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## **A Focus on the US Narrative: Does The New York Times Portrayal of Women Living With HIV and AIDS in Southern Africa Perpetuate HIV/AIDS Stigma?**

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A Focus on the US Narrative: Does The New York Times Portrayal of Women Living With HIV  
and AIDS in Southern Africa Perpetuate HIV/AIDS Stigma?

A thesis submitted in partial fulfilment  
of the requirements for the degree of  
Master of Arts in Journalism

by

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## Abstract

The aim of the study was to determine the dominant and recurring frames influencing the narrative and media portrayal of women living with HIV and AIDS in Southern Africa, a region characterized by a low socio-economic status and the highest HIV and AIDS infection rates globally. The study analyzed 238 stories published in *The New York Times* from 1985 to 2017. Findings of the study show that news reports frequently associate sex workers and pregnant women to coverage on HIV and AIDS therefore stigmatizing them as vectors of the disease. The newspaper stories provided adequate socioeconomic context resulting in African women being vulnerable to HIV and AIDS. This conclusion supports the feminist theory that women are politicized, categorized and victimized according to and as defined by their surroundings and that such media representation further perpetuates HIV stigma for women living with HIV and AIDS.

*Keywords:* HIV stigma, media, women, Africa, AIDS, feminism

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## CHAPTER 1

### Introduction

**AIDS and Women in Southern Africa.** Despite major advancements in prevention, treatment and care strategies, HIV and AIDS continues to be one of the leading global public health crises this century (Woodling et al, 2012. Wouters et al., 2016). The disease has killed almost 30 million people globally, and in the year 2016 an estimated 37.6 million people were living with HIV and AIDS worldwide (WHO, 2017). Southern Africa, with countries such as Botswana, South Africa, Zimbabwe, Swaziland, Namibia, Malawi, Zambia, Mozambique, Lesotho, and Angola, currently have the largest HIV and AIDS pandemic in the world; more than half of the people living with the disease are found in this region (WHO, 2016).

Gender inequalities, particularly for women living in Southern Africa with low social, legal, and economic statuses, reduce the “autonomy” of women in the region (Iroezi et al., 2013; Gibbs, 2010). For example, sex work puts women at high risk of contracting the disease and is synonymous with HIV and AIDS because both are associated with high levels of poverty. Where there are high levels of poverty, there are generations of women, some as young as 12 years selling sex to generate income for their families to survive (Ntseane, 2004).

This study analyzed 238 stories published in *The New York Times* from 1985 to 2017. Findings of the study show that news reports frequently associate sex workers and pregnant women to coverage on HIV and AIDS therefore stigmatizing them as vectors of the disease. The newspaper stories provided adequate socioeconomic context resulting in African women being vulnerable to HIV and AIDS. This conclusion supports the feminist theory that women are politicized, categorized and victimized according to and as defined by their surroundings and that such media representation further perpetuates HIV stigma for women living with HIV and AIDS.

## CHAPTER 2

### Literature Review

**Feminist Theory.** Women in Southern Africa faced with poverty, “...are under extreme pressure to have sex for economic or cultural reasons, forced into early marriages (with potentially unfaithful partners) or into sexual relationships to support themselves or their families” (Fillinger, 2006, p. 341). It is not uncommon to hear of news reports in countries such as Botswana, Zambia, Zimbabwe and South Africa referring to the “Blesser.” The blesser is a term which is used socially by women in these Southern African countries to refer to the older, usually much richer men who they depend on financially or for blessings in return for sex and sexually related favors. Representing sex workers as outcasts, with no emphasis on the lack of access to resources and services, and consideration of the low positions they hold in society, is the missing but critical piece in their portrayed media image (King, 1990; Gibbs, 2016).

These repeated uses of “metaphors, imageries and language” have over the years defined perceptions and ideas on HIV and AIDS particularly in Africa, and simultaneously reinforced the black sister’s stereotypes as loose and dangerous and emphasized her subordinate status in society (Brijnath, 2007, p. 372). By representing and framing women from developing countries and regions such as Southern Africa as promiscuous and loose, and HIV and AIDS as a female borne disease western media supports feminist research concluding that African women are positioned under the metaphor of “Third World women” and corroded by the “Third World effect” as a group of powerless, oppressed, victims who are also a danger to society without further understanding that HIV and AIDS in Southern Africa is also a result of gender inequalities as associated with socio-economical, cultural and political factors (Mohanty, 1984; Brijnath, 2007; Dogra, 2011 and Persson, 2014).



Applying feminist theory in the globalized context, Mohanty (1984) explains that the image of women as a homogenous group which faces similar adversities regardless of their class and cultural differences further erodes the perceptions about the African woman in the media (Mohanty, 1984). Globally women are classified as a sisterhood of dependents and victims of patriarchy, and male violence, who exist largely in context to the developed or underdeveloped economic, political, legal, social, religious and family structures around them (Mohanty, 1984).

**HIV Stigma.** The onset of HIV and AIDS as reported and recognized by the Centers for Disease Control and Prevention was described in June 1981 as “a disease acquired through sexual contact” and associated to five cases of a strain of pneumonia found in homosexual men in Los Angeles, United States (Centers for Disease Control Morbidity and Mortality Report, 2001, pg. 1). Fear of this disease had led to major social stigma for those infected. Randy Shilts (1987) observed that despite giving an impression of providing a conducive and inclusive news room for people living with AIDS newspapers such as *The New York Times* and *Washington Post* would not hire gay men, similarly the homosexual reporters for fear of losing their jobs would keep their sexuality a secret (Shilts, 1987). Three decades later HIV stigma remains one of the most challenging hurdles to ending the global epidemic (Gurmu & Etana, 2015). HIV stigma is defined as a life-altering phenomenon, a feared “negative social identity” resulting in the devaluation, rejection and discrimination of people or groups living with HIV and AIDS (Nthomang et al., 2009; Campbell et al., 2011, p. 1005).

In Tanzania, stigmatizing attitudes leading to people living with HIV being called “walking corpses” have been recorded more in poorer communities with low levels of education, such as villages and such rural isolated areas (Amuria et al., 2011). Campbell et al. (2011) observed that access to health services and the critical HIV and AIDS treatment or antiretrovirals

reduces HIV stigma however, another compounding factor that fuels stigma is that it is multifaceted and includes a socioeconomic and cultural component, as found in areas with high levels of poverty and illiteracy (Campbell et al., 2011; Amuria et al., 2011).

The moralizing, and negative social branding results in people living with the disease being perceived as “others” who are deserving and responsible for contracting the disease, with the underlying assumption that if people living with the disease had not been promiscuous or “playing with her body” they would be free of the disease (Visser et al., 2009). Compared to a sex worker or sexually promiscuous people someone who contracts HIV due to a blood transfusion is not considered to be responsible for their HIV infection and garners less stigma and “sexual embarrassment” because it is a situation deemed out of their control (Ren, Hust & Zhang, 2014; Campbell et al. 2011, p. 1007).

The stigmatizing of people living with HIV and AIDS, which hinders prevention and treatment efforts is also embedded, and intrinsically linked to socio-economic and cultural structures and context; HIV and AIDS in certain gender, religious and traditional perceptions is deemed as symbolic, a “deserving punishment” and “sinners disease” which also infects “dirty” people who go against the cultural grain by engaging in behaviors that are deemed impermissible particularly such as sex work and homosexuality (Nthomang et al., 2009, Visser et al., 2009, p. 198; Campbell et al., 2011) These attitudes result in the shunning and rejecting of groups living with the disease including sex workers and pregnant women.

**HIV/AIDS and the Media.** Media publications particularly, in developed countries such as the United Kingdom and the United States, have the reputation for leading conversations on topics such as HIV and AIDS and where misconceptions about the disease can be cleared (Brijnath, 2007; Jesmin et al., 2013). Apart from governments and other non-governmental

organizations, the media is cited as the most influential and powerful source of information in relation to the disease, and that newspapers specifically set the discourse for all other media (Kaiser Foundation, 2006; Stevens & Hall, 2013; Kiwanuka-Tondo et al., 2012). *AIDS in Africa* was coined as a “rhetorical” term for journalists starting in 2003 when the disease was no longer deemed a threat to Americans and was being framed as an international problem that was affecting sub-Saharan Africa severely (Steven’s & Hull, 2013). The United Nations is reported to have been one of the most vocal voices drawing attention to sub-Saharan Africa’s AIDS problem (Steven & Hull, 2013). Kiwanuka-Tondo et al. (2012) observed that AIDS in Africa received 40% more coverage during the years 2000 and 2002.

News coverage of AIDS in Africa also increased in 2003 when former United States president George W. Bush embarked on a trip to Uganda, Africa to raise awareness about the disease’s impact, and to simultaneously raise funding and create policies that would help “eradicate” the disease in Africa (Steven’s & Hull, 2013, p. 360). News reports frequently referred to the “African-style AIDS epidemic” or HIV infection rates on the alarming scale of the “sub-Saharan epidemic” leading to the perception that the “epicenter” of the global virus was in sub-Saharan Africa (Stevens & Hull, 2013; p. 361). During 1993 and 2007 news coverage of the disease declined particularly because HIV was no longer a threat to America (Stevens & Hull, 2013). As the AIDS coverage reduced in the United States of America, a high-risk, minority group emerged due to the lack of urgency and HIV prevention awareness.

Stevens and Hull (2013) noted that reduced media coverage of HIV during this period resulted in a segment of a population, African-Americans missing critical awareness of the risk they have to HIV transmission particularly the, “women, youth and men having sex with men” (Stevens & Hull, 2013, p. 365). In the limited AIDS news reports specific to the African

American's, focus was given to individual sexual behaviors as compared to the social factors increasing the risk of HIV transmission to one race group compared to another “and neglecting to discuss the social determinants of HIV-related risk, the coverage highlighted individual behaviour as the root cause of disparate infection rates” (Stevens & Hull, 2013, p. 365). Without the complete picture represented in the story readers are left with the impression that the best is being done from all aspects to prevent, treat and care for HIV and AIDS, “news media reports on the state of the epidemic should strive to provide contextualized understandings of a disease trajectory. This may promote support for individual-, social- and structural-level interventions” (Stevens & Hull, 2013, p. 365).

As is the case with AIDS in Africa, in the United States of America, the disease is spreading and progressing due to multiple factors compounded by HIV stigma and the low socioeconomic statuses of affected groups, in this case African Americans. The Centers for Disease Control and Prevention (2016) finds that, “The socioeconomic issues associated with poverty—including limited access to high-quality health care, housing, and HIV prevention education—directly and indirectly increase the risk for HIV infection and affect the health of people living with and at risk for HIV. These factors may explain why African Americans have worse outcomes on the HIV continuum of care, including lower rates of linkage to care and viral suppression” (Centers for Disease Control and Prevention, 2016).

A similar observation was made by Randy Shilts in context to HIV reporting which concentrates on one aspect of the disease (Shilts, 1987). Comparing the *San Francisco Chronicle* to *The New York Times*, Shilts (1987) observed that the paper focused on policy and applying political pressure, while the *Times*' reporting presented HIV as a medical issue, “with little emphasis on the social impact of policy” (Shilts, 1987, p. 385). The main news frame was that

HIV was a disease affecting mostly sexual minorities such as gay men. This loophole, or lack of context in AIDS reporting, exposed the journalists' lack of skill in reporting AIDS (Shilts, 1987). The AIDS stories were further categorized as either science of human interest with limited consideration to the multifaceted impact the disease was having on society (Shilts, 1987). This one-sided, homosexual-centered news coverage of HIV resulted in the perception and attitude that the disease was not a threat to the rest of the population and only infected and affected others.

**HIV/AIDS, Media and Women in Africa.** In the media, Africa is portrayed as a helpless, dark continent stuck in the colonial era (Brijnath, 2007). An example of this portrayal is a story written in 2018 by *The New York Times* titled “Trump Alarms Lawmakers With Disparaging Words for Haiti and Africa” (Davis, Gay, Kaplan, 2018). The article quoted words reportedly said by United States President Donald Trump who referred to Africa and Haiti as “shithole countries” and further stated that Nigerians would never go back to their “huts” (Davis, Gay, Kaplan, 2018). In this article HIV and AIDS was mentioned, “The comments were reminiscent of ones the president made last year in an Oval Office meeting with cabinet officials and administration aides, during which he complained about admitting Haitians to the country, saying that they all had AIDS, as well as Nigerians, who he said would never go back to their “huts,” according to officials who heard the statements in person or were briefed on the remarks by people who had. The White House vehemently denied last month that Mr. Trump made those remarks,” (Davis, Gay, Kaplan, 2018).

Contemporary Africa is overshadowed by this portrayed narrative, and so are the African women particularly when they are represented in comparison to the liberated “First World” women (Brijnath, 2007; Dogra, 2011.p. 346). A study of public messages placed in British

newspapers by international non-governmental organizations indicated that the dominant narrative or “face” used to represent The Third World is the nurturing, helpless women and their miserable looking children, particularly as used in public messages and appeals for funding to help alleviate “natural disasters” and other emergencies or crisis situations (Dogra, 2011. p. 335; Chitando & Vambe, 2013).

Although African women are actively claiming space in the media, they still must endure the dominance of male values and opinions, patriarchy and to also circumvent their social position as political subjects or entities, and not as individuals (Sesanti, 2009; Dogra, 2011). Gibbs (2010) also identifies that media content largely represents gender, particularly women from Africa, as outcasts and “victims” incapable of responding to HIV and AIDS. In addition, media fails to account for high levels of Gender Based Violence (GBV) and Intimate Partner Violence (IPV) (Gibbs, 2010; Gibbs 2016).

In a content analysis of *The New York Times*, with its 28 million global audience, reports or stories about women living with HIV and AIDS in Southern Africa frequently portray them in news coverage about the disease as sex workers and therefore presenting them as main vehicles of HIV transmission (Kalemi, 2017; Brijnath, 2007). Women are further stigmatized because the coverage emphasizes sex workers who receive more coverage in comparison to other high-risk groups, and specifically associating them with HIV transmission (Ren et al., 2016). King (1990) also observed that media, specifically *The New York Times* and *Washington Post*, has created a perception that it is the female prostitutes that are the pariah’s’ in the era of HIV and AIDS, as compared to men, and that these women are the main and sole transmitters of HIV (King, 1990).

Apart from sex workers, pregnant women living with HIV are stigmatized as vectors of HIV. Women who are pregnant are likely to test for HIV and AIDS first and therefore are bound

to be accused of bringing it to the family (Johnson et al., 2015). Johnson et al. (2015) conducted a study of women in 27 countries including Russia, Brazil, China, Argentina, Israel, UK and France and concluded that HIV stigma has a major impact on whether women will access health care (Johnson et al., 2015). Pregnant women experience a negative response when they communicate to either their family, male-partners, nurses, work or other community members that they have HIV or AIDS, to the extent that they would rather avoid going for antenatal HIV testing (Johnson et al., 2016; Kershaw et al., 2007).

**Digital Divide and HIV and AIDS.** Southern Africa's low economic status has also resulted in low levels of communication (Jung et al. 2013). This region with the highest prevalence of HIV and AIDS is coupled with a media industry that was lagging compared to other regions until the twenty first century when there was a noticeable growth (Jung et al. 2013). There are now over fifty pay television services available in Sub-Saharan Africa and close to 40% of people connected to mobile services (Jung et al. 2013). This growth did not go unnoticed by international media and provided an opportunity to increase HIV prevention and communication campaigns (Jung et al. 2013). With only 5.2% of households having a television set there are considerable inequalities regarding accessing this media in Southern Africa, depending largely on socioeconomic status of the people in the region (Jung et al. 2013). Inequalities such as the lack of education makes it difficult for women particularly in traditional, rural areas versus those in urban areas to comprehend HIV and AIDS messages communicated through the popular media (Jesmin et al., 2013).

Mass or mainstream media, in areas with low "HIV awareness" literacy rates, and poor technological such as Southern Africa includes "small media" accessible, culturally relatable, durable and traditional versions of media and disseminating information particularly in rural

areas such as hosting group dialogue sessions, distributing pamphlets, posters and using folk media where folktales, riddles, dramas and songs are used to share information about HIV/AIDS prevention, treatment and care (Adekannbi & Dada, 2017; Beaudoin, 2005, p.4, p.11). A study of media in South Africa observed that there was a lack of context to the multi-faceted impact that HIV and AIDS has on the country therefore not providing the complete picture of AIDS (Kiwauka-Tondo et al., 2012). However, research conducted in this area does not indicate the level of efficiency of HIV media messages transmitted in rural areas with few resources (Jesmin et al., 2013).

**Framing and the AIDS Narrative.** Entman (1991) explains that certain schemas are promoted to satisfy reader and particularly “elite” attitude (Entman, 1991). Entman (1993) clarifies that, “Frames highlight some bits of information about an item that is the subject of a communication, thereby elevating them in salience. The word salience itself needs to be defined: It means making a piece of information more noticeable, meaningful, or memorable to audiences” (Entman, 1993, p. 53). As a disease, HIV and AIDS has over the years been framed, and frames readjusted by global non-governmental or NGO advocates of the “Third World,” to best garner political and policy maker interest, to attract maximum attention to the disease, and mobilize resources and create institutions specifically in efforts to alleviate the impact of the disease in communities around the world (Woodling et al. 2012; Dogra, 2011.p. 333). Initially the dominant frame was of AIDS being a public health disease, which triggered a developmental crisis that stripped people of their human rights (Woodling et al. 2012). People living with HIV and AIDS have their rights violated when they face “...restricted or denied access to health services, education, and social programs. People affected by HIV may progress toward the realization of their rights and better health if the enabling conditions exist to alleviate the impacts



of personal, societal, and programmatic issues on their lives” (United Nations Human Rights.org, 2018). This human rights-based frame progressed to another recurring literary narrative of AIDS being a security threat (Woodling et al. 2012). When the United Nations (UN) Security Council in the year 2000 declared AIDS as threat to global security, organizations such as The United States President’s Emergency Plan for AIDS Relief or PEPFAR were established to combat and fight the global threat (Woodling et al. 2012; President’s Emergency Plan For AIDS Relief, 2017).

Woodling et al (2012) explains that the narrative of AIDS being a security concern has currently been superseded by the United Nations AIDS (UNAIDS) and United Nations Development Programme (UNDP) frame implying that the disease is a strictly developmental issue and “problem” (Woodling et al, 2012, p. S147). Both these institutions are highly influential and lead the global agenda when it comes to AIDS prevention, treatment and care (Woodling et al, 2012). By linking AIDS to the attainment of national developmental goals such as the Millennium Development Goals, or MDG’s, the U.N. organs are emphasizing the importance of eradicating the disease in developing countries. The narrative here is that the eradication of the disease is an indicator that undeveloped countries and regions are developing and reaching critical milestones such as good health and political governance (Woodling et al. 2012). These narratives further complement and support the themes of Africa as diseased and helpless, and the African woman underdeveloped and unliberated (Brijnath, 2007; Kalemi, 2017).

**Direct Observations of HIV Stigma in Botswana.** In hard-hit areas such as Southern Africa, it is becoming common practice for private businesses and companies, including government departments to implement Workplace Wellness HIV programs and Wellness HIV

policies to help monitor and guard against the possible stigmatization of people living with the disease. In Botswana for instance, I worked at a Swedish-based international transportation company for almost seven years as the Wellness Coordinator. The term wellness has been used to avoid further isolating HIV and AIDS as a condition and to incorporate it with all other ailments and provide a holistic approach to health. In recognition of the magnitude and negative impact HIV and AIDS has on workers and their extended families, particularly the women, Scania companies those operating specifically in Southern Africa, are affiliated to the Swedish Workplace HIV/AIDS Programme or SWHAP, a non-governmental organization which provides funding to 370 workplaces in sub-Saharan Africa to implement HIV workplace programs (Swedish Workplace HIV/AIDS Programme.org, 2017). Countries such Botswana, Democratic Republic of Congo, Kenya, Mozambique, Namibia, Rwanda, South Africa, Tanzania, Uganda, Zambia and Zimbabwe receive such financial support and other technical, expertise and guidance to run and eventually self-sustain their internal HIV wellness programs. SHWAP, based in Sweden, is co-funded by the Swedish International Development Cooperation Agency or Sida, and other companies in Sweden.

In the beginning of the AIDS epidemic companies were reluctant to employ, invest in or provide requirements such as training and further development to people and employees living with the disease citing uncertainty as a reason. This discrimination resulted in unethical practices in the workplace, where pre-HIV mandatory testing was a requirement for employment. In other instances, employees were denied medical aid or other general insurance if they were found to be living with the disease. In 2007, while working at the Botswana Network on HIV and AIDS, we advocated for a national HIV Law to protect the human rights of workers living with the disease, this advocacy was based on several cases at the courts of people and workers being unfairly

treated in society for living with HIV and AIDS. Unfortunately, and despite numerous concerted efforts, this discrimination based on one's HIV status can be found ongoing despite the longer and healthier lives that people living with HIV lead due to advanced treatment methods which have resulted in the disease to be a manageable condition.

At Scania Botswana I also observed that people with higher levels of education, such as department managers and head of company were less likely to perceive themselves as needing HIV support or being at risk of HIV infection and are less likely to participate in such wellness programs. Despite this, once the top-end leaders of the company, gain awareness on the importance of inclusivity they follow through and are the first to test for HIV in workplace settings in the attempt to lead by example. Women in the company, are initially more likely to sign up for wellness activities. Once the benefits of testing have been communicated and understood, male colleagues are then more likely to start participating in company wellness programs.

Timely, accessible treatment and information helps workers and general populations to lead healthier, productive lives. At Scania Botswana I observed that professionals abscond less from work when they have access to disease managing treatment, or antiretroviral therapy (ART) and medications. This support is provided together with other psychosocial support such as access to health information, encouraging the importance of a healthier diet and lifestyle, and creating awareness on the need to adhere to medication.

Another observation at the workplace is that when there are visible corporate wellness HIV programs employees can change their personal behaviors and attitudes towards the disease or colleagues living with it. The awareness training, HIV testing and other health information sharing activities in the workplace, which are also extended to families of the workers, help to

reduce the stigma creating a conducive environment for workers. Living a normal life also helps to reduce self-stigmatization for people living with the disease and reinforces that they are much needed members of society. It is therefore imperative that access to HIV and AIDS treatment is upscaled globally.

### **Hypothesis**

This content analysis will add to existing research by determining how the media, specifically *The New York Times* reporting and framing of women living with HIV and AIDS in Southern Africa, increases the potential for HIV stigma towards women living with the disease in this region. The study will also analyze if stories about HIV and AIDS illustrate the socioeconomic and political factors such as culture and gender inequalities that affect the response women have to HIV and AIDS (Mohanty, 1984; Fillinger, 2006; Brijnath, 2007; Persson, 2014 and Gibbs, 2016). The following research questions have been identified to examine the content:

1. What are the recurring frames supporting feminist literature?
2. How HIV stigma is represented in news coverage?
3. What are the recurring frames in context to women living with HIV and AIDS in Southern Africa?
4. What are the recurring themes in context to the topic of sex and morality?
5. Does the news coverage provide adequate socioeconomic, and cultural context?

## CHAPTER 3

### Methodology

#### Content Analysis

The quantitative content analysis method was selected as it is the most appropriate for analyzing various forms of text and communication including newspaper coverage (Neuendorf, 2002).

Neuendorf (2002) describes the content analysis as a replicable, “systematic, objective, quantitative analysis of message texts” (Neuendorf, 2002, p. 1).

**Sample.** The preferred sample for this study would have been a content analysis of newspapers in Southern Africa; a region with countries currently carrying the largest burden of the disease and the highest number of people living with HIV and AIDS globally. Unfortunately, and due to the unequal and sparse search results, I ended up selecting to analyze stories from the *New York Times*. The digital divide in Southern Africa has been documented in the literature review. A content analysis in Uganda, Eastern Africa about AIDS coverage in newspapers also confirmed the impact the lack of technology and communication had on newspaper coverage in parts of Africa, “The year 2004 was selected as the end for this study since archived articles for later years were not available at the time of data collection. To date, articles from Ugandan newspapers are not archived online; therefore, all data had to be gathered and hand-copied in person. Each newspaper assigned a librarian to assist with the data collection” (Kiwanuka-Tondo et al., 2012. p. 365).

*The New York Times*. The sample for this study is a newspaper in the United States *The New York Times* which is deemed influential in HIV and AIDS discourse. This makes the newspaper a representative sample (Neuendorf, 2002). This content analysis therefore focused on analyzing the distinct and recurring frames and characteristics of 238 stories found in *The*

*New York Times* newspaper under the search terms *AIDS* and *Africa* between 1983 and 2017. *The New York Times* also had the bulk of search results as compared to other newspapers. The search was refined by using a Boolean strategy to remove results with ‘AID’ as in foreign AID for Africa and emphasize the disease: “AIDS” and at least 5 (Africa) and HIV and at least 3 (women)’. The period selected is 1983 being the year of the first result on these search terms which returned the article “AIDS Now Seen As A Worldwide Health Problem” by Lawrence Altman (1983).

**Coding Procedure.** A coding sheet was developed through a literature review, and a grounded theory assessment of twenty newspaper articles published in *The New York Times* under the AIDS in Africa search. The recurring themes and frames from the both literature review and the newspaper articles were then grouped or categorized. The coding sheet was divided into five categories answering to the five research questions.

**Coding Categories.** The first category explored how HIV stigma is represented in the news coverage. This category was further split into two codes to observe the stigma directed towards members of the public, and the stigma women living with HIV and AIDS are dealing with, particularly in Southern Africa, which has the highest HIV and AIDS prevalence rate globally.

The second category explored how women are portrayed in context to HIV and AIDS news coverage. The category was divided into two codes. The first seeking to find the instances sex workers were identified as vectors of disease. The second code included finding coverage were other groups of women are identified as vectors of HIV and AIDS, such as pregnant women.

The third category and umbrella theme explored how the media portrays Africa and African women. The first code looked specifically for coverage showing “The Third World effect” as applied to African or “Third World Women” how they are represented as powerless and oppressed compared to their Western and therefore developed sisters. The second code in this theme explored how African women are presented in the media as a group of dependents suffering similar adversities because of being unliberated. The last code in this theme looked for coverage creating the perception that Africa is a dark, diseased female needing AID or help.

The fourth category of sex and morality was included to analyze the representations of sexuality in context to HIV and AIDS news coverage. The first code looked for representations and language that identified black women as promiscuous, or sexually loose and dangerous and therefore as immoral. The second code looked for stories that pitted the immoral gay men in the United States, to people in Africa.

The last code analyzed if the 238 news articles provided adequate context in their portrayal of women living with HIV and AIDS. A story was considered to have adequate context if it showed the diverse socioeconomic and cultural factors that make it difficult for women to protect themselves against HIV and AIDS infection in Southern Africa. Factors which show why HIV stigma is so debilitating that it stops women in Africa from preventing HIV transmission from mother to child during child birth and breast feeding.

**Coding Software.** Maxqda Analytics Pro 2018 program was used to code the data and store the data systematically. One code was used per article, and one article represented a code of analysis. Therefore, if an article had one coded instance of HIV stigma it resulted in (n=1) stories portraying HIV stigma out of 238.

## CHAPTER 4

### Findings

**Research Question One:** What are the recurring frames supporting feminist literature? Three codes were used to explore different themes under the umbrella of feminist views about “Third World Effect” or the categorization, victimization and portrayal of women, and specifically African women as a group of unliberated sisters who need to be saved and freed from their underdeveloped environment (Mohanty, 1984; Brijnath, 2007 & Persson, 2014). The metaphor of “Third World women” is used to describe the powerless, oppressed, victims who are also a danger to society without further understanding that HIV and AIDS in Southern Africa is also a result of gender inequalities as associated with socio-economical, cultural and political factors (Mohanty, 1984; Brijnath, 2007; Dogra, 2011 and Persson, 2014).

The victim theme was observed in 264 instances. From the 238 articles (n=148) referred to the concept of the Third World or African women resulting in 62% of coverage given to emphasize this theme. The first example of the media portrayal of Third World of African Women is in the story headlined “Redesigning A Condom So Women Will Use It,” (McNeil Jr, 2007) described the ‘third world effect’ and the low level of sexual independence of the African women compared to the Western developed women:

“The female condom never caught on in the United States. But in the third world, where it was introduced in the late 1990s, public health workers hoped it would overthrow the politics of the bedroom, empower women and stop the AIDS epidemic in its tracks. It did not. Female condoms never really caught on there, either. Only about 12 million female condoms are delivered each year in poor countries, compared with about 6 billion male condoms. Couples complained that the female version was awkward, unsightly, noisy and slippery -- or, as Mitchell Warren, who was one of its earliest champions, now says, "the yuck factor was a problem." Many women tried it, but in the end, it was adopted mainly by prostitutes...” (McNeil Jr., 2007).



Another Third World comparison and positioning of African women in context to women from developed countries or “...as is the case in the West” was illustrated when the writer uses the childhood survival rates to emphasize the dire need and urgency to control HIV infection in African women in Southern Africa (Holmes, 1994):

“It is the rate of childhood survival in the third world that will be most significantly affected by AIDS, researchers said. Because 94 percent of the AIDS cases in sub-Saharan Africa are the result of heterosexual intercourse, a higher percentage of women become infected during their childbearing years than is the case in the West. But because it may be years before a person infected with the AIDS virus develops symptoms, women may not realize they carry the virus until after they have passed it on to their children in utero.” (Holmes, 1994).

Women were grouped as category of analysis in (n=63) stories. The following examples show the grouping of women as universal dependents and victims of “race, class and sex” (Mohanty, 1987). For example, “All African women are politically and economically dependent and are also considered to be powerless against male violence (Mohanty, 1987). An editorial piece written in 2004 titled “Africa’s Homeless Widows” (Anonymous, 2004) indicates the use of the words women, wives, widows to refer to all African women:

“Traditionally, women lack rights but are supposed to be protected by their fathers, and then by their husbands. And brothers who inherit a dead man's property are supposed to assume responsibility for his widow and orphans. But increased desperation, fueled largely by AIDS, has made a great number of families disregard this obligation. Instead, brothers often violently evict the widow. Sometimes a widow returns from a mourning ceremony to find someone else's lock on her door.” (Anonymous, 2004).

Illustrating further the low status women in Africa hold in society, the writer groups them up as victims of male violence and also for the purpose of furthering a political conversation involving “...the Bush administration” (Anonymous, 2005). This informs the feminist theory that African women continue to endure the dominance of male values and opinions, patriarchy

and to also circumvent their social position as political subjects, and not as individuals (Sesanti, 2009; Dogra, 2011):

“As it is, a majority of young women in some nations have no idea of how to protect themselves from H.I.V., and the Bush administration's overemphasis on abstinence-only programs at home and abroad does little to ameliorate that situation. At least as urgent, there is a need to enhance women's rights under the law and end the traditions of sexual coercion and violence that are largely responsible for soaring infection rates among younger women.” (Anonymous, 2005)

In 2016, the editorial piece titled “Helping Women in Africa Avoid H.I.V” (Anonymous, 2016) the “African women” are positioned against the developing Southern Africa and the “cultural customs” which make the women incapable of protecting themselves from male violence:

“Poverty, a lack of education -- 80 percent of young women in sub-Saharan Africa have not completed secondary school and a third cannot read -- and social and cultural customs that keep women subordinate to their males, with little control over their sex lives, all contribute to women's high infection rates. Investing in educating and empowering women in Africa and elsewhere in the developing world must remain an important part of the fight against this disease.” (Anonymous, 2016).

In 2010, another editorial piece groups and positions African women against their controlling and abusive partners and husbands. The writer celebrates the success of the trials for the new HIV preventive gel being used in South Africa:

“The gel is not perfect. But for the first time in the fight to control the global epidemic, it offers women a way to protect themselves even without the cooperation of their male partners. That is a potentially huge breakthrough. Women make up half of the 33 million people who are H.I.V.-positive around the world and 60 percent of the new cases in sub-Saharan Africa, where sex is the primary mode of transmission. Even a 40 percent to 50 percent reduction in their infection rate could help slow the epidemic. If further developments yield a more potent gel, as seems likely, the impact could be substantial.” (Anonymous, 2010).

The theme of Africa being a dark, diseased, female continent needing donor funding or aid was used in (n=53) stories or 22% coverage. Nixon (2008) describes a scene where a local doctor in Kigali, Rwanda appreciates the efforts of the “American shopper” who is saving the diseased continent, particularly the women (Nixon, 2008):

“A year ago, staff members at the Treatment Research AIDS Center could barely cope. Patients, unable to find care elsewhere, flowed in from every corner of the country. And if one of them was fortunate enough to find a bed here, she often had to share it. Today, a dozen patients, mostly women, sit in neat waiting room, laughing and talking as children play around them. Doctors greet one another as they make their rounds and take all the time they need to explain the complicated schedule H.I.V drugs require. According to the center’s managing director, Dr. Anita Asimwe, doctors spend less time on crises and more time researching how to slow H.I.V transmission in this tiny African nation still recovering from a genocide in 1994. Dr. Asimwe thanks an unlikely benefactor for all these improvements: the American shopper.” (Nixon, 2008).

Altman (2006) described some of the US perceptions towards Africa and her need for aid, and how backward and costly Africa is:

“In 2001, for example, Andrew S. Natsios, then administrator of the United States Agency for International Development, stirred worldwide criticism when he declared that treatment in Africa would not work because the drugs had to be taken every few hours, and that Africans “don’t know what Western time is. Many people have never seen a clock or a watch their entire lives.” Many critics also said H.I.V. would develop a resistance to the drugs if people in poor countries did not take them as prescribed. Dr. De Cock said that the World Health Organization was watching for resistance among patients taking the medicines and that the information would start to become available later this year. In an interview here on Wednesday, Dr. Mark R. Dybul, the United States’ global AIDS coordinator, said, “Three years ago, people were talking about how antiretroviral therapy was not cost-effective, and now the talk is about how can we do more.” Proponents for wider availability of antiretroviral therapy say that AIDS drugs have saved more than three million years of life in the United States alone. But, Dr. Dybul cautioned, “We’re not guaranteed billions of dollars more, and we need to work” for any additional funds. “There are a lot of important priorities in the world.” (Altman, 2006).

In 2002, Swarns painted the dire, diseased situation of AIDS in Africa:

“All across the continent, South Africa is hailed as the promised land, the country of prosperity and plenty. Yet even as blacks seize the opportunities of the post-apartheid era,

the deadly AIDS virus continues spreading here, infecting and killing... South Africa is believed to have five million people infected with H.I.V., the virus that causes AIDS, more than any other nation in the world. Every day, bodies fail, memories fade and patients sink into deep depression. About 30 adults and 50 children are spending their last days here. None can afford the costly but lifesaving AIDS drugs commonly prescribed in the West.” (Swarns, 2002).

Baker (2013) wrote on the significance of two American presidents being in Africa at the same time and importance of investing money and time in “Africa”, to help provide “life-saving drugs” through US AID programs such as the President's Emergency Plan for AIDS Relief or Pefar (Baker, 2013). Pefar is considered to be the largest “humanitarian health effort ever undertaken by any country.” (Baker, 2013):

“Mr. Bush will overlap briefly on July 2 with Mr. Obama in Tanzania, the last stop on the current president's itinerary after Senegal and South Africa. There are no plans for the two to see each other, but Michelle Obama has agreed to attend the first ladies' forum with Mrs. Bush in Dar es Salaam, Tanzania's largest city, to promote women's education, health and economic empowerment. "It's coincidental that we have two American presidents on the continent at the same time - in the same country at the same time - but it's indicative of a continued commitment, which is great news," said Hannah Abney, communications director for the George W. Bush Presidential Center.” (Baker, 2013).

Indicating the levels of funding needed to save the deadly, female centered, health crisis in Africa, Dugger (2009) writes on the urgency of focusing on finding the miracle cure to save sub-Saharan women from AIDS:

“Only about \$58 million of the \$100 million needed for follow-up research has been pledged, according to Unaid, the United Nations AIDS agency. Experts say shifting global health priorities and tight finances in the West are making it hard to raise the rest. Advocates say any delay could be deadly. Most of the 22 million people infected with H.I.V. in sub-Saharan Africa are women, and about a million women on the continent are infected each year. If subsequent studies find the gel effective, women could use it to protect themselves even when men refuse to use condoms. ‘We have to keep our eye on the prize,' said Dr. Catherine Hankins, chief scientific adviser to Unaid. "It's in reach. We have to close the funding gap and get the gel to women." (Dugger, 2009).

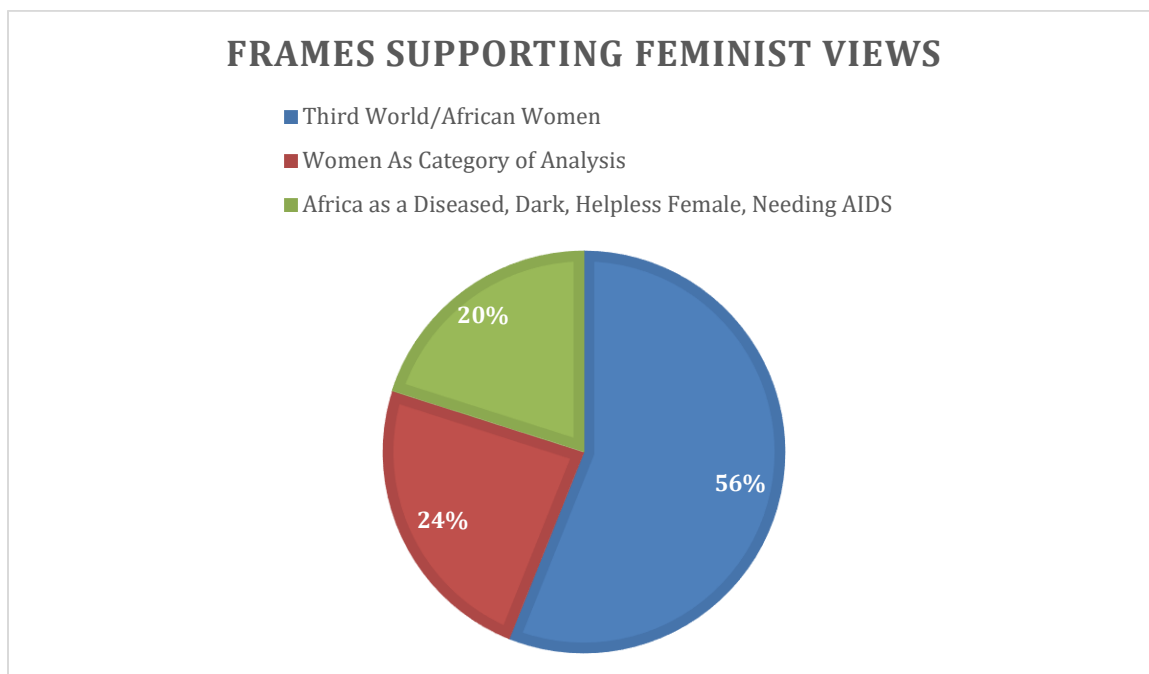


Figure 1.

**Research Question Two:** How HIV stigma is represented in news coverage? Two codes were used to collect examples of how HIV stigma is portrayed in *The New York Times* coverage. One umbrella code for HIV stigma in general, and the second code specifically for exploring how this stigma affects women living with HIV and AIDS in Southern Africa. The overwhelming HIV stigma directed towards people living with HIV and AIDS is a major hindrance to HIV and AIDS prevention, treatment and services (Gurmu & Etana, 2015). HIV stigma was described and illustrated in (n=56) stories, and HIV stigma towards women living with HIV and AIDS in Southern Africa was in (n=16) of stories written.

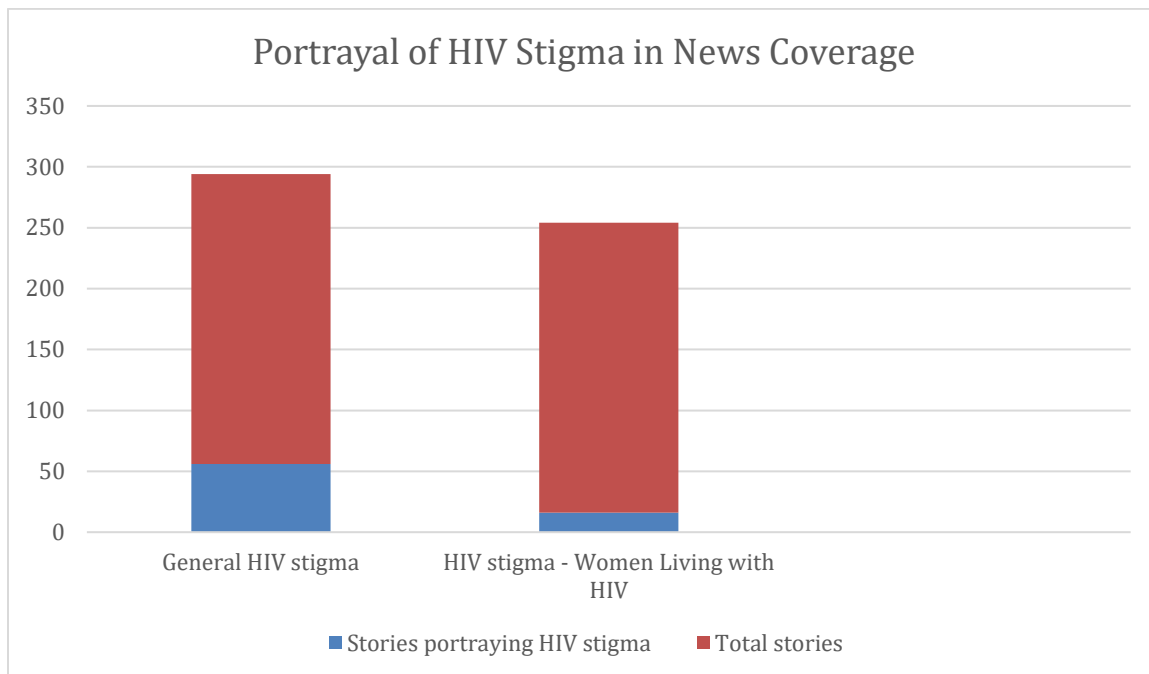


Figure 2.

In the newspaper article titled “Lessons In Helping African Women Avoid H.I.V” McNeil Jr. (2017) describes the overwhelming influence HIV stigma still has in preventing women living with HIV and AIDS from seeking HIV care. McNeil Jr. explains how perceptions and negative attitudes towards the disease have an impact on how or whether women in Southern Africa will access or seek treatment and care for HIV and AIDS. He also illustrates the need for private spaces from which these women can access HIV education and awareness without suffering the negative glare of the people:

“Because young women are afraid to be seen entering H.I.V. clinics, testers went door in villages and then found nonmedical places like schools in which to explain PrEP to small groups. Because women feared being caught with the pills, counselors taught them how to hide or disguise them. For working women, LVCT Health kept its clinics open at night; for those afraid of doctors, it arranged support groups led by counselors who gave out their own cellphone numbers.” (McNeil Jr, 2017).

Meier (1997) shows the detrimental effect HIV stigma has on whether or not someone will disclose their HIV positive status. This therefore affects the prevention of HIV and AIDS spreading specifically in Southern Africa:

“Recently, about 40 women in an AIDS support group gathered in an overheated room at Baragwanath Hospital in Soweto. Several of the mothers were feeding their newborns from bottles, though they said they had initially feared that doing so would disclose their H.I.V. status and make them outcasts in a country where breast-feeding is the norm. "Everyone wanted to know why I wasn't breast-feeding," said one woman, who also asked that her name not be used. "My husband, my parents, everyone. I lied to them and told them that my asthma prevented me.” (Meier, 1997).

In 2009 Dugger reported on the conspiracy-based views of former South African president, Thabo Mbeki who publicly declared that he did not believe that HIV causes AIDS. This article also showed the extreme side of HIV stigma, when women are not only shunned and ridiculed but are also killed because of living with the disease in Southern Africa (Dugger, 2009):

“Among those listening Tuesday at the Pretoria show grounds was the daughter of Gugu Dlamini, a woman stoned and stabbed to death in 1998 near Durban after she said on the radio that she was H.I.V. positive. While Mr. Mbeki once said he had never known anyone who died of AIDS, Mr. Zuma offered his sympathy." (Dugger, 2009).

In Mozambique, another Southern African country, LaFraniere (2007) shows the impact of tradition on attitudes towards HIV and AIDS. This article outlines the strength of patriarchy and the need to empower women to reduce their vulnerability to infection. LaFraniere (2007) also details the fear that a mother has to disclose her HIV positive status to her husband to avoid abuse and rejection. So extreme is the HIV stigma that an HIV positive mother will defy doctor's orders and risk exposing her child to HIV and AIDS by continuing to breastfeed (LaFraniere, 2007):

“At a support group in Nhamatanda, a town of 5,000, H.I.V.-positive new mothers recounted how they followed medical advice and told their husbands they had H.I.V., with disastrous results. Aida Estefani, 29, said her husband abandoned her midpregnancy, telling her, "The child will be contaminated also." Rita Louise, who did not give her last name for fear of ostracism, said her husband demanded that the police arrest her. Isabel Quembo, 30, said her husband beat her and tore their hut to the ground. He threw out pots, pans, food -- and then her.” (LaFraniere, 2007).

In the story about “HIV-positive women in Africa” Rosenberg (2015) details how decades later HIV stigma continues to have negative effects on women, specifically mothers living with the disease:

“A mentor mother can sit down and listen - and calm the patient. "When you tell her you're H.I.V.-positive, some think you are cheating them," said Carolyn Njoga, a mentor mother in Muhoroni, a small town in western Kenya. "They think someone who's H.I.V.-positive is very thin and cannot talk about herself. But you say: 'I was tested. I went through this experience.'" A mentor mother can give another woman practical advice about handling a baby's medicines and feeding or about taking her own medicines, disclosing her status and dealing with the reaction.” (Rosenburg, 2015).

The discrimination of people living with HIV and AIDS in certain aspects stems from long held traditional, cultural and religious beliefs. In South Africa the author observed that:

“Many sufferers complain that church groups often lead the charge in isolating the infected. Even before she was found to have the virus, Musa Njoko was asked to leave her church choir in a township on the outskirts of Durban. She had swollen glands and asthma and people were whispering about her having "the Big A," she said.” (Daley, 1998).

In 2000 reporting from South Africa, Swarns (2000) writes about HIV stigma towards employees and the multifaceted impact AIDS was having on the general population including workers. The story shows how business leaders feared investing in an employee living with HIV or AIDS. Swarns (2000) also highlighted the advocacy and need for laws protecting the rights of workers and other people living with the disease:



“Business leaders -- particularly those in the insurance industry -- said they would suffer financially if they could not discriminate against people with chronic diseases like AIDS. Landlords -- who worried about proposed language that barred discrimination against the poor -- feared that they would have to offer apartments to tenants who could not pay rent.” (Swarns, 2000).

Reporting from Lesotho in Southern Africa, Wines (2004) details the attitude of fear with workers treating HIV and AIDs as a taboo topic in the workplace. The article also shows the lack of investment in workplace wellness HIV programs despite high HIV infection rates in the area:

"They know about the pandemic, but they don't take precautions," she said, because factory illnesses, and even deaths, are never identified as AIDS-related. Nobody knows how many garment workers carry H.I.V., because little testing has been done.” (Wines, 2004).

Apart from workers, people living with disabilities also face HIV stigma and even have specific sign language to demonstrate the fear of death associated with HIV and AIDS (Lacey, 2004). Writing from Kenya, Lacey (2004) shows the language used by deaf people to illustrate the dreaded disease and the need to also educate this group of people to empower themselves against HIV infection and transmission:

“To say AIDS in Kenyan Sign Language requires placing the index finger and thumb of both hands close to the face, which is supposed to be a re-creation of the skeletal appearance of a victim on the verge of death. In other parts of Africa, other signs are used for the disease. AIDS can be conveyed by pretending to pluck clumps of hair out of one's head. Or by forming the letter A with both hands. Or by running one's fingers down the center of one's torso to indicate extreme slenderness. Certainly most deaf people across Africa know there is an awful disease out there. But their knowledge is very limited. When it comes to education campaigns and prevention efforts, deaf Africans and other disabled people across the continent have been largely forgotten.” (Lacey, 2004).

**Research Question Three.** What are the recurring frames in context to women living with HIV and AIDS in Southern Africa? Two codes were identified to evaluate the newspaper’s representation of women living with HIV and AIDS, one for women in general, and another for

women specifically in Southern Africa. Previous research indicates that women living with HIV and AIDS in Southern Africa are frequently presented as vectors of disease; particularly the stigmatization of pregnant women and sex workers living with the disease (Brijnath, 2007; Johnson et al, 2016; Jesmin et al, 2013). This study reflects that in (n=93) stories, pregnant women were represented as vectors of the AIDS virus, and sex workers were mentioned as spreaders of the disease in (n=38) articles. This has resulted in 131 stories presenting women living with HIV and AIDS as the main transmitters of the disease. Therefore, the research suggests the news coverage represented these groups of women as a vehicle of HIV transmission. Other distinct groups considered to be encouraging the spread of the disease include promiscuous African men, homosexual men in the US, intravenous drug users and other such minority and outcasts in society.

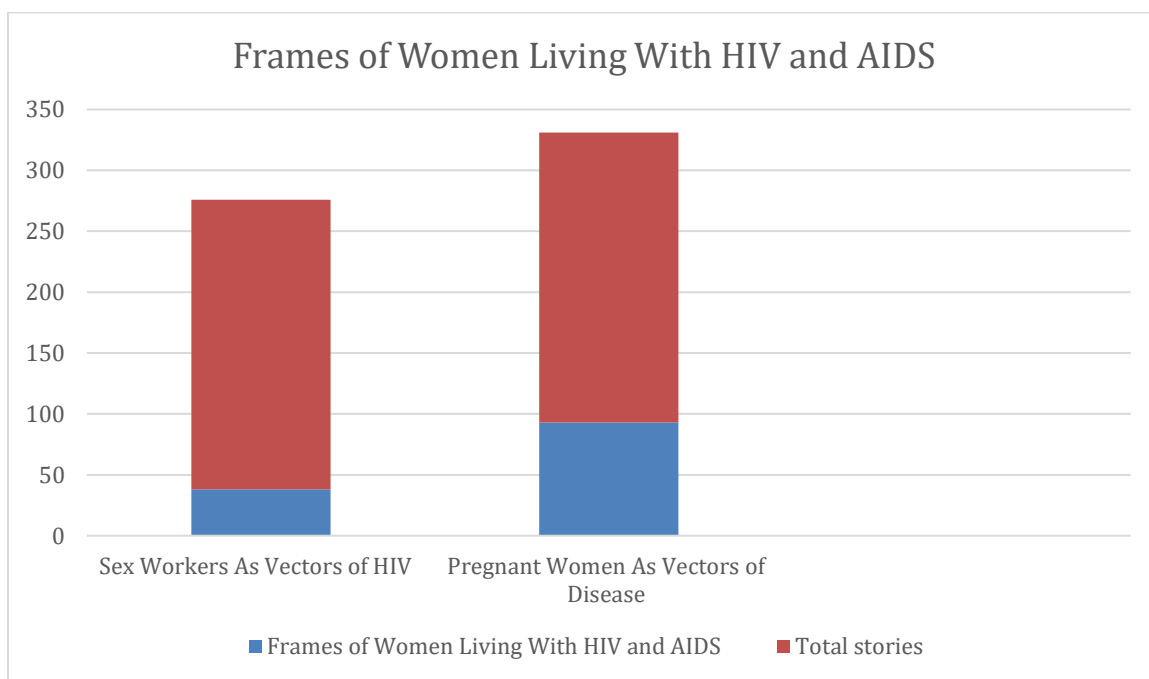


Figure 3.

From the stories portraying sex workers and pregnant women living with HIV as transmitters of HIV “African women” and “South African women” were discussed as equally but

more prominently than the other umbrella groups of “women from sub-Saharan Africa” or “women from developing or poor countries” including Asia and the Caribbean or black women in the US specifically Atlanta and Boston.

Rosenburg (2006) presents pregnant women in Africa as vectors of the disease:

“In the whole AIDS epidemic, no question is more heartbreaking and confounding than this: Why would a mother choose to condemn her baby to death? Mothers with H.I.V., the virus that causes AIDS, pass it along to their newborns at birth 25 to 30 percent of the time, and in poor countries, some half a million babies a year are born with H.I.V. But the rate of transmission can be cut to 14 percent with a simple and cheap program: H.I.V.-positive mothers take a single pill of an antiretroviral called nevirapine when they begin labor, and their newborns are given nevirapine drops” (Rosenburg, 2006).

Apart from pregnant women, prostitutes in Africa have been highlighted as vectors of HIV and AIDS since the onset of the disease as was reflected in a 1988 article. The emphasis on this specific group of women and the “Warnings about the new disease...” reinforces the perception that other groups of women are safe from HIV infection if they are not involved in sex work (Brooke, 1988):

“Throughout Africa, prostitutes are believed to be major transmitters of the AIDS virus. Surveys last year found that 34 percent of prostitutes tested in Brazzaville and 64 percent in Pointe Noire had the virus. “We tell our men when they arrive that if they go with a prostitute, they are stupid,” the British oilman said. In the gloom, there are some rays of hope. Congo, like virtually all countries of sub-Saharan Africa, has started an AIDS information program. Warnings about the new disease have been broadcast in posters, television roundtables, radio call-in shows and question-and-answer sessions at high schools” (Brooke, 1988).

Friedman (2001) writing from Ghana, highlighted how prostitutes were exposing themselves to further risk and escalating the HIV infection rate figures by having unprotected sex for extra money. Emphasizing sex workers by giving them more coverage in comparison to other high-risk groups, and specifically associating them with HIV transmission stigmatizes them further (Ren et al., 2016):

“Indeed, what is scary is that as devastating as AIDS has become in Africa, many Africans remain either uneducated about how H.I.V. is spread or simply do not believe they'll be infected. In Africa, prostitutes know that condoms should be used, but they'll often let men have unprotected sex for double the price. Without any economic opportunities, young women throughout Africa have to sell their bodies for food or simply lack the power to negotiate sexual relations with older men or husbands” (Friedman, 2001).

In 2003, the media spotlight remains on the sex worker. In this instance the writer poses a rhetorical question which links and places the sex worker at the forefront of the spread of HIV and AIDS in Africa:

“Why would girls who have seen what AIDS can do commit suicide by sex? Part of the answer is that the disease carries a mechanism for perpetuating itself: it first devastates families financially and emotionally, then leaves adults unable to mind their children, and finally breeds crippling despair. Death, poverty and hopelessness...” (Kristoff, 2003).

In 2002, during the peak of HIV and AIDS in southern Africa a medical study was conducted primarily using pregnant South African HIV positive women. This extract explains why these groups of women are frequently associated with decreasing or continuously rising HIV infection rates in the region; because they are easily accessible:

“The survey measures the number of infections year to year among pregnant women, a population considered to provide the most reliable cross-section of social and income groups and one most likely to pass through the health care system. It found an apparent increase in H.I.V. infection among women in their 30's. That more than offset an decrease in infections among younger women, the Health Ministry said” (Cauvin, 2002).

Reporting from South Africa in 2008, Hochschild illustrates the significance of addressing the high rates of HIV in pregnant women and why these poor areas, with women who are unable to follow health instructions are “...the perfect place to study.” (Hochschild, 2008):

“Almost one out of three pregnant women in Lusikisiki was H.I.V. positive, but the area also had a first-rate AIDS treatment program: well-stocked clinics run in cooperation with the local health authorities by the respected Medecins Sans Frontieres. It seemed the perfect place to study” (Hochschild, 2008).

In 2014, the author focused attention on pregnant women living with HIV in Malawi, placing them as the main “problem” currently in regard to HIV treatment, prevention and care:

“This was a problem for Malawi. Finding out CD4 counts required lab equipment. Women were, of course, having babies all over the country. But Malawi didn't have laboratories all over the country. So Malawi decided to dispense with the CD4 count and start all H.I.V.-positive pregnant women on lifelong antiretroviral therapy - a strategy that has come to be known as Option B+. Many people thought this was crazy. It meant that every single health clinic that did prenatal care now had to stock large quantities of antiretrovirals and have the ability to prescribe and administer them to patients - for life.” (Rosenburg, 2014).

Illustrating the connection of sex workers to HIV transmission another article datelined from Congo in the early years of the disease’s onset shows the negative attitudes towards prostitutes as vectors of disease. The focus on the prostitute creates an us versus them attitude towards HIV and AIDS, when in fact the disease has affected other African woman who are not living in poverty or involved in sex work:

“When a man here talks about going to “le deuxieme bureau,” the second office, he means he is going to visit a mistress, perhaps at a place like the Hotel Bikoumou. It is one of the many small hotels that have prospered in this capital by renting rooms for two hours at a time. Lately, though, business has been off, and Jean Paul Mampouya looked bored as he sat behind the reception desk at the start of another slow evening. “We used to get four or five customers a day,” he said. “Now it is one or two, or none. Today there has been no one. People are afraid of AIDS” (Tierney, 1990).

In 1990 in Rwanda, the writer illustrates and singles out prostitutes as vectors of HIV and AIDS in Hutu refugee camps during the genocide, also showing the socioeconomic factors which made women vulnerable to HIV infection:

“Not only were the Hutu refugee camps notorious for prostitution and sexual promiscuity, but thousands of Tutsi women were raped by Hutu soldiers and militiamen during the massacres. A guerrilla war between Hutu militias and the Tutsi-dominated army has continued to grind on in the countryside, with massacres taking place on both

sides. The insecurity not only keeps health workers out of remote areas, but also hampers efforts to prevent AIDS” (McKinley Jr., 1998).

Hedges (2001) in an article documenting patriarchy, gender-based violence and the prevailing sexual abuse of nuns by priests particularly in churches in Africa, illustrates how the abuse was fueled by increasing HIV and AIDS infections rates. The writer singles out prostitutes as part of the “high risk groups” (Hedges, 2001):

"There are problems," Father Wolf said in a telephone interview from Rome. "I am not comfortable putting these things in the media, because it looks like this is part of the daily life of the church. There are a few cases. I can understand the feelings of the sisters and nuns, that they feel especially hurt when these cases, although not many, are not dealt with appropriately afterwards." The reports link much of the sexual abuse to the AIDS epidemic sweeping across parts of Africa. The priests, who often live with one or two nuns in isolated villages, are said to fear contracting H.I.V., the virus that causes AIDS, from prostitutes and other high-risk groups. They often turn to nuns, the reports said” (Hedges, 2001).

In Uganda the same perception about prostitutes and the central role they play in HIV transmission was presented:

“The epidemic has changed aspects of Uganda's social life. Kampala's brothels have closed down, and truck-stop hotels on the main highways that a few years ago were teeming with prostitutes are now hurting for business. "Positive Living" and "Love Carefully" are seen on T-shirts, walls and newspapers, and the mottoes are preached from universities to thatch huts, from President Yoweri K. Museveni to farmers” (Lorch, 1993).

A similar demonstration of this competition by women for male sexual attention in order to survive economically is illustrated in another article written with focus on women in Ivory Coast; the article also shows the effects of gender inequalities particularly on women in villages and other remote areas:

“Most African teachers are men, who, especially in Muslim countries, are more likely to be educated beyond primary school. The elite status afforded by their education makes

such men particularly susceptible when, young and single, they enter remote villages for their first teaching jobs: young village women compete for their attention. The result is multiple sexual relationships, made riskier because of ignorance about AIDS and because the men are unlikely to use condoms” (Onishi, 2000).

Another article also emphasizes and connects “the barely dressed women” in Cape Town, South Africa to the high HIV infection rates in the area and the focus on women to use the female condom to give them more protection against men and HIV infection:

“Unaid and other organizations are working to persuade more women to try the female condom. In South Africa, as in many countries, they first approach prostitutes and other women with multiple partners, since persuading them to use condoms has notably reduced rates of AIDS infection. Among all the barely dressed women waving to passing cars on Somerset Road here in Cape Town, Glynis Rhodes looks a little out of place in her baby blue sweatshirt and jeans. But she is bearing gifts. "Hi," she says. "Have you tried the female condom?" (McNeil Jr., 1999).

McNeil Jr. (2001) reporting from South Africa, shows how prostitutes are economically vulnerable and susceptible to HIV infection. The author also links this group of women and the truck driver customers to the escalating and leading HIV infections rates:

“In the 13 years that Thandi has been a prostitute, she has seen a few changes in the attitudes of the truckers at the stop where she works. "Now maybe 7 men in 10 will agree to use a condom," she said. "When I started, it was 2 in 10." She has little power to improve the odds. There is a bouncer in the truck stop's bar and pool hall, but it is not his job to make sure that the men pay the women, let alone practice safe sex. "If we have made enough money, we try to tell him that he must wear one," she said. "But if we do not, we try to ask him." If he still says no? "I will think twice, and then I will do something with him." If she does not, another woman at the truck stop probably will, she said. At least a third of the adults in rural KwaZulu/Natal Province, which has a population of eight million, have H.I.V. This is the worst infection rate in a country that has more people infected with the virus than any in the world” (McNeil Jr., 2001).

In 2002 an editorial piece for *The New York Times*, the author reports how women in South Africa and Ethiopia are exposed to HIV and AIDS due to “survival sex” or forced prostitution:

“As their livelihoods collapse, their family networks fold and their coping strategies vanish, millions of young women are turning to what is called "survival sex" to feed their children. The consequences for H.I.V. transmission do not need to be spelled out. In short, H.I.V. is imperiling the ability of African societies to reproduce themselves. Even when the rains come we will not see a return to normalcy but merely a breathing space. And we will be forced to appreciate just how different this crisis is” (de Waal, 2002).

Kristoff (2003) also highlights the impact of the “quasi prostitution”, an example of how the low socioeconomic status of women living in South Africa makes them vulnerable to HIV infection, and also links them to the high rates of transmission:

“Ms. Tobela seems typical of Africa's AIDS victims. In Africa, 58 percent of H.I.V. carriers are female, and among teenagers with H.I.V., more than 75 percent are girls. This is largely because of an explosion in quasi prostitution between young girls and older men." It's not just promiscuity," said Blanche Pitt, director of the South Africa office of the African Medical and Research Foundation. "It's poverty. It's desperation." As young women become infected, so do their babies. One-fifth of pregnant women in southern Africa have H.I.V., and worldwide, 800,000 babies a year get H.I.V. from their mothers” (Kristoff, 2003).

In Malawi, Southern Africa prostitutes were also seen as the “engine” that drives sexually transmitted diseases such as HIV and AIDS (Eckholm, 1990). Although alluding to the overall topic of sexual promiscuity and lack of gender equality as the driving factor for HIV in Africa, the writer highlights the role of sex workers in HIV transmission:

“Prostitution, always an engine of sexually transmitted diseases, has played a major role in African AIDS. Typically, a small group of infected prostitutes passes the virus to large numbers of men, who take it to their wives and girlfriends. Prostitution is encouraged by migratory labor patterns rooted in the colonial past and current poverty. Millions of couples are separated for months at a time as men work in mines or plantations or move to cities for any paying job. For many women, especially those with little education who have left the dreary cocoon of the village, selling sex may seem essential for economic survival” (Eckholm, 1990).



Showing the weakness of women to be “cajoled” by men into risky “survival” sex is illustrated in the extract from an article written in 2004 from the poor shacks of Cape Town in South Africa (Cohen, 2004):

“This is a poor and dust-blown place where love and trust kill. The young woman asks her suitor to use a condom. He says she doesn't trust him. She insists that he respect her request. He argues that if she loved him, she would not suspect him of sleeping around. She explains that it's not a question of love but survival. He cajoles her: trust me, love me, all will be well. All is not well in this township of wood and corrugated-iron shacks near Cape Town, where the incidence of H.I.V. infection and AIDS continues to rise, particularly among women, as it does all across sub-Saharan Africa. Awareness of the disease and the availability of treatment are growing, but, as Dr. Liesl Page-Shipp, an AIDS expert, put it: "I don't think we yet have a handle on changing people's sexual behavior. So as a nation, we are in serious trouble.” (Cohen, 2004).

Explaining another scenario leading women to exchange sex for money and gifts as seen in poor African nations Kristoff (2006) shows how when the patriarch or head of the family dies the women immediately become destitute, helpless and dependent:

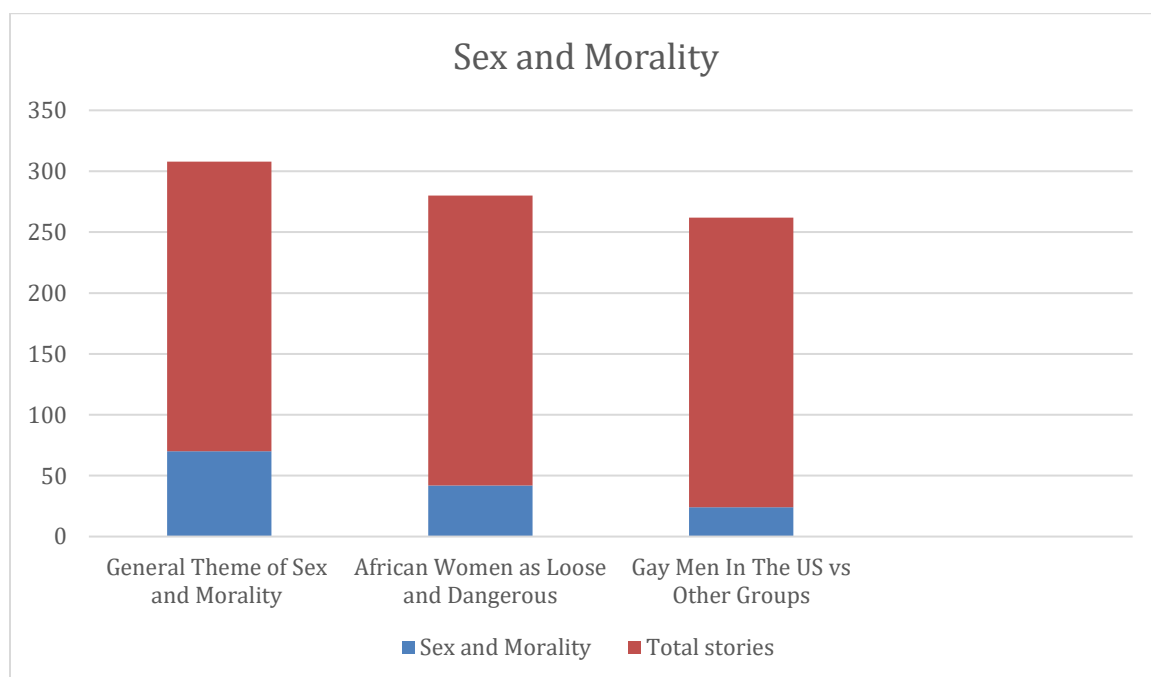
“The women in the family were planning to scour the fields for cassava leaves to cook for dinner. They say they can also go into the forests to look for edible wild plants, but malnutrition looms. The children in technical school have dropped out, because there is no money. One of them is Hermine, a 19-year-old, who is now at risk of being approached by an older sugar daddy offering gifts in exchange for being his mistress, a common arrangement in Africa that has led to high infection rates among young women. "I'd do it," she acknowledged -- after all, the family needs money” (Kristoff, 2006).

In 2011, McNeil Jr. compared the social and economic factors of prostitutes in India and those in southern and eastern Africa; regions in Africa which both have high HIV infection rates. In both India and the African continent, the writer singled out prostitutes and their customers, usually truck drivers for the rising rates of HIV infection in the third world regions. McNeil Jr. distinguished the promiscuous nature of Africans for the higher HIV rates the continent has

compared to India. This reiterates the strong link southern and eastern African prostitutes, teenaged and usually orphaned girls have to HIV because of the sex work and transactional sex:

“That is exactly what some experts on AIDS surveillance techniques have been arguing for years, saying that Indians do not have the same kind of sexual networks that are common in southern and eastern Africa, in which both men and women often have two or more occasional but regular sexual partners over long periods of time. Also, outside of prostitution, "transactional sex" between teenage girls and older men in return for money, food or clothes is much less common in Asia than in Africa” McNeil Jr. (2011).

**Research Question Four.** What are the recurring themes in context to the topic of sex and morality? Three codes were used to identify references to the umbrella theme of sex and morality as it relates to HIV and AIDS. A total of 57% of coverage covered the theme of sex and morality (n=136) articles. Within this group (n=70) articles carried the general theme of sex and morality, and (n=42) stories used metaphors, imageries and words that portray the African woman as loose and dangerous and (n=24) articles juxtaposed gay men in the US and other groups of people perceived as immoral because of living with of HIV and AIDS specifically in Africa.



## Figure 4.

In the earlier years of HIV and AIDS, African mindsets were confronted by two topics they considered taboo; sex and death (Daley, 1998). Other factors that conflicted their response towards HIV and AIDS and resulted in high levels of HIV stigma towards people living with the disease was the traditional and religious beliefs about it, that the disease was witchcraft, superstitious (Daley, 1998).

"We are a culture that knows about death, but we don't discuss it," said Noerine Kaleeba, who works for the United Nations agency helping communities develop AIDS programs. "We don't discuss sex either. With us, you can have sex as long as you don't let us know. There is a whole language for discussing sex, but it is very subtle -- a child could be in the room and would never know that is what you are talking about it. "But a person who has AIDS, every time you look at this person, you must confront sex and death. These are the things that make it too difficult to handle." Mrs. Kaleeba argues that to some degree, however, the stigma is self-imposed. The fear is sometimes greater than it should be and counseling can go a long way toward helping families accept those who are infected. Many sufferers complain that church groups often lead the charge in isolating the infected" (Daley, 1998).

In 2001, reporting from Mozambique the author outlines further the avoidance of the topic of sex, particularly in the presence of children (Mocumbi, 2001). The article also highlights the dominance of politics and culture in influencing people's negative attitudes towards HIV and AIDS and the perception that it is a disease that affects promiscuous people (Mocumbi, 2001):

"Today, in Africa and elsewhere, we are far from achieving these goals. Most political leaders still view adolescent sex as a politically volatile subject to be avoided. Community and religious leaders wrongly believe that sexuality education promotes promiscuity. Health providers and teachers are ill-trained about sexuality and ill at ease with it. Parents know little about sexuality, contraception or sexually transmitted diseases, and many believe that early marriage will "protect" their daughters. They may themselves condone or perpetrate sexual violence as a legitimate expression of masculinity" (Mocumbi, 2001).

Similarly, in Zimbabwe women found themselves vulnerable to their unfaithful husbands due to the low position they hold in society and the lack of economic independence (Kristoff, 2005). In the article "When Marriage Kills" the writer also illustrates the moralization of HIV transmission and need to be faithful (Kristoff, 2005):

"So I wish Mr. Bush would reach out beyond the ideologues to a real expert, like Loveness Sibanda. I met Mrs. Sibanda (no relation to the other Mrs. Sibanda) and her child in her village in Zimbabwe. She is 26, and her husband works in the city of Bulawayo, where she has heard that he has a girlfriend. Every few months he comes back to the village and insists on sleeping with her, without a condom. She now dreads these visits. Perhaps the White House thinks it has the moral high ground when it preaches, completely irrelevantly, to women like Mrs. Sibanda about the need to be faithful. But it strikes me as hypocritical to pontificate about virtue while pursuing an ideological squeamishness about condoms that risks condemning Mrs. Sibanda and millions like her to die of AIDS" (Kristoff, 2005).

In the same year, McNeil Jr. (2001) observed that women in South Africa were so "powerless" they had no choice but to be sexually immoral (McNeil Jr, 2001). In the same instance the article exposes the traditional and cultural circumstances under which southern African women become victims to male physical violence, and are at the sexual mercy of wealthier older men (McNeil Jr. 2001):

"The young women all said they knew their boyfriends slept with other women. "It's our tradition for a man to have many girlfriends and many wives -- it's very difficult to change that," Gugu Chakwe, 21, said. Some men wore condoms, they said, but if the woman suggested it first, her suitor would accuse her of being promiscuous or infected. "And he will hit you," Miss Mbikozi said. "Definitely, he will hit you." The women are so powerless that dumping even a violent lover can be difficult. There are few jobs here, and men are expected to give their girlfriends money that helps support their parents and siblings. "If my boyfriend does not give me money, I will leave him," Miss Mbikozi said. "And if I don't have money, I will fall in love with a 50-year-old man with a pension and sleep with him and take his. Because I like to have watches and jeans and things, and my parents cannot give them to me." Moreover, if a man contemplates marriage and starts paying lobola -- the bride price, calculated in cows but often paid in cash -- he believes that he owns the woman. In traditional Zulu courts, he does. If there is one common element between the women and the men here, it is that poverty and tradition have made safe sex almost impossible" (McNeil Jr. 2001).

An article titled, "Screening Girls for Abstinence in South Africa" (Daley, 1999) shows the emphasis placed on women in the country to prevent HIV and AIDS and to be sexually upright:

"The first two girls drew cheers, but Mrs. Ngobese quickly quieted the group. She was trying to preclude overt discrimination against those whom she deemed no longer virgins. Of the 30 subjects she examined, more than half -- some who had not yet reached puberty -- had in her opinion already had sex. Several she counseled to visit a health clinic because she believed they had a sexually transmitted disease. But regardless of her opinion, she gave all the girls a white mark on their foreheads for completing the tests. This is not, however, how Mrs. Ngobese likes to work. She would like the mothers to come along, too, because she holds them equally responsible for their daughters' virginity. And she prefers to be able to speak to the whole community about the value of respecting women and the dangers of H.I.V" (Daley, 1999).

Showing further the circumstances that prevent women in Southern Africa from protecting themselves against HIV and AIDS is a story titled "Women in Lesotho Become Easy Prey for H.I.V" (Wines, 2004). The article simultaneously presents African women as loose and dangerous:

"Ha Thetsane is home to thousands of women who have fled Lesotho's impoverished countryside to seek jobs as garment workers. But the average wage for such jobs, about 70 cents an hour, is seldom enough to both sustain a worker and allow her to send money to the family she left behind. Thus the detergent boxes in the windows. They signal that the women's husbands or boyfriends are visiting -- and that the men who have been supporting them in exchange for sex should lie low. "One woman will go out with four or five men," said Bolelwa Falten, a 26-year-old former seamstress. "One will help with the rent. One, maybe, will drive a taxi and take her to and from work. One will help with food. One will help her pay her installments" Experts refer to such desperate arrangements by the dry term "transactional sex." (Wines, 2004).

Presentations of southern African women from Malawi as sexually loose and dangerous and as victims of patriarchy continue in an article authored through the editorial desk and written in 2010:

“Other good news came from a new study in Malawi showing that if schoolgirls and their families received small monthly cash payments, the girls had sex later, less often and with fewer partners -- and were less than half as likely to be infected with the AIDS or herpes viruses -- than girls who got no payments. The small payments made it less likely that impoverished girls would agree to sex in return for gifts or money” (Anonymous, 2010).

In an opinion article Kristoff (2005) details how monogamy or the sanctity of marriage, is not a guarantee that women living with HIV and AIDS will not get infected by HIV and AIDS (Kristoff, 2005). The author here emphasizes that promiscuity, sexual work or being sexually loose is not the only reason African women are acquiring HIV and AIDS as perceptions indicate:

“Sex kills all the time, particularly here in Africa. But prudishness can be just as lethal. President Bush is focusing his program against AIDS in Africa on sexual abstinence and marital fidelity, relegating condoms to a distant third. It's the kind of well-meaning policy that bubbles up out of a White House prayer meeting but that will mean a lot of unnecessary deaths on the ground in Africa. The stark reality is that what kills young women here is often not promiscuity, but marriage. Indeed, just about the deadliest thing a woman in southern Africa can do is get married” (Kristoff, 2005).

In 2003, the author showed another dimension to the topic of sex and morality. The article shows the different mindsets between African and American Christians in regard to the morality of using a condom. The article also shows the impact of HIV on religion in Southern Africa:

"The evangelicals abroad are mostly pragmatists, not ideologues, so they should be a good influence on the Christian Right. While fundamentalists in America blindly oppose condom distribution, evangelicals in Africa see their friends dying of AIDS. They thunder against sexual immorality -- but often hand out condoms. "We don't condone adultery, but we're pragmatic enough to see the country we live in," said Steven Lazar, who runs Iris Ministries' orphanage. He notes that in nearly all of the Christian weddings he attends in Mozambique, the bride is pregnant” (Kristoff, 2003).

Since the onset of the disease Gay men in the United States have been the epitome of the discussion on HIV and AIDS transmission, until the spotlight was diverted to AIDS in Africa and the comparisons of how the disease is spreading in these parts of the world started:

“Last year, the Centers for Disease Control and Prevention, using the first comprehensive national estimates of lifetime risk of H.I.V. for several key populations, predicted that if current rates continue, one in two African-American gay and bisexual men will be infected with the virus. That compares with a lifetime risk of one in 99 for all Americans and one in 11 for white gay and bisexual men. To offer more perspective: Swaziland, a tiny African nation, has the world's highest rate of H.I.V., at 28.8 percent of the population. If gay and bisexual African-American men made up a country, its rate would surpass that of this impoverished African nation -- and all other nations” (Villarosa, 2017).

In 2002, sub-Saharan Africa was used to illustrate that AIDS was no longer a “gay, white male disease, that it was in the 1980’s” (Altman, 2002):

“For the first time, about half of the adults infected with H.I.V. worldwide are women, chiefly as a result of sexual intercourse with infected men, the United Nations said today. The trend has been building for years but has only now been confirmed through more refined statistical methods and improved reporting of infection with H.I.V., the virus that causes AIDS. The world figures largely reflect the epidemic in sub-Saharan Africa, the world's worst-affected area, where nearly 1 in 11 adults are infected. There, women account for 58 percent of infections” (Altman, 2002).

**Research Question Five:** Does the news coverage provide adequate socioeconomic, and cultural context? Two codes were used to identify if the coverage cites the various socioeconomic and cultural or traditional factors that make it difficult for the general population, and women in southern Africa to protect themselves from HIV and AIDS infection. In the research, (n=95) stories identified and provided adequate content in terms of leadership, attitude and opinion towards HIV and AIDs. A total of (n=124) stories spoke directly to the factors preventing women from protecting themselves from HIV infection. A total of 92% coverage was contextual.

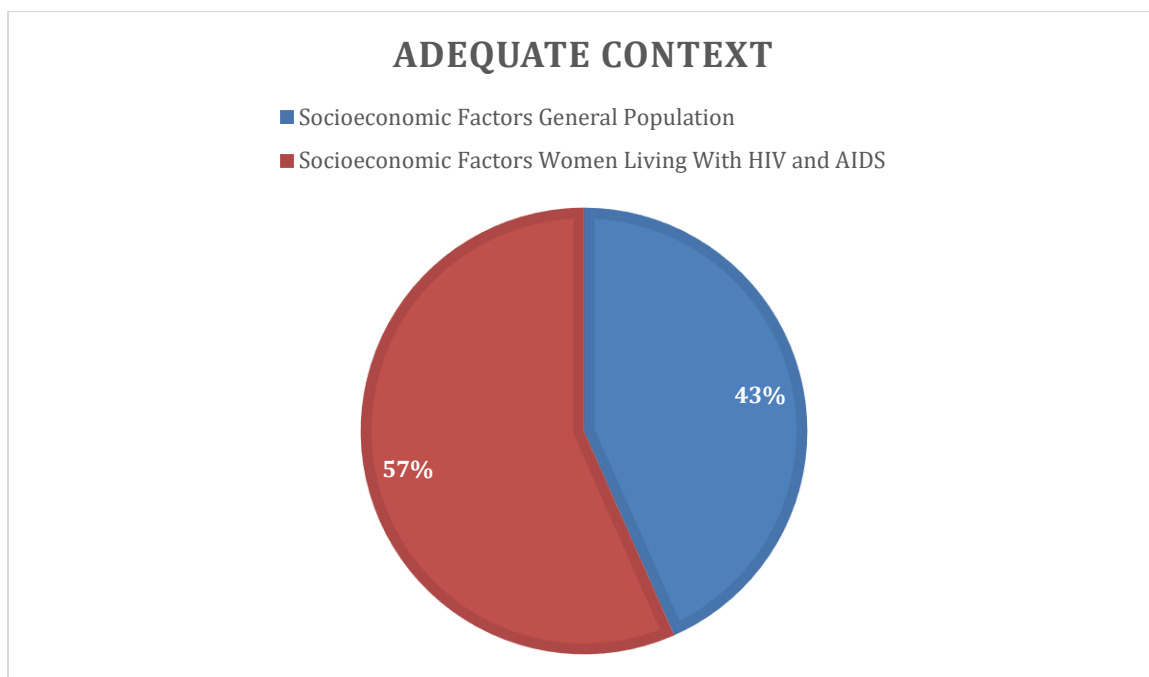


Figure 5.

An example of a story which contextualizes why women are unable to protect themselves from HIV and AIDS in Southern Africa, is written from Malawi. This story shows the negative impact of intrinsic factors such as culture and Gender Based Violence. The article which focuses on the village women also reinforces the image of Africa as undeveloped. AIDS in Africa is not affecting only women of low social status or victims:

"I was hiding my private parts," she said in an interview in the office of Women's Voice, a Malawian human rights group. "You want to have a liking for a man to have sex, not to have someone force you. But I had no choice, knowing the whole village was against me." Loimbani, she said, was blase. "He said: 'Why are you running away? You know this is our culture. If I want, I could even make you my second wife.'" He did not. He left her only with the fear that she will die of the virus and that her children, now 8 and 10, will become orphans. She said she is too fearful to take an H.I.V. test. "I wish such things would change," she said" (LaFraniere, 2005).

Another example of context in news coverage about women living with HIV and AIDS in Southern Africa is a story showing how instances such as forced marriages expose women and



girls to HIV and AIDS in Malawi. This example also supports the feminist theory of media portraying Africa as undeveloped and reinforcing the African or Third World Women effect:

“The consequences of these forced marriages are staggering: adolescence and schooling cut short; early pregnancies and hazardous births; adulthood often condemned to subservience. The list has grown to include exposure to H.I.V. at an age when girls do not grasp the risks of AIDS. Increasingly educators, health officials and even legislators discourage or even forbid these marriages.” (LaFraniere, 2005).

In earlier coverage, Daly and Ferrato (1998) wrote the article titled “Young Vulnerable and Violated in the New South Africa”. The authors describe the low social and economic status of women in Southern Africa making them vulnerable to HIV infection. By focusing on the traditional, the writer presents women in the region as backward therefore reinforcing the Third World Women theme:

“Moreover, women traditionally are held in low regard, and children, in general, are taught to be extremely submissive to adults, even strangers. In recent years, the fear of AIDS has also made young girls attractive to predatory men; for a time, there was even a rumor that sex with a virgin would cure the disease” (Daly & Ferrato, 1998).

More examples were written to illustrate why the cycle of poverty which leads to transactional sex, traps women in Southern Africa and leaves them with little choice but to expose themselves to HIV infection. This also positions women as victims:

“Why would girls who have seen what AIDS can do commit suicide by sex? Part of the answer is that the disease carries a mechanism for perpetuating itself: it first devastates families financially and emotionally, then leaves adults unable to mind their children, and finally breeds crippling despair...And so AIDS insinuates itself into the next generation” (Kristoff, 2003).

McNeil Jr. (2015) writes about the importance of education as a long-term solution to empowering young women against the disease and how education protects girls from HIV infection:

“In both studies, girls who stayed in school, paid or unpaid, were less likely to get infected. And girls who earned the most at the various scholarly tasks, suggesting that they were just better students, also were infected substantially less often. "Is it the smarter kids?" asked the lead investigator, Quarraisha Abdool Karim, an epidemiologist at Columbia University and the University of KwaZulu-Natal. "Is it the intervention? Or is it another factor? I'm not sure. But we really have to do more to lower the infection rate in young women." Typically in Africa, five or more female high school students are infected for every one of their male classmates, Dr. Abdool Karim said. "So it's not peers infecting each other," she said.” (McNeil Jr. 2015).

In 2014, the writer demonstrates how women with no financial power in Johannesburg, South Africa are forced to get involved in high risk, sex for money transactions and the urgent need for economically empowering them:

“The most moving story was that of a woman whose stepfather began raping her 16-year-old younger sister. When their mother refused to believe them, the girls ran away together, hitchhiking to Johannesburg. But every driver demanded money. When they ran out, the men demanded sex with the young beauty as payment. But the woman answered: "No, please, she is young. Take me instead," Ms. Sibanyoni said. "She said, 'I learned sex work because I used my body to pay for our trip to Joburg.' " (McNeil Jr. 2014).

Another example of a contextual story was written in 2006 from South Africa. The author showed how despite the availability of AIDS preventing treatment such as Nevirapine pregnant South African women living with HIV were still exposing their children to the disease. This shows clearly the devastating impact of HIV stigma on women and the need to empower them (Rosenburg, 2006):

“In most of the world, the biggest reason so many babies are born with the AIDS virus is that their governments do not offer nevirapine; because of shortages of health-care personnel, in many countries this program, like all AIDS programs, is available only in urban hospitals. But in South Africa, there's a different problem. Nevirapine is widely available, yet more than 70,000 babies a year are born there with H.I.V. The government can get nevirapine, condoms and AIDS treatment out to the most remote corners of the country -- by truck or wheelbarrow, to modern hospitals and to clinics with no electricity. But it cannot penetrate what has become the most difficult terrain in AIDS work: the insides of people's heads.” (Rosenburg, 2006).

The need for women in Africa to be empowered was demonstrated in an article which also showed the multifaceted impact HIV and AIDS is having on women in the region. The article also showed the low consideration given to the “poor women in Africa” and the “tragedy of a disease that has decimated Africa's women” (Santora, 2004). The reporter writes about Dr. Allan Rosenfield. Rosenfield is an AIDS expert with experience in Africa, who was in New York during the week of World AIDS Day (Santora, 2004). Rosenfield explains why empowering women is critical to HIV and AIDS eradication in Africa:

"Should we not value saving women's lives as an equal priority to decreasing transmission in infants?" he wrote in an article in *The American Journal of Public Health* in 2001. There are no easy answers, but as the number of women infected with AIDS rises steadily -- women now make up roughly half of the 39.4 million people affected worldwide -- the issue could hardly be more pressing. "Making people change their sexual practices is not easy," Dr. Rosenfield said. In the end, he said, "It is about empowering women." (Santora, 2004).

For African women living in Rwanda social ills such as the genocide increased their risk of HIV infection. Rape was cited as the specific driver particularly as used in the genocide in Rwanda as a “tool of war” (Hilsum, 2004):

“I was in Rwanda when the fighting began. It was clear at the time that rape was a tool of war. The majority of women who survived the Hutu attacks on Tutsis were gang-raped, sometimes for weeks on end, by the thugs who murdered their families. Many of them are now dying slow, painful deaths from AIDS. There are 7,800 confirmed cases, with estimates of as many as 14,000 undocumented women who are infected with the virus. (Today a total of 500,000 people, nearly nine percent of the adult population of Rwanda, is H.I.V. positive.)” (Hilsum, 2004).

In Zimbabwe, the promiscuous nature of men was reported to be adding a cultural dimension making it hard for women to protect themselves from HIV and AIDS. This story showed the use of celebrities, in this case a male soccer star, to spread awareness on HIV and AIDS. This article also shows the level of patriarchy:

"We can make value judgments all we want, but through some cultural differences it has been all right for me in Africa to have multiple sex partners," Zohn said." (Bell, 2003).

In the most recent article from the results, a story published in 2017 shows why AIDS in Africa, specifically Southern Africa is a global concern. The writer also demonstrates why despite access to treatment women are unable to protect themselves from infection or to prevent transmitting the disease further (McNeil Jr. 2017). The article cites the "many cultural reasons" which make African women vulnerable to HIV infection. This supports Gibbs (2010) who identifies that media content largely represents gender, particularly women from Africa, as outcasts and "victims" incapable of responding to HIV and AIDS (Gibbs, 2010):

"Even though PrEP, in the form of a pill containing the anti-H.I.V. drug tenofovir, is over 99 percent effective when taken every day, it has been an uphill battle even to get gay American men to embrace it. (In the United States, the pill is sold as Truvada.) South Africa and Kenya have both adopted it, but donors worry that it will be even harder for African women to accept, for many cultural reasons. The history of H.I.V. prevention in Africa, especially for women, has not been encouraging. There is still no vaccine. Abstinence, fidelity and both male and female condoms have failed to turn the tide despite 30 years of often controversial publicity campaigns. Circumcision protects men, which in turns protects women -- but it is expensive, and many men shy away." (McNeil Jr. 2017).

### Conclusion

The study reflects that since 1985 until 2017 stories about AIDS in Africa have been predominantly told through the eyes and words of American or foreign journalists such as Lawrence Altman who wrote 36 articles, Donald G. McNeil Jr. wrote 22 articles, Rachel Swarns wrote 16 articles, and there were 16 anonymously written editorial pieces. Other writers who contributed to the AIDS in Africa story in *The New York Times* include Celia W. Dugger who wrote 8 stories, Michael Wines also wrote 8, Sharon LaFraniere contributed 7 stories, Nicholas D. Kristoff wrote 6, Suzanne Daly wrote 5, Jane Perlez wrote 5 stories and Tina Rosenberg wrote 4 stories. The rest of the authors such as Marc lacey, James Brooke, Henri E. Cauvin,

Elisabeth Rosenthal, Denise Grady, Bill Keller, and the rest of the reporters contributed three or less articles each to the results of this study. One story was co-authored by an American reporter, Lydia Polygreen together with African Journalist, Mukelwa Hlatshwayo from Swaziland titled “Grandmas Grow Gold In Swaziland” (Polygreen & Hlatshwayo, 2012). There were three other authors who were not American or foreign including Pascoal Mocumbi, prime minister of Mozambique who was also cited as a physician and board member of the International Women's Health Coalition. Kofi Annan, former UN Secretary General and Batunde Osotimehin who was chairman of the National Action Committee on AIDS in Nigeria, also wrote pieces. Therefore *The New York Times* could attempt to include more diversity in the reporters of AIDS in Africa, specifically to use the African journalists to write and tell the story.

The results also show that a percentage 46% of the stories about AIDS in Africa were written between the years 2000 and 2006 with majority of stories concentrated in South Africa, Southern Africa, Sub-Saharan Africa. Mentioned on a lesser scale was East Africa, Nigeria, and Ethiopia. From the 238 articles about AIDS in Africa, prominence was given to South Africa with (n=61) or 25.6% of articles and datelines on coverage of the impact of the disease in the country now considered to have the highest number of people living with HIV and AIDS globally. South Africa initially had “controversial opinions” in the past, regarding HIV and AIDS treatment; the leadership of the country was doubtful about the effects of AIDS medicines which is considered to have stalled the AIDS prevention, treatment and care efforts (Swarns, 2001):

Swarns (2001) wrote that:

“The broad outlines of South Africa's epidemic are widely known: This nation of 44 million people has 4.7 million infected with H.I.V. What is less frequently explored is how ordinary communities are coping with a plague that is killing their citizens, threatening their culture and shattering their dreams. President Mbeki has compounded

the crisis by refusing to acknowledge the magnitude of the problem. He has stirred international furor by questioning whether H.I.V. causes AIDS and by challenging infection rates reported by his own government. He has been reluctant to subsidize AIDS treatment, citing the risk of side effects” (Swarns, 2001).

LaFraniere (2004) demonstrates why the South African leadership attitude and opinion on HIV and AIDS resulted in a large epidemic affecting mainly women. Simultaneously, the article explains the dominance of South Africa and South African women in the news coverage of AIDS in Africa. In the article titled “South Rejects AIDS Drug for Women” the author writes about South African women during an International AIDS conference in Bangkok (LaFraniere, 2004):

“South Africa has a reputation for taking unpopular -- and many experts would say unwise -- stands on AIDS. While specialists say some African nations like Botswana and Uganda have tackled AIDS vigorously, South Africa, the continent's richest country, has moved slowly to fight a disease that researchers estimate kills at least 600 South Africans a day. Mr. Lange faulted South Africa's president, Thabo Mbeki, for "not showing leadership." Precious Matsoso, South Africa's register of medicines, defended the decision on nevirapine in an interview on Wednesday, saying that treating pregnant women with single doses of the drug during childbirth increases the likelihood that antiretroviral therapy will not work for them when they become sick later in life. The World Health Organization issued a pointed statement on Tuesday supporting treatment of pregnant women with nevirapine alone. The organization said such treatment should not be limited while health systems gear up to provide more complex therapies” (LaFraniere, 2004).

In comparison other countries in Southern Africa such as Zimbabwe, Mozambique, and Malawi received 1.6% coverage, Namibia and Zambia got 1.26%, Swaziland 0.84%, Angola and Lesotho with 0.42%. Botswana was the only country in southern Africa that did not get special mention in terms of headlines but was written about in context to the southern Africa region. This resulted in a 34% total coverage of AIDS in Africa specifically attributed to Southern Africa. The remaining datelines were about AIDS in Africa, or its impact in specific regions of Africa such as Eastern and Western, and coverage was also given to countries such as India,

China, Haiti, Caribbean and other developing regions and countries highly affected by HIV and AIDS.

This study has determined that groups such as sex workers and pregnant women living with HIV and AIDS in Southern Africa are frequently linked to news reports about the high HIV infection rates in the region. When leading and global advocacy organizations such as the United Nations use sex workers, and pregnant women in the attempt to illustrate the magnitude of the disease's impact, particularly on society's most vulnerable and at-risk populations, they help to perpetuate the perception of these groups of women as vectors of the disease and as victims.

If Africa is undeveloped, so is her people, particularly her women. When advocacy groups such as United Nations NAIDS single out and categorize women living with HIV and AIDS in Southern Africa, to gain funds for the cause, they also help to perpetuate the media image of the African woman as helpless and dangerous, and therefore support feminist view that African women are perpetually portrayed in the media as victims. Coverage in *The New York Times* contextualizes the narrative of the women in Southern Africa living with HIV and AIDS however the strength of the other narratives of African women as helpless and victims of their environment gain similar coverage almost dimming the light on the socioeconomic and cultural context of HIV transmission.

African women are diverse and therefore stories about African women should show this diversity. AIDS in Africa is not only affecting poor, uneducated women who are involved in sex work or other forms of transactional sex. AIDS in Africa has had a multifaceted impact on the general population and economy including the various workplaces. By focusing on a single angled narrative about AIDS in Africa the paper helps to maintain and perpetuate Africa's image as a dark and diseased.

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