# *From Sprint to Marathon: A Strategic Plan for Getting in Shape for a New Era of HIV/AIDS in Ottawa*

submitted to:

Ottawa-Carleton Council on AIDS

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## About the Project Team

This plan has been developed by a project team with Anne Wright and Associates Inc. for the Ottawa Carleton Council on AIDS (OCCA). The project team consisted of:

- Anne Wright (project director)
- Andrea Perrier (project co-ordination and research)
- Ross Hammond (facilitator and HIV/AIDS advisor)
- Lisa Sullivan (consultant)

This plan is tabled with OCCA as a set of recommendations based on an extensive process of data gathering and consultation. The consultants are not experts in HIV/AIDS work. Anne Wright and Associates specializes in community-based program development and planning in the health and human services sectors. As such, the consultants relied on members of OCCA to provide resources, information and guidance to the planning.

## About the Project Steering Committee

OCCA struck a strategic planning committee to advise the work. The strategic planning steering committee members were:

- Ron Chaplin, Chairperson of Ottawa Carleton Council on AIDS
- Orhan Hassan, Program Manager, Sexual Health, Public Health and Long Term Care, People's Services, City of Ottawa (Joined in September)
- Paul Lavigne, Harm Reduction Project Officer, with the Healthy Sexuality and Risk Reduction Outreach Team, Public Health and Long Term Care, City of Ottawa; formerly HIV/AIDS educator with Centre for Addiction and Mental Health
- Kevin Muise, Acting Co-Director, Oasis
- Brent Oliver, Executive Director of AIDS Committee of Ottawa
- Rita Pettes, PHN, Healthy Sexuality and Risk Reduction Outreach Team, City of Ottawa Public Health and Long-term Care Branch of People's Services.

Their commitment of time, energy, and resources to the process of developing this strategic plan was crucial.

# Acknowledgements

The project team would like to acknowledge the participation and contributions of the following individuals:

- ***David Hoe:*** who played the role of steward in the strategy development meetings at the end of September and beginning of October, bringing his many years of experience in the AIDS movement here in Ottawa as well as nationally and internationally, and his encouragement and challenge to see the possible gains that could be made against HIV/AIDS in Ottawa over the next five years.
- ***OCCA members*** who participated with enthusiasm and wisdom at the strategic planning sessions, provided contacts, references and patiently led us through the many complex issues being faced related to the fight against HIV/AIDS, and helped to organize consultations with community members.
- ***Lynne Leonard and Christine Navarro*** who have provided invaluable support and advice along the way.
- ***Dr. Robert Remis*** who has been available and forthcoming with making his latest research available at each stage.
- All those ***key informants*** (see Technical Report for details) who participated in interviews, key informant discussion groups, focus groups, and the September 30th strategic planning session.

A special thank you to the ***Sexual Health Outreach Team at the City of Ottawa Public Health and Long-Term*** for their planning process, which was completed in parallel to OCCA's process, and informed much of the thinking about prevention strategies recommended here.

# Executive Summary

*This plan is tabled with the Ottawa Carleton Council on AIDS (OCCA) by Anne Wright and Associates for its consideration. It contains recommendations for action on HIV/AIDS in Ottawa between 2003 and 2008. The plan is based on a summary of relevant literature, research, and extensive consultation and information gathering with people and organizations working on HIV/AIDS both locally and nationally. The project team hopes that this plan will provide support to OCCA in its ongoing efforts to reduce the impact of HIV in Ottawa.*

## Introduction

HIV/AIDS has not gone away, despite the growing myth that it is no longer a major health issue. What is true is that HIV infection is no longer the almost-certain death sentence that it was 20 years ago. It is, however, an infection that has a severe and often debilitating effect on the life of each person who contracts it, and those around them. It is still sometimes fatal. HIV/AIDS' toll is well-beyond the estimated $9000 per year in treatment costs per person. An individual faces significant lifestyle changes, now over many years, in many parts of life – body, relationships, finances, cost of self-care, income-generating capacity, sense of choice about the present and future. Their loved ones and family members are impacted by their condition. The infection is most prevalent among young adults, so society loses through the loss of human potential and productivity, as well as through public health care costs.

In Ottawa, there are an estimated 2670[1] people who are living with HIV. Every year, over 90[2] Ottawa residents find out they are infected with the HIV virus. An additional 28 people[3] are infected, but their infection stays unreported, and undetected. Over the last five years, the number of new infections reported in Ottawa has declined slightly.

As Ontario's second largest city, and as a city that fosters diversity, Ottawa is a magnet community for people at risk of HIV, and for people who've contracted an infection. It is no co-incidence then, that Ottawa as a community has many strengths to build on in the ongoing fight against HIV/AIDS. For those who are closely affected by HIV/AIDS are the backbone of the effort to conquer HIV. Ottawa houses a medical school that attracts medical and health specialists, practitioners and researchers who are leaders in the treatment and research of HIV/AIDS. PHAs in Ottawa have access to excellent treatment services. Those volunteers, professionals and community groups involved in preventing HIV and supporting those who have HIV are among some of the most committed and dedicated individuals in Ottawa's network of support. From this base of talent and commitment innovative and excellent service models have been developed.

The Ottawa Carleton Council on AIDS has grown from this environment of commitment and good will. It is the only community-wide partnership in Canada dedicated to the full spectrum of

[4] Health Canada, April 2002, HIV/AIDS EPI Updates

HIV/AIDS at the local level in Canada. It is a model which provides a solid foundation for supporting the ongoing "marathon" in the fight against HIV/AIDS.

## Goals 2003-2008

***This plan sets out a three-pronged strategy to reduce the number of new infections in Ottawa by 50% over the next five years.*** Implementation of this strategy will require an investment from funders of between $1.2 and $2.3 million per year. Within five years, the cost savings realized by the Ontario Ministry of Health and Long-Term Care alone will be equivalent to the investment, not factoring in the personal and productivity costs associated with each HIV infection. Part of the strategy for reducing the incidence of HIV includes actively supporting the wellness of those who have HIV (PHAs). This, in turn, will enable PHAs to more consistently participate in reducing the spread of HIV to others and in maintaining optimal health while living with the infection.

The goals are as follows:

- ***Reduce # of new HIV infections in Ottawa by 50% by year 2008***
- ***Increase the percentage of those infected who begin being monitored for treatment within first six months of infection.***
- ***Increase % of PHAs who have supports in place for their wellness and are practicing self-care effectively.***

## Strategies

The key strategies recommended in this report are:

1. ***Increase initiatives around Prevention, Harm Reduction and Wellness.*** Specific strategies and related objectives are recommended for prevention among youth, with a special focus on gay youth and youth who are using substances. Gay men and injection drug users are recommended for focusing targeted and cultural-affinity appropriate prevention efforts. Specific suggestions for outreach, harm reduction, wellness support, and early detection for those at risk are outlined. Specifically, the plan includes the following recommendations to make progress on this strategy.

***Summary of Recommended Initiatives in Prevention, Harm Reduction and Wellness Support***

| *Cultural Affinity Group* | *Recommended Initiatives* | *Estimated Minimum Annual Resources Required* | *Estimated Maximum Annual Resources Required* |
|---|---|---|---|
| a) Youth | ▸ GBQ Youth: City-wide team (French, English): Community development, peer educators, leadership development<br>▸ Education/prevention messaging (annually) | 300,000 | 500,000 |
| b) Gay and | ▸ Wellness strategy | 300,000 | 500,000 |

| ***Summary of Recommended Initiatives in Prevention, Harm Reduction and Wellness Support*** | | | |
|---|---|---|---|
| *Cultural Affinity Group* | *Recommended Initiatives* | *Estimated Minimum Annual Resources Required* | *Estimated Maximum Annual Resources Required* |
| Bisexual Men | o Peer-based prevention (in addition to Man to Man)<br>o Social marketing<br>o Case management and PHA mutual support | | |
| c) Injection Drug Users | ▸ Public Education<br>▸ Needle Exchange Expansion<br>▸ Addictions Stabilization Expansion<br>▸ Policy Development | 200,000 | 400,000 |
| c) Immigrants and Refugees | ▸ Community Development<br>▸ HIV/AIDS support service integration (Coalition Co-ordinator with already-involved partnering organizations)<br>▸ Expanded Case Management | 200,000 | 400,000 |
| e) Families | ▸ Counselling and Case Management<br>▸ Policy Work | 50,000<br>In kind | 150,000<br>In kind |
| f) Women | ▸ Gender Appropriate Community Development<br>▸ Case Management and Mutual Support<br>▸ Monitor Trends<br>▸ Educational Campaign | 50,000 | 150,000 |

***2. Adapt Programs and Services to be "Cultural affinity-appropriate and Increase Capacity of Programs and Services:*** The report recommends some changes to the current configuration of programs and services that are working together to achieve HIV/AIDS goals. There are three critical issues that need addressing at this time:

- ***Extending the Reach:*** There is not enough capacity within the current service system to meet the needs of gay men and

immigrants and refugees particularly. The report contains recommendations for the recruitment of a wider spectrum of organizations to priorize HIV for program development. There is also a need to enroll organizations working with youth to become more active in prevention for all youth and to reach gay, bisexual and questioning youth.

- ***Building Capacity:*** Resources need to be added to maintain and provide needed support for the wellness of the growing population of PHAs. All PHAs need support at various times in the course of living with the infection. For many, support needs are periodic and relatively short-term. For some (often those with addictions and mental health issues), much more intensive and ongoing support is needed. The report includes recommendations that case management resources be added to work with PHAs in supporting their wellness. It also includes recommendations for growing resources in specific areas, particularly: prevention, housing, harm reduction, and wellness support for gay and bisexual men.

- ***Cultural Affinity:*** It's not optimal to mix very different cultural-affinity groups for programs and services that are oriented to prevention that is appropriate to values, beliefs and norms, community development, mutual support-development, and group counselling. Therefore, the report includes a recommendation that over the next five years organizations adapt their service delivery and program models to take account of the need for all aspects of delivery to be appropriate to cultural affinity. It is recommended that rather than trying to serve all cultural-affinity sub-groups affected by HIV/AIDS, that organizations focus their efforts and design programs and services so that they are not expecting different affinity groups to mix. It is estimated that between $50,000 and $100,000 per year will be needed to support co-ordination of training, exchange of best practices, and ongoing capacity development.

3. ***Form Ottawa Coalition on HIV/AIDS:*** The final strategy is that OCCA "remake" itself into the *Ottawa Coalition on HIV/AIDS.* OCCA needs to reshape the mechanisms for planning, influencing policy, and monitoring progress so that it can sustain timely and powerful action over the long run. It should build on its excellent foundation to refresh the support of key organizations in Ottawa and to enroll community leaders who can become champions in influencing policy and public opinion. The report contains substantial detail on the recommended governance structure for the *Coalition.* It is estimated that between $100,000 and $150,000 will be required to support the Coalition in its work. Some of these resources may be contributed by partner organizations with the capacity to do so as services in kind. A dedicated co-ordinator will be required.

As a council of partnering organizations, OCCA does not and the Coalition will not have the power to mandate its members to implement Strategies 1 and 2. The Coalition can encourage, enable, recommend and work with funders and local organizations to support their understanding of the need, the urgency, the feasibility and the benefits of implementation. But, it cannot require or mandate. The decisions about organizational priorities, resource allocation, and implementation of strategies 1 and 2 need to be made by the organizations responsible for various elements of programs and services. Many of the activities recommended in this plan are already being conceptualized among key players. They will need the support of policy-makers and funders to be implemented.

# *From Sprint to Marathon: Getting in Shape for a New Era of HIV/AIDS in Ottawa – 2003-2008*

February 2003

## *Part I. Introduction*

Ten years ago, the Ottawa-Carleton Council on AIDS (OCCA) developed a strategic plan that led to the establishment of a number of new initiatives, including the establishment of Oasis as one of the cornerstones to work more effectively with the growing number of injection drug users who were contracting HIV. Since that time, OCCA has been successful in growing its coalition to over 20 regularly participating organizations, agencies, and groups, and many individual members. This has enabled it to collaboratively address and resolve HIV/AIDS issues throughout Ottawa-Carleton using new and innovative approaches. OCCA has been able to influence the establishment of new initiatives and services, expand current services, and raise awareness.

Over the past 10 years, however, there have been many shifts in the experience of the HIV/AIDS epidemic in Canada. Numerous shifts in trends and changes to circumstances both within and outside the HIV/AIDS community will impact and have implications for shaping a strong future vision for OCCA within the new City of Ottawa.

Since the early 1990's the disease has moved from a sure death sentence to a more chronic, manageable disease that is now only sometimes fatal, because of the discovery of various 'drug cocktails'. In the last couple of years, however, these anti-retroviral combinations of drug treatment have begun to fail for some individuals and there are now new strains of the HIV virus that appear to be drug resistant.

The profile of the epidemic has also evolved. By the early 1990's there was already an awareness that HIV was not only a gay men's disease. Over the past decade, other populations have seen a rise in infections, notably injection drug users, immigrants and refugees from endemic regions of the world, aboriginal people and, more recently there's been a rise among heterosexual women. An initial drop in the rate of new infections among gay men in the mid 1990s has begun to increase again in more recent years. All population groups in which the rate of HIV/AIDS incidence remains high tend to be ones that are pushed to the margins of society. An HIV diagnosis often can push an individual even further into isolation. Policy makers are increasingly exploring ways to reduce marginalization and isolation as one of the ways to reduce the exponential rate of spread of the epidemic.

In dealing with these changes, health care providers, community activists and governments have increasingly become convinced that both the epidemic and the response to it require innovative approaches. Many current approaches incorporate the determinants of health as part of their analysis and in the development of prevention strategies and systems for providing care and treatment. In the Ottawa area one crucial component of that analysis includes street-involved people and the impact of inadequate levels of housing on already vulnerable populations. Co-

infections and multiple diagnoses for many people infected with the virus are another factor to consider. These examples suggest that more sectors are and need to be actively involved than 10 years ago, making planning more challenging but the outcomes more productive. It is this type of approach that is needed stay ahead of the epidemic.

In light of this planning challenge, OCCA decided to undertake a strategic plan to develop strategies for fighting HIV/AIDS in Ottawa over the next five years. Key questions posed were:

- ***Governance:*** How can OCCA organize to maximize the collaborative power to impact on HIV/AIDS in Ottawa?
- ***Prevention:*** What strategies need to be put in place to prevent new HIV infections in Ottawa over the next five years?
- ***Treatment and Support:*** What strategies need to be put in place to support the health and wellness of those who are living with HIV in Ottawa?

It contracted with Anne Wright and Associates in March 2002 to develop a recommended plan.

## 1. Overview of Report

This report contains the following sections:

Part One: Introduction

Part Two: Key Findings

Part Three: Recommended Strategies 2003 – 2008

Part Four: Implementation of the Plan.

The Appendices contain:

Appendix A: Summary of Information-Gathering for the OCCA Strategic Plan

Appendix B: Logic Model Overview of the Ottawa Coalition for HIV/AIDS Plan 2003-2008

Appendix C: A Summary of Harm Reduction Services to Reduce HIV/AIDS Transmission among Injection Drug Users in Ottawa, and Prepare PHAs who are Using Drugs for HIV Treatment

A companion technical report is available. It contains:

- A literature review
- An overview and summary notes/reports from the strategic planning exercise activities, including the key informant interviews, community consultations (focus groups, ethics review application process for one-on-one client interviews), and the two OCCA strategic planning sessions.

## 2. Methodology

Figure One shows the planning steps that led to the development of this plan.

***An Environmental Scan*** was completed in the spring 2002. It summarized data on local HIV/AIDS incidence and prevalence and some of the key issues being faced in the local epidemic (*See Technical Report.)* A day-long meeting with OCCA members in April reviewed and added to the environmental scan. That meeting also focused on:

**Figure 1: Overview of Planning Steps**


- Development of a vision for an Ottawa Strategy on HIV/AIDS
- Summarizing the services currently being offered to prevent, diagnose, treat and support people around HIV/AIDS and identifying perceived gaps in the system.
- Reviewing the proposed methodology for focus groups and data collection over the summer.

***Consultations*** were held between May and September. The consultations were with members of populations at risk, people who are HIV positive (PHAs), and with service providers who are working with populations at risk or with PHAs.

Focus groups were held with two groups of gay men: those who are HIV positive and recently diagnosed (diagnosed 1996 and after); and those who are HIV positive and who have lived with illness for over 5 years (diagnosed pre-1996). They were also held with youth and injection drug users. Focus group participants were generally asked about:

- Their main concerns and personal challenges with HIV/AIDS
- Local HIV/AIDS support services (those they perceive to work well, those that could use improvement and how, and those that are not currently offered in Ottawa but could help)
- What they perceive as happening in Ottawa with respect to the spread of HIV/AIDS
- Challenges of preventing HIV infection in younger gay men
- What helps prevent the spread of HIV now, or what might help to prevent the spread
- What prompts people to seek or not seek HIV testing

- What OCCA's goals and priorities should be

Four separate key informant discussion groups were held with service providers to discuss their perception of needs and recommended ways to reach the following groups:

- HIV positive women or women at risk of HIV
- Youth and youth at risk
- Immigrants and refugees from endemic regions of the world
- People living with HIV with complex needs (e.g. concurrent mental health disorders, substance use issues, etc.)

For a summary of results of the focus groups and key informant discussion groups, see *Technical Report of Information Gathered for OCCA Strategic Planning*.

***Individual Interviews with PHAs:*** As part of the data gathering process, the consultants had proposed to conduct individual interviews with HIV positive immigrants and refugees and parents with HIV positive children. However, the ethics review board of the Public Health and Long Term Care Branch of the City refused to grant ethics approval due to the vulnerability of the individuals to be invited to participate. The service provider key informant discussion groups and key informant interviews were used to provide information about the needs of these populations.

***Strategy Development:*** The consulting team summarized the findings from the data gathering process (see *Technical Report, September 30 Presentation and Summary of What We've Heard So Far)* and presented propositions for goals and objectives to OCCA members and stakeholders who had participated in key informant discussion groups (September 30). The following day, OCCA members worked with the proposals and developed them further. A follow up meeting with OCCA members on November 12 further fleshed out the strategy for governance.

# *Part II. Summary of Key Findings*

*This section contains the following sub-sections:*

1. *Conceptual Model of HIV Risk*
2. *Facts about HIV Patterns in Ottawa*
3. *Current Critical Issues in Ottawa*
4. *Strengths in Ottawa's Fight against HIV/AIDS*

## 1. Conceptual Model of HIV Risk

During the April 30th meeting with members of OCCA, the following conceptual model contained in Figure Two was put forward by Barry Deeprose, a representative of Pink Triangle Services on OCCA, as a way of understanding potential levels of intervention into the development of an HIV infection and its consequences for an individual. This model has also been used by Health Canada and by the Ontario Advisory Committee on HIV/AIDS to the Ontario Minister of Health.

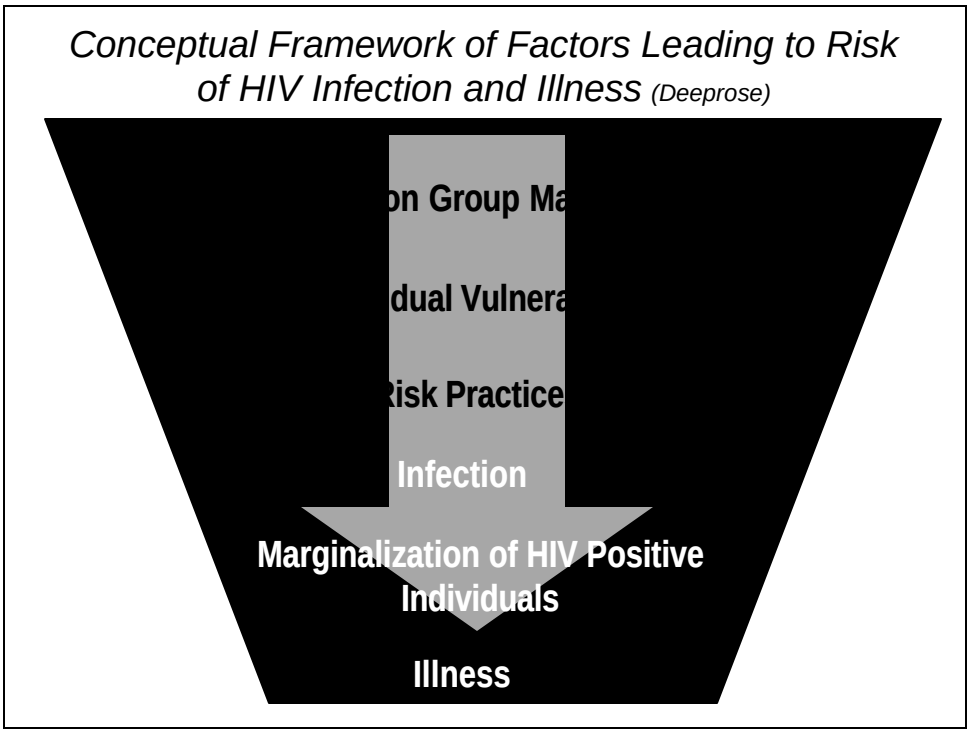


**Figure 2**

Figure shows that the marginalization of groups within society can contribute to their vulnerability to HIV. Vulnerability and relative power can affect how effectively risk practices can be implemented by individuals. This, in turn, affects probability of infection, and probability of an infection being diagnosed. Marginalization of PHAs through loss of income, job, housing, and sometimes friends within their sub-community, can further contribute to lack of self care and access to mutual support and reasons to protect self and others. This then can contribute to illness having a greater impact on health and risk of other infections.

Prevention measures have typically focused on educating individuals about risk practices and creating social norms within sub-groups that support risk reduction and protective practices. Intervention measures have mostly focused on access to testing and treatment for illness. In the past decade, more focus has been given to harm reduction, particularly among injection drug users. In Canada, little has been done to link interventions to early school leaving, homelessness, lack of educational opportunities and other factors that contribute to vulnerability to HIV/AIDS prevention. More could be done to work with PHAs to prevent further marginalization and therefore to help them maintain optimal health and work towards the health of members of their community.

This model informs the strategies that are recommended in this plan.

## 2. Facts about HIV Patterns in Ottawa

### *a) The Number of New Infections Each Year Remains High and May Rise Even Higher*

Since 1996, as Figure Three shows, the number of reported new infections of HIV in Ottawa has hovered between 90 and 100. Reported numbers of new infections among gay men and among injection drug users is slowly declining. Among women, the reported numbers of new infections has remained relatively steady over the past several years. Health Canada[4] and Remis et al.[5] estimate that approximately one third (or 30%) of actual new infections are unreported, so it can be assumed that there have actually been between 120 and 130 new cases of HIV in Ottawa every year since 1996. The City of Ottawa Medical Officer of Health reports that there has been an alarming increase in rates of sexually transmitted diseases in 2001 and 2002 including gonorrhoea and syphilis. This increase is particularly marked among gay men. This trend, along with anecdotal evidence from gay men, indicates that there is a down-turn in the use of safer sex practices among gay men in Ottawa.

### *b) Potential Cost Savings of Prevention*

HIV is mostly preventable. But over the past ten years, prevention efforts have dropped off across Canada, Ottawa included. Albert and Williams (1997) estimate that each new HIV case costs $9,000 per year in treatment costs alone (not counting costs of sick days, potential years of life lost, etc.), for a lifetime cost for treatment (assuming an average of 17 years of life after infection) of $153,000[6].

[5] Remis RS, Major C, Wallace E, Schiedel L, Whittingham EP, December 2001, Report on HIV/AIDS in Ontario 2000. Ontario Ministry of Health and Long-Term Care.

[6] This includes direct drug and health care treatment costs using HAART. It does not include indirect costs such as productivity lost, cost of nutritional supplements, alternative care, or any uninsured care services.

**Figure 3**

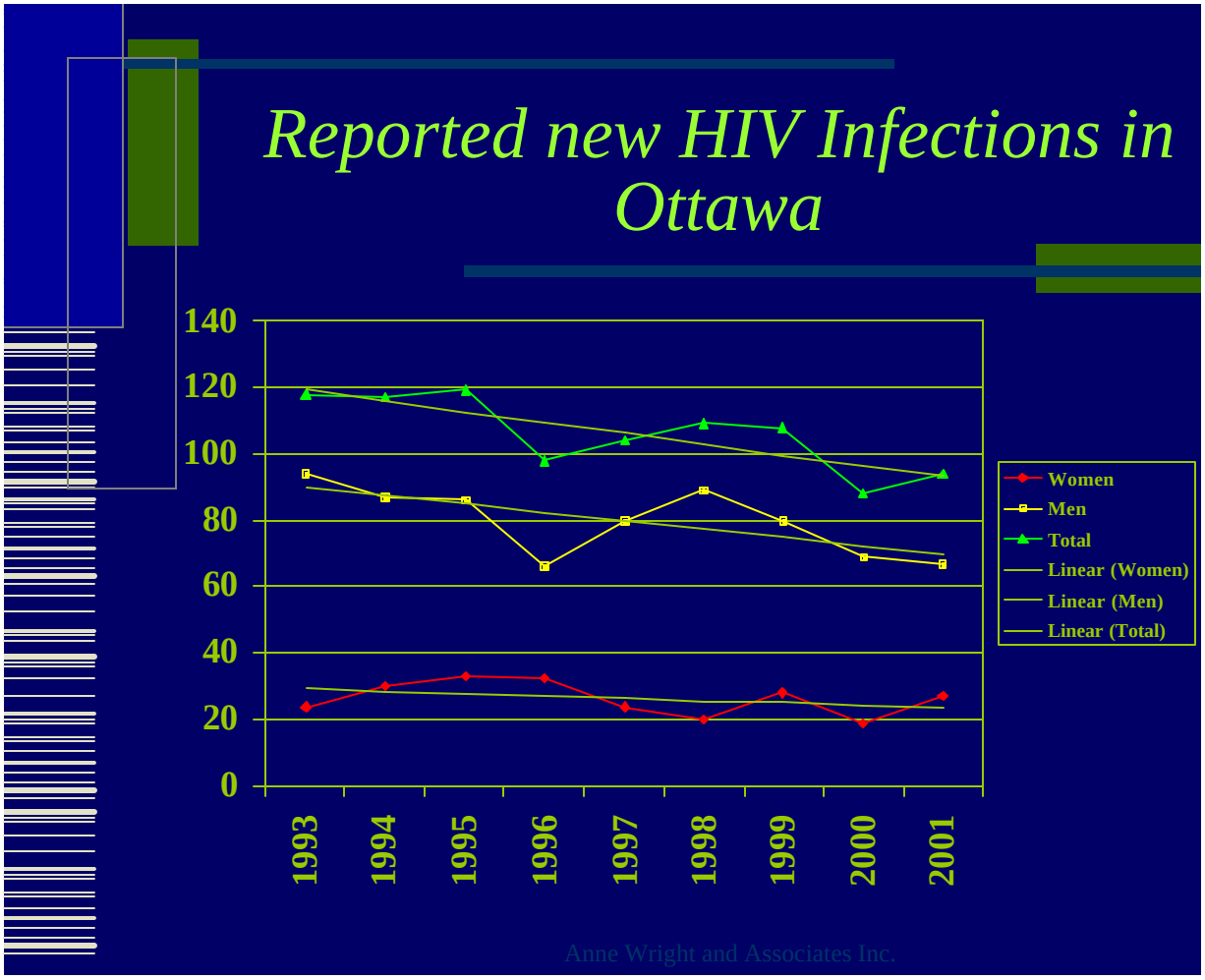


Table One and Figure Four show three projections of HIV incidence between 2003 and 2008 prepared by the authors of this report. Each projection uses actual reported HIV infections between 1996 and 2001as a baseline.

- ***The pessimistic projection*** assumes that the number of new HIV infections will grow moderately over the next five years, as may be indicated by the rising gonorrhoea rate. If this is the case, then 618 new cases will be diagnosed in Ottawa between 2003 and 2008.
- ***The optimistic projection without prevention*** assumes that if no further efforts to prevent HIV are made in Ottawa, numbers of reported new infections will continue to decline at the rate they've declined since 1996. Given rising STI rates, and the

prevalence of HIV within the injection drug using population, this is an optimistic assumption. Under this scenario, there will be 510 new cases reported in Ottawa between 2003 and 2008.

- ***The projection with prevention*** assumes that a concerted, multi-pronged prevention effort could, in five years, cut the number of new infections in Ottawa in half. This projection assumes that prevention efforts will actually have an impact on factors that affect HIV risk. Under this scenario, there will be 375 new cases reported in Ottawa between 2003 and 2008. These projections show that by actively undertaking prevention initiatives, between 135 and 243 people could be prevented from becoming infected with HIV over the next five years. This translates into potential cost savings in treatment costs alone of between $20 million and $37 million.

*The projections in Table One below show that by actively undertaking prevention initiatives, between 135 and 243 people could be prevented from becoming infected with HIV over the next five years. This translates into potential cost savings in treatment costs of between $20 million and $37 million. The human cost of suffering and potential and the economic costs to society of lost productivity and contribution are not included, nor are out-of-pocket self-care costs to the individual and family.*

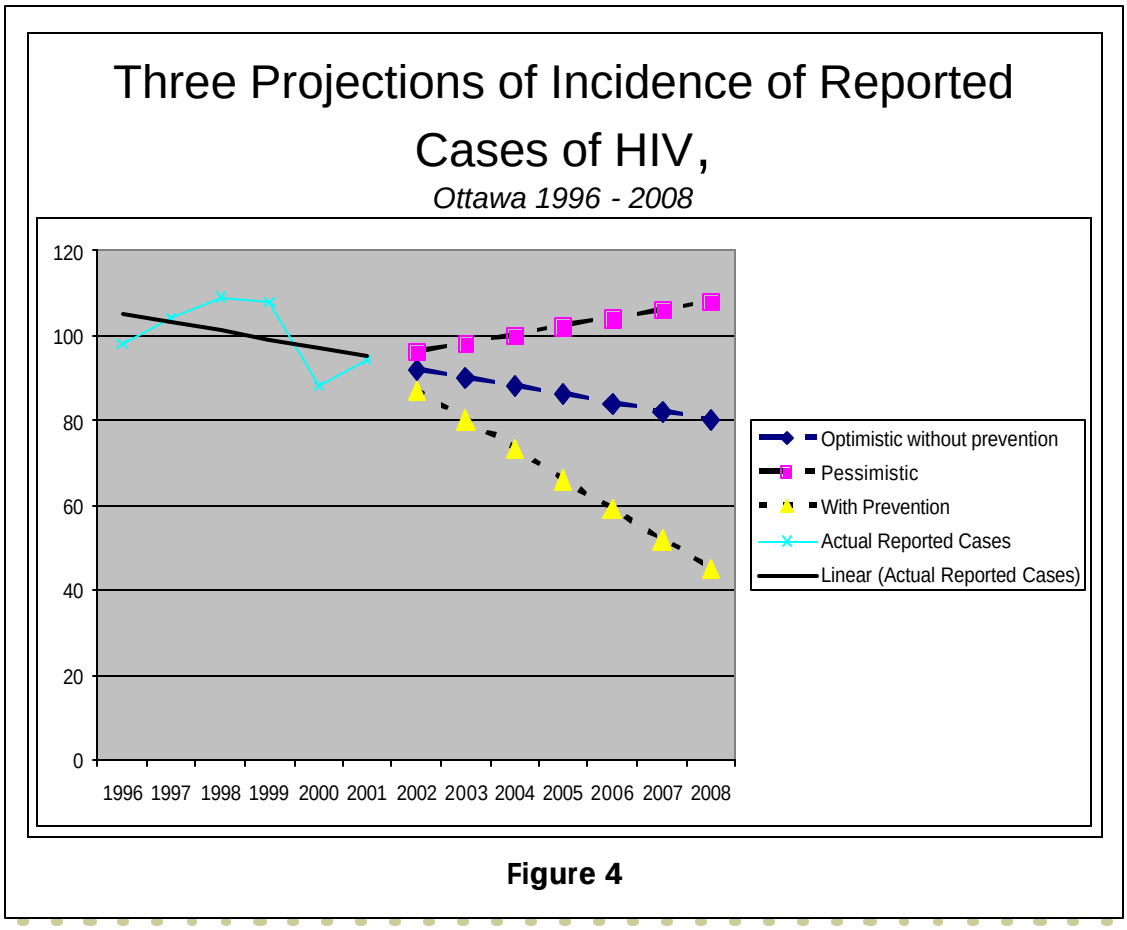


**Figure 4**

**Table 1: Actual, Projected and Targeted # New HIV Infections (diagnosed and estimated actual), Ottawa, 1996 - 2008**

| | *1996* | *1997* | *1998* | *1999* | *2000* | *2001* | *2002* | *2003* | *2004* | *2005* | *2006* | *2007* | *2008* | Total new cases 2003 - 2007 | Difference between # of people infected compared to scenario 1 with prevention | lifetime costs saved ((in millions) 2003 - 2008[7] | Total treatment costs[8] (in $million) saved 2003 - 2008 | Estimated Annual Treat-ment Cost Savings post 2008 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Actual Reported Cases[9]** | 98 | 104 | 109 | 108 | 88 | 94 | | | | | | | | | | | | |
| *Projections* | | | | | | | | | | | | | | | | | | |
| *Scenario 1* **With Prevention** | | | | | | | 87 | 80 | 73 | 66 | 59 | 52 | 45 | 375 | | | | |
| *Scenario 2* **Optimistic without prevention** | | | | | | | 92 | 90 | 88 | 86 | 84 | 82 | 80 | 510 | 135 | $20.7 | 3.78 | $1.2 |
| *Scenario 3:* **Pessimistic** | | | | | | | 96 | 98 | 100 | 102 | 104 | 106 | 108 | 618 | 243 | $37.2 | 6.80 | $2.2 |

[10] With the exception of the perinatal estimate which was provided by the CHEO HIV Team.

## *c) Patterns of Infection among Sub-Populations*

Who is affected by HIV in Ottawa, and how common is HIV among different populations at risk? By knowing the concentration of HIV infection in the sub-populations at risk, we can better target interventions. For example, research shows that intensive and targeted prevention is more cost-effective as the concentration of HIV in the population goes up. Incidence rates (the number of new infections per year divided by the number of people in the population at risk) and prevalence rates (the number of people living with infection divided by the number of people in the population at risk) are indicators of the concentration of HIV in a sub-population.

### Incidence Patterns

Figure Five shows actual reported new infections in Ottawa (as reported by the City of Ottawa Public Health and Long-term Care Department), and estimated actual numbers of new infections (which includes reported infections and estimated undiagnosed infections) as estimated by Dr. Robert Remis and his colleagues from the University of Toronto Department of Epidemiology[10]. Dr. Remis and colleagues have also estimated the size of some of the sub-populations at risk for HIV in Ottawa[11]. The MSM[12] (Men who have Sex with Men) group is primarily made up of men who identify as gay. The IDU population is those who use injection drugs. The population from Endemic Regions includes immigrants, refugees and new Canadians primarily from sub-Sahara Africa and the Caribbean.

The main features to note from Figure Five are:

- Gay men still represent the majority of new infections (both reported and estimated). Given the estimates of the population size, the estimated incidence rate (the number of infections divided by the estimated size of the population at risk) of HIV infections among gay men in Ottawa is 4.5 infections per 1000
- Immigrants and Refugees from endemic regions of the world are second largest # of reported and estimated new infections, with an estimated incidence: 1.1 per 1000
- Heterosexuals are third largest in actual number of reported infections with an estimated number of actual infections at the same number as immigrants and refugees (Incidence .03 per 1000)

[11] See the literature review section of the Technical Report for details on sub-population size estimates.

[12] In this report, the population that is usually referred to by HIV epidemiologists as "MSM" will be referred to as "gay men". By doing so, we acknowledge that the majority of men who are infected with HIV by having sex with men identify with being gay and that interventions to reach this population at risk are most effective when they acknowledge this fact. Gay men who provided input into this report indicate that, in their view, the HIV/AIDS movement has lost some of its relevance to gay men partially because it is giving too much attention to the small minority of men at risk who are men who have sex with men and who don't identify with being gay.

- The latest Canada-wide statistics show that women represent an increasing proportion of new HIV infections[13]
- Injection drug users have a lower actual number of reported and estimated infections, but because of a relatively small estimated population, their incidence rate is almost as high as the rate among gay men – 4 per 1000.

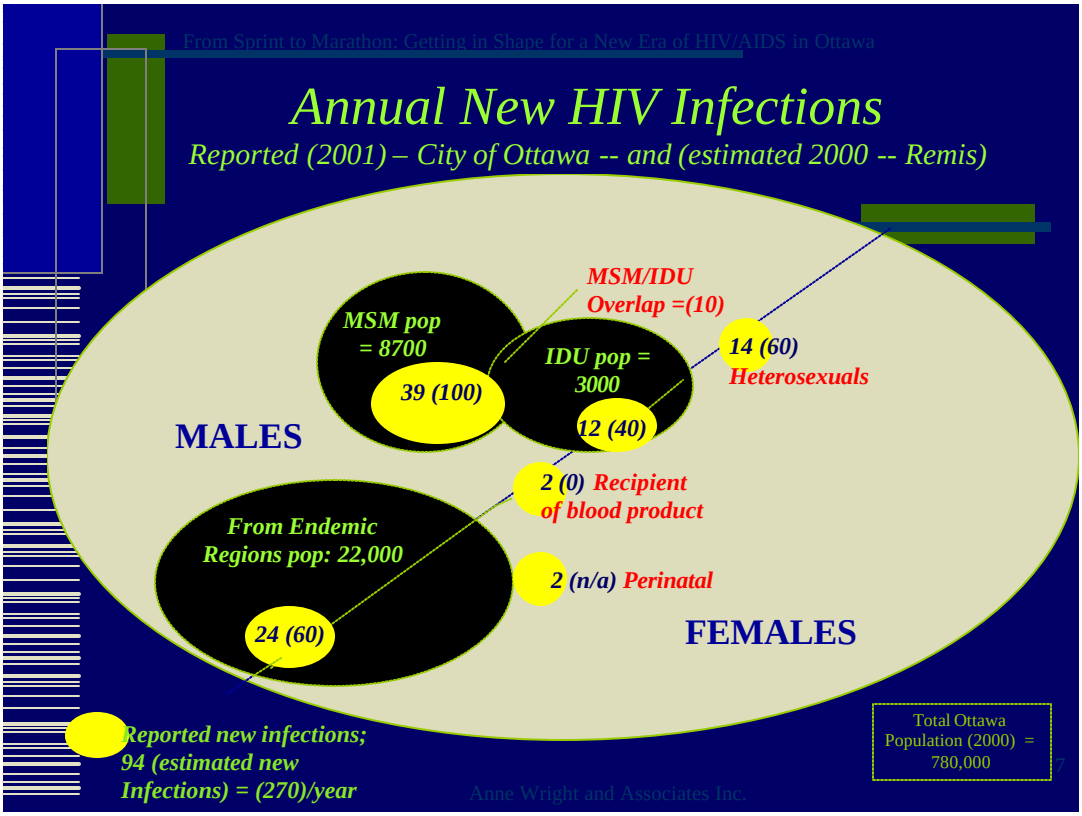


**Figure 5**

## Prevalence Patterns

Figure Six shows the prevalence rate of HIV infections in Ottawa using estimates by Dr. Robert Remis and colleagues[15]. The prevalence is the number of people who are living with infections.

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[13] Health Canada, April 2002, HIV/AIDS EPI Updates (available on-line at www.hc-sc.gc.ca/pphb-dgspsp/publicat/epiu-aepi/hiv-vih/pdf/epiact042002_e.pdf).

[15] Estimates of HIV-infected individuals are from Remis et al., December 2001, Table 4.3 with the exception of the estimate for Infants/Children which is based on the number of infants/children reported being followed by the CHEO HIV Team. See the literature review section of the Technical Report for details on sub-population size estimates. N.B. HIV/AIDS reports by Remis et al. are available on-line at www.phs.utoronto.ca/ohemu/tech%20reports.html.

The number of people that Remis estimates are infected are shown for each sub-population; the prevalence rate is in brackets, assuming the size of the population is as shown in the darker circles.

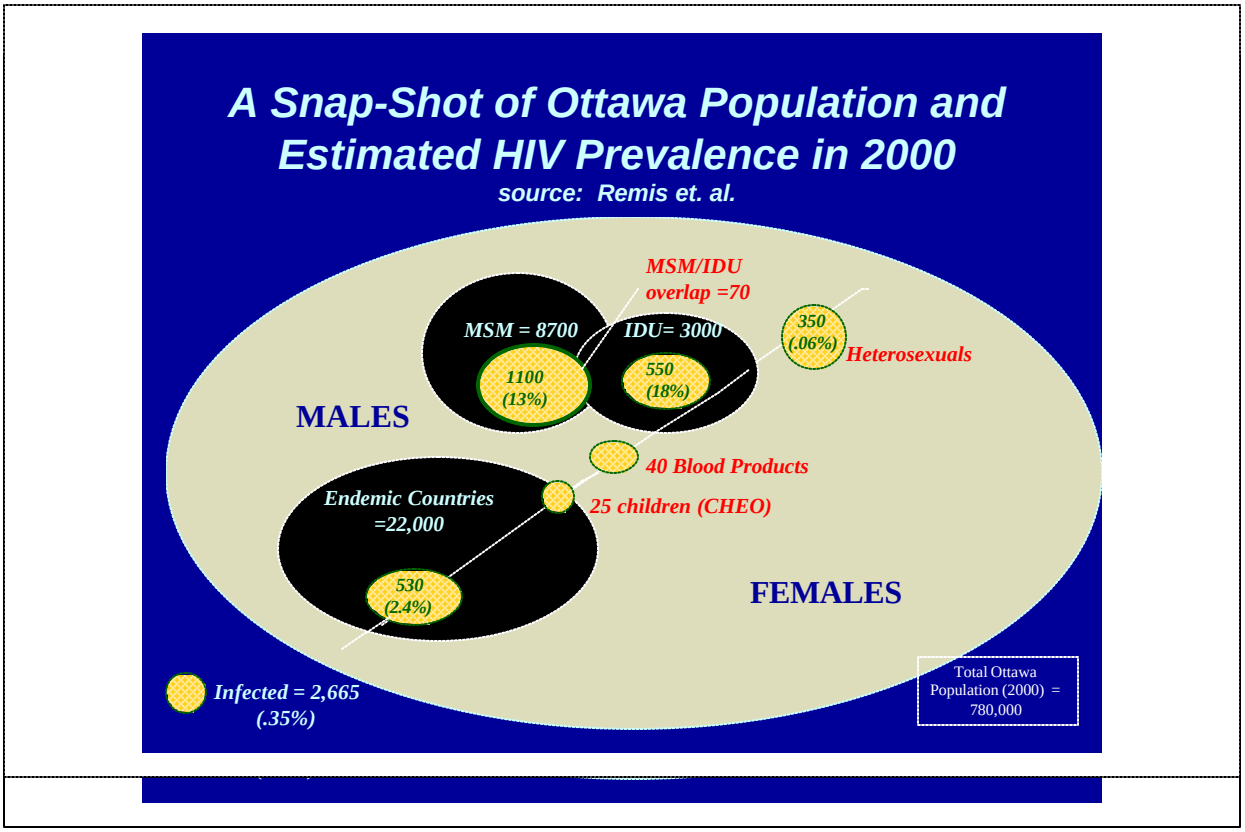



**Figure 6**

Key points to note from Figure Six include:

- Injection drug users have the highest prevalence rates, followed by gay men and then immigrants and refugees.
- While most people living with HIV are men, there is a growing number of women living with HIV, many of whom were infected through heterosexual transmission.

## Women and HIV in Ottawa

While the prevalence and incidence rates of HIV infection remain low among heterosexual women, the numbers of women infected with HIV through heterosexual transmission remain high. These numbers are growing quickly and should be carefully monitored in Ottawa over the next five years. Many IDUs and those from endemic regions who are at risk or infected are

women. Table Two breaks down the HIV incidence and prevalence by gender and sub-population group.

**Table 2: Gender-Specific Incidence and Prevalence in Ottawa for the Year 2000[16]**

| | Population Estimates | Estimated # of HIV-infected Males | Estimated # of HIV-infected Females | Total # of estimated HIV-infected | Overall Prevalence (males & females combined) | Estimated Overall Annual Incidence (# of new infections annually for males & females combined) | Estimated Overall Annual Incidence for Males | Estimated Overall Annual Incidence for Females |
|---|---|---|---|---|---|---|---|---|
| Gay Men | 8,700 | 1,100 | N/A | 1,100 | 12.6% | 100 | 100 | N/A |
| Gay-IDUs | 270 | 70 | N/A | 70 | 25.9% | 10 | 10 | N/A |
| IDUs | 3,000 | 400 | 150 | 550 | 18.3% | 40 | 30 | 10 |
| HIV-endemic Countries | 21,960 | 450 | 80 | 530 | 2.4% | 60 | 40 | 20 |
| Heterosexual | 571,940 | 150 | 200 | 350 | 0.1% | 60 | 20 | 40 |
| Total | | 2,170 | 430 | 2,600 | | 270 | 200 | 70 |

Key informant interviews and research[17] have shown that while the majority of those with HIV are men, there is a growing number of women in Ottawa who are being infected with HIV. Women are more frequently dependent on their partners, economically and often in other ways too, and their success at protecting themselves from HIV exposure often is undermined by this vulnerability. A common belief is that heterosexual sex within a long-term relationship is low risk. Women only have access to the information about their partners' risk that partners choose to share with them. Women who use injection drugs tend to have different patterns of use than men. Women from endemic regions of the world vary depending on age, culture, religion, education levels in what makes sense for them in terms of prevention and helping them cope with HIV infection in themselves or a family member. Some support is appropriately gender-based, and some is appropriately family-based. For these reasons, a gender-based approach to prevention education is needed for women in sub-groups, specifically:

- Women-oriented prevention and harm reduction for women who use injection drugs that is distinct from men-oriented interventions

[16] Developed from Tables One and Two of the Technical Report. Prevalence and incidence estimates from Tables 4.3 & 4.4 of Remis et al., December 2001, Report of HIV/AIDS in Ontario 2000.

[17] See Table Two and Figure Three of the Technical Report.

- Women-oriented prevention for women of similar cultures and religions from endemic regions of the world; complemented by family-oriented and community-oriented interventions that would enable both prevention and the development of community supports for people affected by HIV.
- Heterosexual women – prevention messages for young women and women of all ages that is relevant to them, and mutual support and counseling services for women who are affected by HIV to help them cope with the impact of the infection.

## Sub Populations Where Prevention is Most Likely to Be Effective

Front-end investment in prevention now will prevent expenditures of between $20 million and $37 million in treatment costs alone over the next two decades. Research on prevention of HIV shows that to be cost-effective, more intensive programs should be targeted to populations with high HIV prevalence. The Centre for AIDS Prevention Studies[18] notes that in populations where HIV prevalence is 10 – 15%, $1 million will prevent about 1000 infections. In populations where HIV prevalence is about 1%, $1 million will prevent about 15 infections. In the general population where prevalence is very low (0.1%), only about 2 infections would be prevented for that price.

In Ottawa at the current time, as Table Three shows, the two populations where HIV infection rates are highest are:

- Injection drug users
- Gay men

These two population groups should be targeted with a significant proportion of the prevention resources available for HIV prevention. In addition, resources should be targeted towards gay, bisexual and questioning youth. The remaining resources should be allocated to preventing new infections among immigrants and refugees from endemic regions of the world, and to promoting HIV awareness among the general population including women.

Table Three illustrates that the population group with the highest incidence of new HIV infections in Ottawa is injection drug users with an estimated annual incidence rate of 13.3 new infections per 1000 population. The population with the next highest rate is gay men at an estimated 11.5 new infections per 1000 population. Immigrants and refugees from endemic countries have the third highest estimated incidence rate (2.7 per thousand). While rates are rising among heterosexuals, they still remain relatively low as a percentage of population at risk. *The best investment of prevention efforts will be in preventing new infections among injection drug users and gay men over the next five years.*

[18] Center for AIDS Prevention Studies (1996) *Is AIDS Prevention a Good Investment?* San Francisco, CA, Centre for AIDS Prevention Studies, University of California at San Francisco as cited in McKay, Alexander Prevention of sexually Transmitted infections in different populations: review of behaviorally effective and cost-effective interventions *Canadian Journal of Human Sexuality*, v.9 (2) 2000 pg 95 - 120

**Table 3**: *Reported and Estimated Annual New HIV Infections in Ottawa, 2000, 2001*

| | | Incidence | | Prevalence |
|---|---|---|---|---|
| *Sub Population* | *Estimated Size of Population in Ottawa[19] (2000)* | *Reported New Infections (rate per 1000), 2001 (City of Ottawa)* | *Estimated Actual New Infections (rate per 1000), 2000[20] (Remis et al.)* | *Estimated Actual Number of People Infected (rate per 1000)[21]* |
| Men who have Sex with Men (MSM) | 8700 | 39 (4.5) | 100 (11.5 ) | 1100 (12.6%) |
| Gay IDUs | 270 | | | 70 (25.9%) |
| Injection Drug Users | 3000 | 12 (4) | 40 (13.3 ) | 550 (18.3%)[22] |
| Immigrants and Refugees from Endemic Regions | 22,000 | 24 (1.1) | 60 (2.7 ) | 530 (2.4%) |
| Heterosexual | 572,000 | 14 (.03) | 60 (.1) | 350 (.1%) |
| Infants/Children | 183,360 | 2 (.01) | | 33 (.02) |
| Blood Products | Not estimated | 2 (n/a) | | 40 (n/a) |

[19] See Literature Review in Technical Report for how sub-population size estimates were developed.

[20] Remis, Robert S.; Major, Carol; Wallace, Evelyn; Schiedel, Lorraine; & Whittingham, Elaine P.; December 2001; Report of HIV/AIDS in Ontario 2000; Table 4.4.

[21] All figures are from Remis, Robert S.; Major, Carol; Wallace, Evelyn; Schiedel, Lorraine; & Whittingham, Elaine P.; December 2001; Report of HIV/AIDS in Ontario 2000; Table 4.3; with the exception of the figure Infants/Children which was estimated from the reported 25 HIV infected infants/children being followed by the CHEO HIV Team and adding an additional one-third to account for undiagnosed infants/children.

[22] Dr. Lynn Leonard, Epidemiologist, University of Ottawa, reports that the prevalence rate among injection drug users in Ottawa is rising rapidly (based on the SurvIDU, a prevalence survey of injection drug users), and as of 2002 was up to 21%.

# 3. Current Issues in HIV/AIDS in Ottawa

## *a) Strain on Services that Support People with HIV as Number of People with HIV (PHAs) Climbs*

As the case fatality rate of HIV has declined thanks to anti-retroviral treatments introduced in the mid-1990's, the number of people living with HIV has risen (see Figure Seven below). Currently, there are estimated to be over 2600 people living in Ottawa with HIV. If the incidence of new cases of HIV remains at current levels, it is projected that the number of people living with HIV in Ottawa will climb to over 3300 people by the year 2007. These projections do not take into account potential in-migration of those who become infected and move to Ottawa for access to services.

People with HIV now face different kinds of challenges than they did in the earlier days of the epidemic, prior to anti-retroviral treatment. Sustaining themselves over the long-term, often with shrinking circles of friends and dwindling finances, can lead to isolation and depression. There is less demand for palliative care, but growing numbers of people who are HIV positive facing periodic episodes of crisis and instability as many become increasingly vulnerable over time. Energy levels may dwindle, and the ability to generate an income for those without access to disability pensions can decline. Access to support to pay for expensive drugs, and food supplements through Trillium or Ontario Disability Support Program remains bureaucratic and complex and adds stress.

The shortage of affordable housing in Ottawa is particularly critical for those who are HIV positive and need to comply with complex drug schedules. Lack of housing can mean the difference between maintaining successful treatment or not for someone who is HIV positive.

There is particular strain being felt in organizations that have not been able to grow capacity to accommodate the increasing demand for services, particularly help in negotiating the system and accessing support, for people with HIV.

- Those who are working with people who are HIV positive and are injection drug users or who are

Those services that offer treatment and support to people with HIV include:

***Treatment:***

- University of Ottawa Primary Care Clinic
- Immunodeficiency Clinic at the Ottawa Hospital
- Oasis
- St. Anne's Medical Centre
- Inner City CHCs and Wabano Centre
- Inner City Health Project
- CHEO immunodeficiency Clinic

***Support Services:***

- Bruce House
- Oasis
- AIDS Committee of Ottawa
- Ottawa Interfaith Council on AIDS
- Family Service Centre of Ottawa
- Voices of Positive Women
- Aboriginal Women's Support Centre
- Wabano Centre
- Worldwide AIDS Foundation
- The Source
- Children's Aid Society

***Housing***

- Bruce House (Apartment Program and Group Residence)
- Youth Services Bureau
- Pinganodin Lodge
- Minwashin Lodge
- Oshkigizi for women

***Legal Services***

- U of O Community Legal Clinic
- HIV and AIDS Legal Clinic (Ontario)
- Ontario Legal Aid

***Financial Support***

- Trillium Drug Program
- Ontario Disability Support Program
- CPP Disability Program

***Employment Services***

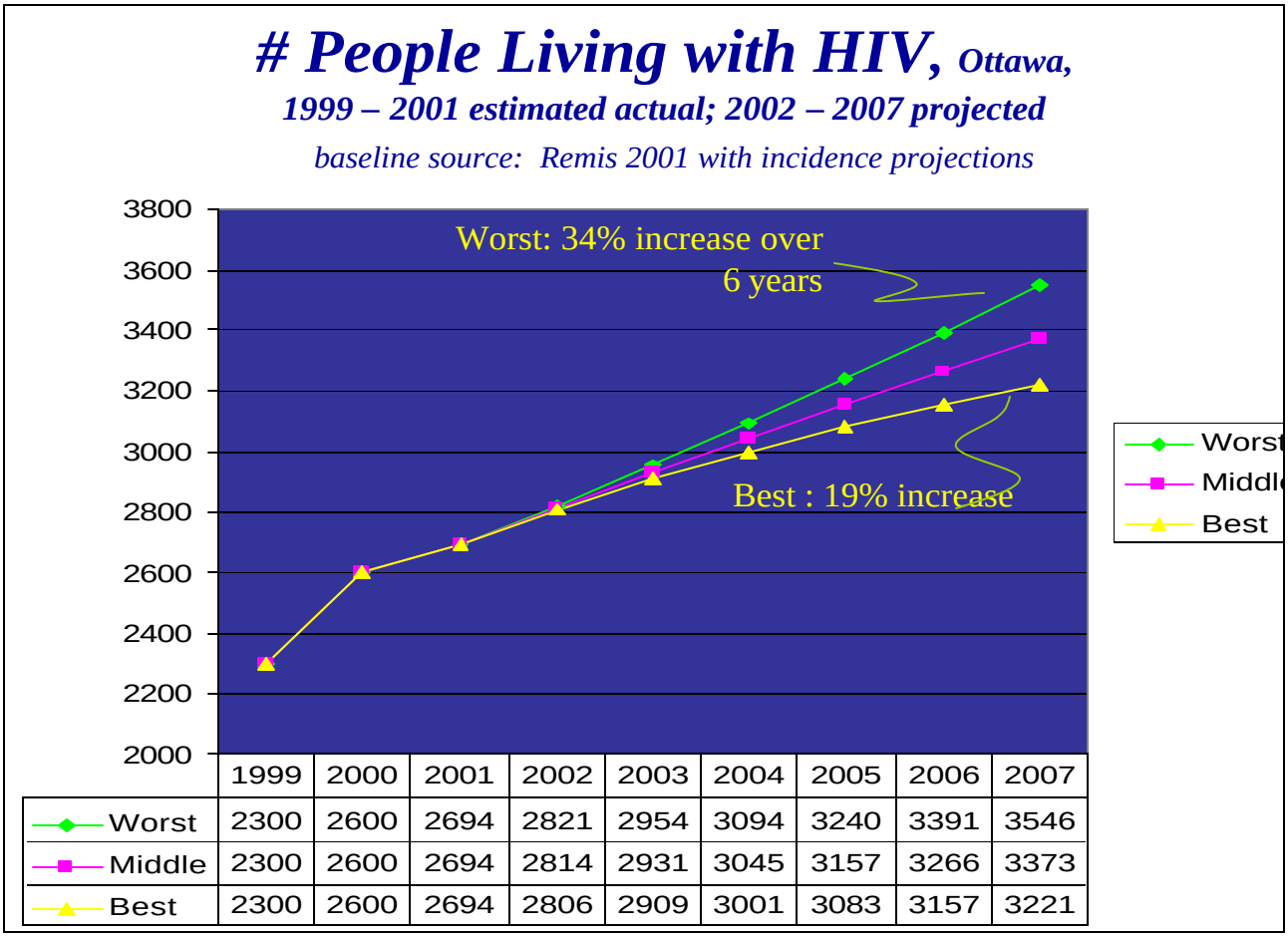
- Ontario March of Dimes
- ABC Positive Resource Centre
- Employment Action

***Palliative Care***

- Bruce House
- Hospice at Maycourt
- Inner City Health Project – Mission Palliative Care Unit
- CHEO
- Wabano

dually diagnosed (with addiction and mental illness as well as HIV and often Hep C) have reported lack of case management resources: University of Ottawa Primary Care Service, Bruce House, Oasis, Community Health Centres in the inner city.

- Those who are working with families have reported a lack of flexibility of options for families with children in the housing, respite and supportive care areas, as well as a lack of resources for counselling for those affected by HIV and case management for arranging support for the various needs of families affected by HIV.
- Those who are aware of the needs of gay men have reported a lack of case management services and availability for counselling and mutual support that is appropriate to this community.




| | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|---|---|
| Worst | 2300 | 2600 | 2694 | 2821 | 2954 | 3094 | 3240 | 3391 | 3546 |
| Middle | 2300 | 2600 | 2694 | 2814 | 2931 | 3045 | 3157 | 3266 | 3373 |
| Best | 2300 | 2600 | 2694 | 2806 | 2909 | 3001 | 3083 | 3157 | 3221 |

**Figure 7**

Several initiatives are recommended as part of Strategy # 1 below to increase the capacity of local services to support the wellness of people with HIV.

### *b) HIV/AIDS has Less Prominence on Public Policy Agenda*

HIV/AIDS has "dropped off the radar screen" of the public policy agenda in Canada the last decade. The City of Ottawa sexual health staff have been key players in enabling OCCA, but the engagement from more senior levels within the City has dropped off in the past decade. There has been little renewal of HIV/AIDS prevention strategies in school health programs over the past decade. Little investment has been made in HIV/AIDS prevention education for many years by the City of Ottawa.

Currently, at the Provincial and Federal levels, the development of new HIV/AIDS policy is underway[23]. There is a need to reinvest in prevention and to take action on factors that lead to the marginalization of people at risk of HIV as well as those with HIV. The Province has done little to examine how HIV/AIDS diagnosis and treatment fits with primary care reform given the need for additional case management services with this vulnerable population living with HIV/AIDS. One of the key activities recommended below as part of Strategy # 1 is to increase investment in prevention that complements hoped-for national and provincial public education strategies, and is specifically targeted to populations at risk.

### *c) Low Rates of Diagnosis*

Remis et al. (December 2001) estimate that 37% of people with HIV infection in Ontario don't know they are infected and aren't receiving treatment[24]. Of these:

- Gay men represent largest group of undiagnosed (57% of total undiagnosed): There are many factors at play affecting propensity not to seek diagnosis including: fear of loss of access to insurance benefits, fear of loss of sexual lifestyle and/or sexual partners, friends.
- Immigrants and refugees from endemic regions represent the next largest group of undiagnosed people (~21% of total undiagnosed). There is a very powerful taboo against HIV in many communities that feeds into fear of loss of community standing, support of family and friends. As well, those with vulnerable status in Canada fear the consequences of an HIV diagnosis on their eligibility to stay in the country.
- Heterosexual women largest group of undiagnosed women (57% of undiagnosed women). Many heterosexual women do not seek testing because they don't perceive themselves at risk.

The consequences of not seeking a diagnosis are potentially harmful for the individual, in that they are not accessing treatment at an early stage in the progression of the infection. The consequences of not being aware of being infected are that an individual is more likely to unwittingly pass the infection on through fetal transmission or through unsafe sexual activity. Although it will be difficult to measure, one of the recommended goals of the plan is to increase

[23] E-mail correspondence with David Hoe, January 28, 2003.

[24] Remis, Robert S.; Major, Carol; Wallace, Evelyn; Schiedel, Lorraine; & Whittingham, Elaine P.. Report of HIV/AIDS in Ontario 2000. Surveillance Report. December 2001, Table 4.2.

the rate of people with HIV infection who are diagnosed within the first six months of their infection.

### *d) Uneven Development of Culturally[25]-Appropriate Services*

The sub-populations that are most at risk for HIV/AIDS and that have the highest prevalence are very "culturally" distinct i.e. their attitudes, beliefs, social norms, values and lifestyles are very different. HIV/AIDS services were dominated by gay male culture in the late 1980's and early 1990's and early services in Ottawa-Carleton were developed by and appropriate for them. Over the 1990's as the injection drug using population began to develop HIV/AIDS, those services and organizations serving gay men also adapted services to be accessible to injection drug users. Gay men started to stay away from these services.

Immigrants and refugees from areas of the world where HIV was endemic require a highly confidential service offered by practitioners who are culturally sensitive and family-oriented. They are generally not comfortable with any services labeled for those with HIV, and they have little in common, except their infection, with most gay men and injection drug users.

It is particularly important that prevention initiatives be culturally appropriate. They are aimed at influencing community values, beliefs, attitudes, skills and behaviour and/or that use media, peer or group programming strategies. Experience has shown that mixing programs for youth, gay men, injection drug users, and immigrants and refugees doesn't work well. It's also important to offer programs specifically for women as well as some for mixed gender – given the particular vulnerabilities of women in negotiating sexual and economic relations with partners, and the particular interest of women who are mothers in safeguarding the health of their children. In Ottawa, it is suggested that the organizations that are working primarily in HIV/AIDS declare their population of focus and adapt their services accordingly (see Strategy 2). The Ottawa Coalition on HIV/AIDS will have a role in recruiting organizations to play a more active role for some populations.

The populations that indicated a need for more culturally appropriate services designed with their needs in mind are:

- Youth: There is uneven engagement of schools and youth-serving agencies in education of youth about HIV/AIDS. The Youth Services Bureau is involved and reaches street youth with an HIV/AIDS youth educator. Pink Triangle Services is involved in OCCA and it has a growing youth group. But, the main providers of sexuality education are not involved: Planned Parenthood Ottawa, Community Services within People's Services (formerly represented by Public Health, now moved to another part of the City's People's Services and no longer effectively engaged in HIV/AIDS planning), and the four area school boards.
- Gay men: a different kind of service cluster is needed for gay men than was needed in the early 1990s. Wellness-oriented services that are age-

[25] The words "cultural affinity-appropriate" and "culturally-distinct" in this report refer to the sub-population's attitudes, beliefs, social norms, values and lifestyles as well as ethno-cultural affiliation and language

appropriate, and that are offered for those who are HIV positive as well as those that are not HIV positive are needed.

- Immigrants and Refugees: Those immigrants and refugees from regions where HIV is endemic need culturally appropriate prevention messages as well as a range of support services and case management services that do not label them or breach confidentiality in their communities.
- Families: Those who are HIV positive and who have children at home have particular needs related to housing, child care, disclosure, and maintaining child custody when energy levels are low. For those with children who are infected, there are many issues including: developmental stages, disclosure to child and to others in child's life, developmental needs of other family members.

## 4. Strengths in Ottawa's Fight against HIV/AIDS

As the information-gathering showed, Ottawa has many strengths to build upon as it prepares for the next decade of HIV/AIDS work.

***HIV/AIDS Movement:*** People living with HIV/AIDS (PHAs) and those affected by HIV/AIDS have had and continue to have a strong impact on the way HIV/AIDS strategies are developed and the way services are delivered. The response to HIV/AIDS continues to be one that is closely monitored and guided by community members. In Ottawa, PHAs and those affected by HIV/AIDS have provided an engine for innovation, service improvement, and excellence. OCCA and the AIDS Committee of Ottawa have been places that have fostered and been fostered by these community members. This plan seeks to continue to stoke this source of vitality for HIV/AIDS services in Ottawa.

***Community Planning:*** Ottawa is the only city in Canada to have a community planning body – Ottawa Carleton Council on AIDS – that is bringing organizations, PHAs, and other interested individuals together to collaborate on HIV/AIDS planning and coordination. Other cities have HIV/AIDS community collaboration groups that are focused around one particular population, or community. The OCCA is founded on good will and strong individual and organizational commitment and perseverance to PHAs and to the prevention of HIV infections. Over the years, OCCA has fostered the development of a number of improvements to services and new initiatives. It has served as a forum for practitioners to stay up to date with new developments in the field and for organizations to identify gaps and develop solutions. It has remained informal and relatively minimally structured over the years, an aspect of the group that has been valued for its flexibility and lack of bureaucracy.

***Leading Edge Treatment Services:*** Ottawa is fortunate to house a medical school and teaching hospital system that enables residents access to leading edge treatment services for HIV/AIDS. The services offered by the Ottawa Hospital and by CHEO are seen as exemplary, and the staff of these services are leaders in their field. They are persevering in their dedication and search for solutions in the ongoing battle with the HIV virus.

***Supportive Funders:*** Policy makers have responded to the crisis and magnitude of the HIV/AIDS epidemic with innovative and stream-lined approaches to policy development and

funding. Consequently, a number of services dedicated to HIV/AIDS in Ottawa (Bruce House, AIDS Committee of Ottawa, and Oasis) as well as a number of special projects and research initiatives benefit from the support of the Ontario AIDS Bureau and the Canadian Strategy on HIV/AIDS. Both the provincial and federal governments are developing new strategies for HIV/AIDS at this time. Early indications are that the recommendations in this plan are likely to complement the strategies being developed at both provincial and federal levels.

***Innovation***: In Ottawa, there has been significant development over the past ten years related to intervention on HIV/AIDS, including:

- ***Reducing Risk among Injection Drug Users:***
  - ***Establishment of Oasis:*** Establishment of a program to provide health and ancillary services particularly appropriate for injection drug users and those who are street-oriented, sponsored by the Sandy Hill Community Health Centre
  - ***Harm Reduction Services:*** A number of harm reduction services have been established with a network of front-line service providers in Ottawa, including:
    - ***Needle Exchange Program:*** providing clean needles and collection of used needles at a number of sites across Ottawa
    - ***Establishment of the SITE Program:*** SITE Needle Exchange Program: Is a comprehensive program that offers health and social services to Injection Drug Users and their partners including HIV, hepatitis B and C testing, vaccinations for hepatitis B and influenza, risk reduction counselling, detox/treatment information, condom distribution and referral services to other community agencies. Services are provided both at fixed sites and through a mobile service.
  - ***Methadone Treatment:*** Provision of Methadone Maintenance Treatment through a number of independent practices including U. of Ottawa Clinic, and St. Anne's Clinic. There is currently a Methadone Working Group that is working to develop more treatment capacity within Ottawa linked with primary care and with addictions treatment providers.
- ***Inner City Health Program:*** Provision of palliative and long-term care services to chronically homeless individuals, many of whom are infected with HIV or dying of AIDS-related causes.
- ***Increasing Access to Testing:*** Introduction of anonymous HIV testing at a number of sites across Ottawa.

***Research***: Dr. Lynn Leonard at the University of Ottawa Faculty of Epidemiology has conducted a number of research studies on HIV and injection drug users in Ottawa, and these studies have been used by OCCA members to adapt services and develop proposals for improvement. Dr. Robert Remis and his colleagues from the University of Toronto have been active in estimating actual prevalence and incidence of HIV, taking into account under-diagnosis rates in various sub-populations. Dr. Ted Myers with the University of Toronto is conducting the Ontario Men's Survey, which is due to release results in June 2003. This survey will provide more information

about risk practices and self care among gay men and other men who have sex with men in the urban areas of the province.

# Part III. Recommended Strategies

The logic model overview of the Ottawa Coalition for HIV/AIDS Plan 2003-2008 shown in Appendix B outlines 3 clusters of strategies for the key population groups that are priority focus groups for HIV/AIDS intervention. They are:

*1. Increase initiatives around Prevention, Harm Reduction and Wellness.*
*2. Adapt Programs and Services to be "Cultural affinity-appropriate and Increase Capacity of Programs and Services*
*3. Increase Strategic Capacity for System Planning, Monitoring and Policy Work by Creating the Ottawa Coalition on HIV/AIDS*

Described within the logic model are key initiatives recommended to achieve population goals and objectives related to:
*a) Youth*
*b) Gay and Bisexual Men*
*c) Injection Drug Users*
*d) Immigrants and Refugees*
*e) Families*
*f) Women*
*g) General and Other*

*Key elements of each of these strategies are described below.*

## Goals

This plan is intended to achieve the following overall community goals:

- ***Reduce # of new HIV infections in Ottawa by 50% by year 2008:*** The priorities for achieving this goal should be targeted prevention that works using strategies that are specifically designed for sub-populations where incidence and prevalence rates are high:
  - Gay and bisexual men and gay, bisexual and questioning youth
  - Injection drug users

  General prevention social marketing aimed alternately at youth, men, and women should also be undertaken to raise awareness that HIV continues to be a serious condition that can be prevented.

- ***Increase the percentage of those infected who begin being monitored for treatment within first six months of infection:*** Early diagnosis is important for those who are infected, so they can begin being monitored for treatment and practicing self-care early. It is also important to lower risk for their partners and contacts. There are many barriers to people seeking diagnosis – some to do with fear of loss of insurance, residency status, job; others to do with fear of facing the consequences of knowing about infection – to lifestyle, to friendships. Knowledge about the benefits of early treatment is only one small factor. Action on this strategy includes public education for those who

may not know they're at risk (heterosexual women, immigrant and refugee women), and targeted outreach as part of prevention to IDUs and gay men.

- ***Increase % of PHAs who have supports in place for their wellness; and are practicing self-care effectively:*** The number of people living with HIV is increasing steadily, but services designed to support them are not growing at the same rate. Service providers are burning out. Some of those services that are in place for providing support to PHAs are trying to serve people from different sub-populations. Gay men, IDUs, immigrants and refugees and heterosexual women don't use the same services and they need different types of services and delivery mechanisms. Actions to reach this goal include:
    - ***Focusing on Culturally-Compatible Groups:*** that the organizations that are working primarily in HIV/AIDS stop trying to serve all PHAs, but rather declare their population of focus and adapt their services accordingly
        - That Oasis specialize in two distinct populations and adapt services to serve each of them independently: IDUs and women affected by HIV who identify with accessing women-oriented services
        - That ACO transfer its direct services to appropriate organizations and shift its role to training, system capacity development and supporting planning and policy work
        - There is a strong cluster of services focused on the needs of injection drug users. Similar clusters should be developed to focus on the needs of other populations, specifically: gay men, immigrants and refugees, women, and families.
    - ***Expanding the Network of Involved Organizations:*** that a wider range of organizations be recruited to be actively involved in HIV/AIDS services including:
        - One CHC to specialize in gay men's wellness
        - Network of CHCs working with immigrant and refugee communitees at risk
        - Schools and youth-serving organizations, City community services to work with youth
        - Engagement of CAS, family services, and housing services along with CHEO to support families affected by HIV.
    - ***Expanding Support Resources:*** Additional resources are recommended in key areas where there are gaps, including:
        - Increasing the availability of case management and mutual support for PHAs (specifically, IDUs, gay men, immigrants and refugees, women and families)
        - Expanding the harm reduction resources available to support the wellness of IDUs, including addictions treatment, housing

- Expanding affordable housing, case management and support resources for affected famlies

## Strategy #1: Improving Prevention, Harm Reduction and Wellness Promotion with PHAs

This strategy addresses the major changes that are foreseen as needed over the next five years to achieve significant progress on the goals. The implementation of this strategy is the responsibility of the many human service organizations in Ottawa that provide needed programs and services. The role of a collaborative planning a co-ordinating body like OCCA (as addressed in Strategy 3 will be to:

- Set objectives
- Make the case for the appropriate organizations to be involved in HIV/AIDS services and programs to both the funders and to organizations that are not traditionally involved in HIV/AIDS;
- Create mechanisms for organizations to plan with one another and in consultation with affected community members
- Monitor progress toward objectives and goals and help organizations make adaptations to programs to maximize results.

Strategy # 1 is divided into target groups as follows:

- youth
- gay men
- injection drug users
- immigrants and refugees
- women
- other.

### *a) Youth*

One of the cornerstones of an effective HIV/AIDS prevention strategy is effective sexual health education for all youth as part of their education from kindergarten through to secondary school. Consultations around teen pregnancy prevention have indicated that sexual health education in the schools in Ottawa does not make the grade[26]. It is inconsistently offered, it is not integrated into the curriculum early enough, and the readiness of teachers to deliver the curriculum is varied. Therefore, one of the target groups for a youth strategy is all youth in schools. Objectives for all youth are:

- All youth have knowledge and skills to practice safer sex

[26] Ottawa Teen Pregnancy Prevention Steering Committee, Summary of Key Points from Youth Speak! Let's Listen: Exploring the Issue of Pregnancy Prevention Forum, March 7, 2002.

- Increase popular acceptance of safer sex among youth who are sexually active, particularly gay, bisexual and questioning young men
- Increase in the umber of youth understanding the seriousness of HIV/AIDS.

Many gay men report that their earliest sexual encounters with other men or boys were in their early teens. Evidence shows that the majority of young adults in Canada have their first experience of sexual intercourse during teenage years[27]. Consistency of condom use among youth is sporadic and well below what would be needed for optimal prevention of STIs or HIV[28]. Gay, bisexual and questioning young men are not getting access to the information they need at an early enough age about specific ways to prevent HIV.

Ottawa has a number of strengths to build on in working with youth around HIV prevention, including the following.

- The developing Teen Pregnancy Prevention Coalition is committed to improving sexual health education in schools. The coalition is devoted to reducing the rate of teen pregnancies, but it shares the objective of improving the quality of sexual health education in schools with HIV/AIDS prevention and STI prevention. Involved in the coalition are the City Community Services that maintains a school health program and sexual health program in schools, Planned Parenthood Ottawa that has a very innovative French and English popular theatre program to break the ice on sensitive subjects and educate school communities about sexual health issues, the Young/Single Parent Support Network, and other partners.
- The sexual health component of school curricula offered within each board
- A number of schools that youth report have sensitive "out" staff who are prepared to help students find support
- The Youth Services Bureau's range of services, all of which are GLBTTQ-positive, and which include
    - ***Counselling:*** offer counselling to LGBTTQ youth and their families through individual, family and group models. *(ongoing)*
    - ***Peer Support:*** YSB developed a partnership with Pink Triangle Services to provide a counsellor for their Pink Triangle Youth Group on a weekly basis – partnership has maintained for at least the past 10 years. *(ongoing – attracting over 60 youth per week currently)*
    - ***Queer Youth Drop-In:*** Developed and offer regular weekly drop-in programs for queer youth, Rainbow Drop-In in Orleans and the Rainbow Drop-In in Bells Corners *(ongoing)*
    - ***Orientation Exploration Group:*** Facilitated a "coming out" group for young lesbian, gay and bisexual youth entitled the Orientation

[27] Maticka et. Al. (1997,2000), "Reducing the incidence of sexually transmitted disease through behavioural and social change" *The Canadian Journal of Human Sexuality*, 6, 89-104

[28] Fisher and Boroditsky, 2000

Exploration group. This group has been offered consistently for the past 12 years. *(ongoing)*

- ***Queer Youth Support Groups:*** Operated in partnership with the Ottawa District School Board queer youth support groups for LGBTTQ youth in several high schools *(ongoing, but inconsistently-offered)*

Pressures on school curriculum are enormous at this time, and it's very challenging to effect the kind of policy change that would enable effective sexual health education within the schools. Key informants have indicated that youth agencies are overwhelming schools with requests (e.g. teen pregnancy prevention, drunk driving prevention, tobacco, STI's, the link between behaviour and drugs. A co-ordinated approach to the schools around health issues for youth is encouraged.

Sex education is still controversial in some communities. Reaching and educating parents should be part of a co-ordinated effort to enable the health of youth through the schools, particularly those from ethno-cultural groups who often do not permit their children's involvement in sex education. There is no GLBTQ-relevant sex education in Ottawa schools currently. Even the sex education for heterosexual youth is inconsistently effective due to many factors:

- It doesn't start early enough
- It's focused on awareness, but doesn't include skill development around negotiating relationships, dealing with feelings, etc. that have been shown to be important in increasing use of safer sex measures
- It's delivered by teachers instead of trained outside sexual health educators
  - Some teachers are not comfortable delivering the material
  - Some youth are more comfortable talking openly with an "outsider" who is not part of their school community.

- The youth component should include a combination of school-based and community-based initiatives including the following:

***i) Increase gay-friendly cultures and supports in school***

- Anti-bullying strategies to reduce discrimination against gay and questioning youth, effeminate boys starting from kindergarten
- The establishment of supports in the intermediate and secondary schools (with priority to alternative schools) for gay and questioning youth including:
  - Support for gay and lesbian staff to be out in the school environment and for LGBTQ-positive staff to be easily identified by students
  - Encouragement and support for the establishment of peer support groups such as Gay –Straight Alliances in schools
  - Training for all teachers and guidance counsellors in appropriate outreach and responsibilities to students around issues related to sexual and gender identity

- Availability of supports for parents who are dealing with issues related to their student's sexual or gender identity.

***ii) Provide all youth with practical HIV prevention and safer sex information***

- A web-based educational strategy linked with sites frequented by youth including those exploring sexual and gender issues
- Sexual health education to all students that includes specific education around oral and anal sex and multiple partners. This sexual health education should be provided by trained sexual health educators.
- Education about safe body piercing and tattooing; information about the dangers of injection of steroids and other drugs.
- Availability and promotion of confidential sexual health services to all students. Consideration should be given to locating sexual health services within a multi-purpose youth-oriented centre, such as the model used by *the Door* in New York City. The Door offers many programs and services for youth, including leadership development, arts and cultural skills training and activities (theatre, dance, music), recreation, employment training and services for youth.

***iii) Provide gay and bisexual youth and those who are questioning sexual and gender identity with a range of supports for self-care, mutual support and mental health***

- Leadership development, peer mentoring, counselling, peer education and social activities alternative to the bars for youth who are gay, bisexual or questioning. Youth Services Bureau and Pink Triangle Services are currently collaborating on a proposal for GLBTQ youth that will include all of these components.

## *b) Gay and Bisexual Men*

The focus groups conducted in the course of the planning indicated "safe sex fatigue" among gay men, including those who are HIV positive. "Bare-backing", the practice of having anal sex without condoms, seems to be increasing according to anecdotal evidence. Soon, the Ontario Men's Survey will have more detailed evidence about self-care and safer sex practices among men in Ottawa. Knowledge of specific information about HIV risk is inaccurate for some, and there needs to be better, specific, and detailed information for men who are HIV positive and want to engage in sexual relations, and those who are knowingly being sexual with partners who are positive.

Negotiating sex, particularly with new or unknown partners, is a key skill that particularly young men and men working in the sex trade could use. Information about safer anal sex should be included in general sexual education for youth in schools and in groups for gay and questioning youth.

***What's Happening with Gay Men?***
***(some comments from focus groups)***

- "risk takers (among young gay men) were significantly more likely to have unstable housing, less education, problems with depression, use cocaine, alcohol and nitrate inhalants and smoke cigarettes than non-risk-takers" (Strathdee et. al, 1996)
- Not using a condom is a sign that I'm part of a couple - a sign of my innate trust…
- If his viral load is low, we don't worry because he's less infectious…
- If I test negative, I'm safe and I can have unprotected sex with someone else who's just tested negative
- Bare-backing is becoming more prevalent
- Safe sex fatigue – among people in their 40's
- It's not easy to talk about safe sex to a one-night stand…
- In schools, gay guys are more of a target than lesbians…

***It is recommended that:***

***i) HIV prevention, early detection and PHA support be part of an overall wellness promotion and early intervention program aimed at gay men***.

- ***Prevention and Early Detection***: Risk taking is highly correlated with substance use, loss of family and community support, depression and lack of opportunity29. The wellness strategy should include a strong HIV prevention component, but HIV prevention should not be the main or the only focus of the wellness initiative. Sexual health, mental health, substance use issues, fitness, and other wellness-related aspects of gay men's lives should be addressed through the wellness initiative. The HIV component should include:
    - Peer-based outreach and education, including "small media" – community newspapers, flyers, information pamphlets etc.
    - Web-based educational sites linked to sites frequented by gay men
    - Ensuring the availability of free condoms and lube in all gay-friendly social and gathering places
    - Confidential sexual health services and counselling.

[29] Strathdee et. Al (1996)

- ***Gay men who are HIV positive should be included as a key target population of the wellness strategy.*** The support of the wellness and self-care practices of HIV positive men is a key component in supporting their health and also supporting them in promoting the health of other gay men.

## *c) Injection Drug Users*

The prevention of HIV/AIDS within the injection drug using population in Ottawa has been a priority since the mid-1990's and it should continue to be a priority. The prevalence of HIV in this population is higher than any other, and without continued and intensified prevention and harm reduction, the rate could escalate exponentially.

In Ottawa, the services that are in place include those listed in Appendix C. Appendix C also contains gaps and suggestions for change. Essentially, key informants emphasized the need for:

- A more effective campaign to develop public understanding and support for harm reduction. Public opposition to existing initiatives such as the Site program in Ottawa have limited the growth of initiatives that could reduce HIV transmission among this population. It is known that the only 4.4 % of the need[31] for sterile needles is being met by the needle exchange program in Ottawa currently.
- More addictions treatment options, including methadone maintenance treatment. The few physicians who are currently offering methadone maintenance are stretched very thin and in danger of burning out. They report spending uncompensated time providing clients with case management and advocacy services to support them in stabilizing their lives to maintain the treatment program.
- There is a need to recognize that men and women use injection drugs very differently. Prevention education and treatment programs need to be offered with gender differences guiding intervention strategies.

### *Harm Reduction Strategies*

***i) Public Education:*** It is recommended that the Coalition undertake public education to educate Ottawa residents about the benefits of harm reduction strategies for all: members of the public and injection drug users. This campaign should be high profile, engage local mass media (radio, newspaper, television) in increasing public support for harm reduction strategies to prevent HIV/AIDS.

[31] Leonard, Lynne E., C. Navarro, R. Remis (2002) ""Going Beyond Individual HIV-Related Risk Behaviours and Practices among Ottawa IDUs : The Importance of HIV-Related Risk Conditions" *Can J Infect Dis* vol 13: Suppl A; March/April 2002 (pp 77A-78A)

***ii) Needle Exchange:*** It is recommended that the City Sexual Health Team expand the distribution of clean needles and kits, as public understanding for harm reduction increases. This should include:

- Expansion of SITE van hours
- Engagement of pharmacies in key areas of city to participate in needle exchange program.
- Expand number of partner agencies
- Expand outreach to youth

***iii) Addictions Stabilization:*** In addition to the initiatives that the Coalition will be advocating for towards the expansion of the availability of addictions treatment services, it is recommended:

- That the Ministry of Health provide the resources for Oasis, the City Sexual Health Centre, and appropriate addictions treatment services to work together to implement the recommendations of the methadone working group. These initiatives will expand services to stabilize addictions for those using injection drugs.

### *iv) Policy Work in Support of PHAs*

There are a number of initiatives that are outside of local jurisdiction that, if they were successfully implemented, would contribute to the prevention of HIV/AIDS, including: decriminalization of drug use, the development of better addictions treatment services including treatment services for injection drug users who are not abstinent; expansion of detox services; and development of housing for recovered drug users that offers on-site support for maintaining recovery (should be located outside of the downtown core). It is recommended that the Coalition recruit champions who can help it effectively advocate municipal, provincial and federal policy makers to foster conditions that will help prevent HIV/AIDs.

- ***Housing***
  - ***Ongoing Supports:*** Ensure that housing support services currently funded by SCPI and hostel redirection funds are continued and provided with secure ongoing funding
  - ***Availability of Affordable Housing with Support:*** Expand # of apartment units managed and/or supported by Bruce House by at least 35 units with commensurate expansion of housing support services
  - ***Family Housing:*** Ensure at least 5 units are located outside of the downtown core and are suitable for families with children
- ***Case Management for the Chronically Homeless***: The Inner City Health Project has been very effective in providing support for those who are homeless and HIV+, who are often dealing with multiple issues. The Oasis SCPI-funded outreach worker provides support to those who would other wise be unable to maintain compliance to their drug treatment regimen. It is recommended that the Inner City Health Project and Oasis SCPI worker be supported to continue the programs that they have established, that have been shown to be cost-effective.

- ***Other Harm Reduction Policies*** The Coalition should continue to work towards the implementation of national, provincial and local policies that reduce marginalization of those who are using injection drugs, including decriminalization of drug use and the implementation of supervised injection sites.

### *d) Immigrants and Refugees*

Infection rates remain high among immigrants and refugees from regions of the world where HIV is endemic (particularly sub-Saharan African regions, and Caribbean countries). Rates of diagnosis are low. Those who are HIV positive are very private about their infection. HIV is still a taboo among many cultures, and some ethno-cultural community groups deny that there is an HIV problem in their community, so informal and organized support is not offered. Some families forbid their children to take part in sexual health education at school. Key informants note that education is needed for men and women about research that has shown that sex education does not promote early onset of sexual activity. They also noted that women are sometimes not able to negotiate sex within marital relationships. Gender-based interventions as well as family-based interventions are important in HIV/AIDS education. The following activities are recommended.

***i) Community Development***: That strategies for each of the key affected communities be developed through a community development approach that involves community leaders, and organizations that are providing settlement services, counselling services, primary care services, and health education. Some of the following tips from key informants should be considered in designing activities:

- Training for cultural interpreters and for other health and community workers who are working within immigrant and refugee communities towards health, so they can incorporate HIV/AIDS education in their messages
- Work through paid peer educators
- Work with physicians who are already reaching this population to enable them to counsel patients on HIV prevention and the importance of early detection
- Develop more creative ways to reach people anonymously, e.g. phone work, internet, home language radio shows
- Bring what works in home countries here
- Engage community leaders
- Educate new families entering the country through settlement organizations
- Promote testing to prevent mother/child transmission; engage fathers in this as well as mothers.

***ii) HIV/AIDS Support Service Integration:*** Currently, there are very few organizations involved with OCCA that are targeting the immigrant and refugee populations effectively. Members of these communities will not use services that are labelled as HIV/AIDS services; nor are they likely to be drawn to being part of any PHA group activities. In order to promote access to needed services, support services for people who are infected with HIV and affected family members should be made available without labelling or distinguishing HIV/AIDS from other chronic conditions.

***iii) Expand Case Management:*** Case management should be included as one of the key support services that are made available to PHAs and affected family members within integrated settings as described above in recommendation ii). Case manager resources should be expanded within organizations already reaching affected communities (such as certain CHCs and immigrant service organizations), and referral protocols should be worked out with community physicians and HIV/AIDS treatment services so that these services are accessed by those who need them in a confidential way.

## *e) Families*

Families affected by HIV include those in which one or both parents are HIV positive and/or one or more children is HIV positive. Issues faced by families include the following:

- Support services are lacking, specifically caregiving, respite, home support. This lack of services can contribute to family breakdown. Child protection practices and legislation are not conducive to flexibly supporting families affected by HIV/AIDS, and sometimes, for example when a parent goes through a health crisis, the only viable solution is to take children into care when provision of more support within the home would have prevented that.
- Services such as counselling for affected siblings are not able to be provided within current resources.
- CHEO is not funded to provide case management services for HIV positive children and their families. Staff try to do what they can, but are feeling stretched by the ever-changing needs of children and other family members and HIV positive children grow through different developmental stages. Often liaison is needed with Children's Aid Society, housing providers, income support sources, Trillium for drug coverage, food banks, schools, employers and more.
- There is a shortage of housing options that are adequate for families – Bruce House supply is oriented to childless couples or singles; more townhouse units or units within family-oriented neighbourhoods are needed to provide stable, affordable housing for families affected by HIV.

The following recommendations are made to support families affected by HIV:
**i) *Counselling and Case Management:*** increase counselling and case management services for family members affected by HIV
***ii) Policy Work:*** The following policy issues should be raised with the support of the Coalition.

- Child Welfare practices: to increase support for affected families to prevent family breakdown
- Housing: to increase the supply of affordable family-appropriate housing for families affected by HIV.

## *f) Women*

Health Canada reported in April 2002 that "Women in Canada are increasingly becoming infected with HIV, especially injecting drug users and women with high risk sexual partners" (see Table Four and Figure 8 below.) As Table 2 on page 13 shows, in the year 2000, it was estimated that over 200 women have been infected through heterosexual sexual activity.

Approximately 150 women PHAs were infected through injection drug use, and approximately 80 women PHAs are from endemic regions of the world. It is known that women face different pressures than men in negotiating safety related to HIV prevention, no matter what type of mode of transmission they are most at risk of. Very few services exist to support women infected through heterosexual activity, and there are few gender-specific prevention programs for women. The following actions are recommended:

***i) Develop Gender-Appropriate Strategies:*** Develop gender-appropriate prevention and PHA support strategies specifically for:

- Heterosexual women
- Women in the sex trades
- Women using injection drugs
- Immigrant and refugee women.

***ii) Case Management and Mutual Support:*** Provide case management services for infected women and develop PHA mutual support groups for women as the demand warrants.

***iii) Monitor Trends:*** The Coalition should monitor the incidence and prevalence among women and adapt strategies to respond to trends as they develop.

***iv) Education:*** Although targeted and concentrated prevention initiatives would not be cost-effective for women at this stage, given the low prevalence and incidence rates, general education should be made available to women to let them know of growing risk, to encourage testing and to help them recognize early signs and symptoms.

**Table 4: Proportion of Positive HIV Tests among Adult Females by Exposure Category and Year of Test, Canada[32]**

| | Exposure Category | | |
|---|---|---|---|
| **Year** | **Heterosexual Contact** | **IDU** | **Blood &Blood Products** |
| 1985-95 | 46.5 | 36.2 | 10.7 |
| 1996 | 43.4 | 51.1 | 1.3 |
| 1997 | 45.7 | 45.0 | 1.4 |
| 1998 | 52.8 | 38.8 | 3.6 |
| 1999 | 48 | 47.9 | 1.2 |
| 2000 | 55.0 | 39.6 | 1.7 |
| 2001 | 63.5 | 31.6 | 1.6 |

[32]Centre for Infectious Disease Prevention and Control, Health Canada, "HIV and AIDS among Women in Canada" *HIV/AIDS Epi Update*, April 2002, Canada)

| | | | |
|---|---|---|---|
| TOTAL | 48.9 | 39.6 | 6.0 |

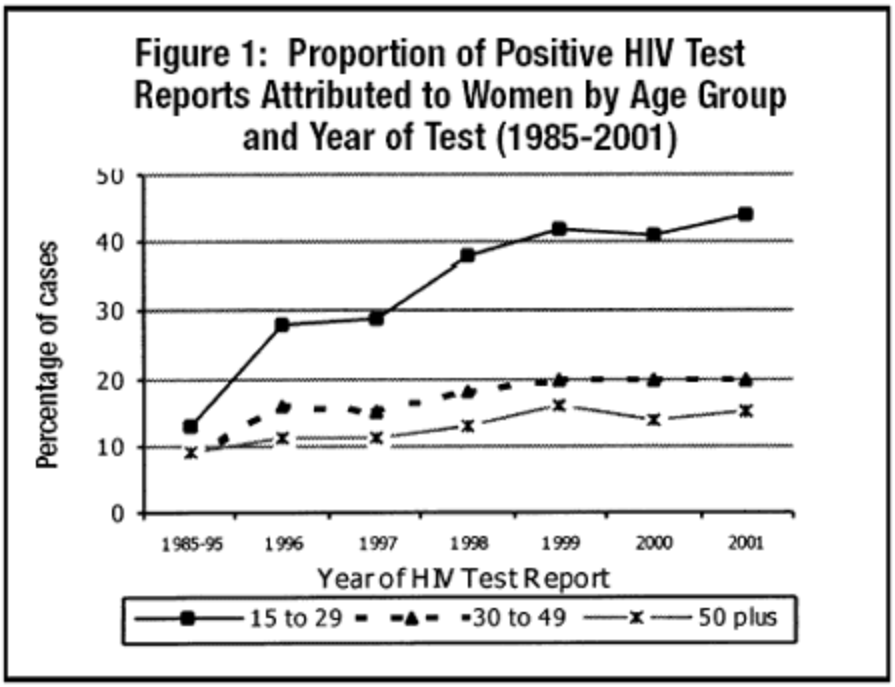



**Figure 8**

## Strategy # 2: System Redesign and Service Enhancements

The key elements of the System Redesign and Service Enhancement Strategy is to:

***i) Adapt Programs and Services*** to be accessible and appropriate to the distinct "cultural" groups affected by HIV/AIDS

***ii) Increase Capacity:*** Enable services to respond to the needs of a growing number of PHAs in Ottawa by working with local organizations and funders to increase resources in both prevention and wellness support. One of the themes running across the service enhancements recommended is that of increasing the availability of case managers to work with PHAs to access resources and deal with the complex needs that arise while living with HIV.

***iii) Expand Engagement of Organizations:*** Bring together clusters of programs and services that are accessible and appropriate to the distinct population sub-groups affected by HIV/AIDS for services development, co-ordination and planning

***iv) Enable and Monitor Adjustments to Service System***

### *v) Provide Capacity Development Support to Organizations*

## *i) Adapt Programs and Services to be Cultural-Affinity Appropriate and Expand Engagement of Key Organizations*

It is recommended that, as a principle, programs and services that are offering community development, outreach, drop-in, group support or counselling or mutual support services not attempt to serve more than one cultural affinity group at a time. While all services should be open to anyone who wishes to access them, organizations are encouraged to priorize service development to serve the needs of specific sub-populations. Users are then free to choose to access those services with which they feel affiliation. In the event that an organization is providing programs for more than one affinity population, it should structure hours, locations and staffing to ensure that delivery is appropriate to the target group's preferences.

The organization that this recommendation will have the biggest impact upon is the AIDS Committee of Ottawa. The AIDS Committee of Ottawa (ACO) provides a number of direct services to PHAs regardless of cultural affinity. The agency has recently entered into a partnership agreement with Pink Triangle Services (PTS) to manage together its Man to Man project, an outreach program to reach gay men. It is recommended that ACO transfer its direct services to community agencies that are specifically accessible to cultural affinity groups. (see recommendation iii below for suggestion about new role for ACO).

It is further recommended that in order to better reach some cultural affinity groups, a wider range of organizations be recruited to provide HIV/AIDS services, and that service clusters of organizations be formed to co-ordinate planning and delivery of services. Where development is needed, these organizations may be recruited on to Joint Action Teams. Where no specific development is needed, they would be part of the cluster as part of the Network. (Joint Action Teams and Network are introduced in Strategy # 3) The recommended clusters are shown in Table 5 below. Within these clusters, there should be particular organizations designated to work with PHAs to develop mutual support and advisory groups (see below under recommended system planning structure).

| ***Table 5: Recommended Clusters of Organizations related to HIV/AIDS Sub-Populations*** | |
|---|---|
| ***Population Groups*** | ***Key Organizations Involved In Service*** |
| Overall System Development | Population-based planning, co-ordination and capacity development:<br>▸ AIDS Committee of Ottawa<br>▸ City of Ottawa Public Health and Long Term Care<br>▸ CAMH |
| General (universal services) | ▸ Immunodeficiency clinics: Ottawa Hospital<br>▸ University of Ottawa Primary Care Centre<br>▸ City of Ottawa Public Health and Long Term Care |
| Youth | ▸ Youth Services Bureau<br>▸ City School Sexual Health Team within Community Services in People's Services<br>▸ Planned Parenthood Ottawa<br>▸ Pink Triangle Services<br>▸ Other youth-serving agencies that participate in the Popcorn Group of Youth-Serving Agencies<br>▸ Wabano<br>▸ Child and Youth Friendly Ottawa |
| Injection Drug Users | ▸ Oasis<br>▸ City of Ottawa Public Health and Long Term Care<br>▸ St. Anne's Clinic<br>▸ University of Ottawa Primary Care Centre<br>▸ Sandy Hill CHC<br>▸ Somerset West CHC<br>▸ Rideauwood<br>▸ Inner City Health Program<br>▸ Bruce House<br>▸ CAMH |
| Gay Men | ▸ Pink Triangle Services<br>▸ Centretown Community Health Centre<br>▸ City of Ottawa Public Health and Long Term Care<br>▸ University of Ottawa Primary Care Centre<br>▸ Bruce House |
| Immigrants and Refugees | ▸ Somerset West CHC<br>▸ Pinecrest Queensway CHC<br>▸ Carlington CHC<br>▸ Southeast Ottawa CHC<br>▸ City of Ottawa Public Health and Long Term Care<br>▸ Canadian Worldwide AIDS Foundation<br>▸ Immigrant Services Organizations<br>▸ Ethno-cultural community organizations developed by sub-Saharan African communities; Caribbean communities |

| ***Table 5 (cont'd): Recommended Clusters of Organizations related to HIV/AIDS Sub-Populations*** | |
|---|---|
| ***Population Groups*** | ***Key Organizations Involved In Service*** |
| Families | ▸ CHEO<br>▸ CAS<br>▸ St. Anne's Source Program<br>▸ Bruce House<br>▸ Link with<br>o Immigrants and Refugee cluster<br>o Women's cluster |
| Aboriginal | ▸ Wabano<br>▸ Aboriginal Women's Support Centre<br>▸ Pinganoden Lodge<br>▸ Minwashin Lodge<br>▸ Odawa<br>▸ Oshkigizi<br>▸ Inner City Health Project |
| Women | ▸ City of Ottawa Public Health and Long-Term Care<br>▸ Oasis<br>▸ Source |

### *ii) Increase Prevention and Service Capacity*

In order to implement Strategy One, the following changes should be made to expand and enhance needed services that can effectively work towards prevention and wellness promotion related to HIV/AIDS over the next five years in Ottawa.

- ***Prevention, Early Detection, and Community Development:*** *Engage community members in developing and adapting services specific to:*
  - *Youth*
  - *Wellness services for gay men*
  - *Integrated services and community programming for target immigrant and refugee communities (sub-Saharan Africa and Caribbean)*
  - *Women (development of gender-appropriate prevention and wellness support strategies for IDUs, heterosexual women, and immigrant and refugee women)*
- ***Harm Reduction:***
  - *Public education campaign to build support for harm reduction policies in Ottawa*
  - *Needle exchange expansion*
  - *Addictions stabilization*

- *Policy Development related to addictions treatment, housing, and other harm reduction strategies.*

- ***Primary Care:*** *Expand the network of primary care providers who provide counselling, testing, and ongoing treatment of HIV/AIDS in consultation with specialists. Specifically:*
  - *Engage the Community Health Centres and primary care physicians who provide appropriate access to immigrant and refugee populations from sub-Sahara Africa and the Caribbean in the provision of the range of HIV-related services so that immigrants and refugees at risk of HIV and with HIV have access to more comprehensive health and case management support.*
- ***Case Management***[33]*: Increase the provision of case management services for individuals who are HIV positive and affected significant others and grow the capacity for service provision at the same rate as the population of PHAs. Specifically:*
  - *Increase the availability of case management support to physicians who are working with high need PHAs and injection drug users (increased resources to Oasis with a mandate to provide services to clients of community physicians offering methadone maintenance treatment)*
  - *As part of gay men's wellness services, introduce at least one community-based case manager for gay men with HIV (increased case management resources based in a community health centre providing lead in gay men's wellness)*
  - *As part of overall wellness services for immigrant and refugees, introduce case management services with specialization in HIV/AIDS in each participating CHC. Make case management services available to private practice physicians serving this community. (increased resources for case management based in 2 or 3 community health centres providing services to key immigrant and refugee populations)*
  - *Expand capacity to provide counselling and case management support for families affected by HIV*
  - *Expand capacity to provide mutual support and case management for women*
- ***HIV Treatment:*** *Continue to expand specialized treatment services at the Ottawa Hospital and CHEO to provide ongoing treatment.*

***iii) Enable and Monitor Adjustments to the Service System and Provide Capacity Development Support to organizations:*** ACO should shift its focus to undertake a system development role in support of HIV/AIDS goals. This role should include:

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[33] Case management in this context can be provided by a nurse, social worker, or nurse practitioner with special training in HIV/AIDS and in cultural sensitivity with the populations with which s/he is working. Case management services include: providing clients with an orientation to the range of community services and resources they may wish to access, assisting the client to set goals related to the range of life domains (mental and physical health, social relationships, housing, employment, safety), working with the client to access appropriate community resources and supports to achieve their goals, providing timely support to manage a crisis, reviewing progress on personal goals.

- Policy education
- System planning and co-ordination (providing the co-ordination resources required by the Coalition)
- Capacity development
  - Co-ordination of training and support to organizations providing direct services
  - Linking local initiatives and players with provincial, national and international initiatives in HIV/AIDS movement.

Organizations that are relatively new to serving people with HIV/AIDS will need extensive support to effectively serve their community.

## Strategy # 3: Creating the Ottawa Coalition on HIV/AIDS

This strategy is intended to support all other strategies. Its purpose is to:

- Preserve the strengths of OCCA
- Expand organizational commitment to fighting HIV/AIDS and serving those who have HIV/AIDS
- Engage more senior-level decision-makers in strategic meetings
- Widen the engagement of other sectors in the fight against HIV/AIDS, and in providing appropriate services related to HIV/AIDS.

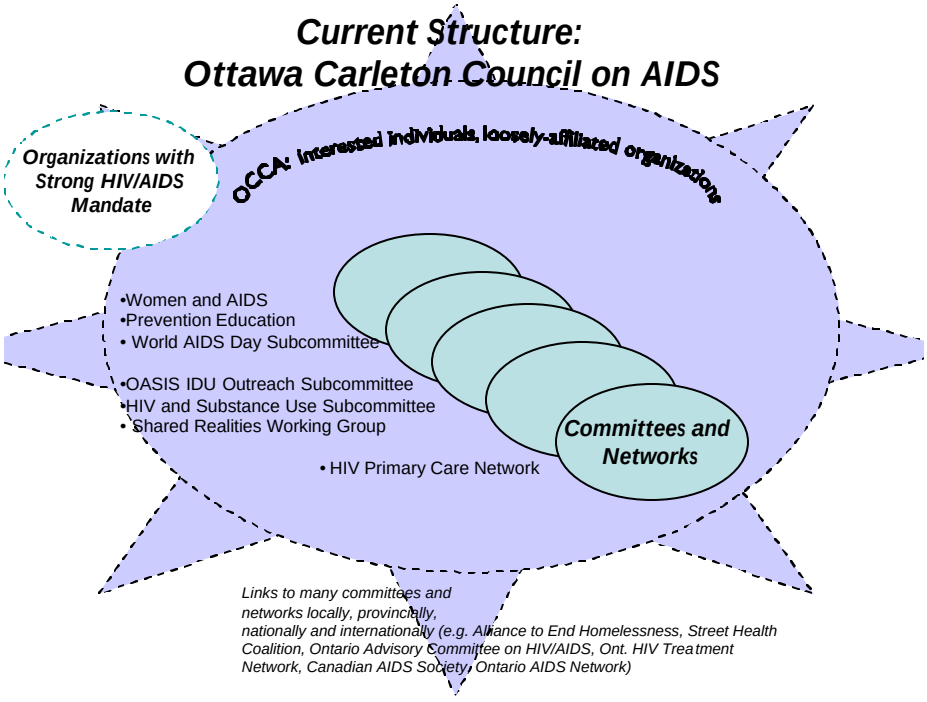



**Figure 10: Current Structure: OCCA**

For the past many years, OCCA has had a relatively informal structure, as summarized in Figure Nine. Membership has been open to anyone who has an interest in advancing work on HIV/AIDS and included HIV+ individuals (PHAs), individuals affected by HIV/AIDS, and those volunteering or working in the field, as well as those who were representing their organizations. The group has a chairperson who is a community volunteer, and the Health Department

contributes admin support time to keep the minutes. The group has been fuelled by the commitment and passion of its individual members.

This current structure has had many advantages that are valued by members, including:

- Its informal and non-bureaucratic approach is valued by some
- Its accessibility to anyone who is interested
- The commitment level of the individuals participating.

However, as the epidemic continues and changes, the group realized that it wanted to develop its capacity in the following key areas:

- Increase capability to take action and enable participating organizations to take action together more effectively
- Clarify the commitment of key organizations
- Focus on strategic issues that need the collaborative effort of the members – and spend less time on immediate or urgent issues that can be dealt with by single organizations
- Enroll more organizations that don't have HIV/AIDS as their central mandate and are reaching populations who are at high risk of HIV
- Secure resources to enable collaborative action.

The following recommendations are intended to maintain OCCA's strengths while developing a greater capacity to respond to strategic issues, effectively engage a wider number of partnering organizations, and enable the group to continue to respond to emerging changes in the epidemic and local conditions.

### *i) Restructure OCCA to create the Ottawa Coalition on HIV/AIDS*

The OCCA should change its name to the *Ottawa Coalition on HIV/AIDS.*

***Mission:*** The mission of the coalition should be:

*The Ottawa Coalition on HIV/AIDS is a coalition of organizations and associated individuals. We work together to reduce the incidence of HIV and support the wellness of people living with HIV in Ottawa.*

*The coalition is responsible for:*

- ***Strategic Planning:*** *Setting community-wide goals and priorities*

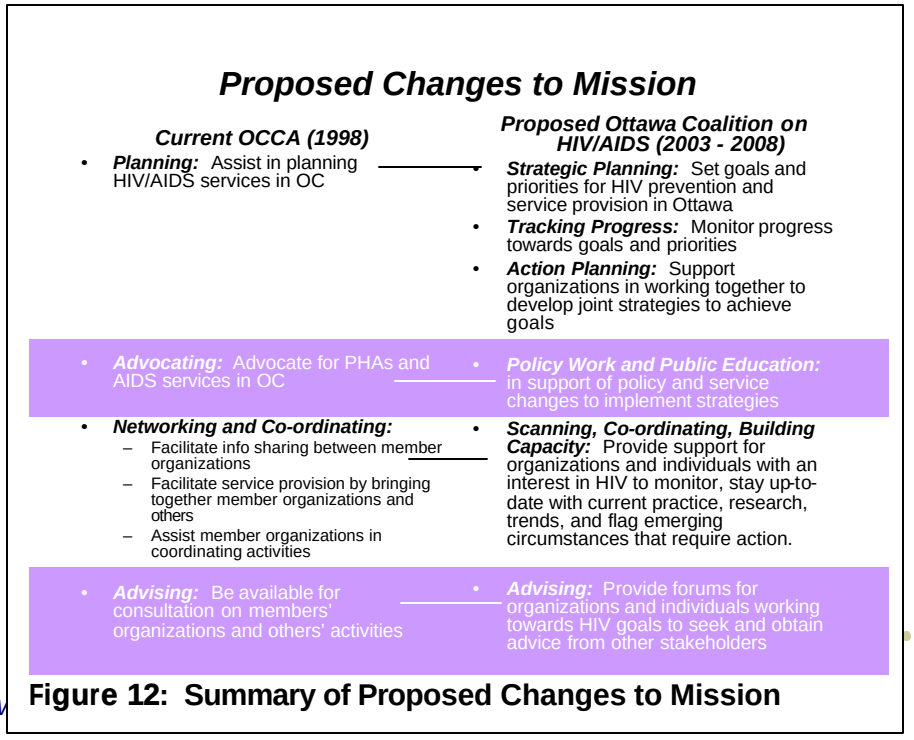



**Figure 12: Summary of Proposed Changes to Mission**

*for HIV prevention and service provision in Ottawa.*

- ***Tracking Progress:*** *Monitoring progress towards community-wide goals and priorities*
- ***Action Planning:*** *Supporting organizations in working together to develop joint strategies to achieve goals*
- ***Advocating:*** *Advocating for policy and service changes to implement strategies*
- ***Scanning, Co-ordinating, Building Capacity:*** *Providing support for organizations and individuals with an interest in HIV to monitor, stay up-to-date with current practice, research, trends, and flag emerging circumstances that require action.*
- ***Advising:*** *Providing forums for organizations and individuals working towards HIV goals to seek and obtain advice from other stakeholders.*

As Figure 10 shows, compared to the mission statement OCCA adopted in 1998, this mission statement provides more emphasis on strategic planning and enabling joint action than was taken in the past by OCCA.

## Structure: An Organizational Coalition with a Network comprised of Associated Individuals

### *Partnership Structure*

It is recommended that the Ottawa Coalition on HIV/AIDS be created as an inter-organizational coalition with the structure illustrated in Figure 11.

***Proposed Governance Structure: Ottawa Coalition on HIV/AIDS***

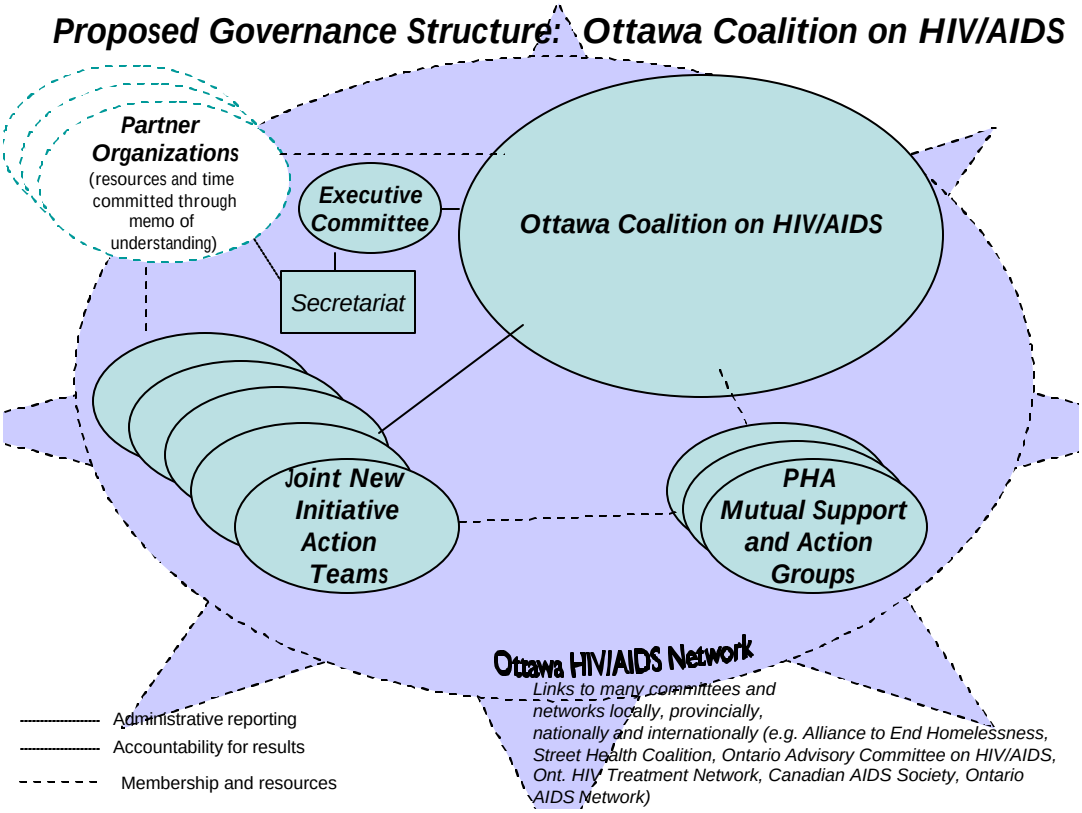


**Figure 13: Proposed Governance Structure: Ottawa Coalition on HIV/AIDS**

This structure includes the following elements:

- The inter-organizational coalition, which will be responsible for strategic decision-making and enabling joint action;
- Joint Action Teams created by the Coalition
- The Ottawa HIV/AIDS Network– co-ordinated by the coalition, comprised of individuals, groups and organizations with an interest in HIV/AIDS. The network will be responsible for co-ordinating events, exchanging information, supporting capacity development.
- PHA Mutual Support and Action Groups – supported and resourced by organizations that are part of the Coalition. PHA mutual support and action groups will be formed for cultural affinity groups of PHAs, as the demand and need arises from PHAs themselves over the short term. There will likely be one for gay men, and one for injection drug users; there may be enough interest to establish one for women.
- There may be one for women. Over time, as PHAs see the need to connect with one another and have a voice in policy and services, more groups may form, with the support of organizations that are working directly with them in supporting wellness.

***Table 6: Examples of Activities that Will be Undertaken by the Coalition and by the Network***

| *Coalition* | *Network* |
|---|---|
| ▸ Bringing key players to the table to develop a workable short-term and long-term solution for getting injection drug users off needles. This may involve Ministry of Health representatives, CHC representatives, Ont AIDS Bureau rep., addictions treatment reps<br>▸ Making representation to the school boards with respect to a youth strategy for HIV/AIDS prevention that's been developed by the Joint Action Team<br>▸ Ensuring that there's a set of indicators and measures in place to monitor incidence and prevalence of HIV in Ottawa and every year, monitoring progress on incidence and prevalence; deciding how to adapt priorities in response, and publicizing progress and developments in strategy<br>▸ Establishing a mechanisms with the Network to stay up to date on the latest | ▸ Generating ideas for World AIDS Day<br>▸ Soliciting others' support for promoting fund-raising initiatives<br>▸ Consulting with others regarding a new program idea that one organization is considering<br>▸ Participating in networking with colleagues elsewhere and bringing the latest research and developments to the attention of other Network members; discussing implications<br>▸ Flagging important developments and implications and feeding in to Coalition with recommendation for action. |

It will be essential that the Coalition only deal with strategic matters relating to inter-organizational initiatives. Table Six summarizes the kind of matters the Coalition should deal with and those the Network should deal with. This will evolve over time, but vigilance will need to be strong to ensure that the Coalition uses its time and power wisely. Communication, updates, and the effort of recruiting support for organizational initiatives should not happen at the Coalition – these activities should happen through Network activities. These elements are described in more detail below.

### *Coalition Mandate*

It will be important to distinguish between the role of the Coalition as distinct from the Network, particularly as the organization transitions from OCCA to the Ottawa Coalition on HIV/AIDS. Table Six provides some examples of the different activities that will be undertaken by each. The Coalition will be responsible for:

- Setting goals, objectives, and priorities for Coalition action
- Recruiting and sustaining organizational participation in the Coalition and Joint Action Teams
- Establishing joint action teams including:

- Establishing mandates, terms of reference, and expected results and accountability expectations
- Appointing members,
- Ensuring adequate resources for joint action teams by recruiting resources from contributing organizations and individuals
- Establishing memoranda of understanding with organizations and individuals participating in Coalition and/or Joint Action Teams
- Reviewing and approving Joint Action Team recommendations and enabling implementation of recommendations

- Co-ordinating Joint Action Teams to enable co-operation and minimization of duplication
- Educating policy-makers and members of the public on issues that go beyond the power of the Coalition members
- Seeking resources in collaboration with organizational members to ensure implementation of recommendations.

### *Coalition Membership*

It is recommended that the Coalition be comprised of the voting and non-voting members as follows.

- ***Voting Members***
  - Senior decision-makers who have the authority to commit resources and take decisions on behalf of organizations that are prepared to allocate resources, knowledge, influence and/or other valued resources toward achieving the Coalition's HIV/AIDS goals and objectives for Ottawa. The organizations represented on the Coalition should include the following:
    - Exec. Director all local ASO's:
      - AIDS Committee of Ottawa
      - Oasis
      - Bruce House
    - Medical Officer of Health responsible for HIV/AIDS
    - Senior Manager responsible for HIV/AIDS Prevention Programs within City Public Health and Long-Term Care
    - Senior Manger responsible for Sexual Health Education within Schools within City Community Services
    - Senior Manager from Ottawa Hospital Immunodeficiency Clinic
    - Senior Manager from CHEO Immunodeficiency Clinic
    - Chairperson HIV Primary Care Network
    - Senior Manager representing an inter-organizational group working toward the health of immigrants and refugees
    - Primary Care Manager representing Primary Care Network within CHCs and/or Executive Director representing Coalition of CHC/CRCs
    - 1 senior manager from Youth Services Bureau (also representing Popcorn Group of Youth-Serving Agencies)
    - 1 MD from U of O Health Services

- 1 sr. mgr from St. Anne's Clinic
- 1 sr. mgr from Wabano
- Director, Inner City Health Project (also representing Alliance to End Homelessness)
- Chairperson of each Joint Action Team
- Chairperson or designated rep from PHA Committee (s)
- Board Member or Senior Manager, Pink Triangle Services

- ***Non-Voting Members:***
  - Recruited "HIV Champions" (recruited as allies to help achieve timely progress on goals -- advise on strategy, act as spokesperson, etc.)
  - AIDS Community Action Program rep
  - Ontario AIDS Bureau rep
  - Champlain District Health Council
  - Local area office, Ontario Ministry of Health
  - The Coalition co-ordinator (see below).

### *Executive Committee*

The Coalition will establish an executive committee comprised of the chairperson, the Executive Director of the ASO administratively sponsoring the coalition staff, and at least one other elected member (size of the executive committee to be determined by the Coalition). The Co-ordinator will be an ex-officio member. The executive committee will meet as often as required and will be responsible for:

- Ensuring effective management of the Coalition and Network
- Ensuring transparency, effective partner relations and accountability of the coalition to its organizational members and funders
- Providing the Co-ordinator with guidance and supervision on functional matters related to Coalition and Network business
- Taking timely decisions between Coalition meetings
- Developing agendas
- Monitoring resource use
- Calling special meetings as required in its judgment.

### *Joint Action Teams*

It is recommended that the Coalition establish Joint Action Teams (JATs) to undertake action planning and co-ordination of implementation for initiatives that require inter-organizational work and commitment. JATs will be established by the Coalition with a specific mandate, targets and milestones and time horizon (some may be indefinite). The Coalition will recruit a co-ordinator for each JAT and active participants.

### *PHA Mutual Support and Action Groups*

Mutual support and action groups will be developed by and for people who are HIV positive. Groups will be formed around particular affinities, as is wanted and needed by PHAs. They will be supported by organizations that are actively working with PHAs with that particular affinity. For example

- Gay men: a gay men's PHA mutual support and action group may be supported by Pink Triangle Services working under the sponsorship of the AIDS Committee of Ottawa.
- Injection Drug Users: a mutual support and action group for PHAs who are recovering from substances may be one group; another group may be for those who are working on wellness and who are currently still using substances. These groups may be supported by Oasis.
- Others: other PHA mutual support and action groups may form with the support of particular agencies. For example, the Source or ACO may support the development of a women's PHA support group. One of the CHCs working with sub-Saharan African communities may find that there are enough people with HIV who are looking for mutual support from others to support the formation of an African group.

### *The Ottawa HIV/AIDS Network*

The Ottawa HIV/AIDS Network is supported by the Coalition. Its role is co-ordination of established initiatives, capacity-building, information-sharing, environmental scanning – raising issues that need attention and action, providing feedback and advice to steering group. It will meet quarterly for first year, then reassess the frequency of meetings. It will be chaired by Chair of Coalition. Participation in the Network will be open to any individual with a personal commitment to the goals of the Coalition. The activities of the Network will be determined by a majority of whoever is at the Network meeting where a proposal is discussed. They may include: various ways of information sharing such as a newsletter, web site, list serve; networking meetings, learning and exploration sessions.

## Coalition Activities and Operating Principles

### *Decision-Making and "Opting Out" of Particular Decisions*

Timely decisions are important and momentum is important – particularly with respect to working to keep up with the HIV/AIDS epidemic.

It is recommended that the Coalition take decisions only on strategic matters related to community-wide planning goals and priorities related to achieving these goals, and positions that it is recommending to advance these goals – to policy-makers, practitioners and organizations. It will aim to achieve the agreement of all members within certain agreed time parameters for discussion – when agreement cannot be reached within the time allocated, a vote will be taken and majority rules.

Coalition members may formally "opt out" of the Coalition's decision or action on a particular issue when there is conflict between the interests or positions of their organization and the interests and position of the Coalition.

### *Guiding Values and Principles*

It is recommended that the Coalition establish a minimal set of guiding values and principles to foster effective working together and to use as reference in taking decisions and setting priorities. Some principles that have been suggested in the course of the planning are as follows.

- ***Respect differences:*** Organizations and individuals each bring different levels of resources, experience, and capacity to table; all are valued. It is recognized that HIV/AIDS is not central to all organizations' mandates, and yet that they have a crucial role to play in HIV prevention and PHA wellness. Options for participation and level of engagement will be offered.
- ***Support Participation:*** Provide honoraria and reimburse expenses to recognize and enable the work of PHAs and other volunteers and work to secure resources to do so
- ***Acknowledging conflict of interest***: It is the nature of coalitions that from time to time conflict of interest arises around a particular issue that the Coalition is addressing, e.g. when one of the organizational partners is a target for policy development. Guidelines should be put in place for such times, and members supported in using them
- ***Population Health Approach:*** In developing strategies for prevention and wellness promotion, the Coalition will include strategies for the general population, and specific "cultural" groups, as well as strategies to create conditions in the community that support prevention and wellness
- ***Other Principles*** that have been found to be useful in collaborative ventures of this nature[34] include:
  - ***Communicate in All Directions:*** Keep those who are directly involved up to date through formal and informal word of mouth regular contact. Help those who are representing networks and organizations to communicate with their constituencies and to know what needs to go back to their colleagues for action. Don't forget to keep the public and key allies informed.
  - ***Momentum:*** The time it takes to get collaborative ventures moving forward can be frustrating and it does take more time to do things together. There needs to be a balance between consultation and action – and key people within the group should be empowered to move forward in key areas to keep momentum going. Not every decision should be checked with every player.
  - ***Continuity and Compromise:*** the continuity of key partners who demonstrate a willingness to compromise

[34] Ekos Research Associates, *Lessons Learned on Partnerships: Final Report*, Ottawa, Voluntary Sector Roundtable 1998

- ***Successes and Celebrations:*** Building in ways to acknowledge short-term concrete successes and taking opportunities to celebrate accomplishments
- ***Tangible Results:*** Clearly measuring and tracking a few simple results and using them to adapt plans for the future.

### *Memoranda of Understanding*

As part of establishing the Coalition and Joint Action Teams, the Coalition will ask organizations (that may or may not be members of the Coalition) to contribute resources in the form of allocating staff or volunteer time, undertaking particular defined tasks, contributing funds or other commitments. Memoranda of understanding between the coalition and contributing organizations will confirm the commitments that enable the JATs. The Coalition may also recruit key individuals (organizational reps, PHAs, or other community members who have contribution to make) to participate in a JAT. Participating individuals will sign memos of understanding regarding their commitment and role within the mandate of the JAT with respect to their time commitment, and the role they'll play in communication, consultation within their networks and home organization.

### Coalition Secretariat

It is recommended that a full-time Coalition Co-ordinator and half-time administrative assistant position be established. The Coalition co-ordinator should report to the Chairperson of the Coalition on all substantive matters. The Coalition staff should be administratively sponsored by one of the AIDS Service Organizations (AIDS Committee of Ottawa, Bruce House or Oasis), and administratively report to the Executive Director of that organization. The Executive Director of the sponsoring agency should be on the executive committee of the Coalition.

The Co-ordinator will be responsible for:

- Providing secretariat support to the Coalition which will include:
  - Enabling effective relations between the Coalition and partner organizations and stakeholder groups
  - Enabling effective Coalition operations
    - Advise Executive Committee on agenda and priorities
    - Developing briefs and statements on behalf of the Coalition
    - Providing support to Joint Action Teams to ensure that they have resources they need and are informed about each others' work to prevent duplication
    - Co-ordinating meeting schedule and activities
    - Co-ordinating workshops and special events
    - Facilitating memoranda of understanding between the coalition and individuals and organizations participating
    - Ensuring timely, relevant and effective formal and informal communication between all stakeholders including:

- Maintaining regular communication vehicles a determined by Coalition or network which may include: web site, newsletter, list serve, e-mail notices

- Respond to media request for information by directing them to appropriate sources
- Ensuring up to date records: minutes, distribution lists.

### *ii) Recruit Key Champions and Partners*

The Coalition will only be as effective as the partnering organizations and individuals that it recruits. Selection of champions and partners in plan implementation will be key.

### *iii) Work with Participating Agencies to Secure Required Resources for Plan Implementation*

The Coalition will not be directly funded for anything, except system co-ordination and planning through ACO. It should, however, work as an active ally with partnering organizations to approach funders to secure the resources required to achieve the goals and objectives in this plan. Participating organizations will be allocated these funds and will be accountable back to the coalition as well as to the funder for reporting progress towards objectives, and/or for recommending adaptation to objectives and strategies.

### *iv) Annual Strategic Progress Review*

Once a year the Coalition should sponsor a gathering for all interested stakeholders to review progress on its goals and objectives and priorities and to adapt its course as needed. These annual gatherings will be a time to:

- Hear the latest developments regarding HIV epidemic, treatment and promising prevention and intervention approaches
- Receive updates from JATS and PHA groups
- Get a report from funders and policy makers regarding key issues (such as housing etc.)
- Get input on how strategies should be adapted and what priorities should be for the coming two to three years.

# Part IV: Implementation of the Plan

## Resources Required

Table Seven is a very rough estimate of the magnitude of resources required to implement this plan. (More refined estimates will be developed as part of the action planning that will follow the adoption of this plan.) Because the foundation of services in Ottawa is so strong, it is estimated that only between $1.25 million and $2.35 million will be required annually over the next five years to save a baseline of between $1.2 million and $2.2 million per year in treatment costs (see Table One on page 9). From a purely cost-effectiveness perspective, return on this investment will be fully realized in treatment cost savings by year five. Over time, cost savings will continue to grow as the effectiveness of prevention is maintained.

**Table 7: Rough Estimate of Annual Resource Envelope Required for Plan Implementation**

| Strategy | Estimated Resources Required | Cost Envelope per Year | |
|---|---|---|---|
| | | Minimum | Maximum |
| ***1. Prevention, Harm Reduction and Wellness Support*** | | | |
| a) Youth | ▸ City-wide team (French, English): Community development, peer educators, leadership development<br>▸ Education/prevention messaging (annually) | 300,000 | 500,000 |
| b) Gay and Bisexual Men | ▸ Wellness strategy<br>o Peer-based prevention (in addition to Man to Man)<br>o Social marketing<br>o Case management and PHA mutual support | 300,000 | 500,000 |
| c) Injection Drug Users | ▸ Public Education<br>▸ Needle Exchange Expansion<br>▸ Addictions Stabilization Expansion<br>▸ Policy Development | 200,000 | 400,000 |
| c) Immigrants and Refugees | ▸ Community Development<br>▸ HIV/AIDS support service integration (Coalition Co-ordinator with already- | 200,000 | 400,000 |

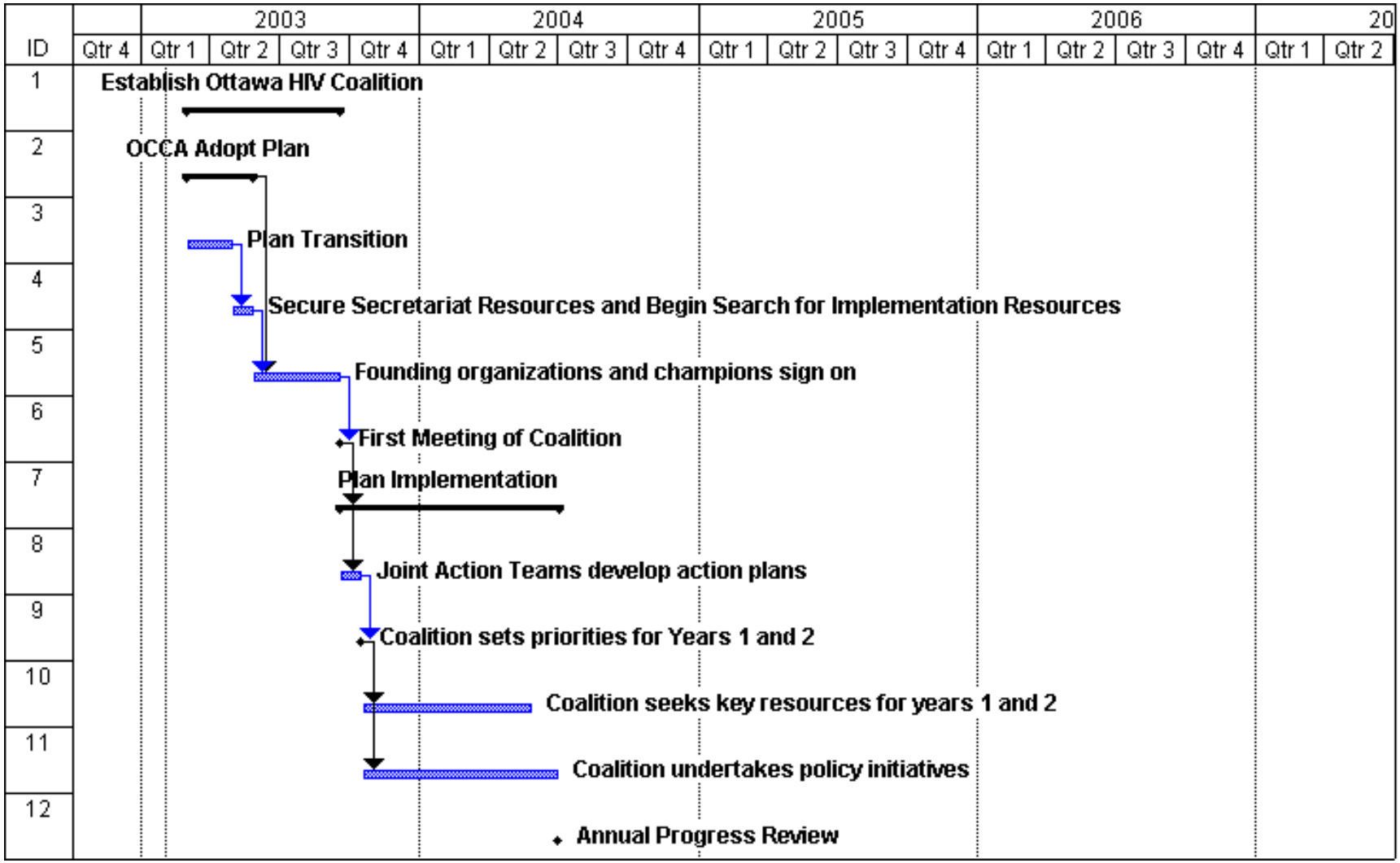
| **Table 7: Rough Estimate of Annual Resource Envelope Required for Plan Implementation** | | | |
|---|---|---|---|
| Strategy | Estimated Resources Required | Cost Envelope per Year | |
| | involved partnering organizations)<br>▸ Expanded Case Management | | |
| e) Families | ▸ Counselling and Case Management<br>▸ Policy Work | 50,000<br>In kind | 150,000<br>In kind |
| f) Women | ▸ Gender Appropriate Community Development<br>▸ Case Management and Mutual Support<br>▸ Monitor Trends<br>▸ Educational Campaign | 50,000 | 150,000 |
| ***2. Extend Capacity of Local Service System to Implement*** | ▸ Capacity Development Support to Organizations | 50,000 | 100,000 |
| ***3. Create Ottawa Coalition on HIV/AIDS*** | ▸ Coalition Co-ordinator and administrative resources<br>▸ Annual review | 100,000 | 150,000 |
| ***Estimated Annualized Envelope of Resources Required*** | | ***$1.25 million*** | ***$2.35 million*** |

## Implementation Staging

As a council of partnering organizations, the Coalition does not have the power to mandate its members to implement Strategies 1 and 2. The Coalition can encourage, enable, recommend and work with funders and local organizations to support their understanding of the need, the urgency, the feasibility and the benefits of implementation. But, it cannot require or mandate. The decisions about organizational priorities, resource allocation, and implementation of strategies 1 and 2 need to be made by the organizations responsible for various elements of programs and services. Many of the activities recommended in this plan are already being conceptualized among key players. They will need the support of policy-makers and funders to be implemented.

The first priority of OCCA should be to decide about whether to adopt the plan in principle. The details will be adapted by Joint Action Teams based on what's appropriate and practical as implementation nears. Once the plan is adopted by OCCA, it should set up a ***Transition Team*** to plan the transition to the Coalition. During the transition, while key members of the Coalition are being recruited, the Transition Team should have the authority to move forward with activities. Financial support for a Coalition Secretariat as soon as possible after the decision about a Coalition has been taken will enable the transition planning and implementation to move forward. Without that, implementation could stall.

Figure 12 is an overview of the suggested timetable for the Coalition's first year. Once the Coalition is in place, it should review the plan, review what partners are prepared to act on. This will be a balancing between readiness, feasibility, funder priorities, and potential impact on goals and objectives. There are some initiatives that will be ready to go immediately without further detailing (program plan has been prepared, resources required). These will need the active support of the Coalition to seek resources along with delivery organizations. Other initiatives will be high priority and need further detailing over the next year. Joint action teams will need to be mandated to take on this work and bring recommendations for action back to the Coalition. Other areas will be flagged as priority for action in later years. These should be monitored and reviewed in the annual strategic review.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Establish Ottawa HIV Coalition
OCCA Adopt Plan
Plan Transition
Secure Secretariat Resources and Begin Search for Implementation Resources
Founding organizations and champions sign on
First Meeting of Coalition
Plan Implementation
Joint Action Teams develop action plans
Coalition sets priorities for Years 1 and 2
Coalition seeks key resources for years 1 and 2
Coalition undertakes policy initiatives
Annual Progress Review

**Figure 14**

# *Appendix A: Summary of Information-Gathering for OCCA Strategic Plan*

PREVENTION-RELATED

| *Objective / Target* | *Vision Ideas (from April 30th and key informant discussion)* | *Strengths, Opportunities, Challenges (from focus groups and key informant discussions and selected literature)* | *Ideas for Moving Forward (from focus groups and key informant discussions)* |
|---|---|---|---|
| **Prevent-ion with Youth** | HIV/AIDS prevention education for all youth (youth generally being defined up to age 25) starting no later than grade 5-6 that includes: skills in negotiating sex issues within a relationship, helping them to generally feel good about themselves and their future<br><br>*Key Messages*<br>▸ Integrate HIV/ AIDS education as part of general safety & prevention messages reinforced everywhere i.e. home, media, school to engage youth in less risky behaviour generally<br>▸ Use positive messages and emphasize benefits. Avoid "don't do this" | ***Strengths / Opportunities***<br>▸ – can integrate with teen pregnancy prevention initiative (multi-agency initiative with City Community Services, Young Single Parent Support Network (YSPSN), Planned Parenthood, and other partners)<br>▸ Youth Net – consolidating national networks. Can open doors across the country.<br>▸ Popcorn Group of youth-serving agencies provides a gateway to all non-profit organizations in Ottawa working with youth<br>▸ Youth Services Bureau – Rainbow Youth Group and services for gay and questioning youth; web site for GLBTQ youth<br>▸ PTY: weekly drop-in for GLBTQ youth out of Pink Triangle Services<br>▸ Information available on the web e.g. www.aidsida.ca<br>▸ Make youth part of solution: peer-to-peer influence is powerful; peer education empowering<br>▸ Offer recreation programs: become too focused on problems and forget to offer something wonderful<br>▸ lots of pamphlets and condoms works – they need to be in places where youth hang out.<br>▸ Schools: HIV/AIDS week, AIDS educators<br>▸ Evidence reviewed by McKay from various North American evaluations of interventions to increase HIV preventive behaviours found:<br>o Abstinence based interventions have not been shown to be effective<br>o School-based programs shown to work: e.g.<br>▪ *Reducing the Risk* (includes social skills, role plays, and encouragement of discussion with parents) Kirby et. al 1991<br>▪ *Safer Choices* ( 5 components: school health promotion council, curriculum and staff dev't, Safer Choices peer team or club, parent education including newsletter, and school-community links to access services, and 10-lesson curriculum and school-wide peer sponsored events) Coyle et. al. 1999<br>▪ Grade 6 and 7 students – 8 one hour classes, based on social cognitive | ▸ City-wide youth strategy: Build support within City of Ottawa for youth agencies working together in a coordinated way via a broad youth development strategy. Working together means sharing tools and resources more effectively, planning better.<br>▸ Link OCCA with other youth initiatives to incorporate HIV prevention messages<br>▸ Provide sensitivity training for teachers (and anyone working with youth) re. homophobia, creating a welcoming environment/safe places for youth<br>▸ Include GLBTQ in school sex education.<br>▸ Use peer-based |

| *Objective / Target* | *Vision Ideas (from April 30th and key informant discussion)* | *Strengths, Opportunities, Challenges (from focus groups and key informant discussions and selected literature)* | *Ideas for Moving Forward (from focus groups and key informant discussions)* |
|---|---|---|---|
| | messages – youth are rebellious and find it cool to do the "don't" things<br><br>*Delivery of Key Messages*<br>▸ Message giver as important as the message<br>▸ Use impacted youth to counter the "this won't happen to me" attitude<br>▸ Deliver via school-appropriate and youth-appropriate materials<br>▸ Use resources that are in with "pop culture" | theory, reasoned action, planned behaviour; skill dev't; use of group discussions, videos, games, brainstorming, experiential exercises and skill building – -- demonstrated positive outcomes Jemmott, Jemmott and Fong (1998)<br>o Programs shown to work with Street Youth<br>▪ Difficult to evaluate, but well-developed intensive programs can be behaviourally effective. However "HIV prevention strategies will only be successful when street youth are provided with long-term and stable living environments." Walters 1999<br><br>***Challenges***<br>▸ Majority of young adults in Canada have their first experience of sexual intercourse during teenage years (Maticka et. al. 1997, 2000)<br>▸ Consistency of condom use is sporadic and well below what would be needed for optimal prevention of STIs (Fisher and Boroditsky 2000)<br>▸ Rates of STIs are highest among teens and young adults – prevalence of HIV is currently relatively low – but could experience increase (Health Canada 1999)<br><u>Schools</u><br>▸ School curriculum – frustrating to work with, success very teacher and Principal dependent<br>▸ Alternative schools are key<br>▸ No sex ed in schools for GLBTQ – only for straight people. School environment may be perpetuating homophobia.<br>▸ Public School Board in crisis due to persistent cut-backs<br>▸ Need to stop focusing only on schools for delivering education/ messages. Schools – very expensive to train teachers & end up with piece-meal approach. Need to surround youth with messages everywhere, outside of schools.<br>▸ Youth agencies are overwhelming schools with requests (eg. teen pregnancy, drunk driving, tobacco, STD's, GLBTQ issues, connection between behaviour and drugs). Need to develop a | education and involve youth in program development and delivery as much as possible. Involve youth in designing literature/materials.<br>▸ Accessible "one-stop shopping" drop-ins offering a broad-base of services eg. health, recreation, employment, housing, welfare<br>▸ Offer education and needle/equipment exchanges for safer tattoo and body piercing; steroid use<br>▸ Public education via media – raise awareness, reinforce safety/prevention messages<br>▸ Hand out "rave cards" with information<br>▸ Contact cards with numbers for free condoms and |

| *Objective / Target* | *Vision Ideas (from April 30th and key informant discussion)* | *Strengths, Opportunities, Challenges (from focus groups and key informant discussions and selected literature)* | *Ideas for Moving Forward (from focus groups and key informant discussions)* |
|---|---|---|---|
| | | coordinated approach.<br>▸ Reaching and educating parents, particularly of children from ethno-cultural groups who won't allow their children to participate in sex ed. Sex ed is proven to encourage/promote better choices and delay onset of sexual activity not the opposite, which some parents think.<br>***Community***<br>▸ Reaching youth not in school via accessible drop-ins eg. in shopping malls, signs at bus stops N.B. Model of "The Door" in New York City; Offering many services at one location ("one stop shopping") -- not STD clinics so everyone will know<br>▸ Reaching GLBTQ-questioning youth, countering homophobia<br>▸ Reaching street-involved and/or youth Sex Trade Workers via cultural affinity-appropriate services eg. later hours<br>▸ Need for safer tattooing and body piercing – many youth doing themselves with non-sterile needles/ equipment<br>▸ Piercing and tattooing, particularly self-administered, is a source of risk<br>▸ Injection of Steroids -- a risk among body builders<br>▸ Mental health services: helping build an appropriate social support network not about professionals for youth disenfranchised from their families<br>▸ Stop working in "silos" – no one knows what anyone else is doing, it's inefficient<br>▸ Funding – lack of sustainability; a lot of "one shot" programs with no continuity<br>▸ More young men and women in the sex trades – need outreach, education specific to them – vulnerability is very high | information |

PREVENTION-RELATED

| *Objective / Target* | *Vision Ideas (from April 30th and key informant discussion)* | *Strengths, Opportunities, Challenges (from focus groups and key informant discussions and selected literature)* | *Ideas for Moving Forward (from focus groups and key informant discussions)* |
|---|---|---|---|
| **Prevention with Gay men** | Gay men need to be explicitly back on the agenda | ***Strengths/ Opportunities***<br>▸ For young gay men: YSB - lots of pamphlets and condoms. It works. PTY - doing a lot of HIV protection and awareness – related to PTS.<br>▸ Gay info-line – can give people info about stuff<br>▸ Gay Pride Parade – handing out "out of the blue" condoms<br>▸ Ad campaigns in Toronto and Montreal<br>▸ GLBTQ Community Centre being planned for Ottawa in future<br>▸ Evidence about Best Practices<br>o Face-to-face individual-focused interventions:<br>▪ *Extending beyond HIV Education alone:* small group (btw 1 and 12 sessions) shown to increase safer sex (from 23% to over 77% ,Kelly et. al 1989; from 35% to 80% Valdiserri et al 1989; 9 hour intervention (3 3-hour sessions) for African American gay men reduced unprotected anal intercourse by half) : skills: condom use, sexual assertiveness and negotiation, self-management training – triggers to risky sex, cognitive self-guidance and self-reinforcement; linking HIV themes to pride, self-respect and responsibility to protect self and others.<br>***Challenges***<br>▸ Rates of STIs are increasing (e.g. gonorrhoea) among men, indicating a drop-off in the use of safer sex (City health department statistics)<br>▸ Misconceptions and lack of knowledge regarding degrees of risk.<br>▸ Attraction of bad boys. Bare-backing, bug chasers. Unsafe sex is dangerous and therefore viewed as worth trying.<br>▸ Everything geared toward youth and pretty boys. Nothing in bar scene for middle-aged men. | ▸ Wellness Strategy for gay men. Part of a community development model for gay men developed by gay men. Health & social services for gay men.<br>▸ Make safer sex "sexy." Eroticise safer sex activities. Make condoms sexy – part of sex play. Make oral sex the "in thing"?<br>▸ Gay sex education in schools<br>▸ Bars: Messages back out to bars. Bar owners should take responsibility for safe sex messages and advertisements, basket of condoms should be visible. Individuals should go around to bars and give safe sex info (N.B. Model Electric Dreams Foundation in U.S.?)<br>▸ Bath houses – should have ads in washrooms<br>▸ Park/Bath House Outreach<br>▸ Money into vaccine<br>▸ More ad campaigns like in Toronto and Montreal – "in your face" campaigns. Convince federal government to come out with another commercial like the anti-racism campaign.<br>▸ Personal responsibility<br>▸ Young gay men:<br>▸ info on oral sex, and type and level of risks associated with.<br>▸ Literature should talk about choices and personal responsibility not consequences – don't preach. |

| *Objective / Target* | *Vision Ideas (from April 30th and key informant discussion)* | *Strengths, Opportunities, Challenges (from focus groups and key informant discussions and selected literature)* | *Ideas for Moving Forward (from focus groups and key informant discussions)* |
|---|---|---|---|
| | | ▸ Vaccine reports lead people to think they can have unsafe sex.<br>▸ False sense of security when new meds came out. Know people taking them who look pretty good. People need to know about side-effects.<br>▸ Safe sex fatigue for people in their 40's.<br>▸ Practicing unsafe sex "proof" of being a couple. Innate trust. Condoms are a temporary arrangement.<br>▸ No condom bowls or safe sex messages in gay bars.<br>▸ Lack of lubes and condoms at Bath Houses ("condoms need lube!")<br>▸ People aren't talking about HIV anymore.<br>▸ No connection between community members. "Lots of screwing but not much love" | ▸ People need to know what it's like taking meds – the "wonder drugs" are not nice |

PREVENTION-RELATED

| *Objective / Target* | *Vision Ideas (from April 30th and key informant discussion)* | *Strengths, Opportunities, Challenges (from focus groups and key informant discussions and selected literature)* | *Ideas for Moving Forward (from focus groups and key informant discussions)* |
|---|---|---|---|
| **Prevention with Immigrants and Refugees** | HIV/AIDS prevention education for individuals within ethno-cultural communities.<br>Prevent Mother/child transmission<br>***Key Messages***<br>▸ Focus group testing to find out what cultural affinity-appropriate messages will "click" (eg. condom training for women that they found offensive – example of inappropriate message).<br>▸ Find indirect ways to address taboo subjects without offending<br>***Delivery of Key Messages***<br>▸ Sensitivity important – talking about HIV and sexuality not like talking about nutrition, Give people choices/variety in where they get messages<br>▸ Incorporate HIV/AIDS as part of general messages to make it easier to move through school system and reach men<br>▸ Resource list of community members who speak different languages and can deliver messages eg. list of trained cultural interpreters<br>▸ Training men to reach men in more informal settings | ***Strengths***<br>▸ The Source – do a lot of phone work (more anonymous), home visits. Find more creative ways to reach people anonymously eg. internet<br>▸ CKCU and smoking cessation education for Somalian community (Carlington CHC).<br>▸ HIV-endemic countries developing solutions -- bring here what works<br>▸ Initiatives to prevent mother/child transmission e.g. new CMA policy adopted<br>***Challenges***<br>▸ Denial amongst some ethno-cultural groups community groups that there is an HIV problem. Offer no HIV/AIDS support services. Individuals needing help are often very isolated within their communities<br>▸ Reaching and educating parents from ethno-cultural groups who won't allow their children to participate in sex education. Often it is men who will not support this. Help them understand that sex education is proven to encourage/ promote better choices and delay onset of sexual activity not the opposite, which they think. Offer alternative educational presentations eg. theatre. Incorporate HIV as part of general safety/prevention messages.<br>▸ Highest rate of maternal/child transmission<br>▸ Lack of power women have in relationships relative to men – women unable to negotiate sex<br>▸ How to reach men from ethno-cultural communities? eg. via Somali men's fathering group<br>▸ Current prevention mandate at agencies might not get addressed because they are just trying to meet clinical demands (eg. OASIS)<br>▸ All ism's affect HIV eg. racism, prejudice.<br>▸ Housing and financial issues | ▸ Training for cultural interpreters and other message givers such as Healthy Baby, Healthy Children workers<br>▸ Work through paid peer educators, using the Healthy Baby, Healthy Children approach<br>▸ Physician awareness and training, particularly physicians who have high #'s of immigrant and refugee families from endemic areas<br>▸ Develop more creative ways to reach people anonymously eg. more phone work, internet<br>▸ Bring here what works in HIV-endemic countries<br>▸ Engage community leaders of ethno-cultural groups.<br>▸ Educate new families entering the countries<br>▸ Promote testing to prevent mother/child transmission -- engage fathers in this as well as mothers |

| *Objective / Target* | *Vision Ideas (from April 30th and key informant discussion)* | *Strengths, Opportunities, Challenges (from focus groups and key informant discussions and selected literature)* | *Ideas for Moving Forward (from focus groups and key informant discussions)* |
|---|---|---|---|
| | | | |

PREVENTION-RELATED

| *Objective / Target* | *Vision Ideas (from April 30th and key informant discussion)* | *Strengths, Opportunities, Challenges (from focus groups and key informant discussions and selected literature)* | *Ideas for Moving Forward (from focus groups and key informant discussions)* |
|---|---|---|---|
| **Harm Reduction aimed at People who inject drugs and sex trade workers** | IDU's have access to and use clean sterile equipment and practice safe sex<br>Comprehensive policies for drug alternatives in jails | ***Strengths/ Opportunities***<br>▸ Some services in place e.g. NEP, Site van, Oasis, many outreach workers, sexuality clinic with the City – located in downtown core<br>▸ Many creative education programs out there e.g. New York competition for getting a condom of a crack pipe<br>▸ Harm Reduction Models: Somerset CHC, OASIS, Amethyst House, Rideauwood (through CAMH)<br>▸ Best Practices evidence<br>o Large scale community-level HIV/STI Prevention Interventions:<br>▪ CDC multi-year five city trial focused on active drug users, female sex partners of male IDUs, female sex trade workers, high risk youth, non gay MSM, and residents where STI rates were high; (1999); Intervention included: small media materials (newsletters, pamphlets, baseball cards) using role model stories; peer outreach using media materials; increased availability of condoms and bleach kits. Showed impact on increasing safer sex and drug use.<br>▪ Women living in housing projects (Sikkema et al 2000): popular opinion leaders recruited as peer educators; risk reduction workshops offered – with reward ($15) for participating; information and skill dev't. Community educational events – with music and pot luck dinner as well as speakers. Impact – increase in condom use and negotiation among women, higher if attended more than one session.<br>o Harm Reduction<br>▪ Common interventions include: needle exchange and/or distribution, substitute drug treatment e.g. methadone; supervised injection sites, drug user education and outreach. To be successful, drug education | ▸ Need for an effective public education campaign to get wider and more vocal support for more extensive harm reduction<br>▸ Decriminalization of drug use and solicitation would make harm reduction more acceptable and would result in less marginalization of people using drugs and working in sex trade<br>▸ Education re: sterile needle use and safe sex among IDU's<br>▸ More accessible needle exchange – 24/7; expand access to clean equipment<br>o Increase friendliness<br>o Decrease restrictions<br>▸ Peer education and support groups e.g. VANDU<br>▸ Need to address system changes<br>▸ Retractable needles?<br>▸ Review and reconsider "barring" policies<br>▸ Clean "rigs" in pharmacies<br>▸ More Safe Rooms where people inject under medical supervision?<br>▸ Training with service providers on need to discuss safe sex<br>▸ Honorarium "just to live" |

| *Objective / Target* | *Vision Ideas (from April 30th and key informant discussion)* | *Strengths, Opportunities, Challenges (from focus groups and key informant discussions and selected literature)* | *Ideas for Moving Forward (from focus groups and key informant discussions)* |
|---|---|---|---|
| | | must be multi-faceted and include following components (UNAIDS 1998)<br>• Education for drug users and their sex partners on HIV and other blood-borne pathogens<br>• Training in skills<br>• Access to sterile injection equipment<br>• Access to condoms<br>• Treatment programs to help user cut down or stop<br>• Information and education to stop the demand for injection drugs.<br>▪ Needle exchange has been shown to reduce HIV infection rates among IDUs without encouraging or increasing illicit drug use Treatment and other interventions should offer a range – including "low threshold" programs that don't require abstinence<br>***Challenges***<br>▸ Access to detox and treatment is limited<br>▸ General public doesn't understand harm reduction and its effectiveness – there's a vocal minority of citizens who are concerned about needles in parks who are influencing the policy in Ottawa<br>▸ Site Van and Needle Exchange programs only reaching a sub-group within the population of those using injection drugs<br>▸ Barring policies prevent IDUs from getting access to support in some facilities<br>▸ High rate of HIV and Hep C with IDU's<br>▸ Denial remains a problem<br>▸ Sharing of equipment with partner(s) = intimacy<br>▸ Volatility of cocaine users<br>▸ The effectiveness of education as a means of prevention is limited due to volatility of cocaine addiction – harm reduction needs to use alternative approaches<br>▸ Needs to be addressed as a health issue not a morality issue. | ▸ Sensitivity training for managers, supervisors, social workers, etc<br>▸ Peer Outreach<br>▸ Mainstream and street outreach<br>▸ Target kids not just addicts and gays – more money for keynote speakers in classrooms |

| *Objective / Target* | *Vision Ideas (from April 30th and key informant discussion)* | *Strengths, Opportunities, Challenges (from focus groups and key informant discussions and selected literature)* | *Ideas for Moving Forward (from focus groups and key informant discussions)* |
|---|---|---|---|
| | | ▸ Need more detox/rehab beds, preventative detox, in-house medical beds, supportive follow-up<br>▸ Fear of quitting because there is "nothing to help you stop gently."<br>▸ Can't afford meds to get off the drugs<br>▸ Need follow-up to initial treatment and transitional housing -- ¾ or half-way houses<br>▸ More support for IDU's in jail<br>▸ Need to do more with people knowingly spreading the disease<br>▸ Need life-skills education (nutrition, budgeting) | |

PHA WELLNESS-RELATED

| *Goal 2: Objective / Target* | *Vision Ideas (from April 30th)* | *Strengths, Opportunities, Challenges (from focus groups and key informant discussions and selected literature)* | *Ideas for Moving Forward (from focus groups and key informant discussions)* |
|---|---|---|---|
| **General – Grow Services for People with HIV at that Same Rate as the Size of HIV+ population grows** | ▪ Funding for programs and services extended to meet the needs of people living HIV<br>▪ Increase community and political awareness of the needs for services<br>▪ Community services providers linked and coordinated to provide services | *Strengths/ Opportunities*<br>▸ Network of services are well-linked through OCCA<br>▸ Excellent treatment services in Ottawa with skilled and dedicated practitioners<br>▸ Range of support services – innovation in the sector<br>▸ People who work in this area really "care"<br>***Challenges***<br>▸ Organizations working with PHAs are facing high growth in demand;<br>▸ burn out in staff is common – with low salaries in sector<br>▸ unevenness of funding, e.g. Bruce House relies primarily on fund-raising for service provision<br>▸ Don't have reliable system of counting # of people who are HIV positive in Ottawa<br>▸ All PHAs, over time, face challenges of living with a long-term illness that extends to many areas of their lives: physical, financial, psycho-social, vocational, housing, spiritual<br>▸ There is a growing sub-population living with HIV who have more complex health and social needs e.g. concurrent disorders: addiction and mental illness – they need a lot of support to maintain treatment;<br>▸ Facing new and different treatment issues e.g. Long term complications, resistance<br>▸ Housing crisis exacerbates risk – leads to even more instability in the lives of PHAs, many of whom have very limited incomes<br>▸ There is a growing demand for crisis services, taking away professionals' time for other kinds of support | ▸ OCCA lobby for formula for increasing funding to programs and services<br>▸ Broad based community awareness campaign re: need for ongoing and long term support for people living with HIV<br>▸ Extend services by engaging practitioners and support services beyond ASO's in supporting people with HIV as appropriate to the sub-group<br>o Educate service providers<br>o Coordinate services<br>o Promote what services exist to public and other service providers |

PHA WELLNESS-RELATED

| Goal 2: Objective / Target | Vision Ideas (from April 30th) | Strengths, Opportunities, Challenges (from focus groups and key informant discussions) | Ideas for Moving Forward (from focus groups and key informant discussions) |
|---|---|---|---|
| ***Earlier diagnosis*** | HIV +ve people receive testing earlier and enter system of treatment and support within __ time of infection<br><br>Leverage "prompts to seeking" testing<br><br>Mitigate "hindrances to seeking" testing | ***Strengths/ Opportunities***<br>▸ Anonymous testing available in many different sites<br>***Some Prompts to Seek Testing:***<br>▸ Encouragement from friends<br>▸ After a scary incident eg. being date-raped<br>▸ After having unprotected sex<br>▸ Entering a serious relationship<br>▸ Curiosity<br>▸ Current or past partner, or someone you've slept with tests positive<br>▸ Good rapport with Family Doctor – suggests battery of tests<br>▸ Showing indicative symptoms<br>▸ Right of passage<br>▸ Body piercing, tattooing<br>▸ Want to have children (more for straight people)<br>▸ Got tested in jail<br>▸ Lifestyle<br>▸ Careless drug use<br>▸ People around you get stuff, makes you think twice<br>▸ I went in for something else but got checked anyhow<br>▸ Found out when donating blood<br>▸ After a workshop or discussion on HIV/AIDS – become paranoid, "scared shitless"<br>▸ Awareness campaigns and outreach to get tested<br>***Challenges***<br>▸ Accuracy of testing and time lag in getting results<br>▸ Anonymous testing run by volunteers – issues around resourcing and confidentiality<br>▸ Some people (small minority) react to the news that they're HIV+ with anger and sometimes the reaction includes a desire to infect someone else – "Someone did this to me – I'm gonna do it to someone else". | ▸ Increase options and choice for testing<br>▸ Targeted awareness programs re: need for testing<br>▸ Physician training |

PHA WELLNESS-RELATED

| *Goal 2: Objective / Target* | *Vision Ideas (from April 30th)* | *Strengths, Opportunities, Challenges (from focus groups and key informant discussions)* | *Ideas for Moving Forward (from focus groups and key informant discussions)* |
|---|---|---|---|
| | | ***Some Hindrances to Seeking Testing:***<br>▸ *"It* won't happen to me" (invincibility, denial)<br>▸ Without good treatment or cure, why bother<br>▸ Mandatory reporting, especially if you travel to U.S. (they won't let you into the country)<br>▸ They can open your medical records in Ontario<br>▸ Financial consequences; life insurance<br>▸ Get thrown in jail if you infect someone when you know – if you don't know doesn't apply (Health Dept's fault)<br>▸ Closeted gay male probably wouldn't get tested<br>▸ May be seen in clinic by someone you know (friends/family), fear and embarrassment<br>▸ Scared of/don't like blood tests<br>▸ Hate waiting for results – fearful time<br>▸ Difficult to find time and place<br>▸ Don't know where to go to get tested<br>▸ Fear of parents finding out<br>▸ Bug chasers – don't want to take action against virus<br>▸ Fear of rejection from friends/family if positive<br>▸ Finding out you're positive takes over your lifestyle – "if I knew what I know now I would not have gotten tested"<br>▸ "I'll get tested once I get cleaned up."<br>▸ In a monogamous relationship | |

PHA WELLNESS-RELATED

| ***Goal 2: Objective / Target*** | ***Vision Ideas (from April 30th)*** | ***Strengths, Opportunities, Challenges (from focus groups and key informant discussions)*** | ***Ideas for Moving Forward (from focus groups and key informant discussions)*** |
|---|---|---|---|
| ***Increase Capacity for Cultural affinity-appropriate Services to Gay men*** | Cultural affinity-appropriate services, providers and settings and confidentiality and privacy | *Strengths/ Opportunities*<br>▸ GLBT community centre being discussed – could be a portal for service access<br>▸ PTS has foundation that could be strengthened as a host for service provision<br>▸ Some CHCs and CRCs have good track record of gay positive service provision (CCHC, Western Ottawa, Nepean,); Centretown CHC embarking on strategic planning over next year<br>▸ Sexual health centre looking at gay men's strategy<br>▸ gay-friendly network of primary care physicians and specialists<br>▸ Ottawa Police Liaison Committee "bending over backwards" for gay community<br><br>*Challenges*<br>▸ No central information centre – where to go for what<br>▸ Not enough services specifically for infected gay men<br>▸ General Hospital works well but over-taxed<br>▸ Certain organizations lack qualified staff<br>▸ Automatic assumption by service providers that we are drug users, therefore no pain relief.<br>▸ Lack of staff to return calls regarding drugs.<br>▸ Difficulty seeing doctor/specialists – maybe cutbacks to staff, medical services? Unavailability of Dr. for repeats on prescriptions.<br>▸ Need more GP's specializing in AIDS<br>▸ Alternative medicines and therapies difficult to obtain<br>▸ People not really interested -- burnout<br>▸ Hours of service being shortened (ACO/Living Room) – not a drop-in centre anymore. Why did services decrease – lack of money, lack of volunteers (difficulty with becoming a volunteer)<br>▸ ODSP/Trillium: no one who seems want or know how to help, needs to be improved; why does it take so long? | ▸ Amalgamation of services under one roof -- would save everyone time and energy eg. Toronto and Vancouver. Centralize things, cooperation between agencies; more coordination and less duplication eg. AIDS Committee in Winnipeg are over everything – Ottawa needs that approach.<br>▸ More funding – cutbacks hurt us<br>▸ ODSP: cost of living has increased but ODSP has not. Getting poorer and poorer.<br>▸ More education for workers at organizations and associations (shelters) on dealing with PHA's<br>▸ More housing for PHA's<br>▸ Vocational rehabilitation services<br>▸ Support groups for people at different stages<br>▸ Someone to organize social opportunities eg. summer |

PHA WELLNESS-RELATED

| *Goal 2: Objective / Target* | *Vision Ideas (from April 30th)* | *Strengths, Opportunities, Challenges (from focus groups and key informant discussions)* | *Ideas for Moving Forward (from focus groups and key informant discussions)* |
|---|---|---|---|
| | | ▸ Lack of professional counselling services – bureaucratic problems with ODSP/Trillium<br>▸ Food bank that recognizes nutritional needs of PHA's<br>▸ Need different support groups for people at different stages<br>▸ Getting back to work: Bureaucratic barriers to i.e. rules with CPP, ODSP, etc<br>▸ Finding people to help you work again, getting a job<br>▸ Discrimination/homophobia<br>▸ Social opportunities | camps<br>▸ Massage services – add or increase<br>▸ Increase alternative medicines and therapies offered either free or at a reduced rate<br>▸ Offer a "drug bank" (like a food bank) – for bridging to help when finances running low |

PHA WELLNESS-RELATED

| Goal 2: Objective / Target | Vision Ideas (from April 30th) | Strengths, Opportunities, Challenges (from focus groups and key informant discussions) | Ideas for Moving Forward (from focus groups and key informant discussions) |
|---|---|---|---|
| ***Immigrants and refugees*** | Cultural affinity-appropriate services, providers and settings and confidentiality and privacy<br><br>Provision of cultural affinity-appropriate confidential and private services for immigrants & refugees that they can and will access. | *Strengths/ Opportunities*<br>▸ The Source – do a lot of phone work (more anonymous), home visits. Find more creative ways to reach people anonymously eg. internet<br>▸ Waiting room design changes at clinics for erectile difficulty – created totally private waiting areas for individuals<br>▸ CHEO pre-adolescent support group<br>▸ Prefer multi-service centres for confidentiality and anonymity. Will not use any service labelled as for HIV, and prefer places where they won't run into members of their community. Involves working more with professionals who are generalists (eg. family physicians). CHC's in a good position for this – are well-placed to reach a lot of people (are already doing anonymous testing, health promotion, have settlement workers)<br>*Challenges*<br>▸ Engaging community leaders (rabbis, imams) – denial amongst ethno-cultural community groups that there is an HIV problem. Offer no HIV/AIDS support services. Individuals needing help are often very isolated within their communities.<br>▸ Seeking out services at multi-service centres will mean more provided by Generalists (eg. Family Physicians) – need to increase their knowledge and comfort working with HIV<br>▸ Find out where groups are getting their info. What media do they listen to, watch?<br>▸ Child care, transportation to access services – barriers to accessing services particularly for women<br>▸ "Hit and miss" attempts to reach out (eg. OASIS) --not sustainable, may be due to lack of funding, lack of volunteers (many support & respite services are volunteer driven). Agencies are already stretched and can't take on a new program.<br>▸ Confidentiality/anonymity issues when volunteers involved<br>▸ Gaps in services in suburbs and rural areas | ▸ Develop more creative ways to reach people anonymously eg. phone, internet. Offer flexibility in some services to protect confidentiality eg. pharmacy delivers in plain paper bags with no logo.<br>▸ Offer practical supports to access services eg. child care, transportation<br>▸ Train family physicians, cultural interpreters, and other generalists, so they feel more comfortable with HIV/AIDS issues. Create Resource List of these people.<br>▸ OCCA- identify and engage community leaders from ethno-cultural communities.<br>▸ OCCA – focal point for sharing strategies from HIV-endemic countries. |

PHA WELLNESS-RELATED

| ***Goal 2: Objective / Target*** | ***Vision Ideas (from April 30th)*** | ***Strengths, Opportunities, Challenges (from focus groups and key informant discussions)*** | ***Ideas for Moving Forward (from focus groups and key informant discussions)*** |
|---|---|---|---|
| | | ▸ Testing: fear of deportation by immigration if positive, fear of rejection by family<br>▸ Power issues between men and women – difficulty discussing intimate issues such as safe sex | |

PHA WELLNESS-RELATED

| ***Goal 2: Objective / Target*** | ***Vision Ideas (from April 30th)*** | ***Strengths, Opportunities, Challenges (from focus groups and key informant discussions)*** | ***Ideas for Moving Forward (from focus groups and key informant discussions)*** |
|---|---|---|---|
| ***People with multiple needs including affected family members*** | Cultural affinity-appropriate services, providers and settings and confidentiality and privacy | *Strengths/ Opportunities*<br>▸ Existing programs e.g. OASIS, Bruce House, outreach work with sex trade workers, Wabano CHC HIV prevention programs<br><br>*Challenges*<br>▸ Increase in concurrent disorders and health and social problems<br>▸ Need for support groups for aboriginal persons with HIV (men)<br>▸ Support and services before HIV treatment<br>▸ Navigating the system and following treatment regime<br>▸ women are not seen as at risk<br>o There is a rise in the rate of HIV infection among heterosexual women<br>o more women using emergency shelters<br>o Often ignorant of their own anatomy and risk<br>o Not enough research done on women<br>▸ the needs of "affected" children, families, significant others are often not recognized – need housing, respite, and counselling around developmental stages, disclosure, sexuality, etc<br>▸ Powerlessness / vulnerable group | ▸ Case management<br>▸ Addictions support and treatment services<br>▸ Harm reduction approaches<br>▸ Case management to help navigate the system<br>▸ Address long term treatment issues e.g.<br>o Bridge funding for meds etc.<br>o Resistance<br>o Side-effects<br>o Return to work<br>o Housing<br>o Disclosure<br>▸ Increase home support and buddy programs |

STRATEGIC LEADERSHIP RELATED

| *Objective / Target* | *Vision Ideas (from April 30th)* | *Strengths, Opportunities, Challenges (from focus groups and key informant discussions)* | *Ideas for Moving Forward (from literature, focus groups and key informant discussions)* |
|---|---|---|---|
| ▪ **Host organization**<br>▪ **Enhance capacity for strategic and operation system coordination, planning, education of decision makers and public information**<br>▪ **Stimulate community Action** | ▸ Solidify and expand partnerships<br>▸ System planning and accountability<br>▸ Coordination of services and funding<br>▸ Play strong policy development<br>▸ Increased public awareness<br>▸ Funding | *Strengths / Opportunities*<br>▸ Excellent Interagency coordination exists and partnerships<br>▸ Have put an end to "turf wars"<br>▸ Collective voice<br>▸ Local leaders<br>▸ In position of influence for HIV service planning and implementation<br>*Challenges*<br>▸ rapidly changing conditions<br>▸ lack of political support<br>▸ some duplication in services<br>▸ not an entity known by all | ▸ maintain a position of neutrality and have a capacity building focus but not become a funder or provider of programs<br>▸ Negotiate members' and their organizations' commitments - honest broker membership means entering into implicit accountability for actively working towards HIV goals and to one another<br>▸ Keep prevention in the forefront<br>▸ Information sharing role important<br>▸ Secure funding and resources in order to<br>o Advocate<br>o Create local innovative hard hitting campaign<br>o Link with national and provincial strategies<br>o Solidify and increase partnerships<br>o Maintain lead role in system planning and accountability<br>o Co-ordinate inter-organizational initiatives<br>o Seek funding and resources on behalf of members, where appropriate |

# *Appendix B: Logic Model Overview of Ottawa Coalition on HIV/AIDS Plan, 2003-2008*

*Logic Model Overview of Ottawa Coalition on HIV/AIDS Plan, 2003 - 2008*

| Key Strategy | a) Youth | b) Gay and Bisexual Men | c) Injection Drug Users | d) Immigrants and Refugees | e) Families | f) Women |
|---|---|---|---|---|---|---|
| ***1. Increase Initiatives around Prevention, Harm Reduction and Wellness*** | ***i) Provide all youth with practical HIV prevention and safer sex information***<br>***ii) Provide gay, bisexual and questioning youth with range of supports for self-care, mutual support and mental health:***<br>***iii) Increase gay-friendly environment of schools and youth-serving programs*** | ***i) HIV Prevention and PHA Support as part of Wellness Strategy for Gay men***<br>▸ Social marketing and peer-based targeted prevention and early detection initiatives developed and annually refreshed with youth, young gay and bisexual men, adult men and HIV positive gay men<br>▸ Expand case management and mutual support capacity for gay PHAs as part of overall gay men's wellness strategy | Harm Reduction<br>i) ***Public education*** and policy work regarding value of harm reduction to Increase public understanding of value of harm reduction<br>ii) Expansion of needle exchange<br>iii) Addictions stabilization expansion<br>iv***)*** Policy Development<br>▸ Expand affordable Independent and supported housing options<br>▸ Case management for chronically homeless<br>▸ Decriminalization of drug use<br>▸ Maintain SCPI resources that support IDUs in maintaining housing and maintaining compliance with HIV treatment<br>▸ Maintain Inner City Health Program for HIV+ homeless population<br>▸ Other harm reduction policies (eg. Decriminalization and supervised injection sites) | ***i) Community Development:*** Develop strategies for reaching immigrant and refugee communities (families, men, women and youth) through community development approaches that build on lessons learned from international experience<br>***ii) HIV/AIDS support service integration:*** Integrate HIV/AIDS support services for PHAs with general family wellness support with organizations already effectively reaching target communities<br>***iii) Expanded Case Management:*** Increase case management resources with specialization in HIV/AIDS within key CHCs or immigrant service organizations | ***i) Counselling and Case Management:*** Increase counselling and case management services for families affected by HIV<br>***ii) Policy work***<br>▸ With child welfare regarding how families with HIV positive parents are supported<br>▸ Increase appropriate affordable housing for families affected by HIV | ***i) Gender-Appropriate Strategies:*** Develop gender-appropriate prevention and PHA support strategies for heterosexual women, IDUs, Immigrants and Refugees and for general population<br>ii) ***Case Management and Mutual Support:*** Develop PHA mutual support group for women, as interest arises<br>***iii) Monitor trends*** - HIV in heterosexual women<br>i***v) Education*** |

***Strategy 2. Extend Capacity of Local Service System to Implement:***
***i) Adapt Programs and Services to be "Cultural-Affinity Appropriate and Expand Engagement of Organizations***
***ii) Increase Prevention and Service Capacity***
***iii) Enable and monitor adjustments to service system and provide capacity development support to organizations***

***Strategy 3. Create the Ottawa Coalition on HIV/AIDS***
i) ***Restructure*** OCCA to create Ottawa Coalition on HIV/AIDS

*Logic Model Overview of Ottawa Coalition on HIV/AIDS Plan, 2003 - 2008*

| ***Key Strategy*** | ***a) Youth*** | ***b) Gay and Bisexual Men*** | ***c) Injection Drug Users*** | ***d) Immigrants and Refugees*** | ***e) Families*** | ***f) Women*** |
|---|---|---|---|---|---|---|
| | ii) ***Partners and Champions:*** Key partnering agencies engaged in collaborating on prevention and wellness<br>iii) ***Resources:*** Work with participating agencies to secure required resources<br>***iv) Annual Review:***<br>▸ Work with PHLTC and local researchers to monitor progress on plan<br>▸ Monitor trends in HIV/AIDS and adapt plan as required | | | | | |
| ***Objectives*** | *Youth*<br>▸ All youth have knowledge and skills to practice safer sex<br>▸ Increase popular acceptance of safer sex among youth who are sexually active<br>▸ Increase # of youth understanding of seriousness of HIV/AIDS<br><br>*GBQ Youth*<br>▸ Increased inclusion of GBQ youth in schools and families<br>▸ Increased understanding of HIV prevention and seriousness of infection among GBQ youth<br>▸ Higher percentage of GBQ youth aged less than 30 are practicing safer sex | ▸ Increased rate of HIV positive men are diagnosed within 6 months of becoming infected<br>▸ Decreased rates of substance use and increase in self-care practices (fitness, smoking, safer sex)<br>▸ Increased access to free information and supports for safer sex<br>▸ | ▸ Increased public and policy maker support for harm reduction in Ottawa<br>▸ Increased % of IDUs using clean needles and injection processes<br>▸ Increase % of injection drug users who have access to addictions treatment including methadone maintenance<br>▸ Increase supports for PHAs to maintain self care and wellness<br>▸ Increase % of IDUs who are housed in affordable, stable housing, with supports as needed | ▸ Increased rate of HIV positive individuals are diagnosed within 6 months of becoming infected<br>▸ More pubic support from community leaders for HIV prevention and wellness support for HIV positive individuals<br>▸ Increased use of self-care and prevention practices by both men and women<br>▸ Higher percentage of HIV positive individuals have support needed | ▸ Children of HIV positive parents have extended network of support<br>▸ HIV positive children and affective family members have developmentally-appropriate counselling and support regarding disclosure, sexuality etc.<br>▸ Lower rate of family breakdown due to HIV/AIDS | ▸ More effective and relevant support for women affected by HIV<br>▸ Women vulnerable to HIV infection and PHAs have developed and are practicing more self-care and negotiation skills<br>▸ More women at risk practice self-care and preventive practices |
| ***Longer-Term Impacts*** | ▸ *Higher percentage of those infected receive treatment within first three months of infection*<br>▸ *Increased % of PHAs have supports in place for their wellness; and are practicing self-care effectively*<br>▸ *Reduce # of new HIV infections in Ottawa by 50% by year 2003* | | | | | |

# *Appendix C: A Summary of Harm Reduction Services to Reduce HIV/AIDS Transmission among Injection Drug Users in Ottawa, and Prepare PHAs who are Using Drugs for HIV Treatment*

| **A Summary of Harm Reduction Services to Reduce HIV/AIDS Transmission among Injection Drug Users in Ottawa, and Prepare PHAs who are Using Drugs for HIV Treatment** | |
|---|---|
| ***Existing Harm Reduction Programs and Services for Injection Drug Users*** | ***Gaps and Suggestions (identified through key informant interviews and focus groups)*** |
| Needle Exchange Program co-ordinated by the City Health Department and offered at a number of community sites through 11 partner agencies. | ▸ Need more innovative strategies for needle distribution, e.g. free through pharmacies<br>▸ There has been some opposition to needle exchange programming from local community associations concerned about needles being left in parks etc. where children and community residents may be exposed to them. This has limited the growth of the program<br>▸ Other initiatives that have been suggested for Ottawa: needle distribution through pharmacies, supervised injection sites. |
| The Site Van program – a mobile service that can be accessed through a phone call to provide needle exchange, clean kits, and harm reduction counselling to injection drug users throughout the City. The van only operates during limited evening and weekend hours. | ▸ Should be available 24 hours a day, seven days a week |
| Oasis drop-in, outreach and clinic services for IDUs using a harm reduction approach | ▸ Generally seen to be providing a valuable service; pressure for more support to methadone providers in case management; also to be lead partner in providing full-service methadone clinic that would include addiction support, case management, and medical services. |
| Wabano Centre clinic and outreach services | ▸ Maintain holistic services for Aboriginal people including IDUs |
| Addictions Treatment:<br>▸ Detox programs<br>▸ Limited range of addictions treatment programs using a harm reduction model in working with injection drug users.<br>▸ Methadone maintenance treatment program:<br>o St. Anne's Clinic | ▸ There is a need for more detox programs to help IDUs get off injection drugs<br>▸ There is a waiting list for methadone treatment, and those who are working with IDUs to stabilize note that more capacity to treat need to be available.<br>▸ Physicians note that those who are on methadone or alternative stabilization programs have extensive need for addictions treatment, case management to help with financial support, housing, safety, and other issues. Physicians are burning out dealing with these complex issues without support |

| **A Summary of Harm Reduction Services to Reduce HIV/AIDS Transmission among Injection Drug Users in Ottawa, and Prepare PHAs who are Using Drugs for HIV Treatment** | |
|---|---|
| ***Existing Harm Reduction Programs and Services for Injection Drug Users*** | ***Gaps and Suggestions (identified through key informant interviews and focus groups)*** |
| o University of Ottawa Medical Services<br>o Dr. Lisa Bromley at Sandy Hill Community Health Centre<br>o Some private practice physicians | ▸ A recent study conducted by Kristiansen and Pelude (2001) examined the feasibility of community health centres providing methadone treatment services in Ottawa. It recommended an enhancement of existing methadone maintenance treatment services in Ottawa by engaging CHCs in a two-step approach to implementation.<br>CHCs and the City PHLTC Department are still considering how to implement these recommendations, given no new growth in resources. A working committee is in place to develop an action plan.<br>▸ Rideauwood Addictions Treatment Centre and Somerset West Community Health Centre have collaborated on a proposal for a "drug court" – which, if funded, will provide court-mandated treatment services for those addicted to substances. Part of the treatment offered will be a methadone maintenance treatment service. |
| Medical treatment services for IDUs<br>▸ Inner City Health Project<br>▸ University of Ottawa Primary Care Clinic<br>▸ Community Health Centres<br>▸ St. Anne's Medical Centre<br>▸ Immunodeficiency Clinic, OH – Civic<br>▸ Regional HIV Clinic (OH – General)<br>▸ CHEO immunodeficiency clinic | ▸ There is strain among medical practitioners who are providing services to HIV+ clients who are presenting with multiple issues (addictions, mental illness, multiple physical health issues, social issues – e.g. income) or in crisis, particularly primary care providers. They do not have the time to provide the case management that is required to ensure appropriate treatment of client during periods of instability –<br>▸ Inner City health project is invaluable for the homeless – and should be continued with stable funding. |
| Support Services for HIV+ IDUs<br>▸ Group Supported Housing: | ▸ Multiple issues, complicated often by Hep C and other physical conditions<br>▸ Often recurring crises and lack of stability due to lack of affordable housing, need |

**A Summary of Harm Reduction Services to Reduce HIV/AIDS Transmission among Injection Drug Users in Ottawa, and Prepare PHAs who are Using Drugs for HIV Treatment**

| *Existing Harm Reduction Programs and Services for Injection Drug Users* | *Gaps and Suggestions (identified through key informant interviews and focus groups)* |
|---|---|
| o Bruce House Group Residence for HIV+ people needing support for ADL and/or palliative care<br>o Hospice at Maycourt<br>o Elizabeth Bruyère Palliative Care Unit<br>o Mission Hospice – Inner City Health Project<br>▸ Independent Housing with Community Supports<br>o Bruce House Apartment program<br>▸ SCPI-funded:<br>o Inner City Health Program provides meds supervision and support as well as on-site health monitoring and medical support for homeless<br>o Oasis and Bruce House provide support for medications supervision, case management | for financial assistance, delays in Trillium drug plan approvals, etc.<br>▸ SCPI-funded services should be permanently funded and should grow at the same pace as the HIV + population. Current services are becoming stretched due to growth in HIV+ population<br>Housing and Housing-related Support Services<br>▸ Need more appropriate housing throughout city, not only in social housing<br>▸ Consider supported housing with separate living units with some on-site support such as medications supervision |