

CANADIAN TREATMENT ACTION COUNCIL



Figures and Figureheads:



Display sparks awe and scepticism in Barcelona

by Enrico Mandarino and Shari Margolese

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There is no denying that it was an incomparable experience to sit three rows before fourteen world leaders coming together to discuss a global commitment in the fight against AIDS. Presented by UNAIDS, *Keeping AIDS At The Top Of The Agenda – A Strategic Dialogue Among World Leaders* included former Canadian Prime Minister Kim Campbell; India’s former Prime Minister, I.K. Gujral; Ali Hassan Mwinyi, the former Prime Minister of Tanzania; the Prime Minister of St. Kitts & Nevis, Dr. Denzil Douglas; and the headliner, former U.S. President Bill Clinton.

The drama began to unfold over an hour before the start time in the foyer where several hundred people slowly gathered waiting to pass security and be let in. Once inside the auditorium, huge maps of the world projected on two screens dominated the stage. They counted minute by minute the estimated increase on Earth of people living with HIV/AIDS. At 6:21 p.m., as the session began, the counter read 43,892,021.

Peter Piot, the Director General of UNAIDS, introduced the session calling AIDS “the top political issue of today.” Piot updated dramatic global statistics including estimates that:

- Almost 9000 people die from AIDS daily
- By 2010 there will be 70 million cases of AIDS worldwide
- By the year 2020 even if AIDS was eradicated today, there will still be over 25 million orphans.

He called the gathering historic: never before had world leaders joined together

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this way to unite in the fight.

The Prime Minister of St. Kitts & Nevis, Dr. Denzil Douglas, described the Caribbean as having the second highest HIV/AIDS incidence and prevalence rate in the world. He drew wild applause from the audience when he announced a Pan-Caribbean agreement with six corporations for the purchase of cheaper HIV/AIDS drugs and called for increased resources to provide these drugs to Caribbean people.

Another crowd pleaser was former US President Bill Clinton, now Co-Chair of the United Nations AIDS Fund, who termed AIDS "the worst thing since the Bubonic plague," saying that ten billion dollars was needed for the Global AIDS Fund. His message was simple: rich countries must calculate what they owe towards this global pandemic and give that money to the poor countries. Alongside, advocates and people representing these countries must aggressively push for the right to treatments. He also called for pharmaceutical companies to make medications at affordable prices and for individual countries to make their deals with pharmaceutical companies.

Although there were calls for "bounding of rhetoric" and commitment shown "by deeds, action and not by talking," rhetoric continued to abound drawing murmurs of scepticism from the crowd.

"We could save 30 million lives by applying what we know. We must become the change that we want to see."

The leaders spoke of the relationships between AIDS and poverty, of the impact of AIDS on health and economic resources, and of the social and religious stigma of AIDS. Every leader was in agreement: access to treatments is paramount to winning the fight.

"Access to the global fund should not be delayed for people who need it," proclaimed President Paul Kagame of Rwanda, one of the countries most affected by HIV/AIDS.

Each leader concurred that this cannot be done by a single country or source alone. Leadership at a global and national level, in a framework whereby politicians are accountable, was called the single most important factor in making such a plan work and in reversing the epidemic. Portugal's President Jorge Sampaio summarized the idea, saying, "Other people's problems are our problems." He also called upon leaders to act

immediately and make it a first priority to confront the disease openly. Prime Minister Dr. Pascoal Mocumbi of Mozambique expressed hope that the partnership of the fourteen leaders would be, "one that will last until the end of AIDS", adding that AIDS cannot be dealt with until nations united.

Several pre-selected community members addressed the leaders including an HIV positive woman from Zimbabwe. She softly and slowly described when AIDS entered her home. Her husband was the first to die. Then, one by one, three of her sons died as well. And then she lost her fourth, not from the disease itself, rather from the discrimination and the toxic stigma attached to it. "He left my home and was never seen again," she told us. Other community speakers abandoned their pre-scripted comments citing that they would only be preaching to the converted and challenged the leaders to use their positions to influence public policy and effect change.

By the end of this session at 8:40 p.m., the counters beneath the large screen maps of the world tracking the estimated number of people living with HIV/AIDS were at 43,893,633.

Another 2000 people on the planet infected in just over two hours. ■

CTAC's Annual General Meeting

CTAC's Annual General Meeting (AGM) and Council Meeting will take place on October 6th-7th, 2002 at the Fairmont Newfoundland Hotel in St. John's, Newfoundland & Labrador

AGM business, which will be conducted on Sunday, the 6th from 2:00 p.m. to 5:00 p.m., will include Directors' reports, approval of the Audited Financial Statements, the election of the 2002/2003 Board of Directors, consideration of By-Law changes, and other business. The AGM is open to all CTAC members. Full Members who are unable to attend may vote by proxy.

The Council meeting and community skills building events will comprise the balance of the 2-day agenda and will include discussions on access to treatment issues and health care reform. For more information, please contact the CTAC office or visit the CTAC website. ■

Women's rights are key to stemming the spread of HIV

Comments after Barcelona. . .

by Louise Binder



The HIV/AIDS epidemic has shifted from being prevalent in men to being prevalent in women and children. It is estimated that in the next five years it will be a two to one ratio, female to male. Why? In my view it is directly related to the systemic and individual discrimination against women in society. The greater the cultural, religious and legal discrimination in a country, the faster the spread of HIV into its female population. There will be no containment of the spread of this epidemic until there is removal of these barriers to equality in each country. Coupled with this is the need to recognize the inextricable link between prevention and treatment. Equality must include equal access to treatments and methods of protection from infection.

Until women's rights become part of the health, policy and legal agenda of countries, we will not stem the tide of this epidemic. History has shown that women's rights and health are always last on the list. Thus the epidemic rages in this population.

How does this premise apply to the AIDS epidemic? In the developing world it means that women must be given legal rights, including the right to own land, to inherit their husband's and family's estate, to borrow money and to run businesses. Laws must be enacted and enforced to protect women against violence. The enforcement of these rights must have teeth. Since these laws are unlikely to be enacted in many countries from within, there must be international pressure on them to do so including the linking of monetary funds to their women's rights records. Getting governments to even want to do so will require advocacy by like-minded people to let the governments know that it is an election issue for them. The general populations in these countries must be educated to the value of these demands on their own lives and the economy of their country. We must ensure that treatment and prevention methods over which women have control and which protect women, such as microbicides and HAART, are made practically and not just theoretically available to women, at no cost if necessary.

In the developed world, discrimination is not as prevalent generally. There are laws that protect women but they are not always enforced e.g. family violence laws. They must be. We know that marginalized women are more at risk than women who do not feel and who are not in fact marginalized. We must direct our prevention and treatment strategies at reaching the women most likely to be at risk and to remove barriers for them through a broad range of policy changes that address poverty, homelessness, lack of education, racial intolerance and discriminatory religious policies and practices. For example, there are policies on homelessness that need changing, and terrible religious practices such as no condom use or other birth control methods that are killing women, not to mention stoning to death for adultery.

We cannot expect women who are marginalized and discriminated against – even subject to death for disobeying men – to openly defy convention and to be public about their needs, let alone be open about their HIV status. Thus the epidemic in women generally remains hidden.

This was evident in Barcelona where a march in support of women with HIV was poorly attended, as was the press conference at which HIV+ women from South Africa, Thailand and India told of their plight. The fact that there is still so little attention given to women's issues as part of the formal part of the conference is shameful. In the research field there are still not enough women in trials, not enough analyses of women-specific data and not enough women-specific research.

Fortunately, Health Gap Coalition which was represented, among others, by Evan Ruderman and Rachel Yassky, arranged a "parallel conference" to educate women and to allow them to educate us about their needs and strategies. CTAC is committed to working more closely with Health Gap, Project Inform and other interested groups to keep the momentum from Barcelona going and to plan next steps leading up to the Conference in Thailand where we believe women's issues should be a major theme. ■

XIV International AIDS Conference 2002 - Measuring the Failure to Treat

by Tom McAulay

As with past conferences, people living with HIV/AIDS received scholarships to attend the XIV International AIDS Conference in Barcelona, Spain. Expectations were high that this was going to be another great experience. Opening ceremony speakers further boosted these expectations when speakers praised the inclusion and participation of people living with HIV/AIDS stressing how “we have benefited from your contributions.”

We heard, for the first time, “how we treat people living with HIV/AIDS today will determine how well we address their issues in the future.” Certainly, in the broader concept of treatment, respect, care, support, and nutrition are just as important as the drugs we consume, and they are important co-factors affecting therapeutic efficacy.

Simply – in Barcelona, the conference failed the HIV community. By failing to treat people living with HIV/AIDS reasonably – evident from the lack of care and respect given – the future of meaningful participation by the HIV community is compromised.

Respect: Entry visas were denied to people with low economic means and from poorer countries. Travel arrangements were challenging – unfit for the healthy and simply appalling for people living with HIV/AIDS. Located outside of Barcelona, scholarship accommodations were isolated, sparse and offered no reasonable means to connect with families at home. Planning for our safety was not evident and especially lacking at night.

Care: Medical services anywhere on site were limited, and non-existent in the PWA Lounge. The lounge was housed in the basement level of a parking garage, dank and noisy, offering nothing more than mattresses on the floor surrounded by thin cloth for resting. The conference site was difficult to maneuver for people with disabilities and especially for wheelchair participants.

Support :

Assistance at the airport upon arrival was inconsistent at best, non-existent at times. Assistance and services for people living with HIV/AIDS at the distant scholarship accommodations did not exist. Guided information on how to reach the

conference site was absent. Cheques given in financial support could not be cashed for several days and transit passes did not fully cover the time period of the conference.

Nutrition: The quality of food in the PWA Lounge was the worst ever (some people were hospitalized with food poisoning, including one Canadian). Food availability was severely restricted; except from 12 to 2 PM, one had to access food at busy and expensive conference venues. No breakfast, no dinner and no allowances for treatment regimens requiring food.

People living with HIV/AIDS are important participants and contributors at these international conferences – not tokens. We are living with a terminal illness and require concerted and conscious efforts to maintain our health while participating. How we are treated affects our health and this can impact on the effectiveness of our medications.

Because how people living with HIV/AIDS are treated today directly affects how well we deal with future issues, the future right now looks critically unwell. The next International AIDS Conference needs to, and can, do better. The future depends on success today. ■



Balloons carrying wishes are released at the closing ceremonies.



ACT-UP Paris demonstrating in the Conference Exhibition Hall.

Advocacy and Policy at the Barcelona Conference

by Daryn Bond

The theme for the 14th International AIDS Conference in Barcelona was 'Knowledge and Commitment for Action.' In the field of treatment advocacy, the conference allowed the expression of these ideals, provided opportunities for skills-building, and asked people to examine their own commitment by focusing their minds towards future action.

Prior to the opening ceremonies a 'March for Life' was held demanding access to treatments for everyone with HIV regardless of their ability to pay. Later, ACT-UP Paris demonstrated against Hoffmann-La Roche claiming unfair trial enrollment for T-20, and Gilead for high drug pricing, by shutting down their exhibition booths. Protests and demonstrations mixed with the regular conference schedule throughout the week.

Many posters and presentations examined advocacy work in today's political climate. 'Cost-benefit analysis', a financial analysis showing that we ignore HIV from an economic perspective at our peril, was cited as an example of effective practical advocacy. Using a human rights based approach, analyzing international treaties and laws to argue for access to treatment, is emerging as a useful tool for AIDS activists. Repeatedly, the involvement of people living with HIV/AIDS in creating policy and action for improved services was shown to be critical to the success of the movement.

An international gathering allows people to see beyond their own borders and personal situations, generating the recognition that the 'prevention – treatment' debate is over. The argument that one must choose to deliver treatment first and leave prevention for later, or vice versa, has finally been exposed as counter-productive. Preventing mother-to-child transmission and refusing to treat the parents produces orphans and little hope for social stability. Testing for HIV seems pointless when there are no options for those testing positive. Clearly, prevention and treatment must go hand in hand to create an effective response to AIDS.

For a vast majority of those infected with HIV, treatment remains inaccessible. The goal to treat 3 million people in Sub-Saharan Africa was set and while admirable, a better goal would be to treat all those who need it. In the administration of the Global Fund to Fight AIDS, Tuberculosis and Malaria, those who argue it is insufficient, unrealistic and doomed to fail, offer no viable alternatives. The reluctance to offer relief to countries until sound 'infrastructure' exists purposely sets barriers that create impossible situations: without infrastructure there is no investment; without investment, no infrastructure.

In terms of our knowledge and commitment to global treatment access, barriers are breaking down and the old excuses are wearing thin. This conference helped to focus attention on the desperate need and overwhelming logic of making treatments universally available. Reasons as to why it is not possible, such as financial constraints, patent protection, intellectual property rights and profits, were shown to be as phony as the people making them. It is certainly not lack of knowledge or commitment that prevents access for all people, but a lack of corporate and political will. ■

** Thanks to Terje Anderson, Advocacy and Policy Rapporteur (and his team including Ralf Jürgens) for access to their conference report.*

Putting Third First:

Vaccines, Access to Treatment & the Law

A satellite meeting prior to the 14th International AIDS Conference

Barcelona, 5 July 2002

by David Patterson

“Never again will I argue for increased vaccine funding by saying HIV treatments are too expensive” – HIV vaccine advocate and participant at *Putting Third First*.

In her novel *Big Shot: Passion, Politics and the Struggle for an AIDS Vaccine*, author Patricia Thomas describes an ugly scene in the early 1990s in which US treatment activists lobbied against US government funding for HIV vaccine research, fearing it would detract from resources desperately needed for AIDS treatment research.

A decade later, over a hundred and twenty HIV vaccine advocates and treatment activists convened in Barcelona to discuss the legal ethical and human rights challenges of both increasing global access to effective treatments for HIV/AIDS, and developing and ensuring access to HIV vaccines suitable for developing countries. By the end of the day, there was a common recognition that global vaccine advocates and treatment activists need to work together more effectively on issues of common concern to advance our respective agendas.

The meeting was organized by the Canadian HIV/AIDS Legal Network, the AIDS Law Project (South Africa) (ALP) and the Lawyers Collective HIV/AIDS Unit (India), and was co-hosted by UNAIDS. Opening speakers included Paul Gully, Senior Director General, Population and Public Health Branch, Health Canada, who took the opportunity to announce that Canada would develop a national HIV vaccine plan (following the recommendations of the Canadian HIV/AIDS Legal Network in its report *HIV Vaccines in Canada: Legal and Ethical Issues*.)

In his opening commentary, Justice Edwin Cameron of the Supreme Court of Appeal of South Africa (and a gay man living openly with HIV/AIDS) highlighted the change in thinking that had occurred in the last two years regarding

global treatment access issues – no longer was it accepted that market forces in developed countries alone should determine the prices of life-saving medications globally. He stressed this paradigm shift had come about through principled leadership and committed activism, through careful thinking and through strategic alliances. Justice Cameron’s theme of strategic alliances between vaccine advocates and treatment activists continued to reverberate throughout the day.

Three short papers on global treatment access issues were presented and debated. Topics covered included the right to health, drug financing and price control, and litigation strategies. The papers were presented by Richard Elliott (Legal Network), Anita Kleinsmidt (ALP) for Vivek Divan (Lawyers Collective, who was unable to obtain a visa to attend the Conference), and Jonathan Berger (ALP). Sam Avrett presented the paper on advancing research on and access to HIV vaccines for developing countries. After lunch and thematic working groups, the plenary reconvened to hear workshop reports, discuss common issues arising, and identify next steps.

The following points emerged from the discussions:

- An HIV vaccine is many years away: prevention, treatment, care and support efforts must be maintained and strengthened, including research into alternative prevention technologies such as microbicides, and more effective treatments for HIV/AIDS;
- The first vaccines will probably not be 100% effective: prevention, treatment (including treatment research), care and support will have to continue after a vaccine becomes available; and
- Vaccine advocates and treatment activists have many

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common objectives, such as reducing stigma and discrimination; promoting voluntary and confidential HIV testing; addressing intellectual property issues in ways that facilitate expanded research and access; health care systems development; and increasing the global awareness of and response to the HIV/AIDS pandemic generally – we need to ‘expand the pie, not fight over the pieces.’

Sofia Monica Mukasa (formerly with ICASO [International Council of AIDS Service Organizations] and now Global AIDS Policy Officer with the Global Health Council) identified key developments, wove together emerging themes, and observed ‘as things change, we have to learn to change the way we think.’ Marika Fahlen, UNAIDS’ Director for Social Mobilization and Strategic Information, noted UNAIDS would shortly hold an international consultation to review and revise Guideline 6 of the International Guidelines on HIV/AIDS and Human Rights

(which addresses treatment access issues), and will establish an international reference group on human rights to advise UNAIDS on issues such as the development of model legislation, and the promotion of rights-based approaches. Mark Heywood, ALP Project Head, identified the need for better collaboration between treatment activists and vaccine advocates, including a defined agenda for discussions. Ralf Jürgens, Executive Director of the Legal Network, announced that the Network would raise funds to hold a strategic global meeting between representatives of treatment and vaccine groups within a year.

Further information about the meeting, including the full background papers, is available on the web site of the Canadian HIV/AIDS Legal Network at <http://www.aidslaw.ca/barcelona2002/e-barcelona2002.htm>.

The proceedings of the satellite meeting will be published in a special AIDS 2002 issue of the *Canadian HIV/AIDS Policy and Law Review*. ■

Barcelona Overview

by Ron Rosenes

From my perspective, the most interesting treatment news at the XIV International AIDS Conference in Barcelona was about the potential for vaccines that may have preventive and therapeutic potential. I was fascinated to hear about a vision for treatment, perhaps in as soon as five years, that might include an immunological boost provided by a therapeutic vaccine.

This was accompanied by a growing sense of disappointment with the earlier promise of virology to eradicate HIV completely from the body using presently available therapies. Since we also know that the virus develops resistance to existing therapies, there is still a need in the short term for drugs which target novel

enzymes like integrase and entry inhibitors such as T20. We also need new drugs in existing classes like tenofovir. I would say the treatment buzz is simplification of therapy using NRTIs and NNRTIs where possible to reduce pill burden, toxicities and the effects of lipodystrophy.

For treatment activists, the focus for the drug naïve continues to be on the when and how to initiate therapy, and for the treatment experienced, the fine tuning of regimens to find effective and durable ways to reduce the potential for damage to the organs, bones and cardiovascular system. While switching to protease sparing regimens has yet to prove its ability to reverse the effects

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of lipodystrophy and lipoatrophy, there are some indications that symptoms may reverse for some over time. However, most of the studies to date are not out much beyond 48 weeks. The need for therapies which do not induce metabolic and hormonal irregularities is paramount. For those initiating therapy, the reports at the Conference continue to suggest that there is no recognizable therapeutic benefit to initiate therapy until CD4 cells have reached a low of 200 to 350 as long as there are no other symptoms of disease and the viral load is stable and below 30,000 copies. Increasingly, both patients and doctors are monitoring blood work closely and conferring on when to initiate. As well, a number of studies increasingly recommend a combination of NRTIs and NNRTIs as effective and durable first line treatment. The countervailing opinion is that by initiating therapy with higher CD4s, the immune parameters may be preserved, making the individual a better candidate for a therapeutic vaccine in the future.

Research into microbicides seems to be moving, finally, toward clinical trials. A product made from Carageenan (found in seaweed) is showing promise in vitro that may now be translated into the real world. Effective microbicides that put the power of prevention into the hands of women and men (who practice anal intercourse) are urgently needed, though the questions of effectiveness and profitability still need to be resolved. This is all the more urgent in light of statistics and predictions that indicate that women will soon represent two thirds of people infected with HIV worldwide.

On the issue of global access to treatment, the Conference put to rest the division between those who focus on prevention to the exclusion of treatment. Speaker after speaker reinforced the idea that prevention and treatment are inseparable; that prevention can never be effective without ensuring that treatment is offered to those infected. Again and again, we heard that we



Louise Binder (CTAC Chair) and Tony Di Pede (CTAC Treasurer) at the Closing Ceremony.

have all the information we need to begin treating in the developing world: we just have to get started. Ironically, it is less the pharmaceutical industry that is seen as the principal impediment to global access, but rather the concern that the developed world is not putting enough money into the proposed \$10 Billion Global Fund. There is a distinct lack of political will in both the developed and the developing world to tackle the issues that would stem the tide of this epidemic. Many also worry about political corruption in developing countries that might prevent the resources, including drugs, from getting to those in need.

How do global issues relate to our work in Canada?

Obviously, we need to continue our work on behalf of all people living with HIV/AIDS. For people living with HIV/AIDS from underserved groups, including women, youth, Aboriginal people and people living in rural areas, there are additional barriers that must be addressed. There are still many barriers to access to therapies, including the federal drug review process and the provincial formulary process. We need continued pressure to achieve the broadest access to treatments for Canadians. ■

PROVINCIAL UPDATES

ONTARIO

by Enrico Mandarino

Collaboration with the Ontario AIDS network continues and plans are underway for a CTAC/OAN day on Saturday November 2nd, 2002 to bring access to treatment activists together for a day of skills building and an opportunity to work on access to treatment priorities in Ontario. The day will include an overview of CTAC's work at the national and provincial (Ontario) levels, discussion on youth specific access to treatment issues, and a report back from the International AIDS Conference held in Barcelona. In addition, committees will have an opportunity to connect and discuss the issues on which they have been working, and to formulate priorities for next year.

The provincial CTAC Network has sent a letter to the Ontario Minister of Health urging the provincial government to include drugs, which have been approved in Canada and are available in other provinces, on the provincial formulary.

Two committees that were formed at the first Ontario CTAC meeting as part of the priorities for access to treatment in Ontario, Care Shortage and Dental Care committees, met in October.

If you would like to get involved in these issues or the CTAC provincial Network, please visit www.ctac.ca or contact the CTAC office.

NEW BRUNSWICK

by Emerald Gibson

The New Brunswick network held a provincial meeting in March, which was attended by CTAC Board member Philip Lundrigan (Newfoundland Provincial Representative) and Council member John Arenburg (Nova Scotia Provincial Representative). The provincial committee was elected and it was confirmed that the Chair and the



Provincial Representative for New Brunswick is Emerald Gibson. Four priority advocacy issues were identified. Action on two of the issues, the Canadian AIDS Society Petition to increase funding for the National AIDS Strategy and the submission of an abstract to the Romanow Public Consultations, are now complete.

The other two issues, improvement of programs for people living HIV/AIDS and the Provincial AIDS Strategy, were reviewed at the September meeting. A report back from the September meeting will be available in the winter issue of the CTAC newsletter.

NOVA SCOTIA

by John Arenburg

On June 2, 2002 Nova Scotia held its first CTAC provincial network meeting in Truro, Nova Scotia with representatives from most of the province. I am pleased to announce that Nova Scotia is finally on the way to developing its own provincial network. A steering committee consisting of nine participants was created to move forward with this development.

The meeting agenda included background information on CTAC and its values and goals. Creation of a board of directors has been postponed until more information is gathered. The network plans to invite another Council Member to a future meeting to act as a leader and to provide direction. I am hopeful that next year at this time I will have a more in-depth update on the network's activities. ■

Clinical Trials – Update



by Jim Boothroyd,
Communications Manager
at the Canadian HIV Trials Network

Community guides Trials Network

This month the Canadian HIV Trials Network will submit its application for refunding by the Canadian Institutes of Health Research, its main sponsor, under the next five-year cycle of the Canadian Strategy on HIV / AIDS.

Among other things, the Network will emphasize the importance of the HIV community in the development of Canadian clinical trials in the last 12 years.

At the end of the CTN's twelfth year, March 31, our Network had reviewed 173 trial protocols, approved 104 trials and implemented 75, with a total enrolment of 7,912 volunteers at 33 clinical sites across Canada. Another 11,000 Canadians had participated in our expanded (or "compassionate") access trials of promising new HIV therapies, life-savers, in many cases.

To contact us, please call this toll free number (1-800-661-4664) or check out our website: www.hivnet.ubc.ca/ctn.html.

Dates set for Toronto workshop

Ontarians, call today and register for one of the two presentations of a popular CTN skillsbuilding workshop, Friday November 1 and Saturday November 2, at the Ramada Hotel & Suites Downtown in Toronto.

The two, free one-day workshops, entitled *Clinical Trials: What You Need to Know*, are being presented in collaboration with the Ontario AIDS Network and the Canadian AIDS Treatment Information Exchange.

The Friday workshop is open to all people living with HIV/AIDS and to representatives of community organizations; the Saturday workshop is open to people living with HIV/AIDS only.

Participants must register in advance. Travel scholarships are available. Please contact Peter Williams, Ontario AIDS Network, (416) 364-4555 or 1-800-839-0369. ■

CHAIR'S REPORT

FALL 2002

by Louise Binder

Well, summer has once again drawn to a close. It is a time I treasure for some rest, relaxation, fun and reflection. This year certainly brought much upon which to reflect, particularly following the news out of the International AIDS Conference in Barcelona in July.

The projected infection rates reported there are staggering, with a large rise in the numbers for women worldwide. Most of these people will die. Many will leave orphans for whom there is no care. We have known about the profundity of the problem in Africa. The enormity of the problem in both India and China is now also becoming known.

Yet much of the world has no access to medications at all. The likelihood of that changing anytime seems minimal at best. Those of us in the developed world that have such access and live in a society where we can raise our voices in solidarity with others with HIV elsewhere must redouble our efforts to help in every way we can. We must certainly hold our own governments accountable for their inaction.

We must also recognize the value of the access to treatment that we have in this country. These include universal access to health care; access to pharmaceutical and complementary and alternative medicines and information about them; a public system of drug reimbursement and both public and private funding discreetly targeted to HIV/AIDS activities.

Our role as watchdogs of the system is to ensure that we sound the alarm if we detect potential erosion of these hard fought rights. Our roles as public policy advisors are twofold: both to inform policymakers of the value of the present system to our society as a whole as well as individuals within it and to provide them with cogent arguments to support further enhancements to the present system.

All of us have a role to play in this work. Ensure that you find out what yours is, if you are not already certain, and help us to fulfill these roles. ■

CALENDAR OF EVENTS

FALL 2002

● **October 6th-7th, 2002**

Canadian Treatment Action Council Annual General Meeting and Skills Building

St. John's, Newfoundland

Contact: ctac@ctac.ca or (416) 410-6538

Local community is invited to join CTAC for a day of skills building in St. John's. Please see www.ctac.ca for details and to register for the day.

● **October 11th-13th, 2002**

Expand Your Horizons Symposium 2002 - Goldeye Retreat Centre

Nordegg, Alberta

Contact: positive@look.ca or (780) 488-5768

● **October 15th, 2002**

Manitoba AIDS Cooperative Annual General Meeting

Winnipeg, Manitoba

Contact: aidscoop@escape.ca or (204) 774-7722

● **October 22nd-23rd, 2002**

Legal Network Workshops

Vancouver, British Columbia

Contact: info@aidslaw.ca or (514) 397-6828

● **October 22nd-25th, 2002**

Alberta Community Council on Health (ACCH) Membership Meeting

Jasper, Alberta

Contact: acch@shaw.ca or (403) 314-0892

Skills building includes a full day

Mini International AIDS Conference.

● **October 26th, 2002**

British Columbia Persons with AIDS Society (BCPWA) Annual General Meeting

Vancouver, British Columbia

Visit www.bcpwa.org or call

1-800-994-2437

● **November 2nd, 2002**

CTAC/OAN Skills Building Day

Toronto, Ontario

Contact: Peter Williams at 1-800-839-0369 ext. 304 or e-mail

pha@ontarioaidsnetwork.on.ca

● **November 14th-15th, 2002**

Annual People Living with HIV/AIDS Fall Forum

Fredericton, NB

Contact: 1-800-561-4009

● **November 15th, 2002**

AIDS New Brunswick Annual General Meeting

Fredericton, NB

Contact: 1-800-561-4009

● **November 25th-26th, 2002**

Mini International AIDS Conference workshops

Edmonton, Alberta

Contact: (780) 488-5742

● **November 26th-December 1st, 2002**

AIDS Awareness Week / World AIDS Day

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

● **December 8th-11th, 2002**

North American Treatment Action Forum (NATAF) Conference

New Orleans, Louisiana

Visit www.nmac.org/nataf/2002 for more information

COUNCIL MEMBERS

BOARD OF DIRECTORS

- CHAIR **Louise Binder** Toronto People With AIDS Foundation (TPWAF)
 - VICE CHAIR **Glen Hillson** British Columbia
 - TREASURER **Tony Di Pede**
 - BOARD SECRETARY **Darren Greer** Canadian Aboriginal AIDS Network (CAAN)
 - ACTING BOARD SECRETARY **Daryn Bond** Manitoba
- Philip Lundrigan** Newfoundland & Labrador
- Enrico Mandarino** Ontario
- Shari Margolese** National Women's Representative
- Ron Rosenes** AIDS ACTION NOW! (AAN!)

- George Clark-Dunning** Prince Edward Island • **John Arenburg** Nova Scotia • **Emerald Gibson** New Brunswick • **Line Carreau** Québec • **Bob Mills** Alberta • **Lelah Ngeruka** Territories • **Paula Braitstein** British Columbia Persons with AIDS Society (BCPWA) • **Patrick Cupido** Canadian AIDS Treatment Information Exchange (CATIE) • **Ken Monteith** Coalition des organismes communautaires québécois de lutte contre le sida (COCQ-Sida) • **Françoise Grothé** Comité des personnes atteintes du VIH du Québec (CPAVIH) • **James Kreppner** Canadian Hemophilia Society (CHS) • **Gerard Yetman** Canadian AIDS Society (CAS) • **Richard Elliott** Canadian HIV/AIDS Legal Network

2002/2003 FUNDERS

Health Canada
 Ontario HIV Treatment Network (OHTN)
 Abbott Laboratories • Agouron Pharmaceuticals • Boehringer Ingelheim • Bristol-Myers Squibb • Gilead Sciences • GlaxoSmithKline in partnership with Shire BioChem • Hoffmann-La Roche • Merck Frosst

CTAC POSITION PAPERS AND SKILLS BUILDING VIDEOS

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: Phillip Lundrigan.
- 1999 - "Timeliness and Transparency: Assessing the Review Process for HIV Drugs", author: David Garmaise.

Video Tapes

- 2001 - "New Drug Reviews and Research: What's the Rush?" - \$9.00
- 2001 - "Making Room for CAM: Advocacy Issues regarding Complementary and Alternative Medicine (CAM)" and "How to Lobby Politicians and Bureaucrats Effectively" - \$11.00

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MEMBERSHIP

Membership applications are available by contacting the CTAC office or by visiting the CTAC web site.

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

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