

CANADIAN TREATMENT ACTION COUNCIL



Canadian Treatment Action Council

INSIDE

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What is Harm Reduction?

THE ANSWER to this question depends on who you are asking. Some will tell you it's to reduce the harms associated with certain behaviours; others that it's enabling drug users to continue on with their lifestyle "choice."

Illicit drug use is not an activity performed by a few "lost causes." It is an aspect of our society which is more common than many people assume. In 1994, 28.5% of Canadians reported having consumed illicit drugs in their life; by 2004, that figure had jumped to 45%.¹ Treasury Board documents show that 73% of the \$368 million spent on targeting illicit drugs in 2004-2005 went toward law enforcement initiatives. Taken together, these two figures indicate that prohibition does not prevent drug use. Therefore, it only makes sense to divert more of the funding which the Canadian government has allocated to this area to treatment and harm reduction programs.

Health care providers in British Columbia are pioneers in developing and implementing successful harm reduction strategies. What began as simply handing out condoms more than 20 years ago has now developed into community, provincial, federal and even global strategies. What began as individuals secretly distributing clean syringes to substance users has developed into comprehensive needle exchange centers, mobile exchange programs and the first supervised injection site in the country. It hasn't been easy to establish these programs, and, in the face of volatile public opinion, it is always a challenge to maintain them.



*By Karen Dennis,
CTAC current and
former substance
user representative*



Still, making a difference begins with meeting individuals where they are; building trust and rapport allows a person who wants to make lifestyle changes to know exactly where and to whom to go. Abstinence based programs are not for everyone. We know this.

The Downtown Eastside of Vancouver, BC has long been known as the poorest postal code in North America. The community and the service providers who worked there encountered open drug use, crime, and the health and social issues caused by widespread poverty. By September of 2003, it had become clear to Vancouver's municipal government that merely enforcing anti-drug legislation was not a comprehensive policy. Therefore, Insite, a safe, supervised injection site, was established as a research project. The facility obtained a federal exemption so that clients could bring illicit drugs into the facility for consumption.

Since being established, Insite has had amazing success. Between April 2004 and March 2006, there has been an increased uptake of clients into detox and treatment, reduced public drug use and reduced overall rates of needle sharing, with 70% of drug users reporting that they were less likely to share.

Research also indicates that Insite has not increased relapse rates. Nor is it a negative influence on those seeking to stop drug use. Since its inception, there HAS NOT been any increase in drug related crime. In fact, arrests for trafficking,

assault, robberies, vehicle break-ins and thefts has declined significantly. Insite attracts the highest risk users, those who are most vulnerable to HIV/HCV infections and overdose and who are also more likely to engage in public drug use and unsafe needle disposal.

In one year, Insite made over 4,000 referrals, with close to 40% of these being to addiction counselling programs. One in five regular visitors began a detox program. The site has also prevented deaths from overdose. Of the 500 overdoses that did occur over two years, none were fatal, as medical staff work at the site.² Imagine if this facility did not exist—not only would too many deaths have occurred, the cost to our police, ambulatory services, service providers and hospitals would have far exceeded the cost of its operation. It was a great victory for preventative health care when British Columbia's Supreme Court granted Insite a permanent exemption from federal drug laws. Canada's Health Minister has indicated he will launch an appeal to this decision. Let's hope he will not succeed.

There have been recent setbacks for harm reduction service providers in British Columbia. The fixed site needle exchange in Victoria, which had been operating for more than 20 years, has had to close its doors. Due to growing homelessness, untreated mental illness and the increased drug use which comes along, many people congregated outside the exchange after hours, often using drugs. In response, neighbours of the exchange formed a group and applied enough pressure to result in its eviction. Even with the support



Images courtesy of the
**Victoria AIDS Resource &
 Community Service Society**

Harm Reduction Across Canada

Whitehorse, YT

Edmonton, AB

Victoria, BC

Winnipeg, MB

Québec, QC

St. John's, NL

WHITEHORSE, YT

**"The No fixed Address Outreach Van",
collaborative**

The No fixed Address Outreach Van travels the streets of Whitehorse at night with the aim of reducing the harmful effects of poverty, drug and alcohol use, and homelessness. It complements existing services by providing nursing, harm reduction material and counselling.

www.manyrivers.yk.ca

VICTORIA, BC

**"Society of Living Intravenous Drug Users
(SOLID)"**

Non-judgemental SOLID services and support are offered in friendship and without judgment. They provide harm reduction services by van, bicycle and on foot when other outreach vans are not operating.

www.canadianharmreduction.com/project

EDMONTON, AB

"Streetworks"

Community-based Streetworks is made up of a team of nurses and outreach workers. They provide all kinds of supplies (condoms, needles, alcohol wipes, water, lube, ties, filters, vinegar, education booklets, pregnancy test kits, Health for Two coupons, etc.) for people who are injecting drugs or working on the street.

www.streetworks.ca

WINNIPEG, MB

"Nine Circles Community Health Centre"

Culturally sensitive, Nine Circles Community Health Centre ensures culturally-based access to HIV/AIDS prevention, educational and people living with HIV/AIDS care and treatment services for aboriginal, treaty, Inuit, Métis and non-status Manitobans in Winnipeg.

www.ninecircles.ca

QUEBEC, QC

**"Projet intervention prostitution de Québec
(PIPQ)", for people in sex-trades**

"Le projet Catwoman" teams up two women with sex-trade experience—one older and one younger—to do outreach to escorts, dancers and masseuses to help ensure their safety and security. PIPQ provides nursing care, needles, safer sex supplies, food, clothing, and extensive personal support.

www.pipq.org

ST. JOHN'S, NL

"Street Reach", for youth

Street Reach workers meet youth where they are, help them go where they want to go, and support them in becoming who they want to be. They support some of the most vulnerable youth in St. John's, a population that is least likely to access services due to multiple barriers.

www.cyn-stjohns.nf.ca

Treating drug users with Hepatitis C (HCV) or HCV/HIV Co-infection:

A “Patient First” Approach—Best Practices

by Colleen Price, CTAC Board

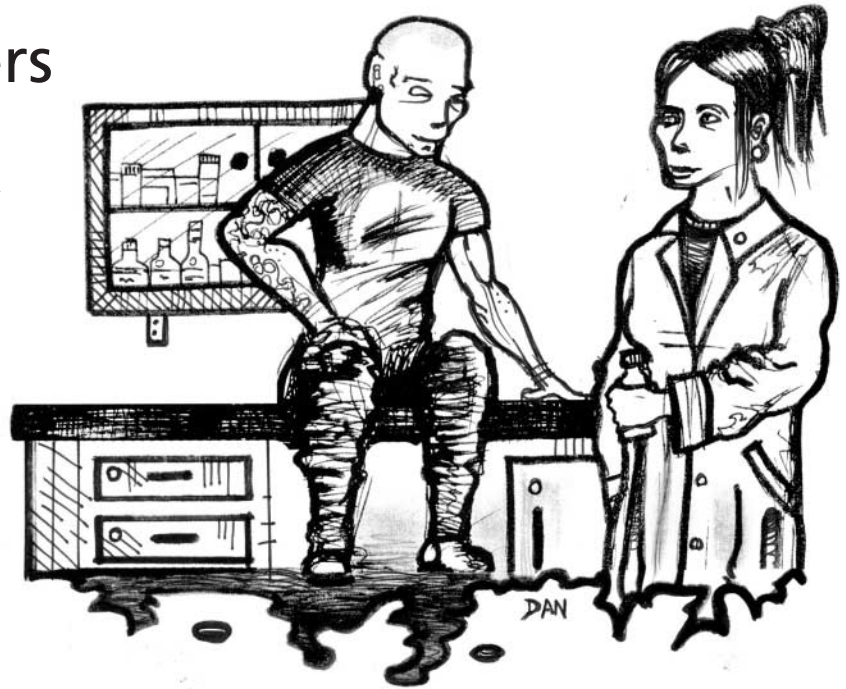


Illustration by Daniel Amyot

HCV treatment must be made accessible to everyone including injection and other substance users, as well as people on Methadone Maintenance Therapy (MMT).

The goal of HCV treatment is either to cure or successfully manage the virus by slowing the development of fibrosis which can lead to cirrhosis and end-stage liver disease. For people living with hepatitis C and HIV, liver failure is the leading cause of death. Early detection is beneficial for both HCV-mono and HCV/HIV co-infected people because in most cases, hepatitis C is manageable and treatable.

People who use injection drugs are among the most marginalized, stigmatized and criminalized people in society. As HCV is transmitted via sharing materials for drug use, many people contract HIV as well, resulting in HCV/HIV co-infection, a growing epidemic. International studies show the rates of HCV among the injection drug user (IDU) population to be as high as 50 to 95%.

Many people who initially seek HCV treatment fall through the cracks due to the lack of multidisciplinary care for addictions, mental health and support services. Access to Hepatitis C treatment, length of treatment allowed and the ability to repeat it vary by province. Access to harm

reduction programs that are not abstinence-based, from MMT to supportive housing, also vary by city and province. The care you receive very much depends on where you live and your ability to navigate social and support systems.

Therapeutic management of drug users (DU) for HCV and/or HIV treatment must take into account social determinants of health, lack of stable housing and social networks and difficulties in attending clinical, psychological or other support services, which also impedes treatment choice and completion for many.

Although effective treatment of HCV is available, the vast majority of HCV infected drug users remain untreated. Treatment has, however, been shown to be effective and well tolerated among those who use drugs with appropriate support services.¹

It is clear that a multi-disciplinary harm-reduction approach coupled with supportive networks is needed to assist the “difficult to treat”, either until completion or for ongoing care. The doctor/patient relationship is vital to ongoing clinical care for people who use drugs while on or off HCV treatment or dual treatments (HCV/HIV). Trust, flexibility and innovative strategies are needed on an individual basis so that an individual’s drug use does not prevent access to



necessary health, mental health and social services.

Dr. Jean Robert is a microbiology and infectious disease specialist and community health specialist. He works in a non-profit community-based clinic and has been practicing medicine for almost four decades. He opened the unique Clinique Santé Amitié in 1989 as part of the Centre Sida Amitié des Laurentiennes. Dr. Robert receives many referrals from Portage at Lac Echo, a residential drug addiction treatment centre with 80 beds for adults, 40 beds for youth and eight treatment centres across Quebec. He also receives referrals from Cap Espoir, a short-term addictions center, from psychologists, social workers and colleagues. Dr. Robert sees substance users not as "difficult to treat, but different to treat." Using a "patient first" perspective, he adapts treatment plans to the needs of the client. "The disease belongs to the patient, not to the caregiver. It's the patient who decides to be treated. It is not up to the doctor to refuse. The doctor supports the patient, that's all."

Dr. Robert considers addiction an illness and believes that good public health policy treats addiction with compassion—not judgment. People who use drugs deserve the same compassion, care and treatment as any other citizen. The body of research around these issues indicates that "for people with opiate addictions, methadone maintenance therapy is very useful in helping patients adhere to HCV treatment as well as HIV treatment. This is another reason why Canadian policy makers should give serious consideration to improving access to and quality of methadone programs."²

Methadone Maintenance programs help prevent injection drug use transmissions of HIV and/or HCV because medications are taken orally. Since June 2, 2008, buprenorphine/naxalone programs are also available in Quebec, but access to this treatment option varies across the provinces.

What makes the Clinique Santé Amitié unique is not only the expertise of Dr. Robert but that he also offers MMT and medical marijuana exemptions which provide patients with access to specialists in both infectious disease and addiction who can help manage both. The goal is functional control of addictions that can enable taking HCV treatment if that is what the patient chooses. Dr. Robert will assist patients to

get MMT if they have been rejected and he will re-treat patients who have relapsed when they are ready. He focuses on the preservation and quality of life, not on the judgment and exclusion criteria found so frequently in other provinces.

There is an extreme shortage of methadone prescribers and providers across the country. More of both are needed urgently for drug users (DU) who choose to treat their HIV and HCV. At Clinique Santé Amitié, there is a pharmacy upstairs and people come in daily, unless they are long-term MMT patients. People also come in once a week for interferon injections. Dr. Robert's open door policy has led people to travel long distances to take advantage of his expertise.

Dr. Robert says, "It is an honour to join patients on their HCV treatment journey." He remains highly successful in helping people who use drugs to choose HCV therapy and to complete treatment. He loses very few patients to follow-up; he has an open caseload of 1500+ patients, of whom the majority are long-term patients.

For many, this is the first time they have ever cared about their health. Dr. Robert accepts his clients' condition of addiction and educates them about treatment options, but the choice to treat remains with the patient. Dr. Robert has helped save many lives and helped people to transform their lives through effective addiction management strategies that improve adherence and enable successful HCV treatment and ongoing clinical care. His "patient first" philosophy epitomizes "best practice" in care for substance users who are living with HIV and/or HCV infection. ■

¹ Centre for Addictions Research of BC – "Viral time bomb": Health and human rights challenges in addressing hepatitis C in Canada – Canadian HIV/AIDS Legal Network, April, 2008, p 1.

² Centre for Addictions Research of BC – "Viral time bomb": Health and human rights challenges in addressing hepatitis C in Canada – Canadian HIV/AIDS Legal Network, April, 2008, p 17



Harm Reduction at CAHR

By Ron Rosenes, CTAC Vice-Chair

Funding under the Federal Initiative for HIV/AIDS for services based on the principles of “harm reduction” may have all but disappeared. But judging by the abstracts presented at Canadian Association for HIV Research (CAHR) this past April, the concept is alive and well among Canadian researchers.

The Public Health Agency of Canada estimates that in the mid 1990s, over one third of new HIV infections occurred among people who inject drugs. This has declined to an estimated 14 percent of new infections in 2005, in part due to harm reduction initiatives. Harm to the individual (and ultimately to the general public) may be reduced through access to methadone treatment for opioid addiction, which can also reduce the use of injected drugs. Access to clean needles reduces the sharing of injection equipment and hence the spread of blood borne diseases. Supervised injection sites not only ensure the use of sterile equipment and reduce the likelihood of overdose, they are also a means to connect some of the most marginalized people who use drugs to other health services including rehabilitation services.

The goal of the Cedar Project, a community based research project of the B.C. Centre for Excellence in HIV/AIDS, is to gain a better understanding of why the incidence of HIV and HCV infection among Aboriginal youth is twice that of non-Aboriginals and to develop strategies that reduce this risk. Several abstracts on the project were presented.

One study sought to determine factors related to the initiation of intravenous drug users (IDUs) among young Aboriginal people in Vancouver and Prince George. Aboriginal interviewers administered baseline and follow-up questionnaires every six months. Blood samples were drawn and tested for HIV and HCV antibodies. This analysis included individuals who completed the baseline questionnaire and at least one of five follow-up visits.

RESULTS CONCLUSIONS

Results: Of participants at baseline, 207 (45%) were non-injection drug users. Among those, 197 (73%) completed at least one of the first five follow-up visits which occurred at a median time of 1.73 years later. As of July 2007, 39 participants had transitioned to IDU, which translates as 11.5 cases per 100 person years or an incidence rate of 19.8%—very high. Analysis of the data showed that becoming an IDU was associated with gender, involvement in survival sex work or overdosing in the last six months, and/or ever having a sexually transmitted infection.

Their conclusion: Culturally sensitive and safe prevention efforts based on Indigenous principles and values are urgently required for this at-risk group of young people.

In another abstract, community researchers sought to determine predictors of HCV seroconversion among a cohort of young Aboriginal people who use injection and non-injection drugs in Vancouver and Prince George. Sharing equipment (such as needles or rigs) in the past 6 months, daily cocaine injection and survival sex were shown to be independent predictors of HCV seroconversion.

Their conclusion: Young Aboriginal people who use drugs require easy access to clean injection equipment. Young Aboriginal women involved in survival sex and injection drug use require programs offering safety and healing strategies based on Indigenous values.

There is insufficient space to report on other topics raised at the conference such as the link between adherence and stable housing which underscore the need for funding and access to programs and services that reduce risk and the potential for harm to the individual. ■

Substance User and More

MY name is Rick Julien. My first addiction to a substance was to tobacco which began at age 20. I acknowledged an addiction to alcohol at age 25. I was able to abstain from cigarettes at age 30 (but it took 5 years to feel like a non-smoker). I have struggled to abstain from alcohol and once used the 12-step program to help.

As a gay man I found it difficult to relate to 'god' as support, but I admired the participants who were helping one another. I have had a year of sobriety several times, with the help of support groups and understanding individuals. Five years ago, after one of my sober years, I had begun drinking on weekends. At the recommendation of a therapist, I registered to meet a HARM reduction therapist at the Centre for Addiction and Mental Health (CAMH).

Unfortunately, two days before my appointment, I binged on alcohol at a friend's birthday and decided to climb a tree on the way home. I regained consciousness a day and a half later, which was when my family and friends located me in the hospital. I lost my left eye, part of my jaw and nearly tore off my right arm (I had landed face first on a metal fence). While in Intensive Care Unit (ICU), the doctor assigned to my case would go by each day and introduce me to the masked med students (during SARS) as patient number, name, injury and blood alcohol level. I thought they must see me as nothing but just another unfortunate drunk.

When I was transferred out of ICU several days later, I experienced body spasms. I told the nurse that I thought something was wrong. He just rolled his eyes and said it was probably just the delirium tremens (DT). I rolled my eyes because I've never been able to consume alcohol in the quantities required to experience DTs. I was right and it proved to be kidney failure as a result of an opportunistic infection. I hadn't disclosed my HIV status due to fear of the stigma attached to it. I headed back to the ICU.

During recovery one of the nurses asked a

*On a
personal note...* 

friend if I would be moving in with him. The nurse assumed that I was a homeless person because I had been found drunk in the street. When I was well enough to look at returning to work (one year later) I discovered that I was still listed as a missing person on police files. I am a fortunate substance user because I have family and friends who love me unconditionally.

As part of my recovery I returned to CAMH and joined a HARM reduction substance user group. I learned to stop judging people who are just like me and continue to work on not judging myself. Some people are substance users and it is no more of a choice than being gay or being HIV positive. One is a human condition and the other is an illness. I believe addiction is somewhere in the middle.

I now co-facilitate a getting started group for gay/bi men looking at making a change in their substance use. HARM reduction supports people in looking at their use honestly while helping them to cope with the shame they are often feeling. When that happens, people can start to make changes in their substance use, which often includes abstinence, but does not stigmatize those of us who can only sustain reduction at this moment.

HARM reduction accepts that substance use is part of the human condition. HARM reduction believes that substance users are people dealing with an increasingly complex world and that they need to be supported in their struggles to manage their lives. I believe people seek support and make the best decisions when they do not feel stigmatized and shamed. I am a substance user and a family member, a friend, a volunteer, an artist, a co-op member, a community participant and I try my best to live proudly in a stressful, frustrating, exciting and complex world. ■

Is There Anything Unnatural about Bill C-51?

By Ron Rosenes, CTAC Vice-Chair

A Bill to bring Canada's Food and Drug Act into the 21st century from the 1960s is about to receive Second Reading in the House of Commons. Notwithstanding the concerns of some "anti-regulationists" widely reported in the press, CTAC remains largely in favour of Bill C-51. The Bill plays catch-up to bring the legislation into line with the complexities and increased public demand for scrutiny and oversight of the drug approval process ("Authorizations and Licenses"), post market surveillance, inspection and power to recall "foods, therapeutic products and cosmetics", as they will be called in the new Act. Whether Natural Health Products (NHPs) should be included among "therapeutic products" is the burning question.

Here are some reasons the regulations need to be modernized:

- First, to entrench regulatory practices that have been in place for some time, such as the ability of the regulator to perform expedited reviews of novel therapies.
- Second, to align more closely with other countries.
- Third, and perhaps most importantly, to put into place a life-cycle approach for the approval of new therapeutic products that determines their risks and benefits (as opposed to the misunderstood concept of "safety"—"your government says these are safe for you to put in your body").

This life-cycle management approach is called Progressive Licensing and it aspires to a more rational and comprehensive pre- and post-approval management of drugs,

biologics, medical devices and NHPs from bench to store. The essential thinking behind Progressive Licensing is that over time, we learn more about a drug and its benefits and risks. This legislation improves the regulator's ability to demand more data collection about products once they have been approved in order to balance the potential benefit of a drug against the potential risk it could cause once the product is in use among the general population.

The legislation also updates the laws around the inspection and recall of products that may not meet standards, or have been adulterated, counterfeited or offered for sale with fraudulent claims. It also raises the penalties that can be imposed for infractions.

The goal is not less regulation nor less rigorous review of health products; it is more intelligent and comprehensive regulation that can provide consumers with better information with which to make informed choices.

Bill C-51 also creates a home for NHP regulations that have been in force since January 2004. Ironically, whereas C-51 plays catch-up to 21st century realities, the regulations for NHPs have put Canada on the cutting edge when compared to most other countries where they are either regulated as a subset of foods (e.g. USA) or in a basket of separate categories (e.g. Europe: homeopathics, herbals, vitamins). The regulations now in coming into force, it



should be noted, were developed specifically for NHPs. While sensitive to cultural and traditional use, they are based on scrutiny appropriate to the levels of risk involved and the claims being made by manufacturers.

In the existing Act, the NHP regulations sit “under” drugs. In the proposed Act, the NHP regulations would be under the umbrella of “therapeutic products” which includes drugs, biologics and medical devices.

During a recent cross-country round of consultations, the question of placing the NHP regulations under the umbrella of therapeutics became a very contentious issue. Many individuals and groups called on the government to define a third and separate category for NHPs. This may be because for some there is a negative connotation of linking NHPs to drugs, but as Andre Picard pointed out in a recent opinion in the *Globe and Mail*: “When you get right down to it, a drug is a drug is a drug, whether its basic chemical

ingredients are synthesized in a lab or derived from plants.”

CTAC supports the legislation as it is written on this particular point. Creating a separate category risks opening a Pandora’s Box of issues. Keeping NHPs under “therapeutics” creates the best balance because it allows the regulator to set a higher standard for the evidence required to prove that products make valid claims to cure, prevent or mitigate illness or disease and to ensure that the Codex Alimentarius does not apply in Canada. In Europe the Codex can be used to limit the amount of NHPs in foods. In Canada, the NHP regulations define upper limits in products. Finally, keeping NHPs under “therapeutics” makes it easier for companies to get International Trade Certificates that are understood and accepted abroad. The NHPD has now issued over ten thousand such Certificates and they are accepted in over 36 countries.

There will undoubtedly be a lively debate at the Standing Committee on Health on this point.

The legislation also proposes to abolish “Schedule A” which prohibits advertising for many conditions that encourage people to seek professional advice instead of self-treating. “Schedule A” runs the gamut from cancer to gout to tuberculosis and is now outdated since many of these diseases are treated today with prescription drugs. The demise of “Schedule A” will also make it possible for NHPs to make claims with regard to these illnesses, but only if the evidence provided meets the regulator’s standards.

CTAC will bring two areas of concern to the attention of the Standing Committee when it holds hearings. First, with regard to the personal information provisions in the proposed legislation that would allow the regulator access to private health information if a person in a clinical trial develops a communicable disease, CTAC believes that the Canada Health Act already adequately covers those situations that are of concern to the regulator and that these provisions should be removed from the proposed legislation.

CTAC is also concerned that the wording around Direct to Consumer Advertising (DTCA) is too vague and could allow for “advertising creep.” The wording needs to define precisely the parameters that will be acceptable for manufacturers making claims, both for drugs and NHPs. Bill C-51 should permit no more DTCA than is currently allowed. ■

Over 35,000 prisoners go through Canadian jails yearly.

Many are denied access to medical treatment for HIV and/or Hepatitis C.



CTAC is currently looking for members to join its ‘advocating for Prisoners’/Ex-Prisoners’ right to treatment’ working group.

Visit

www.ctac.ca

or e-mail prisoners-rep@ctac.ca
for full details.

What is Harm Reduction?

continued from page 2

of the Vancouver Island Health Authority (VIHA), the police and our Mayor, a new location was not found by the time the eviction took place.

When in operation, the exchange took in over one million used syringes per year and provided a place for many addicts to come in off the street, have a coffee, build important relationships with staff, learn of other treatment and prevention programs and see a street nurse, seven days a week. If fewer people have access to these services, more people will share needles, more people will be infected with HIV/AIDS and hepatitis C, and the number of unsafely discarded syringes in the community will dramatically increase. We can only hope that a new site will be secured before the damage is irreversible.

Outside of the urban context, one of the fastest growing incidences of new HIV/AIDS cases is among First Nations people who use injection drugs. There is a lack of comprehensive harm reduction services available to First Nation people, particularly in rural and reserve communities. Much work has and is being done, but the barriers faced in these communities are much different than those encountered in cities. There is stigma attached to addictions and, it follows, the use of harm reduction services by those with addictions. Some clients have reported reluctance to access services within rural communities for fear of being

On a personal note...



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



Canadian Treatment Action Council

Annual General Meeting 2008

CTAC's Annual General Meeting and Skills Building Day will be held in Toronto, Ontario, **October 18 and 19**. Everyone is invited to attend.

For information, please visit

www.ctac.ca

identified as a drug user. Another barrier may also be a lack of support for harm reduction services in the community.³

Prison inmates are another marginalized population facing inadequate health support. We all know that drug use takes place in our jails and prisons. People have gone to prison without having HIV/AIDS or HCV, and have returned to the community infected with one or both of these diseases. I have personally seen some of the makeshift syringes built out of anything prisoners could find in their environment. Although I always advocate for needle exchanges in prisons in the meetings I attend, no prison in British Columbia yet provides this service. And there are no such programs in Canada that I could find.

The success of Vancouver's Insite facility gives us a blueprint of what we need to work towards accomplishing for other marginalized communities. Harm reduction can, and does, work. ■

¹ BC Centre For Excellence in HIV/AIDS

² All Insite information taken from the Vancouver Coastal Health Insite Website at www.vch.ca/sis/

³ All First Nations information from the website www.harmreductionjournal.com



CHAIR'S REPORT

Summer 2008

by Louise Binder

WELL, READERS, it's been some time since our community has had some good news. Now it comes from what some might consider a rather unlikely place—the courts. Yet there it is. The B.C. courts have acknowledged what we have known all along—that addictions are a health issue. People with health issues should receive compassionate treatment instead of being demonized. Treatment, harm reduction and prevention work hand in glove, and we must have comprehensive strategies for all these aspects of health care to ensure that all are successful.

Let's hope this idea gathers momentum, that safe tattooing in prisons will be reinstated since studies show that it is also a form of prevention and harm reduction, that we stop "re-profiling" money into vaccines that is needed for condoms, male and female, and treatments, and that we provide funding in all three areas where it is needed, present and future. Why, perhaps we might even act on the recognition that many issues HIV+ and co-infected people have are rooted in mental health problems and start appropriate mental health programs for all of our needs that are based on our cultures—Aboriginal and non-Aboriginal alike.

There is one small fly in the ointment: the federal government is going to appeal this decision to the Supreme Court of Canada—with our tax dollars.

Let's tell them to quit playing ideological politics with our health, and, in fact, with the health of so many people in this country. ■

CALENDAR OF EVENTS

SUMMER/FALL 2008

► SEPTEMBER

AIDS Walk for Life14-21
– in 50 communities across Canada
www.aidswalkforlife.ca

► OCTOBER

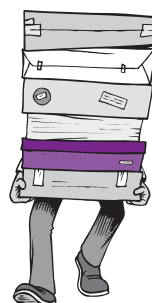
CTAC AGM and Skills Building Day18 & 19
Toronto, Ontario
Contact: (416) 41-6539 or ctac@ctac.ca
www.ctac.ca/en/action/agm

Pacific AIDS Network21-26
**Fall Forum, General Assembly, AGM
& Skills Building**
Richmond, British Columbia
www.pacificaidnetwork.ca

4th Gay Men's Health Summit30-31
Vancouver, British Columbia
www.gaysummit.ca

► NOVEMBER

Ontario HIV Treatment Network13 & 14
Research Conference 2008
Toronto, Ontario
www.ohntn.on.ca/OHTNConf2008_program.htm



Moved? Moving? Let us know!

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

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2007/08 FUNDERS

Public Health Agency of Canada (PHAC)
 Abbott Laboratories • Boehringer Ingelheim Canada Inc. • Bristol-Myers Squibb Pharmaceutical Group • Gilead Sciences • GlaxoSmithKline in partnership with Shire BioChem • Merck Frosst Canada Ltd. • Pfizer Canada • Sanofi-Avantis • Schering Canada • Tibotec, a division of Janssen-Ortho Inc.

CTAC POSITION PAPERS

Papers

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

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MEMBERSHIP

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

Full Membership is reserved for

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

Associate Membership is open to

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

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CTAC's Mandate

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

CTAC...

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

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

PUBLICATION

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