
Horizontal Pilot Project for Homeless Urban Aboriginal People with HIV/AIDS



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Introduction

This document will describe the results of the Horizontal Piloting Project for Homeless Urban Aboriginal People with HIV/AIDS in three components: cultural support worker activities, literature review, and needs assessment (interviews and feedback session). The evaluation of this project, funded by Public Health Agency of Canada, will be summarized in a separate report.

As noted in the proposal, this project sought to:

- Address the housing and health service needs of Aboriginal persons living with HIV/AIDS and made use of culturally appropriate approaches in order to improve their health outcomes and to prevent them from falling into homelessness.
- Utilize pre-existing services to strengthen the existing capacity of community partners, improve inter-agency communication and collaboration, and prevent the harmful impacts of initiating and then pulling services from the community.
- Provide descriptive information about the unique housing challenges and barriers faced by people living with HIV in Manitoba.
- Engage service providers, government, and front-line workers in discussions of how the needs of People Living with HIV can be better met through collaboration and partnership.

This was accomplished through:

- A review of academic and grey literature
- Nine Circles Cultural Mentor offering traditional cultural support to Aboriginal clients
- A Project Coordinator to coordinate and conduct interviews with People Living with HIV (PHAs) to document the challenges experienced by PHAs in the following areas:
securing housing, maintaining housing, accessing required health, cultural, and social support services
- Dissemination of project findings

Timeline

This project commenced in mid-May with the original project coordinator. With this project coordinator, the workplan and interview tool were designed between May and September. The original coordinator was not able to fulfill the contract and, as a result, the position was vacant for six weeks. Jennifer Kozyniak began as the project coordinator on November 15, 2008. From November 15 through to March 31, Jennifer completed the attached Needs Assessment documenting the housing needs and challenges faced by PHAs. During this time, Jennifer was supported by Tara Carnochan, Manager of the Health Promotion and Outreach Program at Nine Circles.

Partnerships

This project involved several different partnerships. The funding for this project included three 0.2EFT positions to be positioned in three community based not-for-profit organizations. Initially, Main Street Project shelter, Native Women's Transition Centre, and Ka Ni Kanichihk were targeted for partnership. Due to the challenges of staff transition, resource shortage, and workload issues, these organizations were not able to commit to participating in the project.

House of Hesed, a transitional supportive housing provider for people living with HIV, recruited participants for the interviews and participated in the evaluation component of the project. Through this partnership, evaluative tools were developed to assess the effectiveness and impact of the House of Hesed's services.

Partnerships with the Community Based Research Program (Canadian Institute of Health Research), the University of Winnipeg, Department of Sociology, and University of Manitoba, Department of City Planning, contributed to the success of this project. Paula Migliardi, Community Based Research facilitator for CIHR acted as a valuable contributor to this project. Rae Bridgman of the University of Manitoba acted as a principle investigator. Kendra Charles, University of Winnipeg, assisted Jennifer Kozyniak with the interviews.

Project Evaluation Activities

Activities With Project Partner:

Nine Circles collaborated with one partner (House of Hesed) to develop a data collection tool, a questionnaire, to monitor and evaluate the effectiveness of interventions in regards to overall health. House of Hesed is a transitional housing centre in Winnipeg, working with people living with HIV.

The questionnaire was developed out of several meetings with House of Hesed, and this partner offered input on the content, and the final version of the questionnaire. House of Hesed indicated they would like the areas of the "whole person" addressed, including: physical health, mental/emotional health, spirituality and social supports; questions concerning the areas were incorporated into the data collection tool. The data collection tool has been implemented at House of Hesed; the data has been gathered, preliminary analysis is complete, and a more in-depth report on the results is to follow.

Feedback From Project Partner:

House of Hesed is currently preparing feedback on their involvement in the project. They will provide feedback for indicators of success such as: reporting benefit to the organization from being involved in the project, increased knowledge of the issue, and identifying ways for the organization to put the information from the project into action.

Feedback Session:

A feedback session was held with participants to present preliminary findings and get direction on some secondary research questions which arose after the initial interviews had been conducted and analyzed. See page 28 for a detailed description of the feedback session.

Focus Group Interviews With Study Participants:

A focus group was held with study participants, and was led by the Nine Circles Research & Evaluation Coordinator. Overwhelmingly, the participants indicated a high satisfaction with their involvement in the study. All felt they were treated respectfully while involved in the project and they were made fully aware of what their role as participants would be. Also, the participants expressed that the key findings were representative of their experiences with housing issues and

the recommendations were useful and attainable. A summary of the information gathered at the focus group is to follow in the evaluation report.

Feedback From Members Of The Research Team:

Members of the research team will provide feedback on their involvement in the project. This feedback is currently being gathered and will consist of such items as: members of the research team report meaningful involvement in the project, the ways they were meaningfully involved and they identify they had opportunities to offer feedback and suggestions throughout the project. The summary of this information is to follow in the evaluation report.

Dissemination

The findings of this project were disseminated, and will continue to be disseminated. The key findings of the interviews were summarized into a poster and executive summary.

The findings have been sent to local, regional, and provincial individuals and groups working in the fields of housing and health (including various levels of government). The initial distribution list targeted approximately 70. The executive summary has been distributed to key community organizations that were initially targeted for partnership, including: Native Women's Transition Centre, Main Street Project, Ka Ni Kanichihk, and House of Hesed. Further distribution of the executive summary and report will be ongoing via Nine Circles staff and management.

Importantly, the participants have received copies of the findings. As housing is an important issue to people living with HIV and, particularly, to those living in poverty – clients continue to demonstrate a genuine interest in this project and its implications. A community forum was scheduled for April 22 to widely disseminate the results to individuals and groups interested in learning more about the ways in which housing affects individuals living with HIV. The invitation list for this event targeted over 60 individuals, groups, government representatives and organizations; ten people had confirmed attendance. The goal of this meeting was to share the project findings and to generate dialogue for further community partnership and collaboration, but subsequently attendance included only a handful of study participants and members of the research team. Rather than a formal presentation to the small group, a discussion commenced around the condensed version of the findings (i.e. the “onesheet” handout summary of the project, findings and recommendations). Positive feedback included a high satisfaction with the findings and recommendations. Those in attendance indicated the findings provided a clear representation of housing issues, and the recommendations were relevant and attainable.

The findings of this project will be shared at conferences to spread the information gained to front line service providers and policy makers. The poster and executive summary will be displayed and distributed at the Canadian Association for HIV Research Conference (Cocktails Scientifique – Prairies HIV Research and Practice) in Vancouver, British Columbia, and at Canadian Nurses in AIDS Care 2009 conference in Saskatoon, Saskatchewan. The poster will also be featured at Partners in Caring Conference in Winnipeg, Manitoba (May 2009) and the North American Housing and HIV Research Summit in Washington (June 2009).

1. Cultural Support Worker

The Cultural Support Worker provides an opportunity for First Nations, Inuit, non-status, and Metis to make an initial connection with someone from their own culture and works to provide improved access to services for all Aboriginal clients of Nine Circles. This includes linking them with resources internally and externally, such as: elder support, cultural ceremonies, language lessons, medicine picking, continued connections spiritually, mentally, emotionally, and physically.

During this project, the Cultural Support worker had 151 in person contacts with clients, made one home visit, and had 24 contacts via phone or writing. As mentioned above, these contacts focus on providing an introduction to traditional culture, assisting clients with identifying barriers to medical care or social support, as well as providing clients with culturally appropriate information, connecting clients with cultural resources and supports in their communities. In addition to supporting clients in a one-to-one manner, the cultural support worker also organized 25 group sessions involving PHAs and those at risk of HIV. These group sessions included 3 sweat ceremonies; nine drumming workshops (drumming, drum making, drum teaching); 3 pipe ceremonies; and 3 Ojibway language lessons. In total, these workshops reached 67 women, 73 men, and 4 transgenders.

The cultural support worker also created resources for client usage: one pamphlet to provide landlords and tenants with information about smudging and another pamphlet used for drumming teachings. The smudging pamphlet was developed as a resource to familiarize landlords with the practice, benefits, and cultural value of smudging. This brochure also provides clients with information about how to smudge safely.

USEFUL INFORMATION FOR LANDLORDS

- The smudge is similar to other religious practices such as the burning of incense in homes and churches.
- ✿ Sage and Sweetgrass do not stain walls because they are natural with no harsh chemicals.
- ✿ Aboriginal medicines are not narcotics (drugs).

SMUDGING AT HOME

- ✿ Individuals are encouraged to use only small amounts (a nickel size or a loonie size) of medicine when smudging.
- ✿ Also, it is suggested to use Sage or Sweetgrass only as it is very effective.
- ✿ People are encouraged to open windows after smudging.



SMUDGING: USEFUL INFORMATION FOR TENANTS, LANDLORDS & CARETAKERS

Things you want to know about aboriginal Traditional Smudging.

For thousands of years some Aboriginal people, in particular First Nations and Métis, have smudged with Aboriginal Traditional medicines.

A smudge is smoke used for ritual cleaning. Smudging is a ceremony traditionally practiced by some Aboriginal cultures to physically or spiritually purify or cleanse negative energy, feelings or thoughts from a place or a person. Also, if an individual is scared or anxious, the smudge helps them to be calm. Some non-Aboriginal people also smudge.

Sacred medicines such as Cedar, Sage, Sweetgrass or Tobacco are burned in an abalone shell or clay bowl. The person puts their hands in the smoke and carries it to their body, especially to areas that needs spiritual healing (mind, heart, body). The smell of the burning medicines stimulate the brain to produce a calming, soothing effect and to promote the healing processes.

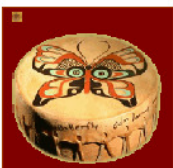


THE DRUM AND THE DRUM TEACHINGS

The Drum teachings have been taught by the Elders for many years. It represents the Circle of Life. It is the heartbeat of our Mother, the Earth. It is a Living Being with the Energy of the Tree and the Animal that gave it Life.

Creating and taking care of a Drum is a big responsibility. It is like taking care of a baby, the Drum needs nurturing. We nurture the Drum by putting it in a bag or wrapping it in a cloth. Smudge the Drum before each use. Sometimes it needs water or warmth. Keep it warm by rubbing your hand on the Drum or if you are out in the country at a Ceremony, gently warm it over the fire.

- Always, keep your Drum in a clean dry place, away from common living areas.
- Respect your Drum. The Drum is not for show.
- The Drum is sacred.
- Only bring out your Drum for singing and drumming or going to a Ceremony.



No two Drums are the same; each has its own distinctive structure, spirit, and life. The hands and the thoughts of the one who makes the Drum are a part of its uniqueness. The Drum is not just a music-maker, but a voice for the soul within the sound.

If you are drinking alcohol or taking drugs (narcotics), please don't bring out your Drum. Elders teach us negative energy can go into the Drum. Elders suggest abstaining from using especially around the Drum and Sacred Medicines. It is like taking care of a baby; you do not want to endanger the child by neglect or abuse.

THE DRUM AND THE DRUM TEACHINGS (Cont'd)

For women on their Moon time (menstrual cycle), Elders teach us to put the Drum away to honor this Sacred Cleansing. This is not a punishment, but a sign of respect that honors your Woman Self.

Remember, taking care of a Drum is a big responsibility. Knowing and respecting these Drum teachings will help you take care of your Drum.

NINE CIRCLES COMMUNITY HEALTH CENTRE at 705 Broadway, Winnipeg, Manitoba is a community based, non-profit centre that specializes in HIV/STI prevention and care. Our Cultural Program offers services to all of our clients, that links them with resources internally and externally with Elder support, cultural ceremonies, and continued connection spiritually, mentally, emotionally and physically. Aboriginal Cultural events in the Nine Circles' Round Room (shown on the right) include: Naming Ceremonies, Sharing Circles, Pipe Ceremonies and Feasts, Smudging/Cleansing, Sweat Lodge Ceremonies (St. Benedict's Retreat Centre), medicine picking, arranging access to conferences and skills building workshops, and referrals to services (e.g. speaking to an Elder). Call 940-6000 for additional information on these services.



2. LITERATURE REVIEW

Introduction

The prognosis for Canadians diagnosed with HIV has become increasingly optimistic since the introduction of highly active antiretroviral therapy (HAART), and infected individuals who test early and adhere to treatment can expect to manage their infection with regular monitoring and medical care. However, it is clear that all populations do not share this idealistic forecast, and many people living with HIV/AIDS (PHAs) encounter challenges and barriers that may lead to less than optimal health care utilization. One of the greatest challenges faced by PHAs is retaining an affordable, stable place to live. An individual's housing status is also one of the most important factors in determining an individual's access to healthcare and consequential success in living with their HIV infection. This review summarizes the impact of housing status on an individual's HIV care, challenges faced by Aboriginal people living with HIV/AIDS, and barriers that limit access to services for persons who are homeless or at risk for homelessness. Pertinent housing and cultural solutions from the literature are also reviewed. The goal of this project is to provide much-needed information about the housing needs of PHAs.

How is “homeless” defined?

It would be a gross generalization to imply that the word “homeless” has a universal definition that applies to all homeless people in the same way. While the classic definition may bring to mind people who are living on the street, in reality there is a full spectrum of other unstable housing situations that could be included under the umbrella of homelessness. These

include staying in shelters, welfare and boarding housing, treatment facilities, single room hotels, and staying in the homes of other people (1,2).

Why stable housing for PHAs?

Stable and affordable shelter is a basic human need, and this is no exception for PHAs. HIV infected individuals can now expect to live longer and healthier lives due to advances in antiretroviral drugs. However, prolonged life does not equate to self-sufficiency (3). In fact, the prevalence of HIV/AIDS is higher in people who are living in poverty, those who are homeless, and those who are unstably housed compared to the rest of the population (4,5). PHAs can become chronically ill and may need to rely on their social networks to support their needs (3).

Conditions such as mental health and substance abuse are more common in homeless or unstably housed individuals than in the general public, and can reduce their ability to access medical services to their full advantage (6-10). In contrast, stable housing has been shown to directly improve health status, independence, and adherence to therapy (11,12), as well as reduce risk behaviors and stress (13,14). Also, a study in the southern U.S. showed that stable housing for PHAs was associated with better physical health, as measured by higher CD4 T cell counts (15). Housing allows for stability, well-being, a sense of belonging, and a sense of personal identity, while also facilitating social connections, and providing the necessary stability to access health and supportive services (16,17).

People living with HIV have housing difficulties

A longitudinal study in Ontario, Positive spaces Healthy places, has shown that PHAs who face less stigma in the search for housing are more likely to obtain stable housing (18) and

they are both mentally and physically healthier than people who experience discrimination. However, stigma and discrimination still occur in many circumstances, both internally and externally (14,18,19), and may act as a barrier to prevent PHAs from receiving affordable, appropriate, and stable housing. Stigma may also prevent retention in care and result in less adherence to therapy, potentially resulting in poorer health outcomes and increased risk behavior due to less disclosure of HIV status to sex partners (20). The Ontario study showed that 1/3 of PHAs have faced discrimination when looking for housing, with 1/5 reporting more than one type of stigma. The discrimination reported was mainly due to sexual orientation, HIV status, employment status, and income (18). Aboriginal people were also more likely to experience discrimination. As well, this study found that nearly half of PHAs in Ontario had housing problems, with 75% having less than \$1,500 income per month, almost half had difficulty paying their rent, 1/3 had a risk of losing their housing, 1/4 felt they did not belong in their neighborhood, and 1/5 had moved at least once within the past year (18). In contrast, financial stability and stable housing for PHAs have been shown to improve health, sense of belonging, and quality of life (18).

Prevalence of HIV/AIDS in homeless individuals is higher than in the general population

The face of the HIV/AIDS epidemic in North America is changing, from one that predominantly affected men who have sex with men (MSM) to an epidemic that also affects the poor and minority groups, including injection drug users (IDUs), heterosexuals, and Aboriginal people (21). There is a strong relationship between poor housing and HIV transmission risk behaviors (13). Poverty and housing instability exacerbate the difficulties associated with HIV prevention, resulting in a higher risk of infection for the homeless. Poverty is not restricted only

to urban PHAs, as revealed by a study showing the diversity and challenges faced by PHAs in rural western Canada (22). As well, shelter environments may facilitate HIV spread, due to the difficulty in maintaining stable sexual relationships, lack of privacy, as well as communal sleeping and bathing (23).

Unstably housed individuals have limited access to medical care, which can have negative effects on prevention, harm reduction, and treatment

People with unstable housing are less likely to access healthcare, and those who do access care may not be utilizing the health care system to its full potential due to a range of barriers (12,14,24). With the exception of a few rare studies such as one in New York City (25), unstably housed individuals are more likely to rely on emergency room care, are less likely to access ambulatory care, and stay in the hospital longer than those with stable housing (3,26-28). In many cases, these individuals do not have a consistent health care team or physician providing them with regular care (28). One multi-site study in the U.S. suggested that case management and mental health care are associated with more ambulatory visits, and could possibly improve the healthcare access for unstably housed PHAs (29). Another multi-site U.S. study found that clients who were newly-enrolled in a community-based case management program had a high return rate (88%) for their HIV testing results, despite serious mental illness (30).

Unstably housed individuals who become infected with HIV face many other health and personal challenges as well. Just a few of the disadvantages of homelessness that are worsened by HIV/AIDS include physical and mental health problems, higher exposure to infectious diseases such as tuberculosis and Hepatitis C Virus (HCV) (1,31,32), and greater prevalence of chronic diseases such as arthritis, asthma, diabetes, and high blood pressure (13,33). Also, there

may be increased exposure to unhealthy conditions like extremes in weather, unsanitary conditions, and stress (34). Unstably housed PHAs may also have difficulty arranging transportation to medical appointments, have difficulty keeping track of appointments, lack a safe place to store medications, have difficulty adhering to treatment schedules, and the side effects of several of the HAART drugs may be limiting for those who are unable to get proper nutrition or rest as a result of their housing and financial situation (35). Other co-morbidities associated with unstable housing include higher addiction rates, as well as risky sex and drug use, such as sharing needles, and trading sex for money, drugs, food, or shelter (2,13,32,36,37). These aspects of an individual's background, as well as low incomes, incarceration, and poor rental or credit history may hamper their search for stable housing (38). These lifestyle factors are clearly closely intertwined with housing, and can exacerbate the risk of HIV transmission (6,39). While programs such as peer-mentoring interventions for IDU have shown to be successful in reducing PHA's risk behaviors (40), this had no effect on access to medical care or adherence. It is thought that the stability offered by housing may hold the key to improving PHA's health status.

Homeless PHAs face challenges adhering to therapy

Immediate subsistence needs such as finding food and shelter on a day to day basis require a great deal of time commitment and can take an emotional toll, so an individual's HIV infection simply may not be their top priority if life's basic needs are not being met (8,41,42). In turn, unstably housed PHAs may have difficulty adhering to therapy (3).

Unstably housed PHAs may lack a phone or constant address, which hinders their ability to be contacted by health care providers (43), and they may lack a safe place to store

medications, with fears of theft, discrimination, and lack of a proper storage temperatures forming the main concerns (44). Another discouraging observation is that some physicians may sometimes be reluctant to prescribe antiretrovirals when they suspect that the patient may not comply, as it can lead to drug resistance strains of HIV (45); however the prevalence of this practice is unknown. In spite of this, unstably housed patients have been shown to be able to comply with treatment regimens, and studies have shown that even less than perfect adherence can be of benefit to the patient's health (1). Most studies suggest that the main factor that prevents homeless individuals from accessing care is lack of access rather than lack of desire to be treated (1). The help of health care professionals will be needed to allow greater access to treatment along with greater adherence, which in turn may result in better prognoses for unstably housed PHAs (46).

A service model called "housing first" is described in the literature, in which housing itself is used as a first-step intervention for preventing and treating HIV/AIDS (42,47). The justification for this model is that HIV transmission may be prevented by removing individuals from the exposure to the risky conditions and lifestyles that can result in exposure to HIV, and that stable housing may improve the prognosis for PHAs by increasing their odds of seeking medical care, testing, and consistent treatment (42,48). It has also been shown that rather than demanding that IDU enter mandatory treatment programs as a condition of accessing assistance, it is more effective to first address the individual's immediate needs of housing and health along with preventing the infection of others through harm reduction programs (49). The introduction of stable housing for PHAs has been shown to improve physical and mental health, improve independence, reduce stress, improve treatment adherence (11,12) and reduce risk behaviors (13). Further research will be needed to determine the full impact of housing on health and HIV

outcomes (treatment adherence, medical care access, HIV disease progression, mental/physical health, and risk of transmitting HIV), but several ongoing studies, including a large scale longitudinal study by Kidder et al in the U.S. should provide valuable information about the effects of housing as a structural intervention for homeless and unstably housed PHAs (47).

Aboriginal PHAs and housing

HIV is over-represented in Aboriginal people when compared to its prevalence in other Canadians. While Aboriginal people made up about 3.3% of Canada's total population in 2002, they accounted for 5-8% of all HIV infections (21), and 6-12% of new infections were in Aboriginals. This group was further categorized by exposure, with 63% IDU, 18% heterosexual, 12% MSM, and 7% MSM-IDU, which provides evidence of the shifting pandemic between different populations, and suggests that Aboriginals may be facing unique challenges in HIV prevention (21,50). An EKOS study commissioned by Health Canada studied the awareness, knowledge, and attitudes of Aboriginal people towards HIV, in an attempt to understand the increased prevalence of HIV in Aboriginal people and to provide information for targeted risk-reduction and education campaigns (51). The study showed that most Aboriginal people, including First Nations, Inuit, and Métis, considered themselves to be at least moderately knowledgeable on the subject of HIV/AIDS and rated their own risk of contracting HIV as low, but their rate of multiple partners was higher than the general public. Aboriginal people were also not as likely as members of the general public to correctly identify certain at-risk groups for HIV/AIDS (MSM, sex workers). A minor proportion of Aboriginal people also thought that HIV could be transmitted through mosquito bites, kissing, casual contact, and toilet seats, although this perception may also be true of the general public. A greater percentage of

Aboriginal people reported that they knew somebody infected with HIV/AIDS compared to the general public, and most said they would be highly supportive of someone with HIV/AIDS, but this support waned for more distant relationships. Most said they would be comfortable using the internet, doctors, or nurses to seek information about HIV, but information sharing in traditional Aboriginal ceremonies or activities was the least popular approach (51). This study provides interesting information that could be used in HIV prevention programs for Aboriginals.

A large rural to urban migration has occurred in the last century for Aboriginals in Canada. Now, almost half of Aboriginals live in urban centres (52). While most Aboriginal people move to cities in search of better jobs, education, and housing, they are often met with even worse housing, with most of the houses deteriorating, located in the inner city, and built before World War II (52). 62% of Aboriginals rent their homes, compared to only 43% for the rest of Canadians. Canada's highest urban Aboriginal populations are located in Winnipeg, Calgary, Edmonton, Regina, and Saskatoon. Winnipeg's Aboriginal population is currently 54,000 out of Winnipeg's total population of approximately 670,000 (53), but this is expected to grow to 92,000 by 2026 (54). This will strain the housing stock, which is currently made up largely of older buildings that need a great deal of maintenance and upgrades to be considered adequate for living (54). Compared to non-Aboriginal people, Aboriginal people are more likely to be facing socio-economic hardship, with three quarters reporting housing problems, most having very low income, and many reporting discrimination by their landlords (52). Aboriginals also live in poorer quality housing and move with greater frequency, with about 70% of Winnipeg Aboriginal people having moved over a 5-year period, half within the same municipality, possibly indicating a unsuccessful search for better housing (52,53,55). They are also more concentrated within the inner city, and expend more resources toward shelter (56).

Winnipeg's Main Street Project reports that a disproportionate 72% of its clients are Aboriginal (52). Unfortunately, Native affairs has proven to be of little interest to the Canadian public, as measured by a Globe and Mail feature in 1997 and an Angus Reid poll in the 1990's (only 1-7% polled considered Native affairs to be a matter of significance over these periods). Attitudes of the public will need to change, and the government must make Aboriginals a priority for policy change in order for better housing conditions to be provided for Aboriginals (52).

Health status, scheduling conflicts, or lifestyle issues may limit work commitments available for PHAs

People living with HIV/AIDS may have difficulties holding jobs or maintaining their careers from pre-diagnosis due to episodic changes in health status, and difficulty scheduling treatment regimens and healthcare (57). As well, many of the mental health issues and substance abuse problems associated with HIV and homelessness may compound the challenges in finding and keeping steady work (57). However, several studies in the literature suggest that many PHAs would appreciate the opportunity to work, as it provides a sense of independence, self-worth, and self-sufficiency. To address the difficulties encountered by PHAs who would like to return to work, many community organizations have created in-house job opportunities for PHAs (57), for jobs that include receptionist, kitchen worker, and maintenance worker. These jobs may become long-term, but were designed as "spring boards" for jobs outside the organization, with payment ranging from gift certificates to paychecks, and most people work two 4-8 hour shifts per week. The advantages of working for these organizations are that the client's health, residence, and program requirements take precedence over their job duties. These jobs provide

financial support to PHAs, but may also enhance the clients' quality of life and sense of independence.

Another study by the Canada Mortgage and Housing Corporation considered the impact of involving homeless and formerly homeless clients in projects to address homelessness (58). While this study was not specific to PHAs, its principles would likely apply to any circumstances where people are experiencing unstable housing. Clients from 12 different agencies that address homelessness in cities across Canada, including Winnipeg, took part in governance structures, policy development, volunteer and paid work, training and mentorship, evaluation and research, development of the buildings, and more. The study found that this involvement, which usually took the form of paid or voluntary work, acted to empower the clients and helped them feel that they had an impact on the agency (58). This suggests that client involvement can profoundly benefit both the agency and client.

What can be done to improve housing for unstably housed PHAs?

Many programs have been recommended in the literature, with the aim of ending homelessness and improving health through improved access to supportive housing. However, it is clear that there are several fundamental requirements, in that housing should be adequate (clean dry, warm, safe, quiet, and secure), accessible (physically, for the disabled or fatigued), close proximity to services, affordable, and available in areas where it is the most needed (59,60). When deciding on housing models for PHAs, there are many choices available, depending on the needs of the population being targeted. For example, there are the decisions of offering rent subsidies vs. HIV-specific supportive housing, congregate or scattered housing; building rehabilitation or new construction; case management inside or outside the agency; and

singles or families (61). One of the popular models from the literature is the holistic approach, which integrates housing and HIV services with ancillary services, including emergency shelters which transition to long-term housing, mobile healthcare teams that can service shelters or areas where homeless or unstably housed individuals can be reached, multiservice centres that offer not only shelter but also mail, laundry, transportation to appointments, employment assistance, clothing, health screening, legal services, substance abuse treatment, and self-help groups for those dealing with mental health issues (43,62-65). As well, a study from Vancouver shows that respite housing for PHAs with more complicated needs would be warranted (66). Other studies suggest that housing and the level of services provided should be tailored to each patient on a dynamic continuum as a way to make the most efficient use of funding dollars (43,59,67). The receipt of ancillary services is associated with increasing an individual's likelihood of entering and maintaining health care for HIV in the majority of these studies, and these services have been shown to be even more effective when matched to a client's needs by a case manager, mental health services, and housing services (68). Additionally, this holistic long-term transitional housing has been shown to be more cost-effective and beneficial to the client than the episodic treatment offered by shelters (64).

The most common challenges reported for the supportive housing models include practical constraints (zoning, agency oversight, licensing requirements); funding constraints, differences in funding eligibility and timelines, unfamiliarity of social service staff with housing-specific funding, inter-agency competition for funds, and finding affordable sites (61). In many cases, securing ongoing support may be more difficult than acquiring start-up funds, and lengthy approvals are often needed when purchasing real estate with government funding (61). Difficulty may also be encountered while applying for licensing for treatment and medical

services, and there may be unforeseen construction costs, administrative clearances, and tenancy issues (61). As well, some studies indicated that AIDS-specific housing may contribute to further discrimination and stigma (66). Despite these initial obstacles, most of the models of supportive housing are generally reported to be very successful.

In addition to the supportive housing models, many other studies cite the successes of rental or cash subsidy programs (69,70), such as Project Independence in San Francisco, in which small subsidies, dependent on household size, rent, and income, were successful in retaining clients in their rental housing after five years (71).

Locally, the Manitoba Urban Native Housing Association (MUNHA) is one of the major providers of Aboriginal housing in Manitoba, but is in need of more funds and better (improved quality) housing stock to support a rapidly growing urban Aboriginal population as supply currently falls short of demand (54). The Winnipeg Housing and Homelessness (WHHI) and Kinew Housing have partnered with the Government of Canada, the Province of Manitoba, and the City of Winnipeg to provide 10 rental housing units for Aboriginal people, with rent subsidized by Manitoba Housing and Renewal Corporation (MHRC) (72). Between 2000 and 2007, the WHHI partnership also committed \$99 million to be used for repair, rehabilitation, or construction of over 4,000 housing units and 137 rooms or beds, and to help the homeless or those at risk of homelessness (73). As well, the Manitoba Housing Authority offers subsidized housing (the tenant pays rent-geared-to-income rate of 27% of household income for 1-5 bedroom apartments) (74). Other recommendations for Aboriginal housing include the elimination of barriers, such as damage deposits and references as well as discrimination from landlords (55). As well, it has been recommended that housing design should be culturally acceptable, or suitable for multi-generational family accommodations (55). Further Canadian

Aboriginal housing providers can be found at the National Aboriginal Housing Association website (75).

In addition, the Government of Canada Homelessness Partnering Strategy (HPS), which began in 2007, allocated \$270 million towards reducing homelessness through providing structures and supports to help homeless people towards self-sufficiency (76). If these funds are used appropriately and efficiently, they have the potential to reduce homelessness in PHAs in Canada.

The Employment and Income Assistance Program (EIA) through the Community Service Delivery Division is available to help cover basic needs, medical costs, and housing as a last resort (74). Employment Insurance and Disability subsidies are available for rent and other expenses; however, amounts paid are generally not adequate to cover the costs associated with HIV/AIDS (4).

To improve these programs, the amounts paid to PHAs should be increased to reflect the true cost of living for a person's expected standard of living. As well, culturally acceptable housing solutions and HIV/AIDS services should be made available for Aboriginal PHAs (55,56), including Aboriginal staff, culturally relevant healing and support services, access to Elders, sweat lodges, and culturally appropriate housing units. Other Canadian studies have reported success with PHA-specific housing projects, such as one in which the Wings Housing Society of Vancouver worked together with BC Housing, a provincial agency, to create a 30-unit apartment for PHAs in a pre-existing building (77). The literature reports that dedicated case management has a substantial effect on retaining clients in care, and in ensuring that clients are receiving appropriate services (medical and ancillary). Referral programs and outreach have also been reported to be successful (78-81). Studies also suggest that PHAs need not only shelter, but

also permanent stability and tenure, to prevent the stress of constantly moving (82), and thus the option of clients staying in their own homes may be favorable if possible, as it often allows the client greater control over their living and health care environments.

Greater accessibility and adequacy of housing, in addition to increased financial subsidies, are greatly needed for PHAs to break the cycle of poverty and housing instability. Several studies have demonstrated the cost effectiveness of housing as an HIV prevention intervention, such as one in the U.S. by Holtgrave et al, which found that permanent housing would be cost-saving if one out of 19 clients avoided HIV transmission to a seronegative partner, while it would be cost-effective if one transmission per 64 clients was prevented (83). Given the costs of treating each new HIV infection, which the Holtgrave et al paper estimates as \$211,365 or more, the costs associated with housing seem minor (83).

What can be done to improve access to housing for PHAs?

To improve the ability of PHAs to find affordable and appropriate housing, several suggestions appear in the literature based on successes in other populations. These include integrating housing help and counseling a part of case management, helping people find housing in their chosen neighborhoods to allow a sense of belonging, and allowing community health providers to develop partnerships with housing providers to target unique issues faced by PHAs (18). It has also proven successful to have peers or volunteers call or meet with clients with HIV/AIDS on regular intervals to determine their housing needs and helping to familiarize them with their neighborhoods (18). To reduce housing discrimination and stigma, suggestions from the literature include that clients should be informed about their rights as renters, as it is illegal for landlords to discriminate on the basis of race, sexual orientation, gender, HIV status, or

physical/mental disabilities; housing providers should be educated about human rights law and effects of stigma on the health of PHAs; more advocacy is needed for more affordable housing targeted at people on social assistance or disability insurance; and more advocacy is required for supportive housing (18,84).

Conclusions

A considerable gap in the literature exists for peer-reviewed publications about Canadian studies pertaining to PHAs and their housing needs. There is especially a lack of research pertaining to Aboriginal housing in urban centres, and the barriers to care faced by these individuals, which is surprising due to the growing rates of infection in this population. Further study should provide evidence of the true extent to which housing affects the health of PHAs. However, from the information available, it is clear that housing is one of the most substantial unmet needs faced by PHAs. Further dedication and support to ensure that PHAs receive appropriate, affordable housing will be needed to ensure their continued health and dignity.

Housing and HIV Needs Assessment



NINE CIRCLES COMMUNITY HEALTH CENTRE
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March 2009

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I. INTRODUCTION

Nine Circles Community Health Centre

Nine Circles Community Health Centre is a community-based, non-profit health centre that specializes in HIV/STI prevention and care. It offers a number of coordinated medical and social supports for people living with HIV. Nine Circles provides medical care, social support, advocacy and other programs under one roof. These services are primarily offered to people who are HIV positive and those who are at risk. The clients who access services through Nine Circles typically have a number of social issues that must be addressed in order to accomplish the goal of good health and well-being. Nine Circles Health Promotion and Outreach Program specifically works to help people gain control over and to improve their lives. Staff in this program provide services to help clients face the challenges they are confronted with and to find necessary supports.

Overview of Needs Assessment

The original title of this project was the Horizontal Pilot Project for Homeless Aboriginal People with HIV/AIDs. It eventually transitioned, through various revisions, to a more appropriate and applicable title of the HIV and Housing Project. It began in May of 2008 and came to completion on March 31, 2009.

The people who access services through Nine Circles Community Health Centre have a unique set of needs. This community-based needs assessment was conducted in order to get a better sense of the issues that people with HIV face with regard to housing. Prior to the implementation of this project, housing was identified as a major social issue that the majority of Nine Circles clients deal with on a regular basis. Stable housing is one of the most important determinants of health and also contributes significantly to successfully living with HIV. It is also fundamental to being able to access healthcare.

This project's main intention was to increase awareness of needs, identify existing gaps and to make recommendations for change in the area of housing and HIV. The goal was to determine the factors and themes that could enable the development of housing projects or programs to improve the quality of life and health of people with HIV. There was also an interest in identifying and understanding any cultural needs experienced by Nine Circles clients. This project presented participants with an opportunity to share their experiences, inform others and to help improve services. The contributions of the people who participated will help to better understand their needs and create plans that will assist people experiencing similar difficulties. It is also hoped that their families and the community at large will be significantly impacted by the outcomes of this assessment.

Funding

Nine Circles is grateful for the funding that has been provided to conduct this needs assessment. This project was generously funded by two independent yet inter-related federal government bodies: Human Resources and Skills Development Canada's Homelessness Partnering Strategy and the Public Health Agency of Canada.

Research Team

A number of people worked on this project to make it a success. The Housing and HIV Research Team consisted of six people: Tara Carnochan, Dr. Rae Bridgman, Paula Migliardi, Tina Sorenson, Kendra Charles, and Jennifer Kozyniak. The project originated in the minds of Tara Carnochan, Manager of the Health Promotion and Outreach Program, Nine Circles and Dr. Rae Bridgman, Department of City Planning, University of Manitoba. Both Tara and Rae provided continued support and guidance through all phases of the project. Jennifer Kozyniak, Project Coordinator, managed the project from start to completion. Kendra Charles, a sociology practicum student from the University of Winnipeg, was an invaluable asset, assisting with all aspects of the assessment. Paula Migliardi, Community Based Research Facilitator, Canadian Institute of Health Research and Tina Sorensen, Research and Evaluation Coordinator, Nine Circles were also a significant part of the research team, providing advice and guidance in research team meetings and acting as facilitators for the project's feedback session.

II . METHODS

Data collection for the needs assessment involved two phases: individual interviews and the feedback session.

Individual Interviews

The main objective of the project was to interview thirty people with HIV who were experiencing substandard housing to determine what challenges and opportunities exist to reduce the harms and barriers to care. Prior to collecting any information for the needs assessment, an interview guide (see Appendix A) was carefully developed with specific questions pertaining to peoples' housing experiences and access to social services. The interview guide was validated through meetings with the PHA Caucus housed at Nine Circles Community Health Centre and the community group Aboriginal Women Responding to the AIDS Crisis, housed at Ka Ni Kanichihk. Once approval was received from those who reviewed it, the interview process began.

The majority of participants came from clients accessing services through Nine Circles. Most stated that they had heard about the project through posters (see Appendix B) that had been posted throughout the centre or had been individually recruited through

either the Project Coordinator or staff from the Nine Circles Outreach Team. Two (2) participants had heard about the project through Kali Shiva AIDS Services. Five (5) clients of Nine Circles had heard about the project through their friends who had previously participated in an interview. Recruitment of the thirty participants took three days with ongoing requests to participate for the duration of the interview phase of the project. The response was so great that eight people were placed on a wait list to be contacted in the event of cancellations.

The individual interviews took place from early November 2008 through to January 2009. All of the interviews were held in a safe, quiet and private room at Nine Circles Community Health Centre at times that were convenient to the participants. The proposed thirty participants were interviewed. (Further demographic information follows in the Results section of this report.) Each of the thirty participants was interviewed by one of two interviewers. Each interview took an average of 45 minutes to complete. The shortest interview was thirty minutes and the duration of the longest interview was an hour and a half.

Prior to beginning the interview, participants were asked to review an information sheet or have it read to them. At that time they were also informed that their interviews would be audio-taped. One participant chose not to have her interview audio-recorded, so the interviewer recorded her comments in writing. Once participants were fully aware of the purpose of the study, they were then assured that what they shared would be kept confidential and were asked to sign a consent form (see Appendix C). They were also asked for future contact information in order to invite them to a feedback session to follow at a later date. All but two people indicated that they were interested in attending the feedback session. Participants were then asked to inform the interviewer if they would like to receive a copy of the final report when it was complete. An honourarium of ten dollars was offered to each participant following the interviews.

Each interview was completed by giving the participant an opportunity to ask questions about the interview and to provide one last opportunity to express concerns or ideas that had not been addressed in the interview itself.

Interview Cancellations

Although not formal information intended to be collected for the purpose of the needs assessment, there was an interesting outcome in the number of cancellations of interviews. It is believed that the unpredictable and episodic nature of HIV may have influenced the number of people that were unable to attend their interviews as planned. A staggering number of thirteen (13) interviewees had to cancel or reschedule their planned interviews. Of the scheduled interviews that were cancelled

three (3) were due to illness, four (4) were related to personal issues (housing, relationship, caregiver stress and legal), six (6) simply did not show with no explanation or follow-up and notably, three (3) arrived significantly late for their interviews due to illness.

Data Collection Tool

The interview guide was designed to access information on a number of topics relevant to housing experiences as well as to better understand participants' access to services. Interviews began with questions pertaining to participants past and current housing experiences. Information was collected on cities and neighbourhoods where people reside, who they live with and the types of housing that they have lived in. Participants were also asked to provide further detail about the neighbourhoods in which they live. The interviewer asked questions about good and bad aspects of their neighbourhood, as well as any environmental factors that might influence their health and well-being.

The next section of the interview guide was the most significant to the needs assessment as it addressed the topic of difficulties and challenges that people face with their housing. Participants were asked to share any hardships that they have encountered and to explain reasons for why they were facing these difficulties. They were also asked if they felt that these challenges were related to their HIV status, how they deal with these difficulties and how it affects them as they live with HIV. Participants were then asked to share what they think could be done to make their situation better.

The next section of the interview guide addressed financial and economic questions. Participants were asked to share how they pay for their housing and if they received a subsidy to pay for their rent. They were also asked to share how much of their income is spent on rent and what they have to give up in their lives in order to afford their housing.

This section was followed by a series of questions surrounding food security. Questions were asked to determine if participants felt that they were getting an adequate diet for somebody living with HIV, where they shop for their food, how they get it home and where they store it when they get it home. Participants were also asked if they ever run out of food and if they have ever felt too sick to keep a healthy diet and what strategies they use when they do.

The following section addressed access to health and social services. Participants were asked to inform the interviewer if they regularly use the following services: doctor, nurse, advocate, therapist, social worker, crisis line, home care, nursing care, other health care services, personal care, housework, meal preparation or delivery, shopping, respite care, Street Connections, elders/cultural/spiritual supports, and other outreach services. Once participants responded to these questions, they were asked if they

every encounter any barriers to accessing services, if they have moved to be closer to services and if they ever felt that they needed some kind of service but didn't receive it.

Finally, the interviewer accessed further information about the participant's age, gender, cultural or ethnic background, citizenship, confirmation of positive HIV test and when, highest grade completed in school, additional schooling and main source of income over the last year.

Feedback Session

Participants for the feedback session were primarily recruited from the thirty people who had been interviewed. There were also a number of individuals who were unable to keep their appointments for the interviews who were invited. In addition, those who were on the wait list to be interviewed were included in the invitation list. Feedback session participants were invited by individually addressed notices (see Appendix D) handed out by the staff at the front desk at Nine Circles one week prior to the feedback session. Most of the interviewees were clients of the Food Bank at Nine Circles and it was thought that it was easiest for them to be reached through this method. Participants with phones were informed about the feedback session through written notice as well as phone calls from the interviewers. Similar to what was found in the cancellations of the interviews, three (3) of the interviewees that were contacted by phone indicated that they were too ill to attend and two (2) were no longer accessible via the phone numbers which they had left for future contact.

The feedback session was held on February 19, 2009. A total of sixteen participants attended, nine of which were men and seven women. Only two participants had not been individually interviewed in the interview phase of the needs assessment. Despite their lack of knowledge regarding the preceding phase, their contributions were beneficial as they had a history of rooming house experiences which was limited in the interview phase of the project. There was no honourarium for this component of the data collection, however a light lunch was made available.

As participants entered the multi-purpose room at Nine Circles they were given one of four coloured stickers to signify which station or group they would circulate around the room with. Four stations were pre-arranged with four different interest areas and questions pertaining to HIV and housing (see Appendix E). Three stations were designed to collect further detail surrounding the outcomes of the interviews and one was specifically designated to collect information found in other research studies. Four participants were assigned to each station which was facilitated by a member of the Housing and HIV Research Team. Fifteen minutes was allotted to access the responses from each group and then participants were asked to rotate clockwise with their group to the next station. Once all of the groups had visited each of the stations, a fifteen minute break was called and the larger group reconvened. Summaries were

presented by each facilitator to ensure that the outcomes were in line with what had been shared in the session. When participants confirmed accuracy of the results, the session was complete and the facilitators documented each of their outcomes individually.

III. RESULTS

See Appendix F for full quantitative analysis of themes and data.

Demographic information

Housing specific information: All but one participant stated that they currently live in Winnipeg. Of the thirty (30) people interviewed, eighteen (18) indicated that they live in the downtown or central part of Winnipeg, with four (4) living in the West End. Eight (8) participants claimed that they live in the more suburban areas of the city like Garden City and St. Vital. Most of the participants live in rental properties ranging from two bedroom apartments (4) to rooming houses (4). Five (5) of the people indicated that they live in the homes of family members, with either parents or siblings. Fourteen (14) of the thirty participants stated that they live alone, followed by eight (8) who live with family, either adults or children. Four (4) reported living with a friend or roommate and the remaining four (4) live with others in shelters, rooming houses or hotels. One third or ten (10) of the participants had been living in their current residence for less than five months. There was also a fairly large subset of participants who had longer term living arrangements with seven (7) indicating that they had been in their current residence for more than five years.

Personal information specific to participants: Ages of the participants ranged from thirty-one to sixty-three years of age. The average age was forty-four. A total of eighteen men and twelve women were interviewed. The majority had an Aboriginal background with seventeen (17) stating that they are First Nations, followed by four (4) who described themselves as Metis. The remaining eight (8) participants had European or Asian ethnic or cultural backgrounds. A majority of twenty-eight (28) participants had been born in Canada with only two (2) stating that they had immigrated. All participants had received HIV positive tests. The number of years since diagnosis ranged from one to twenty-three years. The average number of years since being diagnosed HIV positive was eleven years. There were ten (10) high school graduates. The highest grades completed in school ranged from grade 8 to grade 12. The average grade achieved was grade 10. Thirteen (13) of the participants said that they had received additional schooling after high school. When asked about their main source of income in the last year, twenty-one (21) of those interviewed said they received social assistance or employment and income assistance. Five (5) receive Old Age Security and Canada Pension and two (2) said that they were employed. The remaining two (2) claimed that they live off of their deceased spouse's pension.

It was relatively easy for participants to respond to the demographic questions. However, one interesting outcome surfaced surrounding the question requesting cultural identity. Of the twenty-one (21) participants that identified themselves as having Aboriginal backgrounds, nine (9) either hesitated or seemed uncertain about how to respond immediately after the question was posed. Some examples of what participants said include: "Native, I don't know, I don't even know who I am really....I haven't really followed my culture", "Um, I don't know Native people" or "Aboriginal, I guess".

Challenges and Difficulties

During the interview phase of the project participants were asked to share some of the hardships, difficulties and challenges that they have experienced with any of their housing. Half of the people who participated in the interviews indicated that **finding appropriate housing** is the biggest challenge that they face (15/30). Some examples of their comments include: "Because every place you go [when looking for a place to live] it's either taken or you need someone to share rent with" and "When I was looking for a place, most of the places that I found were filthy, they were disgusting". One participant was so dissatisfied with where he lived that he said, "I'd like to live somewhere else that I can breathe, I can touch the grass I can see the sky... it's killing me being confined in a space like that."

The next three most prominent difficulties and challenges identified by the participants were **being unable to afford housing** (7), "But it's hard to find half decent places because the rent is so expensive", **problems with the landlord** (7), "my landlord is a very slum landlord... he doesn't really do things around the house to fix you know what I mean" and **living in unsanitary conditions** (7), "people throwing stuff down from the balconies and since I live on the bottom floor, on the first floor I get everybody's trash in my front yard". Two other notable responses were having **bed bugs or bugs of any kind** (6) "[Bed bugs] yeah they seem to get to me I don't know" and **being evicted** (6) "I wonder what happened there, like I got evicted because me and my girlfriend lend the place to her son and his girlfriend smashed all the windows and they told".

When participants were asked how these hardships affect them as they live with HIV, ten (10) said that they experience **high stress levels** and eight (8) indicated that they are **not sleeping well**. These outcomes were supported in the feedback session where even further detail was accessed. All of the participants in the feedback session agreed with the major housing issues as listed above. When asked how it affects their health, a new set of detailed information surfaced. It was of particular interest to determine how difficulties and challenges impact health and well-being, so they were asked, "If any of these difficulties or challenges applied to your situation, how do they affect your health?"

Each of the four groups of four participants indicated that both their psychological and physical health is impacted by the difficulties they face with their housing. **Mental health** was the first response for all four groups, however physical health was identified as being significantly impacted as well.

Stress and depression were mentioned numerous times. One feedback session participant said, "I feel like crying all of the time". Many of the respondents also mentioned feeling **helpless, frustrated and angry** about their housing issues. That often they feel "fed up" or like their "going nuts" from all of the issues that they have to deal with. One person said that his housing situation makes him so crazy that his "bipolar meds need bipolar meds". Also, not feeling in control and general apathy came up frequently. The feeling of helplessness can be so strong that one participant said that she has felt suicidal in the past because of her situation.

A male participant said that he was previously living on the reserve where he grew up. When people found out that he was HIV positive he was ostracized so badly that he hitchhiked to Winnipeg and had to walk 25 kilometres in order to get away from the emotional pain he was experiencing.

Most respondents mentioned that **anger** seems to surface more often than other emotions. This anger tends to influence their contact with everyone as the stress and depression associated with living in poor housing can be extremely frustrating. Many said that they feel that they would be nicer to people and not so rude if they had better housing conditions.

Some participants suggested that being in this environment makes them feel **weak**. They noted that being in this situation makes it easier to go back to bad habits that they are trying to escape like drinking and drugs.

One of the female participants said that having to look for a place to live is so difficult and frustrating that it never leaves her mind and results in extreme stress. Others in her group affirmed what she was saying indicating that even though they were currently stably housed that they have experienced that same kind of stress in the past.

One woman told a story about her teenage daughter who lives with her in an area where the local gang is trying to recruit her to belong. This mother was hospitalized because she was experiencing extreme hot flashes and a high temperature which she attributed to dealing with this major stressor. Those with children echoed these sentiments saying that the stress of having a child living in a bad area is terrible because they are always worried that they will be exposed to drugs or other illegal activities. Others mentioned that feel a great deal of stress because they see other kids on the street that they are unable to help.

Physical health is also significantly impacted by difficulties and challenges with housing. Participants reported that their physical health is most impacted by the **environment** in which they live. Many indicated that living in a space that was unsanitary or had bugs seemed to have a negative impact on their physical health. Participants referenced having more infections (skin and lungs) from living in unsanitary living spaces. Some of the participants told stories of living in rooming houses that are filled with mold and moisture that aggravates lung infections and nasal passages. Those living in rooming houses also mentioned that even if they take care of their personal hygiene, they feel that they live with other tenants that do not. One participant mentioned that she walks around the rooming house where she lives on a daily basis reminding the other tenants to please wash their hands in order to keep the spread of disease to a minimum.

Lack of sleep seemed to be a major contributing factor to poor physical health. One participant said that her rooming house is so cold at night that she wakes up shivering and often doesn't get a full night's sleep because of the cold. Also, anger and upset of living in these conditions alone often keeps people awake at night. One male participants said, ""My sleep is being affected, can't sleep at night can't rest, minds always going. When's my next apartment coming... when's it gonna come. How long do I have to stay here?"

Those who reported having **bed bugs** in their home spoke of not sleeping at night and waking up with welts on their skin from the bites. Some reported staying awake and worrying about the bed bugs possibly biting them. One participant said that she had to be hospitalized for five days after her landlord fumigated her apartment because she has asthma and had an extreme reaction to the chemicals used in the fumigation. A male participant said that because of the bed bugs he must wrap his mattress in plastic which makes it uncomfortable and keeps him awake at night.

Others indicated that they lack sleep because of the extreme amounts of **noise** that they are exposed to in the middle of the night. Parties, "crack heads" and drunks were reported to keep people awake in rooming houses. A number of participants said that they often have to deal with people knocking on their rooming house or apartment doors in the middle of the night.

Some of the participants suggested that their **diets** are impacted by their housing conditions, claiming that they do not eat well for a variety of reasons including: not having a space to cook or prepare meals, being occupied daily with having to look for a place and forgetting to eat, and not feeling emotionally well enough to keep a good diet. Food storage was also an issue that was brought up especially when rodents or bugs were involved. One participant said that he had to put all of his food in the fridge and in tins in order to keep rodents and bugs from getting to it. Some participants reported feeling nauseous before eating any of the food contaminated by bugs

likening it to “eating a spoonful of dirt”. Others added that simply having “disgusting” kitchens made them not feel like eating.

Not taking **medications** came up infrequently but one participant said that because he’s in transition he finds that it’s very hard to remember to take his medications when he is supposed to. Another male participant said that his cell count went really low when he was searching for a place to live.

Another topic that was mentioned infrequently yet is relevant to this research is the need for **support in transitions**. One male participant said that he hurt his back when he moved from one place to another because he did not have enough money to pay a mover. He was injured so badly that he had to be hospitalized in order to recover.

The feedback session supplemented the information from the individual interviews nicely. An interesting outcome that was different from the information accessed in the interviews was the association made between living in a highly stressful situation and its impact on physical health and well-being. Also the lack of formal supports became more evident in the feedback session. Participants in one group mentioned that they frequently feel that there are “more people against you than in support of you”. And finally participants’ general dissatisfaction with their living conditions was accentuated. One group went so far as to compare prison with their current housing experience suggesting that they would be better off living in jail than where they currently live.

Difficulties Accessing Services

In order to maintain a consistent interaction between service providers and clients, it is important to be aware of the difficulties that the clients of Nine Circles were experiencing in accessing health and social services. Most of the participants (23) said that they had no problems accessing services from their current location. The ease in accessibility could be due to the fact that many participants (18) have moved to be closer to services (because walking is the main method of transportation). However, half of the participants (15) felt at some point that there were barriers to accessing services that they needed.

Accessibility to services in general were hindered when PHA’s **do not have their own phone**. It is difficult to make appointments and maintain a consistent schedule when there is a lack of communication between the participants and service providers. Some participants received the impression through their social assistance workers that they were “**not entitled to a phone**”, only to find out through other networks that they were. A suggestion was made that “phones should be mandatory for people living with HIV”.

Due to the fact that many are walking to services (17), some indicated that the **cold weather** during the winter was a nuisance that affected their regular interaction with

services. Those who take the bus also find winter to be a nuisance, and some have indicated that there is a **lack of transportation** resources because bus tickets are not always readily available.

The three main services that had barriers to accessibility were **crisis/emergency assistance, housing assistance**, and **food delivery**. Emergency services and funding related to “non-necessities” such as moving costs and damage deposits are difficult to source out and expensive. They also pose a barrier because many individuals do not have upfront cash available that is needed in order for these services to regard them as clients.

In relation to finding housing, access to Manitoba Housing posed a barrier because of long wait times, and the need for “papers” (identification documents) that some do not have in their possession. Even though there are food delivery services available, some participants have expressed that they are few and far between, lack consistency (“one day they deliver, and the next day they don’t”) and/or have zoning restrictions.

What services could be put in place to address housing issues?

During the feedback session, the participants were asked for their opinion on services that could be put in place to address housing issues. Many agreed that a **program designed to place individuals in affordable, quality housing** was essential. With respect to quality, the ideal housing complex for many participants is clean, affordable, and safe. One participant articulated that her view of an ideal housing situation is “something that is clean, something that is quiet, you know I don’t want drugs and alcohol at my doorstep every day... the carpet is not old and mouldy, something that has been somewhat renovated not rundown... well-maintained and in a safe neighbourhood, that would be my ideal place.”

However, for most of the participants, these ideals do not match the reality of their past and current housing situations. Many are forced to live in substandard housing conditions because their housing allowances do not cover the costs of clean, safe, and affordable housing. One participant who grew up in a rural area is paying \$300 per month for an apartment in the city, spoke about the lack of affordable housing options, “My chicken house was bigger then my apartment is, but the rent of the other place was \$550....I was taking all the money I was getting in to pay for my suite and left me nothing for food. So I had to make a choice....” There was a particular concern over the **lack of stable housing options and housing incentives for single people living with HIV**. Rooming houses and hotel rooms are presented as viable options for single people. However, these establishments do not foster healthy independent living. A participant that had lived in several rooming houses suggested “...with every rooming

house everyone's got an addiction....they're in and out of the house at all hours of the night."

Many participants spoke about the rising cost of rent and how their budgets do not reflect this increase. It is important that there should be a **rent control program** that offers a wider variety of housing options for low-income individuals and families. Another suggestion was that **funds that are allocated to housing should be indexed to inflation**.

In general, participants felt that they had to "shop around" for information suggesting that services are too widely dispersed. They expressed that their most consistent services such as **social assistance offices and Nine Circles should work together** and provide them with a multitude of information and resources concerning their health and well-being. Since issues of income, food, health, and well-being are all interrelated, services providers should reflect this knowledge. There needs to be less compartmentalization, and more fluidity in roles and responsibilities of the clinical, administrative, and support staff. These resources should be easily accessible and all staff should be knowledgeable and take part in the coordination of this information.

Useful Services and Best Practice

When asked about which services are helpful and why, the general consensus from the participants was that they felt a sense of personal responsibility for their situation. They feel that they are the only ones that they could rely on for help. Many respondents indicated that they have often had to **deal with issues on their own**, claiming that they generally have to seek out resources themselves. Some people have indicated that conversations with the **staff at Nine Circles** has proved to be helpful. **Informal sources of support** seemed to take precedence over formal support services. **Animals** have a therapeutic effect by promoting physical and mental well-being. Those with cats and dogs enjoy how they encourage activity, and depend on the companionship they provide. One participant was concerned about how his housing was affecting his cat, stating that he would "freak out if I woke up one day and my cat had died from crack smoke". Others mentioned that they tend to **help each other** informally through sharing information on helpful services. **Family and friends** were also mentioned as an informal source of support through a system of trading resources and skills. A few participants mentioned that while they are living with family they are providing child care in exchange for housing and food.

In terms of useful formal services, the dominant theme was that participants are mainly using **medical services and advocacy** to manage their HIV while support services such as counseling and cultural services are accessed on a sporadic basis, if at all. The management of physical health and urgent needs seemed to take priority over an

overall holistic health model based on a combination of medical care and emotional, spiritual, and mental well-being.

All of the participants reported having regular contact with doctors, and almost all (28) have had regular contact with nurses. Most go to Nine Circles or other health clinics located in the central area. Many have expressed positive experiences with the medical staff at Nine Circles and remain committed to their services. Participants stated that they have a true appreciation for the genuine concern and empathy displayed by the doctors and the nurses at Nine Circles.

The advocacy and outreach services at Nine Circles proved to be helpful also. Even though there was some confusion over the definition and responsibilities of an advocate, the majority of the participants have used this service (23) and most have had urgent needs concerning social assistance, housing, and transportation resolved through this program. One participant said in relation to the Nine Circles advocacy staff, that “they are truly you know a bunch of wonderful people here.”

In following a best practices model, there are improvements to be made with **transitional housing**. The existing transitional housing establishments for PHA's are mainly based upon a supportive living philosophy, which caters to the emotional, spiritual, and social needs of the residents. These are significant requirements for overall well-being, however there is also a need for transitional housing to be integrated with an empowerment model through **access to independent living skills**. Programming should include life skills, addictions counseling, employment-related training, budgeting, cooking, and access to health care services such as physiotherapy, and occupational therapy. A former resident from a transitional housing complex spoke about the lack of independence amongst some of the residents, stating that “...everybody else is waiting for somebody to cook them something to eat, like how lazy can the person be...they can't cook a meal.”

Several participants indicated that they want to be more independent and have more control over their lives. Therefore, transitional housing should have a variety of programming based on supportive care and empowerment that would facilitate their transition into a healthy, and independent lifestyle. Furthermore, some participants have been **incarcerated or institutionalized, and have concerns over the lack of transitional assistance available for re-integrating into their community**. A participant that had spent time in a psychiatric ward spoke about the ongoing regulatory effects of that experience in terms of “not [being] free of your movements that much.”

Another participant indicated that his experience of spending time in jail, and having numerous attacks upon his release enforced a cycle of learned helplessness that has been difficult to break. He spoke about having “lost my housing, my kids, and everything that I've owned and loved. “ Transitional housing with an integrated

philosophy based upon support and empowerment would have the benefit of addressing physical health concerns, while enabling a process of increasing individual control over health and well-being.

Food Security, Housing and Health

Food security and good nutrition are important indicators of individual health and well-being. The interview phase of the study investigated a number of areas surrounding food and nutrition. However, prior to the section of the interview guide that contained the food and nutrition questions there was a question generally asking participants “what do you have to give up in order to afford rent?” Without any prompting eight (8) participants stated that they have to **give up food in order to pay for their rent**.

Similarly, when asked directly about their experiences with food, twenty (20) participants said “yes” to the question “have you ever run out of food before you could afford to buy or get more?” Both of these outcomes suggest that there are a number of people living with HIV who go without food.

The responses to these two questions call into question the food security that the participants face. However, an interesting contrast surfaced when nineteen (19) of the participants responded “yes” to the question, “would you say that your diet is good enough for someone living with HIV?”

These conflicting responses required further investigation, so it was addressed again in the feedback session. It was important to determine what the participants' true realities were about food. The question asked in the feedback session was, “do you sometimes run out of food but still feel that your diet is good enough for somebody living with HIV?”

Participants responded with surprise that some interviewed in the study said that they have to give up food in order to afford rent. Also, they were puzzled with the number of people that stated that they had a history of running out of food. The facilitator for this station sensed that the original twenty (20) participants who stated that they had a history of running out of food probably were referring to **fresh, perishable and hard-to-get items** like fruit, vegetables and quality meats. It seems that people do run out of the “good stuff”, but make it through by accessing other resources. The information obtained in the feedback session points to the need for further study in this area to get a true sense of the meaning of these differing outcomes.

Another interesting outcome that surfaced from the food security, housing and health question during the feedback session was that people often feel that they are **resourceful** enough not to completely run out of food. **Most of the participants felt that finding decent housing is a bigger problem than finding food.** Many use canned food as a back-up or safety net, and there are always the food banks and soup kitchens. The general consensus was that there are many resources and options for people in Winnipeg and that no one should go hungry. In general, participants said that resources such as food banks and soup kitchens are a big help. It is especially

appreciated as it gives them the opportunity to have a proper, sit-down meal that is hot and of good quality. This is not to say that they don't have to work hard to put together a good diet, they do so by using the existing resources around them (e.g. getting some food from food bank, then buying a bit of meat with their own money and also going to a soup kitchen for a hot meal).

Some stated that if people in their circumstances didn't waste money on partying and drugs/alcohol, they would have enough money for food. They felt that people with HIV need to be smart about their money, follow a budget and then they will have a decent diet.

There are some **barriers** that prevent people from accessing proper nutrition. Some of the participants noted that their allergies act as a hindrance to maintaining a balanced diet. Some participants stated that they have allergies to fish, milk, eggs, etc. and that there are no other options for substituting since the food bank only gets certain items. When that is all there is to choose from they make do with what they can get. Others indicated that in order to get proper nutrition they require access to vitamins and supplements which are too expensive for them to purchase. Also, the cost of health food can be prohibitive to having a health diet. Some of the respondents said that junk food is cheap and that sometimes it's just easier to eat that instead.

Support for **housing specific to people with HIV** was identified when participants suggested that it would be helpful with food for many reasons: they could afford more and better food, there could be a dietician on-site to teach people about proper nutrition, people could learn how to cook and learn new recipes from each other, there would be a place to store and cook food, they could do group dinners and actually have room for and enough food for guests.

The **challenges of accessing meat** were highlighted in the feedback session. Meat was mentioned as a big issue for many reasons: the expense, it's never on sale when social assistance money is issued, finding good quality meat is difficult (i.e. a good grocery store like Safeway is too far away and everybody rushes to shop when social assistance is issued so there's nothing decent left on the shelves). Participants also mentioned that they have nowhere to store the meat that they are able to purchase (no fridge or freezer; the fridge/freezer does not work properly; fridge or freezer is tiny; mice get into fridge). Often people have nowhere to cook a good quality meat (like a whole chicken or a roast beef) as they don't have an oven or their oven is broken. Some of the participants mentioned that it is difficult to eat enough meat for a person with HIV because they had been information that they need to eat twice as much protein as a person who doesn't have HIV.

Once participants had an opportunity to respond to their experiences with food they were asked how it relates to their health. Again, **mental health** was at the forefront over physical health. Participants stated that they are often worried, stressed, experience mental fatigue, feel defeated, "why bother taking good care of yourself because it is so hard", isolated, "I can't afford to have people over for dinner" and feel guilt, "I feel that I must share my food with others, I can't afford for my child to have a sleepover".

Reference to physical health was only made in relation to the **physical strain** associated with having to carry loads of groceries a distance. A number of participants mentioned that they can only do a shop once per month because it is so difficult to get a big load of groceries home and put away. Participants suggested that Nine Circles should have a van that could drive groups of clients to shop once a month to a good grocery store.

Related Research

The feedback session provided an opportunity to tap into information that was not available through the individual interviews. It was the perfect setting to determine if some of the themes identified by other researchers who have studied housing and HIV could be replicated. Three topics and related questions were targeted as relevant and important for the needs of this project.

One factor that was not considered in the interview phase but had been highlighted in other studies was the priority that people place on their health when dealing with housing issues. Researchers have found that individuals dealing with difficulties with their housing tend to consider their HIV as having a low priority in their lives. In contrast, if participants identified that their basic needs were being met, they were more likely to consider their health as a priority. Therefore, one of the questions in the feedback session asked: "What priority does your health and well-being hold in your life when you have to deal with housing issues?"

In general, participants reported that their negative housing situation tends to be related to **deteriorating health**. One participant stated that, "your housing situation exacerbates your health issues". Similar to the previous Difficulties and Challenges section, participants indicated that their physical and mental well-being is affected every time they have to deal with housing issues. Some of the expressions they used were: "I get sick every time", "it slows you down" and "your health deteriorates". Some participants indicated some specific physical and mental health concerns they have experienced as result of poor housing conditions. These were: allergies, loss of appetite, fatigue, stress, anxiety, suicidal thoughts, anger, bouts of violence toward the self and others, fear of the unknown (i.e., not knowing where you will end up).

Once again, participants spoke mainly about how their housing situation influences their **mental health**. Fatigue, anxiety, stress, suicidal thoughts, perception of lack of safety (due to lack of choice on where you live – many times people did not have any

other choice but to live in rooming houses¹), increased stress due to concerns for others. This was particularly the case for women, and single parents – mostly women – who have to ensure an appropriate place for themselves and their children.

Participants mentioned that they “forget about other things” or “put other things on hold”. For instance, people spoke about missing appointments (sometimes not only because of housing issues), attending meetings, or other commitments. One of the participants indicated that he felt that he couldn’t do anything else as result of the expectations from his social worker with EIA stating, “my worker would push me to get on this [get my housing situation dealt with], and don’t like to hear that I have other things to deal with”). In addition, participants stated that having to deal with housing issues means having to deal with a limited budget, which in turns affects the rest of your life and well-being.

Once again, the negative impact that unstable housing has on **physical health** was confirmed. Many participants noted that they are dealing with allergies or respiratory problems due to dust or mold. And one participant spoke about his experience with spending time in prison where he didn’t have access to his medication.

The second area of concern related to other research outcomes was participants’ relationship with government financial assistance. Similar to other research, the majority of participants in the needs assessment are dependent on social assistance as their main form of income. Other researchers have found that people with HIV consistently report that government staff tend not to have a good understanding of the issues that people with HIV deal with on a day-to-day basis. Other studies have found that the people who act as supports for access to financial assistance tend to treat people with HIV in a demeaning and demoralizing way, often making them feel worse than they already feel about themselves. Also, people with HIV often report being discriminated against by their social assistance workers.

The question asked in the feedback session to determine if this was the case with clients who access services at Nine Circles was: “do you feel that social assistance/welfare/CPP disability truly understands some of the unique issues that people with HIV face?”

Some of the participants said that “some of them [workers in the system] do [understand the unique needs of PHAs]”. This was quickly followed by a comment such as “but, this is not the norm”, “most don’t want to learn or hear about it”, and “the majority lacks understanding”.

¹ Participants’ experience with rooming houses was dismal. Among the issues people mentioned were sanitary conditions and safety. One participant indicated that he got beaten up and kicked out from a rooming house by other residents as soon as they learned he was HIV positive.

There appear to be **two different approaches to HIV in relation to EIA workers**: on the one hand, people with HIV tend to be straightforward about their status and are quick to disclose with all of their workers. This was believed to facilitate the attainment of services. On the other hand, some participants would wait until the trust in their workers was developed until they disclose. For one participant, it took three years until she felt safe to disclose her HIV status to the worker. This also meant that she didn't have access to some additional benefits because of this. Her decision to not disclose was based on her perception of how the worker would react.

Those who have disclosed their HIV status to their workers have faced a wide range of reactions from **being openly judged to being patronized**. This was particularly the case when their workers felt that they were healthy enough to go back to work. Again and again, participants stated that they do not feel able to work as result of the unpredictability of their health situation (i.e. today feeling great, but tomorrow not so). A few believed that the system was too inflexible to be able to accommodate their disability to be able to work, but still rely on the system.

One major issue with the social assistance system was the **quick turn over of workers**. Participants felt that they had to "give an HIV 101 presentation every six months". One participant indicated that he felt that the longer a worker was on a case the colder this person would get, resulting in less sympathy and help.

One participant suggested that social assistance workers **should go on home visits** to see the environment in which their clients are living. He believed that this kind of exposure would give them a clearer idea of their true living conditions. A few other participants indicated that they would advocate for workers specializing in HIV, while most said that they would support the idea of subjugating all staff in the system to mandatory HIV training.

The third and final question related to other research outcomes was "has the stigma or label of your HIV diagnosis ever prevented you from accessing health and social services?" This question was rooted in previous research that found that people with HIV report a perceived stigma and fear of disclosure and that this fear of disclosure can impact the kind and quality of services that they access. These barriers against seeking help are then associated with poor physical and mental health.

Participants reiterated many of the points they made for the second question, as they indicated that they mainly have issues with disclosing their status to Employment and Income Assistance workers. It is primarily under these circumstances that **they feel stigmatized**. In most cases, participants said that they would not disclose their HIV status to ensure access to services and to avoid biases and attitudes from service providers. For example, one participant indicated that he wouldn't disclose his HIV status for fear of not gaining access to some of his treaty rights.

Additional comments were around their experiences with shelters and rooming houses. With shelters some people had to disclose their status (although it wasn't clear if they had to – conversation among participants seemed that they were not clear about their rights to disclose their HIV status to the shelter staff).

A few participants stated that they have had **discouraging experiences with the health care system**, in particular with emergency services. They said that they have overheard medical staff saying things such as “we don't know what to do”, “what should we do?” as indication of their lack of knowledge and negative attitudes toward HIV.

Another major issue was identified with Child and Family Services (CFS). This was mainly brought up by the women in the groups. Women who are mothers mentioned that they do not disclose their HIV status to CFS due to fear of losing their children. This was confirmed by the women who had disclosed their status.

IV. LIMITATIONS

Recruitment

As mentioned previously, participants for this project were primarily recruited through the clients accessing services at Nine Circles Community Health Centre. The majority of participants came from regular visitors to the centre who read about the project on posters advertised on billboards and through contact with the Project Coordinator or staff working at Nine Circles. Most of the people who access services regularly through Nine Circles Community Health Centre are quite resilient and resourceful, tending toward more stability in their lives. As a result a number of the participants came from this pool of clients who are socially and physically better off than others from their cohort. An effort was made to recruit participants from those who are accessing outreach services at Nine Circles, who are often living under more challenging circumstances. However, these individuals accounted for many of those who had to cancel their scheduled interviews. Also, the outreach staff ran into challenges trying to locate specific individuals who would be suitable for the project due to other aspects of their lives taking more precedence over participating in the needs assessment. As a result the majority of participants for this study did not fully represent the client population at Nine Circles who experience extremely distressful social issues. In the event that another similar project is attempted in the future, it would be recommended that these individuals who generally go unheard be represented.

Sample Size

The thirty participants who were involved with the interview phase of this project account for a very small number of the total people with HIV accessing and requiring services from Nine Circles Community Health Centre. The small sample size makes it relatively challenging to be able to generalize the overall findings as there are a

number of individuals who were not represented in this project. A major gap in the data exists in the number of people living in rooming houses and shelters, as well as those that are without homes. It is clear that there are a number of people who were not accessed for this study simply because the potential number of people interviewed was so low.

Nine Circles provides support and services to over 400 people from very diverse backgrounds. Not all of these individuals were represented in this small sample size. However, it is interesting to note that the demographic information accessed in this project approximates some of the demographic information about the total population of people accessing services through Nine Circles.

V. CONCLUSION

Major Outcomes

Housing Issues: Finding appropriate housing was the number one concern of the participants in this project. This concern was followed by issues around not being able to afford housing, having problems with landlords, living in unsanitary conditions, having to deal with bed bugs or other insects and being evicted from their homes.

Impact on health and well-being: When dealing with housing issues, participants claim that their stress levels are extremely high and they often go without sleep. Mental health was reported as being more drastically affected than physical health. Feeling depressed, helpless, frustrated and angry were common emotions associated with housing issues.

Participants stated that their physical health is impacted by the environments in which they live. Some reported more skin and lung infections because of living in unsanitary conditions. Others reported lack of sleep due to noise and the temperature of their rooms. Bed bugs, insects and rodents were also identified as a major contributing factor poor physical health.

Participants diets are also significantly influenced by their housing conditions as they often do not have places to prepare meals, are too occupied with looking for a place to live and sometimes do not feel emotionally well enough to eat. In addition, remembering to take medications is a challenge when finding appropriate housing holds priority.

Access to services: The majority of participants said that they do not have any difficulty accessing services from where they currently live as many had already moved to be closer to services. One of the biggest hindrances to accessing services is not having access to a phone. Cold weather and the lack of accessible transportation were also mentioned as playing a role in not being able to access needed services. Other major

barriers exist in the areas of: crisis or emergency assistance, assistance with finding housing and food delivery services.

Solutions: One popular solution offered by participants was to create a program that could assist individuals with finding clean, affordable and safe housing. Many indicated that they have been forced to live in substandard housing because of their income status and that the housing options for single people with HIV are extremely limited. Rent control and having social assistance indexed to inflation were also presented as solutions.

Another solution offered by the participants was to coordinate services in such a way that those working in social assistance collaborate more with the staff at Nine Circles. Participants felt that less compartmentalization and more overlap in roles would make a significant difference in their situations.

Most participants expressed that feel personally responsible for dealing with the issues that they face and that they are the only ones that they can truly rely on for help. If they require resources, they have to work extremely hard to find them without the help of formal supports. Informal sources of support like assistance from peers, going to family and friends and owning pets were the most common sources of support reported as being helpful.

Helpful formal supports included the medical services and advocacy services at Nine Circles. The majority of participants identified that their physical health takes higher priority than counseling and social services. Generally, a holistic perspective of their health and well-being was not commonly identified.

Almost all of the participants articulated a strong need to develop their independence and gain control over their lives. Some participants stated that they feel transitional housing would be ideal if it were applied as it is presented in theory, however they did not feel that the existing services are meeting peoples' needs. The consensus was that these programs do not lead to living more autonomously.

Food security: Most participants noted that despite challenges around accessing food, finding decent housing is a significantly bigger problem. Participants stated that there are many resources available in the community like food banks and soup kitchens which most people with HIV are able to access.

During the interview phase of the project, a number of participants stated that they have had to give up food in order to pay their rent. The feedback session clarified this outcome finding that participants were mostly referring to having to go without fresh and perishable food items. Participants reported having difficulty affording fresh fruit, vegetables and meat. Most said that even if they could afford meat, they would not have a place to store or cook it.

Nutrition seemed to be more of a factor than lack of food. Those with allergies noted that they have difficulties accessing foods that they are not supposed to eat. Often the food that is available in food banks has limited selection. Participants also mentioned that they often require vitamins and supplements which are too expensive to purchase.

The food security questions once again pointed toward significant impacts on mental health. Participants stated that they often feel worried, stressed, isolated, defeated and fatigued as a result of not being able to access a proper diet.

Related research: Participants expressed some of the same concerns as their peers in other research projects. Dealing with a negative housing situation tends to be related to increased reports of deteriorating health. Most participants reported that their social assistance workers generally do not have a good sense of what their needs are and that they often have to educate them about their unique situations. In addition, participants felt that it can be detrimental to disclose their status to social assistance workers and some health care professionals for fear of being judged and stigmatized.

Future Direction

Supportive Services: An endless number of possibilities exist with regard to the future direction of this research. At the time of writing this report there is an exciting new federal/provincial initiative being introduced that has great potential to drastically influence housing programs and policies. One solution currently being discussed is to provide a rent subsidy to people dealing with housing issues. Although this could significantly make a difference in many peoples' lives, the outcomes from this report point to other important considerations. Certainly a rent subsidy on its own would not be sufficient enough to address some of the complex needs that exist.

One large priority that surfaces from this report is that people with HIV need to access housing initiatives that are linked to other supportive services. As identified in this needs assessment, housing is typically addressed at the crisis point. The ability to look more holistically at other issues that surround housing difficulties would likely address many of the challenges that people face. Linking housing to supportive services would lead to less compartmentalization by integrating services that have not been commonly offered together in the past.

Supportive services have the potential of being helpful yet the need for autonomy and self-empowerment were also common themes identified in this research. Ideally, accessing combined services would not have to be mandatory but offered in a way that it would be up to the individual to make a choice about what he or she requires. Fostering independence and individual strength would lead to greater a sense of control and self-sufficiency. This is also very much in line with what most of participants of this project were requesting. Examples of possible supportive services in the context of Nine Circles includes: creating better linkages with services in the community (ie.

linking clients to local clinics that have doctors accepting new patients), clients going to outreach workers for guidance on possible community based resources and Nine Circles and Employment and Income Assistance working more collaboratively to address the complex issues that many people with HIV face.

Cross-training: To avoid the common concerns of compartmentalization of services, it would be ideal to introduce some form of cross-training that would allow for the sharing of information between services providers. Incorporating those who work in income assistance, food services and health care with social services that are offered through Nine Circles could significantly alter the way that clients receive their services. Collaborative training initiatives that create more fluidity between health, housing and income assistance providers could dramatically influence the lives of people with HIV. This training could be based on the issues in the lives of the people that require services. The awareness that would come from this could create a significantly better understanding of the true experiences of people living in these circumstances. In addition, it would be extremely beneficial for the clients to act as direct educators to service providers by extending information about their situations through methods such as documentary photography or home visits that feature the environments in which they live. Ideally, a reduction in the hierarchical nature of service delivery would foster not only a better understanding but likely lead to the creation of more appropriate services that would effectively address the difficulties and challenges that people with HIV face on a day to day basis. As mentioned in this report, clients at Nine Circles feel that since issues of income, food, health, and well-being are all interrelated, services providers should reflect this knowledge. From a systemic perspective, there needs to be less compartmentalization, and more fluidity in roles and responsibilities that currently exist. Resources should be easily accessible and staff, as well as clients, should be knowledgeable and take part in the coordination of this information.

Increase in Social Services: This research has discovered that in order for people with HIV to live well, they not only need their housing issues effectively dealt with, but they also require social services to provide a more holistic type of support. At present this kind of support is not commonly reported, however with the introduction of specific social services that address some of these pressing life situations, it is likely that more people would find their lives enhanced. The Health Promotion and Outreach Team at Nine Circles currently have limited resources to be able to provide services beyond the reactive, emergent social issues that many of the clients present with. The ultimate hope is that one day there might be a service that could be more proactive at addressing the issues before they become emergent.

This project was limited in terms of the people recruited for the project. There are many who have such extreme social situations that it prevented them from providing their stories for this needs assessment. These are the individuals who need most to have their

housing issue addressed in relation to their health through active social supports. In addition, the importance of medical services in the lives of people with HIV necessitates a better linkage between the social services and the health care practitioners who the research participants claim that they see on a regular basis. This linkage between medical services and social services would be extremely advantageous to the clients but there would also be an added benefit to the two professional entities working in a more integrated way. Incorporating different forms of allied health could also be extremely beneficial. Introducing services that lend themselves to a more whole-person focus such as physiotherapy and occupational therapy could potentially address some of the gaps that have been identified in this study.

Future Research: As mentioned in the Limitations section, future research should take into consideration the individuals who were not represented in this research. Recruiting more widely and accessing the people who don't normally participate in projects like this would provide a more extensive view of the realities of people living with HIV. In the future a different method of recruitment might allow for researchers to tap into undiscovered information that could be of great use to this population. The snowball method of recruitment might be utilized to reach those who are isolated or often leery of projects such as this. Of course, the concerns around stigma, not wanting to be identified and general paranoia about how the information would be used would have to be addressed more carefully. Another method that could successfully access the more disenfranchised people in this population would be to hire an outreach worker to actively recruit for the study. It would be interesting to use the same research tools with these newly accessed individuals to see if the outcomes could be replicated. This would be one of many methods that could potentially validate what has been discovered with the current small sample size.

Advocacy: The intolerable living conditions that were cited in this project are only examples of some of the ways that people with HIV are currently living in Winnipeg. There are countless other stories that are likely more discouraging than what were identified in this project. One consistent message that can not go without mention is the unacceptable amount of housing allowance that is offered to people who are living on social assistance. At the time that this report is being written, a single individual on social assistance in Winnipeg is offered an average of \$285 a month as a housing allowance. Consistently participants reported that this amount is unrealistic and completely insufficient to find appropriate housing. The only logical places to find such housing as a single person are rooming houses and hotels which by no means provide the kind of living environments that people with chronic health conditions such as HIV require. Two possible advocacy topics include: the introduction of rent control and indexing financial assistance allocated for housing to rising inflation.

These solutions are not simple and may require an entirely new perspective and philosophical shift, but in order for improvements to be made they are a necessity. If neglected, there will only be a continuation of some of the personal stories presented in this report.

Appendix A

Housing and HIV Research Project Interview Guide

Introduction:

Thank you for agreeing to participate in this study. The interview will provide you with an opportunity to share your thoughts on your housing and HIV.

Before we begin, could you please first tell me how you heard about this project?

Past Housing Experiences

I would like to start by asking you some questions about the places you have lived in the past 12 months (or the last year).

Provide a doodle pad and pencil and offer participants a choice to draw a map or write their own list of addresses to become aware of their migrations (if necessary).

Which cities or neighbourhoods have you lived in over the past 12 months (or the last year)?

Please describe all of the places that you've lived in over the past 12 months (or the last year).

What type of housing was it?

Apartment

House

Family/friend's place

Hotel

Shelter

Jail

Street

Hospital

Who did you stay with?

Current Housing Experiences

Now I'm going to ask you about the place that you are currently living in.

Do you live in Winnipeg right now?

If no, where do you live?

If yes, how long have you lived in Winnipeg?

If you moved to Winnipeg from another location, why did you move to the city?

Neighbourhood Location, Duration and Cohabitants

We would like to roughly map out where people live now. Could you tell me your address, postal code or street intersection where you currently live?

How long have you lived there?

Do you live alone? If not, how many people do you live with? (adults/children/others) how are they related to you (friends/family/acquaintances)

Neighbourhood

I'd like to know what you think about your neighborhood. What is good and bad about it?

What are you satisfied or dissatisfied with?

Are there any environmental factors in your neighbourhood that may affect your health?

Noise

Pollution

Garbage on the streets

Safety

Difficulties and Challenges

Could you now share some of the hardships, difficulties or challenges that you have experienced with any of your housing.

Physical building/environment

Relationships in the house/with neighbours

Please explain the reasons for these difficulties and challenges.

Do you think these difficulties and challenges have been related to your HIV status?

If yes, how so?

Discrimination

Access to services in home ie. home care or having people assist you

Access to affordable housing

Please explain how you dealt with these hardships or difficulties.

How did they affect you as you live with HIV?

Sleep

Access to bathroom facilities

Kitchen/eating area

Improvements

What would make your housing situation better?

Improvements in the physical building

Moving to other place/location of the city

Having a specific place where needs of HIV people are met

Economics

How do you pay for your housing? Do you receive a subsidy? If you do receive a subsidy, does your rent cost more than your subsidy? If so, how do you pay the extra?

How much of your income is spent on rent?

What do you have to give up in order to afford your rent?

Diet

Would you say your diet is good enough for someone living with HIV?

If no, what stops you from getting the right amount or kind of food you need?

Where do you shop or get your food from?

How do you get the food home?

Where do you store it?

Where do you cook it?

Have you ever run out of food before you could afford to buy or get more?

Do you ever feel too sick to keep a healthy diet?

Too sick to shop, cook, eat

What do you do then?

Health and Social Services

Can you tell me about the types of health or social services you regularly use?

Doctor

Nurse

Advocate

Therapist

Social worker

Crisis line

Home care

Nursing care (e.g., dressing changes)

Other health care services (e.g., physiotherapy, nutrition counselling)

Personal care (e.g., bathing, foot care)

Housework (e.g., cleaning, laundry)

Meal preparation or delivery

Shopping

Respite care (i.e., caregiver relief program)

Street Connections, needle exchange

Elders

Cultural supports
Spiritual supports
Other outreach services

Barriers to Access

Have you had any problems accessing these services from where you live now?
What about in the past?

How do you get to these services?

Have you moved to be closer to any of these services? Why?

In the past 12 months (one year) was there ever a time that you felt you needed some kind of services but didn't receive it? Why?

Not available in area
No way of getting there
Waiting time too long
Felt the services would be inadequate
Cost
Too busy
Didn't know where to go
Language problems
Don't trust doctors, care providers
Stigma (afraid someone would find out I'm HIV positive)

Demographics

Finally, I would like to ask you some questions about yourself.

How old are you? _____ years old

Sex: Male _____ Female _____ Transgender (Male to female)____ Transgender
(Female to Male)____ Other _____

What ethnic or cultural group do you most closely identify with? What is your cultural identity? Community of belonging? Where do you consider home?

Where (were) you born in Canada? Are you First Nations (band affiliation), Metis, Inuit?
If not born here, what is your current immigration status? Permanent/landed immigrant, refugee, temporary resident

Have you had a positive HIV test? Yes_____ No_____ If yes, in what year? __
What is the highest grade you completed in school?

Have you ever taken any schooling at a trade school, college, university or other
Post-secondary school? Yes____ No____

What was the main source of your income last year?

We have completed the formal part of the interview. Is there anything else that you would like to say about your health and HIV status or your housing?

Do you have any questions for me?

Again, thank you for agreeing to be involved in this research project.

Housing and HIV Project



What are we doing?

Nine Circles Community Health Centre and the University of Manitoba would like to talk to people living with HIV / AIDS (PHAs) about their housing needs and their health. Each person will be asked to talk about his or her problems with housing.



What is involved?

A one-hour interview to talk about housing and HIV. Everything you say will be confidential. An honorarium of \$10.00 will be given to people who are interviewed.



Contact Information

If you have any questions or if you would like to participate in this project, please call 802-2237 or email housingandhiv@ninecircles.ca

Appendix C

Research Study Title: Housing and HIV Research Project

Who are the people running this project?

Dr. Rae Bridgman, Department of City Planning, University of Manitoba
Tara Carnochan, Nine Circles Community Health Centre

This consent form is to help ensure that you understand the project before consenting to be part of it. It should give you the basic idea of what the research is about and what would be asked to do. Please take the time to read this carefully and then I will go over it with you.

What is the purpose of the study?

The project's main objective is to talk to 30 persons with HIV / AIDS (PHAs), who are experiencing substandard housing and / or homelessness, about challenges and opportunities to reduce harms and barriers to care.

In particular, the research team will look for factors and themes that will enable the development of housing projects or programs that will improve the quality of life and health of people with HIV/AIDS.

What are you asking me to do?

You will be interviewed by a member of the research team about your housing and your health. What is said during these interviews will be kept confidential.

What will happen during the meeting/interview?

The interviews will be at a safe, quiet place, at a convenient time for you and the researcher. With your permission the interviews will be audio-taped. If you do not want any part of the interview taped, it will not be taped. Your rights as participant will not be affected if you decide not to have the interview taped.

What will I get if I agree to be a part of your study?

You will have the chance to share your experiences, inform others and to help improve services. The study can also help to create plans that will help people like you, their families and the community in providing or receiving care. The interview will last approximately one hour. You will receive an honorarium of \$10.00 for the interview. A summary of the findings as well as copies of the final report will be made available to you.

You will be invited to a feedback session with all other participants to learn about the preliminary findings of the research and to provide comments. The feedback session will last approximately one hour and a healthy snack will be provided.

What are the risks and discomforts I may go through in this study?

You should not be at any risk for physical harm as result of participating in this study. If after your participation in the interview you need to speak with a counsellor, you can call Klinic crisis line at 786-8686 for supportive assistance. If during the interview abuse against children or persons in care is disclosed, the researchers will have the responsibility to report the incident to the appropriate authorities.

How can I know that you will respect my confidentiality?

The information you provide will be kept confidential and your name or any information that could identify you will not be revealed. We will not use your name in any reports. Only the research team will have access to project data.

Do you have any way out from the study?

Your participation is *voluntary*. You do *not* have to answer all of the questions asked during the individual or feedback sessions. You are free to stop participating in the interviews at any time, for any reason.

Ethics Approval

This project has been approved by the Joint Faculties Research Ethics Review Board at the University of Manitoba. This Board may require access to our data for quality assurance purposes. If you have any concerns or complaints about this project, you may contact Tara Carnochan at 940-6000 or the Research Ethics Review Board at 204-474-7122. You do not have to tell them your name. A copy of this consent form has been given to you to keep for your records.

Who can I contact if I have any questions about the project?

Please call Tara Carnochan at 940-6000 or email tcarnochan@ninecircles.ca , Nine Circles Community Health Centre, 705 Broadway, Winnipeg, MB, R3G 0X2.

<p>Sponsor: Funded by the Public Health Agency of Canada's (PHAC) Federal Initiative to Address HIV/AIDS, and Human Resources and Social Development Canada's Homelessness Partnering Strategy (HPS).</p>
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Statement of Consent

If you are willing to participate of this study, please read the following agreement statement very carefully. Then, please sign and date this form and return it to me. I will give you a copy of the form for your records.

Your signature

Date

Researcher's Signature

Date

- I would like a summary report of the findings: ____Yes ____No
- I would like to pick up a summary of the report finding: yes ____ No____ If yes, contact me by email or phone ____ (Contact information is below)
- I would like to receive a copy of the report findings by email ____ or mail ____ .

My home address:

Name: _____

Address: _____

Postal Code: _____

Email: _____ Phone: _____

Contact me for the Feedback Session at the above address Yes ____ No ____

Contact me at the following address for the Feedback Session: (This is an address that they can be contacted at if they move from their current location.)

Name: _____

Address: _____

Postal Code: _____

Appendix D

PLEASE JOIN US

- When:** Thursday, February 19th at 2:00 p.m.
- What:** Housing and HIV Research Project Feedback Session
- Where:** Nine Circles Multipurpose Room
- Who:** Anybody who participated in the interviews and those who wanted to but were not able to make it
- Why:** We would like your feedback on what we have discovered from the interviews.

We will have a light lunch for those who attend.

We look forward to seeing you!

The Housing and HIV Research Team

Appendix E

Housing and HIV Feedback Session Outline

Station #1:

Flip chart Difficulties and Challenges
Finding appropriate housing (15)
Unable to afford housing (7)
Living in unsanitary conditions (7)
Bed bugs/bugs of any kind (6)
Being evicted (6)

If any of these difficulties or challenges applied to your situation, how do they affect your health?

Facilitator's information sheet

When asked to describe any difficulties or challenges experienced with housing the majority of respondents said that **finding appropriate housing** is the biggest challenge they face (15/30).

"Because every place you go [when looking for a place to live] there is it's either taken or you need ah someone to share rent with"

"When I was looking for a place, most of the places that I found were filthy, they were disgusting"

The next three biggest issues were **being unable to afford housing** (7) "But it's hard to find half decent places because the rent is so expensive", **problems with the landlord** (7) "my landlord is a very slum landlord so he doesn't really do things around the house like to fix you know what I mean so" and **living in unsanitary conditions** (7) "And then with people throwing stuff down from the balconies and since I live on the bottom floor, on the first floor I get everybody's trash in my front yard". Two other notable responses were having **bed bugs or bugs of any kind** (6) "[Bed bugs] Yeah they seem to get to me I don't know" and **being evicted** (6) "But then ah I wonder what happened there, like I got evicted because me and my girlfriend lend the place to her son and his girlfriend smashed all the windows and they told".

If any of these difficulties or challenges applied to your situation, how do they affect your health? Even if you are not experiencing any of these difficulties, what kind of impact do you think they would have on your health?

Note: When asked how it affects you as you live with HIV ten (10) respondents said that they experience **high levels of stress** and seven (7) indicated that they are **not sleeping well**.

Station #2:

Flip chart Solutions: What could make it better?

Better housing conditions (8)
Having a place to myself (5)
Housing specific to people with HIV (4)

What services could be put in place to address housing issues?
What has been helpful in the past and in what ways has it been helpful?

Unable to access services

Fifteen (15) respondents said that they had difficulty accessing health and social services in the past.
Assistance with finding housing (3)
Health and psychiatric services (2)

What (if any) services have you found difficult to access?

Facilitator's information sheet

When asked **what would make your housing situation better** a number of respondents said that **better housing conditions** (8) would improve their situation.

"Maybe come in and try to fix the holes that are in the heaters like the holes are too big"

"Insurance that we can all get one [housing] that's decent."

Five (5) of the respondents said that **having a place to themselves** was very important "I don't know having my own place I guess" and four (4) respondents felt that **having housing specific to people with HIV** would be helpful, "we should have an agency like HIV housing you know what I mean....For HIV people only".

What services could be put in place to address housing issues?
What has been helpful for you in the past and in what ways has it been helpful?

Half (15) of the respondents said that they **needed a service in the last year but didn't receive it**. Of the fifteen, three (3) respondents identified challenges accessing services that assist with finding housing and two (2) identified having difficulty with finding health and psychiatric services.

What (if any) services have you found difficult to access?

Station #3:

Flip chart

Question #1: What priority does your health and well-being hold in your life when you have to deal with housing issues?

Question #2: Do you feel that social assistance/welfare/CPP disability truly understands some of the unique issues that people with HIV face?

Question #3: Has the stigma or label of your HIV diagnosis ever prevented you from accessing health and social services?

Facilitator's information sheet

Other researchers who have studied housing and HIV have identified areas of concern that we did not address in our interviews. The following questions will help us to determine if these are areas of concern for you.

Question #1: What priority does your health and well-being hold in your life when you have to deal with housing issues?

Question #2: Do you feel that social assistance/welfare/CPP disability truly understands some of the unique issues that people with HIV face?

Question #3: Has the stigma or label of your HIV diagnosis ever prevented you from accessing health and social services?

Station #4:

Flip chart Food and Nutrition

Give up food in order to afford rent (8)

Have a history of running out of food (20)

HOWEVER:

Diet is good enough for somebody living with HIV (19)

What is your reality about food? Do you often go without food but still feel that your diet is good enough for somebody living with HIV?

How does this relate to your health?

Facilitator's information sheet

When asked “**what do you have to give up in order to afford rent?**” eight (8) respondents said that they have to give up **food**.

When asked “**do you ever run out of food before you could afford to buy or get more?**” twenty (20) respondents said “**yes**”.

Both of these outcomes tell us that there are a number of people living with HIV who go without food HOWEVER:

Nineteen (19) people responded “**yes**” to the question, “**would you say that your diet is good enough for someone living with HIV?**”

What is your reality about food? Do you sometimes run out of food but still feel that your diet is good enough for somebody living with HIV?

How does this relate to your health?

Appendix F

HIV and Housing Research Project – Data Analysis

Q1 How learned about project

Nine Circles (23)

Friend (5)

Kali Shiva (2)

Q2 Cities and neighbourhoods

Downtown/Central (18)

West End (4)

North End (2)

Osborne South (1)

Elmwood (1)

St. Vital (1)

St. Boniface (1)

Garden City (1)

Did not want to disclose (1)

Q3 Describe places

Living in family members home - mother, sister (5)

Two bedroom apartment (4)

Rooming house (4)

One bedroom apartment (3)

Bachelor suite (3)

Apartment – not specified (2)

Shelter (2)

House (2)

Hotels/fishing lodges (2)

House of Hesed (1)

Duplex (1)

Two bedroom condo (1)

Q4 Who stay with

Alone (14)
With family - adults and children (6)
With friend or roommate (3)
With their children (2)
Others in shelter (2)
With partner (1)
Others in House of Hesed (1)
Co-workers in fishing lodges (1)

Q5 Winnipeg or rural

Winnipeg (29)
Dauphin, Kenora, Dryden (1)

Q6 Location

To be flagged on city map

Q7 How long (current residence)

Less than 5 months (10)
Greater than 5 years (7)
Between 5 months and 12 months (5)
Transient – always moving (4)
Between 1 year and 5 years (3)
Not indicated (1)

Q8 Good about neighbourhood

Close to conveniences - shopping, vendors, services (20)
Nothing good (2)
Price of housing (2)
Doesn't matter (2)
Safe (1)
Missing information (1)
Revitalized neighbourhood – improving (1)
Good neighbours/history (1)

Secondary responses Q8

Close to conveniences – shopping, vendor, services (1) + 20 primary = (21)

Safe (7)

Revitalized neighbourhood – improving (2) + 1 primary = (3)

Q9 Bad about neighbourhood

Crime, violence, unsafe (12)

Drugs (5)

Nothing bad (4)

Missing information (3)

Gangs (2)

Lack of privacy (2)

Traffic (1)

Don't know (1)

Secondary responses Q9

Drugs (4) + 5 primary = (9)

Gangs (2) + 2 primary = (4)

Ambulance/emergency vehicles (2)

Noise (2)

Garbage (1)

Q10 Environmental factors that affect health

Noise (7)

Drugs (6)

Nothing (4)

Unsanitary (3)

Air pollution (3)

Safety (2)

Poor housing conditions (1)

Bugs (1)

Temperature in home - cold (1)

Weather (1)

Cat in home (1)

Secondary responses Q10

Noise (2) + 7 primary = (9)
Drugs (1) + 6 primary = (7)
Safety (3) + 2 primary = (5)
Air pollution (2) + 3 primary = (5)
Bugs (1) + 1 primary = (2)
Lack of space (1)

Tertiary responses Q10

Safety (1) + 2 primary + 3 secondary = (6)
Unsanitary (1) + 3 primary = (4)
Sidewalks too icy (1)

Q11 Difficulties and challenges

Finding appropriate housing (9)
Being evicted (6)
Problems with the landlord (3)
Bed bugs – bugs of any kind (3)
Surrounded by drinking, drugs, partying (2)
Owing money to Manitoba Housing (1)
Unable to afford housing (1)
Accessibility in building for people with disabilities (1)
Living with others (1)
Nowhere to rest (1)
No money for damage deposit (1)
Not enough space (1)

Secondary responses Q11

Finding appropriate housing (4) + 9 primary = (13)
Bed bugs (3) + 3 primary = (6)
Unsanitary (5)
Surrounded by drinking, drugs, partying (2) + 2 primary = (4)
Problems with landlord (1) + 3 primary = (4)
Unable to afford housing (2) + 1 primary = (3)
Problems with laundry (2)
Noise (2)
Stigma of being HIV positive (2)
Poor housing conditions (2)
Not enough money for damage deposit (1) + 1 primary = (2)
Not able to cook in shelter (1)

Tertiary responses Q11

Finding appropriate housing (2) + 9 primary + 4 secondary = (15)
Unable to afford housing (4) + 1 primary + 2 secondary = (7)
Problems with landlord (3) + 3 primary + 1 secondary = (7)
Unsanitary (2) + 5 secondary = (7)
Noise (2) + 2 secondary = (4)
Accessibility in building for people with disabilities (2) + 1 primary = (3)
Stigma of being HIV positive (1) + 2 secondary = (3)
Not enough privacy (1)
Finding references (1)

Q12 Related to your HIV status

No (19)
Yes (9)
Missing information (1)
Don't know (1)

Additional information

Of those who said "No" (8) indicated that they never disclose their HIV status

Q13 How deal with hardships

Adapt – move on (12)
Missing information (4)
Drugs (2)
Nothing (2)
Kill bed bugs themselves (2)
God, religion, faith (1)
Planning to move to the country (1)
Entertainment – movies, bingo (1)
Take laundry to friend's house (1)
Beat people up (1)
Volunteer (1)
Go to Nine Circles (1)
File complaints (1)

Q14 Affect you as you live with HIV

Stressed (9)
Not sleeping (7)
Missing information (4)
Not taking medication (3)
Poor mental health (2)
Not eating (1)
No privacy (1)
Living in unsanitary conditions (1)
Yes (1)
No (1)

Secondary responses Q14

Stressed (1) + 9 primary = (10)
Not sleeping (1) + 7 primary = (8)
Doing drugs (1)
Poor air quality (1)

Q15 What would make it better

Better housing conditions (7)
A place to themselves (5)
Specific housing for people with HIV (3)
Missing information (3)
Get rid of bugs (2)
Housing for people on disability – not just HIV (1)
Moving out of the city to the country (1)
Home care (1)
Nothing (1)
Laundry facilities (1)
Furniture (1)
Access to a phone (1)
A place to file complaints (1)
More money for housing (1)
A better landlord (1)

Secondary responses Q15

Better housing conditions (1) + 7 primary = (8)
Specific housing for people with HIV (1) + 3 primary = (4)
More money for housing (2) + 1 primary = (3)
Easier access to conveniences – groceries, services (2)

Let stigma around HIV (2)
No drugs and alcohol at the doorstep (1)

Q16 How pay for rent

Social assistance – EIA - welfare (22)
CPP disability (3)
Deceased spouse's pension (2)
Pension from work (1)
Employment – work (1)
Not paying rent (1)

Q17 Income on rent

Approximately one third or 30% (11)
Not specified (8)
Half or greater (5)
One quarter (2)
Not sure (2)
Missing information (1)
Not applicable (1)

Q18 What do you have to give up

Food (6)
Nothing (5)
Drugs – drinking (4)
Missing information (3)
Personal items – clothes (3)
Entertainment – cable, internet (2)
Being able to see children (1)
Pocket money (1)
Money to fix the house (1)
Travel (1)
Sleep (1)
Stove (1)
Living in a house (1)

Secondary responses Q18

Food (2) + 6 primary = (8)
Personal items – clothes (2) + 3 primary = (5)
Entertainment – leisure, recreation (3)

Q19 Diet good enough

Yes (17)

No (13)

Q20 Where shop

Safeway (6)

Superstore/Extra Foods (4)

Food bank (4)

Corner store (3)

Walmart (2)

Giant Tiger (2)

Siloam Mission (2)

Sobeys (1)

Dinos (1)

Cantors Meats (1)

Foodfare (1)

Avenue Meat Market (1)

Pals (1)

Not shopping – living in shelter (1)

Secondary responses Q20

Superstore/Extra foods (6) + 4 primary = (10)

Safeway (4) + 6 primary = (10)

Foodbank (3) + 4 primary = (7)

Giant Tiger (2) + 2 primary = (4)

Corner store (1) + 3 primary = (4)

Walmart (1) + 2 primary = (3)

Cantors Meats (1) + 1 primary = (2)

DeLucas (1)

Harry's Foods (1)

California Fruits (1)

Shopper's Drugmart (1)

Q21 How get it home

Walk (16)
Bus (4)
Taxi (2)
Missing information (2)
Ride from family (2)
Not shopping – shelter (1)
Volunteer driver (1)
Ride from a friend (1)
Own vehicle (1)

Secondary responses Q21

Walk (2) + 16 primary = (18)
Bus (3) + 4 primary = (7)
Ride from a friend (2) + 1 primary = (3)
Boyfriend (1)
Handi-transit (1)

Q22 Where store food

Working fridge (16)
Fridge needs repair (5)
No fridge (3)
Missing information (3)
Deep freeze (2)
Under the bed (1)

Q23 Where cook food

Working stove (13)
Missing information (6)
No stove – oven (4)
Stove needs repair (4)
Friends or parents home (2)
Don't cook (1)

Q24 Run out of food

Yes (20)

No (7)

History of running out of food but fine now (3)

Additional information

Of those who responded "Yes" (14) indicated that they are able to access food if needed – soup kitchens, food banks etc.

Q25 Too sick for a healthy diet

Yes (16)

No (12)

Missing information (2)

Q26 Doctor

Yes (30)

Additional information

Good experience (7)

Not happy with doctor (4)

Q27 Nurse

Yes (28)

No (1)

Missing information (1)

Additional information

Good experience (12)

Bad experience (2)

Q28 Advocate

There was some confusion about the definition of advocate.

Yes (23)

No (7)

Additional information

Helpful (11)

Q29 Therapist

Yes (15)

No 15)

Additional information

Not helpful (6)

Helpful (3)

Q30 Social worker

No (16)

Yes (14)

Additional information

Bad experience (6)

Good experience (5)

Q31 Crisis line

No (23)

Yes (5)

Missing information (2)

Q32 Home care

No (29)

Yes (1)

Additional information

Tried but couldn't get (2)

Q33 Nursing care

No (29)

Yes (1)

Q34 Other health care services

No (16)

Dietitians/nutritionists (8)

Physiotherapist (5)

Chiropractor (1)

Q35 Personal care

No (27)

Foot care (3)

Q36 Housework

No (30)

Q37 Meal preparation and delivery

No (30)

Q38 Shopping

No (28)

With volunteer (1)

Yes (1)

Q39 Respite care

No (29)

Yes (1)

Q40 Street connections

No (21)

Yes (9)

Additional information

Of those that responded "No" (4) indicated that they have used Street Connections in the past

Q41 Cultural and spiritual supports

No (17)

Yes (2)

Spiritual – prayer, church (6)

Cultural (3)

Combined cultural and spiritual – aboriginal services (2)

Q42 Other outreach services

Yes (15)

No (15)

Additional information

Of those that responded "Yes" accessed the following services:

Kali Shiva (4)

Ma Ma Wai (2)

Seneca House (1)

Klinic – day counseling (1)

MBS – volunteer shopping, out for coffee (1)

Women's Resource Centre (1)

Hands of Hope (1)

Siloam Mission (1)

Friendship Centre (1)

YMCA (1)

Dental (1)

Q43 Problems accessing services (current)

No (23)

Yes (7)

Q44 Problems accessing service (past)

No (18)

Yes (10)

Missing information (2)

Q45 How get to services

Walk (17)

Bus (8)

Vehicle (3)

Bike (1)

Main Street Project vehicle (1)

Q46 Move to be closer

Yes (18)

No (12)

Q47 Unable to access services

No (15)

Yes (15)

Additional information

Of those who responded "Yes" the following services were identified:

Crisis/emergency assistance (3)

Assistance with finding housing (3)

Mental health/psychiatric services (2)

Travel out of country (1)

Childcare (1)

Help filling out forms (1)

Handi-transit (1)

Advocate (1)

Acupuncturist (1)

Q48 Age

Age range 31 - 63

Average = 44 years old

Q49 Sex

Males (18)

Females (12)

Q50 Ethnic or cultural group

Aboriginal (17)

Metis (4)

European or Asian (8)

Additional information

Of those that responded that they have an Aboriginal background (9) were hesitate or uncertain about how to respond (ie. "Aboriginal I guess", "I don't know, I guess Aboriginal", "I'm not sure, probably Aboriginal")

Q51 Where were you born

Canada (28)

Another country (2)

Q52 HIV positive test?

Range of years since diagnosis 1-23

Average = 11

Don't know (2)

Q53 Highest grade completed in school

Grade range = 8-12

Average = 10

Missing information (1)

Additional information

High school graduates (10)

Q54 Additional schooling

No (17)

Yes (13)

Q55 Main source of income

Social assistance/EIA/welfare (21)

OAS/CPP (5)

Employment (2)

Deceased spouse's pension (2)

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