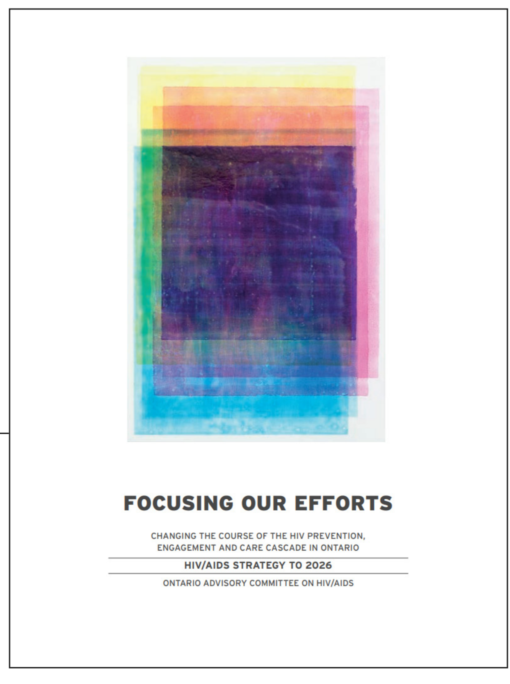
HIV ACTION PLAN TO 2030

Closing the gaps in the HIV care cascade in Ontario

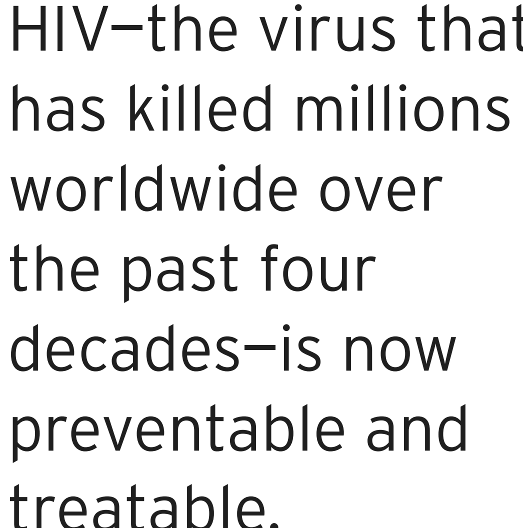
December 2023

ONTARIO ADVISORY COMMITTEE ON HIV/AIDS

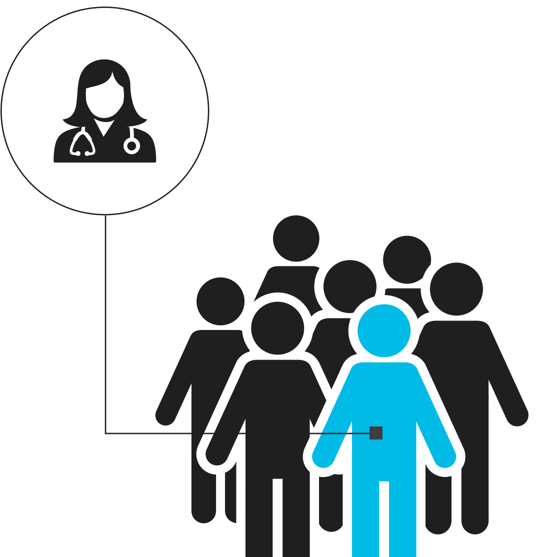


Focusing Our Efforts: Ontario's HIV/AIDS Strategy to 2026, published in 2016, drew design inspiration from Stephen Andrews's Butterfly Effect (2014, oil on Canvas, 60x40 in.) Born in 1956 in Sarnia, Ontario, Canada, the artist says this of the piece: "Among the ideas behind the work is what is commonly 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 **Action Plan** gratefully continues to take inspiration from and elaborate on this beautiful work and its message.

PREFACE



HIV—the virus that has killed millions worldwide over the past four decades—is now preventable and treatable.



The challenge? Getting HIV prevention and treatment to the people who need it, and ensuring no one is left behind.

OUR TIMELINE

2014
UNAIDS establishes the 90-90-90 targets: By 2020, **90%** of people infected with HIV are diagnosed, **90%** of those diagnosed are on treatment and **90%** of those on treatment are virally suppressed – which is better for their health and means they can't pass the virus to their sexual partners.

2016
Ontario Advisory Committee on HIV/AIDS (OACHA) releases *Focusing Our Efforts: An HIV Strategy for Ontario to 2026*. The strategy endorses the 90-90-90 targets and lays out an ambitious vision: By 2026, new HIV infections will be rare in Ontario and people with HIV will lead long healthy lives, free from stigma and discrimination.

2020
By 2020, Ontario comes close to meeting the 90-90-90 targets (see page iv), but, in that same year, UNAIDS moves the goalposts: by 2025, 95% of people with HIV diagnosed, 95% of those diagnosed on treatment and 95% of those on treatment virally suppressed.

2021
Five years into its strategy to 2026, Ontario assesses its progress in meeting the goals and targets.

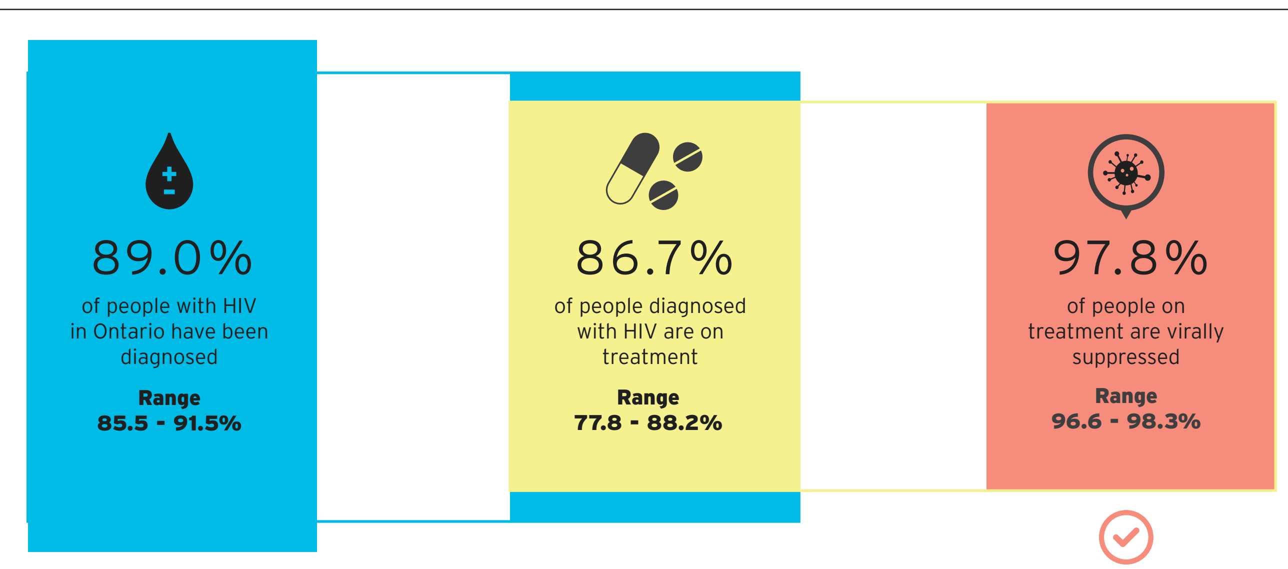
For detailed information on the impact of Ontario's HIV response, see *OACHA HIV Strategy for Ontario to 2026: A Progress Report*.

2022
OACHA develops an *HIV Action Plan to 2030* that will reduce new infections and meet the **95-95-95** targets.

2023
The *OACHA HIV Action Plan to 2030* is released.

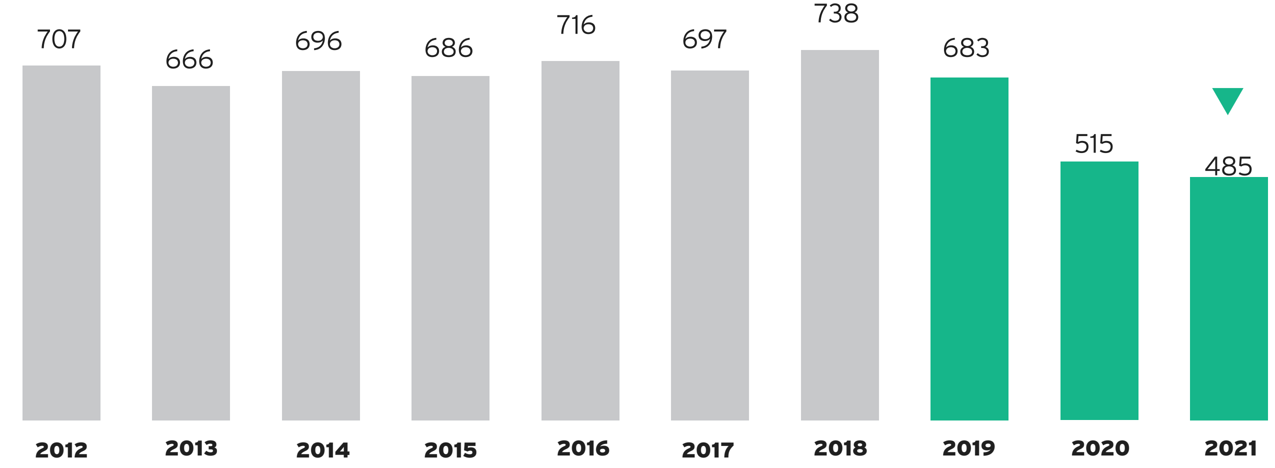
Over the past seven years, Ontario has made progress reducing new infections and getting people with HIV diagnosed and on treatment. It has done this by finding innovative ways to integrate HIV prevention and care into other health and social services, including programs for people who use substances, traditional Indigenous healing practices, and services for newcomers.

To reach the last 10% of people with HIV not yet diagnosed and the 13% of people diagnosed but not yet on treatment – many of whom may also be dealing with other complex health and social challenges, such as mental health issues, substance use, poverty, unstable housing and the impact of racism and colonization – Ontario must continue to innovate and work differently. **Effective and meaningful partnerships between the HIV sector and other services will be key to truly stopping HIV.**



By 2020, Ontario had exceeded **the third 90**, while falling just short of meeting the first two 90s.

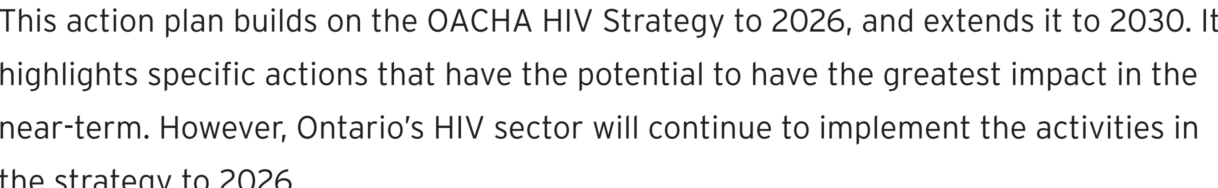
First time HIV diagnoses in Ontario 2012-2021



Around the same time, **Ontario saw a drop in first-time HIV diagnoses[i].**

i. Ontario started to see decreases in first-time diagnoses before the COVID-19 pandemic; however, the more dramatic drops in 2020 and 2021 may have been affected by lack of access to testing and other health services as well as changes in risk activities and migration patterns that occurred during the pandemic.

ACKNOWLEDGEMENTS



This action plan builds on the OACHA HIV Strategy to 2026, and extends it to 2030. It highlights specific actions that have the potential to have the greatest impact in the near-term. However, Ontario's HIV sector will continue to implement the activities in the strategy to 2026.

The Ontario Advisory Committee on HIV/AIDS (OACHA) would like to thank all who contributed to developing the HIV Action Plan for Ontario, 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

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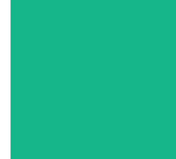
VISION

By **2030**, new infections are rare, very few Ontarians are living with undiagnosed HIV, and all people with HIV have the treatments and other services and supports they need to manage their health well.

GOALS



- Reduce new infections
- Ensure everyone at risk of HIV has access to timely, high-quality, culturally responsive testing services
- Ensure everyone diagnosed with HIV has access to timely treatment, high-quality, culturally responsive care
- Reduce stigma, discrimination, and other barriers to optimal health, including social determinants of health

ABOUT HIV IN ONTARIO

HIV is a sexually transmitted and bloodborne infection. A person can live with HIV for years without developing symptoms, while the virus attacks and weakens their immune system, making them vulnerable to health complications and premature death. During this period—when they do not know they have HIV and before they seek or are offered HIV testing—they may unknowingly pass the virus to sexual and/or drug-use partners.

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 preventing and treating HIV—new HIV diagnoses in Ontario are still concentrated in:

- Gay, bisexual and other men who have sex with men, including trans men
- African, Caribbean and Black populations
- People who use drugs*
- Indigenous Peoples
- 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.

Members of these populations also face stigma, discrimination and/or other barriers related to the social determinants of health, such as poverty, housing instability, intimate partner violence, and trauma associated with homophobia, racism and colonization, that may make them more vulnerable to HIV infection and affect their ability to access services.

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

* **Note:** 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 smoking crack and the use of alcohol, marijuana and drugs like crystal methamphetamine to enhance sex - can also increase HIV risk by affecting judgment and inhibitions. Alcohol and other substance use can result in more sexual risk taking and/or lower adherence to medications such as PrEP and antiretroviral therapy.

WHERE WE WANT TO BE BY 2030

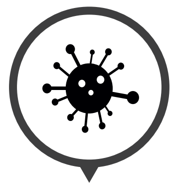
Populations most affected by HIV understand and benefit from the key scientific developments in HIV testing, prevention and treatment. They have confidence in and full access to strategies to help them either avoid or live well with HIV.

At least 95% of Ontarians with HIV are diagnosed

People living with and at-risk of HIV consistently report accessible, stigma-free, welcoming, affirming HIV care

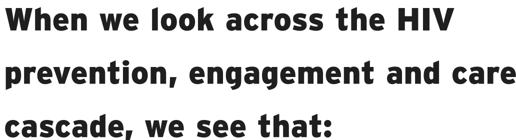
At least 95% of people diagnosed with HIV are on treatment

People living with and at risk of HIV enjoy good quality of life.



At least 95% of people on HIV treatment are virally suppressed

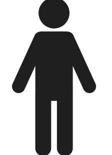
WHERE WE ARE NOW



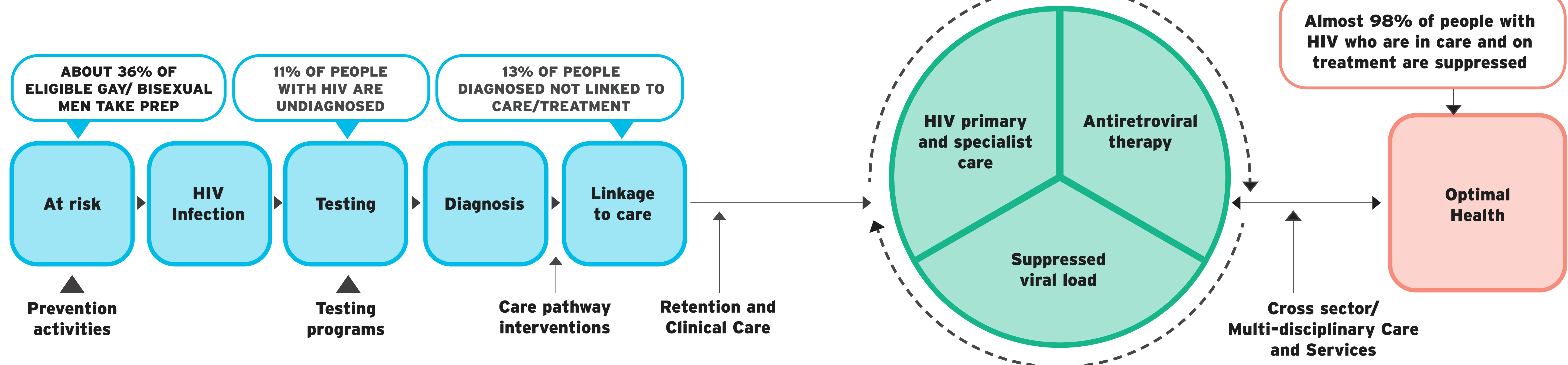
When we look across the HIV prevention, engagement and care cascade, we see that:

- The number of first-time diagnoses has dropped over the past few years; however, some of the decrease may be due to the impact of the COVID-19 pandemic which affected access to testing and other health care services as well as risk behaviors and migration patterns.
- Approximately 89% of the estimated 22,461 people with HIV in Ontario have been diagnosed.
- Almost 98% of Ontarians with HIV who are on HIV treatment are virally suppressed, which means they are healthier and cannot pass the virus to their sexual partners.

Treating HIV is not enough to ensure that people living with HIV lead long lives in good health. Ontario must also look beyond the 95-95-95 targets to measure and improve quality of life of people with HIV, ensuring they have the opportunity to participate fully in their communities, have a sense of belonging and purpose, and are supported to be their whole selves.



Despite this progress, there are still gaps in Ontario's prevention, engagement and care cascade.



- Only about one-third (36%) of gay and bisexual men who are eligible for pre-exposure prophylaxis (PrEP) – a medication that prevents HIV – report using it[1].
- We have not maximized the benefit that PrEP and other prevention tools can offer to ciswomen and transwomen at high risk of HIV.
- Several hundred new infections are diagnosed in Ontario each year (almost 500 in 2021).
- 11% of Ontarians living with HIV (about 2,470 people) are not yet diagnosed.
- 13% of people diagnosed with HIV (about 2,600 people) are not on treatment because of barriers they face engaging in care, staying in care or accessing HIV treatment.

By increasing **awareness** about how to prevent and treat HIV, increasing **access** to HIV testing, prevention and treatment, and addressing the **barriers** that keep people from engaging and staying in care, we can:

- support people at each stage of the prevention, engagement and care cascade
- ensure all people with or at risk of HIV have the health care services and supports they need to avoid or live well with HIV, and achieve optimal health.

Indigenous Peoples, people who use drugs, men and women from African, Caribbean, and Black communities, gay, bisexual and other men who have sex with men – particularly those who are racialized, people living in northern Ontario, and people with HIV who live in poverty continue to see disparities along the HIV cascade of care.

1. HIV pre-exposure prophylaxis (PrEP) in Ontario, 2020. Ontario HIV Treatment Network (https://www.ohesi.ca/wp-content/uploads/2022/03/OHTN-PrEP-report-2020_vf.pdf).

OUR PRIORITIES

By 2030:

- Reduce the number of new HIV infections in Ontario
- Reach the 11% of people with HIV in Ontario who are undiagnosed and link them to testing and treatment
- Reach the 13% of people in Ontario who are diagnosed with HIV but not on treatment to provide the supports they need to improve their health

OUR STRATEGIES

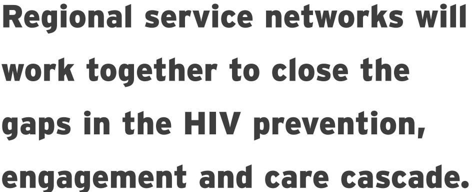
1. REGIONAL SERVICE NETWORK COLLABORATIONS

2. POPULATION-SPECIFIC APPROACHES

3. HEALTH EQUITY

4. EVIDENCE-BASED PROGRAMS AND SERVICES

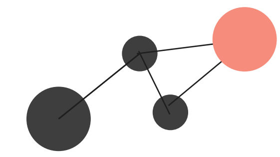
1. REGIONAL SERVICE NETWORK COLLABORATIONS



Regional service networks will work together to close the gaps in the HIV prevention, engagement and care cascade.

The HIV sector—community-based HIV organizations, HIV clinics and public health units—have been involved in community planning since the early 2000s. They have worked with other organizations in their communities—such as community health centres, other HIV care providers, hepatitis C teams, harm reduction services, mental health and substance use services, housing programs, settlement services, and correctional facilities—for more than 20 years to develop local and regional service networks.

Over the past five years, Ontario has seen how stronger, more formal or intentional collaborations between the HIV sector partners and other partner agencies can improve services for people with or at risk of HIV. These collaborations also helped communities respond effectively to urgent health issues, such as HIV outbreaks, the COVID-19 pandemic and, most recently, the Mpox (formerly known as monkeypox) outbreak. Ontario also has many examples of successful collaborations that have improved the overall health and well-being of populations most affected by HIV.

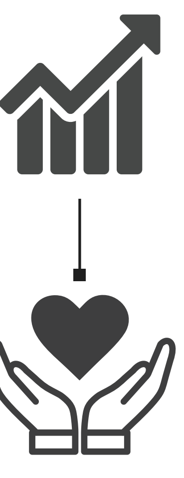


Today's Ontario Health Teams (OHTs) focus on bringing together all health organizations in their communities to coordinate services to meet population health needs.

Over the next seven years, the HIV sector should build on these collaborations and – working with people living with or at risk of HIV – develop stronger regional service networks.

Together these networks will improve access to timely HIV prevention, testing, care, treatment and support services – as well as other services that address the social determinants of health – in their community.

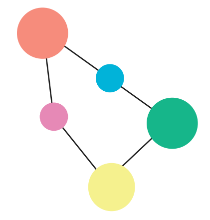
To support regional service network planning, the Ontario HIV Treatment Network will provide biennial reports that include key regional data, such as the number of people tested, number of first-time diagnoses, number of people on PrEP and PrEP prescribers, number of people on treatment, viral suppression rates, and the health and well-being of people living with HIV in each region, as well as evidence about effective interventions. Regional service networks can use the reports to help identify local needs and priorities, improve outcomes and assess their progress.



2. POPULATION-SPECIFIC APPROACHES

The populations most affected by HIV may also face other health issues, and each population may have different unmet needs. For example, many gay men face mental health and substance use issues related to childhood trauma and homophobia. People who use drugs may face challenges related to mental health, substance use, homelessness, and criminalization. Members of African, Caribbean and Black populations may be dealing with settlement concerns, low incomes, and racism. Indigenous Peoples may be coping with colonization, racism and intergenerational trauma. Women at risk of HIV may be living with poverty, substance use and intimate partner violence. Some populations affected by HIV also experience higher rates of criminalization and incarceration, and may face barriers to HIV prevention and treatment within correctional facilities or when they transition between those facilities and the community. Each population needs and deserves services that address their complex, intersecting needs (e.g. racialized gay men may be dealing with both homophobia and racism).

A one-size-fits-all approach will not work for populations most affected by HIV. Approaches must be adapted to the complex health and social needs of each population.



Population-specific service collaborations will foster connections among HIV services and other health and social services focused on improving the health of particular populations, and develop population-led strategies to improve access and health outcomes.

The ministry and the regional service networks should continue to work with populations most affected by HIV to co-develop population-specific approaches to improve both access to services and health outcomes for each population.

The HIV sector should build on its experience implementing population-specific strategies that also address intersectionality, expanding work that is already happening through initiatives like:

- the Priority Population Networks – the Gay Men's Sexual Health Alliance (GMSH), the African and Caribbean Council on HIV and AIDS in Ontario (ACCHO), and the Women's HIV and AIDS Initiative (WHAI)
- Black Toronto to Zero, a group that came together to develop a plan to meet the 95-95-95 targets within the Black community
- the HQ Collaborative Leadership Council, a group of community-based HIV service organizations in Toronto working together to develop integrated sexual health, mental health and social support services for gay, bisexual and other men who have sex with men and two-spirit, trans and non-binary people
- co-ordinated services/integrated care hubs, such as those in Kingston, London, Sudbury and Thunder Bay, developed to respond to the complex needs of people who use drugs by providing low-barrier, wrap-around services such as safe spaces, shelter, food, needle exchange programs, consumption treatment services, mental health and addiction services, and HIV and hepatitis C testing services.

To improve access to services for Indigenous Peoples with or at risk of HIV, the HIV sector and government partners will work with Indigenous leaders/partners to determine how best to reduce barriers faced by Indigenous Peoples, including First Nations (both on and off reserve), Métis, and Inuit people.

3. HEALTH EQUITY

While the needs of each population affected by HIV may be different, all face health disparities, stigma and discrimination.

The lack of culturally appropriate care and resources compounds health inequities. In a mainstream system that lacks diversity and understanding of the unique needs and challenges of different populations, those most affected by HIV may face racism, homophobia, stigma and discrimination which can increase stress, create barriers to accessing care, undermine quality of care, and lead to health disparities. People who have experienced HIV stigma, anti-Indigenous and anti-Black racism, colonialism, transphobia, homophobia and other forms of discrimination may have had bad experiences with the health care system, distrust health care services and avoid care, which means they do not receive the services and support they need. They may also experience structural or systemic barriers related to the determinants of health (e.g. poverty, housing, employment). Living with both societal and individual racism has a negative impact on their ability to achieve good health outcomes and can worsen illnesses, including HIV.

To ensure equitable access to health for the populations most affected by HIV, Ontario's HIV sector should address stigma and discrimination (e.g. racism, anti-Black racism, homophobia, transphobia) in their services and across the regional service networks, improve access to high quality, culturally responsive services, and eliminate disparities in HIV outcomes.

The HIV sector must continue to take concrete steps to end all forms of stigma and discrimination within organizations and the services they provide, including participating in training and ensuring they are equipped with the skills, tools and practices to provide culturally responsive and appropriate services. The HIV sector partners will create work environments where each person can bring their whole self to work and thrive in their roles, and where every service is person-centered, culturally responsive and stigma-free. They will also strive to eliminate disparities in health outcomes along the HIV care cascade, improve health equity, and empower people living with or at risk of HIV.

4.

EVIDENCE-BASED PROGRAMS & SERVICES

Over the past four decades, HIV research – developed collaboratively with people living with or at risk of HIV – has resulted in highly effective prevention tools, faster testing technologies, and better treatments. That scientific research combined with clinical/community and lived/living experience has helped Ontario develop effective evidence-based programs and services. It has also helped us understand all the factors – besides the virus itself – that put people at risk of HIV or make it more difficult for some people with HIV to achieve good health.

To help everyone with or at risk of HIV to achieve optimal health, Ontario's HIV sector should continue to use that combination of research evidence, clinical/community experience and lived/living experience to develop programs and services that respond to the diverse needs of the people in our communities who experience health disparities. The sector should also actively communicate the scientific advances in HIV prevention, testing and treatment – both to reduce stigma and to give people with or at risk of HIV the information they need to make informed health decisions.

We now have evidence-based interventions that can help address the complex health and social needs of populations most affected by HIV. A major part of our strategy is to continue to follow and communicate the science, and use what we have learned to improve health outcomes and stop HIV.

By 2030:

- Reduce the number of new HIV infections in Ontario
- Reach the 11% of people with HIV in Ontario who are undiagnosed and link them to testing and treatment
- Reach the 13% of people in Ontario who are diagnosed with HIV but not on treatment to provide the supports they need to improve their health

PRIORITY #1

REDUCE THE NUMBER OF NEW HIV INFECTIONS IN ONTARIO

HIV is preventable.

Effective tools such as PrEP (pre-exposure prophylaxis), PEP (post-exposure prophylaxis) and condoms can prevent the spread of HIV through sex – as can HIV treatment. People with HIV who are on treatment and virally suppressed cannot transmit HIV to their sexual partners: undetectable = untransmittable. Harm reduction resources, such as sterile drug using equipment, needle exchange programs, and consumption and treatment services (CTSs), can prevent the spread of HIV through sharing drug use equipment.

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

99%

A number of jurisdictions have been able to significantly reduce new HIV infections among gay, bisexual and other men who have sex with men by actively encouraging PrEP uptake, including paying for PrEP.

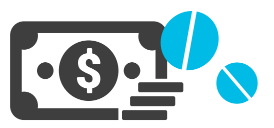
Jurisdictions that provide PrEP at no cost to people at high risk of HIV have higher PrEP uptake and fewer new HIV infections.

However, not everyone has easy access to these effective prevention tools. For example:

- Some people who are at high risk of HIV may be unaware of PrEP or unable to find a provider who prescribes it.
- People who have had a high-risk exposure to HIV (e.g. condom broke, was removed or not used) and could benefit from PEP – a 28-day course of HIV treatment that can prevent infection – may not be able to access PEP within the 72 hours after exposure required for it to be effective.
- Even when people can access PrEP or PEP, cost can be a barrier. When people have access to private insurance, both PEP and PrEP are typically covered. For people relying on public coverage, PEP is identified for coverage by the Ontario government for people exposed through sexual assault, and PrEP is only covered for people who are eligible for government-funded drug programs such as the Ontario Disability Support Program and the Trillium Drug Program[2] (which requires a co-payment), the Interim Federal Health program (IFH)[3] and the Non-Insured Health Benefits Program[4].

Ontario's PrEPStart program offers three months of free PrEP as well as assistance applying for insurance for people who are eligible for OHIP and Trillium.

Even when people do have access to HIV prevention tools, they may not use them consistently. Stopping or reducing new infections requires more than just timely access to condoms, PrEP and HIV treatment.



About 43% of Ontario gay, bisexual or other men who have sex with men who are eligible for PrEP indicate that the main reason for not using PrEP is that they cannot afford it.

2. For residents of Ontario who meet criteria related to disability and/or income
3. For protected persons, settled refugees and refugee claimants
4. For First Nations and Inuit Peoples

To meet its prevention target, Ontario's HIV sector must also help people at risk of HIV address other factors – besides the virus and costs – that increase their risk, including misperceptions about risk, ambivalence about taking drugs like PrEP (i.e. weighing their concerns about acquiring HIV against their concerns about taking a medication), poverty, unstable housing, mental health and substance use issues, being a newcomer and not having legal status in Canada, incarceration and the risks associated with transitioning in and out of criminal justice system institutions, and other social determinants of health.

OBJECTIVES

- Increase the number of Ontarians at risk who are aware of effective HIV prevention tools, and feel supported in their efforts to use them
- Increase access to the range of evidence-based HIV prevention options, including treatment as prevention, PrEP, condoms, PEP and harm reduction resources

ACTIONS

1.1 Raise awareness of HIV prevention tools – treatment as prevention, PrEP, condom use, PEP and harm reduction resources – among populations most affected by HIV by:

- Implementing population-specific approaches for
  - Two-spirit, Black, Latine and other racialized gay, bisexual and other men who have sex with men
  - African, Caribbean and Black communities
  - Indigenous communities
  - People who inject drugs
- Providing education about PrEP – including when PrEP is recommended, its safety and effectiveness, how to use it appropriately and how to access it in Ontario – and actively promoting its use among people who are eligible for PrEP (i.e. meet the high-risk criteria).

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

1.2 Increase access to HIV prevention tools by:

- Working with public health units to offer PrEP education, assessment and referral to individuals who are at high risk of HIV based on their sexual and substance use practices, history of sexually transmitted infections and previous use of PEP
- Training more providers to prescribe PrEP and PEP, paying particular attention to regions where there are unmet needs for PrEP
- Working with health care providers who provide care for Indigenous Peoples, Black, Latine and other racialized communities, trans and non-binary people, people who use drugs and people who are incarcerated to integrate HIV prevention into their services
- Educating providers who serve cis-women and trans women – including those who work in shelters, community health centres, health care organizations that serve Indigenous, Black and trans women, and programs that serve women who use substances – about effective HIV prevention tools
- Expanding access to harm reduction supplies and prevention education across the province, focusing particularly on rural and remote communities.

1.3 Remove barriers to HIV prevention by:

- Helping people and providers accurately assess risk and the need for different HIV prevention tools
- Continuing to promote the PrEPStart program for people who are eligible for OHIP and Trillium
- Exploring other options for providing free ongoing access to PrEP for people in Ontario who are not eligible for OHIP or other government-funded health insurance, do not have private insurance and face financial barriers accessing PrEP
- Introducing a program in Ontario that makes PEP available at no cost to all who seek it and are eligible
- Providing the supports that people on PrEP may need to take it consistently as prescribed
- Addressing other health and social factors, such as poverty, mental health, substance use and incarceration, that may limit people's ability to use effective HIV prevention tools.

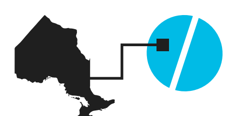
MONITORING

Continue to track and report annually on:

- the number and rate of first-time diagnoses, by population and by region
- the number and demographics of people on PrEP, by sex and by region
- the number and geographic distribution of PrEP providers
- the number of client interactions made by harm reduction programs, and the number and type of referrals provided for people who use substances
- the number of referrals to services that help people with HIV address the social determinants of health (e.g. housing programs, income support programs, settlement services, mental health services)

Gather and report on data to assess whether members of populations most affected by HIV are aware of and have access to effective ways to prevent HIV.

Work with the OHTN and key ministry partners to identify a systematic way to monitor uptake of PEP in the province.



Ontario will not see the full public health benefit of PrEP or eliminate new HIV infections until PrEP is available at no cost to people at high risk.

PRIORITY #2

REACH THE 11% OF PEOPLE WITH HIV IN ONTARIO WHO ARE UNDIAGNOSED AND LINK THEM TO TESTING AND TREATMENT

HIV testing is the doorway to treatment for people with HIV and to prevention services for people at risk (e.g. PrEP, harm reduction services).

People with HIV have the best health outcomes when they are diagnosed early, linked quickly to care and start on treatment as soon as possible after becoming infected. Early diagnosis and treatment also reduce onward transmission.

People at risk of HIV have the best health outcomes when that risk is identified early and they are actively offered effective prevention tools.

To reach both people with HIV who have not yet been diagnosed and people who are at risk, we must encourage more testing and more appropriate testing. We must also reduce barriers that keep people from being tested, such as not realizing they are at risk, feeling uncomfortable talking about their sexual health or drug use, being concerned about confidentiality or the stigma associated with HIV, living a long distance from testing sites or providers offering testing, or – as in the case of, for example, some men who have sex with men and trans people – not being "out" to their primary care provider.

OBJECTIVES

- Increase the number of Ontarians from populations most affected by HIV who test for HIV according to *Ontario Guidelines for Providers Offering HIV Testing, 2023*.
- Increase the offer of HIV testing by health care providers and testing sites according to recommendations in the *Ontario Guidelines for Providers Offering HIV Testing, 2023.*
- Reduce the time between infection and diagnosis, and reduce the proportion of people diagnosed late.

Encouraging providers to take a "status neutral" approach to testing ensures that both people who test HIV positive and people at risk who test HIV negative receive the information and services they need to avoid or live well with HIV.

ACTIONS

2.1 Raise awareness of the importance of timely, guideline-based HIV testing by:

- Actively promoting the new Ontario Guidelines for *Providers Offering HIV Testing, 2023* to health care providers and testing sites, and making them more aware of:
- the signs/symptoms of both acute and chronic HIV infection
- the populations most at risk of HIV, the factors that put them at risk, and how frequently they should be tested
- other triggers for HIV testing, such as a diagnosis of hepatitis C or certain sexually transmitted infections (STIs)
- Launching, in partnership with populations most affected by HIV, a province-wide "test early, test often" campaign
- Working closely with other partner organizations in regional service networks to educate members of populations most affected by HIV about the factors that can increase their risk of infection,

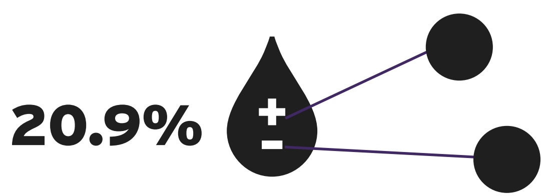
the signs and symptoms of acute and chronic HIV infection, and the recommendations in the new testing guidelines about when and how often to be tested.

2.2 Increase access to culturally responsive testing for members of populations most affected by HIV by:

- Expanding the ministry's point-of-care testing program to community health centres (CHCs), hepatitis C teams, and health care organizations that serve Indigenous, Black and other racialized communities
- Working with primary care providers (i.e. physicians, nurse practitioners) to integrate the new testing guidelines into practice, focusing on providers who are from and/or work with populations most affected by HIV (e.g. Black Physicians' Association of Ontario, Alliance for Healthier Communities)
- Piloting HIV testing in hospital emergency departments to reach people with undiagnosed HIV who may not otherwise access testing.

2.3 Overcome barriers to HIV testing, including concerns about confidentiality, stigma and discrimination, and distance from testing providers by:

- Educating testing providers about the unique needs of populations affected by HIV to create safe, non-judgemental places where people can go for culturally responsive testing
- Offering online sexual health assessments to help people understand their risks and to link them to HIV and other STI testing services
- Integrating HIV testing into other services that populations most affected by HIV use, such as hepatitis C services and Rapid Access Addiction Medicine (RAAM) clinics for people who use drugs
- Making effective use of new evidence-based testing technologies including self-test kits and, when available, multi-plex tests (i.e. a single test kit that can be used to test people for HIV and other infectious diseases)
- Working with public health units to determine whether more can be done to use case and contact management (i.e. partner notification and support) to encourage sexual and drug using contacts of people recently diagnosed with HIV to be tested for HIV
- Working with public health units to develop a systematic way to proactively offer HIV tests to people diagnosed with STIs that indicate they are at high risk of acquiring HIV.



In a recent audit of its testing programs, the United Kingdom found very high HIV prevalence (20.9%) when they reached out and offered an HIV test to the partners of people recently diagnosed with HIV.

MONITORING

Continue to track and report annually on:

- the number of people being tested and the number testing positive, by population, gender, age, race, risk factor and region of the province
- HIV point of care testing, anonymous testing and self-testing data

Improve uptake and completion of the HIV test requisition form to obtain more complete and accurate information on race/ethnicity, gender, risk factor for infection and test history.

Measure provider uptake of new testing guidelines.

Identify a systematic way to track early and late diagnoses and the factors associated with late diagnoses, and use that knowledge to inform testing initiatives.

Identify a systematic way to measure how frequently members of populations most affected by HIV are testing, and assess the rate at which members of populations affected by HIV are testing relative to the burden of HIV in their community.

PRIORITY #3

REACH THE 13%[5] OF PEOPLE IN ONTARIO DIAGNOSED WITH HIV WHO ARE NOT ON TREATMENT TO PROVIDE THE SUPPORTS THEY NEED TO IMPROVE THEIR HEALTH

Starting HIV treatment as soon as possible after infection offers people living with HIV the best opportunity at a long life, with fewer health complications. The sooner people with HIV are on treatment, the sooner they become virally suppressed, which is good for their health and helps prevent onward transmissions.

Despite the benefits of HIV treatment for individuals themselves and for population health, about 13% of people who test positive for HIV in Ontario (about 2,600 people) never link to care, are lost to care or are in care but not on treatment. A number of these individuals have moved out of the province and may be receiving care elsewhere; however, some may still be in Ontario and need support to overcome barriers to engaging in care and treatment.

Clinicians and community leaders report that the people with HIV who are most likely to be lost to care are often coping with complex health and social needs and barriers, such as mental health and substance use issues, poverty, and negative experiences with the health care system rooted in stigma, racism and colonization. People who are in

People with HIV with a viral load < 200 copies/ml are virally suppressed, which is optimal to their health and means the virus cannot be transmitted to their sexual partners.

5. The 13% not on treatment includes the 10% of people diagnosed with HIV in Ontario who are not engaged in care and the 3% who are in care but not on HIV treatment.

care but not on treatment may have misconceptions about the benefits and risks of treatment. Some may be "elite controllers": people who maintain a low or undetectable viral load and who are not taking HIV treatment.

The cost of medication is also a factor. People with HIV in Ontario who earn less than $40K per year are less likely to be on HIV treatment or virally suppressed. Those who rely on the Trillium Drug Plan report sometimes missing doses or delaying refilling their prescriptions because of difficulty affording the co-payments or deductibles.

A 2020 analysis[6] indicates that women in Ontario with HIV were slightly more likely than men with HIV to never link to care or be lost to care (9% vs 5%). People in the Northern region were more likely than those in the Southwest region to not be in care (4% vs 1%). People reporting injection drug use as a risk factor for HIV infection were more likely (17%) than men reporting male-to-male sexual contact (8%) to not be in care. Non-white individuals (11%) were more likely than white individuals (8%) to not be in care.

OBJECTIVES

- Increase the proportion of people who test positive for HIV in Ontario who are engaged in care within 72 hours of diagnosis
- Increase the proportion of people with HIV who are virally suppressed within six months of diagnosis
- Increase the proportion of people living with HIV who are retained in care, on treatment and virally suppressed
- Increase the proportion of people with HIV who report receiving welcoming care, free of stigma and discrimination
- Increase the proportion of people with HIV who report enjoying good quality of health and life.

ACTIONS

3.1 Raise awareness of the importance of people with HIV being in care and on treatment by:

- Promoting the benefits of early diagnosis and rapid initiation of HIV treatment to populations most affected by HIV, including the impacts on long-term health, quality of life and HIV prevention.

3.2 Increase access to high quality, evidence-based care and treatment by:

- Increasing the number of primary care providers in all parts of the province skilled in providing culturally responsive HIV care and treatment
- Adjusting hours of operation, service delivery approaches, cultural responsiveness of staff and recruitment/hiring practices to make services more accessible and welcoming
- Working with people with HIV and HIV care providers to understand who is not linked quickly to care and who is falling out of care, and to implement strategies to prevent delays in accessing care
- Encouraging HIV care providers to partner with Indigenous health services and other population-based service providers to increase access to culturally responsive health services alongside or in partnership with mainstream services.

3.3 Remove barriers to retaining people with HIV in care and on treatment by:

- Identifying and scaling up effective strategies to support people who use injection drugs – a population with poorer outcomes along the HIV care cascade – to either avoid HIV or be diagnosed early in the course of HIV infection and successfully engaged in ongoing HIV care and treatment
- Investigating the potential of long-lasting injectable forms of antiretroviral therapy, incentives and other strategies to help people stay in care, adhere to HIV treatment and

6. Data provided by the Ontario HIV Epidemiology and Surveillance Initiative (OHESI).

maintain a suppressed viral load

- Developing policy recommendations to reduce the negative impact of HIV drug costs and the administrative complexities of government drug programs on people's ability to access and stay on treatment
- Working through regional service networks to address the social determinants of health that affect people's ability to stay in care, including income support, housing, legal services, immigration services, mental health care, social support, violence prevention and services for people who are incarcerated or who move between correctional facilities and the community
- Advocating to end the harm caused by the criminalization of HIV non-disclosure and for changes to other policies and legislation – such as the criminalization of drug use and sex work – that increase stigma and discrimination and undermine Ontario's ability to engage and retain people in care.

Jurisdictions that have done better than Ontario in meeting HIV treatment and prevention targets provide universal access to HIV medication so cost is never a barrier to care.

MONITORING

Continue to track and report biennially on:

- the number of people diagnosed with HIV who are in care, on treatment and virally suppressed overall, by region and by key population

Continue to track and report annually on:

- the number of people linked to care within 72 hours of diagnosis
- HIV cascade outcomes by population, including number of first-time diagnoses, time between diagnosis and linkage to care, time between diagnosis and viral suppression, and rates of viral suppression

Monitor the number of HIV treatment providers relative to the number of people living with HIV, by region.

Report on linkage to and retention in care by populations most affected by HIV.

Develop a systematic approach to monitoring quality of life for people with HIV, both overall and by population, and report the findings at least twice during the life of this plan.

Survey people with HIV biennially to assess their satisfaction with:

- HIV care and treatment services (i.e. clinical services)
- services provided by community-based HIV organizations

Measure annually the success of community-based HIV organizations in:

- improving access to services for members of populations most affected by HIV
- reflecting the populations and communities they serve

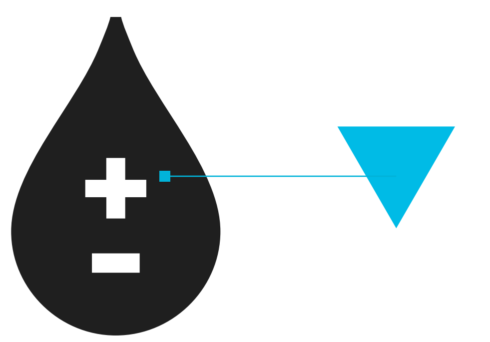
CONCLUSION

Over the past five years, Ontario's HIV sector has succeeded in slowing the spread of HIV and improving health for people living with the virus. However – to keep pace with other comparable jurisdictions that have already exceeded the original 90-90-90 targets, such as the United Kingdom and Australia – we still have work to do.

To surpass the 90-90-90 targets, meet the 95-95-95 targets, and achieve our goals by 2030, Ontario must:

- launch education/awareness campaigns that refocus attention on HIV and actively promote PrEP, HIV testing and the benefits of HIV treatment for individuals and for population health (U=U)
- reach members of populations affected by HIV who are most at risk and link them to prevention and treatment services
- increase HIV testing among populations affected by HIV and diagnose people as early as possible in the course of HIV infection
- remove barriers to engaging in care and treatment, including cost, which is a powerful determinant of health outcomes
- implement innovative strategies to help people living with HIV stay in care, on treatment and virally suppressed.

Investing in HIV prevention, testing and treatment is the way to stop HIV and the burden it places on individuals and communities. It also makes economic sense.



Ontario has made it a goal to reduce the number of new HIV infections. To do so, we must take aggressive steps to expand HIV testing, overcome barriers to PrEP and HIV treatment, and engage and retain people in care.

Every year, the annual, direct-care costs of treating HIV increases by about $13M million in Ontario[7], and the lifetime health care/treatment costs increase by about $360M-$540M. Each case of HIV prevented can save the health care system more than $15,000 a year in direct treatment costs and $500,000 over a lifetime.[8]

Between now and 2030, Ontario must focus on: increasing access to HIV testing for the populations most affected by HIV, linking people at risk to effective prevention tools, such as PrEP; reaching the 11% undiagnosed and the 13% of people diagnosed with HIV who are not on treatment; and supporting them to engage in/stay in care, on treatment and virally suppressed.

In the process of implementing the HIV Action Plan to 2030, the HIV sector should pay particular attention to the unique needs of each region of the province: working with local partners to ensure all populations affected by HIV have equitable access to evidence-based, culturally responsive prevention, testing, care and treatment services as well as the same opportunities to achieve good health outcomes.

> In this way, Ontario can stop the spread of HIV, eliminate disparities in HIV outcomes along the cascade of care, and significantly improve the health and well-being of people with or at risk of HIV.

7. Based on the total number of people being diagnosed and entering care
8. Based on the cost estimate done in 2018 using Alberta and Quebec studies. Annual cost uses median diagnosis at 35 years and life expectancy in Canada of 82 with the lifetime cost of $500,000 per person.