

Behaving 'better'? The media, HIV/AIDS and stigma

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(Speaker's notes for Centre for the Study of AIDS forum, 2004)

Introduction

Discussion about the role of the media in reporting on HIV/AIDS, particularly stigma and denial, tends to rest on two popular assumptions:

1. That the media has a major role to play in reducing AIDS stigma and denial, and that it is obliged to do so.
2. Once people know how HIV is transmitted, they will change their sexual behaviour ("health belief model").

Assumption 1: That the media has a major role to play in reducing AIDS stigma and denial, and that it is obliged to do so.

Media context

South Africa has a wide range of media and freedom of expression and media freedom are constitutionally guaranteed. The majority of South Africans have access to radio and TV, although TV access reduces substantially in rural areas. While print media has a limited reach, it has a longer life span particularly the monthly magazines. Those who read newspapers tend to be decision-makers and policy-makers, so while the print media audience may be small, it is influential.

The vast majority of SA media is commercially driven. While the SABC has a public service mandate and gets taxpayers' money, it seems to have a limited interpretation of what this means (seems to be seen largely as being able to deliver programmes in all official languages rather than promoting issues of national interest).

Commercially-driven media needs to make money, primarily through advertisements. It attracts advertisers by the audience that can be drawn to its products. Increasingly, editors have to reach audience targets to ensure advertising revenue, rather than just dealing with editorial content.

Given its spread and influence, the media is an important tool in the fight against HIV/AIDS. But it should not be assumed that the commercial media will operate in the public interest or be a watchdog over the powerful. The definition of "public interest" is often contested and those who control the media need to be engaged and lobbied if they are to address HIV/AIDS adequately. There is no general consensus within the media about what the role of the media is, although most journalists covering news are likely to accept that one of their responsibilities is to act as a watchdog – but this role is usually restricted to being a watchdog over government rather than all those who have power. In addition, media convergence has brought with it another kind of "convergence" in terms of the definition of who a journalist is. DJs and talk show hosts sometimes also describe themselves as journalists now and their primary task would be to entertain.

The moral imperative for government to provide antiretroviral (ARV) drug treatment has made a compelling story. But now that the government has decided that the drugs will be available in public health, it will be far harder to ensure that the media continues to report in a substantial manner on HIV/AIDS, maintain pressure on govt and play a watchdog role in monitoring the rollout. The ARV rollout has largely removed the political controversy, and it is going to be far harder to maintain the interest of the media industry.

Media failings

It is hard to characterise HIV/AIDS coverage in the media as it has generally been patchy and mixed. However, there are some general shortcomings:

- The reasons behind stigma and denial have not been systematically examined. Yet stigma is one of the major barriers to dealing with HIV/AIDS. At this stage, stigma is a barrier to people going for treatment. Even in companies and countries that offer ARVs, stigma is a barrier that prevents people from coming forward to get the drugs. (Only 6% of infected workers at Tongaat Hulett take advantage of company-sponsored treatment, while in Botswana only around 7000 people out of an estimated potential of 100 000 have come forward to get ARVs since they were offered free in public health last year.)
- The media has generally failed to engage adequately with, represent and seek out the views of PWAs.
- It has politicised HIV/AIDS.
- It has failed to examine the “big picture” context of HIV/AIDS. Numerous studies have shown that a person’s social context and resulting lifestyle is the defining factor in risk. In South Africa, the Nelson Mandela/ HSRC 2002 survey found that those most vulnerable to HIV/AIDS lived in informal settlements. This was irrespective of cultural group. In addition, those living in informal settlements had more income than most of those living in rural areas and farms, yet their risk profile was more than double those of the rural poor who led a far more stable life. Yet persistently, HIV/AIDS is portrayed as a poor black issue. The international context is important too. Globalisation has resulted in increased inequality, rapid urbanisation and huge urban slums. (UN Habitat report 2003) All are risk factors for HIV infection.
- When it does consider ‘culture’, this is often a catch-all code word for attitudes seen to be barriers to behaviour change, and it is usually the ‘culture’ of those who have little power. For example, we read of the “culture of masculinity” of Carletonville mineworkers is to go to sex workers. But what about the “culture” of the mining industry, which has been built on migrant labour, single sex hostels? An analysis of the ‘culture’ of the powerful as well as that of the disempowered is important. This involves an analysis of the political systems and political policies of a particular place and how that relates to HIV/AIDS.

Assumption 2: Once people know how HIV is transmitted, they will change their sexual behaviour

There is little evidence that knowledge alone changes behaviour. In fact, some researchers (eg Varga) report that many young people are tired of hearing AIDS messages.

Factors mitigating against behaviour change in Africa

- Gender violence, with many women being forced to have sex against their will (no condom use; the violence of the sex act can cause cuts and lesions on the genitals which greatly increases risk of infection if the attacker is HIV+)
- Belief that men are biologically programmed to need more sex than women ie. multiple partners are the norm, accepted by men and women (PPASA survey: 65% of young men U 20 had at least 2 partners and almost 40% had 4 or more)
- High degree of premarital and extramarital sex ie marriage does not necessarily decrease risk of infection.
- Condom use is unusual in marriages and steady relationships; unprotected sex is often seen as a sign of love and trust.
- Most HIV+ people don't know their status ie limited success of VCT (HST survey 2002 found most testing was not voluntary ie, took place at health facilities on the recommendation of health worker.)
- High degree of stigma associated with HIV/AIDS. This includes self-stigmatisation/ internalised stigmatisation and results in people being too ashamed to tell others about their HIV status. Thus the disease remains hidden and shrouded in secrecy.
- Death: belief that time of death is pre-determined which leads to acceptance of death; widespread notion that death cannot be caused by one single thing; AIDS believed to have some supernatural elements to it (why do some get it and not others; "bad luck" or bewitchment).

(Caldwell, Varga, Leclerc Madlala, PPASA)

What can be done?

What works to change risky sexual behaviour?

- information about HIV/AIDS and HIV transmission
- peer education and support: NB mobilisation of sub-cultures shown to be effective (eg. gay men in a particular area).
- Increased self-esteem (linked to hope for the future)
- risk perception is important (can be achieved through HIV tests, exposure to PWAs)
- condom access
- Personal contact with the epidemic that may prompt behaviour change. (PPASA survey: 60.5% of young people knew someone with HIV or AIDS and 87.9% said this had led them to reduce risky sexual behaviour.)

(Caldwell, Dowsett, Ugandan model, Leclerc Madlala, PPASA teen pregnancy survey 2003, various interviews)

What is realistic in SA?

- High level of condom use in commercial sex and with casual partners
- Youth behaviour change: delay age of sexual debut, condom use (encouraging and then working within a youth sub-culture eg. loveLife Y Centres, adolescent friendly clinics)
- Encouraging VCT on the basis of people now having access to the full spectrum of treatment if infected (personalising risk)
- ARV rollout can prevent deaths and make HIV a chronic disease, which will reduce fear, stigma etc.

What is needed from the media to fight against HIV/AIDS?

Ideally, HIV/AIDS should be seen as a national emergency that requires the sustained attention of all sectors of society. If this were the case, the media would be part of a campaign for HIV prevention, treatment and care. A national priority right now is the need for a massive treatment literacy campaign to encourage people to take the HIV test, go onto ARVs should they need them and adhere to their treatment regimen.

However, the minimum we should expect from the media is that it reports accurately and comprehensively on how the HIV/AIDS epidemic is unfolding in South Africa. An important aspect of doing this at present is monitoring the ARV rollout as part of maintaining pressure on government to ensure that the drugs are available and that the health infrastructure is built to deliver the rollout programme way past the 2004 elections.

How can civil society engage media to encourage this?

- Engage with the gatekeepers who determine the content of media. These are mainly the news editors and chief sub-editors who are not usually targets of any lobbying or journalism training interventions, yet they should be included.
- Engage with the advertisers: HIV/AIDS gets a great deal of media attention and is also starting to feature prominently in corporate social responsibility programmes. The advertising industry itself needs to be engaged on the issue: what is it doing to prevent HIV/AIDS?
- Empower PWAs, health workers and NGOs to engage with the media themselves rather than always investing in training journalists only.
- Ensure that there is journalist training around HIV/AIDS, preferably starting with journalism schools. HIV/AIDS is a complex field and the science changes rapidly so knowledge needs to be updated constantly.