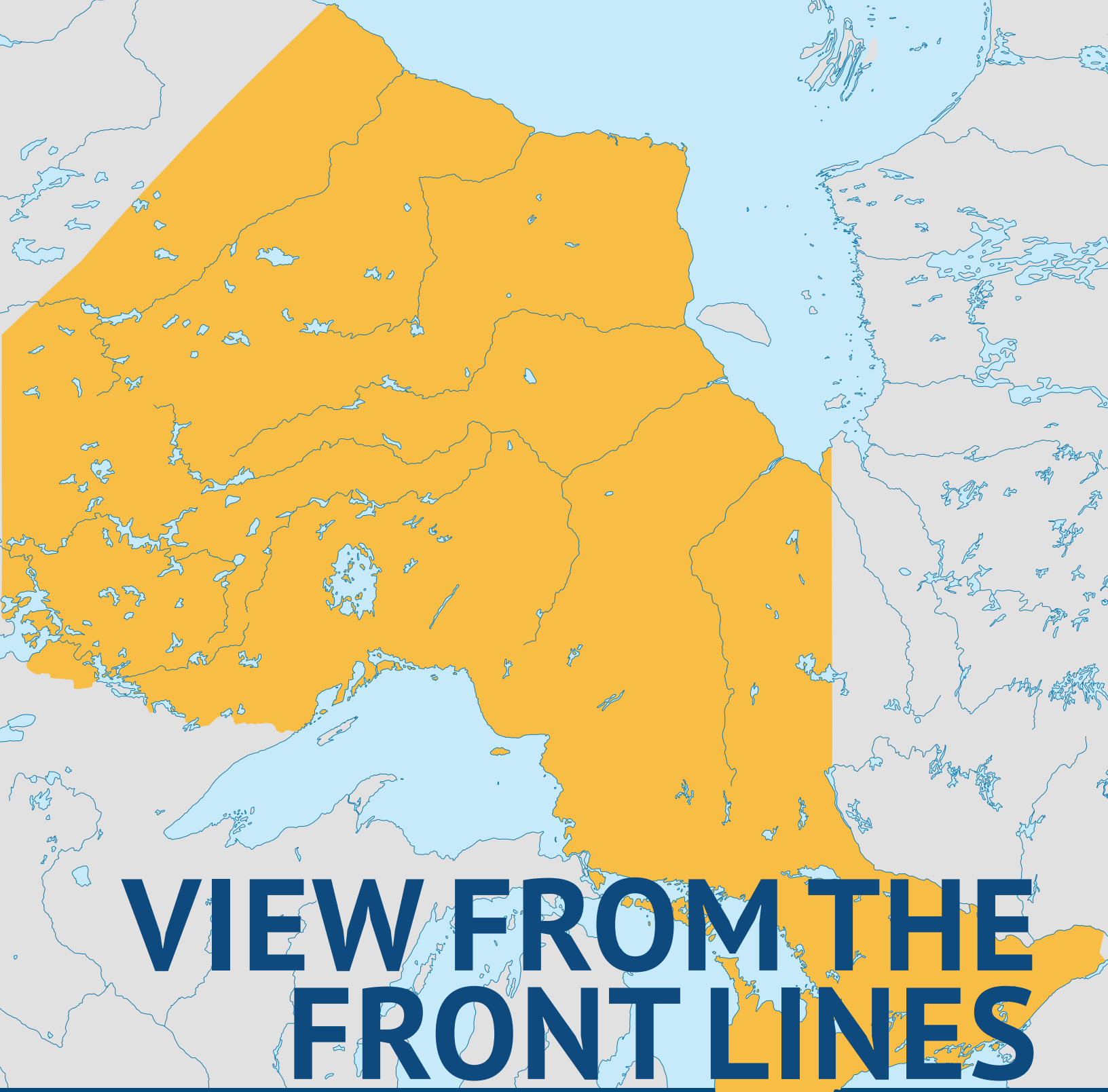

VIEW FROM THE FRONT LINES 2018

OCHART

Annual summary and analysis
April 1, 2017 to March 31, 2018

VIEW FROM THE FRONT LINES

ONTARIO HIV TREATMENT NETWORK

OCHART

Ontario

Contents

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

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

For more information about completing OCHART forms or to request program-specific data and reports, please contact:
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ONTARIO
HIV TREATMENT
NETWORK

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THIS REPORT SHOULD BE CITED IN THE FOLLOWING MANNER:

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List of common abbreviations

Abbreviation	Meaning
ACB	African, Caribbean and Black
AIDS	Acquired Immunodeficiency Syndrome
ASO	AIDS service organization
GBMSM	Gay, bisexual, and other men who have sex with men
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
KTE	Knowledge translation and exchange
LGBT	Lesbian, gay, bisexual, and trans
LHIN	Local health integration network
PEP	Post-exposure prophylaxis
PHU	Public health unit
PLWH	People living with HIV
PrEP	Pre-exposure prophylaxis
STI	Sexually transmitted infection

Preface

The AIDS and Hepatitis C Programs Unit, Ontario Ministry of Health and Long Term Care funds organizations across the province to provide prevention, treatment and care services to people living with, at risk of, and affected by the human immunodeficiency virus (HIV) and/or hepatitis C virus (HCV).

Funded organizations offer a range of health and social services to prevent and treat HIV and HCV, and to provide ongoing care to individuals affected by the negative health and social impacts of the two (often co-occurring) viruses. These organizations are directly and deeply engaged with the populations they serve, adapting their efforts to changing social conditions, medical treatment advances, and an evolving population base. Their work contributes to a reduction in the physical, mental health, social and financial burden connected to HIV and HCV in the health system and overall reductions in disease transmission across Ontario.

A snapshot of HIV in Ontario

In 2015 there were more than 16,000 people living with diagnosed HIV in Ontario. In 2017, about 916 people were newly diagnosed with HIV in the province[1] — although a significant proportion of those had previously been diagnosed with HIV elsewhere and moved to Ontario.

After many years of sustained efforts from people living with and affected by HIV, advances in the biomedical treatment and prevention of HIV have transformed the virus from a virtual death sentence to a manageable chronic illness. However, it remains a serious chronic illness, often associated with other health conditions such as HIV-related cancers, neurocognitive disorders, and lower quality of life.[2, 3]

The personal health impacts of HIV translate into increased long-term health care and social service costs. The average lifetime direct health treatment cost for a person living with HIV is estimated to be more than $400,000.[4] If we can prevent the estimated 4,000 new transmissions that are likely to occur in Ontario over the next five years, we would save the health care system alone more than $1.6 billion. This number does not include the additional savings that would occur in the social service system or the lost opportunity costs that stem from each new transmission.

1 OHESI (2018). HIV testing and diagnosis in Ontario, 2017. Toronto: Ontario HIV Epidemiology and Surveillance Initiative.
2 CATIE (2018). HIV in Canada: A primer for service providers. Toronto: CATIE.
3 CATIE (2014). Long-term HIV infection and health-related quality of life. Toronto: CATIE.
4 See: H.B. Krentz & MJ. Gill (2008). Cost of medical care for HIV-infected patients within a regional population from 1997 to 2006. HIV Medicine, 9, 721-730S. K. Choi et al. (2016). Economic evaluation of community-based HIV prevention programs in Ontario: Evidence of effectiveness in reducing HIV infections and health care costs. *AIDS and Behavior*, 20 (6), 1143-56. B.R. Schackman et al. (2015). The lifetime medical cost savings from preventing HIV in the United States. *Medical Care*, 53(4), 293-301.

A snapshot of hepatitis C in Ontario

Between 221,000 and 246,000 individuals in Canada — between 6 and 7 of every 1,000[5] people — are infected with hepatitis C. If we apply these figures to the current Ontario population, we can estimate that nearly 100,000 people are living with chronic HCV in the province.

Until very recently, treatments for HCV were quite lengthy (up to 12 months), came with significant physical and mental health side effects, and had a relatively low rate of success. Thanks to recent advances in the treatment of HCV, and the inclusion of these treatments in the Ontario Drug Benefit Formulary, we have experienced a revolution in the treatment and cure of HCV, with very high rates of treatment success. Nevertheless, HCV continues to present a significant burden on individuals, with a large number of people with the virus going undiagnosed and/or untreated.

Chronic HCV infection can lead to severe liver damage (cirrhosis), liver cancer, and liver failure. The virus has a very high burden of disease — perhaps the highest of any chronic disease — with direct health and indirect opportunity costs estimated to top $1 billion each year in Canada.[6]

Creating effective, coordinated systems of prevention, treatment and care for HIV and HCV

The populations living with and at risk of HIV and HCV look quite different. However, they share some common characteristics. For example:

- The majority of people diagnosed with HIV and/or HCV are able to successfully manage and, in the case of HCV, clear the virus.
- A significant minority of those affected by HIV and/or HCV go undiagnosed and, when diagnosed, have difficulty attaining and maintaining effective treatment.
- Significant numbers of people within affected populations are dealing with income and food insecurity, unstable housing, and the physical and mental health consequences that follow these and other related issues.[7, 8]
- People living with HIV and HCV face significant and multi-faceted stigma and discrimination.

Many people living with and at risk of HIV and/or HCV are managing multiple interacting health conditions — also known as syndemics — while experiencing the vulnerabilities touched on above. Such populations require

5 M. Trubnikov et al. (2011). Estimated prevalence of hepatitis C virus infection in Canada, 2011. Canada Communicable Disease Report, 40(19), 429-436.
6 Public Health Agency of Canada (2008). Evaluation of the hepatitis C prevention, support and research program, 1999/2000 – 2005/2006. Ottawa: PHAC.
7 T. McLinden (2016). Injection drug use and depressive symptoms are associated with food insecurity in HIV-hepatitis C co-infected individuals in Canada. Toronto: PROOF.
8 T. Bekele et al. (2018). Prevalence and predictors of food insecurity among people living with HIV affiliated with AIDS service organizations in Ontario, Canada. AIDS Care, 30(5), 663-671.

multi-layered and coordinated prevention, treatment and care from Ontario's health system.

View from the Front Lines paints a picture of the system of prevention, treatment and care that are funded through the AIDS and Hepatitis C Programs Unit of the Ministry of Health and Long Term Care. This system is increasingly conceptualized as a coordinated prevention, engagement, and care *cascade* or *continuum of client services*.

While HIV and HCV programs are covered separately in this report, there is significant overlap between them and many organizations deliver direct services to address both issues. All of the highlighted programs unequivocally share a client base that requires intensive, coordinated health care and social services characterized by outreach (reducing barriers to treatment and care), flexibility in meeting diverse client needs, and inclusion of client voices to help shape service delivery.

The organizations and programs profiled in **View from the Front Lines** have developed and evolved over the course of the epidemics. They are rooted in the experiences, needs and input of the populations they serve, which are most at-risk and affected by HIV and HCV. These include: gay, bisexual and other men who have sex with men, including trans men; African, Caribbean and Black communities; Indigenous Peoples; people who use drugs; women at risk of HIV, including trans women; people involved with the correctional system; people who are homeless or under-housed (including street-involved youth); and people living with HIV and HCV.

About this report

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

- 74 community-based HIV/AIDS programs (including programs in AIDS services organizations (ASOs) and other community-based health service providers such as community health centres)
- 4 provincial organizations that provide direct services to clients:
  - Hemophilia Ontario
  - Ontario Aboriginal HIV/AIDS Strategy (Oahas)
  - Prisoners with HIV/AIDS Support Action Network (PASAN);
  - HIV & AIDS Legal Clinic Ontario (HALCO)

- 11 capacity-building programs including:
  - 7 provincial organizations that provide training, information and other services to support local community-based AIDS services and other organizations
  - 3 priority population networks (PPNs) which each have a provincial office and network members based mainly in ASOs throughout the province:
    i. Gay Men's Sexual Health Alliance (GMSH)
    ii. African and Caribbean Council on HIV/AIDS in Ontario (ACCHO)
    iii. Women's HIV and AIDS Initiative (WHAI)
  - The Ontario HIV Treatment Network (OHTN), which provides data and evidence to improve HIV client services across Ontario
- 8 anonymous HIV testing programs
- 5 community-based HIV clinics
- 15 hepatitis C teams and 5 additional organizations funded to deliver hepatitis C services, which work closely with physicians, providing HCV care and treatment, education, outreach and support services.

OCHART data collection tools and support

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

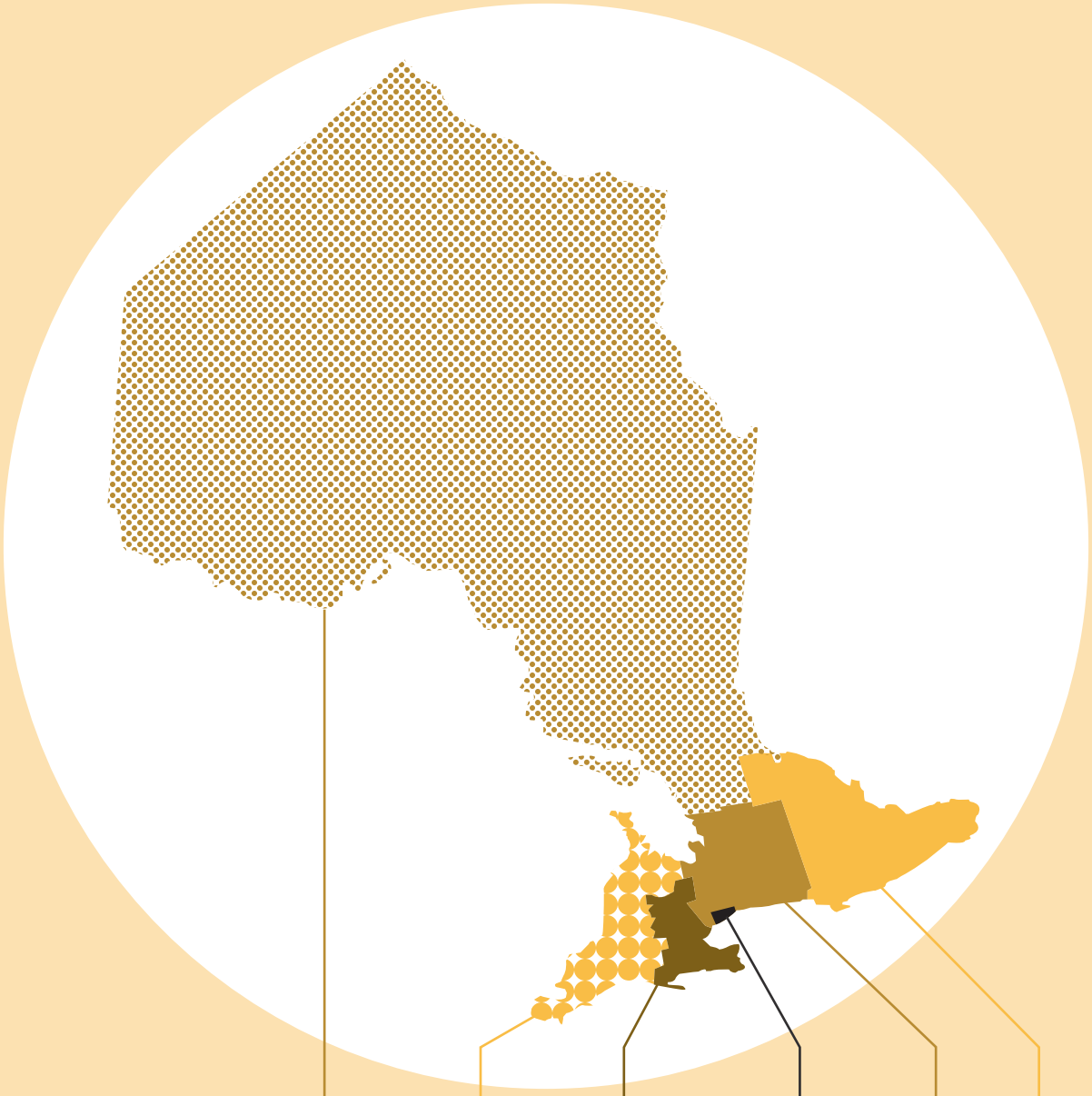
How OCHART data is used

OCHART data is used to:

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

For data limitations, please see Appendix A: Data limitations.

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



	Northern	South West	Central West	Toronto	Central East	Ottawa & Eastern
ASO	3	2	5	11	4	3
Anonymous testing	2	2	1	1	1	1
Clinical services	1	–	2	1	1	–
Non-AIDS service organization	5	1	1	24	–	6
Direct services provincial	–	–	–	4	–	–
HCV position	1	–	–	3	1	–
HCV team	4	2	4	2	1	2

Epidemiology

New diagnoses

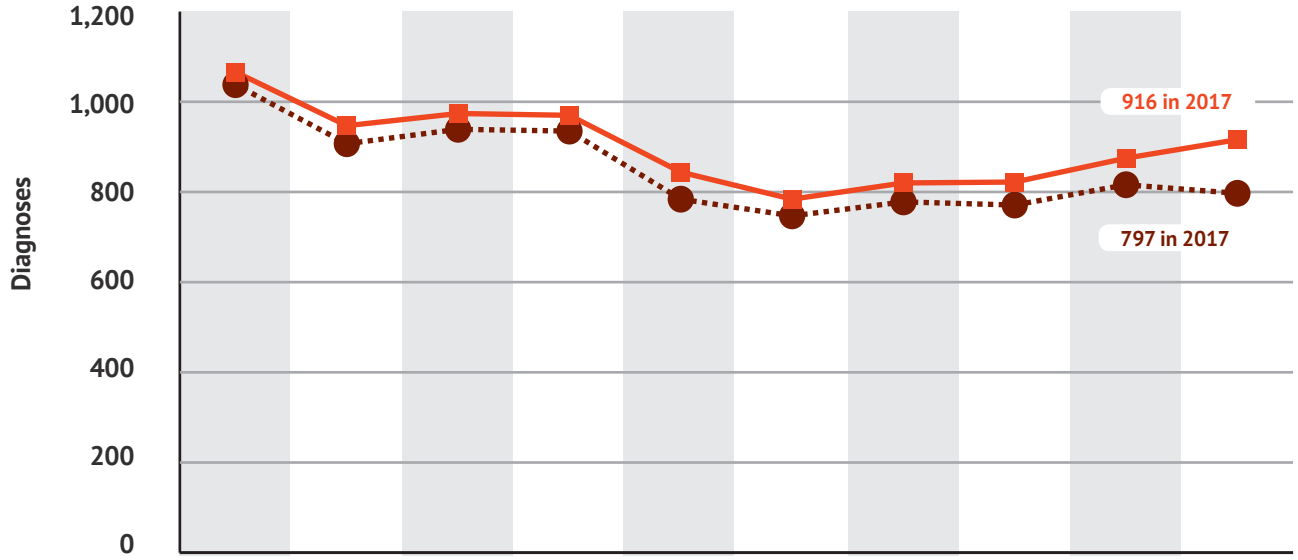
In 2017, there were 916 new HIV diagnoses in Ontario.

Over the past five years, Ontario has had between 800 to 900 new HIV diagnoses each year – down from the approximately 1,000 diagnoses a year between 2008 and 2011, but still equal to more than two new diagnoses each day.

Despite an overall decrease in the number of new diagnoses over the past decade, there has been a slight increasing trend since 2013, when there was a low of 784 new diagnoses. However, when individuals with a new diagnosis have evidence of a prior positive test outside of Ontario (also termed an 'out-of-province' diagnosis) are removed, the trend in new diagnoses between 2013 and 2017 appears more stable. Excluding these out-of-province diagnoses gives us 797 new diagnoses in 2017, which are more likely to be due to transmissions occurring in Ontario.

The relative number of out-of-province diagnoses increased between 2016 and 2017.

Number of new HIV diagnoses in Ontario, 2008-2017



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
All new HIV diagnoses	1,066	947	974	970	844	784	820	822	875	916
Excluding "out-of-province" diagnoses	1,038	907	939	935	784	747	778	771	816	797

Note: Data provided by the Public Health Ontario Laboratory.

By sex

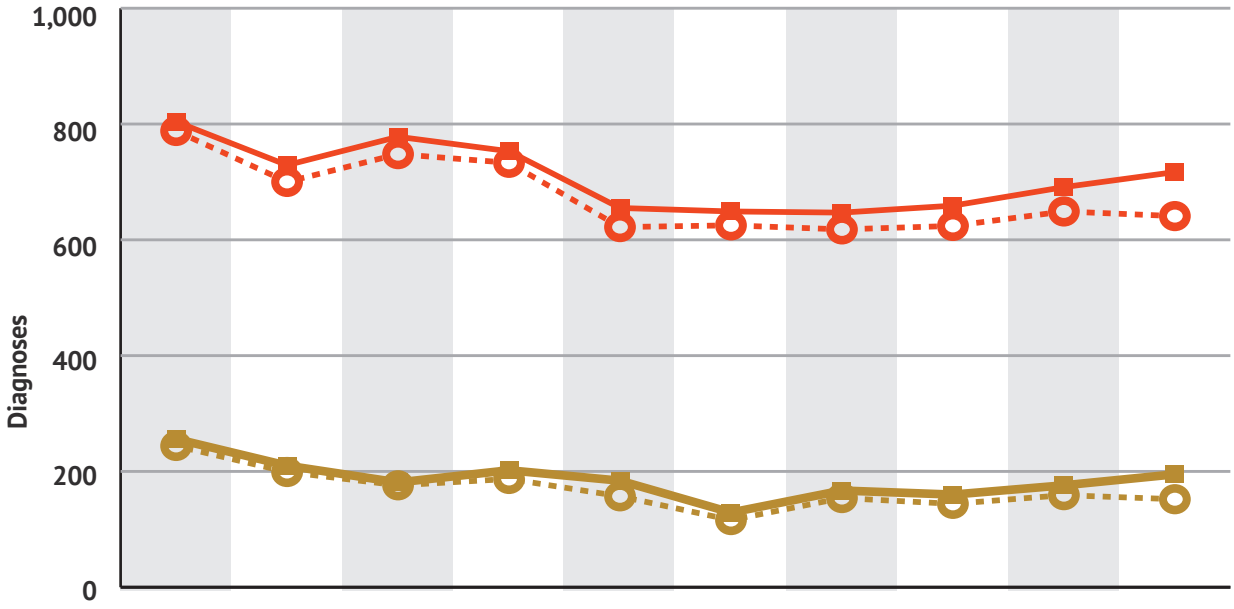
In 2017, four of every five people newly diagnosed in Ontario were male (717 or 78%) and one in five were female (195 or 21%). Sex was unknown for four diagnoses.

Snapshot: In 2016 and 2017 ...	
Female	**Male**
▸ African, Caribbean and Black women accounted for over half (55%) of new diagnoses in women ▸ Over half (56%) of newly diagnosed women were between the ages of 25-44	▸ 72% of newly diagnosed men were gay, bisexual or other men who have sex with men ▸ 50% were white ▸ 59% were between the ages of 25-44

Trends over time

The number of women diagnosed has increased since 2013, after having decreased between 2008 and 2013.	The number of men diagnosed has increased since 2014, after having decreased between 2008 and 2013.

Number of new diagnoses in Ontario by sex, 2008-2017



		2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
New diagnoses	Male	804	729	778	753	655	649	647	659	691	717
	Female	256	210	181	202	184	129	167	160	176	195
Excluding out of province	Male	788	700	748	733	622	625	618	624	649	641
	Female	244	199	176	187	157	116	154	144	159	152

Note: Data provided by the Public Health Ontario Laboratory.

By priority population

In 2016 and 2017 (combined),[1] more than half of new HIV diagnoses were in gay, bisexual and other men who have sex with men (54%), followed by individuals from African, Caribbean and Black communities (27%), at-risk women (21%), people who use injection drugs (12%), and Indigenous men and women (4%).

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

What are the priority populations?

The priority populations are:

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

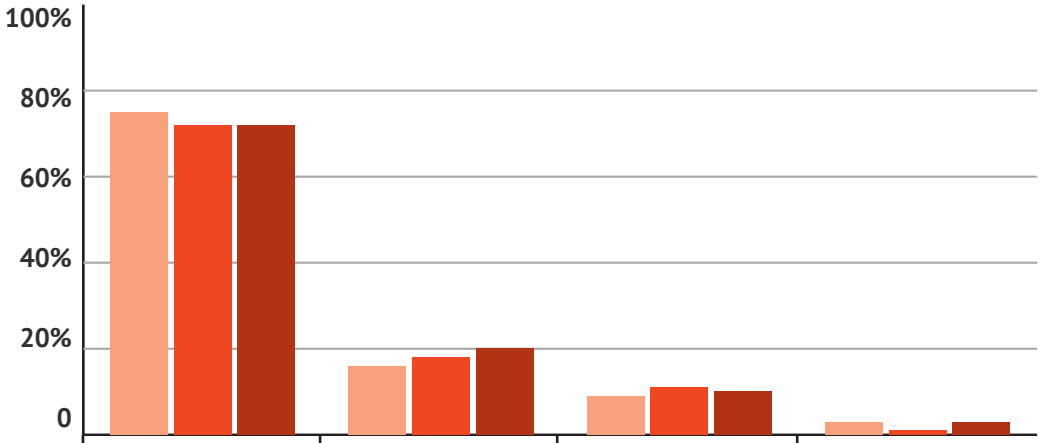
Trends over time

For men, between 2012-2013 and 2016-2017, there was a decrease in the proportion of new diagnoses among gay, bisexual, and other men who have sex with men (from 75% to 72%) and an increase in the proportion of new diagnoses among African, Caribbean and Black men (from 16% to 20%). Further analysis should be done to determine the relative percentage of ACB men who are also gay, bisexual or other men who have sex with men. The percentages of men who use injection drugs and Indigenous men were stable.

For women, between 2012-2013 and 2016-2017, there was a decrease in the proportion of new diagnoses among African, Caribbean and Black women (from 67% to 55%) and increases in the proportion of new diagnoses among women who use injection drugs (from 10% to 17%) and Indigenous women (from 2% to 7%).

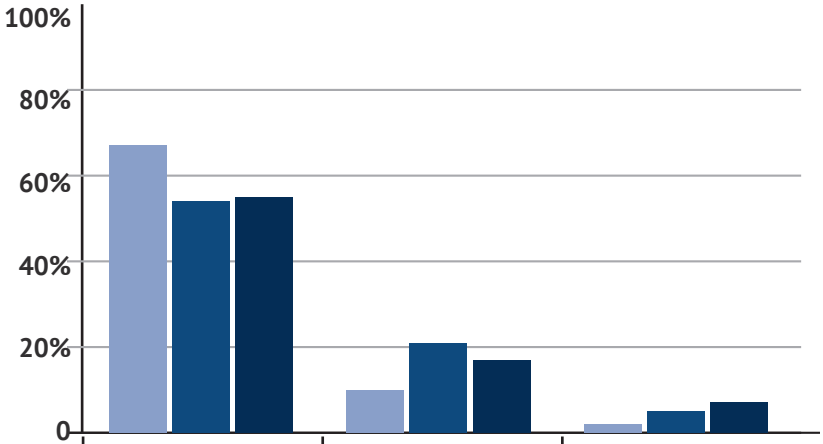
1 Combined over two years in order to reduce year-to-year variation due to small number of diagnoses in some priority populations (where information is known).

Percent of new male HIV diagnoses by priority population (where known), Ontario, 2012-2017



	Gay, bisexual and other men who have sex with men	African, Caribbean and Black communities	People who use injection drugs	Indigenous Peoples
2012-2013	75%	16%	9%	3%
2014-2015	72%	18%	11%	1%
2016-2017	72%	20%	10%	3%

Percent of new female HIV diagnoses by priority population (where known), Ontario, 2012-2017



	African, Caribbean and Black communities	People who use injection drugs	Indigenous Peoples
2012-2013	67%	10%	2%
2014-2015	54%	21%	5%
2016-2017	55%	17%	7%

Note: Data provided by the Public Health Ontario Laboratory.

By race/ethnicity

In 2016 and 2017 combined,[2] the most common race/ethnicity category for new HIV diagnoses was white (46%), followed by Black (26%), East/Southeast Asian (8%) and Latin American (8%).

Note: Race/ethnicity was unknown for about one-third of new diagnoses, and these are excluded from the data below.

Differences by sex/gender

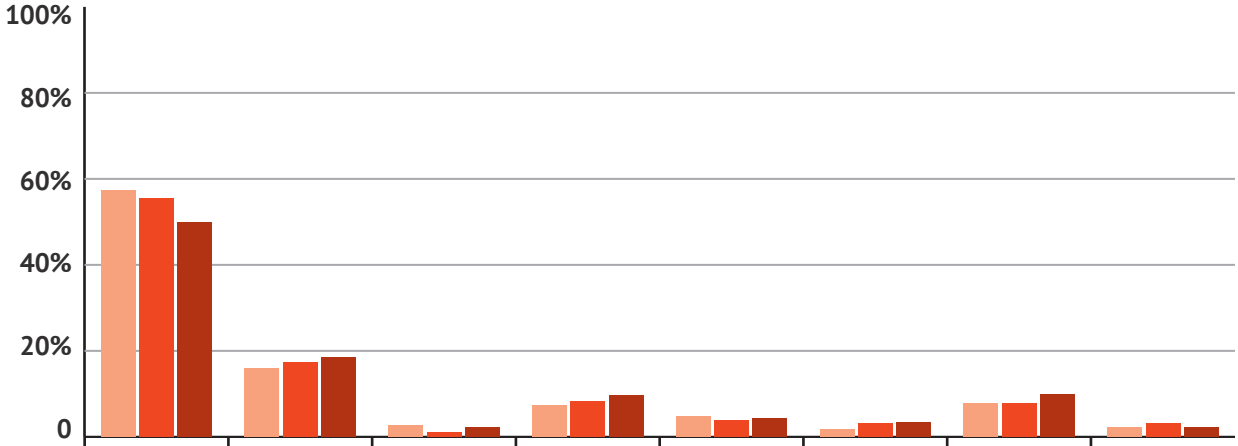
The most common races/ethnicities in 2016-17 differed by sex/gender. Among men, new diagnoses were most common among individuals who identified as white (50%), Black (18%), East/Southeast Asian (10%) and Latin American (10%). Among women, new diagnoses were most common among individuals who identified as Black (54%), white (30%), and Indigenous (7%).

Trends over time

Among men, between 2012-2013 and 2016-2017, the percent of new diagnoses decreased among white men (57.3% to 49.8%), and increased among Black (16.0% to 18.4%), East/Southeast Asian (7% to 10%) and Arab/West Asian (1.7% to 3.4%) men. Among women, the percent of new diagnoses increased among white (from 25% to 30%) and Indigenous (2% to 7%) women and decreased among Black women (66% to 54%).

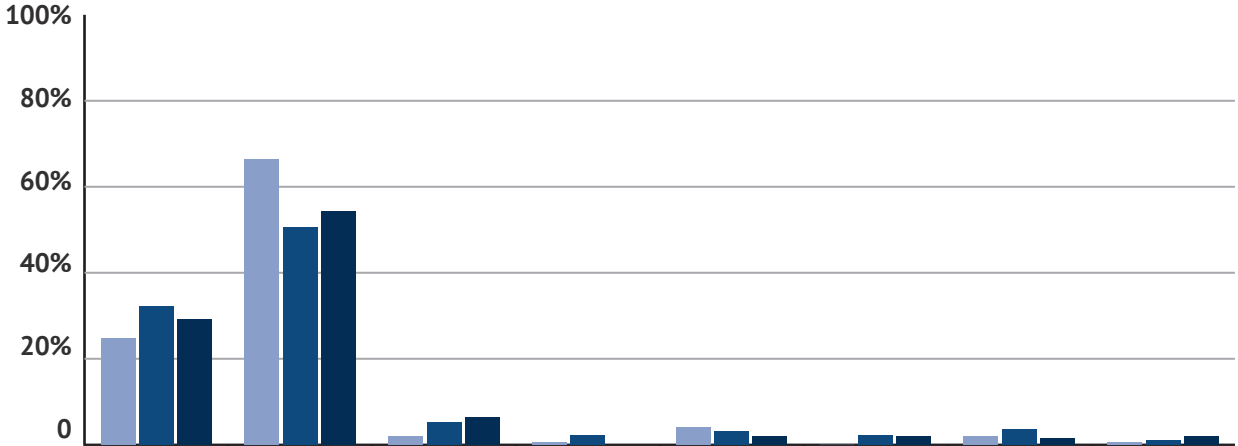
2 Combined over two years in order to reduce year-to-year variation due to small number of diagnoses in some races/ethnicities.

Percent of new male HIV diagnoses by ethnicity (where known), Ontario, 2012-2017



	White	Black	Indigenous	East/ South-east Asian	South Asian	Arab/ West Asian	Latin American	Other/ mixed race
2012-2013	57.3%	16.0%	2.7%	7.4%	4.8%	1.7%	7.8%	2.3%
2014-2015	55.4%	17.4%	1.0%	8.3%	3.9%	3.1%	7.9%	3.1%
2016-2017	49.8%	18.4%	2.3%	9.7%	4.4%	3.4%	9.8%	2.2%

Percent of new female HIV diagnoses by ethnicity (where known), Ontario, 2012-2017



	White	Black	Indigenous	East/ South-east Asian	South Asian	Arab/ West Asian	Latin American	Other/ mixed race
2012-2013	24.8%	66.3%	2.0%	0.5%	4.0%	0.0%	2.0%	0.5%
2014-2015	32.3%	50.5%	5.2%	2.1%	3.1%	2.1%	3.6%	1.0%
2016-2017	29.1%	54.3%	6.5%	2.4%	2.0%	2.0%	1.6%	2.0%

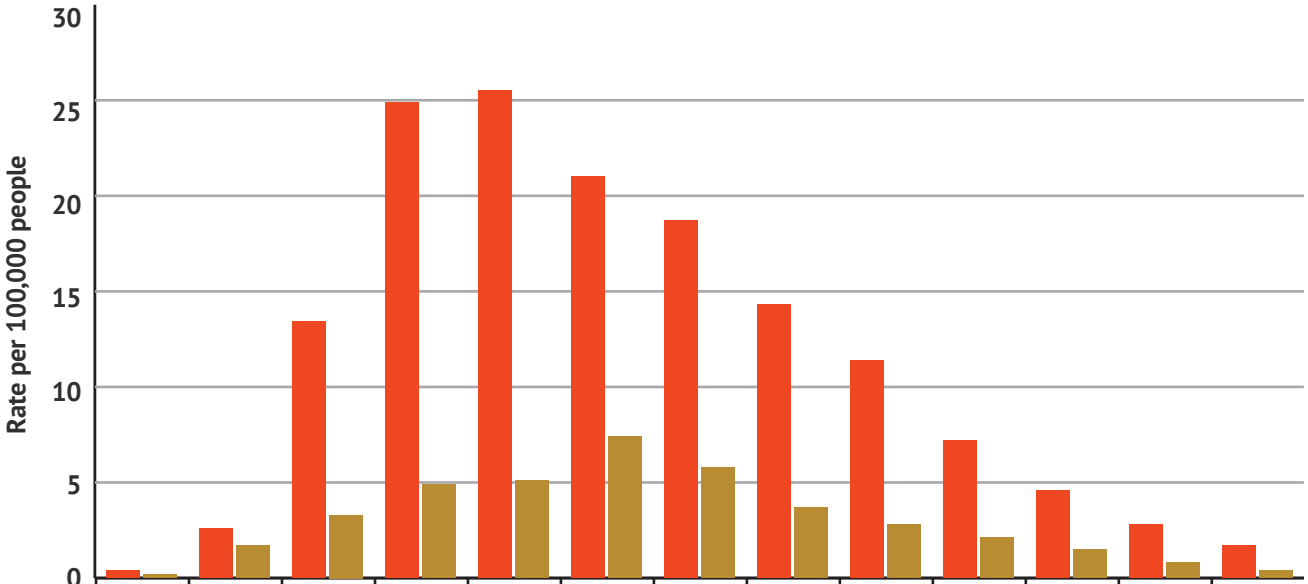
Note: Data provided by the Public Health Ontario Laboratory.

By age

In 2017, most new diagnoses among men were in people aged 25 to 29 years old and among women were in people aged 35 to 39 years old. However, in both men and women, about four of every 10 new diagnoses were in people age 40 years or older.

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

Rate of new HIV diagnoses per 100,000 people by sex and age (years), Ontario, 2017



Age	<15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Male	0.4	2.6	13.4	24.9	25.5	21	18.7	14.3	11.4	7.2	4.6	2.8	1.7
Female	0.2	1.7	3.3	4.9	5.1	7.4	5.8	3.7	2.8	2.1	1.5	0.8	0.4

Note: Data provided by the Public Health Ontario Laboratory.

Regional snapshot

In 2017, there were almost 500 new diagnoses in the Toronto region (accounting for 54% of all diagnoses in the province), followed by Central West, which had 120 new diagnoses in 2017.

However, numbers of new diagnoses don't tell the whole story. We calculate the rate of HIV – that is, the number of new diagnoses per 100,000 population – to account for population size when comparing geographies. When we also look at the rate, we see that some regions with a smaller or similar number of diagnoses compared to other regions, actually have higher rates of diagnosis. For example, while Ottawa had a lower number of diagnoses than Central West and South West, the rate of diagnosis was quite a bit higher.

Overall, compared to 2016, the number of new HIV diagnoses in 2017 increased in the Toronto and Central East regions and decreased in the Ottawa, Eastern, Central West, and South West regions. The highest rate of HIV diagnoses was in Toronto followed by Ottawa.

Health regions and public health units

Northern: Algoma; North Bay Parry Sound; Northwestern; Porcupine; Sudbury; Thunder Bay; Timiskaming

Ottawa: Ottawa

Eastern: Eastern Ontario; Hastings and Prince Edward Counties; Kingston, Frontenac, Lennox & Addington; Leeds, Grenville and Lanark; Renfrew

Toronto: Toronto

Central East: Durham; Haliburton, Kawartha, Pine Ridge; Peel; Peterborough; Simcoe Muskoka; York

Central West: Brant; Haldimand-Norfolk; Halton; Hamilton; Niagara; Waterloo; Wellington-Dufferin-Guelph

South West: Chatham-Kent; Elgin-St. Thomas; Grey Bruce; Huron; Lambton; Middlesex-London; Oxford; Perth; Windsor-Essex

Number and rate of new HIV diagnoses by health region, Ontario, 2016 and 2017

	Northern		Ottawa		Eastern		Toronto		Central East		Central West		South West	
Year	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Number of new HIV diagnoses	21	21	85	77	26	19	427	496	97	120	107	87	100	86
Rate of new HIV diagnoses per 100,000	2.6	2.6	8.7	7.7	3.1	2.2	14.9	16.9	2.3	2.8	4	3.2	6.1	5.2

Note: New diagnosis data provided by the Public Health Ontario Laboratory; population data from Statistics Canada

HIV Care Cascade

Using public health laboratory data on diagnostic tests and viral load data, we can measure the HIV care cascade. The care cascade is a framework to monitor whether people living with HIV have been diagnosed, are in care, taking antiretroviral treatment, and maintaining a suppressed viral load. These are all required for people living with HIV to achieve optimal health.

To focus world attention on the importance of HIV prevention and treatment, UNAIDS established the "90-90-90" targets:

- 90% of people living with HIV will be diagnosed
- 90% of those who are diagnosed will be on antiretroviral treatment
- 90% of those on antiretroviral treatment will be virally suppressed.

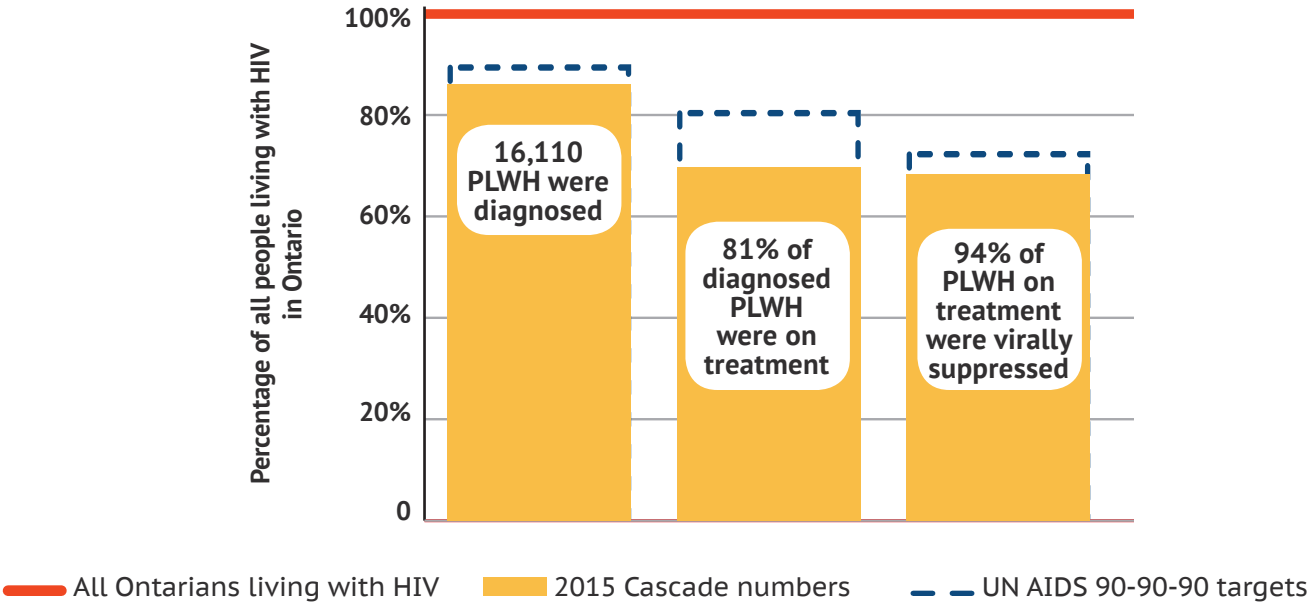
Ontario's progress toward 90-90-90

Ontario has committed to working toward the UNAIDS 90-90-90 targets. As of 2015 in the province:

- 86% of people living with HIV were diagnosed
- 81% of those diagnosed were on antiretroviral treatment
- 94% of those on antiretroviral treatment were virally suppressed.

While the UNAIDS targets are ambitious, they will get us only part of the way to eliminating HIV. When we reach the targets, 90% of all people living with HIV will be diagnosed, 81% of all people living with HIV will be on treatment, and 73% of all people living with HIV will be virally suppressed.

Ontario's progress toward the UNAIDS 90-90-90 targets, 2015

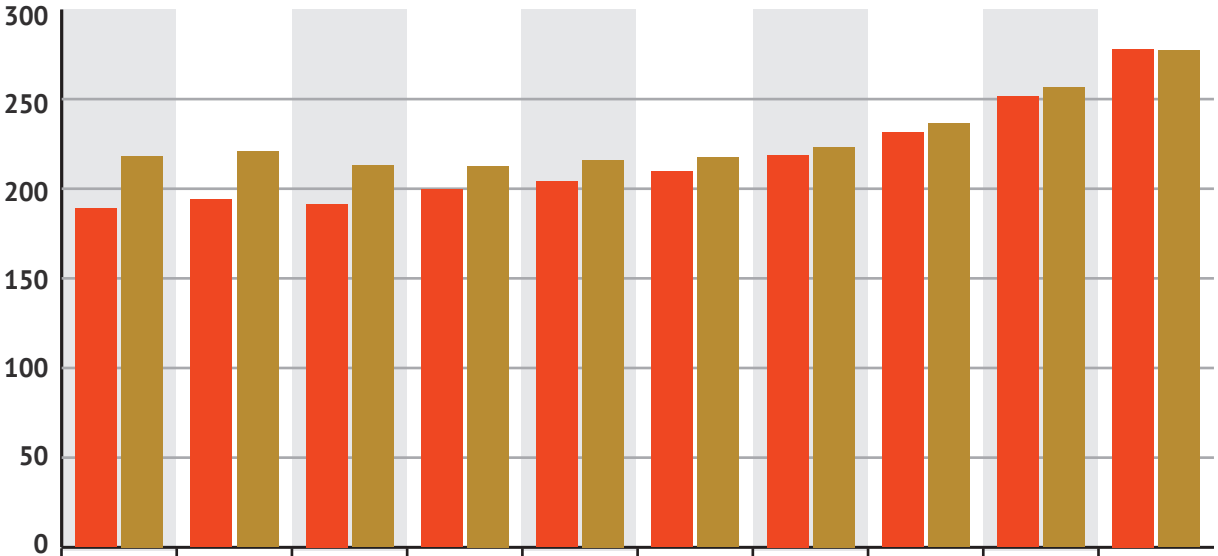


Testing

A snapshot of HIV testing in Ontario:

- 574,035 HIV tests in Ontario in 2017
- 916 of those tests were positive, equivalent to a 0.16% positivity rate
- The total number of HIV tests continues to increase each year, and has increased 30% since 2013

Number of HIV tests (thousands) by sex, Ontario, 2008 to 2017



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Male	188,983	193,915	191,515	199,622	203,948	209,714	218,870	231,284	251,487	277,849
Female	218,188	220,657	212,960	212,606	216,070	217,424	223,237	236,316	256,343	276,987

Note: Tests where sex is known. Data provided by the Public Health Ontario Laboratory.

HIV Services

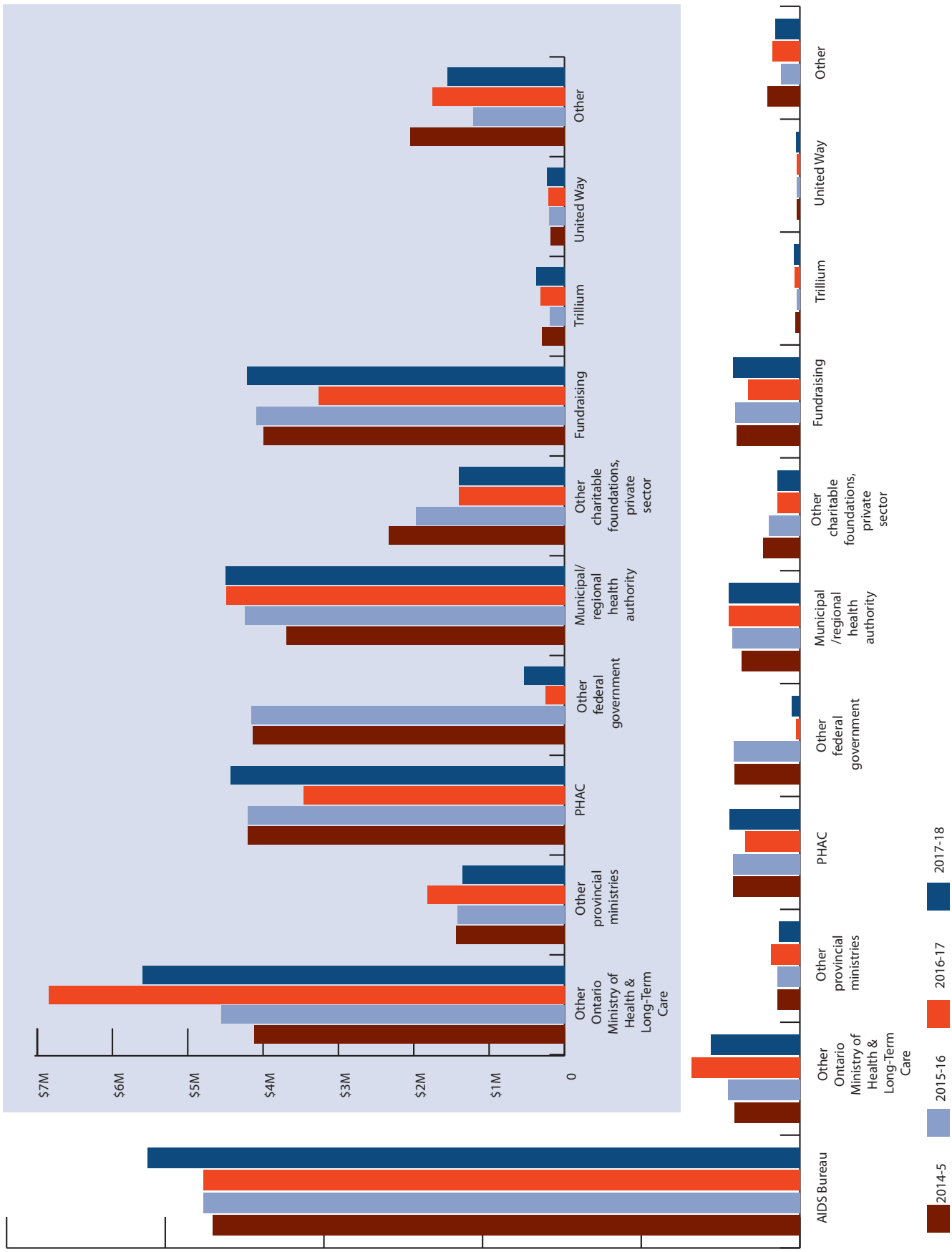
Funding increased in 2017-18

In 2017-18, the sector received a $3,500,000 increase in AIDS Bureau funding. The sector also reported an additional $967,000 from the Public Health Agency of Canada (PHAC), $944,000 from fundraising, and a combined increase of $371,000 from other federal government sources, municipal/regional health authorities, the Ontario Trillium Foundation, and the United Way. Overall, there was an increase in funding to $65,289,000 (6%), from $61,521,000 in the previous year.

Organizational funding amounts by source

	2014-15	2015-16	2016-17	2017-18
AIDS Bureau	$37,000,000	$37,600,000	**$37,600,000**	**$41,100,000**
Other Ontario Ministry of Health & Long-Term Care	$4,117,141	$4,552,044	$6,841,742	$5,599,923
Other provincial ministries	$1,442,933	$1,423,908	$1,821,327	$1,349,259
PHAC	$4,200,000	$4,200,000	$3,462,780	$4,4301,03
Other federal government	$4,137,443	$4,160,439	$249,374	$540,571
Municipal/regional health authority	$3,691,507	$4,244,011	$4,492,194	$4,493,585
Other charitable foundations, private sector	$2,330,015	$1,968,980	$1,405,113	$1,402,828
Fundraising	$3,998,472	$4,085,264	**$3,265,425**	**$4,209,487**
Trillium	$301,032	$194,368	$320,300	$377,146
United Way	$186,752	$203,315	$212,073	$233,174
Other	$2,046,847	$1,214,308	$1,750,300	$1,553,147
Total	**$63,452,142**	**$63,846,637**	**$61,420,628**	**$65,289,223**

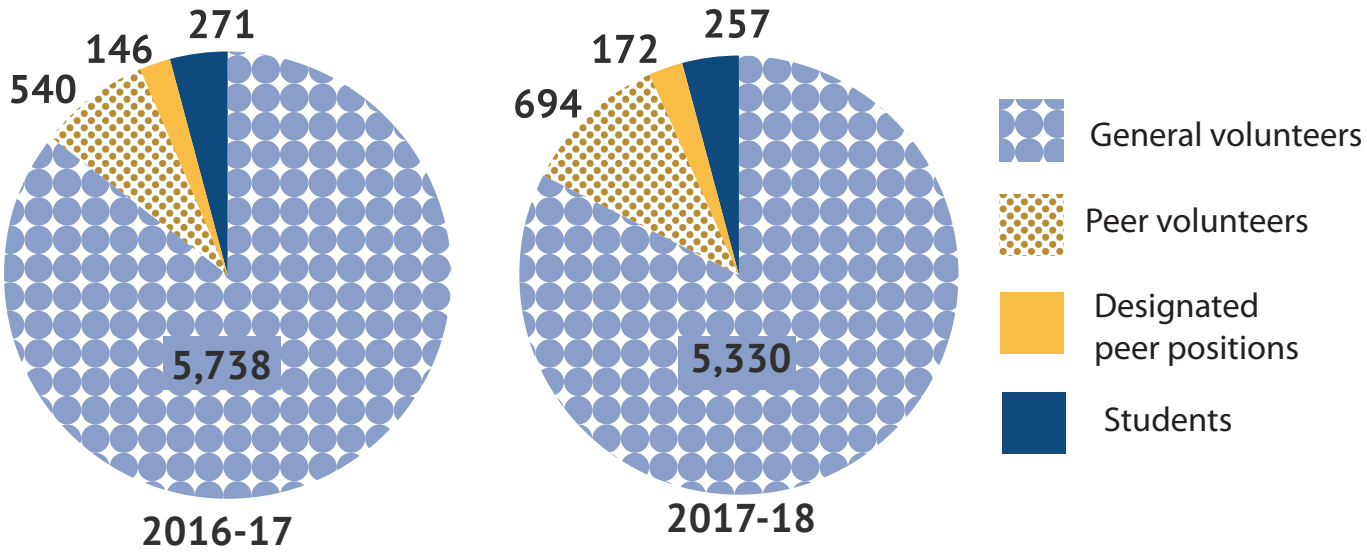
Organizational funding amounts by source



More peers; fewer volunteers and students

From 2016-17 to 2017-18, there was an increase in the total number of peer volunteers, from 540 to 694 (29% increase). There was also a 21% increase in the number of designated, paid peer positions (from 146 to 172) over the same period of time. Slightly fewer student placements were reported in 2017-18 (257) than in 2016-17 (271).

Number of peers, volunteers, and student placements



Fewer volunteers engaged in more hours of work

In 2017-18, programs reported 5,330 volunteers, 7% fewer than in the prior year. However, the number of hours donated by volunteers increased by 8% from 188,483 in 2016-17 to 203,570 in 2017-18. The number of hours volunteered in the sector equals 98 full-time equivalent employees (FTEs) of work in addition to paid employees. Volunteers invested 203,570 hours of time valued at $4,825,719.[1] This is an average of each volunteer donating $905 to the prevention of HIV and to improving the lives of people living with HIV.

Volunteer Hours

8% increase

2017-18

203,570 hrs

2016-17

188,483 hrs

1 See Appendix B.

Narrative Analysis

Themes in community-based HIV prevention, support, and harm reduction services

The ministry funds HIV-specific programs within agencies offering broader health and social services as well as specialized AIDS service organizations (ASOs). Many of these agencies and programs also conduct harm reduction work, whether those activities are ministry-funded or through other partnerships. Ministry-funded HIV programs who work with people living with, at-risk, or affected by HIV in the areas of prevention, outreach, support services, and harm reduction are asked to complete a number of qualitative, narrative questions in OCHART. Analysis of narrative responses shows diversity among organizations in terms of services offered and populations served, as well as common themes across all organizations.

Theme 1: Agencies use community partnerships and coordinated case management to address clients' complex needs.

Organizations made efforts to create new programs and to improve existing programs by leveraging community resources to meet client needs. They work with other community organizations to avoid service duplication and to create better access to services for clients. For example, Hospice Toronto works with various community health care clinics that offer HIV support such as Sherbourne Health, South Riverdale Community Health Centre, and Toronto Public Health.

The Regional HIV/AIDS Connection created "two new memorandums of understanding (MOUs) with local service providers which supported intakes and linkages to ongoing care with priority populations." Some organizations sought to increase client access to care and support services by developing coordinated case management or circle of care programs.

> Our support workers continue to develop relationships with local service providers and offer support to them around understanding our clients' unique needs.
>
> — Positive Living Niagara

> We connect our clients to organizations we have relationships with, many of whom have undergone training with us on how to work well with sex working populations.
>
> — Maggie's: The Toronto Sex Workers Action Project

Theme 2: Community development improves client services and retention in care.

Effective community development leads to the development of evidence-based programming so that clients can more easily access testing, clinical care, and other resources. Some examples include providing on-site medical care and point-of-care testing, counselling, and warm referrals in which frontline workers accompany clients to appointments. In addition, these relationships with other service providers allow frontline workers to feel confident that clients will experience stigma-free care when referred to other services. For example, the AIDS Network notes that "our close relationships with the health care professionals in our regions allow us to make warm referrals and talk to clients about any concerns they may have in accessing care and treatment". Ontario Aboriginal HIV/AIDS Strategy-Sudbury reiterated the importance of community development and warm referrals:

> We physically take [clients] to care or bring services directly to where they are at. We also explain services and processes so that they are less scary and are more likely to be approached and utilized.
> —Oahas (Ontario Aboriginal HIV/AIDS Strategy-Sudbury)

> Supporting clients from a holistic framework includes things like transportation and financial assistance to support appointments with the clinic, direct conversations regarding treatment access, adherence, and symptom management.
> —AIDS Committee of Windsor

Theme 3: Access to and knowledge about biomedical prevention, including PEP, PrEP and U=U, continues to increase.

The larger HIV community's widespread acceptance of the scientific evidence surrounding undetectable=untransmittable (U=U) has led to increased awareness about treatment as prevention — thanks to agencies' awareness campaigns and other national/international media campaigns about Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP) and U=U. This awareness has led to increased demands for information and resources related to PrEP and U=U. For example, the Ottawa Hospital Research Institute has reported an increase in demand for PrEP among men who have sex with men.

> We have good, on-going relationships with hospital clinics and community providers. The activities that have increased are PEP and PrEP referrals.
> — Hassle Free Clinic

> RHAC partnered with a local sex-positive, queer-positive sex shop and LIHC's Options Clinic to offer an information night about PrEP that included opportunities for testing.
> — Regional HIV/AIDS Connection

> We provide information on HIV treatment through a variety of organized events in the evening (e.g., Gay Bar Outreach) that encourages contact with gay PHAs and discussion on the importance of adherence to medication and the use of PrEP and PEP.
> —Réseau ACCESS Network

Theme 4: Agencies are expanding harm reduction teaching, training and services to address the opioid overdose crisis.

Organizations that serve people with HIV have been stepping up to address the devastating effects of the opioid overdose crisis through prevention, education, and harm reduction. For example, Black Coalition for AIDS Prevention noted that "the opioid overdose crisis has resulted in a significant amount of near-fatal overdose and deaths. This has led to an increase in the number of requests we received for naloxone kits". The City of Ottawa Public Health reported several trends as a result of increased rates of opioid overdoses:

> We have seen an increase in demand for naloxone trainings/kits, overdose prevention services, and supervised injection services. We are continuing the assessment of harm reduction services in Ottawa to address the high rates of HIV and Hepatitis C among local populations using drugs.
> — City of Ottawa Public Health

Many organizations are responding to the rise in opioid-related overdoses by expanding their harm reduction and outreach services. Hamilton Public Health and Community Services increased hours for their mobile needle exchange program and expanded access to naloxone through community agencies. In addition to the opioid overdose crisis, many clients are continuing to use crystal meth and crack. In response, organizations are making increased efforts to supply crystal meth and crack pipes and other related harm reduction supplies.

> [There has been a] large increase in demand for HIV/harm reduction/substance use supplies, support, and services due to [the] overdose crisis. Many new participants [are using] opiates as their drug of choice. Crystal meth remains one of the top drugs, meaning that we need to be equipped with appropriate supplies.
> — AIDS Committee of Durham Region

> The opioid crisis has resulted in a significant amount of near fatal overdoses and deaths. This has led to an increase in the number of requests we received for naloxone kits. We also saw an increase in demand for crystal meth pipes. The increase in requests for meth supplies during outreach shifts has highlighted the issue of stigma that individuals who smoke crystal meth experience from peers when requesting supplies in a larger group setting.
>
> — Black Coalition for AIDS Prevention

Theme 5: Peers and volunteers are engaged to address social determinants of health, including stigma, discrimination, and isolation.

Stigma, discrimination, and isolation continue to impact the health and wellness of people living with HIV. Organizations are continuing to mobilize the skills and experiences of peers and volunteers to help address both barriers to care and social determinants of health in areas such as treatment, adherence, stigma, and wellness. Some examples include:

- The use of peer navigators/mentors to provide peer support for newly diagnosed women (Women's Health in Women's Hands)
- A peer support group for children living with HIV to connect them with each other and other services (The Teresa Group)
- A peer navigation model of care-accompaniment to services (Alliance for South Asian AIDS Prevention)
- Peers sharing their experiences around treatment and adherence (AIDS Committee of Cambridge, Kitchener, Waterloo and Area)
- Peer engagement/buddy system: peers check in with each other through telephone and texting (The Gilbert Centre).

> Being a peer and sharing my own personal experiences as it pertains to medication adherence as well as sharing strategies that have worked for others helps to normalize taking medications daily.
>
> — AIDS Committee of Cambridge, Kitchener, Waterloo and Area

> Service users who use services at both Maggie's and Prisoners' HIV/AIDS Support Action Network have connected with each other and provided peer support around treatment and other issues affecting sex workers living with HIV.
>
> — Maggie's: The Toronto Sex Workers Action Project

Theme 6: Outreach and warm referrals connect and retain clients in care.

Many programs continue to focus their resources on ensuring that clients are retained in care, especially vulnerable and hard-to-reach clients. In addition, adherence has become even more important given the impact of treatment as prevention. Some organizations use specific outreach strategies to meet clients where they are. For example, Regional HIV/AIDS Connection reported that they "expanded outreach support services to try and 'catch people where they live' in an effort to literally walk with them if necessary to the local health clinic for treatment". In addition, the AIDs Network makes reminder calls for clinic appointments because many of their clients experience issues with memory.

> For those who have difficulty keeping appointments, have difficulty taking medications, or difficulty following through with planned treatments, an intensified effort has been put forth in staying in touch with them and offering any assistance we can in an effort to retain them not only into treatment but ongoing support and care.
>
> — Group Health Centre

> When we meet clients who are not connected to care we make it a priority to refer them to physicians, including HIV specialists. We have found that what works best is to make the referral in the client's presence and to accompany them on the first appointment. Where possible, we may even accompany them on follow-up or request assistance through the Circle of Care program for accompaniment.
>
> — Black Coalition for AIDS Prevention

Other trends included increased requests for settlement and mental health services as well for PrEP by gay men. Clients continued to experience challenges around mental health, housing and food security, HIV stigma, the physical and psychosocial impacts of aging, increased comorbidities, and the impacts of HIV criminalization.

Prevention Education

Key points

- In 2017-18, the total number of outreach activities where significant outreach contacts were made increased 26% from 1,919 in 2016-17 to 2,416 activities.
- The number of education presentations and workshops delivered by organizations increased 8% from 1,585 in 2016-17 to 1,707 in 2017-18.
- Organizations reported developing 144 new information and health-teaching materials in 2017-18, 78% of which focused on general health promotion and HIV prevention/sexual health.
- In 2017-18, organizations reported providing 975 education activities to other service providers, a 3% increase from 2016-17. Capacity building workshops accounted for 45% of activities, consultations accounted for 15%, and information sessions for 40%.
- Both ASOs and non-ASOs held more community meetings in 2017-18 compared to the previous year. ASOs held 52 activities (an increase of 24 or 86%) with 2,623 participants (83% increase).

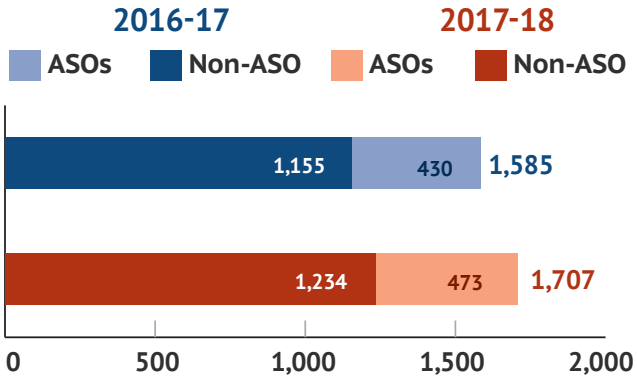
Prevention education, outreach and community development

For the 2017-18 fiscal year, 54 programs that deliver prevention education, outreach and community development services tracked their activities using OCHART. Data is now being collected in two streams: activities targeted to service users and activities targeted to service providers. Activities are also linked to priority populations targeted. The number of ASOs reporting prevention education, outreach, and community development activities remained the same as last year at 34 organizations, and the number of non-ASOs reporting these activities decreased from 22 to 20.

More education presentations and workshops

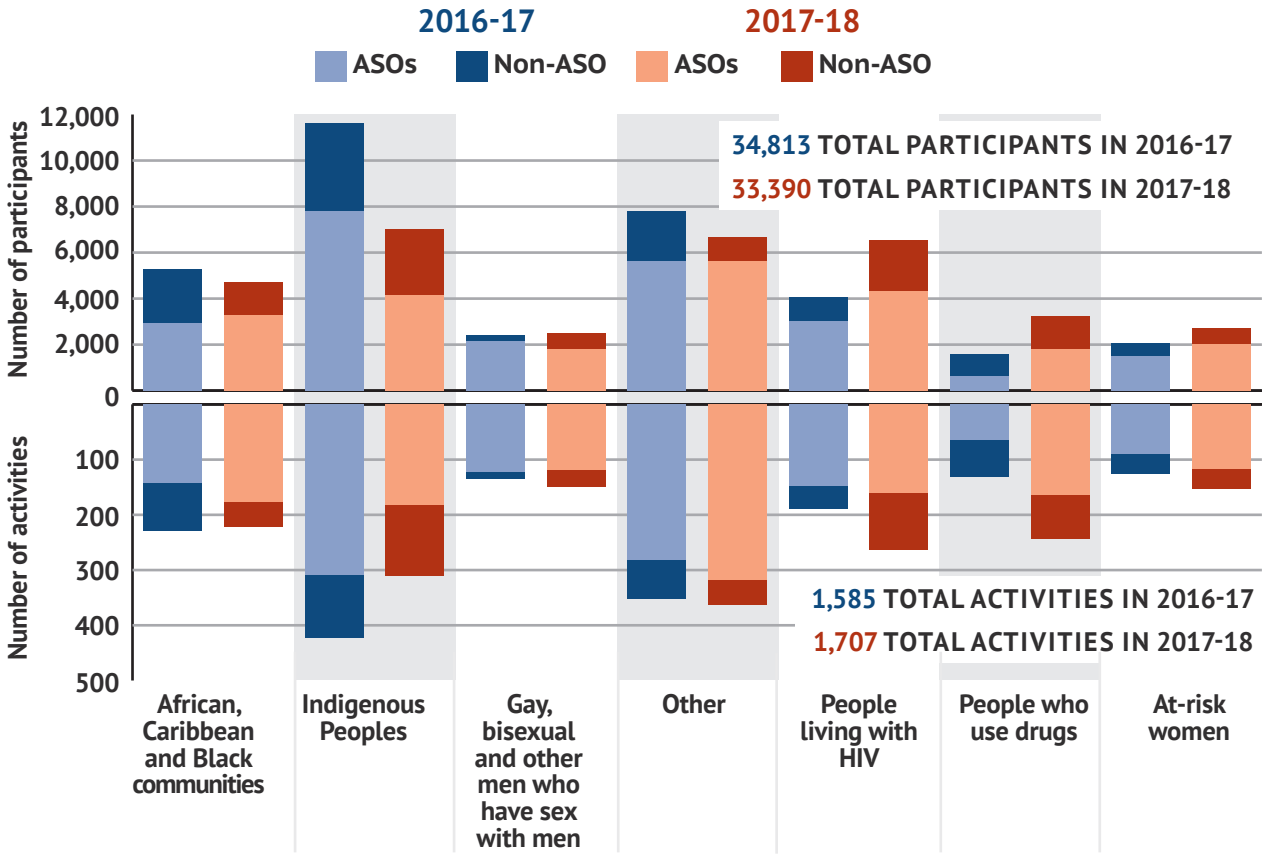
Both ASOs and non-ASOs conduct education, outreach, and community development work. ASOs typically work with a wide range of populations, while non-ASOs have more targeted audiences. In 2017-18 more education presentations and workshops were conducted by both ASOs (7% increase) and non-ASOs (10% increase) than in 2016-17. In total, the number of education presentations and workshops delivered by organizations increased 8% from 1,585 in 2016-17 to 1,707 in 2017-18. While the number of activities increased from one year to the next, the number of participants decreased slightly (4% fewer; 34,813 to 33,390).

The number of education presentations and workshops delivered by ASOs and non-ASOs by year OCHART Q3.4



When looking at the number of activities delivered to each priority population, the number of activities increased for all populations except those to Indigenous Peoples (27% fewer; 423 to 310) and African, Caribbean and Black communities (3% fewer; 228 to 222). The number of participants at activities for Indigenous Peoples decreased 39% and participants at activities targeting African, Caribbean and Black communities decreased 10%.

The number of education presentation/workshop activities targeted to priority populations and the number of participants by year OCHART 3.4



Note: Commonly reported "other" priority populations include youth at risk of HIV, migrants, refugees, and trans individuals.

More significant outreach contacts made

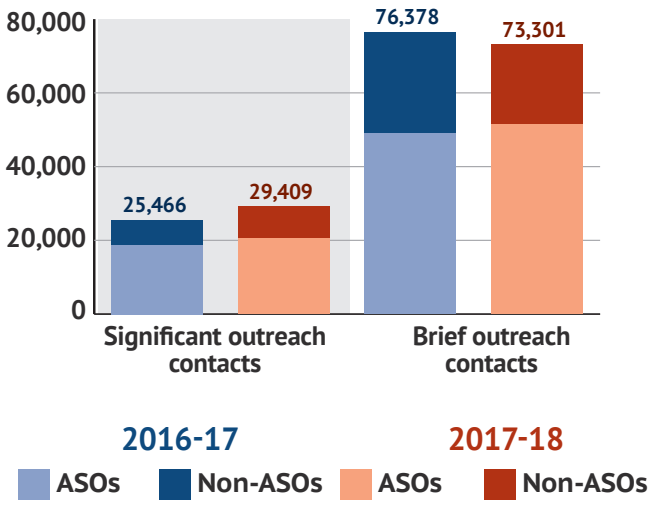
In OCHART, outreach is recorded by the number of brief and significant contacts made at activities. Brief outreach contacts are those made at large activities, such as Pride, where contacts tend to be limited to resource sharing, whereas significant outreach contacts entail a personal, two-way interaction between organization staff/volunteers and a member of the target population.

The number of activities where significant contacts were made increased significantly (26%) from 1,919 in 2016-17 to 2,416 activities in 2017-18. Additionally, the number of activities where brief contacts were made increased 2% from 1,508 last year to 1,540 in 2017-18.

While there was a slight decrease in the brief contacts made from 2016–17 (76,378) to 2017–18 (73,301), organizations reported a 15% increase in the number of significant contacts, from 25,466 last year to 29,409 this year. The shift toward more significant outreach contacts was mirrored in the number of individual contacts made and indicates that organizations are making more significant engagement with individuals during outreach activities.

Brief and significant outreach contacts made by year and organization type

OCHART Q3.4

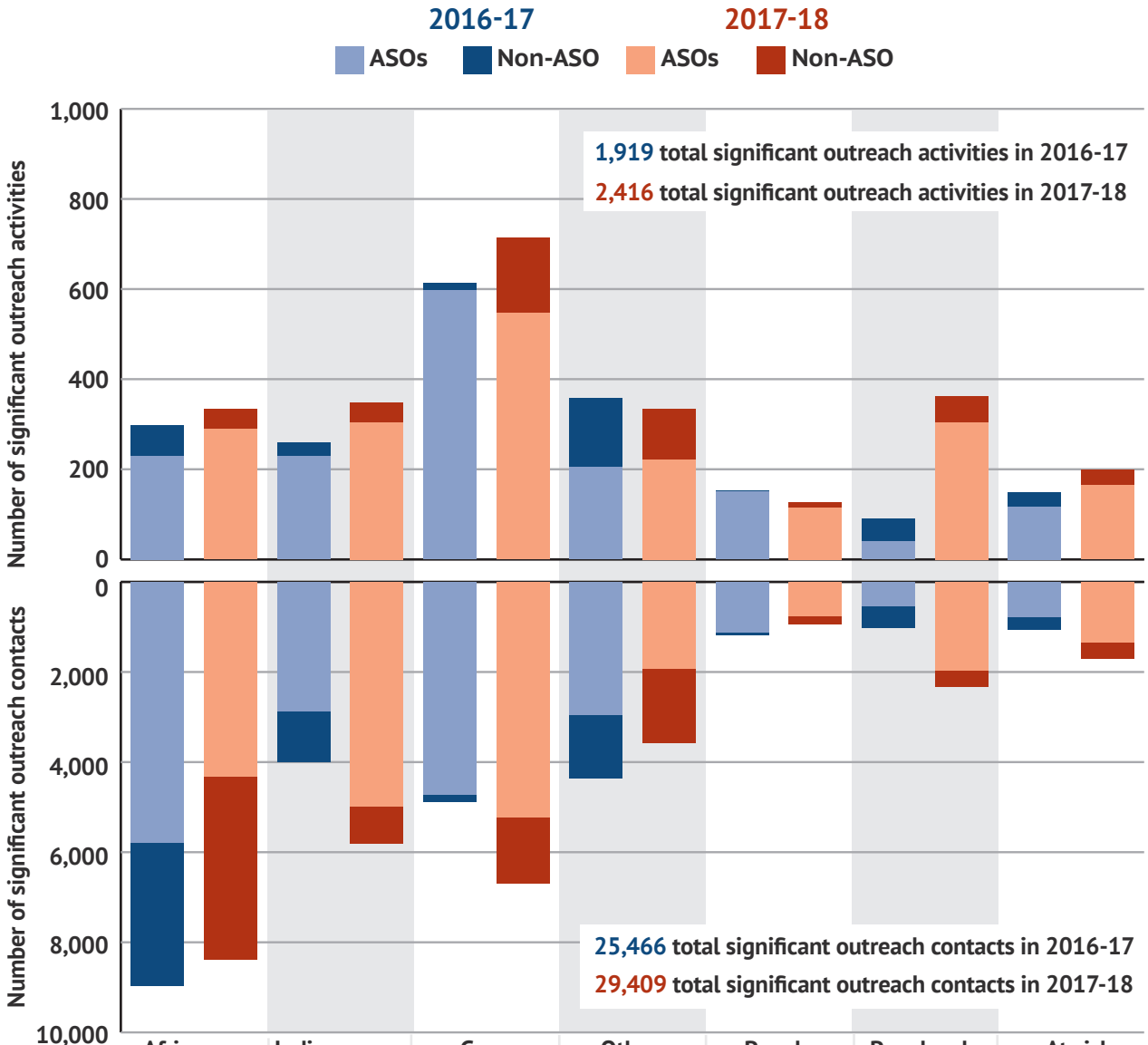


Priority populations

When comparing the populations targeted by outreach from 2016-17 and 2017-18, the number of activities targeted toward gay, bisexual and other men who have sex with men increased 10% from 1,017 activities to 1,120, and the number of activities targeted toward Indigenous communities increased 19% from 510 to 607. Between years, the number of activities targeted to people living with HIV decreased 29% from 258 to 182, while the number of activities for African, Caribbean and Black communities (from 589 last year to 598 in 2017–18) and "other" priority populations (from 520 to 491) remained relatively consistent.

Brief and significant outreach activities targeting priority populations OCHART Q.3.4

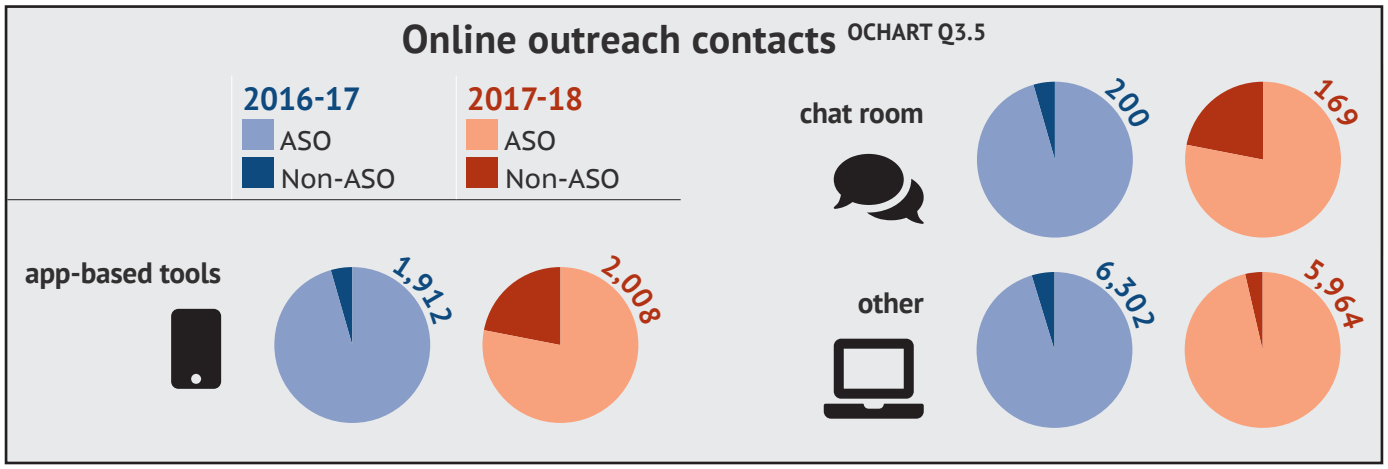
SIGNIFICANT OUTREACH



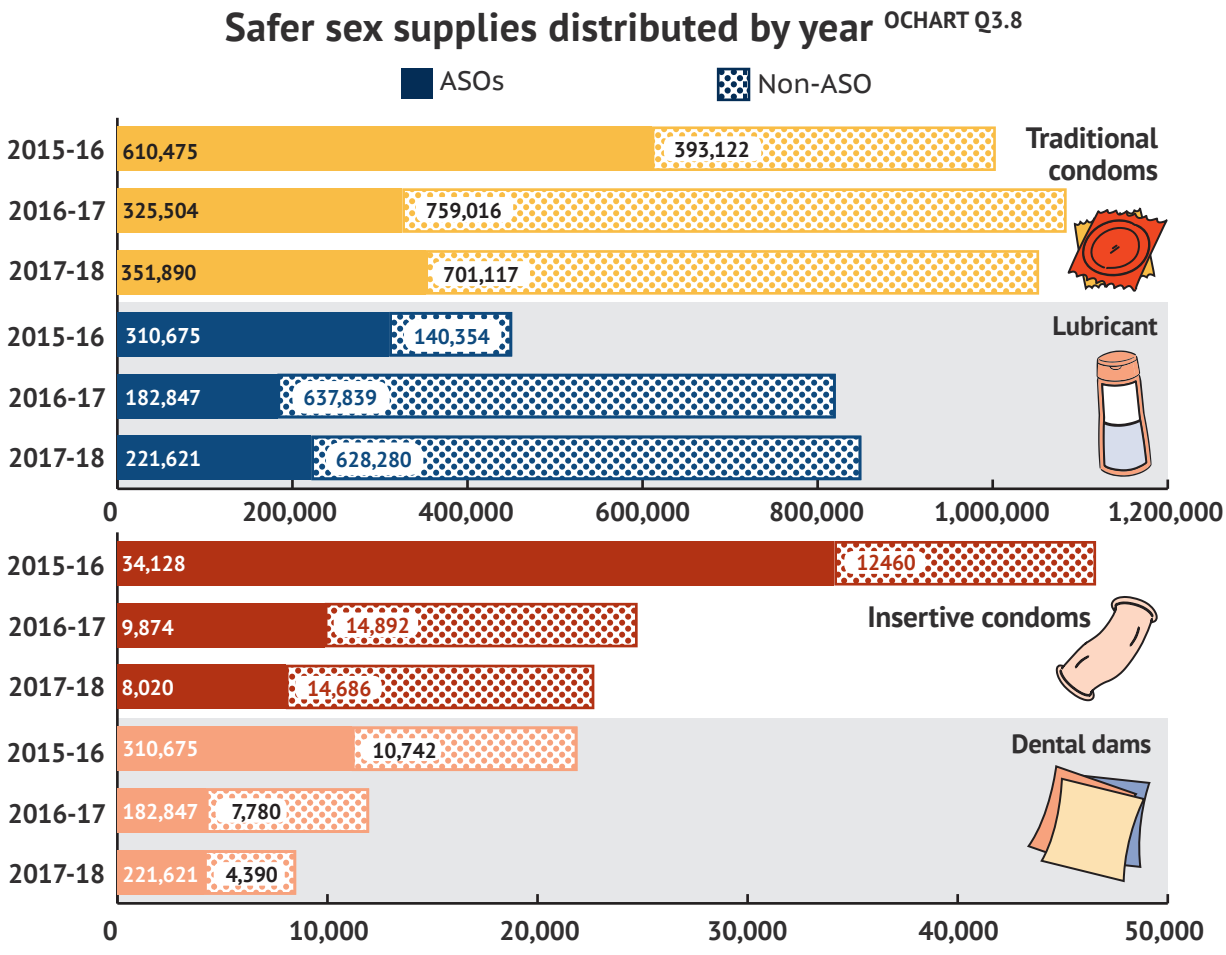
BRIEF OUTREACH	African, Caribbean and Black communities		Indigenous Peoples		Gay, bisexual and other men who have sex with men		Other		People living with HIV		People who use drugs		At-risk women	
	ASO	Non-ASO	ASO	Non-ASO	ASO	Non-ASO	ASO	Non-ASO	ASO	Non-ASO	ASO	Non-ASO	ASO	Non-ASO
2016-17 activities	222	69	199	51	388	16	135	28	105	0	33	44	201	49
2017-18 activities	222	41	214	46	351	55	136	22	51	5	206	42	96	21
2016-17 participants	18,747	12,008	6,185	11,825	14,087	1,057	5,485	1,054	1,655	190	567	1,191	2,213	114
2017-18 participants	15,704	8,073	9,764	5,548	13,786	4,322	5,012	1,437	1,310	436	3,527	1,104	2,407	871

Online outreach

Prevention education workers at reporting organizations also conduct outreach online in chatrooms, on smartphone apps, and other online venues like public forums on websites and specific social media pages.



Safer sex supplies



Structured interventions

A structured intervention is a distinct program that has clear goals and target audiences and includes specific activities that lead to measurable outcomes, with clear indicators of success. There is a defined series of steps that must be followed to implement a highly effective prevention program.

In 2017-18, 29 ASOs and nine non-ASOs reported conducting structured interventions, up from 25 ASOs and six non-ASOs the year prior.

The WILLOW (Women Involved in Life Learning from Other Women) intervention was developed in the US and has been shown to be a highly effective HIV skills-building intervention for women living with HIV. The first Ontario pilot of the intervention was conducted in Toronto at Women's Health in Women's Hands to assess its effectiveness among African, Caribbean and Black women living with HIV.

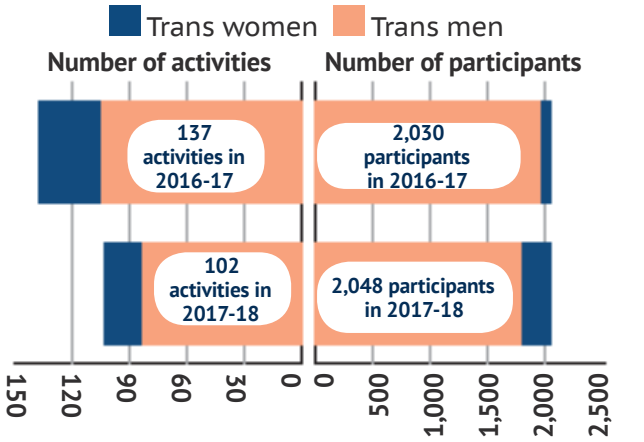
Gender Journeys, offered through the Canadian Mental Health Association at Peel HIV/AIDS Network, provides programming, education, and support services for transgender, 2-spirit, gender diverse and individuals who are questioning their gender identity.

Totally Outright was created by the Community-Based Research Centre for Gay Men's Health (CBRC) to strengthen community and health for young gay, bisexual, trans and queer (GBTQ) men. It has been implemented by a number of organizations across Canada and Ontario, including at the AIDS Committee of Ottawa, AIDS Committee of Toronto, AIDS Committee of Durham, Peel HIV/AIDS Network, and Peterborough AIDS Resource Network.

More education and outreach activities targeting trans men and women

Eighteen organizations reported delivering activities for trans individuals in 2017-18, one more than in the prior year. These organizations reported 26% fewer (from 137 to 102) activities for trans individuals than in 2016-17. However, roughly the same number of people attended these activities in 2017-18 (2,048) as in the previous year (2,030).

Number of activities for trans men and women and the number of participants at those activities OCHART Q3.4



PPN materials used more often

The Priority Population Networks (PPNs), which focus on the specific needs of priority populations across the province, include:

ACCHO
African and Caribbean Council on HIV/AIDS in Ontario

GMSH Gay Men's Sexual Health Alliance

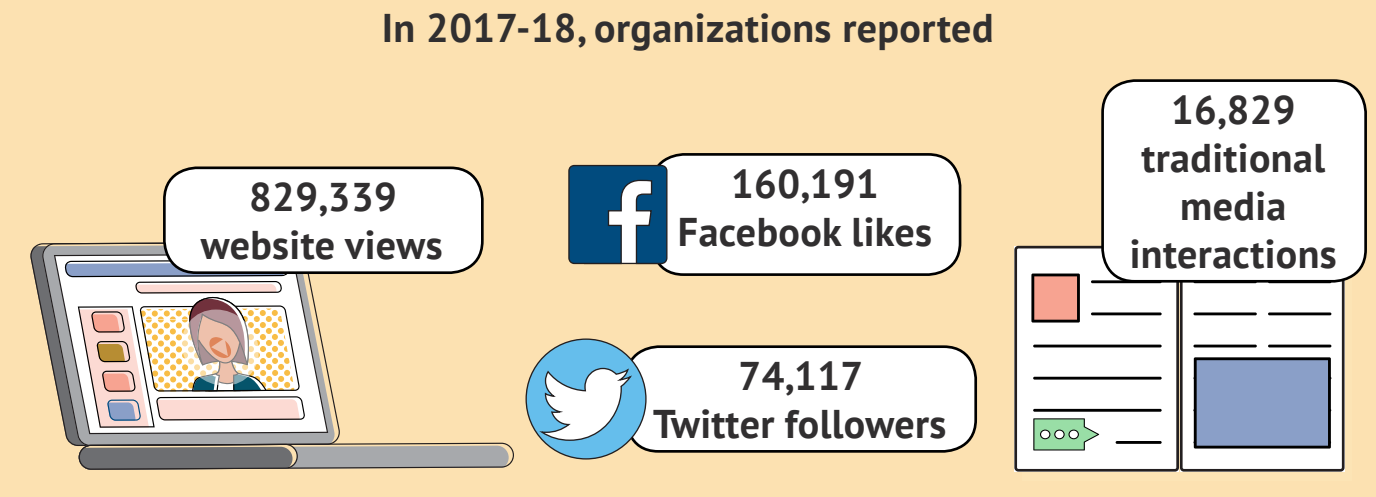
WHAI Women & HIV/AIDS Initiative

As part of the PPNs, the AIDS Bureau funds positions at organizations across Ontario to work to reach these populations and/or improve service delivery to them. Their work is guided by the resources, tools, campaigns, and capacity building initiatives developed by the PPNs. Thirty-two organizations reported using materials developed by one of the priority population networks during at least one activity in 2017-18, one more than in 2016-17. Materials developed by each of the three PPNs were used at more activities compared to the previous year, being used at a total of 393 prevention education activities in 2017-18, a 48% increase from the 265 activities in 2016-17. Each PPN's material was used most often at activities targeting their respective priority populations: 52% of activities using WHAI materials targeted at-risk women, 64% of activities using GMSH materials targeted GBMSM, and 77% of activities using ACCHO materials targeted African, Caribbean and Black communities. People living with HIV were the second most targeted population for all three PPNs' materials. WHAI materials were the most commonly used materials at activities targeted to Indigenous communities and people who use drugs.

Number of education activities where PPN materials were used OCHART Q3.4

	ACCHO 2016-17	ACCHO 2017-18	GMSH 2016-17	GMSH 2017-18	WHAI 2016-17	WHAI 2017-18
African, Caribbean and Black communities	73	95	8	14	9	15
People living with HIV	16	17	16	22	9	17
At-risk women	3	9	3	3	37	63
Indigenous Peoples	2	1	2	6	8	15
Gay, bisexual and other men who have sex with men	–	1	69	95	–	2
People who use drugs	–	–	5	9	5	9

More social media, less traditional media used



Number of organizations using online and traditional media distribution systems OCHART Q3.5

	Facebook	Twitter	Traditional media
2016-17	38	32	31
2017-18	38	34	29

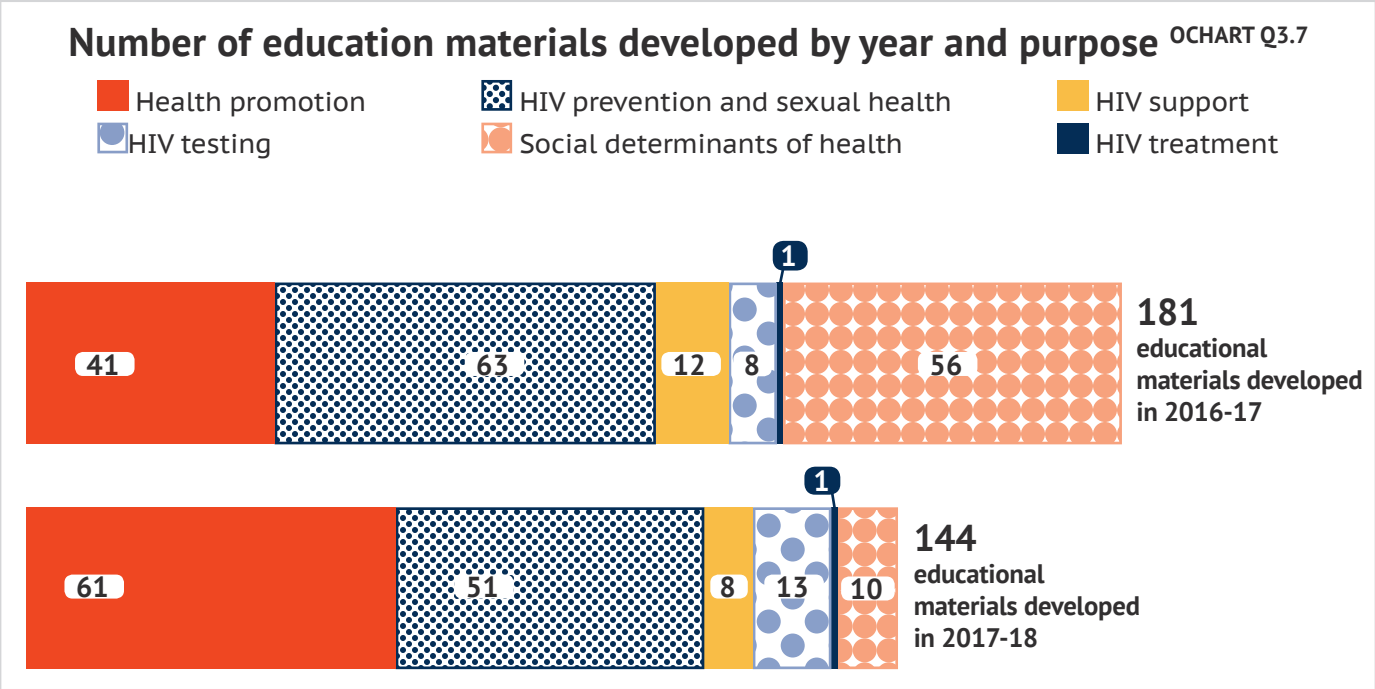
Number of education materials developed by year and medium OCHART Q3.7

	Online	Printed	Total
2016-17	24	157	181
2017-18	41	103	144

Organizations developed more online information and education materials for service users

Organizations developed 144 new information/education materials in 2017-18 — 37 fewer than in 2016-17. Of those materials 41 (28%) were online products, a significant increase from 2016-17 when only 13% of materials were online rather than printed.

General health promotion and HIV prevention/sexual health were the main purposes for most (78%) information/education materials developed by OCHART organizations in 2017-18.



More organizations conducting awareness campaigns

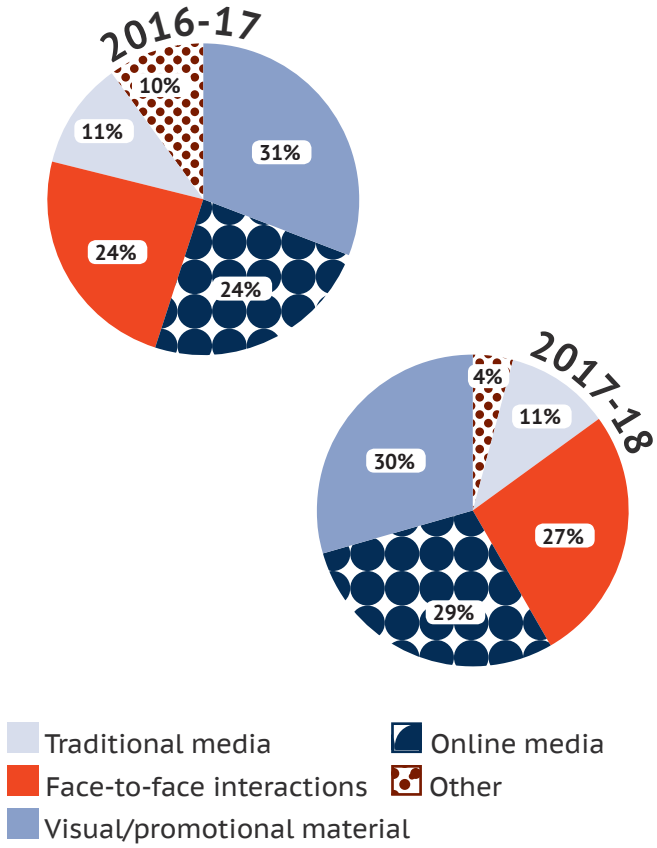
Thirty-four organizations (20 ASOs and 14 non-ASOs) reported conducting awareness campaigns in 2017-18, up from 29 (19 ASOs and 10 non-ASOs) in 2016-17. In 2017-18, a greater proportion of these campaigns targeted gay, bisexual, and other men who have sex with men (26% compared to 23% the previous year) as well as people who use drugs (10% compared to 6%).

Comparing ASOs and non-ASOs in 2017-18, ASOs reported targeting awareness campaigns more often to gay, bisexual, and other men who have sex with men (30% compared to 19% at non-ASOs), people living with HIV (17% compared to 13% at non-ASOs), and people who use drugs (12% compared to 8% at non-ASOs). Non-ASOs, compared to ASOs, targeted a greater proportion of their awareness campaigns to Indigenous (11% compared to 7%) and other populations (21% compared to 5%).

Percentage of awareness campaigns targeting populations OCHART Q3.6b

	Total in 2016-17	ASO in 2016-17	Non-ASO in 2016-17	Total in 2017-18	ASO in 2017-18	Non-ASO in in 2017-18
Gay, bisexual and other men who have sex with men	23%	31%	12%	26%	30%	19%
People living with HIV	16%	16%	17%	16%	17%	13%
Other	25%	15%	38%	19%	13%	29%
African, Caribbean and Black communities	11%	13%	8%	11%	12%	11%
At-risk women	10%	10%	10%	10%	10%	9%
Indigenous Peoples	9%	8%	11%	8%	7%	11%
People who use drugs	6%	7%	5%	10%	12%	8%

Percentage of awareness campaigns using campaign components OCHART Q3.6b



Campaigns used more online and face-to-face components in 2017-18 than in the previous year.

Examples of awareness campaigns

▲ Women's Health in Women's Hands CHC continued its third year of the #GladITested campaign, originally launched on World AIDS Day 2015.

Réseau ACCESS Network hosted a 'Pap n'Pamper' event with PAP tests and HCV/ HIV/STBBI testing, overdose prevention and naloxone training, and free harm reduction supplies and naloxone kits. ▶

More education offered to other service providers

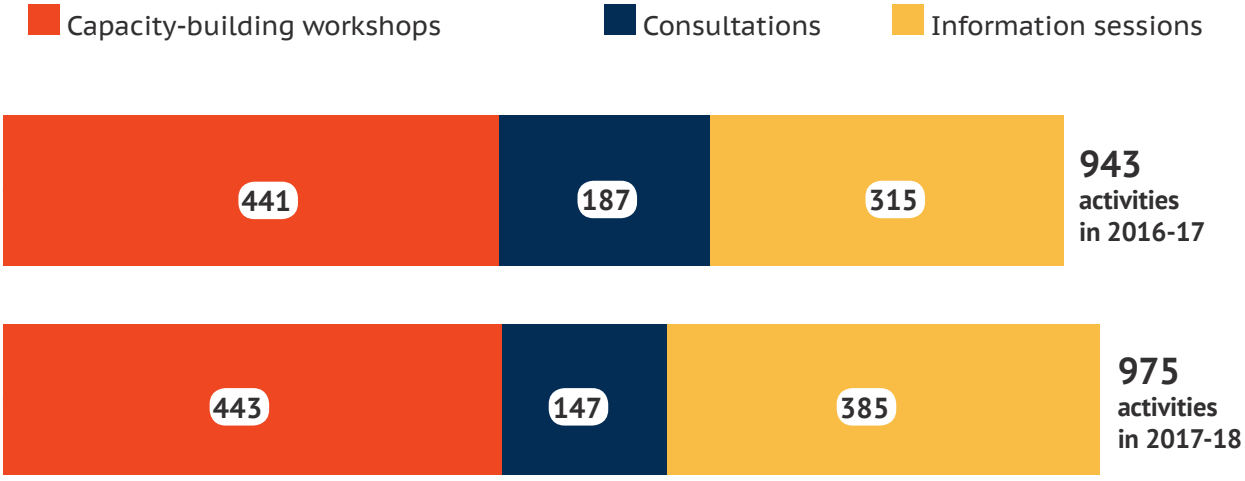
Organizations providing prevention education services often conduct a variety of education and capacity building activities with other service providers. These activities are reported in OCHART as:

- **Information session:** a worker meets with a group of service providers to provide information about a specific topic.
- **Capacity building session:** a worker educates service providers on the steps that organizations can take to improve services for people with HIV or other priority populations.
- **Consultation:** a worker spends time with staff from one or more organizations for the purpose of assisting them to change practices, policies or approaches to better serve priority populations.

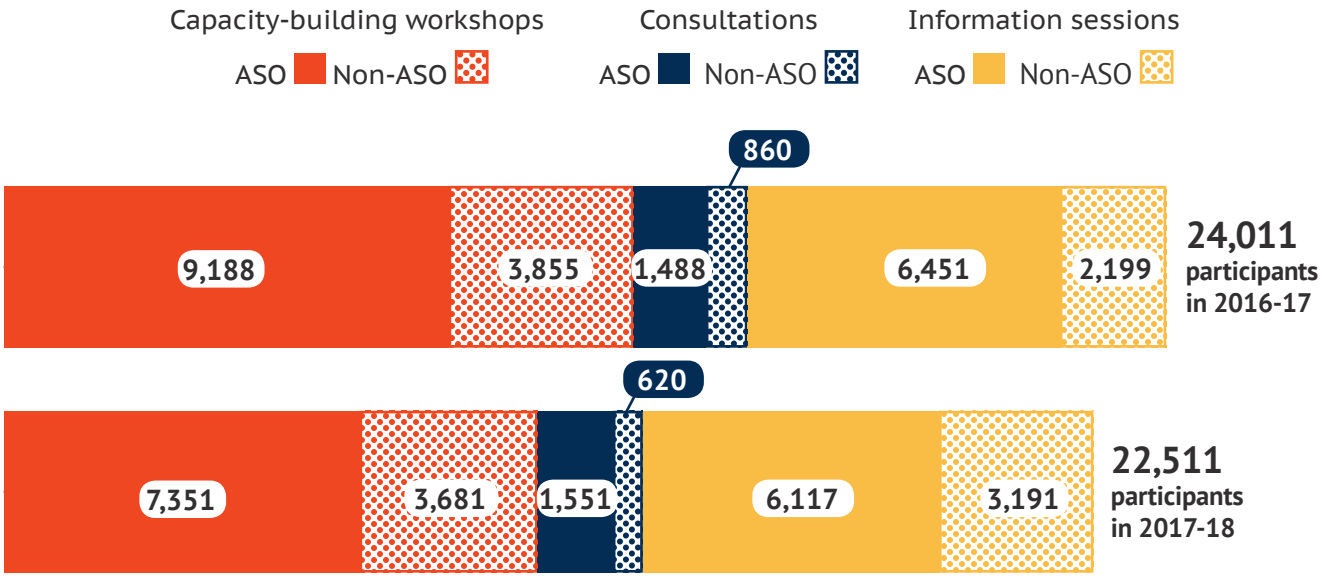
In 2017-18, organizations reported a 3% increase in the total number of education activities provided to service providers, up from 943 in 2016-17 to 975. Capacity building workshops accounted for 45% (443 sessions) of these activities, consistent with the year prior (441 sessions). The number of information sessions increased 22% from 315 to 385 year-over-year and the number of consultations decreased from 187 to 147.

In total, 6% (1,500) fewer participants attended education activities for service providers in 2017-18 than in the previous year. The overall decrease in participants in 2017-18 can mainly be attributed to a 20% (1,857) decrease in participants at ASO capacity building workshops.

Number of education activities for other service providers by year OCHART Q4.3a



Number of participants at education activities for other service providers by year OCHART Q4.3a



When reporting education activities with service providers in OCHART, organizations are asked which priority population was the main focus of each session. Compared to 2016-17, the number of education activities targeted to people who use drugs increased 171%, from 45 activities to 122 in 2017-18. The number of education activities targeted at "other" priority populations increased 62% from 113 in 2016-17 to 183 this year, an increase mainly reported by non-ASO organizations that focus their work on other specialized populations. The number targeted to people living with HIV and to gay, bisexual, and other men who have sex with men decreased the most: 25% and 32%, respectively.

Number of education activities to service providers focusing on priority populations OCHART Q4.3a

Year	People living with HIV	Other	African, Caribbean and Black communities	At-risk women	Indigenous Peoples	Gay, bisexual, and other men who have sex with men	People who use drugs	Total
2016-17	227	179	115	134	116	127	45	**943**
2017-18	171	239	128	107	122	86	122	**975**

Community development with other service providers

Community development activities are meetings and other activities among service providers, professionals and practitioners that seek to improve the lives of community members and enhance the capacity of service providers. Organizations reported conducting a similar number of community development meetings in 2017-18 (3,988 meetings) as in the prior year (4,083 meetings).

In 2017-18, on average each ASO reported participating in approximately 94 community development meetings, up slightly from 90 meetings the year prior. Non-ASOs, which tend to provide more specialized programs and have fewer staff, participated in an average of 42 community development meetings last year, down from 55 in the previous year.

Top five meeting purposes for ASOs and non-ASOs OCHART Q4.4a

ASO	Number of meetings
Coalition/network meeting	591
Community event planning	550
General information sharing	535
Partnership building	489
Improved service delivery	369

Non-ASO	Number of meetings
Advisory/board meeting	163
Community event planning	152
Partnership building	146
Coalition/network meeting	114
Improved service delivery	93

Number of community development meetings by organization type and year

OCHART Q4.4a - 4.4b

	ASO		Non-ASO	
	2016-17	2017-18	2016-17	2017-18
Community development meetings	3,043	3,183	1,040	805
Organizations	16,078	18,983	2,548	3,250
Participants	27,262	31,691	5,015	4,705

Organizations engaged a broader group of community partners

The total number of unique organizations attending community development meetings increased 19% from 18,626 last year to 22,233 in 2017-18. Both ASOs and non-ASOs reported an increase in organizations at community development meetings, despite non-ASOs conducting fewer meetings. The increase indicates that organizations are engaging with a wider variety of community partners.

When looking at the types of partner organizations at community development meetings, the number from each category increased from 2016-17 to 2017-18, with the number from harm reduction service providers increasing the most year-over-year, up 145% from 450 last year to 1,104 this year. The next biggest increases came from partners at non-HIV specific clinical service providers (69%), addiction service providers (62%), and mental health service providers (58%).

Number of community partner organizations represented at community development meetings OCHART Q4.4b

Partner type	2016-17	2017-18	% change
Addiction service provider	451	729	62%
Clinical services: HIV specific care	825	1,080	31%
Clinical services: non-HIV specific care	941	1,586	69%
Community-based HIV service providers	6,133	6,285	2%
Harm reduction service provider	450	1,104	145%
HIV testing site	372	513	38%
Mental health services provider	888	1,404	58%
Other community-based service providers	8,566	9,532	11%
Total	**18,626**	**22,233**	**19%**

Community development meetings focus more on people who use drugs

When reporting community development activities in OCHART, organizations are asked to select one or more populations who were the focus during each meeting. In 2017-18, people who use drugs were the focus at 14% of all community development meetings, up significantly from 9% last year. People living with HIV were the focus at a smaller proportion of meetings in 2017-18 (20%) than last year (23%), as were African, Caribbean and Black communities (11% this year compared to 13% in 2016-17).

Percentage of community development meetings focused on priority population OCHART Q4.4c

Year	People living with HIV	At-risk women	Indigenous Peoples	Gay, bisexual and other men who have sex with men	African, Caribbean and Black communities	People who use drugs
2016-17	23%	17%	17%	15%	13%	9%
2017-18	20%	16%	16%	15%	11%	14%

Percentage of community development meetings by region OCHART Q4.4c

	People living with HIV	At-risk women	Indigenous Peoples	Gay, bisexual and other men who have sex with men	African, Caribbean and Black communities	People who use drugs
Central East	15%	**21%**	9%	**19%**	**21%**	8%
Central West	**20%**	**20%**	8%	**16%**	13%	**16%**
Northern	15%	17%	**29%**	**16%**	**16%**	1%
Ottawa & Eastern	13%	8%	15%	**21%**	**21%**	**15%**
South West	10%	**18%**	**29%**	5%	**21%**	7%
Toronto	**28%**	16%	11%	15%	8%	**17%**
Provincial average	**19%**	**17%**	**16%**	**15%**	**14%**	**12%**

Note: Highlights show regions that discussed priority populations more than the provincial average.

Percentage of community development meetings by issue OCHART Q4.4d

	2016-17	2017-18
Well-being	22%	22%
Social support	17%	17%
Living with HIV	15%	13%
Risk of HIV	14%	12%
Safety concerns	10%	12%
Housing	6%	7%
Education/ employment	5%	6%
Legal/ immigration	5%	5%
Income and benefits	3%	3%
Food security	3%	3%

The percentage of community development meetings by focus was similar in 2017-18 as the previous year.

See Appendix C for definitions.

More conferences and community meetings

Organizations reported organizing 66 conferences in 2017-18, five more than in 2016-17. However, the total number of attendees at all conferences decreased 7% from 5,103 last year to 4,738 this year. This trend was the result of 16% fewer attendees (from 2,813 to 2,352) at non-ASO organized conferences year-over-year.

Comparing 2016-17 to 2017-18, both ASOs and non-ASOs held more community meetings, though the number of participants at non-ASO community meetings declined 17% from 2,403 to 1,994. This was offset by ASOs holding 52 activities (an increase of 24 or 86%) with 2,623 participants (83% increase).

Number of conferences and community meetings by year OCHART Q4.5

	Number of activities	Number of participants
Conferences		
2016-17	**61**	**5,103**
ASO	30	2,290
Non-ASO	31	2,813
2017-18	**66**	**4,738**
ASO	26	2,386
Non-ASO	40	2,352
Community/town-hall meetings		
2016-17	**61**	**3,839**
ASO	28	1,436
Non-ASO	33	2,403
2017-18	**90**	**4,617**
ASO	52	2,623
Non-ASO	38	1,994

Informational materials developed for service providers

In 2017-18, organizations developed 126 informational materials for service providers compared to 145 last year: a 13% decrease.

Number of informational materials developed by year OCHART Q4.6

	2016-17	2017-18
Online materials	**34**	**29**
ASO	23	17
Non-ASO	11	12
Printed materials	**111**	**97**
ASO	62	59
Non-ASO	49	38
Total	**145**	**126**

When comparing online and printed materials in 2017-18, a greater proportion of materials developed for HIV prevention/sexual health and for social determinants of health were online. Online materials were also used for HIV support purposes, particularly for people living with HIV, and for health promotion among a variety of populations.

Number of online and printed informational materials developed for service providers by purpose, 2017-18 OCHART Q4.6

	Online materials	Printed materials
HIV support	11	33
Health promotion	5	27
HIV prevention and sexual health	7	16
Social determinants of health	6	12
HIV testing	–	8
HIV treatment	–	1
Total	**29**	**97**

Resources developed for service providers at non-ASOs focused on people living with HIV and at-risk women, while ASOs developed resources for a wider range of populations.

Number of informational materials developed for service providers by priority population, 2017-18 OCHART Q4.6

Priority population	ASO	Non-ASO	Total
People living with HIV	11	25	36
Gay, bisexual and other men who have sex with men	24	1	25
Other	21	6	27
At-risk women	5	12	17
People who use drugs	14	1	15
Indigenous People	0	3	3
African, Caribbean and Black communities	1	2	3
Total	**76**	**50**	**126**

Reporting organizations

ASO

- 2-Spirited People of the First Nations
- Action Positive
- Africans In Partnership Against AIDS
- AIDS Committee of Cambridge, Kitchener, Waterloo and Area
- AIDS Committee of Durham Region
- AIDS Committee of North Bay and Area
- AIDS Committee of Ottawa
- AIDS Committee of Toronto
- AIDS Committee of Windsor
- AIDS Committee of York Region
- Alliance for South Asian AIDS Prevention
- Asian Community AIDS Services
- Black Coalition for AIDS Prevention
- Elevate NWO
- HIV/AIDS Regional Services
- HIV/AIDS Resources & Community Health (ARCH)
- Ontario Aboriginal HIV/AIDS Strategy
- Ontario Aboriginal HIV/AIDS Strategy – Cochrane
- Ontario Aboriginal HIV/AIDS Strategy – Kingston
- Ontario Aboriginal HIV/AIDS Strategy – London
- Ontario Aboriginal HIV/AIDS Strategy – Ottawa
- Ontario Aboriginal HIV/AIDS Strategy – Sudbury
- Ontario Aboriginal HIV/AIDS Strategy – Thunder Bay
- Ontario Aboriginal HIV/AIDS Strategy – Wallaceburg
- Prisoners with HIV/AIDS Support Action Network
- Peel HIV/AIDS Network
- Peterborough AIDS Resource Network
- Positive Living Niagara
- Regional HIV/AIDS Connection
- Réseau ACCESS Network
- The AIDS Network
- The Gilbert Centre
- The Teresa Group
- Toronto People With AIDS Foundation

Non-ASO

- Group Health Centre, Sault Ste. Marie and District
- Association of Iroquois and Allied Indians
- Centre for Spanish-speaking Peoples
- Centre Francophone de Toronto
- Hemophilia Ontario
- HIV & AIDS Legal Clinic (Ontario)
- Hospice Toronto
- Maggie's: Toronto Sex Workers Action Project
- Nishnawbe Aski Nation
- Ontario Association of the Deaf, Deaf Outreach Program
- Ottawa Gay Men's Wellness Initiative
- Somerset West Community Health Centre
- St. Stephens Community House
- Hassle Free Clinic
- The Ottawa Hospital Research Institute
- Union of Ontario Indians
- Waasegiizhig Nanaandaweiyewigamig
- Women's Health in Women's Hands Community Health Centre
- Sandy Hill Community Health Centre (OASIS)
- Casey House Hospice

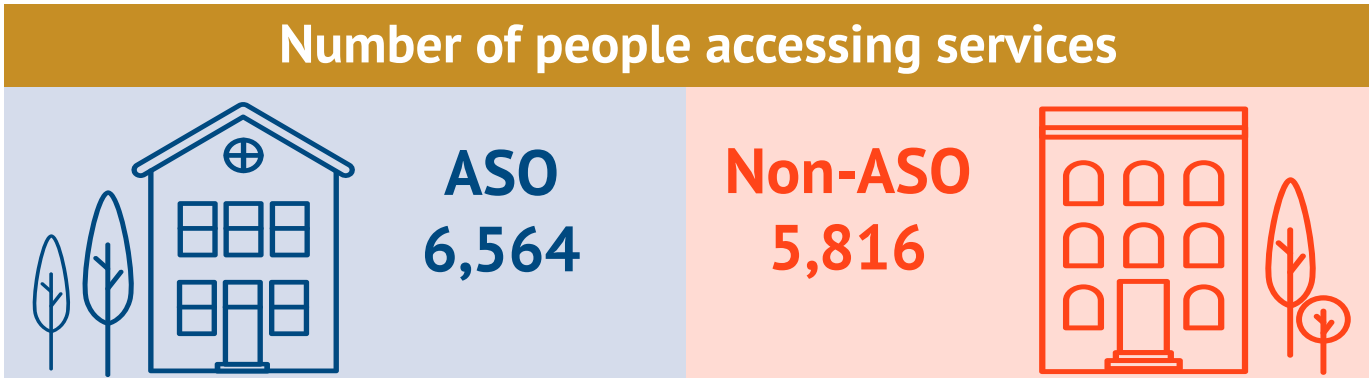
Support Services

Key points

- 55 community-based HIV programs provided support services to an average of 12,380 clients in 2017-18. They saw more at-risk clients than in 2016-17.
- 178,815 service sessions were delivered in 2017-18: 40% were community/social services such as general counselling and support groups and 32% were practical assistance.
- Programs reported 2,833 new clients in 2017-18, similar to 2016-17. A greater proportion of all new clients were from African, Caribbean and Black communities. New clients living with HIV were younger than those in 2016-17.
- Clients reported challenges related to living with HIV (medication adherence, symptom management, connection to care, disclosure, stigma/discrimination), overall wellbeing, and need for social support to reduce isolation.
- In 2017-18, community-based HIV programs made 9,231 referrals to other service providers, 3% more than the 8,988 in 2016-17. More referrals were made to addiction services, HIV/STI testing, and other community-based service providers than in 2016-17.

Who is using support services?

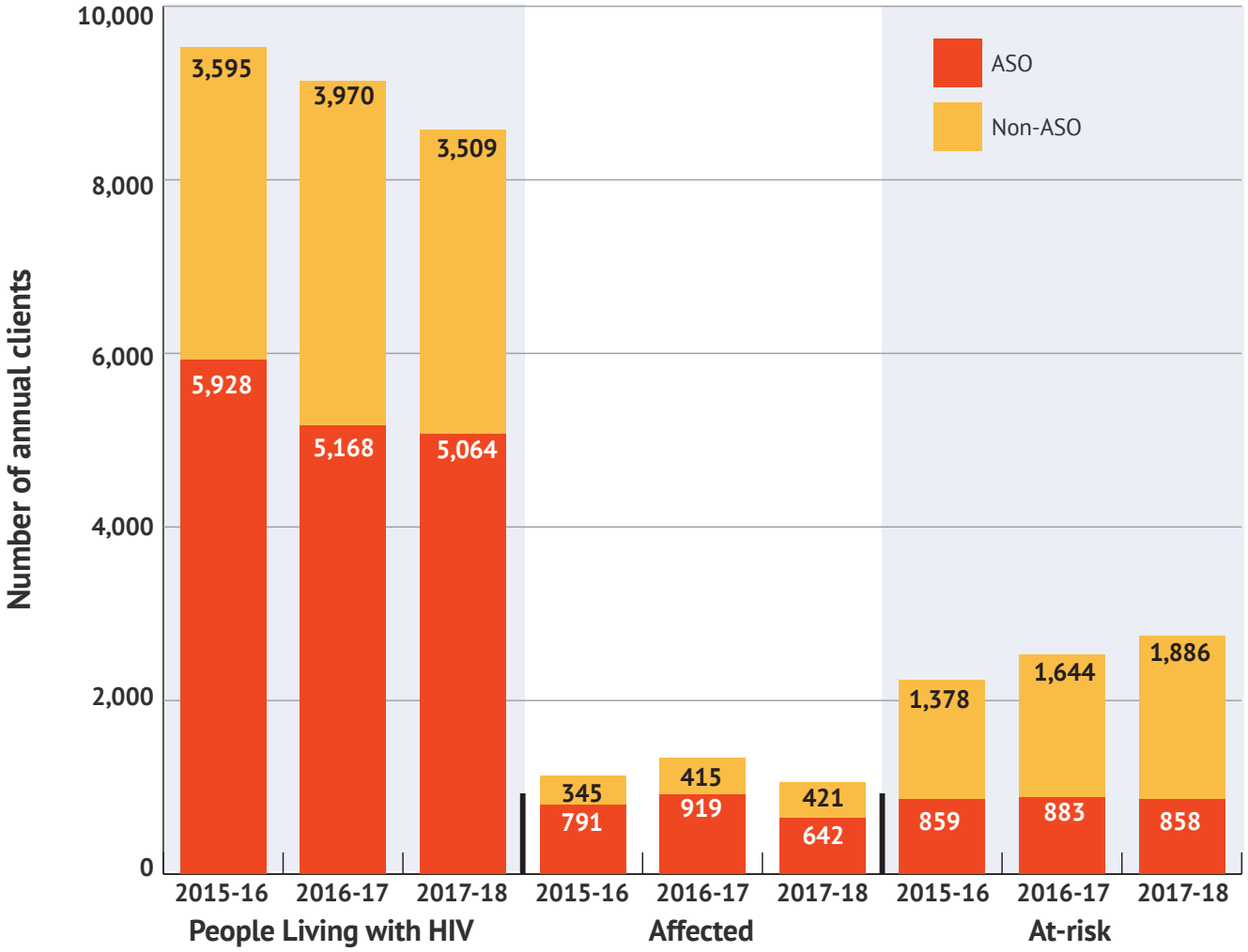
In 2017-18, 55 community-based HIV programs—36 AIDS service organizations (ASOs, which include seven satellite Oahas sites) and 19 non-ASOs—provided support services to a total of 12,380 people.[1] Of these, 6,564 accessed services at ASOs and 5,816 accessed services at non-ASOs. The total number of people accessing support services is down slightly from 12,999 in 2016-17. In 2017-18, the number of clients accessing services in each region of Ontario declined for most regions, except Toronto, where client counts remained stable, and the Northern region, where client numbers increased 37% from 255 in 2016-17 to 349 in 2017-18.



1 The 12,380 clients may not be unique individuals as some may receive services from more than one organization.

Community-based HIV programs saw more at-risk clients in 2016-17, and fewer people living with and affected by HIV. While both ASOs and non-ASOs saw fewer clients overall compared to the previous year, trends differed between the two types of organizations: non-ASOs provided services to more individuals at-risk, fewer people living with HIV, and about the same number of affected clients. ASOs saw very slight decreases in clients living with and at risk of HIV; the decrease in affected clients at ASOs is mainly the result of changes in reporting practices at one organization serving families of people living with HIV.

Average number of annual clients by client group and agency type[2] OCHART Q.5.2

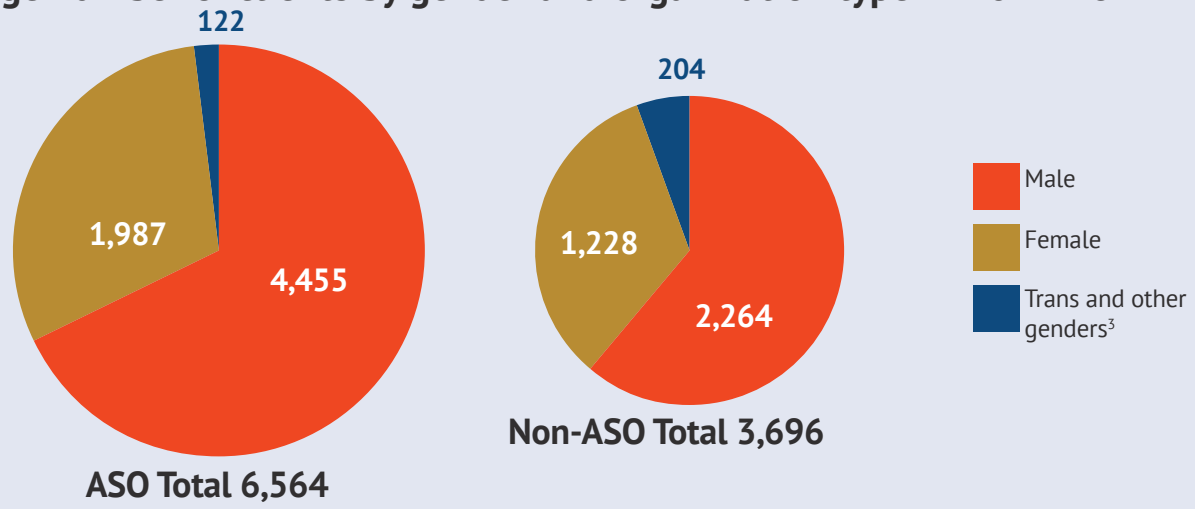


2 One organization was removed from analysis of support service data owing to changes in reporting practices. An additional organization was removed from analysis of demographic data, including gender and ethnicity, as this data was unavailable for 2017-18.

By gender

Similar to previous years, nearly two of every three clients in 2017-18 were male at ASOs (68% male) and non-ASOs (61% male). Non-ASOs, which tend to have more specialized programs, had more clients who identify as trans or other genders not listed in OCHART (6% of their total clients compared to 2% at ASOs).

Average number of clients by gender and organization type in 2017-18 OCHART Q.5.2



Note: Gender was known for 83% (10,260/12,380) of total clients in 2017-18.

Number and proportion of clients served in 2017-18 by client group and gender

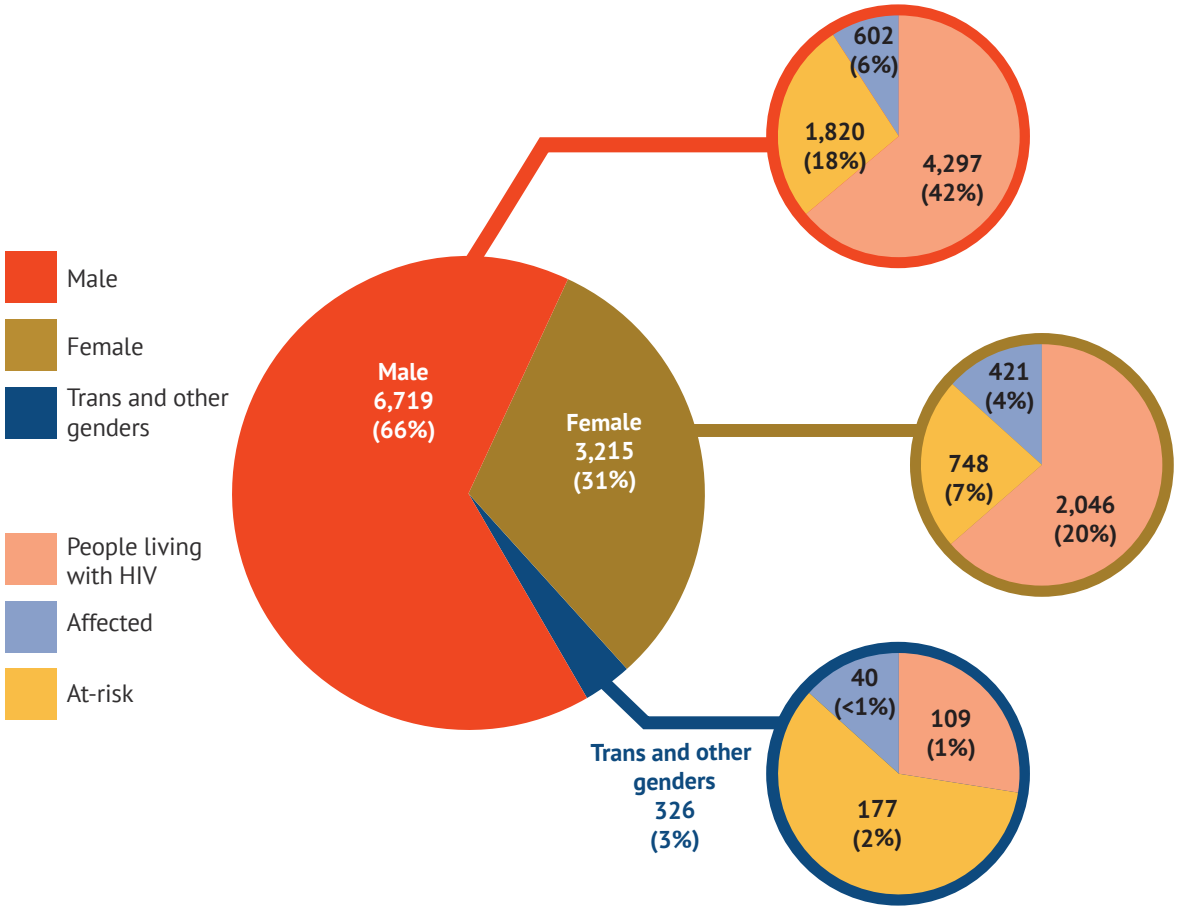
OCHART Q.5.2

Gender	People living with HIV	At-risk	Affected	Gender proportion
Male	4,297 (42%)	1,820 (18%)	602 (6%)	6,719 (66%)
Female	2,046 (20%)	748 (7%)	421 (4%)	3,215 (31%)
Trans and other genders [3]	109 (<1%)	177 (2%)	40 (<1%)	326 (3%)
Total	**6,452**	**2,745**	**1,063**	**10,260**

When looking at all client groups in 2017-18, women made up 40% of affected clients, 27% of at-risk clients, and 32% of clients living with HIV. Trans individuals and clients identifying with other gender expressions not specifically listed in OCHART were more likely to be at-risk (54%) or living with HIV (25%).

3 "Trans men," "trans women," and "not listed" (which refers to gender expressions not listed in OCHART) gender groups are collapsed due to small client counts in some cells. Throughout this document, "trans and other genders" refers to trans men, trans women, and other gender expressions not listed in OCHART.

Proportion of clients served in 2017-18 by client group and gender OCHART Q.5.2



Active client demographics

In OCHART, the community-based HIV programs are asked to report the demographic characteristics of new and active clients separately. Active clients are clients who have completed an intake and received services from an organization in previous reporting periods.

At-risk and affected clients younger than those living with HIV

The age distribution of clients in each group (clients living with HIV, at-risk, and affected) in 2017-18 remained very consistent with the ages of clients served in 2016-17. Most clients (51%) continue to be between 36 and 55 years old, with a larger proportion (57%) of clients living with HIV falling between those ages. Affected and at-risk clients tend to be younger than clients living with HIV. At-risk clients are most commonly (29%) between the ages of 26 and 35 and affected clients are most commonly (44%) under 18, many of whom are children with parents living with HIV.

Age distribution of active clients by gender, where known OCHART Q.5.3

	Under 18	18-25	26-35	36-45	46-55	56-65	66-75	Over 75	Total
2016-17	**624**	**458**	**1,517**	**2,081**	**2,399**	**1,217**	**279**	**44**	**8,619**
Male	296	271	1,048	1,140	1,646	936	223	31	5,591
Female	316	163	437	898	713	266	53	13	2,859
Trans and other genders	12	24	32	43	40	15	3	0	169
2017-18	**503**	**426**	**1,635**	**2,063**	**2,277**	**1,210**	**298**	**42**	**8,454**
Male	247	263	1,101	1,119	1,521	910	237	28	5,426
Female	250	131	474	890	715	278	56	14	2,808
Trans and other genders	6	32	60	54	41	22	5	0	220

Note: Age was known for 67% of total clients in 2016-17, 76% of total clients in 2017-18.

By ethnicity

In 2017-18, where client ethnicity was known, one in three clients (37%) were white, 33% were Black, 15% were Latin American, and 7% were Indigenous. This makeup differed between ASOs and non-ASOs. At ASOs, 43% of clients in 2017-18 were white, 34% Black, and 6% were Latin American, while at non-ASOs, clients were 38% Latin American (primarily reported by one organization focusing one Spanish speaking peoples), 30% Black, and 20% white. The ethnic mix of ASO and non-ASO active clients has been similar over the past two years.

Ethnicity distribution of active clients by organization type, where known OCHART Q.5.3

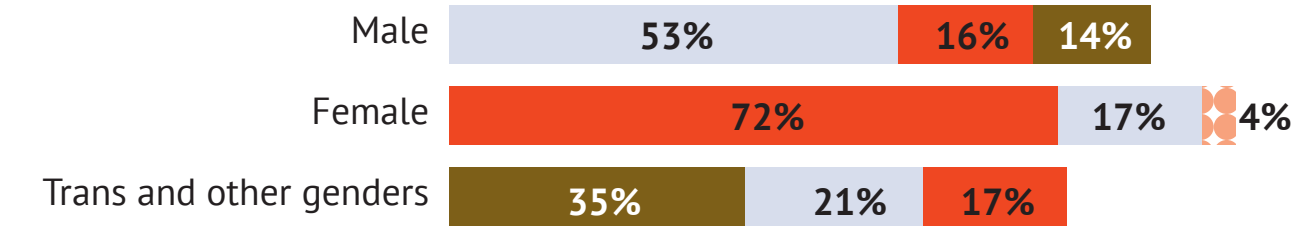
2017-18 organization type	White	Black	Latin American	Indigenous	Southeast Asian	South Asian	Arab/ West Asian	Other[4]
ASO	43%	34%	6%	6%	5%	3%	1%	2%
Non-ASO	20%	30%	38%	8%	2%	2%	1%	0%
Proportion of total clients	**37%**	**33%**	**15%**	**7%**	**4%**	**2%**	**1%**	**2%**

Note: Ethnicity was known for 86% of total clients in 2016-17, 82% of total clients in 2017-18.

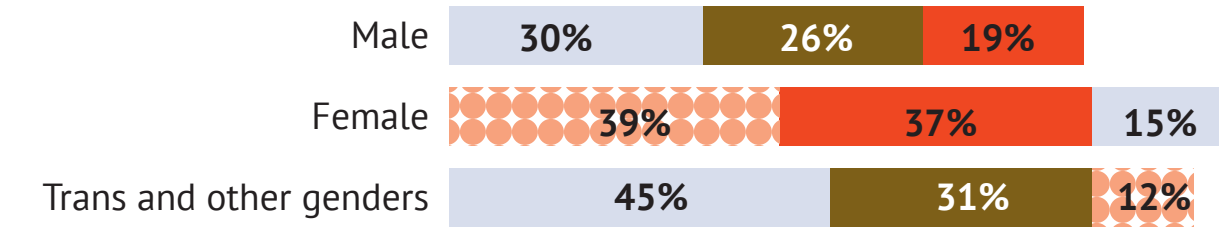
4 Other ethnicities not listed in OCHART.

Top three ethnicities by client group and gender, 2017-18

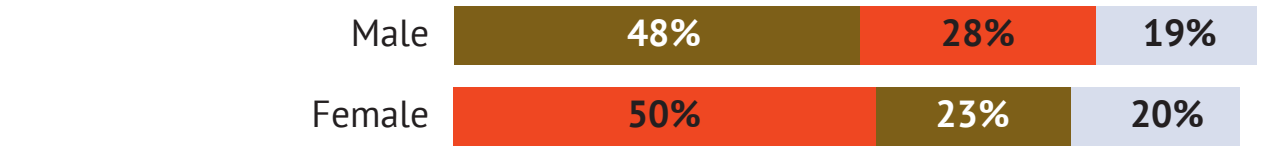
Top three ethnicities by gender for clients living with HIV:



Top three ethnicities by gender for at-risk clients:



Top three ethnicities by gender for affected clients:



Trans and other genders — Not reported due to small client counts

Latin American · Black · Indigenous · White

Ethnicity distribution of active clients by client group, where known OCHART Q.5.3

Year	White	Black	Latin American	Indigenous[5]	South-east Asian	South Asian	Arab/West Asian	Other*[6]	Total
2016-17	**2,539**	**2,138**	**902**	**327**	**250**	**169**	**86**	**308**	**6,719**
People living with HIV	2,103	1,645	461	227	212	124	64	262	5,098
At-risk	268	211	193	74	30	21	13	13	823
Affected	12	24	32	0	40	43	15	3	169
2017-18	**2,347**	**2,113**	**930**	**419**	**243**	**155**	**80**	**113**	**6,400**
People living with HIV	1,986	1,692	493	225	209	123	63	94	4,929
At-risk	248	209	196	179	30	27	14	12	1,451
Affected	113	212	241	15	NR	NR	NR	NR	600

Note: Ethnicity was known for 86% of total clients in 2016-17, and for 82% of total clients in 2017-18. NR= not reported due to low client counts in some cells.

By priority population: ASOs and non-ASOs focus on different populations

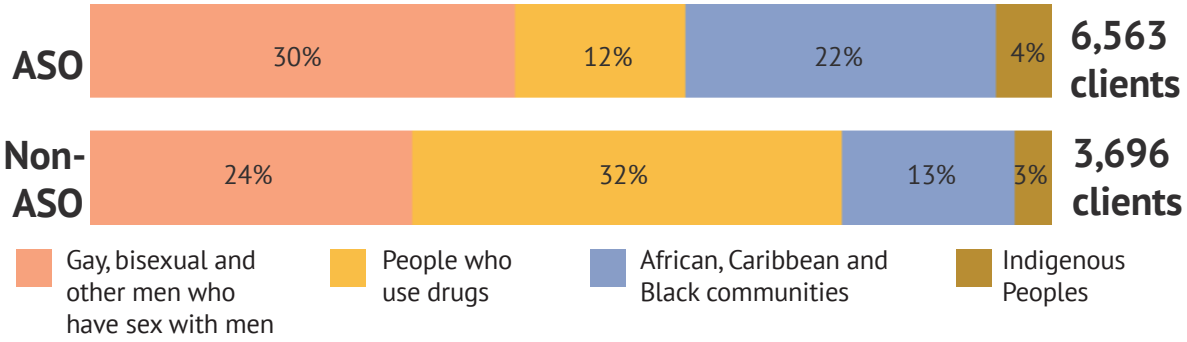
Community-based HIV programs are asked to identify the number of clients that belong to each priority population (clients can be counted in more than one priority population). Among all clients, in 2017-18, 28% identified as gay, bisexual or other men who have sex with men, 19% were people who use drugs, and 18% were from African, Caribbean and Black communities. Smaller proportions of clients were Indigenous (4%) or other priority populations (3%). Overall, women make up 31% of clients across all priority populations, including 69% of clients from African, Caribbean and Black communities, 40% of Indigenous Peoples, and 29% of people who use drugs.

ASOs and non-ASOs differed in terms of the proportion of clients from each priority population. ASOs served a greater proportion of gay, bisexual, and other men who have sex with men (30% compared to 24% at non-ASOs) and clients from African, Caribbean and Black communities (22% compared to 13% at non-ASOs). Non-ASOs served a greater proportion of clients who use drugs (32% compared to 12% at ASOs) and clients from other priority populations (7% compared to 0%), consistent with non-ASOs' mandates to work with more specialized populations affected by HIV.

5 First Nations, Inuit, and Métis groups were combined in analysis as some groups reported numbers too small to be reported.

6 Other ethnicities not listed in OCHART.

Proportion of clients from each priority population at ASOs and non-ASOs, 2017-18 OCHART Q.5.5



Women make up 30% of clients at ASOs and 33% 0f clients at non-ASOs.

Priority population distribution of active clients by client group, where known

OCHART Q.5.5

	Gay, bisexual and other men who have sex with men	People who use drugs	African, Caribbean and Black communities	Indigenous Peoples
ASO				
2016-17	**1,846**	**770**	**1,513**	**309**
People living with HIV	1,576	607	1,032	233
At-risk	254	138	129	68
Affected	16	25	352	NR
2017-18	**1,997**	**772**	**1,420**	**277**
People living with HIV	1,664	636	1,209	218
At-risk	297	116	183	54
Affected	36	20	28	NR
Non-ASO				
2016-17	**887**	**1,281**	**450**	**17**
People living with HIV	278	1,078	25	NR
At-risk	431	194	414	11
Affected	178	NR	11	NR
2017-18	**891**	**1,172**	**469**	**129**
People living with HIV	346	981	10	113
At-risk	375	182	455	14
Affected	170	NR	NR	NR

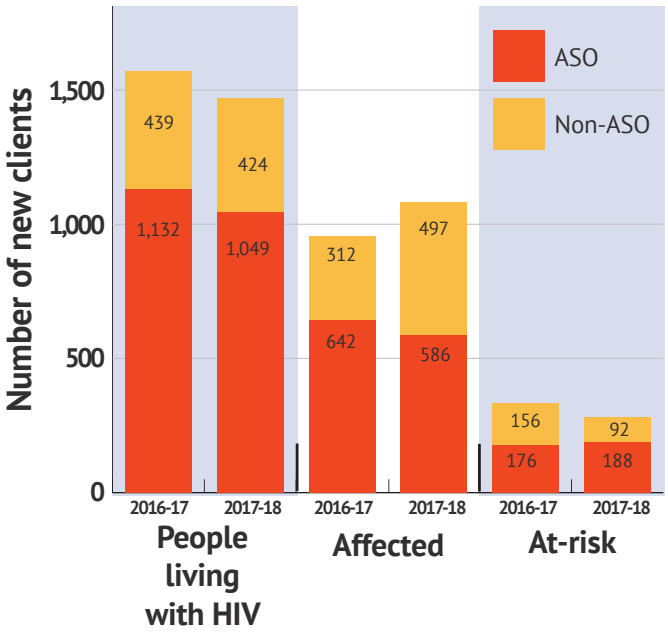
NR= not reported due to lower client counts in some cells. Clients can be counted in more than one priority population.

A snapshot of new clients

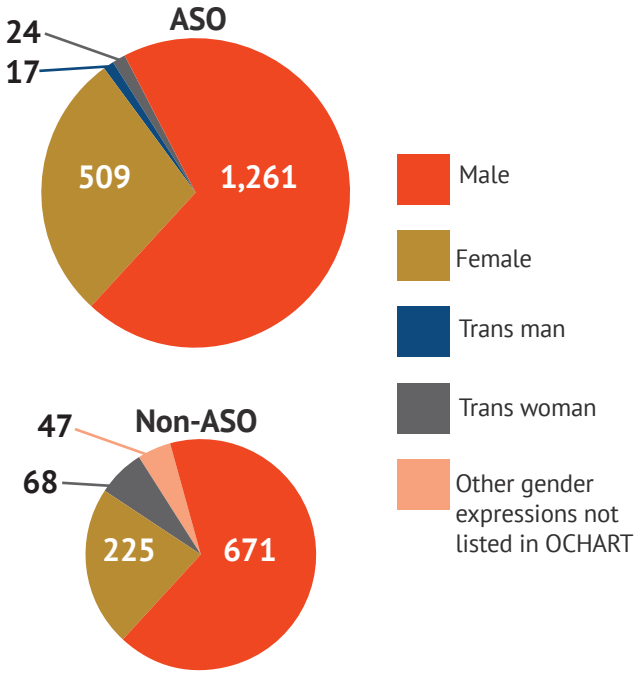
In 2017-18, organizations reported a total of 2,833 new support service clients, similar to the previous year (2,857). Over half of new clients in 2017-18 (52% or 1,470) were living with HIV, 1,083 (38%) were at-risk, and 280 (10%) were affected. Sixty-eight percent of new clients were male, similar to active clients at the organizations, which were 65% male.

The number of new support service clients served at ASOs decreased by 7% from 1,950 in 2016-17 to 1,820 in 2017-18. The decrease in new clients at ASOs was consistent across all genders except trans men (which increased from 12 new clients in 2016-17 to 17 in 2017-18). In contrast, non-ASOs had more new clients across all genders, serving 1,013 new clients in 2017-18, 12% more than in 2016-17 (907).The increase in new clients at non-ASOs was the result of more at-risk clients, which increased from 312 to 497 (59%) year-over-year, even as the number of new clients living with HIV and affected clients decreased by 3% and 41% respectively.

New clients by year and client group at ASOs and non-ASOs OCHART Q.5.12



New clients by gender at ASOs and non-ASOs OCHART Q.5.12



New client demographics

In OCHART, the community-based HIV programs are asked to report the demographic characteristics of new and active support service clients separately. New clients are those who accessed services from an organization for the first time in 2017-18.

New clients were younger in 2017-18

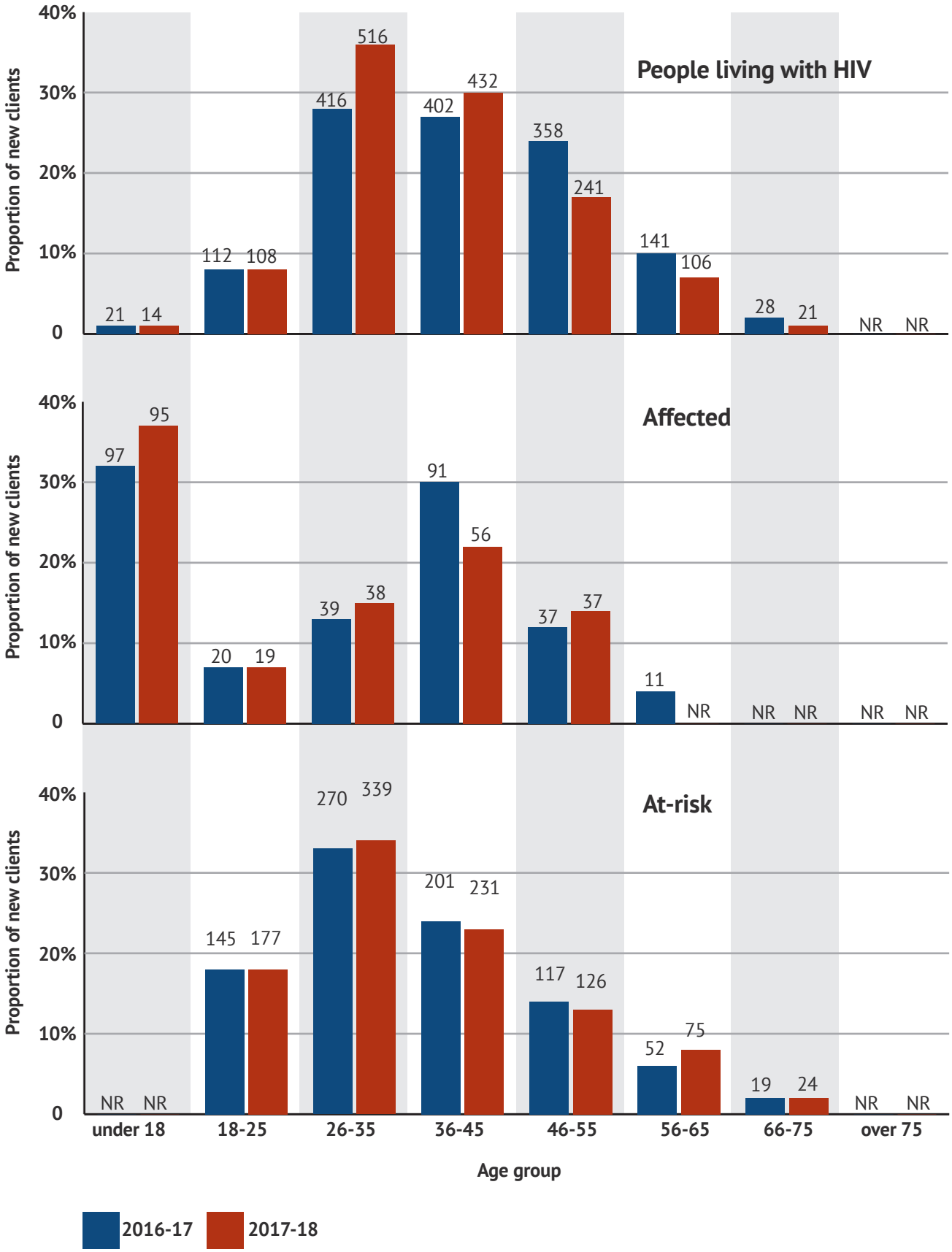
Organizations reported the age of more than 95% of all new clients, up from 92% in the previous year. Where age was known, new clients at both ASOs and non-ASOs tended to be younger in 2017-18 than in 2016-17, though this trend differed across client groups. While the age distribution of new at-risk and affected clients was similar year-over-year, new clients living with HIV were younger compared to the previous year. In 2017-18, new clients living with HIV were more likely to be between the ages of 26 and 35 (36% of new clients living with HIV compared to 28% in 2016-17) or ages 36 to 45 (30% compared to 27%), but less likely to be between 46 and 65 years old (24% compared to 34%). Overall, new clients living with HIV were younger for both males and females, and across most health regions of Ontario.

Age of new clients by client group and year, where known OCHART Q.5.17

	Under 18	18-25	26-35	36-45	46-55	56-65	66-75	Over 75	Total
2016-17	**118**	**277**	**725**	**694**	**512**	**204**	**47**	**NR**	**2,577**
People living with HIV	21	112	416	402	358	141	28	NR	**1,478**
Affected	97	20	39	91	37	11	NR	NR	**295**
At-risk	NR	145	270	201	117	52	19	NR	**804**
2017-18	**109**	**304**	**893**	**719**	**404**	**181**	**45**	**NR**	**2,655**
People living with HIV	14	108	516	432	241	106	21	NR	**1,438**
Affected	95	19	38	56	37	NR	NR	NR	**245**
At-risk	NR	177	339	231	126	75	24	NR	**972**

Note: Age was known for 92% of total in 2016-17, 95% of total in 2017-18. NR = Not reported due to small client counts.

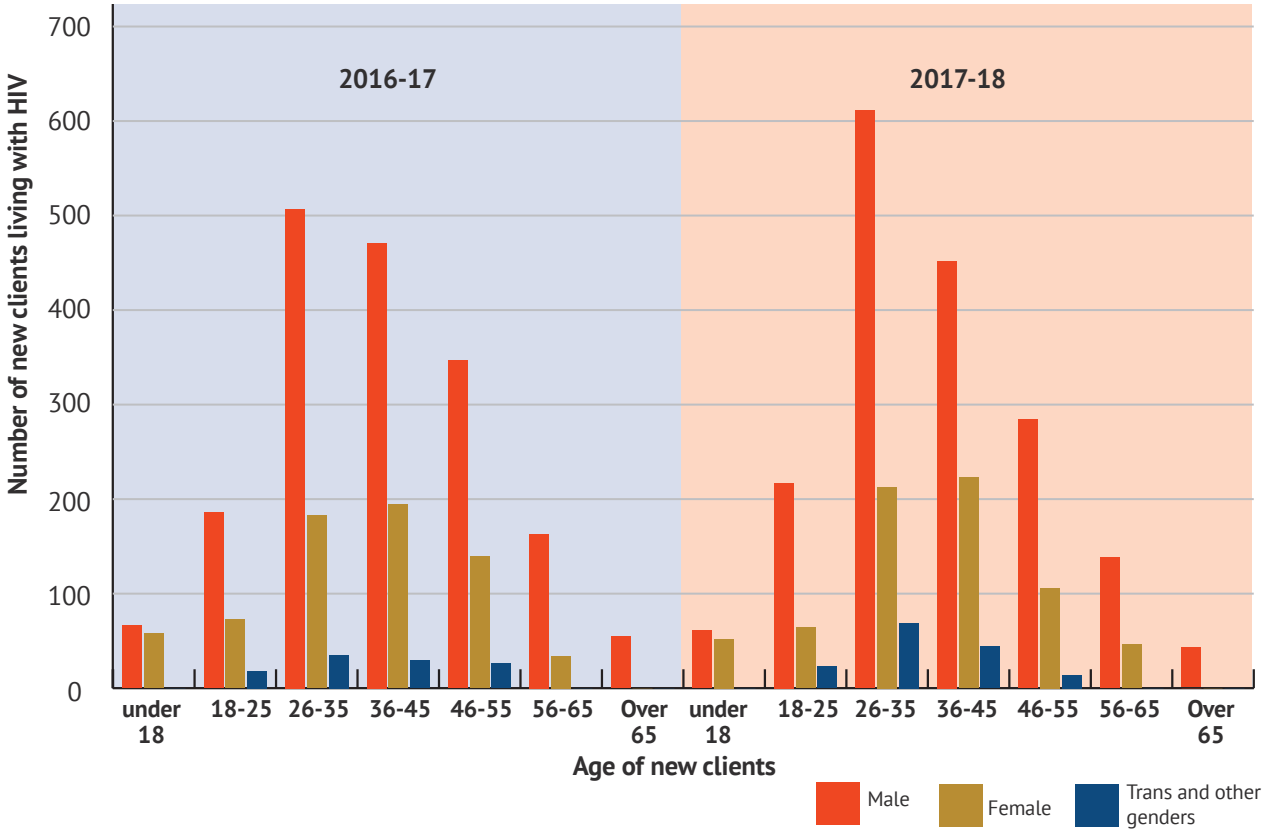
Age distribution of new clients, where known OCHART Q.5.17



Gender

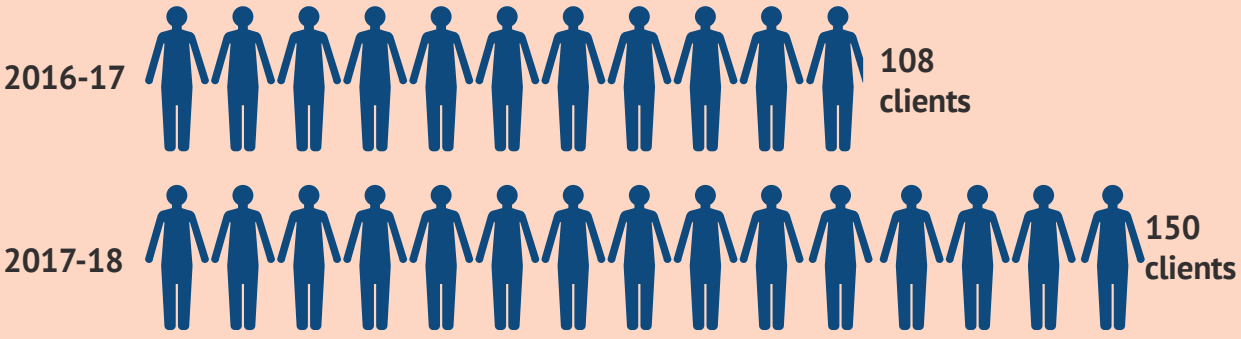
The number of new clients where gender was known increased for all genders from 2016-17 to 2017-18. The number of new clients from trans and other genders increased 39% year-over-year, with most of these new clients being served by organizations in Toronto and Ottawa.

Age of all new clients by gender and year, where known OCHART Q.5.17



Note: Age was known for 92% of total clients in 2016-17, 95% of total clients in 2017-18. NR = Not reported due to small client counts.

Increase in new clients that are trans and other genders OCHART Q.5.17



Ethnicity

Ethnicity was known for 87% of all new clients in 2017-18, similar to last year when ethnicity was known for 92% of new clients. Where ethnicity was known, a smaller proportion of new clients at both ASOs (32% compared to 38% in 2016-17) and non-ASOs (21% compared to 29%) were white. At ASOs, a greater proportion of new clients were Black (42% compared to 36%). More clients were reported as having an ethnicity not listed in OCHART at non-ASOs (17% compared to 8%). These trends were consistent with both males and females.

Number of new clients by ethnicity and organization type, where known OCHART Q.5.15

Year	White	Black	Latin American	Other[7]	South-east Asian	Indigenous	South Asian	Arab/ West Asian	Total
2016-17	**930**	**805**	**393**	**122**	**114**	**111**	**73**	**59**	**2,607**
ASO	714	676	114	61	86	111	63	38	1,863
Non-ASO	216	129	279	61	28	NR	10	21	753
2017-18	**691**	**814**	**441**	**186**	**111**	**74**	**72**	**62**	**2,451**
ASO	516	672	127	39	84	64	51	48	1,601
Non-ASO	175	142	314	147	27	10	21	14	850

Note: Ethnicity was known for 92% of total clients in 2016-17, 87% of total clients in 2017-18. NR = Not reported due to small client counts.

Proportion of new clients by ethnicity and gender OCHART Q.5.15

Year	White	Black	Latin American	Other[7]	Southeast Asian	Indigenous	South Asian	Arab/ West Asian
2016-17	**36%**	**32%**	**14%**	**4%**	**5%**	**4%**	**3%**	**2%**
Male	42%	21%	17%	4%	6%	3%	4%	3%
Female	20%	61%	5%	6%	0%	6%	1%	1%
2017-18	**29%**	**35%**	**17%**	**7%**	**5%**	**3%**	**3%**	**3%**
Male	35%	23%	20%	6%	6%	2%	4%	3%
Female	14%	66%	6%	7%	1%	4%	2%	1%

Note: Trans clients and other gender expressions are not reported due to small client counts.

7 Other ethnicities not listed in OCHART.

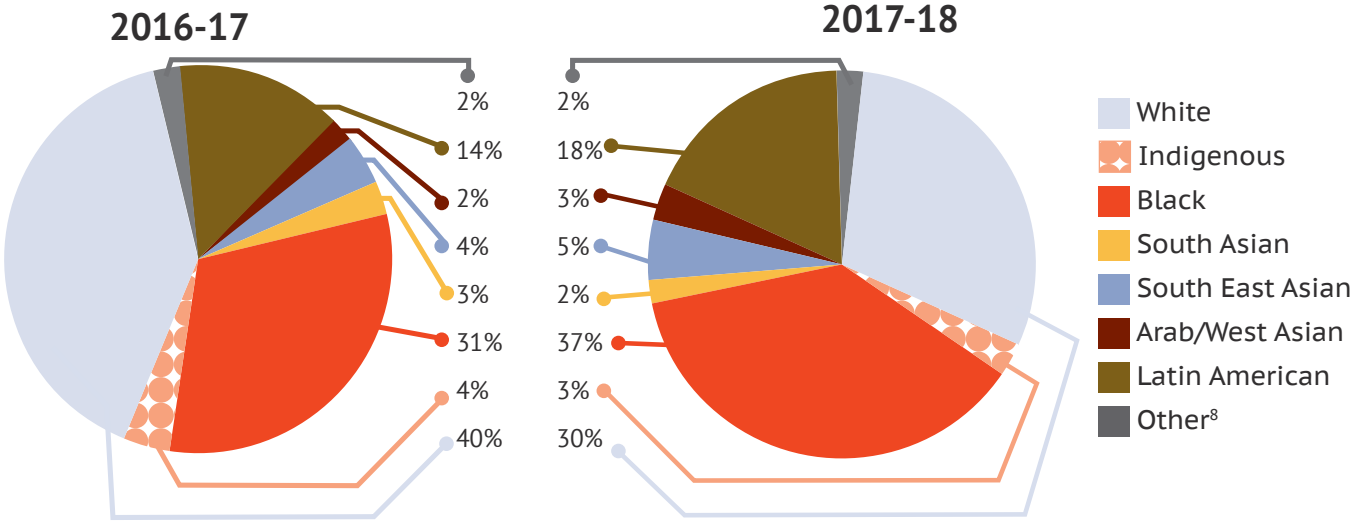
Similar to the year-over-year shift in new clients' ages, changes in new clients' ethnicity from 2016-17 are being driven by changes in demographics among new clients living with HIV. While 40% of new clients living with HIV were white and 31% were Black in 2016-17, 37% were Black and 30% white in 2017-18.

Number of new clients by ethnicity and client group, where known OCHART Q.5.15

Year	White	Black	Latin American	Other[8]	Southeast Asian	Indigenous	South Asian	Arab/West Asian	Total
People living with HIV									
2016-17	600	466	209	32	64	60	38	37	1,506
2017-18	415	505	255	21	69	49	31	36	1,381
At-risk									
2016-17	238	263	77	73	47	54	33	18	803
2017-18	227	279	118	160	40	22	35	23	904
Affected									
2016-17	92	76	107	17	NR	NR	NR	NR	292
2017-18	49	30	68	NR	NR	NR	NR	NR	147

Note: Ethnicity was known for 92% of total clients in 2016-17, 87% of total clients in 2017-18.
NR = Not reported due to small client counts.

Proportion of new clients living with HIV by ethnicity and year OCHART Q5.15

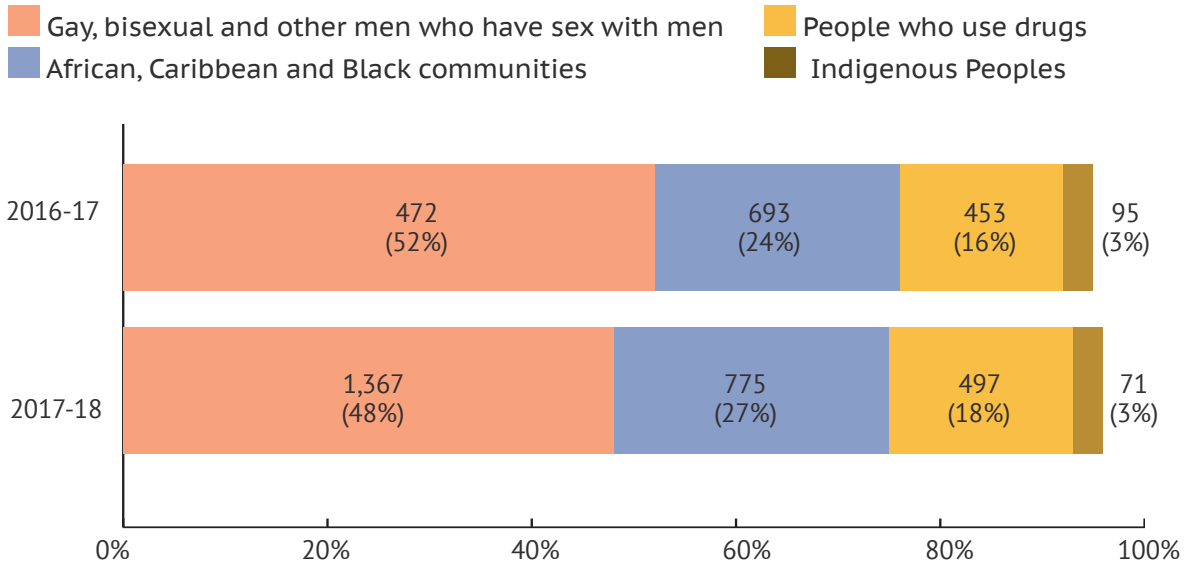


8 Other ethnicities not listed in OCHART.

Generally, organizations reported similar proportions of new clients from priority populations over the last two years. The proportion of new clients from African, Caribbean and Black communities increased from 24% to 27% year-over-year. The proportion of new clients who used drugs increased from 16% to 18% year-over-year and the proportion of gay, bisexual, and other men who have sex with men among new clients decreased from 52% to 48%.

Number and proportion of new clients from priority populations by year

OCHART Q.5.16



Top four presenting issues among new clients in 2017-18 OCHART Q.5.13

People living with HIV	At-risk	Affected
Living with HIV	Risk of HIV/STI	Legal/Immigration
Well-being	Well-being	Well-being
Income and benefits	Social support	Social support
Housing	Legal/Immigration	Income and benefits

Upon intake at an organization, new clients are asked whether or not they experience any of the following issues or concerns:

- **Current safety concerns**: domestic violence, physical violence, sexual abuse, child abuse, emotional abuse, unsafe living conditions, self-harm
- **Living with HIV**: access to medications, adherence to medication, symptoms management, connection to HIV care, disclosure, stigma/discrimination, POZ prevention
- **Housing**: risk of homelessness, homelessness, difficulties paying rent, supportive housing required, accessible/appropriate housing required
- **Food security**: difficulty affording enough to eat, difficulty meeting dietary requirements, difficulty having access to healthy food choices, require food/life skills, difficulty accessing culturally appropriate food, difficulty accessing food stores
- **Well-being**: access to health care, alcohol/substance use, client disclosed injecting or inhaling substances, physical health, smoking, emotional/mental health, personal care
- **Income and benefits**: debt, delay in application process, lack of income, money management/budgeting, need to apply for benefit, poverty
- **Education and employment**: need high school equivalency (GED), need foreign credentials recognized, language barrier (ESL), need to upgrade, recent job loss, skill development/training needed, unemployment, work-related stress
- **Social support**: relationships, family issues, isolation, discrimination, sexual orientation/gender identity, grief/loss
- **Legal issues**: arrest, detention, charge, conviction, incarceration, on bail, probation/parole
- **Immigration**: sponsorship issues, removal/deportation, settlement issues, refugee claim in progress, no status
- **Risk of HIV/STIs**: this is a standalone presenting issue.

In 2017-18, new clients reported living with HIV, well-being, and social support as the key challenges upon intake. Overall, clients reported fewer presenting issues than in 2016-17 (each client reported an average of 2.4 in 2017-18 compared to 2.7 in 2016-17). However, the relative proportion of clients reporting each issue remained similar year-over-year. These challenges highlight the continued need for information and support for medication access and adherence, symptom management, access to health care and other social services, as well as social support to reduce social isolation and stigma.

Number of new clients reporting each issue by client group, 2016-17 & 2017-18

OCHART Q.5.12

	2016-17				2017-18			
	PLWH	At-risk	Affected	Total	PLWH	At-risk	Affected	Total
Current safety concerns	**180**	**69**	**21**	**270**	**77**	**36**	**1**	**114**
Education/ employment	358	82	64	504	269	165	8	442
Risk of HIV/ STI	315	252	70	637	87	389	14	490
Food security	**92**	**279**	**20**	**391**	**319**	**79**	**6**	**404**
Legal/ immigration	420	228	6	654	345	222	53	620
Housing	604	206	19	829	505	192	2	699
Income and benefits	709	224	16	949	552	149	19	720
Social support	**1,080**	**6**	**-**	**1,086**	**421**	**401**	**42**	**864**
Living with HIV	636	431	114	1,181	1058	9	4	1071
Well-being	855	407	52	1,314	747	473	51	1271
Total new clients	**1,571**	**954**	**332**	**2,857**	**1,470**	**1,093**	**280**	**2,833**

The proportion of clients reporting current safety concerns decreased from 10% in 2016-17 to 4% in 2017-18

Nearly four of five clients in 2017-18 (79%) facing food security issues were people living with HIV

The proportion of clients reporting social support needs decreased from 38% in 2016-17 to 30% in 2017-18

Number and percentage of new clients reporting presenting issues by gender in 2017-18 OCHART Q5.13

	Male	Female	Trans and other genders	Total
2017-18 new client count	**1,932**	**734**	**167**	**2,833**
Well-being	**933(48%)**	**290(40%)**	**48(29%)**	**1,271**
Living with HIV	761(39%)	278(38%)	31(19%)	1,071
Social support	**551(29%)**	**242(33%)**	**71(43%)**	**864**
Income and benefits	**442(23%)**	**244(33%)**	**34(20%)**	**720**
Housing	**426(22%)**	**221(30%)**	**52(31%)**	**699**
Legal/immigration	**357(18%)**	**229(31%)**	**34(20%)**	**620**
Risk of HIV/STI	317(16%)	117(16%)	56(34%)	490
Education/employment	**261(14%)**	**158(22%)**	**23(14%)**	**442**
Food security	234(12%)	134(18%)	36(22%)	404
Current safety concerns	53(3%)	34(5%)	27(16%)	114

More males (48%) had concerns regarding their well-being than other genders (38%)

More trans and clients with other gender expressions reported needs for social support (43% compared to 30%)

More females reported issues around housing, income/benefits, education/ employment, and legal/immigration

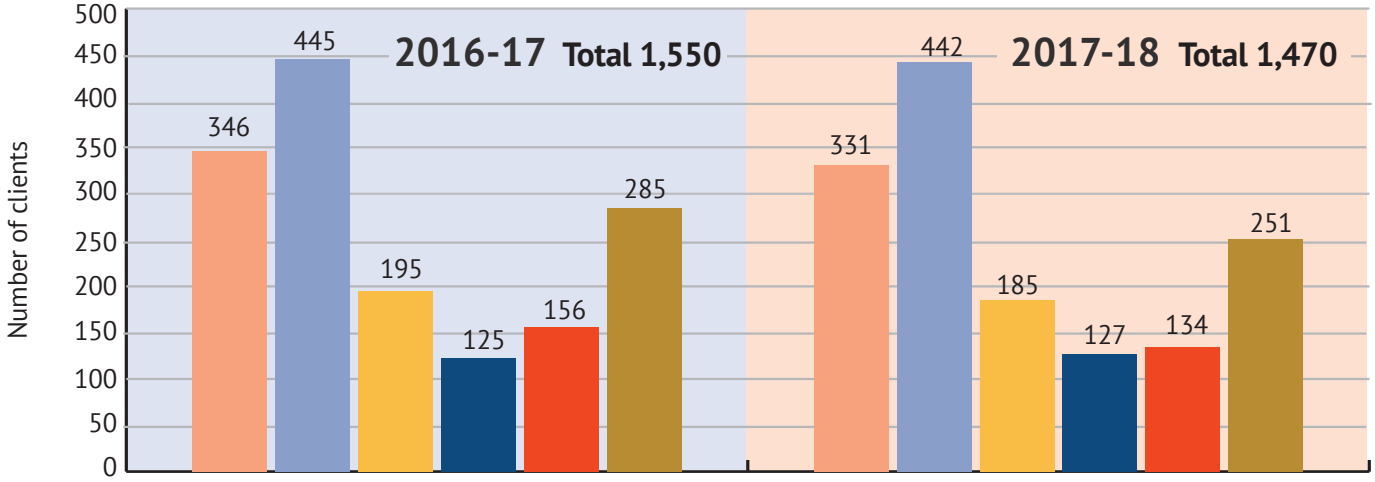
Note: Percentages total more than 100% as clients can report multiple issues.

Men access services sooner post-HIV diagnosis

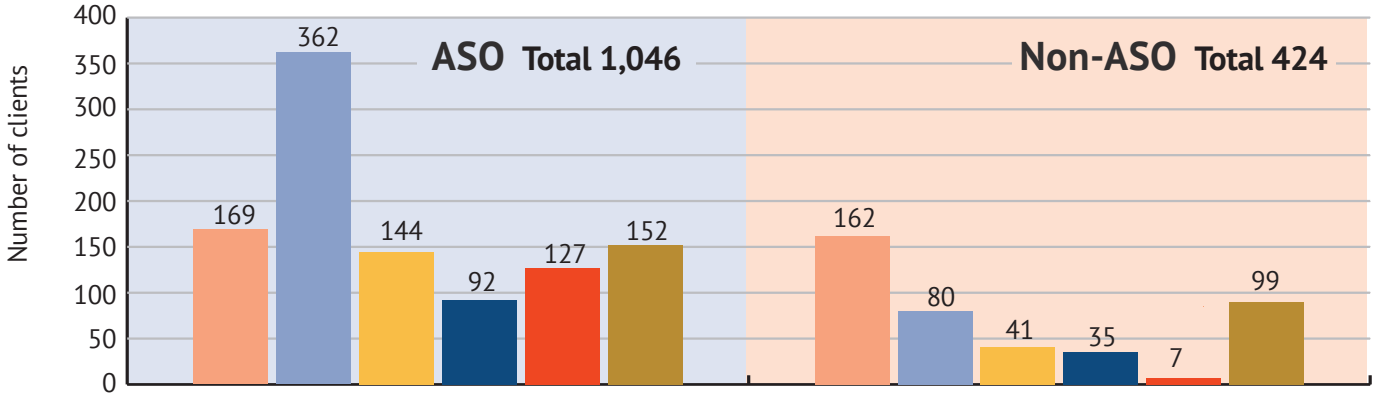
New clients living with HIV began accessing services within similar timeframes post-diagnosis as in 2016-17: 23% were diagnosed within the prior year and 30% had been diagnosed between one and five years prior. However, these trends are dissimilar for men and women. New male clients living with HIV tend to access services more quickly post-diagnosis: 25% access services within one year compared to 17% of females. Thirty-seven percent of females access services more than six years post-diagnosis compared to 27% of males.

Clients of non-ASOs tend to access services sooner after diagnosis: 38% within a year and 19% within five years post-diagnosis. On the other hand, 19% of new ASO clients access services within a year and 35% within one to five years after diagnosis. Clients may be accessing language, housing, and other social services at specialized non-ASO programs sooner after diagnosis than HIV-specific services at ASOs.

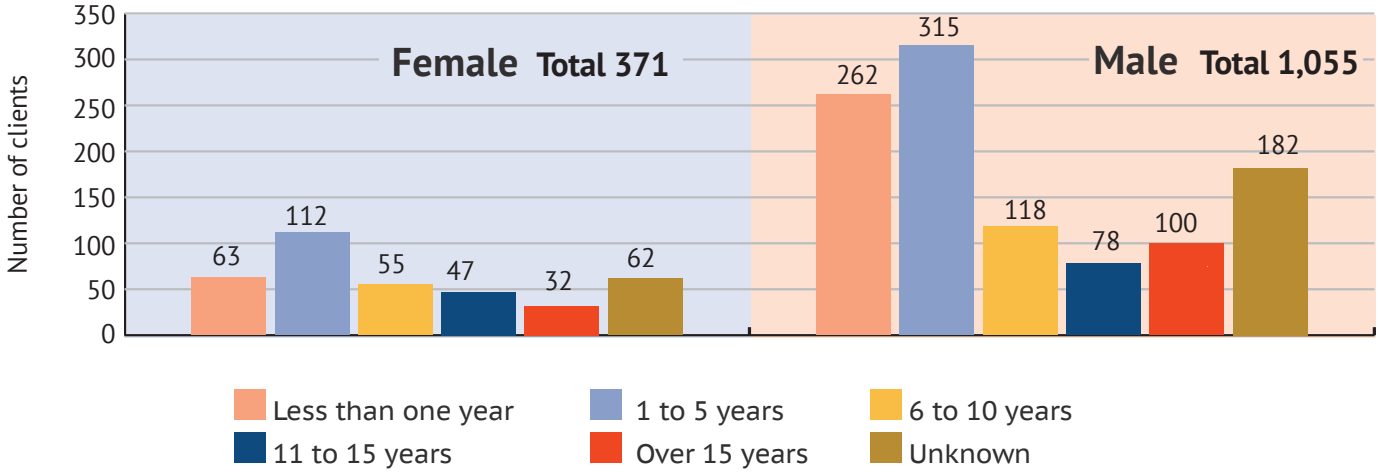
Length of time between HIV diagnosis and accessing services by year OCHART Q5.14



Length of time between HIV diagnosis and accessing services by organization type 2017-18 OCHART Q5.14



Length of time between HIV diagnosis and accessing services for males and females 2017-18 OCHART Q5.14



Unique (new and active) clients accessing HIV support services

Number of unique clients accessing types of services at ASOs and non-ASOs by year OCHART Q5.6

Service category	ASO	Non-ASO	Total
Practical assistance			
2016-17	6,732	488	7,220
2017-18	6,163	376	6,539
Community/Social Services			
2016-17	5,107	1,785	6,892
2017-18	5,153	1,597	6750
Intake			
2016-17	702	2,263	2,965
2017-18	631	2,366	2,997
Case management			
2016-17	435	314	749
2017-18	346	326	672
Support within housing			
2016-17	170	13	183
2017-18	215	24	239
Traditional services			
2016-17	26		26
2017-18	30	1	31

A decline in the overall number of clients from 2016-17 to 2017-18 meant that fewer unique clients accessed most types of services.[9] However, the number of clients receiving support within housing increased from 183 to 239 (31%) at both ASOs and non-ASOs. Additionally, the number of client intakes increased slightly along with the increase in new clients year-over-year, and the number of unique people accessing Indigenous traditional services increased from 25 in 2016-17 to 31 in 2017-18.

The number of unique clients accessing practical assistance services decreased the most (9%) from 2016-17 (when 7,220 accessed practical assistance) to 6,539 in 2017-18. Case management was accessed by 672 unique clients in 2017-18, 77 (10%) fewer than in 2016-17.

Service sessions

Overall, the number of service sessions delivered by community-based HIV programs decreased 10% from 199,316 in 2016-17 to 178,815 service sessions delivered in 2017-18; however, services were used in similar proportion as in 2016-17. Forty percent (71,471) of service sessions in 2017-18 were for community/social services, including 44,854 general support sessions, 8,451 support group sessions, 6,627 sessions on managing HIV, and 5,359 clinical counselling sessions. Practical assistance accounted for 32% (56,838) of service sessions in 2017-18, which included 39,015 sessions related to food programs, and 8,954 sessions for transportation.

9 See Appendix C for a list of service type definitions.

Number of service sessions at ASOs and non-ASOs by year OCHART Q5.7

Service	2016-17	2017-18
Practical assistance	**63,468**	**56,838**
Complementary therapies	2,968	2,265
Food programs	42,048	39,015
Financial	4,403	2,667
Other	4,962	3,937
Transportation	9,087	8,954
Community/Social Services	**77,971**	**71,471**
Bereavement services	750	308
Clinical counselling	5,188	5,359
Employment services	1,706	1,243
Financial counselling services	2,231	2,137
General support	51,118	44,854
HIV Pre/Post-test counselling	431	280
Managing HIV	4,803	6,627
Settlement services	2,079	2,212
Support groups	9,665	8,451
Intake	**6,242**	**8,351**
Case management	**6,879**	**5,788**
Support within housing	**43,751**	**35,872**
Traditional services	**1,005**	**495**

Most used services

Non-ASOs generally provided more clinical counselling and case management services in 2017-18 while ASOs offered more intake and general supportive counselling.

Number of unique clients accessing top 5 services at ASOs and non- ASOs OCHART Q5.18

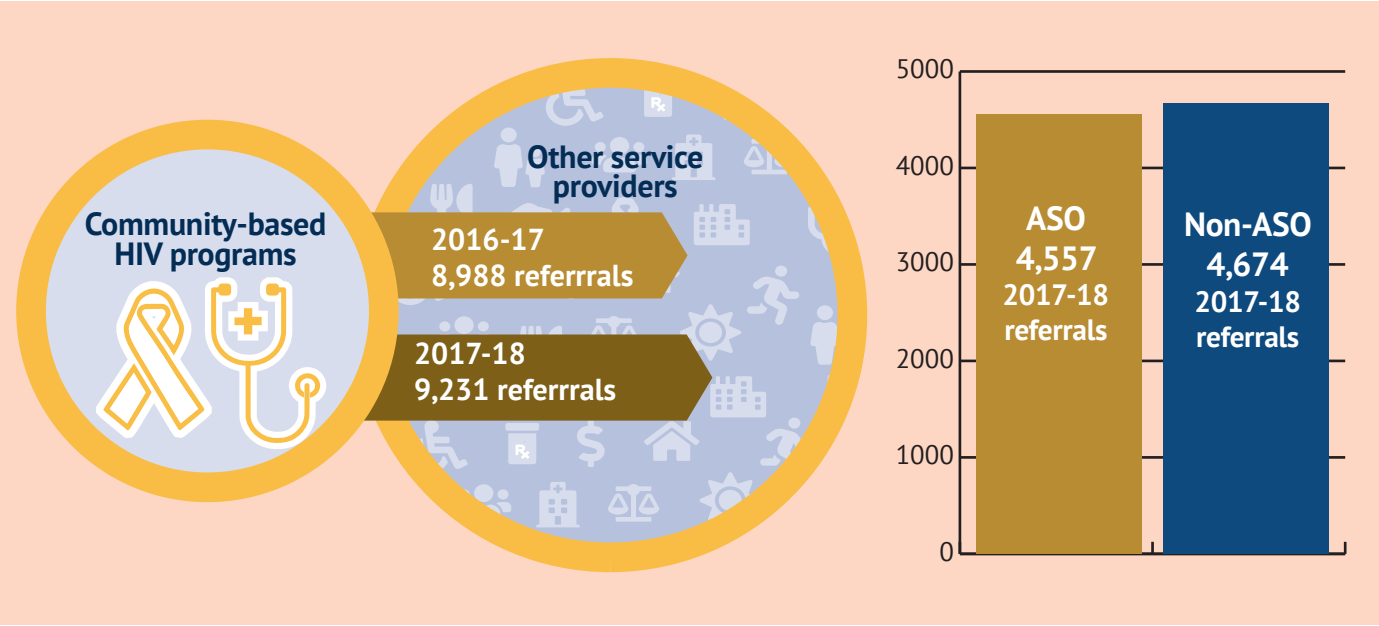
ASOs

- Intake (4,764)
- General support (3,018)
- Food programs (1,662)
- Practical assistance – transportation (886)
- Clinical counselling (798)

Non-ASOs

- Case management (2,297)
- Clinical counselling (982)
- General support (826)
- Intake (418)
- Support groups (344)

More referrals made in 2017-18



In 2017-18, the community-based HIV programs made 9,231 referrals to other service providers, 3% more than the 8,988 referrals made in 2016-17. This trend is consistent at ASOs and non-ASOs, which made 4,557 and 4,674 referrals, respectively.

This year, more referrals were made to:

- addiction services (up 3% to 549)
- HIV/STI testing (up 21% to 570)
- other (non-HIV) community-based service providers for assistance with housing, employment, or legal services (up 23% to 4,785).

The largest declines in referrals made between 2016-17 and 2017-18 were to non-HIV specific clinical service providers (down 27% from 1,571 to 1,137) and mental health services (down 43% from 903 to 513). Fewer referrals to mental health services may be partially due to these types of services being over-capacity.

> There is an increased need for mental health services that are more timely, that are financially accessible, and that are ongoing past an 8-12 week period.
> –Gilbert Centre for Social and Support Services

> We have noticed an increase in complex mental health issues, specifically severe depression and high suicide risk. We are in need of more crisis intervention and long-term mental health services in our community.
> –HIV/AIDS Resources & Community Health (ARCH)

Number of referrals made by referral type and year OCHART Q5.8

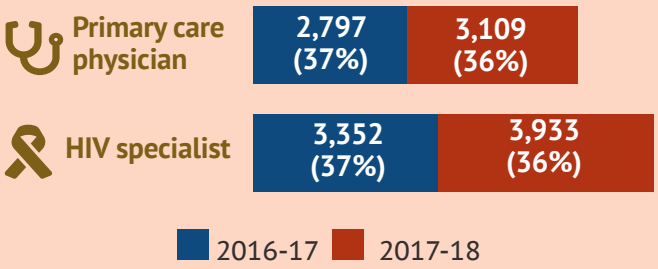
	ASO	Non-ASO	Total
2016-17	**4,362**	**4,626**	**8,988**
Other community-based service providers	2,505	1,380	3,885
Clinical service providers: non-HIV specific	802	769	1,571
Mental health service providers	295	608	903
Community-based service providers – HIV care and support	448	449	897
Addiction services	71	463	534
HIV/STI testing	177	293	470
Clinical service providers: HIV care	36	379	415
Harm reduction services	28	285	313
2017-18	**4,557**	**4,674**	**9,231**
Other community-based service providers	3,144	1,641	4,785
Clinical service providers: non-HIV specific	461	676	1,137
Community-based service providers – HIV care and support	363	496	859
HIV/STI testing	155	415	570
Addiction services	56	493	549
Mental health service providers	181	332	513
Clinical service providers: HIV care	135	351	486
Harm reduction services	62	270	332

Note: One organization was removed from analysis.

More people living with HIV have primary care physicians and HIV specialists

The number of clients living with HIV who have a primary care physician and/or an HIV specialist has increased each of the last two years (when the information started being recorded). At the end of 2016-17, 2,797 clients reported having a primary care physician and 3,352 reported having an HIV specialist. At the end of 2017-18, 3,109 reported having a primary care physician and 3,933 an HIV specialist.

Number and percentage of clients living with HIV reporting having a primary care physician and/or HIV specialist OCHART Q5.9 & 5.10



Organizations reported 77 client deaths in 2017-18, down from 117 in 2016-17.

Number of clients reported deceased by year OCHART Q5.11

Year	Number
2013-14	118
2014-15	100
2015-16	110
2016-17	117
2017-18	77

Reporting organizations

ASO

- 2-Spirited People of the First Nations
- Action Positive VIH/SIDA
- Africans In Partnership Against AIDS
- AIDS Committee of Cambridge, Kitchener, Waterloo and Area
- AIDS Committee of Durham Region
- AIDS Committee of North Bay and Area
- AIDS Committee of Ottawa
- AIDS Committee of Thunder Bay (Elevate NWO)
- AIDS Committee of Toronto
- AIDS Committee of Windsor
- AIDS Committee of York Region
- Alliance for South Asian AIDS Prevention
- Asian Community AIDS Services
- Black Coalition for AIDS Prevention
- Bruce House
- Fife House
- HIV/AIDS Regional Services
- HIV/AIDS Resources & Community Health (ARCH)
- Ontario Aboriginal HIV/AIDS Strategy
- Ontario Aboriginal HIV/AIDS Strategy - Cochrane
- Ontario Aboriginal HIV/AIDS Strategy - Kingston
- Ontario Aboriginal HIV/AIDS Strategy - London
- Ontario Aboriginal HIV/AIDS Strategy - Ottawa
- Ontario Aboriginal HIV/AIDS Strategy - Sudbury
- Ontario Aboriginal HIV/AIDS Strategy - Thunder Bay
- Ontario Aboriginal HIV/AIDS Strategy - Wallaceburg
- PASAN (Prisoners with HIV/AIDS Support Action Network)
- Peel HIV/AIDS Network
- Peterborough AIDS Resource Network
- Positive Living Niagara
- Regional HIV/AIDS Connection
- Réseau ACCESS Network
- The AIDS Network
- Gilbert Centre for Social and Support Services
- Teresa Group Child and Family Aid
- Toronto People With AIDS Foundation

NON-ASO

- Association of Iroquois and Allied Indians
- Centre for Spanish-Speaking Peoples
- Centre francophone de Toronto
- Family Service Toronto
- Good Shepherd Refuge Social Ministries (Barrett House)
- Group Health Centre, Sault Ste. Marie and District
- Hassle Free Clinic
- Hemophilia Ontario
- HIV & AIDS Legal Clinic (Ontario)
- Hospice Toronto
- LOFT Community Services
- Maggie's: Toronto Sex Workers Action Project
- Nishnawbe Aski Nation
- Ontario Association of the Deaf, Deaf Outreach Program
- Ottawa Gay Men's Wellness Initiative (MAX Ottawa)
- Sandy Hill Community Health Centre (OASIS)
- Ottawa Hospital Research Institute
- Waasegiizhig Nanaandaweiyewigamig
- Women's Health in Women's Hands Community Health Centre

Harm Reduction

Key points

- Thirty ministry-funded harm reduction programs, plus six other programs, reported delivering services to 68,390 unique clients in 2017-18, including 10,674 new clients.
- Harm reduction programs reported 180,505 client interactions in 2017-18, including 51,763 outreach interactions.
- Harm reduction programs delivered a total of 128,710 service sessions in 2017-18, including 41,090 harm reduction teachings.
- Harm reduction programs made 40,614 referrals to other services in 2017-18, with females relatively more likely than males to receive referrals to addiction, mental health, and clinical services.
- Programs distributed 32,822,842 harm reduction supplies in 2017-18, 33% more than in 2016-17.

Harm reduction work continues to be a priority for many organizations. In 2017-18, in response to the increased rate of opioid overdoses, the ministry funded an additional eight harm reduction programs. This brings the total to 30 programs providing harm reduction services to people who use drugs, including: harm reduction teaching; distribution of supplies; and referrals to other treatment, health and social services. Six additional programs reported providing some harm reduction services, even though they are not funded for these services by the ministry. They accounted for approximately 5% of the total reported activity. Services at ministry-funded programs are provided both onsite as well as at community outreach locations and via mobile services such as vans.

> Demand for harm reduction outreach services continues to be high, and harm reduction outreach work is generally viewed positively by the community. Opioids continue to be a major substance of concern, and opioid-related overdose events have increased significantly.
>
> — City of Hamilton

In 2017-18, OCHART questions for harm reduction programs were changed in order to gain a more complete understanding of the programs' work and clients. Because the data collected changed from the prior year, year-over-year comparisons are not available for many questions.

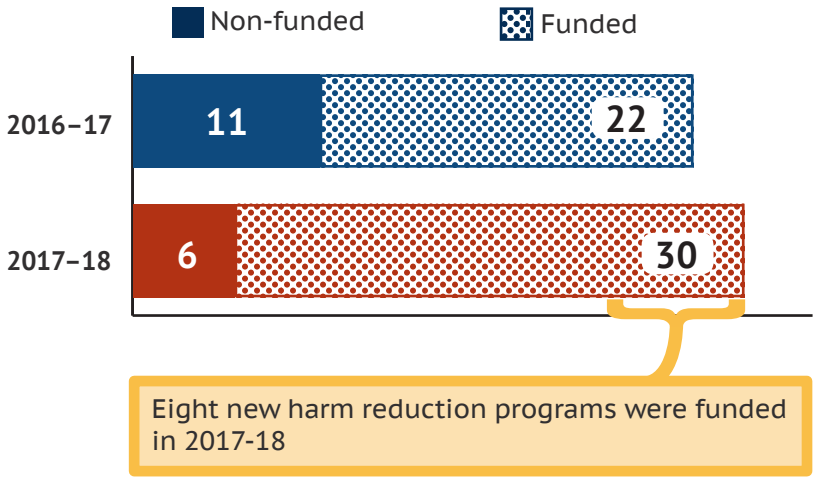
Ministry-funded harm reduction programs

- AIDS Committee of Cambridge, Kitchener, Waterloo and Area
- AIDS Committee of Durham Region
- AIDS Committee of North Bay and Area
- Gilbert Centre for Social and Support Services
- AIDS Committee of Windsor
- Positive Living Niagara
- Elevate NWO
- Group Health Centre, Sault Ste. Marie and District
- Parkdale Queen West Community Health Centre
- City of Ottawa Public Health
- Regent Park Community Health Centre
- The AIDS Network
- City of Hamilton
- HIV/AIDS Regional Services
- HIV/AIDS Resources & Community Health (ARCH)
- Ontario Aboriginal HIV/AIDS Strategy
- Peel HIV/AIDS Network
- Peterborough AIDS Resource Network
- Regional HIV/AIDS Connection
- Réseau ACCESS Network
- Sandy Hill Community Health Centre (OASIS)
- Sioux Lookout First Nations Health Authority
- Somerset West Community Health Centre
- South Riverdale Community Health Centre
- Kingston Community Health Centres
- Sudbury Action Centre For Youth
- Syme-Woolner Neighbourhood and Family Centre
- City of Toronto (The Works)
- Unison Health and Community Services
- Warden Woods Community Centre

Other harm reduction programs

- Black Coalition for AIDS Prevention
- Maggie's: The Toronto Sex Workers Action Project
- Ontario Aboriginal HIV/AIDS Strategy - Sudbury
- PASAN (Prisoners with HIV/AIDS Support Action Network)
- Toronto People With AIDS Foundation
- Waasegiizhig Nanaandaweiyewigamig

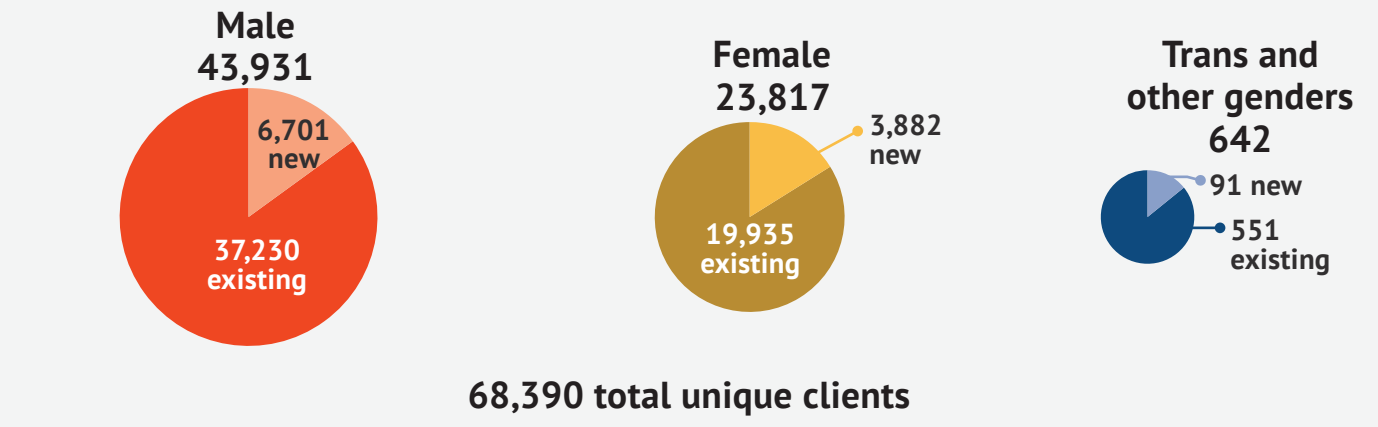
Number of ministry-funded harm reduction and other programs reporting harm reduction activities in OCHART



New and unique clients

In 2017-18, organizations reporting harm reduction services saw a total of 68,390 unique clients,[1] including 10,674 new clients (16% of total unique clients). In terms of gender, new clients had a similar gender breakdown as the entire client cohort (64% male and 36% female), which was consistent across all regions of Ontario.

Number of new and unique clients at harm reduction programs in 2017-18 OCHART Q6.1



Client interactions

Client interactions are the number of times services were accessed during a year; clients may be counted more than once if they access services multiple times throughout the year. Harm reduction programs reported 180,505 client interactions in 2017-18. Two out of three interactions (65%) were with male clients, which reflects the gender makeup of clients overall. Men were more likely to use on-site needle exchange programs, where they made up 67% of client interactions; men also accounted for 59% of interactions at outreach locations. Client interactions were likely underreported in 2017-18 as two of the largest ministry-funded programs experienced data collection and reporting issues, and the eight newly funded programs spent significant time designing, staffing, and rolling out their programs and services throughout the year.

1 The number of clients may not be unique individuals as some may receive services from more than one organization.

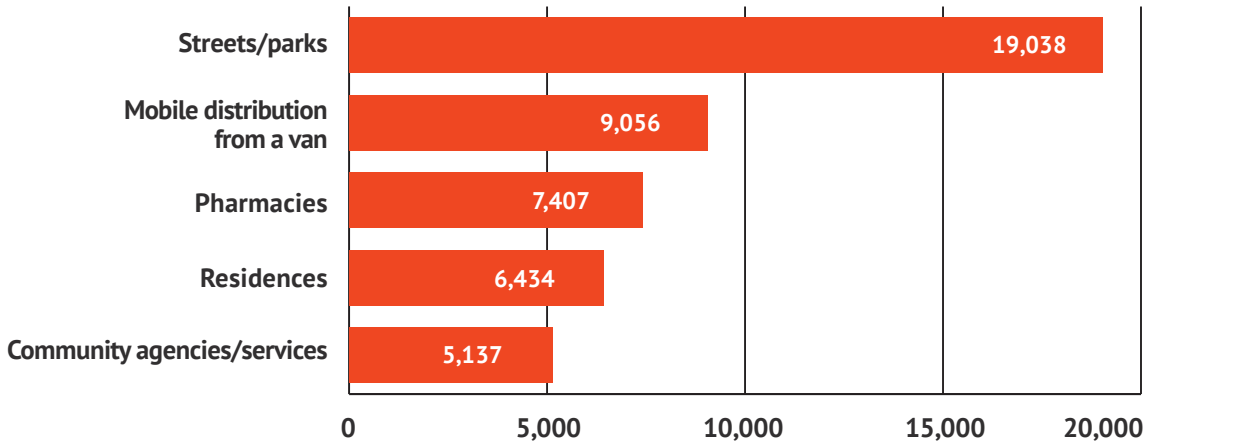
Client interactions by location and gender in 2017-18 OCHART Q6.3

Location	Male	Female	Trans and other genders	Total
Streets/Parks	11,517	7,254	267	19,038
Mobile distribution from a van	5,180	3,734	142	9,056
Pharmacies	4,904	2,503	NR	7,407
Residences	3,459	2,975	NR	6,434
Community agencies/services	3,004	1,965	168	5,137
Addiction programs	776	707	NR	1,483
Methadone maintenance clinics	812	486	NR	1,298
Community public spaces	559	331	17	907
Bars/night clubs	289	220	NR	509
Parties/raves	158	104	NR	262
Jails/detention centres/prisons	118	94	NR	212
Total outreach	**30,776**	**20,373**	**614**	**51,763**
On-site needle exchange program	86,747	37,745	4,250	128,742
Total	**117,523**	**58,118**	**4,864**	**180,505**

NR = not reported due to low client counts.

Outreach programs play an important role in reaching all populations. In 2017-18, harm reduction programs reported 51,763 client interactions at outreach locations, accounting for 29% of all interactions. Streets/parks were the most common outreach location (19,038 interactions), followed by mobile van distribution (9,056), pharmacies (7,407), and residences (6,434). While outreach accounted for 21-33% of interactions in most regions, 67% of interactions in the Northern region were made during outreach.

Top client interactions by outreach location in 2017-18 OCHART Q6.3



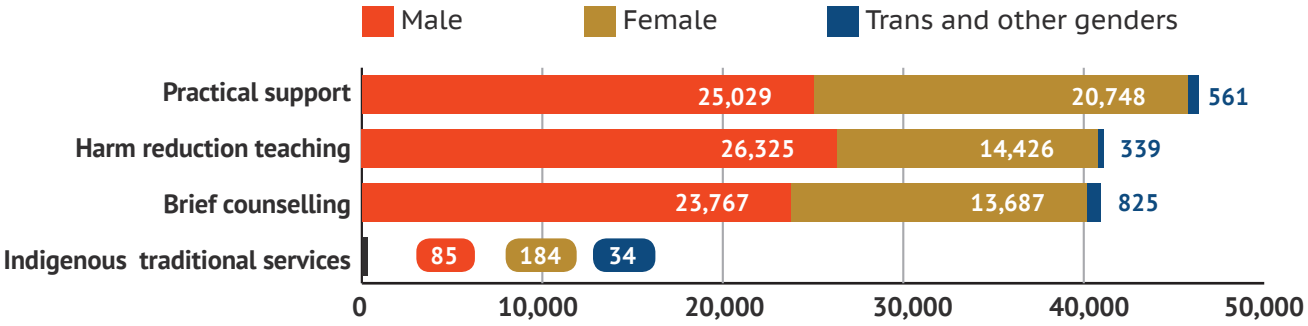
Service sessions

In addition to distributing safer injection and inhalation equipment, organizations provide other services. Harm reduction programs delivered a total of 128,710 service sessions in 2017-18, including:

- 46,338 practical support services (36% of total services delivered)
- 41,090 harm reduction teachings (32%)
- 40,979 brief counselling services (32%)
- 303 Indigenous traditional services (<1%).

The types of service sessions delivered differed by gender. Male clients received a greater proportion of brief counselling and harm reduction teaching, while female, trans, and clients with other gender expressions received a greater proportion of Indigenous traditional services.

Number of service sessions by type in 2017-18 OCHART Q6.2



Over 40,000 referrals made to clients accessing harm reduction services

Harm reduction programs made 40,596 referrals to treatment, health and other social services in 2017-18:

- 3,508 (9%) to addiction services
- 6,977 (17%) to clinical health service providers (primary care, urgent, HIV, and other clinical health care)
- 12,639 (31%) to other in-service and outreach harm reduction services in the community
- 8,011 (20%) to other community-based services such as housing, women-specific, or faith-based social services.

While males accounted for 65% of total clients in 2017-18, they received 58% of referrals from harm reduction programs. Females were relatively more likely to receive referrals to addiction services, mental health services, and three types of clinical services: primary care, urgent care, and HIV care.

> We have taken an active step in supporting adherence. To this end, we have expanded our outreach support services to try and "catch people where they live" in an effort to literally walk with them if necessary to the local health clinic for treatment.
>
> — Regional HIV/AIDS Connection

Number of referrals made by type and gender in 2017-18 OCHART Q6.4

Referral type	Male	Female	Trans and other genders	Total
Harm reduction services	7,137	5,143	359	12,639
Other community-based service providers	4,458	3,463	90	8,011
Addiction services	1,744	1,750	14	3,508
Clinical service providers (primary care)	1,665	1,593	21	3,279
HIV/STI testing	1,714	1,441	17	3,172
Mental health service providers	1,515	1,518	–	3,033
Hep C teams	1,395	802	–	2,197
Clinical service providers (urgent care)	860	870	–	1,730
Clinical service providers (other)	699	484	–	1,183
Clinical service providers (HIV care)	347	438	–	785
Community-based HIV service providers	295	224	10	529
Hep C testing other (non-Hep C team)	188	124	–	312
Hep C treatment other (non-Hep C team)	137	81	–	218
Total	**22,154**	**17,931**	**511**	**40,596**

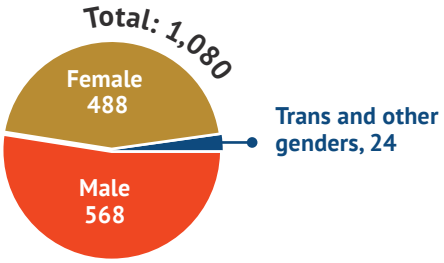
More participants at peer support activities

Harm reduction programs reported 1,080 peers being active in their programs in 2017-18. While females made up 35% of harm reduction clients, they make up 45% of peers. Peers played an important role in harm reduction programs in 2017-18. Of the 36 harm reduction programs, peers were engaged in the creation of harm reduction kits at 30 (83%), equipment distribution at 29 (81%), harm reduction teaching at 27 (75%), and brief counselling at 25 (69%).

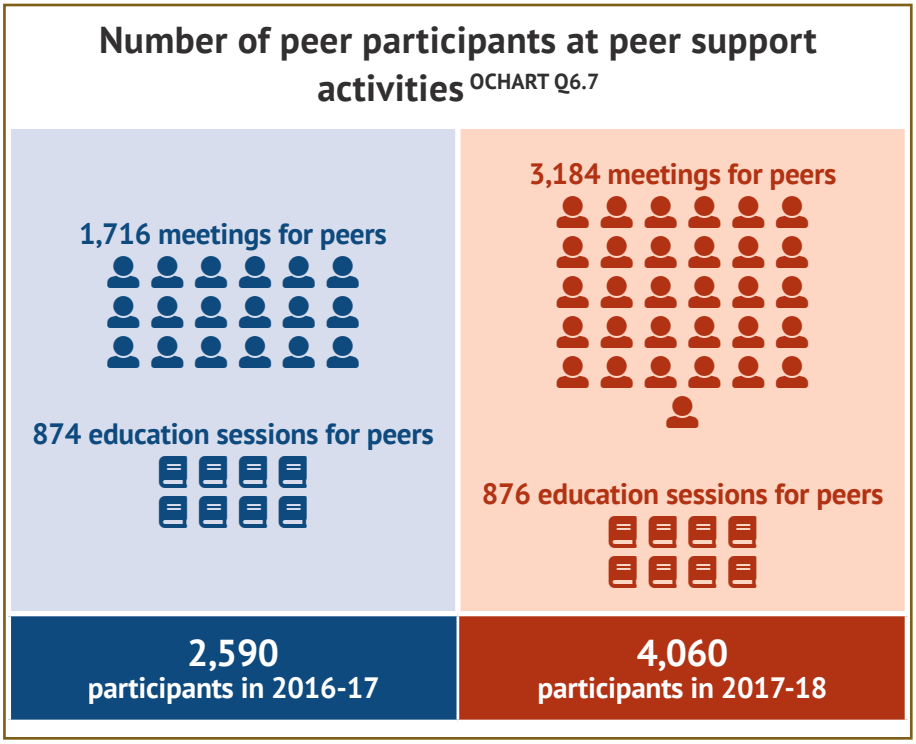
Number of harm reduction programs engaging peers in different activities 2017-18 OCHART Q6.6

Peer activities	Number of organizations
Safer injection/safer inhalation kit making	30
Harm reduction equipment distribution	29
Harm reduction teaching	27
Brief counselling	25
Practical support	19
Community cleanups	12

Number of peers working at harm reduction programs in 2017-18 OCHART Q6.1



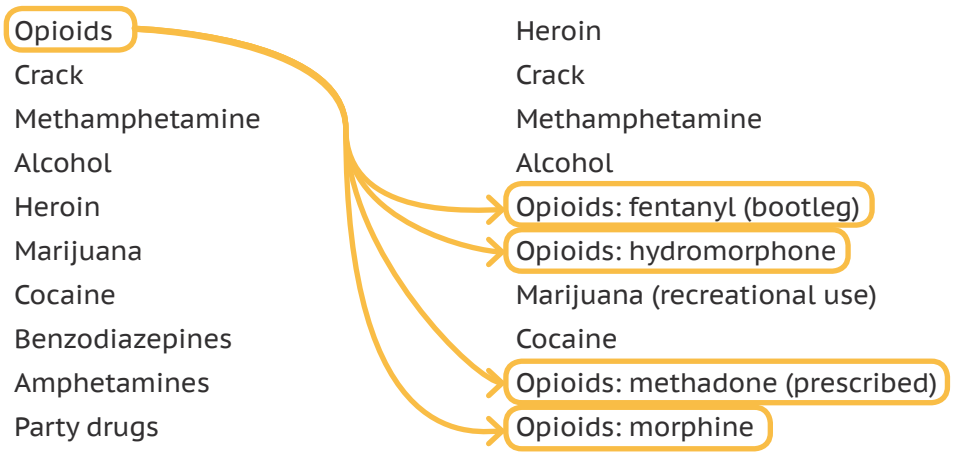
Number of peer participants at peer support activities OCHART Q6.7



Opioids continue to be the most used substance

The "opioids" category recorded in 2016-17 was split to track 11 individual opioids in 2017-18. When added together, the four opioids in the top ten substances used in 2017-18—bootleg fentanyl, hydromorphone, prescribed methadone, and morphine—make opioids the top drug of choice reported by people who use drugs and access services at ministry-funded harm reduction programs.

Top ten drugs of choice as reported by clients at all ministry-funded harm reduction programs OCHART Q6.8



Increase in harm reduction supplies distributed

As the number of ministry-funded harm reduction programs increased from 22 in 2016-17 to 30 in 2017-18, the number of harm reduction supplies distributed increased in nearly every category. Programs distributed 33% more harm reduction supplies in 2017-18, totaling 32,822,842 individual supplies, including:

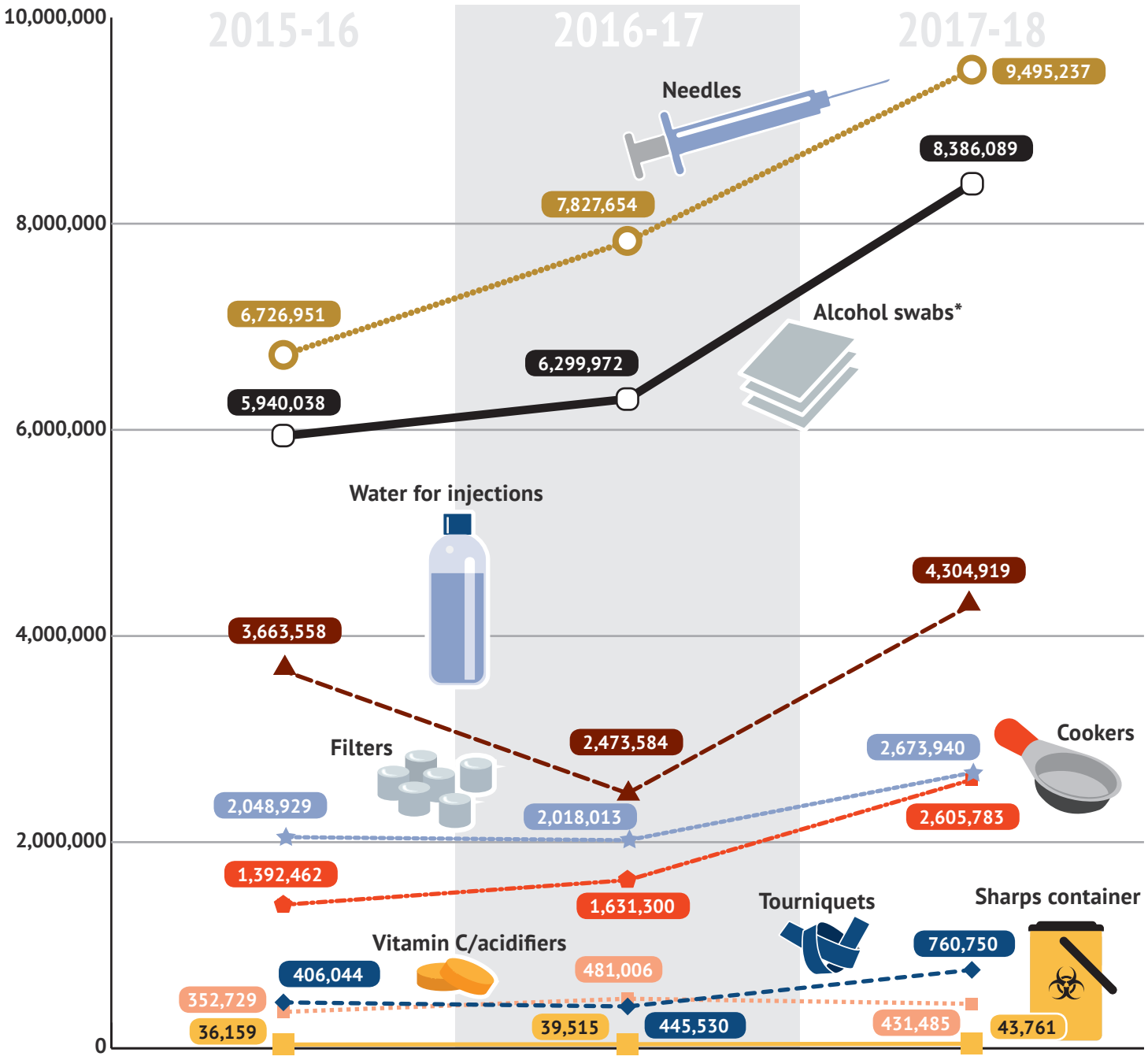
- 28,701,964 safer injection supplies (26% increase)
- 2,294,884 safer inhalation supplies (20% increase)
- 1,751,054 safer sex supplies (6% increase)
- 74,940 other supplies (includes crystal meth pipes, foils, and straws; newly tracked in 2017-18).

Number of harm reduction supplies distributed by year OCHART Q6.9

	2015-16	2016-17	2017-18
Safer injection total	**20,606,356**	**21,177,088**	**28,701,964**
Needles	6,726,951	7,827,654	9,495,237
Alcohol swabs*	5,940,038	6,299,972	8,386,089
Water for injection	3,663,558	2,473,584	4,304,919
Filters	2,048,929	2,018,013	2,673,940
Cookers	1,392,462	1,631,300	2,605,783
Tourniquets/ties	445,530	406,044	760,750
Vitamin C/acidifiers	352,729	481,006	431,485
Sharps containers	36,159	39,515	43,761
Safer inhalation total	**1,708,553**	**1,839,199**	**2,294,884**
Screens (single)	1,076,223	897,087	1,374,227
Glass pipes/stems	333,602	383,692	433,699
Mouthpieces	148,574	293,222	262,611
Wooden push sticks	141,573	258,380	214,132
Lip balm	8,581	6,818	10,215
Safer sex supplies total	**1,208,526**	**1,642,665**	**1,751,054**
Condoms	1,003,012	1,389,325	1,537,043
Lube	191,121	249,495	210,298
Dental dams	14,393	3,845	3,713
Other equipment total	–	–	**74,940**
Foils (for smoking)	–	–	47,714
Crystal meth pipes	–	–	19,393
Straws	–	–	7,833

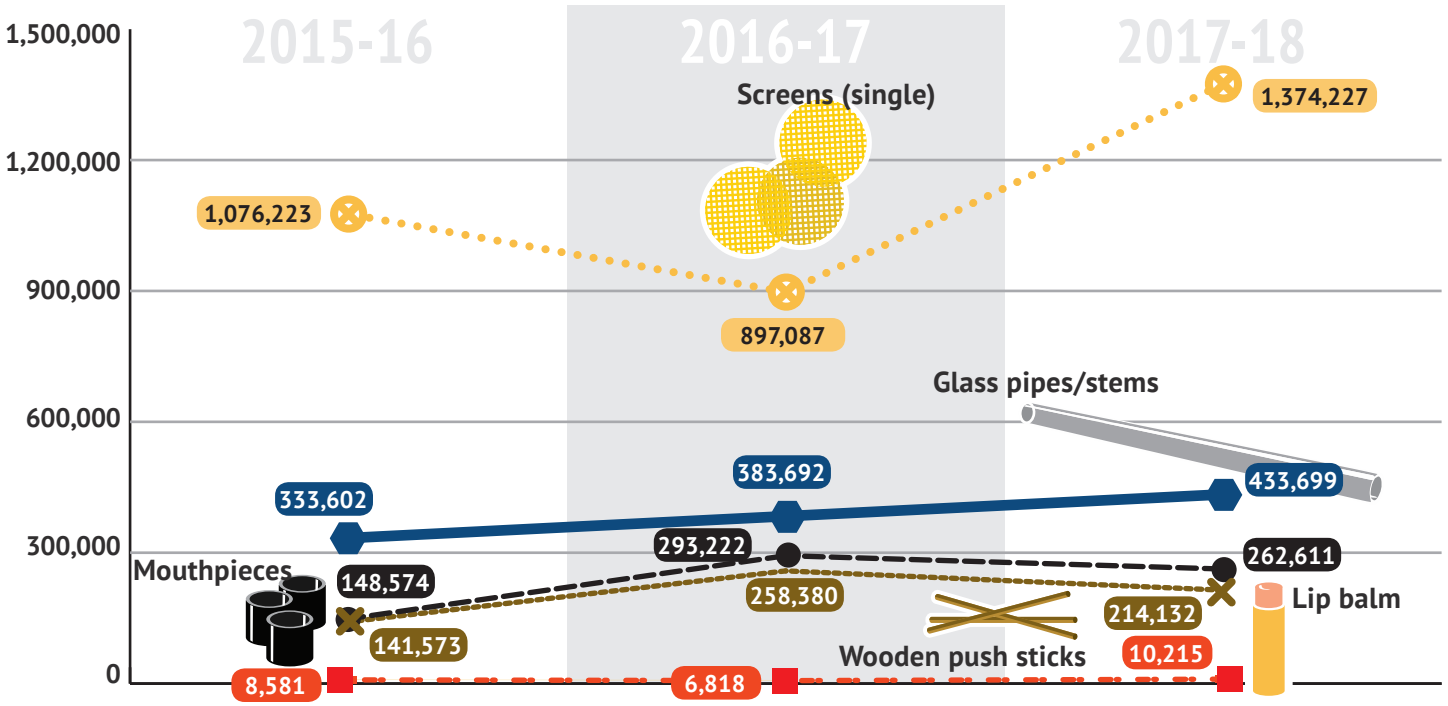
* Due to changes in reporting, this number represents alcohol swabs distributed for both safer injection and safer inhalation.

Safer injection supplies

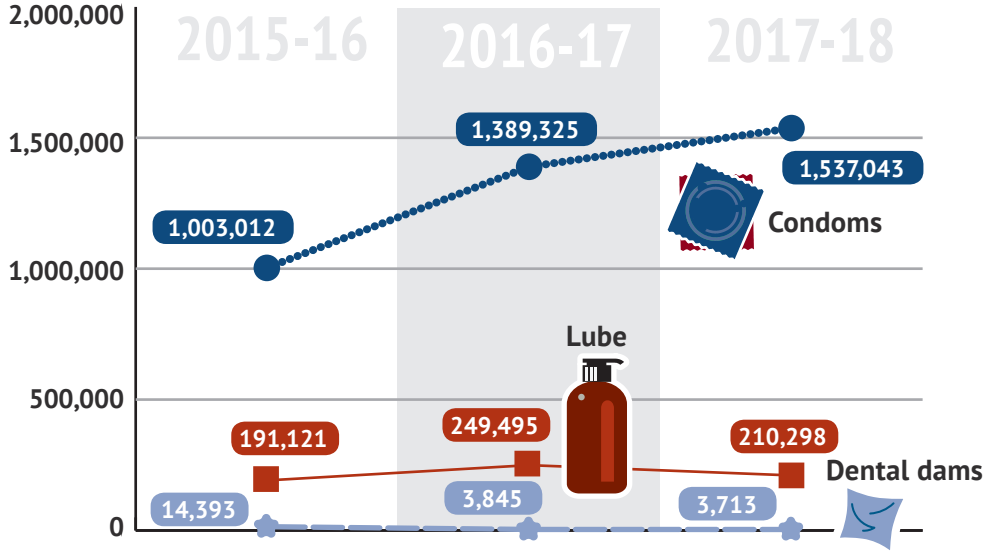


* Due to changes in reporting, this number represents alcohol swabs distributed for both safer injection and safer inhalation.

Safer inhalation supplies



Safer sex supplies



Other equipment distributed in 2017-18


Foil 47,717


Crystal meth pipes 19,393


Straws 7,833

Anonymous Testing

Anonymous Testing

Key points

- Fifty HIV testing sites are legislated to provide anonymous testing in Ontario including rapid/point-of-care (POC) tests; eight are funded by the ministry.
- In 2017, a total of 574,035 HIV tests were conducted in Ontario, 916 of which were positive (0.16% positivity rate).
- The eight ministry-funded testing programs conducted 10,251 anonymous HIV tests in 2017-18, 68 of which were positive (0.67% positivity rate).
- 80% of individuals with a reactive POC test completed confirmatory testing, up from 76% in 2016-17.
- Compared to 2016-17, newly diagnosed clients in 2017-18 were linked to HIV clinical services quicker and were referred to a greater number of other services on average.
- Anonymous testing programs continue to focus on outreach, with 44% (up from 40% in 2016-17) of tests completed at locations other than sites' main locations.
- Amidst the opioid overdose crisis, organizations reported doing more outreach work with and conducting a larger proportion of tests among people who use drugs.

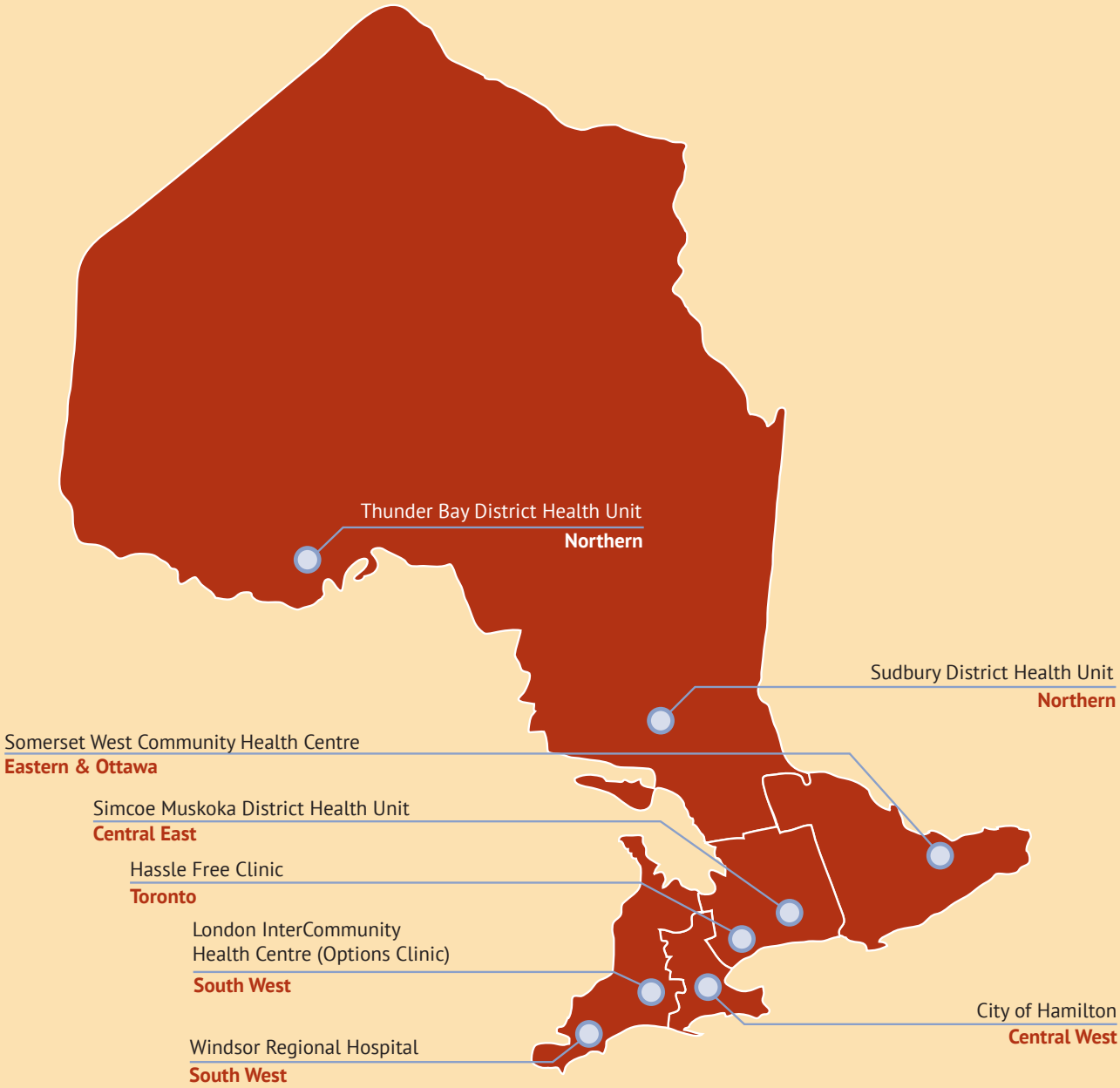
Types of HIV testing offered in Ontario

- Nominal testing: the health care practitioner orders the HIV test using the name of the person being tested.
- Non-nominal or coded testing: the health care practitioner has the person's name on file but uses a unique code instead of the person's name to order the test.
- Anonymous testing: the health care practitioner uses a code that appears on the anonymous test requisition form to order the HIV test and does not collect the person's name or any identifying information. The code cannot be linked to the person's identity.

These types of testing are offered with either standard blood draw tests or rapid/point of care testing.

- Standard blood testing: Blood is drawn and processed by the Public Health Ontario Laboratories (PHOL) and can take up to one week to get final results.
- Rapid/point-of- care testing (POC): Done on-site and results are available right away; if someone has a "reactive" point-of-care test, a standard blood draw test can be ordered for confirmatory testing by PHOL.

Locations of funded anonymous testing sites



HIV testing in Ontario

A snapshot of HIV testing in Ontario:

- 574,035 HIV tests in Ontario in 2017
- 916 of those tests were positive, equivalent to a 0.16% positivity rate
- Total number of HIV tests continues to increase each year, and has increased 30% since 2013.

Highlighting ministry-funded anonymous testing sites

The eight AIDS Bureau-funded testing programs reported conducting a total of 10,251 anonymous HIV tests in 2017-18: 10,163 rapid tests and 88 standard blood draw HIV tests. Of those, 68 tests came back positive, representing a positivity rate of 0.67%, higher than the provincial average of 0.16%.

Number of anonymous tests conducted in 2016-17 and 2017-18

OCHART Q. 7.1

Year	Rapid POC tests	Standard blood draw tests	Positive tests	Positivity rate (%)
2016-17	10,773	140	102	0.93
2017-18	10,163	88	68	0.67

Compared to last year, programs reported performing 6% fewer rapid tests (10,163 compared to 10,773). Programs also reported performing 37% fewer standard blood draw HIV tests (88 down from 140). Positivity rates decreased from the previous year. Approximately one out of every 110 tests was positive in 2016/17, compared to one in every 155 tests this year.

The decrease in the number of tests completed this year can be attributed to a drop in the number of tests delivered by the largest testing site which accounts for 73% of total tests among the eight funded anonymous testing sites. This testing site has the highest positivity rate in the province, which contributed to the overall decrease in positivity rate for these sites.

More people complete confirmatory tests

This year a larger proportion of people completed confirmatory tests than in 2016-17. Last year, 76% (97/127) of individuals with a reactive rapid test completed a confirmatory test, though two did not return for their results. This year, 80% (67/84) of individuals completed a confirmatory test and all of them returned for the results. Clinics report that individuals who decline confirmatory testing at the anonymous testing sites often choose to complete confirmatory testing with their primary care provider or an HIV clinic to obtain immediate access to specialized care.

Number of clients who accepted and declined confirmatory testing after receiving a reactive rapid test

OCHART Q. 7.2

Year	Accepted	Declined	Percent completing confirmatory tests (%)
2016-17	97	30	76%
2017-18	67	17	80%

More testing at outreach locations

Compared to 2016-17, when 60% of anonymous tests were performed at testing programs' main sites, fewer (56%) anonymous tests were performed at testing programs' main sites in 2017-18. The positivity rate for anonymous tests conducted at main sites decreased from 0.94% (2016-17) to 0.73% (2017-18). The decrease in the positivity rate can also be attributed to a drop in the number of tests delivered by the largest testing site which accounts for 73% of total tests among the eight funded anonymous testing sites. This testing site has the highest positivity rate in the province, which contributes to the overall decrease in positivity rate for these sites.

The number of anonymous tests at main site testing locations decreased from 6,498 to 5,773, accounting for the overall decrease in total tests completed at the anonymous testing programs. Seven of the eight funded programs offer testing at outreach locations away from their main site. The decreases in main site tests was partially offset by a 1.4% increase from 4,415 to 4,478 anonymous tests performed at outreach locations, highlighting a trend towards outreach testing. Organizations continue to target testing toward priority populations and less to the general public.

When looking at outreach locations specifically, programs most commonly offered testing at community centres (up to 30% from 25% in 2016-17), bathhouses (6%, even with 2016-17), and community health centres (3% of tests in 2017-18). The positivity rate for outreach tests in 2017-18 was 0.58%. Tests conducted at community centres had a 0.83% positivity rate, suggesting these locations are effective at reaching at-risk communities.

▲ Many anonymous testing sites, like London InterCommunity Health Centre, partner with local ASOs and other community partners to offer testing at locations targeting priority populations.

Number of anonymous tests by location OCHART Q. 7.3

Testing location	2016-17 tests	2017-18 tests
Main site	6,498	5,773
Outreach		
Community centre	2,766	3,025
Bathhouse	703	561
Community health centre	463	266
ASO	158	188
Education institution	139	132
Health/social service agency	40	124
Special event	84	34
Other	22	96
Shelter	34	35
Other local public health unit	0	15
Mobile	6	2
Total	**10,913**	**10,251**

More tests targeting people who use drugs and ACB communities

When anonymous testing sites report the number of tests they perform in OCHART, they are also asked which priority population(s) those tests targeted. In 2017-18, the eight anonymous testing programs reported an increased focus on tests conducted among people who use drugs and African, Caribbean and Black communities than in 2016/17.

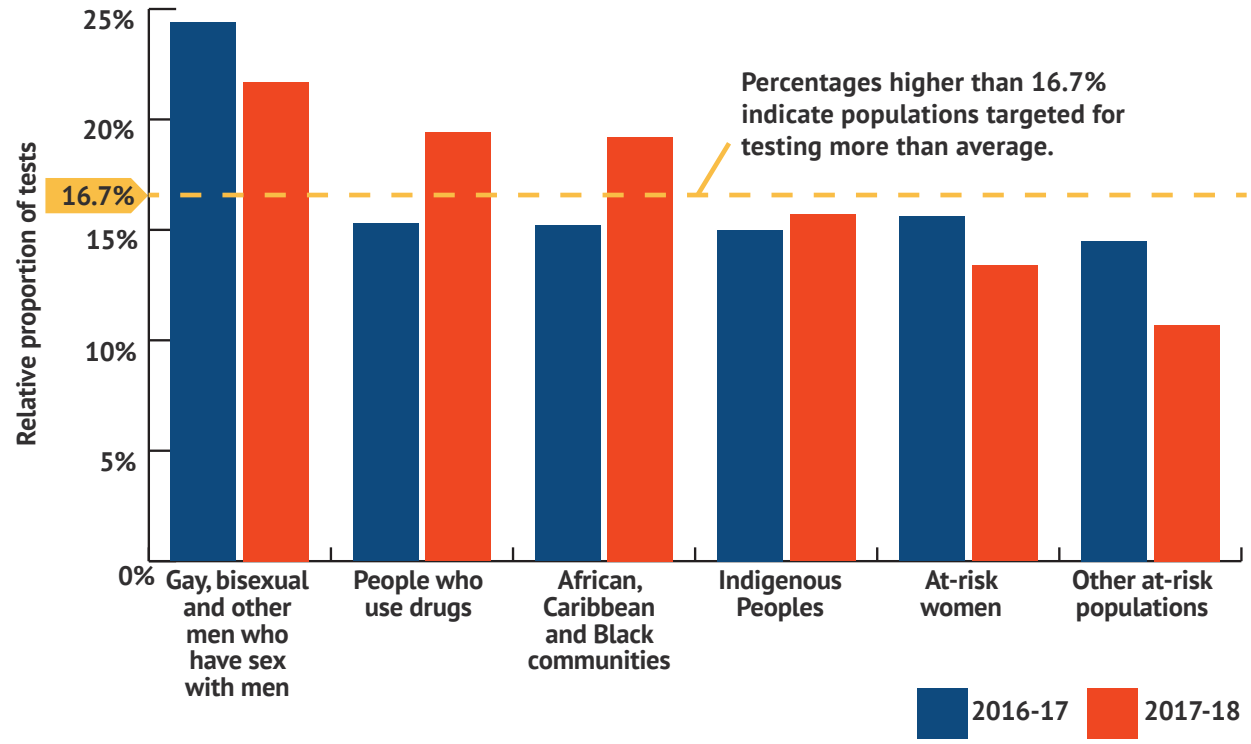
More outreach to people who use drugs and Indigenous communities

Anonymous testing sites are also asked in a separate question to report the approximate proportion of their work targeted to the different priority populations. People who use drugs and Indigenous communities were a focus of outreach programs and testing in 2017-18.

On average, 51% of anonymous testing outreach efforts focus on gay, bisexual, and other men who have sex with men. The percentage of outreach work targeted towards Indigenous Peoples and people who use drugs increased by 1% and 3% respectively. This increase was offset by a slightly smaller proportion of outreach being targeted to gay, bisexual, and other men who have sex with men; African, Caribbean and Black communities; and other at-risk communities.

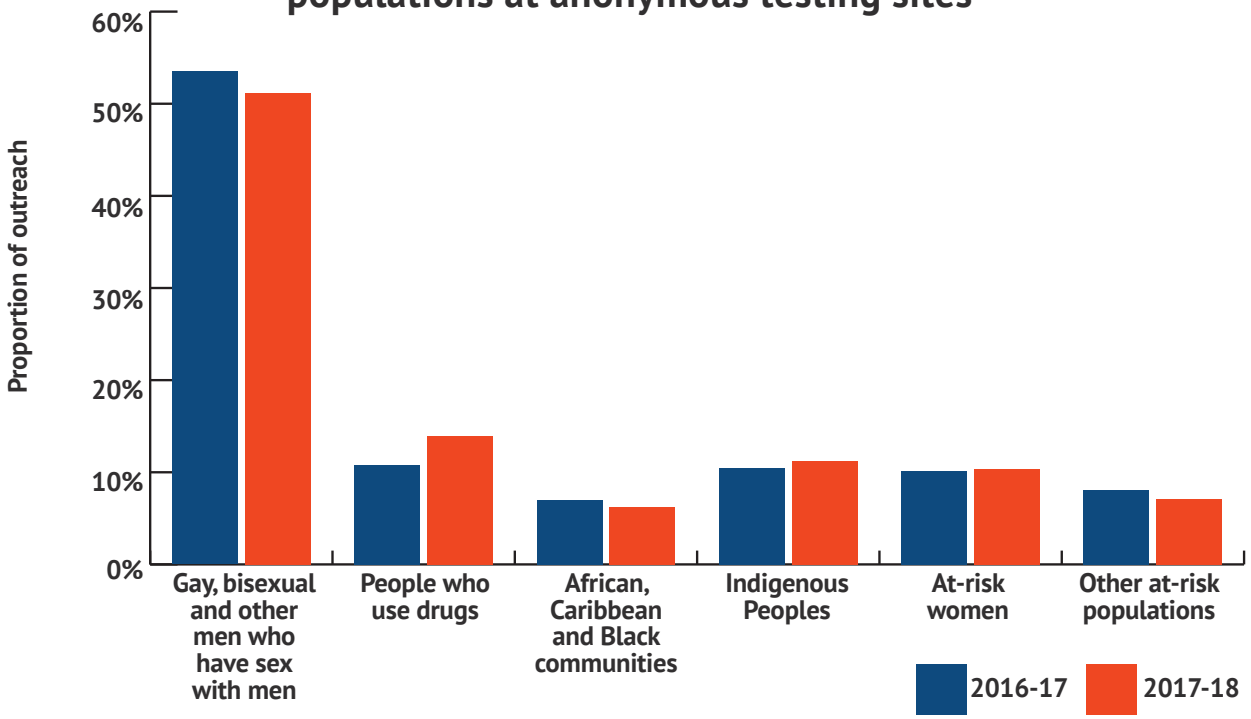
Relative proportion of tests targeted at priority populations

OCHART Q. 7.3



Self-reported proportion of outreach work targeting priority populations at anonymous testing sites

OCHART Q. 7.4



More, quicker connections to HIV clinical care

In 2017-18, the eight anonymous testing sites were more successful in referring individuals with a Public Health Lab confirmed positive test to clinical HIV services. Sixty-seven of the 68 individuals (99.9%) were linked to clinical care compared to 92% last year.

Number of referrals to clinical care

OCHART Q. 7.5

Year	Total number of positive tests	Total number of clients diagnosed by anonymous testing sites referred to clinical care
2016-17	102	94 (92%)
2017-18	68	67 (99%)

The eight sites also played a key role in linking clients who were diagnosed at other programs or agencies to clinical care. In 2017-18, they reported referring 17 individuals diagnosed elsewhere, down from 48 last year.

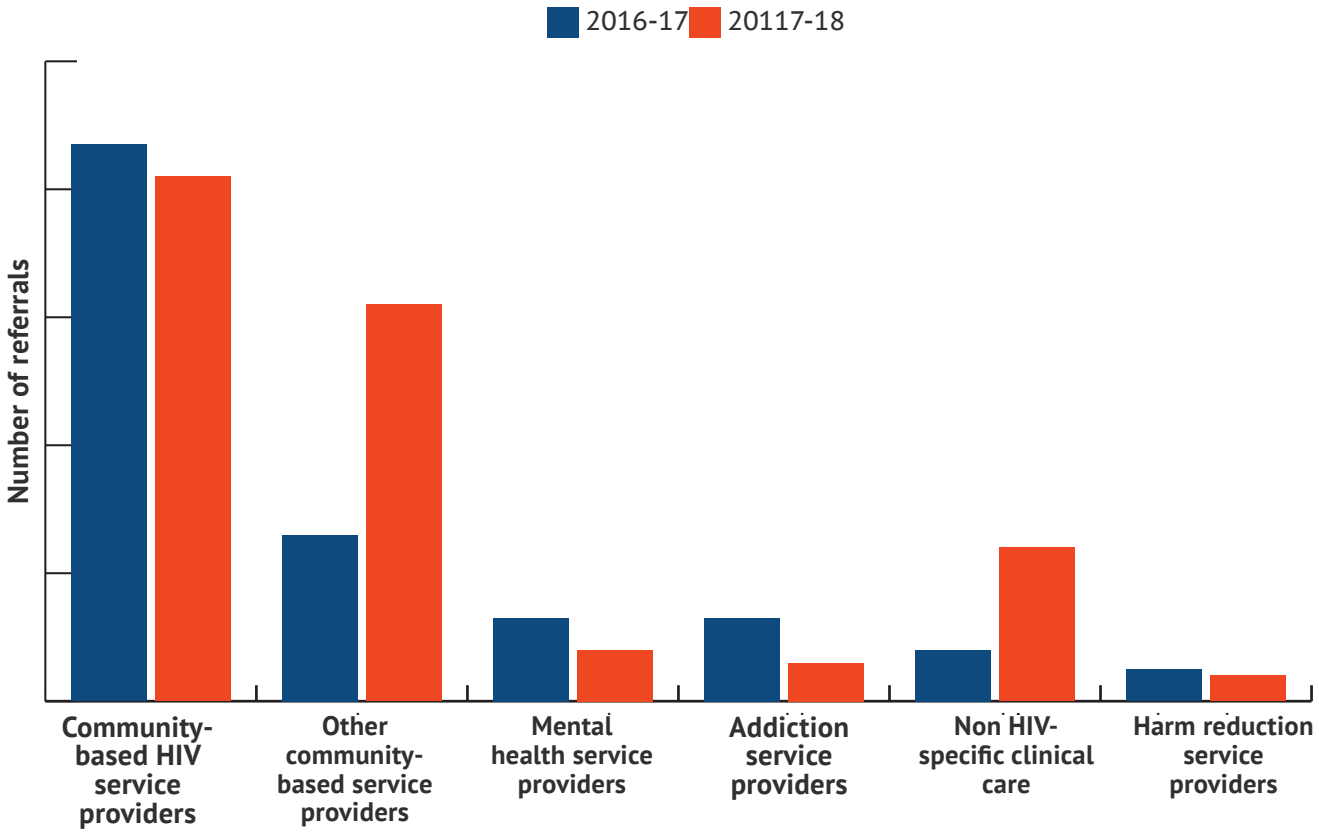
Clients were connected to HIV clinical care more quickly than last year: 86% of clients were connected to HIV clinical care within two weeks of diagnosis compared to only 60% last year.

More frequent referrals to other services

The number of referrals made by the eight ministry-funded anonymous testing programs increased 22% from 152 last year to 186. The number of referrals increased even as the number of newly diagnosed clients needing referrals decreased, indicating that clients are being referred to other agencies and programs more often.

When looking at specific types of referrals, those made to community-based service providers more than doubled compared to 2016-17 (from 26 to 62); referrals to non-HIV clinical care increased threefold (from 8 to 24). Referrals to mental health, addiction, and harm reduction services decreased compared to 2016-17.

Referrals made to other service providers OCHART Q. 7.6.



Note: clients diagnosed at other programs were removed from analysis for one anonymous testing site as they were only able to report those statistics during a single reporting period and not in subsequent periods.

In their own words

Organizations are given the opportunity to provide additional narrative information to contextualize the work done at their programs and to provide a story behind their reported numbers. The narratives provide details on outreach strategies used to reach priority populations in their communities as well as any shifts in demand for their services.

Engaging priority populations by working with community partners

> Overall, engagement with specific communities is done by engaging with community partners. This is often done at population specific agencies but also includes other community organizations such as shelters, harm reduction services, and local businesses. We work with our partner agencies (AIDS Committee of Windsor, Public Health Units, local hepatitis C team) for distribution of clinic information, referrals for testing, follow-up care and acceptance of care pre- and post-diagnosis counselling.
>
> –Windsor Regional Hospital

Gay, bisexual, and other men who have sex with men

We partnered with a local sex positive store to host a workshop geared to men who have sex with men where HIV POC testing service was offered.

–London InterCommunity Health Centre

We make linkages through the Réseau Access Network and twice monthly outreach anonymous testing at the ASO's clinic.

–Sudbury Health Unit

We offer POC anonymous rapid testing at the local bathhouses and men's sexual health clinic at the local ASOs

–Hamilton Public Health & Community Services

Our city-funded Peter Bochove Bath Outreach Program is 96% gay, bisexual, and other men who have sex with men, promoted through the M2M network, the Sexual Health Info Line and posters in the bathhouses.

–Hassle Free Clinic

African, Caribbean and Black communities

We have been working with Regional HIV AIDS Connection and some of their existing outreach contacts to coordinate a "testing day" geared towards African, Caribbean and Black communities. We are also working with formal and informal community leaders and gathering places including faith communities, faith-based gathering places, barbershops and ethnic stores.

–London InterCommunity Health Centre

The Options staff represented the program at the opening celebrations for black history month. The test was demonstrated and brochures and posters were distributed. Staff also connected with local organizations that serve the African, Caribbean and Black communities and provided Options promotional material.

–London InterCommunity Health Centre

We work with BlackCAP in health promotion for women/trans women and Black gay, bisexual, and other men who have sex with men, and youth [populations]. We build testing capacity through ongoing training and consultation with Women's Health in Women's Hands.

–Hassle Free Clinic

Indigenous communities

The Options Clinic has partnered with a local Indigenous focused centre, where we have distributed promotional materials. The Options staff participated at the annual Indigenous health fair on reserve and are actively participating at LIHC drop-in program geared towards Indigenous population. We have updated our promotional materials, to make them culturally appropriate and sensitive including our website.

–London InterCommunity Health Centre

We participated in local events including health fair at Beausoliel First Nation Reserve.

–Simcoe Muskoka District Health Unit

Monthly anonymous testing outreach clinic hosted at the Ontario Aboriginal HIV/AIDS Strategy (Oahas). These events are promoted through Facebook, word of mouth, and Oahas outreach service workers.

–Sudbury and District Health Unit

We have been working doing outreach with Indigenous organizations and are now doing regular testing at 2-Spirited Peoples of the First Nations and are hoping to add Native Women's Resource Centre.

–Hassle Free Clinic

People who use drugs

To engage people who use drugs, we are doing testing at the Needle Exchange program at Regional HIV/AIDS Connection twice weekly, as well as monthly outreach at shelters in London including the Men's Mission as well as the Salvation Army Centre of Hope.

– London InterCommunity Health Centre

The Sudbury and District Health Unit hosts the Needle Exchange Program fixed site, and as such people who use drugs are offered anonymous testing onsite, through general clinic promotion and signage, as well as one-on-one health teaching provided by Needle Exchange Program registered nurses.

–Sudbury and District Health Unit

People who use drugs are linked to testing through Street Health Clinics provided by our Harm Reduction team. Services are promoted through needle syringe program sites, the mobile outreach van, and through community partners. We offer anonymous testing monthly to clients accessing needle exchange or naloxone services at the AIDS Network.

–Hamilton Public Health & Community Services

At-risk women

> To engage women at risk, we have been testing at women's only spaces including a program at Canadian Mental Health Association. Posters and other educational material promoting testing have been made available in these agencies. We also offer testing services at a drop-in centre for street level sex workers.
>
> –London InterCommunity Health Centre

> We promote testing as part of education sessions provided to female population at local detention centre. Testing is offered at a social service agency that serves women with addictions on a weekly basis.
>
> –Hamilton Public Health & Community Services

▲ Anonymous testing programs develop events and services targeted toward diverse populations.

Other at-risk populations

> We offer testing to street-involved youth at homeless shelter. Services are also promoted during Public Health Nurse visits to a local detention centre as part of education sessions for women.
>
> –Hamilton Public Health & Community Services

> The Options Clinic staff have attended local Lesbian Gay Bisexual Transgender Queer (LGBTQ+) groups known to have a large representation of transgender population. The Options Clinic provide information about HIV transmission, risk factors, prevention and how the transgender population can have access to various services offered by the LIHC.
>
> –London InterCommunity Health Centre

> We initiated a partnership agreement with Trans Health Initiative Ottawa's Foundations and Pathways project to run a monthly rapid anonymous HIV testing clinic for trans women.
>
> –Somerset West Community Health Centre

Engagement on social media and apps

With our outreach testing targeted to specific groups, the hosting group has promoted the events.
–Hassle Free Clinic

In order to reach gay, bisexual and other men who have sex with men population we have utilized social media such as having an advertisement on the phone app "Scruff" as well as being in discussion with other places such as Grindr and Squirt to have a similar presence.
–London InterCommunity Health Centre

We maintain a social media presence including Squirt presence and Twitter as well as web-based promotion.
–Simcoe Muskoka District Health Unit

Consistent online outreach using Craigslist, Squirt, Grindr, Scruff, Hornet. Although our Grindr account has been banned numerous times, this app generates the most conversations with guys.
–Somerset West Community Health Centre

Shifts in service needs

Many clients accessing rapid anonymous HIV testing at outreach clinics ask the anonymous testing coordinator for additional STI testing; specifically syphilis testing. The anonymous testing coordinator is not able to accommodate this request as Somerset West Community Health Centre is not a sexual health clinic.
–Somerset West Community Health Centre

The latest trend we have noticed is that clients are looking to have concomitant testing for HIV and hepatitis C.
–London InterCommunity Health Centre

Clients initially present requesting anonymous HIV testing and are also seeking STI testing which requires a name. Clients then request that all testing be done nominally. Anecdotally it appears that after sexual health counselling with the nurse and rapport established, they feel comfortable providing their name and request to have results linked to their chart.
–Sudbury Health Unit

We have seen an increased demand for PrEP.
–Windsor Regional Hospital

Increase in demand for HIV testing right now due to tuberculosis outbreak in under-housed community.
–Thunder Bay Health Unit

Community-based Clinical Services

Ontario has 20 HIV clinics across the province: 15 are hospital-based and five are community-based. The five community-based clinics profiled in the following section receive funding from the AIDS Bureau Funding Program, and report on their activities through OCHART.

The five community-based HIV Clinics are:

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

Key points

- The five community-based HIV clinical service providers served an average of 2,163 unique individuals in 2017-18 (down 2% from the previous year).
- The number of people living with HIV served by the five clinics increased by 2%.
- Clinics retained more people in care, and provided services for 5% more active (existing) clients (1,685 total); at the same time, the clinics served 38% fewer new clients (478 total).
- One in three (583 out of 1,754) people living with HIV accessing services at the five clinics were between the ages of 46 and 55, and 24% were aged 36 to 45.
- Clients living with HIV received more referrals in 2017-18, with each client receiving an average of 2.2 referrals to other services: 42% percent were referred to STI testing, and 29% to non-HIV-specific clinical services.
- More services were provided to people living with HIV than in 2016-17, with treatment information, sexual health services/counselling, and treatment adherence support increasing the most.
- Compared to 2016-17, community-based HIV clinics reported conducting more educational events, including HIV rounds, community presentations, and conference presentations.

More people living with HIV served

Overall, the five community-based HIV clinical service providers reported serving a similar average number of clients (2,163) as in 2016-17 (2,217). Forty (2%) more clients were living with HIV and 20 more clients were affected by HIV than in 2016-17. A 24% decrease in the number of at-risk clients was mainly the result of a change in reporting practices at one of the five clinics.

Number of clients by type and year

OCHART Q. 8.1a

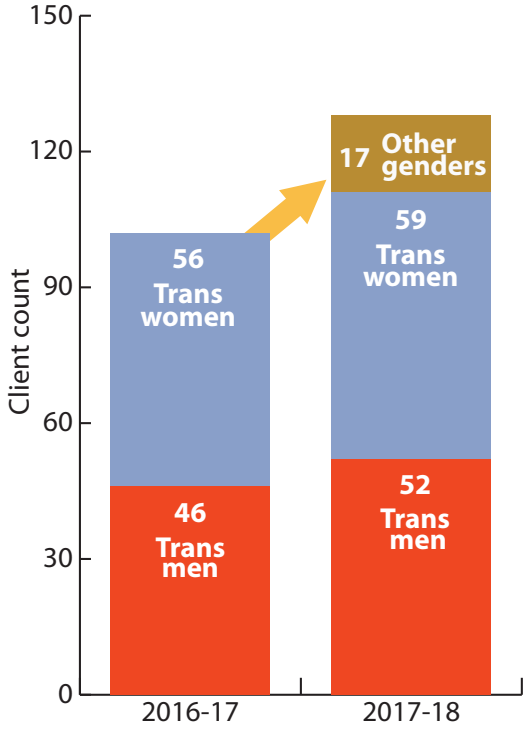
	Affected	At-risk	PLWH	Total
2014-15	57	239	1,629	1,925
2015-16	12	446	1,651	2,109
2016-17	23	481	1,713	2,217
2017-18	42	367	1,754	2,163

More clients were retained in care in 2017-18

The community-based HIV clinics report how many new and active clients they see each reporting period ("active" clients are those who have received services in prior reporting periods). In 2017-18, the clinics reported serving on average 5% more active clients (1,685 total) than in 2016-17 (1,610 total). In other words, more clients were retained in care at these clinics.

Similar to 2016-17, 91% of active clients in 2017-18 were people living with HIV. With respect to the gender of active clients, there was a 26% increase in trans clients and clients with other (not listed) gender expressions.

Number of trans clients and clients with other gender expressions by year OCHART Q.8.1a



Number of active clients* served by sex/gender and year OCHART Q. 8.1a

	Male	Female	Trans men	Trans women	Other[1]	Total
2014-15	1,271	298	NR	NR	NR	1,572
2015-16	1,150	298	16	20	0	1,484
2016-17	1,201	307	46	56	0	1,610
2017-18	1,239	318	52	59	17	1,685

*Averaged between each 6-month reporting period.
NR = Not reported due to low client numbers.

1 Other gender expressions not listed in OCHART.

More women living with HIV served (new clients)

Two hundred and twenty-five new clients living with HIV were seen by the five clinics in 2017-18, a 6% decrease from the previous year. The clinics had 12% fewer new male clients (168 vs 190 in 2016-17) and 25% more female clients (55 vs 44).

Number of new clients living with HIV by sex/gender and year* OCHART Q. 8.1a

New clients living with HIV	Male	Female	Total
2014-15	117	30	148
2015-16	183	49	240
2016-17	190	44	240
2017-18	168	55	225

*Trans and other gender expressions not listed were not reported due to low numbers.

Missed appointments

In 2017-18, clinics began reporting the percentage of clients who missed at least one scheduled HIV clinical service appointment. On average, approximately 20% of clients missed an appointment at a community-based HIV clinic last year; the number of clients missing appointments at individual clinics ranged between 15% and 47%.

As indicated by the quotes below, clinics used a variety of methods to help reduce the number of missed appointments, make services more accessible and retain people in care.

> Appointment reminder calls, email reminders, and text reminders are provided to clients who request or are at risk for 'no show'. With consent of client, ASO staff will assist to remind clients of upcoming appointments as well as locate clients who are lost to follow-up or at risk for disengagement in care. Our partner community pharmacy also plays an important role in locating and providing reminder messages for clinic appointments, offers unique service to improve engagement and adherence such as weekly blister pack dispensing picked up at the clinic. We continue to offer high risk express care for those clients who are at risk for disengagement by providing health care service when the client comes to the clinic even if an appointment was not previously booked.
> –Lakeridge Health Centre

> We have hired a linkages to care HIV coordinator who will work with the team to support retention in care. We are committed to improving the percentage of HIV patients retained in care and have included a measure on our departmental quality improvement plan to monitor our progress.
> - St. Michael's Hospital (410 Sherbourne)

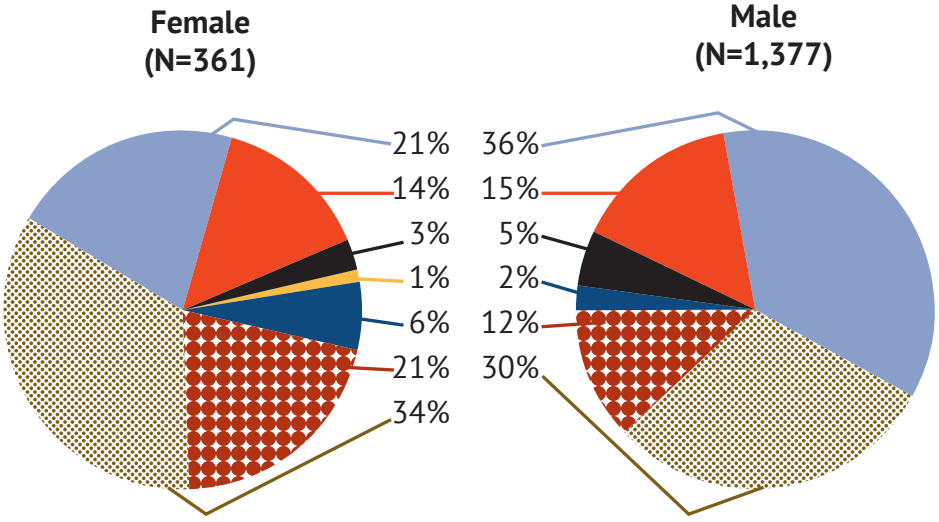
Demographics of new and active clients living with HIV

Age

Three of every four people living with HIV[2] accessing the five community-based clinics were between the ages of 36 and 65: 24% were between 36 and 45, 33% were between 46 and 55, 20% were between 56 and 65, and 6% were over 65. Women tended to be younger than men, with female clients living with HIV most commonly between 36 and 45 years old (36%) and men most commonly 46-55 (34%).

The ages of women living with HIV (including both new and active clients) accessing the five clinics are similar to the ages of all women newly diagnosed in Ontario in 2017,[3] where 35-44 year old women account for 32% of new diagnoses. However, male clients living with HIV accessing the clinics tend to be older than all newly diagnosed men in Ontario in 2017, where 34% of new diagnoses were men between the ages of 25 and 34. This trend highlights the aging population of people living with HIV.

Age groups of new and active clients* living with HIV OCHART Q. 8.1b



Age group	2017-18 total	2017-18 percent
<25	59	3%
26-35	242	14%
36-45	423	24%
46-55	583	33%
56-65	344	20%
66-75	90	5%
>75	13	1%

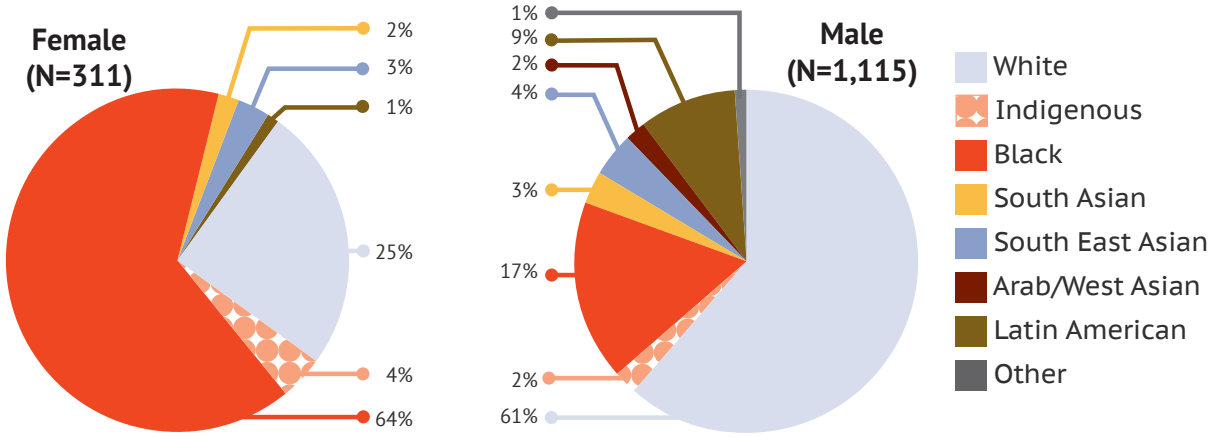
*Trans and other gender expressions not listed were not reported due to low numbers.

2 This was the first year client demographics were collected for clients living with HIV only. In previous years demographics were collected on all client types (including affected and at-risk clients) together, making year-over-year trends for clients living with HIV unavailable.
3 Refer to the data provided by OHESI in the "HIV epidemiology in Ontario" section of this report.

Ethnicity

Ethnicity was reported for 89% of community-based clinic clients living with HIV. Where known, 53% of clients living with HIV were white, 27% were Black, 7% were Latin American, and 3% were Indigenous. These trends reflect the demographics of the large male cohort of clients (who account for 78% of all clients living with HIV). In contrast, two of every 3 female clients (64%) were Black, 25% were white, and 4% were Indigenous.

Ethnicity of clients living with HIV, 2017-18 (where known) OCHART Q. 8.1c



Two out of three clients experience challenges related to social determinants of health

Overall, social determinants of health (e.g., housing, food insecurity and income/poverty) remain the main challenges facing people living with HIV.[4] Nearly two out of three clients living with HIV (64%) experience these challenges, and it is the most common challenge reported by all five clinics. The next most common challenges were treatment issues (23%), maintaining treatment access (21%), and staying engaged in HIV care (20%).

Proportion of clients experiencing challenges related to accessing HIV clinical care OCHART Q. 8.1e

Challenges	Percentage
Starting treatment	12%
Medication adherence	16%
Connection to care for co-morbid conditions	17%
Staying engaged in HIV care	20%
Maintaining treatment access	21%
Treatment issues	23%
Social determinants of health (eg housing, food insecurity, poverty, etc.)	64%

4 Compared to previous years, the challenges experienced by people living with HIV accessing services at the five community-based HIV clinics were recorded differently in 2017-18; categories were streamlined in order to align with the HIV prevention, engagement and care cascade.

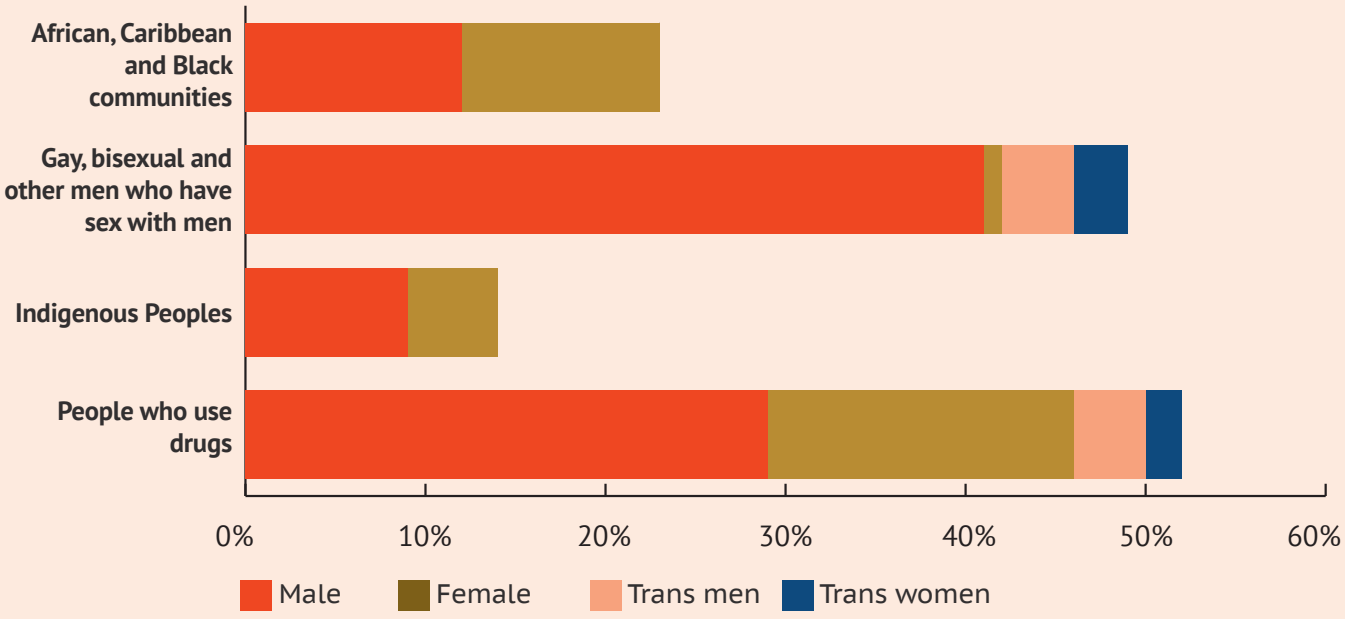
Proportion of clients from priority populations

Community-based HIV clinics report the approximate proportion of people accessing their services that identify with each priority population. This year, clinics were asked to report the proportion of clients who represent each priority population by gender rather than an aggregate of all genders, making 2017-18 the first year gender comparisons are possible for this question. Note: clients may be reported in more than one priority population.

In 2017-18, an average of 41% of male clients were gay, bisexual, or other men who have sex with men; 29% used drugs; 12% were from African, Caribbean and Black communities. An average of 17% of female clients used drugs; 11% were from ACB communities.

Clinics in different regions tend to have clients from different priority populations. Gay, bisexual, and other men who have sex with men are the most common priority population served by clinics in Toronto (63% of all regional clients) and Central East (39% of all regional clients). Clients from African, Caribbean and Black communities are mainly seen at Toronto (32% of all regional clients) and Central West (16%) clinics, while Indigenous clients are mainly seen at the Northern clinic (20%).

Proportion of clients who represent priority populations OCHART Q.8.1d



More services provided to people living with HIV

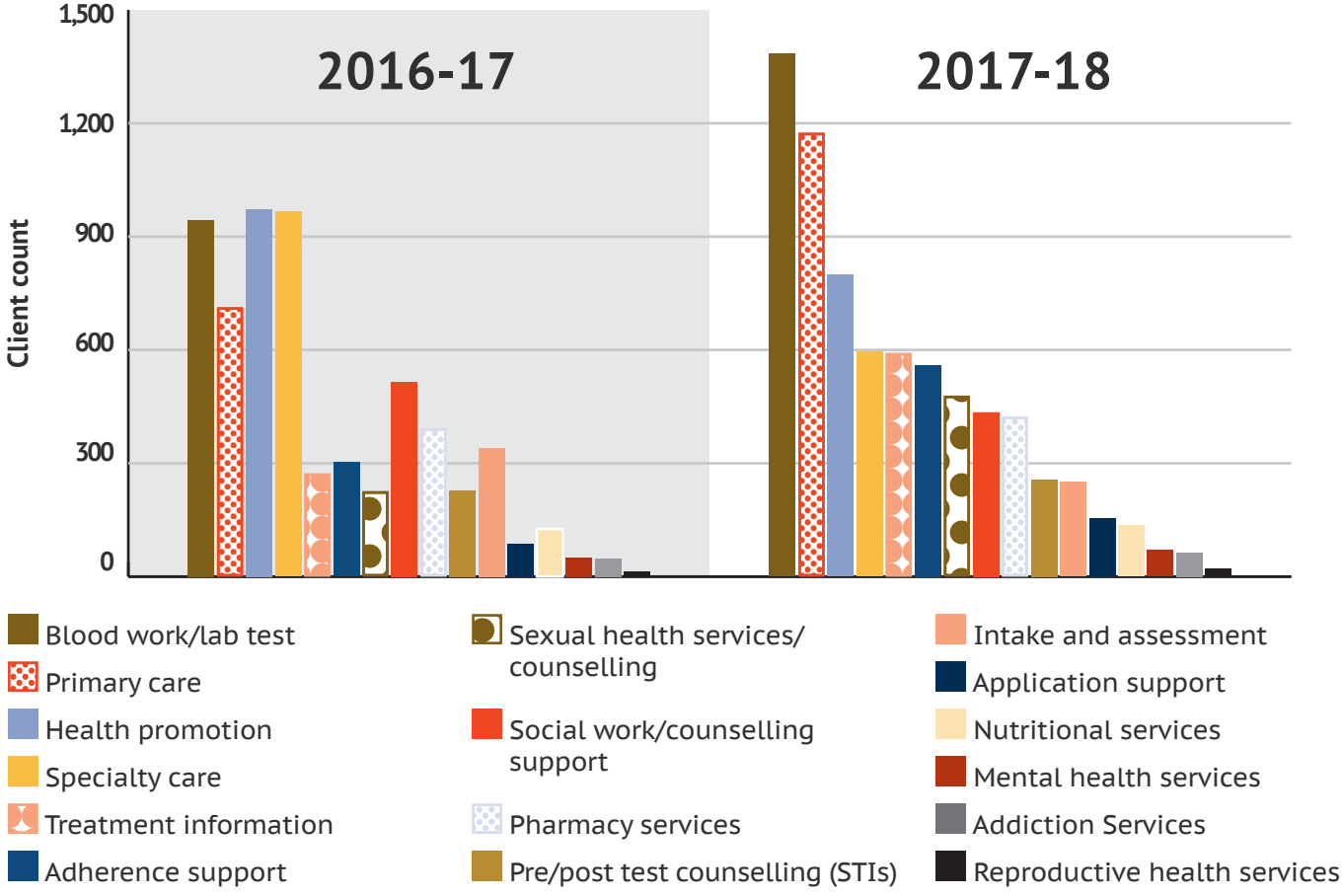
Compared to last year, the five community-based HIV clinics reported providing a greater number of services to clients in 2017-18, even though they saw slightly fewer clients. In other words, on average, clients received more services in 2017-18 than the prior year.

Increases in the number of clients receiving blood work/lab tests and primary care at a large multidisciplinary clinic with extra capacity made these the top two services in 2017-18, up from the third and fourth most common services last year. The types of services used were consistent across genders.

The three types of services that increased the most from 2016-17 were treatment information (117% increase), sexual health services/counselling (112%), and treatment adherence support (85%). Increases in these services indicate that clients are being retained in care, on treatment, and receiving routine sexual health services.

> We have more requests for information about medications and how they work, requests for PEP and PrEP information, and education around the meaning of suppressed viral load.
> -Elevate NWO

Average number of clients accessing different services for the last two years OCHART Q.8.2



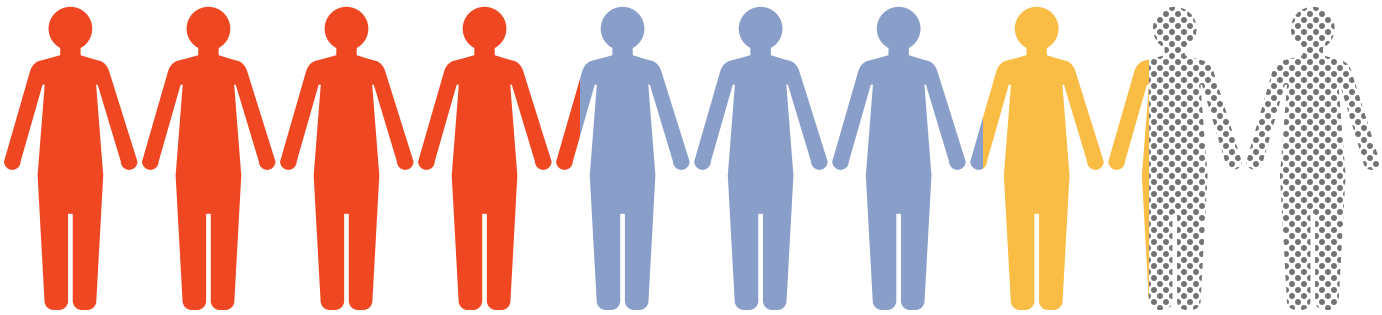
Clients living with HIV referred to STI testing and other clinical services

In 2017-18, community-based HIV clinics provided 4,725 referrals to other service providers for clients living with HIV. Links to STI testing accounted for 42% of those referrals.

The next most common referrals were to other clinical service providers, including both HIV specialists (12%) and non-HIV specific services (29%). While these were the three most common referrals for cisgender clients, trans clients were most commonly referred to non-HIV specific clinical service providers, suggesting the need to refer to trans-competent health care providers. The next most common referrals for trans clients were to harm reduction services and STI testing.

> We have a warm referral process that requires staff to either make contact with the intake worker at another location while the member is still in the office or walk the member through the doors of the other service provider. On rare occasions a member will change their mind about seeking services and will abandon the process; however, this also gives staff an opportunity to reassess the member's needs to ensure it is meeting them where they are at.
> –Elevate NWO

Most common referrals to other clinical service providers, 2017-18



- 42% STI testing
- 29 % Clinical service providers: non-HIV specific
- 12% Clinical service providers: HIV care
- 17% Other service providers

Referrals made to other service providers from community-based HIV clinics OCHART Q.8.3

Referral type	Number of referrals
Harm reduction services	56
Addiction services	91
Community-based service providers: HIV care and support	214
Mental health service providers	215
Other community-based service providers	233
Clinical service providers: HIV care	565
Clinical service providers: non-HIV specific	1,386
STI testing	1,965
Total	**4,725**

Note: Other community-based service providers include services for housing, food, employment, legal assistance, etc.

Top three referrals made to cisgender and trans clients OCHART Q.8.3

Cisgender	Transgender
STI testing	Clinical service providers: non-HIV specific
Clinical service providers: non-HIV specific	Harm reduction services
Clinical service providers: HIV care	STI testing

> Our consult staff follow up with the specialist's office to close the loop on all referrals. Our nurse connects with patients to reinforce appointment dates and to follow up with patients to see if they attended their appointments.
> – St. Michael's Hospital

> After a referral is made by a physician, one of our two nurses is messaged and follows up on the referral to ensure an appointment is made. When the date is confirmed to see the specialist, the nurse contacts the patient to ensure they have the information. If the patient requires transportation or other supports, the nurse connects them with the practical support worker.
> -ARCH Clinic

Increasing education activities

This year, the five community-based HIV clinic service providers reported delivering more HIV Rounds presentations (up 75%), more community presentations (up 127%), and more conference presentations (up 75%) compared to last year. While the number attending conferences and community presentations increased compared to last year, the number of participants at HIV Rounds decreased by 62%.

Number of education events and participants from 2014-15 to 2017-18

OCHART Q.8.5a

	Number of events	Number of participants
HIV Rounds		
2014-15	28	507
2015-16	61	1,023
2016-17	40	343
2017-18	70	130
Community presentations		
2014-15	18	585
2015-16	25	541
2016-17	11	167
2017-18	25	420
Conference presentations		
2014-15	16	268
2015-16	28	286
2016-17	4	50
2017-18	7	637

Overall, community development activities among the five HIV clinical service providers remained stable from 2016-17. An increase in community development activities in 2015-16 was driven by a high number of local hospital/service network meetings recorded by one clinic, after which the number of meetings dropped from 47 to 24 in 2016-17 and 18 in 2017-18.

Community development meetings from 2014-15 to 2017-18 OCHART Q.8.5b

Community development	2014-15	2015-16	2016-17	2017-18
HIV Clinic Coordinator Network	18	23	18	20
Local HIV planning network	8	12	10	8
Local hospital/service network	10	47	24	18
Opening Doors conference/event	26	18	16	17
Total	**62**	**100**	**68**	**63**

Health professionals at the five community-based HIV clinics also continue to engage in professional development activities to stay up-to-date with the most recent and evidence-informed treatment practices. In 2017-18, the clinics reported participating in the same number of professional development activities as the previous year (42).

Professional development activities from 2015-16 to 2017-18 OCHART Q.8.5c

Activity	2015-16	2016-17	2017-18
CME/CPD, post-secondary, or other professional development course	18	19	19
Conference	31	17	14
Nursing update/RPNAO/RNAO course	17	3	7
Other official college requirement	3	3	2
Total	**69**	**42**	**42**

Shifts in demand for HIV clinical services

Increased demand for more complex care, especially for sexual and mental health

> Many of our members do not have or do not see a primary physician. Our new physician creates a 'whole health' profile that includes testing for co-morbidities, and treats other health care issues while managing HIV treatment. This has led to members increased awareness of their health, education on how they can improve their health, active engagement in their health care and hopefully, improvement in their HIV treatment.
> – Elevate NWO

> More manageable treatment and better outcomes are lengthening the life expectancy of PLWH. As a result, concerns around isolation, depression and mental health and chronic disease are continuing to increase.
> – Bloom Clinic, WellFort Community Health Centre

> We have more clients with recent experiences with grief/death due to the opioid crisis. This is a new phenomenon for many who did not experience the trauma of multiple losses during the early days of the epidemic.
> – Lakeridge Health Centre

> We have noticed an increased demand from isolated HIV+ women and increased demand in the areas of counselling and other instrumental supports, including legal services, assistance with forms completion and client accompaniment.
> – Bloom Clinic, WellFort Community Health Centre

> There has been a steady increase in new STIs in our patients. We are also noticing an increase in HIV and TB coinfections.
> – HIV/AIDS Resources & Community Health (ARCH) Clinic

Providing care for clients new to the area

> We have had many new patients who are African immigrants who moved to Alberta but have moved now to Ontario because of the lack of jobs in Alberta. They are not told in Alberta that ARVs are not paid for here in Ontario. Our Clinic Coordinator wrote a document and faxed to the 2 ASOs and 2 HIV Clinics in Alberta, outlining information that would be helpful for PLWH to know when they are moving to Ontario. We are trying our very best to find compassionate coverage for these patients and to connect them with the practical support worker to apply for Trillium funding.
> – HIV/AIDS Resources & Community Health (ARCH) Clinic

> We have seen an increased concern regarding access for mental health services and primary care for individuals who are on a student visa and not eligible for services.
> -St. Michael's Hospital

> We have an increase in the number of individuals known to be HIV+ relocating to the catchment area who were engaged in care at other clinics.
> – Lakeridge Health Centre

Capacity Building

HIV Resources Ontario: Building capacity for client services within Ontario's HIV sector

HIV Resources Ontario (HRO) is a group of 11 provincial programs funded by the AIDS Bureau to support the work of community-based HIV/AIDS organizations (ASOs) and enhance their capacity to deliver client services. While the programs vary significantly in their role and scope, they share the objective of facilitating a more effective, coordinated, and streamlined network of supports for people living with and at risk of HIV.

The following section provides a snapshot of the work and impact of these programs.

Key points

- Ontario's HIV capacity-building programs delivered 643 educational events to a total of 8,041 participants in 2017-18.
- These programs developed 76 new knowledge transfer and exchange (KTE) materials to assist with delivery of client services, with frontline workers being the main target audience for 48% of materials.
- Nearly 500 community development meetings were conducted with 3,104 community partners to support the delivery of more competent care.
- Four new awareness campaigns were launched in 2017-18: 10 Facts About HIV in Ontario That Might Surprise You (OAN), Hello Ontario (GMSH, ACCHO, WHAI, CAAT), World Hepatitis Day (CATIE), and World AIDS Day (CATIE).
- Capacity building programs organized 10 conferences, annual symposia, or community/town hall events, reaching 429 participants in total with a focus on enhancing capacity to deliver HIV client services.

Five capacity-building programs provide organizational supports to HIV organizations across the province:

- The Ontario Organizational Development Program (OODP) provides **mentoring and capacity-building services** that help community-based organizations build effective governance strategies, board skills and manage organizational issues.

- The AIDS Bereavement and Resiliency Program of Ontario (ABRPO) provides **workshops and training** programs that help community-based organizations respond to multiple AIDS-related and other losses, and assist these organizations in building resilience among staff who provide direct services to clients.

- The Ontario AIDS Network (OAN) is a network of community-based HIV organizations that provides **training programs** to enhance HIV service delivery by front-line workers, managers and executive directors, as well as leadership training for people living with HIV.

- CATIE, Canada's source for HIV and hepatitis C information, provides **resources** that community-based organizations can use to promote more effective client services (e.g., prevention, treatment, support and care programs). CATIE also provides **information, webinars and events** about evidence-based programs and practices to promote effective service delivery.

- The Toronto HIV Network (THN) works to improve **access to and coordination of programs and services** for people living with, affected by and at risk of HIV/AIDS in Toronto.

Six provincial capacity-building programs focus on assisting community-based organizations to meet the needs of the populations that are most affected by HIV:

- The Gay Men's Sexual Health Alliance (GMSH), which supports a network of gay men's workers based in ASOs across the province, is an information hub for gay and bisexual men's sexual health. It develops campaigns and materials that are used by ASOs throughout Ontario to ensure coordinated and effective service delivery. It also provides webinars and workshops that help ASOs build the skills to work effectively (provide culturally competent care) with gay and bisexual men.

- The African and Caribbean Council on HIV/AIDS in Ontario (ACCHO), which supports a network of workers based in ASOs across the province, provides leadership in the response to HIV in African, Caribbean and Black communities. ACCHO develops campaigns, provides resources to ensure coordinated and effective service delivery and helps ASOs develop the capacity to work effectively with African, Caribbean and Black communities using culturally competent service delivery models.

- The Women and HIV/AIDS Initiative (WHAI), which supports a network of workers in ASOs across the province, works to build the capacity of communities to support women who are living with or at risk of HIV. WHAI workers focus on community development with organizations that serve women to help them integrate HIV culturally competent care into current programs and build their knowledge and skills.

- The Ontario Harm Reduction Network (OHRN) (formerly the Ontario HIV and Substance Use Training Program) provides training to substance use, mental health and allied service providers in Ontario to ensure a robust provincial response to the needs of people who use drugs.

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

- The Ontario HIV Treatment Network (OHTN) provides data and evidence to support and improve HIV client services across Ontario (including prevention, testing, treatment, support, and care programs).

Presentations

In 2017-18, the 10* capacity building programs delivered a total of 165 presentations with an average of 33 participants attending each session.

- Seventy percent of presentations focused on skills development to deliver effective HIV client services, with 116 sessions reaching a total of 3,472 participants
- Ten percent of presentations focused on HIV syndemics, with 16 sessions reaching a total of 1,080 participants
- Nine percent of presentations focused on issues affected by HIV, with 15 sessions reaching 276 participants

> The blended learning training with ACCHO was a highlight. The blended learning model allows us to augment the core knowledge presented in the eLearning modules, with discussion board questions, webinars, and videos that are representative of ACB communities and address the issues and challenges of these communities.
> - CATIE

* OHTN activities are not included in this analysis and are reported on page 138.

Trainings

Three-quarters of all training sessions provided in 2017-18 were focused on skills development to improve direct client services delivered to people living with and at-risk of HIV. In total, 61 skills development trainings were completed with 1,363 participants. Nine were held for organizational development, six on HIV syndemics, two on GIPA/MIPA, and one on other issues affected by HIV. Approximately 22 people attended each training activity, which was consistent across all training topics.

> With the addition of more needle and syringe programs, overdose prevention, and supervised injection sites, we have received a higher volume of requests for more advanced harm reduction training. These requests are typically for further information on harm reduction equipment as well as information on what to supply for safer crystal meth smoking, drug checking, and naloxone.
> –OHRN (formerly OHSUTP)

Educational presentations, trainings, and consultations 2017-18

OCHART Q11.1

643 sessions were delivered to 8,041 participants in 2017-18

See Appendix D for definitions

165 presentations to 5,379 participants

Focus

- Skills development 70%
- HIV syndemics 10%
- Organizational development 4%
- Issues affected by HIV 9%
- HIV research 6%
- GIPA/MIPA 1%

Audience

- EDs and board members 25%
- Other ASO frontline workers 42%
- Other service providers 44%
- Community 38%
- WHAI workers 11%
- Researchers/academia 10%
- Clinical service providers 18%
- Policy makers (government) 6%
- ACB strategy workers 8%
- GMSH strategy workers 8%

79 trainings to 1,751 participants

Focus

- Skills development 77%
- Organizational development 11%
- HIV syndemics 8%
- GIPA/MIPA 3%
- Issues affected by HIV 1%

Audience

- EDs and board members 22%
- Other ASO frontline workers 51%
- Other service providers 29%
- Community 51%
- WHAI workers 15%
- Researchers/academia 10%
- Clinical service providers 5%
- Policy makers (government) 3%
- ACB strategy workers 6%
- GMSH strategy workers 3%

399 consultations to 911 participants

Focus

- Organizational development 46%
- Skills development 38%
- Issues affected by HIV 9%
- HIV syndemics 5%
- HIV research 1%
- GIPA/MIPA 1%

Audience

- EDs and board members 56%
- Other ASO frontline workers 23%
- Other service providers 8%
- Community 6%
- WHAI workers 7%
- Researchers/academia 5%
- Clinical service providers 1%
- Policy makers (government) 3%
- ACB strategy workers 1%
- GMSH strategy workers 1%

Priority populations		LHIN		Sessions
				165 presentations with 5,379 participants
People living with HIV	23%	Central	5%	ACCHO 1 session, 6 participants
People who use drugs	19%	Central East	3%	ABRPO 96 sessions, 2,759 participants
Gay/bisexual/MSM	19%	Central West	3%	CATIE 20 sessions, 485 participants
ACB communities	10%	Champlain	5%	CAAT 3 sessions, 32 participants
At-risk women	14%	Erie St. Clair	2%	OHRN 12 sessions, 1,012 participants
Indigenous Peoples	7%	Hamilton Niagara Haldimand Brant	6%	GMSH 11 sessions, 380 participants
Other at-risk	8%	Mississauga Halton	3%	OAN 1 session, 19 participants
		North East	6%	OODP 1 session, 1 participant
		North Simcoe Muskoka	1%	THN 5 sessions, 145 participants
		North West	4%	WHAI 15 sessions, 541 participants
		Outside Ontario	11%	
		South East	5%	
		South West	13%	
		Waterloo Wellington	3%	
		Toronto Central	30%	
				79 trainings with 1,751 participants
People living with HIV	18%	Central	8%	ACCHO 3 sessions, 35 participants
People who use drugs	14%	Central East	5%	ABRPO 27 sessions, 678 participants
Gay/bisexual/MSM	12%	Central West	5%	CATIE 2 sessions, 38 participants
ACB communities	17%	Champlain	3%	OHRN 12 sessions, 328 participants
At-risk women	14%	Erie St. Clair	1%	GMSH 1 session, 25 participants
Indigenous Peoples	14%	Hamilton Niagara Haldimand Brant	4%	OAN 2 sessions, 41 participants
Other at-risk	11%	Mississauga Halton	3%	OODP 10 sessions, 214 participants
		North East	5%	THN 11 sessions, 275 participants
		North Simcoe Muskoka	1%	WHAI 11 sessions, 119 participants
		North West	2%	
		Outside Ontario	4%	
		South East	3%	
		South West	5%	
		Waterloo Wellington	3%	
		Toronto Central	48%	
				399 Consultations with 911 participants
People living with HIV	31%	Central	3%	ACCHO 3 sessions, 19 participants
People who use drugs	17%	Central East	4%	ABRPO 87 sessions, 137 participants
Gay/bisexual/MSM	14%	Central West	1%	CATIE 2 sessions, 25 participants
ACB communities	19%	Champlain	6%	OHRN 14 sessions, 30 participants
At-risk women	10%	Erie St. Clair	4%	GMSH 3 sessions, 48 participants
Indigenous Peoples	4%	Hamilton Niagara Haldimand Brant	2%	OAN 88 sessions, 143 participants
Other at-risk	5%	Mississauga Halton	1%	OODP 124 sessions, 274 participants
		North East	3%	THN 1 session, 54 participants
		North Simcoe Muskoka	3%	WHAI 77 sessions, 181 participants
		North West	1%	
		Outside Ontario	0%	
		South East	0%	
		South West	6%	
		Waterloo Wellington	3%	
		Toronto Central	63%	

Consultations

Consultations are highly tailored and in-depth training activities, and generally take place with a small number of individuals–two participants on average. In 2017-18, HRO organizations reported 399 consultations with 911 participants.

- One hundred and eighty-three (46%) consultations focused on organizational development to improve governance structures for effective client services, with a total of 503 participants (55%).
- One hundred and fifty-one (38%) consultations were delivered on skills development to improve the delivery of services for people with or at-risk for HIV, with a total of 217 participants (24%).
- Thirty-six consultations were provided on issues affected by HIV, 21 on HIV syndemics, 5 on HIV research, and 3 on GIPA/MIPA to enhance the voice of people with lived experience (e.g., living with HIV).

The high number of organizational and skills development consultations largely reflects the work of the Ontario Organizational Development Program (OODP), the Ontario AIDS Network (OAN), and the Women and HIV/AIDS Initiative (WHAI), all of which provide supports to frontline agencies to improve delivery of direct client services for people living with or at-risk for HIV. The AIDS Bereavement and Resiliency Program of Ontario (ABRPO) conducted 72% of the consultations on issues affected by HIV, highlighting the significant presence and impact of multiple loss in the sector. There continues to be a pressing need to assist workers in coping with that loss and building resiliency to continue to deliver high-quality services to people living with or at-risk for HIV.

Who attended educational activities?

The majority of trainings (67%) and presentations (59%) were given to ASO frontline workers, workers at other service providers, and community members. The AIDS Bereavement and Resiliency Program of Ontario accounts for roughly half (56%) of the presentations and trainings given to these three types of participants, with the Women and HIV/AIDS Initiative and the Toronto HIV/AIDS Network providing 12% and 10%, respectively, of the presentations and trainings to these audiences.

Looking at consultations, 50% were delivered to Executive Directors and board members, with the OODP and OAN together conducting 91% of consultations with these audiences. Additionally, 20% of consultations took place with other ASO frontline workers, with two out of three of these being conducted by the AIDS Bereavement and Resiliency Program of Ontario.

> Loss support is provided to workers and managers in the Harm Reduction teams. Our theoretical framework, which encompasses a workplace context for multiple loss processing, was validated as practical, relevant and useful to both managers and staff. This sector absorbs the reality of increased opioid-related overdoses and revivals in their buildings and resident communities.
> –ABRPO

Most trainings were delivered in the Toronto Central LHIN, with 40% of total participants coming from this area. The Toronto Central LHIN accounted for 63% of all consultation participants, 48% of trainings attendees, and 30% of presentation participants.

Three structured interventions delivered

This year, OCHART began recording the number of structured interventions delivered by provincial capacity-building organizations. A structured intervention is a distinct program that has been proven effective through research, and that has showed positive behavioural and/or health outcomes that can be attributed to the activities that make up the intervention. In 2017-18, two organizations delivered a total of three structured interventions:

- The Gay Men's Sexual Health Alliance delivered one structured intervention related to its The Sex You Want campaign, reaching 41 individuals.
- The Committee for Accessible AIDS Treatment (CAAT) delivered Synergy of Care – a program designed to improve the health and wellbeing of people living with HIV who work in service provision roles and face complex stressors in balancing family, workplace, and community expectations – to 17 participants.
- CAAT also delivered Ethno-racial Treatment Support Network Level 2: Helping Others – an intensive training program that assists racialized newcomers to meet other people living with HIV, learn how to talk to their doctors about their health concerns, increase their knowledge of HIV, and develop their counselling skills to support peers living with HIV – to 20 participants.

Knowledge products to improve client services

The 10 organizations within HIV Resources Ontario also report the number of knowledge transfer and exchange (KTE) materials developed each year. These materials include peer-reviewed publications, reports, fact sheets, tools such as training guides and manuals, and agency promotional materials (including newsletters). These products are focused on improving client services for people living with and at-risk for HIV and increasing clients' awareness of services available to them.

Fifty-three of the 76 KTE products (70%) developed in 2017-18 were agency promotional materials; 68% of these were regular newsletters published by the Toronto HIV/AIDS Network or the Ontario AIDS Network. Overall, provincial organizations developed a total of ten tools and four fact sheets in 2017-18, while CATIE developed three reports and three peer-reviewed publications.

Issues affected by HIV was the most common focus of KTE materials developed in 2017-18, with the majority (39 out of 46) of these falling within the category of promotional materials. HIV research was the second most common focus of these materials, with 14 products developed in total. Ten newly-developed materials focused on organizational development, three on skills development, and two on HIV syndemics.

Focus of KTE materials developed in 2017-18 OCHART Q.11.11

KTE material focus	Agency promotional materials	Tools	Fact sheets	Reports	Peer-reviewed publications
Issues affected by HIV	39	2	4	0	1
HIV research	4	4	1	3	2
Organizational development	10	1	0	0	0
Skills development	0	2	1	0	0
HIV syndemics	0	1	1	0	0
Total	**53**	**10**	**7**	**3**	**3**

Frontline workers were the primary target group of 48% of KTE materials developed in 2017-18, 21% targeted volunteers, 18% were directed to ASO management, and 13% were developed for boards of directors. Agency promotional materials tended to be directed to a broader range of audiences, whereas other types of materials focused more on frontline workers and volunteers to improve client services.

Target audiences of KTE materials developed in 2017-18 OCHART Q.11.11

	Frontline workers	Volunteers	ASO management	Boards of directors	Number of materials
Agency promotional materials	39%	20%	25%	15%	53
Fact sheets	57%	14%	14%	14%	7
Peer-reviewed publications	80%	20%	0%	0%	3
Reports	57%	14%	14%	14%	3
Tools	48%	28%	12%	12%	10
Total	**6,209**	**6,630**	**6,192**	**7,390**	

Digital and social media

The way that online KTE activities are reported in OCHART changed in 2017-18, and year-over-year trends can only be reported for website views. The number of website views across organizations declined 12% - from 729,677 in 2016-17 to 641,506 in 2017-18. Similar to last year, CATIE accounted for 89% of all website views, a trend explained by the organization's online delivery model for all education and resources developed to enhance service delivery.

In 2017-18, fewer organizations reported maintaining a presence on Facebook, Twitter, and YouTube. Five organizations reported a total of 19,760 Facebook likes, four organizations reported 12,747 Twitter followers, and three reported 36,645 YouTube views.

Digital and social media contacts made in 2017-18 OCHART Q.11.13 and OCHART Q.11.14

Online media	Total number	Promote agency services or resources	Share knowledge (education)	Promote agency events	Share other opportunities (non-agency)
Website views	641,506	51%	43%	4%	2%
YouTube views	36,645	50%	50%	0%	0%
Facebook likes	19,760	36%	29%	20%	15%
Twitter followers	12,747	44%	23%	15%	18%

The ten organizations reported using their websites and YouTube primarily to promote their services and resources, or to share knowledge (education to improve services). Approximately two-thirds of Facebook and Twitter interactions were used for these purposes; the social media platforms were also used to promote events at organizations, or to share other opportunities offered by other agencies.

Engaging with more community partners

For the purpose of OCHART, community development is defined as a complex process that seeks to improve the lives of community members by building opportunities to enhance the capacity of service providers, community stakeholder agencies, businesses and government. The ten HRO organizations work with and provide supports to direct HIV service providers to improve the responsiveness, accessibility and, ultimately, the impact of community-based HIV services.

> The biggest pieces of community development work we have done in the past six months pertains to the rollout and promotion of IT TAKES COURAGE, the development of Hello Ontario, and the development of HIV prevention guidelines for service providers who work with ACB communities. Each are being developed using different approaches that all hinge on community partnerships. – ACCHO

The capacity-building organizations reported conducting a total of 487 community development meetings in 2017-18: 17% fewer than in 2016-17 (the introduction of a new tracking system for recording community development activities in 2017-18 may have affected the way these activities are being recorded). The most common purpose of these gatherings (accounting for 23% of the meetings) was to provide general information to engage community partners. Community event planning and the development of educational materials were the next most common reasons for holding community development meetings, each accounting for 16% of total gatherings in 2017-18.

> Because of the increasing numbers of international students requesting and contacting AIDS service organizations for services and support we engaged a number of key stakeholders to explore the emerging needs and identify strategies to respond to these needs. We have conducted two focus groups with service providers as well as a number of meetings to strategize on this issue. - CAAT

Purpose of community development meetings in 2017-18 OCHART Q.11.15a

Meeting purpose	Number of meetings
General information sharing	112
Community event planning	79
Development of education & prevention materials	76
Improved service delivery	55
Coalition/network meeting	50
Advisory/board meeting	44
New partnership/relationship building	39
Strategic planning	22
Public policy	7
Policy development	3
Total	**487**

For the priority population networks (i.e., WHAI, GMSH, ACCHO), community development refers to the activities delivered to respective PPN local ASO workers and members to strengthen HIV service delivery. In 2017-18, PPNs reported conducting 327 community development meetings with their network members: a 55% increase from the 211 reported last year.

These organizations were able to engage with more local frontline workers compared to last year, even though the number of meetings declined. A 164% increase in the number of participants meant that 3,104 people were part of community development meetings in 2017-18. For every 10 participants at community development meetings, six were from community-based HIV service providers, two came from other community-based service providers, and one from a harm reduction service provider.

> There is an increased relevance of Multiple Loss Journey [loss support] as both a theory and practice, and agency staff are more interested in peer debriefing practices and increasing their frequency in light of the amounts of traumatic loss within client/peer communities.
> –ABRPO

Participants by partner type at community development meetings in 2017-18 OCHART Q.11.15b

Partner type	Number of participants
Community-based HIV service providers	1,827
Other community-based service providers	609
Harm reduction services	305
Clinical service providers (HIV care)	142
Mental health service providers	78
Clinical service providers (non-HIV specific)	72
HIV/STI testing	36
Addiction services	35

In 2017-18, OCHART began recording the proportion of community development meetings where the focus of the meeting was a priority population living with or at-risk for HIV. People living with HIV were the most common focus of meetings in 2017-18. Amidst the ongoing opioid-overdose crisis, people who use drugs were the second most common focus, followed by: gay, bisexual and other men who have sex with men; at-risk women; African, Caribbean and Black communities; and Indigenous Peoples.

Relative proportion of community development meetings focused on priority populations, 2017-18 OCHART Q.11.15c

Priority population	Proportion of meetings(%)
People living with HIV	20%
People who use drugs	19%
Gay/bisexual/MSM	17%
At-risk women	15%
ACB communities	13%
Indigenous Peoples	9%

Note: Percentages higher than 12.5% indicate populations discussed at meetings more than average.

In 2017-18, OCHART also began recording the proportion of community development meetings that focused on specific issues related to HIV client service delivery. The issues most commonly a focus at community development meetings were general well-being including physical and mental health, living with HIV including stigma and discrimination, social support, and risk of HIV.

Relative proportion of community development meetings focused on key issues OCHART Q.11.15d

Issue	Proportion of meetings(%)
Well-being	20%
Living with HIV	18%
Social support	12%
Risk of HIV	12%
Legal/immigration	8%
Safety concerns	7%
Housing	7%
Income and benefits	7%
Education/employment	6%
Food security	4%

Note: Percentages higher than 10% indicate issues discussed at meetings more than average.

Four awareness campaigns rolled out in 2017-18

In 2017-18, capacity-building organizations developed and implemented four new awareness campaigns (defined as a series of coordinated activities designed to engage a specific audience in a specific issue):

- ***10 Facts About HIV in Ontario That Might Surprise You*** - a factsheet by OAN
- ***Hello Ontario*** – a website providing information about HIV; settlement and legal services; health care services and medication access; and social programs and services to newcomers to Ontario
- **World Hepatitis Day** - an international event focused on raising awareness about viral hepatitis and influencing real change in disease prevention and access to testing and treatment
- **World AIDS Day** - a day dedicated globally to commemorate those who have passed on and to raise awareness about AIDS and the global spread of the HIV virus.

Ten conferences and community events in 2017-18

In 2017-18, capacity-building organizations hosted 10 conferences, annual symposia, or community/town hall events, fewer than the 17 reported last year. There was also a corresponding decrease in total participants – from 910 in 2016-17, to 670 in 2017-18.

A total of 429 participants attended community events or town-hall meetings, representing 64% of participants at the reported gatherings. These events included a U=U Community Dialogue hosted by CAAT, the GMSH Mental Health Summit, and "Good Grief Care: Vikki Reynolds Lessons Learned From the Front Lines in BC" hosted by ABRPO. The three annual symposia organized by the three Priority Population Networks had 206 total participants, and the one conference, "Harm Reduction for Indigenous Communities" (sponsored by Ontario Harm Reduction Network) had 35 participants.

The Ontario HIV Treatment Network (OHTN)

The Ontario HIV Treatment Network, or OHTN, is an organization that actively supports and promotes the use of evidence to strengthen HIV programs, client services and policies. The OHTN does this by: funding, conducting, and synthesizing relevant research; analyzing HIV epidemiological data to inform the provincial response to HIV; collecting and analyzing data on the health of people living with HIV; and sharing that information with the sector through presentations, consultations, training sessions, network meetings, webinars, conferences, and other knowledge-sharing events. The OHTN also provides support to HIV service providers, including managing client service data and meeting ministry reporting requirements, providing rapid literature reviews, and assisting with program evaluation.

Responding to the sector's changing needs

In 2017-18, the OHTN restructured to enhance its ability to maximize the collective impact of Ontario's HIV services and strengthen the provincial response to HIV.

The collective impact approach involves different organizations working together to achieve a common agenda and solve difficult health and social issues. In the HIV sector, the common agenda is to strengthen the HIV prevention, engagement and care cascade, linking people quickly to services and improving the health and well-being of people living with or at risk of HIV. This means building close connections between ASOs, public health units, clinics, policy makers, and system planners to create a coordinated and efficient network of services that will help get us to zero HIV transmissions.

How the OHTN supports its partners:

ASOs

- Operating and maintaining OCHART and OCASE on behalf of AIDS and Hepatitis C Programs, Provincial Programs Branch, Ministry of Health and Long-term Care
- Collecting, analyzing and sharing data on the epidemiology of HIV in Ontario
- Providing program evaluation support
- Delivering a rapid response/ knowledge synthesis service
- Organizing knowledge sharing events and opportunities
- Organizing, in collaboration with the OAN, training programs for ASO workers
- Promoting evidence-informed practices
- Working closely with ASOs to address key policy and system issues
- Helping to build stronger connections between the HIV clinics and ASOs
- Funding community-based research projects led by ASOs

Clinicians

- Funding a residency program for physicians who want to specialize in HIV care
- Supporting the Ontario HIV Outpatient Clinic Network (OCN)
- Helping to build stronger connections between HIV clinics and ASOs
- Delivering a rapid response/ knowledge synthesis service
- Organizing knowledge sharing events and opportunities
- Collecting, analyzing and sharing data on the epidemiology of HIV in Ontario
- Following a cohort of people living with HIV to identify ways to improve care
- Managing the POC test inventory and ordering system
- Organizing information sharing events for HIV testing programs
- Funding relevant research
- Partnering to conduct relevant, impact-focused research

Policy makers

- Collecting, analyzing and sharing data on the epidemiology of HIV in Ontario
- Collecting and analyzing data on services provided by HIV programs and services
- Providing program evaluation support and assistance
- Delivering a rapid response/ knowledge synthesis service
- Organizing knowledge sharing events and opportunities
- Promoting evidence-informed practices
- Supporting committees and networks who work to address key policy issues

To that end, the OHTN has created a Collective Impact team that includes:

- The Evidence-Based Practice Unit, which is now known as ASO and Community Initiatives
- Testing and Clinical Initiatives
- Policy and System Initiatives

The OHTN is also putting more emphasis on: creating and building partnerships within the sector as well as with other sectors; making data more accessible to inform client service delivery; and providing more support to AIDS Service Organizations (ASOs) to strengthen direct client services for people living with and at risk of HIV. These shifts in focus are reflected in the deliverables completed and reported by the OHTN for 2017-18.

Working collaboratively

Collaboration is key to the OHTN's mission. The OHTN works to support three main types of partners: 1) testing programs and HIV clinical services; 2) AIDS service organizations and other community-based HIV service providers; and 3) policy and system leaders.

The OHTN builds partnerships with other organizations to support innovative and evidence-informed practices in the Ontario HIV sector and to help maximize collective impact.

Key partnership initiatives from the 2017-18 fiscal year include:

- After endorsing the "undetectable = untransmittable" (U=U) consensus statement in May 2017, the OHTN committed to working with health systems partners to develop consistent education messages and pragmatic interventions that support this message.
- Toronto Public Health and the OHTN are partnering on an incubator project to test a linkage-to-care coordinator who, building on the existing evidence about effective linkage programs, will develop relationships with immigration clinics and hospital emergency departments to support effective linkage and evaluate the impact of the program.
- The OHTN joined the Ontario Aboriginal HIV/AIDS Strategy (Oahas) and 2-Spirited People of the First Nations, to host an event focused on the health and wellness services available to Indigenous Peoples living with and at risk of HIV.

The OHTN supports or is a part of the following committees to develop a more coordinated network of services and effective response to HIV:

- Ontario HIV Epidemiology Surveillance Initiative (OHESI)
- Linkage to Care Working Group Toronto
- Ontario HIV Clinic Network
- Ontario HIV Pharmacists
- HIV Mental Health Professionals Group
- Gay Men's Mental Health
- HIV Resources Ontario and its working groups
- Fast Track City Champions Committee/ Toronto to Zero
- Fast Track City Metrics Committee
- Ontario Clinical Guidelines Working Group

Promoting evidence-informed practice through funded research

In the 2017-18 fiscal year, the OHTN invested approximately $2,760,000 in 36 research grants. Those grants were awarded to research focused on developing culturally competent care and services for the following priority populations:

- Gay, bisexual and other men who have sex with men (includes trans men) (12)
- People living with HIV (9)
- African, Caribbean and Black communities (6)
- People who use drugs (3)
- Indigenous Peoples (2)
- At-risk women (includes trans women) (2)

Using research & evidence to improve client services

The OHTN shares research and evidence to improve client services in a variety of ways including through consultations, presentations, information sessions, skills building trainings and network meetings. In 2017-18, the OHTN delivered over 150 of these activities:

- Consultations (100)
- Presentations/information sessions (67)
- Skills building trainings (9)
- Network meetings (8)

In 2017-18, the OHTN delivered more consultations than in the previous year – 100 compared to 39 in 2016-17 (an increase of 151%). These consultations were mainly focused on the social determinants of health, increasing access to HIV services (34), evidence-based practice to inform service delivery (33) and engagement in care (11).

Of the OHTN's 67 presentations/information sessions, 29 focused on engagement in care, 14 on evidence-based practice and 11 on HIV clinical care. Compared to the previous fiscal year, the OHTN's presentations/information sessions were more often focused on evidence-based practice (21% in 2017-18 versus 12% in 2016-17). This increase reflects the OHTN's focus on supporting the use of evidence to improve HIV programs and client services.

Number of OHTN activities by year and primary focus OCHART Q.10.1

	Evidence-based practice	Social determinants of health	Engagement in care	HIV clinical care	GIPA/ MIPA	Program science	HIV prevention	Total
Presentations/ information sessions								
2016-17	9	19	19	8	16	2	3	76
2017-18	14	9	29	11	-	-	4	67
Consultations								
2016-17	17	5	2	4	4	6	1	39
2017-18	33	34	11	7	-	7	8	100
Skills building trainings								
2016-17	3	2	7	1	11	1	2	27
2017-18	2	4	2	1	-	-	-	9
Network meetings								
2016-17	2	4	-	3	3	3	1	16
2017-18	4	-	-	2	-	2	-	8
2017-18 total	**53**	**47**	**42**	**20**	**0**	**9**	**12**	**184**

The target audiences of OHTN's consultations shifted in 2017-18 in two key ways. The number of consultations targeted to community members living with HIV or at risk of HIV grew from eight in 2016-17 to 31 in 2017-18, and the number targeted to clinical service providers increased from two in 2016-17 to nine in 2017-18.

The majority of the OHTN's 2017-18 presentations/information sessions were conference presentations (28). The OHTN also had twelve presentations/information sessions with an ASO target audience and 11 for other service providers. The focus on these audiences reflects the OHTN's increased emphasis on supporting ASOs and other community-based organizations, and its continued focus on supporting the use of the best available evidence to improve client service delivery and meet client needs.

Number of OHTN activities by year and primary target audience OCHART Q.10.3

	Researcher/ Academia	ASO	Community	Clinical service providers	Other service providers	Policy Makers	Other	Total
Presentations/ information sessions								
2016-17	29	13	15	8	3	5	3	76
2017-18	28	12	6	4	11	4	2	67
Consultations								
2016-17	6	15	8	2	1	-	7	39
2017-18	14	15	31	9	8	15	8	100
Skills building trainings								
2016-17	4	11	8	3	-	-	1	27
2017-18	-	5	4	-	-	-	-	9
Network meetings								
2016-17	6	3	2	3	1	-	1	16
2017-18	-	2	-	5	2	-	2	11
2017-18 total	**42**	**41**	**34**	**18**	**21**	**19**	**12**	**187**

Knowledge translation and exchange materials

Another way that the OHTN uses research and evidence to strengthen HIV clinical and community-based treatment, care and support for clients is through the creation of knowledge translation and exchange (KTE) materials.

Number of OHTN KTE materials produced by type and primary target audience OCHART Q. 10.16

Rapid responses/knowledge synthesis service

The OHTN Rapid Response Service provides summaries of research evidence in response to questions from ASOs and other Ontario HIV sector organizations to help support evidence-informed programs, service delivery and policy. Since the service began in 2009, 131 rapid responses have been published, including the nine rapid responses produced in the 2017-18 fiscal year.

In January 2017, the OHTN published the results of its evaluation of the rapid response service. Rapid response requestors said they were highly satisfied with the service and found most aspects of the final products – particularly the summary, references, and take home messages – very helpful in shaping their programs to meet client needs. They also said that the service aided in the development of new research projects or services and helped them ensure existing services aligned with current evidence. The service users also said that the rapid responses were used to drive improvement in programs and services and to assist them in obtaining program funding.

Rapid Response titles produced in 2017-18 include:

1. Online mental health counselling interventions
2. Blood donor deferral policies for men who have sex with men across high-income countries
3. The effect of non-injection drug use on sexual risk behaviours and ART adherence among men who have sex with men
4. Impact of victimization on the health of men who have sex with men
5. The role of peers in linkage, engagement, and retention in HIV care
6. Impact of medical assistance in dying on family and friends
7. Barriers to accessing health care among transgender individuals
8. Methods for effectively communicating HIV risk
9. Challenges faced by HIV-positive youth transitioning to adult care and evidence-based practices to address them

Supporting the use of data in programs, services, and policy-making

The OHTN operates and maintains several key HIV databases to support the use of data in improving client service delivery, including Ontario Community-Based AIDS Service and Evaluation (OCASE) client case management system, OCHART, HIV View, HIV epidemiological data, and the OHTN Cohort Study (OCS). In total, the OHTN processed 1,249 data requests in 2017-18.

OHTN data requests, 2017-18 OCHART Q.10.8

	ASO service providers	Other service providers	Researchers	Policy makers	Clinical service providers	Community
OCASE data	873	33	3	1	1	-
OCHART data	209	-	-	-	-	-
Epidemiological data	10	1	7	14	3	6
OCS	-	1	7	1	5	-
HIV View	72	-	1	-	-	1
Total	**1,164**	**35**	**18**	**16**	**9**	**7**

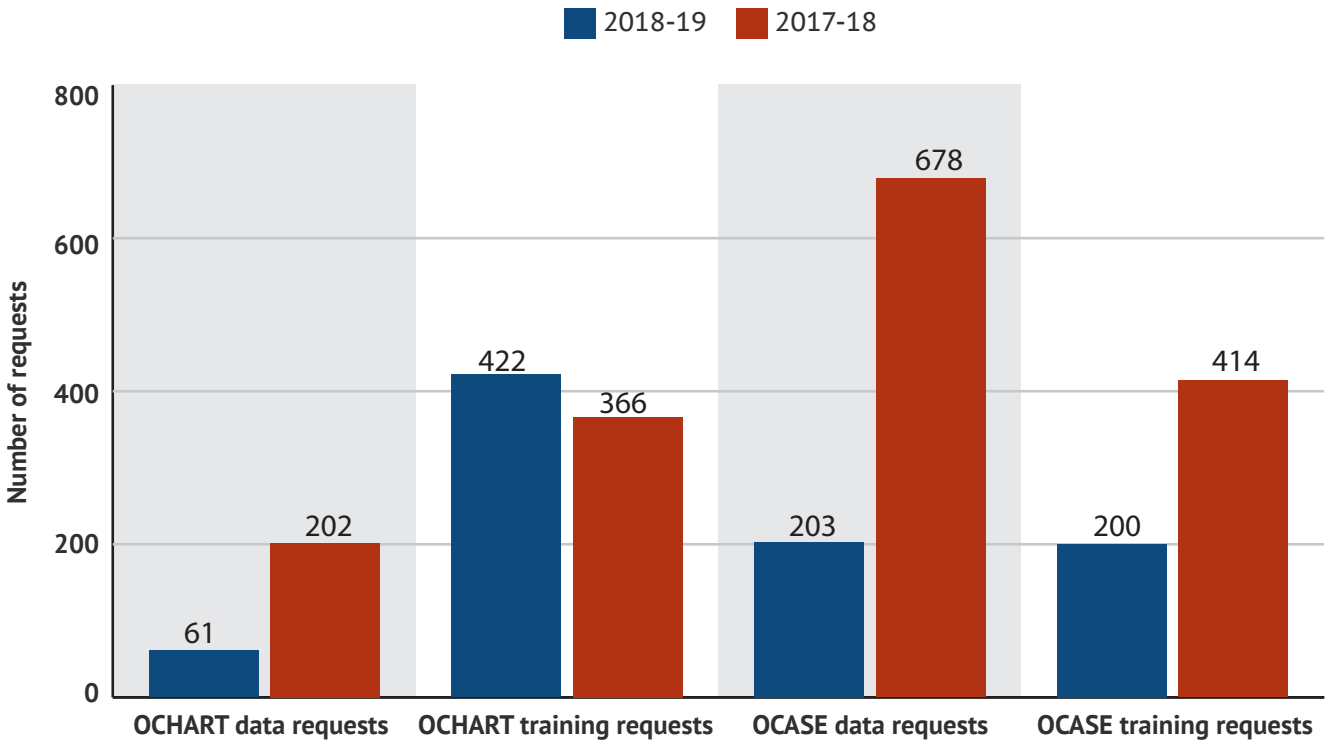
Examples of data requests made to the OHTN

An ASO requested the prevalence of HIV in men who have sex with men from African, Caribbean and Black communities to inform their prevention work and provide more culturally competent care.

A service provider requested the regional breakdown of HIV testing completed in Toronto in order to provide data to improve access and coordination of HIV related services for gay men in Toronto.

In 2017-18, the OHTN worked hard to make data more available to HIV service providers and other key stakeholders. It used data visualization software to share OCASE and OCHART data more efficiently with ASOs and to ensure that the data shared was practical and relevant to their needs. As a result, the number of OCASE and OCHART data requests from ASO providers more than tripled from 2016-17 (264) to 2017-18 (880), reflecting their commitment to delivering effective, quality services that meet client needs. The OHTN also created new tools for capturing data, including a tracking tool and revised OCHART sections. As a result, there was high demand overall for training on OCHART and OCASE data systems, with 366 and 414 training requests respectively in 2017-18, versus 422 and 200 in 2016-17.

Number of OCASE and OCHART data requests and training each year OCHART Q.10.8,9.



Supporting the use of evidence to inform practice

In the 2017-18 fiscal year, the OHTN increased its focus on supporting the use of evidence in Ontario's response to HIV. Examples of efforts in this area include:

- The OHTN created support materials, including fact sheets and media materials, to support the creation of effective services to address opioid overdoses in London and Thunder Bay.
- To support the implementation of evidence-based interventions for HIV prevention and care services, OHTN researchers published a systematic review of HIV/STI prevention interventions. This review found moderate to strong evidence for two particular types of interventions: group-level health education and comprehensive risk counselling and services.
- The OHTN worked with a team of HIV care providers to examine the evidence and to finalize an Ontario guideline document on best practices in HIV care.

Hepatitis C

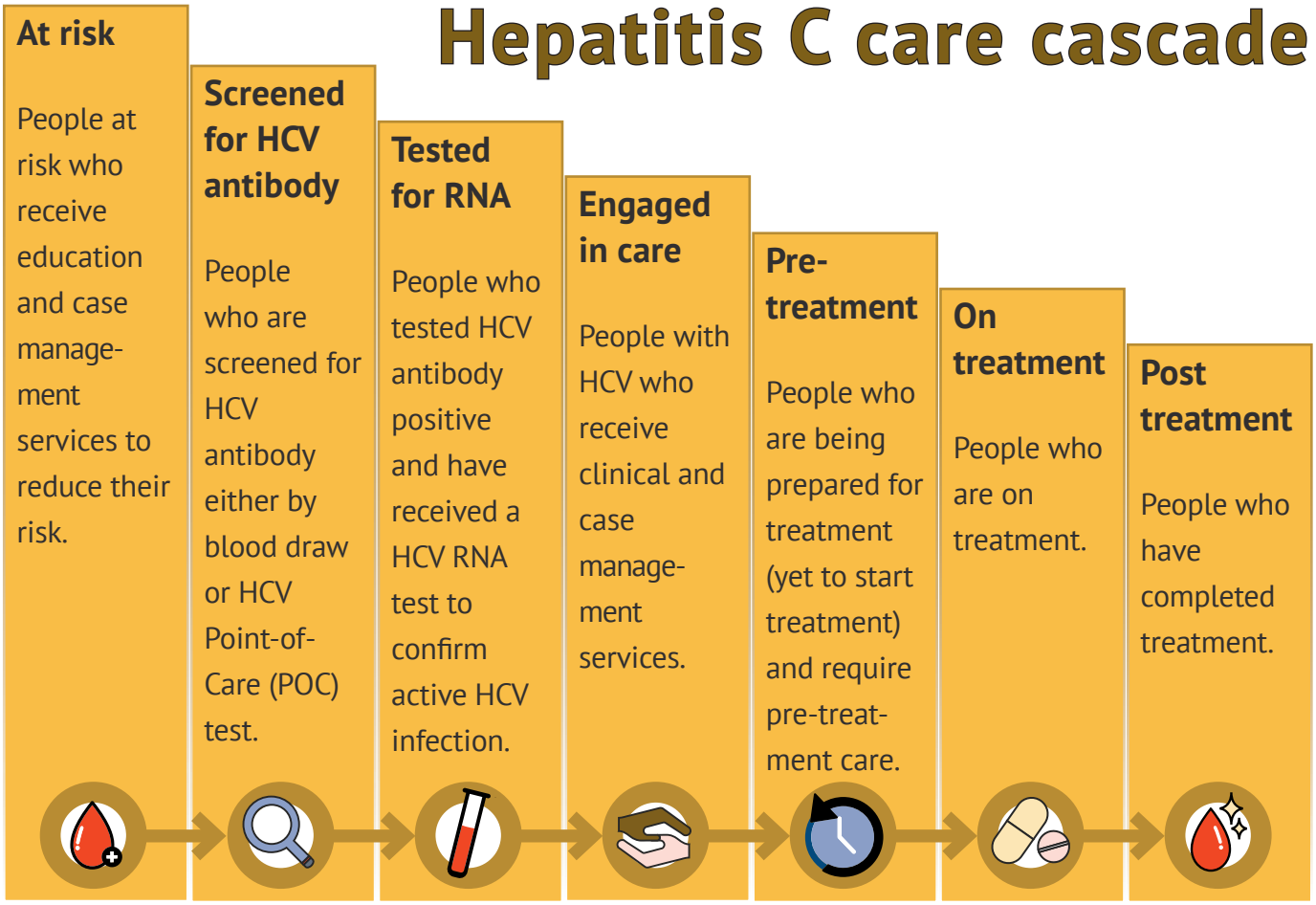
Key points

- Hepatitis C virus (HCV) incidence rates provided by Public Health Ontario (PHO) have increased to 33.6 diagnoses per 100,000 people in Ontario after remaining stable the previous four years between 31.2 and 31.4. The increase occurred especially in major population centres and the Northern region.
- Ministry-funded HCV programs across Ontario saw 6,926 clients last year: 4% more than the year before. The biggest increase came among at-risk clients, which increased 33% to 2,647 clients in 2017-18.
- Changes to the Ontario Drug Benefit Formulary have increased access to and initiation of HCV treatment. This has contributed to an increase in individuals treated through ministry-funded HCV programs, with 1,342 clients starting treatment this year.
- HCV outreach staff continue to provide testing and an increasing number of services to a wider range of locations, providing 14,830 tests (a 20% increase) and making 70,658 contacts, more than double the previous year.
- HCV teams across Ontario continue to deliver frontline harm reduction services, and provide naloxone and overdose prevention training for community members from priority populations and service providers.

Ministry-funded hepatitis C teams in Ontario

- Ministry-funded HCV teams consist of outreach workers, peers, nurses, community coordinators, and psychosocial supports. Teams work collaboratively with physicians to provide HCV care and treatment, education, outreach, and support services to people living with or at risk of HCV.
- Ministry-funded HCV programs in Ontario offer a range of engagement, education, prevention, case management, and clinical services. The services clients use depend on where they are along the HCV care cascade. As people move through the care cascade, they require fewer services. This is likely due to improvements in treatment, which now only takes an average of 12 weeks for most people, is better tolerated with fewer side effects, and has higher cure rates (> 90%).

Hepatitis C care cascade



In 2017-18, AIDS and Hepatitis C Programs funded:

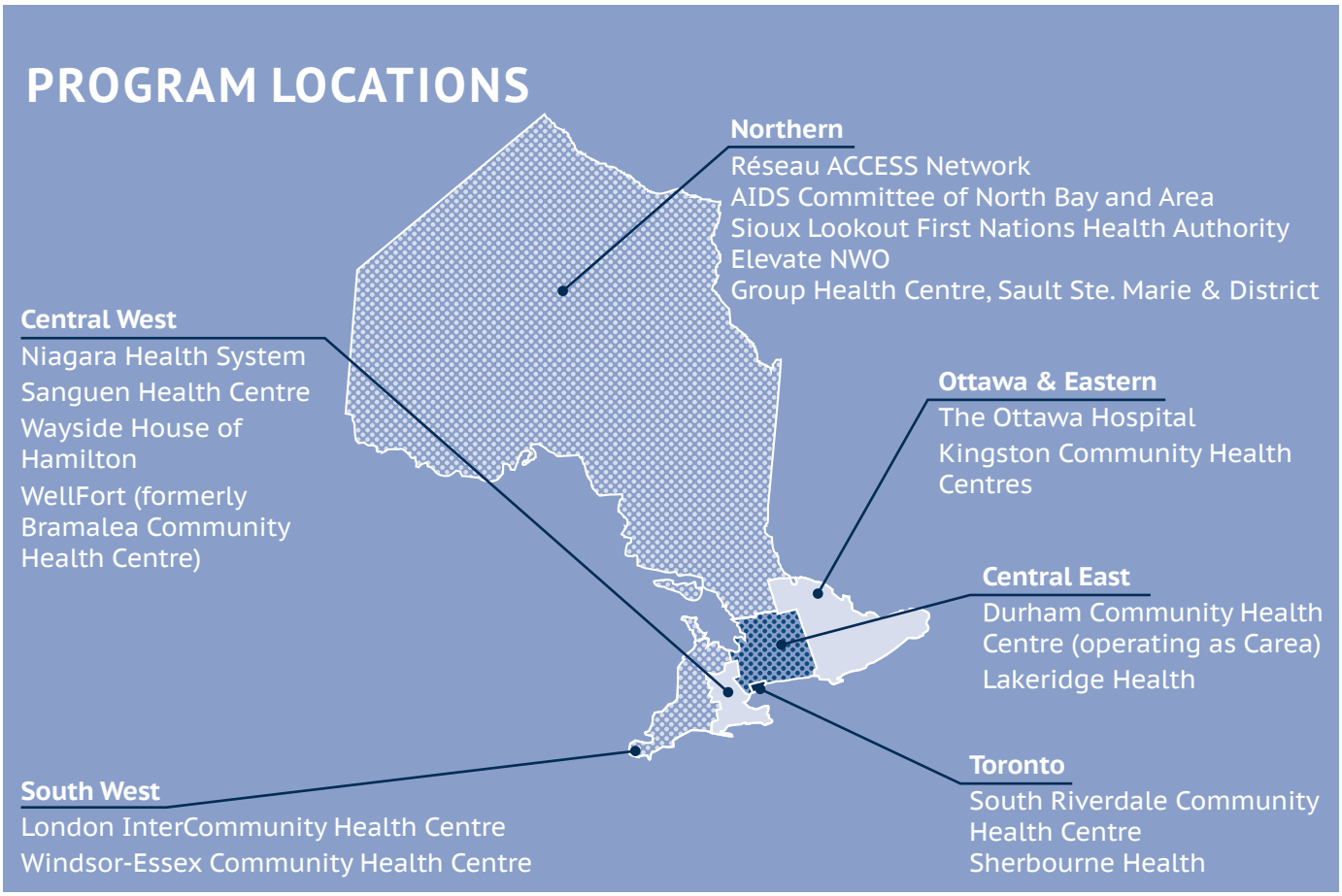
15 multidisciplinary HCV teams that provide HCV education, testing, care, treatment and support to priority populations living with or at risk of acquiring HCV.

1 dedicated outreach worker at the Prisoners with AIDS Support Action Network (PASAN) who connects with people involved in the correctional system.

1 position at the Sioux Lookout First Nations Health Authority related to HCV treatment and support.

1 nurse at Lakeridge Health in Oshawa.

CATIE and the **University Health Network** to provide hepatitis C education and mentoring for HCV team members.



Epidemiology of hepatitis C in Ontario 2017

Through the ministry's Integrated Public Health Information System (iPHIS) database, Public Health Ontario (PHO) extracts annual counts of HCV cases by age and public health unit (PHU) as well as the number of hospitalizations and deaths of people diagnosed with HCV.

In 2017,[1] there were 4,779 reported confirmed cases of HCV in Ontario, representing an increase of 9% (n = 397) from 2016.

The increase in total number of confirmed HCV cases in Ontario corresponds to an increase in incidence rates. From 2012 to 2016, HCV incidence rates remained relatively stable, affecting between 31.2 and 31.4 people out of every 100,000 living in Ontario. In 2017, HCV incidence increased and now affects 33.6 people out of every 100,000.

1 Hepatitis C epidemiological data from PHO covers the 2017 calendar year. OCHART data collected from Hepatitis C Secretariat funded programs covers the time period from April 2017 to March 2018.

Where have incidence rates increased the most?

The increase in Ontario's overall incidence rate was not distributed evenly over all age groups. Incidence rates increased faster than the Ontario average for people aged 15-19 years old, 35-39, and all age groups 65 years and older. However, for many of these age groups, incidence rates remain below the Ontario average and affect a relatively few number of people. Two age groups are an exception to this: people aged 65-69 years old, and people in the 35-39 age group (which now has the second highest incidence rate of all age groups).

When looking at geographic regions, six out of seven public health units in the North experienced incidence rate increases higher than the Ontario average. Many major population centres also experienced increases in incidence rates higher than the Ontario average, including Toronto, Ottawa, Kitchener-Waterloo, and Windsor.

What risk factors are people reporting?

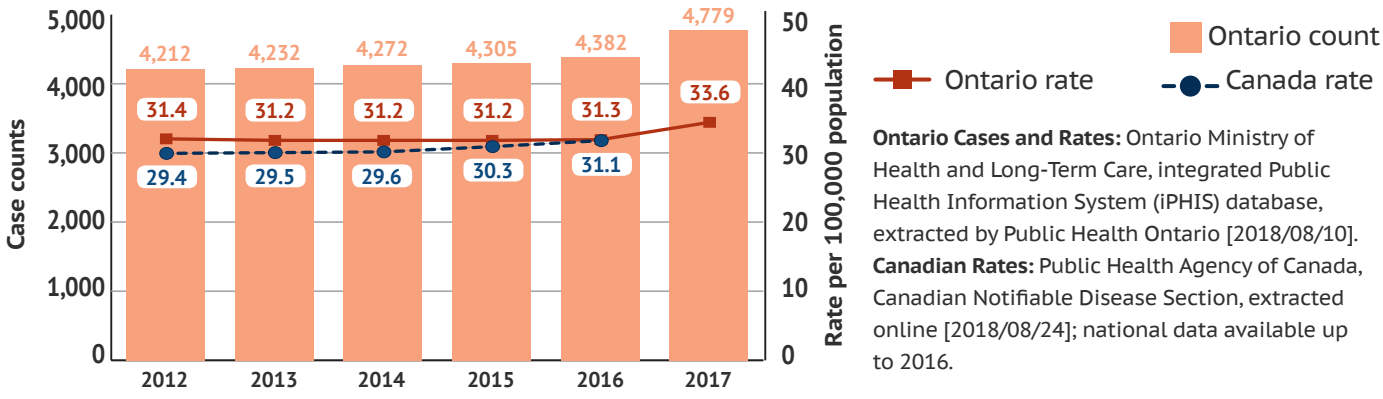
Similar to 2016, 84% of people diagnosed with HCV in 2017 reported at least one risk factor:

- 49% (1,960) injection drug use (2016: 54%)
- 13% (543) high-risk sexual activity (2016: 16%)
- 8% (306) having had a blood transfusion (2016: 7%)
- other possible risks, such as being born in countries with high HCV prevalence, occupational exposure, mother-to-child transmission during birth, other sexual activity, and organ transplant.

More hospitalizations and deaths

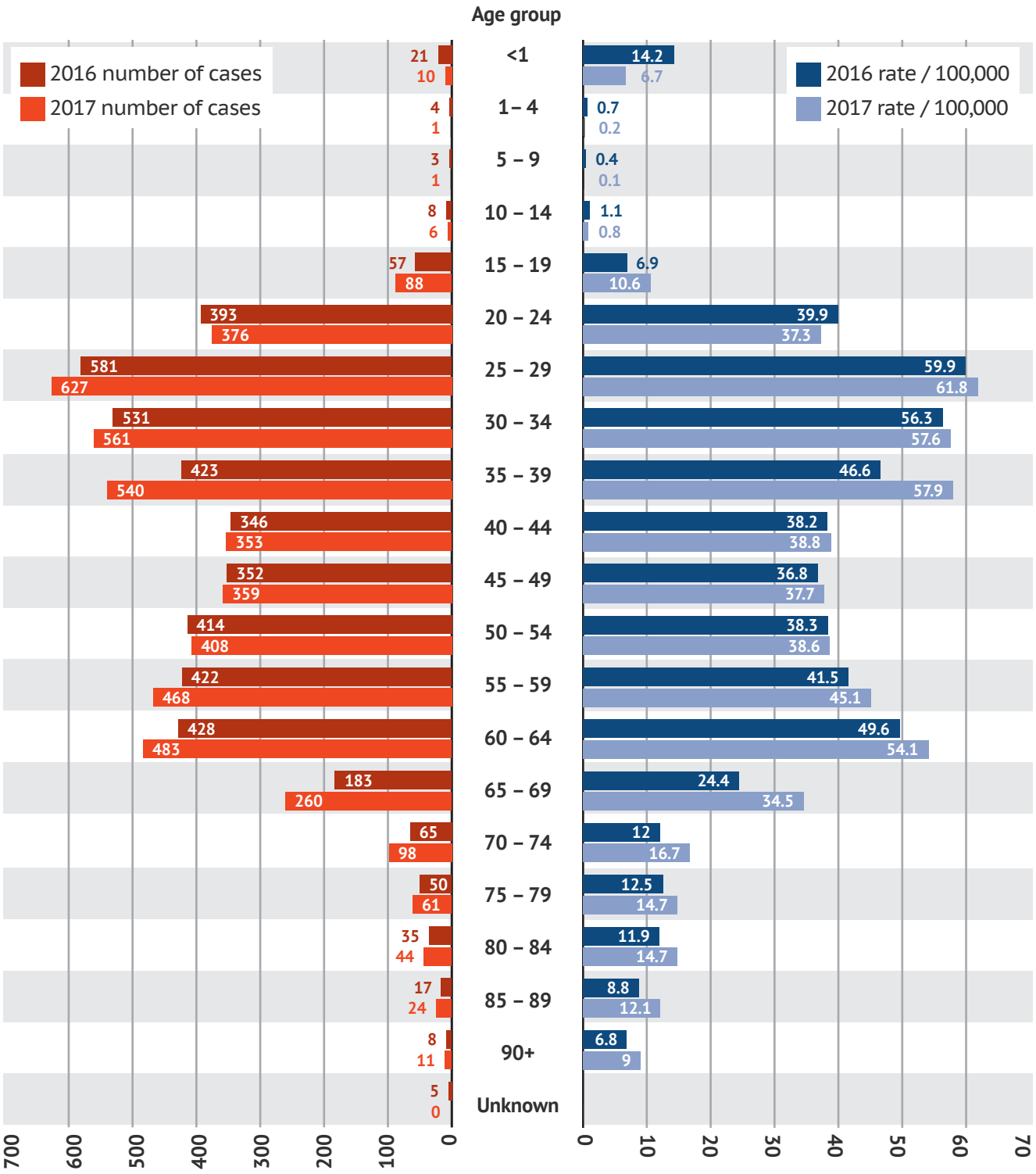
The number of hospitalizations of people diagnosed with HCV increased to 55 in 2017 from 34 in 2016. The number of deaths also increased from 19 in 2016 to 26 in 2017.

Number and reported rates of confirmed hepatitis C cases by year: Ontario and Canada, 2012-2017



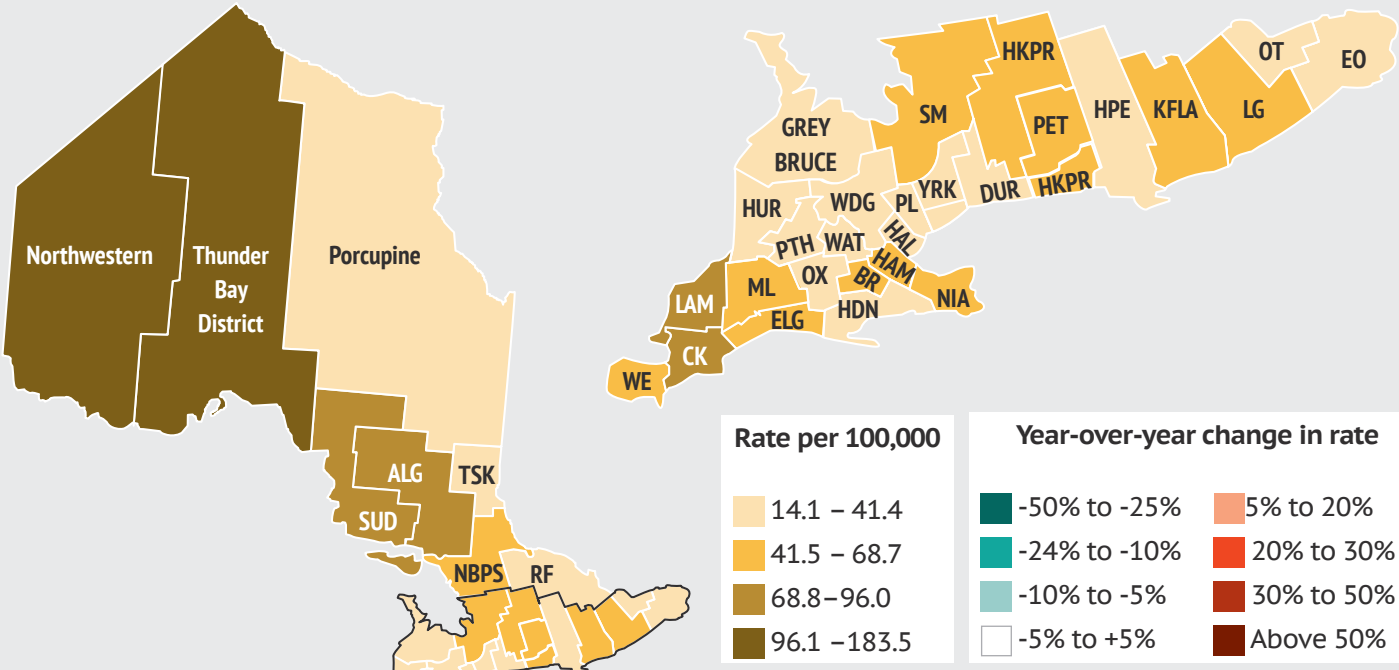
Ontario Cases and Rates: Ontario Ministry of Health and Long-Term Care, integrated Public Health Information System (iPHIS) database, extracted by Public Health Ontario [2018/08/10].
Canadian Rates: Public Health Agency of Canada, Canadian Notifiable Disease Section, extracted online [2018/08/24]; national data available up to 2016.

Number and reported rates of confirmed hepatitis C cases by age group, 2016-17



2016 source: Ontario Ministry of Health and Long-Term Care, integrated Public Health Information System (iPHIS) database, extracted by Public Health Ontario [2017/09/07]. Population Projections 2016-2017, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [2017/02/01]. **2017 source:** Ontario Ministry of Health and Long-Term Care, integrated Public Health Information System (iPHIS) database, extracted by Public Health Ontario [2018/08/10]. Population Projections 2017-2018, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [2017/10/24].

Reported rates of hepatitis C and year-over-year change in rate by public health unit of residence



CENTRAL EAST

DUR	Durham Region	21	-10%
HKPR	Haliburton, Kawartha, Pine Ridge	46.4	15%
PL	Peel Region	21.6	-8%
PET	Peterborough County-City	65.3	1%
SM	Simcoe Muskoka District	43.3	22%
YRK	York Region	14.6	7%

CENTRAL WEST

BR	Brant County	62.3	29%
HAM	City Of Hamilton	44.9	9%
HDN	Haldimand-Norfolk	23.3	-29%
HAL	Halton Region	18	7%
NIA	Niagara Region	51	-4%
WAT	Waterloo Region	25.1	19%
WDG	Wellington-Dufferin-Guelph	23	-11%

EASTERN

EO	Eastern Ontario	21.7	39%
HPE	Hastings & Prince Edward Counties	35.8	-10%
KFLA	Kingston, Frontenac, Lennox & Addington	68.3	9%
LG	Leeds, Grenville & Lanark District	42.9	12%
RF	Renfrew County & District	21.4	-35%

NORTHERN

ALG	Algoma District	74.8	22%
NBPS	North Bay Parry Sound District	65.4	44%
NW	Northwestern	183.5	30%
POR	Porcupine	38.8	-26%
SUD	Sudbury And District	71.1	28%
TB	Thunder Bay District	138.3	8%
TSK	Timiskaming	29.8	68%

OTTAWA

OT	City Of Ottawa	27.2	20%

SOUTH WEST

CK	Chatham-Kent	71.2	50%
ELG	Elgin-St. Thomas	42.5	33%
GB	Grey Bruce	26	21%
HUR	Huron County	38.9	3%
LAM	Lambton County	76.9	4%
ML	Middlesex-London	42.3	-13%
OX	Oxford County	34.4	-35%
PTH	Perth District	13.9	-32%
WEC	Windsor-Essex County	46.1	31%

TORONTO

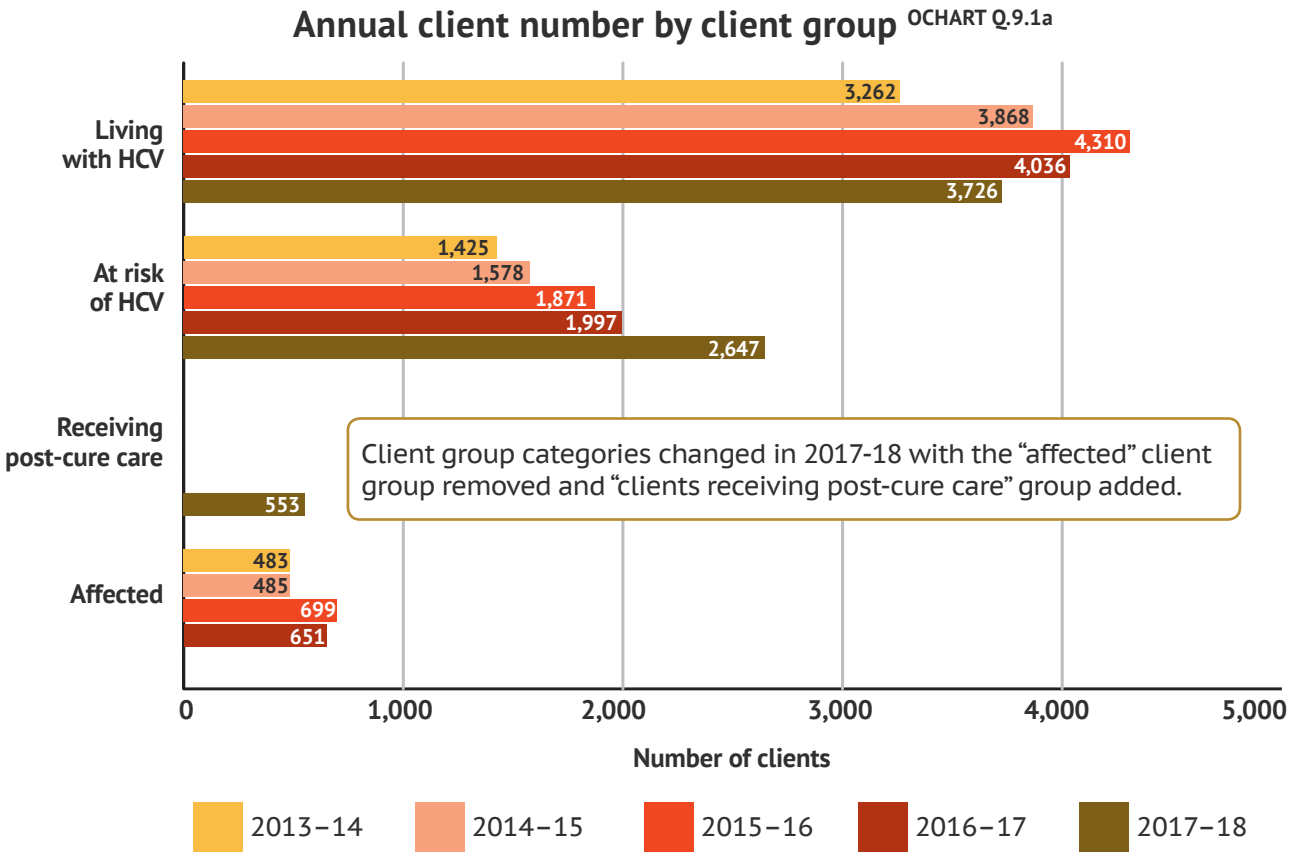
TOR	Toronto	25	14%

Source: Ontario Ministry of Health and Long-Term Care, integrated Public Health Information System (iPHIS) database, extracted by Public Health Ontario [2018/08/10]. Population Projections 2017-2018, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [2017/10/24].

Who is using ministry-funded hepatitis C services?

In 2017-18, ministry-funded HCV teams and positions reported serving a total of 6,926 unique clients: 4% more than were served in 2016-17.

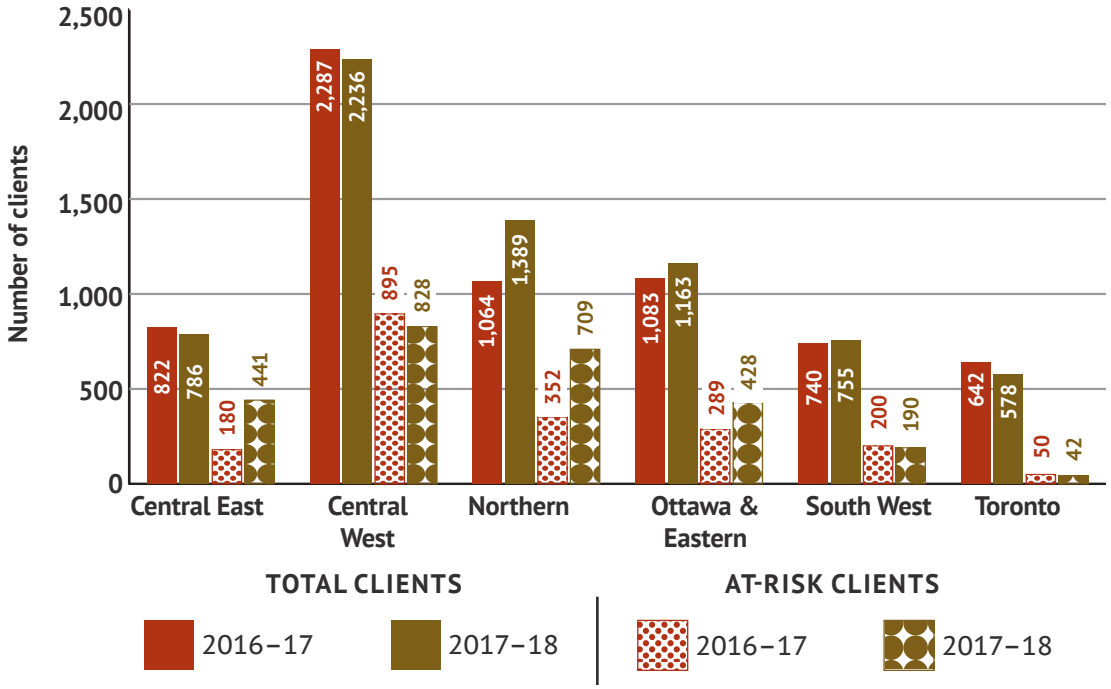
Continuing a trend that started last year, hepatitis C programs served more people at risk of HCV while seeing fewer people currently living with HCV. Clients living with HCV accounted for 53% of the total number of clients in 2017-18, down from 60% in the previous year. Organizations put more resources into prevention and outreach, and into connecting with possible candidates for treatment. They saw 649 (32%) more at-risk clients compared to the previous year, and 84% of these were new clients. In 2017-18, programs also reported serving 553 clients in post-cure care.



Note: Affected clients, people who are partners or family members of people with HCV, are not a focus of the work carried out by HCV teams and are no longer recorded in OCHART. Instead, 2017-18 was the first year the "post-cure care" client group was recorded.

Most regions remained stable or had small decreases in the number of clients served. The Northern region saw a 31% increase, and the Ottawa & Eastern region experienced a 7% growth. When looking at the increase in at-risk clients specifically, the Northern, Central East and Ottawa & Eastern regions reported the largest increases in this client group.

Total clients and at-risk clients by region OCHART Q.9.1a



Note: Data from PASAN (Prisoners' HIV/AIDS Support Action Network) was removed as they offer services across Ontario.

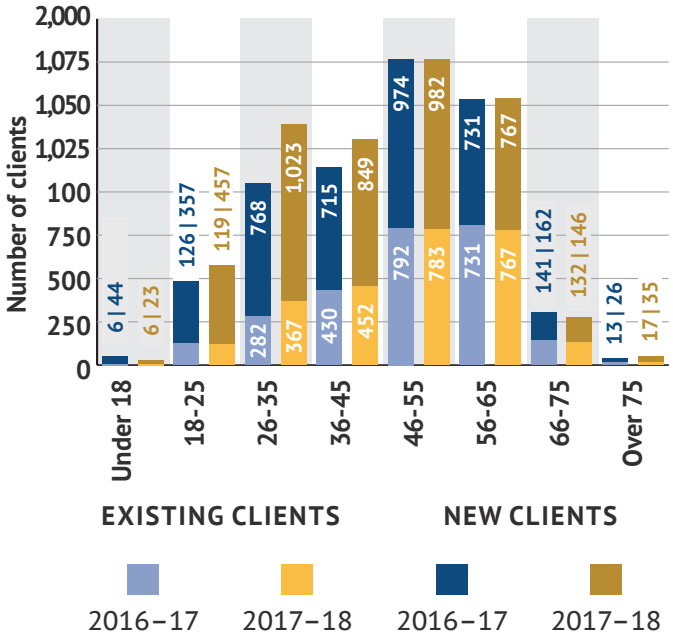
Age and ethnicity

In 2017-18, clients tended to skew towards younger age groups, a trend that was more prominent among new clients. Overall, teams served more clients in age groups between 18 and 45 this year than in 2016-17, while the number of clients served age 46 years and over remained stable year over year.

In 2017-18, new clients tended to be younger than existing clients who had previously received services from the HCV teams. Their average age was 36-45 years, while the average age of existing clients was 46-55.

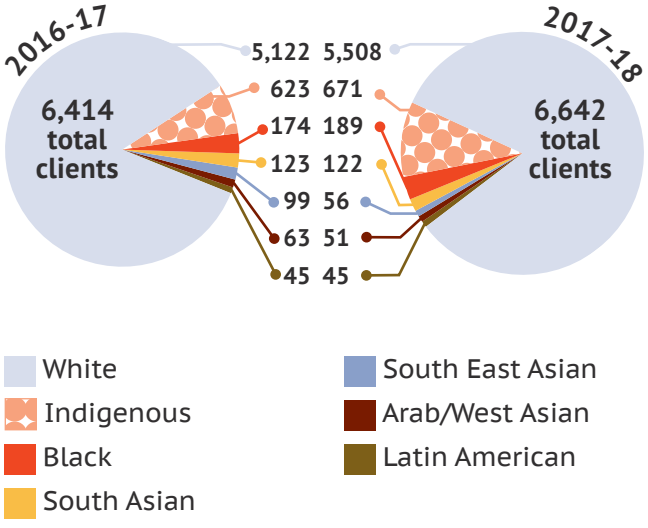
Similar to last year, 83% of clients served identified as white. The number of clients served who identify as white or Black increased by eight percent and nine percent, respectively, and the number of First Nations, Métis and Inuit clients increased by eight percent.3 The number of clients from most other ethnicities decreased marginally in 2017-18.

Age breakdown of new and existing clients OCHART Q.9.1b



Note: 160 clients with an "unknown" age in 2016-17 not shown.[2]

Ethnicity of total (new and existing) clients OCHART Q.9.1c



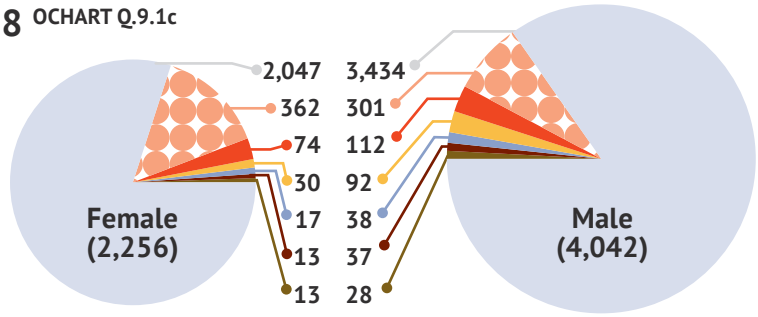
Note: 302 clients with an "unknown" or "not listed" ethnicity in 2016-17 not shown.

2 No clients were reported with an "unknown" age in 2017-18 as this response option was removed.

Client ethnicity by gender in 2017-18 OCHART Q.9.1c

White
Indigenous
Black
South Asian
South East Asian
Arab/West Asian
Latin American

Note: Trans men and women not reported above due to small numbers.



Four out of 10 services are general support or clinical counselling

HCV teams reported providing a total of 73,701 service sessions to clients in 2017-18. In previous years, teams reported the number of unique clients accessing their programs, rather than the total number of service sessions given, so no year-over-year trends are available for the types of services utilized.

In 2017-18, general support and clinical counselling were the top two services provided to all client groups and were used in similar proportion by all genders.

When looking at the next most used types of services:

- Clients living with HCV used wellness checks and practical assistance (7,149).
- At-risk clients received practical assistance (2,320) and had intakes/assessments (1,900).
- Clients in post-cure care used practical assistance (1,237) and ongoing clinical monitoring (1,223).

Service type utilization by client group in 2017-18 OCHART Q.9.1d

Service type	At-risk of HCV	Living with HCV	Receiving post-cure care	Total
General support	2,991	13,705	2,135	18,831
Clinical counselling	2,743	8,050	1,344	12,137
Practical assistance	2,320	7,142	1,237	10,699
Wellness check	1,275	7,244	1,042	9,561
Intake and assessment	1,900	4,945	288	7,133
Ongoing clinical monitoring	0	5,823	1,223	7,046
Adherence counselling	0	4,611	0	4,611
Application completion	347	1,345	90	1,782
Appointment accompaniment	45	826	137	1,008
Vaccinations	170	662	–	–
Total	**11,791**	**54,353**	**7,557**	**73,701**

Outreach

Many HCV teams and other ministry-funded positions across Ontario focused efforts on increasing outreach work in 2017-18, particularly among people who use drugs and other at-risk communities. As a result, funded programs reported a 160% increase in the number of outreach contacts made this year: from 27,153 in 2016-17 to 70,658 this year.

When looking at the different locations where teams provide outreach services, the number of contacts made through each type of location increased everywhere except at mental health service providers (down from 338 to 273) and correctional facilities (down from 2,502 to 1,492).

Similar to last year, food banks, soup kitchens, and shelters remain a major contact point for HCV outreach. The number of outreach contacts made through street outreach increased 283% from last year and is now the second most common contact location. Mobile outreach service contacts increased nearly fivefold (493%) and accounted for 29% of the total contacts made in 2017-18. The large increase in contacts made through street and mobile outreach services resulted from existing mobile services expanding and similar services being provided by more HCV teams in more locations.

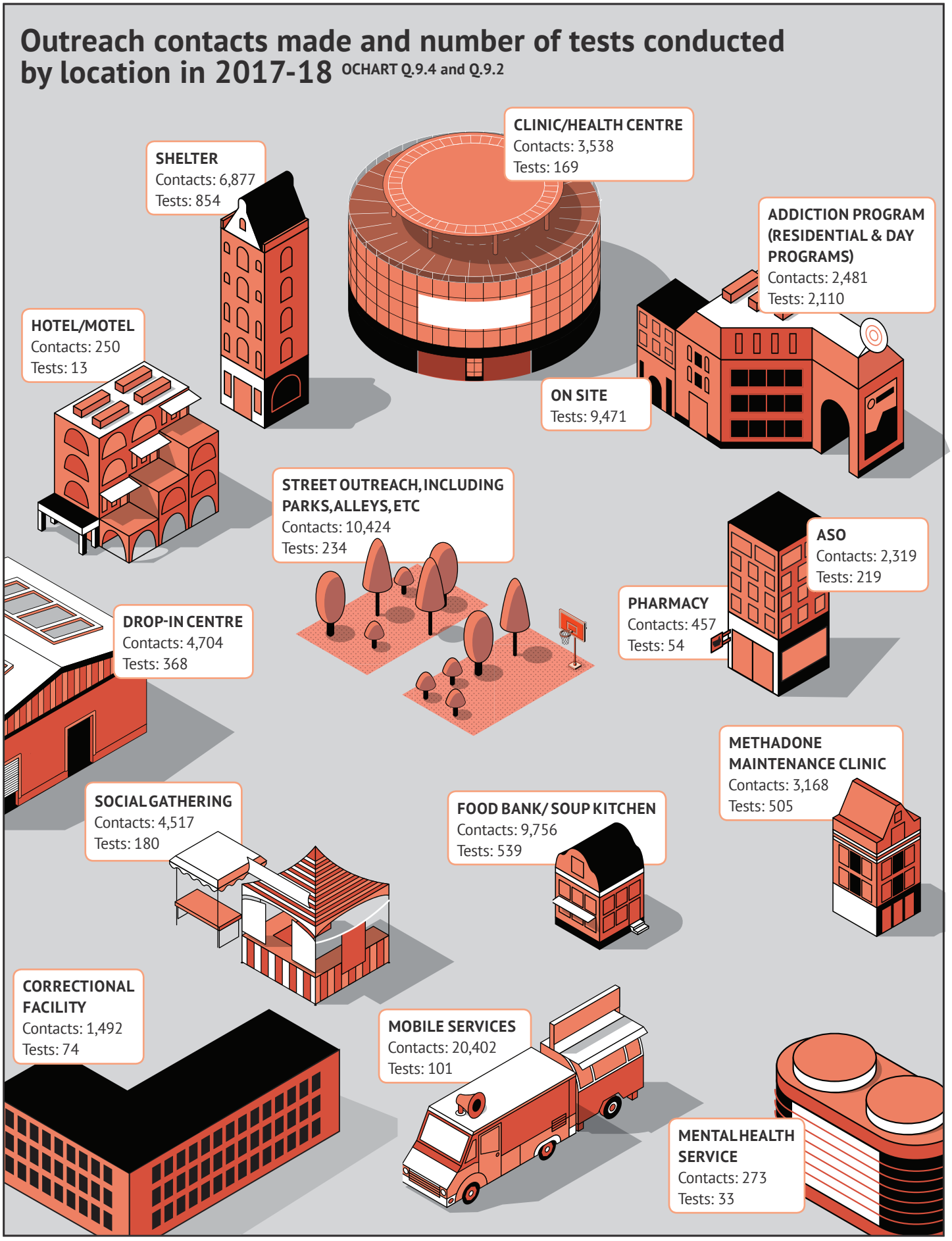
> We have identified that so far most individuals from the priority populations do not walk in to request naloxone Training and a naloxone Kit but seem to be receptive to training provided in an outreach setting.
>
> –Windsor-Essex Community Health Centre

Outreach at ASOs, clinics, food banks, addiction programs, and using mobile services were more likely to lead to significant contacts compared to other outreach locations.

Sanguen Health Centre was one of many organizations that expanded their mobile services in 2017-18. (Photo courtesy Sanguen Health Centre.)

> With the expansion of mobile outreach we have needed to focus staffing support on this initiative. Social support will continue to be a part of the Community Health Van.
>
> –Sanguen Health Centre

Outreach contacts made and number of tests conducted by location in 2017-18 OCHART Q.9.4 and Q.9.2



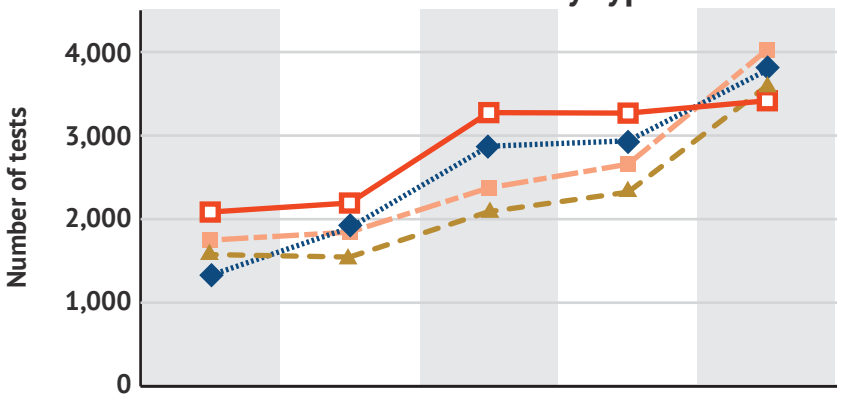
Testing

Seventeen of the HCV programs offered testing during 2017-18. In total, they conducted 14,830 tests: a 20% increase compared to the previous year. The increase is specific to antibody tests, which can be conducted during outreach. This trend highlights an increased focus on outreach and testing by the HCV teams.

> Our agency has been focusing a lot of time and effort on hosting HIV/HCV testing drives both in North Bay and within our catchment area, which has provided unique testing opportunities for us. This has helped to increase testing numbers for our agency. We utilize outreach opportunities (community gatherings/events) to promote HCV point-of-care testing, and having our nurses attend these events to provide the testing for anyone that is interested.
>
> –AIDS Committee of North Bay and Area

2017-18 was the first year that OCHART gathered data about the number of tests provided at specific outreach locations. Nearly two out of every three tests (9,471 total tests) were performed at the organizations' main site locations. Of the remaining 5,453 tests performed at outreach locations, addictions programs and shelters were the most common places to engage clients. HCV tests were the most common tests performed at all locations except ASOs and methadone maintenance clinics, where HIV tests were most commonly performed.

Annual number of tests by type OCHART Q.9.2



	2013-14	2014-15	2015-16	2016-17	2017-18
HCV-RNA	2,085	2,193	3,275	3,269	3,417
HBV antibody test	1,576	1,546	2,089	2,323	3,599
HCV antibody test	1,327	1,896	2,873	2,937	3,785
HIV antibody test	1,749	1,844	2,374	2,658	4,029

Test types

ANTIBODY TESTS: Some HCV teams provide point-of-care tests (POC) that react to antibodies from current or past HCV infections. Many teams also test for HIV and Hepatitis B infections.

RNA TESTS: Because POC tests detect current and past infections, PHO requires testing for HCV genetic material in a blood sample (serum or plasma) to determine if a client is currently living with HCV.

There was a 5% increase in the number of fibrotests and fibroscans conducted from 2,216 in 2016-17 to 2,329 this year.

Fibrosis test results OCHART Q.9.3a

	Fibrosis score 0 (mild)	Fibrosis score 1	Fibrosis score 2	Fibrosis score 3	Fibrosis score 4 (severe)
Number of tests	647	632	322	270	458

Note: 2017-18 was the first year Fibrosis scores were recorded. Fibrosis scores measure the level of scarring to the liver caused by the disease. Scores were used to determine treatment eligibility until changes to Ontario Drug Benefit Formulary removed this criterion in February 2018; however, fibrotests and fibroscans still serve a purpose for clinical monitoring.

> Because of the usefulness of the POC test for HCV, we are offering them during testing on outreach and our regional roadshows. They are very helpful in speeding along the process and results delivery.
>
> –Elevate NWO

Treatment

In February 2018, changes were made to the Ontario Drug Benefit Formulary to include additional HCV treatments and increase treatment access options by removing some qualifying criteria such as liver fibrosis severity.

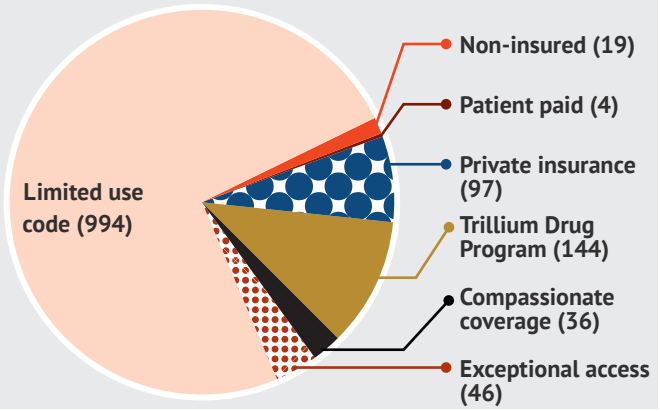
> More clients are on treatment now that treatment criteria has been opened up to include more groups of people. The limited use code has made the treatment process easier for our nurses.
>
> —AIDS Committee of North Bay and Area

Treatment initiations

The way clients on treatment were tracked in OCHART in 2017-18 changed from previous years. In previous years, clients were categorized as being "on treatment" as a client group. In 2017-18, client groups changed and instead treatment initiation events were recorded in order to get a measurement of the number of clients engaged in treatment over the year.

In 2016-17, 1,205 clients were reported as being "on treatment". In 2017-18, 1,342 clients initiated treatment, 94% of whom were a member of a priority population. The increase in treatment initiations comes even as the number of clients living with HCV decreased. This highlights the effectiveness of outreach activities to engage clients in the care cascade sooner, and of the changes to the Ontario Formulary in increasing access to HCV medications. Three out of four (74%) clients had their treatment primarily covered under the Ontario Formulary 'Limited Use' code, 11% were covered under the Trillium Drug Program, and 7% were covered under private insurance. Eighty-five clients (6%) had multiple types of coverage.

Clients' main type of financial coverage for HCV treatment in 2017-18 OCHART Q.9.3e



In 2016-17, three of every four clients who were on HCV treatment were treated for Genotype 1, with smaller numbers of clients being treated for Genotype 2 (6% of cases), Genotype 3 (15%), and Genotype 4 (2%). In 2017-18, larger proportions of clients were treated for Genotypes 2 (10% of cases) and 3 (27%), though clients being treated for Genotype 1 still accounted for 60% of those treated.

Client genotypes by year OCHART Q9.3f

HCV Genotype	2016-17 number	2016-17 % of cases	2017-18 number	2017-18 % of cases
Genotype 1	558	76%	813	60%
Genotype 2	46	6%	133	10%
Genotype 3	109	15%	358	27%
Genotype 4	17	2%	30	2%
Genotype 5	0	0%	6	0%
Genotype 6	1	0%	6	0%

> We are noticing an increase in the number of individuals presenting with Genotypes 2 and 3 during this reporting period.
>
> –Wayside House of Hamilton

More clients qualify for treatment

Similar to treatment initiations, treatment completions and associated outcomes were recorded for the first time in 2017-18. This year, 1,351 clients were reported as having completed a course of HCV treatment during the year. Of the 62% of clients where post-treatment blood work results were reported, 96% had achieved a sustained virologic response (SVR).

Four hundred and forty-eight clients were excluded from treatment this year, half as many as the 906 treatment exclusions reported last year. This decrease reflects the changes in the Ontario Formulary. Those excluded because they did not qualify for drug coverage dropped from 617 in 2016-17 to 173 in 2017-18. Fifty clients were withdrawn from treatment before finishing the full course in 2017-18, with some of the main reasons being side effects or lost to follow-up.

Number of clients withdrawn from HCV treatment by reason in 2017-18

OCHART Q.9.3i

Reason for withdrawal	2017-18
Death	5
Did not achieve treatment milestones	8
Lost to follow-up	12
Medical instability	4
Psychiatric manifestation	1
Psycho-social instability	8
Side effects	12

Number of clients excluded from HCV treatment by reason OCHART Q.9.3h

Reason for exclusion from treatment	2016-17	2017-18
Death	*	9
Did not qualify for drug coverage	617	173
Informed deferral	78	47
Lack of OHIP coverage	*	4
Lost to follow-up	69	78
Medical instability	23	66
Pregnancy	11	23
Social instability	46	48

*new category introduced in 2017-18

The way clients who are receiving clinical monitoring are tracked in OCHART changed from the previous year. In 2017-18, 830 clients were reported as receiving clinical monitoring to assess liver health and manage extrahepatic manifestations. The number of clients reported as spontaneously cleared of HCV decreased from 217 in 2016-17 to 186 this year.

> Treatment initiation rates have increased at our locations, with more responsive and quicker time to treatment from initial contact. We continue to see high SVR rates and treatment completion across sites.
>
> –South Riverdale Community Health Centre

Educating clients and community

Ministry-funded programs engage in different types of education with service users and the larger community. In 2017-18, the ministry-funded programs gave a total of 1,285 education presentations, 81% of which were to priority populations. This is an increase of 69% in the number of presentations delivered compared to 762 last year. The total number of participants reached at education events increased by 88% to 20,726 total participants compared to 10,999 last year. Two major themes encompassed the majority of presentations and participants: HCV testing/treatment, and harm reduction/overdose prevention. These themes are to be expected given the ongoing response to the opioid crisis and the number of new HCV medications available with fewer barriers.

Topics and audiences at education events given by ministry-funded programs in 2017-18 OCHART Q.9.4b

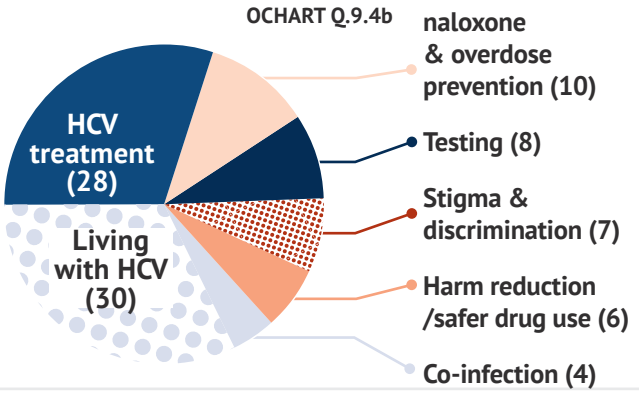
Education topic	Total participants	Priority population	Non-health care service providers	Healthcare providers	Total number of presentations
Naloxone and overdose prevention	5,921	279	89	19	387
HCV treatment	5,277	288	24	20	332
Testing	2,790	198	9	1	208
Harm reduction/ safer drug use	3,928	88	40	11	139
Living with HCV	1,549	106	9	4	119
Stigma and discrimination	1,027	54	16	7	77
Co-infection	196	19	0	0	19
STIs/safer sex	38	4	0	0	4
Total	**20,726**	**1,036**	**187**	**62**	**1,285**

When looking at different audiences, HCV treatment was the most common focus of education presentations for priority populations and health care providers. naloxone/overdose prevention was the second most common focus among these audiences, and made up 74% of the education presentations given to non-health care service providers.

Outreach workers were reported as the lead educators for 50% of the education presentations given in 2017-18, while coordinators led 20%, nurses led 13%, mental health counsellors led 10%, and peers led 7%. Peers were involved mainly in education presentations about living with HCV and HCV treatment.

Number of education events with peer involvement in 2017-18

OCHART Q.9.4b



HCV teams reported giving 3,667 one-on-one education sessions. 2017-18 was the first year these were reported. They include responses to individual requests for information when people phone, text, email or drop into the agency. The majority (62%) of one-on-one education sessions were conducted by HCV coordinators, 20% were conducted by nurses, and the remaining 18% by mental health counsellors, outreach workers, and peers.

> Service users identified the need for more overdose/naloxone information and training sessions. As a result of the increase in service users experiencing overdoses/witnessing overdoses, we also identified a need to increase our counselling services.
>
> –Group Health Centre

Percentage of each presentation topic led by worker types OCHART Q.9.4b(2)

Education topic	Outreach worker	Coordinator	Nurse	Mental health counsellor	Peer
Naloxone and overdose prevention	49%	23%	20%	4%	2%
HCV treatment	49%	12%	14%	18%	8%
Testing	76%	6%	14%	1%	4%
Harm reduction/safer drug use	44%	40%	5%	7%	4%
Living with HCV	29%	27%	3%	17%	25%
Stigma and discrimination	39%	30%	1%	21%	9%
Co-infection	21%	32%	0%	26%	21%
STIs/safer sex	60%	20%	20%	0%	0%

> We have started to successfully transition the group facilitation (as well as most other non-clinical activities) to be led by Community Support Workers (CSW). Another peer training session is being planned for the New Year which will also be led by a CSW.
>
> –South Riverdale Community Health Centre

One-on-one education sessions delivered at HCV programs, by position

OCHART Q.9.4

Coordinator: 2,276 sessions
Nurse: 738 sessions
Peer: 103 sessions
Mental health counsellor: 296 sessions
Outreach worker: 254 sessions
Total: 3,667 sessions

Strengthening services

HCV teams and other ministry-funded positions engage with a number of other community partners formally and informally in order to strengthen the programs and services they provide and better meet the needs of the communities they serve. These activities are recorded in OCHART as community development meetings and consultations with other service providers. Ministry-funded programs also routinely conduct evaluations of their own programs and services to ensure they continue to meet the needs of their clients.

Community development and consultations with service providers

New questions in 2017-18 asked HCV teams and other ministry-funded positions to report the number of community development events they attended with service providers, professionals, and practitioners that seek to improve the lives of community members and enhance the capacity of service providers. A total of 937 community development meetings with 11,291 individuals were recorded in 2017-18. Fifty percent of those events were led by HCV coordinators, and 37% by HCV outreach workers.

Generally, HCV coordinators met with five more people during each community development meeting than other positions, highlighting their role in establishing connections with community partners.

The number of consultations provided were recorded for the first time in 2017-18. Consultations are when a worker spends time with another agency to assist in changing practices or policies. Ministry-funded programs reported providing 184 consultations with 1,251 individuals. Sixty percent of this work was completed by HCV coordinators.

Number of community development and consultation sessions delivered OCHART Q.9.4c

Delivered by	Community development partners	Community development sessions	Consultation partners	Consultation sessions
Coordinator	6,905	467	676	110
Outreach worker	3,532	350	353	43
Nurse	523	75	93	15
Mental health counsellor	200	30	69	14
Peer	131	15	60	2

Programs use various methods to evaluate their services

Ministry-funded programs also gather feedback on the programs and services they provide. All reported gathering feedback, with most using verbal feedback from clients, statistical data, and surveys to evaluate their programs. Service users were the most common group from which feedback was gathered; staff, peers and other service providers were also engaged in evaluation.

Evaluation methods used in 2017-18

OCHART Q.9.6

HOW WAS FEEDBACK GATHERED?

- Verbal feedback from consumers (17)
- Statistical data (e.g., OCHART, OCASE) (15)
- Survey (14)
- Interview (7)
- Focus group (6)
- Advisory committee (6)

FROM WHOM WAS FEEDBACK GATHERED?

- Service users (17)
- Staff (15)
- Peers (13)
- Service providers (13)
- Volunteers (6)

Note: Numbers in the parentheses are the number of programs (out of 21) that used these methods.

Building hepatitis C teams' capacity

CATIE and the University Health Network (UHN) receive funding to provide HCV education and mentoring for HCV team members across the province. In 2017-18, they conducted the same number of presentations as in the previous year, but reached 6% more participants. CATIE and UHN also focused more on engaging with HCV teams in community development meetings to assist in strengthening teams' capacity, participating in 144 community development meetings in 2017-18 compared to 133 in the previous year.

CATIE and UHN also developed sector-wide resources for HCV teams. In 2017-18, they developed eight new resources and distributed 142,647 copies, compared to 10 resources developed in 2016-17 and 183,316 copies distributed. Healthcare providers, HCV teams, and other service providers were the most common audiences for the developed resources.

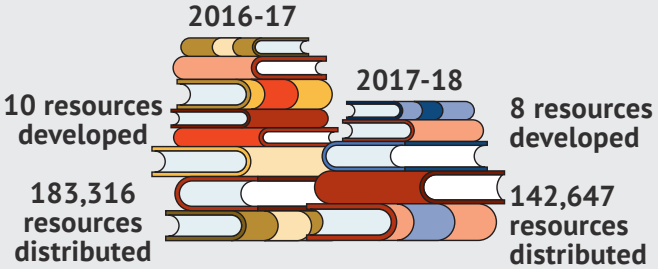
137 presentations in both 2016-17 & 2017-18 — OCHART Q.9.1

931 participants in 2016-17

987 participants in 2017-18

Resources developed and distributed by CATIE and UHN in 2016-17 and 2017-18

OCHART Q.9.1



Successes

Connecting and retaining clients in care and treatment

Increase in the amount of people wanting HIV/HCV testing now that we have had more foot traffic inside of our office and in the needle exchange. Having access to point-of-care testing for HCV, which has made testing efforts more easy and accessible for the people that we serve.

–AIDS Committee of North and Area

During this reporting period, the Hepatitis C Care Team was able to reach out to the Indigenous community (on a reserve) and been able to make more than 90 contacts and some HIV and HCV testing. The Indigenous community has expressed great satisfaction and appreciation for this partnership and would like to maintain it.

– London InterCommunity Health Centre

The implementation of Limited Use Codes for patients through Ontario Drug Benefits and relaxed requirements for access to treatment have alleviated the time taken to complete applications to EAP for the majority of our cases.

–The Ottawa Hospital

Increased requests for overdose awareness and support throughout the Niagara Region. In response to the complex care needs of clients, the outreach worker conducts home visits with a social worker and nurse to support client needs and to help clients through the treatment journey and to help prepare clients for treatment.

–Niagara Health System

The team places a great effort into reconnecting with clients who are lost to follow-up by calling them and if their number is out-of-service we send a letter to the last known address. For those in the shelter system we are sometimes able to track them down via the connected Shelter database.

–Wayside House of Hamilton

Increased naloxone distribution and training

naloxone distribution and overdose prevention training have also been a significant component of staff efforts this period. We experience continued high demand for naloxone and related overdose prevention training from our community partners and clients.

–South Riverdale Community Health Centre

There have been requests and increased need for overdose prevention and naloxone distribution for priority populations, friends and families. The team is now distributing naloxone through the Niagara Region and providing training. Team members provide support when needed for people who administered naloxone.

– Niagara Health System

There is an overdose crisis within the community and prisoners' overdose-related mortality rate is higher for newly released prisoners. PASAN staff have begun integrating overdose prevention information into all of our prison-based programming including providing information to prisoners about post-release overdose prevention strategies and harm reduction resources available upon their release.

–PASAN (Prisoners with HIV/AIDS Support Action Network)

Outreach work remains a focus of many programs

We have identified that so far most individuals from the priority populations do not walk in to request naloxone Training and a naloxone Kit but seem to be receptive to training provided in an outreach setting.

–Windsor-Essex Community Health Centre

Outreach remains vitally important to our operations as our regions continue to see an increase in fentanyl use (intentionally and unintentionally). naloxone has become an increasingly important part of our outreach service.

–Sanguen Health Centre

> The street-based outreach/medicine program has been extremely successful in engaging people who typically don't want to be engaged. The provision of medical services in addition to harm reduction education, materials and supports, as well as overdose prevention is leading to greater credibility of the team.
>
> –Elevate NWO

> We have developed "pop up" testing opportunities in partnership with food banks and larger events where target populations gather across our region.
>
> – Réseau ACCESS Network

> Bloom clinic is incorporating the use of "pop up" events as part of a strategy to develop new partnerships in farther reaches of the community.
>
> –WellFort

Challenges

Programs provide care for clients with complex needs

> With increased access to HCV medications, there is an increase in need for adherence counselling.
>
> –Group Health Centre, Sault Ste. Marie & District

> We are seeing clients who present with higher levels of health care issues. We have an HIV outbreak among people who inject drugs in London. Also among the injection drug use population, we have high rates of Hep C and other infectious diseases including MRSA, IGAS and Endocarditis as well as infected wounds.
>
> –London InterCommunity Health Centre

> An increasing proportion of those living with HCV have complex needs (addiction, homelessness, poverty, mental health, etc.), and are also in search of more basic needs support (food, shelter, companionship, etc.). Contaminated drug supply use continues to increase in our target population, resulting in more concern for the mental, physical and emotional health fallout from these drugs.
>
> –Sanguen Health Centre

> Increase in clients presenting with more complex needs: housing, referrals, support with mental health concerns, clothing, food, basic hygiene supplies, etc. More requests to have client support out in the community, for example, having our social worker accompany clients to the hospital to access withdrawal management beds (as they have been moved from the community to the hospital).
>
> –AIDS Committee of North Bay and Area

Harm reduction work during the ongoing overdose crisis

> The primary issue continues to be the need for expansion of our outreach and support program capabilities. We serve a wide geographic area that includes the cities of Kitchener, Waterloo, Cambridge and Guelph, as well as the surrounding counties, and our current team complement is simply not sufficient to adequately provide the necessary services across our entire area.
>
> –Sanguen Health Centre

> We have noted a significant increase in a) the number of injection drug users in the direct vicinity of our main location who will not come into the building and who are in need of practical supports, including harm reduction materials, and b) who have been banned from or refuse to use the local shelter/soup kitchen services.
>
> –Windsor-Essex Community Health Centre

> Service users identified need for more overdose/naloxone information and training sessions. As a result of the increase in service users experiencing overdoses/witnessing overdoses, we identified a need to increase our counselling services, especially as it relates to trauma.
>
> –Group Health Centre, Sault Ste. Marie & District

> Hep C program staff played a significant role in establishing and supporting the opening of SRCHC's supervised injection service this period, are involved in the ongoing operation of the Moss Park OPS, and continued to consult on a variety of other responses to the overdose crisis (naloxone guidelines, OPS guidelines, OST expansion) at a provincial level, as well as over 40 media interviews with a variety of outlets and mediums.
>
> –South Riverdale Community Health Centre

Testing follow up remains a challenge

> Many clients are provided education and rationale for testing, defer at that moment as they have other priorities that day and "will come back". Those that test HCV Ab positive may not return for further intake and assessment even if this can be delivered in an outreach location that is convenient to the client.
>
> –Lakeridge Health

> The hepatitis C care team has been having difficulty providing HCV standard blood testing at the outreach locations as this requires more time and client follow-up. This resulted in many clients missing opportunities to do proper follow-up and not seeking HCV treatment.
>
> –London InterCommunity Health Centre

> Testing is increasingly difficult as service providers and individuals at risk necessarily preoccupied with overdose prevention and management of other complex needs. Client follow-up for testing on outreach continues to be challenging as individuals in our shelter systems tend to move quickly and often don't have cellphones or have challenges in maintaining follow-up.
>
> –Sanguen Health Centre

Appendices

Appendix A: 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.

Risk of residual disclosure

Privacy standards require that totals of 11 or less are no longer reported owing to client identification risks; therefore, client groups or activities with few number were not reported and unable to be compared to previous years.

Changes in the number of funded programs

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

Appendix B: Economic impact

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

Limitations of this tool

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

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

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

Volunteer hours reported in the "other" category cannot be assigned a dollar value with this tool and use Ontario's minimum wage as a conservative estimate. 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:

1. OCHART Q2.6 data on the total number of volunteer hours, by category of work, in the last fiscal year (H1 + H2)
2. National Occupation Classification (NOC) data, which tells you the average Canadian, provincial and regional wages for various occupations.[1]

1 Government of Canada (2019). *Wage report*. https://www.jobbank.gc.ca/wagereport/location/geo27236.

Economic impact of volunteer hours

Volunteer position	OCHART question	National Occupation Classification (NOC)	Total number of volunteer hours in the past 12 months (A)	Wage Rate Assigned to This Job Type in the past 12 months (B)	Hours × NOC Average Hourly Wage Rate (C)	Fringe Benefit 12% (D)	Total Value (C+D)
Administration (clerical support, reception, etc) and involved in the hiring process (interview panels)	2.6 sum to total # of vol hrs for Involvement in Hiring Process and Administration	General office support workers 1411	38,367	$19.50	$748,156.50	$89,778.78	$837,935.00
Board member	2.6 # of vol hrs for Board Member	Senior manager-Health, Education, Social and Community Services and Membership Organization 0014	15,144	$43.52	$659,066.88	$79,088.03	$738,155.00
Counselling (peer support, etc)	2.6 # of vol hrs for Counselling	Social workers 4152	4,056	$34.35	$139,323.60	$16,718.83	$156,042.00
Practical support (assistance to people living with HIV/AIDS, etc)	2.6 # of vol hrs for Practical Support	Home support workers, housekeepers and related occupations 4412	62,498	$16.50	$1,031,217.00	$123,746.04	$1,154,963.00
Prevention (outreach, targeted education, etc)	2.6 sum to total # of vol hrs for Outreach Activities and Education/ Comm Devt	Community and social service workers 4212	32,123	$21.35	$685,826.05	$82,299.13	$768,125.00

Volunteer position	OCHART question	National Occupation Classification (NOC)	Total number of volunteer hours in the past 12 months (A)	Wage Rate Assigned to This Job Type in the past 12 months (B)	Hours × NOC Average Hourly Wage Rate (C)	Fringe Benefit 12% (D)	Total Value (C+D)
Fundraising (walks, fundraising campaigns, working to secure foundation grants, etc)	2.6 total # of vol hrs for Fundraising	Professional occupation in public relations and communications 1123	14,178	$27.47	$389,469.66	$46,736.36	$436,206.00
Special events (public speaking, special events like pride day, mall displays, etc)	2.6 total # of vol hrs for Special Events	Conference and event planners 1226	10,712	$22.53	$241,341.36	$28,960.96	$270,302.00
Human resources	2.6 total # of vol hrs for Policies and Procedures	Human resources professional 1121	1,639	$35.38	$57,987.82	$6,958.54	$64,946.00
IT Support	2.6 total # of vol hrs for IT support	Web designers and developers 2175	573	$28.57	$16,370.61	$1,964.47	$18,335.00
Other	2.6 total # of vol hrs for Other	Minimum wage	24,280	$14.00	$339,920.00	$40,790.40	$380,710.00
Total			**203,570**		**$4,308,679.48**		**$4,825,719.00**

Appendix C: Support service definitions

Case management

Case management is a time-limited process that involves understanding the client's complex needs, helping to coordinate services to meet those needs, referring clients to other appropriate services and advocating on behalf of clients for the services they need. The process begins with an assessment that aims to identify the client's health goals, works with the client to develop a plan to achieve those goals and then follows the case management cycle.

Community and social services

Community and social services include activities where a client receives specific services directly from a support worker that may be a certified professional, non-professional, volunteer, or peer.

- **Bereavement services:** Services are provided on a wide range of grief and loss issues.
- **Clinical counselling:** A one-on-one session with a client to talk about specific issues or concerns for which the individual is seeking assistance. A trained and certified professional delivers these sessions using a structured form of therapy.
- **Employment services:** Includes general support sessions focused on employment services and ODSP employment services.
- **Financial counselling services:** Includes general support sessions focused on financial counselling.
- **General support:** A general support session provides practical, short-term counselling that does not involve treatment for a mental health issue, such as financial counselling, disclosure, emotional wellbeing, relationship counselling, or risk reduction. General support also includes wellness checks, quick over-the-phone or in-person check-ins to reduce isolation and identify if further scheduled support sessions are needed.
- **HIV pre/post-test counselling:** Counselling that is provided to individuals/couples who are considering HIV testing or have taken the test.
- **Managing HIV:** Services focused on teaching clients strategies to increase their level of medication adherence or to discuss treatment options, including general support sessions focused on HIV symptoms management.
- **Settlement services:** Services targeted towards new immigrants and provided in the areas of health, mental health, housing, legal, employment, childcare, interpretation/translation, or assistance with the immigration system.
- **Support groups:** These can be either closed/formal group activities with pre-registration and regular attendance or open/informal group activities that are drop-in style programs.

Intake

Intake is the process of reaching out and accepting new clients coming to the agency for support. The purpose of intake is to build relationships with new service users, gather information (demographic, medical, social, other) about the client to determine their eligibility for services and identify their need for additional referrals (internal and external).

Practical assistance

- **Complementary therapy:** Includes treatments which may reduce stress, boost the immune system, or have other beneficial effects, such as acupuncture, chiropractic, naturopathy, massage, nutritional counselling, meditation/yoga, art and dance.
- **Food programs:** Includes food banks, vouchers/gift cards for food, holiday hampers, meal programs, cooking classes, supplements, groceries, and infant formula.
- **Practical assistance:** Includes financial assistance (e.g. child care subsidy or Trillium premiums), transportation including rides or taxi/public transit fares, and other items such as clothing, household items, gift cards, or free services.

Support within housing

Support services within housing are provided by organizations that provide supportive housing to their clients and includes services such as medication reminders, housekeeping, cooking, or other personal care.

Traditional services

Indigenous-focused agencies provide these culturally-specific support services to Indigenous communities. Services include personal ceremonies such as crafts, medicines, smudging ceremonies, talking circles, and teachings as well as community ceremonies such as drum circles or sweat lodges.

Appendix D. Capacity-building definitions

Education activities tracked by the 11 organizations within HIV Resources Ontario include:

- **Presentations:** presenting or providing information to an audience, including conference presentations.
- **Trainings:** teaching individuals how to do something (e.g. how to conduct a quantitative interview or how to write a proposal).
- **Consultations:** meeting with individual(s) to help them change practices, policies or approaches, including evaluation, program science work, and research consultations.

PRIMARY FOCUS DEFINITIONS

- **GIPA/MIPA:** activities related specifically to the Greater Involvement of People with HIV, and the Meaningful Involvement of People with HIV.
- **HIV syndemics:** activities that address the multiple factors that increase vulnerability to HIV (e.g., poverty, lack of social supports, experiences of abuse, violence, trauma, racism, homophobia, etc.).
- **Issues affected by HIV:** social issues that are caused or exacerbated by the presence of HIV (e.g., immigration, employment, housing, criminalization of non-disclosure, etc.).
- **Organizational development:** activities related to governance and internal policy, including the work of the board of directors.
- **Skills development:** activities that improve the ability of workers across the sector to effectively.