

CANADIAN TREATMENT ACTION COUNCIL



Canadian Treatment Action Council

INSIDE
FALL 2007
VOLUME 9
ISSUE 4

Liver Transplantation For
HIV-Positive Patients 1

HCV/HIV Co-infection: from the
Abyss toward Hope 3

HBV/HIV Co-infection
and Treatment 5

Women's Issues:
International YWCA Conference:
Platform for Change 6

Sydney Community Statement. . . 7

Progressive Licensing Framework:
Cradle to Grave Drug
Management 8

Chair's Report 11

Calendar of Events. 11

Board and Council Members . . 12



Liver Transplantation For HIV-Positive Patients

By James Kreppner, CTAC Council

BACKGROUND

The subject of transplantation in the HIV-positive has been a source of some discussion. Some transplant surgeons are willing to do kidneys, but to date in Canada, livers have been off the plate. This is particularly concerning as at least a third of HIV-positive individuals are coinfecting with Hepatitis C, which can cause the liver to progress toward failure. Additionally, many HIV medications also have hepatic consequences, and there have been reports of problems arising from those sources alone.

In any case, transplant surgeons have been reluctant to do liver transplants in the HIV-positive. At first, the concern was that it was "experimental", then it was "is there really a need?", and now it is "what if we get infected with HIV — will we be covered by insurance to maintain the income level that we currently have?" On the first point, it is not experimental; the San Francisco transplant team that the Ministry of Health invited to present in Toronto made this perfectly clear (even private insurance companies are paying in California). Secondly, there is definitely



a "need", and the doctors saying this have said they haven't been getting referrals because referring physicians know that the transplant will not be done. In any case, it is now accepted that there is a need.

The final concern is a potential needle stick injury, and having financial protection with respect to contracting HIV. Liver surgery is a messy business with a lot of blood everywhere, and I do understand the concern. However, before I delve into this, I will just make three points:

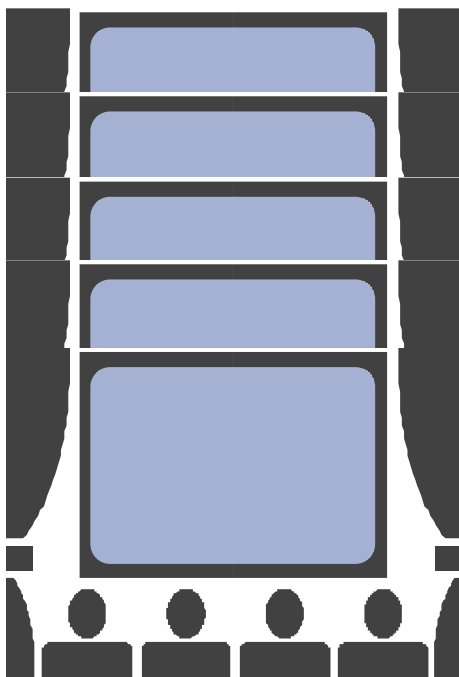
- 1) The transplant patients are supposed to have undetectable HIV viral load.
- 2) Post Exposure Prophylaxis exists.
- 3) The risk of acquiring HCV from a needle stick is much greater than any HIV risk, and surgeons presently get no additional insurance for that risk.

That being said, if the surgeons want the extra financial protection, let's just give it to them. I hope no one ever collects and, certainly, the American experience indicates that the risk may be overblown. American surgeons do not have extra insurance and they have had no instances of infection in their HIV-positive transplant program. However, this should not be a sticking point, and I fully support the extra insurance here in Canada, if it reassures the surgeons.

... at least a third of HIV-positive individuals are coinfecting with Hepatitis C... Additionally, many HIV medications also have hepatic consequences...

WHERE WE ARE IN ONTARIO

The Ontario Ministry of Health AIDS Bureau has been very supportive on this issue, and there is a subcommittee, on which I sit, which meets regularly to advance the case for liver transplantation for the HIV-positive. While the Ontario Health Insurance Plan (OHIP) will make no commitments, just a case by case analysis, there is now a general recognition that this surgery is no longer experimental. Ideally, we would like to see a team set up by the University Health Network (UHN) to undertake liver transplants in the HIV-positive. We do understand that this is a stepwise process, so the idea is to send the first three or so cases to the U.S. at OHIP's expense, and then have them return to UHN for their post-transplant monitoring. As UHN becomes more comfortable, they can proceed to the transplantation process after resolving the insurance issue. ■

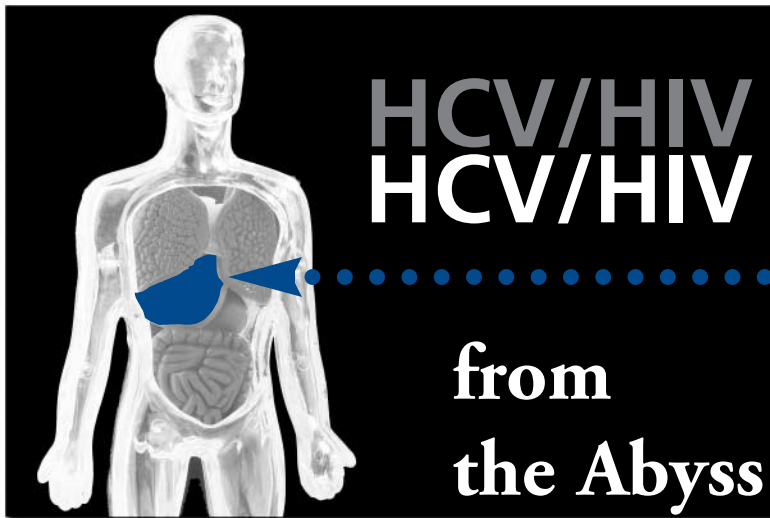


World AIDS Day

Documentary Premier Gala

Positive Voices Leading Together guides viewers through the personal experiences of five Ontario community leaders living with HIV. The OHTN, CTAC, ACT, OAN and 2-Spirited People of the First Nations will co-sponsor this engaging and powerful World AIDS Day event. CTAC is also proud to see three of its members featured in this documentary.

7:00PM
Saturday December 1, 2007
The Bloor Cinema, Toronto



HCV/HIV HCV/HIV

Co-infection: Co-infection:

by Colleen Price, CTAC Board

from the Abyss toward Hope

Many years of advocacy work on HCV/HIV co-infection finally appear to be bearing some fruit. At long last, there is a concentrated effort under way to address gaps in research, policy, program and support services for people living with HCV/HIV.

Reminiscent of the early days of the AIDS epidemic, the response to HCV/HIV co-infection has been hampered by a lack of a coordinated multi-level response. There is still a lingering debate over whether there should be discrete funding for HCV/HIV co-infection rather than trying to secure funding for a strategy from HIV or HCV funding. This has complicated the issues of who is responsible and how best to respond.

The current Hepatitis C strategy and infrastructure do little to support co-infected individuals. It has fallen to AIDS service organizations (ASOs) to respond and that is primarily where we have seen progress being made in the areas of prevention, care, treatment and support. On April 16, 2007 a group of people living with HCV/HIV co-infection, federal and provincial government officials, physicians, researchers, and front-line support workers from ASOs met to share knowledge and expertise, make recommendations regarding care, treatment and support, and influence policy and practice.

“Towards Greater Integration: A Think Tank on Hepatitis C and HIV Co-infection in Ontario” was sponsored by the Ontario HIV Treatment Network, the Canadian Treatment Action Council, the Hepatitis C Secretariat and the AIDS Bureau of the Ontario Ministry of Health and Long Term Care. Recommendations from the think tank will go forward thanks to the Ontario HIV/HCV Task Force that emerged from

it. The task force will address the grey area that HCV/HIV co-infection has existed in for far too long.

Key recommendations include:

- Ontario needs a more integrated approach to managing HIV/HCV co-infection.
- More must be done to educate health care providers—physicians, nurses, social workers, psychiatrists, infectious disease specialists and hepatologists—as well as people living with HIV/HCV about treatment options.
- Policy changes can help reduce systemic barriers to treatment.
- Accessible harm reduction approaches and programs are essential to prevent HIV/HCV co-infection.
- Hepatitis C-specific and HIV/HCV co-infection services need dedicated and sustained funding.
- Approaches that understand the social determinants of health are essential to improving health outcomes for people living with HIV and/or Hepatitis C.
- Surveillance systems must be improved to capture and monitor the incidence and prevalence of Hep C and HIV/HCV co-infection across the province.
- More research is needed on prevention, care and support for people living with HCV/HIV.
- People living with HCV/HIV must be actively involved in shaping programs and services.
- Peer support must be a central component of an integrated care model.

The Ontario HIV/HCV Co-infection Task Force will review the above recommendations and develop an action plan to



address the issues identified and set priorities. The proposed mandate of the provincial task force will be to:

- provide leadership in addressing gaps in research, policy and practice for the provision of effective care and support for people living with HCV/HIV in Ontario;
- identify the main issues in consultation with relevant stakeholders;
- promote strategic partnerships to facilitate communication, collaboration, integration and knowledge transfer and exchange.

As a member of the task force I look forward to participating with others living with HCV/HIV, Hepatitis C and HIV organizations, government and researchers to advance HCV/HIV co-infection initiatives that will positively impact the care, treatment and support of people living with HCV/HIV in Ontario and beyond.

There will be many challenges to overcome. Prime Minister Steven Harper's U.S.-style anti-drug strategy is regressive. Recent funding cuts to harm reduction supplies and programs will only translate into increased incidence of HCV/HIV co-infection, sexually transmitted infections (STIs) or re-infection. As people living with HCV/HIV are at the highest risk of mental health, addiction or concurrent disorders, harm reduction supplies and programs are essential tools for both prevention and intervention. Harm reduction strategies remain the best way to reduce barriers to treatment not just for the viruses, but for other concurrent issues.

Everyone deserves the right to treatment, care and support. It is therefore imperative that harm reduction supplies and programs be increased, not decreased. Research shows that addicts have similar treatment outcomes to non-addicts when they are placed within a multi-disciplinary setting encouraging harm reduction practices and adherence to medications. However, there still remains a resistance to treating addicts, as the cost of a course of HCV treatment is about \$30,000 and there is no research regarding re-infection. More research is needed to show that ensuring access to treatment for addicts is good public health policy.

Harm and risk reduction programs need to be protected from governments promoting abstinence and rehabilitation programs. Recently, I wrote to Ontario's Minister of Health George Smitherman, Mayor of Ottawa Larry O'Brien, and

Ottawa city councillors protesting the funding cuts for "Safer Crack Initiatives" which cost approximately \$7,500 in 2006. (Ottawa is one of the few cities in Canada whose city council also functions as a Board of Health.)

The decision by Ottawa's city council to cease funding for safer "crack-kits", stems and other supplies proven effective in prevention and intervention for Hepatitis C, HIV and STIs is not good public health policy. Vancouver, Winnipeg, Toronto, Montréal, Guelph and Halifax have all included these supplies as part of their needle exchange programs. Ottawa city council's decision effectively blocks an entry point for prevention and intervention from front-line workers for some of Canada's most vulnerable people. Without client engagement, outreach and clinical services, individuals will not have harm reduction strategies in place to prevent them from being infected, re-infected or transmitting their infection to others. Equally worrisome is the lack of an independent Board of Public Health in Ottawa which has allowed city council to make a political decision instead of relying on the advice of public health experts.

InSite, Canada's only safe injection site located in Vancouver, faced closure on December 31, 2007 unless the government renewed funding and further extended the Health Canada exemption under the Controlled Drugs and Substance Act. A six month reprieve was just recently granted to June, 2008.

While the think tank has been a catalyst for HIV/HCV co-infection initiatives, one of the greatest challenges remains overcoming regressive government policies that are already impacting funding for well-researched harm and risk reduction strategies.

CTAC is dedicated to the protection of these hard fought gains by ensuring access to integrated models of treatment for everyone who is co-infected with Hepatitis C and HIV. ■

Visit us at
www.ctac.ca

HBV / HIV Co-infection and Treatment

On a personal note... 

THE TREATMENT OF HEPATITIS B is often either overlooked or dismissed as a priority for individuals co-infected with HIV. In the recent past, the common HBV treatment was Interferon, which was generally considered inappropriate for people living with HIV/AIDS. The paucity of treatment options shifted the focus away from HBV treatment towards HAART with the goal of CD4 count elevation or stabilization and viral load suppression. Tenofovir has been shown to be useful in HBV treatment, but is accessed as an HIV med, not as an HBV med.

For long-term survivors with untreated HBV, Hepatitis B viral loads should probably be monitored. Long-term chronic liver disease has the potential to impact health in any number of ways, especially in terms of cirrhosis of the liver. The pharmacokinetics of many HIV medications involves the processes of hepatic elimination and biotransformation. Liver cirrhosis can lead to an inability to metabolize dietary protein, causing intermediate nitrogen-containing metabolites of protein to build up in the bloodstream. Some of these metabolites are toxic to the brain. Additionally, the liver is one of the few organs in the body with the ability to grow new cells to replace damaged or dead cells. Cirrhosis represents regenerative defeat, as dead cells are replaced by scar tissue.

The drug Entecavir is sometimes used to treat HBV, but there are reports that for some co-infected individuals it appears to be linked with the development of resistance to some HAART meds. It seems that the HBV treatment drug of choice is Adefovir, but while this is covered by private drug plans, it is not accessible through the Ontario formulary. At approximately \$20 per capsule it is an unaffordable medication and therefore inaccessible for many people living with HIV/AIDS.

As a long-term survivor co-infected with HBV and HIV with an HBV viral load 100 times the HBV treatment threshold, I recognize that some of my general health symptoms may be related to untreated HBV. The treatment of HBV can no longer be overlooked or dismissed and must be included in the co-infected armamentarium. Formularies must reflect this reality. ■

Douglas Smith is a CTAC member, a planning committee member of Central West Opening Doors Counselling Conference, a member of the OAN PHA Forum, and is currently completing Addiction Studies at McMaster University.

dougsmithhamilton@hotmail.com

International YWCA Conference Platform for Change



*By Louise Binder,
Acting Chair, Voices
of Positive Women*

IN July, I joined a few Voices of Positive Women members to attend the first YWCA-sponsored *International Women's Summit on HIV/AIDS* in Nairobi, Kenya.

It was exciting to meet with 500 other HIV + women from around the world to tell our stories, discuss common issues and to attend workshops. These women were from many countries, from a wide array of cultures, religions and life experiences. Yet, as different as their personal stories were, the issues that arose were the same.

Women spoke about the need to get jobs in order to get out of poverty and to have control over their own lives. Many spoke of their inability to make decisions about safer sex practices and the violence and intimidation experienced in their personal relationships. Often, it was their male partner who had infected them and who had either abandoned them, blamed and abused them, or died. Money would give them power to get out of these situations.

Many spoke of their lack of property rights. In some countries they were not permitted to own or inherit property. Even where the law gives them this right, their relatives do not let them exercise it, if they even know it exists.

They talked about their desire for an education for themselves, and particularly for their girl children. However, many cannot afford the school fees and other costs so the girls are kept home to help their family members with housework and other chores. These women know that without education, their girls will be doomed to live the same lives as their mothers and be more susceptible to HIV than boys.

Of course, there was much talk about treatments. In some places, treatments are still not available. Where they are available, the choices are limited to non-nucleoside containing regimens (i.e. nevirapine or efavirenz) with nucleosides. Many women told of the side effect problems they have with the

drugs, including lipodystrophy, fatigue, depression, and nausea. They also talked about the lack of food which hampered their ability to take these drugs properly.

We all spoke of our concern about the lack of gynecological care for women. Cervical cancer is a major killer for HIV+ women, and could easily be prevented with early detection. Also sorely lacking are mental health services.

In fact, medical care of all types is a huge issue for women everywhere. Some must walk long distances to clinics that take only so many a day on a first-come, first-served basis. Many did not have the money or the time to go to access care, and some were refused the opportunity to get care by their partners.

The issue we spoke about most, though, was the terrible stigma we carry around because of the discrimination still faced by people with HIV everywhere. We agreed that in some cases this may be based on ignorance about the disease. However, we think it is mainly based on other factors, including the fact that we are women with a history of oppression. We all agreed that changing the power structure is critical to ending this epidemic the world over, and one way to effect this change is by gaining access to ways of making money.

Join us globally and make that happen. Start by signing the Call to Action and the Pledge developed at the conference. For more information, contact me at VOICES at 1-800-263-6961 or through CTAC (see page 12 for contact information). ■

Note: This article first appeared in *Voices of Positive Women's Newsletter*, August 2007.



Sydney Community Statement

The following statement was delivered at the closing session of the IVth International AIDS Conference in Sydney, Australia on July 25th, 2007.

Approximately 350 delegates who described themselves as "community" were in attendance.

The statement was co-authored by John Daye, Evan Collins, Frika Chia, Mauro Guarinieri and Ron Rosenes.

I am honoured to present the closing statement on behalf of the Community Advisory Group and grateful for all the input we have received from fellow community members attending the 4th IAS Conference here in Sydney.

With the introduction of new drugs (especially in new classes with improved efficacy, toxicity and resistance profiles), it has become evident that we need more studies to give us a clearer understanding of what is the optimal time to commence treatment through new randomized clinical trials. If the paradigm around when to begin treatment is shifting, we need to ensure it is based on sound evidence.

Significant improvements in treatment for people who are highly treatment experienced is welcome news at this conference. With access to new drugs and a rich pipeline it should now be possible for most people to reach and sustain undetectable viral loads. However, with these new drugs, it will be important to understand their place in treatment for those initiating therapy as well. We still have more to learn about when and where to use these new compounds.

We strongly support the protest of the Thai activists

against Abbott's hard stance on supplying Aluvia® (Kaletra tablets in North America) to Thailand because it reminds us that no matter how good our research is on new therapies, it will only be successful if these treatments can be accessed globally at affordable prices. One of the successes of this conference is that it has provided an opportunity for needed dialogue between community and industry. This dialogue is critical but must continue until people have access to medicines regardless of where they live. This will become an even greater challenge if antiretroviral guidelines are revised and treatment is recommended to start earlier.

We have been reminded at this conference that for every person who is put on treatment, there are six people who have become infected, and the fear is growing that, as some researchers have said, "we cannot treat our way out of the epidemic".

We heard time and time again in the prevention research track about the importance of community involvement in developing, implementing, monitoring and evaluating prevention research; but we still need to move

continued on page 10



Progressive Licensing Framework: Cradle to Grave Drug Management

By Louise Binder, Chair, CTAC

Bravo to Health Canada for taking a giant leap forward in the way this country manages therapies to be made available to Canadians. It is called “life-cycle” management and will be handled under the Progressive Licensing Framework. So what’s the big deal, and why do I believe this is going to be much better for people with HIV across the country?

Well, in order to understand this, we need to understand how the present system works. Basically, there are two solitudes in our present system. Before a drug is approved for sale in Canada, the data on the drug’s safety, efficacy, and quality must be reviewed. The two directorates responsible for reviewing drugs for approval are the Therapeutic Products Directorate and the Biologics and Genetic Therapies Directorate.

Health Canada either approves the drug for sale, giving it a Notice of Compliance (NOC); or gives the drug an approval on condition of further study data (NOC/C); or turns down the application giving the drug a Notice of Non-Compliance (NON). Health Canada sets guidelines for the time it will take for the review. If it is a fast-track review, i.e., for breakthrough drugs or drugs for unmet needs, Health Canada sets 180 days, and for

all other reviews, it sets 300 days. Part of the cost to do the reviews is paid from a federal government budget and the rest from fees from the applicant company.

When Health Canada approves a drug for sale, it does so on the basis of the safety and efficacy data obtained through clinical trials. Many people interpret this as a blanket seal of approval that the drugs are safe and effective for all people with the disease or condition for which it is made or, where appropriate, for the general population; for example, antibiotics, anti-fungals and pain killers. Of course, that is nonsense. Health Canada can never be expected to do that. Some people have individual allergies or intolerances to a drug; some experience side effects and toxicities that only show up long after a trial is complete. Besides, trials are not always done on all populations (or enough people in any one population) for side effects or toxicities to show up in that group. The same is true for efficacy. Thus, all that Health Canada can “certify” when it approves a drug for sale is that within the context of the clinical trial and any other data available to them, the drug is safe and effective.

Once the drug has been approved for sale, there are limited ways in which Health Canada can continue to receive information to monitor how the drug is affecting wider populations. The Marketed Health Products Directorate, which is responsible for post-market surveillance of drugs, takes in reports of adverse drug events from any source. Practically, they tend to come from the pharmaceutical



company and the doctors. Only the pharmaceutical company has the legal obligation to report serious adverse events; for example, life-threatening occurrences, deaths and seriously disabling events that put a person in the hospital. Doctors often do not report because they cannot tell which drug caused the problem and it is a time-consuming and unremunerated process. Thus, few of the many adverse events that people with HIV experience are ever reported to Health Canada, or, they are underrepresented. This means we have incomplete information on which to make our treatment decisions or to discuss problems with the pharmaceutical industry.

We know that trials cannot tell us everything. They are time limited and the number and populations in them are limited. Without an active, consumer-centred post market surveillance system for which CTAC has been advocating for a very long time, we cannot expect to learn what we need to know about the long-term safety and efficacy of the drugs.

Thus, we can see that our present system definitely has some gaps, both on the pre- and post-market sides.

Enter the Progressive Licensing Framework project presently being undertaken by the Therapeutic Products Directorate of Health Canada. The project is asking why and how this new approach to drug approval for sale and monitoring after sale will be different from the present "siloeed" system. Will it be better and, if so, why?

Progressive Licensing is proposing the adoption of a "life-cycle" approach to the regulation of each drug. Health Canada will develop a plan to follow the drug in a seamless fashion from the time the company first indicates an intention to do a clinical trial and seeks approval to sell a drug in Canada. Four of the key changes that are being considered in this framework are:

1. There will be a formalized pre-submission meeting process through which manufacturers can meet with Health Canada early in the drug development process to obtain scientific or regulatory advice, such as feed back on the target patient population.
2. Health Canada may request life-cycle management plans for certain types of drugs, which would consist of development, licensing, and post-licensing plans.

3. Public input into the decision-making process, such as those regarding licensing decisions and post-licensing activities will be more formally recognized and a structure created that will give patients opportunities to voice their perspectives.
4. Provisional licensing is being proposed as a replacement for the NOC/C process, and will formalize a licensing mechanism for drugs that have the potential to meet an unmet medical need. Provisional approval links the approval to certain conditions, such as to populations, to certain medical conditions or to a requirement for further information. This provisional licensing may or may not be removed in the future.

It has been argued that the Progressive Licensing Framework "lowers the bar" for approvals. This is not accurate. In fact, this process much more closely matches the reality of what clinical trial data supports. This ensures that people understand the limits of the safety and efficacy data that is collected prior to marketing. Health Canada has never been able to guarantee blanket safety and efficacy, so there will be no change in the thorough analysis it does of available data supporting the application. Health Canada will not be requiring any less data than in the past. So, there is no lowering of any substantive or procedural processes. In fact, it is an enhancement to the process by having a pre-submission meeting and a full work plan. It is also an improvement if it invites patients to participate by providing their evidence so that it can be incorporated into the decision-making process. It is a further improvement by looking at post-approval surveillance plans at the outset of the process rather than seeing it as a separate process, to be dealt with on an ad hoc basis as issues arise.

We applaud Health Canada for this bold move. We make the offer to be a "pilot" community to develop and refine this life-cycle approach, before it is rolled out to the entire population. We are, after all, the only disease and disability group that has done a post-approval research study, through CTAC, to determine the best methods of post-approval data collection.

We also urge the Minister of Health to champion the



Sydney Community Statement

continued from page 7

from rhetoric to reality. As Maura Mea said in her opening talk, we need to put into action the principle of "Talk with us, not about us".

With all the excitement around circumcision, we cannot forget that we have existing technologies and harm reduction interventions such as needle exchange that have been shown to be as good as, if not better than circumcision; yet, in many settings they have not been implemented, for lack of political will and policies driven by ideology instead of evidence. The time for pilot studies has passed. Implement them now!

We heard from Dr. Kevin De Cock of the World Health Organization that the need for Provider Initiated Opt-out Counselling and Testing trumps the critical issue of ongoing stigma and discrimination. This is not only naïve, it does not take into account that in countries where human rights are not protected this will inadvertently put peoples' lives at risk.

This is why we do not understand why bio-medical prevention research is presented in a vacuum at this conference. We need socio-behavioural research presented as well as prevention research in order to give us the full picture. You simply cannot separate prevention technologies from human behaviour.

This has been, from all accounts, a rewarding conference for community delegates. We can be proud of the

benchmarks we have set for community participation and engagement in the conference. In particular, I want to acknowledge the contribution of the Community Advisory Group, the activist liaison program, the Positive Lounge, the Local Engagement Tours and the Community Forum which allowed local community members to hear issues from the conference. Thanks go to the IAS team and to all of our volunteers for their support and we very much hope that we have set the bar high for future conferences.

Thank you.

John Daye, on behalf of the Community Advisory Group ■

Community Advisory Group

Frika Chia
Indonesia (co-chair)

Geoff Honnor
Australia

John Daye
Australia (co-chair)

Evan Collins
Canada

Rob Lake
Australia

**Community
Activist Liaison**

Maura Mea
Papua New Guinea

Ron Rosenes
Canada

Robert Baldwin
Australia

Mauro Guarinieri
Italy/Hungary



**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.

Progressive Licensing Framework

continued from page 9

Progressive Licensing Framework, to ensure that it is properly funded and to support a pilot project in the HIV community.

Write to tell Health Canada the Minister of Health, the Honourable Tony Clement, that you support the Progressive Licensing Framework and this pilot.

The Progressive Licensing Framework is an excellent step forward in drug approval and monitoring for the HIV community and, in my view, for Canadians generally. ■

CALENDAR OF EVENTS

SUMMER/FALL 2007

► OCTOBER

**National Pharmaceuticals Strategy18 & 19
(NPS) International Conference**

Toronto, Ontario

Contact: Nancy at 1-800-917-9489, ext. 201

► NOVEMBER

**14th Canadian Conference on4-7
International health (CCIH)**

Ottawa, Ontario

Contact: (613) 241-5785 x. 326
conference@csih.org

**First Canadian Roundtable on8 & 9
Public Health Ethics: Exploring the Foundations**

Montreal, Quebec

Contact: (613) 948-2604
info@ethics-ethique.ca
www.ethics.ethique.ca

**OHTN Research Conference19 & 20
Addressing HIV Vulnerability
from Biology to Policy**

Toronto, Ontario

www.ohtn.on.ca/OHTNConf2007.html

**Canadian Centre on Substance25-28
Abuse National Conference
Issues of Substance 2007**

Edmonton, Alberta

www.issuesofsubstance.ca/IOS/EN

► DECEMBER

WORLD AIDS DAY1
www.worldaidsday.com

Aboriginal AIDS Awareness Week1-5

Contact: 1-888-285-226 or (613) 557-1817

info@caan.ca
www.caan.ca



CHAIR'S REPORT

Fall 2007

by Louise Binder

THIS ISSUE MAY APPEAR to contain a series of eclectic topics. In fact, these pieces do fit together by underlining the great complexity of each issue as it relates to people with HIV today.

In reviewing this issue, I am struck that we are actually living long enough to be concerned about liver transplants and co-infections. We are also seeing the long-awaited dawn of a new integrated system for monitoring the life cycle of treatments. And, at last, women's HIV issues are sharing centre stage with those faced by men.

There is another common thread. The stories showcase longstanding issues central to CTAC's advocacy efforts. Access to treatments has been CTAC's mission, so people living with HIV can live longer, healthier lives. Liver transplants for people with HIV/HCV coinfections came to the fore since our then vice-chair Glen Hillson required a liver transplant. Glen died before he could get one but we vowed to take on both of these systemic problems and we have.

CTAC has also been at the leading edge of advocacy for policy reform in the area of pre and post approval drug monitoring for many years, being a major contributor to Health Canada's move to the life cycle approach.

We have been prominent on women's issues and the need to address them systemically, apart from men's issues, since our formation.

So, as we enter CTAC's 12th year with our 11th AGM this fall, I take pride in chairing a remarkable organization driven by visionary and hard-working women and men that continues to be at the forefront of treatment-related issues for people with HIV in this country.

Louise Binder

BOARD OF DIRECTORS

- CHAIR **Louise Binder**
 - VICE CHAIR **Ron Rosenes**
 - TREASURER **Patrick Cupido**
 - SECRETARY **Brian Finch**
- Ken Clement**
Jennifer Furtney
Marco Gomes
Richard Baker
Colleen Price

COUNCIL MEMBERS

Mark Randall Alberta • **Sam Friedman** British Columbia • **Myles Legacy** New Brunswick • **John Baker** Newfoundland and Labrador • **Mike Sangster** Nova Scotia • **Harlon Davey** Ontario • **Troy Perrot** Prince Edward Island • **José Sousa** Québec • **Mark Ries** Saskatchewan • **Ron Rosenes** AIDS Action Now! (AAN!) • **Ken Buchanan** British Columbia Persons With AIDS Society (BCPWA) • **Christal Capostinky** Canadian AIDS Society (CAS) • **Terry Pigeon** Canadian AIDS Treatment Information Exchange (CATIE) • **James Kreppner** Canadian Hemophilia Society (CHS) • **Richard Elliott** Canadian HIV/AIDS Legal Network • **Ken Monteith** Coalition des organismes communautaires québécois de lutte contre le sida (COCQ-Sida) • **Bruno Lemay** Comité des personnes atteintes du VIH du Québec (CPAVIH) • **Louise Binder** Toronto People with AIDS Foundation (TPWAF) • **Marco Gomes** National Youth Representative • **Sandy Lambert** Aboriginal Representative • **Jeanne Nzeyimana** Representative of Black Canadian, African and Caribbean Communities • **Karen Dennis** Representative of current and former substance users

2007/08 FUNDERS

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

CTAC POSITION PAPERS

Papers

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

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/

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).

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

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
Website: www.ctac.ca

PUBLICATION

This newsletter is a quarterly publication.

Editorial Board: Ken Monteith / Ron Rosenes / Marco Gomes

Editorial Committee: Béatrice Cardin / Laurette Lévy / Leah Stephenson / Theresa Wojtasiewicz / Sonika Lal

Editorial Co-ordination: Béatrice Cardin

Translation: Alain Boutilier

Printing: The Printing House

On-line: www.ctac.ca/en/newsletter

Permission to Reproduce:

This newsletter may be copied for personal use. Content may not be edited and all reprints must include the following text: "From the Canadian Treatment Action Council Newsletter, Volume 9, Issue 4 Fall 2007".

Disclaimer: The content of articles represents the views of the authors and does not necessarily reflect the official policy of CTAC, or of any of its funders. CTAC does not recommend or endorse any therapy or treatment described within any of its print materials.