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Perilous Silences and Counterproductive Narratives Pertaining to HIV/AIDS in the Ugandan, Lesotho and Namibian Press

CECILIA STRAND

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Abstract
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Research on Western mainstream media's framing of HIV/AIDS in the 1980's, showed that media narratives influenced audiences' understanding of the epidemic, as well as society's responses. Subsequently, by analyzing a society's mass media and its framing of HIV/AIDS, it is possible to explore what understandings are given preferential treatment in that society, as well as explore what social change those narratives indirectly or directly facilitate. Such an analysis is particularly important in Sub-Saharan Africa, the continent most affected by HIV/AIDS and which has struggled to reverse the course of the epidemic. This dissertation has in five separate articles, not only identified and described media narratives on HIV/AIDS and the closely related topic of same-sex sexuality in three countries hard-hit by the epidemic –Lesotho, Namibia and Uganda – but also discussed the potential effects of persistent silences, as well as narratives that are counterproductive to the countries' ability to respond to their epidemics. The research uses a combination of quantitative and qualitative approaches: content analysis of independent and government-controlled print media products, semi-structured interviews with media practitioners and representatives from organizations that seek to influence the media agenda, as well as analysis of legislative and policy documents.

The articles discuss a range of persistent silences and counterproductive narratives on HIV/AIDS in the three countries. Overall, the media is found to largely fail in providing its readers with narratives that contain many of the particular factors – economic, social, cultural, biological, as well as those related to stigma and discrimination –that fuel their epidemics. The research however also finds differences between the countries and the types of media. In particular privately-owned media is found to play important role in terms of acknowledging the existence of same-sex sexuality as well as relevance in relation to HIV/AIDS prevention and treatment services in Namibian and Ugandan.

Keywords: HIV/AIDS, mass media, homosexuality, Africa

Cecilia Strand, Uppsala University, Department of Informatics and Media, Media and Communication Studies, Kyrkogårdsg. 10, SE-751 20 Uppsala, Sweden.

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List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

I Strand, C. 2010. Fragmented Narratives and Untold Stories: The Portrayal of HIV/AIDS in Lesotho Print Media. In Luuk Lagerwerf, Henk Boer, and Herman Wasserman (Editors). Health Communication in Southern Africa: Engaging with Social and Cultural Diversity, 71-92.

II Strand, C. 2010. Factors associated with high media coverage of the HIV epidemic in Lesotho. African Journal of AIDS Research 9(3): 225–233.

III Strand, C. 2011. State-sanctioned discrimination and media discourses on homosexuality in Namibia Journal of African Media Studies, 3(1), 57-72.

IV Strand, C. 2011. Kill Bill! Ugandan human rights organizations' attempts to influence the media's coverage of the Anti-Homosexuality Bill. Culture, Health & Sexuality,13 (8): 917-931.

V Strand, C. (forthcoming). Homophobia as a barrier to comprehensive media coverage of the Ugandan Anti-Homosexual Bill. Journal of Homosexuality, (accepted for publication July 2011).

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Part I. Introduction to Research Context and Purpose

In 2010, approximately 1.8 million people died of AIDS (UNAIDS 2010). A quarter of a million of them were children below the age of fifteen. In the same year, 2.6 million people became infected with HIV, bringing the total global disease burden to approximately 33 million (UNAIDS 2010). The global HIV epidemic is however far from equally distributed. A total of 22.5 million people living with HIV are found in Sub-Saharan Africa. In this region, HIV/AIDS has significantly increased morbidity and mortality particularly in those age groups – young adults – where levels of morbidity and mortality are normally low. HIV/AIDS has thus impaired these societies, particularly those in Sub-Saharan Africa, by diminishing the most economically productive population group at a time when they are also likely to have young children.

In the book *Plagues and Peoples* the medical historian William McNeill argues that past epidemics have had and will continue to have political, demographic and psychological effects on affected societies (McNeill 1998). By exploring the effects of smallpox and other infectious diseases brought by the Conquistadors to the New World, resulting in the subsequent fall of the Aztec and Inca empires, and the Black Plague's far-reaching effect on European demographics which led to a raft of changes in the mode of organizing production, McNeill finds a consistent pattern in how large-scale infectious disease relentlessly and inevitably changes the entities it comes into contact with, be they individuals, communities, empires or nation states. Although we are far better equipped to deal with infectious diseases today than the native populations of the New World and the Europeans in the thirteenth and fourteenth centuries, we are far from immune to epidemics and their beyond-health impacts. Accepting that infectious diseases, particularly those with high levels of morbidity and mortality, have an impact on affected societies, inevitably raises questions on how HIV/AIDS is affecting and changing us and our societies.

Although there cannot be just one answer to such a question, and this dissertation certainly does not claim to be able to provide one, it will nevertheless

attempt to contribute to a piece of the puzzle. This piece consists of the role of mass media in making sense of HIV/AIDS and how it should be handled.

The importance of mass media narratives

The HIV epidemic is the first epidemic to be mediated, in the sense that mass media has been, and continues to be, the primary source of information for most individuals. Besides being an important source for medical and health-related information, mass media acts as producers and disseminators of "preferred" readings of the epidemic which influence people's understanding of the epidemic and what it means in their society, as well as how it should be dealt with (Treichler 2006). That being so, media representations carry tremendous influence, whether or not they are factually accurate or distorted, on public understanding of the epidemic (Lupton 1994). Lupton (1994, 22) argues that media "texts are sensitive barometers of social process and change".

Indeed, research on Western media representations of HIV/AIDS in the 1980s provides a number of examples of a close relation between media attention and framing of HIV/AIDS and people's subsequent understanding of the disease, as well as how society has acted as a consequence of media constructions (Cullen 2003; Engel 2006; Treichler 2006; Singhal and Rogers 2003; Dearing and Kim 2008). Studies looking at HIV/AIDS in the early 1980s in the US conclude that the linkages between male homosexuality and HIV/AIDS aetiology resulted in generated two silences: silence among policy makers and silence among the mainstream media. American mainstream media, by largely ignoring the epidemic, left the general public unaware of the new virus that initially was primarily spreading through the gay community (Singhal and Rogers 2003; Kinsella 1989). Dearing and Rogers (2008) argue that that the US national mainstream media coverage was initially low because of the lack of involvement of two key traditional agenda-setters: the White House and *The New York Times*. Their silence was the result of HIV/AIDS association with homosexuality (Singhal and Rogers 2003; Engel 2006). The mainstream media's initial unwillingness to cover HIV did not facilitate public health officials' work of raising awareness on transmission routes and prevention techniques among the general public (Kinsella 1989).

The 1980s however, saw a spate of media coverage of what at that time was often referred to as the "gay plague" (Swain 2005). According to Swain, the issue's close relation to homosexuality positioned the disease "at the intersection of a 'germ panic'. Lack of security against fatal infection caused by a superbug coexisted with a moral panic about forms of social deviance in-

cluding homosexuality, promiscuity, and intravenous drug use" (Swain 2005, 258). Journalists typically framed HIV/AIDS as an emergency among the sexually deviants and socially marginalized, rather than a lasting concern of the general public or policy makers (Swain 2005).

The construction of HIV/AIDS as a gay disease and a disease of socially marginalized people such as drug users, and prostitutes, combined with fear, facilitated a torrent of animosity towards gays in the mid-1980s. "AIDS seemed to galvanize many people's disdain for homosexual practices, and for homosexuals in general" (Engel 2006, 44). The mid-1980s saw a conservative backlash which called for mandatory quarantine of all AIDS patients, i.e. mostly homosexuals, and a range of proposals calling for mandatory reporting by physicians of any patient who had tested positive (Engel 2006). Singhal and Rogers (2003) conclude that it took 20,000 AIDS deaths before the media, including the main agenda setter in the US, *The New York Times*, began to pay any real attention to HIV/AIDS.

The mass media's initial silence and later framing of HIV as disease of homosexuals and drug users had real implications. First of all, the coverage failed to alert the American public on HIV/AIDS and delayed the process whereby HIV/AIDS became registered as an important social problem regardless of sexual orientation (Singhal and Rogers 2003). Secondly, the framing of HIV/AIDS as gay disease resulted in an initial unwillingness among key policy makers to be associated with the disease and respond to it symbolically and substantially (Treichler 2006; Engel 2006).

Only after HIV/AIDS had been ironically reframed as a potentially heterosexual disease, after the death of movie star Rock Hudson did mass media attention increase to the level that HIV/AIDS was acknowledge as a serious public health threat (Klaidman 1991; Singhal and Rogers 2003; Dearing and Kim 2008). Dearing and Kim (2008) find an almost perfect correlation between mass media's attention in the 1980's and the American public's understanding of HIV/AIDS as a public health threat.

With a growing number of HIV cases outside the original groups and the public announcements in the 1990s of Arthur Ashe's and Magic Johnson's HIV infections, sports celebrities who were self-professed heterosexuals, did the framing of HIV/AIDS change from being the result of a behavior rather than a sexual preference (Swain 2005). In the 1990s, after a decade of hysteria and explicit homophobia, had HIV/AIDS become a routine news story (Dearing and Kim 2008; Swain 2005).

Studies on media coverage of HIV/AIDS in Australia (Lupton 1994), and United Kingdom (Cullen 2003) in the first decade, reveals a similar pattern

to that of the US. An analysis of the British press coverage of HIV/AIDS from 1982-84 finds that the term "gay plague" was widely used, and that the framing of HIV/AIDS as a heterosexually transmitted disease only began to appear in the British tabloids in March 1985 (Cullen 2003). The analysis of the British media also revealed that the deaths of heterosexuals were reported in much greater individual detail than the deaths of homosexuals. Studies on the Australian media revealed the same vilification of homosexuality, and clear "distinctions between 'innocent' and 'guilty' people with AIDS," and "the denial of risk to the 'general population' and metaphors associated with plague, death and divine retribution" (Lupton 1994, 49). In short HIV/AIDS was "constructed as a disease of deviance" (Lupton 1994, 125). Lupton (1994) further finds that the media narratives changed temporarily as a result of the Australian government's 1987 Grim Reaper-campaign, which portrayed how the mythological personification of Death was targeting people engaged in unprotected sex. The construction of HIV/AIDS thus "moved from being a disease of the deviant "others" through the "gay-plague"- construct to a disease of "self", i.e. everyone who was sexually active was at risk (Lupton 1994). However, the media soon reverted back to its initial framing of HIV/AIDS as a disease of "others", when the epidemic failed to spread to heterosexual individuals in any significant numbers (Lupton 1994). Lupton (1994, 21) conclude that the US, UK and Australian mass media's coverage of HIV/AIDS in the 1980s showed "a general neglect of AIDS while it seemed confined to gay men", and later was often contradictory, confusing and dramatic.

From a global perspective, these Western countries had relatively small and concentrated epidemics. The situation in East Africa was quite different. But despite several efforts to find studies from the 1980s analyzing Sub-Saharan Africa media's framing of HIV/AIDS, only one from Zambia was found (Kasoma 2000). Kasoma's (2000) study focuses on Zambian media in 1986, the year that HIV/AIDS was officially acknowledged and again in 1989, and finds that 60 percent of the news stories published in the two main daily newspapers were foreign, i.e., the material was bought internationally. While the study does not analyze the framing of HIV/AIDS or dominant narratives around HIV/AIDS, it is likely that bought material reflected the previously described mid- 80s' discourses. It is only towards the end of 1990's, any noticeable scholarly attention is paid to the role of the mass media in Sub-Saharan Africa in relation the epidemic, but then it is typically as a result of international development partners' initiative (UNESCO 2000).

Being a primary source of information, mass media influenced people's understanding of the virus both as a biomedical entity and as a social phenomenon. Although, necessarily brief and incomplete, this overview of primarily Western mass media's framing of HIV/AIDS in the 1980's, indicates that

mass media constructions of the epidemic influenced what social action was regarded as possible and desirable, and thus the afflicted societies' responses.

Another key point of this review is that mass media plays a pivotal role, not only in transmitting medical information but also in acting as producers and disseminators of meanings. Treichler (2006) argues that HIV/AIDS, by being life threatening, linked to sexuality, and indefinitely extended over space and time, compels us to make sense of it and therefore has an enormous power to generate meanings. Treichler (2006, 11) further argues that "the AIDS epidemic is simultaneously an epidemic of a transmissible lethal disease and an epidemic of meanings." This *semantic epidemic*, with all its meanings, definitions, and attributions, influences both our understanding of it as well as our responses to it. Therefore until we fully understand these stories of HIV/AIDS accurately, we will not be able to formulate intelligent interventions. Mass media is an important co-producer of the semantic epidemic, i.e. the definitions, attributions and meanings assigned to HIV/AIDS. Furthermore, the HIV epidemic is constantly socially constructed and reconstructed (Treichler 2006).

Making sense of the HIV-epidemic on an individual level is of course dependent on a number of other sources besides that of mass media. But, while mass media narratives in general are complemented by inter-personal communication channels, personal observations and personal experiences (Weaver, Zhu, and Willnat 1992), the early coverage leaves much to be desired. Indeed, mass media's framing of HIV/AIDS was at times not only overtly discriminatory, but in several instances counterproductive to the audience's efforts to understand the epidemic and take appropriate measures to decrease individual and collective vulnerability.

Counterproductive is a stark and unyielding word. Nevertheless, the mass media's framing and narratives on HIV/AIDS were counterproductive in the sense that they initially failed to cover HIV/AIDS when it was predominantly confined to homosexuals and drug users, and later through its narratives provided a fertile ground for stigma and discrimination. Discrimination is when "in the absence of objective justification, a distinction is made against a person that results in that person's being treated unfairly and unjustly on the basis of belonging or being perceived to belong, to a group of people" (Maluwa, Aggleton, and Parker 2002, 6). Such constructions of individuals as having "spoiled identities" do not exist naturally or randomly, but are created by individuals and communities, who build on and reinforce earlier prejudices against certain groups (Maluwa, Aggleton, and Parker 2002). UNAIDS (2007) identifies HIV-related stigma and discrimination, as key barrier for preventing new infections; provision of treatment and care of

people living with HIV; as well as mitigation of the current and future impact of the epidemic. By fueling stigma and discrimination, as well as the fear of them, individuals become more likely to succumb to a denial of individual risk, less likely to undertake HIV testing, disclose their HIV status to others, adopt HIV preventive behavior, or access treatment, care and support (UNAIDS 2007; Maluwa, Aggleton, and Parker 2002).

Purpose

In light of these historical cases indicating mass media's ability to influence audiences' understanding of the epidemic, as well as influence social action, analyzing media content is a route to explore how societies affected by HIV/AIDS potentially changes as a result of the epidemic. By analyzing a society's mass media framing and narratives of today, it is possible to explore what understandings are given preferential treatment in that society, as well as explore what social change those narratives indirectly or directly promote and facilitate. Subsequently, this dissertation will in five separate articles attempt to not only identify and describe media narratives on HIV/AIDS and same-sex sexuality in three countries hard-hit by the epidemic –Lesotho, Namibia and Uganda, but also discuss the potential effects of persistent silence as well as narratives and frames that are counterproductive to the countries' ability to respond to their epidemics.

Although the historical construction of HIV/AIDS as "gay disease" has been discarded in the US and several other Western countries, same-sex sexuality continues to be an explosive issue in many African countries. Understanding how same-sex sexuality in framed and subsequently understood in relation to HIV/AIDS is thus still highly relevant in an African context.

Admittedly, this dissertation has the ambition of not only providing a description of various narratives and frames, but to discuss and disrupt counterproductive narratives on HIV/AIDS and same-sex sexuality. This hint of activism is summed up by Susan Sontag's (Sontag 1990) solemn conclusion that narratives restricting our thought and understanding of HIV/AIDS will not disappear by us "abstaining from them. They have to be exposed, criticized, belabored, used up".

Outline of the dissertation

This dissertation is divided into four parts: I. *the Introduction*, will besides describing the purpose, provide the reader with the intellectual starting point for the research; II. *Theoretical framework*, *and methodological approaches*, explores the theories that informed the research process, as well as introduces and discusses the methodologies used in the empirical work. III. *Background to the empirical work*, introduces HIV/AIDS as a biological virus, the virus aetiology and the global epidemic with a focus on Sub-Saharan Africa. Furthermore this part introduces the three case-study countries: Lesotho and Namibia in southern Africa and Uganda in eastern Africa, and their HIV epidemics. Finally IV. *The discussion*; summarizes the dissertation's main components, the five articles, and presents a number of key conclusions derived from the empirical analyses.

Part II. Theoretical Framework and Methodological Perspectives

The previous section described how this dissertation rests on an assumption that media analysis can provide insights to social change. In short, media's framing of HIV/AIDS and same-sex sexuality is believed to influence the audiences' understanding of HIV/AIDS and subsequently, if enough people share a particular reading of HIV/AIDS, collective action. The previous section also outlined the motives for this dissertation and the overarching line of inquiry guiding the process as well as the five individual studies. The following chapter will introduce the theoretical perspectives that guided the research, as well as a summary of the individual studies' research design and methods. Furthermore, albeit not exhaustively, some reflections on the theoretical and methodological choices and limitations will be identified and discussed.

Theoretical framework: Agenda-setting theory

All five articles rely heavily on agenda setting theory, its conceptual framework and as a tool for making inferences on media content. McCombs and Shaw (1972) launched the agenda-setting theory after applying a straightforward comparison of media content with a survey of the public's agenda in the now famous Chapel Hill study. They found an almost perfect correlation between what the public considered to be the most important issues of the day and what was being covered by the mass media (McCombs and Shaw 1972). An agenda is defined as a set of issues ordered in a hierarchy of importance at a specific point in time. A later study, the Charlotte Study, focusing on the 1972 Presidential election, used a cross-lagged correlation design, and managed to establish causality when a correlation was found between the newspaper agenda at time period I and the public agenda at time period 2, and not the other way around (Shaw and McCombs 1977). In short, McCombs and Shaw were able to demonstrate that the mass media influenced audiences, rather than that the media reflected the public's ranking of issues. Although the agenda-setting theory was an original contribution, it built on the intellectual heritage of Walter Lippman.

Today, the theory has developed and grown since its inception “from a simple proposition involving only two variables (i.e., media agenda and public agenda) to a complex theoretical framework encompassing various auxiliary concepts and hypotheses” (Zhu and Blood 1996, 108). They also suggest that it is “likely that no other theoretical hypothesis in human communication research has received as much empirical attention by so many scholars and with such diverse methods as has agenda-setting” (Zhu and Blood 1996, 113). In a similar fashion, Bryant and Miron (2004) concluded that agenda-setting is one of the eight most popular theories in communication research.

Agenda-setting theory: a theory on causalities

The agenda-setting theory can be described as the process whereby “the priorities of the press to some degree become the priorities of the public. What the press emphasizes is in turn emphasized privately and publicly by the audiences of the press” (Shaw and McCombs 1977, 6). This is accomplished through a process whereby the mass media signal the importance of an issue by giving it preferential treatment, such as frequent coverage and/or a prominent position in the media product. This process is often referred to as the first level of agenda-setting.

Agenda-setting theory argues a causal relationship between the media’s agenda and the public’s agenda, as well as later the public agenda. The public agenda refers to the list of issues that people regard as important, and is often measured by asking a sample of individuals "what is the most important problem facing our nation today?” Salience and duration of an issue are important factors for influencing the audiences’ perceptions on an issue.

It is equally important to recognize that media silence can also have an effect. Rogers and Dearing (2007, 92) conclude “agenda setting influence may consist of the fact that issues and events that are completely ignored by the mass media do not register on the public agendas.” McCombs (1977, 99) also concluded that “If the media tell us nothing about a topic or event, then in most cases it simply will not exist on our personal agenda or in our life space”. The US mainstream media’s silence on HIV/AIDS in the early 1980s (Kinsella 1989; Singhal and Rogers 2003) accordingly most likely contributed to continued ignorance of the outbreak and failure to acknowledge the new epidemic as an important social issue in need of urgent attention. In short, media’s silence on certain issues, and the issues’ subsequent failure to be registered on our personal agenda, is merely stating the media’s agenda-setting power in reverse. It is however significantly more difficult to prove the “effect” of silence.

Other studies have investigated another type of effect; a so-called "reversed agenda setting effect" in which the public's concerns influence media coverage (Rogers and Dearing 1988). Rogers and Dearing (1988) point out that when it comes to breaking news events where there is no previous public perception, short-term studies on specific events tend to reveal a one-way direction of influence from the media to the public. When a long term perspective is applied, however, it is not unlikely that there is a two-way relationship between the media agenda and the public agenda, where the media pick up issues of significance from the public. In particular, when it comes to persistent and obtrusive issues where people are likely to have acquired some personal experience and/or formed a prior opinion, the public agenda may well have agenda-setting effects upon the media (Rogers and Dearing 1988). For example, countries with a history of high HIV-related morbidity and mortality, most individuals are likely to have a range of personal experiences and opinions on the epidemic.

Finally, agenda-setting theory postulates an even more important effect – that of the media's and the public's power to influence the policy agenda and thus social policy. Fig.1, provides a visual overview of the agenda setting process.

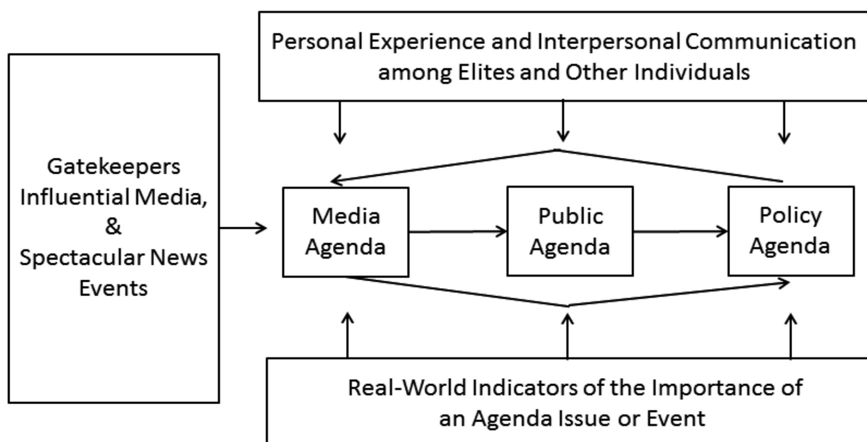

Fig. 1 The main components of the Agenda-Setting Process. Source: Dearing and Kim 2008, 279

Media effects contingent on a number of factors

A key aspect of the agenda-setting theory is, however, that although it deals with measuring universal effects, it does not assume that all individuals re-

ceive media texts in the same way (McCombs 2004, 2005). McCombs and Shaw argued already in 1972 that media probably had different effects on different people. McCombs (2005) highlights the importance of the *need for orientation*, which is based on the assumption that different individuals' need for orientation explains some of the individual differences. "Need for orientation is defined theoretically by two concepts, relevance and uncertainty. Low relevance defines a low need for orientation; high relevance and low uncertainty, a moderate need for orientation; and high relevance and uncertainty, a high need for orientation" (McCombs 2005,547). McCombs (2004) postulates that the greater the need for orientation is, the more likely the individual is to attend to the mass media agenda. For example, as long as HIV/AIDS was constructed as a gay disease, its relevance for most people where low even if there was a high degree of uncertainty on transmission routes and disease progression. This changed fundamentally when HIV/AIDS was reconstructed and eventually understood as a disease of not only homosexuals and drug users in the mid 1980s. HIV/AIDS had become an issue of high relevance and high uncertainty.

Winter and Eyal (1981) also argues for three sets of contingent conditions that impact the degree of media influence: *audience characteristics* (e.g. audience involvement, media preference and media dependency) *issue characteristics* (obtrusive or unobtrusive issue, where the media's agenda-setting effects are stronger for unobtrusive issues where the individual lacks personal experiences,) and finally, *media characteristics*, i.e. different types of media seem to have different weight and thus power to influence (Winter and Eyal 1981).

Walgrave and Van Aelst (2006) argue that while there are an abundance of research establishing and confirming the existence of the agenda setting process, they conclude after a review of 19 studies on the media's power to influence the policy agenda, that media effects appears to be contingent on several factors. Walgrave and van Aelst (2006) explore the key factors that appears to condition media effects. First, they, like Winter and Eyal (1981), argue that the *media itself*, is an important factor, as different media have by their status different weight. Some media, such as *The New York Times*, appear to produce a strong effect, than for example a local newspaper. Furthermore, in order for media to have a strong impact on politics, "a high congruence of the different media outlets is required. Only if all media are focusing on the same issue (focusing), frame it in a similar way (consonance), and if they do so with perseverance (persistence), can the media be expected to strongly impact the political agenda" (Eilders, 1997, 2000, 2001 in Walgrave and van Aelst 2006, 93). A second factor, is the *type of issue*, in short media appear to have more influence on some matters and less for others. In agenda setting research the distinction between obtrusive and unob-

trusive issues has been acknowledged for a long time. Walgrave and van Aelst (2006, 93) also suggest that the media have "more political agenda setting power when it comes to issues that, without media, would simply be not observable". Media's influence increase when it is the only sources, for the public and politicians, for learning about an issue. A third important condition to remember it that media's agenda setting affect is dependent on which type of *political actor* effect is measured on. Some actors, such as the parliament, a party, have very limited possibility to react quickly to the media, while politicians in opposition are freer to respond at least when it come to criticizing the political alternative that is in power. Furthermore, straightforward reporting that clearly defines the problem and points toward solutions might bear more agenda setting power than ambiguous coverage with many ifs and no self-evident solutions (Protess et al., 1987 in (Walgrave and van Aelst 2006, 94). Moreover, "negative coverage has more political agenda setting effects. Because politics is the business of problem solving, negative news automatically turns all heads to politics expecting at least some form of policy reaction" (Walgrave and van Aelst 2006, 94). Fourthly, in a democracy, media's agenda setting effect is determined on whether or not it is *election time*. Election times, decreases media's influence as political actors have a range of other channels to communicate with the public as well as media devote more attention to politics in campaign times. Media gates are more open to a range of politicians. In election times media are also less autonomous as they expected to provide the citizens with a balanced coverage of various political alternatives.

Walters, Walters and Gray (1996), however argue that agenda-setting theory has gone too far in simplifying matters and that more attention should be paid to the process that precedes agenda-setting. They find in their study of the 1992 presidential election that "agenda building involves editor, marketing department, subsidizers, and audience in a complex, dynamic, and perhaps cyclical process" (Walters, Walters, and Gray 1996, 9). In short, issues do not simply arise from nowhere, but are often the result of lobbying by grassroots movements, formal civil society groups or business interests. These various agenda-building activities that take place should accordingly be included in the analysis. McCombs (2005,548) also calls for more research on the question "if the press sets the public agenda, who sets the media agenda?"

In short the agenda setting process and its postulated effects is far from straightforward. The previous review indicates that media's influence is dependent on a range of factors, which needs to be kept in mind when discussing potential media effects on public and policy makers.

The agenda-setting process and HIV/AIDS in the US

Dearing and Kim (2008) have conducted the most comprehensive analysis of HIV/AIDS using the agenda-setting theory. In their study of HIV/AIDS on the American media agenda, captured by measuring the number of articles in *The New York Times*, the *Washington Post*, the *Los Angeles Times*, and items on the cable networks ABC, NBC and CBS, Dearing and Kim (2008) were able to identify four distinct periods (Fig. 2 Dearing and Rogers analysis of HIV/AIDS on the US agenda, 2008, 282).

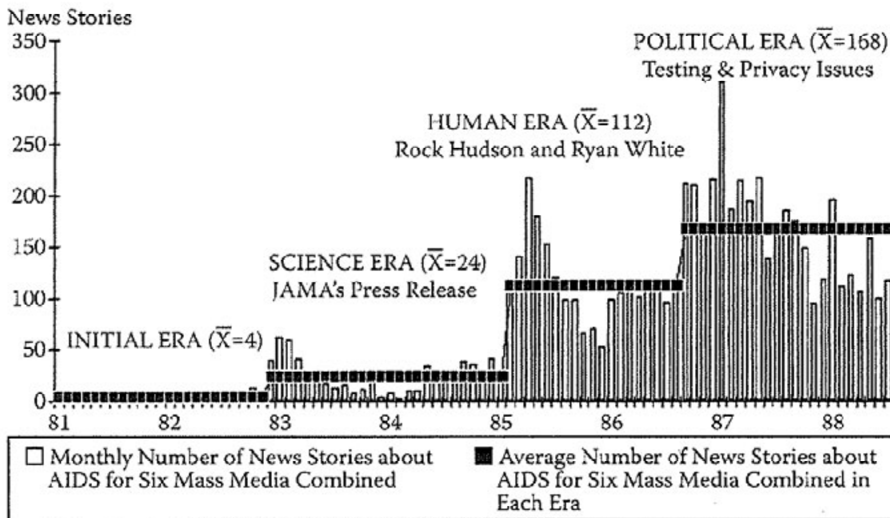

Fig. 2: Dearing and Rogers (2008, 282), analysis of HIV/AIDS on the US agenda in the 1980s.

During the initial era, and the science era the mainstream media's interest is almost non-existence. Dearing and Rogers (2008) argue that that the US national mainstream media coverage was initially low because of the lack of involvement of two key traditional agenda-setters: the White House and *The New York Times*. Singhal and Rogers (2003) similarly argue that White House silence on HIV/AIDS and the fact that *The New York Times* largely ignored the issue – HIV/AIDS first appeared on the front page of *The New York Times* two years into the epidemic on May 25, 1983 – significantly delayed the entry of HIV/AIDS in the public conscience.

Coverage of HIV/AIDS did, however, increase dramatically in 1985 with the announcement that movie star Rock Hudson had AIDS and later with the tragic story of Ryan White, a 13-year-old boy infected through a blood transfusion, who was barred from attending his junior high school by local authorities. These "two tragic figures played key roles in putting the epidemic

on the media agenda" (Singhal and Rogers 2003, 88), as they provided an opportunity to put a familiar face on the disease as opposed to the face of a homosexual or drug user. Thanks to the sad cases of Ryan White and Rock Hudson, the coverage of HIV/AIDS increased tenfold (Singhal and Rogers 2003). Finally, HIV/AIDS is part of the media agenda (Singhal and Rogers 2003). Cassidy (2000), however, argues that the Surgeon General's report on Acquired Immune Deficiency Syndrome, which was the first substantive statement on HIV/AIDS by the White House, greatly facilitated HIV becoming an important socio-political issue as opposed to a *gay story*, and thus making the disease more relevant to the general public. The subsequent increase in coverage cued members of the general public that HIV/AIDS was an important social problem (Cassidy 2000).

In addition to looking at the first level of agenda setting Dearing and Kim (2008) also analyze how HIV/AIDS was framed in their longitudinal study of HIV/AIDS. In the initial phase, coverage was dominated by the mystery of the new disease. The science era, coverage revolved around science's endeavors to unravel the mysterious disease and relied heavily on scientific sources. The third era, the human era, which commenced with the Hudson and White stories, was characterized by personalizing and generalization of HIV/AIDS. This era introduced HIV/AIDS as issue relevant to more than socially marginalized groups. Finally the fourth phase, the political era coverage revolved around discussing various possible policy options. Some were controversial as they included mandatory testing and infringement of privacy, as well as patient and doctor confidentiality.

Agenda-setting theory, postulate that an issue will ascend on the public's agenda once an issue has received significant media attention, and in particular by elite media, as well as preferably framed in such a way that the issue is perceived as relevant, and with an element of uncertainty. That is the public has a need for orientation. In the US, the public agenda is often measured by polls asking: what is the most important problem facing the nation? In late 1985, soon after HIV/AIDS had entered the media agenda because of Rock Hudson and Ryan White, did sizable numbers of Americans begin to identify HIV/AIDS as an important social problem in the opinion polls. In early 1986, HIV/AIDS had climbed further in the national polls and was seen as "the most important health problem facing the nation" (Singhal and Rogers 2003, 86). Furthermore Dearing and Kim (2008) conclude that when HIV/AIDS achieved the status of being an important issue on multiple agendas, i.e., the media, public and policy, the issue can result in social change. "it is this interaction that leads to social change as an issue becomes institutionalized through government, private and non-profit responses to it" (Dearing and Kim 2008, 283).

Dearing and Rogers (2008) also analyzed HIV/AIDS movements on the media agenda in the 1990s, and find that coverage changed significantly. Various federal agencies had at this point, been put in charge of various policy response, such as research, treatment, education of the public and behavioral change campaigns. According to Dearing and Rogers (2008) their analysis "support the idea that when confronted with incontrovertible, conclusive data about problem severity and prevalence, the media agenda and the policy agenda will mutually affect one another" (Dearing and Kim 2008, 291. Dearing and Kim (2008, 291) therefore end up arguing "that circularity better defines the total agenda setting process than does a linear and directional media public policy model." Although Dearing and Kim (2008) argue that a circular model that includes certain general directional relationships is more correct than a straight causality model, and they believe it is time-dependent. "In the first decade of HIVAIDS in our whole-model test, the real-world indicators contributed to the overall ascendancy of the issue. Now, perhaps due to the effects of a perceived satisfactory institutional response, lowered public opinion in terms of issues salience as well as changes in problem severity (at least in the short term) do not much affect continued rates of media coverage and funding allocation" (Dearing and Kim 2008, 291).

Dearing and Kim (2008) also find that the successful institutionalization of HIV/AIDS resulted in the media decreasing the number of articles solely devoted to HIV/AIDS, and coverage became more event-dependent. Dearing and Kim (2008, 285) conclude that "a very large issue that persists (like AIDS) loses its informational value to journalists. It retains its importance, but its omnipresence means that it is subsumed into more event-driven, newer issues about which viewership and readership are not tired." At this stage, issue proponents seeking media interest in HIV-related issues must find new ways of attracting the media's attention and new ways of portraying their cause in order to receive coverage (Dearing 1989 in Dearing and Kim 2008). The Magic Johnson's disclosure in 1991 which resulted in *The New York Times* devoting 300 column inches of news space to him are examples of how coverage under the right conditions can increase even after an issue has lost its original news value (Singhal and Rogers 2003).

Although the first level of agenda setting is important for the overall discussion, it is not the main focus of this dissertation. Instead, this dissertation primarily revolves around the second level of agenda-setting, which is also often referred to as *framing*.

Framing or the second level of agenda-setting

More important for the line of inquiry of this dissertation is the agenda-setting theory's second level. In the 1990s, the agenda setting theory evolved and came to include the new concept of second level of agenda setting or attribute agenda setting (Takeshita 2005). The second level of agenda setting assumes that media has agenda-setting effects also at the attribute level. This new addition to the agenda setting theory effectively entailed that agenda-setting research and framing research were exploring almost the same problem (Takeshita 2005). As a result, some framing researchers argued that agenda-setting researchers were "poaching" (Reese 2007) or oven "colonizing other theories" (Takeshita 2005, 280). McCombs (2005, 546) conclude in his review of the agenda setting theory's evolution that it has "incorporated or converged with a variety of other established communication concepts and theories". Both framing theory and agenda setting theory call attention to "the special status that certain attributes or frames have in the content of a message" (2005, 546).

Weaver (2007, 142) summarizes, "Whereas the 'first level' of agenda setting is focused on the relative salience (usually operationally defined as perceived importance) of issues or subjects, the 'second level' examines the relative salience of attributes of issues". That is, the various objects/issues on the agenda all have attributes, "a variety of characteristics and traits that describe them … some attributes are emphasized, others are mentioned only in passing. For each object on the agenda, there is an agenda of attributes that influence our understanding of the object" (McCombs 2005, 546). The second level of agenda-setting thus postulates that mass media not only influence *which* issues are perceived as important by the audience but also influence *how* the issues are understood. According to McCombs (2005) both framing and agenda setting attempt to understand how certain set or attributes or frames influence the audience understanding. But there is a distinction between *a frame* and *an attribute*. Although a frame is an attribute of the object/issue because it describes it, not all attributes are frames (McCombs 2005). "If a frame is defined as a dominant perspective on the object – a pervasive description and characterization of the object – then a frame is usefully delimited as a very special case of attributes" (McCombs 2005, 546). In short, *not* all attributes are frames, and only the dominant attribute in a message is a frame.

Not all researchers agree that *framing* theory is the same as the second level of agenda-setting. Weaver (2007) concludes that framing seems to be the least well-defined of the three concepts – agenda-setting, framing and priming – conceptually and operationally. Takeshita (2006, 281) suggest that

although both traditional agenda-setting theory and framing theory are interested in the transfer of salience, the differences lies in “agenda-setting effects are characterized as cognitive, while framing effects are considered to be more than that”. Entman (1993, 52) often sited definition of framing states that framing is to select “some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item described’’. Entman’s definition of framing, thus includes not only a cognitive, but a affective dimension, moral evaluation, as well as behavioral dimension (Takeshita 2006).

The historical evidence of a connection between media’s coverage and how HIV/AIDS has been understood and subsequently acted upon, constitute the intellectual point of departure for this dissertation. Agenda-setting theory and in particular framing theory provides a theoretical framework for a more systematic analysis of media content. Agenda-Setting Theory, first and second level, provides grounds to argue that the media’s framing of and narratives on HIV/AIDS matter as they feed their audiences with pictures of “reality” which in turn influence their “sense making process by promoting a particular problem definition, causal interpretation, moral evaluation” (Entman 1993, 52). The choice of Agenda Setting Theory as an overarching framework, might be questioned on the basis that it does not support or even encourage critical analysis of the cultural, historical and ideological factors which influence media’s selection process, frequency or framing of social issues. But, depending on your perspective, the theory’s ‘neutrality’ in regard to aforementioned forces can also be regarded as a strength and a way of balancing and moderating a researcher’s biases, or indeed even ambitions to be disruptive to counterproductive narratives on HIV/AIDS and same-sex sexuality.

Methodological approaches

As stated earlier, the overarching purpose of this dissertation is to not only identify and describe mass media narratives on HIV/AIDS and the closely related topic of same-sex sexuality, but to discuss the narratives’ potential consequence for individuals and communities understanding of the epidemic. A key underlying assumption is, as asserted by Agenda Setting Theory that media’s framing of HIV/AIDS and same-sex sexuality influence audiences’ understanding of their epidemic, as well as their views on what constitute an appropriate and desirable policy response. Subsequently, all but one of the articles directly analyzes media content in an attempt to capture media’s framing of HIV/AIDS or same-sex sexuality.

For the purpose of clarity, it is important to note that none of the five articles attempt to establish the HIV epidemic's relative position on the media agenda. On the basis that all three case countries are hard-hit by HIV/AIDS (See background to the empirical material), and have for an extended time battled with the consequences of high HIV-related morbidity and mortality, it is instead likely that HIV/AIDS is established on multiple agendas. Consequently, the empirical effort revolves around analyzing the *how* HIV/AIDS and same-sex sexuality is framed, and how frames and narratives influence *how* the issues are understood. Again for the purpose of clarity, the articles does not focus on identifying single attributes, but rather attempts to identify and describe frames, which according to McCombs is a pervasive description and characterization of the object. The articles and this introductory text however also refer to the term *narrative.* A narrative in this dissertation refers to the overarching story in a body of texts, in particular in a newspaper's coverage of an issue. A narrative is thus seen as the overarching story that is constructed over time, and consists of several frames. For example, in the first article from Lesotho, the analysis shows that the coverage revolves around the consequences of the epidemic, which consist of frames of several frames of the epidemic's economic, demographic, social impact on society etc. These frames however, all contribute to construct an overarching narrative on the devastating consequences of the epidemic.

Asp (1986) describes three main types of purpose: descriptive, normative, and explanative. Admittedly, the articles included in this dissertation make no such distinction, but rather has an ambition to not only describe but explain, and relate the result to a normative framework. In an attempt to escape criticism for this bias, the norms against which research result are held up against, were kept to a minimum. Subsequently, the normative assessment and discussions does not suggest or even imply that media somehow has societal obligations and should take on the roles and responsibilities of public health educators. It is thus never argued or knowingly implied that media organizations should double as public health educators, rather than attend to core business – produce and sell news. Indeed, the discussion departs from the lowest form of obligation – that media narratives should not be outright counterproductive to individuals of all sexual orientations and communities' ability to understand and lower their individual and collective vulnerability or mitigate impact of the epidemic. While, the assessment of coverage departs from a low denominator, in retrospect, it is clear that some of the articles' purpose's normative influences could have been more clearly articulated.

Nevertheless, depending on your perspectives on the role of research and what a research contribution consists of, a normative framework could be perceived as problematic, or not. Personally the topic of HIV/AIDS, with its

abundance of social constructions, often exacerbating individuals' biological vulnerability, as well as hampers community responses, does not invite neutrality. Weiss (1995, 213) argue that one way of balancing and even counteracting a researcher's bias is "to capture, with scrupulous honesty", the way things appear, and only after the documentation process is completed assess the results' "implications for social action". The Agenda Setting Theory, besides being theoretically appropriate, provide a "neutral" framework.

Finally, it should be noted that this dissertation regarded and treated country experiences as complementary. Consequently, the studies were entirely guided by their individual purposes and no effort was made repeat the research designs to facilitate comparison. The process of exploring the complementary country experiences, however, inevitably also contains elements of comparison. The table below provides a summary of the studies (table 1).

Table 1. Summary of the five articles' research design /mix of methods

Title	***Sample***	***Method***
Fragmented Narratives and Untold Stories: The Portrayal of HIV/AIDS in Lesotho Print Media	Purposive sample	Quantitative and interpretative content analysis of newspaper content
Factors associated with high media coverage of the HIV epidemic in Lesotho	Purposive with attempts to increase range	Semi-structured naturalistic qualitative interviews with key informants
State-sanctioned discrimination and media discourses on homosexuality in Namibia	Purposive sample Purposive sample All available doc.	Tailored qualitative interviews with experts. Quantitative content analysis of media content Document analysis
Kill Bill – Exploring Ugandan human rights organizations' attempts to influence the media's coverage of the Anti-Homosexuality Bill	Snowball sample Purposive sample	Semi-structured naturalistic qualitative interviews with human rights defenders Quantitative content analysis of media content using membership-validated content categories
Homophobia as a barrier to comprehensive media coverage of the Ugandan Anti-Homosexual Bill.	Purposive sample	Quantitative content analysis of media content using a typology for establishing discursive discrimination.

Selection of case countries

It is important to note that this dissertation or its results makes no claim to be representative of the African continent's 54 different media sphere's narrations on HIV/AIDS and same-sex sexuality. The fact that Sub-Saharan Africa's contains a multitude of epidemics, both across and within countries, each with its own specific drivers and manifestations, thus makes selection intrinsically difficult. Indeed, the selection of cases – the three case countries – is an entirely purposive sample. Babbie (2010) defines purposive sampling as a type of non-probability sampling "in which the units to be observed are selected on the basis of the researcher's judgment about which ones will be the most useful or representative". The selection of case countries was thus not made in order to be representative of groups of countries or facilitate a comparative analysis, but rather aimed to include the countries with different and *interesting* experiences. The sample is also in one sense a *theoretical sample* (Babbie 2010), as includes two cases that had been internationally recognized as 'best practices" cases. Both Lesotho and Uganda have gained international recognition for some of their pioneering interventions in dealing with their epidemics, which further motivates why these countries were found to be particularly relevant for empirical analyses. Finally, language accessibility influenced the selection, and benefited countries with English as their official language.

Exploring frames, narratives and production environment

The following section will use the individual articles' abstracts to engage in a presentation and discussion of the research designs and methodology, as well as touch upon limitations of the aforementioned choice of method, operationalization and analysis.

> ***I: Fragmented Narratives and Untold Stories: The Portrayal of HIV/AIDS in Lesotho Print Media.*** In Luuk Lagerwerf, Henk Boer, and Herman Wasserman (Editors) (2010) Health Communication in Southern Africa: Engaging with Social and Cultural Diversity, 71-92.
>
> *In late 2005, the government of Lesotho launched the world's first comprehensive plan to offer its entire adult population voluntary HIV testing and counseling. Using manifest and latent content analysis this study explores how articles in the two largest weekly newspapers in Lesotho portrayed HIV/AIDS and the campaign over seven months. Although HIV/AIDS is frequently covered and recognized as a public health threat, the*

> *227 articles rarely discuss the underlying causes, and do therefore not offer the reader information on the key driving forces behind collective and individual vulnerability to the virus. Moreover, the portrayal of HIV/AIDS as an insurmountable and overwhelming phenomenon could be counterproductive with regard to efforts to persuade an entire population to test for HIV.*

Lesotho was the first country in the world that made an attempt to offer counseling and an HIV test to its entire adult population under the "Know Your Status" campaign. As media were identified as key partners in sensitizing and mobilizing the country around the campaign, they offered a frontier for HIV-related media research. This study analyzed the Lesotho print media's framing of HIV/AIDS in general as well as the Know Your Status campaign. The sample consisted, as in the following content analyses of the Namibia and Uganda media, of the largest, i.e. highest circulating, privately-owned and largest government-owned newspapers. This choice of sample units rested on personal experiences of the significant different editorial house styles used by privately-owned vs. government-owned media.

This first Lesotho study examines print media content by using a method that combines elements of systematic content analysis and more interpretative examinations of the portrayed properties of HIV/AIDS in general and the "Know Your Status" campaign. Berelson (1952, 116) argues that there is no "strict dichotomy" between qualitative and quantitative analysis as much "qualitative" analysis is quasi-quantitative, in the sense that it contains quantitative statements such as statements about the incidence of general categories. Similarly, quantitative content analysis assigns relative frequencies to different qualities (or categories) that are derived qualitatively. Nevertheless, Berelson's focus is on using frequency as a marker for relative importance. Whereas the first article from Lesotho is clearly influenced by Berelson's recommendations for analyzing *manifest* content, the analysis performed on the media texts in Lesotho's two largest newspapers abandons his prescriptions in several instances.

First of all, the analysis does not end with the quantification of an array of meticulously constructed categories using a pre-quantitative technique which refers to "the careful reading of (samples of) the content under analysis in order to discover and/or formulate appropriate categories for subsequent quantification" (Berelson 1952, 115). The study did pay heed to Berelson's (1952, 147) message that "content analysis stands or falls by its categories," but the initial quantitative content analysis of manifest content primarily functioned as a tool for organizing the material. The initial quantitative content analysis subsequently enabled a more interpretative qualitative analysis

where a new set of more complex content categories was discerned from the material. According to Berelson (1952, 127), the content unit of qualitative analysis is likely to be more complex than in quantitative analysis, as qualitative analysis is less concerned with reliability than quantitative analysis that often breaks down complex categories into an atomistic combination of measurable units.

A second and perhaps even more significant departure from classical content analysis is that the analysis attempts to establish, as well as make inferences on, the basis of non-manifest content. So besides analyzing the manifest content, the analysis also attempted to capture the coverage's overarching narratives, as well as absent discourses on HIV/AIDS. These elements were seen as equally important for the understanding the readers sense making process of HIV/AIDS during the first seven months of the government of Lesotho's ambitious "Know Your Status" campaign.

The more interpretative analysis of the content found that media content could be argued to contain only one narrative –that of the *devastating consequences of the HIV epidemic*. This dominant narrative was ever-present and served as a backdrop for coverage of international cooperation, crime, children and youth, the Lesotho healthcare system's struggle to deliver services to an ailing population, the government of Lesotho's response; all themes arrived at through the quantitative analysis. Without a more qualitative interpretative analysis of the quantitative content categories, the analysis would have ended with a set of analytically disconnected content categories. Furthermore, the analysis of latent (unintended or sub-textual) content also came to focus on *absent content – the causes of the epidemic*.

It is argued in the article that both types of content, i.e., manifest and latent influence how the HIV epidemic is ultimately understood and potentially acted upon. A dominant narrative on the devastating consequences of the epidemic, consisting of frames of high death rates due to HIV/AIDS, disruption of communities, changing demographics, an escalating orphan crisis, adverse impact on the economy and the overall development of the country, without narratives on the causes behind the situation might construct HIV/AIDS as an overwhelming force beyond the control of the individual or the government of Lesotho. Incomplete narratives on the epidemic's causes deny the reader any real understanding of why Lesotho is so severely affected. Furthermore, an unclear understanding of the causes behind individual and collective vulnerability may facilitate acceptance that no one is responsible for the current situation or lack of responses to it or can be blamed for any future failures to address it. The article further concludes that even if the two newspapers provided the "Know Your Status" campaign with largely supportive coverage, a reading of the epidemic as incomprehensible and

beyond the control of individuals or the government would not further the campaign goals.

Non-manifest content is admittedly tricky, as it is heavily dependent on the interpretation of the text, as well as the context in which the text was produced. The analysis thus knowingly departs from the ideal of being easily "*replicable*. That is, researchers working at different points in time and perhaps under different circumstances should get the same result when applying the same technique to the same data" (Krippendorff 2004, 18).

> ***II: Factors associated with high media coverage of the HIV epidemic in Lesotho.*** African Journal of AIDS Research 2010, 9(3): 225–233.
>
> *In December 2005 Lesotho launched the world's first attempt to provide all citizens over 12 years old with an opportunity to go for Voluntary Counseling and Testing of HIV – the "Know Your Status" campaign. Through qualitative interviews this study examines Lesotho media workers' experiences and perception of challenges in covering HIV/AIDS 25 years on as well as the "Know Your Status" campaign. Findings are consistent with a regional comparative study, concluding that journalists and editors remain highly committed to covering HIV/AIDS. Although covering the epidemic has become significantly easier thanks to Lesotho government's efforts to keep HIV/AIDS on the agenda, and the government is lauded for its efforts to continue to keep HIV/AIDS on the agenda, it is simultaneously identified as the main barrier to more comprehensive coverage of the epidemic. The article suggests that providing an issue with continuous coverage is a significant challenge, and in Lesotho partly dependent on the capacity of the main agenda-setter – the government– to communicate clearly with the mass media.*

The second article on Lesotho was in many respects an intellectual continuation of the first article. After the analysis of seven months of media coverage in which the absolute majority of items explored the devastation of the HIV epidemic, the perspectives and experiences of the Basotho journalists and editors were brought to the forefront. Subsequently, a second and decidedly different study exploring Basotho journalists' and editors' experiences of covering HIV/AIDS and the "Know Your Status" campaign was conducted. This study also explored factors behind the Basotho journalists' and editors' outperformance of media colleagues in Southern Africa. In a regional comparison, Lesotho's media produced the largest proportion of HIV/AIDS cov-

erage, with 19% of all the monitored items mentioning HIV or AIDS in comparison with the regional average of 3%.

In order to capture Lesotho media workers' motivations, experiences and perception of challenges in covering an "event" stretching over 25 years, semi-structured qualitative interviews provided both the freedom to explore a range of potential factors and yet enough structure to facilitate data collections and analysis. The research and subsequent interviews were guided by three groups of questions:

(1) What motivates Lesotho journalists and editors to give continuous coverage to HIV/AIDS?

(2) What have been the experiences and challenges of individual journalists and editors in covering HIV/AIDS over an extended period of time?

(3) What factors in Lesotho outside the media might have contributed to the high level of HIV/AIDS coverage in the media?

Unlike the previous study, this study contained no content analysis, but rather relied entirely on semi- structured qualitative interviews. The purposive sample contained 16 print and radio journalists and editors. Although 16 interviews may appear to be a modest number, it was a sizable portion of active media workers, according to the UNICEF press officer's (personal communication) list of media contacts containing approximately 40 names. Furthermore, an interview study can be concluded "when the interviews are new, but the stories are the same" (Ryen 2004, 86). Indeed, after 16 interviews, the stories were beginning to be familiar.

Semi-structured interviews are characterized by that main questions and themes are identified prior to the interview, but not the wording or the order of questions (Ryen 2004). Weiss (1995, 9) recommends qualitative interviews as a method when the purpose is: "developing detailed descriptions, integrating multiple perspectives, describing processes, developing holistic description, learning how events are interpreted, bridging inter-subjectivities, identifying variables and framing hypothesis for quantitative research." Semi- structured qualitative interviews are often used when the purpose of the research is fairly clearly defined. Furthermore, semi-structured interviews as a method are appropriate when interviewees need to be asked to think back and engage in a retrospective analysis (Weiss 1995). The interviews carried out with Basotho journalists and editors were naturalistic interviews, that is, they depart from the notion that the social reality is real and exists inside the head of the interviewee (Ryen 2004). The key purpose of naturalistic interviews is to uncover how the interviewees view and under-

stand their reality and the researcher attempt to depict that reality in his/her text. It is the interviewee's version of reality that is of interest and, by using the interviewee's words and descriptions of different phenomena, the researcher gains access to that individual's understanding of his/her reality. According to Ryen (2004, 32) the naturalistic interview has a "long tradition in qualitative research" and still has a dominant position as a qualitative methodology.

The semi-structured naturalistic interviews were guided by an interview guide consisting of a demographic section with pre-specified questions on educational and professional background and additional training in covering HIV/AIDS, as well as a section containing broad themes such as: specific challenges in covering a continuous "event" that was devastating the country, experiences in covering the epidemic, personal motivations and ambitions regarding coverage and if covering the epidemic had changed over the years, particularly for those journalists who had worked for many years. The editors were asked additional questions on how they dealt with HIV editorially. According to Ryen (2004), it is important not to let an interview guide result in the researcher not taking advantage of the unanticipated opportunities, such as when the interviewee is spontaneously sharing unsolicited narratives. Subsequently, the 16 Basotho journalists and editors, had considerable freedom to share their experiences. Survey interviews with fixed questions and limited options for response would have failed to capture the wealth of information the journalists and editors had to offer.

The study found that while high HIV prevalence in Lesotho is an important factor behind the media corps' strong sense of personal commitment (clearly visible in the content produced by the media- Article I.), this alone does not explain the media's collective high coverage of HIV/AIDS. Instead, the high level of HIV/AIDS coverage is most likely *also* the result of the continuous efforts by political leaders to keep HIV/AIDS on the agenda. The study also suggests that government of Lesotho does not utilize their position as the principal agenda builder, as government officials and public servants appear to be at times ambivalent or even reluctant in their role as agenda-builder. The article ends with questioning the government of Lesotho of its agenda building position and the opportunities it presents.

III: State-sanctioned discrimination and media discourses on homosexuality in Namibia. Journal of African Media Studies, (2011) 3(1), 57-72.

The article critically discusses the events arising from the finalization of the Namibian National HIV/AIDS Policy of 2007. A series of consultative meetings throughout Namibia produced a progressive draft policy that recognized individuals engaged in same-sex sexual relationships and emphasized the distinct vulnerabilities of the group. Despite solid epidemiological support and stakeholders' endorsement of inclusion, however, the key section dealing with same-sex relations never made it into print. Through document analysis, interviews and media content analysis, the article concludes that state-sanctioned discrimination against lesbian, gay, bisexual and transgendered (LGBT) individuals, outlined in existing Namibian criminal laws, also resulted in a denial of their rights to health in the new HIV/AIDS policy. Moreover, the study found that the state-sanctioned discrimination is reproduced in the state-owned print media, and that LGBT individuals are dependent on the independent media for visibility. The implications of the media discourses are discussed from an agenda-setting perspective.

Unlike the two previous studies on Lesotho, which predominantly relied on a single method, the following study ventured into a slightly different field – same-sex sexuality – and used three separate methods for data collection: expert interviews, document analyses and, finally, a content analysis of media texts. Triangulation, i.e. the use of multiple methods and data sources, is often used to control biases and enhance the validity of research findings (Mathison 1988). Although triangulation cannot fix a flawed research design, "appropriately used, triangulation might enhance the completeness and confirmation of data in research findings of qualitative research" (Thurmond 2001, 257). It has also been argued that triangulation can assist the researcher to counter accusations that a study's findings are merely the result of a single method, or single source or a single researcher's biases (Patton 1990). Denzin (1978), according to Mathison (1988, 13), was the first to provide a detailed "discussion of how to triangulate" and presents three ways to do triangulation: data triangulation, which includes time, space, and person, investigator triangulation, and methodological triangulation. This study relies on a triangulation of sources and methods. Mathison (1988) does, however, conclude that although triangulation is an important tool, it has a problematic nature insofar as it often renders inconsistent and contradictory results. Mathison (1988) therefore argues that the main value of triangulation

as a strategy is that it highlights inconsistencies and facilitates the convergence of evidence.

The background to the study was the government of Namibia's unilateral decision to exclude individuals engaged in same-sex sexual practices as a vulnerable group from the national HIV/AIDS policy of 2007. The removal, besides being problematic from a public health perspective, was even more noteworthy considering the fact that the inclusion of the group had been broadly endorsed through a national consultative process. Furthermore, despite the inherent drama of a ministry unilaterally and unexpectedly deleting part of a national policy document, the print media awarded the event minimal coverage. Subsequently, the article's purpose was to use interviews with key stakeholders involved in the HIV/AIDS policy process, document analysis and content analysis to reconstruct the turn of events during the finalization of the policy, as well as understand the media's failure to cover the story.

There are, according to Weiss (1995, 17), two distinct types of interviewees: "people who are uniquely able to be informative because they are experts in an area or were privileged witnesses to an event; and people who, taken together, display what happens within a population affected by a situation or event." Unlike the previous article on Lesotho, this study relied on the first type of interviewees – three leading representatives from Namibian civil society. As experts in the field they had been witnesses of the policy process and were able to contribute insights into the process of formulating a national HIV/AIDS policy. Subsequently, each interview was structured around each individual's specific knowledge and involvement in the process. Again, semi-structured naturalistic interviews were conducted.

Parallel to the interviews, a document analysis was conducted. "Document analysis is a systematic procedure for reviewing or evaluating documents – both printed and electronic (computer-based and Internet transmitted) material" which have been produced outside the influence of the researchers (Bowen 2009). That is, the document existed prior to the research process, and therefore can provide invaluable insights into past events that can no longer be studied directly through interviews or observations. The analytical procedure in document analysis "entails finding, selecting and appraising (making sense of), and synthesizing data contained in the documents" (Bowen 2009, 28). According to Bowen (2009), document analysis is often used in combination with other qualitative research methods as a means of triangulation. The collection of documents was greatly facilitated by the interviewees and indeed most documents were retrieved from the interviewees' personal archives. The collection of documents was in the form of meeting minutes, PowerPoint presentations, e-mails, and research review reports, as

well as several dated drafts of the HIV/AIDS policy text. The actual document analysis consisted of establishing and understanding in what sequence events occurred. Initially, the documents were arranged according to a timeline, and as interview material was analyzed it was added to the timeline in an attempt to merge the sources and thereby reconstruct the events during the finalization of the national HIV/AIDS policy. The Ministry of Health was also contacted on several occasions but no response was ever given.

In the process of reconstruction, a growing suspicion turned into a working hypothesis: the unilateral removal of the section on same-sex sexuality and violation of a national consultative process was as a direct result of state-sanctioned homophobia and discrimination. Such hypothesis needed further verification, and subsequently a content analysis of the state-owned newspaper, *New Era*, was assessed as an appropriate alternative to an official response. The media content analysis was thus performed as a last step in the process of trying to substantiate or discard the hypothesis of state-sanctioned homophobia. Unlike the other studies, the content analysis was one method out of several. Indeed, the content analysis's initial and primary function was to function as a litmus test of the hypothesis. Moreover, the largest independent newspaper, *The Namibian*, was also included in order to eliminate the possibility that the selected time frame was the reason behind a particular result. A content analysis of the two newspapers' coverage of *LGBT issues in general* and the HIV/AIDS policy process, was deemed to be an appropriate focus to verify or discard the working hypothesis. Indeed, the content analysis showed that state-owned media remained completely silent on the unilateral removal of the same-sex sexuality section from the policy and LGBT issues in general The study concludes that there seems to be two parallel media discourses in terms of same-sex sexuality as a standalone issue and in relation to HIV/AIDS, whereby the state-owned print media seem to reproduce an "unofficial policy of denial and silence." This discourse is contrasted with the independent media's editorial decisions to challenge the emerging unofficial policy of denial and silence by actually covering the controversy surrounding the HIV/AIDS policy, LGBT and the discrimination of this group.

Although the triangulation of methods and sources indeed facilitated and enriched the research process, in hindsight, contextual knowledge of Namibian society's previous and current discourses on same-sex sexuality turned out to be of even more importance. Without an understanding of the history of vocal and explicit state-sanctioned homophobia, as well as how that discourse has changed as a result of the policies adopted by the current leadership, President Pohamba, the absent coverage of the controversies surrounding the HIV/AIDS policy of 2007 and same-sex sexuality in general would

have failed to be registered. In-depth contextual knowledge was a prerequisite for being able to register what was *not* there.

IV: Kill Bill! Ugandan human rights organizations' attempts to influence the media's coverage of the Anti-Homosexuality Bill. Culture, Health & Sexuality, (2011) ifirst.

The Ugandan Anti-Homosexuality Bill of October 2009 caused an international outcry and sparked intense debate in the local and international media. Particularly contentious was its proposal to impose the death penalty for acts of "aggravated homosexuality." Through a quantitative content analysis of 176 items from two main daily newspapers, the government-owned New Vision and the privately-owned Daily Monitor, for the period October 2009 to June 2010, combined with qualitative interviews with human rights defenders in Uganda, this study explores attempts made by local human rights advocates to influence the media's coverage of the Bill and the extent to which these attempts were successful. The study finds that while there are significant differences between the frequency of reporting on the Bill in the two newspapers, both papers devoted little editorial space to the public health and human rights concerns put forward by local human rights organizations. Despite Uganda's recent and often lauded history of openly addressing HIV/AIDS, human rights organizations' attempts to highlight the Bill's potentially adverse effects on the country's ability to tackle the epidemic effectively were only partially successful and, interestingly, received much less attention than the potential human rights implications of the proposed change in legislation.

This article explored to what extent the Ugandan human rights organizations' agenda building efforts were successful in influencing the media to adopt their main frames on the Anti-Homosexuality Bill. Similarly to the previous study on Namibia, it relied on a research design featuring multiple methods: semi-structured naturalistic interviews combined with content analysis.

Content categories should reflect the purpose, and be exhaustive as well as mutually exclusive. With a nod to Berleson's (1952, 147) message that "content analysis stands or falls by its categories," establishing which content categories to use for measuring influence was a central tenet of the study. In order to assess the result of the various human rights organizations' sometimes disparate agenda-building efforts it was essential to determine which

frames Ugandan human rights advocates promoted in their contacts with the media. Subsequently, a pre- content analysis of the umbrella organization for the campaign against the Bill – the Uganda Civil Society Coalition on Human Rights and Constitutional Laws (press statements from October and December 2009) – was undertaken. Three main frames were identified as follows:

(1) The Bill is a threat against public health, as it threatens to undermine commitments and efforts to provide universal access to HIV/AIDS prevention and treatment.

(2) The Bill is anti-human rights and anti-constitutional as it is contradictory to international human rights commitment and human rights protections enshrined in the Ugandan Constitution.

(3) The Bill has repercussions for all Ugandans and not only homosexuals.

In addition, semi-structured naturalistic qualitative interviews (Ryen 2004) with Ugandan human rights defenders were conducted to map agenda-building activities further, as well as verify the three main frames found through the text analysis of press statements. The interviews thus also functioned as a validation of the results from the content analysis of press material, which also constituted the main content categories for the subsequent content analysis of media texts. Finally, to determine if the framing attempts had been successful and made it into print, a quantitative content analysis of the coverage of the Anti-Homosexuality Bill between October 2009 and June 2010 in the largest government-owned and privately-owned daily newspapers was carried out. This content analysis differed from previous content analyses in one central respect – it was not constructed iteratively. Instead, the content analysis relied on Kiousis's (2004) conceptualization and operationalization of issue salience, i.e. measuring three variables: *attention* (measures the number of times a particular medium publishes a news items on a given issue), *prominence* (measures if the placement of an issue is such that it readily attracts attention, such as front page coverage) and, finally, *valence* (measures whether the story is conveyed in positive, negative or neutral tone).

The result of the content analysis of media texts showed that there were significant differences between the privately-owned *Daily Monitor* and the government-owned *New Vision* regarding inclusion of the three promoted frames, but whereas the privately-owned newspaper awarded the three promoted frames significantly more coverage a closer analysis of all the items that included the promoted frames revealed that inclusion was not primarily the result of the newspapers' journalistic efforts. Rather, inclusion of the

promoted frames was the outcome of social commentators, columnists or ordinary citizens wishing to contribute to the debate on the Anti-Homosexuality Bill. Furthermore, an analysis aiming at eliminating other domestic or international organizations' agenda-building efforts as contributory factors to the coverage, had to contend with the fact that it is likely that other actors also contributed to the coverage of the promoted frames. This conclusion was derived from the fact that Ugandan human rights advocates' influence on the media agenda appeared to be dependent on two factors: (1) being able to mobilize readers and independent commentators to communicate the frames through space earmarked for opinions and commentary and (2) timing, which here refers to the fact that the human rights advocates' influence seems to coincide with the peak of international actors raising their concerns with the Bill. It is thus very likely that international actors' condemnation of the anti-homosexuality bill served as a facilitating factor in the sense that they legitimated explicit criticism.

> ***V: Homophobia as a barrier to comprehensive media coverage of the Ugandan Anti-Homosexual Bill.*** Accepted for publication July 2011. Journal of Homosexuality, (Forthcoming spring 2012)
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> *The Ugandan Anti-Homosexuality Bill of October 2009 caused an international outcry and sparked intense debate in the local media. This paper explores to what degree a discriminatory social environment manifests itself in the Ugandan print media and discusses the potential implic ations for the media's coverage of contentious policy options such as the Anti-Homosexuality Bill. A content analysis of 115 items from two dailies; the government-controlled New Vision and the privately-owned Daily Monitor, in October to December 2009, indicates, in spite of the fact that both newspapers reproduce the surrounding society's homophobia, albeit with different frequency, the existence of two separate house styles. Unlike the New Vision, the Daily Monitor included coverage on homophobia and discrimination, and provided space for criticism of the Bill. By acknowledging discrimination and its negative impact, the newspaper de-legitimizes homophobia and problematizes the proposed Anti-Homosexuality Bill for its readers.*

The background is, as in the previous study, the Anti-Homosexuality Bill of 2009. After having followed the often heated debate on the Uganda Anti-Homosexuality Bill during extended stays in Uganda between June 2009 and December 2010, a question slowly crystallized: how free are the media to frame an event or phenomenon independently and produce their own narra-

tives on socially contentious issues such as the Anti-Homosexuality Bill? The study set out to examine to what degree a discriminatory social environment manifested itself in media texts, and discuss its potential impact on the media's freedom to frame and create independent narratives, as well as the implications of homophobic and discriminatory narratives, in particular in relation to the HIV epidemic.

The last article in this dissertation returned to a single method research design, and departed from the earlier content analysis where the conceptualization and operationalization of purpose was meticulously constructed from scratch. This study instead relies heavily on the intellectual work of Kristina Boreus and the typology she developed to capture *discursive discrimination*. (Boréus 2006, 406) argues that by studying linguistic practice it is possible to successfully uncover discursive discrimination, which is defined as "discrimination carried out through the use of language". Discrimination is defined as the "*unfavourable treatment of members of an (alleged) group on account of their membership of that group. Discursive discrimination is such treatment carried out by linguistic means*" (Boreus 2006, 408). The typology consists of four main concepts: (1) *negative-other presentation*, operationalized by capturing negative labels, negative descriptions, and negative associations; (2) *exclusion from discourse*, measured by the exclusion of voices, images and references; (3) *proposals pointing towards un-favorable non-linguistic treatment*, operationalized by registering explicit proposals, or support for normalization of existing unfavorable treatment; and finally (4) *discriminatory objectification*, which is divided into two sub-categories; (a) *denial of subjectivity* which is when individuals are discussed as if they are non-persons and lack feelings, needs and wishes; and (b) *by instrumentality*, where individuals are discussed as if they are things and/or tools. Boreus's (2006) typology was slightly modified to fit the study's purpose of capturing discrimination carried out through the use of language in Ugandan media.

Although discrimination of same-sex sexuality in Uganda is well known, the study establishes how the patterns of discrimination are reproduced in the print media. Nevertheless, the two newspapers appear to represent two different editorial *house styles.* The article suggests that the two different house styles facilitate and promote two different understandings of the Bill as a policy option for Uganda. For example, the government- owned *New Vision* framing of homosexuality as sinful, unnatural, immoral and homosexuals as non-individuals; supports a reading of homophobia as legitimate response and unproblematic. Furthermore, by excluding a discussion on the Bill's implications for all Ugandans' human rights regardless of sexual orientation, or the Bill's adverse effects on public health, particularly the country's often lauded HIV/AIDS interventions, the Bill is presented as unproblematic. In short, the Bill is framed as a desirable policy response to an unwanted phe-

nomenon – same-sex sexuality – and as an unproblematic institutionalization of a desirable societal response.

The privately-owned *Daily Monitor* on the other hand, while it does reproduce the surrounding society's homophobic discourses to a similar degree, it at the same time partly delegitimizes the same homophobia when it awards space to explicit criticism of both the Bill, and discrimination of same-sex sexuality. By highlighting the negative effects of discrimination and implications of the proposed legislation, the Bill as a policy option is framed as potentially problematic. As this study also aspired to contribute to the understanding of the apparent interplay between a (discriminatory) social climate and the media's freedom to create alternative narratives that question the prevailing climate, the analysis suggests that the wiggle room primarily consists introducing counter-narratives, rather than excluding dominant discriminatory narratives.

Reflections on methodological approaches

In hindsight, it becomes clear that, although each study has its own purpose and subsequent research design, the research design and execution were inspired by ethnographic approaches. In particular in the aspects that progression from data collection, and analysis was circular, reflexive and parallel rather than serial (Altheide 1987). Furthermore, concepts emerged and were subsequently included during the research process and samples were purposive and never random or stratified (Altheide 1987). These influences become apparent in the various types of content analyses. Although the type of content analysis varies with the empirical effort in the individual studies, they share some common traits. First of all, although the content analysis is predominantly quantitative, the process of deriving the often complex content categories, were influenced by ethnography, which allows a "reflexive movement" between concept development, sampling, data collection, data coding and finally analysis and interpretation (Altheide 1987). A related issue is the mix of quantitative and qualitative analysis. Two of the field's giants, Phillip Stone and Ole Holsti, jointly define content analysis as *any* "technique for making inference by objectively and systematically identifying specified characteristics of messages," (Woodrum 1984), which is a departure from the previously influential definition of content analysis as "a research technique for the objective, systematic, and quantitative description of the manifest content of communication" (Berelson 1952, 18). Indeed, the individual studies contain contents analysis that includes both quantitative analysis, as well as more interpretative qualitative analysis. Another distinctive feature in the content analysis is the departure from a focus on manifest content. Neuman (1991, 428), conclude that "the non-appearance of some-

thing can reveal a great deal and provide valuable insights," proved to be of great significance in the study of the media's framing of HIV/AIDS and in particular same-sex sexuality. Indeed, several studies conclude that manifest content cannot be fully understood without a parallel attention to *latent* (unintended or sub-textual) content.

The bird's eye perspective also resulted in a personal epiphany in terms of the importance of a prior contextual understanding. For example, without an understanding of the socio-political context of state-sanctioned homophobia in Namibia, the silence and denial of state-owned press when covering the mysterious disappearance of same-sex sexuality section in the national HIV/AIDS policy would simply not have been registered. The importance of context familiarity and knowledge is equally visible in the case of Uganda where the overt and explicit homophobic coverage of the now infamous Anti-Homosexuality Bill "makes sense" when put into the historical and political context. In short, although some manifest media content certainly could have been "fished-out," in a carefully constructed content analysis, the overall analysis would have stumbled. A prior familiarity with the historical, cultural, and political context greatly facilitated not only content analysis but indeed the process of interpreting the findings beyond their textual existence. Although this conclusion simultaneously implies a key vulnerability, it does not depart from an already established axiom – most social science relies heavily on the knowledge and interpretative skills of the researcher.

Lastly, in preparation for this introductory chapter, it became clear that the ontological position is never articulated in the articles. But rather than attempt to engage in a lengthy retrospective reconstruction, it was decided to note it as a limitation. Nevertheless, in retrospect it can be concluded that although the articles all revolve around the importance of social constructions of HIV/AIDS and same-sex sexuality, as well as assumes they have implications for social action, the existence of a "real" world is never questioned. The articles never question that HIV/AIDS is real in the sense that it is a virus, with a unique potential for devastation, and that these epidemiological realities are affecting millions of individuals. Yet, as Paula Treichler (2006, 11) argues, "[the] AIDS epidemic is simultaneously an epidemic of a transmissible lethal disease and an epidemic of meanings". Our ability to respond is dependent on our understanding both entities.

Part III. Background to the Empirical Material

The global HIV pandemic is constantly changing and is marked by great differences between and within countries in terms of transmission modes, underlying causes for individual and societal vulnerability, as well as overall epidemiological patterns. For example, while HIV transmission in the majority of cases is the result of unsafe heterosexual sex, unsafe sex between men accounts for most HIV infections in Latin America. Outside sub-Saharan Africa, intravenous drug abuse is a major transmission route, particularly in Eastern Europe and central Asia (Merson et al. 2008). Therefore, it is not entirely correct to talk about a single HIV epidemic. Subsequently, the history of the global pandemic and the current pandemic consists of a multitude of epidemics, all with their own complexities. These regional differences could easily fill several volumes. Any brief description of this subject is hence, by default, going to be incomplete.

Nevertheless, it is important to understand the medical and epidemiological realities of the pandemic, the epidemics in Sub-Saharan Africa and the individual case countries' epidemics. This section will briefly describe the history of HIV, its evolution into a global pandemic, but with a special focus on the three case countries. Furthermore, this section will attempt to capture the history of criminalization of same-sex sexuality and the troublesome exclusion of this important group from HIV/AIDS prevention and treatment interventions in sub-Saharan Africa.

The basics of HIV/AIDS

First of all, HIV and AIDS are not the same, even if these two terms are often used interchangeably and in combination. The human immunodeficiency virus (HIV) is a retro-virus that is transmitted through contact with infected blood, vaginal fluids, semen and breast milk. Accordingly, HIV is transmitted primarily through three routes: unsafe sex with an HIV-infected partner; sharing injection equipment with an HIV-infected partner; and vertical transmission between an HIV-infected mother and her child (perinatal or during breast feeding). Other routes, such as blood transfusion, needle stick injury, body scarring and circumcision using unsterile equipment, are rare in

comparison to the abovementioned main routes (Hoffmann and Rockstroh 2010). Table 1 shows the estimated per-act risk of acquiring HIV-1 by the exposure route.

Table 2. Estimated per-act risk of acquiring HIV-1 by exposure route (assuming no condom use)

Exposure route	**Estimated infections per 10,000 exposures to an infected source**
Blood transfusion	9,000
Needle-sharing injection drug use	67
Receptive anal intercourse	50
Percutaneous needle stick	30
Receptive penile-vaginal intercourse	10
Insertive anal intercourse	6.5
Insertive penile-vaginal intercourse	5
Receptive fellatio	1
Insertive fellatio	0.5

Source: Centers for Disease Control and Prevention (CDC) in 2005

The most important route of HIV transmission is sexual contact and in particular during the period of acute infection, which typically occurs a few weeks after primary infection and at the stage of advanced immune deficiency (Hoffman and Rockstroh 2010). The risk of transmission, however, depends on a number of factors such as sexual practices, existence of other sexually transmitted diseases affecting mucous membranes, male circumcision and mucosal trauma prevalent in non-consensual sex (Hoffman and Rockstroh 2010).

The main ways to prevent sexual transmission of HIV is to abstain from penetrative sex, mutual monogamy with an uninfected partner, as well as correct and consistent use of condom. Recently, male circumcision (UNAIDS 2007; Center for Disease Control and Prevention 2008; Weiss, Quigley, and Hayes 2000; Weiss et al. 2008) and antiretroviral treatment (Hammer 2011) were added to the list of prevention interventions. Results from both a meta-analysis of completed studies (Weiss, Quigley, and Hayes 2000) and clinical trials in South Africa, Kenya and Uganda, shows that male circumcision provides a statistically significant reduction in the male's risk of being infected with HIV during vaginal intercourse (Weiss et al.,

2008). In the clinical trials, circumcised men had an approximately 60% lesser incidence (Weiss et al., 2008). "In summary, male circumcision provides a much needed addition to the current HIV prevention armamentarium" (Weiss et al., 2008, 573). With a range of documented difficulties with the 'abstinence, being faithful and condomizing' paradigm in real life situations (Barnett and Whiteside 2006), often referred to as the ABC prevention model, male circumcision as a new prevention technique has rendered significant interest from policy makers in both developed and developing countries (Center for Disease Control and Prevention 2008). Consequently, in 2007, the World Health Organization (WHO) and UNAIDS jointly recommended that circumcision programs should become part of HIV prevention programs in countries seriously affected by HIV (UNAIDS 2007). The societal benefits of male circumcision can however be offset if it leads to an increase of unsafe sex.

Despite years of research on microbicides, i.e., compounds that can be applied inside the vagina or rectum to protect against sexually transmitted infections including HIV, there is currently no microbicides available on the market. The recent results from the CAPRISA trials do however indicate that microbicides can work (UNAIDS 2011).

The second most common transmission mode in the world, vertical transmission between a mother and her child, has almost been eradicated in developed countries thanks to successful screening of expectant mothers and treatment of mothers found to be HIV-positive (Hoffman and Rockstroh 2010). In developing countries, the situation is quite different despite that vertical transmission is relatively inexpensive to prevent. While, both screening and treatment services have been scaled up significantly in the last years, it continues to be a significant route for infection (Kallings 2008; UNAIDS 2011). In 2009, only 53% of HIV-positive pregnant women who needed treatment to prevent transmission of the virus to their child received it (UNAIDS 2010). Without any interventions, up to 40% of newborns are infected if their mothers are HIV-positive (Hoffman and Rockstroh 2010). The third main mode of transmission, the sharing of injection equipment, carries high transmission risks as significant amounts of blood is exchanged (Table 2).

Behavioral change, such as consistent and correct use of condoms, exchange of penetrative sex with non-penetrative, reduction of partners, cleaning injection equipment with bleach if shared and antenatal care, is key for reducing *incidence*. Epidemics are measured through its *incidence,* i.e., the number of new infections that occur over a time period and *prevalence,* i.e., the absolute number of infected people in a certain population at a given time. In 2011, antiretroviral treatment was also added to the list of interventions. In

May 2011, according to the HPTN 052 study, treatment was found to reduce transmission in sero-discordant couples by 96% (UNAIDS 2011). Large-scale programs ensuring HIV positive individuals with life-prolonging anti-retroviral treatment thus stand to save further lives by deferring infections.

HIV inside the body

HIV is a weak virus outside the body, i.e., the virus cannot survive for long outside the body. Once inside however, it attacks the immune system and, in particular, T-cell lymphocytes. Initially, the immune system fights back and the first symptoms are unspecific and in most cases the infected individual remains asymptomatic for several years. As an HIV-positive individual often remains asymptomatic and an infection is only detected through an HIV test, the virus can move through a population without giving any sign of its presence.

As the immune cells are destroyed more quickly by the virus than can be replaced, the immune system slowly breaks down, which results in the body's diminished ability to protect itself from bacterial and viral infections (Engel 2006; Hoffmann and Rockstroh 2010). The loss of the immune system means that the infected individual becomes increasingly vulnerable to opportunistic infections. It is these opportunistic infections that constitute the syndrome referred to as acquired immunodeficiency syndrome or AIDS (Hoffmann and Rockstroh 2010). AIDS is thus not a single disease, but a syndrome observed through a number of diseases that is the result of a severely compromised immune system (Barnett and Whiteside 2006).

As the viral load increases and CD4 (T-cell) count diminishes, infections increase in frequency, severity and duration and eventually, the immune system is unable to fight even simple viruses or bacteria and the infected individual dies (Engel 2006; Hoffmann and Rockstroh 2010).

Time between infection and time of death varies greatly, but it is estimated that an individual can expect to live on average ten years until falling seriously ill (Bauer 2008). However, with the introduction of anti-retroviral treatment, life can be prolonged significantly. In 1996, at the International AIDS conference, clinical researchers reported that a combination of anti-retrovirals had given excellent medium- and long-term benefits (Kallings and McClure undated). This new type of antiretroviral therapy managed to reduce the viral load in blood and allowed for CD4 cells to increase. The new combination resulted in a significant reduction in mortality and morbidity, and provided hope to many patients. With the introduction of this second line of antiretroviral treatment and subsequent development, many individu-

als, particularly in the developed world, could turn HIV into a chronic rather than a deadly infection (Engel 2006; Hoffmann and Rockstroh 2010). The new complex regimens of antiretrovirals, combined with the necessary clinical and laboratory monitoring requirements, did however make the antiretroviral drugs very expensive at the early stages.

Even with significant developments of new drug regimens, HIV has a higher mutation rate than most other cells, and is therefore particularly well equipped to adapt to both new antiretroviral treatment regimens and potential future vaccines (Engel 2006; Hoffmann and Rockstroh 2010). Thus, even if modern antiretroviral treatment can suppress the virus to undetectable levels in a body, it has not yet been possible to eradicate it from the body. There is therefore no cure against HIV/AIDS, despite 30 years of intense research.

The history: evolution of the global pandemic

As concluded previously, any description of this 30-year old and still unfolding pandemic is going to rely on a considerable degree of simplification. Furthermore, the description presented here is going to focus on the events relevant to the most severely affected region in the world, sub-Saharan Africa, which is the particular interest of this dissertation.

Early history of the HIV epidemic

HIV is believed by most scientists to have first emerged in the 1920s or 30s when the simian immunodeficiency virus crossed over from chimpanzees to humans in Western Africa (Keele et al. 2006; Rambaut et al. 2004). Forensic research has found that the first serological evidence of an epidemic in humans dates back to 1959 (De Cock 2001). Stored serum samples from Zaire, now the Democratic Republic of Congo was found to contain HIV (De Cock 2001). From there, HIV spread into eastern Africa (Uganda, Rwanda, Burundi, Tanzania and Kenya) in the 1970s (Serwadda et al. 1985). Blood samples containing HIV from Uganda dating back to 1972 and Malawi to 1974 are clear evidence that HIV did circulate in Africa long before AIDS was "discovered" in the United States in 1981 (Hoffman and Rockstroh 2010).

The first clinical descriptions of AIDS were published in the Morbidity and Mortality Weekly Report when five pneumocystis pneumonia deaths in Los Angeles were described in the 5 June issue in 1981. An editorial note explained, "The fact that these patients were all homosexuals suggests an asso-

ciation between some aspect of a homosexual lifestyle or disease acquired through sexual contact and *Pneumocystis* pneumonia in this population" (Center for Disease Control and Prevention 1981, 250). Soon after, The New England Journal of Medicine also published an article describing the deaths of young, previously healthy homosexual men (Gottlieb et al. 1981). The syndrome informally became known as GRID: gay-related immunodefiency or notoriously at some New York Hospitals as "WOGs: the Wrath of God Syndrome" (Treichler 2006, 27).

Initially, HIV transmission routes were not understood by epidemiologists and a range of hypotheses circulated, such as nitrate drug use, the number of sexual partners and many bacterial, viral and parasitic infections that could be picked up through anal intercourse, including syphilis, gonorrhea (Engel 2006). This theory argued that that the afflicted men's bodies were suffering from "immune overload" (Engel 2006, 7). In 1982, epidemiologists however began to agree that the cause was most likely a blood-borne pathogen that appeared to be transmitted sexually. The term AIDS, acquired immune deficiency syndrome, was selected at a 1982 conference in Washington (Treichler 2006). The existence of AIDS among non-homosexual individuals had triggered a wide search for alternative explanations besides that of a homosexual life style and in 1983, the HIV virus was discovered as the cause of AIDS (Hoffman and Rockstroh 2010). As more and more cases among non-homosexuals were being identified, the unofficial term 'GRID' became less relevant.

While the American Center for Disease Control and Prevention's understanding of risk gradually expanded, it continued to frame the concept of risk as related to being a particular kind of individual, rather than risky behavior. In late 1986, the Center for Disease Control and Prevention's added "hemophiliacs, heroin addicts and Haitians and the sexual partners of people within these groups" to homosexuals as the main groups at risk (Treichler 2006, 20). As a consequence of this early construction of risk, AIDS cases that fell outside the "four H's list" of high-risk groups were considered anomalies that would ultimately turn out to be associated with one of the four H's (Treichler 2006, 20).

In 1985, over 17,000 cases of AIDS had been reported from 71 countries to World Health Organisation (Merson et al. 2008). That same year, a second human immunodeficiency virus was identified and labeled HIV-2. This type is less virulent and hence more difficult to transmit. HIV-2 is primarily found in West Africa with pockets in Angola, Mozambique, France and Portugal (Barnett and Whiteside 2006).

Engel (2006, 35) summarized the growing but still inconclusive understanding of HIV in 1986: "AIDS in America could be spread through normal heterosexual intercourse, but not very well, and more easily from male to female than from female to male… HIV was efficiently spread by prostitutes, who disproportionally carried other sexually transmitted diseases which weakened their immune system and compromised the integrity of their genitals. And most confusing, it was efficiently spread, heterosexually, by Africans, though why and how was simply not known". In short, the United States had a concentrated epidemic, i.e., HIV was primarily concentrated to defined sub-populations, but was not well established in the general population, whereas the HIV epidemics in sub-Saharan Africa displayed a markedly different epidemiological pattern. In sub-Saharan Africa, HIV appeared to have spread mainly through heterosexual contact and networks, and more among affluent members of society rather than the poor and socially marginalized, as was the case in the US. Furthermore, as the symptoms of AIDS are difficult to discern from many other tropical diseases, the existence and spread of a new virus was initially largely unnoticed.

A moving epidemic epicenter in sub-Saharan Africa

In the early 1980s, HIV had spread to eastern and central Africa from its western equatorial origin (Fig 3. Sketch of probable transmission of HIV in Africa, source Kallings, 2008). While HIV spread into western African nations, it did not cause large epidemics. It is likely that long distances and difficulty of travel, as well as the fact that the region primarily had the less virulent HIV-2, contributed to curbing an escalation.

Eastern Africa was a different story. In the early 1980s, HIV had reached epidemic levels in the sense that HIV prevalence had become large enough to be measured in Uganda, Rwanda, Burundi, Tanzania and Kenya (AVERT 2011).

In eastern Africa, the areas bordering Lake Victoria were initially the hardest hit due to a combination of factors, most notably population movement. HIV spread outwards on and from the transport and trade routes. In the 1980s, approximately 35 % of tested Ugandan truck drivers were HIV-positive, as was 30 % of military personnel from the Ugandan army (Avert 2011). Commercial sex workers played a large part in the accelerated transmission rate in East Africa. For example 85 % of commercial sex workers in Nairobi were infected with HIV by 1986 (Piot et al. 1987).

From Eastern Africa, the epidemic moved south (Fig. 3). Even though HIV did not reach southern Africa until relatively late compared to eastern and

western Africa, by the end of the 1990s southern Africa had overtaken eastern Africa in terms of prevalence. Southern Africa had become the new epicenter of the HIV pandemic. In several countries, HIV had by then developed into generalized epidemics, i.e., HIV was firmly established in the general population, but with sub-populations potentially still contributing disproportionately to the spread of HIV. Numerically, a generalized epidemic is when at least 1% of pregnant women attending antenatal clinics test positive for HIV (UNAIDS and WHO 2003). The magnitude of the spread in southern Africa is clearly visible when contemplating that in 1990, less than 1% of adults in South Africa were living with HIV. A decade later, that figure was 16.1% (UNAIDS 2011). During the same period, adult HIV prevalence rose from less than 1% to 24.5% in Lesotho and from 3.5% to 26% in Botswana (UNAIDS 2011).

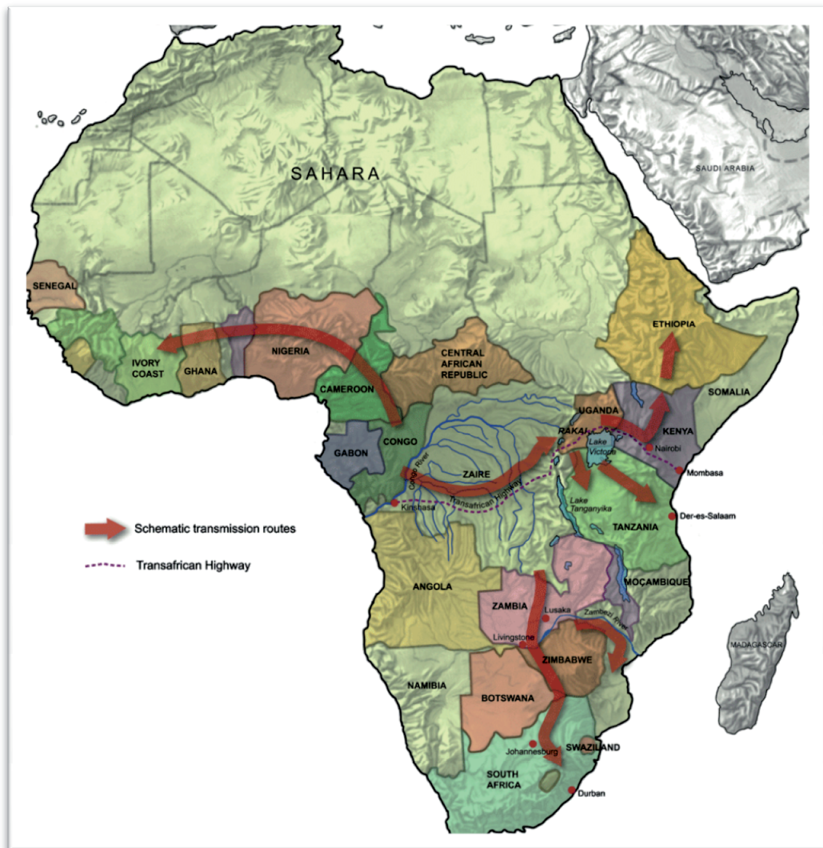

Fig. 3: Sketch of probable transmission of HIV in Africa. Source: (Kallings 2008).

Another important factor behind the rapid proliferation of HIV was the initial lack of treatment. Treatment only became available in 1986 when a highly toxic medicine, which had been previously used to treat cancer but later

withdrawn for its severe side effects, began to be used in the US (Engel 2006). AZT initially showed great short-term effects, but as a mono-therapy, HIV quickly mutated and the drug proved to have no long-term benefits. HIV/AIDS was thus a deadly disease.

Today, southern Africa remains the epicenter. In no other part of the world has HIV/AIDS had a more devastating effect (Merson et al. 2008). It is difficult to grasp the magnitude and try to conceive the impact of a quarter of the adult population being infected, later desperately ill and eventually dying. Especially considering that it was and still is young adults supposed to be entering or in the midst of their most productive years and often leaving young children behind.

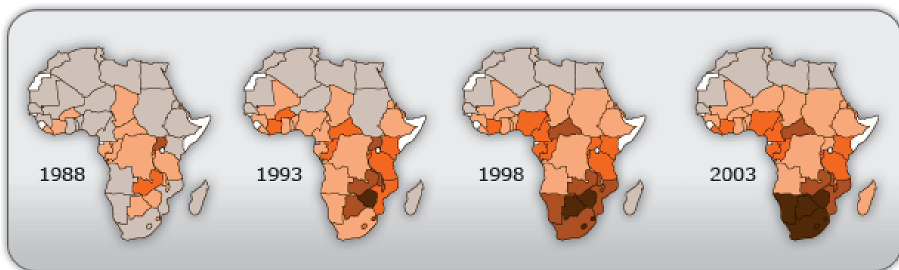

Fig. 4: Map of HIV prevalence in Africa from 1988 to 2003, UNAIDS World Epidemic Update, 2004.

The initial (non)response to HIV/AIDS

The proliferation of HIV to virtually all corners of the world in 30 years cannot be explained by HIV being a particularly virulent virus. Indeed, HIV is not a very effective virus (Table 2). Instead, its strength can be found in the fact that infection is initially invisible, i.e., it takes years before symptoms of infection become visible. In the meantime, the infected individual can unknowingly continue to infect equally unsuspecting sexual partners or children if the infected individual is a woman. Because the time between infection and symptoms spans many years, a wave of HIV infection in a population will only make itself felt when substantial numbers are infected and become ill much later (Barnett and Whiteside 2006). It is only at this point, when AIDS morbidity and mortality rise, that the epidemic is felt throughout the affected society and the virus infection becomes a visible epidemic that is recognized not only by medical services, but also by communities and hopefully governments. The long incubation time inside the body and the time it takes for the virus to be felt in affected societies make the epidemic more difficult to understand and subsequently act upon. To "understand the impact of this epidemic, we must adopt a perspective that

spans several decades and here is a paradox: the longer the required perspective, the easier is it to deny and not take responsibility" (Barnett and Whiteside 2006, 19). By being such a long-term event, the management of the epidemic and its consequences on society "makes novel demands on communities and leaders and requires analysis and commitment beyond the time-frame of most politicians" (Merson et al. 2008, 476). Indeed, in the early 1980's many politicians did not know how to handle these new demands. In the US besides one reference in 1985 (Kinsella 1989), in 1987 with more than 20,000 Americans dead and more than 36,000 infected with HIV, US President Ronald Reagan had yet to speak publicly about HIV/AIDS (Kallings and McClure undated). In Kenya President Daniel arap Moi similarly refused to acknowledge his country's epidemic (Okuro, 2009). A laudable exception from the general rule of silence from high-level politicians and denial in the early days was President Kenneth Kaunda's introductory remarks at the 1986 International AIDS conference, where he spoke about how his son had died of AIDS. He became the first African leader to publicly acknowledge AIDS in his own family (Kallings and McClure undated). The same year, and to the surprise of many, after being in power only four months the government of Uganda openly acknowledged it had a problem with HIV/AIDS (Tumushabe and United Nations Research Institute for Social Development 2006).

Besides being a quintessential long-term event, in the 1980s "it seemed almost incomprehensible to most policy makers and the public at large that overlapping sexual and needle-sharing networks had somehow led to tens of thousands of people around the world being infected with HIV" (Merson et al. 2008, 475). Furthermore, in 1985, where white homosexual men accounted for 73% of cases of AIDS in the USA (Merson et al. 2008), the fact that the disease seemed to be concentrated in various marginalized groups, such as homosexuals, drug users, immigrants and foreigners, made it even easier to ignore. Few policy makers regarded these groups as core constituencies. Whereas, AIDS funding grew significantly between 1982 and 1987, the fact that HIV was first discovered among homosexual men delayed US policy makers' and political leaders' active interest in the issue (Kinsella, 1989, Engel, 2006; Treichler 2006).

In addition, the fact that HIV was predominantly a sexually transmitted disease did not facilitate an open discussion on vulnerability in either the US or in many African countries. In the US, conservative groups initially refrained from exploiting AIDS to attack homosexuals during the early years of the epidemic. But by 1987, both religious and political conservatives began attacking "homosexuality and homosexual behavior in a concerted effort to demonize gay lifestyle and portray gays as self-indulgent, irresponsible, and morally depraved" (Engel 2006, 70). Conservative groups also sought to re-

educate the public that AIDS did not affect everyone equally, but was found predominantly among "homosexuals, drug addicts, and to remind the public that homosexuality violated basic laws of nature and transgressed God's intention" (Engel 2006, 70).

International community's delayed and fragmented

The international community began responding in the late 1980s. World Health Organization (WHO) was initially given the mandate to coordinate the international community's response to the emerging pandemic. The first International AIDS Conference was held in 1985 in an attempt to present an overview of knowledge of the disease aetiology, clinical progression and modes of transmission. This was partly funded by WHO and the US Center for Disease Control and Prevention. Nevertheless, that same year, Halfdan Mahler, the Director General of WHO, asserted that HIV/AIDS was not the primary healthcare concern in Africa compared to malaria and other tropical disease (Carael 2006, Kallings and McClure undated). The following year, he acknowledged that he had failed to recognize the threat of HIV/AIDS to "have been underestimating it (HIV/AIDS), and I in particular". Subsequently, WHO started a Special Program on AIDS, later renamed as the Global Program on AIDS, and began focusing on Africa (Carael 2006).

In 1989, Jonathan Mann, head of the WHO's HIV/AIDS Program*,* concluded that during this initial period of silence and denial, the virus was unchecked by any preventive action. (Merson et al. 2008, 476) summed up the international community's early response as "for the most part delayed, grossly insufficient, fragmented, and inconsistent". UNAIDS (2011) also concluded that the global community indeed failed to act during the epidemic's first two decades. UNAIDS (2011, 16) stated that "a defining feature of the first two decades of HIV was the common failure of leaders to put scientific knowledge to use. Even the most basic prevention tool – the male condom – remained largely unavailable in the countries where the epidemic was expanding the fastest".

The fact that WHO was the designated global coordinator significantly influenced the responses generated by the international community (Barnett and Whiteside 2006). HIV/AIDS was primarily regarded as a health problem rather than an issue intertwined and fuelled or inhibited by economic, cultural and social factors. Subsequently, HIV/AIDS only became widely acknowledged as a threat to development in general towards the end of the 1990s. In 1996, the United Nations brought six United Nations organizations together in a co-sponsored program – the Joint United Nations Programme on HIV/AIDS, or UNAIDS. UNAIDS has since expanded further.

Turn of the century and the international response picks up speed

While civil society organization in afflicted communities had recognized the importance for collective action, HIV/AIDS only entered the agenda of the highest political level in 2000, when the United Nations Security Council debated a health issue for the first time ever, namely HIV/AIDS. Later that same year, HIV/AIDS was included in the eight Millennium Development Goals (MDGs), as MDG 6, to combat HIV/AIDS, malaria and other diseases. MDG 6 has two targets to measure progress. Target 6A reads "Have halted by 2015 and begun to reverse the spread of HIV/AIDS" and target 6B "Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it". The MDGs is a development blueprint endorsed by all UN member countries and all the leading development institutions. In addition, the Accelerating Access Initiative was formed in 2000, which is an alliance between five UN organizations and large pharmaceutical companies that agreed to provide discounted drugs to the least developed countries (d'Adesky 2004). The 2000 International AIDS Conference in Durban, South Africa, aptly went under the theme "Breaking the Silence" in 2000. Conference delegates demanded political leadership and action in terms of increased access to prevention and treatment services.

In 2001, heads of state and government representatives from 189 countries gathered in New York for the first special session of the United Nations General Assembly on HIV/AIDS (UNGASS). The meeting resulted in the Declaration of Commitment on HIV/AIDS, acknowledging that the AIDS epidemic constituted a "global emergency and one of the most formidable challenges to human life and dignity" (United Nations 2001). Besides pledging to reverse the HIV epidemic with the assistance of international partners and civil society, governments committed to submit bi-annual reports on their progress. The core indicators to monitor member country's progress toward achieving universal access to prevention, treatment and care were refined in 2008 (Merson et al. 2008). Besides gathering political leaders, the first UNGASS managed to settle the debate over the merits of prevention versus treatment programs. The UNGASS concluded that they were indeed inseparable (d'Adesky 2004).

The United Nations General Assembly on HIV/AIDS 2001 and 2002 International AIDS Conference in Barcelona, as well as successful on-site trials in developing countries, helped support the growing calls coming from activists, clinicians and health experts to reduce drug prices and introduce antiretroviral therapy in developing countries. In 2002, at the International AIDS conference in Barcelona, UNAIDS and WHO jointly launched the '3 by 5' initiative, which came as a result of fierce civil society campaigning and

global commitments made in previous years to ensure access for all to prevention, treatment and care. The target was to provide three million people living with HIV/AIDS in low-and middle-income countries with antiretroviral treatment by the end of 2005. While the initiative failed at meeting its numerical target, it did manage to conclusively show that a roll out of resources in poor environments was indeed possible and managed to effectively silence the critics arguing that providing antiretroviral treatment to Africa was not feasible. The '3 by 5' initiative was pivotal in creating international momentum around universal access to HIV/AIDS prevention and treatment targets, as well as generating the necessary know-how on delivering treatment in low- and middle-income countries (World Health Organisation 2003).

In 2006, UN member states recommitted to the fight against HIV/AIDS through the Political Declaration on HIV/AIDS. The 2006 declaration reaffirmed the 2001 Declaration of Commitment on HIV/AIDS. A review of the progress of UNGASS 2001 declaration after 5 years did however show that while there was some progress with regard to changes in the political environment, expanding treatment and intensifying prevention, no more than 8% of HIV-positive children received antiretroviral drugs in low- and middle-income countries. Another glaring failure was the proportion of pregnant women receiving service to prevent mother-to-child transmission of HIV. Access had increased from a low 9% in 2005 to only 11% in 2006 (Kallings 2008). Kallings (2008, 234) concluded "this reveals a shocking lack of political will in low- and middle-income countries". In 2006, African heads of state also gathered in the Nigerian capital Abuja to recommit, as well as review, the progress made in implementing the Abuja Declaration and Plan of Action on HIV and AIDS, Tuberculosis and other Infectious Diseases of 2001(African Union 2001).

With increased awareness of the need to provide prevention services and develop new antiretroviral drugs, the requirement of adequate funding was highlighted. In 2002, the international funding mechanism, the Global Fund against AIDS, Tuberculosis and Malaria (GFATM), was launched. The GFATM, financed by governments, the business sector and private philanthropists, is dedicated to attracting and disbursing resources to prevent and treat the three diseases, and currently provides a quarter of all international financing for AIDS, two-thirds for tuberculosis and three quarters for malaria. Other funding mechanisms for HIV/AIDS besides the Global Fund are the President's Emergency Plan for AIDS Relief fund (PEPFAR), World Bank, EU, and various private foundations and organizations such as the Bill and Melinda Gates foundation, the Clinton foundation, the Mandela Foundation, the International Treatment Access Coalition and many others. Funding also comes from bilateral donors.

PEPFAR has been criticized for being a "thinly-disguised unilateral move designed to sabotage the multilateral UN-backed Global Fund", as well as a tool for the Bush administration to promote a religiously conservative agenda (d'Adesky 2004, 25). Nevertheless, its scale of $15 billion funding over five years (2004 to 2008) for HIV/AIDS-related services was an important source of funding. A recent study of PEPFAR showed that since 2003, it had provided the majority of its $18.8 billion budget to 15 focus countries, 12 of them in Africa, to HIV/AIDS prevention, treatment and care. The study further showed that nearly half of the resources had been spent on antiretroviral drugs and treatment infrastructure, which according to the study had led to a decrease in the death toll due to HIV/AIDS in the focus countries. The study found that about a fifth was spent on prevention programs, of which a third had indeed been earmarked for abstinence-only programs (Bendavid and Bhattacharya 2009). The study failed to provide any data on whether the PEPFAR prevention model, i.e., strong focus on abstinence-only programs, had been successful in reducing incidence.

Besides the debate "who is going to pay for prevention and treatment services", the prevention ideology has been another source of international contention. While there was initial confusion of how HIV spread, by the end of the 1980s, there was a general agreement on how to prevent sexual transmission of HIV in terms of technical barriers and behavioral change. Various actors have, however, placed emphasis on various components in their behavioral change messages on safe/r sex based on ideology rather than what is known about the human's intrinsic urge for sexual intimacy and procreation (Barnett and Whiteside 2006). Cafaro and Bicknell (2009) argued that PEPFAR and other similar programs departing from the ABC model fails to acknowledge that the drive to have sex is powerful. Instead, a public health strategy needs to accept the basic premises and focus on educating individuals about prevention methods beyond the ABC, such as oral sex and mutual masturbation. Conservative groups' focus on abstinence and fidelity as key prevention messages, rather than condom use and the almost unilateral focus on prevention messages geared towards heterosexual transmission, continues to be unresolved international debates. While major funders such as Global Fund and PEPFAR have included sexual minorities in the policy guidelines as of 2008 (Global Fund to Fight AIDS TB and Malaria 2008), prevention of non-heterosexual transmission continues to be a thoroughly neglected area in many countries in sub-Saharan Africa.

While the global response picked up speed from 2000 onwards, South Africa – one of the hardest hit countries in terms of absolute numbers – was a glaring exception during most of the early 2000s. After years of silence, President Mbeki proclaimed at the International AIDS Conference hosted in Durban, South Africa, that AIDS was not a problem in South Africa. Further-

more, he doubted that HIV caused AIDS and argued that AIDS was not caused by a viral infection but by poverty caused by colonialism and apartheid (Chigwedere et al. 2008). From 1999 to 2007, it has been estimated that the Mbeki government's AIDS denialism, which resulted in a failure to acknowledge the importance and provision of antiretroviral treatment and prevention of mother to child transmission to expecting mothers to prevent mother-to-child transmission, resulted in the deaths of over 330,000 South Africans between 2000 and 2005 (Chigwedere et al. 2008). It has even been argued that Mbeki's AIDS policies should be regarded as criminal and prosecuted accordingly. The Treatment Action Campaign in South Africa has submitted a complaint of culpable homicide with the police against the former Minister of Health, Tshabalala-Msimang (Geffen 2009). In 2008, an African National Congress cabinet reshuffle brought a definitive end to President Mbeki's era of denial as state policy.

To sum up, since the beginning of the epidemic some 30 years ago, more than 60 million people have been infected with HIV and nearly 30 million people have died of HIV-related causes in the world(UNAIDS 2010). Despite a clear understanding of how the virus transmits and development of more effective antiretroviral treatment, 2.6 million individuals were infected in 2009 (UNAIDS 2010). Today, approximately 33.3 million people are living with HIV globally. Nevertheless, according to UNAIDS's 2010 HIV epidemic report, the fight against HIV/AIDS has had some important success. Foremost, the number of infections has fallen by 19% since 1999, the year in which it is thought that the epidemic peaked, globally (UNAIDS 2010). According to the same report, HIV incidence has fallen by more than 25% between 2001 and 2009 in 33 countries. Among these countries, 22 are in sub-Saharan Africa. In addition, treatment access has increased dramatically to include an estimated 6.6 million people in low- and middle-income countries by December 2011. This treatment scale-up in low- and middle-income countries is "the most notable achievement in the HIV response" (UNAIDS 2011, 42). The world, according to UNAIDS, has managed to turn an important corner—"it has halted and begun to reverse the spread of HIV", i.e., reached Millennium Development Goal 6.A (UNAIDS 2011, 7).

Table 3. Summary of performance in low- and middle- income countries against programmatic targets 2001-2010

Component	Agreed targets	Achieved
Young people's comprehensive knowledge of HIV	2010: 95%	34% (2009) males:34%, females 24%
Coverage of antiretroviral drugs for prevention of vertical transmission	2010: 80%	53% (2009)
Reduction in vertical transmission rate	2010: 50%	21 (2009)
Antiretroviral therapy	2005: 3 million 2010: universal access	1.3 million (2005) 6.6 million (2010)
Reduction in HIV prevalence among young people (as a proxy for incidence) **Global performance**	2010: 25%	24% (2009) in all countries

Source. A summary of a decade of progress: substantial gains but targets missed (UNAIDS 2011).

These accomplishments are, however, fragile according to UNAIDS. HIV incidence still outstrips the number of people put on treatment every year, as for each person put on treatment two become infected. Merson et al. (2008, 485) also concluded that "we cannot treat our way out of this pandemic", and calls for a renewed and revitalized movement for HIV prevention. Increasing prevention and treatment coverage in addition to individual country's ability to deliver these services depend on a reliable flow of funding. UNAIDS (2010) notes that donor funding decreased between 2008 and 2009.

Another area in need of urgent attention is prevention services for most-at-risk populations, i.e., men who have sex with men, transgender people, intravenous drug users and sex workers and their partners. These groups are disproportionately vulnerable to infection due to social, cultural and economic reason and as a consequence, often have higher prevalence in both generalized and concentrated epidemics. Besides, social marginalization, many most a risk populations face institutionalized discrimination as their behaviors are criminalized. Criminalization does not only increases these

groups’ vulnerability to HIV, but also undermine interventions targeting these populations. According to (UNAIDS 2011), 63 out of the 67 countries that monitor the men who have sex with men populations reported a higher HIV prevalence among them compared with the general population in 2009. Indeed, most African governments failed to recognize the need to include men who have sex with men in their national HIV/AIDS prevention and control program (Persson et al. 2011). Indeed, some argue that the international community has a considerable challenge in addressing not only the health needs of men who have sex with men in sub-Saharan Africa, but also the legal constraints and discriminatory environment (Smith et al. 2009; Persson et al. 2011). The adverse public health implications of the continuous denial or neglect of particular men who have sex with men in sub-Saharan Africa will be explored in the next section.

Same-sex sexuality in sub-Saharan Africa and HIV/AIDS

As noted in earlier sections, years of work to contain and reverse the spread of HIV/AIDS appear to be having a significant impact on some core indicators, such as incidence, number of people on treatment, level of access to prevention of mother to child transmission services, and reductions in morbidity and mortality. The previous description of the pandemic in the year 2011 does not, however, adequately reflect the situation for lesbian, gay, bisexual and transsexual in individuals’ access to HIV prevention, sexual health and treatment services and in particular men who have sex with men (Beyrer 2010).

Men who have sex with men are particularly vulnerable to HIV infection as unprotected male same-sex sexual intercourse is due to biological factors significantly riskier in terms of HIV transmission than heterosexual vaginal intercourse (See table 2). For example, it has been estimated that less than 1 in five men who have sex with men globally have access to the most basic interventions, such as information on risk of HIV infection and correct condom use (Beyrer 2010). Baral et al. (2009) concluded that there is both a glaring lack of data on men who have sex with men and HIV in the southern region of sub-Saharan Africa and a lack of HIV/AIDS prevention strategies targeting this group. In a review of funding levels, evidence-based prevention strategies, including structural interventions such as the need for decriminalization and addressing discrimination, it is suggested that “there is really no other explanation than homophobia to understand how the international community can have so signally failed in its response to this component of the AIDS pandemic” (Beyrer 2010, 111).

The origins of denial of same-sex sexuality

Marc Epprecht (2004, 2008, 2010) attempted to trace the origins of denial of same-sex sexuality in Africa and later the construction of the myth of HIV as a heterosexual transmitted disease in Africa. The following section will draw largely from his scholarly contributions.

The compact and systematic silence around same-sex sexuality and current lack of HIV/AIDS services in many sub-Saharan African countries hard hit by the epidemic can only be understood by studying European colonial authorities' ideas and attitudes towards their native subjects (Epprecht 2008, 2010). The colonial authorities', travelers and traders from a range of different European countries and their writings about Africa constructed a myth of a singular African sexuality, a myth that has proven to withstand both time and post-colonial African and non-African scholarly research. According to Epprecht (2008, 2) this "hypothetical singular African sexuality includes, above all, the supposed nonexistence of homosexuality or bisexuality, along with Africans' purported tendencies towards heterosexual promiscuity, gender violence". This idea that Africans did not engage in homosexual or bisexual practices also fitted into Christian missionaries' preferred view of Africans as uncorrupted and close to nature, and consequently having similar ideals as bourgeois European culture in placing reproduction at the center of family life. Simultaneously, Africans' complete lack of control over their natural heterosexual instincts was considered a problem, as it "was thought to oppress and degrade women, engender laziness and stultify intellectual growth in men, threaten public health and safety, and impoverish culture and the arts (no love or higher emotions, just lust and steely transactions)" (Epprecht 2010, 768).

Despite the fact that most African societies have a wealth of pre-colonial evidence of both homosexual and bisexual behavior (Murray and Roscoe 2001; Epprecht 2004), the colonial myth got absorbed and assimilated. This myth became the "truth" and cemented the idea of singular African heterosexuality, mainly by omission of the number of examples of other types of sexualities. It thus appears that colonial powers did not introduce homosexual practices, as has often been argued by post-colonial African leaders, but they successfully did introduce their own homophobia, which in turn has significantly influenced Africans' understanding of their own sexuality, as well as years of studies on sexuality in Africa (Epprecht 2008, 2010).

The onslaught of HIV/AIDS in the mid-1980s created a new demand for understanding sexuality in Africa, but failed to result in scholarly attention or challenge of the myth of a singular African sexuality (Epprecht 2008, 2010).The years of collective silence around same-sex sexuality had created

a “blind spot” (Epprecht 2008). Subsequently, several studies simply did not even ask participants about sexual histories or preferences, and could thus only come to the conclusion that the African HIV epidemic was spread through heterosexual sex. Others who attempted to include other types of transmission failed to capture its existence by using western terms like “homosexuality”, as well as failing to acknowledge that respondents could choose not to be open about same-sex practices with foreign researchers. In addition, according to Epprecht (2010, 774) “many sexual secrets and allusions to sexual diversity in scattered ethnographic footnotes were ignored or (self?) censored. A consensus about widespread heterosexual promiscuity that explicitly ruled out homosexual and anal transmission of HIV thus emerged several years before the first large-scale surveys of knowledge, attitudes, beliefs, and practices were carried out”. Early AIDS researchers thus inadvertently reified the myth of Africa being a homosexual-free zone, mainly by omission (Epprecht 2008), and as a result, failed to capture that the virus was most likely, as in the rest of the world, not only passed between a man and woman, but also by men engaged in sexual relations with other men and in some cases with women.

The magnitude of the HIV epidemic eventually forced researchers to look more honestly at sexual preferences and practices in Africa (Epprecht 2010). The development was assisted by the emergence of groups in South Africa that had used the vacuum created by the fall of Apartheid to fight to have their rights recognized along with all other previously disadvantaged groups, and duly included in the new South African constitution. Their calls for equality cloaked in international human rights language made their existence difficult to ignore (Kennedy 2006). Their increased visibility did however, like similar groups in the US in the 1980s, bring about a conservative backlash and many African leaders and conservative churches changed their previous position of silence to vocal opposition of same-sex sexuality (Epprecht 2010). They resisted and continue to resist changes to the myth of African sexuality as a singular concept, and attribute homosexuality and bisexuality in Africa to Western imperialism. So even if the legal battle was won in South Africa, the social climate is unchanged and hate crime and discrimination against homosexuals is rife(Kennedy 2006). Consequently, many governments have resisted repealing old sodomy laws, often introduced by former colonial powers that remain in many countries. Today, 38 countries in sub-Saharan Africa continue to criminalize same-sex sexuality (Bruce-Jones and Itaborahy 2011).

Denial of same-sex sexuality and implications for policy and programmatic responses

Besides the important human rights perspective, there are a number of reasons why a continuation of denial of same-sex sexuality, including rights to HIV/AIDS services, is incompatible and outright counterproductive to public health objectives and a comprehensive response to HIV/AIDS.

First of all, unprotected anal intercourse, which is often practiced by homosexual men and also heterosexual couples, is, due to biological factors, significantly more risky in terms of HIV transmission than heterosexual vaginal intercourse (Smith et al. 2009; UNAIDS 2009). It has also been suggested that both homosexual and heterosexual anal intercourse are much more prevalent in Africa than what has traditionally been believed (Brody and Potterat 2003). Secondly, high levels of stigma, criminalization and subsequent discrimination attached to non-heterosexual sexual preferences often result in individuals leading parallel heterosexual lives to avoid suspicions of belonging to a sexual minority group(Johnson and International Gay and Lesbian Human Rights Commission 2007; Semugoma 2005; Morgan and Wieringa 2005). In a review of research done on men who have sex with men, "behavioral studies have consistently shown that a high proportion of MSM also report recent female sexual partners, and many are married"(Smith et al. 2009, 418). Similarly patterns were found in Malawi, Namibia and Botswana of MSM having concurrent sexual partners of both genders and many were married (Baral et al. 2009). Furthermore, a significant proportion of the men who have sex with men in the three countries identified themselves as either heterosexual or bisexual. The Crane study (2009) in Uganda found that 31% of the surveyed men who have sex with men in Kampala had been married and 44% had lived with a female partner and that 29% had fathered children. In conclusion, there is thus a significant overlap between various types of sexual networks. Thirdly, criminalization of same-sex sexuality and/or high levels of stigma and discrimination results in non-governmental organizations fear repercussions should they offer services to this group (Hollander 2009). Semugoma (2005) observed similar fears among government employees in his study of Ugandan men who have sex with men. Health care providers were simply afraid of personal repercussions should they oppose official policy and provide sexual health services to homosexuals. Criminalization and discrimination do, however, not only quell the supply of services, but limit services accessibility, since marginalized groups will not utilize services in fear of prosecution or further marginalization by being associated with these services (Amnesty International 2010). Baral et al. (2009) found that such fears were well founded. Disclosing sexual orientation to a health care provider was significantly associated

with being denied health care in the three studied countries (Baral et al. 2009).

Another effect of pervasive hetero-normativity is that safe-sex education in most countries is being entirely dominated by messages geared towards heterosexual individuals, with limited knowledge among non-heterosexuals on what safe/r sex entails as a result (Lorway 2006; Epprecht 2008). The lack of knowledge can result in the individual unknowingly continuing risky behavior, such as using the wrong kind of lubricant or believing that anal intercourse is without risk as it is never featured in safe/r sex education material (Lorway 2006; Semugoma 2005).

To sum up, the unwillingness to revise the myth, years of collective silence and institutionalized homophobia are having detrimental effects on governments' and communities' ability to plan and implement comprehensive HIV/AIDS interventions. Yet, this exclusion has been and, for the most part, continues to be the rule rather than the exception in many countries in sub-Saharan Africa (UNAIDS 2011; Smith et al. 2009; Beyrer 2010). It remains to be seen if the combined pressure from funders, such as the Global Fund since 2008 (Global Fund to Fight AIDS TB and Malaria 2008), and the international community, most notably various UN bodies' calls to end discrimination against sexual minorities (United Nations General Assembly 2008; UN Human Rights Council 2011), manages to influence the African countries' perceptions on same sex sexuality or coerce a change in policy by withholding funding for HIV/AIDS programs.

Table 4. Summary of the development of HIV/AIDS in sub-Saharan Africa and the world.

Time frame	Sub-Saharan Africa	The world
1920s-30s	Simian immunodeficiency viruses are transmitted from primates to humans.	
1959	A serum sample is collected from a Kinshasa resident with HIV infection and stored to be tested more than 20 years later.	
1970s	HIV spreads into eastern Africa (Uganda, Rwanda, Burundi, Tanzania and Kenya) in the 1970s	
1981		The first cases of AIDS in homosexual men in the United States are reported.

1983	Patients from Africa admitted to a hospital in Brussels are diagnosed with AIDS. They do not belong to the 4H categories and provide evidence that HIV is transmitted through heterosexual intercourse.	The human immunodeficiency virus is identified as the cause of AIDS.
1984	According to estimates by WHO, 1 to 5% of adults in 11 African countries are infected with HIV. These countries are Uganda, Rwanda, Burundi, Tanzania, Zambia, Zimbabwe, Ivory Coast, Burkina Faso, Togo, Cameroon and Congo Brazzaville.	
1985		The first antibody test to detect HIV infection is approved by the American FDA. At least one case of HIV/AIDS has been reported from every region in the world. The first international AIDS conference was organized.
1987	With the assistance of WHO, Uganda launches the first AIDS Control Programme in Africa.	First antiretroviral treatment started with azidothymidine (AZT). However, being a monotherapy to which the virus quickly adapted, it only had short-term effects.
Early 1990s	WHO estimates more than 10% of adults in Zambia and Zimbabwe are HIV-infected. The pandemic's epicenter has moved from eastern Africa to southern Africa.	
1996		The UN launches UNAIDS, to coordinate the global response. At the XI International AIDS Conference, results from clinical trials give new hope to already infected individuals. Highly active antiretroviral therapy (HAART) reduces viral loads and allow for CD4+ cells to increase.
1998		A key milestone is achieved when it is shown that a short course of antiretroviral therapy before delivery is highly effective in preventing perinatal transmission of the virus to newborn children.

2000	South African President Thabo Mbeki declares he doubts the existents of HIV/AIDS. In response, 5,000 scientists from around the world publish “The Durban Declaration”, confirming the overwhelming scientific evidence about the aetiology of HIV/AIDS.	UN Nations Security Council makes history when it debates HIV/AIDS. HIV/AIDS is included in the world’s development blueprint, the eight Millennium Development Goals, as MDG 6 to: combat HIV/AIDS, malaria and other diseases.
2001	The majority of countries in sub-Saharan Africa have a generalized HIV epidemic. African Union meets and adopts the Abuja Declaration in the 2001 summit. The declaration states that "AIDS is a state of emergency in the continent”.	The UN General Assembly Special Session on HIV/AIDS produces the Declaration of Commitment on HIV/AIDS which is signed by leaders from 180 countries.
2003	According to UNAIDS *AIDS Epidemic Update: December 2003*, 7.5 to 8.5% of adults in sub-Saharan Africa are estimated to be HIV-infected.	Gates Foundation announces funding for HIV prevention. Bush launches PEPFAR. Clinton Foundation begins the antiretroviral access initiatives. On World AIDS Day, UNAIDS and WHO launch the 3 by 5 initiative
2006	A majority of governments in Africa recommit to the Abuja Agreement.	High-level UN meeting on HIV/AIDS commits to universal access to prevention, treatment and care by 2010.
2007	WHO/UNAIDS 3 by five initiative’s goals are met. African countries benefit particularly.	WHO and UNAIDS recommend circumcision as an HIV prevention tool in Africa and other developing countries and regions.
2010		New WHO treatment guidelines recommend ARV treatment should be initiated when the patient falls below a count of 350 cells/mm^3 instead of 200 cells/mm^3.
2011	22.5 million out of the 33.3 million infected with HIV globally live in sub-Saharan Africa.	UNAIDS, records significant progress in terms of lower incidence, increased access to antiretroviral drugs and preventions services.

Source: Adapted from Buvé (2006, 44), Merson et al. (2008, 482) and Kallings (2008).

Case countries: Lesotho, Namibia and Uganda

This section contains a brief introduction to the individual case countries, which by no means is exhaustive but rather aims to provide a sense of some of the epidemiological "real-world indicators" (Dearing and Kim's model of the agenda setting process Fig. 1). As described in the methodological section, the three countries are at different stages and form a continuum on several epidemiological indicators. Furthermore, Lesotho and Uganda, have gained international recognition for some of their pioneering interventions in dealing with the epidemic, which is another reason why these countries are particularly relevant for empirical analyses.

A epidemiological continuum

Ugandan is the first country to experience a generalized epidemic, but after a rapid rise in the 1980s, prevalence has decreased in Uganda and appears to have stabilized. In Namibia and Lesotho, the onset of the epidemic was much later and the impact of has been much more severe (WorldBank 2000). In Namibia and Lesotho, prevalence peaked in the early 2000s, declining since then in Namibia but remaining high in Lesotho (Fig. 4 HIV prevalence among adults in the three case countries).

In terms of current prevalence, the countries form a continuum, where Lesotho is the third hardest hit country in the world with an adult prevalence rate of almost one in four (23.6 %) in 2008 (Lesotho 2010). The HIV prevalence rate for 2008 was a slight increase from 2007, indicating that the epidemic's reversal has yet to fully stabilize. Namibia, with an adult prevalence at 15 %, is one among the eight countries with the highest prevalence rates in the world, but with indications that it has decreased further (Republic of Namibia and Ministry of Health and Social Services 2010). Uganda, with an adult prevalence at 6 %, is the least affected currently, but has a history of a much higher prevalence. Today, the Ugandan prevalence appears to be on the rise again and according to the latest Ugandan UNGASS progress report, there is evidence of reversals in the earlier preventive sexual practice in the general population (Government of Uganda 2010).

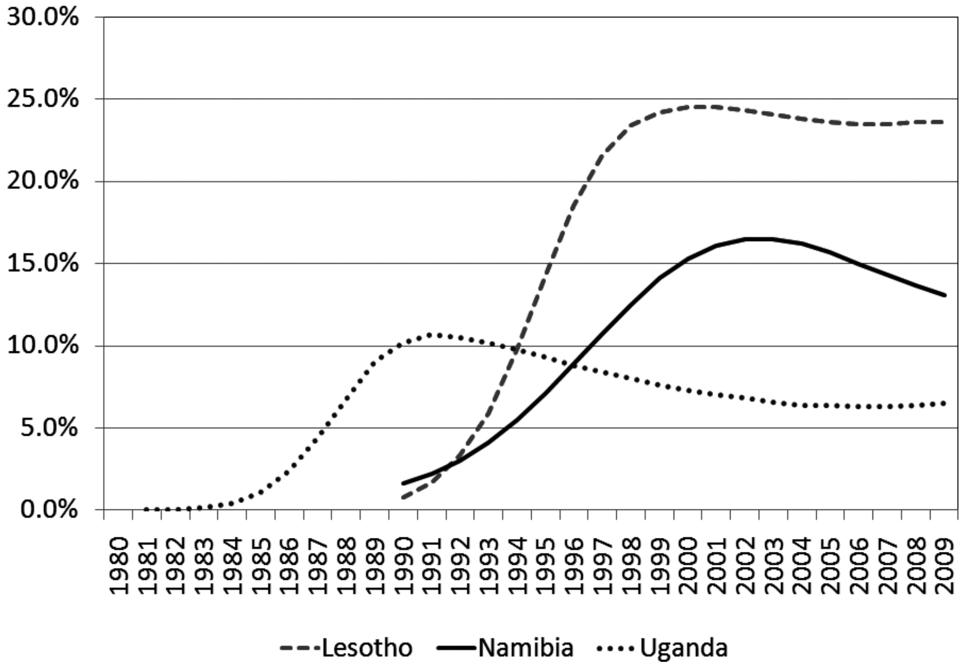

Fig.5 Adult HIV prevalence for Lesotho, Namibia and Uganda 1981-2009.Source: WHO for all countries from 1990 and onwards; for Uganda before 1990, the data are from Hladik et al. (2009) and the UN Population Division.

The countries also form continuum in terms of impact, here represented as annual mortality. Namibia and Lesotho have a similar population size, i.e., around 2 million, which facilitates a comparison of annual death rates due to AIDS. According to the Namibian and Lesotho UNGASS reports (2010), approximately 6,100 people died of AIDS-related causes in Namibia and 12,000 in Lesotho for 2008/2009. High death rate due to AIDS resulted in life expectancy plummeting in Lesotho from 60 years in 1990-1995 to an estimated 42.6 year (World Bank 2000). AIDS is also the primary cause of death among the Namibian population (Republic of Namibia and Ministry of Health and Social Services 2010). Uganda, with its much larger population, has estimated that 64,000 Ugandans died because of AIDS (Uganda (Government of Uganda 2010) The countries thus form a continuum where Lesotho is again the most severely affected and Namibia less so, and Uganda is at the other end, the least affected in terms of citizens dying due to AIDS.

Factors associated with incidence

The different epidemic trajectories in the case countries are a result of a mix of factors related to cultural and economic vulnerabilities, as well as the

nature and effectiveness of public policy responses at regional and country levels. In all three case countries, the epidemic is primarily driven by multiple and concurrent sexual partnerships and insufficient roll out of prevention of mother-to-child transmission programs. Recent incidence studies from Lesotho (Government of Lesotho, The World Bank Global HIV/AIDS Program, and UNAIDS 2009) and Uganda (Uganda AIDS commission 2009) showed that HIV transmission is also high in a group generally perceived as "low risk". Both studies showed that incidence was high among sero-discordant couples, i.e., people in relationships where only one person is HIV-infected and the other is not. In Uganda, the 'Modes of Transmission' study demonstrated that 35% of all new infections occur in sero-discordant monogamous couples and 37% are among people reporting multiple partnerships (Uganda AIDS commission 2009). Ignorance of HIV status is particularly problematic for sero-discordant couples, as condom use tends to be low in stable relationships. There are studies indicating that a significant percentage of new infections in sub-Saharan Africa occur through sero-discordant couples (Matovu 2010).

Mother-to-child transmission is the second most common mode of transmission in all three countries. According to the Ugandan UNGASS report (2010), mother-to-child transmission is responsible for 18% of new infections in Uganda (Uganda AIDS Commission 2009).

As for transmission in most-at-risk populations, especially commercial sex workers and men who have sex with men, it is only recently that some of the countries have started to pay attention to these groups. In Lesotho, it is estimated that commercial sex workers are responsible for approximately 3% of the total incidence, while men having sex with men and their female partners are estimated to constitute 3 to 4% of all new infections (Lesotho UNGASS report). According to the Uganda UNGASS Progress Report (2010), commercial sex workers and their clients and partners of clients are responsible for 10% of new infections. The same report attributes less than 1% of infections to men who have sex with men and intravenous drug users. Namibia does not report any incidence data for commercial sex workers or men who have sex with men.

All three countries state in their 2010 UNGASS report that incidence is attributed to a low rate of male circumcision and relatively low levels of condom use, especially among married or co-habiting partners. As for social and cultural factors, inhibitions around open discussions on sex and sexuality are another key obstacle for lowering incidence. The low status of and higher poverty levels among women in all three countries resulting in women being disproportionately infected and affected by the epidemic is another contributing factor.

Social dislocation caused by the migratory labor system is another critical underlying factor, particularly in Lesotho and Namibia. Extensive labor migration effectively disrupts traditional family life and results in separating couples for lengthy periods of time, which fuel the practice of having multiple and concurrent partners (Barnett and Whiteside 2006). While incidence data are extremely important for understanding an epidemic and how it is developing, it is important to also chart which contextual factors are fuelling the HIV epidemic.

Policy and program responses: a mixed bag

All three countries have identified HIV/AIDS as a threat against long-term development and attainment of international development targets. They have signed the Declaration of Commitment on HIV/AIDS developed during the UN General Assembly Special Session on HIV/AIDS (UNGASS) in 2001, and are thereby also committed to monitoring and publishing biennial reports on the progress toward reaching the UNGASS goals. All three countries submitted reports in 2008 and 2010 and are also signatories to the 2006 Abuja Declaration.

A comprehensive response, however, constitutes far more than signing international declarations. Ultimately, it is about knowing the local epidemic by continuous data collection and analysis, as well as using that knowledge to plan, allocate resources and implement appropriate evidence-based interventions. UNGASS reports, which consist of a set of 25 indicators aimed at facilitating country responses, can provide an indication of how well the countries know their epidemics and if they are responding based on that knowledge. A quick review of the 2010 UNGASS report from the respective countries showed that Namibia was unable to present data on 11 indicators, Uganda on 7 indicators and Lesotho 12 indicators.

All three countries do, however, report in their UNGASS reports 2010 significant improvements in access to antiretroviral therapy and access to prevention for mother to child transmission. In Lesotho, 51% (with eligibility at CD4<350) of those in need are receiving antiretroviral treatment (Lesotho UNGASS reporting 2010). In Namibia, 95% of those in need receive antiretroviral treatment with an eligibility at CD4<200. This means that treatment coverage is going to decrease once the new WHO-revised guidelines are implemented. In Uganda, with eligibility at CD4<200, 53% are currently receiving treatment. WHO 2006 treatment guidelines on when to initiate treatment were still in effect, immediately increasing the number of people living with HIV/AIDS eligible for and in need of treatment. Furthermore, all three countries have made significant improvements in providing access to

prevention of mother to child transmission service. Lesotho has the highest coverage of prevent of mother to child transmission service with 71% of all the expected HIV-positive pregnant women receiving antiretroviral to reduce the risk of mother-to-child transmission. The same figure for Namibia is 58% and 51.6% for Uganda of HIV-positive pregnant women.

According to the countries UNGASS reports, all three countries fail to provide targeted interventions for most-at-risk populations, in particular men who have sex with men and commercial sex workers,for them. Unlike Uganda and Namibia, Lesotho does however report some data on these two most-at-risk populations. Neither country report any government sponsored programs targeting these two groups. Lesotho and Namibia report that there are civil society-initiated interventions targeting these most-at-risk groups, which include peer education and access to tailored health information on HIV/AIDS and condoms in particular.

These shortcomings aside, both Lesotho and Uganda, albeit for different initiatives, have gained international recognition and praise for pioneering interventions addressing their epidemics. These two country experiences will be described in more detail below.

The Mountain Kingdom under siege gains international recognition

As early as the year 2000, King Letsie III declared that HIV/AIDS was a national disaster. In 2003, the Government of Lesotho openly acknowledged the dire situation when the Prime Minister Pakalitha Mosisili warned: "we have to act NOW if we are to avert the potential annihilation of our nation" (emphasis in original document(Government of Lesotho and UN 2003, xxiv)

As a result of this growing sense of urgency, the government of Lesotho together with the Expanded Theme Group on HIV/AIDS, i.e., international development partners, started to create a comprehensive strategy from responding to the epidemic. After a year of national consultation and dialogue, the results were presented in the book *Turning a CRISIS into an Opportunity: Strategies for Scaling Up the National Response to the HIV/AIDS Pandemic in Lesotho.* At a meeting in October 2003, the government decided to adopt the book as an official document and guide for the country's response to the epidemic (Government of Lesotho 2004). A key and novel feature of this strategy was the ambition to create an 'HIV competent society', which is described as (Government of Lesotho 2004, 3):

a society whose citizens are knowledgeable about what HIV is, what AIDS is, how one gets it, what one should do to avoid getting it, how one knows whether or not one has it and what one should do if one or a loved one already has it. Above all, one needs to know that although there is not yet a cure for HIV/AIDS, being HIV-positive is NOT an automatic death sentence; it can be managed through appropriate treatment, food and nutrition, care and support.

The document further clearly acknowledges that in order for the country and its citizens to become HIV/AIDS competent, all major "stakeholder and its institutions—the Government, civil society (the Church, traditional leaders, traditional healers, people living positively with HIV/ AIDS, women's and youth organisations, and more), the business sector, the media— must commit to the process and making the strive for an HIV/AIDS-competent society their priority" (Government of Lesotho 2004, 4).

This concern at the highest political level also resulted in the development of a National AIDS strategic plan 2006-2011 and the establishment of the Lesotho AIDS Program Coordinating Authority directly under the Prime Minister's Office.

In 2004, the Prime Minister, Pakalitha Bethuel Mosisili, along with the Catholic Archbishop of Lesotho, Reverend Bernard Mohlalisi, openly took an HIV test. In a remark at the event, the Prime Minister announced that his wife and he had agreed to take the nation into their confidence and share their results. However, the Prime Minister and his government's commitment to voluntary counseling and testing and indeed the subsequent Know Your Status (KYS) initiative was later questioned when the Prime Minister decided not to disclose his results (Owusu-Ampomah, Naysmith, and Rubincam 2009).

The high-level political commitment generated another bold initiative a year later, the KYS campaign. KYS was launched at the World AIDS day in 2005 and was the first attempt by an African country to provide universal HIV testing and counseling to its entire adult population. The KYS goal was to offer all people above 12 years of age living in Lesotho an opportunity to know their HIV status by the end of 2007. The target was set to test and counsel 70% of the population over the age of twelve, which is roughly 1.3 million people (Owusu-Ampomah, Naysmith, and Rubincam 2009). The rationale behind the campaign was that knowledge of sero-status was believed to provide an incentive to learn more about staying negative for those who tested negative and tools for positive prevention for those who tested positive and onward referrals for those in need of ARVs (MoHSW 2006, 2005). In short, HIV testing and counseling services were regarded as "the gateway" to a range of services, prevention, treatment, care and support.

A key part of the KYS campaign was to involve communities and training of community-based lay counselors (Owusu-Ampomah, Naysmith, and Rubincam 2009; MoHSW 2005). The existing inadequate Lesotho healthcare system could simply not cope with a campaign of that magnitude and hence, training lay counsellors to perform voluntary counselling and testing was a central component of the campaign (Lohman 2008).

The KYS campaign was indeed ambitious. But poor coordination, lack of funding, logistical capacity and inadequate human resources hindered the campaign from reaching its goals. For example, only 3,590 community-based caregivers were trained out of an original target of 7,200, making the campaign critically understaffed (Lohman 2008; Owusu (Owusu-Ampomah, Naysmith, and Rubincam 2009). Furthermore, despite international recognition, the government of Lesotho did not manage to mobilize the necessary funding (Lohman 2008). On the positive side, the campaign had managed to produce great commitment among lay counselors and the nurses supervising KYS counselors to reach the campaign goals. The campaign was, however, fraught with difficulties and significant shortcomings in the implementation of the operational plan. Lay counselors were often poorly trained and in inadequate numbers to perform their duties. There were also repeated examples of poor linkages between testing and referrals for post-test services. Furthermore, several of the campaign components such as a KYS media campaign, quality assurance systems, and monitoring and oversight for potential abuses were either never implemented or implemented only after a long delay (Lohman 2008).

Despite the KYS campaign never being fully implemented, it is believed to have contributed to the increase in the uptake of voluntary counseling and testing (Owusu-Ampomah, Naysmith, and Rubincam 2009; Government of Lesotho 2010). In 2004, only 9 % of men and 12 % of women knew their HIV status (Ministry of Health, Lesotho 2004). According to the Lesotho UNGASS report (2010), an impressive 70 % of the eligible population, i.e., individuals that are 12 years of age, knew their HIV status by the end of 2009.

Uganda - the world's earliest compelling prevention successes

With a significant reduction of prevalence among adults from a peak of approximately 15 % in the early 1990s Uganda has been called one of the world's most compelling HIV prevention successes (Green et al. 2006). The dramatic decline in first incidence and later HIV prevalence has drawn considerable attention from the public health policy and research communities,

and much effort has been spent on trying to understand 'what really happened in Uganda?'

In the 1980s, Ugandan doctors noticed a significant increase in a severe wasting disease known locally as *Slim disease* and a surge in opportunistic infections. Soon *Slim disease* symptoms were being connected to the data that were coming out from the Center for Disease Control in the United States (AVERT 2011). Uganda was among one of the first countries outside the US to acknowledge the existence of a new disease. While there were an abundance of rumors surrounding the disease and confusion with other diseases such as malaria, the Ugandan government did not attempt to hide the case data. Subsequently, 900 cases were reported in 1986, rising to 6,000 cases by 1988 (Uganda AIDS Control Programme 1989 in Slutkin 2006). It has been suggested that initial quick government reaction to HIV/AIDS can be explained by the fact that the epidemic threatened to deplete the army, and that the government needed gain the international acceptance, as well as the fact that the epidemic was concentrated at the heartland of Museveni's political support base (Tumushabe and United Nations Research Institute for Social Development 2006).

In response to the escalating situation, the government of Uganda formed the National Committee for the Prevention of AIDS (NCPA) and the Uganda National AIDS Control Program (NACP) in 1986 (Slutkin et al. 2006). The World Health Organization was instrumental in setting up these structures and assisted the Ugandan government in creating a single national action plan and budget (Slutkin 2006). Uganda was later made a model for the rest of Africa.

Several studies trying to understand the decrease from double to single digit prevalence suggest that a decline in multiple sexual partners is most likely to be responsible for the early declines (Stoneburner and Low-Beer 2004; Low-Beer and Stoneburner 2004; Green et al. 2006; Gray et al. 2006). Stoneburner and Low-Beer (2004, 715) found that between 1989 and 1995, there "was a 60% reduction in persons reporting casual sexual partnerships in the past year". Green et al. (2006, 338) concluded that "changes in age of sexual debut, casual and commercial sex trends, partner reduction and condom use all appear to have played key roles in the continuing declines". Others have however argued that "although HIV prevalence declined in 1990s, we cannot disaggregate the contributions of specific behavioral change (abstinence, monogamy, condom use), postwar social stabilization, the direct effects of government prevention programs, and the natural evolution of the epidemic (i.e., declines in prevalence due to mortality exceeding incidence, and declines in transmission as fewer people were in the early, highly infectious, stages of disease)" (Gray et al. 2006, 348). Below is an

outline of the key interventions that appeared to have facilitated the changes in sexual behavior that brought about Uganda's prevention success (Green et al. 2006).

High-level political support and multi-sectorial response

The importance of high-level political support, most notably by President Museveni, is regarded as a crucial factor in the Ugandan success story (Green et al. 2006). As early as 1986, the President talked openly about HIV and insisted that it was on the political agenda at all levels (Kaleeba, Kadowe, and Kalinaki 2000). President Museveni also guided ministers and senior level government officials to speak about AIDS at all public functions, and he himself always ended his speeches with a note on HIV/AIDS (Slutkin et al. 2006). In Uganda, as elsewhere in Africa, religion plays a tremendous role in society. Early on, Museveni also invited religious leaders to take part in mobilization efforts. Subsequently, religious organizations and their leaders played an important role in various prevention activities (Singhal and Rogers 2003; Barnett and Whiteside 2006; Kaleeba, Kadowe, and Kalinaki 2000). The Anglican Church trained their priests to be able to deliver HIV prevention messages, which were delivered from the pulpit in services (Green et al. 2006). The Mufti declared a jihad (a holy war) on AIDS in 1989 and imams were urged to incorporate information about HIV/AIDS in Islamic teachings during prayers and home visits (Singhal and Rogers 2003). Furthermore, religious leaders were involved at the strategic policy level; and Uganda's national AIDS control program has been chaired by both Protestant and Catholic bishops. Putzel (2006, 183) argued that while "a multi-sectoral approach and the involvement of a diversity of social organizations and associations was essential to progress in both countries (Uganda and Senegal), this was made possible through strong central state leadership". The high-level political commitment to fight against HIV/AIDS and subsequent educational campaigns were greatly facilitated by President Museveni's and his military organization position after the guerrilla war (Putzel 2006).

Decentralized planning and implementation for behavior change communication

President Museveni and the ruling National Resistance Movement also recognized the importance of actively including and supporting civil society organization. Ugandan civil society was mobilized to actively contribute to the government's prevention efforts, as well as launching their own. In 1988, The AIDS Support Organization was founded by people living with HIV/AIDS and members of their families, and has since grown to become a

major player and one of the main non-governmental service providers (Putzel 2006).

By actively including community organizations, programs culturally appropriate that reached beyond the mere delivery of various medical interventions could target individual behavioral changes as well as changes in community norms (Green et al. 2006). President Museveni's government introduced local councils in 1986, which became particularly active in promoting behavioral changes (Allen and Heald 2004). Green et al. (2006, 335) concluded: "It appears that behavior change programs, particularly involving extensive promotion of 'zero grazing' (faithfulness and partner reduction), largely developed by the Ugandan government and local NGOs including faith-based, women's, people-living-with-AIDS and other community-based groups, contributed to the early declines in casual/multiple sexual partnerships and HIV incidence and, along with other factors including condom use, to the subsequent sharp decline in HIV prevalence".

Furthermore, the active involvement of communities facilitated the process of turning HIV/AIDS into a conversation topic. Low-Beer and Stoneburner (2004) found in an analysis of the interplay and importance of vertical and horizontal communication channels in the Ugandan success, a distinct shift from mass and institutional channels to personal channels for communicating about AIDS from 1989 to 1995. In short, HIV/AIDS became a conversation topic in various social networks. However, Ugandan vertical channels were still important for communicating about HIV/AIDS and the importance of reducing sexual partners. One of the main messages was 'Zero Grazing', which referred to the tradition of tethering farm animals to a post, so that it would eat grass in a circle and keep off the neighbors' land. The message was widely interpreted as stick to one partner (Slutkin 2006). Low-Beer and Stoneburner (2004, 9) concluded by "highlighting social communications we are not suggesting the Ugandan response was simple and spontaneous. It was not just talk, but a distinctive policy implemented with local conviction". Another potentially important factor was the efforts to instill fear into people (Green and Witte 2006; Kaleeba, Kadowe, and Kalinaki 2000). Kaleeba et al. (2000, 12) describes it as a "deliberate policy of fear arousal in order to combat denial, dramatize that AIDS is real and provoke Ugandans to feel at personal risk of HIV infection, unless they were willing to change behavior".

Addressing women, youth, stigma and discrimination

Parallel to other interventions, there was emphasis on greater empowerment of women and girls, as well as fighting stigma and discrimination against people living with HIV. Government sought to empower women and youth by giving them access to political power, even though there is a law that

states that women should hold a minimum one-third of the parliament seats (Green et al. 2006). Tumushabe and United Nations Research Institute for Social Development (2006) refute that anti-stigma and discrimination efforts were more than mere lip services to the ideals of international development partners.

Africa's first confidential VCT services and condom promotion

The first Voluntary Counseling and Testing Center, which was also the first in Africa, opened in Kampala in 1991. However, widespread voluntary counseling and testing services only became a reality much later (Green et al. 2006). There is thus no evidence that voluntary counseling and testing directly led to the initial decline, even if their existence may have contributed to a climate of openness around HIV/AIDS.

As for condoms, it appears they played a minor role in the initial strategy (Stoneburner and Low-Beer 2004). Other argue that they were in fact never really promoted and even less after condom use had come under attack by the president and his wife as well as the conservative churches providing substantial funding to Ugandan HIV/AIDS programs (Tumushabe and United Nations Research Institute for Social Development 2006). Allen and Heald (2004), in a comparative analysis of the early interventions in Botswana and Uganda, suggested that the very lack of condoms in the Ugandan original strategy was a contributing factor in the Ugandan success. Allen and Heald (2004, 1151) explained "In Botswana, condom promotion provoked antipathy from church groups, local healers, parents and chiefs. In Uganda, the fact that condoms were not initially introduced, and also the president's negative attitude towards them, played a part in the social acceptance of sexual behavioral change messages. The very groups so alienated in Botswana became actively involved in Uganda".

In conclusion, it is important to bear in mind that the elements of Uganda's response do not affect HIV incidence directly. Furthermore, experiences from Uganda may be difficult to replicate elsewhere, but nonetheless provide other countries with some key building blocks, such as comprehensive behavioral change-communication programs, the importance for high-level political commitment for what- ever -reason and the need to fully include religious organizations as well as community-based organizations when designing national strategies. Another important contribution is that "Uganda provides the clearest example that human immunodeficiency virus (HIV) is preventable if the population is mobilized to avoid risk. Despite limited resources, Uganda has shown a 70% decline in HIV prevalence since the early 1990s" (Stoneburner and Low-Beer 2004, 714).

Part IV. Discussion

This dissertation began with a historically review of several Western countries mass media's, in particular the American and their representations of HIV/AIDS in the first decade after HIV/AIDS was discovered in 1981.

The first decade of HIV/AIDS, showed that the mass media's non-representation or persistent silence is not without consequences. Indeed, silence around HIV/AIDS downplayed the significance of the newly discovered virus and thus delayed public awareness and understanding of its potential implications. The mass media's silence, constructed HIV/AIDS as a non-issue, facilitated policy makers' inaction, and thus delayed both their symbolic response, i.e., speaking on the issue, and substantial response, i.e., creating social policy, interventions etc. and institutionalizing those.

Western mass media silence, and subsequent framing of HIV/AIDS as a disease of homosexuals and drug addicts, eventually gave way for narratives that framed HIV/AIDS as an urgent social problem, for not only sexual minorities. In the US, Dearing and Rogers' (2008) longitudinal study of HIV/AIDS in the US, which is the only country where the media's agenda setting in relation to HIV/AIDS has been fully explored, found that both media's silence and later narratives influenced the public's perception of the virus and subsequently the societal responses, i.e. the policy response. extensive media coverage, resulted in HIV/AIDS being registered by the public as an issue in need of far-reaching medical and social policy interventions. In the US media coverage and overarching narratives appear to have been able to influence, but not single-handedly determine, how society changed as a result of HIV/AIDS. In short, media narratives have material consequences, as they help shape how HIV/AIDS in general and same-sex sexuality in particular (but not exclusively), is understood, which subsequently influences what kind of collective action is deemed acceptable, necessary and desirable.

Against this background the empirical studies presented in this dissertation have explored media frames and narratives pertaining to HIV/AIDS and the closely related topic of same-sex sexuality in three sub-Saharan Africa countries, namely Lesotho, Namibia and Uganda. In addition, the articles on which this dissertation is based, discussed the potential adverse effects of

counterproductive narratives and in some instances silences, on the countries' ability to respond to their HIV epidemics.

In the case of Lesotho, media practitioners, driven by a sense of personal and moral obligation to report on the epidemic outperformed regional colleagues in terms of frequency in the reporting on HIV/AIDS (article II). The sheer volume of coverage, as well as continued efforts by the Government of Lesotho to keep HIV/AIDS high on the agenda, in combination with audiences own personal experiences it is likely that HIV/AIDS is understood as an urgent social problem. But, when looking at how the epidemic is framed by the media in Lesotho, it is doubtful if it promotes individual and collective action. Article I, instead finds that the relentless focus on the consequences of the epidemic–high death rates due to HIV/AIDS, disruption of communities, changing demographics, an escalating orphan crisis, adverse impact on the economy and the overall development of the country–construct HIV/AIDS as an overwhelming force beyond the control of the individuals or government. Moreover, a lack of narratives on the epidemic's causes denied the reader any real understanding of why Lesotho is so severely affected. An unclear understanding of the causes behind individual and collective vulnerability can support a reading of the epidemic as a phenomenon, which no one is responsible for, or lack of responses to it. Consequently, no one can held be responsible or be blamed for any future failures to address it. The study concluded that, the fragmented narratives on the causes of HIV/AIDS, combined with a portrayal of the epidemic as overwhelming and insurmountable, could result in the individual perceiving the struggle against HIV/AIDS individually and collectively as futile. Thereby inaction is an unfortunate, but rational behavioral response.

The studies from Namibia and Uganda explore media narratives specifically related to same-sex sexuality and discuss these narratives' potential effects on the public's understanding of the importance of providing appropriate health services to homosexual individuals in a comprehensive response to HIV/AIDS. In Namibia (Article III), the content analysis revealed the existence of two parallel media discourses in terms of same-sex sexuality in Namibia and in relation to HIV/AIDS. The state-owned newspaper reproduced an unofficial government policy of denial and silence. This silence incorrectly promotes and understanding that same-sex sexuality is non-existing in Namibia and thus irrelevant to the country's fight against HIV/AIDS. This coverage is however contrasted by the independent media's editorial choices to challenge the unofficial policy of denial and silence on same-sex sexuality, by actually covering both the controversy surrounding the HIV/AIDS policy, the existence of same-sex sexuality and the discrimination of this group.

The two studies (Article IV, V) from Uganda revealed a similar dichotomy between state-owned media and privately-owned media in relation to the socially sensitive topic of same-sex sexuality. Again it is the government-owned media who is less prone to cover the topic. One of the articles (V) explored how a discriminatory social climate is manifested in the mass media's and in particular in its coverage of the now notorious proposed Anti-Homosexuality Bill. This study concluded that both government-owned media and the privately-owned media contained roughly the same amount of discursive discrimination, which is defined as discrimination carried out through the use of language. A significant difference between the newspapers only appeared when they were compared on the number of items containing opposition and criticism of the proposed Bill and/or criticism of discrimination of homosexual individuals. The privately-owned newspaper included significantly more opposition and criticism of the proposed Bill and/or criticism of discrimination of homosexual individuals. In short, both newspapers contained a discriminatory linguistic discourse, but the privately-owned print media balanced its negative framing of same-se sexuality and supportive coverage of the proposed Bill by also including alternative readings and ways to understand the draft Bill and discrimination against homosexuals.

The article further concluded that while there were similarities in the two newspapers' coverage, it was likely that they promoted two different readings or ways to understand the proposed Bill as a policy option for Uganda. For example, by framing homosexuality as sinful, unnatural, immoral and homosexuals as "non-individuals", homophobia is legitimized and framed as unproblematic. Indeed, by providing an overall narrative that excluded discussions of the proposed Bill's implications for all Ugandans' human rights regardless of sexual orientation, or the draft Bill's adverse effects on public health in particular the country's often lauded HIV/AIDS interventions, a reading of the proposed Bill as unproblematic is further supported. In short, the government-owned print media constructed a narrative of the proposed Bill that supported a reading of it as a desirable policy response to an unwanted phenomenon, and as an unproblematic institutionalization of a desirable societal response. The privately-owned media on the other hand, while reproducing the surrounding society's homophobic discourses to a comparable degree, at the same time partly de-legitimized homophobia when it awarded space to explicit criticism of the proposed Bill, and to discrimination of same-sex sexuality. By highlighting the negative effects of discrimination and implications of the legislation, the proposed Bill as a policy option was framed as problematic.

Article IV, explored the attempts made by Ugandan human rights activists to influence the domestic mass media's framing of the proposed Anti-

homosexuality Bill. The study revealed that they sought to have the mass media to adopt their framing as: (1) The proposed Bill was a threat against public health, as it threatened to undermine commitments and efforts to provide universal access to HIV/AIDS prevention and treatment. (2) The proposed Bill was anti-human rights and anti-constitutional as it was contradictory to international human rights commitment and human rights protections enshrined in the Ugandan Constitution; and finally: (3) The Bill had repercussions for all Ugandans and not only homosexuals. The analysis concluded that Ugandan human rights advocates were only partly successful in influencing the two newspapers in covering their concerns with the draft Bill in the sense that coverage was neutral or supportive of the frame.

Moreover, the analyses indicated that the human rights defenders' influence was partly dependent on two factors: (1) Being able to *mobilize readers and independent commentators* to communicate the promoted frames through space earmarked for opinions and commentary and (2) *timing*, which here refers to the fact that the human rights advocates' influence seem to coincide with the peak of international actors raising their concerns with the proposed Bill. It was thus likely that international actors contributed to the coverage of the promoted frames, by further legitimizing their concerns.

In conclusion, Articles (III, IV,V) revealed that although there were differences between the government-owned and the privately-owned media, discourses on silence and explicit homophobia found in the 1980's still exists in Namibia and Uganda. As explored in detail in the section *Denial of same-sex sexuality and implications for policy and programmatic responses* both silence and discrimination on same-sex sexuality in relation to HIV/AIDS is counterproductive to the fight against HIV/AIDS. Both narratives fail, either by omission or by fueling stigma and discrimination, to provide the reader with a clear understanding that by failing to provide appropriate HIV/AIDS services to lesbian, gay, bisexual and transsexual individuals, everyone linked directly or via proxy to each other in the same sexual network, becomes more vulnerable. On a community level, collective silence or institutionalized homophobia undermines various actors' ability to implement comprehensive HIV/AIDS interventions. In short, media narrative that remain silent on the need to include all sexual orientations in HIV-prevention and HIV/AIDS treatment services, or explicit homophobic are both undermining prevention and treatment interventions.

The past three decades with HIV/AIDS provides us with an abundance of examples of how media narratives have changed with an increased understanding of the virus as a biological entity, transmission routes, individual and collective vulnerabilities, as well as direct social policy interventions in the shape of public education efforts, development of treatment and various

laws. Social constructions of HIV/AIDS are thus in constant motions, and the day that a microbicide or even better a vaccine is discovered, these media narratives will be reconstructed to include this scientific breakthrough. Nevertheless, until the day a vaccine is discovered and made available to all people especially in sub-Saharan Africa, media narratives are important in the sense they can either facilitate the birth of what the government of Lesotho calls 'an HIV-competent society' or be counterproductive to individual and collective interventions aimed at reducing vulnerability and mitigating impact. These are extreme example to highlight an important point- media's framing and overall narratives have material consequences in the sense that they influence a society's understanding of various social phenomena, which in turn influence collective actions.

Finally, this dissertation began with posing a question, fully knowing that its contribution will be small in the grand scheme of things. The contribution does however not come in the form of fully craved and decorated piece of the puzzle, but rather a suggestion on how the phenomenon could be studied. This dissertation suggests media analysis, especially longitudinal can provide insights on how a given society is handling the pressure to change to become less vulnerable – address sexual inequality between men and women, stigma and discrimination of sexual minorities to mention a few factors fueling vulnerability – or continue to struggle with the epidemic's devastating consequences.

Future research

The previous paragraphs alluded to a need for more longitudinal research regarding the media's agenda setting effects in relation to HIV/AIDS, i.e., both on public opinion and policy response. A closely connected area is the agenda-setting theory focus on Western countries. While, the theory has been found to be valid in a number of countries outside its country of birth – the US – only a handful of studies have been found that apply the theory in resource-poor settings where individual ownership of media products other than a radio are a luxury for segments of the population. The research presented in this dissertation has sought to begin to fill this gap with empirical applications to three countries in Sub-Saharan Africa severely affected by the HIV/AIDS epidemic. Going forward, there is a need for research on the agenda-setting theory in settings where governments and policy makers are an intricate part of the media sphere through its ownership of newspapers, the national radio and TV network. In these countries, policy makers are from the onset co-producers of the media agenda, rather than recipients down the line.

Furthermore, the agenda-setting process becomes further complicated in countries heavily reliant on development assistance. Dependence on development assistance as a source of revenue might result in governments being under less pressure to respond to domestic public opinion and more prone to focusing on the policy priorities of external development partners. While it is not explored in the articles from Uganda, there were several indications that pressure and criticism bill from multi- and bilateral donor concerning the anti-homosexuality had a strong effect on media coverage. There is, to the best of my knowledge, not a single study looking at how development assistants distort the agenda-setting process in developing countries.

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