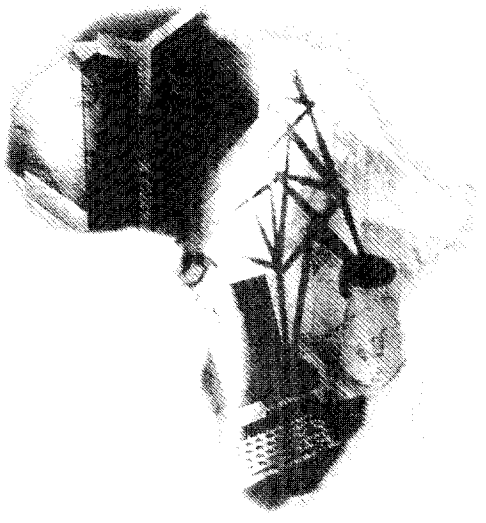
MEDIA & HIV/AIDS

IN EAST AND SOUTHERN AFRICA:

A resource book



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INTRODUCTION

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The HIV/AIDS epidemic – the epidemic of Acquired Immune Deficiency Syndrome that results from infection with Human Immunodeficiency Virus – is perhaps the worst crisis facing Africa today. Within the last twenty years this fatal disease has spread to every country on the globe. By the end of 1998 it had taken the lives of almost 14 million people. A further 33 million were living with the virus, 22 million of whom were in Africa.

More than any other disease, HIV/AIDS is as much a social as a medical problem. Primarily transmitted through one of the commonest human activities, sexual intercourse, it brings protracted illness and early death to men and women in the prime of their lives, kills newborn children and leaves their older brothers and sisters in emotional and physical misery. The epidemic feeds on the deep divisions within our societies – illiteracy, ignorance, poverty and inequality between the sexes – and deepens those divisions by making our communities poorer.

In all but a few countries, the response to AIDS has been inadequate. Millions of men and women who are fully aware of the threat of HIV are unwilling or unable to protect themselves and their partners. Community, religious and political leaders have failed to understand the extent and the complex nature of the epidemic and have failed to provide the leadership required to protect their citizens' lives and livelihoods. And all too often the reaction towards those affected by the disease has been fear, hatred and contempt instead of the compassion and assistance that they and society as a whole require.

Since the beginning of the epidemic, the media have both reflected and moulded the often confused response to AIDS, sometimes spreading fear and hostility, sometimes providing cool and accurate analysis. All too often the media have reported uncritically the statements of governments, non-governmental organisations and individuals. This can change. At the start of a new millenium, there is an opportunity and a need for all the media to provide the leadership that will encourage the public and the leaders of our communities to take positive steps to overcome this disease.

These steps will differ from country to country. There are many Africans, from farmers on the banks of the Nile to miners in the Copperbelt of Zambia, from prosperous businesswomen to homeless and impoverished refugees, from the active young to the resting old. Our cultures, languages, traditions, landscapes and histories are rich and varied; our potential without limit. This resource book cannot reflect such variety and wealth; it can, however, speak to our common humanity, helping us to share our experiences and unite our response. HIV/AIDS can be defeated; it needs only the common will to do so.

HIV: WHAT IT IS, WHAT IT DOES

HIV is a virus – an organism too small to be seen by the naked eye. Viruses survive by entering and reproducing within the living cells of larger organisms. HIV belongs to the class known as retroviruses, whose reproduction is based on RNA (ribonucleic acid) rather than DNA (deoxyribonucleic acid).

HIV enters and replicates within a type of blood cell called CD4 cells. These normally form part of the body's immune system, circu-

lating in the blood and attacking disease organisms. As it replicates, HIV destroys CD4 cells, reducing the body's immunity to other diseases. Eventually these other diseases, known as opportunistic infections, overcome the body's resistance and the patient dies. Although an individual whose immune system has been compromised by HIV is subject to any disease, some opportunistic infections are more common than others. These include Mycobacterium avium complex (MAC), which causes tuberculosis; Pneumocystis carinii, which causes a severe form of pneumonia; herpes viruses; toxoplasmosis and a range of bacterial infections.

Although tests are available to indicate whether an individual has contracted HIV, they are not widespread in many parts of Africa. That means that many people only discover they have contracted the virus when they fall ill with an opportunistic infection which may not respond to regular treatment. Others learn the fact when a recently born child falls ill. Because the virus can be transmitted from mother to new-born, diagnosis of AIDS in the infant confirms that the mother, and probably also the father, is HIV-positive – living with the virus. Depending on the severity of the illness and on how far advanced the HIV infection is, the individual may recover. Inevitably, however, with their immune system weakened, without treatment they will fall ill again and eventually die.

Hard to catch

It is not easy to contract HIV. The virus has to enter the body through the bloodstream and that only occurs in clearly defined circumstances. The commonest is sexual intercourse, when the virus in seminal fluid enters the bloodstream through the mucous membrane of the vagina or rectum, or when the virus, present in vaginal fluid or in blood in lesions in the rectum, enters tiny lesions in the penis. Worldwide, about 90% of cases of transmission occur this way.

HIV can also be transmitted from a mother with the virus to her new born child in the womb, during birth or through breast-feeding. There is a 25% to 40% chance of this happening. That figure is significantly reduced if the mother takes Zidovudine (AZT – other drugs are also under development for this purpose). About 3% of cases worldwide are the result of mother-child transmission; the rate in Africa is about 8%.

HIV can also be transmitted in transfusions of blood products if they are not screened (tested) and through injections of medicinal or recreational drugs if the injecting equipment is not sterilized. It can also be transmitted in any other situation where the blood of an individual with the virus enters another's bloodstream. This occasionally happens in hospital accidents, when a syringe with infected blood accidentally pricks a nurse, doctor or other patient. It may happen during shaving and male or female circumcision (also known as genital mutilation) if the cutting implement is not sterilized between use. It can also be the consequence of a road or other accident where several people's blood is spilled.

The virus is not transmitted by mosquitoes, bed lice or other insects, nor by sharing cooking or eating utensils, nor by physical contact such as hugging, kissing or sharing a bed, toilet facilities or other aspects of home life.

Sex and risk

Even though sex is the commonest means of HIV transmission, it does not occur in every sexual act. A number of factors influence whether or not the virus will pass from one person to another and it is impossible to estimate the extent of the risk in each individual act of intercourse. All that can be said is that the more often an individual has unprotected (without a condom) sex with a partner with HIV, the more likely they are to contract the virus.

In general, however, in any act of intercourse a woman is more liable to contract HIV from a man with the virus than vice versa. This is because the virus is present in greater quantities in semen than in vaginal fluid and because the epithelium (the layer of cells) of the vagina and cervix appear more subject to minuscule rup-

tures than the penis. In the absence of other factors, such as other sexually transmitted infections and how recently the infected partner contracted the virus, a woman is twice as likely to contract HIV during vaginal intercourse than a man. Anal intercourse – which is practised by men with women as well as with other men – is a much higher risk for both partners.

The presence of sexually transmitted infections (STI's, often known as STD's), such as chancroid or gonorrhoea, which result in sores or lesions, significantly heightens the risk of infection. The rapid spread of the virus in much of Africa is at least partly the result of high rates of untreated STI's; in 1996, there were 65 million cases of treatable STI's in Africa, representing one case for every five adults on the continent.

The roots of an epidemic

Diseases, like plant and animal life, evolve. Every so often a virus that has lain dormant or undiscovered for years suddenly appears: recent examples include legionnaires' disease, first observed in the United States in 1976, and Ebola, discovered in the same year in Zaire.

We may never know the point at which HIV ceased to be a harmless virus infecting Central African chimpanzees to become a worldwide killer of men and women. The first cases of AIDS were reported in June 1981 in the United States and in 1983 in Uganda, but there is evidence to suggest cases in the United States in 1969, in Europe in the 1950's and in what is now the Democratic Republic of the Congo in 1959. More speculatively, there are suggestions of HIV infection in different parts of Africa dating back to the 19th century. There is no truth in the rumour that the virus was artificially created – it has existed since long before the development of technology to manipulate genetic material.

In the early days it was suggested that specific groups of people – gay men in the United States, sex workers (prostitutes) in Africa and African men and women in Eastern Europe and South Asia – were either "responsible" for the epidemic or were the only people who could contract the disease. In fact HIV can be contracted by anyone who has sexual intercourse or comes into contact with contaminated blood, and experience has shown that the result of allocating "responsibility" for AIDS is often to lull those most at risk into a false sense of security.

The global epidemic

By mid-1999 HIV had spread to every country on the planet. Sex between men is the predominant means of transmission in some countries, such as the United States and the Scandinavian countries. In other countries or regions, such as Russia or the state of Manipur in India, shared syringes or needles in recreational drug injection are the predominant means of transmission. Worldwide, however, the virus is most often transmitted during sex between men and women.

Because women are physically more vulnerable to HIV than men, and because men, on average, have more sexual partners than women, the rate at which women worldwide are contracting the virus is rising faster than men. Between 1997 and 1998, the number of men believed to be living with HIV rose by 7% (from 17.2 million to 18.4 million); in the same period, the number of women with HIV rose by 13% (from 12.2 million to 13.8 million).

Geographically, the epidemic is worst in Africa, with up to one in four adults in some cities being HIV-positive. Rates in Asia are much lower, with perhaps fewer than one in 100 adults living with HIV, but the speed with which the virus is spreading and the far greater population in Asia suggests that, unchecked, the epidemic may equal the intensity of Africa and surpass it in terms of numbers affected sometime in the next 20 years.

Elsewhere, numbers are static or increasing more slowly. In North America roughly one in 200 adults has contracted the virus, compared to one in 400 in Western Europe. Rates in Latin America are similar to North America and hover around one in 1,000 adults in the rest of the world.

Africa affected

In 1998 alone, 4 million adults and children in sub-Saharan Africa contracted HIV and by the end of the year almost 23 million people were believed to be living with the virus, a million of whom were children. Across the region, 8% of adults – approximately one in twelve – were HIV-positive.

These figures mask substantial differences between countries. In terms of intensity of the epidemic, Southern Africa is worst affected with up to one in four men and women between the age of 15 and 50 being HIV-positive in some areas. In terms of absolute numbers, South Africa was worst affected by the end of 1997 (the latest date for which country estimates are available), with 2.9 million people living with the virus. Ethiopia followed with 2.6 million and Nigeria had 2.3 million.

In North Africa and the Middle East the figures were much lower: 19,000 new infections in 1998 and a total of 210,000 living with the disease. About one in 800 adults in the region were believed to be HIV-positive.

Men, sex and power

The spread of HIV primarily depends on patterns of sexual behaviour – how often men and women have sex and who they have sex with. Not everyone's sex life is the same and patterns of sexual behaviour are strongly influenced by social, cultural and psychological factors over which men and women have little control. In addition to sexually transmitted infections, described above, two factors in particular lie behind the epidemic in sub-Saharan Africa and many other parts of the developing world: male attitudes and poverty.

Concepts of masculinity are changing. Nevertheless, men are generally expected to be strong, to be leaders, to be the primary provider of their families' food and shelter and to defend themselves, their families and their societies from aggressors. Virility – the ability to perform sexually – is an essential component of masculinity in almost every society. Young men are expected to prove their sexual prowess and there is widespread belief that a man's need for sex is beyond his control. For many men anything that appears to interfere with their sexual lives, such as an appeal to abstinence or use of a condom, is a threat to their masculinity.

Impelled by these attitudes, men, on average, report more sexual partners than women. In a study of 12 African cities, men reported casual sex (with more than one partner in the previous 12 months) up to 18 times more frequently than women. The implications of this are that women are likely to contract HIV but less likely to transmit the virus to other sexual partners while men are more likely to contract and transmit the virus. In the long-term, this means that more women than men will contract HIV.

Compounding this situation is the fact that many men do not consider sex as a consensual activity; sex has to take place when the man decides and without a condom if he chooses. Wives are often beaten or ejected from their home if they refuse to submit to their husbands and many women are at risk outside the home. South Africa sees an estimated 1.3 million rapes a year – one for every nine sexually active men. In such circumstances, many women find it impossible to protect themselves from infection with HIV or other STI's. [Rape is not confined to women: in prisons or other single sex environments some men rape other men either as a substitute for sex with a woman or to establish power over their victim. In other situations, however, sex between men may be an expression of mutual desire or the result of one's desire and the other's financial need.]

Not all men behave this way – at any one time only one in three or one in four men have casual sexual relationships. Some men respect their partner's wishes, and factors such as lack of confidence prevent other men from having frequent sex without protection. It is, however, this general expectation that men can insist on intercourse on demand and without use of a condom, which places both men and women at risk of infection. Men do not protect themselves because male attitudes tell them not to; women do not protect themselves because men do not allow them to.

Women affected

Women are affected by HIV/AIDS, directly through their vulnerability to the disease and the fact that they may pass the infection to their newborn children, and indirectly in many ways.

Women are the chief carers in a community, both in hospitals and the home; they are often expected to take such a role even when they themselves are sick with HIV. Women whose husbands die of AIDS may be expelled from their homes accused by the man's family of causing his death even when, as is most likely, the man contracted the infection elsewhere and passed it to her. Old women find themselves taking care of grandchildren when their sons and daughters die, at a time when they expected to be looked after in their old age.

Women who challenge the status quo, by raising the issue of women's vulnerability and trying to organize means of prevention, may be accused by men of addressing issues that the leaders do not consider appropriate or which threaten the status of men as community leaders.

The impact of poverty

Poverty exacerbates the inequality between the sexes in a number of ways. Unable to find a steady independent income, many women enter sexual relationships they would not otherwise choose.

Many women who are single or widowed, or whose husbands have migrated in search of work, find it difficult to provide themselves and their children with food, shelter and clothing without the assistance of men. Some men provide gifts in exchange for sex, but usually on their terms. This exchange can take many forms. The couple may be a sex worker and her client, a teenage girl and a businessman who pays for her school uniform or books, a middle-aged widow and a migrant salesman who visits her two or three times a month or any other situation where a woman's need matches a man's desire. For some, the relationship will be no more than the exchange of sex for money, but for others there may also be a long-term emotional bond.

Poverty leads many men and women to migrate in search of work, to cities or large projects in their own country or abroad, in formal or informal employment. In new environments, separated from families and friends, where the language and culture may be very different, sex may provide a means of alleviating loneliness for both men and women or a much-needed source of income.

The burden of stigma

Perhaps the greatest problem confronting those living with HIV and those working in AIDS care and prevention is the stigma attached to the virus that arises from the powerful combination of disease, apparent illicit sexual intercourse and death. Stigma prevents many from recognizing they are at risk of infection; it prevents many others from admitting they are HIV-positive, which in turn prevents them from seeking physical and psychological support and from protecting their partners; and stigma prevents a compassionate response from individuals and society at large to the disease.

Stigma feeds on itself. Fear of saying "I have HIV" leads to denial and adds to the secrecy and shame that surround the disease. Denial too feeds on itself; the more people who deny they have HIV or are at risk, the easier it is to believe that society itself remains unaffected, even when hundreds a day are dying of the disease.

A few women and men, such as the Ugandan musician Philly Lutaaya in the late 1980's, have had the courage to combat stigma and help educate their fellow citizens by being open about their HIV-positive status. Sometimes, however, the stigma and hostility are overpowering; in December 1998 Gugu Dlamini was stoned to death by her neighbours in a South African township after she tried to help others with the virus by publicly announcing that she was HIV-positive.

Social and economic consequences

In May 1999 it was announced that AIDS was now the world's fourth leading cause of death – and it led to more mortality than any other infectious disease.

The social consequences of the epidemic are staggering. Those most at risk, sexually active adults, are the most productive members of every society, earning incomes for themselves, their families and their communities by tilling the fields or manufacturing goods, transporting, buying, selling and exporting products or providing other services. Furthermore it is adults who raise children, provide for them and teach them to become productive members of society.

When a child or grandparent falls ill and dies, it is a tragedy for the family, but when adults fall ill and die, that tragedy is compounded by repercussions that affect the whole community. If a mother falls ill, not only is her income lost, but the household tasks that women traditionally perform – such as cooking and taking care of the children – are neglected or performed less well by the husband, if present and healthy, or by the older children. Cultivation is less efficient and livestock eat less well. Children lose schooling if they have to stay at home to look after a sick parent or if there is no money to pay for fees or transport.

Eventually grandparents, older siblings or aunts and uncles take over running of the household, but age or inexperience often mean these tasks are performed less well and income is either severely reduced or lost. The children's emotional stability may suffer not only from the death of the parent(s) but from the new environment in which an aunt or uncle may be disinclined, or a grandparent unable, to provide the love and attention that came from their parents. Although still uncommon in Africa, in many cases children find themselves homeless, either placed in orphanages or scavenging on the streets.

Despite this grim scenario, some experts, including the World Bank, believe that the overall economic impact of the disease in Africa will not be severe. Populations will grow more slowly, but are unlikely to go into decline, while high rates of unemployment may mean that a rise in deaths will not affect overall economic production. Others paint a gloomier picture and factors such as social unrest may yet have to be taken into account.

Treatment

In the last five years HIV/AIDS has highlighted one of the most glaring differences between the industrialized and the developing worlds: a disease which responds to successful treatment in Western Europe or North America almost invariably leads to death in Africa and Asia. The reason is simple: the high cost means that treatment is only available in those countries and to those individuals who can afford it.

HIV/AIDS requires two types of treatment - antiviral (also known as antiretroviral) therapy, which combats HIV itself, and treatment for opportunistic infections. Antiviral drugs are not a cure for HIV, but when administered in conjunction with regular monitoring of the individual's health, they reduce AIDS to a long-term manageable disease for many people. This condition is similar to diabetes, which also cannot be cured but can be kept under control. Unlike diabetes, however, HIV can be transmitted and individuals with the virus who take antiviral drugs can still pass the virus to others.

Medicinal drugs

By mid-1999, 15 antiviral drugs had been approved by the US Food and Drug Administration (FDA) and a similar number were under trial. HIV antivirals are generally divided into three types: nucleoside analogues, non-nucleoside reverse transcriptase inhibitors and protease inhibitors. Treatment with only one type of antiviral, such as Zidovudine (commonly known as AZT) is generally not beneficial; it is combination therapy – a combination of drugs, sometimes known as a 'cocktail' – which prevents the virus from replicating. This combination may include up to 20 pills a day, which must be taken at specific times, before, during or after meals, depending on the drug. The cost of such a combination can reach US $10,000 per patient per year.

Ensuring that patients receive the right antiviral treatment depends not only on the ability to pay for the drugs, but on access to doctors with equipment to measure the extent of viral

activity and the body's immune response. That information confirms whether the current combination is working or whether another combination should be tried.

Antiviral drugs are available on a very limited basis in Africa, as part of drug trials or imported by wealthy individuals. For the vast majority of Africans, however, antiviral drugs will not be available in the foreseeable future. Furthermore, the crisis in health care funding facing much of the continent means that even the cheaper drugs that cure or provide relief from opportunistic infections such as fever, diarrhoea and pneumonia are often unavailable.

Traditional healers

Lack of access to the appropriate medical services and a long history of indigenous medicine have led many Africans to consult traditional healers to relieve symptoms and, many have hoped, to cure AIDS. While traditional healers can often alleviate pain and other symptoms, the claims by some that they can cure the disease has been problematic. On the one hand, such claims lead members of the public to be sceptical of Western medicine and diagnosis, and, on the other hand, the fact that none of these "cures" has proved effective leads some supporters of Western medicine to be sceptical of all traditional healers.

Given the lack of adequate medical facilities in much of Africa, there is a role for traditional healers to provide services, particularly in alleviating the symptoms of opportunistic infections. In some countries there is consultation between practitioners of Western medicine and traditional healers; in others, however, co-operation is proving more difficult.

Mother to child

The one area where antiviral drugs are increasingly available to the African public is the prevention of transmission of HIV from mother to her newborn child. Limited doses of Zidovudine reduces the likelihood of the child contracting the virus from about one in three or four pregnancies to about one in 10 or 12. Financial assistance from the French, US and other Western governments has allowed thousands of pregnant women access to Zidovudine across the continent and at the time of writing another cheaper drug, nevirapine, is proving effective in trials.

However, the stigma attached to AIDS prevents large numbers of women from taking the drug, since they may not wish their husbands or birth attendants to learn they have contracted HIV – even when their husbands may be the source of infection and the birth attendants are close members of the family.

Vaccination

The difficulty in persuading sufficiently large numbers of people to change their behaviour, the high cost of antiviral drugs and the general belief that prevention is better than cure, all lie behind the drive to find a vaccine that will either prevent individuals from contracting HIV or prevent the virus from replicating once it is in the body.

Developing a vaccine is not easy, however, and the process is made more difficult by the fact that there are various strains of HIV, which are common in different parts of the world. Strain B is commonest in Western Europe and North America, for example, while strains A, C and D are commonest in Africa.

Financial and ethical considerations also play a role. In the early 1990s, pharmaceutical companies devoted almost all research to potential vaccines against the B strain in anticipation that there would be a market for such a product in the industrialized world. Proposed testing of a candidate B strain vaccine in Uganda led to widespread protest when it was alleged that not only would such a vaccine bring no benefit to that country if developed, but that those on whom the candidate would be tested had not been fully informed of the potential risks.

In the late 1990s, the financial support of Western governments and foundations such as the one established by Bill Gates, the founder of Microsoft, have enabled the New York-based International AIDS Vaccine Initiative (IAVI) to

establish partnerships between northern and southern research institutes. These are intended to develop vaccines appropriate for Africa and elsewhere in the developing world and to ensure that all trials are ethical and fair. At the end of 1998, two such initiatives were announced, one in Kenya and one in South Africa.

Emphasis on prevention

As long as antiviral treatment remains out of reach and until a vaccine is widely available, prevention is essential to bringing the disease under control. Prevention, whether abstinence, mutual fidelity or use of condoms, looks simple, but as the social and cultural context described above makes clear, it is not. Ensuring that 300 million sexually active men and women across Africa protect themselves and their partners during every act of intercourse, and ensuring that the 10 million African children who become sexually mature each year know how to protect themselves, is a difficult and complex task.

A number of conditions must be met to ensure widespread effective prevention. These include basic information about HIV transmission and means of preventing transmission; psychological support for men and women who wish to protect themselves from the virus; deep-rooted social change that will reduce the pressure on men to dominate their partners and enable women to have greater control over their sexual lives; poverty reduction schemes; and provision for the treatment of other sexually transmitted infections.

The severity of the epidemic has meant that most Africans are aware of HIV/AIDS and have some idea as to how to protect themselves. That does not mean, however, that they are sufficiently informed. Women tend to be less aware of the threat and, as has been seen, are less able to protect themselves than men. Men and women who are illiterate or have little access to the print or broadcast media are less likely to be informed than those who are educated or who have regular access to radio and the press; and each year a new generation reaches sexual maturity, often without the accurate knowledge they need to protect themselves and others.

Because sexual behaviour is not fully under our conscious control, information in itself is not enough to ensure change in sexual behaviour. Individuals at risk not only need to learn what behaviour change to make, but need the psychological support to make that change. This support generally comes from one's peers, in formal or informal groups. While both men and women "network", in the fields, at the well, in offices, at market, in bars, women are more likely to use these opportunities more to discuss the emotional and health issues that lead to a desire to change behaviour. Men are less likely to discuss such issues and are, therefore, at a disadvantage – a disadvantage that has repercussions on their partners. Establishment of mechanisms which help men in particular to change behaviour – e.g. discussion groups in the workplace – is, therefore, a critical factor in preventing further spread of HIV.

It is likely, however, that deeper structural changes are needed to ensure the reduction in the spread of HIV in Africa and elsewhere in the developing world. Inequalities between men and women must be tackled at a broader level than HIV and, because poverty lies behind some women's sexual behaviour, they require economic support to reduce their dependence on men. Finally, widespread treatment of other sexually transmitted diseases will severely reduce opportunities for HIV to spread.

Options for change

Options for people who wish to protect themselves and their partners from HIV are: abstaining from sex; ensuring mutual fidelity with their long-term partner; using condoms with all sexual partners; non-penetrative sex; or masturbation. Insistence on only one or other form of prevention, such as abstinence or fidelity, is likely to fail, because it does not take into account the context of people's lives.

Each of these options has advantages and disadvantages. Abstinence and non-penetrative sex are not options for many men or their women partners. Fidelity is not a guarantee, because one partner may be faithful to a partner who is not.

Male condoms are widely available but, despite appearances, not simple to use; many men who would use them may be too embarrassed to admit that they need practice to do so. Female condoms are rare and often expensive. Masturbation as a form of sexual relief is still considered a taboo or weakness in many parts of Africa, although increasingly recommended as an option.

Discussion of sexual issues to resolve such problems is often difficult, whether between partners who have just met or couples who know each other well. As described above, workshops, discussion groups and other means of allowing individuals to explore and understand their own and their partner's sexuality are an essential component in tackling HIV/AIDS and other STI's.

The political response

The political response to HIV/AIDS is similar across Africa, although the strengths of the various organizations may vary from country to country. The global response to the epidemic is co-ordinated by UNAIDS – the Joint United Nations Programme on AIDS – which is sponsored by seven UN agencies (see chapter on The ABC of HIV/AIDS). UNAIDS works with both governments and non-governmental organizations at both international and national level. National responses are usually co-ordinated by National AIDS (Control) Programmes, the composition and effectiveness of which varies from country to country.

Non-governmental organizations (NGO's) have played a major role in fighting AIDS since the beginning of the epidemic. Frequently, they have drawn attention to key issues such as sexual behaviour that governments have been unwilling or unable to address. NGO's are funded from a variety of sources, including foreign governments and donor agencies. Given the proliferation of NGO's and of funding sources, it is not surprising that relations between NGO's and governments and between national and international or foreign institutions have sometimes been strained.

In many parts of the world some of the most effective NGO's have been those which are drawn from the communities most affected by the epidemic, in particular groups of people living with HIV/AIDS.

At the beginning of this new millennium it seems that African leaders are finally responding to the challenge of AIDS in their midst. The presidents of South Africa and Ethiopia have joined their Ugandan and Senegalese peers in recognizing the threat of the epidemic. The experience of Uganda, once the worst affected country on the continent but where rates of infection have dropped amongst young adults, and of Senegal, where rates have remained consistently low, indicates that where the will to combat the disease is universal, it can be overcome.

And now

The HIV/AIDS pandemic in sub-Saharan African countries is a clear and present pernicious threat which demands urgent attention. An integrated approach using all relevant means and channels in society is required to confront the threat and the use of communication media is especially important in this respect. Bringing about positive results in the efforts to stem the prevalence of HIV/AIDS depends, among other things, on the existence of an informed public that is sensitive to the causes, spread and prevention of the epidemic. The mass media have a significant role to fulfil in creating and sustaining public opinion and the political will to deal with the problem.

The media can expose certain trends and phenomena in the community or society that facilitate the spread of HIV/AIDS and inform the public about them. They can also play a central role in educating the public about the importance of preventive measures and serve as signpost to dangers. They can help create public awareness and mobilise public opinion against trends, phenomena and practices which favour the spread of the epidemic. Active involvement of media organizations and communication practitioners in efforts to deal with issues of

HIV/AIDS is critical, if knowledge and awareness are to be increased and risk behaviours reduced among different population segments in African countries.

The challenge then is to prepare journalists and other media professionals for the task of using media resources to arouse, mobilize and sustain public opinion which support the efforts against the practices. The initial step in this process involves the generation of interest, awareness, knowledge and understanding among media practitioners themselves about the disease, its modes of transmission, its prevention and management as well as their commitment to the efforts to prevent and control the spread of the epidemic. In response to this challenge, UNESCO in 1998 initiated a project on preventive information based on investigative journalism and HIV/AIDS in East and Southern Africa. The project's objectives were to: (i) identify a few pertinent trends or phenomena in the region which contribute to the spread of HIV/AIDS; (ii) carry out in-depth investigation on the relationship between the phenomena and the prevalence of the disease; and (iii) study the extent to which the incidence of HIV/AIDS is reported in the media.

This publication presents the reports and papers prepared under the project. It contains practical and technical guidelines for media practitioners specializing or interested in HIV/AIDS issues. Part I presents a general overview of the HIV/AIDS epidemic and its demographic, social and economic impact in sub-Saharan African countries; common concepts, terms and definitions, ethical approaches to reporting on the disease as well as media functions in HIV/AIDS prevention and management.

Chapter 1 by Martin Foreman of the Panos Institute, London contains terms and acronyms commonly used in writing about HIV/AIDS. It presents definitions, explanations and examples of use to a wider audience as well as information of particular interest to the media. Martin Foreman also discusses ethical issues that media professionals need to consider when reporting on HIV/AIDS in Chapter 2. He notes that media professionals must pay particular attention to the confidentiality of an individual's HIV status; use appropriate language which reduces or avoids stigma; be critical in their reporting of claims of effective cure or treatment; be careful about repeating misconceptions and irrelevant controversies; be diligent about verifying information and presenting a balance view of gender issues. Wambui Kiai of the University of Nairobi, Kenya, takes up the subject of media functions in HIV/AIDS prevention and management in Chapter 3. She stresses the need for the media to provide, on a regular basis, accurate and factual information on the epidemic and to demystify it by presenting its statistics in human terms. She calls for a pro-active approach in media coverage of the epidemic and calls for more intensive training, networking and building up of solid sources of information on the epidemic which are accessible to media practitioners.

Part II presents case studies of investigative reporting on selected trends and social phenomena which are suspected to contribute to the spread of HIV/AIDS in five East and Southern African countries. These trends are migrant populations; certain persisting cultural practices; and high consumption of alcohol.

In Chapter 4, Rose Lukalo of the African Women and Child Features Service, Nairobi, Kenya, reports on patterns of migrant populations (refugees, internally-displaced persons, long-distance truck drivers, migrant workers including itinerant commercial sex workers, and tourists) and their links with the spread of HIV/AIDS in Kenya. Noting that population mobility brings into play certain conditions that encourage the spread of the disease, she calls for more thorough examination of the issue of mobility in HIV/AIDS intervention programmes. Charles B. Rwabukwali and his colleagues at Makerere University in Kampala, Uganda, report on similar patterns in neighbouring Uganda in Chapter 5. They observe that, in general, people who are on the move tend to lack the requisite level of knowledge, perception, awareness and precautions required to avoid infection and the spread of the disease. In

Chapter 6, Mkasafari Mlay, a freelance journalist in Dar es Salaam, reports on the same theme in Tanzania. She observes that people who are away from their homes are often tempted to do things they would not dare do at home.

Parkie Mbozie of the University of Zambia, Lusaka, reports on the impact of a number of cultural practices on the spread of HIV/AIDS in Zambia in Chapter 7. His investigation reveals that practices such as ritual cleansing; spouse inheritance; puberty rites; polygamy; and circumcision rituals contribute in some ways to the transmission and spread of the disease in the country. In Chapter 8, Rukee Tjingaete, a freelance writer in Windhoek, reports on his investigation into the social phenomenon of high alcohol consumption and its impact on the spread of HIV/AIDS in Namibia. He notes that high rates of alcohol consumption increases the likelihood of rape and unprotected sexual intercourse – both of which are associated with the transmission and spread of the disease.

Part III deals with findings and recommendations from content analytic studies of media coverage of HIV/AIDS in four East and Southern African countries during the period of January 1997 to June 1998. In Chapter 9, Lewis Odhiambo of the University of Nairobi analyses the coverage of the disease by the three leading newspapers in Kenya from "a moral panic perspective." His study reveals, inter alia, that most of the stories reported in the print media were the product of local journalists' initiatives; that the newspapers relied mostly on local writers and commentators; and that the main information sources were local organizations, researchers and scientists. The findings of Linda Nassanga Goretti's analysis of the coverage of the epidemic by Ugandan print and broadcast media are presented in Chapter 10. Her study showed that HIV/AIDS was reported in the form of news stories, news analysis, feature stories and letters to the editor and the sources of information were mainly local, supplemented by foreign and international syndicate/feature services. She remarks that, although media practitioners had high level of awareness of HIV/AIDS issues, the disease received little coverage in the Ugandan media during the study period.

In Chapter 11, Francis P. Kasoma examines the coverage of HIV/AIDS in Zambia's leading newspapers. His findings show that, in general, the newspapers were more interested in giving their readers current information and hard facts about the disease than in features, and in presenting background information. The findings of the study by Kingo Mchombu of the University of Namibia of how the disease was covered by the leading newspapers and the national radio in Namibia are presented in Chapter 12. His findings lead him to the conclusion that Namibia's media coverage of HIV/IADS was generally low, superficial and not adequately sustained over a long period of time to create the necessary impact in terms of awareness and change in behaviour.

Taken together, the conceptual discussions, the investigative reports and the findings from the content analytic studies point to the need: for enhanced training for media professionals in East and Southern Africa on HIV/AIDS coverage; to create HIV/AIDS resources centres and databases easily accessible to media professionals; for workshops and seminars to sensitise editors, producers and media managers about the social and economic costs of HIV/AIDS and other major health risks in Africa; and for a more sustained and intensive use of media resources in support of efforts to prevent and manage the spread of HIV/AIDS in Africa

Through this publication, UNESCO hopes to contribute to the generation of the requisite interest, awareness, knowledge and understanding among media practitioners of the prevalence of HIV/AIDS in African countries and its immense social, demographic and economic impact. It is equally envisaged that the publication will stimulate efforts to integrate preventive information on HIV/AIDS in the regular fare of mass media in African countries.

ABC OF HIV/AIDS

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This ABC contains terms and acronyms commonly used in writing about HIV/AIDS. In addition to definitions, explanations and examples of use to a wider audience, the symbol ⚠: indicates information of particular interest to the media. Words in bold are defined elsewhere in the ABC.

abstinence	Sexual abstinence means refraining from all sexual activity with others.
adolescence	The period of intense emotional and intellectual development between childhood and adulthood, when boys and girls go through the physical changes known as **puberty.**
AIDS	Acquired Immune Deficiency Syndrome – the disease caused by **HIV.**
anal intercourse	Penetration of the anus by the penis. Anal intercourse is practised by men with women and with other men. HIV is twice as likely to be transmitted in **unprotected** anal intercourse as in vaginal intercourse
antibody	*See* HIV antibodies.
anti(retro)viral	Having the property of attacking (retro)viruses. *See also* **combination therapy, non-nucleoside reverse transcriptase inhibitors, nucleoside analogues** and **protease inhibitors.**
ASO	AIDS Service Organisation: usually a community-based **non-governmental organisation** which undertakes one or more of the following tasks: educating the public about HIV transmission and means of protecting oneself; providing pre-and post-test **counselling;** and care of individuals who have contracted HIV or developed AIDS.
asymptomatic	Not having symptoms. People with **HIV** are asymptomatic until they develop **opportunistic infections** which mark the onset of AIDS. This asymptomatic period can last 10 years or more.
AZT	Azidothymidine; the earlier name for **Zidovudine.**
casual sex	In epidemiological terms, casual sex usually defines situations where an individual has more than one sexual partner in a 12-month period. An alternative term, best avoided, is promiscuity.

CD4 cells

A type of blood cell, also known as T-helper cells or T-cells. When the **immune system** is functioning normally, CD4 cells protect the body by recognising and destroying viruses and bacteria. **HIV** enters and replicates inside CD4 cells, disabling the body's immune system and eventually leading to the development of **AIDS.**

circumcision, female

See **female genital mutilation.**

circumcision, male

The operation which removes the foreskin from the penis. There is some evidence to suggest that circumcised men are less likely to contract and transmit HIV than men who are uncircumcised. Some people believe that male circumcision, though it has fewer harmful consequences than female circumcision, should also be described as genital mutilation.

combination therapy

In HIV/AIDS, combination therapy is the administering of two or three different types of **antiretroviral** drugs at the same time. Combination therapy is more effective in treating HIV/AIDS than **monotherapy.**

condom, female

A pouch made of polyurethane inserted into the vagina before intercourse and held in place by a loose inner ring and fixed outer ring. The female condom prevents conception and provides protection from **sexually transmitted infections.** Unlike the male condom, it does not depend on the man's erection. The female condom, with the inner ring removed, can also be used for protection in **anal intercourse** with men or women.

condom, male

A sheath unrolled over the erect penis. Male condoms made from latex or polyurethane prevent conception and transmission of HIV and other sexually transmitted infections.

contaminated blood (products)

In the context of AIDS, any blood or blood products which has been infected with HIV. **Screening** identifies blood with the virus and prevents it being used in transfusion.

contraception

Any method that prevents a woman from conceiving a child, such as the pill and diaphragm. Of all contraceptive methods, only the male and female condom also offer protection from infection with **HIV** and other **STIs.**

cost of treatment

The direct cost of treatment for HIV/AIDS includes: doctors' fees, test fees (for the **HIV antibody test,** X-rays etc), hospital fees, fees for drugs and other forms of treatment and fees for home and hospice care. *See also* **indirect costs.**

counselling

Providing information and advice. Pre-test counselling helps individuals decide whether to take the **HIV antibody test.** Post-test counselling provides an opportunity for those who test **HIV-negative** to learn how to protect themselves from future infection, and advises those who test **HIV-positive** how to maintain their health and how to avoid transmitting the virus to others.

d4T, ddC, ddI

Examples of **nucleoside analogue** drugs, used in **combination therapy** to prevent HIV replicating.

diagnosis

Interpretation of a disease. HIV Infection cannot be diagnosed, only confirmed by an **HIV antibody test.** Diagnosis of AIDS may be made when a patient contracts an **opportunistic infection;** where possible, the diagnosis of AIDS should be confirmed, or eliminated, by an HIV antibody test.

DNA

Deoxyribonucleic acid. The genetical material of most living organisms. *See* also **RNA.**

drugs, antiretroviral

See **antiretroviral.**

drugs, injecting

The term usually refers to the injection of drugs for recreational purposes – either drugs produced only for recreational use, such as heroin, or medicinal drugs injected in combinations or doses intended for recreational use. Non-sterilised **injecting equipment** carries a high risk of transmission of HIV and other diseases such as Hepatitis.

drugs, recreational

In addition to those which are injected, recreational drugs may be inhaled (eg cocaine, marijuana, tobacco) injected (eg heroin), eaten, chewed or swallowed (eg qat, coca leaf and "ecstasy") or drunk (eg caffeine, alcohol) to alter physical sensations and mental attitudes. Medicinal drugs may also be misused as recreational drugs. Recreational drugs such as alcohol which make people less likely to protect themselves during sexual intercourse carry an indirect risk of HIV transmission.

dry sex

In some African cultures, women use substances to reduce or prevent flow of vaginal fluid during intercourse because their male partners prefer the sensation of "dry sex". Dry sex heightens the risk of HIV transmission as it increases the likelihood of bleeding and if a condom is not used.

ELISA

Relatively cheap **HIV antibody test.** If a blood test is positive, where possible it should be confirmed by the more accurate but more expensive Western Blot test.

faithful

See **fidelity.**

female genital mutilation	Also known as female circumcision. The partial or full removal of the clitoris, labia minora and labia majora.
fidelity	Faithfulness to one's sexual partner and abstaining from **casual** sex. Fidelity only protects an individual from HIV when it is mutual – i.e. when both partners are faithful to each other.
gender	While sex describes physical status – whether an individual has a penis and testicles or breasts and vagina – gender describes the socially constructed differences between men and women and the cultural roles which they are expected to fulfil.
heterosexual	*See* **sexual orientation.**
HIV	Human Immunodeficiency Virus: HIV is a **retrovirus** which enters **CD4** blood cells, where it converts its **RNA** into **DNA** by using an enzyme known as reverse transcriptase. This allows the virus to replicate itself. It also disables the body's immune system and eventually leads to the development of **AIDS.**
HIV antibodies	When confronted with infection, the immune system produces antibodies which circulate in the blood to attack the **pathogen.** With many diseases, the antibodies overcome the pathogen; in the case of HIV, antibodies are produced but they do not succeed in preventing the virus from replicating.
HIV antibody test	A test to confirm whether an individual has HIV antibodies - and therefore whether they have contracted the virus. A positive result suggests they have contracted HIV. Where possible, a second test is generally used to confirm an initial positive result.
HIV-negative	Not having contracted **HIV.**
HIV-positive	Having contracted HIV/living with HIV.
homosexual	See **sexual orientation.**
IAVI	International AIDS Vaccine Initiative: a non-governmental organisation based in New York, with significant funding from Northern government and other sources, whose goal is to support research leading to the development of a vaccine/vaccines that will prevent all or most HIV transmission throughout the developing world.
immune system	The immune system comprises a number of mechanisms to protect the body from disease. These include the lymph glands, which produce **CD4** cells.
IDU	Injecting drug use(r).

incidence

The incidence of a disease is the rate at which new infections occur, usually expressed in terms of annual increase. HIV incidence of 10% means that 10% more people will contract the virus in a given year than in the previous year.

incubation period

The period between infection with a virus or **pathogen** and the appearance of symptoms. HIV is unusual in that the incubation period may be ten years or more.

indirect costs

The indirect costs of a disease generally include loss of income from the patient and from those who take time off work to care for the patient, attend their funeral and look after their dependents. Social costs, which may lead to additional economic loss, include such items as loss of schooling by those who care for relatives with the disease and poorer nutrition resulting from lack of income or labour to gather food and prepare meals.

infected

Although this is the word most commonly used to describe an individual who has contracted the virus, many **PWA** groups prefer to avoid the term and use "living with HIV" instead.

infectious

Capable of infecting others. An individual who has contracted HIV is infectious – through **sexual intercourse, contaminated blood, injection equipment or mother-to-child** – whether or not they have developed symptoms of AIDS and whether or not they are taking **anti(retro)viral** drugs.

informed consent

An **HIV antibody test** should only be undertaken as the result of informed consent—when the individual fully understands, as the result of pre-test **counselling,** the implications of the test and the possible impact of the result on their lives.

injecting equipment

Usually a manufactured syringe, but the term may refer to any instrument, such as one made from a ballpoint pen, used to inject drugs. Failure to thoroughly sterilise injecting equipment between each use can lead to transmission of HIV and other diseases.

intravenous,
intravenous drug user (IVDU)

Intravenous means into the veins. The term IVDU is no longer used because many individuals who inject drugs inject into a muscle, not into a vein.

Kaposi's sarcoma

A skin tumour. Kaposi's sarcoma (KS) is a common **opportunistic infection** in some population groups in Europe and North America, but uncommon in sub-Saharan Africa.

masturbation	Using one's hand for sexual pleasure, generally to achieve orgasm (sexual climax). Masturbation can be practised alone or on a partner. Solitary masturbation cannot lead to HIV infection; masturbation of a partner can only lead to HIV infection if there are is an open cut or lesion on the masturbator's hand or the masturbatee's genital area.
monotherapy	The administering of one type of drug. Monotherapy in HIV is generally not recommended because it can lead to drug resistance and a faster deterioration of the patient's state of health. However, monotherapy is practised to prevent **mother-to-child transmission.**
morbidity	The **incidence** of a disease.
mother-to-child transmission	HIV can be transmitted from a mother with the virus to her newborn child in the womb, during birth or through breastfeeding. Transmission occurs in 25% to 40% of cases without prophylactic treatment. If the mother takes **Zidovudine** (AZT) during the pregnancy and refrains from breastfeeding, transmission rates fall to 10%. Other drugs are being developed to prevent mother-to-child transmission – which is also known as perinatal transmission.
NA(C)P	National AIDS (Control) Programme: government-sponsored body which oversees the national response to HIV/AIDS in each country, working with **UNAIDS, non-governmental** and other organisations.
non-governmental organisation	Non-governmental organisations (NGOs) vary in size, budget and scope from unpaid volunteers in a small district to large international institutions. Most NGOs are non-profit organisations.
non-nucleoside reverse transcriptase inhibitors	A type of antiretroviral drug. Non-nucleoside reverse transcriptase inhibitors prevent HIV from converting its RNA into DNA.
non-penetrative sex	Sexual activity which does not involve penetration of the vagina, anus or mouth. Non-penetrative sex does not allow transmission of HIV unless infected semen or vaginal fluid from one partner comes into contact with a cut or lesion on the other partner's body.
nucleoside analogues	A type of antiretroviral drug. Nucleoside analogues prevent the newly-created DNA of HIV in a disabled CD4 cell from building new virus.
opportunistic infection	Infections which attack the body more easily when the immune system is weakened. Theoretically, any disease can be an opportunistic infection; in practice, the commonest opportunistic infections are: Mycobacterium avium complex (MAC) causing tuberculosis; pneumonia (PCP); herpes viruses; diarrhea; toxoplasmosis.

oral intercourse	Penetration of the mouth by the penis. Practised by women with men and men with other men.
palliative	Palliative treatment relieves suffering but does not cure the underlying condition.
pathogen	Any disease-causing micro-organism. Pathogens include viruses, many bacteria, fungi and protozoans.
perinatal transmission	*See* **mother to child transmission.**
pre-test counselling	*See* **counselling.**
post-test counselling	*See* **counselling.**
prevalence	HIV prevalence is the total number of people with a virus at any one time. In some urban areas, for example, HIV prevalence among adults is over 30% – more than 3 in 10 adults is living with HIV.
prevention programmes	Government or NGO projects or campaigns designed to raise awareness of HIV and the means of preventing transmission, among the general public or a more narrow audience (eg young people, sex workers and their clients, migrant labourers etc).
prophylactic	A prophylactic measure is one which prevents spread of a disease. Prophylaxis is sometimes also used to mean contraception.
prostitution	*See* **sex work.**
protease inhibitors	A type of antiretroviral drug. Protease inhibitors prevent HIV from being released from infected CD4 cells.
protected	Protected sexual intercourse means intercourse with a condom.
puberty	Puberty refers to the physical, including sexual, changes that occur when a child reaches adulthood. *See* also **adolescence**.
PWA / PLWA / PLWHA	P(L)WA: person (living) with AIDS (i.e.: having developed the symptoms of AIDS). PLWHA: person living with HIV/AIDS (whether or not they have symptoms of AIDS).
Retrovir	Trade name for Zidovudine.
retrovirus	*See* **virus.**

risk	Risk of HIV transmission occurs in any situation where the virus may be transmitted from one individual to another – *e.g.* in an act of unprotected intercourse or when unscreened blood is transfused.
RNA	Ribonucleic acid. An organic compound storing genetic information.
screen	Screening blood means testing blood for the presence of HIV antibodies.
semen / seminal fluid	The penis ejaculates semen, the liquid which contains sperm, the male contribution to conception. Infected semen is the primary route through which men transmit HIV to their sexual partners.
seroconversion	The moment at which an infection enters the bloodstream and the individual converts from seronegative to seropositive (in the context of HIV/AIDS, converts from HIV-negative to HIV-positive).
seronegative	Without a specified pathogen in the blood. In the context of HIV/AIDS, seronegative is the same as HIV-negative.
seropositive	With a specified pathogen in the blood. In the context of HIV/AIDS, seropositve is the same as HIV-positive.
serostatus	Literally "state of the blood". In the context of HIV, the term indicates whether a person has contracted the virus or not.
sex work	Sex work, often referred to as prostitution, is the exchange of sexual intercourse or other sexual activity for money or goods. Both women and men can be sex workers; the clients are almost always men.
sexual activity	Any activity, alone or with a partner, which involves direct or indirect stimulation of the sexual organs.
sexual identity	Most individuals identify themselves as men/masculine or women/feminine. In every culture, however, a few individuals either wish to change their sexual identity or consider they have elements of both sexes in their psychological and/or physical make-up. *See also* **gender.**
sexual intercourse	The definition of sexual intercourse can vary according to the speaker. Some people consider only vaginal intercourse as sexual intercourse and see anal intercourse and oral intercourse as forms of sexual activity. Vaginal, anal and oral intercourse may all lead to transmission of HIV if a condom is not used.

sexual orientation	Refers to an individual's pattern of sexual attraction. In Western terms, individuals are seen as heterosexual (attracted to the opposite sex), homosexual (attracted to the same sex) or bisexual (attracted to both sexes). In other cultures, **sexual identity** and sexual orientation are often defined differently.
sexually transmitted disease	*See* **sexually transmitted infection.**
sexually transmitted infection	An STI (also known as sexually transmitted disease or STD) is any infection only or primarily transmitted through sexual intercourse. STIs which cause lesions or ulcers, such as gonorrhea, multiply the risk of transmitting HIV up to sevenfold.
social marketing	Male and female condoms are sold through social marketing in many parts of Africa. This comprises an affordable, subsidised price and marketing and sales similar to commercial items such as beers and other products. This approach increases sales and helps to remove the stigma of condoms and sexual intercourse.
STD or STI	*See* **sexually transmitted infection.**
stigma	A mark of social disgrace.
Sugar Daddy, Sugar Mommy	In some cultures the slang term used for older men who pay, directly or in kind, for the sexual services of younger women, or for older women who similarly pay for the services of younger men.
symptomatic	Having symptoms. A person with HIV is **asymptomatic;** a person with AIDS is symptomatic.
taboo	Contrary to a society's customs and / or laws. Despite taboos, many sexual practices such as oral and anal intercourse exist in many, if not all, societies.
T-(helper) cells	*See* **CD4 cells.**
testing	See **HIV antibody testing and counselling.**
UNAIDS	Joint United Nations Programme on HIV/AIDS co-ordinating the global response to HIV/AIDS. UNAIDS is sponsored by seven UN agencies: the UN Children's Fund (UNICEF), UN Development Programme (UNDP), UN Educational, Scientific and Cultural Organization (UNESCO), UN International Drug Control Programme (UNDCP), UN Population Fund (UNFPA) the World Bank and the World Health Organization.

unprotected	Unprotected intercourse is intercourse without use of a male or female condom. Unprotected intercourse can lead to transmission of HIV and other STIs.
unscreened	Unscreened blood has not been tested for HIV antibodies and may carry HIV. *See also* **screen.**
vaccine	A preparation of disease-producing micro-organisms, or their parts, used to stimulate immune response and raise the body's resistance to a disease. There is currently no vaccine that prevents individuals from contracting HIV; vaccine development, co-ordinated by IAVI, is a global priority.
vaginal fluid	Fluid produced by the mucous membrane – lining – of the vagina. In some African cultures vaginal fluid is welcomed by both partners. In other cultures women are encouraged to find means of restricting vaginal fluid because men prefer dry sex.
vaginal intercourse	Penetration of a vagina by a penis.
viral load	The quantity of virus in the bloodstream. The viral load of HIV is measured by sensitive tests, unavailable in most of Africa. Ability to measure viral load is a key component in effective combination therapy.
virus	A micro-organism which is capable of independent life and reproduction within a living cell. Most viruses store the genetic information they need to reproduce in DNA. Retroviruses, such as HIV, store their genetic information in RNA.
wasting syndrome	Term used to define the rapid loss of weight that often accompanies the development of AIDS.
Western Blot	*See* **ELISA.**
window period	It takes the immune system up to three months to produce antibodies to HIV that can be measured in the HIV antibody test. During this window period, an individual tests negative for the virus but is nevertheless capable of transmitting it to others.
Zidovudine	The first developed and most commonly known nucleoside analogue; commonly known as AZT.

AN ETHICAL GUIDE TO REPORTING HIV/AIDS

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INTRODUCTION

Only 200 years ago the agricultural society which sustained most of humanity for thousands of years began to give way to the industrial society that gradually spread from Europe and North America to the rest of the world. Now, we are entering an age where new information and communication technologies are changing the economic, political and cultural profiles of every society in which we live[1].

The media are at the heart of these changes and the media themselves are undergoing rapid change. Even in Africa, where access to the media is frequently limited by illiteracy and poverty, the growth in the number of radio stations and radio receivers, satellite television and the Internet has begun a process of social change that is as yet little noticed and often misunderstood.

The media can be an essential tool in combating HIV/AIDS. More than any other disease, AIDS is driven by a combination of social factors, including inequality, stigmatisation and ignorance. Whether or not they actively seek to do so, the media either fuel the epidemic through sensationalism and poor or unethical reporting, or helps to restrain it by promoting information, understanding and behaviour change. The media shape attitudes and influence national agendas for good or for ill; it educates or misinforms; it investigates or ignores malpractice; and it raises or ignores questions of cultural values that lie behind the epidemic.

While the impact of the newer media in Africa has not been assessed in depth, evidence confirms the wide influence of radio and the press. A 1997 study confirmed that the greater access Africans had to the media and to accurate information about contraception, the more likely they were to use family planning techniques[2]. On the other hand, uncritical reporting of such issues as the supposed AIDS treatment Kemron in the late 1980s misled many into believing that the disease was less of a threat than it has proved to be.

Few, if any, of those who reported the Kemron issue intended any harm. Indeed, almost everyone working in the media wants their contribution to help prevent further spread of HIV and to help alleviate the problems of those living with the virus. However, the varied nature of the media, its different "players", content, goals and audiences, mean that there will never be a single message or series of messages acceptable to all the media, the public and those working in HIV. Indeed, at times messages are contradictory, as religious radio stations condemn the use of condoms and health columnists advise that condoms are essential.

This chapter examines the ethical issues of covering HIV/AIDS. It is written primarily from the perspective of news reporters, feature writers and producers of documentaries, but the points it makes are applicable to all who work in the media.

1. AN ETHICAL APPROACH TO HIV

Ethics is the study or practice of morals; an ethical approach to a subject is the one intended to result in least harm and greatest good. An ethical approach to HIV/AIDS, whether from the media, the medical profession or the public at

[1] For further discussion, see *World Information and Communication Report*, UNESCO, 1999.
[2] "Mass Media and Reproductive Behavior in Africa", Charles F Westhoff and Akinrinola Bankole, Macro International Inc. Calverton, MD, USA, 1997.

large, aims to achieve a reduction in the numbers of people who contract the virus and to relieve, as far as possible, physical or psychological distress suffered by those living with HIV.

The theory is easy to describe; the practice is more difficult. The fact that HIV infection is strongly identified with the highly emotional issues of sexual behaviour and death, makes it difficult to agree how to achieve the goals of reducing transmission and relieving distress. One group advises the use of condoms; others insist on abstinence from sex outside marriage. Some wish to publicly identify people living with HIV to protect others from the disease; others see that strategy as harmful to society as a whole. Even the apparently simple question as to whether to supply antiviral drugs to pregnant women with HIV to make it less likely for them to transmit the virus to their children can be controversial, as seen in South Africa in early 1999.

1.1. Stigma and human rights

For many the greatest problem confronting those living with HIV and those working in AIDS care and prevention is stigma. As Zambian social worker Elizabeth Mataka says, "being HIV-positive is considered deviant in African society... They tend to deny their situation at a personal level, especially as the disease is wrongly seen as bordering on a person's moral character." [3]

Stigma is not universal, but it is widespread. To overcome the consequences of stigma, many working in HIV/AIDS prevention and care look to strengthen awareness of human rights across the continent. In 1994, the African Network on Ethics, Rights and HIV published the Dakar Declaration, comprising 10 principles that should guide the response to HIV/AIDS, including responsibility, involvement, partnership & co-operation, non-discrimination and confidentiality. In September 1996, UNAIDS and the UN Commission on Human Rights issued guidelines which stipulated that people with HIV/AIDS were entitled to the following rights, amongst others: life; non-discrimination backed by equal protection and equality before the law; the highest attainable standard of physical and mental health; freedom of movement; privacy; work; freedom of opinion and expression and the right to freely receive and impart information; marriage and the founding of a family; and participation in public and cultural life.[4]

The problem for many people living with HIV/AIDS and their families is ensuring that these rights are implemented. In Africa there is little tradition of using the law to guarantee individual human rights and those most affected by human rights abuses are often those who are least able to seek redress. One area of exception is South Africa, where the AIDS Law Project was set up in 1993 by Justice Edwin Cameron, who has since declared that he himself is HIV-positive. ALP offers a legal service, runs a telephone advice service and has taken legal action on behalf of people with the virus who believe they have been discriminated against.

2. The media and HIV. What are the issues?

An informed and ethical approach to reporting HIV/AIDS is no different from an ethical approach to HIV/AIDS in the workplace, in a hospital or any other setting. However, the media have greater influence. A doctor who betrays the confidentiality of an individual's HIV status generally harms only that patient; a newspaper which betrays that confidentiality not only harms that patient but feeds into the cycle of discrimination and stigma described above.

Reporting HIV/AIDS provides many challenges. A reporter's desire to present a sober, optimistic image may be confronted by an editor's or sub-editor's desire to prevent a sensationalist, negative view. Audiences may com-

[3] "Mass Media and Reproductive Behavior in Africa", Charles F Westhoff and Akinrinola Bankole, Macro International Inc. Calverton, MD, USA, 1997. AF-AIDS (listserv) discussion, posting [247] RE: PRE-ICASA 2: Stigmatisation and Discriminatiion in African Communities – Zambia [244], 29 June 1999,

[4] Abstracted from UN Commission on Human Rights, Fifty Third Session, Item 9(a) provisional agenda, Second International Consultation on HIV/AIDS and Human Rights, Geneva, 23 - 25 September 1996. Available on www.unaids.org/unaids/ document/humright/3797.html.

plain that the subject has been covered too much. Frank, respectful discussion of sexual matters may be censored. International agencies may want a specific viewpoint covered. Some health workers and NGOs distrust the media and refuse to help them. Civil servants and politicians may not take kindly to investigations into their inefficiency or corruption. Lack of time to research an article may result in bland reports.

Reporters themselves may hinder good reporting. Some rely too much on optimistic and misleading press releases, others on the statements of government ministers or other community leaders which reflect "official" attitudes to the disease that are far removed from the reality that most of the population face. Some reporters, without any evidence, distrust non-governmental organisations or people who are open about their HIV-positive status, suspecting that their primary goal is to attract funding. Male reporters may hold common attitudes, including violence against women, that underlie the spread of the virus.

At a meeting of West African gatekeepers in 1997, participants pointed out five areas where they considered the media were failing in their responsibility to cover the epidemic[5] :

- lack of involvement in the issue, often the result of poor training and lack of awareness of health issues;
- sensationalism;
- avoidance of key topics, such as living with HIV;
- lack of preparation or transparency;
- lack of a collaborative approach.

These deficiencies are not universal. An increasing number of journalists in Africa demonstrate exemplary coverage of the epidemic while seminars, workshops and media networks encourage and permit reporters to develop their skills. These will be needed for the foreseeable future as the pressures described above persist, inexperienced individuals enter the profession each year, and skilled journalists move into other areas of reporting or leave the media for better paid jobs, taking skills with them that are not easily replaced.

This section covers topics that are frequently the cause of confusion or poor reporting of HIV/AIDS.

2.1. Confidentiality

Confidentiality means not publishing the name of an individual with HIV without their permission. The rule is simple but not always easily applied. When the focus of a report is an individual willingly discussing their HIV-positive status to educate people and reduce stigma, the question of confidentiality does not arise. However, there are many other cases when reporters learn that an individual has HIV but few, if any, cases where that information should be published or broadcast without that individual's permission. The rule to follow is that it is the right of individuals to maintain their confidentiality and the duty of reporters to respect it.

[There is an argument that identifying people with HIV protects others who might engage in unsafe sex with them. However, there is no evidence that "outing" people this way prevents any further transmission of the virus and there is some evidence to suggest it encourages irresponsible behaviour. Furthermore, it is the role of the media to report this discussion, not to take part in it, and it should be noted that falsely declaring an individual to be HIV-positive can be libellous.]

Two specific areas can be looked at in more detail. The first is the example of community leaders with HIV who take antiviral treatment while arguing that the country is too poor to afford such treatment for its citizens; the question here is not the individual's serostatus but the contradiction between their actions and words. Whether that information should be reported is a matter of debate. The second question is that of identifying victims of rape, irrespective of their serostatus or that of their attacker; whatever the circumstances, names and details of rape victims should never be

[5] Abstracted from the report of the second Pop'Mediafrique seminar held in Abidjan, 15-19 June 1997 organised by the Population Reference Bureau, Washington DC and African Consultants International, Dakar.

broadcast or published, since even an intended sympathetic approach from the media can lead to further stigma and even attacks by members of the public.

»» Ethical reporting of HIV/AIDS requires that the confidentiality of those with the virus and their family and friends, is respected. Identities or addresses should not be revealed or hinted at without their permission and reporters should not pressurise people with HIV into revealing their identities. Information given in confidence should never be passed or made accessible to others, inside or outside the media.

2.2. Reducing stigma

The media frequently use words such as "scourge" and "plague" which add to the general perception that HIV/AIDS and those who are affected by it should be avoided. Similarly, politicians, other community leaders and members of the public sometimes use words such as "promiscuous" and phrase their ideas in a way which reflects negative attitudes towards the disease and people living with the virus. These words are often repeated or reported without comment; in this way the media unwittingly or unwillingly reinforce stigma.

»» Ethical reporting of HIV/AIDS requires that the media use language and ask questions that reduce or avoid stigma and, where possible, reduce or avoid reporting the negative attitudes of others to the disease.

2.3. Treatment and "cures"

There is currently no cure for AIDS and the drugs that significantly prolong the life of people with HIV are unavailable or unaffordable to most Africans. Confronted with a fatal disease, it is not surprising that individuals seek any form of medicine that might help them; nor is it surprising that healers seek means of treating or curing AIDS; and, unfortunately, it is not surprising that a few unethical individuals promote "cures" for the disease which they know do not work. Such "cures" may even harm those who take them and impoverish those who buy them.

Sometimes the media become directly involved when they carry paid display or classified advertisements for AIDS "cures" and editors or reporters are encouraged to carry news stories promoting these "cures". However, the media should neither accept nor condemn uncritically announcements of new treatments or potential cures. Indeed, the media can encourage attempts to develop effective treatments and cures by thorough investigation to ensure that those undertaking research do so efficiently and honestly. When covering new drugs or "cures", the following questions should be kept in mind:

- *What is the treatment or cure intended to do?*
  Is it intended to treat opportunistic infections or to attack HIV itself?
- *How does it work?*
  "You rub it on the skin and the symptoms go away" is not an adequate answer. What substances are in the treatment and what is the biological process through which they affect the progress of HIV or the opportunistic infection?
- *Are there any side-effects? What are they and how serious are they?*
  Side-effects include symptoms which did not exist before the treatment was taken, such as nausea or headaches.
- *Have the proponents undertaken comparative trials?*
  Properly monitored and independent comparative trials – which compare the course of the disease in those who took the treatment with those who did not take it – confirm whether or not the treatment has a beneficial effect. Have such trials been undertaken? How many people were involved? What were the results? Have they been published or can the detailed information be given to the journalist? Can the names of those who took part in the trial – both who received the treatment and who did not, including those for whom the treatment did not work – be given to the journalist?

- *What measurements were used to confirm that the treatment worked?*
  Recovering from one or more opportunistic diseases is not an indication that the treatment was successful against HIV. The success of treatments designed to attack HIV can only be confirmed by tests which measure the level of the virus' activity in the blood both pre- and post-treatment.
- *Has there been peer review*?
  Have all the above issues been monitored by an independent team of experts who confirm the process and the success of the treatment?

Proponents of the treatment who avoid direct answers to some or all of the above questions should be treated sceptically.

»» Ethical reporting of HIV/AIDS requires that all claims of effective treatment, from whatever source, are subject to scrutiny and not reported uncritically.

2.4. Misconceptions

Misleading reports on HIV/AIDS stem from a number of sources, including:

- carelessly used, misunderstood or misused language;
- scientific or pseudo-scientific information reported indiscriminately;
- sensationalised information;
- reports influenced by the personal attitudes of writers or editors;
- sub-editors' headlines;
- repetition of information that is out of date or distorted;
- inappropriately used quotes.

Reporters sometimes confuse data, for example failing to distinguish between the virus HIV and the syndrome AIDS, or between the general population and the adult population when reporting the extent to which HIV affects a community. Sometimes reporters covering the epidemic repeat commonly-held, but mistaken, myths about the disease, with potentially serious consequences. Such mistaken beliefs include :

origins/cause

- the disease is the result of witchcraft;
- its origins lie in biological warfare experiments, smallpox vaccinations or other human-made activities.

transmission

- HIV is contagious (eg by touching someone, or breathing the same air);
- HIV can be transmitted by mosquitoes or other insects.

prevention

- taking antibiotics before sex prevents transmission;
- full-bodied, young, healthy-looking people do not have HIV;
- condoms are not needed in long-term relationships.

symptoms & disease

- people with HIV/AIDS always look sick;
- HIV/AIDS only affects certain groups of people, such as whites, sex workers or certain ethnic groups.

treatment

- the disease can be cured by traditional healers or other medicines;
- the disease cannot be treated.

other issues

- the clothing and possessions of people with HIV/AIDS must be destroyed if they fall ill or after their death.

»» Ethical reporting of HIV/AIDS requires that media professionals do not repeat misconceptions or report irrelevant controversies such as the origins of the disease. If members of the public, or experts, are quoted repeating misconceptions, their words should be refuted by corrective quotes from national or international experts.

2.5. Sources of information

The many sources of information regarding HIV/AIDS include:

- international organisations, such as UNAIDS;
- government organisations and officials, such as National AIDS Control Programmes;
- national or international non-governmental organisations, including religious bodies and organisations of people living with HIV/AIDS;

- national or international universities and other academics;
- pharmaceutical companies;
- individuals with HIV/AIDS experience or living with the virus.

Ideally, each source should provide information that is independently verifiable, complete, accurate and relevant. In practice, many organisations and individuals, consciously or not, slant information in a way that presents themselves in a favourable light. Reporters will sometimes be aware that the facts being presented are incorrect or insufficient but lack of time, lack of resources or political pressure prevent them from investigating further. One solution to this problem is persuading editors or producers to support reporters who need to undertake more research.

Sometimes reporters suspect a hidden agenda, eg from international organisations, that does not in fact exist. Overcoming such unjustified suspicion is difficult and depends on others persuading the reporter to adopt a more neutral and analytic point of view.

»» Ethical reporting of HIV/AIDS requires the ability to distinguish facts and the implications of facts from the presentation and from the institution presenting them.

2.6. Investigative reporting

The media can and should play a significant role in highlighting deficiencies in the response to HIV/AIDS. These include such issues as bureaucratic incompetence that prevents adequate medical supplies from reaching hospitals and clinics and corruption within government departments and NGOs that prevents funds reaching those who need them. By reporting on such issues in a manner which maintains the confidentiality of those who bring them to the media's attention and confirms that the facts are correct, the media can play a key role in ensuring a proper response to the HIV/AIDS epidemic.

»» Ethical reporting of HIV/AIDS requires research into and reporting of issues which may not bring credit to individuals or institutions in the short term but which result in long-term improvement in care and prevention.

2.7. Men and women

There is clear evidence that men's behaviour plays a more critical role in the transmission of HIV than women's. Public attitudes, however, including those of the media, which are dominated by men, tend to "blame" women. Sex workers or women in general are often seen as the "source" of the disease. When a man learns that his wife is HIV-positive, it can be easier for him to blame her for bringing the infection into the family than to recognise that it is far more likely to have been his own behaviour.

In fact, it is men's domination of women's sexual lives, as seen in violence against women and such customs as the belief that sex with a virgin girl will cure an older man of AIDS, that lies at the heart of the epidemic. HIV/AIDS will only be overcome when women achieve the social independence that allows them to protect themselves from HIV.

»» Ethical reporting of HIV/AIDS requires an understanding of the unequal relations between men and women that exist in every society and the distorted perspective of the epidemic that results. Wherever possible, media professionals should be trained in gender issues and take care to ensure that reports present a perspective which accurately represents the experience of both men and women.

2.8. Minorities

In every society there are groups of people looked down upon by the general public, such as sex workers, prisoners and members of minority ethnic communities. Prejudices about such groups often lead to misconceptions such as the belief that sex workers "entrap" men. Some of these groups, such as prisoners or men who have sex with men, may be at high risk of contracting HIV, but public attitudes make it difficult to target them for prevention.

»» Ethical reporting of HIV/AIDS requires that minority groups within a society are treated with respect. Those who are particularly vulnerable to HIV should be described as such and not as potential sources of infection for the broader community.

2.9. Sex

HIV is predominantly spread by sexual intercourse. It is often stated that public discussion of sexual matters is taboo in Africa. Until very recently the same was true for most societies across the world. Openness about sexual behaviour began in Western Europe and North America before the advent of HIV/AIDS, but has accelerated as a result of the epidemic. Some of the success in limiting spread of the virus in parts of the industrialized world may have come from willingness to be frank about sexual behaviour.

Failure to discuss sexual matters in most African societies, whether in the public sphere or the privacy of the bedroom, is one factor behind the rapid spread of HIV. There is widespread evidence, as seen in the experience of the Uganda teen-oriented publication *Straight Talk*, to confirm that open and honest discussion of sexual matters in the media helps reduce transmission of the virus.

»» Ethical reporting of HIV/AIDS requires an open and respectful discussion of sexual issues.

2.10. Maintaining a distance

Some media professionals find that international or national organisations working in HIV/AIDS prevention, including NGOs and commercial enterprises such as pharmaceutical organisations, offer payment for writing and publishing "positive" stories on the epidemic. This well-intentioned approach not only subjects editorial judgement to non-professionals but also encourages dependency and discourages professionalism among reporters.

»» Ethical reporting of HIV/AIDS requires that media professionals work with, but maintain an appropriate distance from, all institutions working in HIV/AIDS prevention.

2.11. Reporters or health educators?

Some non-governmental organisations and governments consider the media's first duty is to act as health educators persuading the public to change their sexual behaviour. Some media professionals, such as health columnists, welcome such a role. Many others believe that the media's first responsibility is to provide the public with facts about the broader issues relating to the disease and the response to it. In the short term this can lead to confrontation – in June 1999 one health minister in Southern Africa accused the country's media of scaring away foreign donors with their negative reporting of the government's handling of the epidemic – but in the long term it should lead to a more transparent and effective response to the disease.

»» Ethical reporting of HIV/AIDS requires that media professionals be aware of the potential conflicts between their roles and others' perception of those roles.

3. Guidelines for the media

Given these and other ethical issues, guidelines can help media professionals cover HIV/AIDS. In 1997 a group of senior media professionals from Burkina Faso, Cote d'Ivoire, Mali, Mauritania and Senegal drew up the following principles to assist the media:

- respect for the rights of people living with HIV/AIDS;
- training for journalists on HIV/AIDS issues;
- concern about accurate reporting of facts and figures;
- an approach to reporting that involves the community;
- collaboration with HIV/AIDS organisations and people living with HIV/AIDS;
- making the link between sexually transmitted diseases and AIDS;
- appropriate language;

- commitment to increased coverage of HIV/AIDS issues;
- no discrimination linking HIV/AIDS to a particular ethnic group, country or community.

To the above should be added:

- ***relevance***
  Irrelevant information should be omitted, such as an individual's HIV-positive status if the status is not the focus of the report, or address, if the public have no need of the address. Similarly, relevant information should be included. As one example, reports on aspects of AIDS in other countries, such as HIV among the military, should not give the impression that the problem does not exist in the home country if in fact it does. As another example, the extent of HIV infection in a group of sex workers should, where possible, include the rate of infection among clients of sex workers.
- ***accessibility***
  Audiences have different languages and dialects and different levels of education. Young people speak differently from their parents. Politicians, academics, footballers, popstars each have a certain style. The urban educated elite have a different vocabulary from those who are illiterate and live in rural areas. Media professionals should be aware of the abilities and needs of their audience and use the appropriate language to reach them.
- ***scepticism***
  Media professionals should be sceptical. Opinions which appear to conflict with information from leading experts should not be reported as fact. Press releases or speeches should not be quoted if there are grounds to believe that the information given is inaccurate or misleading. Wherever possible, statistics should be confirmed with a reputable organisation, such as the National AIDS Programme, UNAIDS or leading NGO.
- ***clarity***
  Information should be precise and clear. Statistics should be quoted with care and in a manner that can be understood by individuals who have no experience in HIV/AIDS.
- ***lack of sensationalism***
  Sensationalism covers issues without analyzing them, and encourages a simplistic, emotional response from readers and viewers. Sensationalism gives the impression that there are two kinds of people in the world – the "good" who read sensationalist papers and the "bad" who appear in the news reports and features. Non-sensationalist reporting breaks down these barriers and encourages a response which helps readers/viewers/listeners sympathize with those affected.
- ***appropriate admission of ignorance***
  Reporters sometimes listen to statements or read press releases without fully understanding their contents. The statements may presume knowledge that the reporter does not have or it may be that the speaker or writer has not clarified their own thoughts. Reporters who repeat information that they do not understand lose the opportunity to educate themselves and may mislead the public. By admitting ignorance and asking for help, reporters gain the respect of others who are fully committed to limiting the spread of HIV.
- ***recognition of the context of HIV/AIDS***
  HIV/AIDS touches almost every aspect of our daily lives. It is transmitted during sexual intercourse, one of the most common human activities; its transmission often depends on the unequal relationship between men and women; it leads to loss of work and loss of schooling and breakup of family life; it affects our ability to care for ourselves, our families and our communities. Too often, HIV is reported as an issue that affects other people. Reporting the context of the disease and the fact that it affects "us", not "them", can help the public and policymakers develop strategies to protect themselves and others from the worst impact of the disease.

4. Language

In early 1999, a good description of a Kenyan education programme highlighting the risks of HIV transmission among one ethnic group, was headlined "Project targets repulsive practices". The practice described was "wife inheritance", a respected tradition in that group.

Language both reflects and moulds our attitudes. Words often carry emotions that encourage a positive or negative response - and the response evoked may not be the response that the reporter wanted. The most appropriate language reporting HIV/AIDS is language which is, as far as possible, neutral of emotion.

The United Nations Development Programme (UNDP) includes the following principles in their guidelines for reporting HIV/AIDS:

- language that is inclusive and does not create or reinforce a "them/us" mentality;
- vocabulary drawn from peace and human development rather than war;
- descriptive terms preferred by the persons themselves (eg "sex workers", not "prostitutes");
- language that is value neutral, gender sensitive and empowers rather than disempowers.

The following chart is modelled on lists drawn up by UNDP and other organizations since the start of the epidemic. It should be revised regularly and modified according to the needs of the community it serves – a community which includes the media, the general public and those living with HIV/AIDS.

In addition to the words above, some technically accurate words should be avoided. They include:

- "body fluids" in relation to HIV transmission. Some body fluids (blood, breastmilk, semen, vaginal fluid) can transmit HIV; others (saliva, sweat, tears) do not. Specify the fluids involved;
- "gay/homosexual" generally refers to men who follow a Western lifestyle of only having sex with other men. The words are inappropriate in African cultures where the context of sex between men may be very different. "men who have sex with men" is preferred;

Avoid	Because	Use instead
AIDS / HIV carrier	no-one "carries" the virus or disease living with HIV	HIV-positive person/ man/woman with HIV/AIDS
AIDS virus	the virus exists whether or not the individual has developed AIDS	HIV, the virus which causes AIDS
AIDS test	the test does not confirm whether an individual has developed symptoms of AIDS	HIV (antibody) test
catch AIDS	it is impossible to "catch" AIDS	contract HIV become HIV-positive
full-blown AIDS	there is no "partly-blown" AIDS	AIDS
HIV and AIDS HIV or AIDS	they are not two diseases	HIV/AIDS
innocent	no-one chooses to contract HIV	omit the word
safe sex	no sex with a partner is 100% safe	safer sex
scourge/plague	the words are sensationalist, create alarm and inadvertently stigmatize those with the disease	disease epidemic illness

- "infected" appears to place more emphasis on the infection than on the individual; the phrases "(living) with HIV", "HIV-positive" or "(having) contracted HIV" are preferred;
- "patient" is only accurate if the individual concerned is in hospital or the story focuses on their medical treatment;
- "promiscous" has accrued a negative meaning; "having more than one sexual partner" is preferred;
- "prostitute" also has negative connotations for some. "Sex worker" is a preferred term;
- "PWA" Some people living with HIV/AIDS dislike being referred to by initials; "people (living) with HIV/AIDS" is preferred;
- "rate" can mean prevalence or incidence (see chapter on ABC of HIV/AIDS). The word should not be used without clarification;
- "risk groups" is an epidemiological term referring to individuals whose behaviour regularly places them at risk of contracting or transmitting HIV. It is often inaccurately interpreted to mean that those who are not members of the risk group are unlikely to contract HIV. "Risk behaviour" is preferred;
- "sufferer" and "victim" are best avoided because they suggest a passive, helpless response to the disease;
- "vectors" of transmission: the term dehumanises the individuals or groups referred to. "HIV-positive" is preferred.

(The chapter on "The ABC of HIV/AIDS" includes other appropriate language for reporting the disease.)

5. Conclusion

Whatever the circumstances in which they work and whatever their goals, all media professionals have an interest in ensuring accurate, relevant and accessible reporting of the causes, extent and consequences of the epidemic. Even those media whose primary or sole goal is making money through sales of newspapers advertising, cannot afford to ignore an epidemic which reduces the number of people who will buy their products and restricts the buying power of those who survive. A society where a quarter or more of the population is preoccupied with sickness and death is not a society which will fatten the wallets of media owners. A healthy society means a healthy economy.

Reporting HIV/AIDS in a manner most likely to lead to lower transmission of the virus and greater care for those who are living with HIV is a difficult task. Media professionals are continually confronted by conflicts over time, policy and confidentiality, by prejudice and ignorance, by reluctance to confront issues of sex, illness and death, by government reticence or by malpractice or corruption. Each individual and institution must devise their own means of resolving these conflicts.

Workplace issues

The media's responsibility to cover AIDS ethically extends to their responsibility to provide a workplace that supports staff living with HIV and staff whose close family members may be living with the virus – differently expressed: staff who are "infected or affected". Some media institutions and/or media associations have drawn up guidelines designed to support those affected by the disease. Such guidelines vary from country to country and institution to institution, but generally cover the following points:

- recognition by the employer that employees with HIV/AIDS do not present a risk to other staff;
- confidentiality for those "infected or affected";
- education programmes on transmission, prevention and support for those "infected or affected";
- no discrimination by employers or colleagues against employees or job applicants with HIV;
- the same job security and conditions for employees with HIV as employees with other long-term serious illnesses;

- the same rights for staff to take care of people with HIV/AIDS as for any other medical condition;
- company policy on HIV/AIDS fully disseminated and regularly monitored by both the company and staff members.

Media professionals are encouraged to raise issues within the organisation they work as a means of encouraging discussion around HIV/AIDS and an informed and ethical response.

MEDIA FUNCTIONS IN HIV/AIDS PREVENTION AND MANAGEMENT

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INTRODUCTION

The earliest reported case of the Acquired Immune Deficiency Syndrome was in the United States of America (USA) in 1981. Since then, medical experts and researchers, social scientists, psychologists, and recently the media have been galvanized in efforts aimed at preventing and managing the disease. For Africa, this has been termed as the greatest medical challenge in recent decades; while a cure remains elusive, the delicate and fragile social, economic and political context presents peculiar obstacles in the prevention and management of HIV/AIDS.

This is unlike in the developed countries, where the new combination therapies, buttressed by intensive mass educational campaigns, have succeeded considerably in offering a window of hope for those suffering from the disease and for those who are involved in its management and prevention (Piot, 1997). For those involved in HIV/AIDS prevention and management, the picture at times appears to be gloomy and disheartening.

The figures on the spread and prevalence of HIV/AIDS as well as on the number of people who have died from the disease (*see Introduction*) may not mean much to those who have remained untouched in the sense of not knowing anyone close who is either infected with the AIDS virus, or who has developed full blown AIDS. This is one of the most significant categories of people who should be the focus of prevention strategies because the incubation period of the HIV virus makes everyone vulnerable.

One infected person who appears healthy and who has not been tested for the virus has the ability to cause enormous potential damage in communities such as those in East and Southern Africa where the message of prevention has not become engrained. This potential is best looked at when one pictures the infection pattern of the HIV virus as a chain: it starts with two people, but if either one of them is not careful in his/her sexual behaviour, up to hundreds or thousands of people can be infected over a period of time. Indeed, some researchers have contended that the world is divided not into those suffering from AIDS and those not suffering from AIDS, but into those who know they have AIDS and those who do not know (Berer and Sunanda, 1993).

The focus on HIV/AIDS is further justified by the fact that most of those affected by it in some countries of East and Southern Africa, are aged between 15-45 years (Sessional paper No. 4 on AIDS in Kenya, 1997, AIDSCAP, 1996). Indeed, this should accelerate the efforts towards HIV/AIDS prevention and management as this is the most productive cadre of people and their deaths affect their families (particularly if they are the sole breadwinners) and the economy as a whole.

In the bid to combat the epidemic and its threat to the survival of the human race, researchers and programme/project personnel are intent on developing the most innovative and creative strategies. The search for alternatives has highlighted the crucial role of communication and media in the support of these efforts. The mass media in particular have attracted great interest because of the perception of its role as a powerful and influential tool. Towards this end, several countries have initiated and maintained mass media projects.

This chapter examines the functions of the media in HIV/AIDS prevention and manage-

ment and includes the general impact of HIV/AIDS which presents an outlook on the background on the magnitude of the illness: a brief discussion on the role and functions of the media in development; examples of current approaches on media and HIV/AIDS; and proposes some strategies that can be adopted.

The impact of HIV/AIDS

Sceptics in the media may be tempted to ask why there is so much fuss about HIV/AIDS. This necessitates a look at the impact and future projections of the epidemic. Studies of the epidemiology of HIV/AIDS underscore the statement that it is one of the most important challenges that Africa has faced, especially in the post independence era. The figures continue to escalate; the World Health Organization estimates that by the end of 1999, about 30-40 million people would have been infected with HIV, and that the rate of new infections is 8,500 daily. This raises the issue of the potential negative consequences of multiple infections particularly in sub-Saharan Africa where the trend of testing for HIV has not become deep rooted.

Studies indicate that the highest proportion of AIDS cases are between 14-39 years and that adolescents are becoming sexually active at a younger age, meaning that the risk of AIDS is higher among this group. Further, there is concern about the fact that the reported cases do not represent the real picture of the magnitude of infection as some people are unable or unwilling to seek medical care or to go for testing. It is important that accurate documentation is carried out as this underlines the need to intensify efforts on HIV/AIDS prevention and management by presenting a true picture.

For the media to present a clear and representative picture of the disease, it is necessary that all facets of its impact be well understood and studied. On the economic front, public expenditure on health and welfare will be devoted to the control and management of HIV/AIDS. In Kenya, for instance, it is estimated that expenses related to HIV/AIDS is about Kshs 3,800 million. In 1992, as much as 15 per cent of all hospital beds were occupied by AIDS patients.

One of the most severe consequences of the disease is the loss of young adults in their most productive years, which translates into the loss of the most well educated and professional category of the population. Conversely, this affects human resource development, the size of the labour force, productivity and it negates huge investments in education and professional development. Productivity is affected by time spent on medical care as sick leave, higher medical expenses and the care of those affected by HIV/AIDS, as well as attendance of funerals. It is estimated that about 6,000 funerals are taking place daily in Africa as a result of AIDS (*The Sunday Nation*, Sunday June 13, 1999). At the community and household levels, AIDS at times claims the lives of productive people who have been contributing to the household budget or who have been breadwinners, which propels the households into poverty.

The effects of HIV/AIDS on the social fabric of African society, though difficult to quantify, are no less explosive than the economic ones. The stigma attached to the disease has led to discrimination and even violence against some women when they disclose their HIV status to their husbands. In addition, structures established for the care of the sick are over-stretched and women are increasingly burdened as they are traditionally charged with the care of the sick and ailing. For the girl-child, their future is jeopardized as they are sometimes withdrawn from school to help care for those who have AIDS and are at home. This is besides the fact that the number of orphans has increased and is set to increase if the epidemic is not arrested and managed effectively.

The media fraternity is not immune to HIV/AIDS as people who are potentially vulnerable to infection and as relatives and friends of those who become infected. Thus, they should be well advised like all sectors of society, to use existing tools (such as communication channels) to support efforts to prevent and manage the illness.

Communication and HIV/AIDS

The absence of a cure or vaccine for HIV/AIDS and the urgent need to reach people on the impact of the disease as well as the need to prevent it have resulted in the emphasis on mass education of populations. This inevitably means that effective communication approaches and strategies should be identified and applied to reach people in a way that affects them emotionally and motivates them to change their behaviour. Changing human behaviour is a concept and goal that has long eluded researchers and programme/project officers, since human beings are individually affected by different factors in terms of changing attitude and their behaviour.

It is crucial for the media and for those involved in media and HIV/AIDS prevention to understand the relationship between communication and HIV/AIDS. Various organizations have developed different communication models which they have used in training medical and social workers, programme/project officers, outreach and community workers, peer educators and counselors. In the AIDSCAP/FHI experience (1997), an effective communication model which affects behaviour change involves five steps: awareness of the problem; gathering of knowledge and skills by the target audience; motivation to take action; preparation for trial of the new behaviour; and the sustenance of the new behaviour.

In spite of the lack of consensus on how communication affects behaviour, a discussion on the subject is important, given the severity of the impact of HIV/AIDS and the centrality of the mass media as part of the communication process (Parrish-Sprowl, 1998). This discussion of necessity must lay emphasis on the fact that most communication efforts in development have not been as effective as desired because communication has not been integrated as a primary process at the level of conceptualization as noted by Parrish-Sprowl. The reality has been that communication is referred to as a last resort and it is frantically applied in the form of mass media campaigns without due regard to proper planning, implementation, monitoring and evaluation, and in total disregard of the need to make participation integral to the whole process. The existence of high awareness levels of HIV/AIDS in the absence of behaviour change indicates that effective communication approaches and strategies have not been developed and applied to support programmes and projects on attitude and behaviour change.

Attention in the planning and implementation of communication approaches and strategies is critical, given the sensitive nature of HIV/AIDS education, which requires that reference be made to sexuality. This complicates the process of education on HIV/AIDS generally and communication on the same in particular, because it demands an understanding of the reasons and motivation for specific sexual behaviour and relationships of different groups of people. For the mass media, the issue is even more delicate given the fact that the channels used are open to the public and the need to refer to cultural factors and good taste, especially with regard to adolescents and youth.

Background of the mass media in east and southern Africa

Various organizations in Africa have launched media programmes and projects using different channels, including the mass media and alternative media. It is important to study the history and context within which the mass media have operated to understand their performance so far. The mass media have attracted the attention of many practitioners of development because of their wide reach and in the case of broadcasting, their immediate reach. The first radio station was established in Kenya in 1924 in wireless service form and in 1953, the African Broadcasting Service was started with programmes in Kiswahili, Arabic and local languages. Broadcasting served the interests of the settlers and was an extension of what was happening in the "mother" countries.

The situation was different with regard to the print media where publications in English, Kiswahili and local languages proliferated in the 1930s, buttressing the nationalistic spirit and activities. In 1959, the East African newspaper

was launched by his highness the Aga Khan, while *The Kenya Times* newspaper was started in 1983 by the Kenya National African Union (KANU). *The East African Standard* had been established by the settler community in 1902.

Historically, most African governments took the opinion and model that the media were too important a resource and tool to be left in the hands of private investors. Thus, the media were viewed as being important to national integration and development as exemplified by Kwame Nkrumah's statement:

> "It is part of our revolutionary credo that within the competitive system of capitalism, the press cannot function in accordance with a strict regard for the sacredness of the facts and that the press, therefore should not remain in private hands." (Gadzekpo, 1997).

Although this goal is commendable, it has led to the shackling of the media through direct and indirect control by governments in most African countries. Until recently, most of the broadcast media in Africa were under the complete control of governments and the private press has had to deal with threats of de-registration, sedition and defamation cases and the destruction of equipment like cameras and printing presses. It has been noted that journalists have had to undergo arrests, detention, beatings, and confiscation of their publications. The legal and political environment under which the media operate has often been hostile, lacking in freedom, and thorny which further constrains their work (Mwagiru, 1998).

The prevailing scenario where the mass media are still under the control of the government is pathetic given the potential reach of the media. In Kenya, the highest selling daily the Nation, has a circulation figure of 180,000-200,000 with a reach of about 2 million readers (it is estimated that 10 people read one newspaper). Estimates of radio listeners in Kenya have been put at about 21 million making the radio an ideal medium for mass education and communication (Kiai, 1999).

The media also operate in the background where communication policies have not been developed or even defined. This means that most countries have not given thought to what priorities they should have as regards communication or what communication agenda they should establish. This has given rise to a situation where populations, especially those in the rural areas, have limited access to media channels, and where most people are not conversant with the way media operate and function.

In Kenya, political interference has for long haunted the media. While the restrictive single-party environment was reversed when Section 2 (A) of the Constitution was repealed in 1991, freedom of the press is yet to be fully achieved. The government still has recourse to laws and policies that enable it to threaten the press: such laws include high fines in the case of defamation, and room to disable printing presses. Human rights activists and media practitioners have over the last seven years been pressurizing the government to release its stranglehold on the broadcasting media. To some extent, some milestones have been achieved with the licensing of private radio and television stations. It has been observed, however, that those who obtain licenses are usually 'politically correct'.

Great discontent has been expressed at how the media cover development issues and this includes coverage of HIV/AIDS issues. Much of this can be attributed to a lack of awareness and knowledge on how the media operate and the constraints within their working operations. Musa (1996) has discussed the need to review and redesign the structure and ownership of the media. In his opinion, the structural areas of routine professional practices, profitability and survival have constrained majority empowerment by the media. These include time constraints and strict adherence to deadlines, as well as the notions of "impartiality" and "objectivity". Other obstacles include lack of adequate training facilities and the curricula in operation as well as ownership which set specific priorities and which demand a certain profit margin. The latter factor has led to a skewed emphasis on politics on the part of the media.

FUNCTIONS OF THE MEDIA IN HIV/AIDS PREVENTION AND MANAGEMENT

The primary aim of current mass education on HIV/AIDS is to reach those whose HIV status is negative to encourage them to retain this status; to support those whose status is positive to urge them to be careful so as not to spread the virus and to maintain hope through positive living; and generally to educate society as a whole to develop sustainable structures that will contribute to the prevention and effective management of HIV/AIDS. In communication, the focus has been on identifying methods of communicating messages on HIV/AIDS that will motivate individuals to change their attitudes and behaviour. Ways in which the media can support educational efforts on HIV/AIDS prevention present a vital question in these educational efforts.

The media have been viewed as being influential in building awareness across different sectors of society on HIV/AIDS and the importance of being careful in sexual behaviour and practices. While the media have been termed as having limited effects in attitude and behaviour change, there are experiences which have shown that their contribution can be invaluable and indeed highly powerful in determining behaviour change. The main strength of the media has been viewed as that of agenda setting, meaning that the sustenance of a topic for long in the public forum will lead to extensive and hopefully intensive discussions that spur some action on a given topic. This strength has attracted enormous attention in Africa, partly given the need to democratize authoritative structures and to redesign society for effective development. Besides the traditional role of the media, other functions can be categorized as:

- *Providing accurate, factual information on HIV/AIDS on a regular basis:*
  Although research has shown that there are high awareness levels on the existence of HIV/AIDS (over 90 per cent in some countries), some misinformation exists on the transmission patterns (for example, that mosquitoes can transmit the HIV virus), and on prevention methods. In Africa, one has to deal with myths and interpretation of the disease as a curse. The media can assist in correcting this by consistently referring to the transmission patterns of HIV/AIDS and the importance of going for testing and proper care of those who are infected with the virus. This is a method that has been adopted by the Kenyan press in the coverage of road accidents, which are especially high. Readers are always updated on how high the figure is and that this issue has not been dealt with effectively. As a standard procedure, articles on HIV/AIDS prevention could contain essential information and data as background, including information on where to seek assistance such as testing and counseling.

- *Humanizing the statistics and demystifying the epidemic:*
  As in most areas of specialized writing, media practitioners have to develop methods of putting a picture to the statistics that are being generated from epidemiological and medical research on HIV/AIDS. The bland presentation of the figures most of the time means nothing to the audience and particularly those who do not perceive themselves to be at risk. A case in point is that of a recent news article, which reported that out of 53 deaths in one parastatal organization, 40 have been from AIDS (*The Daily Nation*, June 9, 1999). A follow-up could be made on this kind of story by investigating how many organizations have similar experiences and placing this in holistic context to include the social, economic and cultural dimensions.

  For instance, discussing the global figure of those infected as more than 33 million people may be better imagined as the population of a country, or a city or a section of the population such as adolescents. This helps the audience to have a better picture of the magnitude and urgency of the situation and possibly to begin rumina-

ting over what effect such statistics may have. This is an approach that is being adopted in the training of writers in areas such as economics and environment, where the prevalence of statistical data has often appeared to be bland, dull and technical to journalists.

- *Presenting the opinion of the public on the disease:*
  Since the discovery of the disease, most governments have attempted to put in place programmes that will contribute to its prevention and effective management. These programmes have been established under the auspices of national AIDS and STD's control bodies and there has been tremendous work aimed at improving the capacities of hospitals and clinics in testing for the virus and in intensifying and developing better educational projects.

  The media can promote these efforts by frequently following up on cases of HIV/AIDS and on the experiences that individuals and communities have had in the programmes. As an example, there have been complaints raised in Kenya on the lack of counseling for those about to undergo testing and for those who are found to be HIV positive. Such sentiments can be discouraging to others who may understand the need to be tested but who then use this to justify their avoiding the test.

  Questions such as the levels of public involvement in the formulation of public policies and the methods of implementation need to be investigated as it is now clear that the beautiful policies that African governments have developed often have only a cosmetic value. The need to translate these policies into local languages and to simplify the "officialese" is an issue that the media can be involved in as this holds the policies up for public scrutiny. Such scrutiny can assist policy-makers to understand the impact or effects of their policies as well as the strengths and gaps in the perception of the public.

- *Educating society on the need for community-based structures in HIV/AIDS prevention and management:*
  Most governments in East and Southern Africa have medical care systems that have been inadequate in the care of HIV/AIDS. The medical communities have grappled for long with the control of diseases such as malaria and with the reduction of child mortality rates through immunization. The escalating figures on HIV/AIDS necessitates that other options be identified, developed and sustained since the health care systems are currently grossly inadequate for the care of HIV/AIDS patients.

  The community-based approach has been viewed as a solid and sustainable method of many development problems and issues. Such an approach, in this particular case, would seek to empower communities to develop home-based care of HIV/AIDS patients. This approach is useful in that it brings the issue of HIV/AIDS closer and it seeks to equip the community with the requisite skills while challenging its members to take the responsibility of the care of patients. In addition, the patients convalesce in an environment in which they are familiar and where there is some comfort.

  The media need to lobby for such approaches and to challenge societies to tackle HIV/AIDS head-on, rather than let people bury their heads in the sand. There is still a semblance of stigma attached to HIV/AIDS, and the media should be aggressive in supporting efforts to remove this stigma and in developing in the public the attitude that this is a disease like other disease.

- *Presenting a holistic picture of HIV/AIDS:*
  Most of the information on HIV/AIDS in the media is statistical and related to public statements on the trends. This is based on the current media structures and news values that tend to give prominence to public personalities. As such, most of the stories are government pronouncements on

HIV/AIDS which are primarily warnings and information on the extent of the spread.

It is on rare occasions that the mass media critically analyze the impact of HIV/AIDS on the socio-economic front. This contributes to the invisibility of the disease and the public lethargy in attacking the problem urgently. Society should comprehend well the consequences of ignoring the impact of the epidemic, such as the threats to the socio-economic fabric and structures. The media are well placed to undertake such a task, but this needs to be a deliberate policy on the part of media organizations.

- *Advocating for accountability and responsibility in the HIV/AIDS prevention and management sector:*
The desperation on the part of HIV/AIDS patients in seeking treatment for their infection has given rise to a sharp increase in "medical experts" who claim to have a cure for the disease. These patients are vulnerable to unscrupulous experts who are out to gain from their plight. Some of the medical associations like the Kenya Medical Association (KMA) have been keen cautioning the public on seeking treatment that has not stood the test of rigorous examination by the medical and scientific fraternity.

The vulnerability displayed by HIV/AIDS patients indicates that a gap exists in the provision of treatment that society can trust or depend on. Thus, it is easy for some to exploit this gap. This raises the issue of the lopsided nature of treatment at the global level: those who are infected with the HIV/AIDS virus in the developed world have some hope and they live longer because of the new combination therapies. Those in the developing world have little hope because of the expense and inaccessibility of such treatment.

This highlights the issue of public health care systems and their management as well as the need to encourage local scientists to develop treatment that can be available to local populations. At the global level, the issue of lobbying for support for the provision of new combination therapies should be pursued in the media and sustained. When some "experts" announce that they have discovered new treatment, they should be held up to public scrutiny and their claims verified thoroughly. The media should analyze critically such trends and also bring into the public arena for public debate such issues. For instance, it would be interesting to investigate whether pharmaceutical companies, which import combination therapy treatment, can be exempt from taxation by governments to make them cheaper for the public.

Experiences on media and HIV/AIDS prevention and management

Various organizations have established programmes and projects on media and HIV/AIDS prevention and management; these experiences differ in terms of results and findings. In the Democratic Republic of Congo, for example, Population Services International (PSI) initiated a project in collaboration with the National AIDS programme and funded by USAID Kinshasa (PSI, 1992). The project targeted the youth aged 12-19 and prospective parents who were 20 to 30 years of age. The project was based on the country's rich tradition in music and drama and sought to communicate the message of safer sexual practices. Thus, media materials were developed and messages conveyed through broadcast announcements, music, video, talk shows, interviews and contests.

Evaluation of the project indicated that positive attitudes evolved and that there was intention to practice safer sexual behaviour. There was evidence of increased awareness regarding asymptomatic carriers; increased acceptance and reported practice of abstinence and mutual fidelity and increased knowledge and accepted use of condoms for AIDS prevention.

In Tanzania, the World Bank initiated a project which focused on radio spots. The project included posters/calendars, cartoons, newspaper flashes, and counseling. Similar use of mass

media is evident in Malawi and Zambia with an emphasis on radio spots and use of radio programmes. In Kenya, a project was initiated based on a 1992 needs assessment by the National Council for Population and Development (NCPD) and the Family Planning Association of Kenya (FPAK) with support from John Hopkins University Population Communication Services (JHU/PCS), which targeted adolescents. The project, which was funded by USAID, featured media activities such as radio programmes, print media and a letter answering service. The radio programmes included a talk and the provision of a forum for the youth to question HIV/AIDS experts on the programme. The programme was designed as a variety show with the requisite musical background (Nduati & Kiai, 1996).

A media project that originated in Uganda and which has been adopted in Kenya is that of the *Straight Talk* newsletter. This project was launched by the Ministry of Information, Uganda AIDS Commission, the Save Youth from AIDS, and UNICEF. The newsletter, which began in 1993 and which is issued once every month as an insert of *The New Vision* newspaper, initially laid emphasis on sexuality. This, however, broadened to encompass health and psychological issues (Nduati & Kiai 1996). The mushrooming of youth clubs in Ugandan schools has been attributed to *Straight Talk*.

Some of the constraints cited in the use of mass media include limited media coverage of radio programmes and structural difficulties in coping with issues raised by adolescents during radio programmes. This is because the programme usually has a particular focus, but the adolescents at times call in on a different subject requiring urgent assistance. Other needs identified have been on the need to use local languages, and for greater collaboration with media houses to ensure greater communication on HIV/AIDS prevention and management issues. In addition, there is a need for the incorporation of greater creativity and diverse structures in programming, and more effective cooperation with stakeholders such as parents, health officials and education officials.

PROPOSED STRATEGIES FOR MORE EFFECTIVE MEDIA EFFORTS ON HIV/AIDS PREVENTION AND MANAGEMENT.

While the media have been faithful in the coverage of issues related to HIV/AIDS prevention and management, deliberate and well designed efforts aimed at promoting better communication through the media have not been adequate. There have been meetings organized in East and Southern Africa aimed at raising media practitioners' consciousness on the need to cover HIV/AIDS prevention and management issues more intensively and widely. Additional work could focus on the following strategies:

Training media practitioners in the basic concepts of HIV/AIDS

There is no doubt that there are high awareness levels of the need for greater and more effective coverage of HIV/AIDS on the part of media practitioners. This situation is akin to that of high public awareness but minimal behaviour change for most countries in sub-Saharan countries. Seminars and workshops should be re-designed to ensure that the media adopt a pro-active approach in the coverage of HIV/AIDS prevention and management issues.

A method that has been used recently by the Kenyan Chapter of the African Council for Communication Education has been to ground interested journalists in the basic concepts of specialized subjects. This has been applied in relation to the environment and there is evidence of greater interest among the journalists. This method is beneficial in that it demystifies concepts that may appear to be difficult and technical to the journalists, thus equipping them with confidence and creating an interest for further research and reading.

Despite this interest, constraints exist in the use of this approach. A much ignored but significant category of the media are the editors. In the meetings with journalists, they have expressed their frustration at following up on specialized issues which are "spiked" by edi-

tors. Editors should be sensitized on the need to have more effective coverage of HIV/AIDS prevention and management issues. Innovative approaches are required, however, because logistically, it is difficult to get editors who are often media managers at one sitting or meeting.

Advocacy and lobbying for regular allocation of space in the mass media

This strategy has been well applied by human rights and democratization activists. In the Kenyan press, for instance, it is now common to have specialized writing on human rights and political issues, sometimes by experts from these areas. This trend has been realized by lobbying for space for the coverage of such issues, but more importantly by commitment on the part of these organizations in ensuring that the space is used regularly. Most editors are willing to allocate space for columns, but they require full commitment that the space will be used.

Some of the columnists have taken up the writing as a part of their crusade, while others have been supported by donor agencies. Organizations involved in HIV/AIDS prevention and management can develop a pool of writers or a syndicate where there is shared responsibility for the columns.

Publication of reference materials for the media

Media practitioners often complain that there is little reference material developed for them as an audience on specialized subjects such as HIV/AIDS prevention and management. The structural constraints within media houses are an obstacle for journalists who would like to specialize in technical areas as it is a laborious effort identifying and accessing relevant and essential background material. One effective strategy would be to develop materials which simplify basic concepts on HIV/AIDS prevention and management, such as the epidemiology, socio-economic impact, and trends in scientific, medical and social science research in the area. Journalists then have a text, which they can refer to as a quick reference. The Zambian Institute of Mass Communication (ZAMCOM) has developed a resource book for the media on HIV/AIDS, and there are plans to replicate this effort in other countries in the East and Southern region.

Another required publication would be an inventory of organizations and experts involved in this area in each of the countries in East and Southern Africa. This is useful as a publication that can be easily accessible to all journalists who require specific information and credible sources whom they can interview and seek opinion or clarification from.

Establishment of a network on media and HIV/AIDS prevention and management

Networking as a strategy has fast gained credibility in most development work in East and Southern Africa. The idea has proved to be effective in that there is shared information on emerging trends, constraints and challenges and on strategies to deal with these. Such a network in this case would seek to sustain contacts between the media and experts working on HIV/AIDS prevention and management.

Contact between the different groups of specialists may serve to reduce or remove suspicion of each other and to create understanding of the working environment in which each works. The media have often been accused of being casual; most of these accusations are based on a lack of understanding of how the media work and the constraints they face. Similarly there has been the public perception that scientists are locked up in their lofty and ivory towers, isolated from society, "spewing" technical jargon that cannot be understood by the ordinary citizen.

Networking would help the media to put a face to these scientists and to explain to the public through coverage, the emerging trends on HIV/AIDS prevention and information. An additional benefit of this would be the development and maintenance of sources for journalists for their articles and programmes on HIV/AIDS prevention and management.

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PART II

INVESTIGATIVE REPORTING ON CAUSES AND SPREAD OF HIV/AIDS: CASE STUDIES

HIGHLY MOBILE POPULATION DRIVES THE SPREAD OF AIDS IN KENYA

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BACKGROUND

Kenya covers an area of approximately 569,000 square kilometres out of which 11,200 square kilometres are covered by inland water. Only about 20 per cent of the land is arable, the rest being classified as arid and semi-arid land.

These geographical conditions have led to a concentration of Kenya's 29 million strong population in the central and southern parts of the country where population densities average 47 people per square kilometre but reach 230 persons per square kilometre in the most densely populated areas while northern Kenya has areas averaging only three persons per square kilometre. The incidence of the AIDS epidemic relates directly to population densities with incidence of the disease found to be highest in Nyanza, the Western provinces and the Central Province. By 1997, up to 30 per cent of all Kenyans lived in urban areas where the majority do not have access to proper sanitation, and the demand caused by an average yearly growth rate of 2.6 per cent has strained services.

The *World Development Report for 1998/99* lists the Gross National Product as US $9.3 billion (Kenya shillings 604.5 billion) with an average annual growth rate of 2.3 per cent and Gross Domestic Product of US $9.89 million. Indicators for the quality of life are poor with child mortality resting at 90 per 1000 births. Nearly one in every four children under the age of 5 suffers from some degree of malnutrition. Life expectancy at birth is 57 years for men and 60 years for women. Adult literacy is 70 per cent for women and 86 per cent for men.

Forty per cent of the population live below the poverty line, and the situation is worse in rural areas. Distribution of income and consumption is staggered disproportionately towards the rich with the richest 10 per cent consuming 47.7 per cent while 80 per cent of the population share out 37.8 per cent among themselves. The widespread poverty in Kenya has created conditions in which people are constantly on the move in search of better living conditions and this has implications for the spread of infectious diseases including AIDS.

MOBILE POPULATION AND THE SPREAD OF AIDS IN KENYA

Even in the semi-darkness of dawn there is movement. Busia Town on Kenya's western border with Uganda is already alive with activity as people carry their wares towards the "Bus Park" open market where they hope to make a little money.

Many come from the nearby Sophia Estate while an equally large number have crossed the border from Uganda travelling early to avoid the clinging humidity that will soon trap everything. Paul Wanyama has carried beans and groundnuts from Uganda while his colleagues bring in second-hand clothes and electronics as well as grains. In the evening they will carry home salt, cooking oil and soap to sell on the other side of the border. Sitting next to him and protected from the swelling heat by a perforated sheet of polythene hung on three sticks is Michael Wegesa who makes his living exchanging Kenyan and Ugandan currency.

As the market and shops open for business, traffic flowing into the Town increases rapidly and traders are kept busy by a constant flow of enquiries. The high mobility of people in Busia is typical of busy border regions and areas to which people are attracted and brings into play unique conditions that encourage the spread of AIDS.

"When you think of a border town, there is a lot of movement in and out," says Maureen Ong'ombe of the Kenya AIDS Non-governmental Organizations Consortium, KANCO. "Border towns are a good example of possible impacts of mobility. They tend to be cosmopolitan with a mix of people interacting on different levels many of whom are only there temporarily," Ong'ombe, who works as Communication Officer for KANCO, says.

There tends to be more money in circulation, which encourages an active social life as is evident from the loud music that spills out of the numerous bars and lodgings and hotels in Busia Town. Along the main street it seems that every other shop is a bar and lodging and as early as 10 a.m. patrons are in evidence. Little information exists to link mobility directly with the spread of AIDS in the town and the surrounding Busia District, but infection rates for the District are estimated at 30 per cent of the population and are among the highest in Kenya. Nationally, the highest infection rates are found amongst working men who have money and are mobile.

Mary Makokha works with people with HIV/AIDS in Butula Division of the District and believes migratory patterns do impact on the incidence of HIV/AIDS, changing coping methods and social attitudes to sexuality. People usually leave their homes in search of better economic opportunities, some travelling only a short 10 kilometres to settle in areas where it is easier to find jobs or to trade while others travel further. In the case of Busia, Makokha says they come from both sides of the border and have intermarried and interacted to such an extent that it is difficult to define people by nationality.

In their new context, different lifestyles and coping methods emerge. Makokha, who co-ordinates the Rural Education and Economic Enhancement Programme [REEP] in Butula, Busia District, says promiscuity coupled with alcoholism is deeply rooted. This, she says, leads to risky sexual behaviour and high HIV infection.

"In almost every house in this Division there is someone with AIDS."

Movement between rural and urban homes even within a restricted area like Busia District is now frequent and may explain the rapid increase in HIV infections. Mobility associated with migration is usually temporary; people leave their villages hoping to find seasonal or temporary work but always hope to return home. Despite moving to town, migrants tend to keep in touch with their families and friends at home, ensuring regular contact especially over weekends and holidays and an infected individual may spread HIV/AIDS to others at both ends of the chain.

Fred Majani, a counsellor with REEP, is living with HIV and he believes his experience demonstrates the reality of many people from the area. After graduating as a clinical officer he took up a posting as a district health officer in a neighbouring district. In this way he believed he would remain close enough to be home every weekend with his wife who looks after the home in Busia and still be within easy reach of his work station where he earned a living. During this period he had several relationships with women and he believes one of these resulted in his infection which he passed to his wife.

Mobility linked to urbanization has long been recognized as a factor in the spread of AIDS in Kenya but little has been done to understand the enormity of it, the vulnerability it creates and its impacts on the lives of people. Without this understanding, it is impossible to define prevention strategies which work. In 1960, only 7 per cent of all Kenyans lived in urban centres but this number has risen to 28 percent of Kenya's 29 million people and is largely attributed to economic factors [UNFPA, 1998].

The capital, Nairobi, for example, has experienced rapid growth rising from a population of 343,500 at independence in 1963. "During the last National census in 1989, the population of Nairobi was recorded to be 1,324,570 with a total male and female population of 752,597 and 571,973 respectively," says Nairobi Mayor Councilor Samuel Mbugua. The Council now estimates the popula-

tion of Nairobi to be over 3 million with a growth rate of 6%, more than half of whom live in slums. While a population growth rate of 2.6 has played a role, the urbanization process in Kenya is largely attributed to rural-urban migration. Young school-leavers in search of employment and other opportunities in the urban centres are the most dominant migrants. It is in the slums on the periphery of towns where many of those who migrate from rural areas end up. The lucky ones find employment at minimum wage while those who are not as lucky find themselves trapped in poverty without the means to travel back to their homes and restricted hope of ever leaving the slums.

Ann Njoroge works with people living with HIV/AIDS in Korogocho slums on the eastern side of Nairobi. The Eastern Deanery Aids Relief Program of the Catholic church provides medical, psychological and spiritual services and Njoroge says 68 per cent of the 4,000 people currently in the programme are single mothers with children. Most of them came to Nairobi looking for economic opportunities.

"Many of these women are alienated from their rural families for a variety of reasons," explains Njoroge who says one of the aims of the programme is to reconcile these mothers with their families. "To date we have managed to reconcile almost 170 families and this helps to put the mothers at rest by allowing them to plan for their children with their families before they die."

Alienation from rural families has reached critical proportions as Ann Owiti, coordinator of a community-based programme for AIDS orphans and their families in Kibera slums, knows too well. The Kibera Community Self-help Program (KICOSHEP) which Owiti coordinates is based in Mashimoni, one of 13 villages that constitute Kibera, the giant slum in the heart of Nairobi. Kibera is home to an estimated 850,000 people who, in common with most poor communities world-wide, have had the social and economic systems on which members of the community depend for their survival, challenged and stretched to capacity by AIDS. Ironically this comes at a time when the government of Kenya is encouraging community-based care, based on the context of the extended family to care for people living with HIV/AIDS.

"It is important to understand that relationships in the slum are borne of need and practicality," says Owiti, explaining that those who end up in the slums usually did not plan their lives to turn out this way and most only intend to be there temporarily.

"A man working as a night watchman in the city might enter into a relationship with a woman simply to ensure that he has someone providing security for his house while he is away," says Owiti. In exchange, the woman gets food, shelter and a measure of protection for herself. It is not uncommon for men living in such arrangements in the urban centres to leave behind wives in the village.

The fact that slums are inherently unhealthy places with lack of access to running water and stinking open sewers, no electricity, no roads, high crime rates, over-crowding and limited access to health facilities only aggravates the risks. These factors also make it difficult for those planning AIDS interventions to reach populations living in these areas. The result is that Kibera, said to be the largest slum in sub-Saharan Africa, has a high incidence of HIV/AIDS estimated at 25 per cent and growing. Currently the KICOSHEP programme serves close to 700 children orphaned by AIDS but hundreds of others cannot be reached.

Attitudes towards sex have definitely changed. Achola-Ayayo (1998) conducted a study on sexual practices and risk of the spread of AIDS and found that three quarters of interviewees in urban areas no longer believe in cultural values that restricted sex before and outside marriage. This is strong evidence that social, cultural and economic changes have taken place with rapid urbanization.

With an average population growth rate of 2.6 per cent, the population of Kenya was expected to reach 50.2 million by the year 2025. Revised projections released recently, however, suggest that the AIDS epidemic could stabilize the population at 32 million in 12 years time at

which point population growth will have slowed to 0.6 per cent because of HIV/AIDS.

Busia represents a microcosm in its own right but also features significantly in the pattern of spread of the disease in Kenya. Busia is the most westerly point of the Trans-Africa Highway in Kenya. The Highway begins at Mombasa seaport and cuts a swathe inland to serve six land-locked countries. Everywhere the Highway goes the epidemic follows and the same patterns appear to hold along other significant road networks.

Towns with the highest recorded incidence of HIV/AIDS include Nakuru, Kisumu and Nairobi at 20-30 per cent, followed by Mombassa, Kakamega and Thika with a prevalence of 10-20%.(Kenya, Mulindi et. al., 1998). With the exception of Thika, all these urban areas are also major truck stops on the Highway. Thika, on the other hand, is a rapidly expanding industrial centre and has in recent years attracted droves of people from all over the country who come in search of employment.

Boom towns have grown around the truck stops with many sex workers to whom the truck drivers and their assistants may turn while away from their spouses.

Although they are not counted as migrants, long distance truck drivers are of particular concern because they are at high risk and can spread HIV/AIDS and STD's long distances. They travel frequently, often through urban areas with high levels of HIV and because they are away from home for long periods of time, they tend to have many different sex partners.

A 1994 study showed that about one half of truck drivers arriving in Rwanda from Mombassa and Nairobi, Kenya, were HIV positive. Another study of 200 adolescents who frequent truck stops in Kenya found that half the boys and one third of the girls reported having had at least one STD indicating early sexual activity and hence vulnerability to HIV and AIDS. Studies have also supported the theory that the geographic distribution of HIV and AIDS reflects a diffusion process in which major roads act as principal corridors for the spread of the virus between urban areas and other proximal communities. One such study of truck drivers and their assistants found 1/3 to be HIV infected and there was evidence that they had travelled widely within six countries served by Mombassa Port including Kenya, Uganda, Tanzania, Zaire, Burundi, and Rwanda.

As early as the mid-80s, scientists had shown a series of epidemics among sub-populations with varying levels of risk. Data from a study led by Dr. Peter Piot showed clearly that HIV infection in Kenya spread first and most extensively to Commercial Sex Workers (CSWs). This was followed by STD clinic patients likely to include clients of CSWs and finally to the general population as evidenced by slow and then accelerating spread among pregnant women. This led to interventions that directly targeted truck drivers, CSWs and later to other groups classified as "high-risk" such as beachboys, watchmen, soldiers and prisoners, targeting the distribution and use of condoms and education on how HIV/AIDS is spread. The piece-meal targeting of high-risk populations has had some success but has not addressed the whole phenomenon of mobility, the vulnerabilities it introduces and the impact on the spread of HIV/AIDS. Part of the problem is technical.

"It is a subject that is difficult to research because of the very fact of the mobility of the people," says Maureen Ong'ombe of KANCO. The study group would be constantly changing and migration, being such a temporal phenomenon, would raise questions as to the validity of these studies. She says this is further complicated by attitudes towards the whole issue of sexuality as a private matter. "People tend to tell you what they think you want to hear and study results would not be authentic unless the researchers cultivate a long-term relationship with members of the study group."

In the case of migration, mobility is largely driven by the quest for a better economic potential. Nothing demonstrates this process as clearly as the relationship between the spread of HIV/AIDS and the military.

Prior to the establishment of a military base at Gilgil, about 120 kilometres to the west of the

capital Nairobi, there was little to draw people to this small town. Although the town rests on the trans-Africa highway, truckers and other travellers preferred to stop in Naivasha and Nakuru where tourist attractions had helped to establish thriving urban centres. Once the military barracks was set up in Gilgil things changed.

"People recognized military officers as people with money, and they set up all sorts of businesses around them," says Major Samuel Ndegwa, who is involved in HIV/AIDS programmes in the military. Commercial sex workers were among the first group attracted knowing that the military is mostly made up of salaried and unaccompanied men who would, therefore, be more vulnerable to sexual advances. The liberal availability of alcohol in the camp did not help matters.

Ndegwa says the isolation of soldiers from family and friends coupled with their high mobility are critical issues that have encouraged the spread of HIV/AIDS among this population, and national borders do not limit the movement of soldiers either. "Our soldiers have served on UN Peacekeeping missions everywhere... Yugoslavia, Jordan, Namibia, West Africa and all over Kenya" he says.

"These people have feelings and needs just like you and me. When they are taken away from their wives and girlfriends for even a whole year without a break, what can we expect?"

The links between CSWs and military officers have roots in history. Margaret Gatei of the National AIDS and STDs Control Programme (NASCOP) in the Ministry of Health recounts that the famed Pumwani sex workers are descendants of a group of military camps. These women are currently part of a study which aims to understand their apparent resistance to HIV/AIDS.

The extent of infection in the military is considered high and has led to the establishment of several HIV/AIDS prevention programmes. One of these is the Civil-Military Alliance to Combat HIV and AIDS, a regional network of military organizations which the Kenya Armed Forces are part of. This programme aims to encourage prevention, advocacy, policy debate and programme development in military and defence forces.

People in crisis: Refugees and the internally displaced

Sessional Paper No. 4 of 1997 on AIDS in Kenya says the influx of refugees from different countries in the region has had a negative impact on the AIDS situation in Kenya. There are a number of "permanent" refugee camps in Kenya, most of them located in the North East and North West of the country. In the North East there are three camps, one near Dadaab and two others in Garissa Town. They are home to about 119,000 refugees mainly from Somalia.

In the North West is the UNHCR Kakuma Camp near Turkana housing about 51,000 refugees mainly from Sudan, Ethiopia and Somalia. There is also a camp at Lokichoggio close to Kakuma. Thousands of other refugees who have been able to obtain residency papers live and intermingle without hindrance alongside the rest of the population while others remain among the nameless, faceless unregistered population. Thousands of local and expatriate employees have moved into Lokichoggio alone to provide assistance to the refugees while many others use the town as a base for conflict resolution and development activities targeted at South Sudan.

The Sessional Paper, adopted by Parliament on 25 September 1997 to guide organizations and institutions addressing AIDS in Kenya, says: "the need to collaborate with other agencies is critical. The government will collaborate and work closely with UNHCR to mount preventive education programmes and provide health and social support to those infected with HIV". Beyond this broad statement, nothing is said of what needs to be done and who should be involved or what interventions should be put in place. To date, much of the work of rehabilitation and repatriation has been left to the United Nations through the High Commission for Refugees which has for some time recognized HIV/AIDS as a serious problem requiring a strategy.

UNHCR says the majority of HIV infections in refugee situations are sexually transmitted. "The disintegration of community and family life leads to the break-up of stable relationships and the disruption of social norms governing sexuality."

"Interaction between the refugees and local population is likely to happen and hence the need to provide service to all. Failure to do so would be counterproductive in terms of preventing the spread of STDs and HIV," says a UNHCR report. "A major lesson of the AIDS pandemic so far has been that HIV spreads faster in conditions of poverty, powerlessness and social instability – conditions that generally prevail for refugees."

Refugee populations are recognized by the Kenya government as being particularly vulnerable but there is silence on which government organs or individuals are expected to co-ordinate and follow up on recommendations as well as the means and resources. Programmes undertaken by UNHCR have understandably been preoccupied with providing refugees with the basic essentials although HIV/AIDS programmes are now part of the parcel. It is clear that greater linkage may be necessary between UNHCR and the national programme on HIV/AIDS prevention if both are to realize their goals and the mandate and the policy framework may need to be expanded to include other areas.

Related to the refugee mobility is the largely ignored plight of the internally displaced within Kenya. The international community says primary responsibility for their safety and assistance lies with their own government which has not responded adequately.

Since there is no one agency within the UN with overall responsibility for the internally displaced, a number of different UN agencies have been designated on an ad hoc basis by the UN Secretary General to administer programs for the displaced including UNHCR, UNDP and UNICEF.

Ahead of the 29 December elections held in 1997, four of the six districts in the Coast Province to the east of Kenya experienced violent raids by armed gangs operating under the umbrella of Association of Pwani Peoples who claimed to be on a mission of ethnic cleansing. The four districts, Mombassa, Kwale, Taita Taveta and Kilifi, have a population of about 1.9 million people including a significant population of people who have migrated to the area in search of work in the lucrative hotel industry. It is these people from "up-country" who the raiders were said to be targeting.

More than 70 people were killed in the skirmishes and at least 5,000 people sought refuge in church compounds in the area while the majority of victims found shelter in the homes of relatives or friends and other safer areas of Mombassa. Many others, especially women and children, moved back inland to live with extended family and friends in their places of origin. These people are more difficult to identify but based on the original population of the affected areas the total number of people directly affected by the violence and terror may run to 100,000.

These are not the first cases of internally displaced people. An estimated 350,000 people were displaced by the ethnic conflicts of 1992-1995 which affected three of Kenya's eight provinces – Rift valley, Nyanza and Western Provinces. Many of these people have yet to return to their homes for fear of repeat attacks.

Lucy was, until 1997, a resident of Mishoromoni in Mombassa. "Before I came here (Mombassa) I used to live in Narok at a place called Maela. We were also chased away from there in 1993," she says referring to the Rift Valley clashes. "I have lived here for about 18 months and now I have to move again," she says ponderously.

Many of those displaced from the Rift Valley fled to Nakuru, the largest town in the Province, where they have started self-help groups and small development projects such as tree planting and kitchen farming as well as tailoring and carpentry. They have also started an AIDS awareness campaign after noting a shocking increase in the incidence of the epidemic among their population. Infection rates for Nakuru shot up from 10 per cent in 1990 to about 25 per cent in 1997.

Frederick Ndungu Njenga, Coordinator of Griss Self Help Group based in Molo Town, 40 kilometres west of Nakuru, says the area faced

serious socio-economic crisis following the sudden and large influx of people fleeing ethnic clashes.

"Most of those who came to Molo are young people and women without meaningful employment, technical skills or the means to generate an income," Njenga adds.

He says they have not received much in the way of assistance and they are not recognized as a "real" community and so development activities were not targeted at the community for some time. The hard circumstances forced many into sexual relationships for emotional reasons as well as for money and the number of HIV/AIDS soon began to show up among the 400 women and more than 300 youths over the age of 15. Griss, formed in 1992, has increasingly had to face the burden of addressing the spread of the epidemic within the community and with support from several other organizations, introduced home-based care and health education programmes particularly among the youth.

A similar story of violence and social disruption is told in Isiolo District, in mid-Eastern Kenya.

"They attacked my family and stole all my property, including the ugali that was cooking at the time of the attack," a victim of banditry reportedly told the development organization, MS Kenya. "They also raped my wife, daughters and even my sons. Later the same night, they attacked my neighbour just before killing another neighbour who tried to come and save the situation." "I have finally decided to shift from my house to town and all I can say is: I am a refugee in my own district."

Isiolo District covers an area of 25,605 square kilometres. It is part of what was formerly known as the Northern Frontier District, a semi-arid mass of land transforming itself to the Chalbi Desert in the north of Kenya. The district is home to about 100,000 people, most of them nomadic pastoralists representing five major ethnic groups – Borana, Meru, Turkana, Samburu and Somali Rendile.

Since colonial times, banditry has been synonymous with the lives of the people in this area and in much of North Eastern and Eastern Provinces of the country, who were largely ignored by development efforts. Cattle rustling, which is traditionally part of the culture of many pastoral communities, has in recent years taken on a more violent character.

"They (attackers) take their time to gang rape their victims in the presence of the whole family," says a report compiled by the Kenya Human Rights Commission (KHRC) and MS Kenya. "In almost all cases, victims report the incidents to the local police station but it's only in a few cases that any action has been taken."

Khadijah Adam, an AIDS counselor at Pepo la Tumaini Jangwani, a community-based care programme for orphans and people with AIDS, says the systematic use of rape as a weapon is responsible for the spiraling incidence of AIDS in the area. Barely five years ago, Isiolo was among areas regarded as having a low incidence of AIDS with less that 1 per cent infection rate. Now it is categorized among 29 districts with "medium prevalence" falling in the 10-19 per cent range. Currently Khadijah works with seven women's groups whose members are living with AIDS and she says there are many more.

Those families displaced to urban centres by the violence find themselves without money or any assets and both children and adults may be coerced into sex for basic needs including food, shelter and security as well as for money.

"Some residents of Manta and Maili Saba suburbs have abandoned their homes and have sought refuge at Pepo la Tumaini Jangwani."

"Peter" says he abandoned his farm after being attacked four times. During the last attack he and his wife were raped and all their household items stolen.

It is clear that steps need to be taken to introduce intervention programmes designed to address the unique conditions in situations arising out of civil conflict if Kenya is to meet the stated policy of "building a national response to the epidemic". To date there have been few attempts to understand why and how civil conflict and similar complex emergencies

affect the risk of HIV/AIDS or to identify the reason why vulnerability increases in these situations.

Tourism

Despite its decline in recent years, the tourism industry is still one of Kenya's biggest revenue earners. At its peak in 1996, Kenya attracted close to one million visitors a year earning up to US $500 million. Tourism contributed as much as 10% of the GNP (1996). All government efforts are directed at ensuring that Kenya becomes a primary safari destination and that the number of tourists is increased. Targets are set at attracting 2 million visitors annually and to this end infrastructure including roads, provisions for air travel and all other means of transportation.

Now the government has an aggressive international marketing campaign in place and because tourism is so critical to the economy, to a large extent it determined the denial, which was the first response to the epidemic.

"There is still denial in this country. Initially it was because some people thought that talk of AIDS was sensational and would hurt the tourism industry," says Ong'ombe. She says attitudes are much more practical now but there remains an assumption that awareness among tourists should be the responsibility of their home country; other than placing condoms within easy reach, nothing is done to address the campaign towards tourists. Nowhere in national plans and policies looking at tourism is HIV or AIDS even mentioned. Although no research has been conducted locally to examine the impact of tourism on HIV/AIDS, studies from other tourist destinations around the world indicate that interaction between tourists and local populations represents high risks for those involved.

These studies indicate that tourists generally do not consider themselves to be at greater risk of infection while on holiday than at home and most tourists respond positively to HIV/AIDS prevention campaigns. Factors such as loneliness, freedom from familiar strictures and ignorance of AIDS and foreign customs all contribute to the increased possibility of HIV transmission, especially among young people who travel. Often they do not understand the risks posed in a foreign society. This ignorance is compounded by the ignorance and lack of understanding in the local population, and is particularly true for hotel employees and those in related service industries including commercial sex workers who often follow the tourist trail.

"When the tourist ships are reported to be docking by the media, there is an influx of CSWs to Mombassa Town," says Esther Gatua of KANCO. Currently a programme at Mukomani Clinic in Mombassa is working with CSWs to understand the problems posed by HIV/AIDS. All the sex workers in the programme are required to have a certificate which they show to all partners indicating that they have been screened for HIV and STDs within the current month. No corresponding AIDS prevention campaign exists for other workers associated with tourism.

Until he fell sick, Wafula worked for six years in a small hotel in Malindi. A strong imposing man with a hearty laugh, Wafula augmented his meagre salary by indulging the sexual fantasies of women tourists who paid him to have sex. In 1997 he was diagnosed with AIDS and though at first able to pay his medical bills, illness eventually forced him out of the job and he returned home where he died of tuberculosis in 1999.

At age 18, Christine Nyambura had just left high school and was lucky to find employment in Nakuru in one of the better-known hotels. A huge box of free condoms had been placed in front of her at her station in the reception and clients as well as co-workers often teased her about it or made suggestive remarks. Tired of dealing with the comments, Christine eventually moved the box to a less obtrusive position and forgot about it. Today, she wishes she had bothered to think about the reason why the condoms were placed there.

Christine was infected with HIV in 1996 and is saddened by the fact that she had the

means to protect herself right under her nose.

"I just didn't think that the condoms had anything to do with me," she says. All the messages she had received on HIV/AIDS sounded as though they were geared to women involved in high-risk relationships. She and her boyfriend were in a monogamous relationship and although he had relationships before that she was aware of, this was the first time she had been sexually active in a relationship. Her boyfriend who also works in tourism had been carrying the virus and had unknowingly passed the infection to her.

"I realize now that being in a new place where everyone was essentially a stranger meant that any relationship I entered into would be risky," says Christine. "It's not like when you live in a village where you know everyone and you know their behaviour. You can literally recount what they do and who they were with every day."

Christine feels health education messages need to consider the changing realities of people and advise them that risky sexual relationships are not only those in which prostitutes are involved but also those that take place in circumstances where there is any form of doubt. More emphasis should be placed on encouraging voluntary testing by everyone entering a new relationship and less emphasis should be placed on labelling people as belonging to high risk groups such as truck drivers and commercial sex workers. "We are all at risk at some time or another," Christine insists.

Despite cases like Wafula's and Christine's, little mention is made of AIDS in relation to tourism in Kenya's policy framework documents. It appears to be assumed that visitors to Kenya, most of who are from western countries and Japan, have already been sensitized to AIDS and the means of avoiding it and are therefore at low risk. R.A. Obudho, Editor of the *African Urban Quarterly* noted this presumption. "If you trace the progress of this disease, it came in from the west," he says adding that the annual introduction of three-quarters of a million visitors should not be ignored and must be part of the national strategy addressing AIDS.

"The regional impact of tourism is highly concentrated with the coastal area being by far the biggest and this in itself has implications," Dr. Sobbie Mulindi of Patient Counselling Services at the largest referral hospital, Kenyatta National Hospital, explained. In the same context, thousands of Kenyans travel abroad each year and both their information and medical needs must also be addressed.

Mobility and gender

An interesting aspect of the mobile populations in Kenya is the distinct gender breakdown. More men than women tend to migrate to cities like Nairobi and other urban centres where they can find work, leaving women behind in the villages in the case of rural-urban migration. As can be seen from population figures for Nairobi, the societies to which people migrate as well as those left behind are distinctly polarized according to gender.

Similarly, truck drivers leave behind their wives. In the case of refugees, the bulk of those in refugee camps and the internally displaced are women and their children while men remain behind on the battlefields or seek out new means of survival. Within urban areas similar patterns are recognized and documented. Women tend to be over-represented among the urban poor and in slums, although they are often in the minority when the whole population is considered.

The polarization predictably leads to new coping mechanisms and the breakdown of social norms, especially those governing sexuality, and results in increased vulnerability to risky sexual behaviour and HIV/AIDS. In addition to social trends brought on by human mobility, there are also important changes in the structure of families with an increasing number of homes where women are the head of the family. A significant number of women (24.2 per cent) never marry but do have children, according to studies conducted by the United Nations. Most of these women concentrate in urban areas where such norms are considered acceptable rather than in rural

areas that still tend to frown on single-mothers. They often have different sexual partners over the years.

Conclusion

To date, efforts in Kenya to control the spread of HIV/AIDS have concentrated on health education and awareness creation about the disease based on the knowledge that it tends to spread fastest among people who engage in risky behaviour. Almost the whole population has been reached with information on AIDS and studies have shown that knowledge about the disease is widespread. However, this has not encouraged people to change their behaviour.

"Despite having information at hand, people continue to put themselves at risk on a daily basis," says Dr. Mulindi. "Since the inception of the National AIDS Control Programme in the late 1980s, there has been a presumptive belief that traditional health education about HIV/AIDS would be sufficient to induce widespread behaviour change. This has not proved to be the case."

Clearly there are more powerful factors that continue to influence the choices that people make, even in life-threatening situations as those posed by the risk of being infected with HIV/AIDS.

Human mobility has contributed both positively and negatively to the creation of Kenya as it exists today. The increasing movement of individuals and large populations of people within and outside the country is part of the structure of modern Kenya and cannot be stopped. The strategic geographical position of the country with access to natural harbours; its natural resource base; its reputation as an economic centre for Eastern Africa and the relative peace that it has enjoyed in a region known for conflict, have all contributed to its attraction as a destination within the region and abroad.

The semi-arid and arid nature of the land to the north has seen development efforts concentrated along a central band and it is within this band that agriculture, industry and social amenities are best developed and climatic conditions favour human habitation. As a result, local populations tend to migrate in search of opportunity, trade and communication with neighbouring countries within the same region. Millions of people are on the move around Kenya each year. Their reasons for moving and their circumstances differ widely. But they all face the same problems of dislocation, the need to adapt to new, often different and even difficult surroundings, even if for brief periods of time, the lack of social support structures at their destination, compromised employee rights, unexpectedly harsh economic realities and the absence of family members.

Efforts to stop the spread of HIV/AIDS must begin by recognizing this high mobility of people as a point of intervention and focus specifically on reaching people on the move with programmes that address their real vulnerabilities. This must not be done in a piecemeal manner as has been the case in the past, where certain groups such as CSWs are targeted as high risk, while others like tourists are ignored in the assumption that they have been catered for elsewhere.

The single most important challenge that Kenya has faced in her post-independence history is the HIV/AIDS epidemic. The National AIDS/STD Control programme has reported over 77,000 cumulative cases of AIDS since 1984 and an estimated number of 1.7 million people infected with HIV. The latest situation analysis of HIV/AIDS in Kenya says the epidemic has yet to stabilize and HIV infection rates have increased nationally from 3.1 per cent to 9 per cent in the past seven years. The epidemic remains powerful and dynamic. It is evolving with changing and unpredictable patterns, but a key factor that appears common to all areas where the epidemic explodes is the movement of people.

HIV/AIDS intervention programmes must look at the issue of mobility with greater thoroughness beginning with research to scientifically define the common conditions that encourage exposure to HIV/AIDS and thus influence the impact and spread of HIV/AIDS

in Kenya. Using these research findings, it will then be possible to design appropriate interventions that really reach people wherever they are. This will require greater linkage in addressing a problem of such scope and with so many facets. NGOs and international organizations need to encourage greater levels of coordination in their research and in the development of subsequent prevention programmes. The private sector must be brought in. Efforts to engage employers in prevention programmes need to be expanded to address the needs of employees; the need to be able to support a family on the salary provided, needs for proper housing arrangements for employees or regular leave to enable them to visit partners.

All government ministries and departments must be involved in tackling the underlying insecurities caused by mobility and migration and HIV/AIDS on the whole. Mobility precedes the many vulnerabilities that lead to susceptibility to risky behaviour and has numerous causes. Similarly, it demands solutions that are developed from a multiplicity of fronts as it affects every department touching tourism; trade; regional cooperation; immigration; peace and security, gender; industry, transport and communications; planning and national development as a whole - not just health under which all responsibility for HIV/AIDS programmes is traditionally heaped.

In addressing the trans-border spread of HIV/AIDS, Kenya must go beyond isolated interventions to develop broader programmes in partnership with neighbouring countries which are equally affected by the same phenomena because mobility knows no borders. Failure to contain and control the spread of HIV/AIDS now will demand more expensive and difficult interventions later.

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THE IMPACT OF MIGRANT POPULATIONS ON THE SPREAD OF HIV/AIDS IN UGANDA

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INTRODUCTION

The phrase "migrant population" brings to mind images of large numbers of people undulating beneath baggage, with half-naked children clinging to mothers' sides looking hungry, and tired, but with expressionless faces. In most cases, these images are exactly what migrant populations are. Often they have left behind them, wars, smoking huts and upturned lives.

However, this description leaves out the inconspicuous trickle of youth fleeing rural poverty, nor does it include professionals such as long distance truck drivers, business people and armies. This last category, rarely hungry, mostly travelling alone and often maintaining secure lives, are more mobile compared to refugees. It is only that their more affluent bearing makes them less dramatic than refugees.

If this is so, it is as well: of the migrant persons, refugees are the most susceptible to any kind of suffering. For them, there has always been hunger, statelessness, loss of rights and property, and discrimination. Now with the spread of HIV/AIDS, refugees too are the most susceptible to catching the deadly disease.

"When you are concentrated and living in one place, you are idle, you are not active, you don't move anywhere to anything," says director of Uganda's Aids Control Program (ACP), Dr. Elizabeth Madra. "Indeed, the only thing which will come to your mind much more is drinking, smoking and sex... so there you can pick up infections in between."

The history of refugees stretches decades into Uganda's past. For years, the country has had a permanent presence of stateless and mobile people: it begun in 1955 when Sudan, then under the domination of Anglo-Egyptian rule, yielded the first ever reported wave of refugees into the country. Four years later, ethnic strife in Rwanda to the south of Uganda, brought in another batch of refugees. This was in 1959. When the 1960s came, Sudan once more produced refugees. This time, it was tension between the Arab-Muslim North and the Christian, Animist black South.

As yet, Uganda had not produced any mass displacement. This changed in 1970 when Iddi Amin came to power. The political and economic atmosphere quickly degenerated and soon got worse, enough for the country to keep generating refugees for the next three decades. There was the mass fleeing of Ugandans, especially the Northern Langi and Acholi tribes who had been the supporters of deposed President Apollo Milton Obote.

The next and perhaps the most significant – and certainly the most publicized-refugees out of the country were the Ugandan-Asians. In 1972, President Amin proclaimed an economic reform, a spurious policy that consisted of expelling Asian professionals and business men.

Their departure left a tragic economic gap of 50,000 entrepreneurs.

When Amin was overthrown in 1979, it was the turn of his own ethnic group to suffer political persecution. This third wave of Ugandans were from the North-west part of the country known as the West Nile. Their fault was that they were the tribe from which Amin came. They fled into Sudan and the former Zaire. From 1988, Sudan began to produce a steady flow of refugees as a result of the increased warfare between the Sudanese Peoples' Liberation Army (SPLA) and the Khartoum government.

In 1990, something else happened which, by the reverberation of its consequences, was the most important movement in Uganda. A section of the Ugandan army, composed of Rwandese Tutsis, broke off and fought its way into Rwanda where their parents had fled over three decades ago in 1959. It took four years of guerrilla warfare for the Rwandese Peoples' Forces (RPF) to evict the Hutu-led government. However, not before elements of Hutu extremists *Interehamwe* attacked Tutsis and moderate Hutus to produce the worst massacre in Africa's history and subsequently one of its worst mass movement. The resultant irony was that the Hutus who in 1959 threw out the Tutsis, now ran into Tanzania, ex-Zaire and Uganda.

So far, this history is that of externally displaced people. By their magnitude and drama, nature of the movement and alienation they traverse, coupled with the intense gaze of international media, this category fits well into the noun "refugee".

By July 1997, Uganda had a total of 207,287 foreign refugees living within her boarders. Of these, Sudanese compose 179,750 or 85.9%. The rest were distributed between people from the Democratic Republic of Congo, Rwanda, Somalia, Ethiopia and Kenya.

However, there is another category of displaced people who are rarely thought of as refugees. These are the internally displaced persons. Because they have only moved to neighboring villages or districts, they do not fit the stereotype of refugees. Yet in Uganda, they number 233,000.

Uganda's political atmosphere for the last decade has been producing them at an ever increasing rate. The worst hit part of the country is the Northern region which, for the 14 years that Museveni has spent in power, has been under civil strife. The rebel group, Lords Resistance Army (LRA), assisted by Sudan, has abducted, maimed and killed thousands of people.

As a result, the Northern districts of Gulu, Arua and Kitgum, have between them, contributed 193,000 (79.7%) of the 233,000. The other 40,000 (20.3%) come from the Western districts of Bundibugyo, Kasese and Kabarole. These last three districts began experiencing wars only in the last few years during which a rebel army, called the Allied Democratic Forces (ADF), have taken on the national army and terrorized the local population.

In a country of 20 million people, the external refugees form a ratio of one to 90 people while the internal ones are one in 78 Ugandans.

But what does all this history and numbers mean? The legacy of refugees that began in 1955 still continues to plague the country and often spreads into the Great Lakes region. For the numbers of refugees, whether they come from across the boarder or from other districts, bring enormous problems both for themselves and for their hosts: close to half a million helpless people lean heavily on food supplies, on living space and stretch out health services.

In a poor country like Uganda that itself has little to offer even the employed citizens, the situation is acute. "Mobility is bad if it is in such a way," says Dr. Madra. "People are going to be exposed to a lot of depression. You are so worried, you are pre-occupied with your future, the future of your children, you have lost a lot, you don't have anything on your own, you are totally dependent on relief, your housing may be bad, and your health may be bad."

HIV/AIDS AND MOBILITY

In Uganda, worry over the connection between HIV/AIDS and mobility has been a major preoccupation with the authorities. Migrants, whether they move in frightened masses or as businessmen, are associated with the spread of the disease.

"They are highly vulnerable, they are a source of spreading it because they have contacts with other people," says a Church of Uganda Development official, Frank Rwakabwohe who is head of programmes division. "One person passes on to another and...so it will just keep multiplying."

The first cases of the virus in Uganda were along the Trans-Africa Highway. The western district of Rakai is the most synonymous with the disease. It is this district through which long distance trucks passed. The 1979 intervention of Tanzania in the overthrow of Amin has sometimes been blamed for the introduction of the disease into the country. This is, however, a doubtful supposition, but it shows the concern with mobility and disease communication.

The movement of labour within the country is also blamed for the initial spread of HIV/AIDS. However, to state that travellers are the vehicle for the virus to spread is trite. In Uganda, as in all African countries with refugee problems, the mass movement of people garners more concern from authorities fighting the disease because displacement renders the displaced, more than any other group, vulnerable to catching the virus.

In Uganda, refugees generated from the North and West of the country, as well as from outside the boarders, are found in Mbarara, Gulu, Kitgum, Masindi and Bundibugyo districts. Within Mbarara, a Western district, 20,000 Rwandan refugees occupy Oruchinga Refugees Resettlement camp. Bundibugyo and Gulu, Western and Northern districts respectively, have a new generation of refugee camps called "protected villages", because they are the places into which the nationals fleeing army-rebel crossfire are herded. Among these are Ntandi, Kayimbi, Butama in Bundibugyo and Acholpii in Kitgum.

In all these camps, the health predisposition is gloomy, the basic cause being congestion. "The camp situation has got is own vices," says World Vision International programme officer, Stuart Katwirikirize. "They have brought many people together – they are just huts; one after another. People who were spread over vast pieces of land have scaled down to just a camp – a whole sub-county brought to 10 acres of land."

Food and water shortages follow. The squalid huts become breeding grounds for diseases. The illness common in all these camps is malaria, acute respiratory infection, diarrheal diseases, helminthiasis, skin disease and more recently, though more worrying, HIV/AIDS. UNAIDS estimates that 930,000 Ugandans are currently infected with the disease. The infection rate is put at 9.5%. An estimated I.8 million have already died from the disease.

However, Dr. Madra and another Ministry of Health official, Dr. Saul Onyango, caution against making inference between migrants and the AIDS statistics. "We have to be really objective," warns Dr. Onyango, "the chances of somebody who is a migrant getting HIV is the same as for any other person. The fact that you have to take into consideration is the knowledge base of the individual – what are their perceptions and then what precautions are they taking to prevent infection?"

According to the authorities dealing with the disease and refugees, it is knowledge, perception and precautions against infection that displaced people do not have. But it is not all that they lack.

"There is the extra risk as far as migrants are concerned," says Dr. Onyango. "In most cases, you are displaced from your normal situation. That puts you at a bigger risk because the issue of the economy will come in. What is your financial situation?"

That situation is absolute poverty. Most of the people that live in camps are peasants. They are without savings and dependent on the food crops their land yields. The declined produc-

tion of the cash crops (cotton) and in the national economy hit this group hardest. Besides, the economic gains made in the regime of President Museveni has been more pronounced in urban areas than in rural areas. Eighteen percent are petty traders, 15.1% students, 17.1% idlers, while the salaried workers make only 18.3%. With this line up, economic well-being collapses very fast in the face of instability.

According to Dr. Onyango, in the face of such intense deprivation, perception and precaution offer little protection. "One of the issues which really plays a big role in the transmission is poverty. People are willing to compromise their knowledge and attitudes for just getting some little survival."

The poverty created in this forced deprivation disorganizes the lives of the refugees. Besides their health, the realities of the new social situations they find themselves in change their family compositions and their sexual patterns. The lack of awareness about AIDS further compounds their problems. Added to that, they are susceptible to paid sexual advances from their new neighbors. Prostitution is not uncommon. Families break up very fast. In a survey carried in three camps, it was found that 12.8% of the refugees had lost their spouses while another 14.0% had divorced.

"All my relatives and friends were abandoned by their partners," said a 42-year old Rwandan refugee living in Oruchinga camp. This desperation has got a gender bias to it. The women remain with the children and have to look after them.

A 28-year old woman living in Butama protected village, formerly a petty trader in Bundibugyo, has had to share her husband since joining the camp. "My husband has now married three extra wives," she says. "He may not be using condoms."

Mr. Katwirikirize explains: "One of the ways migrants can meet (their) needs is to just fall prey (to) some scavenger men who can take advantage of (them)."

The notoriety of the protected villages is that while they put distance between the civilians and rebel bullets, they also take away the cohesive social structures once present in peace time. The national soldiers, if they protect the people, also see their women as pawning ground. Migrants are bitter about the Uganda People's Defense Forces (UPDF). "Most of us, our wives, are here," complains a Local Councilor of Kasitu village in Bundibugyo, "now when they (UPDF) see you poor and useless, they take advantage of your wife. She lands on a soldier who has cash."

One 36-year old widow, whose husband died at Oruchinga camp, is uncertain about her own health. "I suspect my husband might have caught AIDS."

Mrs. V. Kibirige, coordinator of the ACP condom distribution programme, believes the gender aspect of vulnerability is most important. "I would consider mainly the women and the girl child to be more vulnerable because normally, when they move from an area, they need support and they can't get it," she says. "Sometimes they might offer themselves so that they can get the support they need in terms of food and shelter."

Even among the refugees, there is an uneven distribution of fortunes. The external refugees tend to fare better than the internal ones. The reason is that external refugees, because of their longer history, have benefited from political solutions. They are often given land on which to make a living. But then again, it is the internal refugees who have had longer exposure to HIV/AIDS awareness campaigns.

The lack of awareness and the difficulty with which to provide sex education to mobile populations is the point that the ACP has been focusing on. "It is very bad because you are in a situation whereby you are not exposed to any education programme," says Dr. Madra. According to her, the danger comes in because the refugees from neighbouring countries have not got the same exposure to HIV/AIDS awareness education that Ugandans have received.

"We do not know how much AIDS awareness is created in their own countries of origin," she says. "We don't know how much they

have been sensitized but they are entering a country which has a highly sensitized population. Now, they are going to mix with these people."

The movement of soldiers is another route for spreading the disease.

"A soldier, whether white or black, has got to have sex, has got to smoke, has got to drink...also under such a situation of war where they need a lot of surgery, they get blood transfusion, because of bullets, accidents and landmines. In the process, if the blood is not screened, they pick up infections. So that is where mobility becomes a risk factor. When you talk of mobility, you have to include the soldiers."

Realization of the potential of migrant people in spreading the virus has led to a conscious targeting of those with the highest risk potential. These are the long distance truck drivers. The ACP has been educating these drivers.

Dr. Madra said that before they started their programme, the rate of spread of the virus along these routes was enormous. This was compounded by the fact that the drivers did not have one, but many sex partners along these routes, besides the wives who they left behind for as long as a month at times.

According to Dr. Madra, offsetting the tide of HIV spread through migrants is a burden of education. Her recommendation for aiding this is through setting up counseling and testing units among the migrant communities. Introducing the triple strategy of information, education and communication (IEC) strategies is another important weapon. Other recommendations include services for other infections, addressing the social and economic conditions in camps as well as encouraging government to end wars.

The spread of the disease through migrants, when these are refugees is different, because while truck drivers might control their habit, for refugees, the drive is not desire, but desperation.

Conclusion

The fact that the mass media are the single most important way to reach large populations also makes them the single most important weapon in the fight against HIV/AIDS. For any public information programme to be a success, the target that a communicator aims at comprises the mind, the attitudes, beliefs and lifestyle of the audience. It is these elements that lead to behaviour change: hence, the communicator, most often the journalist, is a crucial ingredient in fighting the disease through the media.

For journalists, the most important elements in public information are gathering information, the information itself, and the way in which it is packaged. In gathering information on public health, the journalist must identify the root causes of HIV/AIDS. These are fairly well known. The journalist must also identify the patterns of the disease; the age group, the area of the country, the social and economic disposition of that section of the population that suffers most.

The next step is to identify which audiences the journalist is speaking to. These are differentiated along age groups, educational levels, social backgrounds and habits. The importance of this is that the ways in which messages are packaged differ with the audiences at which it is aimed. The risk behaviours of each group must be identified; if the youth, is it casual unprotected sex, drug needles, peer pressure, high-risk socialization?

The messages must be crafted to match the age group. To communicate to adults in the same way as teenagers is useless. Teenagers have their own jargon and interests. The message should be attractive enough to catch the imagination of the audience; it must always have a sense of newness and novelty. They must be repeated all the time, but mostly at the hours when people are at greater risk of catching the virus.

The communicator must create a sense of authority; what are the statistics? Who is delivering them? Is the source believable? Is she/he knowledgeable? Are they liked by the audience? The communicator must create a recognizable structure of communication, which identifies the message with the campaign. For instance, in Uganda, government newspaper, *The New Vision* publishes a monthly youth pull-out called *Straight Talk*. It is about AIDS and is targeted at the youth. The communicator must use different types of com-

munication. It should be on television, radio, newspaper and magazines. There must be multimedia. Often, interpersonal and group communication must be created in the communities.

The communicator must create a channel for feedback. If in the newspaper, letters must be entertained. Telephones must be connected to the radio and TV stations. In this feed back, the communicator must allow a great amount of participation from the audience. Feedback also tells the communicator whether his message has been used the way he intended.

MIGRANTS WITH HIV/AIDS: A CHALLENGE TO THE MEDIA

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INTRODUCTION

Transmission of HIV/AIDS in Tanzania like in other African countries is mainly through heterosexual sex. The HIV virus transmission through blood donation and unsterilized medical instruments is becoming minimal as measures to ensure blood safety and general safety are taken by health workers. Any person from any race, nation or of any age can be infected, as the dreadful disease has no racial discrimination, geographical boundary or age limit.

According to the WHO fact sheet no. 97 revised August 1998, about 1.9 million AIDS cases have been reported by country authorities since the disease was discovered. Although there has not been any medical cure or vaccine, the disease can be controlled by an inexpensive method. Behavioural change is the only reliable preventive measure and the cheapest so far. Every human being can afford to change his/her behaviour without incurring much expense. However, concerted effort of individuals, governments, international organizations and others are needed towards achieving this goal of people changing their behaviour. At national and international levels, it becomes difficult to control the spread of HIV/AIDS because of the nature of the disease, as well as the social, economic and political factors which force a person to do things which may eventually make him/her become infected with the HIV virus.

In trying to escape social, economic and political hardships, people move from one place to another and thus migrate with HIV/AIDS. This tendency of migrating with AIDS within the boundaries of a country or from outside a country has made it difficult for governments and non-governmental organizations as well as bilateral and multilateral efforts to control the spread of HIV/AIDS in Tanzania. According to Lina Lengaki, a librarian at National Aids Control Programme (NACP), there are about 200 institutions in the country dealing with HIV/AIDS related issues.

The media have a role of sensitizing people to live "safely" wherever they are. Media organizations in Tanzania face the challenge of reporting AIDS as a major crisis of our time and, therefore, journalists must be knowledgeable about HIV/AIDS so that they can formulate appropriate programmes with appropriate messages for different groups of people on HIV/AIDS.

MIGRANTS AND THE SPREAD OF HIV/AIDS IN TANZANIA

"People who are away from their homes tend to do things they would not do while they are at home. In most cases they find themselves in circumstances which tempt them or force them to indulge in such things as prostitution and drug taking", said Amina Alli, a well informed researcher at Irish Aid office on HIV/AIDS and the social impact of the disease.

With increasing poverty and unemployment, the spread of HIV/AIDS will continue as people, especially young girls and boys are forced to move from one place to another looking for means of survival. "Street girls you see during day time here in the city become sex workers at night and there is an organized network dealing with this illegal business here in Dar es Salaam," she added.

It is almost 17 years since the first three AIDS cases were diagnosed in Tanzania. It was

in 1983 when at Kagera hospital in Kagera region for the first time Tanzania confirmed that the HIV virus had crossed the borders and entered the country. Since then, the disease has spread at a very high speed like bush fire during the dry season. "Thereafter, reported cases continued to rise rapidly. By 1986 all regions in Tanzania Mainland had reported AIDS cases. By the end of 1997, the number of cases had risen to 103,185. However, this is a considerable underestimation as many cases go unreported. The actual number is estimated to be four or five times the reported number. No one knows for sure when and how the HIV virus got into Tanzania, but people in Kagera region say the disease was there before 1983 as they had cases before presenting similar symptoms and had coined a name for it – "slim" or "Juliana".

Although it is not known when and how the HIV virus crossed the borders into Tanzania, the Executive Director of *WAMATA* (People in Struggle Against AIDS) G. Tibakweitira, shed some light when interviewed by the author of this chapter. He recalled how business centres at the border area of Kakuyu on the Tanzania side and Mutukula on the Uganda side became centres of spreading HIV/AIDS in the early 1980's.

He said immediately after the war with the Amin regime, Tanzania's economy was heavily disrupted, followed by a period of immense scarcities. However, there were plenty of commodities on the Ugandan side. This situation where on one side there was scarcity and no money to buy those goods facilitated the set up of night bazaars at the two centres where people exchanged not only commodities but also pleasure. "There was a high level of intermingling of people from Uganda, Rwanda and Tanzania at Kakuyu and Mutukula where there was a lot of enjoyment", he said.

The Director said that all business centres in Tanzania including fishing villages and mining centres were centres of attraction where people from different parts of the country visit. In this case, young people – girls and boys – are the ones most involved in looking for a better future. That is why AIDS in Tanzania at the moment is more prevalent in Dar es Salaam followed by Mbeya, Kagera and Kilimanjaro which are all border towns. The reason for Dar es Salaam being number one, according to Mr. Tibakweitira, is because it is also a business centre, apart from being an entry port. Most government head offices are here. It has a harbour serving neighbouring countries. Thus because of the diversity of activities, people from different parts of the country and even from outside find themselves in Dar es Salaam. This situation has created a conducive atmosphere for young girls to come to Dar es Salaam with the hope of getting employment. Unable to be employed they end up selling themselves. Evidence to prove this is at Mawenzi Hotel, the once Skyway Hotel and Ohio Street, to mention just few places where these girls are vividly seen during night time.

Long distance truck drivers from Dar es Salaam to Zambia and Malawi along the Tanzania-Zambia route and those from Dar es Salaam to Rwanda and Burundi have a tendency of having "short term lovers" at every stopover. Taking the Dar es Salaam/Zambia route for instance, the road passes through the coast, Morogoro, Iringa and Mbeya before entering Zambia at Tunduma. The drivers would park for the night, drink and be entertained by their lovers. Some of the women, however, confided that they were not permanent dwellers of any of the stations, but kept on changing stations along the route to "appear new" and attract new drivers. "Keeping track of these sex workers is not easy because most of them come from other parts of the country, and once they succumb to HIV/AIDS they go back to their home villages", said Theophil Likangaga, the Iringa regional Health Officer. The African Medical Research Foundation (AMREF) has taken an initiative of educating the drivers in a manner that fits their life-style. The Foundation distributes a lot of literature at the stopovers, and has also trained people to provide AIDS education at these stopovers.

From Kakuyu in the Kagera region, HIV/AIDS has spread to almost every village in Tanzania. HIV/AIDS is present in colleges, prisons, big plantations, army camps, refugee

camps, mining centres and in fishing villages. HIV/AIDS is also present in tourist attraction areas. Dr. Kateregga, who is in charge of the AIDS programme at UNICEF in Dar es Salaam, associates the rapid spread of HIV/AIDS in Tanzania with the opening of new transport facilities which enable quicker movement of people from one place to another. "The number of airlines coming and leaving Tanzania has increased more than ever before. Even local transport has been made easier. Think of the number of buses coming and leaving Dar es Salaam from up country daily", she commented. All these allow interaction of people unknown to each other and, as Amina said, people who are away from their homes are tempted to do things they would not dare to do at home.

Schools in the past were considered as a "window of hope" with a less infected population. Today that hope is fading away as unsafe sex is being practised by primary school pupils. Songea Girls Secondary School Headmistress, Mrs. Anna Chiguro, says between January and December 1997, 12 students were expelled from her school and by the end of the first term in 1998 seven students had been expelled from the same school. "This implies that students are practising unsafe sex, although they are aware of the dangers of practising unsafe sex and despite efforts by teachers to counsel them," the headmistress said.

Mrs. Chiguro's statement reveals a similar problem expressed by the UNAIDS Country Programme Advisor, Mulunesh Tennagashaw, when she says: "there is a high degree of AIDS awareness among the people but they are failing to change behaviour because of a combination of different factors. People know what they should do but they are not doing what they are supposed to do".

Almost every person interviewd was pessimistic about the possibility of controlling the spread of HIV/AIDS in Tanzania because of a number of factors. The major factor hindering campaigns against the spread of the disease is poverty. Tanzania is rated among the poorest countries of the world, with per capita income of 260$ US. Agriculture, which is the backbone of the country's economy, has failed to provide employment to the youth in rural areas and sufficient income for survival. Thus, rural urban influx by young people with hope of getting employment has increased in recent years. Two decades ago, urban dwellers accounted for hardly 4% of the population. Of late there has been a rapid influx from the rural areas and now the urban population is estimated at 40% which is in itself a major developmental problem.

As stated by Tibakweitira and Amina, after failing to get employment, these young people involve themselves in prostitution. "So long as there are people who depend on prostitution for their survival it will become difficult to control the spread of the disease", commented a worker at Kwetu Counselling Centre. Kwetu Counselling Centre is a home project for young girls who are in need of special protection measures after being deprived of family protection, love, shelter, care and support. There are also women who have been forced into commercial sex trade by poverty and broken marriages.

A lady who was being counselled at Kwetu Centre said she came to Dar es Salaam from Kagera when she was a young girl. She spent her life in Dar es Salaam as a sex worker but after being counselled she thought it was good to go back to Kagera and stop the sex business. "I have only one grown-up child and I always feel embarrassed when very young boys come to me and ask me to go bed with them. After all I am sick, I have AIDS," she said. She made a plea that people with HIV/AIDS should be helped by government and people with good will, if people are serious about controlling the spreading of AIDS.

Other situations are the mining centres such as the Tunduru mining area. The acting regional mining engineer, Mr. Oforo Ngowi, says the new mining centres are not governed by law and are high risk areas as far as HIV/AIDS is concerned. Women know that is where money is, and go there to offer services to the men who pay for it. The Mbinga/Tunduru is just one among many in other regions of Tanzania. Other establishments with similar characteristics and life exist in Arusha, Mwanza, Shinyanga, Morogoro and Mbeya regions.

In these areas, the chances of spreading HIV/AIDS are there, and the situational factors encourage it. As migrants, after making money or after a short while, they go back to their traditional communities. In instances where they are already infected with HIV/AIDS, they pass it on to others whenever they have sex. This explains the high rate of HIV/AIDS being reported and the high percentage increases every year.

There are a considerable number of men who have left their families in search of employment. The majority of these are in big plantations of tea, sisal, tobacco and sugar. A typical case is in Makete District in Iringa. The number of orphans as a result of parents having died of HIV/AIDS is alarming. With a population of about 120,000, the number of orphans is 13,000 which is 10.5% of the whole population. This is revealed in a study done by Ledian Mfuru of Tanzania AIDS Programme (TAP). Makete district has the highest number of AIDS cases in the country. Because the district is very poor economically, men are forced to leave their homes and seek employment in tea plantations in the neighbouring district of Mufindi, also in the same region. Lack of good provisions like accommodation in these plantations, forces married men to leave their families behind in the care of their male friends. The labourers stay long in the plantations and most find other lovers around their area of work. Similarly, the wives who were left behind in the care of other men, find themselves temporary lovers. Finally, when they come home, the chances are that either one or both of them could have been infected by HIV/AIDS.

Cases abound of men having to look for work outside their home area, and leaving their wives behind. This encourages promiscuity, and high chances of contracting HIV/AIDS. One famous area for this practise is the Kilimanjaro region. Most Chagga men who are employed outside their villages leave their wives behind to tend the small coffee farms while they go to towns to look for employment. On coming back, anything could have gone wrong. But the practise is being discouraged as men and women are becoming conscious of the dangers of HIV/AIDS when married people stay in different locations for long.

In recent years, Tanzania has hosted hundreds of thousands of refugees from the neighbouring countries of Rwanda, Burundi and the Democratic Republic of Congo because of political instability in those countries. They have always been kept in camps. In Karagwe district, for instance, refugees were twice the number of the local inhabitants. In one of the camps (Bamako) the refugees numbered over half a million. Commenting on the situation in refugee camps, the coordinator of Red Cross activities in Kagera region, Mr. S. Ndyetabula, says women and children outnumbered men, and young girls who have lost their parents in the war take care of themselves. "These became vulnerable to rape as they have no protection. They miss sex education, and hence practice unprotected sex at an early age." The coordinator adds that food provided is not preferred by the refugees as they are more used to potatoes and banana. Thus women venture to surrounding villages looking for food and firewood. In the process they interact and even may exchange sex for food. Sexual acts among refugees take place in alarming degrees because of idleness and psychological despair. The refugee camps were turned into big business centres attracting businessmen, women and prostitutes from other parts of the country and outside the country. It was during this time of the refugee influx in Kagera region that rape cases increased and in one of its districts, 250 rape cases were reported.

Indeed, people living away from their homes may be forced to do things they would not dare to do while they are at their homes. Quite often the media in the country have reported incidences where prisoners have complained of sodomy in the prisons. Prisons Assistant Commissioner of Songea region, Mr. L. Y. Yaunde, when interviewed would not agree with this allegation. Supported by his surbordinates Lameck Mmbaga and Mkwanda Hasseid Mkwanda, they denied that sodomy took place in prisons. He says, "HIV/AIDS cases detected among prisoners does not mean

in any case that the infection takes place while those prisoners are in prison. It is because of poor food in prisons which accelerates the symptoms of AIDS, making people believe that there is a high rate of infection among prisoners". Whether it is the prisoners or the prison officers who are telling the truth, one thing is obvious, that most prisoners are young, energetic and sexually active. They find themselves in a situation where they are denied their human rights. This being the case they become hostile and end up committing inhuman acts such as rape and sodomy.

A CHALLENGE TO THE MEDIA

"A feature story from an individual journalist aimed at stopping the spread of HIV/AIDS cannot bring a meaningful result towards this hazard" says Joys Mhavile, Deputy Managing Director of Independent Television.She believes that concerted efforts of all journalists aimed at formulating programmes against the spread of the disease is the best way journalists can contribute to the fight agains the spread of HIV/AIDS. However, a retired senior information officer, Mr. Willie Mbunga, believes that HIV/AIDS problem is a big challenge to the journalists. He believes that journalists are not well equipped to deal with this dreadful disease.

Mbunga suggests that AIDS education should be introduced in journalism training institutions so that there will be no excuses of not being able to preach correct messages and be good example of HIV/AIDS prevention.

It is this a very big challenge facing journalists and media institutions which calls for a "spirit of working together between media, politicians, non governmental organizations as well as bilateral and multilateral bodies. This will enable journalists to be knowledgeable on social, political, cultural, economic and moral affairs which contribute to the spreading of HIV/AIDS in Tanzania and elsewhere. The experience of all the above people should therefore form a base for a resource book on combatting the spread of HIV/AIDS by journalists.

THE IMPACT OF NEGATIVE CULTURAL PRACTICES ON THE SPREAD OF HIV/AIDS IN ZAMBIA

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INTRODUCTION

Some call it the silent epidemic. Others describe it as a plague. All the descriptions, including the local nicknames, carry the same message: HIV/AIDS presents itself as the fastest growing, most notorious and multi-faceted disaster known to mankind. Though generally a global problem, the statistics presented during the past 18 years tends to suggest that Africa in general, and sub-Saharan Africa in particular, is at the epicentre of the disease. Within the African continent, twelve countries in the East, Central and Southern African region account for 30% to 40% of HIV/AIDS cases.

In the case of Zambia, the 1997 statistics of the Ministry of Health (MOH) projected that 1.2 million of the population of 9.8 million were carrying HIV and at least 200,000 were reported to have died of AIDS-related complexes as at that date. Sadly, all the data reveal that the youth (i.e. 15 to 40 years of age) are the most affected, a situation which is described as a catastrophe for the country's socio-economic development.

Attempts to explain the uniquely high cases of AIDS/HIV in Africa in general, and Zambia in particular, have pointed to a range of socio-economic factors which include the worsening economic conditions and the general breakdown in the social and health care systems. As many groups have pointed out, there is no doubt about economic shortcomings as determinants of the high rate at which this deadly disease spreads. However, there is also evidence that some negative cultural beliefs, traditions and practices, which are deep rooted in the social and sexual lives of most African ethnic groups, have also contributed to the transmission of the disease.

In the case of Zambia, our investigations bring out three categories of culturally-defined and instigated sexual patterns and social relations which can be associated with HIV transmission and the spread of AIDS.

The first category consists of social conduct resulting from the belief in the powers of an external force, usually in the form of a spirit which can befall a person if some prescribed traditional rituals are not carried out. Ritual cleansing, the process of "cleansing" the surviving partner of the spirit of the deceased spouse, is found in this category.

The second category consists of a set of social or sexual traditions and practices which are an outgrowth of beliefs related to a perceived role or roles and/or responsibilities of an individual in a social relationship, such as a marriage union. In this classification are found puberty rites (initiation ceremonies); "dry sex" and the general use of herbs to boost sexual performance, polygamy, and circumcision rituals.

The last category consists of social relations based on tradition which dictates that something has to be done in a particular way simply because it has been done like that for years. These include property and wife inheritance which embraces the habit of having a sexual relationship with a young sister of the wife (known as *Mpokeleshi* among the Bemba-speaking groups) as a way of "anchoring" the old relationship.

Though steps have been taken to eradicate these cultural practices from modern Zambian social life, especially in the light of the AIDS

pandemic, there are traces suggesting that such habits are still a part of Zambian life, albeit in varying degrees.

RITUAL CLEANSING

This custom is documented as one of the most deep-rooted and widespread among Zambia's 73 ethnic groups. Though some tribes use other means to "cleanse" the surviving partner of the spirit of the dead spouse, sexual cleansing (or a relative of the deceased having sexual intercourse with the surviving partner in a ceremony closely monitored by other relatives) is the known and acceptable way among most of Zambia's big ethnic groups. These include the Tonga and allied groups of the Southern and Central Provinces, the Bembas and some allied ethnic groups of the Northern, Luapula, Central and Copperbelt provinces, the Lunda-Luvale of Northwestern Province and some tribes found in the Eastern Province.

The AIDS organizations in the country, including the Ministry of Health, are concerned that, in spite of their concerted efforts to eradicate sexual cleansing, the habit is not dying out as fast as expected. John Kansenzi, Director of the AIDS Programme at Harvest Help (a grassroots nongovernmental organization based in the Southern Province), confirmed that the practice is still rampant, especially in isolated rural areas.

Mr. Kensenzi said that the belief in sexual intercourse as a way of cleansing is so strong among the village communities that they can not even accept the use of a condom as they believe that the condom would not permit the "blood to meet" and, therefore, the ritual would have been incomplete.

Recent studies also attest to the prevalence of sexual cleansing. A 1995 study by the Nursing Council of Zambia, for instance, observes that 72% of Zambia's population still adhered to 'the traditional practice of the surviving partner sleeping with a deceased spouse to "prevent the haunting of the surviving by the ghost of the dead". A more recent (1997) study by Winda Nasilele in the Maamba district of the Southern Province showed that 94% of the respondents were aware that cleansing was rife in their communities, with 80% indicating that sexual cleansing was the most common.

We interviewed 15 widows and widowers who were cleansed in the last eight years and found that at least half were sexually cleansed, some even twice or three times. This was the case with Mollie Chikasha, 51, a Lenje by tribe now living with some of her children and mother in Shandyongo village, about 54 kilometres west of the Zambian capital, Lusaka. Mollie said that she had been sexually cleansed twice after losing two different husbands in a period of nine years. In 1985, Mollie was sexually cleansed by Chishimba, the younger brother to her first husband, Mwila. Nine years later, in 1994, Mollie was sexually cleansed again by a relative of her second husband, Amon Chikasha. Since then she has not married again and she did not show any signs of resisting a third cleansing.

Our investigations found that in some cases sexual cleansing took place even when the person chosen to cleanse may have been aware of the dangers of such sexual interaction. This happens due to fear of sanctions resulting from non-compliance.

"When my brother died I was under intense pressure to have sex with the widow. They (the two families) even offered me money so that I could do it. In the end I accepted," confessed Mwilu Kasiketi, a Kaonde of Solwezi town in the Northwestern Province.

In some cases, sexual cleansing occurred even when the widow did not even know who was going to carry out the ritual. This happened in the case of Judith Nasho, now a retired nurse and a coordinator of a home-based care branch in Lusaka, who ended up contracting syphillis from her cleanser. Judith narrated her ordeal:

"They put me in a small hut at night. I did not even know what was happening. They had wrapped me in one of my husband's garments. In the night somebody I did not even recognise came and cleansed me in their way (sexually). It was so painful. Later I went through a thorough medical check-up during which it was discovered that I had contracted PRP (syphillis). I got treated for it but up to now it still hurts me."

Like most other widows, Judith and her five children also lost most of their property to relatives of her late husband.

We also learnt that the pressure for ritual sexual cleansing sometimes comes from the family of the surviving partner, due to fear of something happening to the surviving spouse. This happened in the case of Theresa, who was co-married to Godfrey with Lenshina for about 10 years after Godfrey's death in 1991. Realizing that Godfrey had died of symptoms related to AIDS, Godfrey's parents objected to sexual cleansing, although Morgan, Godfrey's cousin, was chosen as Godfrey's successor.

The alternative form of cleansing – grazing of the groins over the body of the surviving spouse from chest to knee (known as *kuchutu* among the Tonga-speaking people) – did not please Theresa's relatives who felt that she had not been properly cleansed. Also worried that something bad may occur to her, Theresa started having affairs with Godfrey's relatives in the hope that that could serve as some form of sexual cleansing. Although without confirmation of the cause of her death, Theresa died in 1997.

There has been no study to directly link ritual sexual cleansing to the HIV/AIDS prevalence in Zambia, but there is evidence of significant sexual interaction resulting from this tradition.

Spouse inheritance

A related cultural practice, which also promotes the exchange of sexual partners after death in a family, is wife or husband inheritance (also referred to as levirate unions). In its formal sense this involves marrying off the surviving partner to a relative of the deceased which, as T. Richards (1969) says about the Bemba, was traditionally meant to ensure that there is continuity of the family, its reproductive role and to ensure proper care of the minor children of the deceased. Among the Tonga-speaking people of the Southern Province, for instance, a younger brother or cousin of the deceased would take over the widow and most of the property of the deceased soon after burial. The practice was also observed among other major tribes such as the Bembas, Lozis and Ngonis. Sexual cleansing and levirate marriage are related in the sense that the person who takes part in the sexual cleansing ritual more or less automatically marries the spouse of the deceased.

Our investigations showed that, as with sexual cleansing, levirate sexual relations, whether as full-fledged marriage or an ordinary relation between the surviving partner and a relative of the deceased, take place even in instances where there are misgivings about the cause of death.

Also, as in sexual cleansing, levirate marriages sometimes occur due to pressure from relatives and the rest of the community. This was evident in a case involving Anne Chola, a widow in one of the Zambian villages, as she narrated to a team from the Law and Women in Africa:

> "They appointed somebody in the family to replace my deceased husband, but I refused because I was upset about their accusations that I had killed my own husband with whom I had been married for many years. They would not take no for an answer. They threatened me saying, 'If you refuse to be married in the family it means you know why', meaning that it would be an indication that I killed my husband. There was so much pressure – in-laws, my own relatives and other members of the village – that I reluctantly agreed and even got a son after some months. After that he started beating me badly and ill-treated my children. Then he chased me, physically taking me to my father. He took away all the property."

This case also illustrates that, apart from pressure from relatives and society at large, levirate relationships can result from the desire to take over the widow and property of the deceased. Sadly, apart from increasing chances of HIV contraction due to exchange of sexual partners, such relationships often fail to be consolidated and end up breaking; thus leaving the widow and children in a more desperate and vulnerable situation. Given the fact that most cases of HIV transmission are reported to have occurred heterosexually and that AIDS as the cause of death is usually not disclosed to the relatives, inheritance of spouses poses high risks of exchanging

the HIV virus and, therefore, is significant in understanding the HIV/AIDS prevalence in Zambia.

The closeness of spouse inheritance to HIV transmission can be pictured from the case of Belita Chinyanta (not real name), 35, of Chitentabunga village in Chongwe district, about 60 kilometres east of Lusaka. Belita lost her husband, a soldier in Kabwe, in 1996. Within the same year she was "inherited" by a relative of the soldier in Chitentabunga Village. Two years later, in 1998, the second husband also died of AIDS-related complexes after which Belita was sexually cleansed and "inherited" by another man. In April 1999, both Belita and her third husband were sick and Belita is one of the 500 people under the care of Ntumeni home-based care in Chongwe. Although not tested for HIV, the local and home care-givers are convinced that this is one of the cases of full-blown AIDS.

Polygamy

Another old pattern of sexual relationships, common in Zambia and some other African countries, is polygamy. It is related to sexual cleansing and wife inheritance in the sense that some polygamous marriages are a result of taking over the wife of a deceased. This is the case with headman Peter Nanguma, 54, of Simaamba village in Siavonga district who is married to two women and has fifteen children. Mr. Nanguma told the investigating team that he inherited the second wife from a cousin who died in 1974.

Polygamy, in many cases in the Zambian society, ranges from two to ten wives. In isolated cases, though, it can mean more than 10 as was the case with 65-year-old religious leader Isaac Matongo, who stunned the country in 1994 when the press revealed that he had 55 wives, the youngest of whom was only 16 years old at the time.

Although traditionally only a few ethnic groups, particularly in the Eastern and Southern provinces, were believed to be polygamous, recent studies suggest that marrying more than one wife is now a nationwide practice. In our investigations, we found a marked increase in polygamy in Mweemba and Shandyongo villages of the Lusaka rural area between 1994 and 1998.

In the case of Mweemba village, from a cohort of 37 marriages, polygamous ones had gone up from 30% in 1994 to 43% in 1998. In Shandyongo village, out of the investigated 21 marriages, polygamous ones had increased from 38% to also 43% during the same period. Both cases confirm the continued prevalence of polygamy in some sections of the Zambian society, in spite of the efforts aimed at reducing the number of sexual partners exposed to a particular individual in the advent of HIV/AIDS.

In spite of the dangers it poses, polygamy is widespread and affects every level of the Zambian society. As indicated by Elizabeth Mataka, Director of Family Health Trust, a local NGO involved with AIDS programmes, in some cases the risks associated with polygamous unions are often due to lack of happiness and satisfaction either as a result of economic hardships or other frustrations. In other cases, it is the desire to have children, especially in the event that the first wife is barren. This was the case with Regis Nyerera, also of Mweemba village, who was offered his wife's younger sister because his older wife could not produce children.

Among some ethnic groups, such as the Bemba-speaking people, a man has an uncodified right to have a sexual relationship with his wife's younger sister (known as *mpokeleshi* in Bemba). This is looked at as a way of rejuvenating the marriage as it is assumed that at some point a man gets sexually fed up with his wife.

Given the evidence that having many sexual partners increases one's chances of being exposed to HIV, polygamy and extramarital relationships, both of which are culturally tolerated, play a part in trying to understand the HIV/AIDS prevalence in Zambia. The dangers of polygamy in relation to HIV contraction can be illustrated by the case of Cholwe Muleya (not real name), 39, of Misisi compound in Lusaka. Although not told about her HIV status, Cholwe has suffered various complications which are associated with AIDS, including genital infec-

tions which she says she got from her polygamous husband of five years.

Cholwe, now under the care of the Catholic Church-supported Home Care Programme, narrated to this writer that she married her husband as the third wife in 1994, after divorcing her first husband of 15 years and with whom she had five children. In 1997, she got pregnant and gave birth to a baby girl in March 1998. It is from then that her health problems began to manifest themselves.

> "At the time of marrying my husband I was just okay. However, since then, especially after giving birth, my health has deteriorated. I first developed rashes all over my body, then my body began to swell. Later I could feel very hot at night with persistent chest pains. I was diagnosed as having tuberculosis and put on treatment. In the process I had genital sores. When I told one of the wives about the sores, she told me that even our husband has similar sores."

While Cholwe was going through all this, her child was not spared as she showed signs of lifelessness from the beginning until tuberculosis claimed her in March 1999. Fed up with nursing a sick wife, Cholwe's husband abandoned her. The case was taken to the court, which ruled that the husband should pay Cholwe K2,000,000 (equivalent to US$ 900) for her medical costs.

Initiation ceremonies

Another practice related to culture is the initiation ceremony or puberty rite which is only indirectly related to HIV transmission because it does not directly involve sexual interaction as is the case with some of the other practices already discussed in this chapter. The process of initiating a girl is significant to the understanding of HIV/AIDS in Zambia as it plays a crucial role in shaping a girl's perception of sex and sexuality. This process, which many a Zambian woman undergoes, can be illustrated by the personal experience of Millie Chileshe Kashina, a former initiatee living in Lusaka.

Now separated from her husband of five years, Millie began to go through the process of initiation soon after her husband officially indicated his desire to marry her to her parents, then living in Kitwe, one of the four major cities of Zambia. Having missed the ritual at the puberty stage, Millie's initiation was centred on marriage which included looking after herself, her husband, relatives and general domestic affairs.

Since Millie and her parents lived in town, there was no immediately available grandmother or an old aunt to conduct the initiation ritual. In Zambian families it is a taboo for parents to discuss matters relating to sex and sexuality with their children as only grandparents are supposed to do so. In the absence of grandparents, Millie's parents hired old women (commonly known as *banachimbusa*) who are renowned for the initiation of girls and women preparing for marriage. The fee for the whole exercise was K120,000 (equivalent to US$ 50).

From about a year before the day of the marriage, the initiation process began, which included lessons in some secluded places. Depending on the subject, demonstrations would have to be carried out. This particularly happened during lessons on love-making during which an old woman would lay on top of her for therapeutic demonstrations. The next stage of initiation involved the kitchen party, one month before marriage, during which other women would join in advising her on more or less the same subjects of looking after a marriage. The process ended only on the eve of the wedding with a ritual which involved a hide-and-seek game between her and her husband in the sense that her initiators hid her in some dark place almost naked, and asked her fiancé to find her.

"During all this time the emphasis was on how to please your husband in bed and being submissive to him at all times including making love to him whenever he demands," Millie narrated.

This is the kind of ritual which most Zambian women have either gone through or are yet to go through and which has come to be accepted as a necessary process in the Zambian society. Among the Tongas, Bembas, Lozis, Ngonis and Nsengas, a girl underwent initiation soon after her first menstruation, though the period ranged from

one month, as among the Tongas, to as many as between six and 12 months. Among other ethnic groups, such as the Lambas and Ndambos of Northwestern province, a girl was initiated before the onset of the first menstruation to give her some preparation.

Concerns have been raised by AIDS information organizations about the values inculcated into a woman with regard to sex and sexuality during this ritual. Many representatives of these organizations believe the emphasis on submissiveness of woman to man and sexual satisfaction partly accounts for the disempowerment of the woman to negotiate for safe sex and also forces her to resort to "dry sex", all in order to please her husband. Traditionally, initiation rituals had some positive values aimed at strengthening marriages. However, the HIV/AIDS reality poses a strong challenge to this cultural practice.

Felicia Sakala of the Young Women's Christian Association (YWCA), also observed that: "Even if a woman is aware of the risks involved in unprotected sex, she may find it difficult to insist on safe sex. For a woman, insisting that her husband use a condom could result in her being battered, divorced or abandoned for a girlfriend" (1995). It is against this background that initiation ceremonies need to be examined in attempts to explain the high incidences of HIV/AIDS in Zambia.

"Dry sex" practice

Related to, and usually resulting from, the initiation ritual is the "dry sex" practice, which is reported as another widespread culturally inspired sexual habit in Zambia. "Dry sex" is described as sexual intercourse with a woman who has a very tight vagina, achieved through the repeated use of local substances and herbs. Like the other culturally-related practices, dry sex is also traceable to the traditional society. The practice has seeped through into modern Zambia and, like initiation ceremonies, recent studies suggest that it is one of the most widespread practices and cuts across all social strata and ethnic groups.

In her 1991 study, Nyirenda found that as high as 86% of the respondents practiced dry sex resulting from the use of one type of herb or another. One investigation showed that the continuance of the practice is mainly due to the fact that the perceived benefits or reasons for its practice tended to outweigh its inherent dangers, especially in the light of HIV transmission. The generally highly positive perceptions about the practice of dry sex helped to maintain a market for both male and female traditional medicines to satisfy it. A traditional herbalist, "Doctor" Nawa of Matero township, for instance, regularly advertises himself in the *Zambia Daily Mail* as the "famous bedroom doctor" and "Lusaka's top class herbalist". "Dr" Nawa sells both male and female sexual medicines which are taken in various forms and cost as much as K250,000 (or US$100).

As with the initiation ritual, the practice of dry sex is meant to consolidate relationships. However, with the advent of HIV/AIDS, concerns have been raised linking it to HIV transmission due to genital ulceration of both male and female organs during sexual intercourse, which in turn facilitates the exchange of blood agents, including HIV.

The cases of cultural practices discussed in this chapter suggest that, though a lot of effort has gone into eradicating some of the negative practices, there are strong indications that these practices are still going on among some communities and families. In some cases the practices go on even where people are aware of their dangers in the light of HIV/AIDS and other STDs (sexually transmitted diseases). In other cases, especially in the remote areas, it would appear that these traditions are carried out either from lack of accurate information about the relationship of each or one of them to HIV transmission or simply due to lack of information altogether.

The way forward

Given the complexity of some of the highlighted cultural practices, many individuals and groups we interviewed suggested a combination of strategies, ranging from increased information to legislation, in attempt to root out these practices. As a cross-cutting intervention, more

information will be required, using a combination of both interpersonal and mass media forms of communication, with messages specifically highlighting the relationship between each of the traditions discussed and HIV transmission.

More information is recommended because, as many people interviewed suggested, the perpetuation of some of the practices is based on lack of information relating these practices to the prevalence of HIV/AIDS. In some cases, their perpetuation is due to myths and misconceptions about the disease. This particularly applies to communities in rural areas and high-density areas of cities. Increased information should constitute the thrust of any future attempts to eradicate the beliefs which buttress some of the highlighted cultural practices. In line with this strategy, co-opting families and influential local personalities such as headmen, politicians and church elders among the communities was also suggested. This could have some considerable impact in the struggle to eradicate ritual sexual cleansing in the Southern Province of Zambia. Also, given that most of the mass media sources of information hardly reach the rural population, the use of local media such as theatre, puppetry, drama and open meetings was suggested, particularly by rural-based home-care givers.

The information intervention is particularly required in practices that directly involve the exchange of blood agents These include sexual cleansing, partner inheritance, polygamy, dry sex and circumcision practices. In cases of the initiation ritual, it was strongly suggested that the initiators should be sensitized about HIV/AIDS so that ultimately the content of the initiation would be altered to include, and put emphasis on, HIV/AIDS awareness and general reproductive health and empowerment of the woman as a substitute for submissiveness and sexual satisfaction. The sensitization of the traditional institutions is already being successfully undertaken among traditional healers in Zambia

Another suggested change in the initiation ritual is increasing the age at which the initiation is conducted from about 14 years, as among some tribes, to the period shortly before marriage. This suggestion is based on the expressed concerns about the strong urge for a girl to try out the sex skills taught during initiation, which puts her at risk of engaging in premarital sex in the event of delayed marriages.

It must be noted that the suggestions for changes in, rather than complete abandonment of, the initiation rituals is based on the observations by most people interviewed and other studies of communication sources which suggest that for now this is a critical source of information and counselling, especially on marriage. The relevance of these rituals is also based on the generally low parent-to-child communication because of taboos about sex.

On parents not discussing HIV/AIDS matters with their children, it was suggested that such taboos could be discouraged through increased information which focuses on encouraging and highlighting the beauty of parent-child dialogue. This strategy would also have to involve working closely with the families to strengthen the family ties.

Apart from the information interventions, there were also some suggestions for either the alteration or total abolition of some of the cultural practices by using the judicial system. To this effect, there were specific suggestions that the relevant sections of the law should be amended so that people who engage in some of these practices can be prosecuted. This would particularly apply to property grabbing and sexual cleansing.

On polygamy, property grabbing, cleansing and wife inheritance, there were suggestions for interventions that would empower the woman to be able to stand on her own and be able to take steps for redress in cases where she feels unjustly treated. This recommendation is based on the realization that in most cases some of these practices have been carried out against the woman's will but that the woman may be in such a weak position that she cannot easily take such a step. A combination of these suggested interventions, carried out systematically and with the involvement of the concerned commu-

nities, should provide some starting point in altering some of these negative cultural practices in light of HIV/AIDS.

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IN NAMIBIA AIDS IS STALKING THE ACTIVE AT WORK WHO ARE ALSO THE ACTIVE IN BED

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INTRODUCTION

Namibia is a vast, sparsely populated country on the South Atlantic coast of Africa, with a population of 1.6 million inhabitants. The average population density is 1.7 persons per square kilometre and it is one of the lowest in Africa. Namibia is bordered by Botswana, South Africa and Zimbabwe in the east, Angola and Zambia in the north and South Africa in the south. More than half of the population live in the northern regions of the country, a semi-tropical district with the highest rainfall. The country is mostly arid and semi-arid and a considerable part of Namibia is labelled desert. The Namib Desert is found along the coastline in the west and covers about 15% of the total landscape. The Kalahari Desert forms Namibia's border towards Botswana and South Africa in the southeast.

Namibia gained independence from South Africa on 21 March 1990 after having been under foreign rule for more than 100 years. Since independence, Namibia has been plagued by a very high rate of unemployment and poverty mostly attributed to the return of the country's more than 90,000 refugees from Angola, Zambia, Tanzania and Botswana.

HIV/AIDS IN NAMIBIA: AN OVERVIEW

HIV/AIDS, the killer disease, is rampantly spreading its death trail in most Namibian villages and cities at night. The worst hit age category is between 15 and 40 years, the country's most sexually and economically active population group. Only recently, the Minister of Health and Social Services coined the phrase that in Namibia "the victim is unfortunately the active at work who is incidentally also the active in bed". She said that unless there is substantial change in sexual behaviours, the epidemic impact of the disease on the economically active population group will cripple production and the country will rank as one of the highest afflicted nations on earth.

Although the first four cases of AIDS were identified in 1986, more than half of the reported 21,737 infections were reported in the period 1996-1997 alone. Approximately 3,500 of these reported infections involved full-blown AIDS cases. According to sentinel data collected by the Ministry of Health and Social Services from antenatal clinic patients at selected sites, there was a rapid progression of the epidemic during the last half of the 1990's. The present number of cases is based on diagnostic tests for clinical reasons, screening of voluntary blood donors, voluntary testing for insurance companies and for people applying for external training scholarships. Therefore, these figures may not represent the total picture of the epidemic in Namibia.

The breakdown of these cases by region, age and gender shows the following trend:

1. The regions in the northern part of Namibia (Caprivi, Kavango, and Owambo) constitute 51.7% of all reported HIV infections and AIDS cases. The southern part of the country has the least reported cases of 12%;
2. A total of 54% of the reported cases are male compared to 44% who are female;
3. Most of the reported cases (69%) fall within the sexually active and economically active age group of 15-40 years;
4. The most afflicted region is the Caprivi with the peak age group affected being between 20 and 24 years (NACP Report July 1997) .[1]

The report also indicated that the principal cause of death in hospitals for the ages of 5 years and older in Namibia is HIV/AIDS. While factors directly attributed to the rampant spread of AIDS in Namibia are said to be manifold, the following sources are perceived to constitute its main death-trap: (i) prostitution involving tourists; (ii) border migration patterns along the newly constructed Trans-Kalahari and Trans-Caprivi highways; (iii) sexual ignorance due to high rate of illiteracy; (iv) lack of public awareness campaigns through media; (v) alcohol abuse; (vi) cultural aversion towards the use of condoms, cultural taboo on open discussion of sex and the resultant adolescent ignorance about human sexuality; (vii) increasing incidence of child rape; (viii) the subordinate social and economic status of women; and (ix) the traditional healing practice involving the use of unsterile cutting instruments (for example, circumcision).

In this chapter, we used data collected through field interviews, official statements and research statistics to investigate and analyze the relationship between alcoholism, rape and sexual defilement of young people and the spread of HIV/AIDS in Namibia.

Our findings

Since independence, the rush through the metropolitan districts sometimes led to unfulfilled dreams and expectations for many young rural dwellers. Failure to find employment in the city forced them into squatter areas where they live in squalid conditions. Out of frustration women resorted to prostitution and begging while the men mainly resorted to the bottle, crime and drugs. Today, prostitution, substance abuse and mugging are common features of life in the country. The situation is even more exacerbated by the absence of stringent regulations against petty crime. Namibia's social control agents (such as the courts, police, peers, church, politicians, parliamentarians) seem to lack the will to combat under-age drinking, mugging and prostitution.

The intervention of local breweries in sports through sponsorship seems to contribute to under-age drinking. Castle Brewery's sponsorship of the national soccer team provides the company with access to the youthful population who consume cans of Castle beer during soccer matches. Zeenao Hoveka, the Deputy Director in the Ministry of Youth and Sports, said:

> "The impact of alcohol advertisement during these games is negative and is directly linked to the heart of other social ills such as teen pregnancy, drugs, deviants and the spread of AIDS. We cannot afford to isolate the AIDS epidemic from all other sources of social degradation. Unfortunately, everyone of the big shots in the brewery business is chasing profits at all costs and at the expense of society". (Personal interview on 17 August 1998).

Local experts are convinced that the spread of HIV/AIDS in Namibia is relatively faster in higher alcohol consuming regions. For example, A.K. Mwilima, the Acting Medical Superintendent in the Caprivi region, believes that the increasing number of rape occurs under the influence of alcohol. Similarly, police spokesperson Ratjindua Tjivikua said that most incidences of rape involving the youth are committed under the influence of intoxicating substance. Therefore, more resources should be committed to social awareness campaigns in Namibia. The same call was made by Libertine Amathila, the Minister of Health and Social Services in an interview on 28 August 1998. The Minister also told a press conference held in Windhoek on 7 November 1997 that, in the face of the astoundingly high HIV/AIDS rates, Namibia must redouble her efforts to make AIDS prevention information accessible to everyone through campaigns.

Furthermore, a survey initiated by the Namibian Network of AIDS Service Organizations (NANASO) on knowledge, attitudes and sexual practice among the youth showed that approximately 80% of young Namibians are aware of the HIV/AIDS transmission. But,

[1] National AIDS Control Programme. "Situational Analysis of AIDS in Namibia: Let's Crash AIDS". Windhoek: Namibia, 1997.

despite this high level of awareness, the latest figures indicate that the epidemic continues to double every two years. These figures prompted the Deputy Minister of Health and Social Services, Zedekia Mujoro, to remark:

> "It seems as if at this stage, the correlation between HIV/AIDS awareness and behaviour change is weak. That is precisely why I propagate an intensification of our prevention efforts and at the same time challenging all of us to come up with indigenous, innovative and efficient approaches to get our people to act on this high level of awareness. Approaches that will strengthen the correlation between knowledge and behaviour change". (Telephone interview on 26 August 1998).

The epidemiological report published by National AIDS Control Program (NACP) in 1998 under the title "Let's Crash AIDS" contains devastating statistics. It summarizes the total number of deaths due to AIDS, hospitalization due to AIDS and rate of infection detected during pregnancy. The data indicates that in 1997 a total of 11,608 new HIV infections were added to the list of the Laboratory Services of the Ministry of Health and Social Services (MOHSS). This was a slight increase compared to the 10,576 infections reported for 1996. However, this is a substantial increase if compared to the 4,045 reported in 1992.

The rate of HIV-related hospitalization had also increased in the same period. According to the report, this represents "an important indicator of the increasing workload, costs and an overall burden on the health service of Namibia". In 1997, a total of 3,908 persons were hospitalized for this condition, compared with the 2,620 who were hospitalized in 1996. The data also show that the total reported number of deaths in hospital due to AIDS in 1997 had also surpassed that reported for both 1996 and 1992. However, these figures do not include deaths which occurred at home or in private hospitals. On the basis of ongoing survey results, the MOHSS estimates that there is a total number of 150,000 persons living with HIV/AIDS in Namibia.

Keneth Abraham, a private medical practitioner, said the picture painted by these statistics is alarming. He warned that the present government policy on AIDS is inadequate to "crash" it. According to him, the information campaigns conducted by the Ministry of Health and Social Services should not focus on the use of condoms alone. He said:

> "The AIDS awareness campaigns should not de-emphasize extraneous and intervening factors such as alcoholism, drugs, homelessness and unemployment in society. They remain the causal incentives to unprotected sexual behaviours. The information campaigners should not treat some causes as less causal. They all lead to death". (Personal interview on 28 August 1998).

Similar views were expressed by Andreas Oberholzer, the Windhoek Medical Superintendent (interviewed on 20 August 1998), who said that the use of substance normally lowers the rationale of the addict and thereby his defence against rape or unsafe sex.

Abner Goagub, the Director of NACP, disagrees. According to him, there is a genuine need for concern. But he does not think that it is right to raise the alarm bell because of the 1997 epidemiological report. There are more reported cases today because of improved diagnostic methods, openness and willingness to be tested. For example, the support and compassion that Sara Kamapoha, a very attractive and courageous young woman, received when she declared that she was HIV-positive, has helped to reduce the stigma attached to HIV/AIDS in Namibia. Sara went on to demystify HIV/AIDS in a television documentary funded by the United States Information Agency in 1998. She courageously declared that, although the HIV stigma is not easy to live with, she had become more comfortable and at peace with herself for "going public". An HIV patient at Katutura Hospital who preferred anonymity said, "She represents Namibia's resistance against the killer disease and also the role model for many of us." (interviewed on 12 August 1998).

She also accused the Namibian Broadcasting Corporation (NBC) of lack of commitment to the cause of AIDS. She said:

> "If I had the information that I have today about the right to say no to sex or to use the condom, I would have been a healthy person with a future. If there is a war that the NBC should highlight, it should be the one against AIDS inside our own borders but not the one in Congo. We are slowly dying from AIDS. Without information, more people will die just like me. There are still many people out there who are ignorant like I was when I got infected".

The problem of alcohol among the youth is also confirmed by Pohamba Shifeta, the President of the National Youth Council, who said that five out of 10 young people between the age of 16 and 25 are alcohol addicts (interviewed on 27 August 1998). He agreed that high unemployment rate in Namibia often leads the youth to commit street crimes such as pick-pocketing and mugging.

National policy on HIV/AIDS

Namibia's response to the AIDS epidemic won the highest political endorsement when President Sam Nujoma personally launched the National AIDS Control Programme on 4 July 1990. The national policy is based on two key plans:

Short-term plan

The implementation of a strategy whose development mainly evolved from the following Global AIDS Strategies of the World Health Organization:

1. the setting up of a sound management structure for the programme;
2. the appointment and training of regional administrators;
3. the development of regional testing sites;
4. the training of counsellors and health workers;
5. the promotion of AIDS education in schools; and
6. the conducting of a baseline information survey on AIDS.

Long-term plan

It is a comprehensive five-year plan that is currently being implemented to achieve the following objectives:

i. the prevention of HIV transmission;
ii. the reduction of the social impact of HIV infection;
iii. improved counselling skills;
iv. advocating community-based home care;
v. improved epidemiological surveillance; and
vi. provision of safe blood.

Previous campaigns

Although national campaigns against HIV/ AIDS started immediately after independence, the year 1996 heralded joint activities aimed at AIDS prevention by institutions such as the Ministry of Basic Education, Ministry of Youth and Sports, NANASO, University of Namibia, Polytechnic, Ministry of Broadcasting and Information, Juvenile Justice Programme and UNICEF. It was also realized that since MOHSS campaigns were mostly carried out on an ad hoc basis, there was no sustainability despite the huge amount of donor funds allocated for that purpose. For example, an Independent Review Team concluded that the Information, Education and Communication (IEC) programme run by the NACP for the Ministry was a complete failure and that the materials they produced were sometimes inappropriate[2]. In response to why the IEC programme was not successful, the team was informed that the funds were in fact not for material development.

The UNAIDS initiative was also launched in Namibia as a joint effort by country representatives of all the United Nations agencies to assist national efforts. Its strategies were information collection, analysis and exchange. These included the sharing of information on HIV/AIDS activities in Namibia prevention, care and research. The UNAIDS campaign,

[2] Quoted in "Final Review of the Medium Term Plan I (1992-1996)" prepared by an Independent External Review Team in July 1996.

which was part of a major global programme focused on advocacy and promotion of political commitment and multi-sectoral involvement in combating the AIDS epidemic in Namibia.

As part of the information collection function, a long-term study was commissioned for the period 1996-2000 to investigate the impact of HIV/AIDS on the Namibian economy. Preliminary results indicated that the Namibian government would need US$100 million for that period to meet all the expenditure on HIV/AIDS prevention[3].

Conclusion

While there are possibly many other ad hoc findings that could be derived from this report, the major conclusions are the following:

1. The in-depth interviews confirmed that there is an alarming high rate of alcohol consumption among the youth that increases the likelihood of rape and unprotected sexual intercourse.
2. There is a general sense of apathy and hopelessness as a result of poverty and unemployment which motivate the youth to find consolation in alcohol.
3. There is a general feeling that most national information campaigns against HIV/AIDS are not sustained and, therefore, do not always achieve the desired effects.
4. Despite an increasing social awareness, the official statistics show an unabated increase of AIDS in Namibia, particularly in the Northwestern and Northeastern regions.

[3] "Economic Consequences of HIV/AIDS in Namibia: A Rapid Assessment of Costs". Published by WHO/UNAIDS, Draft Report, November 1996.

PART III

CONTENT ANALYSES OF MEDIA COVERAGE OF HIV/AIDS

MASS MEDIA AND THE AIDS PANDEMIC IN KENYA, 1997-98: A MORAL PANIC PERSPECTIVE

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INTRODUCTION

Since the onset of HIV/AIDS, public pronouncements from official and unofficial sources about sexuality have appeared in the news media and, increasingly, questions around sexuality and morality have become linked with drug abuse, prostitution, homosexuality, and ill health (Rocheron and Linne, 1989). In Kenya, a debate counterpoising sexual rights against culture was recently sparked by President Daniel Arap Moi when he accused a women's professional group, the Kenya chapter of the Federation of Women Lawyers, of advocating "immorality" when the group suggested that the question of homosexuality be addressed by the law instead of being swept "under the carpet" (*Daily Nation*, March 19, 1999). Consequently, the Kenya Television Network (KTN, "News at Nine", March 22, 1999) conducted *op ed* interviews with a cross section of Kenyans all of whom concurred that homosexuality was foreign, immoral and threatened the cultural and moral foundation of Kenya. All, that is, except a local psychiatrist, Dr. Frank Njenga, who expressed the view that homosexuality was a biological and cultural issue which Kenyan law should immediately come to terms with. If anything, this controversy spelled out the emotionalism and ignorance that attend questions of sexuality in Kenya and, perhaps, in other sub-Saharan countries. And the mass media did not seem to be in any better position to enlighten their audiences on the issue despite the much touted "development journalism" perspective associated with the sub-Saharan region's mass media scholarship.

This study examines the nature of and trends in mass media coverage of the HIV/AIDS pandemic in Kenya during an 18-month period, from January 1997 to June 1998. Although the original study design provided for an examination of Kenya's only national broadcast station, the Kenya Broadcasting Corporation's radio coverage along with the three national newspapers, *Nation, Kenya Times*, and *East African Standard,* a number of logistical and financial constraints made this impractical. Consequently, the broadcast system was excluded.

HIV/AIDS IN KENYA: BACKGROUND, TRENDS AND PROJECTIONS

It is widely acknowledged that the HIV virus was probably introduced in Kenya around the late 1970's or early 1980's (Ministry of Health, 1997). But it was only in the early 1990's that the Kenya government acknowledged HIV/AIDS as the greatest public health challenge and "an issue of national priority" (NCPD and CBS, 1994: 127). Since then the National Council for Population and Development (NCPD) and the National AIDS Control Programme (NASCOP) of the Ministry of Health have worked closely to monitor data on seroprevalence levels and AIDS infection in order to evaluate and design the country's response strategies.

Indeed AIDS remains the greatest public health challenge the world over. Since 1984, when the disease was first reported in Kenya,

[1] The research assistance of Isaac Lamba of Population Studies and Research Institute and Rerimoi Chemjor of the School of Journalism is gratefully acknowledged.

420,000 people had developed full blown AIDS by February 1999, 70.0 per cent of them under 25 years of age. Thus, HIV/AIDS is not only a phenomenal public health problem; it is a catastrophic demographic and economic problem for Kenya as well.

Estimates of the prevalence and spread of HIV/AIDS point to a very rapid increase in infection rates. For instance, HIV seroprevalence among women attending antenatal clinics at urban and semi-urban sentinel sites rose from 2.0 per cent in mid 1980's to 14.0 per cent in 1994. At the same time, sentinel data obtained from people attending clinics for sexually transmitted diseases (STD clinics) indicate that the proportions of those with HIV infections rose from 31.0 per cent in 1989 to 58.0 per cent in 1993 (Rau *et al.*, 1996). Meanwhile, NASCOP estimates that in 1994 nearly 300,000 adults living in urban areas and twice that number in rural areas, in addition to 60,000 children nationwide, were infected. It also estimated that by 1996 some 230,000 new infections were occurring annually. Overall, the national infection rate has risen from 3.1 per cent in 1990 to 9.0 per cent in 1997 with the urban average currently standing at 12-13 per cent and rural average at 8-9 per cent (NASCOP, 1998).

The Kenyan data also tell us that the major modes of HIV transmission are heterosexual sexual intercourse, mother-to-child transmission, and blood transfusion but these may change as issues of drug abuse and homosexuality come to the fore. At the moment, however, the pandemic afflicts mainly young, working age, sexually active adults aged 15-50 years. Decomposition of infected cases by sex shows that there may be no significant variability, but women tend to be infected at younger ages than men due to their relatively younger ages of sexual debut and marriage. Thus, the peak HIV infection age group for women is 20-29 years where about 45.0 per cent of all female infections are bunched; the corresponding age group for males is 30-39 years with 35.0 per cent of all male infections. This pattern of infection speaks to the relative vulnerability of young females to the HIV/AIDS pandemic (Baltazar *et al.*, 1996).

The current levels of HIV/AIDS infection are raising critical questions regarding mortality and morbidity rates in Kenya. According to a recent UNICEF-Kenya country office document (1999), "the gains in child survival, growth and development in Kenya are being undone by the HIV/AIDS epidemic. Child mortality is rising with alarming speed... (it has) increased from 60 to 70 per 1000 between 1993 and 1998," and in parts of Kenya where the AIDS epidemic is mature, it has risen from 123 to 189 per 1000 from 1989 to 1998, respectively. This means that in such places the HIV/AIDS pandemic has reversed the child mortality status to the 1960's situation. UNICEF had also estimated that by the end of 1996, over 300,000 children under age 15 would be orphaned in Kenya. Factored into the current mortality rate, the number of AIDS orphans is projected to increase to 600,000 by the end of the year 2000 and reach 1 million in 2005.

Policy responses to the HIV/AIDS pandemic

From the start, the Kenya government's policy response pattern to the AIDS pandemic showed a gradualist approach in three phases (Rau *et. al.*, 1996). The first phase (from 1984 when the first AIDS case was diagnosed in Kenya to around 1987) was characterized by an official view "that HIV/AIDS was not a serious problem" for Kenya (Rau *et al.*, 1996: 3) since it was associated with homosexual lifestyles which were not officially acknowledged in this country. Hence, although the National AIDS Council was created in 1985, it did not become operational until 1987 when it was transformed into National AIDS/STD Control Programme (NASCOP), and only then did it initiate HIV/AIDS awareness campaigns in the mass media and through interpersonal channels.

The next phase of government response (from 1988-1991) was characterized by a more "realistic appraisal of HIV/AIDS as a potentially harmful health issue although the perception still persisted that AIDS was no more harmful than other diseases" (Rau *et. al.*, 1996: 4).

Moreover, the Ministry of Health's campaigns regarding the consequences of AIDS met with generally sceptical audiences, perhaps because of the low-key nature of the campaigns. In addition, there were virulent media criticisms of condom use by influential religious leaders who suggested that condoms were "a Western solution" inappropriate for Kenyans. However, phase three of government response (1992-1995) marked a significant departure from the sceptical scenario hitherto adopted (Rau *et. al.*, 1996) and official surveillance data were released and a national conference on AIDS held in 1993. The Minister for Health acknowledged that AIDS had become a national crisis (*Africa Confidential*, 1993), while government and international donors made socio-economic impact assessments of the pandemic (e.g. Nalo and Aoko, 1993, Forsythe *et. al.*, 1993). From then on, NASCOP assumed a stronger coordinating role in the field activities of non-governmental organizations (NGOs) and religious groups working in the HIV/AIDS field.

Thus, in general, the Kenya government's policy responses to the HIV/AIDS pandemic were driven by hypothesized economic consequences of the disease, not its social and demographic impacts. In fact, until very recently the policy scenario in Kenya revealed a considerable "undercurrent of scepticism or downright opposition to more aggressive positions on HIV/AIDS prevention and care (Rau *et. al.*, 1996: 6). In addition, resistance to sex education in schools by some religious groups coupled with opposition to condom promotion at some senior government levels have made the climate for health education around the HIV/AIDS pandemic considerably inhospitable. Others have argued that a "variety of legal, ethical and cultural issues related to HIV/AIDS prevention and the well-being of families affected by HIV/AIDS remain to be actively debated and acted upon" (Rau *et. al.*, 1996: 7). Usually, the foremost arena for such debates is the mass media, so it is of interest to find out how the mass media in Kenya have handled the issue of HIV/AIDS in recent times.

Mass media and the HIV/AIDS pandemic

Underscoring the importance of obtaining accurate information on mass media coverage of HIV/AIDS issues are the following facts: the 1993 Kenya Demographic and Health Survey (NCPD and CBS, 1994) collected baseline data on knowledge and attitudes of a national sample of women and men regarding HIV transmission and prevention. The survey found that 99 per cent of males and 98 per cent of females reported having heard of AIDS; 96 per cent and 90 per cent of males and females, respectively, said they knew that the HIV virus could be transmitted through sexual intercourse; and 35 per cent of males and 29 per cent of females knew that it could be transmitted through injections. But there was much less knowledge about mother-to-child transmission with only 5 per cent of males and 7 per cent of females citing this mode. Meanwhile the possibility of HIV transmission in the course of circumcision was hardly known to females and only 5 per cent of males.

Thus, while Kenyans were generally aware of the existence of AIDS, their knowledge of its mechanisms of transmission was at best rudimentary. In fact, the 1993 KDHS data also show that there were widespread misconceptions about AIDS. For instance, over 55 per cent of the sample believed that the HIV virus could be transmitted through mosquito bites, about one in three respondents thought it could be transmitted through kissing, over one in four through touching the dead or via eating utensils, and 24 per cent thought the HIV virus could be passed through sharing clothes.

More seriously, even though a vast majority of the respondents believed that the spread of HIV could be prevented (about 86% males and 79% females), only about 36 per cent of the male respondents and 21 per cent of females believed condom use could prevent its transmission. It is no wonder that of the 32 per cent of the men who reported having had two or more sexual partners during the six months preceding the study, only 20 per cent used condoms with those partners. Hence, knowledge of AIDS and

the mode of HIV transmission did not translate into appropriate behavioral responses such as increased condom use. Could this have anything to do with the way matters concerning the HIV/AIDS pandemic were reported in the mass media?

Since HIV/AIDS is a new disease it is only natural that most people will have heard about it mainly through the mass media. In fact others have termed AIDS a "media epidemic" in view of the fact that since its incidence it has generated massive media attention, particularly with regard to the politics of its origins. Such controversies have been associated with the notion of moral panic (Altman, 1986a).

The idea of moral panic has been used in sociological studies of deviance (Becker, 1963; Ericson, 1966; Scott and Douglas, 1972), youth sub-cultures (Cohen, 1972), and drug addiction (Young, 1974). But it also points to a "political epidemic" because it draws attention to special population groups (such as gays or prostitutes) as well as health issues. In this respect, "the more a disease is experienced collectively, particularly by an already stigmatized group, the clearer will be its political dimensions" (Altman, 1986a: 21). Such political dimensions may be reflected in mass media reporting of issues concerning the disease. But the concept of moral panic has also been useful in explaining certain types of reporting. In this regard, moral panic is orchestrated when patterns of behaviour, whether private or public come to be selected by the mass media as unusual or symbolic of a threat to the fabric of society. According to Cohen (1972):

> "A condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests; its nature is presented in a stylized and stereotypical fashion by the mass media; the moral barricades are manned by editors, bishops, politicians and other right-thinking people; socially accredited experts pronounce their diagnoses and solutions; ways of copying are evolved or (more often) resorted to."

In Kenya, social groups who do not practise circumcision like the Luo, or who practice polygamy have been identified as constituting special risk groups in the context of HIV/AIDS since they face the danger of being targeted by the mass media for special treatment. In this regard, the mass media would be seen as a crucial component of an interactive relationship between event, news-making, and political and professional actions that may stigmatize such social groups through amplification of fears associated with HIV/AIDS.

Some previous studies of the relationship between the mass media and the AIDS pandemic have employed the concept of moral panic. Patton (1986) and Altman (1986b) have shown how homosexuals have been stigmatized by the mass media, fundamentalists and politicians to such an extent that provision of health care for seropositive and AIDS patients has been hindered. In the United Kingdom, Weeks (1985) and Fitzpatrick and Milligan (1987) employed the concept to explain the AIDS crisis. Unfortunately our literature search could unearth no such studies in sub-Saharan Africa.

It is important to point out, however, that in the context of sub-Saharan Africa where HIV/AIDS has been associated mainly with heterosexual sex, the concept of moral panic may go beyond identifiable fringe groups and may encompass whole ethnic entities and cultural practices. That is, it may also come to signify a wide range of sexual attitudes, marriage practices, and social behaviours that may be rightly or wrongly characterized as constituting health risks. To the extent that such practices as polygamy and non-circumcision, for instance, are widely considered risky and are reported in the mass media as being so, groups identified with such practices may be stigmatized and public perceptions and, hence, actions against the spread of HIV/AIDS may be seriously influenced by such stigmatization.

Theoretical expectations

This study set out to examine the content, trend and quality of coverage of HIV/AIDS issues in three Kenyan national newspapers. Given the historical reticence of official policy response to

the epidemic as outlined above, we expected to find the independent and concerned press to be particularly critical of government over the spread of the disease. That is, if there was somebody to blame for the spread of the disease, we expected that it would be the government, particularly the Ministry of Health, whose slowness in providing the necessary information and policy framework for confronting the epidemic would be faulted.

We have also reported above that government response to the HIV/AIDS pandemic was premised more on its economic rather than its health and demographic consequences. Hence, we expected media coverage to be slanted more toward the social consequences of the disease. This expectation was further strengthened by the fact that we thought the government, through the Ministry of Health, would be the main source of stories about HIV/AIDS. In this connection, we expected HIV/AIDS stories to be concerned mainly with prevalence, prevention and awareness of HIV/AIDS and the rise in the cost of health care in the wake of the disease.

In terms of quality of coverage, we expected that most of the stories would be fairly balanced, given that health, and particularly HIV/AIDS, is a technical area in which most Kenyan journalists would safely stick to the facts without venturing into speculative opinion. Because of this, we also expected the stories to be of middling technical competency and to be reasonably constructive. We thought most of the stories, particularly those of feature length, would be sourced from international wire agencies or foreign correspondents, but we also expected that there would be a significant number of stories originating from local newsrooms. These theoretical expectations constituted our working hypotheses.

Materials and Methods

This was a content analysis of three national daily newspapers and their Sunday magazine editions, namely, *Daily Nation, Sunday Nation, East African Standard, Sunday Standard, Kenya Times* and *Sunday Times*, over an 18-month period spanning January 1, 1997 to June 30, 1998. The daily and Sunday editions of the newspapers were sampled and analyzed as a unit since, for this study, no theoretical or empirical justification could be made for treating them separately.

For each newspaper edition, the total number of stories on HIV/AIDS was recorded in a tally sheet. This yielded a total of 1,638 newspaper editions for the study, a volume that was considered too large given the time and resources available for the study. Therefore, a representative probability sample of these newspaper editions was selected through a multistage sampling design in which, first, the three national newspapers were purposely selected on the basis of their span of coverage. Second, given that HIV/AIDS coverage may be systematically biased depending on major local and international events, a composite week (Wimmer and Dominick, 1983) was constructed for each month of the study period. This involved a random selection of each day of the week (with replacement) with the sampling rule that no two days of the week may be selected, and that every day of the week was represented for every month of the study period. This yielded 18 weeks for a total of 378 newspaper editions. Due to some missing editions and non-publication during public holidays, our actual sample was reduced to 340 newspaper editions.

The unit of analysis was individual story (feature, editorial, letter to editor or commentary) whose content was examined in terms of (1) number of articles, (2) their size (in $cm.^2$), (3) type (whether news, feature, editorial, photograph/photofeature, book review, letter to editor, science feature, regular column or cartoon), (4) placement (front page/page 2, page 3, other inside page, special feature/magazine section, or back page), (5) prominence (edition lead, page lead, main editorial, or special commentary), (6) origin (foreign, local or international syndicate), (7) main event (or occasion), (8) main actor (researcher/scientist, government, NGO, the United Nations system, etc.), (9) main subject (prevalence, prevention, awareness, medical costs, economic costs, demographic impact, politics of AIDS, etc.), (10) presence of blame

attribution for HIV/AIDS, (11) who is blamed, as well as subjective evaluation of the articles in terms of (12) constructiveness, (13) balance, and (14) technical competency.

The tally sheet (the main research instrument) was designed with the help of an expert computer programmer to assure flawless entry of the data into a micro computer for analysis. Two trained and experienced coders were retrained for the project and a pretest of the coding scheme finally yielded an intercoder reliability of .831 using Scott's pi index (Scott, 1955). This was considered more than adequate in view of the existence of subjective evaluation variables such as balance, constructiveness, and technical competency, the precision of whose definition was at best shaky during training. The pi index was preferred to the Holsti (1969) formula because the former corrects for the number of categories used in each nominal data variable as well as for the probable frequency of use. It is calculated as:

pi = {(% observed agreement - % expected agreement)/(1- % expected agreement)}.

The subsequent data aggregation and analysis was done using the SPSSPC+ computer software and involved mainly frequency distributions, charts and simple cross tabulations to indicate associations and differences in the treatment of HIV/AIDS stories by the three newspaper groups.

Results

Patterns and trends in HIV/AIDS Coverage

The 340 newspaper editions examined carried 99 HIV/AIDS-related articles. *East African Standard* (the *Sunday Standard* included) carried comparatively more articles, 42 in all, compared to 30 in the *Nation* and 27 in the *Kenya Times* (inclusive of their Sunday editions). In terms of space, however, the *Nation* had some 1592.75 cm^2 of space devoted to HIV/AIDS-related articles compared to 1190 cm^2 in the *Kenya Times* and 902 cm^2 in the *Standard*. However, as shown in Table 1, the differences in space devoted to HIV/AIDS by the three groups of newspapers was not statistically significant, as the F-statistic of .895 (Eta^2 =.239) shows.

On the other hand, there were very wide variations in space taken up by individual articles among the three newspaper groups. The *Nation* had the widest variation in terms of article length over the 18-month period covered by this study with a standard deviation (SD) = 261.22, followed by the *Kenya Times* (SD = 191.01) and the *Standard* (SD =174.67). This might mean that the *Nation* and the *Kenya Times* carried some lengthy features or commentaries which the *Standard* did not.

In fact, this contention is supported by Figures 1-4 which show trends in the coverage of HIV/AIDS throughout the 18-month period. Figure 1 shows the trend of mean monthly coverage of HIV/AIDS in all three newspaper groups during the period under study. It is apparent that the intensity of coverage was highest during January 1997 and dropped sharply in February, and in March 1997 HIV/AIDS coverage reached its lowest point though it began to rise gradually and reached another (though relatively lower) peak in July-August 1997 before declining again in September-October. Thereafter coverage began to rise again and peaked in November of the same year. The most notable feature of coverage during 1998 is that there were hardly any articles on HIV/AIDS during February, although by March coverage averaged around 80 cm.2 per month up until June.

The high coverage reflected in Figure 1 in January 1997 is cloned in Figures 2 and 3 which depict the patterns of HIV/AIDS coverage in the *Nation* and the *Kenya Times*, respectively. The minor peaks occurring in August 1997 are apparent also in the two figures indicating, perhaps, that the two newspapers covered similar events. The *Kenya Times*, however, sustained a high tempo of coverage of HIV/AIDS for almost three months, from November 1997 to January 1998 of nearly 148 cm^2, unlike the *Nation* coverage which was relatively higher in November 1997 but declined to an average of only around 30 cm^2 during December1997 to January 1998, inclusive. For the rest of the 1998 period, coverage in the *Nation* showed an increasing trend while the *Kenya Times* coverage was declining. Overall,

however, coverage of HIV/AIDS in the *Nation* and the *Kenya Times* reflect a surprisingly similar pattern, the slight variations notwithstanding. This may speak, not necessarily to commitment by individual journalists to an important national issue but, perhaps, to routine attention to assigned duties, regular beats or events.

The pattern of coverage in the *Standard*, on the other hand, deviated radically from those of the other newspapers. Not only did the *Standard* cover most of the HIV/AIDS events in January, February and April 1997 as well as during a long stretch from September 1997 to February 1998, its pattern of coverage reflected dramatic swings throughout the period. Moreover, from February 1998, its coverage of HIV/AIDS was well above average (> 150 cm^2 from March to June 1998). In addition, the newspaper's coverage was a lot higher around June-August 1997 than those of the other newspapers.

The pattern of coverage in the *Standard* could mean that rather than depend only on assigned jobs of covering formal events, its journalists and correspondents showed greater innovation in initiating their own stories and features. But it could also mean that the *Standard* editors have not clued in to the health beat as an important newsroom activity, something that the editors of the other two rival newspapers might have paid more attention to.

Our speculation about the treatment of HIV/AIDS stories in the *Standard* appeared to be borne out by the distribution of articles by type as shown in Table 2. Whereas in the *Nation* and the *Kenya Times* most of the space devoted to the pandemic went to news and a regular column and, to a lesser degree, to features, the bulk of the space in the *Standard* went equally to news, features and photographs (24.66%). In fact, regular columnists at the *Standard* hardly covered HIV/AIDS in contrast to those at the *Nation* and the *Kenya Times* who contributed 40 per cent and 39 per cent, respectively, of total space devoted to HIV/AIDS.

Figure 1. *Trend in the coverage of HIV/AIDS by the three newspapers, 1997-98.*

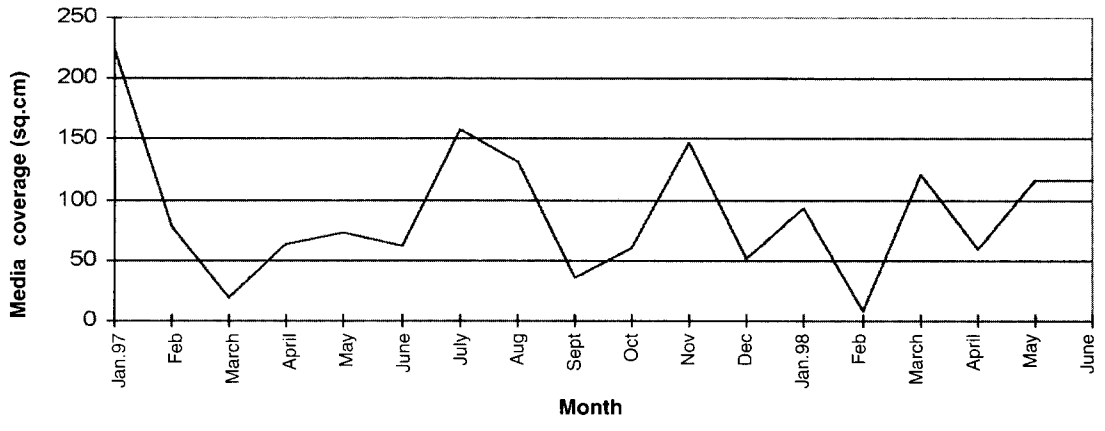


Table 1. *Frequency of and space devoted to the coverage of HIV/AIDS in three Kenyan newspapers, January 1997-June 1998.*

Newspaper	Space ($cm.^2$)	Mean Space	Standard Deviation	Number of Cases
Nation	1,592.75	106.25	261.22	115
Standard	902.00	81.63	174.67	114
Kenya Times	1,190.00	84.32	191.01	111
Total	3,684.75	90.84	212.32	340

Statistics: F = .895; Eta^2 = .239

The data in Table 2 also confirm the basic similarity in the coverage of HIV/AIDS by the *Nation* and the *Kenya Times* that was already apparent in Figures 2 and 3. Both newspapers had no editorials, photographs, book reviews or science features on the disease, and neither did they carry any cartoon of the same. On the other hand, the *Standard* had just over 15 per cent of the total space devoted to HIV/AIDS taken up by readers' letters. Meanwhile, the fact that news was the second most important genre of HIV/AIDS coverage speaks to the key role of the assignments editor as a gatekeeper. In the *Nation* and the *Kenya Times*, whether or not an HIV/AIDS story was carried depended 35 per cent of the time on the decision of the assignments editor; in the *Standard*, he/she influenced the likelihood of the coverage of such a story 25 per cent of the time. It is worth noting that only the *Standard* carried an editorial on HIV/AIDS, something we found surprising in view of the fact that the Ministry of Health or government was the most blamed agency for HIV/AIDS as discussed below.

Placement of HIV/AIDS articles

Coverage of a story is one thing, but its placement within the newspaper is yet another, and the decision in this regard lies, not with the editor who assigns the story but, for the majority of the stories, with the chief sub-editor. In this regard, this is the next most important gatekeeper. As shown in Table 2, most of the

Figure 2. *Trend in the coverage of HIV/AIDS in Nation, 1997-98.*

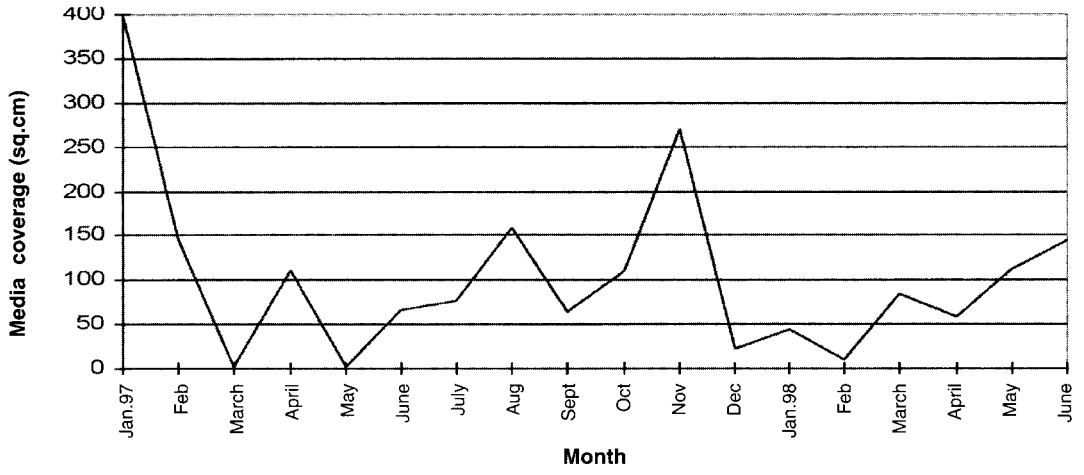


Figure 3. *Trend in the coverage of HIV/AIDS in the Kenya Times, 1997-98.*

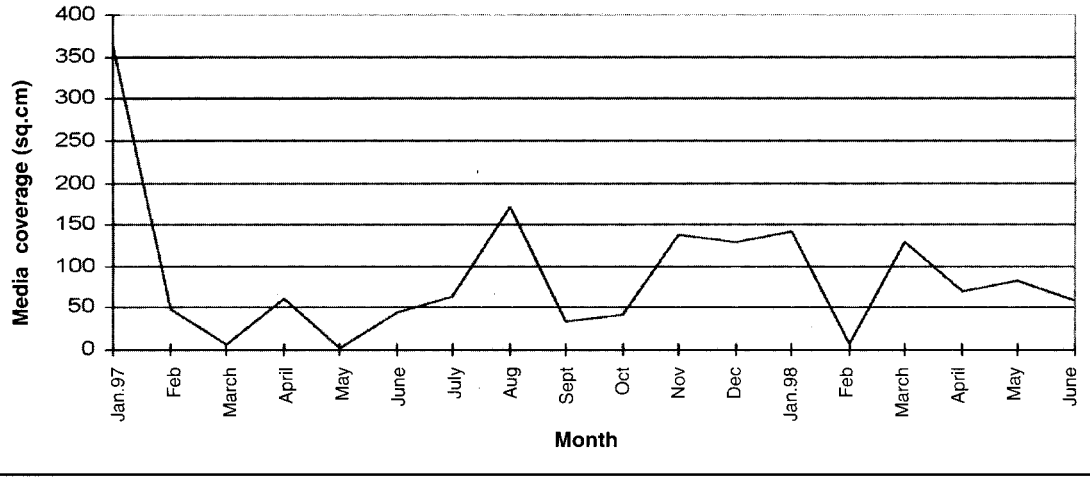
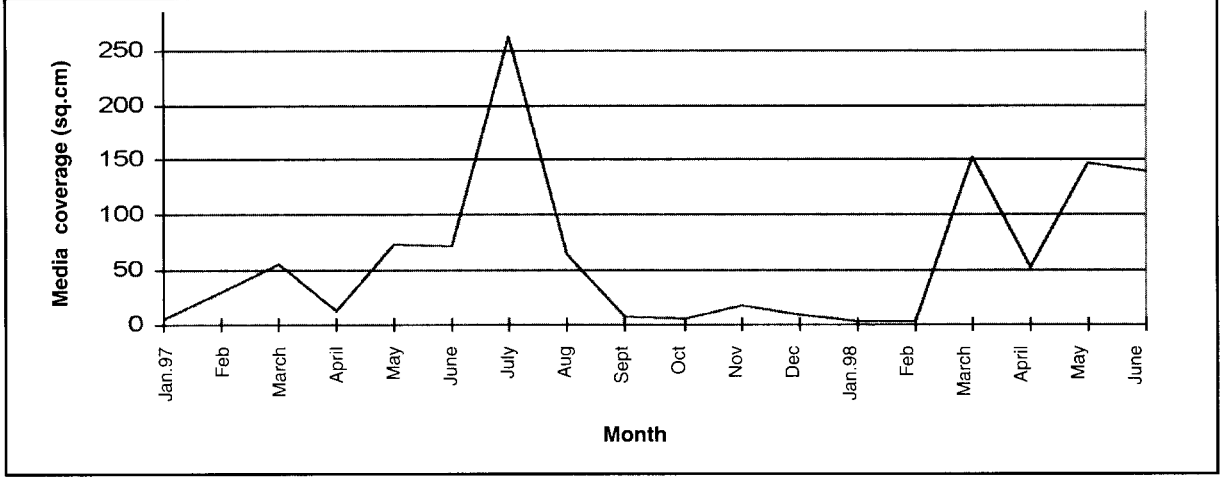


Figure 4. *Trend in the coverage of HIV/AIDS in the Standard, 1997-98.*



HIV/AIDS articles in the *Nation* appeared in the features section (nearly 55%). Consistent with news, features and readers' letters as the most dominant genres in the *Standard*, nearly 65 per cent of such stories appeared mainly in "other inside pages" of the newspaper compared to 35.71 per cent in the *Nation* and 45.65 in the *Kenya Times*.

Placement of an article on page one and on the back page of these newspapers often indicates the importance it is accorded. During the period under study, the three newspapers carried HIV/AIDS stories at least once on the front page. In fact, the *Kenya Times* did so with over 4 per cent of their stories. Meanwhile, the *Nation* and the *Kenya Times* placed HIV/AIDS stories nearly 5 per cent and 4 percent, respectively, on their back pages. On the whole, however, HIV/AIDS stories were treated as pretty routine fare for readers and were mostly consigned to "other inside pages" by the newspapers. A slight deviation from this pattern is their treatment in the *Kenya Times* where nearly 11 per cent of them were treated as important local news and placed on page three.

Prominence of HIV/AIDS articles

Closely related to placement of articles is the issue of their prominence. In this study, prominence was measured by whether or not an HIV/AIDS article was an edition lead, page lead, or whether it was the subject of the main editorial or special commentary in a newspaper edition. Table 2 also shows the percentage distribution of HIV/AIDS articles by their prominence. Over 62 per cent of the *Nation* articles and 65.5 per cent of those of the *Kenya Times* were special commentaries, presumably by regular correspondents. On the other hand, the *Standard* treated over 89 per cent of their stories as page leads in their inside pages while the *Kenya Times* used 31 per cent of them as page leads. Noteworthy is the finding that 12.5 per cent of the *Nation* stories were edition leads indicating how prominently the *Nation* gatekeepers regarded HIV/AIDS stories. In fact, 37.5 per cent of HIV/AIDS articles were either edition or page leads in *Nation*, 34.5 in the *Kenya Times*, and 93 in the *Standard*. The implication of this finding is that HIV/AIDS is a "big story" in Kenya, at least in the opinion of print editors.

Origin of HIV/AIDS articles

We also examined whether or not the articles carried by these newspapers were the handiwork of local journalists or of foreign wire services and international news or features syndicates. Table 2 shows that the stories were overwhelmingly local. Nearly 90 per cent of the *Standard* stories were locally sourced as were 88 per cent of the *Nation* stories and 85 per

Table 2. *Percentage distribution of HIV/AIDS articles in three Kenyan newspapers by type, placement, origin and source, 1997-98.*

Variable	*Nation* (%)	*Standard* (%)	*Kenya Times* (%)
Type of article			
News	35.71	24.66	34.21
Feature	11.90	24.66	13.16
News analysis	4.76	2.74	5.26
Editorial	0	2.74	0
Photograph	0	24.66	0
Book review	0	0	0
Letter to editor	7.14	15.07	7.89
Science feature	0	0	0
Regular column	40.48	1.37	39.47
Cartoon	0	4.11	0
Placement			
Front/page 2	2.38	1.41	4.35
Page 3	2.38	4.23	10.87
Other inside page	35.71	64.79	45.65
Feature/magazine section	54.76	29.56	34.78
Back page	4.76	0	4.34
Prominence			
Edition lead	12.50	3.57	3.45
Page Lead	25.00	89.29	31.03
Main editorial	0	3.57	0
Special commentary	62.50	3.57	65.52
Origin of article			
Local	88.10	89.71	85.00
Foreign	7.14	10.29	7.50
International syndicate/ agency	4.76	0	7.50
Source of article			
Ministry of Health	9.76	10.29	10.52
Other government official	2.43	8.82	7.89
Politician	0	1.47	0
Religious body	0	1.47	0
Workshop/seminar	12.20	2.94	7.89
Scientific report	0	2.94	2.6
Researcher	12.20	5.88	13.16
Research institute/univ.	4.88	0	0
NGO/UN	14.63	7.35	15.79
Journalist's initiative	36.59	50.00	34.21
Reader/ letter to editor	7.31	27.94	7.89

cent of the stories in the *Kenya Times*. Meanwhile, the *Standard* did not carry any HIV/AIDS story from an international news or features syndicate.

Sources of HIV/AIDS articles

Consistent with local origin of most of the stories, our results also show that most of them were the outcome of individual journalists' initiatives, maybe at the behest of their editors. Journalists at the *Nation* contributed nearly 37 per cent of HIV/AIDS stories during the period under study; at the *Standard* and the *Kenya Times* the proportions of individual journalists' contributions were 50 per cent and 34 per cent, respectively. A significant proportion of such articles in the *Standard*, however, came from readers (27%). Other important sources of such stories were non-governmental organizations (NGOs) and the United Nations system for the *Nation* and the *Kenya Times* (14.63% and 15.79%, respectively), individual researchers for the *Nation* and the *Kenya Times* (12.20% and 13.16%, respectively), workshops and seminars for the *Nation* (12.20%) and the Ministry of Health for the three newspapers. The finding about the importance of seminars and workshops as source of news was rather unexpected in view of the many such events that take place in this country virtually every week.

Main actors in HIV/AIDS articles

Given the sources of the articles, we thought it would be interesting to find out as well who the main actors in them were, that is, who was talking or working on HIV/AIDS. Table 3 gives the percentage distribution of the HIV/AIDS articles by main actor and subject. For *Nation* and *Kenya Times* articles, the main actors were individual researchers and scientists (61.11% and 52.63%, respectively) while for the *Standard* they were private citizens, families and social groups (over 55%) and the Ministry of Health (21.74%). In fact *Nation* and the *Kenya Times* also focused in a major way on the plight of individuals, families and social groups in the wake of HIV/AIDS, devoting nearly 17 per cent and 13 per cent of their stories, respectively, to this category. Other important actors were the Ministry of Health/government and NGOs whose activities and/statements comprised over 15 per cent of HIV/AIDS articles in each of the three newspapers.

Subjects of HIV/AIDS articles

We also investigated what it was that constituted the main topic or subject in the articles and the results are reported in Table 3. Again, the *Standard* deviated considerably from the other two newspapers in what they reported as the main subjects of their stories: 35 per cent of them had HIV/AIDS prevention as their main topic, while nearly 19 per cent of them focused on "other social costs" of the pandemic. The newspaper also paid significant attention to the politics of HIV/AIDS (13.5%) and its economic costs (12.16%), something that the other two newspapers appear to have found unappealing.

In fact, the *Nation* and the *Kenya Times* devoted most of their coverage to social costs of HIV/AIDS (21.42% and 23.68%, respectively) and on stories that dealt with claims of breakthrough in HIV/AIDS management and cure (19.04% and 21.05%, respectively). But the two newspapers also gave considerable attention to HIV/AIDS prevalence (16.67% and 13.16%, respectively) and awareness (16.67% and 15.79%, respectively). On the whole, the newspapers seemed to consider the social costs of the pandemic to be the most important topic and, hence, their relative focus on stories claiming breakthroughs in management and treatment of HIV/AIDS, as well as on its prevalence, awareness, and prevention, the marked exception of the *Standard* with regard to "breakthrough in cure" notwithstanding.

Blame attribution in HIV/AIDS articles

To what extent was the spread of HIV/AIDS blamed on somebody, institution or behaviour? Who or what was it that was blamed? These

Table 3. *Percentage distribution of HIV/AIDS articles in three Kenyan newspapers by main actor and subject, 1997-98.*

Variable	*Nation* (%)	*Standard* (%)	*Kenya Times* (%)
Main actor			
Researcher/scientist	61.11	10.14	52.63
Ministry of health/government	16.67	21.74	15.79
NGO	16.67	10.14	13.16
UN agency	2.77	1.45	2.63
Research institute/university	2.77	0	2.63
Religious body/ official	0	1.45	0
Private individual/family/group	16.67	55.07	13.16
Main subject			
HIV/AIDS prevalence	16.67	8.11	13.16
HIV/AIDS prevention	9.52	35.14	7.89
HIV/AIDS awareness	16.67	8.10	15.79
Medical costs of HIV/AIDS	0	1.35	0
Economic costs of HIV/AIDS	4.76	12.16	5.26
Demographic costs of HIV/AIDS	9.52	2.7	10.53
Other social costs of HIV/AIDS	21.42	18.91	23.68
Politics of HIV/AIDS	2.38	13.51	2.63
Breakthrough in cure	19.04	0	21.05

questions were investigated by scrutinizing whether or not any of the articles carried by the three newspapers during the period of study apportioned blame; the results are reported in Table 4. The table shows that 52.38 per cent and 51.16 per cent, respectively, of the articles in the *Nation* and the *Standard* blamed somebody or something for the incidence or spread of HIV/AIDS while the majority (58.69%) of *Kenya Times* articles did not.

Table 4 also shows that the Ministry of Health and government received by far most of the blame for HIV/AIDS followed by reckless lifestyles. But there was also significant recognition that lack of resources hampered the fight against HIV/AIDS with nearly 18 per cent of the *Standard*, 14 of the *Kenya Times* and 14 of the *Nation* stories citing lack of resources as the culprit. Meanwhile, Kenya being a tourist destination and a country with a sizeable number of refugees from neighbouring countries, it is not surprising that more than 9 per cent of the articles in the three newspapers blamed foreigners for the HIV/AIDS pandemic, though this was overshadowed by the recognition that the main problem was reckless lifestyles (nearly 30% in the *Nation* and the *Kenya Times* and 20% in the *Standard*).

Quality of coverage HIV/AIDS

The quality of coverage of HIV/AIDS was investigated in terms of the constructiveness, balance and technical competency of the articles we examined. These subjective evaluation criteria are the more important given the finding above that most of the articles were written by local journalists for a local audience. The results of this investigation are reported in Table 5.

In terms of constructiveness, the results show that most of the stories were constructive and informative, but a significant proportion of them could only be characterized as being of average quality. the *Kenya Times* had the most "very constructive" and "constructive" articles (13.15% and 57.89%, respectively) followed by the

Nation with 11.9 per cent and 54.33 per cent, respectively. The proportion of the *Standard* articles falling under these categories were 5.88 per cent and 47.05 per cent, respectively. As the index of constructiveness shows, the *Standard*'s performance in this score of 2.062 ($p < .001$) was significantly below the other two newspapers.

In terms of balance, the *Nation* had the most balanced articles with over 76 per cent of them being "very balanced" or "balanced" followed by the *Kenya Times* with about 73 per cent and the *Standard* with just about 50 per cent in the same categories. In fact, the other 50 per cent of the *Standard* articles were only of average quality or biased and, as the index of balance of 2.227 ($p < .001$) shows, the newspaper was significantly below the others on this score as well.

Finally, investigation of the technical competency of the articles shows that most of them in all the three newspapers were either simply "competent" or of "average quality". Taken together, 95 per cent of the *Standard* articles fell under these two categories, and so did nearly 78 per cent of those carried by the *Nation* and 76 per cent by the *Kenya Times*. In fact, none of the *Standard* articles were technically "very incompetent", a factor which has no doubt contributed again to its low score (index of competency = 2.217, $p < .001$) in this measure of quality of coverage.

Discussion and programme implications

This section discusses the findings of the study. It also draws some lessons for programmes aimed at using the mass media to combat HIV/AIDS in Kenya. As is evident from the results, HIV/AIDS is a phenomenal social, health and demographic catastrophe for Kenya and the print media have given it varied attention in recent times. The discussion that follows is aimed at clarifying what we have observed in the data with background information and knowledge we bring into the study that the data per se could not tell us. Such information and knowledge, read together with the results of this

Table 4. *Percentage distribution of HIV/AIDS articles in three Kenyan newspapers by blame attribution, 1997-98.*

Variable	*Nation (%)*	*Standard (%)*	*Kenya Times (%)*
Is there blame for HIV/AIDS?			
Yes	52.38	51.56	41.30
No	47.62	48.44	58.69
Who is to blame?			
Foreigners	9.09	8.82	9.52
Truck drivers	0	2.94	0
Prostitutes	4.54	0	0
Gays/lesbians	0	0	0
Reckless lifestyle	31.82	20.58	28.57
Polygamy	0	0	0
Men/husbands	0	0	0
Women/wives	0	0	0
Other ethnic group	0	5.88	0
Nobody in particular	0	0	0
Medical sector	22.73	29.41	28.57
Government	13.64	8.82	19.05
Religious organizations	4.55	5.88	0
Lack of resources	13.64	17.64	14.29

study, subsequently form the backdrop for the recommendations that follow.

Discussion

The finding that there were 99 HIV/AIDS-related stories in the sample of 340 newspaper editions constituting this study may be interpreted in various ways. It may be argued that this is a reasonably adequate attention for a problem that was hardly well understood by Kenyans at the time of the study. On the other hand, the seriousness of the pandemic in this country would suggest that its coverage should have been more intense, even sensational. Yet this was strictly not the case over the 18-month period under study. In fact, it may be argued that HIV/AIDS coverage was rather low key and lackadaisical, if not outright apathetic during long stretches of time in the study period.

Three scenarios suggest themselves as explanations for the level of coverage that HIV/AIDS received during the period January 1997 to June 1998. The first scenario has to do with the fact that 1997 was the year of the second multi-party elections in Kenya and electoral politics received more attention than any other events/issues in the media. In fact, such attention to politics remained high well into 1998 pushing HIV/AIDS to the background of editorial attention. This interpretation is lent credence by the finding that from December 1997 through April 1998 the average space allocated to HIV/AIDS by the three newspapers was less

Table 5. *Percentage distribution of HIV/AIDS articles in three Kenyan newspapers by constructiveness, balance, and technical competence, 1997-98.*

Variable	*Nation (%)*	*Standard (%)*	*Kenya Times (%)*
Constructiveness			
Very constructive	11.90	5.88	13.15
Constructive and informative	54.33	47.05	57.89
Average	33.33	30.88	26.31
Neither constructive nor informative	0	10.29	0
Biased and confusing	2.38	5.88	2.63
Index of constructiveness	3.139	2.062*	3.127
Balance			
Very balanced	11.90	4.23	12.20
Balanced	64.29	46.47	60.97
Average	16.66	39.43	19.51
Biased	4.76	9.86	4.87
Very biased	2.38	0	2.43
Index of balance	3.116	2.227*	3.064
Technical competency			
Very competent	15.00	0	15.78
Competent	55.00	50.00	55.26
Average quality	22.55	44.59	21.05
Incompetent	5.00	5.40	5.63
Very incompetent	2.50	0	2.63
Index of technical competency	3.005	2.217*	3.064

**Significant at $p < .001$*

than 50 cm^2, and that from May 1998 onwards attention to such stories averaged over 120 cm^2 and was rising.

Secondly, the Kenya government's policy response to the HIV/AIDS pandemic was fairly tentative as discussed earlier and government officials remained ambivalent about the seriousness of the problem until fairly late into 1998. In fact, it would appear that, because the government had not found a fitting response, the opposition of certain powerful groups (such as the church and traditional value constituencies) to the provision of reproductive health services especially to the youth, it found it politically unattractive to tackle the HIV/AIDS problem, particularly in the context of declining financial and other allocations to the health sector. In fact, a government policy paper on HIV/AIDS (i.e., Ministry of Health, 1997) that was drafted for parliamentary approval in 1996 was not officially published until late 1997. This means that interventions on HIV/AIDS have lacked an appropriate policy framework. Consequently, even though the Ministry of Health, and NASCOP in particular, has been working with other local and international agencies on HIV/AIDS in the areas of research, awareness and prevention, such efforts had of necessity to be low key during the period under study, and the level of press attention that our results have captured may be a reflection of this official indecisiveness.

The third explanation for the level of coverage that HIV/AIDS received during the period under study may have to do with the inability of editors and reporters to properly appropriate HIV/AIDS and its impacts on society as newsworthy or of human interest. To clearly recognize the news value of HIV/AIDS, journalists and their editors need to have more than passing familiarity with the subject as well as with the health beat. Moreover, newsrooms must clue in to the idea of health being an important social, not just medical, issue that spans politics, economics and the structure of society, as well as possess some idea of the sociology of disease.

Another important finding of this study is that there was significant variation in the trend and pattern of HIV/AIDS coverage in only one newspaper, the *Standard*, the other two papers having almost identical treatment of such stories. As the data clearly show, the *Standard* missed some important events, has relied more than the other newspapers on their own staff for HIV/AIDS stories, does not routinely cover HIV/AIDS as news, and does not have a regular column on the pandemic. Instead, the *Standard* publishes more readers' letters on the disease, a fact that could conceivably lead to a lot of controversies on the problem. Also, the newspaper virtually ignored the topic of HIV/AIDS around the height of electoral politics in Kenya (August 1997-February 1998). Yet, as the findings of this study on placement of articles show, HIV/AIDS is a big story in Kenya: they were frequently treated as important local news (page three stories), occasionally as edition leads, but more often as page leads; moreover, occasionally HIV/AIDS constituted the subject of the main editorial or special commentary.

It is particularly significant that most of the stories were the product of local journalists' initiatives, that the newspapers relied overwhelmingly on local writers and commentators, and that their newsmakers were locally based organizations, researchers and events. Yet the results also show that politicians and religious leaders were hardly important sources of HIV/AIDS stories (Table 2). Given the heated controversies that politicians and religious leaders have often generated over family planning and other reproductive health questions, the finding that these important policy and opinion leaders have not been involved by the press in the debate over HIV/AIDS could only mean that this society had yet to come to proper grips with the reality of the pandemic during the period of the study. In fact, if the mass media do not involve policy makers and opinion leaders in the debate on this important national agenda then we can expect that any other efforts to contain and reverse the spread of HIV/AIDS will only have limited impact.

It is of prime importance that the mass media concentrate on efforts to create awareness about HIV/AIDS and its potentially multifaceted

impact on society. In this regard, it is only proper that media attention should be focused on its prevalence and ways of prevention. In fact, this is all the media can do in the fight against the disease. The results of this study show that, taken together, the three newspapers analyzed here gave gravely inadequate attention to matters to do with prevalence and prevention of HIV/AIDS. In fact, other than the *Standard*, the other newspapers devoted less than 17 per cent of the space they allocated to HIV/AIDS to questions of its prevalence and ways of prevention.

Is the moral panic perspective an appropriate theoretical framework for discussing HIV/AIDS reporting in Kenya? The fact that more attention was given to the social costs of HIV/AIDS and claims of a breakthrough in the cure and/or management of the disease, indeed, suggests that coverage of the disease is beginning to take on a moral panic reportorial approach outlined earlier in this study. It will be recalled that, according to this perspective, moral panic is orchestrated when patterns of behaviour, whether private or public, come to be selected by the mass media as unusual or symbolic of a threat to the fabric of society. Our results show that "reckless lifestyles" were identified in about 30 per cent of the articles as being responsible for HIV/AIDS in Kenya, followed by the Ministry of Health/government. Taken together with lack of resources, the press in Kenya may be beginning to create the impression that Kenyans are practically defenseless against HIV/AIDS, since it may be correctly argued that provision of resources for dealing with a problem of such complexity is indeed beyond the capability of ordinary mortals. Hence, the only realistic option open to Kenyans is restraint from "reckless lifestyles" and to get the government to do more in the way of combating the epidemic.

It is significant, however, that the press has not singled out foreigners, migrants or other social groups to blame for the status of HIV/AIDS in Kenya. Nevertheless, the data suggest that of all social groups investigated, the three newspapers blamed "foreigners" in about 9 per cent of their stories on the pandemic. This may not appear high, yet when analyzed together with other survey data (e.g., Kenya Demographic and Health Survey, 1993) which show that most Kenyans associate HIV/AIDS with multiple sexual partners or indiscriminate sex (euphemistically called here "reckless lifestyle"), or that prostitutes, truck drivers, gays and lesbians and polygamists were hardly blamed in this study, speaks to the potential for foreigners to become an important target group for blame or specialized treatment in HIV/AIDS coverage. If that happens, then the moral panic perspective will have assumed its more familiar form illustrated in Patton (1986), Altman, (1986), Fitzpatrick and Milligan (1987) and Weeks (1985).

Finally, the results of this study have given us some indication of the ability of Kenyan journalists to handle such a complex subject as HIV/AIDS. The overall assessment of this ability is that the pandemic has been moderately well covered in terms of how informative, balanced and technically competent the articles have been. Yet this may properly be said to apply only to the *Nation* and the *Kenya Times* coverage; the *Standard* was significantly below par in its handling of such stories. At the same time, moderate performance is not good enough for a life-and-death issue such as HIV/AIDS that demands clear understanding and appropriate behavioural response. A number of policy and programming implications for media coverage of HIV/AIDS are accordingly indicated by this study.

Implications for policy and programming

1. The quality of HIV/AIDS coverage as established in this study points to the need for enhanced technical training of Kenyan journalists, not just in specialized fields such as health and science journalism, but all round training to empower them to handle complex stories more competently. That is, efforts to improve the skills and professional status of Kenyan journalists need intensification as this society becomes more complex and diversified.

2. There is need to establish HIV/AIDS resource centers to assist journalists to access data and information faster and more efficiently. One way of doing this would be to identify a central institution, such as the ACCE/School of Journalism's Documentation Center in Nairobi where a data bank and a fixed-time project may be established to prepare fact/data sheets in readily usable form for distribution to newsrooms and regional resource centers for use by journalists. The advantage of such a central institution is that it would avail Kenyan-specific data on HIV/AIDS obtained from the National AIDS Control Programme (NASCOP), Central Bureau of Statistics (CBS) and the National Council for Population and Development (NCPD) that routinely collect data on the status and trends of HIV/AIDS in Kenya. The staff of the Documentation Center, with technical support of one part-time quantitative social analyst and a copy writer, would prepare news releases, features and other articles on different aspects of the pandemic for distribution to newsrooms and regional resource centers.
3. Train a cadre of health journalists through seminars, workshops and short courses in the local schools of journalism and communication over, say, a two-year period.
4. Sensitize editors and media managers to establish health desks and regular health beats in their newsrooms and encourage them, through seminars and workshops, to appreciate the social significance of health and, hence, health as having an important news value.
5. In light of points 1-4, there is need for further research:
   - to specifically carry out a training needs assessment of Kenyan media houses and rural journalists,
   - to study the nature and pattern of HIV/AIDS coverage in Kenyan electronic media with a more realistic budget and time frame, and
   - to assess the training capacity of Kenyan institutions in the areas of health, science, and crisis journalism, and to determine areas in which they may require support.
6. Institutional support may be required to empower those to be involved in the training programmes that have been suggested to effectively carry out such training. Support may be sought from the news organizations themselves and from other development partners that are already working in HIV/AIDS area.

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THE COVERAGE OF HIV/AIDS IN UGANDAN MEDIA: A CONTENT ANALYSIS STUDY

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INTRODUCTION

Background

The HIV/AIDS epidemic is still a big threat to humanity as medical research done so far has not come up with definite measures on how to contain it. HIV/AIDS has transcended borders and affects people irrespective of age, sex or status.

In the Sub-Saharan region, Uganda accounts for a big share of the HIV/AIDS cases. The first documented AIDS cases were identified in Rakai District in 1982 but this rapidly spread to other parts of the country. In a Report to Parliament by the Minister of Health, Dr. Crispus Kiyonga, the cumulative figure of HIV positive people stood at 1.9 million (*New Vision*, Nov. 17 1998). However, most of these cases are not reported to the 20 Surveillance Units geographically distributed around the country including major hospitals, antenatal and STD clinics. The HIV/AIDS Surveillance Report of March 1998 by the STD/AIDS Control Programme under the Ministry of Health puts the cumulative AIDS cases which had been reported to the Surveillance units at 53,306. Of these cases, 49,432 (92.7%) were people aged 12 years and above while 3,874 (7.3%) were children below 12 years. Of the adults, 22,445 (46.2%) were males and 26,104 (53.8%) were females. Although the male to female ratio is approximately 1:1, the male to female ratio in the 15-19 age group is 1:6, with boys making up 12% of the cases and 88% being girls (NADIC *Fact Sheet* No. 97/001).

The main mode of transmission among adults was found to be unprotected sex with an infected partner. Residence, mobility and migration patterns have been found to influence HIV prevalence. Migration and mobility may be seasonal where people go to look for work in urban areas or it may be work that involves movements like long distance truck drivers, traders, military and security personnel. Studies have shown that occupational travel is often associated with high rates of changes in sexual partners and unsafe sex. According to research carried out in the Rakai district, findings showed that populations living close to the highway had a 38.5% HIV seroprevalence compared with 25.4% in trading centres and 8.6% in rural villages (Tarantola and Schwartlander, 1997). We have to acknowledge that human behaviour is very dynamic and cannot, therefore, be explained by one general theory. As noted in the HIV/AIDS Surveillance Report of March 1998, although data from HIV infection sentinel surveillance sites continue to show declining trends in the urban sentinel sites and stabilization in the rural sites, the rates are still high in both cases and that there is need for increased effort to improve and sustain existing AIDS control initiatives.

NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

National response to the epidemic has been in three phases: (i) 1980-1986; (ii) 1986-1990; and (iii) 1990 and beyond. In the first phase, it was mainly individual communities, NGOs and religious organizations who were active in the fight against AIDS. In the second phase, having realized the seriousness of the epidemic, the Ministry of Health became fully involved through the AIDS Control Programme. An Information, Education and Communication (IEC) campaign was

embarked on which greatly increased people's awareness to more than 90%. In the third phase, following a review by a National Task Force on AIDS, a multi-sectoral approach was adopted involving government, NGOs and external agencies. The Uganda AIDS Commission was established to coordinate all the HIV/AIDS activities.

The number of infected people would perhaps be even higher had it not been for the government's early acknowledgment of the problem and its adoption of a policy of openness. This has paid off. The *Report on the Global HIV/AIDS Epidemic* (1997:13) recognizes Uganda as a model with the best surveillance system which showed that infection rates were dropping in younger age groups.

To facilitate its work, the Uganda AIDS Commission (UAC) set up a National AIDS Documentation and Information Centre (NADIC) and AIDS Control Programme (ACP) units in various ministries, including that of Information. To supplement the government's efforts in the fight against AIDS, there have been initiatives by local NGOs, United Nations and other external agencies. Among these are: UNAIDS, the AIDS Support Organisation (TASO), People Living with AIDS (PLWA) and Phily Lutaya Initiative. All these have injected funds into information campaigns using the media which has greatly enhanced people's awareness on HIV/AIDS issues. As more people are joining the formal working sector, there is less time for interpersonal or group communication. Increasingly, people are relying more on mass communication or mass media as a source of information for what is happening in their immediate environment and the world at large.

The media in Uganda

The print media

Up to 1983 when there was media liberalization, the government-owned newspaper did not have any serious competitor. Although there was no specific legislation barring private newspapers, the environment was not conducive for their operation. With media liberalization and a more tolerant government, there are now several publications. There are two dailies, the government-owned *New Vision* with a circulation of about 35,000 copies and *The Monitor*, which is privately owned, with a circulation of about 32,000 copies. Other private papers range from tri-weeklies to bi-monthlies. These include: *The Crusader, The Market Place, The People, The Microscope, The East African, The Voice* and *Njuba Times*. Worthy of note is that all these papers with the widest circulation are in English. There have been attempts at publications in the local languages by the government, but these have not been very successful as the circulation is still mainly within the regional towns and does not penetrate into the rural areas. There is *Orumuri* for the Western Region, *Bukedde* for the Central, *Etop* for Eastern and *Rupiny* for Northern. Magazines on the market range from social magazines like *Chic, Secrets, Bella*, to specialized ones like *ARISE* a woman's magazine, and leisure magazines like *Dine-Out*. Because of the low literacy rate of 62% and low eductaional levels, the newspapers tend to circulate mainly in the urban and peri-urban areas.

The broadcast media

The government-owned Radio Uganda was for a long time the only station in the country until the media liberalization in 1983. Since then, 13 FM stations have been created: Radio Sanyu, Capital Radio, Central Broadcasting Service, Radio Simba, Radio Maria, Star Radio, Voice of Toro, Radio Paidha, Top Radio, Freedom Radio, Radio Messiah, Voice of Teso and BBC Africa Service. Several others are in the planning stages and will start soon. Apart from four of those operating, all the FM stations are based in Kampala and use mainly English. Whereas Radio Uganda has a variety of programmes in 28 languages, including English and Swahili, the FM stations mainly have commercial and entertainment programmes. Radio Uganda has an advantage over other stations in that it covers the whole country, unlike the FM stations that broadcast within a certain range. Having government support and funding, Radio Uganda can afford to pick news countrywide, particularly through the information officers stationed upcountry.

Like Radio Uganda, the government-owned Uganda Television (UTV) was the only television station in the country for a very long time. After the liberalization, four private stations were created: Sanyu Television, Channel T.V/CNN, Lighthouse and M-Net. Apart from M-Net to which one needs to subscribe, the other stations can be accessed free of charge but they all do not cover the whole country. Except for UTV which mainly carries local programmes, the bulk of programmes for the other stations are mainly imported English programmes.

Although the circulation figures for newspapers are relatively low in Uganda, the print media are influential since government officials, the business community and the urban elite rely on them as an important source of information. As in other developing countries, the radio is the medium for the mass. Given its wider coverage, the variety of programmes and the use of many local languages, Radio Uganda is the major source of information for most people in Uganda.

Although radio access is quite high, it must be pointed out that there are gender differentials and men tend to have more access to the medium. In the Uganda Demographic and Health Survey (1995), it was found that there were 56.8% women who had no access to any media as compared to 31.4% men. There are also disparities depending on socio-economic and educational status. The urban and peri-urban tend to have more media access than the rural population. As Williams (1989:244) explains while discussing the dependency theory, with urbanization and industrialization, people's dependency on the media increases and the more a society is involved in high degrees of change or conflict, the more its dependency on the media. Since there is a high expansion rate of urban areas, socio-political and economic changes as well as the situation of instability/armed conflict experienced in Uganda, media influence in the country is increasing.

As the media have become major sources of information, and there is a tendency for people to discuss what appears in the media, the media have considerable influence in shaping public opinion and people's behaviour. Depending on how the media prioritize issues in their coverage, the public is likely to attach the same importance. The media have the power to structure issues and to set an agenda for the public to focus on.

Statement of the problem

In the 1980s when AIDS was first identified, there was a lot of media coverage on it. However, the momentum was not kept up and in the 1990s, HIV/AIDS issues no longer got much coverage. Since media focus on those important events or issues in society, it is as if HIV/AIDS was no longer as big a problem like it was in the 1980s.

According to the Minister of Health, Dr. Kiyonga (World AIDS Day 1997), although there was evidence of positive development such as high awareness of HIV/AIDS of over 90% with positive sexual behavioural change and significant declining trends in HIV infections, AIDS still remained a major cause of death in Uganda. There is, therefore, need to go beyond the role of HIV/AIDS information dissemination or awareness stage. The media can play an influential part as an agent of change so that the knowledge acquired is translated into practice or the desired behavioral change. Thus, there is need to re-examine the whole communication process of the HIV/AIDS messages, if the communication objective (behavioural change) is to be achieved.

Study objectives

The purpose of the study was to analyze media coverage of HIV/AIDS in Uganda. The specific objectives were to:

(i) find out the nature of the coverage in terms of number of articles, the type of articles, where they are placed and their prominence;
(ii) find out the media's sources of information on HIV/AIDS;
(iii) find out the main actor(s) in the articles covered by the media and the main subject(s) focused on;
(iv) find out if there is a relationship between migrant populations and the prevalence of AIDS;

(v) find out the reaction to HIV/AIDS in terms of who is blamed for it;
(vi) find out how HIV/AIDS patients are reported on;
(vii) find out the technical competency of the media's handling of HIV/AIDS issues; and
(viii) provide a basis for designing a strategy for using the media to combat HIV/AIDS in Uganda.

Scope of the study

The study examined media coverage over a period of 18 months (January 1997 - June 1998). It looked at the print and broadcast media. The media with the highest circulation or widest reach within the country were used to represent others. For the print media, *The New Vision* and *The Monitor* were used as samples to represent the other print media. Radio Uganda has the widest reach since it covers the whole country. The other stations operate within given distances and none of them cover the whole country. Radio Uganda was selected to represent the broadcast media.

The research design

The research used both qualitative and quantitative methods to analyze the media coverage. A content analysis was done of newspaper articles and radio news broadcasts between the period of January 1997 and June 1998. In-depth interviews with reporters and editors were also conducted to get their views on the HIV/AIDS coverage. In addition, secondary sources of data were used to supplement the primary data from this study.

Population sample

Due to the limited time and the multiplicity of the media in Uganda, the researcher used four months to represent the 18 months of study. Two months were randomly selected, i.e. July 1997 and March 1998 while the other two were selected through constructing of composite months. The composite months helped in ensuring a more representative sample since the two composite months were spread through a period of eight months. One week was taken from successive months, i.e. January 5–11; February 9–15; March 16–22; May 4–10; September 1–7; October 6–12; November 10–16; December 22–28. Coverage on the World AIDS Day which falls on 1 December was also analyzed. This sample gave a representative picture of the treatment of HIV/AIDS issues by the media in Uganda.

Findings and data analysis

After the data collection, the information was coded and aggregated. These primary data formed the basis for discussion with information from secondary sources being used as back-up. The data were analyzed quantitatively using frequency distributions and rank correlations to examine patterns in the media coverage.

Media coverage of HIV/AIDS

The amount of media coverage of HIV/AIDS was found to be quite low. Of the 119 days used as sample, there were 233 articles on HIV/AIDS in *The New Vision*, *The Monitor* and Radio Uganda. Assuming that a newspaper on average has 75 articles, for the two papers, this would be 150 articles a day. For 119 days, there may be 17,850 articles. For Radio Uganda, a bulletin on average has about 15 articles so for 119 days, there would be 1,785 articles. The combined articles during the survey period would be 19,635. The 233 articles on HIV/AIDS gives a 1.19% representation.

Of the 357 editions studied, 72 (20.17%) had one article on HIV/AIDS, 32 (8.96%) had two articles, 13(3.64%) had three, while 22 (6.16%) had four or more articles. World AIDS Day, (December 1) recorded the highest number of articles 28 (7.84%). *The New Vision* had the most coverage 97 (41.63%), followed by *The Monitor* 79 (33.91%) and Radio Uganda accounted for 57 (24.46%) (see Table 1).

The New Vision particularly gave considerable coverage to the HIV/AIDS issues in the four page monthly pull-outs called *Straight Talk* and *Young-Talk*. The inserts contain sex-education materials including information on HIV/AIDS issues. Straight Talk is a project that was started in 1993 by UNICEF. The project's target group are mainly the youth. It was realized that they

needed information during the transition period from adolescence to the adult stage. In most African societies, it is assumed one should get information on sex matters just before marriage, yet many young people do engage in pre-marital sex without knowing the risks involved. Besides, many parents are shy to give sex education to their children. The media have tried to fill this gap. Radio Uganda also hosts two weekly programmes from the Straight Talk Foundation: "Life Watch," is a 15-minute programme and "Youth Straight Talk," is a 30-minute programme. These take the form of drama, interviews, talk shows, and magazine programmes.

Most of the HIV/AIDS articles in the print came under the category of news stories 103 (44.21%) and others were in features, news analysis, letters to the editor, photograph/ photo feature and occasionally as cartoons (see Table 2).

In the print media, the length of the articles ranged from 20 articles (8.44%) with less than 10 cm2 to a total of 14 (19.44 %) pages out of 72 pages on World AIDS day. Most of the articles were placed in the inside pages 75 (32.19%) and on the special features page 36 (15.45%). A few were on the front page/page 2, 12 (5.15%) on page 3, 11 (4.92%) and 5 (2.15%) on the back page. There were six (2.58%) articles which were edition leads or the main editorials. Most of the articles were page leads 39 (16.74%) and special commentary were 21 (9.01%).

For Radio Uganda, the duration of the HIV/AIDS articles ranged from 18 (31.58%) articles with less than one minute to 10 (17.54%) articles which had up to three minutes. On World AIDS Day, there were 4 (26.67%) minutes out of 15-minutes news time that were devoted to HIV/AIDS issues. Almost half of the articles 27 (47.37%) were headlined while the other half 27 (47.37%) were non-headlined.

Sources of information on HIV/AIDS

For both broadcast and print media, the sources of the articles were mainly: local with 163 (69.96%); foreign sources, 20 (8.58%) and international syndicate/feature services accounting for 12 (5.15%) (see Table 3).

The major source of the programmes were NGO/United Nations which accounted for 44 (18.88%); the Ministry of Health with 36 (15.45%) and government officials with 27 (11.59%). Articles out of reporter's/columnist's initiatives were 22 (9.44%) (see Table 4).

The few articles resulting from a reporter's/columnist's initiative reflect the general perception among journalists that AIDS stories no longer sell. In an interview with an editor of *The New Vision*, Mr. J.B. Wasswa, he said that, except for information on major break throughs on AIDS like about possible cures, his paper did not want to dampen people's spirits by over focusing on AIDS. This, for example, could drive away prospective investors to Uganda, if they thought that the potential market would not be realized due to the high AIDS prevalence rates, he explained.

Among the NGOs/United Nations Agencies cited as sources were: UNAIDS, NADIC, WHO, STD/ACP, TASO, Philly Lutaya Initiative, PLWAS, UAC, Safe Motherhood and Family Planning. According to a survey conducted by Uganda AIDS Commission, by August 1997, there were 1294 HIV/AIDS programmes or projects registered in Uganda.

Reporting on HIV/AIDS patients

Generally, the individual HIV/AIDS patients were not focused on much. There is a tendency to be pre-occupied with numbers/statistics and neglecting to highlight the needs and problems of the AIDS patients. This gives an impression of the AIDS patients not being worthy of societal concern apart from the fear of spreading the virus to others. Often times HIV/AIDS is associated with immoral behaviour like prostitution, drug addiction and alcoholism and AIDS patients are portrayed as social outcasts. In the articles analyzed, the main actor was the Ministry of Health or government, 71 (30.47%). Although the category of private individual/family/social group had 67 (28.76%), most of this

was under social groups not individual AIDS patients. Where the individuals were focused on in 28 (12.02%), the images portrayed were negative.

Most articles were concerned with HIV/AIDS prevention, 94 (40.34%), HIV/AIDS awareness, 57 (24.46%), HIV/AIDS prevalence, 55 (23.61%) and demographic costs of AIDS, 13 (5.58%). A few talked about the claim to cure AIDS, 6 (2.58%) (see Table 5).

Table 1. *Coverage of HIV/AIDS.*

No. of articles	*Monitor*	*New Vision*	Radio Uganda	Total
1	28	18	26	72
2	10	13	9	32
3	5	5	3	13
4	1	2	1	4
5	-	2	-	2
6	-	-	-	0
7	-	-	-	0
8	-	1	-	1
9	-	-	-	0
10	-	-	-	0
11	-	-	-	0
12	1	1	-	2
13	-	-	-	0
14	-	-	-	0
TOTAL	79	97	57	233

HIV/AIDS high risk groups

Almost half the articles had HIV/AIDS blame attribution: 95 (40.77%) while 97 (41.63%) did not attribute blame. Most of the blame is put on nobody in particular, 84 (36.05%). Reckless life style had 37 (15.88%). Husbands/men were also cited in 27 articles (11.59%), and wives/women in 5 (2.15%) articles. Prostitutes were cited in 6 (2.58%) articles. Although some studies carried out have linked HIV/AIDS to migrations or mobility, this factor was not reflected in the present study. Truck drivers, foreigners or other ethnic groups were not blamed for HIV/AIDS (see Table 6).

However, mention should be made that Rakai town where HIV/AIDS cases were first reported in Uganda used to be a busy overnight stop for truck drivers. The area has suffered many deaths due to AIDS. For migrant workers, in Kampala and other towns, working men from up country areas tend to have two homes - one in the village and one in town, with a wife in each. In addition, men who travel on official duty or business trips also often engage in sex outside their regular partner(s). Generally, it is the men who have more than one sexual partner which increases the risks of spreading AIDS.

In a NADIC report, it is noted that women continue to be blamed for bringing HIV into a family when their HIV status is identified first, for example, through the illness of a child. Yet, the socially sanctioned behaviours of their male partners are more likely to have been the cause of

Table 2. *Types of HIV/AIDS article.*

	HIV/AIDS article type	*Monitor*	*New Vision*	Radio Uganda	Total
1	News	29	30	44	103
2	Feature	15	13	-	28
3	News analysis	4	6	1	11
4	Editorial	1	1	-	2
5	Photograph/photo feature	3	10	-	13
6	Book review	1	1	-	2
7	Letter to editor	3	13	-	16
8	Science feature	4	5	-	9
9	Regular column	-	1	-	1
10	Cartoon	3	-	-	3

the initial infection (NADIC, 1997:11). In a national survey by Ankrah *et. al.* (1993:89) it was found that transient sexual relations increased the risks of the spread of HIV. They note that casual sex was mainly a feature of towns and trading centres. They attribute this to the fact that these locations provide women with the opportunity to work and live independently of the patriarchal constraints of village life, a phenomenon which permits casual sex. In the survey, among the respondents who admitted to casual sex, only 5.2% of the men had used condoms all the time in their last five sex encounters. On the other hand, no woman had used a condom in all the last five casual sex encounters. In another study by the Uganda Media Women's Association in 1998, one of the problems discovered was the spread of AIDS and other STDs in the war zones and in the Displaced People's Camps through soldiers raping women and defiling girl-children (UMWA, 1998). Since Uganda's situation of armed conflict in the Northern part of the country has gone on for about 12 years, this has had significant impact on the spread of AIDS.

Another study done in Rakai by Karungi (1996) found that the travel of respondents correlated with the HIV serostatus. He found that respondents who had travelled or whose partners had travelled since 1979 (outside the country or within) were at a higher risk of contracting HIV. Of those who had travelled outside Uganda, 27.7% were HIV positive while of those whose partners had travelled, 36.4% were HIV positive. Of those who had travelled outside Rakai but within Uganda, 23.4% were HIV positive and 23.8% of those whose partners had been outside Rakai but within Uganda 23.8% were HIV positive. Of the respondents who had not been away from home, none were HIV positive. The researcher concluded from this study that mobility increases the spread of AIDS and that the further one is from home, the more the likelihood of acquiring HIV.

Table 3. *Sources of HIV/AIDS articles.*

	Sources	*Monitor*	*New Vision*	Radio Uganda	Total
1	Local	52	63	48	163
2	Foreign	7	8	5	20
3	International				
4	Syndicate/feature service	7	5	-	12

Table 4. *Sources of HIV/AIDS programmes.*

	Sources of HIV/AIDS programmes	*Monitor*	*New Vision*	Radio Uganda	Total
1	Ministry of Health (MOH)	9	21	6	36
2	Other Govt. Minister/official	6	3	18	27
3	Other politician	-	-	2	2
4	Religious org./official	7	2	7	16
5	Workshop/seminar	4	3	10	17
6	Science report	1	-	-	1
7	Research	8	5	-	13
8	Research centre/university	1	4	1	6
9	NGO/UN Agency	10	23	11	44
10	Reporters'/columnist initiative	12	9	1	22
11	Listener/letter to producers	6	5	-	11

HIV/AIDS awareness among media practitioners

The articles analyzed show that media practitioners had a high level of awareness of HIV/AIDS issues. Of the articles, 27 (11.59%) were rated as very constructive and informative, 104 (44.64%) were constructive and informative, 56 (24.03%) were average, 2 (0.86%) were neither constructive nor informative, while another 2 (0.86%) were biased and confusing. Also, 187 (80.26%) were average and above in balance and 6 (2.58%) were taken to be very biased or biased (see Table 7).

On technical competence, 74 (31.76%) were rated as of average quality, 111 (47.64%) were competent or very competent, 5 (2.15%) were incompetent or very incompetent (see Table 8).

Like other members of the public, most media practitioners are very much aware of HIV/AIDS and have the ability to communicate these messages well. According to the study, only 4 (1.72%) articles were found to be neither constructive nor informative and 5 (2.15%) were judged as being incompetent. These findings tallied with the views of the editors of the leading newspapers in the country and Radio Uganda, when they were interviewed to get their views on HIV/AIDS coverage in their respective media.

A *New Vision* editor J. B. Wasswa and N. Ojwe editor of Radio Uganda Newsroom concurred that their reporters were well informed about HIV/AIDS issues and that, in most cases, they wrote good articles on the subject. The editors said that it was their duty to keep people informed about health issues, including HIV/AIDS. They, however, admitted that most of the coverage was in the urban areas where the organizations involved in HIV/AIDS activities are based. In an interview with J. Kigozi, Editor at *The East African* newspaper, he said that his paper did not carry many HIV/AIDS stories except for reports from organizations like the Uganda AIDS Commission and UNAIDS. He explained that the paper was business oriented and most of the coverage was centered on this. Kyazze-Simwogorere, a *Monitor* editor, said that the paper has a health page where HIV/AIDS stories are run. He explained that there was no specific policy on HIV/AIDS coverage but articles which are newsworthy on HIV/AIDS were carried by the paper. At the *Crusader* newspaper, the Chief Editor G. Lugalambi, said that most HIV/AIDS articles were from freelance journalists and that so long as they were well researched, the paper carried them. Most of them were usually run on the health page but sometimes they featured on other pages, depending on the news worthiness of the article, he explained. Apart from the editor at *The East African* who said his paper largely carried reports on HIV/AIDS, the other editors judged the stories on HIV/AIDS as being constructive and the journalists as being competent in handling them.

Table 5. *Main subjects of HIV/AIDS articles.*

	Subjects of HIV/AIDS articles	*Monitor*	*New Vision*	Radio Uganda	Total
1	HIV/AIDS prevalence	25	25	5	55
2	HIV/AIDS prevention	30	42	22	94
3	HIV/AIDS awareness	12	23	22	57
4	Medical costs of AIDS	-	-	-	-
5	Economic costs of AIDS	1	3	3	7
6	Demographic costs of AIDS	9	1	3	13
7	Other social costs	-	-	3	3
8	Politics of AIDS	-	1	-	1
9	Claim of ability to cure AIDS	-	5	1	6

Table 6. *Blame attribution for HIV/AIDS.*

	Blame attribution	*Monitor*	*New Vision*	Radio Uganda	Total
1	Foreigners/foreign body	-	1	-	1
2	Truck drivers	-	-	-	-
3	Prostitutes	4	1	1	6
4	Gays/lesbians	-	-	-	-
5	Reckless life styles	9	12	16	37
6	Polygamy	1	-	-	1
7	Husband/men	13	9	5	27
8	Wives/women	2	1	2	5
9	Other ethnic social group	-	1	1	2
10	Nobody in particular	29	46	9	84
11	Medical sector	3	2	1	6
12	Religious org.	-	-	-	-
13	Lack of resources/aid	7	2	9	18

Conclusion and recommendations

Summary of findings

HIV/AIDS issues are given little coverage in the Ugandan media. The articles come mainly as news stories, news analysis, feature and letters to the editor. The sources of this information are mainly local, supplemented by foreign and international syndicate/ feature services. A few articles in the print media find their way to prominent pages - front page, back page or page 2 and 3, while the majority are on the inside pages and in the feature section. Some articles come as page leads while most come as special commentaries.

For Radio Uganda, apart from HIV/AIDS issues that come as news items, there are other programmes that carry these issues. These include Family Life Education, Life Watch, Youth Straight Talk, Drama and Features, and Rural Outreach Programme. Most of the news articles analyzed were non-headlined. As in the newspapers, most of the articles originated from local sources, supplemented by foreign and international syndicates/feature services.

For both print and radio, most of the events covered were from the Ministry of Health/Government. Others were from NGOs and United Nations Agencies. There were a few articles which were through the reporter's initiative. The most frequent subjects of the articles were HIV/AIDS prevention, prevalence, awareness and demographic cost of AIDS with very little focus on the individual AIDS patients. Where this was focused on, the portrayal was mainly negative. There was blame attribution in half the articles but this was directed at nobody in particular. Where blame was attributed, this was on reckless life styles, prostitutes, men and some cases on women. The media practitioners were found to be highly aware of HIV/AIDS issues and had the technical competence to report on these issues.

Conclusion

Whereas the media have done a commendable job in raising people's awareness about HIV/AIDS and the rate of infection has dropped relatively, there is still more to be done with respect to effecting behavioural change. Depending on the way the media handle HIV/AIDS issues, the public is likely to perceive it in the

Table 7. *Constructiveness of HIV/AIDS articles.*

	Constructiveness of articles	*Monitor*	*New Vision*	Radio Uganda	Total
1	Very constructive & informative	4	3	20	27
2	Constructive & informative	34	44	26	104
3	Average	25	25	6	56
4	Neither constructive nor informative	-	-	2	2
5	Biased & confusing	-	2	-	2

Table 8. *Technical Competence in HIV/AIDS Articles*

	Technical competence	*Monitor*	*New Vision*	Radio Uganda	Total
1	Very competent	6	4	5	15
2	Competent	30	37	29	96
3	Average quality	29	28	17	74
4	Incompetent	-	2	3	5
5	Very incompetent	-	-	-	-

same light. In the early stages when HIV/AIDS cases started to be reported in the 1980's, HIV/AIDS featured prominently on the media agenda. At the close of the 1990's, HIV/AIDS was no longer "big" news. Some considerable coverage of HIV/AIDS is given on World AIDS Day but elsewhere it is not generally on a consistent basis. The media have a challenge to keep the public constantly reminded of the seriousness of HIV/AIDS.

Although there was not much direct blame attribution in the study, the images associated with HIV/AIDS patients tend to be negative such that infected people become outcasts in society. Sometimes, people suffer illness with similar symptoms like HIV/AIDS and they fear going for treatment in hospitals, so they die out of shame of being recognized as having HIV/AIDS. The media thus have to endeavour not to portray HIV/AIDS so negatively that people living with AIDS or those with symptoms are afraid of seeking treatment which could prolong their life.

However, to contain the HIV/AIDS situation, media as channels of information dissemination need to be supplemented by other sources since not all people, particularly in the rural areas, have access to the mass media. Even for those who have access, the media may be good for giving information due to their capacity to reach many people simultaneously but if one expects behavioural change, then there is need for other channels to be used such as interpersonal/group communication, theatre and posters.

As in other patriarchal societies, men dominate decisions in the home including those concerning sexual relations. A man's sexual prowess is judged by the number of women and children he has. Even among the elite this attitude persists. One finds many men with more than one sexual partner. Except for female sex workers, it is very rare for a woman to have more than one sexual partner. It is, therefore, necessary not only to focus on women in the fight against AIDS but also on the men. The case in the family planning campaigns earlier used is a good illustration of the interplay of gender relations. Initially, most programmes were targeted at women but there was not much change until the realization that women alone do not make independent decisions and men also started to be targeted. The same situation pertains

to HIV/AIDS communication. For example, on the use of protective measures like condoms, in most cases, the male makes the sexual advances and it would be an insult if a woman suggested to him to use a condom.

The fight against HIV/AIDS needs a multi-disciplinary approach, but above all, there is need to keep the public informed. The media have a vital role to play, especially radio which is the most accessible medium for the majority. The media houses need to move away from the old approaches to communication which involved mere dissemination of information. With the information explosion where people have multiple sources and channels of information to choose from, information has to be put into context otherwise people may just simply ignore the information if it appears irrelevant to their immediate environment.

For the journalists to properly inform and educate the public, they themselves must be informed first. Government, NGOs, United Nations and other external support agencies should keep journalists abreast with any new developments or breakthrough as well as current status of the epidemic. In Uganda, the NADIC of the Uganda AIDS Commission, could serve as the centre for monthly briefings to journalists or to be responsible for sending out press releases. Since editors claim that HIV/AIDS stories no longer sell, there is need to train journalists to package the HIV/AIDS issues in a way that will make them sell. This can be done in the media training institutions or through seminars/workshops for those already practicing.

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THE ZAMBIAN NEWSPAPERS AND AIDS

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MEDIA BACKGROUND

It is important that we give the background of the newspapers which were the subject of the content analysis study. These are, the two government dailies the *Times of Zambia* and the *Zambia Daily Mail* and their Sunday editions, the *Sunday Times of Zambia* and the *Sunday Mail.* We will also give the background of *The Post*, a privately-owned daily.

The *Times of Zambia* is the country's oldest newspaper having been founded in 1943 as a newspaper for white settlers who had come to settle in the then Northern Rhodesia, as Zambia was known during colonial rule (Kasoma, 1986). From its inception to the year of Zambia's independence in 1964, the newspaper was known as *Northern News.* It became a daily in 1953 at a time when Northern Rhodesia became politically part of the Federation of Rhodesia and Nyasaland, a political structure that was vehemently opposed by the African nationalists. Because it was the organ of the white settlers, the *Northern News* was supported by the people who controlled the country's industry and commerce, the whites, who preferred to place advertisements in the newspaper rather than in the *African Mail.* Because of bigger advertising space, the newspaper has always had a higher circulation than the *Zambia Daily Mail.* At independence, efforts were made to make the newspaper a national organ rather than one for the whites only. In 1978 the government nationalized the newspaper.

The *Zambia Daily Mail* started as the *African Mail* at the height of the nationalist struggle in 1960. It was started with capital from the editor of *the Observer* newspaper in London, David Astor. From its commencement, as indicated earlier, it supported the nationalist struggle for self-determination and independence. This editorial policy cost it advertising from the economically-well-to-do whites. But its circulation increased by leaps and bounds, to the extent that it was later renamed *Central African Mail.* It was renamed *Zambia Mail* at independence when Astor sold the newspaper to the Zambian government who within a few years made it a daily newspaper and named it, *Zambia Daily Mail* (Kasoma, 1986).

The Post was started by private Zambian businessmen in 1991 at the climax of the agitation by a sizeable section of the Zambian community for democratic governance which resulted in the re-introduction of a democratically elected government in the same year. Its ownership spread across the political divide since both United National Independence Party (UNIP) and Movement for Multiparty Democracy (MMD) members owned shares in the newspaper. It soon established itself as an outspoken newspaper critical of the government in power, first the Kaunda and later the Chiluba governments. Unlike the other two dailies, *The Post* is not published on Sundays.

All three daily newspapers are essentially town newspapers which circulate almost exclusively in the main urban centres. They are very rarely found in the countryside where a little less than half of Zambia's population lives.

The three newspapers were chosen as subjects for this study because they are the only daily newspapers in the country. Mixing them with other newspapers which appear less often would have compounded the basis for comparison in the study. It would also have made the study too wide and less focused.

EARLIER STUDIES

This is the third study this researcher has undertaken on the Zambian media and the coverage of HIV/AIDS.

The first study, "The Zambian press and the AIDS crisis", (Kasoma, 1990/91) looked at the HIV/AIDS stories which the *Times of Zambia* and the *Zambia Daily Mail* published in 1986, when the Zambian government officially recognized the presence of the Human Immunodeficiency Virus (HIV) which leads to the Acquired Immune Deficiency Syndrome (AIDS) in the country, and 1989 when it was assumed, by this researcher, that HIV/AIDS had become well-known in the country.

The first study established that 60% of the news stories published in the two daily newspapers were foreign. The two newspapers also did not regard HIV/AIDS stories important enough to deserve page one treatment. Only 22% of the stories were used on page one, of which 8% were lead stories.

The two newspapers only published nine editorials between them during the two years, four in 1986 and five, all by *The Times*, in 1989. A total of 29 letters to the editor were published. The most commonly discussed subject-area by both newspapers was that of "AIDS tests/deaths/widespreadness" which surfaced in 50 (45%) articles in 1986 and 84 (47%) in 1989. Only 12% of the articles contained Mobilizing Information (MI), (Kasoma, 1990/91).

MI is described as any information that allows people to act on attitudes and desires they already have (Kasoma, 1990/91:50). As Kristiansen and Harding (1984:243) have stated, "the notion of MI is particularly relevant to studies of health reporting because the literature of fear communications are more likely to promote a given behaviour when specific details about actions which will counteract or prevent the health threat (i.e. how, when, where) are explicitly and precisely described.

The second study, a "Content analysis of AIDS stories in Zambian media", (Kasoma, 1996), was much broader. It included not only *The Times* and *the Mail* but also *the Post*, *National Mirror* and radio and television programmes of the Zambia National Broadcasting Corporation (ZNBC).

The study was carried out in 1993. Unlike the earlier research, this study found that most of the stories were local and not foreign. Rarely were the stories published on page one. The predominant type of story was the feature story. Not much emphasis was placed on advertisements in all the newspapers, but particularly *the Mirror* which did not carry any advertisements. There were only four editorials published during the whole year, two in *the Times* and two in the *Mail*. Very few letters to the editor were published by all the newspapers.

As in the earlier study, most of the stories were about "AIDS tests, widespreadness, sickness and deaths". "Cause and prevention" came second and "cure and vaccine" third. None of the stories contained MI. Most of the stories were not new but had been published before.

The present study followed the 1993 study closely. It looked at the HIV/AIDS publicity in *the Times*, *the Mail* and *the Post*.

Originally, the intention was to include radio and television programmes of the Zambia National Broadcasting Corporation (ZNBC). But the researcher was told by ZNBC senior management that no tapes of either the radio or television programmes were kept since they were reused for other programmes due to an acute and persistent shortage of funds to purchase new tapes. It would have been useful, particularly to look at television programmes since studies elsewhere indicate that television publicity of HIV/AIDS has some considerable impact in other parts of the world.

Apart from the two earlier studies by this author referred to above, there have not been any media content analysis studies on HIV/AIDS in Zambia. But there have been other surveys on the disease in the country. These include Mbozi's study on the impact of billboards on HIV/AIDS on youths in Zambia (Mbozi, unpublished). The focus of this study was to determine how useful the anti-HIV/AIDS billboards had been to the youths of the country who were the target group. Mbozi's conclusion was that billboards did not

have much impact partly because of the way they had been created (without pre-testing and no involvement of the youths) and partly because the messages they carried did not answer the needs of the youths on the issues. Other factors, such as the placement of the billboards and their subject matter, also negatively influenced their impact.

Research method

The editions of the three newspapers were examined for 1997 and the first six months of 1998. This involved physically visiting the respective newspaper libraries and examining the cuttings as well as the full editions of the newspapers to ensure that reports were not left out.

As in the previous studies, a checklist containing 14 items was used. For each story a separate form of the checklist was completed. It is the data from these which were used for analysis.

Results

The Zambia Daily Mail

A total of 110 articles were examined of which 73 (66%) were news stories, 35 (32%) were features, one editorial (.9%), and two letters to the editor (2%).

It is noteworthy that although *the Mail* published the highest number of articles of the three newspapers examined, it had only one editorial. The editorial was published on 2 December 1997 to mark the World AIDS Day which falls on December 1. It, ironically, called on Zambians not to wait until December 1 to make themselves active on preventing the spread of HIV/AIDS. The fact that the newspaper published only one editorial strongly suggests that the editor did not think HIV/AIDS was a subject that warranted commenting on.

It is also surprising that *the Mail* published only two letters on HIV/AIDS for the 18 month period. The newspaper did not think the HIV/AIDS news stories were important enough to deserve being used as page one lead stories. Only four of the stories were used as page one leads. There were 106 articles, representing 96% of the total articles the newspaper published, used in the inside pages. Most of the stories 63 (57%) were not new. They contained material that had already been published by the newspaper. Only 49 (45%) contained new information.

Most of the articles 87 (74%) were local. There were 26 (23%) reports which were foreign. This is a suggestion that the focus of attention was on the local as opposed to the foreign HIV/AIDS scene.

Regarding the categorization of the articles according to what they treated, most of the stories were dealing with the combined topic of "cure and vaccine" which recorded 36 (33%). The next highest category was the area of "test, widespreadness, sickness, deaths" which received 28 (25%) stories; "cause or prevention" had 11 (10%). There was only one story which treated the topic of "origin of HIV/AIDS". Stories which dealt with "other" topics were 45 (41%). The "other" topics were wide-ranging and included subjects like "home care of AIDS patients", "counselling", and "AIDS orphans". The fact that a sizeable number of the stories treated "other" topics suggests that the range of matters raised in the coverage of HIV/AIDS had grown as people devoted more attention to the devastating effects of the pandemic.

No story contained any MI but all the stories were easily comprehensible.

Only five stories, representing 5% named a person as dying from AIDS suggesting that Zambians were still shy to associate people's deaths with AIDS since it was regarded as a "shame disease" referred to only in euphemisms like "died after a long illness".

Seven of the articles, representing 6% of the total number of articles the newspaper published, gave figures of people dying from AIDS. But the figures were misleading and contradictory. For example, three of the stories gave 21 million as the figure of adults who were infected with HIV/AIDS in Sub-Sahara Africa. But one of the stories gave the figure as 14 million. A few self-confessed people were named in a number of stories as being HIV positive.

Surprisingly, only three of the stories discussed, either wholly or partly, negative cultural

issues about HIV/AIDS. One treated beliefs about sleeping with a virgin as making HIV positive people become HIV negative. The second discussed the practice of succession rights for widows in which they are made to have sex with a relative of their deceased husband as responsible for spreading HIV infection. The third was about the practice in which certain men who are impotent make their wives have sex with another man so that he can bear them children.

The Times of Zambia

A total of 78 articles were published of which 47 (60%) were news stories, 25 (32%) features, two (3%) editorials and four (5%) letters to the editor. There was only one page one lead story.

Again it should be noted that *the Times*, like *the Mail*, published very few editorials on HIV/AIDS. The newspaper published only two editorials. Like its sister government paper, *the Times* did not think HIV/AIDS stories were important enough to deserve page one treatment. All the stories, except one, were used on the inside pages.

Unlike *the Mail*, however, most of the stories 47 (60%) were new while 31 (40%) had been reported before. It is remarkable that all the stories the newspaper published were local.

Regarding the categorization of the type of stories the newspaper published, most of them 29 (26%) dealt with topics of HIV/AIDS "tests, widespreadness, sickness and deaths"; "cure and vaccine" had 18 (23%); while "cause or prevention" had 11 (14%). There were no stories dealing with the "origin". But 31 (40%) of the stories dealt with "other" topics.

There was not a single story which contained MI while all the stories were easily comprehensible. No one was named in any of the stories as having died from AIDS, although seven of the stories contained statistics of people who had died from AIDS. Apart from a couple of self-confessed people, there was no one named in the stories as having HIV/AIDS.

The newspaper published only two stories which touched on the subject of negative cultural issues. One was about a man who allegedly had sex with a dog to avoid being infected with HIV. The story said it was unAfrican to have sex with a dog. The other story said the use of condoms was against African cultural tradition.

The Post

Out of a total of 378 newspapers searched, *the Post* only published 19 stories about HIV/AIDS. Of these, 17 (89%) were news stories and one was a letter to the editor. The newspaper did not publish any editorial on the subject. Most of the stories, 11 (58%) treated new subjects while eight (42%) were on subjects already reported. The newspaper published only one foreign story, representing 5% of all the stories it published. The rest 18 (95%) were local stories.

Only two stories (11%) were published on page one. They were both used as leads. One was about a Dr. Ngosa, a Zambian, who was reported by the *London Daily Mail* as having been charged by the British Medical Council for not taking the HIV test soon after a woman claimed she had been infected with HIV by him. The other was about Zambian President Frederick Chiluba urging scientists to find an AIDS cure instead of manufacturing condoms.

Regarding the topics treated by the newspaper, *the Post* gave equal treatment to the two topics: "cause or prevention", eight (42%) and "test, widespreadness, sickness and deaths", eight (42%). The area of "cure and vaccine" had only two (11%) stories. There were no stories about origin of AIDS. Stories covering "other" were seven (37%). They included alleged misconduct by Dr. Ngosa and discrimination of HIV/AIDS people in society.

None of the stories contained MI but all stories were easy to understand. No one was named in any of the stories as having died from AIDS. But three stories (16%) gave some statistics about HIV/AIDS. One said 400,000 children in Zambia below 15 were infected with HIV in 1996. The other said 1,000,000 children were with HIV in 1997. The third one said in 1998 there were 30 million people with HIV/AIDS in the world while sub-Sahara Africa had 14 million cases and Zambia 100,000.

Two people were named in two stories (one in each) as having HIV. There were no stories which treated negative cultural issues.

Comparing frequencies

The Mail, as indicated earlier, published the highest number of HIV/AIDS stories, 110 in all. *The Post* had the least number of stories (19) while *the Times* came second with 78 stories.

However, looking at the type of stories published in terms of whether they were news stories, features, editorials or letters to the editor (Table 1), *the Post*, comparatively, published more news stories (99%). *The Mail* came second at 66% and *the Times* third at 60%. This means that all the three newspapers concentrated on giving people news rather than background information which features usually contain. In fact, *the Post* did not publish any features at all while the HIV/AIDS hole of *the Mail* and *the Times* contained 32% features apiece. *The Post* did not carry any editorials while *the Mail* had one and *the Times* two. But *the Times* published more letters to the editor (5%) as against 1% for *the Post* and 2% for *the Mail*.

In terms of "local" versus "foreign" stories (Table 2), all the stories (100%) published by *the Times* were "local". *The Post* had 95% while *the Mail* had 74%. This was a strong indication that the focus was on the "local" HIV/AIDS scene and not on what was happening outside Zambia.

Considering the categories of "new" and "not new" stories (Table 3), *the Times* published 60% "new" stories while the figures for *the Post* and *the Mail* were 58% and 47% respectively. Conversely, *the Mail*'s reportage consisted of mostly (57%) "not new" stories or repetitions of what had already been published.

Table 4 clearly suggests that the three newspapers did not think the origin of AIDS was worth wasting valuable space on. Only *the Mail* published one story on the subject. The most heavily publicised topic area was "test, widespreadness, sickness, deaths" which had 42% attention from *the Post*, 33% from *the Mail* and 23% from *the Times*. "Cause and prevention" had 42% from *the Post*, 14% from *the Times* and 10% from *the Mail*, while "cure, vaccine" had 33% from *the Mail*, 23% from *the Times* and 10% from *the Post*. In the category of the "other", it is *the Mail* that led with 41% followed by *the Times* at 40% and *the Post* at 37%[1].

These statistics mean that the areas of "test, widespreadness, sickness, deaths" and "cure, vaccine" received the most attention from the three newspapers, strongly suggesting that the general public in Zambia, according to the decision of the editors, wanted to know how widespread HIV/AIDS was and what was being done to arrest its spread. The area of "cause and prevention" of HIV/AIDS got the least attention after "origin". The interpretation is that editors knew that the cause and prevention of HIV/AIDS were common knowledge in Zambia and required very little publicity, if any.

The HIV/AIDS stories newspapers tell

In this section, we discuss the main details of the contents of the stories the newspapers published.

Cure

The three daily newspapers devoted a lot of space to cure for HIV/AIDS. Much of the space was given to the controversy surrounding the claim by Mulenga Lukwesa that the drug *Herbiron Tisaniferon*, which his MLN Laboratory had developed, could cure AIDS. The Medical Council of Zambia (MCZ) and government dismissed the claim and banned the use of the drug by doctors in the country until after it had been tested scientifically. But the test itself was reported not to have been conclusive because those who were carrying it out had, reportedly, run out of funds. An angry Lukwesa, who

[1] The frequencies do not add up to the original total figures or to 100% because some stories were counted more than once since they could deal with more than one category.

Table 1. *Frequency of type of stories.*

Newspaper	Type of story				
	News	**Feature**	**Editorial**	**Letters**	**Total**
Mail	73(66%)	35 (32%)	1 (.9%)	2 (2%)	110 (100%)
Times	47(60%)	25 (32%)	2 (3%)	4 (5%)	78 (100%)
Post	18 (99%)	–	–	1 (1%)	19 (100%)

Table 2. *Frequency of local and foreign stories.*

Newspaper	Type of story		
	Local	**Foreign**	**Total**
Mail	87 (74%)	26 (23%)	110 (100%)
Times	78 (100%)	–	78 (100%)
Post	18 (95%)	1(5%)	19 (100%)

Table 3. *Frequency of "new" and "not new" stories.*

Newspaper	Type of story		
	New	**Not new**	**Total**
Mail	47 (43%)	63 (57%	110 (100%)
Times	47 (60%)	31 (40%)	78 (100%)
Post	11 (58%)	8 (42%)	19 (100%)

Table 4 . *Frequency of categories of stories.*

Newspaper	Category of story				
	Origin	**Cause and prevention**	**Test, sickness, widespreadness and deaths**	**Cure, vaccine**	**Other**
Mail	1(%)	11(10%)	28 (25%)	36 (33%)	45 (41%)
Times	–	11(14%)	29 (26%)	18 (23%)	31(40%)
Post	–	8 (42%)	8 (42%)	2 (10%)	7 (37%)

claimed to have made K2.5 billion from sales of the drug, warned the government and the MCZ to keep off his drug. He had sympathisers in Members of Parliament who advised the government not to discourage people like Lukwesa who were claiming to discover drugs that could heal AIDS. Other supporters included the general public (letters to the editor) and the Traditional Herbalists and Healers Association which urged Zambians to stop fighting and instead find a cure for AIDS.

The Times and *the Mail* also supported Lukwesa. In two editorials (one for each), the newspapers called on the government not to discourage traditional healers and other people who claimed to have found a cure for AIDS. But the government was adamant. It closed the controversy by ruling that *Herbiron Tisaniferon* could only be used as a traditional medicine.

The newspapers gave extensive coverage to traditional healers and others claiming to have found medicine that could heal AIDS. They included a retired nurse from Kitwe who claimed that her Jaroots Herbal Formula healed AIDS-related diseases. Another woman in Kapiri Mposhi also claimed to have medicine to heal AIDS. A woman medical doctor who was reported to be operating from a Kabwe hotel claimed that she had an injection that cured AIDS. But none of these claims were reported to have been authenticated by medical experts.

The newspapers also reported progress being made to find a genuine AIDS cure and vaccine against HIV. Some of the medicines named included *Virodene*, a drug developed in South Africa which, like *Herbiron Tisaniferon*, had split the South African authorities with the government being in support of it and the Medicines Control Council (MCC) being against it. Another drug named in the stories was *Azidothymide* (AZT) which one of the stories warned could be dangerous if not administered properly. The medicine was said to be available in Zimbabwe.

Several stories announced the launching in the United States of America of tests on humans of an HIV vaccine. One story said Zambians were excited about the commencement of the trials of the new vaccine.

Sustiva was reported to be found useful as a drug for AIDS patients. The Tropical Diseases Research Centre in Ndola was reported to have appealed to Zambians to come forward and help test the Chinese drug called *Fesol*. The French drug, *Pasteur Merieux*, was also reported to go on trial in Uganda.

The cost of treating AIDS patients was a subject of a number of stories. One story quoted the Central Board of Health as saying the AIDS treatment bill would reach $21 million in the year 2005. Another, again quoting the Central Board of Health, simply said treating AIDS patients had become too costly.

The building and opening of an HIV/AIDS private hospital in Chilanga, near Lusaka, also received considerable space. The hospital, the only one in Zambia, was built by a Dutch woman, Pola van der Donck, in memory of her brother who had died of AIDS. It was being managed by the Catholic Church. But the punch story was the one which said scientists were still a long way off to find an AIDS cure.

Widespreadness and prevention

Zambian newspapers, contrary to expectations, hardly publicized negative cultural practices that lead to increase in HIV infections, in spite of the fact that Zambians knew this was a big problem in the fight against HIV/AIDS. Only one story in *the Mail* specifically referred to traditional practices as contributing to the spread of HIV infection. Instead of publicizing the common cultural practice in which widows are made to have sex with a relative of the deceased husband, usually a brother, the newspapers (particularly *the Times*) publicized a story in which they said widows whose husbands had died of AIDS were becoming sexually reckless. A curious story was reported by *the Mail* in which the United Nations Population Fund (UNFPA) was reported as calling on Zambians to maintain traditional and cultural values (presumably positive ones) to fight HIV/AIDS.

A number of stories reported on seminars for truck drivers who were widely believed to be spreading HIV because of the number of girlfriends they had along their routes. Some stories reported that the incidence of HIV infection among girls was higher due to factors such as prostitution, "sugar daddies", a name given to promiscuous men, and the rising incidences of incest. Generally, the stories said the HIV infection of women was higher than that of men and was increasing at an alarming rate.

Zambia was reported to be ranked fourth in the HIV/AIDS infection in Africa while Malawi and Zimbabwe were said to be AIDS troublespots where five young people, aged between 10 and 24 years were reported to be infected with HIV every minute, according to *the Washington Line*, a USA Embassy publication in Lusaka. The most popular form of prevention against HIV infection, judging by the number of stories published on it, was the condom which was embroiled in endless controversies. For example, some newspaper reports alleged that condoms were not safe to prevent HIV infection because they had holes. But the Central Board of Health was quick to put out a statement in which it emphatically said there were no holes in condoms. Some stories said condoms were more effective to preventing HIV infection than they were given credit for.

A number of government officials, including Vice President Godfrey Muyanda and President Chiluba, were often quoted as discouraging the use of condoms and preaching abstinence as the only sure prevention against HIV/AIDS. They were supported by the churches. Femidom, the female condom, also received some publicity and similar condemnation, from the same people and organizations criticizing the use of condoms.

Government ministers and the Zambia Congress of Trade Unions (ZCTU) repeatedly expressed worry about the serious effects on Zambia's economy of the spread of HIV/AIDS pandemic. The ZCTU was reported to have been alarmed at the prevalence of HIV/AIDS infection at work places and urged its member unions to help fight the epidemic.

HIV TESTS

Some considerable publicity was given to the issue of HIV tests. In some stories, a chain shop manager in Lusaka was reported to be carrying out "silent HIV tests" among his employees. The manager admitted that he was subjecting workers to the HIV test. In another story, a man who was HIV positive was reported to have hung himself.

Some stories reported that fear of undergoing HIV tests was common among Zambians. Prostitutes were among those who were afraid of knowing whether they were HIV positive or not. One story said they were shunning joining Tasintha, an organisation to reform prostitutes, because it required them to undergo an HIV test. A few stories said HIV tests were necessary if the spread of HIV/AIDS had to be controlled. One story, however, quoted a Japanese doctor in Lusaka as saying the HIV test using anti-bodies was unreliable because it did not reveal infections which were four weeks or less old.

CHILDREN AND ORPHANS

A considerable number of newspaper reports said many children were infected with HIV. No specific numbers were suggested but the problem was said to be very serious. To emphasize the seriousness of the problem, the theme "children living with AIDS" was chosen for the World AIDS Day on 1 December 1997.

Publicity about the so-called AIDS orphans was carried out by *the Times* and *the Mail. The Post* did not publish a single story. Many of the stories kept repeating the fact that life was getting tough for the orphans many of whom had to eke out a living from the streets. Government promised assistance for families looking after AIDS orphans. One story predicted that the number of AIDS orphans in Zambia would swell to 600,000 by the year 2000. There were, generally, no specific figures given for the number of AIDS orphans in Zambia during the period covered by this study. Reference was merely made to thousands of AIDS orphans.

Treatment of HIV/AIDS people

Wide publicity was given to the treatment accorded to HIV/AIDS people. Some of the stories quoted people who were HIV-positive as saying that they were being discriminated against by society, including at work places. This, certainly, contributed to the reticence of HIV-positive people to come out in the open, which a couple of stories complained against. There were only a few Zambians such as Winston Zulu, David Chipanta and Clement Mufuzi who had come out in the open and were regularly quoted by the press as being spokespersons of HIV positive people. Some stories accused those who had come out in the open as having been paid a lot of money for doing so.

Positive living by HIV people was a common subject in many stories. Positive living organizations were reported to be mushrooming throughout the country, particularly in Lusaka and Copperbelt provinces. To promote this, the Commonwealth Youth Programme, based at the University of Zambia in Lusaka, was reported to be organizing workshops and seminars for the so-called "AIDS ambassadors" – people who were HIV positive who were sent around the country to tell their colleagues that being HIV positive was not the end of the world and also warn society about the dangers of contracting HIV.

To support the promotion of positive living, a number of counselling centres were reported to have been started in the country, particularly in major urban centres. These counselling centres were partly to take care of AIDS patients. The most reported HIV/AIDS counselling centre by far was Kara Counselling Centre in Lusaka. Some publicity was also given to the need for home-care for AIDS patients. Development Aid from People to People was reported in one story to have trained 200 HIV/AIDS patient handlers and counsellors at a workshop in Ndola.

A number of banks were reported to have donated funds to HIV/AIDS organizations such as Kara. According to press reports, the country had a number of HIV/AIDS organizations. They included the Catholic Church Home Care (based on the Copperbelt), Network of Zambian People Living with HIV/AIDS, Society for Women Against AIDS in Zambia, Alangizi Women Association of Zambia and the Zambia National AIDS Network.

Discussion and recommendations

A number of issues stand out in the findings of this study. These are the stress on publishing local stories, the lack of MI in the stories published, the few editorials published, and the stress on publishing news stories rather than features.

Local stories

In my first study, it was established that Zambian newspapers had a preponderance of foreign stories on HIV/AIDS. The explanation given then was that HIV/AIDS was a new disease in Zambia and editors wanted to show that HIV/AIDS was "out there" and not a problem in the country. Moreover, most of the information on HIV/AIDS made available to the editors was from outside the country, mainly the North. By the time of the current study, the situation in Zambia had changed so much that Zambia is said to have become the fourth HIV/AIDS country in Africa and one of the highest in the world. HIV/AIDS was now a real threat to the country and deserved a lot of publicity.

Lack of mobilizing information

The lack of MI in HIV/AIDS stories published by Zambian daily newspapers is remarkable. It partly means that those who file the stories that are published are not concerned with follow-up action by giving people information such as addresses, telephone numbers etc. which people can use to act on the information. This is particularly important since the stress on the HIV/AIDS publicity by the newspapers is not on giving knowledge such as how HIV is contracted and how it can be prevented, but on giving practical information such as where to get HIV tests, where to go for counselling and where HIV/AIDS organizations are and how they can be contacted. This information was simply not provided in the HIV/AIDS stories the three newspapers published.

Accordingly, this researcher recommends that a series of seminars/workshops be held for senior reporters of the three newspapers to teach them how to include MI in newspaper stories.

Few editorials

Editorials serve as agenda-setters. Through them, newspapers may not be able to tell their readers what to think but they certainly do tell them what to think about. By publishing a negligible number of editorials on HIV/AIDS, the Zambian daily newspapers were sending a clear message, as already pointed out, that HIV/AIDS was not worth editorializing on. If in the earlier two studies a preponderance of editorials on HIV/AIDS was found, it would have been concluded during the current study that editors had become tired of writing on the issue, pandemic as it may be. But the finding of the earlier studies was the same; there were hardly any editorials published on HIV/AIDS.

Therefore, it is strongly recommended that a series of seminars or round-table discussions be organized for the top two editors of each of the three newspapers to discuss why they shun away from writing editorials on HIV/AIDS.

Preponderance of news stories

The fact that the most popular story was the news story is an indication that the newspapers were more interested in giving people current information and hard facts about HIV/AIDS rather than backgrounders. Since reportage in Zambia is mainly based on speeches made by officials, most of the news stories were reporting speeches made by mainly government officials. There was hardly any in-depth well-researched news item. It is recommended that a series of seminars/courses be organized for senior reporters in the country to teach them how to report effectively on HIV/AIDS.

Sensitizing media people

The biggest problem is that journalists and other media people in Zambia are not attuned to what it means to use the mass media to combat HIV/AIDS or its effects. They do not seem to appreciate the role of the media regarding what they can do and not do in combating the pandemic. Many people think it is merely a question of publishing articles or broadcasting material that warns people against the danger of contracting HIV/AIDS and telling them how the disease can be contracted.

Journalists in Zambia ought to include in their reportage the counselling aspect of the HIV/AIDS sufferers. They need to provide MI to HIV/AIDS patients about where they can obtain counselling help. For this to be effective, the mass media channels in the country need to set up HELPLINES by displaying telephone numbers where people with HIV/AIDS can call toll-free to seek advice. Zambia has a number of HIV/AIDS centres which can give such advice but the people, particularly the HIV/AIDS sufferers, hardly know about their existence or how they can get in touch with them. It would be very useful if media houses got in touch with these centres with a view to requesting them to regularly publicize their activities and how HIV/AIDS sufferers can benefit from these services.

The media also need to establish regular features and broadcast productions to keep in constant focus the HIV/AIDS predicament in the country. These could take the form of regular columns in the daily and weekly newspapers discussing topical issues on the subject as well as providing up-to-date information about developments of the disease. The once-in-a-while articles published in newspapers and productions on the national radio and television station are simply not enough. If HIV/AIDS is the pandemic it is supposed to be, then it ought to be treated as such by the media, making the people constantly aware of its existence.

To further promote the HIV/AIDS awareness, the mass media in Zambia could also be involved in the promotion of jingles and attention-catching gimmicks, all directed at keeping Zambians constantly aware of the presence of the devastating disease in their midst. For this, the press could make use of self-con-

fessed HIV carriers who could be made to participate in publicity-seeking stunts which would bring the reality of HIV to the Zambian population. Such stunts would also help in bringing the ever-increasing HIV-positive community in Zambia to being less discriminated against by society.

Conclusion

The results of this study make more sense if they are read in conjunction with the two earlier studies. The three studies have clearly established a pattern on how the media in Zambia have reported on HIV/AIDS.

This particular study has confirmed that there are certain things that ought to be done for the publicity on HIV/AIDS to be more effective than it has been. But this will only come about if the recommendations made in this report are implemented.

HIV/AIDS is a pandemic that has the potential to devastate the population of Zambia. It is, therefore, a topic that should interest journalists and editors in all respects.

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THE COVERAGE OF HIV/AIDS IN NAMIBIAN MEDIA: A CONTENT ANALYSIS STUDY

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A GENERAL SOCIAL BACKGROUND

Namibia is a big country in Southern Africa, surrounded by Zambia and Angola to the North, Botswana to the East, South Africa to the South, and the Atlantic ocean to the West. The population stands at 1.7 million and is scattered unevenly throughout this large, arid but beautiful country. Economically, per capita income stands at an average of N$ 3608, ranging from a low N$ 1070 in Omaheke region to a high N$ 11,359 in the Khomas region. Thus there are wide disparities in income per capita, which has made Namibia one of the most unequal societies in the world (UNDP and UNAIDS, *Namibia Human Development Report,* 1997). This economic characteristic is largely a legacy of the policy of apartheid which South Africa, the former colonial master had introduced and practised in Namibia for more than 70 years. The present Government, which came into power in 1990 after a long and protracted liberation war, is making efforts to address income inequalities through land redistribution, economic empowerment, broader access to education, and a balanced economic, social, and infrastructural development of the whole country.

The country's literacy rate stands at 66 per cent and the school enrolment rate is 90 per cent, which effectively means that about 10 per cent of the children of school going age do not attend primary school and 34 per cent of the population are functionally illiterate. The literacy map shows variations: whereas the Khomas region has 84 per cent literacy rate, the lowest is in Kunene at 45 per cent literacy rate *(Namibia Human Development Report,* 1997:15). There is, therefore, a significant percentage of the population which cannot directly access HIV/AIDS information provided in the written format.

In the print media, there are five main newspapers, namely: *The Namibian, New Era, Observer, Die Republikien 2000,* and *Almegine Zeitung* and a few magazines and newsletters issued by various bodies outside Windhoek. With the exception of the *New Era* which is government owned, the rest are privately owned. The main languages of publication are English (three papers) and Afrikaans (one paper). The *Almegine Zeitung* is a German language paper targeting the large German community in Namibia. The *Namibian* and *New Era* also carry stories in local languages, mainly in Oshivambo, Otjiherero, Afrikaans and Lozi. The print media are dominated by a few newspapers, mostly based in the capital city, Windhoek, with a heavy urban bias in their coverage. According to CSO (1994), 25 per cent of households in Namibia buy at least one newspaper per week.

Namibia has six radio stations, but only the Namibia Broadcasting Corporation (NBC) has nation-wide coverage. The others are: Radio 99, Channel 77, Radio Energy, Katutura Community Radio, and Kudu Radio. Radio ownership has been growing steadily from a low 50 per cent in 1990 to 60 per cent in 1991, and very likely a much higher figure today (CSO, 1994). Again, there is an urban bias in radio ownership, with 76 per cent of urban households owning a radio as compared to 50 per cent of rural households. According to NBC, their radio coverage reaches 95 per cent of the population. Figures from Central Statistics Office, however indicate a slightly lower percentage (76.6 per cent) (CSO, 1994).

Background to the HIV/AIDS problem in Namibia

HIV/AIDS was first reported in Namibia in 1986. Since then, it has spread to all corners of the country and has become an epidemic escalating at an alarming pace (UNDP and UNAIDS. *Namibia Human Development Report,* 1997). The above report uses the following figures to show how serious the situation has become:

- AIDS has become the leading cause of death in the country;
- There may be more than 150,000 Namibians infected with the virus;
- 20 per cent of the 15-49 age group are estimated to be infected with HIV;
- 39 per cent of the 20-24 age group are estimated to be affected with HIV;
- Globally, Namibia ranks as the third most affected country in the world.

In practically every country in Eastern and Southern Africa, the HIV/AIDS pandemic situation is as gloomy as (or worse than) that depicted by the above statistics. The following questions arise from the HIV/AIDS crisis: What role can the national media play in containing and managing this epidemic? How have the Namibian media been performing in their coverage of HIV/AIDS and how are the various factors associated with the spread of HIV/AIDS handled? What prominence is given to the key factors which cause HIV/AIDS infection among the population? How can the Namibian media be improved to help society to combat HIV/AIDS?

It can be argued that through frequent coverage of stories highlighting HIV/AIDS, giving prominence to the factors which either cause or lead to individuals getting infected with the HIV/AIDS virus, the Namibian media make a major contribution towards managing and ultimately defeating this terrible disease. The media play a dual role of setting the social agenda for politicians and policy makers and disseminating useful information directly to the public which enables them to learn how to avoid the disease.

LITERATURE REVIEW

In the early 1960's, the dominant belief was that media messages would always be followed by the adoption of the communicated ideas through the so called "magic bullet theory". This dominant belief in the impact of media has now been modified and the belief is that the media do not have such complete control over the social change process. DeFluer and Ball-Rokeach (1988: 218) (and many others) have, however, noted that the mass media still play a major role in the social learning process and have influence on how individuals acquire new ideas, attitudes, and change orientation in society.

To succeed in the above goal, however, the media must have a coherent strategy on the coverage of HIV/AIDS. Some attempts at researching media coverage of HIV/AIDS have already been made in other countries, particularly developed countries, but few studies have come out of the developing countries (Childers, 1988; Lester, 1992; Basil and Brown, 1994). An "action plan" of purposeful and impact-bearing information dissemination can only emerge after an assessment of current practices of media in the coverage of HIV/AIDS in a specific country so as to identify strengths, weaknesses, and gaps in the dissemination of information on AIDS.

The research method chosen to analyze media coverage of HIV/AIDS was content analysis. The appropriateness of content analysis for this type of study is supported by many researchers in the social sciences. Adams and Schvaneveldt (1991: 299) point out that: "content analysis is a research tool for the scientific study of speeches, records, and other written communications to determine key ideas, themes, words, or other messages contained in the record". Supporting the above, Holsti (1969) has defined content analysis as a procedure for applying the scientific method to documentary evidence and Krippendorff (1980: 7) asserts that "content analysis is one of the most important research techniques in the social sciences; it seeks to understand data not as a collection of physical events but as symbolic phenomena and to approach their analysis unobtrusively". It

would appear, therefore, that the choice of content analysis for this study is supported by other researchers in the social sciences including mass communications.

Purpose of the study

Given the seriousness of the HIV/AIDS pandemic in Namibia and the constructive role the media can play, the purpose of this study was to examine the coverage of HIV/AIDS in Namibian media and make recommendations for designing a media strategy to combat the disease. The study also examined locally produced materials supporting HIV/AIDS campaigns to assess and evaluate the materials and make recommendations for improvement.

Research questions and definition of terms

To give the study rigour, the following research questions were formulated to provide guidance:

1. To what extent have the Namibian media covered the core factors influencing the spread of HIV/AIDS in society?
2. What angles have the media given in their coverage of the core factors?
3. What weaknesses are apparent in media coverage of the various factors associated with the spread and management of HIV/AIDS in Namibia?
4. How have the Namibian media performed in the coverage of general and preventive factors compared to factors which cause HIV?
5. What are the extent and nature of local publications produced to assist in spreading the message on HIV/AIDS?

From the above research questions, one can derive a number of key concepts or terms which will be briefly explained to make this report clearer to its readers.

Coverage: refers to the presentation by the media of stories on HIV/AIDS. Coverage was measured in frequencies.

Aspects or angle: refers to the central messages which are conveyed during the handling of a factor or content category. Interpretative and qualitative descriptions are used to present the various aspects found in the coverage of each content category.

Factors: refers to the key terms or content categories which play an important role in the spread or management of HIV/AIDS. Factors or content categories were measured in terms of the frequency of occurrence.

Content categories: refers to the key terms or factors found in a media story on HIV/AIDS. This was measured in frequency of occurrence.

Namibian media: refers to the nation-wide organs of news and information dissemination, specifically NBC Radio and the following three newspapers: *Namibian, New Era*, and *Republikien 2000.* The coverage of HIV/AIDS in the Namibian media was measured in frequency counts.

Research method

Three newspapers: *Namibian, New Era*, and *Republikien*, which are the leading newspapers in Namibia with national coverage, were chosen for the study. Namibian Broadcasting Corporation (NBC) Radio was selected because it is the leading radio station in the country with national coverage. The three newspapers and NBC Radio were selected because they are leaders in the Namibian media and have some influence on both policy makers and the general public. *The Namibian* and *New Era*, both publish mainly in English, with a few stories, mostly translations, in the local languages, whereas *Republikien* publishes mainly in Afrikaans. NBC Radio is multilingual and broadcasts in English, with programmes in local languages including: Damara-Nama, Oshiwambo, Afrikaans and German.

The content analysis study covered a period of 18 months, from January 1997 to June 1998. All the copies of the three newspapers were content analyzed as well as radio programmes stored in a computerized database at NBC. The main research was preceded by a pilot study which was aimed at giving the research a sense of direction. The pilot study analyzed stories on HIV/AIDS in the issues of one month of the two English language dailies in Namibia, *Namibian* and *New*

Era. The pilot study revealed two factors: first was that stories on HIV/AIDS by the two newspapers were rare and to make meaningful interpretation one had to have a large sample of issues.

Second was the problem of determining meaningful interpretation of the occurrence of the selected categories: for example, if the concept of drug abuse appeared twice in 20 stories, what significance would this have – was it high or low? It was, therefore, decided to broaden the categories to have a yardstick for measuring the weighting and prominence given the initially selected terms (alcohol abuse, rape, risky sexual behaviour, STDs, and discrimination against AIDS victims). This decision led to the broadening of the content analysis to look into all central messages in the stories analyzed. This broadening, it was believed, would provide a more reliable platform for making suggestions on improving Namibia's media strategy.

All copies of the three newspapers were scanned for stories on HIV/AIDS and content analyzed. For radio, stories were obtained from a computerized database kept by NBC, and only stories on HIV/AIDS falling in the 18-month period were content analyzed. The unit of analysis was the whole story falling under any of the following categories: spot news, editorial, and commentaries – all were analyzed in terms of key words or factors. The coding of the content was done by student assistants and two documentalists. The coding was cross-checked for reliability and there was high inter-coder agreement of about 85 per cent.

Findings and interpretations

After scanning the three newspapers and radio, the following number of stories on HIV/AIDS were found: *Namibian*, out of 366 issues, 42 issues had relevant stories (11.4%); *New Era*, out of 237 issues, 20 issues had relevant stories (8.4%), and the *Republikien*, out of 376 issues, 68 issues had relevant stories (18%). NBC Radio had 35 stories found in their computerized database.

Monthly coverage of HIV/ AIDS in Namibian media

The data collected showed there was a total of 42 articles on HIV/AIDS from the *Namibian*, 20 from the *New Era*, 68 from the *Republikien* and 35 from NBC Radio. On average, this is about nine articles per month. Given the importance of the subject to the survival of Namibian society, this average is considered to be too low. Perhaps of significance is the fact that, during the period under review (1997–mid-1998), 2 December, which is set aside to commemorate World AIDS day, was not marked by a larger output than normal of stories on HIV/AIDS, except in the *Republikien* which had seven stories in December 1997. In contrast, the search for stories on HIV/AIDS in the *New Era* in December 1997 revealed was not fruitful.

The frequencies of publication of the newspapers vary, the *New Era* is published twice per week, while both the *Republikien* and *Namibian* are published daily except during weekends. At NBC radio, only stories stored in their database were used. It should be pointed out that a lot of HIV/AIDS information may be broadcast during programmes such as chat shows and phone-in programmes but was not stored in the database. It is likely, therefore, that the number of stories with HIV/AIDS coverage on NBC under-represents the total coverage of the subject.

There are two ways to interpret this finding. One would be that the various organizations do not make enough use of the media to publicize HIV/AIDS. The other is that, if such initiative has not been taken by the existing structures, the media lack the capacity and will to produce feature articles on this burning issue.

Portrayal of general HIV/AIDS content categories in the media

As already explained, the categories which were covered in the sampled issues were divided into two groups, the first group (Table 1) consists of stories oriented towards general issues, with some bias towards prevention of HIV/AIDS. The second group [shown in Table

2] consists of stories on factors which cause HIV/AIDS.

Below is a brief discussion of the content categories and how they were portrayed by the media.

HIV/AIDS AWARENESS

The category which featured most frequently in all the media stories was AIDS Awareness (Namibian, 43%; *New Era*, 65%; and *Republikien*, 43%; NBC Radio, 43%). In most cases, the concept was portrayed as of critical importance in stemming the spread of HIV. On several occasions it was described as the only "cure", in the absence of drugs to combat HIV/AIDS.

There was a strong assumption that awareness of HIV/AIDS by members of the public would lead to safer sexual behaviour and avoidance of other behaviours which lead to contracting HIV. However, in some cases it was also reported that awareness of HIV/AIDS has not led to changed and safer behaviour. Examples given of this contradictory situation include:

a) unprotected sex by prostitutes, if customers demand;
b) HIV positive patients continuing to have unprotected sex after they have undergone counselling;
c) the youth have a high knowledge of HIV/AIDS, yet the problem of teenage pregnancies is on the rise.

Indeed, NBC Radio, quoting the 1997 *Human Development Report*, notes thus:

> "The report shows that although over 90 percent of Namibians have adequate information about the disease and its dangers, for most, the challenge of translating this information into sustained behavioural change remains."

Mention was also made several times of the variations in levels of AIDS awareness, most notably that rural areas, and the northern part of Namibia, in particular, lag behind the rest of the country in their awareness of HIV/AIDS.

One major constraint noted by counsellors was shortage of information resources and materials they could use to explain and discuss the whole subject of HIV/AIDS with patients and their families. At the moment, many literally have nothing at all. One counsellor, quoted by one newspaper, had this to say:

"The ideal solution would be regional

Table 1. *Portrayal of general content categories in HIV/AIDS newspaper stories.*

	Namibian n = 42	*New Era* n = 20	*Republikien* n = 68	NBC-Radio n = 35
Aids awareness	18=43	13=65	29=43	15=43
Going public	5=12	3=15	2=3	nil
Statistics	16=38	2=10	28=48	10=29
Women	14=33	4=20	8=12	2=6
Discrimination	12=29	4=20	9=13	5=14
Children	12=29	3=15	10=15	4=11
Namibia	30=71	14=70	47=69	26=74
AIDS drugs/cure	7=17	5=25	14=21	1=3
Sex education	1=2	3=15	2=3	2=6
Counselling	6=14	1=5	4=6	2=6
Labour practices	10=23	1=5	9=13	4=11
Impact on economy	10=24	3=15	18=26	6=17
Youth	4=10	5=25	9=13	7=20
Other diseases	3=7	2=10	1=2	nil

centres for counsellors equipped with up-to-date information and relevant materials preferably in a range of languages and region specific posters." (*Namibian,* 3, April,1998).

In a story appearing in the *Saturday Star* (South Africa) of 29 August 1998, it was observed that: "posters and pamphlets are not working by themselves...there has to be a communication back up, especially interpersonal communication in communities...many...are aware of AIDS and have had some form of education but they are not following it...cultural beliefs are a stumbling block...in black communities, there is still a stigma attached to the use of condoms."

Another reason given why it is difficult to translate awareness of AIDS to practices in a real situation, is the linkage to socio-economic factors and empowerment. Writing in the *Saturday Star*, Aurelia Dyantyi notes that: "the solution should be to address socio-economic status. Some women find themselves infected because they lack the power to negotiate with their partners...and because of that it becomes difficult for them to practice safe sex."

The writer of the above story concludes that, until women are empowered, the AIDS epidemic will continue. The issue of empowerment, it would appear, has not received adequate coverage in the media.

A possible conclusion from this presentation is that, whereas awareness of HIV/AIDS is a necessary step towards changed behaviour, there are other factors which influence behavioural change. One must, therefore, go beyond awareness of HIV/AIDS to create changed practice which will lead to safer practices, in line with the prevention of HIV/AIDS. Similarly, it should be noted that other weaknesses in the portrayal of AIDS awareness include scarcity of back-up materials which are region specific and written in the different languages of the country.

Going public

This refers to the few people who have been diagnosed as being HIV positive and have decided to tell their story. In the sampled articles, this content category was represented as follows: The *Namibian*, 12%; *New Era*, 15%; *Republikien*, 3%; not found in the stories covered by Radio. The most significant event was the launching of a video, sponsored by the American Embassy, titled *Emma*, featuring a young woman who had discovered she was HIV positive and decided to share her experience with others. This story was well covered by all the newspapers in January and February 1998.

The story was covered from two broad angles. One angle was to show that HIV positive people are normal and should be treated as normal people and not rejected by society. The second angle had HIV positive people as its target, and the message was that life does not end when one is diagnosed as HIV positive; one must live positively.

The coverage of this category was fairly low in relation to its significance in creating AIDS awareness. It is still believed by many people that AIDS does not exist and also that if one looks perfectly healthy, the person cannot have the HIV/AIDS virus, hence the strategic role of the small number of people who have tested positive and are willing to help educate the public that one can be HIV positive but look normal and healthy was not sufficiently exploited to achieve this communication goal.

Statistics

Statistics were often covered as part of other content categories (*Namibian,* 38%; *New Era,* 10%; *Republikien,* 41%; Radio 29%.) The most popular statistic was the number of HIV/AIDS positive people in Namibia (variously given as 150,000, and 108,000, although the first figure was more popular). There was also mention of unreliability of statistics on HIV/AIDS due to under-reporting for a number of reasons: exclusion of figures of those who die at home, some AIDS-related deaths not recorded as such, and some health officials' reluctance to report AIDS as cause of death, if it may result in loss of insurance benefits for the family. The statistics serve a monitoring purpose and dramatically highlight the increasing dimension of this terrible disease.

The message underlying the statistics was often that HIV/AIDS is a serious disease and many people are already infected. The effect was to convey a sense of urgency and the need for the public to be extra careful.

Discrimination/care for sufferers

This was another high profile topic found in many stories in the media *(Namibian,* 39%; *New Era,* 40%; *Republikien,* 20%; Radio, 14%.). The problem AIDS sufferers face when other members of society discover their plight was the main focus. The newspaper articles indicated disapproval of the rejection of AIDS patients. In one issue of the *Namibian*, reference was made to a "controversial AIDS colony" in Thailand started by Buddhists for AIDS patients, accompanied by a picture of an emaciated patient. In most cases, the media took the stance of advocacy on behalf of AIDS victims.

One conclusion from the stories, it would appear, is that the extent of fear of associating with AIDS victims is quite great. However, apart from vague appeals for the better treatment of AIDS victims, the media did not provide substantive information to address the fears of the public – that any contact with AIDS victims would result in getting infected. Neither was detailed information on how to care for those who are terminally ill, and at home, with AIDS actually provided by the media.

Women

This content category was more frequently mentioned in the *Namibian* (33%) than in the *New Era* (20%). While for the *Republikien* it was 12% followed by a low 6% from Radio. The angle taken in most cases was to portray women as more vulnerable, and more likely to catch HIV/AIDS than their male counterparts. The fact that in affected families, the first person to know might be the women was also raised often.

There was frequent mention of young women, for example, who fall victim to older men because of their economic and sexual disempowerment. The subordinate role of women in society and denial of sexual and reproductive rights was also mentioned several times. When officiating in the project "My Future, My Choice", the Swedish Ambassador to Namibia is reported to have noted that "Fifteen to twenty four year old females have almost double the HIV infection rates as compared to their male counterparts. Sexual relations between older men and young women are largely responsible for bringing HIV into the younger age group" *(Namibian,* 3, April, 1998). The issue of mother to child infection was also raised.

Given the situations portrayed in the media, women are an important target group in the fight against HIV/AIDS. The media were, however, not very successful when it came to addressing gender issues in the fight against AIDS. For example, the issue of empowerment was hardly covered. In addition, apart from pointing out that there is a high likelihood of infected mothers passing on the disease to their babies, there was hardly a detailed discussion of how to prevent this from happening.

Children

This was another fairly well covered content category *(Namibian,* 29%; *New Era,* 15%; *Republikien,* 15%; Radio 11%). It referred to several aspects. One aspect was orphans whose parents have died of AIDS and problems of caring for this numerically growing group. Another dimension covered was the rejection of children whose parents have both died by their next of kin. Infection rates of babies by mothers who are HIV positive was also highlighted. *Republikien* (1, April, 1998) reports of cases where families do not want to report that they are caring for AIDS orphans because they are ashamed to let it be known that they have relatives who have died of AIDS. Facilities available for caring for AIDS orphans were also given publicity.

AIDS drugs/cure

The portrayal of this content category had a fairly high frequency of mention in the newspapers, but had low coverage in Radio *(Namibian,* 17%; *New Era,* 25%; *Republikien,* 21%; Radio

3%). Several messages were dominant: a cure for HIV/AIDS does not exist, existing HIV/AIDS drugs are too expensive for patients in developing countries. Often there was brief but superficial mention of some of the drugs. In the month of February, newspaper stories were dominated by news of three South African researchers who claimed to have discovered an HIV/AIDS cure. Subsequently, other reports followed dismissing the claim as yet another hoax.

The emphasis in the media reports was on "no cure" rather than reporting on the slow but steady research progress which has been made towards prolonging life and stemming deaths of AIDS patients. The ongoing scientific research on the disease was not well reported; rather the stance was that little progress has been made towards understanding and finding a cure.

Counselling

The concept of counselling had a fairly high frequency of mention in the *Namibian* (14%), but the frequency was quite low in the *New Era* (5%), *Republikien* (6%), and Radio (6%). Counselling was often depicted as an important service to those who are HIV positive and their family members to enable them to cope with this potentially terminal disease. Often organizations providing such services or training were mentioned and their contact telephone numbers provided.

The major weaknesses, in current media strategy, in the handling of this concept was the lack of support materials for the counsellors to work with, and the failure to change behaviour of some HIV positive individuals who were counselled and were reported to have continued with unprotected sex after counselling.

Labour practices

This content category was portrayed in terms of mistreatment of HIV/AIDS affected persons by various companies and government departments. Quite often, the newspapers highlighted discriminatory practices against the affected persons both in Namibia and neighbouring countries. Negative policies of organizations were scrutinized, including dismissal of workers and compulsory HIV testing as a condition for securing employment. With the exception of the *Namibian* which has a strong advocacy stance on social issues, the item did not enjoy high coverage *(Namibian,* 24%; *New Era,* 5%; *Republican,* 13%; Radio, 11%). Another aspect portrayed was the effort made by some organizations to provide support to campaigns against HIV/AIDS among their workforce, and to the public in general.

Impact on the economy

This content category focused on the adverse effects of the HIV/AIDS pandemic on the economy, at national, institutional, and family levels. It was well covered by the media *(Namibian,* 24%; *New Era,* 15%; *Republikien,* 26%.; Radio, 17%). The implied reason was that HIV/AIDS was attacking the most productive and educated sectors of the population. The overall message was one of urgency, that AIDS will have a devastating impact on the country unless steps to control it were taken at once.

The media coverage gave several examples of "good practise" by organizations both in Namibia and elsewhere in helping to fight HIV/AIDS among their workforce. A possible media strategy would be to target the top management of institutions who should do more and make their institutions invest more resources in the fight against AIDS, rather than leaving it to the Ministry of Health and donor agencies alone, because ultimately the AIDS epidemic will affect their profit margin due to loss of highly-trained human resources

Youth

The youth were portrayed from several angles and frequently mentioned by the mass media *(Namibian,* 10%; *New Era,* 25%; *Republikien,* 13%; Radio, 20%). As a group, they were most at risk of contracting HIV/AIDS. The youth were also portrayed as disempowered, particularly girls who are often taken advantage of by boys

and older men, leading to a higher than average infection rate. The youth also had lack of control and limited access to the media. Access to condoms was often said to be regulated by adults or stopped all together. Communication between the youth and adults was often one way and the views of the youth were not heeded, which led to resentment and communication breakdown. This is by far the most important target group in terms of the fight against AIDS and they pose communication challenges not yet fully addressed by the media. Sexual behaviour change among the youth would be a major step forward towards controlling the rapid spread of HIV/AIDS.

Sex education

This concept was portrayed as a necessary addition to AIDS awareness, to enable young people in schools to understand their sexuality. Sex education, it was hoped, would help in reducing the problem of teenage pregnancies, STDs infection, and the spread of HIV/AIDS. One sensed there was an ambivalence on the desirability of sex education. That it should be provided to combat the spread of HIV/AIDS, but it should not be a licence for young people to practise sex too early in their lives. The latter attitude was symbolized by the "True Love Waits" Campaign launched by President Nujoma and the Churches. As in the case of the category of youth, the handling of this concept shows that there is a cultural resistance to providing open and explicit sexual education to members of the young generation. Although the media reported well on these concerns, it was unable itself to overcome the barriers.

Portrayal of factors which cause HIV/AIDS

The portrayal of the factors which may cause HIV/AIDS was analyzed separately (Table 2). The assumption was that the frequency of appearance of the HIV/AIDS causing factors in the sampled issues would be higher than of the general factors. The assumption, however, was proven incorrect, as the coverage of general factors far surpassed the coverage of HIV/AIDS causing factors.

Alcohol abuse

This concept was portrayed from several aspects. One angle of presentation was in relation to alcoholism which made individuals ignore responsible behaviour. In the *Namibian* of 30 March 1998, a writer quotes an interviewee commenting on prostitutes and clients behaviour: "both clients and prostitutes were usually very drunk and unlikely to think twice about the risk of HIV infection ..."(p.1).

Another angle was that of minors who get addicted to alcohol, and are preyed upon by adults who can afford to buy them alcohol. Alcohol was also portrayed in relation to the marginalized tribes who find it difficult to escape from alcohol abuse. A story in the *New Era* of 21-23 November 1997 notes "since the 1970's, alcohol abuse has spread among both female and male members of the Xoe. Under the influence of alcohol, the sexual partners feel no responsibility in using condoms".

From the evidence found in the media stories, alcohol abuse is a major factor in the spread of HI/AIDS, but apart from the *New Era*, all the other media organs paid little attention to this factor (*Namibian*, 5%; *New Era*, 30%; *Republikien*, 0%; Radio, 6%). A more effective media strategy should include more coverage of alcohol abuse and how this leads to behaviour which is more likely to increase the chances of getting HIV/AIDS.

Sexually Transmitted Diseases (STDs)

The handling of this concept was to link STDs with a higher possibility of also getting HIV/AIDS. The theme was the need to get quick medical attention, if infected with STD; to avoid sexual partners who are likely to have STDs; and wear condoms during the sexual act. The central message in the sampled stories was that persons with a high rate of infection with STDs also have a higher rate of infection with HIV. There was low frequency of appearance of the concept in the *Namibian* (7%), *Republikien* (6%) and Radio (9%), as compared to the *New Era* (30%), which gave it greater prominence.

Table 2. *Portrayal of content categories causing HIV/AIDS in stories*

	Namibian n = 42	*New Era* n = 20	*Republikien* n = 68	NBC-Radio n = 35
STDs	3=7	6=30	4=6	3=9
Prison	4=10	1=5	1=2	2=6
Homosexuality	2=5	3=15	0=0	0=0
Alcohol abuse	2=5	6=30	0=0	2=6
Rape and defilement of minors	3=7	5=25	3=4	2=6
Risky sexual behaviour	6=14	4=20	9=13	0=0
Non condom use	4=10	5=25	7=10	2=3
Migrant workers	6=14	2=10	1=2	2=6
Deliberate spreading of HIV	4=10	0=0	6=9	1=3
Tuberculosis (TB)	4=10	5=25	5=7	2=3
Drug abuse	0=0	2=10	1=2	1=3

Prison

The main message in handling the concept of prison was that it is a high risk place because male prisoners practise sodomy. Female prisoners are often coerced or "persuaded" to have sexual relationships with male warders, both behaviours often lead to the rapid spread of HIV/AIDS. Other conducive factors mentioned include: overcrowding, skin diseases, violence, gangsterism which sometimes leads to gang rapes of male prisoners by other males. In the *Namibian* of 27 January 1997, the Minister of Correctional Services is reported to have recognized the seriousness of the situation, when she said "we are sitting on a time bomb–and need to move fast".

The portrayal of prisoners and the HIV/AIDS issue revealed several conflicting and contradictory attitudes. There was recognition that condoms should be supplied to prisoners to combat the spread of HIV/AIDS. On the other hand, such supplying of condoms would be tantamount to condoning sexual practices (sodomy) not accepted in main stream society. The level of AIDS awareness among prisoners was said to be very low thus fuelling the rapid spread of the disease. Although the prison population is small in relation to the rest of the population, most inmates are in danger of taking out the infection into their families when they have served their sentences. The frequency of mention of this concept was very low all round (*Namibian*, 10%; *New Era*, 5%; *Republikien*, 2%; and Radio 6%), and an improved media strategy should lead to a higher frequency in the mentioning of the concept of prison life as one conduit through which AIDS may spread into the rest of the population, and how prisoners and warders can deal with this situation.

Homosexuality

The concept of homosexuality had fairly high occurrence in the *New Era* (15%) but it was less frequently mentioned in the *Namibian* (5%), and completely ignored by the *Republikien* and NBC Radio. In most of the coverage, the message was that homosexuality is risky sexual behaviour which may lead to the rapid spread of HIV/AIDS. Underlying this direct linkage, however, was the notion that homosexual behaviour was abnormal in African society, and the claim that where it existed, it was a decadent behaviour imported from Western countries. There

was, often, some high levels of intolerance voiced in readers' letter columns and radio chat show programmes. Coincidentally, at the time of writing this report, several governments in Southern Africa, including Namibia, were considering making homosexual behaviour illegal. In most instances, it was difficult to discuss the subject unemotionally.

One may conclude from the infrequent mention of the concept in certain mass media organs that the target group may find it difficult to access information on HIV/AIDS and how to protect themselves from HIV, in the context of their preferred lifestyle, particularly if they live far away from urban areas which are more cosmopolitan and tolerant of non-conventional behaviour.

Rape and defilement of minors

The coverage of rape had several aspects to it. One aspect portrayed involved adults, possibly already HIV positive, raping women to deliberately spread HIV to their victims. In one such case, a soldier connived with hospital staff to get a certificate that he had tested HIV negative whereas he had, in fact, tested positive and went and had sexual relations with a woman to pass on the disease. Both the soldier and hospital nurse were taken to court.

Another dimension portrayed in the sampled stories involved males who were HIV positive raping minors, allegedly after being instigated by traditional doctors that such an act would make them cleansed and cured of HIV/AIDS. The *New Era* of 27-29 June 1997, reports on a case of 18-months and two-year-old toddlers who were both brutally raped. An underlying problem was that often when women were raped they were blamed for tempting men to rape them, for example, by wearing short dresses or walking alone at night. Again, in spite of this factor being a causal factor in the spread of AIDS, it was not covered as frequently as one would have expected by most of the media organs except the *New Era* (*Namibian*, 7%; *New Era*, 25%; NBC Radio, 6%; *Republikien*, 4%).

Risky sexual behaviour

The above concept includes prostitution and multiple sexual partners. The frequency of mention of the concept was quite high in the *Namibian* (14%), *New Era* (20%), *Republikien* 13% but low in NBC Radio (0%). The dominant message in the coverage of risky sexual behaviour was that there was a link between prostitution, multiple sexual partners, commercial sex workers and HIV/AIDS. From the coverage, it is apparent that behaviour change is complex and takes time but most of the stories lacked sufficient depth to convince anyone indulging in risky sexual behaviour to adopt safer sexual behaviour.

Non-condom use

The use of condoms was portrayed as a vital element in the practice of safe sex and prevention of STDs, HIV, and teenage pregnancies. It enjoyed highest frequency of mention in the *New Era* (25%), followed by the *Republikien* (13%), *Namibian* (10%), and NBC Radio (6%). There was recognition that the prevalence of high rates of teenage pregnancies and STDs infection in the country was indicative of low use of condoms. This meant that there is a high percentage of the population who are exposed to HIV/AIDS because they are practising unsafe sex. The cultural tension underlying the whole terrain of communicating information to combat HIV/AIDS is perhaps nowhere more in evidence than in the use of condoms. To convey messages adequately, one needs to use explicit sexual language which is culturally considered either taboo or vulgar. It is not possible, for example, to explain how to put on a condom or femidom without using explicit language.

There was, therefore, a major information gap, particularly with the target group of youth who are at high risk. In the *Namibian* (27, November,1997), a youth peer educator is quoted as saying:

> " Most (youth) don't know how to put on a condom or say no to a guy...when people talk to young people, they don't give youth

a chance to speak. You can't just say don't drink. You have to give them a chance to participate in the talk."

The above quoted statement also reveals an underlying tension between the young and older generation concerning the control of the communication process by members of the older generation which leads to communication breakdown, and some frustration and resentment among the youth. In another issue of the Namibian (3, October, 1998), it is reported that "condom distribution is very poor indeed: "the counsellors tell people they should use condoms but don't have any to give them". Calls have also been made by the youth to supply free condoms to all high schools in the country. Clearly changed patterns of sexual behaviour depend on timely supplying the necessary inputs and at an affordable price, to sustain the new behavioural change. At the moment, it would appear this vital link required to change and sustain safer sexual behaviour is largely missing.

Migrant workforce

The category of migrant workforce includes several subgroups who are forced to live far away from their families, often in "bachelor" quarters by the nature of their work. The particular groups mentioned often included: lorry drivers who ply the highways, soldiers who live in barracks far away from their families, sailors who visit ports as part of their work, and miners *(Namibian,* 14%; *New Era,* 10%; NBC Radio, 6%; *Republikien*, 2%). The message behind the portrayal of the concept was that the migrant labour lifestyle was a major conduit for the spread of HIV/AIDS, particularly as the behaviour of the migrant workers was often rowdy, linked to alcohol abuse, and risky sexual behaviour.

Discussions and conclusions

The study content analyzed the issues of three newspapers and NBC Radio programmes over a 18-month period, from January 1997 to June 1998. In this period, it was found that the pattern of coverage of HIV/AIDS stories varied in the different media organs. The *New Era* had 20 stories, followed by NBC Radio which had 35, while *Namibian* had 42, and the highest was the *Republikien* with 68 stories. The pattern of coverage on a monthly basis also varied in terms of frequency in all the newspapers. In some months there were several stories covered, the highest number for the *Namibian* per month was five stories and the lowest was zero; for the *New Era* the highest was three stories per month, and the lowest was zero, and for the *Republikien* the highest number of stories per month was eight, while the lowest was one. Comparable figures for NBC Radio could not be worked out because of problems with the database print out which did not indicate monthly breakdowns.

One conclusion from this pattern of coverage is that weeks could pass without a story on HIV/AIDS appearing in the media. The variation of coverage from one month to another also indicates that there is no clear editorial policy to give prominence to this important subject in the media by providing sustained coverage. Most of the stories were of the spot news variety, focusing on local seminars, workshops and speeches given by politicians and other leaders during these workshops. Feature articles and investigative reports were the rare exception. The general impression is that the *New Era* tended to have more feature stories than the others, although overall it also had fewer stories than the other media organs.

Namibia's media coverage of HIV/AIDS is generally low, superficial, and not sustained long enough to create the necessary impact in terms of awareness and change of behaviour. Although newspapers and radio have an important role to play in managing HIV/AIDS, the former is urban based, and cannot disseminate HIV/AIDS information to most of the population who live in rural areas or small towns. Radio has wider coverage which makes it the most important media for the dissemination of HIV/AIDS information. The flow of information divides Namibia into urban information-rich, and rural information-poor sectors. It is not surprising, therefore, that many stories in the newspapers mentioned that AIDS awareness is lower in rural

areas than urban areas. There is, therefore, need to have alternative media strategies which focus on rural areas, and other hard-to-reach sectors of the population. To be noted is the need for information in local languages, rather than mainly English or Afrikaans which are not understood by many people in rural communities.

The findings also reveal certain characteristics about the portrayal and interplay between some key factors in HIV/AIDS infection and current media strategy. Below, we highlight some of the crucial aspects.

Major target groups

There are several major target groups in the media strategy on HIV/AIDS in Namibia. The major target groups include the youth, women, top management of various institutions, and policy makers. The youth are a major target group and have to take a centre stage, if the fight against HIV/AIDS is to be successful. Present media strategy indicates there are several weaknesses.

1. Communication from adult controlled media is mostly one way which does not give the youth a chance to state their case; this leads to frustration and refusal to comply with the suggested (dictated) behaviour.
2. Access to condoms is often regulated and rationed by adult controlled structures and often stopped completely.
3. The youth appear to have a high level of AIDS awareness, but depict low levels of behaviour change. In some cases, it would appear the youth have "theoretical" knowledge which needs to be backed up by practical demonstrations to enable them to bridge the gap between awareness and action.
4. The issue of empowerment, which affects young girls specifically, but also all the youth in general, is not yet part of the media agenda.
5. Some cultural resistance to expressing explicit sexual messages may still be acting as a blockage in the smooth communication of HIV/AIDS messages.

Among the youth, high AIDS awareness has been achieved. However, there is little adoption of safe sexual behaviour; condom use is low and incidences of teenage pregnancies and STDs infection is high. Apart from targeting the youth with more information messages, media strategy must also include training IEC communicators to provide interpersonal communication and two way communication exchanges which include demonstration. The issue of empowerment must be built into the communication strategy, in particular, targeting young women to enable them to learn how to take charge of their sexuality and not fall prey to older men and young men.

Women are the second major target group which must be focused on to combat HIV/AIDS. The findings indicate that:

1. Women catch the HIV virus more easily than their male counterparts but the media portrayal was unable to present and explore this factor in any depth.
2. Sexual disempowerment is a major factor causing women to be at a disadvantage in protecting themselves against HIV/AIDS; included here is the plight of young women who are preyed upon for economic reasons by older men. Again, effective media strategy should target the conflictual situation involved in these sexual relations to enable women and young girls to manage the situation.
3. There are a host of cultural practices which are aimed at reinforcing the subordinate role of women in society which put the lives of women at greater risk. The laws which protect women in society, and their human rights should be focused on by the media as part of an improved strategy.

Another subgroup of women is made up of the commercial sex workers, who are at highest risk because of the nature of their "profession". The media strategy should involve targeting this group, and possibly training some of the prostitutes to become information providers because they are already part of the group and nonjudgmental in their approach. The media strategy should also provide women with clear scientific reasons why they are in greater danger than their male counterparts, as well as ensuring the message content focuses on issues of sexual, economic, and cultural empowerment.

The top management of institutions and policy makers should also be targeted to take the initiative and introduce AIDS campaign and facilities (brochures, condoms, etc.) in the work place to widen social mobilization and provide information from multiple channels.

Reporting on scientific research on HIV/AIDS

The media stance in most of the stories analyzed was to stress the "no cure" message which was useful and strategic because it gave the AIDS awareness and prevention greater prominence as the line of last resort. The effect of this coverage, however, might be that those who already have contracted HIV/AIDS are not in a position to know what options they have and how they can plan their own survival strategies. Other examples of weak coverage of scientific subjects concerned with HIV/AIDS include the handling of HIV positive mother-to-child infection, and home care of terminally ill AIDS patients. There were some clear information gaps on how to stop the infection from mother to child occurring, and also how to take care of someone who is terminally sick, and cope with some of the opportunistic diseases such as sores and diarrhea, TB., without getting infected as well. The fear that such families undergo should be addressed by providing simple information which they can apply and be reassured.

The protocol of reporting of scientific research was exposed by the claims of three South African researchers to have discovered a cure for AIDS, which was a false claim, but it took several weeks before the sham was exposed. Had the reporters had enough experience on how to report scientific and research reports, this would not have occurred, and there would be better coverage of the research advances which have been made in this field.

AIDS awareness

The findings indicate that this was the most popular category of all the key concepts. Indications are that the level of awareness varies between rural and urban areas, with urban dwellers having a higher level of AIDS awareness. This is perhaps not a surprise because of the concentration of media and other information sources in urban areas. The linkage between HIV/AIDS awareness and change in sexual behaviour is still a weak one. In other words, knowledge has not affected attitudes nor behaviour. The time factor is important in changing behaviour of people, with certain groups who are more innovative in society taking the lead. However, availability of condoms to sustain the new behaviour is essential to make the changes sustainable. Some form of saturation coverage of HIV/AIDS is essential to make a breakthrough in peoples' attitudes and behaviour.

The media coverage of HIV/AIDS was also spasmodic, showing highs and lows from one month to the next, rather than sustained for a long time. Such sustained coverage of the HIV/AIDS issue is necessary to build up and maintain awareness and keep the level of interest high. There are several players in the AIDS awareness campaign trail, each with their own agenda and philosophy. There are state organs, NGO's of various descriptions, donor agencies, churches, etc. In some cases, the various players have conflicting goals and this may lead to some confusion. For example, the churches stress awareness of HIV/AIDS and no-sex as the goal, while other players stress awareness and safe sex as the goal. The church efforts, while laudable, may tend towards secretiveness and hence making the task of creating a culture of safe sex, which permits open discussions of sexuality, more difficult.

The findings show that a large number of people still think AIDS does not exist. A useful media strategy would, therefore, make greater use of the individuals who are HIV positive and are willing to educate others and let them see that an HIV positive person looks quite healthy and normal. The coverage of stories of such individuals has followed the same pattern of coverage on other HIV/AIDS issues, a short burst of interest but no continuous coverage.

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