



# Public image and governance of epidemics: Comparing HIV/AIDS and SARS

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## Abstract

A comparative analysis of the 2002–2003 infectious disease outbreak, severe acute respiratory syndrome (SARS), and the HIV/AIDS epidemic that has affected the world over the past two decades reveals the significant role of socio-cultural beliefs and attitudes in the shaping of people's lifestyles and approaches to the control and prevention of epidemics. The main research question is: what can we learn from the SARS experience about effective prevention of HIV/AIDS? The sources of data include population figures on the development of these epidemics and findings from two sociological studies of representative samples of Singapore's multi-ethnic population. The comparative study illustrates the impact of cultural beliefs and attitudes in shaping the public image of these two different infectious diseases; the relevance of public image of the disease for effective prevention and control of epidemics.

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## 1. Overview of the situation

Traditionally, the human suffering inflicted by long-term epidemics have tended to find expression in literature and the fine arts thus becoming a visible part of the collective memory and shaping the public image of the disease. For example, the impact of the bubonic and pneumonic plague or “Black Death” had a major influence on painters of the Gothic Period [1]; tuberculosis is featured in Eugene G. O'Neill's *Long Day's Journey into Night*; Franz Kafka's *Diaries*; Thomas Mann's *The Magic Mountain* [2]; Victor Hugo's *Les Misérables*; Dickens' *Nicholas Nickleby*, Brontë's *Wuthering Heights*; Verdi's *La Traviata* [3]. Among

epidemics in the past three decades (HIV/AIDS, SARS, mad cow disease, and avian flu among others), only HIV/AIDS has lasted long enough to inspire artistic expressions in literature [4–7], theatre [8], dance [9], and film [10] mostly used as vehicles for HIV/AIDS preventive education programs particularly in Africa [8–12].

One of the pioneer studies in prevention was published in 1939 by Zinsser [13]. Ever since, a community of experts worldwide has been dedicated to prevention [14–20]. However, despite the struggle to convey a more accurate and humane public image of AIDS in the past decade, the stigma attached to HIV/AIDS still persists as a formidable obstacle to prevention efforts [21–23]. Figures on the spread of the disease suggest we are losing the battle against HIV/AIDS

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especially in developing countries [3,24–27]. In China alone, the estimated number of deaths due to AIDS as of December 2003 (latest figures available), ranged from 21,000 to 75,000 and 840,000 persons infected with HIV/AIDS. The figures for Thailand, the second most affected East Asian country, are 34,000–97,000 deaths, and 570,000 persons infected with HIV (Appendix A, Table A.1).

In contrast to the dismal HIV/AIDS situation, the 2002–2003 outbreak of severe asymptomatic respiratory syndrome or SARS, offers a completely different picture for the analysis of preventive efforts. Although SARS, like HIV/AIDS, was unknown in the medical world and hit unexpectedly, there are some significant differences, particularly in their etiology, epidemiology, natural history and clinical outcomes of the two diseases. HIV/AIDS is asymptomatic for 7–10 years after infection so that HIV-positive persons may continue to spread the disease unknowingly. The main mode of HIV/AIDS transmission is through direct contact with infected body fluids or blood (sexual intercourse, use of infected needles by drug users and receiving contaminated blood transfusions). SARS is caused by the SARS coronavirus and characterized by airborne transmission. SARS develops very rapidly, with an average incubation period of 5 days or a range of 2–10 days after contact. Within 1 week of the illness patients show typical influenza-like symptoms such as fever, malaise, and headache with cough and diarrhoea getting worst in the second week of infection. It has been determined that “transmission occurs mainly during the second week of illness”. These external signs facilitate prompt action: exposed patients may be placed under fever surveillance twice a day “in an isolation facility or ward for at least 10 days after the last exposure to the source case(s)” [28]. In the span of 9 months SARS infected 8096 persons, caused 774 deaths (Appendix A, Table A.2) and became a widespread visible threat through the serious disruption of normal daily activities of individuals and major sectors of the economy such as transportation, commerce, industrial production, and tourism [28–30]. The first probable SARS case was reported in China on 16 November 2002 and the infection spread to 28 other countries around the world but the largest number of locally transmitted infections and deaths were reported in China, Hong Kong, Taiwan, Canada, and Singapore (Appendix A, Table A.2). Despite the fact that SARS caught the world

unprepared, hit at great speed, and it is very difficult to eradicate [31], the outbreak was contained within 9 months, a relatively brief period of time (Appendix A, Table A.2).

Despite the *medical* differences (in etiology, epidemiology, natural development and clinical outcomes) between these two epidemics, I argue and attempt to demonstrate in this study that we may advance our knowledge on preventive strategies by conducting a systematic comparison of important *social* aspects of HIV/AIDS and SARS.

## 2. Relevant concepts

What can we learn from the SARS experience about effective prevention of HIV/AIDS? More specifically, why were the efforts to contain and prevent the spread of a new epidemic like SARS successful while it has taken 25 years so far to contain the spread of HIV/AIDS and no effective solution is yet in sight? Social science research has identified over the past decades a complex array of factors and conditions associated with disease prevention in individuals (micro-level analysis) as well as collectivities (macro-level analysis) but the factors and conditions vary for different diseases and there may be many other factors yet to be identified. Still, contrasting the two epidemics in terms of social attitudes and beliefs at the micro-and macro-levels, will help us to elucidate some of the major obstacles to HIV/AIDS prevention. Therefore, this paper focuses on only three possible factors: the impact of perceived severity and susceptibility to infection and the public image of the epidemic (micro-level factors); and the governance of epidemics (macro-level factor).

Sociology and social psychology offer some interesting explanations of the sluggishness of preventive health behavior in individuals [32,33]. Among ten theories identified as the “most often used” today [34], the top two explanatory models are the Social Cognitive Theory (SCT) and the Health Belief Model (HBM) [34,35]. Both social theories are useful in the analysis of preventive action: they focus on the individual’s capacity to make his/her own decisions, and the recognition that there are multiple and varied factors involved in a person’s health-related actions. The SCT explains people’s health-related actions primarily in terms of their

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