

A close-up portrait of AA Bronson, a man with a long, full white beard and mustache, wearing black-rimmed glasses and a small hoop earring. He is looking slightly to the side with a gentle expression. The background is a soft, out-of-focus grey.

THE POSITIVE SIDE

SPRING/SUMMER 2022 VOLUME 24 ISSUE 1
HEALTH INFORMATION & VIEWS

Canada's Housing Crisis

How did we get here?

Setting the Stage

Activist oral histories

Cabenuva

The new injectable
treatment

A Bright Idea

AA Bronson on art and HIV

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EDITOR'S LETTER

Welcome to the 2022 edition of *The Positive Side*!

This year, our magazine ties in with two exciting events. 2022 sees the return of the International AIDS Conference to Montreal, and to commemorate we have an oral history of the 1989 conference ("Setting the Stage", page 8). In our set of interviews, you'll hear first-hand from activists who banded together to disrupt the conference and change the field of HIV research for good. We also have a feature interview with cover star AA Bronson, a multidisciplinary artist, healer and former member of the art collective General Idea. This summer, the National Gallery of Canada in Ottawa opens Canada's first retrospective of General Idea's work—turn to page 22 to hear his reflections on the show and the role of HIV in his work.

Elsewhere, we're tackling some difficult—but important—topics. People living with HIV can face structural barriers like racism and stigma towards drug use, which are amplified by stigma towards HIV. In this issue of *The Positive Side*, we're diving into the challenging issues that affect the most vulnerable members of our community. In "A 'Wicked Problem'" (page 14), Alexandra Kimball unpacks intimate partner violence as it relates to HIV; in "A House of Cards" (page 18), Jonathan Velely explores the housing crisis in Canada; and on page 6, Elene Lam from Butterfly takes us through what the law says about sex work. Across all of these, we show how frontline workers and community organizers are fighting back to improve the lives of those who are most affected.

As we roll from spring into summer, we're looking to brighter days ahead. New kinds of HIV treatment are also opening up more possibilities for managing your health—on page 13, Darien Taylor gives us the low-down on the new injectable treatment and what it could mean for our readers. Do you have a story to tell or an idea for a future issue? Here at the *Positive Side*, we love hearing from you! You can email us at contribute@positiveside.ca.

—Dan Udy

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Positive Influence

In 2021, CATIE ran a digital campaign to raise awareness about HIV prevention. *Face HIV With No Fear* was a new kind of project for the organization: for the first time, it collaborated with social media influencers to deliver positive and inspiring HIV prevention information on their own platforms.

BY JORDAN COULOMBE

PHOTOGRAPHS: GABRIELLE MARION, JADE HASSOUNE, NADINE THORNHILL



Gabrielle Marion



Jade Hassouné



Nadine Thornhill

Influencers are a relatively new type of public figure. They can be anyone with an audience on social media platforms, from a famous actor or singer to an amateur chef or photographer. What makes someone an influencer is that the content they post has an impact on what other people think and can change someone's behaviour. While some companies use influencers to sell their products, CATIE hired influencers to talk to their audiences about new HIV prevention tools. The campaign focused on the message

that HIV treatment and pre-exposure prophylaxis (PrEP) are so effective at preventing transmission that everyone, regardless of status, can now face HIV with no fear.

CATIE collaborated with Clark Influence, a Montreal-based influencer marketing agency, to choose 10 influencers for the campaign. Each influencer was selected because their audiences included the people most affected by HIV in Canada. They shared original images, videos and text to their Instagram accounts and

added interactive features like polls and quizzes. This helped spark conversations about sexual health that aimed to reduce anxiety and stigma around HIV.

"I think the more informed you are, the less afraid you are," says Jade Hassouné, one of the influencers chosen by CATIE. Joining the campaign allowed him to participate in shifting attitudes around HIV, ultimately decreasing the amount of fear that still exists about the virus. To help participants with their content, CATIE provided

unifying elements like blue makeup, an earring inspired by the red ribbon, and the hashtag #faceHIVnofear. Each influencer then used these to create Instagram posts and stories in their own unique voice. CATIE's HIV experts were also on hand to ensure that their messages were accurate and informative and that they conveyed a sense of optimism and hope.

Jade says he received some unexpected responses from his followers—some of them didn't understand why he'd say not to fear HIV. Another influencer, Nadine Thornhill, says that "some people might think fear is good and that if you're afraid, you're more likely to practise safer sex." Living in fear can hurt us in the long run, she explains. "When we're afraid to have conversations and afraid of what HIV might do to our bodies, some people will just pretend that it doesn't exist. They'll sort of close their eyes, cross their fingers and hope it's going to be okay." Nadine recognizes that fear and stigma can stop people from getting tested or from getting the healthcare they need. She saw the campaign as a chance to address people's anxieties and start an open and non-judgmental dialogue with her followers. Ultimately, she wanted to tell them that "we don't have to see HIV as this looming threat."

Giant leaps have been made in HIV prevention over the last decade, with the arrival of PrEP and the knowledge that an undetectable viral load makes HIV untransmittable through sex (U=U). During the same period, social media platforms have transformed how we communicate with each other. The number of people who use social media and the time they spend on it have exploded in recent years, which makes these platforms ideal for sharing new prevention messages. This is an urgent task: even though PrEP and U=U have transformed HIV prevention, many people still don't know about them. By using these new platforms, campaigns like *Face HIV With No Fear* can directly reach the communities most affected by HIV in Canada.

Data from the campaign show that it was successful. In total, the influencers

reached more than 600,000 people and had an engagement rate double the average for non-profit organizations. This means twice as many people clicked on or responded to content than usual, which showed that audiences were taking in the HIV prevention messages. Gabrielle Marion is a trans woman from Montreal with 52,000 Instagram followers. "I feel like there's still too much discrimination," she says. Gabrielle chose to get involved "because there's no fear to have about HIV. People with HIV have medication that makes it non-transmittable through sex and people can take PrEP to prevent it."

Sharing information about PrEP and U=U at the same time means that

"The more informed you are, the less afraid you are."

— Jade Hassouné


the campaign applied to all people, no matter their HIV status. This is known as a status-neutral approach. This tactic aims to reduce stigma by showing how everyone has a role to play in preventing HIV. It explains that the options for both HIV-positive and HIV-negative people are highly effective. One of the benefits of this approach is that it gives people information they can share with their partners: for example, U=U is useful knowledge for both people in a mixed-status relationship, while someone with a detectable viral load could share information about PrEP with their HIV-negative partners. The status-neutral approach

also recognizes that everyone can use HIV services, whether for prevention, testing or treatment. It affirms that everyone has the right to be treated with compassion. Ultimately, Jade says, "we're all human and we're all equally lovable."

When CATIE looked at its previous campaigns, it found that these were most effective when they reflected the people they were trying to reach. Language choice is a key way to help people to feel included by a campaign: this is why CATIE approached both English- and French-speaking influencers with audiences across the country. CATIE also chose influencers from groups that face greater barriers to getting information about HIV, like Black, Indigenous and other racialized communities. These groups were more likely to receive the campaign's messages because influencers had built relationships with their audiences based on trust. Gabrielle, for example, has become known as an expert on trans healthcare by sharing her transition online. When it comes to messages about HIV, her audiences are ready to listen. "I feel like I have the credibility to give this type of information," she says, "because my whole career has been based on providing people with information through documenting my transition, surgery and hormones."

Face HIV With No Fear sees people living with HIV working together with HIV-negative people to tackle HIV stigma. This status-neutral approach can empower people to look after their health, but also (most importantly) to enjoy sex. If HIV is nothing to fear, then everyone's sex life improves—whether you're living with HIV or in a community at risk. "My hope is that information makes people better equipped to take care of their sexual health, and also enjoy their sexuality and sexual relationships," Nadine says. "If I can help to de-stigmatize and spread info that makes people less afraid of connecting and of HIV as a virus, I'm really happy to do that." +

Jordan Coulombe is Health Education Coordinator at CATIE.



Sex Work and the Law in Canada

Sex work is highly stigmatized and criminalized in many countries. For many people, though, it offers a reliable way to earn money and support themselves. This includes people living with HIV, who often face discrimination in employment and housing along with racism, transphobia, homophobia and stigma towards drug use. How does the law affect sex workers in Canada, and what can be done to support them? **Elene Lam** explains.

WHAT DOES THE LAW IN CANADA SAY ABOUT SEX WORK?

In December 2013, the Supreme Court of Canada ruled in *Bedford v. Canada* that offences in the *Criminal Code* targeting sex work were unconstitutional. In this ruling, the Court said that these contributed to violence against sex workers and violated their human rights. However, in 2014 the federal government passed the *Protection of Communities and Exploited Persons Act* (PCEPA), which reversed this progress.

The Canadian government and anti-sex work groups promote PCEPA as an “end-demand” model. This is sometimes known as the Nordic model because it was first adopted in Sweden, Norway and Iceland. The PCEPA tries to end sex work by making it illegal to buy sex, therefore “ending demand”. However, it creates sex work offences that apply to more than just clients: it actually makes almost all activities related to sex work illegal. It does this by criminalizing the work of sex workers and third parties (which can include managers and drivers, as well as friends and family who provide other kinds of support).

The PCEPA makes advertising, gaining material benefits from sex work, and arranging other people’s sex work (known as “procuring”) illegal. It also criminalizes communicating in public near a school, playground or daycare about buying or selling sexual services. In all cases, sex workers’ labour is seen as part of a criminal activity. Instead of recognizing sex work as a legitimate and valuable job, this law claims that all sex workers are victims and all clients and third parties are criminals.

WHAT EFFECT DOES CRIMINALIZATION HAVE?

People who advocate against sex work say that “end-demand” laws do not harm sex workers, because they only make *buying* sex illegal. This is false. There is no way to criminalize one

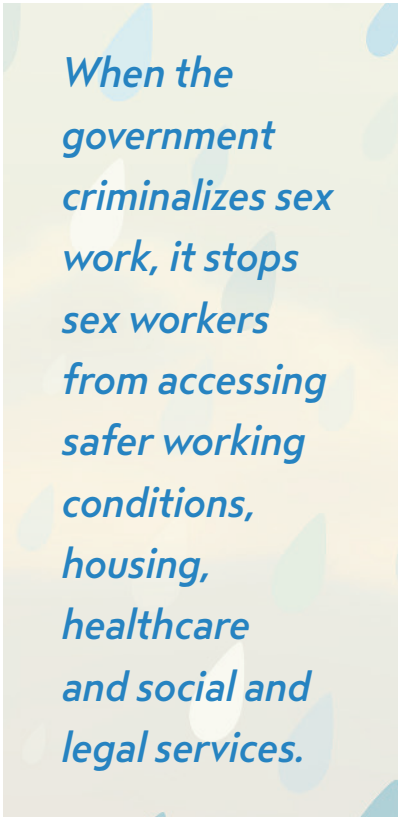
party without affecting the other. When these laws make it illegal to buy sexual services, they create an environment where clients have to become more secretive to try and avoid detection. As a result, clients often rush negotiations and do not provide important screening information. When third parties like managers, security or other sex workers are also criminalized, they may need to work underground to avoid police detection. This prevents them from providing safer working environments for sex workers. Overall, criminalization makes the conditions for sex work unfair and unsafe, and it means that sex workers cannot improve them.

Advocates of “end-demand” laws claim that all sex work is exploitation. This means that sex work is often seen as human trafficking, and it has drawn attention to the sex industry from law enforcement. One effect is that more and more people involved with sex work are being investigated or charged under laws related to sex work. These can include sex workers who provide third-party services and help other sex workers create ads, set prices, travel to and from appointments or book hotels. Migrant and youth sex workers are more likely to rely on each other to navigate their work, which makes them more vulnerable to these charges. Canada’s immigration laws also ban migrants from working in sex-related industries—this means any migrant who does sex work or has a third-party role can be arrested and deported.

When the government criminalizes sex work, it stops sex workers from accessing safer working conditions, housing, healthcare and social and legal services. It also prevents sex workers from asserting their labour rights and improving their working conditions. By framing sex work as something that is harmful to society, criminalization fuels stigma and discrimination against sex workers and their clients. It also fuels the over-policing of sex work and erotic business establishments like body-rub parlours and strip clubs. As a result, some groups that oppose sex work

now advocate for shutting down Asian massage parlours.

Criminalization threatens all sex workers in every sector of sex work. It particularly threatens sex workers of colour, Indigenous sex workers, sex workers who use drugs, trans sex workers, low-income and homeless sex workers, and sex workers with precarious immigration status. In Canada, PCEPA is having a disastrous effect on sex workers’ lives and livelihoods. It denies them their fundamental human rights, including the right to have control over their own body and sexual activity. It makes them targets for surveillance and racial profiling. They face the unwanted



When the government criminalizes sex work, it stops sex workers from accessing safer working conditions, housing, healthcare and social and legal services.

and unsolicited presence of police in their lives, which brings a constant threat of being arrested, charged, detained, deported, imprisoned and having a criminal record. Even if sex workers are not actually charged, arrested or deported, attention from police can have other effects: it can mean being evicted from working and living spaces, targeted for violence by

neighbours or partners, and devalued as a community member and skilled worker. Ultimately PCEPA is an assault on sex workers’ legal, financial and bodily autonomy.

WHAT CAN CANADA DO TO SUPPORT SEX WORKER RIGHTS?

For many years, sex worker advocacy groups have been campaigning to have sex work fully decriminalized. UNAIDS, Amnesty International and the World Health Organization support the decriminalization of sex work. They have recognized that decriminalization creates safer working environments, helps protect workers’ rights, improves their access to health services and reduces their vulnerability to HIV, violence, exploitation, stigma and discrimination.

Canada can respect the rights and dignity of sex workers by fully decriminalizing sex work. This would mean repealing all the sex work offences in the *Criminal Code*, including the activities of sex workers, clients and third parties. Immigration laws that hinder sex work and all other forms of legal oppression must also be repealed. In 2021, the Canadian Alliance for Sex Work Law Reform (an alliance of sex-worker rights groups across the country) launched a constitutional challenge seeking to strike down criminal offences related to sex work.

Sex work is work. It is not human trafficking, an immoral act or an act of violence. Sex work is meaningful and valuable work that provides economic opportunity. Canadian society should work to eliminate discrimination against sex workers as well as fight against all forms of systemic oppression, including whorephobia, transphobia, xenophobia, racism, sexism and classism. +

Elene Lam is director of Butterfly (Asian and Migrant Sex Workers Support Network).

For more information on sex work and the law in Canada, visit www.butterflysw.org/legal-information-for-services-prov



Setting the Stage

The 24th International AIDS Conference (AIDS 2022) is taking place this summer in Montreal. It's not the first time the city has hosted the event—in 1989 it was the host city of the 5th International AIDS Conference, which became a real turning point for HIV activism and research. We take a trip down memory lane with three activists who played a role in that historic event.

INTERVIEWS BY RONNILYN PUSTIL

KAREN HERLAND

Professor, Sexuality Studies and Fine Arts,
Concordia University
International AIDS Conferences attended: 1

When the conference happened, I was in my mid-20s and working at CSAM (*Comité sida aide Montréal*) in education and prevention. It dawned on me that all these activists were coming to Montreal and there wasn't any infrastructure to support that. Something had to happen, but one young lesbian wasn't necessarily going to rally the masses on this one. I got in touch with my friend Eric Smith and we decided to hold a meeting. It was 1989—no Internet, no Facebook, nothing. We had phone trees and went to events and handed out fliers. About 40 to 50 people came to our first meeting in a room on top of an anarchist bookstore.

This was March, and the community was reeling from the murder of Joe Rose, a young queer boy barely out of his teens who was gay bashed to death on a bus. People at the meeting wanted

to draw attention to this homophobic murder. I felt it might be a good way for us to get to know each other and start to organize together, so we developed a protest and that's how we started. We named ourselves *Réaction Sida*.

Eric found a location that we could use as our headquarters in a housing co-op and furnished it with fax machines, typewriters, rudimentary computers and a TV. It became our centre where we held meetings, wrote press releases and prepped for demos. Every night during the conference we'd watch the news together and debrief and figure out what to do the next day. We were naïve and fearless. We accessed the conference in all sorts of ways and protested and disrupted as often as we could. At the opening ceremony, we started protesting outside of the *Palais des Congrès* and at one point someone shouted, "we're going in!" and everyone entered the building.

I have vivid images of us going up the escalators—this gaggle of leather

jackets, T-shirts, multicoloured hair, combat boots—the whole bit. My best friend, Sally, was 5'11", had super-tall, teased dread hair and was wearing roller skates, and she towered over everybody. We took over the stage with our banners and chanted "join us" to the audience. A lot of them stood up and cheered us on. The 1989 conference was very professional—researchers, doctors and government and public health officials were invited. The idea of people who were affected by HIV and AIDS being involved came out of that conference.

What I remember so distinctly is that at one point [AIDS Action Now! chair] Tim McCaskell said, "I want to open the conference on behalf of people living with HIV and AIDS." Taking over the stage was important but reading what became the Montreal Manifesto in English, French and Spanish was a *really* important moment. We delayed the opening ceremony by maybe an hour and then left. Some of the protesters stayed to





“Taking over the stage was important but reading what became the Montreal Manifesto was a really important moment.”

– Karen Herland

heckle [then Prime Minister] Brian Mulroney during his speech.

There were multiple actions every day on behalf of different populations and communities. Out of the hundreds of abstracts presented, only 12 concerned women—and that was entirely women as mothers or sex workers. There was no other acknowledgment of women in HIV at that time. Our actions were political but also social. I met incredible people. We spent so much time together and we were all so engaged and committed to something, but it felt like we were screaming into a void.

The events of that conference and the demands we made led to provincial assistance with a medication program that continues to this day. A lot has been written about how that conference shifted the relationship between “patients” and the scientific

community. It created a situation whereby people directly affected by HIV/AIDS demanded and were recognized as having a voice in how services were provided, how programs were developed and how resources were allocated.

TIM McCASKELL

Self-proclaimed “AIDS dinosaur”

International AIDS Conferences attended: 5

I had just become chair of AIDS Action Now! (AAN!). The conference was coming up and we contacted ACT UP New York. Up until then, AIDS conferences had been for the medical and pharmaceutical industries. If people with HIV and AIDS were around at

all, we were tarted out as specimens for this, that or the other. ACT UP had sort of changed the way we thought about ourselves—not as patients but as people living with HIV and AIDS and as people who needed to change the way the epidemic had been conceptualized. People living with HIV and AIDS wanted to go to the conference to learn about the new science. We were very interested in trying to figure out whether there was anything we could do to keep ourselves alive.

I went to Montreal in March to suss out the conference site. I managed to get an actual blueprint of it, which we shared with ACT UP. We developed with ACT UP the Montreal Manifesto, outlining the rights of people with HIV and AIDS. “Nothing about us without us” was the fundamental message, and it called for more international solidarity, access to treatment, money for research and more.

In June, a gang of us from AAN! went to Montreal. A small group called *Réaction Sida* had found an office space just a quick bus ride from the convention centre. That was the first time there was an activist hub at an AIDS conference where we could all gather. We met with ACT UP and *Réaction Sida* to plan our interventions. For the conference opening, we were planning a protest in front of the main entrance of the convention centre, where different people were supposed to speak as the delegates went in. ACT UP was a bit more assertive than that. I was about to speak when I heard a ruckus behind me. The ACT UP guys had busted through the front doors and the whole ACT UP crowd started marching into the convention centre. They hadn’t told anybody else, and we were like, what’s going on?

We decided to follow them. We all marched into the conference hall and took over the stage... and then didn’t know what the fuck we were supposed to do. We milled around, waiting for Mulroney, and then somebody stuck a microphone in my face. So, as the head of the Canadian activist organization, I officially opened the conference on behalf of people living with HIV and AIDS. What I said was short and off

the cuff. I basically went after the Mulroney government for its inaction, incompetence and negligence in terms of dealing with this crisis, because at that time Mulroney had never publicly said the word AIDS.

The audience clapped; they were entertained. And I think it made them begin to think of things in a different way. There seemed to be a lot of solidarity, but I also think their jaws hit the floor because nothing like this had ever happened before. These were largely medical people who were used to dealing with patients; they weren't used to dealing with activists. After I spoke, we still had no plan. They couldn't bring out the prime minister because there were these crazies on the stage and they couldn't get us off the stage without a battle. On the fly, we decided to read the Montreal Manifesto. At a certain point we had to let the conference begin, so we all

stepped down. A group of us sat in seats in the front that were designated for VIPs. Then security figured it was safe enough to let Mulroney speak. The conference organizers were scrambling to maintain control of the situation. I think they realized the world had shifted, because they ended up getting a person with AIDS from Vancouver to do a closing piece, which hadn't been scheduled when the conference began.

After that year, the International AIDS Society (IAS) found a space for activists at conferences and established an activist liaison group, because they realized we were going to be there no matter what. Our action changed the character of those conferences. Everybody knew that people

with AIDS were going to be active and vocal and our issues were going to be part of the agenda, even if we were not included on the official agenda, so they had to take us seriously. The IAS also began to provide subsidies for people with HIV and AIDS to attend the conferences. It meant that we were there at the table, raising all kinds of uncomfortable questions.

We managed to get compassionate access to experimental treatments. And the kind of media-savvy stunts and protests that ACT UP pioneered became part and parcel of an activist's backpack. We really pushed to make things different.

JOHN GREYSON

Video/film artist

International AIDS Conferences attended: 3

Montreal was memorable because we stormed the stage. I was a member of AIDS Action Now! (AAN!) and my then-boyfriend and I were there making a documentary about global activist voices. Up until then, the AIDS conferences had been dominated by the experts. ACT UP New York, AAN! and other grassroots and queer activists all got together and said, "We need to change the status quo. The time is now. It's 1989 and this is the conference where it's going to happen." We painted banners, posters and placards. Our campaign was called "The World is Sick"—sick of multinationals, Big Pharma, President Bush. We loaded up vans for our road trip to Montreal.

The opening demonstrations were extraordinary and still the most vivid. The plan was that we would chant and protest outside of the convention centre. But were we going in? Not that I remember. Maybe some had decided. Certainly, civil disobedience was very much part of the DNA of the activism that week. There was a turning point where people started going in. We weren't going to be politely chanting outside. *We were going in.* We burst through the barricades and went up the escalators. A lot of this footage is in the documentary—*The World is Sick (sic)*—because I was able to keep filming during the whole thing. I was

"Somebody stuck a mic in my face and I officially opened the conference on behalf of people living with HIV and AIDS."

— Tim McCaskell





accounts were sort of disgruntled. But, by the end of the conference, they were claiming to be on side with the activists. It was a turning point. Doctors and government officials suddenly cared about our issues.

It was a defining moment in terms of activists on a global stage. There had been lots of AIDS activism since 1987, but this was the first time it had played out at a global level. It was a chance for us to open the door on global activism. After the opening ceremony, I mostly worked on my film, running around interviewing some of the most amazing activists from Australia, Africa, South America. Plugging into the energy and brilliance of the international activists, particularly the work of the South Africans, opened my eyes to seeing AIDS from a global perspective. I was also one of the coordinators of the cultural program; Ken Morrison was the mastermind behind it. Every night we had films, poetry readings, an art exhibit. My time at the conference tended to be dominated by those events.

One of the most important things to remember about 1989 was Tiananmen Square. The convention centre was in Chinatown, and each day we went to the arches there, where local Chinese activists were wheat-pasting updates in Mandarin about what was happening in Tiananmen. So much of our courage in breaking through the barricade had to do with the courage and outrage of Tiananmen, that feeling that there's something in the water and we're all catching it. There's a new virus in town and it's called courage!

AAN! had already lost so many members. Seeing that our government matched Reagan's indifference and Mulroney's contempt for people with AIDS was visceral. The medical establishment was happy to take on research projects and placidly proceed with business as usual, but there was no sense of urgency. You're smugly having cocktails in your hotel and leveraging this for what you can expense, but a conference is not a holiday. This conference should have been about recognizing the urgency. And that's what we brought to the stage. +



*"It wasn't about asking
for the microphone;
it was taking
the microphone.
The symbolism
of that cannot be
underestimated."*

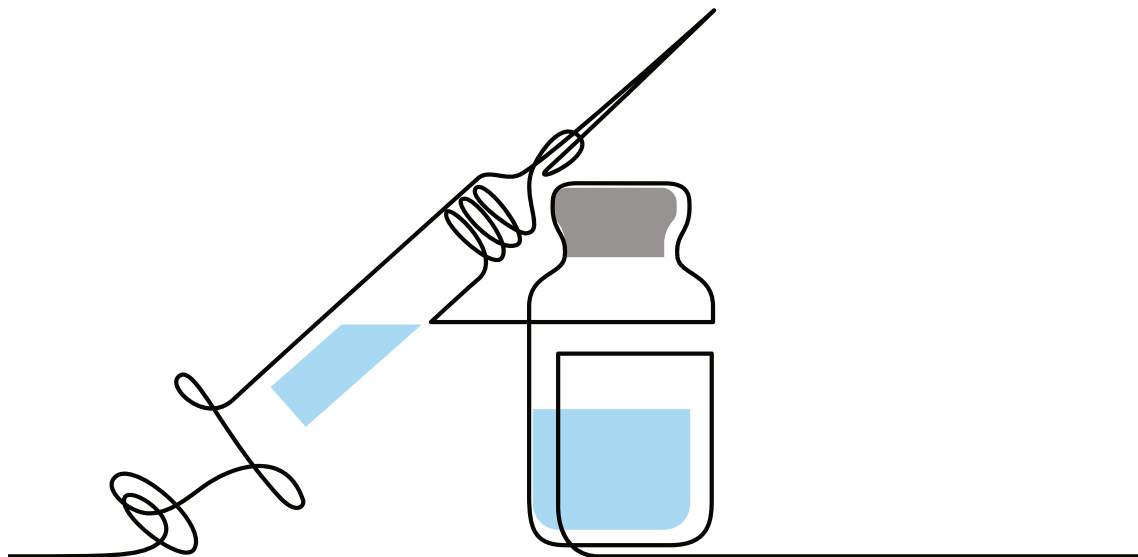
– John Greyson

one of the few people who captured what came next.

We were on the stage, Tim McCaskell seized the microphone and then, on behalf of people living with AIDS, he opened the conference. It wasn't about asking for the microphone; it was taking the microphone. The symbolism of that cannot be underestimated. It was a critical mass of very organized, articulate global activists that went inside the building. And it set a tone for the rest of the week. That declaration, throwing down that gauntlet, gave us permission in every meeting and every context to speak out and change the agenda. After Tim officially opened, we left the stage. We had seized the stage—that was the victory, the symbolic moment—and

then we cleared it. Mulroney got up to welcome the crowd. He had never said the "A" word (or the "S" word if you're in Quebec), as Tim had pointed out in his opening remarks, so we all stood and chanted "it's time!"

Mulroney acted like he was at a wedding party toasting the bride. The utter hubris underlined everything that had been wrong for his entire stretch. When someone is speaking absolute lies, the only appropriate response is to yell back and disrupt business as usual. The doctors and Big Pharma people who liked their AIDS conference junkets with their fancy four-star hotels and expense



Cabenuva

What should we know about injectable HIV treatment?

Darien Taylor explains.

Since the arrival of effective treatment, HIV medications have always been pills. As treatment has evolved through the years, the number of pills in someone's regimen has dropped: where you might have taken fistfuls of pills in the 1990s, your treatment can now be a single daily tablet. But a new medication is transforming the way HIV is managed. Cabenuva—a combination of cabotegravir (an integrase inhibitor) and rilpivirine (a “non-nuke”)—is the first injectable HIV drug approved in Canada. Instead of taking daily pills, all you need are injections every one or two months.

Cabenuva is injected into the muscle of the buttocks by a healthcare professional. Sébastien Poulin, a physician at Clinique I.D. in St-Jérôme and Clinique du Quartier Latin and Clinique L'Agora in Montreal, is one of the first doctors administering Cabenuva to his patients. In Poulin's clinics, staff carefully select patients who are good candidates. “Cabenuva is not for everyone,” he says, “but we are prescribing it often in our clinic and it's working well.” The ideal candidate is someone who, for whatever reason, is

struggling to take pills every day. They must be virally suppressed on their current treatment and have no resistance to the drugs in Cabenuva. Clinic staff must also be confident that the patient will make all their appointments. This is important to remain virally suppressed.

Transitioning from your current HIV treatment to long-acting injections can't be done overnight. It begins with an “oral induction” phase in which you take pills that contain the same drugs as Cabenuva. This phase lasts for a month. If there are no concerning side effects during this phase, then injections can begin. These injections must be given by a doctor or nurse, and in Alberta they can also be given by a pharmacist. Poulin believes that most people enjoy having this closer relationship with their healthcare team. “They feel connected and heard,” he says. And as far as side effects go, he says patients aren't reporting anything aside from temporary swelling and pain at the injection site.

Cabenuva is now on formulary in every province except British Columbia. Overall, Dr. Poulin explains, the injectable treatment “gives another good option to people with HIV that may fit well with their lifestyle and personal preferences.” It gives his patients one less thing to worry about. “They love the freedom of Cabenuva,” he says. “They say they would never go back to oral HIV medications.” +

Darien Taylor has been living with and working in HIV for the past thirty-plus years.



A "Wicked Problem"

Intimate partner violence (IPV) is common in Canada, but it's misunderstood, underreported and under-addressed. What is the relationship between IPV and HIV? **Alexandra Kimball** tells us more.

ILLUSTRATION BY SÉBASTIEN THIBAUT

WARNING: Some readers may find this content distressing.

In 2009, doctors at the Southern Alberta HIV Clinic made a tragic discovery that would transform how they approached HIV care. "We were reviewing the performance of our HIV program, and it was excellent," recalls clinic director John Gill. A large number of their clients were doing well, with high T-cell counts, undetectable viral loads and good overall health. But one case stood out: a patient who had been killed at home by their partner. "On paper, they had been a medical success," Gill explains. "But while focusing on their medical needs, we missed asking about their life-threatening home environment." As a person living with HIV, the client had been at a greater risk of intimate partner violence (IPV).

IPV is also known as domestic violence or family violence. IPV can take different forms: these range from physical abuse and sexual assault to emotional abuse like insults, threats and being possessive or jealous. After their client's death, Gill and his team began researching the link

between HIV and domestic violence to help patients who were dealing with both. They brought in social workers who specialized in IPV. They also started asking patients about violence at home to connect them with emergency housing and counselling if they needed it. "Out of respect for this person," Gill says, "we needed to prevent this from happening to anyone else."

"IPV IS ABOUT POWER"

IPV is "a form of violence that can happen in all types of relationships: heterosexual, queer, two-spirit and otherwise," explains Karen Wood, director of research and education for Solutions to Violence and Abuse (RESOLVE) at the University of Saskatchewan. However, someone's gender can put them at a higher risk. "I use the term 'gendered violence' because gender is about power, and IPV is about power," Wood says. As a group with less social and economic power than men, women are at a much higher

risk for IPV. One American survey found that a quarter of women had suffered severe injury from an intimate partner, compared with one in nine men.

Some marginalized groups—like women, 2SLGBTQ people, racialized people and people living in poverty—are at a higher risk of IPV. They also face more severe outcomes from this violence, like HIV transmission. HIV and family violence are closely linked: violence at home raises someone's risk for HIV, and living with HIV can also put someone at risk for violence. Research from the Southern Alberta HIV Clinic supports this. Gill's team found that just over a third of their clients had experienced IPV, and people who were Indigenous, 2SLGBTQ or both were massively overrepresented. Owing to systemic racism and trauma, Indigenous people face higher rates of poverty, mental health issues and substance use—these all put someone at higher risk of family violence. As with other groups, gender affects this risk. “Indigenous women in Canada are three times more likely to experience violence of all kinds than other women, and IPV in particular,” explains Pamela Downe, professor of anthropology at the University of Saskatchewan. They are also at risk of more severe injuries from IPV than non-Indigenous women.

IPV AND INDIGENOUS WOMEN

In the 1980s, Indigenous women made up 9% of female homicide victims in Canada. By 2015, they made up a quarter. “The majority of these murders occurred in domestic settings,” says Downe. HIV increases the risk of violence for Indigenous women, and vice versa. This compounds the burden of HIV that Indigenous women already bear: the HIV rate among Indigenous people is double that of the non-Indigenous population, and a disproportionate number of new infections are among Indigenous women.

Why are Indigenous women living with HIV at a higher risk of IPV? “One simple answer is poverty,” Downe explains. “Because of structural racism, Indigenous women are more likely to live in poverty. And poverty limits people's abilities to move quickly into a hotel, or to access medication, or even to access a vehicle to drive to a healthcare facility.” Racism from police and the court system can also deter women from reporting IPV to the police. Indigenous mothers are especially vulnerable, as they are already at a high risk of having their children taken by child welfare services. “Subjecting children to domestic violence is considered one form of child abuse by the courts,” Downe says. An Indigenous woman reporting IPV to police might fear losing custody of her children. She could also be charged with child abuse if her children have witnessed her being assaulted.

Indigenous women living with HIV who also face violence find themselves in what sociologists call a “wicked problem,” says Downe. A wicked problem is a situation that has no easy solution because all parts of the problem are connected. For HIV-positive Indigenous women, the worse the violence gets, the harder it becomes to manage their HIV. This means they have fewer choices for how to leave. This wicked problem also affects other marginalized groups

who face higher rates of both HIV and IPV, like 2SLGBTQ people. Their HIV status can make it difficult to seek help for violence, and violent home situations make it harder to get proper HIV care. The discrimination these groups face makes it hard to seek help from both the justice system and the medical system. “It's a problem that becomes increasingly difficult to solve,” Downe explains.

HIV AND IPV

HIV and IPV are linked because they both affect marginalized groups. They're also linked because HIV is commonly transmitted through sex and drug use. These can factor into abusive relationships: for example, a violent partner might force someone into sex without condoms, leading to HIV transmission. They could stop someone from starting pre-exposure prophylaxis (PrEP) or force them to stop taking it. They could also pressure someone into using drugs or using methods the person is not comfortable with, like injecting. If someone is forced to share or reuse drug equipment, this can also raise their risk of HIV.

People living with HIV can face higher rates of physical violence from their partners. HIV stigma can then isolate them; for example, someone living with HIV may stay with a violent partner because they fear they won't find another relationship. HIV also affects what type of violence someone might experience, and how severe it is. Research from the United States shows that an HIV diagnosis raises someone's risk for physical violence and that this violence is often related to HIV. Another study found that many women fear violence when disclosing their HIV status, and 4% had been physically abused when they did. Even if someone isn't physically violent, they can weaponize their partner's HIV for emotional abuse: for example, they could insult or degrade their partner over their HIV status or use HIV to blackmail them. This is because, in Canada, not disclosing your status before sex can be a criminal offence. An abuser may threaten to tell authorities their partner did not disclose their HIV status, even if this is not true, putting their partner at risk for criminal charges. People may then avoid reporting violence to the police because they fear being charged.

PREDICTING HEALTH OUTCOMES

After the Southern Alberta HIV Clinic began screening new patients for domestic violence, staff made another important discovery. They knew that people with HIV were at higher risk for IPV, but they also found that IPV put clients at higher risk for poor health outcomes. “We were able to see that IPV was a major predictor of whether or not someone would continue taking HIV treatment,” says Gill. Violence at home also made it less likely that someone would attend their appointments and follow-up visits. This is consistent with the power dynamic of abusive relationships, where a violent partner might stop someone getting their medication by withholding money or access to a car.

Gill explains that if a client is experiencing IPV, they are more likely to be hospitalized and their HIV is more

likely to progress to AIDS. In 2021, staff reviewed 10 years of data from the clinic and found that people facing IPV had an almost 50% higher rate of mortality, after adjusting for variables like age. This affirmed that the clinic was on the right track by screening patients for IPV in their first appointments. “Screening offers the ability to identify those at risk for poor outcomes, take action and reduce the effects of IPV,” Gill says.

Violence at home raises someone's risk for HIV, and living with HIV can also put someone at risk for violence.

A ROAD TO PROGRESS

For Gill, finding a way to improve outcomes for people living with HIV who are also facing IPV has been as challenging as it is rewarding. One of the most important insights he's gained is the importance of trust, which can be hard to build with patients who have experienced violence. “We had to ask,” he says. “Clients wouldn't talk to us unless we asked—there is so much shame and stigma involved [in IPV]. For effective HIV care you have to establish trust between the care provider and the client,” he explains. “You have to explain the nature of the disease, the nature of the treatment. The patient must experience a compassionate and safe environment.”

Once these clients establish trust with their providers, they're in an excellent position to receive help. “An HIV clinic is actually a good place for people who are experiencing IPV to disclose,” Gill explains. “The repetitive nature of the visits are a great way to build up trust.” From there, patients at the Southern Alberta HIV Clinic can access in-house counselling for IPV or referrals to out-of-house services like emergency housing. The clinic employs three social workers who refer patients to local shelters that are sensitive to HIV issues. “We've had several situations where we could not immediately send someone home,” he recalls. “We were able to get them into safe housing.”

Research shows that HIV clinics can be good places to screen for IPV. The Southern Alberta HIV Clinic's study found that of 158 patients, only 22% had been asked about IPV before in a healthcare setting. The authors recommended that all HIV clinics should screen for IPV, and this was echoed by their clients. “Please ask everyone routinely about their safety at home at every visit,” one client advised. “We will be honest with you but due to shame (and uncertainty that you even want to hear) we will not [disclose IPV] in a routine medical visit.” Clients also said it was important that referral services like counselling are easy to access. Of those who disclosed violence in the study, a quarter were connected to IPV supports after screening—which may have saved their lives.

WHAT NEXT?

There's still a long way to go towards improving outcomes for people who are living with HIV and also facing violence. Gill explains that more research is needed to define what the risk factors for IPV are, and what the outcomes of IPV for clients could be. This will help service providers intervene at the right time and with the right tools. He also points out that researchers can have trouble getting funding for these programs, because they serve very marginalized and misunderstood groups.

Overall, progress will depend on tackling the root causes of marginalization and violence. Policies that address racism and poverty will have a tremendous impact on people living with HIV who struggle to access care or are scared to seek help for IPV. Downe explains that we must also address the stigma that surrounds HIV and IPV. For example, education campaigns could dispel common myths about IPV. They could also share the message that an undetectable viral load is untransmittable (“U=U”), meaning someone can't pass on HIV during sex. The less stigma there is around both HIV and IPV, the less likely it is that people will face discrimination from a care provider.

Most importantly, policies that strengthen vulnerable communities, like Indigenous women or 2SLGBTQ people, can make it easier for people to help others who are struggling. “We need to stop looking [at IPV] as about the individual client and think more collectively,” explains Downe. “What can we do for an entire family, an entire community? What if we started putting resources into housing for collectives—not only the patient, but also their children, their aunties, their trusted friends?” Community-based care has an impact that spreads outwards, improving outcomes for everyone. “There is strength in numbers,” she says. +

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If you are facing violence and need support, visit www.sheltersafe.ca

A HOUSE



of CARDS

One third of Canadians rent their homes, but more people than ever are at risk of eviction. What's going on with Canada's housing crisis? And how does it affect people living with HIV?

Jonathan Valelly investigates.



The Canadian housing supply has been falling behind demand for decades. Today, Canada has the lowest number of housing units per person of any G7 country and would need 1.8 million units to catch up to the group average. At the same time, property values are exploding across the nation. As prices go up, rent follows, which tempts landlords to evict their tenants in search of new ones with bigger budgets. This means there aren't enough housing units for prospective homeowners, fewer people can afford them and people who rent live in fear of eviction. The result is a national housing crisis.

Hundreds of thousands of people experience homelessness in Canada every year, with an estimated 35,000 sleeping rough on any given night. This doesn't include people who are sheltered in situations like couch-surfing or hostels, or people who are awaiting eviction. Data show that communities at risk of HIV and hepatitis C—racialized people, gay and bisexual men and people who use drugs—have lower average incomes and are more likely to live in poverty. This makes them more likely to be renters instead of home owners.

Unstable housing can worsen people's health outcomes. One 2021 study found a robust link between evictions and HIV sexual risk, and a recent study in *The Lancet* found that unstable housing among people who inject drugs was

linked to a 139% higher risk of HIV. This study also found that unstable housing significantly raised someone's chance of having a detectable viral load. Community-led research from organizations like the Ontario HIV Treatment Network backs up these findings: it shows that unhoused people living with HIV have less access to primary care, are less likely to be on medications and are less able to stay on track with treatment. Policy-makers have been slow to respond to this national crisis, and as a result, HIV organizations are aiming to fill the gaps.

AN EVOLVING CRISIS

Donald Keeping never imagined that he'd end up on the streets. The Newfoundland father of two enjoyed a quiet life and a stable job working as a fisherman in Nova Scotia for years. But when he got injured at work, he was handed a prescription for painkillers. "I couldn't work, and I worked on the sea all my life. It was like a life sentence, like, 'you can't do this ever again,'" he recalls. Losing his work felt like losing his identity and he soon became dependent on opioids. "I got hooked on the morphine, and after a couple years I lost my marriage, my siblings. I ended up homeless. I used all my money for drugs."

In the years that followed, Keeping passed through multiple shelters before arriving at the Tommy Sexton Centre

Shelter, a four-bed shelter in St. John's that is managed by the AIDS Committee of Newfoundland and Labrador (ACNL). There, he got onto methadone treatment to help manage his drug use. He also tested positive for hepatitis C. After getting Keeping on treatment to cure the infection, ACNL invited him to live in one of their six longer term supportive housing units. These are affordable apartments earmarked for people diagnosed with hepatitis C or HIV. Housing has made all the difference for Keeping, who said he prays that people in a nearby tent city can find something similar so they can heal. "If you want to get close to sober, you need that mental state, to be safe," Keeping reflects. "And you've got to have somewhere to sleep. Having your own place gives you all that."

Gerard Yetman co-founded ACNL in the late 1980s, and he returned as executive director in 2012 after 20 years in Ontario. When he came home, he noticed things had changed. In ACNL's early years, clients were mostly gay men returning from Toronto or Vancouver to spend their final days at home. Decades later, the number of people applying to live in the agency's housing had dropped and it was struggling to shake its reputation as a hospice. Also, clients were only eligible if they were living with HIV. Meanwhile, ACNL's short-term Tommy Sexton Centre Shelter was busy with new faces. "We saw a big change in the demographics," recalls Yetman. "So, our housing became more for people at risk of HIV or hepatitis C."

Many new clients were people who use drugs, so ACNL pivoted to make mental health and harm reduction part of its mandate. This proved to be a good choice, as the overdose crisis swelled in the years following. Housing costs in the province also spiraled, and an influx of workers to the Muskrat Falls dam project in Labrador put more strain on the housing supply. Community members face these crises as immediate, material issues, but they have bigger root causes: colonialism, resource extraction, income inequality and stigma, to name a few.

HOUSING AND HARM REDUCTION

Sanctum was created to solve a problem playing out in Saskatoon's hospitals. People who inject drugs were arriving with opportunistic infections, wounds and other acute conditions, but they weren't staying to finish their treatments. Ultimately, the hospital environment didn't provide for the specific needs of such patients, who may be expected to suddenly be abstinent in a sterile, lonely place. Hospital clinicians weren't equipped with the resources, trust or cultural understanding to make people who use drugs feel safe and comfortable; Sanctum formed in 2015 to offer another option.

For people who use drugs, "the model of care in a hospital is like a jail sentence," explains Sandra Blevins. Blevins is a longtime board member who also acted as interim executive director in 2021. Clients "were having to stay when they were still very active in their addictions," she explains. "It was just a real clash with the system." Sanctum offers an alternative: they offer people treatment at home and offer

the home, too. Its flagship 10-bed facility offers transitional care to people who use drugs and don't have anywhere to go, let alone a place to address their health concerns. Sanctum's model of care champions unconditional compassion and respect for residents, regardless of their substance use.



"If you want to get close to sober, you need that mental state, to be safe. Having your own place gives you all that."

"Sanctum accepts people with this beautiful mission of being a place that is non-judgmental, meeting people where they are, and practising—truly practising—harm reduction and trauma-informed care," explains Blevins. Sanctum's outcomes speak for themselves: twice as many residents leave the program with undetectable viral load than when they arrive, and 72% of residents report good or excellent mental health at discharge, compared with 40% at admission.

When COVID-19 arrived, Sanctum's harm reduction principles were put to the test. The organization didn't require residents to be abstinent, but they banned substance use in their housing. At first, stay-at-home orders didn't clash with this policy—most residents at the time weren't using drugs, and they had little reason to leave home. But by the time that cohort moved out in summer 2021, Sanctum had loosened its visitor policies as the province opened up. A spate of overdoses among the new residents followed. This showed that unsupervised drug use was now happening on site, which caused staff to reassess their approach. Sanctum could have cracked down on residents using on the premises, but this would have forced residents to go outside more, raising the risk of COVID-19 for those living

and working there. Instead, its board of directors voted to move toward a safe consumption policy on site during lockdowns. Other local policy changes continue to put a strain on Sanctum's capacity: the province changed their rental assistance program and stopped paying rent directly to landlords, while the fire department closed two densely populated, low-income high-rises. "We're in a new place now," Blevins sighs.

WOMEN-CENTRED CARE

For decades, Saskatoon hospital staff, police and welfare services have been called in to delivery wards to take newborns into public guardianship straight out of the hospital. Birth alerts, as they are known, are coordinated communications between hospital staff and social workers or law enforcement. They flag pregnant women who are presumed to be "unfit parents" because of mental health issues, addiction or housing instability. Typically, alerts lead to newborns being placed into the foster system. In 2020, about 70% of these alerts flagged Indigenous mothers. This continues centuries of state-sanctioned disruption to Indigenous families, and as a result, Indigenous children are massively over-represented in the foster care system.

In 2019, the final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls condemned the practice of birth alerts as "racist and discriminatory" and "a gross violation of the rights of the child, the mother, and the community." Soon after, Saskatchewan and other provinces announced that they would abolish the practice. However, the number of apprehensions in the province remains steady each year, even as Canada grapples with the legacy of child abuse in residential schools. Because of policies like these, many Indigenous mothers and mothers-to-be are wary of medical and social institutions. "These moms were not seeking any kind of prenatal care because they were scared of that interaction at the hospital, and of the system, of being found and flagged," explains Blevins. "So the transmission of HIV was happening [during pregnancy and childbirth] as well."

Transmission of HIV during pregnancy and childbirth can be prevented with effective HIV treatment. But trauma and mistrust collide with many more challenges for Indigenous women. Expenses for daily living and healthcare, lack of Internet access, transportation and childcare issues, language barriers and homelessness all work against these mothers. Saskatchewan has the highest rate of HIV of any province in Canada, with triple the number of new diagnoses per year compared with the national average. About 80% of new diagnoses in the province are in Indigenous people. But given the culture of fear surrounding birth alerts and the numerous barriers to HIV-related care, there is a real crisis for pregnant women living with HIV in Saskatchewan, one where immediate health issues are amplified by social inequity.

In response, Sanctum launched a new program in 2018 known as Sanctum 1.5. This is a holistic pre- and post-natal housing option for women living with HIV or hepatitis C and

their newborns. Ten housing units also come with HIV case management and holistic treatment for neonatal abstinence syndrome, along with community-based services. These include peer support, spiritual care with elders, and parenting and life skills development for mothers and their trusted family members. Since its inception, at least 41 women have gone through the prenatal care home. None of the children so far have been born with HIV, nor have any been apprehended. Sanctum 1.5 is the only program of its kind in Canada.

CHALLENGES AHEAD

"I never thought I would ever be in this field. Like, here I am doing social work stuff," says Keith Bowering, Sanctum's housing coordinator and a harm reduction advocate. "But this is just how my life has turned out, right?" Having used and sold crystal meth for 22 years—including 10 without a home—his skills and experience have come in useful. Before formally working as a social worker, Keith was already an advocate for his community. He distributed safe supplies and information around the city, and he still does so after hours. Today, he's often seen biking around town handing out kits, promoting drug safety at a music festival or doing workshops with SayKnow.org, a project that advocates for the decriminalization of drugs.

Bowering has had an outsized impact on local harm reduction efforts, but he's candid about the fight ahead in Saskatchewan. The province recently rolled out a single-channel social assistance program, when previously it paid rent to landlords directly to prevent evictions. The new Saskatchewan income support program puts a total amount of \$575 per month directly in the hands of individuals to be used for rent, utilities and necessities. The result is that people are losing their homes faster than ever. "It has never been so bad. You've never seen so many people wandering with blankets and carts. Everybody is screwed," says Bowering. "You can't even find an apartment for \$575, let alone an apartment where you can pay your power bill and your damage deposit."

These situations show how one policy change can send a housing crunch into overdrive, and all that comes with it—overdoses from the toxic drug supply, high rates of HIV and hepatitis C, and brutal disparities marked by race and class. So far, Sanctum has maxed out at 28 housing units. AIDS Committee of Newfoundland and Labrador have 10, four of them short-term. Without the proper resources, there's only so much organizations can do. That's why Bowering and his colleagues demand structural and legal changes that could create more equity for those with complex needs. That means decriminalizing and ensuring a safe supply of drugs; restoring and improving social assistance programs; regulating private real estate; and, of course, building accessible, affordable and supportive housing. +

Jonathan Valeyly is a queer writer, editor and organizer based in Toronto. Ask him about zines, harm reduction, ballroom, prison abolition and Prince.

Art, AIDS & AA Bronson

Artist AA Bronson talks to
Ryan Conrad about art and HIV.

AA BRONSON PHOTOGRAPHED BY FLORIAN HETZ



exhibition. When former NGC director Marc Mayer had already announced his leaving date, he talked to me about doing a retrospective, which of course I was eager to do. I think it had gotten to the point of embarrassment that it hadn't happened yet. It felt like it would eventually happen, but I was beginning to wonder if it would happen during my lifetime.

RC: You've spent much of your professional life as an artist outside of Canada. The NGC isn't just any gallery, but a place that produces a sense of national identity and culture. What does it mean for GI's work to be shown in this way?

"I've had many people say to me words to the effect of "Why look at this AIDS work? The AIDS crisis is over. Nobody's died of AIDS in decades."

—AA Bronson

AA: I've always been very loyal to the NGC. When I was in high school in Ottawa I would often take the bus downtown from my suburban home and go to the NGC. There was one exhibition in '61 that affected me profoundly. It included people like Ad Reinhardt, Marisol and Warhol. That exhibition, and many other exhibitions that I saw there, influenced my thinking about art. GI did its own versions of Reinhardt's black squares with our black-on-black AIDS paintings in the early '90s. They're nearly identical to the original black square paintings by Ad Reinhardt that I saw at the NGC.

So my life as an artist has been kind of embedded in the NGC. When I was invited to do the retrospective, I happily said yes. The exhibition catalogue is designed to be the definitive GI catalogue, since no such publication exists yet.

RC: Can you talk us through some of the pieces in the exhibition that would be of particular interest to the HIV community?

AA: It's difficult to do because more than half of our work isn't really for the gallery. It's for the street or public spaces, or it's performance work for other venues. That immediately narrows what can be shown because so much of the AIDS work was in the public realm and on the street. We've tried to reflect that in the catalogue by putting in as much information about the non-gallery stuff as possible, like the AIDS posters in the New York subway system or our AIDS animation on the Spectacolor Board in Times Square, and AIDS posters on trams in Amsterdam and Seattle. We can't show these in the gallery and they're the main core of GI's AIDS-themed work.

In June of '87 we made our first "AIDS" painting for the first fundraising project for the American Foundation for AIDS Research. At the time we thought of it as a one-off painting based on the Robert Indiana "LOVE" painting. It got an enormous amount of attention and there was a lot of discussion of what it meant—it just said the word AIDS. By the fall of '87 we decided to do a poster campaign on the streets of lower Manhattan with the same "AIDS" logo and in January of the following year we produced another poster campaign in San Francisco. Around '89 to '90, first Felix and then Jorge were diagnosed with AIDS. Suddenly our lives were full of pills. In a typical GI way, we decided to transform the pills into a part of our art making, and from then on there's a whole series of pill installations. The installation *One Year and One Day of AZT* (1991) is owned by the NGC. There's also a piece called *Fin de siècle* (1990), a term usually assigned

General Idea (GI) was an artist collective made up of Felix Partz (1945–1994), Jorge Zontal (1944–1994) and AA Bronson (1946–). The group came together in the late 1960s amid Toronto's countercultural arts scene and remained active until 1994. Together, they would go on to make much-celebrated queer visual art, performances and videos that have exhibited internationally. GI stopped producing work after Felix and Jorge died from AIDS-related illnesses in 1994, but their art continues to be shown internationally. From June to November this year, the National Gallery of Canada (NGC) in Ottawa is hosting an exhibition looking back at GI's work. In the fall of 2021, queer artist and scholar Ryan Conrad interviewed AA Bronson about this upcoming show and the impact that HIV and AIDS has had on his work, both during and after GI. The following transcript of their conversation has been edited for length and clarity.

Ryan Conrad: I'm very curious to hear how the new GI retrospective at the NGC came to be.

AA Bronson: It was planned long ago by Diana Nemiroff and then cancelled when the leadership at the NGC changed. The NGC purchased their first work by GI in 1971 and I think that was the first work that GI ever sold, and they have acquired many key works since. But it's taken 50 years for them to present a full GI

to European art from the 1890s that fixated on death and morbidity. *Fin de siècle* is a gigantic ice floe of Styrofoam on which three stranded baby white harp seal pups sit. We made this as a self-portrait in the era of AIDS.

RC: From your description of GI's HIV/AIDS-themed works, it's clear you spent a lot of time in New York City. Were artists approaching HIV/AIDS differently in the United States versus Canada?

AA: Towards the end of Jorge's and Felix's lives we moved back to Toronto because they knew they were dying. I only came back to Toronto for five years and then I was gone again. Within that five years there was only one year of producing as much work as we could, and then four years of grieving. What many people don't realize is that when we moved to New York I was 40 and when we did our first AIDS painting I was 41, and I was the youngest of the three. So those works were produced in our 40s, and if you look at the work on HIV/AIDS produced by other artists from the New York area, they were all in their 20s. We were very different generations.

GI had already done many museum shows around Europe and Canada. We were producing work for an international audience. We were operating within a context that did

"Our idea was to say nothing, by creating a blank, in a way just the word AIDS is like a blank—it doesn't say anything about anything."

— AA Bronson

not necessarily have English as its primary language and where the issues were not necessarily the same issues that people in New York had. We were privileged in that we were showing internationally; we were travelling. But we had to come up with a kind of visual language that spoke to people internationally. Our idea was to say nothing, by creating a blank, in a way just the word AIDS is like a blank—it doesn't say anything about anything. And what happens is that people project onto it the issues that they think are important. So how somebody in New York would see it versus how somebody in Cologne would see it was very different. There's another reason our work was different from American artists, and this may sound like an excuse, but we were living in the United States illegally. We didn't go to activist meetings and we didn't take part in demonstrations, specifically because we didn't want to be deported. We didn't have social relationships

with that crowd; we were much older. At the time there was criticism from their side, but we weren't so much aware of it.

RC: The American artist/activist collective Gran Fury made their painting *RIOT* (1988) in response to GI's *AIDS* (1987) painting. You must have been aware of that, right?

AA: That's a little bit later, in '88. The wonderful curator Frank Wagner organized an exhibition about AIDS in Berlin that included mainly American artists and GI. For the exhibition we made an iteration of the "AIDS" poster project, plastering our posters all over an unused but highly visible U-Bahn station. Wagner invited Gran Fury to be in the same show and that's when they produced their *RIOT* painting, in the same format as our AIDS logo. In their minds it was a challenge to GI. We just thought it was a conversation and we thought that was great, but



AIDS (General Idea, 1987)

it was actually intended as a big put-down of our “AIDS” posters. Of course, the word “RIOT” only really applied in the American situation where rioting was definitely necessary; it didn’t apply in Germany.

RC: I want to shift gears to think about the ongoing AIDS crisis revisitation that has been taking place over the last decade. The NGC show follows many other exhibitions, films and memoirs that have focused on the early years of HIV/AIDS. What do you think about this period of revisitation we are in? Some people have critiqued how this is motivated by nostalgia. This argument was made popular through a project called *PosterVirus*, which is named as an homage to GI itself.

AA: I’m not familiar with it.

RC: *PosterVirus* was a project by AIDS Action Now! that used the strategy of creating multiples and pasting them in public, much like GI’s “AIDS” posters. It was Toronto-based, but the posters went everywhere. One of those posters from 2013 contained the phrase “Your Nostalgia is Killing Me.” It was referencing the revisitation of HIV/AIDS activism and aesthetics. The artists thought this was obscuring issues affecting people living with HIV in the present. What do you think it means to revisit historic works now?

AA: Revisiting is not necessarily nostalgia, so I’m not sure. I’ve had many people say to me words to the effect of “Why look at this AIDS work? The AIDS crisis is over. Nobody’s died of AIDS in decades.” And I say, well, you obviously haven’t visited the UNAIDS website recently, otherwise you’d see that 680,000 people died of AIDS last year. I see this as an opportunity for education. I think the issue of HIV/AIDS is now embedded in healthcare issues in general. To do work that is specifically about HIV/AIDS now is difficult without foregrounding class

and race and all those other issues that are so embedded in it. It seems to me that the people who complain about it in that way almost always come from privileged white educated backgrounds and haven’t taken the trouble to notice that there’s an awful lot going on outside of their particular circumstances. I’m not sure whether I answered your question or not, but anybody who says the word “nostalgia” in relation to that time definitely was not there. It was just so scary.

RC: Today you describe yourself as many things, and “healer” is one of them. Could you talk about the direction of your work after GI?

AA: Jorge and Felix both died at home and I cared for them till the end. I had started taking courses at the Body Electric School in San Francisco on the subject of healing, including massage. I received 13 California certifications, but I never really used them except in my caring for Jorge and Felix. After they died, I found it very difficult to do anything, although I did complete the GI exhibitions that had been organized in advance. In ’98 I moved back to New York and around that time I took

“People suggest to me that I should be doing work about COVID but people don’t realize how tough that AIDS crisis was. COVID is nothing in comparison.”

– AA Bronson

a refresher course at the Body Electric that gave me the self-confidence to claim the title of healer. Around that time *BUTT* magazine interviewed me about my healing practice and I was swamped with clients! But eventually I had to step back from the healing

One Year and One Day of AZT (General Idea, 1991)





AIDS Cross (Cadmium Red Medium) (installation shot from Art Unlimited, Art Basel; AA Bronson, 2021)

practice. By the time I moved to Berlin in 2013, I was getting older and just didn't have the stamina or that eager American audience anymore. However, from 2013 to 2018 I produced a series of museum exhibitions loosely built around ideas of healing and community, in the Netherlands, Austria and Berlin, beginning with *The Temptation of AA Bronson* at Witte de With in Rotterdam.

RC: What has been your focus since then?

AA: Recently I've been producing huge AIDS paintings based on the enormous Robert Indiana *LOVE Cross* painting from 1967, in which LOVE logos are arranged in the shape of a cross. GI saw that painting in 1991 in Cologne and we wanted to make an AIDS version, but we didn't have

anywhere we could show it. I think of the AIDS Cross as a talisman against epidemics, against infection. I'm producing them now and while it's like revisiting GI and completing works that were never completed, these are also new works.

RC: That's interesting, thinking about it as finishing work that never had the chance to be done previously through GI.

AA: I figure I'll let the history books decide whether it's work by me or work by GI. The NGC attributes them to me and GI, which I think is probably the correct way to go. But these new paintings come out of this COVID time. People suggest to me that I should be doing work about COVID but people don't realize how tough that AIDS crisis was. COVID is nothing in comparison. Deadly as COVID is, and as much pain and suffering as it's caused, it's a very different situation. The vaccines were developed amazingly quickly, and the healthcare system has really been on top of it. So, I thought I'd rather just continue with the same work about pandemics and about crisis.

RC: I agree that the quick comparisons being made between HIV and COVID aren't very helpful. They are very different pandemics with very different circumstances.

AA: Also, in Canada we had another pandemic with SARS in between, which the United States doesn't really acknowledge as ever having existed. We made it through that one too, but there's going to be more epidemics. With climate change and the collapse of biological systems there's going to be more and more epidemics and medical disasters. Viral emergencies or however you want to think of it. I think my work is more about that these days. +

Ryan Conrad is an artist, educator, and activist living in the Ottawa Valley. Read about his work at www.faggotz.org.

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