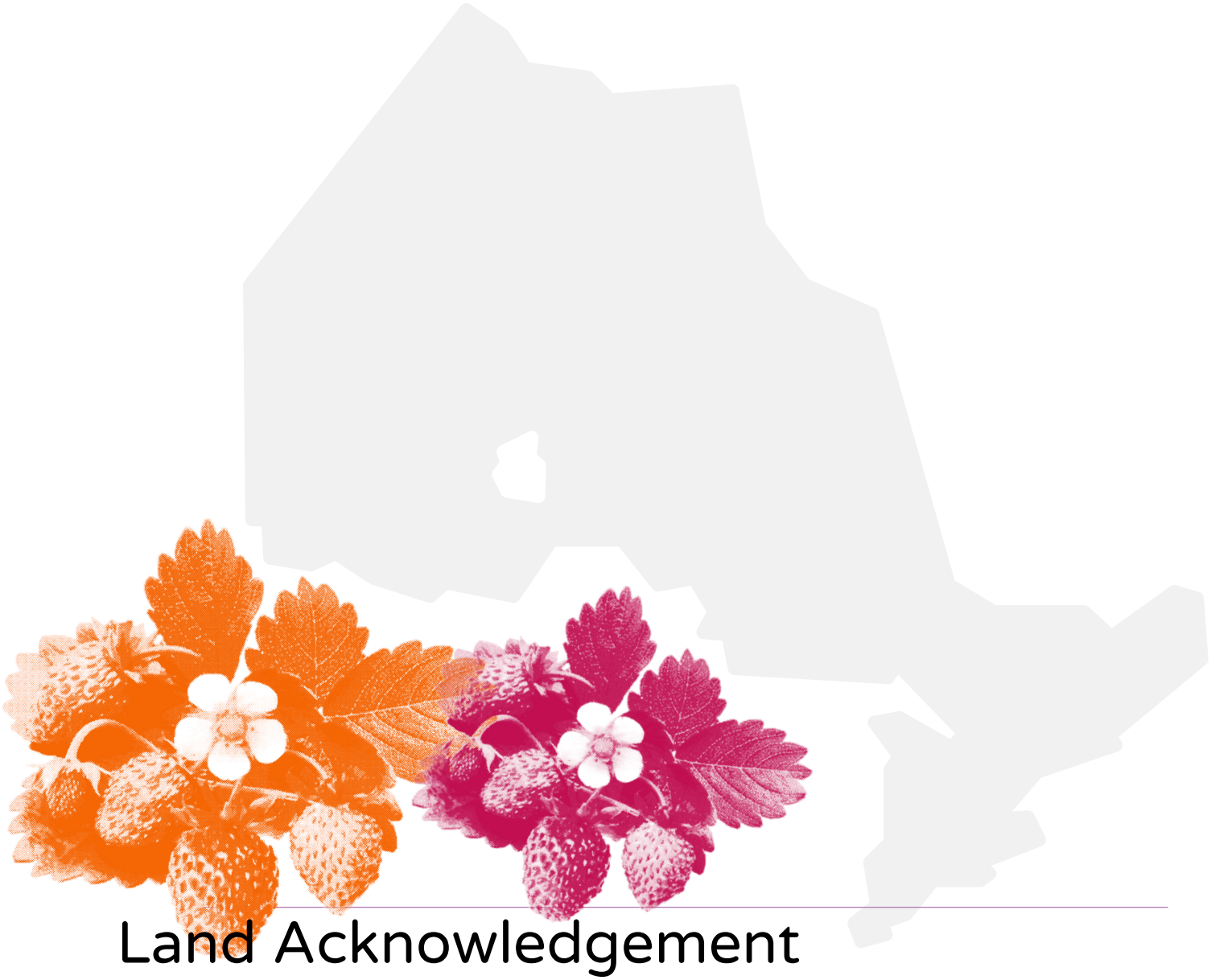
Women & HIV/AIDS Initiative

Collective Action | Community Change

A Local Community Consultation Report

Prepared by Trellis HIV & Community Care



Land Acknowledgement

WHAI acknowledges that this work has been conducted on the various unceded, occupied lands, traditionally belonging to the many First peoples across Ontario, including the ancestral and current lands of a diverse range of First Nations, Metis and Inuit peoples. We honour the many treaties, views, and practices of First people living on this land now and throughout history. We ground our ongoing work in listening, reflection and actions of solidarity in support of movements of justice and self-determination for First Nations, Metis and Inuit peoples in Ontario. We bridge our immigrant experiences and histories on the land with feminist transnational movements seeking freedom from settler occupation and colonialism.

Trellis HIV & Community Care acknowledges that we are situated on traditional Anishinaabe (Ah-nish-in-ah-bay), Haudenosaunee (Ho-den-o-show-nee) and the Huron-Wendat territory. We are grateful to be able to live, learn and play as uninvited guests on these lands. This territory is included in the Dish With One Spoon Wampum Belt Covenant, an agreement between the Iroquois Confederacy and the Confederacy of the Ojibwe and Allied Nations to peaceably share and care for the resources around the Great Lakes. The Kingston Indigenous community continues to reflect the area's Anishinaabek and Haudenosaunee roots. There is also a significant Métis community as well as First Peoples from other Nations across Turtle Island present here today.

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Acknowledgement

Thank you to the individuals and organizations who helped develop this report. Staff at the Elizabeth Fry Society, the Sexual Assault Centre of Kingston, the Integrated Care Hub, and Trellis HIV & Community Care were instrumental in conducting consultations with priority populations.

Special thanks to Spandana Ch, Korna, Steacy Drummond, and Diana Hughes for their participation in this report. There are countless other individuals, including women living at the Integrated Care Hub, women who access services at Trellis HIV & Community Care, and women who use the drop-in space at the Elizabeth Fry Society who provided valuable insight and who have selected not to be named but whose contributions are nonetheless valued.

LIST OF ABBREVIATIONS

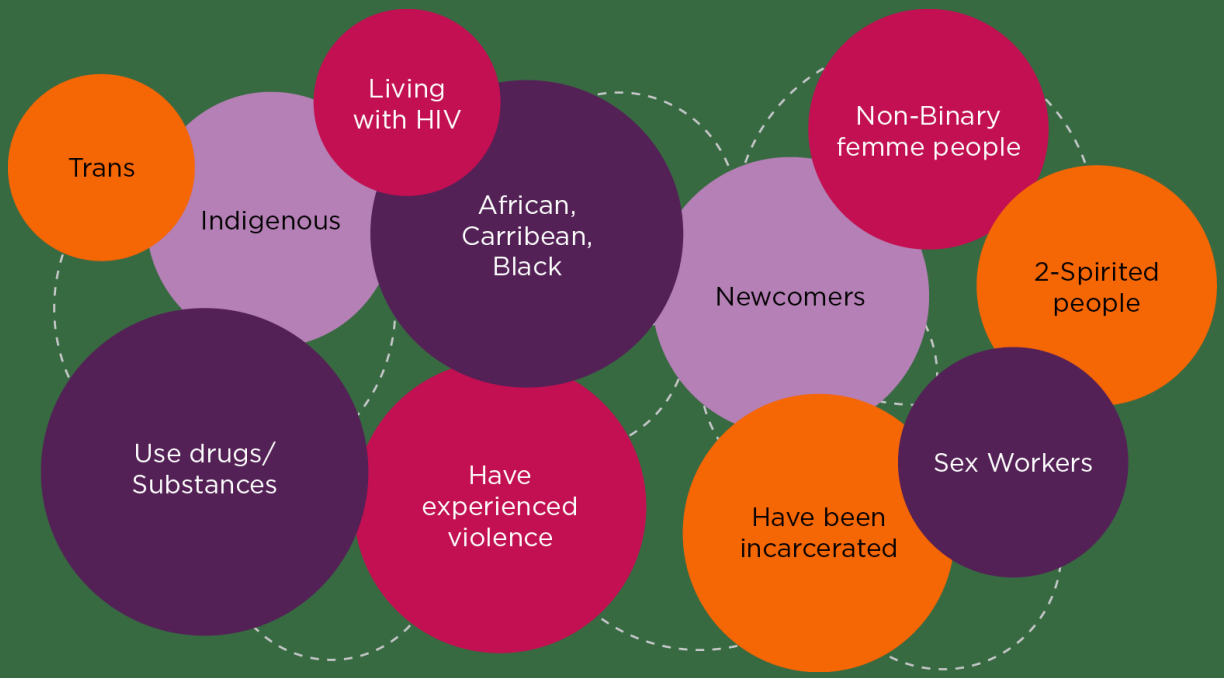
ACB	African, Caribbean, Black
AIDS	Acquired Immune Deficiency Syndrome
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
Priority Population	cis and Trans women, 2-Spirit, and Non-Binary Femme people, who are living with HIV, African, Caribbean, Black, Indigenous, newcomers, who use drugs or substances, who have experienced violence, who have been / are incarcerated.
STBBI	Sexually Transmitted Blood Borne Infections
VAW	Violence Against Women
WHAI	Women and HIV Initiative

Who we work with & What we mean by "Women"

WHAI seeks to be informed by, and amplify, the experiences of those who face structural discrimination and exclusion, impacting HIV risk and the health outcomes of those living with HIV. Our work focuses on engagement with cis and Trans **women**, 2-Spirit, and Non-Binary Femme people who are living with HIV, are African, Caribbean, Black, Indigenous, or newcomers, who use drugs or substances, have experiences with violence and / or have been / are incarcerated. Within these communities, our work includes those who are pregnant or parenting, living with different abilities, and span from young adults to seniors.

Throughout this document, the term '**women**' is written in colour to remind us of the importance of prioritizing and centring communities of **women** who face disproportionate structural risk factors related to HIV, as well as being a reminder that gender is not binary, and the importance of thoughtfulness towards inclusivity for Trans, 2-Spirit, and Non-Binary Femme people in WHAI work. Identities are capitalized throughout, except "cis." This is to remind us of the privilege and space afforded cis gender people, and to support the amplification of identities outside gender-binary constructions.

Priority Population



1.0

Introduction

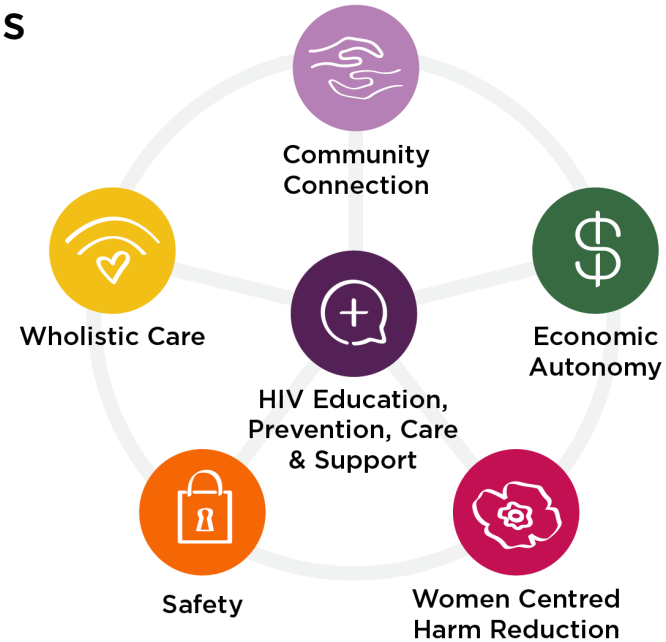
Trellis HIV & Community Care is an AIDS Service Organization located in Kingston, ON that offers stigma-free HIV/AIDS education, harm reduction, and support services for the Southeastern Ontario region. The WHAI program at Trellis works with **women** facing structural risk for HIV including **women** who use substances, **women** who are or have been incarcerated, racialized **women** experiencing structural and interpersonal racism within health and social services, and Trans, 2-Spirit, and Non-Binary Femme people. Trellis HIV & Community Care aims to reduce the risk of HIV acquisition for individuals in priority populations and to provide care and support to HIV+ clients.

This report compiles feedback from members of priority populations in the Kingston region and community partners, to understand how WHAI's priority areas for collaboration have been implemented in the local context and what challenges exist for individuals and services in these contexts.

The report will first briefly introduce WHAI's collective impact approach and outline who was engaged in the creation of this report and what we sought to learn. Next, it will provide an overview of the methods of consultation for this report and who was consulted locally. The main body of the report will focus on the WHAI's priority areas for collaboration in the regional context. Specifically, this section will first discuss challenges in HIV education prevention, care and support locally, then community connection, economic autonomy, **women**-centred harm reduction, safety, and wholistic care. Finally, this report will provide a brief outline of how these findings will be used to guide provincial and local programming moving forward.

The aim of this report is to provide a realistic glimpse at the challenges that **women** living with HIV and at risk of HIV face in the local context and the obstacles service providers face in addressing those challenges.

6 Priority Areas



2.0 Background

In 2021, the **Women** and HIV/AIDS Initiative (WHAI) began the process of province-wide consultations with cis and Trans **women**, 2-Spirit, and Non-Binary Femme people to focus its work to reduce HIV transmission; enhance community capacity to address HIV; and create environments that support **women** in their HIV-related experiences. In keeping with the principles of collective action for community change, the consultation process was thoughtfully designed to be participatory, inclusive and creative, amplifying the wisdom and leadership of **women** who face intersecting and structural barriers to sexual health. The focus of this process was specifically, **women** living with HIV, who identify as ACB, as Indigenous, as newcomers, who use drugs or substances, who have experienced violence and/or incarceration, and/or who engage in sex work.

The consultation process was planned in collaboration with the WHAI Network, community partners and knowledge holders within a de-colonial, anti-racist, participatory and trauma-informed lens. A set of four (4) knowledge gathering tools were developed in consultation with community knowledge holders that included a one-on-one discussion guide, a brief interaction tool, a storytelling tool, and a focus group/talking circle discussion guide. All tools could be adapted amidst COVID-19 related public health restrictions and catered to a range of facilitation and engagement styles, ensuring **women** had meaningful, accessible options for participation.

WHAI Coordinators implemented these tools to consult with **women** in their local communities. The stories they gathered were carefully reviewed to inform a second phase of consultations with community organizations and networks. This included Coordinators sharing what was learned from **women** and gathering stories and experiences from community partners. An additional discussion guide was developed to support Coordinators to facilitate these consultations. A total of 501 **women** from WHAI's priority populations participated, along with 317 partners from 161 community organizations and networks across Ontario, in this intentional process to ensure that community voices directed the themes that emerged.

The collective knowledge gathered from **women** and community partners was collaboratively synthesized, reviewed and analyzed along with relevant research and epidemiological reports. Reviews were conducted collaboratively by the provincial WHAI team, WHAI network membership, and a provincial review team of community knowledge holders to ensure a plurality of perspectives. Subsequently, a mapping of key barriers to HIV care and wellness, as well as strategies for enhancing care was developed.

3.0

What is WHAI?

The **Women** and HIV/AIDS Initiative (WHAI) is a community-based response to HIV and AIDS among cis and Trans **Women**, 2-Spirit, and Non-Binary Femme people in Ontario. Through a network of 17 WHAI Coordinators located in 16 AIDS Service Organizations (ASOs) throughout Ontario, WHAI aims to:

Reduce HIV risk for **women** disproportionately affected by HIV and AIDS

Enhance local community capacity to address HIV and AIDS

Build safe environments to support **women**'s HIV- and AIDS-related needs (1)

WHAI's work across Ontario is rooted in the principles of community development and collective impact. Community development values the ability of community members to affect change in their lives, in ways that are most relevant to them. Instead of organizations identifying the issues of focus, the voices of community members are centred in determining priorities. Community development is an ongoing, iterative process that guides WHAI. Coordinators work as liaisons between community groups and organizations in order to collectively develop relevant strategies to further **women**'s HIV related care. (2)

Collective impact refers to intentional ways of working together and sharing information for the purpose of solving a complex problem resulting in impactful change. Informed by the Collective Impact model shared by the Tamarack Institute, this work is typically determined by a common agenda, shared measurements of progress, mutually reinforcing activities, continuous communication, and strong collaborative supports (3). Collective impact is furthered by values of deepening community leadership, inclusivity, community conversations, collaboration, adopting strengths-based approaches, developing relationships, and investing in long-term change.

1. whai.ca/ourwork
2. Women and HIV / AIDS Initiative Program Guidelines, AIDS Bureau Ministry of Health and Long-Term Care, April 2012.
3. Learn more about the Collective Impact model here https://www.tamarackcommunity.ca/collective-impact.

4.0

Understanding Women's Stories and Community Partner Feedback

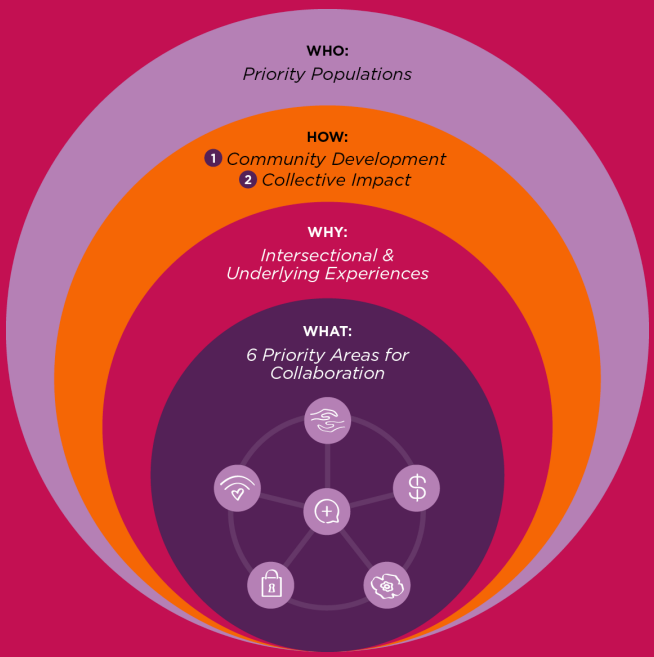
Much like the community development and collective impact approaches used throughout the consultation process, the analysis, interpretation and review of what was shared also followed these principles. The use of community led approaches helped to ensure time and space to understand the experiences and wisdom shared by communities across Ontario through the use of multiple tools and approaches.

Facilitated by the provincial team, WHAI Coordinators utilized a mix of templates, online whiteboards for visual collaboration, individual reflections and collective discussion tools, capacity building sessions on coding and a thematic analysis to support a thorough review process. In parallel, a team of community knowledge holders reviewed what WHAI Coordinators had gathered to provide varying perspectives, systemic insights and analysis to deepen and enhance the thematic review. This group reviewed with an eye to the experiences of Black **women**, Indigenous **women**, Trans, 2-Spirit and Non-Binary Femme people, and other groups who often face structural exclusion, to ensure their voices were captured and amplified. Overall, this uniquely collaborative approach to theming enabled a rich plurality of perspectives to deepen understanding and elevate **women**'s voices in framing WHAI's Priority Areas for Collaboration.

Who What Why & How of WHAI

This process of collective analysis and sense-making led to a categorization of **women**'s experiences into three key areas:

- Intersectional and underlying factors that impact **women**'s health outcomes;
- Priority Areas for Collaboration
- Community actions for change that can be undertaken both at the provincial and local level, rooted in community development and collective impact frameworks.



5.0

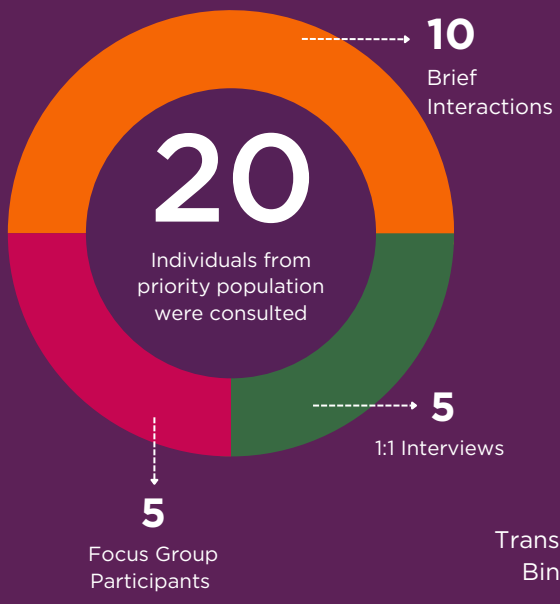
What We Did & Who We Spoke to:

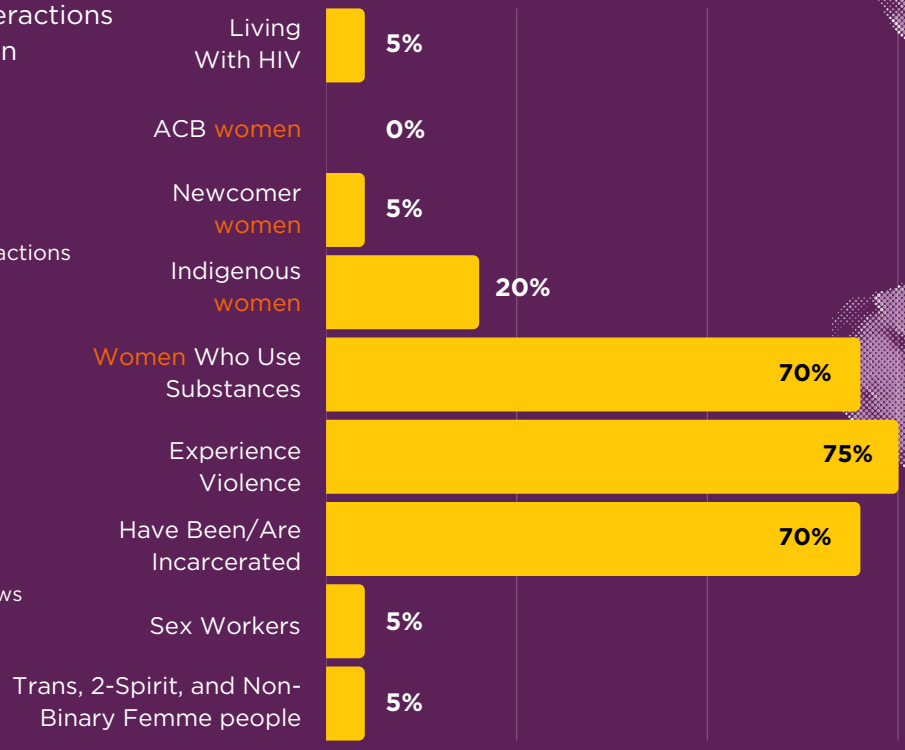
5.1 Consultations with priority populations:

Twenty (20) individuals from WHAI's priority populations were consulted in the preparation of this report. The consultations consisted of brief interactions with 10 individuals, in-depth one-on-one interviews with 5 individuals at the Integrated Care Hub, and a focus group of 5 participants conducted in partnership with the Elizabeth Fry Society and Trellis HIV & Community Care.

The brief interactions were consultation tools developed by WHAI that focused on one or two of the main consultation questions from the in-depth consultation tools. Such tools help WHAI to include voices from **women** who were unable to engage in longer, more in-depth consultations because of lacking time and / or space or facing a range of intersectional barriers. The brief interactions conducted for this report focused on wellness asking: what does wellness mean to the individual? what are some barriers to wellness that the individual has experienced? what are facilitators of wellness? what would the individual like to see change? and of WHAI's Priority Area of Focus, which are the most important or relevant? Not all participants answered all questions.

Focus group questions similarly focused on the theme of wellness, but the collaborative nature of the group allowed participants a greater role in guiding the conversation and building off each other's contributions. The guiding questions for the focus group asked for participants to share their values, explain their understanding of wellness and share with the group an item that symbolizes wellness, identify barriers and facilitators to wellness, and share recommendations for action.





Participants by Priority Population (%)

5.2 Consultations with community partners:

Staff at the Sexual Assault Centre Kingston, the Integrated Care Hub, the Elizabeth Fry Society, and Trellis HIV & Community Care were consulted as part of the consultations with community partners. Four (4) consultations were conducted with partners in the VAW sector, harm reduction sector, HIV prevention and support sector, and the criminal justice support sector. These organizations work directly with priority populations in the Kingston community and have valuable insights into WHAI's local and provincial work.

Consultations conducted with community partners broadly engaged with five main themes:

How the work of the organization is related to provincial themes of the WHAI network and the experiences highlighted by **women** consulted?

How do HIV education, care, and support fit into the local work of the service provider?

How does racism impact the **women** they serve?

How can we build community capacity to support priority populations? How can organizations better collaborate to address local needs?

How would organization like to remain involved with the work of the WHAI network?

> *"Targeted programming which facilitates women feeling safe and being able to thrive. Understanding that women may need on-site programs at the hub, in order to actually partake. Education programs for the staff to understand these issues better. Staff education is really lacking in many areas."*

- Staff at Integrated Care Hub

> *"Educate students from a cross section of areas: nursing, doctors, social workers, lawyers, teachers, etc. Making this an on-going commitment would help for better visibility of our services and hopefully will help them stay connected after they graduate in order to better serve women who face systemic risk factors."*

- Staff at Trellis HIV & Community Care

6.0

WHAI Priority Areas for Collaboration in the context of regional realities

This section focuses on the WHAI's priority areas for collaboration in the regional context. Firstly, it discusses challenges in providing localized HIV education prevention, care and support. Secondly, it shares the importance of building and strengthening community connections. Thirdly, **women**'s economic autonomy is discussed. Next, it provides insights into the importance of centring **women**'s experiences and needs in harm reduction. Fifthly, it analyzes the intersectional barriers to **women**'s safety. Lastly, this section discusses wholistic care for **women**.

6 Priority Areas

6.1 HIV Education, Prevention, Care and Support

Among priority populations and service providers, stigma, discrimination and violence were identified as barriers to accessing healthcare and support services. 60% of focus group participants and 100% of 1:1 participants have identified stigma, discrimination, and institutional violence as barriers to wellness and support. Half of the **women** who participated in consultations had experiences with institutional violence in their interactions with the healthcare system and with community service providers. These experiences ranged from outright maltreatment that resulted in injury to the refusal of pain management treatment or care due to stigma surrounding drug use. One focus group participant linked this mistreatment to inadequate training for hospital staff and police in providing care for people with mental health issues and for people who use substances. Lack of a health card has also been recognized as a significant barrier to accessing healthcare by two participants who were experiencing IPV. One **woman** explained that she could not get prescribed medications and had been turned away from multiple walk-in clinics because she did not have a health card.

100% of 1:1 participants identified stigma, discrimination, and institutional violence as barriers to wellness and support.

60% of focus group participants identified stigma, discrimination and institutional violence as barriers to wellness and support.

50% of **women** had experiences with institutional violence in their interactions with the healthcare system and with community service providers.

Furthermore, HIV+ participants understood the issue of stigma and discrimination in connection with stigma surrounding HIV diagnoses and disclosure. One HIV+ participant understood the theme of 'wellness' as relating closely to the disclosure of HIV status and stigmatization. When participants disclosed their HIV status, they were likely to be ignored or treated rudely by community service providers. She also mentioned experiencing intersectional stigma of HIV discriminations and sexism. For example, the participant stated that she had encountered more gender-based HIV discrimination from men after disclosing her HIV status.

Community service providers who participated in consultations also recognized distrust of medical systems and experiences of institutional violence within these systems as a significant barrier to care for priority populations. Staff at these agencies acknowledged that making HIV education, testing, care, and support more accessible is key. Barriers to accessibility include but not limited to fear of criminalization, lack of access to computers or telephones to check test results or complete self-tests, lack of on-site testing for STBBIs, and the inability to access childcare. Community partners have employed a range of strategies to increase accessibility and improve HIV education, prevention, care and support; for instance, being clear on anonymous vs. confidential testing options, quick response times for clients looking to test, mobile outreach for harm reduction and on-site HIV self-tests, and flexibility regarding childcare.

> *"HIV education, care, and support [as a WHAI provincial theme] resonates deeply with Trellis' work. However, this theme felt like our overarching goal which is facilitated through many of the other themes … Safety is an important facilitator specifically regarding the need to create trusting, safe environments for our clients"*
>
> - Staff at Trellis HIV & Community care

6.2 Community Connection

90%

of the **women** identified social interaction as necessary for individual wellness

The majority of participants in both 1:1 consultations and focus groups identified community as a fundamental aspect of both individual and collective wellness. While participants had different understandings of community, discussion focused on two main ideas: the need for socialization and interaction, and social support. Social interaction was identified by 90% of participants as necessary for individual wellness, and community support was widely identified as a facilitator for wellness, although what "support" entailed was understood differently among participants. Beyond interpersonal support, participants from priority populations highlighted the importance of financial support for HIV+ positive individuals and legal support for those who have experienced institutional violence within the medical systems. Community service organizations were identified as impactful supports for wellness due to their ability to provide space for community connection and care, however participants also noted that quantity and quality of such community spaces has been significantly diminished in the wake of the COVID-19 pandemic.

Means of community support commonly identified by participants

Community service providers highlighted the importance of peer support and connections in providing meaningful support and facilitating wellbeing for clients. While service providers are able to provide some forms of material support, organizations cannot manufacture relationships for clients. One staff member at the Elizabeth Fry Society of Kingston explained "we can give **women** bus passes to events or ferry passes to Wolfe Island and say, 'go have fun!' or 'go do something nice for yourself!' but no one wants to do those things alone." The model of the client / peer worker program at the Integrated Care Hub was identified as an example of meaningful engagement of community members that fosters connections outside of the organization and facilitates spaces in which marginalized **women** can feel safe and supported.

> *"we can give women bus passes to events or ferry passes to Wolfe Island and say, 'go have fun!' or 'go do something nice for yourself!' but no one wants to do those things alone."*
>
> - Staff at Elizabeth Fry Society of Kingston

> *"Wellness requires connection to others, like really connecting with people and being part of a community."*
>
> - Community voice from Kingston

> *"Give a face to services when sharing [HIV-related] knowledge and of meeting people where they are at ... Physically, this can look like having booths at events like the Women's Art Festival. Virtually, this can look like sharing videos through community partners [social media] about how and where to get tested"*
>
> - Staff from Sexual Assault Centre Kingston

6.3 Economic Autonomy

Economic autonomy is a systemic barrier to wellness for many **women** in the priority populations consulted. 60% of participants indicated that they have been financially unable to meet the practical needs of themselves and their families. Food security and housing were identified in both 1:1 consultations and focus groups as the hardest needs to meet. In Kingston, the housing vacancy rate is far below the provincial average, resulting rental prices being significantly higher than other Ontario cities of comparable sizes. A 2022 real estate report found Kingston has the fastest rising home price in Canada. (4)

Participants identified an increased demand for housing assistance in the Kingston area to alleviate the disproportionately high housing costs. One **woman** who was experiencing housing insecurity noted that while food security was a significant barrier to wellness, there were more programs across the Kingston community that provides food support. However, the existing resources for housing assistance were limited, especially in providing financial support for individuals having difficulties to pay rent or put deposits on new rental units. For **women** who have experienced IPV, housing was identified as a major barrier to leaving bad situations or abusive relationships.

Inaccessibility of technology and internet were additional barriers to wellness that participants identified. One **woman** explained that she was unable to access technology for financial reasons and also struggled with technological literacy, while another participant said that while she did have a smartphone, surveillance of technology use and internet access by her partner impeded her access. Service providers at the Integrated Care Hub highlighted how the unaffordability of technologies including cell phones impeded access to healthcare for clients, including access to HIV testing. Two participants identified the importance of having a safe space for learning and accessing technologies and internet at community agencies, and one of them expressed desires for more vocational trainings, budgeting lessons and life skills coaching which can improve their chance of getting hired.

Housing in Kingston

1.2% is Kingston's 10-year average vacancy rate (5), in contrast to an average of 2.1% in Ontario.

Kingston's vacancy rate is the

2nd lowest

in Ontario, 2022.

The average rent for a two-bedroom unit has jumped by

4.9% comparing to 2021.

(4) "Rental Market Report, January 2023 Edition", Canada Mortgage and Housing Corporation (CMHC): https://www.cmhc-schl.gc.ca/-/media/sites/cmhc/professional/housing-markets-data-and-research/market-reports/rental-market-report/rental-market-report-2022-en.ashx

(5) Vacancy rate is the percentage of all available rental units in a rental property that are unoccupied at a particular time. A 10-year average vacancy rate is the average percentage of unoccupied rental units in a specific region in a ten-year period.

6.4 Women-centred Harm Reduction

80% of participants in priority populations indicated that they had experienced some form of GBV, with 50% of participants indicating that they had experienced IPV. Among participants who experienced IPV, all of them used substances. Two participants who are currently experiencing IPV shared similar experiences of police negligence including inadequate response to IPV, exposing women to institutional violence. Another HIV+ participant talked about the reluctance and challenge of reporting IPV to the police, despite that would make her feel safe, because she had to consider her children's feelings especially when her partner had child custody. Therefore, women-centred harm reduction must consider IPV as a barrier to care, as women expressed concerns about their partners learning that they are accessing services.

Community service providers emphasized that women face unique barriers, especially within the shelter system which they view as being designed largely for men and their needs. Notably, the lack of mirrors, women-centered supplies such as hair bands, laundry and privacy in shelters were identified by consulted shelter staff as barriers from creating an inclusive space for women. Staff at the Integrated Care Hub also acknowledged IPV as a grave concern in the shelter environment, and the traditional safety planning was not applicable within such spaces. For instance, it is challenging for women to find excuses to be separated from men. Furthermore, women's outsider status within the shelter environment was perpetuated by staff's prejudiced views such as "why doesn't she just leave [the abuser]?". It points to the need for more education on understanding and responding to IPV among shelter staff. The existing women-centered harm reduction services in Kingston include the mobile harm reduction unit and the Kingston Community Health Centre's Portable OutReach Care Hub (PORCH) bus, which provide services and supplies throughout the region.

80% of women had experienced some form of GBV.

50% of women had experienced IPV.

100% of the women who experienced IPV used substances.

"The shelter system is designed for men and their needs, isolating women's experiences ... We need to consider what women need not only to be safe but what women need to thrive."

- staff at Integrated Care Hub

6.5 Safety

The theme of safety tied intimately to participants' understanding of wellness. Experiences of interpersonal violence including IPV, and institutional violence including discrimination by medical professionals, police and service providers, hindered the safety and wellbeing of participants.

During preparation of the report, staff at the Integrated Care Hub also alerted community partners about increasing incidents of female fentanyl users being sexually assaulted when they were engaging substance use. Integrated Care Hub and Trellis partnered with Sexual Assault Centre Kingston to improve GBV prevention / response mechanisms and provide on-site counselling services for women who experienced drug-facilitated sexual assaults.

Compounding concerns of safety for individuals are structures of sexism, racism, colonialism, and transphobia. Staff at Trellis, the Sexual Assault Centre Kingston, the Integrated Care Hub, and the Elizabeth Fry Society of Kingston all identified systemic racism as a significant factor that compromises the safety of their clients. According to staff at Trellis and the Integrated Care Hub, anti-Indigenous racism has been particularly prevalent in these environments. Indigenous individuals who use substances have experienced intersectional discriminations of anti-Indigenous racism, colonialism and stigma regarding substance use. One coordinator at the Sexual Assault Centre Kingston noted that both the healthcare and legal systems are significantly less accessible for racialized people. A lack of trauma-informed and multi-lingual services has significantly hindered newcomers and racialized people's access to community supports.

Furthermore, bias and negligence in policing was also identified as a safety concern by both 1:1 and focus group participants. Participants shared experiences of their words not being taken seriously by the police in reporting accidents, which deepened their distrusts in community policing. A formerly incarcerated 1:1 participant talked about experiencing police violence when she was in distress. Two (2) participants experiencing IPV were reluctant to ask for police intervention because of distrusts in law enforcement, worrying that police involvement could expose her to other legal issues or the police would not respond to her situation adequately. Although another participant did mention that an increasing police presence on the street made her feel safer, she reiterated that it did not denote liking or trusting the police. Rather, it was a compromise with the reality of growing insecurities for **women**. This report reiterates the importance of implementing more systemic trainings and capacity building in trauma-informed policing, anti-racism and anti-oppression, and VAW responsiveness for law enforcement.

6.6 Wholistic Care

Emotional and mental health were identified as important aspects of wellness, with 80% of participants in the 1:1 consultations identifying these as the most important aspects of wellness. 3 out of 5 participants noted that mental and emotional health have a strong impact on one's physical health and vice versa.

Central to participants' understanding of mental and emotional wellbeing was the concept of community. A formerly incarcerated participant noted that it was important to establish community spaces where formerly incarcerated **women** can establish new, strong, social support networks to reduce the likelihood of recidivism. A newcomer **woman** emphasized the importance of community for sharing practical supports such as where to find resources, as well as in establishing networks of emotional support. An HIV+ **woman** noted that community is important in helping individuals cope with experiences of HIV stigmatization, for providing emotional support, and for providing medical and financial support.

3 OUT OF 5 participants viewed mental and emotional health as having a strong impact on one's physical health and vice versa.

70% of participants noted that productivity and purpose were fundamental to facilitating wellness.

60% of participants cited having a job or volunteering as key to feeling productive and purposeful in their daily lives.

Engaging in creative endeavors was identified by **50%** of the participants as a strong facilitator of wellness.

Staff at Sexual Assault Centre Kingston also discussed dilemma of inclusivity vs. specificity in community-based wholistic care. The current wholistic model aims at building broad inclusivity, however, it has failed to meet the needs of people with intersecting identities who might have more specific demands or require exclusive space. Existing demands for quiet, private spaces were also brought up by both priority population participants and community partners. To tackle this challenge requires deepening inter-agency collaboration in providing a variety of spaces and programming which cater to specific populations and / or needs.

70% of participants also noted that productivity and purpose were fundamental to facilitating wellness. While understandings of this theme varied among participants, key aspects included satisfying one's need for connection to others, spending time outside, and feeling as though you are helping others. While service providers have previously been spaces for community connection, volunteering, and engaging in purposeful activities, COVID-19 restrictions significantly limited the availability of in-person programming. As COVID-19 restrictions ease, participants expressed strong desires for a return to in-person programming.

7.0 Next Steps

Provincial level 7.1

Implementation of this work will be rooted in the principles of collective impact and guided by community development frameworks. Provincially, the WHAI network will select Priority Areas for Collaboration to focus on annually, thereby strengthening our work both provincially and regionally. Each year, HIV Education, Prevention, Care and Support will be our main area of work. In addition, 2 or 3 of the other Priority Areas for Collaboration will be selected collectively as a provincial network to foster collaboration across regional sites, and within local communities, through mutually reinforcing activities. More broadly, a common agenda and shared local strategies with measurable activities and goals for the work will be collectively set based on the Priority Areas for Collaboration. Regular Network meetings will serve as a core space for communication and coordinated efforts to achieve set goals alongside communities across Ontario. WHAI will focus efforts on continuing to facilitate spaces where communities work together to determine strategies that address identified needs including capacity building and knowledge building, and draw on tools and resources that foster community leadership and amplify voices.

Reduce HIV transmission among women

Enhance local community capacity to address HIV

Create environments to support women and their HIV related experiences

7.2 Local level

Consistent with WHAI's provincial vision, WHAI's action in Kingston and Southeastern Ontario will be guided by these consultation findings. Local implementation of this work will also be rooted in principles of collective impact and shaped by community development frameworks. HIV Education, Prevention, Care and Support will remain the main area of focus for work at Trellis HIV & Community Care. This report also recommends prioritizing **Women**-based Harm Reduction in future work. In a nutshell, it puts forth four recommendations for future work based on consultations with **women** and community partners in Kingston and Southeastern Ontario.

Firstly, findings of this report underscores a need to further develop and implement **women**-centred harm reduction strategies. This includes but not limited to reforming the current shelter system to provide more safe space and sense of belonging for **women**, providing more trainings on implicit bias for shelter staff, and developing new safety mechanisms for shelter staff to identify, communicate with and intervene individuals experiencing IPV and GBV in shelters.

Secondly, this report highlights a need for more opportunities for community connection and meaningful engagement. As COVID-19 restrictions have eased, efforts have been made to re-implement in-person community groups such as art classes, Indigenous Knowledge workshops, and in-person mealtimes. These groups provide opportunities for clients to connect with others and engage in meaningful activities, both of which were identified as key to mental and physical wellbeing in consultations with **women** and community partners.

Thirdly, findings also demonstrate an increased need for communication and collaboration between service agencies in the city of Kingston and the Southeastern Ontario region. Increased collaboration and communication between service providers can help centre **women** in harm-reduction strategies, better serve priority populations, and enhance community connection.

Lastly, this report acknowledges its shortcoming in including more knowledge and experiences from **women** who are racialized, Indigenous and newcomers. Only one (1) newcomer and four (4) Indigenous persons participated in the consultation process. No ACB **women** agreed to be consulted for this report. The absence of voices from racialized **women** living with/at risk of HIV and GBV / IPV raises the importance for WHAI of developing localized strategies to build trust with ACB and newcomer **women** in Kingston. This includes collaborating with service agencies in racialized and newcomer communities, providing multi-lingual information, and advocating more employment / volunteering opportunities for racialized **women** in community services.

While this report has provided important feedback to shape future work at Trellis HIV & Community Care, all programming and education efforts will be responsive to the needs of community members and grounded in the realities of intersecting housing, drug toxicity, and healthcare crises in which our clients live.

> *"Immigration in itself is traumatic and newcomers are far less likely to be able to access care that is BOTH trauma informed and culturally sensitive / relevant ... Being rigidly attached to policies and practices is often a barrier for racialized folks as these systems weren't built for racialized folks in the first place. Being flexible to adapt to whoever you are working with is an important way to make services more accessible to racialized folks."*
>
> - Staff at Sexual Assault Centre Kingston

> *"Assumptions of whiteness from staff is a major theme I see, with believing that our population is almost all white, which is not the case. Specialized support for Indigenous clients would be beneficial. I also see colonization impacting harm reduction and shelter systems. I think a conversation about why Indigenous women are disproportionately represented in the shelter system is needed, and how colonization impacted and impacts today's experiences. I also think we need programming and education on "Canada" day."*
>
> - Staff at Integrated Care Hub

Community Art & Craft

by cis and Trans women, 2-Spirit, and Non-Binary Femme community members

Indigenous faceless doll workshop

To remind ourselves that no one is more superior or inferior than any one. Also to remember the Missing or Murdered Indigenous Persons in Canada.

Women's Art Workshop

Indigenous Art Show

"Sisterhood" by Mance

Women's Art Workshop

Indigenous Art Show

to remember hunger and deprivations Indigenous children endured in residential schools.

Women's Moonbeam Bake-together

Women's Art Workshop

Prepared by:

WHAI Women & HIV/AIDS Initiative

TRELLIS HIV and Community Care