

APPENDIX A:

Participant Information Leaflet for Research Project

Title of research: MEDIA FOR DEVELOPMENT: News media coverage of Women's health within the realm of Prevention of Mother-to-Child Transmission of HIV (PMTCT) in South Africa

Introduction

Hello, my name is Róchelle Renere Davidson. I am a Masters student in the Development Studies Programme at the University of Witwatersrand. I am conducting research to understand to what extent media can facilitate the development of women's health in South Africa. I want to explore the engagement of media in the development of women's health in South Africa; particularly in the context of the prevention of mother-to-child transmission of HIV (PMTCT).

I would like to invite you to be interviewed on your experiences and views on this topic.

In order to take part in the research you must be a journalist, media practitioner, development specialist in women's health, or health practitioner specifically dealing with PMTCT.

Some of the things I would like you to talk about are:

- Your opinion on the media coverage of women's health, specifically concerning PMTCT, in South Africa
- How can women's health be raised as vital for development in the public's eye, and should media be expected or responsible for covering such issues in this particular way?
- What does 'media advocacy' mean to you?
- What do you believe to be the challenges that print media face in covering such issues as women's health in South Africa?

Reason for the research

The prevention of mother-to-child transmission (PMTCT) of HIV is one issue that demonstrates the complexity of women's health in development. With mother-to-child transmission (MTCT) accounting for 700, 000 new infections in infants and children worldwide in 2003, most occurring in Sub-Saharan Africa, PMTCT is of significant concern for women's health. Though it is a contested terrain, this research begins with the premise that media has the ability to raise or diminish critical awareness of such developmental issues. A primary concern using the case study of the Nevirapine resistance debates is to understand how the media can responsibly and critically cover the concerns of such a vulnerable yet pertinent group to the development of South Africa: women. Thus this discussion is important because it aims to highlight the concerns and experiences of these women in relation to PMTCT, as critical to their development and the overall development of a country.

If you agree to be interviewed

In total the interview will last for an hour, although in some instances it may take slightly longer. We will meet at a destination of your choosing, or if you are not based in Johannesburg, the interview can be conducted through a sequence of emails. If you do not want to carry on with the interview you can stop the interview at any time.

If you travel to or from the interview for the specific purpose of being interviewed you will be paid back whatever money you spend on transport.

Privacy and confidentiality

If you are willing to be interviewed but don't want to be identified that is fine. I will make sure that your name and any other identifying features are left out of my research and writing. I will keep your identity a secret (i.e. you will remain anonymous). If you change your mind in the middle of the process and decide you want to be anonymous, your wish will be respected.

I would like to tape record the interview and make transcripts of it. Once the research is complete I will destroy the tape recordings and the transcripts will be kept by me.

What if you don't want to participate in the interview?

You don't need to give any reasons for why you don't want to take part.

What if you want to withdraw from the interview?

You are free to stop taking part in the interview at any point in the process.

Benefits

There are no personal benefits to you for agreeing to participate. The only benefit is for people to understand more about the possibilities and limitations of print media in improving the development of women's health, particularly concerning PMTCT, in South Africa. If you like, I will be happy to give you a copy of my research report (which should be available in late 2006) for you to read.

Possibility of problems if you agree to participate in this interview

It is unlikely that there will be any problems if you agree. If you feel emotionally distressed as a result of being interviewed a counsellor will be made available to you at an appointed time.

Ethical Guide

The ethics guiding social science research would be followed when conducting the interviews.

Queries

If you have any questions about this research you may ask now or at any point during the interview. If you feel that at any point you are not being treated properly or your privacy is not being respected you may telephone Ms Natalie Ridgard, my supervisor, at the University of the Witwatersrand at (011) 717 4086.

Informed Consent:

- I hereby confirm that I have been informed by the researcher,
..... (*INSERT NAME OF RESEARCHER*),
about the nature, conduct, benefits and risks of the study:
.....
.....
.....
(*INSERT PROTOCOL NUMBER AND TITLE OF STUDY*)
- I have also received, read and understood the above written information (Participant Information Leaflet and Informed Consent) regarding the study.
- I do/do not wish for my name and identifying features to remain anonymous
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

PARTICIPANT:

Printed Name	Signature	Date and Time
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I, (*INSERT NAME OF RESEARCHER*),
herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Printed Name	Signature	Date and Time
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Informed Consent for interview to be tape recorded

I (*INSERT NAME OF PARTICIPANT*) give my consent for the interview to be tape recorded

Yes ☐

No ☐

Printed Name
Time

Signature

Date and

APPENDIX B:

Interview Guide for Róchelle Davidson's MA Research Report

Title: *Media for Development: News media coverage of Women's health within the realm of PMTCT in South Africa*

- What does your job involve?
 - What is your experience with PMTCT, or women's health if any?
- Is PMTCT a major health issue in South Africa?
 - Is it a developmental issue: does it impact the future socio-economic and human development of this country?
 - What about its impact on women's development?
- What are your perceptions on the media (newspapers) coverage of women's health, specifically concerning PMTCT, in South Africa?
- What are the prominent concerns that the media covers in regards to the Nevirapine resistance debates?
 - What are the gaps?
- How versed are journalists, in your opinion, on the complex issues (medical and socio-economic) of women's health, within the realm of PMTCT, in South Africa?
- What are media's responsibilities as a profit-making enterprise?
- What about media's responsibilities in development?
- And what are the challenges media face in covering such issues as women's health and PMTCT?
- Does media have a moral and social duty to cover HIV/AIDS/?
 - What about women's health?

APPENDIX C:

PARAPHRASED INTERVIEWS WITH VARIOUS STAKEHOLDERS IN NEWS MEDIA AND PMTCT IN SOUTH AFRICA

Paraphrased Interview 1:

Helen Struthers from the Peri-natal HIV Research Unit (PHRU) at Chris Baragwanath Hospital in Johannesburg, South Africa

Helen Struthers has extensive experience with the PMTCT programme in Soweto, and she continually stresses that PMTCT is a very important programme for South Africa. In response to the media's coverage of issues around Nevirapine, she states that because science has not got a clear answer about issues of potential viral resistance that the public gets more confused and it does not help that the media seems to be preoccupied with the political controversy on the issues.

One of the major points she brings out in the interview is that the media contributes to the issue of women's health in the realm of PMTCT by being "silent." Struthers asserts that the stories are generally about the Treatment Action Campaign and the Minister of Health. She says the public should know what happens to individual HIV-positive pregnant women who take Nevirapine for PMTCT, to say "you know this is what happened to me." She also stresses that the media should look at the broader social issues, she suggests "follow up" stories.

When asked what the media's role should be in the particular issue of development she states "If their mandate is to educate the public about what's happening in the world, then they have to... inform- or make the people know...Steer people in –if they want to follow up or want to know more, I think they need to be pointed in the direction of where they can find that information. But I don't think it's supposed to be the newspapers role to run educational supplements on HIV... newspapers needs to... expand their mandate around what news is."

Paraphrased Interview 2:

Libby Lloyd, Director of the Media Development and Diversity Agency (MDDA) in Johannesburg, South Africa

Libby Lloyd as Director of the MDDA has an important perspective on the media's functions in the transformation of a society. Her definition of the media is valuable "by the media...our whole sort of basis on which we are premised is that we need to have many different diverse voices and points of view, so that presumes that [there will be a] media that advocates different positions." This is significant definition because it sheds light on how media can facilitate different development agendas, particularly ones that are generally marginalised.

While she acknowledges the various challenges that a commercial environment can bring to newspapers, she asserts that news media should public issues that are relevant to marginalised communities as well as make their voices heard. Media has a critical function to make these issues relevant to the country as well; she states "HIV/AIDS,

whoever you are in South Africa, has got relevance to you...it's a major issue affecting South Africa, and the development of South Africa..."

Another valuable point that Lloyd brings up is that media should understand their impact on society. She gives the example of HIV-positive women being able to bottle-feed their infants, "one story could spark up something in one woman that gave her the courage to challenge something...media can give few people in those situations the strength to be able to bottle-feed, and that's a huge role to play...As well as that I think that just continual writing about people with particular problems creates more tolerance in society."

Paraphrased Interview 3:

Tusi Fokane, Director of the Media Institute of Southern Africa (MISA)-South Africa branch

Tusi Fokane also has extensive experience with media institutions throughout the Southern African region. She states that commercial media players "tend to target sort of urban areas, metropolitan areas and are more educated, affluent-the target market." What she refers to is the consumers of newspapers are those with disposable income. Consequently issues such as PMTCT may not attract these consumers.

She also makes note of the fact that some newspapers in South Africa are criticised as not adhering to the notion of the 'national interest.' Therefore any discussion of a 'development media' is seen as propagating the interest of the ruling political party, and this goes against one of the fundamental mandates of the press to be a "watchdog" for the public.

However, she states that the media, in this case the newspapers, do have responsibility to report on important issues. She believes that the lack of investigative stories around HIV/AIDS is because it falls under 'women's issues' and these issues tend to be underreported and underrepresented in the press. In order for this to change, Fokane says there needs to be change at the structural levels: more women editors and journalists and a HIV/AIDS policy and Gender policy.

Paraphrased Interview 4:

Kubi Rama- Deputy Director of GenderLinks, Johannesburg South Africa

Kubi Rama is particularly interested in women's representation in media houses. Presently GenderLinks is investigating the impact of having more women journalists and editors in South African media, called "Beyond Numbers". She states that there needs to be qualitative change for better reporting about issues that affect women's development in South Africa, including HIV/AIDS and PMTCT.

She suggests that one of the biggest impediments to investigative writing on such issues is that journalists do not have the "tools" even if they have the will. She states, "quite often what it boils down to is institutional mechanisms, you've gotta have policies in place and you gotta hold people to them" She suggests a "checklist: 'how

do you ensure that your story is balanced' ...So it is a checklist about language relating to sources, relating to stereotypes, and we have those sorts of things that can be adapted to media content and images. Are women's images used, the voices in the story are quite often made but the images are often women, in particular context"

Another significant point that Rama brings up is that presently in South Africa, newspapers are undergoing a circulation crisis; and they need to realize that "women are becoming a stronger and stronger force in the economy; the consumer power of women is growing..." Consequently, Rama asserts that if newspapers recognize the needs of these consumers they could actually sell more papers.

One of the questions that Rama asks to news media, which is important for this research is, "Which of these people are ultimately affected more than anyone else?" ...journalists should always attempt to speak to the subject of the story because you know each story has a subject and it's not the decision-maker." In the context of this research report, the subject of stories about PMTCT is HIV-positive pregnant women. According to Rama, if journalists consider this then there would be a different perspective in writing the stories, instead of being centred on political disputes between government and civil society.

Paraphrased Interview 5:

Dr Francois Venter, Reproductive Health Research Unit at the University of Witwatersrand in Johannesburg, South Africa

Dr Venter has a lot of information on the issue of PMTCT and how it is progressing in South Africa. He says there is not any significant scientific evidence that states Nevirapine is harmful to the mother or the infant, but he does state that there are better regimens for PMTCT that are available in the private health sector and in other parts of the world.

Venter states that his patients often bring news articles to him showing him something they cannot understand or makes them feel confused about issues pertaining to HIV/AIDS and PMTCT. He asserts that news media should provide clear messages, but he does not blame the media for this confusion. Among all of the other interviewees,

Dr Venter does blame government officials who advocate for nutrition and send mixed messages, thru news media, about the use of Nevirapine or other anti-retrovirals which he says "scares" his patients.

He suggests that the media become more proactive and understand the issues that his patients (HIV-positive pregnant women) can relate to in order to provide better coverage; because there are so many things that is involved in the issues of PMTCT that media can really facilitate understanding for these women and awareness to the general public of South Africa.

Paraphrased Interview 6:

Marinus Hendrik Gotnink, Director of UNICEF-South Africa

Marinus Hendrik Gotnink points out through his experience in the Southern African region that PMTCT is a vertical programme that is centred on producing a negative infant without much impact on the health of the mother and the situation of the family as a unit. He states that media has been responsive to this and the political controversy surrounding PMTCT.

He states the media is not doing enough “supporting and informing” HIV-positive mothers about issues in regards to PMTCT, in particular he states that the media can do more around the infant feeding issues. He says because a good amount of HIV-positive mothers are not in an adequate position to safely provide formula to their babies exclusively, media should do more in promoting exclusive breastfeeding.

Gotnink major suggestion throughout the interview is that society as a whole should make an effort to collectively support these women and to investigate more into the parameters surrounding the feminisation of the epidemic in South Africa. He says that if this happens from all different sites in South Africa, then the media will also be more focused on those directly affected by this issue instead of the politicised drama.

Paraphrased Interview 7:

Project Director (wished to be kept anonymous) - from the Peri-natal HIV Research Unit (PHRU) at Chris Baragwanath Hospital in Soweto, South Africa.

This Project Director from PHRU main recommendation for news media in regards to PMTCT coverage is that news media can contribute to the harsh stigma and discrimination by increasing critical coverage and supportive messages for HIV-positive women who may want to bottle-feed their infants.

The Project Director says something that is hampering prevention programmes such as PMTCT is the element of disclosure; women who find out about their HIV-status through the ante-natal clinic are afraid to tell their partners, families and communities because of the painful and lingering stigma against the disease in the society.

The Project Director also states that many times those in the health profession are weary of news reporters because she says they come in with their own perceptions and agendas in writing stories about HIV/AIDS. She states, “the [journalist] would structure the story [to] suit his or her own agenda and that’s not what the community out there needs...” News media can assist in priming communities and the society in general to deal compassionately with issues of HIV/AIDS, and particularly the matter of PMTCT and women’s health.

Paraphrased Interview
Jillian Green, ‘AIDS reporter’ for the *Star*

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Jillian Green as an ‘AIDS reporter’ is an interviewee that gives behind-the-scenes information about AIDS coverage in South African newspapers; she discusses the misconceptions and the perceptions about news media coverage of the Nevirapine debates and other concerns around PMTCT.

The first major misconception she states is ‘reader fatigue’- readers not wanting to read about or can’t relate to HIV/AIDS matters. She states that actually it is ‘media fatigue’ because journalists and the news media in general do not know how to cover these issues holistically and they do not understand the extents of the effects of poor coverage.

She states that news media has a pivotal role in the fight against HIV/AIDS in South Africa. Media has a definite role, according to Green, to educate the public and hold leaders accountable—to get them to discuss issues and policies and to interrogate these policies. She asserts that these roles should not be compromised for commercial purposes, even though it happens on occasion.

In relation to sourcing, Green states that because media reporting is often “shoot from the hip” there is not a search for voices on the ground, rather journalists respond to press releases or controversial statements from public officials. She says if news media “included voices from the ground, [we] could create empathy from the readers and the general population.”

Paraphrased Interview 9:

Philippa Garson- fellow with the ‘HIV/AIDS and Media Project;’ freelance journalist that has written articles published in the *Mail and Guardian*.

Philippa Garson is an example of a journalist that has done extensive research on the area of PMTCT in South Africa. She notes that she got this opportunity through a fellowship at the end of 2004 and throughout 2005. She gained intense experience with pregnant women who are HIV-positive and learned about their social challenges as well as the scientific discussions around the use of Nevirapine. She states that normally journalists would not get the opportunity or the time to sit and engage with these women to find out their complex situations. One of the solutions, she suggests, is more incentive to write about these issues through more fellowships and other opportunities to galvanize reporters to engage in HIV/AIDS and women’s health matters critically.

There are real concerns about the commercial imperative and the space given in a newspaper to write these in-depth stories, Green states that the sale price of a newspaper does not cover the editorial costs or the printing costs of the newspaper, however, advertisements do. There are some newspapers that have as much as 60% of their newspaper in adverts, and the remaining 40% is divided into business, sports and entertainment, with little room for in-depth coverage of the plaguing concerns of HIV-positive pregnant women.

With this in mind, Garson still states that mainstream newspapers “are not managing to target and look at ways of targeting those people [HIV-positive pregnant women and their families and communities]. I think it’s that whole thing of not talking at people and actually telling their stories...People want to know about other people, and they want to hear human stories and I think that means getting out and finding those stories and encouraging people to tell them.”

Paraphrased Interview 10:

Warren Parker- Director of the Centre for AIDS Development and Research and Evaluation (CADRE) Johannesburg, South Africa

Warren Parker states that newspapers in South Africa fail to think beyond the clinical aspects of PMTCT and the use of Nevirapine, and it is about “one tenth of the issue...Furthermore now that TAC [Treatment Action Campaign] aren’t putting nevirapine on the table as an issue for discussion, there’s virtually nothing about PMTCT in the news.”

CADRE has done extensive research on how media has covered HIV/AIDS related topics. Parker states that generally there are not investigative and holistic stories. He says that news media should bring the issues to the surface and be “proactive.” Parker suggests that a publication should pick two to four HIV-related issues that are investigated to “foster a more critical public discourse around the epidemic – with long term implications for policy.”

Parker also asserts that at the core of the media’s lack of analytical engagement with PMTCT is “leadership” –in other words editorial policy. In addition, Parker notes that the issues around HIV/AIDS have been obscured because of the “organisational/governmental posturing;” so again there is mention of the fact that the highly politicised climate has marginalised the human stories.

Paraphrased Interview 11:

Matthew Chersich – from the World Health Organization, presently working for the International Centre for Reproductive Health in Mombasa, Kenya

Matthew Chersich’s responses give a international perspective about the issues of PMTCT. He has worked in this field for many years and knows a lot about the pandemic in South Africa.

Chersich states that “I found the media presented a limited view, focusing on the government’s messy handling of policy and on [Nevirapine] resistance, while deeper more nuanced views were rare.” As other interviewees note, Chersich links the news media’s coverage to the lack of political leadership locally and even internationally. He states that “lack of good leadership from WHO and similar who are meant to

provide direction and meaning to issues but have been silent or directionless for years. ... Without such leadership internationally or nationally, press people have some excuse for narrow views, though are not without blame.”

Chersich states that news media can still foster discussion by being well versed on the issues and undergoing in depth analysis. He says that the market forces in the commercial media setting should not be ignored; however “media needs to continue to promote development issues and social justices. A strong media is key to success in development, both in accountability and in moving the government and multinational institutions towards development goals.”

Source: STAR

Date: 01-Dec-2004

Topic: 10

Ref No:9233



1

ID: 03160404-01 Source Page: 8

NO-FRILLS, NO-HOLDS-BARRED GUIDE TO LIVING WITH HIV/AIDS

Life is a marathon for this gutsy rape survivor

When Emmelinah Sindane (42) first heard she contracted HIV after being raped by gun-toting men she decided to take revenge on the world by spreading the virus around.

However, her plan backfired when she fell pregnant by her first "victim".

"I had decided that if I was going to die, then I wasn't going to die alone. I did not think about getting pregnant and when I did, I realised that my plan was not a good thing."

With the prospect of her child being born HIV positive, Sindane considered abortion. "I had made an appointment and everything but, after thinking about what I was about to do, I could not go through with it."

Instead, Sindane joined the Hillbrow Clinic's HIV support group where she received much-needed advice and information about the options available to her and her unborn child - Nevirapine.

And after taking the anti-Aids drug from when she was seven months' pregnant and a dose being administered to her son soon after birth, her little boy has tested HIV negative.

"I was so relieved. God answered my prayer and that's why I named my baby

Mpendulo (isiZulu for answer)".

But the clinic did not only inform Sindane about how she could possibly save her child, staff there also told her how she could look after herself.

"I asked the counsellor what I could do for myself and she told me that to keep myself relatively well I had to eat healthy foods, exercise, abstain from sex or use a condom.

"I remember thinking at the time, 'Abstain from sex? No problem, I will be celibate. Exercise? No problem, I will run. But when it came to food, I was worried because I didn't have a lot of money."

But Sindane managed to provide for herself and her child. She and two of her children are living at Nkosi's Haven.

And as for the running, she has gone on to be a marathon runner and has taken part in a number of the city's races including the Soweto Marathon.

"I love running. Just because I have HIV does not mean that I cannot take part in these races. I am as good as, if not better than, some of the other runners on the road," she says with a smile.

But even though Sindane followed a

healthy lifestyle and is the picture of health, her CD4 count dropped to 146 and she had to start taking anti-retrovirals (ARVs).

Sindane began taking ARVs in July this year. And while she does not have the results of her latest CD4 count test, she believes that she is much better after having started the treatment.

"I'm not the dying type so if this can help me, I am going to give it my best shot. I am going to live long," the bubbly woman says.

Advising other infected people, Sindane says they should eat healthily, think positive, and not think of dying.

And while Sindane is brimming with happiness, there is one aspect of her life she would like to change.

"I am not working right now, but I would like to have a job. I am not an educated person and probably won't be able to do office work but I know how to clean and I am not scared of hard work," she says.

But until she finds work, Sindane will continue to help out at Nkosi's Haven and attend her support group at the clinic which helped her deal with her status. - *Jillian Green*

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1



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How to prevent HIV after rape

Rape can happen to anyone—woman or man, girl or boy.

In order to protect yourself against HIV infection after rape, it is vitally important to get antiretrovirals (ARVs) as soon as possible after the incident.

This needs to be done within 72 hours (three days) or it becomes too late for these medicines to reduce the risk of contracting HIV.

The optimum time to start post-exposure prophylaxis (PEP) is within three to six hours after the incident.

Here are some steps you can take to protect your health in the event of rape.

- Go to your doctor as soon as you can and ask about ARV medicines.
- Ask the doctor to give you an HIV test. Before taking it, ensure you are counselled and receive information about what the test means.
- While waiting for the outcome of the test, the doctor must give you PEP medicines so that you can start taking it immediately. This is called a starter pack.
- If you test positive, the PEP medicines will be stopped. Ask the doctor about things you can do to look after yourself if you are positive.

● If you test negative, make sure the doctor gives you the full dosage of medicine which needs to be taken for 28 days. You must take the medicine for all 28 days or it will not work.

- PEP medicines are quite strong and may have side-effects which may include, tiredness, headaches, skin rash, diarrhoea and nausea.
- Even though you might test negative after the first test, have another test after six weeks, three months and again after six months after the rape. If you test negative each time, it means that you did not contract HIV from the rape.

● WHERE TO GET THE MEDICINES

- State hospitals and some clinics provide PEP treatment for free. If the hospital cannot help, call the Aids Helpline on 0800 012 322 to find out where you can get the treatment.
- Most pharmacies stock PEP medicines but you will need a prescription from your doctor as these are scheduled drugs.
- Some private hospitals within the Netcare group offer a free service to rape survivors.

● ALSO ASK YOUR DOCTOR FOR:

- Antibiotic medicines to stop you from getting a Sexually Transmitted Infection (STI) from the rapist.
- The "morning-after" pill to prevent you from becoming pregnant.
- Medicines that would prevent you from getting Hepatitis B.
- If you are pregnant, find out about the possibility of HIV infection for your unborn baby.
- If you become pregnant from the rape, discuss your options (termination) with your doctor or a healthcare worker.
- If you are having sex, always use a condom. This is safer for you and your partner.

● USEFUL NUMBERS:

PEP sites

- Nthabiseng Clinic : (011) 933-1206.
- Sinakekelwe Clinic : (011) 389-0563.
- Skiner Street Clinic : (012) 323-4310.
- Sebokeng Clinic : (016) 930-3000.

Netcare, a private hospital group, has established Rape Crisis centres around the country as part of their social responsibility programme. In Gauteng these centres are at:

- Sunninghill Hospital
- Witkoppen Road,

- Sunninghill Park.
- Tel: (011) 806-1500/806-1888.
- Milpark Hospital
- 9 Guild Road, Parktown.
- Tel: (011) 480-5600 / 0800-11-66-16.
- Union Hospital
- Clinton Road, Alberton.
- Tel: (011) 861-3000 / 861-3111.
- Unitas Hospital
- 39 Clifton Avenue, Centurion, Pretoria.
- Tel: (012) 677-8000 / 664-5006.
- Garden City Clinic
- 35 Bartlett Road, Mayfair.
- Tel: (011) 495-5000 / 495-5311.

● Aids Helpline: 0800-012-322.

● People Opposing Women's Abuse (POWA): (011) 642-4345/6.

● Centre for the Study of Violence and Reconciliation (CSV): (011) 403-5650.

● Aids Law Project (ALP): (011) 717-8600.

● Stop Women Abuse Helpline: 0800-150-150.

● Triangle Project Helpline (Men who have sex with men): (012) 422-2500.

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1

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How you can get infected

How is HIV transmitted?

Through blood (including menstrual blood); semen; vaginal secretions; and, breast milk

Blood contains the highest concentration of the virus, followed by semen, vaginal fluids, and then breast milk.

What activities allow transmission?

- Unprotected sexual contact (that is, not using a condom).
- Direct blood contact, including injection drug needles, blood transfusions, accidents in health care settings or certain blood products.
- Mother to baby (before or during birth, or through breast milk).

Risky behaviour

- **Sexual intercourse:** Vaginal and anal intercourse is a high-risk practice, especially if no protection is used. In the genitals and the rectum, HIV may infect the mucous membranes directly or enter through cuts and sores caused during intercourse (many of which would be unnoticed).
- **Oral sex (mouth-penis, mouth-vagina):** The risk of transmission through the throat, gums, and oral membranes is lower than through vaginal or anal membranes. There are, however, documented cases where HIV was transmitted orally, so one cannot say that getting HIV-infected semen, vaginal fluid or blood in the mouth is without risk. However, oral sex is considered low risk.

- **Sharing injection needles:** An injection needle can pass blood directly from one person's bloodstream to another. It is a very efficient way to transmit a blood-borne virus. Sharing needles is considered high risk.

- **Mother to Child:** An HIV-infected mother can pass the virus directly before or during birth, or through breast milk, to her child. Breast milk contains HIV, and while small amounts of breast milk do not pose a significant threat of infection to adults, it is a viable means of transmission to infants.

Sexually Transmitted Disease

Having an STD can increase a person's risk of becoming infected with HIV, whether or not that STD causes lesions or breaks in the skin. If breaks or sores are present this may make it easier for HIV to enter the body during sexual contact.

Non-infectious bodily fluids.

These are saliva, sweat, faeces, and urine.

Casual contact through closed-mouth or "social" kissing is not a risk for transmission of HIV.

Because of the potential for contact with blood in "French" or open-mouth, wet kissing, doing so with a person known to be infected carries a very low risk.

HIV is not transmitted through shaking hands or hugging. You cannot become infected from a toilet seat, a drinking fountain, a doorknob, dishes, drinking glasses, food, or pets.

Sources: Government's Khomanani booklet; San Francisco Aids Foundation; US Center for Disease Control.

Source: WEEKLY MAIL AND GUARDIAN Date: 07-Apr-2005

Topic: 10

Ref No: 2253



1

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Monitor

Nicola Spurr asks if it is morally responsible for HIV-positive women to become pregnant deliberately

Is childbirth an absolute right?

About one-third of HIV-positive women will transmit the virus to their infants during pregnancy, if untreated. So, should HIV-positive women deliberately get pregnant? And if so, will they be held accountable if they pass the virus on to their children?

"If it's within your means to act and prevent something negative from happening, and you don't act, you become responsible for those consequences," says Udo Schuklenk, bioethics professor at Wits University. "Once one makes a decision to have a child, it's not morally neutral. It matters what you do during the pregnancy, because there is now an identifiable victim of any negative behaviour."

"If a woman is an alcoholic, her baby is susceptible to foetal alcohol syndrome. It's hard to change that behaviour but society holds the mother responsible. If a person has tuberculosis there is an accepted public-health argument for compulsory treatment because the disease usually results in other identifiable victims."

Schuklenk believes the high HIV infection rate and the far-reaching effects of the pandemic warrant the introduction of compulsory HIV testing and counselling of pregnant women in the public-health sector. Compulsory testing would mean that women would be aware of their status and could be provided with adequate treatment to prevent mother-

to-child transmission. Compulsory counselling would also make women aware of the risks and consequences of transmitting HIV to their infants and should, according to Schuklenk, offer women the chance to terminate their pregnancies.

Currently, HIV counselling is voluntary and non-directive, meaning that counsellors do not attempt to influence their clients' decision in any way. Schuklenk argues that this approach has little benefit and that counsellors should be more prescriptive so that "the terrible suffering of HIV-positive children" can be avoided.

Schuklenk does not believe women have an absolute right to bear children: "Just because one has a biological capability to reproduce doesn't mean it's okay to do so in any circumstances."

Although this country's libertarian constitutional framework guarantees women's reproductive rights, Schuklenk argues that these need to be balanced with a responsibility to give newborn children "a fair shot at life".

Charles Ngweni, a constitutional law professor at the Free State University, agrees. While HIV-positive people clearly have rights, they also have responsibilities, he says. Some of these may entail modifying behaviour so as not to pass the virus on — such as taking responsibility for being tested and complying with mother-to-child prevention treatments.

However, he says, these individual rights and responsibilities need to be viewed through a contextual lens. "We cannot say that women should be morally account-

able for passing HIV to their infants in a society where women are disempowered and may therefore not be knowledgeable about all the risks involved."

He also points out that these responsibilities should not be confined to HIV-positive women, but that both women and men need to take responsibility for their behaviour and be aware of the possible negative effects of unsafe sex.

Ngweni believes that HIV/Aids organisations have shied away from promoting termination of pregnancies to prevent further stigmatisation of pregnant women.

Angie Maloka, a nurse adviser for Wits University's reproductive health research unit, agrees. She believes that compulsory testing will lead to further stigma for HIV-positive women already fearful of disclosing their status.

Maloka argues that women cannot be singled out as wilful perpetrators of HIV infection as transmission is a complex issue. Many women face pressure from their partners and families to have children and a higher status is often afforded to women with children. This makes it difficult for women to make decisions about conception with only their own interests in mind.

Newborn children may be infected with HIV in the womb, during labour or through breastfeeding, but mother-to-child transmission can be effectively reduced by half with a single dose of nevirapine to the mother during labour and to the child after birth.

Nevirapine and other anti-retroviral drugs, along with extensive voluntary testing and counselling, are now more readily available in the public health sector, providing women with choices and information about safe pregnancies. The roll-out of anti-retroviral medicines and strategies to prevent mother-to-child transmission also means that HIV-positive women have more choices around having children. An effective intervention during pregnancy and childbirth, combined with proper care, reduces the risk of transmission to about 2%.

The issue of moral responsibility for transmitting the virus is then placed not on those who are HIV-positive, but on those who have not accessed available prevention measures.

Nicola Spurr is a research fellow in the HIV/Aids and the Media Project, run by the Perinatal HIV Research Unit and the Journalism Programme at the University of the Witwatersrand

"Because one has a biological capability to reproduce doesn't mean it's okay to do so in any circumstances"

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1

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Despite new doubts about the drug, it has saved the lives of thousands of babies in South Africa, writes **Natalya Dinat**

Curing nevirapine confusion

The announcement this month by the Medicines Control Council (MCC) that nevirapine should not be used as monotherapy to prevent mother-to-child transmission (PMTCT) of HIV has caused much consternation, both in South Africa and abroad.

Many countries in Africa take their cue from the MCC, an independent institution that protects the public against dangerous and sub-standard drugs. So the MCC statement has the potential to damage the PMTCT programme throughout the continent.

Where I work, pregnant women, their spouses, the nurses, doctors and counsellors are asking what is wrong with nevirapine. Some women are reluctant to take the drug. Health-care workers and counsellors are faced with difficulties when trying to explain apparent contradictions between their government protocols and recent press statements by the MCC and the Minister of Health Manto Tshabalala-Msimang. We are seeing mistrust of the health-care workers by women, with many believing that nevirapine alone is "bad" for one's health.

The MCC statement, which cited the dangers of drug resistance, implies that monotherapy is the reason for that resistance. However, the published data shows that any nevirapine-containing regime (whether single,

dual or triple) given as a single dose can cause drug resistance in some women.

We have known for several years that resistant mutations occur after a single dose of nevirapine. But what that means is still unknown.

The key issue is that there is no research, nor are there studies completed, on the clinical significance of drug resistance in HIV-infected women who have taken a single dose of nevirapine. We do not know whether it is very harmful to a significant proportion of women or their babies, or whether the harm outweighs the benefits in terms of the health of an individual or a group.

However new, good-quality evidence has arisen showing that drug regimes containing more than one drug are more effective than nevirapine alone. This has led some authorities (including the Western Cape health authority and the Thai Ministry for Health) to recommend these more effective drug regimes for PMTCT — not because of the dangers of drug resistance, but because they work better. Resistance has not been deemed by them to be an area where new data requires urgent and dramatic responses.

In short, nevirapine works as a single dose and has saved the lives of many

thousands of babies in South Africa. It works even better in combination with other drugs. And we do not yet know the clinical significance of the resistance a single dose causes in women.

Since there seem to be no science and no logical reasoning behind the MCC statement, one is left to wonder what are the intentions behind making it.

Improving a protocol recommendation is to be welcomed. This is very different from the irresponsible act of not recommending the current protocol while omitting to recommend another, more appropriate protocol. Tshabalala-Msimang issued a statement on July 15 saying the government's recommendations for management of MTCT remain unchanged, and that a consultative workshop would be held to revisit treatment recommendations. We are still waiting for the press release on this proposed workshop.

Meanwhile, the confusion at the clinics continues. This could have been avoided if the MCC and the government had simply announced that more effective regimes were going to be looked at.

Here is what we know about nevirapine and resistance: we know that rates of nevirapine resistance reduce over time in a person who has taken the drug. After a single dose of nevirapine given for PMTCT, published studies have shown that resistance levels decrease from higher levels after 10 days to virtual disappearance after 18 to 24 months, although some drug-resistant virus is stored in the lymph tissue. We do not yet know if this is a problem.

There is, however, the option of providing combinations of drugs that do not include nevirapine for people with drug resistance. We also know that the women most likely to become drug resistant after one dose of nevirapine are women with high viral loads and low CD4 counts, who should in any case be on life-long triple anti-retroviral (ARV) therapy.

To mitigate the damaging effects the MCC announcement has had on the PMTCT programme, I would like to see a clear and unequivocal statement by our government that:

- Where possible, to decrease rates of transmission, zidovudine (AZT) should be administered from 28 weeks as well as the single dose of nevirapine at delivery;

- Nevirapine, as currently recommended, should be available in all clinics and hospitals in South Africa that are waiting to receive supplies of AZT. It should be offered to all

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1

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women who are HIV-infected and book into clinics for antenatal care later than the 28th week of pregnancy;

● The roll-out of highly active antiretroviral therapy (Haart) should be accelerated and expanded to all areas of South Africa;

● Research should be funded to examine Haart in pregnancy and the clinical implications of drug resistance;

● Once higher-grade, published scientific work is available, review of the treatment protocols should occur. Until then, we should follow World Health Organisation (WHO)

recommendations;

● Either free formula feeds or exclusive breastfeeding should be offered as a choice to women. The problems of increased transmission with mixed feeding should be emphasised; and

● Pressure should be increased to lower drug prices (especially of the drug class of protease inhibitors) and to make WHO pre-qualified generics available.

Dr Natalya Dinat MD, FCOG (SA), is a specialist obstetrician-gynaecologist. She writes in her personal capacity

The science behind the drug

Nevirapine is provided for two reasons:

- For treatment, as part of an anti-retroviral (ARV) package of three drugs; or
- For prevention of HIV, especially prevention of mother-to-child infection.

When given as part of a treatment package, it is only given to people with a CD4 count of less than 200 cells a mm³. When given as prevention, it is given to all HIV-infected women — regardless of their CD4 count — and their babies, to prevent infection in their babies.

Women who are pregnant and need triple ARV therapy (a CD4 count of less than 200) should be offered an ARV package of three drugs, which both treat the mother and prevent infection in the baby.

For women who are pregnant and HIV-infected with a CD4 count of more than 200, the current thinking is to prevent infection with ARV drugs, caesarean sections, formula feeding and other interventions.

When a woman's CD4 count has fallen, she should be offered triple ARV therapy. This can be any time from six weeks after delivery to 10 years or more.

ARV therapy is given — as opposed to mono or dual therapy — for treatment to prevent drug resistance. It works well, and has reduced tuberculosis rates and deaths from TB, other opportunistic infections, and prevented death by Aids in many people.

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Nevirapine faces axe as sole treatment

Fears that Aids drug poses health risk to newborn babies

By KERRY CULLINAN
AND KHOPOTSO BOHIBE
Independent Foreign Service

The Aids drug Nevirapine is unlikely to be offered as a single drug to pregnant HIV-positive mothers.

The Medicines Control Council (MCC) has recommended to the government that a single dose of Nevirapine is not effective in the prevention of mother-to-child HIV transmission (PMTCT).

The decision is based on concerns about the development of drug resistance to Nevirapine, which could undermine the national anti-retroviral programme being rolled out in the country. Nevirapine is one of the drugs being offered to Aids patients.

Health Ministry spokesperson Sibani Mngadi said a decision on the way forward would be made after the international Aids conference taking place in Bangkok, Thailand.

"There are a number of presentations on effective regimens on PMTCT being made in Bangkok. We will watch these with interest and the health minister will convene a meeting after Bangkok to decide on the way forward," Mngadi said from Bangkok.

Mngadi could not say whether Nevirapine would be dropped altogether or whether it would be used in combination with other drugs.

The MCC said its decision was based on the fact that "Nevirapine leads to significant resistance in mothers and babies when used as a mono-therapy", with "recent studies conducted in South Africa using Nevirapine as a mono-therapy showing significant resistance of up to 50%".

According to MCC registrar

Precious Matsotso, they decided at a meeting on July 2 that "mono-therapy is no longer allowed, and that combination therapy be used".

However, Kevin McKenna, spokesperson for Boehringer Ingelheim, which produces Nevirapine, said his company felt that it had "satisfactorily answered the MCC's questions about the efficacy and safety of Nevirapine".

But McKenna added that it was clear from a meeting of the health minister (Manto Tshabalala-Msimang) and her provincial counterparts, which he had attended two weeks ago, "that things were moving in the

Combination therapy being offered as part of the government's comprehensive plan to treat HIV/Aids is a cocktail of three different classes of anti-retroviral drugs. Each drug acts differently on the HI virus.

Gray said there was some concern that there could be "cross-resistance", meaning that Nevirapine resistance could also affect the other drug in its class (the non-nucleoside reverse transcriptase inhibitors) on offer in the national programme, namely efavirenz (brand name Stocrin).

Meanwhile Tshabalala-Msimang told the Bangkok conference at the weekend that the government had been forced to prescribe Nevirapine before it had completed its own investigations.

This was in reference to the Constitutional Court ruling in 2002 compelling them to offer Nevirapine at all public hospitals - not just at 18 pilot sites - following court action by the Treatment Action Campaign.

However, the TAC's Nathan Geffen said "single-dose Nevirapine for mother-to-child transmission prevention was the government's choice, not the TAC's, as this was the chosen regimen for the pilot sites that preceded the PMTCT court case".

"The TAC's stance is that more effective regimens than the single-dose Nevirapine should be introduced into the public sector wherever possible.

"Where there is a current lack of capacity, a single-dose Nevirapine regimen is the minimum acceptable regimen for mother-to-child transmission prevention," Geffen said. - Health News Service

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Combination
therapy is generally
accepted to be
more effective
”

direction" of Nevirapine being phased out as a single regimen.

"We obviously do not share the view (that a single dose of Nevirapine poses a health risk) and would like to get into discussion with the government and the MCC about the way forward," McKenna said.

Dr Andy Gray, the senior lecturer in pharmacology at the Nelson Mandela School of Medicine in KwaZulu Natal, said there were many "ifs and buts".

"It is unclear whether the level of resistance to Nevirapine would result in clinical failure if a woman later went on to combination therapy," he said.