

LINGERING

Issue 14

The Society for the Diffusion of Useful Knowledge

January 2023



Shan Kelley, *Counting every day, makes everyday count*, 2020, acrylic on geotextile. COURTESY THE ARTIST.

linger (v.)

c. 1300, *lenger* "reside, dwell," northern England frequentative of *lengen* "to tarry," from Old English *lengan* "prolong, lengthen," from Proto-Germanic **langjan* "to make long" (source also of Old Frisian *lendza*, Old High German *lengan*, Dutch *lengen* "to lengthen"), from **langaz-* "long" (see long (adj.)).

Intransitive sense of "delay going, depart slowly and unwillingly" is from 1520s. Meaning "remain long in sickness, be near death for a time" is from 1530s. It shares verbal duties with *long*, *prolong*, *lengthen*. Related: *Lingered*; *lingerer*; lingering.

The Society for the Diffusion of Useful Knowledge is a serial broadsheet publication produced by the Blackwood, University of Toronto Mississauga. Initiated in conjunction with *The Work of Wind: Air, Land, Sea* in 2018–19 to expand perspectives on environmental violence through artistic practices, cultural inquiry, and political mobilization, the SDUK continues as a signature triannual Blackwood publishing initiative in 2023.

Reflecting the Blackwood’s ongoing commitment to activating open-ended conversations with diverse publics beyond the gallery space, the SDUK serves as a platform for varied forms of circulation, dispersal, and diffusion. The series shares interdisciplinary knowledges; terminologies; modes of visual, cultural, and scientific literacy; strategies for thought and action; resources; and points of connection between local and international practices—artistic, activist, scholarly, and otherwise—during a time increasingly marked by alienation and isolation. Distributed free-of-charge as a print publication, and available through a dedicated reading platform on the Blackwood website and as a downloadable PDF, the SDUK engages a diffuse network of readers and contributors.

THE SOCIETY FOR THE DIFFUSION OF USEFUL KNOWLEDGE (SDUK)

The Society for the Diffusion of Useful Knowledge (SDUK) composes and circulates an ecology of knowledge based on the relationship and antagonism of “useful” ideas. The name of this innovative platform is borrowed from a non-profit society founded in London in 1826, focused on publishing inexpensive texts such as the widely read *Penny Magazine* and *The Library of Useful Knowledge*, and aimed at spreading important world knowledge to anyone seeking to self-educate. Both continuing and troubling the origins of the society, the Blackwood’s SDUK platform asks: what constitutes useful knowledge? For whom? And who decides?

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Charming Life/Troubling Death

Shan Kelley

In a pharmacy aisle, a figure holds up a pill organizer still in its packaging. From this perspective, the abbreviations denoting different time slots—morning, noon, evening, and bedtime—are brought into sharp focus. While the name of this piece, *Counting every day, makes everyday count* echoes a cliché adage, it also readily transforms the pillbox into a memento mori, promptly reminding viewers of their mortality.

Paintings featured on the cover and within this issue are part of the series *Charming Life/Troubling Death* (2020–21) by conceptual and mixed-media artist Shan Kelley. Through different representations of pill-

boxes and moments of slumber, the artist reframes sickness by reflecting on mundane daily rituals. As with *Counting every day [...]*, the titles in this series insinuate an inner monologue or intimate dialogue, suggesting how time, medication, and intimacy are closely intertwined within the context of chronic illness.

I saw in you, reflection of a million stars that pierced and filled me of countless ways to dream and feel complete (p. 28) depicts a figure in bed, wearing a drawstring hood pulled tightly around the face, leaving only a small opening for air. Within their cocoon, they breathe, sleep, and dream. *I saw in you [...]* is a portrait of anyone who

has ever been sick, though coloured by the specific cycles and experiences of chronic illness.

For the last decade, Kelley has drawn from his experience being HIV positive to inform his practice. Past works address his encounters with oppressive surveillance and over-medicalization imposed by the healthcare system, fear and judgement from friends and acquaintances, and negative stereotypes about the virus perpetuated in the media. Kelley’s work creates a personal counter-narrative to public misconceptions and stigma surrounding people living with and impacted by HIV/AIDS.

How to Read this Broadsheet

Our fourteenth SDUK broadsheet, *LINGERING*, follows and complements *WISH YOU WERE HERE, WISH HERE WAS BETTER*, a mobile public event series presented by the Blackwood that made space “for people impacted by the ongoing overdose crisis—and its cascading systemic issues of precarity, houselessness, and criminalization—to mourn, while providing opportunities to imagine and work towards a more just future.” Throughout this broadsheet, contributors *linger* with these sociopolitical issues, among others. They navigate complex emotions like grief, joy, and mourning while developing vital forms of activism; celebrating disability and queerness; shaping institutions; or finding poetry in everyday life.

But how do we “work towards a more just future”? **What kinds of methods and practices are necessary to navigate across difference?** A contribution from the What Would an HIV Doula Do? collective (p. 11) roots their own approach in inquiry—sharing ponderous, critical, and rhetorical questions that explore consent practices. Fady Shanouda, nancy viva davis halifax, and Karen Yoshida (p. 18) employ a methodology of listening and recording—oral history—in their emerging archive of disabled Canadian art practices. For Craig Jennex, the queer nightclub and dance floor serve as potent collective spaces, shaped by desire and longing (p. 6).

This issue’s focus on the overdose crisis prompts reflections on drug policy within and beyond Canada. **How does the overdose crisis provoke urgent resistance to the longstanding war on drugs?** Matthew Bonn (p. 4) writes of the varied strategies employed by people affected by the crisis, led by people who use drugs and mothers of individuals lost to overdose. Tamara Oyola-Santiago chronicles the mobile harm reduction practices of Puerto Rican activists in New York City (p. 13), while Jeffrey Ansloos and Karl Gardner (p. 26) reflect on the misuses of harm reduction that obfuscate its radical roots, while echoing the call for police abolition.

With the healthcare system strained by multiple forms of upheaval, **how are its institutions—and the people who shape them—adapting to increased pressure?** A conversation with Rasheen Oliver and Kimone Rodney of Homeless Health Peel (led by Mya Moniz, p. 9) shares how their organization was founded in response to COVID-19, and its continued operations beyond the pandemic’s worst phases. With parallel focus on local initiatives, Emily Cadotte examines doctors’ advocacy responses to the critical issues affecting their profession (p. 29).

Amidst the grave effects of the overdose crisis, the scope of collective grief and mourning has increased in magnitude.

How can grief be lasting, healing, and transformative? “A Good Death” (p. 22) shares diverse responses from four death doulas, who recount ways of normalizing death, planning for it, and claiming time to grieve. An essay and soundwork by Mourning School (p. 20) links grief to speech, sharing experimental ways for lamenting, sounding, and voicing death.

Beyond extraordinary forms of loss, **what are everyday strategies for living with our own illnesses and those of loved ones?** Lynn Crosbie’s poems (p. 24) trace the contours of day-to-day life while caring for her father following a stroke, while Shan Kelley’s paintings (cover and p. 28) magnify the daily routines of living with HIV. Brothers Sick (p. 15) meld personal experiences of chronic illness with their politicized effects, referencing activist slogans and banners in their artworks.

Inside this broadsheet, you’ll also find a postcard—one in a series of six produced for *WISH YOU WERE HERE, WISH HERE WAS BETTER*. Engaging with histories of AIDS activism that employ printed matter, these postcards serve as a takeaway offering for participants and visitors. Visit the Blackwood website to learn more about the project, and to see additional content from this issue, including Mourning School’s soundwork and a Spanish translation of Tamara Oyola-Santiago’s contribution.

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“Every Death a Policy Failure”: The Other Public Health Crisis

Matthew Bonn

Canada has been in the worst public health crisis it's ever seen, years before the COVID-19 pandemic emerged.¹ This is the “other” public health crisis, overshadowed by the pandemic and ignored by the general public: a crisis that has left families devastated and looking for answers. A crisis that has been used for political gain, yet left abandoned when real changes were possible. This is a public health crisis that has personally impacted me: I've been forced to procure toxic and poisonous drugs and to be criminalized for using them, even though I don't drink or consume legal substances. If you know what I'm describing, then I apologize because you've likely been impacted by it too. This is Canada's worst public health crisis, far more stigmatized and discriminated against than any others.

Here is an inside look at Canada's overdose crisis.

From January 2016 to March 2022, there have been 30,843 opioid-related deaths, referred to here as overdose deaths. Since the onset of the COVID-19 pandemic, there was a 91% increase in these deaths. In reality this is a drug poisoning crisis that has claimed the lives of over thirty thousand Canadians, yet very little policy action has been taken.² Even though the majority of these deaths have been in the west of Canada, causing disastrous and catastrophic harm to provinces such as British Columbia and Alberta,^{3,4} Ontario⁵ has also endured lasting and significant harms because of the overdose crisis. What about all the other provinces? What have they experienced? As a Canadian living on the east coast, I can say that every province has been impacted by this crisis, and nearly everyone has experienced some sort of loss due to the contamination of our drug supply.

The government of Canada has created an interactive epidemiological map to display and track these deaths—but what have they done to effect positive change to start saving the lives of some of the most marginalized and discriminated-against citizens?

While political parties continue to drag their heels on implementing demands for policy changes such as decriminalization and safe supply, multiple Canadians die from a toxic unregulated drug each day. Every time someone dies from poisonous

drugs, a family is broken to pieces. In response, unique non-governmental organizations such as Moms Stop the Harm have organized to fight for a wide-level system change, to once and for all end Canada's overdose crisis. Moms Stop the Harm is defined as a “network of Canadian families impacted by substance-use-related harms and deaths.” They “advocate for the change of failed drug policies, provide peer support to grieving families, and assist those with loved ones who use or have used substances.” Sadly enough, during this crisis, they have had an increasing number of new members signing up to change a failed system.

Will politicians listen to these grieving mothers? I hope so.

If they don't listen to family members, will they listen to people who use drugs? Will politicians continue to be able to look into the eyes of—not only mothers grieving the loss of loved ones—but also some of the most dedicated, passionate, and resilient citizens who are set on ending the overdose crisis?

The Canadian Association of People who Use Drugs (CAPUD) has been around a little bit longer than Moms Stop the Harm, but the two organizations have led the fight together for progressive Canadian drug policy over the last few horrific years. CAPUD, which I'm a part of, is defined on their website as a national organization composed entirely of people who use or used drugs, including board members and staff.⁶ They empower people who use drugs currently deemed illegal to survive and thrive with their human rights respected and their voices heard. They envision a world where drugs are legally regulated and the people who use them are not criminalized. CAPUD is structured to have diverse representation from people most directly impacted by the overdose crisis: the organization's board includes members from all over Canada, and the staff are located in Dartmouth, Nova Scotia. As an organization of people who use illegal drugs and have witnessed their communities die, CAPUD's coast-to-coast scope shows just how many people are impacted by this crisis. These are some of the most brave and courageous advocates, fighting for long-term policy change by admitting that the substances they choose to use are criminalized.

If it wasn't for organizations like CAPUD or Moms Stop the Harm, our drug policies in Canada would be as archaic as when drug prohibition started. We may not have the progressive policies advocates are demanding, but some positive change has taken place. Canadian law has mechanisms to “exempt” drugs from the Controlled Drugs and Substances Act, such as Health Canada's exemption bureau. When an organization applies to run an overdose prevention site⁷ or a supervised consumption site,⁸ they apply directly to the federal government for an exemption, which permits drugs that are procured on the unregulated market to be consumed safely and with others present at a stand-alone brick-and-mortar site. To this day, there hasn't been a recorded overdose death in one of these facilities.⁹ Frontline staff are trained to respond to overdoses with rescue breathing or naloxone. Naloxone has been an extremely effective tool in the fight against the overdose crisis, as it reverses opioid overdoses when responded to in a timely manner.

There isn't one silver bullet in the fight against the overdose crisis, but there are long-term policy changes that need to be implemented to allow us a realistic chance against the unregulated toxic drug supply. These include structural policy changes such as implementing patient-centred safe supply,¹⁰ and decriminalizing everyone who uses drugs.

A safe and regulated supply of one's drug of choice informs the consumer of its quality and quantity, reducing the unintentional harms caused by contamination. This concept was coined by CAPUD, which defines safe supply as a legal and regulated supply of drugs with mind- or body-altering properties that have traditionally only been accessible through the illegal unregulated drug market. This concept has been ramped up in practice across the country, including appearing in peer-reviewed studies coming out of British Columbia, Ontario, and Nova Scotia.^{11, 12, 13} While Health Canada's Substance Use and Addictions Program¹⁴ has funded multiple safe-supply programs, healthcare practitioners and providers have increased medical safe-supply prescribing practices since the COVID-19 pandemic.

Safe supply is an intervention; it is not the solution. People who use illegal and unregulated drugs are still at risk of the

structural and social harms experienced by the criminalization of drug use. Safe supply should be scaled up and several models need to be implemented such as injectable opioid agonist therapy and compassion clubs.^{15, 16} People who use drugs are not homogeneous—they come from diverse backgrounds and use drugs in different ways.

Advocates calling for a safe supply, for the most part, have also been demanding decriminalization of drug use. While some political parties support this, our federal government in power still wants more data and research. Therefore, they granted British Columbia a temporary exemption¹⁷ under the Controlled Drugs and Substances Act, subsection 56.1, the same section that allows overdose prevention sites and supervised consumption sites to operate. This exemption was put together quickly, and has fundamental flaws, such as a threshold amount of 2.5 grams. Additionally, benzodiazepines are not included in the exemption (despite the radical shift in the drug supply in British Columbia that has been saturated with novel psychoactive benzodiazepines¹⁸ such as etizolam and flurazepam), and it is only offered in a three-year time slot. This exemption should be granted for at least five-year intervals with options to renew, and offered to any provinces willing to decriminalize drug use, since it is federal drug laws that criminalize people.

It's not just people who use drugs and their family members whose voices we need to hear. If Canada is ever to fully implement safe supply and drug decriminalization, we need every stakeholder at the table demanding the human rights of

every citizen be upheld, regardless if they use currently criminalized drugs, to reinforce the idea that which drugs are criminalized and which aren't is arbitrary. Sometimes this calls for the general public to support people who use drugs and their families at the local drug policy rally. Sometimes it means taking the lead through other forms of advocacy, such as letter writing to politicians or journalism in national or local media. You never know who you may reach by writing your truths in the opinion section of your local newspaper. There are also media outlets dedicated to shifting drug policy, such as *Filter*, an online publication¹⁹ based in New York that amplifies the voices of people who use drugs and work in drug policy all over the world. *Filter* was launched in 2018 and their mission is to advocate through journalism for rational and compassionate approaches to drug use, drug policy, and human rights. Publications like *Filter* have a sustainable and lasting impact by highlighting what's happening with the war on drugs in other regions and jurisdictions.

Through *Filter* I have met people around the world doing the same work that I do, fighting chaotic drug laws. If I'm not writing a piece for *Filter*, then I'm reading someone else's or commenting for an up-and-coming drug policy journalist. This is one of many ways people can get involved in changing the narrative on drug use.

People have altered their state of mind since the beginning of time, and we're not going to stop! The criminalization of drug use has not slowed human drug consumption. Every death caused by a toxic unregulated drug devastates families and

loved ones. The overwhelming amount of grief and trauma experienced by this community needs to be considered, and we need to do everything we can to support this marginalized population.

I have experienced the structural and consistent harms of the toxic drug supply. I have overdosed multiple times from not only fentanyl, but also the new wave of the drug supply that has seen an increase of tranquilizers and benzodiazepines. Just because I like altering my state of mind and shutting it off once in a while doesn't mean I want to die. I need a regulated drug market, just like how the rest of society has the luxury of buying alcohol of known quality, quantity, and purity. I also need to know that I'm not being criminalized for a drug that I decide to use or not. It's my body; it's my choice.

I use drugs, but that's just one part of my identity! I'm a researcher, an advocate, and a journalist. I have seen the power of what advocacy can do and I'm convinced that this overdose crisis isn't going to end until long-term drug policy measures such as safe supply and decriminalization are implemented and in place for everyone who uses drugs in Canada.

I won't stop advocating until we have a comprehensive regulated drug market.

I won't stop advocating until all drugs consumed are not criminalized anymore.

We need to empower the voices of people fighting for this cause. Too much harm and havoc has already been caused by the toxic drug supply and the criminalization of drug use.

1 Government of Canada, “COVID-19: Outbreak update,” accessed November 14, 2022, <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html>.

2 Government of Canada, “Opioid- and Stimulant-related Harms in Canada (September 2022),” accessed November 14, 2022, <https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants>.

3 British Columbia Government News, “Ten thousand lives lost to illicit drugs since declaration of public health emergency,” August 16, 2022, <https://news.gov.bc.ca/releases/2022PSS0056-001250>.

4 Government of Alberta, “Substance use surveillance data,” accessed November 14, 2022, <https://www.alberta.ca/substance-use-surveillance-data.aspx>.

5 Public Health Ontario, “Interactive Opioid Tool,” accessed November 14, 2022, <https://www.publichealthontario.ca/en/data-and-analysis/substance-use/interactive-opioid-tool>.

6 Canadian Association of People who Use Drugs (CAPUD), “Nothing About Us Without Us,” accessed November 14, 2022, <https://www.capud.ca>.

7 Bruce Wallace, Flora Pagan, and Bernadette Pauly, “The implementation of overdose prevention sites as a novel and nimble response during an illegal drug overdose public health emergency,” *International Journal of Drug Policy* 66 (2019): 64-72.

8 Brandon D.L. Marshall et al., “Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study,” *The Lancet* 377, no. 9775 (2011): 1429-1437.

9 Bernadette Pauly et al., “Impact of overdose prevention sites during a public health emergency in Victoria, Canada,” *PloS ONE* 15, no. 5 (2020): e0229208.

10 Patient-centred safe supply involves medication that is desired by the patient for euphoric purposes. Patient-centred prescribing emphasizes and amplifies patients' voices and healthcare outcomes. This is extremely important when discussing safe supply.

11 Ryan McNeil et al., “Implementation of Safe Supply Alternatives During Intersecting COVID-19 and Overdose Health Emergencies in British Columbia, Canada, 2021,” *American Journal of Public Health* 112, no. S2 (2022): S151-S158.

12 Tara Gomes et al., “Clinical outcomes and health care costs among people entering a safer opioid supply program in Ontario,” *Canadian Medical Association Journal* 194, no. 36 (2022): E1233-E1242.

13 Thomas D. Brothers et al., “Evaluation of an emergency safe supply drugs and managed alcohol program in COVID-19 isolation hotel shelters for people experiencing homelessness,” *Drug and Alcohol Dependence* 235 (2022): 109440.

14 Government of Canada, “Substance Use and Addictions Program,” accessed November 14, 2022, <https://www.canada.ca/en/health-canada/services/health-concerns/controlled-substances-precursor-chemicals/policy-regulations/policy-documents/exemption-personal-possession-small-amounts-certain-illegal-drugs-british-columbia/subsection-56-1-class-exemption-adults-18-years-age-older.html>.

15 British Columbia Centre for Substance Use, “Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder,” accessed November 14, 2022, https://www.bccsu.ca/wp-content/uploads/2021/07/BC_iOAT_Guideline.pdf. Injectable opioid agonist treatment is given to patients who have had a hard time with normal opioid agonist treatment medications such as methadone or buprenorphine. It's given to patients with severe opioid use disorder to inject a safe sterile medication such as diacetylmorphine or hydromorphone.

16 British Columbia Centre for Substance Use, “Heroin Compassion Clubs,” accessed November 14, 2022, <https://www.bccsu.ca/wp-content/uploads/2019/02/Report-Heroin-Compassion-Clubs.pdf>. A compassion club is where people who use drugs pool their money together to procure and test large quantities of drugs.

17 Government of Canada, “Subsection 56(1) class exemption for adults in the province of British Columbia to possess small amounts of opioids, cocaine, methamphetamine and MDMA,” accessed November 14, 2022, <https://www.canada.ca/en/health-canada/services/health-concerns/controlled-substances-precursor-chemicals/policy-regulations/policy-documents/exemption-personal-possession-small-amounts-certain-illegal-drugs-british-columbia/subsection-56-1-class-exemption-adults-18-years-age-older.html>.

18 Jon Hernandez, “Benzodiazepines found in 55 fatal overdoses in July as contamination mounts in B.C.,” *CBC News*, September 23, 2022, <https://www.cbc.ca/news/canada/british-columbia/benzodiazepines-55-fatal-overdoses-july-2022-bc-1.6592193>.

19 *Filter*, <https://filtermag.org>.



Elmgreen & Dragset, *(Un)Lucky Strike*, 2008. Installation view, *Elmgreen & Dragset - Biography* at the Astrup Fearnley Museum of Art, Oslo, 2014. PHOTO: ANDERS SUNE BERG. © ELMGREEN & DRAGSET / SOCAN (2022)

Queer Collectivity in the Echoes of the Dance Floor

Craig Jennex

I cautiously move heavy chains that hang over a doorway and peer inside at the dim space beyond, squinting to see what I'm getting myself into. It's so dark in there that I cannot tell if anyone else is inside. I shuffle forward, with my hands in front of me, attempting to feel my way into the space. The anxiety I feel walking into the darkness is intensified by my inability to speak the language of the country I am in. If anyone is inside, or comes in after me, I will simply smile and nod like I have been since I arrived here months ago.

As my eyes adjust, I start to get a better sense of the room. To my right, there's an unstaffed bar littered with empty beer bottles and drink glasses, depleted vials of poppers, and heaps of cigarette butts overwhelming small ashtrays. Ahead of

me, in the far corner of the room, a disco ball has fallen from the ceiling and shattered next to a dirty red sofa and some small coffee tables. Broken glass and pieces of mirror glisten on the floor. Barely-illuminated, larger-than-life images of naked go-go boys hang on the walls that surround me. I step on a crumpled poster, pick it up off the floor, and flatten it enough to read the text: "TOO LATE T-DANCE @ The Mirror. Sunday, March 16, 18:00-23:00." It's mid-May; I am almost two months late for the party. All that remains are traces of the night. The jangling chains that I left in my wake as I entered the room finally still, and the calm, ethereal sounding electro folk song that has been playing fades to silence. In the silence, I hold my breath and wait. A few seconds later, the same song begins again.

Jarringly, two middle-aged white women push through the heavy chains behind me. The swinging chains are loud but are overshadowed by the sounds made by the women themselves—they hold onto each other and giggle as though they are being pushed through a haunted house. They holler at each other but I don't know what they're saying. One notices the images of the go-go boys on the wall and shrieks. Her friend takes a photograph—the bright flash from her camera fills the space; they both laugh. Then they turn, walk down a small hallway and back through the heavy chains. They return to the brightly lit lobby of Oslo's Astrup Fearnley Museum of Modern Art. I am once again alone, lingering in the empty bar space that is at once foreign and yet somehow familiar.

This sequence happens often: strangers tentatively enter the space, look around for a minute or two, get the gist of the installation, giggle, shrug, or scoff, and then leave again. But I sit in the space for over an hour. Some of the visitors notice me in the dark and some do not. One man points at me and whispers something to the person he is with. I get the sense that they think I'm part of the installation. One of the other installations in this exhibition features a live performer, so their interpretation of me is understandable. In this setting, I play the role of a real live gay man who couldn't find someone to go home with when the dance ended months ago. In the space, I am stuck in time, too late for the party and the experiences I may have had there but refusing to accept it. They watch me, alone and still, basking in the echoes of what I imagined I missed and what I continue to miss.

I stay because I find the space inviting. I've been in Oslo for months now but have not built the courage to visit one of the city's queer bars alone. Being in this space feels like a step in the right direction—today, this artists' rendering; tomorrow, a real gay bar. The song, which I've heard repeat dozens of times by this point, also adds to the comfort and familiarity of the space. It's in English and repetitive. Before long I know the song structure and lyrics and each additional hearing confirms its familiarity. But this familiarity is framed in its inaccessibility, as the refrain keeps reminding me: "it's over, it's over, it's over, it's over..."

When I eventually leave the installation and find my way to the gift shop, I learn

that the song is entitled "Too Late." It's performed by Michael Elmgreen and Ingar Dragset—the two artists whose exhibit *Biography* is on display at the museum—along with Simon Fujiwara (who also goes by the moniker "Asia Today" for solo and collective musical projects). Like most of the other elements of *Biography*, the queer sensibility of the song is not subtle. Lyrics sung by masculine-coded voices reference "college boys...quoting gender theory," the "salty taste / left in after giving head," and evoke golden showers twice in the opening verse. The song references queer potential in public experiences of sex and sex work.

The lyrics of the song suggest the impossibility of a return to queer pasts. "It's over," the lyrics repeatedly contend, and we are too late. What's worse, the vocalists tell us, is that "you thought it'd never end," making the impossibility of return all the more difficult to handle. The lyrics are captivating—a nostalgic reflection on the complex opportunities that blossom in a dark room—but it seems to me that the queer work being done by this song is most salient in specific musical details of rhythm and musical temporality. The song—and the installation it is part of—plays with listeners' sense of time and seems to open up the possibility of alternative temporal experiences. It is not simply that we are "Too Late," in arriving at the bar long after the party has ended, but that the desire to linger in what has passed is made impossible by the musical structure of the song.

There are multiple rhythmic devices used to pull listeners in, attempting to lull them

into a state of nostalgic longing in the present, and then immediately disallowing that possibility. Throughout the piece, vocal lines enter a full beat before the phrase begins, serving as an anacrusis (or "pick up") into the section that follows. As a result, and despite the blasé delivery of the lyrics, the vocal lines have the effect of moving the song—and the listener—forward rather deliberately. Oddly-framed musical phrases mean that listeners' efforts to luxuriate in each verse are frustrated by the entrance of the chorus. While the verses are framed in five-bar phrases, the chorus unfolds in more conventional groupings of eight. While the choruses might, in this respect, seem like an act of temporal normalization, the addition of two bars of 6/4 time elongates the section's musical temporality and simultaneously shakes the foundation of 4/4 time to which listeners have become accustomed. You can linger, all of these choices seem to suggest, in your desires to access this past—but you can never get there. So what's the point?

The song "Too Late"—and its complicated temporality—is emblematic of the broader musical experiences that allow us to linger in and alongside queer musical pasts. As it makes clear, we may be too late—that is, in fact, the primary meaning of the song and the installation in which it is performed—but we are here now, and we can be inspired by listening closely to and basking in what is left behind. As we experience the present and imagine the future, the echoes of the past matter.

Queer dance floor experiences of the past can continue to offer possibility in the



Elmgreen & Dragset, *Too Late*, 2008. Installation view, *Elmgreen & Dragset - Biography* at the Astrup Fearnley Museum of Art, Oslo, 2014. PHOTO: ANDERS SUNE BERG. © ELMGREEN & DRAGSET / SOCAN (2022)

present. Indeed, when we embrace music's ability to elicit collective experiences of lingering, we bind ourselves to historical echoes and the individuals moved by them in the first place. One thing that makes these experiences of dance floor bliss so profound is that they are simultaneously individual and collectivizing—they feel so personal yet they necessarily tether us to others. Perhaps contemporary queerness is less about an identity claim or a series of acts in the present—maybe it's about how we linger in and with the queer past. Perhaps it is this history and our ongoing orientation to it that allows us access to the radical potential of queerness today.

Outside of the art gallery, there are multiple contemporary experiences of musicking that challenge the normative framing of the past as distant, distinct, and fruitless; these experiences re-embrace past dance floors as sites of queer world-making. In Toronto, Balls Deep Disco at the Black Eagle returns us to the dancing and cruising practices of the past under the guidance of resident DJ Kris Steeves. Other local dance parties embrace the queer dance floor as a site of collective potential with a vital performative force.

Crip Rave, created by Renee Dumaresque and Stefana Fratila, prioritizes dance floor access and bliss for crip, disabled, deaf, mad, and sick individuals. Strapped, a dance party that centres women of colour and non-binary people of colour, worked with Toronto's Club Quarantine to move dance parties online at the start of the pandemic. As Strapped organizer Marisa Rosa Grant tells *Toronto Life* in 2020: "What I love about the queer community is that we always find a way to party."

These events reference histories of queer dance and collective formation while simultaneously positing a better, queerer future. They remind us that queerness, as a concept, is at its most promising when it is embodied, collective, and expanding—when it signals something not-yet-here, but something worth reaching for and moving toward. This is why dance floor collectivity is so important both in a broad sense—in creating queer possibility within a social world that is conditioned by cis- and hetero-normativity—and within LGBTQ2+ communities that often mimic the very exclusions we repudiate in broader society. The queer dance floor can allow participants access to feelings, possibilities, and fleeting moments of collective bliss

that can radically reshape our understanding of the world and our place within it.

Another Toronto-based dance party similarly turns to the past to imagine a queerer future. SUDS—a dance party inside a bathroom—references the popular Continental Baths in New York City and the gay bathhouses of Toronto's past in its advertising. SUDS is also reminiscent of the queer dance party SOAP, hosted by Toronto's Gay Community Dance Committee (GCDC) in 1982 one year following the infamous Toronto bathhouse raids. Thousands attended this fundraising dance party in the early 1980s, which served as both an opportunity to dance and an opportunity to remember—and resist—organized police violence and harassment. Contemporary dance parties like SUDS encourage participants to embrace dance and sex as continued processes through which queer connections and collectives are formed. SUDS is not just an opportunity to dance and cruise and be with others, it's also an opportunity to linger—to bask in the echoes of the queer past—and to imagine what is possible in the fading light of the past and present.

A few weeks after visiting Elmgreen and Dragset's *Biography* exhibition, I finally mustered the courage to visit a gay bar in Oslo. Just before midnight, I walked to the venue that I had researched online for months. I'm not sure if the persistent glow of twilight in the city in early July made me more or less confident as I walked through the city streets alone, but it certainly recalled my experience at the museum of moving from the brightly lit straight world into a dark space rife with queer possibilities. After months of anticipation, I finally arrived at a gay bar.

Ultimately, I didn't stay long. The drinks were horrifically expensive and most of the gorgeous, tall, slender men on the dance floor showed little interest in the chubby Canadian smiling and nodding awkwardly in the corner. But for a few songs, I joined the dance floor collective and moved to the music. In the moment, I considered myself lucky that queer dance practices seldom require dance floor partnerships—that the dance floor can swallow up individuals into a collective body.

Despite my disappointment that the venue didn't live up to the high hopes I had fabricated for months prior, this brief moment on the dance floor reminded me that I'm not too late. We are not too late. The possibility of queer bliss on the dance floor has existed for generations and will continue for as long as we recognize the collective potential of such sites. Lingering, in this case, is not an attempt to reconstruct and return to a past but a practice through which we can remember and revive the experiences that existed therein. Lingering on the queer dance floor creates the conditions for queer kinship: an opportunity to convene in embodied and affective ways, to move to the pulsating rhythm on and of the dance floor, and to connect—across time—to queer movements of the past.

Nowhere to Isolate: Homeless Health Peel in and beyond the Pandemic

Rasheen Oliver, Kimone Rodney, Mya Moniz

Homelessness in Hiding is a podcast that discusses youth homelessness in Peel Region and elevates the voices of people with lived experience while highlighting social service workers on the frontlines. This conversation addresses the gaps in healthcare that complicate access for a person experiencing homelessness, and highlights the importance of providing coordinated services from trained nurses specialized in trauma-informed care for people of all ages. *Homelessness in Hiding* is produced by the Restoration and Empowerment for Social Transition Centres (REST Centres), an organization that combats housing insecurity among BIPOC youth in Peel. In this episode, producer and host Mya Moniz is joined by Rasheen Oliver, Director of Operations, and Kimone Rodney, Nurse in Charge, at Homeless Health Peel. Founded in 2020 in response to the COVID-19 pandemic, Homeless Health Peel provides coordinated access to healthcare for people experiencing homelessness in the Region. This is an edited and condensed version of *Homelessness in Hiding* episode 5, first released March 25, 2022.

Mya Moniz: How did both of you end up working with Homeless Health Peel?

Kimone Rodney: We ended up at Homeless Health Peel when the pandemic happened. They were pulling nurses from

hospitals and community settings to help as they started the isolation program. I loved our philosophy and what we stand for: our value in trauma-informed care, autonomy, and self-determination. I was like, "This is me." At that time, our contract was month-to-month. We literally gave up our full-time job that we had—that had stability—and went into an isolation centre to help our community out when the world was in dire need of nurses. And we went straight forward. That was it. Now, we haven't looked back.

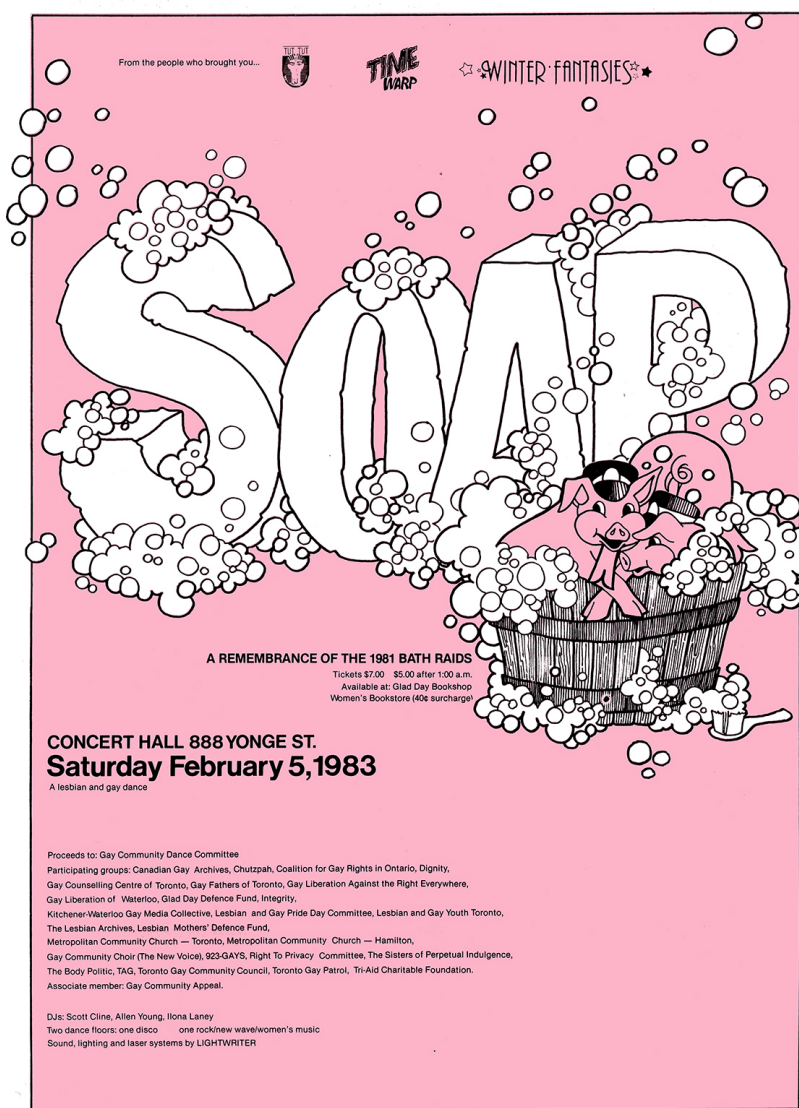
Rasheen Oliver: Not for a moment. I was wrestling with wanting to leave the nursing home. I was yearning to learn more, in my field, within my scope. Coming over and seeing [everything] within the first week of working alongside the nurses, as well as [working with] our Nurse Practitioner, Clinton Baretto, I had learned so much from him and I fell in love with the work. I'm glad that Kim accepted the position and brought me along.

MM: I want to start off by defining what homeless healthcare is and why [it] deserves attention. I have a statistic from the World Health Organization. There are social determinants to health, which they define as "the non-medical factors that influence health outcomes." These factors are often out of one's control such as, "the conditions in which people are born, grow,

work, live, and age," as well as "the wider set of forces and systems shaping the conditions of daily life." That can include things like economic policies and systems, development agendas, social norms, social policies, and political systems. Near the top of the list is "access to stable housing." With these social determinants in mind, my question to you both is: **What is the goal of a coordinated effort to provide homeless healthcare?**

RO: Our goal is essentially to ensure that homeless people have access to healthcare. In Peel, there isn't an agency that provides access, and we're the only region that doesn't have it. So, people are going to hospitals and walk-in clinics to access care. And when they do such things, for lack of better words, there's a lot of hands in the pot. There are a lot of people dealing with the care, and there's no follow-up to [it]. Essentially, what Homeless Health Peel is trying to do is become that agency where people know that they can come to us, and they're able to get these services and we're able to follow [up with them] whether they're in Mississauga or Brampton. We want to have a nurse in every shelter, whichever city they go to, [so] we're able to track their care and assessments.

MM: What makes homeless health its own subcategory of the public sector of health?



Poster for SOAP, a remembrance of the 1981 bath raids. COURTESY THE AUTHOR.

Questions Of, For & About Consent

What Would an HIV Doula Do?

What Would an HIV Doula Do? (WWHIVDD) is a collective who conceptualize ways of better supporting people with HIV while also intervening in the lack of present-day AIDS-related discourse. Considering how there are doulas specializing in birth, abortion aftercare, end-of-life, and gender transition, they ask: how might we imagine a doula for a culture living with HIV? The collective, which has members across the US and in Canada, is named as a question, which is a fundamental feature of their methodology: the questions they ask challenge HIV narratives from personal and political perspectives. This can be guiding, unsettling, confrontational, and liberating. Some questions are rhetorical, others are more pointed, while others operate like statements.

WWHIVDD uses printed matter, PDFs, pamphlets, and zines to share their work, which is all free to download online, and with many of their materials shared in English and Spanish. WWHIVDD actively engages broad local communities, enabling more people to access these resources and contribute to the conversation.

Questions Of, For & About Consent was created initially for a 2016 screening of the short documentary, *CONSENT: HIV Non-Disclosure and Sexual Assault Law* produced by the Canadian HIV/AIDS Legal Network and Goldelox Productions. The titular questions were used to spur on post-screening conversation, and extend it beyond that one-time event, guiding self-reflection on how we learn about consent, HIV, stigma, and the ways testing positive intersects with overlapping oppressions like racism, criminalization, and sexual violence. By asking questions as a processing tool—instead of providing answers—WWHIVDD frames an open-ended dialogue that folds in various levels of knowledge and life experiences. Readers are inclined to fill in gaps of understanding by using the questions to guide further research.

KR: Why do the homeless have to be in [their own] category away from regular population? It infuriates me. What we've noticed at the isolation centre was when patients would go to the hospital for COVID-related symptoms, they weren't seen as patients, but they were put on a bed in the hallway. [Many unhoused people] didn't even have ID, they didn't have health cards, and no one was helping them with that. A lot of them are not on Ontario Works (OW) or Ontario Disability Support Program (ODSP), where [access to] medication and certain [supports] can be built. What the hospital did was send the patient right back out. A doctor never assessed them. They were never seen by a nurse. Just the fact of them being homeless, and they're not getting the same care. It makes me sad that we have to have a subcategory for the homeless. But this is why Homeless Health Peel is here. We're trying to break down those barriers.

MM: How was homelessness healthcare being neglected before, and how has the pandemic made the community aware?

KR: While everybody else had their home, the homeless had nowhere to isolate. Shelters were overcrowded. There are not enough beds...When they came to the isolation centre to isolate and to social distance in order to stop the spread of COVID-19, it wasn't a runny nose, or chills or fever, it was addiction withdrawal that came along too, and a lot of them didn't have their medication with them. We had their mental health, addiction, [and trying to access] harm reduction, [which] we were dealing with in an isolation centre in a hotel.

MM: What are some of the hurdles that an individual experiencing homelessness might face when trying to access healthcare?

KR: In the shelter, there's no one there managing medication. Some of them need to be tapered off certain medication, or some of their medications need to be changed. Some of them have family doctors, but if they don't have OW, or ODSP, they don't have funding to be able to take the bus to their family doctor. If no one is doing follow-up work with them, the cycle continues. I understand that the world was at the mercy of COVID-19, but it really shined a spotlight on what the homeless are facing. It wasn't just a cough, runny nose, and a fever. They were dealing with so much more.

RO: Lack of funds and transportation to get to a healthcare provider. Some of them may be chronically depressed. To get up and go all the way down to Toronto—that's a barrier for them. If you're chronically depressed, you're homeless, you've got a lot of things going against you, do you really want to get on a bus and go all the way down to Toronto or to see a specialist?

MM: How does the Region and broader healthcare navigate an individual who

doesn't have a mailing address, a permanent address, or doesn't have ID?

RO: They shy away from it. ID is a big one. If you don't have a health card and you're going to the hospital, they're asking you these questions: where's your ID? Where's your health card for a clinic? If unhoused people don't have OW or ODSP, the doctor prescribes a medication, but then, they don't have the funds to pay for the medication.

KR: If they don't have the funds to get the medication, nobody even assists them to find out why. A lot of times, it's their OW. Their OW is frozen, it got frozen, or the ODSP got frozen, because they're deemed to be difficult.

RO: Or they are blocked from a different region. For example, they're coming from Toronto, and they're coming to the Region of Peel—their OW was cut off, they've got to reapply for it in this region. What if they need their medication right now? And they have to wait for a whole process: go into the shelter, get a housing worker, fill out the application, but they need it now. [...] It has to be a holistic approach with wraparound services, because it's not only stable housing that they need, but what about their health? What about the pain that they're having? If they're having a lot of pain, and you get them into stable housing, and they're able to pay for [it] but they have so much pain that they have to seek drugs...how long are they going to have that stable housing for? They need that follow-up care.

MM: I want to know more about stigma. What should we watch for?

KR: I think first we just need to look at ourselves, because we all could have made that one bad decision [where we] could have ended up homeless. [At] Homeless Health Peel, we meet [unhoused people] where they're at. For a lot of them, they were working, had a work injury that hurt their back, a doctor put them on Percocet and gave them a whole bunch at once that they abused. That's how they started tapering down. The stigma that's been portrayed out there for the homeless is how they look: "They're addicts, they might rob you, or beat you up." We've worked at the isolation centre with all of them. When they are going through the worst withdrawal you can ever think of, they are very respectful. Never [have] I felt like I was put in a position or a situation where I was going to be harmed or hurt by any of them. Never once, and we've seen hundreds, maybe even thousands of them that have passed through the isolation centre. When you hear someone's telling you, "This is not who I used to be. This is not who I want to be anymore." Asking for help; not receiving the help. It truly does break your heart.

RO: They're not receiving the help because of the way they look. They're perceived as dirty, or people [fear] home-

less people. They're people just like us. They're perceived as criminals. People look down on them. So, they don't get the treatment. Whereas if they were clean, shaved, with clean clothes on, they get treated differently. They're now fearful to go to seek healthcare, because they don't want to be looked upon like that. They'd rather stay amongst the people who they're with, where they're not being judged.

MM: What correlations have you both noticed between individuals experiencing homelessness and their mental health?

KR: The fact that they had to isolate was hard for them. They were in a hotel room by themselves now, and everybody's thinking, "Why are they complaining? They should be fine." But all their traumas are coming back to haunt them. They've always been on-the-go. A lot of times they get into substances to mask what they're feeling. Now, they're not using any substance[s], they're getting cleaned up. All of their traumas come back. They don't know how to internalize what they're feeling. They've never been taught. This is where the urge comes back in to self-medicate. So again, it wasn't just COVID-19 we were dealing with.

MM: I think there's definitely a gap between the shelter and the instant sort of help. [In] thinking about the long term, especially regarding mental health, you've said it: you can't have all these individuals in a shelter for the rest of their lives. They need long-term housing [and] they need long-term healthcare. It's that transitional piece that I've picked up on that is lacking.

KR: But you're on the outside. I completely understand where you're coming from. And this is what everybody sees on the outside, but we're in it, right dead-centre in it. It's not just about one thing; not having access to healthcare, that's a big part of it. But there's so many other things as well. And then, the youth are going into adulthood, and then they're becoming seniors. Alzheimer's and dementia are kicking in. You can't have thirty, forty, fifty, sixty men or women in a shelter that have Alzheimer's and dementia. So, what is the future plan?

MM: How [are you two] feeling regarding the work and how [does] it impact you [physically, mentally, emotionally]?

KR: What frustrates me are the barriers. I've never been affected by a patient. All our nurses get trauma-informed training. That's how we lead. A lot of times a patient gets deep into just wanting to talk; we listen. We're not trained therapists or counsellors. A lot of times you hear a patient say: "You know what, thank you for listening. I haven't had anyone that has listened to me in a long time." That is where [the] majority of my energy goes [as well as] trying to get them their IDs, or trying to get them that 24-hour drug card so

that we can get them back on their medication. A lot of them are on narcotics, we can't just supply them with a seven-day supply of narcotics—their methadone—they have to go to a pharmacy every day to get a daily dispense, because it's an observed dosing. Without funds, without money, without their health card, the pharmacy won't be able to provide them with any of that. It goes really, really deep. What we do at the isolation centre is we just focus on who we have in front of us, and we just take it one at a time. The frustration doesn't come from the patients. I enjoy seeing them. I enjoy our conversations.

RO: I agree with Kim. It's the barriers and the lack of support that they get, and the lack of people's willingness to help them, which goes back to being stigmatized, and then they don't want to go to the people who are supposed to be helping them. There's a thing that we always say in our office, "Stay in your lane." As the nurses, practicing in a trauma-informed way, providing trauma-informed care, we want to be able to give them that wrap-around service, but there's only so much that us as a nurse can do. There are other people that have their roles that they have to do. When you hear the patients saying stuff like, "I don't want to go to them and ask for their help." And they're asking me for the help and it's out of my scope, like getting ID—I don't know how to do it. My frustration is the lack of helping people showing the willingness and the compassion. Where's the compassion? If this is what you're here to do? This is what your role is in helping them...Why can't we get it done? Why can't we work together and get it done for them? Why do they have to wait? People are looking at them like, "Oh, they're homeless. They can wait. It doesn't have to get done right now." No, it does. Because based on other people's work, this is how we complete our work. This is why we all need to be on the same page. Like Kim said, [the frustration never comes from] the patients.

MM: How has the intervention of Homeless Health Peel and coordinated homeless healthcare impacted the community?

RO: It seems like a simple question because we know we've impacted the community in such a positive way. How do we put that into words? We see the outcomes of what we've done. We've gotten people into long-term care facilities, gotten them off the streets, gotten a few people in housing. We've seen positive outcomes. We had a patient that came to us from outreach. He was an elderly man; he was considered palliative, had cancer, and he came into the isolation centre. Through the services that we provided to him, we were able to nurse him back to health. He was able to get up and walk. When he came, he wasn't able to walk that well, wasn't steady on his feet, and needed a commode by him to use the washroom. After a few months, we were able to transition him into long-term care.

MM: From both of your perspectives, where do you want this discussion to go? Where should I and our listeners start?

RO: We'll start with checking ourselves when we come across somebody who's homeless. We [tend to] automatically start stigmatizing, judging, and looking at them differently. It has to start within everybody; you and how you look at them, because they're no different. They were just dealt a bad hand; as such, all of us could have been dealt a bad hand, and could have went down that path. [Take] a chance to speak with these people because they all have stories, and they're heartbreaking stories. How the community can help is by looking at yourselves and how you react when you see a homeless person. Because essentially, that will be a doctor, that will be another nurse, that will be a social service worker, that will be a grocery store clerk. [Everyone] that these people have to deal with, if they are looked at just as if they were clean [and] in proper clothes, they wouldn't face a lot of the barriers. They wouldn't feel like, "I'm scared to go to the hospital because of the way people are going to look at me. I'm scared to go to certain places because of what people are going to say to me." Let's figure out how we can help them to overcome these barriers as a community.

KR: To add to Rasheen, COVID-19 had shined the spotlight on what's happening in terms of the barriers that the homeless are facing, but I think, whether COVID-19 is dying down or we learn to live with COVID, we need to continue to have this conversation. Start reaching out to your Regional Council or the mayor of your city and start having these conversations. What we need is funding, in order for us to do the work. We're ready and willing. We have a team of twenty-five nurses that are ready to be placed in a shelter [and] ready to have our own facility where we can start helping our community. Even though we've been doing this for the last two years, we have the records, we have the data to show that our model [is] working, and it's very successful. But it's the constant conversation of: why do the homeless need nursing? I think we just need to continue to have this conversation. People need to continue to be aware that this is a problem. My fear is that when COVID-19 is finished, then what? What happens to them? Do we just go back to how we were? That is why Homeless Health Peel is here. We're willing to do the work.

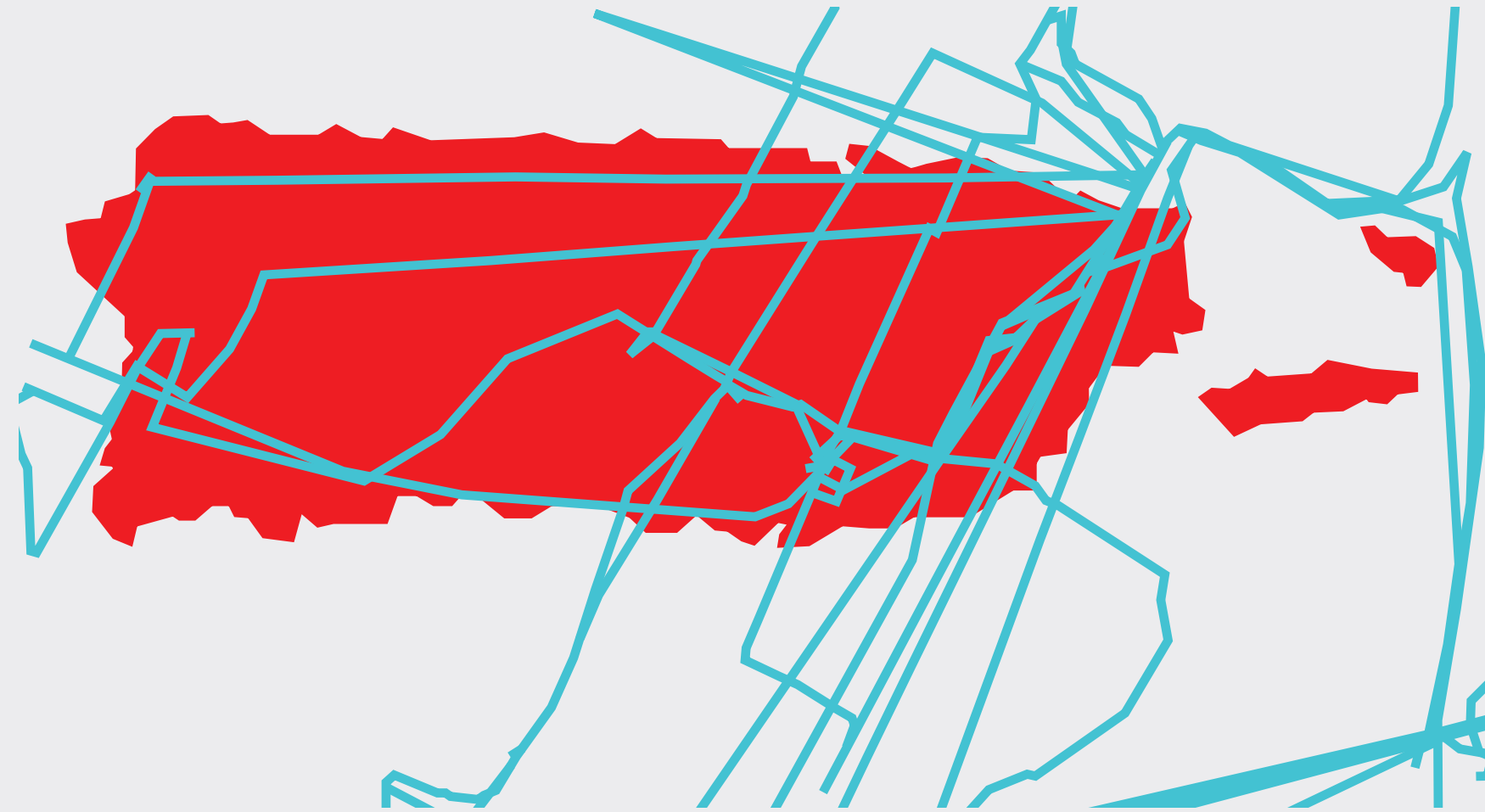
MM: Every day, people experiencing homelessness struggle to be seen, heard, and advocated for, especially in regards to their health, from fighting the uphill battle of stigmatization to receiving the same standard of care that we as residents of Peel and as Canadians take for granted. These human beings have been consistently overlooked by not only the healthcare system, but by us. Our community needs to come together and consider the lives of those experiencing homelessness as valid and as deserving of care.

QUESTIONS OF, FOR & ABOUT CONSENT:

How did you first learn about Human Immunodeficiency Virus (HIV)?	What impact does HIV criminalization have on the personal, spiritual, cultural, physical, emotional, legal, and political life of people living with HIV?	What are the impacts of intersecting systemic oppressions on HIV criminalization?
What is consent?		Is HIV criminalization part the new Jim Crow?
How does criminalization contribute to stigma, discrimination and victimhood?	What does it mean to be born with HIV when HIV is a crime?	What is the role of feminism in ending criminalization?
How is HIV disclosure stigmatized?	How could activists working to end sexual violence include anti-HIV criminalization into their work?	What role does anti-black racism play in HIV criminalization in the US?
How does HIV criminalization contribute to stigma?	How important is it to explain that risk of HIV transmission during sex is negligible if a person living with HIV is virologically suppressed?	Who is the most burdened by HIV criminalization?
How does the idea of disclosure impact people living with HIV, and those reporting sexual violence?	Has the introduction of PrEP changed HIV criminalization laws?	Who is charged most on HIV criminalization charges?
What is HIV criminalization?		What does HIV criminalization tell us about HIV/AIDS now?
How are the laws around consent, sexual assault, rape and HIV criminalization different in the USA and Canada?	How do everyday folks get their information about science, policy and information they may need to save their own lives?	What role could the federal AIDS Czar play in ending HIV criminalization?
What do consent and HIV criminalization laws take for granted, ignore and /or privilege?	How did criminalization laws come to be?	How can allies work to reduce HIV criminalization?
Why do HIV criminalization laws fail to consider advances made in addressing and treating the HI Virus?	How and why are they maintained?	What do people need when they are newly diagnosed?

Puerto Rican Harm Reduction is Everywhere

Tamara Oyola-Santiago



Map of Bronx Móvil's outreach route in New York City, July 4, 2022, overlaid onto map of Puerto Rico. Illustration: Matthew Hoffman.

Recently my mom told me that “diaspora” is a tricky term that connotes an additional layer of otherness that is unnecessary. That, as Puerto Rican people, we are *boricua*. Period. Her sentiment echoes across generations; I feel it deeply. That my *matria*, homeland, resides in my grounding bone marrow and singsong of my voice. It can resonate as a deep wave that pours out and other times it is a gentle internal lullaby that, with rose gold hues, tells me you are you. *Eres*.

Dialogues around identity and migration, of home, of being and belonging are part of Puerto Rican existence. In his poem on migration, Juan Antonio Corretjer wrote, *Boricano aunque naciera en la luna* (Puerto Rican even if I had been born on the

moon). And for those of us who migrate—repeatedly over generations, over lifespans, because of a hurricane, to work, for healthcare, for survival, who we are is also how we live. The migration between the archipelago and the mainland is the result of colonialism and imperialism. Puerto Rico, Guam, the Philippines, and Cuba as part of the Treaty of Paris of 1898 became bounties between Spain and the United States of America (US). Since then, migration, a result of the privilege and burden of US citizenship, is part of Puerto Rican life.

Harm reduction is deeply personal as well as a movement. I am a harm reductionist because it is how I heal. I am a harm reductionist because I am an organizer. And I believe this is true for most of my

comrades in the *reducción de daños* movement. I am part of *Bronx Móvil*, a mutual aid collective and harm reduction organization that, since 2018, has been hitting the streets of The Bronx and Washington Heights in Upper Manhattan with radical love. Created by harm reductionists who are Puerto Rican, our vision is harm reduction 24/7 that is culturally and linguistically centred. We organized because 70% of our participants (over 1,000 as of December 2022) are Puerto Rican, and most are housing insecure and unsheltered. ***We do this because how can we not?*** Bronx Móvil’s multiple identities include Queer, gay, formerly homeless, heterosexual, currently living in shelters, migrant, lovers, and loved ones of people who died due to HIV/AIDS, living with HIV,

living or treated for Hepatitis C, trans, Black, multiracial Latinx, users of PEP/ PrEP, formerly incarcerated, survivors of overdose, users of injection and other drugs, among many others.

I work with a group of people in The Bronx and in El Punto en la Montaña where we do not see (people who use drugs) as villains of the movie, as people who are irresponsible, as hedonists, as people who are harming themselves, who are in their current situation because of their own fault. We see them, we see us, as victims of a financial system that is designed to oppress people from racial groups, that villainizes so that they appear to be the villains. The problem is the system that is villainizing us. So, we are in the streets with those that are most vulnerable, doing all possible to humanize.

Puerto Rican harm reduction crosses oceans. The previous quote by a member of the two harm reduction collectives Bronx Móvil and El Punto en la Montaña notes the challenges of the war on drugs, imposed in Puerto Rico as part of the colonial operating system that criminal-

izes people. Due to the intersections of patriarchy, capitalism, ableism, racism, colonialism, poverty, transphobia, homophobia, and sexism, it is those who are Black, Indigenous, people of colour, and Queer folks who are targeted.

An example of our work that transcends geography is Narcanazo. Members of both collectives collaborated to create this bilingual health promotion campaign. Narcanazo is a play on Narcan, the brand name for naloxone, a medication that reverses an opioid overdose. And we are centring Puerto Ricans in The Bronx, where Bronx Móvil lives, and one of the epicentres of the US overdose crisis. Our pillars are education and action:

- Get trained and train others.
- Let's talk about drugs, specifically about opioids.
- Learn harm reduction tools, including the use of naloxone.
- Together we heal and we work towards community empowerment where we end the war on drugs and respect the human rights of people who use drugs.

We created posters and a social media campaign in Spanish and English.

Our goal is community *charlas* and community naloxone kits readily available for use; it should be everywhere—cafeterias, *bodegas*, nail salons, barber shops, churches, etc. In 2022, Community Leaders trained the leaders of a coalition of Black churches, which resulted in over 100 naloxone kits distributed among parishioners in The Bronx. Staff of community kitchens, nail salons, and retail businesses have been trained, including a security guard of a Burlington Coat Factory who witnessed a sidewalk engagement and came out to be trained.

Harm reduction is our way of creating homeland, here and there. It is to resist oppression including colonialism that manifests itself in rampant capitalism, the destruction of our archipelago, and the migration of Puerto Ricans. Once in the US, the struggles continue. The micro-battles to humanize in the mountains of the archipelago of Puerto Rico and on the streets of Nueva York are victories to save lives.

An Army of the Sick Can't Be Defeated

Brothers Sick

“AN ARMY OF THE SICK CAN'T BE DEFEATED”—printed in red capital letters and repeated—frames a pair of intravenous medical devices. At each corner of this border, black triangles buttress the phrase as an unrelenting gesture to pay attention. Together, this diction and series of triangular emblems recall the coalitional ethos and visual language established by LGBTQ+ activist groups, such as ACT UP (AIDS Coalition to Unleash Power), who in the 1970s reclaimed the pink triangle to underpin a similar rallying cry: “An army of lovers cannot lose.”¹ Carrying forward these legacies, Brothers Sick—a collaborative art project by siblings Ezra and Noah Benus—juxtapose text with images drawn from their personal archive to centre the collective and often stigmatized experience of the chronically ill, disabled, and queer communities of which they are part.

Brothers Sick forge alliances across time and space in *An Army of the Sick Can't Be Defeated* (p. 16), calling for participation in mutual aid and movements for health and disability justice. Reminders to “GIVE CARE” and “TAKE CARE” transmit as neon blue messages across the screens of two IV monitors, the right of which is inverted. The parallel apparatuses, carrying medication bags, tubes, tags, and other medical equipment, suggest embodied experiences of healthcare through their connection to and nurturing of the body. Creating an echo and doubling effect, the duplicated IV instruments allude not only to the multiplicity of disability experiences and the interdependency needed within systems of care, but also to the reciprocal practice of the artist duo's collaborative work.

The intravenous therapy seen in *An Army of the Sick* unfolds as remnants in *A Sign To Linger* (p. 17). Capturing the discarded

IV kits, the mirrored composition of undulating cylindrical tubing and fluid solution bags within a disposal bin becomes an acknowledgment of harmful ableist practices, which undervalue and abandon sick and disabled bodies. Obscured and grainy like a photocopy, the black-and-white image evokes the abstract quality of medical imaging, such as MRI scans and X-rays, while the entangled refuse emulates the contours of a seated human figure. Breaking the image's symmetry, two scroll-like pages, one in Hebrew and the other in English, are inscribed with a verse found in tefillin.² Embracing their Jewish heritage, Brothers Sick join the long tradition of *midrash*—the practice of Torah interpretation done in *hevrutah*, with study partners—to reconceive the intergenerational prayer ritual through the lenses of illness and disability. Drawing affinities between the markings left on the body by the tefillin and IV insertion, *A Sign To Linger* ruminates on the enduring practices of activism and social justice that bind us in community and resistance.

Following spread: left, Brothers Sick, *A Sign To Linger*, 2022. Digital print. Right: Brothers Sick, *An Army Of The Sick Can't Be Defeated*, 2020. Digital print. IMAGES COURTESY THE ARTISTS.

¹ “Queers Read This,” ACT UP NY, June 1990, <https://actupny.org/documents/QueersReadThis.pdf>. Brothers Sick cite artist Gregg Bordowitz, who recalls this phrase when he says, “an army of the sick cannot be defeated,” in conversation with Corrine Fitzpatrick at the performance-lecture *Gimme Danger*, presented at Triple Canopy on March 28, 2018: <https://www.youtube.com/watch?v=P0a6sT3Z0sQ>.

² Part of Jewish prayer rituals, tefillin is a set of two black leather boxes that contain prayer scrolls. Worn on the head and arm, the boxes are secured by leather straps that are tightly wrapped around the arms and hands.

Did you know...

In 2018, roughly 1 in 5 of all overdose deaths among Puerto Ricans in the United States were New Yorkers?

Graphics by Bronx Móvil. COURTESY THE AUTHOR.

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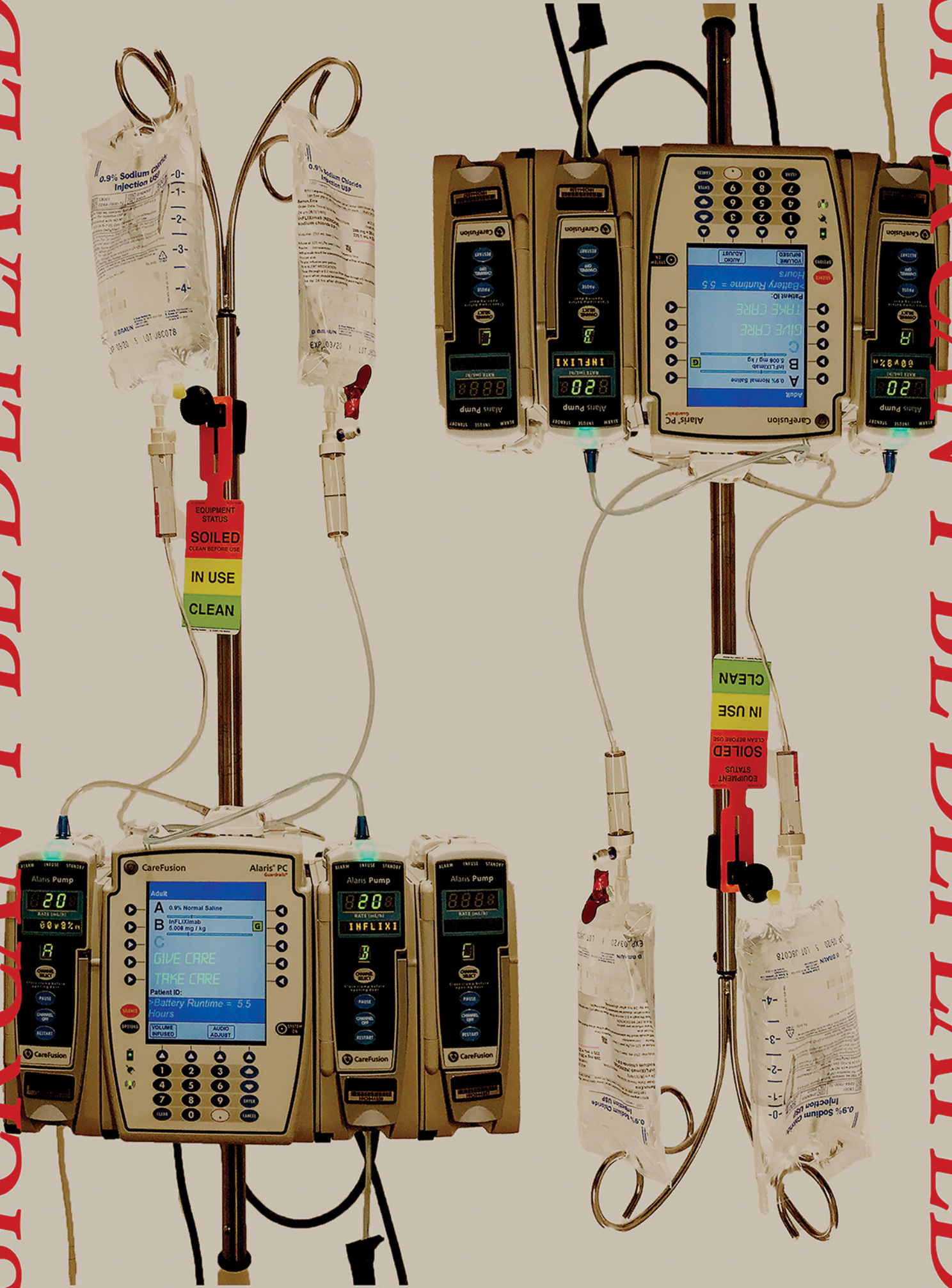
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▶ AN ARMY OF THE

SICK CAN'T BE DEFEATED

▶ AN ARMY OF THE

SICK CAN'T BE DEFEATED



שמתם
את דברי אלה
על לבבכם
וקשרתם אתם
לאות
לתמורה
על ידכם

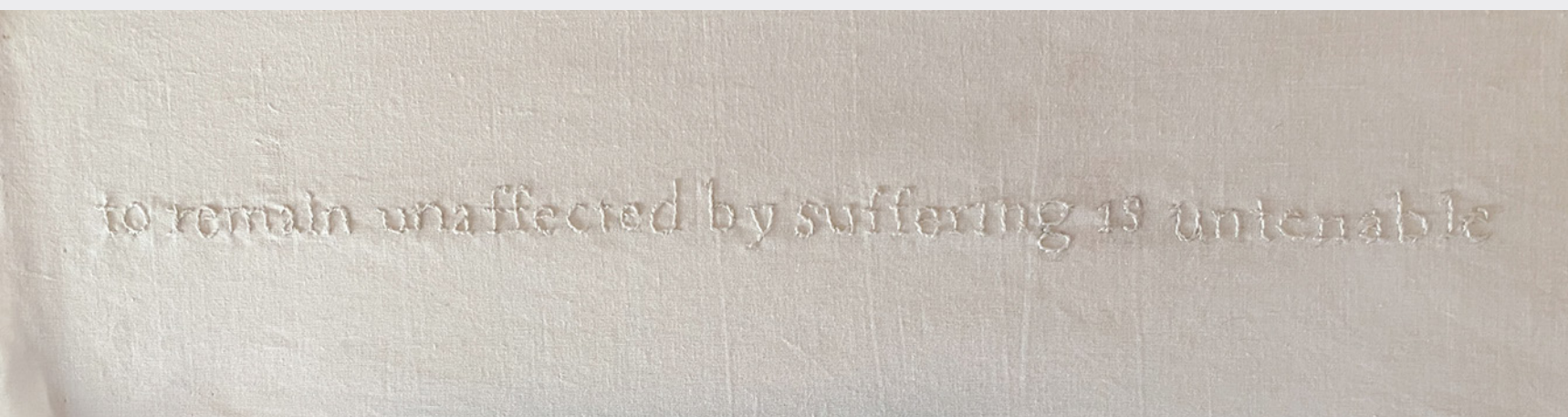
You shall place
these words
upon
your heart and
bind them
as a sign
to linger
upon your
hands

Gesture toward Justice: The Possibilities of Disability Art

Fady Shanouda, nancy viva davis halifax, Karen K. Yoshida

begin with language its delays
gesture toward justice
panic the fear
that you're a distraction
for others they point at you
your past they'll deny that they're hangin'
loosely on the line

the silences that lure breath &
there there is the lingering



nancy viva davis halifax, *to remain unaffected by suffering is untenable*, unbleached cotton, 19" x 6 in.
The artwork's title is positioned centrally in hand-embroidered text. COURTESY THE ARTIST.

Linger...and find that disability is not limited...linger and find out how difference is disruptive—how that disruption is freeing from the shackles of expectation, productivity, and the status quo.

This essay celebrates disabled artists. It is based on an oral history research project of disabled and mad artists who discuss their personal histories and reflect on experiences that formed their developing passion toward their art. Central in their stories is the creative disruption and productive force that disability is in their work. This force, or disability aesthetic, manifests in the products of their art and in the process and practice of making art. These artists are actors, singers, sculptors, sewers, and builders who demonstrate the value of disability through art. Their work speaks back to discrimination and exclusion within normative art/practices. By doing so, their work proves a past and re-imagines the art landscape for the 21st century.

We write from a Critical Disability Studies (CDS) perspective, which embraces the diversity and intertwining of communities—e.g., of ability, race, sex, gender, age, size, Indigeneity, citizenship status, class, linguistic, and extra-linguistic. CDS rejects the narrow view of personhood, what are seen as taken-for-granted practices and what is assumed to constitute a “good life” in many societies. As a trans- and interdisciplinary field of study, CDS centres these diverse communities and their knowledges. As an academic-activist scholarship, CDS supports and nurtures disability cultures, arts, and political activism at all levels.

An oral history approach was important for this project to document disabled artists' origins, personal histories, stories, blocks, and avenues to where they are now.

Jeff Thomas: Oral history has been a tenet in the Indigenous world... With this in mind, I thought about oral history and how important it is\ my elders would comment on a knowledge keeper's passing, and say that there was no one to pass his or her knowledge to...

Disabled artists are largely absent from the Canadian arts canon—the story that's

told about arts in this country. In interviewing disabled artists, this oral history project tells the story of how they have influenced and contributed to the Canadian arts scene, and most importantly, how they have tried to make it more accessible—in the broadest sense of the term. Disabled artists have made art practices more accessible to disabled communities through mentoring, and exhibiting art in and outside of gallery systems.

Sean Lee: Accessible curatorial practices (e.g. Zoom art gallery exhibit tours, use of ASL) are leading the way and having documentaries and capacity to historicize this knowledge\ learn these experiments that are happening and showing there is a history\... is a really, rare opportunity.

Disabled artists define what it means to be an artist and to engage in different art forms—from dancing, to singing, sewing, and sculpting. They have contributed to the transformation of these contemporary and ancient practices—opening them up, slowing them down, retooling, hacking, and tinkering, playing with what is im\possible.

We learned this history of disabled arts and artists in Canada because we lingered on their stories. After all, oral history as a methodology is one of sitting down, asking a few questions, and listening closely to a long story of life, death, and everything in between. This is a methodology that takes time, is patient, and asks one to travel back and consider the life journey that brought them to the now. What is generated in this process is expansive. A whole life story. In it, you find moments that describe inevitable change and openings to reimagine these inevitabilities.

nancy: oral history is at least for me \ an orientation to a larger history but also my history \ which awakens & ties itself to my day to day life \ so oral history can feel like an exposure \ being exposed \ i don't want to return to a trauma filled past \ & i don't necessarily want others to know \ i don't want the words \ my languaging of a past to turn into a something \ not sure what \ but i don't always want

to live in the present moment unsettled \ & yet this is also \ this body \ is also where the work lives \ it's a specific embodiment that exists & communicates in subtle & imperfect ways \ & what makes it complicated is that this body depends on so many others for its existence

as an artist i think i'm always engaged in work & drawn to work that exceeds the boundaries of conventional arts culture & which may never be acknowledged outside of or beyond those spaces \ maybe it's useful to imagine dis arts as a reconfiguration \ a movement beyond the ways in which disability and the areas are circumscribed \ but i also recognize that conventional space as a legitimate one \ although for me the conventions don't really fit...

remember — everything i say or feel or think is inadequate & not enough & that's ok \ lets imagine making visible some small part of a social fabric that perceives \ the arts as enlivened \ that refuse linear and objectifying categorizations \ that support the ontolepis-temological existence of *artists* \ who provide a form of an *otherwise* through works that do\can\ not answer the questions being asked with confidence or precision \ which defy the (en)closure secure answers offer

We learned that crip aesthetics are a response to living—really, surviving—in an ableist world. In many of their oral life histories, the artists describe their art as responding to what it's like to move through a world that doesn't imagine them as part of it...and how this leaves marks on the body. Crip aesthetics are often a response to these lingering marks—from medicalization, stigmatization, and devaluation. Disability is too easily abjected as is disability art. We invite you to turn into it—to linger—to learn and feel its affective capacities. Doing so is one way of valuing the disruptive possibilities of disability that can lead us toward building crippled worlds.

We show our respect and deep appreciation to the ten artists who collaborated in the oral history project: David Bobier, Alex Bulmer, Mark Brose, Eliza Chandler, Jane Field, nancy viva davis halifax, Sean Lee, Elaine Stewart, Jeff Thomas, Kazumi Tsuroka. We also acknowledge our lead producer of the documentary, Erin MacIndoe-Sproule. This project was part of a larger Social Sciences and Humanities Research Council Partnership Grant—Bodies in Translation: Activist Art, Technology, and Access to Life.

For a link to this documentary, “Disruptions Embraced,” please visit the Bodies in Translation website, <https://bodiesintranslation.ca>.

Start Slow, Feel the Vibrations in Your Gut

Mourning School

This is an invitation for you to start experimenting with your voice; what follows are humble sonic and written offerings that reflect on the relationships between grief and the voice. The text and the sound-work are companions: you can listen first and read after or the other way around, you can also try it simultaneously if you like.

I.

I HOPE I'M LOUD WHEN I'M DEAD, CAConrad says in their clear voice in the opening of Beatrice Gibson's eponymous short film.¹ The proclamation sits in our bodies long after we've heard it, because who gets to be loud after they die? Physiologically, as we learn from the YouTube channel *Are you dying to know?*, we are all loud, or our bodies make noises at least. Mortician Tracy mimics them with high-pitched whistles and low sighs that come out as the air expels from all orifices. In the comment section, she adds in an answer to user Turtle Tail that they "sound like a small squeaky low scream." But the idea of being loud when you're dead resonates deeper with us than just how our bodies sound when we're twisted and turned in preparation for our final destination.

Inequalities sit firmly in what is often deemed to be the great equalizer: *everyone's gotta die sometime*. The Queer Death Studies Network (QDSN) has theorized around questions of a "privileged after-life," something that they argue is only possible for those subjects who are "not located beyond the boundaries of what is considered to be grievable in terms of citizenship, migrant status, geopolitical positioning, racialization, class, gender, sexuality, dis/ability, etc."² The idea of grievable and ungrievable lives, taken from Judith Butler and furthered by QDSN, lies at the core of Mourning School's queries into grieving practices. How can we scream, sob, wail, moan, and cry louder for those who are deemed ungrievable? How can we make sure that we are all loud when we're dead?

II.

Artist and musician Johanna Hedva has shared the grief ritual they developed after the death of their mother through the doom-metal album *Black Moon Lilith in Pisces in the 4th House*, which opens with "O Death," a distorted, rage-filled and violent encounter with death loudly personified.³ We try to moan and groan with Hedva, and feel how our fear shifts into catharsis.

Voicing death isn't always the stuff of catharsis though. The idea that announcing someone's passing is the thing that makes it real frequently punctuates films and stories about being confronted with intimate deaths—if a tree falls in the forest and no one is around to hear it, does it make a sound? It is this kind of magical thinking that author Joan Didion describes in her account of the first year after the passing of her husband. For instance, as she reflects on the hours after he died, she remembers hearing her friend speak to *The New York Times* about an obituary; frantically she picks up the phone to deliver the news to *The Los Angeles Times* but, as the person on the other end of the line picks up, it hits her. LA is in a different time zone, and John, her husband, may not be dead yet on the West Coast.⁴

III.

According to clinical psychologist Dr. Glenn Doyle, the vagus nerve lights up like a Christmas tree when we speak, shout, or sing, which is why those activities can be so emotional and cathartic for people.⁵ Vagus means wandering, and that is quite literally what this nerve does, as it connects our heart, guts, and voice with one another. It is because of this nerve that Hedva's moans work; it pulls us out of our flight, fight, or freeze response and back into ourselves.

IV.

In a private workshop with music pedagogue and folk musician Emilia Kallonen, we learned about the ancient lamenting

tradition of Karelia, known as *itkuvirsi*. In this visceral and transcendental practice, women mark transitional situations through music, language, gesture, and cries.⁶ What this practice makes palpable is the fact that grief work is part of every transition, not just the ones related to death. When it does relate to this directly, the lament acts as a bridge between two worlds, a way to guide the transition of the deceased from one realm to the next.⁷

The words in lamenting are largely improvised, poetic, and filled with metaphors that describe the person to whom the lament is directed; the melody starts up and moves down until it is time for a next breath, a handkerchief rests on the cheek or temple of the lamenter as they rock back and forth. All of these elements contribute to a whole that surpasses its parts. What struck us when reading about the lamenting tradition is the fact that it is found in all corners of the world.⁸ In many ways these practices, despite their different origins and localities, overlap. It demonstrates that the relationship between grief work and the voice is omnipresent.

Yokhor, an artwork from 2018 by Natalia Papaeva, could be read as a contemporary lament. In this short film, the artist stands under a bridge while she repeats the same two phrases of a traditional Buryat song. Papaeva becomes visibly upset, her voice starts to shake, and she eventually starts crying, as she forces the words out of her mouth, using the same hand gestures to steer herself forward. This forgotten song symbolizes the possibility of the disappearance of her language, whilst Papaeva also points to a sense of hope in the possibility that languages on the verge of extinction can be saved.

These acts of lamenting, as we experienced it in the workshop, as we see it in Papaeva's work, and even in Hedva's album, as well as the works of so many others that we did not touch upon here, are not (only) about the words or the act of singing itself. It is as Emilia described it: "a way to see your inner world, and mirror it back, it is a journey through your body that comes out in song."

These thoughts are situated in Mourning School's current research on grief, loss, death, and the voice; they were formulated during a residency at HIAP, Helsinki, in Autumn 2022. Mourning School is a long-term artistic and curatorial research program initiated by Lucie Gottlieb and Rosa Paardenkooper in January 2021.

Start slow, feel the softness of your breath, perhaps you want to mimic some sounds, do you sense the vibrations in your gut, the echoes of your voice? Listen here:



Audio clips are used with permission, except in cases where copyright holders could not be contacted. Please contact the publishers if any corrections should be made to the digital version.

Audio Description

00:02

[CAConrad strongly proclaims]: I hope I'm loud when I'm dead.

00:05 – 00:38

[Strong electric guitar strum that reverberates into a droning noise and slowly fades. A jolted short strum stops the reverberation. The guitar strum repeats twice more, reverberating into a droning noise and slowly fades. A voice sings "ooooohhh" over the third strum and stops]

00:38 – 01:09

[Strong electric guitar strum that reverberates into a droning noise and slowly fades. The guitar strum repeats three times more. The voice sounds like it's from far away and harmonizes drawn out sounds moving between lower and higher keys]

01:09 – 01:36

[Strong electric guitar strum happens three times more. It reverberates into a droning noise and slowly fades. The voice sounds like it's closer and continues harmonizing]

01:36 – 01:39

[Soft piano music fluctuates between middle and high notes. It continues; each note played lingers until the next]

01:39 – 01:51

[Overlapped with the piano, a light jingling trickles in, getting louder until...]

01:51 – 02:29

[A distant voice that is difficult to decipher overlaps with the piano and jingling. The voice says:] For the ancients, the voice is generated by the alchemy of internal fluids, it coagulates in the

Tracklist

1. CAConrad in Beatrice Gibson's short film, *I Hope I'm Loud When I'm Dead*, 2018
2. Johanna Hedva, *Black Moon Lilith in Pisces in the 4th House*, 2021
3. dolphins in heaven, "get well soon," 2013
4. Rosa Paardenkooper reads Corrado Bologna quote from Adriana Cavarero's book *For More than One Voice*, 2005
5. Voice exercises
6. William Hoyland in *The Future's Getting Old Just Like the Rest of Us* by Beatrice Gibson and George Clark, 2010
7. Natalia Papaeva, *Yokhor*, 2018
8. William Basinski, *The Disintegration Loops*, 2002/2003
9. Pirkko Fihlman in "På gråterskekurs i Helsingfors," SVT, 2018
10. Pauline Oliveros, "Lear," from the album *Deep Listening*, 1989
11. Seana McKenna in *The Year of Magical Thinking* based on the book by Joan Didion, 2009
12. Maria Antonovna Prohorova, "I died at my mother's grave," 2000
13. Pirkko Fihlman in "På gråterskekurs i Helsingfors," SVT, 2018

vital organs, in the heart and diaphragm; in the seat of the *thumos*, which is force, energy, ire, and impulsive instinct (its etymology is the same as *fumus*; and in Dante smoke rises from the chest when the passions pulsate).

02:29 – 03:05

[Light piano music continues the same echoing chords, with soft jingling, which continues, then crescendos and ends. The piano moves into a higher key, with jingling trickling in again]

03:05 – 3:30

[A voice humming monotonously overlaps with piano and jingling]

03:30 – 03:58

[Voice stops. The high key piano, jingling, and a soft digital thud continue]

03:58 – 04:31

[A male voice says]: Voice C. Voice characteristics, fast-paced, as if compensating for gaps in memory, stuttering, spluttering, magnified in relation to an inability to recollect detail, struggles with articulation and volume. Speech caught at the intersection of throat and mouth. Erratic when words are not forthcoming. Actively addresses the other voices.

4:31 – 04:53

[Repetitive rhythm: high key piano chord music layered with jingling and interspersed thumps. Music becomes much lighter. Duration between thumps shortens a bit until...]

04:53 – 6:03

[A new distant voice slowly begins to sing over the rhythm. The thumps continue, voice continues, and jingling in the background stops. White noise begins behind

singing, then a swell begins to layer in over white noise]

06:03 – 06:24

[Voice has faded, sound of gentle swell takes over]

06:24 – 06:39

[A new voice comes in over the sounds, it says:] Where you sent your lament... It can be the trees, it can be the nature, a prayer to God, whatever, but it has to go outside, you. And you must also say it loud.

06:39 – 7:06

[Music continues]

07:06 – 07:25

[Voice says:] There was a level on which I believed that whatever had happened remained open to revision. That was why I needed to be alone, I needed to be alone so that he could come back, so that he could come back.

07:25 – 08:21

[Loud droning sound slowly fluctuates between lower and higher pitches]

08:21

[Voice singing while wailing, then fades out]

09:09

[Droning sound continues]

09:43 – 09:46

[A voice says:] And you follow your breathing.

09:46 – 11:01

[Droning sound continues, a voice sings over droning sound until it fades out and the piece ends]

¹ *I Hope I'm Loud When I'm Dead* is the title of a poem by CAConrad published in *ECODEVIANCE: (Somatics for the Future Wilderness)* (2014); it is also the title of Beatrice Gibson's short film from 2018.

² Marietta Radomska, Tara Mehrabi, and Nina Lykke, "Queer Death Studies: Coming to Terms with Death, Dying and Mourning Differently, An Introduction," *Women, Gender and Research* 28, no. 3-4 (2019): 3-11.

³ Johanna Hedva, *Black Moon Lilith in Pisces in the 4th House*, crystalline morphologies and Sming Sming, 2021, LP, cassette, and digital recording.

⁴ Joan Didion, *The Year of Magical Thinking* (New York: Alfred A. Knopf, 2005).

⁵ Sarah Jeanne Browne, "What The Vagus Nerve Is And How To Stimulate It For Better Mental Health," *Forbes*, April 15, 2021, <https://www.forbes.com/sites/womensmedia/2021/04/15/>

⁶ [what-the-vagus-nerve-is-and-how-to-stimulate-it-for-better-mental-health](https://www.what-the-vagus-nerve-is-and-how-to-stimulate-it-for-better-mental-health).

⁷ Elizabeth Tolbert, "Women Cry with Words: Symbolization of Affect in the Karelian Lament," *Yearbook for Traditional Music* 22 (1990): 80-105.

⁸ Eila Stepanova, "The Register of Karelian Lamenters," in *Registers of Communication*, ed. Asif Agha and Frog (Helsinki: Finnish Literature Society, 2015), 258-274.

⁸ The lamenting tradition we have studied was practiced in several parts of what is now Finland, Russia, and the Baltics. In "Women Cry with Words," Elizabeth Tolbert describes how this Karelian lamenting tradition shows strong similarities with laments from the Bororo of Brazil. Similarly, we have come across traditions of ritualized wailing from ancient China, and "oppari," an ancient form of lamenting from southern India, amongst others.

A Good Death: Supporting the Living and Dying

Sarah Bird, Rayne Foy-Vachon, Kayla Moryoussef, Chrystal Waban Toop

“Death doula” is a new term for a long-standing custom. Death doulas are workers who provide non-medical support to the dying, caregivers, those diagnosed with a terminal illness, and those seeking information on death and dying, among others. Many death doulas subscribe to the Death Positive Movement, which encourages discussing death, honouring the wishes of the dying, and informing family and friends of end-of-life wishes.¹ We invited death doulas working in the Greater Toronto Area and beyond to discuss their work, how it differentiates from the care already provided in hospitals and hospices, and what constitutes a good death. Respondents include Chrystal Toop, founder of Blackbird Medicines and the Indigenous Death Doula Mentorship Program; Rayne Foy-Vachon, founder of Winnipeg-based Dying to Help End of Life Services; independent death doula Sarah Bird; and Kayla Moryoussef, founder of Good Death Doula.

What does providing end-of-life support look like for you?

Rayne Foy-Vachon: I am a death doula. I am not a counsellor or a healthcare provider. I am a professional who offers support and companionship to people who are experiencing death and dying. I offer the dying the ability to bring choice, autonomy, and person-centred care into their dying process. My goal is to remove stigma and normalize death in our death-denying society. It is my role as a death doula to listen to those fears and give space for folks to discuss without judgment. I also help bring a focused and intuitive presence to the dying’s bedside, and I explain the signs and symptoms of the dying process.

Supporting the dying looks like many different things; every person is unique in their needs and wishes. For example, I will assist in writing an advance care plan that will include health documents, ongoing discussions, values and beliefs, substitute decision makers, advanced directives, quality of life vs. quantity of life, medical and non-medical decisions. Pre-arranging and personalizing the celebration of life/funeral services and legacy projects (creating memorials with the dying person and loved ones). I will help create a document with contact information, passwords, and other pertinent information that loved ones would require at time of death and after.

What if you were unable to dress, bathe, or toilet yourself—would you have concerns about your gender identity, expression, or physical appearance? For those who are part of the 2SLGBTQ+ community, there is a risk that you will not receive the care you want or deserve. I instruct my queer clients to be extremely specific with their instructions. Having an advance care plan will lessen the chance of dead-naming, use of wrong pronouns, and misgendering.

Having loved ones continually surrounding a dying person can take an emotional toll on all of them. This is where a death doula comes in. I will give the dying person space to be with their thoughts and emotions. I have training in guided imagery, which is a relaxation technique that involves visualization. The dying focus on positive, peaceful, and relaxing images that, according to research, may help reduce pain and anxiety. I will provide bedside respite for the family/loved ones; anticipatory grief can be overwhelming and exhausting.

Can you speak to the queer-specific services you offer to the 2SLGBTQ+ community? How does this honour a person’s death?

RF-V: 2SLGBTQ+ community live with many barriers such as mistrust, stigmatizing and abusive language, misgendering, dead-naming, and transphobia within the healthcare system. My role as a queer death doula is to help reduce those barriers by assisting queer folks to navigate the healthcare system. I have 18+ years of working in healthcare and I follow the model of harm reduction and trauma-informed care. I will always respect my clients’ confidentiality regarding their sexual orientation and gender identity. I will help guide complex decisions and facilitate conversations with healthcare professionals in the care of the dying person. In death care the focus tends to be from the typical heteronormative family lens. I will educate service providers on behalf of the dying person by making sure any resources they recommend are 2SLGBTQ+ inclusive, train staff in diversity training, inclusive language, and working with non-traditional families.

What does providing end-of-life support look like for you?

Kayla Moryoussef: I provide whole-self

support—that means physical, psychological, social, and spiritual wellbeing. It’s understood that medical care teams tend directly to the physical, but our health care systems and expectations do not accommodate the remaining facets. This means you’re being treated as dying long before you’re dead.

Whether my clients are dying or are young people coming to me for mortality coaching, what I do, firstly, is combat the common social understanding that death is traumatic. My philosophy is to focus on the fact that death is a natural, universal part of living, from which none of us are exempt. People need to know that death, in the Western world, need not be uniquely traumatic.

How does your role differ from the dominant ways end-of-life care is currently provided?

KM: I am here to educate and empower clients and their loved ones, to give them some measure of control and choice in their end-of-life. I am a resource navigator; I put in place requests for last wishes, and help create their legacy. I also do what is called death planning: organize the details—from who is in the room to the smells, sights, tastes, and sounds that are present—around the active death, the last days and moments of a person’s life.

My work entails active listening; sitting in silence; cultivating safe spaces; celebrating beauty; and insofar as is legal, “planning” this final great event of a person’s lifetime.

What does providing end-of-life support look like for you?

Chrystal Toop: Like many people with Boomer generation parents, I am looking at ways to prepare for my parents’ and loved ones’ deaths emotionally, mentally, and spiritually. Providing end-of-life support for me has looked different than most, I think, because it has not been about supporting individuals in their transition. For me, providing end-of-life support has been about bringing others into this death work realm, while illuminating options and resources. As an Anishinaabekwe, this work has included restorative justice; missing, murdered, Indigenous youth, women, 2Spirit people, men; LGBTQIA+, safe spaces; trauma-informed care; and Indigenous harm reduction.

My role as an Indigenous death worker is vastly different from the dominant ways end-of-life care is provided and discussed. I am a death worker when I am a birth doula. I am a death worker when I operate on the frontlines of social work. I am a death worker when I parent my children. Everything about First Nations, Inuit, and Métis end-of-life care is grounded in harm reduction to prevent the historic and ongoing systemic, genocidal destruction of my family, culture, stability, and security in the world. This work is more than a cool new business or outlook; it is the resistance against systemic oppression that continues each day that an Indigenous person dies trying to access health care or safety.

We know Canada has committed genocide and continues to put Indigenous lives at risk for systemic, violent, premature, unnatural deaths. This is the reality for a First Nations woman like myself, and my children. I was at risk in the womb, walking this Earth walk, and the same is true for my kids, until the day each of us die.

Can you speak to Blackbird Medicines and its Indigenous Death Doula Mentorship Program? How does this program support Indigenous youth communities?

CT: Dominant end-of-life care is focused on a transition from old age and a life lived, while my end-of-life care lens is focused on the fight for survival. The Indigenous Death Doula Mentorship Program was an idea formed to encourage others to take up this work. So many Indigenous community members are caregivers from a young age, fighting similar fights, and the pandemic created this overwhelming need for First Nations, Inuit, and Métis death workers. Generations of history has determined that more of our community members would die from diseases and afflictions like cancer, addictions, homelessness, displacement, neglect, and mental illness—manifesting from traumas endured.

As a life circle doula, I have been cognizant of the importance of reclaiming traditional roles and ways of living and supporting community, which led me to reclaiming death rituals and teachings. The mentorship program was a way to serve those who were looking for opportunities to learn. This program became the first stepping stone to realize the Indigenous Death Doula Training, a course I designed as part of my social enterprise Blackbird Medicines.

Blackbird Medicines has been my heart-work, born from an ambitious hope to embody the traditional roles I would have occupied, once upon a pre-colonization. A Storyteller and caregiver, I am grateful for the spaces and conversations I am invited to share and hold.

What does providing end-of-life support look like for you?

Sarah Bird: My work focuses on caregiver support. When caregivers are well

supported and empowered, they have access to a greater sense of purpose. My clients express that, not only are they better able to be present with their dying person, but they also feel more equipped to support their loved ones and themselves.

What this looks like in practice is to first identify who the primary caregiver is for a dying person. I help them to assess their own needs, current supports that surround them, and to connect them with community resources. These conversations can take time and care, ensuring the client is leading and is given space to share what’s important to their loved one and themselves. This guides which resources/services will be appropriate for their unique needs.

Having worked within the healthcare system for nearly two decades, I have witnessed how overwhelming it can be for caregivers to navigate. Working together to build the confidence needed to be able to advocate for the dying person at every stage is paramount. This might mean discussions on rights of the dying person, asking for support from their care team in interpreting medical information and what this means for their loved one, and knowing who to connect with to navigate complicated legal requirements (e.g., power of attorney).

I often find myself facilitating difficult conversations. We base our conversations on the dying person’s autonomy and sovereignty and how we can ensure it be protected, that their wishes be known and respected, and that their caregiver be able to advocate on their behalf if and when it is needed. Impending death can be accompanied by many complex emotions, and because the focus is so often on the dying person, the caregiver’s journey is often overlooked. By putting a special focus on the additional needs of the caregiver, I strive to ensure that they are heard and witnessed in their own journey, as they work through these complicated emotions alongside their dying loved one.

Planning is a big part of the process. By walking the dying person and their caregivers through non-medical comfort plans, by supporting them in creating vigils, ceremonies, and legacy projects, the clients I walk alongside discuss feeling more prepared and less afraid of the end of life and what will come to pass.

Support with the caregiver continues after their loved one has died, by offering tools and resources as they begin to process their grief and reconceptualize their lives without their beloved person. We sit together. We witness their grief move and change and explore what their unique journey feels like for them. I listen and hold space. I help them to find answers within themselves as they come to terms with the idea that grief never truly goes away, that it softens over time.

How does your role differ from the dominant ways end-of-life care is currently provided?

SB: Care teams, in their various forms, are exceptional; however, our healthcare system is strained, and our teams have extremely heavy caseloads, which may limit their capacities. Death doulas have the gift of time, and because of this, we get to know our clients, their needs, their hopes, and their limitations in depth. We work alongside (and never replace) medical care, social work, and family—creating a human-centric approach that is highly personalized and based on compassion and empathy.

On your website, you address the “layers of grief” you witnessed while working at a fertility clinic in the GTA. Can you speak to what you mean by that, and how a death doula can support the grieving process?

SB: During and after the death of a loved one, there are many secondary losses—loss of income and assets, loss of childcare, loss of identity, loss of sexual partner, loss of shared memories/what you envisioned your future to be, loss of security and safety, loss of a witness to your life. When society does not take these various aspects of loss into account, we disenfranchise our grief, compound it, and make it an even more isolating experience.

What would you like to see change in the dominant ways of approaching death?

SB: I take a very direct (yet gentle) and honest (with empathy) approach to death, dying, and grief. Discussions of death and grief shouldn’t be avoided and/or postponed until it is happening in real time; important conversations don’t need to hide behind euphemism. Only when we meet death head on, unafraid and unashamed to speak its name, can we do our best to be open to it, to prepare for it, to come to terms with it, and embrace it as a fully natural, fully human part of our experience.

¹ History of the Death Positive Movement.” The Order of the Good Death, <https://www.orderofthegooddeath.com/history-of-death-positive-movement/>.

The Corpses of the Future

Lynn Crosbie

PAROLE

Aphasia consists of a breakdown in the two-way translation process that establishes a correspondence between thoughts and language...
Aphasia is not a disorder of perception.

– M. Marsel Mesulam

Neurologists posit a number of steps between a thought and its expression. In other words, a thought can really *move*,

Stretch out its hamstrings, run in place then leap, landing beyond the cirrus cloud, inside the geological survey, its grid colour-coded and intact.

Or, it may behave like a drunken slattern at her toilet, atomizing with Avon Crystal Aura and drawing on her eyebrows with a burnt match;

I am Gloria Gaynor, the thought – originally an ominous MasterCard bill – spills out of a low-cut, nylon-trimmed rayon slip.

Mid-trip, the thought may change tack or list with ennui, retreating to its bachelor pad, a cushy, crenellated line –

This is something I talked about with my dad, more or less.

That is, I talk without talking, as he does with the bombs are poised to detonate, or the cyanide capsules are breaking open in the chamber.

Meaning, naturally, that he is trapped in a violent ward filled with screams and heavy doors with recessed numerical code-boxes;

That he is blind, and locked also in the dark that spreads like a stain until everything has been soiled;

And that his words too are captive, on occasion, when they mutate memory, emotion impairing their objectivity, as when someone has died

Long ago but it *feels* new and this is not news, I feel the same.

My sister is visiting my parents.
She tells my father that she saw a groundhog at the bus station this morning.

“Where was he going?” he says, thought and language fusing into a key that lets him out and lets us in, and we laugh, it’s that simple.

WHAT WOULD YOU DO

If, *when* Dad gets better? I ask my mother on the last night I am there, then fall asleep.

I see my pillow expand and rest beneath my father’s head; watch it wrench open and snow over us both until there is no pain.

I want to give you this gift, I say, and he thanks me, as we grasp the air like newborns, at all of its harmless magic and forgetting.

When Dad gets better, I would make us coffee, my mother says, then sit with him in bed, talking all night.

Her dream reminds me of an incubator I saw for newborn sea horses, so few of whom survive,

Those golden, constant lovers –

I latch them to my heart, and nourish them: so much rests on their tiny shoulder.

Still, they prevail, in their resolute, ill-starred way.

On the Incommensurability of Police and Harm Reduction

Jeffrey Ansloos, Karl Gardner

In recent years, the concept of harm reduction has increased in popularity and is being applied in many contexts beyond drug use and sexual health. Today it is invoked in contexts as wide ranging as housing-first initiatives,¹ voting in electoral politics,² establishing a living wage,³ and suicide prevention. As long-time organizers and activist scholars, we have been interested in these evolving uses of the term and what effects they might have on its meaning. For example, looking closely at harm reduction in suicide prevention, we have witnessed harm reduction equated with mitigating the risk of self-harm through involuntary and carceral measures—often involving police—in the name of public health and safety. Ironically, this occurs despite well-documented evidence that police involvement in mental health emergencies *increases* the likelihood of harm to people, especially those who are Black and Indigenous.⁴ This is an illustrative example of how such uses of harm reduction, especially those that involve police, undermine its radical meaning and intent. This dissonance prompted the creation of the Radical Harm Reduction Project at the Critical Health and Social Action lab, which seeks to examine the evolving politics and practices of harm reduction initiatives across North America. In this brief article, we consider a specific area of the project: the incommensurability of police and harm reduction.

What is Harm Reduction?

While there are many accounts of the history of harm reduction, we believe that there can be no history of harm reduction without centring the community organizing efforts of people who use drugs. As Christopher Smith reminds us, “before it was institutionalized as a public health policy...harm reduction originated as an illegal activity, where activists and politicized frontline workers risked arrest by distributing clean syringes.”⁵ Since then, many policies and practices have been labelled “harm reduction.” But it has consistently remained a radical practice of care and mutual aid in the face of governmental abandonment and criminalization, largely by communities experiencing the brunt of the HIV/AIDS epidemic, people who use drugs, queer and trans people, and sex workers.⁶ For us, the concept and practice of harm reduction is rooted in a series of principles that emerge from its radical history. Within these, we include:

Pragmatism. Harm reduction recognizes activities deemed “illicit” and/or “illegal” will inevitably occur, and that *all* behaviours incur some risk. Therefore, responses that seek to eliminate risk through abstinence or criminalization actually serve to *increase*, rather than decrease, harm. Pragmatic approaches necessitate a focus on any and all actions that are effective in mitigating risk and reducing harmful effects.⁷

Unconditionality. Harm reduction requires a commitment to non-judgment: there can be no preconditions for care. Effective strategies must “meet people where they are at,” enacting value neutrality and non-discrimination in the creation and delivery of interventions.

Autonomy. Related to unconditionality, harm reduction must be dedicated to respecting individual and community self-determination. Harm reduction therefore opposes all forms of coercive or compulsory intervention, and relies upon meaningful and consenting relationships of mutual aid.⁸

Community-Based. Against the prioritization of so-called experts and the process of evidence-making outside of communities, harm reduction centres the wisdom, leadership, and evaluation of people with lived and living experience.⁹ At its core, harm reduction redistributes power to communities.

A Complex Understanding of Risk. Harm is never exclusively the product of individual behaviour, but the product of complex interactions between structures, systems, individual behaviours, and power relations in society. Harm reduction is therefore committed to addressing risk at multiple levels, and includes strategies that decrease individual health risks and address the broader conditions that produce risk environments.¹⁰

With these principles in mind, we can more clearly articulate the ways in which harm reduction is necessarily opposed to the police, an inherently harmful institution wedded to the process of criminalization.

Two Trends in “Harm Reduction Policing”

In our research, we have observed at least two major trends that attempt to reframe policing practices as “harm reduction.”

First, there is an increased rebranding of police reform as constituting a kind of “harm reduction.” For example, responding to critiques of racist police violence, police have adopted reforms such as the use of body cameras and incorporating implicit bias training into policing programs. Such measures have had little to no effect in reducing racist police violence, and they increase police budgets, but are justified because they “reduce harm.” Similarly, equity, diversity, and inclusion measures aimed at increasing representation of racialized peoples in police forces are broadly billed as a panacea to reduce harms associated with police violence in racialized communities, again lacking substantive evidence of reduced harm. Another example is the promotion of community-based policing models, meant to soften the public image of police, and provide greater discretion to police in their dealing with individuals engaged in illegalized behaviors.¹¹ While each of these reforms purport to reduce the harms of racist police and policing practices, they fail to uphold the principles of harm reduction outlined above and, in many cases, have been actively opposed by communities most subjected to police violence.

The second major trend is the incorporation of “harm reduction” into police mandates. The expansion of notions of public safety to include health service provision has meant the increased use of harm reduction interventions by police. Examples include the equipping and training of police with naloxone kits; mental health first-aid certification; or police distribution of sexual health resources. It also rebrands police as public health personnel, through the creation of mental health crisis units and the incorporation of police into networks of service provision and public health systems. A notable example emerged in 2021 when it was discovered that, despite being banned from the Pride Parade, the Toronto Police Service received training from Pride Toronto in harm reduction strategies aimed at “community safety” and were then contracted to provide harm reduction interventions during the 2022 festival. Against the better wisdom of communities directly affected by violent

policing practices, the incorporation of systems of criminalization into contexts of health care increases risk.¹² Risks include the likelihood of harm caused by police interaction (e.g., injuries, carding, arrests), as well as the systemic consequences of those interactions (e.g., police records being used in future legal proceedings, the impact of criminal records on employment). The involvement of police in domains traditionally run by communities and allied health service providers undermines a set of practices that have emerged despite criminalization and in the face of state abandonment.

These “harm reduction” approaches to policing—what we understand as a paradigm of *harm reduction policing*—fundamentally misappropriate the concept and may often produce an increased risk of harm. In other words, we do not believe that everything that purports to “reduce harm” constitutes harm reduction. In the realm of policing, reforms that try to “soften” their inherently violent role in society only function to further entrench police power in society. “Harm reduction policing” has the effect of obscuring the inherently violent function of police and, in doing so, increases the legitimacy, economic resources, and presence of police in our lives. The idea that police can be active participants in the work of harm reduction therefore represents a hollowing out of the concept’s radical history and principles. Sustained resistance to police co-option of harm reduction is nec-

essary, and people’s lives depend on it. Echoing the work of many harm reduction organizers across North America, we believe that a key dimension of saving lives and improving collective well-being is opposing all forms of criminalization and judiciously resisting the involvement of police in our lives.

Harm Reduction and Abolition

We argue that the only harm reductionist approach to police is abolition. In the negative sense, this means a dismantling of police, both within contexts of harm reduction and community health, as well as in society more broadly. As Geo Maher observes, “we live in a world of police, a society built around policing and that presumes their necessity” as a “one-size-fits-all solution for every social problem.”¹³ The expansion of police into harm reduction spaces reflects this insidious reality. And people seeking access to harm reduction know full well that the role of police in these contexts is irredeemable. The answer, then, is not to improve police engagement in these spaces, but to dismantle and eliminate the presence of police altogether.

By demonstrating the ways that pragmatic and compassionate community care reduces harm, harm reduction reveals exactly why police are unnecessary to make life safer. As such, abolition is also an affirmation. As Ruth Wilson Gilmore suggests, it is about cultivating a greater

presence, rather than absence, with each other.¹⁴ It is about *building* institutions and systems of support that have been historically denied to many communities. The work of abolition is about reducing our dependence on police by cultivating strong, connected, and self-determining communities that can collectively decide how to meet the needs of everyone and enhance individual and collective joy. This is what Angela Davis means when she similarly advocates for rendering prisons “obsolete”: not just a dismantling of prisons but the creation of alternatives that eliminate the need for prisons in the first place.¹⁵ In the place of police, harm reduction invites us to build community-based responses¹⁶ that adequately empower people navigating varying forms of risk, in ways that are non-violent, non-criminalizing, and anti-oppressive.

For too long, police and the gnawing violence of their presence in our communities has persisted, subjecting us to unabating assaults on our lives. At its core, harm reduction is an affirmation of our right to life, unconditionally. In the face of police violence, and acknowledging that we diversely negotiate risk in a world that is unjustly structured, harm reduction is a life-affirming and power-building practice aimed at more than mere survival. It is not an injunction to live, but an invitation. Harm reduction is about our abiding together, and the belief that joy and freedom linger in the practice of mutual aid and collective struggle.

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13 Geo Maher, *A World Without Police: How Strong Communities Make Cops Obsolete* (New York: Verso, 2021).

14 Ruth Wilson Gilmore, *Abolition Geography: Essays Towards Liberation* (New York: Verso, 2022).

15 Angela Y. Davis, *Are Prisons Obsolete? An Open Media Book* (New York: Seven Stories Press, 2003).

16 For examples of such efforts, we would direct attention to the Indigenous-led Toronto Community Crisis Service Team pilot program, in collaboration with 2-Spirited People of the First Nations, the ENAGB Indigenous Youth Agency and Parkdale Queen West Community Health Centre; the Toronto Indigenous Harm Reduction; and Yúsnewas (YouthCO) programs, including Taking Care of Communities, Taking Care of Ourselves, and Culture Is Healing.



Shan Kelley, *I saw in you, reflection of a million stars that pierced and filled me of countless ways to dream and feel complete*, 2021, acrylic on wood panel, COURTESY THE ARTIST.

Crises of Visibility: The Activism of MDs

Emily Cadotte

Among the many varied effects of the pandemic, the visibility of systemic inequities has been significant: the sight of encampments across the GTA; the imagery of protests for Black Lives and defunding the police; and cellphone footage of police brutality shared on social media platforms. Alongside the rest of us, healthcare practitioners witnessed those injustices, perhaps even more acutely, and from a different lens: the inscription of systemic forms of oppression on the body.

These inscriptions are typically articulated in public health discourse through the framework of “social determinants of health” (SDH). The SDH broadly encompass all conditions under which humans live.¹ This includes a person’s economic, housing, and employment status, their integration into a social network, the surrounding air quality, pollution, and geographic factors in which a person resides. The World Health Organization’s 2005 Commission on SDH recognized the social environment’s “direct influence on access to health care and lifestyle choices.”² But it curiously omits the risk of violence associated with the social environment, including police violence. In Toronto, the risk of experiencing violent police force is five times more likely as a Black Torontonian than a white one, while the specific risk of being fatally shot by police is twenty times more likely.^{3,4} Policing is an impulse to collect what’s deemed unsightly to a classist, anti-Black, and anti-Indigenous society and put it away into prisons and other elsewhere, where the privileged needn’t be confronted with the troubling

visuals of racialized poverty and its many forms of resistance. By opening the criteria of a public health concern—which is to say a collectivized concern voiced by the medical community—to encompass violence at the hands of police, it’s more difficult to feign ignorance or invisibility.

Enter Doctors for Defunding Police, which began in June 2020 as an initiative by a handful of medical doctors “concerned about the toll anti-Black and anti-Indigenous policing was taking on the health of residents in the City of Toronto.” It goes without saying that this was a summer of reckoning with police brutality, especially those most egregious forms often reserved for individuals in mental health crisis, facing housing insecurity, or criminalized due to their racial background. The group’s initial press release identified the healthcare system’s complicity “in systemic anti-Black and anti-Indigenous racism [which] often works in concert with police services, especially as it relates to mental health crises.”⁵ Respectability politics are often leveraged to keep policing impervious to critique, but doctors have a similar leverage in terms of shaping public discourse, specifically around what gets included in conversations about health. Doctors for Defunding Police now includes over 600 members from diverse medical, cultural, and racialized backgrounds within Canada.

Doctors for Defunding Police is expanding not only in size but also in scope, acknowledging the interrelated crises of addiction, housing, and policing. This is

reflected in their recent membership in an activist coalition, comprising several organizations in the GTA that—in a statement titled “Another Toronto is Possible”—voiced support for harm reduction models, equitable forms of housing, and moves away from the criminalization of poverty in the city.⁶ The coalition cites the municipality’s police budget spending (which is about double the combined budgets of Toronto Public Library, Public Health, Toronto Region Conservation Authority, Toronto Community Housing Agencies, and the Association of Community Centres)⁷ as a cause of underfunded social services.⁸

Relatedly, and with an overlap in signatories for a growing total of more than one thousand, are Doctors for Justice in LTC (Long-Term Care)—who have turned their attention toward another form of housing in crisis. Concerned about the health of both workers and residents, Doctors for Justice in LTC note that Canada had the highest proportion of LTC deaths as compared to other OECD countries,⁹ with Ontario’s LTC death toll at around 2,000 at the time of publishing their press release in January 2021. This number amounts to a humanitarian crisis, and one that cannot be made right for the families of lost loved ones, in part due to Premier Doug Ford raising the threshold for liability of wrongdoing for LTC operators, many which are private and for-profit.¹⁰

In light of this, the first demand from Doctors for Justice in LTC is immediately removing the profit motive from LTC,

noting that “for-profit LTC homes have had far worse outcomes during the pandemic as compared to non-profit and municipal LTC homes.”¹¹ It is because of the system’s opacity that so many infractions around staffing ratios and infection control protocols at LTC homes are able to slip through the cracks, especially during lockdowns. It’s difficult to hold LTC operators accountable (in particular those private and for-profit long-term care homes) when so few can witness what’s happening from the inside. Much like policing’s attempt to hide unsightly inequities through force and incarceration, privatized LTC homes apply the insidious, out-of-sight-out-of-mind model that works in favour of for-profit interests. Doctors for Justice in LTC’s press release makes clear that LTC homes are gravely understaffed, and with the province’s current nursing shortage, this troubling reality will worsen unless immediate governmental action is taken.

Many social systems in Canada, from housing to healthcare, find themselves on the brink of collapse. And it’s no coincidence, given that so many were established on the unsustainable foundations of settler-colonial capitalism. Doctors are beginning to expand the notions of SDH to incorporate the language of decolonial and anti-capitalist thought, turning a critical gaze on narrower definitions of public health. Making these concerns around police violence and inadequate care in LTC visible and heard through a public health lens places them in that unavoidably visible and discursive space we call the public. It’s difficult to gauge the impact activist medical groups have on policy measures at the municipal, and especially provincial, level. But there have been developments such as the City of Toronto’s Community Crisis pilot projects, which launched in the spring of 2022 in four targeted neighbourhoods.¹² Only a few months old, one of the major concerns is an underuse of the Community Crisis service, with few direct calls from community members or 911 diversions by dispatchers.¹³ This could represent a learning curve, or another question of visibility: how to assess a need when you can’t see the problem? What assumptions of criminality are made by bystanders? Can trust be established between civilian, non-civilian, and response teams dubiously in the middle?

In the meantime, crises of health and housing remain visible throughout the GTA. As witnesses to these systemic inequities on the intimate level of the body, doctors are offering not only their professional medical opinions but their personal and experiential ones on the root causes of systemic bodily harm. They see the effects of stress, trauma, and anxiety on their patients. They work in the environments of chronically underfunded long-term care and tend to the often-fatal effects of inadequate housing. As professional members of the community, these groups of largely BIPOC doctors are speaking out about not only the symptoms of systemic injustices, but its causes.

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Biographies

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Sarah Bird is a death doula and grief educator. In addition to her decades-long experience in healthcare, Sarah trained to become a death doula through the Institute of Traditional Medicine in Toronto, Ontario, and splits her time working between private practice and community hospice. Alongside her intensive training, she is a grief movement guide, grief ritualist, and collaborates with organizations such as the Alzheimer Society Toronto to co-facilitate bereavement support groups.

Matthew Bonn is the program manager with the Canadian Association of People Who Use Drugs. He’s also a board member of the International Network of Health and Hepatitis in Substance Users and a knowledge translator for the Dr. Peter Centre. His writing has appeared in *The Conversation*, *CATIE*, *Doctors Nova Scotia*, *Policy Options*, and *The Coast*. Matthew was on the 64th Canadian Delegation to the Commission on Narcotic Drugs. He is a current drug user and formerly incarcerated person.

Brothers Sick is the sibling collaboration of New York-based artists Ezra and Noah Benus, whose activities centre on disability justice, illness, and care. Drawing on lived experience—disability, queerness, chronic illness and pain, Jewish upbringing—their work often contrasts image and text. They utilize their own text compositions with photos, footage, and medical files from the Benus’s personal archive that document their care routines to create powerful contemplations of how we understand the body as healthy or ill. They integrate reflections on histories and legacies of activism, illness, eugenics, otherness, Jewishness, and spirituality with the contemporary, ongoing struggles of marginalized and sick/disabled people.

Emily Cadotte is a doctoral student at the University of Western Ontario where she is also the editor of *tba: journal of art, media, and visual culture*. She holds an MA from OCAD University where she was awarded the program medal for Contemporary Art, Design and New Media Histories. She has taught at Brock University and OCADU, and worked in various arts admin roles. She has published in *Art Education*, *Esse*, and *Canadian Art*.

Lynn Crosbie is a cultural critic, author, and poet. A PhD in English literature with a background in visual studies, she teaches at OCADU and the University of Toronto. Her books include *Queen Rat*, *Dorothy L’Amour*, and *Liar*. She is also the author of the controversial book *Paul’s Case*, and most recently *Life Is About Losing Everything* and the Trillium Book Award-nominated novel *Where Did You Sleep Last Night*. She is a contributing editor at *Fashion* and a National Magazine Award winner who has written about sports, style, art, and music.

Rayne Foy-Vachon is an end-of-life/death doula from Winnipeg, Manitoba. Her work focuses primarily within the 2SLGBTQ+ community and is rooted in harm reduction, trauma-informed care, sex positivity, and social determinants of health through a social justice lens. Rayne comes from an eighteen-year background as the Clinic Coordinator at Nine Circles Community Health Centre. Her journey as a death doula began in April 2021 and has since evolved into a successful end-of-life business—Dying to Help End of Life Services.

Karl Gardner writes and works with social movements committed to migrant justice, Indigenous solidarity, and abolition. He is currently a post-doctoral fellow at the University of Toronto in Political Science, where his work is exploring migrant and Indigenous solidarity in settler colonial contexts. He is also working with the Critical Health and Social Action Lab on a project examining the increasing role of police in contexts of harm reduction and mental health crisis.

Craig Jennex is an Assistant Professor of English at Toronto Metropolitan University. He is co-author of *Out North: An Archive of Queer Activism and Kinship in Canada* and co-editor of *Popular Music and the Politics of Hope: Queer and Feminist Interventions*. His forthcoming book *Liberation on the Dance Floor* will be published by Cambridge University Press in 2023.

Shan Kelley was raised in the prairie backdrop of Alberta, Canada’s beef and petroleum heartland. His work sits amidst a slippage of intersections between art and activism. In this fascination with language, Kelley uses text as material, to scrutinize the ways relationships to self, identity, body, and power are deconstructed, created, and curated. After an HIV+ diagnosis in 2009 he became increasingly inspired to find his voice within the context of disease and adversity, and to push forward using art as action again apathy or surrender.

Mya Moniz is the Advocacy Podcast Coordinator for Restoration and Empowerment for Social Transition (REST Centres). Moniz is an independent youth and former crown ward of the Peel Children’s Aid Society. She studies English, Professional Writing and Communications, and Sociology at the University of Toronto. She also sits at the Senior Leadership Table for the Peel Alliance to End Homelessness, and is a member of the Peel Poverty Action Group and REST’s Youth Council.

Kayla Moryoussef has been a death doula and grief worker since 2012, having been trained and certified through the Home Hospice Association, where she now trains and teaches others. She works in Toronto and everywhere, virtually. She started her private practice, Good Death Doula, in 2019.

Mourning School is an artistic study program on the notion of being in grief as the stuff of our everyday, initiated by Lucie Gottlieb and Rosa Paardenkooper. In a series of exhibitions, public programming, and publications, we imagine new ways of collective mourning to give name to and make space for the feelings that come with death, dying, loss, and mourning.

Rasheen Oliver is Director of Operations at Homeless Health Peel. Oliver has nine years of experience working as an RPN. She graduated from Sheridan College and started her career in long-term care working with stable geriatric patients with comorbid mental health conditions and complex behaviours. She brings this empathy and compassion to Homeless Health Peel where she views patients as individuals and not just a diagnosis.

Tamara Oyola-Santiago is a public health educator and harm reductionist navigating the multiplicities of home, justice, and healing. She is co-founder of Bronx Móvil where radical love and hope humanize.

Kimone Rodney is the Nurse In Charge at Homeless Health Peel. She obtained her Registered Practical Nursing diploma at Sheridan College. From a young age, she knew she would dedicate herself to helping others. With a particular interest in mental health, women’s health, preventative health, and palliative care, Rodney brings a dedication that is deeply rooted in her faith, to provide the highest quality of care to every one of our patients who have been left behind.

Dr. **Fady Shanouda** is a critical disability studies scholar who draws on feminist new materialism to examine disabled and mad students’ experiences in higher education. He is Assistant Professor at the Feminist Institute of Social Transformation (FIST) at Carleton University. He conducts this research diversely-positioned as a disabled, fat, POC, immigrant, and settler who is living, working, and creating on the ancestral and traditional territories of the Algonquin nation.

nancy viva davis halifax was born on the North shore of New Brunswick on Mi’gma’gi territory \ they is a white \ queer \ crip poet & settler \ a celtic mongrel \ they is the author of *hook* & has recently completed *act normal* \ their writing is oriented as an activist & embodied practice—of the body & responsive to wounds written on body\ \ they imagines life as lived through deep connections & ways of knowin’ that are off-centre multiple sensuous \ their life is entangled with a glorious array of sparkley wonderfuls.

Chrystal Waban Toop is a restorative circle keeper, public speaker, published author, life spectrum doula, counsellor, sociologist, and registered social services worker. For over twenty years, she has focused on healing as an intergenerational residential school survivor whose path began as a youth-at-risk, surviving on the streets of downtown Ottawa and Thunder Bay. Chrystal is a member of the Algonquins of Pikwakanagan First Nation and the founder of Blackbird Medicines, a professional social enterprise that advances healing justice through her work as an Indigenous counselor, spiritual caregiver, and matriarch.

The **What Would an HIV Doula Do?** collective comprises artists, activists, academics, chaplains, doulas, health care practitioners, nurses, filmmakers, AIDS service organization employees, dancers, community educators, and others from across the HIV spectrum joined in response to the ongoing AIDS crisis. We understand a doula as someone in community who holds space for others during a time of transition. For us, HIV is a series of moments in someone’s life that does not start with diagnosis nor end with treatment or death.

Karen K. Yoshida is Professor Emerita at the Department of Physical Therapy, University of Toronto. Since 1987, she has initiated and led an innovative Critical Disability Studies component in partnership with the disability rights community. She was a fellow in Columbia University’s Oral History Summer Institute in 2008. Her most recent research has focused on activist disability oral history, disability leadership in the community, and arts-based dissemination. Karen led the oral history research project that is part of the SSHRC-funded Bodies in Translation Partnership grant.

GLOSSARY

An entangled lexicon for a rapidly changing world

Archipelago: A group of islands. Often used theoretically or metaphorically to convey ideas of migration, diaspora, and cultural exchange; for Tamara Oyola-Santiago (p. 13), the diversity of the Puerto Rican archipelago has been homogenized through US imperialism. Archipelagos often blur cultural and state boundaries; whereas islands are conceived as distinct and bordered entities like nations, archipelagos blend local, regional, and national contexts into new conceptions of culture and home (see also: **Matria**).

Contamination: A process that makes a pure substance impure by adulterating its original makeup. Due to reaction with the outside substance, the original substance becomes poisonous. Matthew Bonn (p. 4) advocates for a safe and regulated drug supply to counter the lethal harms of drug contamination. Contamination may also be environmental; see Murphy (*SDUK02*, p. 10), Simmons (*SDUK05*, p. 10) or Wool (*SDUK09*, p. 8) for perspectives on the toxic legacies of chemical contamination.

A **doula** is a person who supports an individual during a time of life transition. Doulas are trained non-medical professionals who bring lived experience to their work in supporting different life transitions: birth doulas provide care through pregnancy; intimacy doulas navigate sexual health and trauma; and death doulas (p. 22) support end-of-life care. What Would an HIV Doula Do? collective (p. 11) considers how the profession can support people with HIV and their kin.

Harm reduction aims to reduce the negative consequences of substance use and offers an alternative to abstinence-only intervention. Rooted in activism by people who use drugs, many harm reductionists advocate for safe drug supply and decriminalization (see Bonn, p. 4). An expanded understanding of harm reduction as a movement encompasses notions of collective healing, unity across geographies, and resistance to all forms of systemic oppression (Oyola-Santiago, p. 13; Ansloos and Gardner, p. 26).

Hevrotah: The traditional Jewish practice of studying the Torah with a partner or group. Rooted in the Hebrew word for “friend” (*haver*), hevrotah describes the collective and peer-guided approach to learning and interpreting biblical texts. With a hevrotah, the act of reciting is animated by critical thinking and intergenerational exchange. See Brothers Sick whose practice is informed by collaborative Torah exegesis to underscore contemporary experiences of illness and disability (p. 15).

Lamentation is the outward expression of grief, sorrow, or mourning. In referencing *itkuvirsi*, the Karelian (present-day Finland, Sweden, and Russia) folk tradition of singing and crying with words, Mourning School

(p. 20) underscore that grief work is involved in all forms of transition, not only death. Many ancient and contemporary acts of lamentation across different cultures are anchored by language and the voice.

Longing: Desire, loss, craving, nostalgia, wistfulness. Often framed in the present while reflecting on the past, longing denotes the sustained desire for an absent person, place, thing, or feeling. Craig Jennex (p. 6) describes longing for queer collectivity forged through nightlife; in his account, longing is both temporal and geographic, provoked by artworks that simulate missing out. Longing might also be brought on by grief, where a loss causes the sufferer to long for a previous state (see Crosbie, p. 24; “A Good Death,” p. 22; Mourning School, p. 20).

A neologism for the term “homeland,” **matria** posits nationhood in relation to matriarchal belonging. Entrenched in feminist thought as well as literary, poetic, and anthropological traditions, the Spanish word “matria” maps out interdependent worlds grounded in practices of mutual aid, radical love, and care for Mother Earth. For Tamara Oyola-Santiago, experiences of migration and diaspora are met with a sense of matria, a feeling that binds her with other *boricua* (Puerto Rican people) across time and distance (p. 13).

Medication: Pharmaceutical drugs used for treatment of illness or disease. Artworks by Brothers Sick (p. 15) and Shan Kelley (cover; p. 28) position pharmaceutical medications as vital tools for living with chronic illness, alongside networks of care and support. Matthew Bonn (p. 4) calls attention to the sociopolitical factors that distinguish between licit medications and illicit drugs; he cites the existing framework for regulation of medications as a basis for decriminalizing illicit drugs (see also: **stigma**).

An **obituary** is a written text, usually in a newspaper or online, that commemorates a deceased person. It might include their photo, name, age, surviving family members, and fond memories. With a long history dating to the earliest written records, and vastly expanded with developments in printing, obituaries have become an important source of public record-keeping. Writing an obituary can be an opportunity for the living to express their grief (see Mourning School, p. 20; “A Good Death,” p. 22).

Ritual is a sequence of actions, words, and objects determined and practiced by an individual or community. Commonly used interchangeably with “habit” and “routine,” ritual differs as it implies meaningful intention. It also departs from the formality of ceremony and can occur in everyday circumstances. Rituals are employed for a myriad of reasons: fulfilling rites as part of religious or cultural traditions; processing grief and restoring agency (see Brothers Sick, p. 15; Mourning School, p. 20); managing or honouring relationships (agbayani, *SDUK07*); healing

and reflection (Kelley, cover; p. 28).

Safe Supply refers broadly to the legal and policy measures needed to combat the ongoing overdose crisis. Driven largely by the proliferation of fentanyl in the drug supply—which is the leading cause of fatal overdoses—drug poisoning has risen dramatically in Canada since 2016 (Bonn, p. 4). Measures for transitioning to a safe supply include many of the current safeguards on legal products such as alcohol or cigarettes, such as decriminalization and regulation; additional measures include the expansion of drug testing kits, and the creation of buyers’ clubs or cooperatives.

Social Determinants of Health (SDH) is a leading global framework that considers the direct effects of an individual’s broader social environment on their health. Responding to the common understandings of SDH, contributors critically examine its shortcomings, citing that it fails to fully acknowledge systemic inequities. Social factors are often beyond a person’s control (“Nowhere to Isolate,” p. 9) and are made invisible or exacerbated by forms of structural oppression (including police violence and legislative liability protection; Cadotte, p. 29). SDH has also been criticized for overlooking health as a relational process.

Stigma is a discriminatory idea that perpetuates false notions about a marginalized person or group. Stigma contributes to further ostracizing its targets from society, marking them as “other.” Kimone Rodney (p. 9) describes stigma as a major barrier for unhoused people due to the judgement they experience in accessing housing and healthcare; Matthew Bonn (p. 4) asserts it’s a major cause of policy inaction toward the overdose crisis; and Shanouda, viva davis halifax and Yoshida (p. 18) discuss stigmatization as a reason for the marginalization of people with disabilities.

Trauma-informed care: A patient-centred approach that facilitates healing through understanding the widespread impacts of trauma. Healthcare and social service providers who implement trauma-informed care are trained to discern the signs and symptoms of trauma, and apply that knowledge in promoting safe spaces for treatment, patient empowerment, and staff wellness. Amid health and housing crises that perpetuate inequalities in access to services, medical practitioners are fostering systems of trauma-informed care that break down barriers for unhoused and marginalized individuals (see “Nowhere to Isolate,” p. 9; Cadotte, p. 29).

From the Latin *vigilia* meaning “wakefulness,” **vigil** is the act of staying awake, often as part of a ritual or devotional practice. To keep vigil typically refers to being present with a person who is critically ill or dying. It is also a way to prepare for and process the end-of-life of a loved one (see “A Good Death,” p. 22; **ritual**) and a method for public mourning, commemoration, or protest.