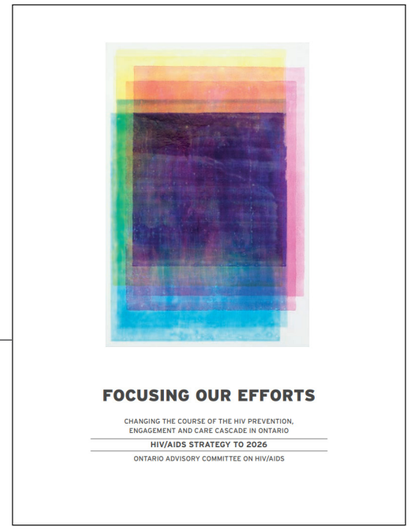
HIV STRATEGY FOR ONTARIO TO 2026

A PROGRESS REPORT

December 2023

ONTARIO ADVISORY
COMMITTEE ON HIV/AIDS



Focusing Our Efforts: Ontario's HIV/AIDS Strategy to 2026, published in 2016, drew design inspiration from Stephen Andrews's Butterfly Effect (2014, oil on Canvas, 60x40 in.) Born in 1956 in Sarnia, Ontario, Canada, the artist says this of the piece: "Among the ideas behind the work is what is commonly known as the 'Butterfly Effect.' It is a theoretical supposition from chaos theory that considers how one small action like that of a mere flap of a butterfly wing can result in wildly differing consequences." This **Progress Report** gratefully continues to take inspiration from and elaborate on this beautiful work and its message.

ONTARIO ADVISORY COMMITTEE ON HIV/AIDS

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PREFACE

Over the past four decades, the world has made amazing progress in stopping HIV. A once-deadly virus is now treatable and preventable.

New testing technologies can detect the virus as early as three weeks after exposure.

People with HIV can be diagnosed faster and immediately linked to care and treatment, which we now know results in better long-term health outcomes.

People at high risk can be linked to preventive treatments, such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), as well as other prevention and harm reduction tools, such as condoms and safer drug use equipment, that can protect against HIV infection.

PrEP is up to 99% effective at preventing HIV when taken consistently, as prescribed.

HIV medications are easier to take, more effective and have fewer side effects.

Treatment suppresses the virus to a level where it is undetectable, which is better for the long-term health of people with HIV and which stops transmission.

Undetectable = untransmittable. People with HIV who are on treatment and virally suppressed cannot pass HIV to their sexual partners.

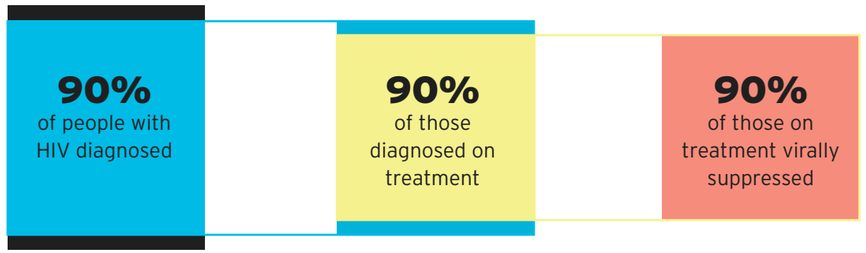
Today, the more than 22,000 Ontarians with HIV can look forward to long full lives, free from the worry of passing the virus to sexual partners – as long as they are diagnosed, on treatment, virally suppressed, and have access to services that meet their other health and social needs.

These dramatic, game-changing advances in HIV prevention, testing and treatment make it possible to plan for the end of the HIV epidemic and a future where all people with HIV have the opportunity to lead healthy lives, free of stigma and discrimination.

OUR TIMELINE

2021

UNAIDS, recognizing the critical role of diagnosis and treatment in preventing and treating HIV, establishes ambitious HIV targets. By 2020, jurisdictions should aim to have:



2022

In 2016, the Ontario Advisory Committee on HIV/AIDS (OACHA) recommends Ontario strive to meet the UNAIDS targets and launches an HIV Strategy for Ontario to 2026, called Focusing our Efforts. The OACHA strategy sets out five goals that integrate the UNAIDS diagnosis and treatment targets into a holistic approach to the health needs of people with or at risk of HIV:

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

2023

In 2021, UNAIDS revisits its HIV targets. By 2025, jurisdictions should aim to have:

- 95% of people with HIV diagnosed
- 95% of those diagnosed on treatment
- 95% of those on treatment virally suppressed

ONTARIO'S VISION

By **2026**, new HIV infections are rare and all people with HIV have access to a long, full life free of stigma and discrimination.

Seven years into the HIV Strategy for Ontario to 2026 and faced with new targets, it's time to reflect. Are we meeting our targets and achieving our goals? Is everyone with or at risk of HIV benefiting from the advances in HIV science? If not, who is being left behind and why?

This progress report:

- describes the HIV epidemic in Ontario and the services in place to respond to the needs of people with or at risk of HIV
- reports on Ontario's progress in achieving the goals of the OACHA strategy and the 90-90-90 targets
- identifies the gaps, barriers, and inequities that keep some people from engaging in the HIV prevention, testing, and care and treatment cascade.

108/113

RECOMMENDATIONS

A review of our efforts to implement the strategy shows that work is either underway or complete on 108 of the 113 recommendations. There are only five recommendations (4%) where work has not yet been started.

While we have made progress, there is still work to do. In addition to this progress report, OACHA has developed ***HIV Action Plan to 2030: Closing the gaps in the HIV care cascade in Ontario*** designed to guide the province's HIV sector as it strives to overcome barriers and inequities, and reach the 95-95-95 targets.

ACKNOWLEDGEMENTS

The Ontario Advisory Committee on HIV/AIDS (OACHA) would like to thank all who contributed to developing the this Progress Report, including:

- Members of OACHA
- Community leaders representing populations most affected by HIV, including Indigenous and Black communities, gay and bisexual men and people living with HIV, who provided valuable insights on how to adapt HIV services to meet the unique needs of populations that experience disparities accessing services
- The Ontario HIV Treatment Network, which provided data and evidence, as well as design and layout
- Within the Ministry of Health, The Office of the Chief Medical Officer of Health and Strategic Policy, Planning & French Language Services for their work reviewing and providing feedback, and
- HIV and Hepatitis C Programs staff, who provide secretariat support to OACHA

I.

HIV IN ONTARIO

HIV IN ONTARIO

Early in the HIV epidemic - before the virus had been identified - HIV established itself in a small number of populations, which now have higher prevalence of HIV than others in the general population. Almost four decades later - despite the significant progress these populations have made at preventing and treating HIV - new HIV diagnoses in Ontario are still concentrated in:

- Two-spirit, gay, bisexual, and other men who have sex with men, including trans men
- African, Caribbean, and Black populations
- Indigenous Peoples
- People who use drugs[1]
- Cis and trans women, including those from the communities above, who face systemic and social inequities, and are more likely to be exposed to HIV through a sexual or drug using partner.

1. People who use drugs are at high risk of acquiring HIV if they share equipment to inject drugs; however, other (non-injecting) drug use – including the use of alcohol, cannabis and drugs like crystal methamphetamine to enhance sex – can also increase HIV risk by affecting judgement and disinhibiting behaviour. Alcohol and other substance use can result in more sexual risk taking and/or lower adherence to medications such as PrEP and antiretroviral therapy.

While most people diagnosed with HIV in Ontario each year are members of these populations, **not everyone in these populations is at risk**.

For HIV transmission to occur, the following three things all have to be true:

P a sexual or drug use **partner** has transmissible HIV (i.e. an unsuppressed viral load), and

P a sexual or drug use **practice** (e.g. sharing drug use equipment, having vaginal or anal sex) makes HIV transmission possible, and

P effective tools to **protect** against HIV (e.g. condoms, pre-exposure prophylaxis) are either not accessible or not used consistently and correctly.

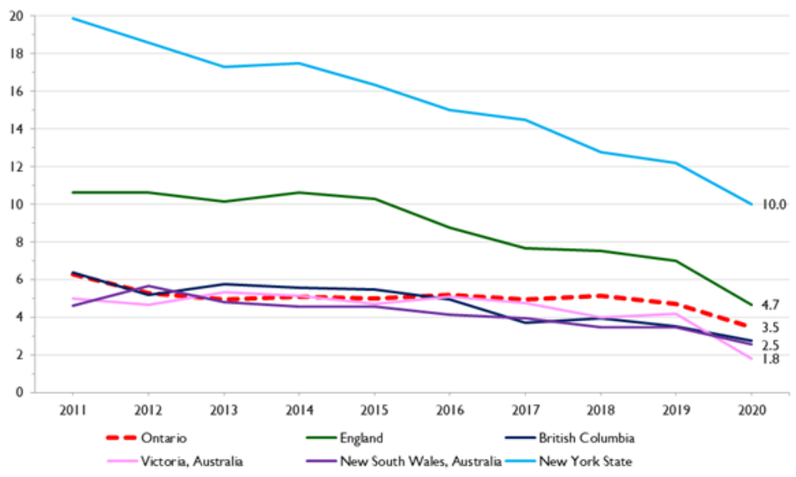
Note: other factors can affect people's choice and ability to protect themselves from HIV, including mental health and substance use issues, trauma associated with homophobia, racism and colonization, intimate partner violence, and social issues such as poverty, housing instability and incarceration.

UNDERSTANDING OUR HIV EPIDEMIC

ONTARIO HAS RELATIVELY LOW RATES OF HIV

Compared to other jurisdictions with a similar HIV epidemic, Ontario has been able to keep rates of HIV relatively low over time. However, in recent years, Ontario has not made the same progress as some jurisdictions – such as BC and some Australian states– in driving down rates of new infections.

Figure 1. Rate of new HIV diagnoses per 100,000 people in Ontario and select jurisdictions, 2011 to 2020

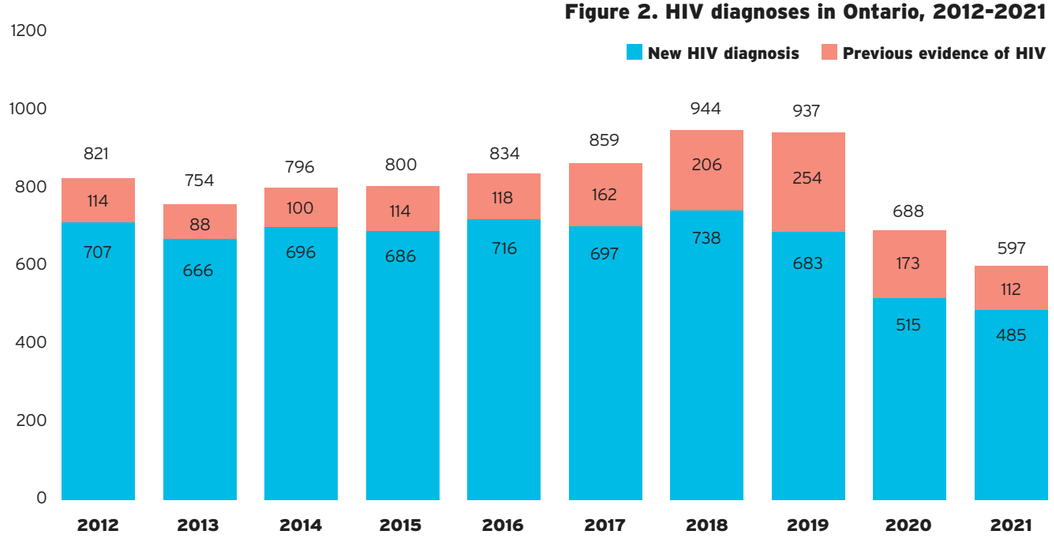


In 2019, Ontario had the lowest number and rate of positive HIV tests since the beginning of its epidemic. After 2019, HIV diagnoses continued to decline. Part of that decrease was likely due to the increase in PrEP use. However, it may also have been influenced by the lack of access to HIV testing and other health services as well as changes in risk activities and migration patterns during the COVID-19 pandemic (2020 and 2021).

UNDERSTANDING RISK AND THE NEED FOR CARE

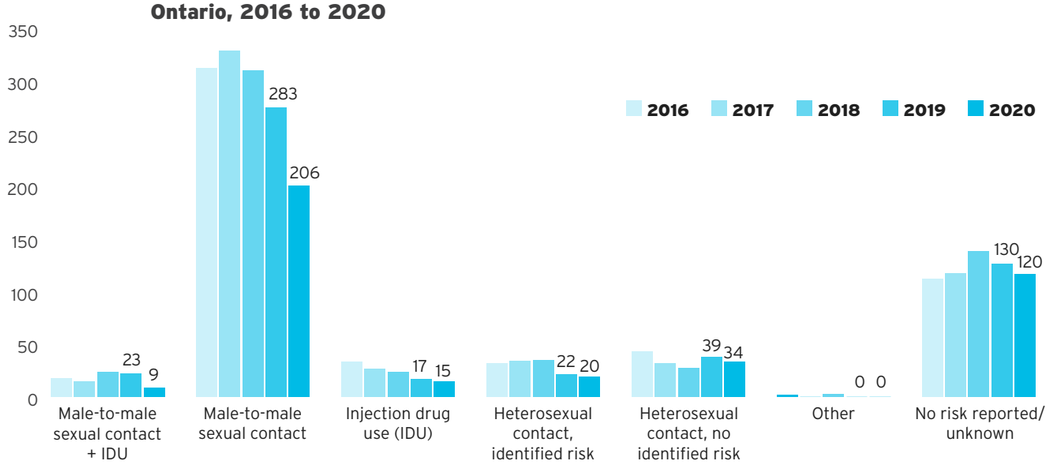
Each year, several hundred people test positive for HIV in the province. When looking at positive HIV tests, Ontario tries to distinguish between people learning about their HIV infection for the first time (i.e. first-time diagnoses) and people who are already aware of their HIV diagnosis, have moved to Ontario from other provinces or countries, and are entering care in the province (i.e. previous evidence of HIV). Understanding first-time diagnoses – people more likely to have been infected in Ontario – helps us target prevention efforts to those at greatest risk. Understanding the needs of people with HIV who have moved to Ontario helps ensure they have access to culturally responsive health and social services.

Figure 2. HIV diagnoses in Ontario, 2012-2021



Note: To distinguish between first-time diagnoses and previous evidence of HIV, Ontario uses linked diagnostic tests and reported test history. Because this information is missing on 22% of positive tests, some people with previous evidence of HIV are misclassified as first-time diagnoses.

Figure 3. Number of first-time HIV diagnoses by exposure category (where reported), males, Ontario, 2016 to 2020



MALES ACCOUNT FOR ABOUT 80% OF FIRST-TIME DIAGNOSES

About four of every five first-time diagnoses are in males. As Figure 3 shows, most of the diagnoses in males are in gay, bisexual, two-spirit and other men who have sex with men. Male to male sexual contact accounted for about 76% of first-time diagnoses in males in 2020. (The actual proportion is likely higher because risk factor information was missing for 30% of first-time diagnoses, and many men who have sex with men are not "out" to their care providers so may not disclose having sex with men as a risk factor when they are tested.)

Figure 4. Percent of first-time HIV diagnoses by exposure category (where reported), males, Ontario, 2016 to 2020

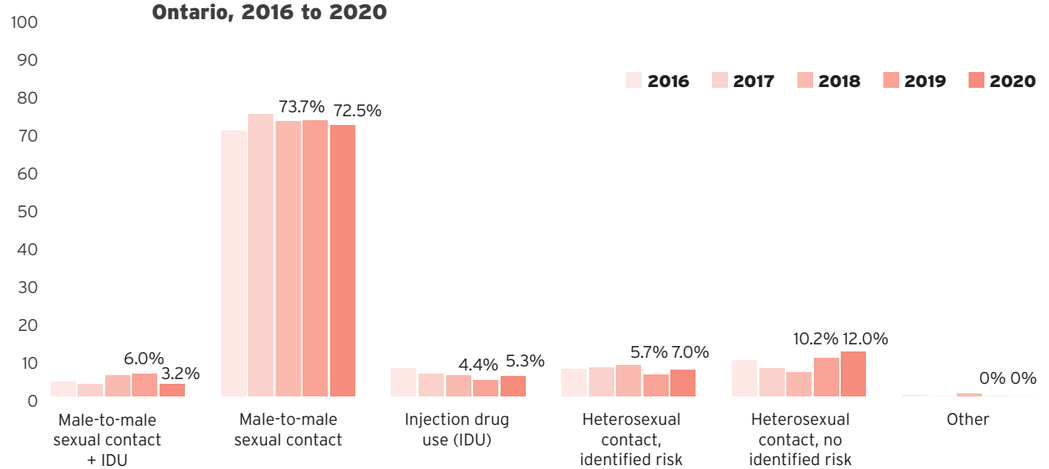
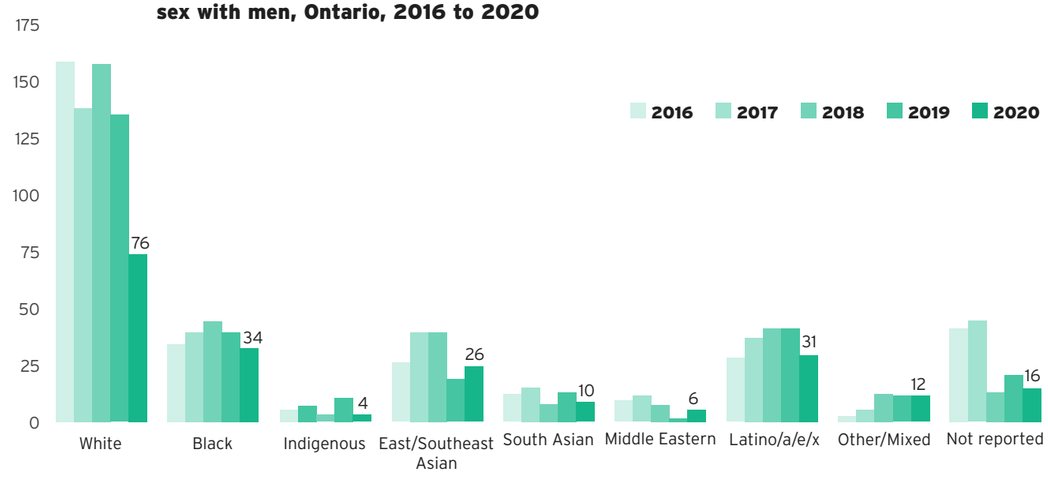


Figure 5. First-time HIV diagnoses by race/ethnicity in gay, bisexual and other men who have sex with men, Ontario, 2016 to 2020



First-time HIV diagnoses occur among gay and bisexual men of all races and ethnicities reported on the HIV test requisition form. The number of first-time diagnoses in white males has decreased since 2016, with a more substantial reduction in 2020 (I.e. the beginning of the COVID pandemic). For men from other races/ethnicities, counts of first-time HIV diagnoses have been more stable. As a result, racialized gay and bisexual men now account for a larger proportion of first-time diagnoses.

Figure 6. First-time HIV diagnoses by race/ethnicity in women, Ontario, 2016 to 2020

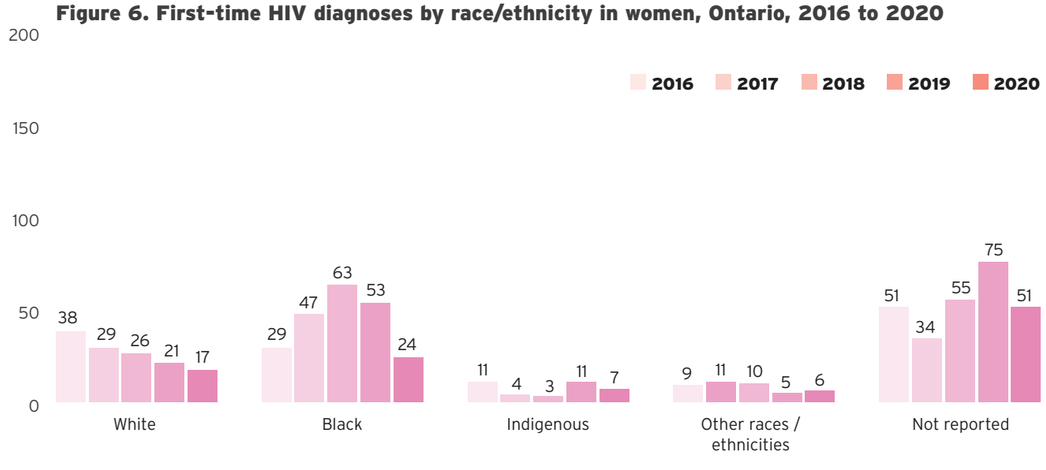
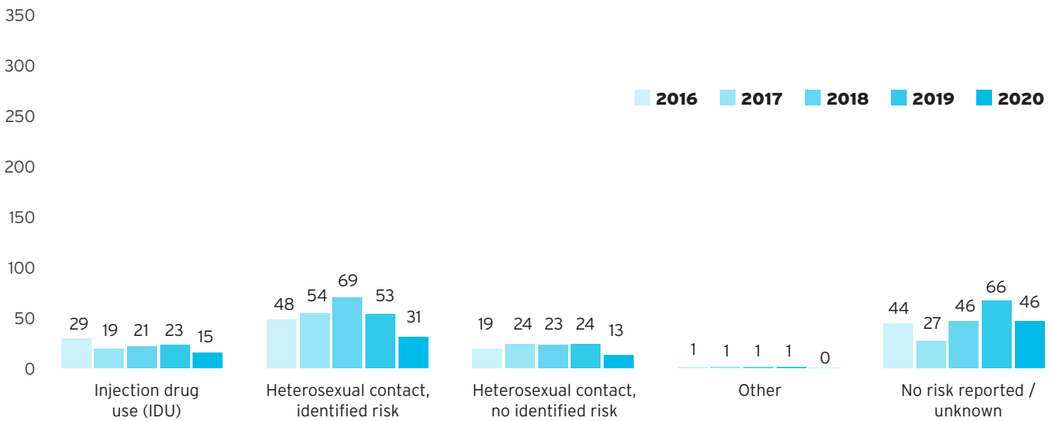


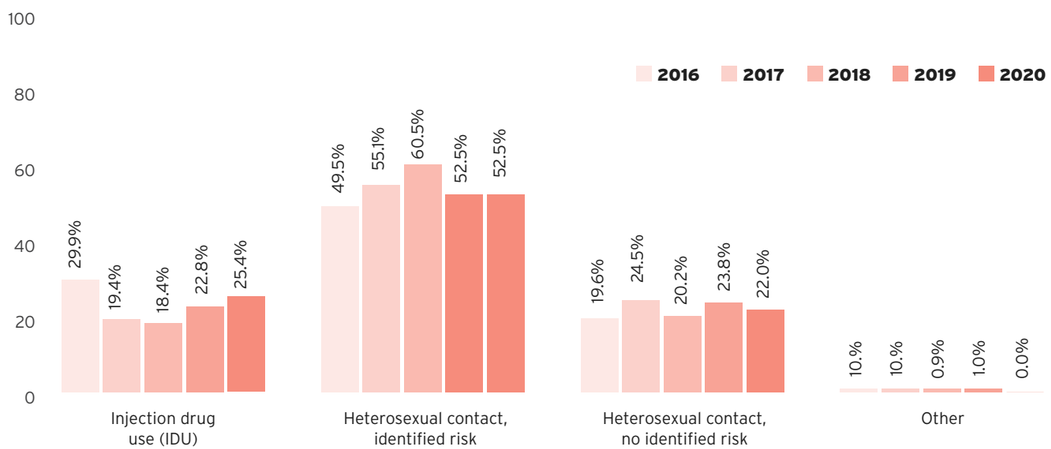
Figure 7. Number of first-time HIV diagnoses by exposure category (where reported), females, Ontario, 2016 to 2020



FEMALES ACCOUNT FOR ABOUT 20% OF FIRST-TIME DIAGNOSES

About one in every five people diagnosed with HIV for the first time in Ontario is female. Black women account for about 44% of first-time diagnoses in women (when ethnicity is reported) followed by White women (31%) and Indigenous women (13%).[3] The most common risk factors for HIV for women (when reported) are: heterosexual contact with a partner who had an identified HIV risk (i.e., is HIV positive, uses injection drugs, was born in a country where HIV is endemic, and/or is a male who reports sex with males) followed by injection drug use, and heterosexual contact with no identified risk.

Figure 8. Percent of first-time HIV diagnoses by exposure category (where reported), females, Ontario, 2016 to 2020

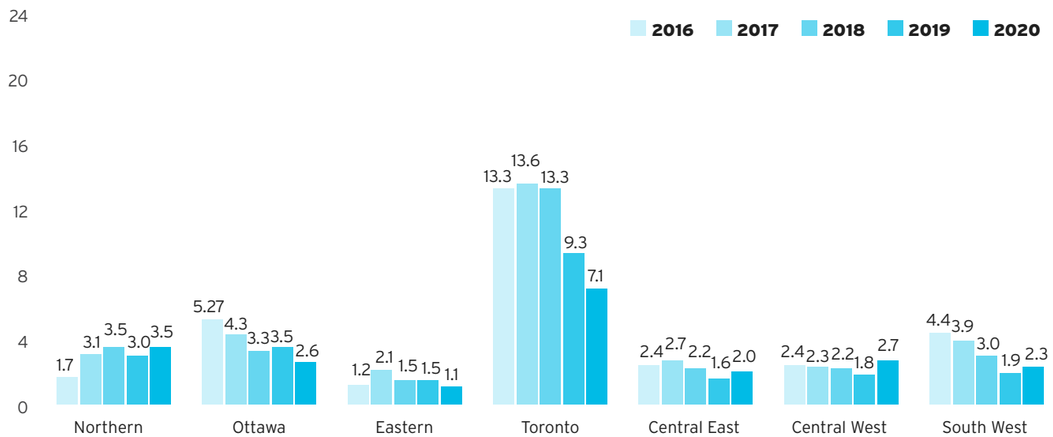


3. HIV Diagnoses in Ontario, 2020. Ontario HIV Epidemiology Surveillance Initiative (OHESI), 2020.

THE HIV EPIDEMIC IN ONTARIO VARIES BY REGION

Between 2019 and 2021, the number and rate of first-time HIV diagnoses dropped in Ontario. However, that trend varied by region: the rate of first-time HIV diagnoses (# of first time diagnoses per 100,000 population) was down 47% in Toronto and 23-25% in Ottawa, Eastern and South West regions, but stable in the Northern region and up slightly in Central West. (Note: the more dramatic decreases in HIV rates in 2020 and 2021 may have been affected by the lack of access to testing and other health services as well as changes in risk activities and migration patterns that occurred during the COVID-19 pandemic.)

Figure 9: Rate of first-time HIV diagnoses by region, Ontario, 2016-2020

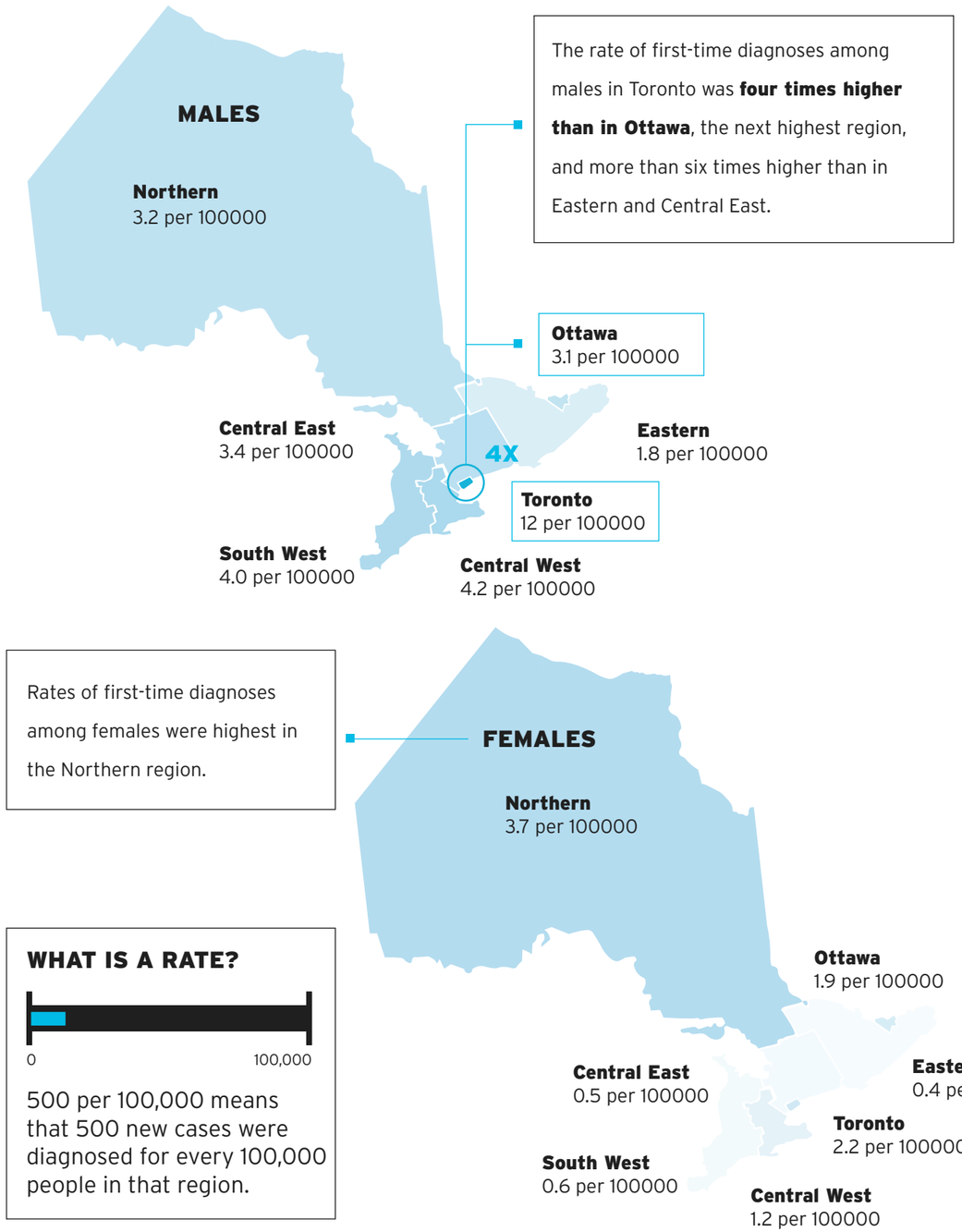


Despite the decreases, both the number and rate of first-time diagnoses in Toronto were significantly higher than in other parts of the province. This was particularly true in males, where the rate of first-time diagnoses in Toronto was four times higher than in Ottawa, the next highest region, and more than six times higher than in Eastern and Central East, the regions with the lowest rates of first-time diagnoses in males. Rates of first-time HIV diagnoses in females were highest in the Northern region.

OHESI
Ontario HIV Epidemiology and Surveillance Initiative

For a more complete overview of HIV diagnoses in Ontario, including a more detailed understanding of trends by priority population and region, please see OHESI's HIV diagnoses in Ontario, 2020 report.

Figure 10. Rate of first-time HIV diagnoses by gender and health region, Ontario, 2021



The rate of first-time diagnoses among males in Toronto was **four times higher than in Ottawa**, the next highest region, and more than six times higher than in Eastern and Central East.

Rates of first-time diagnoses among females were highest in the Northern region.

WHAT IS A RATE?

500 per 100,000 means that 500 new cases were diagnosed for every 100,000 people in that region.

Figure 11. Number of first-time HIV diagnoses in males by health region, Ontario, 2021

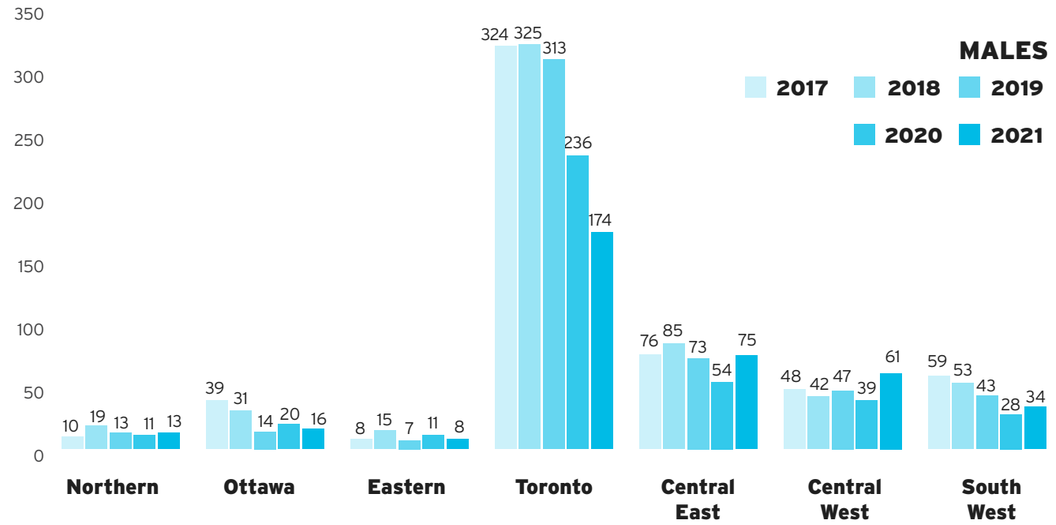
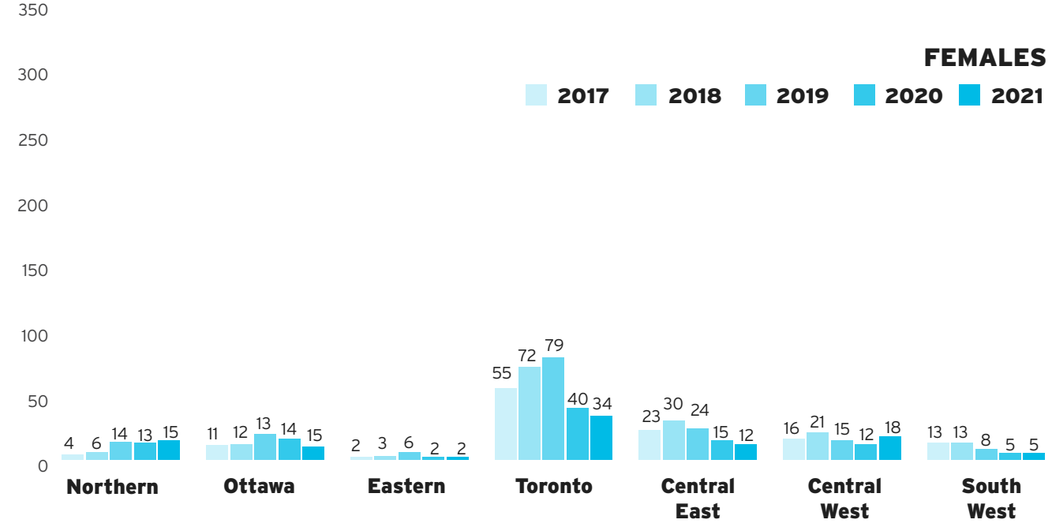


Figure 12. Number of first-time HIV diagnoses in females by health region, Ontario, 2021



The populations most affected by HIV also vary across the province. For example, in 2020, Toronto had the highest percentage of first-time diagnoses in men who have sex with men while the Northern Region had the highest percentage of first-time diagnoses among people who inject drugs.

THE HIV SECTOR AND ITS PARTNERS

The needs of people with and at risk of HIV vary widely and increase with the challenges they face. For example, many will manage their HIV care or risk with the help of primary care providers or nurse practitioners, while some may have complex co-morbidities and need more specialized care. People with or at risk of HIV who are struggling with challenges related to the social determinants of health may also need other services, such as income support, housing, employment services, legal, immigration and settlement services, or services related to intimate partner and domestic violence. People with complex mental health and substance use issues will need more specialized mental health and substance use services.

HIV services in Ontario are delivered by a mix of programs and organizations that work collaboratively to meet the varied health and social needs of people with or at risk of HIV. The goal is to connect people to the right services at the right time in the right place with the right provider to meet their needs.

THE HIV SECTOR

- Public health units – monitor HIV, operate sexual health clinics, notify people who may have been exposed to HIV, provide harm reduction services and assist in providing case management services for those with complex needs
- HIV testing programs – provide HIV testing and link people at high risk who test negative to prevention services and people who test positive to HIV care and treatment
- Public Health Ontario – conducts laboratory-based diagnostic and viral load testing and provides data on the epidemic
- AIDS service organizations (ASOs) and other HIV programs – provide HIV prevention and harm reduction services for populations at risk, promotion and referrals to testing and testing events, and support services, including counselling and practical or social supports for people living with HIV.
- For the approximately one-third of people living with HIV in Ontario who use ASO services – mainly those facing barriers to the social determinants of health – ASOs are a bridge to other health and social services: they provide referrals and linkage to income support, food programs, settlement, housing, employment and legal services.
- Specialized HIV clinics – provide medical care, psychosocial support and referrals to other specialists for people with HIV, particularly long-term survivors who are aging with HIV and/or people with complex co-morbidities
- HIV housing programs – provide supportive housing and case management services for people living with HIV who are unstably housed
- Provincial capacity building programs – provide tools and resources to support the sector
- The Ministry of Health – provides policy direction and funding for HIV services

People living with HIV and members of the populations most affected by HIV play key roles in planning and delivering HIV services. They serve on boards and advisory committees, guiding organizations and shaping policies and programs. They are also employed as staff and work as volunteers in prevention and harm reduction programs, and peer navigation and support services.

PARTNERS

- Primary care practitioners, including community health centres and family health teams –provide care and services for people with or at risk of HIV, such as HIV and STI testing, PrEP, harm reduction services, HIV care and treatment, and referrals to specialized HIV care and other medical services
- Other health services, such as emergency departments, and obstetricians and gynecologists, provide HIV testing
- Ontario Hepatitis C Teams, multidisciplinary teams providing "wrap-around care" for people who use drugs, Indigenous Peoples, and other populations at risk of Hepatitis C, and HIV, including testing, linkage-to-care and treatment, psycho-social support, harm reduction and linkage to housing, employment and other social services
- Traditional Indigenous and other culturally specific services – provide healing and other health and support services
- Social services – provide income supports, housing, food security, employment, settlement, legal, and intimate partner and domestic violence programs
- Mental health services
- Substance use services – provide harm reduction, consumption and and addiction treatment services

HIGH INTENSITY
Fewer clients

LOW INTENSITY
More clients

BETTER HEALTH OUTCOMES

HIV positive

HIV negative

NEEDS

MAIN PROVIDERS & TYPES OF SERVICES

COMPLEX MENTAL HEALTH AND/OR SUBSTANCE USE AND/OR HOUSING NEEDS

- Intensive case managment
- Specialized mental health services
- Addiction treatment programs
- Supportive housing
- Public health units

MEDICAL CO-MORBIDITIES AND COMPLEX HIV CARE

- HIV primary care
- HIV Clinics
- Medical specialists

ASO referrals to ▼

SOCIAL DETERMINANTS OF HEALTH

- Income support programs
- Food banks
- Housing programs
- Employment programs
- Settlement service
- Legal services
- Domestic violence programs
- Transition programs for people leaving the correctional system

SYSTEM NAVIGATION, PRACTICAL SUPPORTS, SOCIAL SUPPORTS

- HCV Teams
- HIV Clinics
- ASOs
- Public Health Units

HIV CARE AND TREATMENT, PEP/ PREP, HARM REDUCTION, CONDOMS

- Community Health Centres
- Primary care providers
- HIV Clinics
- Harm reduction programs
- Consumption treatment services

TESTING AND COUNSELLING

- Community Health Centres
- Sexual health clinics
- Emergency departments
- Self testing
- Immigration clinics

AWARENESS RAISING, PUBLIC EDUCATION

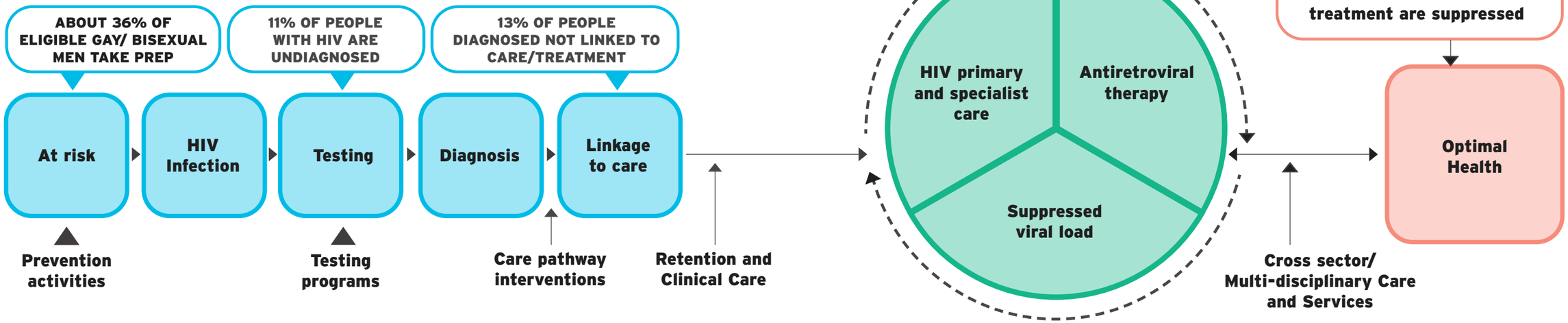
START HERE

POPULATIONS WITHIN WHICH HIV IS CONCENTRATED IN ONTARIO

II.

OUR PROGRESS …AND GAPS, BARRIERS AND INEQUITIES

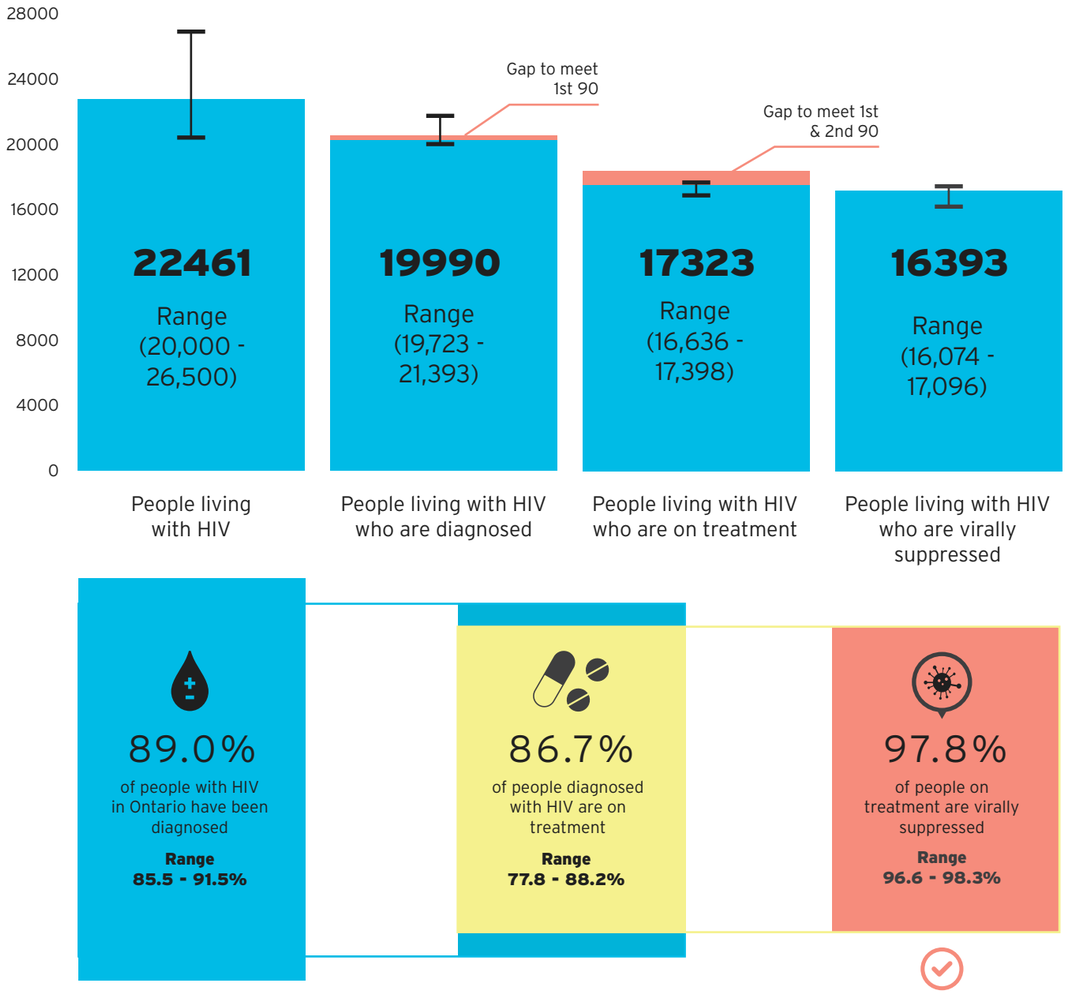
OUR PROGRESS …AND GAPS, BARRIERS AND INEQUITIES



Over the past seven years, Ontario's HIV sector has had some success in reaching its goals and targets across the HIV prevention, engagement and care cascade, and there is still work to do.

In terms of the 90-90-90 targets, in 2020 Ontario fell just short of meeting the first two 90s but exceeded the third 90.

Figure 13. UNAIDS 90-90-90 VS. ONTARIO'S ACHIEVEMENTS, 2020



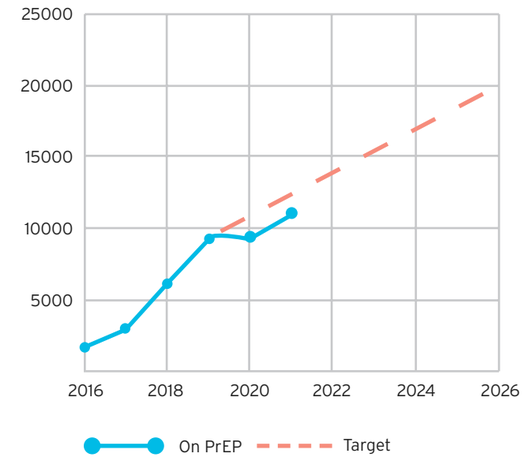
Ontario has made progress in achieving the 90-90-90 targets; however, when we look more closely at specific aspects of the HIV prevention, testing and care and treatment cascade, we get a clearer picture of what is working well, and where we can improve.

PREVENTION

Over the past five years, Ontario's prevention efforts have focused on making new infections rare by:

- Increasing the number of people at risk of HIV through sex who are on PrEP – with a particular focus on gay and bisexual men – while continuing to promote condom use and PEP[4]
- increasing access to a range of harm reduction supplies and services for people who use drugs.

Figure 14. PrEP uptake in Ontario to 2026 (projected)



MORE ONTARIANS ON PREP

Progress. Between 2016 and 2021, Ontario saw a dramatic 661% increase in the number of people (>11,000 in 2021)[5] prescribed PrEP[6], 97% of whom are males[7].

4. Note: Ontario does not have data on the number of people who are prescribed PEP (i.e. a 28-day course of antiretroviral therapy to be given within 72 hours of a high-risk exposure to HIV) each year.
5. Communication with OHTN. Kesler, M., PrEP users in Ontario: an update to 2021, September 28, 2022.
6. Note: between 2019 and 2020, the number of people prescribed PrEP did not increase. This was due to the impact of COVID.
7. HIV pre-exposure prophylaxis (PrEP) in Ontario, 2020. Ontario HIV Treatment Network.

The increase in PrEP uptake is due to a combination of initiatives by the HIV sector and industry, and policy changes:

- AIDS service organizations and programs, sexual health clinics and physicians promote PrEP and other prevention tools (e.g., PEP and condoms) to people at high risk of HIV
- **Ontarioprep.ca**, a web portal and capacity-building program, trains providers to prescribe PrEP and provides tools that individuals can use to see if PrEP is right for them.
- PrEP was added to the Ontario Drug Benefit Formulary in 2017, and then added to OHIP+ in 2018. Anyone covered by an Ontario Drug Benefit Program (i.e., people who are: age 65 and older, under age 25 and covered by OHIP+, on the Ontario Disability Support Program (ODSP) or Ontario Works (OW), or enrolled in the Trillium Drug Program) can access whole or partial coverage for PrEP – as can people who have private drug coverage.
- For those who don't have drug insurance, **PrEPStart** provides the first three months of PrEP for free along with help registering for ongoing drug coverage that reduces the cost of PrEP.

PrEP is both an individual prevention strategy and a public health intervention. At the individual level, gay and bisexual men taking PrEP report a range of benefits in addition to preventing HIV infection, such as less anxiety, greater comfort having sex, feeling more in control of their health, feeling they are supporting the health of others and less stigma.[8] At the level of public health, PrEP has been shown to be cost-effective and even cost-saving, by reducing new infections and the health care costs associated with those infections.[9]

PREP – GAPS, BARRIERS AND INEQUITIES

While Ontario has made progress in scaling up the use of PrEP, some gaps remain.

8. Tan, Darrell H.S., PrEP Uptake and Reach. Ontario HIV Treatment Network PrEP Think Tank, December 12, 2022, Toronto.
9. Gaspar, Mark, Tan, D., Lachowsky, N., et al. HIV pre-exposure prophylaxis (PrEP) should be free across Canada to those meeting evidence-based guidelines, The Canadian Journal of Human Sexuality, 2022.

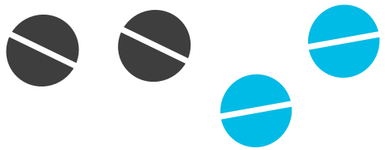
For males, only about one-third (36%) of men who have sex with men who are eligible for PrEP (i.e. at high risk of HIV) are on PrEP. And more evidence is needed to understand how gay and bisexual men are using PrEP. Some men take PrEP only when they need it, and some adjust their use based on changes in their sexual risk. For example, during the COVID- 19 pandemic, some men stopped taking PrEP because their sexual behaviour changed[10]. While there is evidence to support on-demand use of PrEP in men who have sex with men and that it can be safe to adjust PrEP use based on sexual activities, there is also evidence that going on and off PrEP may put some men at risk. A recent study showed that the real-world efficacy of PrEP was much lower than what was seen in clinical trials[11]. To ensure optimal health outcomes for people using PrEP, the HIV sector must develop strategies to support people on PrEP and address the factors that negatively impact PrEP efficacy in the real world.

Women continue to account for 1 in 5 first-time diagnoses, yet most people on PrEP in Ontario (97%) are men. Many women at-risk may not be aware of PrEP or may perceive it to be an option primarily for men. More work can be done to remove barriers to access and ensure that women at high risk are fully informed about PrEP (i.e. benefits, risks, where to access PrEP) and about other forms of effective HIV prevention.

The gaps and barriers to more widespread and consistent use of PrEP include:

Lack of awareness. Many people who could benefit from PrEP are not aware of PrEP or do not perceive themselves to be at high risk. Some are reluctant to use PrEP because of stigma and/or concerns about possible side effects. Some struggle to manage PrEP use effectively in the context of their changing sex lives, relationship status and/or perceptions of HIV risk.[12]

11. Ibid.
12. Jourdain, Hugo, Billioti de Gage, Sophie, Desplas, David, Dray-Spira, Rosemary, Real-world effectiveness of pre-exposure prophylaxis in men at high risk of HIV infection in France: a nested case-control study. Lancet Public Health. 2022 Jun;7(6):e529-e536. doi: 10.1016/S2468-2667(22)00106-2.



Jurisdictions that cover the full cost of PrEP have higher PrEP uptake than Ontario and fewer new HIV infections.

Ontario will not eliminate new HIV infections amongst gay, bisexual or other men who have sex with men or see the same public health benefits of PrEP as other jurisdictions until PrEP is available at no cost to all Ontarians who are eligible for it.

Cost. Cost continues to be a significant barrier to PrEP uptake. About 43% of Ontario gay, bisexual or other men who have sex with men who are eligible for PrEP indicate that the principal reason for not using PrEP is that they cannot afford it.[13] Cost is a bigger barrier for people with low incomes and for those experiencing other health and social issues that increase their risk, such as two-spirit and other Indigenous Peoples, Black, Latine, East/Southeast Asian and other racialized men, and men who use drugs. While there are both public and private insurance programs that will cover at least part of the costs of PrEP, government drug programs are administratively complex and difficult to access, and the co-payments are a barrier for many people to start or stay on PrEP consistently. The time and resources health care providers invest helping people navigating these programs could be better spent addressing their other health issues.[14]

Racial disparities. Decreases in first-time diagnoses among gay, bisexual and other men who have sex with men are largely driven by the drop in the number of new HIV cases among white men. PrEP programs may not be reaching Indigenous or Black and other racialized men equitably.

13. Gaspar, Mark, Tan, D., Lachowsky, N., et al. HIV pre-exposure prophylaxis (PrEP) should be free across Canada to those meeting evidence-based guidelines, The Canadian Journal of Human Sexuality, 2022.
14. Ibid.

CHALLENGES ACCESSING PEP AND MONITORING ITS USE

Access. To be effective, PEP must be started within 72 hours of a high-risk exposure, which means people often go to emergency departments to access it. However, access to PEP through emergency departments varies and is not systematic. It often depends on the experience and priorities of individual hospitals and clinicians.

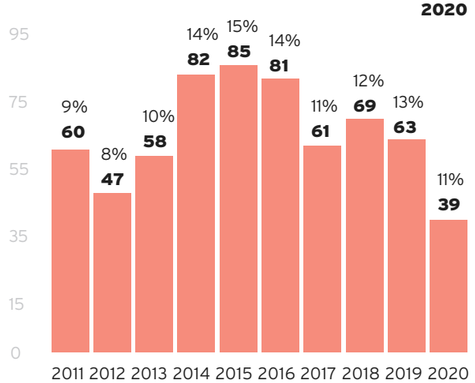
Cost. PEP use and uptake is limited by its cost, which is only explicitly publicly funded for people exposed through sexual assault (through the Sexual Assault and Domestic Violence Treatment Program). Others have to rely on private insurance, pay out-of-pocket or potentially go without.

Lack of monitoring. With the exception of PEP prescribed through the Sexual Assault and Domestic Violence Treatment Program, there is no systematic way to monitor PEP use and uptake in Ontario, or to assess the role it plays in HIV prevention.

MORE ONTARIANS WITH ACCESS TO HARM REDUCTION SUPPLIES AND SERVICES

Progress. The number of HIV infections attributed to injection drug use in Ontario remains comparatively low. Between 2017 and 2020, people who reported injection drug use accounted for about 12%[15] of first-time HIV diagnoses in the province.

Figure 9. Number and proportion of first-time HIV diagnoses in people who inject drugs, 2011 to 2020



The relatively low number of first-time diagnoses in people who inject drugs is due to Ontario's strong commitment to harm reduction. Each year, community-based organizations report distributing thousands of harm reduction supplies to people at risk of infection through drug use and sex.

	Safer drug use supplies[16]	Needles	Condoms[17]
2016	**48,052,884**	**17,848,143**	**3,584,621**
2017	**59,137,724**	**20,966,067**	**3,685,179**
2018	**66,714,176**	**23,069,250**	**3,669,440**
2019	**78,127,672**	**23,508,693**	**2,408,788**
2020	**94,815,106**	**21,040,399**	**2,133,488**
2021	**89,171,178**	**20,632,994**	**Not available**

15. This proportion includes first-time diagnoses who reported injection drug use as a risk factor as well as those who reported male to male sexual contact as well as injection drug use as risk factors for infection in 2020.
16. Safer drug use supplies distributed by the Ontario Harm Reduction Distribution Program (OHRDP) to core Needle Exchange Programs across Ontario include: alcohol swabs, filters, cookers, sterile water, tourniquets, vita min C (acidifier), push sticks, screens, straight stems, tubing, bowl pipes, foil, straws and wipes
17. Self-reported distribution of condoms, lube, and dental dams by AIDS service organizations and HIV programs in Ontario

HARM REDUCTION – GAPS, BARRIERS AND INEQUITIES

Criminalization and stigma. The criminalization of drug use, negative experiences with the health care system, and the stigma associated with drug use may keep people who use drugs from using health care services, including primary care, harm reduction services, testing services, and mental health and addictions services that could help them improve their health, and either avoid or live well with HIV. Criminalization also forces people to rely on an unregulated supply of drugs, which leaves them vulnerable to the toxic drug supply, overdose/drug poisoning and death.

Crystal methamphetamine use. Crystal methamphetamine and other party drugs used to enhance sex can put gay, two-spirit, bisexual and other men who have sex with men at higher risk of acquiring HIV. For men who are living with HIV, drug use can affect their ability to adhere to treatment and maintain a suppressed viral load.

The impact of the drug poisoning crisis. In 2020, 2,423 deaths in Ontario were attributed to opioid overdoses. People at risk of acquiring HIV from sharing drug equipment are now also at risk of opioid overdoses and opioid overdose-related death. In response, a number of AIDS service organizations are now directly involved in delivering comprehensive harm reduction services for people who use drugs.

Trellis HIV and Community Care, the AIDS service organization in Kingston, partners with public health, the community health centre, a local shelter, the hospital and the United Way to operate a 24-hour drop-in and rest area where people who use drugs can get harm reduction supplies, consumption treatment services, meals, showers, and shelter. Over several months, this Integrated Care Hub served almost 90,000 meals, distributed >11,000 naloxone kits, reversed 600 overdoses/drug poisonings, and diverted almost 800 people who would have ended up in hospital.

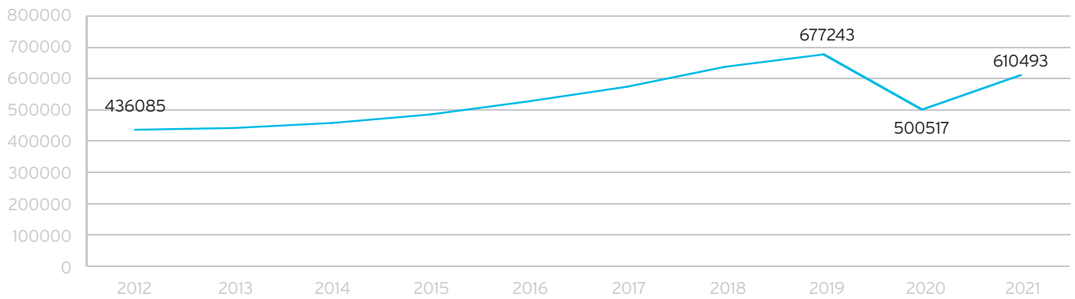
TESTING, DIAGNOSIS AND LINKAGE TO CARE

Over the past five years, Ontario has worked to make testing more accessible and to increase the proportion of people living with HIV who are diagnosed and linked quickly to care.

MORE ONTARIANS TESTED

Between 2016 and 2019, Ontario saw a steady increase in the number[18] of diagnostic HIV tests each year. HIV testing was down 26% in 2020 due to the impact of COVID-19. While there was some recovery in the number of HIV tests done in 2021, it is still lower than 2019 pre-pandemic levels.

Figure 15. HIV tests in Ontario, 2012-2021



18. Note: these numbers do not include the approximately 135,000 prenatal HIV screening tests conducted each year.
19. HIV care cascade in Ontario: Linkage to care, in care, on antiretroviral treatment, and virally suppressed, 2020. Ontario HIV Epidemiology Surveillance Initiative (OHESI), 2020.

MORE PEOPLE WITH HIV DIAGNOSED

In 2020, based on Public Health Agency of Canada modelling, there were about 22,461 people living with HIV in Ontario. As of 2020, an estimated 89% of them had been diagnosed and know their status[19] – just shy of the first 90 target.

MORE ACCESSIBLE TESTING

The HIV sector has also implemented a number of initiatives that have improved access to testing:

Improved testing technology. With 4th generation testing technologies, the window period (i.e., the time between when someone is infected with HIV and when tests can detect antibodies in blood) has been reduced from three months to six weeks. Ontarians who have had a high-risk exposure to HIV are now able to test for HIV earlier.

Point-of-care and anonymous testing programs focused on people at highest risk. Between 2016 and 2019, HIV point-of-care and anonymous testing accounted for under 3% of all HIV testing in Ontario. Yet, the positivity rate from these forms of testing was four to five times higher than through standard testing[20]. Point of care and anonymous testing continues to be targeted to people at risk with the program being expanded strategically to organizations serving key populations.

Self-testing. November 2020, Health Canada approved an HIV self/home test. Since then, two approaches to self-testing were introduced and are being studied in Ontario to better understand the role and use of self-testing to increase access to testing: GetaKit, based at the University of Ottawa, and REACH 3.0 I'm Ready, a research program of the MAP Centre for Urban Health Solutions. In addition, the federal government invested in making self-test kits available to community organizations in the province in 2022/23 through the Community Link initiative, in order to increase access. We are still learning from these initiatives, but to-date the

20, Note: 2020 is not being considered in this analysis because of the impact the pandemic had on access to testing services.
21. There are two other HIV self test initiatives in Ontario: I'M Ready self test study led by Reach Nexus, a national research group, affiliated with St. Michael's Hospital, Toronto; and, Community Link, a PHAC funded project to distribute self-test kits through community-based agencies.

evidence is supporting the early understanding that self-testing is one effective approach to increase access to testing for people who have never previously tested, people at-risk for HIV, and people from racialized communities, to name some of the potential benefits seen in the data. At the same time, ensuring systematic ways to link people who selt-test to PrEP and to HIV treatment, remain a priority.

FASTER LINKAGE TO CARE

The sooner people diagnosed with HIV are linked to care and start antiretroviral treatment, the earlier most will achieve a suppressed or undetectable viral load – which enhances their health and means they can't pass the virus to their sexual partners.

Between 2000 and 2019, the percentage of Ontarians diagnosed with HIV who were linked to care within one month of diagnosis increased from 35% to 67%, and another 20% were linked to care within three months[22].

HQ
790 Bay

Express testing and treatment. Seven ASOs – 2-Spirited People of the 1st Nations, Asian Community AIDS Services, ACT, Action Positive, Alliance for South Asian AIDS Prevention, BlackCAP and the Centre for Spanish Speaking Peoples – worked with Hassle Free Clinic, the OHTN and the Centre for Addiction and Mental Health (CAMH) to create **HQ Toronto**: a health hub for cis guys into guys and two-spirit, trans and non-binary people. HQ offers integrated express HIV and STI testing, rapid initiation of PEP, PrEP and HIV treatment, sexual health services, mental health assessments, mental health and addiction services, and social programming for cis guys into guys and two-spirit, trans and non-binary people. With HQ's onsite laboratory, people who test positive are able to get their results and start HIV treatment within 24 hours of being tested, and people at high risk who test negative are able to get their results and start PrEP within the same time frame.

22. HIV care cascade in Ontario: Linkage to care, in care, on antiretroviral treatment, and virally suppressed, 2020. Ontario HIV Epidemiology Surveillance Initiative (OHESI), 2020.

MORE CULTURALLY APPROPRIATE APPROACHES TO CARE

As part of its commitment to providing services in a good way for Indigenous Peoples, Elevate NWO – the ASO in Thunder Bay – has an Elder on staff who uses ceremony, Indigenous medicines and the Seven Grandfather Teachings to create a safe and welcoming space for both Indigenous and non-Indigenous people. The Elder has helped Elevate connect services to culture, shaping outreach services, creating an outdoor café, and establishing a warming centre that attracted Indigenous Peoples to the ASO. Connecting services to culture has resulted in more testing, more people newly diagnosed quickly linked to on-site clinical services, and more people with HIV in Thunder Bay (86%) being virally suppressed. The Elder has also played a key role in helping Elevate reach people at risk and bring them into services: 42 people who had been living in local encampments are now housed, and Elevate won the city's Respect Award for its work with the encampment.

Having an Elder on staff has also led to significant changes in organizational culture: Elevate is collaborating more closely with Oahas, and the Oahas worker in Thunder Bay is now working out of an office within Elevate; 25% of Elevate staff are Indigenous; and the whole organization is offering services that are inclusive of Indigenous ways of knowing and healing. This summer Elevate and Oahas will be sitting in ceremony to create a new vision for their partnership and engaging in a naming ceremony for the shared drop-in centre.

New testing guidelines. The ministry, working in collaboration with public health and the Ontario HIV Treatment Network, has developed the new *Ontario Guidelines for Providers Offering HIV Testing, 2023*. To reach people earlier in their infection, the guidelines recommend testing as early as three weeks and again at six weeks after a high-risk exposure. People who are at risk of acquiring HIV will be encouraged to test at least annually, or more frequently depending on their risk activities. Clinicians will be encouraged to: pro-actively offer HIV testing to patients based on a number of HIV-related indicators; and take a "status neutral" approach to testing, actively engaging both clients who test HIV positive and those at risk who test negative. People who test positive will be immediately linked to care and treatment, while clients at risk will be linked to appropriate prevention tools, including PrEP.

GetaKit.ca

At least 19 ASOs in Ontario are collaborating with GetaKit.ca, a provincial HIV self-testing project[21]. The ASOs actively promote self-testing and support people who test positive by linking them quickly to care. The GetaKit program, based at the University of Ottawa, provides fast access to an online assessment, self-test kits, linkage to care for people who test positive wherever they are in the province, and referrals to PrEP for people who test negative but are at high risk. Many of the ASOs involved are working with populations that may not be reached by regular testing programs and are more likely to be diagnosed late, including Indigenous Peoples, racialized populations, and people who use substances.

Between July 2020 (when the program launched in Ottawa) and November 2022, GetaKit has distributed 4,750 self-tests, identified 18 people who tested positive and linked them successfully to care. The mail-out self-test appears to be a highly effective way to reach racialized populations – including gay men and heterosexual men and women – many of whom had not tested before and who may avoid regular testing programs because of concerns about stigma or discrimination. Of the 4,750 people who tested, 65% were male and 20% were female, 2% were trans-male, 1% trans-female. 53% were men who have sex with men, 17% were African, Caribbean or Black, and 3% were Indigenous.

23. Communication with OHTN: Subpopulations and key populations in the Ontario HIV Care Cascade, September 2022.
24. Ibid.
25. Ibid.

TESTING – GAPS, BARRIERS AND INEQUITIES

An estimated 11% of Ontarians who have HIV – about 2,471 people – have not yet been diagnosed. They are at-risk of preventable health complications and premature death. People living with undiagnosed and untreated HIV can also unknowingly pass HIV to sex and drug use partners, resulting in more preventable HIV infections. Even when people are diagnosed, many are diagnosed later in the course of HIV infection when the virus has already damaged their immune system, and about 10% either do not link to care or experience delays in linkage to care. Key gaps and barriers include:

Challenges reaching people at risk. Current testing programs and options may not be flexible (i.e., operating hours, type of testing available) or targeted enough to reach Ontarians at high risk.

Racial disparities. Indigenous Peoples are less likely to be in care and experience longer delays in linking to care after diagnosis than the Ontario average. When compared to the Ontario average, African, Caribbean and Black people diagnosed with HIV are more likely to be engaged in care. However, Black women take 12 days longer on average than Black men and 17 days longer than the Ontario average to be linked to care. Other racialized people diagnosed with HIV, including Latine, East/Southeast Asian and South Asian people, are less likely to be in care than the Ontario average[23].

Gender disparities. Among women diagnosed with HIV, Indigenous and Black women, and women living in the Northern Region are less likely than males to be in care, and they take longer to link to care[24].

Stigma, discrimination and distrust of the health system. Many people – particularly Indigenous people and Black and other racialized people as well as people who use substances – experience racism, colonization, stigma and discrimination when using health services. These

26. Wilton, J, L Light, B Rachlis, et al., Late diagnosis, delayed presentation and late presentation among persons enrolled in a clinical HIV cohort in Ontario, Canada (1999-2013). HIV Med. 2019 Feb;20(2): 110-120.

discourage people from seeking HIV testing and/or linking to care. For example, people diagnosed with HIV who inject drugs are less likely to be in care and take longer to link to care than the Ontario average[25].

Geography. HIV testing is still more difficult to access in rural and remote parts of the province, and people in those areas may not seek testing because of concerns about privacy and confidentiality.

Lack of provider awareness. Many primary care providers may not be aware of the HIV risks in their patients' lives and may not know the signs and symptoms of either acute or chronic HIV infection. Some people with HIV are not offered HIV testing until they are quite ill and present with other health complications that arise once they have lived with untreated HIV for some time. Within the OHTN Cohort Study, about half of people were diagnosed late, meaning they either had a CD4 count below 350 cells/µL or they had an AIDS-defining condition within three months of diagnosis[26]. People diagnosed late face poorer health outcomes and increased risk of severe disease and death.

HIV TREATMENT AND RETENTION IN CARE

Over the past seven years, Ontario has focused on getting people diagnosed with HIV on treatment suppressed more quickly them in care.

MORE PEOPLE LINKED TO CARE, MORE QUICKLY

In 2000, 73% of people with diagnosed HIV in Ontario were linked to care. By 2020, the figure had increased to 89%. Over the same time period, people linked to care within one week of diagnosis increased from 6% to 21%; within one month from 35% to 67%, and within three months from 67% to 86%.[27]

MORE PEOPLE ON TREATMENT

From the early 2000s to 2020, the proportion of Ontarians diagnosed with HIV who are on treatment increased from about 50% to 87%.[28]

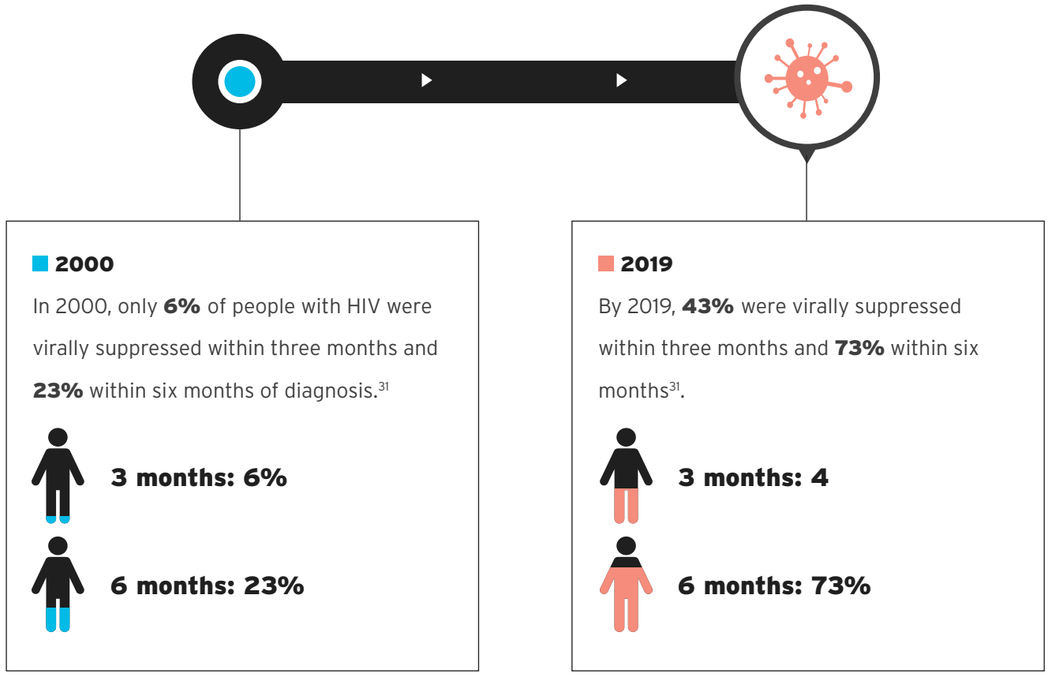
MORE PEOPLE VIRALLY SUPPRESSED

In 2000, only 35% of people in Ontario with diagnosed HIV were virally suppressed. By 2020, that figure had increased to 85%. When Ontarians with HIV are in care and on treatment, they do extremely well. Among people with diagnosed HIV who are on HIV treatment, the rate of viral suppression has reached 98%[29], exceeding the UNAIDS target for the third 90.[30]

27. HIV care cascade in Ontario: Linkage to care, in care, on antiretroviral treatment, and virally suppressed, 2020. Ontario HIV Epidemiology Surveillance Initiative (OHESI), 2020.
28. Ibid.
29. Ibid.
30. Ibid.

PEOPLE VIRALLY SUPPRESSED MORE QUICKLY

Because people newly diagnosed with HIV are being linked to care and treatment more quickly, it takes less time for them to become virally suppressed – which is better for their long-term health, and reduces the risk of new HIV infections.



BETTER ACCESS TO HIV CARE FOR PEOPLE WHO ARE PRECARIOUSLY INSURED

Depending on how they come to Canada, newcomers can face challenges getting health care coverage. The Interim Federal Health Program provides coverage for health care services for protected persons, resettled refugees, refugee claimants and others until they become eligible for provincial coverage (i.e. OHIP, Ontario Drug Benefit Program). However, newcomers who come to Ontario on student, work or visitor visas are required to buy their own health insurance, which is often not enough to cover the full cost of the health care services they may need. This group may be precariously insured and, therefore, may not have access to or seek testing, PrEP or HIV treatment, although individuals with work permits that have been valid for six months can apply for OHIP after meeting work requirements, such as working 90 days full time.

31. Ibid.

PEOPLE WHO USE SUBSTANCES

Faced with an HIV outbreak among people who inject drugs in London in 2016, Regional HIV/AIDS Connection, Middle-sex London Health Unit, St. Joseph Hospital Infectious Disease Care Program, London Intercommunity Health Center, London Care Homeless Response Services, My Sister's Place, Indigenous services, harm reduction programs, other clinicians, and the Southwest LHIN (now the Ontario Health Team) created an HIV Leadership Table that took bold steps to reduce new infections in this population (increasing outreach and testing), and to actively engage people in care and on treatment. Since then, the number of first-time diagnoses in people who inject drugs has dropped every year, and people in the southwest region who inject drugs have the same high levels of viral suppression as other populations. In 2020, the region saw the highest percentage of people with HIV in care (92%), on treatment (88.2%) and with a suppressed viral load (86.8%) in the province.

HIGH SATISFACTION WITH HIV CARE

In 2020, over 95% of people living with HIV who participate in the Ontario HIV Treatment Network (OHTN) Cohort Study (OCS[32]) annual survey reported having a good, very good or excellent experience when making appointments and receiving care in an HIV clinic setting. They reported feeling comfortable in the clinic and in their interactions with clinic staff. Over 95% of OCS participants also reported having good, very good or excellent experiences at their last visit with their primary HIV care provider. They had positive experiences communicating with their provider and reported being treated with respect.

32. The OCS is a longitudinal study that follows almost 6,000 people living with HIV in Ontario https://ohtncohortstudy.ca/

The Blue Door Clinic is a multidisciplinary coalition of health and community agencies* working with precariously insured or uninsured people with HIV, to ensure they are linked to care and treatment, have access to the social determinants of health and are retained in care. In its first two years of operation, the clinic has served clients from more than 40 different countries of origin, including people who are Black/African/Caribbean, Asian and Latine, a significant percentage of whom require services in languages other than English, including Spanish, Portuguese and Chinese (Mandarin and Cantonese). The coalition has successfully supported people to get HIV treatment, improve health outcomes, and access holistic primary care.

TREATMENT ACCESS - GAPS, BARRIERS AND INEQUITIES

Despite the increase in the percentage of people with HIV on treatment, about 10% or 2,000 Ontarians diagnosed with HIV are either not in care or have fallen out of care[33] and another 3% or about 600 are in care but not on antiretroviral treatment. These gaps are due to:

Complex health needs. The people with HIV who are least likely to engage in care and most likely to fall out of care are those coping with complex health needs, such as serious mental health, substance use and housing/homelessness issues. These complex needs make it difficult to attend appointments and take daily medications. For example:

- people who inject drugs who are diagnosed with HIV are more likely to fall out of care and struggle to stay on treatment, and are less likely to be virally suppressed;
- women living with HIV who use substances, are unstably housed and/or have been incarcerated are more likely to fall out of care and less likely to stay virally suppressed.[34]

Social and other determinants of health. People who experience poverty, unemployment or precarious employment, food insecurity, lack of education, unstable housing/homelessness, violence, depression,

* Black Coalition for AIDS Prevention, Committee for Accessible AIDS Treatment, Casey House, Center for Spanish Speaking Peoples, Fife House, Hassle Free Clinic, Ontario HIV Treatment Network, Parkdale Queen West Community Health Centre, Regent Park Community Health Centre, Sherbourne Health Centre, Toronto People with AIDS Foundation/Latinos Positivos

Poverty, regardless of drug coverage, can make it much more difficult for some people with HIV to successfully manage their health.

and incarceration are at greater risk of HIV infection, being diagnosed late if they do acquire HIV, facing more barriers to staying in care and on treatment, and having poorer health outcomes. For example, people living with HIV who have annual incomes under $40,000 are less likely to be on treatment and report lower rates of viral suppression than those who earn more. Rates of viral suppression drop even more for people with annual incomes less than $20,000, even when the cost of their HIV treatments are covered, such as people with HIV on ODSP. Since the late 1990s/early 2000s, income for people newly diagnosed with HIV in Ontario has declined while the Ontario median income has increased.[35]

Cost of medications. Jurisdictions that have met or exceeded the UNAIDS 90-90-90 targets provide universal access to HIV treatments and PrEP. For many people with HIV in Ontario, the cost of HIV treatments is only partially covered. For example, Ontarians with HIV who qualify for Ontario Drug Benefit Programs, which have minimal or no deductibles (i.e. ODSP/OW, OHIP+, drug program for seniors over age 65) essentially receive full coverage for their HIV medications. Other Ontarians with HIV must rely on the Trillium Drug Plan, and/or private coverage, which have co-payments or deductibles. These co-payments create barriers, and can cause treatment delays or interruptions, which result in poorer treatment adherence, and poorer health outcomes. For example, about 31% of people in the OHTN Cohort Study rely on the Trillium Drug Program, and they report sometimes delaying filling a prescription or missing doses because of difficulty making co-payments. As a result, they have lower rates of viral suppression.

33. Defined as not having had a viral load test in the past two years.
34. Communication with OHTN: Subpopulations and key populations in the Ontario HIV Care Cascade, September 2022.
35. Kroch, A., Light, L., The relationship between demographics, health needs and the HIV care cascade outcomes: from infection to viral suppression. Ontario HIV Treatment Network, Ontario Cohort Study, 2020.

Managing complex government drug programs. The administrative requirements to access the Trillium Drug Plan are complex and cumbersome, and particularly challenging for people who have low incomes, are precariously employed or experience an unexpected job loss, and/or have mental health or substance use issues. The requirement to provide proof of income such as a completed tax return for all members of the household may be a barrier for many people, particularly those involved in sex work or other criminalized activities. Administrative errors can also cause delays or unexpected interruptions.

The impact of migration. Many Indigenous Peoples in Ontario move between remote First Nations communities and urban centres, which can make it more difficult for them to stay in care. Some have to leave their communities and families to be able to get care, and that care may not be culturally sensitive. Canada is also a country that welcomes hundreds of thousands of immigrants every year and is known as a welcoming place for 2SLGBTQ+ individuals who face stigma in their countries of origin. Each year, in addition to the people diagnosed with HIV for the first-time in Ontario, more than 200 people living with HIV move to the province from other regions of Canada or other countries. They need to be quickly connected to high quality, stigma-free, culturally responsive HIV care and support services. A significant proportion of these newcomers – many of whom are racialized – may also need to be connected to services beyond the scope of the HIV sector, such as settlement, legal, social and employment services to be able to stay in care and on treatment, and enjoy good quality of life..

Geography. People with or at risk of HIV who live in more rural or remote parts of the province – particularly Indigenous Peoples – do not have access to the same range of health and social services as those in more urban areas. They may also avoid local services because of concerns about confidentiality and stigma in their communities.

36. Communication with OHTN: Subpopulations and key populations in the Ontario HIV Care Cascade, September 2022.

About 8% of OCS survey participants reported having been refused care or service from a health care provider. Of those, 63% attributed the refusal of care to their HIV status, while 7% attributed it to their race. Indigenous people living with HIV were more likely than people of other races to have been refused.

Negative experiences with the health care system/stigma and discrimination. The populations most affected by HIV in Ontario face barriers accessing and staying in care, including: stigma related to HIV, homophobia, and substance use; trauma related to experiences of colonization and racism – especially anti-Black and anti-Indigenous racism; services that are not culturally responsive and do not provide adequate translation/interpretation services; and services only available at times when people are working. For example:

- Indigenous people diagnosed with HIV are more likely to experience stigma and discrimination in the health care system, and less likely to be in care, on treatment or virally suppressed.[36]
- A significant proportion of men who have sex with men are not "out" to their primary care provider so are not getting the care they need to protect their health.

Although Ontarians report high levels of satisfaction with their HIV care, some still experience stigma and discrimination when accessing other (non-HIV) health services. The greatest challenges appear to be related to the provider's knowledge of the person's medical history and HIV care, and ability to communicate and share information.

Indigenous peoples, members of racialized communities, gay men, trans and non-binary people, and people who use drugs are more likely to experience stigma and discrimination when accessing services.

IMPACT OF COVID-19

When OACHA was working on this report, COVID-19 and its impact on the populations most affected by HIV was a key concern. The pandemic exacerbated poverty and homelessness, mental health and substance use challenges, and poisonings and deaths from a toxic, unregulated drug supply.

During the pandemic, the HIV sector demonstrated its capacity to continue to be a vital source of support for people living with and at-risk of HIV. While it is too soon to understand the full impact of the pandemic on the HIV epidemic, the data shows that in 2020 - the first year of the pandemic - there were a greater percentage of people diagnosed with HIV in care, on HIV treatment and virally suppressed than in any prior year. Many innovative, collaborative and responsive services were developed to meet the needs of the most marginalized members of our communities – including commitments to address anti-Black, anti-Indigenous and anti-Asian racism – and these programs are likely to continue.

While the HIV sector was able to maintain and even strengthen services, staff doing front-line work experienced high levels of grief and trauma, as well as anger and frustration about the slow pace of government response and the lack of increased investment in HIV and harm reduction services. However, people came together to help each other cope with grief and loss. In 2023, communities are slowly recovering from the impacts of the pandemic, integrating lessons learned, and building and reconnecting – even though the way we work has changed and is unlikely to go back to the way it was.

ADDRESSING STIGMA, DISCRIMINATION, RACISM AND COLONIALISM

Trying to stop stigma and discrimination has always been part of the HIV response. In the last few years, the HIV sector has been even more intentional in its efforts to prevent discrimination, racism and colonialism within our services and organizations. All community-based agencies participated in training about the colonialism and genocide Indigenous Peoples experienced in Canada, and the sector developed guidelines to support a process of reconciliation. Some organizations have begun to build more meaningful relationships with Indigenous Peoples in the communities they serve, and they are making progress in enhancing the capacity of HIV services to support Indigenous Peoples's efforts to improve their health. Steps have also been taken to provide training and resources to help the HIV sector address anti-Black racism, and understand how a service system built on white supremacy can create barriers to health and well being for Black and other racialized peoples. If we are to successfully close the gaps along the HIV cascade of care and ensure equitable access to health, this anti-stigma and anti-discrimination work must continue.

CONCLUSION

Over the past five years, Ontario's HIV sector has succeeded in slowing the spread of HIV and improving health for people living with HIV. Uptake of PrEP amongst gay and bisexual men has increased significantly. And the proportion of people diagnosed with HIV who are in care, on treatment and virally suppressed has increased every year. At the same time there continues to be several hundred preventable new infections each year and too many people with HIV in the province who are not engaged in care and treatment, either because they have yet to be diagnosed, or because they experience barriers to accessing health services.

The people most likely to experience these barriers include people who use drugs, Indigenous Peoples, people from African, Caribbean, Black communities, gay, bisexual and other men who have sex with men - particularly those who are racialized, people living in northern Ontario, and people living with or at-risk of HIV who are living on lower incomes or in poverty.

To achieve the vision of the HIV Strategy for Ontario to 2026 and meet the targets in the Action Plan to 2030, Ontario's HIV sector should continue to build on the progress that's been made and develop effective strategies to close the gaps, remove barriers and eliminate inequities.