

# THE POSITIVE SIDE

## HIV Criminalization

What you need  
to know

## The Overdose Crisis

How did we  
get here?

## The ABCs of CBD

Our experts  
weigh in

# Stigma, Sex & Safety

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## EDITOR'S LETTER

Looking back over 40 years of HIV, we've come forward in leaps and bounds. Treatment for HIV is simpler, with fewer side effects, and we now know that if you have an undetectable viral load you can't pass it on through sex. If HIV-negative folks take HIV drugs as PrEP, they can also prevent the transmission of HIV. It's a lot to celebrate! In this issue we're doing just that: In "Can't Pass It On" (page 16) you'll get an inside look at CATIE's recent U=U campaign, and in "Chatty CATIE" (page 6) you'll hear about the impact that PrEP and U=U have had on our sex lives. Changes in treatment and prevention have opened dialogue between people with and without HIV, and it's great news.

As we take stock of how far we've come, though, it's important to remember what else needs our attention. In "HIV Criminalization in Canada" (page 8) we look at how people can still be prosecuted for not disclosing their HIV status before sex, but we also show where the law is slowly changing. Elsewhere, we delve into the opioid overdose epidemic in "Lessons Not Learned" (page 22) which outlines how the crisis emerged and what we can do to end it. Our profile—"Stigma, Sex & Safety" (page 10)—tells the story of two transgender women and their journeys with gender and HIV; it shows that although trans rights are entering the mainstream, stigma and discrimination still persist.

Also in this issue, we've got the answers to some of your burning questions: On page 21 we give you the lowdown on "Viral Load Blips" (spoiler: you don't need to worry!), and in "Ask the Experts" (page 26) we ask our panel all about CBD. In "Art Posi+ive" (page 28) we hear from designer and activist Juan Saavedra, who uses design to ask difficult questions about power and bureaucracy.

Welcome to the Spring 2020 issue! Winter is finally over, and we're excited to dive into the hot-button issues that matter to our readers. We're also thankful for everyone who's told their stories in these pages. If you'd like to contribute to an upcoming issue, we'd love to hear from you: Send any thoughts and suggestions to [contribute@positiveside.ca](mailto:contribute@positiveside.ca).

—Dan Udy

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Publications Agreement

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Editor-in-Chief

Dan Udy

Editors

Jennifer Thomas,

Debbie Koenig

Creative Direction

and Design

David Vereschagin,

Quadrat Communications

Cover Image

Cassidy Quinn by

Kamil Bialous

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# Victoria Cool Aid Society

**For many people, HIV comes hand-in-hand with other challenges. Housing, employment, healthcare and harm reduction services can all be hard to find, so some organizations bring everything under one roof. Jennifer McPhee looks at the Victoria Cool Aid Society in B.C., which does just that.**

**I**n Canada, people who experience homelessness, mental illness or take injection drugs are especially affected by HIV. The Victoria Cool Aid Society is a non-profit organization in downtown Victoria with a long history of responding to this by delivering a full range of integrated services to people who need it most. The Canadian Association of Community Health Centres recently recognized Cool Aid's trailblazing work by selecting it for a 2019 Transformative Change Award. This recognized its leadership and innovation in the integration of programs, services and advocacy that address the intersection of housing and health.

Garrett Gordon, 52, is a long-time client of Cool Aid. Until five years ago, he had a "bad drug and alcohol addiction" and lived on the street most of the time. He would stop by to pick up HIV medication and clean needles, or to eat at AVI Health and Community Services' lunch program, located in the same building. Since quitting alcohol and drugs, he's become a daily user of Cool Aid's healthy living and support programs. Reached by phone at the mobile home where he now

lives, he apologizes for taking a while to answer. He explains that he couldn't hear the phone ring because he was in the middle of blending a smoothie. "It's a blueberry, cranberry, pumpkin seed kind of thing with kale and turmeric and all that good stuff," he says.

Cool Aid was founded in 1968, when it mainly provided emergency shelter to transient youth travelling across Canada. The organization incorporated as the Victoria Cool Aid Society in 1976, several years after opening the "Cool Aid Free Medical Clinic." It went on to establish British Columbia's first supportive housing apartments in 1991, and was a pioneer of harm reduction. This is now a widely accepted evidence-based approach that seeks to reduce the risks and harms of substance use without preachiness or requiring abstinence.

Today, hundreds of Cool Aid's employees work in Victoria, Saanich and Langford providing homes, shelter, healthcare and other services to Victoria's most vulnerable. Cool Aid currently operates 14 supportive housing apartment buildings, as well as three large shelters that provide a

critical link to a wide variety of services for those experiencing homelessness. These include rent supplements, landlord liaison, a dental clinic, a casual labour pool, healthy recreation and other community services such as detox.

Like Gordon, many people living with HIV get to know Cool Aid through its Community Health Centre, designed to make it easier for people experiencing marginalization to connect with healthcare. One of the unique aspects of Cool Aid's approach is its delivery of HIV care in the context of primary healthcare. The clinic's family doctors are well-versed in HIV management as well as in opioid agonist therapy, so people living with HIV can see their family physician whether they are dealing with a sprained ankle, HIV-related concern or substance use issue.

Once someone becomes a patient, they have free access to a multidisciplinary team that also includes nurse practitioners, nurse clinicians, mental health and addictions counsellors, dietitians, pharmacists and an acupuncturist. Because these professionals

are also involved with HIV care, they incorporate the fact that someone lives with HIV into treatment for different aspects of a patient's health. Then, if someone's HIV or mental health issues become too complex for the clinic's family doctors and counsellors, they can see the visiting psychiatrist or infectious disease specialist. The clinic

could also be smoking cessation or trying to get people to be more physically active. And for people who want to go to addiction treatment, we do the paperwork to facilitate that." This approach disarms and engages clients, leading to more honest interactions. "People feel comfortable asking questions and telling you what's going

long-term survivors (the oldest is in his 90s) who are dealing with typical age-related conditions like diabetes, cardiovascular illness and arthritis. Newly diagnosed patients are mainly young men who have sex with men. "That is something we need to address as a society," says Drost. As a way of doing exactly that, Cool Aid's nurses



**The principles of harm reduction guide the clinic, and staff strive to meet clients where they're at in a non-judgmental way.**

also offers free medication delivery, and it's the pharmacist who personally delivers these medications.

Cool Aid's staff don't sit around waiting for people who need support to arrive, they go out and find them. Outreach, teaching and advocacy are all significant parts of the team's work. Staff members hold regular health clinics at Cool Aid's shelters and housing sites and team up with other agencies to offer things like free HIV testing at a park known for cruising. The staff frequently team up with AVI Health and Community Services—the area's largest HIV organization located in the same building—to provide joint programs, including a weekly HIV support group. "We run up and down the stairs here all the time to work together, which is wonderful," says clinical nurse leader Anne Drost.

The principles of harm reduction guide the clinic, and staff strive to meet clients where they're at in a non-judgmental way. "That might be providing clean needles or crack pipes to help prevent the transmission of illnesses," says Drost. "It might be teaching someone to inject safely. It

on and you can come up with a plan to deal with a particular concern that's realistic and achievable for people," she says. "For a client who might be feeling depressed and overwhelmed, we might set a goal like washing the dishes the next day."

The entire healthcare team also has access to patient electronic medical records, so clients don't have to retell their life story every time they see a new member of the team. This system also facilitates collaborative care, says Drost. For example, a nurse may find out that someone has gone off their HIV medication while treating them for a broken leg, and call over a doctor to discuss possibly restarting treatment. Or, a pharmacist may notice that a regular client dropping by to pick up pills looks unwell, and ask a nurse to examine her.

Drost knows most of the clinic's 230 patients living with HIV by name. "Relationship building is key," she says. "I know what's going on in their lives. I know if someone is homeless, if someone got married, if someone's dog died." Many of Cool Aid's HIV-positive clients are seniors and

set up a PrEP program at the clinic that allows serodiscordant couples and men who have sex with men to get access to the HIV prevention drug.

The health centre also runs the Resource Employment Education Service (REES) and the Downtown Community Health Centre. Located in a separate building, REES offers education and support to people living with mental health and addiction issues, access to an employment agency and assistance with an assortment of other tasks such as filing taxes or filling out disability forms. The Downtown Community Health Centre's free activities focus on healthy living, health promotion and social diversity including cooking classes and an 'Every Step Counts' walking and running program, which Gordon participates in. He says he now relies on Cool Aid for everything from daily emotional support to dental work. "The place is a one-stop shop," he says. "I give it two thumbs and two toes up." +

Jennifer McPhee is a Toronto-based writer who contributes regularly to *The Positive Side*.



## Sero-Different Sex

In recent years, we've gained two HIV prevention options: pre-exposure prophylaxis (PrEP) and the knowledge that "Undetectable=Untransmittable" (U=U). But has this changed our sex lives? We spoke to two guys to hear how these are affecting the sex people have across viral status.

INTERVIEWS BY RONNILYN PUSTIL

**DILLON WALDRON**, 28  
Taking PrEP on and off since 2015  
Toronto

I take PrEP every day. For the first two months I had some side effects—upset stomach, headaches and digestive issues—but then they went away. I took Gravol now and then to deal with them. PrEP gives me peace of mind because I'm able to make sure I stay negative. When I take it every single day, I no longer have to worry about HIV, and I can get tested and not have the same concern that I had before when waiting for my results.

U=U allows you to have more productive conversations with people who are HIV positive and undetectable because you know that they're among the safest people to have sex with, in terms of HIV risk.

Now, you're most likely to contract HIV from someone who doesn't know they have it. But if I take PrEP, then I know I won't get HIV. Before, there was always a risk, big or small. Now, with me being in control of it, I don't have to worry about risk.

PrEP and U=U are both ways of making sure that people have peace of mind and can be confident with a sex partner. They help to destigmatize having sex with HIV-positive people.

In the past, I'd ask the other person about their status and they would ask me, but with PrEP I can take the pressure off. Rather than asking about



*I don't need  
to ask people  
what their  
status is  
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"I'm on PrEP."*

them, I'm now talking about myself more. I don't need to ask people what their status is now, because I can say "I'm on PrEP." And then from there, they can decide whether or not to disclose. So, PrEP not only allows people to talk more openly but it also destigmatizes HIV-positive people, and that's something that needs to happen. I definitely feel like PrEP is helping in that sense.

Recently I've been finding that more people are aware of U=U. I think when you say "U=U" most people know what you're saying; overall the basic knowledge is there, at least for a lot of gay cis males. It's on Grindr, it's on Scruff, it's on *RuPaul's Drag Race*, and it's definitely talked about in gay cis male culture. More and more, you see "U=U" on profiles of HIV-positive people, even on some HIV-negative people's profiles. Maybe it's a way of encouraging people to destigmatize HIV, maybe they have a partner who is HIV positive or maybe they're acknowledging that they want to have a conversation about it.

I want to see HIV eradicated in my generation. I have confidence that we can make that happen if we have the political will to do it. I think that PrEP and U=U have both given people peace of mind, and as we destigmatize the disease, we get closer to eradicating it.

## SHAD TURNER, 43

Diagnosed with HIV in 2014

Undetectable since 2014

Edmonton

I was diagnosed in 2014, so I wasn't living with HIV for very long before PrEP became widely available. And after I was diagnosed, I continued to be in a monogamous relationship for three years, so I wasn't running in all the same circles as PrEP users who were single or in open relationships.

I see the wide availability of PrEP and the increasing awareness of U=U as two separate but related issues. The availability of PrEP seems to be coming hand-in-hand with the understanding that U=U. With PrEP and U=U, I am generally less reluctant about disclosing my status to friends or people I'm chatting with (particularly people on PrEP, who I think are more likely to be aware of U=U). I suspect that guys on PrEP will be more informed about what U=U means—and less likely to behave in ways that stigmatize me due to my HIV-positive status—than guys who are not.

On the other hand, it's sort of re-stigmatizing, because the common question—at least in the online chat scene—is “are you on PrEP too?” Guys are very quick to state that they're on PrEP. Many of these same guys have asked me if I am on PrEP also, even though it is hard to rationalize their question about my status. I feel a little bit sheepish not being able to tell them, “Yes, I'm on PrEP,” even though I know that being undetectable means that I don't pose a risk of transmitting HIV.

When people are on PrEP and make inquiries into my HIV status, I take that as an indication of a “you can't be too careful” mindset. I address the question in a nuanced way that doesn't result in me having to disclose my health information to a stranger so bluntly. I don't want to be put in the position of having to choose between making an untrue statement about my HIV status and disclosing my status under duress or on account of a perceived duty that doesn't necessarily exist.

In a situation like that, I'll usually turn the tables and answer the question by asking another question: “You're on PrEP, so you're covered. What is it that you'd really like to know?” That line of conversation sometimes ends the conversation completely. Or, I'll just simply flat out say “You don't need to be worried about that. You've already told me that you're on PrEP, so we're good.”



*From the tone of the conversation it seems to me that people are much more receptive to guys being sero-different.*

From the tone of the conversation today, even compared with three or four years ago, it seems to me that people are much more receptive to guys being sero-different. Certainly, people who have been researching PrEP or are on PrEP are going to come across the U=U message. The other HIV-positive guys I've spoken to about this are not as hesitant as they once were to push back a bit more

assertively and do some of that education themselves. I'm running into a lot more people who are very casual and nonchalant about having sex with someone who is undetectable; these are different people from those asking the question, “Are you on PrEP?”

On the whole, I think more open conversations are happening and they're more sophisticated and nuanced. That said, there's always going to be a core group of guys who will insist on PrEP or condoms for HIV prevention because “you can't be too sure.” Often, these people don't even consider that being undetectable is an option. Very often, people's inquiry still is just a one-word question: “Neg?” It's a leading question and it forces people to either voluntarily self-disclose to a near stranger or be dishonest about their status.

Overall, I think there is a general improvement in the atmosphere with regards to stigma because people are generally more educated and aware of the facts and their options. But that being said, I think there's now a new kind of stigma directed at non-PrEP users. I think that the core group of people who adopted that stigmatizing mentality before are still doing it now. It seems as though there are now two different tiers of people: those who are taking PrEP and those who are not.

PrEP has had a much stronger impact than the U=U campaign on my sex life. I live in a conservative part of the country, and here there seems to be less of an appetite for nuanced viewpoints on HIV risk. The U=U messaging still requires navigating the generally held (but flawed) understanding that if you have HIV you must disclose before having condomless sex, period, regardless of viral load.

U=U in and of itself doesn't overcome misinformation about the state of the law. People think that the criminalization of a positive person who has sex with a negative person suggests a risk, regardless of U=U. They think there's got to be a reason why the law is the way it is. I think that remains the unspoken spectre in the back, behind all of this chipper campaigning about scientific discovery. +



# HIV criminalization in Canada

In Canada, people living with HIV can face prison if they do not disclose their status to a sex partner in certain situations.

The law is severe, but things are slowly improving.

**Cécile Kazatchkine** from the Canadian HIV/AIDS Legal Network breaks down what you need to know about HIV non-disclosure.

## W

### hy do I have to disclose my HIV status before sex?

In 1998 the Supreme Court of Canada made a legal ruling that people must disclose their HIV status before having sex. This applied to sex that posed a “significant risk of serious bodily harm”. In 2012 they refined this to mean sex that poses a “realistic possibility of transmission of HIV.” If someone doesn’t disclose their HIV status (that is, tell someone they have HIV), they could be charged with and convicted of aggravated sexual assault. This carries a maximum penalty of

life imprisonment and forces someone to be registered as a sex offender. People are charged under the general law of sexual assault in cases of non-disclosure. There is currently no specific provision in our Criminal Code that targets HIV transmission, exposure or non-disclosure.

### When do I have to disclose my HIV status before sex?

Legally, you don’t have to disclose before vaginal or anal sex if you use a condom *and* you have a “low” viral load (under 1,500 copies per ml).

Whether someone can be prosecuted for not disclosing their status in other situations is still evolving. It depends on how judges and prosecutors (the government lawyers in charge of prosecuting criminal cases) interpret the legal test of a “realistic possibility” of HIV transmission.

### How have these laws affected Canadians living with HIV?

At the time of writing, almost 200 people in Canada have been charged for not disclosing their HIV status to someone they’ve had sex with. We

have one of the highest numbers of reported cases in the world after Russia, Belarus, the United States and Ukraine. In Canada, someone can be charged even if they had no intent to harm their partner and the other person didn't get HIV. In some cases people have been charged and imprisoned because they didn't disclose before sex acts that posed negligible to no risk of transmission, such as sex with an undetectable viral load, oral sex or sex with a condom.

### How are things changing?

You might have heard about more recent developments in the Canadian legal system. In 2016, the then-Attorney General of Canada and federal Minister of Justice recognized that there was an “overcriminalization of HIV non-disclosure.” As a result, in December 2018, she told federal lawyers to stop prosecuting people who have maintained a suppressed viral load (i.e., under 200 copies per ml). She also told them to “generally” not prosecute people who used a condom, took treatment as prescribed or just had oral sex, because there is “likely no realistic possibility of transmission” in these cases.

### What does this all mean?

This is an exciting development, because directives to prosecutors can change how the law is enforced, even if they can't change the law itself. This can prevent unfair prosecutions against people living with HIV. Unfortunately, the federal directive only applies in the three territories (Northwest Territories, Nunavut and Yukon), and provinces are lagging behind. Only Ontario, B.C., Alberta and Quebec have sent instructions to their prosecutors.

In Ontario, B.C., Alberta, and Quebec, you now shouldn't be prosecuted if you are on treatment and have maintained a suppressed viral load (under 200 copies/ml); this applies whether or not you used a condom. In B.C., you shouldn't be prosecuted if you only had oral sex.

Only B.C. and Quebec offer some protection for people who used a

**Legally, you don't have to disclose before vaginal or anal sex if you use a condom and you have a “low” viral load (under 1,500 copies per ml).**

condom (but did not have a low viral load) but they are not completely protected. Unfortunately, this ignores the scientific evidence we have about condoms—they're a highly effective prevention strategy.

### What have people done to challenge HIV criminalization?

HIV criminalization varies across the country, depending on how prosecutors and judges in each province apply the law and interpret the legal test of a “realistic possibility of HIV transmission.” Because of this, advocates have been pushing for instructions to be sent to prosecutors at a provincial level. As described above, they've had some success but there's still more work to be done.

At a national level, a group made up of people living with HIV, lawyers, researchers and activists formed the Canadian Coalition to Reform HIV Criminalization in 2016. A year later, they released a Community Consensus Statement, which said that criminal prosecutions should only take place when HIV was *actually transmitted* and this transmission was *intentional*. They called for law reform to limit HIV criminalization. The statement was

endorsed by more than 160 community organizations across Canada from the HIV sector and beyond. It shows a clear consensus for specific steps that must be taken by federal and provincial governments to end the misuse of the criminal law.

### Where do we go from here?

In June 2019 the House of Commons Standing Committee on Justice and Human Rights released a report which recommended that HIV non-disclosure should stop being charged under sexual assault law. They also suggested that the use of the criminal law in cases of HIV non-disclosure should be limited to cases of actual transmission. This is an important step forward, but the ultimate goal of anti-criminalization groups is that charges are limited to *intentional* transmission.

The Committee called for a prosecutorial directive that would apply across Canada. This would tell all prosecutors to stop criminalizing HIV non-disclosure, except when HIV is actually transmitted. It would also ensure that HIV non-disclosure is never prosecuted when the HIV-negative partner was on PrEP, condoms were used, the HIV-positive partner had a suppressed viral load, or the risk was negligible (like in oral sex). They also recommended that a specific offence should be created to deal with non-disclosure of an “infectious disease” (including HIV) that is transmitted.

At the HIV Legal Network, we disagree with creating a new law that would criminalize other infectious diseases, but it's clear that the Committee's recommendations are a tremendous opportunity for change in Canada. We must keep up the pressure to ensure concrete actions follow. +

For additional information on the state of the law in Canada, see Canadian HIV/AIDS Legal Network, *The Criminalization of HIV Non-Disclosure in Canada: Current Status and the Need for Change*, June 2019, at [www.aidslaw.ca/criminalization](http://www.aidslaw.ca/criminalization)



# Stigma, Sex & Safety

**We've come a long way on transgender rights in Canada, but trans people still face stigma in housing, employment and healthcare. Are things getting better? Two trans women living with HIV, Cassidy Quinn and Isabella Gamk, share their unique stories.**

BY DEIDRE OLSEN

PHOTOGRAPHS BY KAMIL BIALOUS AND CARLOS OSORIO

**On** World Aids Day 2017, 26-year-old trans adult performer Cassidy Quinn disclosed publicly on Twitter that she had been diagnosed with HIV. People were largely supportive, but she attracted the interest of porn tabloids, including notorious gossip website TheReal-PornWikiLeaks.com. Despite this, she continued to work in the industry, provoking a much-needed conversation about HIV stigma and prevention.

When Quinn found out she was HIV positive, she was at the height of her career. She had recently undergone breast augmentation, was working regularly and would soon learn she was nominated for several industry

awards. This major revelation about her health caused upheaval for someone who was carving out a place for herself in porn.

Quinn grew up in Saskatoon, Saskatchewan, where she was the captain of her high school football team and involved in every sport imaginable. She says her teenage self was an “emo jock” with black-and-blond hair and lots of piercings who performed toxic masculinity to fit in. In 2011, she moved to Vancouver to pursue culinary arts at the Art Institute of Vancouver. Eventually, she was working as a fine dining chef at *Le Crocodile*, an acclaimed high-end French restaurant. It wasn't until 2014, at age 22, that she realized

she was transgender. “One day it just kind of clicked. I was sitting outside on my porch reading stuff and then it all fell into place,” she says.

Quinn reached out to people in the queer community who told her what to do and where to go. She ended up at Three Bridges Community Health Centre, where she's been a client ever since. When it comes to accessing gender-affirming care, her experience has proven straightforward. “In B.C., there are pretty much no barriers. It's consent-based,” says Quinn. “Sometimes, it takes a long time. They have to go through your background and do all these tests.” But she was able to access hormone therapy after

five months. “I’ve been there for five years. Same doctor and same clinic. I see my counsellor there and that’s where I got my STI tests done when I was regularly working [with other performers],” she says.

Quinn decided to move on from her culinary career, terrified of the judgment that would ensue following her transition. “I quit work because I was scared that no one would accept me, especially in the kitchen, which is male dominated and full of Gordon Ramsay types yelling at everyone.” After quitting, she lived off her savings and started escorting.

of a support system. In turn, this contributes to high levels of poverty and homelessness, causing them to enter the sex industry as “a means of survival.” Sex work can put trans women at higher risk for violence and incarceration, but one positive finding was that some trans women “felt appreciated as real women by their male clients.” Often, this was missing from their daily lives.

“I had no idea what I was doing and my safety was always in jeopardy,” says Quinn. She started dating another trans woman, who did porn, and this introduced her to a different, safer

front cover of DVDs, [and] the backs of playing cards and calendars.”

In the summer of 2017, Quinn spent two months recovering from breast augmentation in Long Beach, California. She then returned to Vancouver, where she lived with her partner of two years, with whom she was in a polyamorous relationship. Quinn says she was neither working nor having sex while she recovered, but as she began to feel better she felt like sleeping with a cis man—something she does only once in a while as she’s mostly interested in women.

After perusing Grindr one evening, she met with a man for an evening of fun. Despite taking precautions, Quinn came down with symptoms of the flu within a week (a common experience for people who have recently contracted HIV). She was supposed to leave for Los Angeles but her agency encouraged her to get tested before taking off. That’s when she found out she was HIV positive.

“I got retested three times and cancelled my trip to L.A. My partners were all there for me at the time,” she recalls. “My local clinic was really awesome. My counsellor, the doctors and the nurses were all in the same room with me, consoling me. They knew me, so it was hard for them too.”

Quinn says that when she has visited other testing centres she hasn’t received such kindness and compassion. “I wasn’t expecting it, as someone who is a sex worker and trans. But in the end, everyone [at my local clinic] was there for me,” says Quinn. She went to the hospital, where her viral load was tested and found to be 1 million copies per ml. After going on antiretroviral medication, she quickly became virally suppressed.

For people living with HIV who are undetectable, the virus is sexually untransmittable. So long as someone like Quinn continues taking their medication and remains undetectable they can have condomless sex without passing on HIV. For an undetectable HIV-positive adult performer, this means they could hypothetically continue working in the porn industry without transmitting the virus. But, in

**“My local clinic was really awesome. My counsellor, the doctors and the nurses were all in the same room with me, consoling me.”**

**– Cassidy Quinn**

In 2013, researchers at the City University of New York looked at systemic discrimination experienced by trans women who view sex work as their “only viable career option.” They found that these women are often unable to keep jobs because of discriminatory hiring practices, workplace harassment and lack

of a support system. While all forms of sex work carry risks, working in a structured environment with a reputable company made Quinn feel less vulnerable to abuse. A year later, she was in the United States filming for several major adult production companies. After that, she says, her career blew up. “They started putting me on the

the “straight” corner of the profession, industry protocols lag behind the science. Since coming out about her HIV status, Quinn has been shooting solo scenes; while this isn’t equal treatment, she’s still with her agency and continues to work. This, she says, is a sign of progress.

After several cases of on-set HIV transmission during the AIDS epidemic of the late 80s and early 90s, the Adult Industry Medical Health Care Foundation (AIM) was created to provide monthly STI testing to performers in the United States. However, in 2011, AIM was shut down following a massive leak of adult performers’ medical information.

In the wake of this, the Performer Availability Screening Services (PASS) system was set up, which provides a database of STI testing services for adult performers. If a performer contracts HIV, the entire industry temporarily shuts down to ensure it is not spread (this happened after Quinn tested positive). Because HIV-positive performers are barred from the PASS system, many gay production companies have not opted in. Instead, they rely on their own measures for onsite safety. These can include PrEP, treatment as prevention, or condom usage.

Most positive performers, Quinn says, are blacklisted for life and disappear from the straight scene forever. People living with HIV are still heavily stigmatized in the porn industry, despite modern treatment. But by going public and facing this head on, she hopes to advance a larger conversation about how to treat adult performers who are undetectable.

Within the span of five years, Quinn came out as both trans and HIV positive, joined the porn industry and became an award-nominated adult performer. This is no easy feat for someone living on the margins, but it’s a sign of changing times.

**T**hings were different for Isabella Gamk, a housing activist based in Toronto’s Church-Wellesley neighbourhood. The 59-year-old has

been living with HIV for more than 30 years. In 1992, while working in Vancouver, Gamk was formally diagnosed and told she’d probably been living with the virus for five to 10 years already. In 2016, Gamk came out as trans, after a lifetime of knowing she was a woman.

Gamk grew up poor, one of seven children raised by a single mother in Havelock, Ontario. From an early age, she supported her family by working on farms in the area. Later, she spent

latter. Her calm response surprised the doctors treating her. “I thought I was dying of cancer. What’s the difference?” At the time, she viewed an HIV diagnosis as a death sentence. Thirty years later, though, she’s still here.

Gamk was prescribed AZT and told to avoid medical clinics because her immune system was fragile. At the time, she didn’t feel connected to the AIDS epidemic that was devastating the gay and trans community. In the years that followed, she navigated a

**“I told the doctor,  
‘You know, I always  
wanted to be a girl.  
I want to get on  
hormones.’”**

**– Isabella Gamk**

time between B.C. and Ontario in pursuit of employment in the trades. In the mid-80s, Gamk and her partner at the time lost a newborn child, who lived only minutes. Things didn’t get any easier when, a few years later, her estranged father died of cancer.

While living in Vancouver in the early 90s, Gamk developed a rash on her shoulders and back that wouldn’t go away. At first, doctors thought it was lice and later, impetigo. But Gamk thought she was dying of cancer, like her father had. Eventually, she underwent tests to see if she had either cancer or HIV. The results came back, to her relief, determining she had the

life of illness, substance abuse, homelessness and suicidality.

When Gamk came back to Ontario in 1994, her mother helped her find somewhere to live. She settled in at 127 Isabella Street, the address of a residence for people living with HIV (formerly associated with Casey House, Canada’s first and only stand-alone hospital for HIV-positive people).

Gamk says that disclosing her HIV status has been key to keeping herself safe throughout the years. It’s when she hasn’t told people and they have found out and responded angrily that danger has presented itself. She advises young people, even if they are



undetectable, to be open about their HIV status where and when they feel safe to. For women like Gamk and Quinn, the double stigma of being trans and HIV positive makes them especially vulnerable to abuse.

Gamk hasn't had sex with anyone in more than a decade, despite being undetectable. When the opportunity presented itself a couple of years ago, a man got dressed and left following her disclosure. But this, Gamk says, is preferable to the risk of an altercation were she to keep her HIV a secret. She will continue to disclose her status to any potential sex partners—despite being unable to transmit the virus—given the stigma that persists.

In addition to the struggles associated with living with HIV, Gamk has faced adversity in her journey to transition. “I struggled with thoughts of suicide and attempted five times. The last attempt was about 10 years ago. If I hadn't started hormones, I might have tried again in the last couple of years,” she says. According to the Centre for Suicide Prevention, more than 10% of all trans people have attempted suicide in the last year and 22% to 43% of trans people have attempted suicide in their lifetimes.

In the early 2000s, Gamk visited the Centre for Addiction and Mental Health (CAMH) in the hopes of starting hormone therapy. But the experience turned out to be a terrible one that delayed her transition. “I did try to get on hormones about 15 years ago. But they shot me down,” recalls Gamk. “They told me that I couldn't afford it, they didn't think it was going to be a good fit for me and I needed to live as a female for two years before they'd even consider giving me hormones.” Gamk's experience differed significantly from Quinn's; when it comes to accessing treatment, rules about waiting periods have now been relaxed.

A 2014 UNAIDS report showed that 19% of trans women around the world are living with HIV. On top of this, the risk of contracting the virus is 49 times higher for trans women than for the general population. This is supported by Canadian research: In Ontario, the Trans PULSE community-based

research project found that trans women are disproportionately affected by HIV. In the study, interviews were conducted with both HIV-positive trans women and service providers to better understand the relationship between the two; these showed that trans women faced barriers to care such as “negative interactions with healthcare providers, deficits in provider knowledge, gender-segregated programs, and frequent pathologizing of trans identities.” Such barriers foster hostile health environments and deter trans women from accessing important services.

It's because of negative interactions with health professionals that Gamk didn't end up transitioning until 2016. “Three and a half years ago, I was fading away. I was down to 128 lbs. I'm 6'5½” barefoot. I overheard someone talking about taking hormones and gaining weight. I told the doctor,

‘You know, I always wanted to be a girl. I want to get on hormones.’” By finally being able to access hormone therapy, Gamk not only gained weight but finally achieved her dream of transition.

Fast forward to 2019, and Gamk successfully underwent vaginoplasty—a surgery that constructs a neovagina using penile tissue—at a private clinic in Montreal, covered by Ontario's provincial insurance plan. Previously, the only options available for Canadian trans women seeking bottom surgery were to travel to this clinic or abroad. Recently, though, things have started to change: In 2018 the Women's College Hospital in Toronto established its Transition-Related Surgery Program and performed Ontario's first vaginoplasty in two decades. +

Deidre Olsen is a writer and editor based in Toronto.

## Resources

### National

Canadian Professional Association for Transgender Health (CPATH): [www.cpath.ca](http://www.cpath.ca)

### Alberta

Trans Equality Society of Alberta: [www.tesaonline.org](http://www.tesaonline.org)

### British Columbia

Trans Care B.C.: [www.phsa.ca/transcarebc](http://www.phsa.ca/transcarebc)

### Manitoba

Rainbow Resource Centre: [www.rainbowresourcecentre.org/resources/organizations](http://www.rainbowresourcecentre.org/resources/organizations)

### New Brunswick

New Brunswick Transgender Health Network: [www.facebook.com/transhealthnetworknb](https://www.facebook.com/transhealthnetworknb)

### Newfoundland & Labrador

Trans Support NL Inc.: [www.facebook.com/tsnl.umbrella](https://www.facebook.com/tsnl.umbrella)

### Northwest Territories

Rainbow Coalition of Yellowknife: [www.rainbowcoalitionyk.org](http://www.rainbowcoalitionyk.org)

### Nova Scotia

Halifax Sexual Health Centre: [hshc.ca/transgender-health](http://hshc.ca/transgender-health)

### Ontario

Rainbow Health Ontario: [www.rainbowhealthontario.ca](http://www.rainbowhealthontario.ca)

### Prince Edward Island

Health PEI: [www.princeedwardisland.ca/en/information/health-pei/transgender-health-services](http://www.princeedwardisland.ca/en/information/health-pei/transgender-health-services)

### Quebec

Action Santé Travesti(e)s et Transsexuel(le)s du Québec (ASTT(e)Q): [www.astteq.org](http://www.astteq.org)

### Saskatchewan

TransSask Support Services: [www.transssask.ca](http://www.transssask.ca)

### Yukon

Trans Resource Yukon: [transresourceyukon.com](http://transresourceyukon.com)



# Can't Pass It On

CATIE's *Can't Pass It On* campaign rolled out across Canada in fall 2019, and featured 12 serodifferent couples sharing a simple message: People living with HIV on effective treatment can't pass it on to a partner. **Jonathan Valelly** talks to three of these couples to hear why they got involved.

# M

elvin Blackwood didn't feel like talking to anybody. He was in a bad mood that particular day and was trying to avoid any attention as he approached the bus stop. But Breklyn Bertozzi wasn't willing to miss her chance to say hello. "I hit on him, brought him home with me and never let him go," laughs Bertozzi as she recounts the lucky pickup. "I'm a very abrupt and blunt person." As it turns out, Blackwood was an agreeable target. The pair opted to walk back to Bertozzi's place. They got to talking along the way.

"She told me that she had HIV," says Blackwood, who is HIV-negative. "So I heard her out and managed to accompany her home with the intent of seducing her and making her my wife." Bertozzi explains that people aren't always so receptive when she discloses her status, but "he

was educated about HIV, so he didn't need me to say much more." Eight years later, the pair are now raising their one-year-old daughter (pictured) and Bertozzi's 15-year-old son in Hamilton, Ontario.

Blackwood and Bertozzi knew what so many couples discover—that a difference in HIV status is no reason to put the brakes on romance. And since that first encounter at the bus stop, even more possibilities have opened for couples like them. With a growing mountain of evidence behind it, the global HIV community has radically changed its messaging on sex. The research is unequivocal: *People living with HIV who maintain an undetectable viral load through treatment cannot transmit the virus to their sex partners.*

“Undetectable = Untransmittable” or “U=U” has rapidly taken hold as a shorthand within a buoyant HIV sector. But many people living with or affected by HIV aren’t seeing the change in their communities. “There are a lot of ignorant people out there,” says Blackwood, who finds that he and Bertozzi often have to educate people on the subject. “When I talk to certain people, I try to make them see how hard this thing is to pass on.”

Blackwood’s experience reflects how little many people know about U=U. That’s why a video campaign from CATIE called *Can’t Pass It On* gives people the opportunity to hear this from Bertozzi, Blackwood and 11 other couples who live the reality of U=U every day. Together, these real-life stories are meant to equip every Canadian with a clear and simple message: HIV-positive people on effective treatment *Can’t Pass It On* to a partner.

“This campaign is an effort to bridge the gap between what we know from the science and what people know in the community,” says CATIE’s Director of Communications, Andrew Brett, who oversaw the project. CATIE’s campaign is adapted from a project of the same name, launched by the U.K.-based charity Terrence Higgins Trust in 2018. Like CATIE’s, the Terrence Higgins campaign highlights real, relatable people living with HIV sharing their stories. Both campaigns seek to challenge stigma by explaining the crucial new science of HIV transmission to folks who might not otherwise encounter it. “It’s so important to make sure this is accessible and understandable to people who don’t know a lot about HIV,” says Brett, citing as an example CATIE’s decision not to use the word “undetectable,” since people may have never heard the term.

CATIE typically works with service providers and agencies, providing them the best and most current information on HIV. Brett says the decision to build a project for the broader public was bolstered by surveys demonstrating that many people were still not aware of the research on HIV transmission. “This is one of the first times in a very long time that we have an opportunity to share good news about living with HIV,” he says. “It’s unconscionable that this knowledge should remain hidden from the people most affected by HIV in Canada.”

**E**ka Nasution started to cry when he heard the news. The HIV test had come back positive. But he wasn’t the one who was now living with HIV. It was his boyfriend, Rainer Oktovianus. The two had gone for a routine test together but neither had anticipated the result. “It was just like, terrifying, because we lived in a society so far away from open-mindedness,” he recalls. It was 2011, and the couple had met a year earlier while working at a queer film festival in their home city of Jakarta. Nasution was worried for his partner’s future. “How do you overcome that? HIV treatment in Indonesia is still AZT.”

Oktovianus tried to comfort his partner. “I told him it’s fine,” he says, adding that his experience organizing with Indonesian LGBTQ+ communities gave him a different perspective. “I’m OK with it; I’m an activist. I knew a lot about HIV even before I was positive.” While activism provided a starting place for living with HIV, it also opened up new challenges for the two. In the years that followed, life for LGBTQ+ Indonesians went from bad to worse. A government crackdown was coupled with a wave of social media vigilantism, and not only did Oktovianus become a target—so did Nasution.

**“This is one of the first times in a very long time that we have an opportunity to share good news about living with HIV.”**

“We literally had to hide in our apartment,” says Oktovianus. The online harassment included public posts of both men’s identity cards and home address. While Oktovianus was used to confrontation, Nasution had mostly avoided too much attention, aware of how it could affect his career. “I was just afraid for his safety,” says Oktovianus. The couple looked for a way to move away, and Canada seemed like an obvious choice, especially since they had got married on a whim when they visited Ottawa in 2014. The couple successfully moved to Vancouver in March 2016, but the immigration process wasn’t without a few hiccups. Oktovianus was asked to prove that he could afford his HIV medication to get his study permit. As a result, he had to switch his regimen to AZT for a few months during the application process, which he had managed to avoid until then. The treatment is notorious for causing extreme side effects.

“It was just horrible,” recalls Oktovianus. “My skin was dry; I was losing my hair.” “The most important thing was his mood! It was so unpredictable,” Nasution interrupts with a smirk. “Some moments you’re happy and some moments you’re a pain in the ass.” Things did improve overall. Nasution says it’s much easier to be open about HIV and about being gay in Canada, and despite experiencing intense

harassment in Indonesia, he didn't hesitate to take part in the CATIE campaign.

Nasution knows firsthand how important it is to be informed about transmission risk. In fact, throughout so many changes—changes in HIV status, changes in safety, changes in country and changes in medication—the couple continued to use condoms. “I wasn't sure if undetectable meant that I could do bareback [condomless sex] with him,” he says. With time, trust and increasingly clear evidence, this would eventually change.

The number of people living with HIV in Canada who reach undetectable after beginning treatment is generally very promising. But compared with similar countries like Australia and the U.K., Canada lags behind on getting people tested and diagnosed. An estimated 14% of people living with HIV in Canada don't know their status, meaning they are not accessing treatment or aware that they could transmit the virus to other people.

The *Can't Pass It On* campaign is a celebration of the fact that people on effective treatment can't transmit HIV through sex. Crucially, it also aims to get that information to folks who are HIV-negative or don't know their status as well as to folks who aren't accessing treatment because of fear, secrecy or other effects of stigma.

Brett says that CATIE recognizes that not enough Canadians know their status. “Good health is the best motivation to get tested and get treatment,” he explains. But he adds that sharing the news about U=U can help chip away at the stigma that may prevent people from doing so.

“It gives people one more reason to start treatment.” Brett points out that getting this information out is akin to reversing the official story given to the public since the beginning of the epidemic. “We are trying to undo more than 30 years of public health messaging that has said that people living with HIV are a risk,” he says.

This framing also affects HIV-positive folks' view of themselves. “Some people are struggling to change their attitude towards something they've been told ever since their diagnosis, about the possibility of passing HIV to their partners,” says Brett. “It's hard to unlearn that.” Nasution says that the hesitation about ditching condoms with his husband came from a shared place of caution, even after his partner had reached undetectable status consistently. “I was thinking, let's just wait two or three years. But even though there were some scientific publications about

undetectable people who can't transmit, I still needed to wait for something more... some direction.”

Oktovianus also wanted his husband to feel sure. He approached their decisions around sexual health much like he did the escalating threats they faced in Indonesia—from a place of care and support. “The burden is also on me,” he says, echoing the risk narrative that has framed sexual transmission for such a long time. “For him, he needs all the scientific facts... I'm safe, I'm fine, but I wanted him to know all the risks before he decided.”

Eventually, once the World Health Organization and CATIE had endorsed the U=U message, Nasution and Oktovianus began having condomless sex. Even so, they still use condoms when it comes to sex with others, to protect against STIs. Online, they find that gay men prefer to eschew condoms because many are using pre-exposure



**“It’s one thing when you read something in the literature, and it’s another thing when someone shares their personal experience.”**

prophylaxis (PrEP), a medication that prevents them getting the virus. But many are still less sure about viral suppression as a way to prevent transmitting HIV. Oktovianus is hardly surprised. “Convincing my own husband was challenging,” he points out. “I don’t know how to convince strangers or say, ‘Hey, undetectable, do you know what that means? Do you still want to have sex with me?’”

Despite the widespread stigma and misunderstanding, the two are cautiously hopeful. They decided to participate in the campaign because it has the potential to reach people in a different way. “There’s a chance that this campaign will get into people’s minds,” says Oktovianus. “But it’s going to be a challenge overall.”

**B**esides his parents and his partner at the time, Shan Kelley didn’t tell a soul when he got his HIV diagnosis. A multidisciplinary artist based in Montreal, Kelley moved in fairly progressive social circles. But even so, it was hard to know where to begin. At the time, most HIV awareness campaigns remained pretty fear-based and often trafficked in clichés. “There wasn’t generally a positive tone, even in testimonials from poz people,” he recalls. But within a year, Kelley grew more optimistic about his status. Soon, he was making work about HIV and practising what he called “radical disclosure.” That’s around the time he met his now-wife, Samia Hannouni. Hannouni had already informed herself about HIV when they started dating nine years ago.

“She made me feel safe,” says Kelley, adding that he doesn’t remember the two ever using condoms. Kelley and Hannouni continue to hook up and date other people, however, and he says he still commonly encounters “some heavy HIV-phobic shit” when disclosing his status. While frustrating, telling people has also become a kind of filter. “If you aren’t okay with it, I can’t be bothered,” Kelley explains bluntly, adding that it’s especially upsetting to

hear discriminatory attitudes from someone he knows or trusts.

One evening in April, Kelley and Hannouni met an acquaintance for dinner. When the conversation turned to the criminal proceedings that faced a mutual friend who allegedly did not disclose their HIV status, their dinner partner said the charges were deserved. Canada has a reputation for aggressively prosecuting positive people for non-disclosure, even when transmission isn’t even possible, and Kelley was shocked to hear this from his friend. “I couldn’t bite my tongue; there was no resolving it,” he remembers. “It was really timely.” It just so happens that earlier in the day he had received an email looking for couples to take part in CATIE’s new campaign. Before dinner, he and Hannouni had agreed they would pass on participating. After dinner, they changed their mind. They are one of the three couples who appear in the French-language video.

Kelley is no stranger to doing testimonials as part of awareness projects (his story and work were also spotlighted in the Winter 2015 issue of *The Positive Side*). His own art practice often draws on his personal experience with HIV. He sees that kind of repeated sharing as necessary. “It has to fade into the normalcy of daily life, so that people understand,” he explains. “I just wish this messaging had been out earlier.”

Kelley emphasizes that HIV awareness work often drags behind the science, and that people with HIV are also experts on their own health, sex and relationships. In that spirit, *Can’t Pass It On* puts HIV-positive people and their partners front and centre, ready with backup from the latest research. “It’s one thing when you read something in the literature, and it’s another thing when someone shares their personal experience,” says Brett, from CATIE. “An HIV-negative person who is with an HIV-positive person telling you that there is no risk of transmission—that’s completely different than a scientist telling you that fact.”

Breklyn Bertozzi sees value in both. “Everybody learns differently,” she says. “Some people like to read facts, and other people like to see facts.” Despite being a very outgoing person, Bertozzi has not previously spoken quite this publicly about living with HIV. But she sees the video as a unique opportunity to get the word out. “The fact that I can use my relationship as an example of ‘can’t pass it on’ is really important,” she reflects.

Meanwhile, Eka Nasution still finds it best to read the data for himself. But he recognizes that a video with a personal touch might better reach younger folks and others who prefer digital media. His husband, Rainer Oktovianus, always the activist, sees the project as a call to action. “I can be my own living proof,” says Oktovianus. “My husband is still negative. What are you afraid of?” +

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

# Viral Load Blips

The prospect of a blip—a temporary spike in your viral load—may sound troubling to a person on HIV treatment or their partners, but it needn't be.

BY BOB LEAHY

**B**lips are uncommon. They're also unpredictable: They can occur even when you have been adherent and treatment is working well. If your viral load suddenly becomes detectable, though, don't panic! Blips can occur if you are experiencing a brief illness such as a cold or flu at the time of your viral load test. They can even happen following a vaccination or severe allergies. If you have a detectable viral load result, your doctor may want to order a second viral load test. This is to make sure that the treatment you are on is still effective. If the next test shows you are back in the undetectable viral load range, you have experienced a blip, and there's nothing to worry about. (If your viral load is raised on two or more tests in a row, it may be time for you and your doctor to discuss other treatment options.)

How do blips affect the risk of transmitting HIV? If your viral load has spiked above the undetectable level, don't assume you are capable of sexually transmitting the virus to others, or that U=U no longer applies to you. This may sound odd, but it's important to know that the research on which U=U was based used different thresholds for "undetectable." These studies (HPTN052, PARTNER and Opposites Attract) used a detection value of below 200

copies of the virus per millilitre (ml) of blood to define an undetectable viral load. In Canada, viral load testing is capable of detecting virus in your blood at levels as low as 20 copies per ml. However, an undetectable viral load is usually defined as below 40 or 50 copies per ml.

Why is this important? Let's assume your viral load was previously undetectable, but your latest test shows a viral load of 150. That is technically "detectable" but falls well within the definition of undetectable used by research supporting U=U. Viral load results higher than 200 copies may even mean it's still not possible for you to transmit the virus to your sexual partners. We just don't know the upper limit for this. What we do know with certainty is that if your viral load is below 200, you "can't pass it on." +

For more on viral load testing, visit our website at [www.catie.ca](http://www.catie.ca).

Bob Leahy has been living with HIV for over 25 years and has been on treatment since 1996. He has never experienced a blip.

# LESSONS NOT



# LEARNED

## The overdose crisis in Canada

### Canada is in the midst of an overdose epidemic, but how did we get here? And what can be done to stop it?

BY REBECCA PENN

ILLUSTRATIONS BY SÉBASTIEN THIBAUT

Communities across Canada are reeling from an unprecedented opioid overdose crisis. Until recently, harm reduction for people who inject drugs has focused on the risks of HIV and hepatitis C. But harm reduction authorities are grappling with an even more urgent problem: the risk of death from an opioid overdose.

Officially, health authorities say the crisis started in 2016, when British Columbia declared a public health emergency. Community members had sounded the alarm long before then, though. Today, this emergency rages on across the country. For those who remember the AIDS epidemic in the 1980s and 1990s, this current moment feels eerily familiar. In the early AIDS years, tremendous loss and government inaction forced activists to fight for access to treatment and healthcare. Thirty years later, the same can be said for the overdose crisis. We could even ask, is this a new crisis? Or is it the same one driven by stigma, discrimination and laws that target people who use drugs?

Tackling the overdose epidemic is a difficult task, and depends on how we understand the problem. There are multiple ways to look at the crisis, and each of these leads to a different response. So far, the focus has been on three main causes: These are the over-prescription of opioids (and attempts to correct this), the toxic illegal drug supply and the stigma towards and criminalization of people who use drugs. Each of these is one piece of the complex puzzle

that has led to the current crisis, and each suggests ways to intervene. Before we can think about responding, though, we need to understand the scale of the problem.

#### The numbers

Between January 2016 and June 2019, 13,900 Canadians died from an opioid overdose. From January to June 2019, one Canadian fatally overdosed every two hours, and almost all of these deaths were accidental. As a result, life expectancy in Canada didn't go up from 2016 to 2017 for the first time in over 40 years. Overdoses don't always result in death, but surviving one can lead to physical and mental trauma, and even witnessing one can have similar psychological effects.

Every province and territory across Canada has been touched by the crisis, but some have been hit harder than others. It also affects both rural and urban Canadians—in fact, smaller communities have double the overdose hospitalization rate of Canada's largest cities. Men aged 30 to 39 make up the biggest group of deaths across the country, but women are dying at a similar rate in the Prairies and eastern provinces. Overdose deaths cut across social and economic lines, but vulnerable groups like prisoners and the homeless are at higher risk. First Nations people are five times more likely to have an overdose than other Canadians, and they're three times more likely to die from one. People living with HIV may also be at higher risk if they're managing chronic pain with high doses of opioids or if they have substance use or mental health challenges. Data from the United States showed a 43% increase in fatal overdoses for people living with HIV from 2011 to 2015.

#### Causes and solutions

##### Over-prescription of opioids

The first way of looking at the crisis focuses on the over-prescription of powerful opioid drugs. This began in North America in the 1990s, when drug companies encouraged doctors to prescribe such drugs by playing down their addictive potential. As a result, prescription opioid

consumption in Canada quadrupled between 1999 and 2010, even though the number of Canadians who reported chronic pain stayed roughly the same. During this time, Canadians became the world's second largest consumers of opioids, following Americans.

Over-prescribing exposed many Canadians to addictive drugs, and provided a steady supply of opioids for non-medical use. People began to obtain them through family members, dealers, fake prescriptions and the Internet, or by visiting multiple doctors at the same time. As pharmaceutical opioid use increased, so did rates of addiction and overdose. In 2012, the government and medical community tried to reduce this supply by tightening prescription guidelines, monitoring prescription closely and removing certain drugs (like OxyContin) from provincial drug programs. Despite warnings from the harm reduction community, these measures had serious consequences: People who had previously been using reliable prescription drugs suddenly couldn't access them and they were forced to buy illegal street drugs of an unknown strength and quality. As a result, overdoses shifted from legal to illegal opioids, and the number of deaths increased.

In this narrative, the problem is opioid use and opioid addiction. This has encouraged responses that aim to reduce opioid use, prevent addiction and increase access to treatment. Opioid agonist therapy (OAT)—also known as opioid substitution therapy (OST)—is the gold standard for treating opioid use disorder. It involves prescribing long-acting oral or injectable opioids to improve stability and reduce withdrawal symptoms. The most common drugs are oral opioids like methadone and buprenorphine, but programs offering injectable heroin and hydromorphone are expanding. OAT/OST is safe and can be effective for some people, but it's not an option for everyone and is not well distributed across Canada. Importantly, it can't protect people who continue to use drugs from the illegal supply.

### The toxic illegal drug supply

The second way of looking at the overdose epidemic says it is caused by the toxic illegal drug supply. Since 2011, synthetic opioids like fentanyl (used for pain management) and carfentanyl (used for anesthetizing large animals like elephants) have entered the illegal drug supply. Both are fast acting and much more powerful than other prescription opioids or heroin, which increases the risk of overdose. Fentanyl is 80 to 100 times more powerful than morphine, and carfentanyl is about 100 times more powerful than fentanyl. This means that a dose of heroin contaminated with carfentanyl could be thousands of times stronger than someone expects.

The strength of illegal drugs is increasing, and fentanyl is now the drug of choice for some people. For other users, their

drugs are unpredictable. What people may think is heroin could be a toxic mix of substances; for example, research in Toronto found 14 different drugs in a single sample of street heroin. Although it's uncommon, fentanyl has also been found in crystal meth and cocaine, and in the U.S. there are reports of fentanyl being found in MDMA. Anyone buying illegal drugs needs to be cautious, do small "testers" of each new batch and carry naloxone (a drug that reverses opioid overdose, available as injection or a nasal spray).



The criminalization of drug use makes it hard to address this toxic drug supply, and the Canadian government is resistant to such policy change. As a result, community members and activists have focused on overdose prevention and management, stepping in where governments and health authorities have been slow to act. They have set up innovative programs that address the harms of drug use, like overdose prevention sites (OPS). Many OPS started off as unsanctioned spaces funded by crowdsourcing campaigns, where users take drugs under the supervision of volunteers trained in overdose response. These are similar to supervised consumption sites (SCS)—where people can safely use drugs in a legally approved setting—and both provide entry points to health and other social services. Slowly, SCS and OPS have spread to six different provinces (B.C., Alberta, Saskatchewan, Ontario, Quebec and Nova Scotia). Although non-lethal and lethal overdoses continue to rise, this is now at a slower rate; in B.C. alone, OPS have prevented around 3000 deaths.

Despite their effectiveness, harm reduction services are not evenly distributed across Canada. Their existence is also politically charged. For example, Ontario and Alberta's recent leadership changes now threaten local overdose prevention programs like SCS or OPS. Across the provinces that do have SCS/OPS, most are in larger urban areas. Smaller communities are often unable to access even well-established harm reduction services like needle distribution.

SCS, OPS and naloxone respond to overdoses, but they can't prevent them. A better solution would be measures that address the toxic illegal drug supply. One such measure is

“safer supply,” a new approach gaining traction in Canada. Safer supply involves prescribing people pharmaceutical opioids as a safer alternative to contaminated illegal drugs. Safer supply programs are starting to be piloted across the country to divert people from the illegal supply and connect them to health and social services.

### Stigma and criminalization

The third way of looking at the crisis focuses on structural issues: discrimination, stigma and criminalization. These increase risks and harms for people who use drugs, and particularly affect marginalized groups like those who are homeless, poor and/or racial minorities. Here, racism intersects with stigma to especially criminalize black and Indigenous people who use drugs. Structural factors force people to use in secret—which pushes them into unsafe, isolated environments—and also create barriers to health-care and social services like SCS and addictions treatment. Stigma towards people who use drugs can hold back governments when it’s time to act. If society does not think that people who use drugs are deserving of care, then governments are not compelled to invest in healthcare and social services for them.

From this perspective, the overdose crisis begs us to address the structural factors that create harm, like drug policies, policing practices and social norms that see drug use as immoral. Responding to the crisis in this way would frame drug use as a public health issue rather than a legal one. It would also encourage policy reform that would decriminalize, legalize and regulate drugs. In some regions, public health officials are already calling for decriminalization, which would remove criminal penalties for possession but keep them for production and trafficking. Activists are also pushing for legalization and regulation of drugs. They say that it can disrupt the illegal drug supply, ensure the quality and potency of drugs and control who produces and uses them. There are already examples of these in Canada: SCS are spaces where drugs are decriminalized, and the cannabis industry provides one model for legalization and regulation, with ongoing research looking into models for other drugs.

## OPIOID OVERDOSE PREVENTION

- **Get naloxone!** Learn where to get it and how to use it by calling your local public health unit.
- Let people know you have naloxone and where it is.
- When possible, don’t use alone. If you’re alone, tell someone and make sure they can get to you. If available in your community, consider using a supervised consumption site.
- Do a small tester first for each new batch.
- Use less when you haven’t used in a while. Your tolerance or the drugs may have changed.
- Prepare doses yourself so you can control the hit.

## The fight isn’t over

In the 1980s and 90s, AIDS activists marched on Parliament Hill carrying banners reading “Silence = Death”. They demanded access to treatment and a seat at the decision-making table. This led to the 1994 *Greater Involvement of People with AIDS Declaration*, which recognized the expertise of people with lived experience. From this came the *Nothing About Us Without Us* principle, which health and social service organizations have adopted to include people with lived experience in the decision-making process—at least on paper.

Today, the banners read “They talk, we die”. In 2017, then Health Minister Jane Philpott recognized that the death toll from overdose “is worse than any other infectious epidemic in Canada, including the peak of AIDS deaths.” She acknowledged that “our country ignored innovators in our domestic context, and we shut out some of the most important voices in this discussion.” Those voices are the community members, activists, family members and frontline workers who fight to keep people safe while grieving the loss of loved ones. Two years on, their fight is not over; stigma, discrimination and criminalization are still stopping us from saving lives. +

Rebecca Penn is a Toronto-based community worker, researcher and harm reduction consultant.

## OPIOID OVERDOSE RESPONSE

### Signs of an opioid overdose:

- Difficulty staying awake
- Difficulty walking or talking
- Difficulty breathing, slow shallow breathing, gurgling sounds, unusual snoring
- Cold, clammy skin
- Lips or nails turn grey, blue or purple
- Tiny pupils

### What to do:

- **Call 911**
- Try to wake the person: shout their name, pinch the back of their arm. Check if they are breathing.
- Provide rescue breathing: check the airway, tilt the head and lift the chin to open the airway.
- Give naloxone.
- Wait three to five minutes, continuing to give breaths.
- If they’re not responding, give a second dose of naloxone.
- If you can, wait with the person until the ambulance arrives. If you’ve taken drugs or have some on you, the *Good Samaritan Drug Overdose Act* could protect you.
- If you have to leave, put the person in the recovery position. Leave a note about what the person took and make sure that paramedics can get to the person (e.g., door is unlocked).

# ASK THE EXPERTS

Get answers to your treatment questions

## The ABCs of CBD

We ask four experts whether CBD is worth all the hype.

**C**annabis contains over 100 different compounds, known as cannabinoids. The most well-known of these is tetrahydrocannabinol (THC), which produces the plant's intoxicating effects. Recently another cannabis extract has been getting a lot of attention: Cannabidiol, or CBD. It's being touted as a wonder drug for everything from aches and pains to inflammation, all without getting you high. But what exactly is it and how does it work? We asked pharmacist Maria Zhang, clinician Cecilia Costinuk, scientist Mohammad-Ali Jenabian and cannabis CEO Alison Gordon for the lowdown on all things CBD.

### Why do people use CBD?

**Maria:** Depression, anxiety and sleeping problems are some of the top reasons why people use cannabis. There are many anecdotes of people finding benefit with CBD (or cannabis) for these issues, but there are currently no CBD products approved for any of these uses. The current evidence isn't strong enough to recommend CBD as a first-line treatment for any medical condition.

**Cecilia:** In my practice, I find that people are already using cannabis, especially now that it's legal. It seems to be helping people a lot. The positive anecdotal reports are mostly about mood—cannabis use makes people feel happier and much lighter. People say they can manage their relations with others more easily. We know that

people living with HIV seem to suffer from anxiety and depression more than the general population, and cannabis is thought to be very useful in that regard. Also, many people report that it's helpful for insomnia and chronic pain. Although anecdotally cannabis seems to be doing good things for people, it's hard to tease out what molecule is doing what because you don't know exactly what people are taking.

### How do people take CBD?

**Maria:** CBD can be found as a part of the cannabis plant. It can also be taken in the form of capsules, oils and sprays supplied by licensed producers. It can be taken by itself or with other

ingredients like THC. In addition, Health Canada has approved some medicines containing CBD for certain uses, and these medicines are available by prescription from pharmacies.

**Cecilia & Mohammad-Ali:** Most people tend to smoke cannabis and consume CBD alongside THC in this way. When they crush up the full plant there is an "entourage effect," which means that other molecules inside the plant are influencing the CBD or THC and contributing to the effect it's producing. Ingesting the oil is thought to be one of the safest ways of consuming CBD because there's no smoke, which can lead to secondary effects on the lungs. It should be emphasized, though, that we discourage smoking in any form.

**Alison:** There are a number of ways to consume CBD. In October 2019, Canada expanded the number of CBD and/or THC products you can legally buy—you can now find edibles, drinks, vapes and topicals (creams or balms) for sale at licensed retailers. However, each province can determine what they will allow to be sold. Quebec is the only province to create its own regulations in this area, and they allow drinks but have banned edibles and topicals.

In Canada, what you mostly find are products that are two parts CBD to one part THC or equal amounts of both. Some consumers want CBD products without getting high, but it's a lot more lucrative when you have



Maria Zhang is a pharmacist and clinician educator at the Centre for Addiction and Mental Health (CAMH) and University of Toronto.

a cannabis licence to grow cannabis with THC in it. This means we have a lack of pure CBD products in Canada, which makes things hard for people looking for a product that won't produce a high. Canada, while being ahead of the curve on the legalization of cannabis, is somehow now behind the curve on CBD.



Dr. Cecilia Costiniuk is an HIV clinician and assistant professor at the division of infectious disease and chronic viral illness service at the McGill University Health centre.

Dr. Mohammad-Ali Jenabian is an HIV scientist and associate professor at the Université du Québec à Montréal (UQAM) and the holder of the Canada Research Chair in Immuno-Virology.

#### What does the research say?

**Maria:** Evidence of CBD's anxiety-relieving effects comes from animal models. CBD hasn't been well studied in humans. It also hasn't been studied much in the treatment of depression. With sleep, more is known about the effect of THC than CBD: Low doses of THC may increase total sleep time, but high doses can cause sleep disturbances. However, we don't know what exactly makes a "low" or "high" dose. Clearly, much more research needs to be done.

**Cecilia & Mohammad-Ali:** Much cannabis-based research has focused on risks and harms, but a Canadian HIV Trials Network pilot trial that we are doing will focus on the potential

benefits of cannabinoids, such as their anti-inflammatory properties. Our study has two goals. The first is to show that cannabinoid capsules taken by mouth are safe and well tolerated in people with HIV. The second is to see if cannabinoids can lower immune activation markers, or inflammation, in the blood. We also hope this study will help reduce the stigma associated with cannabis use.

**Mohammad-Ali:** For our 12-week study, we're going to use a pure form of CBD and THC extracted from the cannabis plant by the company Tilray. We'll give two groups of participants capsules that contain both CBD and THC oil, but the ratio of CBD to THC will differ—the capsules will contain either low or high amounts of CBD compared with THC. The reason for using THC is that it's thought to also have some anti-inflammatory properties, and using the two compounds together might enhance these effects. We need to complete this study and then perform larger studies to say conclusively whether CBD and THC can fit alongside an HIV treatment regimen for particular people. But we think there's something there and we're going to test it out.

#### What should people be mindful of when consuming CBD?

**Maria:** If you use CBD, it can have an impact on how your body processes medications, and other medications can change the effect of CBD in your body. In general, drug interactions are complex to predict. When it comes to CBD, several factors can affect the intensity of the drug interaction, or whether or not it happens. For instance, how is CBD consumed—is it taken orally, taken under the tongue, inhaled or smoked? If it's taken orally, high-fat meals can dramatically increase the amount of CBD absorbed by the body. If it's smoked, the compounds in the smoke itself can interact with things like caffeine and medications like olanzapine (Zyprexa and generics) and clozapine (Clozaril and generics). Also, what is mixed with the CBD? Is it a pure product and how can you be sure of it? Anything else that's

mixed with CBD, even in low amounts, may affect the interaction as well.

#### How is CBD regulated?

**Alison:** CBD is found in both hemp and marijuana. Hemp is cannabis, but it's cannabis with less than 0.3% THC. In Canada, when the government legalized recreational cannabis and put the Cannabis Act into effect, they also changed the regulations around hemp. As a result, the government does not distinguish between CBD and any other cannabinoid; they're all treated the same way. In Canada, CBD products are legal in the same way that THC products are legal: when they're produced by a licensed producer and sold in legal dispensaries. Licensed



Alison Gordon is the chief executive officer of 48North, a cannabis company focused on the health and wellness market, and on the board of directors for the Cannabis Canada Council.

producers can only sell to legal dispensaries and legal dispensaries can only buy from licensed producers.

Each province has a different distribution structure, like with alcohol. In Alberta, Newfoundland and Labrador, Manitoba, Ontario and Saskatchewan, stores are privately run but regulated by the government. In British Columbia, New Brunswick, the Northwest Territories, Nova Scotia, Prince Edward Island and Quebec, the government runs the dispensaries. In Nunavut the government sells cannabis products online or by phone. +



## Disruptive Design

**Juan Saavedra** blends design and activism to challenge the status quo.

**M**y attitude to success follows American philosopher Robert Grudin's understanding of design: it's at its best when it goes unnoticed. Sharing my successes never seems like a priority. I find myself constantly rejecting the compliments I receive, as I don't wish to be anyone's inspiration porn. As for

the projects that have enabled me to be successful, I can attribute many of them to design's ability to reframe issues with clarity and candour. And perhaps to living with HIV, just a little bit.

Formally, I'm trained as an advertising art director, but I've held design

roles across fashion, e-commerce and community health. My undergraduate degree was a hybrid between a graphic/digital design diploma and a marketing strategy diploma, but I didn't finish on time; I got all the way to my senior year and final project, only to drop out in the last semester.

The first time I dropped out was a result of me wishing to connect to my cultural roots. In short, I went to the Philippines for a family reunion, and didn't get back on the plane. A year later, I came back to Canada and attempted my final thesis, only for it to be disrupted again by my HIV diagnosis. I tried again, for the third time, this time informed by HIV. My thesis asked: Did HIV/AIDS advertising do more damage than HIV itself? This project was fun, as it involved exploring over 25 years of HIV advertising with young adults living with HIV. I used their anonymous submissions to start a group discussion, and turned many of their comments and concerns into illustrations for my final thesis.

As I write this, I'm now nearing the end of a Master of Design program. This



social service settings. I now recognize that my feelings of doubt were actually positive signs, which showed I was moving into uncharted territory.

Design activism is the process of using design-based thinking outside of commercial venues, for the purpose of social change. My master's thesis

*Design activism is the process of using design-based thinking outside of commercial venues, for the purpose of social change.*

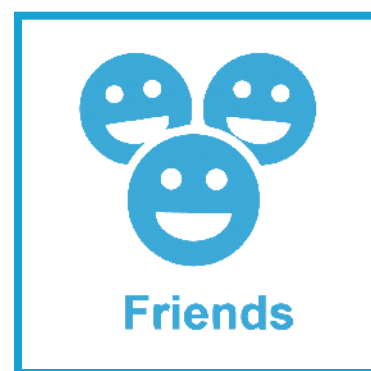
journey has been exciting—along the way, I have been invited to give talks in Toronto and Paris—but I've had many doubts about whether I chose the right path. At one point, I almost dropped out of my current program because I didn't feel I belonged, as I wasn't designing chairs, tables or objects. Instead, I was focused on applying design activism to

focused on how it can inform social service design for LGBTQ people living with episodic and invisible disabilities. To accomplish this, I used three different research methods to understand the differences between how HIV organizations and their users establish priorities and make decisions. First, I measured both groups' familiarity with terms and concepts like design activism. Then, I gave cameras to my participants and asked them to document their experiences within the healthcare system. Finally, I gave each group a deck of cards with various symbols (pictured) along with a scenario about a person newly diagnosed with an episodic disability. I then asked them to sort the cards according to what the person's next steps should be. I also asked whether anything was missing from the deck.



My research uncovered telling information about the differences between the two groups, because it allowed members of each group to describe their decision-making processes in tangible ways. This revealed problems and pinpointed opportunities for improvement. When I compared their answers, I discovered that services are often designed according to the limitations of service providers instead of around the needs of service users. For example, users needed service organizations to address barriers such as poverty and racism. I also found that a power imbalance exists between the two groups because service providers are the "experts" who know how the system works, but they don't always pass this knowledge on to service users. This creates a kind of forced dependency.

Service users expressed concern that their access to programs is controlled and monitored by gatekeepers, which can prevent them from passing along critical feedback; if they do so, they fear that services on which they have become dependent will be withdrawn. To remedy these and other problems, I believe users should co-design services, so that providers can't design services around their own limitations or use evaluation methods that generate only positive results.



If design techniques like card sorting are implemented, I'm confident that service users can co-create solutions that address their true needs and re-establish their autonomy. It's worth cautioning, though, that these participatory techniques need to be

carried out in ways that don't exploit or violate the privacy of service users.

Before my thesis, I worked on several other research-based projects, even though I didn't view them as research at the time. These were also collaborations with other Toronto-based creatives. Our first project was *Surveillance of the Body* (2016), a public life-drawing class for queer and trans youth held at Toronto's nude beach, Hanlan's Point. Rather than just the model being naked, though, everyone was naked. In these sessions we discussed issues around body image and how we negotiate our own bodies while simultaneously judging others and

ourselves. We wanted to subvert traditional power dynamics and comment on the male gaze and art institutions, but eventually we started jokingly referring to the project as being about the male "gays," since we'd focused too much on gay men.

Shortly afterwards, we named our group as Softball Collective, and produced another project: *Turnip Time Machine* (2017). We decided to address the limits of sexual health education, and thought it would be interesting if HIV history, activism and sexual health were taught in a kitchen. We did so through a pickled turnip workshop, given the similarities between fermentation and HIV (both

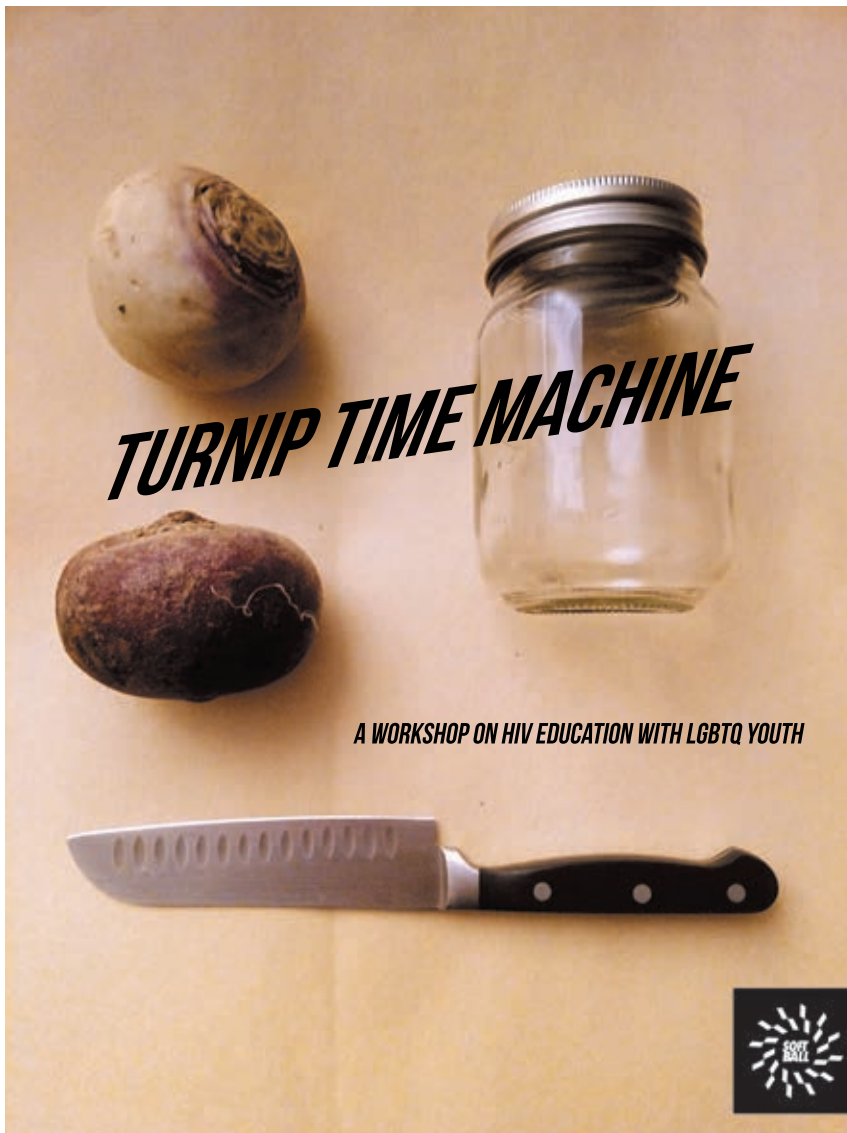
are biological phenomena that change through time, and they're shared across many cultures). Kitchens also



involve various guidelines for safety and effectively support communication within their environment, and we felt both of these features were mostly lacking in today's HIV education. Our most recent project, *Disposed* (2019), was an online mini-documentary that focused on the phenomenon of "ghosting," looking at how queer people build and dispose of relationships.

Collectively, we designed, co-designed and used co-creation techniques to facilitate storytelling. Using a combination of design and art, we enabled participants in our projects to tell hidden, agonized and untold stories. Power dynamics and the ability to produce evidence were a recurring theme across these works. These approaches led me and our participants to question the limits of evidence-based approaches, especially in cases when the evidence created is controlled by a select few.

As I move forward in my life and career, I hope to continue to use design techniques to examine power dynamics and to disrupt the status quo. I can see myself working in public policy because policy analysts often use the same techniques that designers do to collect and analyze data and to think through problems. I want to work for an organization that is comfortable when research points to uncomfortable truths. Why can't I talk about those things? That's always been my attitude, because that's how problem-solving begins. +



## CONTRIBUTE

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**IMPORTANT:** Decisions about particular medical treatments should always be made in consultation with a qualified medical practitioner knowledgeable about HIV-related illness and the treatments in question.

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