Saskatchewan HIV Strategy

Mid-Term Implementation and Progress Report 2012

February 2014

SK HIV Provincial Leadership Team

Government of Saskatchewan

Introduction

In 2010, the *Saskatchewan HIV Strategy 2010-14* was released following extensive consultation with a number of stakeholders including Regional Health Authorities (RHAs), municipalities, community-based organizations and First Nations and Métis organizations.

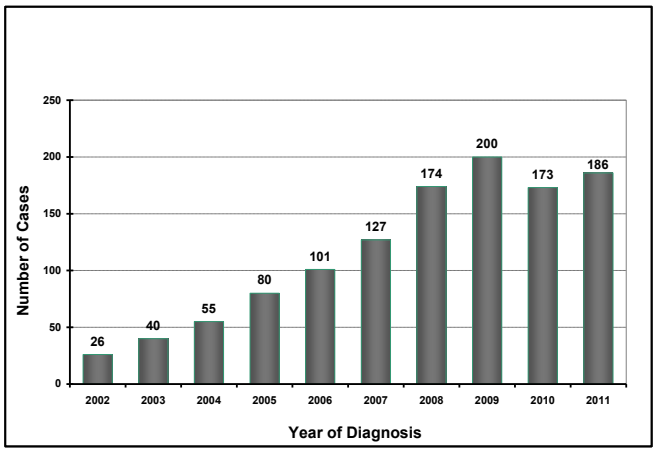
The vision for the Saskatchewan HIV Strategy is aligned with the strategic priorities of the health care system which include: Better Health, Better Care, Better Value, and Better Teams. These strategic priorities focus on achieving the best possible health for communities and care for patients (by putting the patient's care needs first), while also maintaining a financially sustainable healthcare system and ensuring the professionals working in that system have the tools they need to do their best work.

A comprehensive, coordinated and collaborative approach is essential to addressing the increasing rates of HIV in the province of Saskatchewan. Based on high rates of co-infection of HIV with Hepatitis C along with high rates of Sexually Transmitted Infections (STIs) and tuberculosis (TB) it is important to look at an integrated approach with a wide range of partners and multidisciplinary teams to focus on a continuum of services for people living with or at increased risk of acquiring HIV infection.

Background

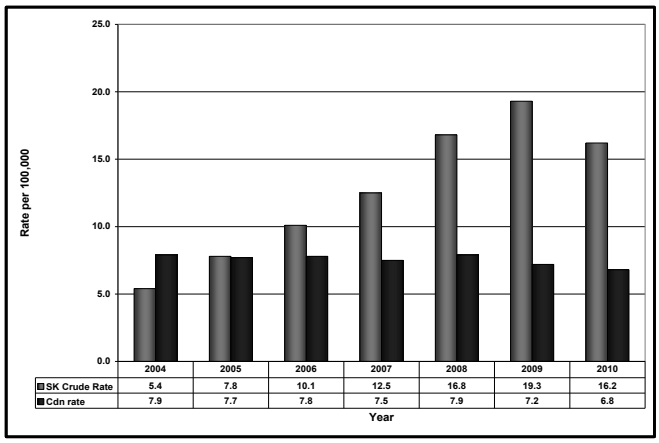
Since 2003, Saskatchewan has seen a substantial increase in new cases of HIV and continues to have the highest rate (per 100,000 population) of new cases of all the Canadian provinces at over twice the national average (PHAC, 2011), which translates to 186 new cases of HIV infection reported in the province in 2011. See Figures 1. and 2. (below)

Figure 1. Number of New HIV Cases in Saskatchewan, 2002 to 2011



Source: Population Health Branch, Ministry of Health, ISDB Database

Figure 2. HIV Rates – Provincial and National Comparison, 2004 to 2010*



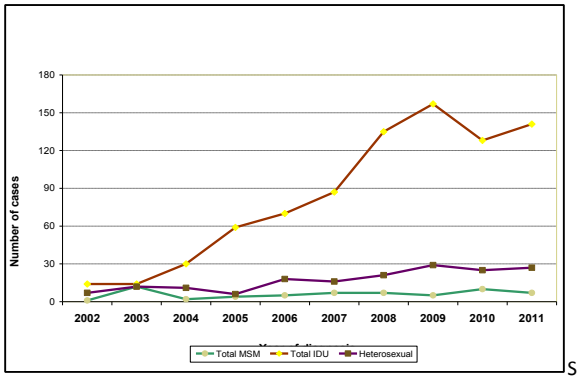
Source: Statistics Canada/ Public Health Agency of Canada. HIV and AIDS in Canada. Surveillance Report to December 31, 2009. Surveillance and Risk Assessment Division, Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada, 2010.

*Canadian Data available only to the end of 2010

HIV has the greatest impact on vulnerable populations such as those living in poverty, and experiencing a range of economic, health and social inequities. Factors such as chronic poverty, unstable housing, mental illness often accompanied by either addictions or problematic substance use (and abuse) and a history of sexual and physical abuse are important factors that promote the risk of acquiring HIV.

The epidemiology of HIV in Saskatchewan is unique because 76% of new HIV cases in 2011 were predominantly associated with injection drug use behavior as the main risk factor. This is followed by heterosexual HIV transmission and men who have sex with men which is different from the order of predominance of these same risk factors in Canadian provinces. (See Figure 3.)

Figure 3. Number of HIV Cases per Selected Risk Factors, Saskatchewan, 2002 to 2011.



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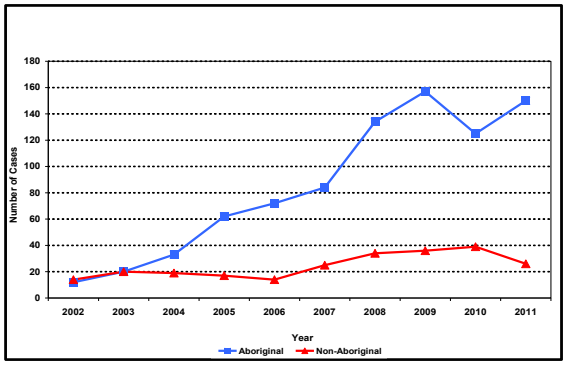
Source: Population Health Branch, Ministry of Health, ISDB Database

In the global distribution of HIV, minority groups are often disproportionately represented and impacted by the global HIV/AIDS epidemic. People self-reporting as Aboriginal ethnicity continue to be highly represented among the number of newly diagnosed HIV cases in the province. For example in 2011, 81% of the new HIV cases reported in the province were reported as belonging to Aboriginal ethnic groups. (see Figure 4).

Figure 4: HIV Cases by Self-reported Ethnicity in Saskatchewan, 2002-2011



Source: Population Health Branch, Ministry of Health, ISDB Database

Saskatchewan's HIV Strategy (2010–2014)

The goals of the provincial HIV Strategy are to:

- *Reduce the number of new HIV infections;*
- *Improve quality of life for HIV infected individuals; and*
- *Reduce risk factors for the acquisition of HIV infection.*

In order to achieve these goals a comprehensive and integrated approach to HIV is required. The HIV Strategy is aligned under four main pillars in order to ensure a comprehensive and integrated approach to addressing HIV in Saskatchewan. The four strategic pillars are:

- *Community Engagement and Education;*
- *Prevention and Harm Reduction;*
- *Clinical Management; and*
- *Surveillance and Research.*

In order to determine to what extent the goals and objectives of the HIV Strategy are being achieved, an evaluation framework was developed and ongoing evaluation is being conducted.

Due to the diversity of the local context across the province, services can look different in various geographical areas of the province. A key aspect of the provincial strategy is to establish province wide standards in order to minimize wide practice variation and support high quality care to all patients in Saskatchewan regardless of the location of their home community.

The current HIV strategic plan is due for formal evaluation by the end of March 2014. The PLT hopes to achieve strategic operational excellence in the delivery of HIV programming in Saskatchewan that leads us to a sustainable future state, beyond 2014 where we are effectively addressing the HIV/AIDs crisis in Saskatchewan. This can be achieved using a continuous quality improvement approach.

A More Coordinated Provincial Response to HIV

Establishment of the Saskatchewan HIV Provincial Leadership Team (PLT)

In 2011, the Saskatchewan HIV PLT was established, consisting of two Clinical Directors (0.4 FTE), a Medical Health Officer (0.6 FTE), a Pharmacist (0.5 FTE), an Administrative Assistant (1.0 FTE) and HIV Strategy Coordinators (SUN Nursing positions) that are located in six of the RHAs (Regina Qu'Appelle, Saskatoon, Prince Albert Parkland, Prairie North, Sunrise and the North (Athabasca, Keewatin Yatthé and Mamawetan Churchill River)). In 2012, an additional Clinical Director (0.2 FTE) and a Nurse Educator Mentor (0.8 FTE) joined the HIV PLT.

Highlights of 2011–2012 and Accomplishments[1,2]

The HIV PLT in collaboration with the regional HIV Strategy Coordinators are responsible for ongoing implementation, coordination on the ground and monitoring and evaluation of the provincial HIV Strategy.

The HIV PLT meets weekly via conference call to discuss implementation of initiatives. Integral to the coordination of programming is the participation of representatives from Northern Inter Tribal Health Authority (NITHA) and First Nations Inuit Health Branch (FNIHB) in these weekly meetings and their direct involvement with HIV PLT members on a number of ongoing initiatives. These partnerships have ensured that service delivery, programming and monitoring are reflective of the unique geography and representation of the province, while further addressing barriers and gaps due to jurisdictional boundaries.

Funding

The annual budget for the HIV Strategy is $2.5 Million. In 2011– 12, RHAs received funding in the amount of $1.3 Million and $950,000 was distributed for engagement of clinical expertise, social marketing, education/training, HIV Point of Care (POC) Testing and peer-to-peer pilot programming. In 2012-13, just over $1.5 Million was base-funded to RHAs and $1 Million was distributed for engagement of clinical expertise, social marketing, education and training, and peer to peer pilot programs.

Guidelines

Saskatchewan-based **HIV Case Management Guidelines** have been developed by the HIV PLT. Work is also underway towards developing **Clinical Guidelines**, **Labour and Delivery Guidelines** and an **infant formula supplement program** for babies born to women living with HIV.

Policy/Advocacy

An important part of the PLT work has been addressing several provincial-level policy levers to assist in furthering the goals and objectives of the provincial HIV strategy. Some of the key HIV policy initiatives include:

- A new Saskatchewan HIV Testing Policy (2013) (SK HIV Provincial Leadership Team, 2012)
- Policy work undertaken jointly with the First Nations and Inuit Health Branch of Health Canada (FNIHB), to work with the Non-Insured Health Benefits (NIHB) and the Saskatchewan Drug Plan to facilitate access to the new First line Anti-viral medications in Saskatchewan (discussed on page 15 of this report).

Surveillance, Monitoring & Evaluation of the Saskatchewan HIV Strategy

Monitoring of the HIV Strategy has been by gathering key data elements, with a set of key metrics that was considered to best represent the potential complexity of combining policy improvements, financial and human resources, improved clinical services and community mobilization.

[1] The responses for this report were collected from Communicable Disease Coordinators and HIV Strategy Coordinators in eleven out of 13 Health Authorities using Survey Monkey. Information was also collected from members of the HIV Provincial Leadership Team (PLT), the Ministry of Health, Northern Inter-Tribal Health Authority (NITHA) and First Nations and Inuit Health Branch (FNIHB) of Health Canada.

[2] In some cases, information may be underreported due to lack of ability to track information and in other cases information may have been over reported due to reporting from more than one source. Quarterly reporting from the RHAs, NITHA and FNIHB was only collected on some of the indicators commencing July 1, 2012, (as indicated in the pertinent sections of the report).

The Ministry of Health releases the provincial HIV/AIDS Annual Report, which includes HIV and AIDS surveillance data reported in Saskatchewan to provide an up-to-date profile of individuals diagnosed with HIV and AIDS.

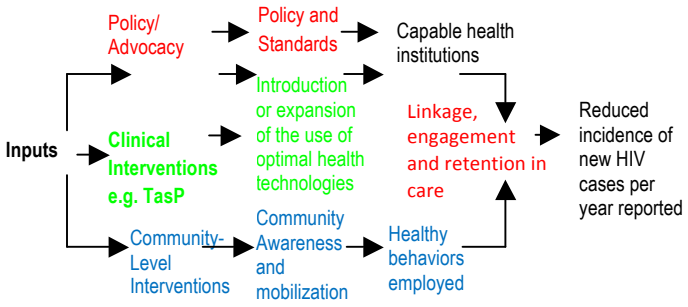
Social marginalization and material deprivation has anecdotally been associated with increased risk of HIV infection in Saskatchewan (Lemstra M. Neudorf C. & Opondo J, 2006) (Neudorf C., 2008). The social determinants of health that escalate the risk of acquiring HIV, especially injection drug use, include factors such as poverty, inadequate housing, lack of education or job training, child abuse and family violence. Addressing the social determinants of health, injection drug use, and HIV requires a concerted effort, and a coordinated and multi-sectoral commitment,

The information gathered on HIV case report forms for routine surveillance provides information on illicit substance use or sexual contact, but it does not provide information on all correlates of these risky behaviours. An HIV Enhanced Surveillance Questionnaire was implemented for individuals newly diagnosed between June 1, 2011 and September 30, 2012. The purpose of the provincial enhanced surveillance questionnaire was to quantify the rates of occurrence of the social determinants of health associated with elevated risk of HIV infection. The analysis of these questionnaires will be included in the final evaluation of the Strategy.

As a part of a Federal HIV surveillance project in Canada, the Ministry of Health, and the HIV PLT has continued to work in partnership with the Public Health Agency of Canada (PHAC) and the BC Centre for Excellence (BCCfE) in HIV/AIDS on HIV sample analysis for circulating strain-type (phylogeny) and monitoring the emerging HIV anti-viral drug resistance patterns in Saskatchewan.

Taking all the elements of the provincial strategy, the following logic model has been used as a high-level summary, displaying how different parts of the intervention were conceptualised to work together.

Saskatchewan HIV Provincial Strategy Conceptual Framework



Inputs: Capacity Building

Human Resources: Increased Personnel

Since 2010, the Ministry of Health funded RHAs for an additional 23.5 FTEs of frontline staff which have been hired and deployed to implement the HIV Strategy, in addition to the HIV PLT. Disciplines hired include nursing staff and social workers, some who work as HIV case managers, outreach workers, and community development coordinators intended to engage whole communities in the HIV strategy. In addition, the provincial strategy has provided funding for a primary care physician, additional HIV pharmacists, and a Medical Office Assistant.

Improving Health Care Worker Capacity to Deliver HIV Care (Better Teams): education events to increase the numbers and diversity of HIV providers in the province

In July 2011, an HIV-specific training needs assessment survey was completed by over 600 health care and allied health care professionals. The respondents indicated a need for training in the following topic areas: Basic/Introductory HIV information; Best practice clinical guidelines and current treatment protocols; Harm reduction strategies; counselling for HIV clients; and, Training in cultural competence and strategies aimed at reducing stigma associated with HIV.

In February 2012, a province-wide E-learning training event was hosted by the Ministry of Health and the HIV PLT in partnership with the College of Nursing Education (U of S) and the Canadian AIDS Treatment Information Exchange (CATIE), entitled, *"HIV Treatment in Saskatchewan".* One hundred and eighty-five participants attended this training event and over 97% of respondents indicated that the training provided them with new knowledge and skills sets that would help them in their work.

The HIV PLT and Ministry of Health also sponsored 14 RHA staff from Saskatchewan to attend the Manitoba HIV Conference in 2011 and another 10 in 2012. The HIV PLT and Ministry of Health also presented at both Manitoba HIV Conferences on emerging promising practices in relation to the Saskatchewan HIV Strategy, as well as innovations in HIV Testing being developed in the province, including the experience with introduction of the rapid Point of Care (POC) testing technology in Saskatchewan. As a result of this inter-provincial experience, a partnership was developed with Nine Circles Community Health Centre in Manitoba to develop content for the HIV and Sexual Health Assessment training modules for Saskatchewan. The modules will be utilized as core HIV training materials for health care and allied health care professionals, paraprofessionals and peers. The HIV PLT and the Ministry of Health have partnered with

the Manitoba HIV Program to host a joint conference in 2013.

Surveys and needs assessments have been conducted with over 100 pharmacists in Saskatoon and Sunrise Health RHAs. Overall, there was interest in more education regarding HIV treatment and medication interactions. Contact has been made with approximately 40 individual pharmacists and pharmacy students to initiate an interest group in the province for pharmacists interested in providing improved care to people living with HIV. An initial pharmacist interest group in Saskatoon has met to identify potential topics of general interest. In the future, there is potential for this group to formally develop through an organized mentorship program.

The HIV PLT Pharmacist has provided various education sessions in the province to multidisciplinary teams throughout Saskatchewan. For example, when the HIV PLT Pharmacist attends HIV outreach clinics in Prince Albert Parkland Health Region, or visits "on-reserve" First Nations communities, each clinic visit is accompanied by contact with local pharmacists and physicians to provide tools and information for improving current care to people living with HIV.

In September 2012, the HIV PLT sponsored the HIV/Hep C Nursing Education Organization's face-to-face event. The annual event is an education and networking event held to increase the capacity of nurses and other care providers in providing HIV care. Topics included HIV advocacy, Hepatitis C treatment, care for people living with HIV, nurse mentorship in HIV care and pre- and post- test counselling for HIV. Eighty-five percent of attendees either agreed or strongly agreed that the content met their needs.

HIV Grand Rounds

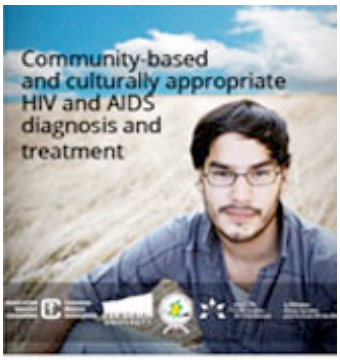
In 2011-12, 23 HIV Grand Rounds sessions were offered to the province. Local experts and national experts from other provinces shared information during these one hour sessions on their innovative programs, clinical and case studies, research, and best practices for the treatment of HIV. These sessions were accessed by approximately 500 participants. *Note: not all sign-in sheets were submitted for each event; therefore,* this is likely an underestimate. An evaluation of the HIV Grand Rounds sessions will be completed in 2013.

Health Care Worker Training

From July 1 to December 31, 2012, RHAs and FNIHB reported over 50 training sessions to communities and health care and allied health care professionals. Participants include physicians, nurses and nursing students, pharmacists, social workers, people living with HIV/AIDS, Elders, peers, lab staff, mental health and addictions personnel and community-based organization personnel.

The HIV PLT has endorsed and promoted *Community-Based and Culturally Appropriate HIV and AIDS Diagnosis and Treatment in Rural and Aboriginal Communities, an* online course developed by the Canadian Institute for Health Research (CIHR), Canadian HIV Trials Network (CTN), the Canadian Medical Association (CMA) and the Canadian Aboriginal AIDS Network (CAAN). This course provides physicians and other health care professionals with the resources to enhance their knowledge of the primary care of people living with HIV/AIDS and tools to assist in the better understanding of the

culturally diverse considerations required to provide culturally relevant HIV care to the populations most vulnerable to HIV infection in Canada.



Supporting Community-Based Organizations (CBOs):

After criteria was established, an approval process was developed by the HIV PLT to support AIDS service organisations (ASOs) in all regions as a part of the HIV Strategy goal of meeting the programming needs of various local interest groups. Sixteen proposals from community-based organizations in eight RHAs were approved for Community-Based Supports funding to implement programming in the areas of HIV awareness, education, community engagement, prevention, outreach, harm reduction and clinical management.

Communications and Knowledge Exchange

A PLT website (www.skhiv.ca) and a Facebook account (SK HIV PLT) were developed in December 2011 to increase knowledge exchange efforts and communicate with various partners.

Primary Prevention

Community Level Interventions: community awareness and mobilisation

During 2011-2012, over 100 presentations were given by HIV PLT members, FNIHB and NITHA providing epidemiologic information and/or information on the HIV Strategy to various stakeholders.

Development of Local Strategies

To date, local HIV Strategies have been developed in six out of the 11 RHAs. Development of a local HIV Strategy is underway in one of the five RHAs that do not currently have a local HIV Strategy. Seven RHAs have an active HIV Strategy Group with wide representation of different stakeholders.

Development of Partnerships

Since the HIV PLT was established, there have been over 30 partnerships established with community-based organizations and educational organizations as well as with other provincial and federal government departments.

Saskatchewan HIV Communication Plan

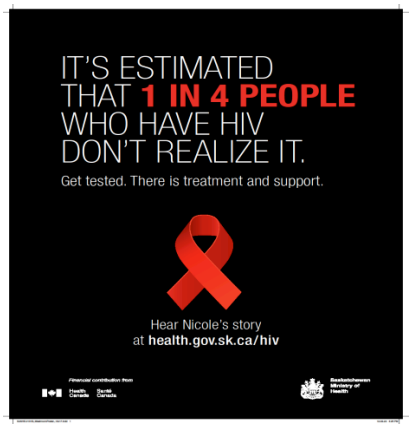
The Ministry of Health and FNIHB partnered on two social marketing campaigns. For both campaigns YouTube videos were produced and advertising was created which directed people to view the videos and access the HIV PLT and Ministry of Health websites for more information regarding HIV. The advertising mediums used were:

- posters distributed to CBOs and health regions, as well as larger versions which were placed on buildings and transit shelters in urban centers;

- television cable scrolls;
- radio advertisements;
- Facebook advertising ; and
- captive audiences advertising.

The provincial communication strategy on HIV has been divided into phases for each fiscal year.

Phase 1:



On December 1, 2011 (World AIDS Day), the first phase of the campaign was started to encourage testing for HIV. The messaging emphasized that 1 in 4 people who currently are infected with HIV don't realize it. Get tested. There is treatment and support.

In phase 1, four videos were created with the messaging related to the importance of HIV testing. Subjects for the videos included a young woman living with HIV, an Infectious Disease Physician, a Chief from a First Nations community and a Community Health Nurse. Slides supporting the testing initiatives were created to play on televisions in physician office waiting rooms with information on testing and testing locations. Education was provided to the HealthLine staff on the supports available if they were to receive calls requesting more information in regards to HIV testing, locations and what to do in general.

Over a period of three months 750 posters were distributed. It is estimated that there were approximately 400,000 views of the online advertisements and 6,500 views of the videos which resulted in over 3,500 clicks on the HIV/AIDS page of Ministry of Health website (http://www.health.gov.sk.ca/hiv).

Phase 2:

In October 2012, the second phase of the campaign was started to address HIV-related stigma.

The messaging used was "The Best Way to Treat People Living with HIV is With **Respect**. Educate Yourself. Show Your Support".

Five videos were created for this phase of the campaign - with messages from a woman living with HIV, a member of the Lesbian, Gay, Bisexual, Transgender, Queer community, an Elder, an HIV Strategy Coordinator and a young adult - all challenging HIV-related stigma

From October 15 to December 9, 2012, 750 posters were distributed. It is estimated that this campaign received approximately 250,000 views of the online advertisements and 5,300 views of the videos which resulted in over 4,000 clicks on the HIV/AIDS page of the Ministry of Health website. (http://www.health.gov.sk.ca/hiv).

Broad-Based Education Campaign Efforts

From July 1 to December 31, 2012, FNIHB distributed *Sexual Health and Wellness Teaching Kits* for educators and health care providers in on-reserve First Nations communities to deliver education to school-aged Aboriginal youth. These kits were developed in alignment with the provincial comprehensive school health curriculum adding culturally appropriate content.

Over 400 HIV awareness sessions were reported by RHAs and FNIHB, including: 128 sessions to youth, one to new Canadian immigrants, 70 to persons that use injection drugs, 34 to incarcerated persons, 148 to First Nations (both on- and off-reserve) and Métis communities, and 34 to "other populations" – women, professionals, public, city council and "street-involved".

One hundred presentations were delivered in schools regarding sexual wellness. The majority, 91, of the presentations were to students and the other 9 to staff. Note: includes sessions delivered by community-based organisations, RHAs, NITHA and FNIHB.

Know Your [HIV] Status Campaign[3] (FNIHB-SK)

In January 2011, an HIV testing campaign was developed in response to Big River First Nation's Health Priorities and concerns brought forth by members from Big River First Nation and Health Canada's nursing team. They worked in collaboration with the Prince Albert Parkland Health Region, Ministry of Health, Saskatchewan Disease Control Laboratory, HIV PLT, and the Positive Living Program (Saskatoon, SK) to develop the "*Know Your Status Project.*" This project aligns with the pillars of the HIV Strategy and includes a number of key activities:

- Obtained informed consent for HIV testing;
- Gathering blood specimens for HIV testing;
- Pre- and post-HIV counselling by nurses;
- Providing additional Addiction and Mental Health support;
- Enhanced communication and partnership with the regional health authorities;
- Collaborative Clinical case management including access to an onsite Infectious Disease physician for clinical follow up and management;
- Access to prescriptions for antiretroviral therapy;

[3] Know your status campaigns are well known health promotion strategies that attempt to engage groups of individuals in knowing their HIV status, by participating in HIV testing so that they can take action to protect their health.

- High levels of trust developed with nursing staff, case managers/Mental Health therapist who were all there on site to assist;
- Enhanced confidentiality; and
- culturally relevant services like Elder mentorship were made available.

The Know Your Status project increased awareness, community education and knowledge about HIV and testing services, it improved access to screening, testing, treatment and referrals; and enhanced surveillance including social network analysis.

As a result of the Know Your Status Project, people in Big River First Nations and surrounding communities have improved access to a continuum of HIV related services which include awareness, education and prevention, testing and follow up.

For example, the program allowed nursing staff to actively engage a client in a meaningful manner through discussing risks and need for testing over multiple months, ensuring during that time that the client made healthier choices, to the day the client was ready for testing. When the client presented for testing, an HIV Point of Care (POC) test was performed, the confirmatory blood draw was completed, the client received significant pre- and post-counseling, was able to meet with an outreach worker from Prince Albert Parkland Health Region to arrange addictions follow up if needed, and was able to have an initial appointment with an Infectious Disease physician and pharmacist in their home community.

Addressing Stigma and Discrimination

In conjunction with the social marketing campaign in 2012, another partnership between the HIV PLT, Ministry of Health and FNIHB resulted in the *"Addressing Stigma and Discrimination Community Toolkit".* The Toolkit was made available on the Ministry of Health website on December 1, 2012 (http://www.health.gov.sk.ca/hiv-related-stigma-toolkit) and included a number of resources such as training manuals to address stigma and discrimination and Human Rights Commission documents.

Secondary Prevention and Treatment Services

Expansion of Standard HIV Testing Technology

In December 2012, the Saskatchewan HIV Testing Policy was released and implemented effective January 1, 2013. The HIV Testing Policy was created to increase the offer of routine HIV testing amongst health care providers in Saskatchewan. Additional resources are being created to support the HIV Testing Policy and will be distributed in the future. Since 2002, the number of standard HIV tests conducted in the province has doubled.

Since 2009, the peak year of HIV incident case reports and immediately prior to the HIV Strategy, the number of HIV tests increased by 21%. (See Table 1.)

Table 1. Number of HIV Tests Completed at the Saskatchewan Disease Control Lab from 2002-2012

Year	Number of HIV Tests
2002	26,341
2003	30,137
2004	36,778
2005	40,500
2006	42,955
2007	44,779
2008	47,294
2009	48,843
2010	52,229
2011	54,463
2012	58,863

Introduction of Innovative Testing Technology

In 2009, the Saskatchewan Disease Control Laboratory (SDCL) introduced HIV Point of Care (POC) Testing technology to the province of Saskatchewan, using the INSTI Test™ Kit. At the time of introduction, it was anticipated that the HIV POC testing technology would enhance access to and the quality of the HIV testing program in the province, particularly among difficult to engage clients that were most impacted by HIV. Training in use of the kit has been provided by the kit manufacturer, and the SDCL.

In 2010, after the development of training capacity and the introduction of guidelines for its use (Public Health Agency of Canada, 2007), it was thought that regional health authorities had experience in running their own quality assurance programs, so some changes to program implementation were made. Most significantly, the requirement to draw a parallel venous sample with each INSTI test performed, regardless of result, was reduced to only requiring the drawing of a confirmatory sample with a reactive test or an indeterminate test and the INSTI tests could now be performed on a fingerpick whole blood sample. This offered the promise of improved access to HIV testing, even in non-traditional locations and in outreach health care settings.

By December 2012, 19 testing sites have been established in seven RHAs (including First Nations communities), and are all licensed to conduct HIV POC testing. The following is a list of the specific locations of all licensed HIV POC testing services in Saskatchewan.

1. Battlefords Union Hospital
2. Meadow Lake Hospital
3. Westside Community Clinic (Saskatoon)
4. Saskatoon Tribal Council Health Centre
5. Lloydminster Hospital
6. Weyburn General Hospital
7. La Ronge Health Centre
8. PAPHR Hep C Clinic
9. Victoria Hospital (Prince Albert)
10. St. Joseph's (Estevan)
11. Sexual Health Clinic (Saskatoon Public Health)
12. All Nations Healing Hospital (Fort Qu'Appelle)
13. Southeast Integrated Care Centre (Moosomin)
14. Spiritwood Health Centre
15. Yorkton Regional Hospital
16. Communicable Disease & Sexual Health (RQHR)
17. La Loche Health Centre
18. Sexual Health Centre (Saskatoon)
19. Ahtahkakoop Health Centre

An evaluation of HIV POC testing pilot has been completed and the final report is close to release. In 2012 from a total of 559 HIV POC tests performed in the province, 26 were reported as "reactive" and 530 as "non-reactive" and 3 as "indeterminate" (HIV PLT, 2013).

The positivity rate of HIV POC tests for this year was 4.6%, or a rate of 46 in 1,000. Cost effectiveness studies conducted in British Columbia report that a positivity rate of greater than 1 in 1,000 tests performed justifies the cost of the test kit (Gustafson Réka, 2012).

Local (Regional) Testing Strategies

From July 1 to December 31, 2012, there were 102 HIV screening and/or testing events (both on- and off-reserve) targeting the most at risk and/or hard to reach groups at venues outside of the traditional clinic setting (e.g., community health fairs, acute care settings, outreach vans, methadone clinics, etc.). Over 600 individuals were tested for HIV and over 37,000 condoms were distributed at these events. The recommended immunizations for Hepatitis A and B as well as Varicella were offered to these individuals.

The routine requirement to offer HIV Testing

Development of the Saskatchewan HIV Testing Policy occurred in 2012 and became effective January 1, 2013. The policy states that an HIV test should be offered to all individuals between the ages of 13 and 64 years of age; and younger or older if there is evidence or indication of risk activity. The offer of HIV testing is very important for certain settings like labour and delivery

Routine HIV testing in Saskatchewan is now being offered to individuals diagnosed with tuberculosis that are 14 years of age or older.

Expansion and Standardization of Harm Reduction Programs

Following the provincial review of needle exchange programs in Saskatchewan in 2008 (Laurence Thompson, 2008), standardized reporting and supplies for Needle Exchange Programs (NEPs) has been implemented in the province. Data is being collected not only on the supplies used, but the range of services and referrals offered by harm reduction programs in the province.

The Saskatchewan Ministry of Health is a member of the Working Group on Best Practice for Harm Reduction Programs in Canada. The release of the Best Practices guidelines will be implemented in Saskatchewan to ensure programs are evidence-based.

Quarterly meetings are held between the Ministry of Health and the Needle Exchange Program (NEP) supervisors to ensure ongoing programming needs are addressed.

In 2011-12, NEPs reported 50,326 visits. Over 4.7 million needles were distributed and over 4.4 million needles were returned, representing an exchange rate of 93%.

With community and drop box recoveries, 99% of needles distributed were returned or recovered.

On reserve, community harm reduction services have been adopted in certain locations throughout the province. The acceptability of such programming varies from community to community. FNIHB is working in collaboration with the Ministry of Health, RHAs and First Nation communities to ensure alignment of needle exchange services with provincial standards, to implement an improved reporting system for overall provincial data collection, and to raise awareness of the effectiveness of harm reduction programs.

The PLT has continued to be involved in consultations with correctional services in the province. The Provincial Correction system has begun implementing standardized "release kits", which consist of condoms, dental dams, lubricant and a list of community resources with contact information. Corrections have been made aware of the HIV strategy coordinators in each health region that hosts one, with the intent of better management of HIV treatment and support services on release.

Treatment Services

The landscape around HIV infection has significantly altered since 2011 with the release of the results of the landmark HPTN 052 study (Myron S. Cohen, 2011). The study found that the early incitation of Anti-Retroviral Treatment (ART) leads to a 96% reduction in HIV transmission risk. Therefore, a key initiative of the provincial HIV Strategy is to promote strategies that lead to individuals having quicker access to HIV medications and the introduction of program strategies in Saskatchewan to help individuals link to, engage in and adhere to their HIV treatment as well as work on the long-term retention of patients in care. Highlights of work done to increase emphasis on patient linkage, engagement and retention in care and support for people living with HIV are listed further in this report.

Better Care: putting the patient first

The client experience is critical to engaging and retaining persons affected and infected with HIV. Multiple barriers are present throughout the client experience and it is essential that HIV prevention, treatment and support create a low threshold, non-discriminatory and seamless experience. The literature is clear that interventions must be enhanced together to achieve a comprehensive response to prevent and overcome bottlenecks which inhibit care. In Saskatchewan, HIV has challenged us to work together in a way we have not done so before.

HIV Case Management and Care Coordination

HIV case management is effective care management; it is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the client's immediate, and long-term health and human service needs for daily living.

HIV case management is sometimes also referred to as "program coordination" or "service coordination," phrases that reflect a more client/consumer-centered approach. In its simplest form, case management involves the referral of clients to providers of the

necessary services, a situation in which case managers act largely as care navigators. At the other end of the spectrum, intensive models feature more frequent contact with clients, co-located services to address the broad array of client needs (the team-based approach) or empowerment strategies designed to build client core competencies (the strengths-based model) (HIV PLT., 2011).

Operationalizing HIV Case Management

The Saskatchewan HIV Provincial Case Management Standards have been operationalized in Regina Qu'Appelle, Saskatoon, Prince Albert Parkland, Prairie North and Sunrise health regions and some First Nations communities. Each health region has developed processes and protocols based on the provincial case management standards.

The stated intent of the Saskatchewan HIV brief case management model is that all individuals diagnosed with HIV and willing to participate in the intervention have an initial formal assessment for care needs, and work with a health care provider or care coordinator to prepare a written service plan.

The provincial standards suggest priority criteria to participate in coordinated case management, however locally determined priority groups are also acceptable:

Provincial priority groups

- Are less than 16 years of age
- HIV positive pregnant women
- New clients diagnosed with HIV that have any/all of the following challenges: unstable housing, addictions/poly-substance use, are street involved, are involved in sex work/survival sex, report concerns and require assistance in navigating the legal/justice system, have inadequate social/familial supports, have no history of HIV treatment or have adherence concerns.
- New immigrants
- Not currently on antiretroviral treatment
- Not received case management or social work services for HIV-related needs in the past
- Co-infected with Hepatitis C/TB

By September 30, 2012, 74 clients underwent screening for case management. Of these, 35 were offered case management and consented to participate. (See Appendix A for Submission 1.)

HIV Treatment Clinics –Remote and Rural Areas in Saskatchewan

In July 2011, the first Infectious Diseases Clinic was held on-reserve.

As a result of collaboration between FNIHB, the Ministry of Health, the HIV PLT, SDCL, RHAs, Infectious Disease physicians, pharmacists and individual communities and sites a process has been formalized for multidisciplinary teams to deliver combined HIV/Hep C clinics in rural and remote locations and First Nations communities.

From July 2011 to September 2012, there have been seven multidisciplinary outreach clinics in six different locations where a team of health care professionals, including an Infectious Disease specialist, were available. In total, approximately 90 clients were seen at these clinics.

Perinatal HIV Treatment Outcomes

The stated goal in the Saskatchewan HIV strategy is zero transmission from mother-to-child, i.e., to prevent all perinatal transmissions of HIV in the province.
There have been no perinatal HIV cases in Saskatchewan in 2011 and 2012.

In July 2012, an environmental scan was completed by the HIV PLT and Saskatchewan Prevention Institute to determine patient needs by assessing current policies and access to essential HIV testing, and other critical obstetric care interventions for women living with HIV who present in labour at hospitals and health centers throughout Saskatchewan. Of the 41 facilities that indicated they provide obstetric care:

- close to 75% do not have access to labour and delivery orders for women with HIV in labour or policies in place to address these needs effectively;
- over half do not have the critical medications to prevent the transmission of HIV from mother-to-child (i.e., liquid zidovudine (AZT) for infant and mother) available; and,
- when asked about access to HIV testing for women in labour, 31 (76%) of the facilities offer standard HIV testing, two offer “stat” lab test testing (6%) and four offer HIV POC Testing (13%).

According to the Society of Obstetrics and Gynecologists of Canada (SOGC) guidelines it is recommended that every health care facility that self identifies itself as a place that conducts normal labor and delivery care should be ready to provide the needed safe delivery care services for pregnant HIV positive, or HIV at-risk pregnant mothers. The HIV PLT recommended that a working group develop guidelines to provide recommendations to all obstetric health care providers to minimize practice variations for HIV screening, while taking provincial and territorial recommendations into account (Society of Obstetricians and Gynaecologists of Canada (SOGC), 2006).

Table 2: Number of Perinatal HIV Cases in Saskatchewan from 2003 to 2012

Year	Perinatal Transfer
2003	0
2004	0
2005	3
2006	0
2007	4
2008	0
2009	1
2010	1
2011	0
2012	0
Cumulative Total	**9**

The proportion of women coming in to labour and delivery in the Saskatoon health region with untreated HIV in pregnancy has decreased from 44% in 2005-08 to 0% in 2012. In comparison the proportion of women living with HIV untreated in pregnancy in Canada was 21% in 1997, and came down to 6% in 2012. (Canadian Perinatal HIV Surveillance Program (CPHSP) April, 2013)

Since 2009, in the Saskatoon Health Region, there have been a total of 45 babies born to mothers actively engaged in HIV case management. Of those births, 40 were returned to the care of either the birth mother or family. There have been zero babies born with HIV whose mother has been involved in HIV case management.

HIV/TB Co-infection

Combined TB/HIV clinical case conferences are occurring in order to ensure a combined approach to clinical management of those who are co-infected.

Routine testing is now being offered to individuals diagnosed with tuberculosis that are 14 years of age or older.

Clinical Indicators

The HIV Treatment Cascade[4] "describes the journey that HIV-positive persons take as they navigate the health care system," as Kevin Fenton, M.D., Ph.D., a former-director of the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, eloquently put it at the International AIDS Society (IAS) Rome 2011 conference. An article originally published in a journal of Clinical Infectious diseases in March 2011 by Cohen et al. describes the Spectrum of engagement in HIV care and its relevance to test-and-treat

[4] The creation of the Cascade is a tool that not only assists in the understanding of the HIV epidemic globally, but is also an epidemiologic tool to portray data visually.

Strategies for the prevention of HIV infection (Cohen M., 2011).

Over the past few years, the distinction between human immunodeficiency virus (HIV) prevention and HIV treatment has become blurred. At the basis of this lies mounting evidence that effective antiretroviral therapy, which reduces plasma HIV-1 to minimal levels, also reduces the sexual transmissibility of HIV to virtually nil (Attia S, 2009), (Donnell D, 2010). Scaling up of antiretroviral therapy has thus been proposed as a strategy to lower the number of new HIV infections at the population level (Montaner JS, 2006). A strategy of universal voluntary HIV testing for persons aged ≥15 years and the immediate administration of antiretroviral therapy for those found to be positive, in a mathematical model based on data from South Africa, it is thought that this could lead to rapid reductions of HIV prevalence, reducing the prevalence to <1% within 50 years.

The cascade has been through various visual incarnations, and in Saskatchewan, several health regions and HIV treatment clinics have embraced this concept as a way to monitor patient engagement and progress through the health care system as described below.

Work is underway to develop a clinical management tool to report clinic level data, using the clinic-based electronic medical record (EMR) (Med Access).

Regina Qu'Appelle Health Region reports that as of March 31, 2012, 271 active cases - active referring to patients who had attended clinic within the last year - 60% (207/271) were on HIV treatment medications and 81% of the patients (168/271) had fully suppressed Viral Loads (Dr. Alex Wong, March 2012).

Westside Community Clinic in Saskatoon reports, that as of January 2013, 95% of HIV-positive clients who attend their clinic were on treatment - including those "hard to reach" - and 32.6% (114/386) of HIV-positive clients had suppressed Viral Loads (Dr. Morris Markentin, January 2013).

SK HIV Medication Policy

Access & Adherence to medications

The Non-insured Health Benefits (NIHB) of Health Canada, upon the request of the HIV PLT, have moved two first-line medications for HIV to open benefit in Saskatchewan, meaning there is no formal approval process for patients to be eligible to receive this medication

Barriers to adherence studies are being conducted by the Saskatchewan HIV/AID Research Endeavour (SHARE) and will be available in the next report. In certain areas of the province, individuals who are on Methadone Maintenance Therapy can also access antiretroviral medications through Direct Observed Therapy.

Furthermore, new Hep C medications are covered under the NIHB plan. The approval process for antiretrovirals has also been simplified with the Saskatchewan Drug Plan.

Programs to Provide Support Services for Persons Living with HIV

Addressing the Social Determinants of Health[5,6]

It is well understood that poverty, poor housing, and poor health systems are among the root causes of poor health in a population, referred to as "the cause the causes". These causes of ill health refer to the social conditions that give rise to the high risk for both communicable disease and non-communicable diseases which may act through adopted unhealthy behaviours (e.g., smoking or drug use), or as a response to living a life under stressful conditions (e.g., crowding, violence, physical and sexual abuse).

Housing Initiatives

By September 30, 2012, 176 individuals living with HIV or families who had at least one family member living with HIV were identified as either close to losing their current accommodation or homeless. Provincial funding was provided to Regina Qu'Appelle, Saskatoon and Prince Albert Parkland health regions to implement pilot programs that address housing. The only restrictions were that this funding was not to be used for rental assistance or for the construction of housing structures as there are other government funded programs in those areas to which the HIV program was expected to utilise to link their patients to avoid service duplication.

Eighty-eight percent (88%) (155/176) of these identified individuals or families were engaged with housing supports in community, of which forty-eight percent (48%) (85/176) were placed in a housing situation[7]. An example of the complex issues involved in housing programming is discussed in submission 1 - The Horizontal Project in the Prince Albert Parkland health region (See Appendix A, Submission 2).

Transportation Services

Lack of access to consistent, reliable transportation has often been cited as a reason for poor patient attendance at medical appointments. Funding was provided to the health regions of Regina Qu'Appelle, Saskatoon, and Prince Albert Parkland for client transportation.

In the three regions, by September 30, 2012, 1,668 instances of transportation were provided for medical or non-medical appointments.

Direct transportation services were provided by outreach staff, community-based organizations or case managers, or in the form of taxi vouchers or bus passes. Health programs that already had formal patient transport services were reimbursed for their costs.

[5] The provincial HIV strategy has chosen to address only some of the common social determinants within the context of the SK provincial HIV strategy, namely; housing, transportation, social support (e.g., peer programs) and food insecurity. Most are addressed using community development principles.

[6] Of the reported areas of activity on the social determinants reports are only provided up to September 30, 2012.

[7] There exists in Saskatchewan a continuum of housing supports, but no overall housing policy. This situation is not unique to this province but unfortunately is the situation in many provinces in Canada. Housing solutions may range from, emergency shelter, temporary housing, rental assistance (through social services), supportive housing or subsidized housing.

The FNIHB HIV Case Manager also reported 15 instances of transportation for HIV related care.

Peer Support Pilot Programs

In Canada, the range of terms used to describe community-based, non-licensed health service providers reflects the wide variety of functions that they perform: peer educator, counselor, or advisor; community health worker; lay heath worker; buddy; promotores de salud, or patient navigators. Peers may also be defined as individuals who are from infected or affected communities that share similar characteristics with the clients being served. In the context of this report, the term "peer" refers to all non-licensed HIV service providers, who either work as volunteers or receive honorariums in the community whose qualifications and roles rest on their connection with the community they serve, and their lived experience with managing all the complexities of living positively with HIV (Boston University School of Public Health, Health & Disability Working Group, Center for Health Training, Columbia University and Harlem Hospital, Justice Resource Institute, Kansas City Free Health Clinic St. Louis Area Chapter of the American Red Cross , August 2009).

HIV Strategy funding has been provided to four groups, Regina Qu'Appelle, Saskatoon, Prince Albert Parkland and Prairie North RHAs to introduce peer support pilot programming. A community-based organization has received community supports funding to support an additional peer program in Regina, SK.

The Regina Qu'Appelle Health Authority (RQHR) Peer Mentor Program noted the following successes:

- *Improved communication between HIV positive peers and peer mentors and health-care service providers.*
- *Able to provide pre-tests to all peers and peer-mentors which will contribute to future research (post-tests not completed at this time).*
- *Training contributed to increased development and skills in Peer Mentors as well as greater capacity in the community (knowledge is power). Peers had access to 16 orientation and training sessions ranging from HIV 101, communication and listening skills, boundaries, relationship-building, relapse and suicide intervention.*
- *Matches benefited both Peer Mentors and mentees.*
- *Greater awareness of program staff of complexities of both mentors and mentees.*
- *Practiced, implemented or utilized harm reduction approaches.*
- *Put a "face" to HIV.*
- *Mentors able to maintain strong linkages within the RQHR community, utilizing the community, to provide care and treatment support for individuals living with HIV.*

As of September 30, 2012, 62 clients (mentees) had accessed peer to peer programming.

Interest has been expressed by First Nations communities in using the peer support program to address HIV fear and stigma thought to be still prevalent in many communities. Meanwhile more specific community education efforts continue. Community awareness and education sessions on-reserve have been conducted in 2011/12, 2012/13, and will continue in 2013/14, as a means to address stigma and discrimination in First Nations communities.

Plans for the Future of the HIV Strategy

A renewed investment in HIV prevention does not need to wait for a vaccine or other major new breakthrough. There are a range of effective HIV prevention tools at our disposal right now that could allow us to make dramatic progress in reducing new infections. The problem, it can be argued, is that the scale of our response has been insufficient.

In Canada today, the Public Health Agency still reports that one in four individuals living with HIV today, or 25% of HIV infected people do not know it, indicating that too few people are being reached by testing and counseling services as presently configured. In addition, in Saskatchewan so far only a small percentage of people at risk for HIV are able to access the effective behavior-changing programs that are proven to reduce a person's chances of becoming HIV infected in the first place.

Prevention services for people who are HIV-positive (prevention services with positives) also need to be expanded, particularly as the number of people living with the disease continues to increase due to effective treatments. There is significant work remaining in adopting strategies to ensure patient retention to care and adherence to medication.

Complacency about HIV is another key challenge for us in the province. Data from *Taking the Pulse of Saskatchewan 2012-Health and Wellbeing Survey*[8] show that in many communities in Saskatchewan HIV and AIDS is still not considered a high priority concern. The survey also indicated that despite the high rates of HIV in Saskatchewan, residents perceive their communities as exempt from the HIV/AIDS problem, as most respondents disagree (60%) that HIV/AIDS is a problem in their community - most respondents across all demographic groups "strongly disagree" while close to half of respondents who identify as Aboriginal "strongly agree" 46% (University of Saskatchewan: Social Science Research Laboratory (SSRL), 2012).

Recommendations

By reviewing what has been accomplished to date with resources from the HIV Strategy, keeping up with best practice evidence in the field of HIV and in literature, continued efforts in the following areas are still required Saskatchewan:

1. **Continue to enable people to know their HIV status early**
    - By increasing access to HIV testing, by following through with the implementation of the routine, opt-out HIV testing policy and supporting documents; and
    - HIV POC testing must be scaled up appropriately to all areas in the province with appropriate oversight.

[8] Taking the Pulse of Saskatchewan 2012 is a research, public outreach and knowledge mobilization project of the Division of Social Sciences, College of Arts & Science at the University of Saskatchewan aimed at informing policy making and spurring dialogue on issues of importance to the province. A telephone survey resulted in 1,750 interviews among adult Saskatchewan residents. Results are generalizable to the adult Saskatchewan population ±2.34% at the 95% confidence interval (19 times out of 20) (University of Saskatchewan: Social Science Research Laboratory (SSRL), 2012).

2. Maximize the health sector's contribution to HIV prevention

- By intensifying HIV prevention and awareness efforts;
- Implementing the Social Marketing campaign – phase 3; and
- Streaming access to baby formula feeds, or access to safe donor breastmilk for infants born to mothers living with HIV

3. Address appropriate access to and accelerate the scale up of HIV/AIDS treatment and care

- By outlining a clear role for Primary Care providers in ongoing HIV Treatment;
- Completion of the HIV Primary Care Standards, for example:
    - The Treatment of HIV in pregnancy, and Labour and delivery HIV care Saskatchewan standards; and
- Addressing challenges of adherence to Antiretroviral (ARVs) and new innovations by looking at new innovations at long-term retention strategies and adherence to medication supports.

4. Consider system redesign to address issues of access, redundancy and efficiency

- By following a more formalized approach for the deployment of Rural and Remote HIV Treatment Clinics;
- Supporting multi-disciplinary HIV provider mentoring programs that quickly share and build on the Saskatchewan experience in one area, and quickly spread this same innovation to other areas.
- The integrated approach to the care of and management of HIV/ HCV/ Addictions/ STI Clinical services and TB is most urgent and critical to help sustain gains in HIV; and
- We need continued focused work on interministerial work with Corrections, Education and Social Services.

5. Invest in strategic information to guide a more effective response

- The provincial strategy must follow to completion the HIV EMR implementation process that will lead to an annual surveillance report for Saskatchewan on the provincial performance on the HIV treatment cascade;
- Evaluation of the 4 Saskatchewan HIV Peer to Peer Pilot programs and the 3 HIV and housing pilot programs;
- Improving HIV surveillance and streamlining standard clinical indicators.
    - One quick win is to expand the already reportable first CD4 and first viral load (V_L) report, to all CD4s and all viral load reports as recommended by the Centers for Disease Control and prevention as a beast practice in HIV surveillance; and
- Formal evaluation of the provincial strategy by an external evaluator will give us an unbiased assessment of progress.

Appendix A

Submissions

Submission 1: The Oasis Group Support Sessions

Prepared by the Saskatoon health region case management support team
The OASIS (Opportunity, Acceptance, Support, Invitation and Safe) was founded in partnership by the Saskatoon Health Region, Kids First Program and West Side Community Clinic. This program is facilitated by Mental Health and Addiction Services but is driven by the participants in the program. The program has built in child care, lunch and transportation as these were barriers for many of the participants to get to other programing offered in the community.

The material covered in the program is chosen by the participants and focuses on life skills, parenting, [proper] nutrition and addictions recovery. The parenting portion of the program was requested so often that it has become one of the components offered on an ongoing basis. This particular program is facilitated by Building Health Equities Department [a division of the Population Health Promotion Department] of the Saskatoon Health Region.

The OASIS parents have been participating in nutrition programs and learning to make basic meals as well as the importance of proper nutrition for their children. This particular portion of the program brings out large numbers of people. The Saskatoon Health Region works in partnership with the West Side Community Clinic's nutritionist to help facilitate.

The program has also focused on the health care needs of both parents and children. There have been several guest speakers who talk about why immunization is important and the general health of their children. The [OASIS] group has become a safe place for these parents to ask health related questions.

Individuals in the program are also involved in volunteering in their community. They go to St. Paul's Hospital and visit patients as well as to the Friendship Inn, which has given the participants a feeling of what it feels like to give back to their community as well as to discover and develop many talents. This volunteer experience has evolved to participants being involved in the arts program that is offered at St. Paul's Hospital and as a result some of their art work is displayed in the hospital.

Everyone involved in the program is offered addictions recovery support and has the opportunity to meet with a therapist and work on trauma issues. This has helped many of the participants to move forward in their lives. If circumstances in people's lives have lead them to abuse alcohol or drugs they know they can return to the program to get the support needed.

The program has just celebrated its second anniversary and one of the highlights of the event was a couple of past participants visiting and announcing that they have both gone back to school. They spoke highly of the program and the support they experienced from it, and know that supports are never far away if needed to keep their lives moving in a positive direction.

Submission 2: Horizontal Project
Following is a submission from Karen Bear, with the Horizontal Project in Prince Albert in February 2012:

To date I've assisted nine families with ten children, ranging in age from one month to 17 years old, and 14 single individuals. The majority are aboriginal who are street involved and have HEP C and/or HIV/AIDS.

They all come with only their personal belongings so as well as finding housing I also help them find all the furnishings required.

I've worked with Social Services Income Assistance in accessing funding and with Child and Family Services in ensuring the home meets their requirements in order to return the children to their parents. This is an ongoing process with each new client that is referred to me.

All the clients have issues with all or some of the following: alcohol and drugs, mental and physical health, conflict with the law, abuse (e.g., foster care, home, residential schools, etc.), family or relationship breakdown, financial crisis, violent behavior, Fetal Alcohol Spectrum Disorders.

I have a directory of landlords, which I've built along the way, and I contact them every month for any vacancies. I also use the newspaper, Kijiji and word of mouth. These lists of landlords are ones that are willing to give people a chance. Many others do not want anything to do with the homeless with issues. Another challenge is finding homes that are affordable, especially for single people, as initially all are dependent on social assistance. I assist them with applying for the Rental Housing Supplement and have completed income tax returns, some going back to 2004, so they can get the GST/HST rebate and the Canada Child Benefits.

Once they are housed, we work together to access any supports and services they and their children require. This includes addiction services, grief counseling, anger management, parenting, education, residential school survivor's counseling, mental health, food bank, and they are able to start any long term medications they may require.

Some do very well and no longer require my help and there are others where I've had to meet with landlords to avoid eviction and continue to work with the tenant to ensure they remain housed. Some return to drugs and alcohol and have had their children apprehended and we work together to take the necessary steps to get them back on track and ensure they do not lose their home if they have to go to a treatment program.

Success is not determined by the number of people whom I've assisted, but by the ones that have gone on and are moving forward.

Another part of this position involves transportation for my clients to appointments and I also assist with transportation on clinic days at the Sexual Health Center.

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