

# Canadian Treatment Action Council



## Confidentiality and Choice

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Canadian Treatment Action Council

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## CHAIR'S REPORT

Winter 2009

The theme of this month's issue is confidentiality and choice.

I have just been on the phone with an international colleague discussing the next International AIDS Conference to be held in Vienna in 2010. We were discussing where we should focus the women's issues at that conference. I keep thinking that wherever we live the common issue that comes up is stigma and discrimination. It is certainly one of the main reasons that we are so concerned about confidentiality and choice in all areas. We want them in prevention, in treatment, in research, in employment and benefit coverage, in housing, and, in fact, in all areas of our socio-economic interactions.

Yet, everything in our systems works against our rights to confidentiality. If we do not tell our sexual partners about our status, we face dire consequences if they find out, even imprisonment. On the other hand, we may also face dire consequences if we do tell them, including violence, blackmail, ostracism, public knowledge, and other forms of discrimination.

To get treatment we must disclose. What do we do in a small community where to disclose to a treater, health care provider and pharmacist may mean public disclosure? What do we do if our employers find out? The landlord where we live? Our neighbours? We need sustained public education campaigns about HIV, not only how to prevent it, but also what it is and is not so that we can really start to turn the tide of discrimination and allow real choice for people. The federal government promised one a few years ago, but we have yet to see it. It should be in schools from the first day, but where is it? To stop HIV, we need to challenge stigma and discrimination. Let's demand our governments take this on.



# Treatment as Prevention in the BC Context



by Glyn Townson, Chair, BC Persons With AIDS Society

There has been a lot of discussion about the use of Highly Active Anti Retroviral Therapy (HAART) as a prevention tool since Dr. Julio Montaner's 2006 paper, which described a mathematical model showing the potential to reduce the spread of HIV with the strategic use of HAART.

The British Columbia Persons With AIDS Society (BCPWA) responded to the expanded use of medication to curb the spread of HIV with a position paper suggesting "guarded optimism" of the proposed research findings.\*

From the beginning of our discussion with the BC Centre for Excellence in HIV/AIDS (BCCfE), we have stressed that the individual rights of the patient must not be compromised, and that informed consent, including the right to refuse treatment without prejudice, is simply not negotiable.

The BC model in its current form proposes that all individuals meeting the current guidelines for treatment have access to appropriate treatment. BC has a regionalized healthcare system in which local Health Authorities are responsible for direct patient care. As a result of this decentralization, we find that some local implementation and procedures are unacceptable. Unless such practises are reported, it is difficult to effect change. This lack of standardization is a concern in terms of the ability to ensure that patients give informed consent to undertake HAART.

While a process may appear to be "good" public health policy, informed consent must still apply. Everyone must have the right to choose and to not have choices made for them. Dr. Montaner has always been open to continued dialogue about this issue. In response to a question we asked when his report was released regarding patient consent to treatment and the possibility of anyone being forced onto treatment, Dr. Montaner stated that "if the patient is not willing to take medications the likelihood of proper compliance with the regimen would be in question, so it would not be in our best interest to force any individual into taking treatment."

Although we have had some sway and influence with policy makers and researchers at the provincial level, it remains our responsibility as advocates to ensure that these practises make it to individual patient care in all settings. When coerced consent or the breach of patients' rights occurs, the matter must be pursued vigorously and corrections must be implemented.

In BC, there has been a discussion of expanding HAART and ramping up service provisions throughout the province. For those living in areas where the regional health authorities have limited resources and no indication of funding increases to deal with increased demand, the provisions of expanded HAART ring hollow. Anti-retroviral drugs are not currently listed on the provincial electronic pharmacy records (Pharmanet).

\*The paper can be accessed at [www.bcpwa.org/articles/Position\\_Statement\\_HAART\\_Prevention.pdf](http://www.bcpwa.org/articles/Position_Statement_HAART_Prevention.pdf).

All prescriptions covered through the BCCfE are held locally in the Out Patient Pharmacy at St Paul's Hospital. St Paul's is the main dispenser of HIV medications in the province. BCPWA has been working with the BC College of Pharmacists, the BC Ministry of Health, and the BCCfE to find a working model for those living with HIV for over five years to find a workable Opt In or Opt Out model. (The individual's HIV medications would be either listed and visible, or delisted and not visible from the provincial Pharmanet electronic network.) This work has recently been complicated by the BC Government's move towards an electronic health records system, although a working model was submitted by the HIV Medications Task Working Group to the government in early fall of 2008.

As research and technologies continue to evolve, so must the protocols ensuring informed patient consent and protection. Recently, the University of BC acquired access to new technology, Gene Sequencing, that may have far reaching impacts on future HIV treatment trends and thus on all of us living with HIV. Several key BCPWA members and staff attend ongoing meetings with the BCCfE to monitor and recommend action when required. Over the past few months the group has been consulting with some of the researchers to come up with plain language consent forms that provide clear guidelines and rules on how to inform patients of their rights and of the nature of the studies involved. These forms would offer patients an option to not participate, to partially participate, or to fully participate. These will also include an explanation of how the samples will be stored (anonymized) and labelled, and what information the individual may want to receive about the ongoing research (through their general practitioner). The new consent forms are still in the process of an ethics review, but we are hopeful that they will soon be in effect.

Through its Prevention Department, BCPWA has also worked closely with the BC Centres for Disease Control and the Public Health nurses responsible for follow up

// the **individual rights** of the patient must not be compromised... **informed consent**, including the right to refuse treatment without // prejudice, is simply not negotiable.

of HIV-positive blood tests. Under the new procedures, each individual is provided with a small handbook containing basic information for those newly diagnosed with HIV and references to services available throughout the province. The booklet is available in eight languages, including English. The goal of this partnership is to inform newly diagnosed individuals in the province of what services and protections are available to them. The English version of the booklet can be accessed from the BCPWA website:  
[www.bcpwa.org/articles/NewlyDiagnosedBooklet071.pdf](http://www.bcpwa.org/articles/NewlyDiagnosedBooklet071.pdf).

This issue has been brought to the fore by a recent announcement from the World Health Organization (WHO). They intend to expand the research question to actually actively testing and treating individuals en mass to eradicate HIV. Following this protocol too aggressively, the "Public Health" model could overwhelm or, at the very least, cause the guidelines of the civil rights based patient consent model to become blurred.

People living with HIV/AIDS and AIDS Service Organizations have a responsibility to monitor trends in care and research protocols throughout our regions and the country. Although it requires some time commitment to meet with the various researchers, medical practitioners, doctors and the various levels of health governance, it is time well spent if we ensure that patient consent continues to be properly practised. ■

## Treatment as Prevention

*On a  
personal note...* 

Lance Lamore

The concept of treatment as prevention has recently spurred a lot of interest, discussion, and debate. The way I see it, both sides have made points that anyone facing this decision should consider.

On one side, there is the powerful argument that a reduced viral load in the plasma means reduced risk for transmission of HIV. In addition, there are benefits to starting treatment with a higher CD4 count because treatment helps prevent cardiovascular, renal, and hepatic diseases that plague people living with HIV/AIDS but who are not on treatment.

The other side points out that treatment should not be forced on anyone and that people need to come to treatment as an option in their own time, with informed consent and a full awareness of the potential toxic side effects of treatment. Some might also argue that the costs of treatment could exhaust our already tired healthcare system.

Personally, I am somewhat divided on this issue. Eight years ago, I met my former partner, who is HIV negative. The thinking at that time was also one of "wait to treat" and had shifted from "hit hard hit fast." I was told by my doctor that I could reduce my partner's risk of contracting HIV if I was on treatment. At the time, I had been living with HIV for six years, my CD4 count was well over 500 and my viral load was still quite low. I decided that for the sake of my partner I would start treatment.

I have not regretted my decision. We were together for six years and despite the occasional slip up and broken

condom he is still HIV negative. I remain undetectable with a CD4 count that is consistently above 500.

I realize that I am "lucky." I am on (practically) the same regimen I started with; Kivexa (no heart attack thank you very much) and Sustiva (no I am neither "crazy/psychotic" nor dealing with sleep loss or lipid issues). Not everyone has been this fortunate. Knowing what I know now about the possible long term effects of going without treatment, I am glad that I am in Quebec, a province with a prescription plan in which treatments are accessible and affordable. I am also glad that I decided to start treatment when I did.

Everyone's treatment experiences are and will be different. I agree that people need to come to this decision in their own time. Becoming informed and weighing the pros and cons of being on treatment are really important and necessary steps to take. I don't think that anyone should be forced to do something that they aren't ready or willing to do or that those pushing treatment as a form of prevention should "roll the dice," so to speak, and take ARVs themselves for a few months just to see if they are as "lucky" as I feel I have been. ■

# The New Brunswick Prescription Drug Program

by James Lord Edwards

The New Brunswick Prescription Drug Program (NBPDP) provides prescription drugs to eligible residents of New Brunswick who are registered with the New Brunswick Medicare. This program is sponsored by the New Brunswick Department of Health.

### THE APPROVAL PROCESS

For a drug to make it to the NBPDP, it must first pass through a drug review process. Drugs are subjected to a standard review process by the Canadian Expert Drug Advisory Committee (CEDAC) or the Atlantic Expert Advisory Committee (AEAC). These expert advisory committees are composed of practicing physicians, pharmacists and others with expertise in the field of drug evaluation and drug therapy. These bodies review and evaluate economic and scientific information on new drugs and then make recommendations to the provincial programs on whether or not they should list a drug as a benefit to their program. The final listing decisions for the NBPDP are made by the Provincial Minister of Health.

The NBPDP is a participant in the National Common Drug Review (CDR). The CDR provides participating federal, provincial and territorial drug benefit plans with a systematic review of the best available clinical evidences, a critique of manufacturer-submitted pharmacoeconomic studies and a formulary listing recommendation made by the CEDAC.

In addition, in New Brunswick, drugs may also be subject to the Atlantic Common Drug Review (ACDR). There are some types of drug submissions that do not fall under the CDR and that are reviewed instead by the ACDR. These include line extensions, new single source products that do not contain new chemical entities, products with new indications reviewed prior to the CEDAC and resubmissions for products reviewed prior to CEDAC. Submissions are then reviewed by an external consultant and drug evaluations are prepared and then submitted to the AEAC. They then make recommendations to the Atlantic Provincial Drug Programs on whether a drug should be listed as a benefit to the program.

In the province of New Brunswick there are several beneficiary groups that are served by the NBPDP:

### A (Seniors)

– persons 65 years of age or older who receive the Federal Guaranteed Income Supplement (GIS) or qualify based on annual income

### B (Cystic Fibrosis)

– individuals diagnosed with cystic fibrosis, juvenile or infant sclerosis of the pancreas, who are not entitled to receive similar services from other sources.

### E (Family and Community Social Services)

– individuals who reside in a licensed adult residential facility. The Department of Family & Community Services determines your eligibility for drug coverage under this plan.

### F (Family and Community Services)

– individuals who hold a valid health card issued by the Department of Family & Community Services. The Department of Family & Community Services determines eligibility for drug coverage under this plan.

## G (Children)

- children in care of the Ministry of Family & Community Services and special needs children.

## H (Multiple Sclerosis)

- individuals diagnosed with Multiple Sclerosis and who have a prescription written by a neurologist for the drug Avonex, Rebif, Betaseron or Copaxone.

## R (Organ Transplant)

- individuals who have received an organ or bone marrow transplant and who are not entitled to receive similar benefits from other sources.

## T (Human Growth Hormone)

- individuals diagnosed with growth hormone deficiency or hypopituitarism, registered to the plan by an endocrinologist, and who are not entitled to receive similar benefits from other sources.

## U (HIV)

- individuals diagnosed with HIV/AIDS, registered to the plan by a New Brunswick infectious disease specialist, and who are not entitled to receive similar benefits from other sources.

## V (Nursing Home)

- individuals who reside in a registered nursing home

## MORE ABOUT PLAN U (HIV)

Individuals who have been diagnosed with HIV/AIDS and are registered to the plan by a New Brunswick infectious disease specialist are not entitled to receive similar benefits from other sources. If you have a plan through your work, although you may not want to have your drugs covered by that plan, you really do not have a choice in the matter.

Once registered with the provincial Medicare, coverage will continue as long as you meet the eligibility requirements and continue to reside in the province. The Department of Health has provided an overview on how exactly the program works for people wanting to access Plan U. Prescriptions for these drugs must be filled by a pharmacy or designated dispensing physician in New Brunswick in order to be reimbursed.

Individuals on this plan are required to provide a co-payment of 20% of the cost for each prescription up to a maximum of \$20. The maximum in co-payments is \$500 per family unit in one fiscal year and there is an annual registration fee of \$50 for this plan. Individuals who hold a valid health card for prescriptions drugs through the Department of Social Development (Plan F) do not pay the annual registration fee and their co-pays reflect their respective plan.

A prescription issued in another province may be filled at a New Brunswick pharmacy. However, it is best to consult with the NBPDP or a pharmacist as the drug may not be covered by the plan. If you are planning to move to New Brunswick, you will not be able to receive prescription drug coverage until you qualify as a resident of the province and you should plan to have a few months' supply with you at the time of the move.

## WHAT DRUGS ARE COVERED?

Many drugs are covered by the NBPDP. A complete listing of these drugs and new updates to the plan are available on the New Brunswick Government Website ([www.gnb.ca](http://www.gnb.ca)). Drugs not listed may be accessed through special authorization by sending a written request to the New Brunswick Prescription Drug Authorization Unit. ■

## Compassionate and Expanded Access Programs for Treatments in Development

by Philip Lundrigan

### Executive Summary

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Prescription drugs increasingly play a vital role in the healthcare of Canadians. New drugs have helped to improve the quality and length of life for many Canadians. Frequently, prescription drugs are used as a substitution for other treatments and medical interventions, including surgery. New discoveries have had a positive impact on a wide variety of illnesses, medical conditions and disabilities.

Individuals who are seriously ill need timely access to drugs in development. This is particularly true for those for whom no treatments are available or those for whom available treatments have failed or are intolerable. In many cases, the health of people waiting for access to new treatments deteriorates, and in some cases, people die while waiting for treatment access. Access to new treatments can mean the difference between life and death for some people.

HIV/AIDS is a very complex illness and results in a weakened immune system in those who are infected. Research has shown that the maximum benefit of HIV treatments is realized when the drugs are provided to patients in multiple drug combinations. HIV/AIDS treatments can have serious side effects and can often interact with other prescription drugs as well as non-prescription drugs. Side effects of currently available

treatments can be just as serious as the illness being treated. In some cases side effects are so serious that the drug has to be stopped.

Drug resistance can develop in people taking HIV/AIDS treatments, which means the drugs no longer work in these people. Drug resistance can be further complicated by cross-resistance to other drugs, which means that when you develop resistance to one drug in one class, it may also result in resistance to other drugs in that class. For people who have developed resistance, or those for whom current treatments are unsuitable, access to drugs in development is often their only hope.

The Therapeutic Products Directorate (TPD) of Health Canada regulates prescription drugs in Canada. It can be two years or more from the time a New Drug Submission (NDS) is submitted to the TPD until the drug is commercially available. The release of drug through compassionate/expanded access programs or other early access mechanisms has been an accepted and expected aspect of drug development in Canada.

Early access to drugs in development can normally be obtained either through Canada's Special Access Program (SAP), or through compassionate and expanded access programs. Compassionate access

programs are set up at the discretion of the drug sponsor and generally offer the drug to a very small number of people. Expanded access programs are also provided at the discretion of the sponsor in the form of an arm of a clinical trial. This means that the trial drug is provided to all participants in this trial. These open label programs are usually initiated late in the research process and provide early access to drugs to a larger number of people; however, there are usually limitations and restrictions. All forms of early access to drugs in development require the support of a physician.

Since a variety of stakeholders are impacted by the implementation of early access programs for drugs in development, there are many perspectives on whether early access should be mandatory including the accompanying legal, moral and ethical issues. The philosophy behind Canada's drug legislation is to ensure that drugs available to Canadians are safe, effective and of high quality. Drugs which have not gone through the complete review and approval process, have not been licensed by the Therapeutic Products Directorate (TPD), the regulatory authority at Health Canada.

The pharmaceutical industry makes huge profits from its products and takes advantage of favourable tax regulations and a sophisticated, publicly funded health care system in Canada. None of the profits enjoyed by the industry would be possible without the commitment of clinical trial participants. Therefore, it is incumbent upon the pharmaceutical companies that are bringing new drugs to market to provide early access to these products, particularly for the catastrophically ill.

CTAC has, since its inception, worked with pharmaceutical companies, physicians, and governments to increase early access to drugs in development. While most, if not all, pharmaceutical companies provide early access to the drugs they have in development, such access is not mandatory,

and is completely at the discretion of the drug sponsor. CTAC supports the concept of mandatory compassionate and expanded access programs for drugs in development.

For purposes of this document, Compassionate Access is defined as the provision of emergency medical treatment to catastrophically ill patients. Catastrophic Illness is defined as a serious or life-threatening condition, for which no effective/tolerable treatments are currently available, and for which the prognosis is death or considerable deterioration of health in the next twenty-four months. CTAC believes in the right of patients who are catastrophically ill, in consultation with their physician, to access any treatment or treatment combination, which causes no direct harm to others, which the patient and doctor believe may have benefit. Expanded access is defined as access for people who are not necessarily meeting the criteria for a clinical trial but are in need of the experimental drug to create a viable regimen. Generally expanded access programs are administered as an arm of a clinical trial. CTAC takes the position that compassionate and expanded access programs should be designed so that the most seriously ill get first access to drugs.

In order to ensure that early access to drugs is provided in a manner that has minimal impact on the delivery of emergency or compassionate treatment, it is crucial that guidelines be developed in regard to a variety of aspects of early access. Health Canada has a responsibility to initiate a dialogue with stakeholders to develop guidelines for the implementation of mandatory compassionate and expanded access. Health Canada has a further responsibility to ensure that appropriate legislative measures are enacted to prohibit the sale of experimental drugs provided through all early access mechanisms.

*continued on page 13*



## The Road to Health Starts Here

by Ron Rosenes

Canada Health Act were silent on a number of matters when they formulated the Act. They got the following five principles right: Public Administration, Comprehensiveness, Universality, Portability, and Accessibility) but were silent on the obligation of the health care system to cover the cost of drugs (outside of hospital) and, specifically, to ensure coverage of basic dental health care within the principles of "Comprehensiveness and Accessibility."

**T**he 2005 updated Ontario Curriculum for Grades 1-8 on Health and Physical Education says the following:

"Topics related to healthy eating include nutrition, eating disorders, body image, and dental health. Students require knowledge to make healthy eating choices. Using this knowledge, they will examine their own food choices and eating patterns, and then make wise decisions and set appropriate goals. In later grades, students will learn more about the factors that affect healthy body weight and lead to eating disorders, and will increase their understanding of a healthy body image. Throughout the healthy living strand, the importance of healthy eating and regular physical activity is emphasized."

Dental health is integral to physical health but what our teachers may have neglected to mention is that except for the lucky few with private insurance, the cost of maintaining the health of your teeth and gums would have to come out of your own pocket. For people living and coping with the many stresses of HIV/AIDS, the burden and responsibility of maintaining healthy teeth and gums can prove to be onerous indeed. The fathers (and hopefully mothers) of the

CTAC has long believed that people living with HIV/AIDS are particularly susceptible to problems related to the teeth and gums that arise with a compromised immune system regardless of where people are on the spectrum of treatment—watchful waiting or on antiretrovirals.

Today we know that no treatment of any oral health problem should be avoided simply because a person is HIV+. This is in contrast to assumptions years ago that some procedures such as root canals should not be performed in people with HIV, or that dental treatment should be postponed for anyone with a low CD4 cell count.

We still encounter stories of people who are refused treatment even though the Canadian Dental Association (CDA) said on WAD in 2007: "CDA has led in development of guidelines for patient care and in the dissemination of information to the dental community in Canada since the onset of the epidemic." (Dr. Joel Epstein)

It is now recognized that all procedures and devices, including periodontal surgery, root canals, orthodontics (braces and retainers), implants, bleaching, and bridges can be safely and effectively provided regardless of

// Topics related to **healthy eating** include nutrition, eating disorders, body image, and **dental health.** //

immune status. Decisions about such procedures should be made by the HIV-positive individual in consultation with his or her dentist. While dentists recommend that all people seek routine care to prevent oral health problems from developing, this is particularly important for those living with HIV. One rationale for this preventive measure is that individuals with a compromised immune system need to avoid bacterial infections. The two major oral health conditions, dental caries and periodontal disease, are both caused by bacteria and may be exacerbated by other factors.

The cost of many of these procedures can be prohibitive for people who are already coping with "catastrophically" high medical expenses.

That is why CTAC has decided to create a position paper that will examine how dental costs are covered for citizens of other countries and for Canadians in different provinces and territories. The paper will make recommendations for coverage for Canadian people living with HIV/AIDS who are low income, without private insurance or inadequately covered for dental care. It is expected the paper will take a look at how various public and private insurance plans define "basic" dental care. It will attempt to cost out the added cost to governments of assisting low income people living with HIV/AIDS with coverage for basic dental care, and will examine possible cost-control options such as means testing or deductibles. The Trillium Drug Program in Ontario is one example of a provincial catastrophic drug

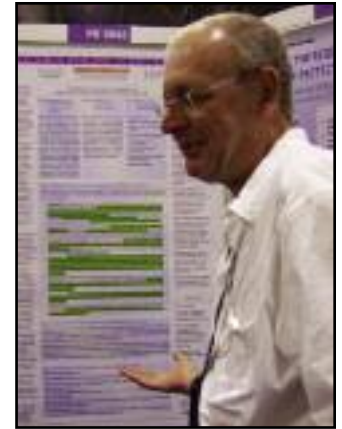
program that could be extended to offer coverage for dental or oral care.

When AIDS activists in Ontario fought for and won the creation of the Trillium Drug Program, it was extended to offer assistance to all Ontarians with low income and high drug costs—in other words, a victory for all Ontarians. As you may know, CTAC is working currently on its "White Paper on a National Catastrophic Drug Program" and it is expected that in advocating for people living with HIV/AIDS, we are at the same time striving to create a national program of benefit to all Canadians based on need and not on specific illness or disability.

Look for the release of the CTAC paper on coverage for dental care in mid 2009. ■



## Interview with Jean-Pierre Bélisle on the subject of clinical trials



### ▶ What does someone who is asked to participate in a clinical trial need to know before signing on?

That it's better to take the time to reflect on it and to consult someone not involved with the trial.

Before any decision or signature, it's better to:

- Get a copy of all of the documents
- Consult someone not involved in the trial with the documents in your hand
- Understand the experimental nature of a clinical trial
- Understand what phase of trial it is (I to IV): the smaller the phase, the greater the level of uncertainty
- Understand the objective of the study. More and more, companies are running non-inferiority trials instead of superiority trials

### ▶ In your opinion, what are some common practices that compromise the rights of people participating in clinical trials today?

I wonder more and more about the actual system of protection of the research participants. It seems to me that research ethics boards spend a lot of time revising long consent forms, while it is the verbal interaction with the research team representatives that has the greatest impact on the potential participants' decision making. The consent forms mostly serve to protect the researchers. Research ethics boards serve more as resources to researchers than to participants. How can we explain that those who have the role of protecting participants have no contact with them, while they have so much with the researchers?



There is also this culture of secrecy which often translates into the difficulty of obtaining a copy of the consent form before it is signed.

### ▶ Do you have any particular advice for someone who is newly diagnosed who is invited to participate in a clinical trial?

There are so many things to understand and the shock of an HIV diagnosis can be so difficult that it is not clear that a person in this position would be able to give a truly free and informed consent. In these cases, it becomes even more important to have access to an external person with whom to discuss.

### ▶ Is there an ethical problem with financial compensation of clinical trial participants?

It is reasonable for participants in a clinical trial to receive monetary compensation for their time and inconvenience. However, the current inflation in these compensations risks becoming too much of an incentive to participation. When the amount is too large, or when money becomes an element in the decision of whether or not to participate, the sense of free and informed consent is lost. ■

Jean-Pierre Bélisle has been an activist in the fight against HIV since 1993 and is a past board member of CTAC. He has a particular interest and expertise in research and research ethics.

## ► MARCH

### 12-14

**Quebec's HIV Days**  
Montreal, QC  
[www.symposiumsida.ca](http://www.symposiumsida.ca)

### 13-15

**Alberta Positive Voices Conference**  
Camp Horizon  
Bragg Creek, AB  
Contact : [bakrboy@hotmail.com](mailto:bakrboy@hotmail.com)

### 27-29

**BC's Positive Gathering**  
Vancouver, BC  
[www.positivegathering.com](http://www.positivegathering.com)

## ► APRIL

### 23-26

**18<sup>th</sup> Annual Canadian Conference on HIV/AIDS Research (CAHR 2009)**  
Vancouver, BC  
[www.cahr.-acrvc.ca](http://www.cahr.-acrvc.ca)

## ► JUNE

### 3-5

**Fourth Housing and HIV/AIDS Research Summit**  
Washington, DC  
<http://nationalaidshousing.org>

### 12-13

**CWGHR's Annual Forum on HIV and Rehabilitation, and Annual General Meeting**  
Toronto, ON  
[www.hivandrehab.ca](http://www.hivandrehab.ca)

### 12-14

**Canadian HIV/AIDS Legal Network's 1<sup>st</sup> Annual Symposium on HIV, Law and Human Rights: "From Evidence and Principle to Policy and Practice" and AGM**  
Toronto, ON  
[www.aidslaw.ca](http://www.aidslaw.ca)

### 18-21

**2009 People Living with HIV/AIDS Forum and the Canadian AIDS Society AGM**  
Ottawa, ON  
[www.cdnaids.ca/2009PLWHIVAIDSForum](http://www.cdnaids.ca/2009PLWHIVAIDSForum)

### 23-27

**5<sup>th</sup> Youth Action Institute**  
Oakland, California  
[www.c2ea.org](http://www.c2ea.org)

### 28-July 1

**18<sup>th</sup> ISSTD International Society for STD Research**  
London, UK  
[www.isstdlondon2009.com](http://www.isstdlondon2009.com)

## Compassionate and Expanded Access Programs for Treatments in Development

*continued from page 9*

CTAC holds firmly the beliefs that:

- compassionate and expanded access to drugs in development is crucial for the survival of many people living with HIV/AIDS,
- compassionate and expanded access programs can be administered in a way that does not interfere with ongoing research or the drug review and approval process, and
- all other challenges to successful implementation of compassionate and expanded access programs can be resolved.

Health Canada's Special Access Program (SAP) should be made more readily accessible for patients to access drugs not yet approved for use in Canada. ■

The full version of this paper will soon be available at [www.ctac.ca](http://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.

Permission is given to reproduce all or any part of the papers provided appropriate accreditation is given. Papers are available free of charge electronically at [www.ctac.ca/en/resources/position\\_papers](http://www.ctac.ca/en/resources/position_papers) or on hard copy from the CTAC office (see contact information below).

## MEMBERSHIP

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