

**CATIE Forum**

**New Science & New Directions in HIV & HCV**

**Final Report**

**November 2013**



Canada's source for  
HIV and hepatitis C  
information

La source canadienne  
de renseignements sur  
le VIH et l'hépatite C

**CATIE Forum: New Science, New Directions in HIV and HCV – Report**

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## Introduction

Globally, we are at a pivotal point in our response to HIV and hepatitis C, one which is filled with tremendous optimism. In recent years there has been a rapid acceleration of research findings in HIV prevention, transmission, testing, and treatment and new, more effective and well-tolerated hepatitis C treatments are imminent. Our newer understandings of HIV and HCV include biomedical knowledge and knowledge of the continuum of care (i.e. prevention, testing, treatment, care and support efforts), but also understanding about people, communities, health systems, and front-line practice.

If taken up appropriately into frontline programming, this knowledge has the potential to turn the tide on the epidemic. However, translating this knowledge into reduced infections and improved quality of life is challenging. New research is fundamentally changing our understanding of HIV and hepatitis C treatment and prevention, but integrating knowledge into programs, as well as breaking down silos in our work, is complex.

As Canada’s national knowledge exchange broker on HIV and hepatitis C information, CATIE is driven to encourage and support dialogue on *integration* – the integration of biomedical knowledge into programming, integration across the silos of our work in prevention, testing, treatment, care and support, as well as across HIV, HCV and STBBI programming broadly.

The *CATIE Forum: New Science, New Directions in HIV and HCV*, the focus of this report, was an event hosted by CATIE to encourage dialogue on the implications of integration on frontline programming.

This event, which took place in Toronto, Ontario, on September 18 and 19, 2013, at the Eaton Chelsea Hotel, brought together 273 frontline service providers, health care providers, program planners, policy makers, and people living with HIV and/or HCV to challenge each other to consider how we can better respond to HIV and HCV, and to share best practices related to integration.

## **Background: New knowledge guiding our approach**

New knowledge of biomedical research in HIV and HCV, about the continuum of care, and about our health systems and communities has the potential to shift our response to HIV and HCV, if understood and taken up appropriately.

### ***New biomedical knowledge***

Our knowledge of HIV has grown significantly over the last few years. Possibly one of the most significant recent research developments is “treatment as prevention”, our knowledge that HIV antiretroviral treatment can reduce the risk of onward HIV transmission (1). At the same time, better-tolerated HIV treatments have been developed and research has shown that, not only can antiretroviral treatment dramatically improve the long-term health of someone living with HIV, there are clear benefits of early treatment as well. (2)(3)

This knowledge emphasizes the increasing importance of frontline responses that work from an integrated approach to prevention, testing, treatment, care and support.

Other research developments also have the potential to further improve the effectiveness of our response. Roughly one quarter of people living with HIV are undiagnosed in Canada; they represent an important group to engage in our programming. (4) This hidden population may account for more than 50% of new HIV infections, particularly among people who are newly infected and have high viral loads. (5)(6)(7)

There are also a significant number of people who are not being diagnosed until the late stages of HIV infection and therefore are not benefiting from earlier treatment. (8)(9) New testing technologies have been developed that have higher uptake and can detect HIV earlier. (10)(11)(12)(13)

Prevention and treatment of other sexually transmitted infections (STIs), among people living with HIV and those who are HIV-negative, can reduce risk of HIV transmission. (14)(15)(16) Research developments in the biology of HIV transmission are changing the way we talk about risk and individual risk-reduction strategies in prevention counselling. (17)(18) Research has also shown that antiretroviral drugs can prevent HIV transmission through pre- and post-exposure prophylaxis, although these tools have yet to be significantly researched or implemented in the Canadian context. (19)(20)(21)(22)

Hepatitis C treatments are rapidly advancing. New direct-acting antiviral drugs for HCV treatment are showing great promise both in terms of effectiveness and tolerability. As a result, HCV treatment is becoming much more manageable for people living with the virus. Timely and affordable access to these new treatments, as well as access to clinical and community-based services to support people living with HCV is a pressing issue. (23)

### ***New understandings of integration***

Not only has new research offered new strategies and tools in our frontline response to HIV, it has also demonstrated that prevention, testing, care, treatment and support are mutually reinforcing elements of an effective response to both HIV and HCV. There is a need to work towards more integrated, client-centred programming that addresses engagement and linkages across the full continuum of prevention, testing, care, treatment and support, in order to break down the traditional “silos” of HIV services. (24)(25)(26)

Additionally, research is suggesting that holistic approaches are needed that also address other sexually transmitted and blood-borne infections (STBBIs) and related health factors (such as mental health). Such approaches, which work within a larger framework of sexual health and /or harm reduction, are important for several reasons: 1) they result in more integrated client-centred services across the continuum of care; 2) they involve similar interventions which focus on common modes of transmission, common risk behaviours and common social and structural factors; and 3) they address the synergistic relationships between different infectious disease epidemics. (27)(28)(29)

As a result of these understandings, researchers, health planners and frontline workers are beginning to reflect more broadly on the combined frontline response as a continuum of integrated services, including prevention, testing and diagnosis, linkage and retention in care, access and initiation of treatment and ongoing support for adherence to treatment. (30)(31)(32)

This integrated approach raises new and important research questions, particularly related to Program Science, which is the systematic application of scientific knowledge to improve the design, implementation and evaluation of public health programs. (33)(34)(35)(36) Large-scale, pilot implementation of “treatment as prevention” research projects has taken place in British Columbia (called STOP HIV/AIDS) and in other countries. These projects are large coordinated efforts to integrate new research evidence into prevention and treatment programming in order to reduce HIV transmissions and improve quality of life for people living with HIV. These projects also include a research component that is designed to provide evidence of effectiveness of frontline programming, as well as to guide adaptation, scale-up and improvement of programs.

### ***New understandings of our health systems***

As HIV treatment and prevention have converged, programming and research attention has also turned to health systems integration, particularly as it relates to the engagement and linkage of clients throughout the full continuum of prevention, testing/diagnosis, care/support and treatment services. For example, the concept of an HIV *treatment or care cascade* refers to the sequential steps necessary for successful treatment, including testing, active engagement in care, initiation of treatment, retention in care and long-term suppression of viral load.

As a result of lack of engagement or poor linkages between services at different points in the treatment cascade, people living with HIV and HCV are lost to care. The result of this can be, for people living with HIV, that only a small proportion ultimately are able to maintain the viral suppression necessary for both treatment and prevention benefits. (37) For example, in the United States it is estimated that only 19% to 28% of people living with HIV have an undetectable viral

load. (38)(39) Preliminary data suggest that there are also significant problems in the care cascade in Canada (40) and this is an important area for future research.

While the treatment cascade may be useful for conceptualizing how the current model of service delivery could be improved, it has several shortcomings. One of the most important is that it does not include prevention as a component of an effective response. As a model of care for people living with HIV, it indirectly reinforces the false view that the responsibility for HIV prevention rests solely with people living with HIV.

There is a need to work from a more integrated framework that recognizes prevention is a shared responsibility and all people, regardless of serostatus, have an important role to play. Additionally, treatment as a mechanism for prevention is only one of several effective prevention strategies, all of which, when appropriately combined, will provide a more effective response to the HIV epidemic than any one strategy on its own. (41)(42)

In developing our frontline programming, we need to collectively reflect on the ways in which HIV and HCV prevention, testing/diagnosis, care/support and treatment are all reinforcing elements of an effective response.

### **CATIE's role in brokering knowledge on integration**

The knowledge and understandings of integration outlined above, if taken up into our frontline programming, has the potential to significantly affect the epidemics of HIV and hepatitis C. Therefore, as the national knowledge broker on HIV and hepatitis C information, CATIE aims to enhance understanding of this newer knowledge, as well as to showcase what integration could look like in practice, through activities such as the *CATIE Forum: New Science, New Directions in HIV and HCV*.

CATIE's interest in brokering dialogue about and knowledge related to more integrated approaches is not new. CATIE grew out of the early activist agenda of AIDS ACTION NOW!, which focused on the treatment needs of people living with HIV and criticized government inaction on HIV research. CATIE's history has long been implicated in the integration of silos in our work, such as HIV prevention and HIV treatment. Long before the evidence demonstrated treatment helped prevent onward HIV transmissions, CATIE was making the link between treatment and prevention – the need for safe and effective treatments for people living with HIV to prevent their HIV progressing to AIDS.

More recently, in October 2012, CATIE hosted an invitational Deliberative Dialogue on integrated approaches to HIV prevention and treatment, the outcomes of which significantly informed the development of the CATIE Forum. The purpose of the Deliberative Dialogue, attended by 40 service providers, researchers, policy makers, and other people living with HIV, was to critically discuss the meaning of “integration” in the context of HIV prevention, testing, treatment, care and support. This included lengthy dialogue about the challenges and benefits associated with this approach. There was a sustained effort to move beyond polarization in the dialogue by identifying common ground and priorities.

While the Deliberative Dialogue focused on conceptual discussions of challenges and successes, in 2013, CATIE took the next step in this process by hosting a national forum to discuss the real implications of integration on frontline programming – *CATIE Forum: New Science, New Directions in HIV and HCV*.

## **CATIE Forum: Organizing principles and objectives**

Through the Forum, 273 frontline and public health workers, program planners, health care providers, people living with HIV and/or hepatitis C, and policy-makers were challenged to discuss the implications of integration on our frontline response. Specifically, the Forum sought to encourage learning and dialogue on four forms of integration, outlined below.

### ***Four forms of integration to guide our collective response***

The Forum sought to encourage dialogue on four forms of integration:

1. **Integration of biomedical research into programming.** An example of this form of integration is a program which uses our knowledge of the role of acute HIV infection in HIV transmission to inform which messages are shared and how services are delivered.
2. **Integration of prevention, testing, treatment, and care & support efforts and approaches.** An example of this form of integration is an HIV testing program that has formalized links to enhanced prevention services, such as access to pre-exposure prophylaxis.
3. **Integration of HIV and HCV in services and systems.** An example of this form of integration is a testing program that promotes and offers access to both HIV and HCV testing together.
4. **Integration of HIV and HCV services into a broader “sexually transmitted and blood-borne infection” (STBBI) approach.** An example of this form of integration is a frontline drop-in program that provides comprehensive knowledge of HIV, hepatitis C, STIs, and TB testing, as well as harm reduction.

Importantly, at the centre of all forms of integration are people living with and affected by HIV and hepatitis C. As health systems, program approaches, and best practices were considered at the Forum, “the person” was maintained at the centre of dialogue, in recognition of the fact that the interest of the individual is critical to any programmatic success. Retaining this at the centre of our focus keeps our response grounded and honest.

These four forms of integration, and the research behind them, were addressed in a series of pre-Forum webinars, outlined in a section below.

### ***Forum Objectives***

The purpose of the Forum was to:

- Enhance understanding of the programming implications of new biomedical research, including new approaches to the integration of prevention, testing and diagnosis, treatment, and care and support services;
- Encourage more effective responses to HIV and/or hepatitis C through the sharing of promising models of treatment and prevention service integration and program collaboration;
- Increase understanding of HIV and/or hepatitis C service delivery within a broader sexually transmitted infections/blood-borne infections (STIBBI) framework.

In addition to these clear outcomes for Forum participants, CATIE also hoped that the Forum would assist CATIE in establishing new and strengthening existing connections and partnerships with organizations and networks and increase our own understanding of how HIV and hepatitis C work fits into a broader STIBBI framework.

## **CATIE Forum Supporters and Sponsors**

### ***Forum Advisory Committee***

To help guide the development of the Forum agenda and objectives, CATIE convened a national advisory committee of program planners, clinicians, and researchers. This committee supported a successful CIHR Meetings, Planning, and Dissemination Grant and provided important feedback on the Forum program. In addition, Advisory Committee members were responsible for supporting promotion of the event to their members/contacts at regular intervals. For a list of advisory committee members, please see Appendix 1.

### ***Forum National Partners***

CATIE engaged the support of a number of national organizations to support the early stages of development of the CATIE Forum, including the submission of a successful CIHR Meetings, Planning, and Dissemination Grant. National organizations who committed to become CATIE's partners in this event included: Canadian Association of HIV Research (CAHR), Canadian Aboriginal AIDS Network (CAAN), Canadian Public Health Association (CPHA), Canadian Working Group on HIV and Rehabilitation (CWGHR), Canadian Association for Nurses in AIDS Care (CANAC), Interagency Coalition on AIDS and Development (ICAD), and Action Hepatitis Canada.

### ***Forum Sponsors***

Without the support of the Forum Sponsors, the event would not have been possible. Sponsors included:

- Gold level sponsors: AbbVie, Gilead, and Boehringer Ingelheim
- Silver level sponsors: Janssen, Roche, and Merck Frosst
- Government funders: Public Health Agency of Canada (PHAC) and Canadian Institutes of Health Research (CIHR)
- Webcast partner: Ontario HIV Treatment Network (OHTN)

## **CATIE Forum Participants**

Two hundred and seventy-three participants attended the Forum. Participants included: frontline and public health workers, program planners, health care providers, people living with HIV and/or hepatitis C, and policy-makers.

CATIE sought to encourage diverse national representation and was able to attract participants from most regions of Canada:

- 38 participants from British Columbia
- 32 participants from the Prairie provinces
- 116 participants from Ontario (excluding 33 CATIE staff)
- 31 participants from Quebec
- 23 participants from the Atlantic

## **Interpretation and translation**

CATIE sought to ensure accessibility at the Forum through multiple means. The pre-Forum webinars and plenary sessions, including the webcast, were simultaneously interpreted in English and French. In addition, the plenary sessions were interpreted in American Sign Language simultaneously. CATIE translated into English or French, as required, all PowerPoint presentations, including those that were presented in the concurrent sessions. For these sessions, CATIE printed and made available all slide decks in French.

The archive of Forum webinars and plenary sessions hosted on [catie.ca](http://catie.ca) are also available in English and French.

## **CATIE Forum Program**

The CATIE Forum program was designed to provide the opportunity for participants to investigate the programming implications of recent biomedical research and learn about new approaches to the integration of prevention, testing, treatment, care and support services. In addition, the program was designed to support participants to strategize on how to develop more integrated approaches to HIV and HCV service delivery. Finally, the program also included sessions that aimed to enhance understanding of HIV and HCV service delivery within a broader framework of sexually transmitted and blood-borne infections.

This was accomplished through the development of a diverse agenda, which started well before the two-day Forum with a series of pre-Forum webinars (see below). The in-person Forum agenda included over 70 speakers in 19 plenary and concurrent sessions.

To develop the program, CATIE put out a call for program descriptions, convened an advisory committee of external experts, and drew from broad internal expertise at CATIE. CATIE also convened informal expert sub-committees to curate the 10 concurrent sessions held during the two days.

To extend the reach of the CATIE Forum program, CATIE partnered with the Ontario HIV Treatment Network (OHTN) to webcast the Forum plenary presentations.

To review the CATIE Forum program, please see Appendix 2.

### ***Pre-Forum Webinars***

As a part of the CATIE Forum program, in June and July 2013, CATIE hosted eight national webinars, four presented in English and four presented in French. The webinars, which were open to Forum attendees and those not attending the event in person, provided an introduction to the different types of integration that would be the themes of the forum. They also provided the rationale and evidence for integration. The webinars were designed to prepare Forum participants to engage fully in dialogue at the in-person event and to share knowledge of the four forms of integration, outlined above.

It was highly recommended that all those planning to attend the Forum participate in the webinars. The series was also promoted nationally to encourage involvement from healthcare providers, community-based and public health workers, and program planners working in frontline HIV and HCV programming. These webinars were presented live and posted on <http://www.catie.ca/en/forum#preforum> shortly after they were presented. They will remain on [catie.ca](http://www.catie.ca) as an archive and are still available for viewing.

In total, 464 “log-ins” to the webinars were recorded. However, the viewership of the webinars was higher than the total number of log-ins. According to the webinar evaluation, outlined in a section below, 70% of viewers watched the webinar alone, 17% watched the webinar with one other person, 6% watched it with two other people, and 7% watched it with three or more other people (average six other people). Applying these responses to the total number of log-ins, the conservative estimate for viewership is 762.

The webinar series included:

**Webinar 1:** New developments in HIV research and their implications for front-line practice.

Presented by James Wilton and Sophie Wertheimer, both of CATIE, in English and French respectively, this webinar explored new developments in HIV research and their implications for programs. Topics included viral load and its relationship to HIV transmission, PEP and PrEP, STIs and HIV transmission, and acute HIV infection, among others.

**Webinar 2:** New developments in HCV research and their implications for front-line practice.

Presented by Dr. Curtis Cooper (University of Ottawa) and Dr. Marie-Louise Vachon (Centre Hospitalier de l’Université Laval) in English and French respectively, this webinar explored new developments in hepatitis C research and their implications for frontline programs. Topics included new HCV treatments, HIV/HCV co-infection, and the sexual transmission of HCV, among others.

**Webinar 3:** Integrated approaches to HIV treatment and prevention.

Presented by Dr. Tim Rogers and Michael Bailey, both of CATIE, in English and French respectively, this webinar introduced participants to and explored an integrated framework for service provision, which provides insights for new directions in prevention, testing, treatment, care, and support.

**Webinar 4:** Working from a sexual health or harm reduction perspective: Integration of HIV, HCV, tuberculosis and other sexually transmitted and blood-borne infections (STBBIs).

This webinar, presented by Dr. Marc Steben (Institut national de santé publique du Québec) in English and French, explored the practice implications of the integration of HIV, HCV, and other STBBIs.

Webinar log-ins

<i>Date</i>	<i>Name</i>	<i>Log-ins</i>
June 6, 2013	New developments in HIV research and their implications for frontline practice	80
June 11, 2013	Nouveaux développements en recherche sur le VIH et leurs répercussions sur la pratique de première	13
June 17, 2013	New developments in HCV research and their implications for frontline practice	113
June 20, 2013	Nouveaux développements en recherche sur le VHC et leurs répercussions sur la pratique de première ligne	17
July 9, 2013	Integrated approaches to HIV treatment and prevention	111
July 11, 2013	Approches intégrées du traitement et de la prévention du VIH	12
July 22, 2013	Working from a sexual health or harm reduction perspective: Integration of HIV, HCV, tuberculosis and other sexually transmitted and blood-borne infections	100
July 24, 2013	Travailler du point de vue de la santé sexuelle ou de la réduction des méfaits : Intégration du VIH, du VHC, de la tuberculose et des autres infections transmissibles sexuellement et par le sang	18

***Call for program descriptions***

To help build the Forum program, for the first time CATIE conducted a “call for program descriptions”. In this call, CATIE reached out nationally to service providers to learn more about their programs.

Over 60 programs were submitted for consideration by CATIE. These submissions represented excellent programs from across the country and those that demonstrated the four forms of integration that were the focus of the Forum. Using a formal assessment system, CATIE selected 26 programs to profile at the Forum.

To select these programs, submissions were reviewed and assessed to determine how well the program demonstrated:

- The integration of prevention, testing, treatment, care and support services;
- The integration of services related to HIV, HCV and/or STIs;
- The integration of research knowledge related to HIV or HCV prevention, transmission, testing, or treatment; and
- Client-centred services.

In addition, regional diversity was also considered in the selection of programs to help ensure national representation in the program. Because of the high number of submissions and the specific focus of the event very specifically on integration, many good programs were not selected for inclusion in the program.

### ***Webcasting the CATIE Forum***

To share knowledge presented at the Forum more broadly, CATIE partnered with the OHTN to live webcast the Forum plenary sessions using *Instant Presenter*. These presentations were filmed and live streamed over the internet to a diverse audience of service providers from across the country. The webcast was recorded and has been archived online for ongoing viewing. To view these presentations, please visit: <http://www.catie.ca/en/forum/webcast-archive>.

There were 51 discrete English and French log-ins to the live webcast on September 18 and 27 discrete English and French log-ins on September 19. However, due to the potential for multiple viewers at a single computer, the number of people reached through the live webcast may have been larger than these numbers indicate.

### **Themes emerging from the CATIE Forum**

Several key themes emerged from the CATIE Forum overall, which shed light on the current state of integration in practice in Canada, as well as on priorities, challenges, and successes related to integration. As well, key ideas and perspectives were raised during concurrent session discussions. Given that these sessions were not filmed and archived on [catie.ca](http://www.catie.ca) (see “webcasting”, above), themes from these sessions are documented below.

#### ***Overall themes from the CATIE Forum***

*While diverse, all regions in Canada face similar challenges*

The Forum provided an opportunity to explore local challenges associated with addressing HIV, HCV, and other STBBIs and what integration may look like “on the ground” in a diversity of

settings. While each region in Canada faces different realities, a number of common issues emerged, such as access to services, poor engagement and linkage between services, and service gaps in the continuum of prevention, testing, care, support and treatment. Further, all regions discussed, in a variety of ways, the importance of looking at integration in entire health systems, particularly through the lens of holistic, client-centred care.

*The importance of accurate, usable data to guide our work*

A number of speakers, including Tiffany West of Dare Global Innovation, Thomas Haig of SPOT in Montreal, and Chris Buchner of Vancouver Coastal Health in Vancouver, discussed the importance of generating and using reliable data to inform our approach to addressing HIV, HCV, and other STBBIs. Generating, having access to, and using reliable data requires that data processes, policies and protocols—including its collection, management, analysis, and dissemination—are integrated into various levels of our work, such as the local program level, the organizational level, and at the level of the health system.

*The importance of meaningful engagement of people living with and affected by HIV and hepatitis C*

The importance of ensuring that people living with and affected by HIV and hepatitis C remain at the centre of our planning and our programs, including but not limited to being meaningfully engaged in programs and policies, was a theme throughout the two-day event.

When considering integration in services and systems, we must keep in mind that overall health and wellbeing are broader than biomedical factors. Further, movement within a continuum of care or services is rarely linear and meeting people wherever they fall within this continuum and supporting them to move through it, as they determine is appropriate, is critical to success.

A number of programs were presented that demonstrated meaningful engagement of people living with and affected by HIV and hepatitis C, including Pause-Santé from CAPAHC and Peer-Facilitated HIV Treatment Decisions from Toronto People with AIDS Foundation, among others.

*Limited perspective on what “integration” means remains an issue among service providers in Canada*

While many service providers in Canada deliver programming that represents one or more forms of integration, there is a limited perspective across the country of what “integration” means. The Forum revealed that many service providers view “integration” in only one form – that is, either as referring to the integration of HIV and HCV services in one program, for example, or the integration of the silos of the continuum of care in one organization. Some participants demonstrated a limited perspective on the role that program collaboration and system integration can have in improving our response to HIV and HCV. This may be due, in part, to the lack of a national vision or strategy for integration in programming and health systems.

This limited understanding of “integration” may be a barrier to service providers taking up

integrated approaches to service delivery. Many sessions at the Forum included comments related to the inability to provide all services in “one-stop-shop”, due to limitations of expertise, time, or other resources, or the inappropriateness of this approach, particularly for specific populations of marginalized people.

Importantly, integrated service delivery approaches go far beyond “one-stop-shop” services (see definitions of “integration”, above). It is important to acknowledge that all forms of integration are not appropriate for all services or communities. However, this need not be a barrier to moving towards integration generally.

### *Role of partnerships and collaboration in moving forward with integrated approaches*

An important theme that emerged throughout the two days related to the importance of partnerships and collaboration in moving forward with integrated approaches. Collaboration and partnerships across services, both within and across disease silos of HIV, HCV, and STIs, builds bridges for clients and staff, allowing for more seamless service delivery.

Collaboration across sectors—clinical care, public health, and community-based organizations—was also demonstrated in presentations from programs moving successfully towards more integrated approaches. Bridging community and clinical services by engaging peers in clinical programs and/or bringing nurses into community services fosters learning and more effective linkage and engagement in services for clients. Programs that demonstrated collaboration across sections included the Peer Navigation Services Program from Positive Living BC, Peer to Peer Program from Regina Qu’Appelle Health Region, among others.

By looking at the entire continuum of services and identifying where the gaps are, new opportunities for partnerships can emerge. We can challenge ourselves to consider what we do well in our organizations and build our capacity there, rather than expecting ourselves to take on work that we are ill-equipped to provide. Instead, investigating partnering and collaboration opportunities to support programming where our own organizations are lacking may be the best approach to developing more integrated and effective services.

### *Additional themes arising from specific sessions*

The CATIE Forum included 10 concurrent sessions, each of which was focused on participant discussion. The following summarizes some of the key themes that emerged from these sessions, in addition to the overarching themes outlined above.

#### **Session 1: Communicating sexual risk with people living with HIV and at risk**

This session built on four plenary presentations that focused on how newer understandings of HIV transmission can change the way that we understand and communicate information about HIV risk. This discussion focused on how service providers can take up new information and translate it into tools and service for sexual risk assessment and counselling.

*Service providers are eager to take up new knowledge, but understanding the science continues to be a challenge*

Many service providers are eager to take up new information and approaches to explaining and understanding the risk of HIV transmission. However, there continue to be challenges in understanding and properly communicating new HIV transmission research, such as the HPTN 052 study. Organizations like CATIE should continue to translate biomedical research knowledge into usable information for service providers.

*Communicating risk requires a flexible approach*

The experiences of service providers, including those who work in social services as well as clinical services, indicate that communicating about sexual risk requires a flexible approach that allows clients to discuss their fears, anxieties, and mental health concerns.

*Communicating risk requires an understanding of criminalization of HIV non-disclosure*

It's valuable for service providers talking about risk to understand the implications of the 2013 Canadian Supreme Court ruling around the criminalization of non-disclosure of HIV status. However, these laws should not necessarily dictate how health information (and what health information) is communicated.

## **Session 2: HIV, STI and hepatitis C testing and partner-notification strategies**

This session began with a short series of “ignite talks” on HIV, HCV and STI testing and partner-notification strategies. Following this, discussion took place on engaging people who do not know their status and exploring engagement and linkage approaches important for success.

*Integration of testing services may increase feelings of safety and confidentiality for clients*

Integrating HIV testing with other testing services, such as STI testing, may support more people to engage in testing services as there may be lessened concern about a lack of confidentiality around accessing an HIV test. During this session, HIV and STI testers from different settings discussed challenges with confidentiality and that, if multiple services are offered under one roof, clients may be more likely to access testing for this reason.

*Current testing strategies may lead to missed opportunities to engage people in health care services*

Risk-based HIV testing has been the cornerstone of our HIV testing approach across Canada. While critical to our overall testing strategy, risk-based HIV testing can lead to missed opportunities for engaging people who are at risk in HIV testing in some settings, as was demonstrated through the Vancouver STOP Project pilot initiative to routinely offer HIV testing in acute care settings. Using a single, risk-based approach requires that individuals recognize their risk and request a test and/or a provider recognizes the risk and offers a test.

By moving towards integrated testing strategies—those that combine risk-based with other approaches, such as routine offers—may help to capitalize on opportunities to engage people at risk in HIV and hepatitis C testing and other services.

Combining risk-based approaches with routine offer of HIV testing can also be considered in some areas where HIV testing is currently not offered alongside STI testing, particularly in regions with high rates of STIs, such as gonorrhea and chlamydia, or where it would be appropriate to implement the routine offer of HIV testing in other settings, such as primary care.

*The discussion of the need for pre- and post- HIV test counselling is ongoing*

Streamlining HIV testing into other health care services, such as primary care, may require a reassessment of pre- and post-test counselling protocols, as was carried out in Vancouver as a part of the Vancouver STOP Project's pilot initiatives.

However, some concerns remain among some service providers/clinicians regarding the shift from pre-test counselling to pre-test information. For example, clinicians providing such information must be skilled in doing so; however, the knowledge required to competently provide this service may be lacking among some health care providers.

### **Session 3: Peer Mentoring and Health Navigation**

The session began with a short series of Ignite Talks on peer mentoring, peer navigation and health navigation programs. Following this, participants engaged in a facilitated discussion on engaging people who are living with HIV or hepatitis C in treatment, care and support through these types of programs.

*Navigation services can address barriers to accessing and staying in care, treatment, and support services.*

Participants discussed that various barriers exist for people living with HIV or HCV in accessing and staying in care, treatment, and support services. These include: poor linkage to care procedures in testing sites; challenges navigating HIV- and HCV- focused and allied health care systems; mistrust of community agencies and/or discrimination faced in community agencies; lack of understanding about client/patient experience among some health care professionals; misinformation or limited information among clients about the new realities of medication; and silos between physician care and community-based services.

Programs presented demonstrated various approaches to addressing these barriers through peer-based and non-peer based navigation services.

*Meaningful engagement of people living with HIV or HCV through navigation programs can take different forms*

For some programs, such as Peer Navigation Services from Positive Living BC, meaningfully engaging people living with HIV as peers in the programs meant, among other things, providing

the program with a distinct space in the hospital. Through the establishment of the office within the clinic, peers were able to more effectively engage clients in the program and their value as care providers was demonstrated concretely. Navigation programs need to consider the lives and contexts of the peers involved and work with them to determine what meaningful engagement means.

*Compensation to peers varies based on the context*

Most peer mentoring and navigation programs presented at the Forum pay peers for their work in these programs, while a small number do not. Programs that utilize peers in a more ongoing way (vs. as facilitators in a short-term workshop series) pay peers for their work as well as for training and consider the position a paid staff or contract position.

It is important to consider the possibility of financially compensating peers for their involvement in navigation programs. Speaking with peers already engaged in the program may help to inform what the best approach to providing financial compensation is.

*Developing and implementing peer mentoring or navigation programs have costs and benefits important to consider pre-implementation*

Speakers and participants discussed the costs and benefits of developing and implementing peer mentoring and navigation programs. “Costs” included issues that may not be effectively addressed, but “worth it” in light of the benefits of such programs to clients. For example, engaging peers/clients actively in programming can disrupt the staff/patient divide – a divide that can be important for client confidentiality and the maintenance of professional boundaries. In addition, employing peers as staff can raise challenging power/control issues between peers and other staff. However, with patience and proper staff and peer training, this cost can be minimized.

Proper training and ongoing support for peers is also very important in managing confusion in the role that the peer is playing at any given time in the organization/clinic, particularly if they are a current or past client/patient of the organization/clinic.

Providing space for peers (e.g. an office) can take up valuable real estate in an organization or clinic that would otherwise have been used for other services. Paying peers, an important component of many programs, obviously takes up limited financial resources, another important consideration.

The benefits of peer mentoring and navigation programming seemed clear to presenters and participants. These programs, when successfully implemented, were seen to enhance patient-centred care and improve education and self-management for clients. Peer navigators successfully introduce lived experience to the clinic and can provide clients with better access to community resources. Importantly, these programs can also reduce the gaps between testing, treatment, care, and support, a goal in moving towards more integrated services.

## **Session 4: Nursing and Other Health Care Provider Education**

Given the rapid evolution of our healthcare system and the demand for new health-related knowledge, nurses and other health care providers are constantly challenged to stay current in their professions. This session explored education and mentorship initiatives that play an important role in strengthening professional expertise and supporting the best possible provision of care to patients. This session was co-organized by CANAC (Canadian Association of Nurses in AIDS Care), CAHN (Canadian Association of Hepatology Nurses), and CATIE.

### *Challenges associated with engaging nurses and other health care providers in education*

While education is critical to providing the best possible care to patients, engaging already over-stretched healthcare providers in such initiatives can be a challenge. We need to focus on shifting the perception from education as a “nice to have” on top of a full workload to a “must have” in providing quality care. It is also a challenge to fund continuing education for health care providers, particularly in an environment of already limited resources.

### *Diversity of specialities and health care settings can be a barrier to education*

Patients affected by HIV and HCV move in and out of the health care system and have broad, but often similar needs. The divide between acute/hospital care and primary/community public health and long-term care can be a barrier to providers in these settings offering the best possible care. It is important to find or create links between these areas. Further, HIV-specific nurses can benefit from HCV education, while hepatology nurses can benefit from HIV education.

### *Building awareness and support of education opportunities is important*

Better awareness of mentorship and education is needed to support engagement in training and education programs across disciplines. One strategy to build this awareness is to use a multidisciplinary team approach that incorporates specialists from HIV *and* HCV.

## **Session 5: The integration of HIV and HCV services within community-health and AIDS-service organizations**

Recognizing that the introduction of hepatitis C services into community-health and HIV-focused organizations can represent a sometimes complex and lengthy process, this session explored the relevance, feasibility and challenges associated with adopting this integrated approach from the perspective of the health needs of the service user. Preliminary results from CTAC’s project to develop a “*Good Practices Guide to HIV-HCV Integration*” were presented to guide the discussion, with added commentary from organizations directly engaged in integration efforts.

### *History of HIV that led to the creation of the “ASO-sector” is very different than the history of HCV*

The broad “ASO sector”, which provides HIV-specific and increasingly, HCV-specific services, emerged in a very particular historical context. When HIV emerged, HIV-dedicated services were urgently needed and important because of the devastating nature of the disease, the stigma surrounding it, and the failure of the existing health-care system to handle it. However, given the current strains on the healthcare system and the different nature of hepatitis C, there is very little support for setting up a completely separate and unique system to respond to HCV across the whole spectrum of the continuum of prevention and care. This session explored the notion that this disease-specific model is not one that will gain traction. Instead, we need to identify ways to better integrate HCV services into existing health care delivery structures.

*Integration of HIV and HCV programming is beginning to take place in community organizations, but engaging in the required partnership development and collaboration remains a challenge for some*

Many community-based and AIDS-service organizations are already doing both HIV and HCV-focused work, primarily with people who use drugs. However, not many organizations had developed explicit organizational supports for the integration of HCV into their work, such as constitutional changes, explicit mandates/missions, or focused position statements. For those who have moved towards the integration of HIV and HCV services, the fact that HIV and HCV affects similar populations has made this shift relatively easy. Further, maintaining an explicit harm reduction approach, employing a model of comprehensive care, and developing strong partnerships were also cited as being facilitators of integration.

Barriers to moving towards integration include working with certain populations who may focus more on one disease over another (e.g. gay men) and the stigma associated with HCV – that it is connected to injection drug use. Further, it can be challenging to develop the partnerships required to successfully integrate services; strong commitment on the part of an organization to partnership development is key.

*Education for health care providers not yet skilled in HCV care or culturally competent regarding people who use drugs is important*

Participants discussed the need for even better education for general practitioners and other health care providers who provide services to people who use drugs and are affected by hepatitis C. Many are unaware of the basics of HCV transmission and can be apprehensive about treatment. Further, stigma associated with drug use can create barriers to accessing quality care, which can be partially addressed through health care provider education.

## **Session 6: Practical approaches to integrated health services for Aboriginal communities**

This session, co-hosted by the Canadian Aboriginal AIDS Network (CAAN) and CATIE, focused on facilitated discussion of the unique implications of an integrated STBBI approach by organizations and clinics serving Aboriginal communities across Canada. This session explored what culturally appropriate integrated models could look like, and created national connections between Aboriginal services working hard to address the needs of their communities alone.

*Use of the word “integration” may not be appropriate for some communities, but the concepts are still useful*

During this session, it was discussed that the word “integration” may carry negative associations for some Aboriginal communities, given the important history of colonization in Canada and attempts by Canadian governments to ‘integrate’ Aboriginal peoples into other cultures. However, more “integrated” or “holistic” approaches are useful. Therefore, CAAN has started to use the language of “*wholistic*” (with a “w”), in recognition that integrated approaches are about supporting the whole person and seek to balance the mind, the body and the spirit within community.

*Culturally appropriate integrated services must take many forms*

Integrated health services for Aboriginal communities should take into consideration a wide range of health topics, not only HIV or HCV – including, but not limited to, diabetes, food security, osteoporosis, addictions, mental health, home and community care services – as appropriate for the community.

Further, when we consider “cultural traditions” and “culturally appropriate services” we should consider that all Aboriginal peoples come to services with specific histories and traditions. Not only is the “Aboriginal community” an incredibly diverse population, not everyone identifies with traditions indigenous to their First Nation, Inuit, or Métis community. To provide competent services, providers should consider that how individuals choose to live their lives and connect with their identity as an Aboriginal person is up to them.

*Extending our reach to overcome geographic isolation is a challenge*

Facilitators challenged participants to look over and above what is usually done to more effectively extend our services beyond the geographic isolation faced by many communities. This may mean involving new service providers and other resources to extend teams already working with these communities. Some participants discussed their success in utilizing tele-health technology and the importance of *education* – when individuals don’t understand an illness, they develop misconceptions. Education is key in breaking stigma associated with HIV, HCV, and drug use, in all communities, but particularly in remote communities.

*Jurisdictional boundaries can cause barriers to integration*

How Aboriginal health care is managed in Canada creates sometimes significant jurisdictional issues that can act as a barrier to providing comprehensive, integrated services to Aboriginal peoples. In some communities, such as Big River First Nation (Saskatchewan), service providers have developed programs that can cross these boundaries, but this is rare.

What is important in eliminating these barriers is for communities to work with provinces and national groups to address health issues. Engaged local and provincial leadership can help ensure that partnerships are effectively developed and jurisdiction does not cause unnecessary barriers

to health care and social services, particularly for people moving on and off of their home reserve community.

### **Session 7: Providing integrated health services to gay men**

This session focused on a facilitated discussion of existing programs and services for two-spirit, gay, bisexual and other men who have sex with men from across Canada, including those that focus on HIV prevention, as well as those that offer services that address gay men's health more broadly.

*There is a need for providers of gay, bi, queer, and "MSM" services to network and share best practices*

Gay men's health work is happening in concert with other queer health initiatives throughout the country; however, there are few opportunities for professionals to network and share best practices, particularly given that services and opportunities are often provincially siloed. In addition, some outreach workers and organizations are struggling to meet the needs of men who have sex with men who are not necessarily connected to or identified with "gay communities". Innovative and promising practices should be identified, described, and shared that meet the needs of these men. In addition, those who are serving gay men broadly may benefit from learning from those who are more familiar with the needs of newcomer and immigrant men who have sex with men – a "population" that is incredibly diverse and has complex needs.

*The changing nature of gay men's relationship with HIV means new issues are emerging*

As gay men's relationship to HIV changes, new issues are emerging that need to be considered by service providers and policy makers, such as how funding structures do (or do not) meet the broader health needs of gay men. Further, a lack of viable sources of funding from outside of the HIV sector creates a challenge for people to move beyond sexual health when understanding and addressing gay men's health in a broader sense.

### **Session 8: Practical approaches to providing integrated health services in a harm reduction context**

This session focused on the implications of integration for our harm reduction work. It provided participants with an opportunity to learn about HIV, HCV and STBBI integration, and the integration of our HIV and HCV work with other health conditions, in the context of working with people who use drugs. Participants reflected on what others have done to address the needs of people who use drugs through integrated approaches, considered challenges faced, and discussed what "integration" can really look like in a harm-reduction context.

*Integrated services means more than HIV, HCV, and STIs*

During this concurrent session, participants discussed that, in the context of harm reduction, "integration" means more than HIV, HCV, and STIs. Our integrated services need to address other health care-related issues, including poverty, mental health, stigma, housing, and

addictions. “Umbrella services” were discussed, where more integrated programs or partnerships can provide services for basic needs, such as nutrition, and also actively link to medical services at the same time.

When working with people who use drugs, “integration” really means “flexibility”. Service providers should consider how flexible they can be to the needs of clients who use drugs and if they are doing everything that can be done to provide easy-access, non-judgemental services in ways that make sense to the client.

#### *Removing barriers to health care access is an important part of integration*

Barriers faced by clients and strategies to remove barriers were discussed during this break out session. It can be challenging for service providers and clients to work with health care providers who do not want or are not equipped to provide adequate health care to people who use injection drugs. Clients who use drugs can face discrimination in both health care settings and in our community organizations, which can be a significant barrier to accessing services. Strategies to address barriers to access include developing partnerships across multiple organizations and multiple settings (clinic/community organization/public health unit), and providing mobile services, including outreach on foot.

#### *Providing integrated health services in rural settings requires tailored approaches*

Participants in this session discussed the challenges and facilitators associated with providing integrated health services in a harm reduction context in rural and under-resourced settings. Participants agreed that to most effectively provide services, many services must be removed from the office or clinic and taken to where people are. Outreach and partnerships are vital.

#### *Engagement of people who use drugs in services as providers is key to successful programming*

Employing people with lived drug using experience (including current users) is important to delivering successful programming in all regions, but particularly in rural and remote areas. Even in places where people fear being “outed” as a drug user, there are often natural leaders who can be employed to reach out to others who prefer anonymity. It also may be important to use *other* commonalities from communities and populations, aside from disease or drug use patterns, to bring people together to address disease- or drug-use related needs.

### **Session 9: Providing integrated health services for women and trans people**

This session focused on issues and examples of the strengths and limitations of integrated health services for women and trans people. Discussion focused on identifying barriers and facilitators to integrated health services for women and trans people.

#### *Political and legal context of service delivery*

Integrated services do not necessarily mean “centralized” services. In some cases, more centralized services may not work for women and trans people. For example, women or trans

people who are involved in the sex trade may want to access health and other services from a specialized organization or clinic, where there is more room for anonymous services, and where their records will not be shared or easily accessible. This point highlights the importance of taking into consideration the broader political and legal context within which women and trans people's experiences take shape. This broader legal context needs to be actively addressed when formulating and delivering services.

#### *Women and trans people face barriers to services*

Women and trans people face many barriers to service access, such as lack of finances for travel, lack of time, or responsibilities as caregivers. Other barriers include issues with the services themselves, such as lack of access for transwomen in women's services, or a focus on reproductive health over and above other types of health.

When discussing integrated health services, just as any other type of service, it is important to address and respond to these barriers (for example by providing childcare, financial support for travel, etc.).

#### *Existing or potential violence affects engagement and retention in services*

Special attention needs to be given to addressing the real or potential impact of violence in the lives of women and trans people, and how violence may affect access to services. Moreover, violence or fear of violence may also affect women and trans people's ability to "follow through" on services (e.g. abstaining from taking medications out of fear that these may be found). One approach to addressing this issue is by designing programs that work with partners and families when developing services for women and trans people, including making sure that men who have sex with women are considered as active agents in sexual and reproductive health programming.

#### *Education in the broadest sense*

Because many women and trans people continue to experience discrimination, prejudice or erroneous assumptions when seeking health-care, there is a need for the further training of health-care providers, whether they are new to the field or have been providing services for a long time.

Participants also called for greater education of the general population, including education in schools and more nuanced media representations of people living with HIV and/or hepatitis C. By raising awareness, stigma will diminish and access to services will be made a bit easier.

Finally, there is also a need for additional and more targeted information for women and trans people. Resources should draw from more traditional approaches (pamphlets) and new communication technologies (including social media).

## **Session 10: Moving Intervention Research Forward in Canada**

This session was organized with the support of the Public Health Agency of Canada, Canadian Institutes of Health Research, CIHR Social Research Centre in HIV Prevention, CIHR Centre for REACH (Research Evidence into Action for Community Health), and the Aboriginal HIV & AIDS Community-Based Research Collaborative Centre. It focused on how we can effectively move intervention research forward in Canada to support integrated approaches to prevention, testing, treatment, care and support.

*We understand our epidemics and our communities in many ways, but translating this knowledge into better programs is a challenge.*

Understanding what is working in our approaches to STBBI prevention, testing, treatment, care and support is critical in providing the best possible care to clients. Many behavioural and biomedical programs and interventions exist, but in an environment of limited resources, choices have to be made about which programs to implement. To do this effectively, we need more information on what works, for whom, in what circumstances, and why.

One of the reasons for the slow and uncertain translation of research into practice is likely due to the emphasis in science on explanatory models and efficacy designs, rather than more pragmatic approaches. Intervention research and, on a larger scale, program science, can help to bridge this gap.

*We should consider “program science” – research embedded into programs*

Rather than thinking of “intervention research” as a set of distinct research projects, it is helpful to look more broadly at “program science”, which considers the whole process of connecting research with the frontline response. In program science, the research process can be quite different from traditional research approaches, such as “clinical trials”, for example. Program planners, frontline workers, community members, and researchers collectively establish research priorities, build the interventions together and interpret the research outcomes. The research process itself is iterative; interim outcomes provide evidence for making changes to interventions. Research questions address issues of implementation, context and adaptability, in addition to more traditional questions related to outcomes.

The co-organizers of this session are leaders in HIV research nationally and are working together to move intervention research and program science forward in Canada.

*Working with community, frontline providers and policy makers from the start*

In intervention research and program science, it is important to fully engage community partners from the start. There is an appetite for researching interventions that are driven by the frontline needs and are responsive to the community context, including the social determinants of health. Engaging all the stakeholders throughout the process is very important, including priority setting, intervention design/implementation and interpretation of research outcomes. This will help to

ensure interventions are relevant, adaptable and the system has the capacity to sustain the work after the research is completed.

### *Sustainability, transferability and scale-up of programs through program science*

It is important that research that we conduct adequately considers the long-term sustainability of interventions. Research priorities and design need to consider the system capacity for sustaining the interventions in the long-term. They also need to consider questions related to adaptation of interventions in other regions or community contexts, as well as potential scale-up of interventions. There is a history of funding research on HIV interventions that were not sustainable and/or too expensive for scale-up.

### *Funding models need to consider how to become more integrated*

The current funding landscape in Canada is one in which research and program funding occurs from different sources. Research funding typically will not cover program-related costs (and if they do, only while the program is being evaluated, at which point continuity of funding becomes problematic), while program funding will not cover research-related costs. Furthermore, this divide between program and research funding means that the priorities for programming are not necessarily aligned with priorities for research, which creates a divide between what are “fundable” programs and what gets researched. These issues make the implementation of programming science within the Canadian landscape quite difficult.

## **CATIE Forum Evaluation**

The CATIE Forum webinars and in-person program were evaluated by CATIE to determine if we successfully met our objectives. CATIE also uses evaluations such as these to learn lessons to inform our future directions in designing and implementing knowledge exchange activities on topics related to “integration”.

The evaluations were designed to answer three questions, based on CATIE’s evaluation framework:

1. Was the event *well organized* and/or *accessible*?
2. Was the event *relevant* for the participants?
3. Was the event *effective* for knowledge exchange (i.e. participants reported increased knowledge and increased capacity to use knowledge as a result of the event)

### ***Evaluation methodology***

#### Pre-Forum webinar evaluation

An evaluation form was developed in survey monkey and promoted to webinar participants (Appendix 3). Frequency descriptives were produced to summarize the outcomes for the webinars. A paired t-test was also conducted to look at changes in self-reported knowledge.

### In-person event evaluation

An evaluation form was distributed to attendees to fill out upon completion of the event (Appendix 4). CATIE staff collected the evaluation forms. Frequency descriptives were produced to summarize the outcomes for the event.

### ***Evaluation results***

#### Webinar Results

146 completed evaluations forms were analyzed. A total of 463 sites participated in the webinars, resulting in a 32% response rate (evaluation forms were emailed only to those who logged into the webinar).

Based on the survey responses, the webinars reached the diversity of audiences for whom they were intended:

- 29% of participants were from an AIDS service organization.
- 12% of participants were from a community health centre.
- 6% were from an 'other' community based organization.
- 21% of participants were from a public health unit/sexual health clinic.
- 14% of participants were from a government organization.
- 1% of participants were from a clinic/hospital.
- 2% of participants were from corrections.
- 5% of participants were from a university or academic institution.
- 9% of participants were from an 'other' type of organization.
- 1% of participants were not affiliated with an organization.

#### *Were the webinars accessible?*

Based on the survey responses, the webinar technology was easy to use and conducive to learning:

- 92% agreed or strongly agreed that the technology was easy to use.
- 91% agreed or strongly agreed that the webinar was conducive to learning.
- 92% agreed or strongly agreed that they liked the webinar format.

#### *Were the webinars relevant for participants?*

The webinars were very relevant to frontline audiences:

- 96% agreed or strongly agreed that the webinar was appropriate for them.
- 96% agreed or strongly agreed that the webinar content was relevant to them/the work that they do.
- 91% agreed or strongly agreed that they would recommend this webinar to their co-workers/friends.

- 86% were satisfied or very satisfied with the event
- 86% felt the forum was useful or very useful for the work that they do.

*Were the webinars effective for knowledge exchange?*

The webinars were effective at increasing knowledge and awareness of the nature of HIV/AIDS and other infections:

- 80% agreed or strongly agreed that the webinars increased their knowledge of HIV and/or hepatitis C.
- On average, people rated their knowledge of HIV and/or hepatitis before the webinars at 7.0 (on a 10 point scale). This increased to 7.6 (on average) after the webinars ( $P > 0.01$ ). 51% of respondents reported an increase in knowledge using this scale.

The webinars were very effective at increasing individual and organizational capacity to apply knowledge and to respond to HIV and/or hepatitis C:

- 91% agreed or strongly agreed that they will use/apply the knowledge gained at the webinar in their work/life.
- 82% agreed or strongly agreed that the webinars increased their capacity to respond to HIV and/or hepatitis C within their community/personal life.

*Key themes related to knowledge exchange*

Webinar viewers were asked a series of qualitative questions. In terms of how respondents thought they might use the information from the webinars, two key themes emerged: 1) sharing knowledge with others including clients, health professionals, and practitioners and 2) developing and adapting resources.

In terms of the main benefit of the webinars for the viewer or their organization, key themes emerged: 1) inform on the latest research and best practices, 2) increase capacity/comfort level with topic, 3) convenience of the webinar format.

### In-Person Evaluation Results

A total of 123 completed evaluation forms were analyzed. Not including the 30 CATIE staff who attended the Forum, 243 people participated in the CATIE Forum, resulting in a 51% response rate. (CATIE staff were requested not to complete evaluation forms.)

Based on the survey responses, participants at the forum reflected the diversity of audiences for which the forum was intended:

- 31% of participants were from an AIDS service organization
- 10% of participants were from a community health centre
- 11% were from an 'other' community based organization
- 18% of participants were from a public health unit/sexual health clinic

- 3% of participants were from a government organization
- 5% of participants were from a clinic/hospital
- 3% of participants were from corrections
- 6% of participants were from a university or academic institution
- 12% of participants were from an ‘other’ type of organization
- 1% of participants were not affiliated with an organization

*Was the forum well organized?*

The forum was extremely well organized:

- 100% agreed or strongly agreed that the forum was well organized.

*Was the forum relevant for participants?*

Overall, the forum was very relevant to participants:

- 98% agreed or strongly agreed that the forum was appropriate for them
- 97% agreed or strongly agreed that the forum was relevant to the work of their organization
- 86% felt the forum was useful or very useful for the work that they do.
- 86% were satisfied or very satisfied with the event
- 98% agreed or strongly agreed that they would recommend CATIE continue to offer this type of event

Specific sessions were also evaluated individually. They were all found to be useful to participants:

- 85% felt that the session entitled “Setting the stage – perspectives on integration (Opening Plenary)” was useful or very useful to the work that they do.
- 90% felt that the session entitled “Integrated community services: Designing programs to respond holistically to the needs of clients” was useful or very useful to the work that they do.
- 88% felt that the session entitled “Integrated health systems: Designing systems to respond holistically to the needs of clients” was useful or very useful to the work that they do.
- 95% felt that the session entitled “Integrating new knowledge: Communicating sexual risk with people with HIV and people at risk” was useful or very useful to the work that they do.
- 91% felt that the workshop entitled “Integrating prevention, testing, and care: Reaching people who do not know their status” was useful or very useful to the work that they do.
- 92% felt that the workshop entitled “Integration: Improving engagement and linkage to care for people living with HIV or HCV” was useful or very useful to the work that they do.
- 94% felt that the concurrent sessions held on Day 1 (September 18, 2013) were useful or very useful to the work that they do:

- Communicating sexual risk with people living with, and at risk of HIV
- HIV, STI and hepatitis C testing and partner-notification strategies
- Peer mentoring and health navigation
- Nurse and other healthcare provider education and mentoring
- The integration of HIV and HCV services within community-health and AIDS-service organizations
- 90% felt that the session entitled “Integration of HIV, HCV and other STBBIs: evidence and practicality” was useful or very useful to the work that they do.
- 94% felt that the session entitled “Integration of HIV, HCV, STBBIs, and other health factors: examples from practice” was useful or very useful to the work that they do.
- 92% felt that the concurrent sessions held on Day 2 (September 19, 2013) were useful or very useful to the work that they do:
  - What might integrated services for gay, bisexual and other MSM look like?
  - Integrated Health Services for Women and Trans People: Challenges and opportunities
  - Practical approaches to integrated health services for Aboriginal communities
  - Practical approaches to integrated health services in a harm-reduction context
  - Moving intervention research forward in Canada

*Was the forum effective for knowledge exchange?*

The forum was very effective at increasing knowledge and building networks:

- 92% agreed or strongly agreed that the forum increased their knowledge of new directions in HIV and/or HCV programming.
- 98% agreed or strongly agreed that the forum provided an opportunity to network with others.

The forum was very effective at increasing individual and organizational capacity to apply knowledge and to respond to HIV and/or hepatitis C:

- 97% agreed or strongly agreed that they will use/apply the knowledge gained at the forum in their work.
- 92% agreed or strongly agreed that the forum increased their capacity to respond to HIV and/or HCV within their community.

*Key themes related to knowledge exchange*

Forum participants were also asked a series of qualitative questions. Forum participants provided many ways in which the forum might inform the work that they do. Several key themes emerged: 1) new programming ideas/improvements to current programming, 2) learn new knowledge to share with others, including clients, health professionals, practitioners, 3) integration and what it means to them/their organization (knowledge and concrete examples), 4) networking, and 5) partnership ideas

Forum participants also provided many ways in which the forum was useful. Several key themes emerged: 1) variety, diversity and quality of speakers, 2) provision of a diversity of models and service provision from across the country, 3) networking, and 4) increase in knowledge in programming and integration.

Forum participants also provided a few mechanisms which could have improved the forum. Key themes included: 1) more time or fewer speakers, 2) more peer presenters, 3) including poster

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## Appendix 1: CATIE Forum Advisory Committee

Name	Organization
Stephen Alexander	AIDS New Brunswick
Jonathan Angel	Canadian Association of HIV Research (CAHR)
James Blanchard	University of Manitoba
Chris Buchner	Vancouver Coastal Health (VCH)
Liviana Calzavara	The CIHR Social Research Centre in HIV Prevention (SRC)

Tara	Carnochan	Nine Circles Community Health Centre
Ken	Clement	Canadian Aboriginal AIDS Network (CAAN)
Curtis	Cooper	Ottawa Hospital Research Institute
André	Corriveau	Government of the Northwest Territories
Michelle	Crosby	Canadian Association of Hepatology Nurses (CAHN)
Ian	Culbert	Canadian Public Health Association (CPHA)
LeAnn	Dolan	Canadian Working Group on HIV and Rehabilitation (CWGHR)
Monique	Doolittle-Romas	Canadian AIDS Society (CAS)
Marilou	Gagnon	University of Ottawa
Scott	Harrison	Canadian Association for Nurses in AIDS Care (CANAC)
Evin	Jones	Pacific AIDS Network (PAN)
Rick	Kennedy	Ontario AIDS Network (OAN)
Susan	Kirkland	Atlantic Interdisciplinary Research Network (AIRN)
Akim Ade	Larcher	Canadian Treatment Action Council (CTAC)
Lisa	Lockie	Government of Saskatchewan
Frank	McGee	Ontario Ministry of Health and Long-Term Care
Deborah	Money	Oak Tree Clinic
Julio	Montaner	BC Centre for Excellence in HIV/AIDS (BC-CfE)
Ken	Monteith	COCQ-SIDA
Robin	Montgomery	Interagency Coalition on AIDS and Development (ICAD)
Tracy	O'Hearn	Pauktuutit
Joanne	Otis	L'Université du Québec à Montréal (UQAM)
Sean	Rourke	CIHR Centre for REACH in HIV/AIDS
Deb	Schmitz	Action Hepatitis Canada
Rita	Shahin	Toronto Public Health
Marc	Steben	Institut national de santé publique du Québec
Darryl	Tan	St. Michael's Hospital
Tom	Wong	Public Health Agency of Canada (PHAC)

## Appendix 2: CATIE Forum Program



COLLOQUE DE  
**CATIE** 2013  
FORUM

**New Science**   
**New Directions**  
in **HIV & HCV**

TORONTO SEPTEMBER  
18-19  
2013

THE EATON CHELSEA HOTEL  
Toronto, ON



[www.catie.ca/forum](http://www.catie.ca/forum)  
#CATIEforum



Canada's source for  
HIV and hepatitis C  
Information



**DAY ONE:**  
**Wednesday, September 18, 2013**



**7:30 | Registration and Continental Breakfast**

Churchill Foyer

**8:30 | Forum Opening and Welcome**



Churchill Ballroom



Trevor Stratton, CAAN & Mississaugas of the New Credit First Nation  
Laurie Edmiston, CATIE

**8:45 | Opening Plenary:**



*Setting the stage - perspectives on integration*

Churchill Ballroom



In this session, participants will be introduced to perspectives on the integration of research knowledge into programs, and the integration of services, sectors and systems. Through an exploration of personal perspectives in public health and service provision, we will learn how integration can improve client experience and outcomes.

Moderator: Tim Rogers, CATIE

Speakers:

- Tiffany LaDana West, DARE Global Innovations
- Murray Jose-Boerbridge, Toronto People With AIDS Foundation & Gay Men's Sexual Health Alliance

**9:45 | Integrating community services:**



*Designing programs to respond holistically to the needs of clients*



Churchill Ballroom

Integrated frontline programs will be presented which highlight the importance of using new research knowledge related to HIV and HCV in developing innovative services. How programs have successfully integrated HIV and HCV and/or the components of the continuum of care will also be discussed.

Moderator: Ed Jackson, CATIE

Speakers:

- Thomas Haig, SPOT
- Julie Kille, Immunodeficiency Clinic, St. Paul's Hospital
- Carla Pindera, Nine Circles Community Health Centre

10:30 | **Break**

Churchill Foyer

10:45 | **Integrating health systems:**



*Designing systems to respond holistically to the needs of clients*

Churchill Ballroom

Speakers will introduce three different regional integrated approaches to HIV or HCV. The presentations will include a discussion of how research has informed the strategies, as well as key challenges and successes of the implementation of systematic health systems integration.

Moderator: Laurie Edmiston, CATIE

Speakers:

- Chris Buchner, Vancouver Coastal Health
- Samantha Earl, Ontario Hepatitis C Strategy, Ontario Ministry of Health and Long-Term Care
- Lisa Lockie, Ministry of Health, Government of Saskatchewan

11:30 | **Integrating new knowledge:**



*Communicating sexual risk with people with HIV and people at risk*

Churchill Ballroom

New research on HIV transmission is changing the way we understand and communicate information about HIV risk. Four professionals with experience thinking about, and communicating, new scientific knowledge about HIV transmission will share their process of taking up new information and translating it into tools and services for sexual risk assessment and counselling.



**DAY ONE:**  
**Wednesday, September 18, 2013**



Moderator: Len Tooley, CATIE

Speakers:

- Ann Burchell, Risk Assessment Tool, OHTN
- Jody Jollimore, Do the Math, Health Initiative for Men
- Mona Loutfy, Communicating risk with serodiscordant couples, Maple Leaf Clinic
- Rahim Thawer, AIDS Committee of Toronto

**12:30 | Lunch**

Churchill Foyer and Ballroom

**1:30 | Integrating prevention, testing and care:**



*Reaching people who do not know their status*

Churchill Ballroom

Approximately 25% of people living with HIV do not know their status. Engaging and linking this population with HIV testing and other services is a priority in many regions. This session will include presentations in which frontline workers highlight new approaches to engaging people who are at high risk for HIV.

Moderator: Tsitsi Watt, CATIE

Speakers:

- Réka Gustafson, Implementing the routine offer of HIV testing in hospitals, Vancouver Coastal Health
- Lorette Dreaver, Big River First Nation
- Johnmark Opondo, Partner notification, Saskatoon Health Region

**2:15 | Integration:**



*Improving engagement and linkage to care for people living with HIV or HCV*

Churchill Ballroom

Moderator: Michael Bailey, CATIE

Aspects of our testing, treatment, care and support practice are often provided independently (in "silos"). The integration of these components requires reflection on how to engage individuals and communities

in the services that we provide. This session will explore how some programs have enhanced linkages across various services and improved engagement with people living with HIV or HCV.

Speakers:

- Cindy Maclsaac, Direction 180
- Glen Bradford, Peer Navigators, Positive Living BC
- Laurence Mersilian, Pause-Santé, CAPAHC
- Sam Milligan, Maximally Assisted Support Program, Central Interior Native Health Society
- Ivan Martinez Arredondo, STOP HIV/AIDS Outreach Team, Vancouver Coastal Health

3:00 | **Break**  
Churchill Foyer

3:30 | **Concurrent Sessions**

**Concurrent Session 1:**

En

*Communicating sexual risk with people living with, and at risk of, HIV*

Carlyle

This concurrent break-out builds on the *Communicating Sexual Risk* plenary session earlier in the day by presenting a number of scenarios (case studies) and inviting panellists and Forum participants to collectively brainstorm ways of communicating sexual risk of HIV transmission.

Facilitator: Len Tooley, CATIE

Panel Members:

- Ann Burchell, OHTN
- Jody Jollimore, Health Initiative for Men
- Mona Loutfy, Maple Leaf Clinic
- Rahim Thawer, AIDS Committee of Toronto

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**Concurrent Session 2:**

En/fr

*HIV, STI and hepatitis C testing and partner-notification strategies*

Rossetti

[ Bilingual CATIE Staff will assist with interpretation. ]

This session will begin with a short series of "Ignite Talks" on HIV, HCV and STI testing and partner-notification strategies. Following this, participants will engage in a facilitated discussion on engaging people who do not know their status, exploring engagement and linkage approaches important for success. This session will build on the *engaging people who do not know their status* plenary session that took place earlier in the day and offer participants the opportunity to investigate this topic more deeply.

Facilitator: Tsitsi Watt, CATIE

Speakers/Panel Members:

- Lyn Pierre-Pitman, HIV Point-of-Care Testing in Aboriginal Communities, London InterCommunity Health Centre
- Mark Randall, HEAT: Threeway in the Bathhouse, AIDS Calgary
- Claire O'Gorman, Know on the Go, YouthCO HIV & Hep C Society
- Martine Stomp, Integrated Hepatitis C Testing, Sanguen Centre
- Bruce Clarke, Partner Notification with InSpot, Toronto Public Health

Panel Members:

- Réka Gustafson, Vancouver Coastal Health
- Lorrette Dreaver, Big River First Nation
- Johnmark Opondo, Saskatoon Health Region

### Concurrent Session 3:

#### *Peer Mentoring and Health Navigation*

Churchill Ballroom

En/Fr



This session will begin with a short series of "Ignite Talks" on peer mentoring, peer navigation and health navigation programs. Following this, participants will engage in a facilitated discussion on engaging people who are living with HIV or hepatitis C in treatment, care and support through these types of programs.

Facilitator: Thomas Egdorf, CATIE

Panel Members:

- Kira Haug, Health Navigator/Health Services, ASK Wellness Centre
- Nicole Bachynski, Peer to Peer Program, Regina Qu'Appelle Health Region
- Maureen Ringlein, Prenatal Group, Teresa Group
- Sylvain Beaudry, My Life with HIV, ACCM
- Rick Julien, Peer-Facilitated HIV Treatment Decisions, Toronto People With AIDS Foundation
- Danièle Dubuc, The Street Messenger Project, Cactus Montreal
- Glen Bradford, Peer Navigation Services, Positive Living BC

### Concurrent Session 4:

#### *Nurse and other healthcare provider education and mentoring*

Scott

En

Co-led by CATIE, the Canadian Association of Nurses in AIDS Care (CANAC) and the Canadian Association of Hepatology Nurses (CAHN).

The rapid evolution of our healthcare system and the demand for new health-related knowledge pose challenges to nurses and other healthcare providers to stay current in their professions. Education and mentorship initiatives have an important role to play in strengthening professional expertise and supporting the best possible provision of care to patients.

**DAY ONE:**  
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This session will begin with a series of “Ignite Talks” highlighting examples of nurse and other healthcare provider education or mentorship programs. Following this, participants will engage in a facilitated discussion on various approaches to education and mentorship, as well as key issues related to these approaches. These issues include developing a baseline of HIV or hepatitis C knowledge, challenges and successes in learning across borders, the involvement of people living with HIV and/or hepatitis C as ‘peers’ in education, and how providers in HIV and hepatitis C care may more effectively learn from each other.

Facilitator: Lara Barker, CATIE

Panel Members:

- Susanne Nasewich, Pacific to Prairies Partnership, Regina Qu’Appelle Health Region
- Michelle Crosby, Canadian Association of Hepatology Nurses
- Christina Clarke, HIV Quality Improvement Network, BC-CfE
- Vera Caine, A Critical Look at a Mentorship Model for Health Care Professions, University of Alberta
- Jane McCall, Caring for Clients who are at Risk for and Living with HIV/AIDS: Best Practices, CANAC
- Diane Sylvain & Kathy Tremblay, Programme National de Mentorat sur le VIH-Sida

#### **Concurrent Session 5:**

En

*The integration of HIV and HCV services within community-health and AIDS-service organizations*

Wren

Co-led by CATIE and CTAC

The introduction of hepatitis C services into community-health and HIV-focused organizations does not “just happen” but can represent

a sometimes complex and lengthy process. This session will explore the relevance, feasibility and challenges of adopting this integrated approach from the perspective of the health needs of the service user. Preliminary results from CTAC's project to develop a *Good Practices Guide to HIV-HCV Integration* will be presented to guide the discussion, with added commentary from organizations directly engaged in integration efforts.

Facilitators: Paul Sutton, CTAC & Ed Jackson, CATIE

5:00 | **Networking Reception**

Market Garden Court (first floor)



**DAY TWO:**  
**Thursday, September 19, 2013**

7:30 | **Registration and Continental Breakfast**

Churchill Foyer

9:00 | **Welcome**

Churchill Ballroom



Laurie Edmiston, CATIE

9:15 | **Integration of HIV, HCV and other STBBIs:**

*Evidence and practicality*

Churchill Ballroom



This session will explore what integration of HIV and HCV in the context of other sexually transmitted and blood-borne infections means, and the rationale for fully-integrated services. This session will also discuss the existing evidence on the effectiveness of practices to support delivery of integrated services and relevance to a Canadian context.

Moderator: Laurie Edmiston, CATIE

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**DAY TWO:**  
**Thursday, September 19, 2013**



Speakers:

- Dana Paquette, Public Health Agency of Canada
- Marc Steben, Institut national de santé publique du Québec
- Gina Ogilvie, Clinical Prevention Services, BC Centre for Disease Control
- Brian Lester, Regional HIV/AIDS Connection

10:30 | **Break**

Churchill Foyer

10:45 | **Integration of HIV, HCV, STBBIs and other health factors:**

*Examples from practice*

Churchill Ballroom



This session will include a series of "Ignite Talks" focused on sexual health and harm reduction programs that demonstrate various forms of integration, including the integration of HIV, HCV or STBBI services with other health factors. These talks will inform discussion sessions taking place later in the day.

Moderator: Ed Jackson, CATIE

Speakers: *Integrated Harm Reduction Programs*

- Darwin Fisher, Insite, Portland Hotel Society
- Suzanne Pierlot, Outreach Urban Health, Interior Health
- Michelle Crosby, Positive Wellness North Island: North Island HIV & HCV Services, Vancouver Island Health Authority: Positive Wellness North Island
- Keri-McGuire-Trahan, Hepatitis C Triple Therapy Program, AIDS Committee of North Bay and Area
- Lorrie Dodwell, Delivering Culturally Sensitive Care and Support, Ahtakakoop First Nation Health Centre

Speakers: *Integrated Sexual Health Programs*

- David Lessard, l'Actuel sur Rue, Clinique médicale l'Actuel
- Pierre-Yves Comtois, S'Exposer, Portail VIH/sida du Québec
- Lyne Massie, Pouvoir Partager/Pouvoirs Partagés, UQAM
- Gina McKay, SERC (Sexuality Education Resource Centre)

11:45 | **Lunch**

Churchill Foyer and Ballroom

12:45 | **Concurrent Sessions**

**Concurrent Session 1:**

En

*What might integrated services for gay, bisexual and other MSM look like?*

Carlyle

Across Canada, programs and services for two-spirit, gay, bisexual and other men who have sex with men range from a strong focus on HIV prevention to services that address gay men's health more broadly. What should we aim to achieve in creating integrated services for these populations? How can the values and goals of a gay men's health movement be introduced and made accessible to new people in the community?

Participants will be presented with a number of 'catalyst presentations' to spark discussion about what these services might look like. A special focus on newcomer and immigrant men who have sex with men will provide an opportunity to think about how programs and services for populations can be tailored to individuals with unique histories and needs.

Facilitators: Hywel Tuscano, CATIE & Len Tooley, CATIE

Speaker: Bill Ryan, McGill University

**DAY TWO:**  
Thursday, September 19, 2013



**Concurrent Session 2:**

En/fr

*Integrated Health Services for Women and Trans People:  
Challenges and Opportunities*

Wren

[ Bilingual CATIE Staff will assist with interpretation. ]

Throughout the history of the HIV epidemic, women and trans people have fought to ensure that their diverse needs be adequately understood and comprehensively addressed. The move towards an integrated approach to health services offers an opportunity to assess existing and new models of service delivery, and to examine the challenges and opportunities that these might offer for women and trans people and their service providers.

The session will begin with a series of short presentations that will raise key issues and provide tangible examples of integrated approaches to health services for women and trans people, which are currently underway in different parts of Canada. Through facilitated discussions in small groups, participants will have the opportunity to explore these issues and share their own experiences, working together to develop a realistic understanding of the challenges, strengths and possibilities offered by integrated approaches to health-service delivery for women and trans people.

Facilitators: Sophie Wertheimer, CATIE & Louise Binder, International Community of Women Living with HIV/AIDS North America

**Concurrent Session 3:**

En

*Practical approaches to integrated health services  
for Aboriginal communities*

Rossetti

Co-led by CATIE and Canadian Aboriginal AIDS Network (CAAN)

This session is being co-hosted by CAAN and CATIE to facilitate a discussion on the unique implications of an integrated STBBI approach by organizations and clinics serving Aboriginal communities across

Canada. This session will explore what culturally-appropriate integrated models look like, the issues and challenges with providing integrated services and some practical ways to overcome these challenges.

Facilitators: Ed Bennett, CAAN & Art Zoccole, CAAN

#### **Concurrent Session 4:**



#### *Practical approaches to integrated health services in a harm-reduction context*

Churchill Ballroom

This session will focus on the implications of integration for our harm-reduction work. It will provide participants with an opportunity to learn about HIV, HCV and STBI integration, and the integration of our HIV and HCV work with other health conditions, in the context of working with people who use drugs. Participants will reflect on what others have done to address the needs of people who use drugs through integrated approaches, consider challenges faced, and discuss what “integration” can really look like in a harm-reduction context.

Facilitators: Tsitsi Watt, CATIE & Barb Panter, CATIE

#### **Concurrent Session 5:**



#### *Moving intervention research forward in Canada*

Scott

Organized with support from REACH, SRC, CIHR, PHAC and CAAN

This session will focus on how we can effectively move intervention research forward in Canada to support integrated approaches to prevention, testing, treatment, care and support. Speakers will provide short presentations on the work of their organizations in HIV intervention research and what priorities they see for Canada. Speakers will act as key participants in the following facilitated discussion.

Facilitator: Tim Rogers, CATIE

Speakers:

- Dana Paquette, Public Health Agency of Canada
- Jennifer Gunning, Canadian Institutes of Health Research
- Liviana Calzavara, CIHR Social Research Centre in HIV Prevention
- Renee Masching, Aboriginal HIV & AIDS Community-Based Research Collaborative Centre
- Jean Bacon, CIHR Centre for REACH (Research Evidence into Action for Community Health)

2:30 | **Break**

2:45 | **Closing Plenary:**



*What should our services look like five years from now?*

Churchill Ballroom

What might the knowledge shared at the CATIE Forum mean for practice in Canada in the future? This session will offer insight into the perspectives of six passionate HIV and hepatitis C leaders on what the future of HIV and HCV prevention, testing, treatment, care and support practice for people affected by HIV and hepatitis C might look like. They will challenge us to consider what we can learn from each other and what else we can do to address these epidemics.

Moderator: Laurie Edmiston, CATIE

Speakers:

- |                      |                |
|----------------------|----------------|
| - Ezra James         | - Cheryl Reitz |
| - Marvelous Muchenje | - Mario Gagnon |
| - Trevor Stratton    | - Bob Leahy    |

4:00 – 4:15 | **Thank You and Closing**



Churchill Ballroom

Laurie Edmiston, CATIE

## Appendix 3: Webinar Evaluation Form

### We would like your feedback!

Thank you for taking the time to fill out this evaluation form. This information will be used to evaluate the webinar series and to improve any future events. Please mark only one answer per question. Some of the questions may not be relevant to you – for these questions please mark not applicable (NA).

- 1. We need to evaluate each of our webinars separately. Please select the webinar you are evaluating. If you want to evaluate more than one webinar please fill out a form for each webinar attended.**

<i>Date</i>	<i>Name</i>
June 6, 2013/ June 11, 2013	New developments in HIV research and their implications for frontline practice/ Nouveaux développements en recherche sur le VIH et leurs répercussions sur la pratique de première
June 17, 2013/ June 20, 2013	New developments in HCV research and their implications for frontline practice/ Nouveaux développements en recherche sur le VHC et leurs répercussions sur la pratique de première ligne
July 9, 2013/July 11, 2013	Integrated approaches to HIV treatment and prevention / Approches intégrées du traitement et de la prévention du VIH
July 22, 2013/ July 24, 2013	Working from a sexual health or harm reduction perspective: Integration of HIV, HCV, tuberculosis and other sexually transmitted and blood-borne infections/ Travailler du point de vue de la santé sexuelle ou de la réduction des méfaits : Intégration du VIH, du VHC, de la tuberculose et des autres infections transmissibles sexuellement et par le sang

- 2. Please indicate your agreement with the following statements.**

	<b>Strongly disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly agree</b>	<b>NA</b>
The webinar was well presented.	<input type="checkbox"/>				
The webinar presenter(s) was knowledgeable about the topic being discussed.	<input type="checkbox"/>				
The webinar was appropriate for me.	<input type="checkbox"/>				
The webinar content was relevant to me/the work that I do.	<input type="checkbox"/>				
I would recommend this webinar to my co-workers/friends.	<input type="checkbox"/>				
I will use/apply the knowledge gained at this webinar in my work/my life.	<input type="checkbox"/>				
The webinar increased my capacity to respond to HIV and/or Hepatitis C within	<input type="checkbox"/>				

my community and/or my personal life.					
Overall, the webinar increased my knowledge of HIV and/or Hepatitis C.	<input type="checkbox"/>				
The technology was easy to use.	<input type="checkbox"/>				
The webinar was conducive to learning.	<input type="checkbox"/>				
I liked the webinar format.	<input type="checkbox"/>				

**3. On a scale of 1 to 10 please rate your knowledge of HIV and/or Hepatitis C BEFORE this webinar:**

No Knowledge									Expert Knowledge
1	2	3	4	5	6	7	8	9	10

**4. On a scale of 1 to 10 please rate your knowledge of HIV and/or Hepatitis C AFTER this webinar:**

No Knowledge									Expert Knowledge
1	2	3	4	5	6	7	8	9	10

**5. Overall, how satisfied were you with this webinar?**

dissatisfied    somewhat satisfied    satisfied    very satisfied

**6. Overall, how useful was the webinar for you/the work that you do?**

not useful    somewhat useful    useful    very useful

**7. For my experience level, the webinar was:**

too basic    about right    too advanced

**8. At your location, how many viewed the webinar from the same computer?**

I viewed it myself

Two (including yourself)

Three (including yourself)

More than 3 (please specify)

**9. How would you best describe the organization in which you work?**

AIDS service Organization (ASO)

- Community health centre
- Other community based organization
- Public health unit/sexual health clinic
- Government organizations (other than public health unit)
- Clinic/Hospital
- Corrections
- Academic/University
- Not applicable
- Other (please specify) \_\_\_\_\_

10. How might you use the information you received at this webinar in your work/life?

11. What is the main benefit of this webinar for you/your organization?

**Thank you for your time and effort!**

All responses are confidential and will be used to improve the services CATIE offers.

Please return this form to a CATIE representative.

## Appendix 4: In-person Evaluation Form

### New Science, New Directions in HIV & HCV

#### We would like your feedback on this Forum!

Thank you for taking the time to fill out this evaluation form. Please circle only one answer per question.

**1. Please rate how useful each of the sessions were for the work that you do. Please only rate the ones you attended.**

	Not useful	Somewhat useful	Useful	Very useful	Didn't attend	Don't know
Opening plenary: Setting the stage – perspectives on integration  (Sept. 18, 8:45-9:45 am)	<input type="checkbox"/>					
Integrating community services: Designing programs to respond holistically to the needs of clients  (Sept 18, 9:45-10:30 am)	<input type="checkbox"/>					
Integrating health systems: Designing systems to respond holistically to the needs of clients  (Sept 18, 10:45-11:30 am)	<input type="checkbox"/>					
Integrating new knowledge: Communicating sexual risk with people with HIV and people at risk  (Sept 18 11:30 am-12:30 pm)	<input type="checkbox"/>					
Integrating prevention, testing and care: Reaching people who do not know their status  (Sept 18, 1:30-2:15 pm)	<input type="checkbox"/>					
Integration: Improving engagement and linkage to care for people living with HIV or HCV  (Sept 18, 2:15 -3:00 pm)	<input type="checkbox"/>					

Concurrent Sessions (Sept 18, 3:30-5:00 pm)	<input type="checkbox"/>					
Integration of HIV, HCV and other STBBIs: Evidence and practicality (Sept 19, 9:15-10:30 am)	<input type="checkbox"/>					
Integration of HIV, HCV, STBIBIs and other health factors: Examples from practice (Sept 19, 10:45 -11:45 am)	<input type="checkbox"/>					
Concurrent Sessions (Sept 19, 12:45-2:30 pm)	<input type="checkbox"/>					
Closing plenary: What should our services look like five years from now? (Sept 19, 2:45-4:00 pm)	<input type="checkbox"/>					

*The following questions are about the forum. Please check the box that best reflects your response.*

	<b>Strongly disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly agree</b>	<b>NA</b>
The forum was well organized.	<input type="checkbox"/>				
The forum was appropriate for me.	<input type="checkbox"/>				
The forum was relevant to the work of my organization.	<input type="checkbox"/>				
This forum provided an opportunity to network with others.	<input type="checkbox"/>				
The forum increased my knowledge of new directions in HIV and/or HCV programming.	<input type="checkbox"/>				
The forum increased my capacity to respond to HIV and/or HCV within my community.	<input type="checkbox"/>				
I will use/apply the knowledge gained through this forum in my work.	<input type="checkbox"/>				
I would recommend CATIE continue to offer this type of event.	<input type="checkbox"/>				

**2. Overall, how satisfied were you with the forum?**

Dissatisfied  Somewhat Satisfied  Satisfied  Very Satisfied

**3. Overall, how useful was the forum for the work that you do?**

Not Useful  Somewhat Useful  Useful  Very Useful

**4. How would you best describe the organization in which you work?**

- AIDS Service Organization (ASO)
- Community health centre
- Other community-based organization
- Public health unit/sexual health clinic
- Government organizations (other than public health unit)
- Clinic/Hospital
- Corrections
- Academic/University
- Not applicable
- Other (please specify) \_\_\_\_\_

**5. Please provide one example of how participation in this forum might inform the work that you do.**

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**6. What was useful about this forum?**

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**7. What do you think would have made the CATIE Forum better?**

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**Thank you for your time and effort!**

All responses are confidential and will be used to improve the services CATIE offers.

Please return this form to a CATIE representative.