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Stigma and empathy in Dutch newspaper coverage of HIV/AIDS

A frame analysis covering one year of reporting

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To the memory of my dear colleague and friend
José Francisco Martinho de Andrade (1974-2005)
with whom I understood what stigma was and what
it can lead to.

The single story creates stereotypes. And the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story.

Chimamanda Adichie

in 'The danger of a single story' presented at TED Talks (July 2009)[1].

[1] Video available at: http://www.ted.com/talks/chimamanda_adichie_the_danger_of_a_single_story.html

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Abstract

This report presents the results of an in-depth qualitative content analysis of the seven largest circulating newspapers in the Netherlands in the period between May 2010 and April 2011. Theories on media frames, meaning and social construction, stigma and empathy were used in order to identify and interpret the emerging and missing frames in the way HIV/AIDS was reported. The analysis revealed eight prevalent frames in the Dutch press: (1) HIV/AIDS is the distinguishing mark of the victimised and helpless Sub-Saharan region; (2) people with HIV are framed as patients; (3) HIV/AIDS is seen as a problem in continuous need for money; (4) there is a war going on; (5) HIV/AIDS is a stigmatised condition; (6) HIV/AIDS is a medical and scientific matter; (7) In the Netherlands: HIV is a gay issue; and lastly,(8) HIV/AIDS is seen as a chronic condition in the Western World. The analysis also showed that three important frames that contribute to the HIV/AIDS definition were missing: HIV transmission, HIV testing and individual stories. The interpretation of these frames revealed that stigma is more embedded than empathy in the way HIV/AIDS was reported. The manner in which the press frames HIV/AIDS is more favourable to the enforcement of the perception of 'them', the stereotype of those who have or are thought to have HIV.

Key words: HIV, AIDS, Netherlands, social construction, media frames, framing, stigma, empathy.

Contents

Figures and Tables

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HAART	Highly Active Antiretroviral Therapy
HIV/AIDS	When referring both to HIV and AIDS
PLWHA*	People living with HIV and AIDS
STI	Sexual transmitted infection

*In this report, the terms PLWHA and PLHIV to refer either to 'people living with HIV and AIDS' or 'people living with HIV' are deliberately avoided. However, PLWHA was used in the cognitive-emotional model of HIV-related stigmatisation (Bos, et al, 2008, based on Dijker and Koomen, 2003), as part of the theoretical framework adopted for the current study.

I. Introduction

1. HIV/AIDS: an overview

HIV/AIDS remains a challenge to public health in Europe. Between 2000 and 2007, the rate of newly reported cases of HIV in this continent nearly doubled (van de Laar, Likatavicius, Stengaard, & Donoghoe, 2008). In the Netherlands approximately 1.200 new HIV infections occur each year (SHM, 2009) and 21.500 people aged between 15 and 70 years were estimated to be living with the virus as of January 2008 (RIVM, 2011). Not everyone knows about their HIV-positive status as Dutch hospitals had only 17.868 patients in care up to December 2010 (RIVM, 2011). According to the Dutch HIV Monitoring Foundation (SHM, 2009), HIV infection in the Netherlands is predominantly present among men, with unprotected homosexual contact as the most important risk factor for acquiring the virus. Heterosexual unprotected contact is the second most important risk factor among men and the most important among women.

Late diagnosis is an important issue for HIV/AIDS response. In the European Union, it is believed that one third of people with HIV are not aware of their infection, a fact that has been acknowledged as the major challenge in tackling the epidemic (Coenen, Lundgren, Lazarus, & Matic, 2008). In the Netherlands, an estimated 40% of persons living with HIV are unaware of it (Hamers & Phillips, 2008; RIVM, 2010). The percentage rises to 50% among sub-Saharan immigrants (RIVM, 2008).

Getting tested when one has already either signs or symptoms brings important implications. Individuals who present an advanced stage of immune suppression are at higher risk of clinical events or death and are likely to have a poorer response to the Highly Active Antiretroviral Therapy (HAART) (Egger et al., 2002). Late diagnosis also implies that people with HIV are unable to reduce their risk of transmission, either by adopting risk-reduction behaviours or as a consequence of HAART which lowers the viral load (Egger, et al., 2002).

Delayed diagnosis is more prominent among those with a low perceived risk of infection and those who are not actively offered testing (Girardi, Sabin, & Monforte, 2007). In the Netherlands, all STI clinic attendees are tested for HIV, except those who explicitly refuse, which is known as ‘opting out testing’ (RIVM, 2011). The challenge thus lies in bringing those who have been at risk of infection to the clinics. Having the conscience of personal risk has a twofold importance: preventing HIV and other STIs and enabling timely testing for a successful treatment.

2. Different HIV perspectives, the invisibility of stigma and its apparent effects

The dominant belief that HIV/AIDS is merely an infectious disease, mostly put forward by scientists, physicians and public health authorities, has prevailed throughout the history of the epidemic (Treichler, 1999). Most public health strategies addressing HIV/AIDS have been typically focused on individual processes and supported by theories and models that expect individuals to follow a linear path from awareness, to attitude, to action (Airhihenbuwa & Obregon, 2000). HIV/AIDS is nonetheless more than a biomedical issue or a public health concern. There has been a growing acknowledgement that HIV/AIDS needs to be understood as a socio-cultural phenomenon (Airhihenbuwa & Obregon, 2000; PANOS, 2003; Parker & Aggleton, 2003). Decisions about preventing HIV infection are mediated by cultural norms often without one's perception (Airhihenbuwa & Obregon, 2000).

Stigma, a socially-defined attribute, is one of the mediators that intervene in prevention and care in a negative and unperceived way. In the early history of HIV, Jonathan Mann, then head of the World Health Organisation (WHO) Global Program on AIDS, identified stigma as the "third epidemic", the other two being the accelerating spread of the virus and the rise of AIDS cases (Mann, 1987). Stigma and its main mechanisms – discrimination, blame and collective denial – were then recognised as the most difficult, and yet fundamental, aspects to address in the HIV/AIDS response (Mann, 1987).

Besides interfering with an individual's attitude towards risk acknowledgment, as I further analysed, several studies worldwide show that HIV-related stigma negatively impacts the health, quality of life and well-being of people tested positive for HIV (Brooks, Etzel, Hinojos, Henry, & Perez, 2005; Buseh & Stevens, 2006; Herek, 1999; Stutterheim et al., 2009). Additionally, HIV-related stigma may also interfere with disclosure of HIV status, entering care, relationships with physicians and adherence to treatment (Chesney & Smith, 1999). Stigma manifests in a more extensive way among socially vulnerable groups because stigma is experienced on the basis of multiple attributes, such as HIV, sexuality, ethnicity, poverty, gender or sex work, rather than HIV alone (UNAIDS, 2007). Members of these groups are already stigmatised and are more likely to face discrimination than others living with HIV (Parker & Aggleton, 2003).

Among some who live with this condition and/or are affected by it, stigmatisation also provoked defiance. It prompted new media spaces where those affected by HIV, often holding 'stigmatised identities', could create new discussion forums to seek out mutual support, education and advocacy (Gillett, 2004). Publications, telephone hotlines, internet (chat-rooms, blogs and internet-pages)

among other media served to challenge misconceptions , provide information and transform power structures (Juhasz, 1995). In particular in the United States, this phenomenon has transformed the infections' "victims" that were facing fear and prejudice on a massive scale and that were already being stigmatised on other accounts into "activist-experts", capable of credibly speaking on biomedical issues and putting pressure on governments (Epstein, 1996).

In the three decades since the outbreak of the HIV epidemic, the rapid development of treatment possibilities did not go hand in hand with the disentanglement of stigma and its manifestations. These remain as difficult to understand and to tackle as when Mann acknowledged that stigma had to be considered at least as important as the infections' public health and biomedical dimensions. As a concept, stigma also remains poorly understood and efforts to overcome or to react to it are scarcely reported (Brown, Macintyre, & Trujillo, 2003; Mahajan et al., 2008). Nonetheless, stigma remains in the research agenda and it is acknowledged as an important barrier to both HIV prevention and care (Chesney & Smith, 1999; Coenen, et al., 2008; Deacon, 2006; Herek, Capitanio, & Widaman, 2002; Kalichman et al., 2005).

3. Stigma in action: how does it undermine prevention and care?

Stigma was first defined as 'an attribute that is significantly discrediting', disqualifying the individual from social acceptance (Goffman, 1963). Goffman recognized that stigmas are inherently rooted in social interactions (1963). When associated with HIV, stigma leads to a lower engagement in prevention behaviours and preventive services given that stigmatising beliefs are associated with denial of risk and they perpetuate the idea that HIV 'only happens to others' (UNAIDS, 2007). The very meaning of HIV/Aids is shaped by the perception of them as "the sort of people who get the disease" (Epstein, 1996, p. 11). People feel protected from the risk of contracting HIV based on the group they belong to, their in-group, thus not engaging in protective measures (Deacon, 2006).

Those stigmatised are placed in distinct categories, or stereotypes, and an inevitable separation of "us" from "them" occurs (Devine, 2001; Morone, 1997). Devine has looked into detail into this separation as it relates to HIV-related stigma. The author acknowledges that uninfected people try to protect their identity as healthy and non-deviant (Devine, 2001). In HIV communication, the use of risk-group labels encouraged collectivised rather than individualised perceptions of people with HIV, which created a sense of invulnerability. Commonly, the general population assumes a stereotypical image of high-risk groups, instead of high-risk individual behaviours. It has been argued that placing the blame on specific social groups can free people from the anxiety of possibly having been at risk of

acquiring the infection themselves (Pittam & Gallois, 2000). Theories of risk perception have also focused on these assumptions and their connection to invulnerability to the infection, causing *unrealistic optimism*: people underestimate what others do to protect themselves and have stereotypes of people who tend to engage in high risks (Salovey, Rothman, & Rodin, 1998).

HIV/Aids is commonly associated with norm-violating behaviours and taboo topics such as sex and drug use. Inevitably, this connotation creates a hierarchy among those who live with HIV. Clear distinctions have been found among those who were presumed to have become infected through "improper" behaviours thus seen as "guilty", and those who were deemed "innocent victims" – such as faithful women (or men) who became infected because of their spouses' extra-marital relationship; health care workers or police infected in the course of their work or children infected through vertical transmission (through their mother, during labour or breastfeeding) (Ogden & Nyblade, 2005). Figure 3 shows these findings in a simplified manner.

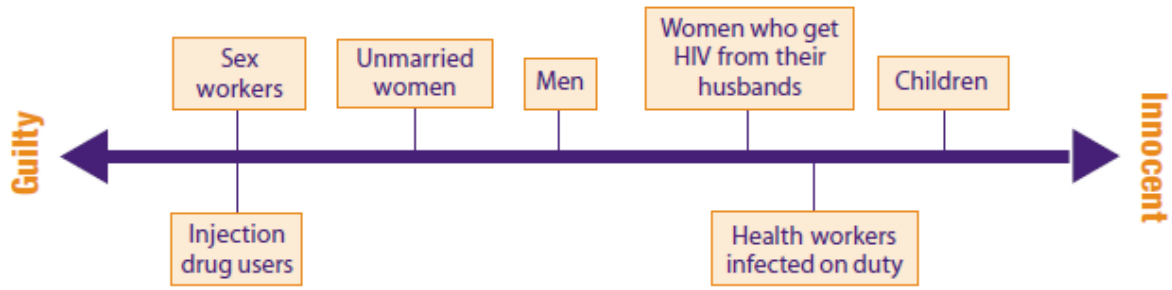

Figure 1 - Diagram of the "innocence-to-guilt" continuum (Ogden & Nyblade, 2005).

It has been demonstrated that the association of HIV with certain groups as it is often communicated, can hamper the disclosure of people with HIV about their status and testing among those who have never been tested (Parker & Aggleton, 2002). The following figure illustrates how the association of HIV infection to specific groups can trigger or even justify the separation between "us" and "them" and lead inevitably to risk denial and the stigmatisation of those with HIV.

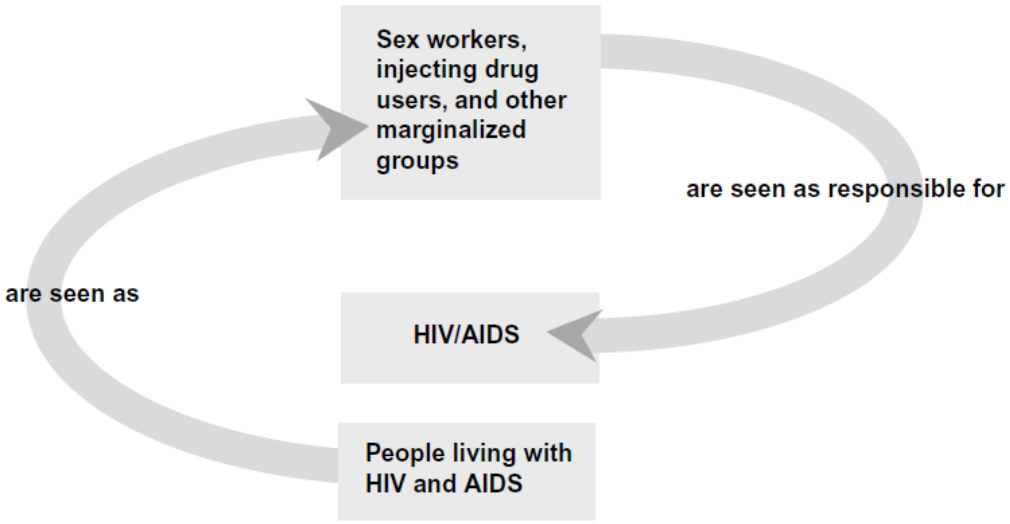

Figure 2 - The circle of stigmatisation and marginalisation (UNAIDS, 2005). Adapted from (Parker & Aggleton, 2002).

Men diagnosed HIV positive might be reluctant to disclose based on fear of being associated with homosexuality. Women might prefer to keep their status private to avoid being associated with promiscuity. The population in general will not get voluntarily tested because they do not see themselves as part of the groups generally associated with the infection; those that belong to the marginalised groups will be even more oppressed, which can increase their vulnerability to HIV infection (Parker & Aggleton, 2002).

4. HIV-related stigma in the Netherlands

In a recent report, perceived HIV-related stigma was shown to be a problem in the Netherlands and proved to considerably affect the lives of those who live with the virus (Stutterheim, Bos, & Schaalma, 2008). It also became clear that many of the determinants, manifestations and consequences of HIV-related stigma cut across various cultures (Stutterheim, et al., 2008). This confirms the findings of other authors who reported that across very different cultural contexts there were nuanced variations in terms of language, culture or epidemic history; HIV-related stigma (*what* causes stigma, the *forms* in which it is expressed, and its *consequences*) appeared nevertheless to be quite consistent (Ogden & Nyblade, 2005; Van Brakel, 2006).

The report that shed light to the extent that people with HIV in the Netherlands experience HIV-related stigma, included the results of two studies (Stutterheim, et al., 2008). The first one, of qualitative nature, focused on the Antillean, African and Surinamese ethnic communities. The latter, a quantitative survey, was conducted specifically among people with HIV.

In the first study it became evident that the perceived contagiousness and severity of HIV and the degree to which a person is considered personally responsible for their infection are associated with the likelihood of HIV-related stigma. HIV-related stigma is also intensified by the association between HIV and norm-violating behaviour like having multiple partners and men having sex with men. Additionally, given the fact that having HIV was seen as a condition to keep secret, disclosing one's status is faced as a dilemma for those living with the virus. Manifestations of stigma include avoidance, rejection, abandonment, exclusion, increased physical distance, excessive protective measures, gossip, blaming, disdain, negative remarks and denial – likely to occur among family, friends, within the health care sector and among other people living with HIV. Stigma was shown to negatively impact social relationships and the psychological well-being of those positive for HIV. Lastly, the study revealed that in most cases, people living with HIV do not attempt to change the social reality of the stigmatisation but rather adapt to the circumstances and most often seek comfort in other people living with HIV.

For Dutch and Western Europeans with HIV living in the Netherlands, who were the subjects of the second study (Stutterheim, et al., 2008), stigma was experienced through blaming, increased physical distance, avoidance, excessive hygienic measures, indifference and exclusion from social activities. Contradictory advice about HIV disclosure was also reported: while some people said they should disclose, others advised they should conceal their HIV status, which created confusion and insecurity. Overall, HIV-related stigma was proven to have a strong and significant impact on the self-esteem and psychological well-being of these study participants living with HIV. The greater majority of the participants (79.1% of a total sample of 492) acknowledged experiencing stigmatisation from the media. HIV-related stigma was also shown to be a significant problem and likely to occur in the gay community (66.7%), acquaintances known from going out and partying (65.4%), the financial services sector (58.4%), work (52%) and sexual partner(s) (51%). Figure 3 displays all the settings in which people with HIV reported experiencing stigmatisation.

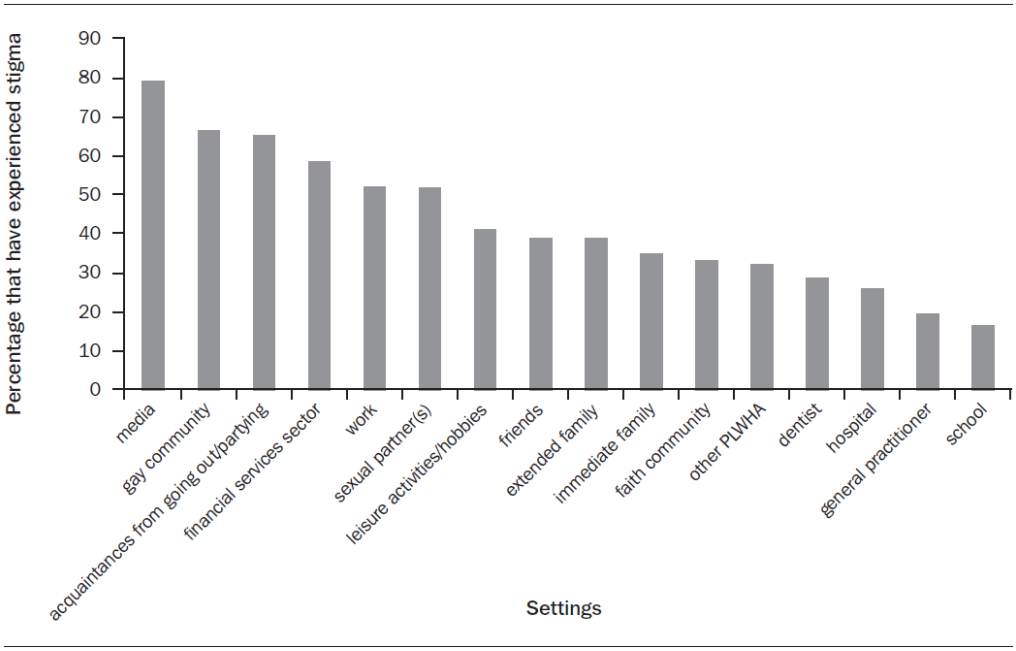

Figure 3 - Settings in which HIV-related stigma occurs in the Netherlands (Stutterheim, et al., 2008).

Given that the results of this study were obtained through a survey it remained unclear why the media was considered to be so stigmatising in the Netherlands. The authors believe the striking outcome concerning the media is in part the result of the specific circumstances at the time of the study when, prior to the distribution of the surveys, a number of people with HIV in Groningen were accused of intentionally infecting people with the virus (Stutterheim, et al., 2008). This event might indeed have had an influence in the study's outcome. However, since the results of the study were obtained through a survey, it remained unclear why the media was considered to be so stigmatising. "Have you ever experienced stigmatization by the media?" was the only question that originated this result (personal communication with the author). At the time of producing the survey the authors underestimated the importance of this setting and therefore failed to ask the respondents any further information, when they provided a positive answer.

The results concerning the manifestation of HIV-related stigma in the Netherlands are rather worrisome. One does not expect that the Dutch media would be aligned with these outcomes. It would then be appropriate to conduct semi-structured interviews with people with HIV to explore the way the media can be experienced as a stigmatising context. The preparation for this approach would nonetheless be vague without prior analysis of the media itself. It seems thus pertinent to conduct an in-depth analysis of the way the media construct the meaning of this epidemic and to identify the nuances in its discourse. That is the focus of the current study.

II. Theoretical framework

In order to identify the signification the Dutch media attribute to HIV/AIDS, different concepts are further presented, namely the role of the mass media in social construction, media frames, stigma and empathy arousal. These allow for a comprehensive analysis of the collected and coded data and form the basis for the discussion of this study's results, which are presented later on.

1. Media, meaning and social construction

In current modern societies the greatest depository of stories is made up from the various organs of the mass media: television, newspapers, magazines, radio and the internet (Seale, 2004). Media sociology has, particularly since the 1970s, looked at the effects media have on audiences (Hutchby, 2006). The way media affects cognitive activity and style; the impact of media images on the social construction of reality; and the effects media bias has on stereotyping, are the most commonly unintended outcomes to have been studied (Perse, 2001).

Mass media have been recognised for some decades as a 'dominant source of creation and reproduction of meaning' (Lupton, 1999a, p. 259). Social reality, particularly in Western cultures, is largely constructed by mass media (McQuail, 2005). As with other social phenomena, mass media accounts contribute to the creation or reproduction of knowledge about health and illness, medical care and treatment (Lupton, 1999a). Therefore media have the capability to influence and shape attitudes, beliefs and behaviours associated with both health and disease (Clarke, McLellan, & Hoffman-Goetz, 2006; Seale, 2004). Mass media news and stories also contribute to portray people with a medical condition in a certain light, for instance, as "innocent victims" or conversely "deserving their fate" (Lupton, 1999a). Overall, mass media considerations over health and illness were not considered helpful to those coping with health challenges and are thought to have, in fact, perpetuated social and political power imbalances with regard to health-related issues (Kline, 2006).

The social construction of HIV/AIDS has been deeply intertwined with the media as many studies suggest. HIV/AIDS has been pointed out as a symbolic and communicative reality (Bardhan, 2002); as an epidemic of attributions and signification (Treichler, 1999). HIV/AIDS has received a great level of attention by researchers interested in how knowledge about this condition is constructed, produced and challenged in the mass media. "The sensational media coverage given to HIV/AIDS, its association with homosexuality and illicit drug use and its status as a new and potentially fatal syndrome combined to render it a fascinating topic for media analysts" (Lupton, 1999a, p. 260).

Particular attention has been given to the cultural and linguistic framing of HIV as a direct response to the stigmatisation faced by those with the virus and the controversial debates over the syndrome in the 1980s and 1990s (Wallis & Nerlich, 2005).

The way HIV is reported has been object of study in Western countries, particularly in the early years of the epidemic (Albert 1986, Watney 1989, 1992, Juhasz 1990, Crimp 1992, Grover 1992, Treichler 1992, Beharrell 1993, Kitzinger 1993, 1995, Lupton 1994, Sacks 1996 in Lupton, 1999b). HIV/AIDS reporting was then characterised by 'intense fear, hysteria, stigmatisation, scapegoating and discrimination' (Gilmore & Somerville, 1994, p. 1352). Social scientists began to argue that the media were misrepresenting those affected by the epidemic, subsequently fostering a 'growing moral panic' (Gillett, 2004). Several dominant archetypes and the way the media exacerbated the image of people with HIV as morally deviant, victims and associated with death were identified (Lupton, 1999b). Military metaphors were also commonplace in the HIV discourse, they turned the virus into the "alien *other*, as enemies are in modern war (…) [and] the move from the demonization of the illness to the attribution of fault to the patient is an inevitable one, no matter if patients are thought of as victims" (Sontag, 1991, p. 97).

Some of the few studies conducted in more recent years still seem to be aligned with the findings of the earlier years on the HIV discourse. Content analysis of Israeli media revealed that HIV is portrayed as a 'foreign illness' afflicting immigrants and constructed as a condition of the 'deviant other', particularly gay men (Soffer & Ajzenstadt, 2010). In India, war metaphors and the rhetoric of quantification are used to describe the severity of the problem and a decline in morality is often identified in newspapers as the cause for the spread of the infection (De Souza, 2007).

Over time, HIV/AIDS has changed significantly mostly in industrialised countries, in particular with the development of more effective medications that transformed the 'deadly disease' into the 'chronic condition'. This period of 'normalisation' slowed public interest and decreased panic (Berridge, 1992). HIV has also deserved less attention in the media in more recent years which has been interpreted as 'the end of AIDS', an event that could have implications in general attitudes towards the infection, policy and funding decisions (Lupton, 2003). It has also been pointed out that scientific knowledge about the transmission of HIV should have reduced the level of fear and raised empathy towards those positive for the infection (Gilmore & Somerville, 1994).

Analyses of the way Dutch media reports health topics are scarce. Some exceptions indicate a certain level of bias: the engagement of the press in health promotion efforts was pointed out as a necessity

after it was found that newspaper coverage of health etiology in the Netherlands was incongruent in many important ways with the central doctrines of health promotion (Commers, Visser, & De Leeuw, 2000). More frequent and accurate coverage of chronic diseases in the Dutch written press has also been recommended (Van der Wardt, Taal, Rasker, & Wiegman, 1999).

In a recent study that analysed the construction of ethnicity in HIV and STI epidemiological research by the *Rijksinstituut voor Volksgezondheid en Milieu (*Dutch National Institute for Public Health, RIVM), the authors concluded that the category "migrants from areas with generalised HIV-epidemics" evolved over the last decade to the "*high risk sexual ethnic other* who is at heightened risk of HIV and who spreads HIV in the Netherlands through promiscuity and absent sexual practices. (…) ethnic minorities are [thus] constructed as sexually promiscuous, unsafe and, most importantly, *different* from the Dutch population" (Proctor, Krumeich, & Meershoek, 2011, pp. 1844-1845). The authors question the validity of this approach "as the epidemiological and behavioural data is not compared to a "non-migrant" population in the same setting (age, urban setting, recruitment location, payment for participants etc.)" (Proctor, et al., 2011, p. 1841). It is argued that this construct is reaffirmed and self-validates itself. It sources the methodological choices of the RIVM and its programmes, whose results are then widely disseminated in the Dutch House of Representatives, HIV/STI prevention practice and in newspaper articles (Proctor, et al., 2011).

2. Media frames

Definitions of reality are also termed "frames" (Goffman, 1974). In several research fields, from cognitive psychology, health communication, communication science to sociology, economics or policy research, among others, *frames* explain the way reality is constructed (Van Gorp, 2007).

A *frame* is an interpretative context that help us to better understand a message (Goffman, 1974). When *framing* an issue in news production, journalists select "some aspect of a perceived reality and make [it] 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, 1993, p. 52). Frames *define problems* (determine the causes, costs and benefits, often in term of common cultural values); *diagnose causes* ('identify the forces creating the problem'); and *make moral judgments ('*evaluate causal agents and their effects'*)* (Entman, 1993, p. 52). One sentence may include more than one of these frames while entire texts may fail to include any of the four frames (Entman, 1993).

In communication processes frames can be present in the *communicator* (who will make conscious or unconscious framing judgments in deciding what to say; guided by frames they organize their belief system); in the *text* (where frames are manifested by the presence or absence of certain key-words, stock phrases, stereotyped images, sources of information, and sentences that provide thematically clusters of facts or judgments); in the *receiver* (where frames serve to guide the receiver's cognition and conclusion (Entman, 1993). Receivers, or "media consumers", are perceived to embrace frames and view reality according to them (McQuail, 2005).

In media content analysis, *themes* and *frames* have a complementary role. Themes bring the general meaning to a report (Altheide, 1996). T*hemes* are the 'recurring typical theses that run through a lot of reports' and *frames* are the 'focus, a parameter or boundary, for discussing a particular event' (Altheide, 1996, p. 31).

There seems to be some degree of variation when researchers define frames (Carragee & Roefs, 2004; Van Gorp, 2007). Carragee and Roefs have identified mainly two possible interpretations in the literature: frames in a metaphoric sense (frames are described as broad definitions of an issue or event) and frames as story topics or themes (2004). The authors consider that, by reducing frames to story topics, attributes or issue positions, some approaches neglect the ideological nature and consequences of the framing process as well as the power relationship that influence that process (Carragee & Roefs, 2004). Framing processes need therefore to be taken into account within wider political and social contexts (Carragee & Roefs, 2004).

Van Gorp (2007) reflects on the need of bringing culture back in when examining framing processes since the audience will interpret frames within a specific culture. This is done through various mechanisms such as word choice and the usage of metaphors and symbols, which constitute what the author terms 'frame package'. The notion of a 'cultural stock of frames' is suggested to explain that there are more frames than those currently applied (Van Gorp, 2007). Alternative frames lead to different definitions of topics, issues and persons; therefore framing "enables journalists and the audience to see that the same events make different kinds of sense depending upon the frame applied" (Van Gorp, 2007, p. 63). Since frames are embedded in cultural phenomena, they are often implicit and go unnoticed and their use becomes so normal and natural that the process of social construction remains invisible, which constitutes a power mechanism in itself (Van Gorp, 2007).

In a health context it is important to study media frames because of the implications they have for individual behavior and institutional policy (De Souza, 2007; Lupton, 2003). Media frames can dictate

what will be discussed and how it will be discussed (Van Gorp, 2007). By analyzing and documenting how HIV/AIDS is being framed in news media, part of the 'invisible process' of social construction can be disentangled, leading to a more thorough understanding of the collective attitude towards this epidemic and people living with this condition. The way this epidemic is socially constructed has inevitable repercussions on the expression of empathy or stigma towards those living with the virus and the acceptance or denial of HIV/AIDS by the community as a whole.

3. HIV-related stigma: sources and mechanisms

The term *stigma* dates back to the Greeks when it meant a physical mark (made through a cut or burn) that could identify criminals, slaves and traitors (Goffman, 1963). Sociologist Erving Goffman defined stigma as a discrediting social difference that yields devaluation or a 'spoiled social identity' and an attribute inherently rooted in social interactions, marking the individual as socially unaccepted or inferior (1963). Other authors have later focused on the cognitive, affective, and behavioural aspects of stigma (Dijker & Koomen, 2003; Pryor, Reeder, Yeadon, & Hesson-McInnis, 2004).

An important distinction was made between public stigma and self-stigma (Rüsch, Angermeyer, & Corrigan, 2005). The former refers to the "reactions of the general public towards a group, based on stigma about that group" (Rüsch, et al., 2005). The latter occurs when members of a group, being aware of the prejudice, stereotype, and discrimination in society, endorse and internalize those beliefs, feelings and behaviours (Corrigan & Watson, 2002). Both are social cognitive models and comprise the negative belief about a group (public stigma) or the self (self-stigma), prejudice and discrimination (Rüsch, et al., 2005).

Different factors considered to have an influence on the stigmatisation of people living with HIV were identified in more recent studies (Bos, Dijker, & Koomen, 2007; Bos, Schaalma, & Pryor, 2008; Dijker & Koomen, 2003; Herek, 1999; Herek & Capitanio, 1998). Bos, Schaalma and Pryor have specifically identified four main factors that lead to HIV-related stigma (2008). First, the *perceived contagiousness* of HIV relates to fear and stigmatisation. Despite the fact that HIV is not contagious in social contact, people tend to respond with fear and social rejection. Second, the *perceived seriousness* of HIV/AIDS is related to stigmatisation. People tend to respond negatively because of the life-threatening nature of the disease and its association with death. Third, *perceptions of responsibility* are related to stigmatising reactions. People tend to respond with less pity, stronger anger and more stigmatisation towards people positive for HIV who are held personally responsible

for the onset of the infection (e.g., due to unsafe sexual behaviour). Fourth, HIV/AIDS is frequently associated with *norm-violating behaviour* (e.g. homosexual intercourse or injection drug use), which is likely to evoke negative emotions and stigmatisation. Figure 4 depicts a model of the HIV-related stigmatisation.

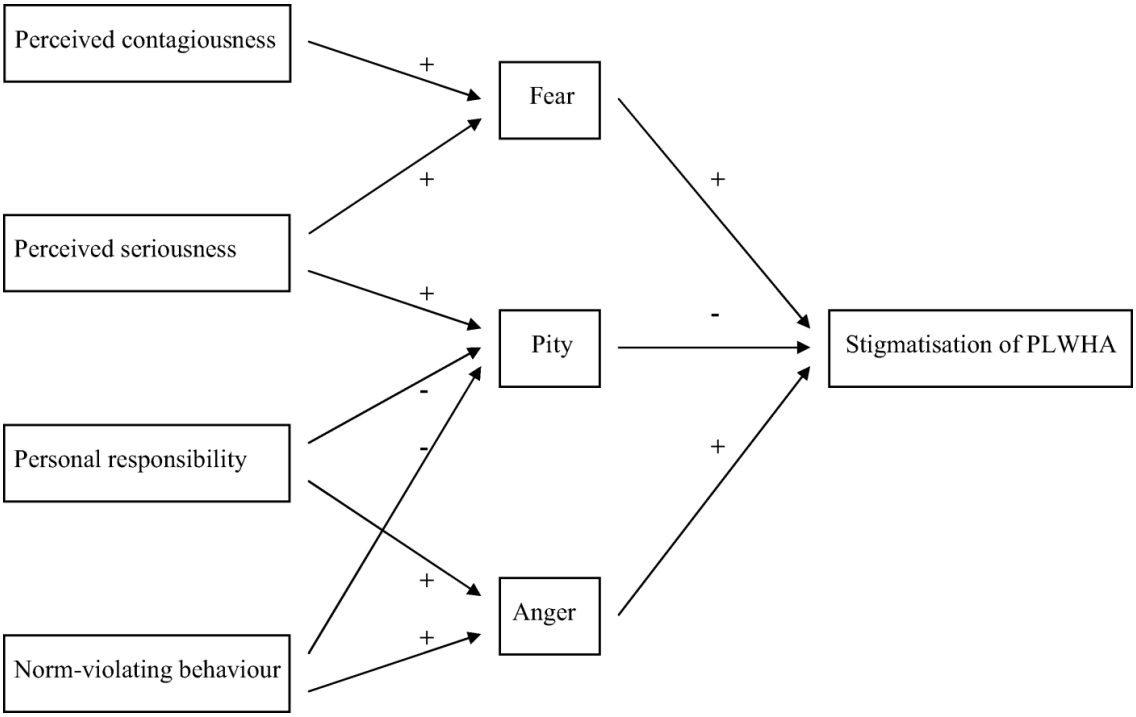

Figure 4 - Cognitive-emotional model of HIV-related stigmatization (Bos, et al, 2008, based on Dijker and Koomen, 2003).

The concept of stigma has been pointed out as being poorly understood although it has been acknowledged since the early efforts of the epidemic response (Link & Phelan, 2001; Parker & Aggleton, 2003). In a response to these criticisms, Link and Phelan have proposed to define stigma as the co-occurrence of its components: *labelling*, *stereotyping*, *separation*, *loss of status*, and *discrimination* – which need to be combined with power (social, political or economic) to enable stigmatisation (Link & Phelan, 2001). People distinguish and label human characteristics; dominant cultural beliefs link labelled persons to undesirable characteristics and negative stereotypes; labelled persons are placed in distinct categories as to accomplish some degree of separation between 'us' and 'them'; labelled persons experience loss of status and discrimination that lead to unequal outcomes; stigmatisation is entirely contingent on access to social, economic and political power that allows the identification of differences, the construction of stereotypes, the separation of labelled

persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination (Link & Phelan, 2001).

Phelan (2001) illustrates how power mediates the stigma mechanisms by mentioning the example of a group of patients with serious mental illness that may be likely to identify and label the differences in behaviour of their hospital staff members by tagging some of the nurses as “pill pushers” and applying stereotypes connected with the labels they create (e.g. cold, paternalistic, or arrogant). Patients may treat people they identify as pill-pushers in a different way, but that group of hospital staff will never be a stigmatised group because the patients do not hold the power to allow their cognitions to create a discriminatory consequence.

The term *label* was elected by Link and Phelan because other terms like ‘attribute’, ‘condition’ or ‘mark’ imply that the designation has validity. *Labelling* entails a social selection of human differences when it comes to identifying differences that are socially relevant. Therefore the characteristics deemed social relevant vary considerably in time and according to culture. The authors give the example of how individuals with large foreheads and large faces were salient in the XIX century and associated with criminality. The label links a person to a set of undesirable characteristics that form a *stereotype*.

Stereotypes are “simplistic representations of social groups that deny any diversity among members of the same group” (Perse, 2001, p. 165). Stereotypes operate in a preconscious, automatic way and spare cognitive resources by functioning as mental shortcuts. Categories and stereotypes are often automatic and facilitate cognitive efficiency. The media in particular makes use of them in order to attract large audiences, presenting content that is easily understood by a wide range of people (Perse, 2001). Time limitations and entertainment demands make stereotypes easily accessible particularly in television, and over the years, content analysis has shown how this medium is filled with stereotyped images of women, minorities and the elderly (Perse, 2001).

To demonstrate the power of labels and the stereotypes associated to it, Link and Phelan refer to an experiment conducted among African-American and white students (Steel & Aronson, 1995, in Link & Phelan, 2001). The former group had lower scores on a test when the study participants were led to believe that the test was measuring intellectual ability. When the same test was not labelled as being a diagnostic of ability, the African-American students scored as well as white students.

Link & Phelan argue that, in the extreme, the stigmatised person is thought to be very different from 'us' to the point of not being really human, which can make a terrible treatment of 'them' possible (Link & Phelan, 2001). Labels can make this separation of 'us' and 'them' directly available when people speak of persons as being 'epileptics' or 'schizophrenics' rather than describing them as having epilepsy or schizophrenia (Link & Phelan, 2001). People become the things they are labelled as. Acronyms that refer to people with HIV might have the same effect: people with HIV (often referred to as PLHA) are not HIV or AIDS, they just happen to live with a virus, one of their many other characteristics.

An almost immediate consequence of successful labelling and stereotyping is a downward placement in the hierarchy, which can lead to very concrete forms of inequality in the context of social interactions, in particular within small groups (Link & Phelan, 2001). If stigmatised groups accept the dominant view of their lower status, they will be less likely to challenge structural forms of discrimination that block the goals they would like to achieve (Link & Phelan, 2001). This is reflected in research findings in the Netherlands, where people living with HIV 'do not attempt to change the social reality of stigmatisation but rather adapt to the circumstances they found themselves in' (Stutterheim, et al., 2008, p. 8).

Link and Phelan recall Ajzen & Fishbein's Theory of Reasoned Action and its claim that 'attitudes predict behaviours' to explain that discrimination becomes inevitable after the sequence of labelling, stereotyping and the subsequent separation between 'us' and 'them' (Link & Phelan, 2001). Deacon argues that stigma always results in blaming, shaming and status loss for the stigmatised person or group, in the eyes of the stigmatiser and that the three alone can already have a negative effect before discrimination comes into the picture (Deacon, 2006).

Stigma is totally dependent on social, economic and political power, according to Link and Phelan's conceptualisation (2001). Power, within groups, allows stigma to occur. Parker and Aggleton also point out the importance that *power* and *domination* played in stigmatisation, reason enough to justify a paradigm shift from the individualistic conceptualisation of stigma to understanding stigma as a social process (2003). In addressing HIV-related stigma, the focus has to be on those who hold the power to challenge labels, stereotypes, eliminate in- and out-group boundaries and block discrimination, by disentangling HIV perceived contagiousness, seriousness, responsibility and the association of the infection to norm-violating behaviours.

Complementing the stigma conceptual model focused on the sources of stigma (Bos, et al., 2008) with a conceptual framework that privileges the stigma mechanisms (Link & Phelan, 2001) provides a good overview of the concepts that emerge when analysing HIV discourse in the media. Figure 5 depicts this combination for a broader overview of HIV-related stigma.

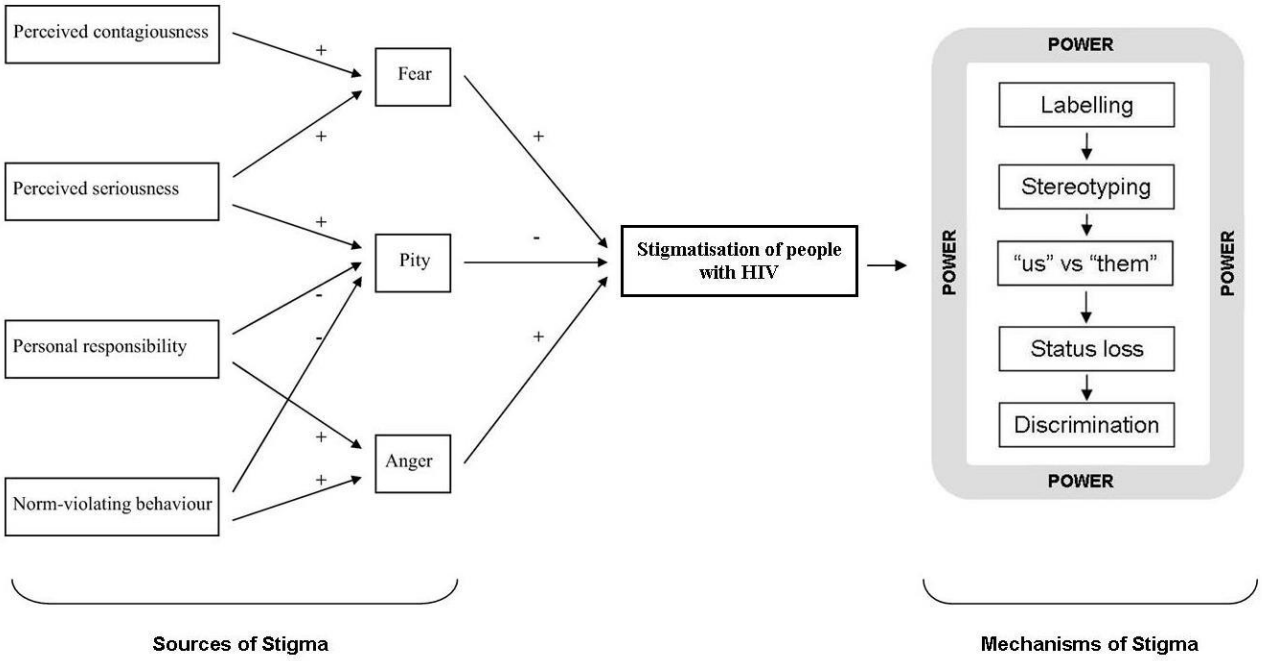

Figure 5 - HIV-related stigma conceptual model adapted from Bos, et al. (2008) and Link & Phelan (2001).

Bringing together both the structural and the individual follows what has been suggested in the literature (Link & Phelan, 2001; Ogden & Nyblade, 2005), that stigma acknowledges differences between categories of people, based in systems of power that produce and reproduce stigma and social exclusion (Parker & Aggleton, 2003). Mass media, through its influence or 'invisible power' to shape society through the way it frames issues, is therefore in a privileged position either to foster or challenge stigma.

4. Empathy arousal

Empathy "allows us to tune into how someone else is feeling or what they might be thinking" (Baron-Cohen & Wheelwright, 2004, p. 163). It has been described as "the competence to understand other people's feelings by identifying expressive cues and by attributing them to situational features" (Leibetseder, Laireiter, & Köller, 2007, p. 549). A distinction can be made between *emotional-empathy*—empathy triggered by spontaneous emotional contagions–and *cognitive-empath*y or an

active volitional sensitivity towards the situation of the other person (Leibetseder, et al., 2007). Specifically in the context of intergroup relations, Batson and Ahmad (2009) establish that the term *empathy* has been applied to four different psychological states. Two refer to forms of *perspective taking*: imagining how one would think and feel in an out-group situation and imagining how an out-group member thinks and feels. And the other two refer to forms of *emotional response*: feeling what an out-group member feels and feeling for an out-group member. These four states are distinct but not unrelated. Batson and Ahmad believe one can lead to the other, like a stepping-stone bridge (Batson & Ahmad, 2009). The definitions are summarised in Table 1.

Table 1. Four psychological states called 'empathy' in the intergroup relations literature (Batson & Ahmad, 2009).

Psychological State	What the State Involves
Cognitive/perceptual states	
1. Imagine-self perspective	Imagining how one would think and feel in another's situation or "shoes."
2. Imagine-other perspective	Imagining how another person thinks or feels given his/her situation.
Affective/emotional states	
3. Emotion matching	Feeling *as* another person feels.
4. Empathic concern	Feeling *for* another person who is in need.

Empathic feelings happen when an individual takes the perspective of a person in need (Coke, Batson, & McDavis, 1978). It became evident in a social psychology experiment that taking the perspective of a stigmatised group member resulted into the generalisation of the empathic feelings toward the group as a whole (Batson, Early, & Salvarani, 1997). In their perspective-taking experiment with the aim of arousing empathy, Batson and colleagues (1997) also showed that participants with high empathy reported more empathy arousal and expressed more favourable attitudes toward the group to which the stimulus target belonged than did participants with low empathy. Differences in empathy are in turn linked to sex differences, with women scoring higher (Baron-Cohen & Wheelwright, 2004 and Davis, 1980; Davis & Franzoi, 1991 in Baron-Cohen & Wheelwright, 2004).

Based on the meta-analysis by Pettigrew and Tropp (2008) comprising more than 500 studies and covering 10-15 years of research on empathy, Batson and Ahmad (2009) organised the results

according to the four empathy states and the ways in which intergroup attitudes and relations can be improved, as demonstrated by empirical evidence. The results are summarised in Table 2.

Table 2. Intergroup effects of the four empathy states (Batson & Ahmad, 2009).

Psychological State	Intergroup Effects
Cognitive/perceptual states	
1. Imagine-self perspective	Reduced stereotyping and more positive evaluation of (a) the out-group member in whose situation one imagines oneself and (b) the out-group as a whole.
2. Imagine-other perspective	Increased situational attribution for plight of the specific out-group member; increased empathic concern for him/her; more positive attitudes toward the out-group as a whole; increased readiness to help the out-group.
Affective/emotional states	
3. Emotion matching	More negative evaluation of those causing other's plight; more positive feelings toward the out-group.
4. Empathic concern	Increased valuing of welfare of the specific out-group member for whom empathic concern felt; more positive attitudes toward the out-group as a whole; increased readiness to help the out-group.

Taking the perspective of someone belonging to a stigmatised group seems to be fundamental to developing empathic feelings. It has been shown that media (books, plays, films, documentaries and the radio) can help empathy emerge by inducing the audience to imagine the thoughts and feelings of a member of a stigmatised group as he/she attempts to cope (imagine-other perspective), making the message recipient value this person's welfare and consequently triggering more positive attitudes toward the group as a whole (Batson & Ahmad, 2009). Films like *Rain Man*, The *Elephant Man* or *Hotel Rwanda* confirm this view (Batson & Ahmad, 2009).

The results of Batson and Ahmad's social psychological experiments regarding perspective-taking and empathy arousal towards members of stigmatised groups seem to be aligned with the strategies reported to be effective to overcome HIV-related stigma. Before taking the perspective of someone who belongs to a group that is generally stigmatised, fear is an important cognition that needs to be identified and challenged as it sources HIV-related stigmatisation. In the treatment of anxiety disorders and cognitive-behavioural phobias, 'exposure therapy' has been used for long-term fear reduction. It consists of intentionally confronting feared, but otherwise not dangerous, objects, situations, thoughts, memories, and physical sensations for the purpose of reducing fear reactions associated with those stimuli (Cahill & Foa, 2005). Exposure to the cue, or stimulus, which triggers an unrealistic fear, modifies the automaticity (cue-response) of that fear. Being in contact with people living with HIV, directly (e.g. a person with HIV speaks to an individual or group) or vicariously (e.g.

through the media), fosters familiarity and challenges the initial and automatic fear response (Bos, Kok, & Dijker, 2001). It has been argued that giving voice to people living with HIV 'humanizes' HIV (McKee, Bertrand, & Becker-Benton, 2004). In literature reviews on stigma-reduction strategies (specifically addressing HIV stigma) the contact hypothesis focusing on face-to-face interactions with members of a stigmatised group has proved to be the most promising strategy to diminish stigma (Brown, et al., 2003; Heijnders & Van Der Meij, 2006).

The same cue-response training can happen in relation to eliminating *self-stigma,* the endorsement and internalisation of stigma by those living with HIV. Disclosing their status and sharing their experiences greatly benefits the person with HIV. Paxton called it a paradox: through disclosure, the person with HIV comes in contact with HIV-related stigma and experiences a psychological release: liberation from the burden of secrecy and shame (Paxton, 2002). Paxton's literature review indicated that speaking out can be very rewarding for people with HIV and disclosing leads to a less stressful, more productive life and to improved wellbeing (2002).

Changing negative stereotyping is an important issue to be taken into account in efforts to foster a greater empathy towards those with HIV. Contact with people with a stigmatised condition have positive results in inducing empathy but may have a twofold outcome when the wished result is the suppression of stereotypes. When people encounter an individual who violates the group stereotype, they tend to sub-type that individual, by using the deviants' additional attributes to justify sub-typing them (Kunda & Oleson, 1995). If sub-typing occurs, people might not change their attitude towards the stigmatised group, as they will assume the person showing different characteristics from a pre-conceived stereotype is the exception to the rule. However, if individuals who disconfirm a stereotype have very different backgrounds and represent various occupations, ages, geographic origins, or family backgrounds, it would be hard to attribute them an atypical sub-type (Kunda & Oleson, 1995). It is therefore important to consider the participation of people when reporting on HIV/AIDS who can disconfirm the stereotype and to prevent sub-typing. In the previously mentioned experiment by Batson (1997) , his stimulus targets included atypical group members (e.g. heterosexual women with HIV, rather than gay men with HIV). This resulted in improved attitudes toward the specific subgroup to which the target belonged (i.e. women with HIV), as well as more favourable attitudes toward broader more inclusive groups (i.e. people with HIV).

In sum, when considering empathy arousal, eliminating the unrealistic fear towards HIV and people living with this virus, as the principles of exposure therapy suggest, may open the way to perspective-taking. Having frequent contact with people living with HIV (belonging to the stigmatised 'out-group'

or ‘them’, the deviant) does not only eliminate fear but is in itself an opportunity for perspective-taking. The analysis of Batson and Ahmad (2009) show that attaining empathy in its different variations has important implications for intergroup relations. The effects of the four empathy psychological states indicate a continuum that ranges from the reduced stereotyping and a more positive evaluation of the ‘out-group’ member in whose situation the individual imagines themselves and the out-group as a whole; to the increased readiness to help the out-group. This continuum indicates the way to the process of unravelling the mechanisms of HIV-related stigma.

Empathy leads ultimately to an increased ‘self-other overlap’ (Galinsky & Moskowitz, 2000) and eventually to the conclusion that ‘*we* are all *us’* (Gilmore & Somerville, 1994). When communicating about HIV/AIDS, this acknowledgement can alter the notion that HIV is an infection of ‘them’ by eradicating in- and out-group boundaries (e.g. by addressing risk behaviours rather than groups), prompting a higher demand for HIV-testing services, a better adherence to treatment and greater empowerment of people living with HIV.

5. Summary

Risk denial and late testing are among the behavioural challenges linked to the HIV/AIDS response. The inherent causes and mechanisms of HIV-related stigma have proven to interfere with an individual’s risk acknowledgement (presenting a barrier to prevention and timely treatment) and with the wellbeing of those who have the virus (which can hamper disclosure about their status or treatment adherence). Contact with people with HIV who can disconfirm the stereotypes of who it is to live with the virus, promotes a greater understanding of how the other feels and builds a greater acceptance toward the group of people with HIV as a whole (arousing empathy).

The media holds an important source of power to construct the meaning of the epidemic and shape the public image of those living with the virus. The degree to which the media frame the epidemic, by bringing certain themes forward and by omitting others can either widen the gap between ‘us’ (the normal, virtuous, presumably uninfected) and ‘them’ (the deviant, immoral, those known or presumed to be living with HIV) – leading to stigmatisation – or, on the other hand, contribute to a ‘self-other overlap’ (where status loss of those with the virus no longer takes place) – leading to empathy.

The most comprehensive study to date on HIV-related stigma in the Netherlands (Stutterheim, et al., 2008) showed how omnipresent the phenomenon is in Dutch society and left one important open question: why is the media considered the most stigmatising setting for those living with HIV? It

therefore seems relevant to carry out an in-depth analysis of the Dutch written media in order to shed light on the way the overall meaning of the epidemic is being constructed in the newspapers.

III. Research focus

1. Aim of the research

The aim of this study is to help overcome HIV-related stigma.

2. Research objective

This study examines the representation of HIV/AIDS in the Dutch written media and explores whether it encompasses a discourse of stigma-enforcement or empathy-building. This has been done by conducting an in-depth qualitative content analysis of written Dutch media in the period of May 2010 to April 2011.

3. Research question

Are the Dutch media adopting a discourse, when reporting on HIV/AIDS, that widens the gap between "us" and "them" (leading to stigmatisation) or one that contributes to the "self-other overlap" (leading to empathy)?

3.1 Subsidiary research questions

1. How is the HIV/AIDS debate framed in the Dutch written media?
    a. As a public/societal issue, as a group issue or an individual issue? Who is affected by the epidemic?
    b. How is HIV/AIDS framed overall?
    c. How is HIV/AIDS framed in terms of its severity or normality?
    d. How is HIV/AIDS framed in terms of its transmission?
    e. How is HIV testing framed?
2. How are people living with HIV framed?
    a. How are people living with HIV referred to?
    b. What is the level of participation of people with HIV in the news coverage of the infection? What angle is used?

IV. Methodology

1. Study design

The current study is an in-depth qualitative content analysis of the portrayal of HIV/AIDS in the Dutch written media. Unlike quantitative methods, among its many of possibilities for understanding data, qualitative research can provide an explanation to the '*how*' questions; uncover meaning and identify the contexts where activities take place; and provide 'depth, detail, nuance and context to the research issues' (Hennink, Hutter, & Bailey, 2011, p. 10).

Articles were collected from the Dutch press and the chosen time frame for the sample was the previous year (May 2010 to April 2011).

2. Data sources

The press still plays a significant role in public life. Newspapers can have an indirect influence, for example, on television reporters and can provide a more in-depth and comprehensive news coverage, as some studies suggest (Walgrave & Van Aelst, 2006). For these reasons, newspapers remain an important data source for discourse analysis. In order to answer this study's research question, data was collected from the seven biggest Dutch newspapers in circulation, namely: *De Volkskrant*, *Trouw, NRC Handelsblad, De Telegraaf*, *Reformatorish Dagblad, NRC Next* and *Algemeen Dagblad* (Table 3 provides an overview).

Table 3. Overview of the most relevant newspapers in the Netherlands (Source: Wikipedia, 2011).

Newspaper	Headquarters	Circulation	Owner
De Telegraaf	Amsterdam	719,000	Telegraaf Media Groep
Algemeen Dagblad	Rotterdam	540,000	De Persgroep Nederland
De Volkskrant	Amsterdam	282,000	De Persgroep Nederland
NRC Handelsblad	Rotterdam	240,000	NRC Media
Trouw	Amsterdam	107,000	De Persgroep Nederland
nrc.next	Rotterdam	75,000	NRC Media
Reformatorisch Dagblad	Apeldoorn	57,000	Erdee Media Groep

The Dutch version of the database Lexis/Nexis [2] was used to locate the articles including the terms "HIV" and "AIDS". Images and videos were not analysed given the restricted timeframe available for this study. Articles from May 2010 to April 2011 inclusive were selected. This timeframe was

[2] http://www.lexisnexis.nl/dutch/bronnen/nederlandstalige-bronnen/

pinpointed in order to: (1) ensure enough diversity in terms of the stories and news reported; (2) represent the contemporary period; (3) ensure a sufficient number of articles on the topic of HIV/AIDS in the seven highest circulating newspapers. If the article merely mentioned HIV and AIDS, or discussed HIV/AIDS along with another topic, it was included in the sample as the interest lay in analysing the context in which the topic emerged. The key words used were "HIV" and "AIDS". This search yielded 220 articles. Three articles were excluded because they were duplicated. The final sample was thus comprised of 217 articles (Figure 6 shows its distribution). The average size of the articles was 604 words.

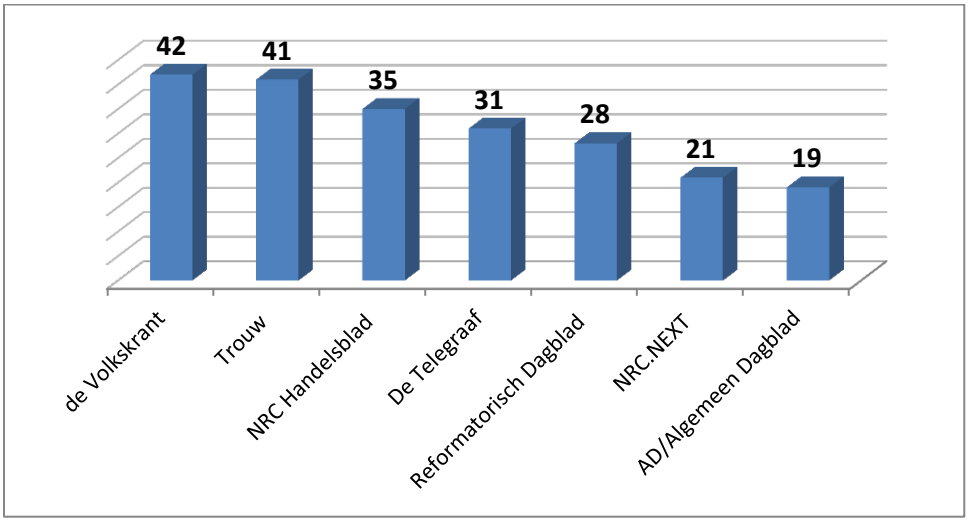

Figure 6 - Articles retrieved *per* newspaper.

The number of articles that focused exclusively on issues related to HIV/AIDS was slightly inferior to the number of those that mentioned HIV and AIDS but had another focus, representing 44% and 56% of the sample, respectively.

Of the articles that had a non-HIV/AIDS focus, 16% (n=10) focused on general descriptions about the African continent (the focus was in all cases on Sub-Saharan Africa). HIV/AIDS is therefore frequently mentioned as one of the problems afflicting the continent. News about condoms came in second: 11% (n=14). It is important to mention that all these articles were debating the exception on condom use among male sex workers which Pope Benedict acknowledged in his book 'Light of the world'. These 14 articles framed the debate in terms of condom use, whereas other articles framed the discussion in terms of the implications this acknowledgement could have in the HIV/AIDS response (these will be further discussed). Another considerable part of the sample that did not exclusively focus on HIV/AIDS (n=11, 9%) reported issues around fund-raising in general, mostly in terms of the

money needed or the money still missing to achieve certain goals. The same sample size concerns articles focusing on science issues. And again, 9% (n=11) centred on development issues in general. Other topics covered in the articles that mentioned HIV and AIDS were philanthropy in general (a different category from fund raising because it does not focus on money issues): 7% (n=8); TV and entertainment with 6% (n=7); International politics with 6% (n=7); illegal drug use (4%, n=5); the World Football Cup (4%, n=5); Health/Sexual education (3%, n=4). The remaining 20% concentrated on issues such as national politics (n=3), Human Rights violation in Africa (n=2), Sub-Saharan African politics (n=1), religion (n=1), homosexuality (n=2), biographies (n=3), Chechnya (n=1), detainees (n=1), asylum seekers in the Netherlands (n=1) and the human milk bank in Amsterdam (n=1). Table 4 summarises these characteristics.

Table 4. Sample main characteristics

Sample Main Characteristics	N	%
Type of article		
HIV/AIDS-focused	95	44
Non-HIV/AIDS-focused	122	56
Total	*217*	*100*
Average length (words)	604	-
Themes of non-HIV/AIDS-focused articles		
Sub-Saharan Africa characterisation	19	16
Condoms	14	11
Fund raising	11	9
Science	11	9
International development	11	9
Philanthropy	8	7
TV and entertainment	7	6
International politics	7	6
Illegal drug use	5	4
Sports	5	4
Health/Sexual Education	4	3
Other	20	16

3. Research instruments

A protocol guided both data coding and analysis (Appendix 1). Both manifest (obvious and explicit) and latent (unintended and sub-textual) content were collected and analysed (Neuman, 2004). The

manifest analysis was intended to give a comparative overview of specific characteristics of the articles, namely: source, date, size and focus (primary or secondary) on HIV and AIDS).

The latent content considered repeated meanings and absences and is the main focus of this study. These results are presented in Chapter V. Latent analysis is grounded on the theoretical framework presented in Chapter II of this report (from which deductive codes were defined) and refined during data analysis (through which additional inductive codes were identified) (Hennink, et al., 2011). Code development stopped at the point of saturation, when no more issues were identified in the data, taking into account the purpose of this study (Glaser & Strauss, 1967 in Hennink, et al., 2011).

Data was processed using the qualitative data analysis software *Atlas TI.* Each article was read thoroughly to identify emerging themes and establish codes to which words and/or text fragments were assigned.

The following graphic presents an overview of the frequency of the different codes that support the results presented in Chapter V.

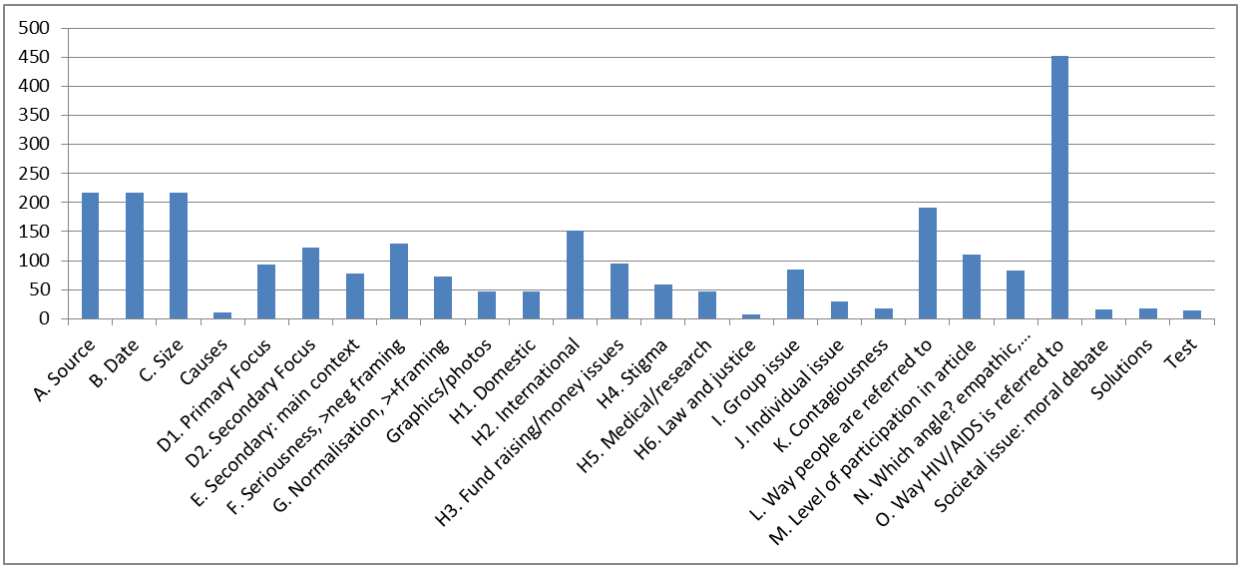

Figure 7 - Frequency of codes.

Most of the articles under analysis (78%) focused on the public or societal level, followed by the 'group level' (16%) and the 'individual level' (6%). Figure 8 presents an overview of the distribution of the news according to its level of content.

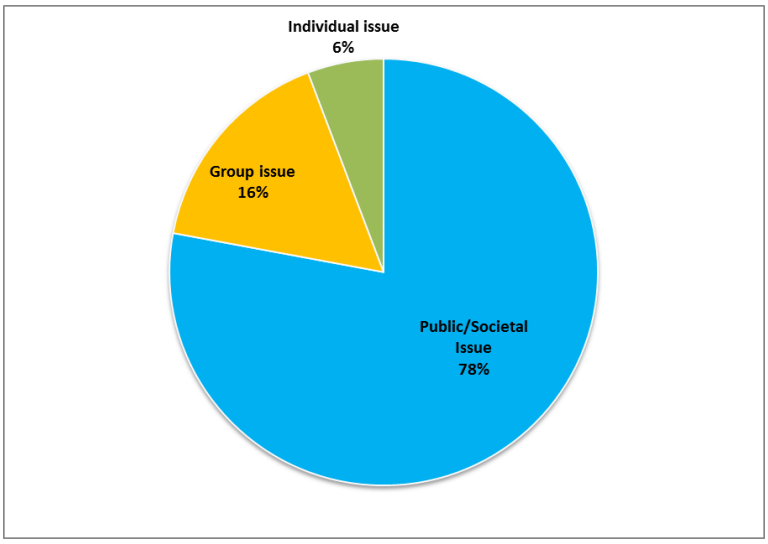

Figure 8 - Articles' distribution: public/societal, group and individual levels.

Within the societal level, six different sub-themes were identified, namely: international issues (42%), fund-raising and/or money issues (27%), stigma (16%), medical/research issues (13%) and law and justice (2%). Figure 9 provides a graphic overview of these results.

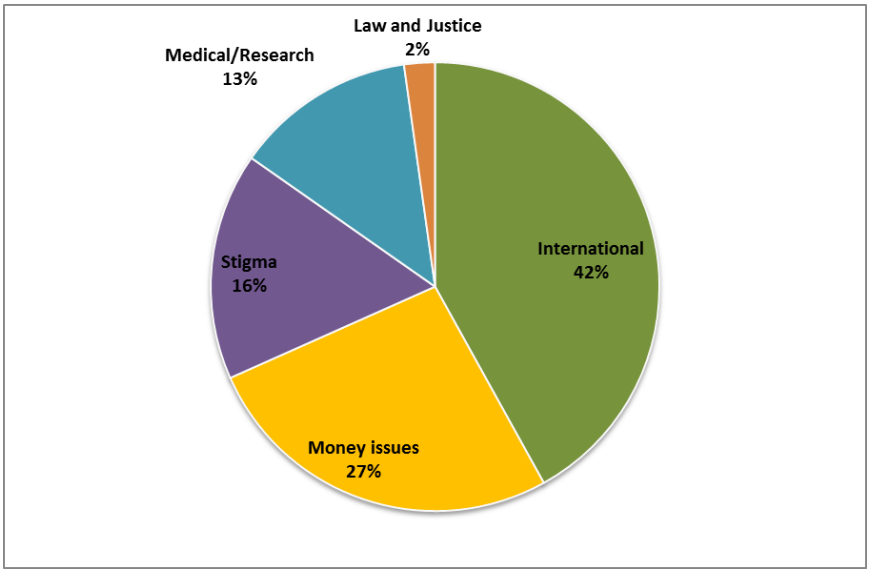

Figure 9 – Distribution of the issues that emerged within the Public/Societal level.

The news that were reported at the international level, had as an almost exclusive focus the African Sub-Saharan region. Following this particular region , the debate around HIV/AIDS is situated in international forums such as the United Nations, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Global Fund, or the International AIDS Conference (held in Vienna in 2010) where policy, fundraising and research issues are generally discussed. When the topic is debated with Western countries as scenario, mostly sensational stories come forward, such as the declarations of a

Belgian bishop stating that AIDS was a form of justice; the case of Nadja Benaiss, a German singer who was taken to court because she had unprotected sex without telling her partners she was positive for HIV; or the panic in 'Porn Valley' (the centre of the porn industry in California) when one of the actors was found to be HIV-positive. When the focus is in East Europe, HIV/AIDS is often associated with drug use.

V. Results

The current chapter describes the prevalent frames that characterise HIV/AIDS found salient during data analysis (part 1). Additionally, it looks at the frames that would be considered relevant to disentangle stigma but that were found to be scarce or inexistent in our study sample (part 2).

1. How is HIV/AIDS framed

Frame #1: the distinguishing mark of the victimized and helpless Sub-Saharan African region

Although other geographical areas deserve press attention, HIV/AIDS is distinctively considered a condition of the Sub-Saharan African region. Within this geographical delimitation, HIV/AIDS appears together with poverty, sex work, famine, corruption, conflicts or sexual abuse. Quotes such as the one below are a commonplace.

> *In Sub-Sahara Afrika blijft het op veel terreinen nog kommer en kwel. Veel landen kampen met corruptie, oorlog, politieke instabiliteit en een gehavend arbeidspotentieel als gevolg van ziektes als hiv, tuberculose en malaria.* (de Volkskrant, 28 December 2010) [Sub-Saharan Africa remains in many areas still doom and gloom. Many countries suffer from corruption, war, political instability and a battered workforce as a result of diseases such as HIV, tuberculosis and malaria.]

HIV and AIDS are often coupled with the gloom scenarios reported in the news when it comes to describing the epidemic and the reality of some Sub-Saharan African countries. It also resembles a fate that escapes personal or overall human control, as exemplified by headlines such as: Russische roulette in Afrika/ Russian roulette in Africa (Trouw, 16 June 2010). HIV/AIDS is frequently mentioned as one of the negative attributes of a continent in despair. The victimisation was common to the whole region but in this specific period one country deserved more media coverage than the others. South Africa appeared more often in the news due to the presence of journalists covering the Football World Cup (in June and July 2010). The news angle for the reported stories from South Africa remained nevertheless aligned with the news referring to other Sub-Saharan African countries.

The figures of people living with HIV in African countries are usually the first sign that indicates the severity of the problem. HIV/AIDS is omnipresent and overwhelming. The figures come mostly from the yearly UNAIDS epidemiological report but some unaccounted epidemiological interpretations usually claimed by interviewees are also encountered such as the following citations:

> *Daar zag ik met eigen ogen hoe de samenleving verscheurd is door aids. We werkten met kinderen in sloppenwijken. Ontzaglijk veel weeskinderen leven er op straat. Tachtig procent van de kinderen heeft aids.* (Reformatorisch Dagblad, 9 October 2010) [I saw with my own eyes how

society is torn by AIDS. We worked with children in slums. Huge number of orphans living on the streets. Eighty percent of the children have AIDS.]

In Afrika is aids de belangrijkste oorzaak van moedersterfte. In sommige regio's is 50 procent van de jonge meisjes geïnfecteerd. (de Volkskrant, 26 July 2010) [In Africa, AIDS is the leading cause of maternal mortality. In some regions 50 percent of the young girls are infected.]

Figures are also used to demonstrate the consequences of the cuts on financial spending on international development programmes. The scarcity in the allocation of funds to HIV/AIDS programmes results in more victims, increases in the number of people with HIV, decreases the number of people with access to treatment and results, overall, in more 'AIDS victims' in an already very fragile continent. The following example portrays this continuing debate triangulation (less funds - more victims - escalated suffering continent).

Als de bijdrage aan het Global Fund met twintig procent afneemt zullen per jaar dus zo'n 100.000 mensen geen toegang meer hebben tot aidsremmers. Voor hen wordt de gemakkelijke korting van CDA, VVD en PVV hier dan een zware doodstrijd daar. (NRC.NEXT, 20 October 2010) [If the contribution to the Global Fund decreases by twenty percent, about 100,000 people will no longer have access to AIDS treatment. For them the easy reduction of CDA, VVD and PVV here becomes a severe agony there.]

HIV/AIDS is specially related to groups of vulnerable women, children (more frequently orphaned, living in slums or in the streets) and young people. Particularly relating to the last group, an amply publicised study conducted in several Sub-Saharan African countries, revealed that the number of infections is dropping among young people because they are using more condoms and having less sex.

Het aantal AIDS-patiënten in Afrikaanse landen is aanzienlijk gedaald doordat jongeren de afgelopen jaren minder sekspartners hebben, pas later met seks beginnen en vaker aan veilige seks doen. (De Telegraaf, 14 July 2010) [The number of AIDS patients in African countries has fallen significantly in recent years because people have fewer sex partners, start having sex later and have more often safe sex.]

In some accounts it was also mentioned that abstinence is becoming more established among young people through the establishment of Church groups or other non-religious youth groups that advocate abstinence until marriage. The phenomenon was called a "prevention revolution" and it constituted one of the rare examples where the epidemic was framed in a more positive light:

Het percentage jongeren met hiv neemt af in vijftien landen in Afrika bezuiden de Sahara, de regio die het zwaarst is getroffen door AIDS. (NRC.NEXT, 15 July 2010) [The percentage of young people with HIV is declining in fifteen countries in sub-Saharan Africa, the region most affected by AIDS.]

Another study, also related to prevention, that attracted some attention indicated that paying young women to have safe sex works:

(…) daaruit blijkt dat Afrikaanse meisjes en jonge vrouwen die maandelijks geld krijgen, minder en veiliger seks hebben, waardoor de kans op hiv en andere seksueel overdraagbare infecties fors

> vermindert. *(de Volkskrant, 24 July 2010)* [(…) It shows that African girls and young women who receive a monthly fee, have fewer and safer sex, leading to a significantly reduced risk of HIV and other sexually transmitted infections.]

Although sub-intended, the idea that the 'AIDS problem' in Africa is related to promiscuity and the absence of sexual safe practices comes forward.

Frame#2: people with HIV are patients

People with HIV are framed as patients, implying a constant state of illness. *Hiv-patiënten* (HIV patients) is the most common expression found in the news. Other expressions that emphasise the virus or the positive result of the test and disregard the person are also often highlighted: HIV-infected (*hiv-geïnfecteerden, hiv-besmet*), HIV-positive (*hiv-positief),* seropositive (*seropositief)* and seropositive patients *(seropositieve patiënten*). Although used to describe people with HIV, the term 'aids patients' (*aidspatiënten)* is often used. Other even less empowering expressions are also found: aids victims (aidsslachtoffers), virus carriers (*dragers van het virus*), and people suffering from aids (*mensen die lijden aan aids*). The more factual and non-judgmental expression: 'people with HIV' (*mensen met hiv*) was also found although it is far from being predominant. The association of particular groups 'with HIV' is also recurrent (pregnant women with HIV, homosexual men with HIV, children with HIV).

People with HIV do not participate in the construction of the HIV/AIDS meaning. There is a certain triangulation in the communication process. Journalists mention the experiences and challenges of people with HIV through the testimonies of researchers, development workers, NGOs' spokespeople, and physicians or through epidemiological reports. People that are usually given a voice confirm the stereotype of the victimized person with HIV and are very often fragile because of their overall social and economic vulnerability. Other interviewees confirm the behaviour assumptions of particular 'risk groups' such as homosexual men that acknowledge their many sexual partners with whom they had unprotected sex before they were tested positive.

The experiences of people with HIV are reported with a victimisation angle. In part this is due to the prevalent frame of HIV as being one of the important features of a victimised and helpless continent. Therefore, in the Sub-Saharan African context, no examples are found of people that were tested positive for HIV and run their lives normally. The cuts on financial spending threaten these people's access to the treatment; an antiretroviral vaginal gel that could help vulnerable women protect themselves against infection results inefficient; people *suffer* because of HIV or AIDS; children (whose parents died because of AIDS) *survive;* women got infected through rape – people with HIV are

always poor, powerless and have no control over their lives. Victims cannot do anything about their situation, people with HIV can. The stories of the people that do not suffer because of HIV or AIDS are absent.

In the Netherlands, the life of a person with HIV is associated with the life of a patient, implying a constant state of illness which can be misleading and demoralising. People with HIV are patients in the clinical setting where they are routinely checked and/or participate in scientific research. They are nonetheless still patients outside the medical context, as they are mostly often referred in that way.

Frame #3: a problem in continuous need for money

HIV/AIDS is defined as a public health issue in constant need for money and going through a serious funding crisis. Most of the debate rotates around donations, grants, subsidies and charity actions (such as festivals, parties, auctions or gala dinners to raise money). Within these contexts HIV/AIDS becomes a reality that needs to disappear, to be fought and drastically reduced , should the financial means be promptly available. No money, no fight – seems to be the trend. The explanations are usually left abstract and martial: lack of money jeopardises the fight against AIDS. More explicit scenarios are also pointed out: people in Sub-Saharan Africa can be left without access to treatment, further research will be on hold, treatment will no longer be affordable or the growing in the number of people waiting for treatment. Lack of political will is often stressed:

> *Wetenschappers constateren echter dat er sprake lijkt van een afnemende politieke wil om AIDS te bestrijden. Zo wordt minder geld vrijgemaakt voor onderzoek. (de Volkskrant, 24 July 2010)* [Scientists note however that there seems to be a declining political will to fight AIDS. Less money is being made available for research.]

But it is specially the world financial crisis that is mentioned as the main cause for this funding decline. Developing nations are directly affected by this situation: due to the crisis, richer nations are giving less to poorer nations.

> *(…) maar onder invloed van de economische crisis geven rijke landen veel minder geld uit aan de bestrijding van hiv en AIDS. (Trouw, 17 July 2010)* [(…) Under de influence of the economic crisis, rich countries are giving less money to the fight against HIV and AIDS.]

When it comes to identifying specific groups that will be affected by this fund shortage the more vulnerable (and 'innocent') come forward (e.g. schoolchildren, orphans, babies and their mothers, girls forced to become sex workers). In some rare exceptions, the debate becomes more complex and detailed, when experts, advocates and critics are interviewed. The following examples show how the consequences of fund shortage can be explained in more analytical and detailed terms.

> *Alves spreekt namens Health Action International, een non-profitorganisatie die ijvert voor betere beschikbaarheid van medicijnen in arme landen. ,,In sommige landen worden patiënten resistent voor bestaande, betaalbaar geworden medicijnen. Zij hebben nieuwe medicijnen nodig. Er blijft beleid nodig om die betaalbaar en beschikbaar te maken."* (NRC.NEXT, 26 July 2010) [Alves speaking on behalf of Health Action International, a non-profit organisation that fights for better access to medicines in poor countries. "In some countries, patients become resistant to existing affordable drugs. They need new drugs. There is an ongoing need for policies that can make these drugs affordable and available."]

And, in the same article:

> *Hoogleraar Joep Lange onderkent het dilemma. Hij ziet wel onbedoeld voordeel in de financiële krapte: hulporganisaties worden gedwongen naar hun eigen functioneren te kijken. Het Global Fund tegen AIDS, tuberculose en malaria ontvangt nu minder donorbijdragen, maar betaalt nog wel mee aan hiv/AIDSbestrijding in opkomende economieën als Brazilië en China. Lange: ,,Waarom kan China wel de Amerikaanse staatsschuld financieren maar niet zelf betalen voor programma's tegen hiv/AIDS?"* (NRC.NEXT, 26 July 2010) [Professor Joep Lange acknowledges the dilemma. He sees unintended benefit with the financial constraints: relief agencies are forced to look to their own performance. The Global Fund against AIDS, tuberculosis and malaria is now receiving less donor contributions, but it still pays the fight against HIV/AIDS in emerging economies like Brazil and China. Lange: 'Why can China finance the U.S. debt but does not pay for its own HIV/AIDS programs?"]

In the Netherlands, fund-raising and the impact of the financial crisis in development aid programmes are the main areas that frame the discussion around HIV/AIDS. School events, festivals, dinners or the national lottery are reported to gather money for HIV response projects. The Dutch Government, on the other hand is reported to cut drastically on the funds available for HIV/AIDS projects.

Frame #4: there is a war going on

HIV/AIDS is both framed in factual and militaristic ways. The latter seems to prevail, however.
In many of the analysed articles, AIDS often correctly refers to the range of conditions (syndrome) that occur when a person's immune system is seriously weakened by the HIV infection. HIV is also used when someone or certain key populations have antibodies to the virus but may not have developed any of the illnesses that constitute AIDS. HIV has been correctly used when referring to HIV (e.g. a person with HIV when he/she has been tested positive for HIV). AIDS has been used when referring to AIDS; and HIV/AIDS (when referring to both) have been used when referring to HIV/AIDS. Terms like 'HIV epidemic' (referring to a large number of people living with HIV) and 'AIDS epidemic' (referring to a large number of people living with AIDS) have also been appropriately used. The term 'HIV test' referring to the test that determines the presence of HIV antibodies in the blood was also correctly used.

In most of the analysed articles however, HIV and AIDS are used interchangeably (e. g. AIDS virus, AIDS test or AIDS infected pregnant women). More often than not, it is AIDS that prevails to refer to the virus. Despite the good prospects that ARV medication brings, HIV is very often referred to as 'HIV, the virus that causes AIDS'. HIV/AIDS is recurrently associated with danger and metaphorically framed as a war. Many protective measures, fund-raising events, medication and assistance programmes are conducted *against HIV/AIDS*.

The war metaphor is a constant resource to indicate the severity of the condition. Different militaristic terms (e.g. struggle, battle, fight, campaign) are used to refer to the response to HIV and AIDS. It is very recurrent to encounter the phrase *battles against HIV* or *AIDS*. And within the battles, fighters are important participants (e.g. 'AIDS-fighters' referring either to activists or HIV-specialised researchers). The emotions attached to a war are also described: AIDS anxiety, AIDS drama and AIDS misery. HIV/AIDS is also called the *AIDS ghost* or the *AIDS bomb*, to highlight the severity and hopelessness of the phenomenon.

Frame #5: a stigmatised condition

HIV/AIDS is framed in the press as a stigmatised condition. Stigma is an acknowledged societal problem in the press although its sources and mechanisms are very rarely pointed out or explained; it is mostly acknowledged as a problem with no further explanations. It is also commonly referred that HIV is still a taboo and an overall denied condition mainly because of its association with sex. Some of the interviewees refer that stigma against people with the infection has to stop or to be fought. Again, most of the debate is metaphorically framed as a war, with fighters, enemies and victims. Here, stigma itself becomes an attribute to be fought and not the illness. People with HIV are the victims (and they are apparently not involved in the fight) and everyone else seems to assume the role of the combatant. Some extreme manifestations are described: people that have been discriminated, blamed, prosecuted, repatriated and isolated, all because of their positive status for HIV. It is also latent that societies that allow the extreme stigmatising situations are to blame.

According to the data, stigma is a phenomenon that happens in poor countries. The only exception that situates stigmatising situations in Europe within the sample was the case of the German singer taken to court because she had concealed her HIV positive status to her sexual partners. In a reaction to the very factual news about this particular case, the director of the AIDS Fonds, in an opinion article, stresses that both partners are responsible for having safe sex and disapproves the lack of criticism by the Dutch press, as the following quotation confirms:

> *Het is jammer dat de Nederlandse pers de berichten klakkeloos overnam. Seksueel gedrag van mensen met hiv is geen zaak voor de rechter. In Nederland weten we dat al sinds 2004.* (Trouw, 25 August 2010) [It is unfortunate that the Dutch press takes over the messages gratuitously. The sexual behaviour of people with HIV is not a matter for courts. In the Netherlands we know that since 2004.]

Particular events also take place in Europe or in the Netherlands like the World AIDS Day (December 1st) that is commonly referred to as a day of solidarity towards people with HIV, when one minute of silence is dedicated to those who perished because of AIDS. The messages attached to these 'awareness events' tends to be rather abstract or rather like a slogan, a simple rhetorical expression which is often repeated leaving little room for detail.

Some concrete examples of ways to overcome stigma were encountered. The described actions show how empathy and acceptance can be achieved. These were also examples drawn from abroad: a Sesame street puppet that has HIV in Nigeria created in order to foster empathy among the programme's audience for those living with the same condition; an educational package targeted at Sub-Saharan Africa that pretends to demystify stereotypes connected with people with HIV; a pastor in South Africa that claims in his services that the body of Christ also has HIV and talks about pastors who are themselves positive for HIV; Dutch princess Mabel that acknowledged to have been tested for HIV in South Africa in order to break the taboo and promote HIV testing in that country; South African president Jacob Zuma who also publicly acknowledged having taken the HIV test.

Frame #6: a medical and scientific matter

Part of the debate around HIV/AIDS is related either to research or the medical domain. A great part of the news discusses the new findings about controlling (through antiretroviral medication) and eliminating the virus (through possible research advances to create a vaccine). The debate is mostly centred in the virus itself (and the topics around it), scientists and patients.

When research was conducted in countries with higher prevalence rates (mostly in Sub-Saharan Africa), the 'general population' is mentioned as study participants (as opposed to patients). At this level, two major studies deserved most of the media attention. The first one was a vaginal antiretroviral gel tested among sexually active women in South Africa, Tanzania, Uganda and Zambia that yielded disappointing results. The second was a behavioural study conducted in Tanzania that paid study participants to practice safe sex. It yielded quite considerable media attention and fast conclusions like this headline shows:

*Betalen voor veilige seks kan hiv voorkomen. Achtergrond AIDSbestrijding in Afrika (*de Volkskrant, 24 July 2010) [Payment for safe sex can prevent HIV. Background HIV/AIDS fight in Africa.]

Frame #7: in the Netherlands: a gay issue

An explanation about HIV/AIDS or its epidemiology begins with a group attribution. HIV/AIDS is thus overall framed as a group issue. Often, explanations about the virus or its prevalence begin with a description of key populations where the infection is taken as most predominant. When the news stories are focused in the Netherlands, the emphasis on groups (particularly 'risk groups') is also commonplace. The following factual information that characterises the Dutch epidemiological situation is recurrent:

> *In Nederland komt hiv voor onder alle bevolkingsgroepen maar het vaakst bij mannen die seks hebben met andere mannen. En hiv komt relatief meer voor onder mensen die afkomstig zijn uit landen waar hiv vaker voorkomt of mensen die seksuele partners hebben (gehad) die afkomstig zijn uit landen met een grote epidemie.* (De Telegraaf, 5 October 2010) [In the Netherlands HIV is present among all population groups but most often in men who have sex with other men. And HIV is relatively more common among people originating from countries where HIV is more common or who have (or had) partners originating from countries with a large epidemic.]

The characterisation of HIV/AIDS is presented in the figures from epidemiological reports by the National Institute for Public Health and the Environment (RIVM), SOA AIDS Nederland and the HIV Monitoring Foundation (SHM). The situation is usually described in a factual way, by presenting the numbers of the general population living with the virus and/or the number of people living with HIV within specific groups (based on sex differences, geographical origins or sex preferences). Following the information in the reports, HIV is mostly present among homosexual men.

In 2010, an 'alarm' around HIV/Aids was triggered by the SHM. The number of people living with HIV in the Netherlands was greater than the number of people with the virus in the beginning of the epidemic, the foundation's report stressed. And about 70% of the new 'HIV patients' were homosexual men. The following quotations illustrate the concern caused by the report:

> *De Stichting HIV Monitoring (SHM) kwam deze week met onrustbarende cijfers over het aantal hiv-geïnfecteerden in Nederland. De SHM spreekt van bijna 1.200 nieuwe hiv-patiënten. Dat aantal is ,,groter dan bij de start van de epidemie aan het begin van de jaren tachtig", stelt het rapport. Van die 1.200 besmette patiënten zijn 850 homoseksuele mannen.* (NRC.NEXT, 26 November 2010) [This week the HIV Monitoring Foundation (SHM) came with alarming figures on the number of HIV infected in the Netherlands. SHM speaks of the nearly 1200 new HIV patients. That number is "greater than at the start of the epidemic in the early eighties", the report said. Of the 1200 patients infected 850 homosexual men.]

> *Het aantal homo's dat besmet raakt met het aidsvirus is groter dan ooit. Het afgelopen jaar raakten 850 homo's geïnfecteerd met hiv, dat aids veroorzaakt. Dat is meer dan aan het begin van de hiv-epidemie in de jaren tachtig, toen het aantal besmettingen opliep tot 800 per jaar.* (de Volkskrant, 23 November 2010) [That the number of gay men infected with HIV is greater than

> ever. During the past year 850 homosexual men were infected with HIV, which causes AIDS. That is more than at the beginning of the HIV epidemic in the eighties, when the number rose to 800 infections per year.]

All different news articles went after these findings: most new infections (or most 'HIV patients') are men that have sex with men, creating moralistic article titles like:

- NONCHALANCE rond AIDS groeit (De Telegraaf, 21 December 2010) [Nonchalance about AIDS grows];
- Zonder is lekkerder (NRC.NEXT, 26 November 2010) [Without is tastier];
- Veel nieuwe hiv-infecties onder homos (Reformatorisch Dagblad, 22 November 2010) [Many new HIV infections among gays].

According to the SHM report, out of the new 1200 patients with HIV in Netherlands, 850 were men that have sex with men. This information was interpreted in the SHM report and then multiplied in the press as an increase never seen before, even greater than what had been registered in the early years of the epidemic. Of the new infections, 70% was found in a very specific group: homosexual men. What is omitted is that the SHM, the Dutch organism that monitors HIV infection in the Netherlands, collects its data from 25 HIV treatment centres and 4 paediatric centres in the country and one HIV treatment centre in Curaçao (SHM, 2010). Thus, the SHM looks at patients' registries, computer records of people that have been tested positive for HIV and that get enrolled in the Dutch HIV treatment centres. There can be then one or more confounding factors: homosexual men can be more aware of their risk of infection and get more (or more often) tested than other people. Or they can seek treatment more promptly than others (it can be that they have less self-stigma) and enrol sooner and in greater proportions in HIV clinics.

The only exception that clarifies the way HIV/Aids data is collected and reported in the Netherlands is the following:

> *Volgens de meest recente cijfers van het Rijksinstituut voor Volksgezondheid en Milieu (RIVM) daalde zowel het aantal als het percentage positieve hiv-testen in Nederland licht in 2009. Dat verschil is te verklaren door de andere bronnen die de SHM en het RIVM gebruiken. De SHM krijgt cijfers van alle hiv-behandelklinieken in Nederland, terwijl het RIVM gegevens van alle soa-klinieken gebruikt.* (NRC.NEXT, 26 November 2010) [According to the latest figures from the National Institute for Health and Environment (RIVM) both the number and percentage of positive HIV tests in the Netherlands slightly decreased in 2009. This difference can be explained by other sources being used by the SHM and the RIVM. The SHM receives data of all HIV treatment clinics in the Netherlands, while the RIVM uses data of all STD clinics.]

Who is getting tested in the Netherlands? – Is an important question that is being omitted in Dutch HIV/AIDS reporting.

It is quite clear from the analysed articles that the chosen approach to communicate about HIV is in most cases primarily defined in reports of the organisations responsible for the response to the

epidemic, such as the UN, UNAIDS, CDC or *SOA AIDS Nederland*. However, the distance between the focus on certain groups (instead of risk behaviours) and the group stereotyping seems quite narrow. The following passages exemplify this assertion:

> *Polygamie, prostitutie en verkrachting maken de bestrijding van AIDS in Afrika tot een groot probleem.* (de Volkskrant, 11 November 2010) [Polygamy, prostitution and rape make fighting AIDS in Africa a big problem.]
>
> *Veel hiv-patiënten - homo's, Afrikanen, maar ook mannen en vrouwen die per ongeluk de verkeerde vriend of vriendin tegen het lijf zijn gelopen, zoals de Libanees - zetten het alarm van hun telefoon om de inname niet te vergeten*. (de Volkskrant, 22 May 2010) [Many HIV patients - gay men, Africans, but also men and women who met the wrong friend accidently, like the Lebanese - set the alarm of their phone not to forget medication intake.]
>
> In Haïti is de ziekte meer en meer een vrouwenziekte geworden, die overdragen wordt via heteroseksuele contacten. Iets meer dan de helft van de met hiv besmette personen is vrouw (53 procent). (Reformatorisch Dagblad, 23 June 2010) [In Haiti, the disease has more and more become a disease of women, which is transferred through heterosexual contact. Slightly more than half of HIV infected people are women (53 percent).]

In these quotations, group attribution allows the association with moralising terms like 'promiscuity', fuels the idea that polygamy involves necessarily risk, indicates that the HIV infection is mostly present in certain 'wrong groups' and that women are somehow to blame because it is mostly among them that the infection is to be found.

Frame# 8: a chronic condition in the Western World

In many accounts situated within the Western context, HIV is framed as a chronic condition (most often compared to diabetes), easier to deal and live with especially since the appearance of the HAART. Emphasis is put on the advantages of treatment, mainly as the life-prolonging factor for those with the virus and also as a way to prevent further infections – treatment lowers the viral load in the blood and therefore the possibility of infection of a negative person through sexual contact is very small. Because of the WHO's declarations that if more people were given access to treatment at an earlier stage of their infection, the number of people with HIV could diminish by 20%, HAART was often associated with a prevention strategy. The knowledge the scientific community has significantly acquired since the early years of the epidemic and the efforts that demonstrate that more control for the infection is in people's reach (like the trials of a vaginal gel containing an antiretroviral substance) were also amply reported. All these aspects can convey a certain 'normalisation' of the infection and it is no longer seen as a deadly disease.

2. The missing frames

a) HIV transmission

An absent topic in the HIV/AIDS discourse in the press refers to the contagiousness of the virus, one of the stigma sources that fuels stigma about the condition. Very few references have been found to individual behaviours that can both lead to infection and or that do not represent any risk of infection. It is rarely referred that unprotected sex can lead to the risk of getting HIV. Exceptional examples of references to contagiousness include: a kidney patient that got HIV after receiving a transplant from a donor with the virus, women in Uganda that got HIV after being raped, porn actors in California that do not use condoms and the German HIV-positive singer taken to court because she had unprotected sex without disclosing to her partners. An exceptional example is an article authored by *AIDS SOA Infolijn* that answers the query of a reader about the way HIV can be transmitted:

> *Risico op hiv bestaat bij: 1. Vaginale of anale seks zonder condoom, 2. Orale seks waarbij er sperma of (menstruatie)bloed in de mond komt. Hiv wordt niet overgedragen door insecten zoals muggen of vlooien. In tegenstelling tot bijvoorbeeld malaria kan hiv zich niet in een mug nestelen. Ook via glazen, bestek of wc-brillen kun je geen hiv oplopen.* (De Telegraaf, 5 October 2010) [Risk of HIV consists of: 1. Vaginal or anal sex without condoms, 2. Oral sex in which sperm or (menstrual) blood comes into the mouth. HIV is not transmitted by insects such as mosquitoes or fleas. In contrast to malaria, HIV cannot be carried by the mosquito. HIV cannot be contracted through glasses, cutlery and toilet seats.]

b) HIV-testing

HIV testing is an almost absent topic in the news coverage about the epidemic. The increase of HIV tests accompanied by the decrease of positive results as reported by the RIVM is referred now and again, generally accompanying the figures of the people living with HIV in the Netherlands. The focus is therefore on positive tests and HIV patients. 'Aids test' is still a term occasionally used. Exceptional examples of references to testing include: the possibility of getting an HIV test for free in Nijmegen, testing for HIV and other STIs as a way of replacing safe sex practices, HIV testing made compulsory among couples that want to get married in Chechnya, positive HIV test as the fastest way to being deported from Syria and voluntary testing among detainees in East Europe.

c) Individual stories

Very few personal stories are represented in the analysed articles. In the very few exceptions, individuals are given voice or mentioned when they represent a special situation or to illustrate the vulnerability of certain groups. Regarding the findings that young people in some African countries are having less partners and practicing safe sex more, only in one of the several articles a young man that stated his options was interviewed, and these were aligned with the findings of the reported

study. In the Sub-Saharan African context, the stories of poor and powerless women are the most reported. The only more positively framed account of an African living with HIV that could overcome the stigma surrounding it and go on with his life, relates to the story of a Tanzanian church pastor:

> *In 2004 hoorde de pastor van een organisatie van religieuze leiders met hiv/AIDS. Toen besloot hij openlijk voor zijn status uit te komen. Het stigma is nog altijd groot, maar ik wil mensen sterk aanmoedigen zich te laten testen. Ook geestelijken.* (Reformatorisch Dagblad, 1 December 2010) [In 2004, the pastor heard of an organization of religious leaders living with HIV / AIDS. Then he decided to disclose. The stigma is still great, but I would strongly encourage people to be tested. Also the clergy.]

In the rest of the World, the individual stories of people living with HIV refer to cases where stigma and discrimination were experienced, like in Syria. In an article of 749 words, the only more positive experience accounted is the following:

> *Onlangs is hij begonnen zijn medicijnen in te nemen, zegt hij, en hij hoopt dat de samenleving hem nu de kans geeft om een normaal leven te leiden. ,,Werken, waardig leven en sterven wanneer het mijn tijd is."* (Trouw, 4 May 2010) [He has recently begun to take medication, he says, and he hopes that society now gives him the chance to live a normal life. “Working, dignity and to die when my time comes."]

In the Western World, the exceptions are mostly brought to the individual level, like the American kidney patient who got HIV after a transplant and the German singer with HIV taken to court. The particular cases of celebrities that are involved in advocacy actions and take the topic at an individual level are limited to Carla Bruni-Sarkozy (and the reference to her brother that died because he had AIDS) and Dutch princess Mabel who announced having done the test for HIV in South Africa to encourage HIV testing in this country. As for people living with HIV, specifically in the Netherlands, one Lebanese man was interviewed at an Amsterdam academic hospital and he shared the difficulties he has with his treatment.

Other examples of testimonies are of gay men living with HIV who specially talk about the time they got infected and their current sexual life. The following three quotations illustrate how certain stereotypical behaviours of a group (men that have sex with men) are stressed. Their testimonies validate the stereotype. The journalist has deliberately chosen men that engage in unprotected sex and/or have multiple partners.

> *Robin (27) krijgt die vraag geregeld, of hij seks wil zonder condoom. Hij gaat met ongeveer twintig mannen per half jaar naar bed. ,,Sommigen vinden dat veel, anderen vinden het weinig", zegt hij. Bijna vijf jaar geleden liep hij hiv op, en dus houdt hij het nu bij veilige seks ,,Al verandert het de zaken wel als de ander ook hiv heeft."* (NRC.NEXT, 26 November 2010) [Robin (27) gets that question regularly, whether he wants sex without a condom. He has sex with about twenty men per half year. ,, Some think that’s many, others find it little", he says. Nearly five years ago, he got HIV, and so he sticks to safe sex. ,,Everything changes a bit when the other also has HIV”].

Lagerwaard (45) liep in de jaren tachtig hiv op tijdens een vakantie in Griekenland. Hij heeft sinds 1996 AIDS. Hij is sterk vermagerd en loopt moeilijk door een zenuwziekte in zijn voeten. (de Volkskrant, 23 November 2010) [Lagerwaard (45) contracted HIV in the eighties during a holiday in Greece. He has AIDS since 1996. He is very thin and walks with difficulty due to a nerve disease in his feet.]

Wouter Pietersen (35) liep het AIDS-virus op na één keer onveilige seks, tijdens een one night stand acht jaar geleden. Hij liet zich niet testen, maar kwam er een half jaar geleden 'per ongeluk' achter, na een algemeen bloedonderzoek bij zijn huisarts. (de Volkskrant, 23 November 2010) [Wouter Pietersen (35) got the AIDS-virus after having unprotected sex once, during a one night stand eight years ago. He was not tested, but found it out "accidentally" about half year ago after a common blood test requested by his general practitioner.]

The only positively framed personal story of a person living with HIV appears in a long article about the Dutch writer and art collector, Han Nefkens (Trouw, 30 October 2010). A part of this article talks about his life and work. One section of the article refers his experience with HIV because he tested positive for this virus and has written two books about his experience. HIV is thus referred to and explored by the journalist as one of Nefkens' many characteristics. At the end of the long article (2886 words), a summary of his biography is presented where the fact that he is positive for HIV is simply omitted, conveying the impression that there are more important aspects to mentioned than an infection he has tested positive for.

VI. Conclusion and discussion

This report presents the results of an in-depth qualitative content analysis of the seven largest circulating newspapers in the Netherlands (i. e., *De Volkskrant*, *Trouw, NRC Handelsblad, De Telegraaf*, *Reformatorish Dagblad, NRC Next* and *Algemeen Dagblad)* covering the period between May 2010 and April 2011. The aim of the study was to examine the representation of HIV/AIDS in the Dutch written media and explore whether it encompassed a discourse of stigma enforcement or empathy building. Theory on media frames, meaning and social construction, HIV-related stigma and empathy provided a framework to this research (chapter II), guided data analysis (the results of which are presented in chapter V) and were the basis for its discussion (current chapter).

This study specifically focused on the way HIV/AIDS was framed at the public/societal, group and/or individual levels. Additionally, the way the following aspects were framed was also considered during data analysis: HIV/AIDS itself, people with HIV, the epidemic's seriousness and/or normalisation, HIV test and HIV transmission. The identified frames during data analysis allowed the answer to the study's research question: *Are the Dutch media adopting a discourse, when reporting on HIV/AIDS, that widens the gap between 'us' and 'them' (leading to stigmatisation) or one that contributes to the 'self-other overlap' (leading to empathy)?*

Study limitations

This study is time-limited to 12 months which may present a bias as certain frames may be more prominent in the period under analysis. Data analysis was based on literature. The analysis pointed possible effects of the identified media frames based on empirical findings. An additional study measuring the occurrence of effects on the audience could eventually complement the current analysis.

1. Conclusion

Data analysis revealed eight prevalent frames regarding HIV/AIDS: (1) HIV/AIDS is the distinguishing mark of the victimised and helpless Sub-Saharan region; (2) people with HIV were framed as patients; (3) HIV/AIDS is a problem in continuous need for money; (4) there is a war going on; (5) it is a stigmatised condition; (6) it is a medical and scientific matter; (7) In the Netherlands: it is a gay issue; and lastly,(8) it is a chronic condition in the Western World. The analysis showed that three important frames that contribute to the HIV/AIDS definition were missing: HIV transmission, HIV test and the individual level (relating to personal stories).

Among the frames that became salient during data analysis and its interpretation in the light of a comprehensive theoretical framework, it was evident that stigma is more embedded than empathy in the way HIV/AIDS was reported. The attention in the press is being directed away from topics that could have a positive impact on HIV response (like HIV testing). It concentrates instead on issues that mainly serve the interests of fundraising. The press does not overtly discriminate but follows the predictable pattern of news selection based on the frames familiar to the readers, which are mostly supported by stereotypical reasoning. Assuming that press frames are aligned with the frames of its readers, the construction process of the stigmatised meaning of HIV/AIDS is mostly invisible.

2. Discussion

What follows is an interpretation of the results in light of frames, stigma and empathy theories, hoping to contribute to a wider picture of the construction of the HIV/AIDS meaning in the Dutch press.

2.1 Interpreting the results through theory on frames and construction of meaning

The way media influences social construction of reality, particularly in the Western culture, has been thoroughly discussed in chapter II of this report. The meaning of HIV/AIDS in particular and the way it is constructed in the media has been subject of extensive attention mainly in the early years of the epidemic. It was then a fascinating new topic for social scientists because of its association with controversial issues like homosexuality, illicit drug use and/or imminent death (Lupton, 1999a). The development of more effective medications in the late 1990s transformed the deadly disease into a chronic condition, mostly in industrialised countries that could easily provide the treatment to those in care. Panic but also public interest waned, which was manifest in the frequency the media reported on HIV/AIDS. Lupton (2003) argued that this phenomenon could be interpreted as 'the end of AIDS' which would be unrealistic considering the number of people that still live with HIV. News occurrence on HIV/AIDS has decreased in the Western World but one would expect that the way the meaning about the current normality of the condition would be reflected in the media discourse. Analysing HIV/AIDS discourse in the press and looking at its salient frames in countries that responded promptly to the epidemic and provided immediate care and support to those directly affected, like the Netherlands (Sandfort, 1998), seemed thus pertinent.

Frames are a valuable interpretative context that help us to understand a message (Goffman, 1974). The current study looked at frames present in the text, although in communication processes frames can also be present in the *communicator* (who guided by his/her own frames, organises his/her belief

system) and in the receiver (where frames serve to guide his/her cognition and conclusions) (Entman, 1993). In news production, some aspects of reality become more salient in a text providing frames that contribute to the problem definition, the diagnosis of what causes the problem and moral definitions attached to it (Entman, 1993). In the text, frames are manifested by the presence or absence of certain words, stock phrases, stereotypes, sources of information, and sentences that provide clusters of facts or judgements (Entman, 1993).

Looking at the list of frames that were found salient in the Dutch press during one year of reporting, it is clear that they are closely related and mutually reinforce each other. They are however not aligned with the relevant aspects of primary prevention or support to people with HIV. HIV/AIDS is therefore not framed in the press to serve these goals. The encountered frames point at a different problem definition. The victimisation of those with the virus is undoubtedly dominant in the press (frame #1: HIV/AIDS is the distinguishing mark of the victimised and helpless Sub-Saharan region) bringing an angle to the problem that seems to attend fund-raising interests (frame #3: a problem in continuous need for money). The overall victimisation of the African continent is related to aspects that go beyond the scope of this study. It does however reinforce the image of people in Sub-Saharan Africa as powerless regarding prevention and unable to escape this 'fate' that will bring even more misery to their lives.

The need for money to tackle HIV (mainly to provide treatment to everyone, as it seems to be presented) justifies the use of the war metaphor and its associated expressions (frame #4: there is a war going on). Among the readers, this may trigger a wish to be 'engaged in the fight' which can translate into donations to organisations involved in the HIV response. The money is not only supposed to be allocated to the 'victims in need for treatment' but also to the research, continuously unravelling ways to eliminate the virus (Frame #6: a medical and scientific matter). The aim of this war everyone is engaged in (at least metaphorically) seems to be the end of HIV/AIDS, the wishful vision of 'a world without HIV'. Nevertheless, HIV is something that 33.3 million people in the world live with (UNAIDS, 2010). The boundary between a world without HIV and a world without people that have the virus is a thin one.

In the Western World HIV/AIDS is framed as a chronic condition (frame #8). We believe however that this frame almost loses its salience in comparison to the earlier mentioned frames (as if the other frames are calling off the reason of existence of this frame). HIV/AIDS is acknowledged as a stigmatised condition (frame # 5). We have seen that stigma is very rarely understood or explained in the press. Stigma is an attribute that, like the virus, needs to be fought. In this respect, this frame

distracts the readers and conceals what stigma is really about. By pointing at and criticising examples of discrimination, which occasionally occur, the press takes a moral stand but does not criticise the complex issues around the phenomena.

Lastly, in the Netherlands HIV/AIDS is framed as a condition affecting homosexual men (frame #7), allocating the problem to a specific group of people, and almost liberating the (heterosexual) reader of any involvement with the possibility of having been in contact with the virus and even allowing a scapegoating reaction. This leads to a black-white thinking that HIV can be found mainly among African victims; homosexual men or among those 'who just had bad luck' as it was mentioned in one of the articles (de Volkskrant, 22 May 2010).

In this study, the identified frames are calling 'attention to some aspects of reality while obscuring other elements, which might lead audiences to have different reactions' (Entman, 1993, p. 55). The attention in the press is being directed away from important topics like HIV testing, transmission of HIV or individual stories of people that effectively cope with their chronic condition. One could then argue that the way HIV/AIDS is being reported contradicts an approach that stimulates health promotion behaviours (HIV testing and condom use), understanding and care for those with HIV. It can, in fact, even trigger stigmatisation. Further down, there is a more detailed look into the content of the identified and absent frames and how it can relate to stigmatisation or empathy.

The salient frames in this study are not surprising if one looks to literature on the production of media culture (McQuail, 2010). Frames are not just story topics, attributes or issue positions (Carragee & Roefs, 2004). Frames need to be interpreted in wider social and cultural contexts (Carragee & Roefs, 2004; Van Gorp, 2007). The selection of news follows an 'ideological' influence relating to the 'values and cultural influences which are not purely individual and personal but which stem also from the social (and national) setting of news activity' (McQuail, 2010, p. 310). Routinely, news editors make use of standardisation, stereotypes, routine judgements and disregard subtlety (W. Lippmann, 1922 in McQuail, 2010). The content of news therefore follows a predictable pattern, whereby news decision makers have a perception about what is likely to interest the audience which is in consonance with similar social-cultural settings and explains the limited diversity within the media system as a whole (McQuail, 2010).

Another important aspect that might explain our results relates to the fact that news are selected to fit the audience's expectations (consonance with past news), which can be quickly placed within a familiar frame (Harcup and O'Neill, 2001 in McQuail, 2010). News selection is therefore embedded in

a system that does not privilege alternative news framing, one that would allow more diversity, able to disconfirm the existing stereotypes.

2.2 Interpreting the results through theory on Stigma

Presenting an explanation of the frames that were found salient during data analysis and its contents based on the theories of stigma enhances the understanding of the findings. Overall, the way the press frames HIV/AIDS is more favourable to the enforcement among readers of the perception of 'them', the stereotyped vision of those who have HIV and the people who cannot have a regular life like 'us' (excluded from the possibility of being a member of the affected category), which determines stigmatisation. Additionally, important frames that could demarcate these boundaries (namely regarding transmission, testing and personal stories) were mainly absent in the press.

Stigma has been the object of study of both sociologists and social psychologists. The former concentrates on the structural factors that promote and maintain stigma, and the latter on the cognitive origins of stigma (Parker & Aggleton, 2003). These two angles will be here further explored.

i. Sociological angle

A correlation can be drawn between this stigmatising constructed meaning and the stigma mechanisms as described by the sociologists Link and Phelan (2001). The authors have defined stigma as the co-occurrence of the components – labelling, stereotyping, separation ('us' versus 'them'), status loss, and discrimination. The interplay between these components is strongly guided by the dominant forces in a society, leading to the entrenchment of these mechanisms in the dominant culture, allowing stigmatisation to occur. For the aforementioned authors, the social production of stigma is therefore entirely dependent on social, economic and political power which 'can often be so taken for granted as to seem unproblematic' (Link & Phelan, 2001, p. 375). This process of 'stigma invisibility production' is thus possible because society (or individuals) tend not to question what is supported by structures (or individuals) whose power is overall accepted. Van Gorp (2007) goes further by acknowledging that when this invisible process of social construction occurs, it constitutes a power mechanism in itself.

The Dutch press does not overtly discriminate. It even occasionally denounces stigmatisation and discrimination examples, blaming those who perpetrated it. The press does however maintain and validates what is already embedded in society: the way human differences are recognised, labelled and linked to stereotypes. The process remains thus invisible as the press does not question these

assumptions. It even validates them. And by doing so, it stigmatises and leaves an open door for discrimination to occur.

Following Link and Phelan reasoning, 'HIV/AIDS', 'HIV' or 'AIDS' in the Dutch press can be acknowledged as a label because a certain meaning comes attached to the expression and to the acronyms. This label is in turn linked to particular stereotypes: HIV/AIDS as the distinguishing mark of the victimised and helpless Sub-Saharan region, a person with HIV is essentially a patient and particularly in the Netherlands HIV/AIDS is mainly a 'gay issue'. The way the press primes these stereotypes facilitates cognitive efficiency and automaticity among readers. 'When people are labelled, set apart, and linked to undesirable characteristics, a rationale is constructed for devaluating, rejecting, and excluding them' (Link & Phelan, 2001, p. 371).

The people linked to HIV/AIDS (African victims, patients, homosexual men) – 'them' – are reported as a separate group, different from the others, or the readers – 'us' – excluded from the former categories. Should the readers nevertheless identify with the groups, stigma will most likely not occur. The negatively-labelled people tend nevertheless to be essentially different from those who do not share the same label. We believe that it is at this point of cognition that risk denial or risk acceptance occurs. Those who identify with the stereotyped groups are more likely to seek health promoting behaviours (like using condoms or getting tested for HIV). Those who do not identify with those groups will not easily acknowledge their past or present risk towards HIV infection and will most likely not consider safe sex or HIV testing as necessary. The latter group will also most likely stigmatise. Should they have HIV, chances are that they will only get tested at a later stage of the infection. Late diagnosis together with the fact that they might have internalised stigma (resulting in self-stigma) will in turn interfere with treatment response and adherence.

Additionally, the press frames the response to HIV/AIDS as a war. This metaphor motivates strong reactions against an infection many people live with, automatically devaluating them or those thought to have HIV. The war metaphor is able to implement the interpretation that those with HIV or HIV itself (that everyone is fighting) are the alien 'other' and the 'demonization of the illness to the attribution of fault to the patient is an inevitable one, no matter if patients are thought of as victims' (Sontag, 1991, p. 97).

ii. Social psychological angle

Besides being socially constructed as sociologists such as Link and Phelan (2001) emphasise, stigmatisation is sourced by cognitions, the focus of study for social psychologists. The adapted

model of the sources of stigma from Bos and others (2008) allows a complementary interpretation of the results, although only the measurement of the readers' cognitive reactions to the identified frames could prove the underlying assumptions. According to the authors, stigma is sourced by emotions – fear, pity and anger – which are promoted by the perceived contagiousness and seriousness of HIV/AIDS (in the case of fear); promoted by the perceived seriousness and inhibited by personal responsibility and norm-violating behaviour (in the case of pity); and promoted by personal responsibility and norm-violating behaviour (in the case of anger) (Bos, et al., 2008). I next look to these three emotions – fear, pity and anger – and explore, in the light of the identified (and also missing) frames how these can eventually be disentangled or reinforced.

Firstly, the press frames HIV/AIDS as a chronic condition in the Western World attributing some 'normality' to the infection, which could dissipate fear. This 'normality' is mainly achieved through antiretroviral treatment, responsible for an almost 'normal life' for the people with HIV. People with the condition are nevertheless framed as patients in the press, implying a constant state of illness which is misleading for the readers and demoralising for those with HIV. It can possibly lead to a fearful reaction as most likely not many people enjoy being a patient. Additionally, the dominant frame indicates that HIV/AIDS is indeed a very serious condition afflicting the African continent and almost escaping human control. Moreover, the problem is metaphorically framed as a war that needs to be fought, which only aggravates the severity and danger surrounding HIV and AIDS. Contagiousness or the transmission of HIV are absent frames in the press, leaving room for the maintenance of myths and misconceptions about the virus. The combination of these factors therefore allows fear of HIV or people with the virus to carry on.

Secondly, pity for those with HIV may eventually be maintained because if it is true that overall HIV is portrayed as a serious condition, many readers may not deem people with HIV responsible for their infection or consider that they have engaged in a norm-violating behaviour. The press frames HIV as a group issue and omits individual stories which could trigger the cognition that the infection affects groups and not individuals. Here pity seems to be dependent on the way readers regard these groups.

Finally, by attributing responsibility to specific groups that are already marginalised on other accounts and enforcing the idea that their behaviours go against the norm (e.g. both Africans and homosexual men were implicitly portrayed has having multiple unsafe sexual contacts) anger towards those with HIV (or groups attributed to have HIV) is likely to be fuelled among some readers.

2.3 Interpreting the results through theory on empathy

Although far from being predominant, the way HIV/AIDS was occasionally reported in the press can foster empathy towards people with this condition creating a 'self-other overlap' (Galinsky & Moskowitz, 2000) potentially capable of triggering acceptance and care for people with HIV and increase HIV-related health seeking behaviours. During data analysis, several examples were encountered that could have these desirable effects. Important omissions were also identified that can prevent empathy arousal.

Imagining how one would think and feel in another's situation or 'shoes'- 'imagine-self perspective' is one of the cognitive/perceptual states Batson and Ahmad (2009) identified in an extensive review covering studies on empathy. Taking the perspective of a member of a stigmatised group can result into the generalisation of empathic feelings toward the group as a whole (Batson, et al., 1997). This exercise in perspective taking has been acknowledged as the first step to start developing empathic feelings towards a group member (Batson & Ahmad, 2009). This state would then be followed by the 'imagine-other' perspective (imagining how another person thinks or feels given his/her situation), and by the affective-emotional states of 'emotion matching' (feeling *as* another person feels) and finally by 'empathic concern' (feeling for another person who is in need) (Batson & Ahmad, 2009). If attained, the four empathy psychological states result in a continuum of effects that ranges from the reduced stereotyping and a more positive evaluation of the 'out-group' member in which situation one imagines oneself and the out-group as a whole; to the increased readiness to help the out-group (Batson & Ahmad, 2009).

Arousing empathic feelings can be achieved through media like books, plays, films, documentaries or through radio as some studies suggest (Batson & Ahmad, 2009). The press can therefore be a privileged medium to bring individual stories of those running their lives as everyone else and who additionally cope with the challenges of a virus. When journalists label people with HIV emphasising the person and not the virus or the temporally patient state of the person, imagining how one thinks and feels seems more likely. The personal story of Han Nefkens, a Dutch writer and art collector, illustrates how the experience of living with HIV can be brought up in an interview that tackles many other topics (Trouw, 30 October 2010). Because this man is rich, a Maecenas and an intellectual, his story might however go against the stereotype of the person who 'is supposed to have HIV' as portrayed in the identified media frames of this study. The readers might thus sub-type the individual and this can prevent attitude change towards the stigmatised group (Kunda & Oleson, 1995). Alternatively, since Han Nefkens is homosexual he might immediately be associated with the 'risk group' that HIV in the Netherlands is associated with, confirming the stereotype in this case.

Sub-typing can be prevented if individuals that can disconfirm the stereotype have very different occupations, ages, geographic origins or family backgrounds (Kunda & Oleson, 1995). According to the literature, many individual stories of people from all walks of life (that share the fact that they live with HIV) could enable the 'imagine-self perspective' and consequently reduce stereotyping. These stories are however absent in the Dutch press. The individuals that either are interviewed or are mentioned are usually representative of the vulnerability of certain groups, most often the powerless people of Sub-Saharan Africa and occasionally homosexual men in the Netherlands, whose stories (in particular of the latter) confirm the stereotype of sexual permissiveness associated with this group. In this case, the 'self-other overlap' (Galinsky & Moskowitz, 2000) might be difficult to achieve.

One of the main challenges in the HIV/AIDS response in Europe and also in the Netherlands is the large proportion of people that are unaware of having the virus (Coenen, et al., 2008). Some public health approaches believe the solution lies in 'identifying these individuals' by implementing programmes targeting 'certain groups' although it is acknowledged that the 'number of people in each European country being diagnosed late suggest that testing across the region remains inadequate' (Coenen, et al., 2008, p. 3). Empathy seems difficult to trigger if the focus remains on 'risk groups', the way groups vulnerable to the infection are framed in the press, a consequence of the widespread public health approach. Lupton (1993) argued that definitions of risk may serve to identify the 'self' and the 'other' and allocate blame within stigmatised minorities. *Risk* in modern society has replaced the old-fashioned notion of *sin* and being at risk is the modern day equivalent to sinning (Douglas, 1990 in Lupton, 1993). Not only does this construction contribute to widening of the 'us' and 'them' dimensions as seen earlier, making the 'imagine-self perspective' difficult to achieve but it neglects the focus on important HIV health seeking behaviours such as testing.

VII. References

Airhihenbuwa, C. O., & Obregon, R. (2000). A critical assessment of theories/models used in health communication for HIV/AIDS. *Journal of Health Communication, 5*(SUPPL.), 5-15.

Altheide, D. L. (1996). *Qualitative media analysis*. Thousand Oaks [etc.]: Sage.

Bardhan, N. R. (2002). Accounts from the field: A public relations perspective on global AIDS/HIV. *Journal of Health Communication, 7*(3), 221-244. doi: 10.1080/10810730290088102

Baron-Cohen, S., & Wheelwright, S. (2004). The empathy quotient: An investigation of adults with asperger syndrome or high functioning autism, and normal sex differences. *Journal of Autism and Developmental Disorders, 34*(2), 163-175.

Batson, C. D., & Ahmad, N. Y. (2009). Using Empathy to Improve Intergroup Attitudes and Relations. *Social Issues and Policy Review, 3*(1), 141-177.

Batson, C. D., Early, S., & Salvarani, G. (1997). Perspective taking: Imagining how another feels versus imagining how you would feel. *Personality and Social Psychology Bulletin, 23*(7), 751-758.

Berridge, V. (1992). AIDS: History and contemporary history. In G. Herdt & S. Lindenbaum (Eds.), *The time of AIDS: Social analysis, Theory and Method*. London: Sage.

Bos, A. E. R., Dijker, A. J. M., & Koomen, W. (2007). Sex differences in emotional and behavioral responses to HIV+ individuals' expression of distress. *Psychology and Health, 22*(4), 493-511.

Bos, A. E. R., Kok, G., & Dijker, A. J. (2001). Public reactions to people with HIV/AIDS in the Netherlands. *Aids Education and Prevention, 13*(3), 219-228.

Bos, A. E. R., Schaalma, H. P., & Pryor, J. B. (2008). Reducing AIDS-related stigma in developing countries: The importance of theory- and evidence-based interventions. *Psychology, Health and Medicine, 13*(4), 450-460.

Brooks, R. A., Etzel, M. A., Hinojos, E., Henry, C. L., & Perez, M. (2005). Preventing HIV among Latino and African American gay and bisexual men in a context of HIV-related stigma, discrimination, and homophobia: Perspectives of providers. *AIDS Patient Care and STDs, 19*(11), 737-744.

Brown, L., Macintyre, K., & Trujillo, L. (2003). Interventions to reduce HIV/AIDS stigma: What have we learned? *AIDS Education and Prevention, 15*(1), 49-69.

Buseh, A. G., & Stevens, P. E. (2006). Constrained but not determined by stigma: Resistance by African American women living with HIV. *Women and Health, 44*(3), 1-18.

Cahill, S. P., & Foa, E. B. (2005). Anxiety Disorders: Cognitive-Behavioral Therapy. In Kaplan & Sadock (Eds.), *Comprehensive Textbook of Psychiatry, eighth edition* (Vol. One, pp. 1788-1799). Philadelphia: Lippincott Williams & Wilkins.

Carragee, K. M., & Roefs, W. (2004). The neglect of power in recent framing research. *Journal of Communication, 54*(2), 214-233. doi: 10.1093/joc/54.2.214

Chesney, M. A., & Smith, A. W. (1999). Critical delays in HIV testing and care: The potential role of stigma. *American Behavioral Scientist*(7), 1162-1174.

Clarke, J. N., McLellan, L., & Hoffman-Goetz, L. (2006). The portrayal of HIV/AIDS in two popular African American magazines. *Journal of Health Communication, 11*(5), 495-507.

Coenen, T., Lundgren, J., Lazarus, J. V., & Matic, S. (2008). Optimal HIV testing and earlier care: The way forward in Europe. *HIV Medicine, 9*(SUPPL. 2), 1-5.

Coke, J. S., Batson, C. D., & McDavis, K. (1978). Empathic mediation of helping: A two-stage model. *Journal of Personality and Social Psychology, 36*(7), 752-766. doi: 10.1037//0022-3514.36.7.752

Commers, M. J., Visser, G., & De Leeuw, E. (2000). Representations of preconditions for and determinants of health in the Dutch press. *Health Promotion International, 15*(4), 321-332.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology-Science and Practice, 9*(1), 35-53.

De Souza, R. (2007). The construction of HIV/AIDS in Indian newspapers: A frame analysis. *Health Communication, 21*(3), 257-266.
Deacon, H. (2006). Towards a sustainable theory of health-related stigma: Lessons from the HIV/AIDS literature. *Journal of Community & Applied Social Psychology, 16*(6), 418-425. doi: 10.1002/casp.900
Devine, P. G. (2001). Implicit prejudice and stereotyping: How automatic are they? Introduction to the special section. *Journal of Personality and Social Psychology, 81*(5), 757-759.
Dijker, A. J., & Koomen, W. (2003). Extending Weiner's attribution-emotion model of stigmatization of ill persons. *Basic and Applied Social Psychology, 25*(1), 51-68.
Egger, M., May, M., Chêne, G., Phillips, A. N., Ledergerber, B., Dabis, F., . . . Sterne, J. A. C. (2002). Prognosis of HIV-1-infected patients starting highly active antiretroviral therapy: A collaborative analysis of prospective studies. *Lancet, 360*(9327), 119-129.
Entman, R. M. (1993). Framing - Toward clarification of a fractured paradigm. *Journal of Communication, 43*(4), 51-58.
Epstein, S. (1996). *Impure Science: AIDS, activism, and the politcs of knowledge*. Berkeley, Los Angeles, London: University California Press.
Galinsky, A. D., & Moskowitz, G. B. (2000). Perspective-taking: Decreasing stereotype expression, stereotype accessibility, and in-group favoritism. *Journal of Personality and Social Psychology, 78*(4), 708-724. doi: 10.1037//0022-3514.78.4.708
Gillett, J. (2004). Media activism and internet use by people with HIV/Aids. In C. Seale (Ed.), *Health and the media*. Malden, Mass., [etc.]: Blackwell Publishing.
Gilmore, N., & Somerville, M. A. (1994). Stigmatization, scapegoating and discrimination in sexually transmitted diseases: Overcoming 'them' and 'us'. *Social Science and Medicine, 39*(9), 1339-1358.
Girardi, E., Sabin, C. A., & Monforte, A. D. (2007). Late diagnosis of HIV infection: Epidemiological features, consequences and strategies to encourage earlier testing. *Journal of Acquired Immune Deficiency Syndromes, 46*(SUPPL. 1).
Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. New Jersey: Prentice Hall.
Goffman, E. (1974). *Frame analysis: an essay on the organization of experience*. New York: Harper & Row.
Hamers, F. F., & Phillips, A. N. (2008). Diagnosed and undiagnosed HIV-infected populations in Europe. *HIV Medicine, 9*(SUPPL. 2), 6-12.
Heijnders, M., & Van Der Meij, S. (2006). The fight against stigma: an overview of stigma-reduction strategies and interventions. *Psychology, health & medicine, 11*(3), 353-363.
Hennink, M., Hutter, I., & Bailey, A. (2011). *Qualitative Research Methods*. Los Angeles, London, New Delhi, Singapore, washington DC: Sage.
Herek, G. M. (1999). AIDS and stigma. *American Behavioral Scientist, 42*(7), 1106-1116.
Herek, G. M., & Capitanio, J. P. (1998). Symbolic prejudice or fear of infection? A functional analysis of AIDS-related stigma among heterosexual adults. *Basic and Applied Social Psychology 20*(3), 230-241.
Herek, G. M., Capitanio, J. P., & Widaman, K. F. (2002). HIV-related stigma and knowledge in the United States: Prevalence and trends, 1991-1999. *American Journal of Public Health, 92*(3), 371-377.
Hutchby, I. (2006). *Media talk : conversation analysis and the study of broadcasting*. Maidenhead [etc.]: Open University Presss.
Juhasz, A. (1995). *AIDS TV*. London: Duke University Press.
Kalichman, S. C., Simbayi, L. C., Jooste, S., Toefy, Y., Cain, D., Cherry, C., & Kagee, A. (2005). Development of a brief scale to measure AIDS-related stigma in South Africa. *Aids and Behavior, 9*(2), 135-143.
Kline, K. N. (2006). A decade of research on health content in the media: The focus on health challenges and sociocultural context and attendant informational and ideological problems. *Journal of Health Communication, 11*(1), 43-59.

Kunda, Z., & Oleson, K. C. (1995). Maintaining Stereotypes in the Face of Disconfirmation: Constructing Grounds for Subtyping Deviants. *Journal of Personality and Social Psychology, 68*(4), 565-580.
Leibetseder, M., Laireiter, A. R., & Köller, T. (2007). Structural analysis of the E-scale. *Personality and Individual Differences, 42*(3), 547-561.
Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363-385.
Lupton, D. (1993). Risk as moral danger: The social and political functions of risk discourse in public health. *International Journal of Health Services, 23*(3), 425-435.
Lupton, D. (1999a). Editorial: Health, illness and medicine in the media. [Editorial]. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness & Medicine, 3*, 259.
Lupton, D. (1999b). Archetypes of infection: People with HIV/AIDS in the Australian press in the mid 1990s. *Sociology of Health and Illness, 21*(1), 37-53.
Lupton, D. (2003). The end of AIDS?: AIDS reporting in the Australian press in the mid-1990s. *International Journal of Medicine, 5*(1), 58-67.
Mahajan, A. P., Sayles, J. N., Patel, V. A., Remien, R. H., Sawires, S. R., Ortiz, D. J., . . . Coates, T. J. (2008). Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward. *AIDS (London, England), 22 Suppl 2*.
Mann, J. (1987). Statement on an Informal Briefing AIDS to the 42nd session of the United Nations General Assembly. New York.
McKee, N., Bertrand, J., & Becker-Benton, A. (2004). *Strategic communication in the HIV/Aids epidemic*. London: Sage Publications.
McQuail, D. (2005). *McQuail's mass communication theory*. London: Sage.
McQuail, D. (2010). *McQuail's Mass Communication Theory* (6th ed.). London: Sage.
Morone, J. A. (1997). Enemies of the people: The moral dimension to public health. *Journal of Health Politics, Policy and Law, 22*(4), 993-1020.
Neuman, W. L. (2004). *Social research methods: Qualitative and quantitative approaches* (4th ed. ed.). Toronto: Ally and Bacon.
Ogden, J., & Nyblade, L. (2005). Common at Its Core: HIV-Related Stigma across contexts. Washington, D.C.: International Center for Research on Women (ICRW).
PANOS. (2003). Missing the message? 20 years of learning from HIV/AIDS. London: The Panos Institute.
Parker, R., & Aggleton, P. (2002). HIV/AIDS-related Stigma and Discrimination: A Conceptual Framework and an Agenda for Action. New York: Horizons Program. The Population Council Inc.
Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Social Science and Medicine, 57*(1), 13-24.
Paxton, S. (2002). The paradox of public HIV disclosure. *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV, 14*(4), 559-567.
Perse, E. M. (2001). *Media effects and society*. Mahwah, NJ [etc.]: Erlbaum.
Pettigrew, T. F., & Tropp, L. R. (2008). How does intergroup contact reduce prejudice? Meta-analytic tests of three mediatorsy. *European Journal of Social Psychology, 38*(6), 922-934.
Pittam, J., & Gallois, C. (2000). Malevolence, stigma, and social distance: Maximizing intergroup differences in HIV/AIDS discourse. *Journal of Applied Communication Research, 28*(1), 24-43.
Proctor, A., Krumeich, A., & Meershoek, A. (2011). Making a difference: The construction of ethnicity in HIV and STI epidemiological research by the Dutch National Institute for Public Health and the Environment (RIVM). *Social Science and Medicine, 72*(11), 1838-1845.
Pryor, J. B., Reeder, G. D., Yeadon, C., & Hesson-McInnis, M. (2004). A dual-process model of reactions to perceived stigma. *Journal of Personality and Social Psychology, 87*(4), 436-452.
RIVM. (2008). HIV and sexually transmitted infections in the Netherlands. An update: November 2005. Bilthoven: Rijksinstituut voor Volksgezondheid en Milieu (RIVM).
RIVM. (2010). Sexually transmitted infections, including HIV, in the Netherlands in 2009. Bilthoven: Rijksinstituut voor Volksgezondheid en Milieu (RIVM).

RIVM. (2011). Sexually transmitted infections, including HIV, in the Netherlands in 2010. Bilthoven: Rijksinstituut voor Volksgezondheid en Milieu (RIVM).
Rüsch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry, 20*(8), 529-539.
Salovey, P., Rothman, A. J., & Rodin, J. (1998). Health behaviour. In D. T. Gilbert, S. T. Fiske & G. Lindzey (Eds.), *The handbook of social psychology, 4th edition* (pp. 633-683). Boston: McGraw-Hill.
Sandfort, T. (1998). Pragmatism and Consensus: The Dutch Response to HIV. In T. Sandfort (Ed.), *The Dutch response to HIV. Pragmatism and consensus.* London: UCL Press.
Seale, C. (2004). *Health and the media*. Malden, Mass., [etc.]: Blackwell Publishing.
SHM. (2009). Report 2009: Monitoring of Human Immunodeficiency Virus (HIV) in the Netherlands. Amsterdam: HIV Monitoring Foundation.
SHM. (2010). Report 2010: Monitoring of Human Immunodeficiency Virus (HIV) in the Netherlands. Amsterdam: SHM: HIV Monitoring Foundation
Soffer, M., & Ajzenstadt, M. (2010). Stigma and otherness in the Israeli Media's mirror representations of illness. *Qualitative Health Research, 20*(8), 1033-1049.
Sontag, S. (1991). *Ilness as a metaphor & Aids and its methaphors*. Great Britain: Penguin Books.
Stutterheim, S. E., Bos, A. E. R., & Schaalma, H. P. (2008). HIV-Related Stigma in the Netherlands. The Netherlands: Aids Fonds.
Stutterheim, S. E., Pryor, J. B., Bos, A. E. R., Hoogendijk, R., Muris, P., & Schaalma, H. P. (2009). HIV-related stigma and psychological distress: The harmful effects of specific stigma manifestations in various social settings. *AIDS, 23*(17), 2353-2357.
Treichler, P. (1999). *How to have theory in an epidemic: Cultural chronicles of HIV/Aids.* Durban, NC: Duke University Press.
UNAIDS. (2005). HIV - Related Stigma, Discrimination and Human Rights Violations. Case studies of successful programmes *UNAIDS Best Practice Collection*. Geneva: Joint United Nations Programme on HIV/AIDS.
UNAIDS. (2007). Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes: a resource for national stakeholders in the HIV response. Geneva: Joint United Nations Programme on HIV/AIDS.
UNAIDS. (2010). AIDS epidemic update. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO).
Van Brakel, W. H. (2006). Measuring health-related stigma--a literature review. *Psychology, health & medicine, 11*(3), 307-334.
van de Laar, M. J., Likatavicius, G., Stengaard, A. R., & Donoghoe, M. C. (2008). HIV/AIDS surveillance in Europe: update 2007. *Euro surveillance : bulletin européen sur les maladies transmissibles = European communicable disease bulletin, 13*(50).
Van der Wardt, E. M., Taal, E., Rasker, J. J., & Wiegman, O. (1999). Media coverage of chronic diseases in the Netherlands. *Seminars in Arthritis and Rheumatism, 28*(5), 333-341. doi: 10.1016/s0049-0172(99)80018-3
Van Gorp, B. (2007). The constructionist approach to framing: Bringing culture back in. *Journal of Communication, 57*(1), 60-78. doi: 10.1111/j.1460-2466.2006.00329.x
Walgrave, S., & Van Aelst, P. (2006). The contingency of the mass media's political agenda setting power: Toward a preliminary theory. *Journal of Communication, 56*(1), 88-109.
Wallis, P., & Nerlich, B. (2005). Disease metaphors in new epidemics: The UK media framing of the 2003 SARS epidemic. *Social Science and Medicine, 60*(11), 2629-2639.
Wikipedia. (2011). List of newspapers in the Netherlands. Retrieved 10-05-11, from http://en.wikipedia.org/wiki/List_of_newspapers_in_the_Netherlands

Cited newspaper articles:

25 jaar bestrijding AIDS en SOA'S. (25 October 2010). De Telegraaf.

Aids dreigt in Haïti ramp na de ramp te worden. (23 June 2010). Reformatorisch Dagblad.

Aidsconferentie legt kloof tussen wetenschap en politiek bloot. (24 July 2010). de Volkskrant.

Andersen, R. (4 May 2010). In Syrië wordt aids bespreekbaar; Regering geeft voorlichting Vooroordelen en misverstanden nog wijd verbreid, Trouw.

Betalen voor veilige seks kan hiv voorkomen Achtergrond Aidsbestrijding in Afrika. (24 July 2010). de Volkskrant.

Coenen, T. (17 July 2010). Aids is niet op zijn retour, hiv zal juist toenemen, Trouw.

Coenen, T. (25 August 2010). Seksueel gedrag is geen zaak voor de rechter, Trouw.

Coenen, T., & van Deth, L. (26 July 2010). Aidsbestrijding is goed voor hele bevolking; Column oral, de Volkskrant.

Een impasse die zonder groei niet te doorbreken is; Terugblik op een decennium VN-millenniumdoelen voor bestrijding van armoede en honger. (28 December 2010). de Volkskrant.

Hiv neemt af onder Afrikaanse jongeren. (15 July 2010). Nrc .Next.

Irrgang, E. (20 October 2010). Mensen sterven als we bezuinigen op ontwikkelingshulp; De plannen van het nieuwe kabinet zijn dus ook niet bepaald iets om trots op te zijn, eerder iets om je voor te schamen, Nrc .Next.

Kas, A. (26 November 2010). Zonder is lekkerder, Nrc .Next.

Koole, C., & Wildschut, H. (22 May 2010). Een beetje prikken en kijken wat eruit komt; tekst Corine Koole fotografie Henk Wildschutmedisch centrum, de Volkskrant.

NONCHALANCE rond AIDS groeit. (21 December 2010). De Telegraaf.

Ros, E. (23 November 2010). Aantal gevallen van hiv stijgt fors, de Volkskrant.

Schenkel, M. (26 July 2010). Ook de aidsbestrijding kampt met crisis; Financiële krapte dwingt tot een nieuwe aanpak: vanaf nu is vooral preventie het credo, Nrc .Next.

Spectaculaire daling aids onder jongeren Afrika. (14 July 2010). De Telegraaf.

Veel nieuwe hiv -infecties onder homo s. (22 November 2010). Reformatorisch Dagblad.

Verheul, C. (9 October 2010). Groenten eten tegen aids? Onzin. Reformatorisch Dagblad.

Vos, C. (11 November 2010). Ontwikkelingshulp die wel levens redt. de Volkskrant.

Wallet, M. (1 December 2010). Aidspatiënt moet welkom zijn in kerk De dominee heeft aids, Reformatorisch Dagblad.

Appendix 1: Coding Protocol

Coding Protocol - Analysis of HIV/AIDS discourse in the Dutch press

Manifest content

A. Source [name newspaper]
B. Date [article]
C. Size [# words]
D. Focus [primary/secondary]
E. If secondary, indicate main context

Latent content

Problem definition

Seriousness/normalisation framing

F. Seriousness of HIV/AIDS
[How is it indicated? E.g. Metaphors, euphemisms, statistics?]
G. Normalisation of HIV/AIDS
[How is it indicated? E.g. Metaphors, euphemisms, statistics?]

Responsibility framing

H. HIV/AIDS as a public/societal issue
1. Domestic
2. International
3. Fund raising
4. Stigma/empathy
5. Medical/Research
6. Law and justice

I. HIV/AIDS as a group issue
[Focus on 'risk groups'? How is it indicated? E.g. Metaphors, euphemisms, statistics? Factual information? Moral judgment?]
J. HIV/AIDS as an individual issue
[Focus at the individual level? How is it indicated? E.g. Metaphors, euphemisms, statistics? Factual information? Moral judgment?]

Contagiousness framing

K. How one can get/not get HIV

Identity and characterisation frames

L. Way people are referred to [expressions]
M. Level of participation in the article [mentioned, interviewed, none]
N. Which angle?: empathic, victimising, stigamtising? How?
O. Way HIV/AIDS is referred to?