

# CANADIAN TREATMENT ACTION COUNCIL



Canadian Treatment Action Council

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## HIV/AIDS Recommendations for Aboriginal People



- Clear information in basic English about the effects of Western medication
- Increase Aboriginal-driven research for HIV/AIDS and coinfection treatments
- Anonymous HIV/AIDS testing across Canada
- Remote regions doctor satellite offices
- Improve and ensure access to mental health services
- Culturally based HIV/AIDS programs run by Aboriginal people
- Additional support for Aboriginal people that are receiving treatment and medication
- Mandatory Aboriginal specific courses related to HIV/AIDS care for doctors, nurses and other health care professionals
- Pharmaceutical providers to be inclusive of childcare and family issues
- Understand and incorporate traditional medicine and the holistic approach
- Take into account underlying problems, conflicts, collective choices and risky behaviour
- Break down barriers for individuals living on and off reserve



On February 9th, 2008 the Canadian Treatment Action Council (CTAC) in collaboration with the Canadian Aboriginal AIDS Network (CAAN), Healing our Spirit, Red Road HIV/AIDS Network Society and the Positive Women's Network (PWN) hosted a workshop on HIV/AIDS treatment access issues for Aboriginal people at the Vancouver Aboriginal Friendship Centre. The workshop entitled 'Walking the Western Medicine Road: HIV/AIDS Treatment

Access Issues for Aboriginal People' focused on treatment access and information about Western medicine to help Aboriginal men, women and youth make informed decisions about their health care. This workshop was very successful and the work done throughout the day helped formulate these recommendations needed to improve access to treatment for Aboriginal people. ■

## CROI REPORT

### April, 2008

by Louise Binder, CTAC Chair

There was a treasure trove of information at CROI this year. Here is a summary of some of the researchers' findings regarding ARV treatment that were particularly interesting.

#### WHEN TO START

Antiretroviral treatment is generally commenced when the patient's CD4 count drops below 350. Still, there is continuing debate about whether this threshold applies to all people with HIV/AIDS.

One cohort study reported at CROI analyzed the mortality rates of 46,400 HIV+ people. The researchers concluded that antiretroviral naive HIV+ people with over 350 CD4s still had a higher death risk than the non-HIV+ population. However, HIV+ people with over 350 CD4s had a greater survival chance than those who had a count under 350.

Another study from CROI showed that people with CD4 counts below 350 were more likely to suffer from non-HIV-related illnesses and malignancies than those above 350.

The SMART study of treatment interruption also showed that low CD4 cells increased the risk of non-HIV-related illnesses, including heart disease, cancers, kidney and liver disease.

It does appear that the pendulum is swinging back to supporting the case for starting treatments earlier.

#### WHAT TO START

Treatment naive patients have a number of combination therapies to choose from when they start treatments. One class of therapies is the protease inhibitor class.

At CROI, a 48-week study called CASTLE, comparing atazanavir to lopinavir, was presented. Both protease inhibitors were boosted with ritonavir and the background treatment was abacavir and fixed dose tenofovir/emtricitabine. Atazanavir/ritonavir was found to be non-inferior to lopinavir/ritonavir in the capsule formulation but atazanavir takers had much better lipid profiles and suffered fewer gastrointestinal problems than people taking lopinavir.

Interestingly, the study found that those patients taking lopinavir experienced viral load decreases proportionate to their CD4 count when treatment was commenced, i.e. the higher the CD4 count, the lower the viral load drop. Conversely, patients taking atazanavir experienced a viral load response which was the same regardless of their baseline CD4 count at the initiation of treatment.

Abbott reported a study concluding that that once daily dosing of the protease inhibitor Kaletra (lopinavir/ritonavir) plus tenofovir/emtricitabine is as effective at viral control as a twice-daily dose.

The protease inhibitor darunavir/ritonavir is also reported to be safe and effective taken once daily at 800/100 mg. This may help people to improve adherence.



## NEW THERAPIES FOR TREATMENT EXPERIENCED PATIENTS

Resistance develops over time with HIV drugs generally and it is rare for anyone to stay on only one treatment regimen his/her entire life. Luckily, new drugs have been discovered that allow us to make the necessary changes.

A study across the U.S. and Canada of treatment failures in the years after triple therapy was introduced in 1996/7 was reported at CROI. CCR5 antagonists and integrase inhibitors were not included as they were not available. It showed that higher viral loads and lower CD4s and the incidence of clinical AIDS at the point of second failure independently increased the risk of death from AIDS. CD4 counts lower than 200 coincided with an 81% increase in mortality rate, and a viral load of between 10,000 and 100,000 accompanied an increase in mortality rates of more than 29%.

Thus it is very important to address second virological failures quickly, particularly in people with low CD4s, high viral loads and clinical AIDS.

### CCR5 ANTAGONISTS

CCR5 antagonists are definitely very important to treatment-experienced patients. They appear to boost CD4s more than any other new antivirals, independent of their effect on viral load, according to researchers from Cornell and Harvard universities.

CCR5 antagonist maraviroc, or Celsentri, was reported in the MOTIVATE 1 and 2 studies of treatment-experienced HIV+ people with R5 virus when taken with an optimized background treatment (OBT) of other HAART drugs. It was well tolerated at 48 weeks and showed sustained antiretroviral efficacy. Note that investigational drugs darunavir, etravirine and raltegravir were not part of OBT.

One safety issue with maraviroc is the possibility of liver toxicity in some people. If, after taking this drug, you get symptoms of allergic reaction including itchy rash and white blood cell abnormalities, see your doctor immediately.

The CCR5 antagonist vicriviroc also demonstrated potent and sustained viral suppression at 48 weeks with an OBT in treatment-experienced patients, as compared to those patients taking OBT alone. There was both a decrease

in viral load and higher CD4 cells generally in the patients in the vicriviroc arm of the study.

The first small study of vicriviroc to include coinfecting patients was reported. Although no meaningful clinical changes in HCV viral load were noted, the drug was safe and well tolerated with OBT for 28 days.

The results of research concerning several second-generation CCR5 antagonists were also reported, including PF-232,798 and SCH 532706. Both look promising in Phase 1 trials of healthy volunteers.

### INTEGRASE INHIBITORS

The new class of integrase drugs continues to show success. Raltegravir, or Isentress, in combination with other anti-viral medications, maintains significant viral load reductions and CD4 cell increases. Of course, combining these treatments with other HIV drugs to which one is sensitive increases these favourable results.

### NNRTIS

Etravirine, a second-generation non-nucleoside (NNRTI), also called Intelence, was compared to placebo in people starting the protease inhibitor darunavir as background therapy of a salvage regimen. At 48 weeks, this study, called DUET-1 and DUET-2, showed that 61% of those in the etravirine arm had viral load below 50. Adding first time enfuvirtide further helped suppression of the virus. Not being resistant to darunavir and adding more active drugs also helped.

The only reported difference in side effects was more rashes experienced by trial participants in the etravirine arm of the trial. This trial continues to 96 weeks. One serious safety problem with etravirine, found in < 0.1 cases, is a life threatening rash called Stevens-Johnson Syndrome. Get to a doctor immediately if you suspect it. Treatment must stop immediately if this is diagnosed.

This drug was also studied in a pediatric context with a sample group of treatment-experienced children from 6 to 17 years old. It was safe and effective following a meal at 4 mg/kg twice daily, as compared to 200mg twice daily, the prescribed dose for adults.

*continued on page 10*

## Formularies Series:

# Aboriginal Formulary



*by Sandy Lambert, CTAC Aboriginal Representative and Board Member*

**T**HE Federal Aboriginal Formulary is run by Non Insured Health Benefits (NIHB), a national health benefit program. The program covers some or all of the costs of medical, dental and pharmacy service that eligible First Nations and Inuit people may need. If the provincial or territorial Medical Service Plan or other third party insurance health plans apply, NIHB will cover the costs of necessary prescription medicine.

### Non Insured Health Benefits

To be eligible, a recipient must be a resident of Canada as well as being:

- A registered Indian according to the Indian Act,
- An Innu member of one of the two Innu communities in Labrador (Davis Inlet and Sheshatshiu),

Illustration: "Wind", by Joe Wilson.  
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- An Inuk recognized by one of the Inuit Land Claim organizations, or
- An infant under the age of one, whose parents are eligible

The NIHB program helps First Nations and Inuit people to access medical care which is at a par with other Canadians. The program helps to maintain health, prevent disease, and detect and manage illness, injuries, and disabilities. Eligible individuals must apply to a regional office of NIHB to receive assistance. Locations of these offices can be found at [www.hc-sc.gc.ca/fnihb/nihb/index.htm](http://www.hc-sc.gc.ca/fnihb/nihb/index.htm). The NIHB does not cover the cost of surgical procedures as this is provided by provincial and territorial health authorities across Canada.

The policy of Health Canada's NIHB drug program for First Nations and Inuit is to have all provincial drug plans provide generic drugs. Most generic drugs in Canada have been researched and produced in Canada. When brand name and generic drugs have the same ingredients, NIHB will pay for the lower cost drug, which is usually the generic drug. If, for any reason, a patient requires or needs to use the brand name drug then the patient is required to pay the difference in the cost of the brand name drug versus the generic drug. In very rare cases, a doctor may find that one particular brand name drug should be used for the individual. If that is the case, the NIHB will evaluate the request from the physician and, if it is approved, will pay for that drug.

All drugs approved for coverage by NIHB are listed on the Drug Benefit List. The list is decided upon once a year with updates every three months. The complete list of benefits and policies can be found at [www.hc-sc.gc.ca/fnihb/nihb](http://www.hc-sc.gc.ca/fnihb/nihb). Drugs that are not approved on the formulary are looked at on a case by case basis for exceptional needs. These products may be recommended as "limited use benefits" and have special requirements for use. There are two types of limited use benefits:

1. Multivitamins up to the age of 6 and prenatal or postnatal vitamins which benefit women who are



pregnant or breastfeeding between the ages of 12 and 50 years.

2. Limited use benefits which require a physician's recommendation (using Exceptional/Limited Use Drug Request Form).

### Reimbursement Process

The process for reimbursement or approval for ARVs/HAART medication throughout Canada (except for patients that reside close to BC Centre for Excellence at St. Paul's hospital) is as follows:

- After the patient receives the prescription from his/her physician, they take it to pharmacy.
- The pharmacist telephones NIHB Drug Exception Centre and provides their agent with client information, benefit information and costs.
- NIHB reviews and determines eligibility according to their guidelines.
- If the prescription is a request for drugs not on the formulary, the NIHB asks that the physician to complete a form outlining the medical requirements for the drug.
- If necessary, the request will be forwarded to a medical consultant for another professional opinion.
- The NIHB Drug Exception Centre will provide the pharmacy with prior approval details by telephone.
- Once approved, the patient will receive the requested medication.
- The pharmacist then submits a claim to the claims payer.

### De-Insurance of Provincially Insured Services

From time to time provinces may de-insure a health benefit. When de-insurance occurs, a determination will be made by the First Nations Inuit Health agency as to whether the benefit will be included in the services provided by the FNIH.

### Barriers Which May Prevent Access to Drugs

Many Aboriginal HIV/AIDS (APHAs) patients face barriers that prevent them from accessing the drugs they need. Some of these barriers are:

- The social determinates of health such as urban or rural community issues, drug use, alcohol abuse, methadone dependency, housing issues, water supply, poverty

affecting quality of food, family dysfunction

- The difficulty of accessing a doctor due to there being no transportation to the central clinic
- The stigma and discrimination related to this disease, causing the patient to feel shame
- The difficulty of confidentiality within the patient's rural community (gossip)
- Access to doctors that are often present at the clinic only once to twice weekly
- The weather conditions that may cause delay in receiving ARVs in remote areas
- There is not enough information available regarding ARVs/HAART
- The side effects are difficult to cope with and control; they are sometimes worse than the disease
- The lack of support once a person is on medication and experiencing side effects—often due to the lack of education of side effects within communities
- The persistence of harmful myths about HIV/AIDS
- The lack of funding to provide education within the community (most bands only receive \$500-\$1,000 for their HIV/AIDS portfolio)

### Access to Drugs in British Columbia

ARVs/HAART drugs are available to urban and rural Aboriginals within British Columbia. Funding for the BC Centre for Excellence in HIV/AIDS at St. Paul's Hospital is provided by the BC Ministry of Health through Pharmacare and the Provincial Health Authority. ARVs/HAART drugs are either couriered or mailed to satellite pharmacies or doctors' offices within British Columbia. The ARVs that are available through this program are too extensive to list but can be found at the BC Centre For Excellence in HIV/AIDS website, [www.cfenet.ubc.ca](http://www.cfenet.ubc.ca), by clicking on Drug Treatment Program. Treaty (Status) Indians who live in British Columbia are able to access all drugs listed on the website. ■

For more information about  
CTAC, please visit us at...

[www.ctac.ca](http://www.ctac.ca)

**H**aving spent the past few years researching, attending many Aboriginal and non-Aboriginal conferences across Canada, and taking part in many discussions, I am a bit miffed that in the year 2008, First Nations, Inuit, and Metis populations continue to be recognized as third class citizens within our Provincial and Federal health care system. HIV/AIDS is growing rapidly on a daily basis on and off reserve. I believe Aboriginals have done a full circle from smallpox to HIV/AIDS.

Budget cuts are not helping the situation, resulting in closures of Aboriginal AIDS service organizations and AIDS service organizations from coast to coast. The lack of awareness materials, treatment information, prevention, harm reduction programs, counsel and support and other necessary services for rural Aboriginal populations needs to be addressed. Thus we need to empower the Assembly of First Nations (Chiefs) to continue to make strong recommendations to policy makers to increase and continue funding. Our leaders also need to make sure that HIV/AIDS stigma and discrimination be abolished completely, on and off reserve. Breaches of confidentiality by health care workers and band managers does not make it easy for an Aboriginal person living with AIDS to access treatment without encountering stigma and discrimination from relatives, friends and neighbors. For instance, if a person needs to travel to and from the reserve they must contact the band manager or health clinic for authorization which would possibly come from a family member or friend.

FNIB (non-insured health benefits) provide the necessary drugs to status Indians in Canada, and at St. Paul's Hospital the BC Centre for Excellence

## *On a personal note...*



*Anonymous*

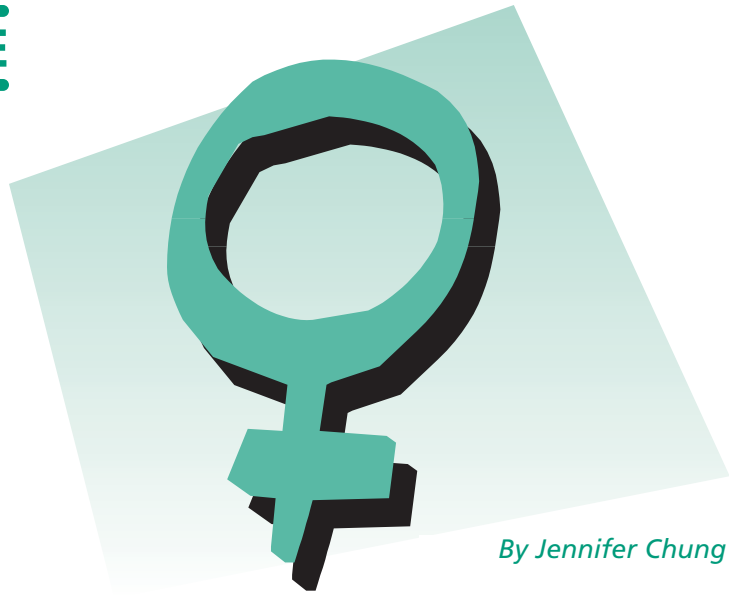
(CfE) provides British Columbia residents with the necessary HAART/ARV medications to increase an individual's CD4 count and lower their viral load. Regarding non-insured health benefits, the list for pharmaceutical drugs is thirty pages long. However, more needs to be done. It should be standard practice to for the CfE to provide Aboriginals living with AIDS with consistent treatment for side effects on and off reserve.

For on reserve HIV/AIDS patients, treatment becomes more difficult as they must wait to see a doctor that only comes into the community once or twice a week. Adherence can be a problem as trying to get medication to on reserve patients causes disruption in their treatment; remote locations and weather conditions can mean inaccessibility for vehicles and planes. The Aboriginal communities are starting to work with the non aboriginal world and this is important in order to get the knowledge and support they need.

I feel much more work and time needs to be invested in the First Nations communities, rural and urban, for healthier Canadians. Just over 60% of Aboriginals find themselves leaving the reserves for a better lifestyle, health services, housing, and education where only four per cent of the population are Aboriginal. Just a reminder for those who have forgotten that health, education, and housing are treaty rights: no First Nation person in Canada should live without the everyday necessities of life. ■

## WOMEN'S ISSUES: UPDATE

# Women highlighted in new Canadian HIV Trials Network study



*By Jennifer Chung*

**W**OMEN make up more than 40 per cent of all HIV cases globally and 27 per cent of new cases in Canada. While the number of women living with HIV continues to climb worldwide, little research is available on the way the virus and HIV drugs affect women differently than men. To generate more evidence for this field of research, Dr. Mona Loutfy of the Women's College Research Institute in Toronto is spearheading a new study supported by the Canadian HIV Trials Network (CTN) to observe HIV-positive women on combination antiretroviral therapy (CTN 233).

"Understanding the reasons for the differences of adverse events between HIV-positive men and women is critical and needs to be evaluated within a large cohort. We don't know whether these differences relate to hormonal influences, drug metabolism, adherence, fat distribution, or other factors," says Loutfy.

CTN 233 will investigate whether antiretroviral drug levels are associated with body weight in women, as well as higher frequency and severity of adverse events such as nausea, diarrhea, liver toxicity and lipodystrophy. In addition, the study will examine how anti-HIV drugs are processed in the body and whether drug levels are higher in women compared to men—with information regarding HIV-positive men obtained from historical data.

Studies examining drug levels and adverse events in women remain a relatively new area of research. Loutfy says the findings from her study could help guide treatment for HIV-positive women, resulting in better care and more

knowledge on issues like side effects and drug levels.

According to Loutfy, when HIV clinical trials began in the 1990s, women were excluded due to concerns over pregnancy and lactation. However, over the past decade, more women have become infected with HIV—increasing the need to understand how antiretroviral drugs affect this group.

"It has only been in the past five years that women have been properly represented in trials, meaning that 20 to 30 per cent of trial participants should be women to match the epidemiology," says Loutfy.

Enrolment of women in clinical trials continues to be a challenge for a number of reasons. For instance, women tend to be primary caregivers and have childcare responsibilities, making it difficult for them to attend clinic and follow-up visits regularly. This study is unique because it attempts to address these issues through higher reimbursement fees for participants and the inclusion of AIDS service organizations (ASOs) in trial recruitment.

"The higher reimbursement fee is being provided with the understanding that women may have more of a financial burden to participate in clinical trials because of responsibilities like childcare," Loutfy explains. "Working with ASOs like Voices for Positive Women based in Toronto and other community health centres that work with women is effective because, if there is one woman that can advocate for your trial and the researcher, it may encourage others to participate because women tend to listen to their peers."



Louise Binder, a member of the CTN's Community Advisory Committee which reviewed and approved the study protocol, feels this study will provide much-needed data on HIV drugs and women.

"This study will help fill some gaps in the information available about how women metabolize HIV drugs in the body," says Binder. "There are few pharmacokinetic studies that involve women only and we are very glad that Dr. Loutfy is investigating this area further."

CTN 233 is looking to enroll 80 participants across Canada at 15 sites in Hamilton, Montreal, Ottawa, Quebec City, Toronto, Halifax, Windsor, and Vancouver. ■

**For more information about this trial and other CTN studies, please visit [www.hivnet.ubc.ca](http://www.hivnet.ubc.ca) or call 1-800-661-4664.**

## ENROLLING CTN TRIALS

### CTN 233 – Pharmacokinetics of antiretroviral therapy (ARV) in HIV-positive women

#### Study sites:

- |           |  |
|-----------|--|
| Halifax   | • Dalhousie University   |
| Ste-Foy   | • Centre hospitalier de Québec–<br>Pavillon CHUL   |
| Montreal  | • Montreal Chest/Royal Victoria Hospital<br>• CHUM–Notre-Dame Hospital   |
| Ottawa    | • University of Ottawa Health Services<br>• Ottawa Health Research Institute   |
| Toronto   | • Maple Leaf Clinic<br>• Toronto General Hospital<br>• St. Michael's Hospital<br>• Sunnybrook Health Sciences Centre |
| Hamilton  | • McMaster University Medical Centre   |
| Windsor   | • Windsor Regional Hospital  |
| Vancouver | • Children's and Women's Hospital<br>• St. Paul's Hospital<br>• Downtown Infectious Diseases Clinic                  |

### CTN 227 – Hepatitis C therapeutic vaccine

#### Study sites:

- |          |                            |
|----------|----------------------------|
| Montreal | • Hôpital St-Luc           |
| Toronto  | • Toronto Western Hospital |

### CTN 222 – Canadian co-infection cohort

#### Study sites:

- |           |   |
|-----------|---|
| Halifax   | • Capital District Health Authority   |
| Montreal  | • Montreal Chest Institute/<br>Royal Victoria Hospital<br>• Clinique du Quartier Latin<br>• Montreal General Hospital<br>• CHUM – Notre-Dame Hospital |
| Ottawa    | • Ottawa General Hospital   |
| Toronto   | • Toronto General Hospital  |
| Hamilton  | • McMaster University   |
| Sudbury   | • HAVEN Program   |
| Calgary   | • Southern Alberta HIV Clinic   |
| Vancouver | • Downtown IDC<br>• St. Paul's Hospital   |

### CTN 218 – Effect of rosuvastatin (Crestor®) on blood vessels

#### Study sites:

- |          |   |
|----------|---|
| Montreal | • Montreal Chest/Royal Victoria Hospital<br>• Clinique médicale L'Actuel              |
| Ottawa   | • University of Ottawa Health Service   |
| Toronto  | • St. Michael's Hospital<br>• Toronto Western Hospital<br>• Maple Leaf Medical Clinic |



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**CTN 218 – continued**

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- |           |                               |
|-----------|-------------------------------|
| Hamilton  | • McMaster University         |
| Calgary   | • Southern Alberta HIV Clinic |
| Vancouver | • St. Paul's Hospital         |

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**CTN 216 – Argon Plasma Coagulation for Anal Dysplasia in MSM**

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**Study sites:**

- |          |  |
|----------|--|
| Montreal | • Notre-Dame Hospital                                  |
|          | • Montreal Chest Institute/<br>Royal Victoria Hospital |

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**CTN 214 – Effect of a One-Year Course of HAART in Acute/Early HIV**

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**Study sites:**

- |           |                                       |
|-----------|---------------------------------------|
| Toronto   | • Sunnybrook Health Sciences Centre   |
| Victoria  | • Cool Aid Community Health Centre    |
| Vancouver | • Downtown Infectious Diseases Clinic |

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**CTN 210 – Effects of Bodybuilding on Abdominal Fat**

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**Study site:**

- |          |              |
|----------|--------------|
| Montreal | • Hôtel-Dieu |
|----------|--------------|

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**CTN 208 – HAART alone or with Remune Vaccine followed by STI in early HIV infection / observation of recent HIV infection**

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**Study sites:**

- |          |  |
|----------|--|
| Montreal | • Montreal Chest Institute/<br>Royal Victoria Hospital |
|----------|--|

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**CTN 198 – Supportive Therapy for Adherence to ART (STAART)**

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**Study sites:**

- |        |                   |
|--------|-------------------|
| Ottawa | • Ottawa Hospital |
|--------|-------------------|

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**CTN 194 – Peg-Interferon and Citalopram in Co-infection (PICCO)**

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**Study sites:**

- |            |  |
|------------|--|
| Sherbrooke | • Centre hospitalier universitaire de Sherbrooke       |
| Montreal   | • Montreal Chest Institute/<br>Royal Victoria Hospital |
|            | • Notre Dame Hospital                                  |
|            | • Montreal General                                     |
| Ottawa     | • Ottawa General                                       |
| Toronto    | • Toronto General                                      |
| Hamilton   | • McMaster University                                  |
| Winnipeg   | • St. Boniface General Hospital                        |
| Vancouver  | • St. Paul's Hospital                                  |
|            | • Downtown Infectious Diseases Clinic ■                |

## We want to know what you think!

As part of a National Policy Development and Capacity Building Project, CTAC has been involved in work in four areas in the past year:

1. International policy/women's issues
2. Hepatitis C/HIV co-infection issues
3. Post Approval Surveillance System cross-disabilities issues
4. Cost containment/treatment barrier issues

To assist us in an evaluation of this work, we invite CTAC members and newsletter readers to complete a brief survey.

The survey should take about 5-10 minutes to complete and responses will be completely anonymous.

[www.ctac.ca/en/survey](http://www.ctac.ca/en/survey)

**CROI Report: April 2008***continued from page 3***SIDE EFFECTS AND TOXICITIES**

At the Conference, the big news on this front was the relationship between the nucleoside drug abacavir and the risk of heart attack. According to findings in a cohort study, Abacavir increased the risk of myocardial infarction (MI) by 90%, ddi by 49%, and AZT and d4T not at all. There has been much debate about these findings and there is definitely much more research that is needed to prove this finding true. There were lots of things about the study that need further analysis. Before you make any decision to discontinue abacavir because of this one study please have a talk with your doctor and read what has been written about the study including Jules Levin's analysis of questions about the results at [www.natap.org](http://www.natap.org). The manufacturer GlaxoSmithKline is also doing further in depth analysis of this issue. Their representative would certainly be willing to talk to community members about it.

Also of interest to us is the study that showed that having the HLA-B\*5701 allele is strongly associated with abacavir hypersensitivity. A simple blood test will determine if this is the case for you.

Another major problem associated with the drug is lipoatrophy or fat loss. A study reported at CROI concluded that the nucleoside-sparing regimens had the least

lipoatrophy and that race/ethnicity is not associated with lipoatrophy. Lipoatrophy was associated with male gender, having been diagnosed with AIDS at baseline, lower extremity fat measured at baseline, lower cholesterol and LDL gains at 12 weeks, higher baseline CD4s, and less body weight and trunk fat.

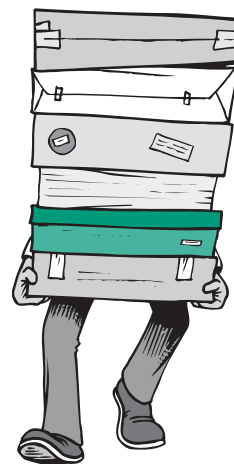
Another problem is atherosclerosis, the abnormal thickening and loss of elasticity in the artery walls. One study found that HIV itself and the length of time on HIV drugs were independently associated with this form of cardiovascular disease which may cause heart problems. Higher risk was associated with older age, wider waist, higher total and LDL cholesterol, prior coronary artery disease, hypertension, higher glucose, longer HIV duration, and length of time on antiretroviral therapy.

**CONCLUSION**

The news is generally favourable in terms of drug options for HIV+ people but we continue to face the reality that these drugs do not come without risks which are, for some people, as serious as the disease itself. Prices continue to climb for these new treatments and most will not become readily available worldwide for some time, if at all. ■

***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](mailto:ctac@ctac.ca), phone or fax at (416) 410-6538.



## CHAIR'S REPORT

Spring 2008

by Louise Binder

**I HAVE BEEN DOING** more international work lately. I thought that in Canada we are so far ahead that more of us could direct our attention elsewhere. I have seen hungry people with HIV in Rwanda and tortured and raped women in the Congo. I have seen impoverished people in India living in shanty towns and Sri Lankans in the midst of a civil war and an early monsoon season that was ruining their source of livelihood, the rice crop.

There is no doubt of the tragedies unfolding all around us in other countries. And yet, as I read this issue and as I remember my visits to the downtown eastside in Vancouver, the prison visit I once made and the stories of so many women in our home and native land, I realize that Canada has more in common with these places than it has differences.

In my view that commonality is brought about by the action of the two main levers of power throughout the world: social position and wealth. I have hoped that by educating those with power about the lives of those of us who do not hold it, they would see that we are not dissimilar; that drug use, alcoholism, poverty, and poor mental and physical health are not lifestyle choices but symptoms of, and responses to, deep rooted societal injustice and personal tragedy.

I no longer believe that it is ignorance of these facts that creates stigma and motivates discrimination in all its guises. Evidence is available for the privileged to see and they are well-schooled enough to understand it. Rather I conclude that they do not want to understand it. They do not want to make room for us at the table. It would require sharing power and this they are unwilling to do. Power will only come to us when we join together in common cause and say, "No". No, we will not run the engines of your society without a seat at the table and with all that that implies, including good health, education, housing and the other determinants of health. ■

## CALENDAR OF EVENTS

SPRING/SUMMER 2008

### ► JUNE

**2008 High-Level Meeting on AIDS . . . . . 10 & 11**  
New York, New York  
United Nations Headquarters  
[www.unaids.org/fr/Conferences/2008HLM/default.asp](http://www.unaids.org/fr/Conferences/2008HLM/default.asp)

**2008 People Living with HIV/AIDS . . . . . 12-15**  
**Forum and Canadian AIDS Society**  
**Annual General Meeting**  
Ottawa, Ontario  
Delta Hotel & Suites  
Contact : Sarah Tremblay  
(613) 230-3580 ext. 110

**2008 Annual General Meeting and . . . . . 16 & 17**  
**Workshop & Consultation of the Canadian**  
**HIV/AIDS Legal Network (Legal Network),**  
**the Canadian Working Group on HIV and**  
**Rehabilitation (CWGHR) and the Interagency**  
**Coalition on AIDS and Development (ICAD)**  
Ottawa, Ontario  
[www.aidslaw.ca/agm](http://www.aidslaw.ca/agm)

### ► AUGUST

**XVII International AIDS Conferences . . . . . 3-8**  
Mexico City, Mexico  
[www.aids2008.org](http://www.aids2008.org)

**BCPWA AGM . . . . . 23**  
Vancouver, British Columbia  
Best Western Chateau Granville  
1100 Granville Street  
Contact : Ken Buchanan  
[kenb@bcpwa.ca](mailto:kenb@bcpwa.ca)  
(604) 646-5345

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## CTAC POSITION PAPERS

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

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## MEMBERSHIP

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

### Canadian Treatment Action Council (CTAC)

P.O. Box 203  
 555 Richmond St. W., Suite 1109B  
 Toronto, Ontario M5V 3B1

**Phone and Fax:** (416) 410-6538  
**Email:** [ctac@ctac.ca](mailto:ctac@ctac.ca)  
**Website:** [www.ctac.ca](http://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.

position\_papers or on hard copy from the CTAC office (see contact information below).

## PUBLICATION

**This newsletter is a quarterly publication.**

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