

CANADIAN TREATMENT ACTION COUNCIL



Canadian Treatment Action Council

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The XVI International AIDS Conference



Pillow Case Action

by Brian Finch,
CTAC Board

PRIME MINISTER STEPHEN HARPER did not find it necessary to appear the day of the opening ceremonies of the XVI International AIDS Conference in Toronto. CTAC felt it was important to send a message to Canada and to the world that this was unacceptable.

A week prior to the conference, Board members Louise Binder and Brian Finch began collecting a total of 1000 white pillowcases. With the help of Brian Finch’s co-op, friends and neighbours, we pulled off stenciling our 1000 pillowcases to be distributed the next day during the “Access to Treatment” march. Volunteers stencilled “Sleep in Steve? HIV Never Sleeps, Time To Deliver,” and “Renew Canada’s Only Safe Injection Site.”¹ The remainder of the pillowcases were given out on the floor of the Rogers Centre. They were held up for all the world to see while Minister of Health Tony Clement spoke during the opening ceremonies.

The amazing part of this experience was how fellow neighbors with whom I’ve never spoken before lent a helping hand and contributed to a successful grassroots action.

Congratulations to everyone for a job well done, and for delivering to our Prime Minister a very important message: HIV should and has to be on your agenda.

¹ (in point of fact, there is more than one safe injection site in Canada)

Paradigms in prevention: a longer alphabet

Access to the latest in prevention technologies

By Ron Rosenes, CTAC Vice-Chair

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Although a busy member of the organizing committee for AIDS 2006, I managed to attend this year's plenary on prevention. Perhaps as this was the 25th anniversary of the discovery of the virus that causes AIDS, and because the national newspaper told the story of my single delta 32 deletion and the protection it may have conferred upon me over the past 25 years, I received many questions about what it is like to be a "genetic mutant" and witness to the history of the pandemic.

At year 25 and still responding to a four drug regimen I now have to take only once a day, I was struck by the irony that the vast majority of people on the planet are exactly where I was 25 years ago—without access to the tools of prevention, let alone access to care, treatment and support. In a global context, for most people who may be infected or at risk, the same old question still applies: why bother getting tested if there is no hope of getting treated? Although we have heard it said at recent conferences, it never rang louder or truer than in Toronto where a chorus of researchers and activists reiterated that

prevention and treatment are inextricably linked. You can't have one without the other.

At CTAC our mandate is to improve access to the technologies of treatment. It is time to broaden our focus to include advocacy efforts for access to the latest advancements in technologies for both primary and secondary prevention.

Technology alone is useless without understanding the social, economic, cultural and political context in which HIV flourishes. In her talk entitled "Conceptual Frameworks and HIV/AIDS Prevention Paradigms," Christina Pimenta, Executive Director of the Brazilian Interdisciplinary AIDS Association, made several important points.

First, we seem to be moving backwards because HIV prevention programs are failing to reach the most vulnerable populations. A global report shows that only nine percent of men who have sex with men received any type of prevention service. Less than twenty percent of injecting drug users received HIV prevention services. Only nine percent of pregnant women received services to prevent HIV infections in infants and less than fifty percent of young people worldwide have any significant level of knowledge about HIV and AIDS. To do better requires a multi-sectoral collective response that promotes non-discrimination of people living with HIV/AIDS based on sexual diversity, ethnicity, gender, age or drug use and approaches that combat violence against women and children, homosexuals, transgender persons and sex workers.

Second, biomedical intervention can never be implemented in a social and political vacuum. Research for the development of preventative vaccines and other new technologies must be done with the involvement of civil society and the participation of the most affected populations within a human rights framework. As Pimenta says, "We need to confront inequality in social oppression and aim for full human development."

This set the stage for Gita Ramjee, Director of the HIV/AIDS Lead Programme at the South African Medical Research Council, to enumerate the advances that are being made in prevention technologies. Her list extends the alphabet beyond ABC (Abstinence, Be faithful, Condomize, Counseling and Testing) to add the following letters:

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Paradigms in prevention: a longer alphabet

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C IS FOR CIRCUMCISION

Biological data shows that men who are circumcised are at reduced risk of spreading and getting HIV infection. While a meta-analysis has shown that the prevalence of HIV is lower in countries where male circumcision is routine, we are still waiting for the results of more clinical trials to confirm this result. If the results prove the hypothesis, there are still safety and ethical challenges that will have to be faced in order to take circumcision from evidence-based research to public health action.

D IS FOR DIAPHRAGM

The cervical barrier or diaphragm is another woman initiated contraceptive method that has been proven safe, effective and acceptable. In theory (and it is only theoretical at this point), you may reduce the risk of HIV infection if you cover the cervix since the upper genital track may be susceptible. Currently, there is one Phase III clinical trial ongoing funded through USAIDS by the Bill and Melinda Gates Foundation with three sites in Africa: Durban, Johannesburg and Harare.

E IS FOR EXPOSURE PROPHYLAXIS (PRE- AND POST) (PREP)

The proof of concept exists here in research on the transmission of the virus which causes malaria and in PMTCT, prevention of mother to child transmission. As a person who takes these drugs post infection, I have to wonder about the ability of HIV negative people to adhere to difficult or demanding regimens. We also need to consider the implications of break-through infection with resistant virus for future therapy options. And what is the potential for abuse of PrEP among those people who refuse to or do not want to use condoms?

F IS FOR FEMALE-CONTROLLED MICROBICIDES (AS ABOVE)

Louise Binder will discuss microbicides for women, but I would add that a rectal microbicide for men as well as women is greatly anticipated.

G IS FOR GENITAL TRACT INFECTION CONTROL

We know that the testing and treatment of STIs reduces the risk of infection for women and men.

H IS FOR HSV-2 SUPPRESSIVE TREATMENT

We know from many studies that Herpes Simplex Virus (HSV-2) increases the risk of HIV infection. While there are still questions about adherence, continuous vs. episodic treatment and the possibility of emerging resistance, there is no question that treating HSV-2 preemptively would affect susceptibility to the acquisition of HIV.

I IS FOR IMMUNITY

The holy grail of an effective and affordable vaccine is still thought to be 10 years away.

While understanding the need to continue the work on the tremendous challenges which stigma and discrimination present for our advocacy efforts, it was exciting to learn more about the clinical trials and promising future for new prevention technologies. ■

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WOMEN'S ISSUES: UPDATE

Women's and Girls' Voices Are Finally Heard

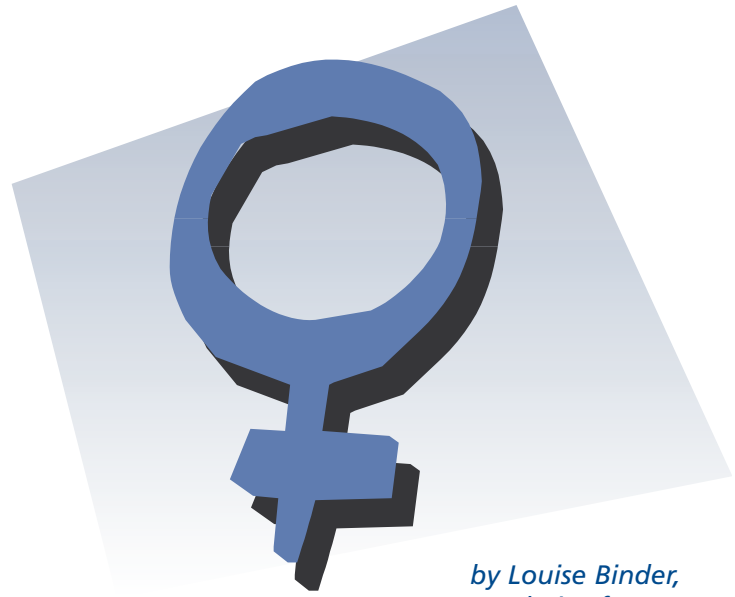
or, *Did I feel the power paradigm actually shift one degree?*

The XVI International AIDS Conference held in Toronto in August has been hailed by many as the "Women's Conference." Some say it with pride, some with disdain and others with envy. Not surprisingly, I am proud and delighted when I hear it named this way.

There was an incredible amount of energy—physical and emotional—put in by so many people (including some phenomenal men, famous and not) to ensure that women and girls were finally not relegated to a back seat—a satellite session or two—to placate us. Our issues were front and centre, as befits the group making up 50% of the infections around the world and, in some places, a far greater percentage.

So what issues were discussed concerning women and girls at this Conference? Of course, there was much discussion of prevention. The need for targeted, culturally sensitive prevention and education for women, the availability and use of condoms (both male and female), male circumcision, and the exciting developments in microbicide research were among the topics discussed.

We must ensure that all populations of women and girls are at the table with veto power in the structures of policymaking and programming for women, with particular emphasis on those overrepresented groups that face greater oppression: lesbians, prisoners, illicit drug users, Aboriginal women, including Métis, First Nations and Inuit, transgendered persons, transsexuals, women from countries where HIV is endemic including the Caribbean and Africa,



by Louise Binder,
Chair of CTAC

East and Southeast Asian women, women in poverty and/or violent relationships, street involved women, sex trade workers, refugees, youth.

Thank goodness there was overwhelming support for the fact that the U.S.-backed idea of prevention, ABCs (abstinence, be faithful and, if absolutely necessary, use condoms) is sheer nonsense for all and especially for women who do not control negotiations about sex. There was generally agreement that, while the U.S. international donor programme is very generous, it is hamstrung and ineffective in many ways because of its "abstinence until marriage" conditions for granting funds to other countries. This is neo-colonial thinking and practice at best.

For those not familiar with microbicides, they are a new prevention technology that will give women, and hopefully eventually also men, the ability to initiate, and in some cases even control, prevention techniques. They will come in the form of gels or creams that a woman will use at some point before sex to stop HIV from infecting her. Some microbicides aim to block HIV while permitting conception, an important consideration for many women that condoms cannot address. With a doubling of present research funding, we could have a 60% effective microbicide within five years. This could save 2.5 million lives over three years. While it is not a replacement for condoms, it will be a very important tool in the armamentarium of prevention techniques.

Unfortunately, I did not hear enough about how the

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Women's and girls' voices are finally heard

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movers and shakers are going to integrate HIV and women's health within the entire women's health agenda, including reproductive health and rights. The silos still exist, generally because of funder demands to keep them separate, but this is not only inefficient, it is deadly. Women often only enter the health care system through the reproductive health door, so we must use that opportunity for broader health messages and care for women, including HIV.

Underlying causes for the high rates of HIV infection were also a topic of much discussion. Often described as determinants of health, or internationally, development issues, these refer to those social factors that determine whether or not a person or population of people will remain healthy. Thus, they include education, training, employment, gender, social supports, housing, and access to health care. Although not officially on the list, many of us would add race as a factor because it is another form of socially conceived oppression that intersects with this list to exacerbate the deterioration of one's health.

Why do these factors often impact women more adversely than men? Because they impact socio-economic independence, and therefore power, the root cause of this epidemic. Women often do not have power over money. They must rely on men to provide them food, shelter, health care, childcare, housing and the other necessities of life. This leaves them with not much bargaining power when it comes to anything, including sex, work, cultural practices and religious practices.

I was pleased that a number of influential speakers spoke about determinants of health or development issues. I was disappointed that they did not make closer links with health policy and implementation as partners to determinants in programme planning. This is a huge mistake in my view. Until they are linked, we will not have long-term impact on stopping this epidemic.

If the woman does make any requests, including condom use, fidelity, no genital cutting, not to be married off as a child, not to be forced to work in the sex trade or to continue her education, she will often face the other

entrenched epidemic around the world—violence against women. I was disappointed that there was not more open discussion about this issue, especially about proposed strategies and funding.

The community people talked a lot about violence against women, and there are some incredible programmes on the ground, but we need to bring practice and policy together in this area. We need to stop early childhood marriage by law everywhere and enforce it; decriminalize the sex trade; stop cultural practices such as female genital cutting; make it illegal everywhere to rape your wife; protect prisoners' rights and ensure they receive the health standards of care of the general population—the list of demands is long but we can work at it until it is much shorter and, finally, gone.

Within the issue of treatment, I believe, with every fibre of my being, that where we do not have an effective treatment programme, we do not have an effective prevention programme. The big wigs talked about this at the Conference; but when I see where the funding is going it seems to be mainly on the prevention side. The words and the music are just not going together. For women, this means both effective treatments for the woman whether she is pregnant or not. In the area of pregnancy, it must be standard of care to treat the mother and not just the child. And, the woman's treatment must continue for as long as it is working for her and she wants it. This would greatly reduce the number of orphans everywhere, including in Canada.

And where is the women's research to determine so many unanswered women's clinical questions, including metabolic issues, dosing, drug interactions, side effects and toxicities and their management, basic safety, tolerability, efficacy and durability? I was heartened that one company, Tibotec, a division of Johnson and Johnson, is starting a gender and race trial in Canada and the U.S. for its new protease inhibitor drug in treatment-experienced women. Seventy percent of the participants must be women. At last someone is starting to ask questions about the impact of

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Formularies Series:

Quebec

By Ken Monteith

INTRODUCTION

To understand the accessibility of medications in Quebec, it is necessary first to understand the functioning of the province's public prescription drug insurance plan. Since 1997, all Quebec residents must have medication insurance coverage. Those who do not have access to a private prescription drug insurance plan (group insurance plan) through their employers, professional associations, spouses or parents, have to register to the Public Plan administered by the Régie de l'assurance maladie du Québec (RAMQ) - the Quebec Health Insurance Board.

Due to jurisdictional issues, employees of the federal government and persons covered by the First Nations and Inuit Health Branch of Health Canada are not covered by the provisions of Quebec's medication insurance rules.

THE PUBLIC PLAN

Persons covered under the Public Plan must pay an annual premium, whether or not they purchase prescription drugs. If they purchase prescription drugs, they pay only a portion of their costs. This is called their contribution. It consists of a deductible and a co-insurance amount. The deductible is the first portion of a person's drug monthly costs while the co-insurance is a percentage of the

person's drug costs that exceed the deductible. When a person reaches the maximum monthly contribution, there are no more costs. Table: The Public Plan (see below) gives the details for adults age 18 to 64. It should be noted that the rules for seniors (persons aged 65 and over) may differ from those explained in this table.

Unlike most other provinces, Quebec does not participate in the Common Drug Review, following its own drug review process through a committee (the Conseil des médicaments) at arm's length from the Ministry of Health and Social Services. This committee reviews applications for inclusion on the Quebec drug formulary according to a pre-set schedule and publishes formulary updates three times per year.

Coverage is ensured without restriction for all prescription drugs listed in the general section of the Quebec drug formulary. This general section of the drug formulary includes a broad range of medications covering most medical conditions. All but three antiretroviral medications for the treatment of HIV approved for sale in Canada are included in this general section. Many drugs, known as exception drugs, appear in a special section of the drug formulary. An example is Enfuvirtide (Fuzeon, T-20). It is listed as an exception drug, meaning that certain conditions relating to the state of health and treatment history of the patient must be satisfied for payment to be approved. Aptivus and Prezista, both relatively recently approved by Health Canada, have been submitted to the Conseil des médicaments for consideration in the next update of the formulary.

When a particular medication is not covered, or not fully covered, on the formulary, there may be additional costs to the patient. For example, when there is a generic formulation of a medication available, brand name medications are covered only up

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Table: The Public Plan

Category of persons	Annual premium	Monthly deductible	Co-insurance	Maximum monthly contribution
employment assistance recipients with severe employment constraints	\$0	\$0.00	0%	\$0.00
employment assistance recipients without severe employment constraints	\$0	\$8.33	25%	\$16.66
other adults age 18 to 64	from \$0 to \$538 (depends on net family income)	\$12.10	29%	\$73.42

Formularies Series: Quebec

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to the price of the generic version. Enteric coated versions of medications may be covered only up to the cost of the regular formulation, unless authorization has been given by the Quebec Health Insurance Board.

THE PRIVATE PLANS

Under the law and regulations applying to prescription drug insurance, all private plans are required to cover at least the drugs listed on RAMQ drug formulary. Their co-insurance rate cannot exceed 29%. When insured persons reach the annual maximum contribution set by RAMQ, their plans have to cover the entire cost of the insured drugs purchased during the remainder of the year. This maximum annual contribution, which is revised every year, is \$881 since July 1, 2006. It corresponds to the monthly maximum contribution under the public plan, \$73.42, multiplied by 12.

When the law was introduced in 1997, community groups fought to ensure that patient contributions would be calculated on a monthly basis. This fight was successful for those covered by the public plan. These provisions do not apply to those covered by private group insurance, who may find themselves paying the whole of their contribution (deductible and coinsurance costs) in the first few months of the year before reaching the maximum contribution and receiving full reimbursement for the rest of the year.

OUTSTANDING ISSUES

- *Coverage of exception drugs by private group insurance plans.* People who are covered by the public insurance plan have a defined process to apply for coverage of exception drugs: the prescribing physician completes a form outlining the medical conditions which justify the prescription of the medication and the Quebec Health Insurance Board rules on whether the patient can receive reimbursement. This is generally done before the first purchase of the medication. No such process has been defined for private insurers, so some patients with private coverage may find themselves paying additional costs. This loophole needs to be addressed.

- *Reimbursement issues for persons covered under private plans.* Few private plans allow the persons they insure to pay the

pharmacy only the amount of their contribution as it is the case for the public plan. Most plans require them to pay the pharmacy in full at the time of purchase and reimburse them afterwards for the difference.

- *Confidentiality for persons covered by private group insurance through their employers.* People submitting claims for medication costs through their employers face the possibility of disclosure of their status in the workplace if proper standards of confidentiality are not observed. Employees can address this issue by making claims directly to their insurance companies. Another related issue is the summary of insurance claims provided to the employer which, while not nominal, may serve to identify employees making large medication cost claims, especially in small companies.

- *Employment discrimination for people on HIV/AIDS treatment.* The cost of antiretroviral medications may be perceived as an excessive burden on group insurance in the workplace. In a small company, this might make the group insurance too expensive for the employer, endangering the coverage of all the employees, and could be a reason for discrimination in the hiring process.

- *Cost increases applicable to persons covered by the public plan.* Each year, almost without fail, the provincial government has increased both the premium and the allowable coinsurance amount under the plan. The high cost of the public plan may be attributable to the fact that the least healthy individuals in society tend to be covered by the public plan, while the healthier are covered by private insurers. One solution to this cost control issue would be to make the public plan universal, ensuring that healthier, employed individuals help to subsidize the costs of medication coverage for all.

CONCLUSION

While there remain issues to be resolved for access to medications in Quebec, the current system has ensured that Quebec residents have broad coverage of almost all of the medications they might need at a cost which is adjusted to their incomes. ■

Ken Monteith is Executive Director of AIDS Community Care Montreal and the COCQ-Sida representative to the CTAC Council. He was diagnosed with AIDS in 1997.

References

For more detailed information, please consult the RAMQ website:
www.ramq.gouv.qc.ca/en/citoyens/assurancemedicaments/index.shtml

Two studies on Lipoatrophy from CAHR

By Ron Rosenes, Vice-Chair of CTAC

There were two studies presented at CAHR in Quebec City this year that will be of interest to people suffering from facial wasting or lipoatrophy (FLA). Fat loss in the cheeks and temples (lipoatrophy) is the most visible sign of the syndrome known as lipodystrophy. Lipodystrophy refers to the body shape changes that occur in some people who have been on certain HIV antiretrovirals for several years. Other symptoms include thickening of visceral fat in the abdomen, gynecomasty or thickening of the breasts in men and women, thinning of the arms and legs, and “buffalo hump” behind the neck. In Ontario and some other provinces, patients with “buffalo hump” may have the fat removed in a procedure that is covered under the public health care system. At present, this is not the case for procedures that can reverse facial wasting.

Some drugs like the thymidine analogues (d4T, AZT) have now been identified as possible causes of lipodystrophy. Doctors have begun to start or switch their patients to regimens that are less likely to lead to lipodystrophy but there is no guarantee that the metabolic abnormalities that include elevated lipids (fats in the blood) and the development of insulin resistance (that can also lead to Type II diabetes) can be avoided and thus prevent the occurrence of unwanted body shape changes. However, one study presented at CAHR and funded by Gilead Sciences did show an improvement in fat loss and lipid abnormalities in patients who were switched from d4T to Tenofovir (Viread™, TDF) in combination with Lamivudine (3TC) and efavirenz (Sustiva™). This was a 48-week follow-up from Study 903E.

METHODS

During the course of this study, patients from two arms receiving either d4T or TDF as part of their regimen were rolled over into a 192-week open-label extension phase

(903E). This means that all patients were now put on a TDF containing regimen. Patients came from selected sites in Argentina, Brazil and Dominican Republic. There were almost equal numbers in both arms (85, 86) and data obtained from patients participating in 903E who substituted d4T to TDF were included in the analysis.

CONCLUSIONS

Virologic suppression (below 400 copies) was maintained through 48 weeks after switching from d4T to TDF. Significant improvement in limb fat was observed 48 weeks after switching. Switching resulted in significant decreases in blood triglycerides and LDL cholesterol through week 48. No changes were seen in spine Bone Mass Density but small decreases in hip BMD were seen. These results suggest less fat wasting but do not necessarily translate to the face. It does make sense however to monitor your lipids and discuss with your doctor which meds have the least likelihood of elevating the fats in your blood. Studies like 903E add to the body of knowledge about the drugs we take. We need to have access to newer therapies that are less likely to cause elevated lipids even though we don't yet know the long term effects of these newer drugs.

Now that one new product (Bio-Alcamid™) has been approved for sale in Canada, and another product (Sculptra™ or Newfill™) will be approved soon, there are options to treat this disfiguring condition.

METHODS

A study led by Dr. Mona Loutfy of the Maple Leaf Clinic reported on a randomized open-label comparison of immediate versus delayed Bio-Alcamid™ injections for the reconstructive management of facial lipoatrophy in HIV+ patients. Bio-Alcamid is a polymer in sterile water that once injected becomes encapsulated in the body's own collagen and is permanent but removable. The objective of the study was to assess the safety, efficacy and impact on Quality of Life (QoL) at 12-week follow-up of two randomized groups (median age 48, 97% men) who were given treatment with Bio-Alcamid either immediately or 12 weeks later. Thirty people living with HIV/AIDS with FLA were randomized into two groups that were treated immediately (week 0) or

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Two studies on Lipoatrophy from CAHR

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delayed to week 12. A touch-up was performed at week 6. At various intervals (weeks 1, 6, 12, 18 and 24 for the immediate, and week 13 for the delayed) three well-recognized QoL questionnaires were completed by patients. Researchers used the Carruther's Scale to classify the degree of FLA from 0 to 4, the latter being the most severe.

RESULTS

All patients completed 12 weeks of follow-up. Physicians gave both groups a median rating of grade 2 FLA before treatment. This means there were as many people with grade 2 or less or grade 2 or more FLA before receiving treatment. The median amount of product used in both groups for the injections was 15mL. As expected, the adverse events (side

effects) were transient and included swelling, redness, bruising and pain. These were considered mild and resolved within 1-2 weeks. At week 12, physicians rated people in the immediate group at 0, that is, no noticeable FLA. At 24 weeks, physicians rated FLA in both groups at 0, in other words the same result was achieved. Patient self-assessment revealed much higher QoL scores for the immediate group versus the delayed who had not yet received treatment. While this may seem obvious, it does demonstrate the comparative ratings before and after of degree of FLA by physicians as well as patients' own assessment of their treatment.

Please see the accompanying articles for a better understanding of the advocacy that CTAC and groups like Lipo-Action! are now engaged in to better educate people living with HIV/AIDS about their treatment options and to seek reimbursement in the public health care system for these reconstructive techniques. ■

Women's and girls' voices are finally heard

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drugs on women with enough women in the trial to actually answer them in a scientific way, not just anecdotally or by trying to extrapolate from the outcome of trials in men. We need to advocate for more companies and more trials, not only in new drugs but also in drugs that we have been taking for years on faith.

Overall, my impressions of the conference are that women's issues finally did get the attention they deserve after years of long neglect. The key is to keep up the momentum and never again be patronized and pushed to the sidelines. The Coalition for a Blueprint on Action for Women and Girls and HIV/AIDS delivered its first report card on how Canada is doing against the manifesto of demands the Coalition developed. Canada scored an overall D. We must work to make that better.

Other groups such as ATHENA: Advancing Gender Equity and Human Rights in the Global Response to HIV/AIDS, CHANGE: Center for Health and Gender Equity, CHAMP: Community HIV/AIDS Mobilization Project, WEACTx: Women's Equity in Access to Treatment, ICW: International Community of Women Living with HIV/AIDS, WABA: World Alliance for Breastfeeding Action, and

UNAIDS' Global Coalition on Women and AIDS are all hard at work on women's many HIV/AIDS-related issues. We are definitely going to work with them.

We are also going to launch research in Canada to investigate the relationship between determinants of health and the status of women. Two Spirited People of the First Nations, Voices of Positive Women, Wangari Esther Tharao, Canadian Treatment Action Council, the AIDS Committee of Toronto and the Ontario HIV Treatment Network are developing a microfinance study to see if this will benefit women in Ontario. We have much to learn from the success of these projects in the South.

I am not an optimist by nature as many of you know. I have, however, always believed that if we do nothing, or just the same things that have not taken us all the way to our goals, we must try something else. And women are on the move.

This does not mean, as some have said to my regret, that we are pushing aside gay men in this epidemic. Not at all. Please tell us how we can continue to support your strategies in this epidemic, and even enhance that support, as many of us have in the past. We will be there, as I hope you will continue to be for us. If one of us is not safe, none of us is safe. ■

Reflections on the XVI International AIDS Conference

Natasha Garda, CTAC



The Global Village at the XVI International AIDS Conference (www.aids2006.org) at the Metro Convention Centre in Toronto conveyed a real sense of community. Every morning waving at the neighbouring booths, we shared smiles with visitors from South Africa, Nigeria, Mexico, Uganda, Brazil, Canada, India... and realized that HIV/AIDS has enveloped the world in solidarity against injustices, bigotry, inequality and ignorance.

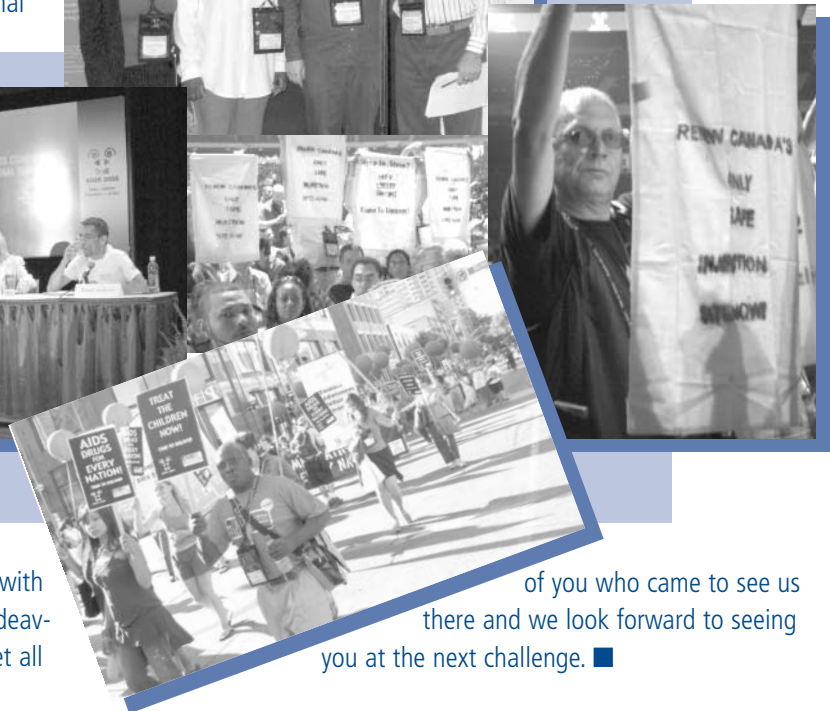
The Conference theme—*Time to Deliver*—aimed to focus AIDS 2006 on the promises and progress made to scale-up treatment, care and prevention.

CTAC enriched the conference by participating in various initiatives:

- The Women’s and Girls’ Rally & March
- Scientific Poster exhibitions including “The principle of free and informed consent: Gaps between theory and practice” and “Access to the information needed for informed treatment decisions”*
- CTAC held a press conference on “Access to Treatment in Canada.” The panel included leading Canadian AIDS activists Esther Tharao (African and Caribbean Council on HIV/AIDS in Ontario), Randy Jackson (Canadian Aboriginal AIDS Network), Louise Binder (CTAC) and Jean-Pierre Bélisle (CTAC). The panel challenged the myth that Canadians have full access to the medications they need as they called for a national catastrophic drug coverage plan, a national formulary based on the best available medications, a comprehensive orphan drug plan, and the dismantling of the Common Drug Review which only adds unproductive time to the drug review process.

Through these powerful contributions, CTAC joined hands with others in the global village creating connections in this endeavour to learn, share and grow. We were pleased to have met all

*To request a copy of the scientific posters, please contact CTAC.



of you who came to see us there and we look forward to seeing you at the next challenge. ■

CALENDAR OF EVENTS

FALL/WINTER 2006

- **November 4-5**
Canadian Treatment Action Council Annual General Meeting and Community Consultation
 Montreal, Quebec
 Contact: (416) 410-6538 or www.ctac.ca
 Join CTAC at its AGM and community consultation in Montreal! All members are welcome to attend. Please visit www.ctac.ca for details and to register for the day.
- **November 5-7**
Canadian Conference on the Public's Health and the Law
 Toronto, ON
 Contact: (416) 595-1666, info@aidslaw.ca
www.aidslaw.ca
- **November 14**
Conference / debate: "The Doctor-Patient relationship"
 Montreal, QC
 Contact: (514) 521-8720 or 1-800-927-2833, info@cpavih.org
www.cpavih.qc.ca
- **November 27-28**
The OHTN Research Conference
 Toronto, ON
 Contact: (416) 642-6486 x222, researchconference@ohln.on.ca
www.ohln.on.ca/OHTNConference
- **December 1**
World AIDS Day
www.worldaidsday.com
- **December 1-5**
Aboriginal AIDS Awareness Week
 Canada
 Contact: 1-888-285-2226 or (613) 567-1817, info@caan.ca
www.caan.ca

CHAIR'S REPORT

FALL 2006

by Louise Binder



DEAR READERS,

Well the International AIDS Conference has come and gone, as has the summer of 2006. Where does the time go?

By most accounts, the Conference was a success. The Prime Minister did not show up, as I predicted in my last report, but the "Double Bills", as I have heard Clinton and Gates described, were there. So were other celebrities, including Richard Gere. Mary Robinson and the Princess of Norway were there, both of whom I thought had a much better handle on the situation than some other big name attendees.

Was it a success? On some fronts, yes. On others, it was a dismal failure. Women's issues came out loud and clear and were well covered in the media. There was finally serious discussion of our issues by speakers and in the halls of the Conference, where the real work gets done.

The part that I found so disappointing was that gay men's issues, usually well covered at these Conferences, seemed to be neglected. This led to a lot of complaints from gay men, including my colleagues, that they were being ignored. I think this is a legitimate complaint. I trust that we will work together to get their issues back on the table along side those of other populations of infected and overrepresented people in this epidemic. We have always stood beside gay, lesbian, transgendered and transsexual members of the HIV community. We will continue to do so.

What I considered a failure at the Conference was talk that suggested that we were returning to the bad old days of competition between overrepresented groups in the epidemic. There should be no competition for resources but a mutual demand for adequate resources to do all of the things that we need to do. And there should never be a suggestion by any group that there is a competition for attention or support by any part of the HIV population at the expense of another. That plays right into funders and government and anti-gay and anti-AIDS sentiment. It lets people off the hook for doing nothing because we become a house divided. We must not fall into that trap. We must work as the diverse and mutually supportive team that we have shown we can be. Solidarity must be our watchword. Do not forget that if one of us is not safe, none of us is safe. ■

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- Ward Health Strategies

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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- 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

CONTACT US

Canadian Treatment Action Council (CTAC)

P.O. Box 203
 555 Richmond St. W., Suite 1109B
 Toronto, Ontario M5V 3B1

Phone and Fax: (416) 410-6538
Email: ctac@ctac.ca
Website: www.ctac.ca

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.

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Editorial Co-ordination: Béatrice Cardin

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