Rethinking Mass Media Campaigns against HIV and AIDS:
The Hypocrisy Paradigm

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Abstract
It is worrisome that the high level of awareness campaign against HIV and AIDS could not guarantee adequate knowledge about the virus or even change in the sexual behaviour of some people. People hardly go for voluntary HIV screening even when it is free of charge and some still engage in unsafe sex with multiple partners. Cognitive Dissonance theory suggests that information about HIV and AIDS may create dissonance in the people and as such may decide not to be exposed to such messages through selective exposure, attention and retention. Studies have attributed the seeming ineffectiveness of these messages to denials that accompany sexual behaviour. Many as such do not practice what they preach. The present study therefore suggests a paradigm shift that will remind us of this hypocritical tendencies and the consequent guilty feeling that will eventually engender the desired behavioural change.
Keywords: ***.HIV .Perception .Behavioural Change .Cognitive Dissonance .Paradigm Shift***

Introduction
HIV and AIDS have been an issue of global concern especially in Asia and Africa as millions of people have been reported killed by AIDS and the number of infected people keeps increasing. Our concern in this paper is to explore the cause(s) of the rising number of infected people in spite of the intensive and aggressive media campaign that have gulped billions of naira. Also worrisome is the fact that, the high level of awareness about the virus failed to guarantee adequate knowledge about the virus even among media practitioners who are the carriers of the anti-HIV messages. It has also been discovered that many people are yet to adopt the behavioural change messages from the media. Many are not willing to go for voluntary HIV test even when it is free and available in many 'heart to heart' centers spread across the country. More worrisome is the fact that the benefits of voluntary test outweigh the fear of stigmatization which has been pointed as one of the reasons for avoiding voluntary test.
This paper will examine some of these points with the aid of certain theories and suggest a paradigm shift in the HIV campaign effort.

HIV Pandemic: Nigeria Situation
Below is the lead of an Editorial in *Daily Sun Newspaper* of March 16, 2010.

> The fight against the Human Immune-Deficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) has recorded a major setback with the recent revelation that 70,000 babies are born with HIV in Nigeria annually.

The above is just the number of people infected through mother to child transmission which is just one of the modes of transmission. That is, different from other modes such as heterosexual intercourse, blood transfusion, homosexuals and use of infected shapes objects. The report simply proves that the number of infected persons are truly increasing even in Nigeria. According to Imasnnu (2010,p.39) Nigeria presently experience an infection rate of 1000 people per day. This was corroborate by Idoko (2010,p.39) who stated as follows:

> Between 1986 and 2005, we had an emergency, more and more people were getting infected, but we have reached a point now where technology has improved greatly that HIV/AIDS rate of infection has reduced drastically from an emergency to a

> chronic disease, but it's not yet Uhuru since we still have at least 1000 infections daily…

The HIV sero-prevalence level across the country as revealed by 2008 national survey indicate as follows:
It ranges from 1.0 percent in Ekiti State (South West) to 10.6 percent in Benue State (North Central), 17 states and the federal capital territory (FCT) were reported to have 5 percent sero prevalence; this was found to be 7 percent higher in seven states, Benue, 10.6 percent, Nassarraw 10 percent, Kaduna 7 percent, AKwa-Ibom 9.7 percent, Bayelsa 7.4 percent.

The report further showed that, the median sero-prevalence rate for the geopolitical zones varies significantly, North-Central 5-4 percent, North East 4 percent, North West 2.4 percent, South East 3.7 percent, South-South 7.0 percent, South West 2.0 percent. The FCT with a sero-prevalence of 9.9 percent is reported to be one of the worst hit in Nigeria.

The 2009 National Agency for the Control of AIDS (NACA) update shows that an estimated 2.99 million people, 1.38 million males and 1.61 million females have so far died from HIV related causes in Nigeria. While the Federal Ministry of Health in its 2008 HIV sero-prevalence sentinel survey, puts the current annual deaths rate from HIV related causes at 280,000. The 2003 survey estimate that up to 2.5 million Nigerians live with the virus and more prevalent among 20-30 years age group. The infection rate is put at 1000 people per day. It was also reported that the prevalence rate among commercial sex workers has been on the increase; 17.5 percent in 1991, 22.6 percent in 1993 and 32.6 in 2013.

The result of the periodic national HIV sero-prevalence survey obtained through sentinel survey of antenatal care attendees, showed an increase from 1.9 percent in 1991 to 5.8 percent in 1998. It declined to 5.0 percent in 2003, and to 4.4 percent in 2008.

However, based on the latest result, NACA estimate that 2.95 million people in Nigeria are presently infected, out of these number, 278,000 are children, and 1.72 million (58.3 percent) are female, young people are reported to be disproportionally infected with the prevalence in age being 5.6 percent.

The result of the mode of transmission analysis in Nigeria carried out by NACA in 2008 showed that 62 percent of new infections occur among persons perceived as practicing "low risk sex" in the general population including married sexual partners. The rest of the new infections; 38 percent are attributed to injecting drug users, female sex workers, and homosexuals; about 3.5 percent of the adult population. Heterosexual sex accounts for over 80 percent of the infections, mother to child transmission and transfusion of infected blood and blood product with each accounting for virtually ten percent of infections.

Theoretical Perspectives

Cognitive Dissonance Theory (CDT)

Cognitive Dissonance was propounded by Leon Fesringer in 1957. According to Severin and Tankard (1992,p.140) Cognitive Dissonance is the most general of all the consistency theories that has generated the largest body of empirical data and considerable controversy in the field of social psychology.

West and Turner (2010,p.113) note that, consistency theories in general posit that the mind operates as an intermediary between stimulus and responses. They explained that these theories assert that when people receive information (a stimulus) their mind organizes it into a pattern with other previously encountered stimuli. If the new stimulus does not fit the pattern, or is inconsistent then people feel discomfort.

Festinger (1957) called this feeling of imbalance; that is, lack of balance among your cognitions, or ways of knowing, beliefs, judgments, thought and so forth. Cognitive dissonance, according to Brown (1965), being psychological uncomfortable will motivate the person to try to reduce dissonance and achieve consonance and in addition to trying to reduce it, the person will actively avoid situations and information which would likely increase the dissonance.

According to Festinger, dissonance is the feeling people have when they find themselves doing things that do not fit with what they know or having opinion that do not fit with other opinions they hold.

West and Turner (2010,p.115) identified four assumptions basic to the theory to include:

- Human beings desire consistency in their beliefs, attitudes and behaviours.
- Dissonance is created by psychological inconsistencies.
- Dissonance is an aversive state that drives people to actions with measurable effects.
- Dissonance motivates efforts towards dissonance reductions.

Similarly, Aronson, Wilson and Akert (2010:185) write that social psychologists have demonstrated through a half century research that cognitive dissonance is a major motivator of human thought and behaviour.

They further identified three basic ways of reducing dissonance as follows:

- By changing our behaviour to bring out in line with the dissonant cognition.
- By attempting to justify our behaviour through changing one of dissonant cognitions.
- By attempting to justify our behaviour by adding new cognitions.

The foregoing can lead us to the following explanations. Someone that engages in unsafe sex is likely to experience dissonance if he knows and beliefs that such behaviour can lead to a painful experience of contracting HIV/AIDS if not well managed. To avoid such discomfort, the person may choose not to engage in unprotected sex or sex with multiple partners. This choice will help the person maintain balance since the behaviour is consistent with his//her knowledge that unsafe sex can expose one to HIV infection.

Others who tried but failed to practice safe sex can come up with some creative ways of rationalizing or justifying their behaviour in other to maintain balance or avoid discomfort. Some will "say something must kill somebody someday or somebody must die of something" while some may even deny the existence of the diseases by describing it as America's Idea of Discouraging Sex (AIDS) or America's Population Control Strategy.

Aronson, Wilson and AKert (2010) similarly observed that people experiencing dissonance will often deny or distort reality to reduce dissonance. They noted that researchers have shown that people who try and fail to lose weight, who refuse to practice safer sex, or who receive bad news about their general health can be equally creative in denying risk and reducing their discomfort. They noted that occasionally this illusion can be helpful with the research findings of Shelley Taylor and Colleagues who demonstrated that individuals who harbor unrealistic positive illusions about surviving a terminal illness like AIDS live longer than those who are more "realistic".

West and Turner (2010) further note that cognitive dissonance relates to the process of selective exposure, selective attention, selective interpretation and selective retention because the theory predicts that people will avoid information that increases dissonance. In other words, where information about HIV creates dissonance the audience may avoid it to reduce dissonance. For instance, where they believe that HIV is a punishment from God and that there is nothing that could be done about it, they are left with no option.

In the same vein, Baran (2002,p.380) writes that, we consciously and subconsciously work to limit or reduce dissonance or discomfort through three interrelated selective processes. He explained that, these processes help us to 'select' what information we consume, remember and interpret in personally important and idiosyncratic ways.

***Selective Exposure*:** Cognitive dissonance theory predicts that people avoid information that increases dissonance seek out information that is consistent with their attitude and behaviour. To Baran (2002), people only expose themselves to or attend to those messages consistent with their pre-existing attitudes ad beliefs. HIV message may create dissonance for someone that wants to have the real 'thing' and decides not to use condom or go for voluntary test to know his status. He/she may decide to avoid such messages to avoid discomfort.

Selective Attention: People attend to information in their environment that conforms to their attitudes and beliefs while ignoring information that is inconsistent. If one believes that HIV

and AIDS are not real or that the message is inconsistent with any held belief or attitude, attention will not be paid to such message.

Selective Retention: People remember best and longest those messages that are consistence with their pre-existing attitudes and beliefs (Baran 2002,p.380). People remember and learn consistent information with much greater ability than inconsistent information (West and Turner, 2010,p.119). In other words, where there is dissonance, the message may not be remembered neither will the expected knowledge be acquired as learning may not take place. In this situation, awareness may be created but will not be retained.

Health Belief Model (HBM)

This is another model employed to explain the phenomenon involved in this study. The Health Belief Model (HBM) was developed in the 1950s by a group of US Public Health Service social psychologists. They investigated why few people took part in disease prevention and detection programme even when the service was without charge and in a different convenient location. The model received further insight through the work of researchers who concluded that six main construct influence people's decisions about whether to take action to prevent screen for, and control illness. The six constructs are perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cue to action and self efficiency. It is the position of this theory that people's belief influences their health behaviour. In other words, people will act under the following conditions in line with the six constructs as follows:

***Perceived Susceptibility*:** This implies that people will act if they believe they are vulnerable to a condition. For instance, people will go for voluntary HIV test if they believe they are vulnerable. They will not engage in unsafe sex or keep multiple sex partners if they believe, they are vulnerable. The question here is, why do people who know and believe they are vulnerable still engage in behaviours that will expose them to the virus? Also, there are people who know about voluntary HIV test and the advantage of early detection of infection yet they fail to go for voluntary test.

Perceived Severity: The model posits that people will act if they believe that the consequence of not acting is serious or severe. The question here again is why do people fail to go for voluntary test and engage in unsafe sex even when they are aware and believe that the consequences of contracting HIV is very serious especially the social stigma.

Perceived Benefits: Here, it is believed that people will act if they believe that taking the required action will reduce the chances of getting a particular illness or diseases or reduce the consequences or effect of the illness. Many people know the benefit of knowing their HIV status yet they do not go for the test.

Perceived Barriers: People will act if they believe that the benefit of taking action outweighs the cost. For instance, the cost of voluntary test such as stigmatization if positive and made public, outweighs the cost of dying of full blown AIDS.

Cue to Action: People will act if they are exposed to factors that prompt action (media message serve as reminders to take appropriate action). Media messages promote voluntary test and the use of condom and faithfulness to partners, yet some people do not take action.

Self-Efficacy: People will act if they believe that they can perform the desired task or take the desire action. It emphasizes a person's confidence in his/her ability to adopt health behaviours.

HIV Pandemic: Awareness, Knowledge versus Behaviour

There exists a wide gap between knowing and doing in the fight against HIV and AIDS. It has also been shown that awareness does not imply knowledge. Inadequate knowledge of the virus has been found to be responsible for its continued spread in spite of the high level of awareness.

According to Okoye (2001,p.42) HIV is feeding fat on lack of knowledge. Knowledge he noted requires a deeper understanding of the phenomenon rather than mere awareness of the existence of the virus. McQuail (2000,p.419) expressed similar view thus "information acquisition could occur without related attitude change, and attitude change without behaviour change. Thus Okoye observes that low level of knowledge of the causes and preventive measures in spite of the high level of awareness about HIV and AIDS in sub

Saharan Africa. He noted that there is very little behaviour change, hence the rapid spread of the pandemic.

Cases abound to illustrate ignorance about HIV and AIDS in our society even among media experts who are the carriers of the anti HIV message. Imoh (2007,p.407) conducted a study in ten Nigerian cities among the youth between ages 12-29 which indicated that 83 percent of the respondents have heard about HIV and AIDS through radio, television and newspaper in ranking order. However, 94.8 percent did not know the meaning of AIDS while 62 percent did not believe that AIDS exist in Nigeria. More than half of them (54.6 percent) did not feel vulnerable to HIV infection. She further identified poverty, ignorance difficulty in maintaining a regular sex partner, proper and consistent use of condom and feelings of personal invulnerability as major constraints to compliance with HIV and AIDS preventing messages.

In a related finding, Omenugha and Ekwugha (2008,p.436) discovered that out of 160 respondents, 109 representing 68 percent believe that HIV and AIDS are the same while 51 representing 32 percent said no. The study also indicates that the respondents were not well informed about the stages of HIV which ranges from:

- Period of infection
- Incubation/window period
- Maturity period and its opportunistic infection to the
- Full blown AIDS.

They also discovered that 45 percent and 21 percent respondents did not know that HIV and AIDS cannot be transmitted through handshake and embracing respectively. This they rightly noted must have contributed to different forms of stigmatization against people living with HIV and AIDS in Awka South Local Government Area.

Some of the respondents in the study, about 22 percent, still believe they can recognize a HIV infected person by merely looking at him/her while 19 percent think HIV can be cured. Studies have also shown that, people who have little knowledge or are misinformed about HIV transmission are more likely to hold discriminatory attitudes than those who are well informed.

Oji (2008,p.253) also reported that people are yet to apply the knowledge of the disease in their personal lives. This was corroborated by the report of Communication for Development Round Table Report (2001,p.25) as follows:

> Surveys shown that well over 90 percent of people in the worst affected countries are aware of the disease. However, more often than not, that awareness is limited, does not include accurate knowledge or development of the skills needed to protect oneself and has not resulted in reduced HIV transmission.

From the forgoing, analysis, it is clear that a wide gap exist between awareness of the diseases and correct knowledge of the disease. There also exist a gap between knowledge and willingness to take positive action to prevent the disease or action aimed at checking the growth of the virus in the body through early detection of the virus.

Mass Media: Stigmatization and Voluntary HIV Test

The mass media have been accused of over bloating AIDS messages thereby creating fear in the people both of the disease, stigmatization and knowing ones status through voluntary HIV test. For instance, Mogu (2008,p.35) notes that, with the alarming media reports and escalating figures about AIDS, the mass media created fear for themselves, health care recipients and the entire society. Adegboye (2009,p.39) has this to say about media report on HIV and AIDS:

> When I open newspapers, switch on the television or radio, and read, see or hear stories on HIV and AIDS, I marvel at the barrage of inappropriate, fear-inducing and stigmatizing languages used by reporters, editors, presenters, producers and those who should have equipped themselves with new and better knowledge. And these the reading and viewing public are daily inundated with, making them to become perniciously fearful and disgustingly discriminatory of people LIVING WITH HIV'….

The above captures the nature of media report with respect to HIV and AIDS treatment. This will further be illustrated with empirical studies. However, we can deduce a hypothesis that the media encourages stigmatization through inappropriate use of language. This may not be deliberate but related to inadequate knowledge of the disease. However, it is unfortunate since the media are the carrier of the anti HIV campaign. The fear induced by the media with the consequent stigmatization, no doubt, makes voluntary test difficult. This fear and show of ignorance can also affect reader's interest depending on the reader's background. While it will discourage the knowledgeable as an insult on his/her intelligence, it will induce fear in the not-so-knowledgeable.

According to Imasunu (2010,p.39) HIV/AIDS related stigma and discrimination also contribute to the continuing spread of the infection as the stigma associated with HIV/AIDS does not allow Nigerians to come out and have a voluntary test. Mogu (2008,p.35) further noted that, the mass media selective reinforcement, selective focus, emphasis and agenda setting has forced society to degenerate, even creating cautious situations which in turn have become devastating.

Similarly Kayode et al (2008,p.226) noted that wide spread stigmatization is not unconnected with factors such as lack of knowledge about how the disease is contracted and spread, lack of adequate treatment and the fact that it is still incurable, ineffective policy and legislation against stigmatization and perhaps media reporting. It is more likely that well informed people will understand better and at least learn from others who are HIV positive since they know the various modes of transmission and can avoid it.

Kayoed et al (2008,p.230) explained that a story is considered stigmatization when terms like "AIDS victims", "Killer Disease", "AIDS scourge", "Patient" or "carrier" are used to describe those living with the virus rather than persons living with HIV or infected person. The use of such terms as 'victims' they noted is subjective and judgmental.

Adegboye (2009,p.39) worried about the language of the media as expressed above threw further light on HIV and AIDS as follows:

> While HIV is a virus that compromises the body's immune system, AIDS is a medical condition that arises from untreated or ill-managed HIV status. AIDS is not a disease as being peddled by most, but a pot pourru (combination) of opportunistic infections or diseases arising from a weakened immune system'.

He further pointed out that, HIV does not attract any illness or death; people, however die from AIDS related instance. According to him, HIV does not have symptoms but AIDS does. And going for HIV screening (HCT) is the only way of knowing his or her status, so that one can live a healthy life with HIV and not necessarily gravitate towards AIDS. He further explained that, the current trend and language is therefore to separate HIV and AIDS by referring to the or addressing them as HIV/AIDS.

From the above enlightenment, most people will sincerely confess to have adopted improper language, attitude and behaviour toward PLWH for lack of knowledge resulting from inappropriate use of language by the media.

The study carried out by Kayode et al also reveal that most stories on HIV/AIDS in the two papers studied are lacking in analysis and back grounding and merely focus on the pronouncements of government officials, as well as those of key figures of NGO's rather that on issues. They observed that most of such stories or event are based on press statements and events without critical attempts to link such statements or events to long-term issues that is, most of the stories lack balance.

The above development cannot make for proper and in-depth understanding of the issues surrounding HIV and AIDS infection and spread. This may also be attributed to inadequate knowledge on the part of media practitioners or shallow sense of social responsibility.

Conclusion

HIV infection has continued to rise in spite of the media campaign against it. This is attributed to inadequate knowledge about the disease, although the awareness level is high. Inadequate knowledge about the disease is also reflected in the inappropriate language used in the media

and the attendant stigmatization. While some feel invulnerable, many are unwilling to go for voluntary test as a result of the fear of stigmatization.

It is also clear from the analysis so far that many do not practice what they preach in terms of the preventive measures such as engaging in safe sex, not stigmatizing against people living with the virus and knowing ones status. We deny engaging in some of this inappropriate behaviour, we preach against.

As noted in the analysis of the Health Belief Model (HBM), the present situation with respect to the fight against HIV and AIDS puts a big question mark on the efficacy of the model in explaining the attitude of the people towards adopting appropriate behaviour.

However, cognitive dissonance theory suggests that some people may decide to avoid ant-HIV messages if it conflicts with their pre-existing attitudes or beliefs. People may also adopt a particular behavioural pattern to reduce dissonance. For instance, a partner may interpret the use of condom as lack of trust or promiscuity and to reduce this discomfort may engage in unsafe sex in other to douse the fear of mistrust or unfaithfulness.

Some still publicly claim invulnerable to the disease because they pretend not to engage in unsafe sex. Assuming the feeling is real, there are other means of transmission. People living with the virus are often seen as sinners who suffer for their sins or serving a deserved punishment from God and should be avoided.

There are a lot of hypocritical behaviour towards the HIV campaign both in the mass media and in interpersonal communication. Many do not practice what they preach. How many can sincerely embrace a person living with HIV without fear of contracting the infection. But this we must learn to live with since the situation is real.

Research has consistently shown that sexual behaviour is often accompanied by denial (Aronson et al, 2010,p.194). That is, we believe that, although the disease affects most people we cannot be affected or are not at risk. Many will not go for voluntary test as a result.

Recommendations

In view of the foregoing, a case is being made for the adoption of the hypocrisy paradigm in the campaign against HIV infection especially with respect to safe sex, stigmatization and voluntary HIV test.

The hypocrisy paradigm involves the arousal of dissonance by having individual make statements that run counter to their behaviour and then reminding them of the inconsistency between what they advocated and their behaviour (Aronson et al. 2010,p.195). This could be likened to the biblical experience of casting the first stone, where people that condemned a woman for adultery were asked to cast the first stone if they were not guilty of the same sin. They all disappeared. In other words, in the anti-HIV campaign we need to be reminded that we do not practice what we preach. This will create dissonance in us. In order to reduce this dissonance, we will behave more responsibly with the induction of hypocrisy.

Some stigmatize, yet we preach against stigmatization. Some are not faithful to their partners and even engage in unsafe sex, yet we claim to be 'righteous' and invulnerable just like in the parable of the Pharisees and the Publican.

This paradigm which was worked elsewhere in checking certain social problems like road rage and smoking should be empirically tested in Nigeria. Empirical studies should be carried out based on the cognitive dissonance theory to find out whether there are people that avoid anti-HIV messages and why. There is a need to know whether people actually expose themselves to anti-HIV message and whether such messages are learnt and retained. How do they interpret such messages?

For instance, we need to find out whether people that engage in unsafe sex experience dissonance whenever they are exposed to anti-HIV messages such as voluntary test and practice of safe sex and as a result avoid such messages to reduce dissonance. Media practitioners and other change agents should make conscious effort to equip themselves with proper knowledge of HIV infection.

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