

# Reporting ethically and effectively on HIV/AIDS in South Africa

Journ-AIDS Roundtable

May 2003

By Kerry Cullinan

*“The questions must be asked. Most important: What is the strategy? How can we slow this plague in the absence of a vaccine or cure? I know of no more important question for journalists to be asking at this moment. After all, there is no other force on Earth -- no wars, no famines, no genocides -- that is killing as many millions of people today as is this damnable microbe.”* -- Laurie Garrett, Pulitzer prize-winning journalist for Newsday, 2000.

## **A. General perspective: What is ethics?**

In its briefest form, ethics can be described as professional morality. But we all have different reasons for becoming journalists and our media organisations are motivated by different interests and are often in competition with one another. Can there be common guidelines for all SA journalists? Perhaps the three general principles advocated by the Poynter Institute’s Bob Steele (see attached: Guiding Principles for Journalists) are broadly acceptable:

- Seek the truth and report it as fully as possible
- Act independently
- Minimise harm.

## **B. African perspective on ethical HIV/AIDS reporting**

In 1997, a meeting of journalists from Burkino Faso, Cote d’Ivoire, Mali, Mauritania and Senegal and UNESCO drew up the following guidelines for ethical reporting for African reporters:

- Respect the rights of those with HIV/AIDS
- Go for training
- Ensure accuracy
- Report with clarity
- Report in collaboration with communities, PLWA and HIV service organisations
- Make the link between STIs and HIV
- Use appropriate language
- Ensure increased coverage
- Accessibility (NB Language)
- Be sceptical (about cures, miracle treatments etc)
- Report in context.

## **C. HIV/AIDS media reporting in South Africa**

How do we apply all these guidelines to the South African media?

### *1. Seek “the truth” and report as fully as possible*

It is really important to provide as much *context* as possible for an epidemic that is so complex because it is driven by private sexual behaviour. Statistics (such as the table below) are almost meaningless unless provided in context. (I have relied heavily on the Nelson Mandela/ HSRC Study on HIV/AIDS as, despite its drawbacks, it is the

based on the biggest and most representative sample so far.) The most important indicators of context in SA are gender, race, culture and class.

***HIV prevalence in South Africa: Gender and Race***

<b>Sex and Race</b>	<b>n</b>	<b>HIV+ (%)</b>
Total	8428	11.4
Male	3772	9.5
Female	4656	12.8
African	5056	12.9
White	701	6.2
Coloured	1775	6.1
Indian	896	1.6

(Nelson Mandela/ HSRC Household Survey, November 2001)

**Importance of gender relations:**

- Twice as many young women (12%) aged 15-24 are HIV infected as young men (6%), according to the NM/ HSRC survey. In all adults, 12.8% of women and 9.5% of men are infected.
- Gender relations affect every aspect of the epidemic from prevention to transmission, care, support and treatment. We have to be aware of, and if possible present, a gendered view. (Can a woman realistically negotiate use of a condom? How can a woman who feels unable to disclose her HIV status at home explain why she's not breastfeeding her baby? Won't a woman on an ARV pilot who has an HIV+ partner or HIV+ children share her drugs with them? Caring for the sick seems generally allocated to women and girls, who sometimes have to drop out of school etc.)
- Women also respond differently to treatment. According to Cathy Christeller, executive director for the Chicago Women's AIDS project, women generally weigh less and have lower viral loads than men who are just as sick. Thus ARV dosages have to be adjusted to suit them.
- BUT we must be aware of our own gender-based assumptions and prejudices. Continuous negative stereotyping of men is not helpful. (eg Sometimes women don't want condoms to be used; "transactional sex" is sometimes driven by women's desire for non-essential luxury items, not just economic necessity.)

**Influence of race and culture:**

- President Thabo Mbeki, Peter Mokaba and others have criticised the West for having a racist view of African sexuality, believing that the rapid spread of HIV/AIDS is due to promiscuity. In South Africa, Africans have a significantly higher HIV infection rate than whites. (See table above). Unless this is explained in context (eg history of labour migrancy, more Africans live in informal settlements), the inference can be drawn that Africans are more promiscuous than whites.
- Our own racial and cultural backgrounds influence our ability to write accurately. Language and cultural practices are often barriers to effective reporting. We need to learn indigenous languages and take time to understand unfamiliar cultural practices if we are to write well.

**Influence of class:**

- The relationship between HIV/AIDS and poverty is complex. The people most vulnerable to HIV/AIDS are those living in informal settlements, according to the NM/HSRC survey. However, this does not mean the poorest are the most vulnerable as there is often greater poverty in rural areas. Rather, informal settlements reflect transitional lifestyles. A study of HIV infection rates in Carletonville some years ago found that those living in the more affluent stand-alone township households (mainly civil servants) had a higher HIV rate than mineworkers and those in poorer areas (possibly more money meant the possibility of more sexual partners).
- However, once a person is HIV+, if they are middle class their chances of surviving for longer are much higher. Poor nutrition and high stress have a direct influence on the progression of the disease. In addition, those with medical aids are generally able to get ARVs.
- By the time a person gets to be a mainstream journalist, they can be classified as middle class. It is sometimes hard to understand the challenges faced by people who lack the basic means of survival. Again we need to take time to understand unfamiliar social situations. In some areas, for example, there are often complicated systems of patronage and support that may have bearing on HIV transmission. (Parents accepting financial support from the elderly lovers of their daughters etc)

## 2. *Act independently*

*“Reporting on HIV/AIDS is principally sourced from press releases, press conferences and wire services. The number of reports generated from newspapers’ own inquiry and based on primary information sought out independently of official sources, falls far below the number generated on the initiative of instances outside the news room.”* (Shepperson, A. November 2000. HIV/AIDS reporting in SA: an analysis of the response of the press).

- Scepticism is something we tend to see too much of when it comes to government’s efforts to fight HIV/AIDS (very little media credit is given to government programmes that are working eg in Gauteng) and too little of when it comes to new treatments, drug trials, vaccine developments, drug companies “special deals”.
- Sometimes we censor ourselves because we hold a particular belief or advocate a particular policy direction. Is it helpful to avoid writing about adverse side-effects of ARVs, for example, because we want government to agree to universal treatment?

## 3. *Minimise harm*

- We need to ensure that we get proper “informed consent” from people we want to interview. It is very hard for a person to refuse to grant an interview if asked by their health provider or home-based carer on whom they are dependent. We need to explain all the consequences of a particular article and not apply pressure to get the story.
- If you are unsure of the facts, especially scientific ones, ask for help from the experts. We only get one chance to present the story in the press.

**And finally: Advocacy:**

Do journalists have a special duty in an epidemic? Clearly, the future of our country is being undermined by HIV/AIDS and we should all be committed to trying to prevent it's spread. But what does that mean?

1. What kind of an advocacy role, if any, is legitimate for journalists? We are not health promotion campaigners who simply push the ABC line. However, we are also not TAC activists and need to ensure that we keep a healthy distance so that our independence and judgement is not compromised.
2. First and foremost, the best service we can provide is to ensure that we are well informed by keeping up-to-date on the latest scientific information, keeping in touch with what PWA organisations are advocating and producing accurate and contextual reports.
3. How is it that in other countries such as Nigeria, Cote d'Ivoire, Gambia and Kenya, journalists have been able to set up collaborative networks to work together on special events, develop training materials etc, whereas in SA there is intense competition rather than collaboration? Is there any scope for us to work together and if so, what form could this take?