

GEM NEWS

THE DAILY PAPER OF THE AFRICAN GENDER AND MEDIA INITIATIVE (GEM) DURING THE XVth INTERNATIONAL AIDS CONFERENCE IN BANGKOK

US 'beating about the Bush'

By Martin Adhola, Rosemary Okello and Nawaal Deane

The future of the Global Fund for AIDS hangs in the balance following revelations that there is tension between UNAIDS and the fund's largest donor, the USA.

A confidential memorandum in the possession of *GEM News* from UNAIDS Executive Director Peter Piot, to the UN Secretary General Kofi Annan, reflects his concerns over the threat by the US government to withdraw from the Global Fund.

The memorandum, summarising key points from the fund board meeting in Geneva from 28-30 June, says that the US had threatened to pull out funding if Piot failed to present a good business plan on time.

The memo says that among areas where "significant differences and tension" have emerged are disagreements be-



tween the USA, NGO constituencies and recipient country constitutions on the role of the state versus the Country Coordinating Mechanisms (CCMs). During protests and in press

conferences yesterday, AIDS activists accused the US of scaling down its assistance to the multilateral Global Fund as an insidious way of promoting its own President's Emergency

Plan For Aids Relief (PEPFAR).

Kamon Uppakaew, chair of the Thai Network of People Living With AIDS declared that "the people of the world and

especially those living with AIDS will not accept the lies and excuses put forth by rich nations, we have found the leaders of those countries guilty of mass murder."

With 30 percent of the wealth of the G8 nations, the US should be contributing \$30 billion to the fund, to which contributions are calculated according to GDP, over the next five years.

Instead, it has reduced its contribution from \$500 million last year to \$200 million this year, a mere four times the amount committed by one private foundation in the USA, the Bill and Belinda Gates Foundation.

In contrast the US government intends to channel \$15 billion through PEPFAR to 12 African countries, two Caribbean, and one South East Asia country. This aid carries heavy conditionalities including giving precedence to abstinence over

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Treatment: Whose truth?

By Juliana Omale

What is the truth on pricing and are generics as cheap as the world has been made to believe? The divergent opinions on this subject were apparent at separate media briefings as the conference got underway yesterday.

According to Jeremiah Norris, a researcher at the Hudson Institute in Washington, by focusing on just the price of drugs the media and health ac-

tivists perpetuate the misunderstanding that this is the largest barrier to effectively treating AIDS: "Insisting that innovator or patented "brand name" drugs are significantly more expensive is fundamentally misleading."

He cautioned that the singular focus on antiretroviral drug prices shifts attention from the real obstacles to treatment access in developing countries,

which are; high import taxes, lack of medical personnel and infrastructure and honest governments.

But the position at Medicins Sans Frontier is radically different. Dr Paul Cawthorne, Head of Mission for MSF, Thailand cautioned that access to new drugs will be more difficult after the full implementation of the World Trade Organisation's Trade and Related Intellectual Property Rights (TRIPs) agreement in 2005. This will happen if patent terms are extended beyond 20 years, limiting the grounds for the issue of compulsory licences and blocking generic registration where no patents exist.

"Thailand and Brazil are leaders in the developing world by investing in the production of generic medicines for AIDS,"

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Demanding generics

By Antonette Miday

Drug giant GlaxoSmithKline, the largest manufacturer of HIV/AIDS drugs, yesterday faced protests over its reluctance to license the manufacture of generics of its drugs in developing countries.

The protest march to GSK's stand was organised by the AIDS Healthcare Foundation, an American AIDS organisation that provides medical care to about 1,800 people in developing countries.

Carrying placards that read "Not one pill" and "GSK drugs kill millions", the protesters also decried the slow implementation of the voluntary licences granted by GSK to South Africa. GSK granted the voluntary licences to South Africa's Aspen Pharmacare company in October 2001 to produce generic versions of several key GSK AIDS drugs. However, according to the pro-

testers, no generic version of any of GSK AIDS drug has been produced by Aspen. And GSK is reluctant to allow voluntary licences in other African countries.

"We have been in contact with GSK for over two years, yet there is no response. We have no choice but to protest against this shameful exploitation of AIDS patients in developing countries," said Mr Michael Weinstein, the foundation's president.

Dr Bernard Okong'o from a Ugandan organisation, Uganda Cares, said: "Most AIDS patients in Africa can hardly afford the generic drugs. Denying the countries the right to manufacture the drugs is sending them to their death. It is therefore important to put pressure on the big companies for the benefit of the AIDS patients."



Herbal treatments link continents

Janine Morna and Rosemary Okello

As the conference spotlight turns to treatment today, community groups from Africa and Asia are comparing notes on herbal treatment at the Global Village.

The two continents most affected by the pandemic, have found creative and effective responses to the virus through traditional knowledge.

"I am an example of a person who gets treatment for HIV/AIDS from herbal therapy," declared Amina Achieng'.

The exchanges between healers at the Global Village yesterday served as a reminder that sometimes solutions are close to home than might be imagined.

Stephen Lewis, the UNAIDS envoy who attended the session commended the linkages

between Africa and Asia when it comes to treatment. "The two continents have proved that you don't have to have labs or research institutes in order for you to respond to treatment," said Lewis.

Wiang Kaen hospital, which has a small stall in the global village, is a local example of the power of herbal treatments. The organisation was founded by Dr Bongkot Leucha who, after testing HIV positive 12 years ago, has been using her own herbal recipes to remain healthy.

Bongkot now teaches the rest of her group to prepare herbal recipes. Some members use the remedies in conjunction with ARV treatment. The combination appears effective: One infected member claims to now have a CD4 count of over 1000

(a CD4 count over 300 is considered healthy).

Wiang Kaen hospital dispenses two herbal capsules, each compiled of seven different ingredients. The capsules help improve appetite, sleeping habits and control the spread of HIV in the body.

Similarly the Department for the Development of Thai Traditional and Alternative Medicine in the global village is helping to promote the use of herbal medicines. Public relations officer, Weerapan Dhareethai comments that because Thailand is predominantly Buddhist, locals feel most comfortable with herbal remedies. Her organisation works together with traditional healers to strengthen knowledge and research.

The village comes to Bangkok

By Antonette Miday

People locked out of the conference by the prohibitive \$800 participation fee can still participate through the Global Village, taking place at the conference venue.

The Global Village, which was officially opened yesterday, allows non-delegates to interact with people attending the various conference sessions and share their experiences.

It also gives them access to the thousands of journalists covering the conference.

It was officially opened by Dr Lieve Fransen, the EU representative, who praised the organisers for the noble initiative.

The Global Village, the theme "listening from those who live it", has been organised by Community Programme Committee in Thailand.

Participants include people living with HIV/AIDS, activists and representatives of various groups.

The forum will operate a community radio with live broadcasts from sessions, reports on discussions and activities both in and out of the conference rooms and interviews with people involved in HIV/AIDS work around the world including community members, activists, among others.

"The community radio is available for only three dollars. It will enable local people to follow proceedings and know what is happening. This has been the missing link in host countries of International Conferences," says Sangsiri Teemanka, the Global Village coordinator.

Broadcasts will be in English and Thai and a special programme time will be allocated for international broadcasting in other languages, including Lao, Khmer, Vietnamese, Chinese, French and Spanish. Some of the stands at the village are the health communities market, the Centre for Community Networking and Advocacy and Promoting Spiritual and Mental Health Centre.

Organisers are optimistic the concept of a "global village" will be carried on to other conferences.

"Participation fees to International Aids Conferences are too often high, which shuts out most interested people. The global village therefore seeks to encourage the participation of people who cannot raise money for registration to meet and share their concerns," says Sutthida Malikaew, the community programme co-ordinator of the Global Village.

'Marriage for life' with the gentle giants

By Susan Mwangi



Elephants, the symbol of the 15th IAC, are here in the flesh, cared for by two women making a mark in the traditionally male art of caring for ceremonial Thai elephants. They will delight delegates to a daily elephant show at the conference.

"We train them and they teach us how to talk the elephant language," laughs Dr Helena Zimova, a veterinarian who, with her colleague Lenka Pilousova, both from the Litomerice Town in the Czech Republic, are volunteers with the Ayutthaya Elephant Palace and Royal Kraal organization. In Thai, the carers are known as *mahout*.

Elephants are a symbol of Thai culture and of the conference where they

represent the power of partnerships in the fight against HIV/AIDS.

The Ayutthaya Elephant Palace and Royal Kraal organisation educates the local people on the need to take care of elephants. It also cares for lone and sick elephants and pays for treatment of elephants at the two animal hospitals in the country.

Dr Zimova says of her calling: "Having a relationship with elephants is part of the Thai culture. It is very interesting for us. I have never seen anybody with such a relationship with elephants. The relationship between a *mahout* and an elephant is like a marriage forever."

Another *mahout*, Margo Somboon, has been at the job for the last five years. She has worked in Asia for over 35 years, most of the time in Singapore where she cared for race horses and polo ponies.

Thailand has about 3 500 domesticated elephants and over 2000 wild elephants. Male elephants born without tusks cost between \$40 and \$60. They are mainly used for shows while the white are the King's property.

Traditionally, elephants were used in trekking, battles and in logging wood before the government ban of logging in the 1980's.

Treatment v/s reproductive health

By Arthur Okwemba

Campaigners from developing countries – especially in Africa — are apprehensive that access to reproductive health and rights may be sacrificed at the altar of donor conditionalities and prioritisation of treatment.

In many countries, there is a glaring difference between resources allocated to preventive services such as family planning and access to contraceptive information, on one hand, and money spent on treatment of people infected with HIV/AIDS.

A number of African countries, some of which are sending diplomatic protests to donors, are anxious that provision of contraceptives is notoriously becoming erratic as donors' interest shifts to HIV/AIDS treatment.

Says Dr Mabel Blanco, president of Foundation for Studies and Research on Women: "There is real a problem here. Donors are insisting HIV/AIDS money is principally for treatment, and countries or NGOs



are not allowed to use it for prevention programmes, such as family planning and empowering women to pursue their sexual rights."

According to the campaigners, the current shift towards treatment, while turning a blind eye to reproductive health, is failing to recognise the interrelation of prevention-testing-treatment in any successful HIV/AIDS

programme. Access to reproductive health information and condoms, particularly, is being compromised in this oversight.

The Bush administration came under a scathing attack for concentrating on treatment and only certain aspects of prevention.

Reproductive health activists accuse the US of downgrading condoms and instead pushing

options that are difficult to achieve, such as abstinence.

Of the one billion dollars pledged for HIV/AIDS programmes in Africa by the Bush administration, 33 per cent goes to campaigns for abstinence.

According to US House of Representative Barbara Lees, "this administration has let politics, rather than science,

guide its policies, and has not developed strategies to protect young girls and women."

Loretta Hieber-Girardet, World Health Organisation's technical officer in the Communications Department maintains that although there appears to be a shift, prevention remains the main focus.

She says the real urgency now is to save lives and put more productive infected people in developing countries on ARVs.

But participants said the agenda of some of the main sponsors of the conference adds credence to their claims. They focus on treatment, with little being talked about prevention and care.

Pharmaceutical companies deny these claims. "Our expertise is in treatment and diagnostic matters. So we are working and focusing on areas we understand best, not those other groups like governments and NGOs are better placed to handle," said Brian Kyhos, Abbott Laboratories' director of public affairs.

Three by five doesn't add up

By Martin Adhola

With only 18 months to the deadline, the possibility of giving AIDS drugs to three million people by 2005 seems to be in doubt.

Although the World Health Organisation and UNAIDS that are spearheading the ambitious initiative are optimistic, Joep Lange, President of the International Aids Society and co-chair of the conference,

says the target is unrealistic.

For the target to be achieved, the existing healthcare infrastructure in the developing world must first be rehabilitated to ensure drugs reach the communities and quality treatment is offered, he adds.

Dr J.Y. Kim, head of the WHO says the organisation is accelerating its evaluation processes to fast-track the

programme. So far, 440,000 people from developing countries living with AIDS have been put on treatment since the initiative was inaugurated at the last AIDS conference in Barcelona in 2002.

UNAIDS itself has conceded that attempts to enroll people in treatment programmes are behind schedule. The executive director, Dr Peter Piot, has described the Three by Five initiative as "a massive challenge, but one we cannot afford to miss." He said: "The focus should now shift from when and how we will get the drugs to how many people we can actually treat."

30 million people have already died of AIDS and at least 40 million more are infected.



US... Continued from page 1

condoms; rules about generic drugs that favour big companies and forbidding aid to organisations that support legalised abortion.

Currently the global fund is faced with an acute cash crunch with a bank account reading \$ 900 million that activists say will not be able to finance the next round of disbursements. The board is due

to meet in Arusha Tanzania in November to launch the fifth replenishment of the fund. The total pledges by all donors up to the end of 2008 amount to US\$ 5.4 billion.

Richard Feacham, Executive Director of the Global Fund argues that from 2007 onwards, US\$ 20 billion would be needed every year for AIDS alone with another US\$

3-5 billion needed to fight TB and malaria.

But Feachem has been careful not to criticise the Bush Administration approach to the Fund saying that both bilateral and multi-lateral donor approaches to combating AIDS are welcome.

Treatment... Continued from page 1

he said. "If they sign these agreements they will have to close down their plants, impeding access for millions of people with AIDS," he said.

The national treatment plan in Thailand has pledged to treat up to 70,000 people by the end of 2005, but the concern of activist organisations is that should a United States-Thailand free trade agreement come into force, it will restrict the sustainability and expansion of the ARV treatment plan by restricting the production and use of generics.

The Campaign for Access to Essential Medicines advocates overcoming patent barriers, the simplification of treatment protocols, including the use of fixed dose combination drugs and bringing the cost down to below \$300 per patient per year by stimulating competition between producers in the search for quality medication that is least expensive.

Joan Chamungu of the Tanzanian Service Health Development for People Living with HIV/AIDS, which has 70,000 members, says that the cheapest ARV is *Trimune*, at \$420 per person per year, but the majority of women in her country live on less than a dollar a day, restricting their access to the most basic of their needs.

"In Tanzania, very few people are on ARVs; the data is scanty and, therefore, AIDS is suffered in silence."

The International Community of Women Living with AIDS, of which Chamungu's organisation is a member, has pointed out that costs and distance barriers are likely to be more severe restrictions for women than for men. Women often lack money or the time to travel long distances to distribution points and often have to account for their time to husbands or other family members.

Dr Myrto Schaefer, medical programme manager at MSF, said the profile of patients in the developing countries where the organisation works was significantly different from those in wealthier countries. "More than half of all the patients treated within MSF programmes are women of child-bearing age, and there are high numbers of children in need of ARV treatment."

This profile fits the gendered dimensions of restrictive treatment access. For instance access to *Nevirapine* focuses on prevention for the unborn child in disregard to the mother's right to the need for antiretroviral therapy for herself.

Access: Treatment and care

THE FACTS

- Less than one in 10 people who need anti-retroviral therapy receive it

- An estimated five to six million people in low and middle-income countries will die in the next two years if they do not receive anti-retroviral treatment. As of December 2003 only an estimated 400 000 people in these regions were obtaining ARVs

- Several South American countries have universal coverage for anti-retroviral therapy, including Argentina, Brazil, Chile, Cuba, Mexico and Uruguay

- In Sub-Saharan Africa, an estimated 4.3 million people need AIDS home-based care, but only approximately 12 percent receive it

- Ethiopia, Kenya, Mozambique, Nigeria, Tanzania, Uganda and South Africa have plans to start manufacturing generic drugs sometime during 2004-2005

- A survey of 700 HIV-positive people in Cote D'Ivoire indicated that those with access to anti-retroviral treatment were more likely to use condoms during sex than those without access

- Africa has a major shortage of nurses, midwives and doctors as they leave their native countries for better salaries, working conditions and opportunities in higher income countries

- 70 percent of doctors trained in South Africa currently live abroad

- While adolescent girls are at the highest risk of HIV infection due to gender power imbalances, early marriages, sexual violence and intergenerational sex, they have the least power to demand treatment and also face legal barriers such as age-of-consent laws

- In Thailand, lower drug prices have contributed to a fivefold increase in the number of HIV-positive patients receiving anti-retroviral treatment

Still a drop in the ocean

By Arthur Okwemba

A major resolution of the 14th International AIDS Conference in Barcelona in 2002 was to accelerate access to anti-retroviral drugs (ARVs).

Two years later, the *UNAIDS 2004 Report on the Global AIDS Epidemic* highlights that "less than one in ten people who need anti-retroviral therapy receive it". Is it premature to begin measuring progress in this context?

The response at the start of the 15th Conference in Bangkok is ambiguous. Some reports emphasise positive localised action, while others argue that much still remains to be done.

While coverage remains extremely low, African governments have begun implementing anti-retroviral therapy (ART) programmes in public and private sectors, specifically targeting those who cannot afford the drugs at market rates. Access to

ARVs in other African countries is also improving as attempts are made to move beyond the current five percent coverage.

The prices of ARVs are falling as more generic drugs become available on the market. In Kenya for example, the cost of one month's supply of ARVs has dropped by 95 percent! As a result of the price cuts, Kenya's National AIDS and STD Control Programme estimates 18 600 of the 200 000 people who need the drugs are now able to access them.

However, not all is well as some women accessing treatment in Kenya claim that there is no equity in the way in which the programme is being implemented. They argue that it is difficult for them to get enrolled into the programme compared to men.

Caroline Adero says she has

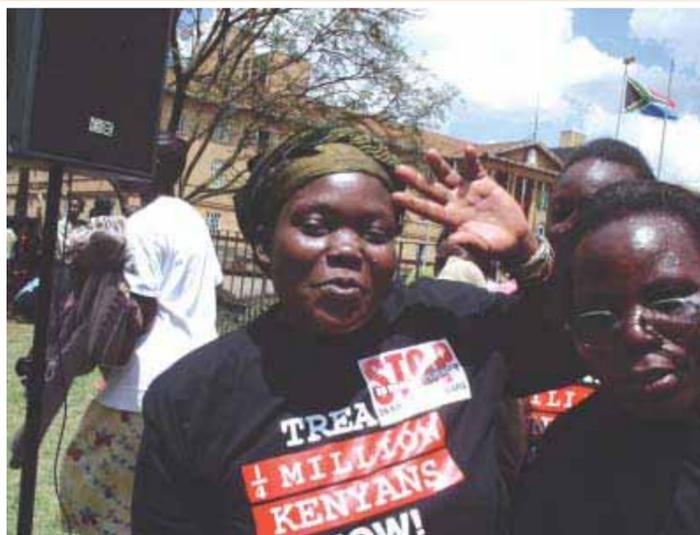
tried in vain to get enrolled into the programme. "I think something is wrong with how the programme is being run. There is a certain degree of corruption that locks out many women."

A single mother of two, Adero had to go elsewhere, and was assisted by an international NGO, which gives her ARVs and meets the costs of viral load and CD4 count tests, critical in monitoring her well being.

However, hospitals such as the Mbagathi District hospital, in Nairobi, one of the government hospitals implementing the ARV programme, offer a different view.

"The decision is taken by a committee and not one individual, after the persons' viral load and other indicators have been measured," says a medical official.

However, the feeling in Bangkok is that poverty, marginalisation



and cultural factors make it difficult for women, who constitute almost 50 percent of those infected, to access ART. Added to these gender imbalances, a concern for many African governments is the possibility of resistance strains developing as more people access the drugs in response to falling prices, but fail to adhere to the dosage.

Experts are anxious that adherence, and therefore the effectiveness of the drugs may be compromised as a result of bad nu-

trition due to poverty. Integrating a dual programme of ART and nutrition is essential.

Another concern is that while the prices of ARVs are falling, those for drugs for opportunistic infections are either increasing or remain static.

In addition, Joia Mukherjee of Department of Social Medicine at the Harvard Medical School, who has worked in Africa, says an acute shortage of medical personnel is also likely to affect the ARV scale-up process in de-

veloping countries.

Speaking at the Bangkok conference, during the World Health Organisation's session on the 'Three by Five' initiative, she observed:

"In some countries, drugs may not reach as many people as fast as possible since money is still needed to train health personnel who will deliver the drugs and monitor the patients using them."

Slow roll out in South Africa

Political prevarication and weak management has hampered the implementation of the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa.

This is according to a preliminary report, the first in a series that will monitor the implementation of the Operational Plan, researched and produced by the AIDS Law Project (ALP) and the Treatment Action Campaign (TAC), a powerful treatment lobby group in South Africa.

The report deals with the first seven months since the South African Department of Health's announcement of the operational plan in November 2003. It focuses on the numbers of people who have begun to receive ARV treatment in the country and also the degree to which information about the plan is being made available.

"It is worrying that several months after the Operational Plan was publicly released, information relating to time-lines and targets have not been made public," says Fatima Hassan, of the Law and Treatment Access Unit of the ALP and one of the authors of the report.

She says that the people who were to benefit most from the plan were the poor who needed treatment in the public sector as well as accurate and reliable information in order to make important decisions about accessing treatment.

TAC and the ALP began corresponding with provincial health departments as well as the na-

tional department of health early in 2004. By the end of March 2004 researchers found that substantially less than the 53 000 people government announced stood to benefit from the plan were on ARV treatment in the public health sector.

In his



State of the Nation Address to Parliament on May 21, 2004, President Thabo Mbeki said

government hope to reach the initial 53 000 target a year by March 2005. Despite this, by June 2004, less than 10 000 people had begun ARV treatment in the country.

The TAC are still in the process of confirming that the 27 sites accredited to provide ARV treatment, as stated by the Minister of Health Dr Manto Tshabalala-Msimang, were indeed accredited. In KwaZulu-Natal, 12 sites that had been accredited earlier in the year had not been given the go-ahead to begin treatment until June 2004.

The report found that "a great deal of effort is going into implementing the Operational Plan at a district and provincial level" but that "unfortunately this effort was not being matched at a national level".

It also found that communication about the plan was "extremely weak" in most provinces and that the Department of Health continued to "violate the right to access health care services by operating secretly and refusing to make important information available".

Another obstacle was that although hospitals and clinics were under pressure to provide ARV treatment, they were not getting additional capital or staff.

"This is a critical management question - the plan is meant to better the health service, rather than further overload it."

Source: Health-e News Service South Africa

Women demand treatment

By Caroline Maposhere

An absence of information and the location of HIV/AIDS treatment activities in urban areas has severely limited Zimbabwean women's ability to access treatment for HIV/AIDS. This is de-

spite women accounting for nearly 57 percent of infected people living with HIV in Sub-Saharan Africa. In fact, in each of the 38 African countries for which data available, women

constitute more than 50 percent of the total infected population.

"Women do not have access to information about what is and what is not available," says Matilda Moyo, an activist with the Pan African Treatment Access Movement (PATAM). "Although the Prevention of Parent-to-Child Transmission (PPTCT) programme has been going on for over two years in the country, there are still some women who do not know that they can access the intervention".

Echoing the need for the provision of information, Angeline Chiwetani, coordina-

tor of the Network for Zimbabwean Positive Women (NZPW) says it is essential for women who have taken Nevirapine to be aware of the consequences once they start ART. "As positive women we lack adequate information on whether or not there will be drug resistance when the same woman who has taken Nevirapine to prevent transmission to an infant now needs ART."

"If the government could follow up the women in PPTCT programmes and give them anti-retroviral therapy (ART) when they qualify, then treatment would be accessible to more women."

Another concern is that HIV/AIDS treatment activities remain concentrated in urban cen-

ters far removed from the large majority of Zimbabwean women who live in the rural areas. ART programmes are located in major hospitals in Harare and Bulawayo, or in workplace programmes, where the majority of the employees are men.

"To date there are about 4 500 people on ART, of which 1 200 are through the public health care system. Others access ARVs through either private physicians, general practitioners or workplace initiatives," said a Ministry of Health and Child Welfare official in the AIDS and TB unit.

The Zimbabwean government has made some of the anti-retroviral drugs available to centres closer to rural areas through the public health care system.

Diflucan, for example, a potent drug that treats opportunistic infections like cryptococcal meningitis and esophageal thrush, has been made available to 53 centres in the country, including district and mission hospitals.

HIV/AIDS treatment requires the involvement of both women and men. "Through the voluntary counseling and testing that is done at ante-natal clinics, women carry the burden of [bearing] the bad news about there being HIV infection in the family. However, through the community mobilisation efforts, more men are accompanying their spouses to the ante-natal clinic where they are both tested and counseled at the same time," said Sostain Moyo, a counseling coordinator with the Zimbabwe AIDS Prevention Project.



Opinion

We can learn a lot from traditional medicines

Mary Ann Burris

In the more than 20 years that the world has been living with HIV/AIDS, we have learned a lot about caring for those who are infected with the virus. Our arsenal of treatments includes new drugs, those developed with considerable care and astonishing amounts of money like anti-retrovirals (ARVs), which indeed represent huge steps forward.

Our arsenal also includes other approaches which are the tried and true measures that we all know shape our health and keep our immune systems strong — good food, appropriate exercise, a positive attitude, herbal medicines, vitamins and minerals, and supportive living conditions.

We know that there is a huge range in the way the virus acts on individuals and even wider gaps in the treatments available to positive people across the world. In the face of so much diversity, why are we now finding a narrowing of ideas in global conversations about good treatment?

When we listen to the treatment experiences of positive people, particularly those in the developing world, we hear about effective ways of using traditional, herbal and nutritional remedies to stay healthy or get healthier.

We find that most medical traditions have ways to help our bodies cope with the virus, ways to boost our immune system and keep us strong. Research has also shown that some of these traditions have



effective ways of reducing the virus in our bodies.

And, we learn that positive people have themselves been using these with good results. Our treatment decisions are always made in circumstances of limited choice. Whether it is our economic circumstance, our knowledge, our gender, or our nationality that shapes these choices, for each person the range of options is different and they are often shaped by things outside our control.

Also, for each person our aspirations in terms of treatment, our ability or willingness to drastically change our diets or our lifestyles varies. We make our choices based on what we want as well as what is available to us.

Our varying treatment experiences lead us back to question structural realities which shape the epidemic and our responses

to it. Individual vulnerability brings us back to the systems which create it.

Listening to positive people share their decisions and their fears brings us face to face with the lived effects of stigma, guilt over our sexuality, of silence and ignorance surrounding our bodies, of our yearning to live, our need for love.

It shows us that our blood, whether it has signs of HIV antibodies or not, runs through veins shaped at every level by what lies outside our skin. Global treatment agendas which do not take broader health needs and alternative treatment therapies into account are not going to be as effective as they could be. They are not going to take us where we need to go.

When we see treatment becoming synonymous with the roll out of ARVs, we feel that this does not adequately reflect the

realities of many of our lives — in part because many of us do not meet the requirements of ARV protocols.

We feel that this overlooks the basic ingredients necessary to secure good health — a nutritious diet, clean water, secure living conditions, the ability to maintain safe and pleasurable sexual lives.

We welcome all effective treatments, including ARVs, into the mix of what is available to us, but we call on those who make decisions about treatment to consider, fund, and broaden their definitions so that they honour the knowledge that we have about staying healthy, some of it from medical traditions outside the bounds of conventional biomedicine.

(Mary Ann Burris is the director of the Trust for Indigenous Culture and Health in Kenya.)

Editorial Beating Bush

There is something uncanny about the USA. There is not a single global conference in the last decade in which the superpower has not been the party pooper, whether the subject is the environment, reproductive rights, or housing.

And it's not just because we all love to hate or are secretly envious of the rich and the wealthy. It's because, without fail, the US manages to behave itself badly, flaunting its wealth, laying down the rules and throwing its toys out of the cot.

All the tell tale signs are here at the IAC in Bangkok: the demand that no one be allowed to heckle the USA (the global champion of free speech and democracy); the downscaling of the size and level of the delegation; the threat to withdraw aid; the strings attached to US aid; the strong leaning towards bilateralism (read divide and rule) at an event where the world is grappling with a catastrophe that knows no boundaries.

President George Bush has added to this familiar milieu his own fanatical and infantile view of global politics. No American president has managed to make such a mess, in such a short time or to put global security in such peril.

It should be pause for thought that HIV/AIDS poses a far greater threat to world security than any of the "terrorists" that the US has relentlessly (and mostly unsuccessfully) sought to "smoke out", ahem, from behind the bush.

The \$30 billion that the Global Fund for AIDS is seeking from the USA over the next five years (\$6 billion a year, compared to its commitment of \$200 million a year) is petty cash in Bush's war chest. It would do much to restore the faith of the world's most vulnerable communities, and especially People Living with AIDS, if the richest nation on earth sent out even the most muted message that it cares about their lives.

All is not lost. Present at the conference are many US citizens here to say that they disagree with their President's bully boy tactics. Bush's contender in the imminent US elections, Senator John Kerry, has nailed his colours to his mast by supporting the \$30 billion to the Global Fund.

It's time to stop beating about the bush and get on with the business of beating Bush.

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Project Director:

Rosemary Okello-Orlale

Managing Editor:

Colleen Lowe Morna

Editors:

Pamella Makotsi Sittoni, Janine Moolman

Writers:

Juliana Omale, Nawaal Deane, Loga Virahsawmy, MarieAnnick Savripene, Arthur Okwembah, Martin Adhola, Omar Faye, Susan Mwangi, Janine Morna, Betty Oyugi and Antonette Miday

Photographer:

Nonqaba Msimang
Susan Mwagi

Layout:

Fredrick Tantuo

Printed by: Smart Document Co. Ltd

893 Prachachuen 29, Bagsue, Bangkok 10800.



Gender Links

1 Ernest Oppenheimer Street,
Cnr Queen Lakeside Place,
Lower Ground, Bruma, 2198
tel: +27116222877
fax: 27116224732
email: info@genderlinks.co.za

website:
www.genderlinks.org.za



African Woman and Child
Feature Service

P.O Box 48197, Nairobi, Kenya
Nairobi Baptist Church
Apartments,
4th gate on the right, Maisonette
No.1

tel: +25422724756, 2720554
fax: +25422718469

email: awcin@kenyaonline.com

website: www.awcfs.org