

# CANADIAN TREATMENT ACTION COUNCIL



## Antiretrovirals and treatment interruptions in prisons

*by Terry Howard, Coordinator of the Prison Outreach Program, BC Persons With AIDS Society*

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In theory, Canadian prisoners have access to HAART. In practice, prisoners' access is complicated by a number of factors that determine whether medications successfully reach HIV positive prisoners. What makes the situation different from the community, aside from the obvious incarceration, is that prisons are under the care and control of a military style hierarchy with unresponsive chains of command, which leads to delay and



inconsistency in decision-making and policy implementation. Health care is often contracted out by the prison authorities, and health care personnel are looked upon as "civilians," meaning they occupy the lowest rung on the prison hierarchy. The militarism of the prison environment and the lack of power among health care staff within that system often result in lengthy delays when trying to rectify a medical problem for HIV positive prisoners, to bring about a policy change implementing harm reduction tools, or to ensure access to harm reduction tools where a policy already exists.

HAART access is not immune to the disease of militarism that too-often characterizes prison administration and that can get in the way of appropriate and timely health care. In a federal prison (where prisoners serve sentences of two years or more), prisoners must submit a written request explaining briefly why they wish to see a doctor, and then wait for a response. Few prisons in Canada have a doctor on-site daily so prisoners will usually first see a nurse in response to their request

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## Antiretrovirals and treatment interruptions in prisons

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for care. The nurse would then refer to the institution doctor who, in the case of evaluating a prisoner for HAART, will usually consult with a specialist. In institutions with significant numbers of prisoners living with HIV, a specialist visits the institution monthly and usually has a very large caseload. If a prisoner is not satisfied with the health care they receive, they can file a first level grievance with the head of the institution. Failing resolution, the prisoner can submit a second level grievance to Regional Headquarters to be reviewed. A third level grievance to Correctional Service of Canada national headquarters is the end of the line.

This process can take weeks or months to reach a satisfactory conclusion. Most prisoners forego this process out of frustration with the system, thereby causing high risk situations to develop, for example, risk of virus mutation from running out of a single medication in a cocktail. The HIV/AIDS Legal Network<sup>1</sup> and HALCO<sup>2</sup> can attest to the problems that arise from the delays involved.

HAART requires specialized skills to administer and monitor to every patient, and new information becomes available at a rate that is difficult to keep up with in the community<sup>3</sup>. In prison, keeping up with current treatment options and new medications becomes almost impossible for health care staff treating often 500 prisoners or more. The burden of care in the BC/Pacific Region falls largely to the Infectious Disease (ID) nurse in the federal system, where one or two ID nurses per institution care for the entire prisoner population requiring treatment for HIV, Hepatitis C, and other infectious diseases. In BC, the close working relationship developed by community organizations with the ID nurses has allowed for much quicker and more effective access to treatment information and rapid answers to questions regarding HAART and the related effects.

The Prison Outreach Program at BC Persons With AIDS Society (BCPWA) recently helped facilitate more streamlined HAART service delivery in federal institutions located in BC. The institution pharmacy now obtains HAART medications

**In prison, keeping up with current treatment options and new medications becomes almost impossible for health care staff who often treat 500 prisoners or more.**

directly from the BC Centre for Excellence (BCCfE). In BC, all HIV medications are administered free of charge to BC residents by the BCCfE, and HIV medication records are kept on file. Purchasing HAART directly from the BCCfE has almost eliminated lengthy treatment interruptions that can result when prisoners on HAART leave prison and re-enter the community health care system. In the case of people who return to prison, the delay to receive medications upon re-entry to prison has also been reduced due to the prompt availability of HIV medication records.

Problems with access to HAART and/or unscheduled treatment interruptions are considerably more problematic in provincial correctional facilities in BC, where the average length of stay is 17 days<sup>4</sup>. When a prisoner arrives at pre-trial, all medications are directed to health care for verification. An assessment of the prisoner is done immediately and medical history/records are obtained. If the prisoner is taking regularly prescribed medications and records are readily available then the process is facilitated quickly and the prisoner receives his/her meds without interruption. However, prisoners often complain that some of the components of their cocktail are not readily available and they are forced to choose between taking their remaining meds or interrupting their treatment entirely while waiting for the missing medication to be provided. Prisoners have reported they have been told by the prison doctor to just continue taking the rest of the medications while they wait for the missing component, a situation which increases the person's risk of developing drug resistance and treatment failure.

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## Antiretrovirals and treatment interruptions in prisons

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In the past, many adherence problems were attributable to a system that required prisoners to notify health care when they were running low on medication, and then the required medication was ordered from the prison pharmacy. In a population with a high percentage of low-functioning individuals due to addiction, psychological barriers, and street involved habits, this system doesn't work very well to ensure adequate time to keep medications in stock and prisoner adherence.

Accessing specialists in the community to address HIV/AIDS related conditions or a required cocktail change also poses many barriers. Staffing of correctional officers required to escort a prisoner to a specialist, usually needing several visits to health care services to determine who should be consulted, and the prison doctors' steadily increasing prisoner caseload in provincial and federal prisons all across Canada are just a few factors to negotiate.

Many dedicated individuals and community groups provide support to HIV positive prisoners in Canada. The involvement of people from outside the walls provides the best opportunity for success in improving access to HAART for prisoners with the same consistency as anyone in the community. The Canadian AIDS Society<sup>5</sup> and the HIV/AIDS Legal Network<sup>6</sup> both coordinate national committees where community-based organizations strategize around improving the care and treatment available to prisoners living with HIV/AIDS. Through the HIV and HCV Networking and Advocacy Committees, groups providing support share best practices when bringing forward issues that require advocacy, and undertake collective action to address systemic problems, including problems involving access to HAART.

Across the country, prisoners complain of running out of their HAART meds, errors in prescription (e.g. incorrect or substitution of medication), and lengthy delays to deal with side effects/conditions, as well as little or no help with pain associated with HIV/AIDS. This has prompted the HIV/AIDS Legal Network to undertake a study to determine barriers to

proper access to HAART in prisons in Canada. The prison service delivery community eagerly awaits the findings of the study. ■

- 1 Canadian HIV/AIDS Legal Network publications on [www.aidslaw.ca](http://www.aidslaw.ca)
- 2 HALCO publication: *Advocacy for care and treatment for prisoners*. CAS Skills building, October 2005.
- 3 Montaner, Julio et al., *ARV update – Vancouver*. November 30, 2005
- 4 Joye Morris Health Services, BC Corrections health care.
- 5 CAS HIV/HCV Prison Networking Committee – Claire Checkland
- 6 Canadian HIV/AIDS Legal Network HIV/HCV Prison Advocacy Committee – Glenn Betteridge

The Prison Outreach Program of BC Persons with AIDS Society is currently awaiting funding for "Breaking the Cycle", a community-based research project to determine the causes of recidivism in HIV positive, drug-addicted prisoners in Vancouver's downtown eastside. The project starts in April 2005 and will provide valuable programming information for the care and treatment of this population.

### *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! **The next issue of the newsletter will have an article on women and leadership in the fight against HIV/AIDS.** If you have a story to share about access to treatment related to this story, tell us! Contact the CTAC office (see page 12) for more information. *Confidentiality will be respected. We may not print all stories submitted.*



# NPS: Does it stand for “National Pharmaceutical Strategy” or “No Pills for Sure?”

*By Louise Binder, Chair of CTAC*

The latest big idea from the First Ministers of Health is the 10 Year Plan to Strengthen Health Care, including the so-called National Pharmaceutical Strategy (NPS). You may recall that the last big idea from this group was the Common Drug Review (CDR), a recommendation body to participating provincial drug plans about public reimbursement. Many of us have dubbed CDR the Common Drug Rejection body, so you can imagine that I read the new big idea with a jaundiced eye (this jaundice not being a result of my current drug regimen, but rather my huge skepticism that any of these schemes have anything to do with improving people’s health outcomes).

The governments tell us that NPS is a starting point for a better, more integrated approach to pharmaceuticals, recognizing the need to engage providers, researchers, policy makers, industry, patients and the public. Sounds good, but it does beg the question of what we have been using as a process to date to make these decisions - reading tea leaves or tarot cards or maybe just making it up as we go along in a black box called “the Government”?

The process is meant to be ongoing, with a report to the First Ministers in June 2006 - just around the corner. There are nine “Elements” to NPS. My analysis is that they generally fall into three categories: access to treatments, cost containment and drug safety.

Let’s start with the last (and best) first. Element 4 is to “strengthen evaluation of real-world drug safety and effectiveness.” The HIV/AIDS community, including CTAC, has been telling governments for a long time that we need an active, consumer-centred post approval surveillance

system. Consumers have the greatest interest in reporting their experiences with drugs in the real-world. Yet no practical mechanisms have been set up for us to do so. The federal government has proposed that mandatory reporting by doctors will solve the problem, but that is nonsense — a band-aid solution to a system that needs major surgery. Oh well, I give them “A” for effort for at least finally getting the message that we need a comprehensive post approval reporting system. If they do not include us in the solution, I fear that it will be another good idea gone wrong in the implementation.

In the cost containment area, there are four Elements: to develop, assess, and cost options for catastrophic drug coverage, to pursue purchasing strategies to obtain best prices for Canadians for drugs and vaccines, to accelerate access to non-patented drugs and to achieve international parity on prices of non-patented drugs, and to enhance analysis of cost drivers and cost effectiveness, including best practices in drug plan policies.

Many of the ideas here may be new to government but we have been telling them to undertake some of these Elements for some time. “Why do we not negotiate bulk buying agreements with brand name pharmaceutical companies?” we have asked repeatedly. “Why do we pay higher generic drug prices than even the United States?” we have demanded to know. Why do we have the Common Drug Review that only looks at the cost of one drug against another in its drug class? How many times must we explain that we take drugs in combination, not singly, and it is the

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## NPS: Does it stand for “National Pharmaceutical Strategy” or “No Pills for Sure”?

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cost of the combination that should be taken into account? We have repeated so many times that one needs to look at the improved side effect and toxicity profiles of newer, maybe more costly, drugs that are probably saving the drug budget money by keeping down the cost of medications to combat the side effects of the less expensive, earlier drugs and formulations. This is not to mention the savings to other parts of the health care budget: doctors visits, hospital stays, emergency room visits. When, we have pleaded, will you stop the silo budget mentality in health care? Reward overall savings and effective management of the health care budget and measure real health outcomes — not nickels saved while dollars are wasted. This is not to mention the overall health of the economy when people are well and contributing rather than needing services.

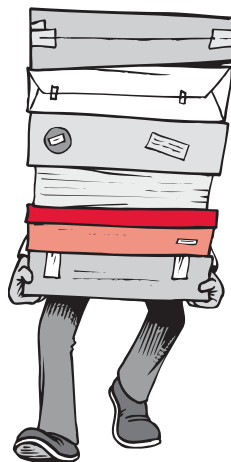
Once again I give the Ministers an “A” for effort but the proof, as the saying goes, will be in the pudding and in whom they invite to make the pudding with them.

The third Element is access to treatments. It includes the creation of a “common” National Drug Formulary. This is not necessarily a good idea for all provinces. We know that provinces have unequal coverage and we certainly do not want the lowest “common” denominator to apply. We want the right drug for the right person at the right time no matter where they live and what their ability to pay. It also includes a commitment to broaden the practice of e-prescribing. I have no quarrel with this at all, as it is especially needed in our remote and rural communities.

Another Element is “to influence prescribing behaviours.” This kind of language makes my skin crawl. (No, this is not a side effect of my drugs but rather my recognition of this language as code for “we will punish doctors who prescribe more expensive drugs in a class rather than the cheaper ones or generic ones, even if the doctor and patient know that they are the better drugs for the patient.”) I do not give the Ministers very high marks for creativity in this area.

Of these nine Elements, governments have decided to focus on catastrophic drug coverage, expensive drugs for rare diseases (also known as orphan drugs), common national formulary, real-world safety and effectiveness and non-patented drug pricing. Those are as good a place to start as anywhere. I have a few niggling concerns though. Will they really consult with stakeholders on these issues before issuing the report in June? Why are they focusing all of their efforts at the end of the life cycle of drug development and marketing and nothing pre-approval, including clinical trial management and the drug review processes? Where is the recognition of the impact of the social determinants of health on health outcomes? Will they really take into account the big picture in health care and its impact on the overall economy or will they yet again fiddle while Rome (a.k.a. Canada) burns?

I sincerely hope not. There is an opportunity here — missed many times in the past in my view — to bring us together to build a solution that lasts. Tell your MPs this is an election issue for you. Tell your MPPs it will be one when election time comes around for them. Support advocacy by CTAC and other disease and disability group advocates to ensure that this is not just another case of governments’ good intentions gone awry. ■



### 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](mailto:ctac@ctac.ca), phone or fax (416) 410-6538.

*CTAC introduces a new series that provides information about Canada's various formularies. Each installment in the series will give insight into a different provincial or territorial formulary.*

## Formularies Series:

# Alberta

*By Mark Randall, CTAC's Alberta Representative*

### What is a Formulary?

A drug formulary is a compilation of all drugs available to those covered by some form of insurance. Generally, senior citizens, persons on social assistance and those with a high level of drug costs are covered by provincial insurance, while war veterans, military personnel, the RCMP and Aboriginal Canadians are covered under a federal insurance plan. Many Canadians are covered under some form of private insurance that is most often paid by their employer. It is important to note that each insurer has a different formulary that determines which drugs it will cover for the individual.

Other than the Canada Health Act, individual pharmacy agreements and provider agreements, there is no specific legislative authority for drug programs in Alberta. It is under the Canada Health Act that the Ministry of Health and Wellness through the Alberta Health Care Insurance Plan (AHCIP) provides residents of Alberta with full coverage for medically necessary physician and hospital services, as well as specific surgical services provided by oral surgeons. Supplementary health insurance plans providing coverage for prescription drugs to residents of Alberta are also funded by the Alberta Ministry of Health and Wellness and are administered by Alberta Blue Cross.

In each provincial drug benefit plan there is included a "formulary", which is a list of prescription and non-prescription drugs that are covered under the plan. Prescription drugs are medications prescribed by a doctor for a patient and non-prescription drugs are those that can be bought over the counter without a prescription. The

provinces also have a special committee that reviews any new drug to decide if it is to be added to this formulary, which may also include medical supplies, such as syringes.

The formulary has two categories defined as "full listing" and "restricted listing". Full listing means a doctor can prescribe a necessary drug and the province will pay for that drug (or a portion of it). Restricted listing means a doctor must get a special written approval from the province before prescribing the drug for the province to cover its cost (or a portion of it). Most drug benefit plans will list the price they are prepared to pay for each drug on the formulary, with most choosing a generic drug over a patented (brand name) drug if available.

### What about the Alberta Formulary?

In Alberta, this formulary is known as the Alberta Drug Benefit List (DBL). It defines which medications and supplies the government will cover under the drug programs sponsored by Alberta Health and Wellness.

The DBL provides a maximum price for medications and supplies that are eligible for reimbursement under a provincial government drug plan or program. The maximum price is defined using three policies as they apply to drug prices: "least cost alternative" (LCA), "maximum allowable cost" (MAC) and "actual acquisition cost" (AAC).

The LCA is the lowest unit cost for a drug product within a set of interchangeable drug products (similar products). For consumers this means a generic medication will be used to fill a prescription with the consumer responsible for the additional cost if they choose a patented (brand name) medication.

MAC is the maximum unit cost established for a specific drug product or selected group of interchangeable products with only a small number of products being subject to this form of pricing.

AAC is the amount the pharmacists are expected to charge Alberta's supplemental health plans for a drug product. For interchangeable drug products this charge can only reach a maximum of the LCA price. There is a drug review process that determines the inclusion of new drug products to the DBL.

The DBL uses a LCA pricing policy for selected

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## Formularies Series: Alberta

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interchangeable groupings of medications and, where applied, the Alberta government will pay the AAC of the drug material to the maximum of the LCA price. If a physician prescribes a higher priced product, the individual is responsible for the additional costs unless the physician applies for special authorization and the request is granted.

There are currently more than 3,700 medications and supplies listed on the DBL with three types of coverage available: Regular Benefits (full listing and coverage), Special Authorization (only reimbursed with a doctor's request approved by government) and Restricted Benefits (listed but only available under special circumstances).

The Alberta Human Resources and Employment Drug Benefit Supplement is used to define coverage provided to clients of Income Support, Alberta Adult Health Benefit, Assured Income for the Severely Handicapped and Alberta Health Benefit.

In Alberta, most drugs are classified as Regular Benefits, with Special Authorization available as a way to ensure high priced drugs are used according to defined clinical criteria and are considered as an option for a specific patient. There are specific forms that must be completed by a doctor, reviewed by a clinical pharmacist with prior approval

granted ensuring coverage, before a patient can access these medications. There are also a small number of drugs in the formulary that are restricted to specific age groups.

For persons living with HIV/AIDS, access to all current approved HIV/AIDS treatment medications is available. There is currently only one HIV medication not yet available and that is Tipranivir (Aptivus). Tipranivir is currently awaiting approval from the Common Drug Review in April 2006 and will most likely be available through special authorization. Coming off the market is Hivid and Fortovase soft gel caps that are being discontinued by the manufacturer. These treatment options are available through the special authorization process where a physician request must be made.

For more information on the Alberta Formulary, Health Care Coverage and medications available, contact Alberta Health and Wellness at [www.health.gov.ab.ca](http://www.health.gov.ab.ca). ■

## References:

- **Alberta Health and Wellness**  
[www.health.gov.ab.ca](http://www.health.gov.ab.ca)
- **Canada Research Based Pharmaceutical Companies**  
[www.canadapharma.org/home\\_e.htm](http://www.canadapharma.org/home_e.htm)
- **Southern Alberta Clinic – Calgary**  
[www.crha-health.ab.ca/clin/sac/sac.htm](http://www.crha-health.ab.ca/clin/sac/sac.htm)

## Hold on to that 3TC – Resistance or not

*By Louise Binder*

**A**t the recent Interscience Conference on Antimicrobial Agents and Chemotherapies (ICAAC), one of the issues under discussion was the role of 3TC in drug regimens. It is well known that resistance to 3TC develops quite early after its use, generally within twelve weeks of starting the drug. The primary mutation is the 184V mutation. The question arises whether or not there is any value in continuing the drug after this time. This is important not only for ensuring the most effective, durable regimen for a person but also to ensure that HIV drug benefit dollars are being spent wisely.

The verdict appears to be that there is value for the

patient to keep 3TC in their regimen even after resistance to the drug has developed. In studies where 3TC was taken out of the regimen, it took about six months for 3TC resistance to disappear. Concurrent with the loss of 3TC resistance was an increase in viral load by at least .5 log. Thus, it seems that 3TC is having a significant adverse impact on viral fitness; it is decreasing the ability of the new virus to replicate.

For this reason, 3TC is a valuable drug to keep in one's regimen even when one is making a drug switch due to a failing regimen. Fortunately, it also appears to have few, if any, side effects in most people. ■



*A personal perspective*



by Lydia Thompson

**TANISI** (Hello). My name is Lydia Thompson and I am an Assiniboine woman from Carry The Kettle First Nations Reservation in Saskatchewan. My life is surrounded by my three beautiful children and a wonderful spirited partner, who all support me in the work I do.

I support, advocate and refer clients who are infected and affected by HIV and AIDS, as well as those who are at risk of infection. Activities at the AIDS Programs South Saskatchewan include World AIDS Day, AIDS Walk, clients' newsletters, treatments, resources and upcoming

conferences. We network with many other agencies in our area and throughout the province, such as the Canadian AIDS Treatment Information Exchange, on an exciting project, "Integrating HIV/AIDS Treatment Information, Prevention and Support Services Capacity Building Project."

The Canadian Treatment Action Council tele-workshops I attended enhanced and broadened my knowledge of advocacy work. Advocacy is what we do every day. There are many different ways in which we do advocacy work: helping with the rights of people with HIV/AIDS and helping them to be their own advocate. We advocate around social issues, housing, treatment, social assistance and more. We may use the softer approach to advocacy, using our network of agencies, communities and clients to help when necessary. Hearing peoples' experiences has given me a better understanding when one has been through a different advocacy situation.

I brought this subject up in our staff meeting and presented what I had learned in the tele-workshops. I am in the process of writing about advocacy for our staff directory. Participating in the tele-workshops sponsored by CTAC has been quite an experience and I look forward to the other modules. Thank you. All My Relations. ■



**Tools for Action:  
HIV/AIDS Treatment  
Access Advocacy Series**

**REGISTRATION FORM**

Name \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_

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Do we have your permission to leave a message?  Yes  No

E-mail \_\_\_\_\_

Mailing Address \_\_\_\_\_

\_\_\_\_\_

Are you a member of CTAC?  Yes  No

If you are attending on behalf of an organization, please include the following:

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

*The following section is optional. All responses are completely confidential.*

<b>Gender</b>	<b>Age Range</b>	<b>Are You:</b>
___ Male	___ 15-25	___ HIV+
___ Female	___ 26-40	___ HIV- or
___ Transgendered	___ 41-55	Undisclosed
___ Other	___ 56+	Status

To register for this workshop, or for more information, please contact:

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Toronto, Ontario M4Y 2L5  
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# The future of therapy?

## Maturation Inhibitors



*By Ron Rosenes, Vice-Chair of CTAC*

**W**hile we are still waiting to see if the CCR5 class of entry inhibitors and an integrase inhibitor will make their way through clinical trials and market approval over the next few years, the recent Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC) Conference in Washington, D.C. brought news of yet another potentially new class of therapy for HIV: maturation inhibitors.

PA-457 is the first in a new class of orally bioavailable HIV therapies under development called maturation inhibitors. By targeting a novel step in the virus life cycle, namely inhibition of a protein required for new virus to mature and go on to re-infect, maturation inhibitors may have potent activity against a broad range of HIV, including strains that are resistant to existing classes of drugs. This is important as development of drug resistance is one of the most pressing problems in HIV therapy and can lead to treatment failure.

Data were presented at ICAAC of a placebo controlled RCT Phase IIa trial, the primary endpoint of which was to demonstrate antiviral effect in 10 day monotherapy study at day 11. Secondary endpoints were safety and pharmacokinetics (PK). Trial participants were randomized to receive 25mg, 50mg, 100mg, 200mg or placebo (6 patients per dose, 8 placebos). Patients were ART naive or no ARV therapy within 12 weeks of first dose; CD4 >200; HIV RNA 5000-250,000 c/ml. Except for the 200mg group, patients had some NRTI, PI & NNRTI mutations.

The 200mg dose achieved an average 1 log reduction in viral load, whereas the lower doses ranged from .17 to .48 log, indicating that greater response may be possible with a higher dose.

There was one serious adverse event reported possibly related to the drug. A patient with a 5 year history of poorly controlled hypertension had transient findings of a probable cerebrovascular accident, a sudden loss of consciousness due to the rupture or occlusion of a blood vessel leading to oxygen lack in the brain.

Most adverse events were mild to moderate and included diarrhea or altered bowel habits. 1-6 patients in each dose group reported this, but so did 5 of 8 patients in the placebo arm. Headaches were also reported.

There were no grade 3-4 lab abnormalities and only one grade 2 lab abnormality (triglycerides on day 5 which later returned to baseline). There was no evidence of hepatic, renal or other organ toxicity.

A Phase IIb trial is planned for 2006. CTAC will follow the progress of this and other potential new therapies to ensure that ethical clinical trials are conducted at sites around Canada as appropriate when Phase III trials are announced. ■

For more information about CTAC,  
please visit us at...

[www.ctac.ca](http://www.ctac.ca)

# PROVINCIAL UPDATES

## NOVA SCOTIA

*by Earl Giles, one of CTAC's  
Nova Scotia representatives*

Over the past year, the newly formed Nova Scotia CTAC committee has been busy striving to become more informed about treatment issues that affect people living with HIV/AIDS in Nova Scotia. Our focus for the upcoming year will be to build a stronger network in Nova Scotia. We will accomplish this by reaching out to past CTAC members and inviting them to a networking/skills get-together in the Spring/Summer of 2006.

## NEWFOUNDLAND & LABRADOR

*by Richard Neron, CTAC's  
Newfoundland and Labrador  
Provincial Representative and Chair of  
the Newfoundland and Labrador Positive  
People Network*

We have seven new members of the Newfoundland Positive People Network. Our Board of Directors is working hard right now to provide more visibility for the network. We are looking at getting shared office space with the AIDS Committee of Newfoundland and Labrador, a phone line as well as developing a website and designing a poster. We continue to have a close working relationship with the HIV Clinic in the province and the AIDS Committee of Newfoundland. We are doing some advocacy work and continue to develop the network and new members. The Newfoundland and Labrador Positive People Network would like to personally thank Phil Lundrigan for his contribution to the network in his previous CTAC roles and congratulate him on his recent Glen Hillson Award for Excellence.

## ONTARIO

*by Brian Finch, Board  
Member and CTAC's  
Ontario Representative*

At the last CTAC Annual General Meeting, I was elected to the Board. A process will be initiated sometime in the New Year to seek nominees for a new Ontario Representative. Since the AGM, I have been involved in the CDR/provincial drug formulary review as well as other government stakeholder consultations. A community forum was held last October to discuss reference based pricing. A lot is happening in Ontario, and this would be a great time to become involved.

## BRITISH COLUMBIA

*by Daryle Roberts,  
CTAC's BC Representative*

Following the CTAC Annual General Meeting in Moncton, I attended the Pacific AIDS Network Fall Gathering in Vancouver. During the HIV Forum, I shared the information from the AGM about the BC Government informing the BC Centre for Excellence in HIV that it is not able to provide new therapies if they have not been recommended by the Common Drug Review. This led to a bigger discussion on what is happening with the BC Centre for Excellence in HIV and what Providence Health Care is planning on doing with the Centre. Apparently, they are talking to the Ministry of Health about taking over the Centre, and integrating it with the other communicable diseases within Providence Health Care. This is a very big concern for people living with HIV and what our care and treatment may look like in the future in British Columbia. The British Columbia Persons with AIDS Society is currently working with the BC Centre for Excellence and Providence Health Care to find a workable solution to this issue. Keep tuned for more... ■

## CALENDAR OF EVENTS

### WINTER/SPRING 2006

#### ● February 1 & 2

**Epidemics in our Communities 2006**  
**Phase 4 – Health and Healing**  
 Regina, Saskatchewan  
 Contact: (306) 924-8420 or 1-877-210-7623

#### ● February 5-9

**Conference on Retroviruses and Opportunistic Infections**  
 Denver, Colorado  
 Contact: (703) 535-6862 or info@retroconference.org

#### ● February 14 & 15

**7<sup>th</sup> Annual Alberta Harm Reduction Conference**  
 Lethbridge, Alberta  
 Contact (403) 327-8900 or  
 info@albertaharmreduction.ca

#### ● March 16-18

**International Conference on Women and Infectious Diseases**  
 Atlanta, Georgia  
 Contact: (202) 924-9330 or iceid@asmusa.org Website:  
 www.womenshealthconf.org

#### ● April 4-8

**XI International Course of Infectious Diseases,  
 XII Comprehensive Meeting on AIDS,  
 2<sup>nd</sup> International Course/Workshop on Public Health  
 and Applied Epidemiology for HIV/AIDS  
 2<sup>nd</sup> International Symposium: Dentistry and AIDS**  
 Santiago de Cali, Colombia  
 Contact: (572) 514-2061 or corposida@clsida.org.co

#### ● April 8-11

**Canadian Association of Nurses in AIDS Care  
 14<sup>th</sup> Annual Conference**  
 Montreal, Quebec  
 Contact: (416) 962-5147 or  
 canacmontreal2006@yahoo.ca

#### ● April 30-May 4

**17<sup>th</sup> International Conference on the Reduction of  
 Drug Related Harm**  
 Vancouver, British Columbia  
 Contact: 1 (800) 555 1099 ext. 2 or  
 info@harmreduction2006.ca

## CHAIR'S REPORT

### WINTER 2006

*by Louise Binder*



**I HAVE JUST RETURNED** from the North American Treatment Action Forum, a skillsbuilding conference with 700 people in attendance. They were mainly people living with HIV/AIDS and people working in the HIV/AIDS field. More than 500 of them were Mexican, with some Americans and a few Canadians. I had the privilege of presenting the first plenary of the Conference. I decided to talk about the issues in HIV/AIDS that our three countries have in common. I drew on my experience here in Canada as well as information that my U.S. and Mexican colleagues have shared at previous treatment conferences.

I focussed on four issues. The first, and in many ways the most serious, issue in our community is the pervasive and pernicious problem of unrelenting stigma and discrimination we face every day and in every aspect of our lives. It is totally irrational, given all that we have learned about how this disease is contracted.

The second is the lack of universal, equal access to safe and affordable treatments, including prevention options, no matter where we live or how much money we have.

The third issue is the right wing agenda of the wealthy and powerful in our countries that has on its platform abstinence, zero tolerance for substance users, prisoners, sex trade workers and, in fact, for anyone who does not belong to its bigoted, mostly white, straight, male, morally impoverished world.

The last issue is the lack of an adequate social safety net, including affordable housing, food, education, training and employment for all.

These barriers make the work hard but certainly not impossible. Each of us has a role to play in this work. Not only does it make a real difference to people with HIV/AIDS and those most susceptible to this virus, but it also makes a difference for every person doing the work. It gives each of us a sense of pride and self-respect that we richly deserve. And it keeps us from internalizing the feelings of lack of self-worth and shame that so many in society would like us to feel. ■

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## CTAC POSITION PAPERS

### Papers

- 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.
- 1999 - "Timeliness and Transparency: Assessing the Review Process for HIV Drugs", author: David Garmaise.

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### Full Membership

- Person living with HIV/AIDS
- Group, organization and/or project with a substantive HIV/AIDS mandate

### Associate Membership

- Any individual
- Group, organization and/or project whose substantive mandate coincides with the objectives of the Corporation

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## Organizational Mandate

The mandate of the Canadian Treatment Action Council (CTAC) is to work with the public and private sectors to:

1. **Support access to therapies and treatments** for people living with HIV/AIDS by informing research and public policy, and by promoting public awareness
2. **Provide mentoring and skills building** in these areas to people living with HIV/AIDS
3. **Encourage and facilitate the exchange** of related information to stakeholders

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