

CANADIAN TREATMENT ACTION COUNCIL



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Treatment decisions for youth: barriers and approaches

By Marco Gomes, CTAC Board

FOR millions of young people living with HIV/AIDS, little treatment or care is available. Indeed, for most young people in the countries hardest hit by the HIV/AIDS epidemic, no treatment is available at all. Although there is treatment for related conditions such as STIs and opportunistic infections, many young people cannot afford it. They cannot ask their parents or others for financial help if they do not want to reveal their infection.

Youth represent a small proportion of the total number of reported HIV and AIDS cases in Canada. Individuals between the ages of 10 and 24 account for 3.5% of cumulative AIDS cases. In spite of these low proportions, risk behavior data on young Canadians show the potential for HIV transmission. A national study found that approximately 50% to 60% of grade 9 and 11 students think there is a vaccine available to prevent HIV/AIDS¹. A 2005 survey of adolescents between 14 and 17 showed that 27% were sexually active. Of the sexually active, each had had three partners, 24% did not use a condom the last time they had sex, 38% engaged in casual sex, 16% reported their partner had had other partners while dating them, and half of those who used condoms reported never checking after sex to see if the condom had remained intact².

Globally, half of all new HIV infections occur among young people. Currently there is an estimated 11.8 million youth aged 15-24 years living with HIV/AIDS³.



In Canada, youth, particularly young women aged 15-29, represent a growing population who are being infected with HIV and AIDS. Due to under-reporting and under-diagnosis, as well as a long asymptomatic period, the actual prevalence of HIV in youth is likely much higher than indicated in official statistics. Surveillance data in the United States shows that although AIDS incidence is declining, there has not been a comparable decline in the number of newly diagnosed HIV cases among youth.

Despite this prevalence of incidence, there is a profound lack of resources for HIV-positive youth. In particular, youth-accessible resources outlining treatment options are scarce. Although material is available to help adults make treatment decisions, many of these resources are not appropriate for youth because they fail to address their unique clinical and developmental challenges. Furthermore, texts written for adults are often intimidating to younger audiences, both because of language and literacy barriers, and the less engaging ways in which information has traditionally been presented.

While many HIV-positive adolescents are at early stages in the course of their disease, health promotion messages are very important for them. Studies of adolescents living with HIV have shown high morbidity and mortality rates. Other studies looking at the subjective health experience have documented that a quarter of those interviewed described their health as "fair" or "poor." These findings illustrate the importance of treatment, self-care and prevention of co-infections for this population.

HIV-positive youth are unique in their treatment and self-care needs. Many youth for whom antiretroviral medications are clinically indicated choose not take them. Many do not access health care services. There are more antiretroviral drugs available for adults than there are for children because of the way some of them react negatively with a growing child's immune system. Children are given combination treatment based on body surface area (calculated by measuring height and weight) or sometimes on weight alone. As a child grows the dosage increases, as does the number of treatment options.

Treatment with antiretrovirals is the most powerful tool for improving the health of adolescents living with HIV and,



There is an estimated 11.8 million youth aged 15-24 years living with HIV/AIDS

when combined with counseling, leads to reduction in transmission of HIV. Client-centered behavioral counseling, psychosocial support and other interventions, such as reminder systems like the use of box pills, have been shown to help adolescents adhere to ART, as well as prophylactic and treatment regimens. Management of HIV/AIDS among young people requires a variety of assistance and referral networks for their range of problems. As with other chronic diseases, compliance with a strict regimen of complex care and medications for HIV is difficult and often is not a high priority for youth. To keep young people in the health care system, a balanced approach is essential—both working with young people to address personal issues and developing a realistic prevention and care plan is essential.

Fixed-dose combinations are not recommended for youth because the amounts of each drug in one tablet cannot be tailored to suit an individual. A youth may at times have to take a higher dosage than an adult because their metabolism processes the drugs more quickly. Youth may have perceptions of treatment that differ from adults, favoring a present quality of life over improving biological markers. In contrast to adults, peer influence has been identified as one of the key factors affecting youth treatment decision-making. Thus, there is a strong need for peer-driven resources about HIV/AIDS treatment presented in youth-friendly formats. Moreover, these resources need to be sensitive to the ways in which self-care and treatment decisions are contextualized within the broader scope of these youths' lives.

Adolescence and early adulthood are the stages when lifelong health and social behavior patterns are formed. HIV-positive youth are particularly vulnerable during this period, as they experience disproportionate rates of homelessness, sexual and physical abuse, financial difficulties, addictions, legal concerns, social isolation and stigma, and mental

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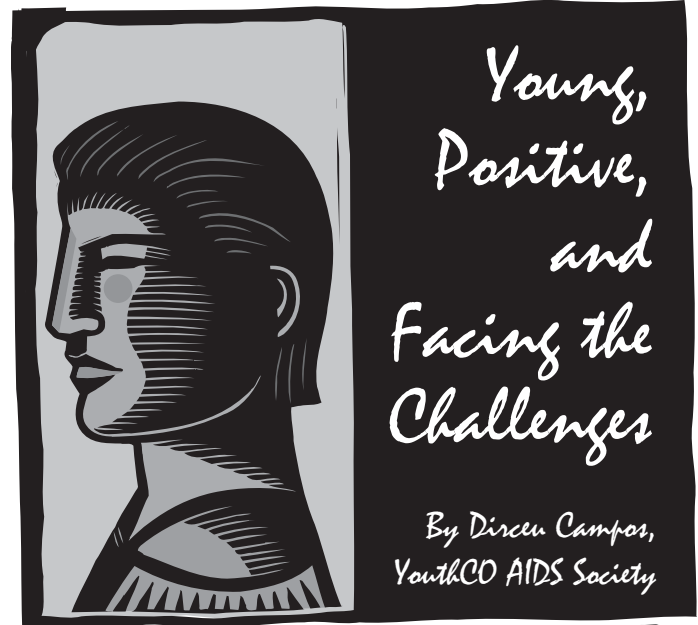
WHEN I first agreed to write this article, I was not really sure that I would have a whole lot to say on the topic of treatment. I am 26 years old, and I have been HIV positive for three years. I am not on medication for my HIV at this point, and I am still learning about life as an HIV-positive youth.

I work at YouthCO AIDS Society in Vancouver, an organization dedicated to assisting positive youth in British Columbia. I thought about where I was in my life when I was first diagnosed and I realized all that it had taken, to just be where I am today.

The largest barrier to accessing treatment I have faced to date has been myself. Before I started accessing AIDS service organizations (ASOs), I felt pretty comfortable staying away from "that world". I went to see my doctor when necessary, but I never sought out anything further out of fear and a lack of knowledge. "I'm young, I have a good job, an education, I'm healthy, I don't need medication at this point in my life, I'm fine", I thought. I was new to Vancouver at this point and didn't really have a lot of friends. I wanted to meet people who were in the same situation as me. I needed peers.

One day at an appointment, I asked my doctor about AIDS organizations in Vancouver. He told me about YouthCO and it sounded like just what I had been looking for, an organization specifically for HIV positive youth. It sounded too good to be true! I immediately went home and googled their website. I found out where they were located and realized I had to make a decision. I, like many other positive youth, felt that walking through that door asking for help meant admitting defeat, and that it would put me in a group that I did not feel connected with. I imagined AIDS service organizations were places where only homeless, sick, and addicted people convened. I felt I would be broadcasting my status by going to these places, and for a long time, that was not something I was ready to do. It was not denial about being positive, but I was scared of people knowing this secret I took such care to keep, scared that I had to ask for help and scared to admit I was deteriorating.

In retrospect, I realize how exceptionally wrong I was. Since becoming involved with YouthCO, I have learned much more about HIV than I would have learnt otherwise. I have learned about various forms of mainstream and alternative



treatments available and I have been able to make more informed choices about my health.

My life changed drastically again. At this point, I now had access to information, access to a group of people who were positive like me, young like me and who had the same fears as me. I also met a group of people who were not like me, but worked tirelessly to make this community available to people like me. Having worked in this field for a year now, I see that same fear I used to have when a new youth comes through the front door. I realized how very important this work is to combat isolation, fear, and lack of knowledge, to provide a safe place for youth affected by something they cannot face alone.

The youth that I meet through work and my involvement in the "poz youth" community come from every conceivable background and are facing issues around HIV in infinite combinations. It was not until a couple of months into my job that I first knowingly met an HIV-positive female! I learned that young women face a whole different set of issues, stigmas, and dangers around HIV than men. I have learned that HIV negative people are also affected by this epidemic and that this virus really does not discriminate.

The youth that do muster the courage to seek out help have radically different needs. Some youth, like me, need a community to belong to and contribute to. Some youth need

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Parenting and Living with HIV/AIDS

My son and I were diagnosed with HIV in 1993. He was only three months old. Treatment choices were limited in those days. I was fortunate. I had a strong immune system that allowed me to wait until the advent of HAART to start therapy, but my son's treatment history is another story.

At 18 months old, the young person living with HIV/AIDS started his first antiretroviral treatment, AZT monotherapy. About a year later, when dual therapy was the latest development in HIV treatment, he added 3TC. It wasn't long before he developed resistance to AZT and he needed a new combination. In 1996, he started d4T, 3TC and a therapeutic dose of liquid Ritonivir.

The "ritonavir days", as we now refer to them, were difficult. Trying to convince a three year old to swallow a liquid that burned his throat, tasted nasty and left his mouth numb was like trying to rope and tie a feisty calf. He would writhe around and kick and scream until I got the nasty liquid down his throat. Eventually, I discovered that the promise of a "chocolate milk chaser" could improve his adherence. When the news broke that gel caps would soon be available in Canada, my son started to practice swallowing Smarties so he would be ready to make the switch. He was only five years old. Unfortunately, a more palatable pediatric version of Ritonivir continues to be unavailable.

Protease inhibitors eventually took their toll on my son's lipids and with high low-density lipoprotein (LDL) and triglyceride levels plus newly released switch studies, we traded Ritonivir for Sustiva.

On a personal note... 

By Shari Margolese

At 15, he remains suppressed with a healthy CD4 count on this regimen. However, he does experience side effects. Since beginning Sustiva, he tends to have more fatigue and his ability to concentrate at school has suffered. While I could make a choice to change his regimen again, he is already highly treatment experienced and is resistant to some drugs. Besides, as the old saying goes, if it ain't broke, don't fix it.

Unfortunately, there are very few resources available to assist adolescents and youth who are having difficulty in school due to HIV medication side effects. Private tutors are expensive and the fear of disclosing HIV status often prohibits families from taking advantage of school affiliated programs available for children with "underlying health conditions".

More recently, fearing lipodystrophy, we switched d4T and 3TC for Kivexa. On a positive note, he has now grown into adult dosages of medications and has taken advantage of combination pills which are not available for children in Canada. His current routine of Kivexa and Sustiva has reduced his pill burden to two pills once a day. My son is delighted to take fewer pills less often. Since his regimen has been simplified he has definitely been more adherent and less defiant about taking his meds. But some things will likely never change; to this day he gets nauseous if he smells my Ritonivir, even in a gel cap.

My son says, "It would be great if we could take one pill and cure HIV, wouldn't it?" ■

By Sam Friedman,
CTAC British Columbia Representative

Pharmaceutical drugs improve health outcomes, decrease overall healthcare costs, and contribute to the economic sustainability of our public healthcare programs. Patented and non-patented prescription drugs together account for less than 10% of yearly government spending on health care¹. However, policy makers and bureaucrats within British Columbia's Ministry of Health continuously fail to base their policy decisions on a realistic evaluation of the costs and benefits of pharmaceutical drugs.

In August, British Columbia's Minister of Health initiated a trial of yet another misguided price and supply based expenditure control attempt called "tendering" within British Columbia's PharmaCare program. The pilot tendering program accepted bids from manufacturers competing to become the primary supplier of diabetic test strips.² If further implemented to include pharmaceutical drugs, tendering would join British Columbia health policies of reference based pricing, low cost alternative and therapeutic substitution initiatives that have the potential to restrict patient choice and access, redistribute costs and create negative health outcomes.

Based on a model used in New Zealand, tenders would be invited to participate in a closed bidding competition over lucrative sole supplier contracts for large volume non-patented purchases—with the contract being awarded to the lowest bidder. At first glance this appears like a sound means to contain the cost for PharmaCare's procurement of these pharmaceuticals. What is not so obvious is that PharmaCare would likely restrict benefit coverage to the tendered drug, eliminating benefit coverage for all other formulary listed versions within that category. For the majority of drug plan beneficiaries, this would lead to a forced switching to this exclusively available cheapest version of a drug. Steering patients towards greater use of a less expensive generic version of a brand name drug is fine when the necessary clinical consideration of ensuring chemical equivalence is in place. However, the cheapest version is not always the most effective version. Making cost containment decisions, which would restrict drug availability based solely on fiscal

TENDERING:



a
misguided price and
supply based cost
containment initiative

reasoning, is not only economically short sighted, but also medically inappropriate.

Treatment failures occur in a very small proportion of any given population. However, the overall costs incurred by the various provincial healthcare service sectors required to stabilize these patients is likely to be far greater than the total amount of economic savings that tendering may secure for the PharmaCare program in the first place. For example, in New Zealand, the tendering process of statins led to treatment failure disasters before it was chosen in many cases to go back to the more expensive, more effective brand.³

PharmaCare has taken the public stance of being in favour of choice and access while maintaining affordability and sustainability. Its public statements continue to perpetuate the "blame game" of the increasing, and

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Formularies Series:

Nova Scotia

By Mike Sangster, CTAC Nova Scotia Representative

IN the four Atlantic Provinces of Canada, the Atlantic Common Drug Review's (ACDR) Expert Advisory Committee makes a recommendation as to which Anti Retroviral Drugs (ARVs) should be used in the various provincial formularies. This Expert Advisory Committee is composed of physicians, pharmacists and other persons with expertise in drug therapy and drug use evaluation, with one glaring omission: a patient representative. Based on the best available clinical and economic evidence the committee makes recommendations to each of the Atlantic Ministers of Health regarding the coverage of a drug on the provincial drug program formulary. The ACDR only makes recommendations on drugs which have been denied by the CDR. They do not make recommendations for reimbursement on drugs that have already been recommended by the CDR. The ACDR has actually provided a means for people living with HIV/AIDS in Atlantic Canada to get access to various ARVs which have been denied by the CDR.

In Nova Scotia a process exists to consider the Canadian Common Drug Review (CDR) and ACDR recommendations. The Drug Plan Manager is responsible for presenting the recommendations and budget impact information to Nova Scotia's Provincial Government. Final decisions are made based on provincial priorities and resources. Ultimately, the Nova Scotia Minister of Health's approval is required.

At present all persons infected with HIV/AIDS in Nova Scotia must come to the Infectious Disease Clinic at the QE2 Hospital in Halifax in order to obtain treatment. All naive patients (those who have not previously taken ARVs), as well as those patients needing to make a change to their therapy,

will receive genotype testing and a virtual phenotype will be done. Essentially, this procedure analyzes the patient's resistant mutations (genotype) and compares it to a database in order to predict which drugs should work best (phenotype).

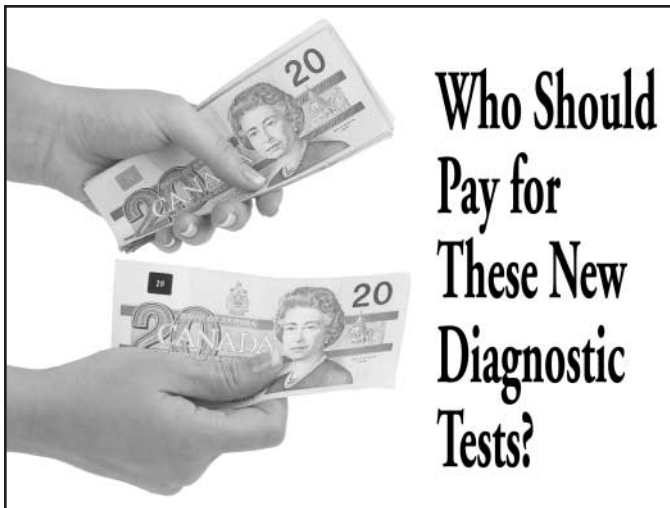
All ARVs approved by the CDR and ACDR are free for HIV/AIDS patients in Nova Scotia. However, the clinic pharmacy and pharmacies in general in Nova Scotia do charge a dispensing fee for all prescription drugs. This places a financial burden on anyone who is not on social assistance (in this case social assistance pays the dispensing fee). People who have a health plan through their employer must first pay the cost of their ARVs through their employer's health plan and the province will pick up the remaining costs of the ARVs.

If a patient needs to access a drug that is not listed on the Nova Scotia formulary, he or she may access it through one of the following three protocols: compassionate access, special access and expanded access. Compassionate access applies in cases where a drug is available on the Canadian market and is in the process of being approved to go on provincial formulary. With some paper work, the pharmaceutical company may give a limited supply free of charge to individual patients. For example, there are delays in the approval of Raltegravir to the Nova Scotia formulary but it has been made available through compassionate access to around ten patients in the province.

Through the special access program, the clinic may send a request to Health Canada to receive a drug not yet approved for sale in Canada. Additional paperwork is also supplied/required by the manufacturer that releases the drug. The drug may or may not have a cost associated with it. There is usually a long waiting period before receiving the drug and only a limited supply is sent at once.

Patients may also receive a drug through expanded access if they participate in a clinical research study for this drug. When the study is over and the drug comes to market, the company is still obliged to continue to supply the drug to patients free of charge until there is some mechanism to pay for the drug, i.e., covered by the provincial formulary.

All in all, the clinics in Nova Scotia have never been denied access to any ARVs requested for treatment of patients living with HIV/AIDS. ■



by Ron Rosenes, Vice Chair, CTAC Board

TESTS to determine whether people will be successful on new drugs or if they may develop a severe reaction to a particular drug have recently been developed. This article will examine the thorny question of who should pay for these tests—the companies whose drugs require them or the health care system.

A new class of drugs known as CCR5 inhibitors was recently approved for sale in Canada. This drug is not for everyone. It has been approved for use in highly treatment experienced people with HIV but only under certain conditions. They must have experienced failure on existing drugs in other classes and be in need of at least two active new drugs based on genotyping in order to construct a

viable regimen. They will only be a candidate for the CCR5 inhibitor if their virus uses the CCR5 co-receptor specifically in order to attach to and ultimately take over their CD4 cells.

Some people, who may be in the minority but are unfortunately often those with advanced HIV disease, carry a virus that predominantly uses another co-receptor, the CXCR4, to attach to the CD4 cell. There is now a test which can determine on an individual-case basis if the carried HIV attaches using the CCR5 co-receptor and if the patient is therefore likely to be susceptible to this new drug. The test is called a “tropism” test and refers to the shifts that can occur between the two co-receptors which the virus chooses to use to enter the CD4 cell.

At the present time, Pfizer, the company that manufactures the first CCR5 inhibitor to reach the market, has agreed to cover the costs of the tropism test which has been developed by a diagnostic company. Pfizer purchases the tropism test from this company and offers it to all patients who may be considering this drug. There will soon be more CCR5 inhibitors coming to market from other companies such as Schering and they, too, will require the use of the tropism test.

In the world of oncology, there are new drugs such as Tamoxifen® which can only be used successfully in patients who are pre-tested to show they have a genetic bio-marker that makes them a suitable candidate for this drug. This may



We recently learned that in the United States, the following changes in the Department of Health and Health Services (DHHS) ART Treatment Guidelines for Adults and Adolescents were announced:

Tropism Assay

The Panel recommends tropism testing prior to the initiation of a CCR5 antagonist, such as maraviroc (AII). Coreceptor tropism testing might also be considered for patients exhibiting virologic failure on maraviroc (or any CCR5 inhibitor) (BIII).

HLA-B*5701 Testing

The Panel recommends HLA-B*5701 testing prior to initiating abacavir therapy to reduce the risk of hypersensitivity reaction (AI). HLA-B*5701-positive patients should not be prescribed abacavir (AI), and the positive status should be recorded as an abacavir allergy in the patient’s medical record (AII). When HLA-B*5701 screening is not readily available, it remains reasonable to initiate ABC with appropriate clinical counselling and monitoring for any signs of abacavir-associated hypersensitivity reaction (CIII).

be the wave of the future—tests to determine bio-markers that will predict an individual’s likelihood of responding to a given treatment based on their genetic make-up. As additional CCR5 inhibitors are brought to market, it only makes sense for the health care system to cover the cost of the tropism test as “standard of care”.

A different case for coverage needs to be made for the tests that can determine if a person is likely to develop a potentially life threatening hypersensitivity reaction to the drug abacavir. The allergy, frequently referred to as an abacavir hypersensitivity reaction (AHR), is a serious side effect that occurs in up to 8% of those taking the drug. Symptoms, including fever, rash and shortness of breath, often worsen with continued use of the drug. These symptoms can be fatal, especially if the drug is stopped and then restarted.

Various studies have shown that people (most frequently Caucasians) with an inherited gene (called HLA-B*5701) are far more likely to experience an AHR than those who don’t have the gene. A number of studies have found that excluding patients with the gene from abacavir therapy has helped to greatly reduce the risk of AHRs. Canadian researcher Elizabeth Phillips and Simon Mallal of Australia have done pioneering work to create reliable blood and patch tests that can be used to determine the likelihood for an individual to experience the rash. Their ongoing research was presented at IAS Sydney and ICAAC Chicago this year. The fact is that many people who may be good candidates for this well studied NRTI have shied away from it for fear of the allergic reaction, especially women.

This test for a specific “bio-marker” can determine if an individual is predisposed to have the severe allergic reaction and whether they will be a likely candidate for successful initiation of therapy with abacavir. Like the tropism test, the manufacturer is presently covering the cost of the test for patients considering an abacavir containing regimen. It may be harder to make a compelling case for the public health care system to cover a test which relates to the use of a single therapy but as research continues to investigate susceptibility to rash with a number of different drugs, this should hasten the time when this test gets covered. A further

and perhaps more important rationale could be made around ensuring patient safety. In today’s world, where provinces are increasingly exercising their purchasing power with the pharmas, there is no reason why the public system shouldn’t pay a lower reasonable price for the drug and the associated test to ensure its safety. ■

Young, positive and facing the challenges

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help with addictions, mental problems, abuse, and housing. Some just need food. Some still keep their distance, but know who we are and where to find us when they need a hand. Some, unfortunately, do not. And this, I guess, is where our challenges lie, in engaging and reaching out to youth and overcoming stigma, discrimination and fear, so that youth will access information, services and support.

In my ongoing quest for improved health, I have attempted many alternative therapies with varied results. I have also discovered that personal self-care is a vitally important form of treatment as well. Since my diagnosis, I have started taking better care of myself physically and emotionally which has resulted in better health in general. I have learned that sleep is precious and you can never have enough. I have started hiking outdoors and the emotional benefits of enjoying nature has healthy effects for me. I have acquired an addiction to swimming and the effect on my energy level has been phenomenal. I have also taken an active role in my nutrition and now I actually care what the nutritional value of my food is! The Canadian AIDS Treatment Information Exchange (CATIE) has put out a nutrition guide for positive people which explains what foods are better specifically for positive people in respect to symptoms and side effects, and how food requirements differ for positive people. This information has proven indispensable to me in maintaining good health.

Taking an active role in my own health is the most important and empowering thing I can do for myself. It has benefited me physically, mentally and spiritually. ■



Are you
youth living with HIV/AIDS?

Have you ever
been confronted with barriers in accessing
the treatment and care you need?

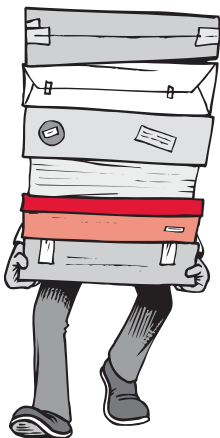
Do you wish
to better understand the policies behind access
to HIV/AIDS treatment in Canada?

Do you wish
to make a difference for youth living
with HIV/AIDS across Canada?

If so, this committee might be for you!

The Canadian Treatment Action Council (CTAC) is currently looking for people living with HIV/AIDS from across Canada under the age of 30 to form a CTAC Youth Committee. The roles of this committee will be to guide the advocacy and policy development of young people living with HIV with regards to access to treatment and treatment barriers. Members of this committee will take part in youth oriented activities to better understand the barriers of access to treatment for youth and will work on strategies to overcome them.

If you are interested or would like more information on this committee please contact us directly at ctac@ctac.ca.



Moved? Moving? Let us know!

Help us keep our records up to date by giving us your current mailing address. Email us at ctac@ctac.ca, phone or fax (416) 410-6538.

On a personal note...

What barriers stand in the way of accessing the HIV treatment that you need? Do you have a story to share about how you advocated for access to a treatment or therapy for yourself or on behalf of someone else? We want to hear your stories! Contact the CTAC office (see page 12) for more information. *Confidentiality will be respected. We may not print all stories submitted.*





CHAIR'S REPORT

Winter 2008

by Louise Binder

I WONDER IF ALL POLITICIANS make New Year's resolutions like we common folk. I have a few suggestions for politicians who have been a bit tardy in getting to them.

They relate to the way they use words when speaking to the electorate, a.k.a. their employers, so that they are clearly understood. I offer these suggestions because I think some of the anger and poor opinion we feel about some politicians from time to time stems from a lack of good communications.

BE CLEAR IN YOUR COMMUNICATIONS.

For example, don't call things "new" when you are announcing them unless they really are new. We usually think that the term "new" means "of recent origin; fresh or unused", to quote Webster's Dictionary. For instance, when announcing new money, we would expect that the Bank of Canada actually has the printing presses going or at least that it has an order to print the new money.

When politicians use it they often mean "recycled" or "taken from one place we promised to use it and moving it to another". For example, when the government announced "new" money for AIDS vaccine research and a production facility, we thought they meant they were adding to the federal funding to pay for that deal with Bill Gates. In fact, they meant they were taking money out of existing AIDS funding at the federal level, leaving a gaping hole to keep up the work we desperately need to prevent new infections and treat today's citizens.

BE EVIDENCE-BASED IN YOUR DECISION MAKING.

For example, when you have a hunch that you are not getting good value for money in the Grants and Contributions you give to the HIV/AIDS community to do prevention, care, treatment, support, research in our many populations, do a proper review with those directly involved before taking money out. You will then either have the evidence you need for your hunch or you will learn that you are getting so much more for your money than you ever dreamed from both the paid and volunteer members of that community.

RE-READ THE CANADA HEALTH ACT.

This act puts the federal government in the business of health whether it likes it or not. It is part of the job description. Since the provinces, territories, and local governments are also in that business, partnerships would sure get better value for money in health for Canadians. And it would support that "peace, order and good government section" of the Constitution, too.

You know, I suspect that many politicians have already got these resolutions figured out. Whether they have or not, even if they make them, like most resolutions, they will not be long in breaking them. ■

For more information
about CTAC, please visit
our website

www.ctac.ca

Treatment decisions for youth: barriers and approaches

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health concerns. Often, the immediacy of these social and structural determinants of health may overshadow worries about HIV infection. This results in a need for information that is sensitive to the unique situations of HIV-positive youth, while framing their experiences within the perspective of normal youth development to avoid further marginalization and stigmatization. ■

¹ Sexual Health in Canada – Baseline 2007. Canada Federation for Sexual Health (CFSH), www.cfsh.ca

² Sexual Health in Canada – Baseline 2007. Canada Federation for Sexual Health (CFSH), www.cfsh.ca

³ UNAIDS. Report on the global HIV/AIDS epidemic. Geneva: UNAIDS; 2006.

Tendering: a misguided price and supply based cost containment initiative

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apparently unsustainable, program expenditures caused by the high cost of new pharmaceutical drugs. Yet, British Columbia's formulary has one of the lowest proportion of new and innovative pharmaceuticals listed, while it lists and covers one of the greatest numbers of "me too" drugs in all of Canada.

If you live in British Columbia, I urge you to write to the Minister of Health to let him know about the harm tendering of drugs could cause. If you live outside of British Columbia, keep an eye open for signs of similar practices being implemented in your own province and let CTAC know about them. CTAC has already met with community stakeholders in Vancouver to discuss how best to deal with this situation and will keep its members updated on the issue. ■

¹ Drugs not the culprit in health costs. The Fraser Institute. www.fraserinstitute.org/commerce.web/article_details.aspx?pubID=4540. Accessed January 7, 2008.

² Best Medicines Coalition

³ The sorry saga of the statins in New Zealand – pharmacopolitics versus patient care. New Zealand Medical Journal. 2003. www.nzma.org.nz/journal/116-1170/360. Accessed January 7, 2008.

CALENDAR OF EVENTS

WINTER/SPRING 2008

► FEBRUARY

1st Annual Aboriginal HIV/AIDS & HCV ... 28-29
Conference "In the Spirit of the Family"

Prince Albert, Saskatchewan

Marlboro Inn

www.allnationshope.ca

► MARCH

Journées Québécoises VIH 2008 6-8

Montréal, Québec

Contact: (514) 340-8308

gdipanocr@ldi.jgh.mcgill.ca

www.symposiumsida.ca/JournQbc_Fr/JQ08_inscription

Positive Gathering 2008 28-30

Living Positively in a HIV Negative World

Vancouver, British Columbia

Plaza 500 Hotel

Contact: 1-800-994-2437

info@positivegathering.com

www.positivegathering.com

► APRIL

17th Annual Canadian Conference on 24-27

HIV/AIDS Research

Montreal, Quebec

Fairmont Queen Elizabeth

www.cahr-acrc.ca

► MAY

2008 Western Canadian 8th Biennial 1 & 2

Sexual Health Conference

Lister Hall, University of Alberta

Edmonton, Alberta

www.aspsh.ca/western_canadian_sexual_health_conference

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CTAC POSITION PAPERS

Papers

- 2007 – “Generic Drugs in Canada : A Policy Paper”. Authors: CTAC and Ward Health Strategies.
- 2006 – “Timeliness and Transparency: Assessing the Review Process for HIV Drugs.” Revised April 2006. Author: David Garmaise.
- 2004 – “Roadmap for Addressing the Epidemic of HIV and Hepatitis C Co-Infection in Canada.” Author: Paula Braitstein.
- 2001 – “Improving our Health: The Need to Enhance the Post-Approval Surveillance System for HIV/AIDS Drugs in Canada.” Author: David Garmaise.
- 2001 – “Making Treatments Accessible: A Policy Paper on Determining Appropriate Pricing for Brand-name Pharmaceutical Treatments for HIV/AIDS in Canada.” Author: Glen Brown.
- 2000 – “Position Paper on Direct to Consumer Advertising (DTCA) of Prescription Medications.” Author: Philip Lundrigan.

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MEMBERSHIP

Membership applications are available by contacting the CTAC office or by visiting the CTAC web site at www.ctac.ca/en/membership.

Full Membership is reserved for

- Persons living with HIV/AIDS
- Groups, organizations and/or projects with a substantial HIV/AIDS mandate

Associate Membership is open to

- Any individual, group, organization or project that supports CTAC's mandate and objectives

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CTAC's Mandate

To secure and ensure access to therapies and treatments for people living with HIV/AIDS by working with the public, private and not-for-profit sectors.

CTAC...

- Informs research and public policy, and promotes public awareness;
- Provides mentoring and skills building in these areas to people living with HIV/AIDS;
- Encourages and facilitates the exchange of related information to stakeholders;
- Builds and works with coalitions to address broader health care issues impacting access to therapies and treatments.

position_papers or on hard copy from the CTAC office (see contact information below).

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