

Distance and Treatment: How far do you have to go?

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Canadian Treatment Action Council

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CHAIR'S REPORT

SUMMER 2009

In this issue, CTAC focuses on distances of different kinds. There are so many ways to look at the question of distance — physical, mental, emotional, geographic, spiritual, racial, cultural. Each creates a different set of issues for people with HIV accessing treatments. We know that if you cannot tolerate medications or have run out of medications to which your virus is not resistant, the distance to good health is cavernous. The same is true if you are in a province or a rural community where drugs are not accessible because of cost or stigma. Mental health issues emotional problems and other health issues can keep you out of the system you need to get medications. Aboriginal people face huge access issues for a variety of reasons as do people who have immigrated to Canada. But I have been thinking a lot about another kind of distance lately — the distance between rich and poor, middle class and low-income working people. Isn't this the root of the distance that divides us — money? I think it is.

There is an old adage that countries start wars — civil or external — so people won't notice how bad things are at home, and blame someone else for their woes. I would never suggest that anyone started HIV. That's just nonsense. But fighting about HIV drug access and prevention issues and doing little to stop the stigma surrounding this disease has been quite a fortunate diversion for some country leaders. Problems like tuberculosis, malaria, clean water, access to food and health care go neglected either for the whole population or, as in Canada, for those from whom the power players want to distance themselves. This is otherwise known as scapegoating.

Yes, distance is definitely at the root of the epidemic.

People Living with HIV/AIDS in Rural Newfoundland and Labrador



By John Baker, CTAC Newfoundland and Labrador Provincial Representative

We all know how hard life can be when you live with HIV. We have to make sure we take our meds and see our doctors as well as eat right, get enough sleep, and of course endure treatment side effects. In a larger centre we can take advantage of our local AIDS Service Organization as well as an HIV clinic. We can also seek out other people living with HIV/AIDS for additional support.

In St. John's, the capital of Newfoundland and Labrador, supports exist to help with addictions (needle exchanges and methadone programs), mental health issues (access to psychiatric help) and housing, and shelter for people living with HIV/AIDS (The Tommy Sexton Centre).

It is quite a different story in rural areas.

Our Provincial HIV Clinic, located in St. John's, is going through big changes. This clinic is offered through the Infectious Disease Services of Eastern Health and is responsible for the care of all people living with HIV/AIDS in Newfoundland and Labrador. Although our province would regularly have had two adult infectious disease doctors at any one time, there hasn't been one here since March 2009. After December of last year, clients left their last appointment with no sense of when a follow-up appointment would be

scheduled! People living with HIV/AIDS ideally see an HIV specialist about four times a year.

Stress began to grow among people living with HIV/AIDS, and so the AIDS Committee of Newfoundland and Labrador (ACNL) began to do some advocacy work. ACNL met with the Minister of Health to get some answers and were told that a contingency plan was in place. It was not until ACNL and others went to the media did any action take place. It was during this time that the HIV Clinic Nurse Practitioner resigned after more than twenty years working with people living with HIV/AIDS. She was more than a nurse: she was our support, our friend, and our go-to person whenever we had an HIV-related question, no matter where we lived in Newfoundland. A new Nurse Practitioner has recently been hired and will begin work in the HIV Clinic in July after a week of "training" in Nova Scotia. Wow, only one week to learn how to treat HIV/AIDS!!

To be fair, things have moved forward. We have two infectious disease doctors who return every month or so to hold clinics until a permanent doctor can be hired. So far, clinics have been held in St. John's and Conception Bay North. Patients are being contacted directly by Eastern Health and informed of their next appointment. Much needed support staff and a social worker have also been hired.

In rural Newfoundland, care for people living with HIV/AIDS is a little more complicated. Many do not disclose their status, even to family, and are unwilling to discuss their status with their family doctor (if they even have one). In many cases people living with HIV/AIDS are afraid that if others find out about their status, it will result in stigma and discrimination in their small communities. Often a person living with HIV/AIDS knows their family doctor and/or their support team (nurses and admin staff) on a personal basis and fears disclosure. As a result, the HIV support team in St. John's, and especially the nurse, have become the main support link for all people living with HIV/AIDS in Newfoundland and Labrador. People living

with HIV/AIDS in the central part of the province, the South Coast or Labrador must travel to St. John's for their treatment. There has been talk of a traveling clinic in western Newfoundland, but no firm date to establish one has been set.

Susie, in Western Newfoundland, says: "I haven't had blood work done in about a year and haven't seen a doctor in about that long as well. The doctors around here know next to nothing about HIV/AIDS and so if something goes really wrong I'm not only up sh*t creek with no paddle, where could I go if I had one!?! Nowhere...circling around in hopelessness and despair..." ■



Green Acres

by Gregory Scratch in conjunction with Michael Hamilton and Jack Haight

CHATHAM-KENT in Southern Ontario seems to be becoming a hot spot for retiring people living with HIV/AIDS.

Who knew???

I moved here permanently in 2003. Michael Hamilton and his partner moved here in 2004 and Jack Haight and D. J. came to the area in 2006. We know several other HIV-positive gay and straight singles and couples that have chosen to live here in recent years, mostly due to the affordability of housing. Rural life is quiet and peaceful with fresh air and room to move. The success of HIV

treatments for many of us make living next door to our HIV care physicians less necessary.

However, it also has its challenges. The long distance from Chatham-Kent to HIV and other medical services, such as specialist appointments, can be an issue: drive time to Windsor or London is one hour and to Toronto, about three. The AIDS Committee of Windsor has a satellite office in Chatham, but until recently, had funds for only 1.5 staff and very limited office hours. Health statistics for the area helped secure funding for IDU and sex trade worker outreach positions, allowing the office to be open on a regular basis.

Chatham-Kent seems to be unique in that many of the people living with HIV/AIDS here are actually long term survivors. Many of us have taken the leadership training from the Ontario AIDS Network and developed a myriad of other skills through our years of volunteerism, work and life histories. We provide a challenge for our ASO and HIV care providers, not only from the point of view that we are an aging population of people living with HIV/AIDS with changing needs in a rural setting, but also from the fact that we have the experience and contacts provincially to know what can be done regarding services; we are strong voices for change. There is a saying that "with age comes wisdom." Hopefully that is true as we advocate for change in treatments and services being made available locally and beyond. We continue to work to encourage the hiring of people living with HIV/AIDS into AIDS Service Organizations, to provide peer support and counselling, addiction counselling and therapies, sex trade education, and gay men's outreach, and to combat homophobia and AIDS stigma and criminalization. All of this work is directed towards matters that are very real concerns, not only in bigger city centres, but even more in rural communities.

The very peacefulness that drew us here can also be an isolating factor, making our connection to each other in the HIV community even more important. As an HIV positive single gay man, I have found that the sexual and social

Jack, a gay man of Métis descent and the father of two sons, chose the Chatham-Kent area as a new environment for his recovery. Little did he know that the community has an increasingly devastating problem with substance abuse and is seriously lacking in support services for people using drugs or methadone replacement services. He had to drive weekly to Windsor for his methadone maintenance program until he had successfully weaned himself off, a rarity in itself!! The incorporation of leadership skills from the Ontario AIDS Network (OAN) and facilitation training with the AIDS Bereavement Project of Ontario have helped Jack in his work with the Chatham-Kent Drug Strategy and Opiate Project, whose vision is to bring a methadone clinic to the area within the next year based on a community health centre approach to support and promote recovery. He is the current Chair of the Harm Reduction Pillar in that effort.

Michael has been involved as a volunteer provincially for over a decade, serving on many boards, taking training and facilitating workshops. He is involved in the Prevention Pillar of the Chatham-Kent Drug Strategy Program and is a peer research assistant in the current ongoing study "Positive Spaces: Healthy Places."

isolation living in a rural community can be very depressing. My re-engagement in AIDS activism and participation in training made available through the OAN are paramount to my mental, emotional, and spiritual health.

Jack sums it up for us in his statement: "Being out about being gay, having HIV and being in recovery gives others the permission to do the same. Using my struggles and pain to help others is my gold and my gift to community and helps me fully love who I am and where I have been." ■

THE TERRITORIES

by Eileen Wennekers, Research Assistant

NUNAVUT

In Nunavut, health care is provided through the Department of Health and Social Services. Residents of Nunavut can access coverage for prescription drugs through:

- The NIHB plan, which provides non-insured health services for Inuit, Innu, and Registered Indians (this formulary is discussed in CTAC's Spring 2008 newsletter)
- Indigent Health Benefits, for individuals receiving income support
- Extended Health Benefits, for seniors and for non-aboriginal people who have been diagnosed with a specified disease or condition

Under the Extended Health Benefits plan, both "HIV infection" and "all other HIV-related diseases" are identified as a Specified Disease Condition. If your physician has applied for you to be covered, your prescription drug costs will be covered. As well, medically necessary travel costs, including accommodation, may be covered.

The Nunavut formulary corresponds to the NIHB formulary. Drugs not listed on this formulary may be covered by the Department of Health and Social Services under exceptional circumstances. If a health care practitioner needs to prescribe a drug that is not on this formulary, he or she must complete and submit a Request for Exception Drug Form. Upon receiving this request, the Minister will appoint an independent pharmacist from another province or territory who will make a recommendation. The Minister makes the final decision to provide or not provide coverage for the drug.

THE NORTHWEST TERRITORIES

In the Northwest Territories (NWT), the Health Benefits Program provides prescription drug benefits to eligible residents. As in Nunavut, the Extended Health Benefits program provides coverage for non-Native and Métis people who are registered with the NWT Health Care Plan, are permanent residents, and have been diagnosed with a specified disease. In the NWT, HIV infection is listed as a "Specified Disease" but related HIV diseases are not, which may mean that drugs necessary to treat secondary infections and side effects of HAART drugs might not be covered under the program.

Prescription drug benefits are administered by the Alberta Blue Cross on behalf of the Government of the NWT. This program provides up to 100 per cent coverage for eligible prescription drugs as listed in the NIHB formulary. If a drug is prescribed for you but not included in this list, your health care professional or pharmacist must submit a request to Alberta Blue Cross on your behalf, which may result in dangerous bureaucratic lag times for people who need to switch medication immediately due to resistance or intolerance.

At present, the best solution for this problem is to make sure that new HAART and other medications make it onto the NIHB formulary with as little delay as possible. However, a supplementary health benefits and a catastrophic drug costs program are in the works in the NWT, with an implementation deadline of April 1, 2010.

For further information, contact the NWT Health Services Administration Office at 1-800-661-0830.

THE YUKON

In the Yukon, the Chronic Disease and Disability Benefits Program provides benefits for Yukon residents who have a "chronic disease or serious functional disability." Your health care practitioner must apply on your behalf for coverage for prescription drugs or other approved means to manage your condition.

The Yukon formulary is compiled by the Health Services Branch, which is advised by the Yukon Formulary Working Group. This group's recommendations of drugs for exclusion and inclusion on the formulary are based on reviews forwarded from the CDR as well as the Saskatchewan Formulary Committee. It meets on a monthly basis to review drug requests, criteria, and exceptional drug applications.

The formulary benefits are based on the lowest price interchangeable brand available. In cases where the lowest cost brand is not feasible, the physician must make a written exception drug application and include comprehensive supporting information. The drug that has been applied for will be covered for 30 days while this application is being

processed. Once the request has been approved, coverage remains in effect unless the physician requests a change in status; but if it is not approved, it is discontinued. This is an obvious problem for patients who must continue taking specific antiretrovirals without interruption in order for the treatment to remain effective.

There is an annual deductible for this program of \$250, up to \$500 per family. This fee may be waived based on income and family size but if you apply for this consideration, the application must be approved prior to any benefits being received through the program. Anyone who leaves the Yukon for more than six months is no longer eligible for coverage, and this is applied retroactively to the date of departure. On returning to the Territory, the resident must re-apply for coverage. This may create a difficult situation for people who have left the Yukon in order to seek out specialized health care.

Further information is available through the Chronic Disease Program's office at (867)-667-5092. ■

CTAC Community Skills Building and AGM

October 4th and 5th
Vancouver, British Columbia

Join Us!



Canadian Treatment Action Council

www.ctac.ca





MY FIRST CAHR CONFERENCE

REVIEWING ABSTRACTS

by Richard Baker, CTAC Board of Directors

I WOULD LIKE TO START OFF by saying that this was my first time attending a big research conference. I found all of the sessions to be interesting and the abstracts quite impressive. It really did give me a different outlook on research.

Below you will find a selection of abstracts presented at CAHR, their objectives and conclusions, and my opinion as a person living with HIV/AIDS. The full list of abstracts presented at the conference is available at www.cahr-acrv.ca/english/resources/abstracts_2009/index.php.

FIRST NATIONS CANADIANS HAVE REDUCED ACCESS TO HEPATITIS C (HCV) TREATMENT

OBJECTIVE: To determine whether there is equitable access to HCV treatment amongst different ethnic groups.

CONCLUSION: People of First Nations were less likely to have received HCV treatment. The reasons for this low uptake of HCV treatment remain unclear, since most determinants are comparable between Caucasians and First Nations people.

I found this abstract to be quite interesting regarding people that are co-infected, especially in terms of looking at

the social determinants of health. These remain a barrier to treatment access for people of First Nations, and we need to conduct more research on why this is the case. This study shows that First Nations people are not getting the access to treatment that they need. In this pan-Canadian study, First Nations people with HCV were the only ethnic group that had lower rates of treatment. Only 25 participants out of the 474 individuals who were followed in this study identified themselves as belonging to a First Nation. It would be interesting to see more research where the majority of the group identifies as First Nations. This way, we could get a more precise outcome and pinpoint the reasons why there is a lower uptake of treatment within this population that has especially high rates of HCV infection.

THE RIGHT THING TO DO? A CRITICAL ANALYSIS OF PUBLIC HEALTH ETHICS, RIGHTS DISCOURSE, AND THE EXPANSION OF ANTIRETROVIRAL THERAPY (ART)

OBJECTIVE: The expansion of HIV treatment in Vancouver's inner city has been discussed in relation to low numbers of individuals accessing ART and concomitant mortality increases, changing treatment guidelines, and the potential public health advantages in reducing HIV transmission. These justificatory schemas seem to

Photo credits: Ela Pia Czesny, courtesy of CAHR. **From left:** 1. Premier Campbell addressing the conference at the opening ceremony. 2. Hereditary Chief Robert Williams presenting talking stick to Dr. Mark Tyndall. 3. Dr. Elenore Maticka-Tyndale, recipient of the Mark A. Wainberg Lecturer Award.



2009 CAHR CONFERENCE 2009 CAHR CONFERENCE 2009 CAHR CONFERENCE 2009 CAHR CONFERENCE

demonstrate convergence of sound ethical, clinical and economic interests. As public health ethics continues to engage with rights-based ethical frameworks, the expansion of HIV treatment appears to be an intervention that is coherent, rational and good, an ideal exemplar of the utility of a rights framework for public health.

CONCLUSIONS: The subtleties of negotiation, resistance, and acquiescence to the governance of individual and public health suggest that rights may be insufficiently attentive to the ways in which micro networks of power shape agency (and by extension, treatment decisions); central issues of poverty and colonialism further trouble a rights framework, given the historical predication of rights on property and citizenship.

This was a hot topic in Vancouver which showed that a lot of individuals on the street and/or homeless are not getting access to HIV treatment. It means that the government needs to put more money in this area and its programs and services, such as access to safe and affordable housing, access to supports, clean water and food banks, and the provision of information and education. The Vancouver government made an announcement at the opening of the CAHR conference that they have agreed that this is a critical matter that needs to be addressed immediately. They have committed millions for this population, and are hoping to save hundreds of individuals' lives in the inner city community within 5 years. In my opinion this is a right to life issue in Vancouver. No one in this country should be without treatment.

EXPLORING YOUNG PEOPLE'S INITIATION INTO A LOCAL DRUG SCENE IN VANCOUVER, CANADA

OBJECTIVE: Recent research has highlighted the ways in which the social-structural processes and physical environments of drug scenes operate to push young people towards HIV-related risk behaviors and numerous drug-related harms. We undertook this study in order to explore how young drug users characterize and understand their initiation into the downtown drug scene in Vancouver, Canada.

CONCLUSIONS: The findings stress the need for early intervention with youth who are exposed to the various push and pull factors that lead to drug scene involvement, before they are initiated into the social networks and processes that rapidly propel young people towards risk. We found that once initiation has occurred, the boundary between safety and risk becomes increasingly difficult to navigate, and young people become highly vulnerable to numerous harms, including HIV infection.

This is a research area that I am very familiar with. As one of the co-founding members of Positive Youth Outreach and from having been a positive youth many, many years ago, it seems to me that things have not changed for the better in some cases.

We are seeing higher numbers of youth becoming infected these days. A total of 39 young drug users were recruited in this study. The study shows that

Photos, from left: 1. From left to right: Dr. Brian Conway – CAHR president at time of conference, Mark Wainberg, Dr. Elenore Maticka-Tyndale, Ted Myers – CAHR past president, Dr. Mark Tyndall – Chair, CAHR 2009 Conference. 2. Dr. William Cameron – current president of CAHR. 3. Dr. Mark Tyndall with Angela Kaida, recipient of the 2009 New Investigator Award – Epidemiology and Public Health.

youth go in this direction because of many factors that may include child abuse, unstable housing, difficulties encountered by LGBT, behavioral issues and run-ins with police. Having said all this, I still think there is a bigger problem and that is that there are not enough social programs and prevention methods available in schools. Youth are thinking that they are still not at risk, or if they get HIV

that it is not a big deal, "all they have to do is take medication" and people with HIV are living longer so it is not a factor for them. Of course, we all know that this is not the case. People are living longer but their lives are still shorter because of cardiovascular disease, diabetes, bone density loss, not to mention the other side effects of nausea, resistance to medications and so forth. ■

Lately, when faced with an opportunity to be active in the HIV/AIDS movement, I have to ask myself two things: is it going to cost me money, and is it going to cost me t-cells? If it costs me money, it ultimately costs something more to my two children, usually food or transportation.

The gap between the haves and have-nots is vast and often invisible in the HIV/AIDS world. I am an Aboriginal woman with two kids, living in poverty. This is one of the hardest places to be when trying to access HIV care. Lately, I can see the stigma and the gap clearly, and I realize how much they affect my access to the best HIV care in British Columbia.

HIV/AIDS care, treatment, and support can be a rocky road because it is not standardized and integrated into provincial or federal health programs in Canada. HIV/AIDS care, treatment and support is generally outsourced through project funding to a small and competitive not-for-profit sector, while medical services are located in larger city centres.

Policy is a strong determinant of how people access much needed life-saving treatments and services. People living with HIV have to find ways to move through the bureaucracy in order to access the treatment and care they need. We find ourselves alone to do all the leg work to find a good doctor, access treatment, manage our side effects and deal with the social issues that surround HIV.

*On a
personal note...*



by Kecia Larkin

Inevitably, the way to access treatment always costs money! If you are not living in a city where centralized services are available, you have to travel to access them. This costs time and money and if you are limited in either, travelling then becomes literally impossible. Childcare for a parent costs on average \$75-90 per day, and that is assuming you have someone reliable for childcare. I have had to take my children with me to my HIV appointments many times.

Lately, provincial cutbacks and new regulations for specialist referrals have been preventing me from accessing HIV care. In addition, my travel assistance request was scrutinized and cut back by workers at my provincial disability office. I am now doing someone else's job by monitoring my own HIV.

I deal with unpleasant side effects every day, but I now have more t-cells than I have had in a decade, so I stick with the treatment. The barriers are still there and are very real, but I have no choice but to work through them! I have learned how to be resilient and not take no for an answer when dealing with my health care. ■

Regional Clinic for Integrated HIV/AIDS Care in Abitibi-Témiscamingue

Monitoring individuals living with HIV/AIDS is complex and requires the concerted involvement of numerous specialists. The virus, just like the syndrome, can often lead to numerous complications, which are often compounded by significant social problems. Complete disruption is often at the core of the problem for individuals.

Until the establishment of the regional clinic in 1999, the lack of specialised training and limited access to care meant that patients made multiple visits to hospital emergency rooms in the region or had to travel to large urban centres more than 500 km away to obtain specialised services. This difficulty getting access to treatments, associated with isolation and the weakness of support networks, actually augmented the rates of morbidity and mortality for clients in the region.

For the past 10 years, the Regional Clinic for Integrated HIV/AIDS Care has furthered its principal mission to improve the quality and accessibility of care and services for persons living with HIV/AIDS in their living environment. The clinic also promotes sharing of expertise by peer teaching in the region. The model used by the Clinic permits the provision of a range of services, delivered by an interdisciplinary team involving nursing, nutritional, pharmacological and psychosocial services. Moreover, the links established with the Hospital for Research, Teaching and AIDS Care (UHRESS) of the Centre hospitalier universitaire de Montréal (CHUM) brings updated expertise to our service providers. Most notable is a monthly visit from a specialist in HIV/AIDS to our Clinic. In this unique health care model, a nurse is responsible for the coordination of the Clinic and plays a pivotal role. He or she acts as the liaison with other service providers, individuals, establishments and community organizations.

*By Danielle Gélinas, nurse and coordinator,
Regional Clinic for Integrated HIV/AIDS Care in
Abitibi-Témiscamingue*

The constant challenge of such a project that serves numerous cities and towns, often far apart, is the development of a local and regional partnership. Links need to be established with home care services in some cities in the region, as well as with laboratories at health centres. The strength created by the interdisciplinary nature of the team cannot be denied, and pre- and post-clinic consultations with patients are conducted regularly. Home visits are also available as needed, allowing a better evaluation of how affected people are living and what their needs are. With the goal of facilitating visits, many clients maintain dossiers at the clinic in Rouyn-Noranda, the central city of the region and accessible in less than 90 minutes by car.

In addition to HIV/AIDS, various related problems are confronted on a daily basis at the Clinic, such as addiction, homelessness, prostitution, mental health, co-infections like HIV/HCV (Hepatitis C), pregnancy and HIV, homosexuality, ethical considerations, discrimination and stigmatisation. Professionals at the Clinic participate in diverse round tables, including one on challenges facing gays and lesbians and another on prevention services and screening in native and non-native communities (Pikatemps project).

In conclusion, this regional clinic is considered an ideal model for care delivery for semi-urban and rural communities in Québec. The expertise demonstrated by its nurses and the services offered are at the heart of the planning process. Moreover, this model constitutes an appropriate response to the shortage of medical resources in far-apart regions by offering adequate monitoring and multidisciplinary support to persons living with HIV/AIDS. ■

For clients of the AIDS Support centre, access to care is no longer

A Question of Geography

By *Hélène Legaré, Director of the Sidalys AIDS Support Centre*

ALFRED has spent the last three months living on the streets, and with HIV. He was diagnosed HIV-positive four years ago, but today he is more troubled by mental health issues and drug addiction than by his physical health. Lately, though, Alfred has been feeling weak and wants to consult a doctor. But how can Alfred get in touch with a doctor who specializes in HIV/AIDS, who will give him a complete check-up with the goal of starting him on a course of antiretroviral drugs? Even if he lives in a large urban centre, the road could be a long one between Alfred and the office of a specialist. The AIDS Support Centre aims to help people like Alfred who are marginalized and living outside the system.

The Centre's objective is to establish the best possible conditions so that people living with HIV/AIDS, including the most disenfranchised, can have access to health care and social services; services that they have a right to, as does the rest of the population. To reach that goal, the Centre collaborates with numerous partners, and has opened a shelter where individuals can take charge of their health.

The Centre's services reach out to both men and women, 18 years and older, who are living with HIV/AIDS, reside on the island of Montreal, and are experiencing:

- A significant deterioration in their health that is connected to HIV/AIDS
- A significant incapacitation in terms of their psychological well-being such as disordered thinking
- Difficulty living in a place such as a shelter, where rules are perceived as too rigid

WHO ARE OUR CLIENTS?

- Individuals struggling with addiction issues, many of them users of intravenous drugs
- Individuals struggling with mental health issues or personality disorders that are often associated with socially deviant behaviour
- Individuals with a history of displacement and/or homelessness, prostitution, violence or encounters with police, or a history of incarceration

Truth be told, our clients can be difficult to help. Frequently, they have experienced rejection and the majority can be mistrustful at first contact. They also tend to live in the immediate present and, in order to help them, counsellors at the Centre must adapt to, as much as possible, their way of living.

The Centre does not actually provide health care but it does do its utmost to facilitate access to appropriate resources. The counsellors work in direct collaboration with colleagues in the field and offers space at the shelter for clients of these partners.

In keeping with our goal of encouraging our clients to stay at the Centre, we must accept them as they are, promoting flexible structures that can bridge the gap between their lifestyle and our resources. At the same time, we must keep a calm, serene environment inside the Centre. That's why, from the moment they arrive, we present our future residents with a code for daily life at the Centre, one with relatively minimal rules. This code is signed by our residents and they receive a copy.

► SEPTEMBER

28-29

Meeting the Challenge: HIV Prevention and the African and Caribbean Diaspora ICAD Annual General Meeting and Joint ICAD/ACCHO Workshop
Ottawa, ON
www.icad-cisd.com

► OCTOBER

1-3

The Changing Face of AIDS: 2009 AIDS Conference
Regina, SK
www.aidsprogramssouthsask.com/conference.html

4-5

CTAC Community Skills Building and AGM
Vancouver, BC
www.ctac.ca/en/action/agm

7-8

Atlantic Region Educational Conference
CATIE
Truro, NS
www.catie.ca

15-16

Western Region Educational Conference
CATIE
Calgary, AB
www.catie.ca

28-29

Pacific Region Educational Conference
CATIE
Richmond, BC
www.catie.ca

► NOVEMBER

12-14

2009 International Drug Policy Reform Conference
Albuquerque, New Mexico
www.reformconference.org

15-17

Women: Keepers of the Tipi – 3rd Annual Aboriginal HIV/AIDS and HCV Conference
All Nations Hope AIDS Network
Regina, SK
www.allnationshope.ca/News.htm

16-17

Research at the Front Lines: Finding New Solutions in HIV Prevention, Treatment and Support
Ontario HIV Treatment Network (OHTN)
Toronto, ON
www.ohtn.on.ca/Pages/Whats-On/2009-Conference.aspx

18

Annual General Meeting
CATIE
Toronto, ON
www.catie.ca

29-December 1

IAPAC 2009
International Association of Physicians in AIDS Care (IAPAC)
Toronto, ON
www.iapac.org/iapac09

► DECEMBER

1

World AIDS Day

Many individuals that come to the Centre face serious addiction issues and are active drug consumers. The consumption of drugs is an addiction and must be considered as such. In the case of our residents, they are no longer engaging in recreational drug use, and their addiction has reached the point of disease. How can we demand sobriety and abstinence from our residents?

In order to achieve our mission, we have decided to permit the consumption of illicit substances and alcohol inside our Centre. However, we have put in place the following rules:

- Consumption must not harm or interfere with the intervention plan
- It must be carried out individually, in the resident's room

- Materials for injection are available for residents and there is a receptacle for syringes in all of the rooms

In operation for nine years, this experiment has proven to be very positive as it allows individuals excluded from other centres to have access to food and shelter, and a space to have some stability in their lives while taking the first steps towards taking charge of their health. ■

For more information about CTAC,
please visit us at

www.ctac.ca

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2008/09 FUNDERS

Public Health Agency of Canada (PHAC)
Abbott Laboratories • Gilead Sciences • Glaxo-SmithKline in partnership with Shire BioChem • Merck Frosst Canada Ltd. • Pfizer Canada • Sanofi-Anvantis • Schering Canada • Tibotec, a division of Janssen-Ortho Inc.

CTAC DISCUSSION 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

CONTACT US

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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.