

CANADIAN TREATMENT ACTION COUNCIL



Canadian Treatment Action Council

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National Pharmaceuticals Strategy:

An urgent, emerging issue

Prepared by the Best Medicines Coalition

The following is an Executive Summary of the Best Medicines Coalition's National Pharmaceuticals Strategy (NPS) Issue Paper. To read the full report, which includes background and supporting information, visit www.bestmedicines.ca or call 1-888-807-7904.

The Best Medicines Coalition (BMC), whose members represent Canadians living with or affected by chronic disease, is an alliance of representatives from a broad base of organizations and Canadians concerned about effective health care. The group believes the safe, timely and equitable access to the best evidence-based medicines is a key component of effective health-care treatment and prevention for all Canadians. The Canadian Treatment Action Council is an active member of the BMC.

National Pharmaceuticals Strategy

Best Medicines Coalition (BMC) – Executive Summary

As part of the 10-year plan to strengthen healthcare, Canadian First Ministers¹ agreed to develop a National Pharmaceuticals Strategy (NPS). They agreed that no Canadian should suffer undue financial hardship in accessing needed drug therapies, and that affordable access to drugs is fundamental to equitable health outcomes for all our citizens. What they have neglected to do, however, as this Strategy has unfolded, is gather information directly from viable, knowledgeable sources. It is the BMC view that, unequivocally, Canadian patients, as healthcare consumers, must be part of the decision process that fundamentally affects every aspect of their lives, stemming from their health state.

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¹ First Ministers include the Prime Minister and all provincial and territorial Premiers



National Pharmaceuticals Strategy: An urgent, emerging issue

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How can government decision-makers reach effective conclusions without valuable input from all affected? The short answer is they can't. The most important perspective in administering medications is involving those for whom the medications exist. The healthcare system must be designed for the person who does not have optimal health. Intuitively, these people, and those who care for them, need to be a central part of the process from the beginning. *It is outrageous that the federal and provincial governments have closed the door on patients and will not even reveal to the Canadian public what is going on behind those closed doors.*

What we do know about the proposed NPS is that it is to focus on five areas, prioritized from nine action points, and that a progress report from the Ministerial Task Force will be provided to Canadian First Ministers on June 30, 2006. With this deadline looming, the Task Force has yet to engage the patient or healthcare consumer in any meaningful consultation. The BMC has developed recommendations around the five focus areas and continues to ask the government to invite us to join their discussions so these recommendations may be fully explored.

BMC Recommendations based on these five areas of focus:

1. "Real world" drug safety and effectiveness

- A transparent post-marketing surveillance strategy must be forged, which sets standards that provide the means of thorough and ongoing evaluation of drug safety and effectiveness, following through on the findings of reputable sources.
- Patients must be involved in developing this process, and be active in the ongoing plan.
- A collaborative process should also include many other stakeholders and encompass international information resources, without losing the uniquely Canadian perspective.
- Surveillance must not be used to delay access of medications to patients.

2. Expensive drugs for rare diseases

- To safeguard the rights of people with rare disorders to access the best medicines and treatment, a policy for rare disorders should be developed as a priority. A recent study indicates that every dollar invested in new treatments and medicines relieves the healthcare system of expenses seven times greater in other medical or emergent areas such as hospitals, physicians/specialists, and home care.
- A strategy must be developed for a coherent, justifiable rule to determine how much to pay for orphan drugs.
- Canada must join the global fight to protect those individuals with rare disorders, and support global research and development for new effective treatments.

3. Drug pricing and purchasing

- A national drug pricing and purchasing plan should make every effort to control the cost of drugs to patients and consumers, without denying drugs to people who need them, simply because they are not bulk-purchased.
- No plan should put patient access at risk by making drug supplies dependent on a few manufacturers, or by limiting/restricting access of more expensive drugs to physicians and their patients.
- NPS must have the means to identify the factors contributing to escalating drug expenditures, and the means to control these expenditures with consideration of the cost/benefit trade-offs for patients, physicians, pharmacists, governments, and drug manufacturers.
- Patient access to medications that improve long-term health or quality of life cannot be restricted, costs cut cannot be deferred to the patient, and physicians' options to prescribe the medications they believe are right for their patients must be unrestricted.

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4. Catastrophic drug coverage

- NPS must be created with the solid foundation that no Canadian will face financial hardship in order to receive the best medical care available, and not lose sight of the special needs of patients dealing with persistent chronic disease requiring expensive treatment and/or medicines.
- Deliberations must take place around equity for all Canadians, giving special consideration for those households where even 3% of income is too much burden to bear out-of-pocket for their prescription needs.

5. Common drug formulary

- Governments must eliminate the duplication of efforts created by the Common Drug Review (CDR), and other levels of administrative redundancy. If this is not done or possible, CDR should be eliminated altogether.
- Provincial drug plans must revise their approvals of drugs to the formulary listing, not by the CDR recommendations but by the scientific evidence that

supports the benefits for their population and their healthcare delivery.

- There needs to be universal and equitable access to drugs across Canada regardless of a NPS or provincial plans. A national plan makes sense for many reasons including joint efforts around cost savings for administration of the NPS as well as consistency in drug coverage and availability across Canada.

It is paramount to remember the overall benefit that medications bring to healthcare. The BMC recommends that access to medicines for patients be based on physicians' choice for their patients, while at the same time recognizing the impact on increased business investment by the pharmaceutical industry in this country to finance any potential increases in government spending.

The overarching message of the issue paper this summary speaks from is clear: involve patients in NPS and let the process be transparent. ■



Activism Lipo-Action Style!

By Brad Monteith, Interim Director of Lipo-Action!

If you want something done, do it yourself! We have all heard that expression before, but what does it mean in practice? The members of the *Comité Lipo-Action!*, situated in Montréal, want something done and they have set out to do it themselves and to recruit others to their cause.

The group was formed by a number of people living with HIV/AIDS in order to address the problem of lipodystrophy, a complication of HIV/AIDS medical treatments characterized by a selective loss of body fat. It draws inspiration from a number of sources: treatment activists of the TRT-5 group in

France, community researchers working to compile stories of the impact of lipodystrophy on the lives of people living with HIV/AIDS and a tradition of street theatre.

The *Comité Lipo-Action!* worked first to define its goals and to express these clearly to politicians and medical professionals who could have an impact on the lives of people living with lipodystrophy, as well as to people living with HIV/AIDS themselves:

- prevention of lipodystrophy by prescription of less toxic medications not associated with the disorder;

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Activism Lipo-Action Style!

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- clear information to patients to allow them to make informed decisions regarding their treatment options; and
- coverage of reparatory treatments for lipoaccumulation and lipoatrophy.

The group set out first to consolidate support within the HIV movement. There was entertaining street theatre along the route of the Walk for Life as well as demonstrations outside and inside a number of meetings of HIV researchers and specialists in Montréal.

When the Québec Minister of Health responded to a question posed in the National Assembly by a member of the opposition with the usual political answer ("We need more precise information about this topic"), the group again sprang into action to produce a brief for the minister outlining the science of the problem as well as the serious social impacts for people living with HIV/AIDS. They then set about rounding up support for the brief through a campaign of letter-writing that continues to this day. The group hopes to present thousands of letters of support for its position to the Minister of Health and other politicians and senior public employees in the fall.

All along the way, the *Comité Lipo-Action!* meets to assess the impact of its actions and to plan for new ones that are adjusted to the new realities they face. This might mean pressuring pharmaceutical companies to speed up their applications for approval of their products in Canada, making sure that people living with HIV/AIDS are aware of enrolling trials for reparatory treatments or working to ensure that treatments approved by Health Canada will ultimately be reimbursed by provincial authorities.

The tactics and the targets of the actions are constantly

To read the *Comité Lipo-Action!* Brief to the Québec Minister of Health and the model letter of support in English, go to:

www.accmontreal.org/en/lipo.html

To read the *Comité Lipo-Action!* Brief to the Québec Minister of Health and the model letter of support in French, go to:

www.frequencevih.ca/rubrique.php3?id_rubrique=22

adjusted along the way, but the goals remain clear: improving the lives of people living with HIV/AIDS and taking back a little control over the things that have such a profound impact on our lives. ■

**You can contact the
Comité Lipo-Action! at
lipoaction@yahoo.ca**

A personal perspective

Brad's Story: The Making of a Militant!



My name is Brad. I am a 42 year old co-infected gay male residing in Montréal since 1986. When I was diagnosed HIV positive in 1984 at the tender age of 21, I cried like an abandoned child in a very cruel world. Then I got pissed off and decided I was not going to die from this 'frickin' gay plague! I was going to fight it! I exiled the virus into my big toe (no vital organs in that area) and since I couldn't get rid of the virus, its place was going to remain very small! (That was my first experience in visualization.)

The determining factor that plunged me into activism was the suicide of my lover in 2001. He committed suicide in large part because of low self-esteem due to his facial lipoatrophy and intolerance from his co-workers. Lipodystrophy provokes discrimination, even by people in our own community! I became an activist out of necessity for my own survival.

I was complacent and in a state of isolation and depression when I decided I needed to rejoin the world and come out of my isolation. I volunteered for the first time in my life at the age of 39 and after a couple of years at a local AIDS service organization I heard about *Comité Lipo-Action!* When I walked into my first meeting, I knew I had found my place. I could take charge of my own health by demanding the government take charge of lipodystrophy! ■

Treatment-Experienced Patients: New Options, New Cost

By Brian Finch, Board Member of CTAC

On the very last day of the Canadian Association for HIV Research (CAHR) Conference in Quebec City this past May, Dr. Anita Rachlis gave an overview of treatment choices for those, like myself, who are treatment experienced. In her presentation entitled *Redefining the Goals of Therapy for Treatment-Experienced Patients*, Dr. Rachlis spoke about viral load in the broader framework of treatment. Not so long ago the tendency was to “hit it hard, and hit it early.” With viral suppression often being difficult or impossible to achieve, the goal shifted towards stabilizing immune deterioration and the progression of disease. Recently, however, the pendulum appears to be swinging back towards re-establishing maximal virologic suppression, acknowledging that some people living with HIV/AIDS may not obtain undetectable status through such treatment.

Dr. Rachlis’ slide, entitled “How to wait?”, was of keen interest to me given my circumstances: switching from a disconnect treatment—a slight CD4 increase and a stable but detectable viral load—to a new combination. How do we, as treatment experienced patients, do this with limited options? Dr. Rachlis’ presentation suggested using at least two new agents such as Fuzeon (approximately \$30,000 per year) in combination with a Protease Inhibitor (PI) (\$8,000-\$15,000 per year) while throwing in nucleosides and non-nucleosides wherever we can. With new drugs such as Tibotec’s TMC 114 and TMC 125 and future options of Integrase and Maturation Inhibitors, and CCR5 entry inhibitors, there appears to be a growing set of options for those of us whose choices are limited.

As we all know, all the breakthrough drugs in the world are meaningless if they are inaccessible. New reforms to the *Ontario Drug Benefits Act* and *Bill 102*, more specifically, the part of the legislation relating to the interchangeability of drugs, specifically, the use of the words “same and similar”, is quite worrisome for all patient/consumer groups. The Ministry of Health will be adding amendments to the legislation to better express the intent of this language, which is to stop evergreening (the practice of changing a drug slightly to extend its patent life).

According to the new Bill, *breakthrough* drugs will enter the review process as soon as the Notice of Compliance has been issued. But, how do you define breakthrough? The legislation remains unclear.

I am convinced through CTAC’s participation at stakeholder consultations that this legislation will translate into important changes to the system that will facilitate treatment access. However, much of the *intent* of the act is not specifically stated. Time will tell if the legislation will contribute to better treatment accessibility.

This good news only serves to highlight the need to remain vigilant on the access to treatment front. This is not the time for complacency or taking for granted the gains we have made over the past years. HIV is not the only health issue for which newer and more expensive drugs are a matter of concern and we will find ourselves competing for limited resources within the provincial drug reimbursement plans. ■

Formularies Series:

Saskatchewan

By Lydia Thompson, Client Programs, AIDS Programs South Saskatchewan Inc. and Mark Reis, Client and Board Member of AIDS Programs South Saskatchewan Inc.

The Saskatchewan Formulary is a listing of the therapeutically effective drugs of proven high quality that have been approved for coverage under the Drug Plan. It is compiled by the Minister of Health with the advice of the Saskatchewan Formulary Committee (SFC) and is then prepared, maintained and distributed by the Drug Plan and Extended Benefit Branch.

The SFC is advised and assisted by the Drug Quality Assessment Committee (DQAC). Members of both committees are appointed by the Minister of Health.

The Saskatchewan Formulary is published annually in July, with quarterly updates. Fall 2005, Winter 2006 and Spring 2006.

The on-going work of the SFC includes the evaluation of new drug products as they are introduced, and the periodic re-evaluation of all listed products. The goal is to list a range and variety of drugs that will enable physicians to prescribe an effective course of therapy for most patients.

The Drug Review Process

Saskatchewan is participating in the Common Drug Review (CDR) process. The CDR process provides participating federal, provincial and territorial drug benefit plans with a systematic review of the available clinical evidence, a critique of manufacturer-submitted pharmacoeconomic studies and a formulary listing recommendation made by the Canadian Expert Drug Advisory Committee (CEDAC). For more information about the CDR process and CEDAC, visit www.ccohta.ca.

Note: The Drug Review process described below is in transition and will be changing to reflect the CDR process. When a drug is introduced to the Canadian Market, the

manufacturers submit a request to the Drug Plan so that it can be considered for possible coverage. The requests must be supported by scientific reports and manufacturing documents to show that the product meets standards of quality, effectiveness and safety. The DQAC carries out an initial evaluation of the submission.

The recommendation from the CEDAC are submitted to the Saskatchewan Drug Review Committees: the Drug Quality Assessment Committee (CQAC) and the Saskatchewan Formulary Committee (SFC).

The DQAC is a committee of clinical experts; this committee only considers the clinical place in therapy, not the cost.

The SFC is made up of health care professionals who look at the clinical information provided by the Common Drug Review process and the DQAC as well as the cost of the drug. This includes the potential number of people who could benefit from the drug and how its use will impact other parts of the health system. The SFC makes a recommendation to the Minister of Health based on the benefits of the drug relative to its cost.

The Drug Plan and Extended Benefits branch provides resources and staff support to the Committees in the review of products for listing in the Saskatchewan Formulary. This support includes forecasting drug costs and preparing use/cost analysis reports.

- **Exception Drug Status:** Certain drugs are approved for coverage under the Exception Drug Status (EDS) Program, upon review and recommendation of the Saskatchewan Formulary Committee.
- **Over-The-Counter Products (OTC)** are generally not included as benefits of the Drug Plan.
- **Product Interchangeability Pricing.** Interchangeable products are different brands of the same drug with the same strength and dosage form that are equivalent in therapeutic effectiveness and quality.

The Formulary lists two types of interchangeable drug groups:

1. **Low Cost Alternative** – Any drug in a Low Cost Alternative interchangeable group can be used to fill a prescription. The drug cost component in the approved prescription price is the actual acquisition cost of the

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Formularies Series: Saskatchewan

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drug up to the lowest price listed in the Formulary within that interchangeable group.

2. **Standing Offer Contract (SOC)** – The Drug Plan tenders high volume drugs in certain interchangeable groups to obtain the lowest possible price. An accepted tender, called SOC, requires the manufacturer to guarantee delivery of the specific drug to Saskatchewan pharmacies through approved distributors at the contracted price. In return, the manufacturer's product will be used almost exclusively. This tender process saves Saskatchewan residents and the Drug Plan a considerable amount annually.

Maximum Allowable Cost (MAC) policy began on July 1, 2004. Currently this policy applies to one drug class, the proton pump inhibitors, and it will be expanded to other drug classes in the future. Savings achieved with MAC will be available to fund significant new therapies that will be coming in the future and will help to ensure the viability of the Drug Plan.

The Province of Saskatchewan has one of the largest and fastest growing Aboriginal peoples. First Nations and Metis residents made up 13.5 per cent of the provincial population as of 2001, and that figure is rising with some projecting it will grow to 28 percent by 2015.

Health Canada:

Manitoba and Saskatchewan Region

The First Nations and Inuit Health Branches in Manitoba and Saskatchewan fund the delivery of community-based health promotion and disease prevention programs on reserves. The branches also provide First Nations people living on- or off reserve with certain health benefits which are not insured by provincial health care, such as prescription drugs, eyeglasses and ambulance services.

First Nations and Inuit Health Branch (FNIHB)

The federal government and the province of Saskatchewan recognize that working collaboratively with First Nations, Metis and Service providers will improve Aboriginal Health.

Activities delivered through various branches:

- Health Products and Food Branch
- First Nations and Inuit Health Branch
- Healthy Environments and Consumer Safety Branch
- Public Health Agency of Canada: Preschool programs for aboriginal children, diabetes prevention, HIV/AIDS prevention, health promotion in rural areas, promotion of prenatal nutrition and promotion of awareness of the dangers of alcohol during pregnancy
- Pest Management Regulatory Agency
- Saskatchewan Health Drug Plan and Extended Benefits Branch

In Saskatchewan, under the Formulary Drug Plan the following Antiretrovirals are available without cost to the patient:

- ANTI-INFECTIVE AGENTS (as of June 9/06)
- NONNUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS – NNRTIs
- DELAVIRDINE MESYLATE
- EFAVIRENZ
- NEVIRAPINE
- ABACAVIR SO4/LAMIVUDINE/ZIDOVUDINE
- DIDANOSINE (ddI)
- LAMIVUDINE (3TC) LAMIVUDINE/ZIDOVUDINE
- STAVUDINE (d4T)
- ZALCITABINE (ddC)
- ZIDOVUDINE (AZT, ZDV)
- PROTEASE INHIBITORS – PIs
- AMPRENAVIR
- ATAZANAVIR SO4
- INDINAVIR SO4 – Crixivan (EDS)
- LOPINAVIR/RITONAVIR – Kaletra
- NELFINAVIR Mesylate – Viracept
- RITONAVIR – Norvir Sec
- SAQUINAVIR – Invirase and Fortavase

Miscellaneous – Infusion Inhibitors

- ENFUVIRTIDE 108MG/VIAL POWDER FOR SOLUTION - FUZEON (EDS) HLR \$ 40.2600

"For management of HIV disease on a case-by-case basis, following committee review of each case. (It was noted that enfuvirtide is not first-line therapy. The most appropriate use of this product is for "salvage

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WOMEN'S ISSUES: UPDATE

Addressing the gender inequalities that drive the HIV/AIDS epidemic among women and girls in Canada

The face of HIV/AIDS has changed. In most parts of the world, the time is long past that HIV/AIDS can be regarded as affecting primarily gay men. Since the beginning of the epidemic, women and girls have accounted for a steadily larger proportion of new HIV infections in Canada, primarily as a result of sex with an HIV infected male partner. Part of women's vulnerability to HIV/AIDS is physiological. However, in Canada as in the rest of the world, the impact of the disease among women and girls cannot be understood without reference to their marginalization, subordination, and exposure to poverty and physical and sexual violence. Canada is beginning to recognize the need to address women's subordination in response to the epidemic. More action is needed.

An overwhelming number of women and girls in Canada are exposed to violence and abuse. Women in Canada are more likely than men to live in poverty and to be economically dependent on others. Women suffer sex-related stigma and discrimination at home, at work, on the streets. They tend to bear disproportionately the burden of caring for children and other family members. Many of these inequities themselves amount to human rights tragedies. They also lie at the root of women's vulnerability to HIV/AIDS. Patterns of HIV prevalence, as well as AIDS-related health outcomes, closely track poverty and social marginalization among women in Canada.

Virtually all women have to deal with social and economic subordination in some aspects of their lives, but some women in Canada face additional challenges that augment their HIV risk. HIV prevalence is higher among Aboriginal women who, due to historical and continuing



*by Alana Klein,
Senior Policy Analyst,
Canadian HIV/AIDS Legal Network &
Member of the Blueprint for Action
on Women and Girls and HIV/AIDS*

marginalization of their communities, face heightened poverty, violence and exclusion. Some women in the sex trade may also face risks of violence and coercion, which is compounded by the criminal prohibitions related to prostitution that drive sex work underground into less safe venues. Women in prison in Canada often have poor access to prevention, treatment and care information and services. Women from HIV endemic countries may face racism and xenophobia, compounded by harmful traditional practices like female genital mutilation, and may fear deportation or lack information on their immigration status. These factors may prevent them from seeking HIV/AIDS services, including testing. HIV/AIDS-related stigma from their own communities may create additional barriers.

Prevention strategies in Canada risk being ineffective where they fail to take women's second-class status into account. Programs in Canada often focus on curbing particular behaviours like sex with multiple partners and condom use. But poverty, threat of violence, and economic dependence means that women often cannot choose when, with whom, and on what terms they have sex. Does it make sense to spend money urging women to use condoms when they may face violence, abuse, or economic abandonment for raising the issue with their partners? A broader approach

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Addressing the gender inequalities that drive the HIV/AIDS epidemic among women and girls in Canada *continued from page 8*

is needed—one that focuses on getting women out of situations that put them at risk.

Current prevention strategies can contribute to women's subordination. In many provinces, pregnant women are tested for HIV routinely unless they take the initiative to decline testing. There is some evidence that women do not receive the information and counselling that are supposed to accompany HIV testing. They may not feel empowered to refuse testing, or they may not have a good understanding of the consequences of testing positive. Pre- and post-test counselling is especially important for women, who may face more stigmatization upon diagnosis than men. They may be accused of promiscuity or other bad behaviour. Women who risk violence, abuse or abandonment by partners on whom they are economically dependent will have especially difficult choices to make if they test positive. All women should be encouraged to take HIV tests, but the right of all women, including pregnant women, to informed consent should not be sacrificed.

Women may find it more difficult to start and maintain HIV treatment. Research shows that women tend to be diagnosed with HIV later in the course of the disease than

men, which compromises the chances for successful treatment. This may be because women are not as readily referred for testing as men due to lingering misconceptions that they are not at risk. Upon diagnosis, women may have a hard time balancing their own need for treatment with the burden of caring for children, family members and partners.

Treatment programs are not sufficiently tailored to meet women's needs. Part of the problem is that the research has not focussed on women's treatment needs. Antiretroviral therapy is effective for both women and men, but it affects women slightly differently. For example, women may experience different changes in body fat distribution associated with antiretroviral therapy, of which the psychological impact specific to women is little understood. There is a shortage of scientific studies on sex differences in response to antiretrovirals, partly because women have been so underrepresented in large sample studies. Women have turned to informal networks and sharing of personal anecdotes to make up for the lack of research-based clinical information and advice on treatment that is tailored to women.

Governments in Canada have recognized some of these problems, but greater recognition and action are needed. Programs that address poverty among women and violence against women and girls should be expanded and linked to HIV/AIDS efforts. Research must be conducted on how prevention and treatment programs affect women compared to men. Prevention and treatment programs should be tailored to women's realities, including creating and expanding peer-driven programs that speak credibly to them. Treatment programs should take into account the constraints that women face in child care, transportation and other practical demands, as well as fear and stigma that they live with. Finally, human rights institutions need to be made more accessible and effective so that women can call on legal protection against discrimination.

These steps will not eliminate the gender inequalities that drive the epidemic among women in Canada. But they are steps in the direction of a more coherent, effective, rights-respecting response to HIV/AIDS among women and girls. ■

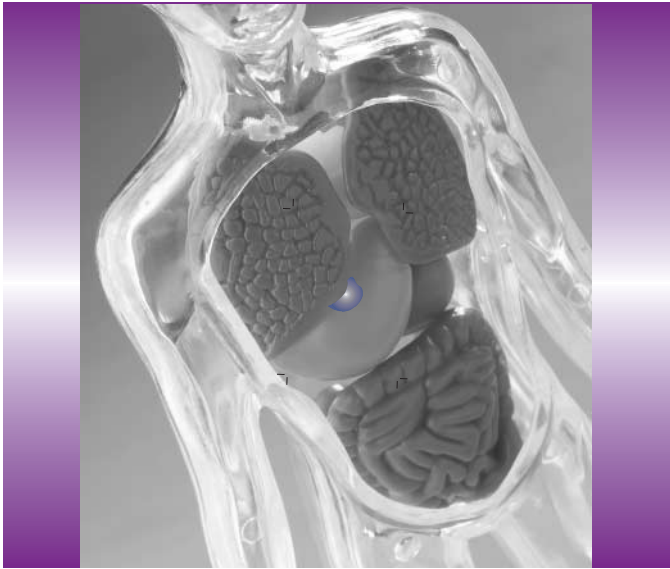
CTAC's Annual General Meeting 2006

CTAC's Annual General Meeting (AGM) will be held in **Montreal, Quebec, November 3rd-7th**. All Members are entitled to participate in the AGM.

For information, please visit

www.ctac.ca

HCV/HIV Co-infection



by Tony Di Pede, Board member of CTAC

HCV/HIV co-infection is associated with Canada's least politically viable causes—the addicted, incarcerated, street-involved, and others—and the stigma makes access to treatment challenging. At the Canadian Association of AIDS Researchers (CAHR) conference in Quebec City this past May, the results of some interesting research on HCV/HIV co-infection were presented.

HCV infection can build up scar tissue in the liver, which is called fibrosis of the liver. The liver's primary functions are to clear toxins from the body, metabolize drugs and produce clotting factors to control bleeding. As scar tissue replaces healthy tissue, liver function becomes diminished. Priority of treatment concerning HIV and HCV varies on a case to case basis. Sometimes it is better to treat the HIV first and sometimes it is better to treat the HCV first.

The effectiveness of Highly Active Anti-Retroviral Therapy (HAART) on the progression of liver fibrosis in the HCV/HIV co-infected is a matter of serious debate. HAART often results in increasing CD4s. High CD4 counts retard the progress of HCV infection including fibrosis of the liver. Yet, HAART itself may cause fibrosis of the liver. When M. Klein et al at McGill University in Montreal studied the effect of HAART on liver fibrosis progression in the HCV/HIV co-infected, they concluded from their research that HAART (especially Protease Inhibitor based regimens) in HCV/HIV

HCV/HIV co-infection is associated with Canada's least politically viable causes . . . and the stigma makes access to treatment challenging.

co-infected individuals appears to contribute to fibrosis of the liver. In addition, some patients in the study on HAART who were exclusively infected with HIV experienced a low level of liver toxicity.

J. Grebely at the University of British Columbia in Vancouver studied the safety and efficacy of treating HCV infection in Injection Drug Users (IDUs) in a structured, directly observed therapy (DOT) program. The individuals were treated with Ribavirin and/or PEG-interferon. All injections were directly observed. This study concluded that treatment of HCV infection in IDUs within a structured DOT program can be as successful in achieving a sustained virological response as those in the published literature, irrespective of ongoing drug use. This is a very important finding. It demonstrated that regardless of continued drug use, when a directly observed therapy is used in the treatment of HCV infection in IDUs, the same benefits can be achieved from therapy as those observed in non-IDUs.

H. Tossonian presented a study on hepatotoxicity in IDUs and non-IDUs receiving Nevirapine-based HAART. Hepatotoxicity is a condition in which the liver is damaged and is a major cause of people terminating their anti-retroviral therapy, especially IDUs co-infected with HCV. This study concluded that 15% of both IDUs and non-IDUs experienced clinically significant hepatotoxicity. In addition, HCV patients inexperienced with HAART and certain abnormal lab results were associated with higher risk of hepatotoxicity. Hopefully, these findings will assist patients and doctors in deciding who are the best candidates for Nevirapine based therapy.

Because of the tricky interaction between HIV and the liver, liver transplants and treatment strategies for illicit drug users are a pressing issue due to the "double decade demographic"—those infected with HIV/HCV before 1990. Presentations at CAHR indicate that strategies for hard to treat individuals co-infected with HIV/HCV can be successful. ■

National Walk for Life



WALK FOR LIFE began as a one of the first fund raising "Walks" in Canada. The Walks hold the twin goals of raising awareness and funds. Society continues to need to be shown that ignorance, homophobia, racism, sexism, homelessness and poverty all contribute to the spread of HIV and cause significant suffering to people in their communities.

AIDS is still fatal and everyone is potentially at risk. There is a need to address the assumptions surrounding HIV transmission, such as who is at risk and the realities of treatment. Prevention in all of its forms remains a vital message incorporated into the WALK FOR LIFE.

By bringing these issues into their communities, AIDS service agencies increase discussion about HIV/AIDS, build support for programs and services, and help create a society where people living with HIV/AIDS can live independent and meaningful lives.

WALK FOR LIFE is the only event where a significant number of AIDS service organizations across Canada participate collectively in a national fundraising and awareness campaign.

This year, a number of walks will again be held in Aboriginal communities. These walks play an important role in HIV/AIDS awareness and prevention in these communities.

Across Canada communities, large and small, will be hosting a WALK FOR LIFE between September 17th - 25th 2006.

Visit the National AIDS WALK FOR LIFE web site, www.walkforlife.ca for local information. ■

Formularies Series: Saskatchewan

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therapy"). *This drug, as with other antivirals in the treatment of HIV, should be used under the direction of an infectious disease specialist.*"

Other Meds that are available are:

- FOSAMPRENAVIR CALCIUM
700MG TABLET TELZIR (EDS)
- Fuzeon (EDS)

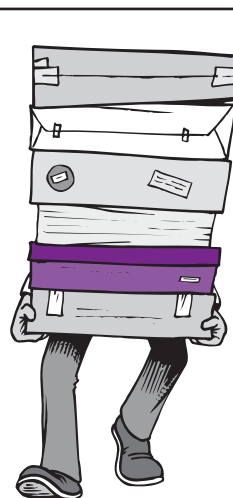
According to Regina Qu'Appelle Health District pharmacist Linda Sulz who works with the Infectious Disease Clinic team here in Regina, we currently do not have access to FTC (Emtriva) or Tenofovir (Viread), or Truvada (which is combo of FTC + Tenofovir). ■

References

Websites:

www.health.gov.sk.ca

- Saskatchewan Health Drug Plan
- Aboriginal Blueprint (Saskatchewan Approach – Draft Discussion)
- Saskatchewan Health
- Regional Health Authorities. (Linda Sulz; Pharmacist – Regina Qu'Appelle Health)



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.

CTAC at the XVI International AIDS Conference

Toronto, Canada – August 13-18

From August 13th to 18th, 2006, Toronto will host the XVI International AIDS Conference (www.aids2006.org) at the Metro Convention Centre.

The Conference theme—**Time to Deliver**—will focus AIDS 2006 on the promises and progress made to scale-up treatment, care and prevention. Conference sessions and activities will be designed to engage all delegates in dialogue about strategies to meet these shared goals.

CTAC will have an NGO booth in the Global Village. We will be there from 8:30am-8pm daily Monday to Thursday and 8:30am-12:30pm Friday. If you are in Toronto for the conference, please visit us at booth #1040.

CTAC will be involved with the following:

Monday, August 14

Womens' and Girls' Rally & March: 7:00 am-8:00 am
Begins at Metro Hall Square

(King Street West, between John St. and Simcoe)

If you are interested in volunteering, please contact Venus Yam, Volunteer Coordinator at venus.yam@gmail.com

Plenary Session: 8:45 am-10:15 am

Theme: Taking Stock: Current Challenges in the Global Response

Venue: Session Room 1, Level 800 (South Building)

Speakers: Julie Overbaugh (United States), Chris Beyrer (United States), Anand Grover (India), Louise Binder (Canada)

There will be a simultaneous transmission of this session in Session Room 8, Level 100 (North Building)

Poster Exhibition: 10:15 am-6:30 pm

Poster Presentation: 12:30pm-2:00pm

Theme: "The principle of free and informed consent: Gaps between theory and practice"
J.-P. Belisle, L. Binder

Venue: Poster Exhibition area, Level 800, South Building
#MOPE0943

Wednesday, August 16

CTAC Press Conference 11:00 am-11:45 am

Theme: "Access to Treatment in Canada"

Speakers: Louise Binder, CTAC Board Chair and Jean-Pierre Belisle, CTAC Board Secretary

Venue: Room 2, Media Centre

Poster Discussion 1:00 pm

Theme: "Access to the information needed for informed treatment decisions"

Venue: Key Challenge Area 3, Level 800
P. Cupido, J.-P. Bélisle, L. Binder, L. Edmiston
WEKC304

Thursday, August 17

Poster Exhibition 10:15 am-6:30 pm

Theme: "The Blueprint for Action on Women and HIV/AIDS: a Canadian and International coalition advocating for an improved response to women and HIV/AIDS"

J. Smith, M. Summers, L. Binder, P. Frank

Venue: Level 800, Track E
THPE0879

We look forward to seeing you there!

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 14) for more information. *Confidentiality will be respected. We may not print all stories submitted.*

CALENDAR OF EVENTS

SUMMER/FALL 2006

- **August 10-11**
Canadian Aboriginal AIDS Network (CAAN) Annual General Meeting
Toronto, Ontario
Contact: (613) 567-4652, info@caan.ca or www.caan.ca
- **August 13-18**
The XVI International AIDS Conference
Toronto, Ontario
www.aids2006.org
- **August 26**
BCPWA Society Annual General Meeting
Vancouver, BC
Contact: (604) 646-5317, derekb@bcpwa.org or www.bcpwa.org
- **September 27-30**
Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC) 2006
San Francisco, CA USA
Contact: (202) 942-9248, icaac@asmusa.org or www.icaac.org
- **September 28-30**
Interagency Coalition on AIDS and Development (ICAD) & Canadian HIV/AIDS Legal Network Annual General Meeting
Gatineau, QC
Contact: (613) 233-8361, info@icad-cisd.com or www.icad-cisd.com
- **October 3**
CATIE's Annual General Meeting: Learning and Sharing – 15 Years of Knowledge Exchange
Vancouver, Edmonton, Toronto, Montreal, Halifax
Contact: 1-800-263-1638 info@catie.ca or www.catie.ca
- **October 20-22**
British Columbia Positive Gathering 2006
Vancouver, BC
Contact: 1-800-994-2437 or stephenm@bcpwa.org
- **November 3-7**
Canadian Treatment Action Council Annual General Meeting and Skills Building
Montreal, Quebec
Contact: (416) 410-6538 or www.ctac.ca
Join CTAC at its AGM and for a day of skills building in Montreal! All members are welcome to attend. Please visit www.ctac.ca for details and to register for the day.
- **November 27-28**
The OHTN Research Conference
Toronto, ON
Contact: (416) 642-6486, x222, researchconference@ohtn.on.ca or www.ohtn.on.ca/OHTNConference

CHAIR'S REPORT

SUMMER 2006

by Louise Binder



IT IS THE HEIGHT of the

Summer of 2006. In many ways, for me, there is a strong sense of déjà vu to a decade ago. Another International AIDS Conference is in full swing in Canada. Another Canadian Prime Minister has found neither the issue nor the event of significant enough importance to attend and represent our country. I am once again ashamed, as I was in 1996, of this lack of a public show of federal political support regarding the greatest health crisis the world has ever known.

There are some differences in my perspective from that of a decade ago. The fact that I am actually here writing this piece is something I would never have predicted then. We were just hearing about protease inhibitors and combination, multi-class therapies. We wanted to believe, but many of us were afraid to have our hopes dashed yet again.

Now we know that there are therapies that can keep many of us alive and with a relatively good quality of life for long periods of time. I am glad that I have been able in some small way with my colleagues at CTAC to contribute to getting people access to these treatments. I also honour my colleagues at AIDS ACTION NOW! in Toronto who did this work before there was a CTAC. As well, I honour all of you who have come out to support our efforts when we have needed you to do so.

I hope that one day very soon that people all around the world who require these drugs will have them and the food, water and other basic needs necessary to take them and to stay alive.

Unfortunately, 2006 takes me back to 1996 in a few other ways. We still do not have a cure for this disease. We still need one.

And I continue to lose my friends and colleagues to HIV. ■

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2006/07 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 • Hoffmann-La Roche • Pfizer Canada • Schering Canada • Tibotec, a division of Janssen-Ortho Inc.
- Ward Health Strategies

CTAC POSITION PAPERS

Papers

- 2001 - "Improving our Health: The Need to Enhance the Post-Approval Surveillance System for HIV/AIDS Drugs in Canada", author: David Garmaise.
- 2001 - "Making Treatments Accessible: A Policy Paper on Determining Appropriate Pricing for Brand-name Pharmaceutical Treatments for HIV/AIDS in Canada", author: Glen Brown.
- 2000 - "Position Paper on Direct to Consumer Advertising (DTCA) of Prescription Medications", author: Philip Lundrigan.
- 1999 - "Timeliness and Transparency: Assessing the Review Process for HIV Drugs", author: David Garmaise.

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 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.

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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Website: www.ctac.ca

CTAC's Mandate

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

CTAC...

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

PUBLICATION

This newsletter is a quarterly publication.

Editorial Board: Jean-Pierre Bélisle / Derek Bell / Ken Monteith

Editorial Committee: Beatrice Cardin / Laurette Lévy / Leah Stephenson / Eileen Wenneker / Theresa Wojtasiewicz

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