Toronto HIV Network (THN) – Co-location of HIV Services

Background

Throughout the 30 plus years of the HIV epidemic in Toronto, people affected by HIV have come together to protect each other. Each of Toronto's community-based HIV service organizations was built with the vision and input of specific communities facing the catastrophic effects of HIV/AIDS on their families, friends and their own health. The Toronto HIV Network brings these agencies together to *facilitate HIV/AIDS planning, collaboration, engagement and innovation to improve access to programs and services for people from diverse communities living with and most affected by HIV/AIDS*.[1] THN is currently comprised of 25 community-based agencies with HIV programming; five community health centres; eight community-facing HIV programs based in Toronto hospitals; and seven other public health, housing and counselling resource organizations with relevant mandates.[2] HIV community-based organizations in Toronto are each committed to the greater involvement of people living with HIV in the services they provide and to integrating the perspectives and addressing the needs of the specific communities they serve. Community-based member organizations take a social justice and anti-oppression approach in striving to recognize, and where possible, mitigate the structural inequities that clients face on a daily basis. In working together, THN members also strive to recognize and, where possible, mitigate the ways that these inequities create power imbalances among the members.

The ability to understand and direct prevention and support services to specific communities from within, is a tremendous strength of HIV services in Toronto, especially given the remarkable diversity of Toronto's population.[3] Government funders have recognized these strengths: all 25 THN-member community-based service providers have at least partial funding from the HIV and Hepatitis C Program of the Ontario Ministry of Health and Long-term Care to provide HIV prevention education to at-risk communities (including harm reduction services) and/or support services to those living with and affected by HIV.[4] Research has demonstrated that community-based HIV agencies across the province save Ontario taxpayers $5 for every prevention dollar invested.[5] Ontario research has also shown that community-based HIV organizations are uniquely effective in reaching the most vulnerable among our populations.[6] Toronto has lower rates of new HIV diagnoses, with 16.9 per 100,000 population in 2017, compared to other major cities such as New York (29.2 in 2016) and San Francisco (40 in 2015).[7] However more than one person is still newly diagnosed with HIV each day in our city and over half of new Ontario HIV infections are diagnosed in Toronto.[8] New diagnoses are not declining, despite new prevention options. Most new infections clearly occur in our city, but the high rates of migration to Toronto also mean that some infections happen outside our borders.[9] Wherever infections occur, THN members recognize that the fundamental purpose of any collaboration, including any co-location initiative, must be to improve access and outcomes for HIV service clients.

The Evolving Needs of HIV Service Clients

Data[4] gathered through the OCHART (Ontario Community HIV/AIDS Reporting Tool) used by ministry funded agencies shows that the complexity of client needs addressed by HIV service agencies is growing. OCHART reporting discussed below shows that the intensity of interactions with clients is also increasing rapidly.

Prevention and Education

The 20 organizations funded in the city for prevention activities reach over 11,000 clients each year with presentations and workshops about HIV prevention and transmission. They make approximately 30,000 annual outreach contacts. However, the number of participants engaging in each prevention/education event is declining slowly, while the demand for more structured interventions to foster improved prevention strategies has increased markedly with nearly 2700 participants in 2018, a 32% increase over the previous

year. These more intensive services are likely being used due to the growing array of current prevention options including oral pre-exposure prophylaxis (PrEP) medications and the dapivirine vaginal ring (likely to be approved this year in Canada).[10] These prevention strategies require knowledge and support to be used in effective and sustainable ways, as well as increased health promotion efforts and support to secure coverage. Structured prevention interventions around mental health and addictions are also a growing focus.

There has been a dramatic increase in harm reduction activities, as the opioid crisis has hit Toronto. Client interactions by Toronto harm reduction teams increased 92% (46,046 interactions in 2016 to 88,509 in 2018). With two newly funded programs joining seven originally funded programs, service sessions have more than tripled from 53,847 to 163,430 in 2018. The impact of opioid overdose and death on several of the key populations served by HIV service organizations continues to grow and cannot be understated.

Support Supports for Clients

Twenty-two agencies receive Ministry funding to provide supports for clients living with HIV, as well as those affected (largely family members) and those at-risk. HIV specific agencies saw 5,094 clients in 2018, while non-HIV specific agencies used HIV-specific funding to provide services to another 2,056 clients. This was a 7% increase from 2016. Although the median age of those living with HIV has been steadily increasing in Ontario, Toronto service agencies have seen the greatest client growth in the 26-35 age range. These increases are relatively modest (~3%) and may reflect the youth bias of newcomer populations.

Men make up the majority of clients. The number of male clients living with HIV has remained stable, while the number of female clients and those with other gender expressions is rising. There is also an increase (2.4%) in the number of at-risk men served, likely due to PrEP-related medication supports. The ethnicity data (shown at right) has been relatively stable over the last three years, with a small increase in Latin American clients.

Ethnicity of clients (%) seeking HIV support services in Toronto, 2018

Ethnicity	**Men**	**Women**
Black	17	75
Latin American	25	6
White	39	9
Indigenous	2	1
Other	17	9

Issues related to living with HIV (such as medication access, symptom/adherence management, disclosure, and stigma/discrimination) were the most reported by all HIV services clients in Toronto, and these needs increased 7% in the past two years. After HIV related support, men are most likely to require assistance seeking health care and mental/emotional/ physical health support (46%) while women most often report issues related to immigration and legal issues (42%). Both men and women often report needs around income and benefits (over 40%) and over a third are now reporting housing challenges. While the number of housing spaces for people living with HIV has increased in Toronto over the past two years, (Fife House alone now houses more than 300 clients[11]) the escalating cost of rent is having an impact, and many more clients are seeking help. The capacity of Toronto agencies to provide practical supports (i.e. food, financial aid) has largely not changed over the past two years, despite increasing client needs (such as an 8% increase in the proportion of clients seeking food bank access.) Referrals to other community based service providers (e.g. food banks, housing, legal aid, settlement services and employment supports) are by far the most common form of referral from HIV service organizations, increasing from 67% of all referrals in 2016 to 80% in 2018. HIV service organizations are also increasingly referring clients for HIV primary care and mental health services. While HIV service agencies have been able to increase capacity in some areas such as counselling around managing HIV, the biggest change has been a dramatic increase in the delivery of case management services, as HIV service organizations increasingly became a gateway to other agencies. Delivery of case management has increased 250% over the past two years totaling 12,654 sessions in 2018. Clients who are able to be housed by HIV service providers are also using higher levels of in-home services with a 31% increase in the *support within housing* category in the past two years.

Although the rate of new client intake by HIV service agencies is not increasing, all reporting points to a client base with increasingly complex needs requiring an increasingly complex web of referrals. Frontline service providers are highly aware of these challenges, and the *desire to see more inter-agency collaboration to better meet the needs of service users* was a dominant theme of THN's most recent strategic plan.[12]

The Co-location Vision

THN member agencies wish to explore the co-location of services. Co-located organizations would share a rental space, but would maintain distinct identities and governance of their program activities. Participating organizations would share large and small meeting spaces, facilities (such as a staff kitchen) and potentially some types of program space. There may also be potential to share administrative services. (The Canadian non-profit resource agency, Charity Village has published a review[13] comparing different forms of non-profit administrative partnership, which may be helpful in these discussions.)

Co-location arrangements are typically structured through a series of agreements between the partners. Three possible models for multi-partner co-location are cited by the US-based Nonprofit Centers Network:[14]

- Independent Providers - An independent non-profit organization provides services to other independent organizations via service agreements or contracts. THN might serve as this organization, or another entity might be formed strictly for space management.
- Joint Venture – Multiple, but not necessarily all, of the participating organizations share governance of the co-location site, with appropriate collective structures created to oversee the facility.
- Fiscal Sponsorship - One organization acts as a legal and fiscal umbrella for other, often smaller entities.

In each of these instances, a series of agreements would need to be in place describing the ways that leasing and other costs would be shared, how the physical space is governed and tenants approved, and how site security is arranged (see the Edmonton Non-profit Shared Space Feasibility Toolkit for a list of useful agreements).[15] There would need to be processes for scheduling the use of common facilities. Participating organizations would need to have agreed on how the space is branded, how the confidentiality of clients is protected and whether some services would share intake. THN members already share many common values; however, the commitments made to clients at the site would need to be spelled out and agreed to in terms of equity, social justice, anti-racist practice, reconciliation and sex positivity.

There are a broad array of programmatic challenges that will need to be discussed and addressed. Examples include hours of service or the facilitation of low barrier access to harm reduction supplies. Some organizations have unique physical needs around particular services such as food bank operations. There will also be opportunities to explore synergies between the services provided and to consider ways to use scarce resources wisely. Best practices[18] in co-location and collaboration tell us that partners should start slow and grow our levels of collaboration over time. However, it may make sense to establish newly collocated services in thematic groupings of services, which may be located in more than one space. Consideration of these options will be part of our visioning exercise. This approach might also make it easier to find appropriate spaces.

At this point in the process, the THN working group wishes to leave potential participation in the co-located space open to consideration by all THN community-based partners. Other organizations associated with our priority populations may also be considered as co-location participants. THN has contracted with *Strategisense Consulting* to consult with potential stakeholders, build a stakeholder engagement framework, conduct a design vision meeting, create an overall vision for the co-location project and ultimately present options, requirements and recommendations for moving forward. It is anticipated that this work will be completed by the fall of 2020.

Evidence for Co-location

There is no significant body of literature on the co-location of HIV support services. Some research has been done looking at the co-location of clinical and support services, and a 2019 systematic review[16] analyzed 36 co-location initiatives of this type, in terms of 90-90-90 outcomes. Positive associations were seen with regard to linkage to care and antiretroviral uptake, with more mixed outcomes around retention in care and viral suppression. However, at this point in the THN co-location initiative, no clinical partners are foreseen.

A much more extensive body of literature exists on the co-location of non-profit services in general, including a large number of non-academic publications[17] by coalitions of agencies exploring and/or evaluating co-location initiatives. This literature was reviewed with a particular focus on co-locating agencies providing human and social services to diverse low-income populations.

Key factors in the success of co-location initiatives were identified from five primary sources two Canadian evaluations of co-location initiatives[18,19] and one Canadian best practice guide,[20] as well as two large evaluations of co-location efforts one conducted in the US,[21] the other in Australia:[22]

- Identify and collocate partners that provide complimentary services and serve overlapping populations.[18-22]
- Have a common vision and guiding principles for the initiative – undertake visioning meetings. [18-22] Carefully manage the scale and scope of the initiative, co-location fever is a risk.[18, 20]
- Have leaders committed to the vision and to reconcile inevitable differences between partner interests and strategic directions.[19-22] Accept that some partners may leave. Some research suggests that a lead coordinating individual or organization is critical to success[21]
- Consider issues of stigma and how the layout of services will affect confidentiality, interactions between user groups, and how the cultures of partner agencies fit together[19, 20] Multiple studies show that maintaining privacy is critical to ensure that HIV services are accessible to all.[23,24]
- Create clarity by developing memorandums of understanding and putting things in writing as soon as possible; establish formulas around who pays for what and get additional agreements underway as soon as is feasible[18, 20, 22]
- Recognize that creating a great co-located space will take large amount of time and energy, place a significant burden on those engaged in the initiative, and require effort to maintain momentum.[18, 20, 22] Evaluations often reveal that establishing the space took longer than initially envisioned.[20, 22]

Not surprisingly, the largest barriers[21, 22] to success were conflict between the parties, lack of financial resources and leadership as well as the absence of an appropriate building for co-locating.

An evaluation of co-location projects providing social and settlement services[21] in Indianapolis interviewed 30 individuals involved in different co-located sites. Over 75% of these co-located sites had been established for 10 years or more. This unique group of informants provided data about what they felt did and did not happen at established co-located sites.

Perception of Co-location Benefits from Established Sites (Indianapolis Key Informant Interviews[21])	
Majority Agree	– cost-effective – allows sharing of resources and ideas – increases clients served – improves client outcomes
Approximately 50% Agree	– reduces service duplication – leads to effective communication between organizations
Disagree	– increase the number of services that each family/individual accesses – reduces competition between organizations

Potential Drivers of Co-location

Non-profit organizations may choose to co-locate for multiple reasons including: clients' need for co-located services, the desire to share resources, the direction of funders and the availability of space. In the Toronto community based HIV service environment, the following drivers are relevant:

Making service access easier for clients

There is an increasing emphasis on integrated service delivery in the HIV sector – and across Ontario's entire health care sector.[25] Collaboration to improve access to programs and services for our clients is already an element of THN's mission.[1] Integration does not necessary rely on physical proximity, however 12 percent of all ASO referrals are to other HIV-specific service providers,[4] so physical co-location of HIV agencies will make access easier for some clients. Careful planning of group services thematically in one or more locations may further advance this goal.

Co-location may also facilitate communication between the partners, and ultimately lead to innovation in developing joint service models and better defining care pathways. All 11 of the respondents to the recent THN survey who were interested (or might be interested) in co-location, also stated they were interested in (or might be interested in) developing new models of HIV service delivery. Co-location could be an opportunity to reflect on and streamline client services.

THN community based organizations recognize that there are currently multiple initiatives underway in our sector to improve service integration, which will influence service delivery in Toronto. Two specific initiatives are described at right. Service integration is a key goal of the **Toronto to Zero** action plan, which will set priorities for bringing services together and addressing systems gaps. All of the partners in a future co-location hub are likely to be engaged in implementation of the Toronto to Zero priorities, and this plan must be a consideration in how co-located services are established and operated.

Planned Integration Initiatives of Toronto Services

Two significant service integration initiatives are already underway relevant to Toronto HIV services:

The **gay men's health hub** will create a new model of comprehensive, holistic and non-judgemental care for men who have sex with men (MSM). Space has been secured for the hub, and the service delivery partners are in place. It will launch in late 2020. The hub will offer culturally competent, walk-in services for rapid HIV, STI and HCV testing; PrEP and PEP prescribing/ monitoring, as well as HIV prevention counselling. It will also offer men comprehensive mental health assessments, mental health and addictions counselling and group programs. It will use health navigators to make warm hand-offs that link clients to primary care services for HIV and other health concerns and to mental health and addiction services. The vision includes social programming to build community and reduce social isolation.

The **PHA hub** is a key element of Toronto PWA's strategic plan. The hub will be a community centre connecting people living with HIV/AIDS to services, community and practical support. The plan aims to enhance the role of PWA staff as resource experts for PHAs' complex needs and to use peer navigators to support people as they move along the care pathways to access services. PWA is embarking on a plan to map these care pathways: first through their own services and then to outside resources. Ultimately, they hope to build partnerships with other HIV and non-HIV specific providers and to make specialized agreements to speed PHA access. In the hub' physical space PHAs will connect with others through drop-in programs and other PHA-led programming. The mapping process has begun, and PWA already uses peer navigators in some roles, but the hub is planned to rollout over the next three years. The hub does not necessarily require physical co-location of care pathway agencies.

The Need to Contain Operating Costs Particularly Rent

Housing is a challenge for HIV service clients, but it is also a growing challenge for community based HIV organizations. Rents have risen quickly in the past several years. Toronto Real Estate Board (TREB) data[26] for the third quarter of 2019 suggests space costs of $22.42-22.58 per square foot depending on the size of space leased in Toronto Central. However, disclosure of these rates is voluntary. Other sources of data[27] suggest an average rate of $33.40 downtown and $28.13 midtown. A recent survey of 11 THN members with interest in co-location revealed that three members already pay more than $33.40. Six of these organizations will need to end or renegotiate their leases before March 31, 2021.

Combining our buying power may help manage rental costs, although our space needs will be extensive and difficult to secure. Likely pace requirements would be in excess of 25,000 square feet if all currently interested services co-located together. Co-location of services would help smaller organizations secure meeting space that they could not otherwise afford, and may give them access to other administrative resources such as photocopying through larger partners. The majority of potential partners in a co-located facility, who responded to the recent THN survey (11 organizations), were also interested in sharing administrative services including accounting, IT, payroll, human resources and support systems for fundraising activities. Consolidating these services for multiple organizations would have upfront costs, but would produce cost efficiencies over the long term.

Staff Pressures and Support

The 2013 environmental scan of HIV support workers across Ontario describes a challenging reality for many support workers. *Support workers often felt frustrated and overwhelmed by the increasing demand for services, the continuing stigma, and the difficulty accessing allied services and supports in their communities such as housing and social assistance. Support workers said they struggle to meet complex client needs within available time and resources, and they feel ill equipped to respond to some particularly challenging problems, such as complex immigration issues, mental health needs and providing services for people within the prison system.*[28] While it is important to acknowledge that workers in Toronto have more allied services available to them than is the case for some of the workers in this Ontario wide survey, they also often have more clients. Of the 29 agencies currently funded by the HIV and Hepatitis C Program who reported staffing levels,[4] there was an average of 4.4 staff funded to deliver HIV programs. A third of the agencies had the equivalent of less than two funded program staff.

Placing the staff of multiple agencies together has the potential to help reduce staff isolation and burnout. Organizations with similar services may be able to provide backup in times of stress. Organizations will have more opportunity to share information about effective referrals and resources for clients. Just as important is the building of support relationships among employees of different agencies – a benefit observed[21] by co-location research. Organizations were also able to combine professional development opportunities for managers[21] and other pools of specialized workers. In our sector, research[29] has shown that workers living with HIV often feel isolated, and experience emotional triggers from client's narratives, as well as feelings of burnout from over-immersion in HIV at both personal and professional levels. Formal and informal peer support networks amongst service providers living with HIV has been reported as a successful strategy to address both personal and professional challenges.[30] Proximity would increase the potential formation of such networks. It may also increase opportunities for mentorship in a variety of roles, including supportive mentorships for workers living with HIV,[31] another proposed supportive strategy.

Sustaining Dedicated Culturally-sensitive Supports for Vulnerable Clients

THN member agencies are uniquely linked to their communities. Research shows that community-based agencies are trusted providers of culturally sensitive care.[32] Research also shows that community-based HIV programs are markedly more effective than most forms of community-based health promotion.[33]

Throughout the years, community based HIV organization in Toronto have adapted to the changing needs of the populations they serve, and modified programs to address specific needs within communities.[32] Today, as part of the Toronto to Zero initiative, these organizations have begun to imagine a Toronto where the impact of HIV on our communities is reduced, meeting the 90-90-90 goals. THN members are part of work to achieve this outcome, but many organizations also worry about the most vulnerable 10-10-10 who will remain. As the overall impact of HIV is reduced in our city, pressure will increase to fold HIV services into sexual health care and into broader social service agencies. The most vulnerable clients living with HIV will be faced with less dedicated support then ever before.

Community based organizations have unique expertise in reaching the most vulnerable among our populations.[5] Creating a critical mass of agencies, who demonstrate their ability to share scarce resources and work together to create more streamlined services for those most in need, will help build a stronger case for the continued existence of dedicated HIV services. It will allow smaller, more culturally specific organizations to operate more efficiently, ensuring that agencies with unparalleled expertise in serving the most vulnerable can continue their missions. When, the need for HIV-specific services decreases, the co-located agencies will have established a collective resource, where needed services can be consolidated as well as a unified voice for helping to shape the next generation of services.

References

[1] Toronto HIV/AIDS Network. Mission Statement. At http://www.torontohivaidsnetwork.org/about-us/

[2] Toronto HIV/AIDS Network. 2019 Membership list. Accessed December 2019.

[3] CBC. Census 2016: More than half of Torontonians identify as visible minorities. Oct 26, 2017. https://www.cbc.ca/news/canada/toronto/census-visible-minorities-1.4371018

[4] OHTN. The Ontario Community HIV/AIDS Reporting Tool (OCHART). Unpublished data extracted December 2019.

[5] Choi SK, Holtgrave DR, Bacon J, et al. Economic Evaluation of Community-Based HIV Prevention Programs in Ontario: Evidence of Effectiveness in Reducing HIV Infections and Health Care Costs. AIDS Behav. 2016 Jun;20(6):1143-56.

[6] Williams P, Narciso L, Browne G, Roberts J, Weir R, Gafni A. Characteristics of People Living With HIV Who Use Community-Based Services in Ontario, Canada: Implications for Service Providers. JANAC: Journal of the Association of Nurses in AIDS Care 2005;16(4):50- 63.

[7] Toronto to Zero. A Call to Action to End HIV in Our City, May 2019. At https://torontotozero.ca/resources/

[8] Ontario HIV Epidemiology and Surveillance Initiative (OHESI). New HIV diagnoses in Ontario, 2017.Toronto, Ontario, July 30,2019. At: http://www.ohesi.ca/wp-content/uploads/2019/07/OHESI-2017-new-diagnoses.pdf

[9] OHESI. HIV Diagnoses in Ontario: Refinements to Surveillance Data in the 2018 reports. December 16, 2019. At: http://www.ohesi.ca/hiv-diagnoses-in-ontario-refinements-to-surveillance-data-in-the-2018-reports/

[10] Ontario HIV Professional Specialty Group. Eleventh Annual HIV Pharmacy Education Day Report, December 12, 2019.

[11] Fife House. Annual Report 2018-19. At: https://www.fifehouse.org/wp-content/uploads/AR-web-final.pdf

[12] Toronto HIV/AIDS Network. Strategic Plan, April 1st 2016 to March 31st 2020. At http://www.torontohivaidsnetwork.org/wp-content/uploads/2018/09/THN-Strategic-Plan-2016-to-2020.pdf

[13] Charity Village. Friendship, Courtship, Partnership: Why Canadian Nonprofits need to think about working together differently. 2011. At https://charityvillage.com/cms/Portals/0/charityvillage/Downloads/Shared_Services_Report.pdf

[14] Cefola J, Brotsky C, Hanson R. Shared Services: A Guide to Creating Collaborative Solutions for Nonprofits. The Nonprofit Centers Network, 2010. At: https://www.nonprofitcenters.org/publications/ [For purchase access.]

[15] Bubel A, Cabaj P, Soots L. Edmonton Nonprofit Shared Spaces Feasibility Toolkit. At: https://www.edmonton.ca/programs_services/documents/PDF/Non-profit-SharedSpace-Toolkit.pdf

[16] Mizuno Y et al. Is co-location of services with HIV care associated with improved HIV care outcomes? A systematic review. AIDS Care. 2019 Nov;31(11):1323-1331.

[17] Charity Village. Collaboration 101. June 2012. At: https://charityvillage.com/Content/92041/Collaboration_101.pdf

[18] Ryser L, Patterson D et al. Learning from Smart Services and Infrastructure Projects in Rural BC: Final Report 2016. At: http://rplc-capr.ca/wp-content/uploads/2016/06/Smart-Services-CASE-STUDIES.pdf

[19] Sudbury & District Health Unit. Equity-Focused Health Impact Assessment – A Community Pilot: An Assessment of a Shared Space Model for Sudbury Community Service Agencies, December 2012. At: https://www.phsd.ca/wp-content/uploads/2015/03/EfHIA_Pilot_Shared_Space_Full_EN.pdf

[20] Bubel A, Cabaj P, Soots L. Edmonton Nonprofit Shared Spaces Feasibility Toolkit. At: https://www.edmonton.ca/programs_services/documents/PDF/Non-profit-SharedSpace-Toolkit.pdf

[21] Bradbury S, Laca G et al. Building Co-Location: A Report Prepared for Marion County Coalition On Youth and the Early Intervention and Prevention Initiative, April 2011. At: https://bit.ly/38R8PUI

[22] Lennie J. Learnings, case studies and guidelines for establishing shared and collaborative service delivery in the non-government sector, Feb 2010. At: https://communitydoor.org.au/collabcasestudies

[23] Rapid Response Service. The impact of location on implementation of HIV/STI prevention interventions among LGBTQ communities. Toronto, ON: Ontario HIV Treatment Network; April 2019.

[24] Cooper V, Clatworthy J, Youssef E, et al. Which aspects of health care are most valued by people living with HIV in high-income countries? A systematic review. BMC Health Services Research 2016; 16(1): 677.

[25] Premier's Council on Improving Healthcare and Ending Hallway Medicine. Hallway Healthcare: A System under Strain, January 2019. At: http://www.health.gov.on.ca/en/public/publications/premiers_council/report.aspx

[26]Toronto Real Estate Board. Commercial Realty Watch, Third Quarter 2019. At: http://www.trebhome.com/files/market-stats/commercial-reports/cw19Q3.pdf

[27]Statista. Asking rent per square foot of office space in Toronto in the 4th quarter of 2019, by submarket. At: https://www.statista.com/statistics/802500/asking-rent-per-sf-office-space-toronto-by-submarket/

[28] Collins E., Cain R., Bereket T., Chen Y.Y., Cleverly S., George C., Hayes P., Jackson R., Layman-Pleet D., Li A., Prentice T., Taylor D., Travers R., (2007) Living & Serving II: 0 Years Later - The Involvement of People Living with HIV/AIDS in the Community AIDS Movement in Ontario. Toronto: The Ontario HIV Treatment Network.

[29] Li, Alan & Wales, Joshua & Wong, Josephine & Owino, Maureen & Perreault, Yvette & Miao, Andrew & Maseko, Precious & Guiang, Charlie. (2014). Changing access to mental health care and social support when people living with HIV/AIDS become service providers. AIDS care. 27. 1-6. 10.1080/09540121.2014.940269.

[30] Li, Alan & Wales, Joshua & Wong, Josephine & Owino, Maureen & Perreault, Yvette & Miao, Andrew & Maseko, Precious & Guiang, Charlie. (2014). Changing access to mental health care and social support when people living with HIV/AIDS become service providers. AIDS care. 27. 1-6.

[31] Collins E., Cain R., Bereket T., Chen Y.Y., Cleverly S., George C., Hayes P., Jackson R., Layman-Pleet D., Li A., Prentice T., Taylor D., Travers R. Living & Serving II: 0 Years Later - The Involvement of People Living with HIV/AIDS in the Community AIDS Movement in Ontario. Toronto: The Ontario HIV Treatment Network, 2007.

[32] Rapid Response Service. Impact of Community-Based Organizations for People Living with HIV. Toronto, ON: Ontario HIV Treatment Network; October 2015.

[33] Merzel C, D'Affilitti J et al. Reconsidering Community-Based Health Promotion: Promise, Performance, and Potential. Am J Public Health. 2003 Apr;93(4):557-74.