

BABY STEPS

Reporting on the Prevention of Mother-to-Child Transmission of HIV (PMTCT)

An HIV/AIDS Indaba hosted at the Nelson Mandela Foundation
in partnership with the HIV/AIDS and the Media Project

Picture by: ANDREW BANNISTER



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A project of the Wits Journalism and Media Studies Programme

The Prevention of Mother-to-Child Transmission of HIV (PMTCT) is of critical strategic importance in combating the HIV/AIDS pandemic in South Africa. By its nature, however, the implementation of a PMTCT programme in South Africa faces myriad political, cultural, social-economic, psychological and other challenges. In the second of the HIV/AIDS Indabas you are invited to join a discussion on the successes and difficulties encountered by people who are implementing and participating in the PMTCT programme, and the extent to which the media is reflecting and addressing their experiences.

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Picture: Helen Struthers



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"MEN THINK WE BRING THE DISEASE": Challenges facing HIV-positive mothers in Soweto



BY PHILLIPA GARSON

INTRODUCTION

Every year, for the past three years, around 8 500 pregnant women in Soweto's clinics have tested positive for HIV (Violari, 2004). This project aims to give insight into the challenges these women face in accepting and disclosing their status, living with uncertainty around their own, their partners' and their babies' health and navigating stigma, relationships under strain and grief.

In a climate where denial around HIV/AIDS still prevails in both public and private spheres, and where women are often blamed for "bringing the disease into the home", the burden these women carry is immense. They struggle, often in secret, against stigma and rejection, coping alone with their own and their baby's health problems.

RESEARCH SETTING

With over two million inhabitants, Soweto is the most populated black urban residential area in the country. Poverty co-exists with pockets of wealth. Most people are working class; they live in matchbox homes or shacks. Most have access to clean water, sanitation and electricity. English and Zulu are the most widely spoken languages. Unemployment is rife, at around 44 percent and even higher among young people. Single-parent families make up one third of all households. The HIV rate in the general population is estimated at 10 percent (JHB Dept Finance and Economic Development, 2004) and is 30 percent in pregnant mothers (Violari, 2004).

RESEARCH OBJECTIVES

With regard to Prevention of Mother-to-Child Transmission of HIV (PMTCT), the media have focused mainly on the conflict between the government and Treatment

Action Campaign (TAC) over the former's slow implementation of PMTCT programmes (Finlay, 2004). However there is a hunger, particularly among those directly affected by HIV, for more media coverage on ordinary people's experiences of the disease. (Jooste, 2004).

By investigating some of the myriad daily challenges facing thousands of HIV-positive women in contemporary South Africa, this study aims to address this gap. Informed by some of the rich academic research on stigma and gender – the two overarching themes of the project – the research project and the media reports to follow will attempt to convey a more nuanced and human face to the predicament.

RESEARCH QUESTIONS

In an attempt to elicit information around some of the key problems encountered by HIV-positive women in Soweto, questions addressing the following issues were asked:

- ▶ barriers to disclosing HIV status, including stigma, both real and perceived;
- ▶ stigma around bottle-feeding and coping strategies;
- ▶ fears and feelings around the baby's status and health;
- ▶ motherhood – disclosing to older children and attitudes to future child-bearing;
- ▶ the impact of HIV on spousal relationships – perceived attitudes of denial, blame, rejection or acceptance;
- ▶ the impact of HIV on sexual relationships; and
- ▶ attitudes towards practicing safe sex.

METHODOLOGY

A qualitative, phenomenological research methodology was used. Extensive, indepth interviews were conducted with eight women drawn from the Perinatal HIV Research Unit (PHRU) and Lilian Ngoye community clinic, both at Chris Hani Baragwanath Hospital. Background interviews were held with experts in the field of PMTCT and staff members at the PHRU.

The research process also involved being a non-participant observer in several support groups offered by HIVSA, the PHRU's social support arm. The primary

focus was on men's support groups, with the aim of finding out how men – so often the missing piece in the puzzle – are responding to the challenges that HIV brings to bear on their own identities, roles and responsibilities as husbands and fathers.

Ethical clearance to conduct the interviews and attend the support group was obtained from Wits University's Human Research Ethics Committee.

PMTCT THE CONTEXT

- ▶ Almost half of the 42 million people worldwide with HIV/AIDS are women of child-bearing age. (UNAIDS/WHO, 2002).
- ▶ Of the two million HIV-positive women who become pregnant every year, 90 percent are from developing countries. (McIntyre, 2003, p127).
- ▶ In 1990, one percent of pregnant women attending public sector antenatal clinics in South Africa were HIV-positive; by the end of 1999, this figure had risen to 22.4 percent. (Abdool Karim in Gilbert and Walker, 2002, p1093).
- ▶ HIV prevalence in pregnant women in Soweto is around 30 percent and has been so for the past three years. (Violari, 2004).
- ▶ Currently, transmission of HIV to babies averages at around 10-12



Picture: Andrew Bannister

percent in Soweto clinics. These figures are not reliable however, with relatively few mothers on studies returning to test their babies. (Violari, interview).

- ▶ The introduction of the polymerase chain reaction (PCR) test at six weeks of age will hopefully increase the number of babies tested, however.



Picture: Andrew Bannister

THE PMTCT PROGRAMME

Around 30 000 pregnant women who seek antenatal services from the 13 clinics around Soweto have access to the PMTCT programme. This includes:

- ▶ Voluntary counselling and testing (VCT) for HIV.
- ▶ Nevirapine (NVP) for HIV-positive mother and baby.
- ▶ Free formula for six months for the majority who opt to bottle-feed.
- ▶ PCR testing at 6 weeks to reveal the baby's status.
- ▶ The provision of ARVs, other medication and immunisations for baby.
- ▶ Access to regular support groups and counselling where issues like disclosure, practicing safe sex, feeding options and family planning are discussed.

ISSUES AROUND PMTCT

The fraught political history around PMTCT provision and the medical and political debates around NVP resistance are important to any comprehensive discussion on PMTCT. However, owing to time and space constraints, they are not discussed here.

THEORETICAL FRAMEWORK

Theoretical research for the study was conducted around the two broad – and related – themes of stigma and gender.

STIGMA – SOME KEY POINTS

- ▶ HIV/AIDS, the latest in a long line of diseases to be stigmatised, brings out the best and the worst in people. (UNAIDS, 2003).
- ▶ HIV/AIDS makes people feel they are 'lesser beings' with a spoiled identity. (Erving Goffman in Parker & Aggelton, 2002).
- ▶ Stigma around HIV/AIDS is particularly intense because it concerns the already taboo subjects of sex, death and bodily leakage. (Posel, 2004, p4) and because the virus is transmitted from one person to another.
- ▶ Stigma is socially constructed and reinforces existing prejudices in society. It further marginalises the already-marginalised, for example, black people, gay people, women, commercial sex workers, intravenous drug users. (Parker & Aggelton, 2002, p10).
- ▶ Stigma from the family, often experienced by pregnant women and mothers, is seen as the most damaging and difficult form of stigma to deal with. (Advocacy for Action on Stigma and HIV/AIDS in Africa, 2001, in Siyam'kela, p5).
- ▶ A distinction must be made between "enacted" or external stigma and "felt" or internal stigma, with the former being experienced stigma and the latter, perceived stigma. (Brown & Trujillo, 2001, p4).
- ▶ Despite ongoing stigma, some individuals develop "resistance identities" and actively seek to change the status quo. (Parker & Aggelton, 2002, p10).

GENDER – SOME KEY POINTS

- ▶ Women are for physiological, economic and social reasons more vulnerable than men to HIV.
- ▶ The rapid spread of HIV is placing gender relations under intense scrutiny.
- ▶ Like stigma, gender is a socially constructed phenomenon that defines men as dominant, aggressive and sexually promiscuous and women as submissive, monogamous and child-bearing. (Gupta, 2000).
- ▶ Some men, emasculated by unemployment and the erosion of traditional, patriarchal values, resort to sexual violence to enact their masculinity. (Niehaus, 2003).
- ▶ Women with violent or aggressive partners and those who engage in

transactional sex are more at risk of HIV. (Dunkle, Jewkes et al, 2003).

- ▶ Men are perceived as being in denial about HIV/AIDS and unable to take responsibility for their health. (Mane & Aggelton, 2001).
- ▶ Women who are tested when they are pregnant may become the first to know their status, and may often be blamed for "bringing the disease into the house". (Barolsky, 2003).
- ▶ The spread of HIV/AIDS is unlikely to be curtailed without a change in gender relations. (UNAIDS, 2004).

SUMMARY OF PRELIMINARY FINDINGS

- ▶ Despite the sheer numbers of people living and dying with the illness, stigma has not diminished as much as one may expect.
- ▶ Many women are failing to disclose their status to partners and families, fearing rejection and isolation.
- ▶ In such a climate of secrecy, bottle-feeding (seen as an "HIV label") presents enormous difficulties for women, who nevertheless develop creative strategies to avoid disclosure and resulting stigma.
- ▶ Women suffer intense anxiety, guilt and grief around their baby's status, finding the latter's positive status more difficult to deal with than their own.
- ▶ For varied and complex reasons, some HIV-positive women actively choose to fall pregnant.
- ▶ HIV places tremendous strain on relationships, with women expressing intense anger around men's perceived "denial" of their roles and responsibilities in respect of the prevention and management of HIV. And most importantly:
- ▶ Some men and women are beginning to stand up to the tyrannies of both stigma



Picture: Andrew Bannister



and gender stereotyping and in so doing, are acting as agents of change in their own communities.

Given space constraints, only some of the preliminary findings are explored here. Those relating to women's experiences of motherhood, the PCR test, their babies' status and attitudes towards having more children will be explored in the oral presentation and an upcoming research paper.

STIGMA

The prevailing climate around HIV/AIDS is still one of secrecy, lack of disclosure and discourses around witchcraft or other, invented illnesses like breast cancer (to explain why breastfeeding cannot occur.)

HIV-positive women's reluctance to disclose their status is cited as one of the most daunting challenges by counsellors working in the programme.

Nevertheless, many women do disclose, some facing denial or the wrath of their partners and rejection from family.

FELT STIGMA

D, 34, with two children, has disclosed to her mother but not to her partner.

"When I got the results I didn't tell him. It was just my secret . . . You know, it's a question of who came with the disease or what happened, you know. I don't know whether I am the one who came with the disease with my first relationship or was he . . . At the end of the day I am the one to be blamed."

Z, 30, has a two-year-old and baby who is HIV-positive and sick. She has disclosed to no-one. Her baby wasn't given NVP because she was too scared to disclose to the hospital where she gave birth in KwaZulu Natal.

"It's not easy to just disclose yourself. Ja, because you are thinking, eish, lots of questions. Maybe these people, they'll neglect me, you see, all these questions."

Ag, 26, disclosed to her husband straight away.

"What encouraged me is I was not

alone. There were many others. There were 10 that day and seven were positive . . . I was in a hurry to tell my husband. I didn't believe because I know my husband, he is faithful to me."

ENACTED STIGMA

Of all the women interviewed, two experienced profound rejection – by their mothers.

Three women were forced to leave their homes and one couple experienced more subtle rejection from the family who refused to eat their food.

T, 43, is a single mother of four children from three different fathers – two of whom have died of AIDS. T has experienced ongoing rejection from her mother and sisters. She was forced to leave home several times and recently stayed in shelter.

"My mother just said, 'Hey, she's got AIDS, she's got AIDS . . . I don't want her in my house'. Now my sisters came, all of them now, saying, 'Ja, she must be out, she must be out'. Now I was crying. I asked myself, 'where must I go now?'"

STIGMA AROUND BOTTLE-FEEDING

HIV-positive mothers with access to clean water and electricity are advised to bottle-feed.

However, the resultant stigma and pressure from family members to breastfeed may lead to breastfeeding or mixed feeding (considered a more risky option than exclusive breastfeeding for four months). Many women deal with the stigma around the government-issue Pelargon, sometimes referred to as the "orange tin" or "AIDS milk", by transferring the milk into another milk formula container.

P, 28, whose baby and ex-partner are both HIV-positive, has not disclosed to any family members.

"My grandmother forced me to breast-feed. I told her my breasts were dirty, the nipples were cracked. Then I just take a razor blade and then I just cut so the blood will come out and I tell her that there is blood in my breast, it is not good to breast-feed. Then she stopped forcing me."

T: "The problem started at my home when they said, 'Ja, you've got AIDS now because mothers who have AIDS, they get this milk, the AIDS milk'. They knew before but now they didn't have proof, you understand, because I was fit and strong . . .

But when they saw that tin now, they said, 'Here it is'."

M, 28, whose baby is negative, has the support of her mother in Lesotho but is trapped in an abusive relationship. M is

open about her status however and took the decision not to hide the government-issue formula.

"I was happy about it. I accept it. I didn't want to infect my baby. I can accept everything the doctor said I must do . . . people do look at me. I said 'I decided not to breastfeed, why are you asking me? It's my choice. I don't have a problem . . . I don't feel worried about using it (government-issue milk)."

RESISTANCE IDENTITIES

There is no doubt that some individuals are developing the resistance identities referred to earlier. They are speaking out about their status and are refusing to follow the general trend of denial, fear and secrecy or invoking discourses of witchcraft and blame.

M: "I am ready to confront everyone to say living with HIV is not a problem. . . I want people to know about HIV. I don't care whether the others are going to talk . . . I think we have to go house-to-house to teach the families – especially boys and men – about HIV/AIDS. The people who have to go there must be the people who are HIV-positive. If you go there they say, 'She's lying. She's not HIV, see how healthy she is.' We must take our results. Explain why we are still living healthily, so they know everything about HIV."

A, 34, discovered his status after his wife tested positive in pregnancy. He is rapidly taking on the mantle of "activist" encouraged by his employers who lost nine factory workers to AIDS last year. "As a shop steward to workers, the time will come when I'm going to tell them about my status. My boss knows, he's very supportive . . . My plan is to tell them about this virus. They must stop going to sango-



mas, wasting a lot of money ... I will encourage everyone to go and get tested. And I will tell them, me I'm HIV positive and I will come there."

GENDER

All the women who were interviewed and who were in relationships were financially dependent on their partners. Several would not disclose for risk of losing this support.

Violence or the threat of violence is also clearly a barrier to disclosure. Some women face the denial of their partners who "know, but don't want to know" and refuse to discuss it. Most women are critical of men in general, blaming them for spreading HIV. All women interviewed say they insist on using condoms, despite the fact that they are not always able to wield power in other areas of their relationships.

Some women say HIV has ruined their enjoyment of sex. Several women say their partners – two of whom are taxi drivers – have sex with other women. Only two women appeared to be in stable, supportive relationships, characterised by communication and openness.

GENDER-BASED VIOLENCE

The threat of an unpredictable, aggressive or violent response is often a stumbling block to disclosure.

D *fears violence from her partner, so won't disclose to him.* "He said if he can find out that he is HIV positive he is going to kill himself, so I can't risk that, I can't test that ... So you won't know if he will kill himself only or he start with the baby and then me and then himself, those are the things that made me know I must never touch this..."

SEX

Most women say they are not interested in sex. Although factors such as ill-health, high stress levels and caring for small children may play a part, insistence on safe sex appears to bring more tension to the sexual relationship.

M *says her husband sleeps with other women, using her insistence on condoms as an excuse.* "I ask him when we're fighting, 'are there other women?' He says, 'yes, you don't want to sleep with me without condoms'. He says I'm a wife, he married me, I'm not his girlfriend. He says, 'I am not satisfied with condoms. I can sleep with the others'. ... I say, 'Okay if you don't use a condom you better leave me or go and make some divorce.' ... Since I tell him I will use condoms for the rest of my life he didn't force me not to use it."

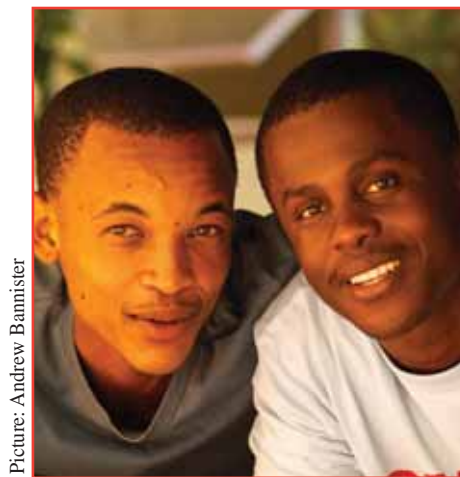
K: "Since I found out, I never slept with my husband. If you sleep with them, you will give them your virus. Even if he's going to use the condom, what if the condom blasts? I'm really scared. Since he found out he asked me once. I said I don't want to do it. I'll tell you when I'm ready. I just want some time to think about these things."

MEN'S DENIAL

Most women interviewed express anger towards men. They say men unfairly blame them for introducing HIV into the home, yet refuse to acknowledge or take responsibility for their own role or HIV status.

J: "If a man is positive, he don't want to accept it. The men, they are the ones who spread this thing ... who gave us this thing, but if you can see, even they don't take treatment. It's very simple, they are scared of this thing, they don't accept it like us..."

B, *support group participant.* "This thing of women always bringing the virus: we are the first to know about the virus. I would like to know, why don't men go for testing? Men are ignorant about health matters. We as women found out we are positive. Men think we bring the disease into the relationship."



Picture: Andrew Bannister

MALE TRANSFORMATION

However, in the support groups I attended, men who are living with HIV are clearly being forced to confront normative notions of masculinity and male stereotypes and reassess the way they relate to women.

They are beginning to realise that this behaviour makes them more vulnerable to HIV and illness. Like women, they too sit with the burden of non-disclosure and realise that communication with their partners is the only solution. They are under pressure to negotiate condom use and are

compelled to confront their health problems and seek medical treatment. Men are also re-evaluating intimidating and aggressive behaviour as they witness the consequences of lack of disclosure by their partners – illness and death.

X, *young male.* "The problem lies with us. We are always intimidating our partners."

We are saying, 'I will kill you'. We have fear that if we are positive everyone outside will know. We have this thing of wanting to hold on to our dignity. We [think] people won't respect you if you are positive ... There is a difference between respecting someone and fearing someone.

When you're in love with someone you shouldn't fear them. It's like putting yourself in prison. It's not a love relationship."

Q, *middle-aged man.* "We are cowards to face the issues regarding our health – especially the issue of HIV. There is pressure from the ladies to be aware of our health but we are not like that – we are weak and ignorant about our health."

R, *youngish man.* "What we as men should do is respect our ladies and partners. If we intimidate them they won't open up to us. Eventually you will find you are positive. Let them know. Let's use condoms and continue our relationship."

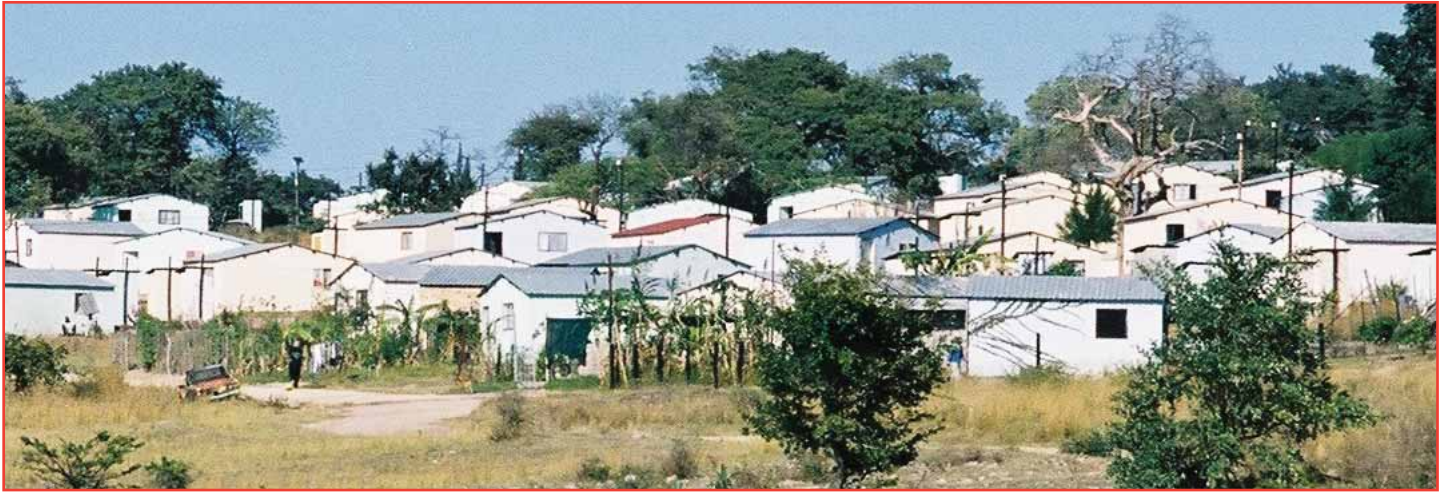
Y, *middle-aged man.* "When my wife found out she was positive, I said its okay and supported her through and through. If I didn't have enough information I would have told her she was dirty and must pack her bags and go ... I went for testing, I was positive. We are living happily. We are using condoms. At first when I realised I was positive I didn't believe it, I thought it wouldn't happen to me. Now I realise it happens to everyone. Now my wife delivered last week. She had a baby boy."

CONCLUSION

The social services provided by the clinics offer a lifeline against isolation and despair for HIV-positive mothers. However, an energetic public campaign to stamp out stigma, intensive educational programmes targeting men and greater media reporting on the human face of the illness could do so much more to offer support and eradicate stigma.

In the absence of these critical interventions, many women are nevertheless devising their own, often creative, survival strategies. Men too, in the safe spaces that support groups offer them, are beginning to examine their own role in the spread of

HIV and the "machismo identities" that place them at greater risk of infection, illness and death.



RDP housing: Acornhoek, Limpopo

“IF YOU WANT TO SEE ME BRIGHT, TOUCH ON THE QUESTION”: Attitudes of health care workers to the PMTCT programme in a rural area



**BY NATALIE
RIDGARD**

Now as I work with [HIV] everyday, talking about it and helping people, I am becoming passionate about it. If you want to see me bright, touch

on the question. I want to talk about it, teach people about it and let them know what it's all about.

– Innocentia, staff nurse, Tintswalo Hospital Maternity ward

INTRODUCTION

This paper forms part of a larger study of the otherwise under-researched uptake of the PMTCT programme in rural areas, using the Tintswalo Hospital and its surrounds as a case study. The study has included women who visit antenatal clinics, a range of health care workers from the hospital itself, community members and leaders, volunteers, field workers and NGO workers from this area.

This data has been gathered not only to be disseminated in an academic setting, but also to assist in addressing audience needs identified by the former research fellows in the HIV/AIDS and the Media Project for media coverage of HIV/AIDS to depart from being event- or celebrity driven

(Finlay, 2004) and to engage with individual and community experiences of the epidemic (Jooste, 2003).

RESEARCH OBJECTIVES

The primary research objectives in respect of the health care workers were:

- ▶ to understand the rural health care workers' experiences of the PMTCT programme; and
- ▶ to establish the successes and challenges of the PMTCT programme in a rural area from those experiencing its implementation.

RESEARCH QUESTIONS

In general, the research aimed to establish what the abovementioned stakeholders considered to be the successes and challenges facing the PMTCT programme, using Tintswalo hospital as a case study.

In relation to health care workers, the research aimed to investigate the experiences, perceptions, attitudes and beliefs of health care workers towards the PMTCT programme in a rural area, including:

- ▶ their attitudes to their jobs;
- ▶ their experiences of successes and challenges of PMTCT programme;
- ▶ their perceptions of the benefits and difficulties which participants in programme face;
- ▶ the impact which the programme has had
 - ▶ on their own lives;
 - ▶ their attitudes to HIV/AIDS; and
 - ▶ their relationships with their partners, families and communities.

RESEARCH SETTING

Tintswalo Hospital, situated near the town of Acornhoek, is the second biggest district hospital in the Bohlabela District of the Limpopo Province. Every month roughly one hundred women visit the Tintswalo antenatal clinic and three hundred women deliver children at the hospital. Tintswalo is a teaching hospital of the University of the Witwatersrand and enjoys some advantage from the on-site presence of the Rural Aids Development Action Research programme (RADAR, HSDU).

LIMITATIONS

- ▶ Successes at Tintswalo may not be representative of the more widespread experiences of rural South Africa.
- ▶ Although most of the healthcare workers were first language Shangaan or Sotho speakers, all of the interviews were conducted in English.

METHODOLOGY

The larger research project comprised five researchers who conducted 54 in depth, semi-structured interviews in and around Tintswalo hospital over the period of one week. In total, 25 health care workers and community members and 29 patients were interviewed. The interviews ranged from 45 minutes to an hour and a half, depending on whether interpreters were used. The researchers worked from interview guides but tailored specific questions to issues which their interviewees wished to discuss.

All of the health care workers inter-



Rexile Wellness Clinic onsite at Tintswalo Hospital

viewed were employed at Tintswalo Hospital, in the antenatal clinic or related wards. Nevertheless, many of the interviews covered the relationship between the hospital and the 14 outlying clinics.

The principal investigator has conducted a thematic content analysis of the data and the findings will be discussed under distinct themes. These themes will be drawn from certain assumptions which were made before entering the research setting, considered in light of any further themes which emerge from the analysis of data.

This paper is a preliminary presentation of the significant findings drawn from the interviews conducted with the health care workers of the Tintswalo Hospital.

IMPLEMENTATION OF THE PMTCT PROGRAMME – SOME KEY POINTS

Many of the findings in this study resonate with those of earlier studies conducted on the implementation of PMTCT programmes (Beresford 2005, Doherty et al, 2003a, Doherty et al 2003b and McCoy 2002). The most significant for present purposes are Doherty (2003a) and (2003b), which outline key lessons learnt from provincial and nationwide pilot PMTCT sites in both urban and rural areas. Nevertheless, the most relevant findings from all of these studies are:

- ▶ Rural facilities usually experience chronic staff shortages due to their remote settings. Note, however, that this problem may be slightly alleviated by the rural allowance for health professionals which was announced in mid-2004 (Reid, 2004).
- ▶ The management of lay counsellors has been “haphazard and unsatisfactory” (Doherty, 2003b, p. 49).
- ▶ Space appears to be an issue at many sites (Doherty, 2003a, p. 101). In this study this seems especially to impact on uptake of VCT.
- ▶ A lack of proper supply and

distribution of consumables, such as Nevirapine (NVP), test kits and formula milk seems to be a persistent and universal challenge to the success of the implementation of the PMTCT programme (Beresford, 2005). The unreliable supply of formula especially heightens one of the greatest challenges, infant feeding (Doherty, 2003b, p. 37-39). In addition, disruption in supplies results in mixed feeding (*ibid*, p. 66).

- ▶ Other challenges to infant feeding are stigma associated with formula feeding and health workers involved in PMTCT not being properly trained in infant feeding (*ibid*, p. 39)
- ▶ Follow up is a problem, and there is a particularly low uptake of testing of babies at one year (WHO guidelines require an ELISA test at one year, and this is standard practice in rural sites).
- ▶ According to the WHO, at least 50% of partners of antenatal clients should be tested, which is overambitious in light of the findings below.
- ▶ Strategies to increase male involvement in PMTCT are critical to the success of the PMTCT programme (*ibid*, p.20).

SUMMARY OF PRELIMINARY FINDINGS

- ▶ There is a shortage of staff, particularly nursing staff trained in PMTCT
- ▶ There is chronic shortage of facilities, which has a direct impact on the uptake of VCT
- ▶ The supply and distribution of formula is a major challenge
- ▶ Stigma associated with bottle feeding is the main difficulty facing women in the PMTCT programme (which results in low levels of disclosure)
- ▶ The community’s access to information on HIV/AIDS and PMTCT is the most identified success of and challenge for the PMTCT programme at Tintswalo Hospital

STAFF

As is the case with the majority of rural sites, staff shortages present a significant problem, especially with regard to nursing staff specifically trained in PMTCT.

Josephine Makhubela, head of ANC Services: “It is too much for us. We are working too hard. The way it is, we need people who will be dealing with the programmes specifically. Not mixing the job. Though the antenatal and the PMTCT are one and the same, we need more staff so that

you are able to attend to it more properly.”

Patients are given a card on which a code (which can only be decoded by trained health care workers) identifies whether they are HIV-positive. A certain code would mean that at delivery they should have taken NVP and the pediatric syrup must be given to their baby.

A2: “Sometimes you find that the PMTCT nurse is not there, then we [are] supposed to teach the other one that after decoding, they must give NVP and ask the lady whether she is having the pill... sometimes because of the shortages they forget to decode until postnatal where it is discovered she needed NVP.”

This presents even more of a problem if the patient visits an outlying clinic for antenatal care but delivers at Tintswalo – often she forgets her card at home, does not tell the nurse her status and the nurse does not ask.

The following suggestions were offered as possible solutions to chronic staff shortages:



A member of the support group at Cottondale Clinic, Limpopo

UNIVERSAL TRAINING IN PMTCT

A3: “All the sisters have been taken for PMTCT, [but] the staff nurses have not been exposed to it, the nursing assistants have not been exposed to it... I wish all the categories of nurses should undergo VCT and PMTCT training so that we ensure that 100% of our clients have undergone counselling and testing because if today this one who is trained is not in, on holiday the other one is on leave, the others who remain cannot counsel the patients, they say ‘we failed because we are not trained.’”

ASSISTANCE FROM “LAY” PEOPLE WHO HAVE BEEN TRAINED IN PMTCT

Joyce Nyalungu, *coordinator of the Hashikota project*: “In the system if it was possible that they recognise people who were trained [in VCT] who can bring in assistance, then it would be easier. With our NGOs, like home-based care, there are people who are trained – coordinators or whoever, other caregivers – we are trained in VCT. Then they could assist with the training and the giving of information.”

A “ONE-STOP PMTCT SHOP”

While universal training would ensure the availability of the necessary skills, other suggestions were concerned with ensuring better uptake.

Dr. Adele Heyer, *medical doctor at RADAR*: “I also think you need like a one stop service... So that a patient who does test positive, she shouldn’t sit between the other antenatal clients. She can, but there should also be a dedicated PMTCT service. If she wants to formula feed, she shouldn’t go to the antenatal clinic for antenatal care then come to us for the support group then go to the pharmacy for the NVP and then go to dietician for formula feed and to the social worker for whatever. Everything should be built in sort of one place so that you know that they get everything they need.”

However, this does not fall in line with current government policy, in which new health services are integrated into existing structures.

Surprisingly, the staff shortages do not affect the lay counsellors in the antenatal clinic at Tintswalo Hospital.

AH: “... There are enough lay counsellors. Lay counsellors are supposed to do between six and eight tests a day. So if you add that up, they should be able to do around a 100 tests a month. We’ve got around 300 deliveries a month... Between four lay counsellors, they should be able to

do around 400 tests a month. And there are only 300 deliveries. But only 100 people come for antenatal care. The amount of tests they do at the moment – last month I think they did 40 tests. So the uptake is not good.”

The poor uptake of VCT is influenced by other factors discussed below.

VCT FACILITIES

Lack of physical space results in a waste of human resources, and negatively affects the uptake of VCT.

JM: “It is a big problem because this is the only counselling room here. We have three lay counsellors. They relieve each other, because the counselling room is the only one [available]. One counsellor will come in, counsel maybe two and then she goes out. The other one comes in, counsels – just like that. It delays the process and some women wait outside until they become hungry and decide to go home and leave. Meanwhile they need to be attended [to] at the first visit. But we don’t manage to see them all because of the one counselling room”.

POOR MANAGEMENT OF THE LAY COUNSELLORS

In line with national Department of Health policy the lay counsellors are managed by a faith-based organisation in Dwarsoop, a town 20km outside of Tintswalo. It is reported that the organisation does not take an active interest in the management of the counsellors. This causes confusion and frustration not only on an individual level for nurses and counsellors alike, but also makes performance appraisals difficult.

THE COUNSELLORS PERCEIVE THEIR WORK AS VOLUNTARY

Lwazi Maluleke, *lay counsellor*:

“Otherwise I’m really frustrated because as I said earlier, this is my fourth year at the



A grandmother with her grandchild, Cottondale Clinic, Limpopo

hospital but I’m still a volunteer. They are not employing us but they expect us to do the job. They pay us a salary every month but it’s a little amount – R1500, what can I do with that? It is very difficult to discuss this concern of ours with hospital administration. We have confronted them with the question ‘why don’t you try to pay us?’ and they say there’s no money. Clearly they are undermining us because they even still call us ‘lay counsellors’, so I think they don’t want to commit themselves to us because we are ‘lay’ people ... What I can say is that [the implementation of the state-run PMTCT programme] has relieved me because when there were only two of us, I used to stay in the counselling room for maybe eight hours and now I’m in the counselling for maybe two hours.”

CONSUMABLES: FORMULA MILK

One of the most significant findings is that the supply of formula to Tintswalo and the resulting distribution to women is poor.

This is a result of a convoluted system, burdened with bureaucracy. Even short term failures have long term effects on implementation.

SUPPLY

Every single one of the interviewees identified the lack of a continuous supply of formula as a major challenge to the success



Picture: Helen Struthers



Picture: Helen Struthers

of the PMTCT programme. At the time of the research formula was once again in stock, but had not been for several months.

Connie, dietician: "... We didn't have any milk supply for the mothers and it affected them a lot, and since then, when we receive the milk for the PMTCT, they didn't come in good numbers, because they were coming and there was nothing, then they end up giving up. So we are no longer having a good turn up for the PMTCT."

DISTRIBUTION

As the outlying clinics are not permitted to stock formula they are compelled to refer women to the hospital. The distribution to clients is managed solely by the dietician.

JN: "For instance, you find that there is milk supply at the hospital, which is put in the hands of a dietician. Those people who are diagnosed right at the clinic, they don't have access to this type of milk. So they have to come and register in the hospital. And some of them are staying very far and [are] very poor. So the programme doesn't reach those people outside... Many people who come into the hospital find that there is no milk. And when they try to find out, they are not even sure when they are going to have the next supply. So it's not properly managed. It is not sustainable. So you find people flocking into the hospital and they go home without anything. Next time they come, there is no milk again. They go back and decide not to come back. So this is a problem. That's where the challenges really

depress me."

The system thus inadvertently encourages mixed feeding.

JM: "Maybe she will come back again and there is no milk again. Maybe she will go home and try some meals to feed the baby. We tell them to go home without milk and you'll see that it's a pity. We don't know what to do. And it is not safe for the baby. Women and health care workers become frustrated, discouraged and disillusioned with the system".

Uniformly the health care workers identified the difficulty that patients face as **STIGMA ASSOCIATED WITH BOTTLE FEEDING**. Poor supply and distribution only seems to exacerbate the stigma and discourage women from adhering to bottle feeding.

C: "... Some of the [women] they come from far away. And you find that they don't have money to come back and collect. So it's better if our clinics have the milks also, and the communities would be aware of these. That is why there is this stigma, you can see when they leave the hospital, they try by all means to hide the tins, because they are afraid they might see people they know and when they see it, they know 'that milk, that milk, that orange tin'."

Besides the problem with a commitment to what has already been promised, health care workers express frustration with the current system and say it should be improved.

C: "I think that the formula should con-

tinue [for more than six months]. You can see that that child still needs milk, if only they can do it for up to a year, going hand in hand with other products, that one will help [the women]. After a year, you'll be able to follow up those children, because [women] will know that 'we should go and collect milk'. But now if you give them for six months and you expect them to come back after a year, the problem is they won't come back, most of them."

JM: "I talked about the 40 tins that get finished while the baby is still small. That is my main concern. If the government can add more tins. Because the 40 tins, they are saying it is for six months. Babies don't use the 40 tins for six months. They use the 40 tins for less than six months. Six months are measured by the government... After you have told the woman that she has exhausted her formula tins, they are no longer even coming for follow-up. They become frustrated. They disappear."

Barbara Shoni Maloka, nurse at RADAR: "I think the government tendering process should be revised. I'm not clear on what happens during this process but it's not fair for mothers to have to come to the hospital from far and wide for infant formula, only to return empty handed just because the supplier's contract has expired and the hospital cannot get from any other supplier because the whole tendering process has to be done afresh."

ACCESS TO INFORMATION

Most of the healthcare workers identified the main benefit of the PMTCT programme as increased access to information about HIV/AIDS. In addition, VCT has helped large numbers of people to know their HIV status.

JM: "We think [the PMTCT programme] is a success because our people of the community are now having information."

However, most of these people are women, as they are the ones who access the services at the antenatal clinic where VCT is offered. Although increasing numbers of women are now equipped with information they mostly remain unable to do anything with it because of the difficulties around disclosure to partners and other family members. Despite the success of increased access to information, it still seems to be a major challenge to extend this information provision beyond the antenatal clinic.

A1: "But I think that if not only the participants themselves but also the community is involved, because from what I understand, if you are in the programme,

according to our culture, you ought to breastfeed the child and to explain to your in-laws (and in our culture the in-laws play a big part)... that you are HIV positive, it will be very difficult for one, because you don't disclose that easily. So if the awareness can be done in the community. Even those that are usually happening in December, with the radio broadcasting ... I don't think everybody who has got a radio can have an understanding. [Then] it will be easier for the mothers to go home and tell their husbands, 'I am HIV positive, let's go and be tested', then the [husband] will be interested to go."

Most health care workers suggest that door-to-door campaigns are needed as mass media are not visible enough and this would ensure that all gain access to the information.

Richard Mashaba, *lay counsellor*: "[We need] some outreaches or awareness campaigns so that they must understand that this happens to each and everybody... Things on the radio [and] TV, sometimes it doesn't reach them. So whenever the outreaches are from the hospitals and clinics... maybe it can help."

I: "The main problem the programme is facing I think is the issue of lack of knowledge within people... I think [the PMTCT programme can be improved] by doing awareness campaigns and sending the counsellors into the communities to tell them about the programme."

According to one health care worker, community leaders provide the best access into communities.

BSM: "One approach [to awareness] that is being used by health workers and which I like is approaching headmen to organise community gatherings which is a good platform to disseminate HIV/AIDS information. The attendance is usually very excellent because headmen are respected in their areas."

Many health care workers identified what is already wellknown in research into HIV/AIDS – the crucial way in which **GENDER** underpins the pandemic. They describe again and again how gender relations need to be improved to ensure the success of the PMTCT programme.

A4: "Men. It is still a problem for the men to be open enough."

JM: "We've realised that if the partner is involved, everything runs smooth[ly]. But if the partner is not involved, she keeps it as a secret...Some they did bring partners, though they are very few. Those who brought their partners will realise it makes the programme to run smoothly because

after she has disclosed, she brings the partner ... And she is free, the female. You'll see her even improving in her condition, improving. She doesn't need to be impressed. She understands everything and she also support[s] other mothers."

In a revealing comment, a lay counsellor alludes to emasculation as a result of structural oppression and the complexity of gender relations in the area:

RM: "... I don't know what you can do with a man. This [programme] is basically for women and children. The men have to [learn that] we are not animals. We have to agree: It is my wife – just like that. Most of the men, they are just against those rights of children and women. Because [men are saying] 'we are being oppressed'. So now it comes to this. 'Now [women] are taking us, it is not us who are telling them what to do in the family'. So they think the government is oppressing, we are oppressed men."

Those perceptions have to be out of our mind[s] so that the epidemic will never have that chance."

ATTITUDE TO JOB

Despite the constraints and the many daily frustrations that working in a resource-poor setting present, the majority of health care workers perceive their work as a vocation and their personal fulfilment is derived from "helping people".

C: "Since I arrived here, things are better, because of the knowledge which I have been able to disseminate to the people

they grab it, and when they come back, they even come and tell me that since you told me this, I have been sticking to it and I can see that things are better."

RS: "I feel good most especially when a person gets out of the office smiling, with much information that will help them, though sometimes they won't smile, but if you provide good information, they'll end up smiling when you are not there, they'll know the truth..."

Many of the health care workers feel empowered by the training that they have undergone, PMTCT-related and other.

JM: "I think gaining knowledge is part of the reward. The workshops that we attend, we feel good... if you are not in the programme, if you are not interested you'll just remain like a health worker who only knows to give medication to a patient and who doesn't know why. You just give medication because the doctor is prescribing... We are gaining as health workers."

CONCLUSION

As previously mentioned the findings presented here are preliminary and represent only one aspect of the broader project. The full findings of this research will be made available at a later date. Nevertheless, this aspect of the research has thrown into relief some interesting insights into the PMTCT programme in a rural area, with respect to the success and the challenges that such a programme brings.



Picture: Helen Struthers

WHO IS SETTING THE PMTCT AGENDA?

A quantitative content analysis of media coverage of PMTCT in SA



BY NICOLA SPURR

INTRODUCTION

The objective of this research is to investigate the South African media's coverage of issues surrounding PMTCT. This article comprises preliminary research findings

from a quantitative media monitoring exercise on PMTCT conducted in February and March 2005.

The research investigates the relationships between the media and prominent stakeholders in PMTCT, including government and civil society. It analyses the portrayal of these role-players, establishes whether a diverse range of perspectives are depicted and looks at the most prominent messages around PMTCT.

Issues around PMTCT have been prominent in the South African press in recent years, mostly because of the various controversies surrounding the roll-out of PMTCT interventions in the public health sector. It is evident that mother-to-child transmission of HIV can be significantly reduced with the provision of antiretroviral drugs, safe labour and delivery, and the use of proper infant feeding techniques. Yet, the development of policies and legislation enabling these interventions have been fraught in this country, with strident viewpoints playing out among key stakeholders, including government, AIDS treatment advocates, pharmaceutical companies, international donors and others.

The Treatment Action Campaign (TAC) launched its first campaign around PMTCT in 1999 (Heywood, 2005), demanding that antiretroviral drugs be provided to HIV-positive pregnant women in the public health sector. According to the TAC (*ibid*), it was around this time that the ANC-led government first began to strongly disagree with civil society activists campaigning for HIV/AIDS treatment.

Subsequently, there has been a landmark Constitutional Court case ruling on

the provision of Nevirapine (NVP), as well as much debate and public dispute around issues such as the link between HIV and AIDS, antiretroviral drug resistance, and the effective roll-out of treatment in public hospitals and clinics.

All of these events make for a relevant and interesting exploration into the depiction of PMTCT by the media.

RESEARCH OBJECTIVES

Specifically, the research seeks to understand which role-players have been setting the agenda and determining the news values around PMTCT. Previous research (Stein, 2002; Finlay, 2004) has already shown that much HIV/AIDS reporting in South Africa is fuelled by political conflict and sensationalism.

This project looks at PMTCT to evaluate whether the media have been influenced by the advocacy of powerful actors and whether or not a balanced view of the issues is generally provided. The research also assesses whether or not the voices of ordinary citizens – those women and men affected by PMTCT and related issues – are adequately represented by the media.

LITERATURE REVIEW

In the context of a political democracy, Gurevitch and Blumler (2002, p.25) argue that the mass media should perform a number of specific functions, including:

- ▶ Identifying and reporting on socio-political issues that affect

citizens, as well as the underlying forces that influence issues;

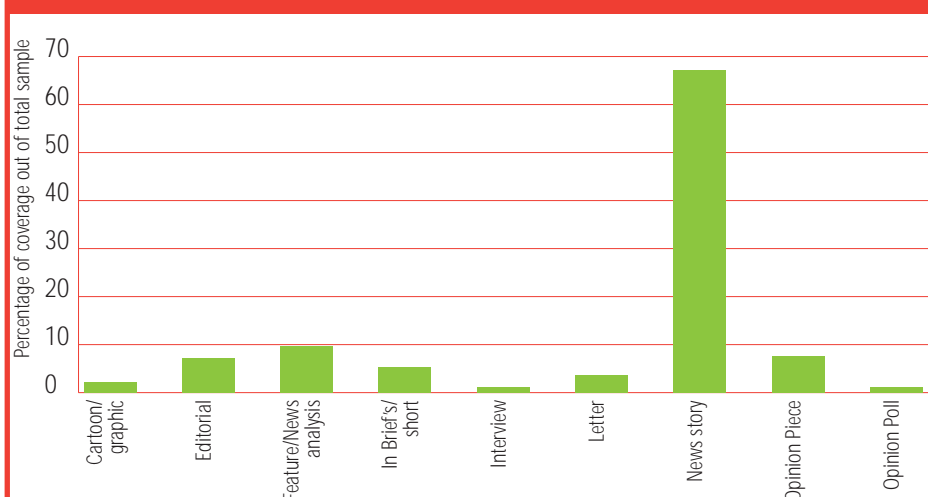
- ▶ Stimulating dialogue across a range of views and providing a platform for specific interest groups to engage in advocacy around particular issues;
- ▶ Holding public officials accountable for their actions and encouraging citizens to become involved in political processes; and
- ▶ Maintaining their own integrity and independence from the political process.

Wolfsfeld (2000) argues that there is a two-way flow of influence between the media and the primary actors in any political debate. Each actor presents their own, specific ideological stance on an issue, and the media sets up the conflict between these competing ideologies. In South Africa, reporting on HIV/AIDS has been predominantly characterised by the political conflict between government and civil society around the rights of HIV-positive people (Finlay, 2004).

Government develops policy and legislation and communicates its policy agendas to the public through the mass media. HIV/AIDS groups and other civil society movements also use the media to advance and publicise their advocacy aims and mobilise support, and this, in turn, influences the broader public policy cycle.

The influence of the media in setting a public agenda largely depends on how important the issues are to readers, and

GRAPH 1: BREAKDOWN OF PMTCT ARTICLES BY CATEGORY



whether or not the events are unfolding rapidly or gradually (Rogers and Dearing, 2000). The media prioritises quick-onset news events, usually because there is significant associated drama and tension, and these are at the top of the agenda. This research explores the extent to which the South African media prioritises quick-onset news events, over slow-onset, issue-based reporting.

The media, ultimately, has discretionary control over which issues and events are highlighted for public attention.

The ability of any interest groups to influence reporting on specific issues is very much dependent on the relative newsworthiness of the issue at any particular time.

Issues and agendas must compete for space in newspapers and, therefore, compete for public attention. HIV/AIDS is often topical, largely due to the political infighting that characterises the policy agenda in South Africa and this means that much of the reporting around HIV/AIDS is eventbased (Finlay, 2004). This research seeks to understand whether the same is true for PMTCT.

Terkildsen et al argue that the news readers eventually see is the result of “a complex interaction between the media and interest groups, which in turn is largely dependent on a series of media decisions about what constitutes news, news space and reader interests.” (2000, p.338). All stakeholders shape the debate – reporters act as both catalysts and intermediaries in the policy process, while government and civil society frame issues for the public.

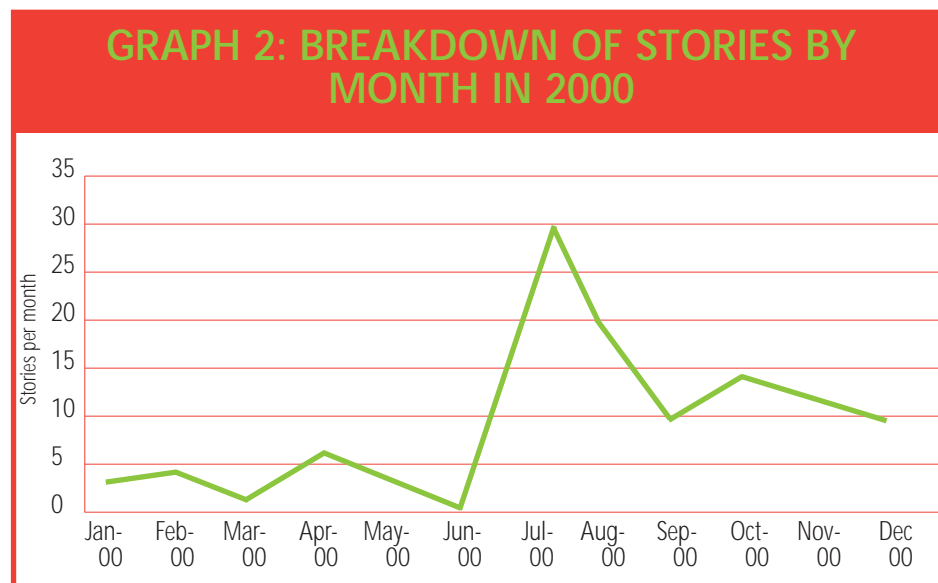
This research investigates whether the different viewpoints and perspectives clearly at play in the PMTCT debate are fairly and accurately depicted, and whether particular interest groups enjoy more favourable coverage than others.

RESEARCH METHODOLOGY

A retrospective print media monitoring exercise has generated the quantitative findings captured in this article.

Essentially, the total number of articles written about PMTCT in South African newspapers during a specific time period were counted, analysed and compared against each other.

Articles were collected using a pre-selected keyword search from a news clippings service run by the University of the Free State. The phrase “prevention of mother-to-child transmission” was not captured in this database, so articles were identified on the basis of a set of related keywords:



- Nevirapine;
- AIDS and (babies, women, pregnancies);
- AZT and AIDS and (babies, women, pregnancies);
- Medicine and AIDS and (babies, women, pregnancies); and
- Antiretroviral therapy and AIDS and (babies, women, pregnancies)

This keyword search yielded a total sample of 807 articles.

The research focuses on three calendar years: 2000, 2002 and 2004. These time periods were chosen because of important events around PMTCT that unfolded then.

For example, 2000 saw the TAC campaign for HIV drugs take off, while the XIII International AIDS Conference was held in Durban in July. In 2002, the Constitutional Court announced its verdict in the case for antiretroviral drugs and the government began publicising its intentions to provide drugs in the public sector. In 2004, the XV International AIDS Conference in Bangkok both meant that PMTCT were on the agenda.

The Media Monitoring Project (MMP) was contracted to manage the monitoring exercise. A list of possible sources, topics and key messages relevant to PMTCT were identified and a group of 10 monitors analysed each of the articles according to a standardised set of criteria.

LIMITATIONS:

- The exercise is restricted to English language print media
- The monitoring covered limited time periods, identified because of the nature of the events that took place then
- Although the monitors were trained uniformly, guided by a standardised monitoring approach and managed

closely, it is possible that some differences in interpretation of the material may have influenced the data.

PRELIMINARY RESEARCH FINDINGS

TYPES OF MEDIA COVERAGE ON PMTCT

It is clear from Graph 1 that the vast majority of coverage on PMTCT during the periods monitored is news reporting. 65% of all reporting is news, with 10% in features.

Of course, most of a newspaper's column space is allocated to news but this result reflects the newsworthiness of issues around PMTCT and points to the likelihood that much of the reporting covers the political events unfolding around PMTCT.

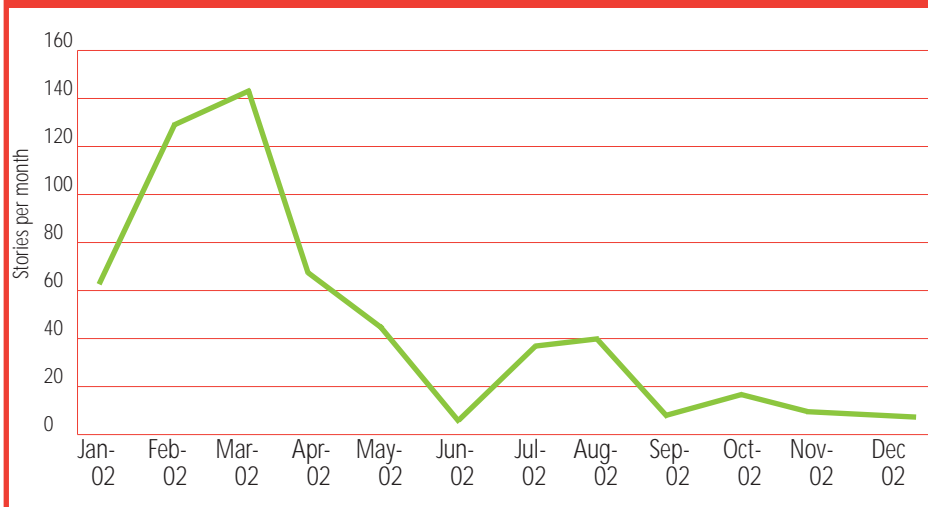
This seems, therefore, to suggest that much of the coverage has been responsive and based on the occurrence of events at any given time. There seems to be little ongoing, systematic coverage of the complexities around PMTCT, which would more likely be covered in opinion and editorial sections.

PEAKS AND DIPS IN REPORTING

The monitoring shows that there are periods in each of the years monitored when reporting on PMTCT peaked and dipped. This correlates with the sequences of events playing out on the political stage at these times and therefore substantiates the premise that much reporting is event-based.

In 2000, there were 112 articles captured (out of the total sample) which portrayed some aspect of PMTCT. A total of 28 stories were printed in July when the XIII International AIDS Conference was held in Durban. Another peak in reporting is

GRAPH 3: BREAKDOWN OF STORIES BY MONTH IN 2002



reflected in October, when Presidential spokesperson, Parks Mankahlana, died – Mankahlana was an avowed Aids denialist who was rumoured to have died an AIDS related death and it is likely that PMTCT related topics were on the news agenda during this time.

PMTCT received a lot more general coverage in 2002 (see graph 3), with a total of 578 stories published on the issue. In early 2002, a document was circulated within the ANC and leaked to the press, espousing dissident views about the causes of HIV/AIDS (Heywood, 2005). It caused a stir because it was not officially discredited by the ANC, nor officially sanctioned. However, it did receive a lot of press coverage, largely due to the intrigue and sensationalism around its authorship and the responses from different stakeholders. The debates about HIV/AIDS and denialism reached a fever point in these few weeks.

In March 2002, Parliament also debated a committee report on whether women had a right to antiretroviral drugs to reduce transmission of HIV to infants, or after rape. In the same month, Nelson Mandela publicly called for antiretroviral drugs to

be made available to HIV-positive people and by April, Cabinet had committed itself to rolling out treatment.

The Constitutional Court ruling around the provision of treatment to HIV-positive pregnant women and rape survivors also occurred in mid-2002. Interestingly, although the graph shows a peak here, the coverage is not as high as expected, with only 82 stories published between June and August of that year. This is a lot more coverage than usual, relative to other months across the spectrum of this project, but it may also indicate that the court ruling was less interesting to the media than the events leading up to the case.

By 2004 (see graph 4), PMTCT coverage had tapered off again, with only 115 stories published in the year. The early months of 2004 reflect a dominance of elections coverage and HIV/AIDS was definitely on the public agenda during this time.

However, coverage around PMTCT really peaked during the XV International AIDS Conference held in Bangkok in the middle of the year, when the health minister came to blows with treatment activists around NVP provision and resistance to this drug. This

was a highly conflicted time, with the health minister publicly lambasting AIDS activists, and being publicly lambasted in return, on an international platform and then leaving the conference early.

In November 2004, coverage rises again, largely due to some further controversy around NVP resistance and evidence published about the methods used on a key NVP trial in Uganda. Although this was not a national issue, it did raise some interest in the media, presumably based on earlier debates about resistance.

GEOGRAPHIC COVERAGE

In graph 5 we see that most coverage of PMTCT is national, meaning that the stories report on national aspects of the issue, without any regional or local focus. Even those publications physically located in different provinces, with presumably provincial readership, focus on national issues and almost 68% of all stories on PMTCT are nationally focused.

This supports the premise that most of the reporting on PMTCT focuses on those events unfolding at a national level and therefore points to the debates around national policy on PMTCT. There is much less emphasis on finding the local stories, or linking national, provincial and local issues. This may reflect a lack of capacity in smaller, regional publications and a reliance on news wires for stories but it also seems to support the notion that the media largely responds to the conflict played out at national level.

Among the provinces, it is clear most coverage is focused on Gauteng, KwaZulu Natal, and the Eastern and Western Cape. This could be due to several factors. There are more newspapers in these provinces, especially Gauteng and the Western Cape, which means that coverage is higher. The rural provinces receive much less coverage in general and are less well resourced for journalists and newspapers. Also news agencies are most likely to be located in the urban provinces and therefore sourcing their stories there.

It is interesting, however, to compare these findings against the provincial HIV prevalence rate published in the HSRC HIV/AIDS survey (2002) which found that Gauteng, Free State and Mpumalanga had the highest infection rates. This shows that the importance of issues around HIV to local populations, based on how many people may be infected, does not correlate to the amount of coverage. Less than 1% of articles featured local issues around PMTCT, another revealing finding that

TOP FIVE SOURCE GROUPS (across all periods)

Source	number	% of all sources
Government	556	33
NGO's	216	13
Medical Community	191	11.4
Political Parties	148	8.8
International Community	99	5.9

shows that stories portraying ordinary people are least likely to be profiled.

SOURCES

Out of the total sample, it is clear which sources are most likely to be featured (see page 13). It emerges that 33% of all stories quote government sources, including the national and provincial departments of health. The health minister is the most prominent individual from this category.

Non-governmental organisations are the next most prominent sources, with 13% of stories quoting NGOs, especially the TAC, Aids Law Project and the Aids Consortium. TAC leaders Zackie Achmat and Mark Heywood features are the most prominent individuals here.

What is even more revealing is that government and the TAC are often quoted in the same stories. Out of the 33% of stories featuring government mentioned above, the TAC is also quoted 21% of the time. And out of the 13% of stories featuring the TAC, the government is also quoted in 56% of them. This indicates that these two actors are highly likely to be played off against each other in articles, thereby fuelling the idea of conflict around PMTCT.

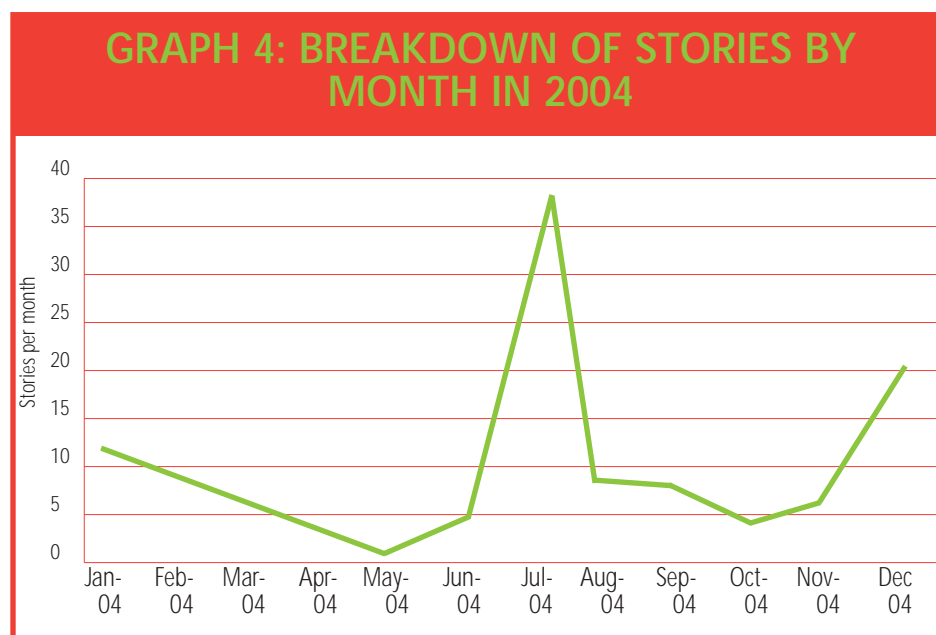
Further, it is interesting to note that stories sourcing government officials and politicians most often feature multiple government sources. In fact, some stories feature up to 4 government sources at a time. Stories sourcing the TAC and other NGOs, however, usually only feature one source.

This seems to indicate that journalists struggle to obtain a clear message from government sources, or that there may be different messages coming out of different government structures (for example, politicians and officials may be saying different things). It also indicates that the TAC is more direct and clear in its messages – the use of a single voice in the press is a mark of successful advocacy.

The ANC and the Democratic Alliance (DA) also both feature as regular sources, each coming up in 3,2% of total stories.

For the ANC, it is revealing that the party may be sourced independently from the government that it runs – this may point to a lack of clarity about whether PMTCT policies are clearly owned by government and its representatives, or a blurring between the party and the state. For the DA, this points to the nature of opposition politics – the DA is often sourced in order to obtain an alternative viewpoint on controversial political topics.

Boehringer Ingelheim, the pharmaceu-



tical company that manufactures NVP is quoted in 1,8% of all stories, whereas other pharmaceuticals are hardly sourced at all.

This further supports the thesis that much coverage of PMTCT has revolved around the provision of NVP in the public health sector, but also indicates that the pharmaceutical company has not played a particularly significant role in the political tussles around the issue.

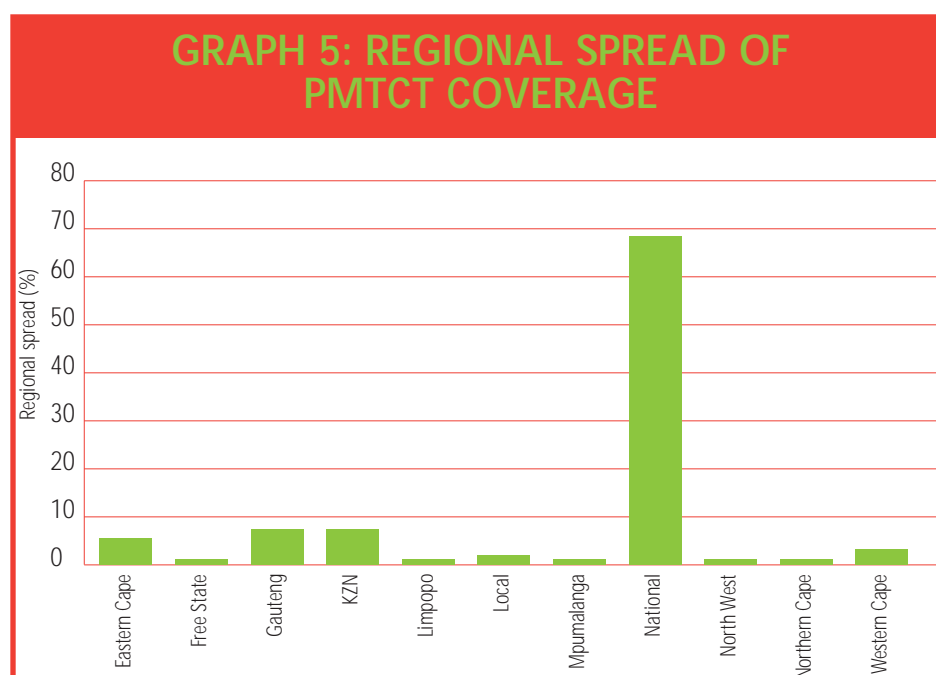
These findings thus support the idea that the public agenda around PMTCT is being set and challenged, in turn, by civil society and government actors in South Africa. The media seem to be mostly responding to and reflecting this conflict, using the idea of opposing forces to stimulate tension and create news, as suggested by Gurevitch and Blumler (2002) and Wolfsfeld (2000). This also corresponds to

Finlay's (2004) findings about broader HIV/AIDS coverage.

It is also revealing that that TAC is clearly favoured in 17% of all the stories and is only clearly opposed in 1% of the stories. The government, on the other hand, is favourably portrayed in 11% of stories and clearly opposed in 78% of stories.

This, together with the regular use of multiple government sources, indicates that reporters often neither trust government's standpoints, nor agree with them. And, although the TAC and other civil society movements may be depicted as disruptive in their protest tactics, there seems to be a tacit support for their messages.

Interestingly, women affected by issues around PMTCT hardly feature at all. Only 15 stories out of the total feature people living with HIV/AIDS (0,9%) and 9 stories



(0,6%) source mothers or pregnant women.

Fathers barely feature at all, only showing up in 2 stories (0,1%). Thus, those ordinary people most affected by issues of mother-to-child transmission – HIV-positive women attending antenatal clinics, and their male partners and families – are almost invisible in the press.

Overall, the most likely people to be sourced on issues of PMTCT are those politicians and bureaucrats responsible for developing and implementing public policy and legislation, and those civil society leaders who speak out about it. Even though the TAC states that it is a grass-roots movement, with many members able to speak from personal experience on HIV/AIDS issues (Heywood, 2005), the media keeps coming back to those same sources that they know. In the meantime, ordinary citizens do not have much of a voice at all in the media.

TOPICS

Each article monitored was assigned a topic code which captured the most central aspect of the story. The most prominent topics were:

- ▶ NVP (37% of all articles)
- ▶ PMTCT strategies and policies (4% of all articles)
- ▶ The Constitutional Court case (9% of all articles)

Once again, it becomes clear that most PMTCT coverage centres on the political and public policy debates around anti-retroviral drug provision.

KEY MESSAGES

A set of 153 possible key messages was developed for the monitoring, in order to analyse what perspectives are most prominent within the coverage of PMTCT in the media.

Positive messages around NVP featured most often:

- ▶ “NVP is central to PMTCT” (7,4% of all articles);
- ▶ “NVP is good because it prevents transmission” (3%); and
- ▶ “NVP is an antiretroviral” (2%).

Negative messages about NVP are far less prominent:

- ▶ “Resistance to NVP has an impact on your broader health” (1,1%);
- ▶ “There are better alternatives to NVP” (0,6%); and
- ▶ “NVP is not a good intervention” (0,5%).

A message stating “AZT is central to

PMTCT” only comes up in 1% of all stories. This is interesting because AZT was the drug of choice originally promoted by the TAC in its PMTCT campaign in 1999-2000 (Heywood, 2005), but it became surpassed by NVP in later advocacy efforts. NVP is a cornerstone of the PMTCT treatment strategy, especially as advocated by the TAC and other civil society groups.

It is interesting to see how NVP is mostly positively promoted by the media, despite the active debate about its effects and possible resistance. Since it has been mostly government raising the issue of resistance to NVP, and the research has already established that government sources are less favourably portrayed on the whole, it seems clear that the TAC’s messages about the efficacy and desirability of NVP have sunk into the media’s discourse too.

The second most prominent message overall is that “It is the government’s responsibility to provide PMTCT”, which features in 5,1% of all stories. A message stating “The government is being stubborn (in the face of scientific evidence and other public pressure)” arises in 4,2% of all stories.

Generally, there are many negative messages about government which feature prominently, including “Government lacks a comprehensive policy to deal with HIV/AIDS” and “Government lacks the political will to deal with HIV/AIDS”. The prominence of these messages points to the media’s generally negative portrayal of government, as also seen in their use of sources. Ultimately, it seems as though government has not been using the media

as effectively as the TAC and others, when it comes to promoting their own PMTCT agenda. Although government is obviously a major player and needs to be quoted and acknowledged, the media seems disinclined to actively promote the government’s viewpoints. Further analysis of this finding will be explored in a more detailed assessment of which publications promote or challenge particular messages around PMTCT.

REPRESENTING FACTUAL AND SCIENTIFIC EVIDENCE ABOUT PMTCT

Monitors were asked to capture whether or not articles portrayed medical or scientific evidence about PMTCT. It emerges that 38% of all stories do provide some factual information about PMTCT or HIV/AIDS.

This is a significant finding when assessing the media’s responsibility to inform citizens of the key issues affecting them and to do so in an accurate, balanced manner (Gurevitch and Blumler, 2002, p.25).

However, the research has not yet investigated how accurate this information is. This will be done by extracting a small sample of these articles and having a medical expert evaluate their scientific content.

CONCLUSION

A further component of this project will involve a qualitative, textual analysis of a small sample of articles on PMTCT. This will explore in more depth the nuances of these texts and the ways in which these texts illustrate the editorial agendas of the publications in which they appear.

TOP TEN KEY MESSAGES (across all periods)

Key message	number	% of all key messages
Nevirapine is central to PMTCT	239	7.4
It is the government's responsibility to provide PMTCT	166	5.1
The government is too stubborn (in the face of scientific evidence and public or other pressures)	135	4.2
Anti-retrovirals need to be distributed as part of a comprehensive/sustained treatment programme	128	3.8
PMTCT drugs are not available throughout the country	127	3.7
Nevirapine is good because it prevents transmission	113	3.0
Nevirapine is an anti-retroviral	106	2.0
An impediment to effective PMTCT is political will	101	3.0
The government lacks a comprehensive policy for tackling the HIV/AIDS pandemic	87	2.5
The government lacks the political will to deal with HIV/AIDS	84	2.5

RESEARCH TOPICS

THE ROLE OF THE MEDIA IN DEVELOPING COUNTRIES: the case of media coverage of PMTCT in South Africa



**ROCHELLE
DAVIDSON**

INTRODUCTION

According to the United Nations Development Report (2002) progression in the achievement of gender equity and empowerment for women and girls is the third Millennium Development Goal. The report states, "Worse outcomes for women in many aspects of human development result from the fact that their voices have less impact than men's in the decisions that shape their lives" (23). In particular, the situation of HIV/AIDS the "voiceless" position of women is an actuality that contributes to the risk and vulnerability of women and girls in Sub-Saharan Africa, with approximately 75% of all HIV-positive women worldwide living in this region (UNAIDS, 2004).

With poor women being a high-risk group for HIV infection, PMTCT involves many social issues surrounding gender and poverty that create a very complex story.

Past coverage of PMTCT issues has been focused on political controversy, making for sensational and one-dimensional stories, often ignoring the voices of those directly affected.

RESEARCH OBJECTIVES

In this study, I will discuss the media's current role in the development of South Africa, using news media coverage of women's health in the realm of PMTCT as a case study. In particular, I would like to investigate the implications of media coverage of the recent Nevirapine (NVP) resistance debates for women's health and their socio-economic development in South Africa. This research will examine the media using a framework of human development, locating them as a key institutional mechanism to promote developmental issues in South Africa, in particular women's health concerns.

RESEARCH QUESTIONS

- ▶ What is the role of media in developing countries?

- ▶ What has been the media's role in promoting women's health within the realm of PMTCT in South Africa?
- ▶ What is the influence, if any, of global news on local news media?

THEORETICAL FRAMEWORK

The World Bank (2002) suggests three conditions that provide media with the ability to promote equitable and democratic development:

- ▶ Independence: autonomy, not being controlled by particular interests groups;
- ▶ high quality reporting: the ability of the media to provide diverse views on economic, social and political issues; and
- ▶ a broad reach in society: being able to bring news (through newspapers, radio or television) to the entire population in their various languages.

Though these are suggestions that apply to any developing country, these conditions will be investigated using the specific history and reality of South Africa and its HIV/AIDS pandemic. In addition, I will use theories of gender and HIV/AIDS to frame this study.

METHODOLOGY

I have a two-pronged approach to the methodology for this study. Firstly, I will conduct a qualitative content analysis or textual analysis of South African print media between July 2004 and January 2005, particularly coverage of the recent NVP resistance debates. About 100 articles will be analysed, in order to explore whether there is in-depth representation and sourcing of women within PMTCT programmes. This textual analysis will be generally thematic – what were the main themes of the coverage, and what themes were omitted?

Secondly, I will conduct a range of in-depth, semi-structured interviews with development experts, media analysts, health journalists, editors, and academics, as well as other stakeholders. These interviews will form part of a perspective on the role of media in South Africa and its development, and in particular on the role of media in its coverage of women's health issues within the realm of PMTCT.

CONCLUSION

According to empirical studies "...women's access to media is associated with better

health and fertility outcomes, even after accounting for different income and education" It is evident that media have a socially useful function that can promote such matters as women's empowerment.

My primary concern, using the case study of women's health within the realm of PMTCT, is to understand how the media can responsibly represent the concerns of vulnerable populations such as women. How can media define their role and how can there be a shift in media understanding of gender concerns from "soft" issues to the more critical subject of development in South Africa?

THE SOURCING OF HIV/AIDS TREATMENT NEWS IN SELECTED SOUTH AFRICAN PRESS:

*The Star and the Sowetan
in South Africa*



**CAROLE
MUCHENDU**

RESEARCH OBJECTIVES

The objective of this research report is to analyse the sources that are used in the coverage of HIV/AIDS treatment news and to ascertain whether there is a dominant use of government and expert sources as opposed to non-expert and activist sources.

This will assist in determining whether there is growing use of non-official/alternative sources in the coverage of these issues in selected South African newspapers.

RESEARCH QUESTIONS

- ▶ Is there a growing use of non-official sources (non-expert and activist sources) in the South African press where HIV/AIDS treatment news is concerned and if so, why?

SUB-QUESTIONS:

- ▶ What is the range of sources being used and which ones dominate?
- ▶ What importance and value do these sources bring into a story?
- ▶ What are the ways in which the non-expert and activist sources mobilise their material and symbolic resources to secure media opportunities?

THEORETICAL FRAMEWORK

While being informed by the theory of dominance in which Stuart Hall and his colleagues first articulated the concept of “primary definition”, in this study I also attempt to build on the works of the critics of this concept. Hall et al., (1978) argue that the media is “structurally biased” to official sources, making them the “primary definers of topics”. Official sources are considered to be the “powerful” and these, according to Hall et al., (in Manning, 2001) include:

- ▶ the institutions of the state;
- ▶ leaders and senior figures within the main political parties;
- ▶ the institutions of law and security; and
- ▶ the established interest groups close to government

However, Phillip Schlesinger (1990), while wishing to retain “a theory of dominance”, insists that there are more opportunities for non-official news sources to intervene in the defining of news agendas than implied by the concept of “primary definition”.

Non-official/alternative sources are generally considered to include:

- ▶ activist groups;
- ▶ NGOs, PWAs; and
- ▶ opposition parties and other politically marginal and subordinate groups.

According to Schlesinger, Hall’s concept is deterministic, static, ahistorical and temporal and Schlesinger therefore proposes a less rigid theory of domination that does not accept the triumph of the official, but rather that it is something to be struggled over.

METHODOLOGY

In this study I used both qualitative and quantitative research methods to acquire data. The quantitative content analysis consisted of counting of sources in the sample articles to determine the range of sources used. Then, the qualitative analysis involved the examination of the texts to establish the value that a source brings to a story.

I also conducted semi structured interviews, in order to establish if and why there was a growing use of non-official/alternative sources in the South African press and the strategies that are used by source organisations to acquire media access.

SUMMARY OF FINDINGS

- ▶ There is a dominant use of official

sources.

- ▶ The Minister of Health, Manto Tshabalala-Msimang, and government spokespersons are the most frequently used sources.
- ▶ Nevertheless, a frequent use of non-official sources is also noted, namely:
- ▶ The Treatment Action Campaign (TAC);
- ▶ Aids Law Project (ALP); and
- ▶ NGOs, for example, Médecins Sans Frontières (MSF).
- ▶ The voices of opposition parties such as the Democratic Alliance (DA), especially that of Mike Waters (DA spokesperson on HIV/AIDS) and the former New National Party (NNP) are also often used.
- ▶ The use of academics and people living with HIV/AIDS as sources is not as high as would be expected.

In conclusion, there is a growing use of non-official/alternative sources in HIV/AIDS treatment news in the South African press.

PMTCT MESSAGES ON THE ENTERTAINMENT-EDUCATION TELEVISION PROGRAMME *TSHA TSHA* and the response to these messages by men in Soweto, Johannesburg



FREDRICK OGENGA

INTRODUCTION

Observations by staff at the Perinatal HIV Research Unit (PHRU) reveal that very few men participate in PMTCT programmes at antenatal clinics in Soweto, Johannesburg.

In addition, there is a trend in current literature on PMTCT that emphasises the role of women and does not adequately account for men (see Cohen, 2004). While men’s lack of participation can be attributed to several factors, one that cannot be overlooked is the role of the media in constructing messages that are appropriate and relevant to men.

RESEARCH OBJECTIVES

In this study, I hope to provide insight into the nature of existing PMTCT media messages on a particular entertainment-education (EE) television programme, *Tsha Tsha*,

the response by men to these messages and the possible impact this has on their participation in PMTCT.

RESEARCH QUESTIONS

- ▶ How does PMTCT messaging on EE programmes impact on men’s participation in PMTCT?

SUB QUESTIONS

- ▶ How are PMTCT messages produced on *Tsha Tsha*?
- ▶ How do men respond to these messages?
- ▶ Does this response have an impact in their participation in PMTCT?

THEORETICAL FRAMEWORK

I will take a cultural studies approach to audience reception studies. Stuart Hall’s seminal essay “Encoding/ Decoding” (in During, 1993) will be discussed within the wider context of the abovementioned approach. Hall’s theory will be used to give an account of how PMTCT messages are produced and how men receive them.

However, Hall’s theory cannot explain how these messages may or may not impact on participation, therefore EE theories will be also used to explain production and reception, particularly Bandura’s (1969) social learning theory. Bandura also uses theories of reasoned action and parasocial interaction to explain a direct link between attitude and behaviour/participation.

METHODOLOGY

The research methods are of a qualitative nature:

- ▶ In-depth, semi-structured interviews with producers of *Tsha Tsha* will be conducted in order to ascertain considerations of the producers and factors influencing message production
- ▶ Initially in-depth, semi-structured interviews will be conducted in order to understand men’s attitudes towards, knowledge and perceptions of PMTCT
- ▶ *Tsha Tsha* will be screened to these same men in a series of focus groups to assess their response to the PMTCT messaging

CONCLUSION

I hope that this work can contribute to a body of knowledge and provide a model for constructing PMTCT media messages that take into account a myriad of socio-cultural factors, including gender.

WHAT IS THE HIV/AIDS AND THE MEDIA PROJECT?

The HIV/AIDS and the Media Project investigates the role and the impact of the news media on the HIV/AIDS pandemic in South Africa. The focus of the project for 2004/5 has been on media coverage of the Prevention of Mother-to-Child Transmission of HIV (PMTCT).

SPECIFIC OBJECTIVES OF THE PROJECT ARE:

- ▶ To encourage and enable journalists to play an informed role in combating HIV/AIDS
- ▶ To promote discussion and debate among journalists and other key role-players in this area
- ▶ To monitor the role and the impact of the media and to provide research which ensures an informed and useful debate around this issue

WE UNDERTAKE THE FOLLOWING ACTIVITIES:

- ▶ We offer 4-6 month fellowships to working journalists to conduct longer term and in-depth research and writing outside of the newsroom. We partner with the Media Monitoring Project on some aspects of the research. The writing that results from these fellowships is published in various forms of media and peer-reviewed journals
- ▶ We identify and research gaps in reporting. For instance, this year we are looking at the role of men in PMTCT, uptake in rural areas and infant feeding
- ▶ We are in the process of developing the website *journ-aids*, in partnership with Cadre, which will be a resource on HIV/AIDS and PMTCT for journalists
- ▶ We run wider discussion forums on HIV/AIDS and the Media to stimulate debate and discussion amongst journalists, activists, doctors, scientists, academics, government and other stakeholders
- ▶ We run smaller discussion forums specifically for journalists on various aspects of the HIV/AIDS pandemic and the role of the media. The South African National Editors' Forum (Sanef) partners with us in these forums
- ▶ Each year we are involved in the training of career-entry Honours

students from the Wits Journalism Programme in HIV/AIDS reporting

If you would like any more information on the project, please do not hesitate to contact the Research Coordinator, Natalie Ridgard, at:

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Owing to space constraints we were unable to include bibliographies. For the full **bibliographies** of the papers in this booklet, or **transcripts** of the panel discussion please visit www.journalism.co.za or email ridgardn@journalism.wits.ac.za

This booklet was compiled and edited by **NATALIE RIDGARD**.



Picture: Andrew Bannister



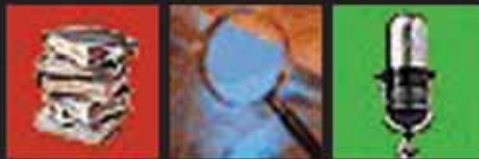
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