (Oahas)	Elizabeth Fry Society of Toronto
Peel HIV/AIDS Network (PHAN)	The AIDS Network (Hamilton) (TAN)
Peterborough AIDS Resource Network (PARN)	HIV/AIDS Regional Services (HARS)
Positive Living Niagara	Maggie's: The Toronto Prostitutes' Community Service Project
Regional HIV/AIDS Connection	Ontario Aboriginal HIV/AIDS Strategy (Oahas) Sudbury
Réseau Access Network	Prisoners with HIV/AIDS Support Action Network (PASAN)
Somerset West Community Health Centre	Sandy Hill Community Health Centre
South Riverdale Community Health Centre	Toronto People with AIDS Foundation
Street Health Centre, Kingston Community Health Centres	Youth Services Bureau of Ottawa
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	

*Between 2010/11 and 2013/14, at least 10 other programs (not listed above) reported in section 13 of OCHART.

Key trends in IDU outreach programs

- Opiates, including Oxyneo, Oxycodone, Fentanyl, Percocet, Dilaudid and Morphine were the most commonly used substances, followed by crack and alcohol. Reports of methamphetamine use continued to rise.
- The types of services that people who inject drugs use have stayed consistent over the past 5 years.
- Funded IDU outreach programs reported fewer outreach interactions over the past two years (-16% in 2013/14 and -12% in 2014/15) while the other programs reported more outreach interactions over the past two years (+12% in 2013/14 and +63% in 2014/15).
- Central West Region reported more outreach interactions for three consecutive years in both funded IDU outreach programs and other programs. Funded IDU outreach programs in the region also reported increases for three consecutive years in in-service contacts.
- Toronto's funded IDU outreach programs reported fewer outreach contacts for four consecutive years.

Is there a difference between the funded IDU outreach programs and the other programs?
The data provided by the funded IDU outreach programs is more consistent over the years because the same programs are reporting. These data may provide a more accurate picture of service trends in the province while the other programs (which can change from year to year) give us a sense of additional work being done.

Funded IDU outreach programs	• Fewer in-service contacts (the biennial trend is drop and then increase) • Fewer outreach interactions reported for the past two years • Outreach locations focused on community agencies, mobile services, residences and pharmacies • Provided more services in the areas of counselling, education, practical support and referrals to social services
Other programs	• For the past four years, more in-service interactions • For the past two years, more outreach interactions • Outreach locations focused on community agencies, community public spaces, streets and parks, as well as bars and nightclubs • Whereas more services were provided in the areas of counselling, education, practical support and referrals to social service, it should be noted that, in 2013/14, far fewer services were reported than the previous year • Other programs provided more service to trans women.

Fewer IDU in-service interactions

The total number of unique in-service interactions (i.e. funded IDU outreach programs + other programs) is down 13% from the previous year (101,976 in 2014/15; 116, 869 in 2013/14) -- while the number of outreach interactions is up slightly from last year but still lower than in 2012/13.

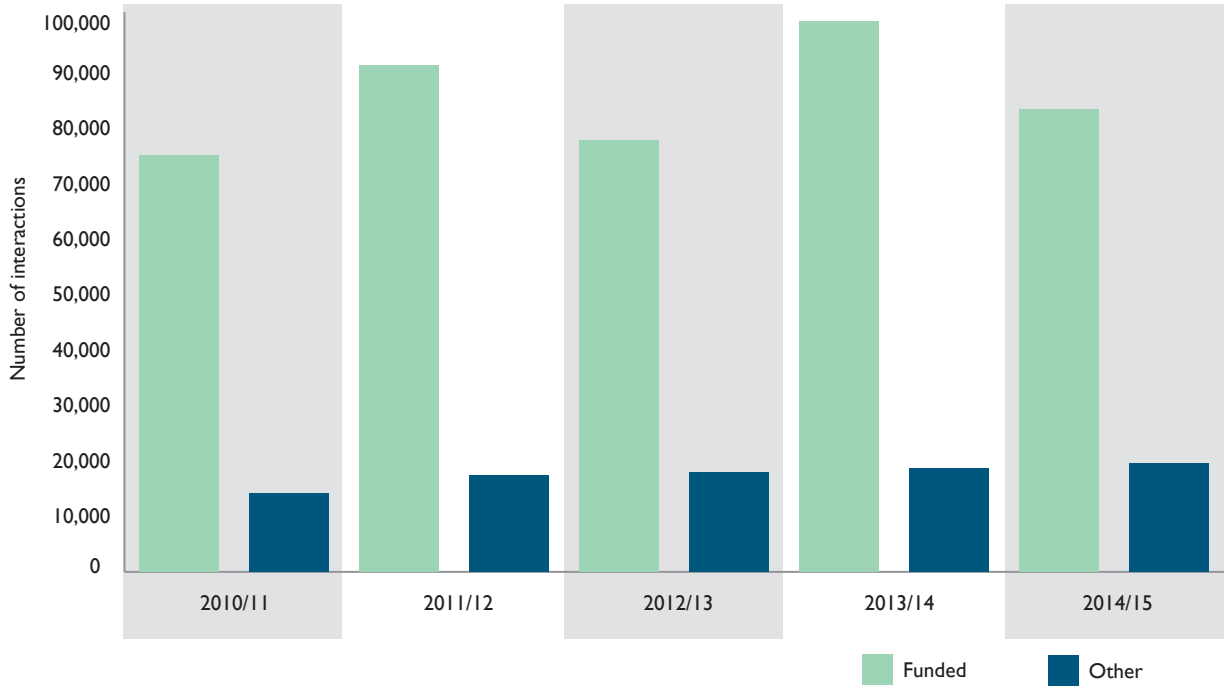
Table 2. Total IDU interactions reported by funded and other programs (OCHART q. 13.11 & 13.21)

	2012/13	2013/14	2014/15
IDU in-service interactions	94,739	116,869	101,976
IDU outreach interactions	76,881	67,538	68,647

For the past several years, programs have reported more in-service than outreach interactions. However, the pattern varies by type of program. The funded IDU outreach programs reported a 16% decrease in in-service interactions whereas the other programs reported a 5% increase.

In general, the number of interactions tends to fluctuate more among funded IDU outreach programs and to be more stable among the other programs – although the number of other programs reporting can vary year to year. However, the funded IDU outreach programs deliver significantly more service than the other programs.

FIGURE 30 Total number of IDU in-service interactions by funded IDU outreach programs and other programs(OCHART q. 13.21)



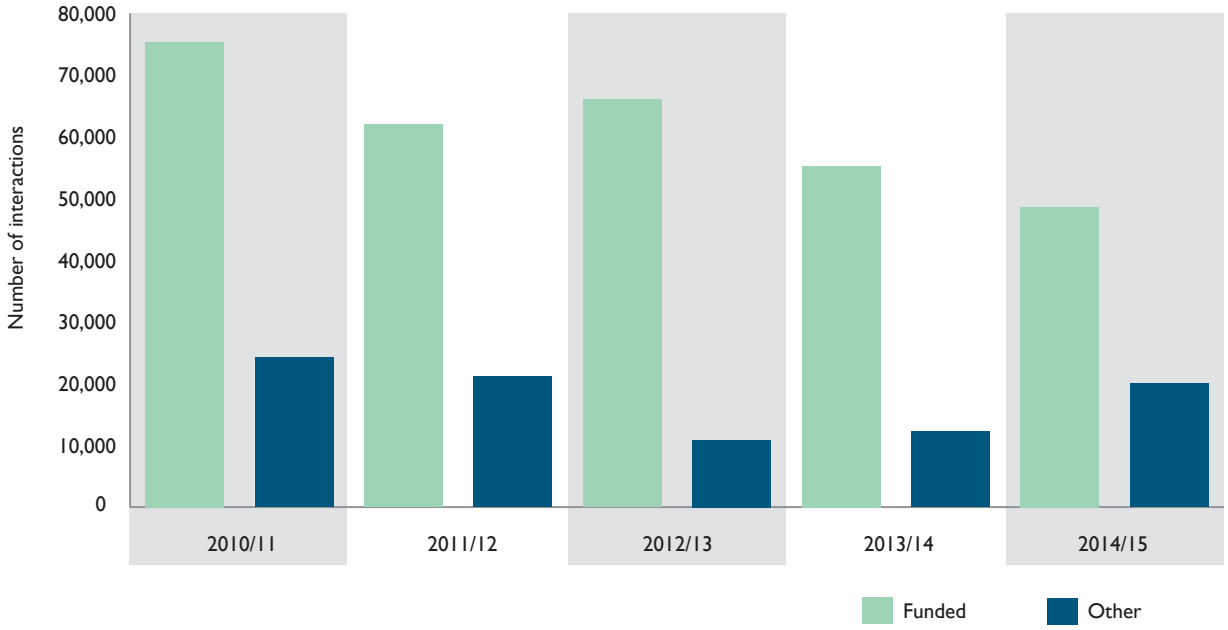
Introduction of harm reduction tracking tool may be affecting numbers

Some changes in the total number of interactions may be due, in part, to the introduction of the NEO harm reduction database, which is now in use in several agencies. A more in-depth analysis revealed that all agencies that began using NEO reported fewer interactions, which may mean the data are becoming more accurate or that agencies are still learning how to use the new system.

Trends in outreach interactions

Funded IDU outreach programs reported fewer outreach interactions for the second consecutive year while non-funded programs reported more outreach interactions over the past three years, including 63% more outreach contacts in 2014/15. As IDU outreach often depends on a program's capacity, part of the increase may be due to a few agencies reporting having more peers (see FigureFIGURE 42).

FIGURE 31 Total number of IDU outreach interactions by funded IDU outreach and other programs(OCHART q. 13.1.1)



Reaching people who use drugs via community agencies/services

In the 2014/15 reporting year, the question about outreach locations changed so we cannot compare this year's data with previous years. However, we can highlight some trends in the 2014/15 data. A new outreach location added in 2014/15 — community agencies/services — was the most reported site for outreach for both funded IDU outreach and other programs. Funded IDU outreach programs also reported doing a significant amount of their outreach through mobile services, at people's residences and in "other" locations while other programs focused on outreach in community public spaces and parks.

More contacts were made through pharmacies (3,970 in 2014/15 from 475 in 2013/14) while fewer contacts were made at methadone clinics (1,163 compared to 3,960 in 2013/14). This shift is most likely the result of more pharmacies dispensing methadone. Over the past three years, more contacts have been reported at correctional facilities and fewer at parties.

FIGURE 32 Top seven outreach locations for funded IDU outreach programs for 2014/15(OCHART q. 13.4)

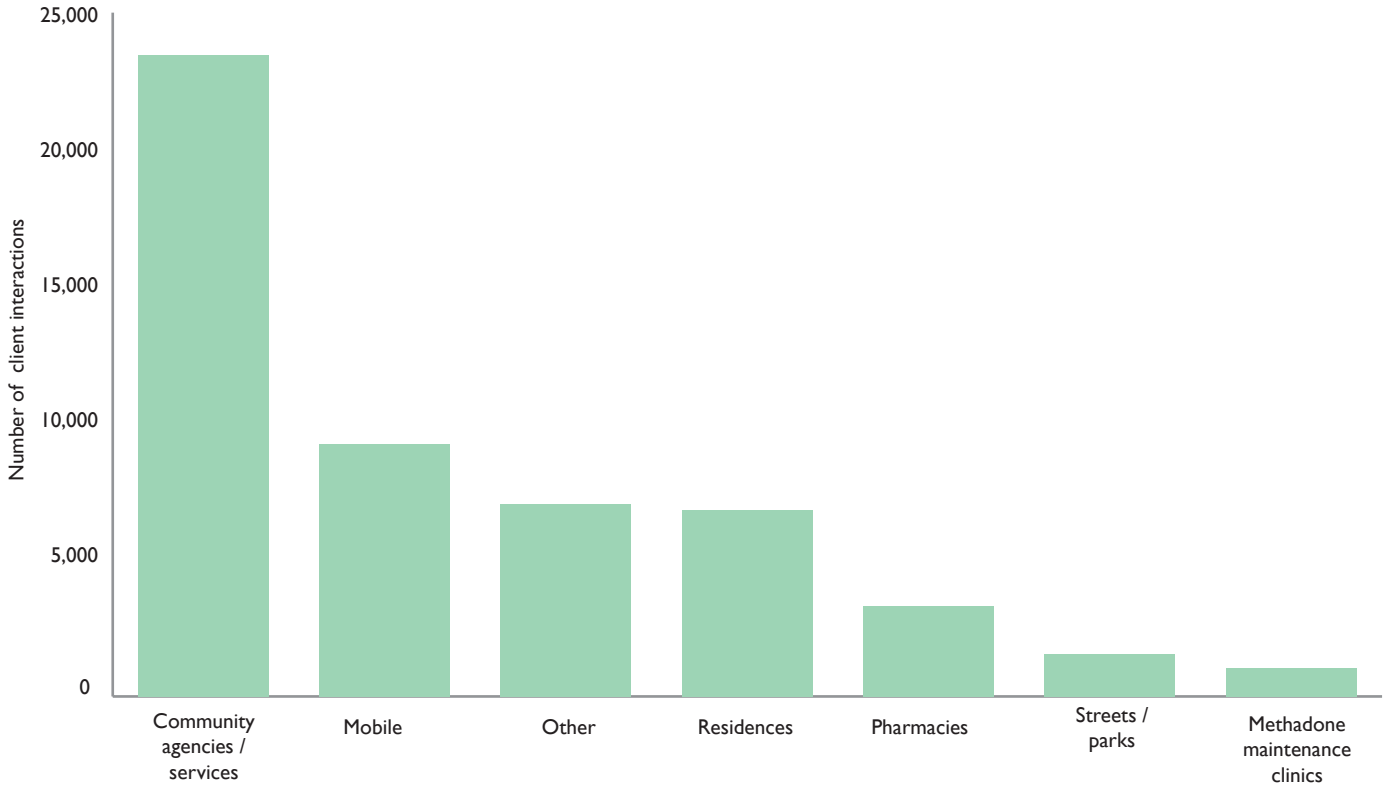
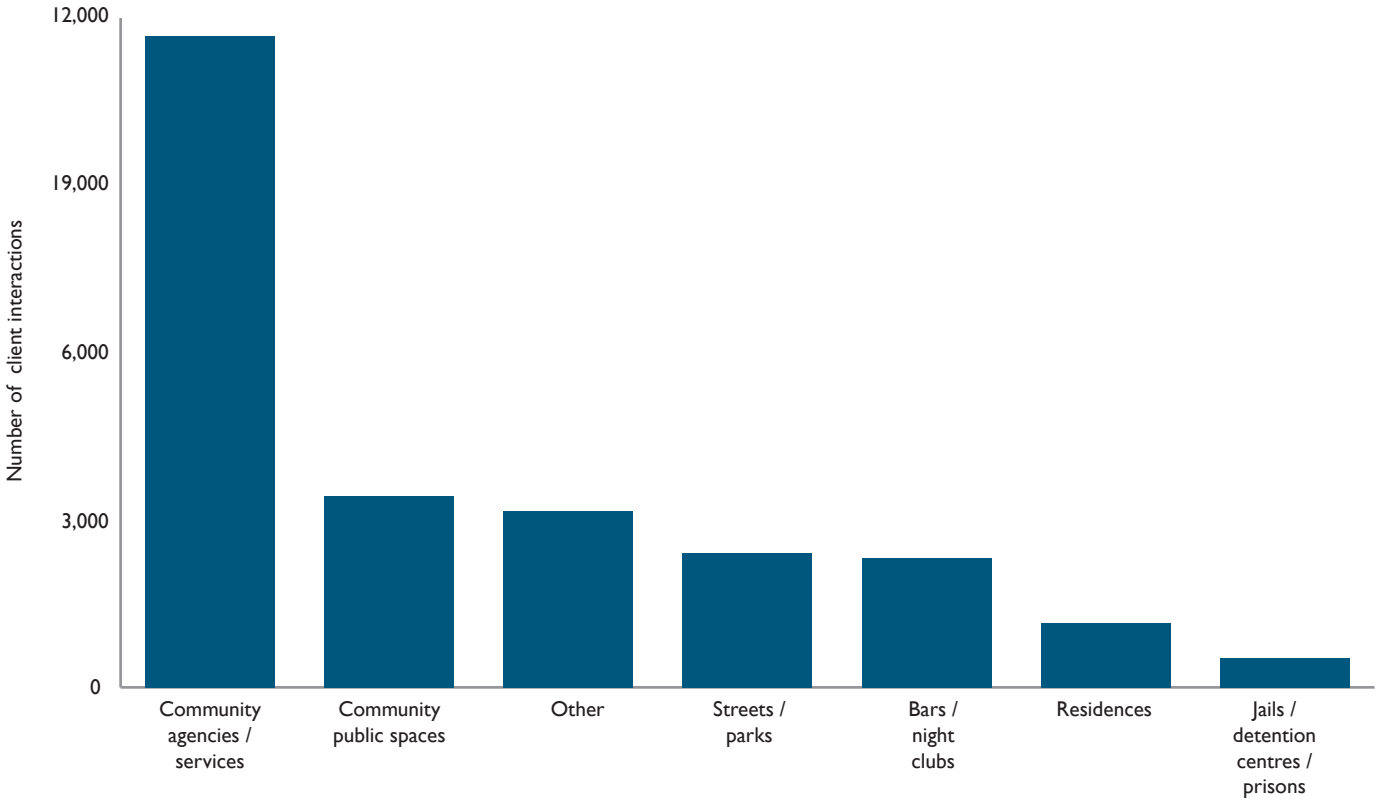


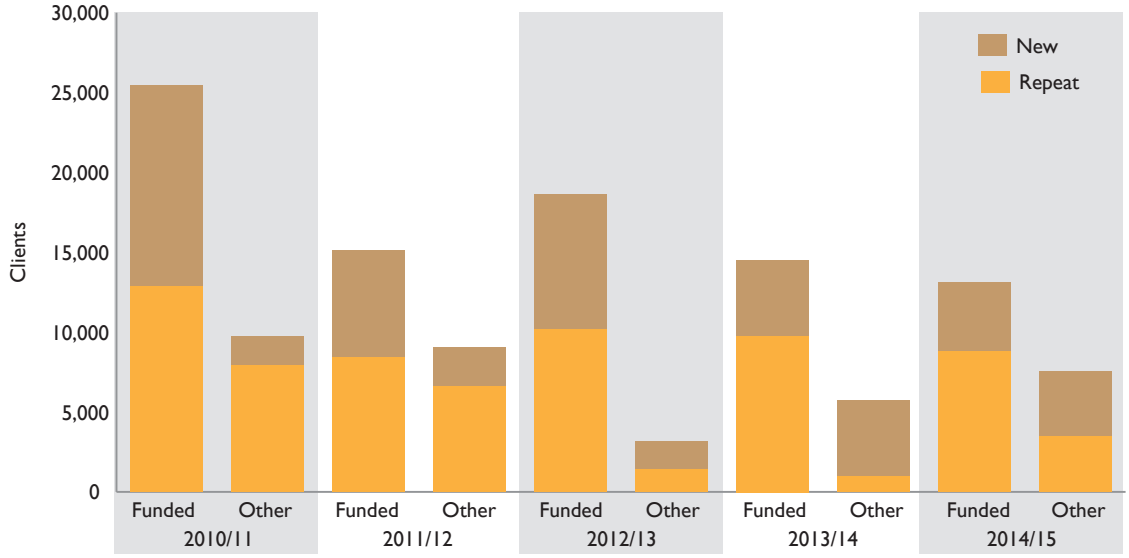
FIGURE 33 Top seven outreach locations for other programs for 2014/15(OCHART q. 13.4)



Unique outreach clients

OCHART asks programs to report the number of unique clients. Not all agencies have a way to track unique clients so these numbers tend to fluctuate over time and may not represent all people accessing services. Overall, the total number of unique outreach clients reported in 2014/15 was up 6%. Funded IDU outreach programs reported fewer new (-8%) and repeat (-10%) unique outreach clients, while other programs reported 14% fewer new unique outreach clients and more than a 250% increase in repeat outreach clients. Building trust with IDU outreach contacts is a challenge and it is encouraging to see an increase in repeat unique clients.

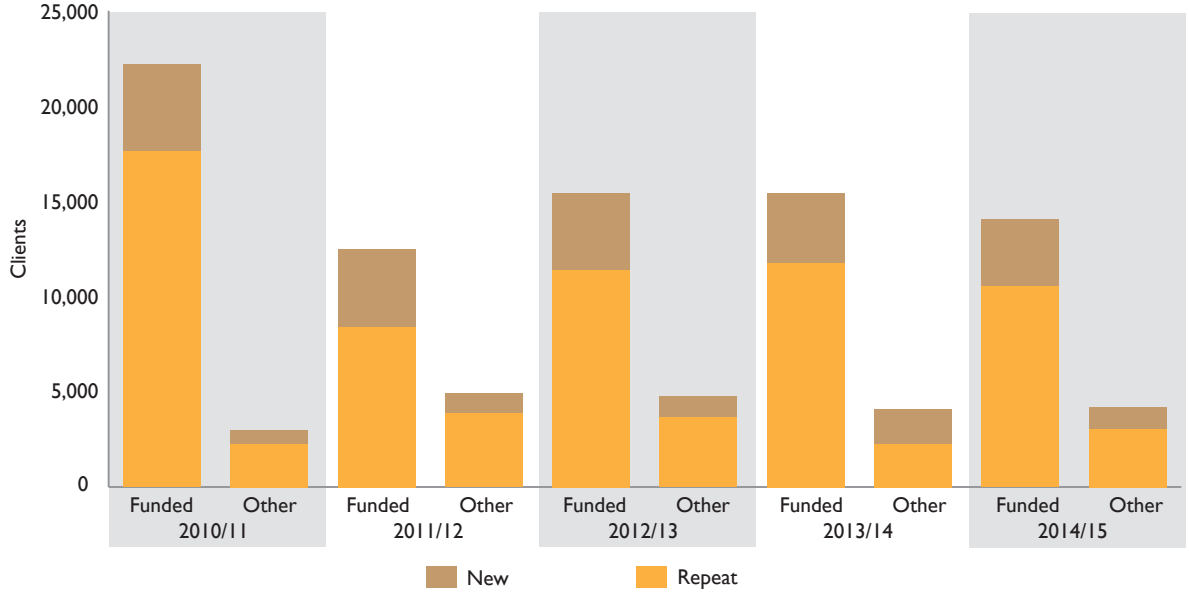
FIGURE 34 Total number of unique outreach clients reported by funded IDU outreach programs and other programs 2010/11-2014/15 (OCHART q. 13.1.2)



Unique in-service clients

For funded IDU outreach programs, the number of new unique in-service clients has remained relatively stable over the past four years while the number of unique repeat in-service clients dropped by about 10% (see figure X). Other programs reported 40% fewer new and 36% more repeat unique in-service clients.

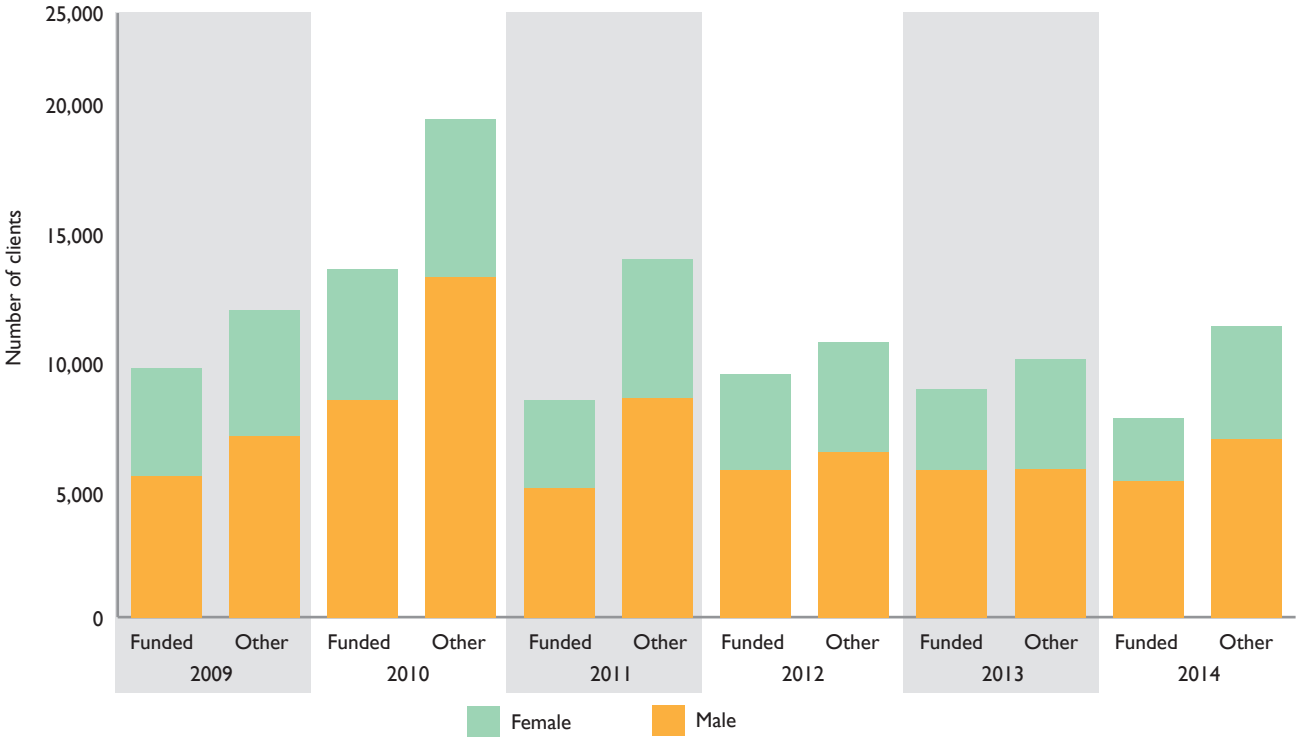
FIGURE 35 Total number of unique in-service clients reported by funded IDU outreach programs and other programs 2010/11-2014/15 (OCHART q. 13.2.2)



More males than females use IDU services

Figures 47 and 48 reinforce that more users of IDU services – both new and repeat – are male.

FIGURE 36 IDU outreach clients by gender(OCHART q. 13.1.2)



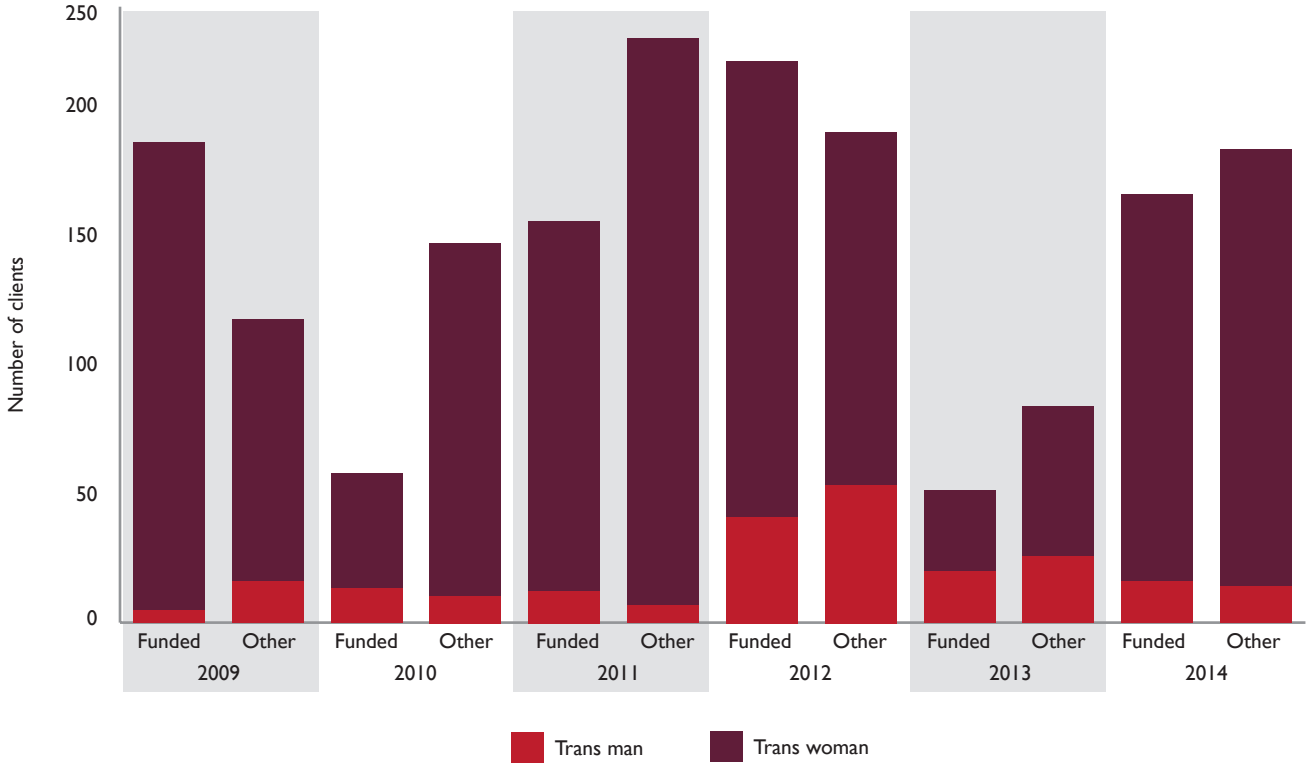
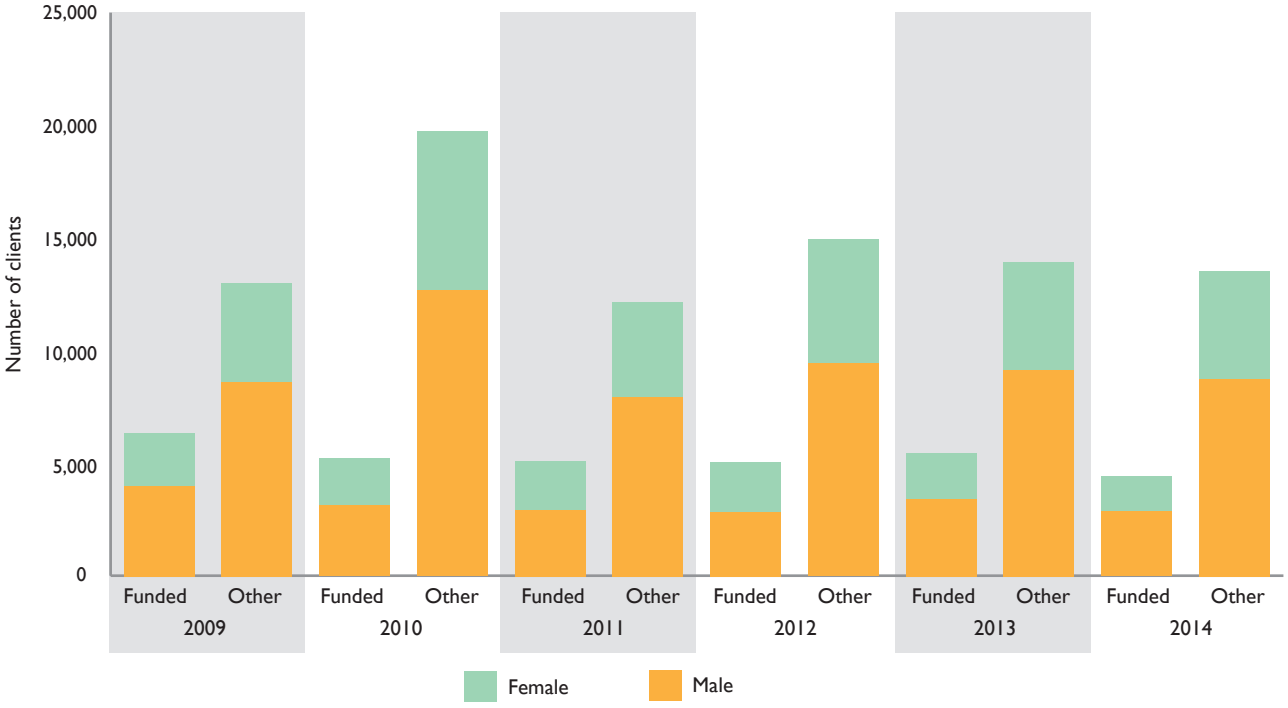
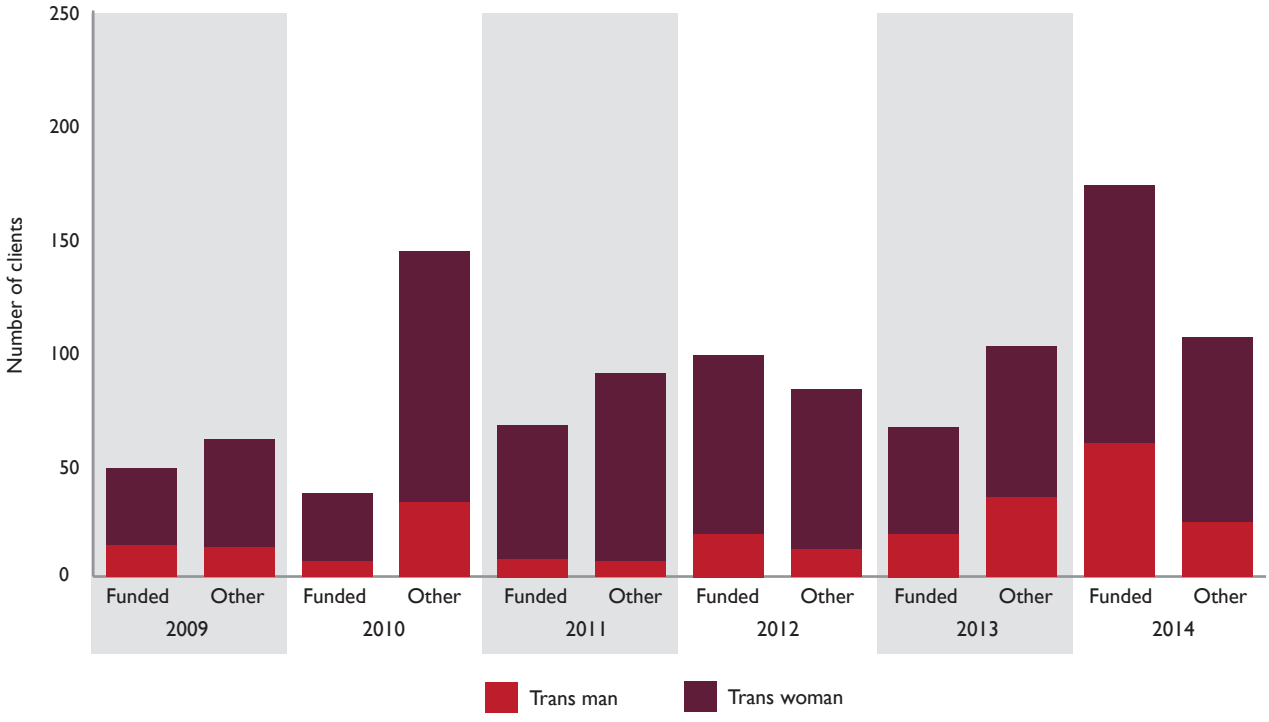


FIGURE 37 IDU in-service clients by gender(OCHART q. 13.1.2)



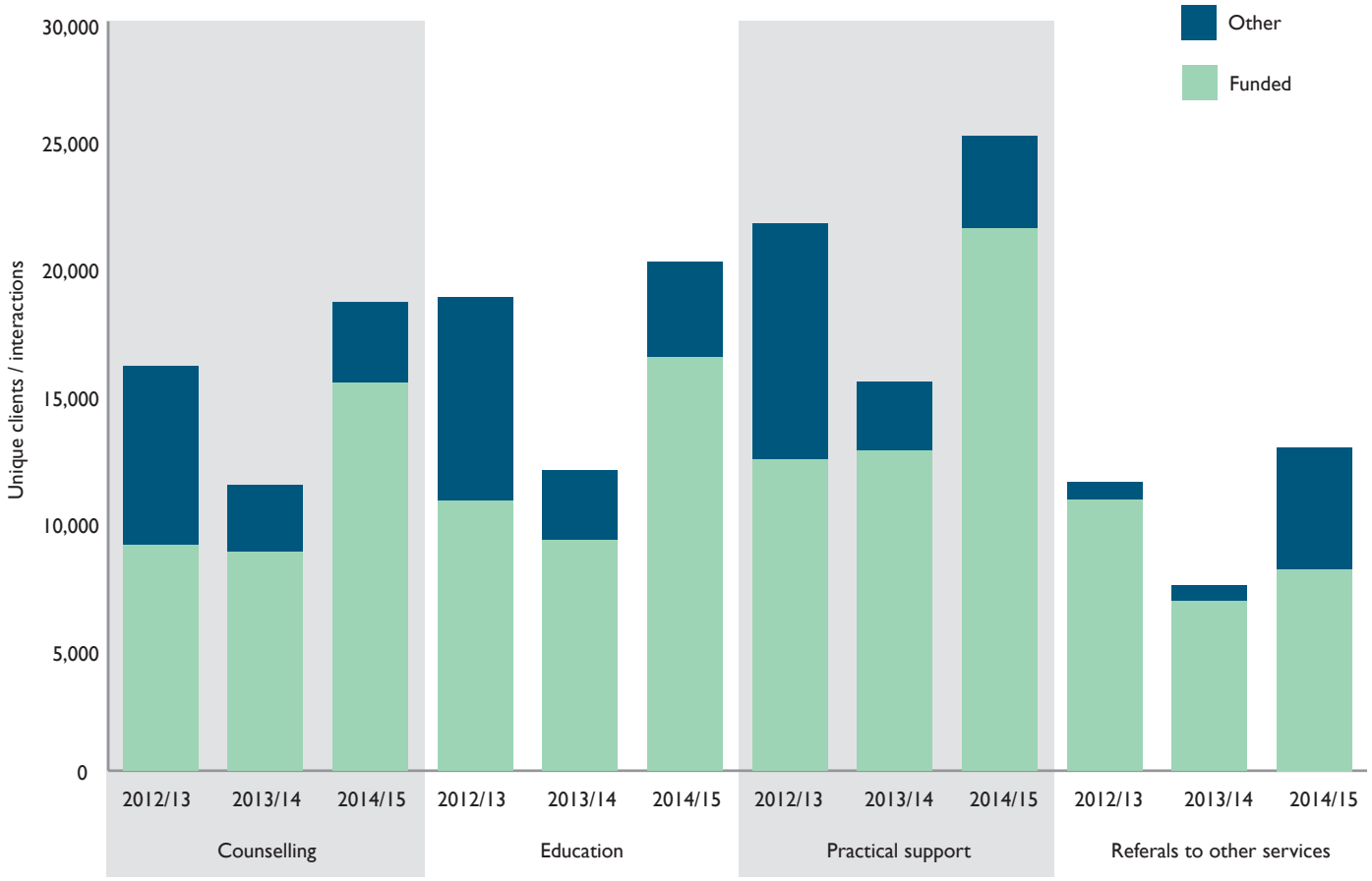


More IDU clients used counselling, education, practical support and referral services

Services for people who inject drugs are a critical part of Ontario's HIV and HCV prevention strategies. Both the funded IDU outreach programs and the other programs reported more clients using counselling, education, practical support and referral services.

The proportion of the services provided by funded or other programs does shift over time. In general, the funded IDU outreach programs provide more practical support and education services while other programs provide more referrals to social services.

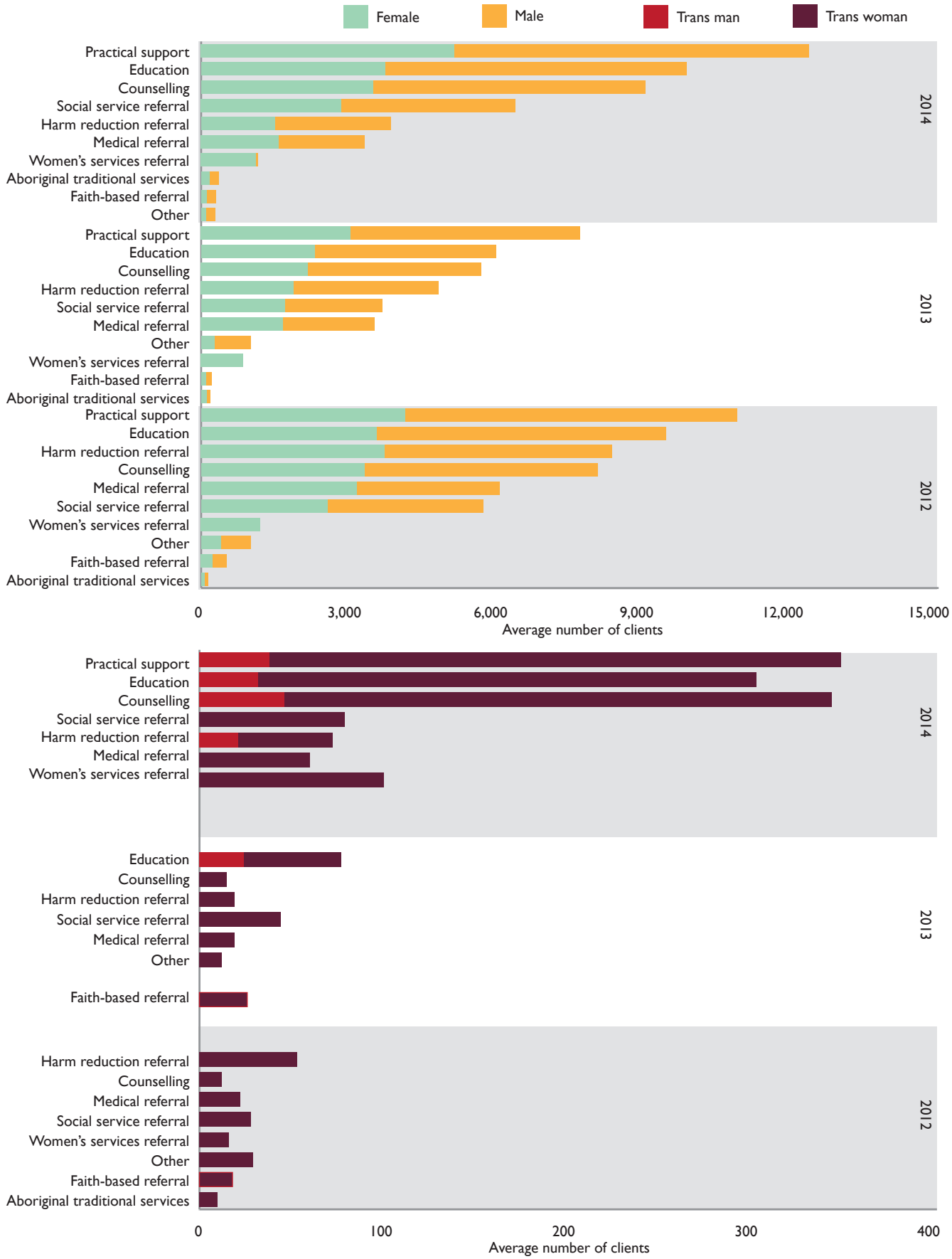
FIGURE 38 Top 4 IDU services provided over 3 years(OCHART q. 13.3a)



Women use more services

In terms of gender differences in service utilization, females generally account for more than half the services used although they represent only 35% of clients. It appears that men are willing to access practical support services, education and counselling services but are less likely to access referrals to other health and social services.

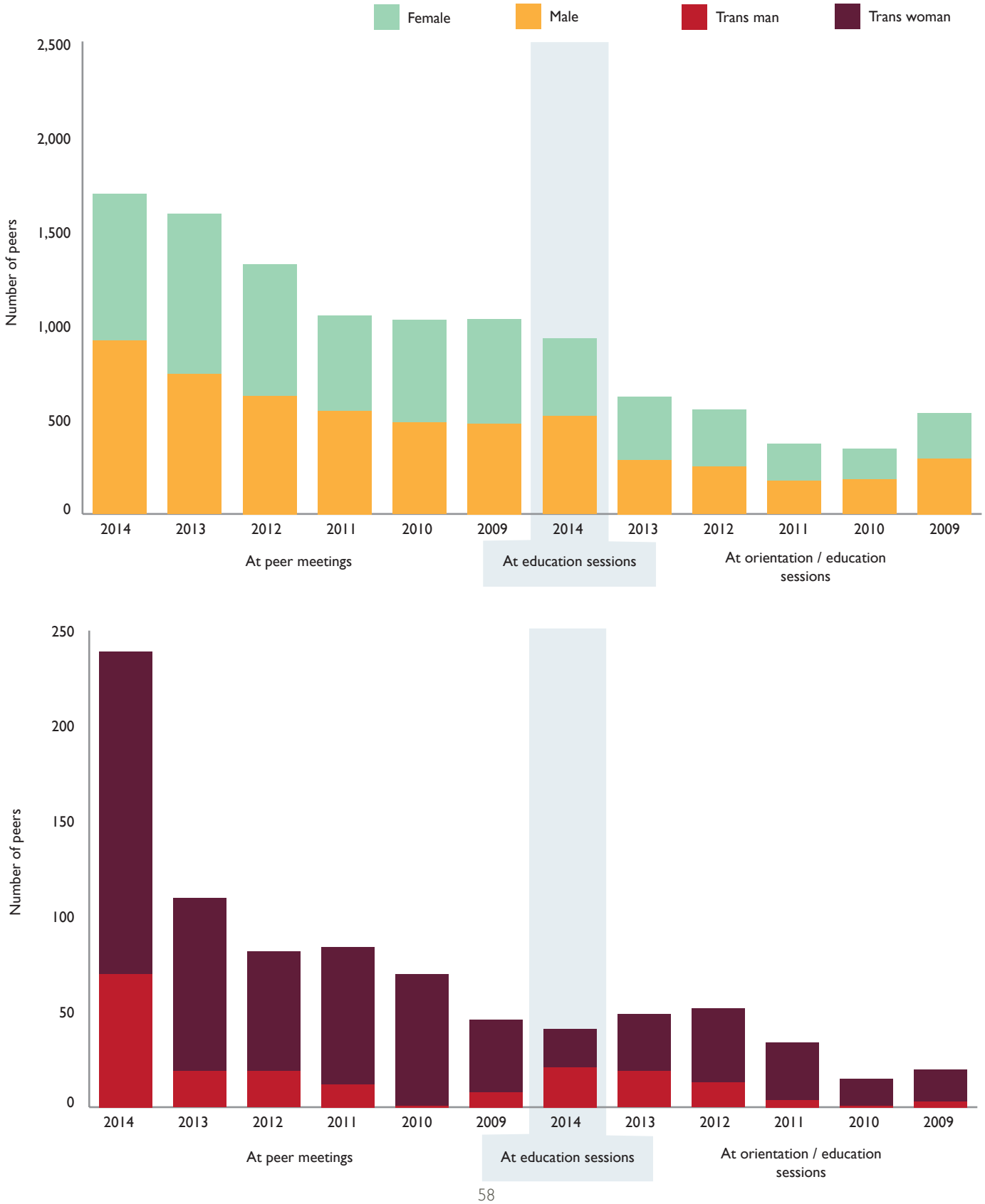
FIGURE 39 Use of IDU support services by gender

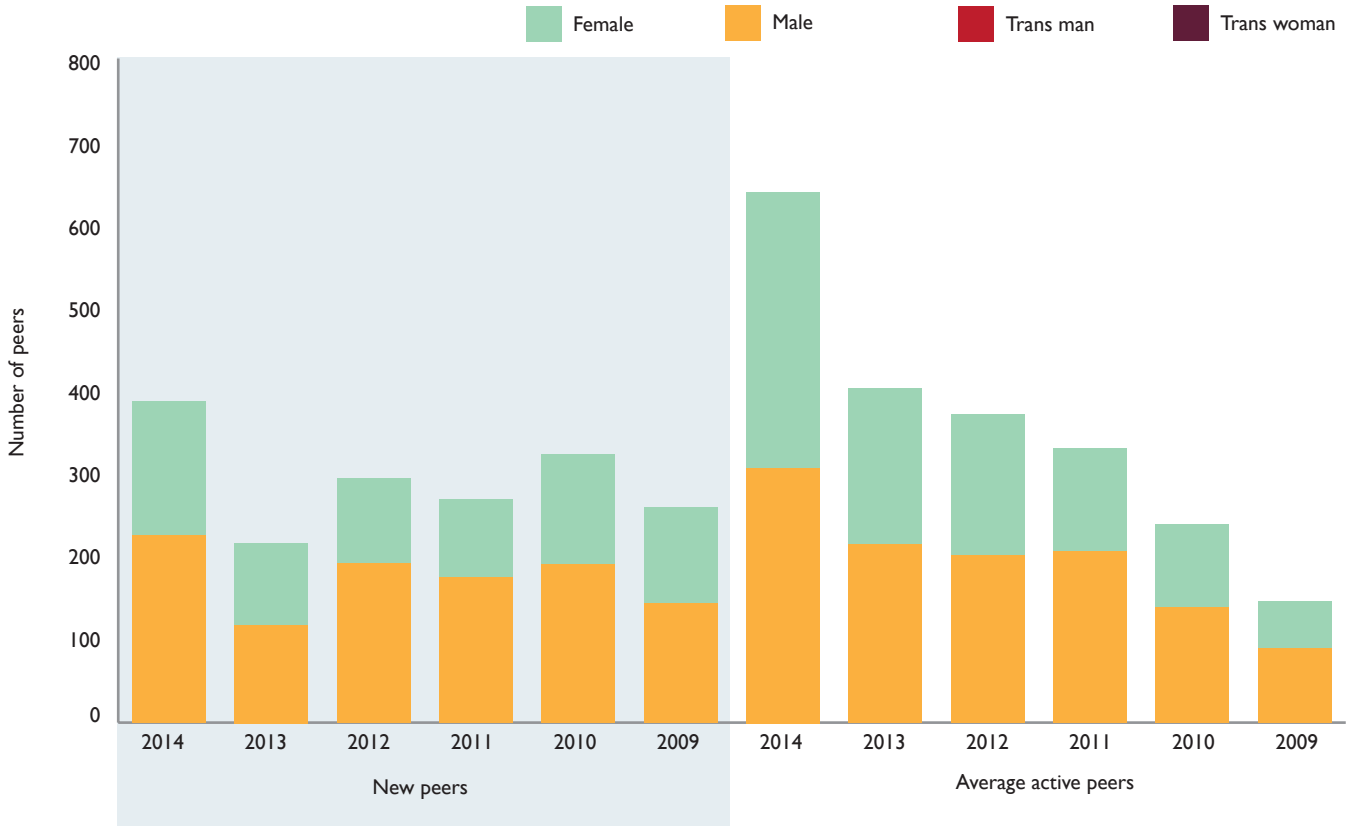


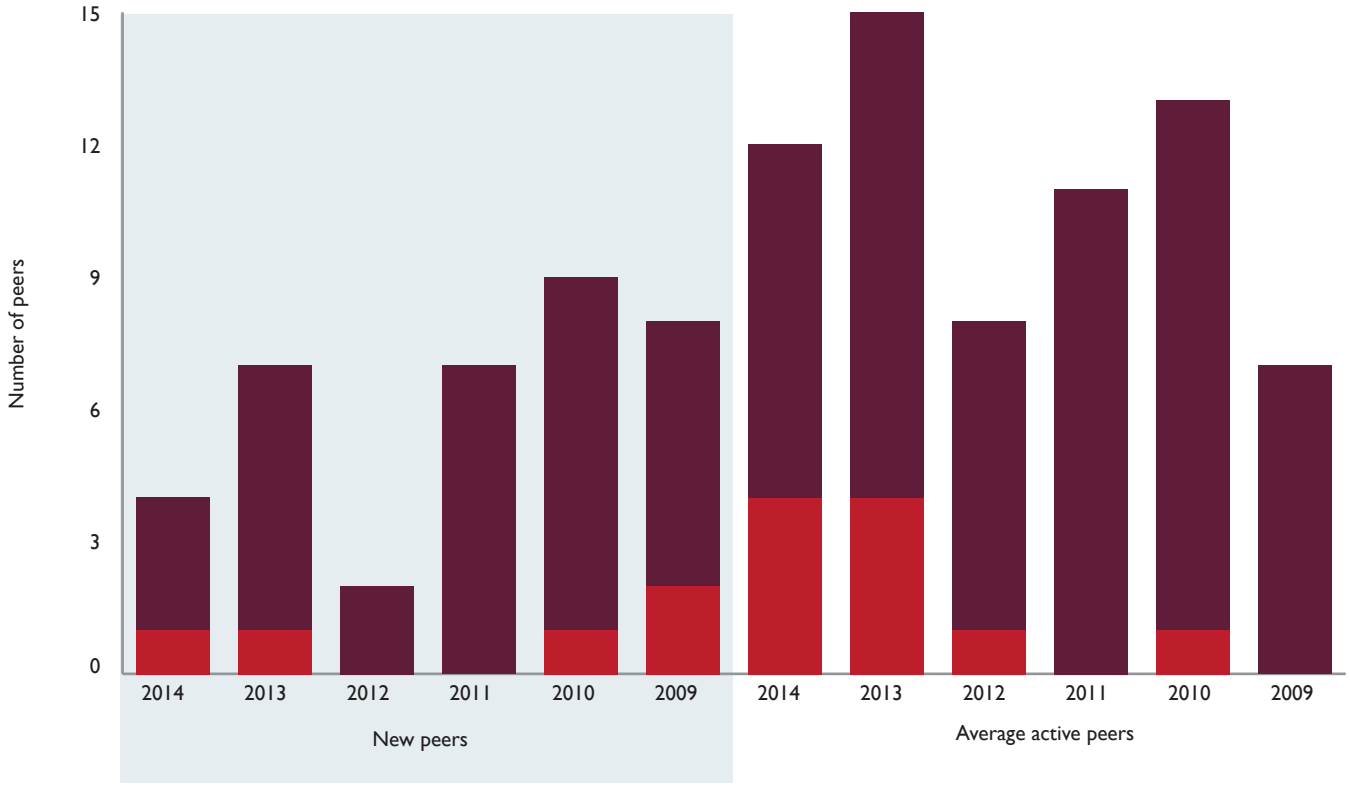
More peers are women

Although women accounted for only 35% of IDU clients in 2014/15, they made up 51% of active peers and 41% of new peers.

FIGURE 40 IDU peers by gender (OCHART q. 13/5)



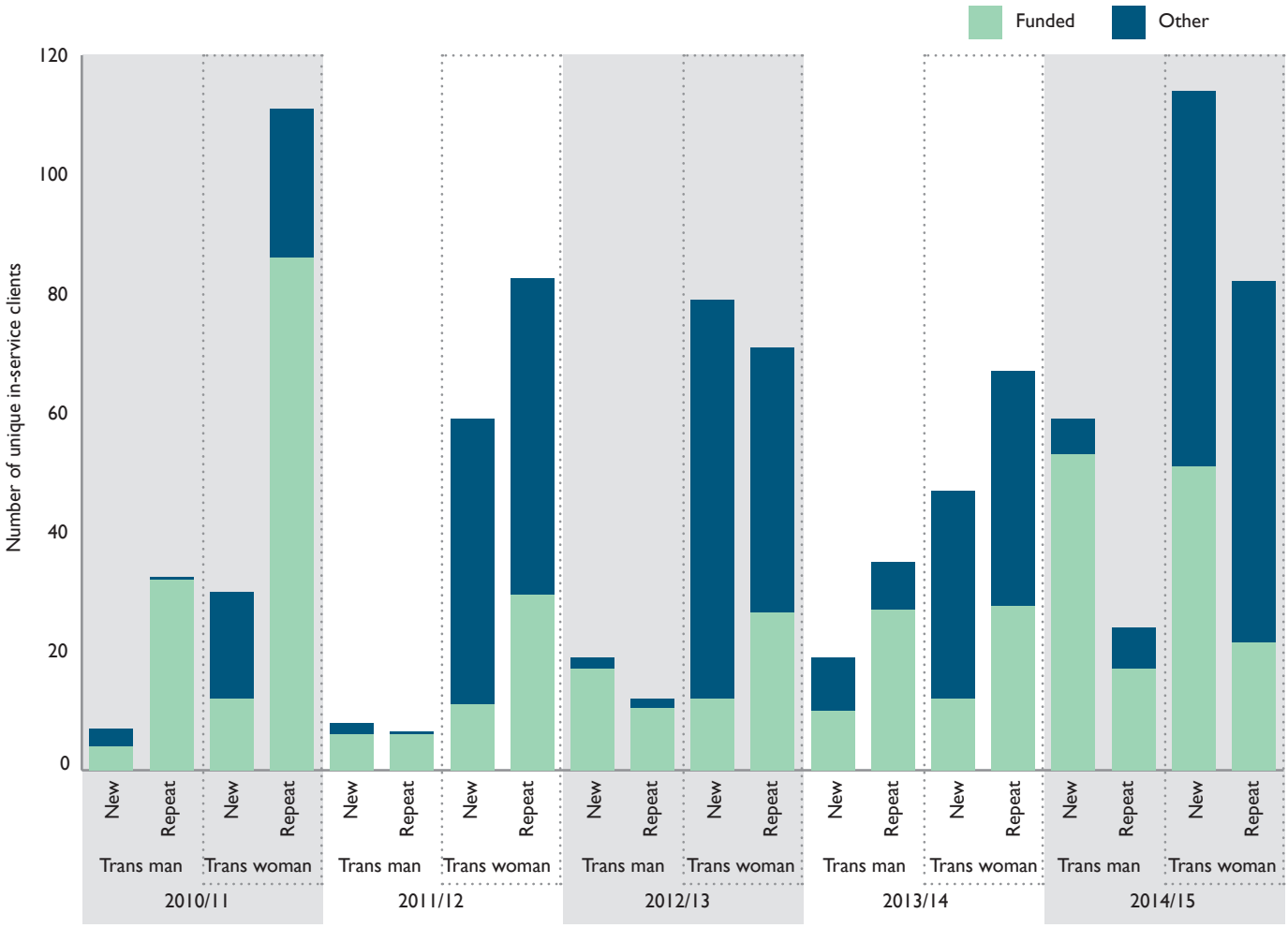

Female
Male
Trans man
Trans woman
Number of peers
800
700
600
500
400
300
200
100
0
2014
2013
2012
2011
2010
2009
New peers
Average active peers


Number of peers
15
12
9
6
3
0
2014
2013
2012
2011
2010
2009
New peers
Average active peers

More targeted services for trans women

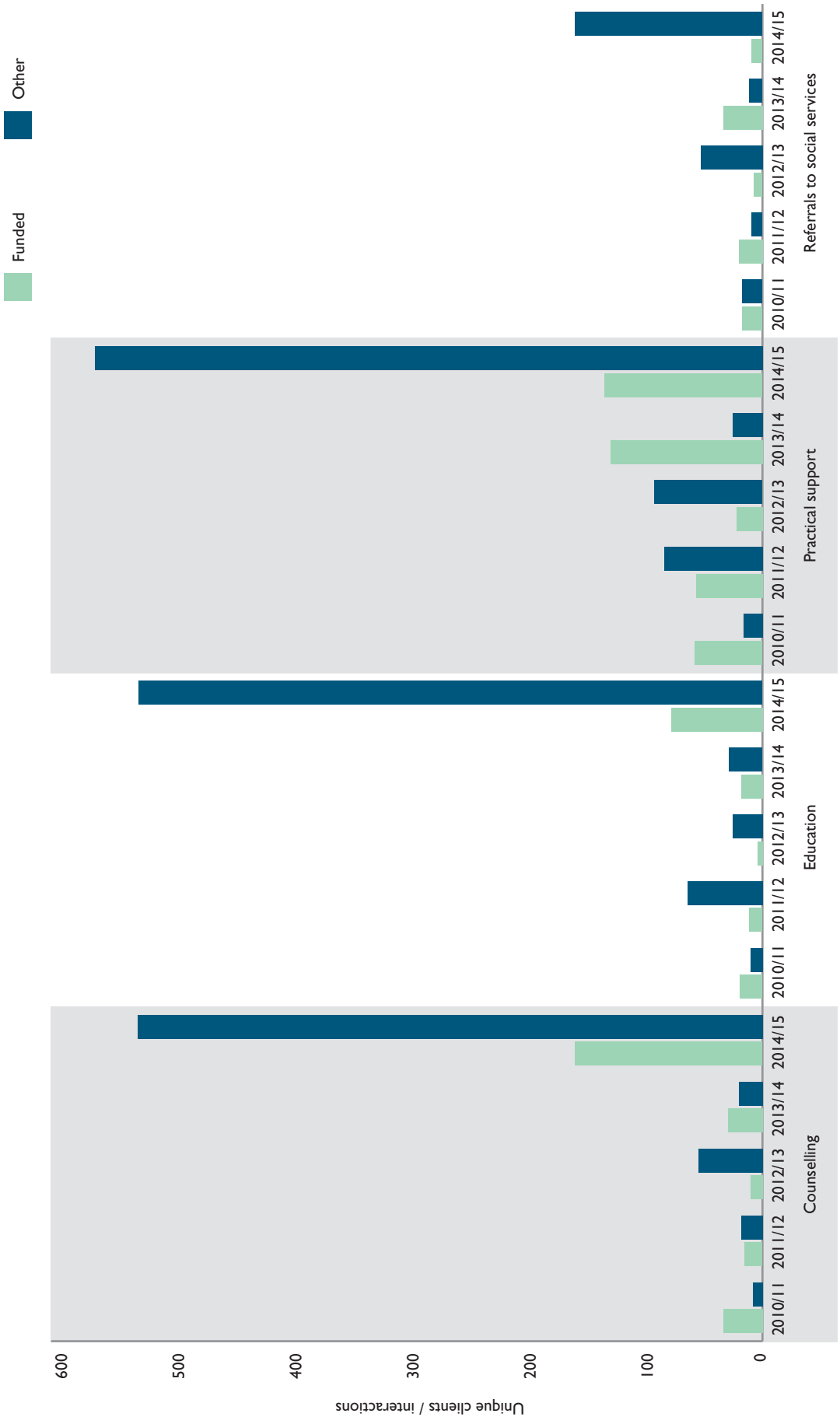
In the Toronto region, a sizeable portion of the increase in unique clients was due to more trans women accessing services. This change is most likely the result of two new program initiatives targeting the trans community (see Figure 52).

FIGURE 41 Total number of unique in-service trans clients over 5 years(OCHART q. 13.2.2)



Compared to trans men, trans women were more likely to use services and used more harm reduction services over the past five years.

FIGURE 42 Top 4 IDU services provided to trans clients over 5 years by funded and other programs(OCHART q. 13.3a)

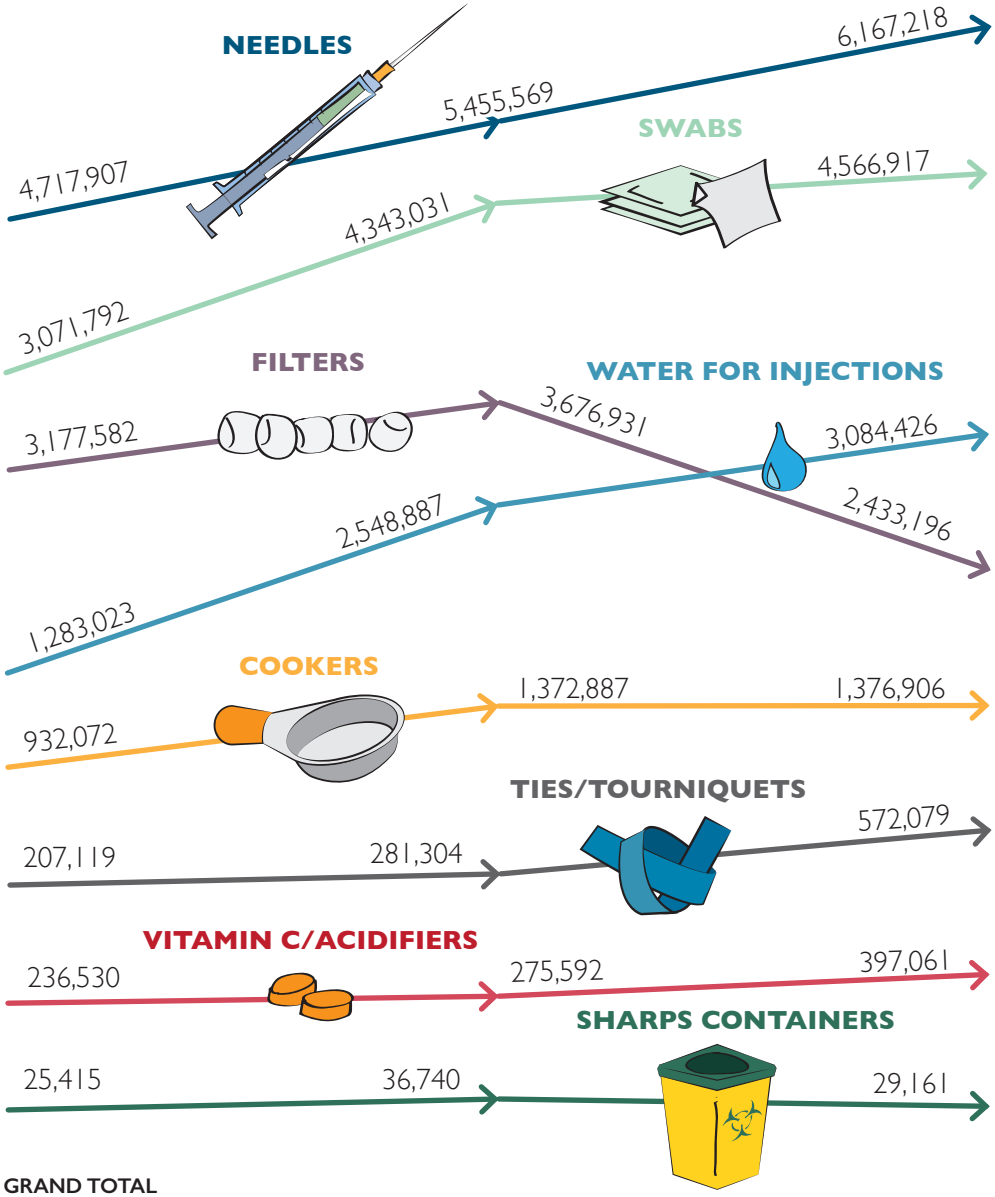


Need for safer injection equipment

Over the past three years, programs distributed about five million more units of safer injection equipment. The number of cookers distributed has remained consistent while the number of filters has dropped. This shift may be a result of fewer kits and more individual pieces being distributed based on user requests. Although the need for sharps containers continues, fewer are being distributed. One agency reported that the cost of sharps containers was becoming a barrier.

FIGURE 43

SUPPLIES DISTRIBUTED (OCHART Q. 13.10A)



GRAND TOTAL

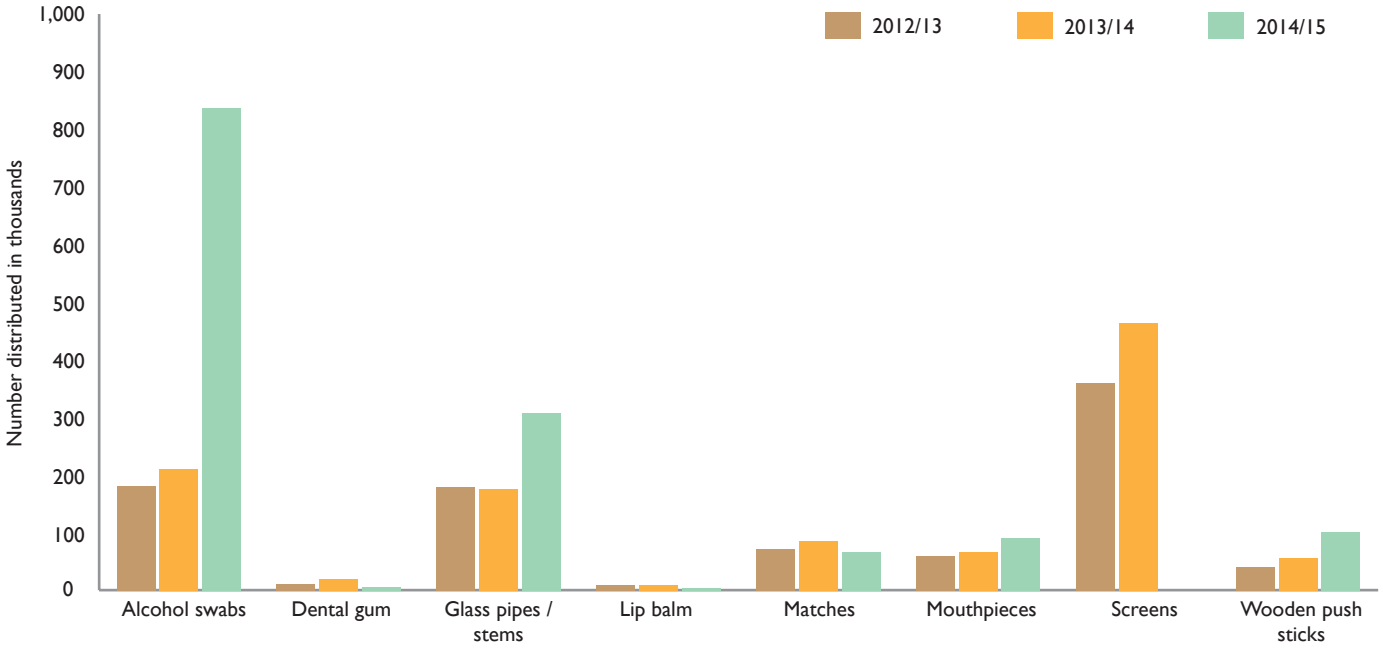
2012/13	2012/13	2012/13
13,651,440	17,990,923	18,626,964

Distribution of safer inhalation supplies varies across the province

While most programs reported distributing fewer pipes, several handed out more and reported more demand for and greater shortages of safer inhalation equipment. The differences cannot be explained by geography.

The 300% increase in the number of swabs distributed may be due to a reporting error. However, several agencies reported distributing more swabs and they explained the reason for the increase as "more access to swabs so we could give more out." If the swab number is removed from the analysis, the overall number of safer inhalation equipment distributed increased in all but one region. This increase is attributed to stems, mouthpieces and sticks.

FIGURE 44 Trends in safer inhalation supplies distributed 2012/13 – 2014/15 (OCHART 13.10a)



Shifts in IDU outreach needs and services in 2014/15

CRYSTAL METH, HEROIN AND FENTANYL USE ON THE RISE

Peterborough AIDS Resource Network

We continue hearing reports from clients about an increase in fentanyl abuse, as well as an increase in the availability of heroin.

Réseau Access Network

Fentanyl use has increased during the reporting period increasing the need for overdose prevention education and messaging along with the introduction of naloxone into our community to prevent lethal opiate overdoses from continuing to occur.

AIDS Committee of Durham Region

There is an increase in the number of short-tip needle requests.

Algoma Group Health

We have noticed more people accessing needle exchange disclosing their drug of choice being steroids.

AIDS Committee of Cambridge, Kitchener, Waterloo & Area

There is a need for methamphetamine inhalation supplies as their use has gone up dramatically.

AIDS Committee of North Bay Area

More requests for food, clothing, practical items, likely showing marginalized population becoming more at risk.

ADVERSE EFFECTS OF METH

Hamilton Public Health

We have noticed more clients reporting crystal meth use, as well as two instances of workers dealing with clients experiencing crystal meth induced delirium.

The AIDS Network

More clients demonstrating that they are experiencing psychosis related to noticeable spike in crystal meth use, and seeing more K and GHB and less heroin use. Steroid use not as high as previous years at the end of this reporting period for seasonal change into spring.

SHIFT IN COMMUNITY PERCEPTION

Réseau Access Network

An encouraging change we have seen is an influx of people utilizing a new methadone clinic. There have been numerous positive reviews by our clients about how well they are being treated and respected, as well as about the services they are being provided.

Syme-Woolner Neighbourhood and Family Centre

Since the implementation of the needle exchange program, as well as community cleanups, there has been a significant drop in complaints from surrounding buildings about used equipment discarded in and around their buildings.

Warden Woods

Generally there seems to be positive shift in attitude from the larger community and the negativity around addiction has softened.

AIDS Committee of Durham and Region ACDR

There continues to be a significant shift in the community towards reducing opioid overdoses.

Positive Living Niagara

There have been a high number of overdoses reported that have involved heroin almost exclusively, but in many cases naloxone has been used to successfully reverse the overdose.

INCREASED OVERDOSES

Réseau Access Network

We have lost several clients during the reporting period to lethal opiate overdoses.

CONCERNS ABOUT WAIT TIMES

Ontario Aboriginal HIV/AIDS Strategy (Oahas), Toronto

We continue to see wait times for affordable housing in the downtown core. We also find that people are being housed around the GTA and not downtown as a result of gentrification of low-income communities in the downtown core. This is problematic as services for people who use substances are lacking in those parts of the GTA.There is a 10-12 year wait for a three-bedroom home in Native Housing here in Toronto.

AIDS Committee of Ottawa (ACO)

Catchment areas and finding a general practitioner who is well versed in queer men's issues or HIV makes it complicated.

Youth Services Bureau Ottawa

For trans-identified clients who would like to access medical supports for physical transition, there are significant barriers for receiving hormones through medical channels including long wait times, multiple service providers, and issues with access to pharmaceutical care. Youth often state that accessing medical supports for life-saving transition needs is urgent and that it is not possible to wait. As a result, youth access street hormones and inject these without supervision. The Youth Health Clinic reports that there are three youth who are seeking support from the nurse practitioner to reduce harms associated with this practice.

Algoma Group Health

Mental health services specific to the needs of LGBTQ++ identifying individuals (specifically youth) as well as gay, bisexual and other MSM are not available in our district, so this is also an ongoing challenge.

AIDS Committee of North Bay & Area (ACNBA)

We are speaking with clients about potential dangers from wellbutrin being 'cut' and discussing safer usage.

Somerset West

We have responded to the increase in heroin use by distributing foil that can be used to smoke heroin. We have developed a poster and distributed over 300 copies on the safer use of Fentanyl.

DEVELOPING INFORMATION RESOURCES AND PROGRAMS TO ADDRESS CHANGES IN DRUGS OF CHOICE

AIDS Committee of Cambridge, Kitchener/Waterloo & Area (ACCKWA)

We are currently seeking more information about safer inhalation methods for people using methamphetamine as well as creating awareness of the dangers around mixing stimulants and opiates.

AIDS Committee of Durham Region (ACDR)

We continue to work with community partners to implement both a Fentanyl patch exchange program and a Naloxone program along with providing education to our clients and the general community.

City of Ottawa Public Health

Weekly outreach to a peer-led drop-in for IDU; expansion of youth harm reduction drop-in to include bi-weekly drop-in for LGBTQ+ youth in partnership with Youth Services Bureau; monthly outreach to Dave Smith Youth Treatment Centre; and exploration of peer-based HIV testing as part of our on-going service delivery model.

DEVELOPING PROGRAMS TO ADDRESS CHANGING DEMOGRAPHICS

Peel HIV/AIDS Network

In collaboration with other community partners we have helped to set up a peer-led women's drop-in with a focus on sex work which has steady participation. This has led to interest by other agencies in expanding services for sex workers.

Unison Health and Community Services

We are going to collaborate with public health to do more overdose training. We are currently in process of developing a training to educate the dealers of our clients. We think this is a very important step within the harm reduction approach because those dealers have the most contacts with our clients in this community. The increased use of heroine is also new territory for these dealers so we think that's the reason for a larger scale of overdoses. Our clients are very paranoid of the purity of the products they are getting from these dealers. And they are also aware that they have lost at least three of their peers in last couple of years to drug overdoses.

DEVELOPING AND IMPLEMENTING NALAXONE PROGRAMS TO PREVENT DEATHS FROM OVERDOSE

Positive Living Niagara

We have attempted to step up a number of naloxone trainings, with 80 new people trained in this time period. We are looking for a funding source to fund a naloxone trainer as staff capacity is limited to continue at this pace.

Somerset West Community Health Centre

Eighteen of our peer workers have now received Peer Overdose Prevention Training and those that meet the criteria have naloxone kits.

AIDS Committee of Windsor

Operating a naloxone program.
Increase in meth information pamphlets.

4. Anonymous HIV testing services

In 2014-15, eight agencies and programs funded by the AIDS Bureau Ministry of Health and Long-Term Care to provide anonymous HIV testing started reporting their activities and services through OCHART. Here is the first snapshot of their data.

Anonymous HIV testing sites by public health region

Northern
- Thunder Bay District Health Unit
- Sudbury District Health Unit

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

Toronto
- Hassle Free Clinic

The context for HIV testing in Ontario

Anonymous HIV testing has been available in Ontario since 1992. Fifty (50) organizations that provide HIV testing (some with multiple sub-locations) are designated under the *Health Protection and Promotion Act* to also provide anonymous HIV testing. Of the 50 sites, eight have been funded by the AIDS Bureau to support delivery of anonymous testing in their communities. The data reported in this section reflects HIV testing by the eight sites that report in OCHART.

In Ontario, HIV testing is available nominally, coded/non-nominally, and anonymously:

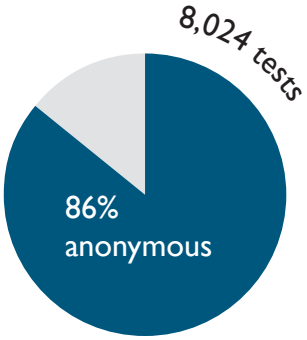
- **Nominal HIV tests:** A person tests using their name which appears on the test requisition form sent to the Public Health Laboratory and on their medical file retained at the medical facility. This testing is available at all medical facilities that provide HIV testing. The majority of HIV testing is done nominally in Ontario.
- **Coded (non-nominal) HIV tests:** A person tests for HIV using a code which appears on the test requisition form sent to the Public Health Laboratory. Their name would appear on their medical file retained at the medical facility. Their code could be linked to their name through their medical file. This testing is available at some medical facilities that provide HIV testing.
- **Anonymous HIV tests**: A person tests for HIV using a code and no identifying information is collected about them. The code appears on the test requisition form sent to the Public Health Laboratory and on their medical file retained at the medical facility. Their anonymous medical file is kept separate and cannot be linked to their identity. Only Ontario government designated anonymous HIV testing sites are authorized to provide anonymous testing.

Almost all anonymous HIV testing sites can provide both standard blood-draw testing and rapid testing. Standard blood-draw testing requires a blood sample from a tester's arm which is sent to the Public Health Laboratory for results in a few days to one week. Rapid testing requires a finger puncture of blood and can provide results in about 60 seconds (20 minutes with pre and post-test counselling).

Regardless of the way people choose to test for HIV, they will receive pre and post-test counselling and referrals to services, as needed. In addition, information on age, sex/gender and risk factors is collected to help understand the epidemiology of HIV in the province.

How many HIV tests did the eight sites administer?

In 2014/2015, the eight testing sites administered 8,024 HIV tests (anonymous, nominal, coded) using either a rapid or standard blood draw testing method. Most — 6,875 (86%) — were anonymous tests. The remaining 14% (1,149 tests) were coded and nominal tests. (Note: the total number of tests does not include the blood tests that are used to confirm a reactive rapid test.)

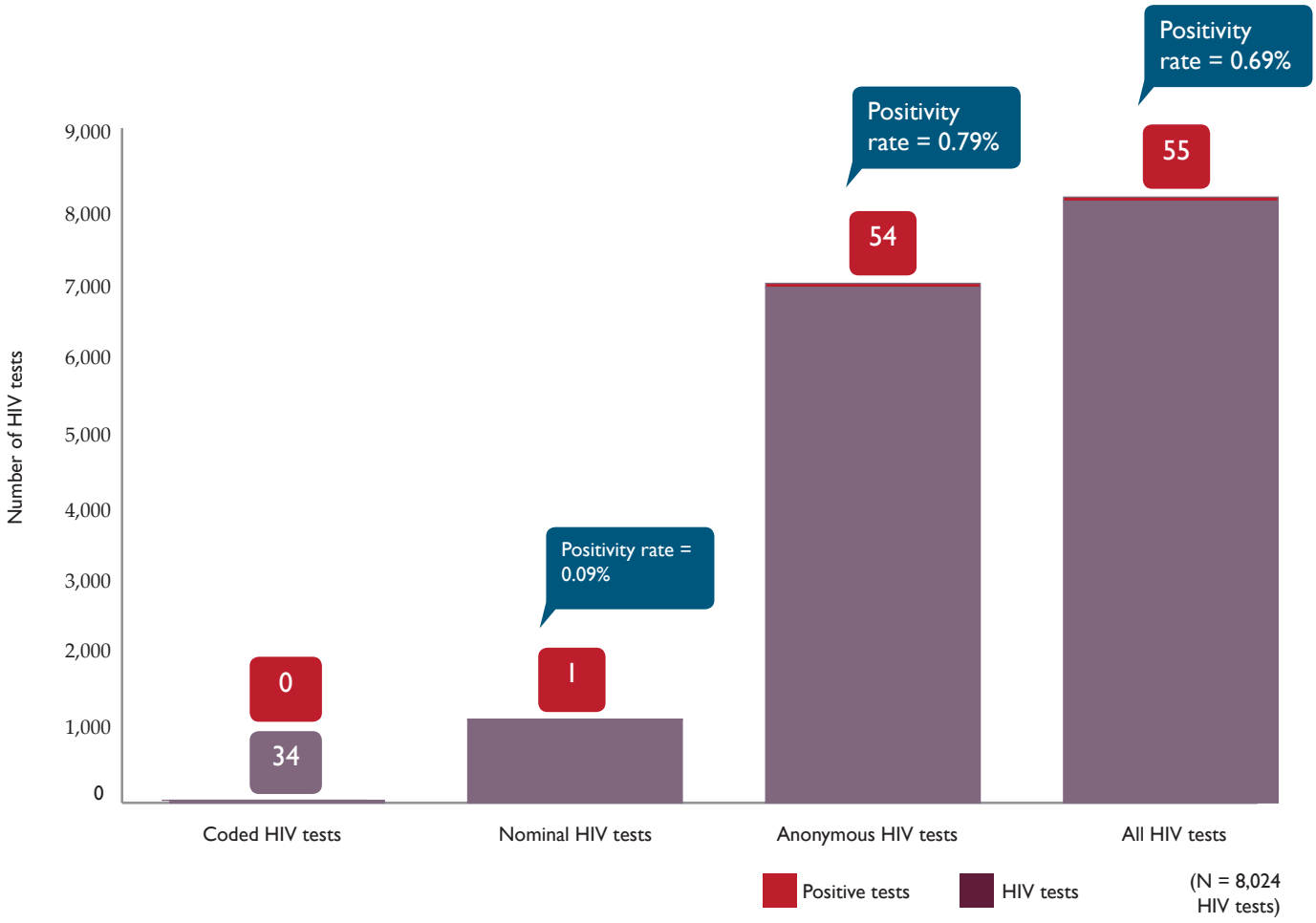


How successful are we at diagnosing people infected with HIV?

Majority of people diagnosed using anonymous tests

In 2014/15, the eight sites diagnosed 55 individuals with HIV (includes nominal and anonymous HIV tests). This represents a 0.69% positivity rate (55/8,024). However, when we look at the positivity rate across the different tests, we see that anonymous testing yields a 0.79% positivity rate and nominal tests yields a 0.09% positivity rate. (The eight sites did not have any positive tests from their coded HIV tests.) These positivity rates are consistent with data for HIV testing across the province (as provided by the Public Health Ontario Laboratory), which shows that anonymous HIV testing attracts those who are undiagnosed at a significantly greater rate than nominal and coded testing.

FIGURE 45 Number of HIV tests by test type and positivity rate 2014/15 (OCHART q. 8.1)

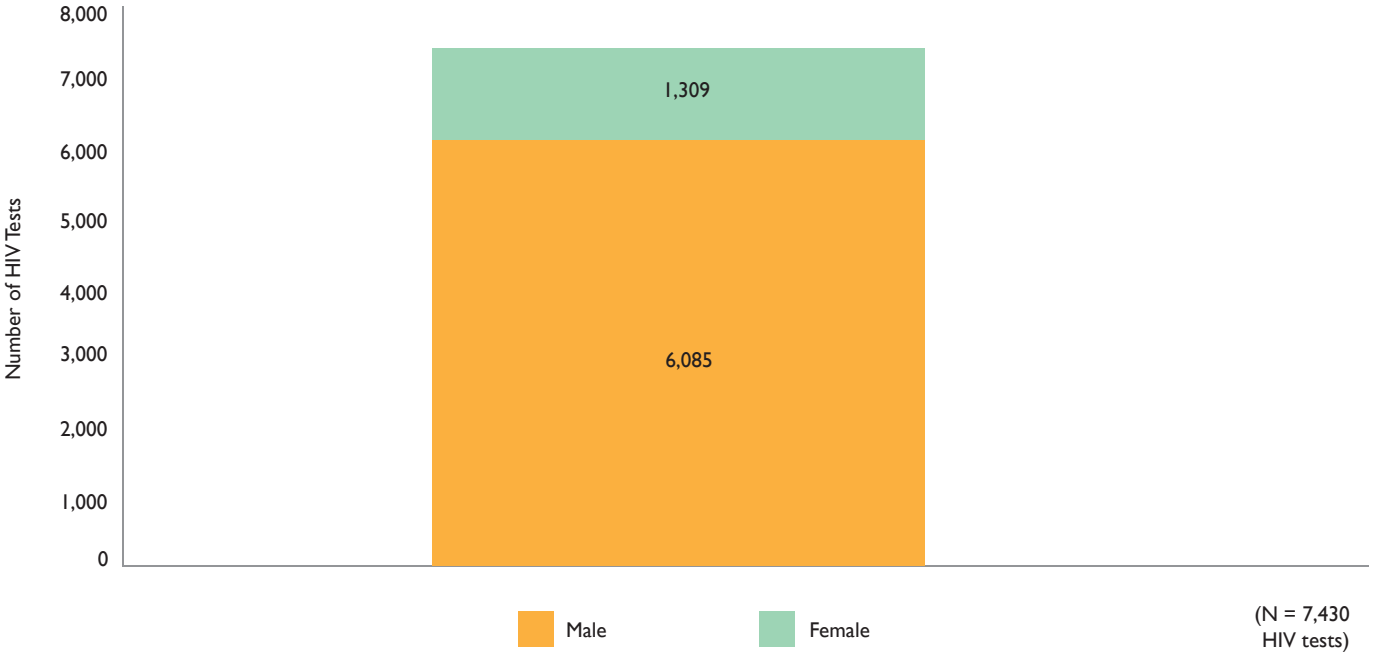


Who are we testing through the anonymous testing program?

More men tested

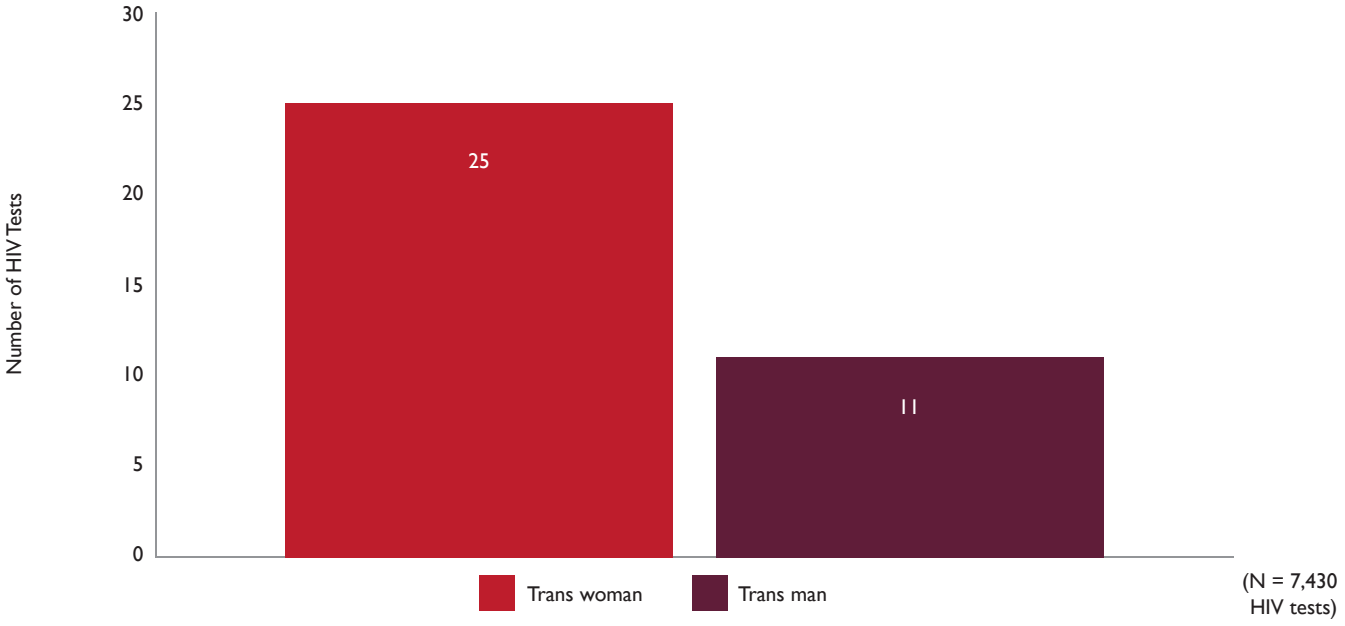
Overall, men accounted for 82% (6,085/7,430) of all HIV tests administered by the eight sites in 2014/15. Women made up approximately 17.5% (1,309/7,430) and trans people collectively made up less than 1% (36/7,430) of all tests. This testing pattern is consistent with the overall rate of new diagnoses in Ontario for 2013/14; where 82% of newly diagnosed people were male and 17% were female.

FIGURE 46 Number of HIV tests by males and females 2014/2015 (OCHART q. 8.1b)



Note: Data on sex/gender was available for 93% of all HIV tests conducted in 2014/15 (7,430/8,024).

FIGURE 47 Number of HIV tests by trans women and men 2014/2015 (OCHART q. 8.1b)



Nearly 90% of HIV tests were for people ages 20 to 49

In 2014/15, 86% of all HIV tests at the eight sites were administered to individuals between the ages of 20 and 49. Most (68%) were for individuals ages 20-39. Across all age ranges, the highest proportion of females tested (40%) were age 19 or under. Trans people made up ~1% of those tested across all age ranges.

Note: Data on age was reported for approximately 93% of all HIV tests conducted at the eight sites in 2014/15 (7,424/8,024)

FIGURE 48 Number of HIV tests by age and sex/gender 2014/2015 (OCHART q. 8.1d)

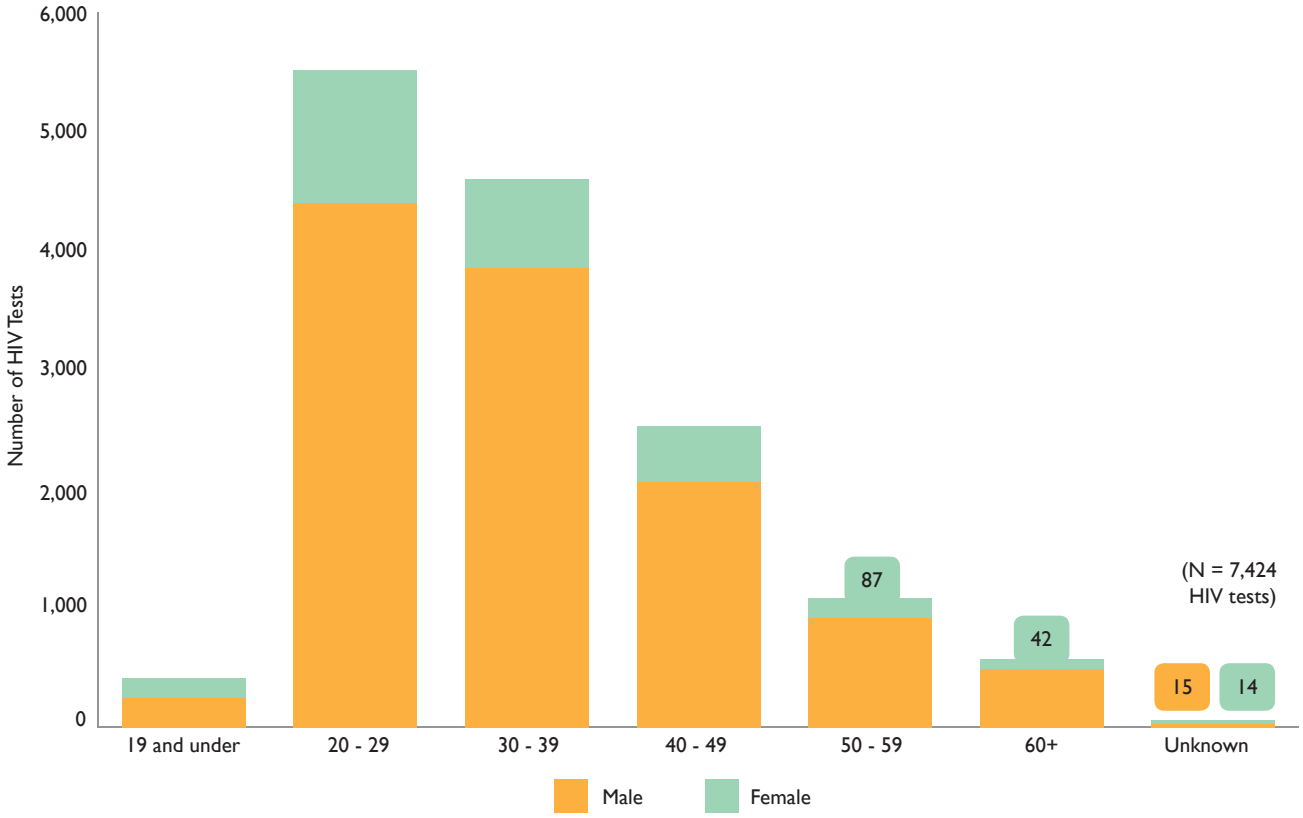
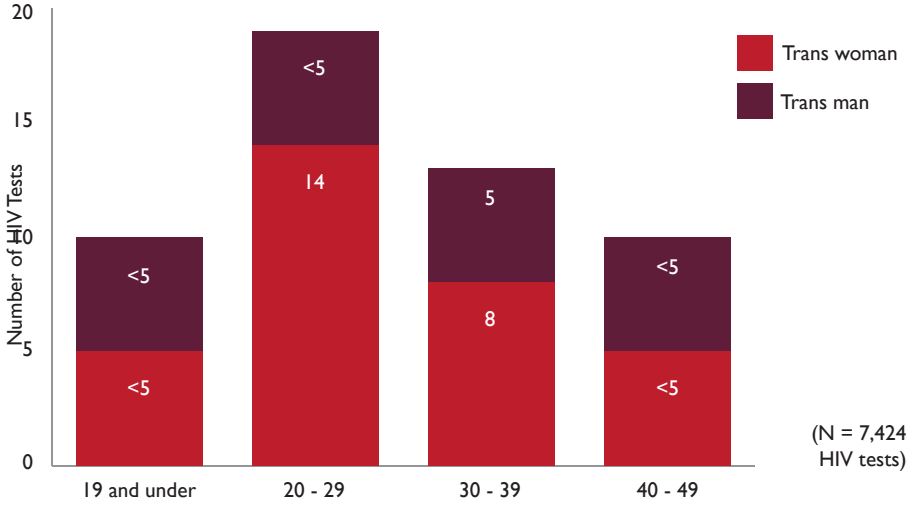


FIGURE 49 Number of HIV tests by age and sex/gender 2014/2015 (OCHART q. 8.1d)

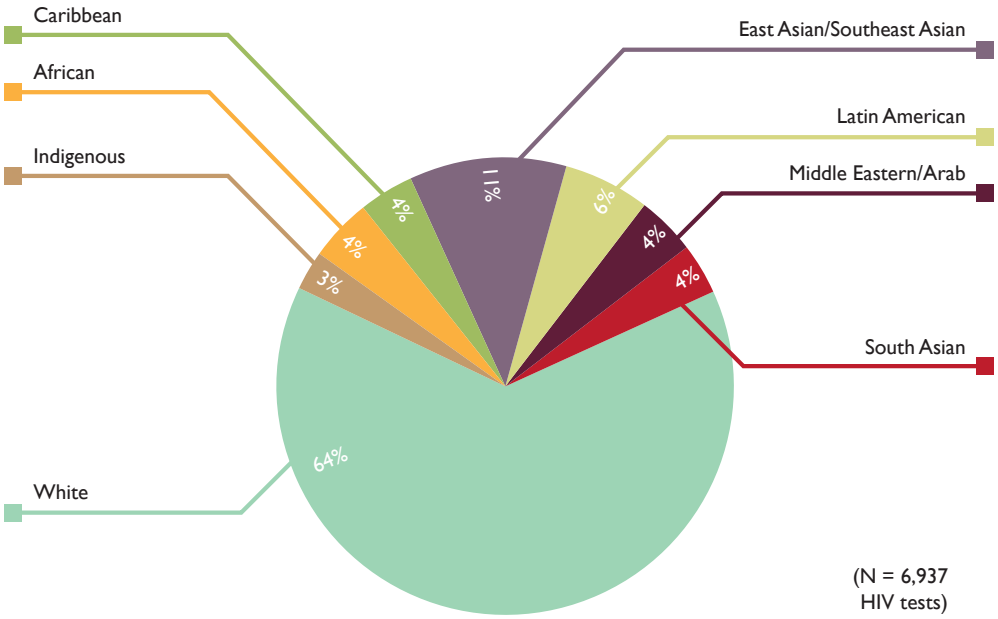


Most testers are White

In 2014/15, 64% of HIV tests were for individuals whose ethnicity was reported as White (includes Western and Eastern European), 11% of tests were East Asian/Southeast Asian, and 8% were African or Caribbean.

Note: Ethnicity data was reported for approximately 86% of HIV tests conducted in 2014/15 (6,937/8,024) at these eight sites.

FIGURE 50 Number of HIV tests by ethnicity 2014/2015 (OCHART q. 8.1c)



The risk picture

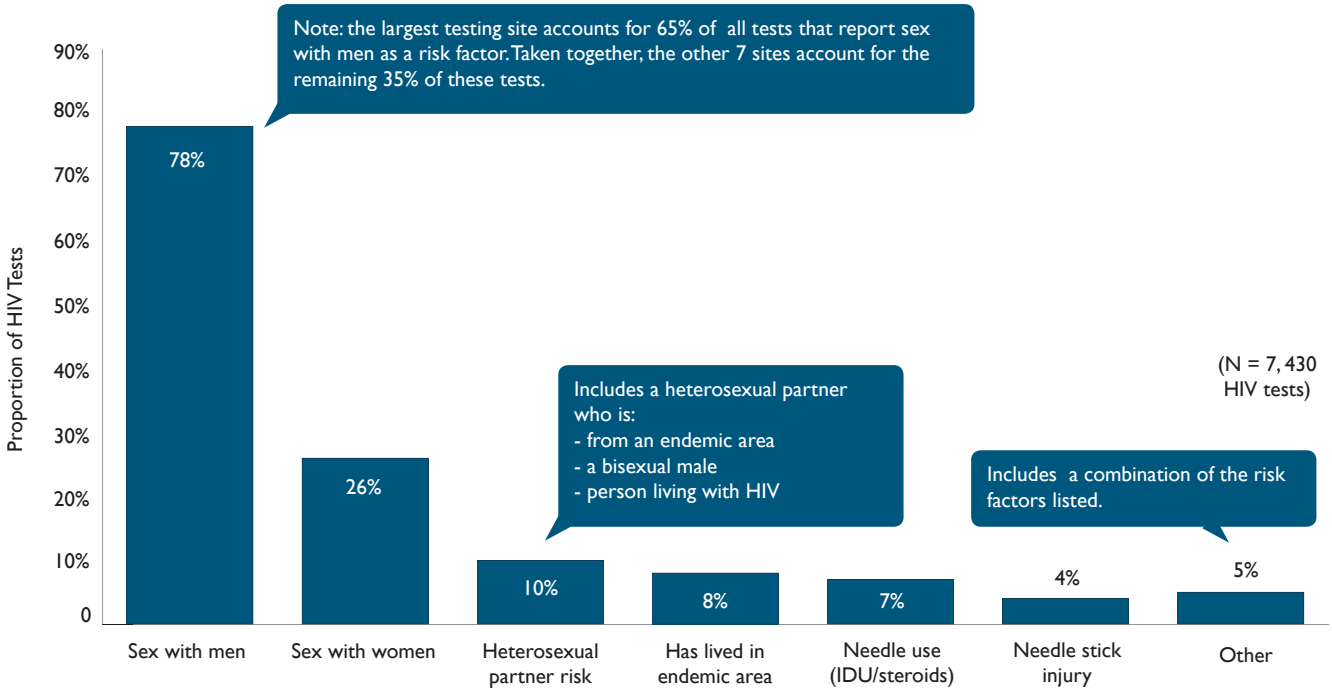
Individuals tested for HIV often report multiple factors (exposure categories) that put them at risk for HIV (for example, having sex with men and being from an endemic country). Therefore, the total number of tests with each reported risk factor is greater than 100%.

In 2014/15, the most commonly reported risk factor was sex with men (78% of all HIV tests). Of those who reported sex with men as a risk factor, 81% were male. The next most common risk factor was sex with women (26%). In about 10% of tests, clients reported having a heterosexual partner at risk (i.e. a heterosexual partner who is from an area where HIV is endemic, a bisexual male, a person living with HIV or a person who uses injection drugs).

In 5% of tests, the reported risk factors were "other"; however, many risks identified in the "other" category actually fall into established risk categories, such as heterosexual partner risk, needle use and sex with men. Their identification as "other" reflects site-specific data entry and reporting practices and the challenges associated with documenting an individual's complex life experiences. Consistent with the pattern of new HIV diagnoses across Ontario, less than 1% of HIV tests administered by these eight sites identified mother-to-child transmission or blood transfusions (pre 1986) as a risk factor.

Risk data for the eight sites is consistent with the provincial testing picture, which shows that a larger proportion of priority populations — those at greatest risk of infection — choose to test anonymously compared to coded/non-nominal and nominal testing.

FIGURE 51 Proportion of HIV tests that reported each risk factor 2014/2015 (OCHART q. 8.1b)



Note: Risk factor data was reported for approximately 93% of all HIV tests conducted in 2014/15 (7,430/8,024).

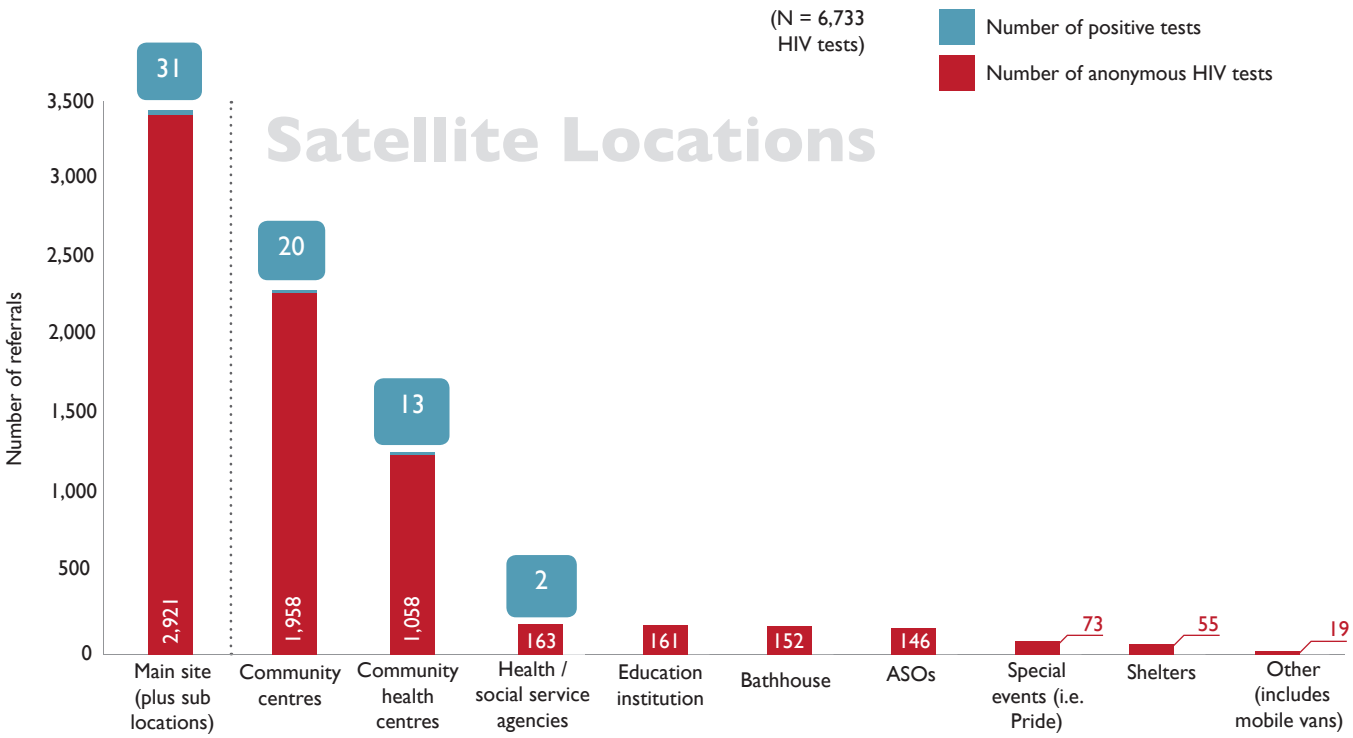
Where are we reaching people for testing?

Most (88%) anonymous HIV tests were administered at anonymous testing clinic main sites and satellite sites at community centres and community health centres.

Almost half (43%) of anonymous HIV tests 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 (29%) and community health centres (16%), while bathhouses and mobile outreach (e.g. vans) each accounted for approximately 1-2% of all anonymous HIV tests.

The highest positivity rates were found at satellite locations at community health centres (1.20%, 13/1,085 tests positive) and health/social service agencies (1.23%, 2/163 tests positive). Due to how data are reported, we are unable to link these positive tests with client demographics.

FIGURE 52 Number of anonymous HIV tests by location 2014/2015 (OCHART q. 8.2a)



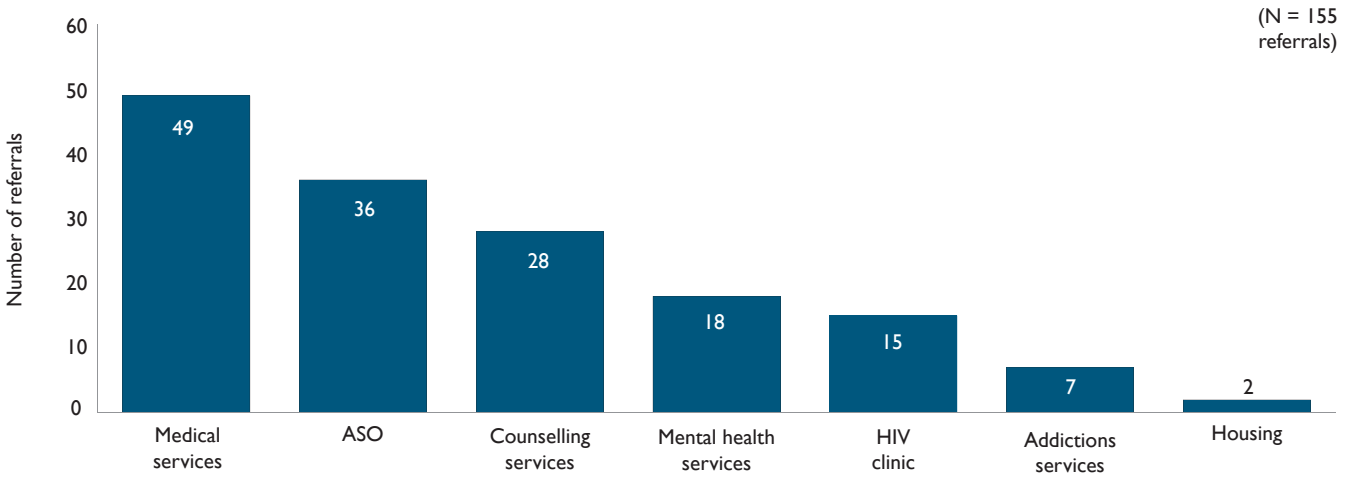
Note: Location data was reported for approximately 98% of all anonymous HIV tests conducted in 2014/15 (6,733/6,875).

What referrals are we making?

Seven of the eight programs reported at least one positive diagnosis in 2014/2015. In total, the programs diagnosed 55 individuals with HIV and provided 155 referrals to additional services.

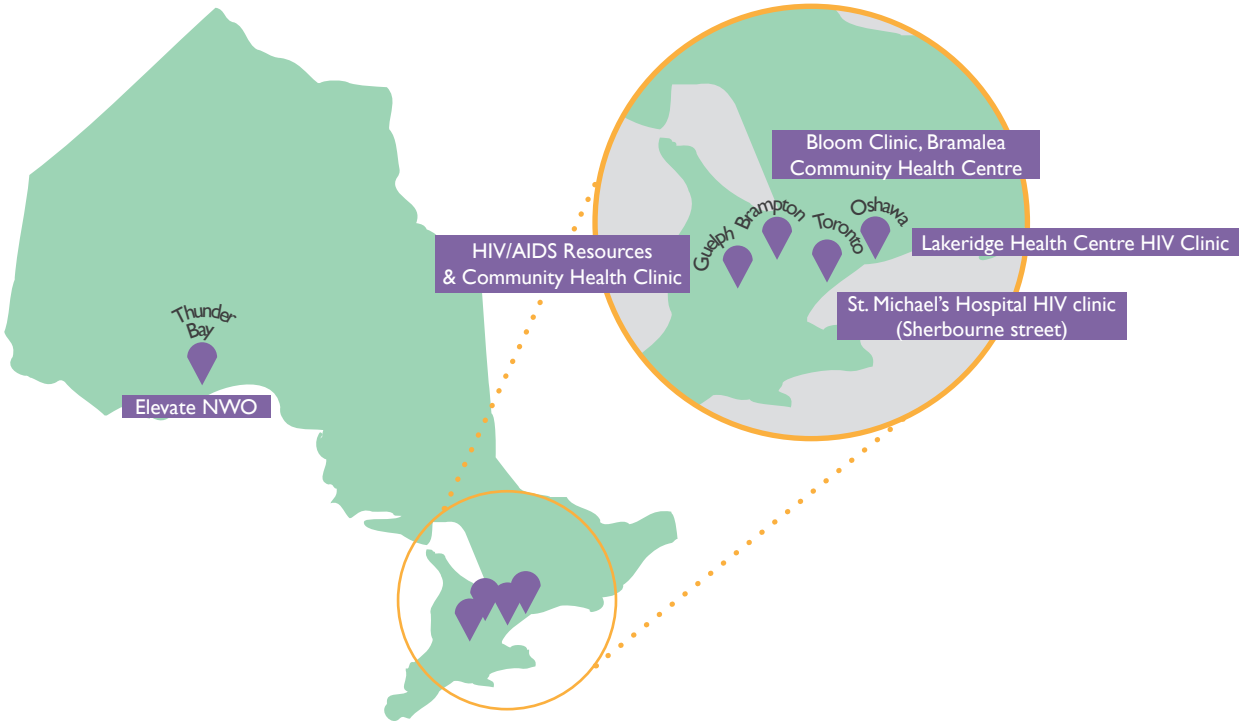
The top three referrals were to medical servies, ASOs and counselling services.

FIGURE 53 Referrals made for HIV positive clients in 2014/15 (OCHART 8.3)



5. Community-based HIV clinical services

In 2014/15, five community-based HIV clinical service providers reported their data for the first time through OCHART.



These five multidisciplinary community-based clinics provide HIV clinical care, mental health and addiction services, case management, sexual and reproductive health services, pharmacy, nutrition and primary care. They also link their clients with other medical and social services in their communities, deliver education presentations and participate in community development activities. Unlike the other 16 HIV clinics in Ontario, which are all hospital-based, these five clinics are located in the community.

Note: Data on the services provided by the 16 hospital-based clinics are not included in this section or in OCHART. Trends described in this section are only relevant to the five programs.

Who do these community-based HIV clinical services serve?

These five community-based services clinics serve people living with HIV, people at risk of acquiring HIV and people affected by the virus, such as family members of people with HIV. However, it is difficult for some clinics to extract information on "at risk" and "affected" clients from their clinical records. For this reason, the total number of clients served includes only people living with HIV at the St. Michael's Hospital clinic and all three groups of clients at the other clinics.

In 2014/15 the five clinics served a total of 1,629 people living with HIV of whom 148 were new clients and 1,481 were repeat clients. The majority — 70% — received services at St. Michael's Hospital Sherbourne Street clinic.

In terms of priority populations:

- the clinics in Toronto and Central East saw mainly gay men followed by people who inject drugs
- the clinic in Northern Ontario saw mainly people who inject drugs followed by Indigenous people
- the clinics in Central West saw mainly people from the African, Caribbean and Black community followed by people who inject drugs and men who have sex with men.

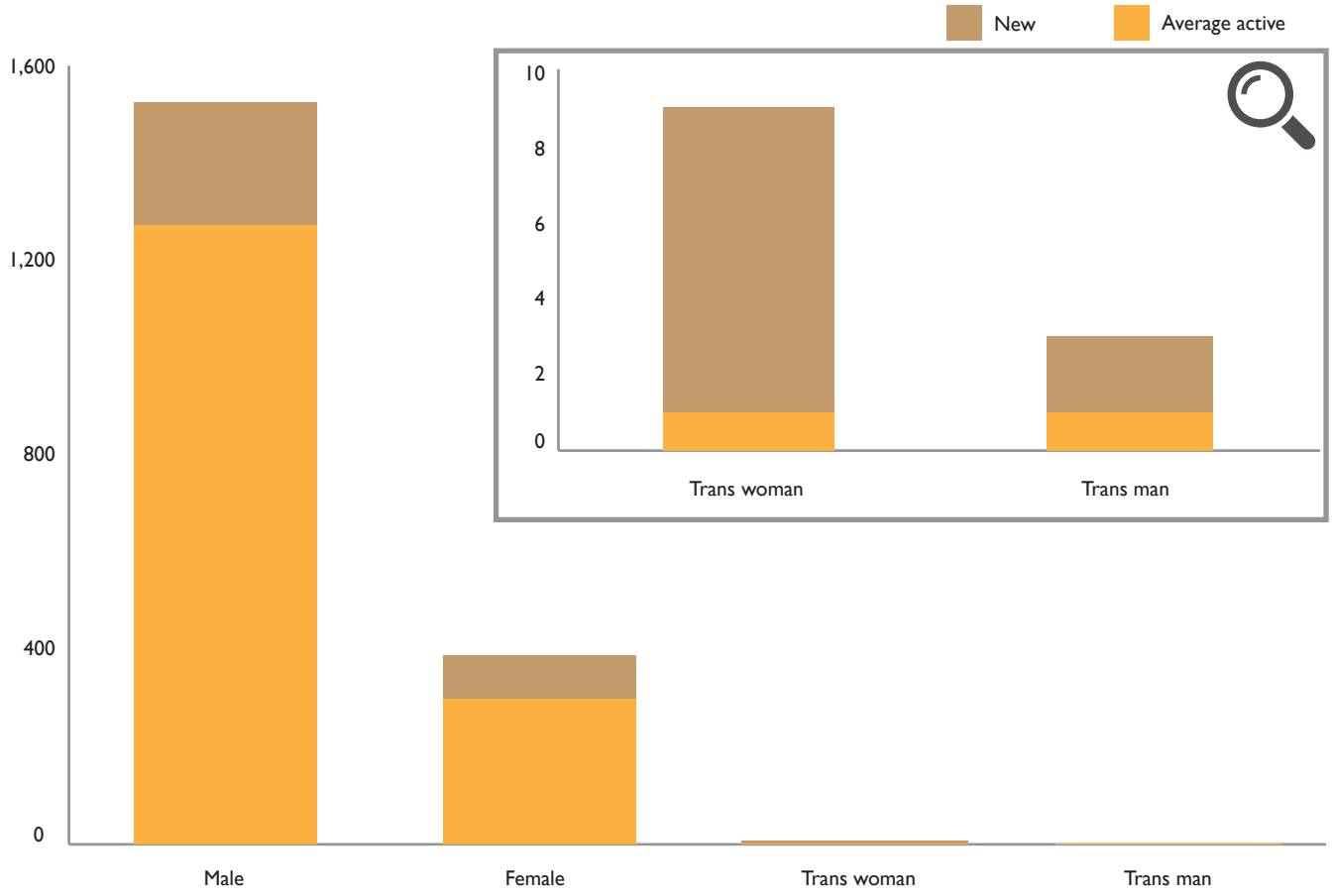
It is interesting to note that all the clinics estimate that a significant proportion of their clients are people who inject drugs – although they make up a relatively small proportion of the people in Ontario who are living with HIV. It may be that people with a history of drug use are more comfortable accessing care in community-based (rather than hospital-based) clinics.

Note: Priority populations are not mutually exclusive: a person can be counted in more than one priority population.

The sex/gender and age picture of people who use clinical services

The clinics reported that 82% of clients were male and 18% were female. Only 12 clients were trans men and trans women.

FIGURE 54 Number of new and average active clients served by sex/gender(OCHART q. 7.1a)



In terms of age, the majority of clients served in 2014/15 were between the ages of 30 and 59, with over one third between 50 and 59 years old.

FIGURE 55 Number of clients (new and average active) by age(OCHART 7.1b)

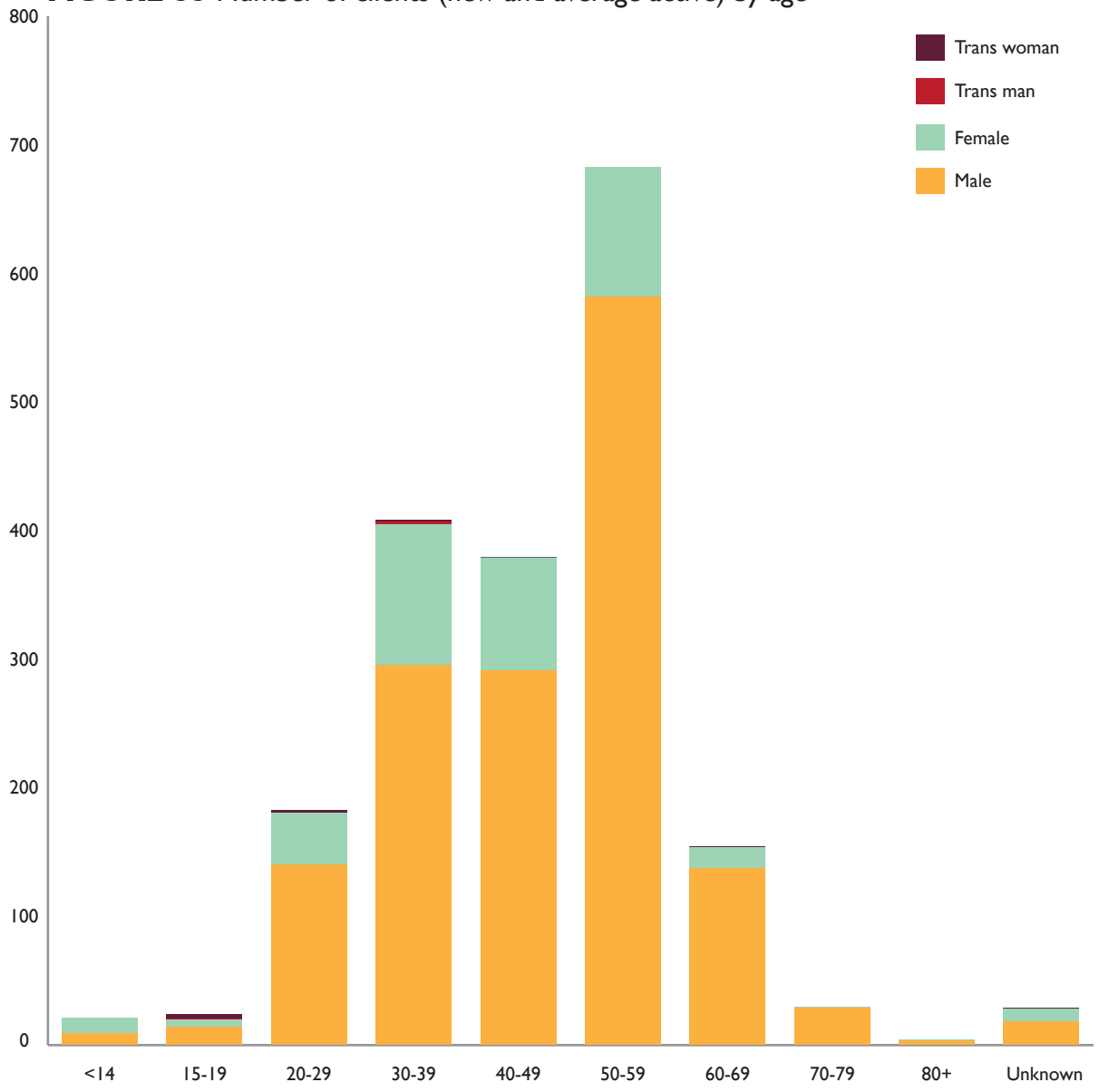
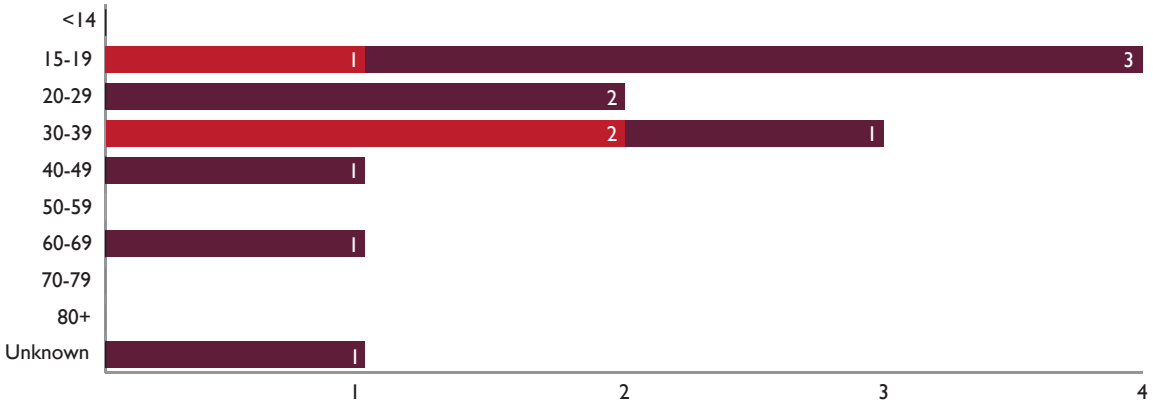


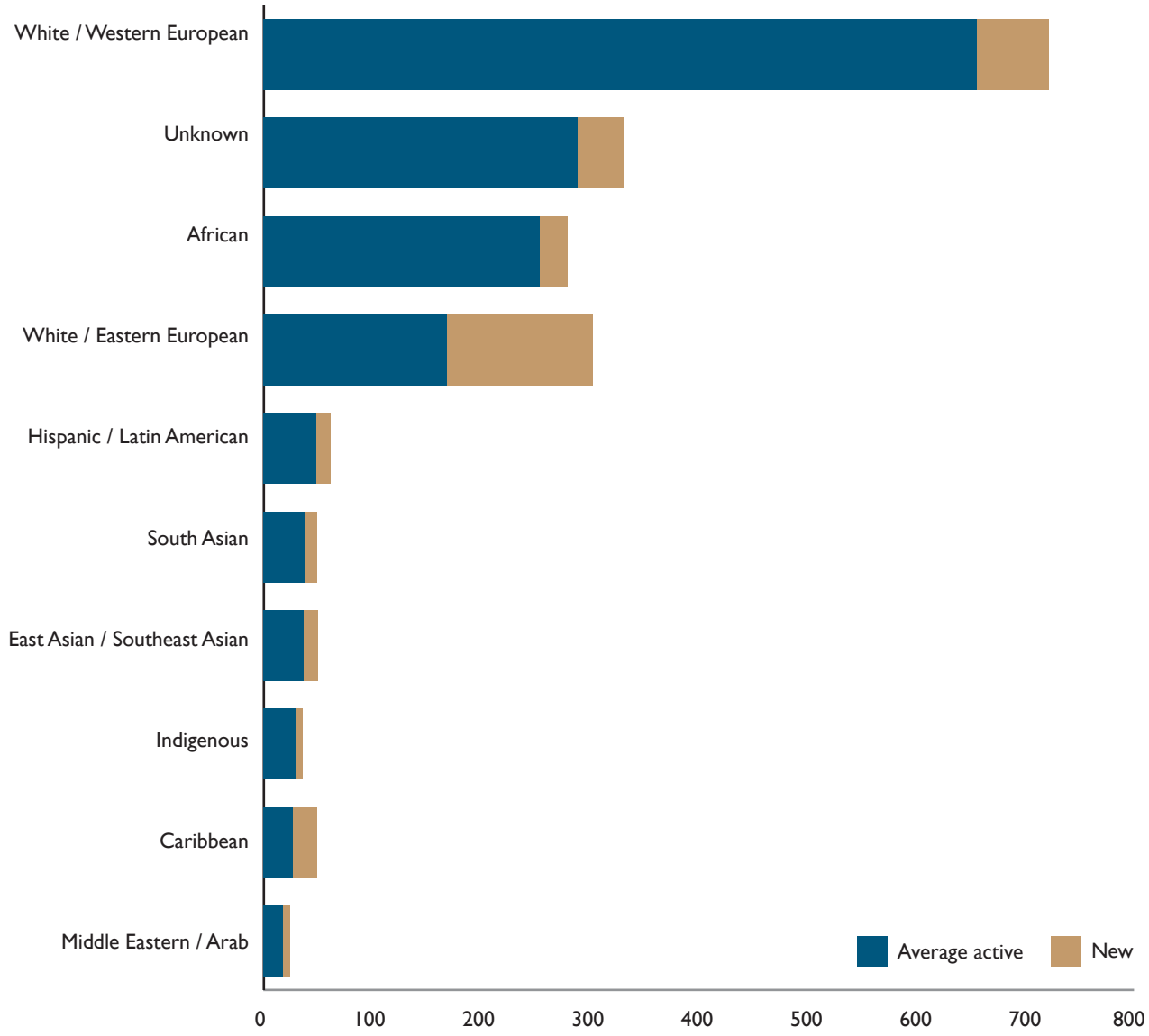
FIGURE 56 Number of clients (new and average active) by age(OCHART 7.1b)



While most clients are older, the clinics reported that 25% of new clients in 2014/15 (84) were between the ages of 20 and 29 — compared to only 6% of active clients. It's important to note that "new" clients are new to the clinic and not necessarily newly diagnosed infections.

In terms of ethnicity, clinics reported that most active and new clients are White. When we combined White/Western European with White/Eastern European, they accounted for 54% of all clients in 2014/15. African and Caribbean people accounted for 17% of clients.

FIGURE 57 Ethnic origin of new and average active clients(OCHART q.7.1c)

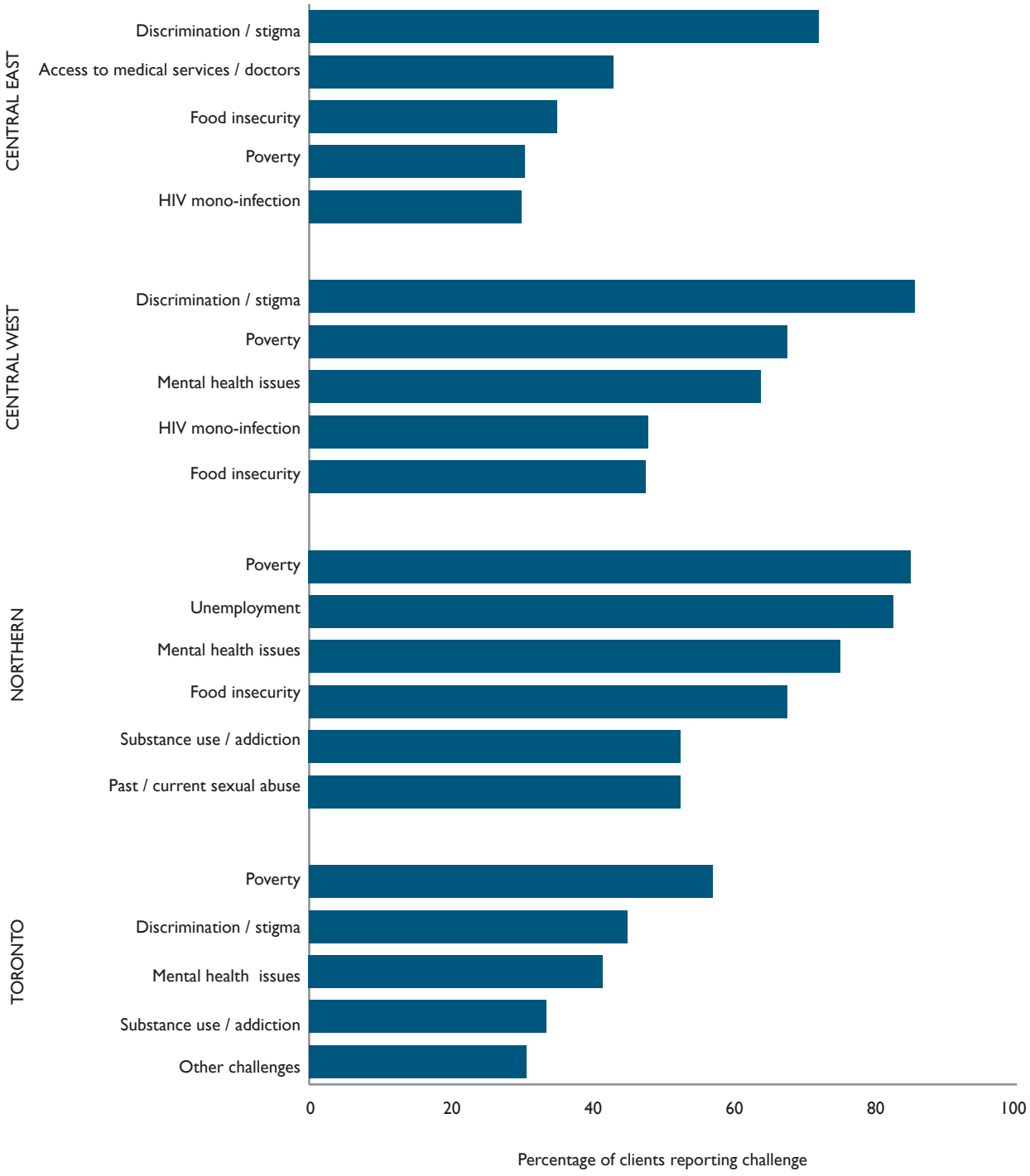


What challenges do clients face?

Clinics were asked to estimate the proportion of their clients experiencing certain barriers or challenges. *Note: the responses are estimates only.*

The challenges that clients experience vary from region to region and between clinic populations. As the following chart illustrates, food security, unemployment and poverty are bigger issues for clients in the North than in Toronto while stigma and mental health issues are bigger challenges in Central West.

FIGURE 58 Top five challenges facing clients by clinic (OCHART q. 11.1.6)



What services do clients use?

HIV clinical services are grouped into four categories:

"We will continue to monitor and ensure existing clients engage in healthcare at intervals recommended by MD, affording greater quality time for new clients entering the treatment cascade, and efforts to maintain and re-engage with clients who have been lost-to-follow-up."
— St. Michael's Hospital

"We have had a continued increase in need for treatment services both for new diagnoses and transfers-of-care. We have also seen an increase in the number of transgender "at-risk population" services and young MSM."
— HIV/AIDS Resource Community Resources and Community Health

FIGURE 59
WHAT SERVICES DO CLIENTS USE?
(OCHART Q.7.2)

"… nearly all respondents indicated that they felt they had "very much" or "somewhat" gained new knowledge or strategies to support them in adopting safer and healthier behaviours."
— HIV/AIDS Resources and Community Health

"We have experienced a high degree of success providing flu vaccination clinics in past years. […] Client feedback has been positive with a number of members stating they wouldn't have gotten a shot if it were not offered at our clinic."
— Elevate NWO

As would be expected in a clinical setting, the most commonly used services were treatment related --particularly primary care and blood work/lab testing services. There is little difference in service utilization by gender, except that women used more health promotion and reproductive health services than men while men used more mental health and addiction services. Transgender clients accessed more sexual health counselling as well as support applying for programs like Trillium.

What other services are clients linked to?

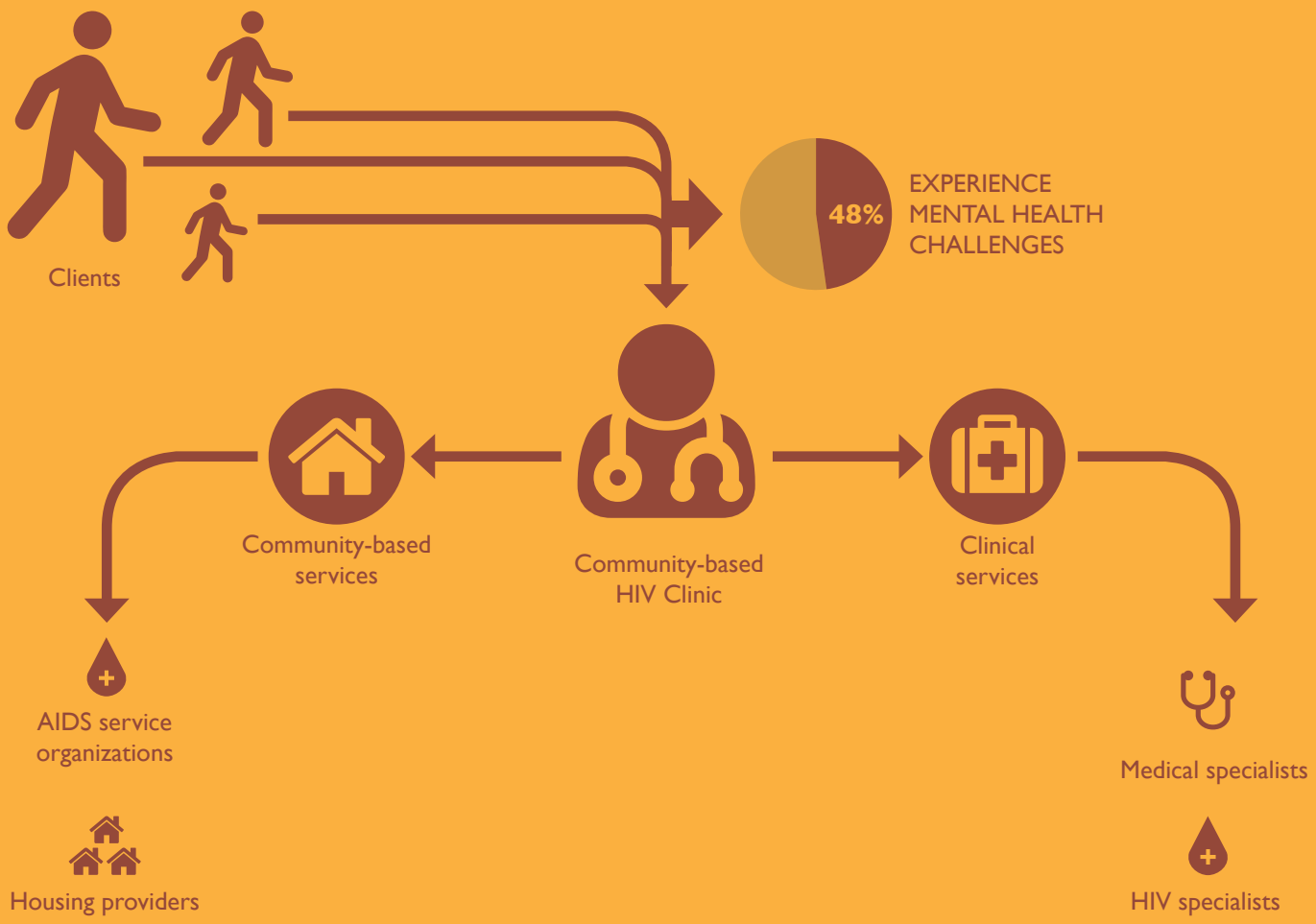
Community-based HIV clinics actively link clients with other clinical and social or community-based services in their communities.

In terms of clinical services, the greatest number of referrals by far are to medical specialists followed by HIV specialists. As most of the community-based clinics are primary care clinics (with expertise in HIV), they refer clients when appropriate to specialists, including infectious disease/HIV specialists. The community-based clinics that are specialist-based also refer clients to primary care. Although clinics reported that about 48% of clients (overall) were experiencing mental health challenges, only 119 clients were referred to clinical mental health services. This apparent gap may be due to the fact that the clinics have some capacity on their own (e.g. social workers) to provide mental health services.

In terms of community-based services, the greatest number of referrals are to AIDS services organizations followed by housing service providers. One clinic reported that 95% of their active clients receive services from an ASO. Clinics rely on ASOs to assist in serving clients with complex needs, they establish formal partnerships, share information and coordinate care plans.

FIGURE 60

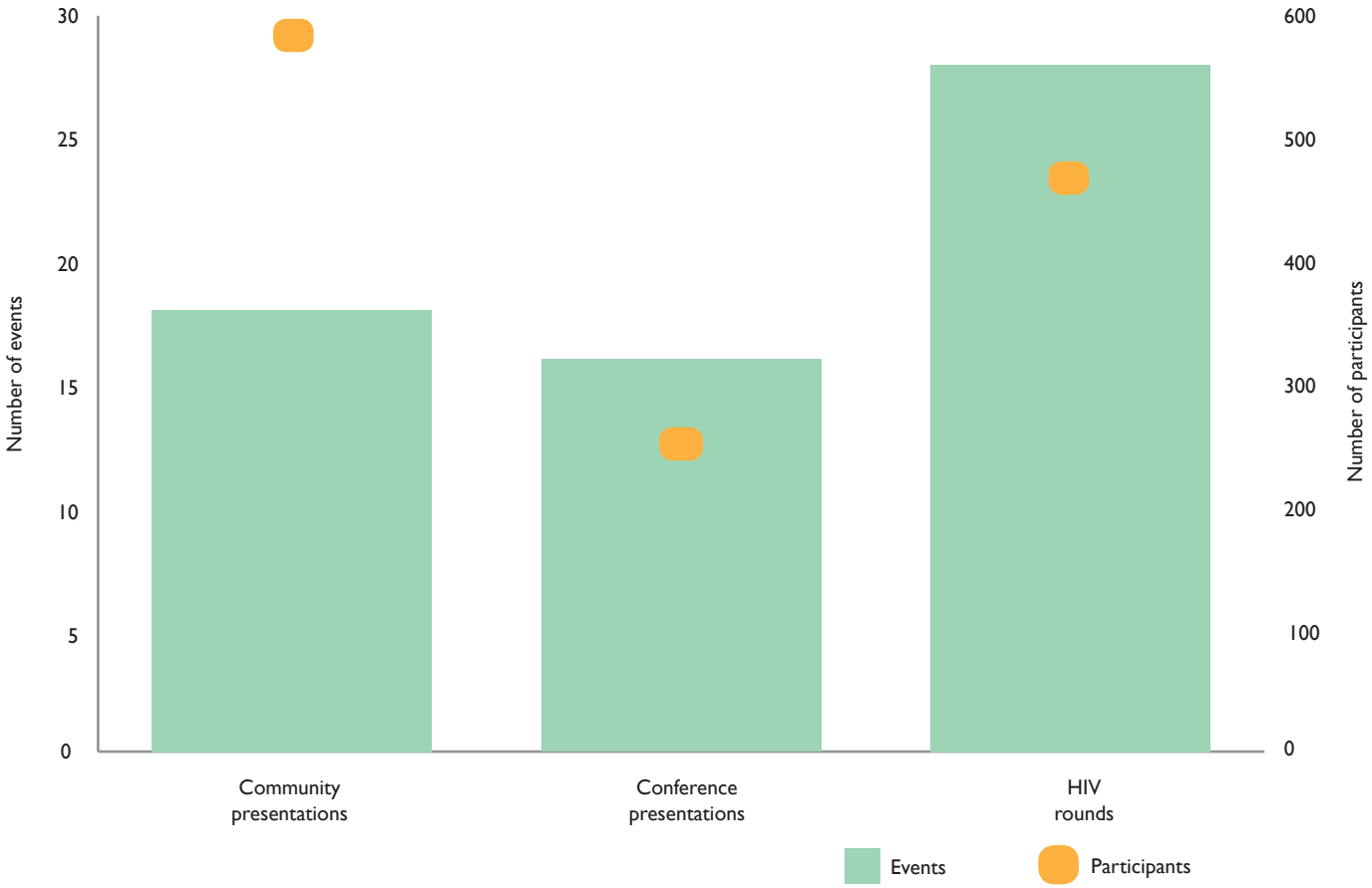
WHAT OTHER SERVICES ARE CLIENTS LINKED TO?



Their role in education and community development

Community-based HIV clinical services are active in educating other health professionals and the community about HIV. In 2014/15, they delivered a total of 44 presentations for professionals and 18 for community audiences.

FIGURE 61 Number of education presentations and participants by presentation type
(OCHART q.7.4a)



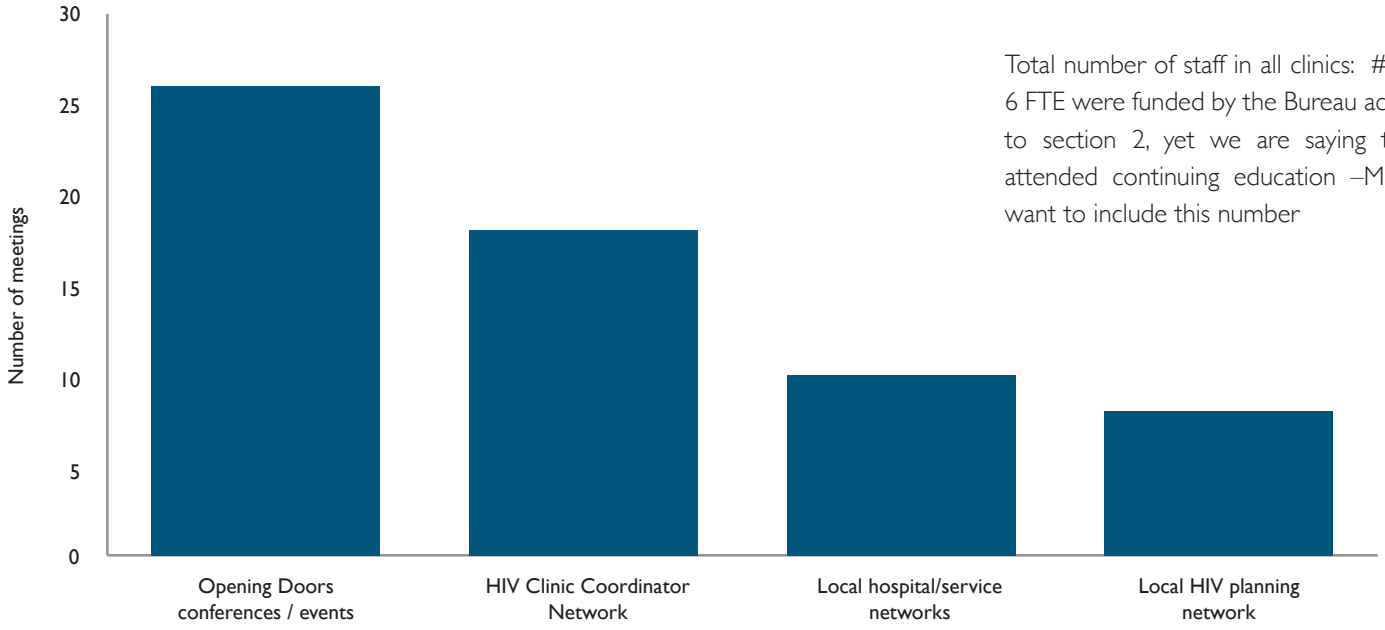
St. Michael's Hospital

There is increased focus on accountability for allied health services to demonstrate their contributions to the clinical outcomes for clients. We will work towards formalizing evidenced based practices and interventions as well as developing tracking methods over the course of the next year.

The community-based HIV clinical services also participate in community development activities in two ways: attending events/conferences and being part of professional networks, such as the HIV Clinic Network, hospital networks and community networks.

They are involved in building partnerships and expanding their referral networks.

FIGURE 62 Number of community development meetings by type(OCHART 7.4b)



Total number of staff in all clinics: # ONLY 6 FTE were funded by the Bureau according to section 2, yet we are saying that 27 attended continuing education –May Not want to include this number

Providing better client-centered care

The community-based clinical services reported ongoing efforts to improve the client experience, including surveying clients and using the results to inform changes in service delivery and adjusting or developing services to meet client needs.

Lakeridge Health Centre

Initial planning meetings targeting process improvement have begun and will continue in H1 2015-16 with corporate quality improvement experts to assist the interdisciplinary team with individual and team efficiency while focusing on improving the client experience, maintaining and retaining clients within the treatment cascade, and developing strategies to re-engage clients lost to follow-up.

HIV/AIDS Resources and Community Health

Clients have reported frustrations in finding a family doctor and so we now have a family physician on staff to care for these clients.

Having counselling, blood or lab work, medical services and referrals all available 'on site' or 'under the same roof' was seen as especially helpful.

St. Michael's Hospital

Clients have reported excellent health care and friendly staff. Clients have commented that they have referred HIV+ friends to our clinic because our staff always goes beyond what is asked of them to make sure everyone is cared for.

To provide better care, clinic staff participate in professional development activities. In 2014/15, clinics reported that:

- 27 staff attended continuing medical education (CME) or post-secondary courses
- 25 attended conferences
- 9 completed nursing updates
- 4 took courses required by their professional College.

6. Support services

Key trends

- Community-based programs reported providing support services to an average of 16,323 people over the year — of whom 4,735 (29%) were new to the program.[1]
- 29% were new clients and 71% returning clients.
- Most (62%) were people living with HIV followed by people at risk (18%) and people affected by HIV (11%).
- Women accounted for 35% of new clients — although only 21% of new diagnoses were in women.

Who is using support services?

In 2014/15, 61 community-based HIV programs (in 47 agencies) reported providing support services to an average of 16,323 people over the year.

Of those, 4,718 were new clients and 11,553 were ongoing or returning clients. These numbers are within 10% of what was reported the previous year.

Among those who used support services in 2014/15:
- 62% (10,050) were people living with HIV
- 18% (3,015) were people at risk
- 11% (1,795) were people affected, such as partners, friends and family members of people living with HIV
- 9% (1,463) were recorded as "other".

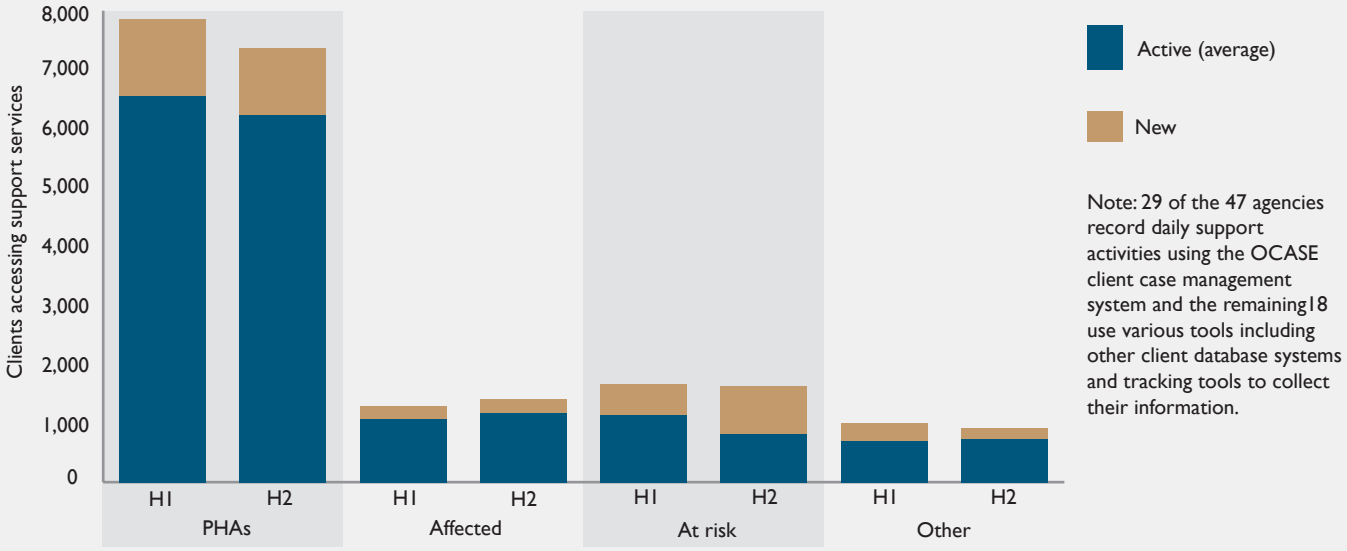
FIGURE 63
WHO IS USING SUPPORT SERVICES?

1 Because some people with HIV — particularly those in Toronto — may use the services of more than one community-based program, they may be counted more than once in the total average number of people served in each half of the year.

ASOs are effective at retaining clients who are living with HIV: 76% are active clients, meaning they have been associated with the agency for more than six months and have accessed service within the reporting period.

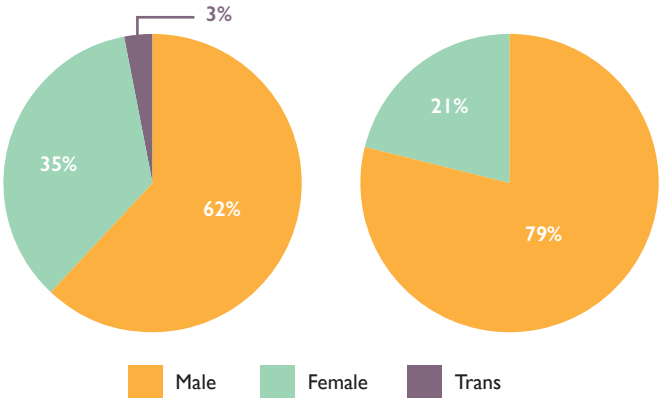
Most (45%) at-risk clients were new. This client group generally doesn't require ongoing service.

FIGURE 64 Clients accessing support services by client group and H1 and H2 — 2014/15
(OCHART 1.11.1.1.)



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 65 Breakdown of people with HIV using support services by gender



More female and trans clients in 2014/15

In 2014/15, 62% of new clients were male and 35% were female although 79% of people newly diagnosed in Ontario were male and 21% were female.

- Most clients are male.
- Women accounted for 35% of new clients – up 5% from the previous years.
- 3% of new clients were trans people who represented 1% of all clients.

The age picture

In 2014/15, we changed the age ranges in OCHART to help us understand the aging of people with HIV (in the past, our age categories stopped at 55+). A significant proportion of support services clients are between the ages of 50–59 and 60–69. Even though programs are serving more older clients, they reported fewer deaths for the third consecutive year: 142 (2012/13), 118 (2013/14) and 100 (2014/15).

Almost three-quarters of the clients whose age is unknown can be attributed to one provincial program that provides direct service to clients and does not collect age data.

FIGURE 66 Number of clients accessing support services by client type and age: 2014/15 H2
(OCHART q. 11.1.3)

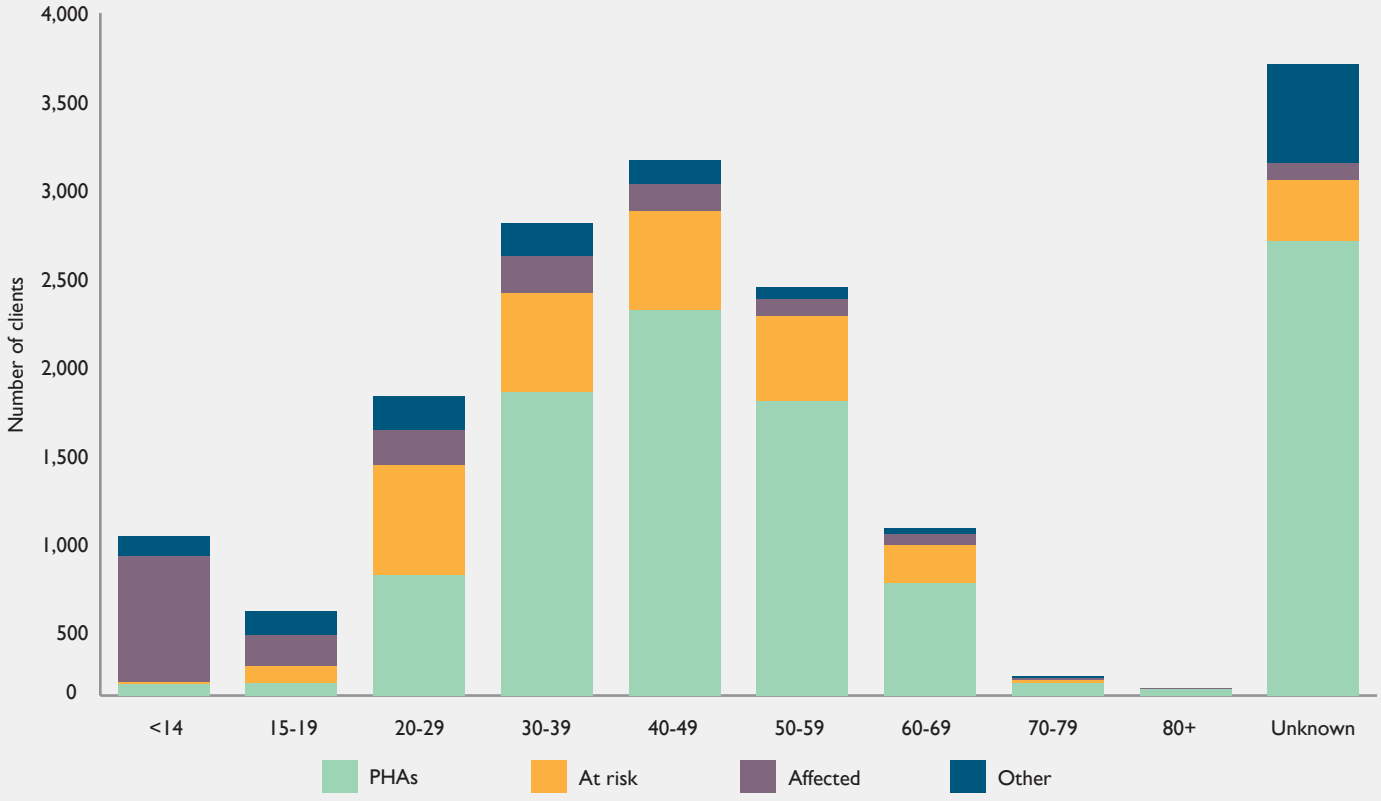
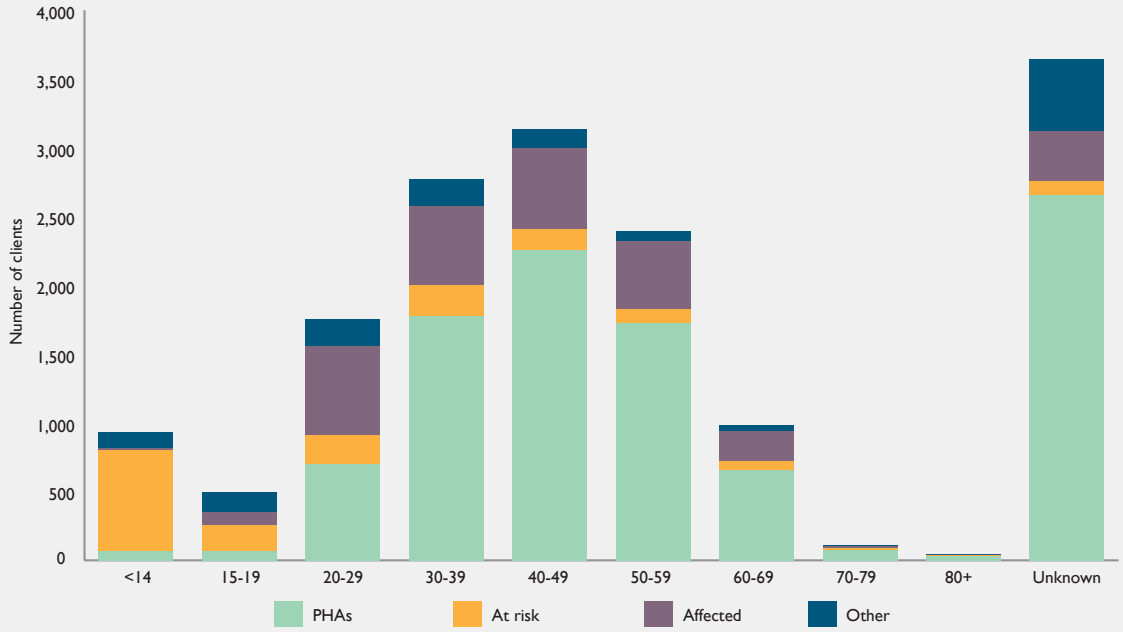


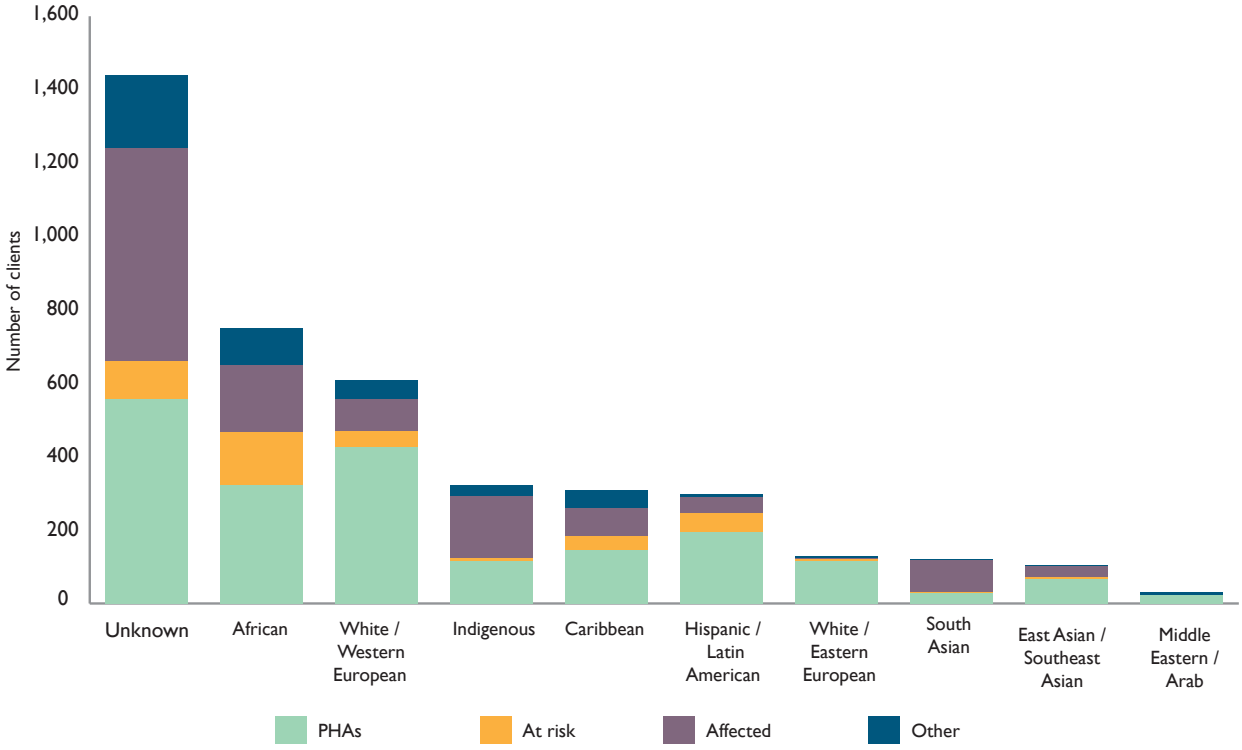
FIGURE 67 Number of new clients by age range 2014/15(OCHART q. 11.1.3)



The ethnicity picture

Understanding the ethnicity of our clients continues to be a challenge. Programs do not consistently provide information on clients' ethnicity. In fact, ethnicity information is missing for 32% of existing clients and 35% of new clients. This information is important because it helps identify and understand any changing service needs. For clients where we have ethnicity information, the majority are African, White, Indigenous, Caribbean and Hispanic – which is consistent with the pattern of HIV diagnoses.

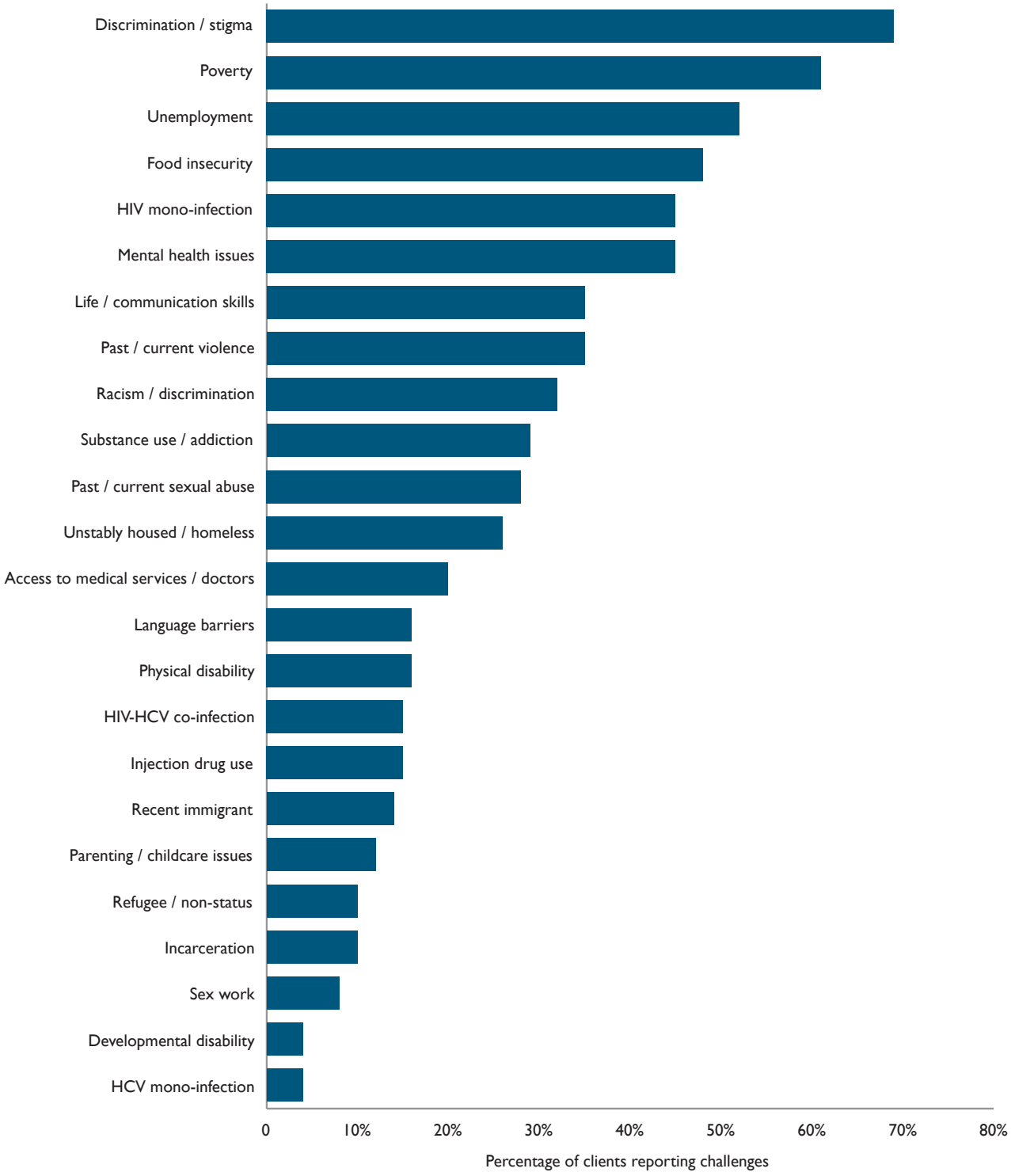
FIGURE 68 Total number of new clients by ethnicity 2014/15(OCHART q. 11.1.4)



What challenges do support service users face?

Clients continue to face challenges associated with the social determinants of health. Figure 79 shows discrimination/stigma, poverty, unemployment, food insecurity, HIV mono-infection and mental health issues as the most commonly reported challenges.

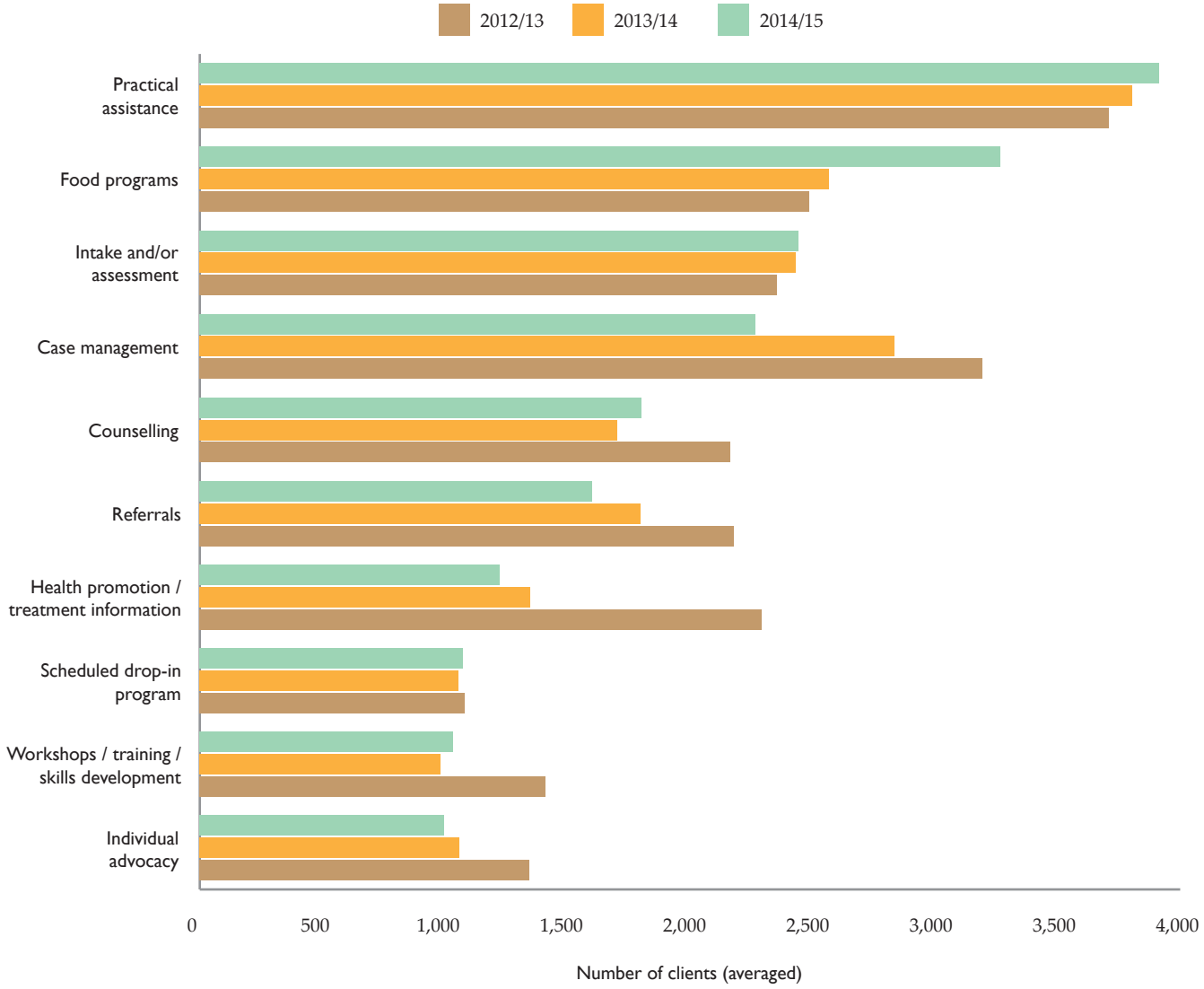
FIGURE 69 Challenges faced by clients (proportional)(OCHART q. 11.1.6)



Which support services are people with HIV using?

Practical assistance continues to be the most commonly used service in 2014/15 (see FIGURE 81) followed by food programs and case management. The need for these services reinforces the fact that a significant number of people with HIV who use community-based services are living in poverty and coping with food insecurity. The range of services provided reflect client needs as well as partnerships developed with other organizations to address gap and more intensive service needs.

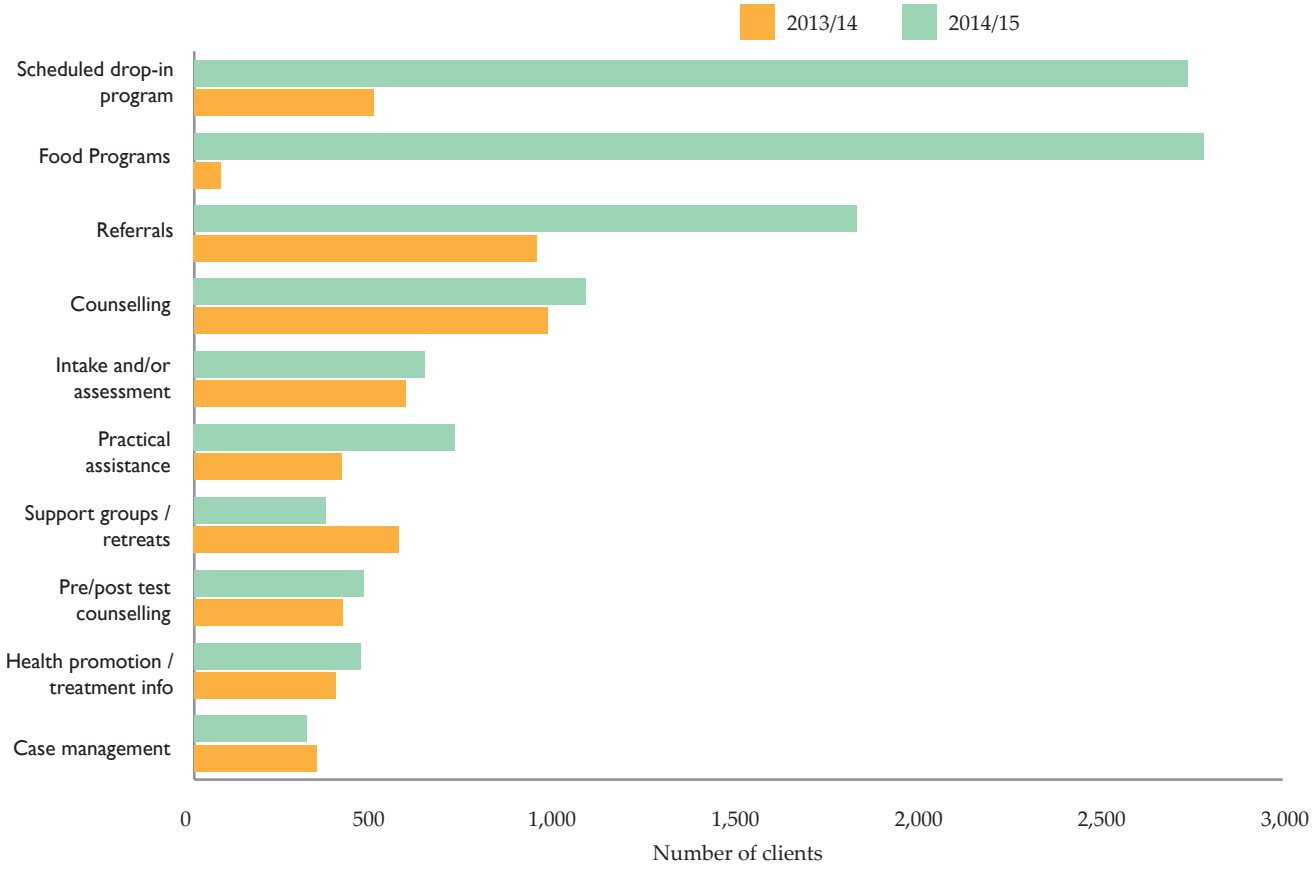
FIGURE 70 Top 10 services being accessed by people living with HIV (OCHART q. 11.2.1)



What support services are people at risk receiving?

Programs reported a shift in the services used by at-risk clients. In 2014/15, they used substantially more scheduled drop-in programs, food programs and referrals — mainly due to one program that reported for the first time in these categories. Fewer at-risk clients participated in support groups/retreats; however, their use of counselling services remained consistent. This shift may be due to agencies adopting a more focused strategy, as part of the HIV cascade, to help people at risk stay uninfected.

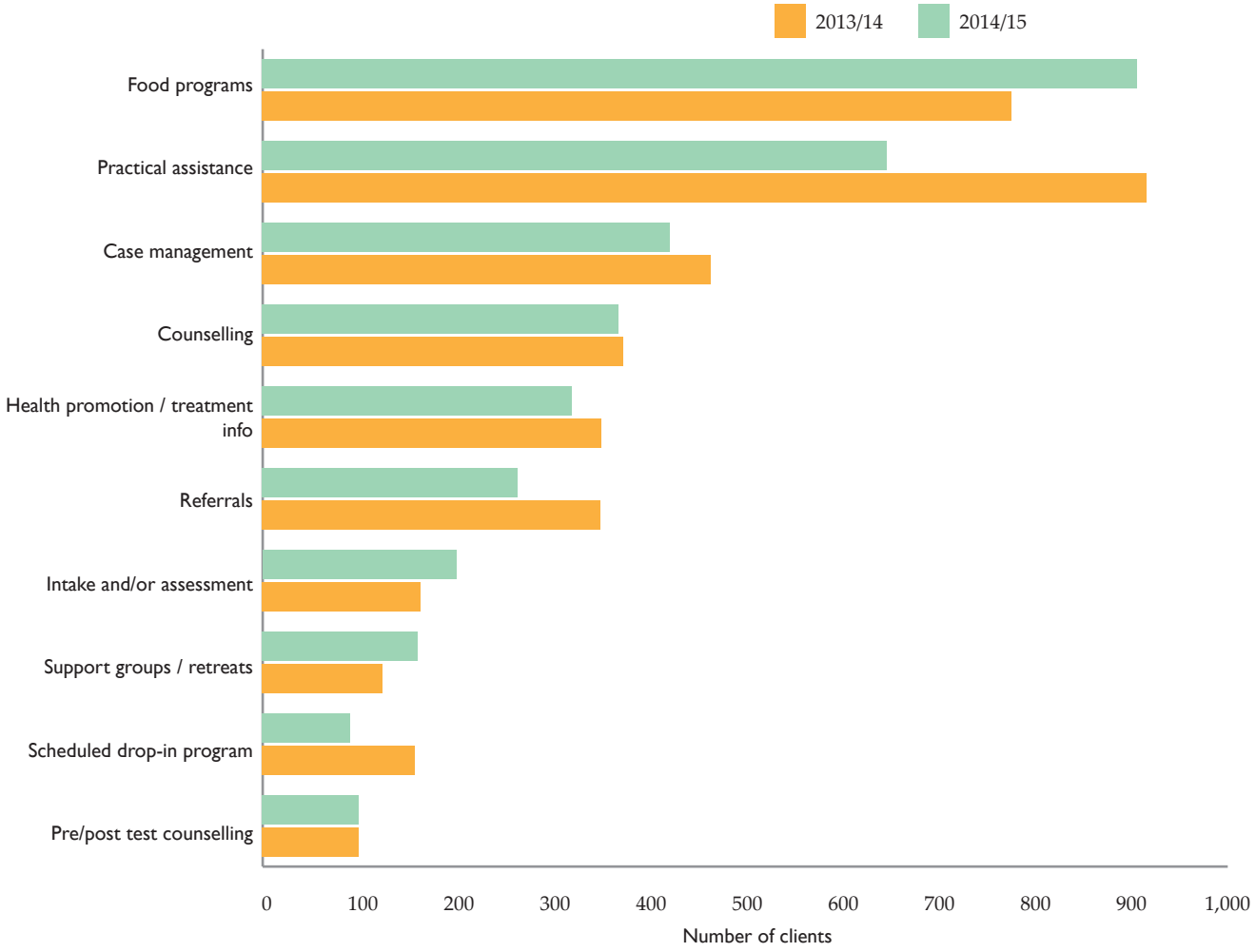
FIGURE 71 Number of at-risk clients accessing support services (top 10) 2013/14 & 2014/15 (OCHART 11.2.1)



What support services are people affected by HIV receiving?

People affected by HIV use similar services as people living with HIV — food programs and practical assistance, followed by case management, counselling, referral services and health promotion services. This similarity is not surprising because most affected people are family members of people living with HIV and have the same basic needs.

FIGURE 72 Number of affected clients accessing top 10 services (OCHART 11.2.1)



Is there a difference in service use by gender?

Both male and female clients use practical assistance, case management, health promotion, 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.

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; however, the number of services used by trans men is too low to draw conclusions. As a result of two Toronto based agencies targeting trans women sex workers, we saw more trans women clients using practical assistance and referrals.

Of the 354 trans people who used support services in 2014 / 15: 34% were at risk, 21% were living with HIV, 2% were affected and 43% were classified as "other." About 8.5% of trans clients were in programs funded only by ACAP.

FIGURE 73 Top five services used by trans women(OCHART q. 11.2.1)

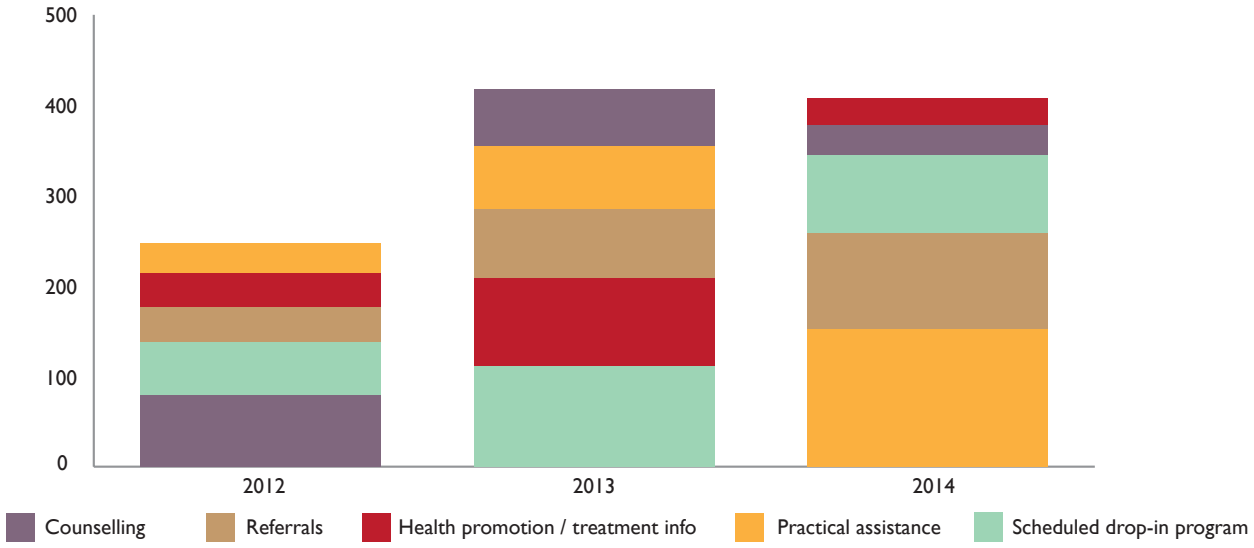
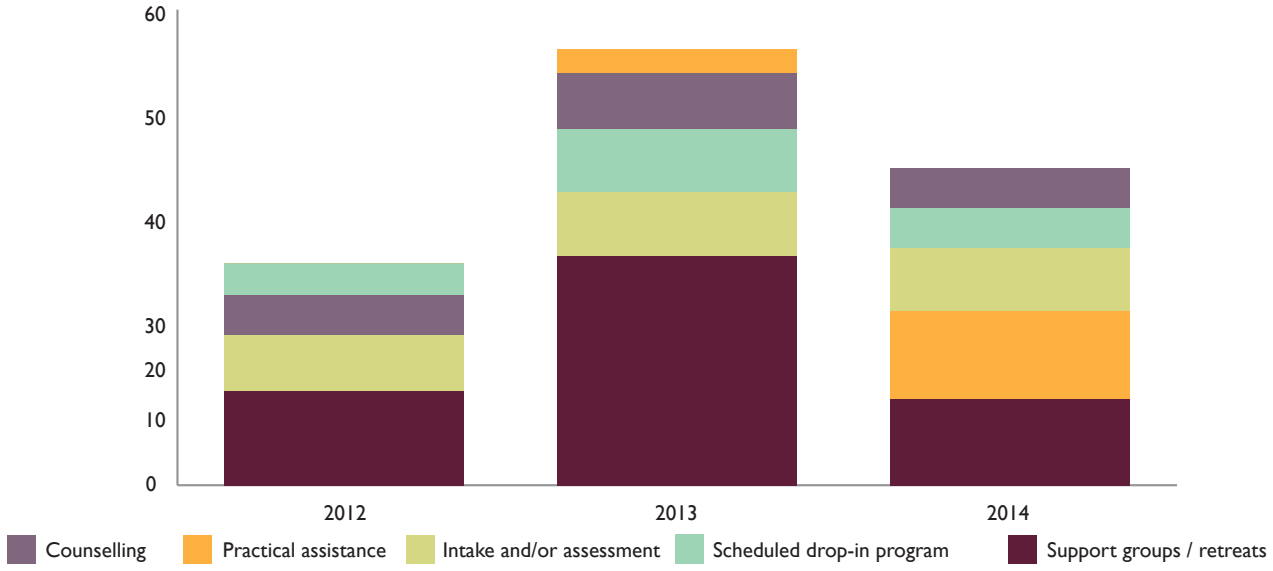


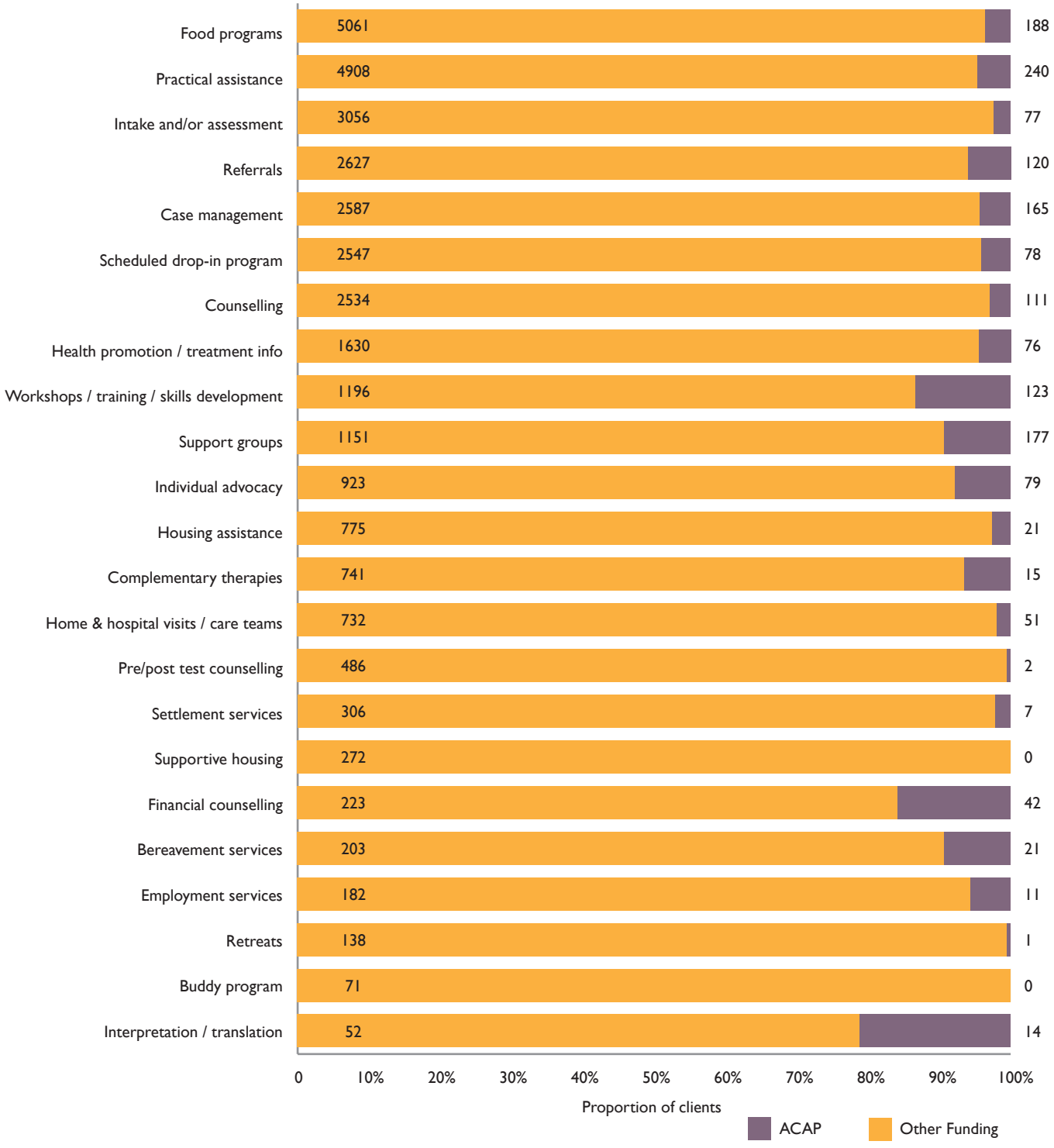
FIGURE 74 Top five services used by trans men(OCHART q. 11.2.1)



ACAP funding supports food programs, scheduled drop-in programs and support groups

Organizations that receive ACAP funding for support services use that money primarily to provide support groups, food programs and scheduled drop-ins programs. ACAP funding accounted for a similar proportion of support services in 2014/15 as in the previous year.

FIGURE 75 Proportion and number of all clients accessing services by funder 2014/15 (OCHART q. 11.2.1)



Referrals from support services

Referrals play a critical role in providing comprehensive client-centred care and in creating a network of services for people with or at risk of HIV. In 2014/15, OCHART asked for information on referrals broken down by gender. Most of the referrals were to clinical services (see FigureFIGURE 86) including counselling, STI testing and sexual health clinics, and HIV testing. The next most common referral is to population-specific services.

FIGURE 76 Number of unique clinical and community referrals by gender
(OCHART q. 11.2.1b)

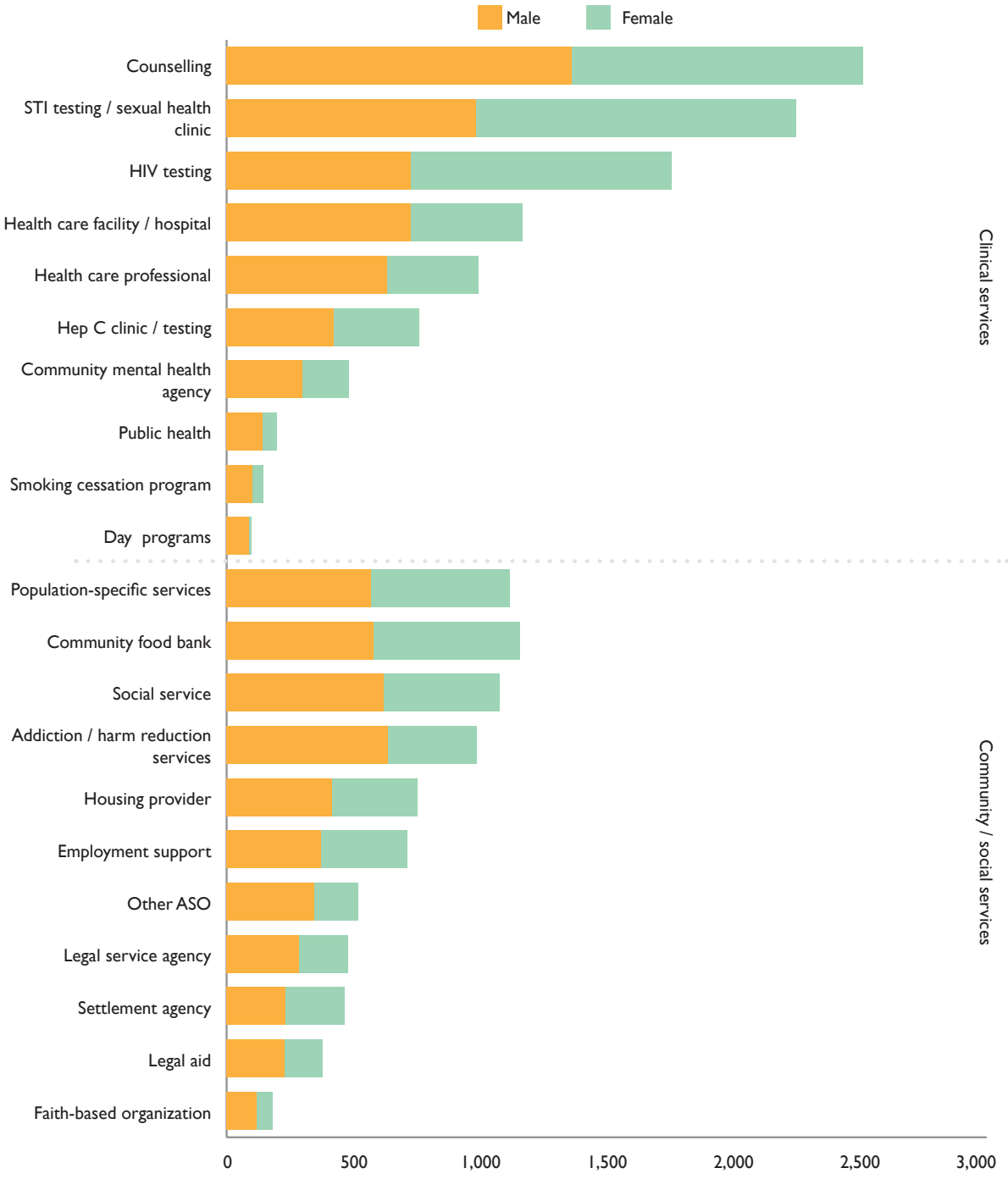


FIGURE 77 Number of unique clinical and community referrals by gender (trans men and women) (OCHART q. 11.2.1b)

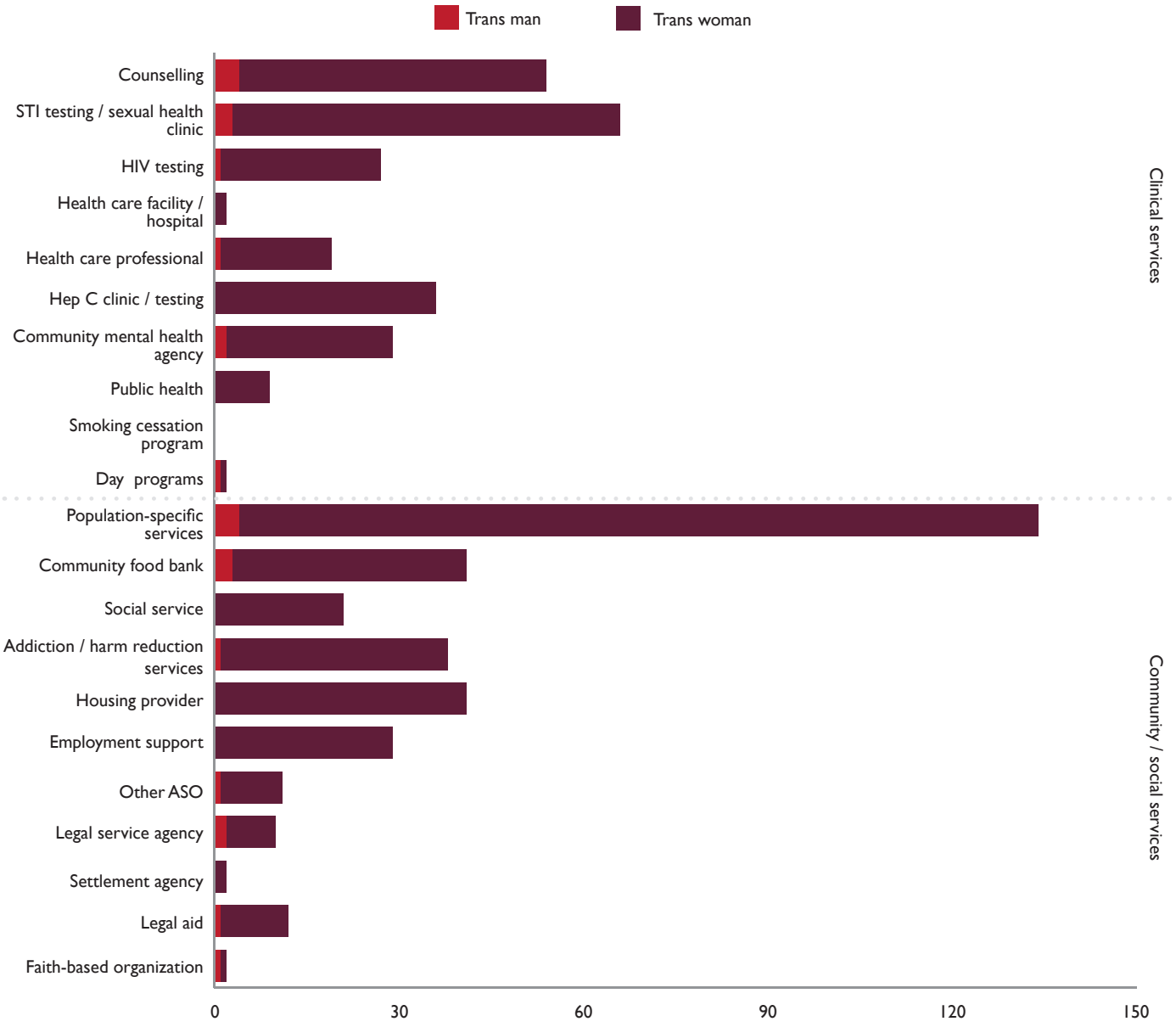


Table 6. Shifts in demand for support services

Shift in demand	Examples
More demand for trans-specific services	"Trans people requested some specific services." — Action Positive "The trans community, in particular trans women, continue to be underserved. We are hoping to explore partnerships moving forward to enhance access to services for women, in particular trans women at risk of violence." — AIDS Committee of Toronto "Increased phone calls and emails from Latino Trans Women (they usually don't come in person due to shame and fear of discrimination) requesting for services or referrals, but then they seem to get lost in the system." — Centre for Spanish-Speaking Peoples "More requests to support trans clients." — Oahas Ottawa
More age-related issuess	"20% of clients served have transitioned to LTC and other care facilities. Significant prevalence of HIV Associated Cognitive Disorders (with the majority of clients having moderate to severe) not only increases the frequency of services provided by all partners but also the intensity (the amount of time)." — Fife House "We are noticing an increase in clients whose cognitive abilities have been affected by HIV, or who had pre-existing developmental delays or acquired brain injuries." — Barrett House "A growing trend among participants is the experience of diminished cognition, memory recall and dementia." — HIV/AIDS Regional Services
Immigration issues and financial assistance	"Due to immigration changes and faster processing times we are experiencing a larger number of appointments for one on one assessment which in entails a long and short term goal plan for clients and assisting the goals in settlement. We've found that upon assessment clients are demonstrating high levels of trauma, internalized homophobia and mental health issues based sexual orientation and relationships and also on the context of their migration and fleeing countries with high levels of homophobia." — Black Coalition for AIDS Prevention "Financial assistance provided. Increase in demand of clients requesting financial assistance to cover their immigration fee costs (e.g permanent residence, humanitarian and compassionate application fees)." — Africans in Partnership Against AIDS

Table 6. Shifts in demand for support services

Shift in demand	Examples
Immigration issues and financial assistance (continued)	"The temporary suspension of deportations to refugee claimants from Zimbabwe and Haiti was lifted in December 2014, resulting in fear of being deported for our clients without legal status." — WHIWH "Increased number of new immigrants and some of them requiring refugee status." — Action Positive VIH/sida
Housing insecurity	"Affordable housing is always a huge problem for clients. Shared housing is not appropriate for clients with medical conditions." — Somerset West Community Health Centre "Housing continues to be an issue along with transportation for service users who live in the rural areas of our catchment area." — HIV/AIDS Regional Services "Affordable housing is always a very high priority." — AIDS Committee of Cambridge, Kitchener, Waterloo and Area
Changing demographics	"Most of the new PHAs we conducted intakes with were individuals in their 30s. Three of the new PHAs were Spanish-speaking gay men who are new to Durham Region." — AIDS Committee Durham Region "Compared to previous periods, we have seen more new clients who are youth (age 18-25)… We have received service inquiries from PHAs who are incarcerated, as a result of the prison outreach working with the ACAS volunteer program." — Asian Community AIDS Services "We have an increase in Spanish speaking clients and Latin American immigrants….There is an increased demand for service from the 50+ age group of PHAs." — Positive Living Niagara "Increased HIV/STIs new infections in young Newcomers (mostly from Spain, Chile and Venezuela). Increased demand for online counselling (Skype)." — Centre for Spanish Speaking Peoples "Related to new intakes (newly HIV/AIDS diagnosed) with 8 PHA individuals in their 20s, there has been an increased demand for support services for youth." — The AIDS Network "Increased requests to link both younger and older adults to services that are appropriate for those under 25 and over 55 years of ages." — Hospice Toronto "We have noted that a number of our regular clients who utilize practical supports are above the age of 40." — Regional HIV/AIDS Connection

Table 7. Responding to emerging trends

Trend	Examples
Strengthening partnerships and referral network	"Where these clients were not registered with PASAN prior to being incarcerated, we have made the necessary referral so their needs can be adequately met." — Black Coalition for AIDS Prevention
	"In active communication with partners engaged in in-prison programming to provide support through education resources … support case managers keep open lines of communication with parole and probation and addictions services to ensure stable reentry into community and engagement to access care and treatment" — The AIDS Network
	"We are working with ETSN (Ethnoracial Treatment Support Network) to provide youth-focused and youth-only training to our youth clients." — Asian Community AIDS Services
	"Clients from Haiti and Zimbabwe are being referred to HALCO for legal support. WHIWH is providing support letters to the clients who are applying on Humanitarian and Compassionate grounds." — Women's Health in Women's Hands
	"Regarding housing we have entered into a great partnership with All-together Housing in Belleville and this has lead to the opening of two permanent units for PHAs and the possibility of two more. We have also connected with other housing agencies and continue to work on this issue." — HIV/AIDS Regional Services
	"We have expanded our partnerships and have also made new connections to new partners and programs that support those who are marginalized that include a new program called PEACH: Palliative Education and Care for the Homeless (and those who live marginally in the city). We are working closely with their community physician and nurse practitioner as they support many individually who live in the shelter system or are homeless. This has allowed us to support mutual clients and find ways to share our resources that included our trained volunteers." — HIV/AIDS Regional Community Health

Table 7. Responding to emerging trends

Trend	Examples
Creating new programs/ services	"Partnerships (for example Ottawa Senior Pride Network) and introduction of programs/support groups geared towards HIV and aging (for example HIV 50+ group and Golden Girls social)." — AIDS Committee of Ottawa "Starting two supports groups: one for Francophones and the other for Muslims." — Africans in Partnership Against AIDS "We are beginning a support group/social group for seniors aged 60+ as a beginning to find ways to better serve our aging population." — Positive Living Niagara "With growing demand to have South Asian MSM support space in Peel region, we have made sure to have support groups 3 times per OCHART reporting period in Mississauga, as well as keeping the location the same, so as to have some consistency for existing and potential new service users." — Alliance for South Asian AIDS Prevention "Additionally we have developed an intensive 12 week Trauma Recovery Program for participants who have identified trauma within their narratives. It explores the physiological detriments of trauma and how it can manifest spiritually, physically and mentally in one's life. The program offers several interventions from narrative and cognitive behavioural modalities, mediating damage to the limbic system and neocortex. A notable difference between traditional therapeutic groups and the Trauma Recovery Group is that the most predominant interventions are body-oriented strategies, such as controlled breathing strategies, progressive muscle relaxation and yoga." — HIV/AIDS Resources & Community Health
Applying for more funding	"We are searching for funding streams for Trans specific life skills and practical support." — Asian Community AIDS Services "Developing new partnerships, and thinking of new funding avenues such as: research, Hep C funding, community development funding, CIHR funding, etc." —Centre for Spanish-Speaking Peoples "We applied for a 3-year Trillium grant to increase our capacity for working with migrant sex workers." — Maggie's

Table 7. Responding to emerging trends

Trend	Examples
Increasing capacity within the organization	"We trained more buddy volunteers and that has played a key role in supporting clients through home and/or hospital visits and also peer to peer practical support and interpretation." — Africans in Partnership Against AIDS "In response to the interest in employment services we have begun working on a partnership with YMCA employment services in our region to build our capacities as an agency." — AIDS Committee of Cambridge, Kitchener, Waterloo and Area "We are responding to the geographic shift by providing outreach through our partnership with the Ajax Welcome Centre (a CIC-funded inititative administered by CDCD)." — AIDS Committee of Durham Region "We have worked on translating our information and have recruited Spanish-speaking volunteers." — Positive Living Niagara "With the high demand for our services, we continue to place our refugee claimants on a wait list to meet with the Refugee Settlement Coordinator for a full assessment after they have completed an intake at our agency. Formerly, these assessment appointments would happen within 3 weeks, but with the increased demand an emerging issue has been that we are now placing clients on a a waitlist to have an intake appointment. This therefore means that it could take anywhere between 5-6 weeks before someone completes an intake and assessment appointment. This has led to a shift in the way we provide services to refugee claimants. In order to ensure that our refugee claimants are tied in to an agency while we face a back log on intake appointments, we allow them to attend LGBT and PHA newcomer focused support groups and information sessions at our agency. These groups/sessions provide claimants with much needed information, support and direction around the settlement process that they may not otherwise receive until they meet with a professional one on one. They are also introduced to other resources in our agency's community room, provided the opportunity to become an active volunteer and to meet with other workers such as our employment counselor and the housing worker." — Black Coalition for AIDS Prevention "Developing a rapid response plan/intervention for the OHTN in relation to the 1,980 GRINDR selfidentified Latino MSM found in January 2015." — Centre for Spanish-Speaking Peoples "Working with partners Casey House and CCAC to provide training and support on HIV care and stigma with LTC and other care facilities." — Fife House

7. Capacity-building and community development

Capacity-building activities

Capacity building is a key part of Ontario's response to HIV and it occurs at two key levels in the sector:

- **the provincial level**: 11 provincial capacity building programs help front-line community-based programs develop new skills and implement evidence-informed practices and programs. The work of these organisations generally falls into three categories: capacity building, skills development and mentoring.
- **the local level**: the community-based programs themselves help other organizations in their communities develop the skills and capacity to create a network of comprehensive health and social services for people with or at risk of HIV. Their work generally involves community development activities.

This chapter describes both provincial and local efforts to build capacity.

Provincial Capacity Building Organizations

- African and Caribbean Council on HIV/AIDS in Ontario - ACCHO
- AIDS Bereavement and Resiliency Program of Ontario – ABRPO
- Canadian AIDS Treatment Information Exchange – CATIE
- Committee for Accessible AIDS Treatment – CAAT
- Gay Men's Sexual Health Alliance – GMSH
- Ontario AIDS Network – OAN
- Ontario HIV and Substance Use Training Program – OHSUTP (sponsored by Fife House)
- Ontario HIV Treatment Network - OHTN
- Ontario Organizational Development Program – OODP
- Toronto HIV Network - THN (sponsored by the Toronto People With AIDS Foundation)
- Women and HIV/AIDS Initiative - WHAI

Key findings

- Programs are trying new models of capacity training for peers.
- Fewer short or conference-style presentations and more half to full-day workshops were reported.
- More community development meetings are occurring with other front line workers in HIV programs particularly for networking and program planning purposes.

Provincial capacity-building programs

The province's 11 capacity building programs provided a total of 727 KTE, mentorship/coaching and capacity building presentations — down 19% from 2013/14. The drop was mainly due to a change the way grief and loss training for peers was delivered in 2014/15. Historically these sessions were offered as one-on-one sessions, with each session reported as one training. In 2014/15, these trainings were delivered as group sessions so, even though there were 42% fewer mentorship and coaching sessions, there were not necessarily fewer people trained. If we remove these sessions from the analysis, the overall number of capacity building presentations was relatively similar to previous years.

Table 1. Number of capacity presentations/sessions (OCHART q. 14.1a)

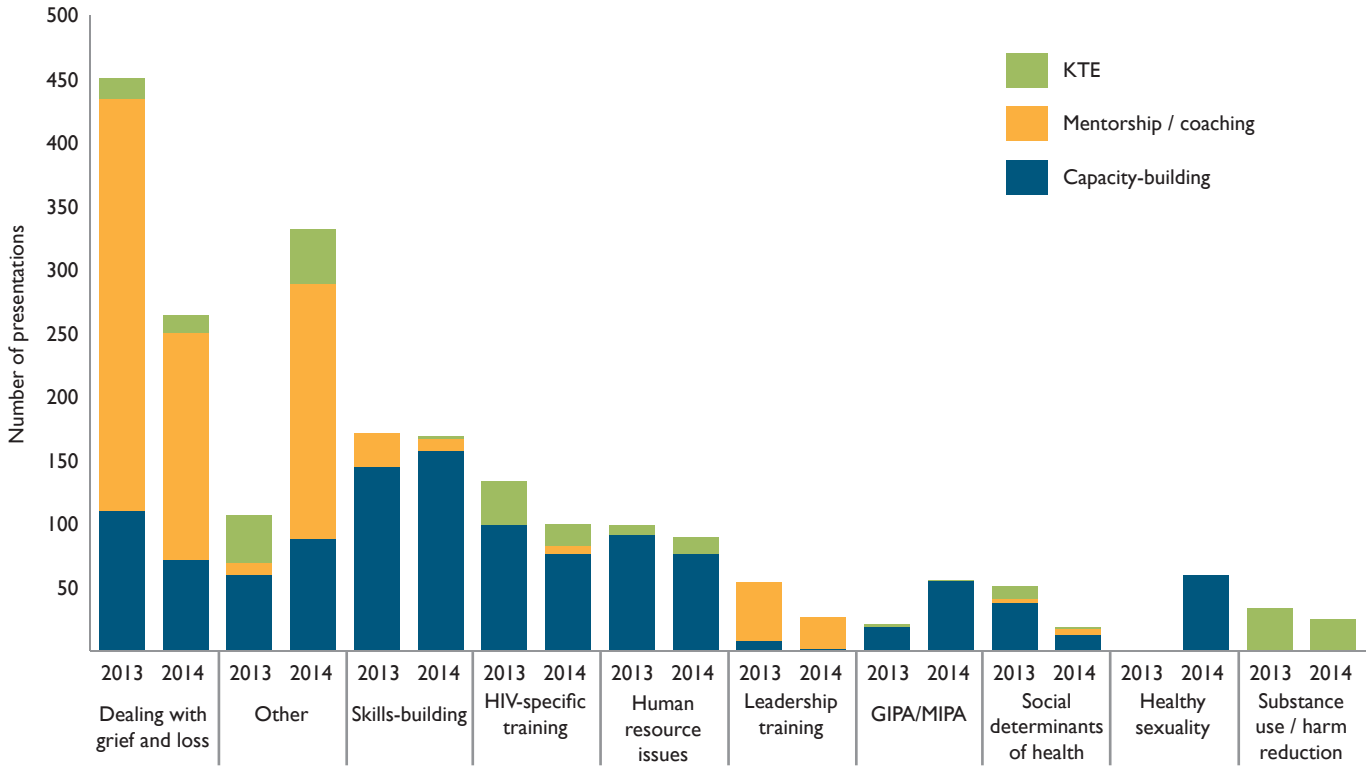
Presentation category	2013-14	2014/15
Capacity building	394	400
KTE	101	95
Mentorship and coaching sessions	402	232
Membership and coaching sessions (excluding grief and loss training)	78	54

More focus on health sexuality, boundaries and GIPA/MIPA

When reviewing the data on the focus of provincial capacity-building presentations, it is important to note that programs can report two topics for each presentation, meaning that the number of presentations reported will exceed the number of presentations actually given. In 2014/15, OCHART offered more options for categorizing presentations. This change combined with what appears to be a genuine shift in program focus, resulted in more presentations focused on healthy sexuality, boundaries and GIPA/MIPA than in the past (see Figure 94). However, in terms of focus, provincial programs reported a very large number of capacity, KTE and mentorship presentations in the "other" category, which suggests that OCHART needs to find a better way to categorize these activities.

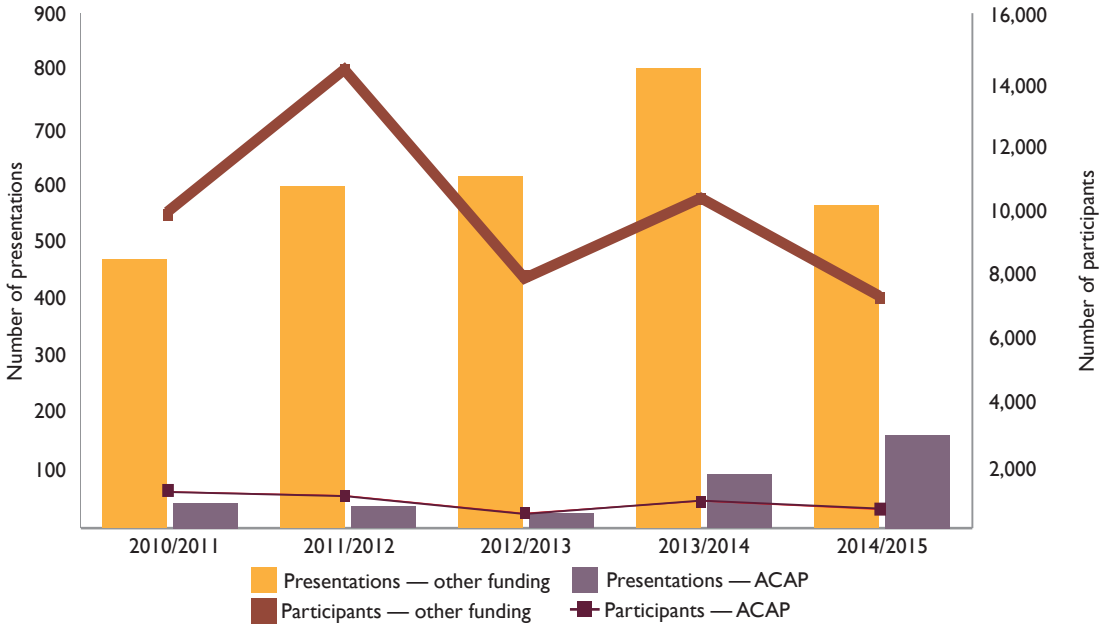
In general, the sector reported a shift in KTE presentations away from HIV-specific training and toward social determinants of health and disclosure and legal issues.

FIGURE 78 Number of presentations by focus(OCHART q. 14.1.a)



Provincial programs reported giving more ACAP-funded presentations in 2014/15. Although the number of ACAP-funded presentations was up, the number of participants was down — which may indicate that more skill-specific training is being provided to smaller groups of workers.

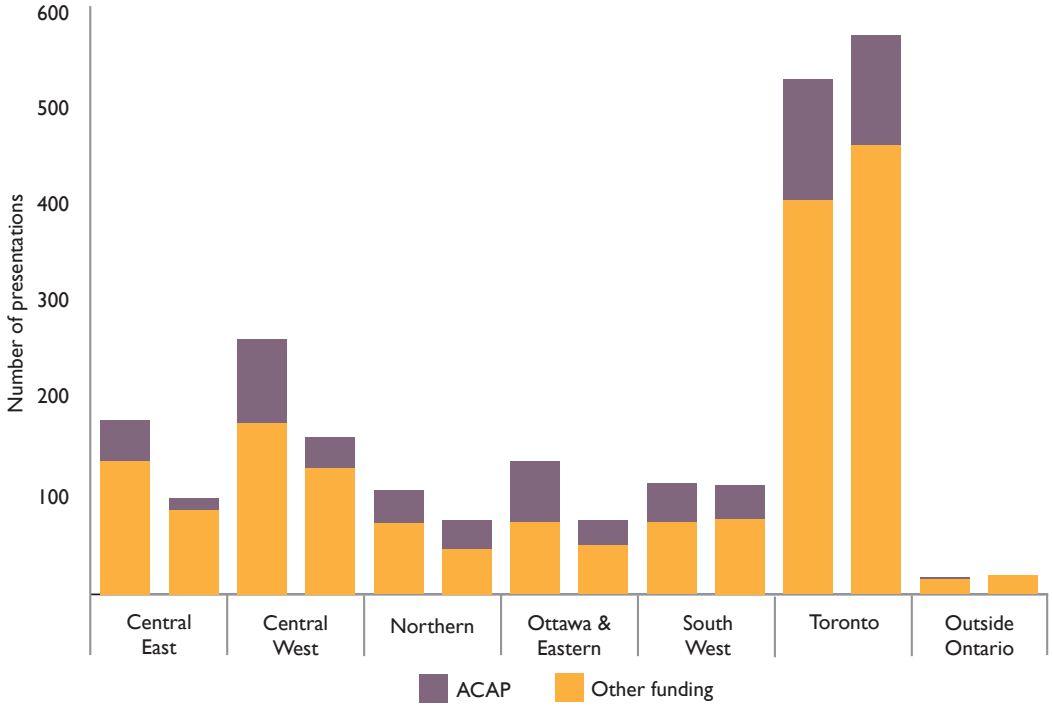
FIGURE 79 Capacity-building presentations and participants by funder
(OCHART q. 14.1a)



Provincial programs provide capacity-building across the province

Most presentations delivered by provincial capacity building programs take place in Toronto — likely due to travel costs (i.e. it is more cost effective to bring people to Toronto than go out to all the regions). However, a proportion of capacity building sessions occur in each region, although the number dropped in all regions except South West in 2014/15. A few presentations were delivered outside of Ontario to showcase work being done in our province.

FIGURE 80 Location of presentations delivered by capacity-building programs by health region(OCHART q. 14.1c)

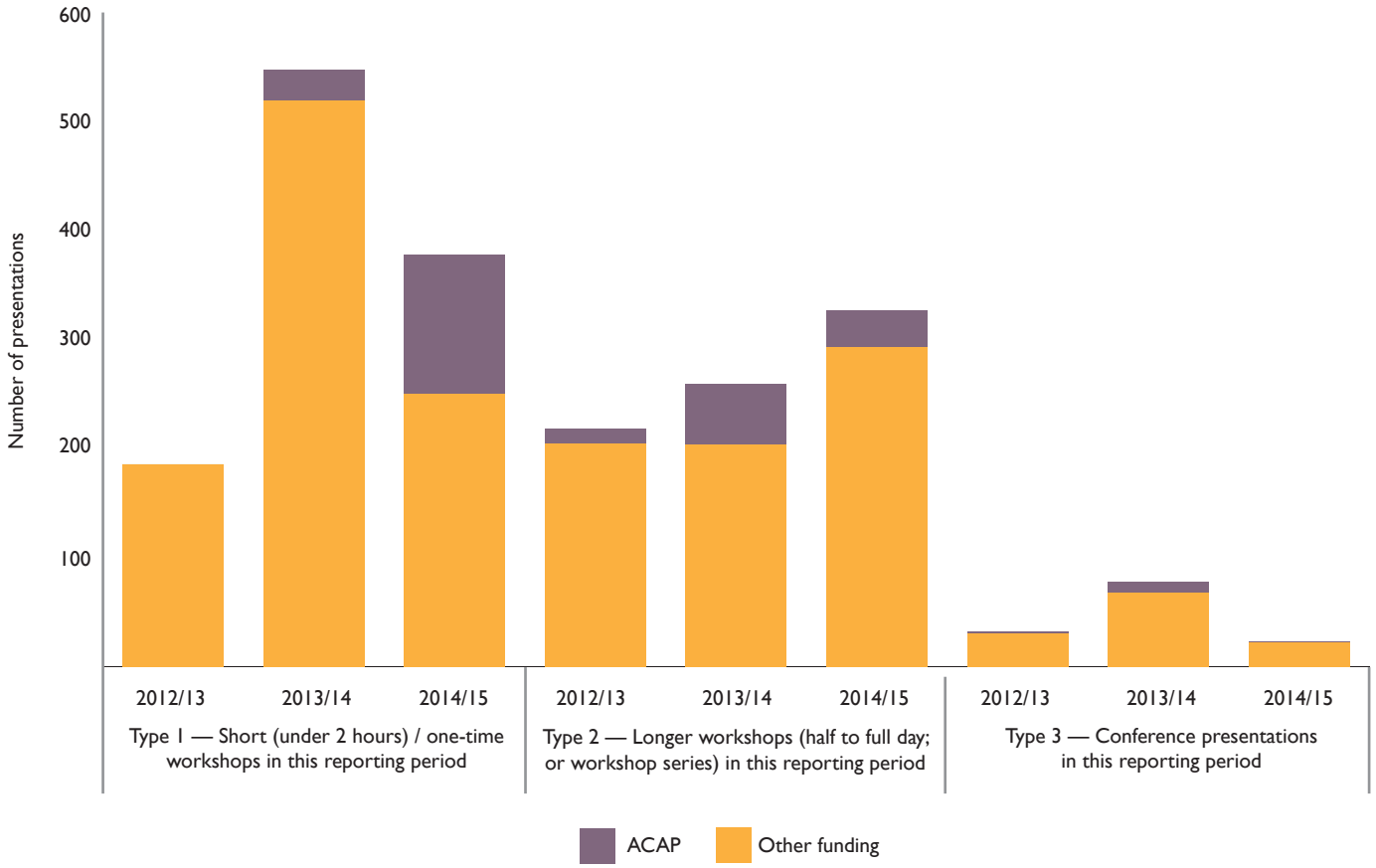


Conferences and workshops target administrators and frontline workers

Capacity building programs reported organizing or being involved in 30 conferences and workshops over the year, which reached a total of 1,561 participants. One-third (10) of the 30 conferences or workshops focused on organizational skills, such as human resources, governance and fundraising; the rest aimed to improve service delivery skills. Most workshops were short (under 2 hours) one-time events.

In 2014/15, capacity building programs reported fewer short or conference-style presentations and more half to full-day workshops. This change is likely due to feedback from frontline community-based programs that more in-depth workshops are a more useful form of training.

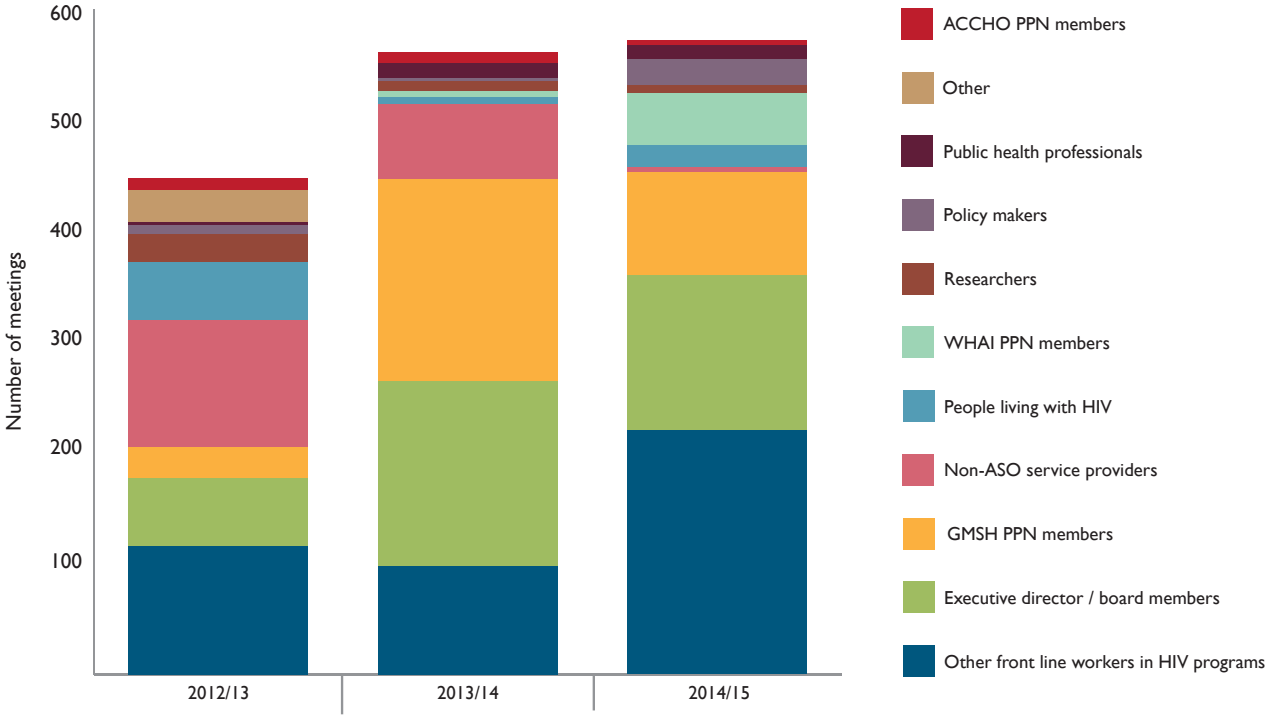
FIGURE 81 Format of capacity building presentations(OCHART q. 14.1b)



More community development meetings with frontline workers

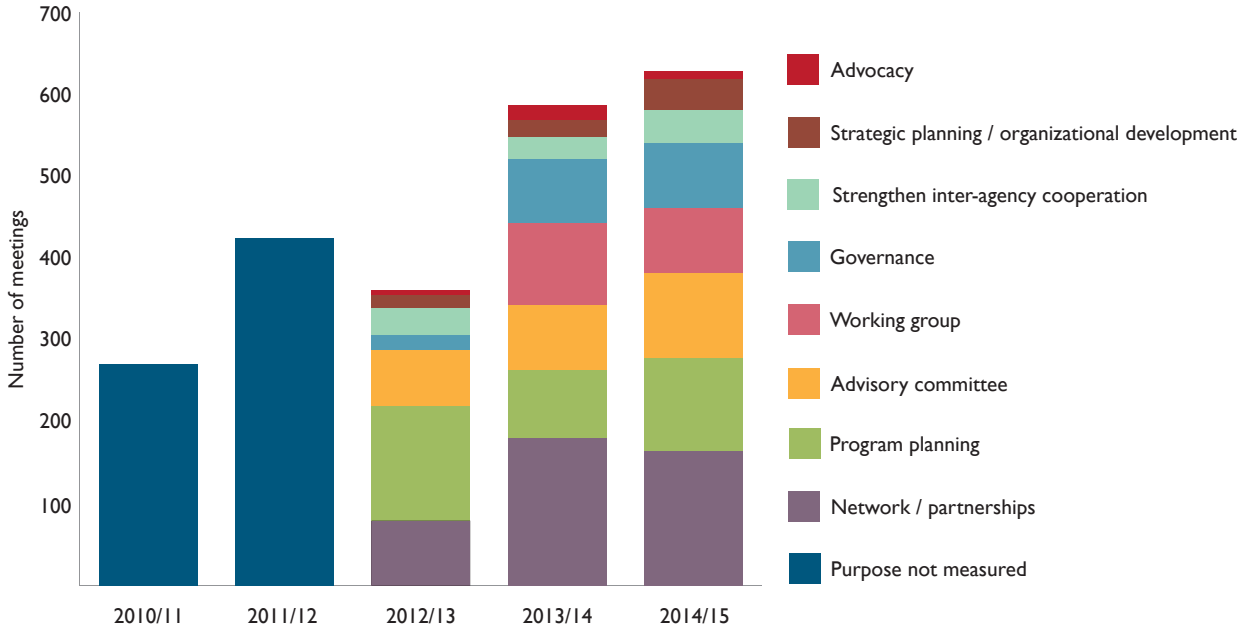
Provincial capacity-building organizations reported more community development meetings in 2014/15 (628) than in 2013/14 (586), with more of those meetings held with front-line workers than with executive directors/board members than in the past. The significant increase in meetings with WHAI workers (47 in 2014/15 from 5 in 2013/14) was most likely related to program planning.

FIGURE 82 Number of community development meetings by target audience (for capacity-building programs)(OCHART q. 14.4)



The main purposes of community development meetings were similar to previous years: network building / partnerships, program planning and advisory committees. However, there were also more meetings related to governance, inter-agency cooperation and strategic planning.

FIGURE 83 Purpose of capacity-building programs' community development meetings (OCHART q. 14.4)



What is the impact of provincial capacity-building programs?

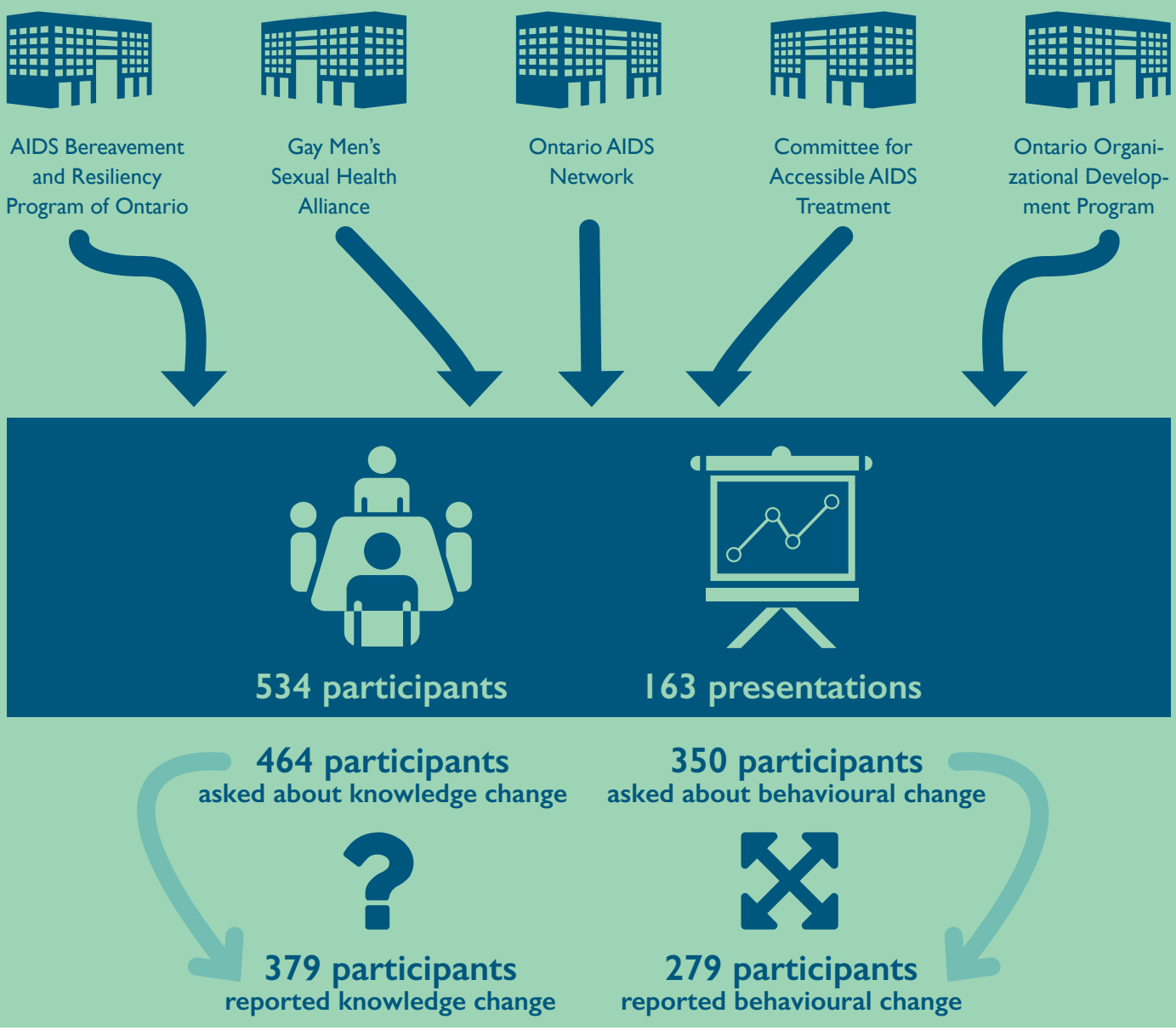
OCHART does not currently collect a lot of information on the impact of capacity-building programs. However, ACAP requires its funded programs to assess the impact of their initiatives on knowledge and behaviour. Five provincial capacity-building organizations that received ACAP funding in 2014/15 reported providing 163 presentations to a total of 534 participants. Of these:

- 464 were asked about knowledge change — of which 379 (80%) reported a change as a result of the capacity building presentation or workshop
- 350 were asked about behaviour change — of which 279 (71%) reported changing how they delivered services based on what they had learned.

FIGURE 84

ACAP PRESENTATION PARTICIPANTS REPORT CHANGES IN KNOWLEDGE AND BEHAVIOUR

(OCHART Q. 14.1.C & 14.1.D)



Promoting research and evidence-based practice

In 2014/15, the Ontario HIV Treatment Network (OHTN) — an organization funded to promote rigorous and relevant research, and move evidence into action — reported for the first time in OCHART.

Funding research related to priority populations

The OHTN funds and conducts research that will contribute to the goals of the provincial strategy. In 2014/15, the OHTN funded 119 research studies: 25 new and 89 ongoing — as well as five grants to support medical trainees.

Most of the research projects were focused on questions identified as priorities by the populations most affected by HIV.

FIGURE 85 Number of active funded research studies by priority population(OCHART q. 6.5b)

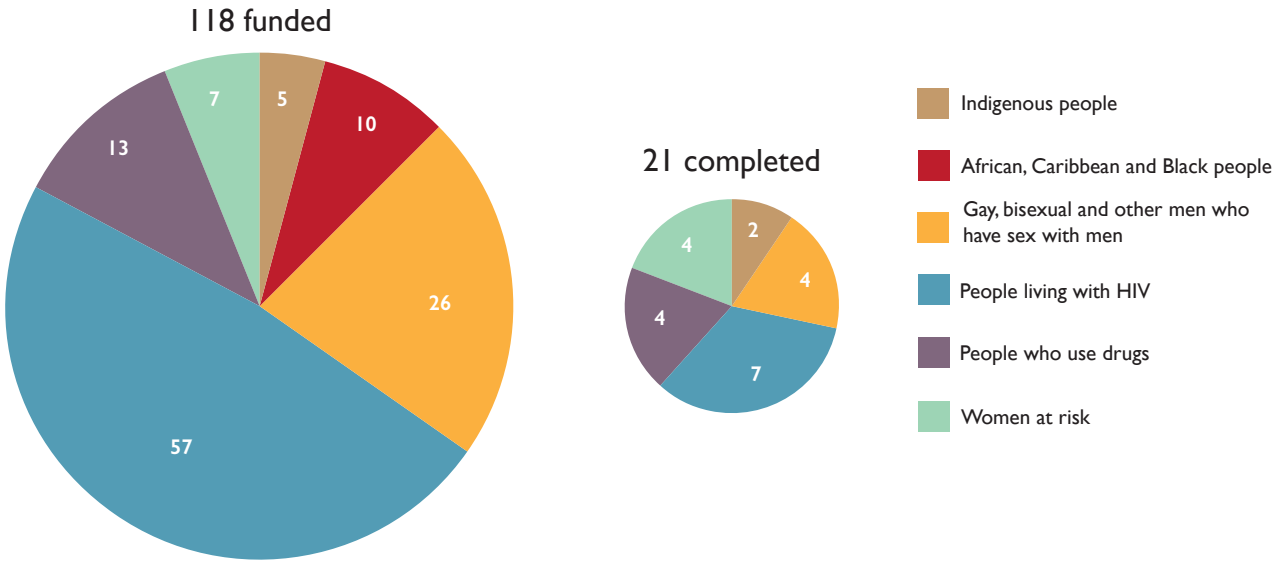
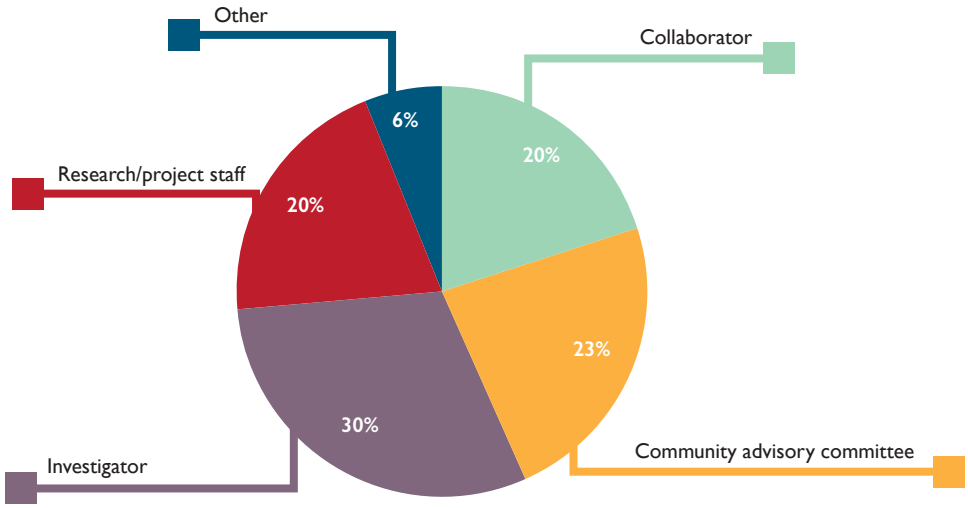


FIGURE 86 Contributions to research from people living with HIV(OCHART q. 6.5d)

75 people living with HIV contribute to research as:



GIPA/MIPA in research

The OHTN engages people with or at risk of HIV in meaningful ways in research, including as investigators, advisors, collaborators and staff.

Supporting community-based research teams

The OHTN's education and training unit supports: a) community-based research teams (through interactive and self-directed instructional modules); b) emerging HIV researchers in Ontario and beyond; and c) peer researchers in HIV research. Its training includes non-formal education such a monthly online talk show about peer researchers and helping agencies plan and deliver multimedia educational events through its request tool[1].

Outputs

- More than 173 events (including web-conferencing, social media, recording and post production) reached a total of 2,150 people
- 18 online modules — half have been translated into French
- More than 30 peer researchers trained
- One blended learning certificate course through York University
- 110 research-based videos viewed by 11,681 visitors.

In 2014/15, OHTN scientists and staff participated in more than 10 research projects and produced a range of resources and products for the HIV sector including:

- 21 peer-reviewed articles
- 10 grey literature publications
- 40 resources (including newsletters and study support pieces).

1 http://ohtn.fluidsurveys.com/s/OHTN-Mulitmedia-RequestTool

OHTN Cohort Study

The **OHTN Cohort Study (OCS)** is a nine-site research study that collects clinical and socio-behavioural data on over 5,000 people living with HIV in Ontario. In 2014/15, the OCS enrolled 435 new participants, of whom: 24% were MSM, 10% African, Caribbean or Black, 6% people who use drugs, 6% women at risk and 3% Indigenous people.

OCS data are used to understand the health needs of people living with HIV and improve care. Key findings in 2014/15 include:

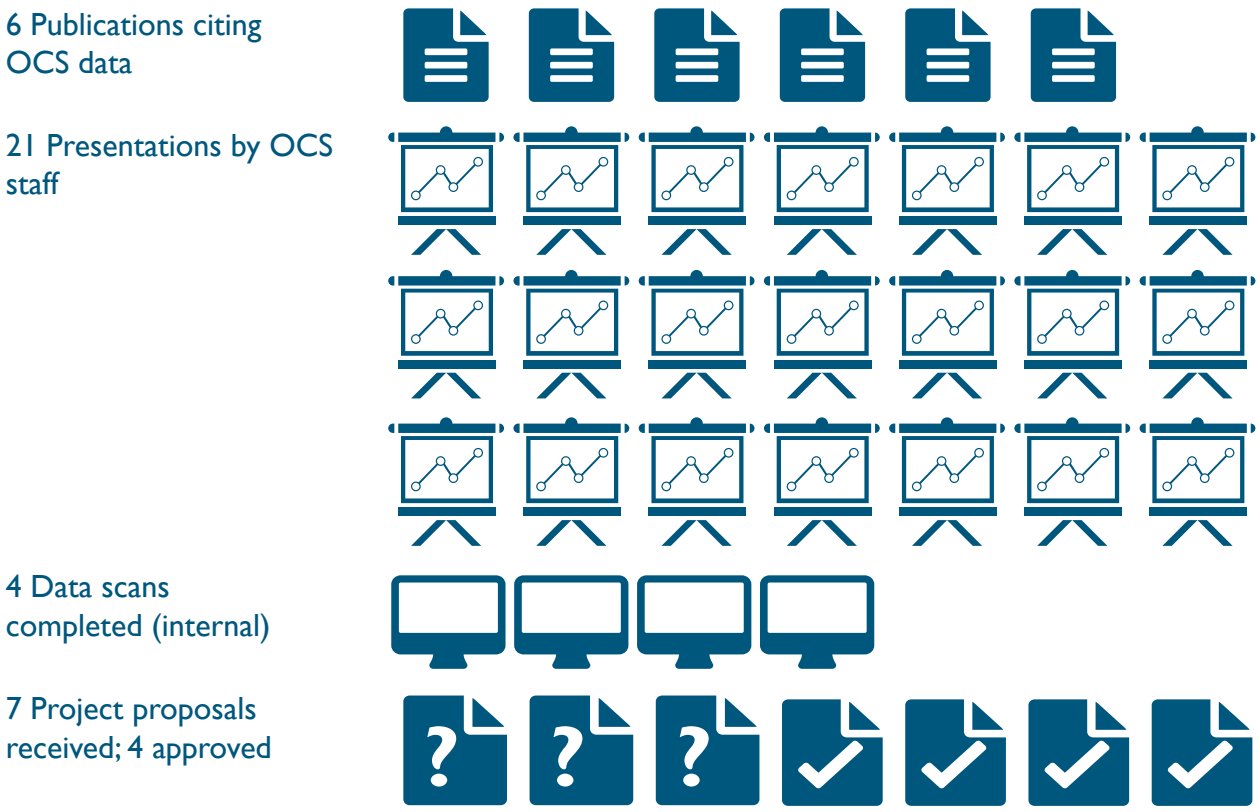
Table 2. OCS key findings for 2014/15 fiscal

Key finding	Why this is important
Testing rates for chlamydia and gonorrhea are on the rise	Since HIV is a disease of the immune system, having another STI can affect how the body manages HIV or the STI, and symptoms may be worse than if a person was not co-infected. Also, people living with HIV who have another STI, such as chlamydia or gonorrhea, may transmit HIV more easily (i.e., they may be more infectious).
Women have higher depression scores than men	Previous research has shown that depression can have a negative impact on the lives of people living with HIV. Knowing the risk factors for depression among people living with HIV can help clinicians identify who among their patients might need treatment or support. Helping people living with HIV manage their depression can improve their overall health outcomes.
High rates of HCV infection in HIV-positive men	Outbreaks of HCV infection among HIV-positive gay and other men who have sex with men have been reported internationally, even among men who don't report injection drug use (which is the main route of HCV transmission). There is growing evidence that HCV can be transmitted sexually, particularly among MSM who are living with HIV. Although sexual transmission of HCV occurs rarely during vaginal sex, researchers think that it could occur through blood-to-blood contact during anal sex, during sexual activities such as fisting or during any sexual encounter if there are sores present (such as those caused by syphilis). The finding that HCV infection can occur among men long after an HIV diagnosis means that occasional HCV testing may be important for HIV-positive men who have sex with men. Timely HCV diagnosis may prevent the further spread of HCV. Diagnosis is also important to guide treatment and care decisions, since co-infection with HCV may complicate HIV therapy.

OCS data are often cited in publications, presentations and as a data source in numerous project proposals (see Figure 102).

FIGURE 87

WAYS OCS DATA WAS USED IN 2014/15 (OCHART Q. 6.4C)



Moving evidence into practice

To help move evidence into practice, the OHTN synthesizes information. In 2014/15, the OHTN completing seven literature reviews — including three systematic reviews[2] — as well as 14 rapid responses. Topics for literature reviews are often identified by researchers and policy makers, while the topics for rapid responses come mainly from the community. 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. In 2014/15, the OHTN reported completing 14 rapid responses on a variety of topics including HIV service provision, mental health and HIV, and HCV and MSM health. (see Table 3).

2 Systematic reviews, the gold standard of literature reviews, critically assess research findings.

Table 3. OHTN summarizes research evidence via systematic reviews and rapid responses

7 Literature reviews	14 Rapid Responses
1. Community-based research literature review	1. Case management and community engagement
2. Housing and HIV systematic review	2. Common conditions among HIV+ MSM
3. IAS Literature Review	3. Crystal meth, sex behaviours and MSM
4. Mental health interventions and HIV	4. Current state of telemedicine
5. Prisons and HIV	5. HCV reinfection
6. Prevention interventions for sexually transmitted and bloodborne infections systematic review	6. HCV reinfection rates among drug users
7. Stigma systematic review	7. MSM behavioural emergencies
	8. Newcomers living with HIV/HCV
	9. Peer-based ARV adherence programs
	10. PTSD among people living with HIV/AIDS
	11. Sexual health of heterosexual MSM
	12. Supervised injection services
	13. Telemedicine and HIV health care
	14. Treatment of HIV/HCV+ newcomers

Helping community-based programs with data and evaluation

The Evidence-based Practice Unit at the OHTN supports the province's HIV sector with data management, reporting, program development and evaluation services. The EBPU's goals include supporting ASOs to use the information they collect via OCASE and other tools to improve their services, report on the impact of their work (via OCHART) and evaluate their programs to improve service delivery. In 2014/15, the EBPU responded to 364 data requests (189 simple and 175 complex), held 162 training sessions and was involved in the evaluation of 33 projects/programs. It also developed OCASE training/support modules and 33 evaluation tools.

FIGURE 88

OCHART AND OCASE TRAINING IN 2015

FIGURE 89

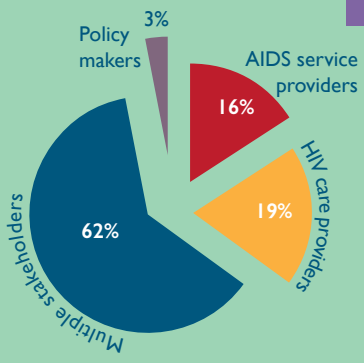
TOTAL OHTN PRESENTATIONS & PARTICIPANTS BY GOAL

(OCHART Q. 6.1A)

Enhance research skills / capacity

23 presentations

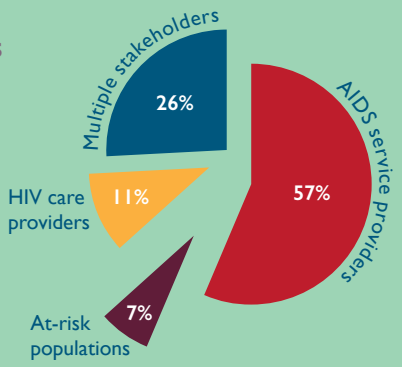
1,655 participants



KTE

21 presentations

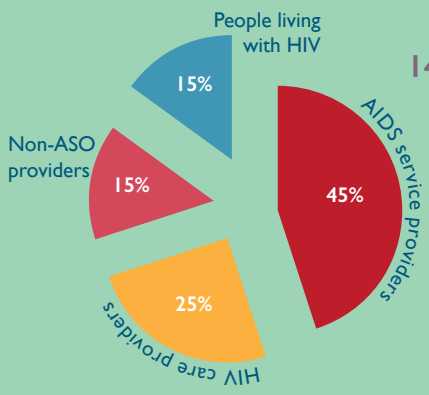
1,017 participants



Capacity-building

14 presentations

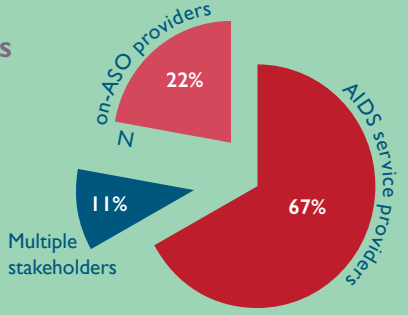
316 participants



Mentorship / coaching

5 presentations

64 participants



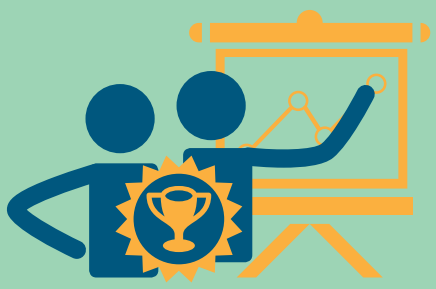
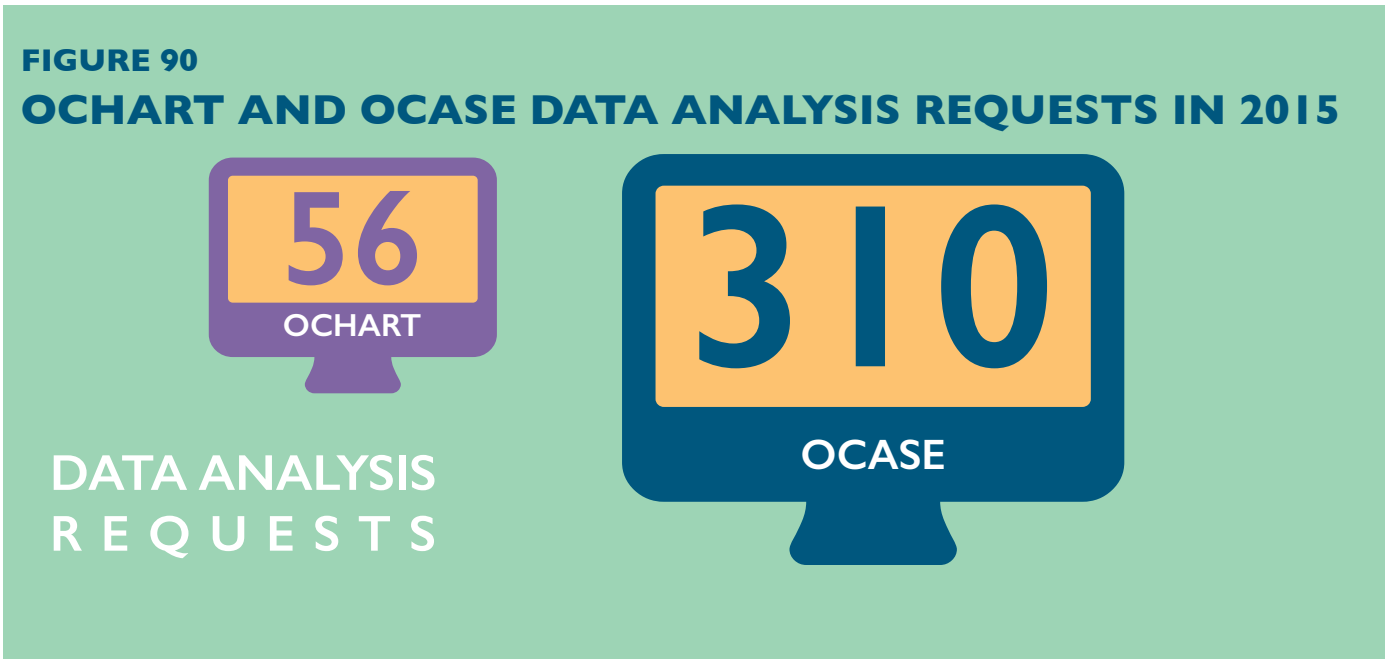


FIGURE 90

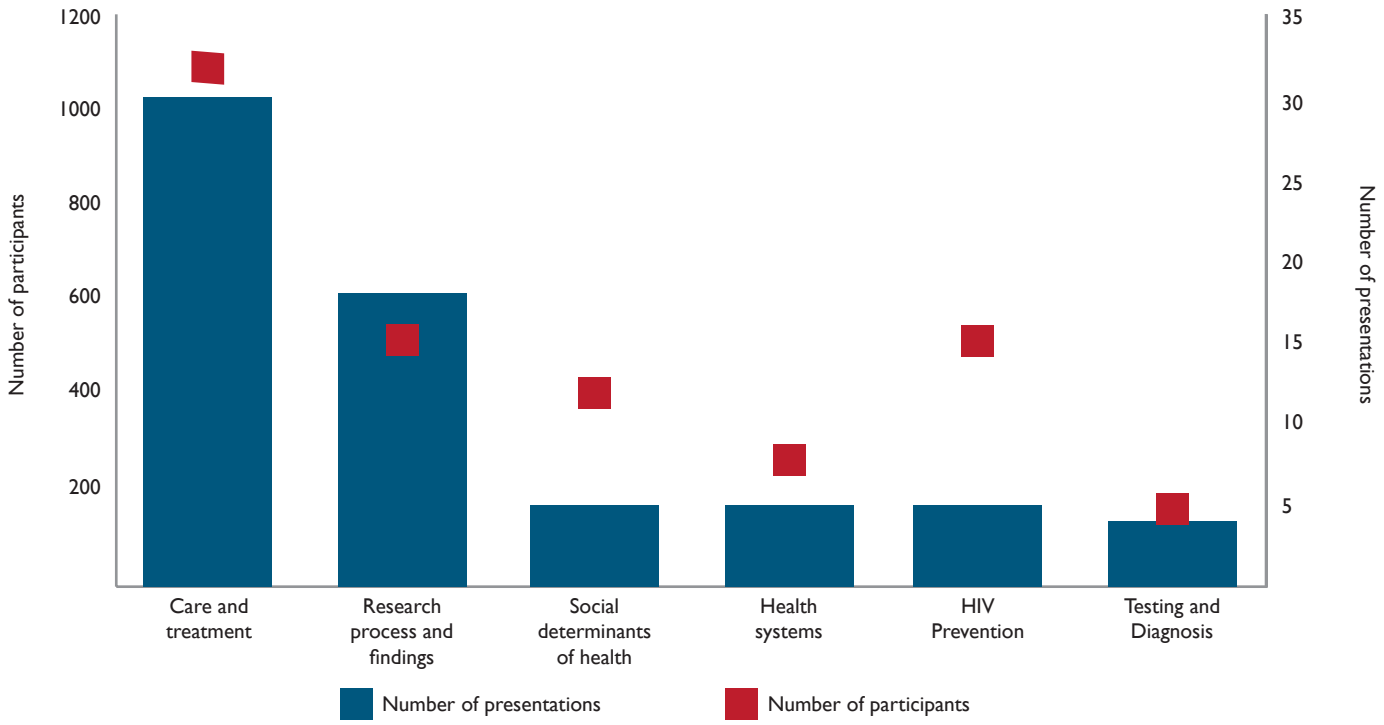
OCHART AND OCASE DATA ANALYSIS REQUESTS IN 2015



Talking research

The OHTN reported delivering 67 presentations to a total of 3,052 participants. Care and treatment was the focus for many of the presentations followed by research process and findings.

FIGURE 91 Total number of presentations and participants by presentation focus 2014/15
(OCHART q. 6.1a)

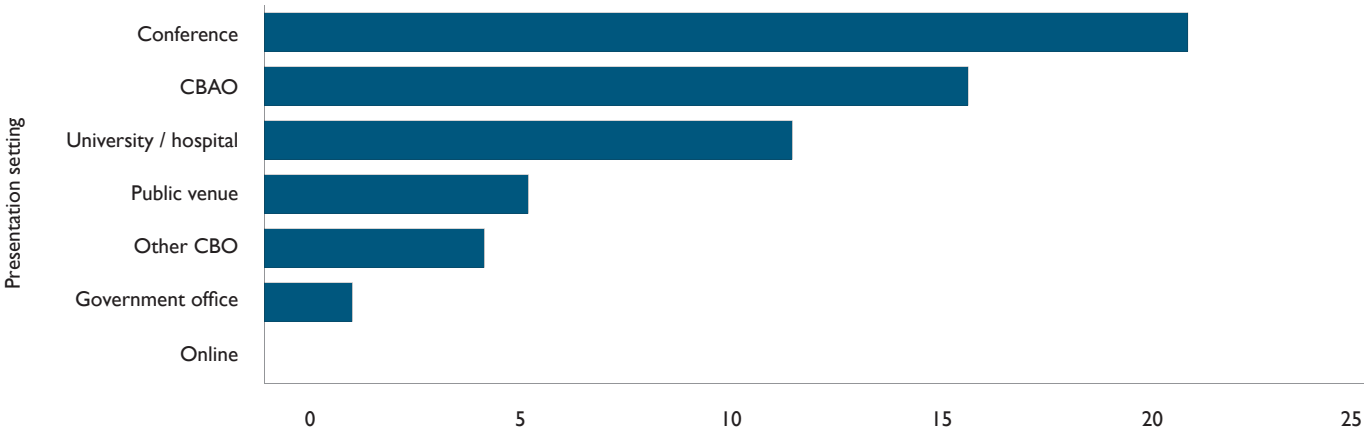


In terms of interest and impact, a large number of people attended a relatively small number of presentations on HIV prevention and social determinants of health – indicating the importance of these issues. It is likely that these presentations were aimed at community-based agencies.

ACAP and community development
ACAP funds 14% of community development meetings and the focus of these is similar to the focus of meetings funded by other sources.

The goals of OHTN presentations are to enhance research skills, disseminate research findings (KTE), build capacity to use research in practice and mentor or coach the next generation of leaders. Given that disseminating knowledge about research findings is one of the OHTN's goal, the most common settings for presentations in 2014/15 were conferences, followed by ASOs and universities/hospitals.

FIGURE 92 Number of presentations by setting 2014/15 (OCHART q. 6.1b)



Local capacity-building: HIV service providers fostering relationships and partnerships in their communities

Strengthening capacity of communities to support people living with HIV

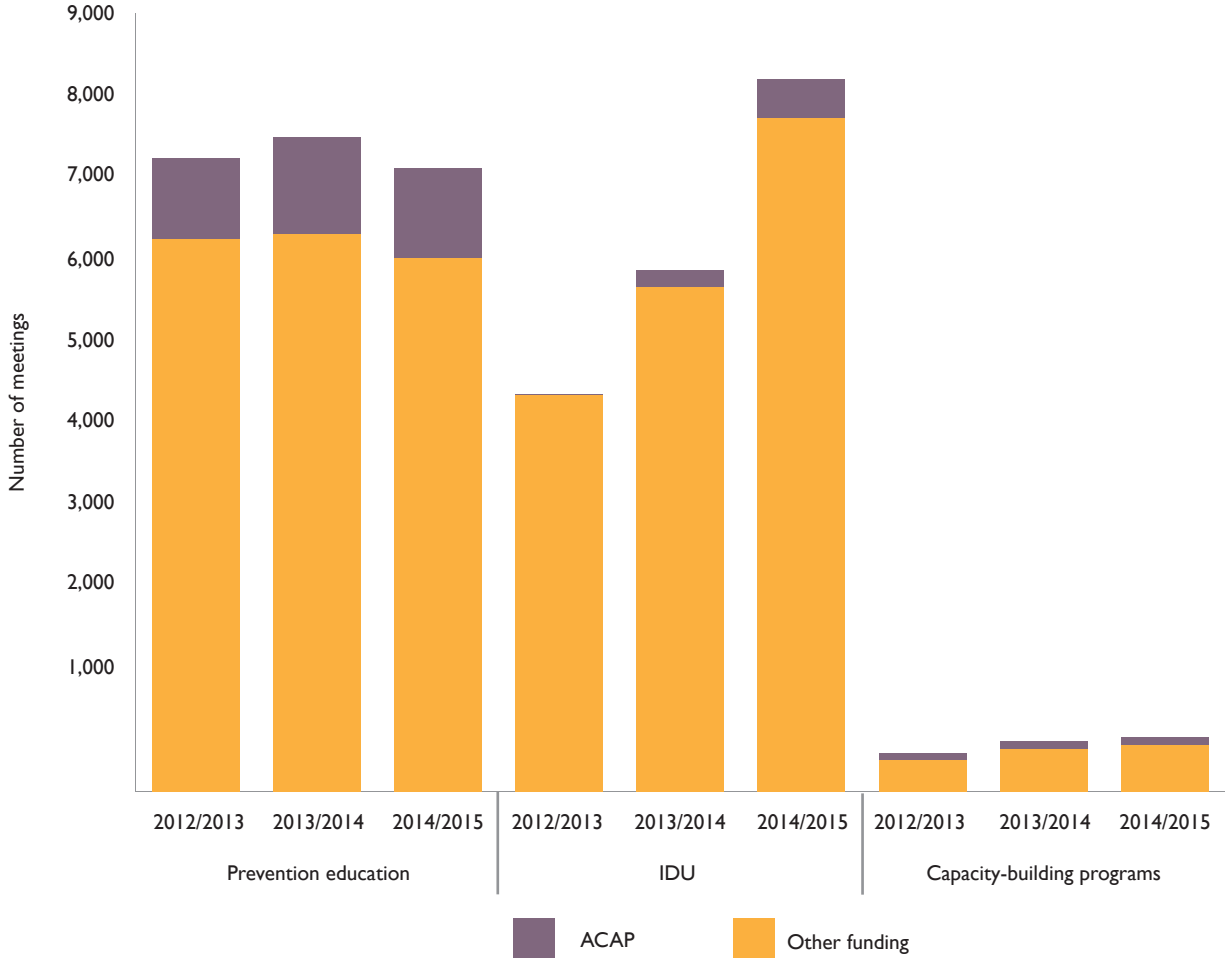
To reach people at risk and to ensure that people with or at risk of HIV receive comprehensive health and social services, community-based HIV programs are expected to foster relationships, build partnerships and — in some cases — negotiate service agreements with other service providers in their communities. The underlying goal is to develop networks of services that clients can access.

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.

Community development meetings up

One way to measure how effective the sector is in creating service networks is to track community development meetings. In 2014/15, programs reported a total of 16,078 community development meetings — up from 14,193 in 2014/15. This increase can be primarily attributed to IDU community development.

FIGURE 93 Community development meetings by funder(OCHART q. 9.5 and 13.7 and 14.4)



Who provides leadership in community development?

Community development is a particularly important activity for executive directors, program managers and priority population network members involved in HIV prevention.

- Executive directors and program managers are more involved in advisory or network meetings, developing new partnerships and meetings to improve service delivery.
- General prevention workers focus mainly on network meetings, information sharing, new partnerships and improving service delivery.
- Priority population network members are mainly involved in network meetings, community event planning, advisory committee meetings and building relationships.

Community development helps build networks

The purpose of prevention (education and outreach) community development meetings is to increase individual, organizational and community capacity. The main goals of the meetings are to develop coalitions/networks and plan community events (see Figure 108).

FIGURE 94 Top 5 community development activities by funder(OCHARTq. 9.5)

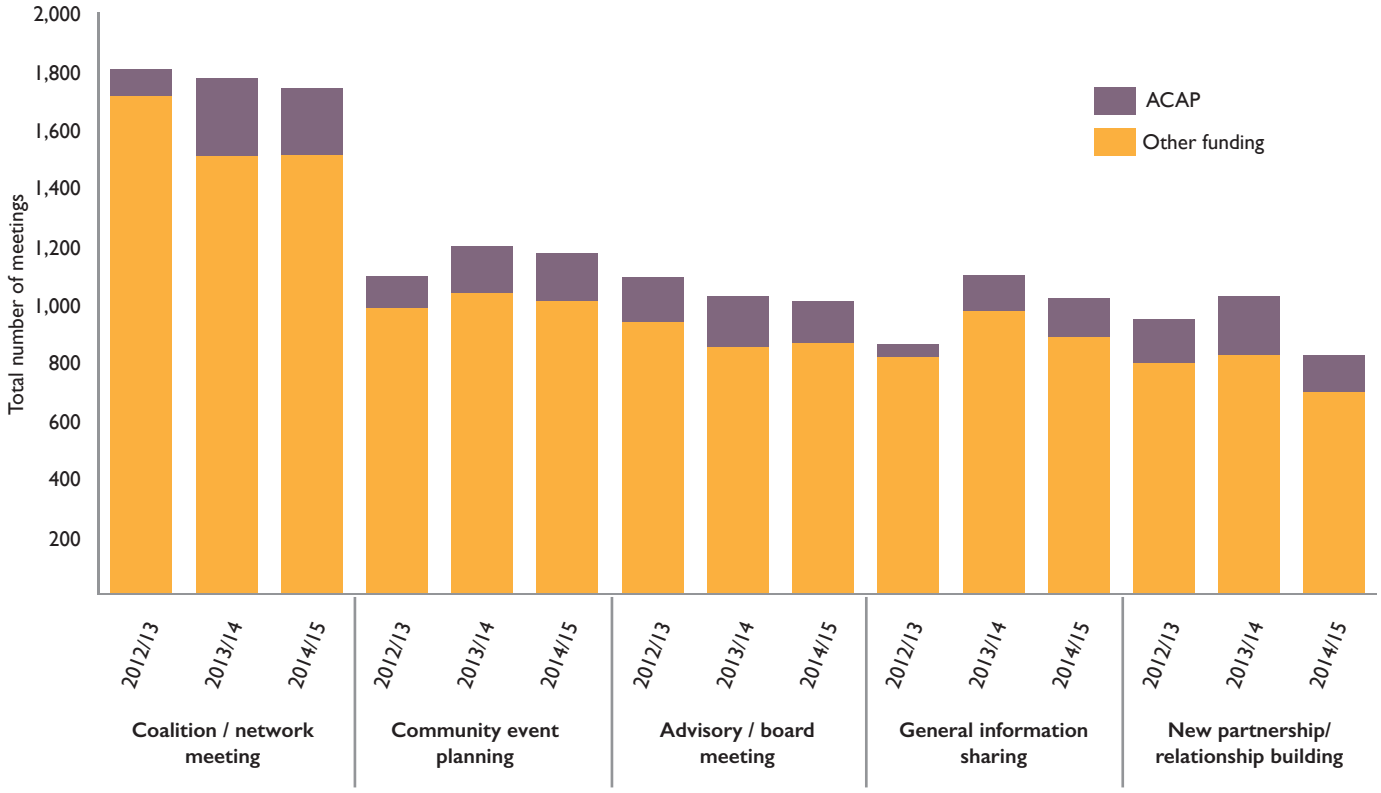
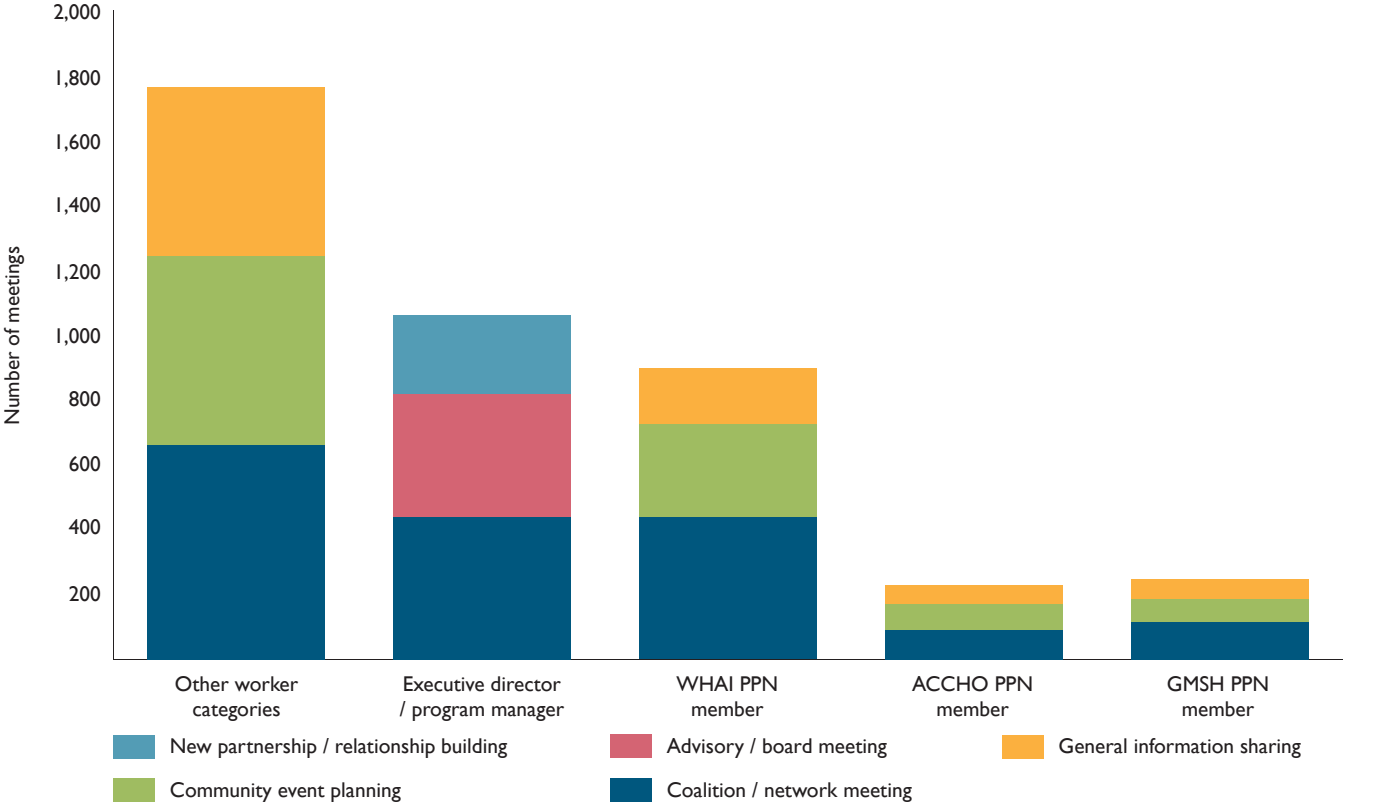


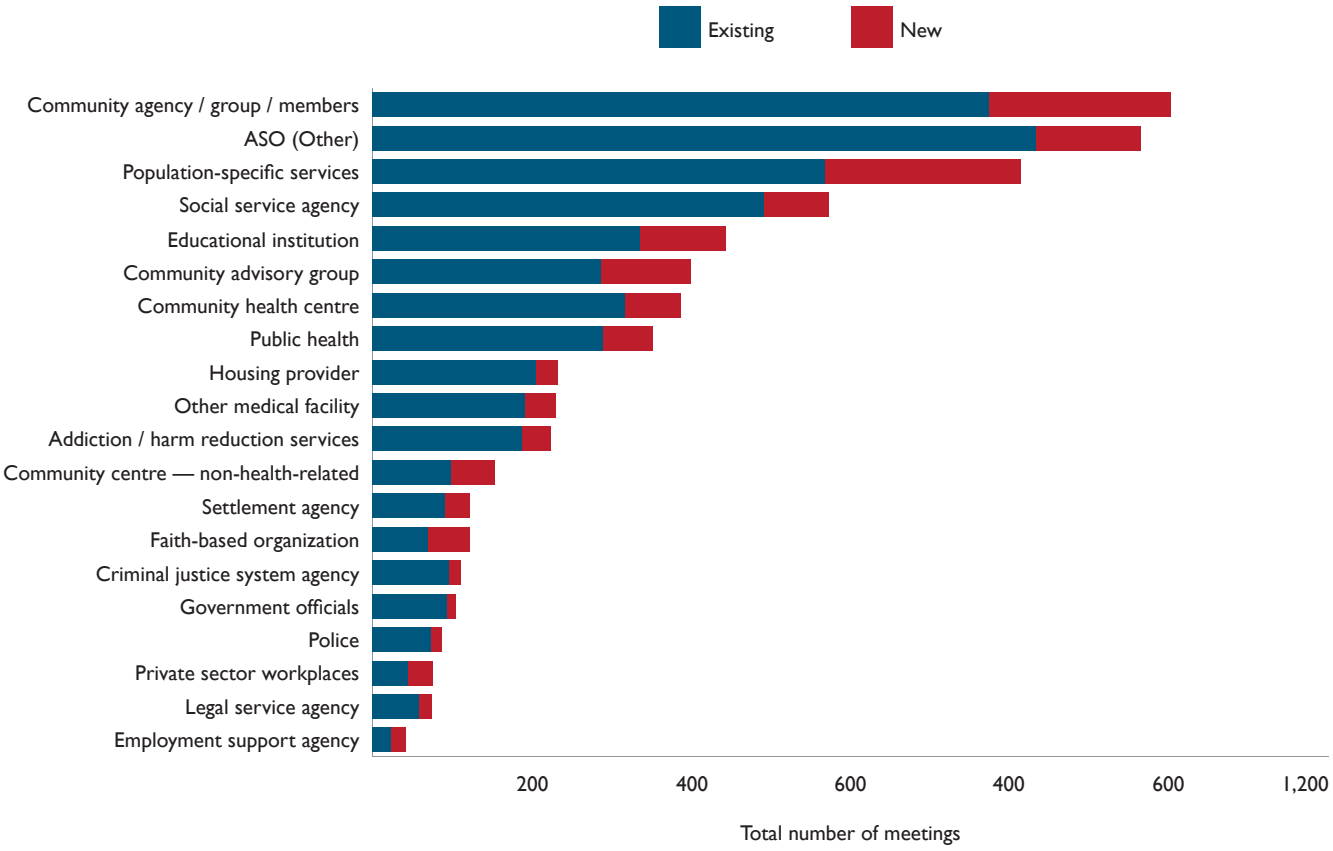
FIGURE 95 Top 3 community development activities by role(OCHART q. 9.5)



Population-specific services a growing partner for community development

A large portion of community development work done by prevention workers centers on community agencies, other ASOs and population specific services. In keeping with the provincial strategy, it is promising to see an increase in partnerships with population specific services, community health centres and public health (see Figure 110).

FIGURE 96 Community development meetings by partner type (for prevention workers) 2014/15 (OCHART 9.5b)



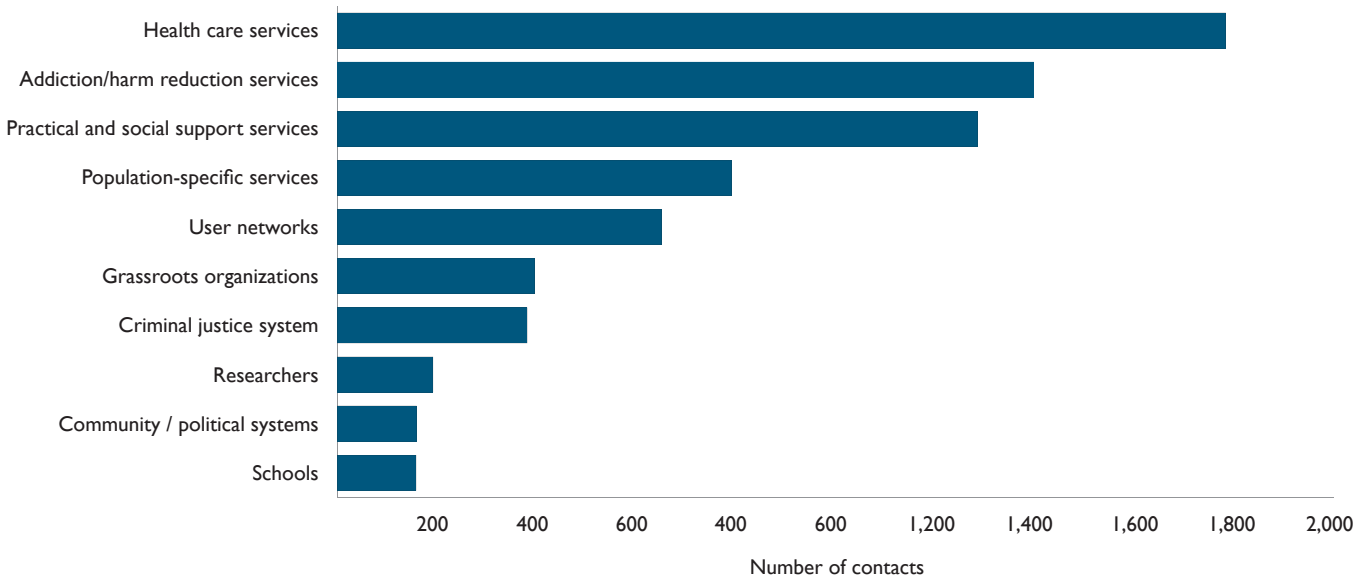
Who is involved in IDU community development activities?

IDU community development activities are targeted mainly to other health and social service providers. In 2014/15, IDU programs made efforts to engage health care services, addiction/harm reduction services and practical and social support services. This is part of broader efforts to meet the complex health and social needs of people who use substances.

FIGURE 97 Participation in IDU community development

	Committee / network / coalition meetings	Community clean-ups	Community events	Education presentations / formal programs	Research
ACAP					
# of meetings/ contacts	91	11	17	103	13
# of participants	206	34	1,603	1,559	7
OTHER FUNDING					
# of meetings/ contacts	795	230	198	991	35
# of particpants	4,117	232	7,302	9,490	280

FIGURE 98 IDU community development meetings 2014/15 (OCHART 13.8)



8. Regional snapshot

Geographic trends in the epidemic

FIGURE 99
In 2014/15, new HIV diagnoses were concentrated in following regions:

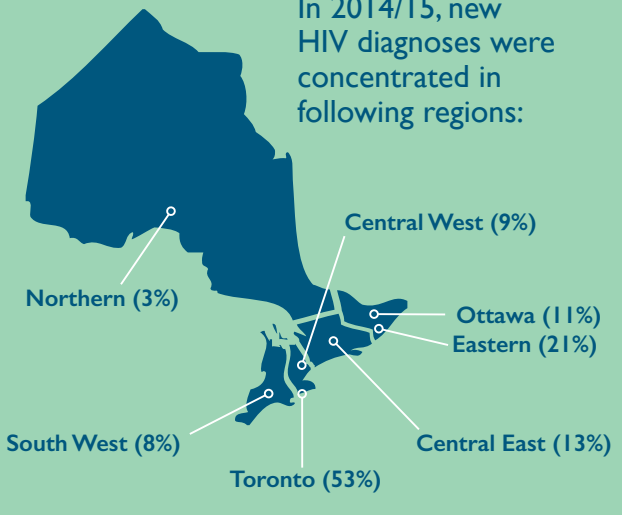
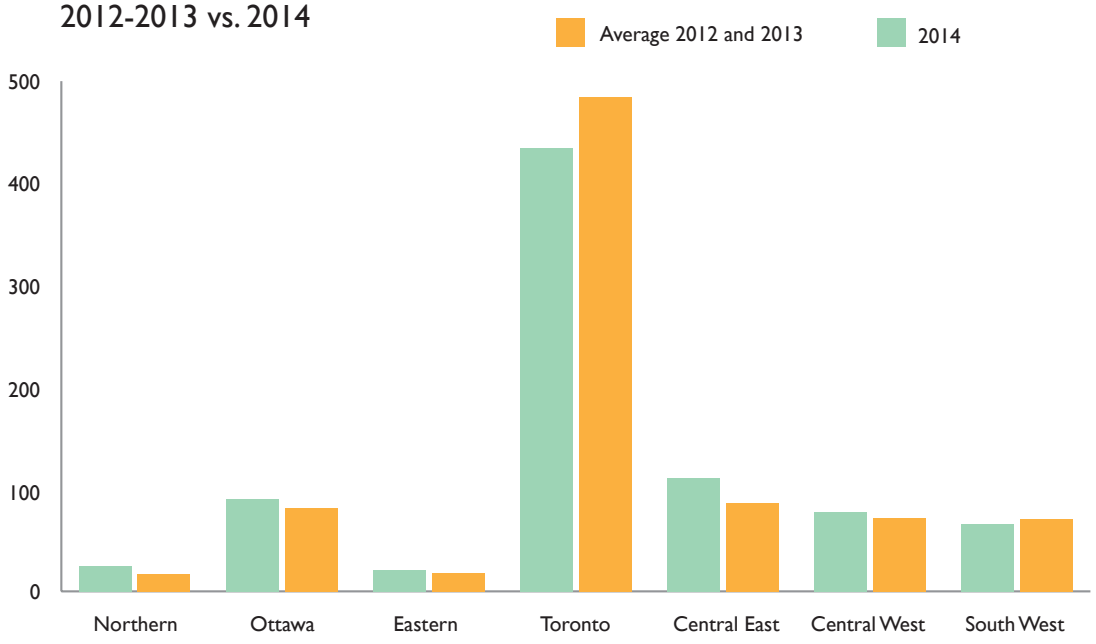


Table 8. Number and percent of new HIV diagnoses attributed to different regions of Ontario, 2014

Region	Number of new HIV diagnoses	Percent of new HIV diagnoses
Northern	25	3%
Ottawa	91	11%
Eastern	21	3%
Toronto	434	53%
Central East	111	13%
Central West	78	9%
South West	66	8%
Out of province	11	-

Trends over time: Compared to the average number of HIV infections over the previous two years (2012-2013), the number of new infections decreased in the Toronto and South West regions, and increased slightly in all other regions (Figure 12).

FIGURE 100 Number of new HIV diagnoses attributed to different regions, 2012-2013 vs. 2014



Differences by sex: Among females, there were increases in new HIV diagnoses in the Northern, Eastern, and Central West regions (FigureFIGURE 100). Among males (FigureFIGURE 101), there were no major differences compared to the previous two years.

FIGURE 101 Number of new *female* HIV diagnoses attributed to different regions, 2012-2013 vs. 2014

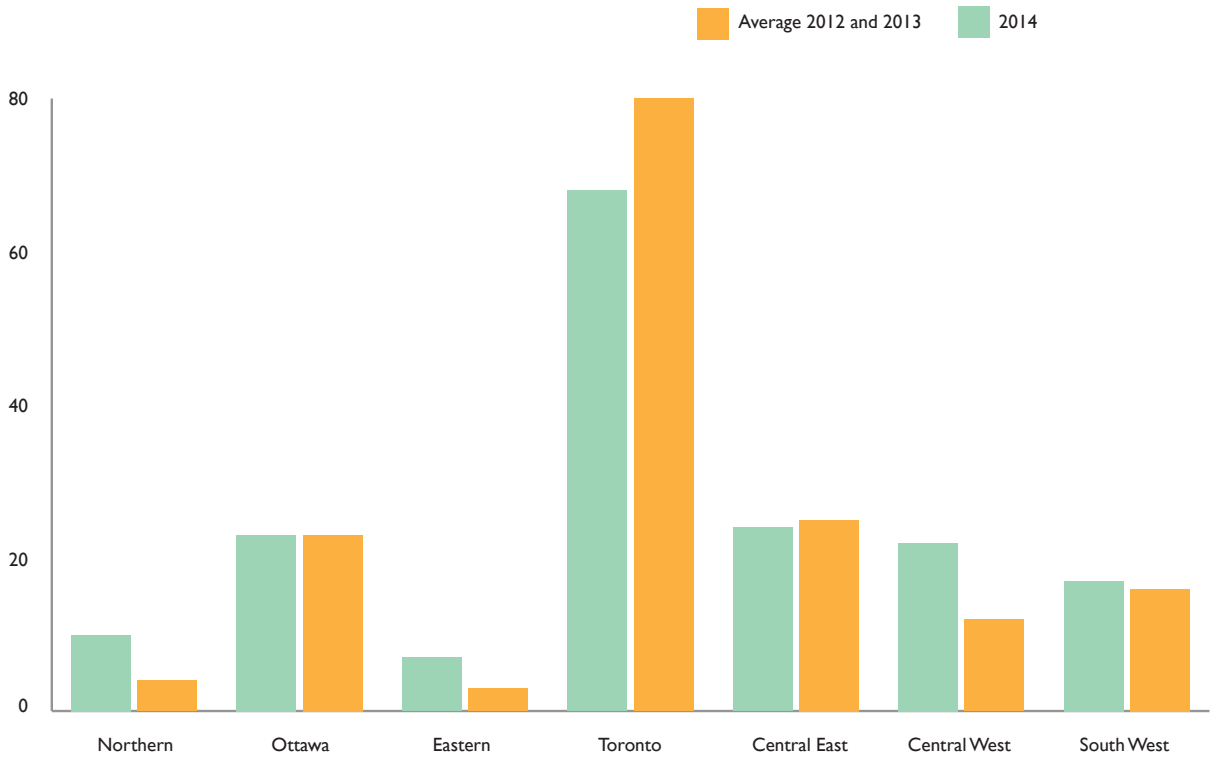
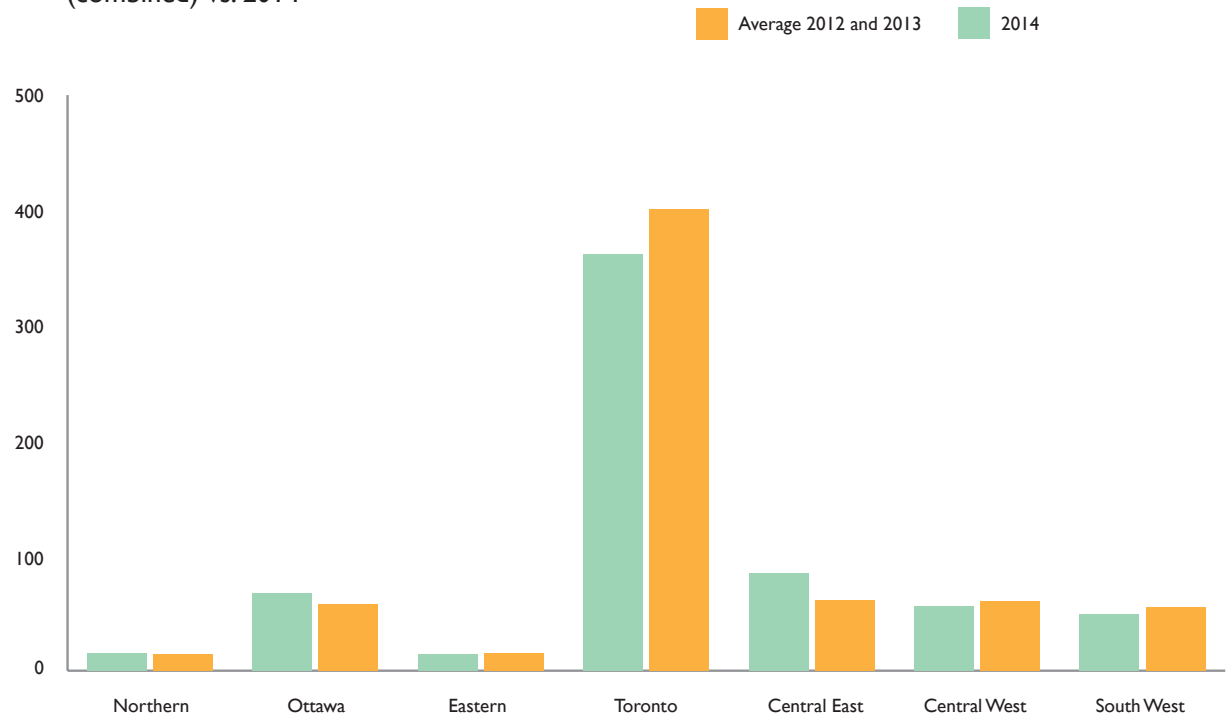


FIGURE 102 Number of new *male* HIV diagnoses attributed to different regions, 2012 and 2013 (combined) vs. 2014

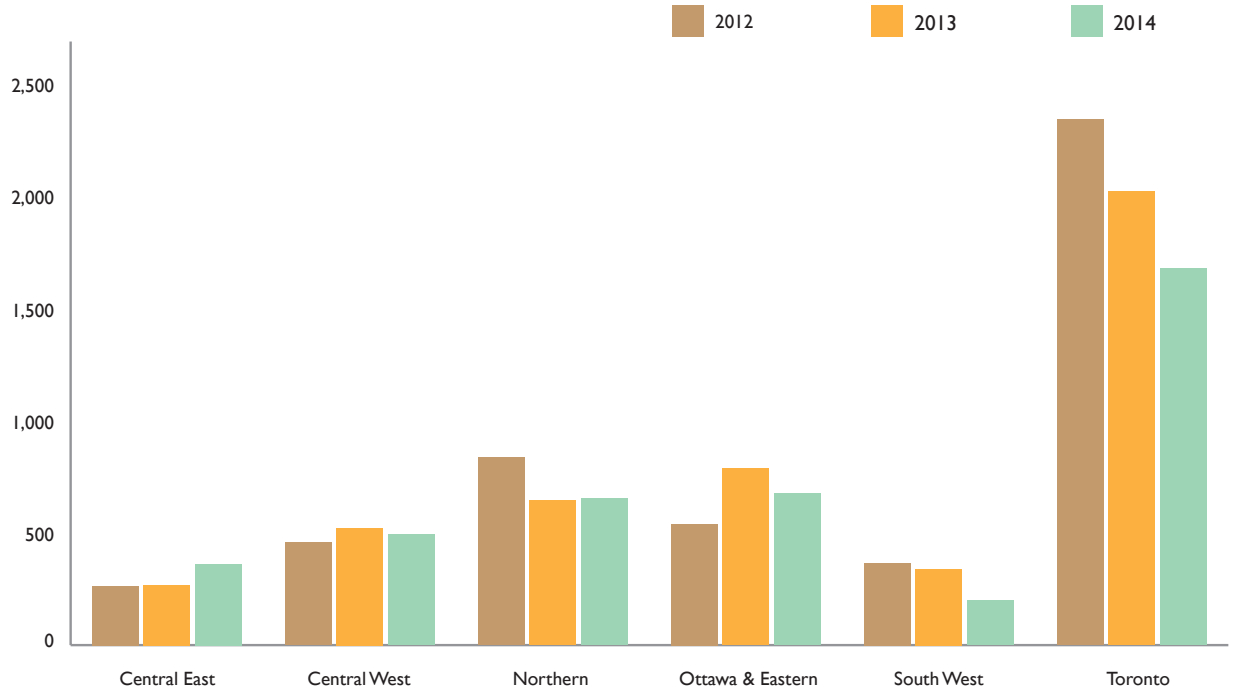


A regional look at prevention presentations

Where are we talking?

Education presentations are happening across the province. In 2014/15, Central East reported giving more presentations than in the previous year.

FIGURE 103 Total presentations by region(OCHART q. 9.1a)



At least four regions — Northern, Ottawa/Eastern, Southwest and Central West reported fewer presentations to youth. These shifts are consistent with the stronger focus on priority populations (see Figure 50).

FIGURE 104 Trends in regional presentations by audience[OCHART 9.1a]

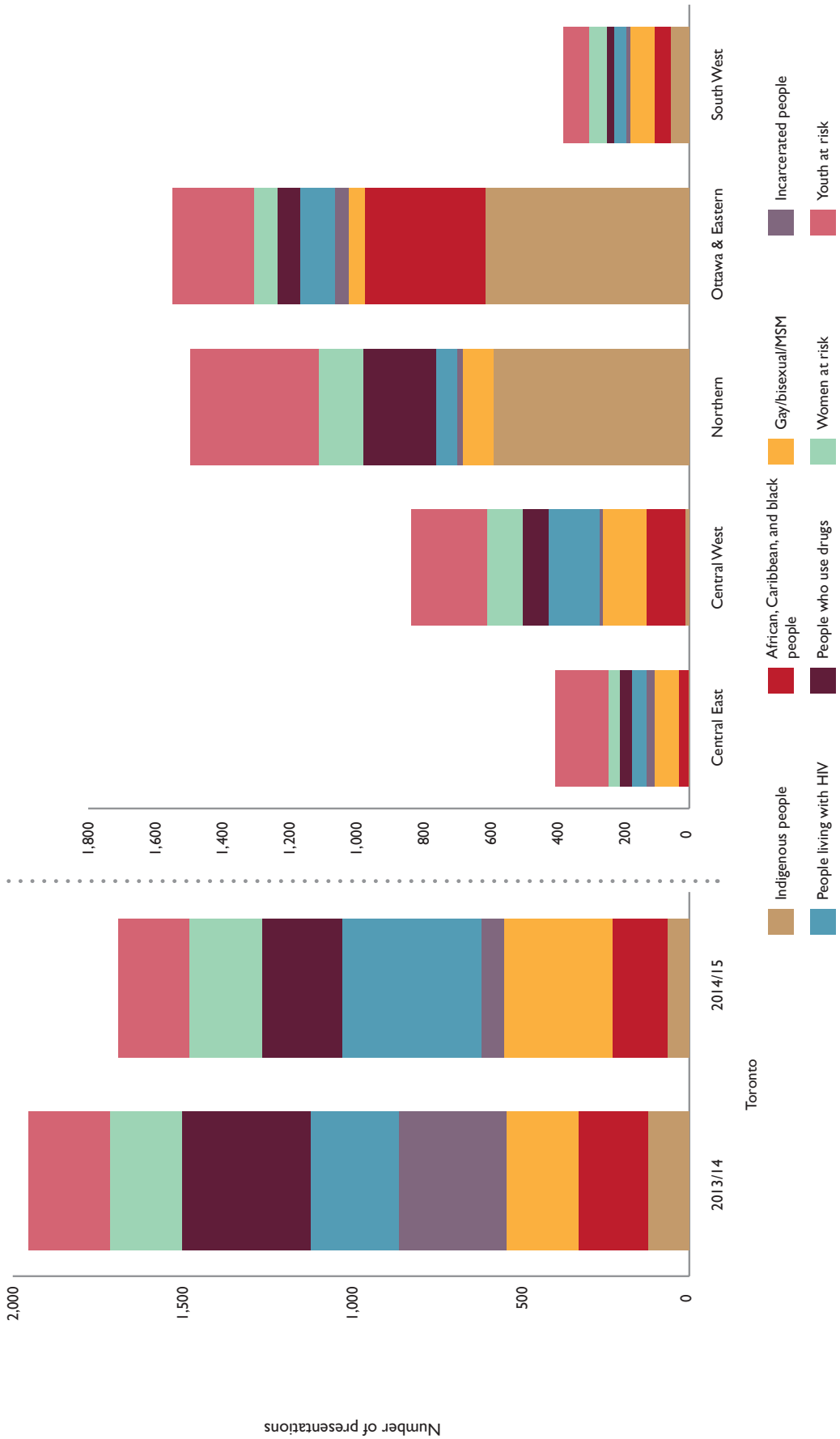


FIGURE 105

SHIFTS IN TARGET AUDIENCES FOR PRESENTATIONS

Northern

More presentations to people who use drugs and Indigenous peoples; fewer to all other categories, particularly youth at risk.

Ottawa and Eastern

More presentations to Indigenous people, people living with HIV and women at risk; fewer to African, Caribbean and Black people and youth at risk.

Central East

More presentations to youth at risk, people who use drugs, people living with HIV and African, Caribbean and Black people; fewer to gay, bisexual and other men who have sex with men and incarcerated people.

Central West

More presentations to people who use drugs, gay/bisexual/other men who have sex with men and Indigenous peoples; fewer to youth at risk and people living with HIV.

South West

More presentations to gay/bisexual/other men who have sex with men, African, Caribbean and Black communities; fewer to youth at risk and incarcerated people.

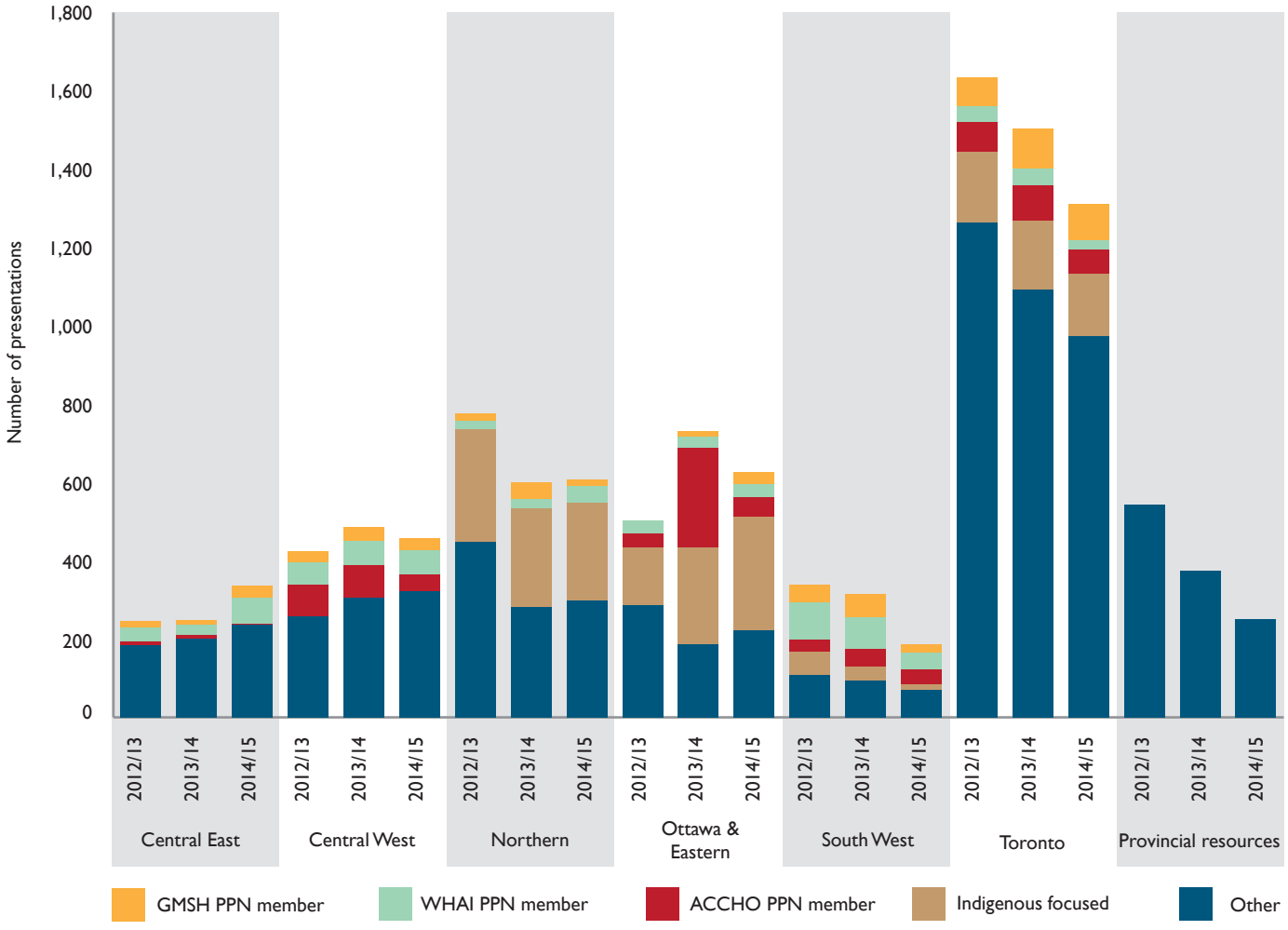
Toronto

Increase in presentations to people living with HIV, gay, bisexual and other men who have sex with men; fewer in all other categories.

Who is delivering prevention presentations in each region?

Most presentations are still delivered by general prevention workers — which is to be expected given the ratio of general prevention workers to population specific workers. However, as the local members of priority population networks and population-specific workers develop stronger relationships and become more established within their communities, they are delivering more presentations. Any drop in the number of presentations given by these staff in a region is usually due to turnover.

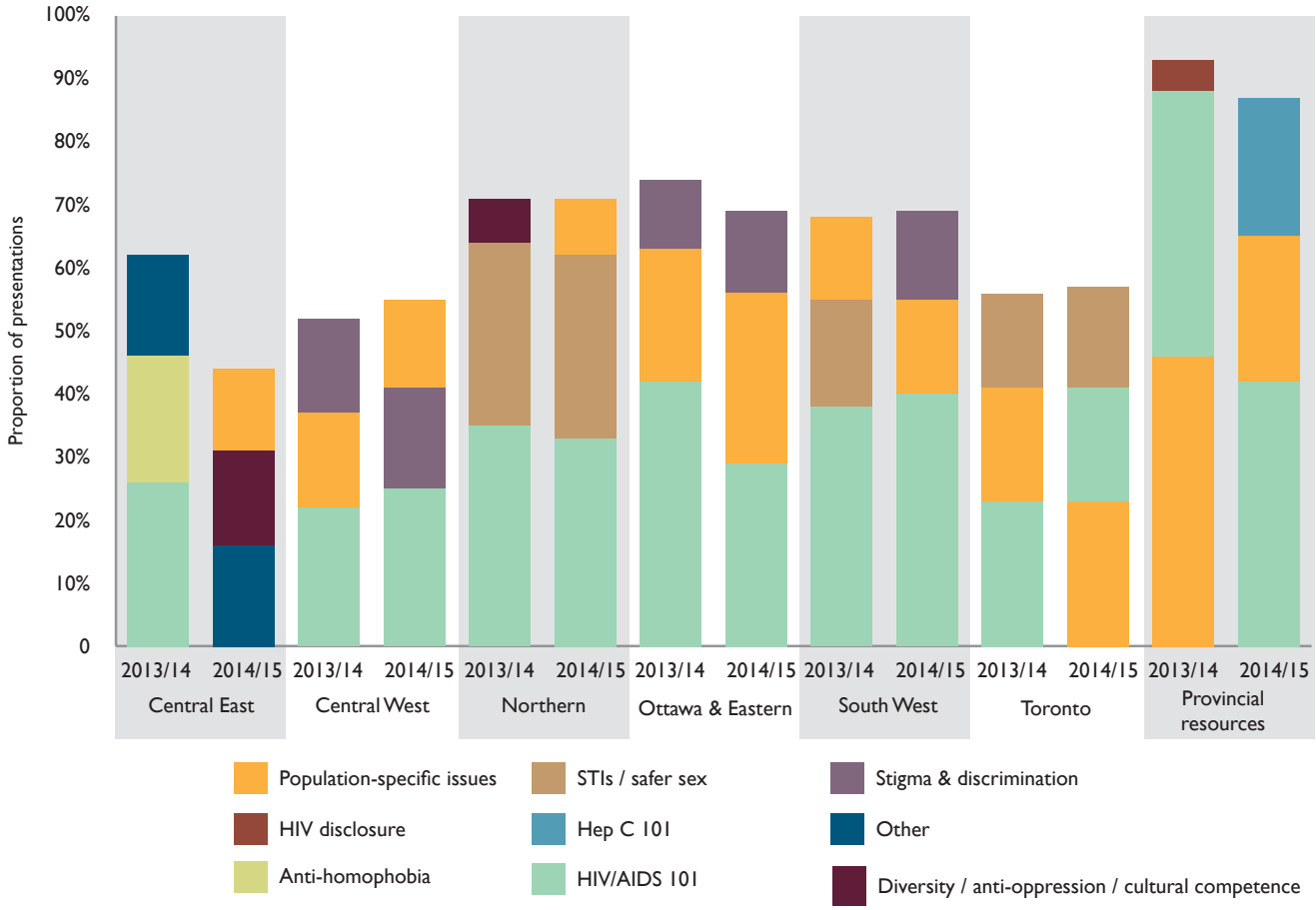
FIGURE 106 Number of presentations by region and type of worker(OCHART q. 9.1a)



What are the most common topics in each region?

FIGURE 107 illustrates the most common topics in each region. The four most discussed topics include HIV 101, population-specific issues, hepatitis C 101, and stigma and discrimination; however, the proportion of presentations on each of these topics varies among regions. The most popular topics in Central East include diversity/anti-oppression/cultural competence and "other." More information is required on what "other" includes.

FIGURE 107 Top 3 topics by region(OCHART q. 9.1a)

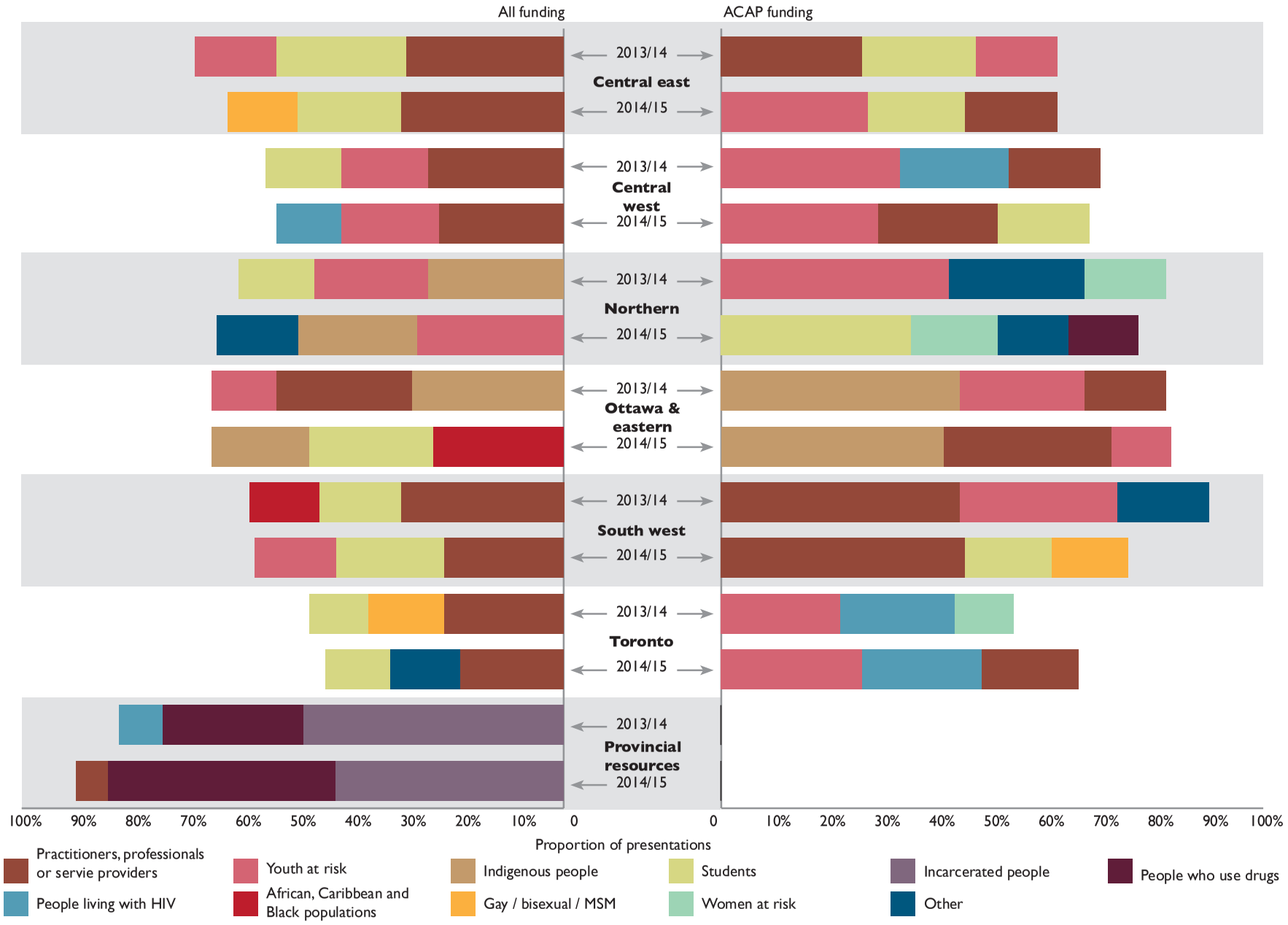


Are we reaching the right people in our regions?

Looking at the top three audiences for education presentations by region, it appears that programs in the Ottawa and Eastern and Northern Regions are devoting a significant amount of their education resources to Indigenous people. At-risk youth are a main target of education in four of the six regions – despite the fact that there are not high rates of new diagnoses in youth. For two regions, youth-at-risk account for more than a third of the audience presented to. Is this because they planned to reach this audience or they planned to reach a priority population and did not accurately record/report this? Although there are high rates of new diagnoses in men who have sex with men in most regions, and African, Caribbean and Black communities are a priority population, these populations were each among the top three audiences for only one region. Is this because these communities prefer to be reached in formats other than formal presentations?

Practitioners, professionals or service providers, youth at risk and students make up a bulk of the audiences for ACAP-funded presentations across all regions except for capacity building programs which use funding to reach incarcerated people and people who use drugs.

FIGURE 108 Top 3 presentation audience types by region (OCHART q.9.1.a)

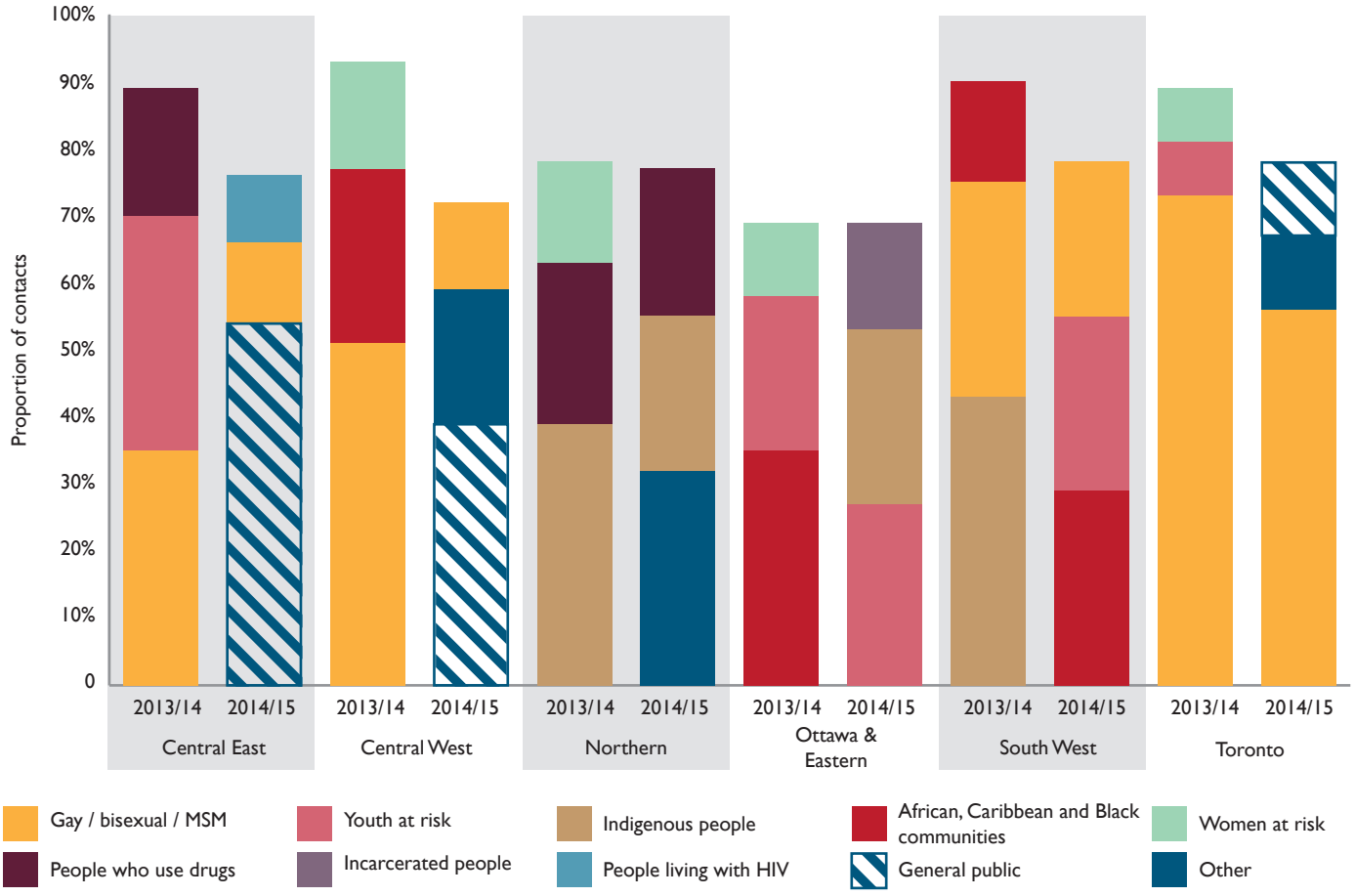


A regional snapshot of outreach services

Who are regions reaching through outreach?

- Toronto and South West were focused on gay, bisexual and other men who have sex with men
- Ottawa and Eastern region and South West targeted youth at risk
- Northern and Ottawa/Eastern targeted Indigenous people
- Northern targeted people who use drugs. (Note: other regions appear to have reported their outreach to people who use drugs in the IDU outreach section of OCHART rather than in general outreach.)
- Central East and West focused on the general population.

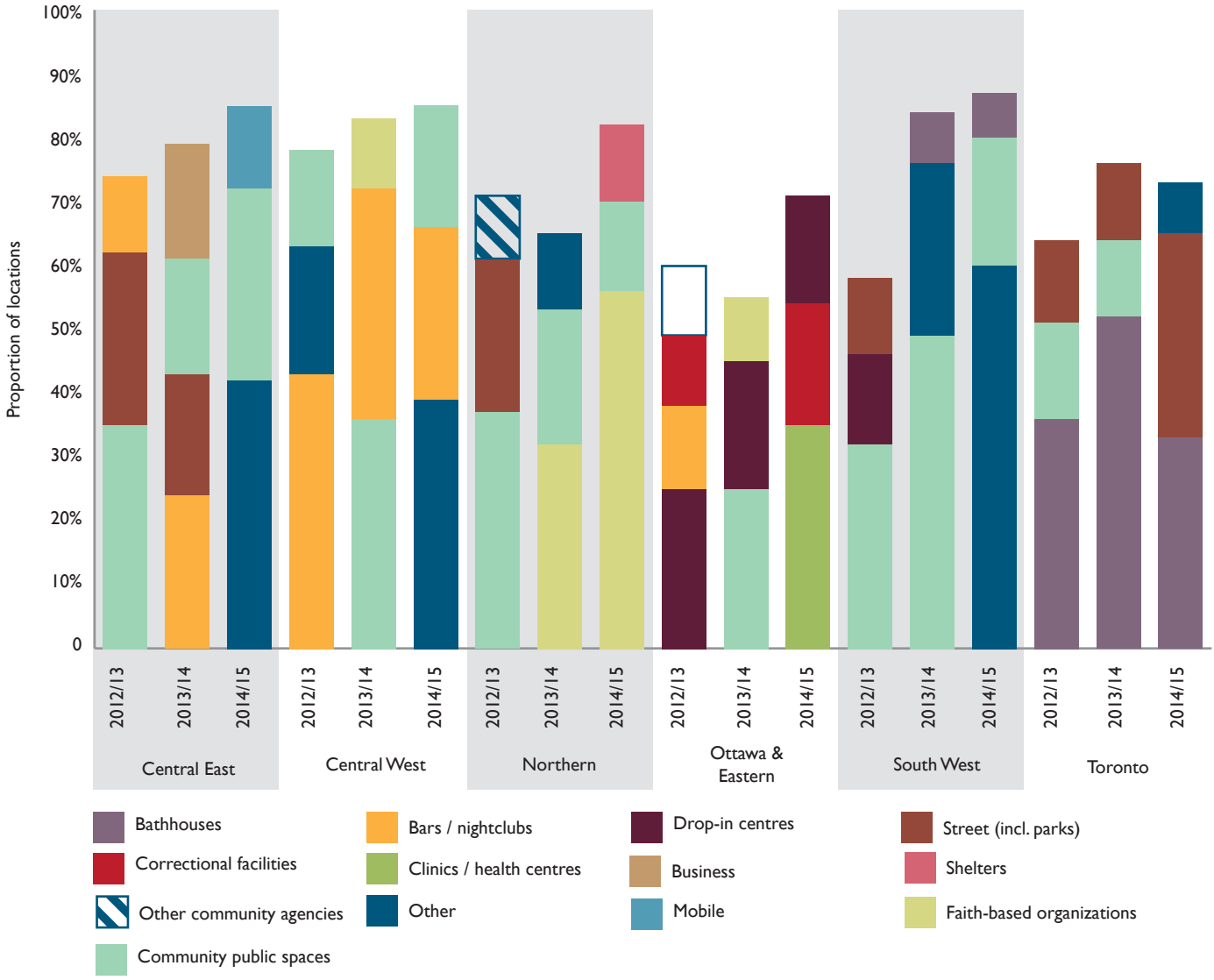
FIGURE 109 Top 3 significant outreach contacts by region(OCHART q. 9.10a)



Outreach locations shifted

All regions report community public spaces as a key place to do outreach. Ottawa/Eastern region reported a large portion of their outreach work now being done at clinics/health care centres; they are the only region reporting this location. Northern region is focusing more on shelter outreach. Central East, Central West and South West report doing a significant amount of outreach in "other" locations. It is unclear if this is because a new location to do outreach is emerging in these regions or if this is a data error.

FIGURE 110 Top 3 outreach locations by region(OCHART q. 9.10a)



Regional differences in IDU outreach trends

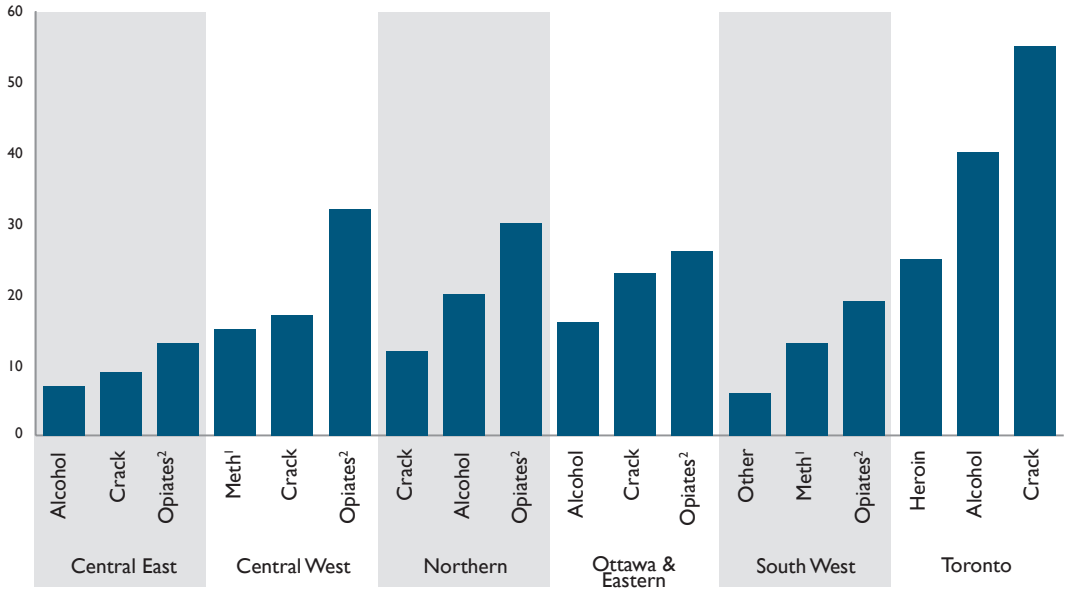
When looking at trends in IDU outreach services, regional differences are apparent. For the fourth consecutive year, Toronto reported fewer interactions (while the number of interactions by funded IDU outreach programs were down, the number reporteded by the other programs increased). Ottawa/Eastern, Northern and Central East all report more outreach interactions (see figure X).

Table 9. Regional differences in IDU outreach programs

	Funded programs	Other programs
Outreach interactions	Four of the six regions reported an increase — Central East, Central West, Ottawa and Eastern, and Northern Toronto region continues to report far fewer outreach interactions	Four of the six regions report an increase — Central East, Central West, Toronto and Northern Toronto & Ottawa and Eastern reported far more interactions
In-service	Central West and Ottawa and Eastern reported more interactions while all other regions reported fewer	Other programs in Ottawa and Central West reported more in-service contacts than those in Toronto In South West and Central East no other programs reported

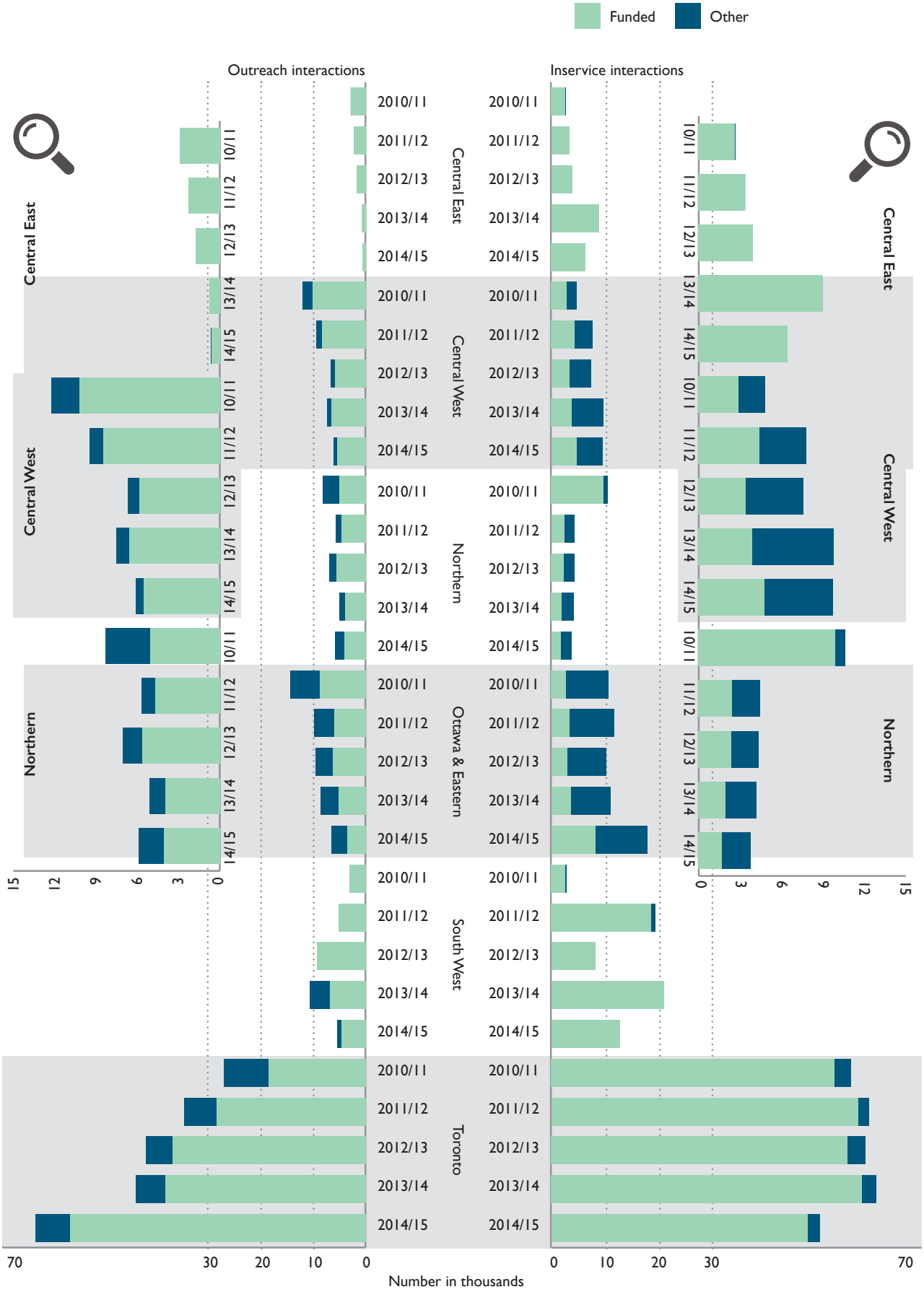
Fewer in-service interactions were reported in 2014/15. Overall there was a 13% decline (-16% in funded IDU outreach programs and +5% in other programs). However, Ottawa/Eastern was the sole region to report more in-service interactions attributed to both funded IDU outreach and other programs. The in-service IDU interactions reported by Toronto, South West and Central West were primarily though funded IDU outreach programs work whereas in the Ottawa/Eastern and Northern regions, other programs provided most of these services.

FIGURE 111 Drugs of choice by region



1. Meth: Includes Methamphetamine, crystal, meth, ice.
2. Opiates: Includes Oxyneo, Oxycodone, Fentanyl, Percocet, Dilaudid, Morphine, etc.

FIGURE 112 Total number of IDU outreach and in-service interactions(OCHART q. 13.11 & 13.2.1)



A regional snapshot of support services

Who is using support services?

While males account for about two-thirds of support service clients, the proportion of men and women accessing support services varies in some regions of the province. For example, programs in Central East reported that 43% of support service clients were women — the highest proportion in the province. At the same time, programs in Ottawa and Eastern were mainly serving men.

FIGURE 113 Proportion of clients accessing support services by region and gender 2013/14 H2
(OCHART q. 11.1.1)

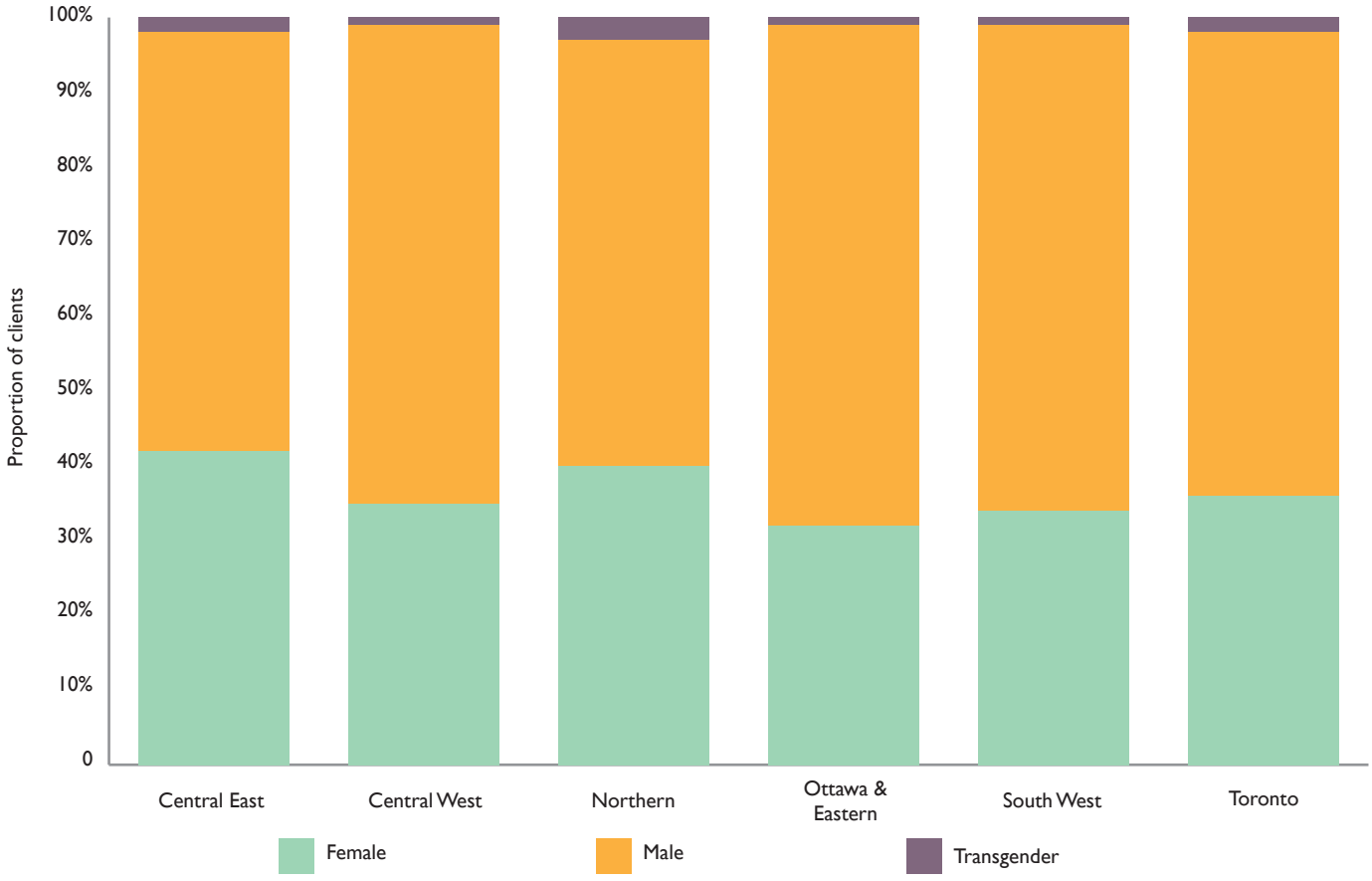
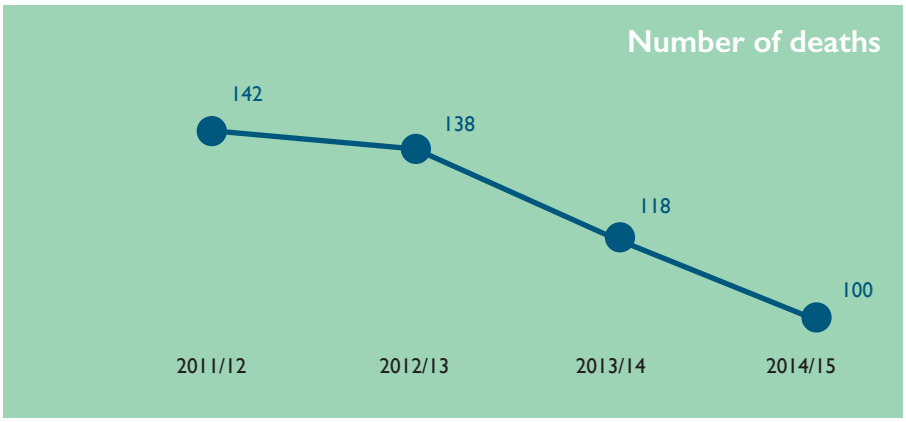


FIGURE 114 Regional distribution of 16,323 support service by client group and gender(OCHART 11.1.1)

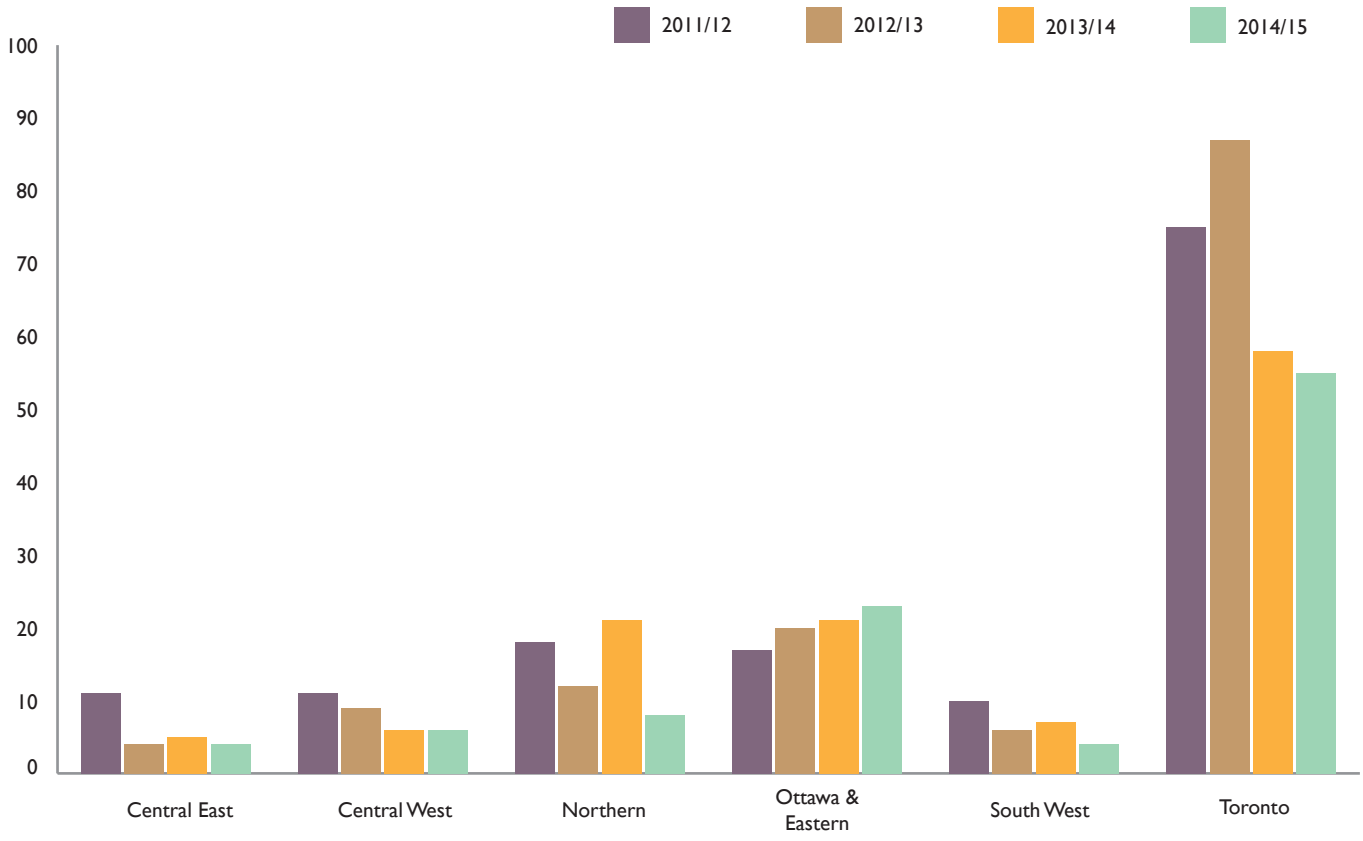
	Female	Male	Trans man	Trans woman	Total
Central East					
Avg. active and total new	***273***	***381***	***10***	***27***	***690***
Affected	131	113	0	1	244
At-Risk	29	49	10	22	109
Other	2	2	0	0	4
PHAs	112	218	0	4	333
Central West					
Avg. active and total new	***239***	***441***	***1***	***5***	***685***
Affected	38	28	0	0	65
At-Risk	2	4	1	2	8
Other	14	36	0	1	50
PHAs	186	374	0	3	562
Northern					
Avg. active and total new	***231***	***346***	***16***	***11***	***603***
Affected	16	17	1	0	33
At-Risk	108	149	16	11	283
Other	31	42	0	0	72
PHAs	77	138	0	0	215
Ottawa and Eastern					
Avg. active and total new	***815***	***1,569***	***7***	***12***	***2,402***
Affected	55	76	0	2	133
At-Risk	491	833	5	6	1,335
Other	77	116	1	3	196
PHAs	192	545	1	2	739
Provincial Services					
Avg. active and total new	***819***	***1,703***	***6***	***16***	***2,542***
Affected	55	1	0	0	4
At-Risk	491	0	0	1	2
Other	77	8	0	1	9
PHAs	192	1,695	6	14	2,528
South West					
Avg. active and total new	***182***	***326***	***8***	***4***	***519***
Affected	27	32	0	0	59
At-Risk	25	31	4	3	63
Other	48	58	4	1	111
PHAs	82	205	0	0	287
Toronto					
Avg. active and total new	***3,204***	***5,444***	***21***	***216***	***8,884***
Affected	584	672	1	2	1,258
At-Risk	290	883	11	33	1,217
Other	553	326	8	136	1,022
PHAs	1,777	3,564	2	45	5,387
Total	**5,761**	**10,208**	**66**	**288**	**16,323**



Fewer deaths

Although programs are serving older clients, this is the fourth consecutive year where they reported fewer death. Northern region reported a substantial decrease in deaths. The number of deaths remained stable across all other regions.

FIGURE 115 Number of client deaths by region(OCHART 11.1.5)



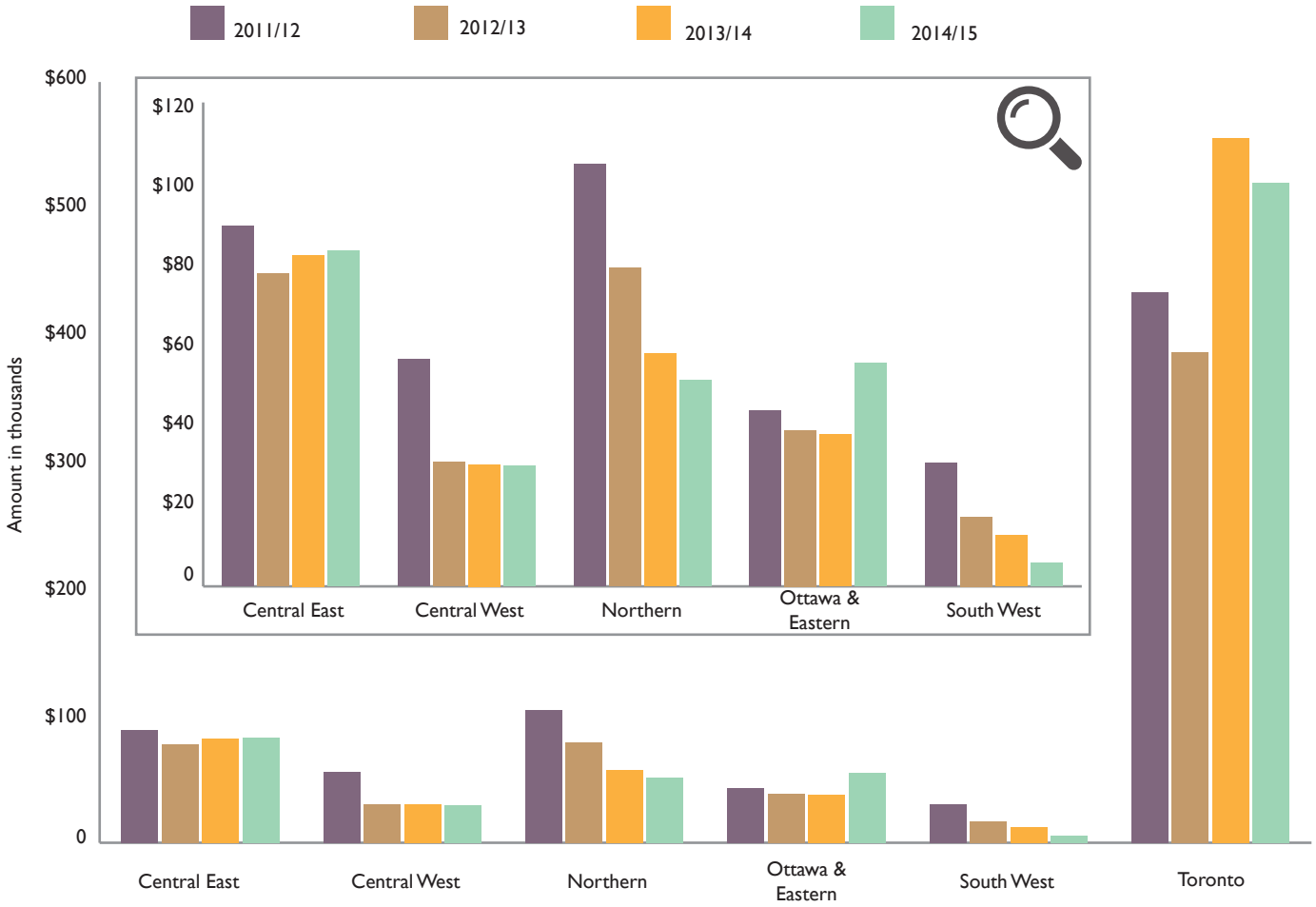
Financial assistance by region

When we look at financial assistance across the province, there were slightly fewer dollars available overall — despite the fact that the need for this service continues to grow. The ratio of dollars to clients continued to decrease except in Toronto where, even though less funding was available, fewer clients accessed it, increasing the amount available per client. Central East reported having slightly more funds available, but they also reported 89% more clients accessing this service.

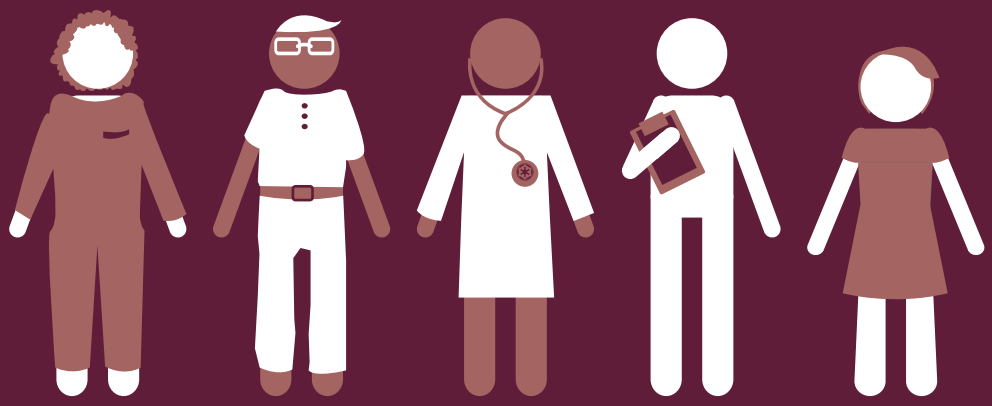
Table 10. Financial assistance distributed by region and number of recipients

	Total $ distributed		Number of recipients	
Regions	**2013/14**	**2014/15**	**2013/14**	**2014/15**
Central East	82,142.36	83,208.89 ▲	248	468 ▲
Central West	30,221.7	29,934.79 ▼	210	205 ▼
Northern	57,681.94	51,123.59 ▼	207	280 ▲
Ottawa and Eastern	37,637	55,415 ▲	350	520 ▲
South West	12,644.2	57,56.58 ▲	67	81 ▲
Toronto	553,156.82	520,721.41 ▼	4,426	3,762 ▼

FIGURE 116 Financial assistance given out by region(OCHART 11.4)



III. Hepatitis C teams



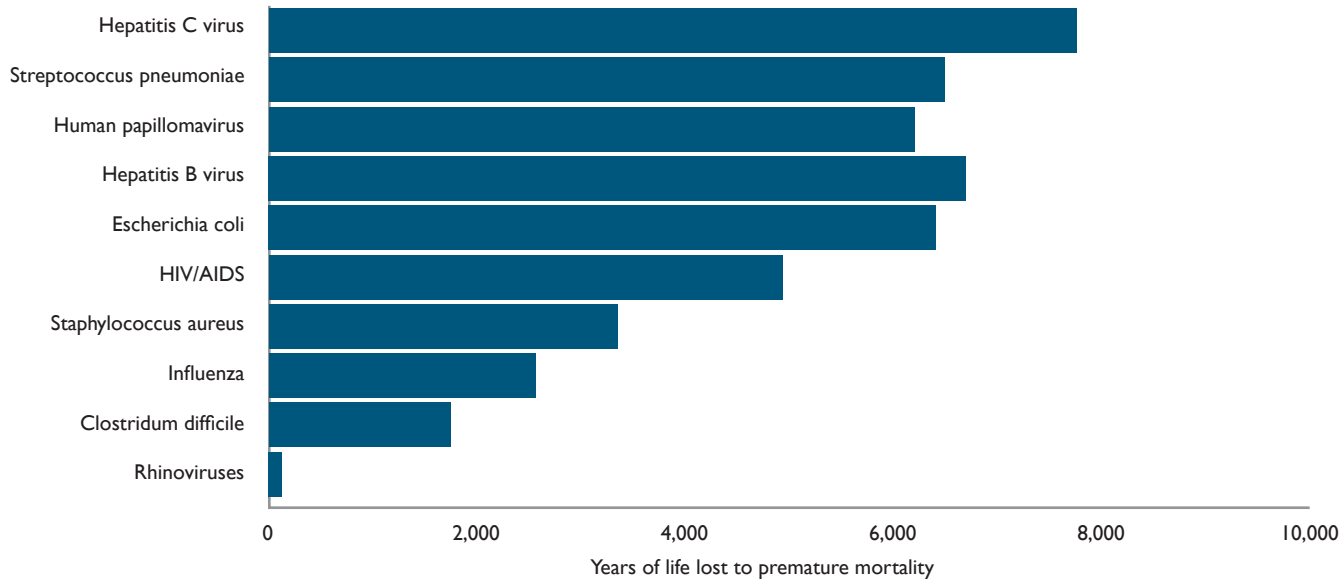
1. HCV epidemiology

Hepatitis C is a virus that attacks the liver, and can lead to long-term complications such as cirrhosis, liver failure and liver cancer. About 15-20% of people who become infected with hepatitis C will clear the infection on their own; however, 80% will remain infected even though they may not develop symptoms for many years. Because of this long asymptomatic period, between 20 and 70% of people with hepatitis C are unaware of their infection.

In 2014, 32 of the 4,214 people reported with hepatitis C were hospitalized (0.8%) and 23 died (0.5%). Rates of hospitalization for people with hepatitis C are highest in the North.

Hepatitis C is the most burdensome disease in Ontario in terms of years of life lost.

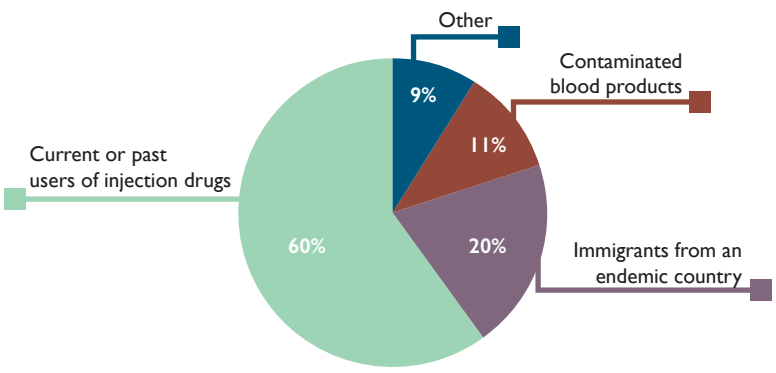
FIGURE 117 The most infectious agents in Ontario



Injection drug use most common risk factor

The main risk factors for hepatitis C infection are: injection drug use, coming from a country where hepatitis C is endemic and having received contaminated blood products. Rates of hepatitis C are higher among people who inject drugs and among Indigenous people. In Ontario, about 60% of hepatitis C cases are in current or past users of injection drugs and 20% in people from countries where HIV is endemic.

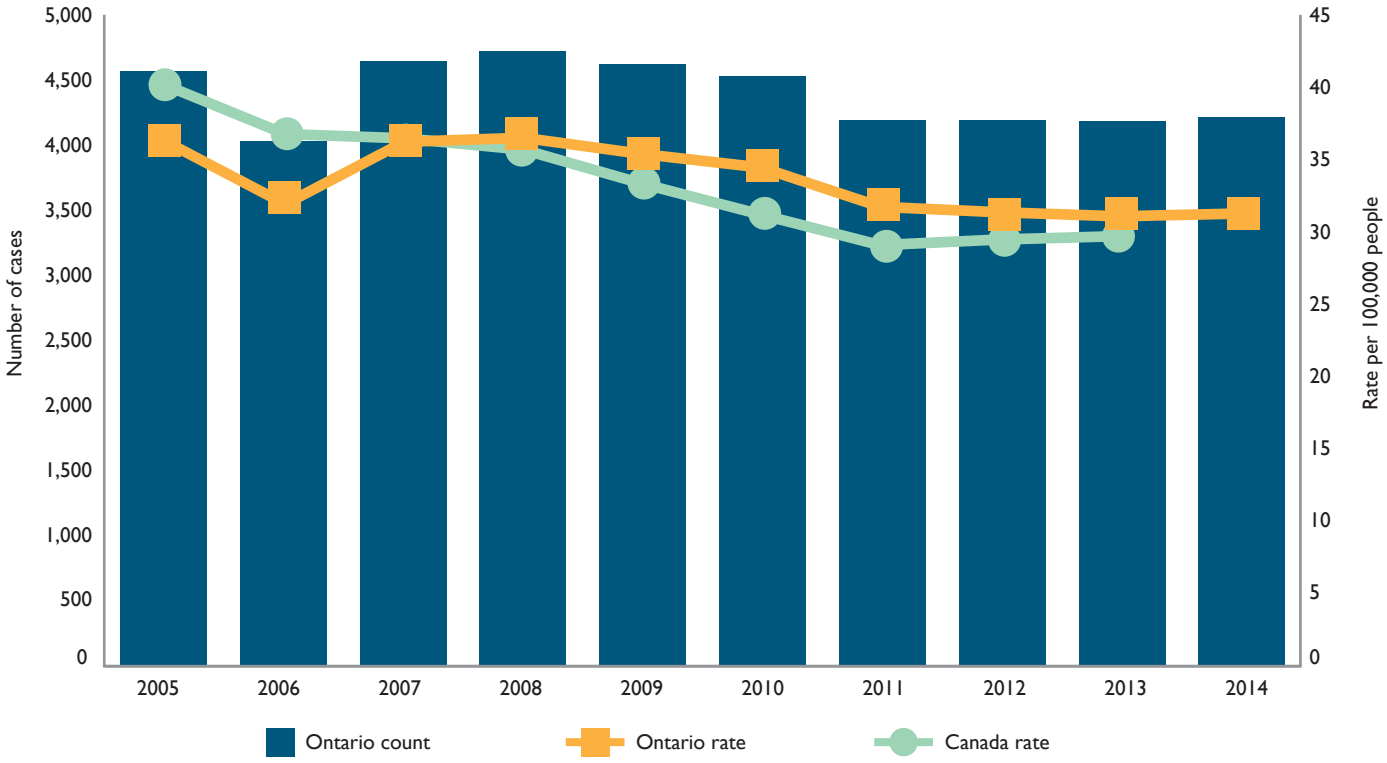
FIGURE 118 Hepatitis C risk factors among people with hepatitis C



Number of new cases holding steady

Hepatitis C continues to be a serious health issue in Ontario. In 2014, 4,214 confirmed hepatitis C cases were reported in the province. Although the number and rate of new cases are down from the high in 2008, they have remained stable over the past four years. Rates of hepatitis C (i.e. number of cases per 100,000 population) are higher in Ontario than in the rest of Canada.

FIGURE 119 Reported cases and rates of hepatitis C: Ontario & Canada, 2005-14



About Ontario's Hepatitis C Strategy

The key elements of the Strategy include:

- **Enhanced services and supports**
16 HCV Teams to ensure a coordinated, comprehensive approach to treatment and support of those living with/at risk of acquiring hepatitis C.

- **Education and outreach**
A targeted education and outreach strategy for at-risk communities, and a continuing medical education program for physicians and health professionals.

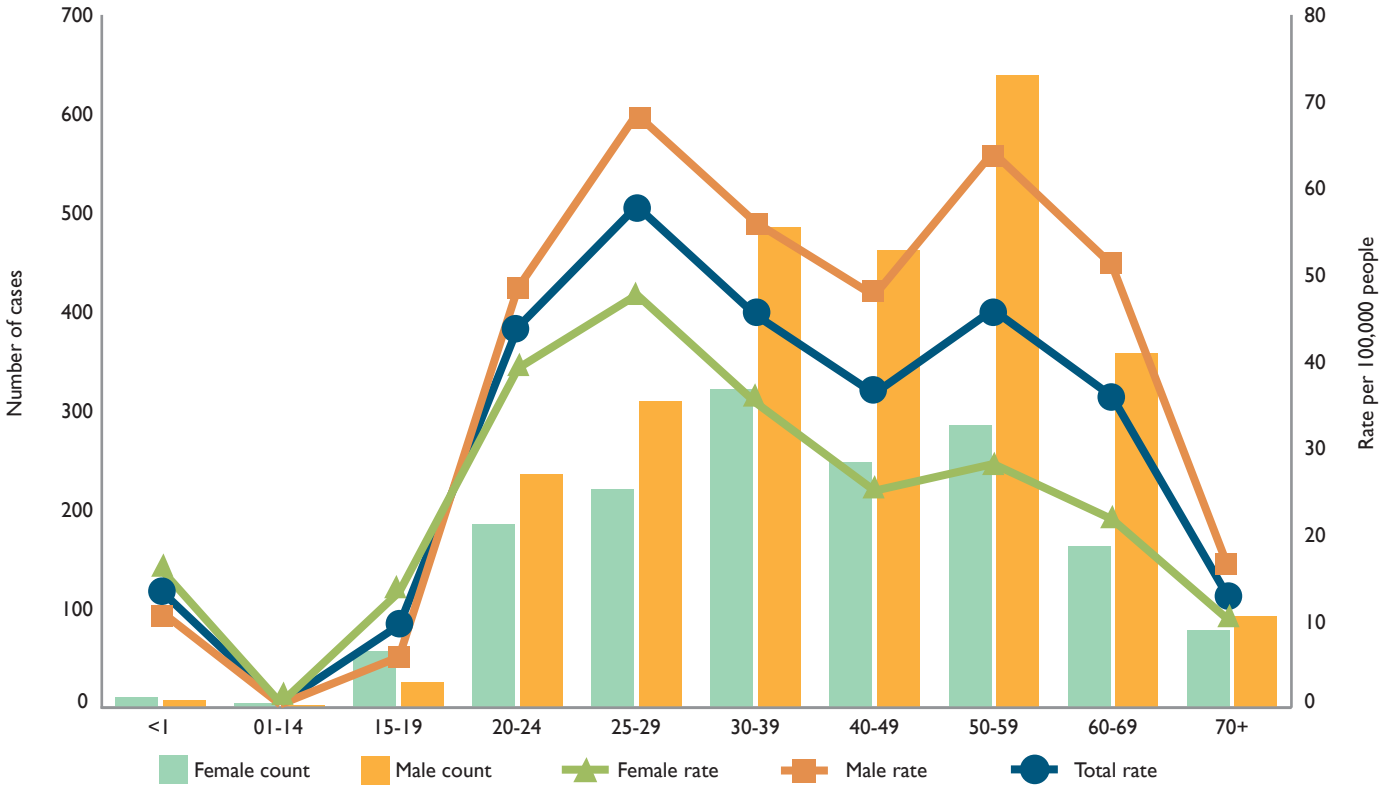
- **Encourage prevention**
Additional support for the Ontario Harm Reduction Distribution Program.

- **Better service co-ordination**
An inter-ministerial Reference Group to support further collaboration and aid in seamless program integration that includes Aboriginal Affairs, Children and Youth Services, Citizenship and Immigration, Community Safety and Correctional Services, Community and Social Services, Health Promotion and Research and Innovation.

Hepatitis C more common in males than females

Hepatitis C is more commonly reported among males. In 2014, males accounted for 62.2% (2,623/4,214) of hepatitis C cases reported in Ontario, with an overall rate of 39.5 cases per 100,000 people, compared to a rate of 22.9 cases per 100,000 people among females. Among both males and females, the rate was highest in the 25 to 29 year age group at 68.6 and 47.8 cases per 100,000 people, respectively. Twenty cases were reported in infants under the age of one, likely due to mother-to-child transmission.

FIGURE 120 Reported rates of Hepatitis C by age and sex, Ontario 2014



Target populations

Hepatitis C services target six priority populations of people living with, at risk of or affected by HCV:

- people who use drugs
- people involved with the correctional system
- people who are homeless or under-housed
- Indigenous people
- street-involved youth
- people with tattoos and/or piercings.

Hepatitis C rates highest in the North

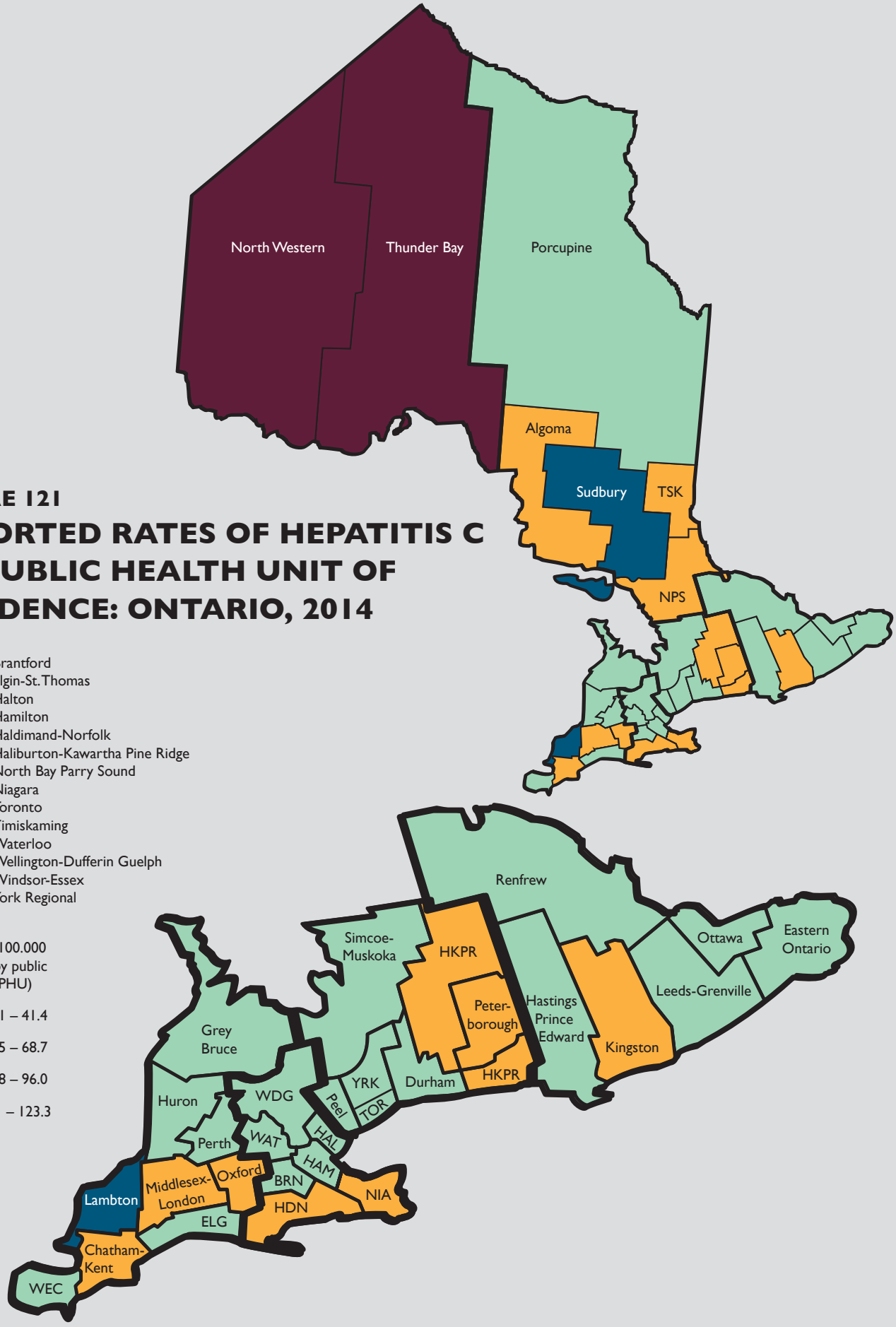
In terms of geographic distribution, reported rates of hepatitis C are much higher in the North. While rates of hepatitis C are decreasing in most of Ontario, they are rising in the North. The highest reported rates in Ontario were in the Northwestern, Thunder Bay District and Sudbury and District public health units, with 123.3, 103.1 and 75.6 cases per 100,000 population, respectively. In Northwestern and Thunder Bay health units, at least 88% of cases were in people who reported injection drug use.

Table 1. tktktkt

Public health unit (PHU)	Cases (n)	*Rates
Algoma	73	62.6
Brant	51	35.7
Chatham Kent	51	48.2
Durham	137	25.9
Elgin-St. Thomas	15	16.6
Eastern Ontario	50	24.4
Grey Bruce	34	20.9
Halton	98	18.2
Hamilton	208	38.1
Haldimand-Norfolk	61	55.5
Haliburton-Kawartha Pine Ridge	76	42.4
Hastings-Prince Edward	52	31.8
Huron	17	29.1
Kingston	128	64.1
Lambton	91	69.8
Leeds-Grenville	63	37.2
Middlesex-London	216	46.8
Niagara	250	56.1
North Bay Parry Sound	61	47.6
Northwestern	100	123.3
Ottawa	235	25.2
Oxford	47	42.4
Perth	11	14.1
Peel	304	21.9
Porcupine	29	33.4
Peterborough	61	43.9
Renfrew	18	17.1
Simcoe-Muskoka	196	36.7
Sudbury	151	75.6
Thunder Bay	160	103.1
Toronto	649	23.4
Timiskaming	9	26.0
Waterloo	122	22.8
Wellington-Dufferin Guelph	52	18.7
WEC	146	36.3
York Regional	162	14.6
Ontario	**4,214**	**31.1**

FIGURE 121

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
- 14.5 – 68.7
- 68.8 – 96.0
- 96.1 – 123.3

2. The hepatitis C teams

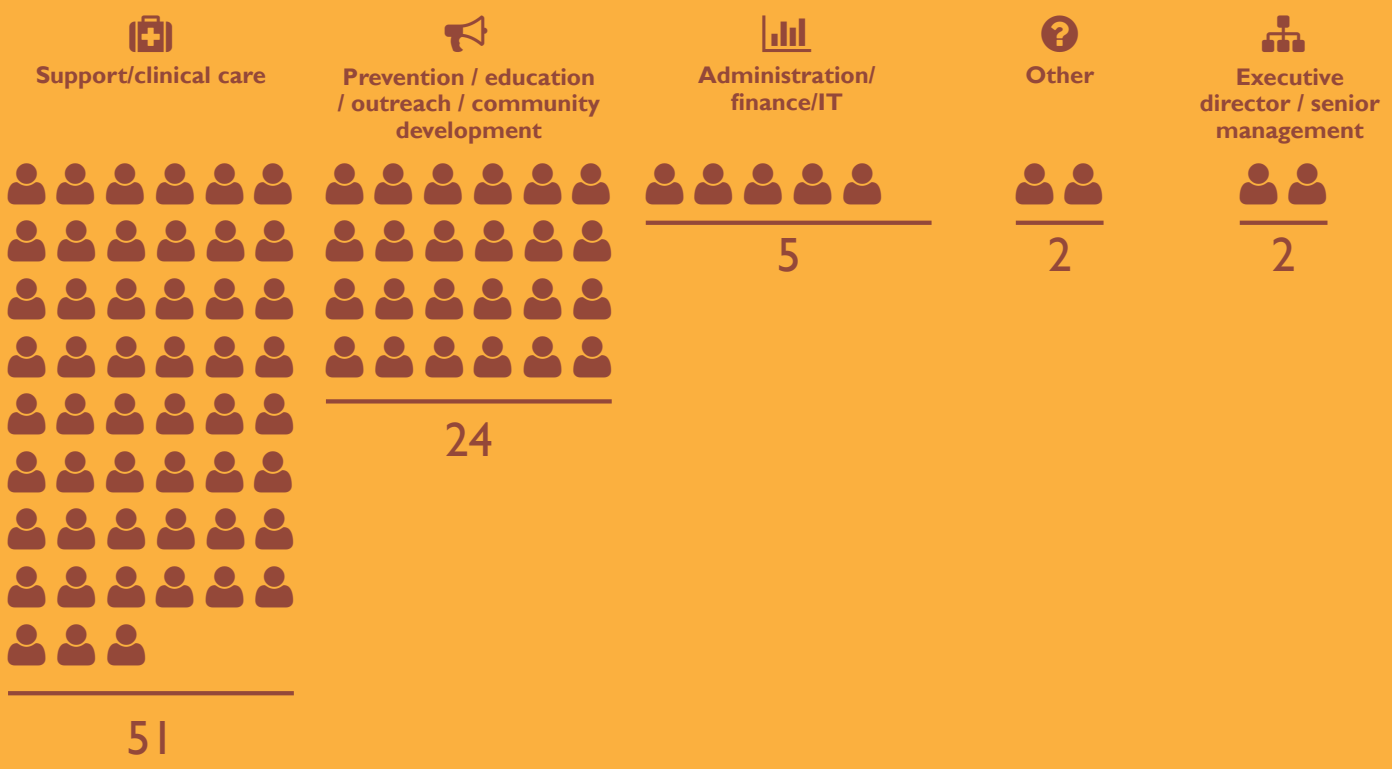
Who delivers hepatitis C services?

The Hepatitis C Secretariat funds 85 FTE positions to provide hepatitis C (HCV) services, including 16 multidisciplinary hepatitis C care teams (HCV teams) which each include: an outreach worker; peers; nurses; a community coordinator; a program coordinator; and psychological support. Teams work closely and corroboratively with treating physicians to provide HCV care and treatment, education, outreach and support services. In addition, the Secretariat funds:

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

FIGURE 122

HEP C FUNDED POSITIONS BY ROLE 2014/15 (ROUNDED)

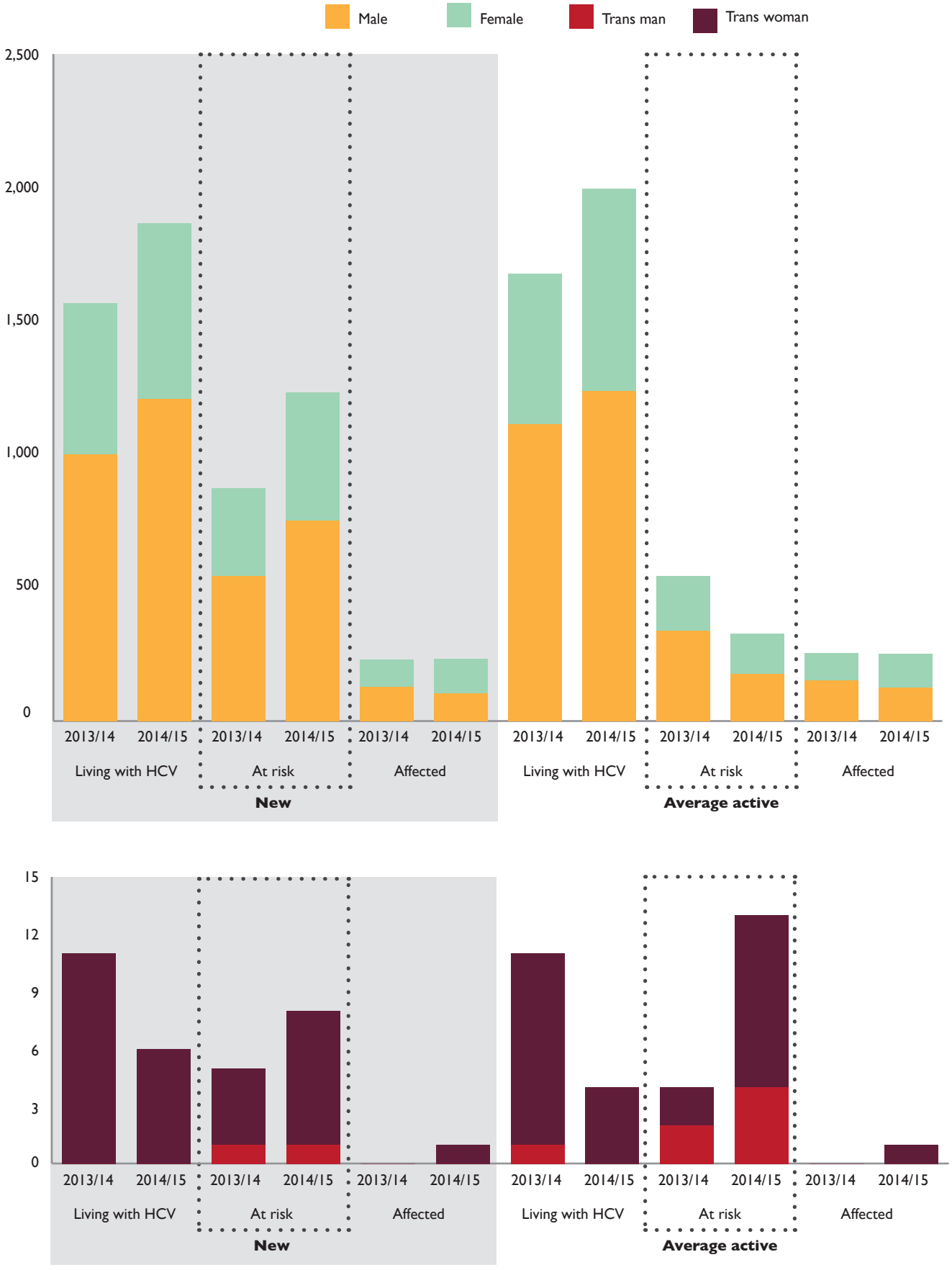


The people we served in 2014-15

In 2014/15, programs served an average of 5,932 clients – up 15% from the previous year. Of these clients:

- 1,871 were new clients living with HCV — up 19%
- 1,998 were active clients with HCV — up 18%
- 1,579 were at-risk clients — up 11%
- 484 were affected clients

FIGURE 123 Total number of clients served by gender and client type 2013/14 – 2014/15
(OCHART q. 15.1a)



More women accessing services in all client groups

Although men account for 63% of new clients living with HCV and at-risk clients, more female clients accessed services in 2014/15 than in the previous year. Women accounted for 56% of clients affected by HCV.

Although trans clients accounted for less than 1% of new clients, 43% fewer trans clients accessed services in 2014/15 than in 2013/14.

Gender mix varies by region

Most clients who used HCV teams in Toronto were male. Toronto also had 63% of all trans clients in the province, of whom 80% were trans women. In both Central and South West, two-thirds of their clients were male and one-third were female. In Northern Ontario and Central East, teams reported serving about 55% males and 45% females. Ottawa reported serving 18% more women compared to last year, while Toronto reported serving 4% fewer females. PASAN, the provincial program that serves people who are incarcerated, reported that 88% of their clients were male.

FIGURE 124 Clients by region, gender and client group 2014/15 (OCHART q. 15.1a)

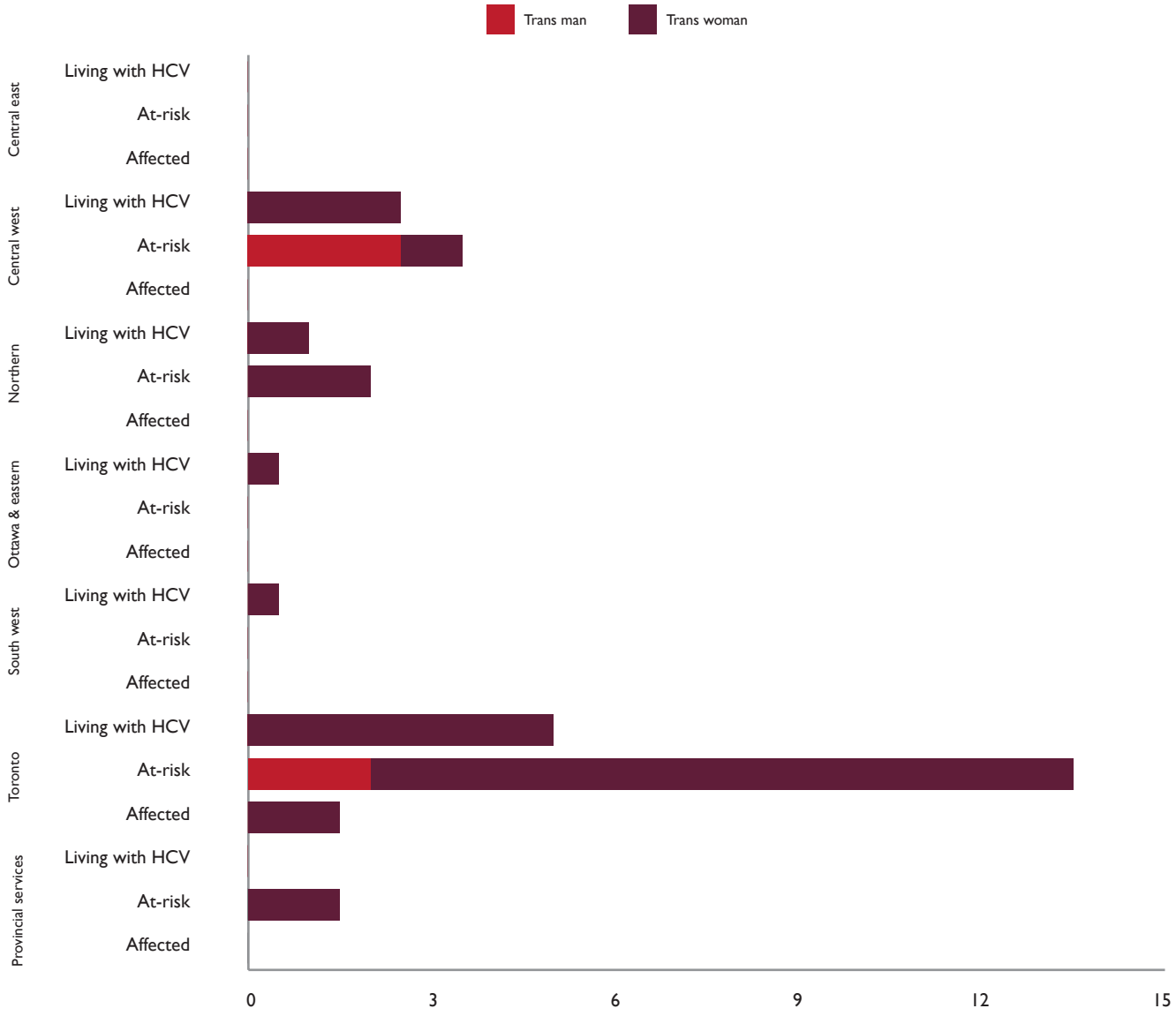
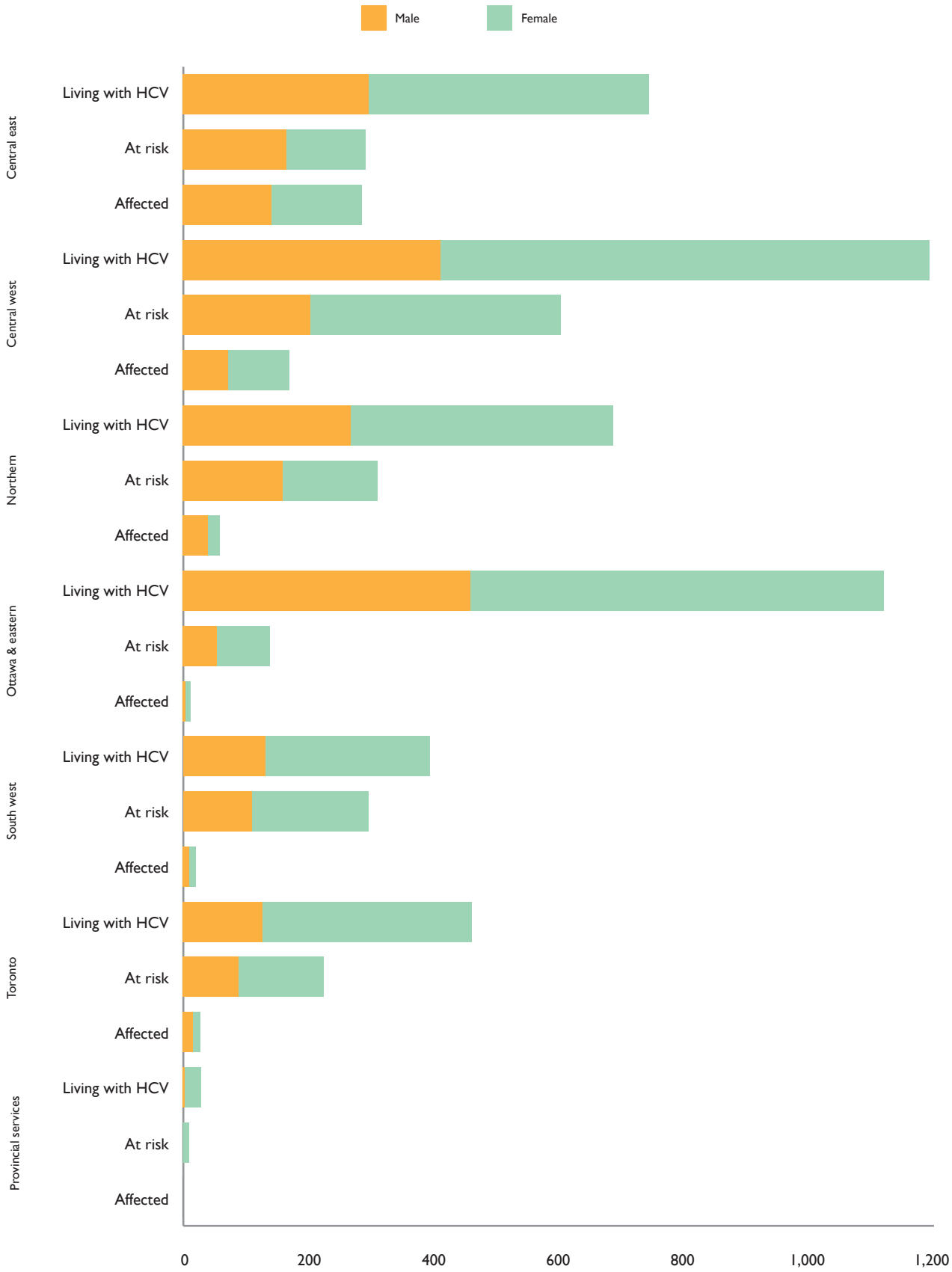


FIGURE 125 Clients by region, gender and client group 2014/15(OCHART q. 15.1a)



HCV prevention engagement and treament services

Client groups

The people who use the services of HCV teams fall into one of six categories depending where they are along the treatment continuum:

At risk	Engaged with HCV Teams	Pre-treatment	On treatment	Post-treatment	Affected
People at risk of acquiring HCV — usually because of injection drug use, who can receive 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 have not yet started treatment and who require close monitoring.	People who are on treatment.	People who have completed treatment.	People who are partners or family members of people with HCV who receive education and support services.

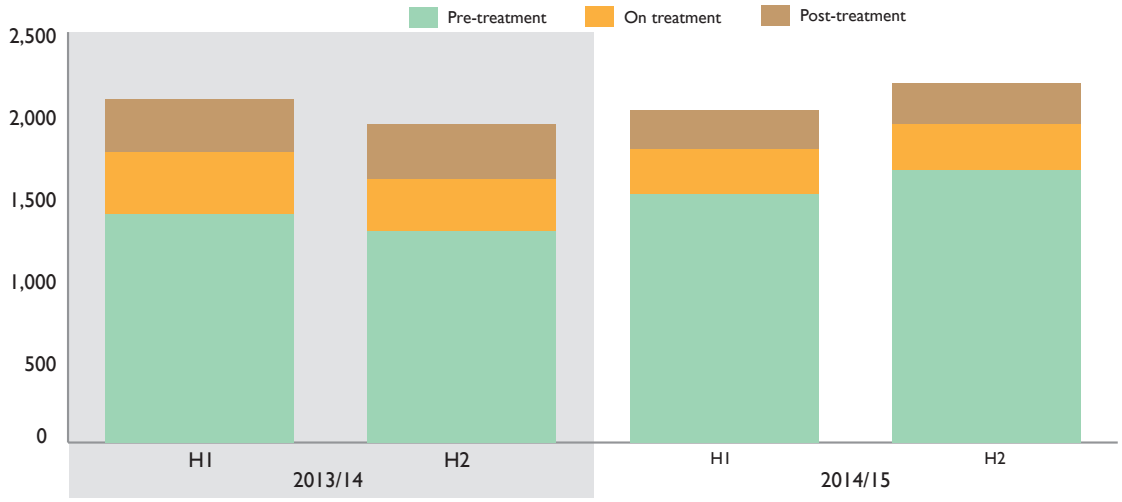
OBJECTIVE: To increase access to hepatitis C care and treatment for priority populations in Ontario

Over the past year or so, the treatment landscape for HCV has changed dramatically. New, shorter, better tolerated and more effective treatments are now available.

In 2014/15, HCV teams served 493 more clients in the pre-treatment stage than in the previous year. Pre-treatment clients represented 75% of the caseload compared to 67% in 2013/14, while clients on treatment declined from 17% of the caseload in 2013/14 to 13% in 2014/15. Post-treatment clients represented 12% of the caseload, down from 16% in 2014/15.

The larger proportion of people in the pre-treatment phase was due to the fact that many people either chose to delay treatment until the newer treatments were available or were waiting to become eligible for the newer treatment. (Note: eligibility is based on stage of liver disease.)

FIGURE 126 Total caseload by treatment stage by reporting period 2013/14-2014/15(OCHART q. 15.3a)



People engaged with HCV teams

The largest group of clients served in 2014/15 were people engaged with HCV teams. This increase was due mainly to the fact that many people who were previously lost to follow-up re-engaged with the HCV teams after hearing about the new treatments.

Although the number of clients engaged with HCV teams increased, they used a smaller proportion of clinical and case management services — 39% and 43% respectively — than in the previous year.

At-risk clients

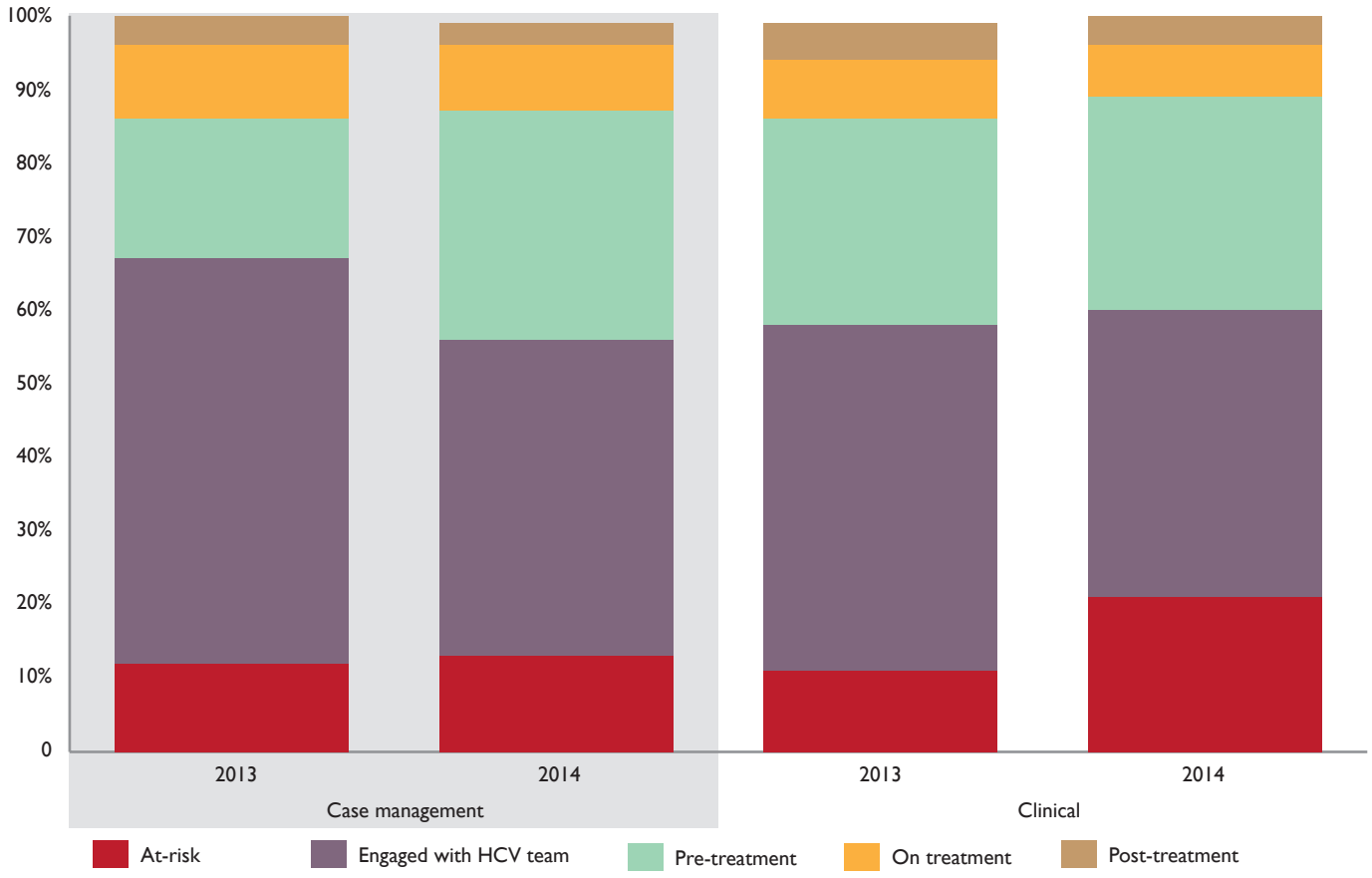
In contrast to people engaged with HCV teams, at-risk clients accessed a greater number of services in 2014/15 even though they accounted for the same proportion of clients (27%) as in 2013/14. They consumed 21% of all clinical services and 13% of all case management services.

Clients pre-/on/post-treatment

As treatment options have changed, so have the services clients access at each stage of treatment. In 2014/15, pre-treatment clients used a larger proportion of case management services (31%) than in 2013/14 (19%). Clients in the post-treatment stage used just 2.6% of case management services in 2014/15, down from 4.4% in the previous year.

All these changes are mainly due to the fact that clients on the newer treatments now have less need for the intense case management services that were essential with the older, longer regimens, which had significantly more adverse side effects.

FIGURE 127 Proportion of clients receiving clinical services & case management by treatment stage (OCHART q.15.1f)



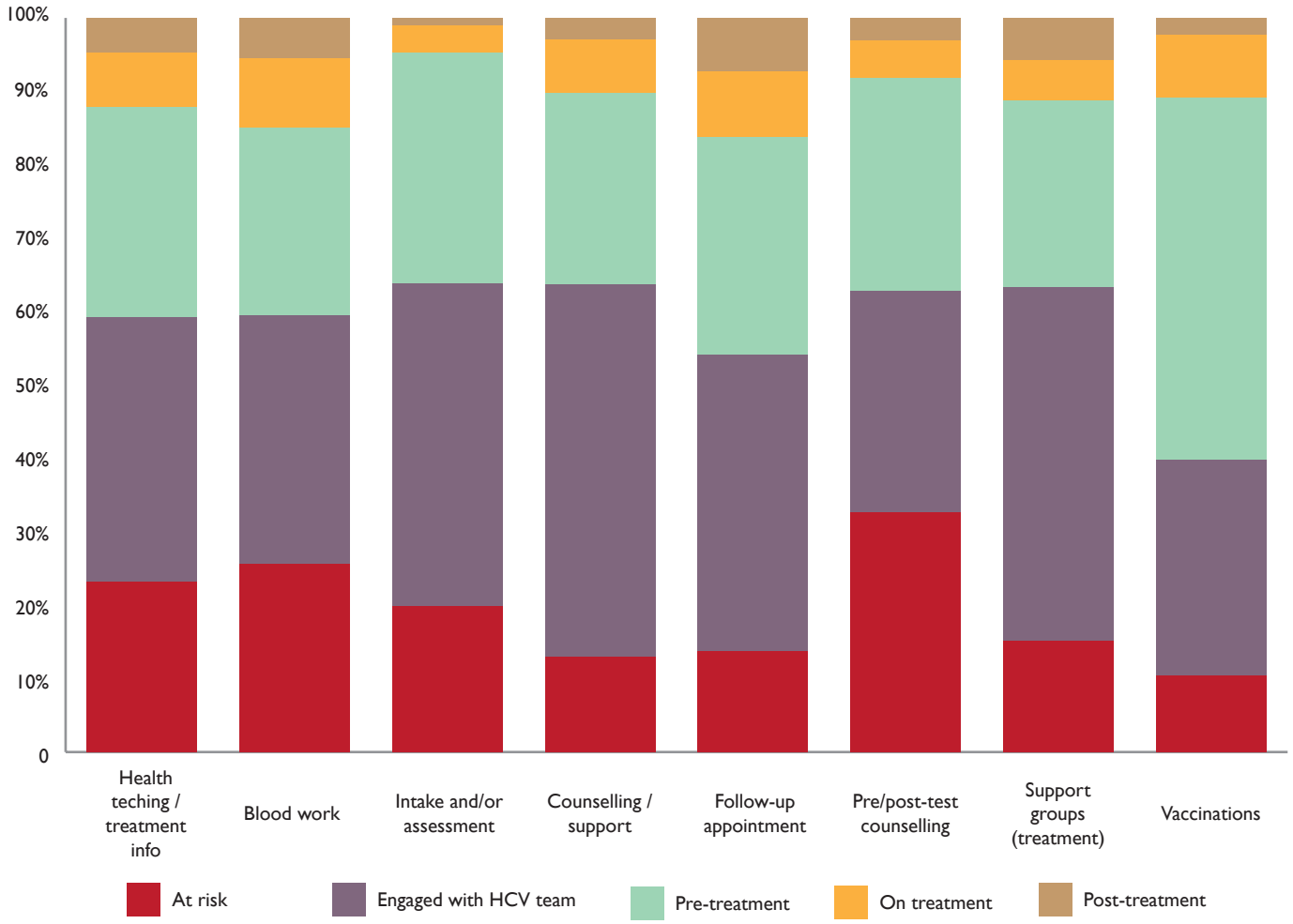
Clinical services

People engaged with HCV teams or in the post-treatment process used fewer clinical services, while clients who were at risk or in the pre-treatment phase used more. For example:

- in 2014/15, people engaged with teams accounted for 30% of all vaccinations — compared to 70% in 2013/14
- people in the pre-treatment phase accounted for 50% of vaccinations — up from 13% the previous year
- people engaged with HCV teams accounted for 30% of test counselling — compared to 44% in 2013/14
- people at risk used 33% of the counselling services — up from 13% in 2013/14.

Again, these changes are largely due to the types of services needed to support people at different phases, given the new treatment regimens.

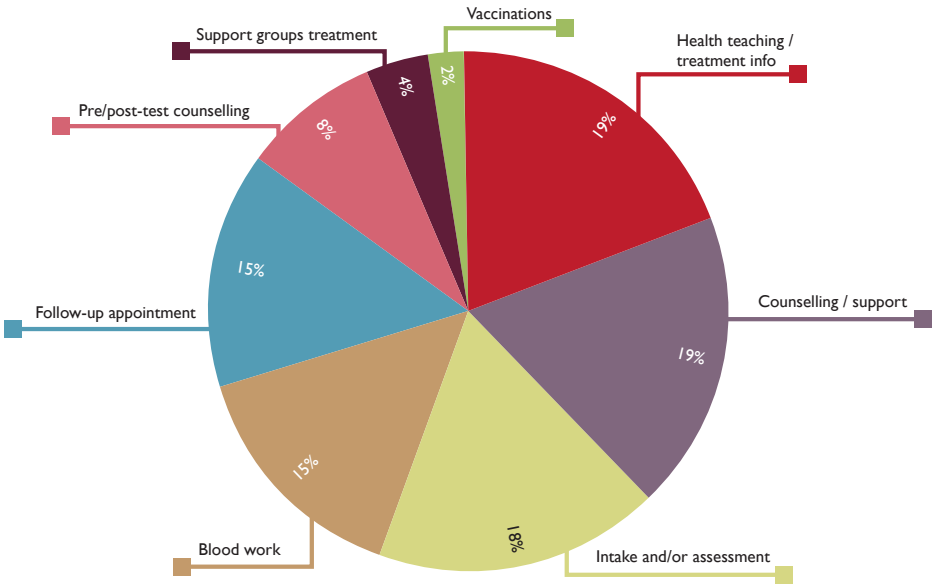
FIGURE 128 Clinical services accessed by group - 2014/15(OCHART q.15.1f)



Health teaching/ treatment information is the most frequently used clinical service

Education accounts for 21% of all clinical services accessed by clients who were moving through the treatment process as well as by those not involved in treatment. Vaccinations and support groups are the least used services -- mainly because people do not require the same level of support with the new treatments.

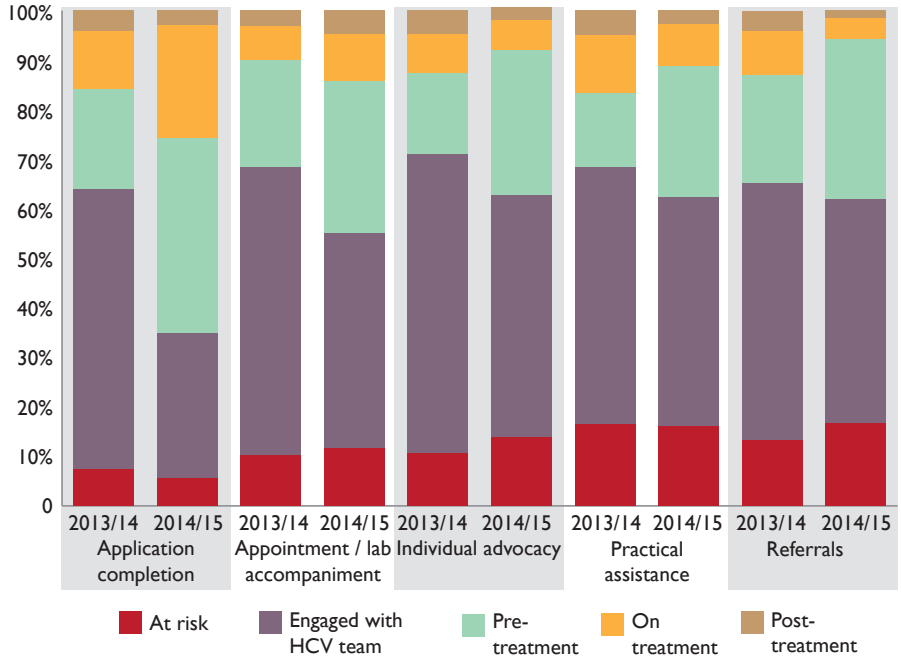
FIGURE 129 Clinical services accessed - 2014/15 (OCHART q. 15.1f)



Case management Services

People from all client groups continued to access case management services but, in 2014/15, those engaged with HCV teams used fewer case management services, while those in the pre-treatment or at risk used more. Pre-treatment and at risk clients combined accounted for 49% of all referrals and 45% of all application completion services.

FIGURE 130 Case management services accessed by client group 2013/14-2014/15 (OCHART q. 15.1f)



HCV teams reported spending more time doing advocacy work, assisting clients with ODSP and housing applications, and helping clients navigate the medical insurance market and understand treatment coverage. Several programs reported that they are serving more clients with complex needs than in the previous year. The growing number of pre-treatment clients with multiple challenges requires more coordination and stronger referral networks.

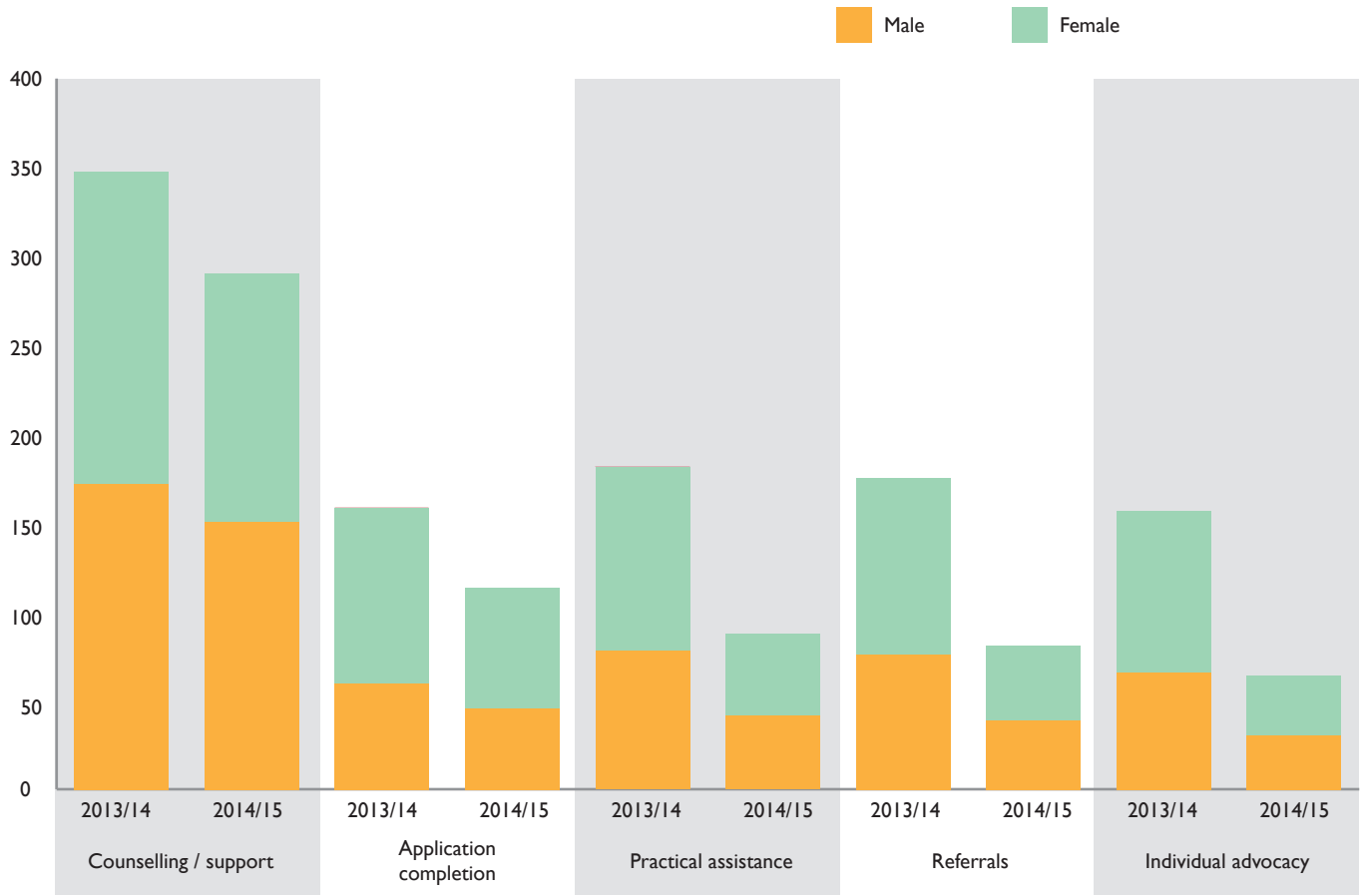
Referrals remain the most frequently used case management service

Referrals accounted for 30% of all case management services accessed by clients who are currently moving through the treatment process as well as by those not involved with treatment. Practical assistance was the second most commonly used service (25%), while lab accompaniment was the least used service, accounting for only 10% of all case management services.

Affected clients using fewer services

While teams offer services to people affected by HCV, there has been a marked decrease in the number of clients accessing these services: down 37% from 2013/14. The gender picture has changed as well. In 2014/15, 51% of affected clients accessing services were male compared to 57% in 2013/14. For affected clients, counselling was the most commonly accessed service, while individual advocacy was the least used service in 2014/15. This change is likely due to the new eligibility criteria and process for approving people for treatment.

FIGURE 131 Affected client service utilization by gender 2014/15 (OCHART q. 15.1f)



HCV testing

Sioux Lookout First Nations

We recognize the critical importance of continuing to increase our testing efforts in order to identify those living with HCV, especially with the emergence of treatment that should be more accessible, with higher likelihood of cure.

HCV antibody tests up

In 2014-15, there was a sharp (44%) increase in the number of individuals who received HCV antibody testing.

Teams have been more focused on testing and, as information about new HCV treatment spreads through the media and word-of-mouth, more people at risk, including those who are incarcerated, are interested in getting tested.

FIGURE 132 Number of clients tested by diagnostic test type

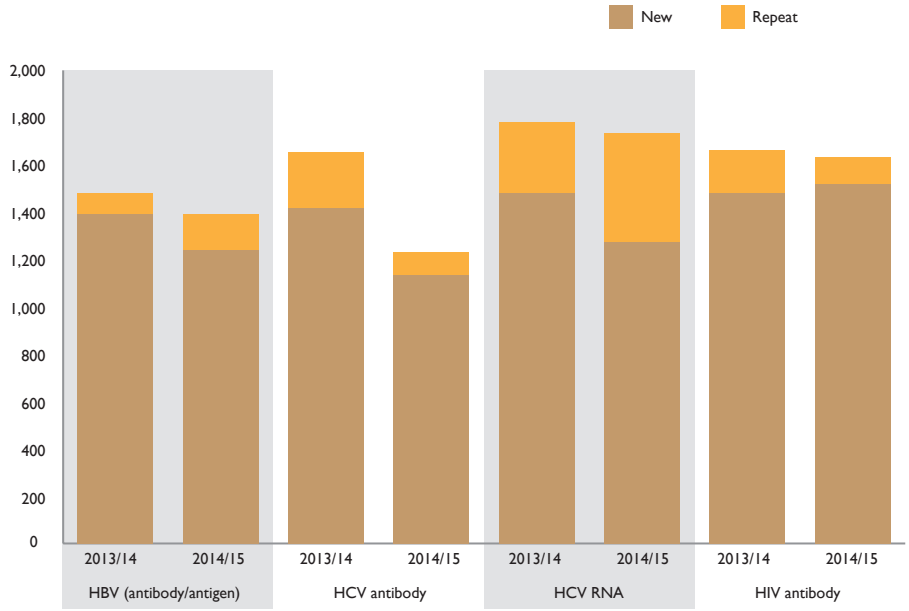


FIGURE 133 Number of fibroscans and fibrotests provided in 2014/15

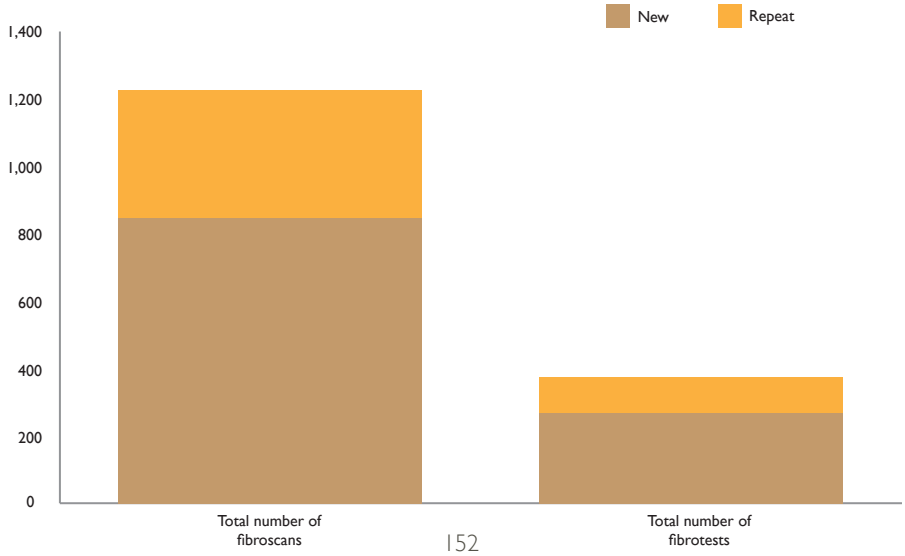
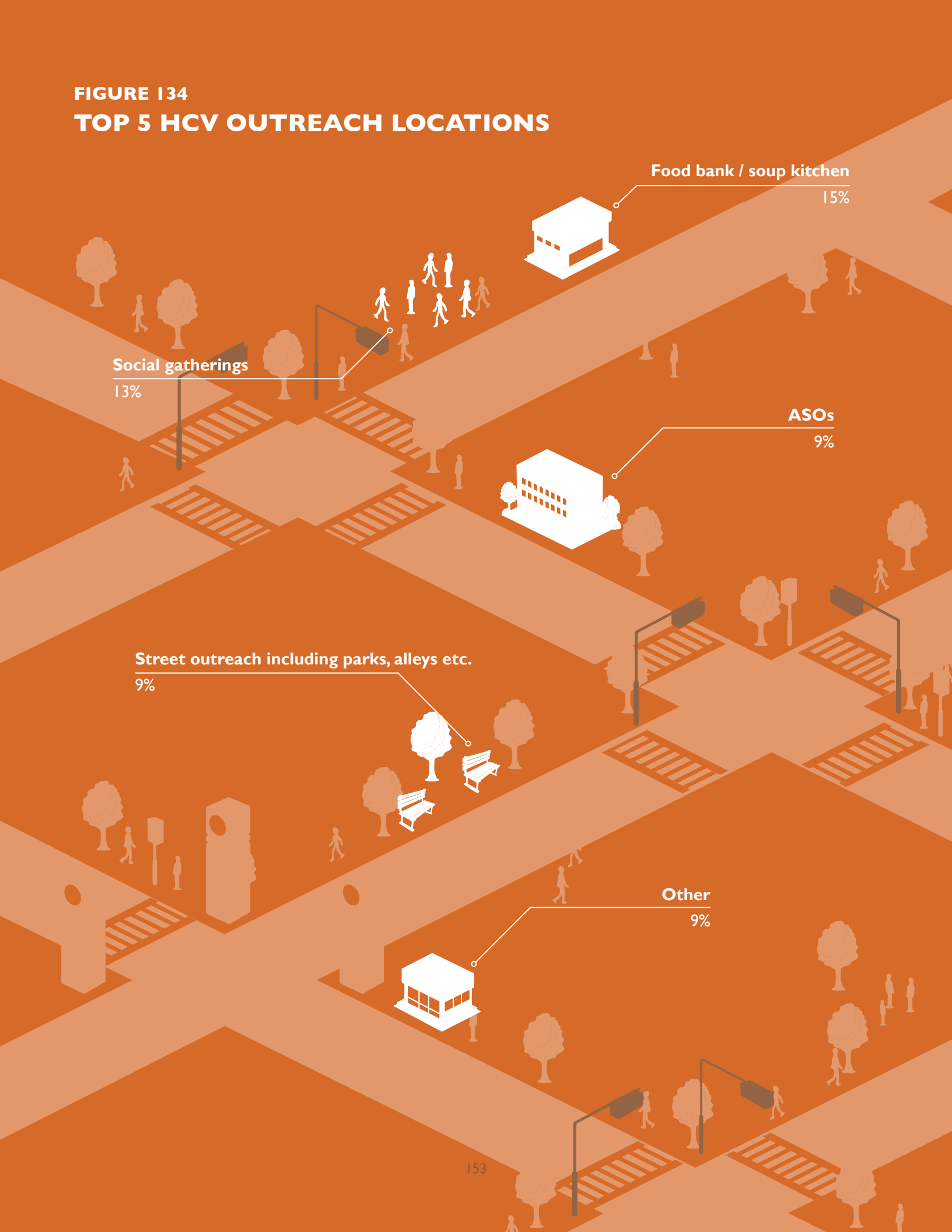


FIGURE 134

TOP 5 HCV OUTREACH LOCATIONS



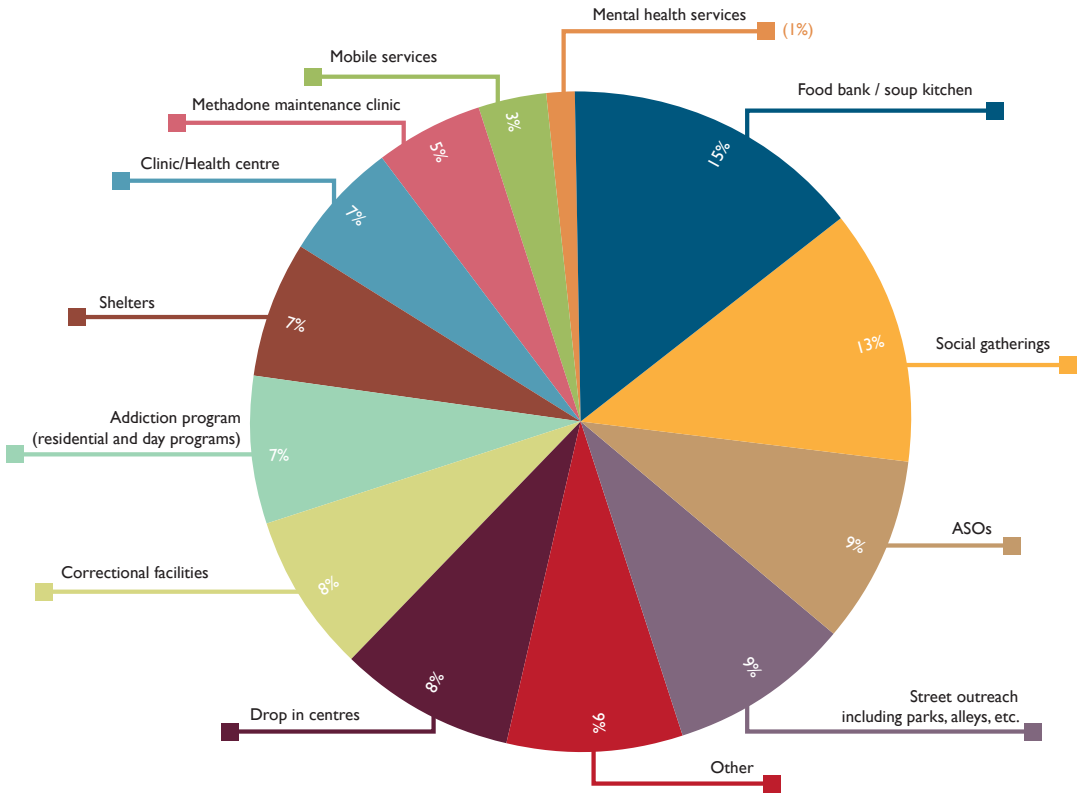
In terms of the "other tests," programs continued reporting only fibroscans and fibrotests. In addition to being a mandatory test to get approval for publicly funded HCV treatment, fibroscan tests are an important way to engage and re-engage clients. To sustain the service, one team is developing a community fibroscan referral network.

Outreach

HCV teams offer HCV outreach testing in various locations. In 2014-15, HCV teams reached clients more often at ASOs, mobile sites and social gatherings. (See Figure XX).

Programs reported seeing more young at-risk clients. They also noted an increased demand for education and information as people learn more about HCV treatment. HCV teams developed new partnerships to provide more outreach to Indigenous people. In their efforts to increase their reach, programs continued developing protocols to ensure both safe and accessible services.

FIGURE 135 HCV outreach by location



Impact: treatment outcomes

In 2014/15:

- 3,172 clients were in the pre-treatment phase – up 493 from the previous year
- 218 spontaneously cleared the virus
- 557 clients were started on treatment
- 488 completed treatment
- 54 clients withdrew from treatment (39% fewer than in the previous year). Fifteen of the 54 withdrawals were due to side effects from the treatments
- 48% —278 clients — had a sustained virologic response.

With the introduction of new treatment regiment some clients moved through all three treatment stages within a 6-month reporting period.

FIGURE 136 Treatment outcomes 2013/14-2014/15 (OCHART 15.3b & 15.3c)

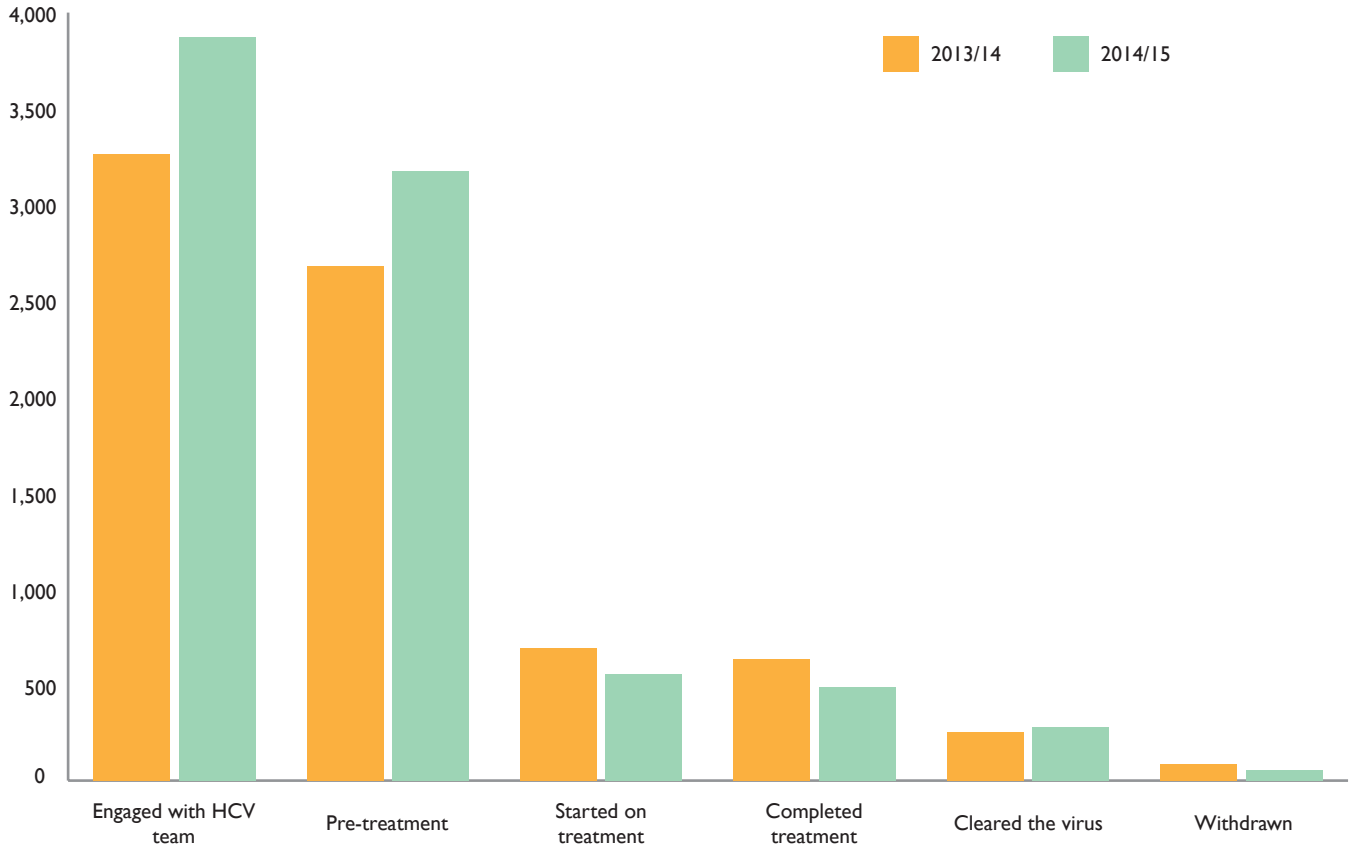
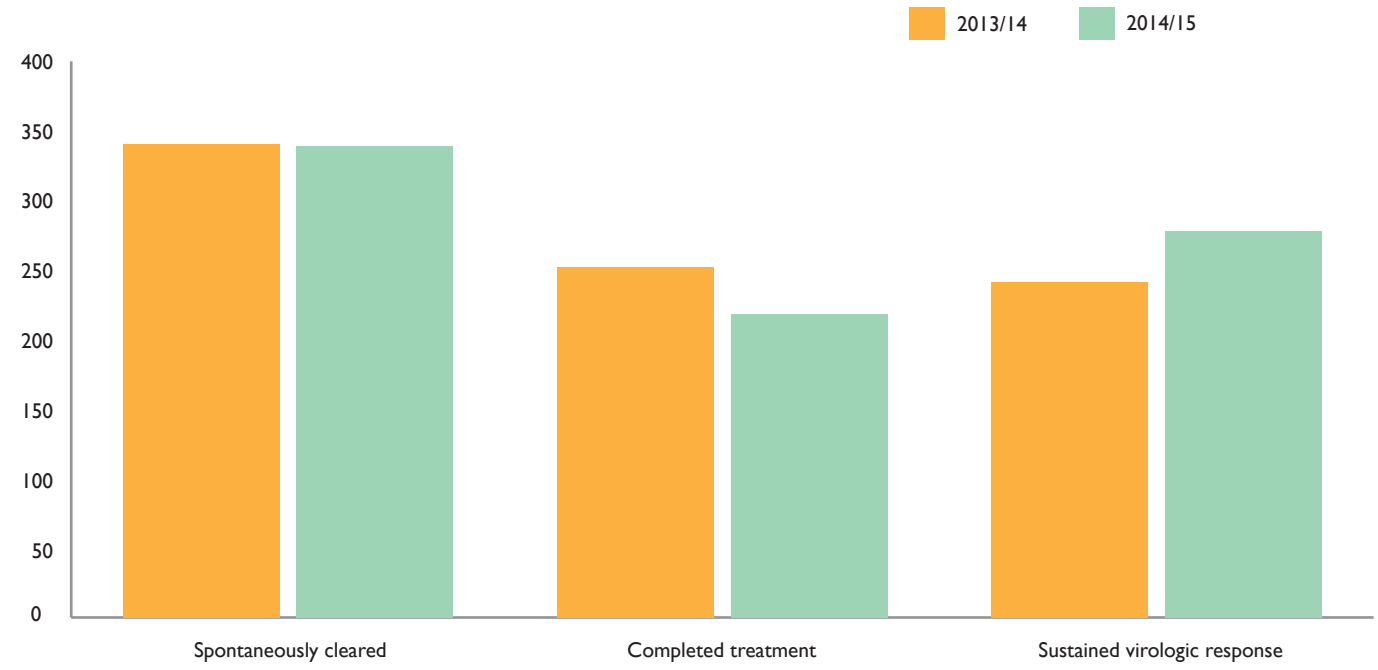


FIGURE 137 H1 and H2 treatment outcomes 2013/14-2014/15 (OCHART q. 15.3b)



Treatment eligibility and treatment interruptions

The large gap between the number of clients engaged with treatment and the number who completed treatment in 2014/15 is mainly due to the fact that many were not yet eligible for drug coverage. However, because of the work of the HCV teams, far fewer clients were lost to follow-up (-52%) or experienced treatment interruption due to social instability (-55%). Over the same period, the number of clients initiated on treatment who were ineligible for EAP coverage more than doubled. See Figure 83 for the reasons why people are ineligible for treatment and Figure 84 for why some people stop treatment.

FIGURE 138 Reasons for treatment ineligibility (OCHART q. 15.3c)

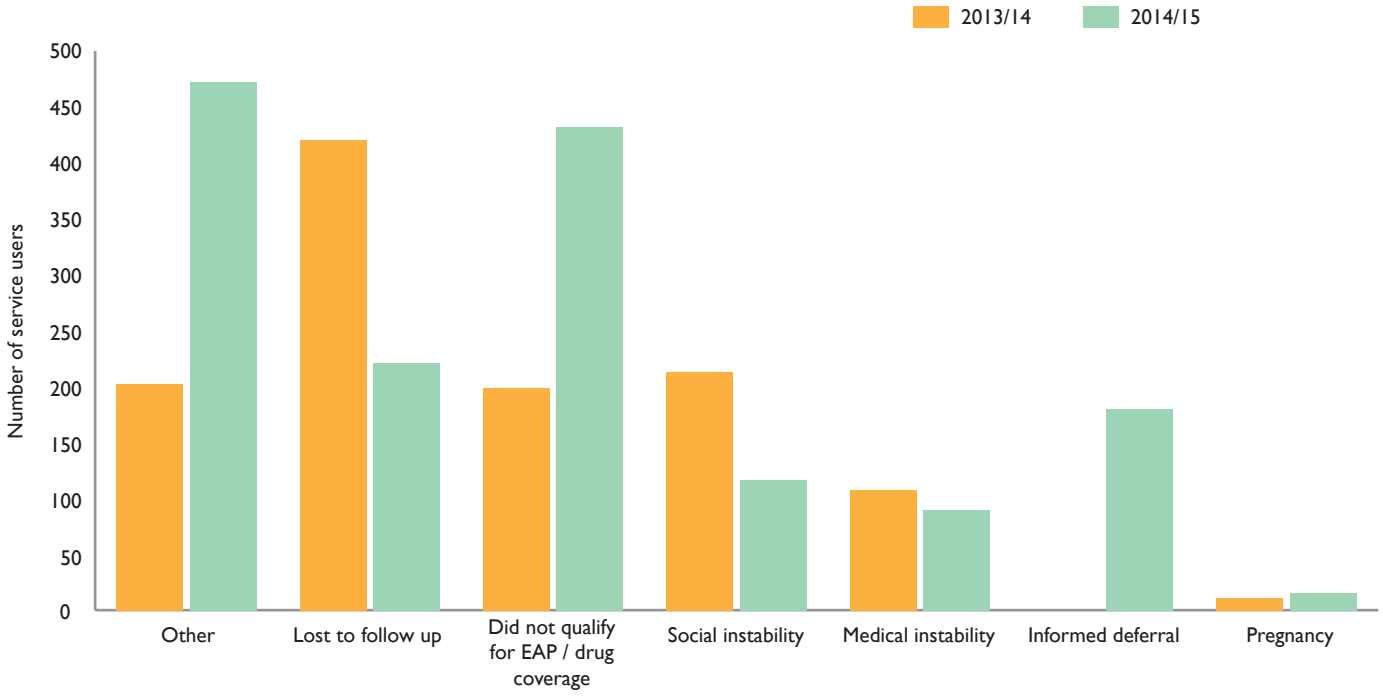
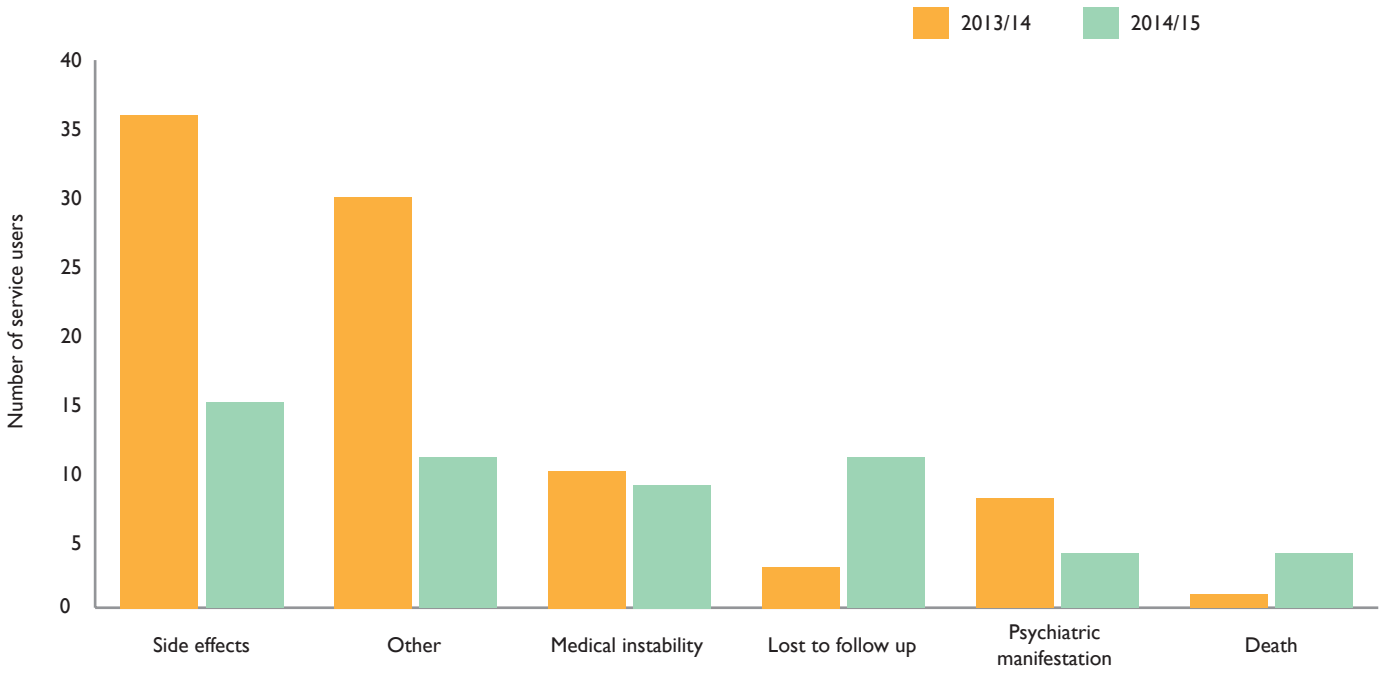


FIGURE 139 Reasons for treatment interruptions(OCHART q. 15.3b)



More details on genotypes and access to treatments

Most clients presented with genotype 1, 3 or 2. Genotype 1 is the most common genotype in Canada among people who use drugs.

Eligibility gap

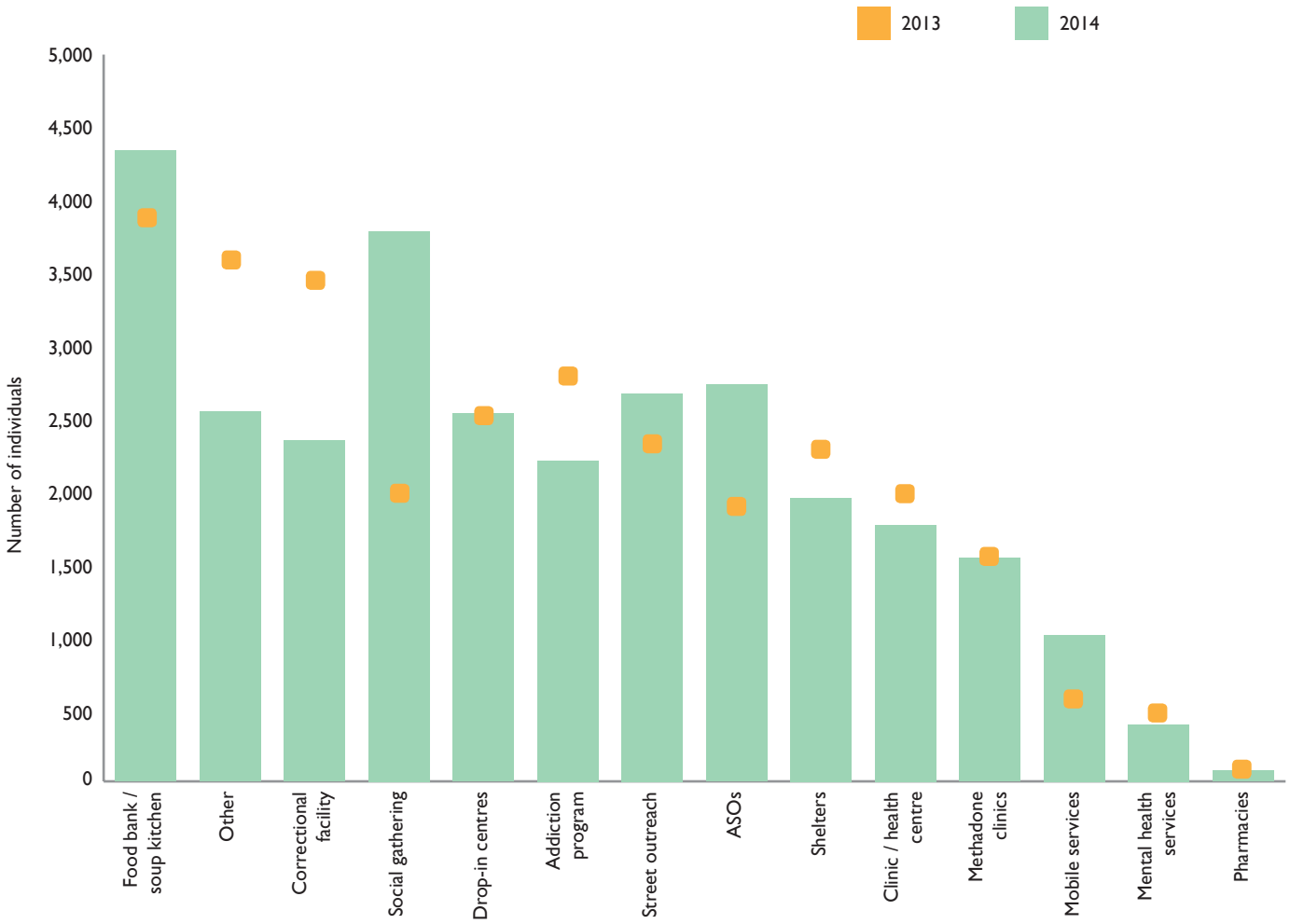
For many people with HCV, cost is a barrier to accessing treatment. Not all clients are eligible for the EAP, which covers drugs not included on the Ontario Drug Benefit Plans. With the introduction of new treatments in 2014/15, HCV teams reported the EAP covered drug costs for a total of 128 clients (12% of those started on treatment compared to 36% in the previous year). At the same time, sites reported that recent changes in the EAP approval process mean that patients who were previously interferon ineligible can now be reconsidered for the shorter, interferon-free regimens. The outcomes of these changes will be more visible in the next reporting period.

Although the number of people who received treatment in 2014/15 was not significantly different from the previous year, teams expect the number of "on treatment" and "post treatment" clients to increase rapidly as more people become eligible.

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

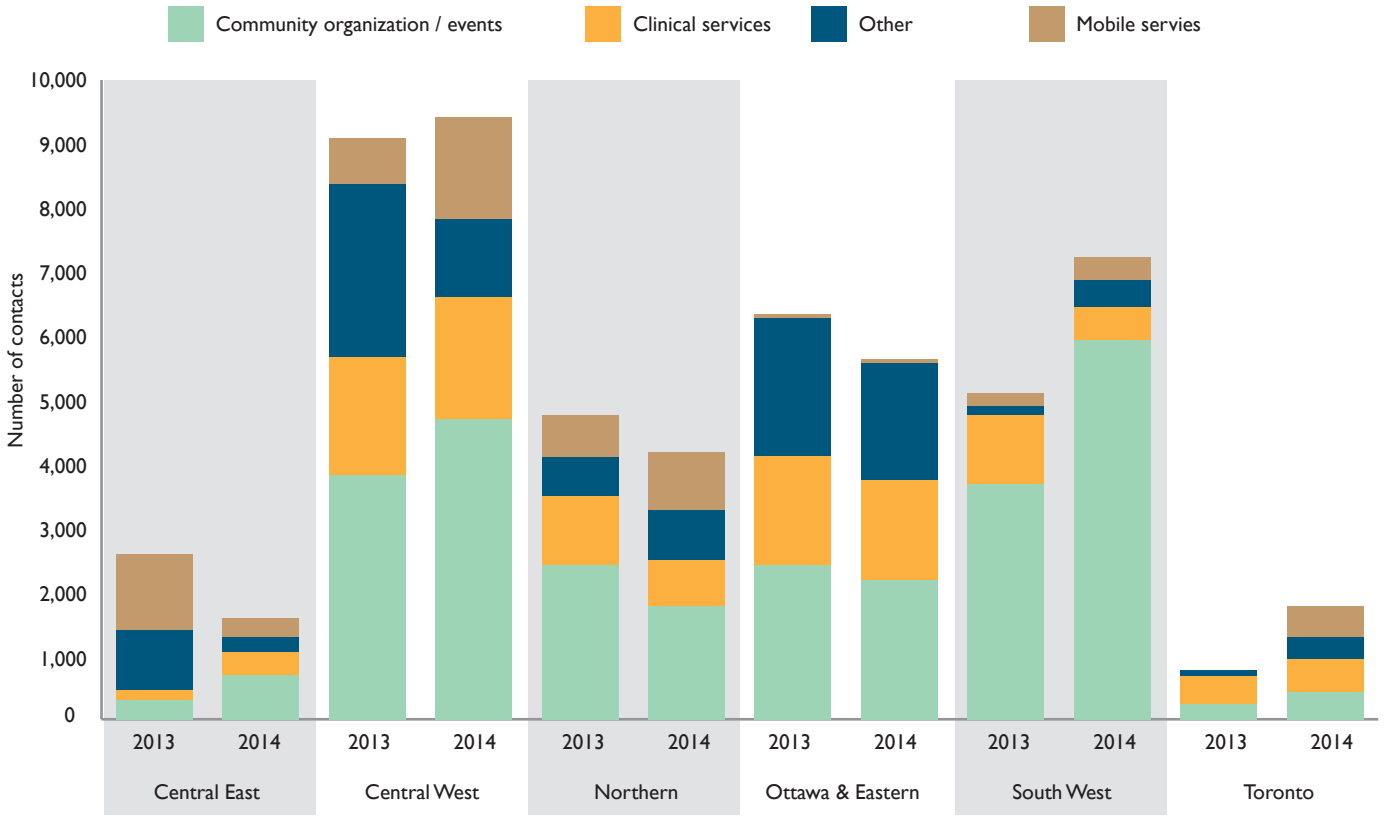
HCV teams continued providing education to raise awareness and prevent HCV transmissions — particularly among the six priority populations. They reported a total of 29,881 outreach contacts in a range of community settings, delivering a significant amount of education through food banks and social gatherings (See Figure XX).

FIGURE 140 Education contacts by location(OCHART q. 15.4a)



Outreach sites vary by region, with South West using mainly other community organizations and events, and Central East using mobile services and "other" sites (See Figure XX)

FIGURE 141 Education contacts by region and location(OCHART q. 15.4a)



OBJECTIVE: TO INCREASE COLLABORATION, COORDINATION AND EVIDENCE-BASED PRACTICES ACROSS THE SYSTEM RESPONDING TO HCV

To build stronger networks of services to respond to HCV, HCV teams gave a total of 1,456 presentations throughout their communities and regions (-23% from the previous year). The most common topics for these presentations were: harm reduction/safer drug use, HCV treatment and living with HCV. The change in the number of Hep C 101 presentations is due to a change in reporting. This topic was removed from the list and programs included this topic under "other."

Different team members share responsibility for increasing collaboration and coordination, although most presentations were given by outreach workers and coordinators. Most presentations were to service providers and professionals, followed by people who use drugs and health care providers.

FIGURE 142 Top 5 education presentations by topic(OCHART q. 15.4c)

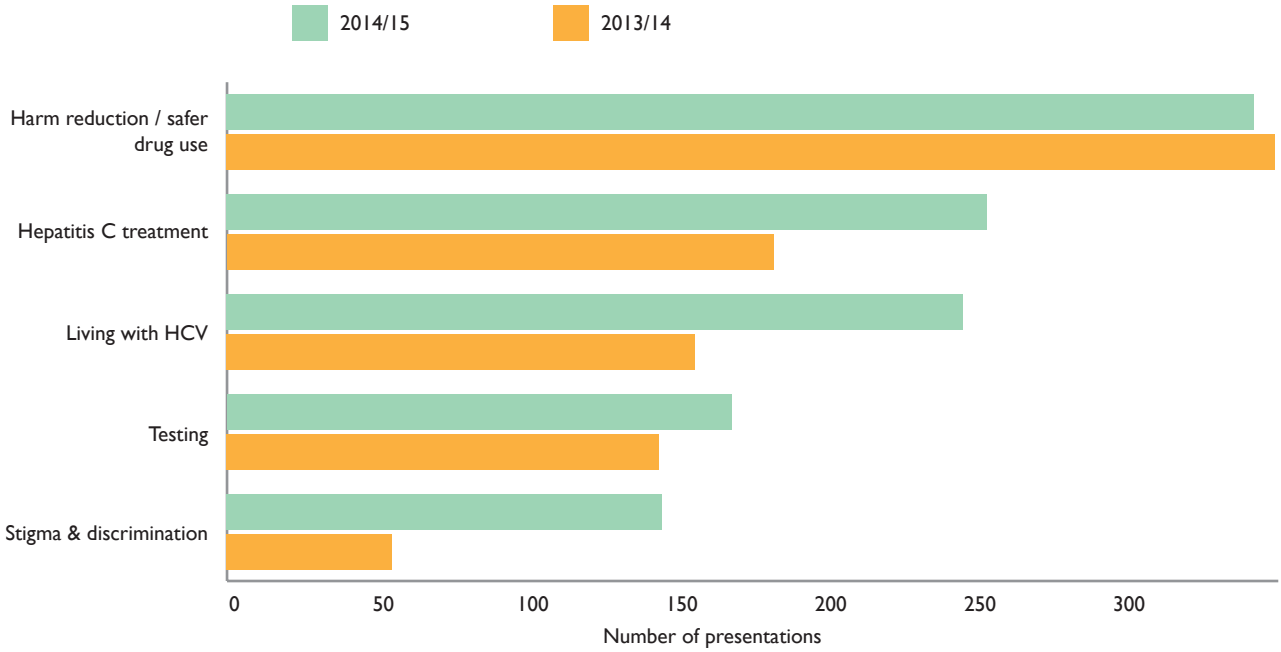
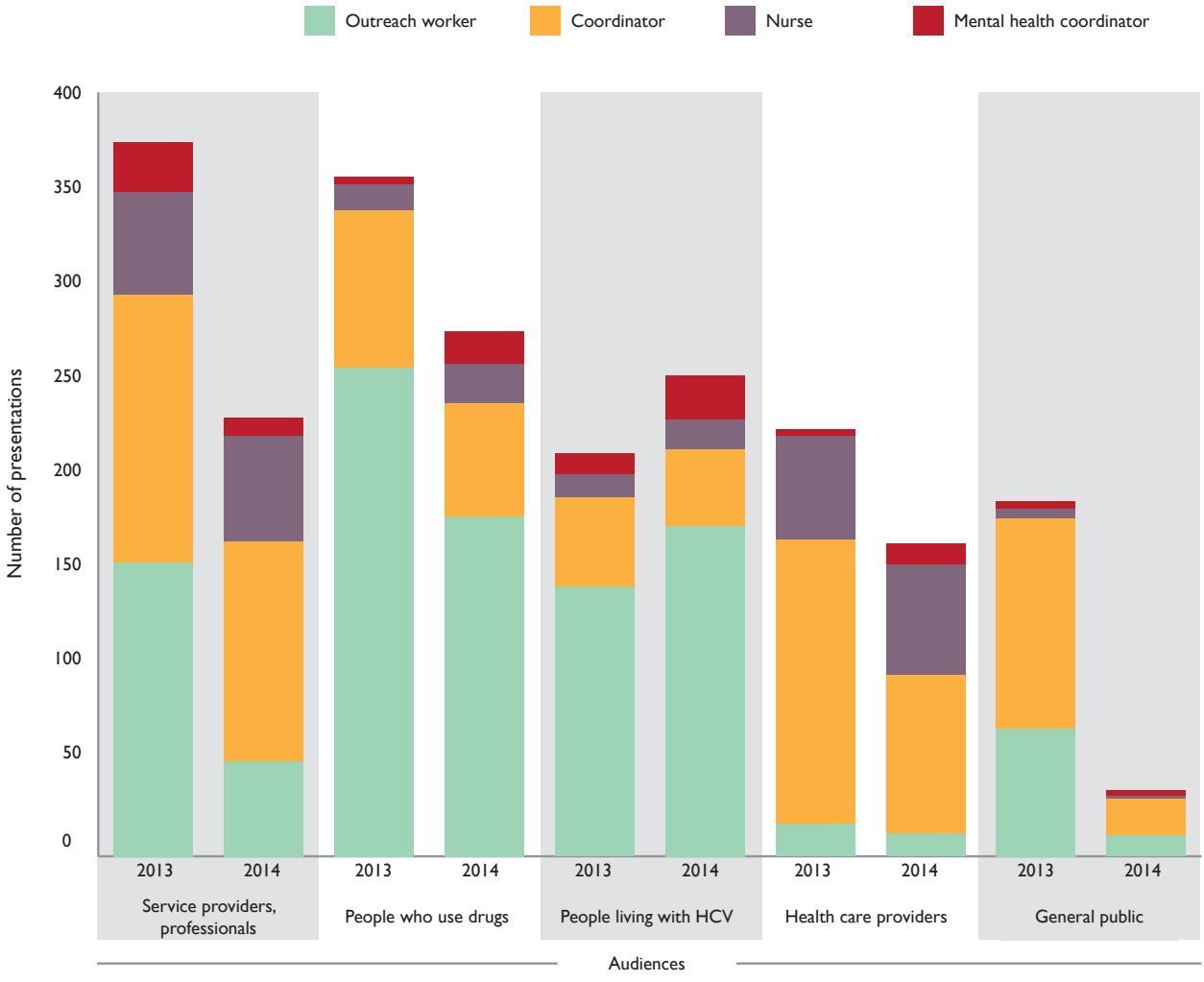


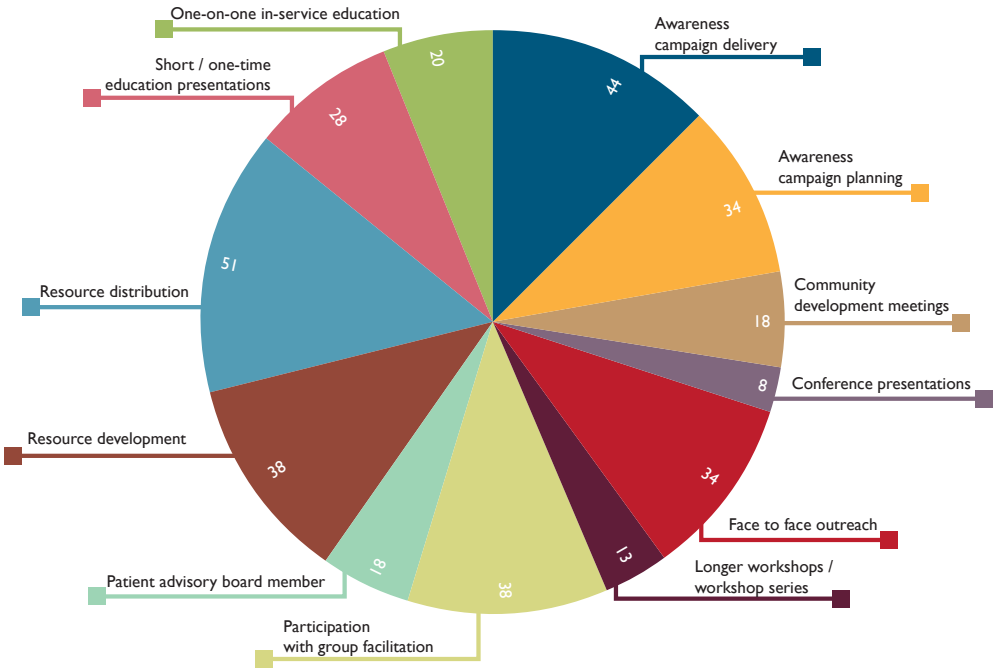
FIGURE 143 Top 5 education intended audiences by worker type(OCHART q. 15.4c)



Peer involvement

HCV teams actively engage people with lived experience in delivering education and outreach services. Peers provided a wide spectrum of services and were actively involved in distributing resources, planning and implementing awareness campaigns and delivering outreach activities. On average, 345 peers delivered services in each half of 2014-15.

FIGURE 144 Number of peers involved in delivering hepatitis C services (OCHART q. 15.4d)



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

Hepatitis C Education is often integrated with providing harm reduction services. HCV teams continue developing partnerships with community health centres, reaching small and remote communities. Teams emphasized the importance of the integrated care framework and have been actively involved in promoting and supporting it.

Hep C nurses provide HCV education to other nursing staff in community health centers and hospitals.

Many clients are in need of basic necessities. Providing them with the basics creates a window of opportunity to engage them in care.

Peer outreach is key to success. Programs continue investing in peer training and are looking for efficient ways to make peer-based initiatives sustainable, including providing more training and more opportunities for people to contribute to peer programs in "a less formal way than is implied in a peer program."

New comprehensive evaluation tools, such as treatment satisfaction and knowledge gain surveys, have been developed and used. Several teams are planning more complex evaluation initiatives, such as a community impact survey.

Programs reported successfully using technology (i.e. texting) to reduce the number of missed appointments.

For many agencies direct client feedback continues to inform program enhancement. Based on these feedback, several programs made changes to the times and locations where services are provided and reported much better participation rates.

IV. Appendices

A. Programs
B. Logic models
C. Synthesized logic model
D. Data limitations
E. Funding Sources
F. What is a PPN?
G. Economic impact of volunteers
H. Acronyms

Appendix A. Programs

Health Region	Organization Name	LHIN (Local Health Integration Network)
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
	The AIDS Network - Hamilton	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
	Réseau Access Network	North East
	Sudbury Action Centre for Youth	North East
	Sudbury and District Health Unit	North East
	Union of Ontario Indians	North East
	Elevate NWO	North West
	Nishnawbe Aski Nation	North West
	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

Health Region	Organization Name	LHIN (Local Health Integration Network)
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 VIH/SIDA	Toronto Central
	Africans In Partnership Against AIDS	Toronto Central
	AIDS Committee of Toronto	Toronto Central
	Alliance for South Asian AIDS Prevention	Toronto Central
	Asian Community AIDS Services	Toronto Central
	Barrett House - Good Shepherd Ministries	Toronto Central
	Black Coalition for AIDS Prevention	Toronto Central
	Casey House Hospice	Toronto Central
	Central Toronto Community Health Centres	Toronto Central
	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

Health Region	Organization Name	LHIN (Local Health Integration Network)
Toronto	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 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
		Toronto Central

Health Region	Organization Name	Program Type
Provincial	Hemophilia Ontario	Direct Services
	HIV & AIDS Legal Clinic (Ontario) (HALCO)	Direct Services
	Ontario Aboriginal HIV/AIDS Strategy	Direct Services
	PASAN (Prisoners with HIV/AIDS Support Action Network)	Direct Services
	African and Caribbean Council on HIV/AIDS in Ontario	Capacity Building
	AIDS Bereavement and Resiliency Program of Ontario (sponsored by Fife House)	Capacity Building
	Canadian AIDS Treatment Information Exchange	Capacity Building
	Committee for Accessible AIDS Treatment	Capacity Building
	FIFE House - Ontario HIV and Substance Use Training Program (OHSUTP0	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

Hepatitis C programs

Health Region	Organization Name	LHIN (Local Health Integration Network)
Central East	Lakeridge Health Centre*	Central East
Central East	Oshawa Community Health Centre	Central East
Central West	Bramalea Community Health Centre	Central West
Central West	Niagara Health System	Hamilton Niagara Haldimand Brant
Central West	Wayside House of Hamilton	Hamilton Niagara Haldimand Brant
Central West	Sanguen Health Centre	Waterloo Wellington
Northern	AIDS Committee of North Bay and Area	North East
Northern	Algoma Group Health	North East
Northern	Reseau Access Network	North East
Northern	Elevate NWO	North West
Northern	Sioux Lookout First Nations Health Authority*	North West
Ottawa & Eastern	The Ottawa Hospital	Champlain
Ottawa & Eastern	Street Health Centre, Kingston Community Health Centres	South East
Provincial Resource	Canadian AIDS Treatment Information Exchange*	Provincial Resource
Provincial Services	PASAN (Prisoners with HIV/AIDS Support Action Network)*	Provincial Services
South West	Windsor-Essex Community Health Centre	Erie St Clair
South West	London Inter-Community Health Centre	South West
Toronto	Sherbourne Health Centre	Toronto Central
Toronto	South Riverdale Community Health Centre	Toronto Central
Toronto	University Health Network	Toronto Central

* HCV-funded staff

Anonymous testing

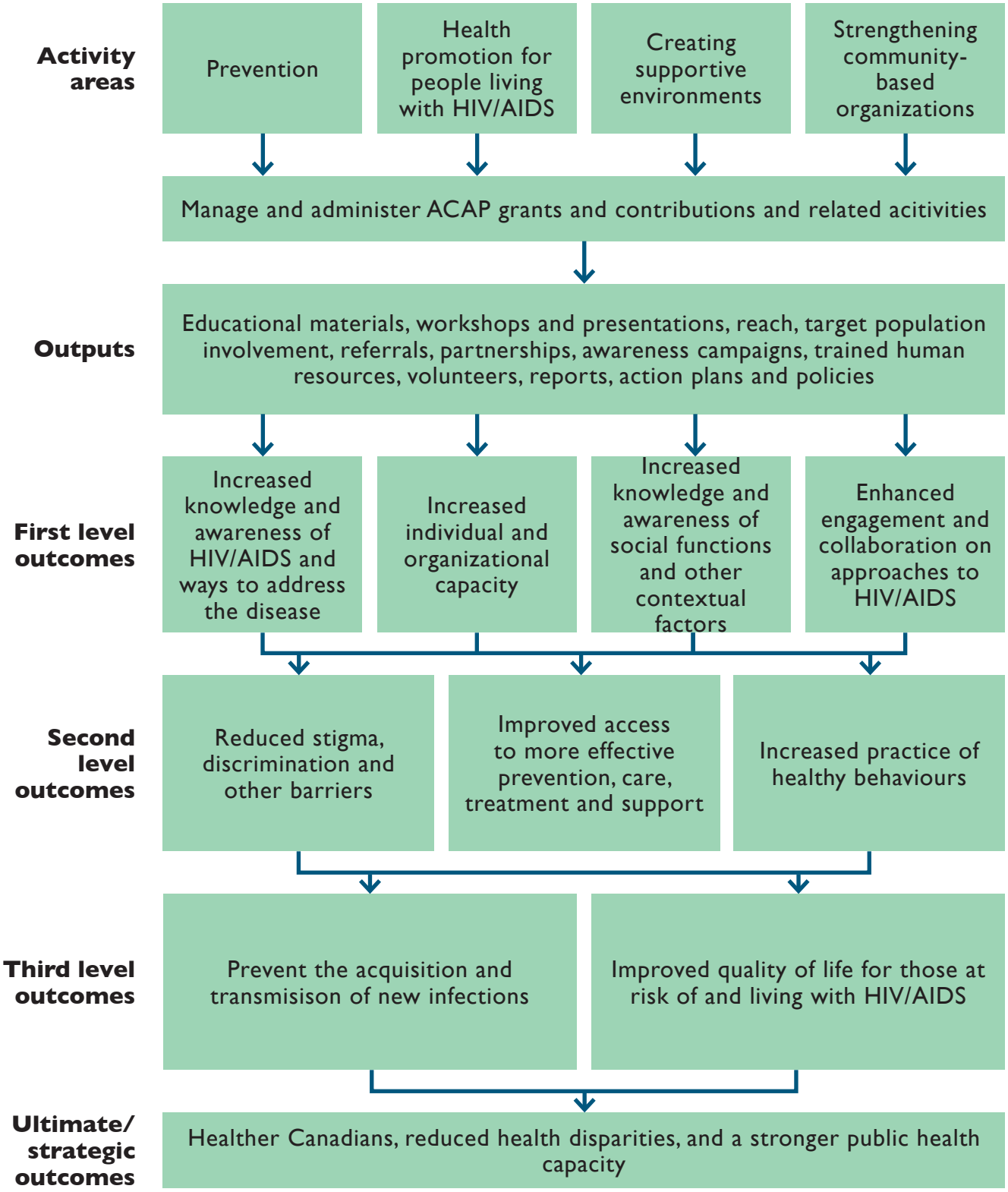
Health Region	Organization Name	LHIN (Local Health Integration Network)
South West	London Inter-community Health Centre (Options Clinic)	South West
Central East	Simcoe Muskoka District Health Unit	North Simcoe Muskoka
Northern	Thunder Bay District Health Unit	North West
Northern	Sudbury and District Health Unit	North East
South West	Windsor Regional Hospital	Erie St.Clair
Toronto	The HIV/AIDS Counselling, Testing and Support Program (Hassle Free Clinic)	Toronto Central Champlain
Ottawa & Eastern	Somerset West Community Health Centre	Hamilton Niagara Haldimand Brant
Central West	Hamilton Public Health & Community Services	

Community-based HIV clinical services

Health Region	Organization Name	LHIN (local Health Integration Network)
Toronto	St Michael's Hospital	Toronto Central
Central West	Bramalea Community Health Centre	Central West
Northern	Elevate NWO	North West
Central East	Lakeridge Health Centre	Central East
Central West	HIV/AIDS Resources & Community Health-Clinic	Waterloo Wellington

Appendix B. Logic models

AIDS Community Action Plan logic model



AIDS Bureau Funding Program Logic Model

Ontario Government Goal — To build a patient-centered health care system that delivers quality, value and evidence-based care in Ontario.
Objective — Preventing injury and illness: Managing disease

Objectives	Strategies	Inputs/resources	Outputs
To increase knowledge and awareness to prevent the transmission of HIV/AIDS within priority populations in Ontario	• Increase knowledge and awareness of HIV/AIDS through prevention programming for priority populations • Increase awareness and provision of HIV testing options among priority populations • Provide harm reduction services • Promote integration of GIPA/MIPA principles, including the involvement of PHAs and others with lived experience	• Provincial HIV/AIDS Strategy • Base & one time funding • Program guidelines and strategies • Program materials, staffing, administrative and management costs	• Education, prevention and outreach Programs • HIV testing initiatives • Harm reduction programs • Peer-based programming • Prevention programming to address stigma, marginalization & discrimination such as homophobia, racism, HIV stigma, etc. • Includes such funded strategies as: GMSH, ACCHO, IDU Outreach, OAHAS
To increase access to services for people living with and/or affected by HIV/AIDS	• Support organizations and communities in providing services to people living with and/or affected by HIV/AIDS • Provide support to reduce gaps in service for people living with and/or affected by HIV/AIDS • Provide support services for Ontario's priority populations • Promote integration of GIPA/MIPA principles, for both PHAs and others with lived experience	• Provincial HIV/AIDS Strategy • Base & one-time funding • Program guidelines and strategies • Program materials, staffing, administrative and management costs	• Care and support for PHAs • Health promotion and capacity-building programs for PHAs • Support programming to address stigma, marginalization & discrimination such as homophobia, racism, HIV stigma, etc. • Care and support for those affected by HIV/AIDS

Program Description
Program provides transfer payment funding to support an evidence-informed, community-based response to HIV/AIDS in Ontario through the provision of such services and programs as: prevention education and awareness, harm reduction, HIV testing, support and care, community mobilization, and research.

Objectives	Strategies	Inputs/resources	Outputs
To increase capacity of organizations and communities to effectively respond to HIV/AIDS	• Promote system effectiveness, transparency and responsiveness • Support leadership capacity and coordination of communities, organizations, staff, volunteers and PHAs • Foster supportive and engaged communities • Build capacity of the wider health and social service sector to meet the needs of people living with HIV/AIDS • Promote integration of GIPA/MIPA principles, for both PHAs and others with lived experience	• Provincial HIV/AIDS Strategy • Base & one-time funding • Program guidelines and Strategies • Program materials, staffing, administrative and management costs	• Organizational development programs • Volunteer and staff capacity development programs • Includes funded strategies: WHAI, ACCHO, GMSH, OAHAS • Established referral network of allied service providers • Community development programming to address stigma, marginalization & discrimination such as homophobia, racism, HIV stigma, etc.
To increase coordination, collaboration and evidence-based practice across the system responding to HIV/AIDS	• Support opportunities for relevant and high quality research • Provide opportunities for knowledge translation and exchange across sectors • Provide opportunities to integrate evidence into practice • Build capacity of the wider health and social service sector to meet the needs of people living with HIV/AIDS • Promote integration of GIPA/MIPA principles, for both PHAs and others with lived experience	• Provincial HIV/AIDS Strategy • Base & one-time funding • Program guidelines and Strategies • Program materials, staffing, administrative and management costs	• Partnership and service coordination programs • CBR, clinical and other research including Epidemiological Monitoring • Knowledge translation and exchange to increase evidence-based practice • Data collection, input and analysis to increase evidence-based and informed practice

Health outcomes

- Reduced transmission of HIV/AIDS in Ontario
- Improved health and well-being of people living with HIV/AIDS (PHAs)
- Strengthened community capacity to respond to people living with, affected by or at risk of HIV/AIDS

Activities	Data measures	Short-term outcomes
• Education sessions/workshops • Community development • Social marketing campaigns • Resource distribution • HIV prevention counseling • Outreach activities • Distribution of harm reduction materials • Harm reduction counseling with service users • HIV testing initiatives – POC testing, anonymous HIV testing, prenatal HIV testing; and partner notification	• Total funding contributed to each objective • OCHART reporting (Sect 9, 10 & 13) including such things as # presentations, # education participants, # community development meetings, # resources distributed, # outreach contacts, # harm reduction supplies, etc. • Other data measures including # HIV tests & other HIV testing data • Program evaluations, reviews or environmental scans	• Increased knowledge and awareness of HIV/ AIDS prevention and harm reduction for priority populations in Ontario • Increased capacity for individuals to use harm reduction practices • Increased awareness and provision of HIV testing options, and number of people tested for HIV, among priority populations in Ontario • Integration of GIPA/MIPA principles, for both PHAs and others with lived experience
• Counseling and case management for PHAs, affected and those at-risk • Referrals for allied services • Practical assistance and other supports • PHA peer-led programming • PHA health promotion and capacity-building activities	• Total funding contributed to each objective • OCHART reporting (Sect 11) including such things as # clients, client gender and age, # new clients, type of services accessed, financial assistance distributed, # clients receiving financial assistance • Program evaluations, reviews or environmental scans	• Increased access to services for people living with &/or affected by HIV/AIDS • Integration of GIPA/MIPA principles, for both PHAs and others with lived experience

Priority populations in Ontario

- People living with HIV/AIDS
- People who use drugs
- Gay, bisexual and other MSM
- African, Caribbean and Black Ontarians
- Indigenous peoples
- Women in the above groups &/or who engage in high-risk activities with them

Activities	Data measures	Short-term outcomes
• Provincial resources to support community-based HIV sector: i.e. OAN, ACCHO, GMSH, OODP, ABRPO, OHSUTP, OPRAH, CATIE • WHAI programming • Opening Doors conferences • Knowledge transfer and exchange days/ activities • Organizational development programming • Volunteer management activities • Staff development • Peer involvement in organization or program development or delivery	• Total funding contributed to each objective • OCHART reporting (Sect 3, 4, 12 & 7) including such things as provincial resources accessed, • # activities by provincial resource programs, # staff attending trainings, # volunteers, # student placements, # peers involved including PHAs, IDU peers, & other priority population involvement • Program evaluations, reviews or environmental scans	• Strengthened community and organizational capacity to respond to HIV/ADS • Integration of GIPA/MIPA principles, for both PHAs and others with lived experience
• Knowledge Development & Research • Knowledge Resource Dissemination • Ontario HIV Treatment Network programming • Evidence-based Practice Unit – OCHART, OCASE, and evaluation supports • Partnerships and collaborations • Community development activities • Evaluation activities	• Total funding contributed to each objective • Total funding for research & KTE related activities • OCHART reporting (Sect 13, 5, & 8) including such things as partnerships, # community development meetings • Other data measures including # research reports, KTE events, data collection activities, # requests for evaluation support, etc. • Program evaluations, reviews or environmental scans	• Increased coordination, collaboration and evidence based practice in responding to HIV/AIDS • Increased system effectiveness, transparency, and responsiveness. • Integration of GIPA/MIPA principles, for both PHAs and others with lived experience

Appendix C. Synthesized logic model

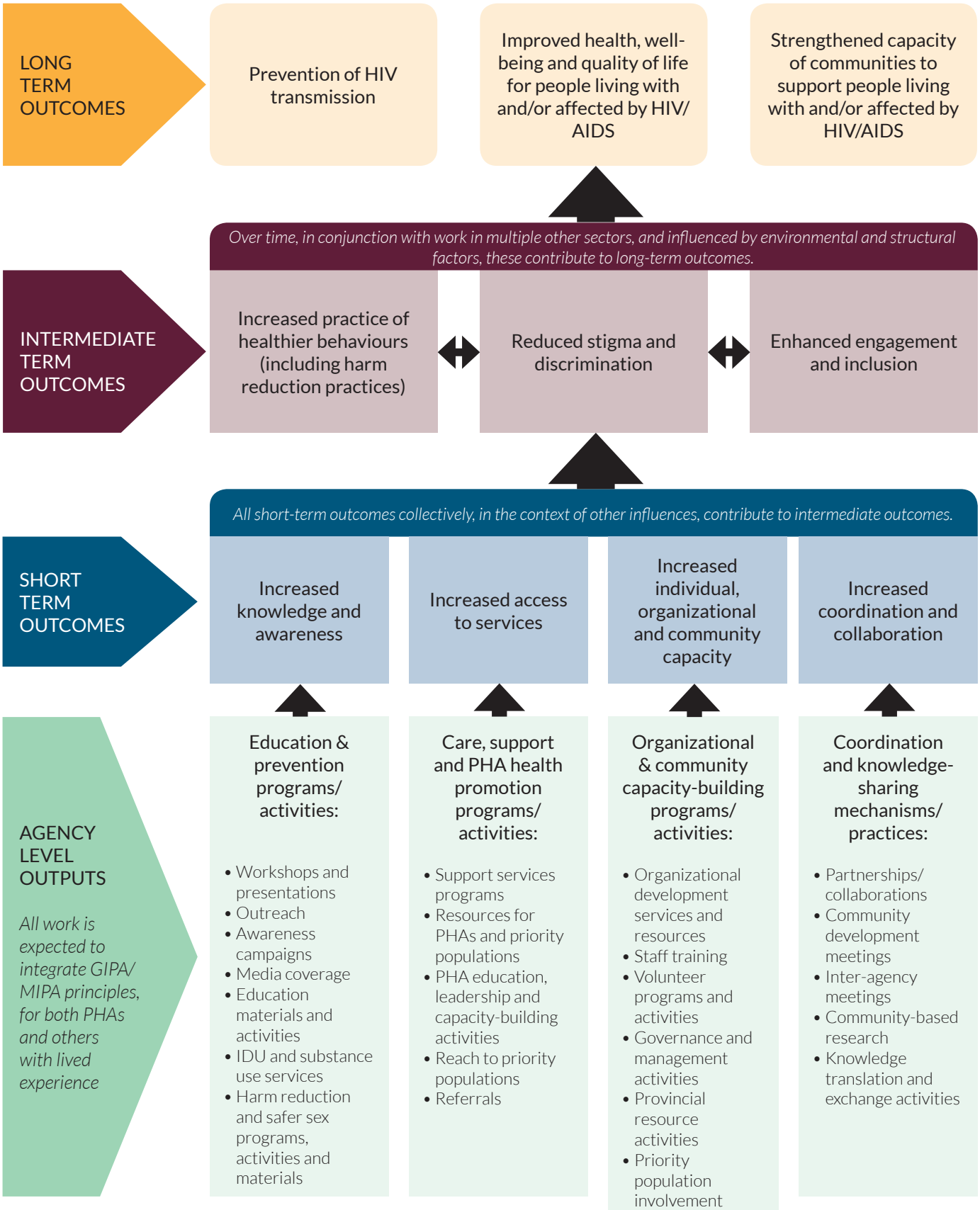
Understanding the logic model

The OCHART logic model — a synthesis of both the AIDS Bureau and PHAC logic models — reinforces how the two funding programs are working together to achieve common goals. Because the synthesized logic model represents the work of two funders, not all populations and outputs will apply to all funded programs. For example, youth at risk are a priority population for ACAP but not the AIDS Bureau, and IDU outreach and harm reduction services are funded by the AIDS Bureau but not ACAP.

The box at the top of the logic model describes the long-term outcomes or goals of our work. The rest of the logic model explains how our work contributes to achieving these outcomes. To read the logic model, start at the bottom of the page:

- The outputs list the activities or services of community-based HIV programs, which are a means to an end.
- The end is the desired change or "outcomes" that we expect to see. For reporting purposes, we linked each output to just one short-term outcome; however, in practice, outputs can contribute to more than one outcome. For example, "workshops and presentations" contribute to the outcome "increased knowledge and awareness" but they can also contribute to other outcomes, such as increased access to services or increased organizational capacity.
- There are different levels of outcomes in the logic model, based on time and reach:
    - Short-term outcomes generally occur first and are where we can see the clearest cause-effect relationship between outputs and outcomes. These are the areas where funded agencies have the strongest influence, and where change can be most directly attributed to their work.
    - Outcomes become more complex to measure as we move up the logic model. Intermediate and longer-term outcomes take more time to achieve, and depend more on the work of other programs and sectors. Funded agencies contribute, along with other community and government initiatives, to achieving these outcomes.

Synthesized Logic Model for Community-Based HIV/AIDS Funding Programs in Ontario



Appendix D. 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 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 changes 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

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 E. Funding sources

FIGURE 145 All sources of funding 2012/2013 – 2015/2016 (OCHART 5.1, 5.2 and 5.3)

		2012/13	2013/14	2014/15	2015/16
Government of Ontario	AIDS Bureau*	$24,700,000	$24,800,000	$24,800,000	$37,00,000
	Other Ministry of Health & Long-Term Care	$3,598,497	$4,237,608	$4,258,142	$4,491,678
	Other Provincial Ministries	$1,049,518	$1,073,804		$1,442,933
Federal government	ACAP*	$4,000,000	$4,200,000	$4,200,000	$4,200,000
	Other Federal Government	$4,762,165	$3,997,281	$3,702,316	$3,691,506
Local	Municipal / Regional Health Authority	$3,696,247	$3,555,399	$3,702,316	$3,691,506
Private sector	Other Charitable Foundations, Private Sector	$3,194,259	$2,264,300	$2,026,199	$2,330,015
	Fundraising	$3,317,337	$5,390,831	$4,722,147	$3,998,471
Non-Governmental Funding	Trillium	$372,385	$532,413	$470,781	$301,032
	United Way	$260,434	$213,582	$173,197	$186,751
Local	Other	$2,574,860	$1,601,824	$1,024,761	$2,046,846
	Total	**$47,022,829**	**$48,491,207**	**$49,305,406**	**$51,043,830**

**funder reported*

Appendix F. What is a PPN?

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

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

Gay Men's Sexual Health Alliance (GMSHA)

www.gmsh.ca

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

Women and HIV/AIDS Initiative (WHAI)

www.whai.ca

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

African Caribbean Council on HIV/AIDS in Ontario (ACCHO)

www.accho.ca

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

Priority Population Network Members are 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.

Appendix G. Economic impact of volunteers

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 past 12 months	NOC average wage rate assiged to this job in the past 12 months	Total volunteer hours x NOC average hourly wage rate	Fringe benefit 12%	Total value
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**

Appendix H. Acronyms

ABRPO	AIDS Bereavement and Resiliency Program of Ontario
ACAP	AIDS Community Action Plan
ACB	African, Caribbean and Black
ACCHO	African and Caribbean Council on HIV/AIDS in Ontario
APPA	African in Partnership Against AIDS
ASO	AIDS service organization
AT	Anonymous testing
BLACKCAP	Black Coalition For AIDS Prevention
CAAT	Committee for Accessible AIDS Treatment
CATIE	Community AIDS Treatment Information Exchange
CHC	Community health centre
CMHA	Canadian Mental Health Association
CTAC	Canadian Treatment Action Council
EBPU	Evidence-Based Practice Unit
FTE	Full-time equivalent
GIPA	Greater involvement of people living with HIV/AIDS
GMSH	Gay Men's Sexual Health Alliance
H1	April to September reporting period
H2	October to March reporting period
HALCO	HIV/AIDS Legal Clinic Ontario
HCB	Hepatitis C virus
IDU	Injection drug use
KTE	Knowledge transfer and exchange
LGBTQ+	Lesbian, gay, bisexual, trans, queer, questioning
LHIN	Local Health Integration Network
MIPA	Meaningful involvement of people living with HIV/AIDS
MOHLTC	Ministry of Health and Long Term Care
MSM	Men who have sex with men
Oahas	Ontario Aboriginal HIV/AIDS Strategy
OAN	Ontario AIDS Network
OCASE	Ontario Community AIDS Services and Evaluation
OCHART	Ontario Community AIDS Reporting Tool
OCS	OHTN Cohort Study
OHTN	Ontario HIV Treatment Network
OODP	Ontario Organizational Development Program
PARN	Peterborough AIDS Resource Network
PASAN	Prisoners with HIV/AIDS Support Action Network
PHAC	Public Health Agency of Canada
PLWH	People living with HIV
POC	Point of care testing
PWUD	People who use drugs
PP	Priority populations
PPN	Priority population networks
PSAs	Public service announcements
STI	Sexually transmitted infection
WHAI	Women & HIV/AIDS Initiative

OCHART

ONTARIO HIV TREATMENT NETWORK

Public Health Agency of Canada

Agence de santé publique du Canada

Ontario