

A Report on Alberta's Community- Based Sexually Transmitted and Blood-Borne Infections Programming

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Abbreviations:

ACB = African, Caribbean, and Black

ACCH = Alberta Community Council on HIV

AHS = Alberta Health Services

ART = antiretroviral therapy

BC = British Columbia

CBO = Community-Based Organizations

gbMSM = gay, bisexual, and men who have sex with men

HCV = Hepatitis C virus

HIV = human immunodeficiency virus

IDU = injection drug user

M/GIPA = Meaningful/Greater Involvement of People Living with HIV

PHAC = Public Health Agency of Canada

PLWHIV = person living with HIV

PrEP = Pre-exposure prophylaxis

SCS = Supervised Consumption Sites

SSM = Self-Sufficiency Matrix

TasP = Treatment as Prevention

U = U = Undetectable = Untransmittable

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Executive Summary

Sexually Transmitted and Blood-Borne Infections (STBBIs) are a serious public health issue in Alberta. Last year 23,029 new STBBI cases were reported in Alberta, including an ongoing syphilis outbreak resulting in 34 preventable stillbirths since 2017. Modelling estimates suggest that a significant number of people living with HIV (13%) and HCV (44%) are undiagnosed (Trubnikov, Yan & Archibald, 2014). Recent advances in treatment have dramatically improved health outcomes for people with STBBIs, but access and ongoing support to such medications is uneven. Priority populations at higher risk of infection include men who have sex with men, sex workers, people who use drugs, young people, and Black and Indigenous communities.

This impact evaluation assesses the contribution of community-based programming on client and community outcomes related to Alberta's STBBI strategic plan. Program data is drawn from two six-month snapshots – one before COVID-19 (October 2019 to March 2020) and one during the pandemic (October 2020 to March 2021) – and is combined into a one-year snapshot. Interviews with CBO staff and people living with HIV provide qualitative insight into the lives of people who use the program and the wider community capacity to address STBBIs. The following Alberta Community Council on HIV (ACCH) members are included in this evaluation:

- Northreach with offices in Grande Prairie, Fort McMurray and coverage in North Zone
- OPTIONS HIV West Yellowhead with services in Jasper, Hinton, Edson, and Whitecourt
- HIV Edmonton and Streetworks in Edmonton
- Turning Point with an office in Red Deer and coverage in Central Zone
- HIV Community Link in Calgary, Medicine Hat, and Brooks
- AAWEAR (Alberta Addicts Who Educate and Advocate Responsibly) with groups in Edmonton, Calgary, and Lethbridge

Key program outputs from the one-year snapshot reporting period include:

- **143,241 client contacts related to STBBIs** from office visits (76,667), outreach (24,556), education and support (29,763), and peer activities (12,255)
- **939,272 free condoms** distributed to priority populations
- **143 new clients living with HIV** were supported
- **510 organizational partnerships** with community agencies, schools, health services, Indigenous groups, government, business, committees, and public events
- **2,982 client referrals** to STBBI testing, treatment, and services
- **218 satellite sites** trained to distribute prevention supplies and educate clients
- STBBI education provided to **3,653 service providers**

The report finds that community agencies included in this analysis play an important role in preventing and diagnosing STBBIs by engaging people who would otherwise not access mainstream services. With recent treatment advancements, most significant gaps now involve engaging vulnerable and marginalized populations with access and supportive services. Unfortunately, many Albertans still face stigma, barriers to services, and low awareness about infections. Data suggests that community agencies are well positioned to address these public

health gaps because of their experience building trusting relationships with these populations. As this client, recently diagnosed with HIV, states: “You were there for me when everything else was unavailable. I will always remember this.”

This report found that CBOs impact client outcomes in five key areas:

- Reaching marginalized and stigmatized Albertans
- Supporting newly diagnosed people
- Building client capacity to make evidence-informed decisions
- Improving access to care and supportive services
- Creating social and community connection for people living with HIV

The report highlights the strengths of a grassroots outreach approach in reaching priority populations. With 142,241 recorded client contacts over the reporting period, the numbers tell a story of successful and in-demand STBBI programming. The direct impact of connection with CBO staff is improved client capacity to make informed decisions about their life, as well as low barrier access to testing, treatment, and wraparound care. For people who are living with HIV, peer support programming creates meaningful opportunity for engagement and natural support networks that address isolation and stigma.

This report also found that CBOs impact community level outcomes in three key areas:

- Improving service provider awareness and education
- Building community capacity improves service navigation
- Leveraging research and innovation to advocate

The report concludes that these community agencies play an important role in training and building capacity among service providers in Alberta. Agencies develop partnerships with ally agencies to spread key educational messages and build awareness, as well as improve service navigation and wraparound care for their clients. CBOs also participate in research projects and use those findings to advocate for change. For example, the Alberta Stigma Index project found a shocking 57% of people living with HIV reported that their primary HIV healthcare provider didn't discuss U = U (Undetectable = Untransmittable) messaging. Now CBOs are spreading this message more widely and the Positive Voices Caucus (ACCH committee of people living with HIV) is engaging directly with physician groups to improve education on this issue.

The report concludes that community-based programming improves client access to education, support, treatment, and wraparound care for people who would otherwise not access services. Agencies play a unique role in building community capacity and service provider awareness, resulting in better service navigation and non-judgmental support for clients.

Methods

This impact report uses the principles of program evaluation to assess the effectiveness of community-based agencies involved in STBBI programming. The report uses two program evaluation frameworks to guide assessment:

- Process evaluation assesses the degree to which program activities have been implemented as designed and accessible to priority and target populations.
- Outcome evaluation measures program impact and effectiveness on priority populations to achieve its intended objectives.

The process evaluation will provide an assessment of the number and type of activities, as well as who and how clients access services. Outcome evaluation will provide insight into the effectiveness and impact on (a) the lives of people who use the program and (b) the wider community capacity to address STBBIs.

A mixed methods approach uses seven data sources:

- a. Program reporting to Alberta Health from seven agencies. A one-year combined snapshot is used in this report.¹
- b. Interviews and focus groups with STBBI program staff (n = 9).
- c. Focus group with people who are living with HIV (n = 4).
- d. Site visits at seven agencies (prior to COVID-19), including participatory observation of office hours and van outreach.
- e. STI Outreach Reports from one agency.
- f. Pre/post case management data from two agencies.
- g. Alberta Health surveillance data, drawn from annual reporting and the [Interactive Health Data Application](#).

Multiple qualitative and quantitative data sources are used to triangulate program outputs (e.g., number of clients contacted) with ethnographic and contextual analysis (e.g., how street outreach works) to explain what is happening at the client and community level (i.e., program outcomes).

¹ Program data from two six-month snapshots – one before COVID-19 (October 2019 to March 2020) and one during the pandemic (October 2020 to March 2021) – was combined into a one-year snapshot. Data was combined for ease of data analysis and to avoid over-emphasizing pre/post COVID-19 activity.

Limitations

There are several limitations that should be considered when interpreting this impact evaluation. This report is limited to a selection of community organizations who participate as ACCH members. Other community agencies (directly or indirectly) involved in STBBI-related services are not included in this analysis. Unfortunately, the number of other agencies (including community, AHS, and Indigenous) involved in STBBI work in Alberta is unknown. However, the agencies included in this report do represent the largest CBO agencies in size and scope focused on STBBI programming in Edmonton, Calgary, Red Deer, Grande Prairie, Fort McMurray, Medicine Hat, Brooks, Edson, and Hinton.

Community-based agencies do not currently have access to electronic health records in Alberta Netcare. This lack of access to medical records makes it impossible for community agencies to track clients across the healthcare system. As such, it is not possible to directly attribute their activities to *population-level* impacts like provincial STBBI rates. That is why this report is limited to client and community level impacts.

Another limitation of data is the lack of shared measurement between the assessed programs. There are currently no shared metrics or provincial evaluation plans to guide community data collection. Several other jurisdictions, such as British Columbia and Ontario, have developed detailed evaluation plans and tools to assess program impact. Where methodologically appropriate, program data is coded and re-categorized so that it is comparable to other community-based activity.

COVID-19 impacted access to programs and data collection activities. One of the six-month snapshots used in this report (October 2020 to March 2021) took place during the pandemic. Reported numbers are lower than typical because of pandemic restrictions and social distancing. Despite this limitation, data from two different six-month snapshots (one right before and one during COVID-19) was combined for ease of data presentation and to avoid 'COVID fatigue' in the analysis. The primary focus of this report is on the impact of STBBI programming on client and community outcomes, not the negative consequences of the pandemic.

Section 1: Epidemiology of Sexually Transmitted and Blood-borne Infections in Alberta

Introduction

Sexually Transmitted and Blood-Borne Infections (STBBIs) are a serious public health issue in Alberta. Several infections are on the rise and many people face barriers to education, diagnosis, and care. This despite the fact HIV (human immunodeficiency virus), Hepatitis C virus (HCV), and other sexually transmitted infections (STIs) are *preventable* and *treatable* diseases.

This report focuses on the impact of STBBI community-based programming on client outcomes and community capacity. Alberta has identified six key areas for coordinated action required to enhance the health and wellness of Albertans (Alberta Health, 2018), including:

- Prevention
- Early detection and diagnosis
- Treatment
- Support and care
- Raising awareness
- Addressing stigma

Within Alberta's strategy, community-based agencies (CBOs) play a core role in meeting these six action areas through their grassroots connection to vulnerable people and engagement with stakeholders and decision makers. Canada is also signatory to 90-90-90 global commitments to improve HIV and HCV outcomes, including that 90% of people living with HIV/HCV will know their status (i.e., diagnosed), 90% diagnosed with HIV/HCV will receive treatment, and that 90% receiving treatment will have an undetectable viral load (HIV) or cleared (HCV).

The purpose of this chapter is to explain Alberta's STBBI surveillance data. Three questions guide this section:

- How many people in Alberta have STBBIs?
- Who and how are people getting HIV and HCV?
- How is the HIV and HCV treatment cascade going in Alberta?

How many people in Alberta have STBBIs?

We don't know exactly. We have accurate testing data, but not everyone who has an STBBI gets tested. In Canada, modelling estimates that 13% (or 8,300 people) of people living with HIV are unaware (PHAC, 2018), while nearly half of people living with HCV (44%, or 110,000) are unaware of their infection (Trubnikov, Yan & Archibald, 2014). People with HCV (and to a lesser extent HIV) can live many years without any symptoms. 25% of all HCV cases clear on their own, while the rest develop chronic HCV (Challacombe, 2019).

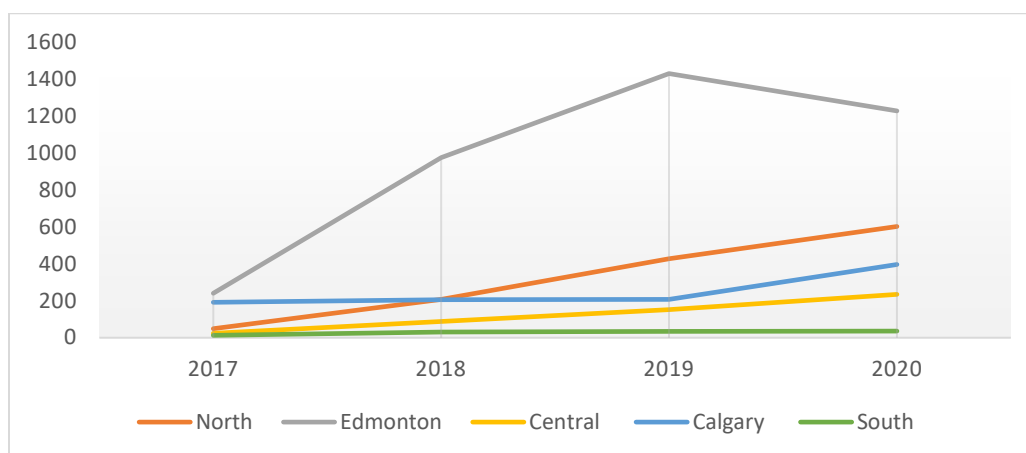
In 2020, Alberta reported 23,029 new STBBI cases (Alberta Health, 2021):

- 14,110 chlamydia cases with a rate of 319 cases per 100,000 population
- 4,893 gonorrhea cases with a rate of 110 cases
- 2,509 syphilis cases with a rate of 56 cases
- 190 HIV cases with a rate of 4.3 cases
- 1,327 HCV cases (2019 data) with a rate of 26 cases²

STIs stand out in Alberta. Chlamydia alone accounts for more cases than all other infections combined, although there was a significant decrease of 23% in the rate compared to 2019. 60% of chlamydia cases are young people aged 15 to 24 years. Young women are the most likely group to be infected. Gonorrhea is the second most common STI, although it too saw a decrease of 9.5% compared to last year. Men accounted for 57% of gonorrhea cases and people aged 30 to 39 had the highest number of cases. Several forms of treatment resistant gonorrhea are on the rise in Alberta, which the Public Health Agency of Canada (PHAC) describes as a “serious threat to effective treatment of gonococcal infections” (PHAC, 2016).

In recent years, syphilis has skyrocketed in Alberta.

Figure #1: Syphilis Cases by Region: 2017 to 2020



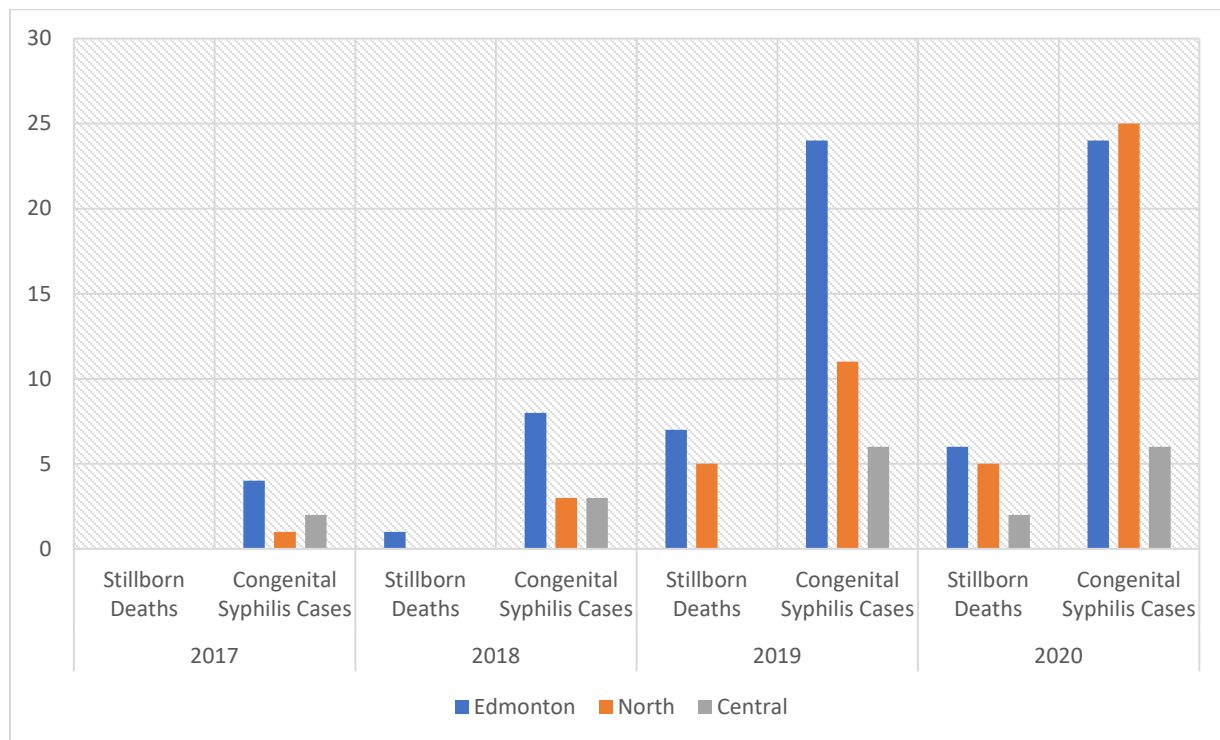
Source: Alberta Health, 2021; Alberta Health, 2020; Alberta Health, 2019

² Source for HCV data is the “Notifiable Diseases” section of the [Interactive Health Data Application](#).

The Medical Officer of Health declared a syphilis outbreak in November 2019. Alberta nearly eliminated syphilis 20 years ago, when it reported 17 total cases. Last year there were 2,509 cases. Since 2017, Edmonton Zone has accounted for 57% of all cases. Recently, Alberta Health added extra resources to support community response with improved outreach. While Edmonton did see a 16% decline in syphilis compared to last year, caution is needed reading too much into a single year. Overall, there was a 9% increase in cases across Alberta in 2020, with notable increases in North Zone (39%), Central Zone (54%), and Calgary (91%).

The most urgent concern is the increase of syphilis cases in women, particularly pregnant women resulting in the resurgence of congenital syphilis (i.e., in-utero transmission of the infection to the unborn child).

Figure #2: Number of Congenital Syphilis Cases and Syphilitic Stillbirths by Region: 2017 to 2020

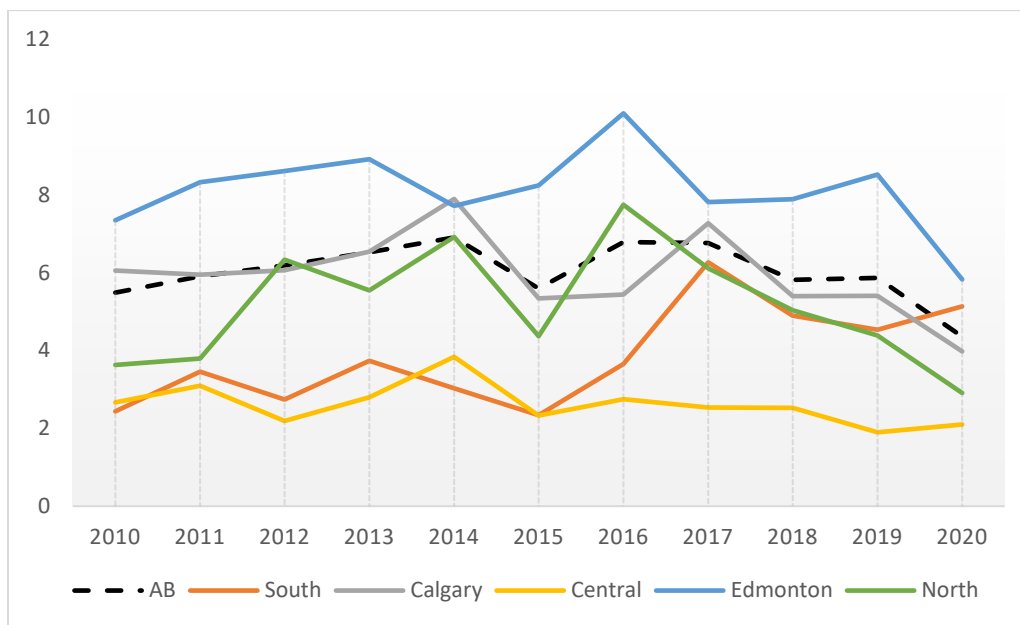


Source: Alberta Health, 2021; Alberta Health, 2020; Alberta Health, 2019

In 2017, there were zero stillborn deaths and only seven congenital syphilis cases. The numbers have tragically increased since then. From 2017 to 2021 (Q1 and Q2), 34 syphilitic stillbirths and 141 congenital cases were reported. Most cases are in Edmonton and North Zone, but there has also been a gradual increase in Central Zone. Calgary reported their first stillborn death in 2021.

Concerted efforts to prevent and reduce HIV infections are making a difference. Alberta's rate of new HIV cases has stabilized, with modest declines across most regions the last several years.

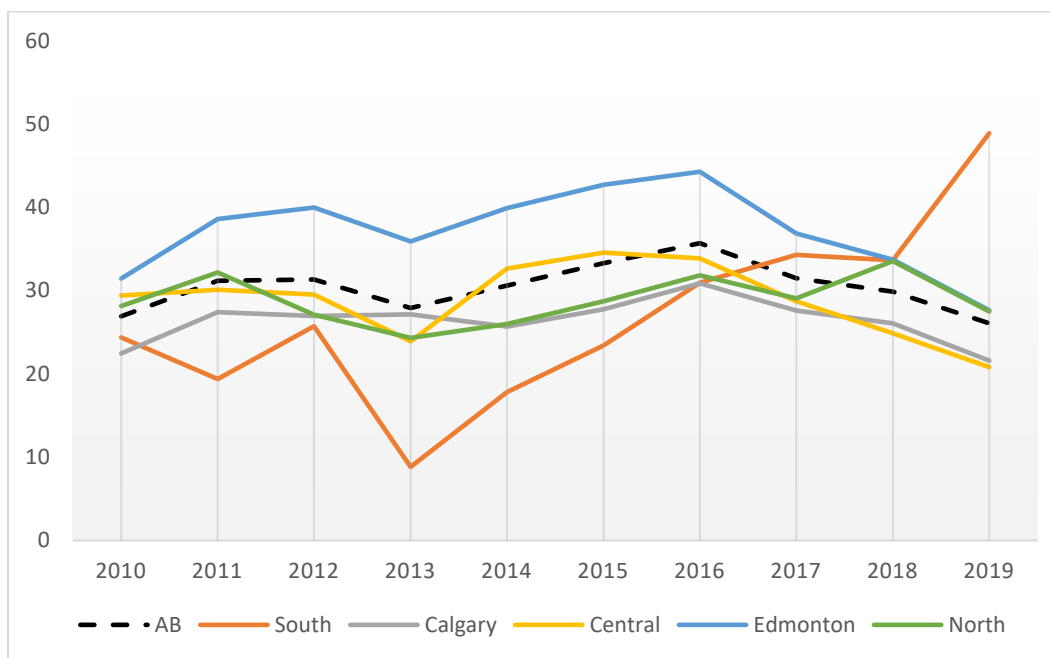
Figure #3: HIV Incident Rate by Region: 2010 to 2020



Source: Alberta's Interactive Health Data Application – Infectious Disease

Edmonton is the hardest hit by HIV infections but has been trending down since a peak in 2016. Since 2015, South Zone is the only region to see significant increases (120%) in their HIV rate.

Figure #4: HCV Incident Rate by Region: 2010 to 2019



Source: Alberta's Interactive Health Data Application – Infectious Disease

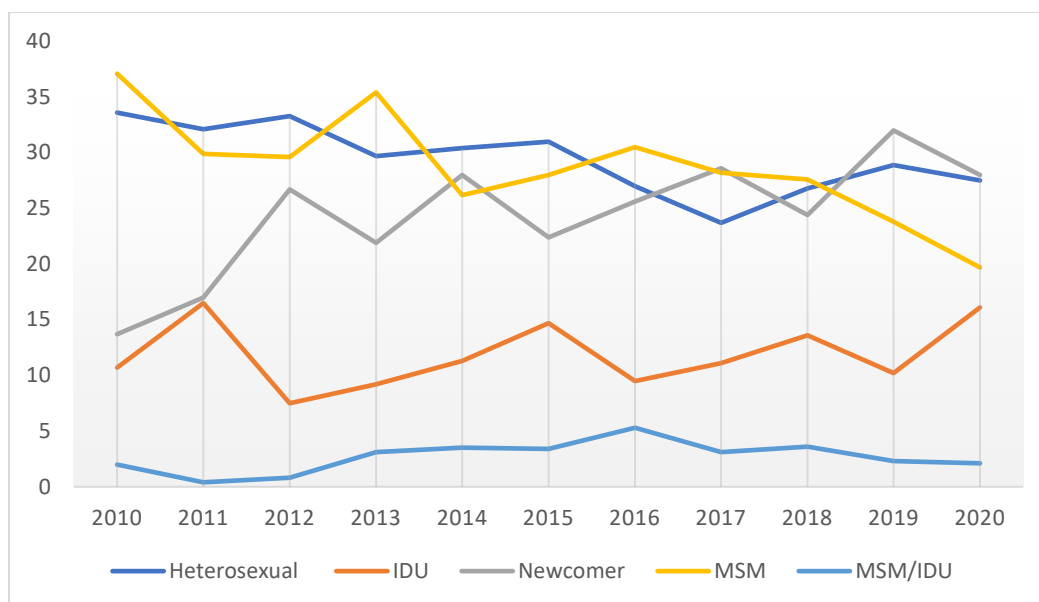
Over the last nine years, the HCV incident rate has mostly followed HIV trends. The trends are very similar across four zones (North, Edmonton, Calgary, Central) – the rate of new HCV has been stable over the last decade with modest declines in the last several years. South Zone stands out again, after dropping to their lowest point in 2013, the HCV rate has sharply increased more than 500%. South Zone’s 2019 HCV rate (49 cases per 100,000) was the highest recorded in any region this decade.

Who and how are people getting HIV and HCV?

Most HIV transmission occurs through sexual contact. For known cases in 2019, Canadian surveillance data shows that 68% were from sexual contact, 22% from injection drug use, 7% from other sources (blood products, perinatal, occupational exposure), and 3% could not determine if it was sex or drug use (Haddad et al., 2021).

Alberta Health codes each HIV case with a primary ‘exposure category’. As the graph below illustrates, the trends in Alberta are undergoing a landscape change.

Figure #5: HIV Incident Rate by Exposure Category: 2010 to 2020



Source: Alberta’s Interactive Health Data Application – Infectious Disease

Two notable trends stand out over the last decade: first, a 104% rise in newcomer (or out of country) cases, suggesting that targeted programming for immigrants and refugees is a strategic priority. And second, a 47% decline in gay, bisexual and men who have sex with men (gbMSM) cases, which indicates that dedicated programming and community response has made a significant population-level impact. However, on a per capita basis, gbMSM continue to be overrepresented in HIV cases.

There is important gender difference in HIV cases. Out the 192 HIV cases in 2020, men accounted for 66%. The exposure category for 127 men with known case information was as follows:

- 32% gbMSM
- 27% heterosexual³
- 25% out of country (i.e., immigration and refugee cases)
- 13% injection drug user (IDU)
- 3% gbMSM or IDU (could not determine)

Of the 65 female HIV cases in 2020 with known case information, the exposure category was:

- 41% transmitted out of country
- 34% heterosexual
- 25% IDU

There is also considerable racial disparity in HIV cases. According to 2020 data, Black people account for 29% of cases (about 7 times higher than the Alberta population), with women (57%) at greater risk. 25% of cases were Indigenous, which is about 3.8 times higher than the Alberta population.

In contrast to HIV, sharing drug using equipment (e.g., needle) is the leading cause of HCV transmission in Canada (see Trubnikov, Yan & Archibald, 2014). Although estimated at 1% of Canada's population, people who inject drugs and houseless people account for nearly half of all HCV cases (44%). Modelling estimates that about 35% of cases are newcomers to Canada. Men are more likely (61%) to be living with HCV than women (39%). People aged 25 to 29 had the highest rates of HCV. Modelling data suggests the following groups are disproportionately impacted:

- 66% of people who inject drugs are living with HCV
- 24% of incarcerated people are living with HCV
- 5% of gbMSM are living with HCV
- 5% of street-involved youth are living with HCV

HCV rates for First Nations people living on reserve are three times higher than the Canadian population. Unfortunately, Canada's HCV modelling data is a decade old now, so the impact of programming and strategic priorities over the last decade is unknown.

³ This combines three exposure categories: heterosexual (endemic), heterosexual (partner at risk), and heterosexual (no identified risk).

Cascade of Care

Advances in HIV treatment are a game changer. A recent study of Alberta patients at the Southern Alberta Clinic (SAC) found the HIV-related annual mortality rate was 11% in 1994. By 2017, the rate was down to 0.1% (Hanhoff et al., 2019).

Once people are diagnosed with HIV or HCV, how many are cured (HCV) or have undetectable viral loads (HIV)? The cascade of care tells us the major milestones it takes to get someone to successful treatment.

A retrospective study looking at Alberta's HCV cascade of care analyzed 6,154 people diagnosed with HCV. They found that very few people were cured (only 3.4%) over a two-year period (O'Neil et al., 2019). The study indicates that Alberta has major system-level gaps when it comes to delivering successful HCV treatment, noting that "Indigenous people, women, people who are unstably housed and people with the lowest income were less likely to achieve cascade of care milestones" (ibid).

In contrast, people living with HIV in Alberta have had much more success reaching an undetectable viral load. A retrospective study looking at HIV patients over three decades in Alberta's SAC clinic found a massive rise in the number of patients on antiretroviral therapy (ART) from 30% in 1989 to 93% by 2017 (Hanhoff et al., 2019). Of those patients on ART, about 20% had an undetectable viral load in the 1990s, but in the last decade this number has consistently been around 90%. The average number of HIV pills per day has also dropped significantly from 12 per day (1997) to about 2 a day (2016).

Alberta still needs to close the gap on reducing the number of undetectable HIV cases (rough Canada wide estimate is 13% are undiagnosed). A recent Alberta study of 231 HIV patients at SAC (Powell et al., 2020) found that 25% (n = 57) who engaged healthcare with recognized HIV risks were not tested. The report concludes that "protocols beyond the current recommendations are urgently required to address missed HIV diagnostic opportunities who engaged healthcare" (ibid). Improved access to education and low barrier testing is the only way to reach this undiagnosed population.

Section 2: STBI Services and Activities

Introduction

“It’s not just about STIs. It never will be just about STIs. It’s about making a real human connection... I feel like a lot of our clients are not treated like humans” – Outreach worker

Community agencies play a key role in preventing and diagnosing STBIs by engaging people otherwise *not* accessing mainstream services. With recent treatment advancements, the most significant gaps now involve engaging vulnerable and marginalized populations with access and supportive services. Unfortunately, many Albertans still face stigma, barriers to services, and low awareness about infections. Community agencies are uniquely positioned to fill these public health gaps because of their experience building relationships with these populations, as well as expertise implementing evidence based STBI programming. This chapter describes six core community-based programming activities:

- Engaging target populations
- Prevention and education strategies
- Support and referral services
- Peer activities for people living with HIV
- Partnership and community development
- Service provider education

“I’m usually the first point of contact”

Many of the clients who use community services would never go to STI clinic, let alone follow through on treatment, without more intensive and dedicated support. Some people have more pressing concerns. As this peer outreach worker with lived experience puts it:

“You know when I was homeless, I was like, hell with that. I would never leave my camp... that’s your home and that’s all you have. That’s challenging. I had better things to do when I was living on the streets than go see a doctor or get care.”

Although community acceptance and understanding has improved, stigma and shame about STBIs makes it hard for people to have open and honest discussions. For some people, like those with negative experiences, getting an STI test or treatment can be re-traumatizing. As this outreach worker shares, there is often more involved than just medical procedures.

“[Client] had a couple positive results and I would talk about – just remember to use protection, you can spread this to other people. And then the person literally told me, nobody cares about me. Nobody cares about anybody that I sleep with.”

When asked how they approach people who feel shame and low self-worth, a common theme emerges from program staff: respect and building authentic relationships.

“Our biggest approach is always to come at it with a non-judgemental, person centered way of delivering services. It has to be sex positive” (STBI Educator).

“There’s always an open door. There’s always someone who is going to really listen to them. And not do that stigmatization or kind of rush out the door piece” (STBBI Program Manager).

CBOs across Alberta create opportunities for their staff to meet vulnerable people – how and where they feel comfortable – as a touch point for care. These touchpoints are opportunities for staff to build relationships with clients, and ultimately, are at the core of CBO success in reaching vulnerable populations. Many clients have complex needs and competing priorities that require intensive support from staff who offer trusted and non-judgemental care. This approach contrasts with some STBBI services that use a passive approach, waiting for a population that won’t take the first step through their doors because of previous negative experiences.

Program data from six agencies over a one-year reporting period found an estimated **143,241** client contacts. Contacts were categorized into four broad types:

- Office visits⁴
- Outreach, including street outreach, mobile van outreach, and public events
- Support and capacity building, which includes a broad range of activities such as one-on-one support, workshops, case management, and service navigation
- Peer support activities with people who are living with or impacted by HIV and other STBBIs

Table #1: Estimated Number and Type of STBBI Client Contacts

Agency	Office Visits	Outreach	Support and Capacity Building	Peer Activities	Total Client Contacts
Streetworks	50,228	4,920	4,814	-	59,962
HIV Edmonton	-	973	3,920	5,003	9,896
Northreach	1,855	7,763	2,279	-	11,897
Turning Point	24,584	1,526	1,420	6,482	34,012
AAWEAR	-	6,114	846	48	7,008
HIV Community Link	-	3,260	16,484	722	20,466
TOTAL	76,667	24,556	29,763	12,255	143,241

Source: STBBI program reporting

⁴ Some services record office visits (HIV Community Link and HIV Edmonton) as other types of contacts. Office visits to Streetworks, Turning Point, and Northreach do *not* include SCS site visits.

The actual number of contacts is likely higher because some programs do not count all activities (especially outreach and peer activities). A limitation of this combined provincial data set is that it is not possible to determine how many unique individuals were supported. Despite this under reporting, more than 143,000 contacts from priority populations such as gbMSM, people who use drugs, sex workers, ACB people, and Indigenous people were engaged with STBBI services.

Prevention and Education

Four types of prevention and education activities are discussed in this section:

- Safer Use Supplies
- Targeted priority population initiatives
- Client Education and Capacity Building
- Low barrier testing

Safe Use Supplies

Table #2: Number of Condoms Distributed and Satellite Sites per Region

Region	Number of condoms distributed ⁵	Number of satellite sites ⁶
North	136,745	54
Edmonton	200,680	66
Central	72,547	14
Calgary	470,434	60
South	58,866	24
TOTALS	939,272	218

Source: STBBI program reporting

⁵ Condoms include male condoms, female condoms, and dental dams. At the time of reporting, the number of distributed condoms from two sites was not available, so purchase orders were used instead.

⁶ Some satellite sites distribute condoms, but most focus on increasing access to safe drug use supplies.

CBO agencies distributed more than **930,000 free condoms** to people at risk of STIs, such as sex workers, gbMSM, and Albertans in general. In addition to clients accessing supplies during office visits, staff also engaged in targeted education and safe sex supplies at public events (prior to the pandemic), such as pride events, rodeos, bathhouses, body rub centres, bars, and community events. Condoms, as well as other safe use supplies like needles, are engagement tools for further conversation. Consider this example from my participation on a mobile outreach van shift (prior to COVID-19):

We got a call to meet someone at a gas station. She was looking for condoms – the flavoured ones – clients liked those ones. She was in a rush, but the outreach nurse asked if she needed anything else. She did. The nurse gave the referral information and encouraged her to visit the next day.

Each supply distribution is an opportunity to educate and understand what a client needs, whether that conversation is 30 seconds or two hours. With over **218 satellite distribution sites** distributing safe drug use and sex supplies, CBOs have built partnerships with many different agencies to increase their coverage and reach. Examples of satellite locations include pharmacies, health clinics, high schools, shelters, and housing agencies.

At each location, staff build relationships and train staff how to educate and distribute supplies. One unique approach is in Grande Prairie, where Northreach has established partnerships with 12 local pharmacies to distribute safe use packs. Clients can surreptitiously pickup supplies, making the health service routine and confidential.

Supply distribution is also improved by peer-to-peer networks. As this outreach worker notes, peers are a great way to reach people who won't or can't meet with program staff:

“Some pickup condoms and take extras to give to their social circles and stuff like that. Or we'll have people in my experience who will text us and be like my friend is having this symptom or that. Can you advise on that?”

Peer engagement is a great way to reach rural and isolated locations. For example, Turning Point (Central Zone) reported 6,482 peer-to-peer contacts to an estimated 599 people who would not otherwise be reached.

Targeted priority population initiatives

Community agencies develop targeted initiatives and programs to reach people at high risk of STBBIs. Programming is adapted to the culture and readiness of each population. Some examples include:

- HER (Health, Empowered, Resilient) Pregnancy Program – supports vulnerable and street-involved pregnant women (mostly indigenous) with access to healthcare, including encouraging women to get tested and linking them to care
- Drumbeat – engages ACB communities by working closely with leaders to reduce stigma, improve prevention, and improve access to services

- HEAT (HIV Education and Awareness Today) – engages gay, bisexual, and trans people through non-judgemental outreach, education, and safer sex supplies
- Shift – supports sex workers with access to supplies, education, and support
- STI Outreach Team – addresses high rates of STIs by engaging street-involved and vulnerable Indigenous women
- CAMO (Central Alberta Men’s Outreach) – peer led program to improve health and capacity of queer, gay, trans, two-spirit, and non-binary men
- Rural outreach – individualized support, education, and access to safer use supplies to those at risk who would not otherwise have support

Programs are developed with client needs and readiness in mind. For example, consider the difference between two HIV Community Link programs. The HEAT program engages with the gbMSM population who has a high readiness for services and supports. Clients feel comfortable discussing STBBIs, in the right setting, and are supported with point of care testing.

Contrast that with the Drumbeat program, where readiness for discussing HIV and other STIs in the ACB community is low. A significant part of the program activity is about creating a safe space to even discuss HIV, which has a lot of stigma and misconceptions in the community. Consider this description of the readiness for STBBI programming:

And because of that [previous social events], they have accepted, and we can talk about sex. We can talk about HIV. We can ask our husbands... about the importance of protection and the importance of, if you can't negotiate, we can then bring the idea of using PrEP. I could only talk to them as a sister or as an aunt because otherwise if you're just doing it from an academic point of view, not going to work with African communities (STBBI Educator).

All these more targeted programs require deep ethnographic and lived experience knowledge of the culture and communities they work within. Attempting to implement a top-down model that imposes a one size fits all approach would result in backlash and little client engagement.

Client Education and Capacity Building

“You have an STI. Let's all take care of ourselves. Let's just talk about it and open up the discussion, you know?” - Peer Support Worker

Agencies are highly involved in this area with 29,763 client support and capacity building interactions. Each encounter is an opportunity to learn about client needs, risks, and share educational messages.

In addition to one-on-one education, which is based on client need, agencies also support at-risk groups in the community. For example, Streetworks staff provided weekly presentations to 225 incarcerated people in Edmonton (prior to COVID-19) to improve their skills and knowledge in primary STBBI prevention while incarcerated and to know where to access services after release. Staff also met with street involved youth (mostly Indigenous, homeless youth who use drugs and/or engaged in high-risk sex) during 41 visits to youth agencies to have honest conversations about sex and drug use, share information, and how to be safer and healthier.

Northreach also has developed education strategies to reach 44 vulnerable youth (shelters, day homes, Indigenous services) and 1,573 high school students at over 20 unique schools with their STBBI and harm reduction presentations.

CBOs are also provincial leaders in the development of educational materials for different client audiences and groups. A total of **52 unique STBBI educational materials** were created or updated during this reporting period, including pamphlets, newsletters, information sheets, and presentations. Although many agencies have now moved to online formats, including social media and website materials to expand their reach, they distributed **51,329 STBBI print materials** to targeted populations at risk or living with HIV. Some examples include targeted testing information cards in their condom packs with specific messaging appropriate for gbMSM, newcomer, and sex worker populations; and STI pamphlets for street-involved populations that shares facts in engaging and interesting ways. Like other activities, educational materials create opportunities for client conversation.

A new to sex worker (female/Indigenous) saw our information on the back of a condom package and contacted us for condoms and other harm reduction supplies... we worked on a plan to help her stay safe and take care of her health as best as possible (Program Reporting).

Targeted messaging and local educational campaigns that speak to populations can help build connections and opportunities for engagement on topics that they might otherwise not discuss. As the one agency puts it, “*our priority demographic and their inner circles demonstrate more responsiveness to this messaging instead of mainstream healthcare jargon*” (STI Outreach Report).

Low Barrier Testing

“If you guys didn’t come to me, I probably wouldn’t get tested” – Client

Several agencies also provide direct access to STBBI testing, including HIV, HCV, syphilis, gonorrhea, and chlamydia. It is challenging to establish on-site testing in community. It requires partnerships (or staff) who can do the tests (draw blood and urine) and partnerships in place with testing labs. Because most testing is done by other agencies, the actual number of STBBI tests facilitated by CBOs is unknown. The model in each community is different.

In Edmonton, Streetworks staff have established relationships with street-involved clients and a model to collect blood and urine samples at the point of contact. Many clients have had negative healthcare experiences, but because of the trust built in the community staff are successfully encouraging hesitant people to get tested. An agreement with STI testing clinics and oversight from a physician ensure appropriate protocols. Staff create follow-up plans to share results, noting “*it’s so much more than just getting the samples from them and making sure that they’re clean, it’s making sure that they understand how to keep themselves safe and healthy, keep their partners safe and healthy, how to provide education to their friends*” (Outreach Nurse).

In Grande Prairie, Northreach partners with the STBBI Partner Notification Nurse and a Nurse Practitioner from a medical centre to conduct testing at public events. Staff use events such as HIV Awareness Day and rodeo as fun, low stakes situations to build awareness, distribute safe sex supplies, answer questions, and offer testing. Point of care testing is donated by a national agency (Canadian AIDS Society).

In Calgary, gbMSM can get tested right on site with staff and nursing support at a bathhouse (when safe to do so with COVID-19 restrictions). The HEAT coordinator communicates with clients, sets testing schedules, and works with Safeworks to get testing done.

These examples speak to the innovation and community development required to create low barrier testing opportunities. They also speak to the barriers that need to be over come, such as follow up contact, healthcare professionals in the field who can collect samples, access to point of care testing, and relationships with testing labs.

Support and Referral Services

Agencies also engage and support Albertans diagnosed with HIV. During the one-year snapshot period, a total of **143 new clients living with HIV** were supported. Client demand for service continues to be high with **459 active clients living with HIV** (who declared their status) supported. The table below outlines the regional breakdown of the data.

Table #3: Number of New and Active Clients Living with HIV

Region	New Clients Living with HIV	Active Clients Living with HIV
North	11	11
Edmonton	75	180
Central	8	8
Calgary	37	145
South	12	115
TOTAL	143	459

Source: STBBI program reporting

Support is based on individual need. As this STBBI outreach worker notes, case management for people living with HIV could involve many different supports:

I work with people and if they're not adhering to medication or staying connected to health care, then we get into what are the barriers – why people are falling out of healthcare. And if it's mental health supports, I can help guide them towards mental health supports or all sorts of different things. And then I can transport to and from the SAC and the NAC program for in-person appointments.

Program data suggests that a significant number of Albertans recently diagnosed with HIV are supported by community agencies. For example, agencies reported a total of 113 new clients living with HIV over a six-month window (October 2019 to March 2020). During a roughly similar period (2019), 252 new HIV cases were reported, suggesting that roughly 45% of new people living with HIV are supported with case management by community agencies.⁷

When clients living with HIV ask for support, what do they need? While data is limited on this question, two agencies with a specialized focus on supporting HIV clients (HIV Community Link and HIV Edmonton) tracked this question with 230 combined clients. When clients were first diagnosed, they often asked for social support and felt isolated. They also found:

- More than 60% of support is for basic needs, such as housing, financial, food, and legal services
- Physical health is a prominent need, including issues such as connecting to medical professionals, nutritional intake, and HIV medication adherence
- Mental health and addiction services is an ongoing need for some people
- Social supports, especially since COVID-19, such as connecting with family and peer support network
- Increasing demand for immigration and resettlement services

Improvements to basic needs help stabilize clients, giving them space to build more meaningful relationships and reach their personal goals over time.

CBOs have also developed strong relationships with services in the community. A total of **2,982 referrals for STBBI clients** were reported by agencies. Given the reticence of clients to use other services, these referrals are often based on “warm hand-offs” to a trusted source who they know will provide non-judgemental care. Staff often attend meetings to support and advocate for clients who won’t go without staff they have a pre-existing relationship with.

CBOs make referrals through a broad network of cross-sector partners, such as the following:

- Navigation of HIV/HCV services and treatment
- STBBI testing and counselling services
- Legal support, such as victim services and landlord/tenant issues
- Mental health and addiction services
- Pharmacists
- PCNs and physicians
- Social services, including food security, clothing, furniture, housing and childcare
- Financial assistance, employment and education support
- Services related to trauma, sexual, emotional or physical abuse

⁷ This is only a rough estimate. Actual referrals would only be known through client records at the SAC/NAC, which is beyond the scope of this report.

As this list attests, CBOs are often supporting clients who have complex and competing needs that require caring and dedicated staff to meaningfully address service access. Many of these supports are not straightforward and involve intensive relationship building to understand the issues that clients face before solutions are developed.

Peer Support Activities

A core principle of HIV programming from the start has been the meaningful or greater involvement of people living with HIV/AIDS (also known as MIPA/GIPA). These principles support the self-determination of people living with HIV to be directly involved in decisions that impact their life.

People living with HIV continue to experience stigma and discrimination. The Alberta Stigma Index team of peer researchers surveyed 145 people living with HIV about their experiences. They found the following:

- 58% decided not to have sex because of their HIV status
- 50% reported their HIV status negatively impacted their relationships
- 22% worry that healthcare workers won't listen to their concerns
- 10% were advised by healthcare workers not to have sex because of their status

There is significant demand for support. This report found 12,255 peer support contacts with people living with HIV/HCV. Peer to peer support takes three forms:

- Peer activities to increase social inclusion, bonding, community, and natural supports among people living with HIV
- Skill development and capacity building
- Meaningful involvement of people in programming, policy development, and advocacy

The first set of activities, with a focus on community building and reducing social isolation, takes many forms across agencies. Informal social gatherings like weekly lunches and social events (e.g., movie night) are common. The basic idea is to create fun events for people to socialize, share stories, and learn new skills or knowledge. COVID-19 had a major negative impact on social bonding and community. Many agencies tried to replicate such events online but found “Zoom fatigue” and actual human interaction was needed. Some started addressing this by holding outdoor events.

The second type of activity is capacity building to improve their skills in areas that impact their lives, such as new laws, policies, and research. This creates opportunity for people living with HIV to access to updated information and self-improvement. Common examples include peer mentorship, legal rights, nutrition, aging, and improving HIV knowledge.

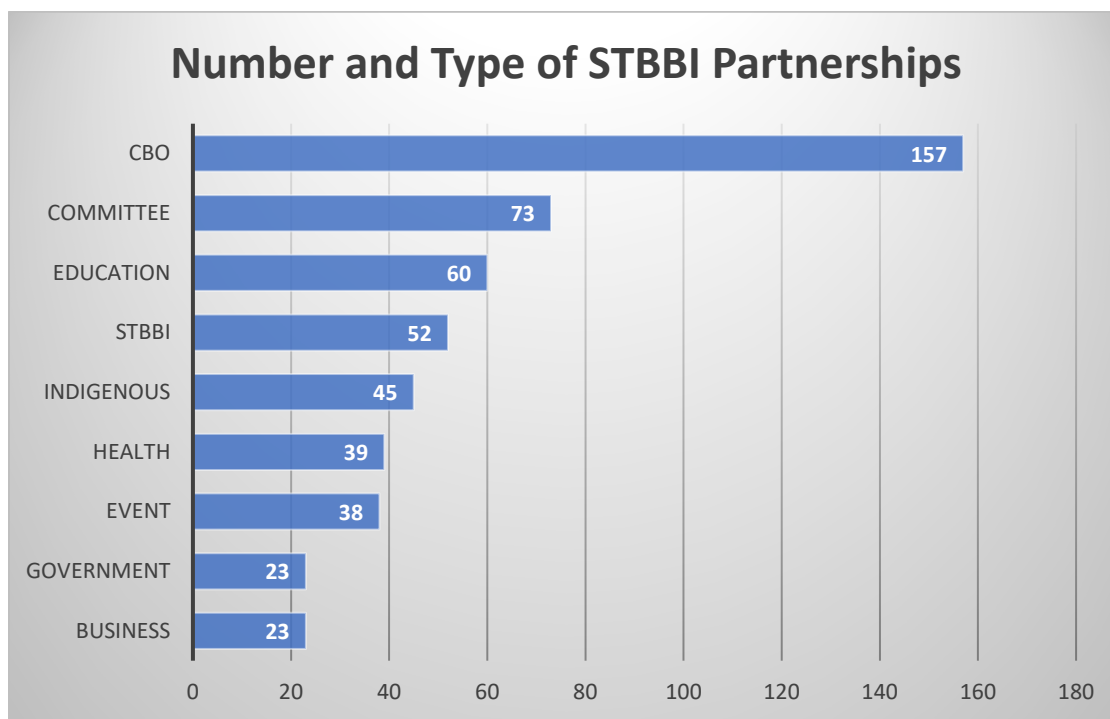
The third type of peer activity involves the meaningful involvement of people in programming delivery and policy development. However, access to such programming varies based on dedicated funding for peer initiatives, with resources heavily concentrated in Calgary and Edmonton. Examples include hiring staff with lived experience, peer to peer networking, and meaningful involvement in policy and research.

Partnership Development

Agencies form cross-sector partnerships with other groups to improve service navigation, expand awareness into new sectors, and build community capacity to respond to STBBIs. A total of **510 external organizational partnerships** have been developed to improve STBBI community responses to address a variety of strategic priorities like supply distribution, referrals, support services, capacity building, advocacy, and coordination.

Thematic analysis categorized partnerships into nine types of organizations: CBOs, committees, education, STBBI specific, Indigenous, health services, community events, government services, and businesses. Partnership development with other agencies is a core part of the capacity building and community development work that CBOs support. However, the reach and spread of partnerships goes beyond a narrow STBBI response, as these touchpoints often focus on enhancing community resilience to address the social determinants of health such as housing, immigration, and employment. The range and diversity of allied organizations who are engaged by CBOs speaks directly to the complex needs that their clients face, as well as the key role they play in creating low-barrier access to services that are confusing to navigate.

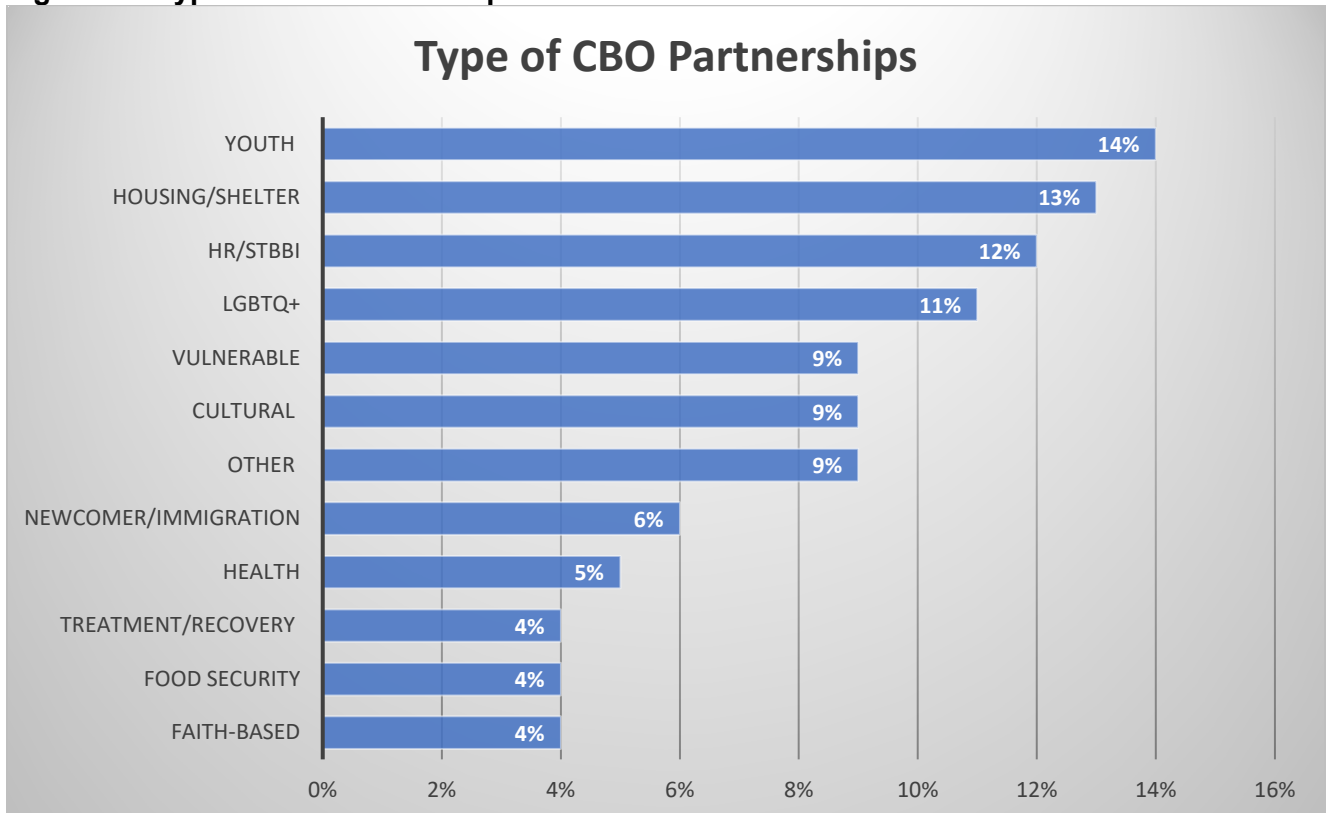
Figure #6: Partnership Development: Number and Type of Partners



Source: STBBI program reporting

CBOs account for 31% of all partnerships. Community agencies had the greatest variety of groups, including those working in harm reduction, housing, faith-based agencies, vulnerable youth, immigration, legal services, LGBTQ+, ethnic and cultural groups, food security, and violence or sexual exploitation. A breakdown of the percentage of CBO partnerships by type shows that their engagement is diverse in reach.

Figure #7: Type of CBO Partnerships



Source: STBBI program reporting

Committee participation (on non-STBBI topics) accounts for 14% of relationships. Agencies advocate for client needs and awareness about community issues related to STBBIs. Examples include committees on sexual health, community groups, homelessness, immigration, business relations, and cultural and ethnic activities.

Education accounts for 12% of partnerships, with about 60% of those with high schools and 40% with post-secondary institutions. CBOs support training knowledge related to consent, sexuality, substance use, and STBBIs in schools. All partnerships start with a request from schools or teachers to address knowledge gaps, with most requests from Central and North Zone. Post-secondary activities usually involve public events on campus to raise awareness or targeted presentations with departments likely to encounter people at risk of infection during their careers (e.g., nursing students).

Naturally, agencies established strong partnerships with other agencies involved in STI, HIV, and HCV work. This accounted for 10% of partnerships. Examples include all the core services involved in this field, ranging from STI and health clinics, CATIE (national HIV/HCV educator), SAC/NAC HIV clinics, peer-based groups, pharmacists/prescribers, testing labs, research projects to strategic planning initiatives. Agencies work side by side with these other organizations to fill service gaps, improve navigation, and build capacity. For example, SAC/NAC – the two HIV clinics who provide medical support for all patients in Alberta – work closely with community agencies to support wraparound care. Likewise, many research projects and strategies look to community agencies for input and access to people with living with HIV/HCV for their contributions.

Engagement with Indigenous groups accounted for 9% relationships. CBOs engage with urban services (such as Friendship Centres) and on-reserve partnerships. While all the CBOs discussed in this report are non-Indigenous mainstream agencies, a significant number of Indigenous people use their service. Agencies seek partnerships with Indigenous agencies who offer culturally relevant services. Organizations also act as allies to support Indigenous-led responses to STBBI issues in their communities.

Agencies also work closely with health services to support referral and service navigation for their clients. Health services account for 8% of relationships, including primary care providers, clinics, health centres, hospitals, addiction, and mental health services. Staff engage in relationship building and education with health services to promote culturally relevant and non-judgmental service. Staff will attend appointments to advocate and provide emotional support for clients.

The last three remaining partnerships – public events, government, and business – account for 16% of engagement. The focus here is building connections with diverse public and community groups to increase the reach of STBBI educational messaging. Examples include bars, libraries, and large community events where staff can interact with or share educational materials with the public.

Service provider education and training

Service providers – such as nurses, social workers, pharmacists, physicians, counselors, and social service providers (e.g., shelter) – are critical touchpoints because they often contact people living with or at risk of STBBI transmission. Over a one-year period, a total of **307** individual STBBI training events were provided to **3,653 service providers** across Alberta.

Table #4: Number of STBBI training events and service providers trained

Agency	Number of STBBI training events	Number of service providers trained
Northreach	33	255
Streetworks	70	376
Turning Point	75	876
HIV Community Link	129	2,146
TOTAL	307	3,653

Source: STBBI program reporting

Improving capacity on the frontlines to screen/identify people at risk, share prevention messages, and provide non-judgemental support has the potential to significantly improve care. Many providers either don't have STBBI training or need updating (e.g., HIV PrEP medication).

A data limitation is that not all agencies count the number of providers trained, so the actual number of people trained is higher. While each training event is individualized to the audience, topics include the following:

- Basic HIV, HCV, and STI facts
- Experiences of people living with HIV or other relevant lived experience (e.g., drug use)
- Building staff capacity to support clients with respectful and non-judgmental care, including population specific training to support ACB, Indigenous, and LBGTQ+ communities
- Game changing HIV medications, such as ART and PrEP, that prevent HIV transmission if used appropriately; the Undetectable = Untransmittable (U = U) and Treatment as Prevention (TasP) are core messages in this campaign
- HCV treatment training course
- Culture of street people who use drugs and are involved in sex work
- Dispelling common myths and misconceptions about STBBIs

CBOs also train students (e.g., nurses) with workshops and practicums so that they can experience supporting real clients. Last year, agencies hosted **29 practicums for nurses and social workers** supporting clients in a community setting.

Section 3: Client and Community Impact

This section outlines how the community programming described in Section 2 impacts client and community outcomes. While supporting Alberta’s broad STBBI strategic goals, each individual agency has the flexibility to implement services based on their unique community context and emerging needs.

As noted in the limitation section, (a) STBBI programs don’t have access to Netcare at this time, making client tracking across the healthcare system impossible; and (b) Alberta does not have shared measurement practices. This makes it impossible to assess the role of community programming on population-level changes, such as the HIV rate or medication adherence.

Instead, this section answers the question: what is the client and community level impact of STBBI programming? A mixed-methods approach is used to triangulate program outputs with qualitative analysis to identify client and community level impacts.

Client Impact

Client impacts include:

- Reaching marginalized and stigmatized Albertans
- Supporting newly diagnosed people
- Building client capacity to make evidence-informed decisions
- Improving access to care and supportive services
- Creating social and community connection for people living with HIV

Reaching marginalized and stigmatized Albertans

“Thank you for the information and thank you so much for coming into the spa like that. You have no idea how much that helps me with my crazy schedule. I really appreciate that and I know the other girls do too” – Client

Program output data tells us that more than 143,000 client contacts were made during the one-year reporting period. Most of these contacts were with marginalized and stigmatized populations who are unlikely or unwilling to access mainstream services without support from these agencies. A recurring theme from clients, staff, and partners is that because CBO agencies treat people with trust and non-judgement, they can build trusting relationships with so-called “hidden” or “hard to reach” populations.

These ideals are not accidental. They are key components of service delivery models utilized by the CBO's. CBOs report that their clients often feel shame and fear asking questions about their sexual health, such as their symptoms or how to have safer sex. A good example of this comes from a client who drove several hours to Edmonton for STBBI testing:

An unknown individual on an online forum posted about our team saying that we are non-judgemental and knowledgeable healthcare providers, according to this client. She expressed that she did not feel comfortable seeing other healthcare providers because they do not understand the complexities of the sex industry and she has experienced stigmatization (STI Outreach Report).

People won't use services they don't trust and/or feel they will be judged or otherwise treated less than human. The huge number of interactions shows that, when service is delivered with heart and compassion to these populations, they will engage with STBBI services. As one STBBI outreach worker puts it: "They do want to be connected to community... they keep coming back." In addition to the numbers, which speak for themselves, staff report that client feedback shows their approach works: "They feel safe here. I mean, that's one thing that we really get from our community members is that they feel like it's family here" (STBBI educator).

Agencies appear to have established 'street cred' with clients through word of mouth and social networking in their communities. Priority specific programming and client demographic data tells us that the people at greatest risk of STBBIs in the surveillance data are being reached, including:

- ACB populations (many of whom are newcomers), with targeted and culturally appropriate programming that is based on their readiness.
- Sex workers, with direct outreach efforts to ensure they have low barrier access to safe sex supplies, education, and care
- gbMSM, with direct outreach programming that meets them where they are
- Indigenous people, who are the highest usage demographic at several agencies, demonstrating that non-Indigenous agencies have successfully built trust with these communities
- At-risk youth, with direct outreach and education
- People who are incarcerated, with direct prevention and education engagement

Supporting Newly Diagnosed People

"You were there for me when everything else was unavailable. I will always remember this." – Client, recently diagnosed with HIV

Data suggests that CBO services play an important role in supporting newly diagnosed people. Even with lower intake numbers due to COVID-19, agencies reported 143 new intakes with people living with HIV.

Every Albertan diagnosed with HIV is supported with publicly funded outpatient care at either the NAC in Edmonton or SAC in Calgary with intake, medical assessments, and follow-up appointments (every 3 to 6 months). The clinics have HIV specialist physicians, nurses, social workers, and pharmacists who monitor the health and treatment regime for over 6,000 people

with HIV. NAC and SAC also refer clients to local HIV serving community agencies. Program data suggests that roughly half (45%) of newly diagnosed Albertans seek further support and client management from community agencies.

As this STBBI outreach worker describes, staff guide and support people through this challenging time:

“I went with people when they’ve got their diagnosis and most of them, they don’t even want to talk to you about it. They’re not ready. I guess it’s like finding out you have cancer or something. It was pretty overwhelming. Sometimes it takes them a good while to make the move to come here. So, you know, like people just don’t understand how hard it is, you know? Stigma is getting a bit better, but it doesn’t take away from how the person themselves feel.”

Agencies provide specialized community HIV support to help newly diagnosed with the ripple effect on their lives. During the focus group session with people living with HIV, they reflected about their experiences. One stated:

“Living with is a different word than having HIV, because we’ve learned to live with HIV. And if we can actually reach the people who just got HIV, then we can show them how their life can progress on the timeline” (PLWHIV).

A key theme from the focus group was that seeing other peers could act as natural supports for their own journey. Community agencies have a key role to play because they are funded to provide this service, but also because other services like STI clinics are only focused on prevention and diagnosis, not supporting those who will manage HIV as a life long chronic illness.

Roughly 60% of clients living with HIV say their biggest need is basic supports like housing, food security, and transportation. An example of this impact is the following client story:

Client was referred for NAP [Northern Alberta Program for HIV patients] over a year ago but was hesitant to become a client and come to the office for support. Earlier this year, client reached out to a support and outreach worker because she was facing a possible eviction. Though little previous connection existed, client and staff were able to navigate complex re-housing challenges. Through providing support through her re-housing experience, client developed a trusting relationship with staff. She is now a client and engaging in regular supports. She has accessed supports for employment, housing and food security (Program Reporting).

CBOs are well situated to support people with complex needs and provide low-barrier wraparound support services.

A limitation of this data is that we only know directly about supports for people newly diagnosed for HIV. However, anecdotal feedback suggests that people do require support with new or reinfection from STIs as well. This support often takes the form of conversations about their partner notification and negotiating safe sex (e.g., partner refuses to get tested or use condoms). Staff face highly complicated situations with clients that extend way beyond the scope of access to medical procedures, but the fact that clients share these stories suggests the non-judgemental approach is effective.

Building Client Capacity to Make Evidence-Informed Decisions

Program data also shows that staff are reaching many clients to support evidence-based decisions. Staff are quick to point out they can't force people to make safe and healthy choices. But what they can do is create equitable access to education and continue engaging in conversations.

A unique contribution that frontline staff provide is identifying emerging trends and issues from their conversations with clients, service providers, and the public. Staff report the following issues emerged as capacity building areas they were addressing:

- Condom use
- STBBI Contact Tracing
- HCV treatment
- Increasing access to HIV PrEP

Condom use

Agencies distributed more than 900,000 condoms to promote safe sex during this reporting period. Research suggests that free condom distribution increases actual usage of condoms during sex, especially among gbMSM and sex workers (e.g., Sadler et al., 2017). However, equally important is the educational discussions staff have with people about condom use. Staff across the province report that many Albertans don't know how to properly use condoms and don't know the different types and varieties of condoms available.

"I always am surprised that patients don't know how to don and doff the condom properly. A lot of people actually don't know how to do it properly. A lot of people don't even know what an internal condom is" (Outreach Worker).

In addition to improving effective condom usage through demonstration, agencies also encourage use of lube. There is low awareness about the protective role lubrication plays in reducing friction that causes condoms to break or tear skin.

Staff also encounter challenging discussions with people who want to use condoms (usually women) but can't get their (usually male) partner to use them. For example, when a female client on syphilis treatment was asked about using condoms, she said: *"Are you kidding me? He would never let that happen, ew"* (STI Outreach Report). Staff support clients with options to negotiate condom use with their partners or clients, although the complexity and dynamics at play are more than simply improving educational messaging.

STBBI Contact Tracing

Staff also report misconceptions about contact tracing.

“There’s notification for the people that you’ve been with, if you have any information on them and the fact that it can be one hundred percent confidential and the person that you had contact with also may have potentially spread something to you. They never have to know who was the one who put their name forward. Contact tracing is a really effective way to make sure that you control outbreaks, especially within specific groups and communities” (Outreach worker).

Staff are involved in many nuanced interactions with clients to reduce the syphilis outbreak. Encouraging contact tracking is a critical part of ending cycles within groups passing infections back and forth. Qualitative feedback from staff indicates that this is a direct impact CBO programming can make with at-risk clients.

HCV treatment

Staff across the province report widespread misconception about HCV treatment. Many people refuse to take treatment because of this false information.

“Folks need to have a lot more knowledge and information around Hepatitis C. The fact that the new treatment does not involve all those old things, especially for folks who tried it before and failed or made it through a whole year using interferon and like that just destroyed them. They need to know that this is a six-to-eight-week process and it doesn’t come with all those side effects” (STBBI Educator).

Agencies have responded with concerted effort to spread the message that new HCV treatment approaches are publicly funded, shorter in length, and have less side effects. While CBO staff can make a difference by sharing this message, a population-level impact on improving HCV treatment uptake would likely require a dedicated provincial campaign and strategy.

Increasing access to HIV PrEP

In 2018, Alberta made PrEP available at no cost to people at high risk of HIV transmission. PrEP is highly effective at reducing HIV transmission for people who don’t have HIV. Community agencies have been at the forefront promoting PrEP access to eligible populations, often playing a broker role in referring clients to registered prescribers. For example, the STBBI outreach worker has been connecting clients across Central Zone directly to their nearest prescriber, increasing client access to a key HIV prevention tool.

While there is no referral data available in the province to quantify the impact, we know agencies are actively building awareness and referring clients to prescribers, mostly with a focus on gbMSM populations. Staff also help guide clients who are on PrEP with support and education. One important message is that, while PrEP prevents HIV, ongoing safe practices and regular testing is important. A related knowledge gap is that many people are not aware they can test positive without any symptoms.

Improving access to care and supportive services

There is strong evidence that case management supports at CBO agencies in this study facilitate improved client outcomes across several key areas. Out of the 459 active clients living with HIV, there is pre/post case management data for 71 combined clients from the large urban agencies that specialize in HIV services (HIV Edmonton and HIV Community Link). Clients with only baseline (one-time) data were excluded from analysis. A limitation of this sample is that it only represents about 15% of all clients living with HIV, but nonetheless provides a validated pre/post indication of program impact.

Each agency uses an adapted version of the self-sufficiency matrix (SSM), which assess the program impact on specific clients over several snapshots of time. SSM is validated measure for tracking client change on key domains for people living with HIV. A lower score indicates that the person is in crisis and/or highly vulnerable, while a higher score suggests they are more stable and self-sufficient. Eight domains were tracked: HIV medication adherence, housing, mental health, physical health, social supports, income, substance use, and access to services.

The first assessment provides a baseline score for everyone. Baseline scores indicate that clients in crisis ranged from about 20% to 30% across the domains. The domains with the greatest vulnerability at baseline were housing, social supports, income, and mental health. Most clients showed improvement after their baseline score, with more than 50% of clients showing positive change on mental health, income, social supports, housing, and access to services. Of particular interest here is that the four domains with the greatest client vulnerability all showed 50% or more improvement. While client change is dynamic and susceptible to peaks and valleys based on many factors (e.g., job loss, traumatic event), the case management data indicates that programming is helping to improve client lives.

Agencies are effective at improving access to services. During the reporting period, more than 2,900 referrals to supportive services for STBBI clients were made, many of which were attended by staff and/or involved a warm hand off to a trusted provider. Partnership data confirms that such referrals cut across many different sectors, including those that support HIV/HCV services, STBBI testing, health services, immigration, legal, housing, financial support, and access to cultural programming. However, a limitation of this data is that we do not know the result or full impact of these referrals without access to Netcare records.

Community agencies are uniquely situated to support clients with complex needs that require a wide range of supports. Referrals can have a major impact on a client's life. Consider this example:

An individual contacted us facing multiple barriers to accessing their HIV medication including immigration status, health care coverage, financial situation and limited access to services. We were able to advocate on behalf of the client to connect them with health care professionals and cover cost of medication while supporting getting medication shipped from client's country of origin. The client is now successfully connected with a health care team and has access to medication covered by Alberta Health (Program Reporting).

Agencies report that supporting clients with immigration and settlement needs such as language, education, employment, and legal services is increasingly an important part of their role.

Supporting clients with access and ongoing support with HIV/HCV medication is another important role that agencies.

"Fellow yesterday hadn't taken his meds for three months. So, we're trying to get them in to see the doctor again, he lost his meds that he didn't follow through sitting more, you know, because they get yelled at because they're expensive. And how did you lose your meds? It's still tough and it's hard for people to take a pill every single day. Sometimes they want to break" (Outreach Worker).

Clients, staff, and providers all report that CBOs have improved awareness about treatment, service navigation, and warm hand offs to more mainstream services. While impossible to attribute a precise attribution, community agencies have contributed to the rise in ART (HIV treatment) from 30% in 1989 to over 93% in 2017.

Agencies work closely with NAP/SAC HIV clinics (and other testing labs) to ensure that clients living with HIV don't fall through the cracks. Consider this example:

The client was not making her subsequent NAP appointments. The social worker our team had connected her with also stopped receiving information from her to continue the progress they were working on. Fortunately, we were able to reconnect with her in May 2021, after no other agencies were able to connect with her for approximately four months. The team's Outreach worker saw her around BSCS and subsequently the client has restarted going to her NAP appointments. She has restarted her HIV medication and has received follow-up STBBI testing as well (STI Outreach Report).

All the data is pointing to the same conclusion: that CBOs know how to identify client needs and connect them to the right service.

Creating social and community connection for people living with HIV

A variety of data sources tell us that agencies are successfully creating community connection and reducing isolation, although access is not evenly distributed across the province (most programming is in Calgary and Edmonton). The one-year reporting of peer activities identified 12,255 client contacts. Why is peer support and connection so important for people living with HIV? During the focus group with people living with HIV, several participants shared their experiences with peer groups.

“I just remember how empowering it felt to walk into a room filled with – there had to be back then 75 to a 100 people there. Right. It was packed full of people. And there were so many people who were there who were talking about what we could do to change things” (PLWHIV).

“I actually did workshops, mostly self-care type workshops because peer support has been something that I've been a big proponent of over the years. So, it was those kinds of things, how to look after yourself and ensure that you're staying well, mentally, physically, all those kinds of things” (PLWHIV).

To hear people living with HIV describe it, nothing can replace natural peer supports and the community it creates. However, access to peer support is uneven across Alberta. Nearly all dedicated programming is run in Edmonton and Calgary, likely because specialized HIV services are more feasible there. Staff in other cities report challenges running HIV peer groups in areas like Red Deer where the readiness for such programming among a smaller client base is low. In the focus groups, people felt peer activities were focused on priority populations, which made them feel left out and ignored.

For those people who use existing peer support programming, clients report positive experiences. As detailed in the prior section, agencies have processes in place to meet M/GIPA criteria for people living with HIV. For example, one agency engages with different advisory committees to ensure that programming is going to meet their needs and be effective.

“We want to make sure that it resonates. Is there something that's missing? Is there something that could be better yet? Are we totally off base? Trust me, we've been told this... we really got called out on not pushing U = U, we got called on not promoting PrEP... And we started putting them in our content” (STBBI Educator).

As the above quote implies, the experience of people living with HIV – who see the gaps and biases firsthand – is an important part of creating impactful programming, even if those voices challenge the status quo. Peer support programming makes a direct positive impact on clients living with HIV. The challenge facing CBOs is how to deliver such programming during multiple competing priorities (opioid overdose, COVID-19, congenital syphilis) and at a time when budgets have shifted their focus to prevention, diagnosis, and treatment.

Community Impact

A core goal of CBO collaboration and partnership development with other agencies is to improve their capacity to support people impacted by STBBIs and increase awareness. What impacts have agencies made in their communities? This section describes three community level impacts:

- Improving service provider awareness and education
- Building community capacity improves service navigation
- Leveraging Research and Innovation to Advocate

Improving service provider awareness and education

“It wasn’t until about a year and a half ago that my doctor actually told me I couldn’t transmit HIV with an undetectable viral count. And the reason they didn’t tell me - I asked them about this - he goes, ‘well if told you, you would probably have syphilis’. I had no idea! And for years - years - that was never given to me, as honest as I was with my medical professional, he was not honest with me.” – Participant living with HIV from the Alberta Stigma Index (Alberta Positive Voices Caucus, 2021)

During the one-year reporting period, 307 STBBI training events were held with 3,653 service providers. Key educational topics and messages are listed on page 25.

At the individual level, survey data from agencies indicates that providers who are trained increase their knowledge and awareness level on key topics. For example, one agency that surveyed providers after their workshop found that more than 90% self-reported improvement on the following domains:

- Better prepared to talk about HIV with clients
- Better prepared to address HIV-related stigma in their workplace
- Better prepared to work with people impacted by HIV
- Increased knowledge of HIV after the workshop.

However, training is about more than just increasing the knowledge of individual providers. Capacity building for service providers is also built on the champion model (see Miech et al, 2018 for a review of the concept). Another goal is to develop champions and advocates in these organizations who spread STBBI messaging and best practices to others on their team. Service providers tend to be more responsive to educational messages from members of their own team or profession. For example, last year CBOs hosted 29 practicums for nurses and social workers supporting clients in a community setting. The hope is that those providers will carry this experience forward and perhaps emerge as advocates on their healthcare teams.

Staff also report that the way services providers talk about hot button issues like stigma and gender identity suggests better awareness. For example, this is a trend a few agencies noted:

“I think we're starting to see a big change around folks understanding that when someone comes in for healthcare and identifies as gay, the first thing out of your mouth should not be, oh, you need to be test. Maybe it should be around, why are you here? Because most often it's mental health, it's isolation, it's substance use that are the most common interests” (STBBI Educator).

Agencies also ensure that their clients are getting the best care possible. For example, one agency has their staff do site visits to partner agencies with the express goal of reducing their fear, judgement and stigma associated with street-involved people who use substances.

Building community capacity improves service navigation

Partnership development improves how clients are cared for in the community. During the reporting period, agencies worked with more than 500 individual partners across sectors, including community, health, social services, and education. Agencies used these partnerships to spread key educational messages and build awareness. They also engage with services to improve navigation and wraparound care for their clients.

While it is challenging to quantify community impact, one agency (HIV Community Link) surveys their partners to gather evaluation data. They found the following impacts of their partnership development work:

- 60% reported increased knowledge about HIV and HCV
- 37% reported updating their policies to engage better with people living with HIV/HCV
- 68% reported updating their policies to engage better with people who use drugs

These survey results are consistent with other data sources that indicate community agencies play a significant role in STBBI capacity development. What does this look like in practice? Consider this example of a staff member creating low barrier access to HCV treatment for their street-involved clients.

In Red Deer it was quite a process to get referred up to hepatology department [Red Deer Regional Hospital] and then just see specialists. There is months of waiting and they really wanted stability before they would treat people. And so, we just lost so many people in the process. People would get confirmatory testing and then we would just lose them... I connected with the Street Clinic. [Staff] are good about getting people connected to medication right away, as opposed to referring up to the hospital (Outreach Worker).

As a result, their clients now have a more direct line to treatment from someone at the Street Clinic who understands this population. This is just one of example of hundreds that community agencies impact and improve service capacity.

Partnership is a two-way street, and agencies also learn from other organizations. For example, one agency identified that COVID-19 was negatively impacting their most vulnerable clients with housing. They established a formal agreement with Calgary Homeless Foundation to train their case manager as a housing specialist, empowering their team to work within Calgary's Coordinated Access and Assessment system. Now clients can directly access housing services.

While larger urban areas focus on service navigation and eliminating duplication, agencies in rural areas are often trying to find one person who can help. OPTIONS HIV West Yellowhead, which services rural communities (Jasper, Edson, Hinton, and Whitecourt), searched far and wide to find the only prescribing PrEP physician in the region and then facilitated telehealth for their clients to access specialists in Edmonton. Staff also partnered with the Primary Care Network to bring a Nurse Practitioner at their drop-in space, improving access to STBBI assessment, testing and treatment. Travel is a massive barrier, made much worse since Greyhound bus services closed. For clients who need access to specialists in Edmonton, they fundraise money for bus and taxi service to and from their communities. Without such community development in rural areas, clients would be on their own, and given the navigation and travel barriers in place, would never get connected with services they need.

While it is impossible to calculate the impact of community partnerships on broader STBBI rates, community agencies do support client navigation and access to services through these engagements. Evidence from surveys, program reporting, and interviews also indicates that such partnerships are improving community awareness around key educational messages, such as the syphilis outbreak and PrEP access.

Leveraging Research and Innovation to Advocate

Agencies are also involved in research and program innovation. Many pilot tests and innovations happen at these community agencies. For example, the HER Pregnancy Program started at Streetworks in 2008 in response to rising syphilis rates. The goal was to help high-risk pregnant women (mostly street-involved Indigenous women) access healthcare and STBBI services. Project evaluation demonstrated promise as a model for further spread. When syphilis rates skyrocketed in North and Central Zone, the model was expanded to Turning Point (Red Deer) and Northreach (Grande Prairie) under provincial funding to address congenital syphilis.

Other examples of high impact research and innovation include:

- Alberta Stigma Index, a national research project run out of Mount Royal University, which is assessing how people living with HIV experience stigma
- Community role out and implementation of HIV self-testing (starting this Fall 2021) to reach the undiagnosed with care
- In partnership with the Ribbon Rouge Foundation (Black run HIV organization), HIV Edmonton supported the HIV photovoice project with ACB women living with HIV
- A study of HCV treatment efficacy with people who use drugs to improve health outcomes

Agencies and participants want to see action and improvements from research engagement. The Alberta Stigma Index is instructive here because it involved the coordination of community agencies, the hiring of people living with HIV as peer researchers, and 145 participants. The

survey results provided credibility to what frontline were observing: many providers aren't telling their HIV patients about the U = U evidence (see Eisinger et al., 2019 for a review of evidence). Despite scientific consensus that you can't transmit HIV if your viral load is undetectable, providers "aren't telling people living with HIV that this is their reality. They seem quite content to leave that anxiety and shame and fear of transmission burden on the shoulders of the person with HIV" (Outreach worker). The Alberta Stigma Index found that for people living with HIV, this message had a profound impact on their lives, including reducing fear about their HIV infection, improving quality of life, combatting stigma, and changing how they viewed sexual relationships. Agencies are actively involved in improving awareness and education about U = U on the frontline.

Providers in Alberta are either unaware or unmoved by the U = U evidence. The Positive Voices Caucus, which is a provincial advocacy group for people living with HIV, found that they needed to hear directly from people with lived experience to understand the urgency of the campaign. The Alberta Stigma Index found a shocking 57% (n = 83) of people living with HIV reported that their primary HIV healthcare provider didn't discuss U = U messaging. The Positive Voices Caucus is currently leveraging this finding to push for change. The group has engaged directly with the NAC, SAC, and College of Family Physicians – the key leaders and decision makers in the province for HIV providers – and has commitments to educate their membership.

Conclusion

STBBIs continue to be a serious public health issue in Alberta. Last year alone, more than 23,000 new STBBI cases were reported, with rising rates of syphilis a particular concern. Surveillance data over the last decade also shows STBBIs disproportionately impact marginalized and stigmatized populations.

A key finding of this report is that community level STBBI programming is addressing key gaps in Alberta's response, such as reaching the undiagnosed, improving access to testing and treatment, and targeted programming to support the most at-risk populations. CBOs accomplish these goals by building relationships with people who don't use mainstream services. While it is not possible to determine the impact of such programming at the population level, client and community level impacts suggest important contributions to support Alberta Health's six key strategic action areas: prevention, early detection and diagnosis, treatment, support and care, raising awareness, and addressing stigma.

Community-based programming improves STBBI prevention of clients with approaches such as low barrier access to safe use supplies (e.g., condoms) that prevent STIs, increasing awareness about testing and treatment options, and culturally appropriate programming that supports where they are at. Early detection of STBBIs is improved by supporting low barrier access to onsite testing and referrals for clients who face many obstacles to diagnosis.

Community programming supports people living with HIV with access to treatment and care. A total of 142 new clients with HIV were supported during this reporting period. Along with supporting their access to care and providing a support base, program data indicates that many of these clients (approximately 60%) need help with basic supports like housing and food security. Agencies also provided 12,255 peer support activities for people living with HIV that has helped build community and reduced isolation. Case management data from people living with HIV indicates that the programming is effective and improves lives of clients.

In addition to direct impact on clients, CBOs are also improving community awareness and service provider knowledge to support people with STBBI services. A total of 3,653 service providers were provided STBBI training during the reporting period. Many of these trainings involve raising awareness about the negative role that stigma plays in client care. The report also found that CBOs make significant contributions to system navigation and community development by engaging with other partners, including community groups, educators, Indigenous communities, health providers, government, and businesses. The impact of such partnerships is improved STBBI awareness and capacity in other agencies that are likely to see clients with STBBI-related needs (e.g., immigration services). Agencies also work closely with service providers in the community to enhance service navigation and care for their clients.

The report also identified several situations where STBBI programming has likely reached its maximum capacity, at least based on current staffing levels. Several agencies reported a huge demand for their outreach and education services, such that they couldn't reach everyone or spend as much dedicated time with clients due to competing priorities. The report also found that peer support services for people living with HIV are concentrated in Calgary and Edmonton and typically focused on priority populations. People outside those cities and demographic profiles may have less access to peer activities, which have created very important community bonds and natural support networks for people living with HIV.

This report concludes that the community programs in this analysis support improved access to a range of STBBI services – prevention, education, testing, treatment, and care – for people who likely otherwise not use mainstream services. Agencies also play a grassroots role in building community capacity and service provider awareness that results in improved client access to needed supportive services. The report concludes that these community agencies play a unique and important role contributing to Alberta's STBBI response.

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