

CANADIAN TREATMENT ACTION COUNCIL



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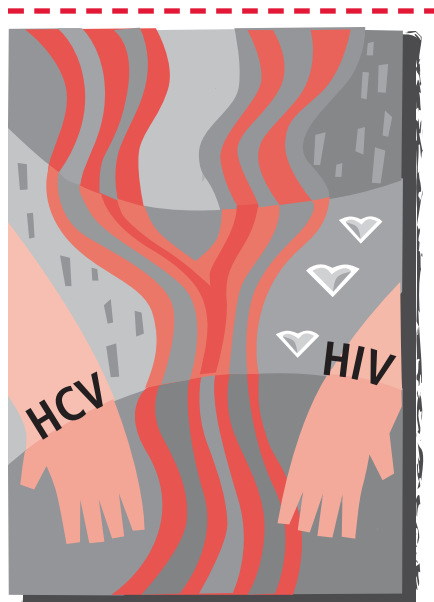
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By Colleen Price, CTAC Board

Converging Separate Tracks:

Responding to HCV/HIV Co-infection

Although 30% of people living with HIV are co-infected with Hepatitis C, policies and programs to address treatment, care and support have evolved along separate disease tracks. To better serve the needs of co-infected people, these tracks need to converge. Co-infected individuals often belong to vulnerable groups such as current or former injection drug users, First Nations, youth, the incarcerated, sex workers, the homeless or underhoused. They may have been recipients of transfused blood or blood products. Since people co-infected with HCV/HIV are also at highest risk for addictions, mental health or concurrent disorders, they often fall between the cracks of both HIV and Hepatitis C treatment systems and service organizations.

It is therefore essential to develop distinct and innovative approaches that recognize the unique social and health needs of the HCV/HIV co-infected.

Treatment for co-infected individuals is very complex and as a result can be hard to understand, especially as treatment must be individualized and no one size fits all. Treatment of HCV (typically with Pegylated interferon and ribavirin) has improved response rates; however, it is not effective for everyone depending on the HCV strain and is usually accompanied by a multitude of side effects including flu-like symptoms and depression that require specific medical and emotional support.

Specialized policies, programs and support services need to be developed for



Converging separate tracks: responding to HCV/HIV co-infection

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the co-infected. Physicians, mental health and addictions specialists and other health care professionals must be encouraged to specialize or at least receive additional training in HCV/HIV co-infection in order to develop and implement services that will assist not only in prevention and treatment but in rebuilding shattered lives. HCV and HIV frontline workers also need cross-training to effectively assist a clientele that faces dual stigma and complex treatment issues. Strategic planners must also look beyond the medical model towards a holistic approach that takes into consideration social determinants of health, including mental health and addictions, poverty and housing components, all of which pose barriers to testing, treatment, adherence and harm-reduction strategies.

Where they exist at all, strategies to support the co-infected exist in a grey area. The current federal strategy on Hepatitis C ignores HCV/HIV co-infection and there is no standardized or centralized data collection that could be used to estimate the incidence and prevalence of co-infection. We don't know the numbers. The lack of funding, the lack of a federal strategy, next to no programming or policy development and no directives on accessing testing or treatment – these only serve to perpetuate ignorance about co-infection and the associated stigma.

AIDS service organizations (ASOs) are overwhelmed by the needs of an increasingly complex clientele, a condition which is made worse by insufficient funding to assist in hiring additional staff and in developing relevant support programs. Within the Hepatitis C community, services and support for co-infected persons are almost non-existent, and staff are often not well-versed in HIV/AIDS issues. The two communities need to unite and seek joint funding beyond their respective mandates to meet their clients' needs for education, prevention and support services.

Barriers to treatment include factors which are:

1. Individual (fear, isolation)
2. Clinical (CD4<200, active opportunistic infection) or
3. Systemic (lack of access to testing, standards of care that vary by province, physician or clinic).

Treatment decisions must be made for each individual

The **lack of funding**, the **lack of a federal strategy**, next to **no programming or policy development** and **no directives on accessing testing or treatment** – these only serve to **perpetuate ignorance about co-infection and the associated stigma**.

about the order in which to treat the HCV or HIV or whether to treat concurrently. Since Hepatitis C is a chronic, progressive disease, the decision to treat may be delayed ("watchful waiting"). For those who do start treatment for HCV, clinical benefits may include slowing or reversal of the rate of fibrosis (or more seriously, cirrhosis) of the liver and the possibility that risk of liver cancer may be diminished.

The development and implementation of comprehensive, multi-disciplinary treatment plans that include drugs, micronutrients and nutritional counseling would enable co-infected individuals to overcome physical and mental barriers to treatment, reduce its side effects and would facilitate adherence. Access to harm-reduction services and counseling needs to be increased and included in these treatment programs as alcohol dramatically accelerates HCV progression. The choice to abstain or drink in moderation can dramatically decrease HCV disease progression and resulting liver damage. Street drugs such as crack cocaine also raise the risk of rapid disease progression. The availability of harm-reduction services can assist individuals to change patterns of thinking, feeling and behaving that will positively impact treatment outcomes and quality of life.

As a survivor of HCV and HIV, I, too, have experienced stigma, the gaps in ASO services, difficulties in getting information and the general lack of support. I finished 48 weeks of Pegatron (Pegylated interferon and ribavirin) in June, 2005, experiencing some of the negative side effects of HCV treatment, including depression, aggression, suicidal ideation and cognitive impairment, which resolved once off treatment. It is important to note that side effects are highly individual and can vary in nature and intensity. There is no shame in asking for help; the shame is in not asking. Anti-



Converging separate tracks: responding to HCV/HIV co-infection

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depressants, individual counseling, harm-reduction and peer-support groups can really help develop coping strategies to manage the clinical and emotional side effects. I strongly encourage ASOs to start peer support groups for the co-infected such as the "Choices" support group at the AIDS Committee of Ottawa.

We also need our HCV and HIV organizations to start working more closely together. We need leadership at the federal level that starts with dedicated funding for research that examines HCV/HIV disease interaction, drug interactions including street drugs, issues of aging and solid organ transplantation.

CTAC is responding to HCV/HIV co-infection by creating a Working Group on access to treatment issues which will continue the work begun in the "Roadmap for Addressing the Epidemic of HIV and Hepatitis C Co-infection in

Canada" (www.ctac.ca/papers/Roadmap.pdf). CTAC will partner with the Ontario HIV Treatment Network (OHTN) at an upcoming Think Tank on HCV/HIV to identify and address gaps in research, service and care for the co-infected. The Think Tank will bring together people living with HCV/HIV, service and healthcare providers, researchers and policy makers to identify priorities and create a plan for concrete action steps on a research agenda and the development of policies and programs. ■

To learn more about CTAC's work on HCV/HIV Co-infection please contact
Colleen Price at colleen@ctac.ca or
Sonika Lal at sonika@ctac.ca

The HIV / HCV **Fact Box**

Adding up the numbers...

30% of people living with HIV/AIDS are co-infected with HCV

10% of people living with HCV are co-infected with HIV/AIDS

50 to **80%** of IDUs are HCV/HIV co-infected

Approximately **58,000** Canadians are living with HIV/AIDS – but **27%** don't know it

About **251,000** Canadians have HCV – but **95,000** don't know it

More than **5,000** Canadians – many of whom are youth – are infected with HCV each year

Canada's federal HIV/AIDS budget is increasing from
\$42.2 MILLION to **\$84.4 MILLION** annually by 2008-2009

Since 1999, Canada spends **\$10.648 MILLION** annually on HCV

FUTURE FUNDING FOR HCV IS NOT GUARANTEED

Formularies Series:

Ontario

By Brian Finch, Secretary of the Board, CTAC

INTRODUCTION

Ontario is currently in the process of reforming the way in which medications are approved and provided through its publicly funded drug reimbursement programs. These programs are delivered through the Ontario Drug Benefit Program in the form of the Ontario Drug Benefits Card or the catastrophic drug plan, Trillium.

This article will review the previous system, much of which is still in place, and the proposed changes in Bill 102.

PRE BILL 102

- The Drugs Program operated under the auspices of the former *Ontario Drug Benefit Act*.
- Before drugs can be listed on the public formulary they have to be reviewed and recommended by the Drug Quality and Therapeutics Committee (DQTC, established 1968).
- The DQTC is a committee that has always rendered its decisions without transparency under the guise of cabinet secrecy.
- Certain drugs have restricted access status as a result of the DQTC decisions. Tenofovir is one such example. In order to access these "Limited Use" drugs, the physician has to complete a form commonly known as a "Section 8." Once completed, the attending physician faxes the request to the MoH to request a review from the Ministry bureaucrats. That person has the authority to grant or deny the request.
- Social assistance or long-term disability (LTD) provides an Ontario Drug Benefits (ODB) card to cover all drugs on the provincial formulary. All prescriptions require a \$2.00 co-payment. Some pharmacies may choose to waive this co-payment.
- The Trillium program provides reimbursement for all medications listed by the Ontario Drug Program for

working individuals and families who are uninsured or under-insured and who have "catastrophically high" drug costs. Individuals pay an annual deductible calculated on last year's income, plus \$2.00 co-pay. Drugs available through "Limited Use" also require the writing of Section 8 requests.

- The Trillium program can be used in combination with private plans to assist in covering the high cost of medications. Trillium can pick up the unpaid portion depending on the individual or family income formula but cannot make the necessary calculations by computer. Partial Trillium payments are done via reimbursement, with the potential to cause undue financial hardship.

BILL 102, TRANSPARENT DRUG SYSTEM FOR PATIENTS ACT

In the fall of 2005, the Ministry of Health began a consultation process led by the Drug Systems Secretariat to identify problems and develop solutions to the present system. CTAC provided a written submission and attended the first stakeholder's meeting on Dec 1, 2005.

WHAT EXACTLY WAS PROPOSED?

The Transparent Drug System for Patients Act was intended to strengthen the governance and management of the public drug system, and to create new standards of transparency and accountability. Here are the main points:

EXECUTIVE OFFICER, DRUG PROGRAMS

The intent of creating an Executive Officer independent of Cabinet is to streamline the decision-making process, to communicate decisions and rationale publicly, and to oversee negotiations with manufacturers to improve access to newer medications.

COMMITTEE TO EVALUATE DRUGS (CED)

- This replaces the DQTC that reviewed medications for listing on Ontario's public formulary.
- Two Patients will be included on the CED, along with a proposed sub-group for cancer with two patients, and various ad hoc sub-groups as needed.



Formularies Series: Ontario

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CITIZEN'S COUNCIL

This newly created council is to be composed of citizens including consumers with the goal of providing advice to the MoH on broader public policy issues including ethical issues.

IMPROVEMENTS TO CONDITIONAL LISTING AND EXCEPTIONAL ACCESS MECHANISMS.

- Access to newer drugs will be improved by allowing listings for particular indications while awaiting further evidence.
- Individual drug requests will be reviewed through the Exceptional Access mechanism.
- Reducing doctors' paper work will reduce waiting for access.
- Greater transparency in the decision making process will be created through the new Executive Officer as opposed to decisions which were made in secrecy in Cabinet.

RAPID REVIEW OF BREAKTHROUGH DRUGS.

The Ministry intends to do its own separate review within three to four months (in addition to the Common Drug Review) of breakthrough drugs in order to get them onto the formulary faster.

INCREASED INTERCHANGEABILITY AND OFF-FORMULARY INTERCHANGEABILITY

- CTAC had expressed concern at the stakeholder meetings that the legislation would permit unacceptable substitutions through the wording of "same and similar". CTAC was concerned this would lead to the type of Therapeutic Substitution policy similar to that in B.C.
- As a result of advocacy, the intent of "same and similar" was redefined in the Act so that it refers strictly to non medicinal ingredients or fillers in an effort to prevent industry from "evergreening" or using slight changes in the formulation of a product to unfairly extend patent life.

ALIGNMENT OF FUNDING POLICIES

This refers to the creation of policies to allow, for example, the use of so-called "hospital based" therapies to be used in other settings.

PARTNERSHIP AGREEMENTS & COMPETITIVE AGREEMENTS FOR BRAND NAME DRUGS

The province has begun negotiations with manufacturers to come to agreements on pricing and listings in order to achieve greater economies for the system.

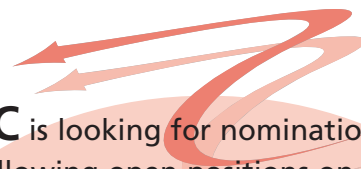
PARTNERSHIP AGREEMENTS & COMPETITIVE AGREEMENTS FOR GENERIC DRUGS

The Ministry attempted to cap prices of generic drugs at 50% of the brand name price. The Ministry ultimately reversed course, allowing for exceptions to the 50% threshold. The Ministry, as is the case with brand name products, plans to negotiate more competitive prices.

PROMOTING THE APPROPRIATE USE OF DRUGS

- Pharmacists will be given a greater role in primary care. A new reimbursement scheme will be set up to reimburse pharmacists for services provided to consumers such as medication management reviews.
- A Shared Care Network will be developed to help doctors make the best prescribing decisions and help patients adhere to their drug therapies. Web-based, independent, best practice guidelines will be developed

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CTAC is looking for nominations for all of the following open positions on its Council:

- National Women's Representative;
- National Youth Representative;
- Aboriginal Representative;
- Representative of Black Canadians, African and Caribbean Communities;
- Representative of current and former substance users;
- Representative of prisoners/ex-prisoners.

Visit our website for more details.

CASE STUDY: PATIENT X

The ordeal of Patient X is a clear example of how the Ontario drug reimbursement system pre Bill 102 has failed patients by interfering with the doctor patient relationship. This is an apocryphal tale of why it makes sense to improve access to certain HIV medications even though the price may appear to be higher.

About a year and a half ago, this long-term survivor discovered that he had lymphoma. He and his physician both felt Tenofovir was required in his combination for a couple of reasons:

- 1) there was concern about AZT induced anemia as he was about to undergo chemotherapy
- 2) there was concern about lipodystrophy caused by thymidine analogue drugs.

The first Section 8 request was reviewed “by an expert at the Drugs Branch” who thought this individual should take Abacavir, 3TC and boosted Reyataz, and therefore denied the request for Tenofovir.

The physician explained that Patient X could not take boosted Reyataz as he had liver problems and therefore prone to side effects with that drug. Tenofovir was considered to be the best and only option to help him achieve undetectable VL.

A second Section 8 requesting access to Tenofovir was also denied. By this time Patient X had to be hospitalized for TWO blood transfusions likely due to AZT-induced anemia.

Patient X’s physician is very experienced in treating HIV and knew his patient required 4 active agents to achieve an undetectable VL.

The second request was denied on the basis of Tenofovir being metabolized by the kidneys despite the fact that Patient X had no prior renal problems while on treatment for lymphoma. Many HIV positive patients have taken Tenofovir along with this type of chemotherapy.

It would seem that the MoH preferred that Patient X fail his treatment and be forced to move on to increasingly more expensive third and fourth-line therapies. Instead of paying the higher price for Tenofovir (viewed in isolation as opposed to part of a combination), the Province of Ontario chose to pay for hospitalizations, blood transfusions, added doctors visits, and increased workload for the treating physician.

A year and a half later, the THIRD request for a Section 8 was finally approved.

All of which begs the question: “Why not just provide the drug?”

The answer is an attitude that favours short term COST CONTAINMENT over consideration of what is the best treatment for Patient X. His welfare and his doctor’s recommendations were not considered in this process, and only a few dollars saved in the drug budget line regardless of the costs incurred in other parts of the system.

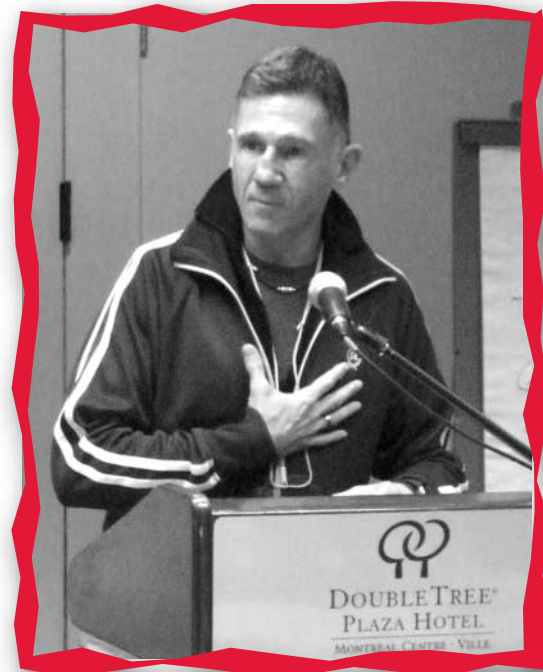
With the advent of Bill 102, this writer is pleased to report that Tenofovir, an important medication in the HIV armamentarium, has now been made available on the general listing, thereby removing the need to access via Section 8. It is to be hoped that this is the first of many decisions that will improve access to the drugs we use in combination therapy in order to suppress ever-mutating HIV. ■

Glen Hillson Award – 2006

Ron Rosenes

Ron Rosenes has been named the recipient of the Glen Hillson Award for Excellence 2006. This award was created by the Canadian Treatment Action Council (CTAC) to honour the memory of Glen Hillson, who died of AIDS-related liver failure in 2003. Glen Hillson, who was Vice Chair of CTAC and Chair of British Columbia People with AIDS (BCPWA) Society, was a tireless advocate for the health and human rights of people living with HIV/AIDS.

Ron Rosenes has been an active member of the HIV/AIDS community in Toronto since 1991. Living with HIV since the early days of the epidemic, Ron developed his advocacy skills with the AIDS Committee of Toronto (ACT), first as Chair of AIDSWalk, then as Board Chair from 1995 to 1998. In September of 1999, he was appointed ACT's first Honorary Director. Ron is a founding Board Member of the Sherbourne Health Centre and a member of AIDS Action Now! He was a member of the Steering Committee of the



Canada AIDS Russia Project and chairs the Priority Initiatives Program at the OHTN.

This award underlines Ron Rosenes' tireless commitment to improving the health and lives of people living with HIV/AIDS and his outstanding work at the Toronto Local Host, which helped to organize the XVI International AIDS Conference, AIDS 2006. ■

Thanks, Mardie!



MARDIE SERENITY, who has been a dedicated member of CTAC's staff for the past eight years, has resigned from her position to take on new challenges. Mardie has been invaluable in assisting CTAC to fulfill its mandate. In addition to her excellent work in finance and grant management, Mardie facilitated CTAC's organizational development processes, and provided much appreciated administrative support to the PASS I and II projects and CTAC's Hepatitis C co-infection work.

Thank you for all the hard work. We will miss you, Mardie!

INTERNATIONAL

“If HIV had a face, it would be the face of an African woman.”

Stephen Lewis, the UN’s special envoy on Aids in Africa, uses this phrase to illustrate the global burden of HIV/AIDS, a load that rests most heavily on women and girls in sub-Saharan Africa. Nowhere is this truer than in South Africa, where 5 million people are HIV-positive, more than any other nation. Yet if hope for relief from the pandemic were also to have a face it too would likely be that of a woman. For in the struggle for treatment and rational HIV/AIDS policy, the leadership of two courageous and powerful women has been crucial to the most recent victories.

For those unfamiliar with South Africa’s tortuous journey, it may seem unremarkable for Nozizwe Madlala-Routledge, deputy minister of health, to have affirmed in an interview recently that HIV causes AIDS, and anti-retrovirals (ARVs) are a necessary and life-saving treatment for those who need them. After all, the link between HIV and AIDS has been known for two decades, and the Lazarus effect of ARVs has transformed AIDS from a terminal to a chronic disease wherever they are available. But in South Africa the deputy minister’s words are a brave stand. A similarly frank admission from the deputy president, Phumzile Mlambo-Ngcuka, that government at the highest levels has contributed to “confusion” around HIV, has provided more cause for hope that new leaders willing to work with civil society might rectify the mistakes of the past.

The mistakes began soon after the magnitude of South Africa’s HIV epidemic became apparent. The government of Nelson Mandela did little in the crucial early years, focused as it was on economic equality and forging a united nation after the end of apartheid. His successor, Thabo Mbeki, publicly questioned the cause of AIDS, and Mbeki’s minister of health, Manto Tshabalala-Msimang, put forward

beetroot, lemon juice and garlic as supposed anti-AIDS treatments. Mbeki sought “African solutions to African problems”, and decried Western pharmaceutical companies he saw profiting from African misery and perpetuating the myth of the promiscuous, diseased native. In the meantime, the public health care system, whose users were 85% black, did not administer ARVs.

HIV-positive activists like Zackie Achmat of the Treatment Action Campaign (TAC) began to advocate for access to treatment. TAC was successful in legal challenges against the government and profiteering pharmaceutical companies. Yet despite court injunctions ordering it to provide treatment, and falling drug prices, the government remained reluctant to offer treatments.

Frustrated from the lack of action their court victories provided, TAC launched a civil disobedience campaign in 2003. With the support of civil society, powerful trade unions, and international allies, the campaign pressured the government into promising to begin work on a national treatment plan. The plan was announced six months later, just weeks after TAC had publicly decided to restart its civil disobedience campaign because of the government’s foot-dragging. In November 2003, the cabinet-approved plan called for 1.4 million people to be placed on treatment by 2010, 53 000 by the following April. It was to be the largest treatment program in the world.

Three years later, at the XVI International AIDS Conference in Toronto in August 2006, the plan seemed to have had little effect. Though she had been opposed to establishing the treatment plan, Tshabalala-Msimang had remained in charge of its implementation. Her department had much to answer for: no identifiable plan had been implemented to address severe health worker shortages; the government had not yet sought licenses for generic second-line drugs; and even the total number of people placed on treatment was unknown, since the government did not yet have the capacity to monitor its programs. At the



If HIV had a face, it would be the face of an African woman

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conference, the government's booth displayed baskets overflowing with lemons, garlic, and beetroot, but no ARVs. Frustrated TAC activists occupied the booth, mockingly passing around the produce and calling for the firing of the minister of health. The international media featured the event prominently, encouraged by special envoy Lewis's closing speech, which singled out South Africa for policies "more worthy of a lunatic fringe than of a concerned and compassionate state".

This may have been the turning point. Soon after the conference, President Mbeki called on his deputy, Mlambo-Ngcuka, rather than the health minister, to review the government's HIV policy. She also took the helm of the Inter-Ministerial Committee on Aids and the South Africa National Aids Council, and became the official spokesperson of the cabinet on HIV/AIDS. In her new role atop the government's HIV hierarchy, she emerged as a mediator between the government bureaucracy charged with implementing the treatment plan and civil society groups desperate to help it succeed. She has called for unity among those involved in the fight against AIDS, admitted of the government's difficulty in fighting AIDS, and unequivocally affirmed that HIV is the cause of AIDS.

Meanwhile, the formerly censured deputy-minister of health told a British journalist that the government has been in "denial at the very highest level" over AIDS, and was "very, very embarrassed" by the conference display that seemed to present nutrition as an alternative to treatment. She went on to challenge leaders at the highest level to publicly take an HIV test, which both Mbeki and Tshabalala-Msimang have refused to do. Madlala-Routledge, along with her family, was publicly tested in November 2006.

The response to the apparent rapprochement from government has been measured but hopeful. Activists and editorialists alike have praised the two women at the center of the government's new approach. Achmat has called attention to the government's renewed commitment to eliminating AIDS, and voiced his hope that the confrontations of the past "are behind us". Yet the worry

remains that, as after 2003, encouraging statements from government may not be accompanied by substantial action. Activists fear that denialists who remain in government may attempt to undermine those who desire change. The deputy-minister of health could be fired, or reassigned to another portfolio. The government may continue to refuse to rein in denialist scientists and opportunists who cast doubt on the effectiveness of ARVs while selling vitamins and nutritional supplements as AIDS cures.

Even if the spirit of cooperation between government and civil society remain, the job ahead is immense. While prices for first-line ARVs have dropped considerably, prices for second-line drugs are still prohibitive. The TAC has identified Abbott's pricing of Kaletra (lopinavir) as particularly egregious. Scaling up a treatment program in a health system that loses many of its health professionals to developed countries shoring up their own health services is a continuing challenge. And, perhaps most distressingly, a form of "extensively" drug-resistant tuberculosis (XDR-TB) was recently discovered in South Africa. AIDS-weakened immune systems are particularly vulnerable to TB, and this new strain killed 98% of infected persons in one study. Inadequate access to both AIDS and TB treatment will only encourage the spread of XDR-TB.

However difficult these challenges are, the goal of universal treatment inches closer as the forces struggling for it learn to cooperate. Crucial first steps have been taken, but only continued and concerted action by committed persons will result in a true sea change. ■

Justin Noble is a volunteer for Friends of Treatment Action Campaign North America (FoTAC). For more information on FoTAC or how to support the Treatment Action

Campaign, please go to
www.tac.org.za/fotacna.html
or email fotac.na@gmail.com.

Formularies Series: Ontario

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to ensure the right drug is prescribed for the right person at the right time.

REWARDING INNOVATION

A fund has been created to support research that promotes innovation in providing health care, as well as research into potential savings in the usage of drugs and the interrelationship with other parts of the system.

WHAT IS HAPPENING TODAY?

- Bill 102, *Transparent Drug System for Patients Act*, received its final reading in the Ontario legislature on June 19, 2006, and is now law.
- The actual legislation gives the government the power to create the Executive Officer and to enter into price

related negotiations with industry. It also creates the Council to Evaluate Drugs and the Citizen's Council. Most of the other changes will be developed through the regulatory process.

- The devil is in the details. We have yet to see a substantive improvement in transparency. Patients or consumer reps have yet to be chosen for the CED and the Citizen's Council. The patient representative appointed to The Ontario Pharmacists Council is a physician.
- HIV drugs have not been placed in a unique category relative to other drugs.
- Section 8's are slowly being phased out as drugs are moved to General or Conditional Listing. However, the majority of drugs on "Limited Use" still require a Section 8.
- The Ministry of Health and Long Term Care has recently moved Tenofovir onto the General Listing, thus eliminating the need to access via Section 8. ■

For those in the Winnipeg area

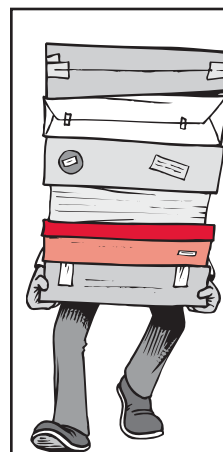
CTAC will be coordinating a meeting on Access to HIV/AIDS Treatment in the Province of Manitoba. We would love to hear what barriers are currently making it difficult to get access to the latest treatments or clinical trials. CTAC Board members will give a "Tools for Action" workshop on government systems that will help you understand how decisions to fund treatments are made – this is a great opportunity to learn how the system works and some advocacy skills that you can put to use to change it for the better.

The meeting will be held on **March 23** in Winnipeg. If you are interested in attending or learning more, please contact Sonika Lal, Project Coordinator at Sonika@ctac.ca or (416) 410-6538.

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.*



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.

CALENDAR OF EVENTS

WINTER/SPRING 2007

- **February 25-28**
Conference on Retroviruses and Opportunistic Infections (CROI)
 Los Angeles, USA
 Contact: (703) 535-6862 or
info@retroconference.org
www.retroconference.org/2007

- **March 23, 2007**
CTAC Community Based meeting on Cost Containment
 Winnipeg, MB
 Contact: (416) 410-6538 or sonika@ctac.ca

- **March 25-30**
HIV Vaccines: From Basic Research to Clinical Trials
 Whistler, AB
 Contact: (800) 253-0685 or (970) 262-1230
info@keystonesymposia.org

- **April 16**
Towards Coordination and Integration: A think Tank on Hepatitis C and HIV Co-Infection in Ontario
 CTAC in partnership with the OHTN
 Contact: (416) 410-6538 or sonika@ctac.ca

- **April 23-24**
Canadian Agency for Drugs and Technologies in Health (CADTH)
 Ottawa, ON
 Contact: (613) 226-2553,
symposium@cadth.ca
www.cadth.ca/index.php./en/events/sympos-2007

- **April 26-29**
Canadian Association for HIV Research (CAHR)
 Toronto, ON
 Contact: Muriel Mathieu at (604) 984-6449,
muriel@seatoskymeetings.com
www.cahr-acrv.ca

CHAIR'S REPORT

Winter 2007

by Louise Binder



DEAR READERS,

We are half way through winter 2007.

The world appears to have woken up to the issue of the environment and the profound adverse effects it will have on human health and survival. This is a very positive step for future generations.

Health has slipped to second priority for Canadians. I trust this is only temporary, until we see that the politicians have gotten our message about global warming and are acting on it.

Health is certainly related to the environment. There are, however, additional health contributors to longevity and quality of life. Social determinants of health including education, poverty, employment, homelessness, gender and income all contribute to health outcomes.

Societal and cultural norms including prohibition of gender violence, racial and cultural equality and a strong underpinning of beliefs in social justice and human rights also impact on health outcomes.

A well-functioning public healthcare system and access to necessary care, treatments and support are also crucial.

Each of us has a role to play in making this planet a sustainable and vibrant place for all of its inhabitants. Our efforts, whether in environmental causes, human rights, health, education, gender equality or other social determinants are synergistic and symbiotic. We must continue to respect and support each other's efforts.

I am proud to be the chair of CTAC, which continues to play a role alongside so many courageous and tenacious people and organizations here in Canada and worldwide to be part of the solutions to improving the human condition. I have always believed that a group of people, large or small, with conviction and hard work, can make a huge difference. The recent recognition of the work of environmental advocates is further proof that we must remain true to our beliefs and to working for action on them. ■

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- VICE CHAIR **Ron Rosenes**
- TREASURER **Patrick Cupido**
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Jennifer Furtney
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Ward Health Strategies

CTAC POSITION PAPERS

Papers

- 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.
- 1999 – “Timeliness and Transparency: Assessing the Review Process for HIV Drugs.” Author: David Garmaise.

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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

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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.

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