Réseau
ACCESS
Network

HIV/Hepatitis Health and Social Services

Services sociaux et de santé pour l'hépatite et vih

STRATEGIC PLAN

2020 – 2025

DECISION-SUPPORT & TEAM NOTES

Réseau ACCESS Network

HIV/Hepatitis Health and Social Services | Services sociaux et de santé pour l'hépatite et vih

STRATEGIC PLAN 2020 – 2025

DECISION SUPPORT & TEAM NOTES

Réseau ACCESS Network is incorporated in the province of Ontario. Copyright - Réseau ACCESS Network © 2020	Contact: Website: http://www.reseauaccessnetwork.com/ Address: Réseau ACCESS Network 111 Larch Street, 4th Floor Box 10 Sudbury ON P3E 4T5 Phone 1 (705) 688-0500 Toll Free Phone: 1-800-465-2437

Public Funders:

Ontario Ministry of Health

Gouvernement du Canada / Government of Canada — Public Health Agency of Canada

This copy belongs to:_____If found, please contact_____at _____

Click-through CONTENTS

EXECUTIVE SUMMARY

Réseau ACCESS Network

HIV/Hepatitis Health and Social Services | Services sociaux et de santé pour l'hépatite et vih

The individuals served by Réseau ACCESS Network depend on our comprehensive services, aimed at wellness, harm or risk reduction and education services. People accessing our services tell us how we help them with preventing illness, chronic disease management, promotion of health and wellness and many services and programs to help them lead better lives.

With individuals at the heart of our decision-making, the Réseau ACCESS Network Board of Directors (Board) has made key strategic decisions for 2020-2025. Our dedicated, skilled staff are poised to maintain and further develop our services and programs to continue fulfilling our Mission and work towards the achievement of our Vision: Universal ACCESS – ACCÈS Universel. We are working towards this Vision with a focus on three priorities and related goals and strategies:

Engagement – Goal: Ensure delivery of service meets individuals' needs

Knowledge Mobilization – Goal: Provide quality services and programs based on demonstrated need and feedback collected.

Organizational Wellness – Goal: Strengthen practices and processes that foster a healthy organizational environment

Board and staff will work from the strategic and the operational plan, to support positive outcomes for individuals. With the leadership of the Executive Director, Board decisions within this plan are supported by ongoing collection and analysis of key data, including organizational performance tools. New challenges have emerged since the development of our last strategic plan, with the overdose crisis and poisoned drug supply being the most critical at this. Staff are working to find solutions for individuals struggling with substance use, on a daily basis. This is one of the greatest challenges the healthcare and community support sector has faced in many years. We intend to continue to partner in seeking solutions to the increased number of overdoses and look forward to a better day for individuals who struggle with substance use. Central to this approach to the success of the strategic plan, is Réseau ACCESS Network's commitment to the greater involvement and meaningful engagement of people with lived/living experience with HIV/AIDS & Hepatitis.

Réseau ACCESS Network is a community leader in diversity acknowledgment and approaches. We see diversity as a multi-dimensional element of being human, not limited to any factor or characteristic. We consider the Truth and Reconciliation Principles and Calls to Action an important part of our approach moving forward and have included these in this decision support document.

Keeping individuals who need our services first in the transformation of the Ontario health care and community support sectors is integral to our work, and Réseau ACCESS Network is ready to be a full participant in positive change. We look forward to continued support from the Ontario Ministry of Health (OMOH), Public Health Agency of Canada, as well as our donors and collaborating partners, to ensure Mission success. Through a Social Determinants of Health lens, driving positive outcomes for individuals remains our focus and the Board, along with the Réseau ACCESS Network Leadership and Staff Team is confident in the choices made within this plan.

Success requires change management which meets individuals where they are. It requires professional development, process adjustments and innovation as well as a supportive organizational culture. The Board will be monitoring the progress of our Strategic Plan: meeting agenda's will be framed to support governing within the strategic priorities.

Through the operating plan, staff will capture the details and data required to stay the course with indicators or targets and monitor the results of strategies implemented. Reporting by the Executive Director (ED), at regularly scheduled Board meetings and other opportunities, will drive Board decisions related to any strategy revision, which may be required at any time during the term of the plan. As well, data is collected and documented for the OMOH as per reporting requirements and terms of funding agreements. Monitoring individual satisfaction will continue, and innovation will drive effectiveness.

Grief and loss are recurring stressors for Réseau ACCESS Network service providers as well as for operational and governance teams. From the candle lighting ceremony performed at Board meetings, to supporting each other on a day-to-day basis, to using strategies shared sector-wide, we will continue to address this element of our reality in the most effective ways possible.[1]

The Réseau ACCESS Network Board of Directors and Executive Director thank all participants in the strategic planning process, for their contributions and ongoing collaboration for towards achieving our Vision:

- Universal ACCESS – ACCÈS Universel.

SVP voir le site web pour info en français : http://www.reseauaccessnetwork.com/?lang=fr

President, Board of Directors Date: _____

Executive Director Date: _____

For ease of reading, this document includes the following terms for persons served by Réseau ACCESS Network and/or partner agencies: individual(s), persons, people, client(s), community member(s), patient(s).

The terms HCV (Hepatitis C Virus), hep C and Hepatitis/hepatitis are used by various funders and resource documents and are left as such where data is included from these sources.

[1] https://www.catie.ca/sites/default/files/When%20Grief%20Comes%20to%20Work_e.pdf

VISION MISSION VALUES

VISION

Universal ACCESS – ACCÈS Universel

MISSION

Réseau ACCESS Network is a non-profit, community-based charitable organization, committed to promoting wellness, harm and risk reduction and education. Réseau ACCESS Network supports individuals and serves the whole community, in a comprehensive / holistic approach to HIV/AIDS, Hepatitis C, Harm Reduction and related health issues.

As a team working collaboratively and with passion, dedication and creativity, we value the following.

VALUES

ACCEPTANCE

We ACCEPT every individual regardless of race, colour, creed, religion, ethnic origin, gender, language, physical or mental status, sexual orientation, drug and/or alcohol use, age, gender identity, sexual risk behaviour or level of education.

AFFIRMATION

We do all within our power to AFFIRM in each individual's unique self-worth.

ASSISTANCE

We provide ASSISTANCE to individuals in an atmosphere of confidentiality.

ADVOCACY

We ADVOCATE for continuous improvement in support services, education, harm reduction, public awareness, and ongoing public financial support.

ACCOUNTABILITY

We are ACCOUNTABLE to the public, individuals we serve, and our funders and supporters for our programs and services and stewardship of funds.

STRATEGIC PLAN 2020-2025

On behalf of the people served by Réseau ACCESS Network, the Board of Directors leads the Agency through the 2020-2025 strategic plan focused on the following Priorities: ENGAGEMENT, KNOWLEDGE MOBILIZATION, ORGANIZATIONAL WELLNESS. Each priority is linked to goals and strategies for achieving desired outcomes. The agency is responsive and works towards health equity and the elimination of stigma and discrimination as it relates to those we serve. The agency recognises a person's journey may not be done alone. Through a person-centered approach, we support those who access or use the services of Réseau ACCESS Network in their inclusion of chosen family, friends and significant others. We invite you to join us in our Vision of UNIVERSAL ACCESS – ACCÈS UNIVERSEL.

ENGAGEMENT	KNOWLEDGE MOBILIZATION	ORGANIZATIONAL WELLNESS
GOAL Ensure delivery of service meets individuals' needs	**GOAL** Provide quality services and programs based on demonstrated need and feedback collected	**GOAL** Strengthen practices and processes that foster a healthy organizational environment
STRATEGIES		
Partner with subject matter experts to enhance services and programs. Partnership approach includes: • Demonstrated integration, in all programs and services • Greater and more meaningful involvement of persons with lived/living experience		
1. Build ongoing innovative relationships to reach underserviced individuals 2. Further develop medical care and mental health supports and services 3. Expand services to diverse populations. Initiatives include: • Approaches, programs and services which contribute to ending stigma and discrimination against people served by Réseau ACCESS Network • Actively work to eliminate barriers to accessing our services	1. Improve feedback process for individual satisfaction and inform ongoing development of programs and services based on feedback / data collected 2. Increase community awareness through communication and social marketing 3. Share best practices and key knowledge with the wider service community	1. Develop quality organizational practices: • Organizational culture • Retention • Succession • Team relationships 2. Maintain and further develop partnerships through: • Effective responses to needs • Collaborations with like organizations • Leadership

DECISION SUPPORT

PERSON-CENTERED DECISION-MAKING

DECISION SUPPORT DATA

The Board of Directors (Board) and leadership team of Réseau ACCESS Network has a track record of success in making decisions based soundly on individuals' needs and realizing these through operations. The strategic plan (the plan) was developed through a person-centered, evidence-based, system-aware approach, aligned with funders' goals. Ongoing stakeholder feedback, best practices, clinical data and day to day interactions will continue to inform the implementation of the plan as well as any amendments during its five-year term.

An operational plan is used by staff to measure and drive progress towards goals. Supporting a commitment to ongoing success, the information in this section provides a sampling of the decision support data which is foundational for the choice of priorities, goals and strategies in the 2020-2025 strategic plan.

EVALUATION

Evaluation will continue through the collection and submission of data through to funding bodies as well as regular reporting to the board. Where it will be a value, staff will explore the measuring of particular indicators related to the plan's strategies and goals, such as service satisfaction.

THE ONTARIO ACCORD

In line with the Ontario AIDS Network Ontario Accord statement, Réseau ACCESS Network "Commits to the greater involvement and meaningful engagement of people living with HIV/AIDS (GIPA/MEPA); GIPA/MEPA puts PHAs at the centre and is grounded in human rights and the dignity of the full human being."

Statement of The Ontario Accord / Led by OAN - "We, people living with HIV/AIDS and allies in the community:

- Commit to the greater involvement and meaningful engagement of people living with HIV/AIDS (GIPA/MIPA); GIPA/MIPA puts PHAs at the centre and is grounded in human rights and the dignity of the full human being
- Aim to transform all who live with, work in, and are affected by, HIV/AIDS in Ontario
- Commit to personal and social transformation
- Value community expertise in embracing the challenge for the betterment of society
- Value inclusion over exclusion, a quest for integrity at all times and the embodiment of self-determination
- Promote the evolution of thought, action and collaboration among us and with our allies
- Because GIPA/MIPA is about human struggles and aspirations, ethics, empowerment and accountability are its foundation."

We acknowledge that Greater involvement of people with HIV/AIDS (GIPA) is never achieved once and for all; it is a goal and commitment that must be continually renewed. GIPA is a practice, not a project, and is similar to all other accountabilities of healthy HIV organizing and service delivery. Our practices in AIDS service organizations (ASOs) must be continually re-evaluated in light of the changing realities of HIV/AIDS and of those living with it.

Within the North American context, GIPA principles have often been considered as only applying to persons living with HIV/AIDS. We affirm that GIPA concerns all who live with, work in, and are affected by, HIV/AIDS. Another way of stating this is that GIPA engages people with HIV/AIDS and their allies in a culture of inclusivity intended to foster an expanding and inclusive approach that embraces HIV Positive individuals in all their diversity and circumstances and includes those affected by HIV/AIDS and all allies. In naming this accord, "The Ontario Accord" we acknowledge the foundational work that continues to inspire us and have continued the precedent of naming our work after its geographic birthplace. We invite citizens of the world to join us in our efforts and organizations globally to affirm their support of the Ontario Accord."[2]

Réseau ACCESS Network has incorporated this philosophy in all of the services we provide including HIV/Hepatitis C and harm reduction.

See APPENDIX B OAN for more details.

TRUTH AND RECONCILIATION

The Board and leadership staff of Réseau ACCESS Network are clear in our intent to lead through the lens of the Truth and Reconciliation Principles. Our Truth is the alarming incidence of HIV and Hep C in the Indigenous people of our area - our call to action. As stated by the Truth and Reconciliation Commission of Canada and in alignment with the mission of the Ontario Aboriginal HIV/AIDS Strategy[3], we serve to respect the principles of Reconciliation, which are as follows.

PRINCIPLES OF RECONCILIATION
Truth and Reconciliation Commission of Canada

The Truth and Reconciliation Commission of Canada believes that in order for Canada to flourish in the twenty-first century, reconciliation between Aboriginal and non-Aboriginal Canada must be based on the following principles.[4]

1) The United Nations Declaration on the Rights of Indigenous Peoples is the framework for reconciliation at all levels and across all sectors of Canadian society.

2) First Nations, Inuit, and Métis peoples, as the original peoples of this country and as self-determining peoples, have Treaty, constitutional, and human rights that must be recognized and respected.

3) Reconciliation is a process of healing of relationships that requires public truth sharing, apology, and commemoration that acknowledge and redress past harms.

4) Reconciliation requires constructive action on addressing the ongoing legacies of colonialism that have had destructive impacts on Aboriginal peoples' education, cultures and languages, health, child welfare, the administration of justice, and economic opportunities and prosperity.

[2] https://oan.red/ontario-accord/
[3] https://www.oahas.org/
[4] http://www.trc.ca/assets/pdf/Principles%20of%20Truth%20and%20Reconciliation.pdf

5) Reconciliation must create a more equitable and inclusive society by closing the gaps in social, health, and economic outcomes that exist between Aboriginal and non-Aboriginal Canadians.

6) All Canadians, as Treaty peoples, share responsibility for establishing and maintaining mutually respectful relationships.

7) The perspectives and understandings of Aboriginal Elders and Traditional Knowledge Keepers of the ethics, concepts, and practices of reconciliation are vital to long-term reconciliation.

8) Supporting Aboriginal peoples' cultural revitalization and integrating Indigenous knowledge systems, oral histories, laws, protocols, and connections to the land into the reconciliation process are essential.

9) Reconciliation requires political will, joint leadership, trust building, accountability, and transparency, as well as a substantial investment of resources.

10) Reconciliation requires sustained public education and dialogue, including youth engagement, about the history and legacy of residential schools, Treaties, and Aboriginal rights, as well as the historical and contemporary contributions of Aboriginal peoples to Canadian society.

CALLS TO ACTION

The TRC issued its final report in 2015. Within the report, were issued 94 calls to action to redress the legacy of residential schools and address the process of reconciliation pertaining to. The underlined items align directly with the needs of individuals served by Réseau ACCESS Network, and elements of our 2020-2025 strategic plan.

 child welfare education language and culture health justice Canadian government and the United Nations Declaration on the Rights of Aboriginal People Royal Proclamation and Covenant of Reconciliation settlement agreement parties and the United Nations Declaration on the Rights of Aboriginal People equity for Aboriginal people in the legal system

 national council for reconciliation professional development and training for public servants church apologies and reconciliation education for reconciliation youth programs museums and archives missing children and burial information national centre for truth and reconciliation commemoration media and reconciliation sports and reconciliation business and reconciliation, and newcomers to Canada.[5]

[5] http://www.nelhin.on.ca/~/media/sites/ne/News%20and%20Events/Internal%20Publications/Aboriginal%20Health%20Care%20Reconciliation%20Action%20Plan_EN.pdf?la=en

ALIGNING WITH FUNDERS' PROGRAM GOALS

Donor Funding

As a non-profit, community-based charitable organization, Réseau ACCESS Network highly values its donors as important partners in the agency's work. This source of funding is a direct validation of the community's alignment with our Vision and Mission and is assurance that the voice of the community is part of the day-to-day work, including planning information.

Government-sourced Funding

The goals and/or objectives of Réseau ACCESS Network's federal and provincial funders at the time of the launch of the strategic plan, are clearly aligned with the agency's new priorities, goals and strategies. Alignment can be shown between all the plan's elements and all funders' goals and objectives. A 2-page graphic drawing examples of alignment between Réseau ACCESS Network and funders' plans is included in Appendix F, for teams to use as a discussion tool to ensure front goals and strategies are on target.

Ontario

The Ontario Ministry of Health, Réseau ACCESS Network's main funder, has been a strong supporter of the agency since its original funding and approval of it in 1989. At the time of the strategic plan's launch, the Ontario government provides funding under the following Ontario Ministry of Health – AIDS Bureau & Hepatitis Programs.

A. Ontario Ministry of Health – AIDS Bureau & Hepatitis Programs

AIDS Bureau Goals:

1. Improve the health and well-being of populations most affected by HIV
2. Promote sexual health and prevent new HIV, STI and Hepatitis C
3. Diagnose HIV infections early and engage people in timely care
4. Improve the health, longevity and quality of life for people living with HIV
5. Ensure the quality, consistency and effectiveness of all provincially – funded HIV programs and services

Hepatitis C Goals:

1. To increase access to hepatitis C care and treatment for priority populations in Ontario
2. To increase knowledge and awareness to prevent the transmission of HCV among priority populations in Ontario
3. To increase collaboration, coordination and evidence-based practice across the system responding to HCV

Gouvernement du Canada Government of Canada

An important federal funder, the Public Health Agency of Canada has provided financial support for Réseau ACCESS Network since 1990. At the time of the strategic plan's launch, the government of Canada provides funding under the following Public Health Agency of Canada programs.

B. Public Health Agency of Canada

Community Action Fund Objectives:

1. By 2022, the AIDS Bereavement & Resiliency Program of Ontario, Elevate N.W.O., AIDS Committee of Windsor, Fife House, Toronto People with AIDS Foundation, and Réseau ACCESS Network will deliver 500 educational workshops to 2,000 people living with HIV, Hepatitis C or related STBBIs in Thunder Bay, Windsor, Toronto, and Sudbury, respectively, to increase the capacity (e.g., knowledge of treatment options; knowledge of where to access programs/services and treatment; confidence in ability to get support to access treatment; ability to get support to adhere to treatment) to increase adherence and retention to care by 50%, and 20% will increase adherence to treatment and/or retention to care behaviors (e.g., continuing with treatment plan; getting peer support to retain care) that improve health outcomes.

2. By 2022, Elevate N.W.O., and Réseau ACCESS Network will deliver 140 educational workshops to 150 Indigenous People in Thunder Bay and Sudbury to increase the capacity (e.g., knowledge of where to access treatment; confidence in ability to access treatment; ability to get peer support to access treatment; intention to access treatment, disclosure of HIV/Hep C and/on STBBIs) to use harm reduction practices by 50% and 5% will increase the adoption of harm/risk reduction behaviors (e.g., safe sex practices, negotiating safe sex with partners; getting support from peers to negotiate safe sex) that prevent the transmission of HIV, Hepatitis C or related STBBIs.

3. By 2022, Elevate N.W.O. and Réseau ACCESS Network will deliver 140 educational workshops to 150 people who use drugs through injection in Thunder Bay and Sudbury to increase the capacity (e.g., knowledge of where to get sterile/new equipment; confidence and skills in being able to negotiate not sharing needles/equipment; intention not to share needles/equipment; disclosure of HIV/Hep C and/or STBBIs) to use harm reduction practices (e.g., not share needles/equipment; getting sterile needles/equipment; supporting peers with getting sterile needles/equipment) by 50% and 5% will report increased adoption of harm reduction behaviors that prevent the transmission of HIV, Hepatitis C or related STBBIs.

Harm Reduction Fund Objectives:

1. By March 31st, 2021, 64 Peers will have strengthened their knowledge of risk factors associated with HIV and hepatitis C among people who share drug-use equipment by 50%.
2. By March 31st, 2021, 44 trained Peers will strengthen the skills, competencies, and abilities of people who use substances and share drug-use equipment to prevent HIV and hepatitis C infections by 50%.

Kathy's Voice

My name is Kathy and I am HIV positive. I have been a client of the Réseau ACCESS Network four or five years now and without their support I would not be able to do the work in the community that I do with outreach and supporting other people with HIV and Hep C. Réseau ACCESS Network was there for me at a time in my life when I felt hopeless and isolated. They gave me the tools to support my peers and gave me the confidence to do that.

Kathy S.

Strategic Priority (of 3) **ENGAGEMENT**

STRATEGIES

1. (Common to all Priorities) Partner with subject matter experts to enhance services and programs. Partnership approach includes:
   - Demonstrated integration, in all programs and services
   - Greater and more meaningful involvement of persons with lived/living experience
2. Build ongoing innovative relationships to reach underserviced individuals
3. Further develop medical care and mental health supports and services
4. Expand services to diverse populations. Initiatives include:
   - Approaches, programs and services which contribute to ending stigma and discrimination against people served by Réseau ACCESS Network
   - Actively work to eliminate barriers to accessing our services

GOAL

Ensure delivery of service meets individuals' needs

ENGAGEMENT

DECISION SUPPORT FOR ENGAGEMENT AS A PRIORITY[6]

At a system level, the Board will support and monitor Engagement through ensuring that delivery of service meets individuals' needs. Relationships, feedback from individuals accessing services and stakeholders, as well as collaborations and partnerships, are all required to succeed with this priority and goal. Though data on engagement has been included in governance and operational work, and will continue to inform decision making, Réseau ACCESS Network is ready to take interaction to the next level.

Satisfaction testimonials shared by people served have been included in this document, and some participated in strategic planning. Réseau ACCESS Network is providing many services across a wide spectrum of system care points, including multiple collaborations with other agencies. We know that the strategies within this priority will support the goal of ensuring that delivery of service meets individuals' needs. In particular, we intend to apply these strategies to support persons who use substances and prevent further opioid-related deaths in our community.

For community agencies struggling to meet needs, the systems with which they interact are also experiencing massive and sometimes unpredictable transformation. Ontario is experiencing system transformation. The Board and leadership team are committed to participating, advocating for and driving positive impact for the people we serve. Key to our participation is engaging individuals at all opportunities for dialogue and sharing of challenges, ideas and potential solutions to emerging challenges.

Discussion about exploring new strategies to increase individual feedback is ongoing. Frequent interaction with our stakeholders tells us they support each of the three priorities, goals and related strategies. Board and Management have access to all feedback data through the Executive Director and have the opportunity to draw from these again during the term of the strategic plan. Staff, Board and volunteers are passionate about the work, and engaged in continuing to provide high quality services to support our Mission success, helping our individuals experience positive outcomes.

At an operational level, we will ensure strategies are flexible in response to ongoing and changing needs of the people we serve. Réseau ACCESS Network staff interact with stakeholders in the community and provincially. We know that further developing partnerships with subject matter experts is key to meeting people's needs through evidence-based service delivery. Underserviced individuals need to be reached by methods we may not have used in the past and building relationships will be instrumental in helping these individuals.

Medical care, as well as mental health supports and services are limited: the development of these services is crucial and may also require innovation. Diverse populations and all groups will benefit from expanded services. To ensure engagement, we know that we must be diligent in identifying and addressing any barriers which have historically prevented access to programs and services. In doing so, we will ensure a sustainable engagement mechanism is in place.

[6] Note that all data within this document stands as decision support for the strategic plan.

Cindy-Lou's Voice

I am a long-term survivor who is standing strong and tall, trying to give back helping others. I walked in the doors of Réseau ACCESS Network in 1996 a broken person feeling ashamed, confused and scared of dying. Today I walk through life proud and confident due to the emotional support and education received by Réseau ACCESS Network. Because without that support I would not be who I am today.

Cindy-Lou

Strategic Priority (of 3) **KNOWLEDGE MOBILIZATION**

STRATEGIES

1. (Common to all Priorities) Partner with subject matter experts to enhance services and programs. Partnership approach includes:
   - Demonstrated integration, in all programs and services
   - Greater and more meaningful involvement of persons with lived/living experience
2. Improve feedback process for individual satisfaction and inform ongoing development of programs and services based on feedback / data collected
3. Increase community awareness through communication and social marketing
4. Share best practices and key knowledge with the wider service community

GOAL

Provide quality services and programs based on demonstrated need and feedback collected

KNOWLEDGE MOBILIZATION

DECISION SUPPORT FOR KNOWLEDGE MOBILIZATION AS A PRIORITY

Included in our Values statement, is:

- We ADVOCATE for continuous improvement in support services, education, harm reduction, public awareness, and ongoing public financial support.

At the system level, the Board will support and monitor Knowledge Mobilization through ensuring we provide quality person-centered services and programs based on demonstrated need and feedback collected. The need to prioritize Knowledge Mobilization is in alignment with funder goals as well as with our Advocacy Value and the Réseau ACCESS Network Mission:

- Réseau ACCESS Network is a non-profit, community-based charitable organization, committed to promoting wellness, harm and risk reduction and education. Réseau ACCESS Network supports individuals and serves the whole community, in a comprehensive / holistic approach to HIV/AIDS, Hepatitis C, Harm Reduction and related health issues.

Knowledge mobilization for our team will be done through an increasingly wide range of strategies. These relate to the use of data, best practice guidelines and research results, as well as the effective dissemination, transfer, exchange of knowledge. The Board looks forward to seeing this element of the agency's work develop further and include knowledge mobilization regarding potential integration initiatives. As part of the sector network, we will continue to share challenges and successes, for the greater good of all.

At the operational level, the importance of partnering with subject matter experts, including our staff and persons with lived/living experience, to enhance services and programs is pivotal. Measuring results at the individual level will include demonstrating integration and satisfaction in programs and services. Greater and more meaningful involvement of persons with lived/living experience will be supported through enhanced and modernized feedback processes.

Increasing community awareness through communication and social marketing as a key strategy is timely, and the agency is poised to take strides in this direction. Subject matter experts, including people with lived/living experience, staff and partners in this area will be key, in partnering with Réseau ACCESS Network on this strategy.

Eric's Voice

People living with HIV/AIDS in Sudbury face many barriers and stigmas in our community. Réseau ACCESS Network becomes a lifeline for us to be able to achieve our best selves by accessing support and other necessary services through the many programs they offer.

Eric Cashmore, community activist

Strategic Priority (of 3) **ORGANIZATIONAL WELLNESS**

STRATEGIES

1. (Common to all Priorities) Partner with subject matter experts to enhance services and programs. Partnership approach includes:
   - Demonstrated integration, in all programs and services
   - Greater and more meaningful involvement of persons with lived/living experience
2. Develop quality organizational practices:
   - Organizational culture
   - Retention
   - Succession
   - Team relationships
3. Maintain and further develop partnerships through:
   - Effective responses to needs
   - Collaborations with like organizations
   - Leadership

GOAL

Strengthen practices and processes that foster a healthy organizational environment

ORGANIZATIONAL WELLNESS

DECISION SUPPORT FOR ORGANIZATIONAL WELLNESS AS A PRIORITY

From a corporate responsibility perspective, the Board is committed to governing in a manner that models and leads Organizational Wellness. The evidence abounds, supporting that the most successful employers attract and retain a talented employee largely via a healthy organizational culture. Organizational wellness is not just a perk: it is a strategic priority which can only be realized when all are aligned and engaged.

As the goal, “Strengthening practices and processes that foster a healthy organizational environment” was chosen for its clarity and measurability. Some of the themes which emerged as key words during planning sessions were: Together, Wellness, Empowered, Relationship, Responsiveness, Team development, Optimism and Innovation. These are more than words and will help the operational leadership team maintain a focus on the related strategies.[7] Board and staff look forward to developing quality organizational practices in the areas of Organizational culture, Retention and Succession as well as Team relationships.

Ongoing professional staff development currently supports organizational wellness. Based on agency capacity, and in alignment with the Mission and strategic plan, the employee can choose the type of development they will participate in. There are sector opportunities as well, with some funding available at times to support participation. Department and staff meetings provide weekly opportunities for communication, learning and working in alignment. The agency’s benefit package features access to benefits in as little as three months from the start of employ, including EAP. Holidays and other benefits become available at six months.

Staff will develop organizational wellness initiatives under the strategies, with reporting flowing to the Board on major challenges and successes, as part of regular Executive Director reports.

Partner relationships are essential to organizational wellness for Réseau ACCESS Network. Collaborating with organisations who work with us to achieve results for the people we serve benefits staff as well. The acknowledgement of staff members’ skill set, and subject matter expertise is a motivating factor in aiming for quality care and excellence in delivery. Staff experiencing the rewards of effective individual intervention through partnerships are more likely to be satisfied with the organization which employs them.

[7] See Appendix E – Organizational Culture Team Tool .

Partner Voice

It is recognized that through active engagement and partnerships with the private sector, not-for-profit sector, organizations within and outside the health sector, and other levels of government, progress can be made to support and sustain behaviour change that will positively impact health.

Public Health Canada

https://www.canada.ca/en/public-health/services/funding-opportunities/multi-sectoral-partnerships-promote-healthy-living-prevent-chronic-disease.html

ABOUT the PEOPLE WE SERVE

The primary goal for Réseau ACCESS Network is clearly stated as our Mission:

- Réseau ACCESS Network is a non-profit, community-based charitable organization, committed to promoting wellness, harm and risk reduction and education. Réseau ACCESS Network supports individuals and serves the whole community, in a comprehensive / holistic approach to HIV/AIDS, Hepatitis C, Harm Reduction and related health issues.

We know that the people served by Réseau ACCESS Network look to us for assistance and face a variety of challenges. Réseau ACCESS Network must respond with evolving programming that meets the specific needs of the individuals and population we serve.

Diverse residents of the Sudbury region and communities in other areas of North Eastern Ontario look to Réseau ACCESS Network for the above supports. Though this defines our catchment area, as with many community and health agencies in Ontario, exact geographic divisions (“turf”) for services is not always typical, nor is it clear for the person seeking services. The population we serve is composed of persons with lived/living experience, affected by, or at risk, with regards to HIV and Hep C. With this in mind, health equity is part of our day-to-day work, conversations and planning.

Board and Staff work with a clear and common understanding of demographic trends affecting the individuals who come to us for services and the characteristics particular to the populations we serve.

To provide the reader with a needs snapshot of the people served by Réseau ACCESS Network, we have included next, data summarized from the Ontario Community HIV and AIDS Reporting Tool (OCHART), from one recent 6-month period, reported 5/1/2019 under the three funder titles as in use by the OMOH.

HEALTH EQUITY

NORTHERN ONTARIO HEALTH EQUITY STRATEGY

A PLAN FOR ACHIEVING HEALTH EQUITY
IN THE NORTH, BY THE NORTH, FOR THE NORTH

Northerners face health inequities relative to the rest of the Ontario population. But beyond this, there are significant inequities within the North itself. Indigenous populations experience some of the worst health outcomes of any population in Canada, and Northern Ontario is no exception. Francophones face challenges accessing healthcare in their own language, which can impede access to quality care and good health. These disparities are socially produced, unfair and unjust.

https://www.hqontario.ca/Portals/0/documents/health-quality/health-equity-strategy-report-en.pdf

About the people we serve (Continued)

1. **Education for Service Users & Support Services (HIV)**

Of individuals served directly at the agency, demographic highlights are:

- Men outnumber women
- Though the most common ethnicity accessing our services is white, while First Nations individuals are served in significant numbers, as well as black, metis and unknown ethnicities
- Persons from the ages of 18-75 are included in our services and statistical data to date
- Most individuals are between the ages of 36 and 55, though significant numbers are also served in the 26 to 35 age group and the 56 and older cohort.

Our priority populations are people who identify as:

- Gay/bisexual/MSM
- African Caribbean Black communities
- People who use drugs
- Indigenous people.

Based on the data collected by staff, the needs of individuals served are highest in the areas of:

- general and group support
- food programs
- case management
- transportation
- managing HIV.

Other services individuals are accessing include:

- bereavement services
- financial counselling
- HIV pre and post test counselling.

Our statistics also show individuals presenting with the following issues:

- living with HIV
- housing
- food security
- well being
- income and benefits
- education and employment
- social support
- risk of HIV/STIs.

2. Harm Reduction (HIV)

Within our Harm Reduction Outreach services, the most common needs are:

- brief counselling
- harm reduction teaching and practical support.

Individuals access our services at various locations. These include:

- a needle exchange program
- community agencies
- public spaces
- streets and parks.

Harm reduction services include providing a wide variety of harm reduction supplies.

3. Hepatitis C

The greatest demographic cohort within our Hepatitis C priority population is people at risk of acquiring HCV, with the second highest category being patients[8] living with HCV followed by those receiving post cure care.

Most of the patients within our hepatitis C cohort come to us for general support and begin by receiving intake and assessment services. Their needs at the time include:

- application completion
- appointment accompaniment
- clinical counselling
- adherence counselling
- wellness checks
- ongoing clinical monitoring (Included are HCV antibody tests and HCV RNA tests.)

The Hepatitis C population seeks out our services at a variety of locations which include:

- addiction programs
- drop in centre
- food bank/soup kitchen
- methadone maintenance clinic
- shelter
- street outreach such as parks and alleys, and social gatherings.

Note that the food bank/soup kitchen and street outreach are the most popular point of care locations for individuals living with Hep C.

[8] The term “Patients” is used for Hep C clients, in reporting to our funder through OCHART.

SOCIAL DETERMINANTS OF HEALTH

The social conditions we live with have a powerful influence on our health. The interaction of these conditions may increase risks to our health. The more vulnerable we are within our social conditions, the more we are prone to disease and injury.

Def.: Social Determinants of Health (World Health Organization [WHO]): the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness.[9]

Fourteen interrelated factors are accepted as the Social Determinants of Health for Canadians. They are listed as:[10]

1. First Nations, Inuit, or Métis status
2. Disability
3. Early life
4. Education
5. Employment and working conditions
6. Food insecurity
7. Health services
8. Gender
9. Housing
10. Income and income distribution
11. Race
12. Social exclusion
13. Social safety network
14. Unemployment and job security.

Economics, politics and other factors within society also have an impact on these 14 determinants of health. They do not exist in isolation and compound effects can seem insurmountable for some. The Board and staff of Réseau ACCESS Network are keenly aware of the impact of the Social Determinants of Health for our service population. We seek to explore these issues and any related challenges for every individual and provide support towards positive outcomes at every opportunity. This includes the agency itself advocating publicly to create positive change within all fourteen determinants of health.

FEEDBACK FROM THE INDIVIDUALS WE SERVE

KEY THEMES

Réseau ACCESS Network individuals participated in the strategic planning process, including the first session, May 25-2019.

As well, staff provided key feedback from individuals served, with voiced needs as the focus.

Themes voiced included the need for:

- Addressing the overdose crisis and poisoned drug supply
- Broader inclusiveness
- More education
- More client support including proactive outreach
- Increased connections with northern peers
- More support for the affected
- Reaching intersections of population such as persons from Indigenous and other cultures

[9] http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html
[10] http://nccdh.ca/images/uploads/comments/NCCPHSDOHFactsheet_EN_May2012.pdf

Participant Voice - Ontario Health Equity Strategy Report

Over the last several decades, those of us queer people who are older have lived through and survived being declared illegal, mental health diagnoses and the HIV/AIDS crisis. Rejections from family, friends, church groups, and work environments haunt queers daily. Even if direct harassment and rejection isn't occurring, the constant anxiety about its potential is emotionally damaging. Mental health and social acceptance and security are social determinants of health that affect the physical health of LGBTQ populations across the North regardless of age, ethnicity, language or Indigenous status.

https://www.hqontario.ca/Portals/0/documents/health-quality/health-equity-strategy-report-en.pdf

WHO IS RÉSEAU ACCESS NETWORK?

OUR HISTORY[11]

The following is an abbreviated account of RÉSEAU ACCESS NETWORK's history. Developments are ongoing, and the reader is encouraged to explore the full text in policy or contact the agency for information.

1. 1988 - Founded by Tom Reid, after brother diagnosed with AIDS. Many HIV/AIDS resources available in Vancouver where brother was residing, unavailable in Sudbury. Mr. Reid decided to do something about it.

2. 1989 – Incorporation / Doors opened: 2 individuals served, one and a half staff, as "ACCESS, the AIDS Committee of Sudbury" . Philosophy : Acceptance, Affirmation, Assistance, Advocacy, Accountability > still stand as agency values

3. 1990s - First programs: (1) Needle exchange program, "The Point", (2) Haven program and HIV outpatient clinic for HIV and Hep C co-infection treatment support, (3) Living Well fund, for practical assistance including food bank, travel to appointments, access to medication

4. 2000 - Public Health Agency of Canada funds development and promotion of educational material including Train The Trainer, regarding Hep C

5. 2001 - Ontario Ministry of Health and Long Term Care (MOHLTC) drive amalgamation with Algoma AIDS network, Sault Ste Marie.

6. 2003 - amalgamated agency to serve Algoma + Sudbury Manitoulin opens as ACCESS AIDS Network. 2009 > Group Health Centre in Sault Ste Marie take the lead for all HIV/AIDS programming for Algoma.

7. 2008 - Ontario Hepatitis Nursing Program initiated to assist individuals mono infected with Hep C or Co-infected with HIV/AIDS gain access to Hep C treatment.

8. 2011 - Funding enhanced through the Hep C Secretariat, MOHLTC to create Sudbury HCV team to help underserviced individuals living with, affected by, or at risk of Hep C. Included nursing services education, case management, community outreach, practical assistance and counselling
    - Name change to Réseau ACCESS Network, recognising agency's history, commitment to bilingualism, the French-speaking community, and the services needed by those living with , affected by, or at risk of HIV and or Hepatitis C.

    - Logo unveiled

9. Leading up to 2020 and ongoing:
    - Increase in work being done by Réseau ACCESS Network in response to the increasing number of overdose-related deaths, mostly due to poisoned drugs. Both Provincial and Federal Funders have responded with increased funding to enhance existing outreach services.

    - May 2017 - Relocation from 111 Elm Street, Suite 203, to 111 Larch Street, 4th floor, with ten-year lease. Space is limited; however, the benefits include being central to where folks meet.

[11] See Policy 100.10 HISTORY for full text.

GOVERNANCE & LEADERSHIP

As with most successful not for profit agencies, Réseau ACCESS Network was started as an urgent response to human need. Launched by a small group of community members and a handful of health care professionals seeing the need to support individuals living with HIV/AIDS, the agency developed and matured organically, and is now a leader in the Sudbury area health care and community sector.

Incorporated in 1989, the Board of Directors is now diverse in its composition. Maintaining this diversity-focus, it is composed of from three to thirteen volunteer Directors. The Board strives to maintain a composition which includes individuals from the following groups and communities: Francophone, Indigenous, persons living with HIV/AIDS and/or with HCV.

The Réseau ACCESS Network Board's governance approach is person-centered, system-aware and evidence-based. The Board's approach is founded on the needs of individuals served and supported by policy. Confident in its readiness to lead the agency through the term of the plan, the Board is engaged and governing from recently renewed By-law and governance policies.[12] Ongoing Board development takes place and modelling a positive organizational culture is foundational to the Board's approach.

The Executive Director (ED) reports directly to the Board through the President and is accountable to the Board for all agency operations. Reporting on program and service results and matters requiring decision making by the Board are tabled by the ED for inclusion in regular Board meeting agendas. In addition, urgent matters are brought to the attention of the Board as required through ongoing open communications between the Board President and ED.

The Organizational Structure is included in APPENDIX A Organizational Structure / Fall 2020 , showing management staff – ED relationships.

OPERATIONAL APPROACH & HUMAN RESOURCES

Management, staff, persons with lived/living experience and volunteers work in an engaged, team-based approach, based on day-to-day living the agency values. I.e.: Acceptance, Affirmation, Assistance, Advocacy and Accountability. Change is constant in the sector, and team members work together to provide the best possible programs and services in all circumstances. Diversity is a thread which binds all that we do.

Réseau ACCESS Network's Mission is accomplished through a multidisciplinary team approach. The team includes regulated staff such as registered nurses, physicians and social workers, as well as staff and volunteers and persons with lived/living experience from various backgrounds. Professional development opportunities are provided based on availability of opportunities and capacity.

Operational Policies are current and aligned with legislation, with compliance in place. The leadership team is confident that the status of human resources will support the achievement of the plan's goals.

Other resource links are included on the website with all contact information for the above as well as those listed as links only: http://www.reseauaccessnetwork.com/community-partners/

[12] See By-law # 4, confirmed 2017

PROGRAMS & SERVICES

Direct Client and Clinical	Education and Prevention
1. Case management 2. Counselling 3. Psychiatric 4. HIV, Hep C, STI testing 5. Hep C treatment and clinical services 6. Gay / MSM supportive and clinical services 7. Services for people who use injection drugs and/or other substances 8. Outreach services 9. Supportive practical assistance	1. Education 2. Speakers bureau 3. Women and HIV, Hep C 4. Gay / MSM education 5. Opening Doors conference North Eastern Ontario 6. Community development 7. Classroom Closet Conference: 2SLGBTQ and bullying issues within educational institutions 8. New Horizons: Seeking Safety & Seniors Program

For updated information, please see full details at: http://www.reseauaccessnetwork.com/#direct_services

FINANCIAL STATUS, FUNDING RELATIONSHIP & LEGISLATIVE REQUIREMENTS

The Board is committed to continuing to govern with a “no deficit” policy, maintaining budget controls and staying on target. The annual budget cycle and related practices are successful, and financial oversight is strong.

Accountability agreements with funders are in place, and the agency has the capacity to implement the strategic plan within current guidelines. Revenue diversification is possible, for example, through increased donor participation.

The Board has chosen strategic priorities which are important, will require focus on goals and strategies in new ways, and which align with the agency’s projected capacity over the next 5 years.

FEDERAL, PROVINCIAL & MUNICIPAL ENVIRONMENT

Ontario

Gouvernement du Canada

Government of Canada

Greater Grand Sudbury

Réseau ACCESS Network has built strong partnerships with the municipality as well as provincial and federal ministries, as evidenced in funding. The Board leads with a solid non-partisan approach and has been successful in the growth and development of the agency regardless of any party in power. We intend to continue with this approach and look forward to advocating for the people we serve in the ongoing development of relationships with all governing bodies.

SWOT Highlights – Team Tool

TEAM TOOL - Highlights of successes, opportunities, threats and weaknesses from focused discussions are included below, as determined in May 25th, 2019. Note that an element can sometimes be seen as a strength and a weakness depending on events and situations.

Board members, staff, volunteers and teams can add to and edit this tool throughout the term of the plan.

STRENGTHS & SUCCESSES	**WEAKNESSES – areas for improvement**
• Client support • Education • Proactive Outreach • Connecting with northern peers • Passion, reputation • Peer training • Advocacy	• Supporting the affected / families etc • Reaching intersections of populations including Indigenous and various cultural groups • Positioning & advocacy, including our skills and programming • Governance support of operations in advocacy work
OPPORTUNITIES	**THREATS**
• Addressing discrimination • Meeting the needs of MSM population • Ontario Health Teams – ensuring we are providers at the table • Continued focus on French Language Service delivery	• Keeping up with opioid crisis[13] • Mandate – need to ensure we don't waiver • Funding – change, uncertainty • Poisoning of local street drug supply line

[13] In the time period since this session was held, the terms "overdose crisis and poisoned drug supply" have emerged and are in use.

DEMOGRAPHICS & TRENDS

EPIDEMIOLOGY OF HIV IN CANADA (Please refer to APPENDIX C for full text, references and links)

According to 2016 national HIV estimates: There were an estimated 63,110 Canadians with HIV at the end of 2016. This represents an increase of 2,945 people (5%) since 2014. The HIV prevalence rate is 173 per 100,000 people living in Canada. Risk Factors (Highlighted): Drug injection[14] . Key statistics:

- The number of people with HIV in Canada (prevalence) is increasing.
- An estimated 14% of people with HIV in Canada are unaware that they have HIV.
- The HIV epidemic in Canada is concentrated in specific populations (prevalence).1

According to 2016 HIV estimates, people with HIV in Canada include:

- 32,762 gay, bisexual and other men who have sex with men (gbMSM). This represents 51.9% of all people with HIV in Canada.
- 10,986 people who used injection drugs (PWID).
- 20,543 people whose HIV status was attributed to heterosexual sex.
- 601 people whose HIV status could not be attributed to sex or injection drug use.
- 6,055 Indigenous people. This represents 9.6% of all people with HIV in Canada.
- 14,520 females. This represents 23% of all people with HIV in Canada.

Ontario populations most impacted by HIV (prevalence):

- The most recent estimates available by region are for 2011. The HIV epidemic is concentrated mainly in gbMSM in Ontario (56.0%).
- The number of new HIV infections in Canada (incidence) has increased slightly in the past several years.

The number of new HIV infections (incidence) may be increasing in all populations. According to 2016 national HIV estimates:

- 1,136 new HIV infections (52.5% of new infections) were attributed to men having sex with men, compared to 1,053 new infections in 2014.
- 66 new HIV infections (3%) were attributed to men whose HIV status could be attributed to either having sex with men or injection drug use, compared to 47 new infections in 2014.
- 244 new HIV infections (11.3%) were attributed to injection drug use, compared to 219 new infections in 2014.
- 719 new HIV infections were attributed to heterosexual sex (33.2%), compared to 641 new infections in 2014.
- 245 new HIV infections (11.3%) occurred in Indigenous people, compared to 217 new infections in 2014.
- 507 new HIV infections (23.4%) occurred in females, compared to 436 new infections in 2014.

Ontario populations most impacted by new HIV infections (incidence) / Based on estimates from 2011:

- New HIV infections are concentrated mainly in gbMSM in Ontario (51.8%).
- Indigenous people and people from countries where HIV is endemic are over represented in the HIV epidemic in Canada.
- According to 2016 national estimates: Indigenous people made up 4.9% of the total Canadian population in 2016 but represent 11.3% of new infections in 2016.
- People from countries where HIV is endemic made up 2.5% of the Canadian population in 2011 but represent 13.6% of new infections in 2016.

[14] https://www.catie.ca/en/fact-sheets/epidemiology/epidemiology-hiv-canada

Certain populations have higher rates of new HIV infections (incidence). The most recent estimates available that compare HIV incidence rates among key populations are from 2014. According to 2014 national estimates:

- Indigenous populations have incidence rates 2.7 times higher than people of other ethnicities.
- People from HIV-endemic countries (living in Canada) have incidence rates 6.4 times higher than people of other ethnicities (living in Canada).
- gbMSM have incidence rates 131 times higher than other men.
- People who inject drugs have incidence rates 59 times higher than people who do not inject drugs.
- Males have incidence rates 3.4 times higher than females.

EPIDEMIOLOGY OF HEPATITIS C IN CANADA

At the end of 2011, an estimated six to seven in every 1,000 Canadians were living with chronic hepatitis C (prevalence). Additionally:

- An estimated one out of every 100 Canadians were antibody positive for hepatitis C, indicating either a current or past infection.
- Hepatitis C is more prevalent among people who inject drugs than in any other group.
- The annual reported rates for hepatitis C infections are declining.
- Two-thirds of diagnoses are among males.

At the end of 2011, an estimated one out of every 100 Canadians were antibody positive for hepatitis C, indicating either a current or past infection.[1]

- People who inject drugs (both current and former) comprised 42.6% of all antibody-positive cases.
- People born in a country outside of Canada comprised an additional 35.0% of all antibody-positive cases.

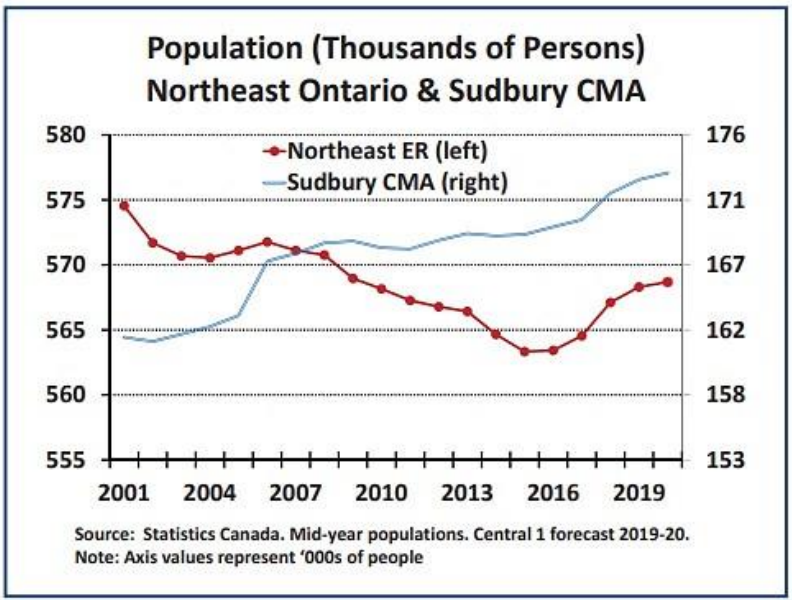
Hepatitis C is more prevalent among people who inject drugs than in any other group.[1,2,3]

- 66.0% of people who inject drugs and 28.5% of people who formerly injected drugs were antibody positive for hepatitis C (2011).[1]
- 24.0% of federal prisoners and 23.3% of provincial prisons were antibody positive for hepatitis C (2011).[1]
- 3.0% of people living in nursing homes and long-term care hospitals were antibody positive for hepatitis C (2011).[1]
- 5% of street-involved youth were antibody positive for hepatitis C (2005-2006)[3] and 2.3% of people who are homeless (who do not inject drugs) were antibody positive for hepatitis C (2011).[1]

The annual reported rates for hepatitis C infections are declining.[4]

- 11,592 hepatitis C diagnoses were reported to the Public Health Agency of Canada. This is equal to 31.7 cases of hepatitis C per 100,000 Canadians. The rate of reported hepatitis C diagnoses has declined steadily since 2008 when the rate was 35.7 per 100,000.
- Two-thirds of diagnoses are among males.[4]
- Among men, those aged 25 to 29 had the highest rate of hepatitis C diagnoses at 66.3 cases per 100,000.
- Among women, those aged 25 to 29 had the highest rate of hepatitis C diagnoses at 56.7 per 100,000.

POPULATION



General population trends in the Réseau ACCESS Network catchment area are important to consider with regards to program and service development, as well as potential impact in donor partnership. Please see Census Profile, 2016 Census / Northeast & Ontario for comprehensive details about the Northeast's demographics.

However, of note, a slight increase in population has been determined since the 2016 Census (505,625 in 2016).

The population of the Northeast is forecast to increase 0.2 per cent in 2019 and 0.1 per cent in 2020 as net in-migration continues to outpace net natural decline. [15]

EMPLOYMENT

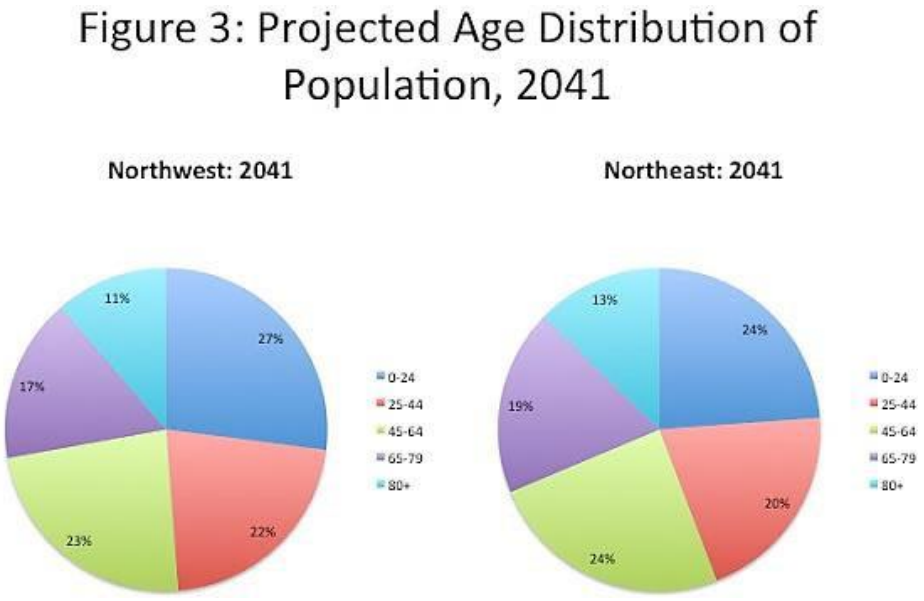
There is reason for optimism, as employment in the Northeast increased by approximately 2% in 2018 after three years of decline. "The unemployment rate continued to decline, reaching a 10-year low of around six per cent. The rate at which adults participate in the labour force increased following three years of decline." [16] Of note:

- Forecasted employment increase/Northeast region: 1.7 % in 2019 and 0.2 % in 2020.
- Forecasted decline in unemployment rate: down to 5.5 per cent in 2020.
- Job growth/2018 was led by services: health, social, professional, technical and business + manufacturing, forestry, mining

The most recent statistical data available for Northeastern Ontario shows the well-established increase in the aging demographic.

[15] https://www.central1.com/wp-content/uploads/2019/06/ea-2019_ont02.pdf
[16] https://www.central1.com/wp-content/uploads/2019/06/ea-2019_ont02.pdf

Population Age Projection to 2041 – Northwest and Northeast Ontario[17]



CULTURAL GROUPS[18]

The Indigenous and Francophone populations of Northeast Ontario (NE) are large groups with more significant health challenges than the rest of the province. Of the total NE population, 11% identify as Indigenous and 23% as Francophone. Though the most common ethnicity within the typical Réseau ACCESS Network client cohort is white, Indigenous persons are served in significant numbers, as well as black, metis and unknown ethnicities. (OCHART report)

Of note - The Indigenous population in the District of Manitoulin is expected to increase from 5,408 in 2013 to 7,192 in 2041, a growth rate of about 33.0 percent. The Indigenous population's share of total population in the District is expected to increase from 40 percent in 2013 to 53 percent in 2041.[19]

HEALTH - Health Outcomes Are Worse in the North

People in the Northeast and Northwest have life expectancies of 79 and 78.6 years respectively, compared to 81.5 years in Ontario as a whole. Additionally:

- Life expectancy for Indigenous people remained about 10 years lower than for the non-Indigenous population (71 years compared to 81 years).[20]
- The premature death rates in the Northeast and Northwest are 235 and 258/100,000 people, compared to only 163/100,000 in Ontario as a whole[14]

[17] https://northerneconomist.blogspot.com/2017/02/demographics-in-northern-ontario.html
[18] https://www.hqontario.ca/Portals/0/documents/health-quality/health-equity-strategy-report-en.pdf
[19] https://www.northernpolicy.ca/upload/documents/publications/reports-new/hcs_manitoulin-en.pdf
[20] https://www.ontario.ca/document/spirit-reconciliation-ministry-indigenous-relations-and-reconciliation-first-10-years/indigenous-peoples-ontario

- Only 24% in the Northwest and 28% in the Northeast report being able to see their primary care provider the same or next day when they're sick, compared to 43% in Ontario[15]
- 45% of Northern Ontario Francophones feel they are in very good or excellent health, compared to 62% of the province's general Francophone population
- Of note: With lower education's known negative impact on health, fewer people in Northern Ontario have secondary and postsecondary education than in the province as a whole[17]

Also see Health Quality Ontario[21] Health Status for NE ON – infographic/reference below.

For comprehensive data on health by various conditions and factors, see:

- Health Profiles by Public Health Unit, LHIN and Census Metropolitan Area

HIV statistics – Sudbury & Districts[22]

In 2015, an estimated 182 people were living with HIV in Public Health Sudbury & Districts' region. Of those (182), 84% were in care, 74% were on antiretroviral therapy, and 69% were virally suppressed.

Between 2013 and 2017, a total of 29 188 HIV tests were completed for residents of Public Health Sudbury & Districts' service area with an average HIV positivity rate of 0.14% locally.

[21] https://www.hqontario.ca/HealthintheNorth
[22] https://www.phsd.ca/news/uu-anti-stigma-messaging-about-hiv-endorsed-by-public-health-sudbury-districts

TEAM NOTES

The following section is for Réseau ACCESS Network Board members and Staff to jot down ideas, questions and things to bring up at meeting and at the next strategic plan refresh.[23]

[23] Numbering of Strategies is modified to show the common Strategy as #1 for each Priority &Goal.

Strategic Priority: **ENGAGEMENT** / Notes

GOAL - Ensure delivery of service meets individuals' needs

STRATEGIES - The first strategy is common to all priorities/goals:

1. Partner with subject matter experts to enhance services and programs. Partnership approach includes:
    - Demonstrated integration, in all programs and services
    - Greater and more meaningful involvement of persons with lived/living experience
2. Build ongoing innovative relationships to reach underserviced individuals
3. Further develop medical care and mental health supports and services
4. Expand services to diverse populations. Initiatives include:
    - Approaches, programs and services which contribute to ending stigma and discrimination against people served by Réseau ACCESS Network
    - Actively work to eliminate barriers to accessing our services

NOTES

Strategic Priority: **KNOWLEDGE MOBILIZATION** / Notes

GOAL - Provide quality services and programs based on demonstrated need and feedback collected

STRATEGIES - The first strategy is common to all priorities/goals:

1. Partner with subject matter experts to enhance services and programs. Partnership approach includes:

    - Demonstrated integration, in all programs and services
    - Greater and more meaningful involvement of persons with lived/living experience

2. Improve feedback process for individual satisfaction and inform ongoing development of programs and services based on feedback / data collected

3. Increase community awareness through communication and social marketing

4. Share best practices and key knowledge with the wider service community

NOTES

Strategic Priority: **ORGANIZATIONAL WELLNESS** / Notes

GOAL - Strengthen practices and processes that foster a healthy organizational environment

STRATEGIES – The first strategy is common to all priorities/goals:

1. Partner with subject matter experts to enhance services and programs. Partnership approach includes:

    - Demonstrated integration, in all programs and services
    - Greater and more meaningful involvement of persons with lived/living experience

2. Develop quality organizational practices:

    - Organizational culture
    - Retention
    - Succession
    - Team relationships

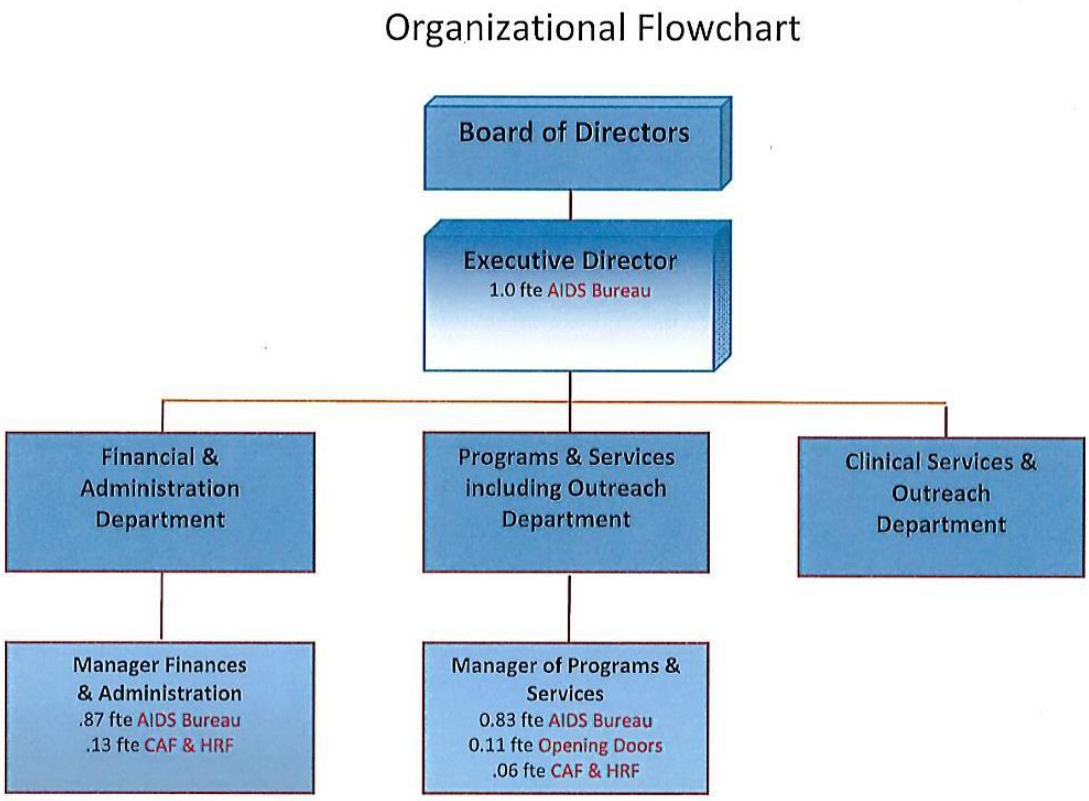
3. Maintain and further develop partnerships through:

    - Effective responses to needs
    - Collaborations with like organizations
    - Leadership

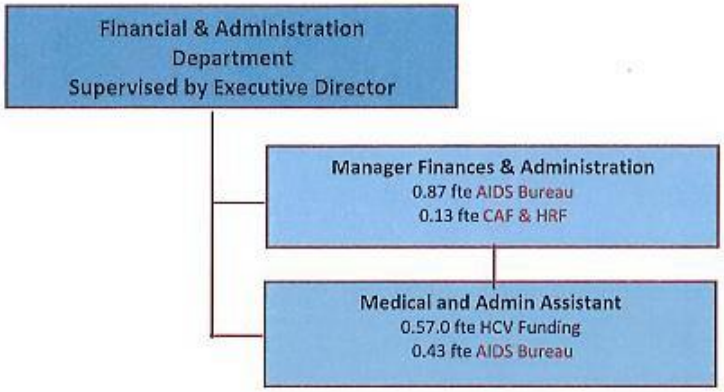
NOTES

APPENDICES

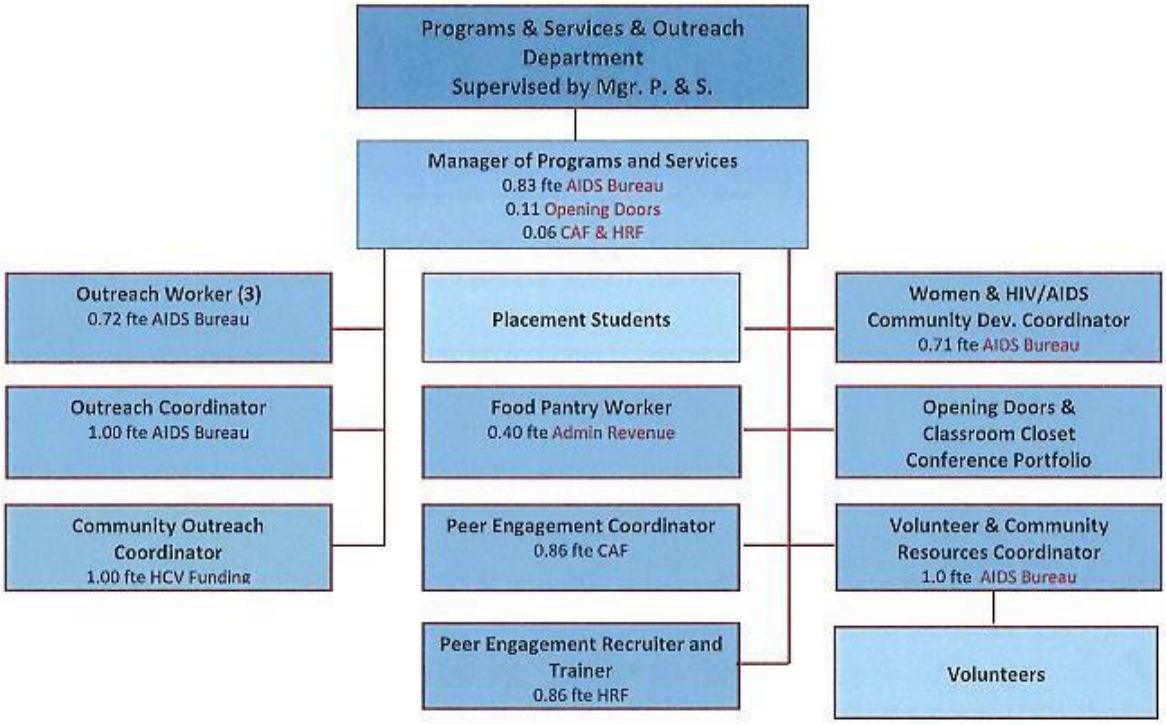
APPENDIX A - Organizational Structure / Fall 2019



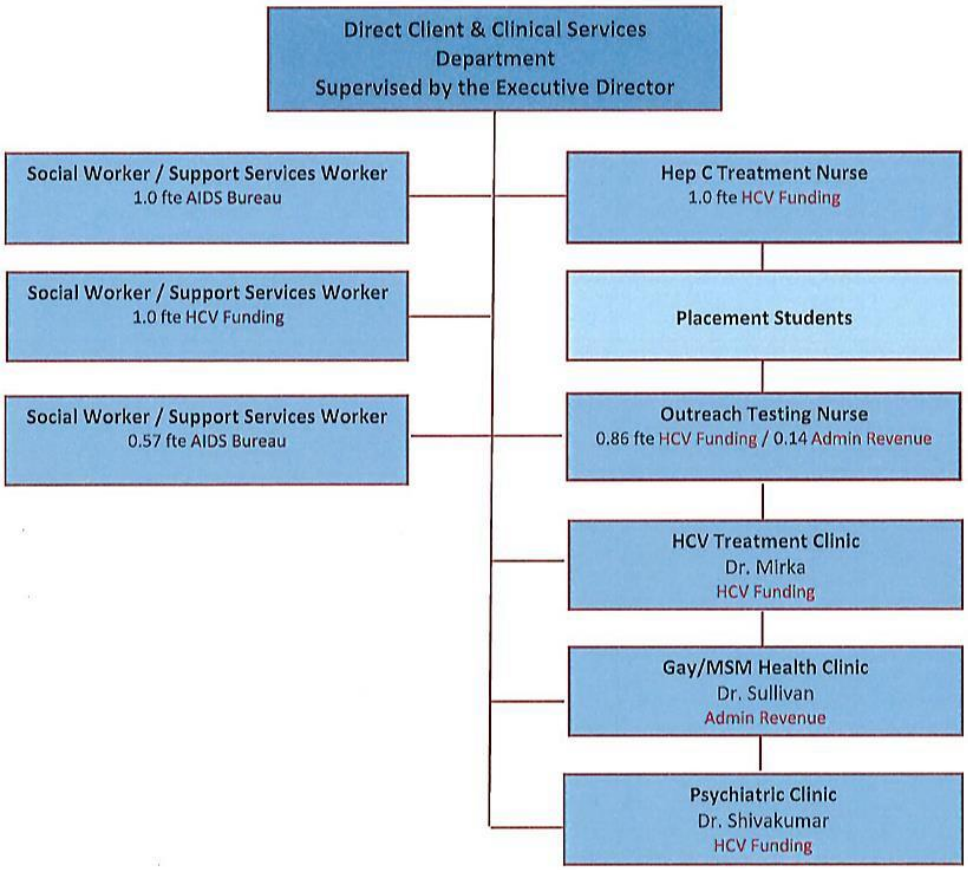
Financial and Administration Department Flowchart



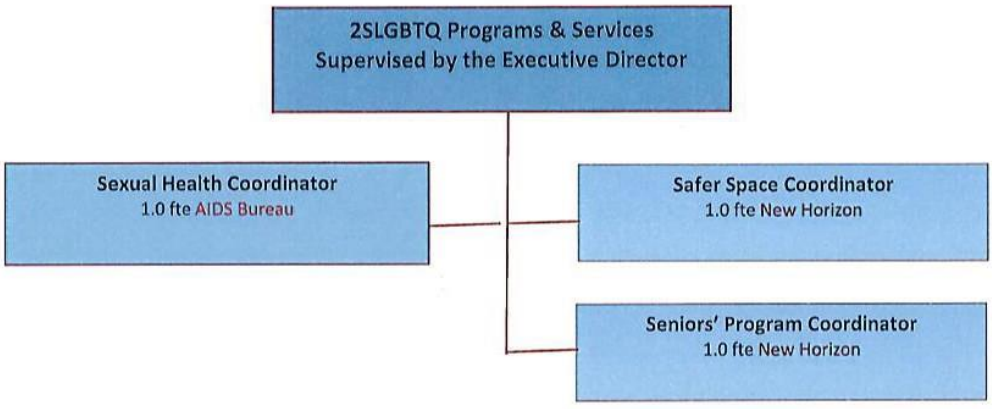
Programs and Services Department Flowchart



Direct Client & Clinical Services Department Flowchart



2SLGBTQ Programs and Services From Programs and Services Department



APPENDIX B - OAN

The Ontario AIDS Network (OAN) is a network of community-based organizations which were formed as a grass-roots response to needs for AIDS services and information. The OAN is grounded by the following key principles:

GREATER INVOLVEMENT AND MEANINGFUL ENGAGEMENT OF PEOPLE WITH HIV/AIDS (GIPA/MEPA)

The OAN is a signatory to the Ontario Accord and commits to GIPA/MEPA. The lived experience of people living with, and vulnerable to, HIV drives and informs our activities and is the central focus of our work.

ANTI-RACISM, ANTI-OPPRESSION AND ANTI-STIGMA

OAN acknowledges and celebrates our diversity which includes: gender, culture, sexual orientation, socio-economic status, language, ethnicity, immigration status and country of origin. We are committed to removing barriers that impede access to information and services. We train our staff and members to be sensitive and respectful to the needs of people from all backgrounds. We advocate for support and information that is personally meaningful and respectful of each person's particular culture and socio-economic experience, is sex-positive, gay-positive and non-judgmental concerning injection drug use. We make accommodations to serve the specific needs of our diverse population. Those living with and affected by HIV continue to face stigma and discrimination in many aspects of their lives. The OAN will ensure that its members have the necessary tools, services and programs that will combat stigma and end discrimination.

HARM REDUCTION

OAN promotes and supports harm reduction strategies throughout our work. We build capacity and advocate for programs and services that reduce the health and social harms associated with sexual and drug-use practices. We respect individual rights and choices around drug use and seek to provide services that promote well-being of individuals.

ACCOUNTABILITY AND TRANSPARENCY

The OAN is accountable to its stakeholders and operates in a transparent manner. We are responsive to the needs of our members, report on our actions and communicate regularly with our members.

Back to Decision Support

APPENDIX C – HIV Epidemiology

The Epidemiology of HIV in Canada[24]

The number of people with HIV in Canada (prevalence) is increasing.[1]
According to 2016 national HIV estimates:
There were an estimated 63,110 Canadians with HIV at the end of 2016.
This represents an increase of 2,945 people (5%) since 2014.
The HIV prevalence rate is 173 per 100,000 people living in Canada.
HIV prevalence increased during the 1980s, slowed down in the mid-1990s, but began to rise again in the late 1990s. This increase is a result of both new HIV infections and fewer deaths due to effective treatment options.

An estimated 14% of people with HIV in Canada are unaware that they have HIV.[1]
According to 2016 national HIV estimates:
An estimated 9,090 people with HIV remained undiagnosed in 2016.
This represents 14% of the estimated number of people with HIV.

The HIV epidemic in Canada is concentrated in specific populations (prevalence).[1]
According to 2016 HIV estimates, people with HIV in Canada include:
32,762 gay, bisexual and other men who have sex with men (gbMSM). This represents 51.9% of all people with HIV in Canada. The estimate includes 30,980 men whose HIV status was attributed to having sex with men and 1,782 men whose HIV status could be attributed to either having sex with men or injection drug use.
10,986 people who used injection drugs (IDU). This represents 17.4% of all people with HIV in Canada. The estimate includes 9,204 people whose HIV status was attributed to injection drug use and 1,782 men whose HIV status could be attributed to either having sex with men or injection drug use (please note that these 1,782 men are the same as those noted in the bullet point above).
20,543 people whose HIV status was attributed to heterosexual sex. This represents 32.6% of all people with HIV in Canada. Of these, 9,438 people (15% of all people with HIV) were from a country where HIV is endemic (primarily countries in sub-Saharan Africa and the Caribbean).
601 people whose HIV status could not be attributed to sex or injection drug use. This includes people who likely contracted HIV through blood transfusions or clotting factors, transmission from mother to child, or needle-stick injuries in the workplace. This represents less than 1% of all people with HIV in Canada.
6,055 Indigenous people. This represents 9.6% of all people with HIV in Canada.
14,520 females. This represents 23% of all people with HIV in Canada.

The populations most impacted by HIV vary from region to region (prevalence).[2]
The most recent estimates available by region are for 2011. Based on estimates from 2011:
The HIV epidemic is concentrated mainly in gbMSM in British Columbia (45.5% of people with HIV), Ontario (56.0%), the Atlantic Provinces (54.2%) and Quebec (54.2%). These estimates include men whose HIV status was attributed to having sex with men and men whose HIV status could be attributed to either having sex with men or injection drug use.
The HIV epidemic is concentrated mainly in people who use or have used injection drugs in Saskatchewan (71.4% of people with HIV).
The HIV epidemic is concentrated mainly in people who engage in heterosexual sex in Alberta (42.8% of people with HIV) and Manitoba (56.7%). These estimates include people whose HIV status was attributed to any type of heterosexual sex including those who were born in an HIV endemic country.

[24] See https://www.catie.ca/en/fact-sheets/epidemiology/epidemiology-hiv-canada for references.

Note: Because different methods were used to create the 2016 estimates, these regional estimates from 2011 cannot be directly compared to the 2016 national estimates.
An infographic is available which graphically displays HIV prevalence by region.

The number of new HIV infections in Canada (incidence) has increased slightly in the past several years.[1]
According to 2016 national HIV estimates:
There were an estimated 2,165 new HIV infections in Canada in 2016. This is slightly higher than the 1,960 new infections in 2014.
The HIV incidence rate is 6.0 per 100,000 people in Canada.

The number of new HIV infections (incidence) may be increasing in all populations.[1]
According to 2016 national HIV estimates:
1,136 new HIV infections (52.5% of new infections) were attributed to men having sex with men, compared to 1,053 new infections in 2014.
66 new HIV infections (3%) were attributed to men whose HIV status could be attributed to either having sex with men or injection drug use, compared to 47 new infections in 2014.
244 new HIV infections (11.3%) were attributed to injection drug use, compared to 219 new infections in 2014.
719 new HIV infections were attributed to heterosexual sex (33.2%), compared to 641 new infections in 2014.
245 new HIV infections (11.3%) occurred in Indigenous people, compared to 217 new infections in 2014.
507 new HIV infections (23.4%) occurred in females, compared to 436 new infections in 2014.

The populations most impacted by new HIV infections vary from region to region (incidence).[2]
The most recent estimates available by region are for 2011. Based on estimates from 2011:
New HIV infections are concentrated mainly in gbMSM in British Columbia (57.4% of people with HIV), Ontario (51.8%), the Atlantic Provinces (68.6%) and Quebec (58.5%). These estimates include men whose HIV status was attributed to men having sex with men and men whose HIV status could be attributed to either men having sex with men or injection drug use (MSM-IDU).
New HIV infections are concentrated mainly in people who use or have used injection drugs in Saskatchewan (76.1% of people with HIV).
New HIV infections are concentrated mainly in people who engage or have engaged in heterosexual sex in Alberta (44.8% of people with HIV) and Manitoba (61.7%). These estimates include people whose HIV status was attributed to any type of heterosexual sex including those who were born in an HIV endemic country.
Note: Because different methods were used to create the 2016 estimates, these regional estimates from 2011 cannot be directly compared to the 2016 national estimates.
An infographic is available which graphically displays HIV incidence by region.

Indigenous people and people from countries where HIV is endemic are over represented in the HIV epidemic in Canada.[1]
According to 2016 national estimates:
Indigenous people made up 4.9% of the total Canadian population in 2016 but represent 11.3% of new infections in 2016.
People from countries where HIV is endemic made up 2.5% of the Canadian population in 2011 but represent 13.6% of new infections in 2016.

Certain populations have higher rates of new HIV infections (incidence).[3]
The most recent estimates available that compare HIV incidence rates among key populations are from 2014.
According to 2014 national estimates:
Indigenous populations have incidence rates 2.7 times higher than people of other ethnicities.

People from HIV-endemic countries (living in Canada) have incidence rates 6.4 times higher than people of other ethnicities (living in Canada).
gbMSM have incidence rates 131 times higher than other men.
People who inject drugs have incidence rates 59 times higher than people who do not inject drugs.
Males have incidence rates 3.4 times higher than females.

Key definitions
HIV prevalence—The number of people with HIV at a point in time. Prevalence tells us how many people have HIV.
HIV incidence—The number of new HIV infections in a defined period of time (usually one year). Incidence tells us how many people are getting HIV.

Where do these numbers come from?
All epidemiological information is approximate, based on the best available data. The data contained in this fact sheet comes from the 2011, 2014 and 2016 estimates published by the Public Health Agency of Canada (PHAC).

National estimates of HIV prevalence and incidence
National HIV estimates are produced by PHAC and published every three years. Estimates of HIV prevalence and incidence are produced by PHAC using statistical methods which take into account some of the limitations of surveillance data (number of HIV diagnoses reported to PHAC) and also account for the number of people with HIV who do not yet know they have it. Statistical modelling, using surveillance data and additional sources of information, allows PHAC to produce HIV estimates among those diagnosed and undiagnosed. The most recent estimates available are for 2016.

Appendix D – Hep C Epidemiology

The epidemiology of hepatitis C in Canada[25]

At the end of 2011, an estimated six to seven in every 1,000 Canadians were living with chronic hepatitis C (prevalence).[1]

Based on national 2011 hepatitis C estimates:

An estimated 220,697 to 245,987 Canadians were living with chronic hepatitis C. That is the equivalent of six to seven people out of every 1,000 Canadians (or 0.6% to 0.7% of the total Canadian population).

An estimated 44% of people living with chronic hepatitis C infection were unaware of their status (97,107 to 108,234 Canadians).

Chronic hepatitis C was most prevalent among people born in 1955 to 1959 (1.5%), followed by those born in 1950 to 1954 (1.25%); 1960 to 1964 (1.2%); 1965 to 1969 (1.1%); and 1970 to 1974 (0.8%).

At the end of 2011, an estimated one out of every 100 Canadians were antibody positive for hepatitis C, indicating either a current or past infection.[1]

Based on national 2011 hepatitis C estimates:

An estimated 332,414 people were antibody positive for hepatitis C. This indicates either a current or past infection with hepatitis C. This is the equivalent of one person out of every 100 Canadians (or 1.0% of the total Canadian population).

People who inject drugs (both current and former) comprised 42.6% of all antibody-positive cases.

People born in a country outside of Canada comprised an additional 35.0% of all antibody-positive cases.

Hepatitis C is more prevalent among people who inject drugs than in any other group.[1,2,3]

Based on national hepatitis C estimates and a few Canadian surveillance systems:

66.0% of people who inject drugs and 28.5% of people who formerly injected drugs were antibody positive for hepatitis C (2011).[1]

24.0% of federal prisoners and 23.3% of provincial prisons were antibody positive for hepatitis C (2011).[1]

3.0% of people living in nursing homes and long-term care hospitals were antibody positive for hepatitis C (2011).[1]

1.9% of people born in a country outside of Canada were antibody positive for hepatitis C (2011).[1] Data on prevalence rates among specific immigrant populations is not available; however, immigrants from countries where hepatitis C is more prevalent may have higher hepatitis C rates upon entry to Canada. Since hepatitis C testing is not done upon entry to Canada, there may be immigrants living with hepatitis C who are not aware of their infection.

5% of gay men and other men who have sex with men were antibody positive for hepatitis C (2005–2007).[2]

5% of street-involved youth were antibody positive for hepatitis C (2005-2006)[3] and 2.3% of people who are homeless (who do not inject drugs) were antibody positive for hepatitis C (2011).[1]

The annual reported rates for hepatitis C infections are declining.[4]

Based on 2017 national surveillance data, 11,592 hepatitis C diagnoses were reported to the Public Health Agency of Canada. This is equal to 31.7 cases of hepatitis C per 100,000 Canadians. The rate of reported hepatitis C diagnoses has declined steadily since 2008 when the rate was 35.7 per 100,000.

Two-thirds of diagnoses are among males.[4]

Based on 2017 national surveillance data:

61% of hepatitis C diagnoses were among males and 39% were among females.

Among men, those aged 25 to 29 had the highest rate of hepatitis C diagnoses at 66.3 cases per 100,000.

Among women, those aged 25 to 29 had the highest rate of hepatitis C diagnoses at 56.7 per 100,000.

---

[25] See https://www.catie.ca/en/fact-sheets/epidemiology/epidemiology-hepatitis-c-canada for references.

Appendix E – Organizational Culture Team Tool

Caring Ethical Positive Organizational Culture / TEAM TOOL[26] (1/2)

Organizational Culture - What is it and why should we care? Key elements are described in this 2-page Tool: organizational culture affects all interactions and outcomes for individuals and groups, including clients and stakeholders.

Caring, Ethical Positive Organizational Culture is a building Block of Client Centered Governance ® (CCG). It results in positive client outcomes. The evidence is in feedback and engagement from clients and others. It is Board-led and embedded in the organization's Vision, Mission, Values and practices.

A CCG "Caring Ethical Positive Organizational Culture" is deliberately created by the Board Team, supporting Mission Success.

Team Exercise: Explore organizational culture through discussion about the information in the graphic on the 2nd page of this tool. With positive Client Outcomes as the central goal, each circle shows key elements of Organizational Culture. Use the following first two questions, plus two of your own design, to lead a team discussion:

1. What does your Values statement say about your agency culture?

2. Are you living those Values?

3. _____

4. _____

[26] Client Centered Governance ® is a Registered Trademark of VisionarEase Inc.

Caring Ethical Positive Organizational Culture / TEAM TOOL[2] (2/2)

[2] Client Centered Governance ® is a Registered Trademark of VisionarEase Inc.

Appendix F – Alignment **TOOL: Sample alignment pathways** (1/2) **Réseau ACCESS Network PLANS – FUNDERS PLANS**

Réseau ACCESS Network Strategic Plan 2020-2025*

ENGAGEMENT

GOAL

Ensure delivery of service meets individuals' needs

STRATEGIES

**Note: this strategy applies to all 3 priorities. For the purpose of this alignment illustration, it only shows here.*

*Partner with subject matter experts to enhance services and programs. Partnership approach includes:

- Demonstrated integration, in all programs and services
- Greater and more meaningful involvement of persons with lived/living experience

1. Build ongoing unique innovative relationships to reach underserviced individuals
2. Further develop medical care and mental health supports and services
3. Expand services to diverse populations. Initiatives include:
   - Approaches, programs and services which contribute to ending stigma and discrimination against people served by Réseau ACCESS Network
   - Actively work to eliminate barriers to accessing our services

KNOWLEDGE MOBILIZATION

GOAL

Provide quality services and programs based on demonstrated need and feedback collected.

*STRATEGIES

1. Improve feedback process for individual satisfaction and inform ongoing development of programs and services based on feedback / data collected
2. Increase community awareness through communication and social marketing
3. Share best practices and key knowledge with the wider service community

ORGANIZATIONAL WELLNESS

GOAL

Strengthen practices and processes that foster a healthy organizational environment

*STRATEGIES

1. Develop quality organizational practices:

- Organizational culture
- Retention
- Succession
- Team relationships

4. Maintain and further develop partnerships through:
- Effective responses to needs
- Collaborations with like organizations
- Leadership

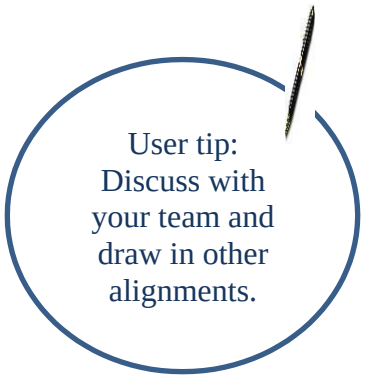
Ministry of Health – AIDS Bureau and Hepatitis C Funding Programs

AIDS Bureau Goals:

1. Improve the health and well-being of populations most affected by HIV
2. Promote sexual health and prevent new HIV, STI and Hepatitis C
3. Diagnose HIV infections early and engage people in timely care
4. Improve the health, longevity and quality of life for people living with HIV
5. Ensure the quality, consistency and effectiveness of all provincially – funded HIV programs and services

Hepatitis C Goals:

1. To increase access to hepatitis C care and treatment for priority populations in Ontario
2. To increase knowledge and awareness to prevent the transmission of HCV among priority populations in Ontario
3. To increase collaboration, coordination and evidence-based practice across the system responding to HCV



TEAM TOOL: SAMPLE ALIGNMENT PATHWAYS (2/2) ACCESS PLAN – FUNDERS PLANS

Réseau ACCESS Network Strategic Plan 2020-2025*

ENGAGEMENT

GOAL

Ensure delivery of service meets individuals' needs

STRATEGIES

**Note: this strategy applies to all 3 priorities. For the purpose of this alignment illustration, it only shows here.*

*Partner with subject matter experts to enhance services and programs. Partnership approach includes:

- Demonstrated integration, in all programs and services
- Greater and more meaningful involvement of persons with lived/living experience

4. Build ongoing unique innovative relationships to reach underserviced individuals
5. Further develop medical care and mental health supports and services
6. Expand services to diverse populations. Initiatives include:
   - Approaches, programs and services which contribute to ending stigma and discrimination against people served by Réseau ACCESS Network
   - Actively work to eliminate barriers to accessing our services

KNOWLEDGE MOBILIZATION

GOAL

Provide quality services and programs based on demonstrated need and feedback collected.

*STRATEGIES

4. Improve feedback process for individual satisfaction and inform ongoing development of programs and services based on feedback / data collected
5. Increase community awareness through communication and social marketing
6. Share best practices and key knowledge with the wider service community

ORGANIZATIONAL WELLNESS

GOAL

Strengthen practices and processes that foster a healthy organizational environment

*STRATEGIES

2. Develop quality organizational practices:

- Organizational culture
- Retention
- Succession
- Team relationships

4. Maintain and further develop partnerships through:
- Effective responses to needs
- Collaborations with like organizations
- Leadership

Public Health Agency of Canada

COMMUNITY ACTION FUND (abbreviated)
Objectives/2022:

1. Deliver educational workshops to people living with HIV, Hepatitis C or related STBBIs to increase the capacity to increase adherence and retention to care and increase adherence to treatment and/or retention to care behaviors

2. Deliver educational workshops to Indigenous People to increase the capacity to use harm reduction practices and increase the adoption of harm/risk reduction behaviors that prevent the transmission of HIV, Hepatitis C or related STBBIs.

3. Deliver educational workshops to people who use drugs through injection in Sudbury to increase the capacity) to use harm reduction practices and increase adoption of harm reduction behaviors that prevent the transmission of HIV, Hepatitis C or related STBBIs.

HARM REDUCTION FUND (abbreviated)
Objectives/2021:

1. Peers will have strengthened their knowledge of risk factors associated with HIV and hepatitis C among people who share drug-use equipment.
2. Trained Peers will strengthen the skills, competencies, and abilities of people who use substances and share drug-use equipment to prevent HIV and hepatitis C infections.