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FOR PEOPLE LIVING
WITH HIV AND OTHER
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INVALIDITÉS ÉPISODIQUES

How can rehabilitation lead to better health for people living with, and vulnerable to, HIV? Thinking, Doing and Feeling beyond 90-90-90

2017 Think Tank Report

24 March 2017

Toronto, Ontario

Realize (formerly Canadian Working Group on HIV and Rehabilitation [CWGHR]) is a national charitable organization working to improve the quality of life of people living with HIV and related conditions through rehabilitation research, education, and cross-sector partnerships. ***Realize*** members are individuals and organizations that have an interest in HIV, disability and rehabilitation. These include: community-based HIV/AIDS, disability and rehabilitation organizations; national professional associations and individual clinicians; unions; private-sector companies; people living with HIV and other disabilities; health care, social care and human resources professionals; and other people who are interested in HIV, disability and rehabilitation.

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Acknowledgements

Realize (formerly the Canadian Working Group on HIV and Rehabilitation) would like to thank all those from across Canada who participated in this Think Tank, entitled "**How can rehabilitation lead to better health for people living with and vulnerable to HIV? Thinking, Doing and Feeling**" held at The Centre for Social Innovation - Annex in Toronto, Ontario on Friday, March 24th 2017.

Think Tank 2017 Partner:
We would like to thank our valued partner, the Institute for Global Health Equity and Innovation (IGHEI) at the University of Toronto, for their input, support, and participation during the entire Think Tank process.

UNIVERSITY OF TORONTO
Institute for Global Health Equity & Innovation

Think Tank 2017 Planning Committee:
Along with IGHEI, ***Realize*** would like to recognize and thank Larry Baxter and Stephanie Nixon, as well as other members of our Research, Education and Practice Advisory Committee (REPAC), who provided rich input into the form and content of the event.

Think Tank 2017 Financial Partner:
Realize would like to recognize the financial support from Theratechnologies Inc. with which we were able to support participant attendance from across Canada.

Thera technologies

Think Tank Facilitators:
We would like to particularly acknowledge and thank Glyn Towson and Stephanie Nixon for facilitating the Think Tank.

Table of Contents

Introduction

The UNAIDS 90-90-90 treatment cascade was developed as a strategy to end AIDS by 2020. [i] These targets call on the HIV movement to create a world where 90% of people at risk of HIV know their status, 90% of people who are HIV+ receive antiretroviral treatment, and 90% of people receiving treatment achieve an undetectable viral load. Globally this strategy is being adopted by governments as part of their HIV/AIDS strategies. In 2015, the Public Health Agency of Canada adopted these targets as the focus of their national response to HIV. [ii]

Although the utility of the cascade and the overall goal to end the HIV/AIDS epidemic is supported by many, including federal and provincial governments, there is concern about the increasing use of the cascade in isolation, as a policy strategy within which decisions regarding care and treatment for people living with HIV (PLWHIV) are made.[iii] [iv] Questions arise as the treatment cascade focuses mostly on the viral load of a person living with HIV. This focus medicalizes HIV instead of emphasizing the right to health of people living with and vulnerable to HIV across the life course. 90-90-90 defines prevention using only the secondary and part of the primary domains (See Appendix A). It fails to acknowledge the full breadth of primary prevention or the role of tertiary prevention, or the fact that most people living with HIV perceive themselves to be healthy. Furthermore, 90-90-90 does not address the myriad non-medical factors that contribute to the health of people living with or vulnerable to HIV, including stigma, and social determinants of health.

But rehabilitation does. ***Realize*** defines rehabilitation as any services or activities that address or prevent body impairments, activity limitations and social participation restrictions experienced by an individual.[v] Historically, rehabilitation has been considered a tool for tertiary prevention of HIV. However there may be a role for rehabilitation in primary and secondary prevention as well, which could contribute to increasing the proportion of PLWHIV who consider themselves healthy.

This leads to the question of "How can rehabilitation lead to better health for people living with and vulnerable to HIV? Thinking, Doing and Feeling."

On March 24th 2017, ***Realize*** and the Institute for Global Health Equity and Innovation (IGHEI) asked that question.

Think Tank Goals

The goals for this year's Think Tank were:

1. Identify what being healthy means to people living with HIV and how to achieve it
2. Identify how rehabilitation has a role to play in prevention and to improve or expand upon the scope of the treatment cascade
3. Identify the gaps in the 90-90-90 treatment cascade and its impact on people living with and vulnerable to HIV
4. Foster dialogue and collaboration between and among diverse communities, sectors and professions. (See agenda in Appendix A)

The Day

The Think Tank was held at the Centre for Social Innovation in Toronto, Ontario and ran from 8:30am to 1:00pm. Twenty-nine people (36 including ***Realize*** staff) attended the Think Tank. Participants came from all across Canada, and various sectors of the HIV community, and included people with lived experience of HIV and/or other chronic health conditions, rehabilitation specialists, and researchers. This diverse group also included women, indigenous people, people from many ethnic backgrounds, and people with disabilities.

Carrielyn Lund, ***Realize***'s Aboriginal Elder, opened the day with a welcome message from the Aboriginal community. Tammy Yates, ***Realize***'s executive director, welcomed the participants, and acknowledged and thanked IGHEI for partnering with us on this important topic. Tammy introduced the day's co-facilitators, Glyn Towson and Stephanie Nixon, and Ellena, a representative from IGHEI. Ellena welcomed participants on behalf of IGHEI and outlined the importance of this topic to people living with HIV. The facilitators followed by covering the aims for the day, reviewing the agenda and outlining group norms. Finally, before the discussion of the day started, Puja Ahluwalia from ***Realize*** set the context of the day by providing definitions of the key concepts of the 90-90-90 treatment cascade, levels of prevention, health, and rehabilitation (See Appendix B)

Methodology

The Think Tank was divided into two parts focusing on two different questions. The brainstorming around the questions involved small and large group discussions, and personal reflection:

- What are the pros and cons of using the treatment cascade as a measure of the health of people living with HIV?
- What are some of the ways that rehabilitation can be used to improve overall health for PLWHIV and/or expand the reach of the treatment cascade? (See Appendix A)

Participants were seated at one of six tables with a facilitator from ***Realize***. Each table's discussion was guided by one of three themes:

- Quality of Life
- The Care People Want
- Rehabilitation as Prevention

A note-taker took notes during the large group discussions and participants were encouraged to write thoughts down on note-cards at each table. Finally, all participants were encouraged to complete pre-event and post event surveys. Both surveys attained an approximately 80% response rate (24/29 pre-event, 23/29 post-event) (See Appendices C and D).

Discussion

The overall consensus was that the current direction of HIV treatment and care does not fully encompass all the needs of PLWHIV. As the 90-90-90 treatment cascade is increasingly being used as the basis for HIV strategies at the federal and provincial levels in Canada, participants delved into the question of "What are the pros and cons of using the treatment cascade as a measure of the health of people living with HIV?"

Attainment of the final stage of the treatment cascade is considered the current goal for all PLWHIV, and what their HIV care should focus on. Provinces have already or are currently creating policy centered on the cascade as the way to provide care for PLWHIV. In light of that policy direction, participants felt that the cascade focuses on the individual's HIV status and viral load, while failing to acknowledge that HIV has an impact on more than those limited aspects. Care needs to, instead, be provided to people within the context of their lives, and meet them where they are – physically, emotionally, etc. During the discussion, two participants highlighted the differences in their respective provinces with regards to provision of HIV medication. In Southwestern Ontario, PLWHIV have to travel to one of two major cities to obtain specialized HIV care, whereas in British Columbia HIV care has been decentralized and PLWHIV can go to their local health centre. Looking at these two cases, in the Ontario example the context of the person has not been acknowledged in the way that care is made available. At times, it was described that a taxi would cost over $200, and it would take an entire day to attend the clinic. In Canada, specifically, because health care is provincially distributed, each province has their own interpretation of how to implement HIV care and therefore geographical disparities exist.

Participants also felt that the focus on the linearity of the cascade did not fully capture what living with HIV is like. There needs to be acknowledgement of the fluidity of a person's experience with HIV; they may not move towards viral suppression in a direct way, and once achieved, it may not be the end of the journey. One participant shared that there is "value from a medical model for measuring and controlling the movement of HIV in a community" but "what you measure is what gets done". What if the cascade is measuring the wrong thing? Or just not measuring the entire story? It was acknowledged within the room that the cascade is something that must be part of HIV care, but not the entirety of it. The cascade provides no direction with regards to quality of life. It doesn't explicitly take into account people's interaction with lipodystrophy and body image, their fatigue, memory concerns, employment status or even the barriers they face with regards to stigma, to name but a few. "The focus is too much on the number" and not the person. Participants noted that with the focus on the numbers of 90-90-90, that we cannot forget the 10% that don't meet each level. Care needs to be taken to ensure that the 10% who do not

Where is the person in the cascade?

move through the cascade to the next level are not disproportionately representative of a single population. HIV care needs to be accessible to all despite their socio-economic, immigration, gender, or cultural status. There was consensus that 90-90-90 is a good starting point, but can't be the entire story.

Along with needing a broader focus on HIV care, participants did not feel that the cascade should be used as a measure of overall health. Firstly, it wasn't developed to be one and secondly, as previously discussed; it does not fully capture the person and their story with HIV. They felt that the discrete entry and exit points of the cascade misrepresented the person living with HIV and their needs. As one participant asked, "What happens at the end of the cascade? That is not ultimate health!" It was recognized that even though a person may achieve an undetectable viral load, they may not feel healthy and may continue to have needs related to their HIV status, such as lipodystrophy or neuropathic pain. Each person has their own definition of health, and what it means to be healthy and using just one marker of health, undetectable viral load, does not allow an individual or a community's definition of health to be achieved.

What happens at the end of the cascade? That is not ultimate health!

After looking at the pros and cons of the cascade as a measure of health and focus in HIV care, the discussion moved towards examining rehabilitation: "What are some of the ways that rehabilitation can be used to improve overall health for PLWHIV and/or expand the reach of the treatment cascade?" Participants were provided with the Worthington et al (2005) comprehensive definition of rehabilitation: "Any service or activity that addresses or prevents body impairments, activity limitations, and social participation restrictions experienced by an individual", on which to base their discussions.[vi] Rehabilitation was seen as a basket of services that can assist people to engage and/or re-engage with their communities. It was felt that rehabilitation workers, including social workers, can be case managers and link PLWHIV to the variety of service providers that may assist them, and be a source of support for PLWHIV. It was postulated that rehabilitation could be a framework on top of 90-90-90 to allow us to work with people where they are in their lives. As one participant said "Rehabilitation can lead to better health for PLWHIV by facilitating community development, and providing people with the skills they need to connect, feel included, and decrease loneliness." Clients of community-based HIV organizations who are connected to community health centres, and other team-based primary care organizations, were described as being better connected to

Any service or activity that addresses or prevents body impairments, activity limitations, and social participation restrictions experienced by an individual. (Worthington, et al., 2005)

Rehab provides a framework on top of 90-90-90 and allows us to think of people in context

a whole host of services, including physiotherapy and occupational therapy, that clients in other models of care had difficulty accessing. People felt that rehabilitation needed to be more accessible and incorporated into every stage in the cascade. This in turn would make the entire cascade more impactful and lead to better health overall.

Despite this wholehearted support of rehabilitation, there were messages of caution. Participants felt that it needs to be acknowledged that "rehabilitation can't do everything" and there is a disconnect between the definition of rehabilitation, its understanding and how it is provided. The way that people understand and conceptualize rehabilitation was seen as a barrier and strong recommendations were made for ***Realize*** to raise awareness further about the broader definition of rehabilitation; some participants queried whether we needed to change the word rehabilitation to improve clarity. 'Pre-hab' (coined by one of the particitipants) was discussed as a term that could encompass the preventative and maintenance aspects of rehabilitation work. Participants queried if primary care settings could do more to identify people at risk of HIV, or PLWHIV who are experiencing symptoms beyond their viral load that may impact their journey through the cascade. Primary care workers could be the entry point for PLWHIV or at risk of HIV to rehabilitation services as a form of pre-habilitation – prevention of impairments, activity limitations, and social participation restrictions and/or maintenance of current functional and social status. Although 'Pre-hab' was the main alternate term discussed, no final consensus was made as to an appropriate alternative word for rehabilitation.

Participants came up with an '**ABC'** of concrete action items that those in the room could move forward on:

1. **Advocate** –we need to advocate more strongly and more strategically at all levels to ensure that the message of **quality of life** for PLWHIV is heard. Those participants from community-based HIV organizations acknowledged that they could have a stronger voice in the advocacy community.

2. **Be creative** – participants encouraged each other to think outside the box of traditional avenues of health care:

    a. Could rehabilitation professionals like physiotherapists be trained to participate in point-of-care rapid testing?

    b. Advocate for increased access to rehabilitation services. For example, in Ontario we could focus on increasing access to team-based primary care settings, such as community health centres and family health teams.

3. **Connect the dots** – work together with health care settings and professionals, and community-based HIV organizations to improve information sharing (while following the Health Insurance Portability and Accountability Act) to improve comprehensive care for PLWHIV.

Participant Evaluation Results

Participants were invited to complete an online pre-event survey to determine expectations, knowledge of Think Tank concepts, and intention to take action on HIV and rehabilitation (see appendix C). Each participant was also provided with a survey to complete at the end of the event (Appendix D). Twenty-four participants completed the pre-event survey, while 23 completed the post-event survey.

More than half of the respondents (58%) indicated that this was their first Think Tank event. Participants identified a number of expectations for the Think Tank: learning more about the rehabilitation needs of people living with HIV; understanding how rehabilitation fits within the care cascade and its role in prevention; sharing of ideas and experiences; opportunities for networking, making new connections and partnerships; and identifying actions to take.

Overall, the feedback received from participants in the post-event survey indicated that they were very satisfied with the Think Tank.

The most relevant take-away messages for the participants included: an increased understanding of rehabilitation and how it is relevant to/can support 90-90-90; the notion of 'Pre-hab' (prehabilitation); definitions of health and rehabiliation need to change – move away from a deficit focus and towards a model of maximizing well-being; the role rehabilitation can play in improving HIV care; how rehabiliation can be incorporated into the treatment cascade; advocacy points; recognizing the strengths and limitations of the treatment cascade; and that care gaps remain.

All participants who responded to this question indicated that they would be able to apply the content from the Think Tank in their work. They indicated they would use this information to: undertake advocacy and encourage self-advocacy by others; share information, educate and report back to others (e.g. the Canadian Association of Occupational Therapists, members of a support group, other health professionals, integrate into e-learning, presentation at CAHR, a possible opinion piece); and use it to inform research (scope and measures) and policy.

Recommendations for future Think Tank events included: providing more pre-reading and stronger linkage between readings and the agenda; increasing diversity by table; more time and opportunities for networking and exchange of ideas (e.g. change tables part way through, name tags); and sharing ideas generated during the Think Tank with policy makers and people living with HIV.

Conclusion

During the Think Tank participants discussed what it means to be healthy for people living with HIV, the role of rehabilitation in prevention and in the context of the 90-90-90 treatment cascade, and how the cascade is currently being implemented and used.

Health was seen as an individual definition that could not be measured only by the treatment cascade. The consensus from the group was that the 90-90-90 treatment cascade is not comprehensive enough as a sole treatment focus and measurement of health for PLWHIV. It was agreed that we need to have a broader view of HIV care that acknowledges the context of the person, their community and their life. However, we cannot stop working towards achieving the UNAIDS targets of 90-90-90 as a way to end HIV/AIDS.

Rehabilitation was seen as a framework that the cascade fits within or as a lens through which to view the framework. It allows access to a wraparound approach to revitalized treatment, care and support within the cascade for PLWHIV. A cautionary note - we cannot overreach with rehabilitation, it may not be able to do everything. A change in terminology may be appropriate as the Worthington definition of rehabilitation is not universally accepted; many people often still use a narrower definition of rehabilitation. 'Pre-hab' might be a way to bring primary care and HIV specialty care on board with prevention and maintenance of health and wellness.

Finally, participants in the Post-event evaluation (See Appendix D) responded that the day was thought-provoking and engaging. They appreciated the "diversity of the crowd" in attendance and that the participants at the table were a "mix of backgrounds and lived experience".

In order to make change at the community, provincial and national levels, people who attended the Think Tank and others in the communities of HIV, rehabilitation, policy, and research need to move forward on the '**ABC**' action items collaboratively. With the 90-90-90 treatment cascade and rehabilitation, we have the tools to improve the lives and health of PLWHIV and end the HIV/AIDS epidemic.

Appendices

Appendix A - Agenda

Annual Think Tank

How can rehabilitation lead to better health for people living with and vulnerable to HIV?
Thinking, Doing and Feeling Beyond 90-90-90

Friday, March 24, 2016
8:30 AM to 1:00 PM
Venue: CSI-Annex, 720 Bathurst Street
Room: The Garage

Facilitators: Glyn Townson and Stephanie Nixon

Goals for the Session:

1. Identify what being healthy means to people living with HIV how to achieve it
2. Identify how rehabilitation has a role to play in prevention and to improve or expand upon the scope of the treatment cascade
3. Identify the gaps in the 90-90-90 treatment cascade and its impact people living with and vulnerable to HIV
4. Foster dialogue and collaboration between and among diverse communities, sectors and professions.

Agenda:

Time	Item
8:30 to 9:00	Registration and light breakfast ***Realize*** Aboriginal Elder Welcome – Carrielynn Lund
9:00 to 9:05	Welcome from ***Realize***
9:05 to 9:10	Welcome from the Institute of Global Health Equity & Innovation
9:10 to 9:20	Framing the Day and Introductions What is a "Think Tank"? *"A think tank is defined as a process for in-depth consideration of issues and challenges whose relevance reaches beyond the individual person or program and the immediate time frame."* *(Caliva & Scheier, 1992)*
9:20 to 9:25	Setting the Stage: ➢ What is the treatment cascade and 90-90-90? ➢ Levels of prevention ➢ What is health
9:25 to 9:55	Small Group Brainstorm (4-6 ppl) ➢ What are the pros and cons of using the treatment cascade as a measure of the

	health of people living with HIV?
9:55 to 10:15	Large Group Discussion ➢ What are the pros and cons of using the treatment cascade as a measure of the health of people living with HIV?
10:15 to 10:30	Pre-break wrap up
10:30 to 10:45	Wellness break
10:45 to 10:50	Setting the Stage: ➢ What is rehabilitation?
10:50 to 11:50	Small Group Brainstorm (4-6 ppl) ➢ What are some of the ways that rehabilitation can be used to improve overall health for PLWHIV and/or expand the reach of the treatment cascade?
11:50 to 12:35	Large Group Discussion ➢ What are some of the ways that rehabilitation can be used to improve overall health for PLWHIV and/or expand the reach of the treatment cascade?
12:35 to 1:00	Wrap up and evaluation

Appendix B – Definitions

LEVELS OF PREVENTION

Primary Prevention: Prevention of disease or injury before it occurs

Secondary Prevention: Reducing the impact of the disease or injury once it has occurred

Tertiary Prevention: Reducing the long-term impact of the disease or injury once it has occurred

TREATMENT CASCADE

90	**90**	**90**
90% of all people living with HIV will know their status	90% of all people with diagnosed HIV infection will receive sustained ART	90% of all people receiving ART will have viral suppression (undetectable viral load)

HEALTH

Health is the ability of a person or a community to adapt and self-manage when facing physical, mental or social challenges (Jadad, 2016)

REHABILITATION

Created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members. (Ottawa Charter)

Any service or activity that addresses or prevents body impairments, activity limitations, and social participation restrictions experienced by an individual. (Worthington, Myers, O'Brien, Nixon & Cockerill, 2005)

Appendix C – Pre-Event Survey

Welcome! Thank you for agreeing to participate in our Think Tank this year. We look forward to seeing you.

The goals of the Think Tank are to:
1. Identify what being healthy means to people living with HIV and how to achieve it
2. Identify how rehabilitation has a role to play in prevention and to improve or expand upon the scope of the treatment cascade
3. Identify the gaps in the 90-90-90 treatment cascade and its impact on people living with and vulnerable to HIV
4. Foster dialogue and collaboration between and among diverse communities, sectors and professions.

Taken together, the results of the pre and post-event surveys will give us a sense of what may have changed for Think Tank attendees as a result of participating.

Please note that completion of this survey is voluntary and all responses will be anonymous.

It will take approximately 10 minutes to complete.

We thank you for your support and look forward to rich discussions on March 24th.

1. Please rate how much you agree with the following statements from 1 (Strongly disagree) to 5 (Strongly agree):

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I have thought about the strengths and weaknesses of the HIV treatment cascade	○	○	○	○	○
I understand the three levels of prevention (primary, secondary and tertiary) and how they relate to HIV and/or chronic health conditions	○	○	○	○	○
I believe that rehabilitation has a role to play in HIV prevention	○	○	○	○	○
I feel that people living with HIV can enjoy good health	○	○	○	○	○
I plan to take action (e.g. make referrals, champion policy change, etc.) to improve access to rehabilitation for people living with HIV or other chronic health conditions in the next six months	○	○	○	○	○

2. What are your expectations for the Think Tank?

3. What is your area of expertise? Please check all that apply.

- ☐ Lived experience with HIV
- ☐ Lived experience with a chronic health condition
- ☐ Prevention/Poz Prevention
- ☐ Rehabilitation services
- ☐ Community-based HIV work
- ☐ Research
- ☐ Other (please specify)

4. Have you attended a ***Realize*** (or CWGHR) Think Tank previously?

- ○ Yes
- ○ No
- ○ Don't know/Can't remember

Thank you for taking the time to complete this pre-survey. See you on March 24th!

Appendix D – Post-Event Survey

Think Tank Post-Survey:
How can rehabilitation lead to better health for people living with and vulnerable to HIV?
Thinking, Doing and Feeling

Friday, March 24th 2017

We encourage you to complete this tool with honesty and with confidence that the results are private and confidential. Results will only be shared as summarized data. It should take you no longer than 10 minutes to complete. Your completion of this questionnaire will inform our ongoing work.

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1. **Please rate how much you agree with the following statements from 1 (Strongly disagree) to 5 (Strongly agree):** *(please circle)*

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I have thought about the strengths and weaknesses of the HIV treatment cascade	1	2	3	4	5
I understand the three levels of prevention (primary, secondary and tertiary) and how they relate to HIV and/or chronic health conditions	1	2	3	4	5
I believe that rehabilitation has a role to play in HIV prevention?	1	2	3	4	5
I feel that people living with HIV can enjoy good health	1	2	3	4	5
I plan to take action (e.g. make referrals, champion policy change, etc.) to improve access to rehabilitation for people living with HIV or other chronic health conditions in the next six months	1	2	3	4	5

2. **In terms of today's discussion, what was the most relevant take-away for you?**

3. **Will you be able to apply any of the content discussed today in your work?**

☐ Yes ☐ No

If yes, how so? If no, why not?

4. **Overall, how would you rate the following aspects of the Think Tank?**

	Not Satisfied	Somewhat Satisfied	Neutral	Satisfied	Very Satisfied
The relevance of the topic	1	2	3	4	5
The objectives of the day were met	1	2	3	4	5
Participant diversity in terms of expertise, experience and ideas	1	2	3	4	5
Quality of the facilitation	1	2	3	4	5
Opportunities to network and connect with others	1	2	3	4	5

5. **Any recommendations to improve the Think Tank model of knowledge exchange?**

6. **Any additional comments?**

Thank you for taking the time to complete this post-event survey.

References

[i] UNAIDS. (2014). *90-90-90 An Ambitious Treatment Target to Help End the AIDS Epidemic*. Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS. http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf

[ii] Public Health Agency of Canada. (2015). *Statement by Honourable Jane Philpott - World AIDS Day - December 1, 2015.* http://news.gc.ca/web/article-en.do?nid=1022689

[iii] Public Health Agency of Canada. (2016). *Summary: Measuring Canada's Progress on the 90-90-90 HIV Targets*. http://www.healthycanadians.gc.ca/publications/diseases-conditions-maladies-affections/hiv-90-90-90-vih/index-eng.php

[iv] Ontario Advisory Committee on HIV/AIDS. (2017). HIV/AIDS Strategy to 2026: Focusing our efforts - Changing the course of the HIV prevention, engagement and care cascade in Ontario. Toronto: Ministry of Health and Long-Term Care. http://www.health.gov.on.ca/en/pro/programs/hivaids/docs/oach_strategy_2026.pdf

[v] Worthington, C., Myers, T., O'Brien, K., Nixon, S., Cockerill, R., & Bereket, T. (2008). Rehabilitation Professionals and Human Immunodeficiency Virus Care: Results of a National Canadian Survey. *Archives Of Physical Medicine And Rehabilitation*, *89*(1), 105-113. http://dx.doi.org/10.1016/j.apmr.2007.10.009

[vi] Worthington, C., Myers, T., O'Brien, K., Nixon, S., Cockerill, R., & Bereket, T. (2008). Rehabilitation Professionals and Human Immunodeficiency Virus Care: Results of a National Canadian Survey. *Archives Of Physical Medicine And Rehabilitation*, *89*(1), 105-113. http://dx.doi.org/10.1016/j.apmr.2007.10.009