TORONTO

STAFF REPORT ACTION REQUIRED

Toronto Urban Health Fund Changes to Target Populations and Funding Objectives

Date:	June 17, 2016
To:	Board of Health
From:	Medical Officer of Health
Wards:	All
Reference Number:	

SUMMARY

This report outlines changes to the Toronto Urban Health Fund (TUHF) target populations and funding objectives. The revisions will determine priorities and direction for future funding allocation cycles for the three TUHF funding streams: HIV Prevention, Harm Reduction, and Child and Youth Resiliency. This report also includes a recommendation for consideration of the establishment of an indigenous funding track specifically targeting the Indigenous population.

RECOMMENDATIONS

The Medical Officer of Health recommends that:

1. The Board of Health request the Medical Officer of Health to report in 2017, in consultation with the Toronto Indigenous Health Advisory Circle, on the feasibility and design of a Toronto Urban Health Fund funding stream for projects targeted at the Indigenous population.

Financial Impact

There is no financial impact resulting from this report.

DECISION HISTORY

At its meeting on September 16, 2013, the Board of Health approved consolidation of AIDS Prevention Community Investment Program (APCIP) and Drug Prevention Community Investment Program (DPCIP) and budgets into the Toronto Urban Health Fund (TUHF) with three streams offering, one and three year funding.
http://www.toronto.ca/legdocs/mmis/2013/hl/bgrd/backgroundfile-61647.pdf

ISSUE BACKGROUND

TUHF funds 1-year and 3-year projects that are responsive to emerging and long term local trends in HIV incidence rates and patterns of illicit substance use. Funding priorities that inform target populations and funding objectives are reviewed annually by the Medical Officer of Health to ensure that funding addresses community needs. Recent developments in HIV prevention research, the introduction of high impact HIV prevention technologies and the public health concern about the harms of opiate use in the community has led to the need to update and revise current funding priorities.

The review of HIV and STI epidemiological data done in consultation with TPH's Communicable Disease and Surveillance Unit (CDSU) shows an overall increase in the incidence rates for HIV, chlamydia, and gonorrhea among youth. From 2004-2014, there was a slight increase in the incidence of HIV in people under the age of 30, and a slight decrease in people over 30. In addition, the proportion of HIV cases among people aged 15 to 29 years in men who have sex with men (MSM) exposure category was 84% in 2014, compared to 68% during the 10-year historical period. Similarly, the incidence of HIV among men who reported having sex with men and using illicit substances was higher in 2014 compared to the 10-year historical average.

In 2003-2013, there was an overall increase in the number of reported cases of chlamydia among all age groups. However, youth, specifically females up to age 29, were disproportionately affected. In 2013, females aged 15-29 accounted for 60% of the reported cases of chlamydia. Similarly, in 2013, among all age groups, the highest number of cases of gonorrhea were reported compared to an 11-year historical period, and youth ages 15-29 represented 58% of the reported cases of gonorrhea[1]. The increase in STI rates among youth supports the need to enhance primary prevention and early interventions targeting youth.

At the 2014 World AIDS Conference, UNAIDS launched a strategy known as the "90-90-90" which proposes that by 2020, 90% of all people living with HIV will be diagnosed, 90% of those diagnosed will be provided with antiretroviral therapy, and 90% of those on treatment will achieve undetectable HIV viral load.[2] The targets, if achieved according to plan, would result in the end of the epidemic spread of HIV by 2030. This new approach has been described as the treatment cascade and is defined by the sequence of outcomes that are required to achieve maximum benefits from treatment. The key elements in the cascade include HIV diagnosis; engagement in care and treatment; and suppression of the viral load. From a prevention perspective, screening and testing individuals who have been involved in high risk activities will be primary. In addition, the prevention of secondary transmission of HIV will be managed through the strategy know as Treatment as Prevention (TasP) whereby the risk of new transmission will be reduced significantly through the consistent use of antiretroviral medications to maintain undetectable viral loads among those who are living with HIV. The scaling up of biomedical prevention technologies such as early diagnosis of new HIV infections though testing and the reduction of viral load through consistent use of antiretroviral therapies are essential prevention tools.

In February 2016, Health Canada approved the daily use of a pill called Truvada for use as pre-exposure prophylaxis (PrEP) to prevent the sexual transmission of HIV.[3] Truvada when used in combination with safer sex practices, such as consistent condom use, has been shown to be effective in reducing the risk of the sexual transmission of HIV.[4] The uptake of PrEP as an effective prevention tool in the community will require increasing the awareness and access to PrEP in HIV prevention programming.

In September, 2015, a report was presented to the BOH highlighting the increasing role of opioids, such as heroin and fentanyl in drug overdoses in Toronto. The report indicated a 41% increase in the reported number of people dying from overdose in Toronto – from 146 in 2004 to 206 in 2013, the highest annual number to date. The strategies to address this alarming public health issue are multi-sectorial and need to involve community based responses.

Comments

The changes to the funding objectives and target populations are the result of a priority setting process conducted from January through May 2016.

TUHF priority setting consultation consisted of the following:

a) a review of Toronto HIV/STI epidemiological data was done in consultation with TPH's Communicable Disease and Surveillance Unit (CDSU)
b) an environmental scan of the priority populations, objectives, and funding criteria for funders that provide project funding and address HIV and drug prevention for community-based organizations in Toronto. These included the Community Action Fund from the Public Health Agency of Canada; the provincial AIDS bureau within the Ministry of Health and Long Term Care; the Trillium foundation; the Laidlaw Foundation; and the City of Toronto's Community Partnership and Investment Program. The objective of the scan was to determine where funding gaps exist and to reduce duplication
c) in-person consultation with 62 community members and three community members representing Indigenous organizations who attended a half-day community consultation on April 21st, 2016
d) survey results from 32 community members that were unable to attend the half-day consultation
e) in-person or telephone consultations with 19 experts in HIV prevention, harm reduction, child and youth resiliency. consultations with 11 members of the 2016 TUHF Review Panel
f) internal consultation with TPH managers and staff

Using the data from these consultations, the priority populations and funding objectives were revised in order to ensure accessible language and reflect community need. The changes to funding priorities will be implemented for the 2017 funding cycle.

Rationale for examining an Indigenous Funding Stream

A preliminary scan of reports on Indigenous HIV/Hepatitis C (HCV), health disparities and social determinants of health indicate that Indigenous people are over represented in

the HIV/HCV epidemic in Ontario and Toronto. The following are data that are specific to Indigenous populations in Ontario and Toronto:[5]

- In 2008 Ontario estimated that HIV prevalence was 0.66% among Indigenous males and 0.21% among Indigenous females, or 2.4 and 1.6 times higher than the general male and female population in Ontario[6]
- As of 2008, 7,194 Indigenous people in Ontario had HCV infection, an overall prevalence of 3.0%, which is 3.5 times higher than the estimated 0.85% prevalence among people in Ontario[7]
- In Toronto, among current injectors, HCV prevalence was higher for Indigenous than non-Indigenous people (70.0% vs. 58.8%)[8]
- HIV prevalence is higher among Indigenous men who have sex with men in Toronto (39% in Toronto compared to 7% in Ottawa)[9]
- In 2007, the Lambda study compared Indigenous and non-Indigenous men who has sex with men in Toronto and Ottawa; and Indigenous men who have sex with men who provided a dried blood spot had the highest HCV prevalence of any racial/ethnic group in the study.[10]

Indigenous organizations have in the past accessed funding through the AIDS Community Investment Programs (APCIP) and Drug Prevention Community Investment Programs (DPCIP) and most recently through the Toronto Urban Health Fund. In 2014 and 2015, Indigenous projects were not successful in funding submissions and hence no Indigenous organizations were funded by TUHF in both years. To address the funding gap TUHF tailored its outreach and support and provided Indigenous-specific support to Indigenous organizations and in 2016, three Indigenous organizations were funded. The effort needs to be enhanced to have an impact and change the trajectory of HIV infections among Indigenous populations. In Fall 2015, TUHF started a review of current funding practices and processes to ensure a harmonized approach to Indigenous cultural and learning practices that respect the key principle of Indigenous self-determination.

TPH is currently exploring the feasibility of identifying urban Indigenous populations as a distinct priority population with specific funding objectives developed to address HIV Prevention; Harm Reduction; and Child and Youth Resiliency. As part of the implementation plan of the Toronto Indigenous Health Strategy, exploration is currently underway to examine a process for TUHF that respects the vision, mandate and the five operating principles of the strategy.

TUHF Target Populations and Funding Objectives

The changes to TUHF target populations and funding objectives reflect collective community input into emerging epidemiological trends, shifts in the semantics of terms and phrases used in HIV and drug prevention, and the emergence of new prevention technologies (see Appendix A). The changes have incorporated the need to enhance HIV testing activities to identify and treat new infections early and the use of antiretroviral medication as a prevention tool both to reduce viral load and control new transmission as well as to prevent the acquisition of HIV infection. The changes will also provide opportunities to develop community based responses to address the rise in overdoses as a

result of opiate use. Finally, revisions in the Child and Youth Resiliency funding priorities will provide greater clarity and focus to address the increase in STI rates among youth.

CONTACT

Nicole Welch
Director, Healthy Communities
Toronto Public Health
Tel: 416-338-7435
Email: nwelch@toronto.ca

Herbert Co
Supervisor, Toronto Urban Health Fund
Toronto Public Health
Tel: 416-338-7946
Email: hco@toronto.ca

SIGNATURE

_____

Dr. David McKeown
Medical Officer of Health

ATTACHMENTS

Appendix A: TUHF Target Populations and Funding Objectives

Appendix A: TUHF Target Populations and Funding Objectives

The tables below outline the changes to TUHF target populations and funding objectives for HIV Prevention, Harm Reduction and Child and Youth Resiliency funding streams. Italicized areas indicate where revisions have been made.

A. HIV Prevention

Projects in the HIV prevention stream should primarily reach people from the priority populations who are engaged in high risk sexual behaviours. High risk activities depend on the context and on the people involved. These activities could include (but do not always include) condomless sex, sex with multiple partners, sex work, and/or sex with people with detectable viral loads.

Projects should focus on interventions that include behaviour change, enhanced access to preventative technologies and services (e.g., testing, condoms, treatment as prevention), or enhanced access to information on prevention strategies (e.g., PrEP, PEP, undetectable viral load) as a primary intended outcome.

Priority Populations	**Funding Objectives**
1. Gay and bisexual men and youth, and other men who have sex with men. 2. People from countries with emerging or high prevalence rates of HIV. 3. People living with HIV. 4. Sexual partners of people living with or at risk for HIV infection. 5. People who are or who identify as transgender. 6. People who identify as Two-Spirit or Indigenous LGBT identity. 7. People who are from First Nations, Inuit and Métis populations.	1. To increase knowledge and awareness of behaviours that put people at risk of HIV. 2. To increase knowledge and awareness of, and/or access to emerging and existing prevention technologies, strategies, and services. 3. To increase access to HIV/STI prevention and sexual health promotion information. 4. To increase engagement and access to preventive and supportive environments that promote health, including reducing stigma and discrimination. 5. To increase access to resources that can facilitate change in behaviours that put people at risk of HIV.

B. Harm Reduction

Harm reduction projects should be aimed at working with populations using illicit substances and diverted pharmaceuticals to prevent the transmission of communicable diseases such as hepatitis C and HIV, an overdose, as well as other negative impacts of drug use. Projects should increase access to harm reduction/prevention resources to these populations by offering services which are responsive to their health needs in a respectful and non-judgmental manner, without necessarily reducing consumption.	
Priority Populations	**Funding Objectives**
1. People who share drug use supplies. 2. People who are homeless, precariously /under/unstably housed or street-involved. 3. People who are not regularly accessing harm reduction services. 4. People who are incarcerated or who have been involved with the criminal justice system. 5. People who are involved in sex work activities. 6. People who use or choose to use illicit substance(s) and/or diverted pharmaceuticals. 7. People who are from First Nations, Inuit and Métis populations.	1. To increase access to supportive environments that promote health, and reduce stigma and discrimination. 2. To increase awareness and access to resources and services including overdose education and prevention for people who use substances. 3. To increase healthy behaviours of people using substances. 4. To increase knowledge and awareness of harm reduction strategies, skills, supplies and services. 5. To increase the capacity of organizations and the community to promote health and offer services within a harm reduction framework.

C. Child and Youth Resiliency

The Child and Youth Resiliency Stream supports community-based prevention interventions that provide opportunities for children and youth who are marginalized and face multiple barriers to achieve optimal health outcomes. Projects must use a resiliency approach. More information about resiliency can be found at: TUHF Resiliency Funding Guide While TUHF recognizes the need to provide comprehensive programming, TUHF funded activities should focus on addressing sexual behaviours and/or substance use.

Priority Populations	**Funding Objectives**
1. Children and youth with history of family members and/or caregivers using alcohol or other substances. 2. Children and youth with behavioural, mental health, and/or social challenges. 3. Children and youth excluded from school or with poor school engagement. 4. Children and youth who have been involved with the criminal justice system. 5. Children and youth in care under protection services or foster care. 6. Children and youth from racialized groups residing in designated Neighbourhood Improvement Areas (NIA)s or those facing extreme socio-economic disadvantage. 7. Children and youth facing challenges related to their identity including (but not limited to) race, sexuality, gender identity and gender expression. *8.* Children and youth from First Nations, Inuit and Métis populations.	1. To increase knowledge and awareness of behaviours that may put children and youth at risk of HIV transmission and substance use. 2. To equip children and youth with the skills to successfully negotiate and navigate situations should they choose to or engage in behaviours that may put them at risk of HIV transmission. 3. To promote social and emotional competence for children and youth. 4. To increase the practise of healthy behaviours by identifying and working with children and youth's strengths and assets that contribute to avoiding or reducing vulnerability. *5.* To increase children and youth engagement and access to supportive community resources and services that promote health.

REFERENCES

[1] Toronto Public Health. Communicable Diseases in Toronto 2014. City of Toronto: Toronto, Canada. February 2016.
[2] UNAIDS, 90-90-90 An ambitious treatment target to end the AIDS epidemic, 2014.
[3] Health Canada, Regulatory decision summary: TRUVADA, 2015.
[4]CATIE (the Canadian AIDS Treatment Information Exchange), Pre-exposure prophylaxis (PrEP) resources.
[5] Burchell, Warren & Ellis, et al. The Current State of HIV Epidemic Among Indigenous Population in Ontario, OHTN, May 2014.
[6] Burchell, Warren, & Eliis, et al, pg. 21.
[7] Burchell, Warren, & Eliis, et al, pg. 25.
[8] Burchell, Warren, & Eliis, et al, pg. 26.
[9] Burchell, Warren, & Eliis, et al, pg. 24.
[10] Burchell, Warren, & Eliis, et al, pg. 27.