National Collaborating Centre for Infectious Diseases

Centre de collaboration nationale des maladies infectieuses

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PLAINS SPEAK on STBBIs, 2019

An emergent challenge for the Prairies

GIFT THAT KEEPS ON GIVING STI THE POX THE GREAT IMMITATOR CRABS THE BUG THE SYPH GOOEY STUFF THE DOSE HI-V STBBI CLAP THE THE BUG THE SYPH GOOEY

Meeting Report

March 14 & 15, 2019

Prepared by

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Plains Speak on STBBIs 2019

Meeting Report

Marcy 14 & 15, 2019

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Introduction

Sexually transmitted and blood borne infection (STBBI) rates—including syphilis, gonorrhea (NG), hepatitis B (HBV), hepatitis C (HCV), and human immunodeficiency virus (HIV)—are rapidly increasing in the Prairie provinces. Public health professionals are struggling to set programmatic priorities and identify the best interventions to suit the epidemiological context to decrease the burden of infections. Currently in the Prairies, individuals affected by STBBIs frequently present with co-infections and become re-infected. Infections are increasingly associated with challenging circumstances, including unstable housing and substance use, which contribute to onward transmission and complicate public health management.

The National Collaborating Centre for Infectious Diseases, with the support of the National Collaborating Centre for Aboriginal Health, hosted a gathering on March 14 & 15th, 2019, in Winnipeg, Manitoba to provide a space for knowledge exchange regarding successful programming and interventions for STBBI prevention and response within the Prairie context. This forum brought together public health specialists from the Prairie Provinces, British Columbia (BC), and northern Ontario (ON), including practitioners, managers, program coordinators, epidemiologists, researchers, policy makers, community-based partners and knowledge brokers.

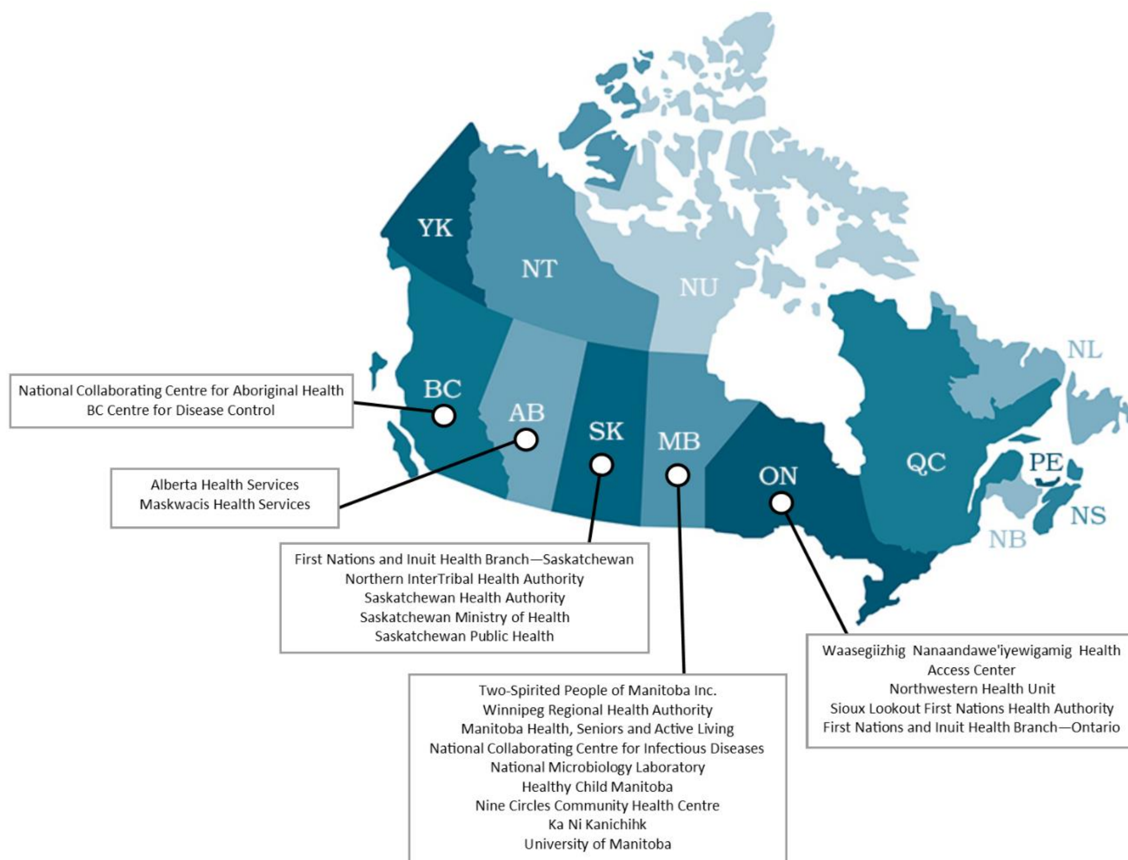

Figure 1. Participants at Plains Speak on STBBIs came from the Prairie Provinces, northern Ontario and British Columbia.

Objectives of the Meeting

Working in collaboration and consultation with potential guests and other experts in the weeks preceding the forum, four objectives for the gathering were determined:

- To share knowledge of the current drivers, determinants, and trends of STBBIs in the Prairies.
- To share and explore features of successful STBBI responses.
- To explore interventions to decrease STBBI transmission in people who are disadvantaged by social and structural factors such as problematic substance use and poverty.
- To spark discussions towards essential elements for building sustainable public health infrastructure to prevent and rapidly respond to STBBIs.

Please see the Appendix A for the full agenda.

Day 1 - March 14, 2019

Opening -- Acknowledgement of the Land and Welcome to the Territory

On the evening of March 14th, 2019, *Plains Speak on STBBIs* began with an acknowledgement of the land honoring the gathering on Treaty 1 Territory as the traditional lands of the Anishinaabeg, Cree, Oji-Cree, Dakota, Dene peoples, and on the homeland of the Métis Nation. After the acknowledgement, Elder and Co-director of Two-Spirited People of Manitoba Inc., Albert McLeod, provided a welcome to the territory, recognizing the gifts of the people in the room. Sage was burned to honour the individuals deliberating about the human realities and complexities of STBBIs in the Prairie Provinces, but also to honour all people and diversity, and the unique history that every person contributes.

An Overview of the Provincial Epidemiological Contexts

The purpose of the presentations given in the first evening was to set the context with up-to-date information on the status of STBBIs in the Prairie Provinces. Presentations began with Alberta (AB), Saskatchewan (SK), and Manitoba (MB) presenting their provincial epidemiological contexts of increasing rates of syphilis, gonorrhea (NG), HCV, chlamydia (CT) in AB and SK, and HBV in MB, including significant co-infection rates. Provinces discussed ongoing but stable syphilis outbreaks in men who have sex with men (MSM), but identified new outbreaks affecting young heterosexual people and particularly young women, increasing the risk for congenital syphilis and other pre- and post- natal sequelae. Common risk factors for STBBIs included problematic substance use (methamphetamine and injection drug use), unstable housing, and incarceration in AB and MB. Indigenous people were

identified as being disproportionately affected by STBBIs in the Prairies and common contributing disparities discussed included racism, poverty, history of colonization, and resulting chronic disengagement and lack of trust in the healthcare system. These risk factors were termed as syndemics of the current STBBI outbreak.

Common challenges raised by presenters included a lack of resources to respond to current STBBI numbers; the contributing complexity of syphilis management including co-infections, re-infections, and a decreased ability to find and follow up with syphilis cases; a lack of connection to care or follow up for individuals who have already tested positive for STBBIs; and the added complexity of affected populations already struggling and affected by structural violence.

Saskatchewan: Johnmark Opondo, Medical Health Officer and Medical Director of Communicable Disease Prevention and Control at the Saskatchewan Health Authority, described the province of SK as a demographically young province, with larger proportions of Indigenous people than the rest of Canada (10.7 % vs. 2.8%). SK continues to have the highest (though declining) rates of HIV and HCV in Canada, but Dr. Opondo stated that there have been many improvements since 2010 and the beginning of the HIV epidemic. Despite governmental coverage for HIV and HCV treatment, SK continues to be challenged in how to engage people in care. Dr. Opondo noted currently low, but sharply rising syphilis infection rates, as well as increasing rates of NG and CT. He discussed the role of social media in creating new relationships with mobile phone applications such as Grindr and Tindr, and noted that there is a lack of a digital strategy to respond.

Manitoba: Carla Loeppky (epidemiologist, Manitoba Health), Souradet Shaw (epidemiologist, Winnipeg Regional Health Authority), and Michael Isaac (Chief Medical Officer of Health, Manitoba Health) highlighted a 2-3 fold increase in syphilis infections in MB in the last year. They are concerned about the 34-fold increase in young women affected since 2014 and the number of co-infections, but also that 11% of female cases of syphilis are pregnant. The province is experiencing a resurgence of congenital syphilis cases. They outlined the difficulty in keeping up with the increasing rates in terms of clinical and surveillance human capacity as traditional response is not keeping up with cases and contacts. They have created an incident command system for response and have created a STBBI outbreak response committee with five expert task groups to identify priorities and work to respond to increasing STBBIs.

Alberta: Jennifer Gratrix, AB Health Services Public Health Program Manager, presented Alberta's modest increases in CT, rising NG rates since 2015, and now an epidemiological shift and spike in 2018 of syphilis infections affecting heterosexual people, particularly in Edmonton. AB is also experiencing increasing cases of congenital syphilis and is responding with a prenatal syphilis public health nursing position to manage infections. The context in Alberta includes the current economic downturn resulting in increased unemployment, increase of problematic use of methamphetamine, and the opioid crisis. They identified one of their challenges as ongoing awareness of STBBI outbreaks and ask the question, how do we continue to keep people engaged or interested in a multi-year outbreak scenario?

See Appendix B for a list of Interventions for current STBBI outbreaks presented by the Prairie Provinces.

Stories From the Ground

The objective of these informal presentations was to provide an overview of the social and structural context including strengths, challenges, and needs for individuals with increased opportunity for acquiring STBBIs in the Prairie Provinces. Three frontline service providers described what they see day-to-day on the ground and discussed strengths and challenges of the individuals affected.

Nine Circles Community Health Centre, Winnipeg: Tania Wiebe, Health Promotion Coordinator, discussed experiences in harm reduction work and creating a welcoming space for people who are using substances or with unstable housing. She discussed the importance of understanding that many clients have immediate needs that have to be addressed and STBBIs are not always their immediate priority.

STI Outreach, Alberta Health Services, Edmonton: Garret Meyer, Outreach STI Nurse, discussed his experiences as a STBBI outreach nurse, where he often deals with individuals with problematic substance use and/or experiencing mental wellness issues. He outlined clients' challenges related to shelter and food, making STBBIs low on their priority list. He pointed out that stigma, fear, and previous trauma contribute to avoidance of STBBI healthcare. He discussed building working relationships with people and identifying individual's strengths and using those strengths to move forward.

Ka Ni Kanichihk, Winnipeg: Laverne Gervais, Program Coordinator, discussed experiences with people accessing services at the Indigenous led community organization Ka Ni Kanichihk, and encountering many stories of Indigenous women who have had negative encounters with healthcare, particularly with regard to the stigma of STBBIs. She stated that many people would rather not know their STBBI status and don't want another negative label placed on them. She outlined the strength of Indigenous people in spite of all of the difficulties and noted that Indigenous people are resilient and continue to move forward. She stated it is challenging to get people to understand that the increased rates of STBBIs in Indigenous people are due to colonialism and the negative effects of healthcare.

Day 2-March 15, 2019

Opening -- Acknowledgement of the Land and Welcome to the Territory

The morning of March 15, 2019 began with a welcome from Elder Albert McLeod. He honoured the individuals in the room coming together to collaborate to make the best decisions from knowledge and experience, but also discussed drawing on the guidance of Elders as well as the spirits for help and guidance. He stated that many cultures have these belief systems that each person has a spiritual component. He talked about acknowledging that while discussions in the room are about science

(diagnosis and treatment), it needs to be considered that for others including Indigenous people, the spiritual world is real and the efficacy of that belief system has been experienced for thousands of years.

The Structure of STBBI Programming and the BC Experience

The morning continued with Jason Wong, physician epidemiologist from the British Columbia Centre for Disease Control (BCCDC), presenting on building public health infrastructure and the BC experience. Dr. Wong began by recognising the increasing STBBI rates in the province of BC as similar to the Prairie Provinces. He used the example of syphilis to outline BC's centralized system for testing, diagnosis, treatment, and surveillance (STBBI physician, nurses, laboratory staff, and epidemiologists in the same building) and how this has benefited the construction or creation of infrastructure to support communicable disease response.

Dr. Wong discussed how BC has created multiple data sets through centralized management, stakeholder engagement and partnerships, a data governance and stewardship model, algorithm development, and common data structure that inform BC public health programming. The STIBBI data mart uses enhanced syphilis surveillance data since 2016 to understand social networking contributing to syphilis transmission. Case data and laboratory data are linked to testing episodes by a probabilistic algorithm and assigned a unique identifier that changes daily and can be accessed by authorized users to create quarterly syphilis indicator reports and partner notification cascades.

BCCDC is also currently constructing an Integrated Data and Enhanced Analytics (IDEA) cohort including all STBBI and tuberculosis cases that will be linked to administrative data, prescription dispensing data, cancer registry, and vital statistics that will be updated every 6-24 months (depending on the data set) and used for longer term planning.

Dr. Wong discussed how these data were used to create a syphilis action plan that includes spatiotemporal epidemiology, understanding networks, piloting new testing techniques, monitoring time to syphilis treatment, enhancing support for people living with or at risk for syphilis, improving partner notification, and developing new syphilis prevention strategies. They have tried to think outside of syphilis infection as the ultimate end point to better understand syndemics and STBBI risk.

Rich discussion from this presentation included questions about the skills required to build data structures, strategies for addressing problematic substance use and intimate partner violence, authority for data agreements, providing value for stakeholders, funding strategies, as well as BC's current epidemiology and a potential shift of syphilis infections towards women and infants (as has been seen in the Prairie Provinces).

Innovative Interventions: Sharing Successes & Failures

The objective of this session was to provide an opportunity to share successes, failures, and challenges around specific interventions or approaches in the Prairie Provinces, with a focus on evaluation.

Test One, Test All – SK: Janice Seebach, Nurse Clinician and Johnmark Opondo from the SK Health Authority Population and Public Health in Saskatoon, presented on the *Test One, Test All* strategy that was implemented as a prevention measure for STBBIs and syphilis. They created syphilis presentations with visual information and tools for healthcare providers that included client messaging for testing guidelines and public health follow up. Their message is for comprehensive STBBI testing including urine, serology, and tri-site testing for NG/CT, when indicated.

Assertive Syphilis Testing Strategy - MB: Alicia Lapple, Communicable Disease Coordinator from the Winnipeg Regional Health Authority (WRHA), presented on the assertive syphilis testing intervention that was implemented in 2015 based on evidence reviews and mathematical modelling. The WRHA, along with primary care partners, reminded men diagnosed with syphilis to test for all STBBIs every 3 months due to evidence that individuals diagnosed with syphilis are at higher risk for re-infection. On evaluation, the strategy was successful in identifying repeat infections and therefore averted syphilis transmission. They attributed the strategy to potentially decreasing syphilis infections in MSM, but have had to discontinue the intervention due to lack of capacity and increased challenges in following up with current cases of syphilis.

Questions and discussion addressed unstable housing and the current difficulty in following up with syphilis cases. The WRHA is currently encouraging ongoing STBBI testing every 3 months without reminders as well as encouraging primary care partners to test quarterly. They identified the challenge that primary care partners are also struggling with high number of syphilis cases and capacity. A question arose about adopting universal testing guidelines to decrease stigma since syphilis is affecting both MSM and heterosexual people. Manitoba answered that the provincial lab does not have the capacity for this number of tests currently and that people who are diagnosed with syphilis are struggling with feeling safe in healthcare and being STBBI tested. Therefore, universal screening will likely not reach the people they need to reach.

Syphilis Intervention in the North - MB: Tammy Stuart Chester, Senior Public Health Officer-epidemiologist, presented on syphilis interventions in the Northern Regional Health Authority after the start of a heterosexual outbreak in 2014 and concern regarding congenital syphilis. Response included enhanced surveillance, location data regarding case and contact connections, policy changes specifically for women including recommending STBBI testing 3 times in pregnancy, and campaigns for practitioners and the community. Evaluation of interventions have been initiated, but have not been yet conducted.

Questions arose about how to evaluate healthcare provider compliance and Dr. Stuart Chester answered that they are thinking of looking at compliance with treatment according to guidelines as well as laboratory information. There were also questions regarding the evaluation question of a presented poster that led to discussion about posters addressing many different types of sex in homosexual, bisexual, and heterosexual people. There was discussion about digital platform use versus poster presentation. Manitoba used data regarding where people were meeting to decide to use posters rather than digital platforms, but acknowledge the use of digital platforms would be valuable in other circumstances.

DBS in Western Canada- NML: John Kim, Chief of the Public Health Agency of Canada National HIV and Retrovirus Laboratories Division, spoke about Saskatoon Tribal Council Indigenous-led STBBI dried blood spot (DBS) testing initiatives in communities as well as other DBS initiatives across Canada. DBS testing is currently validated for HBV, HCV, HIV, and there is work toward validation for syphilis. There is the potential to validate for other markers including hemoglobin A1C and latent TB. Dr. Kim suggested the potential for drone delivery of specimens from rural communities.

Dr. Kim answered questions about CT and NG testing being available by DBS. There was also a question about the comparability of tests and communities having the information to choose methods of testing and the implications for treatment and management of these tests. Dr. Kim discussed, in their experience, of rapid tests being less acceptable in rural environments, and DBS has been more accepted. Grace Akinjobi, Public Health Program Manager for Northern Inter-Tribal Health Authority (NITHA), agreed with this and stated that rapid testing is generally not as acceptable as DBS in rural and remote northern SK because most clients are not often ready for positive results and need time to prepare.

Incentivized Testing Program - AB: Penny Parker (Manager) and Garret Meyer (Outreach Nurse) from the Edmonton STI Clinic presented on their initiative of providing $10 gift cards as incentives for STBBI testing and treatment in hard-to-reach populations. Since the program started on October 18, 2018, testing volume has increased. They recorded over 498 visits, and 342 clients received incentives of which 61 % returned for their test results. The program identified 82 positive STBBI results.

A comment from SK was that incentives have been used in SK for case management for HCV and HIV via prepaid phones that increased access to clients. There has been pushback because the thought is that incentives will be expected for engagement in care. SK asked about the Alberta experience in this regard. Alberta stated that it has helped build relationships, but their experience is that people haven’t always expected incentives and they are promoting it as a temporary initiative, though they have had people present looking for gift cards.

Data to Care Model - SK: Johnmark Opondo presented about using HIV surveillance data to re-engage persons in HIV care. He discussed the details of data used to identify individuals not in care in SK, policy level support from recommendations from the piloted projects, and information sharing with clinical teams for HIV case management with ongoing communication with public health. The project has increased the number of individuals in care in Saskatoon from 2017 to 2018.

Dr. Opondo ended the presentation with a discussion and question regarding whether viral suppression less than 200 copies per milliliter of blood was sufficient to prevent transmission by injection drug use. He questions whether <40 copies/ml should be used as a standard.

Group Activity/Think Tank

For the Think Tank exercise, participants selected to join a topic discussion group, relating to people significantly affected in the current epidemiology of STBBI rates in the Prairie Provinces. Organically, two groups formed to discuss supports and partnerships for Indigenous people with increased opportunities for STBBI acquisition, and one group focussed on supports and partnerships for people dealing with problematic substance use. The objective of this exercise was to encourage contribution from all participants to discuss barriers and challenges, share successful existing interventions, and to determine new strategies that can be adapted to their local context. The groups addressed the following questions:

1) What are barriers to achieving decreased burden of STBBIs in your chosen group?
2) Discuss successful partnerships and/or strategies that are currently implemented in prevention and response. Indicate if they are evaluated.
3) What are short term and long-term public health strategies to prevent STBBIs in your chosen group?
4) What are short term and long-term public health strategies to respond to STBBIs in your chosen group? (Note that short and long term strategies were not differentiated in group responses.)
5) What could be indicators to measure effectiveness? Could they be common indicators for the Prairie Provinces?

The following are summaries of these table discussions:

Supports and Partnerships for Indigenous people: In discussions regarding supports and partnerships for Indigenous people with increased opportunities for STBBIs, the group first identified barriers to reducing the burden of STBBIs. These barriers were identified as a lack of access to care in urban and rural environments or lack of access due to lack of trust in the health system from past negative or traumatic experiences, systemic stigma regarding STBBIs or using drugs, and systemic racism. They also identified barriers resulting from fragmented health systems, lack of information and education in

communities, as well as service provider hesitation or non-acceptance of Indigenous knowledge. Overall, a lack of connection between health systems and Indigenous people was communicated.

The majority of interventions discussed as successful with Indigenous people with increased opportunity for STBBIs were interventions where Indigenous communities meaningfully contributed to decision making or led the intervention or program. Other interventions that were seen as successful were the evaluated incentive testing and treatment STBBI outreach program in Edmonton, using social media as a mode to contact and connect with individuals, and a shared provincial electronic medical record.

Supports and Partnerships for people struggling with problematic substance use: The third group discussed supports and partnerships for individuals using substances problematically with increased opportunities for STBBI transmission. They identified barriers to decreasing the burden of STBBIs as lack of access due to other priorities or due to previous negative experiences with the health system, that many solutions are often beyond the health system, that there is push back in harm reduction policy and strategies, and harm reduction is not incorporated into all areas of healthcare. They also discussed lack of messaging and information about substance use (particularly crystal meth) and lack of connection to services or relationships with people who are problematically using substances.

Successful interventions for people problematically using substances in the prairies were identified as social work services embedded in public health, using incentives for STBBI screening and treatment, and building capacity for harm reduction in other parts of the health sector including primary and acute care such as the Addiction Recovery and Community Health (ARCH) program in AB. It was outlined that the best way to find solutions is to ask people and listen to what they say will help them.

See Appendix C for notes from group discussion.

World Café Session - Partner notification: History and moving forward

The objective of this session was to share and discuss experiences across jurisdictions, best practices, prioritization, evaluation, as well as innovation and evidence in the area of Partner Notification (PN). The discussions underscored the need for technology to quickly and efficiently share information regarding STBBIs, to notify contacts in an era of digital communication, and for real time surveillance and efficient evaluation of partner notification interventions. Most jurisdictions are using paper forms that require data entry and are operating with computer systems and software that do not communicate. It was noted in one jurisdiction that PN does not seem to be affecting numbers and rates and highlights that evaluation is essential to understand what is working and what is not effective in reducing STBBIs. Other ideas discussed were to improve the skills of health care providers in having health promotion and PN conversations regarding STBBIs as well as expanding the hours of public health nurses to times when individuals are likely to be reached. One suggestion was to change the question for PN to ask the question who else in their network needs testing?

Groups changed tables every 15 minutes to answer the following questions:

1) What barriers affect the success of PN in your contexts? Are these capability, motivation or opportunity barriers, and what solution could that imply?
2) What are some ideas to strengthen existing PN strategies to make them more efficient and productive? What could partner notification also be? (Be creative.)
3) What innovative partner notification strategies are currently being used or can be explored? Are these current strategies being evaluated?
4) How do you prioritize PN among other strategies (e.g. by infection, risk criteria)?
5) What current evaluation methods have you used to monitor and measure the effectiveness of PN strategies? What is needed to evaluate PN strategies in your contexts? What are the indicators of success for PN?

Please see Appendix D for group outputs.

STI Frameworks: Setting the structures for sustainable STBBI programming

The final presentation for the *Plains Speak on STBBIs* was by Cari Egan, AHS Strategy Development and Innovation Lead, who presented on the conception and implementation of the Alberta provincial STBBI framework. The new framework was created in 2017, in the context of increasing NG and syphilis rates. In 2016, they developed a STBBI network of over 200 organizations and over 500 individuals (including community organizations, provincial organisations, federal organisations including First Nations Inuit Health Branch (FNIHB), First Nations and Metis community members and organisations throughout the province, and individuals belonging to overrepresented populations) and asked what stakeholders in Alberta think will improve STBBI Services. They developed root cause diagrams based on interviews conducted during an environmental scan, and created 74 priorities for their strategy. Most of the priorities relate to access and interagency collaboration.

In the 2nd year, AHS created an implementation plan with 5 working group streams including prevention, screening & diagnosis, treatment, support, and stigma. Dr. Egan spoke about some of their achievements including Pre-exposure prophylaxis (PrEP) & Post-exposure prophylaxix (PeP) guidelines and education, universal PrEP access since October 2018, expanded Human Papilloma Virus immunization access, expansion of nursing scope of practise, expanded outreach services, and contributing to expanding the Extension for Community Health Outcomes (ECHO) program to Indigenous communities. They have formed a coalition of 40 organizations in Edmonton to optimize care in response to the current syphilis outbreak, and are creating a response strategy for their work. Anticipated outcomes of the framework are interagency and inter-sectoral collaboration, optimizing testing for STBBIs, meeting people where they are at, building Provincial STBBI screening guidelines, building comfort and capacity for STBBI management within primary care providers (Physicians,

Pharmacists, NPs), expanding the Nursing scope of practice, ensuring equity in access to STBBI clinical and support services, having a wrap-around care pathways, and reducing stigma.

After the presentation, questions were asked about expanding nursing scope of practise and funding for the process and framework. Dr. Egan answered that they have received some government funding, but are also relying on research and pharmaceutical funding. In response to a question about how the collective meetings work practically, Dr. Egan stated that the groups initially met 2 hours weekly, and then every 2 weeks. They rely on teleconference and having consistent people at the table. She is inspired in seeing the change in culture with people and organisations working collaboratively that started with a vision and collective priorities.

Conclusion

To conclude the meeting, there was discussion and comments regarding continued communication, sharing, and collaboration between the Prairie Provinces including suggestion toward common STBBI indicators for a more a coordinated response. It was made clear that traditional systems for STBBI response are not working in the Prairies. The event outlined the importance of evidence and having the ability to share programmatic evaluation of programs and interventions, the need to move toward STBBI prevention rather than only response, that technology and shared data systems are essential for program and intervention processes, the importance of linkage and creating comfortable environments in health care broadly, as well as the necessity of meaningfully including and engaging communities' input in all program processes.

Appendix A. Plains Speak on STBBIs, 2019 Agenda

March 14, 2019	**DAY 1. The Context of Increased Burden of STBBIs in the Prairies**
3:00-4:00 PM	**Registration & Refreshments**
4:00-4:15 PM	**Welcome to the Territory & Opening Remarks** Albert McLeod, Margaret Haworth-Brockman, and Jami Neufeld
4:15-6:00 PM	**Presentations** An overview of the provincial epidemiological contexts • SK: Johnmark Opondo • MB: Souradet Shaw & Carla Loeppky • AB: Jennifer Gratrix **Specific objective**: To provide an overview of the context of STBBIs in the Prairie Provinces.
6:00-7:00 PM	**Stories from the ground** Focus on strengths and an overview of the social and structural contexts ***Specific objective****:* To provide an overview of the social and structural for individuals with increased opportunity for STBBIs in the Prairie Provinces. • Indigenous community organization: Laverne Gervais, Ka Ni Kanichihk • Experiences in harm reduction work: Tania Wiebe, Nine Circles Community Health Centre • Experiences in outreach: Garret Meyer, AHS STI Outreach
7:00-8:00 PM	**Dinner**
March 15, 2019	**DAY 2. Strategy and Interventions for Improving STBBI Prevention and Response**
7:30-8:00 AM	**Breakfast**
8:00-8:10 AM	**Welcome to the Territory & Highlights from Day 1** Albert McLeod, Margaret Haworth-Brockman, and Jami Neufeld
8:10-9:00 AM	**Presentation -** The structure of STBBI programming and the BC experience Jason Wong, Physician Epidemiologist BCCDC
9:00-10:30 AM	**Presentations -** Innovative Interventions: Sharing Successes & Failures

	Specific objective: To share successes, failures, and challenges around interventions or approaches in the Prairie Provinces with a focus on evaluation. • Test One, Test All –SK: Janice Seebach • Assertive Syphilis Testing Strategy - MB: Alicia Lapple • Syphilis Intervention in the North - MB: Tammy Stuart Chester • DBS in Northern SK - NML: John Kim • Incentivized Testing Program - AB: Penny Parker, Garret Meyer • Data to Care Model - SK: Johnmark Opondo
10:30-10:45 PM	**Break**
10:45-12:00 PM	**Group Activity/Think Tank** ***Specific objective:*** To encourage contribution from all participants to discuss barriers and challenges, successful existing interventions, and to determine new strategies that can be adapted to their local context. 1) Supports and partnerships for Indigenous people with increased opportunities for STBBIs 2) Supports and partnerships for people struggling with problematic substance use and with increased opportunities for STBBIs
12:15-1:15 PM	**Lunch**
1:15-2:30 PM	**World Café Session -** Partner notification: History and moving forward ***Specific objective****:* The objective of this session is to share and discuss experiences across jurisdictions, best practices, prioritization, evaluation, as well as innovation and evidence regarding PN activities.
2:30-2:45 PM	**Break**
2:45-3:15 PM	**Presentation -** STI Frameworks: Setting the structures for sustainable STBBI programming AB: Cari Egan
3:15- 3:30 PM	**Group Wrap-Up Discussion** What are the ideas that resonate? Are there next steps?
3:30 PM	**Evaluation**

Appendix B. Interventions for current STBBI outbreak in presentation by Prairie Province

	Saskatchewan	Manitoba	Alberta*
STBBI awareness campaigns:	*Know your Status-led by First Nations groups *You test, we'll do the rest *Test for one, test for all *Sexual health at all ages *Wrap it up Sask – award winning condom design including Indigenous languages, street lingo	*Yo Bro, Hey Girl social media campaigns *FNIHB test for one, test for all- campaign on testing day *Health Care Provider notification-2015-2019 *Northern poster campaign *Update provincial website re: syphilis, congenital syphilis *Animal Instincts poster NRHA	*Collect apps that people use to guide where media should go. How did you meet your partner? *Media Buys
Harm reduction strategies:	*Recently launched safe inhalation supplies *Incorporated PrEP into system *STBBI treatment as prevention (TaSP) *Ongoing discussion regarding supervised consumption or safe injection sites	*Peer workshop being planned for harm reduction *Community based harm reduction and obtaining budget for peers *State need to enhance harm reduction and need to have capacity to increase needle distribution *Need Regional harm reduction workers	
Access to STBBI testing & treatment:	*Urine drop off *Express STBBI testing *Considering self-swabbing/testing *Empirical treatment with syphilis after testing *Partnerships with care providers to routinely	*Enhanced screening for pregnant women in Northern Regional Health Authority *Early discussion for enhanced screening for pregnant women, addiction services, corrections	*Operational strategy and plan *Increasing positions for testing and treatment-MSM clinics, outreach, syphilis treatment clinic appointments in Edmonton

	screen "at-risk" patients STI/BBPs * DBS STBBI testing in First Nations Communities *Patient assistant tools to demand testing- online & through electronic medical record *Expanding HIV POCT *Outreach and event based testing	* Partnering with primary care providers to enhance STBBI testing and treatment *Standards & Evaluation working – trying to have public health nurses able to treat uncomplicated syphilis *Recommendation to enhance public health prenatal supports *Continue work to improve ability of nursing staff across province to treat for select STBBI	*Incentive testing-$10 testing, $10 treatment in Edmonton Outreach STI *Increased access to Bicillin *Opt out testing in Corrections
Partnerships & Collaborations:	*Working with family physicians providing patient assisted tools about deciding when to test *NITHA has introduced an integrated care model that includes traditional healing	*STBBI Outbreak Response Committee formed with 5 working groups including community partners *Syphilis management tool for physicians *Linking with addiction providers and corrections *Presentations about having phlebotomy on site to urban physicians *Letters to providers- with variable success and trying to get the information to come from regions *Community alerts *Infographic with recommendations for providers	*Physician letters *Community group consultations-Petra phone in and aid in teaching and awareness *Presentations to Healthcare Provider groups

		*Talking to emergency departments. They are considering a Public health nurse or harm reduction nurse position in the emergency department vs. training ER staff. *Congenital syphilis series, public health lab data	
STBBI Partner Notification:	*Thinking about Venue based Contact Tracing and Outreach *Social network investigations *Expedited Partner Therapy-struggling with how to operationalize		*Partner notification nurses-using Facebook to reach people and want to expand to other social media *Patient delivered partner therapy * Test and Treat Visits expanded to include extra-genital CT/NG testing and HCV testing *Partner notification nurses have guidelines to test and treat syphilis *FNIHB test and treat model for their nurses *Prenatal nurse position to care for prenatal cases mother
Surveillance and Electronic Medical Record:	*Panorama has been introduced to system and streamlined the flow *Moving toward digital strategy *Annual HIV Public Health Case Audit	*Roll out panorama faster to regions *Increase use of Public Health lab data *Increase capacity in surveillance	*Quarterly STI data available publicly * Alberta First Nations Information Government Centre created

*Interventions presented were for syphilis only

Appendix C. Answers to Group Activity/Think Tank regarding supports and partnerships for Indigenous people and people experiencing problematic substance use with increased opportunities for STBBIs

Group 1 & 2: Supports and partnerships for Indigenous people with increased opportunities for STBBIs

1. **What are barriers to achieving decreased burden of STBBIs in your chosen group?**

Access:
-Access when it's their choice, not reaching out to the population
-Mistrust and misunderstanding from client perspective (TB history)
-Mistrust from providers
-Having to travel to reach health care in remote communities
-Having to change Indigenous identity to get care
-Lack of confidentiality in health centres because everybody in the community knows when you are there

Systems:
-Systemic issues of stigma and racism in the community and health system
-Health sector is not in the community—in schools, nurses are not doing sex education
-Traditional clan system
-Fear of child apprehension due to lack of system compliance
-Intergenerational trauma—perpetuated negative experience with our system
-Public health is different in the community than in the city
-Primary care in communities and public health not coordinated resulting in fragmented care
-Fragmented care on reserve
-Difficulty in tracking people who move or migrate
-Turnover of nurses and lack of continuity of care
-Individuals assessed by residents in hospital environment
-Health sector is not integrating traditional ways of knowing
-Displacement due to natural disasters e.g. People on suboxone being displaced to a community that does not dispense this. Using Indigenous insight could help this barrier because natural disasters have always been around.
-Need urban Indigenous strategy as well as rural
-Urban childbearing, women are avoiding care and trust needs to be built
-Phlebotomy threatening from drug tests in past history, DBS less threatening. Conventional health care has not been successful.
-Provincial strategies can differ from FNIHB
-Incomplete surveillance data

-Public health needs to be decolonized
-Presenting Indigenous data is challenging-are figures and tables appropriate with stories woven through?
-Going to chiefs, but this may not lead to community level
-nursing station is for primary care and public health is a luxury
-Cellular and data service is poor, are posters are needed?
-First Nations Health Authority is a priority for community led program data stewardship
-Every community is different and it's not always possible to implement the same program in a community 100 km away
-Can we test our way out of an outbreak? There are laboratory capacity issues and how do we quickly improve efficiencies?

Knowledge/Information:

-Lack of information and education in the community
-Loss of traditional ways of transferring knowledge and traditional ways of knowing, integration of sex and harm reduction education. Whose responsibility is this?
-Health sector is the only people doing health promotion E.g. Nurses leave clinics to go teach sex education in schools
-Resistance and hesitation to accept Indigenous knowledge
-Community Tinder

2. **Discuss successful partnerships and/or strategies that are currently implemented in prevention and response. Indicate if they are evaluated.**

-Indigenous communities are close knit; good partnerships are a strength and are working. It takes building relationships. Infrastructure needed for success and resilience rather than systemic alienation. Communities communicate what they need and this builds trust.

-A project to reduce inadequate prenatal care in Winnipeg in poorest communities with health system improvement funds. They are having success by working with communities. They are using a survey to ask what are the barriers to care in order to address these barriers.

-A harm reduction program (Aboriginal Youth Opportunities) in Point Douglas with the Indigenous community. The program was created and is driven and designed by community. The community is saying what they need. Provide harm reduction supply at Merchant's corner (used to be hotel with reputation for substance use). They have asked WRHA Public Health to provide STBBI testing.

-AB Provincial STBBI Operational Strategy. They are engaging with First Nations and Metis communities to bring their perspective to services. Implementation phase is to engage with partners with similar goals. E.g. AB cancer legacy fund-First Nation prevention program, HCV-ceremony + partnering with prevention practitioner in their community.

-Tuberculosis example-upholding principles of data stewardship

- Alberta First Nations Information Governance Centre telling stories in their own way. They are sharing data stories and changing the message and had positive feedback from changes.

- AB Public & Population Health going to communities with FNIHB and they are mutually ensuring FNIHB and province are aligned in strategy. The communities then decide what are the next interventions. Being community led, more numbers are present for presentations from Telehealth nurses or in the community.

-Working with Indigenous people to expand the ECHO project in Alberta. There is increased stakeholder engagement from First Nations and Metis people within Alberta STBBI Network working groups. They have made improvements to access to care and are doing unique things. The communities are a part of development of cascades of care. Indigenous knowledge holders are sharing the work of practitioner.

- Saskatchewan Know Your Status (KYS) program – enhanced STBBI program implemented in 2011 that destigmatized testing and harm reduction. The program incorporates testing, harm reduction, and case management. The logo was designed by community and leadership and ownership is in the community. Elders are active in prevention strategies and relay the messages to the community. The community has invested in the program above and beyond. KYS is now present in several SK First Nations communities, and looks different in each community. Know your status in many communities is far exceeding 90-90-90 HIV targets, and have had many successes in HCV treatment They are reducing stigma associated with testing but also bringing in access to different resources in one forum E.g. Wellness Days-nutrition, know your status. Know your status made people want to participate.

- SK having one unified electronic data base- a nurse can see if someone needs treatment in another part of the province-decreases fear and stigma. Group discussed access to contact to individual. Is there cell phone access?

-AB using Facebook as major communication mode in communities to contact people.

-AB incentive testing in Edmonton.

-AB Mark of Mothers- physician and nurses went to reserve to learn for a day and followed by full day of providers normalizing testing and sexual health and providing support to health mothers and babies.

-ON-regional tribal health authority – open opportunity to increase testing in Kenora, Sioux Lookout.

-AB has had success in connecting with community based organizations including Churches and Native Health Centre to connect with hard to reach clients.

-Public Health Nursing Prenatal Practice: Evidence Informed Care Pathway 2019. Streetworks run Marlas Taylor with specific STI services for women of childbearing age. This started out of the last outbreak of congenital syphilis.

-AB providing teaching and testing at Poundmakers' Addiction Recovery Program.

-Hepatitis C liaison & prevention Hep C care coordinator. All of the work is grounded in community.

-AB empowering the community- community of people who inject drugs working with province, FNIHB for sharing agreements & health trend reports. Who owns the data?

-AB-SNUG ED, police/vice – Metis CFS providing bannock, soup, social work, and screening. Providing condoms. Supporting outreach. Photos of missing and murdered women.

3a. What are short-term public health strategies to prevent STBBIs in your chosen group?

3b. What are long-term public health strategies to prevent STBBIs in your chosen group?

4a. **What are short-term public health strategies to respond to STBBIs in your chosen group?**

4b. What are long-term public health strategies to respond to STBBIs in your chosen group?

Note: One of the 2 groups answered above questions, but strategies were not differentiated.

-ON needs to build up own capacity, they need more medical officers of health. They need to build capacity for traditional case and contact. They need to engage with clients, including issues that are important such as clean water and housing. Community Health Representatives (CHRs) are an untapped resource that need to be trained and compensated.

-BC- working towards a sexual health strategy and framework where other ministries outside health have a role. E.g. Public education. What is sustainability? What is effectiveness? BC province wide on Grindr (with less clicks), e-blasts more effective with syphilis websites have more clicks. The highest risk groups do not have the internet and posters that are strategically placed could be better.

5. What could be indicators to measure effectiveness? Could they be common indicators for the Prairie Provinces?

-Meaningful joint governance

-Community leadership, functioning system

-Finding out from community leadership where they think things are going. Not by numbers, but do they feel that people are engaged—that is when we know the work is successful.

-A community has to speak to success

-Decreasing STBBIs in Indigenous people, but more than reduced numbers

5. What could be indicators to measure effectiveness? Could they be common indicators for the Provinces?

Not answered.

Group 3: Supports and partnerships for people struggling with problematic substance use and with increased opportunities for STBBIs

1. What are barriers to achieving decreased burden of STBBIs in your chosen group?

Individual level:

-person’s behavior and experience in accessing care
-Prioritizing other needs like food rather than screening and treatment

Distal level:

-solutions are beyond the health system
-lack of cooperation from private sectors instead of just health
-income, education

Policy Level:

-revisiting harm reduction strategies beyond housing, sobriety. There is pushback of harm reduction strategies and accepting benefits of strategies and advantages.
-complexity of health care delivery-addictions & mental health-under service delivery; case coordinating and social work; involvement of Infectious Disease physician at connections
-gaps in communication and policy, incorporate a “focus person”/”gapleader” to care
-harm reduction not stressed at all levels of care-how other sectors are approaching the problem-

Environmental level
-lack of follow up regarding treatment and screening, needs more sustainable programming
-need to improve relationships with clients
-lack of engagement to health care system
-cultural problem
-lack of access to screening and treatments-do we need other avenues?
-lack of messaging regarding meth treatment or hope for treatment

3. **Discuss successful partnerships and/or strategies that are currently implemented in prevention and response. Indicate if they are evaluated. Add these to the solution list if the group agrees.**

-SK-engaging families

-Northern RHA SK – partnering with communities; incorporate Indigenous ways of treatment including chiefs when working with Indigenous people

-SK HIV Collaborative
-engaging medical professionals in PHC workshops to build capacity (doctors, nurses)

-proposal re: complex testing (PHICO?)

-peer support program

-HIV Strategy coordinators engaging with peer groups using CATIE document as a guideline – evaluation document can be shared

-MB Harm reduction network partnering with peer groups to known barriers; to find better ways to build relationships

-MB is wanting to embed social worker to the public health team like the Toronto TB strategy to increase treatment rates. Group discussed social work not only being in acute care because people live their lives in the community.

-SK-social worker used in HIV programming in SK because people have concerns regarding income, benefits, housing (also in Regina as peer coordinator for HIV, social worker is in corrections working along with the nurse with the newly diagnosed for HIV and follow them to other care environments and will bridge to community)-cross training from nurses

-AB-public health needs to be multi-disciplinary like acute care and like the ARCH program with supervised consumption site while admitted to the hospital. The ARCH Team delivers specialty consult services to emergency department patients and hospital inpatients at the Royal Alexandra Hospital. They assist with complicated drug and alcohol withdrawal, assessment and treatment recommendations for substance misuse, motivational interviewing, initiation of maintenance of opioid agonist therapy, harm reduction supplies and overdose prevention, linkage to primary and community based care, housing, healthcare coverage and identification, and health promotion and disease prevention. https://www.albertahealthservices.ca/findhealth/service.aspx?Id=1068151. Accessed May 5, 2019.

-AB there is a psychologist working with public health in Edmonton-using coping mechanisms to help deal with substance use-100 clients have contacted him outside of care.

-MB encouraging emergency department (ED) physicians to do testing and talked about having a Public Health Nurse at EDs 24 hours/day. AB has had success in building capacity in ED's who later take on the harm reduction work on their own.

-being visible in parks with local celebrities

-AB-developing capacity outside of public health in primary and acute care environments

-ON-peer outreach workers providing cultural work in Indigenous communities-smudging, fishing events, bannock making to engage people-not yet evaluated

-MB-considering incentives like Alberta to McDonald's, Tim's for screening and treatment, going to community-based organizations that provide alternative services e.g. Housing

-AB-provides evaluation for incentive program for STBBI testing and treatment and state that it gives people the reason to screen while removing the stigma. Cash vs. gift cards were discussed-AB decided against cash so that outreach worker's weren't carrying cash and so that they didn't create unsafe conditions for individual by having cash. Regina is using lunches instead of gift cards to provide incentives for people for testing and treatment.

-MB provided program where when individuals returned used needles, they were able to enter a draw for a Giant Tiger gift card.

-SK collegiate nurses are doing testing with urine drop offs.

-Alberta was asked questions about targeting schools and presenting regarding syphilis at school activities regarding STBBIs, but not substance use due to lack of evidence in the youth population.

Appendix D. Answers to World Café Session - Partner notification: History and moving forward group concepts.

1. **What barriers affect the success of PN in your contexts? Are these capability, motivation or opportunity barriers, and what solution could that imply?**

Barriers	Solutions
- Limited access - Anonymity of partners/lack of sufficient info - Casual hook-ups - Lack of PN in social media - Complexity of monogamous relationships - Stigma for partner identification - Feelings of guilt - Letting partners know - Client completing healthcare provider form (AHS) - Transient population - Travel between provinces - Lack of engagement from clients - Re-infections - Privacy issues (technology) - Lack of clinic staff; service workload; human resources - Following up not a priority - Fee for service provider says no - Understanding the value of PN and how much to cover - Lack of evaluation of PN programs - Demographics of people - Geography – large vs small communities - Over medicalization of testing - Previous negative interactions - Point of care tests are expensive	- Keep spreadsheet of partners - Digital anonymous reporting - Building relationships - Provincial follow-up - Building capacity; relationship building - Increasing accessibility – longer hours; more clinics - Having a main contact person (nurse) - Technology - Network notification (California) - Similar characteristics of San Francisco PN based on networks - Moving further into communities - Training physicians - Partner therapy - DBS and urine - Using drop off

**** Type of barrier not identified by all groups.*

2. **What are some ideas to strengthen existing PN strategies to make them more efficient and productive?**

- Patient delivered partner treatment
- Using Facebook to contact people
- Using social media without barriers (using clinic account)
- Using provincial call center with algorithms
- Using technology – filling up a digital form and sending it digitally as well
- Using concrete strategies to find relevant information – where do people hang out?
- Having a Provincial EMR – 1 patient 1 record to piece everything together
- Expedited partner therapy then ask partner to go to lab 1 month after for testing
- Prioritization of Chlamydia (on the bottom of the list)
- Social media apps
- Gender neutral identity Facebook
- Incentive for physicians to complete partner notification paperwork
- Ask the client who else in your network needs testing?
- Improve the skill of providers on how to have these conversations
- Expanding hours of work for PH nurses
- Public campaigns

What could partner notification also be? (Be creative.)

- Test and Treat PN
- Geopoking
- Education
- Connection to resources
- Public dialogue of healthy sexuality and relationships
- Opportunity for harm reduction
- Health promotion conversation
- Public campaigns

3. **What innovative partner notification strategies are currently being used or can be explored? Are these current strategies being evaluated?**

AB

- Test and treat guidelines – "blue book" for PN nurses; 6-7 online modules that RNs need to complete before they start doing PN
- House to house in rural areas
- One dedicated PN for congenital syphilis
- Significant shift in the last 5 years: nobody's giving info re: partners anymore. Needs a campaign on why it's important to do PN
- Installing cellphone chargers at clinics to prevent people from leaving especially when wait times are long; also enables patients to open apps in their phones to identify partners

- Getting notification from Remand Centers
- Sends letters to Primary Care Physician re: date of diagnosis, treatment; used like a clinical management tool
- When pts go to clinics, they are given a package of requisitions that are already pre-dated

MB

- Use of Facebook for contact tracing; also good to use if pts do not have phones (also used by AB)
- Reframing questions instead of asking who they had sex with: "Is there anyone else you think might benefit from testing?"
- Partnering with FNIHB to re-allocate funds so pharmacist and doctors can go to the communities rather than pts going to them
- Changing RN hours who do PN – most effective after supper
- Use of incentives (gift cards) when index brings their partners (not yet implemented)

BC

- Using dating apps

SK

- For pts being treated at the clinic, they start to build trust with nurses over time then starts to tell them about their partners
- Page 26:
- Shared Client Index (SCI) – can see if patients have been at certain clinics then nurse can call that clinic to get info
- Social networking
- Venue –based – instead of asking "who are your partners?, ask "where do you meet your partners?"
- Business cards of RNs that are being given to pts so they can give these to their partners

Ontario

- Face to face interaction then try to bring people in
- Parole officers helping to identify partners

General

- Searching patient names in databases (PANORAMA, etc.)

4. How do you prioritize PN among other strategies (e.g. by infection, risk criteria)?

MB

- As resources permit
- PN doesn't seem to affect numbers and rates
- Personal Health Information Act concerns over social media
- Be great to determine as a collective that CT can go

SK

- Following all contacts for everything
- One attempt of CT; don't do beyond standard attempt (3 calls-1 letter-1 visit-close) due to dynamic population
- NG and syphilis – high priority

AB

- -Complex – HIV>NG>CT (like a matrix)
- Changed behavior
- If known to be treatable and curable
- Consequences to partner and baby
- Online reporting

Ontario

- Pregnant women, HIV, syphilis
- Language loosened CT; not notifying all

BC

- Pre-natal syphilis - priority
- Immigrant
- Would like to see CT decrease cumbersome labor

General

- PH is treating cases not prioritizing PN
- PN is labor intensive
- Social networking, venue-based testing
- Needs support regulations

What other ideas for PN prioritization can be explored?

MB

- Talk about stopping PN
- Testing enough volume NAAT

SK

- Disease based
- Depends on infection urgency
- Anyone with dual infection
- CT 1 notification for 14 days; home visits for Hep C and syphilis
- Any travel outside SK is being asked
- Data entry is onerous

- No home visits; texting but can't phone; some do call back

AB

- Changing over model

General

- Phylogenetic clusters over time
- Re-doing PN
- Beyond PN: not just disease of immediate concern

5. What current evaluation methods have you used to monitor and measure the effectiveness of PN strategies?

- Tracked by Accuro electronic record
- Prioritize by underage/pregnant women
- WRHA – chart review; looked at case and contact database; how many contacts turned into cases
- No cases of Chlamydia over 18 – stopped following
- SK – access database; drop down if people were notified; nurses print a list of daily work
- Incentive based – now accessing sites that they never could before
- Evaluation of other PN approach versus traditional contact tracing
- Syphilis evaluation – time to treat and time to follow up
- Program indicators - how many actually identified partners? How many were tested and treated?
- Standards - # of contacts to follow up with; look at the case:contact ratio (4.3 contacts for 1 case of GN)
- How many clients to reach
- Referrals from PNN – when they have tried to contact clients but can't; "creative approach department"
- Anecdotal observation for Chlamydia – flat curve from 1997-2000; spiked in 1998 due to urine testing, when syphilis rates increased in 2012-2013 and they had to abandon Chlamydia all together. Curve doesn't change with Chlamydia.
- Syphilis contacts at 2018 – 12% became cases – how was contact tracing the reason for having the knowledge as a case
- Processed pieces around contact/partner notification – even in qualitative research methods
- Client surveys how they feel about the process
- Resources to collect data – time, tools, entering data, targets, feedback

What is needed to evaluate PN strategies in your contexts?

- Home visiting for high priority contacts
- Use of Accuro
- Access databases

- Good database
- Systemic data collection
- Keeping track of strategies that were used
- Team meets with PN nurses to review the cases – discuss what attempts have been made and what needs to be done. They can track how long and where to locate.
- Using observation and medical students as “cheap labour”
- Consistency from province to province and across the world
- Measure amount of re-infections

What are the indicators of success for PN?

- Early on if found primary or secondary, felt successful. This year found at tertiary.
- Graphs of if you found people in 90 days
- Measure how many receive treatment
- Time to opening to closing case – set time limits
- 6 months syphilis; 8 months CT
- How many people can you find
- No disease or that you found disease
- Prevention of re-infection
- % of testing on partners
- Treatment of cases with a positive result
- BC partner notification is quite high - worth the investment