

# CANADIAN TREATMENT ACTION COUNCIL



## INSIDE FALL 2005 VOLUME 7 ISSUE 4

Eat this! A private member's bill aims to reclassify natural health products as "food" .....	1
Access to HAART is good for prevention too. ....	3
Discrimination from a Doctor. ....	4
New Antiretroviral Agents. ....	6
What's been happening with the <i>Tools for Action</i> workshop series? .....	7
Women's issues: update HPV vaccine not targeted at the HIV+ community. ....	8
On a personal note. . . A personal perspective on Oral HPV from an HIV+ member of the BC Persons With AIDS Society. ....	9
Calendar of Events. ....	11
Chair's Report. ....	11
Board and Council Members. ....	12



## A private member's bill aims to reclassify natural health products as "food"

by Ron Rosenes

Reprinted from *Living Positive* May/June 2005 issue

**I**f a private member's bill now going through the House of Commons is successful, all of the work to date of the Natural Health Products Directorate (NHPD) of Health Canada may come to nothing. Bill C-420 proposes to amend the definition of "food" to include natural health products (NHPs). This amendment would move the regulation of NHPs to the Food Directorate of Health Canada. While it may be easy to dismiss this situation by claiming that private member's bills rarely succeed, this one might be different if we don't sit up and pay attention. So far, the bill is flying quite low on Canadian radar screens. That may be about to change.

Why should we care? Before I answer that, I must declare my bias: I sit on the Management Advisory Committee of NHPD where we provide advice to the Directorate on various aspects of implementation of the regulatory regime. My involvement is in the capacity of consumer advocate, and I sit alongside representatives of the manufacturers of such NHPs as vitamins, minerals, herbs, homeopathic remedies, and Traditional Chinese Medicine (TCM). The industry representatives are in favour of compliance with the new regulations, to be phased in over the next five years, but also want to ensure that the process is fair and expeditious.

We should care because it is essential to ensure access by maintaining competition and low prices for the products we use. I am personally in favour of regulating NHPs, which so many of us use in our daily self-care management of HIV.

*continued on next page*



## Eat this!

*continued from page 1*

////////////////////////////////////

### Food labelling would not require the listing of medicinal ingredients by quantity, but only in descending order of presence.

////////////////////////////////////

I want to know that what is on the label is also in the bottle, and that Canadian products use good manufacturing processes (GMPs), in facilities that are regularly inspected. I also want assurance that there is a consumer-centered system of post-market surveillance to monitor adverse events.

#### An anti-drug legislation

Dr. James Lunney, Conservative MP for Nanaimo-Alberni, originally introduced Bill C-420 to the House of Commons in March 2003. Dr. Lunney is a chiropractor who says on his Web site: "Most Canadians are shocked to learn that vitamins, minerals, and other food products are drugs under Canadian law, and that any product can be reclassified as a drug just by making a claim that it has health benefits." Dr. Lunney would have us believe that classifying NHPs as "drugs" limits our choice as consumers. While the original Bill C-420 died during the last session of parliament, it was reintroduced this year by another chiropractor, Dr. Colin Carrie, Conservative MP for Oshawa.

Proponents of the amended legislation are both anti-regulation and anti-drug. They wish to reopen the whole debate held by the Standing Committee on Health that decided that NHPs need their own appropriate regulatory regime. It was only due to the complexities involved in passing major new health legislation—creating a separate, "third" category—that it was decided to regulate NHPs as a subset of the drug regulations under the existing Food and Drug Act. The new

NHP regulations were given their own regulatory administration within Health Canada.

According to the NHP Directorate Web site, its mission is "to ensure that all Canadians have ready access to natural health products that are safe, effective, and of high quality, while respecting freedom of choice and philosophical and cultural diversity." This means prioritizing the regulation of NHPs based on their likeliness to cause harm, while respecting tradition and the patient-provider relationship. It also means not regulating herbs or compounds that are made for individual use, as for TCM or traditional aboriginal medicine.

What would happen if parliament votes, as reflected in Bill C-420, to amend the definition of "drug" to exclude "food" and to amend "food" to include "any article *grown*, manufactured, sold or represented for use as food or drink for human beings, chewing gum, and any ingredient that may be mixed with food for any purpose whatever, *including dietary supplements, herbs and other natural health products* [emphasis added]?" There would be two possible outcomes: either NHPs would fall under food regulations, or the Food Directorate would administer the current NHP regulations.

#### The problem with classifying NHPs as food

If NHPs were regulated as food, there would be major inconsistencies in critical areas such as health claims, labelling, GMPs, routes of administration (topical versus ingested), and adverse event reporting. Many common self-care products that have been on the market for decades with evidence-based claims, such as Metamucil, Tums, and Hall's cough drops, would have to be removed from the market in order to meet food regulations.

Bill C-420 does not address these inconsistencies. Dosages of vitamins and minerals, as we know them, might have to become "serving sizes." Food labelling would not require the listing of medicinal ingredients by quantity, but only in descending order

*continued on page 10*

#### More information and making your voice heard on the issue

- The NHPD Web site can be found at [www.hc-sc.gc.ca/hpfb-dgpsa/nhpd-dpsn/index\\_e.html](http://www.hc-sc.gc.ca/hpfb-dgpsa/nhpd-dpsn/index_e.html).
- The anti-regulationists can be found at: [www.friendsoffreedom.org/article.php?sid=2284](http://www.friendsoffreedom.org/article.php?sid=2284).
- Dr. James Lunney can be reached at [www.jameslunneymp.ca](http://www.jameslunneymp.ca).
- Dr. Colin Carrie can be reached at [www.colincarriemp.ca/home.htm](http://www.colincarriemp.ca/home.htm).

# Access to HAART is good for prevention too

## So why don't provincial governments get off the cost containment bandwagon?

*By Louise Binder*

**A**t the 3<sup>rd</sup> International AIDS Society Conference on HIV Pathogenesis and Treatment in July in Rio, there was an excellent plenary about the impact of Highly Active Antiretroviral Therapy (HAART) on HIV prevention. The presenter reminded us of the incredible decrease in mortality in the U.S. since the advent and dissemination of HAART in 1996. In 1995, there were approximately 40 deaths per 100,000 population, dropping to 12 deaths in 2000 in people 25-44 years old. This, in itself, should be a compelling enough argument for full access to HAART therapies.

If that isn't enough, the presenter provided additional support for the value of access to HAART, i.e. it has a positive impact on the prevention of new HIV infections. He described three ways in which HAART does this:

- (1) biological effects
- (2) behavioural effects and
- (3) operational health system effects.

On the biological level, he reviewed clinical trials showing that HAART reduces viral load in blood, semen and the female genital tract. Trials link lower viral load with lower transmissibility of the virus. HAART also prevents mother-to-child transmission. This has been demonstrated in a number of trials with AZT or nevirapine monotherapy administered to mother and /or child as well as triple drug combinations administered to the mother. As well, it is a prevention tool in post-exposure prophylaxis. There have been several studies that have shown that HAART can avert up to 81% of HIV infections. Although there is not yet clinical

data to show its efficacy as pre-exposure prophylaxis, results are anxiously being awaited from studies of once-daily tenofovir for HIV prevention.

On the behavioural level, he argues that HAART prevents HIV by increasing the uptake of voluntary counselling and safer sex. He reviewed studies from Africa, Haiti and Brazil that support this position. Conversely, he did point out the rise in new infections among gay men in Canada since 1996 as an indication that it may, however, increase behaviours that put people at risk for HIV. This phenomenon is referred to as "behavioural dis-inhibition." In 1996, the percentage of new infections in gay men was at a low of just under 30%, down from a high of over 80% in 1981-83. In 1999, it had increased to 38 % and in 2002 was at 40%. This argues for ongoing awareness and education campaigns in the developed world.

In the area of operational health system effects, he pointed to evidence of changing perceptions and improved morale in health services where HAART is available as well as improved sexually transmitted diseases treatment. In one study, post-HAART health service provider counselling reduced unprotected sex by 38%. In a South African study, HAART improved the morale of both health care providers and patients. In Haiti, improving HIV/AIDS prevention and care led to a dramatic improvement in general primary health care.

The presenter concluded that due to the substantial evidence that HAART is likely to prevent sexual transmission of HIV on these three levels, there is a need for randomized controlled trials of HAART impact on prevention to provide the scientific evidence of this link. This is certainly an interesting challenge for us to put to our researchers. More important are his conclusions that

- (1) even without these data, the evidence for integrated prevention and treatment is compelling and
- (2) for global control of the HIV epidemic, HIV/AIDS treatment must be accompanied by successful prevention.

For those of us involved in the HIV/AIDS field, there is nothing new in these conclusions. We have been telling politicians at all government levels to integrate prevention, diagnosis, care, treatment, support and research efforts as they are all inextricably

*continued on page 10*

# Discrimination from a Doctor

*By L.L., a member of the Kali Shiva AIDS Services Women's Support Group, Winnipeg Manitoba printed earlier in For Just Us, Manitoba AIDS Cooperative PHA Caucus Newsletter, Spring 2005*



**E**arly 2005, I made an appointment to see the ear specialist about an ear infection. After two confirmed conversations on the phone, I arrived at my appointment on time and then found out my appointment had been cancelled. They told me this was due to the procedure not being able to be done in her office. After asking repeatedly 'why?' the receptionist told me flat out that it was because of 'sterilization'.

I was so appalled. I was a nervous wreck. Upset and crying, I asked 'aren't all doctors supposed to use universal precautions with all their patients?' She didn't say anything to me. All the people in the waiting room were staring. I had no choice but to leave.

In my opinion, the reason I was treated this way was because I disclosed to her that I had HIV. I disclosed to her because it was my choice, and thought it would help her treat my ear infection. Actually, I did not have to tell her anything.

After I left, I went to see the counsellor and advocate at my local health clinic and explained everything to them. They both advised me to write a letter of complaint to the College of Physicians and Surgeons. Right now, I am still waiting for a response.

I know that I have the right to speak up for myself, ask the questions I did, receive proper medical care regardless of my health status, and not be discriminated against in this way. If the doctor were to use universal precautions, there is no way of spreading this disease to her, her staff or any of her other patients. It is amazing to me that a doctor doesn't know about the real risks of treating a person with HIV.

By making my complaint to the College of Physicians and Surgeons, I hope the doctor will learn and get educated about HIV. Besides helping others, I'm hoping that people will stand up for themselves, speak up and know that being HIV positive

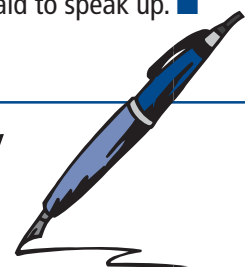
does not mean that you can be treated differently.

The doctor should know that there are many faces of HIV. She could have already treated many people who do not know or did not disclose their status. What I feel should happen is that this doctor should have to sit in a closed room with all different races of men and women who are HIV positive. Then she'll see this affects all people and you cannot catch it by being in the same room with someone who has HIV.

If you do experience something like this, know that you have rights. You can go see your counsellor for help, file a complaint, talk with friends at a support group, or phone a local information line.

But most of all, don't be afraid to speak up. ■

## *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! **The next issue of the newsletter will have an article on issues related to incarceration and access to HIV treatment and the Alberta and BC formularies.** If you have a story to share about access to treatment related to these stories, tell us! Contact the CTAC office (see page 12) for more information. *Confidentiality will be respected. We may not print all stories submitted.*

## Discriminated against by a doctor?

If you think that you have been refused treatment or been treated unfairly by your doctor because of your HIV status, don't be afraid to speak up. Contact your provincial College of Physicians and Surgeons or medical council, and make your concerns known.



### British Columbia

The Registrar College of Physicians & Surgeons of BC  
400-858 Beatty Street, Vancouver, BC V6B 1C1  
[www.cpsbc.ca/cps/patient\\_resources/complaints](http://www.cpsbc.ca/cps/patient_resources/complaints)

### Yukon

Yukon Medical Council  
P.O. Box 2703 C-5, Whitehorse, YK Y1A 2C6

### Alberta

College of Physicians and Surgeons of Alberta  
900 Manulife Place, 10180-101 Street  
Edmonton, AB T5J 4P8  
[www.cpsa.ab.ca/complaints/complaintprocess.asp](http://www.cpsa.ab.ca/complaints/complaintprocess.asp)

### Northwest Territories

Northwest Territories Medical Association  
PO Box 1732, Yellowknife, NT X1A 2P3

### Saskatchewan

Director of Communications and Education  
College of Physicians and Surgeons of Saskatchewan  
211-Fourth Avenue, South Saskatoon, SK S7K 1N1  
[www.quadrant.net/cps/complaints/index.html](http://www.quadrant.net/cps/complaints/index.html)

### Manitoba

The Complaints Department  
The College of Physicians and Surgeons of Manitoba  
1000-1661 Portage Avenue, Winnipeg, MB R3J 3T7  
[www.cpsm.mb.ca/core\\_functions/complaints/process](http://www.cpsm.mb.ca/core_functions/complaints/process)

### Nunavut

Government of Nunavut  
Department of Health & Social Services  
Operations & Professional Practice  
Nunavut Government Building Second Floor, Box 390  
Kugluktuk, NU X0B 0E0

### Ontario

The Registrar  
c/o Investigations and Resolutions Department  
The College of Physicians and Surgeons of Ontario  
80 College Street Toronto, ON M5G 2E2  
[www.cpso.on.ca/Info\\_Public/compform.htm](http://www.cpso.on.ca/Info_Public/compform.htm)

### Québec

Direction des enquêtes  
Collège des médecins du Québec  
2170, boulevard René-Lévesque Ouest  
Montréal QC H3H 2T8  
[www.cmq.org/CmsPages/PageCmsSimpleSplit.aspx?PageID=0bc5375e-1d0d-4165-b90c-8a0841f4e3a0](http://www.cmq.org/CmsPages/PageCmsSimpleSplit.aspx?PageID=0bc5375e-1d0d-4165-b90c-8a0841f4e3a0)

### New Brunswick

Registrar  
College of Physicians and Surgeons of New Brunswick  
One Hampton Road, Suite 300, Rothesay, NB E2E 5K8  
[www.cpsnb.org/english/complaint.html](http://www.cpsnb.org/english/complaint.html)

### Nova Scotia

Investigations Department  
College of Physicians and Surgeons of Nova Scotia  
Suite 200, 1559 Brunswick Street, Halifax, NS B3J 2G1  
[www.cpsns.ns.ca/publications/investigations-faq.html](http://www.cpsns.ns.ca/publications/investigations-faq.html)

### Prince Edward Island

College of Physicians and Surgeons of PEI  
199 Grafton Street, Charlottetown, PE C1A 1L2

### Newfoundland and Labrador

Newfoundland Medical Board  
Suite 603, 139 Water Street, St. John's, NL A1C 1B2  
[www.nmb.ca/Complaints.asp](http://www.nmb.ca/Complaints.asp)



By Tony Di Pede

**A**t the 3<sup>rd</sup> International AIDS Society Conference on HIV Pathogenesis and Treatment, scientific data was presented on five new therapies. Three of the therapies are in a new class called “Fusion Inhibitors”, one was an “Immune Based Therapy” and one was a “Gene Immune Therapy.” The development of new antiretroviral agents continues to be vital.

### Gene Immune Therapy:

In this therapy, blood is drawn from the patient and the T Helper cells are isolated. Once isolated, the T Helper cells are genetically modified in the laboratory and then re-fused into the patient. In this case, the T Helper cell is genetically modified with an antiviral gene (M870) to express a peptide that will prevent the virus from entering the cell. The theory is if the virus cannot enter the cell, HIV replication and infection cannot take place.

The results of a phase 1 pilot study on 10 patients were promising and demonstrated:

- Good tolerability within an average follow-up of 6 months
- CD 4 counts rose significantly after cell infusion
- Patients with higher CD 4 counts before treatment tended to show a more pronounced increase in CD 4
- No effect on viral loads
- Significant increase in T Helper Cells was observed

**Cautionary note:** These results are from the early days in this field of research. Much more research is needed to determine if this type of therapy will be useful.

### Immune Based Therapy:

Two studies reported that treatment with Growth Hormone is associated with increases in CD 4 cell counts in persons living with AIDS on HAART. Because opportunistic infections are associated with low CD 4 cells that tend to decline the longer one has been infected, the goal is to boost the immune system by increasing CD 4 cell counts and therefore help ward off infections.

The ACTG 5174 study, with 60 participants, was undertaken to evaluate the impact of recombinant growth hormone (rGH) on thymus size and naïve T-cell reconstitution. The preliminary results of this study are again promising, but important questions still need to be addressed. Treatment with rGH is associated with significant increases in total and naïve CD 4 count and naïve CD 4 percentage compared to HAART alone. Also, treatment with rGH is associated with increase in thymus size. Adverse events were infrequent but more intense monitoring of potential side effects is necessary. Laura Napolitano et al. on a study with 20 persons living with HIV/AIDS reported similar findings. Further questions remain such as: What are the clinical outcomes? Will the increases continue once the therapy is stopped? What are the long term toxicities?

### Fusion Inhibitors:

This is a new class of drugs. The drugs in this class use various mechanisms to prevent the HIV virus from “fusing” or attaching itself to the cell. This prevents the HIV virus from entering and infecting the cell. If the virus cannot enter, it cannot replicate itself. CCR5 antagonists are one type of fusion inhibitor. Scientific data on 3 CCR5 antagonists was presented: Maraviroc, Vicriviroc and Pro 140.

Although the research on CCR5 antagonists presented at the conference in July 2005 showed great promise, recent evidence indicates serious concerns about toxicities and effectiveness. In October 2005, the Phase III studies for Atraviroc (GW873140), also a CCR5 antagonist, were terminated due to safety concerns, primarily liver toxicities.

Also in October, an arm of another Phase II study on Vicriviroc in treatment of HIV naïve persons was terminated. It's important to note that the clinical trials of Vicriviroc for

*continued on page 9*

**B**eginning this past summer and continuing into early fall, a number of tele-workshops (workshops offered over the telephone) have been delivered, and it is fascinating to see the wide-range of advocacy experience that they continue to draw. The challenging work that communities are involved with never ceases to amaze me, and I am grateful for the opportunity to hear peoples' stories. One of the many wonderful aspects of the tele-workshops has been the sense of community that this environment fosters. People throughout the country have been learning from each other by sharing their experiences, and you can almost hear the networks being built over the telephone! Many people living in rural or non-urban areas have quickly realized the benefits of tele-workshops, and now make up the largest share of our participants.

Participants regularly tell me that, at first, they did not think a workshop over the phone could be effective—it is strange, after all, to take part in a learning activity when you cannot see the other people involved. Afterward, I often hear their appreciation of the telephone as an innovative learning tool, and how many were pleased with what they had learned. Some have even asked me how they can use the tele-workshops to offer skills-building opportunities to their staff and communities. As well, a lot of participants have been asking for a space to continue sharing ideas with each other, and as a result, we have adapted the *Tools for Action* website to allow people to post and share advocacy resources!

### **Glen Hillson Award for Excellence**

Congratulations to **Philip Lundrigan**, a founding member and past Board member of CTAC, who was the recipient of the Glen Hillson Award for Excellence at the CTAC AGM in October!

CTAC created this award to honour the memory of Glen Hillson, a tireless advocate for persons living with AIDS, former Vice Chair of CTAC and former Chair of British Columbia Persons With AIDS (BCPWA) Society, who died in 2003.



## **What's been happening with the *Tools for Action* workshop series?**

*by Sugandhi Wickremarachchi*

*Project Coordinator, Treatment Access Issues Project*

Our website was launched this summer, and the response so far has been wonderful. A tremendous amount of research and community consultation went into developing an accessible, safe and easy-to-use website. Please take a moment to visit us at [www.ctac.ca/tfa](http://www.ctac.ca/tfa). Here, you can view and complete the workshops, share ideas and download resource materials that can help you with your advocacy work. You can create a participant profile that will keep track of which workshops you have completed so that you can earn credit towards a *Tools for Action* certificate! This is your online advocacy community, and is a tool meant to help you reduce isolation and increase partnerships.

We offered several *Tools for Action* workshops at a number of community events early this fall. On October 6, we were in Regina for the Skills-Building Day of the Canadian Aboriginal AIDS Network's AGM. On October 17, we offered five workshops at CTAC's post-AGM Skills-Building Day in Moncton. Between October 28 and 30, we also offered a total of five workshops at the National HIV/AIDS Skills-Building Symposium in Montreal. Similar to the tele-workshops, it was interesting to see the wide range of advocates that attended the community workshops, and it was an invaluable opportunity to hear their perspectives on the work that they do. These events have further promoted the workshop series and have led to a spike in our new participant rates!

For more information about the workshop series, please contact me at (416) 410-1369 or [sugandhi@ctac.ca](mailto:sugandhi@ctac.ca), or visit our website at [www.ctac.ca/tfa](http://www.ctac.ca/tfa). ■

## WOMEN'S ISSUES: UPDATE

# HPV vaccine not targeted at the HIV+ community

**A**t the 22<sup>nd</sup> International Human Papilloma Virus (HPV) Conference and Clinical Workshop held in Vancouver, BC on May 4, 2005, a public forum was held to discuss up and coming HPV vaccines that are being developed by two pharmaceutical companies and are due for approval by the end of this year. That's the good news. The bad news is there are currently no clinical trials aimed at HIV+ people and the therapeutic versions are a long way from approval. The two pharmaceutical companies with competing HPV vaccines are

- (1) Merck Frosst that is developing a vaccine that covers the cervical and anal cancer types of HPV and the genital warts types, and
- (2) GlaxoSmithKline that is developing a vaccine that covers only the cervical and anal cancer types.

The vaccines should be available within the next year or two. Merck Frosst is seeking regulatory approval by the end of 2005.

Throughout Canada, mainly Eastern Canada, there are clinical trials for HIV-negative young women. To date in young women, there have been no serious side effects and there is a 90-100% protection rate against cervical abnormalities after 1.5 years. There are three large-scale trials underway, two multi-centre with over 10,000 participants (Merck Frosst and GSK), and one trial in Costa Rica by the University of Maryland. Merck is currently setting up a clinical trial in Vancouver for gay young men. The efficacy of the HPV vaccine in men is currently not available. Therapeutic vaccines are currently still in Phase III trials, which means they are far away from being developed. The HPV vaccines would not replace pap screening and would not make existing lesions go away. However, it would reduce the number of abnormal paps, follow-up visits and surgeries. It would also reduce cervical cancer, and eventually anal cancer, rates within 10 years and would be most



*By Carole Lunny,  
CTAC National Women's Representative*

beneficial in countries without pap screening. The HPV vaccines are being targeted to young women in developing countries where PAP screening is unavailable. They recommend that young girls aged 10-13 years, older women, and adolescent boys be vaccinated (with ongoing clinical trials).

There are a few remaining questions that arise from the forum: Will public health authorities and the public openly receive the HPV vaccines? How long will protection last? Will boosters be needed? How much will the vaccines cost? (When the Hepatitis B vaccine came out it initially cost \$200 and now the price is reduced to 0.25 cents in developing countries.) Will the vaccines reach poor women at the highest risk? Most importantly, research shows that rates of cervical and anal cancers are higher in HIV+ individuals, which makes the need for clinical trials for HIV+ people even more important. The BC Persons With AIDS Society is doing some preliminary inquiry into trying to get a clinical trial for HIV+ British Columbians, but this is only in the initial stages and so far there has been no movement from the pharmaceutical companies to accommodate the HIV+ community. CTAC recommends that you send a letter to either Merck Frosst or GlaxoSmithKline, saying that you would like to see a clinical trial in your community. ■

## On a personal note...



*A personal perspective on Oral HPV from an HIV+ member of the BC Persons With AIDS Society*



In June of 2003, I saw my dentist for a regular check up and cleaning. I showed him a patch of white tissue that appeared on the gum-line of my lower front teeth. He scraped it off, stating it was nothing.

Six months later, I returned for a regular check-up and cleaning. I showed him that the problem had reoccurred in the same spot and had, in fact, spread. The dentist decided to perform a biopsy on the tissue.

In January 2005, I received a positive diagnosis of Oral HPV (Human Papilloma Virus) and was referred to an oral surgeon at a local hospital. The surgeon looked at the test results and suggested

that a new clinical trial might be a treatment option. He also explained other possible treatment options: oral surgery to excise the diseased tissue or liquid nitrogen applied directly to the area. I found out a couple of weeks later that I was ineligible for the clinical trial. The option I was forced to choose was liquid nitrogen.

As the surgeon had opted out of the BC Medical Services Plan, I was responsible for covering the treatment costs, office fees and travel costs. Each visit was costing me over \$120. It got to the point where I could no longer afford to see this MD and asked my GP if he would be able to continue the treatment in his office. He agreed. For the next 5-6 weeks, I had a taste in my mouth that was of decaying flesh. In order to go out in public, I was living on mints and mouthwash. In the end, it was a successful treatment. ■



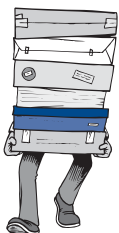
Tony Di Pede, Phil Lundrigan and Ron Rosenes at the presentation of the Glen Hillson Award at the CTAC AGM in Moncton, October 2005.

## New Antiretroviral Agents

*continued from page 6*

treatment experienced HIV persons have not been halted and we need to follow this study closely. Phase III trials on Maraviroc are continuing. We await the outcome of the trials on CCR5's to determine what, if any, role they will have in the treatment of HIV.

It's important to note that these are not the only drugs in the pipeline, but rather just the ones reported on in the oral abstracts at the Rio Conference in July 2005. There may be as many as 24 new drugs currently in clinical trials, and about a dozen drugs in Phase 2b/3 clinical trials, including four NRTI's, two NNRT's, and five or six entry inhibitors, including the CCR5 inhibitors. As always, we must stay focussed on the need for new HIV treatments that will be safe and effective. ■



### 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 (416) 410-6538.

**Eat this!**

*continued from page 2*

of presence. The result would be market and consumer confusion about the different ingredients and levels of active components in a given product. Simply migrating the NHPD into the Food Directorate is not the intention of the bill's proponents, as that would only lead to more legislative confusion.

**Revoking subsections of the Food and Drug Act**

Bill C-420 also proposes to repeal two subsections of Schedule A of the Food and Drug Act. This is a good idea. First introduced in 1934, these regulations were designed to curb advertising of medicines for diseases that had no known treatments at the time. The diseases listed in Schedule A include cancer, arthritis, diabetes, depression, and hypertension. Today, we know that there is a strong body of evidence for the use of glucosamine in the treatment of arthritis, and St. John's wort for the treatment of moderate depression. But people with HIV want more than the evidence base alone; we also need to know the potential for interactions with our medications.

The NHPD regulations presently allow manufacturers to make a full range of claims, including structure, function, risk reduction, treatment or cure, provided there is sufficient evidence—including thousands of years of traditional use—to support the claims. These subsections of Schedule A prevent Canadians from learning more about natural remedies.

Bill C-420 in its present form must be defeated. However, the outdated provisions in Schedule A should be revoked. We need to call for the amendment of the bill to remove any

definition changes and get on with revoking Schedule A to finally allow proper and complete labelling information, including health claims for the products we use.

People with HIV increasingly face out-of-pocket expenses to maintain health. The use of NHPs and other self-care products is on the rise. Regulations undoubtedly create costs that are passed on to the consumer, but the costs may be controlled if there is meaningful competition on a level playing field. ■

On November 22, 2005, the Standing Committee on Health recommended that the House of Commons not proceed further with Bill C-420, while noting that Health Canada will proceed with regulatory changes to modernize Schedule A of the *Food and Drug Act*. Evidence convinced the Committee that the current *Natural Health Product Regulations* ensure safety and high product quality, and permit a full range of evidence-based health claims that support Canadians' ability to make informed decisions about their health with trustworthy product information.

**Access to HAART**

*continued from page 3*

linked. Concerted, cohesive efforts in all of these areas are necessary for maximum strategic effect throughout.

We have also repeated that cost containment that limits HIV/AIDS drug access is false economy. This is further proof of that fact. Not only is it a bad strategy for maintaining the health of people with HIV/AIDS, with higher attendant costs in other areas of the healthcare system, but it also hinders prevention efforts, with further attendant costs.

The silo mentality of looking at cost/benefit must stop across the local, provincial and federal budgets. Providing access to needed treatments means more on the revenue side for each province and the federal government, not just less expense. Surely, if we and the researchers can figure that out, the gurus in our governments can too. If not, give us a call. We have lots of substantial cost saving proposals that do not risk people's health. ■

**Order of Ontario**

Congratulations to our Chair, **Louise Binder**, who was invested into the Order of Ontario in September!

The award was created in 1986 by the Government of Ontario to recognize the highest level of individual excellence and achievement in any field.

# CALENDAR OF EVENTS

## FALL 2005/WINTER 2006

### ● December 1

#### **World AIDS Day 2005**

Contact your local ASO for details on activities and events in your area

#### **World AIDS Day Breakfast (Blueprint for Women & HIV/AIDS Launch)**

Toronto, Ontario  
Contact: (289) 259-9623 or  
bpwcanada@essentient.ca  
Montreal, Quebec  
Contact: casm@netrover.com  
Ottawa, Ontario  
Contact: kimt@cdnaids.ca

#### **World AIDS Day Press Conference (Blueprint for Women & HIV/AIDS Launch)**

Vancouver, British Columbia  
Contact: marcies@pwn.bc.ca

### ● December 1-5

#### **Aboriginal AIDS Awareness Week**

Contact the Canadian Aboriginal AIDS Network for information about activities and events in Canada at 1-888-285-2226 or info@caan.ca

### ● December 16-19

#### **Interscience Conference on Antimicrobial Agents and Chemotherapy**

Washington, D.C.  
Contact: (202) 942-9248 or icaac@asmusa.org

### ● January 16, 2006

#### **Application deadline for the 2006 International Human Rights Training Program (IH RTP)**

(The program runs June 11 - June 30, 2006)  
Montreal, Quebec  
Contact: (514) 954-0382, ihrtip-ifdh@equitas.org or  
www.equitas.org

### ● February 5-9, 2006

#### **Conference on Retroviruses and Opportunistic Infections**

Denver, Colorado  
Contact: (703) 535-6862 or  
info@retroconference.org

### ● February 14 & 15, 2006

#### **7th Annual Alberta Harm Reduction Conference**

Lethbridge, Alberta  
Contact: (403) 327-8900 or  
info@albertaharmreduction.ca

## CHAIR'S REPORT

### FALL 2005

*by Louise Binder*



#### **THIS ISSUE IS LARGELY DEDICATED**

to treatment information that attendees learned while at the International AIDS Conference this summer in Rio. The main reasons we attend these conferences are to keep up with the latest news on treatments in development for HIV/AIDS and opportunistic infections and to gather information about the drugs in the real world, post market.

Lately, though, one wonders what is the value of learning these things when new drugs are being kept out of the reach of people who need them through a series of ever more byzantine rules and regulations to access medications across the country.

Witness the latest pronouncements from the recent Ministers of Health meeting. Among them is a plan to expand the powers of the Common Drug Review, a body that has failed miserably to make consumer friendly and wise pharmacoeconomic recommendations to the nine participating provinces about public reimbursement plan coverage for new drugs. Now they will get to make those same kinds of ill-advised decisions about generic drugs and drugs prescribed in hospitals as well.

This same group, that works more like a secret society than a taxpayer funded public body, has recently done an evaluation of itself, primarily by itself and, lo and behold, it is doing a great job. The few dissenting complaints provided by the limited consumer input allowed was, in effect, dismissed out of hand in the evaluation as ill conceived from a group lacking understanding and knowledge about drugs. What a laugh. No one knows our drugs better than those of us who take them and the physicians who prescribe them for us.

Even though we face these mounting hurdles to drug access under the mantra of fiscal responsibility and cost containment, we are not going to stop learning about the new science at conferences or spreading the word about new life saving and enhancing drugs coming down the pipeline. We will continue to fight wrong-headed government policies and practices that save money in the short run but cost the entire economy, let alone the health care budgets, hugely in the longer term—not to mention the loss of life and quality of life to our citizens. ■

## BOARD OF DIRECTORS

- CHAIR **Louise Binder**
- VICE CHAIR **Ron Rosenes**
- TREASURER **Tony Di Pede**
- SECRETARY **Jean-Pierre Bélisle**  
**James Edwards**  
**Brian Finch**  
**Horace Josephs**  
**Troy Perrot**  
**Geraldine Trimble**

## COUNCIL MEMBERS

**Derek Bell** British Columbia Persons With AIDS Society (BCPWA) • **Jean-Pierre Bélisle** Québec • **Clément Bolduc** Comité des personnes atteintes du VIH du Québec (CPAVIH) • **Louise Binder** Toronto People with AIDS Foundation (TPWAF) • **Daryn Bond** Manitoba • **Patrick Cupido** Canadian AIDS Treatment Information Exchange (CATIE) • **James Edwards** New Brunswick • **Richard Elliott** Canadian HIV/AIDS Legal Network • **Brian Finch** Ontario/Representative of Current and Former Substance Users • **Earl Giles and Mike Sangster** Nova Scotia • **Horace Josephs** Representative of Black Canadian, African and Caribbean Communities • **James Kreppner** Canadian Hemophilia Society (CHS) • **Carole Lunny** National Women's Representative • **Malsah** Canadian Aids Society (CAS) • **Ken Monteith** Coalition des organismes communautaires québécois de lutte contre le sida (COCQ-Sida) • **Richard Neron** Newfoundland & Labrador • **Roky Paul** Canadian Aboriginal AIDS Network (CAAN) • **Troy Perrot** Prince Edward Island • **Mark Randall** Alberta • **Daryle Roberts** British Columbia • **Ron Rosenes** AIDS Action Now! (AAN!)

## 2005 FUNDERS

Public Health Agency of Canada (PHAC)  
Canadian Institutes of Health Research  
Abbott Laboratories • Boehringer Ingelheim Canada Inc. • Bristol-Myers Squibb Pharmaceutical Group • Gilead Sciences • GlaxoSmithKline in partnership with Shire BioChem • Hoffmann-La Roche • Pfizer Canada, Agouron Pharmaceuticals Inc. • Schering Canada  
Ward Health Strategies

## CTAC POSITION PAPERS

### Papers

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

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

## MEMBERSHIP

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

### Full Membership

- Person living with HIV/AIDS
- Group, organization and/or project with a substantive HIV/AIDS mandate

### Associate Membership

- Any individual
- Group, organization and/or project whose substantive mandate coincides with the objectives of the Corporation

## CONTACT US

### Canadian Treatment Action Council (CTAC)

P.O. Box 116, Station "F"  
Toronto, Ontario M4Y 2L4

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

## Organizational Mandate

The mandate of the Canadian Treatment Action Council (CTAC) is to work with the public and private sectors to:

1. **Support access to therapies and treatments** for people living with HIV/AIDS by informing research and public policy, and by promoting public awareness
2. **Provide mentoring and skills building** in these areas to people living with HIV/AIDS
3. **Encourage and facilitate the exchange** of related information to stakeholders

## PUBLICATION CREDITS

**This newsletter is a quarterly publication.**

**Editorial Board:** Derek Bell / Daryn Bond / Horace Josephs / Ken Monteith

### Editorial Committee:

Laurette Lévy / Leah Stephenson / Theresa Wojtasiewicz

### Editorial Co-ordination:

Leah Stephenson

**Translation:** Alain Boutilier

**Printing:** The Printing House

**On-line:** [www.ctac.ca/en/newsletter](http://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 7, Issue 4 (Fall 2005)".

**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.